Liverpool Women's
NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

Board of Directors Meeting

HELD ELECTRONICALLY

2 APRIL 2020

Meeting of the Board of Directors
HELD ELECTRONICALLY
Thursday 2 April 2020 at 1000hrs
VIRTUAL MEETING

Item no. 2020/ 21/	Title of item	Objectives/desired outcome	Process	Item presenter	Time
001	Thank you	To provide personal and Team thank you – above and beyond	Verbal		1000 (10mins)
002	Apologies for absence Declarations of interest	Receive apologies	Verbal	Chair	
003	Meeting guidance notes	To receive the meeting attendees' guidance notes	Written	Chair	
004	Minutes of the previous meeting held on 6 February 2020	Confirm as an accurate record the minutes of the previous meetings	Written	Chair	1010 (5 mins)
005	Action Log and matters arising	Provide an update in respect of on-going and outstanding items to ensure progress	Written	Chair	
006	Chair's announcements	Announce items of significance not found elsewhere on the agenda	Verbal	Chair	1015 (5 mins)
007	Chief Executive Report	Report key developments and announce items of significance not found elsewhere on the agenda	Written	Chief Executive	1020 (5 mins)
BOARD COMMITTEE ASSURANCE					
008	Chair's Reports & Terms of reference from Quality Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	1025 (5 mins)
009	Chair's Reports & Terms of reference from Finance, Performance and Business Development Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	1030 (5 mins)
010	Chair's Report & Terms of reference from Audit Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	1035 (5 mins)
TO DEVELOP A WELL LED, CAPABLE AND MOTIVATED WORKFORCE; TO DELIVER SAFE SERVICES; TO DELIVER THE BEST POSSIBLE EXPERIENCE FOR OUR PATIENTS AND OUR STAFF					
011	Covid-19 – Trust response and preparations	For assurance	Written	Director of Operations	1040 (30 mins)
012	Safer Nurse/Midwife Staffing Monthly Report	For assurance and to note any escalated risks	Written	Director of Nursing and Midwifery	1110 (10 mins)
TRUST PERFORMANCE - TO DELIVER THE MOST EFFECTIVE OUTCOMES; TO BE EFFICIENT AND MAKE BEST USE OF AVAILABLE RESOURCES					
013	2020/21 Operational Plan and Budget Update	For Assurance	Verbal	Director of Finance	1120 (5 mins)
014	Operational Performance Report period M11, 2019/20	For assurance –To note the latest performance measures	Written	Director of Operations	1125 (10 mins)

Item no. 2020/	Title of item	Objectives/desired outcome	Process	Item presenter	Time
015	Finance Report period M11, 2019/20	For assurance - To note the current status of the Trusts financial position	Written	Director of Finance	1135 (5 mins)
BREAK					
BOARD GOVERNANCE					
016	Well-Led Framework Self-Assessment	For approval	Written	Trust Secretary	1140 (10 mins)
017	Risk Management Strategy	For approval	Written	Director of Nursing & Midwifery	1150 (5 mins)
018	Board Assurance Framework – Review of 2019-20	For assurance and approval	Written	Trust Secretary / Executive Leads	1155 (5 mins)
019	Proposed Risk Appetite Statement 2020-21	For approval	Written	Director of Nursing & Midwifery	1200 (5 mins)
020	Trust Board Terms of Reference	For discussion	Written	Trust Secretary	1205 (5 mins)
021	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair	1210 (5mins)
CONSENT AGENDA (all items 'to note' unless stated otherwise) *All these items have been read by Board members and the minutes will reflect recommendations, unless an item has been requested to come off the consent agenda for debate; in this instance, any such items will be made clear at the start of the meeting.*					
	No items on the consent agenda				
HOUSEKEEPING					
022	Any other business & Review of meeting	Consider any urgent items of other business	Verbal	Chair	1215

Date of next meeting

Board (held virtually): 7 May 2020

1220-1230	*Questions raised by members of the public submitted in advance of the meeting.*	To respond to members of the public on matters of clarification and understanding.	Verbal	Chair

Meeting to end at 1230

Liverpool Women's

Meeting attendees' guidance using Microsoft Teams

Under the direction and guidance of the Chair, all members are responsible for ensuring that the meeting achieves its duties and runs effectively and smoothly.

Before the meeting

- Prepare for the meeting in good time by reviewing all reports
- Submit any reports scheduled for consideration at least 8 days before the meeting to the meeting administrator
- Ensure your apologies are sent if you are unable to attend and *arrange for a suitable deputy to attend in your absence
- Notify the Chair in advance of the meeting if you wish to raise a matter of any other business

*some members may send a nominated representative who is sufficiently senior and has the authority to make decisions. Refer to the terms of reference for the committee/subcommittee to check whether or not this is allowable

Microsoft Teams

- Arrive in good time to set up your laptop/tablet for the virtual meeting
- Switch mobile phone to silent
- Find the appointment and open
    - If you have been sent the appointment as a diary invite click on Calendar on the left hand column. Open appointment and click join.
      Alternatively click on the link within the emailed diary appointment 'Join Microsoft teams'
    - If you have been asked to join an **existing** TEAM then please open Microsoft Teams, Click on Teams on the left hand column. Click on the relevant team you want to open, then click on Meet Now.
- Four screens (participants) can be viewed at one time. Those speaking will be viewable automatically.
- Click Show Participants to see who has joined the call as only 4 screens can be viewed at one time.
- Mute your screen unless you need to speak to prevent background noise
    - Only the Chair and the person(s) presenting the paper should be unmuted
    - Remember to unmute when you wish to speak
- Show conversation: open this at start of the meeting.
    - This function should be used to communicate with the Chair and flag if you wish to make comment
- Open files within Microsoft teams
    - Within your team, click on Files – top of the page.
- Use headphones if preferred
- Camera on option
- Screen sharing
    - If you wish to share a live document from your desktop click on share and identify which open document you would like others to view
- Use multi electronic devices to support teams.
    - You might find using both mobile and laptops is useful. One for Microsoft teams and one for viewing papers

At the meeting

- Focus on the meeting at hand and not the next activity
- Actively and constructively participate in the discussions
- Think about what you want to say before you speak; explain your ideas clearly and concisely and summarise if necessary
- Make sure your contributions are relevant and appropriate
- Respect the contributions of other members of the group and do not speak across others
- Ensure you understand the decisions, actions, ideas and issues agreed and to whom responsibility for them is allocated
- Do not use the meeting to highlight issues that are not on the agenda that you have not briefed the chair as AoB prior to the meeting
- Re-group promptly after any breaks
- Take account of the Chair's health, safety and fire announcements (fire exits, fire alarm testing, etc)
- Consent agenda items, taken as read by members and the minutes will reflect recommendations from the paper. Comments can still be made on the papers if required.

Attendance

- Members are expected to attend at least 75% of all meetings held each year

After the meeting

- Follow up on actions as soon as practicably possible
- Inform colleagues appropriately of the issues discussed

Standards & Obligations

1. All documentation will be prepared using the standard Trust templates. A named person will oversee the administrative arrangements for each meeting
2. Agenda and reports will be issued 7 days before the meeting
3. An action schedule will be prepared and circulated to all members 5 days after the meeting
4. The draft minutes will be available at the next meeting
5. Chair and members are also responsible for the committee/ subcommittee's compliance with relevant legislation and Trust policies
6. It is essential that meetings are chaired with an open and engaging ethos, where challenge is respectful but welcomed
7. Where consensus on key decisions and actions cannot be reached this should be noted in the minutes, indicating clearly the positions of members agreeing and disagreeing – the minute should be sufficiently recorded for audit purposes should there need to be a requirement to review the minutes at any point in the future, thereby safeguarding organisational memory of key decisions
8. Committee members have a collective duty of candour to be open and honest both in their discussions and contributions and in proactively at the start of any meeting declaring any known or perceived conflicts of interest to the chair of the committee
9. Where a member of the committee perceives another member of the committee to have a conflict of interest, this should be discussed with the chair prior to the meeting
10. Where a member of the committee perceives that the chair of the committee has a conflict of interest this should be discussed with the Trust Board Secretary
11. Where a member(s) of a committee has repeatedly raised a concern via AoB and subsequently as an agenda item, but without their concerns being adequately addressed the member(s) should give consideration to employing the Whistle Blowing Policy
12. Where a member(s) of a committee has exhausted all possible routes to resolve their concerns consideration should be given (which is included in the Whistle Blowing Policy) to contact the Senior Independent Director to discuss any high level residual concerns. Given the authority of the SID it would be inappropriate to escalate a non risk assessed issue or a risk assessed issue with a score of less than 15
13. Towards the end of the meeting, agendas should carry a standing item that requires members to collectively identify new risks to the organisation – it is the responsibility of the chair of the committee to ensure, follow agreement from the committee members, these risks are documented on the relevant risk register and scored appropriately

Speak well of NHS services and the organisation you work for and speak up when you have Concerns

Page 129 Handbook to the NHS Constitution 26th March 2013

Liverpool Women's NHS Foundation Trust

Board of Directors

Minutes of the meeting of the Board of Directors
held in public at 9.30am on 6 February 2020
at Liverpool Women's NHS Foundation Trust, Crown Street Liverpool.

PRESENT

Mr Robert Clarke	Chair
Mrs Kathryn Thomson	Chief Executive
Mrs Michelle Turner	Director of Workforce & Marketing
Mrs Jenny Hannon	Director of Finance
Dr Andrew Loughney	Medical Director & Deputy Chief Executive
Mrs Caron Lappin	Director of Nursing & Midwifery
Mr Gary Price	Director of Operations
Mr Phil Huggon	Non-Executive Director
Mr Tony Okotie	Non-Executive Director/SID
Dr Susan Milner	Non-Executive Director
Mr Ian Knight	Non-Executive Director
Ms Jo Moore	Non-Executive Director

IN ATTENDANCE

Mr Paul Buckingham	Interim Trust Secretary
Dr V McKay	Consultant
Ms Cheryl Mould	Programme Director, Liverpool Provider Alliance
Mr Robert McGough	Hill Dickinson LLP

APOLOGIES:

Mrs Tracy Ellery	Non-Executive Director
Prof Louise Kenny	Non-Executive Director

2019/20/231	
	Thank You **Holly Ellis, Genetic Scientist -** The Chief Executive thanked Ms Ellis for her commitment during her time in the Genetic Laboratories and for representing the Trust and her profession so successfully as the 'Scouse Scientist' in encouraging women and girls to pursue careers in the science professions. The Chief Executive noted that Ms Ellis delivered an important message in encouraging scientists of the future and was a great advocate for her profession. **Anne Bridson, Samantha Willis, Tom Poole, Telaid Alaw and Abigail Larkin** – The Director of Workforce & Marketing advised that these individuals had represented the Trust at a Careers Open Day at the Archbishop Beck College which was attended by over 700 pupils. She thanked the team for proudly representing their host departments, the Trust generally and for their enthusiasm in representing their respective professions. **Jacqui Matthews, League of Friends** – The Director of Operations thanked Mrs Matthews, along with her colleagues Ms M Matthews and Ms C Lawrence for their hard work and efforts in putting up a fabulous set of Christmas decorations throughout the hospital. He noted that approximately 70 hours had been spent in putting up decorations to make the hospital feel festive for patients, visitors and

	staff. The Director of Operations noted that Ms M Matthews and Ms C Lawrence had taken annual leave to support Mrs J Matthews in this mammoth task. The Director of Workforce & Marketing then briefed the Board on Mrs J Matthews work on behalf of the Trust as a volunteer for almost 39 years and advised that her efforts had resulted in her nomination as Volunteer of the Month for December 2019. Three members of staff from various departments then briefed the Board on the qualities displayed by Mrs Matthews which had resulted in their nominations. The Director of Workforce & Marketing then presented Mrs Matthews with her award. Pauline McBurnie, Sarah Martin, Marie Kelleher: The Honeysuckle Team – The Director of Nursing & Midwifery thanked the team for their commitment and dedication in organising the annual Remembrance Service in October 2019. She noted an increased workload, with two services being held for different audiences, and advised that the team had worked diligently to deliver what were positive although emotional services. Board members collectively thanked all the members of staff for their contributions to the work of the Trust.
232	Apologies – as above Declaration of Interests – The Director of Finance advised the Board of her interest as a trustee of Person Shaped Support in relation to the agenda item on the Liverpool Provider Alliance.
233	Meeting guidance notes The Board received the meeting attendees' guidance notes.
235	Patient Story Dr V McKay, Consultant, joined the meeting to present Shaun's story and noted that Shaun's family had been supportive of her sharing Shaun's experience with the Board. She explained that, at the age of 10, Shaun had experienced a cardiac arrest in the school playground. While Shaun recovered, the reason for his cardiac arrest had not been immediately clear but, after some specialist testing a possible diagnosis of the rare genetic heart condition Brugada Syndrome was given. Shaun was referred to a Consultant Geneticist with special expertise in paediatric inherited heart conditions. Further testing was requested non-urgently but, prior to receiving the test results, Shaun suffered a further cardiac arrest. Unfortunately, Shaun is now a permanent inpatient at Alder Hey Hospital with a tracheostomy, a PEG feeding tube and needs 24-hour care. Dr V McKay suggested that, while the outcome may have been the same, closer working amongst clinicians to share clinical information and expertise may have made a small improvement to the clinical scenario. She advised that prevalence data suggested the potential that 3,000 children could be affected in the North West and provided the Board with an overview of the Trust's developments in this area. She noted that the Trust was currently the only centre outside London which was undertaking this work and advised of changes made as a result of lessons learned from Shaun's case which included quarterly paediatric inherited heart disease MDT meetings and technology-led communication for urgent cases. The Chair thanked Dr V McKay for delivering Shaun's story and for her dedication to work on paediatric inherited heart disease. The Chief Executive advised that she and her Executive colleagues would like to learn more about work currently being undertaken and future plans and invited Dr V McKay to an Executive Team meeting to provide a briefing on the subject. She noted that the Executive Team would consider how the work could be supported from a resource perspective. The Medical Director commented on the inherent link between genetic testing and delivery of services

	and noted the importance of effective interaction between clinicians across separate organisations and locations. In response to a question from Mr P Huggon, regarding links with other organisations such as Manchester University Hospitals NHS Foundation Trust, the Medical Director noted work to build alliances through partnership board arrangements for laboratories. The Director of Finance also commented on the potential for developments to be informed by data from the 100,000 genomes programme. The Chair again thanked Dr V McKay for sharing Shaun's story with the Board. *Dr V McKay remained in the Boardroom to observe the remainder of the meeting.* *Ms C Mould and Mr R McGough joined the meeting.*
234	Liverpool Provider Alliance Agreement The Chief Executive introduced the agenda item and emphasised the importance of working across and between organisations in developing effective services in the city of Liverpool and beyond. She advised that she was seeking Board approval for a Provider Alliance Agreement which sets out the structure to facilitate system decision-making for the transformation and better integration of health and care services in Liverpool. Mr R McGough briefed the Board on the content of the draft Alliance Agreement and noted the number and range of participating organisations. He advised of the aim to avoid overly complex arrangements and noted that the Alliance Agreement was based on a simple governance system with a two-tier structure comprised of a Strategic Oversight Group and a Strategic Delivery Group. He then provided an overview of the role of each of these Groups. Mr R McGough advised that a consensus-based decision-making model would be adopted and noted that the Alliance Agreement would not replace existing service contracts and would not increase liability of individual organisations. Ms C Mould advised that there would be a focus for progress on specific services and noted that the initial range of services had been agreed at a recent Liverpool Provider Alliance meeting. She also noted that each service workstream would be led by a Chief Executive in the role of Senior Responsible Officer (SRO). Dr S Milner noted comments made by Mr R McGough, regarding use of data from Liverpool City Council, and noted patient flow from outside this specific area. She also commented on the likely interest of other local authorities from a reporting perspective. Mr R McGough acknowledged these comments and advised that the Liverpool Provider Alliance developments would not force participating organisations to pursue initiatives which could be to the detriment of patients living outside the city. In response to a question from the Interim Trust Secretary, Ms C Mould provided an overview of engagement with other parties to the agreement and advised that no formal objections to the Alliance Agreement had been raised. She noted that the Alliance Agreement had been formally endorsed by 50% of the participating organisations to date. In response to a question from Mr P Huggon, regarding specific requirements for the Trust, Ms C Mould advised that she was scheduled to meet with Mrs K Thomson to discuss the Trust's level of involvement in delivery plans. Mrs K Thomson noted that the Trust's services and the sustainability of women's services across the city formed a key part of the One Liverpool plan. The Chair commented on the importance of a single plan for the city which transcended the needs of individual organisations. In response to a question from Mr I Knight, who queried whether the alliance arrangements were unique, Mr R McGough advised that there were a number of existing alliance arrangements across the NHS and noted regulatory and commissioner support for collaborative working between

	organisations without creating new or artificial boundaries. He also provided an overview of the commissioner perspective in relation to resource allocation. The Director of Finance noted that there was an increasing system-based approach in relation to finances. The Chair thanked Ms C Mould and Mr R McGough for attending to present the draft Liverpool Provider Alliance Agreement. The Board of Directors: • Endorsed the Trust's participation in the Liverpool Provider Alliance and approved completion of the Liverpool Provider Alliance Agreement by the Chief Executive.
236	Minutes of previous meeting The minutes of a Board of Directors meeting held on 5 December 2019 were agreed as a true and accurate record.
237	Matters arising and action log. There were no matters arising. The Board of Directors reviewed the Action Log and noted that there were no outstanding actions.
238	Chair's Announcements The Chair briefed the Board on events since the last meeting as follows: • The Chair had met with Mrs S Musson, Chair of Liverpool University Hospitals NHS Foundation Trust, on 23 December 2019 to discuss the development of productive relationships between the two organisations. • An introductory meeting with Mr A Yates, Chair of the Cheshire & Merseyside Health & Care Partnership on 23 December 2019. • Board members had participated in a Board Workshop day held on 9 January 2020. The Chair noted the Trust's participation in a Shadow Board Programme with the aim of developing future Board-level leaders. He provided an overview of the programme and noted that the first of three Shadow Board meetings had been held on 5 February 2020. • A meeting of the Nominations & Remuneration Committee of the Council of Governors had been held on 27 January 2020 during which Committee members had considered a report from the Interim Trust Secretary which detailed outcomes of analysis of various guidance documents published by NHS England / NHS Improvement relating to Provider Chairs and Non-Executive Directors. The Chair noted that a report on outcomes of the Committee's deliberations would be presented to the Council of Governors on 13 February 2020. • The Chair advised the Board of a launch event for the opening of a Knitting Shop and advised that shop contents were produced by volunteers with all proceeds going to the Trust's Charitable Fund. He also noted recent publication of a children's book which was on sale in the Knitting Shop. • The Chair advised that a time capsule containing Trust memorabilia and material produced by two local primary schools had been 'buried' in the Neonatal new-build. The Chair concluded his report by noting the selection of Dr A Loughney, Medical Director, to participate in the Aspirant Chief Executive's programme. He congratulated Dr Loughney on his selection for the programme and noted that one of his colleagues on the programme, Mr B Morrin, Director of Workforce at University College of London Hospitals, would be working with the Board in May 2020 as part of reciprocal 'buddying' arrangements. The Board noted the Chair's verbal update.

239	**Chief Executive's report** The Chief Executive presented a report which detailed local, regional and national developments. She briefed the Board on the content of the report and noted the following subjects in particular: • Launch of a new Nursing, Midwifery & Allied Health Professionals Strategy on 29 January 2020 • Completion of a Memorandum of Understanding with Liverpool University Hospitals NHS Foundation Trust and planned establishment of a Partnership Board to facilitate joint working to develop effective and sustainable services for women in the city • Listening Event held on 5 February 2020 which focused on staff survey outcomes and provided an opportunity for Board members to engage with a large number of staff The Chief Executive provided the Board with an overview of a Well Led inspection which was carried out by the Care Quality Commission 14-16 January 2020. She thanked staff from across the organisation for how they had conducted themselves during both this inspection and a core services inspection which took place in early December 2019. The Chief Executive advised that the Trust anticipated receipt of a draft inspection report for factual accuracy checking mid to late February 2020. The Chief Executive concluded her report by reading an e-mail message from a senior level colleague at a different NHS organisation who had recently been a patient at the Trust. She noted that the colleague had wanted to share their positive experience at the Trust and had been "blown away by the care, compassion and professionalism of the staff". The Board of Directors: • Received and noted the Chief Executive's Report
240	**Chair's Report from Quality Committee (QC)** Dr S Milner presented the Chair's Report from a meeting of the Quality Committee held on 27 January 2020. She briefed the Board on the content of the report and noted in particular the Committee's consideration of a significant revision of Risk ID 2297 on the Board Assurance Framework. She commented on the dynamic nature of the Board Assurance Framework with content being subject to a general review by the Executive Team. The Board of Directors: • Received and noted the Chair's Report from the Quality Committee meeting held on 27 January 2020.
241	**Chair's Report from Finance, Performance and Business Development Committee (FPBD)** Ms J Moore presented the Chair's Report from a meeting of the Finance, Performance and Business Development Committee held on 28 January 2020. She briefed the Board on the content of the report and noted a positive financial performance in Month 9 with a deficit position of £0.7m against a planned deficit position of £0.9m. With regard to the Board Assurance Framework, the Committee endorsed a proposal to reduce the risk score for Risk ID 1663 which related to delivery of the annual financial plan. The Board of Directors: • Received and noted the Chair's Report from the Finance, Performance & Business Development Committee meeting held on 28 January 2020.

242	**Chair's Report from Putting People First Committee (PPF)** Mr T Okotie presented the Chair's Report from a meeting of the Putting People First Committee held on 27 January 2020. He briefed the Board on the content of the report and noted in particular that the Committee had received a powerful Staff Story from a healthcare assistant which had detailed the positive impact of mental health first aid training for both staff and patients. Mr T Okotie also noted that the Committee had conducted a 'deep dive' to better understand the control measures in place for managing sickness absence levels. With regard to the Board Assurance Framework, the Committee had endorsed a proposal to reduce the risk score of Risk ID 2294 which related to clinical staffing levels. Mr T Okotie concluded his report by noting improving trends in performance against metrics for both mandatory training and completion of appraisals. The Board of Directors: • Received and noted the Chair's Report from the Putting People First Committee meeting held on 27 January 2020.
243	**Chair's Report from Audit Committee (AC)** Mr I Knight presented the Chair's Report from a meeting of the Audit Committee held on 28 January 2020. He briefed the Board on the content of the report and noted in particular complimentary remarks from the Internal Audit representative in relation to the effectiveness of the process in place to ensure that recommendations arising from audit reviews were completed in a timely manner. He also noted that the Committee had approved the Charitable Funds Annual Report & Accounts 2018/19, under delegated authority from the Board of Directors, for submission to the Charities Commission in advance of the 31 January 2020 deadline. Mr I Knight concluded his report by advising that Mrs T Ellery had now assumed the role of Chair of Audit Committee. The Board of Directors: • Received and noted the Chair's Report from the Audit Committee meeting held on 28 January 2020.
244	**Chair's Report from Charitable Funds Committee (CFC)** Mr P Huggon presented the Chair's Report from a meeting of the Charitable Funds Committee held on 18 December 2019. He briefed the Board on the content of the report and noted the Committee's consideration of the draft Charitable Funds Annual Report & Accounts 2018/19. He also noted that the Committee had reviewed a 6-month fundraising action plan and the planned development of a comprehensive fundraising strategy. He advised that Board members had been invited to express their views on this subject in advance of a planned Board workshop on 5 March 2020. The Chair noted that the subject of Charitable Funds would be considered at the Council of Governors meeting on 13 February 2020. The Board of Directors: • Received and noted the Chair's Report from the Charitable Funds Committee meeting held on 18 December 2019.
245	**Serious Incidents & Learning Report** The Director of Nursing & Midwifery presented a report regarding serious incidents reported during Quarter 2 and Quarter 3 2019/20. She briefed the Board on the content of the report and noted a correction to the second paragraph of the report. She advised that there had been a total of eight reported instances as opposed to the total of nine referenced in the report. The Director of Nursing & Midwifery referred the Board to Table 1 in the report and provided an overview of the eight

	reported incidents. She then noted the 'root cause' outcomes for the incidents as detailed in Table 2 of the report. With regard to learning from incidents, Dr S Milner noted that there had been positive discussion on this subject during a recent listening event. The Medical Director advised that he was confident that the level of openness across the Trust was reflected in reporting levels. In response to comments from the Director of Workforce & Marketing, Dr S Milner noted that reports detailing a thematic analysis of learning from incidents were presented to the Quality Committee. The Director of Workforce & Marketing acknowledged this response but noted that the report being considered by the Board did not detail outcomes from this thematic analysis and suggested that there was scope for greater assurance reporting to the Board. The Chief Executive suggested that an appropriate review of the Trust's arrangements for serious incidents be included in the Internal Audit programme for 2020/21. This suggestion was endorsed by the Board. The Board of Directors: • Received and noted the Serious Incidents & Learning Report.
246	Safer Nurse / Midwife Staffing Monthly & Six-Monthly Reports The Director of Nursing & Midwifery presented a report which detailed Ward Staffing levels across all inpatient clinical areas during November and December 2019 together with a six-monthly Nursing & Midwifery Staffing Report. She briefed the Board on the content of the reports and noted positive fill rates in November and December 2019. She then provided an overview of the various factors covered in the six-monthly report. The Director of Workforce & Marketing commented on the need to maintain a line of sight in relation to development of the Consultant Nurse workforce. The Chair noted that the Trust also had a cohort of medical students and queried the level of engagement with Edge Hill University. The Medical Director advised that there was a good level of engagement but noted that there were relatively small numbers of students and that students tended to be primarily primary care-facing. Mr P Huggon noted that the Trust's turnover rate of 6% was positive in comparison with others and facilitated a stable workforce. The Chair acknowledged this comment but noted that there could also be disadvantages such as restricted opportunities for advancement, for example. The Board of Directors: • Received and noted the Safer Nurse / Midwife Staffing Monthly Report and Six-Monthly Report.
247	Operational Performance Report Month 9, 2019/20 The Director of Operations presented the Operational Performance Report for Month 9 2019/20. He briefed the Board on the content of the report and provided an overview of performance against key national standards as detailed at s2 of the report. In response to a question from Mr P Huggon, regarding recruitment to Consultant posts, the Director of Operations advised that applicants were primarily from outside the local area. In response to a follow-up question from the Chair, the Director of Operations advised that it was too soon to judge whether changes in the recruitment offer had had a positive effect. The Director of Operations concluded his report by noting that the Partnership Board would report service developments via the Future Generations Project Group for onward reporting to the relevant Board Committees. The Board of Directors: • Received and noted the Month 9 Operational Performance Report.

248	**Financial Report & Dashboard Month 9, 2019/20** The Director of Finance presented the Finance Report and Financial Dashboard for Month 9, 2019/20. She briefed the Board on the content of the report and advised that at Month 9 the Trust was reporting a deficit of £0.7m against a deficit budget of £0.9m, giving a year to date favourable variance of £0.2m. She advised that the Trust remained on plan to achieve a breakeven position for the financial year. The Director of Finance then briefed the Board on contract performance, cash position, capital expenditure and the cost improvement programme. In response to a question from the Chair, the Director of Finance provided an overview of risks relating to the 2020/21 budget associated with Acting as One contract arrangements, non-recurrent provisions in 2019/20 and planned clinical case for change developments. The Chief Executive commented on a risk associated with future levels of endometriosis activity. In response to a question from Mr I Knight, regarding Gynaecology activity, the Director of Finance advised that activity was related to levels of staff availability. Mr T Okotie commented on the need to understand if birth level trends were consistent with those experienced by other organisations and whether there were factors specific to the Trust. The Director of Finance concluded her report by advising that the financial and planning position would be reviewed by the Finance, Performance & Business Development Committee on 25 February 2020 prior to submission of a draft annual plan on 4 March 2020. She also noted a recommendation to revise the risk score for Risk ID 1663, relating to delivery of the financial plan, in the Board Assurance Framework with a proposed reduction in the score from 25 to 15. The Board of Directors: • Received and noted the Month 9 Financial Performance Report and approved the reduction in risk score for Risk ID 1663.
249	**Trust Strategic Plan** The Director of Finance delivered a presentation to support Board discussion on the Strategic Plan. The presentation covered the following subject areas: • Vision Statement • Strategic Objectives • Future Generations – Clinical Strategy • The Journey 2014-2020 • Where are we now? • What have we delivered? – partnerships for Care Delivery • What have we delivered? – Care Closer to Home • What have we delivered? – Technology Enabled Care • What have we delivered? – Focus on Staff • What Next? Board members agreed that the content of the slide set was helpful in summarising progress to date and developments made in recent years. In response to a question from Mr I Knight, the Director of Finance advised that the Future Generations Business Case would be reviewed and updated once the current review of the Clinical Strategy had been completed. The Medical Director noted that currency of the Trust's Strategy documentation had been an area of focus during the Well Led inspection and Board members agreed that an updated document for the Trust's overarching strategy should be produced. Dr S Milner commented on the importance of ensuring that supporting strategies were clearly connected to the Trust's strategy with consistent use of appropriate metrics.

	The Board discussed next steps and agreed that a Board workshop should be held to consider the overarching strategy once the Clinical Strategy had been completed. It was agreed that an initial discussion on this subject would be incorporated in the programme for the next Board workshop on 5 March 2020. Mr T Okotie noted that it would be helpful to have a timeline detailing various steps in the review process. The Board of Directors: • Noted and discussed the Strategic Plan presentation and agreed next steps as detailed above.
250	Board Assurance Framework The Interim Trust Secretary presented the Board Assurance Framework 2019/20. He briefed the Board on the content of the report and noted the proposed reduction in risk scores for Risk ID 1663 and Risk ID 2294 as discussed earlier in the meeting. The respective Executive leads then briefed the Board on the rationale for the proposed reduction in risk scores. Dr S Milner then referred the Board to Risk ID 2297, which related to Sustainability, and advised that modified narrative had been included in the relevant Board Assurance Framework entry. She noted that this particular risk would continue to be subject to dynamic review by the Quality Committee. The Board of Directors: • Received the Board Assurance Framework and approved the reduction in risk scores for Risk ID 1663 and Risk ID 2294.
251	Review of risk impacts of items discussed The Board noted that the following risks had been discussed during the meeting: • General development of Board Assurance Framework content • Commissioning of an Internal Audit review in relation to serious incidents • Risks associated with the operational / financial planning process
252	Any other business & Review of meeting The Chair introduced Mr M Grimshaw, who had been present to observe the meeting, and advised that Mr Grimshaw would assume the role of Trust Secretary with effect from 1 March 2020. He thanked Mr P Buckingham for his work in undertaking the duties of Interim Trust Secretary since October 2019. Date of next meeting The Chair reported that the next meeting of the Board of Directors in public would be held on 2 April 2020.

TRUST BOARD
2 April 2020
Action Plan

Meeting date	Minute Reference	Action	Responsibility	Target Dates	Status
6 February 2020	19/20/245	The Chief Executive suggested that an appropriate review of the Trust's arrangements for serious incidents be included in the Internal Audit programme for 2020/21. This suggestion was endorsed by the Board.	Director of Nursing & Midwifery	Completed	The Audit Committee approved the 2020/21 Internal Audit Plan on 24 March 2020 and this included a review of the Trust's arrangements for serious incidents.

	Completed actions: concluded before the next board or on the agenda of the next Board
	In Progress - either at Committee stage or awaiting presentation at Board or Board workshop
	in progress - missed original deadlines agreed at Board

Liverpool Women's NHS Foundation Trust

Agenda Item	

MEETING	Board of Directors
PAPER/REPORT TITLE:	Chief Executive's Report
DATE OF MEETING:	Thursday, 02 April 2020
ACTION REQUIRED	Information
EXECUTIVE DIRECTOR:	Kathy Thomson, Chief Executive
AUTHOR(S):	Mark Grimshaw, Trust Secretary
STRATEGIC OBJECTIVES:	*Which Objective(s)?* 1. To develop a well led, capable, motivated and entrepreneurial ***workforce*** ☒ 2. To be ambitious and ***efficient*** and make the best use of available resource ☒ 3. To deliver ***safe*** services ☒ 4. To participate in high quality research and to deliver the most ***effective*** Outcomes ☒ 5. To deliver the best possible ***experience*** for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	*Which condition(s)?* *1. Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust…….* ☒ *2. Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have sufficient numbers of clinical staff with the capability and capacity to deliver the best care. ……* ☒ *3. The Trust is not financially sustainable beyond the current financial year……* ☒ *4. Failure to deliver the annual financial plan ……* ☒ *5. Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision ……* ☒ *6. Ineffective understanding and learning following significant events……* ☒ *7. Inability to achieve and maintain regulatory compliance, performance and assurance……* ☒ *8. Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) ……* ☒
CQC DOMAIN	*Which Domain?* ***SAFE-*** *People are protected from abuse and harm* ☐ ***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☐ ***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☐ ***RESPONSIVE –*** *the services meet people's needs.* ☐ ***WELL-LED -*** *the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.* ☐

	ALL DOMAINS ☒	
LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	1. Trust Constitution ☒ 2. Operational Plan ☒ 3. NHS Compliance ☒	4. NHS Constitution ☒ 5. Equality and Diversity ☒ *6.* Other: Click here to enter text.
FREEDOM OF INFORMATION (FOIA):	1. This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting	
RECOMMENDATION: *(eg: The Board/Committee is asked to:-….)*	*Board is asked to receive the content of the report.*	
PREVIOUSLY CONSIDERED BY:	Committee name	Not Applicable
	Date of meeting	

Executive Summary

In this briefing for the Board I aim to summarise recent and relevant information which relates to:

Firstly, in Section A, news and developments within the Trust itself that is not already reported elsewhere.
Secondly, in Section B, news and developments within the immediate health and social care economy.
Thirdly, in Section C, other news and developments within the wider national health and social care economy, including regulatory developments.

Further information is available on request on any of the topics covered by the report.

Report

SECTION A – Internal

COVID-19 Response – As an NHS Trust, under the Civil Contingencies Act, we have a duty to respond to the COVID-19 outbreak and prioritise our services for our most vulnerable patients. We already have established plans to do this and over the past few weeks divisional leadership teams have been working hard to refresh these with the latest information. These plans have been updated to consider an increase in staff absence of up to 20% which is the most likely event to impact on our services.

As part of our plans for preparedness we have temporarily reduced services. This has been done in line with clinical need and mandated guidance. We have some specific services at LWH that not only support the families of Liverpool but Cheshire and Merseyside and beyond. We are working with our regional clinical networks to ensure we do the best for the region too. Potential future options may include the repurposing of sections of the hospital estate to support the capacity in the system to care for patients with COVID-19. Additionally, due to COVID-19 The Hewitt Fertility Centre have made the very difficult decision to put fertility treatments on hold. Please visit The Hewitt Fertility Centre website for most up-to-date details.

The Trust has also taken steps to restrict visiting across all services and it is likely that further restrictions will be put into place as the situation develops. Triage at the hospital front door has been enhanced and any individual without an appointment is being asked to phone in advance of presenting.

The risk associated with disruption to business as usual has been escalated to the corporate risk register and will be reviewed. The implications of the risks will also be considered as part of the Board Assurance Framework.

Staff are now encouraged to take a 'remote first' approach to any meetings that are scheduled to take place. The IM&T department have worked hard to accelerate the implementation of measures that support staff with remote working. Two primary roll-outs that have been available are Microsoft Teams (an easy to use tool that allows for remote collaboration) and Virtual Clinics (an easy to use tool that allows for video consultations with patients).

The Board, including this public Board meeting, and the Board Committees will be held virtually from this month. The public Board papers have been made available on the Trust website and the option to submit questions in advance of the meeting for consideration will be available. Attempts will be made to make the minutes accessible to the public as soon as possible after the meeting to maintain a commitment to transparency.

I am very grateful to all of our staff for the tremendous amount of work they have been doing, and will continue to do, to help contain the spread and to be fully prepared. Understandably some of our staff are concerned about Coronavirus and its impact and our focus will continue to be on how best to protect them as well as our patients and visitors at this very difficult time.

Please refer to the more detailed report on the agenda for more information on the Trust's response to Covid-19.

Care Quality Commission (CQC) - As Board members will be aware, the CQC visited the Trust on two occasions in recent months, firstly, to carry out an unannounced core services inspection in December 2019 and, more recently, to complete a Well-Led inspection which took place between 14-16 January 2020. We have received the draft report for a factual accuracy check and the Trust was due to respond by the end of March 2020. Once the final report is received an action plan will be developed and tabled for Board consideration.

Use of the Trust Seal – In line with paragraph 118 of the Trust's Standing Orders, there is a requirement to report all sealings to the Board of Directors on an annual basis. The report should contain details of the seal number, the description of the document and date of sealing. The Trust Seal was not used during the 2019/20 financial year.

Division of Family Health:

a) Maternity Incentive Scheme – Year 3 - NHSR (NHS Resolution) (the operating name of NHS Litigation Authority, Department of Health and Social Care) is operating a third year of the Clinical Negligence Scheme for Trusts (known as CNST), which supports Trusts with the delivery of safer maternity care. The scheme incentivises ten maternity safety actions, and by working closely with the Maternity, Neonatal and Information Teams, the Trust is required to demonstrate to NHSR that we can achieve all ten safety actions. This will result in the Trust recovering an element of our financial contribution relating to CNST. In Year 2, we successfully achieved all safety actions, resulting in a payment to the Trust of just over £1m, and we are hopeful in achieving the same in Year 3.

The Family Health Division is underway with collating evidence for Year 3 and would like to thank everyone for their support with this process. A weekly meeting is scheduled to ensure all elements of the safety actions are on target to deliver the required outputs within the required timescale.

b) National Picker Maternity Survey - Following the release of the National Picker Maternity Survey results, the Trust is pleased to report an increase in the overall positive scoring in our patient satisfaction and experience within the Survey.

c) 'Face Mums' – There has been a recent recruitment drive for women booked with the Trust on their pregnancy journey, to join 'Face Mums'. After a successful take up of women wanting to participate, the scheme is now fully recruited to, with four Band 5 Midwives facilitating groups to promote relationships and continuity. The group work is ongoing, with excellent feedback received to date.

d) Neonatal New Build - On 10th February 2020, all babies requiring Intensive or High Dependency Care were transferred safely into the new build. The move involved extra support from our Consultants / ANNPs / Nurses / Clinical and Non-Clinical staff working to minimise any disturbance to the babies and their families. Feedback from our Parents has been very positive, with appreciation for the additional facilities offered such as recliner chairs at the cot side and personal baby lockers allocated at each cot space. Timescales to complete the building to provide parent facilities, end of life suite, cot-wash / laundry facilities and office space for the Neonatal Team will be impacted by the COVID-19 epidemic. The Trust continues to work closely with its construction partner Interserve on the best way forward.

Clinical Support Services Division:

a) Physiotherapy – The service noted an increase in activity during January and February 2020.

Gynaecology:

a) Gynaecology Ward: The ward trialled a new drugs trolley which features a built-in laptop device. Following the successful pilot, a procurement exercise for further trolleys is now underway.

b) Premenstrual Dysphoric Disorder (PMDD) Research – Research undertaken by Trust clinicians into PMDD was shortlisted in the North West Coast Research and Innovation Awards 2020.

SECTION B – Local

Cheshire and Merseyside Health & Care Partnership: Mr A Yates, Chair of the Cheshire and Merseyside Health & Care Partnership recently announced the appointment of Dr J Bene to the position of Chief Officer. Dr Bene is scheduled to commence her appointment with effect from 1 May 2020 and a copy of a stakeholder briefing is included for information at Annex A to this report.

SECTION C – National

March 2020 Budget - The Chancellor, Rishi Sunak, delivered his first Budget on 11 March 2020, which included a significant package of measures designed to support those affected by COVID-19. He also outlined a number of announcements which make good on promises committed to in the Conservative Party manifesto. The most significant announcement for the NHS was the Chancellor's announcement of a rise to the annual allowance taper thresholds. Although there is a restatement of the government's commitment to abolish car parking charges, there was no mention of how the associated costs will be met. There was also an extra £1bn of capital funding announced for the NHS for this year, with further details to come in the comprehensive spending review later in the year.

This Budget saw a change in approach from the government on public finances, with an increase in both short and longer term spending on public services and a large programme of investment although the implications from the COVID-19 epidemic will need to factored in once the impact is known.

Coronavirus bill - The government published the coronavirus action plan on 3 March 2020, which set out a range of measures to respond to the COVID-19 outbreak and details on the government's strategy to delay, contain, mitigate and research to tackle the pandemic. The plan highlighted that some changes to legislation would be necessary to give public bodies across the UK the tools and powers they needed to carry out an effective response.

The Coronavirus bill was introduced on Thursday 19th March 2020 to give public bodies the powers they need to respond to the pandemic. Safeguards have been put in place to ensure that the powers outlined in the bill are only used as necessary, for example during the peak of the COVID-19 outbreak. The aim is to balance the need for speed to the risk posed by the virus, with safeguards to ensure proper oversight and accountability.

The legislation is intended to take effect from the end of this month and will be time-limited – for 2 years – and not all of these measures will come into force immediately. The bill allows the UK government and devolved administrations to switch on these new powers when they are needed, to switch them off again once they are no longer necessary, based on the advice of Chief Medical Officers of the four nations.

The bill aims to achieve the following:

- Increase the number of health and social care workers available
- Ease the burden on frontline staff, both within the NHS and beyond
- Delay and slow the virus
- Manage the deceased with respect and dignity

Cheshire & Merseyside Health & Care Partnership

"Be the reason someone receives better care today"

February 18, 2020

New clinical leader appointed at Cheshire & Merseyside Health & Care Partnership

Stakeholder briefing

Dear Colleagues

We are pleased to announce the appointment of Dr Jackie Bene as Chief Officer at the Cheshire & Merseyside Health & Care Partnership.

Jackie brings with her a wealth of experience which will benefit the people and health and care system of Cheshire and Merseyside.

A consultant geriatrician by background, Jackie has had career-long involvement in service integration, reducing health inequalities and quality improvement. She has served as a Board Director first as Medical Director and for the last seven years as Chief Executive of Bolton NHS Foundation Trust.

Since her tenure as Chief executive she has led the Trust to an overall good CQC rating and notably outstanding for the well-led domain. Dr Bene also has considerable experience of leading Bolton and its transformation programme across Greater Manchester.

Alan Yates, Cheshire & Merseyside Health & Care Partnership Chair said "I am delighted that we have been able to appoint someone of Jackie's experience and understanding of partnership working.

"Her approach and career-long commitment to service integration, reducing health inequalities and quality improvement will be a great asset and will help the Health & Care Partnership go from strength to strength."

Dr Jackie Bene said “I have thoroughly enjoyed my time as Chief Executive at Bolton NHS Foundation Trust, particularly where this has enabled involvement in the development of Bolton partnerships and leading programmes within the Greater Manchester Health and Social Care Partnership.

“I am joining the Cheshire & Merseyside Health & Care Partnership at a significant point in development. Much has already been achieved across the region but more needs to be done.

“I am passionate about system transformation, eliminating inequality and improving care quality and I very much look forward to helping deliver this for the communities of Cheshire and Merseyside.

Jackie will start the role formally on May 1, 2020.

If you have any questions or queries regarding the Partnership or Jackie’s appointment please contact cm.partnership@nhs.net.

Many thanks

Alan Yates
Chair
Cheshire & Merseyside Health & Care Partnership

Liverpool Women's NHS Foundation Trust

Board of Directors

Committee Chair's report of Quality Committee meeting held 24 February 2020

1. **Was the quorate met?** Yes

2. **Agenda items covered**

~ **The role of the Board Maternity Safety Champion -** The Committee received an overview of the role of the Maternity & Neonatal Safety Champions to clarify the purpose of the role at both specialty and Board level. It was noted that these roles are a requirement for every maternity provider and are also a requirement of the CNST Maternity Incentive Scheme. It was confirmed that Mr Ian Knight, Non-Executive Director is the Board Maternity and Neonatal Safety Champion and that Mrs Caron Lappin, Director of Nursing & Midwifery and Mr Andrew Loughney, Medical Director are executive sponsors operationally.

~ **CNST** – The Committee noted that NHS Resolution is operating a third year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care. The Committee agreed to receive monthly assurance reports monitoring progress to date against the 10 safety action standards. There was a discussion about ensuring Board oversight to meet the requirements for Board sign off is appropriate and in place to be eligible for payment under the scheme. The completed Board declaration form to NHS Resolution must be submitted by 17 September 2020.

~ **Board Assurance Framework (BAF) –** Quality Related Risks: The Committee reviewed the Quality related BAF risks and noted that both the Sustainability and EPR risks remain under review.

~ **Subcommittee Chairs reports**: The Committee received Chair's Reports from the Safety Senate, Experience Senate, the Effectiveness Senate and the Future Generations Project Group. With regard to the Effectiveness Senate, the Committee noted a potential risk relating to stillbirth certification as presented in the NEST study which will be added to the divisional Risk Register if confirmed.

~ **Quality Committee Annual Workplan 2020/21:** The Committee reviewed and provided some feedback on the draft committee annual workplan. A final workplan would be provided in March 2020 along with the Committee Terms of Reference for approval.

~ **Quarterly Integrated Governance Report Quarter 3**: The Committee received quarter 3 2019/20 integrated governance report detailing incidents, complaints, clinical audit, and claims information during that period. The Committee considered the information presented and put forward recommendations to expand the content to further strengthen assurances provided.

~ **2019 Care Quality Commission (CQC) Inspection Update Action Plan:** The Committee reviewed an updated action plan in response to the issues raised by the CQC during and following the unannounced inspection in December 2019. The Committee noted clear ongoing action being taken to address the concerns raised. A further report was received on the specific medicine management issues raised during the inspection. Assurance was provided that twice weekly

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audits were in place and a robust long-term process would be implemented. It was also noted that the Trust Internal Auditors MIAA will be undertaking an audit of compliance in March 2020, and the subsequent report will be shared with the Committee.

~ Medicines Management Quarterly Report: The Medical Director presented the first Medicines Management Quarterly report to the Committee and requested feedback on content provided. The Trust Secretary advised as a Board assurance report it would be useful to identify key areas that would provide assurance to the Board. It was also suggested that the internal auditors might be supportive in terms of report content as part of their review.

~ Adult Mortality & Perinatal Mortality Quarterly Report: The Committee received the quarter 3 2019/20 adult mortality and perinatal mortality report. The Deputy Medical Director referred to appendix 1 of the report and advised that it is a mandated requirement for the Board to have sight of the Perinatal Mortality Review Tool (PMRT) action plan. This will be included in all future quarterly reports to the Committee. The Committee commented on the length of the PMRT action plan and asked if a summary could be provided for purposes of Board consideration.

~ Quality Strategy 2017/20 Quarterly Update: The Committee received the quarter 3 report noting progress made in relation to each of the quality initiatives within the 2017/20 quality strategy.

~ Draft Quality Strategy 2020/25: The Head of Governance presented an overview of progress in relation to the development of the five-year Quality Strategy and provided details of quality improvement initiatives to be included. The Committee provided feedback upon the content to be included. It was agreed that national quality metrics should be included however it was felt amongst committee members that there is scope for improved trust specific initiatives. The Director of Workforce asked about the ambition of the strategy and suggested a goal relating to learning from events would be both an ambitious and relevant initiative for the Trust.

~ Maternity Inpatient Survey: The Committee received the results of the maternity inpatient survey conducted in 2019 and noted that overall the Trust had improved its position, now ranking 34 out of 63 participating Trusts compared to 31 in 2018. The Director of Nursing & Midwifery informed the Committee that the Trust has been identified as a pilot site by the CQC for a repeat Maternity survey for mothers who gave birth between 1 October 2019 and 30 November 2019. The main aim of the pilot is to test the uptake of an online questionnaire and increase the response rates as this has been an area of concern at LWH.

~ Monthly Quality Performance Review M10 2019/20: The Committee received an update on Operational Performance at Month 10 2019/20. The Director of Operations advised that the KPI's are being updated to reflect the new CQUIN indicators and the Quality Strategy initiatives and would be included in the dashboard as of April 2020/21.

~ Equality and Human Rights Quarterly report: The Committee received quarter 3 2019/20 report. The Deputy Director of Nursing and Midwifery informed the Committee that the Trust has invited Healthwatch to provide an external review of point 1.3 'Transitions from one service to another, for people on care pathways, are made smoothly with everyone well informed'. This will provide external assurance that this patient goal has been achieved before updating the EDS2 module in the next few months.

3. Board Assurance Framework (BAF) risks reviewed
   No changes to existing risks were identified as a result of business conducted during the meeting.

4. Escalation report to the Board on Performance Measures
   None.

5. Issues to highlight to Board
   None.

6. Action required by Board
   None

Susan Milner
Chair of Quality Committee
24 February 2020

Liverpool Women's NHS Foundation Trust

Board of Directors

Committee Chair's report of Quality Committee meeting held 23 March 2020

1. **Was the quorate met?** Yes (meeting was held virtually)

2. **Agenda items covered**

~ **Coronavirus Update:** The Committee received an in-depth verbal position update with regards to planning in relation to coronavirus and potential impact on quality. It was noted that all non-urgent elective surgery had been suspended, restrictions are in place for visitors and standard operating procedures are being finalised. It was noted that gynaecology services will experience the largest impact and maternity and neonatal services should continue as planned.

With regards to co-ordinating and sharing information to manage the Trust position in relation to the Coronavirus the following meeting groups have been established: daily safety huddle; daily incident command meeting; Covid-19 Clinical Advisory Group; and a twice weekly oversight meeting. All four groups will provide information to the Finance, Performance & Business Development Committee which will report any matters arising to the Board. It was noted that a fortnightly NED update had been scheduled which one Executive and the Trust Secretary would attend. It was noted that any direct queries from NEDs would be co-ordinated by the Chair and escalated to the Medical Director and Director or Nursing & Midwifery.

The Committee queried the decision-making ethics and principles being adopted and noted that decision making, such as suspending services, is centrally mandated. It was agreed that the Trust should remain mindful of its patient demographic and the care that should be maintained. The Committee noted workforce issues, in particular staff sickness rates due to coronavirus symptoms and noted the Trust would follow the emergency continuity plan to manage services with significant reduced staffing. The Committee noted a skills audit is underway to identify clinically trained staff within corporate departments, as well as a national drive to return retired NHS professionals and provide quick registration for qualified students.

~ **Board Assurance Framework –** Quality Related Risks: The Committee reviewed the Quality related BAF risks and noted a new narrative is being written for risk 2184, EPR. It was agreed that a new BAF risk relating to COVID-19 should be written, or alternatively the risks posed by the COVID-19 outbreak should be mapped against the existing BAF risks.

~ **Subcommittee Chairs reports**: The Committee received and noted the Chair's Report from the Future Generations Project Board.

~ **Quality Committee Annual Workplan & Terms of reference:** The Committee approved the committee workplan and terms of reference for 2020/21. It was noted going forward the agendas and some items of business would be reported on a consent agenda basis to allow for timely and concise meetings to be held. The quality of the narrative within the executive summaries will be important to allow more rapid consideration. Whilst the 2020/21 Workplan was approved, it was acknowledged that items would require prioritisation in the context of COVID-19. The workplan will remain an iterative document, flexing to the developing situation.

~ **Risk Appetite Statement 2020/21:** The Committee approved the risk appetite statement and risk tolerance levels for 2020-21 in relation to quality committee related risks and would recommend to the Board.

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- **Risk Management Strategy:** The Committee noted the contents of the report and was assured that the Trust has a robust strategy in place. It was noted that the Risk Management Strategy would provide a key framework for managing the emerging risks from the COVID-19 outbreak. The Committee approved the Risk Management Strategy ahead of submission to the Board.

- **Corporate Objectives 2019/20 year-end review and Draft Corporate Objectives 2020/21:** The Committee noted the year-end review. With regards to the draft corporate objectives 2020/21 aligned to the Committee, members were unsure how to provide a view due to current and anticipated Trust position in relation to the Coronavirus during 2020/21. It was agreed that the executive team should review and identify what realistically can be achieved.

- **Quality and Regulatory Update:** The Committee noted that the Care Quality Commission (CQC) had provided a one-week extension for the factual accuracy check to be returned. The Director of Nursing & Midwifery advised that the Theatre review had been completed and an action plan is being written. This would be shared with the department and Committee.

- **Clinical Negligence Scheme for Trusts (CNST) Assurance Report:** The Committee noted considering current events relating to the Coronavirus the Trust might not meet CNST targets. The Director of Finance advised that NHS Resolution had confirmed that they are aware that timescales will slip and will provide an update to all Trusts.

- **Quality Strategy 2020/25 Update:** The Committee noted the ongoing work to develop the Quality Strategy and the development of a Quality Improvement Strategy as part of this work.

- **Monthly Quality Performance Review M11 2019/20:** The Committee received an update on Operational Performance at Month 11 2019/20 and noted the improved performance position against 52-week breaches. The Director of Operations noted that performance against metrics is likely to slip due to work undertaken to support Coronavirus patients within the Trust and regionally.

- **Counterfactual Case:** The Committee received the report and noted the requirement to consider what can realistically be achieved within the current environment. It was noted that external support is being maintained at a reduced level to continue to project manage the future generations project.

3. **Board Assurance Framework (BAF) risks reviewed**
   No changes to existing risks were identified as a result of business conducted during the meeting. It was suggested that a new risk should be created to identify COVID-19 as a BAF risk.

4. **Escalation report to the Board on Performance Measures**
   The Committee highlighted potential impact on performance measures going forward in response to the COVID-19 pandemic.

5. **Issues to highlight to Board**
   None

6. **Action required by Board**

The Committee recommend to the Board the appetite and risk tolerance levels for 2020-21 against the key strategic aims for which this Committee is responsible.

~ Approval of the Committee terms of reference (enclosed).

Susan Milner
Chair of Quality Committee
23 March 2020

QUALITY COMMITTEE

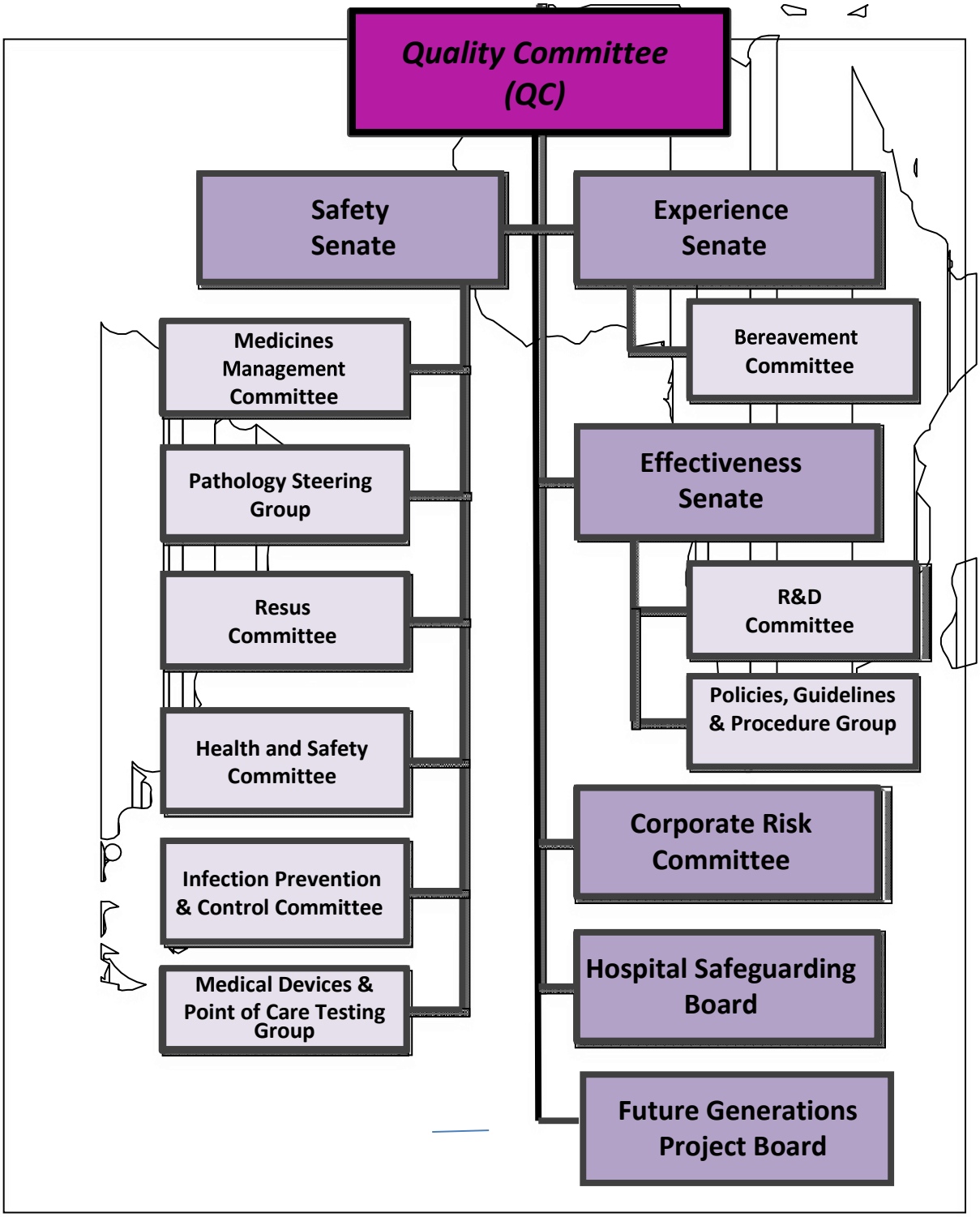
TERMS OF REFERENCE

Constitution:	The Committee is established by the Board of Directors and will be known as the Quality Committee (QC) (the Committee).
Duties:	The Committee's responsibilities fall broadly into the following three areas: **Strategy and Performance** a) Oversee the development and implementation of the Quality Strategy with a clear focus on upholding the tenants of quality (Governance, safety, patient experience and clinical effectiveness). b) Ensure that the Quality Strategy and performance are consistent with the Trust's; Vision and strategic objectives and oversee any initiatives undertaken by the Trust that relates to the development and implementation of the Quality Strategy. c) Review trends in patient safety, experience and outcomes (effectiveness) to provide assurance to the Board on performance and commission 'deep dives' as appropriate. d) To receive assurance that action plans arising from in-patient, out-patient and other care related surveys are being undertaken and make recommendations to the Board as appropriate. e) Oversee the implementation of key national reports and inquiries recommendations and provide assurance to the Board on its delivery. **Governance** f) Oversee the effectiveness of the clinical systems developed and implemented to ensure they maintain compliance with the Care Quality Commission's Fundamental Standards in relation to Quality, Safety, experience and effectiveness. g) Obtain assurance of the Trust's ongoing compliance with the Care Quality Commission registration. h) Review the controls and assurance against relevant quality risks on the Board Assurance Framework and provide assurance to the Board that risks to the strategic objectives relating to quality and safety are being managed and facilitate the completion of the Annual Governance Statement at year end. i) Obtain assurance that the Trust is compliant with guidance from NICE (through receipt of an Annual Report) and other related bodies. j) Consider external and internal assurance reports and monitor action plans in relation to clinical governance resulting from improvement reviews / notices

	from NHSI, the Care Quality Commission, the Health and Safety Executive and other external assessors. k) Receive the annual clinical audit programme and provide assurance to the Board that clinical audit supports the Trust to provide safe and clinically effective patient care and obtain assurance that there is delivery against agreed annual clinical audit programme. l) Implement and monitor the process for the production of the Trust's year end Quality Report before it is presented to the Trust Audit Committee and Board for formal approval. m) Undertake an annual review of the Quality and Risk Management Strategies to ensure that they reflect all required priorities. n) To have oversight of the Committees performance measures to ensure they are appropriate and provide assurance of compliance and escalate exceptions to Trust Board. o) To review the proposed internal audit plan for all functions areas within the Committees remit e.g. Clinical Audit, Safety, Experience and Effectiveness. p) Review the Trust's Research and Development Strategy and Innovation Strategy prior to their recommendation it to the Board of Directors. q) Approving the terms of reference and memberships of its subordinate committees. Overall r) To approve any matters that, due to time constraints, could not be approved by the Board within the scope of the Committees areas of responsibility. s) Referring relevant matters for consideration to other Board Committees as appropriate. t) Considering relevant matters delegated or referred to it by the Board of Directors or referred by any of the Board Committees. u) Escalating matters as appropriate to the Board of Directors. Assurances will be provided from internal and external sources and will be included in a work plan approved by the Committee at the commencement of each financial year.
Membership:	The Committee membership will be appointed by the Board of Directors and will consist of: • Non-Executive Director (Chair) • Two additional Non-Executive Directors • *Medical Director • *Director of Nursing and Midwifery • *Director of Finance • *Director of Workforce and Marketing

	• *Director of Operations • *Committee Chairs of the Safe, Experience and Effectiveness Senates • Deputy Director of Nursing and Midwifery • Head of Governance *or their nominated representative who will be sufficiently senior and have the authority to make decisions. Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. The Board of Directors will appoint a Non-Executive Director as Chair of the Committee. Should the Chair be absent from a meeting of the Committee, the Committee may appoint a Chair of the meeting from amongst the Non-Executive Directors present.
Quorum:	A quorum shall be three members including two Non-Executive Directors and one Executive Director (one of whom must be either the Medical Director or Director of Nursing and Midwifery or their deputy). The Chair of the Trust may be included in the quorum if present.
Voting:	Each member will have one vote with the Chair having a second and casting vote, if required. Should a vote be necessary a decision will be determined by a simple majority.
Attendance:	a) Members Members will be required to attend a minimum of 75% of all meetings. b) Officers The Trust Secretary shall normally attend meetings. Other executive directors (including the Chief Executive) and officers of the Trust will be invited to attend the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed. Representatives from partner organisations or other external bodies may be invited to attend as appropriate. Such representatives will not have voting rights.
Frequency:	Meetings shall be held monthly. Additional meetings may be arranged from time to time, if required, to support the effective functioning of the Trust.
Authority:	The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of representatives from partner organisations or other external bodies or organisations with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities.

	The Committee is authorised to approve those policies and procedures for matters within its areas responsibility.
Accountability and reporting arrangements:	The Quality Committee will be accountable to the Board of Directors. A Chair's Report will be submitted to the next following Board of Directors for assurance (see Appendix 1). Approved minutes will be made available to all Board members. The Committee will report to the Board annually on its work and performance in the preceding year. Trust standing orders and standing financial instructions apply to the operation of the Committee.
Reporting Committees/ Groups	The sub committees/groups listed below are required to submit the following information to the Committee: a) Chairs Report; and b) Annual Report setting out the progress they have made and future developments. The following sub committees/groups will report directly to the Committee (See appendix 2): • Safety Senate • Effectiveness Senate • Experience Senate • Corporate Risk Committee • Hospital Safeguarding Board • Future Generations Project Board
Monitoring effectiveness:	The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements.
Review:	These terms of reference will be reviewed at least annually by the Committee.
Reviewed by Quality Committee	~~18 March 2019~~23 March 2020
Approved by Board of Directors:	~~5 September 2019~~
Review date:	March 2021
Document owner:	~~Colin Reid,~~ Mark Grimshaw, Trust Secretary~~-~~, Email: mark.grimshaw@lwh.nhs.uk Tel: 0151 702 4033


Quality Committee (QC)
Safety Senate
Experience Senate
Medicines Management Committee
Bereavement Committee
Pathology Steering Group
Effectiveness Senate
Resus Committee
R&D Committee
Health and Safety Committee
Policies, Guidelines & Procedure Group
Infection Prevention & Control Committee
Corporate Risk Committee
Medical Devices & Point of Care Testing Group
Hospital Safeguarding Board
Future Generations Project Board

Board of Directors

Committee Chair's report of Finance, Performance and Business Development Committee meeting held 25 February 2020

1. Was the quorate met? Yes

2. Agenda items covered

~ **Finance Performance Review Month 10 2019/20:** The Committee received a report on the Month 10 finance position noting that, as at 31 January 2020, the Trust was reporting a deficit position of £0.3m which is slightly behind plan after the benefit of prior year PSF of £0.2m. It is expected that this will recover by year end, although the underlying financial position remained a cause for concern.

The Committee expressed concern relating to the capital expenditure position: a remaining £5.6m of the £18m forecast to spend before end March 2020. It was noted that the procurement team are positively supporting divisions to process orders as quickly as possible before the year end. The Committee also noted the aged debt position continues to improve with further payments received from aged debtors.

Following further assurance on the financial position and forecast, the Committee was asked to consider the proposal to further reduce the Board Assurance Framework (BAF) risk score relating to the achievement of the annual financial plan 2019/20. The Committee agreed a reduction of the likelihood score from 3 to 2, and risk score from 15 to 10 due to a reduced risk to delivering the in year financial position.

~ **Operational Performance Month 10 2019/20 including RTT and Cancer Targets:** The Committee received a report on Operational Performance as at Month 10 2019/20 and noted the position in relation to performance against RTT and Cancer standards. With regard to cancer performance, performance against the two week wait remains good. The Committee was advised that a cancer alliance peer review would be conducted in May 2020. The Committee noted potential changes to national cancer targets is out for consultation and would be kept informed by the Director of Operations.

~ **Strategic Outline Case Update:** The Committee received a comprehensive verbal update from the Director of Finance on a number of workstreams underway. The Committee noted as part of governance oversight a Clinical Advisory Group (CAG) had been created and an independent group Chair is being identified. The Committee was informed that the Trust had submitted an emergency capital bid for a CT scanner, blood bank and theatre robot. A response is expected after April 2020.

Operational Planning Update: The Deputy Director of Finance provided a presentation outlining the planning process for the 2020/21 operational plan. It was noted that the draft submission is due to the Health and Care Partnership (HCP) by midday on 2 March 2020 and the final submission on 29 April 2020. The Committee considered the shift to a system-based focus with regards to operational planning across North Mersey and was advised that all Trusts must complete their returns individually to the HCP, and the HCP will collate a system narrative. It was clarified that the movement towards a system based operational planning has come from NHSI/E.

The Committee approved the assurance statements, indicating acceptance of the Financial Improvement Trajectory and approval of the Plan as presented at draft stage.

~ **Emergency Planning Response & Resilience (EPRR) Bi-Annual Review:** The Committee received the EPRR bi-annual report. The Director of Operations reported that the Trust had completed its annual external audit in the form of a self-assessment against the NHSE EPRR Core Standards in October 2019 and met 52 of the 55 core standards, achieving an outcome of substantial compliance. The Committee agreed to deescalate EPRR board reporting to an annual basis with additional reporting as required. It was noted that the business continuity plans are regularly reviewed by the EPRR Committee.

In relation to preparation for Coronavirus, EPRR and IPC leads attend NHSE national and regional meetings to receive guidance, share information and benchmarking. Internal meetings have also been introduced to monitor the position. A programme of mask fit-testing / refresher training led by Health & Safety is in place across the Trust with personal protective equipment stocks monitored.

~ **IM&T Update:** The Chief Information Officer provided an update on IM&T matters, advising that they had achieved milestone 4 of the GDE fast follower programme ahead of the completion date of 31 March 2020. He advised that work on the schemes would continue and that an integrated assurance review would be undertaken. The Committee noted positive developments with regards to digital maternity record (K2) and was informed of the project aim to deliver a system go-live date in November 2020. The Committee noted the ongoing push towards information governance training compliance ahead of the data security and protection (DSP) toolkit submission.

The Director of Finance led a discussion relating to IMT risks and suggested that there is nationally a significant level of risk to cyber security and requested committee support to progress to add a cyber security risk to the board assurance framework.

~ **Neonatal Capital Programme Build Update:** The Committee noted that good progress continues to be made on the Capital Build which continues to be on-budget. The Committee noted that assurance continues to be managed through the Neonatal Project Board.

~ **Liverpool Neonatal Partnership:** The Director of Operations provided a verbal update and informed the committee that discussions were ongoing with Commissioners. He reiterated the importance of ensuring the project is not destabilising for the Trust's core service.

~ **Board Assurance Framework (BAF):** The Committee reviewed the risks that it was accountable for within the BAF and agreed that no amendments were required. With regards to risk scores, the Committee agreed as per earlier discussion to recommend approval to reduce the likelihood score of BAF risk 1663 - failure to deliver the annual financial plan, from 15 to 10.

The Committee agreed to develop a new risk in relation to cyber security.

~ **Sub Committee Chairs reports:** The Committee received and noted the following chair reports: Digital Hospital Sub-Committee, EPRR Sub-Committee; and Information Governance Committee.

3. Board Assurance Framework (BAF) risks reviewed

The Committee recommends a reduction of BAF risk score relating to the achievement of the annual financial plan 2019/20, likelihood score from 3 to 2, and risk score from 15 to 10.

4. Escalation report to the Board on Performance Measures
None.

5. Issues to highlight to Board
Operational Planning: To note the timescales as described within the operational planning update.
BAF: Introduction of a new BAF risk relating to Cyber Security.

6. Action required by Board
Approve recommendation as described in item 3.0 BAF risks.

Jo Moore
Chair of FPBD Committee
25 February 2020

Board of Directors

Committee Chair's report of Finance, Performance and Business Development (FPBD) Committee meeting held 24 March 2020

1. Was the quorate met? Yes (meeting was held virtually)

2. Agenda items covered

~ Operational Planning Update – Impact of COVID-19: The Committee was informed that the operational planning process and contract negotiations with commissioners had been suspended. The Trust will be paid a block contract as of 1st April based on Month 9 2019/20 position. This position would be reviewed nationally in July 2020. It was the intention to continue with CIP planning and finalising budgets with a record of all COVID-19 costs being kept separate from the core budget. The year-end timescales had been deferred and further discussion on the implications was being held at the Audit Committee. Assurance was provided that whilst dealing with the impact of the virus operationally and clinically, the finance team was maintaining grip and control despite the changing landscape.

It was confirmed that senior management resilience had been reviewed and the Executive Team had agreed a seven-day presence on a rotation basis. Alongside visibility, the Director of Operations advised that specific COVID-19 meeting groups had commenced. The Committee discussed workforce ratios working within contingency planning and requested that it is kept informed of staffing levels.

~ Finance Performance Review Month 11 2019/20: The Committee received a report on the Month 11 finance position noting that, as at 29 February 2020, the Trust was reporting a deficit position of £0.4m against a planned position of £0.4m. The Trust continues to forecast delivery of the breakeven control total. It was noted that the cash position had improved slightly in month 11 and is expected to remain in a positive position at year end. It was highlighted that capital expenditure had been committed with purchase orders up until the end of March, however confirmation of delivery of all items is required considering potential impact of COVID-19.

~ Operational Performance Month 11 2019/20: The Committee received a report on Operational Performance as at Month 11 2019/20 and noted the position in relation to performance against RTT and Cancer standards. The improved cancer waiting time metric was commended. It was reported that the recent COVID-19 outbreak had required further new ways of working, most recently with the introduction of virtual follow up clinics.

~ Strategic Outline Case Update: The Committee was informed that progress had been made and an external chair for the Clinical Advisory Group had been appointed. However, future action was being reviewed in the context of the COVID-19 outbreak. A risk was highlighted regarding the realisation of the emergency capital bid application and planned capital developments on site since the COVID-19 outbreak. Progress on the current Neonatal Capital Build was also under review. The Committee requested that the Executive Team manage the position operationally and assess potential impact on the contract whilst ensuring patient safety and social responsibility.

- **Board Assurance Framework (BAF):** The Committee reviewed the risks that it was accountable for within the BAF and agreed that no amendments to risk scores was required. The Committee reviewed a new narrative for risk 2184 - EPR and a newly introduced BAF risk 2335 - relating to cyber security. The Committee recommended both for Board approval.

- **Corporate Objectives Outturn 2019/20:** The Committee was assured by progress identified against the corporate objectives 2019/20.

- **Draft Corporate Objectives 2020/21:** The Committee requested that the draft 2020/21 Corporate Objectives be reviewed in the context of the COVID-19 outbreak and be reported back to the next scheduled meeting.

- **Risk Appetite Statement – Review of FPBD Committee related risks:** The Committee approved the risk appetite statement and risk tolerance level as moderate in relation to the FPBD Committee related risk it is accountable for, "to be ambitious and efficient and make the best use of available resources."

- **Committee Annual Workplan 2020/21 & Terms of Reference:** The Committee reviewed and approved the committee workplan and terms of reference for 2020/21. It was noted going forward the agendas and some items of business would be reported on a consent agenda basis to allow for timely and concise meetings to be held. Whilst the 2020/21 workplan was approved, it was acknowledged that items would require prioritisation in the context of COVID-19. The workplan will remain an iterative document, flexing to the developing situation.

- **IM&T Update:** The Committee was informed that a new Clinical Chief Information Officer had been appointed and would commence post 1st April 2020. It was acknowledged that the planned workshop approach to develop the IMT Strategy would be reviewed due to COVID-19 recommendations. The Committee noted the latest position in relation to the EPR system and the Committee was informed that NHS Digital had extended the submission timescales for the information governance DSP toolkit until September 2020 due to the COVID-19 pandemic.

  The Committee thanked the IMT team for the swift action taken to provide virtual solutions to meetings and clinics and for the ongoing support.

3. **Board Assurance Framework (BAF) risks reviewed**

   No changes to existing risks were identified as a result of business conducted during the meeting. The Committee would recommend for Board approval a) the new narrative for risk 2184 - EPR and b) the introduction of BAF risk 2335 - cyber security, noting FPBD as the appropriate assurance committee.

4. **Escalation report to the Board on Performance Measures**

   The Committee highlighted potential impact on performance measures going forward in response to the COVID-19 pandemic.

5. **Issues to highlight to Board**

   - A risk to the Neonatal Capital programme build completion timescales
   - A risk to realisation of the emergency capital bid application

6. **Action required by Board**

   The Committee recommend to the Board the appetite and risk tolerance levels for 2020-21 against the key strategic aims for which this Committee is responsible.

~ Approval of the Committee terms of reference (enclosed).

Phil Huggon
Chair of FPBD Committee
24 March 2020

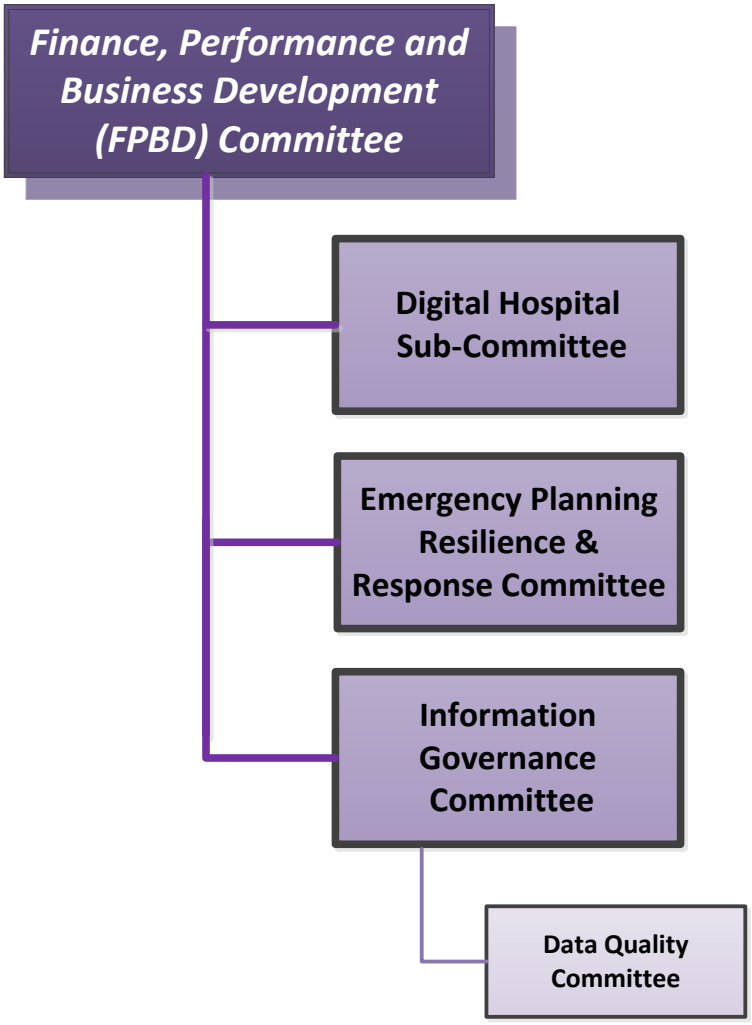
FINANCE, PERFORMANCE AND BUSINESS DEVELOPMENT COMMITTEE TERMS OF REFERENCE

Constitution:	The Board hereby resolves to establish a Committee of the Board to be known as the Finance, Performance and Business Development Committee (the Committee).
Duties:	The Committee will operate under the broad aims of reviewing financial and operational planning, performance and business development. The Committee's responsibilities fall broadly into the following two areas: **Finance and performance** The Committee will: a. Receive and consider the annual financial and operational plans and make recommendations as appropriate to the Board. b. Review progress against key financial and performance targets c. Review on behalf of the Board, financial submissions (as reported in the Financial Performance Report) or others, as agreed by the Board, to NHS Improvement for consistency on financial data provided. d. Review the service line reports for the Trust and advise on service improvements e. Provide oversight of the cost improvement programme f. Oversee external financing & distressed financing requirements g. Oversee the development and implementation of the information management and technology strategy h. Examine specific areas of financial and operational risk and highlight these to the Board as appropriate through the Board Assurance Framework i. To undertake an annual review of the NHS Improvement Enforcement Undertaking. j. To review and receive assurance on the appropriateness of the Trust's Emergency Planning Resilience & Response processes and procedures. **Business planning and development** The Committee will: k. Advise the Board and maintain an overview of the strategic

	business environment within which the Trust is operating and identify strategic business risks and opportunities reporting to the Board on the nature of those risks and opportunities and their effective management l. Advise the Board and maintain an oversight on all major investments, disposals and business developments. m. Advise the Board on all proposals for major capital expenditure over £500,000 n. Develop the Trust's marketing & communications strategy for approval by the Board and oversee implementation of that strategy
Membership:	The Committee membership will be appointed by the Board of Directors and will consist of: • Non-Executive Director (Chair) • Two additional Non-Executive Directors • Chief Executive • Director of Finance • Director of Operations • Director of Nursing and Midwifery Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. The Board of Directors will appoint a Non-Executive Director as Chair of the Committee. Should the Chair be absent from a meeting of the Committee, the Committee may appoint a Chair of the meeting from amongst the Non-Executive Directors present.
Quorum:	The quorum for the transaction of business shall be three members including at least two Non-Executive Directors (one of whom must be the Chair or Vice Chair of the Committee), and one Executive Director. The Chair of the Trust may be included in the quorum if present.
Voting:	Each member will have one vote with the Chair having a second and casting vote, if required. Should a vote be necessary a decision will be

	determined by a simple majority.
Attendance:	a. Members Members will be required to attend a minimum of 50% of all meetings. b. Officers Ordinarily the Deputy Director of Finance and Trust Secretary will attend all meetings. Other executive directors and officers of the Trust will be invited to attend the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed.
Frequency:	Meetings shall be held at least 8 times per year. Additional meetings may be arranged if required, to support the effective functioning of the Trust.
Authority:	The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of representatives from partner organisations or other external bodies or organisations with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities. The Committee is authorised to approve those policies and procedures for matters within its areas responsibility.
Accountability and reporting arrangements:	The Finance, Performance and Business Development Committee will be accountable to the Board of Directors. A Chair's Report will be submitted to the next following Board of Directors for assurance (see Appendix 1). Approved minutes will be made available to all Board members. The Committee will report to the Board annually on its work and

	performance in the preceding year. Trust standing orders and standing financial instructions apply to the operation of the Finance, Performance and Business Development Committee.
Reporting Committees and Groups	The sub committees/groups listed below are required to submit the following information to the Committee: a) Chairs Report; and b) an Annual Report setting out the progress they have made and future developments. The following sub committees/groups will report directly to the Committee: • Information Governance Committee • Emergency Planning Resilience & Response Committee • Digital Hospital Sub-Committee
Monitoring effectiveness:	The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements.
Review:	These terms of reference will be reviewed at least annually by the Committee.
Reviewed by Finance, Performance & Business Development Committee:	~~25 March 2019~~ 24 March 2020
Approved by Board of Directors:	~~5 September 2019~~
Review date:	March 2021~~0~~
Document owner:	Mark Grimshaw ~~Colin Reid,~~ Trust Secretary Tel: 0151 702 4033


Finance, Performance and Business Development (FPBD) Committee
Digital Hospital Sub-Committee
Emergency Planning Resilience & Response Committee
Information Governance Committee
Data Quality Committee

Board of Directors
Committee Chair's report of Audit Committee meeting held 24 March 2020

1. Meeting Quorate: Yes

2. Agenda items covered

~ Chair's Announcements: The Chair noted the importance of maintaining good governance and systems of control during the COVID-19 pandemic and highlighted the role of the Committee in providing assurance on this.

~ Follow up of Internal Audit and External Audit Recommendations: The Committee received an updated position on audit recommendations from the Deputy Director of Finance and noted that there were no overdue actions. The Committee was advised that recommendations relating to consultant job planning and EPR that were scheduled to be completed by 31 March 2020 would be closed by this point. It was also expected that a recommendation from the Procurement Review Assignment Report would be closed out in a timely way but should an extension be required this would be escalated to the Executive Team.

~ Internal Audit Progress Reports: The Committee received a report which detailed outcomes of Internal Audit Reviews as follows:

- Assurance Framework - Meets Requirements
- Cyber Security – Moderate
- Quality Spot Checks
    - Gynaecology Inpatients – Substantial
    - Gynaecology Emergency Department – High
    - Bedford Centre – Substantial

The Committee welcomed the encouraging outcomes of from the Quality Spot Checks. The Committee sought assurance that the actions identified following the Cyber Security Review would enable the Trust to move towards substantial assurance. The internal auditor confirmed that they were satisfied that the management responses identified would address the issues raised. The efficacy of the actions would be monitored through the usual follow up processes. The Director of Finance added that the Trust had taken steps to develop a BAF risk on cyber security which would provide additional visibility on how the risks were being managed.

~ Head of Internal Audit Draft Opinion: The Committee received the draft Head of Internal Audit Opinion. This provided Substantial Assurance that that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently. It was noted that whilst the delay to the Data Security and Protection Toolkit (DSPT) submission would be a consideration in the Internal Audit Opinion, it would not have an impact on the overall rating.

~ Internal Audit Plan 2020/21: The Committee received the 2020/21 internal audit plan and was assured that the areas for audit were relevant to the risks faced by the Trust. It was noted that the delivery of the plan was likely to be fluid with the timetable re-profiled to enable 'desk-based' reviews to be undertaken in the earlier part of the year. The content of the plan would

also need to be regularly reviewed in the context of the COVID-19 outbreak. The addition of the Audit Committee effectiveness review was noted.

~ **Internal Audit Charter**: The Committee received the Internal Audit Charter that defines the internal audit activity's purpose, authority and responsibility. The Committee was assured that the process adopted by MIAA fell within the charter.

~ **Counter Fraud:** The Committee received three reports from counter fraud, the 2019/20 progress report, draft annual report 2019/20 and the Counter Fraud work plan 2020/21. The Committee received assurance on the work of counter fraud for the year and actions taken to engage with staff at the Trust to highlight counter fraud measures. There had been two cases of fraud identified during the year and two out of 23 NHS Counter Fraud Authority (NHSCFA) standards had been rated as 'amber' until evidence of Trust action could be demonstrated. Assurance was provided that this evidence would be provided shortly and the standards would then be rated as 'green'.

~ **Data Security and Protection Toolkit Assurance 2019/20 –** It was noted that the deadline for submission of the toolkit had been extended until September 2020.

~ **KMPG External Audit Progress Report and Sector Update:** The Committee received an update from the External Auditor on progress made to date. Consideration was being given to the impact of COVID-19 on the year-end audit process. It was noted that certain requirements had been relaxed by the government including the need to audit the quality account and the implementation of IFRS 16 was being deferred until 2021/22. The logistics of working with the Trust's finance team to gain access to key documents was being discussed and the utilisation of IMT solutions had worked well to date.

~ **Area of Judgement in the Annual Accounts:** The Committee noted the areas in the 2019/20 accounts requiring the judgement of management. It was noted that the deferment of IFRS 16 meant that there were minimal changes from the 2018/19 approach. The Committee approved the approach that the accounts should be prepared on a going concern basis and noted the areas of judgement.

~ **Risk Management Strategy:** The Committee received the updated Risk Management Strategy noting that it had also been received by the Quality Committee. The Committee noted the recent (2018/19) assurance provided from the MIAA Internal Audit review of the risk management process, which had provided substantial assurance that the core control mechanisms were in place to manage the risk management process. The Committee recommended the Risk Management Strategy for approval to the Board.

~ **Clinical Audit Forward Plan 2020/21:** The Committee received the Trust's Clinical Audit Programme for 2019/20 noting that it would also be received by the Quality Committee in April 2020 for approval. The Committee was assured that appropriate processes and procedures were in place and that the clinical audits were prioritised according to clinical risks. A query was raised on whether the number of clinical audits identified would be deliverable considering the likely forthcoming pressures from managing COVID-19. A request was made by the internal auditor to consider the inclusion of an audit on safety standards for invasive procedures (theatres).

~ **Losses and Special Payments:** The Committee was assured that there were no identified items for write off and all outstanding debt was being pursued.

- **Review of Audit ToR and Business Cycle 2020/21**: The Committee reviewed and approved the Audit Committee terms of reference and business cycle. It was noted that the workplan would need to be consistently monitored to react to the requirements of the organisation. It was agreed that it would be good practice to include the Business Cycle at the end of each subsequent meeting pack. It was suggested that other Board Committees would also wish to adopt this practice. The Terms of reference would be submitted to the Board of Directors for ratification.

- **Chairs Reports**: The Committee received and noted the Chair's reports for recent meetings of the Finance, Performance and Business Development Committee, the Quality Committee, the Putting People First Committee and the Charitable Funds Committee.

3. **Board Assurance Framework (BAF) risks reviewed**
   - **Board Assurance Framework:** The Committee was assured of the processes in place to review the BAF, consistent with the outcome from the completed internal audit report earlier in the meeting. The Trust Secretary noted that future reports on the BAF would provide additional focus on the efficacy of the processes underpinning the BAF.

4. **Escalation report to the Board on Audit Performance Measures**
   - None

5. **Issues to highlight to Board**
   - The Committee was informed that work was underway to articulate the risks posed by COVID-19 and how this would be reflected on the BAF.

6. **Action required by Board**
   - Approval of Audit Committee terms of reference (enclosed).

Tracy Ellery
Chair of Audit Committee
24 March 2020

Liverpool Women's NHS Foundation Trust

AUDIT COMMITTEE
TERMS OF REFERENCE

Constitution:	The Committee is established by the Board of Directors and will be known as the Audit Committee (the Committee). The Committee is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference.
Duties:	The Committee is responsible for: **a. Governance, risk management and internal control** The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the Trust's activities (both clinical and non-clinical) that supports the achievements of the Trust's objectives. It will provide an independent and objective view on internal control and probity. In addition, the committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to its financial performance, reviewing significant financial reports and the judgements contained in them. In particular, the Committee will review the adequacy of: • All risk and control related disclosure statements (in particular the Annual Governance Statement and declarations of compliance to external bodies), together with any accompanying Head of Internal Audit opinion, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board • The process of preparing the Trust's returns to NHS Improvement (which returns are approved by the Board's Finance and Performance Committee) • The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements • The policies for ensuring that there is compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification • The Trust's standing orders, standing financial instructions and scheme of delegation • The policies and procedures for all work related to fraud and corruption as set out in the Secretary of State directions and as required by the NHS Counter Fraud ***Authority*** ~~Security Management Service~~ • The arrangements by which Trust staff may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. In so doing

the Committee's objective should be to ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.

In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

The Committee will undertake an annual training needs assessment for its own members.

b. Internal audit

The Committee will ensure that there is an effective internal audit function established by management that meets mandatory government and Public Sector Internal Auditing Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by:

- Consideration of the appointment of the internal audit service, the audit fee and any questions of resignation and dismissal
- Review and approval of the internal audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework
- Reviewing the internal audit programme, considering the major findings of internal audit investigations (and management's response), and ensuring coordination between internal and external auditors
- Ensuring that the internal audit function is adequately resource~~d~~***ds*** and has appropriate standing within the organisation
- Annual review of the effectiveness of internal audit.

c. External audit

The Committee shall review the independence, objectivity and work of the external auditor appointed by the Council of Governors and consider the implications and management's response to this work. This will be achieved by:

- Consideration of the appointment and performance of the external auditor, including making recommendations to the Council of Governors regarding the former
- Discussion and agreement with the external auditor, before the audit commences, of the nature and scope of the audit as set out in the annual audit plan and ensure coordination with internal auditors and

with other external auditors
- Discussion with the external auditors of their local evaluation of audit risks and assessment of ***the*** Trust and associated impact on the audit fee
- Reviewing all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Board and any audit work performed outside the annual audit plan, together with the appropriate***ness*** of management's response
- Recommending to the Council of Governors the engagement of the external auditor in respect of non-audit work, taking into account relevant ethical guidance regarding the provision of such services
- Annual review of the effectiveness of external audit.

d. Other assurance functions

The Committee will review the findings of other significant assurance functions, both internal and external to the Trust, and consider the implications to the governance of the Trust. These will include, but will not be limited to, reviews and reports by the Department of Health, arms length bodies or regulators/inspectors (e.g. Care Quality Commission, NHS Resolution, etc), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc) or the Local ***Anti*** ~~Counter~~ Fraud Specialist.

In addition the Committee will review the work of other Committees within the Trust, whose work can provide relevant assurance to the Audit Committee's own scope of work. This will particularly include the Quality Committee, Finance, ~~and~~ Performance ***Business Development*** Committee and Putting People First Committee, and include a review of an annual report of each of the Committees against their terms of reference. In reviewing the work of the Quality Committee, and issues around clinical risk management, the Audit Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

The Committee will also review all suspensions of standing orders and variation or amendment to standing orders.

The Audit Committee will report to the Board and to the Council of Governors any matters in respect of which it considers action or improvement is needed.

e. Counter fraud

The Audit Committee will satisfy itself that the Trust has adequate arrangements in place for countering fraud and will approve the appointment of the Local ***Anti*** ~~Counter~~ Fraud Specialist. The Committee will review the outcomes of counter fraud work.

	f. Management The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control. *The* ~~They~~ *Committee* may also request specific reports from individual functions within the organisation (e.g. clinical audit) as they may be appropriate to the overall arrangements. g. Financial reporting The Audit Committee shall monitor the integrity of the Annual financial statements of the Trust. The Audit Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board. The Audit Committee will review the Trust's annual report and financial statements before submission to the Board, focusing particularly on: • The wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee • Changes in, and compliance with, accounting policies and practices • Unadjusted mis-statements in the financial statements • Major judgemental areas, and • Significant adjustments resulting from the audit • Letter of representation • Qualitative aspects of financial reporting.
Membership:	The Committee membership will be appointed by the Board of Directors from amongst its Non-Executive members and will consist of not less than three members. Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. The Board of Directors will appoint a Non-Executive Director as Chair of the Committee. Should the Chair be absent from a meeting of the Committee, the Committee may appoint a Chair of the meeting from amongst the Non-Executive Directors present.
Quorum:	A quorum shall be two members.
Voting:	Each member will have one vote with the Chair having a second and casting

	vote, if required. Should a vote be necessary a decision will be determined by a simple majority.
Attendance:	a. Members Members will be required to attend a minimum of 75% of all meetings. b. Officers The Director of Finance, Deputy Director of Finance, Financial Controller and Deputy Director of Nursing & Midwifery shall normally attend meetings. At least once a year the Committee will meet privately with external and internal auditors. The Chief Executive and other executive directors will be invited to attend, particularly when the Committee is discussing areas of risk or operation that are within the responsibility of that director. The Chief Executive will also be required to attend when the Audit Committee discusses the process for assurance that supports the Annual Governance Statement. The Trust Secretary will attend to provide appropriate support to the Chair and Committee members.
Frequency:	Meetings shall be held at least four times per year. The external auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.
Authority:	The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of representatives from partner organisations or other external bodies or organisations with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities.
Accountability and reporting arrangements:	The Audit Committee will be accountable to the Board of Directors. A Chair's Report will be submitted to the next following Board of Directors for assurance (see Appendix 1). Approved minutes will be made available to all Board members. The Committee will report to the Board annually on its work and performance in the preceding year and, as part of this report, will provide

	commentary in support of the Annual Governance Statement ***(AGS)***, specifically dealing with the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the Trust, the integration of governance arrangements and the appropriateness of the evidence compiled to demonstrate fitness to register with the Care Quality Commission and the robustness of the processes behind the quality accounts. In providing this commentary in support of the AGS the Committee will seek relevant assurance from the Chair of the Board's Quality Committee. Trust standing orders and standing financial instructions apply to the operation of the Audit Committee.
Monitoring effectiveness:	The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements.
Review:	These terms of reference will be reviewed at least annually by the Committee.
Reviewed by Audit Committee:	*24 March 2020* ~~25 March 2019~~
Approved by Board of Directors:	*2 April 2020* ~~5 September 2019~~
Review date:	March *2021* ~~2020~~
Document owner:	Mark Grimshaw, Trust Secretary Email: mark.grimshaw@lwh.nhs.uk Tel: 0151 702 4033

	Agenda Item	
MEETING	**Board**	
PAPER/REPORT TITLE:	**COVID-19 Update**	
DATE OF MEETING:	Thursday, 02 April 2020	
ACTION REQUIRED	**Assurance**	
EXECUTIVE DIRECTOR:	Gary Price, Director of Operations	
AUTHOR(S):	Gary Price, Director of Operations	
STRATEGIC OBJECTIVES:	***Which Objective(s)?***	
	1. To develop a well led, capable, motivated and entrepreneurial ***workforce***	☒
	2. To be ambitious and ***efficient*** and make the best use of available resource	☒
	3. To deliver ***safe*** services	☒
	4. To participate in high quality research and to deliver the most ***effective*** Outcomes	☒
	5. To deliver the best possible ***experience*** for patients and staff	☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?***	
	1. *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust……*	☐
	2. *Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have sufficient numbers of clinical staff with the capability and capacity to deliver the best care. ……*	☒
	3. *The Trust is not financially sustainable beyond the current financial year……*	☐
	4. *Failure to deliver the annual financial plan ……*	☐
	5. *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision ……*	☐
	6. *Ineffective understanding and learning following significant events……*	☐
	7. *Inability to achieve and maintain regulatory compliance, performance and assurance……*	☒
	8. *Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) ……*	☐
CQC DOMAIN	***Which Domain?***	
	SAFE- *People are protected from abuse and harm*	☐
	EFFECTIVE - *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.*	☐
	CARING - *the service(s) involves and treats people with compassion, kindness, dignity and respect.*	☐
	RESPONSIVE – *the services meet people's needs.*	☐
	WELL-LED - *the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.*	☐
	ALL DOMAINS	☒

LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution ☐ **2.** Operational Plan ☒ **3.** NHS Compliance ☒	**4.** NHS Constitution ☐ **5.** Equality and Diversity ☐ ***6.*** Other: **Click here to enter text.**
FREEDOM OF INFORMATION (FOIA):	1. This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting	
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	***The Board is recommended to note the update for information and assurance.***	
PREVIOUSLY CONSIDERED BY:	**Committee name**	N/A
	Date of meeting	

Executive Summary

This paper summarises the Trusts response to date to the international Covid 19 (Coronavirus) pandemic. It details the Trusts response as a Category 1 responder under the Civil Contingencies Act in order to support our patients, our staff and the wider Health and Social Care System

Report

1. Introduction

Covid 19 (Coronavirus) originated in China in December 2019 and rapidly spread through Asia and Europe. The NHS declared the coronavirus outbreak a national major incident on 3rd March 2020 requiring NHS Trusts to respond under the Civil Contingencies Act (1994).

On March 11th 2020 the World Health Organization (WHO) declared this a global pandemic.

The major incident response requires business continuity measures to be enacted, potentially for several months with an as unpredictable end date. This paper details the work undertaken to date by the Trust.

2. Key issues

A flu pandemic is a "rising tide" event. These events typically continue for several months with slow and unpredictable sustained progression, a peak and a slow, unpredictable and sustained regression. Rising tide events are therefore one of the most challenging type of business continuity events to manage over a sustained period.

The Trust in response has enacted business continuity measures in response to this major incident. The Trust has an established major incident policy and business continuity plans that are regularly reviewed by the Emergency Planning Resilience and Response Committee that reports to the Trust Board. In addition, for this type of major incident the Flu Pandemic Plan has also been considered.

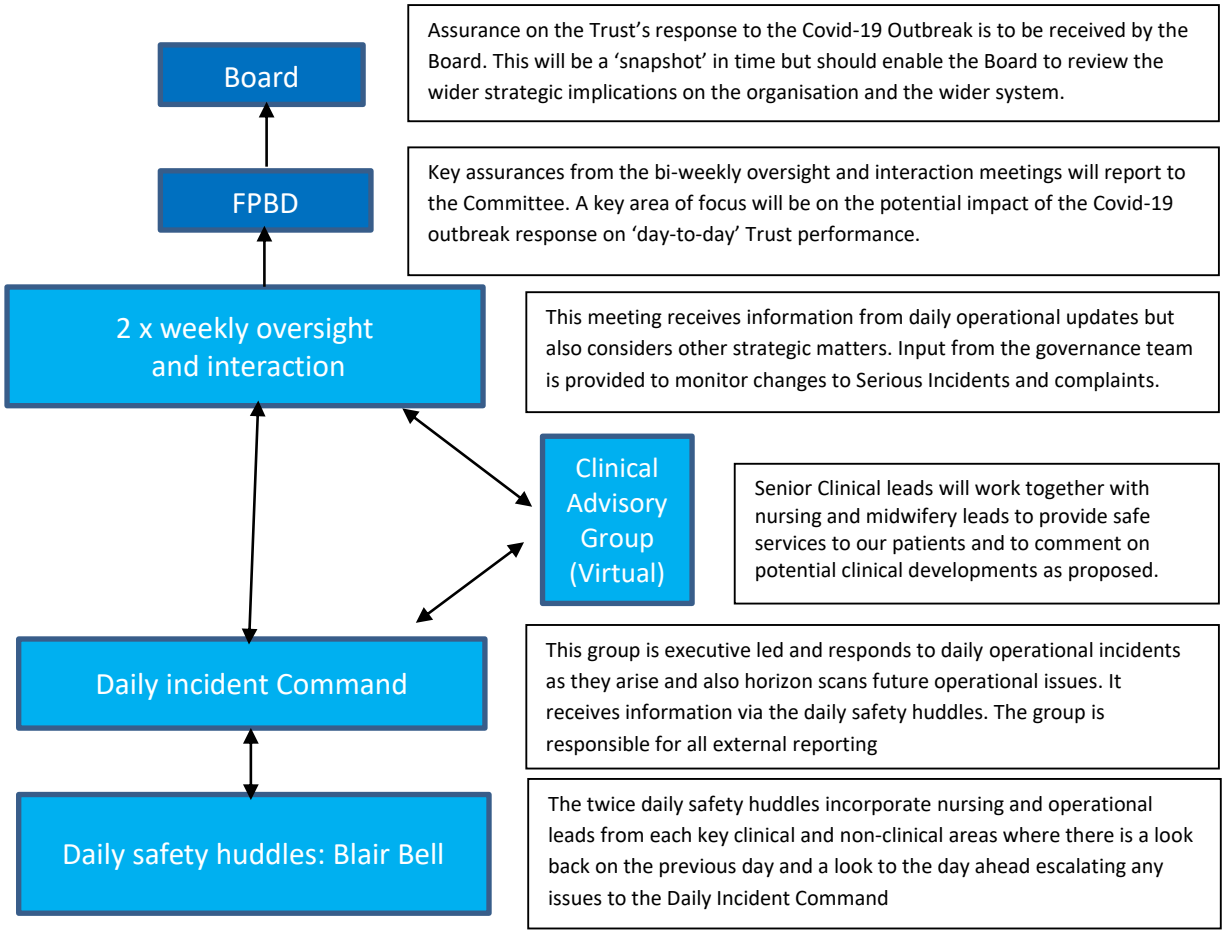
The challenge to date has required Trusts to enact Business Continuity against a backdrop of a reduction of staff of 20% for a sustained period prioritising essential services. Staff will be absent for a variety of reasons related to the outbreak.

In addition, services that the Trust relies on and the ability of wider health and social care partners to interact with the Trust for normal business has been challenged due to reductions in workforce in those areas, for example reductions in Primary and Community Care provision or provision of routine supplies and equipment

Once essential services are sustained then the Trust is required to consider mutual aid to the system to support the system response

Governance Structure and Processes

The response to the Covid-19 outbreak is generating a significant amount of information and guidance from various sources. Requests are also being made of the Trust to provide information to local, regional and national systems. The Trust has implemented a governance structure which is intended to ensure that there is a co-ordinated response to information being received and that is sufficiently agile for timely yet robust decision-making. The structure supports the Trust in managing the day-to-day demands whilst also remaining sighted on wider, strategic considerations.



Summary of key actions taken to date

Essential services have been prioritised; these are:

- Neonates
- Maternity and Obstetrics
- Gynaecology Emergencies
- Gynaecology Cancer
- Termination of Pregnancy
- Theatres and Anaesthetics
- Pharmacy
- Essential corporate services including estates, security and facilities
- Risk and Governance

Other services have been reduced or stepped down

- Fertility
- Routine Gynaecology outpatients and elective surgery
- Routine therapies
- Genetics
- Research and Development
- Non-essential corporate services

Skill mix

The Trust has conducted a skill mix review of all staff who are working as part of the non-essential services. Heads of Nursing and HR teams have identified staff who can support those essential services during the pandemic

Visitor restrictions

Visitor restrictions are in place in line with national guidance. These are regularly reviewed by the oversight and interaction group. Visitor restrictions are in place to reduce the interactions within the organization and therefore potential spread of Covid 19.

Virtual ways of working

The Trust has seen the rapid introduction of software that has allowed team meetings to be conducted virtually right through the organization. This has been done to stop the number of physical interactions and therefore contribute to the poetical reduction in spread of Covid 19. Virtual clinics have been established for some of our more vulnerable patients who may be able to have their consultation undertaken in this way.

Staff Wellbeing

There has been an increased focus on staff wellbeing with staff being reminded of the existing routes of support available to them via the Trust's occupational health and wellbeing services. National support lines have also been introduced and will be widely promoted to staff over the coming days and weeks. A focus on thanking staff with gifts such as tea, coffee and biscuits from the Trust and gifts from local restaurants and businesses (such as John Lewis) will continue over coming weeks.

Clinical Governance

Clinical Governance is an essential service and will remain so through this pandemic. Staff are encouraged to report incidents relating to the pandemic to support the Trusts oversight of issues relating to patient care during this period

24/7 Management

The Trust has senior management and Executive presence daily within the organization during the pandemic period which supplements the already exiting senior management and executive on call rota

Recovery

The nature of a pandemic is that a date for recovery and the end of business continuity is unknown. Specific operational support has been allocated within the organization to oversee the impact on normal activity of the organization to date and to commence planning for recovery. This work is done via the Access Board that reports into FPBD

Communications Approach

Messages at both national and local level are fast moving and changing on a daily if not hourly basis. The Trust has adopted the approach of one centralised daily brief for staff, which includes twice weekly video messages from Executives. The daily brief also includes Frequently Asked Questions. A range of media is being adopted to ensure patients, visitors and their families are aware of the changing situation on the site including our social media channels. Issues such as short notice changes to visiting arrangements are being supplemented by text messaging and direct telephone calls in advance of appointments.

Risks

Work is underway to map and characterise the risks relating to the COVID-19 outbreak. It is recognised that there will be risks to quality of care, operational performance, the financial position, governance and compliance and to the workforce. Whilst there are existing BAF risks in these areas, the extent of the risks posed and potential impact on services is such that it is felt that a separate entry as a BAF risk is necessary. Interdependencies between COVID-19 specific risks and their impact on other BAF risks will be monitored and reflected. Whilst the Finance, Performance and Business Development Committee has overall oversight of business continuity, the other Board Committees will have a role in ensuring that there are adequate controls and mitigations in place for the identified risks. The first iteration of the COVID-19 BAF risk will be considered by the Board Committees later in the month and reported through to the Board in May 2020.

The update later in the agenda on the 2020/21 Operational Plan will provide further detail on the potential financial impacts of the COVID-19 outbreak.

3. Recommendation

The Board is recommended to note the update for information and assurance.

Agenda Item	

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Safer Nurse/Midwife Staffing Monthly Report**
DATE OF MEETING:	2nd April 2020
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	Choose an item. Caron Lappin, Director of Nursing and Midwifery
AUTHOR(S):	Janet Brennan, Deputy Director of Nursing and Midwifery
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** 1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☐ 2. To be ambitious and *efficient* and make the best use of available resource ☐ 3. To deliver *safe* services ☒ 4. To participate in high quality research and to deliver the most *effective* Outcomes ☐ 5. To deliver the best possible *experience* for patients and staff ☐
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust* ☒ ***2.*** *The Trust is not financially sustainable beyond the current financial year* ☐ ***3.*** *Failure to deliver the annual financial plan* ☐ ***4.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision* ☐ ***5.*** *Ineffective understanding and learning following significant events* ☐ ***6.*** *Inability to achieve and maintain regulatory compliance, performance and assurance* ☒ ***7.*** *Inability to deliver the best clinical outcomes for patients* ☒ ***8.*** *Poorly delivered positive experience for those engaging with our services* ☒
CQC DOMAIN	***Which Domain?*** ***SAFE-*** *People are protected from abuse and harm* ☐ ***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☐ ***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☐ ***RESPONSIVE –*** *the services meet people's needs* ☐ ***WELL-LED -*** *the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.* ☐ ***ALL DOMAINS*** ☒
LINK TO TRUST STRATEGY, PLAN AND	**1.** Trust Constitution ☐ **4.** NHS Constitution ☐ **2.** Operational Plan ☐ **5.** Equality and Diversity ☐

EXTERNAL REQUIREMENT	**3.** NHS Compliance ☒	***6.*** Other: **NHS England Compliance**
FREEDOM OF INFORMATION (FOIA):	1. This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting	
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	The Board is asked to note: • The content of the report and be assured appropriate information is being provided to meet the national and local requirements. • The organization has the appropriate number of nursing & midwifery staff on its inpatient wards to manage the current clinical workload as assessed by the Director of Nursing & Midwifery	
PREVIOUSLY CONSIDERED BY:	**Committee name**	***Choose an item.*** Or type here if not on list: Click here to enter text.
	Date of meeting	

Executive Summary

Data presented in this report demonstrates the effective use of current Nursing & Midwifery resources for all inpatient clinical areas. The monthly report identifies staffing fill rates to demonstrate nursing and midwifery and care support levels. Fill rates of 100% mean that all planned staff were on duty. Fill rates of greater than 100% represent increased staffing levels to meet unplanned demand to meet patient care needs.

Fill rates of less than 100% reflect unplanned sick leave, vacancy or when staff are moved to work in another clinical area of greater clinical needs, due to low occupancy rates on their own area, or where by demands are greater in another clinical area.

Where there is a variance against planned rates the reallocation of nursing and midwifery resources are implemented where necessary to maintain safe staffing levels.

The use of CHPPD as a benchmark within and against other organisations is still under development by NHS Improvement and subsequent reports will be amended accordingly, presently CHPPD is featured alongside fill rates for each ward and department.
Care hours per day remain at a sustained level indicating a consistent level of care nursing/midwifery resource to provide care to our patients. The staffing across the inpatient ward areas for January and February remained appropriate to deliver safe and effective high-quality family centred patient care day and night.

The Trust has increased student placements by 63% since 2016 and there is limited opportunity to increase by anymore.

Workforce reviews have been undertaken by the divisions which include succession planning. planning.

Due to Covid-19 there are a number of Nurses and Midwives unable to work, This is being monitored and managed on a daily basis.

Ward Staffing Levels – Nursing and Midwifery
Report January and February 2020

1.0 Introduction

This report provides a monthly summary of Safe Staffing on all inpatient wards across the Trust. It includes the safe staffing exception report related to staffing levels, incidents and red flags which are triangulated with a range of quality indicators for both nursing and midwifery.

2.0 Safer staffing exception report

The safer staffing fill rate (appendix 1) provides the established versus actual fill rates on wards split by registered and unregistered staffing hours and by day and night shifts. Fill rates are accompanied by supporting narrative by exception at ward level, and a number of related factors are displayed alongside fill rates to provide an overall picture of safe staffing.

- Sickness rate and vacancy rate are the two main factors affecting fill rates, a growing trend is maternity leave, especially within maternity division, and this is being closely monitored. It has been agreed that maternity can over establish by 10 midwives to cover maternity leave.
- The trust has introduced a ward accreditation system which is required to support the collection of quality indicators alongside real time patient safety flags. Ward accreditation baseline assessment was rolled out to 5 areas in April 2019. A further review of the 5 areas has been undertaken. 5 other areas are starting audits as part of the accreditation programme and will be fully accredited by the end of 2020.
- ACE incident submissions related to staffing and red flags, are monitored daily at the huddle
- Nurse sensitive indicators demonstrate outcome for patients measuring harm these include;
    - Pressure Ulcers grade 1&2/Grades 3&4
    - Falls resulting in harm / not resulting in physical harm
    - Medication errors resulting in harm/ not resulting in harm
    - Babies requiring thermo cooling resulting in an Each Baby counts report
    - Cases of Clostridium Difficile (CDT)
    - In line with the National Quality Board 2016 the trust publishes nursing and midwifery staffing data on a daily basis at entrances to wards, staffing data is also submitted on a monthly basis through a unify submission to the NHS choices site.

2.1 Summary of fill rates

The inpatient wards have been able to maintain safe fill rates during the month of **January and February 2020.**

- Maternity has seen a decrease in fill for care staff- due to vacancies, recruitment in progress
- Gynaecology has seen an increase in fill rate of care staff
- Neonates has had a drop in HCSW fill rate but is offset by registered staff

Staffing is monitored across maternity every 2 hours by the 104-bleep holder who has an over view of the whole of maternity service. Staff are moved between areas depending on activity. The Neo-natal unit uses an acuity model of staffing which is used every 12 hours. It should be noted that Jeffcoate ward is sometimes closed due to staffing and they are re-deployed to other areas in maternity.

There is currently a review of Bands 2, 3 and 4 JD and competencies across the organisation to ensure consistency.

2.2 Red Flags

In January there were 15 red flags reported (1 staffing shortfall) and February 2020 there were 9 red flags reported (3 staffing shortfalls).
Investigations into these concluded that staffing levels and skill mix were safe at the time and did not contribute directly to any incidents.

3.0 National information

There is no nationally agreed measure of the shortfall in the nursing and midwifery workforce in England, however, Health Education England state that there are circa 43 ,000 nursing vacancies and 3,500 midwives in the NHS in England.

Due to the shortages there is a requirement for each Trust to increase their student capacity by 20%. The Trust has increased student numbers by 63% since 2016. The new NMC proficiency standards have meant a different approach to mentoring students. This has been implemented across Nursing in September 2019. This is to be implemented in maternity in September 2020.

4.0 Vacancies

There are currently minimal vacancies for Registered staff across all areas. Theatres have now recruited to full establishment. There are several HCSW vacancies which are currently being recruited to.

Currently the Matron for CSS post is vacant. A review of the Job description has taken place, and this is currently out to advert.

Retaining staff is a key element in addressing the workforce position and we commenced a retention programme with NHSI starting in Nov 2018 to review our data and processes around recruitment and retention. The action plan has been submitted and is being monitored through NMPF and PPF. Currently the turnover is 6% in N&M. It must also be noted that there are 24 wte in family health division on maternity leave.

Further work is currently being undertaken to improve the quality of the staff rosters via the Health Roster system which will then provide more detailed accurate information that will assist in supporting safer staffing across the organisation. Each division undertakes health roster challenges led by HON/M.

Annual workforce reviews have also now taken place across the divisions.

5.0 Forward look

Since the onset of Covid- 19 as of 27.03.2020 there are 79 Nurses & Midwives with Covid- 19 related absences across all divisions. This is changing daily as staff return from isolation and others commence isolation. Each division is managing this daily with cross divisional support being offered when able. Some services have reduced considerably which is enabling this support to happen (Hewitt and Gynaecology). LWH is also supporting LUFT with the transfer of 15 patients onto the gynaecology ward. Training and support for staff is being undertaken to enable them to support other areas. As the situation escalates plans are in place to provide training to support maternity and neo-natal areas.

6.0 Medical Staffing Forward Look

Whilst this report provides assurance on nurse safe staffing, in the context of COVID-19 it is germane to provide a forward look in relation to medical staffing also. COVID-19 has had a significant impact upon medical staffing across the Trust with 47 staff members thus far having been absent because of either the development of symptoms, self-isolating because of a symptomatic family member, being themselves in a high-risk group or being pregnant. A twice weekly update on medical absences and expected times of return to work is being provided to the MD for oversight. Individual specialties are responding as necessary with consultants and trainees producing resilience rotas to ensure that emergency services remain fully covered. Some cross-specialty training is also taking place, for example, with consultant gynaecologists being retrained in the management of obstetric emergencies. Additional on-site accommodation has been provided so that consultants are better able to stay in the trust overnight, with on-call rooms being increased from two to seven in number. The possibility of the medical workforce being supplemented by return-to-work recently retired doctors is being explored.

7.0 Summary

During the months of **January and February 2020** all wards were considered safe with low/no levels of harm and positive patient experience across all inpatient areas indicating that safe staffing has been maintained. 1:1 care in established labour remains a green KPI, and midwifery indicators such as Breast-feeding rates have seen an improvement in performance.

Maternity has seen a rise in bank costs and overspends with a reduction in births.
The divisions are monitored bank and agency spend at performance review
The Board also needs to note there is a number of Nurses and Midwives off currently due to Covid-19, this is being monitored daily.

8.0 Recommendations
The Board is asked to receive the paper for information and discussion.

Appendix 1

Jan 2020

WARD	Fill Rate Day% RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff
Gynae Ward	90.3%	100%	98.9%	100%
Delivery suite	93.3%	67.7%	94.2%	71%
Mat Base	93.5%	79%	91.2%	73.4%
MLU	87.1%	96.8%	84.5%	83.9%
Jeffcoate	100%	95.2%	100%	78.9%
Neo-nates	114.5%	79%	111.5%	95.2%

Feb 2020

WARD	Fill Rate Day% RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff
Gynae Ward	87.9%	100%	100%	100%
Delivery suite	84.6%	94.8%	85.1%	77%
Mat Base	97.5%	82.2%	87.7%	95.8%
MLU	95.2%	120%	91%	110%
Neo-nates	119%	93.1%	120.5%	86.2%

Liverpool Women's NHS Foundation Trust

Agenda Item	

MEETING	**Trust Board**
PAPER/REPORT TITLE:	**Performance Report**
DATE OF MEETING:	Thursday, 02 April 2020
ACTION REQUIRED	**Assurance**
EXECUTIVE DIRECTOR:	Gary Price, Director of Operations
AUTHOR(S):	Gary Price, Director of Operations
STRATEGIC OBJECTIVES:	***Which Objective(s)?***
	1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☐
	2. To be ambitious and *efficient* and make the best use of available resource ☒
	3. To deliver *safe* services ☒
	4. To participate in high quality research and to deliver the most *effective* Outcomes ☐
	5. To deliver the best possible *experience* for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?***
	1. *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust…….* ☐
	2. *Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have sufficient numbers of clinical staff with the capability and capacity to deliver the best care. ……* ☒
	3. *The Trust is not financially sustainable beyond the current financial year……* ☐
	4. *Failure to deliver the annual financial plan ……* ☐
	5. *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision ……* ☐
	6. *Ineffective understanding and learning following significant events……* ☒
	7. *Inability to achieve and maintain regulatory compliance, performance and assurance……* ☐
	8. *Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) ……* ☐
CQC DOMAIN	***Which Domain?***
	SAFE- *People are protected from abuse and harm* ☐
	EFFECTIVE - *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☐
	CARING - *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☐
	RESPONSIVE – *the services meet people's needs.* ☐
	WELL-LED - *the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.* ☐

	ALL DOMAINS ☒	
LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution ☐ **2.** Operational Plan ☒ **3.** NHS Compliance ☒	**4.** NHS Constitution ☐ **5.** Equality and Diversity ☐ ***6.*** Other: Click here to enter text.
FREEDOM OF INFORMATION (FOIA):	*Choose an item.*	
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	***The committee is asked to note the report***	
PREVIOUSLY CONSIDERED BY:	**Committee name**	Not Applicable
	Date of meeting	

Executive Summary

This report has been produced to provide a performance position and for the Board to be assured of the measures taken to improve them where required.

Report

1. Introduction

This report provides an overview of the Trust's key performance indicators highlighting those where the targets have not been met in month and subsequent actions taken to improve this position. The performance for each quality standard is detailed in the Appendix. Where data is not available for month 11 due to reporting timescales the information will be provided the following month.

2. Workforce

KPI ID	Source	Service	Target < or >	Target	Value	Trend	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20
Sickness Absence Rate	Owner - Deputy Director of Workforce																	
KPI101T	NHSI	Trust	<=	4.5%	Numerator		2093	2278	2162	2083	1700	2041	2321	1989	2499	2264	2532	2549
					Denominator		36383	40680	39457	41042	39805	41056	39241	38077	40070	39330	40809	40902
					Performance		5.75%	5.60%	5.48%	5.07%	4.27%	4.97%	5.92%	5.22%	6.24%	5.76%	6.21%	6.23%
					Trend		▲	▼	▼	▼	▼	▲	▲	▼	▲	▼	▲	▲
					Target %		4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%
					Qtrly Performance		5.52%	5.52%	4.94%	4.94%	4.94%	5.37%	5.37%	5.37%	6.07%	6.07%	6.07%	6.23%
Mandatory Training Compliance	Owner - Deputy Director of Workforce																	
KPI095T	Quality Strategy	Trust	>=	95.0%	Numerator													
					Denominator													
					Performance		84.00%	86.00%	85.00%	86.00%	88.00%	89.00%	89.00%	90.00%	90.00%	89.00%	91.00%	91.00%
					Trend		▶	▲	▼	▲	▲	▲	▶	▲	▶	▼	▲	▶
					Target %		95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
					Qtrly Performance													

Sickness absence increased slightly in month by 0.02% to 6.23%, giving a year to date position of 5.59%. By comparison, the in-month figure for January 2019 was 5.22%. There remains a bias towards long term sickness absence which accounts for 66% of the overall total, and in terms of diagnosis, anxiety/stress/depression has now become the most common issue, followed by gastrointestinal problems, with cold/cough/flu dropping to third most common.

The level of sickness absence remains a concern. Sickness absence continues to be regularly scrutinised at Divisional Boards and Divisional Reviews. Local actions plans have been developed in key areas and assurance regarding the operational management of sickness absence is being reported to the Putting People First Committee. Trust wide, a variety of initiatives have been put in place to support the local operational management of sickness absence, these include: training of more mental health first aiders, the development of a return to work toolkit, resilience training, and the inclusion of health & wellbeing in objective setting for all managers.

Mandatory training compliance remains unchanged at 91%, 4% below the target figure. Local exception reporting is now in place within the divisions, and mandatory training compliance figures are scrutinised at Divisional Performance Reviews. Trajectories have been agreed at local level to support the achievement of the required compliance rate of 95%.

3. Experience

5.1 Access standards

INDICATOR		METRIC	THRESHOLD		ACTUALS										
					Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20
Cancer	2WW for suspected cancer	%	≥93%	Higher values are better	94.2	97.7	93.3	95.0	*93.9*	*96.3*	*97.9*	*96.7*	*95*	*92.58*	*96.7*
	31 Days from Diagnosis to 1st Definitive Treatment	%	≥96%	Higher values are better	83.3	90.3	60.0	70.3	*59.1*	*28.5*	*60.0*	*85.1*	*70.0*	*78.4*	*88.0*
	62 Days for First Treatment from urgent GP Referral **(After re-allocation)** Final Reported Position	%	≥85%	Higher values are better	54.3	80.9	22.2	32.3	*33.3*	*28.5*	*22.7*	*47.1*	*37.0*	*44.4*	*33.0*
	104d Referral to First Definitive Treatment	Count	0	Zero tolerance	0	1	3	0	*1*	*7*	*2*	*1*	*5*	*2*	*3*
RTT	RTT Incomplete Pathways <18 weeks	%	≥92%	Higher values are better	84.6	83.0	81.5	81.95	*83.0*	*83.3*	*83.1*	*83.7*	*82.00*	*82.60*	*82.60*
	Incomplete Pathway > 52 Weeks	Count	0	Zero tolerance	6	3	3	1	*1*	*1*	*3*	*5*	*1*	*0*	*0*

Cancer: for all Trusts data every month is submitted to the national data base (CWT) 5 weeks after the month end to ensure the accurate reallocation of the breaches. Data shown in grey is the **unvalidated** position and subject to change due to on-going data validation Trends therefore cannot incorporate or reflect the Jan data until the formal submissions are made.

RTT: All Trusts release the RTT data to the CCG at the end of the third week of the month for scrutiny with final upload to NHSE when this is then released publicly by the end of that month. Dates will vary according to calendar month and months with a bank holiday in them.

Cancer

Cancer performance remains a significant concern for the Trust with long term sickness within the speciality and vacancies.

The 2-week target was not achieved in month 10 missing by 1 patient. This target is on track to achieve as required for the quarter. The 31-day and 62-day target were not achieved. There were 2 104-day breeches for month 10.

The service has a medical establishment of 6 sub-speciality oncologists. At present there are three Consultants in post and due to sickness, two undertaking clinical duties. Regional escalation through the Cancer Alliance, NHSI and E and Liverpool CCG has taken place. The strategic view of the Trust is that cancer targets will remain a challenge whilst services are not co-located with appropriate surgical, critical care and diagnostic support. A formal partnership board with Liverpool University Hospitals is being established to attempt to address these issues.

In addition to the strategic actions the service is focussing operationally to mitigate wherever possible the reduced workforce. This is managed via a weekly Executive lead oncology action plan meeting.

The themes for local operational action are all based around maximising the existing resource to support the service and our patients. CCG and other commissioning colleagues are encouraged to attend these meetings in a partnership approach and have done.

As per the NHS Long Term Plan the Cheshire and Mersey Cancer Alliance will now be held to account for improving cancer performance with a view to addressing the regional failure to achieve the 62-day target. The Trust is engaged in this work. This proposes to move to a system level cancer improvement plan.

RTT

RTT incomplete 18-week pathway performance was 82.6% for January 2020 which was an increase from December 2019.

There were no 52-week breeches for January and February 2020, the first time in over a year.

There are at present three Consultant vacancies that are due to be recruited to in March 2020 which will provide the additional capacity to improve performance in line with trajectory. In addition, January 2020 saw unplanned Consultant absence.

4. Impacts of Covid-19 on access standard

The national picture is that it is anticipated that routine elective work may be significantly impacted due to Covid-19. The Trust is risk stratifying patients to understand the potential impact of this on the 18-week position. Cancer patients will be prioritised over routine patients.

5. Conclusion

This paper highlights the key access metrics where there is challenge in achievement and outlines the steps taken to address improvement.

Liverpool Women's NHS Foundation Trust

Board Performance Report

Published Month - March 2020

Data Included - Up to February 2020

Workforce

KPI ID	Source	Service	Target < or >	Target	Value	Trend	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20
Sickness Absence Rate	**Owner - Deputy Director of Workforce**																	
KPI101T	NHSI	Trust	<=	4.5%	Numerator		2278	2162	2083	1700	2041	2321	1989	2499	2264	2532	2549	2229
					Denominator		40680	39457	41042	39805	41056	39241	38077	40070	39330	40809	40902	38492
					Performance		5.60%	5.48%	5.07%	4.27%	4.97%	5.92%	5.22%	6.24%	5.76%	6.21%	6.23%	5.79%
					Trend		▼	▼	▼	▼	▲	▲	▼	▲	▼	▲	▲	▼
					Target %		4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%
					Qtrly Performance		5.52%	4.94%	4.94%	4.94%	5.37%	5.37%	5.37%	6.07%	6.07%	6.07%	6.02%	6.02%
Mandatory Training Compliance	**Owner - Deputy Director of Workforce**																	
KPI095T	Quality Strategy	Trust	>=	95.0%	Numerator													
					Denominator													
					Performance		86.00%	85.00%	86.00%	88.00%	89.00%	89.00%	90.00%	90.00%	89.00%	91.00%	91.00%	91.00%
					Trend		▲	▼	▲	▲	▲	▶	▲	▶	▼	▲	▶	▶
					Target %		95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
					Qtrly Performance													

Efficient

KPI ID	Source	Service	Target < or >	Target	Value	Trend	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20
Financial Sustainability Risk Rating: Overall Score					**Owner - Deputy Director of Finance**													
KPI087	NHSI	Trust	<=	3	Performance Value		3	3	3	3	3	3	3	3	3	3	3	3
					Trend		▶	▶	▶	▶	▶	▶	▶	▶	▶	▶	▶	▶
					Target Value		3	3	3	3	3	3	3	3	3	3	3	3
					Qtrly Performance Value		9	9	9	9	9	9	9	9	9	9	6	6

Safety

KPI ID	Source	Service ID	Target < or >	Target	Value	Trend	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20
Never Events	**Owner - Head of Governance**																	
KPI181T	NHSI	Trust	=	0	Performance Value		0	0	0	0	0	0	1	0	0	0	0	0
					Trend		▶	▶	▶	▶	▶	▶	▲	▼	▶	▶	▶	▶
					Target Value		0	0	0	0	0	0	0	0	0	0	0	0
					Qtrly Performance Value		0	0	0	0	1	1	1	0	0	0	0	0
NHSE / NHSI Safety Alerts Outstanding	**Owner - Head of Governance**																	
KPI193	NHSI	Trust	=	0	Performance Value		0	0	0	0	0	0	0	0	0	0	0	0
					Trend		▶	▶	▶	▶	▶	▶	▶	▶	▶	▶	▶	▶
					Target Value		0	0	0	0	0	0	0	0	0	0	0	0
					Qtrly Performance Value		0	0	0	0	0	0	0	0	0	0	0	0
Infection Control: Clostridium Difficile	**Owner - Infection Control Lead**																	
KPI104T	Quality Schedule	Trust		0	Performance Value		0	0	0	0	0	0	0	0	0	0	0	0
					Trend		▶	▶	▶	▶	▶	▶	▶	▶	▶	▶	▶	▶
					Target Value		0	0	0	0	0	0	0	0	0	0	0	0
					Qtrly Performance Value		0	0	0	0	0	0	0	0	0	0	0	0
Infection Control: MRSA	**Owner - Infection Control Lead**																	
KPI105T	Quality Schedule	Trust		0	Performance Value		0	0	0	1	0	0	0	0	0	0	0	0
					Trend		▶	▶	▶	▲	▼	▶	▶	▶	▶	▶	▶	▶
					Target Value		0	0	0	0	0	0	0	0	0	0	0	0
					Qtrly Performance Value		0	1	1	1	0	0	0	0	0	0	0	0
Neonatal Deaths (All Live Births within 28 Days) - all booked births	**Owner - Clinical Director Neonates**																	
KPI168a	Trust Objectives	Neonates	<=	4.6%	Numerator		1	1	2	2	0	0	5	1	1	1		
					Denominator		659	649	659	662	692	699	689	696	574	655		
					Performance		0.15%	0.15%	0.30%	0.30%	0.00%	0.00%	0.73%	0.14%	0.17%	0.15%		
					Trend		▼	▲	▲	▼	▼	▶	▲	▼	▲	▼		
					Target %		4.6%	4.6%	4.6%	4.6%	4.6%	4.6%	4.6%	4.6%	4.6%	4.6%	4.6%	4.6%
					Qtrly Performance		0.21%	0.25%	0.25%	0.25%	0.24%	0.24%	0.24%	0.16%	0.16%	0.16%		
Neonatal Deaths (All Live Births within 28 Days) - all live births	**Owner - Clinical Director Neonates**																	
KPI168b	Trust Objectives	Neonates	<=	6.1%	Numerator		1	1	4	2	0	0	5	1	3	2		
					Denominator		665	656	673	668	699	753	698	699	580	662		
					Performance		0.15%	0.15%	0.59%	0.30%	0.00%	0.00%	0.72%	0.14%	0.52%	0.30%		
					Trend		▼	▲	▲	▼	▼	▶	▲	▼	▲	▼		
					Target %		6.1%	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%
					Qtrly Performance		0.20%	0.35%	0.35%	0.35%	0.23%	0.23%	0.23%	0.31%	0.31%	0.31%		

Effective

KPI ID	Source	Service ID	Target < or >	Target	Value	Trend	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20
Intensive Care Transfers Out	**Owner - Clinical Director Gynaecology**																	
KPI107T	Trust Objectives	Trust			Performance Value		0	1	2	0	2	0	2	1	2	1	0	0
					Trend		▶	▲	▲	▼	▲	▼	▲	▼	▲	▼	▼	▶
					Target Value													
					Qtrly Performance Value		1	3	3	3	4	4	4	4	4	4	0	0

Liverpool Women's NHS Foundation Trust

Experience

KPI ID	Source	Service ID	Target < or >	Target	Value	Trend	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20
18 Week RTT: Incomplete Pathways	**Owner - Divisional Manager Gynaecology**																	
KPI003T	NHSI	Trust	>=	92.0%	Numerator		4715	4881	4973	5033	5117	5307	5310	5324	5224	4971	5187	5152
					Denominator		5539	5769	5990	6173	6244	6396	6377	6405	6243	6061	6283	6349
					Performance		85.12%	84.61%	83.02%	81.53%	81.95%	82.97%	83.27%	83.12%	83.68%	82.02%	82.56%	81.15%
					Trend		▲	▼	▼	▼	▲	▲	▲	▼	▲	▼	▲	▼
					Target %		92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%
					Qtrly Performance		85.15%	83.02%	83.02%	83.02%	82.74%	82.74%	82.74%	82.95%	82.95%	82.95%	81.85%	81.85%
18 Week RTT: Incomplete Pathway > 52 Weeks	**Owner - Divisional Manager Gynaecology**																	
KPI002T	Quality Schedule	Trust	=	0	Performance Value		3	6	3	3	1	1	1	3	5	1	0	0
					Trend													
					Target Value		0	0	0	0	0	0	0	0	0	0	0	0
18 Week RTT: Admitted Completed Pathways	**Owner - Divisional Manager Gynaecology**																	
KPI001	Trust Objectives	Trust	>=	90.0%	Numerator		361	305	353	334	329	387	340	359	374	230	192	196
					Denominator		409	348	397	396	401	462	411	469	453	283	290	278
					Performance		88.26%	87.64%	88.92%	84.34%	82.04%	83.77%	82.73%	76.55%	82.56%	81.27%	66.21%	70.50%
					Trend		▲	▼	▲	▼	▼	▲	▼	▼	▲	▼	▼	▲
					Target %		90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
					Qtrly Performance		81.92%	86.94%	86.94%	86.94%	82.89%	82.89%	82.89%	79.92%	79.92%	79.92%	68.31%	68.31%
18 Week RTT: Non-Admitted Completed Pathways	**Owner - Divisional Manager Gynaecology**																	
KPI004T	Trust Objectives	Trust	>=	95.0%	Numerator		1508	1441	1786	1615	1681	1384	1619	1589	1605	1490	1864	1766
					Denominator		1717	1598	2021	1869	1999	1617	1924	1888	1958	1774	2230	2073
					Performance		87.83%	90.18%	88.37%	86.41%	84.09%	85.59%	84.15%	84.16%	81.97%	83.99%	83.59%	85.19%
					Trend		▼	▲	▼	▼	▼	▲	▼	▲	▼	▲	▼	▲
					Target %		95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
					Qtrly Performance		89.60%	88.23%	88.23%	88.23%	84.55%	84.55%	84.55%	83.35%	83.35%	83.35%	84.36%	84.36%
All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (After Re-allocation)	**Owner - Divisional Manager Gynaecology**																	
KPI030	NHSI	Gynaecology	>=	85.0%	Numerator		5.5	9.5	8.5	3.0	5.0	2.0	4.0	2.5	4	4.5	4	
					Denominator		7	17.5	10.5	13.5	15.5	6.0	14.0	11	8.5	12	9	
					Performance		78.57%	54.29%	80.95%	22.22%	32.26%	33.33%	28.57%	22.73%	47.06%	37.50%	44.44%	
					Trend		▲	▼	▲	▼	▲	▲	▼	▼	▲	▼	▲	
					Target %		85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
					Qtrly Performance		59.65%	50.60%	50.60%	50.60%	30.99%	30.99%	30.99%	34.92%	34.92%	34.92%	44.44%	44.44%
Cancer: 62 Day Screening Referrals (Numbers)	**Owner - Divisional Manager Gynaecology**																	
KPI033	NHSI	Gynaecology	<=	5	Performance Value		2.0	0.0	4.5	0.5	2.0	3.5	1.5	2.0	2.0	0.0	1.0	
					Trend		▲	▼	▲	▼	▲	▲	▼	▲	▶	▼	▲	
					Target Value		5	5	5	5	5	5	5	5	5	5	5	5
					Qtrly Performance Value		5.5		5	5	7	7	7	4	4	4	1	1
Cancer: 62 Day Screening Referrals (Percentage)	**Owner - Divisional Manager Gynaecology**																	
KPI034	NHSI	Gynaecology	>=	90.0%	Numerator		2	0.0	4.0	0.0	1.0	3.5	1.0	2	2	0	1	
					Denominator		2	0.0	4.5	0.5	2.0	3.5	1.5	2	2	0	1	
					Performance		100.00%		88.89%	0.00%	50.00%	100.00%	66.67%	100.00%	100.00%		100.00%	
					Trend		▲			▼	▲	▲	▼	▲	▶			
					Target %		90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
					Qtrly Performance		90.91%	80.00%	80.00%	80.00%	78.57%	78.57%	78.57%	100.00%	100.00%	100.00%	100.00%	100.00%
Cancer: 104 Day Breaches	**Owner - Divisional Manager Gynaecology**																	
KPI352	Trust Objectives	Gynaecology	=	0	Performance Value		1	0	1	3	4	1	7	2	1	5	2	
					Trend		▼	▼	▲	▲	▲	▼	▲	▼	▼	▲	▼	
					Target Value		0	0	0	0	0	0	0	0	0	0	0	0
					Qtrly Performance Value		8		4	4	12	12	12	8	8	8	2	2

Experience

KPI ID	Source	Service ID	Target < or >	Target	Value	Trend	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20
Diagnostic Tests: 6 Week Wait	**Owner - Divisional Manager Gynaecology**																	
KPI204	NHSI	Trust	>=	99.0%	Numerator		500	429	493	526	568	493	633	468	516	436	464	421
					Denominator		517	451	507	531	571	501	644	477	522	456	481	426
					Performance		96.71%	95.12%	97.24%	99.06%	99.47%	98.40%	98.29%	98.11%	98.85%	95.61%	96.47%	98.83%
					Trend		▼	▼	▲	▲	▲	▼	▼	▼	▲	▼	▲	▲
					Target %		99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%
					Qtrly Performance		97.44%	97.25%	97.25%	97.25%	98.72%	98.72%	98.72%	97.59%	97.59%	97.59%	97.57%	97.57%
A&E: Total Time Spent in department (95th Percentile)	**Owner - Divisional Manager Gynaecology**																	
KPI012	Trust Objectives	Gynaecology	<=	240	Performance Value		260	236	222	221	226	213	211	221	215	210	214	218
					Trend		▲	▼	▼	▼	▲	▼	▼	▲	▼	▼	▲	▲
					Target Value		240	240	240	240	240	240	240	240	240	240	240	240
					Qtrly Performance Value		721	679	679	679	650	650	650	646	646	646	432	432
Complaints: Number Received	**Owner - Head of Audit, Effectiveness and Patient Experience**																	
KPI038T	NHSI / Quality Strate	Trust	<=	15	Performance Value		10	6	6	7	3	10	4	6	4	5	7	4
					Trend		▲	▼	▶	▲	▼	▲	▼	▲	▼	▲	▲	▼
					Target Value		15	15	15	15	15	15	15	15	15	15	15	15
					Qtrly Performance Value		26	19	19	19	17	17	17	15	15	15	11	11

Liverpool Women's NHS Foundation Trust

	Agenda Item
MEETING	**Trust Board**
PAPER/REPORT TITLE:	Finance Performance Review Month 11 2019/20
DATE OF MEETING:	Thursday, 02 April 2020
ACTION REQUIRED	**Assurance**
EXECUTIVE DIRECTOR:	Jenny Hannon, Director of Finance
AUTHOR(S):	Eva Horgan, Deputy Director of Finance Claire Scott, Head of Financial Management
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** **1.** To develop a well led, capable, motivated and entrepreneurial ***workforce*** ☐ **2.** To be ambitious and ***efficient*** and make the best use of available resource ☒ **3.** To deliver ***safe*** services ☐ **4.** To participate in high quality research and to deliver the most ***effective*** Outcomes ☐ **5.** To deliver the best possible ***experience*** for patients and staff ☐
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust…….* ☐ ***2.*** *Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have sufficient numbers of clinical staff with the capability and capacity to deliver the best care. ……* ☐ ***3.*** *The Trust is not financially sustainable beyond the current financial year……* ☒ ***4.*** *Failure to deliver the annual financial plan ……* ☒ ***5.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision ……* ☐ ***6.*** *Ineffective understanding and learning following significant events……* ☐ ***7.*** *Inability to achieve and maintain regulatory compliance, performance and assurance……* ☒ ***8.*** *Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) ……* ☐
CQC DOMAIN	***Which Domain?*** ***SAFE****- People are protected from abuse and harm* ☐ ***EFFECTIVE*** *- people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☐ ***CARING*** *- the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☐ ***RESPONSIVE*** *– the services meet people's needs.* ☐ ***WELL-LED*** *- the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care,* ☒

	supports learning and innovation, and promotes an open and fair culture. ***ALL DOMAINS*** ☐	
LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution ☐ **2.** Operational Plan ☒ **3.** NHS Compliance ☒	**4.** NHS Constitution ☐ **5.** Equality and Diversity ☐ ***6.*** Other: **Click here to enter text.**
FREEDOM OF INFORMATION (FOIA):	1. This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting	
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	***The Board is asked to note the Month 11 Financial Position.***	
PREVIOUSLY CONSIDERED BY:	**Committee name**	Finance Performance and Business Development Committee Or type here if not on list: ***Click here to enter text.***
	Date of meeting	Tuesday, 24 March 2020

Executive Summary

The 2019/20 Board-approved budget is a breakeven position, after the delivery of £3.6m CIP, and receipt of £4.6m Provider Sustainability Funding (PSF), Financial Recovery Fund (FRF) and central Marginal Rate Emergency Threshold (MRET). The control total includes £0.3m of agreed investment in the costs of the clinical case for change identified in the 2019/20 operational plan, in addition to the £1.5m 2017/18 and 2018/19 investments, as well as investment in other clinical areas for safety and quality reasons.

At Month 11 the Trust is reporting a year to date (YTD) deficit of £0.4m against a deficit budget of £0.4m, which is slightly behind plan after adjusting for the benefit of prior year PSF of £0.2m. It is expected that this will recover by year end. The key areas of financial performance are summarised below.[1] The Trust is forecasting to achieve against all key metrics, although non recurrent CIP has increased again to £0.5m YTD.

	Plan	Actual	Variance	RAG
Surplus/(Deficit) YTD	-£0.4m	-£0.4m	-£0.0m	↓
Surplus/ (Deficit) FOT	£0.0m	£0.2m	£0.2m	↔
NHSI Rating	3	3	0	↔
Cash	£4.6m	£2.7m	-£1.9m	↑
Total CIP Achievement YTD	£3.0m	£3.0m	£0.0m	↔
Recurrent CIP Achievement YTD	£3.0m	£2.5m	-£0.5m	↓
Capital Spend YTD	£14.8m	£14.5m	-£0.4m	

The Month 11 financial submission to NHSI is consistent with the contents of this report.

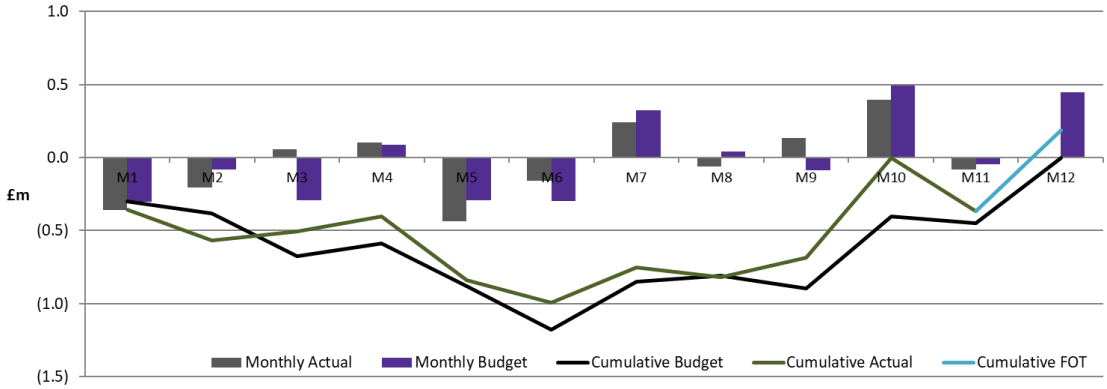
[1] NHSI Rating: Red is 4 or 5, Amber 3 and Green 2 or 1. Cash: Red is <£1m, Amber £1m-£4m and Green £4m+. Capital is not RAG rated. All other KPIs: Red is >10% off plan, Amber 0-10% off plan and Green at plan or better. Arrows denote movement from the prior month.

Report

1. Summary Financial Position

At Month 11 the Trust is reporting a deficit of £0.4m against a deficit budget of £0.4m. The Trust is forecasting delivery of the breakeven control total, after £4.6m of central funding. The actual forecast is a £0.2m surplus due to receipt of PSF in 2019/20 in relation to 2018/19, but this is adjusted out in the control total calculation (shown in Appendix One).

2019/20 Surplus/ Deficit



This position includes a benefit under the Acting as One arrangement of £2.6m as detailed below. In addition, note that release of provisions no longer required of £1.7m in total was phased in from November and will be released evenly until year end.

CIP is on track for Month 11, although is now reliant on £0.5m of non-recurrent delivery.

2. Divisional Summary Overview

Family Health: The divisional position remains favourable year to date (£0.3m favourable variance) and in the forecast (£0.2m).

Gynaecology: The forecast for the division has further deteriorated to £3.8m adverse to plan.

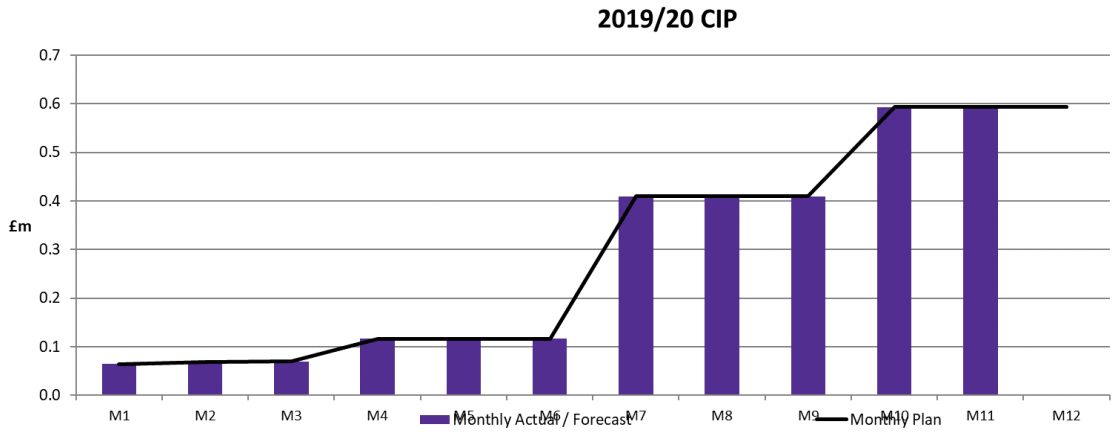
Clinical Support Services: The division remains on track in month, year to date, and is forecasting an underspend of £0.9m in line with previous months.

Agency: Agency remains within the cap level at £1.5m year to date, forecast at £1.6m against a cap of £1.9m.

3. CIP

CIP remains on track year to date and in the forecast. The risk of not achieving overall is now low, although there are a number of individual schemes which have not achieved and for which mitigation has been found. However, the Trust remains reliant on some non-recurrent savings. This is due to the expected underperformance of Procurement savings, largely related to national issues with the new arrangements for central procurement and tariff top-slice. It is anticipated that this will improve in 2020/21.

The graph below shows current performance and plan.



4. Contract Performance

Income YTD is £2.6m higher than would have been received under PbR under Acting as One.

5. Forecast Out-turn

The overall forecast remains unchanged from Month 10 although the Trust is still reliant on a number of non-recurrent favourable items to be able to achieve the Control Total.

6. Cash and Borrowings

The cash position improved slightly in month (to £2.7m), but is expected to increase further before year end due to the expected receipt of a drawdown of the neonatal loan (£1.3m), PDC receipt (£1.8m), payment from the charity (£0.5m) and Quarter Three FRF (£0.7m).

7. Capital Expenditure

Capital expenditure has increased as expenditure on key schemes ramped up. Spend in month was £2m with a further £3.6m to spend in March. Plans are in place for all of this expenditure which has been put in place following a re-prioritisation exercise.

8. Balance Sheet

Debtors have increased, however it should be noted that further payments were received in March, including £0.6m longstanding debt owed by Manchester FT relating to the transfer of Genetic Labs assets.

9. BAF Risk

The BAF risk score relating to achievement of the annual financial plan remains at 10, which is the target level. With only one month to go and the year to date and forecast on track to deliver, the level of in year risk remains low, although there is concern relating to the underlying financial position.

10. Conclusion & Recommendation

The Board are asked to note the Month 11 financial position.

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

FINANCE REPORT: M11

YEAR ENDING 31 MARCH 2020

Contents

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 1
NHS IMPROVEMENT RATIOS: M11
YEAR ENDING 31 MARCH 2020

USE OF RESOURCES RISK RATING	YEAR TO DATE Budget	YEAR TO DATE Actual	YEAR Budget	YEAR FOT
CAPITAL SERVICING CAPACITY (CSC)				
(a) EBITDA + Interest Receivable	5,653	5,683	6,661	7,159
(b) PDC + Interest Payable + Loans Repaid	6,788	8,842	7,262	9,327
CSC Ratio = (a) / (b)	**0.83**	**0.64**	**0.92**	**0.77**
NHSI CSC SCORE	4	4	4	4
Ratio Score 1 = > 2.5 2 = 1.75 - 2.5 3 = 1.25 - 1.75 4 = < 1.25				
LIQUIDITY				
(a) Cash for Liquidity Purposes	(13,349)	(13,147)	(13,172)	(13,381)
(b) Expenditure	101,418	98,893	110,554	107,017
(c) Daily Expenditure	303	295	303	293
Liquidity Ratio = (a) / (c)	**(44.1)**	**(44.5)**	**(43.5)**	**(45.6)**
NHSI LIQUIDITY SCORE	4	4	4	4
Ratio Score 1 = > 0 2 = (7) - 0 3 = (14) - (7) 4 = < (14)				
I&E MARGIN				
Deficit (Adjusted for donations and asset disposals)	448	532	(4)	(54)
Total Income	(107,025)	(104,355)	(117,167)	(113,951)
I&E Margin	**-0.4%**	**-0.5%**	**0.0%**	**0.0%**
NHSI I&E MARGIN SCORE	3	3	2	2
Ratio Score 1 = > 1% 2 = 1 - 0% 3 = 0 - (-1%) 4 < (-1%)				
I&E MARGIN VARIANCE FROM PLAN				
I&E Margin (Actual)		-0.50%		0.00%
I&E Margin (Plan)		-0.40%		0.00%
I&E Variance Margin	**0.00%**	**-0.10%**	**0.00%**	**0.00%**
NHSI I&E MARGIN VARIANCE SCORE	1	2	1	1
Ratio Score 1 = 0% 2 = (1) - 0% 3 = (2) - (1)% 4 = < (2)%				
AGENCY SPEND				
YTD Providers Cap	1,639	1,639	1,792	1,792
YTD Agency Expenditure	1,089	1,536	1,188	1,641
	-34%	**-6%**	**-34%**	**-8%**
NHSI AGENCY SPEND SCORE	1	1	1	1
Ratio Score 1 = < 0% 2 = 0% - 25% 3 = 25% - 50% 4 = > 50%				
Overall Use of Resources Risk Rating	3	3	3	3

Note: NHSI assume the score of the I&E Margin variance from Plan is a 1 for the whole year and year to date budget. This is because NHSI recognise the fact that an organisation would not "plan" to have a variance from plan and have not applied a calculated ratio to the budgeted columns of this metric.

Note: scoring a 4 on any of the metrics will lead to a financial override score of 3.

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
INCOME & EXPENDITURE: M11
YEAR ENDING 31 MARCH 2020

INCOME & EXPENDITURE	MONTH			YEAR TO DATE			YEAR		
£'000	Budget	Actual	Variance	Budget	Actual	Variance	Budget	FOT	Variance
Income									
Clinical Income	(8,262)	(7,984)	(278)	(95,699)	(93,243)	(2,456)	(104,520)	(101,720)	(2,799)
Non-Clinical Income	(1,319)	(1,122)	(197)	(11,325)	(11,277)	(48)	(12,647)	(12,395)	(252)
Total Income	**(9,581)**	**(9,107)**	**(475)**	**(107,025)**	**(104,520)**	**(2,505)**	**(117,167)**	**(114,116)**	**(3,051)**
Expenditure									
Pay Costs	5,913	5,706	207	64,916	64,322	593	70,856	70,519	336
Non-Pay Costs	2,152	1,927	225	24,447	22,558	1,889	26,634	23,477	3,157
CNST	1,009	1,008	1	12,056	12,013	43	13,064	13,021	43
Total Expenditure	**9,074**	**8,641**	**433**	**101,418**	**98,893**	**2,525**	**110,554**	**107,017**	**3,537**
EBITDA	**(507)**	**(466)**	**(41)**	**(5,607)**	**(5,627)**	**20**	**(6,613)**	**(7,099)**	**486**
Technical Items									
Depreciation	386	373	13	4,249	4,211	38	4,641	4,631	10
Interest Payable	39	32	7	370	292	77	402	327	75
Interest Receivable	(4)	(3)	(1)	(47)	(56)	9	(48)	(60)	12
PDC Dividend	135	145	(11)	1,483	1,593	(110)	1,617	1,738	(120)
Profit/Loss on Disposal or Transfer Absorption	0	0	0	0	(17)	17	0	276	(276)
Total Technical Items	**555**	**546**	**9**	**6,055**	**6,025**	**30**	**6,613**	**6,912**	**(299)**
(Surplus) / Deficit	**48**	**80**	**(32)**	**448**	**398**	**50**	**0**	**(187)**	**187**
Control Total Adjustments									
18/19 Additional PSF					*165*	*(165)*		*165*	*(165)*
Remove capital donations/grants I&E impact					*-2*	*2*	*-4*	*-7*	*3*
Profit on disposal of equitment			*0*		*42*	*(42)*		*42*	*(42)*
Adjusted Control Total	***48***	***80***	***(32)***	***448***	***603***	***(155)***	***(4)***	***13***	***(17)***

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 3
EXPENDITURE: M11
YEAR ENDING 31 MARCH 2020

EXPENDITURE £'000	MONTH Budget	MONTH Actual	MONTH Variance	YEAR TO DATE Budget	YEAR TO DATE Actual	YEAR TO DATE Variance	YEAR Budget	YEAR FOT	YEAR Variance
Pay Costs									
Board, Execs & Senior Managers	379	295	83	4,179	3,406	773	4,558	3,825	733
Medical	1,500	1,398	102	16,162	16,297	(135)	17,682	17,891	(209)
Nursing & Midwifery	2,598	2,638	(40)	28,121	28,588	(467)	30,719	31,287	(567)
Healthcare Assistants	452	422	29	4,941	4,573	368	5,393	5,005	387
Other Clinical	348	338	10	4,493	4,191	303	4,842	4,560	283
Admin Support	178	174	4	1,957	1,797	160	2,140	1,976	164
Corporate Services	360	358	3	3,980	3,934	46	4,340	4,334	6
Agency & Locum	98	83	16	1,082	1,535	(453)	1,180	1,641	(461)
Total Pay Costs	**5,913**	**5,706**	**207**	**64,916**	**64,322**	**593**	**70,856**	**70,519**	**336**
Non Pay Costs									
Clinical Suppplies	635	823	(188)	7,224	7,662	(437)	7,860	8,327	(467)
Non-Clinical Supplies	509	519	(10)	5,603	5,331	272	6,116	5,861	255
CNST	1,009	1,008	1	12,056	12,013	43	13,064	13,021	43
Premises & IT Costs	495	673	(178)	5,405	5,873	(468)	5,931	6,437	(506)
Service Contracts	513	(88)	601	6,214	3,693	2,522	6,726	2,852	3,874
Total Non-Pay Costs	**3,161**	**2,935**	**226**	**36,502**	**34,571**	**1,932**	**39,698**	**36,498**	**3,201**
Total Expenditure	**9,074**	**8,641**	**433**	**101,418**	**98,893**	**2,525**	**110,554**	**107,017**	**3,537**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
BUDGET ANALYSIS: M11
YEAR ENDING 31 MARCH 2020

INCOME & EXPENDITURE £'000	MONTH Budget	MONTH Actual	MONTH Variance	YEAR TO DATE Budget	YEAR TO DATE Actual	YEAR TO DATE Variance	YEAR Budget	YEAR FOT	YEAR Variance
Maternity									
Income	(3,568)	(3,456)	(112)	(41,080)	(41,045)	(35)	(44,885)	(44,741)	(144)
Expenditure	1,864	1,835	29	20,340	20,460	(120)	22,204	22,380	(176)
Total Maternity	**(1,704)**	**(1,621)**	**(83)**	**(20,740)**	**(20,585)**	**(155)**	**(22,681)**	**(22,361)**	**(320)**
Neonatal									
Income	(1,354)	(1,354)	(0)	(15,628)	(15,818)	190	(17,072)	(17,345)	272
Expenditure	1,100	1,085	15	12,059	11,817	242	13,158	12,912	247
Total Neonatal	**(254)**	**(269)**	**15**	**(3,569)**	**(4,001)**	**432**	**(3,914)**	**(4,433)**	**519**
Division of Family Health - Total	**(1,958)**	**(1,890)**	**(68)**	**(24,310)**	**(24,586)**	**277**	**(26,595)**	**(26,794)**	**200**
Gynaecology									
Income	(2,254)	(2,094)	(160)	(25,257)	(23,481)	(1,776)	(27,724)	(25,847)	(1,878)
Expenditure	980	1,054	(73)	10,444	11,187	(744)	11,445	12,284	(839)
Total Gynaecology	**(1,273)**	**(1,040)**	**(233)**	**(14,813)**	**(12,294)**	**(2,519)**	**(16,280)**	**(13,563)**	**(2,716)**
Hewitt Centre									
Income	(921)	(856)	(65)	(10,030)	(9,603)	(427)	(11,001)	(10,583)	(418)
Expenditure	667	902	(235)	7,463	8,003	(540)	8,130	8,780	(650)
Total Hewitt Centre	**(253)**	**46**	**(300)**	**(2,567)**	**(1,600)**	**(967)**	**(2,871)**	**(1,803)**	**(1,068)**
Division of Gynaecology - Total	**(1,527)**	**(994)**	**(533)**	**(17,380)**	**(13,894)**	**(3,486)**	**(19,151)**	**(15,366)**	**(3,784)**
Theatres									
Income	(39)	(39)	(0)	(433)	(444)	11	(472)	(484)	12
Expenditure	702	661	41	7,709	7,698	11	8,411	8,400	10
Total Theatres	**662**	**621**	**41**	**7,276**	**7,254**	**22**	**7,938**	**7,916**	**22**
Genetics									
Income	(304)	(253)	(51)	(4,319)	(4,540)	222	(4,640)	(4,872)	232
Expenditure	187	147	40	2,791	2,907	(116)	2,979	3,087	(109)
Total Genetics	**(117)**	**(107)**	**(11)**	**(1,528)**	**(1,634)**	**106**	**(1,661)**	**(1,785)**	**123**
Other Clinical Support									
Income	(29)	(21)	(9)	(326)	(296)	(29)	(357)	(321)	(36)
Expenditure	677	646	31	7,439	6,704	735	8,121	7,369	752
Total Clinical Support	**647**	**625**	**22**	**7,113**	**6,407**	**705**	**7,764**	**7,048**	**716**
Division of Clinical Support - Total	**1,192**	**1,140**	**52**	**12,860**	**12,027**	**833**	**14,041**	**13,180**	**861**
Corporate & Trust Technical Items									
Income	(1,112)	(1,033)	(78)	(9,952)	(9,292)	(661)	(11,015)	(9,922)	(1,092)
Expenditure	3,452	2,858	595	39,230	36,143	3,087	42,719	38,716	4,003
Total Corporate	**2,341**	**1,824**	**516**	**29,278**	**26,851**	**2,427**	**31,705**	**28,794**	**2,911**
(Surplus) / Deficit	**48**	**80**	**(32)**	**448**	**398**	**50**	**0**	**(187)**	**187**

Liverpool Women
NHS Foundation

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
CIP: M11
YEAR ENDING 31 MARCH 2020

				MONTH 11			YTD			YEAR			FYE		
NHSI SCHEME REFERENCE	SCHEME NAME	ACCOUNTING	RISK RATING	TARGET	ACTUAL	VARIANCE	TARGET	ACTUAL	VARIANCE	TARGET	FOT	VARIANCE	TARGET	FOT	VARIANCE
Trust scheme 1	Car Parking Consumables	Non-Pay	Medium	1	1	0	11	11	0	12	12	0	12	12	0
Trust scheme 2	CNST Maternity Incentive	Non-Pay	Medium	160	160	0	800	843	43	960	1,003	43	960	960	0
Trust scheme 3	Estates Income Generation	Income	Low	3	1	(2)	33	23	(10)	36	24	(12)	36	36	0
Trust scheme 4	Contract Savings	Pay	Low	14	14	0	154	154	0	168	168	0	168	168	0
Trust scheme 5	Coding & Counting	Income	Low	13	13	0	143	143	0	156	156	0	156	156	0
Trust scheme 6	Decontamination Contract	Non-Pay	Low	3	3	0	33	33	0	36	36	0	36	36	0
Trust scheme 7	Meeting Utilisation	Income	Low	1	1	0	10	9	(1)	11	10	(1)	11	12	1
Trust scheme 8/9	HFEA Tender	Income/Pay	Medium	2	2	0	22	22	0	24	24	0	24	24	0
Trust scheme 10	HTE Contract Fees	Non-Pay	Low	3	3	0	33	110	77	36	113	77	36	36	0
Trust scheme 11	Imaging Income Opportunities	Income	Low	2	2	0	22	22	(0)	24	24	0	24	24	0
Trust scheme 12	Midwifery Productivity	Pay	Medium	23	23	0	205	205	0	228	228	0	228	228	0
Trust scheme 13	Pharmacy Review	Non-Pay	Medium	31	16	(17)	248	108	(140)	279	123	(156)	279	251	(28)
Trust scheme 14	Private Patient Fees	Income	Low	33	33	0	165	212	47	198	345	147	198	198	0
Trust scheme 15	Procurement (various)	Non-Pay	Medium	95	0	(95)	475	13	(462)	570	143	(428)	570	570	0
Trust scheme 16	Rateable Value Review	Non-Pay	Medium	5	0	(5)	25	0	(25)	30	0	(30)	30	0	(30)
Trust scheme 17	CQC Fees	Non-Pay	Low	7	7	0	77	77	0	84	84	0	84	84	0
Trust scheme 18	Restructuring	Pay	Low	7	7	0	77	77	0	84	84	0	84	84	0
Trust scheme 19	Section 106	Income	High	167	0	(167)	334	0	(334)	501	0	(501)	501	0	(501)
Trust scheme 20	Job Planning	Pay	Medium	4	4	0	40	40	0	44	44	0	44	44	0
Trust scheme 21	Sperm Bank	Non-Pay	High	17	0	(17)	34	0	(34)	51	17	(34)	51	204	153
Trust scheme 22	Sutures	Non-Pay	Low	2	2	0	22	22	0	24	24	0	24	24	0
Non-recurrent Mitigation	Gynaecology	Non-Pay	Low	0	0	0	0	1	1	0	1	1	0	0	0
Recurrent Mitigation	Genetics Overheads	Income	Low	0	46	46	0	91	91	0	137	137	0	228	228
Recurrent Mitigation	Contracts Review	Non-Pay	Low	0	0	98	0	209	209	0	209	209	0	92	92
Non-recurrent Mitigation	Family Health	Non-Pay	Low	0	0	0	0	123	123	0	123	123	0	0	0
Non-recurrent Mitigation	Corporate	Non-Pay	Low	0	256	159	0	415	415	0	424	424	0	0	0
TOTAL				**593**	**593**	**0**	**2,963**	**2,963**	**0**	**3,556**	**3,556**	**(0)**	**3,556**	**3,471**	**(85)**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 6
BALANCE SHEET: M11
YEAR ENDING 31 MARCH 2020

BALANCE SHEET £'000	YEAR TO DATE Opening	YEAR TO DATE M11 Actual	YEAR TO DATE Movement	YEAR TO DATE Budget	YEAR TO DATE M11 Actual	YEAR TO DATE Movement
Non Current Assets	**79,968**	**89,509**	9,541	**91,488**	**89,509**	(1,979)
Current Assets						
Cash	9,066	2,652	(6,414)	4,600	2,652	(1,948)
Debtors	7,273	6,851	(422)	7,827	6,851	(976)
Inventories	489	479	(10)	452	479	27
Total Current Assets	**16,828**	**9,982**	**(6,846)**	**12,879**	**9,982**	**(2,897)**
Liabilities						
Creditors due < 1 year - Capital Payables	(1,347)	(2,191)	(844)	(266)	(2,191)	(1,925)
Creditors due < 1 year - Trade Payables	(13,661)	(13,919)	(258)	(17,123)	(13,919)	3,204
Creditors due < 1 year - Deferred Income	(2,428)	(2,575)	(147)	(3,471)	(2,575)	896
Creditors due > 1 year - Deferred Income	(1,654)	(1,626)	28	(1,621)	(1,626)	(5)
Loans	(13,635)	(16,311)	(2,676)	(18,696)	(16,311)	2,385
Provisions	(4,631)	(3,227)	1,404	(4,870)	(3,227)	1,643
Total Liabilities	**(37,356)**	**(39,849)**	**(2,493)**	**(46,047)**	**(39,849)**	**6,198**
TOTAL ASSETS EMPLOYED	**59,440**	**59,642**	**202**	**58,320**	**59,642**	**1,322**
Taxpayers Equity						
PDC	40,088	40,688	600	41,313	40,688	(625)
Revaluation Reserve	14,503	14,503	0	15,367	14,503	(864)
Retained Earnings	4,849	4,451	(398)	1,640	4,451	2,811
TOTAL TAXPAYERS EQUITY	**59,440**	**59,642**	**202**	**58,320**	**59,642**	**1,322**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 7
CASHFLOW STATEMENT: M11
YEAR ENDING 31 MARCH 2020

CASHFLOW STATEMENT	YEAR TO DATE		
£'000	Budget	Actual	Variance
Cash flows from operating activities	1,352	1,414	(62)
Depreciation and amortisation	4,249	4,211	38
Movement in working capital	(675)	(697)	22
Net cash generated from / (used in) operations	**4,926**	**4,928**	**(2)**
Interest received	47	56	(9)
Purchase of property, plant and equipment and intangible assets	(15,475)	(13,616)	(1,859)
Proceeds from sales of property, plant and equipment and intangible assets	721	42	679
Net cash generated from/(used in) investing activities	**(14,707)**	**(13,518)**	**(1,189)**
PDC Capital Programme Funding - received	1,225	600	625
Loans from Department of Health Capital - received	9,998	9,632	366
Loans from Department of Health Capital - repaid	(306)	(306)	0
Loans from Department of Health Revenue - received	0	0	0
Loans from Department of Health Revenue - repaid	(4,630)	(6,650)	2,020
Interest paid	(100)	(278)	178
PDC dividend (paid)/refunded	(806)	(822)	16
Net cash generated from/(used in) financing activities	**5,381**	**2,176**	**3,205**
Increase/(decrease) in cash and cash equivalents	**(4,400)**	**(6,414)**	**2,014**
Cash and cash equivalents at start of period	9,000	9,066	(66)
Cash and cash equivalents at end of period	**4,600**	**2,652**	**1,948**

LOANS SUMMARY £'000	Loan Principal Drawndown	Loan Principal Repaid	Loan Principal Outstanding at M11
Loans from Department of Health - Capital (ITFF) - 2.0% Interest Rate	5,500	(2,446)	3,054
Loans from Department of Health - Capital (Neonatal) - 2.54% Interest Rate	13,257	0	13,257
Loans from Department of Health - Revenue - 1.50% Interest Rate	14,612	(14,612)	0
Total	**33,369**	**(17,058)**	**16,311**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 8
CAPITAL EXPENDITURE: M11
YEAR ENDING 31 MARCH 2020

CAPITAL EXPENDITURE	Year to Date			Full Year		
£'000	Budget	Actual	Variance	Plan	Forecast	Variance
Neonatal New Building	9,998	10,487	(489)	10,410	10,947	(537)
Estates Schemes	880	382	498	960	554	406
Global Digital Examplar Fast Follower Project	1,080	1,478	(398)	1,225	2,400	(1,175)
Medical Equipment	2,177	1,343	834	2,177	2,848	(671)
IT Schemes	1,351	768	583	1,479	1,272	207
Total	**15,486**	**14,458**	**1,028**	**16,251**	**18,021**	**(1,770)**

Note: The Capital Expenditure is shown on an "Accruals" basis based on the date of receipt of the capital item by the Trust. This figure differs to the capital expenditure figure shown in the cashflow statement which is on a "Cash" basis.

	Agenda Item	
MEETING	**Board**	
PAPER/REPORT TITLE:	**Well-Led Framework Self-Assessment**	
DATE OF MEETING:	Thursday, 02 April 2020	
ACTION REQUIRED	**Approve**	
EXECUTIVE DIRECTOR:	Kathy Thomson, Chief Executive	
AUTHOR(S):	Mark Grimshaw, Trust Secretary	
STRATEGIC OBJECTIVES:	***Which Objective(s)?***	
	1. To develop a well led, capable, motivated and entrepreneurial ***workforce***	☒
	2. To be ambitious and ***efficient*** and make the best use of available resource	☒
	3. To deliver ***safe*** services	☒
	4. To participate in high quality research and to deliver the most ***effective*** Outcomes	☒
	5. To deliver the best possible ***experience*** for patients and staff	☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?***	
	1. *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust……*	☐
	2. *Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have sufficient numbers of clinical staff with the capability and capacity to deliver the best care. ……*	☐
	3. *The Trust is not financially sustainable beyond the current financial year……*	☐
	4. *Failure to deliver the annual financial plan ……*	☐
	5. *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision ……*	☐
	6. *Ineffective understanding and learning following significant events……*	☐
	7. *Inability to achieve and maintain regulatory compliance, performance and assurance……*	☒
	8. *Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) ……*	☐
CQC DOMAIN	***Which Domain?***	
	SAFE- *People are protected from abuse and harm*	☐
	EFFECTIVE - *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.*	☐
	CARING - *the service(s) involves and treats people with compassion, kindness, dignity and respect.*	☐
	RESPONSIVE – *the services meet people's needs.*	☐
	WELL-LED - *the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.*	☒

	ALL DOMAINS ☐			
LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution ☐ **2.** Operational Plan ☐ **3.** NHS Compliance ☒		**4.** NHS Constitution ☐ **5.** Equality and Diversity ☐ ***6.*** Other: **Click here to enter text.**	
FREEDOM OF INFORMATION (FOIA):	1. This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting			
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	***The Board is recommended to approve the Well-Led Self-Assessment template, agree to the development of an improvement plan and look to commission an external Well-Led review to be undertaken when appropriate.***			
PREVIOUSLY CONSIDERED BY:	**Committee name**	N/A		
	Date of meeting			

Executive Summary

NHS Improvement encourages all Foundations Trusts to undertake a development review of leadership and governance against the well-led framework approximately every three years. The most recent external review was carried out in 2016/17 by Deloitte LLP with outcomes reported to Board in May 2017. It is now timely for the Trust to undertake a review.

A self-review process has been undertaken and an evidence template completed. This has produced RAG ratings against the eight KLOEs within the framework and a series of improvement actions. It is suggested that an improvement plan be developed and reviewed alongside a procurement exercise for an external review. The timeline for this review will need to be considered within the context of the COVID-19 outbreak.

Report

1. Introduction

In June 2017, NHS Improvement issued guidance relating to well-led reviews (around the scoping of any review, the commissioning of an external facilitator and descriptors of good practice against the 8 Key Lines of Inquiry (KLOEs); and more detailed advice which provided template specifications and example evaluation criteria for use in any procurement process. These documents can be found at (https://improvement.nhs.uk/resources/well-led-framework/). Board members are advised to read this guidance prior to the Board discussion.

NHS Improvement encourages all Foundations Trusts to undertake a development review of leadership and governance against the well-led framework approximately every three years. The most recent external review was carried out in 2016/17 by Deloitte LLP with outcomes reported to Board in May 2017. It is now timely for the Trust to undertake a review.

2. Process

NHS Improvement/England guidance suggests the following steps in a Well-Led Review:

- Initial investigation to determine scope of review
- Commissioning an external reviewer
- Detailed review
- Board report and action planning
- Letter to NHS Improvement
- Implementing the action plan

The Trust is currently in stage 1 which involves the undertaking of a comprehensive self-assessment. The self-review is an important first step in preparing for externally facilitated development reviews. The purpose of regular self-review is to promote self-knowledge, reflection and vigilance, and the development and improvement of leadership and governance. It helps providers identify their strengths and development areas to deliver continuous improvement.

It is important that the Board is as honest as possible in this assessment as the congruence between the Trust's self-review and the external facilitator's perception can be a strong indicator the Trust's level of insight. Boards should also ensure that their approach facilitates continuous improvement rather than a compliance mindset. The reviews should not be about 'meeting a bar', but rather about prioritising improvement actions.

The following steps have been undertaken in completing the Trust's self-assessment:

1. •3 March 2020 – Executive Away Day – Initial Review of Evidence Schedule
2. •5 March 2020 - Approach discussed and agreed at Trust Board Workshop
3. •9-17 March 2020 - Refinement of Evidence Schedule
4. •19 March 2020 - Discussion of Updated Evidence Schedule at Executive Team Meeting
5. •20 March 2020 - Circulation of Evidence Schedule to allocated NEDs
6. •W/C 23 March 2020 - Feedback from allocated NEDs received and factored into the self-review template

The detailed self-assessment template has been made available to Board members via the Document Library on Virtual Boardroom. Each of the eight Key Lines Of Enquiry (KLOE) has been provided with a RAG rating utilising the following scoring matrix:

Risk rating (or other means of assessment)	Definition	Evidence
Green	Meets or exceeds expectations	Many elements of good practice and there are no major omissions
Amber-green	Partially meets expectations, but confident in management's capacity to deliver green performance within a reasonable timeframe	Some elements of good practice, no major omissions and robust action plans to address perceived gaps with proven track record of delivery
Amber-red	Partially meets expectations, but with some concerns on capacity to deliver within a reasonable timeframe	Some elements of good practice, some minor omissions. Action plans to address perceived gaps are in early stage of development with limited evidence of track record of delivery
Red	Does not meet expectations	Major omission in quality governance identified. Significant volume of action plans required and concerns about management's capacity to deliver

The initial self-assessment scores against each of the KLOES is as follows:

Key Line of Enquiry (KLOE)	RAG Rating	
KLOE 1. Is there the leadership capacity and capability to deliver high quality, sustainable care? Executive Lead: Chief Executive Management Lead: Trust Secretary NED Lead: Trust Chair		
KLOE 2. Is there a clear vision and a credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver? Executive Lead: Director of Finance Management Lead: Strategic Finance Manager NED Lead: Jo Moore		
KLOE 3. Is there a culture of high quality, sustainable care? Executive Lead: Director of Nursing & Midwifery Management Lead: Deputy Director of Nursing NED Lead: Tony Okotie		
KLOE 4. Are there clear responsibilities, roles and systems of accountability to support good governance and management? Executive Lead: Chief Executive Management Lead: Trust Secretary NED Lead: Tracy Ellery		
KLOE 5. Are there clear and effective processes for managing risks, issues and performance? Executive Lead: Director of Operations Management Lead: Head of Governance & Quality NED Lead: Susan Milner		
KLOE 6. Is appropriate and accurate information being effectively processed, challenged and acted on? Executive Lead: Director of Finance Management Lead: Chief Information Officer NED Lead: Ian Knight		
KLOE 7. Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services? Executive Lead: Director of Workforce & Marketing Management Lead: Deputy Director of Workforce NED Lead: Phil Huggon		
KLOE 8. Are there robust systems and processes for learning, continuous improvement and innovation? Executive Lead: Medical Director Management Lead: Deputy Medical Director NED Lead: Louise Kenny		
Overall Rating:		

3. Key Issues

Each of the KLOEs has several sub-questions and these have each been reviewed and provided with an individual RAG rating. Bespoke improvement actions have been identified against a number of these sub-questions. The following overarching themes and key actions have also been identified:

- The need for an updated Organisational Development & Leadership strategy which will provide focus on:
    - Roles, Responsibilities and Accountabilities
    - Ensuring that there are robust governance processes within the newly formed Divisional teams
    - Strengthened succession planning and talent management
    - Continuing to embed the 'Fair & Just' Culture
- The requirement for a defined approach to Continuous Improvement that is recognised and utilised throughout the organisation so that it becomes a demonstrable 'improvement mindset'.
- To ensure that the Trust's strategy is well understood by all staff and external stakeholders and that there are clear links between the Trust's short and medium term plans to the overarching strategy.
- To ensure that there is a consistent approach to 'lesson learning' throughout the organisation

4. Next Steps

Should the self-review template be agreed by the Board an action plan will be developed to ensure that improvements are made against the identified areas. This will be monitored by the Executive Team and the Board. Once the finalised CQC report has been made available, the findings pertinent to 'well-led' will be reviewed against the action plan and alignment made where possible.

Progressing the procurement process for an external review will need to consider the impact of the COVID-19 outbreak on the available resource at the Trust. An updated timeline will be developed once further information is available.

5. Recommendation

The Board is recommended to approve the Well-Led Self-Assessment template, agree to the development of an improvement plan and look to commission an external Well-Led review to be undertaken when appropriate.

Liverpool Women's NHS Foundation Trust

	Agenda Item
MEETING	**Trust Board Meeting**
PAPER/REPORT TITLE:	**Review of Risk Management Strategy 2020**
DATE OF MEETING:	Thursday, 02 April 2020
ACTION REQUIRED	**For Approval**
EXECUTIVE DIRECTOR:	Caron Lappin, Director of Nursing and Midwifery
AUTHOR(S):	Allan Hawksey Risk and Patient Safety Manager and Christopher Lube, Head of Governance and Quality
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** 1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☒ 2. To be ambitious and *efficient* and make the best use of available resource ☒ 3. To deliver *safe* services ☒ 4. To participate in high quality research and to deliver the most *effective* Outcomes ☒ 5. To deliver the best possible *experience* for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust* ☒ ***2.*** *The Trust is not financially sustainable beyond the current financial year* ☒ ***3.*** *Failure to deliver the annual financial plan* ☒ ***4.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision* ☒

	5. *Ineffective understanding and learning following significant events* ☒ ***6.*** *Inability to achieve and maintain regulatory compliance, performance and assurance* ☒ ***7.*** *Inability to deliver the best clinical outcomes for patients* ☒ ***8.*** *Poorly delivered positive experience for those engaging with our services* ☒
CQC DOMAIN	***Which Domain?*** ***SAFE-*** *People are protected from abuse and harm* ☒ ***EFFECTIVE*** *- people's care, treatment and support achieves good outcomes,* ☒ *promotes a good quality of life and is based on the best available evidence.* ***CARING*** *- the service(s) involves and treats people with compassion, kindness, dignity* ☒ *and respect.* ***RESPONSIVE –*** *the services meet people's needs.* ☒ ***WELL-LED*** *- the leadership, management and governance of the* ☒ *organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.* ***ALL DOMAINS*** ☐
LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution ☒ **2.** Operational Plan ☒ **3.** NHS Compliance ☒ **4.** NHS Constitution ☒ **5.** Equality and Diversity ☒ ***6.*** Other: **Click here to enter text.**
FREEDOM OF INFORMATION (FOIA):	2. This report will not be published under the Trust's Publication Scheme due to exemptions under S21 of the Freedom of Information Act 2000, because the information contained is reasonably accessible by other means
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	The Trust Board members are requested to note the contents of the report and gain assurance that the Trust has a robust Risk Management Strategy in place and the KPIs associated in the main have been met.

	The Trust Board Members are requested to approve the revised Risk Management Strategy for 2020/21 which has been recommended for approval by the Quality Committee and Audit Committee in March 2020.	
PREVIOUSLY CONSIDERED BY:	**Committee name**	Quality Committee Audit Committee
	Date of meeting	Tuesday, 24 March 2020

Executive Summary

Risk management should be embedded in all of the organisation's practices and processes in a way that it is relevant, effective and efficient. The risk management process should be part of, and not separate from, those organisational processes. In particular, risk management should be embedded into policy development, business and strategic planning and review, and the change management processes. Risk is an inherent part of the delivery of healthcare.

The risk management strategy outlines the Trust's current approach to risk management throughout the organisation.

Achievement of objectives is subject to uncertainty, which gives rise to threats and opportunities. Uncertainty of outcome is how risk is defined. Risk management includes identifying and assessing risks, and responding to them. Risk is defined as the uncertainty in achieving an objective.

To support and enable this process to occur the Trust has a defined Risk Management Strategy in place which is led by the Head of Governance and Quality and supported through the management structure of the organisation.

Report

The following report provides a review of the current Risk Management Strategy (last reviewed in 2019) and provides an updated Risk Management Strategy for 2020/21, which identifies changes which are required to maintain it as a live document.

The Risk Management Strategy has previously been developed with consideration and adoption of available guidance and consultation with the Trust Executives.

Review of Risk Management Strategy 2019/20

The Risk Management Strategy (2019, v12.0) approved in March 2019 by the Quality Committee has been in place for the past 12 months and during this time a number of improvements, outlined below, have been made the risk management process in the Trust, which also underpin the risk management strategy:

- Following discussion with the executive directors and the Board members it was agreed that the Board Assurance Framework would move from being documented in a word document format and onto the Trust risk management system Ulysses. This meant that all risk registers were in the same place and would use very similar formats when provided as reports for meetings and reviews. The change also meant that as the BAF was on the Ulysses system the access to it was not reliant on the Head of Governance and Quality as it had been previously with the word document. This has made the process more robust and accessible to the executive directors.

- In June 2019 following review of the risk register management processes in place at the Corporate Risk Committee, the Head of Governance and Quality developed and introduced a new Standard Operating Procedure for the Management of Risk and Risk Registers. This was introduced following concerns identified regarding the lack of guidance for all staff and lack of a formal process when adding risks to risk registers, including the corporate risk register. Since the introduction of the SOP there has been a marked improvement in the process for the identification risks and management of risk registers including a more robust approach to escalation. There is still more progress required to strengthen the closure of risks and the provision of assurance around this activity by risk owners.

- Face-to -Face risk management awareness sessions are now part of the Trust Corporate Induction day which ensures all staff commencing employment receive an overview of the Trusts approach to risk management and their roles and responsibilities in the work place.

- Changes to the Corporate Risk Management Committee were completed following the introduction of the divisions in April 2019. To ensure clear ownership at divisional triumvirate level the membership of the group was clearly defined to include Executive Directors, Divisional Managers, senior corporate managers, Head of Governance and Quality and the Risk and Patient Safety Manager. The committee continues to be chaired by the Chief Executive Officer. The changes have proved successful with clear ownership of risk being held by the divisional and corporate services with clear lines of reporting.

Achievement of Key Performance Indicators

Describe Key Performance Indicators (KPIs)	Target	Outcome for 2019/20
All verified BAF risks are reported to the Board of Directors at each formal meeting of the Board.	100%	**Achieved to 100%** As part of the Risk Management reporting arrangements, each committee including the board received a BAF update report as per their work plans. This can be evidenced via agenda, reports and minutes.

Describe Key Performance Indicators (KPIs)	Target	Outcome for 2019/20
All significant risks are reported to and reviewed as a standing agenda item at each formal meeting of the Corporate Risk Committee.	100%	**Achieved to 100%** All reports presented to the Corporate Risk Committee as per the scheduled work plan. This can be evidenced via agenda, reports and minutes.
The risk profiles (for risks ≥10) for all divisions are reviewed by the Corporate Risk Committee at a frequency determined by the Corporate Risk Committee as part of a rolling programme of reviews.	100%	**Achieved to 100%** All reports presented to the Corporate Risk Committee as per the scheduled work plan. This can be evidenced via agenda, reports and minutes.

Local risk registers are in place, maintained and available for inspection.	100%	**Achieved to 100%** Risk Registers are in place for all local areas which are reporting up into divisional governance and risk meetings. All risk registers can be accessed via Ulysses Risk Management system. This can be evidenced via agenda, reports and minutes.
Local risk registers show details of control, assurances, location, owner, action plan (where necessary) and ≥80% of risks are within review date and none are overdue for review by 6 or more months	100%	**Achieved to 80%** There are some risk registers which still require some work to bring them into line with the Trust SOP on Risk and Risk Register Management and the Risk Management Strategy. The work required to ensure that 100% of risk registers meet the required standard is being led by the Divisional Governance Managers / Facilitator supported by the Head of Governance and Quality. The aim is to achieve this standard by June 2020. This can be evidenced via agenda, reports and minutes.

Risk Management Strategy for 2020/21

The Risk Management Strategy 2020-21 (version 13) has undergone a number of amendments and additions to reflect developments in the Trust's approach to assessment, management and mitigation of risk as follows:

- Reviewed statement of intent from the Chief Executive
- Alignment with the new Patient Safety Strategy 2019 underpinning principles
- The re-introduction of initial risk assessment scoring for all new risks from March 2020
- Increased audit compliance of open, overdue and closed risks by the risk team
- New key performance indicators for mandatory risk management training
- New key performance indicator for annual review of the Trust's risk appetite
- Risk team profile (and key contacts) including divisional governance management structure

Conclusion

The Risk Management Strategy (2019) has been reviewed by the Head of Governance and Quality against the set KPIs contained in the strategy and as can be seen from the paper 100% compliance has been achieved in four out of five KPIs with 80% compliance in the fifth.

From the review it can be seen that following the introduction of new elements of risk management in the Trust during 2019/20 period, the overall risk management processes has become more robust and co-ordinated to ensure

that risks are identified, assessed and then recorded appropriately on a risk register and escalated or deescalated as required through a defined structure.

The updates and changes which have been made to the attached Risk Management Strategy for 2020/21 relate to measures implemented to continue to improve the Trust's assessment, management and mitigation of risk to ensure that risk is mitigated as much as is practicable, in accordance with the Trust's risk appetite.

The proposed Risk Management Strategy Version 13.0 which has been recommended for approval by the Quality Committee and Audit Committee (March 2020) is attached for reference.

Recommendation

The Trust Board members are requested to note the contents of the report and gain assurance that the Trust has a robust Risk Management Strategy in place and the KPIs associated in the main have been met.

The Trust Board Members are requested to approve the revised Risk Management Strategy for 2020/21 which has been recommended for approval by the Quality Committee and Audit Committee in March 2020.

Risk Management Strategy

Liverpool Women's NHS Foundation Trust

Version 13.0
March 2020

Contents (to be re numbered once main body is finalised)

1 Foreword : Trust Risk Statement

We are committed to delivering high quality services, which are safe and promote the wellbeing of service users, their relatives and carers, staff and other stakeholders. We will ensure consistent risk management systems and processes are in place for continuous quality improvement and safer patient care. Managing risk is a key organisational responsibility and as such is seen as an integral part of the Trust's governance arrangements. The Trust is committed to implementing the principles of good governance, defined as:

The system by which the organisation is directed and controlled to achieve its objectives and meet the necessary standards of accountability, probity and openness.

The Trust recognises that the principles of governance must be supported by an effective risk management system that is designed to deliver improvements in patient safety and care as well as the safety of its staff, patients and visitors. This strategy describes a consistent and integrated approach to the management of all risk across the Trust.

The principles of risk management apply to all staff and all areas of the Trust regardless of the type of risk. The Trust Board will ensure that risk management, quality and safety receive priority and the necessary resources within budgets, to achieve the Trust's strategic objectives. The Board recognises that the provision of healthcare and the activities associated with the treatment and care of patients, employment of staff, maintenance of premises and managing finances by their nature incur risks.

The Trust is committed to having a risk management culture that underpins and supports the business of the Trust. The Trust intends to demonstrate an on-going commitment to improving the management of risk throughout the organisation. Where this is done well, this ensures the safety of our patients, visitors, and staff, and that as an organisation the board and management is not surprised by risks that could, and should, have been foreseen.

Strategic and business risks are not necessarily to be avoided, but, where relevant, can be embraced and explored in order to grow business and services, and take opportunities in relation to the risk. Considered risk taking is encouraged, together with experimentation and innovation within authorised limits. The priority is to reduce those risks that impact on safety, and reduce our financial, operational and reputational risks.

Kathryn Thomson
Chief Executive

2 Introduction

Risk management should be embedded in all the organisation's practices and processes in a way that it is relevant, effective and efficient. The risk management process should be part of, and not separate from, those organisational processes. In particular, risk management should be embedded into policy development, business and strategic planning and review, and the change management processes. Risk is an inherent part of the delivery of healthcare. The risk management strategy outlines the Trust's approach to risk management throughout the organisation.

Achievement of objectives is subject to uncertainty, which gives rise to threats and opportunities. Uncertainty of outcome is how risk is defined. Risk management includes identifying and assessing risks, and responding to them. Risk is defined as the uncertainty in achieving an objective.

This board approved strategy for managing risk identifies accountability arrangements, resources available, and provides guidance on what may be regarded as acceptable risk within the organisation.

This strategy applies to all Trust staff, contractors and other third parties working in all areas of the Trust. Risk management is the responsibility of all staff and managers at all levels are expected to take an active lead to ensure that risk management is a fundamental part of their operational area.

The strategy is supported by a comprehensive 'risk assessment and process toolkit' and a programme of mandatory training, underpinning the fundamentals of the patient safety agenda 2019 and NHS England / Improvement and Care Quality Commission ambitions

2.1 The Core Elements of the Strategy

Risk Management Process

The Trust's risk management process ensures that risks are identified, assessed, controlled, and when necessary, escalated. These main stages are carried out through:

- Clarifying objectives
- Identifying risks to the objectives
- Defining and recording risks
- Completion of risk registers and identifying actions
- Escalation and de-escalation of risks

Governance Structure to Support Risk Management

There are different operational levels ensuring the governance of risk in the Trust:

- Board of Directors
- Executive Management Team

Divisional Management supported by divisional governance managers

Risk management by the Board is underpinned by a number of interlocking systems of control. The board reviews risk principally through the following three related mechanisms:

1. **The Board Assurance Framework (BAF)** sets out the strategic objectives, identifies key risks in relation to each strategic objective along with the controls in place and assurances available on their operation. Additionally, the BAF is cross-referenced with, and contains all risk within the Corporate Risk Register. The BAF can be used to drive the board agenda.

2. **The Corporate Risk Register (CRR)** is the corporate high level operational risk register used as a tool for managing risks and monitoring actions and plans against them. Used correctly it demonstrates that an effective risk management approach is in operation within the Trust.

3. **Divisional and Local risk registers** are for recording and managing risks to the routine daily activities of each service. Local risks are discussed at team meetings, risks that cannot be managed at the local level may be escalated to the CRR

Additionally, the annual governance statement is signed by the Chief Executive. It sets out the organisational approach to internal control. This is produced at the year-end (following regular reviews of the internal control environment during the year) and scrutinised as part of the annual accounts process and brought to the board with the accounts.

2.2 Aim

The aim of this strategy is to set out the Trust's vision for managing risk. Through the management of risk the Trust seeks to minimise, though not necessarily eliminate, threats and maximise opportunities.

i. The key objectives of risk management at the Trust are to:
- Reduce the level of exposure to harm for patients, colleagues or visitors by proactively identifying and managing personal risk to a level as low as reasonably practicable.
- Promote success and protect everything of value to the Trust, such as high standards of patient care, safe working environment, the Trust's safety record, reputation, community relations, equipment or sources of income.
- Continuously improve performance by proactively adapting to mitigate risk as much as possible and remaining resilient to changing circumstances or events.

ii. The Trust will establish an effective risk management system which ensures that:
- All risks are identified that have a potential adverse effect on quality of care, safety and wellbeing of people, and on the business, performance and reputation of the Trust
- Priorities are determined, continuously reviewed and managed through objectives that are owned and understood by all staff.
- Risks to the achievement of objectives are anticipated and proactively identified.
- Controls are put in place, effective in their design and application to mitigate the risk, and understood by those expected to use them.
- The operation of controls is monitored by management.
- Gaps in control are rectified by management in the most appropriate manner determined.
- Management are held to account for the effective operation of controls.
- Risks that exceed timescales for completion are proactively reviewed and escalated to the appropriate management for action.
- Assurances are reviewed and acted on.
- Staff continuously learn and adapt to improve safety, quality and performance.
- Risk management systems and processes are embedded locally across operational divisions and in corporate services including business planning, service development, financial planning, project and programme management and education.

2.3 Risk Appetite and Statement

Risk Appetite

Risk appetite is the 'the amount of risk that an organisation is prepared to accept, tolerate, or be exposed to at any point in time.' *(Definition from HMT Orange Book, 2005).* It can be influenced by personal experience, political factors and external events.

The resources available for managing risk are finite and so the aim is to achieve an optimum response to risk, prioritised in accordance with an evaluation of the risks. Risk is unavoidable, and every organisation needs to take action to manage risk in a way that it can justify to a level which is tolerable. The amount of risk that is judged to be tolerable and justifiable is the "risk appetite". (Appendix A provides a guidance template on setting the Trust risk appetite).

Risks need to be considered in terms of both opportunities and threats and are not usually confined to money - they will invariably also impact on the capability of our organisation, its performance and its reputation.

We need to know about risk appetite because: If we don't know what our organisation's collective appetite for risk is and the reasons for it, then this may lead to erratic or inopportune risk taking exposing the organisation to a risk it cannot tolerate; or an overly cautious approach which may stifle growth and development. If our leaders do not know the levels of risk that are legitimate for them to take, or do not take important opportunities when they arise, then service improvements may be compromised and patient outcomes affected.

The Trust will periodically review its appetite for and attitude to risk, updating these where appropriate. This includes the setting of risk tolerances at the different levels of the organisation, thresholds for escalation and authority to act, and evaluating the organisational capacity to handle risk. The periodic review and arising actions will be informed by an assessment of risk maturity, which in turn enables the board to determine the organisational capacity to control risk. The review will consider:

- Risk leadership.
- People.
- Risk policy and strategy.
- Partnerships.
- Risk management process.
- Risk handling.
- Outcomes.

Risk Appetite Statement

The risk appetite of the Trust is the decision on the appropriate exposure to risk it will accept in order to deliver its strategy over a given time frame. In practice, an organisation's risk appetite should address several dimensions:

- The nature of the risks to be assumed.
- The amount of risk to be taken on.
- The desired balance of risk versus reward.

On an annual basis the Trust will publish its reviewed and current risk appetite statement as a separate document. The statement will define the board's appetite for each risk identified to the achievement of strategic objectives for the financial year in question.

Risks throughout the organisation should be managed within the Trust's risk appetite, or where this is exceeded, action taken to reduce the risk.

The Trust's risk appetite statement will be communicated to relevant staff involved in the management of risk and published publicly.

2.4 Responsibility and Accountability

Liverpool Women's Hospital will ensure that there is accountability, authority and appropriate competence for managing risk, including implementing the risk management process and ensuring the adequacy, effectiveness and efficiency of any controls. This will be facilitated by:

- Identifying risk owners that have the accountability and authority to manage risks.
- Identifying who is accountable for the development, implementation and maintenance of the framework for managing risk.
- Identifying other responsibilities of people at all levels in the organisation for the risk management process.

- Establishing performance measurement and external/internal reporting and escalation processes; and
- Ensuring appropriate levels of recognition.

To enable all staff to fulfil their respective roles and responsibilities the Trust Governance Team will provide support, guidance and training in risk management.

2.5 Individual Responsibilities

Risk management is the responsibility of all staff. Ultimately all who work at the Trust have a responsibility for the delivery of high quality, safe care, although this may manifest itself in various day to day to activities conducted by members of staff. The following sections define the organisational expectations of particular roles or groups:

Chief Executive

The Chief Executive is the responsible officer for Liverpool Women's NHS Foundation Trust and is accountable for ensuring that the Trust can discharge its legal duty for all aspects of risk. As the 'accountable officer', the Chief Executive has overall responsibility for maintaining a sound system of internal control, as described in the annual governance statement. Operationally, the Chief Executive has designated responsibility for implementation of this strategy as outlined below.

Director of Finance

The Director of Finance has responsibility for financial governance and associated financial risk.

Director of Nursing and Midwifery

The Director of Nursing and Midwifery has joint authority for clinical governance and absolute delegated authority for quality improvement, risk management, complaints, and is executive lead for health and safety, emergency planning, safeguarding and infection control.

Head of Governance and Quality

The Head of Governance and Quality, working closely with the Director of Nursing and Midwifery and supported by key staff, will be responsible for systems and processes for risk management and for reporting risk performance to board sub-committees.

Trust Secretary

The Trust Secretary is responsible for maintaining the Board Assurance Framework.

Medical Director

The Medical Director has joint responsibility for clinical governance, and responsibility for audit and clinical effectiveness.

Executive Directors

Executive Directors have responsibility for the management of strategic and operational risks within individual portfolios. These responsibilities include the maintenance of the corporate risk register and the promotion of risk management to staff within their directorates.

Executive Directors have responsibility for monitoring their own systems to ensure they are robust, for accountability, critical challenge, and oversight of risk.

Clinical Directors, Divisional Managers, Heads of Nursing/ AHP and Head of Midwifery

Clinical Directors, Divisional Managers, Heads of Nursing/ AHP and Head of Midwifery take the lead on risk management within the division as the triumvirate and set the example through visible leadership of their staff. They do this by:

- Taking personal responsibility for managing risk.
- Sending a message to staff that they can be confident that escalated risks will be acted upon.

- Ensuring risks are reviewed regularly, updated and acted upon appropriately.
- Identifying and managing risks that cut across delivery areas.
- Discussing risks on a regular basis with staff and up the line to help improve knowledge about the risk faced; increasing the visibility of risk management and moving towards an action focussed approach.
- Communicating downwards what top risks are, and doing so in plain language.
- Escalating risks from the front line.
- Linking risk to discussions on finance, and stopping or slowing down non-priority areas or projects to reduce risk as well as stay within budget, demonstrating a real appetite for setting priorities.
- Ensuring staff are suitably trained in risk management.
- Monitoring mitigating actions and ensuring risk and action owners are clear about their roles and what they need to achieve.
- Ensuring that people feel supported when identifying and escalating risks, and fostering a fair and just culture, which encourages them to take responsibility in helping to manage them.
- Ensuring that risk management is included in appraisals and development plans where appropriate.

Heads of Corporate Services

Heads of Corporate Services will undertake the same roles and responsibilities as those outlined above for the divisional triumvirate.

Senior Managers

Senior Managers are expected to be aware of and adhere to risk management best practice to:

- Identify risks to the safety, effectiveness and quality of services, finance, delivery of objectives and reputation- drawing on the knowledge of front line colleagues.
- Identify risk owners with the seniority to influence and be accountable should the risk materialise.
- Assess the rating of individual risks looking at the likelihood that they will happen, and the consequence if they do.
- Identify the actions needed to reduce the risk and assign action owners.
- Record risks on the risk register.
- Check frequently on action progress, especially for high severity risks.
- Apply healthy critical challenge, without blaming others for identifying and highlighting risks, or consider that they are being unduly negative in doing so.
- Implement a process to escalate the most severe risks, and use it.

All Staff

All staff are encouraged to use risk management processes as a mechanism to highlight areas they believe need to be improved. Where staff feel that raising issues may compromise them or may not be effective they should be aware and encouraged to follow guidance on whistle blowing and raising concerns.

Staff side representatives also have a role in risk management including providing support and guidance to staff undertaking risk assessments where appropriate, and providing advice in the event of a dispute to the validity of a risk assessment.

2.6 Committee Duties and Responsibilities

The Board sub-committees are responsible for assuring that the risks are being managed appropriately by taking into account the gaps, mitigation and Trust tolerance levels, and for assuring the board where appropriate or raising any concerns to other relevant sub-committee, additionally each board sub- committee should review the board assurance framework and the corporate risk register at each of its respective meetings. (Appendix B)

Board of Directors

The board is responsible for ensuring that the Trust has effective systems for identifying and managing all risks whether clinical, financial or organisational. The risk management structure helps deliver the responsibility for implementing risk management systems throughout the Trust.

The responsibility for monitoring the management of risk across the organisation has been delegated by the board to the following inter-relating committees:

- Audit Committee
- Finance, Performance and Business Development Committee
- Quality Committee
- Putting People First Committee

Specific responsibilities for the management of risk and assurance on its effectiveness are delegated as follows:

Audit Committee

The Audit Committee is responsible for providing assurance to the Trust board on the process for the Trust's system of internal control by means of independent and objective review of corporate governance and risk management arrangements, including compliance with laws, guidance, and regulations governing the NHS. In addition, it has the following responsibilities relating to risk:

> *To maintain an oversight of the Trust's general risk management structures, processes and responsibilities, including the production and issue of any risk and control related disclosure statements.*

Finance, Performance and Business Development Committee

This Committee is responsible for providing information and making recommendations to the Trust board on financial and operational performance issues, and for providing assurance that these are being managed safely. The committee will consider any relevant risks within the Board Assurance Framework and Trust corporate risk register as they relate to the remit of the committee, as part of the reporting requirements, and to report any areas of significant concern to the Corporate Risk Committee or the board as appropriate.

Quality Committee

The Committee is responsible for providing the Trust board with assurance on all aspects of quality of clinical care; governance systems including risks for clinical, information and research and development issues; and regulatory standards of quality and safety. The committee will consider any relevant risks within the Board Assurance Framework and corporate risk register as they relate to the remit of the committee, as part of the reporting requirements, and to report any areas of significant concern to the Corporate Risk Committee or the board as appropriate.

Putting People First Committee

The Committee is responsible for providing the Trust board with assurance on all aspects of governance systems and risks related to the workforce, and regulatory standards for human resources. The committee will consider any relevant risks within the Board Assurance Framework and corporate risk register as they relate to the remit of the committee, as part of the reporting requirements, and to report any areas of significant concern to the Corporate Risk Committee or the board as appropriate.

Trust Executive Team

The Trust executive team is responsible for the operational management and monitoring of risk, through the corporate risk register and Board Assurance Framework, and for agreeing resourced treatment plans and ensuring delivery.

2.7 Clinical Services and Corporate Risk Management Arrangements

All service areas will put the necessary arrangements in place within their areas for good governance, safety, quality and risk management.

Clinical services have the responsibility, through the respective governance/risk leads, for the risks to their services and for the putting in place of appropriate arrangements for the identification and management of risks. Services will develop, populate and review their risks, drawing on risk processes to ensure risk registers are kept up to date through regular review.

In doing this, due account will be taken of the Trust's strategic and corporate objectives, particularly in terms of meeting regulatory standards and guidance, national performance standards and targets and relevant legislation, and of the issues and risks relevant to specific areas within the particular services

Operational Board meetings will review risk registers and contribute to the development of the risk registers and ensure that they are in place and operating within the defined tolerances and escalation processes.

Corporate Risk Committee

The Committee consists of a quorate of Executive Director and Divisional/Senior Managers as members and the committee functions ensure effective oversight and scrutiny of the entire business of the Trust, the relationship between the Corporate Risk Committee, and the other Board Sub- Committees, is based on inclusiveness, clarity of purpose and constructive challenge. The Corporate Risk Committee will oversee the management of all corporate risks, reviewing closed assurance and new risk reports and will provide the Audit Committee with assurance on the effective operation of internal controls. The Trust's divisions (Corporate, Family Health and Gynaecology) report to the Committee bi-annually in addition to Clinical Support Services who report at each meeting.

3 Process for Managing Risk

The Trust has a Standard Operating Procedure for the Management of Risks and Risk Registers (2019) which underpins this Risk Management Strategy and provides a clear structure and process required to ensure that robust risk assessment and the management of risk and risk registers occurs. The following section provides an overview of this process.

Stage 1 – Clarifying Objectives

Whether a new risk has been identified or staff need to know what to do next; clarifying objectives is a critical stage of the risk management process. To understand whether something constitutes a risk it must first be understood what are the objectives/outcomes to be achieved.

Strategic or corporate objectives; to identify and clarify which Trust strategic or corporate objective is relevant to the division, directorate, or service. Look at the Trust business plan and the latest local business plan. If this step is missed or omitted then the risk register will be neither relevant nor effective.

Local objectives should also be considered. By clarifying the objectives it can be identified whether there is a risk to manage.

Stage 2 – Identifying Risks to Objectives

Once the objectives have been identified then risks can start to be identified. Consider the following questions:

- Do you know what all of the risks to the delivery of your objectives or work are, especially those that impact on delivering high quality, safe services?
- What could happen, and what could go wrong?
- How and why could this happen?
- What is depended upon for continued success?

- Is there anyone else who might provide a different perspective on your risks?
- Is it an operational risk or a risk to a strategic objective?

If possible gather those staff together who are able to assist with the identification of risk for the area. Guidance on how to do this is available from the Governance Team (Section 6).

Stage 3 – Defining and Recording Risks

Once the risk has been identified then:

- Undertake a comprehensive risk assessment
    - Describe the risk, so that others understand what the risk is in relation to the description of condition, cause and consequence, being clear for each one.
    - Complete an initial risk assessment score so that the risk is appropriately escalated to management where required
    - Assign an owner to the risk who will oversee the risk management and review the initial score
    - List the key controls (actions) being taken to reduce the likelihood of the risk happening, or reduce the impact.
    - All risk assessment of consequence are to be generated for using the NPSA Risk Assessment Matrix (Appendix C) then consider what the contingency action plan is, i.e. what will you do should the risk happen.
    - Rate the likelihood of the risk materialising.

All of these things should be recorded which will allow the risk to be recorded on and appropriate risk register(s) following risk assessment, if the risk assessment process has not enabled the risk to be eliminated or managed. The following sections describe in detail how to complete the risk register.

Stage 4 – Risk Register(s)

All service areas are to maintain a local risk register. This register contains operational and strategic risks that are routinely managed within the service, and for which the service has the required resources, controls and mitigation within the parameters of risk set by the risk appetite.

The Corporate Risk Register is a collection of risks that directly impact on to the delivery of the corporate aims. This register is populated by a variety of sources, i.e. risks that cannot be controlled or mitigated in the service area, external audit reports, and principle risks from the board assurance framework.

Traditionally, completing a risk register can be daunting but the aim is to have a simplified process to allow the monitoring of actions and aid decision-making, electronically.

Headings in the register(s) that need to be completed are:

1. The risk identification (ID) is the unique identifier to distinguish the risk from the other risks in your register. The ID will not change throughout the life of the risk.

The risk owner is the individual who is accountable and has overall responsibility for a risk; it may or may not be the same person as the action owner. High severity corporate risks, for example, will be owned by one Executive Director, but there may be many action owners. The risk owner must know, or be informed that they are the owner, and accept this.

2. Source of, how or where the risk was identified. This could include:
    - Business planning.
    - Clinical audit.
    - Complaints/PALS.
    - External audit.
    - External review.

- Incident.
- Internal audit.
- Legislation.
- Litigation.
- National risks such as financial fraud
- NICE guidance.
- Regulatory standard.
- Risk Assessment.

3. Risk description as the name suggests, allows the risk to be described. It is important that risks are clearly articulated. If not, then it is difficult to put effective controls, or actions, in place to reduce the risk materialising and contingency plans. Using the following subheadings will help to clearly describe risk:

    - Condition
    - Cause
    - Consequence

For example:

Condition: Inability to release clinical staff for mandatory training due to staffing levels.
Cause: Results in staff not receiving compulsory training in resuscitation or blood safety.
Consequence: Leading to an increased safety risk to patients.

Getting this right is important as the key controls relate directly to the description of the risk. Key controls are the measures put in place as preventative measures to lessen or reduce the likelihood or consequence of the risk happening and/or the severity if it does. You must ensure that each control (or action where a gap in control has been identified) has an owner and target completion date.
These must describe the practical steps that need to be taken to manage and control the risk. Without this stage, risk management is no more than a paper based or bureaucratic process.

Not all risks can be dealt with in the same way. The 5T's provide an easy list of options available to anyone considering how to manage risk:

- **Tolerate** – the likelihood and consequence of a particular risk happening is accepted.
- **Treat** – work carried out to reduce the likelihood or consequence of the risk (this is the most common action).
- **Transfer** – shifting the responsibility or burden for loss to another party, e.g. the risk is insured against or subcontracted to another party.
- **Terminate** – an informed decision not to become involved in a risk situation, e.g. terminate the activity.
- **Take the opportunity** – actively taking advantage, regarding the uncertainty as an opportunity to benefit.

In most cases the chosen option will be to treat the risk. When considering the action to take remember to consider the cost associated with managing the risk, as this may have a bearing on the decision. The key questions in this instance are:

- Action taken to manage risk may have an associated cost. Make sure the cost is proportionate to the risk it is controlling.
- When agreeing responses or actions to control risk, remember to consider whether the actions themselves introduce new risks or affect other people in ways which they need to be informed about.

Stage 5 – Escalation and De-escalation of Risks

The consequence of some risks, or the action needed to mitigate them, can be such that it is necessary to escalate the risk to a higher management level, for example from a service risk to Division and up to the corporate risk register reviewed by the Corporate Risk Committee, Board Sub-Committee, and finally the Board.

Risk will be escalated or de-escalated within the defined tolerances and authority to act for each level.

For example: a service risk scoring high or extreme should only be escalated to the corporate risk register if it is **not** manageable within the service. If the risk **is** manageable within the service then it remains on the service risk register. In a case whereby the risk is to be escalated to the corporate risk register, options for controls or mitigation must be offered. The risk owner should discuss and seek approval from their manager before risk escalation to the next level.

Once an escalated risk has reached the Corporate Risk Register, the Corporate Risk Committee will consider the risk control options advised and make recommendations for action, the risk will then be de-escalated and returned to the risk owner for implementation. Where a risk is de-escalated this must be communicated to the management level below, and the risk monitored at the appropriate management level and risk forum.

If in analysing the risk, the Corporate Risk Committee feel that the risk is outside its remit, the risk will escalated to the BAF.

It is important that risks are reviewed regularly to ensure appropriate action, including closing risks or action plans where necessary.

Stage 6 - Closure of Risk

Risk registers need to be current and up to date. It is therefore essential that risks are continually monitored and fully reviewed at least annually. They should be closed under the following circumstances:

- The Risk has materialised.
- The Risk has reached its target score and has remained stable for an acceptable period of time (following Senior Members authorisation)

All closed risks will have a closed assurance review completed by the Governance team which will be reported at the Corporate Risk Committee as part of the committee workplan. Risks will be archived and not deleted

3.1 Risk Profile

A summary risk profile is a simple visual mechanism that can be used in reporting to increase the visibility of risks; it is a graphical representation of information normally found on an existing risk register. A risk profile shows all key risks as one picture, so that managers can gain an overall impression of the total exposure to risk.

3.2 Horizon Scanning

Horizon scanning is about identifying, evaluating and managing changes in the risk environment, preferably before they manifest as a risk or become a threat to the business. Additionally, horizon scanning can identify positive areas for the Trust to develop its business and services, taking opportunities where these arise. The Trust will work collaboratively with partner organisations and statutory bodies to horizon scan and be attentive and responsive to change.

By implementing formal mechanisms to horizon scanning the Trust will be better able to respond to changes or emerging issues in a planned structured and co-ordinated way. Issues identified through horizon scanning

should link into and inform the business planning process. As an approach it should consider on-going risks to services.

The outputs from horizon scanning should be reviewed and used in the development of the Trust's strategic priorities, policy objectives and development. The scope of horizon scanning covers, but is not limited to:

- Legislation.
- Government white papers.
- Government consultations.
- Socio-economic trends.
- Trends in public attitude towards health.
- International developments.
- NHS England publications.
- Local demographics.
- Seeking stakeholders views
- Risk assessments.

All staff have the responsibility to bring to the attention of their managers potential issues identified in their areas which may impact on the Trust delivering on its objectives.

Board members have the responsibility to horizon scan and formerly communicate matters in the appropriate forum relating to their areas of accountability.

4 Training

Knowledge of how to manage risk is essential to the successful embedding and maintenance of effective risk management.

Training required to fulfil this strategy will be provided in accordance with the Trust's training needs analysis.

All new staff receive Face to Face risk management training as part of their Corporate Induction. Annual mandatory update training is mandated for all other staff.

Management and monitoring of training will be in accordance with the Trust's statutory and mandatory training policy.

Specific training will be provided for the board, in respect of high level awareness of risk management. Risk awareness sessions are included as part of the board's development programme.

5 Evidence Base

1. Home Office Risk Management Policy and Guidance, Home Office (2011).
2. A Risk Matrix for Risk Managers, National Patient Safety Agency (2008).
3. NHS Audit Committee Handbook, Department of Health (2011).
4. UK Corporate Governance Code, Financial Reporting Council (2010).
5. 'Taking it on Trust: A Review of How Boards of NHS Trusts and Foundation Trusts Get Their Assurance', Audit Commission (2009).
6. The Orange Book (Management of Risk – Principles and Concepts), HM Treasury (2004).
7. Risk Management Assessment Framework, HM Treasury (2009).
8. Understanding and Articulating Risk Appetite, KPMG (2008).
9. Risk Appetite Frameworks- how to spot the genuine article, Deloitte (2013).
10. Defining Risk Appetite and Managing Risk by Clinical Commissioning Groups and NHS Trusts, Good Governance Institute (2012).
11. Good Practice Guide: Managing Risks in Government, National Audit Office (2011).
12. Risk Management – principles and guidelines ISO 31000 (2009).

6 Monitoring Compliance and Audit

The Trust risk team, led by the Head of Governance oversee all risks recorded on the Ulysees risk management system. The team review all new, closed and outstanding risks and quality assures every risk assessment whether ongoing or completed. The team re-open closed risks if necessary, where it is deemed appropriate action has not been taken and audit risks exceeding timescales, escalating to the appropriate management level where necessary, The Head of Governance reports to the Corporate Risk Committee via a compliance and audit assurance report.

This strategy will be reviewed annually.

The Trust Risk Team, which includes the Divisional Governance Managers/Facilitator, are always available for operational advice / support when required and are contactable as follows:

Name	Role	Extension
Chris Lube	Head of Governance and Quality	1383
Allan Hawksey	Risk and patient safety manager	4437
Rowan Davies	Governance support officer	4292
Jenny Lamble	Governance support officer	4489
Elaine Eccles	Divisional Governance facilitator (CSS)	1671
Laura Thorpe	Divisional Governance Manager (maternity)	4433
Julie Connor	Divisional Governance Manager (Gynaecology / Hewitt Centre)	1048
Heather Watterson	Divisional Governance Manager (Neonatal)	1015

7 Dissemination, Implementation and Access to the Document

This strategy is available on the Trust intranet. All staff will be notified via email of the strategy and other amendments.

8 Key Performance Indicators

Describe Key Performance Indicators (KPIs)	Target	How will the KPI be Monitored?	Which Committee will Monitor this KPI?	Frequency of Review	Lead
All verified BAF risks are reported to the Board of Directors at each formal meeting of the Board.	100%	The following mechanisms will be used to monitor compliance with the requirements of this document:	Corporate Risk Committee	Annual Report	Head of Governance and Quality (Exec Lead: Director of Nursing & Midwifery)

Describe Key Performance Indicators (KPIs)	Target	How will the KPI be Monitored?	Which Committee will Monitor this KPI?	Frequency of Review	Lead
All significant risks are reported to and reviewed as a standing agenda item at each formal meeting of the Corporate Risk Committee.	100%	• Evidence of reporting verified significant risk exposures to the Board of Directors at each formal meeting. • Evidence of review of significant risk exposure by the Risk Management Committee at each formal meeting of the committee. • Periodic internal audit of any or all aspects of the Risk Management process as determined by the Audit Committee (risk identification, assessment, control, monitoring and reviews).	Corporate Risk Committee	Annual Report	Head of Governance and Quality (Exec Lead: Director of Nursing & Midwifery)
The risk profiles (for risks ≥10) for all divisions are reviewed by the Corporate Risk Committee at a frequency determined by the Corporate Risk Committee as part of a rolling programme of reviews.	100%		Corporate Risk Committee	Annual Report	Head of Governance and Quality (Exec Lead: Director of Nursing & Midwifery)
Local risk registers are in place, maintained and available for inspection.	100%		Corporate Risk Committee	Annual Report	Head of Governance and Quality (Exec Lead: Director of Nursing & Midwifery)
Local risk registers show details of control, assurances, location, owner, action plan (where necessary) and ≥80% of risks are within review date and none are overdue for review by 6 or more months	100%		Corporate Risk Committee	Annual Report	Head of Governance and Quality (Exec Lead: Director of Nursing & Midwifery)
Annual review and approval of the Trust's Risk Appetite	100%		Corporate Risk Committee	Annual Report	Head of Governance and Quality (Exec Lead: Director of Nursing & Midwifery)

Describe Key Performance Indicators (KPIs)	Target	How will the KPI be Monitored?	Which Committee will Monitor this KPI?	Frequency of Review	Lead
Risk management training mandatory for all staff at Corporate induction	100%	Evidence of staff having received risk management training on arrival in the Trust	Corporate Risk Committee	Annual Report	Head of Governance and Quality (Exec Lead: Director of Nursing & Midwifery)
Risk management training mandatory for all staff as part of their mandatory training	100%	Evidence of staff receiving on going annual updates in risk management	Corporate Risk Committee	Annual Report	Head of Governance and Quality (Exec Lead: Director of Nursing & Midwifery)
Staff compliance with the risk management standard operating procedure (SOP)	100%	Evidence of a robust process for the management of risk and risk registers and staff compliance with the SOP.	Corporate Risk Committee	Annual Report	Head of Governance and Quality (Exec Lead: Director of Nursing & Midwifery)

9 Appendices

Appendix A – Risk Appetite

Risk Appetite for NHS Organisations
A matrix to support better risk sensitivity in decision taking

Developed in partnership with the board of Southwark Pathfinder CCG and Southwark BSU – January 2012

Good Governance Institute

Risk levels ▶ / Key elements ▼	0 **Avoid** Avoidance of risk and uncertainty is a Key Organisational objective	1 **Minimal** (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	2 **Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	3 **Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	4 **Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	5 **Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
Financial/VFM	Avoidance of financial loss is a key objective. We are only willing to accept the low cost option as VfM is the primary concern.	Only prepared to accept the possibility of very limited financial loss if essential. VfM is the primary concern.	Prepared to accept possibility of some limited financial loss. VfM still the primary concern but willing to consider other benefits or constraints. Resources generally restricted to existing commitments.	Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities.	Investing for the best possible return and accept the possibility of financial loss (with controls may in place). Resources allocated without firm guarantee of return – 'investment capital' type approach.	Consistently focussed on the best possible return for stakeholders. Resources allocated in 'social capital' with confidence that process is a return in itself.
Compliance/ regulatory	Play safe, avoid anything which could be challenged, even unsuccessfully.	Want to be very sure we would win any challenge. Similar situations elsewhere have not breached compliances.	Limited tolerance for sticking our neck out. Want to be reasonably sure we would win any challenge.	Challenge would be problematic but we are likely to win it and the gain will outweigh the adverse consequences.	Chances of losing any challenge are real and consequences would be significant. A win would be a great coup.	Consistently pushing back on regulatory burden. Front foot approach informs better regulation.
Innovation/ Quality/Outcomes	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems/ technology developments.	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations.	Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems / technology developments limited to improvements to protection of current operations.	Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.	Innovation the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice.
Reputation	No tolerance for any decisions that could lead to scrutiny of, or indeed attention to, the organisation. External interest in the organisation viewed with concern.	Tolerance for risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior management distance themselves from chance of exposure to attention.	Tolerance for risk taking limited to those events where there is little chance of any significant repercussion for the organisation should there be a failure. Mitigations in place for any undue interest.	Appetite to take decisions with potential to expose the organisation to additional scrutiny/interest. Prospective management of organisation's reputation.	Willingness to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation.	Track record and investment in communications has built confidence by public, press and politicians that organisation will take the difficult decisions for the right reasons with benefits outweighing the risks.
APPETITE	NONE	LOW	MODERATE	HIGH	SIGNIFICANT	

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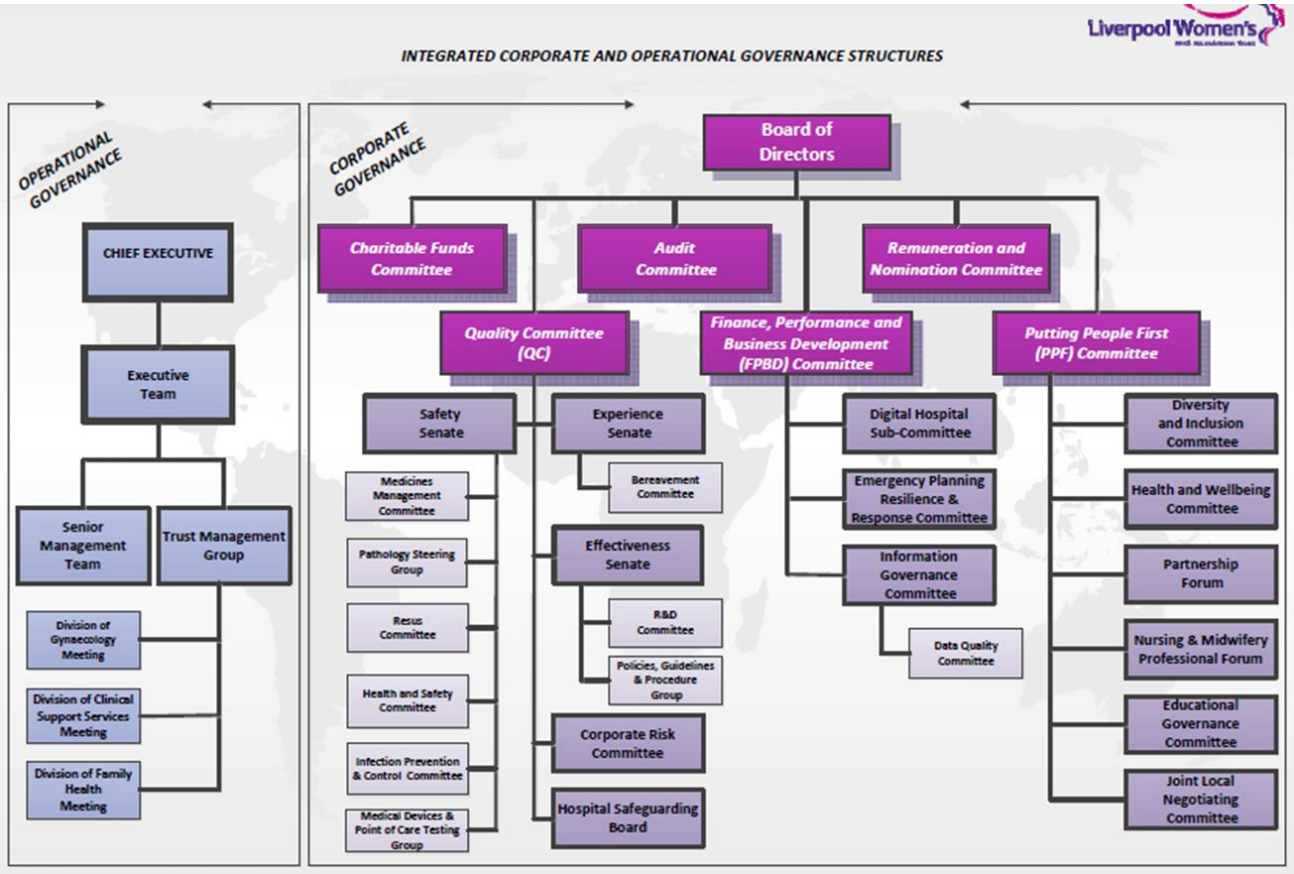
Appendix B – Integrated Corporate and Operational Governance Structure (2019)



Appendix C -Risk Descriptors and Grading

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long- term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis

Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10– 25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/busines s interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Likelihood score (L)
What is the likelihood of the consequence occurring?
The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood score	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

Risk scoring = consequence x likelihood (C x L)

	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic	5 Moderate	10 High	15 Extreme	20 Extreme	25 Extreme
4 Major	4 Moderate	8 High	12 High	16 Extreme	20 Extreme
3 Moderate	3 Low	6 Moderate	9 High	12 High	15 Extreme
2 Minor	2 Low	4 Moderate	6 Moderate	8 High	10 High
1 Negligible	1 Low	2 Low	3 Low	4 Moderate	5 Moderate

For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

1 - 3	Low risk
4 - 6	Moderate risk
8 - 12	High risk
15 - 25	Extreme risk

Appendix C – Glossary

Action	A response to control or mitigate risk.
Action Plan	A collection of actions that are specific, measurable, achievable, realistic and targeted.
Assessment	A review of evidence leading to the formulation of an opinion.
Assurance	Confidence based on sufficient evidence, that internal controls are in place, operating effectively and objectives are being achieved (Building the Assurance Framework: A Practical Guide for NHS Boards (2003), Department of Health. Taking it on Trust, Audit Commission (2009), Care Quality Commission, Judgement Framework, (2009).
Board Assurance Framework (BAF)	A matrix setting out the organisation's strategic objectives, the risks to achieving them, the controls in place to manage them and the assurance that is available.
Clinical Audit	'A quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria the implementation of change' (Principles of Best Practice in Clinical Audit (2002), National Institute of Clinical Excellence).
Compliance	Acting in accordance with requirements.
Contingency plan	The action(s) to be taken if the risk occurs.
Consequence	The result of a threat or an opportunity.
Corporate Governance	The system by which boards of directors direct and control organisations in order to achieve their objectives.
Control	Action taken to reduce likelihood and or consequence of a risk.
Cumulative Risk	The risk involved in several related activities that may have low impact or be unlikely to happen individually, but which taken together may have significant impact and or be more likely to happen; for example the cumulative impact of cost improvement programmes.
Escalation	Referring an issue to the next appropriate management level for resolution, action, or attention.
External Audit	An organisation appointed to fulfil the statutory functions in relation to providing an opinion on the annual accounts of the Trust.
Gap in Assurance	Failure to gain sufficient evidence that policies, procedures, practices or organisational structures on which reliance is placed are operating effectively.
Gap in Control	Failure to put in place sufficient effective policies, procedures, practices or organisational structures to manage risk and achieve objectives.
Hazard	A potential source of damage or harm.
Internal Audit	The team responsible for evaluating and forming an opinion of the robustness of the system of internal control.
Internal Control	A scheme of checks used to ensure that systems and processes operate as intended and in doing so mitigate risks to the organisation.
Inherent/ Initial Risk	The level of risk involved in an activity before controls are applied.

Integrated Risk Management	A process through which organisations identify, assess, analyse and manage all risk and incidents for every level of the organisation and aggregate the results at a corporate level e.g. patient safety, health and safety, complaints, litigation and other risks.
Key Risk / Key Control	Risks and controls relating to strategic objectives.
Likelihood	The probability of something happening.
Mitigation / treatment of risk	Actions taken to reduce the risk or the negative consequences of the risk.
Negative Assurance	Evidence that shows risks are not being managed and/or controlled effectively e.g. poor external reviews or serious untoward incidents.
Reasonable	Based on sound judgement.
Reassurance	The process of telling others that risks are controlled without providing reliable evidence in support of this assertion.
Residual / Current Risk	The risk that is still present after controls, actions or contingency plans have been put in place.
Risk	The uncertainty of outcome of activity, described as the combination of likelihood and consequence, including perceived importance.
Risk Appetite	The level of risk that the organisation is prepared to accept, tolerate and be exposed to at any point in time.
Risk Capacity	The maximum level of risk to which the organisation should be exposed, having regard to the financial and other resources available.
Risk Management	The processes involved in identifying, assessing and judging risks, assigning ownership, taking actions to mitigate and anticipate them, and monitoring and reviewing progress.
Risk Matrix	A grid that cross references consequences against likelihood to assist in assessing risk.
Risk Maturity	The quality of the risk management framework.
Risk Owner	The person/group responsible for the management and control of all aspects of individual risks. This is not necessarily the same as the action owner, as actions may be delegated.
Risk Profile	The overall exposure of the organisation or part of the organisational to risk.
Risk Rating	The total risk score worked out by multiplying the consequences and likelihood scores on the risk matrix.
Risk Register	The tool for recording identified risks and monitoring actions and plans against them.
Risk Tolerance	The boundaries of risk-taking that the organisation is not prepared to go beyond.
Strategy	In the NHS a document that sets out the corporate approach and policy to a particular area or work activity. This is sometimes described as a policy, particularly outside the NHS.
Sufficient	Whatever is adequate

Appendix E - Equality Impact Assessment

Name of policy/ business or strategic plans/CIP programme:	**Risk Management Strategy v 13**	
Does the proposal, service or document affect one group more or less favourable than another on the basis of:	**No**	**Justification/evidence and data source**
Age	No	No discrimination / inequality identified, the document sets out the Trust's approach and framework for Risk Management, ensuring this is systematic and objective and applied without prejudice or favour.
Disability: including learning disability, physical, sensory or mental impairment.	No	
Gender reassignment	No	
Marriage or civil partnership	No	
Pregnancy or maternity	No	
Race	No	
Religion or belief	No	
Sex	No	
Sexual orientation	No	
Human Rights – are there any issues which might affect a person's human rights?	**No**	**Justification/evidence and data source**
Right to life	No	No impact on human rights, the document sets out the Trust's approach and framework for Risk Management, ensuring this is systematic and objective and applied without prejudice or favour. The aim being to reduce risks to the organisation, its services and the safety and well-being of patients, visitors, staff and the wider public.
Right to freedom from degrading or humiliating treatment	No	
Right to privacy or family life	No	
Any other of the human rights?	No	

Assessment carried out by: **Christopher Lube**
Date: **6th March 2020**

Signature and Job Title: **Head of Governance and Quality**

Liverpool Women's NHS Foundation Trust

	Agenda Item
MEETING	**Trust Board Meeting**
PAPER/REPORT TITLE:	**Board Assurance Framework – Review of 2019-20**
DATE OF MEETING:	Thursday, 02 April 2020
ACTION REQUIRED	**Assurance**
EXECUTIVE DIRECTOR:	Mark Grimshaw, Trust Secretary
AUTHOR(S):	Christopher Lube, Head of Governance and Quality
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** 1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☒ 2. To be ambitious and *efficient* and make the best use of available resource ☒ 3. To deliver *safe* services ☒ 4. To participate in high quality research and to deliver the most *effective* Outcomes ☒ 5. To deliver the best possible *experience* for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust…….* ☒ ***2.*** *Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have sufficient numbers of clinical staff with the capability and capacity to deliver the best care. ……* ☒ ***3.*** *The Trust is not financially sustainable beyond the current financial year……* ☒ ***4.*** *Failure to deliver the annual financial plan ……* ☒ ***5.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision ……* ☒ ***6.*** *Ineffective understanding and learning following significant events……* ☒ ***7.*** *Inability to achieve and maintain regulatory compliance, performance and assurance……* ☒ ***8.*** *Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) ……* ☒
CQC DOMAIN	***Which Domain?*** ***SAFE****- People are protected from abuse and harm* ☒ ***EFFECTIVE*** *- people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☒ ***CARING*** *- the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☒ ***RESPONSIVE*** *– the services meet people's needs.* ☒ ***WELL-LED*** *- the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care,* ☒

	supports learning and innovation, and promotes an open and fair culture. ***ALL DOMAINS*** ☐	
LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution ☒ **2.** Operational Plan ☒ **3.** NHS Compliance ☒	**4.** NHS Constitution ☒ **5.** Equality and Diversity ☒ ***6.*** Other: Click here to enter text.
FREEDOM OF INFORMATION (FOIA):	1. This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting	
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	The Trust Board members are requested: • To review the contents of the paper and gain assurance as to the BAF management process and identify any changes they consider necessary for consideration by the sub-committees. • The Board are asked to approve the new risks in relation to EPR and Cyber-attacks for inclusion onto the BAF. • The board members are asked to approve the March 2020-19 BAF moving forward into 2020-21 BAF.	
PREVIOUSLY CONSIDERED BY:	**Committee name**	The Committees of: Finance, Performance and Business Development, Putting People First Quality Committee
	Date of meeting	March 2019

Executive Summary

The Board Assurance Framework (BAF) is one of the tools that the Trust uses to track progress against the organisations Strategic Aims. As part of the development of the BAF, each financial year, the key priorities of the year are identified and the potential risks to achieving these assessed for inclusion on the framework. As such, all risks on the BAF are set out under strategic aims.

The BAF is based on based on seven key elements:

- Clearly defined Key Priorities for 2019/20 (aligned to the Trust Strategic Aims)
- Clearly defined principle risks to the key priorities together with an assessment of their potential impact and likelihood.
- Key controls by which these risk can be managed.
- Potential and positive assurance that risk are being reasonably managed.
- Board reports detailing how risk are being managed and objectives met, together with the identification of gaps in assurances and gaps in control.
- Risk reduction plans, for each risk, which ensures the delivery of the objectives, control of risk and improvements in assurances.
- A target risk rating.

Each of the sub committees of the Trust Board with BAF risks continues to have the responsibility to review and gain assurance to controls and any required actions.

The following report will provide an overview of activity across the 2019-20 period in relation to the BAF and identify key changes which have occurred.

During 2019-20, the Head of Governance and Quality has continued to meet with each of the Executive Director leads on a monthly basis to ensure the BAF is maintained as a live document. Following these meetings a BAF report is presented at each PPF, QC and FPBD meeting for committee members to review the proposed changes to the BAF risks they are responsible for and approve these is appropriate.

This process continues to provide an effective approach to maintaining a live BAF, which reflects the risks to the organisation and the achievement of the strategic aims for 2019-20, aligned to the agreed risk appetite for the Trust.

Since the last report to the Board, the sub-committees have further reviewed the risks within their remit and there have been changes and alterations completed to a number of risks to ensure they remain relevant to the Trust and our on-going approach to ensuring the safety of patients and staff.

The report reflects the active process of reviewing BAF Risks by the Board sub-committees and the resulting changes to scores mitigation. The BAF risks are supported by corporate and service risks which are managed in accordance with the review and escalation and de-escalation processes of the Trust.

Report

1. Introduction

This report seeks to assure and inform the Board of the process and outcomes from Board and sub-committee review of risks assigned to the Board Assurance Framework.

Any changes in risk score or escalation / de-escalation proposals made by sub-committees after consideration of risks within their remit are conveyed via the Head of Governance and Quality to ensure reflection of proposed and approved changes in the BAF dashboards.

2. Sub-Committee Changes to Risks

Since the last report to the Board, the sub-committees have further reviewed the risks within their remit and there have been changes or alterations completed to a number of risks throughout the 2019-20 period.

Risk Targets Achieved

During the 2019-20 periods there are 2 BAF risks which have archived their target risk score:

1663 - Condition: Failure to deliver the annual financial plan. Initial score was 25 and current score has been reduced to 10 which is the set target score. This has been due to the achievement of key actions to ensure the delivery of the annual financial plan.

2293 - Condition: Staff is not engaged, motivated or effective in delivering the vision, values and aims of the Trust. The initial risk score was 25; this has been reduced to 10 which is the set target score. This has been achieved following the publication of the 2019 staff survey, which demonstrated improvements in key areas.

Risk Targets Not Achieved

During the 2019-20 period there are 5 BAF risks which have not achieved their target risk score, of these 3 have had a reduction in their risk score, but not to the target level set. Further work is continuing in relation to the management of these risks with the continued aim to reach a level where the risk can be deescalated from the BAF. There are 2 risks which have not had a reduction in this risk score, due to the level and complexity of the risks and external influences on the Trust:

1986 - Condition: The Trust is not financially sustainable beyond the current financial year. Initial risk score was 25 and current risk score remains at 25. This risk has had a substantial revision in line with Future Generations Strategy and developments in the Trust being able to move forward with original business case.

2266 - Condition: Ineffective understanding and learning following significant events. The initial risk score was 20 and the current score is 12 with the target score being 6. Work has progressed in relation to developing the Trust approach to learning lessons, further progress is required to achieve the target score.

2294 - Condition: Insufficient numbers of clinical staff resulting in a lack of capability to deliver safe care and effective outcomes. The initial risk score was 25, this has been reduced to a current score of 15 but the target score of 10 has not been achieved. This is in the main due to the current issues relating to the Trusts ability to recruit to Gynaecologist consultant posts. A full plan is in place to mitigate this issue and continue to work on recruiting consultants.

2295 - Condition: Inability to achieve and maintain regulatory compliance, performance and assurance. The initial risk score was 20 and this has been reduced to a current score of 12. As part of the final review on being able to achieve the target score of 8, the Trust is awaiting the outcome of the CQC inspection. Depending on the outcome of this report the risk may achieve its target score of 8.

2297 - Condition: Location, size, layout and accessibility of current services do not provide for sustainable integrated care or safe and high quality service provision. The initial risk score was 25 and this score has not been able to be reduced. The risk description, controls and assurances underwent a significant review in January 2020 to ensure the risk reflected the current situation for the Trust.

3. New Risks

Since the last report to the Trust Board, two new risks have been identified, developed and approved by sub-committees of the Board. The Trust board members are requested to review these risks and approve their inclusion onto the BAF.

2335 - Condition: Major and sustained failure of essential IT systems due to a cyber-attack. This risk has been developed by the Chief Information Officer following the identification of the need to strengthen cyber controls and technology, investment in systems and infrastructure, the skills and/or capacity of staff or service providers, end user culture regarding cyber security and IT systems use and contract management. The risk has been approved by FPBD for inclusion onto the risk register due to the possible significant impact on the Trust. Initial risk score of 20, current risk score 15 and a target risk score of 10.

2337 - Condition: The Trusts current clinical records system (paper and Electronic) are sub-optimal. Since the last report to the Trust Board a new risk has been agreed at FPBD for inclusion on the BAF in

relation to Electronic Patient Records (EPR). As the Board will be aware there has been a significant change to implementation of a new system and the risk which has been on the BAF to date no longer describes the key risk or any associated control or assurances and therefore a revised risk has been developed. Initial risk score of 25, current risk score 20 and a target risk score of 20.

4. Closed Risks

During the 2019-20 period 2 risks have been reviewed and closed on the BAF:

2168 – Best Clinical Outcomes: The risk was reviewed by the executive director and the Quality Committee and it was identified that key elements were covered in other BAF risks. The Trust participates in high quality research and this area is not considered a risk for the organisation at this time. Therefore it is proposed and agreed at Board this BAF risk is closed.

2167 – Positive Patient Experience.

Following further review by the Executive Director, senior nursing staff and Quality Committee and it was identified that this was no longer a BAF level risk, due to significant improvement that have been made since the risk was originally placed on the BAF. Therefore it is proposed and agreed at Board this BAF risk is closed.

4. Current BAF status

The current BAF is outlined in the Dashboard and the full BAF register in appendix 1 and 2 respectively. It is proposed to the Board members that the as of March 2020 will move forward into the 2020-21 period as a live document being reviewed and updated in line with the established process previously described in the report. The board members are asked to approve the March 2020-19 BAF moving forward into 2020-21 BAF.

BAF Dashboard: March 2020

Please refer to appendix 1

5. Conclusions

The report reflects the active review of BAF Risks by the Board sub-committees and the resulting changes to scores mitigation and supporting corporate and service risks in accordance with the review and escalation and de-escalation processes.

6. Recommendation

The Trust Board members are requested:

- To review the contents of the paper and gain assurance as to the BAF management process and identify any changes they consider necessary for consideration by the sub-committees.
- The Board are asked to approve the new risks in relation to EPR and Cyber-attacks for inclusion onto the BAF.
- Board members are asked to approve the March 2019/20 BAF moving forward into 2020/21 BAF.

Appendix 1 – BAF Dashboard as of March 2020

Risk No.	Assurance Committee	Description	Current risk score			Target	Assurance				Proposed Changes, Additions & Removals
			Severity	Likelihood	Risk Score	Risk Score by 31/03/2020	Status	Controls identified	Gap in Controls Identified	Assurances identified	
1663	Finance, Performance and Business Development Committee	**Condition:** Failure to deliver the annual financial plan **Cause:** Slippage against CIP targets (inc EPR delivery & CNST contribution reduction); Loss of activity resulting in reduced contribution; Increases in patient activity as contracts are largely on a block basis; Workforce cost pressures; Pressure to deliver national targets; Pension changes for consultants affecting additional activity **Consequence:** Breach of license conditions resulting in financial special measures	5	↓ 3	15	10	↓	Y	Y	Y	Reviewed at FPBD 25 February. Agreement to reduce risk score (likelihood) further to 2 meaning overall reduction from 15 (3x5 to 10 (2x5). New risk version created
1986	Finance, Performance and Business Development Committee	**Condition:** The Trust is not financially sustainable beyond the current financial year **Cause:** On-going requirement for annual CIPs; Significant CNST premium; Overhead costs; Impact of service change **Consequence**: Lack of financial stability, invocation of NHSI sanctions, special measures. Continued borrowing to meet operational expenses resulting in significant debt.	5	5	25	25	↔	Y	Y	Y	Review by DoF, additions made to control, gaps in control and internal assurance. Actions realigned to Future Generations Strategy.
2184	Quality Committee	**Condition:** Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) by the proposed schedule May 2020 which may lead to the implementation of a system that is not fit for purpose **Cause:** Poor programme management and product design **Consequence:** Impact on Patient Safety, Quality and Experience; Impact on patient clinical services, such as e-prescribing, staff documentation and consent; Unable to meet contractual reporting arrangements linked to performance and finance; Financial impact on delivery of control total leading to inability to deliver annual plan.	5	5	25	25	↔	Y	Y	Y	Risk approved at March FPBD to be closed and replaced with new risk.
2266	Quality Committee	**Condition:** Ineffective understanding and learning following significant events **Cause:** Failure to identify root cause, system structures and process, failure to analyse thematically, failure to respond proportionately. **Consequence:** Patient harm, failure to learn and improve the quality of service and experience, poor quality services, loss of income and activity, reputational damage, increased staff turnover.	4	3	12	6	↔	Y	Y	Y	No change to the risk, a number of actions are due for completion by 31st March 2020 and progress will be included in Aprils report.

Risk No.	Assurance Committee	Description	Current risk score			Target	Assurance				Proposed Changes, Additions & Removals
			Severity	Likelihood	Risk Score	Risk Score by 31/03/2020	Status	Controls identified	Gap in Controls Identified	Assurances identified	
2293	Putting People First Committee	**Condition:** Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust. **Cause**: Poor staff morale, lack of clarity around objectives, lack of ability to influence in the workplace, lack of organisational/job security, lack of leadership, behaviour contrary to the Trust values. **Consequence:** Failure to deliver high quality, safe patient care, impact on recruitment and retention, failure to achieve strategic vision, potential for regulatory action and reputational damage.	5	2	10	10	⟷	Y	Y	Y	Staff survey results recently published show increases in a number of key areas including support from immediate manager and recommending the trust as a place to work. Results are currently being analysed and split down to ward/dept level and these will then be used to inform local and divisional action plans.
2294	Putting People First Committee	**Condition**: Insufficient numbers of clinical staff resulting in a lack of capability to deliver safe care and effective outcomes. **Cause:** Insufficient numbers of doctors in training; Aging workforce; National shortage of nurses and midwives; Isolated site and associated clinical risk impacting on recruitment and retention of specialist consultant staff; pension tax changes impacting on the retention of consultant medical staff (early retirement or reduction in working time). **Consequence:** Gaps on junior doctor rotas; Loss of highly experienced nursing staff due to retirement; Impact on the quality of junior doctors in training; This may result in unsafe patient care and less effective outcomes, status of teaching hospital and impact on retention of specialist services.	5	↓ 3	15	10	↓	Y	Y	Y	No change to risk - actions on-going.
2295	Quality Committee	**Condition:** Inability to achieve and maintain regulatory compliance, performance and assurance. **Cause:** Lack of robust processes and management systems to provide evidence and assurance to regulatory agencies. **Consequence:** Enforcement action, prosecution, financial penalties, reputational damage, loss of commissioner and patient confidence in provision of services.	4	3	12	8	⟷	Y	Y	Y	Work on-going to introduce Ulysses CQC module. CQC well Led visit completed and outcome report awaited. Risk to be reviewed following the review of this report.

Risk No.	Assurance Committee	Description	Current risk score			Target	Assurance				Proposed Changes, Additions & Removals
			Severity	Likelihood	Risk Score	Risk Score by 31/03/2020	Status	Controls identified	Gap in Controls Identified	Assurances identified	
2297	Quality Committee	**Condition:** Location , size, layout and accessibility of current services do not provide for sustainable integrated care or safe and high quality service provision. **Cause:** Lack of onsite multidisciplinary provision, no ITU or Blood bank on site, very limited diagnostic imaging on site; Failure to meet multiple clinical standards; Senior staff recruitment and retention very difficult, lack of co-located paediatric surgical support. **Consequence:** Patient harm, poor continuity of care, poor patient experience due to transfer away for booking location.	5	5	25	25	⟷	Y	Y	Y	Risk reviewed with Medical Director. Changes made to provide updates in relation to current positions for: controls, gaps in control and external assurance. Adequacy of assurance changed from negative to positive. Updates also made to two target dates for actions 1 &2 to bring into line with business case action plan and risk number 1986
2337	Quality Committee	**Condition**: The Trusts current clinical records system (paper and Electronic) are sub-optimal. **Cause:** Failure to upgrade present Electronic Patient Records system in recent years and failure of 3 Trust electronic Patient Records to deliver on time. **Consequence:** There is potential impact on patient safety, quality, experience and negative effect on staff, Staff are unable to work effectively and safely. Reporting requirements will be impacted if systems fail. There is a financial cost of replacement and penalties to the Trust, of withdrawal from three way electronic Patient record	5	4	20	20	New Risk	Y	Y	Y	New risk developed in line with current status of EPR and approved at FPBD March 2020.

Listing For: 4. BAF | **Risk Register Level:** 4. BAF | **Directorate:** Financial Services | **Service / Department:** Finance | **Position at:** 26/03/2020 11:51:01

Risk Number: 1663 **Version:** 23 **Domain:** Finance Including Claims **Linked Risks:**

Executive Lead: Jenny Hannon **Operational Lead:** Eva Horgan

Strategic Objective: To Be Ambitious & Efficient & Make Best Use Of Available Resources

Risk Appetite: 3.Moderate

Assurance Committee: Finance, Performance & **Review Due:** 29/03/2020

Risk Description:

Condition: Failure to deliver the annual financial plan

Cause: Slippage against CIP targets (inc EPR delivery & CNST contribution reduction); Loss of activity resulting in reduced contribution; Increases in patient activity as contracts are largely on a block basis; Workforce cost pressures; Pressure to deliver national targets; Pension changes for consultants affecting additional activity

Consequence: Breach of license conditions resulting in financial special measures

Last Review Narrative: **Date:** 28/02/2020 **Reviewed By:** Jenny Hannon

Reviewed at FPBD 25 February. Agreement to reduce risk score (likelihood) further to 2 meaning overall reduction from 15 (3x5 to 10 (2x5). New risk version created

Control	Control Description	Gaps in Control	Effectiveness	Internal Assurance	External Assurance	Gaps in Assurance	Adequacy of Assurance
Prevent	Robust Budget setting process Quality Impact Assessment of all CIPs and post evaluation reviews Sign off of budgets by accountable officers FPBD and Board approval of budgets Budget Holder Training programme in place Monthly reporting to all budget holders with variance analysis Monthly reporting to FPBD and Trust Board Monthly reporting and feedback from NHSE/I Vacancy control process well established and monitored Control of expenditure through activity monitoring spends Monthly performance meetings Divisional performance reviews	Lack of contingency in budgets External influences and national policy	Not Yet Tested	Month 9 on Target 2019/20 Budget approval (BoD - April 19) Budget holder training manual and attendance records Performance and finance reports (monthly to FPBD and BoD) Finance and CIP achievement (Monthly to FPBD) Executive Team and Board oversight Internal Audit report provides significant assurance (Oct 17) Sustained performance above plan Delivery of control total in previous years	Monthly reports to NHSI with feedback Internal audit review of budgetary controls External Audit opinion Internal Audit assurances on Financial Reporting and Integrity given as high	Assurance is available re; controls, but is not on delivery Delivery of control total in 19-20 Delivery of £3.6m CIP for 19-20 NHSI use of resources risk rating - 3	Inconclusive
Detect	Internal audit reviews of systems and controls	None Known	Effective	Performance and Finance Reports to FPBD	External Audit Opinion Internal Audit assurances on Financial Reporting and Integrity given as high	Assurance is available on controls but not on delivery	Inconclusive

Action	Action Description:	Start Date	Target Date	Person Responsible	Progress	Status	Date Completed
1	Ongoing review of position in Divisional Performance meetings and finance committee	01/05/2019	31/03/2020	Eva Horgan	Ongoing monthly monitoring Action rewritten following exec review and risk being placed back onto Ulysses. Date Entered : 09/08/2019 14:43 Entered By : Christopher Lube	Ongoing	/ /
2	Quality performance challenge meetings	01/04/2019	31/03/2020	Eva Horgan	Ongoing monthly monitoring Date Entered : 09/08/2019 14:45 Entered By : Christopher Lube	Ongoing	/ /
3	Ongoing review of CIP	01/04/2019	31/03/2020	Eva Horgan	Ongoing monthly review Date Entered : 09/08/2019 14:46 Entered By : Christopher Lube	Ongoing	/ /
4	Monthly budget meeting with variance analysis	01/04/2019	31/03/2020	Eva Horgan	Ongoing monthly monitoring Date Entered : 09/08/2019 14:47 Entered By : Christopher Lube	Ongoing	/ /

Initial Assessment		
Severity	Likelihood	Risk Score
5 Catastrophic	5 Almost	25

Current Assessment		
Severity	Likelihood	Risk Score
5 Catastrophic	2 Unlikely	10

Target Assessment		
Severity	Likelihood	Risk Score
5 Catastrophic	2 Unlikely	10

Listing For: 4. BAF | **Risk Register Level:** 4. BAF | **Directorate:** Financial Services | **Service / Department:** Finance | **Position at:** 26/03/2020 11:51:02

Risk Number: 1986 **Version:** 6 **Domain:** Finance Including Claims **Linked Risks:**

Executive Lead: Jenny Hannon **Operational Lead:** Eva Horgan

Strategic Objective: To Be Ambitious & Efficient & Make Best Use Of Available Resources

Risk Appetite: 3.Moderate

Assurance Committee: Finance, Performance & **Review Due:** 25/04/2020

Risk Description:

Condition: The Trust is not financially sustainable beyond the current financial year

Cause: Ongoing requirement for annual CIPs; Significant CNST premium; Overhead costs; Impact of service change

Consequence: Lack of financial stability, invocation of NHSI sanctions, special measures. Continued borrowing to meet operational expenses resulting in significant debt.

Last Review Narrative: **Date:** 26/03/2020 **Reviewed By:** Christopher Lube

Reviewed at FPBD March 2020, no changes required.

Control	Control Description	Gaps in Control	Effectiveness	Internal Assurance	External Assurance	Gaps in Assurance	Adequacy of Assurance
Prevent	5 Year financial model produced giving early indication of issues Business case to Trust Board which identifies a solution which minimised deficit, including relocation to an acute site and merger Early and continuing dialogue with NHSE/I Active engagement with CCG resulting in a pre-consultation Business Case Agreement for merger proposals with partner Trusts approve by three BoD's Advisors with relevant experience (PWC) engaged early to review strategic options Clinical Engagement and support for proposals Review of open claims and legal processes Engagement in place with Cheshire and Mersey Partnership to review system solutions Update review against clinical standards and financial consequences. Reduction in CNST Premium Reduction in back office overheads costs. Application for emergency capital for mitigations on site	Implementation of business case is dependent on decision making external to the Trust (CCG, NHSE/I) Uncertainty regarding availability of capital funding necessary to implement business case Establishment of governance procedures to manage the merger transaction Merger dependent on external partners National CDEL Issue. Financial short term impact of mitigation's on site	Not Yet Tested	5 Year plan approved (BoD Nov 2014) Future Generations Clinical Strategy and Business Plan (BoD Nov 15) Sustainability and Transformation Plan (FPBD, Jul 16) PCBC Approval (FPBD, Oct 16) Strategic Outline Case for merger approved by three Trust Boards (BoD, Jun 16) SOC for preferred option approved by Board - Sept 17 Submission of Cheshire and Mersey STP capital bid Summer 2018 ranked no1 of schemes Long Term Plan Submission Nov 19 NHSE/I use of resources rating above 3 over 5 year period 5 year Strategy refresh underway	CCG Pre Consultation Business Case approved by CCG Committees in common Northern Clinical Senate Report supporting preferred option Cheshire and Mersey Partnership Support	Final approval for business case Lack of capital nationally Delivery of surplus Capital to invest on site while awaiting approval	Inconclusive

Action	Action Description:	Start Date	Target Date	Person Responsible	Progress	Status	Date Completed
4	Business Case 4 - Revision of SOC following unsuccessful STP capital bid Target has been put back based on initial feedback from TU readiness assessment - system buy in to be initial focus ahead of SOC update.	02/05/2022	29/07/2022	Eva Horgan	Work ongoing Date Entered : 09/08/2019 14:11 Entered By : Christopher Lube	Ongoing	/ /
6	Business Case 2 - Public consultation by CCG following development of preferred option (Subject to capital bid)	01/07/2021	29/10/2021	Eva Horgan	Dependent on external influences and agencies Date Entered : 09/08/2019 14:14 Entered By : Christopher Lube	Ongoing	/ /
7	Business Case 3 - Decision making business case produced in partnership with CCG and final decision following outcome of public consultation required	01/11/2021	29/04/2022	Eva Horgan	Closely linked to other actions and external influences Date Entered : 09/08/2019 14:16 Entered By : Christopher Lube	Ongoing	/ /
8	Business case - to support the application for capital to support the relocation required	01/04/2019	31/03/2020	Eva Horgan	Timescale TBC - requirements to be confirmed, subject to outcome of bid. Date Entered : 09/08/2019 14:18 Entered By : Christopher Lube	Ongoing	/ /
11	Merger 1 - Agree in principle to proceed to merger	13/02/2020	31/03/2020	Eva Horgan		Ongoing	/ /
12	Merger 2 - Establish Merger Project (internal group)	01/04/2020	30/06/2020	Eva Horgan		Ongoing	/ /
13	Merger 3 - Develop Strategic case working with external organisations	01/07/2020	31/03/2021	Eva Horgan		Ongoing	/ /

14	Merger 4 - Develop and complete business case in conjunction with external organisations	01/04/2021	30/11/2021	Eva Horgan	Ongoing	/ /
15	Merger 5 - Merger / acquisition approval process with external organisation	01/12/2021	31/03/2022	Eva Horgan	Ongoing	/ /
16	Shared Exec Model 1 - Develop Shared Exec Model - Work in partnership with external body (LUHFT) in order to develop and assess options for a shared executive model which will deliver financial savings	01/07/2020	31/03/2021	Eva Horgan	Ongoing	/ /
17	Shared Exec Model 2 - Agree Model - Review and agree preferred model in conjunction with external organisation (LUHFT)	01/04/2021	30/06/2021	Eva Horgan	Ongoing	/ /
18	Shared Exec Model 3 - Implement Shared Exec Model - Detailed implementation plan to be developed in conjunction with external organisation (LUHFT) to implement agreed shared exec model.	01/10/2021	31/12/2021	Eva Horgan	Ongoing	/ /
19	Procurement 1 - OJEU - Undertake most appropriate formal procurement process to appoint primary building contractor & architect	03/10/2022	30/12/2022	Eva Horgan	Ongoing	/ /
20	Procurement 2 - PQQ Stage - Procurement team to complete Pre Qualification Questionnaire stage	02/01/2023	31/03/2023	Eva Horgan	Ongoing	/ /
21	Procurement 3 - ITPD Stage - Procurement team to complete Invitation to Participate in Dialogue stage	03/04/2023	31/10/2023	Eva Horgan	Ongoing	/ /
22	Procurement 4 - Financial Close - Procurement team to complete financial close stage	01/08/2023	31/01/2024	Eva Horgan	Ongoing	/ /
23	Procurement 5 - Contract Award - Trust to approve contract award	01/02/2024	29/03/2024	Eva Horgan	Ongoing	/ /
24	Short term investment through operational plan to ensure safety on site	06/01/2020	31/03/2020	Eva Horgan	Ongoing	/ /
25	Emergency capital funding application - submit emergency capital funding application to NHSI/E regarding new build and refurbishment work to house mitigations designed to reduce clinical risk on isolated site	06/01/2020	17/04/2020	Jennifer Huyton	Ongoing	/ /
26	Business Case 1 - Work in partnership with CCG to refresh PCBC document, including stakeholder engagement and refresh of data	01/01/2020	31/12/2020	Jennifer Huyton	Ongoing	/ /
27	Business Case 5 - Approval for funding from NHSI/E based on refreshed SOC	01/08/2022	31/10/2022	Eva Horgan	Ongoing	/ /

Initial Assessment		
Severity	**Likelihood**	**Risk Score**
5 Catastrophic	5 Almost	25

Current Assessment		
Severity	**Likelihood**	**Risk Score**
5 Catastrophic	5 Almost	25

Target Assessment		
Severity	**Likelihood**	**Risk Score**
5 Catastrophic	5 Almost	25

Listing For: 4. BAF | **Risk Register Level:** 4. BAF | **Directorate:** Governance | **Service / Department:** Governance | **Position at:** 26/03/2020 11:51:02

Risk Number: 2266 **Version:** 2 **Domain:** Impact On The Safety Of Patien **Linked Risks:**

Executive Lead: Devender Roberts **Operational Lead:** Christopher Lube

Strategic Objective: To Deliver SAFE Services

Risk Appetite: 2.Low

Assurance Committee: Quality Committee **Review Due:** 25/04/2020

Risk Description:

Condition: Ineffective understanding and learning following significant events

Cause: Failure to identify root cause, system structures and process, failure to analyse thematically, failure to respond proportionately.

Consequence: Patient harm, failure to learn and improve the quality of service and experience, poor quality services, loss of income and activity, reputational damage, increased staff turnover.

Last Review Narrative: **Date:** 26/03/2020 **Reviewed By:** Christopher Lube

New Risk and Patient Safety Manager in post.
Review of lesson learnt dissemination process ongoing to identify new ways of working.

Control	Control Description	Gaps in Control	Effectiveness	Internal Assurance	External Assurance	Gaps in Assurance	Adequacy of Assurance
Prevent	Regular dialogue with regulators. Incident reporting and investigation policies and procedures. MDT involvement in safety HR policies in relation to issues relating to professional and personal responsibility Mandatory training in relation to safety and risk Staffing level acuity exercises Scoping for relevant national reports Quality strategy 3yr programme in place Risk Management Strategy Governance structure Serious Incident Feedback form Serious Incident panels Corporate level engagement by Trust Board Listening events Never events reported though Safety Senate and BoD 2nd Year of Quality strategy delivered Safety is included as part of executive walk rounds. Close working with safety collaborative being maintained	Inconsistent completion and dissemination of actions and improvement plans Inconstant implementation of lessons learnt and lack of evidence Pace of implementing change, Monitored via effectiveness senate Lack of opportunity to deliver bespoke training for staff groups in relation to risk management and patient safety.	Effective	CQPG Meetings Reporting of incidents and management of action plans through Safety Senate Reflection of risks and Corporate Risk Register and Board Assurance Framework CQC Assessment Annual Quality Account Report	Internal Audit of Risk Management External Audit or Risk Maturity CQC Assessment, safe as 'Good' across all areas of the Trust NRLS Incident Reporting MIAA Report on Duty of Candour Safety Senate Reports	Inconsistent use of benchmarking tools Difficult to gain consistent assurance that clinicians are following best practice Some national audits/studies do not provide benchmarking of data if they do, this is in an inconsistent format making it difficult to accurately assess and compare Trust status Lack of testing of action plans following audits to ensure they lead embedded change External and internal reporting structures.	Inconclusive

Action	Action Description:	Start Date	Target Date	Person Responsible	Progress	Status	Date Completed
1	Introduction of Fair and Just Culture process	01/04/2019	31/10/2024	Chris McGhee	Initial stages of training staff via book clubs in progress. Mapping exercise of SI ongoing Date Entered : 31/07/2019 10:57 Entered By : Christopher Lube	Ongoing	/ /
3	Develop better reporting from the Ulysses System	01/04/2019	30/04/2020	Christopher Lube	Upgrades commencing to be rolled out to staff, review and close march 2020. Date Entered : 04/03/2020 13:23 Entered By : Christopher Lube ---------- Updates to the Ulysses system have been completed and a plan is in place to roll out by 1st Feb 2020. Some final testing to be completed and training. Date Entered : 11/01/2020 10:40 Entered By : Christopher Lube ---------- The Upgrade of the Ulysses system is progressing. A slight delay was encountered due to the	Ongoing	/ /

					need to move to a new server. Date Entered : 30/10/2019 14:47 Entered By : Christopher Lube ---------- Governance team currently working with Ulysses to develop the current system and implement new modules to support RCA investigation, Action Planning and CQC compliance monitoring, Audit module to come later in year. Date Entered : 31/07/2019 10:56 Entered By : Christopher Lube		
6	Business case for the provision of Human Factors Training to be developed and submitted to education governance committee	01/04/2019	04/05/2020	Linda Watkins	Business case for sim lead developed. Need to identify funding. As a result of feedback need to develop simulation strategy for the trust to present to ed gov. Delay as DME has been supporting colleague on mat leave as well as the acting specialty tutor for O&G after Specialty tutor resigned. Date Entered : 29/01/2020 17:57 Entered By : Linda Watkins ---------- Discussions are ongoing via Ed Gov Committee Date Entered : 11/01/2020 10:44 Entered By : Christopher Lube ---------- There is currently no lead for SIM Training in Trust, Lead for action has been changed to Chair of Ed Gov Comm. Date Entered : 03/10/2019 16:38 Entered By : Christopher Lube ---------- Update Received from Dr Hurst as to current position of Simulation Tranining. See Document section for further detail. Date Entered : 14/08/2019 14:19 Entered By : Elaine Eccles ---------- Initial paper presented to Ed Gov and Safety Senate, acting Medical Director requested further information Date Entered : 31/07/2019 11:01 Entered By : Christopher Lube	Ongoing	/ /
7	New risk management and patient safety training package to be developed	01/04/2019	31/03/2020	Christopher Lube	Work on Risk Training Package is ongoing with the appointment of new Risk and Patient Safety	Ongoing	/ /

Manager. RCA training dates are available for staff to book on, bespoke training continues to be available and Risk Management is part of Cooperate induction and Annual Mandatory Training,

Date Entered : 11/01/2020 10:48
Entered By : Christopher Lube

Work is ongoing, plan for completion Nov 19

Date Entered : 03/10/2019 16:39
Entered By : Christopher Lube

Head of Governance in planning stages.
May be affected by new national training system and curriculum which is due to be published in 2019-20.

Date Entered : 31/07/2019 11:00
Entered By : Christopher Lube

Initial Assessment		
Severity	**Likelihood**	**Risk Score**
4 Major	5 Almost	20

Current Assessment		
Severity	**Likelihood**	**Risk Score**
4 Major	3 Possible	12

Target Assessment		
Severity	**Likelihood**	**Risk Score**
3 Moderate	2 Unlikely	6

Listing For: 4.BAF **Risk Register Level:** 4. BAF **Directorate:** Human Resources **Service / Department:** HR **Position at:** 26/03/2020 11:51:02

Risk Number: 2293 **Version:** 4 **Domain:** HR/Organisational Development/ **Linked Risks:**

Executive Lead: Michelle Turner **Operational Lead:** Jeanette Chalk

Strategic Objective: Develop A Well-Led, Capable, Motivated And Entrepreneurial Workforce

Risk Appetite: 3.Moderate

Assurance Committee: Putting People First **Review Due:** 04/04/2020

Risk Description:

Condition: Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust.

Cause: Poor staff morale, lack of clarity around objectives, lack of ability to influence in the workplace, lack of organisational/job security, lack of leadership, behaviour contrary to the Trust values.

Consequence: Failure to deliver high quality, safe patient care, impact on recruitment and retention, failure to achieve strategic vision, potential for regulatory action and reputational damage.

Last Review Narrative: **Date:** 05/03/2020 **Reviewed By:** Simon Davies

Staff survey results recently published show increases in a number of key areas including support from immediate manager and recommending the trust as a place to work. Results are currently being analysed and split down to ward/dept level and these will then be used to inform local and divisional action plans.

Control	Control Description	Gaps in Control	Effectiveness	Internal Assurance	External Assurance	Gaps in Assurance	Adequacy of Assurance
Prevent	Appraisal policy, paperwork and systems for delivery and recording are in place for medial and non-medical staff. Consultant revalidation process. Reward and recognition processes linked to values. Pay progression linked to mandatory training compliance. Targeted OD intervention for areas in need to support. Management development training programme. Aspirant talent programme for aspiring ward managers and matrons. Programme of health and wellbeing initiatives. All new starters complete mandatory PDR training as part of corporate induction ensuring awareness of responsibilities. Extensive mandatory training programme available. Value based recruitment and induction. Workforce planning processes in place to deliver safe staffing. Shared decision making with JLNC and Partnership Forum. Putting People First Strategy. Quality Strategy. Guardian of Safe Working. People strategy revised and agreed PDR training programme in place	Quality of appraisal. Poor attendance at non-mandatory training e.g. leadership training. Requirement for further development of middle managers. Talent management programme is newly implemented and not yet fully embedded.	Effective	Quarterly internal staff survey (Go Engage System). Monthly KPI's for controls. Performance Repots (monthly) Quarterly Learning events. Bi-annual Speak UP Guardian Reports. Report form Guardian of Safe Working	National Staff Survey(annual). POPPY study RCM culture survey findings CQC regulatory inspection in 2018. National Workforce and Wellbeing Charter - 2018	Staff survey engagement score not improved in year. Mandatory training currently below target. Sickness absence above target.	Positive
Detect	Recruitment intentions annual exercise. Staff engagement programmes. Two Freedom to Speak Up Guardians. Whistle Blowing Policy Engagement Tool Implemented.	Ongoing challenges of engaging effectively with all staffing groups due to rota patterns.	Effective				

Action	Action Description:	Start Date	Target Date	Person Responsible	Progress	Status	Date Completed
1	PPF deep dive into service level workface risks	01/04/2019	31/03/2020	Jeanette Chalk	To be completed on a monthly basis Date Entered : 08/08/2019 11:31 Entered By : Christopher Lube	Ongoing	/ /
2	Aspirant managers programme in place	01/04/2019	31/03/2020	Jeanette Chalk	Aspirant managers programme in place and 1st cohort have completed with 2nd cohort to commence. Date Entered : 16/11/2019 12:04 Entered By : Christopher Lube ---------- To be monitored monthly Date Entered : 08/08/2019 11:33 Entered By : Christopher Lube	Ongoing	/ /
3	Executive team and staff side walkabouts	01/04/2019	31/03/2020	Jeanette Chalk	To be monitored monthly	Ongoing	/ /

4	Launch of Fair and Just Culture Project	01/04/2019	31/03/2020	Chris McGhee	Date Entered : 08/08/2019 11:35 Entered By : Christopher Lube Year 1 completed on timescale in accordance with project plan. Date Entered : 16/11/2019 12:04 Entered By : Christopher Lube ---------- Initial development work and staff training in progress Date Entered : 09/08/2019 15:24 Entered By : Christopher Lube		Ongoing	/ /

Initial Assessment		
Severity	**Likelihood**	**Risk Score**
5 Catastrophic	5 Almost	25

Current Assessment		
Severity	**Likelihood**	**Risk Score**
5 Catastrophic	2 Unlikely	10

Target Assessment		
Severity	**Likelihood**	**Risk Score**
5 Catastrophic	2 Unlikely	10

Listing For: 4. BAF | **Risk Register Level:** 4. BAF | **Directorate:** Human Resources | **Service / Department:** HR | **Position at:** 26/03/2020 11:51:02

Risk Number: 2294 **Version:** 7 **Domain:** HR/Organisational Development/ **Linked Risks:**

Executive Lead: Michelle Turner **Operational Lead:** Rachel London

Strategic Objective: Develop A Well-Led, Capable, Motivated And Entrepreneurial Workforce

Risk Appetite: 3.Moderate

Assurance Committee: Putting People First **Review Due:** 04/04/2020

Risk Description:

Condition: Insufficient numbers of clinical staff resulting in a lack of capability to deliver safe care and effective outcomes.

Cause: Insufficient numbers of doctors in training; Aging workforce; National shortage of nurses and midwives; Isolated site and associated clinical risk impacting on recruitment and retention of specialist consultant staff; pension tax changes impacting on the retention of consultant medical staff (early retirement or reduction in working time).

Consequence: Gaps on junior doctor rotas; Loss of highly experienced nursing staff due to retirement; Impact on the quality of junior doctors in training; This may result in unsafe patient care and less effective outcomes, status of teaching hospital and impact on retention of specialist services.

Last Review Narrative: **Date:** 05/03/2020 **Reviewed By:** Simon Davies

No change to risk - actions ongoing.

Control	Control Description	Gaps in Control	Effectiveness	Internal Assurance	External Assurance	Gaps in Assurance	Adequacy of Assurance
Prevent	Annually agreed funding contract with HEN. Regional Training Programme Directors manage the junior doctor rotation programme and highlight shortages to the Lead Employer. Lead Employer notifies the Trust of Gaps in local rotations, giving the Trust autonomy to recruit at a local level into these gaps. Effective electronic rota management system implemented. Director of medical Education (DME) to ensure training requirements are met, reporting to the Trust Medical Director and externally to HEN. Guardian of Safe Working Hours appointed in 2016 under new Junior Doctor Contract. Acting down policy and process in place to cover junior doctor gaps. National Revalidation process ensuring competent staff. Shared decision making and review of risk with JLNC. Putting People First Strategy. Quality Strategy. Strategic Workforce Group established. Aspirational Ward Manager Programme. Succession Planning and Talent Programme NHSE Retention Improvement Programme NHSI Sickness Improvement Programme Shared appointments with other providers Secured operating time at the LUH Increased consultant recruitment with incentives Neonatal Partnership Maternity introduction of ACP Midwives Policy to mitigate impact on LTA and AA on senior staff in place	Further utilisation of the rota management system. E-Roistering System not fully utilised	Effective	Quarterly reporting by Guardian of Safe Working. Strategic Workforce reporting to PPF. Leadership Development programme Review (annual to PPF). Exception Reporting System and process working effectively. Junior Medical Staff GMC survey reporting to Education Governance and PPF - No concerns areas of specific concerns identified. Clinical and nursing roles being developed and enhanced to mitigate the gas in junior doctor workforce. Roles include: Physicians Assistants, Surgical assistants, ANP's, Consultant Nurses, ER Practitioners.	DME reports to HEN on an annual basis in relation to junior doctor training. Annual GMC Survey. Annual Staff survey NHS Ed SAR. DME Annual Report GMC Revalidation Process HEN Visit - Regular (next due 2019 due to satisfactory report in 2016) GMC Medical Staff survey - annual.	None identified at this time	Positive
Detect	GMC Survey 018 - action plan in place						

Action	Action Description:	Start Date	Target Date	Person Responsible	Progress	Status	Date Completed
4	Await outcome of Business case sent to NHSI to develop E-Rostering System Collaborative	16/11/2019	31/03/2020	Jeanette Chalk		Ongoing	/ /
5	Medical Workforce Recruitment and Retention process being developed	01/11/2019	31/03/2020	Jeanette Chalk		Ongoing	/ /

Initial Assessment		
Severity	Likelihood	Risk Score
5 Catastrophic	5 Almost	25

Current Assessment		
Severity	Likelihood	Risk Score
5 Catastrophic	3 Possible	15

Target Assessment		
Severity	Likelihood	Risk Score
5 Catastrophic	2 Unlikely	10

Listing For: 4. BAF | **Risk Register Level:** 4. BAF | **Directorate:** Governance | **Service / Department:** Governance | **Position at:** 26/03/2020 11:51:02

Risk Number: 2295 **Version:** 1 **Domain:** Impact On The Safety Of Patien **Linked Risks:**

Executive Lead: Caron Lappin **Operational Lead:** Christopher Lube

Strategic Objective: To Deliver SAFE Services

Risk Appetite: 2.Low

Assurance Committee: Quality Committee **Review Due:** 25/04/2020

Risk Description:

Condition: Inability to achieve and maintain regulatory compliance, performance and assurance.

Cause: Lack of robust processes and management systems to provide evidence and assurance to regulatory agencies.

Consequence: Enforcement action, prosecution, financial penalties, reputational damage, loss of commissioner and patient confidence in provision of services.

Last Review Narrative: **Date:** 26/03/2020 **Reviewed By:** Christopher Lube

Work on Ulysses system has progressed and staff are now required to risk score incidents as they report them, this will allow for early harm review to be completed.
New formats for disseminating lessons learnt are in review.
Final report of CQC is awaited.

Control	Control Description	Gaps in Control	Effectiveness	Internal Assurance	External Assurance	Gaps in Assurance	Adequacy of Assurance
Detect	Board Assurance visits NED walk rounds National Audits Local Audits Ward accreditation scheme H&S Executive inspections Human Tissue and Embryology Authority Inspections External Peer reviews CQC inspections	None identified	Effective		MIAA Audits Collaborative meetings with CCG CQC Inspections NHSE/I reviews with LWH	None identified	Positive
Prevent	Regular meetings with NHSE/I CQC engagement meetings Maintenance of CQC registration Regulatory information provided to staff at induction Committee structures in place to monitor regulatory compliance An integrated approach between corporate operational and governance teams Quality impact assessments for all service changes and CIP's that are considered. Professional Standards Trust Polices and Procedures Risk Management Strategy and culture Quality and Independence of QIA's by DoN and MD Completion and submission of Annual Quality Report	Benchmarking data can make the Trust appear an outlier due to specialist nature of the services provided and attract regulatory attention	Effective	Executive Walk rounds Matron walk rounds Ward accreditation Internal H&S walk rounds and annual audits Internal Fire Safety Inspection's	MIAA Audits CQC Visits CCG Meetings HFEA Inspections H&S Executive inspections Fire Service Inspections Safeguarding regulatory Inspections	Monitoring of regulatory reports and action plans to completion	Positive

Action	Action Description:	Start Date	Target Date	Person Responsible	Progress	Status	Date Completed
1	Provide assurance to CQC in relation to risk with appropriate information	01/04/2019	31/03/2020	Christopher Lube	Information provided to CQC on request and at quarterly engagement meetings. Action to be monitored monthly Date Entered : 08/08/2019 14:57 Entered By : Christopher Lube	Ongoing	/ /
2	Ward accreditation to be rolled out following completion of pilot	01/04/2019	31/03/2020	Janet Brennan	Meeting with Ward Accreditation providers due on 08/08/19. Progress on pilot to be discussed and review of software to log data. Date Entered : 08/08/2019 15:00 Entered By : Christopher Lube	Ongoing	/ /
3	To embed process for monitoring of regulatory reports and action plans at divisional boards	01/04/2019	31/03/2020	Christopher Lube	New CQC compliance monitoring module being developed by Ulysses. Due for implementation in September 2019. Date Entered : 08/08/2019 15:02 Entered By : Christopher Lube	Ongoing	/ /

4	Report regulatory exceptions form Divisional Boards to Quality Committee	01/04/2019	31/03/2020	Christopher Lube	Once CQC compliance module in place in Ulysses Divisions will be able to provide exception report to Quality Committee on status and planned actions. Date Entered : 08/08/2019 15:05 Entered By : Christopher Lube		Ongoing	/ /
5	Undertake intermittent deep dive reviews into specialist services	01/04/2019	31/03/2020	Christopher Lube	Reviews to be completed as and when identified by sub-committee of the board or at divisional board level. Date Entered : 08/08/2019 15:08 Entered By : Christopher Lube		Ongoing	/ /
6	New CQC monitoring system via Ulysses to be introduced across all core areas of the Trust. Process will provide quarterly reports to Quality Committee on CQC commence levels and associated actions.	01/07/2019	31/03/2020	Christopher Lube	New module has been commissioned and developed by Ulysses. It has been tested in some clinical areas prior to end of December 2019 and plan to roll out across all areas to establish base line assessment prior to 31st March 2020. Date Entered : 11/01/2020 10:56 Entered By : Christopher Lube		Ongoing	/ /

Initial Assessment		
Severity	**Likelihood**	**Risk Score**
4 Major	5 Almost	20

Current Assessment		
Severity	**Likelihood**	**Risk Score**
4 Major	3 Possible	12

Target Assessment		
Severity	**Likelihood**	**Risk Score**
4 Major	2 Unlikely	8

Listing For: 4.BAF **Risk Register Level:** 4. BAF **Directorate:** Governance **Service / Department:** Executive Office **Position at:** 26/03/2020 11:51:02

Risk Number: 2297 **Version:** 3 **Domain:** Impact On The Safety Of Patien **Linked Risks:**

Executive Lead: Andrew Loughney **Operational Lead:** Jennifer Huyton

Strategic Objective: To Deliver SAFE Services

Risk Appetite: 2.Low

Assurance Committee: Quality Committee **Review Due:** 03/04/2020

Risk Description:

Condition: Location , size, layout an accessibility of current services do not provide for sustainable integrated care or safe and high quality service provision.

Cause: Lack of on site multidisciplinary provision, no ITU or Blood bank on site, very limited diagnostic imaging on site; Failure to meet multiple clinical standards; Senior staff recruitment and retention very difficult, lack of co-located paediatric surgical support.

Consequence: Patient harm, poor continuity of care, poor patient experience due to transfer away for booking location.

Last Review Narrative: **Date:** 04/03/2020 **Reviewed By:** Christopher Lube

Risk reviewed with Medical Director. Changes made to provide updates in relation to current positions for: controls, gaps in control and external assurance. Adequacy of assurance changed from negative to positive. Updates also made to two target dates for actions 1 &2 to bring into line with business case action plan and risk number 1986

Control	Control Description	Gaps in Control	Effectiveness	Internal Assurance	External Assurance	Gaps in Assurance	Adequacy of Assurance
Prevent	Continuing dialogue with regulators Active management with all commissioners Putting People First Strategy Leadership and Management development programme Programme for a partnership in relation to Neonates with AHCH has been established. £15m capital investment in neonatal estate to address infection risk Transfer arrangements well established for neonates and adults Formal partnership and board established with Liverpool Universities Hospitals with respect to: -Diagnostics -Medical and surgical expertise -Intensive care facilities -Theatre access at Liverpool Universities Hospitals for women with Gynae cancers Blood product provision by motorised vehicle from near by facility. Investments in additional staffing inc. towards 24/7 cover Enhanced resuscitation training provision Future Generations project group established with the Trust	Clinical case for change is dependent on decision making external to the Trust (NHSE) Lack of system support outside of Cheshire and Mersey to secure the capital case H&CP submissions for capital bids not successful despite system agreement of clinical case Financial and workforce constraints for delivery of additional facilities on site. - No blood bank on site -No 24/7 cover on site - No CT Neonatal unit at Alder Hey Children's Hospital funding agreed re: capital. Alder Hey Children's Hospital estate not yet established Onsite and partnership mitigations cannot fully address the clinical risk - this can only be achieved through co-location Emerging clinical standard leading to potential lose of services and increase in difficulty in relation to recruitment of consultants	Not Effective	Corporate Objectives 2019-20 Board performance reports DIPC Reports Staff Staffing levels reports to board Incident and Serious Incident reports to Safety Senate Quality Committee, Divisions and Trust Board. Mortality and Morbidity reviews in all areas Performance monitoring of patient experience and clinical outcomes Transfers out monitored at HDU Group Data reviewed regularly and reported through HDU and Sepsis Group.	Approval of NNU Business case CQC inspection (2018) - Good Meetings with CCG via Clinical Quality and Performance Group (CQPG) Negative - North East clinical senate report - Neonatal ODM - Maternity SCN Dashboard Counterfactual clinical case (2020) Output from Clinical Summit report (2019) Divisional Performance Reports Quality Data Serious Incident Investigation Reports	Improved data reporting required with respect to: -acuity of patients on HDU -number of women with highest level of medical conditions - in maternal and Termination of Pregnancy Services -Where services data is collated and acted upon	Positive

Action	Action Description:	Start Date	Target Date	Person Responsible	Progress	Status	Date Completed
1	To commence public consultation (external control of this action by NHSE/I)	01/04/2019	29/10/2021	Andrew Loughney	Target date changed to come into line with business case action plan - risk number 1986 Date Entered : 04/03/2020 07:28 Entered By : Christopher Lube ---------- To be monitored monthly Date Entered : 09/08/2019 13:40 Entered By : Christopher Lube	Ongoing	/ /
2	Agree Business Case for new build	01/04/2019	29/04/2022	Jennifer Huyton	Target date changed to come into line with business case plan - risk 1986 Date Entered : 04/03/2020 07:29 Entered By : Christopher Lube ---------- To be monitored monthly Date Entered : 09/08/2019 13:41 Entered By : Christopher Lube	Ongoing	/ /

4	Divisional plans to be developed to support long term clinical sustainability via operational plan	01/04/2019	31/03/2020	Jennifer Huyton	Operational plans under development but not due until March 20. Target date amended to March 20. Date Entered : 10/01/2020 14:18 Entered By : Jenny Hannon ---------- Work ongoing in Divisions Date Entered : 09/08/2019 13:46 Entered By : Christopher Lube	Ongoing	/ /
5	Outcomes form the clinical summit to be actioned.	27/09/2019	31/03/2020	Jennifer Huyton	CT scanner and Blood Bank provision has been added to the draft operational plan, which is awaiting approval. Date Entered : 04/03/2020 07:27 Entered By : Christopher Lube ---------- Target date amended following development of MoU with LUH. Detailed plan is in place (to be attached) actions are in progress Date Entered : 10/01/2020 14:18 Entered By : Jenny Hannon ---------- Acting Medical Director working with Strategic Finance Manager on reviewing summit outcomes. Date Entered : 27/09/2019 08:43 Entered By : Christopher Lube	Ongoing	/ /
7	Management of Futuire Generations Strategy through Project Management Office	16/11/2019	31/03/2020	Andrew Loughney		Ongoing	/ /
8	Development of counter factual arguement	16/11/2019	31/03/2020	Jennifer Huyton		Ongoing	/ /
9	Agree funding for mitigations on site (Blood Bank, MRI, Diagnositics, CT and Staffing) for inclusion in 20/21 operational plan	31/03/2020	31/03/2020	Jennifer Huyton		Ongoing	/ /
10	Lobby systems and MP's for active support	16/11/2019	31/03/2020	Kathryn Thomson		Ongoing	/ /

Initial Assessment		
Severity	**Likelihood**	**Risk Score**
5 Catastrophic	5 Almost	25

Current Assessment		
Severity	**Likelihood**	**Risk Score**
5 Catastrophic	5 Almost	25

Target Assessment		
Severity	**Likelihood**	**Risk Score**
5 Catastrophic	5 Almost	25

Listing For: 4. BAF | **Risk Register Level:** 4. BAF | **Directorate:** IM & T | **Service / Department:** IM & T | **Position at:** 26/03/2020 11:51:02

Risk Number: 2335 **Version:** 1 **Domain:** Impact On The Safety Of Patien **Linked Risks:**

Executive Lead: Jenny Hannon **Operational Lead:** Matt Connor

Strategic Objective: To Deliver SAFE Services

Risk Appetite: 2.Low

Assurance Committee: Finance, Performance & **Review Due:** 11/04/2020

Risk Description:

Condition: Major and sustained failure of essential IT systems due to a cyber attack

Cause: ineffective cyber controls and techology, inadequate investment in systems and infrastructure, failure in skills or capacity of staff or service providers, poor end user culture regarding cyber security and IT systems use, inadequate contract management.

Consequence: Reduced quality or safety of services, financial penalties, reduced patient experience, loss of reputation, loss of market share/ commissioner contracts.

Last Review Narrative: **Date:** / / **Reviewed By:**

Control	Control Description	Gaps in Control	Effectiveness	Internal Assurance	External Assurance	Gaps in Assurance	Adequacy of Assurance
Prevent	1. Microsoft Windows security and critical patches applied to all Trust servers on all servers\laptops and desktop devices on a monthly basis. 2. Network switches and firewalls have firmware updates as and when required installed. Wifi network firmware patches applied for Controllers and Access points. 3. Mobile end devices patched as and when released by the vendor. 4. Externally managed network service provider to ensure network is a securely managed with underpinning contract. 5. Robust carecert process to enact advice from NHS Digital regarding imminent threats. 6. Network perimeter controls (Firewall) to protect against unauthorised external intrusion. 7. Robust Information Governance training on information security and cyber security good practice. 8. Regular staff educational communications on types of cyber threats and advice on secure working of Trust IT systems.	Lack of Cyber Security strategy	Effective	Cyber Essentials Plus Standards/ KPIs IMT Risk Management Meeting Digital Hospital Sub Committee Finance, Performance & Business Development	MIAA Cyber Controls Review Cyber Essentials Plus Accreditation Cyber Penetration Test NHS Care Cert Compliance	None known at this time	Positive
Detect	1. Malware protection identifies and removes known cyber threats and viruses within the Trusts network and at the network boundaries. 2. Cyber Security Moniroing System identifies suspicious network and potential cyber threat behaviour. 3. National CareCert alerts inform of known and imminent cyber threats and vulnerabilities.	1. Lack of Network Access Controls within the physical network.	Effective	Cyber Essentials Plus Standards/ KPIs IMT Risk Management Meeting Digital Hospital Sub Committee Finance, Performance & Business Development	MIAA Cyber Controls Review Cyber Essentials Plus Accreditation Cyber Penetration Test NHS Care Cert Compliance	None Known at this tiime	Positive
Contingency	1. Departmental Business Continuity Plans being invoked. 2. Enactment of the IMT Dept. Disaster Recovery (DR) Plan 3. Seek C&M system wide support in recovery.	None known at this time	Not Yet Tested	~~EPRR~~	MIAA Audit on BCP and DR C&M Cyber Security workstream C&M Digital Leadership forum	None known at this time	Inconclusive

Action	Action Description:	Start Date	Target Date	Person Responsible	Progress	Status	Date Completed
1	Implementation of the MIAA Cyber Security audit action	12/03/2020	31/08/2020	Philip Moss			/ /
2	Implementation of new network will introduce enhanced security capabilities.	13/03/2020	30/07/2020	Philip Moss			/ /
3	Implement a Cyber Security strategy	01/04/2020	30/09/2020	Matt Connor			/ /

Initial Assessment		
Severity	Likelihood	Risk Score
5 Catastrophic	4 Likely	20

Current Assessment		
Severity	Likelihood	Risk Score
5 Catastrophic	3 Possible	15

Target Assessment		
Severity	Likelihood	Risk Score
5 Catastrophic	2 Unlikely	10

Listing For: 4. BAF | **Risk Register Level:** 4. BAF | **Directorate:** Human Resources | **Service / Department:** Executive Office | **Position at:** 26/03/2020 11:51:02

Risk Number: 2337 **Version:** 1 **Domain:** Impact On The Safety Of Patien **Linked Risks:**

Executive Lead: Jenny Hannon **Operational Lead:** Matt Connor

Strategic Objective: To Deliver SAFE Services

Risk Appetite: 2.Low

Assurance Committee: Quality Committee **Review Due:** 25/04/2020

Risk Description:

Condition:The Trusts current clinical records system (paper and Electronic) are sub-optimal.

Cause: Failure to upgrade present Electronic Patient Records system in recent years and failure of 3 Trust electronic Patient Records to deliver on time.

Consequence: There is potential impact on patient safety, quality, experience and negative effect on staff, Staff are unable to work effectively and safely.Reporting requirements will be impacted if systems fail. There is a financial cost of replacement and penalties to the Trust, of withdrawal from three way electronic Patient record

Last Review Narrative: **Date:** / / **Reviewed By:**

Control	Control Description	Gaps in Control	Effectiveness	Internal Assurance	External Assurance	Gaps in Assurance	Adequacy of Assurance
Prevent	Maintenance of present system Development of individual / service solutions e.g. PENs (Gynaecology) and Staff training Development and deployment of ADT Whiteboard system to reduce risk of multiple systems. Incident reporting Oversight form Digital Hospital Committee, reporting into Finance, Performance and Business Development Committee (FPBD). Quarterly risk assessments reported to FPBD Tactical solutions including planned purchase of K2 Athena system Single Sign on Financial provisions made for exit penalties Exchange/LHCRE enables for patent information sharing Legal Advice from Hill Dickinson regarding previous system supplier Robust exit action plan to mitigate residual financial exposure and liability	Leadership group to be set up to manage clinical and financial implications of new system New product to be procured No plan for development and implementation phase Staff fatigue and loss of confidence. Not all Trust using LHCRE for patient information exchange	Effective	Quarterly risk assessments completed Quality Committee oversight and scrutiny FPBD Committee overview and scrutiny Digital Hospital Committee oversight	Independent lessons learnt review	Lack of Information Management &Technology Strategy Reactive rather than proactive identification and approach to problems caused by current sub optimal Electronic Patient Record, including patient risk and staff experience. Lack of revised business case	Positive

Action	Action Description:	Start Date	Target Date	Person Responsible	Progress	Status	Date Completed
1	Terms of Reference for leadership group to be formalised	24/03/2020	30/04/2020	Andrew Loughney			/ /
2	Business case for revised system	24/03/2020	30/04/2020	Matt Connor			/ /
3	Develop staff communication plan for new system	24/03/2020	30/04/2020	Andrew Duggan			/ /
4	Develop plan for system development and implementation	24/03/2020	30/04/2020	Matt Connor			/ /
5	Procurement of new system following evaluation	24/03/2020	31/07/2020	Matt Connor			/ /
6	Ongoing review of systems and mitigations quarterly (report to FPBD & QC)	24/03/2020	31/12/2020	Matt Connor			/ /
7	Development of an Information Management And Technology Strategy	24/03/2020	31/05/2020	Matt Connor			/ /

Initial Assessment		
Severity	Likelihood	Risk Score
5 Catastrophic	5 Almost	25

Current Assessment		
Severity	Likelihood	Risk Score
5 Catastrophic	4 Likely	20

Target Assessment		
Severity	Likelihood	Risk Score
5 Catastrophic	4 Likely	20

Agenda Item	

MEETING	**Trust Board Meeting**
PAPER/REPORT TITLE:	**Proposed Risk Appetite Statement 2020-21**
DATE OF MEETING:	**2nd April 2020**
ACTION REQUIRED	**For Approval**
EXECUTIVE DIRECTOR:	Caron Lappin, Director of Nursing and Midwifery
AUTHOR(S):	Christopher Lube, Head of Governance and Quality

STRATEGIC OBJECTIVES:	***Which Objective(s)?***	
	To develop a well led, capable, motivated and entrepreneurial *workforce*	**X**
	To be ambitious and *efficient* and make the best use of available resource	**X**
	To deliver *safe* services	**X**
	To participate in high quality research and to deliver the most *effective* Outcomes	**X**
	To deliver the best possible *experience* for patients and staff	**X**
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?***	
	Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust	**X**
	The Trust is not financially sustainable beyond the current financial year	**X**
	Failure to deliver the annual financial plan	**X**
	Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision	**X**
	Ineffective understanding and learning following significant events	**X**
	Inability to achieve and maintain regulatory compliance, performance and assurance	**X**
	Inability to deliver the best clinical outcomes for patients	**X**
	Poorly delivered positive experience for those engaging with our services	**X**
CQC DOMAIN	***Which Domain?***	
	SAFE- *People are protected from abuse and harm*	☐
	EFFECTIVE - *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.*	☐
	CARING - *the service(s) involves and treats people with compassion, kindness, dignity and respect.*	☐
	RESPONSIVE – *the services meet people's needs.*	☐
	WELL-LED - *the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.*	☐
	ALL DOMAINS	**X**

LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution	**X**	**4.** NHS Constitution	☐
	2. Operational Plan	**X**	**5.** Equality and Diversity	**X**
	3. NHS Compliance	**X**	***6.*** Other: Click here to enter text.	
FREEDOM OF INFORMATION (FOIA):	2 . This report will not be published under the Trust's Publication Scheme due to exemptions under S21 of the Freedom of Information Act 2000, because the information contained is reasonably accessible by other means			
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	The Board is requested to receive the recommendations of its sub-committees regarding risk appetite and risk tolerance levels for 2020-21 and approve the Risk Appetite Statement for 2020-21.			
PREVIOUSLY CONSIDERED BY:	**Committee name**		Quality Committee Putting People First Committee Finance, Performance and Business Development Committee	
	Date of meeting		April 2019	

1. Executive Summary

The Trust's Risk Management Strategy determines that on an annual basis the Trust will publish its risk appetite statement as a separate document. This paper asks the Board to discuss and agree a risk appetite statement setting out the Liverpool Women's NHS Foundation Trust's tolerance levels for risk in relation to the key strategic aims. The statement will define the Trust's appetite for risk to the achievement of strategic aims for the current financial year.

What is Risk Appetite?

Risk appetite can be defined as the amount of risk, on a broad level, that an organisation is willing to take on in pursuit of value. Or, in other words, the total impact of risk an organisation is prepared to accept in the pursuit of its strategic aims. Risk appetite therefore goes to the heart of how an organisation does business and how it wishes to be perceived by key stakeholders including employees, regulators, rating agencies and the public.

The amount of risk an organisation is willing to accept can vary from one organisation to another depending upon circumstances unique to each. Factors such as the external environment, people, business systems and policies will all influence an organisation's risk appetite.

What is the Process?

The Liverpool Women's Risk Management Strategy describes the process as follows:

"The risk appetite of the Trust is the decision on the appropriate exposure to risk it will accept in order to deliver its strategy over a given time frame". In practice, the Trust's risk appetite should address several dimensions:

- The nature of the risks to be assumed.
- The amount of risk to be taken on.
- The desired balance of risk versus reward.

Risks throughout the organisation should be managed within the Trust's risk appetite, or where this is exceeded, action taken to reduce the risk. The Trust's risk appetite statement will be communicated to relevant staff involved in the management of risk"

The Board is requested to receive the recommendations of its sub-committees regarding risk appetite and risk tolerance levels for 2020-21 and approve the Risk Appetite Statement for 2020-21.

2. Report

Risk Appetite Levels

The following risk appetite levels, developed by the Good Governance Institute (see Appendix), from the background to discussion in relation to appetite. Using this model as guidance the Trust should agree an appetite statement that aligns to our strategic aims. The statement should be then be considered when assessing risk target and tolerances in the Board Assurance Framework

Appetite Level	Description:
None	**Avoid** : The avoidance of risk and uncertainty is a Key Organisational objective
Low	**Minimal** : The preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential.
Moderate	**Cautious** : The preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.
High	**Open** : Being willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and value for money).
Significant	**Seek** : Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk). Also described as **Mature** : Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust.

Proposal for 2020-21 Risk Appetite Statement

Following review and discussion at sub –committees of the board the following Risk Appetite Statement for 2020-21 is proposed for review by the Trust Board.

To develop a well-led, capable and motivated **workforce** is a **Moderate risk appetite**

Liverpool Women's NHS Foundation Trust has a **moderate** appetite for risk to this objective. The Trust operates in a complex environment in which it faces challenging financial conditions and changing demographics alongside intense political and regulatory scrutiny. However, the continued delivery of high quality healthcare services and service sustainability requires some moderate risk to be accepted where this is likely to result in better healthcare services for patients.

Support for moderate risk in service redesign that requires innovation, creativity, and clinical research to improve patient outcomes are considered by Liverpool Women's NHS Foundation Trust to be an essential part of the risk profile of the Trust.

To be ambitious and **efficient** and make the best use of available resources is a **Moderate risk appetite**

Liverpool Women's NHS Foundation Trust has a **moderate** appetite for risk to this objective. This is in respect to meeting our statutory financial duties of maintaining expenditure within the allocated resource limits and adherence to departmental and internal expenditure and financial controls. **This includes the demonstration of value for money in our spending decisions, while ensuring quality and safety is maintained.**

To deliver **safe** services is a **Low risk appetite**

Our risk appetite for safety is **low**. Our fundamental strategic aim describes our commitment to patient and staff safety. When and wherever possible we will apply strict safety protocols for all of clinical and non-clinical activity. We will not compromise the safety of our patients, we will report, record and investigate our incidents and we will ensure that we continue to learn lessons to improve the safety and quality of our services.

To participate in high quality research and to deliver the most **effective** outcomes is a **High risk appetite**

Liverpool Women's NHS Foundation Trust supports **High** risk against this objective. A level of service redesign to improve patient outcomes that requires innovation, creativity, and clinical research are considered by Liverpool Women's NHS Foundation Trust to be an essential part of the risk profile of the Trust.

To deliver the best possible **experience** for patients and staff is a **Low risk appetite**

Liverpool Women's NHS Foundation Trust has a **low** risk appetite for actions and decisions that, whilst taken in the interests of ensuring quality and sustainability of the Trust and its patients, may affect the experience of our patients, the reputation of the Trust or the reputation of the wider NHS. Such actions and decisions would be subject to a rigorous risk assessment and be signed off by the Senior Management Team.

3. Conclusion

Agreeing a Risk Appetite statement is a requirement of the Board under the Trust Risk Management Strategy. In order to treat, terminate, transfer, or tolerate risks staff undertaking risk assessments and making decisions will need to understand what level of risk is acceptable to the trust.

The Board's sub-committees, QC and FPBD have met and agreed the parts of the statement for which they are operationally responsible. The PPF committee has not met in March where the review and approval the risk appetite for their area would have taken place, therefore the Director of Workforce and Marketing undertook a virtual approval process of committee members and approval from PPF was gained. The Risk Appetite will be presented at the next PPF for formal ratification and sign off. The Board are now asked to review the statement in its entirety and agree its publication.

4. Recommendations

The Board of Directors is asked to:

a) Receive the recommendations of its sub-committees regarding risk appetite and risk tolerance levels for 2020-21
b) Approve the Risk Appetite Statement for 2020-21.

5. Appendix

Liverpool Women's NHS Foundation Trust

Risk Appetite for NHS Organisations
A matrix to support better risk sensitivity in decision taking

Developed in partnership with the board of Southwark Pathfinder CCG and Southwark BSU – January 2012

Good Governance Institute

Risk levels ▶ / Key elements ▼	0 **Avoid** Avoidance of risk and uncertainty is a Key Organisational objective	1 **Minimal** (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	2 **Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	3 **Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	4 **Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	5 **Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
Financial/VFM	Avoidance of financial loss is a key objective. We are only willing to accept the low cost option as VfM is the primary concern.	Only prepared to accept the possibility of very limited financial loss if essential. VfM is the primary concern.	Prepared to accept possibility of some limited financial loss. VfM still the primary concern but willing to consider other benefits or constraints. Resources generally restricted to existing commitments.	Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities.	Investing for the best possible return and accept the possibility of financial loss (with controls may in place). Resources allocated without firm guarantee of return – 'investment capital' type approach.	Consistently focussed on the best possible return for stakeholders. Resources allocated in 'social capital' with confidence that process is a return in itself.
Compliance/ regulatory	Play safe, avoid anything which could be challenged, even unsuccessfully.	Want to be very sure we would win any challenge. Similar situations elsewhere have not breached compliances.	Limited tolerance for sticking our neck out. Want to be reasonably sure we would win any challenge.	Challenge would be problematic but we are likely to win it and the gain will outweigh the adverse consequences.	Chances of losing any challenge are real and consequences would be significant. A win would be a great coup.	Consistently pushing back on regulatory burden. Front foot approach informs better regulation.
Innovation/ Quality/Outcomes	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems/ technology developments.	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations.	Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems / technology developments limited to improvements to protection of current operations.	Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.	Innovation the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice.
Reputation	No tolerance for any decisions that could lead to scrutiny of, or indeed attention to, the organisation. External interest in the organisation viewed with concern.	Tolerance for risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior management distance themselves from chance of exposure to attention.	Tolerance for risk taking limited to those events where there is little chance of any significant repercussion for the organisation should there be a failure. Mitigations in place for any undue interest.	Appetite to take decisions with potential to expose the organisation to additional scrutiny/interest. Prospective management of organisation's reputation.	Willingness to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation.	Track record and investment in communications has built confidence by public, press and politicians that organisation will take the difficult decisions for the right reasons with benefits outweighing the risks.
APPETITE	**NONE**	**LOW**	**MODERATE**	**HIGH**	**SIGNIFICANT**	

Agenda Item	

MEETING	**Board**
PAPER/REPORT TITLE:	**Board Terms of Reference**
DATE OF MEETING:	Thursday, 02 April 2020
ACTION REQUIRED	**Approve**
EXECUTIVE DIRECTOR:	Mark Grimshaw, Trust Secretary
AUTHOR(S):	Mark Grimshaw, Trust Secretary
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** **1.** To develop a well led, capable, motivated and entrepreneurial ***workforce*** ☒ **2.** To be ambitious and ***efficient*** and make the best use of available resource ☒ **3.** To deliver ***safe*** services ☒ **4.** To participate in high quality research and to deliver the most ***effective*** Outcomes ☒ 5. To deliver the best possible ***experience*** for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust…….* ☐ ***2.*** *Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have sufficient numbers of clinical staff with the capability and capacity to deliver the best care. ……* ☐ ***3.*** *The Trust is not financially sustainable beyond the current financial year……* ☐ ***4.*** *Failure to deliver the annual financial plan ……* ☐ ***5.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision ……* ☐ ***6.*** *Ineffective understanding and learning following significant events……* ☐ ***7.*** *Inability to achieve and maintain regulatory compliance, performance and assurance……* ☒ ***8.*** *Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) ……* ☐
CQC DOMAIN	***Which Domain?*** ***SAFE-*** *People are protected from abuse and harm* ☐ ***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☐ ***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☐ ***RESPONSIVE –*** *the services meet people's needs.* ☐ ***WELL-LED -*** *the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.* ☒

	ALL DOMAINS ☐			
LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution ☒ **2.** Operational Plan ☐ **3.** NHS Compliance ☒		**4.** NHS Constitution ☐ **5.** Equality and Diversity ☐ ***6.*** Other: **Click here to enter text.**	
FREEDOM OF INFORMATION (FOIA):	1. This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting			
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	***The Board is asked to:*** • ***Consider the adoption of a Board Terms of Reference in principle*** • ***If deemed appropriate, approve the adoption of the terms of reference included as appendix 1***			
PREVIOUSLY CONSIDERED BY:	**Committee name**	N/A		
	Date of meeting			

Executive Summary

The Trust does not currently have a Terms of Reference for the Board. Whilst this is not a requirement, it is considered good practice and has been highlighted as a development point following the recently completed NHS Improvement Well-Led Framework Self-Assessment. This report outlines why a Board Terms of Reference is not required and continues to describe why the adoption of a Terms of Reference would be a useful way forward as single point of reference for the duties of the Board.

Report

1. Introduction

Since boards of directors exercise all of the powers of the Trust it is not necessary for boards to have defined terms of reference. The generality of the powers and liabilities of boards of directors are widely known and the specifics of what a board does tends to be implied from board committee terms of references, schemes of delegation, policies and procedures. There is also the Standing Orders in the Trust Constitution which outlines the role and duties of the Board.

However, the role of the board of directors is not currently set out in one place. It is suggested that it would be useful to adopt a document which brings together the respective duties of the Board into one reference point.

A draft Board Terms of Reference has been included at appendix 1. This document sets out to describe the totality of the board's role from strategy development through supervising the management of the organisation, to giving account to stakeholders. The purpose of the document is to ensure that nothing falls 'through the gaps' by providing a point of reference for those responsible for drafting committee terms of reference, schemes of delegation etc. and to provide a reference for board members themselves. The

document has been adapted from a model Terms of Reference from NHS Providers' 'Compendium of Good Practice'.

It is also worth noting that the NHSI Well-Led Framework Key Line of Enquiry One 'Is there the leadership capacity and capability to deliver high quality, sustainable care?', asks Boards to assess whether there is clarity of roles and accountabilities. A Board Terms of Reference would be useful point of reference to fulfil this requirement.

2. Recommendation

The Board is asked to:

- Consider the adoption of a Board Terms of Reference in principle
- If deemed appropriate, approve the adoption of the terms of reference included as appendix 1

Appendix 1:

BOARD OF DIRECTORS
TERMS OF REFERENCE

Role and Purpose:	The Terms of Reference describe the role and working of the Board of Directors (hereafter referred to as the Board) and are for the guidance of the Board, for the information of the Trust as a whole and serve as the basis of the Terms of Reference for the Board's own Committees. The Trust exists to 'provide goods and services for any purposes related to the provision of services provided to individuals for, or in connection with, the prevention, diagnosis or treatment of illness, and the promotion and protection of public health.' The Trust has a Board which exercises all the powers of the Trust on its behalf, but the Board may delegate any of those powers to a Committee of directors or to the Chief Executive. The Board consists of Executive Directors, one of whom is the Chief Executive, and Non-Executive Directors, one of whom is the Trust Chair. The nominated deputy for the Chief Executive and Trust Chair, upon appointment to a substantive or acting up role, must be formally recorded in the minutes.
Duties:	The Board leads the trust by undertaking four key roles: • setting strategy; • supervising the work of the executive in the delivery of the strategy and through seeking assurance that systems of control are robust and reliable; • setting and leading a positive culture for the board and the organisation; • giving account and answering to key stakeholders, particularly the Council of Governors. The general duty of the Board of Directors, and of each director individually, is to act with a view to promoting the success of the trust so as to maximise the benefits for the members of the corporation as a whole and for the public. Each director also has a duty to avoid conflicts of interest and not to accept benefits from third parties (as well as to declare interests in proposed transactions or arrangements with the Trust). The practice and procedure of the meetings of the Board, and of its committees, are not set out here but are described in the Board's Standing Orders.

GENERAL RESPONSIBILITIES:

The general responsibilities of the Board are:

- to maintain and improve quality of care;
- to work in partnership with service users, carers, local health organisations, local government authorities and others to provide safe, effective, accessible, and well governed services for patients, service users and carers;
- to ensure that the Trust meets its obligations to the population served, its stakeholders and its staff in a way that is wholly consistent with public sector values and probity;
- to ensure relationships are maintained with the Trust's stakeholders, regulators, public, governors, staff and patients, such that the trust can discharge its wider duties;
- to exercise collective responsibility for adding value to the Trust by promoting its success through direction and supervision of its affairs in a cost effective manner;
- to ensure compliance with all applicable law, regulation and statutory guidance.

In fulfilling its duties, the Trust Board will work in a way that makes the best use of the skills of non-executive and executive directors.

LEADERSHIP

The Board provides active leadership to the organisation by:

- ensuring there is a clear vision and strategy for the Trust that is well known and understood by stakeholders and is being implemented within a framework of prudent and effective controls which enable risk to be assessed and managed;
- ensuring the Trust is a good employer by the development of a workforce strategy and its appropriate implementation and operation;
- implementing effective board and committee structures and clear lines of reporting and accountability throughout the organisation.

STRATEGY

The Board:

- sets and maintains the trust's strategic vision, aims and objectives ensuring the necessary financial, physical and human resources are in place for it to meet its objectives;
- determines the nature and extent of the risk it is willing to take in achieving its strategic objectives;
- monitors and reviews management performance to ensure the trust's objectives are met;

- oversees both the delivery of planned services and the achievement of objectives, monitoring performance to ensure corrective action is taken when required;
- develops and maintains an annual business plan, with due regard to the views of the council of governors, and ensures its delivery as a means of taking forward the strategy of the trust to meet the expectations and requirements of stakeholders;
- ensures that national policies and strategies are effectively addressed and implemented within the Trust.

CULTURE, ETHICS AND INTEGRITY

The Board:

- is responsible for setting values, ensuring they are widely communicated and adhered to and that the behaviour of the Board is entirely consistent with those values;
- promotes a patient-centred culture of openness, transparency and candour;
- ensures that high standards of corporate governance and personal integrity are maintained in the conduct of foundation trust business.

GOVERNANCE

The Board:

- ensures compliance with relevant principles, systems and standards of good corporate governance and has regard to guidance on good corporate governance and appropriate codes of conduct, accountability and openness applicable to NHS provider organisations;
- ensures that all licence conditions relating to the Trust's governance arrangements are complied with;
- ensures that the trust has comprehensive governance arrangements in place that guarantee that the resources vested in the Trust are appropriately managed and deployed, that key risks are identified and effectively managed and that the Trust fulfils its accountability requirements;
- ensures that the Trust complies with its governance and assurance obligations in the delivery of clinically effective and safe services taking account of patient and carer experiences and maintaining the dignity of those cared for;
- ensures that all the required returns and disclosures are made to the regulators;
- formulates, implements and reviews standing orders and standing financial instructions as a means of regulating the conduct and transactions of foundation trust business;

- agrees the schedule of matters reserved for decision by the Board of Directors;
- ensures that the statutory duties of the Trust are effectively discharged;
- Acts as corporate trustee for the trust's charitable funds.

RISK

The Board:

- ensures an effective system of integrated governance, risk management and internal control across the whole of the Trust's clinical and corporate activities;
- ensures that there are sound processes and mechanisms in place to ensure effective user and carer involvement in the development of care plans, the review of quality of services provided and the development of new services;
- ensures there are appropriately constituted appointment and evaluation arrangements for senior positions such as consultant medical staff and those reporting to executive directors.

COMMUNICATION

The Board:

- Ensures an effective communication channel exists between the Trust, its governors, members, staff and the local community.
- Ensures the effective dissemination of information on service strategies and plans and also provides a mechanism for feedback.
- Ensures that those Board proceedings and outcomes that are not confidential are communicated publicly through Board meetings in public and also via the Trust's website.

FINANCIAL AND QUALITY SUCCESS

The Board:

- Ensures that an effective system of finance and quality is embedded within the Trust.
- Ensures that the Trust operates effectively, efficiently and economically.
- Ensures the continuing financial viability of the organisation.
- Ensures the proper management of resources and that financial and quality of service responsibilities are achieved.
- Ensures that the Trust achieves the quality targets and requirements of stakeholders within the available resources.
- Reviews performance, identifying opportunities for improvement and ensuring those opportunities are taken.

RESPONSIBILITIES OF BOARD MEMBERS

All Members of the Board:

- Have joint responsibility for every decision of the Board regardless of their individual skills or status. This does not impact upon the particular responsibilities of the Chief Executive as the Accounting Officer.
- Have a responsibility to constructively challenge during Board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy.

Role of the Trust Chair:

The Trust Chair is the guardian of the Board's decision-making processes and provides general leadership of the Board and the Council of Governors.

- Responsible for leading the Board and for ensuring that it successfully discharges its overall responsibilities for the Trust as a whole.
- Reports to the Board and is responsible for the effective operation of the Board and the Council of Governors.
- Responsible for ensuring that the Board as a whole pays a full part in the development and determination of the Trust's strategy and overall objectives.

Role of the Chief Executive

- The Chief Executive reports to the Trust Chair and to the Board directly. All members of the management structure report either directly or indirectly to the Chief Executive.
- The Chief Executive is responsible to the Board for running the Trust's business and for proposing and developing the Trust's strategy and overall objectives for approval by the Board.
- The Chief Executive is responsible for implementing the decisions of the Board and its Committees, providing information and support to the Board and Council of Governors.

Role of Executive Directors (EDs)

- Share collective responsibility with the Non-Executive Directors as part of a unified Board.
- Shape and deliver the strategy and operational performance in line with the Trust's strategic aims.

Role of Non-Executive Directors (NEDs)

- Bring a range of varied perspectives and experiences to strategy development and decision making.
- Ensure that effective management arrangements and an effective management team are in place.
- Hold the Executive Directors to account for performance of the operational responsibilities.

	• Scrutinise the performance of the executive management in meeting agreed goals and objectives, receive adequate information and monitor the reporting of performance. NEDs should satisfy themselves as to the integrity of financial, clinical and other information, and make sure that financial and clinical quality controls, and systems of risk management and governance, are robust and implemented. Role of the Senior Independent Director (SID) • Is a Non-Executive Director appointed by the Board in consultation with the Council of Governors to undertake the role. Normally the SID will not be the Vice Trust Chair although this may be the case if the Board deems it necessary. • Will be available to members of the Foundation Trust and to Governors if they have concerns which, contact through the usual channels of the Trust Chair, Chief Executive, Deputy Chief Executive, Director of Finance and Trust Secretary, has failed to resolve or where it would be inappropriate to use such channels. • Has a key role in supporting the Trust Chair in leading the Board and acting as a sounding board and source of advice for the Trust Chair. The SID has a role in supporting the Trust Chair in his/her role as Trust Chair of the Council of Governors. In addition to the duties described here, the SID has the same duties as the other Non-Executive Directors. Role of the Trust Secretary The Trust Board shall be supported by the Trust Secretary whose duties in this respect will include: • agreement of the agenda, for Board and Board committee meetings, with the relevant Chair, in consultation with the Chief Executive; • collation of reports and papers for Board and committee meetings; • ensuring that suitable minutes are taken, keeping a record of matters arising and issues to be carried forward; • ensuring that board procedures are complied with; • supporting the Chair in ensuring good information flows within and between the Board, its committees, the Council of Governors and senior management; • advising the Board and Board committees on governance matters; • supporting the chair on matters relating to induction, development and training for directors
Membership:	The composition of the Board shall be: • A Non-Executive Chair

	• Not more than seven other non-executive Directors
	• Not more than seven executive Directors including:
	  o The Chief Executive (who is the Accounting Officer)
	  o The finance director
	  o A registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984)
	  o A registered nurse or registered midwife.

Quorum:	Six Directors including not less than three executive Directors (one of whom must be the Chief Executive or another Executive Director nominated by the Chief Executive) and not less than three non-executive Directors (one of whom must be the Chair or the Vice Chair of the Board of Directors) shall form a quorum. An officer in attendance for an executive Director but without formal acting up status may not count towards the quorum. If a Director has been disqualified from participating in a discussion on any matter and/or from voting on any resolution by reason of declaration of a conflict of interest, that Director shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minute of the meeting. The meeting must then proceed to the next business.
Voting:	All questions put to the vote shall, at the discretion of the Chair, be decided by a show of hands save that no resolution of the Board of Directors shall be passed if it is opposed by all of the non-executive Directors present or by all of the executive Directors present. A paper ballot may be used if a majority of the Directors present so request. In case of an equality of votes the Chair shall have a second and casting vote. If at least one third of the Board members present so request, the voting on any question may be recorded so as to show how each member present voted or did not vote (except when conducted by paper ballot). If a Board member so requests, her vote shall be recorded by name. In no circumstances may an absent Director vote by proxy. Subject to Standing Order 59, absence is defined as being absent at the time of the vote. An officer who has been appointed formally by the Board to act up for an executive Director during a period of incapacity or temporarily to fill an executive Director vacancy, shall be entitled to exercise the voting rights of

	the executive Director. An officer attending the Board to represent an executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the executive Director. An officer's status when attending the meeting shall be recorded in the minutes. Where an executive Director post is shared by more than one person: • Each person shall be entitled to attend meetings of the Board • Each of those persons shall be eligible to vote in the case of agreement between them • In the case of disagreement between them no vote should be case • The presence of those persons shall count as one person.
Attendance:	The Board of Directors may agree that Directors can participate in its meetings by telephone, video or computer link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting. Directors who are unable to attend a meeting shall notify the Secretary in writing in advance of the meeting in question so that their apologies may be submitted.
Frequency:	Ordinary meetings of the Board shall be held at regular intervals at such times and places as the Board may determine. The Secretary will publish the dates, times and locations of meetings of the Board in advance.
Accountability and reporting arrangements:	The Council of Governors is responsible for holding the Board to account, for example by attending and observing Committees of the Board, attending Board meetings in public and meeting with the Trust Chair, Chief Executive and Committee Chairs on the day of Board meetings / Council of Governors' meeting. The agenda and minutes of board meetings will be shared with the council of governors. The Trust Chair will be responsible for ensuring the Board of Directors adheres to its Terms of Reference and Annual Work Plan. The Board shall self-assess its performance following each board meeting. A full set of papers comprising the agenda, minutes and associated reports and papers will be sent within the timescale set out in standing orders to all directors and others as agreed with the Chair and Chief Executive from time to time.
Monitoring effectiveness:	The Board will undertake an annual review of its performance against its duties in order to evaluate its achievements.
Review:	These terms of reference will be reviewed at least annually by the Board.

Reviewed by Board of Directors:	*2 April 2020*
Approved by Board of Directors:	*TBC*
Review date:	April 2021
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