Liverpool Women's
NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

Board of Directors Meeting

PUBLIC

5 November 2020

Meeting of the Board of Directors
HELD ELECTRONICALLY
Thursday 5 November 2020 at 1000hrs
VIRTUAL MEETING

Item no. 2020/21/	Title of item	Objectives/desired outcome	Process	Item presenter	Time
PLEASE NOTE – Due to the Covid-19 pandemic, the Board is utilising a 'consent agenda'. It will be assumed that all of 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, it is requested that the Trust Secretary be notified prior to the meeting and this will be made clear at the start of the meeting.					
169	Thank you	To provide a Team thank you – above and beyond			1000 (5mins)
170	Apologies for absence Declarations of interest	Receive apologies & declarations of interest	Verbal	Chair	
171	Meeting guidance notes	To receive the meeting attendees' guidance notes	Written	Chair	
172	Patient Story • Physiotherapy	To receive the patient story	Verbal	Chief Operating Officer	1005 (15mins)
173	Minutes of the previous meeting held on 3 September 2020	Confirm as an accurate record the minutes of the previous meetings	Written	Chair	1020 (5mins)
174	Action Log and matters arising	Provide an update in respect of on-going and outstanding items to ensure progress	Written	Chair	
175	Chair's announcements	Announce items of significance not found elsewhere on the agenda	Verbal	Chair	1025 (5mins)
176	Chief Executive Report	Report key developments and announce items of significance not found elsewhere on the agenda	Written	Chief Executive	1030 (5mins)
BOARD COMMITTEE ASSURANCE					
177	Chair's Reports from Quality Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	1035 (5mins)
178	Chair's Reports from Finance, Performance and Business Development Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	1040 (5mins)
179	Chair's Report from Putting People First Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	1045 (5mins)
180	Chair's Report from Audit Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	1050 (5mins)
181	Chair's Report from the Charitable Funds Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	1055 (5mins)
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					
182	Covid-19 Pandemic: Trust Update	For assurance	Written	Chief Operating Officer	1100 (10mins)

Item no. 2020/21/	Title of item	Objectives/desired outcome	Process	Item presenter	Time
183	Equality Diversity and Inclusion: Update on WRES and WDES 2020 Data and overview of future strategy	For assurance	Written	Chief People Officer	1110 (15mins)
184	Safer Nurse/Midwife Staffing Report, M5 & M6 2020/21	For assurance and to note any escalated risks	Written	Interim Director of Nursing and Midwifery	1120 (5mins)
185	Care Quality Commission Update	For assurance	Written	Interim Director of Nursing and Midwifery	1125 (10mins)
186	Safeguarding Annual Report 2019/20	For assurance	Written	Interim Director of Nursing and Midwifery	1135 (15mins)
187	Clinical Negligence Scheme for Trusts Update Year 3	For assurance	Written	Chief Operating Officer	1150 (10mins)
188	Clinical Mandatory Training Update	For assurance	Written	Chief People Officer	1200 (10mins)
TRUST PERFORMANCE - TO DELIVER THE MOST EFFECTIVE OUTCOMES; TO BE EFFICIENT AND MAKE BEST USE OF AVAILABLE RESOURCES					
189	Operational Performance Report period M6, 2020/21	For assurance –To note the latest performance measures	Written	Chief Operating Officer	1210 (5mins)
189a	Assessment of Perinatal Mortality in Quarter 1 2020 in relation to COVID 19 – including figures for stillbirth in Q2	For assurance	Written	Medical Director	1215 (5mins)
190	Finance Report period M6, 2020/21	For assurance - To note the status of the Trust's financial position	Written	Director of Finance	1220 (5mins)
BOARD GOVERNANCE					
191	Well-Led Self-Assessment Action Plan Update	For assurance	Written	Trust Secretary	1225 (5mins)
192	Board Assurance Framework 2020/21	For assurance and approval	Written	Trust Secretary/ Executive Leads	1230 (5mins)
193	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair	1235 (5mins)
CONSENT AGENDA (all items 'to note' unless stated otherwise)					
194	Medical Revalidation Annual Report 2019/20	For assurance & approval of Annex D	Written	Medical Director	Consent
195	Guardian of Safe working Hours Annual Report 2019 - 2020	For assurance	Written	Medical Director	Consent
HOUSEKEEPING					
196	Any other business & Review of meeting	Consider any urgent items of other business	Verbal	Chair	1240 (5mins)

Date of next meeting

Board in Public: 3 December 2020

Meeting to end at 1245

	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

The Board of Directors is invited to adopt the following resolution:
'That the Board hereby resolves that the remainder of the meeting to be held in private, because publicity would be prejudicial to the public interest, by reason of the confidential nature of the business to be transacted'. [Section (2) of the Public Bodies (Admission to Meetings) Act 1960]

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

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Liverpool Women's NHS Foundation Trust

Board of Directors

Minutes of the meeting of the Board of Directors held virtually at 1.00pm on 3 September 2020

PRESENT

Mr Robert Clarke	Chair
Mrs Kathryn Thomson	Chief Executive
Ms Jo Moore	Non-Executive Director/Vice Chair (until item 158)
Mrs Michelle Turner	Chief People Officer
Mrs Jenny Hannon	Director of Finance
Dr Andrew Loughney	Medical Director & Deputy Chief Executive (item 146 onwards)
Ms Gaynor Thomason	Interim Director of Nursing & Midwifery
Mr Gary Price	Chief Operating Officer
Mr Phil Huggon	Non-Executive Director (until item 151)
Mr Tony Okotie	Non-Executive Director/SID
Dr Susan Milner	Non-Executive Director
Mr Ian Knight	Non-Executive Director
Prof Louise Kenny	Non-Executive Director (item 149 onwards)

IN ATTENDANCE

Mr Mark Grimshaw	Trust Secretary
Mrs Mary McDonald	Appointed Governor
Mrs Denise Richardson	Public Governor
Mr Matt Connor	Chief Information Officer (item 160 only)
Dr Lynn Greenhalgh	Medical Director of the North West Genomics Laboratory Hub
Dr Christopher Dewhurst	Clinical Director, Neonatal Service (item 141 only)
Mrs Melanie Pickering	Head of Nursing, Gynaecology (item 138 only)
Mrs Valerie Irving	Matron, Neonates (item 138 only)
Dr Bill Yoxall	Consultant, Neonates (item 138 only)

APOLOGIES:
None noted

20/21/ 138	Thank You **Caron Lappin** – The Chair stated the Board's thanks to Caron Lappin, former Director of Nursing & Midwifery, who retired from the NHS on 31 August 2020. The significant amount of work undertaken by Caron during her time at the Trust was noted, particularly in terms of engaging and empowering the nurse workforce. **Gynaecology** – The Board extended thanks to the Gynaecology Service that had achieved an overall rating of 'better' in seven out of ten available categories in the 2019 inpatient survey results which were published by the Care Quality Commission (CQC). Across all categories the Trust was rated either better or in line with other NHS hospitals across the country. The Trust scored particularly well in a number of areas of feedback including; the admission process and referral to other services,

	confidence and trust in doctors and the way they answered questions, care provided before and after procedures, and the support given when leaving the hospital. **Neonatal Team** – The Director of Finance noted that the build of the Neonatal Unit had completed and was a good example of the Trust successfully managing a significant capital project in partnership with the contractor, particularly in challenging circumstances with the Covid-19 pandemic. Key to the success of the project was the input of the Neonatal team who had been flexible and continued to provide exemplary care.
139	**Apologies** – as above **Declaration of Interests** – Ms Gaynor Thomason noted that she was a Non-Executive Director at Merseycare NHS Foundation Trust.
140	**Meeting guidance notes** The Board received the meeting attendees' guidance notes which had been updated to reflect 'virtual meetings'.
141	**Patient Story** Dr Chris Dewhurst attended to present how the Trust had developed a teleneonatology program in response to the Covid-19 pandemic. It was explained that the neonatal unit usually had a low level of consultant staff sickness. However, with the onset of the lockdown, several consultants were away from the Trust either off sick, isolating or shielding. This resulted in a loss of c. 40% of clinical facing time and would mean that the service became unsustainable. In response, the Trust purchased telemedicine equipment, providing training and restructuring work patterns. This meant that off-site consultants could continue to work, reducing the need to engage with agency staff. It was estimated that this had resulted in a saving of £99,795 in 'additional payments', and that staff had been able to remain feeling that they were 'part of the team'. Dr Chris Dewhurst introduced a patient and her baby via the telemedicine system to provide a demonstration of its functionality. It was noted that patients accepted the technology quickly and appreciated the speedy reviews, convenience and continuity. However, patients had stated that it was preferable to meet with the doctor face-to-face first. The Chief Operating Officer noted that considering the high degree of speciality within the service, accessing cover would have been challenging. The service had acted quickly and positively to maintain service levels and should be commended. The Chief Executive stated that there would be applications for this approach more widely across the organisation. Dr Chris Dewhurst confirmed that this was the next step, noting that the case had been presented internationally with interest from the Innovation Agency also. The Board noted the presentation, thanking the team for their innovative working and the patient for her participation.
142	**Minutes of previous meeting** The minutes of the Board of Directors meeting held on 2 July 2020 were agreed as a true and accurate record.
143	**Matters arising and action log.** There were no matters arising. The Board of Directors reviewed the Action Log and noted that there were no overdue actions.
144	**Chair's Announcements**

	The Chair briefed the Board on events since the last meeting. The Council of Governors had met on the 30th July 2020 and covered the following items: • The Trust's External Auditors KPMG formally reported on the Annual Report and Accounts • Opportunity provided to input into the Trust Clinical and Quality Strategy • The Council formally enacted a two-year contract extension option for KPMG as the Trust's external auditors. It was noted that a Governor election would be held for the two central Liverpool seats as four nominations had been received. Only one nomination was received for the Sefton and Doctors' seats so individuals would be elected unopposed. Unfortunately, the Trust would be carrying a vacancy in both the North Liverpool and Nurses constituencies until next year's elections as no nominations were received. At the Annual Members Meeting (AMM) on 8th October 2020, the Trust would be saying a fond farewell and big thank you to the following governors whose terms of office will be coming to an end; • Isaac Olaitan • Gillian Walker • Adrian O'Hara • Sarah Carroll • Pat Speed Regarding the upcoming AMM, the Chair noted that this would be a virtual event with videos showcasing key achievements released prior to the event. The Chair reported that the Liverpool Integrated Care Partnership Group had recently recommenced with its meetings. It was stated that the Covid-19 pandemic had energised the aims and objectives of the groups and that there was a strong sense of mutuality. Meetings were now being held monthly to drive progress. A number of key changes to the key roles (e.g. Committee Chair) and responsibilities of the Non-Executive Directors (NEDs) were outlined. The aim of this was to strengthen continuity ahead of a recruitment round in 2021 and refresh oversight and scrutiny. It was highlighted that Susan Milner would be taking over the role of Senior Independent Director from Tony Okotie, effective immediately. The Chair continued to report that the Trust was participating in the Insight Programme which aimed to give aspiring NEDs experience of NED roles in the NHS, particularly from underrepresented groups. Participants were observers and would be shadowing NEDs with mentoring and learning opportunities provided over a six-month placement. The Trust welcomed Michelle Corrigan as its first observer, ahead of a second placement in six months' time. The Chair reported that a Nominations & Remuneration Committee had been held immediately prior to the Board. Items discussed had included the Trust's approach to very senior manager (VSM) pay, the appointment process for a Director of Nursing & Midwifery and assurance on the Trust's Fit and Proper Person process. To support the Trust's Big Tiny Steps Charity Appeal, a virtual quiz had taken place as part of the Trust's 25th anniversary celebrations with £700 raised. Thanks were extended to: • Sponsors; Johnny Bongo, DJ Lee Butler and Dr Fauzia Paize (LWH Neonatal consultant) • Organisers; Kate Davis and Rhianna McDermott • Question Master; Dr Alex Cleator The Board noted the Chair's update and appointed Susan Milner as Senior Independent Director subject to approval from the Council of Governors.
145	**Chief Executive's report**

	The Chief Executive presented the report which detailed local, regional and national developments. The Board of Directors received and noted the Chief Executive's Report. *Andrew Loughney, Medical Director, joined the meeting.*
146	**Chair's Report from the Quality Committee** Dr Susan Milner presented the Chair's Reports for the meetings of the Quality Committee held on 20 July 2020 and 24 August 2020. She briefed the Board on the content of the reports noting that several of the items would be discussed later in the meeting. The LocSSIPs Quarterly Assurance Report had been received and the Committee had been assured that progress was being made in terms of process with implementing the required standards. Although assured that progress was being achieved against the LocSSIPs standards the Committee considered the current reports under commission, most notably the Never Event thematic review, and the Gynaecology Oversight review. Within this context it was agreed that it was not currently germane to approve the recommendation to reduce the frequency of reporting both to the LocSSIP implementation group or to the Quality Committee. The Draft Quality Account 2019/20 had been considered and recommended for adoption by the Board once stakeholder feedback had been provided. The Chair noted thanks to Dr Sue Milner for chairing the Quality Committee for four years, highlighting the progress that had been made in that time period. The Board of Directors: • Received and noted the Chair's Reports from the Quality Committee meeting held on 20 July 2020 and 24 August 2020.
147	**Chair's Report from Finance, Performance and Business Development Committee (FPBD)** Ms Jo Moore presented the Chair's Report for the meeting of the Finance, Performance and Business Development Committee held on 21 July 2020. She briefed the Board on the content of the reports noting that a focus had been provided on the operational report with the Committee seeking assurance that there were realistic plans in place for recovery and improvement. The Committee received a presentation on the Estate Strategy Development from the Director of Estates and Facilities. The Committee noted that engagement with speciality teams regarding clinical priorities continued. A position update in relation to the Enforcement Undertakings with Monitor (the statutory body which now operated as NHS Improvement (NHSI)) was provided with confirmation given that all actions had been completed and/or breaches were no longer in place. The Director of Finance had written to NHSI on this matter in May 2020 and this has been followed up subsequently with NHSI, who had agreed to share a date when this could be taken to the Regional Support Group (RSG) Committee for review. The Committee received an update on the One to One Midwives investigation which was now underway. The Trust was fully co-operating with the investigation process. The Board of Directors: • Received and noted the Chair's Report from the FPBD Committee meeting held on 21 July 2020.
148	**Chair's Report from the Audit Committee** Mrs Tracy Ellery presented the Chair's Report for the meeting of the Audit Committee held on 21 July 2020. She briefed the Board on the content of the report noting that the Committee had received an updated position on audit recommendations. The majority of the outstanding actions related to a Cyber Security Baseline Security Review and a number of deadlines had been required to be extended due to the impact of the Covid-19 pandemic. The Chief Information Officer provided assurance that

	the outstanding actions had been prioritised following a risk assessment and that the Trust maintained robust cyber security processes. The Committee had been informed of the need to flex the internal audit programme due to the Covid-19 pandemic. Whilst there was a risk, assurance had been provided that the programme would be completed on schedule. A concern regarding the lack of face-to-face anti-fraud training due to Covid-19 had been raised and this would continue to be monitored by the Committee. The Board of Directors: • Received and noted the Chair's Report from the Audit Committee meeting held on 21 July 2020. *Prof. Louise Kenny, Non-Executive Director, joined the meeting.*
149	Covid-19 Pandemic: Phase 3 Trust response The Chief Operating Officer reported that the pandemic outbreak of Covid-19 continued to place pressure on the whole of the NHS. The Trust had responded to this pressure to date as part of the Cheshire and Mersey system response. The nationally declared level 4 incident had been maintained throughout April, May and June 2020. The level of incident had been stepped down in July 2020 to a level 3, however the Trust remained under command and control arrangements. Phase 3 guidance had been published in July 2020 with subsequent further guidance in August 2020. It was stated that the report detailed the guidance and outlined the Trust's response. The Chair highlighted the action that required the Trust to restore NHS services inclusively, noting that the assurance provided related to the maternity service only. The Chief Operating Officer explained that the maternity service had led on this area and lessons would be learned and extended to other Trust services. Objectives to meet this action would be developed for each Division. Mr Ian Knight, Non-Executive Director, queried the progress the Trust was making to support the health and wellbeing of staff. The Chief People Officer noted that a number of actions had been taken that were outlined in the report. There was a recognition that the Trust could always do more, and a key next step would be embedding existing initiatives into a sustainable general offer to staff. The Trust had agreed to invest in Schwartz Rounds which would provide an additional support mechanism. Positive feedback had been received to date from staff and this would be monitored closely in the 2020 Staff Survey. The Chair observed the need to use patient-initiated follow-ups as part of the NHS Covid-19 recovery and queried whether there was a risk that issues might not be followed up. The Chief Operating Officer acknowledged that this was a risk and a key mitigation was having a clear agreement between the patient and clinician. The Trust was currently developing policies and procedures for this area as it was noted that there could be a large cohort of patients that this would apply to. It was noted that one of the 'must do' actions in the guidance was to appoint an Executive Board lead for inequalities. As the existing lead for Equality and Diversity it was agreed that the Chief People Officer would assume this role. The Board: • noted the report for information and assurance • Approved the Chief People Officer as the Trust's Executive Lead for Inequalities.
150	Safer Nurse/Midwife Staffing Report, M3 & M4 2020/21 The Interim Director of Nursing & Midwifery presented a report which detailed Ward Staffing levels across all inpatient clinical areas during June and July 2020. She briefed the Board on the content of

	the report noting that the uncertainties of the Covid-19 pandemic continued to present workforce challenges. There had been number of Health Care professionals unable to work due to shielding / isolation and this was being monitored and managed on a daily basis with improvements evident. The introduction of swabbing of index cases had enabled the return of some health care professionals earlier than would have been prior to swabbing. The inpatient wards had been able to maintain safe fill rates during the month of June and July 2020. A daily staffing huddle across the Trust had been commenced with data recorded. Whilst there had been vacancies in the maternity service due to maternity leave, all posts had been recruited to. A review of Bands 2, 3 and 4 job descriptions and competencies across the organisation had been completed to ensure consistency and to support divisional workforce planning. A review of senior nursing positions was underway. The Medical Director noted that whilst a number of staff had been away from the Trust due to isolating and shielding as part of the Covid-19 response, the majority had returned to the hospital site with risk assessments undertaken. Whilst acknowledging that sections of the report were required for statutory reporting, the Chair requested that the formatting and presentation of future reports be reviewed to enhance the clarity of the information being presented. **Action: For the Trust Secretary to work with the Deputy Director of Nursing & Midwifery to review the formatting and presentation of the Safer Nurse/Midwife staffing report.** The Board of Directors: • Noted the content of the report and the assurances that appropriate information was being provided to meet the national and local requirements. • Noted that the organisation had the appropriate number of nursing & midwifery staff on its inpatient wards to manage the current clinical workload as assessed by the Interim Director of Nursing & Midwifery • Noted the staffing position relating to CNST – safety standard 5 - Maternity • Noted the staffing issues highlighted in the report relating to the Covid-19 pandemic. *Phil Huggon, Non-Executive Director, left the meeting.*
151	**CNST – Maternity Incentive Scheme Year 3: Monthly Update: September 2020** The Board received an update regarding progress towards the Maternity Incentive Scheme Year 3. The Chief Operating Officer reported that submission of the Trust's position against the ten safety standards had been deferred to 2021 (date TBC) and the scheme revised as a result of the Covid-19 Pandemic, therefore no longer requiring Board sign off in September 2020 as originally intended. However, the Trust intended to continue to internally monitor progress as patient safety was a key priority for the Trust. Assurance was provided that Divisional monitoring on all safety standards was in place with designated safety leads, to provide the Family Health Division with assurance that all safety elements could be achieved by the required timescales. The Chair queried whether it was expected that the Trust would be compliant with all the safety actions by 2021. The Medical Director stated that whilst there were a number of unknowns, it was unlikely that the standard regarding multi-disciplinary training would be achieved due to the complexity of delivering training with social distancing in place. NHS Resolution was cognisant of the challenges and updated targets were awaited. The Board noted the report for information and assurance.

152	**Clinical Mandatory Training - Compliance** The Chief People Officer reported that in July 2020, the Board was alerted by the Putting People First Committee regarding two specific areas of concern with respect to clinical mandatory training – namely, Resuscitation Training and Blood Competencies, where compliance was consistently below the requirement of 95%. Resuscitation Training had been impacted by Covid-19 as it was taught in person. There was also a small team that delivered training that was also impacted by Covid-19. In response, the Trust had recruited on a short-term basis to provide training and the Divisions were making progress. A longer-term sustainable staffing solution was also in development. In relation to blood competency training, it was noted that there was a need to increase the number of cascade trainers within the Trust. Action had been taken to improve the position. It was agreed that a further update be provided to the November 2020 Board to ensure that improvement trajectories remained on-track. On-going oversight would be provided by the Quality and Putting People First Committees. **Action: For an update report on clinical mandatory training be provided to the November 2020 Board.** The Board of Directors: • Noted the current position on compliance with regard to Core Clinical Mandatory Training; • Took assurance from the actions in place to monitor and drive improved compliance and associated actions to address any deficiency in training provision, specifically with regard to Resuscitation and Transfusion training • Remitted ongoing oversight of compliance and provision of training to the Quality and Putting People First Committees to provide assurance to the Board of Directors through their respective Chairs Reports.
153	**Clinical & Quality Strategy** The Medical Director of the North West Genomics Laboratory Hub introduced the Clinical and Quality Strategy 2020–2025 noting that it had been developed over the past year following engagement with key stakeholder groups and consideration of national, regional and local requirements in the context of the Trust's strategic framework. The strategy outlined the Trust's plans to become outstanding and highlights its aspirations and ambitions for the clinical services. The Quality Committee had considered the strategy on 24 August 2020. The Committee felt that the content of the strategy was both appropriate and sufficiently ambitious to drive the Trust towards becoming outstanding and delivering its vision, however it was agreed that the more ambitious elements of the strategy needed to be more prominent, to ensure that the direction set by the strategy was immediately clear. Following Quality Committee, the foreword had been re-written to bring more of the strategy's ambitious elements to the fore. The Quality Committee also discussed whether the Trust's existing work and future aspirations regarding research, development and innovation were adequately expressed in the strategy. It was noted that the Trust did have an accompanying Research and Development strategy, which sat alongside and complemented the document. The Board acknowledged that whilst improvements regarding presentation had been made since the Quality Committee, further work was required to provide enhanced focus on the Trust's Quality priorities and successes from the previous strategy. The Medical Director noted that this work would

	be supported with the development of a 'strategy on a page' document to aid communication across the organisation. The Board of Directors: • Approved the content of the Clinical and Quality Strategy 2020–2025 • Requested that further work be undertaken on the presentation of the strategy with particular attention given to how to emphasise the 2020-25 quality ambitions and 2017-20 successes. • Agreed to receive the final version at the November 2020 Board
154	Care Quality Commission Update The Interim Director of Nursing & Midwifery reported that a further inspection was carried out on July 28 focusing on issues raised in the Warning Notice received by the Trust in late 2019. Data was requested prior to the inspection, with a further two data requests for information relating to fridge monitoring temperatures on maternity base and My Kit Check (resuscitation trolley checks). An action plan in relation to these two issues had been developed and was being progressed. A report following the re-inspection had been provided by the CQC for factual accuracy checks with the final report awaited. An engagement call with the CQC had been held on 20 August 2020 at their request to discuss the Board's assurance regarding the effectiveness of the Trust's Infection Prevention and Control measures. A report had been received from the CQC on 26 August 2020 stating that the CQC found that the Board was assured that the Trust had effective infection prevention and control measures in place. The Board noted the report for information and assurance.
155	Serious Incident Report – Quarter 1, 2020-21 The Interim Director of Nursing & Midwifery presented a report regarding serious incidents (SIs) reported during Quarter 1 2020/21. She briefed the Board on the content of the report noting that there were two SIs which were similar in nature which had occurred in the Neonatal service and reported to the CCG. The second incident occurred before the review of the first incident had been completed, with the learning from both likely to be similar in nature. There were some contributory factors which had occurred in previous SIs such as poor documentation, lack of escalation and not adhering to LocSSIPS procedures. These issues had been shared with staff and specific local actions were included in actions plans which were being monitored internally and by the CCG. It was confirmed that Duty of Candour had been met in 100% of all SI cases and there were no overdue actions at the time of writing the report. The Chief People Officer noted that the Trust had freedom to define tolerances for what constituted a SI. It was suggested that the Board consider whether the current tolerances were appropriate. Action: For the Board to review Serious Incident definition tolerances at the January 2021 Board workshop. The Trust Secretary queried how the Trust was demonstrating that learning from SIs was being embedded in practice. The Interim Director of Nursing & Midwifery noted that the divisions would demonstrate this through the use of 'deep dives' to illustrate how practice had been amended in response to a particular incident. It was suggested that the Board receive a report on the processes for learning lessons and embedding updated practice at the November 2020 meeting.

	Action: A report on the processes for learning lessons and embedding updated practice to be tabled at the November 2020 Board meeting. The Board noted the report for information and assurance.
156	**Operational Performance Report Month 4 2020/21** The Chief Operating Officer presented the Operational Performance Report for Month 4 2020/21. He briefed the Board on the content of the report and provided an overview of performance against key national standards as detailed at section two of the report. Despite the challenges posed during the Covid-19 pandemic cancer services performed well in both the two week wait and the 31-day standard in Q1 2020/21, with the Trust now achieving the 31-day target with more regularity. The 62-day target performance was 43% for Q1 2020/21 in large part due to the national mandates of the Covid-19 pandemic and patients being allocated priority levels. This similarly affected the 104-day position. The 62-day target in July 2020 was at 76% which was the best result for a 12-month period. In November 2020 the service was planned to have a full complement of Oncology Consultants for the first time in two years. This would allow maintenance of the 2 week and 31-day target and improvement of the 62-day target. In terms of general recovery from the Covid-19 pandemic, the Chief Operating Officer noted that theatre staffing and efficiency remained the most significant challenge. Additional capacity was required and a forecast trajectory for improvement could not be provided until this was in place. The Chief People Officer reported that there were discussions to create 'staffing bubbles' across a regional footprint to enable staff to move to pressured areas. It would therefore be important for the Trust to remain cognisant of its own safe staffing requirements. The Chief Executive added that there was a concern regarding the Christmas period and the potential for increased staff absence following socialising. Clear messages would be communicated to staff regarding their professional responsibilities. The Board of Directors: • Received and noted the Month 4 Operational Performance Report.
157	**Financial Report & Dashboard Month 4, 2020/21** The Director of Finance presented the Finance Report and Financial Dashboard for Month 4, 2020/21. She briefed the Board on the content of the report and advised that the Trust remained in the financial regime enacted post the Covid-19 pandemic. Under this regime, the Trust received a block income payment each month from main commissioners and a top up payment from NHSI/E to bring the position to breakeven. This top up was the subject of a high level of scrutiny and would not be fully paid across by NHSI/E until further checks and scrutiny had taken place (across many organisations). The Trust was averaging a £1.2m top-up each month. The Director of Finance noted that once information was received on a new financial regime, the Trust's BAF risk relating to financial performance would require review. The Board of Directors: • Received and noted the Month 4 Financial Performance Report. *Ms Jo Moore, Non-Executive Director, left the meeting.*
158	**NHS People Plan August 2020**

	The Chief People Officer introduced the report noting that it outlined the key themes contained within the NHS People Plan and how they linked with the Trust workforce priorities and strategy. It was noted that whilst there was broad alignment between the NHS People Plan and the Trust's existing Putting People First (PPF) strategy, there were specific actions the organisation needed to take in some areas. It was explained that the NHS People Plan placed emphasis on two issues already recognised by the Trust as areas of focus, namely Equality, Diversity and Inclusion and psychological support for staff. Detailed plans in these two areas would be presented to the relevant committees in due course and a detailed overarching action plan was scheduled to be reviewed by the PPF Committee in September 2020. The Board of Directors: • took assurance that the organisation was fully sighted on the requirements of the NHS People Plan and work would be undertaken to ensure it was aligned with the existing workforce strategy and action plan. • Noted the requirement for additional work in the areas of E&D and psychological support
159	**Trust Strategy Update** The Director of Finance noted that the Trust launched its five-year Future Generations strategy in late 2015. The period this strategy covers was coming to an end and the Trust was looking to refresh this strategy, with particular regard to the changes which have taken place in the health and care landscape. Whilst there had been changes to the health and care landscape, the evidence underpinning the Trust's case for co-location with an adult acute site had not changed. This evidence had been kept under regular review and new clinical standards and service specifications published in recent years had further highlighted the clinical risks presented when delivering tertiary services from an isolated site. Whilst the Trust had been able to address a number of risks through measures put in place, for example within the neonatal estate, the risks faced by maternity, gynaecology and anaesthetics services had heightened. Therefore, it was not the intention to recreate a new strategy from the ground up. Delivering safe and sustainable services through co-location with an adult acute site would remain a central theme of the Trust's plans for the future, alongside a programme of work to ensure our services were as safe as possible and the best they could be whilst located at Crown Street. A new 'public-facing' strategy document had been produced and was appended to the report. The Director of Finance confirmed that this document would be utilised to communicate the strategy to the Trust's staff and stakeholders ensuring that the short, medium and long terms aims were well understood. The Board noted the update. *Mr Matt Connor, Chief Information Officer, joined the meeting.*
160	**Digital.Generations Strategy** The Chief Information Officer explained that the Trust was required to refresh its IM&T strategy on a regular basis, with an update agreed for 2020. A refresh had been undertaken and this had taken into account the requirements of the Trust in terms of the needs of its patients, families and staff, as well as the wider Cheshire and Mersey developments and the national context. Following review and recommendation at the Finance, Performance and Business Development Committee the Board was asked to approve the Digital.Generations strategy ahead of its launch across the organisation in September 2020. Mr Ian Knight, Non-Executive Director, commented that the strategy was well presented and was effective in explaining the technical aspects with clarity and meaning. The Director of Finance added

	that a post-implementation review would be undertaken which would link with the Trust's emerging Quality Improvement methodology. The Board approved the Digital.Generations strategy
161	**Well-Led Framework Self-Assessment – Action Plan** The Trust Secretary reminded the Board that it had been agreed in July 2020 to review an updated Well-Led Framework Self-Assessment action plan at each Board meeting to monitor progress. Since the action plan had been received by the Board in July 2020, lead executives had reviewed the actions and provided status updates. On occasion, the action and timescale had been refined as the context had moved forward since July 2020, particularly in light of the Covid-19 challenges. These were shown utilising strikethroughs and parentheses (for showing updates to timescales). The Board received the well-led assessment action plan, noting updates where appropriate.
162	**Board Assurance Framework 2020/21** The Trust Secretary presented the Board Assurance Framework 2020/21. Since the last report to the Board, the executive directors and Board Committees had reviewed each of the BAF risks and several updates had been made. The Director of Finance noted that the narrative for BAF Risk 2337 (The Trusts current clinical records system (paper and Electronic) are sub-optimal), had been updated following the approval of the EPR business case but had not been reflected in the body of the report. The Trust Secretary noted that improvements continued to be sought to the BAF process including the presentation of information (including frequency) and embedding the use of the document to inform Board and Committee forward planning. The Board of Directors noted the report for information and assurance.
163	**Corporate Governance Manual** The Trust Secretary reported that a review of the Corporate Governance Manual was undertaken with input from the Finance Team, Head of Procurement and the Deputy Director of Workforce. This led to a series of amendments detailed in the report. The Audit Committee had received the amended Corporate Governance Manual in July 2020 and recommended its adoption to the Board. The Chair identified three further amendments that were required: • Updating the Committee Membership page with the changes noted in the Chair's Announcements item. • 6.27.14.1 - updating reference to the Quality Committee • 6.15.1.3 – ensuring this paragraph was consistent with the Nomination and Remuneration Committee Terms of Reference approved by the Board in July 2020. Subject to the above amendments, the Board of Directors approved the Corporate Governance Manual.
164	**7 Day services – self –assessment against priority standards** The Medical Director introduced the report noting that NHSI/E had instructed trusts to delay submission of their Spring 2020 Seven Day Services Assurance Framework reports until 30th September 2020 because of the novel Coronavirus (Covid-19) pandemic. The report outlined the Spring 2020 position and added detail regarding the current state of services for the assurance.

	The Chief Executive noted that Priority Standards Five and Six were not currently met and requested that focused improvement work be undertaken and for this to be captured within the next self-assessment. **Action: For focused improvement work to be undertaken for Priority Standards Five and Six and for this to be captured within the next self-assessment (Autumn 2020).** The Board of Directors noted the report for information and assurance.
165	**Review of risk impacts of items discussed** The Board noted that the following risks had been discussed during the meeting: • The on-going risks and challenges posed by Covid-19, particularly in relation to staffing. • The staffing challenge in theatres impacting on the Trust's access target recovery. *The following items were considered as part of the consent agenda*
166	**Corporate Objectives 2020/21: Three Monthly Review** The Board noted the position to date against the 2020/21 Corporate Objectives.
167	**Membership Strategy Update** The Board approved the addendum to the 2017-20 Membership Strategy.
168	**Any other business & review of meeting** None noted. **Date of next meeting** The Chair reported that the next meeting of the Board of Directors in public would be held on 5 November 2020.

TRUST BOARD
5 November 2020
Action Plan

Meeting date	Minute Reference	Action	Responsibility	Target Dates	Status
3 September 2020	20/21/164	For focused improvement work to be undertaken for Priority Standards Five and Six and for this to be captured within the next self-assessment (Autumn 2020).	Medical Director	Dec 20 In Progress	
3 September 2020	20/21/155	A report on the processes for learning lessons and embedding updated practice to be tabled at the November 2020 Board meeting.	Chief People Officer	Feb 2021 (Nov 20) In Progress	Work continues to identify evidence for the Trust effectively learning lessons. A comprehensive report on this is scheduled for February 2021.
3 September 2020	20/21/155	For the Board to review Serious Incident definition tolerances at the January 2021 Board workshop.	Medical Director	Jan 21 In Progress	
3 September 2020	20/21/152	For an update report on clinical mandatory training be provided to the November 2020 Board.	Medical Director	Nov 2020 Complete	See item 188 on the agenda.
3 September 2020	20/21/150	For the Trust Secretary to work with the Deputy Director of Nursing & Midwifery to review the formatting and presentation of the Safer Nurse/Midwife staffing report.	Trust Secretary	Nov 2020 Complete	The format of the report has been altered.
2 July 2020	20/21/89	To review the WRES objectives to consider they were sufficiently ambitious for the Trust to meet its equality aims.	Chief People Officer	Oct 2020 Complete	See item 183 on the agenda.
18 June 2020	20/21/76	To review the priority areas established by the Board around equality, diversity and inclusion, prior to the Covid-19 pandemic to identify whether issues needed to be re-prioritised.	Trust Secretary	Oct 2020 Complete	Priority areas related to increasing the number of staff from under-represented groups into senior positions. Progress against this is outlined in item 183 on the agenda.
18 June 2020	20/21/76	For the Putting People First Committee to revisit the actions agreed from the October 2019 Board workshop and develop measurable equality goals with defined timescales. This would include reference to the 'insight programme' – a development	Chief People Officer	Oct 2020 Complete	See item 183 on the agenda.

		programme for potential NEDS from underrepresented groups.			
18 June 2020	20/21/75	To develop an outline of the new ways of working on a divisional basis during the recovery from the Covid-19 pandemic and beyond.	Chief Operating Officer	Nov 2020 In Progress	Divisional Business Continuity plans to be made available to the Board via the supporting documents.

	Completed actions: concluded before the next board or on the agenda of the next Board
	Progress paused due to Covid-19 pandemic
	In Progress - either at Committee stage or awaiting presentation at Board or Board workshop
	In progress - missed original deadlines agreed at Board

Agenda Item	2020/21/176

MEETING	Board of Directors
PAPER/REPORT TITLE:	Chief Executive Report
DATE OF MEETING:	Thursday, 05 November 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

Update on Director Appointments

The Trust is currently in a recruitment process for the Director of Nursing & Midwifery and Medical Director posts. Interviews for the former were held on Thursday 22 October 2020 and an offer has been made to a candidate following a very strong interview field. Shortlisting has taken place for the latter, with interviews scheduled for the 3 November 2020. Hopefully an announcement regarding both roles can be made shortly.

Temporary Suspension of birth / support partners in the antenatal and postnatal inpatient areas

Due to the growing seriousness of the Covid-19 situation in Liverpool and the recent move into Tier 3 restrictions, we have made the difficult decision to temporarily stop antenatal and postnatal visiting on the hospital wards for the time being.

We understand that this decision will be frustrating for women and their families so soon after antenatal and postnatal inpatient visiting was re-introduced. However, the decision to put restrictions back in place has not been taken lightly.

To make this decision we have taken into consideration the government's recent introduction of tiered restrictions across the country and the fact that Liverpool's current situation is among the most serious at Tier 3. Therefore, to keep everyone safe we feel it is the most responsible and safest thing to do to temporarily stop antenatal and postnatal visiting.

Our decision making for any further changes to visiting restrictions will be reviewed regularly in line with the wider restrictions in place across the region. These restrictions will remain while Liverpool has Tier 3 restrictions in place. If restrictions across the region change, our hospital restrictions will then be reviewed further.

Health Tech Newspaper 2020 Awards

The Health Tech Newspaper 2020 Awards were held (virtually) on the 22 October 2020 to celebrate great technology, partnerships, teams and innovations making a difference across health and care. I am delighted to announce that the Trust had a very successful evening.

- In the 'Excellence in Engagement and Communications' award the Trust won for the Ask Alice project – Keeping pregnant women safe and reassured during Covid-19.

- In the 'Best Digital First Project' award – the Trust won for a project using Virtual Reality to support patients, carers and families

- In the 'Tech Project of the Year' award the Trust was Highly Commended for the Neonatal Telehealth Partnership with Alder Hey Children's NHS Foundation Trust

- In the 'Major Project Go Live' the Trust was Highly Commended for delivering a paper free health record alongside Fortrus.

This success demonstrates the excellent progress being made on the Digital agenda and I congratulate our Chief Information Officer, Matt Connor, the Digital Services team and the teams involved in the specific projects.

Memorandum of Understanding – Re Collaborating to Share Staff to Address any Service Issues Caused by Covid-19

In April 2020, the Trust was a signatory of a Memorandum of Understanding (MoU) that set out the intention of the NHS bodies who were signatories to work together to address anticipated staff shortage issues arising from dealing with or as a consequence of any increase in the spread of COVID-19. This MoU was not invoked but has been refreshed in response to an increase in infections. The Trust has signed up to the updated document.

University Hospital Status

The Trust has aspirations to achieve Teaching and University Hospital status by becoming part of the University Hospitals Association (UHA). This would recognise and build on the significant research and teaching activities the Trust currently undertakes. There is a formal accreditation process for NHS Trusts to become part of the UHA and to be able to call itself a 'University' hospital.

In order to meet the criteria to be recognised as a Teaching and University Hospital, NHS Trusts need to demonstrate they have met the standard in 3 areas. These standards are summarised below:

1. Teaching.
    a. The Trust needs to be able to demonstrate it delivers a significant teaching commitment.
    b. The teaching needs to be high quality, with enough resource to support its delivery.
    c. The teaching needs to be delivered in collaboration with the University.
    d. The Trust must be able to show evidence of participating in the University Assurance measures.
2. Research
    a. The Trust must have a Memorandum of Understanding with the University on Joint Working for Effective Research Governance.
    b. The Trust must work collaboratively with the University to develop a joint research strategy.
    c. There must be evidence of significant research activity to include
        i. A minimum of 10 University staff with honorary contracts based in the Trust who have acted as Principle Investigators in research studies.
        ii. All research output to be REF returnable.
        iii. The Trust must have a Research Capability Funding of at least £100,000 per annum.
3. Governance
    a. University representation on the Trusts Local Awards Committee.
    b. University representation on the Trusts Advisory Appointments committees for consultant posts.
    c. Board Membership of a non-Executive Director from the University
    d. The Trust Chief Executive attending formal meeting with the University Dean's advisory Committee.

The Trust is currently able to meet two of these standards with an outstanding issue being the Research Standard which requires that the Trust has 10 FTE clinical academic staff who have a substantive contract with a university but who have an honorary contract with the Trust. Work is being undertaken to progress this issue and further updates will be reported to the Board as and when appropriate.

2020 Flu Campaign Update

In autumn each year, all NHS organisations are tasked with running a campaign to provide flu vaccinations for their staff. The aim of the campaign is to support staff in ensuring that their own health, and the health of our patients, is protected against seasonal flu.

This year, the CQUIN target for staff flu vaccinations has been increased from 80% of frontline staff to be vaccinated to 90%. This is being monitored through monthly data submission to NHS England and our aim is to try and reach that target as soon as possible, ideally before the end of the year. Although the CQUIN target only relates to frontline staff who have patient contact, as in previous years, we will make the vaccination programme open to all our staff with the ambition to reach 100% of our staff being vaccinated.

The Trust is working closely with our occupational health providers, Liverpool University Hospitals, to provide a comprehensive programme of drop in sessions and ward/department visits, including some to cover nights and weekends. There continues to be a comprehensive communications campaign which includes posters around the Trust, screensavers, all staff e-mails, twitter feeds, regular updates in the Trust's LWH Weekly Digest, and regular updates at 'In The Loop'.

The position as at 26 October 2020 was as follows:

By Staff Group								Total on other page	0
	Doctor	**Nurse**	**Allied Health Professional**	**Clinical Support**	**Non Clinical Support**	**Total**			
No of staff	92	700	54	327	272	1445			
TOTALS	**43**	**208**	**17**	**69**	**25**	**362**		Frontline total	1173
								Frontline staff vaccinated	337
								Non frontline staff vaccinated	25
	46.7%	29.7%	31.5%	21.1%	9.2%				
								% of total frontline	28.7%

Financial Planning Update

Having performed relatively well financially for the past two years and having had a balanced plan approved by the Board in March 2020, the Trust now faces a significant deficit for the second half of 2020/21.

Clearly there are exceptional circumstances due to the Covid-19 pandemic and this has impacted the NHS financial regime during 2020/21. This has resulted in the suspension of Payment by Results, no local negotiation or opportunity for service developments, and a central command and control in place. In addition, the-Health and Care Partnerships (HCPs) have been given further prominence, being given system wide allocations and co-ordinating plans at a system level.

For the Trust, despite significant efforts to plan effectively, deliver CIP, and deliver the best possible financial position, the Trust now faces a deficit for 2020/21. This primarily relates to the calculation methodology used by NHSI/E to inform income for 2020/21 (which was designed to be sufficient to cover costs) being not representative for the Trust.

The outlook for 2021/22 and beyond is very uncertain.

Further information on this will be provided in the Finance Report later in the agenda.

SECTION B – Local

Cheshire and Merseyside Health and Care Partnership appoints two new Executive Directors to aid transformation in the region

The Cheshire and Merseyside Health and Care Partnership (Partnership) has appointed Sarah O'Brien as Executive Director of Strategy and System Development and Christine Hughes as Executive Director of Communications and Engagement.

Sarah currently holds a joint post as Executive Director, Peoples Services for St Helens Council and as Clinical Accountable Officer for St Helens Clinical Commissioning Group (CCG). She is a nurse by profession and has received national acclaim for her work in establishing and delivering high quality diabetes care. She has also been awarded a visiting Professorship from Liverpool John Moores University in recognition of her achievements. Her work in integrating services in St Helens such as 'St Helens Cares' is nationally recognised and she is also the Place lead for the borough.

As Executive Director of Strategy and System Development, the Partnership has stated that Sarah will be pivotal in supporting the development of place-based commissioning and provision, as well as ensuring the Partnership's strategy centres around population health, reducing inequalities and obtaining the benefits of inter-organisational cooperation.

Christine joins the Partnership from East Lancashire Hospitals NHS Trust, where she is Executive Director of Communications and Engagement. She has been central in enabling the Trust to build and retain its good reputation and high profile through engagement with partners, the media and staff, and has worked extensively across the Lancashire and South Cumbria Integrated Care System (ICS). She has enjoyed a long and successful NHS career working with a range of organisations including commissioners, acute providers and mental health trusts. She also holds a Master's degree in International Journalism.

In her role as the Partnership's Executive Director of Communications and Engagement, Christine will play a crucial role in communicating the Partnership's strategic vision and will be a driver for the region's communications and engagement approach, whilst also ensuring that patients and the public are fully engaged as transformation plans are designed and become a reality.

The Partnership has stated that both appointments will be vital in supporting the region's local authorities, CCCs, Providers and Voluntary, Community, Faith and Social Enterprise (VCFSE) Sector organisations that make up our Partnership. It is expected that both will take up their posts later this year or in early 2021.

CQC Provider Collaboration Reviews

CQC provider collaboration reviews (PCRs) look at how health and social care providers are working together in local areas. They aim to help providers learn from each other's experience of responding to coronavirus (COVID-19). The first PCRs focused on 11 areas. These areas are all Integrated Care Systems (ICS) or Sustainability and Transformation Partnerships (STP). In these 11 areas the CQC focused on health and social care services for people over 65. This group has been particularly affected by coronavirus.

The CQC published their findings to date in the latest edition of their COVID-19 Insight report.

Phase two: Urgent and emergency care

Starting in early October, the next phase of this work will focus on urgent and emergency care in eight systems. The CQC will look at how providers are collaborating to develop urgent and emergency care services together in light of COVID-19, to share learning to support with the challenges of a second peak and winter pressures on the health and care system.

The eight systems involved in the reviews are:

- Cheshire and Merseyside Health and Care Partnership

- Hampshire and the Isle of Wight
- Cornwall and the Isles of Scilly
- Northamptonshire Health and Care Partnership
- Herefordshire and Worcestershire
- East London Health and Care Partnership
- Suffolk and North East Essex
- West Yorkshire and Harrogate

For each review the CQC will interview a range of providers, including NHS 111, primary care, out of hours, urgent treatment centres, Accident & Emergency, and ambulance services. They will also speak to providers such as care homes and domiciliary care agencies who are likely to experience urgent and emergency care services. The CQC are also planning to work with Experts by Experience and local Healthwatch to explore how they can engage with local patient forums and user groups.

The CQC will share the findings with the systems involved to help inform their winter planning. They will publish a headline summary of the findings in December 2020, followed by a national report in January 2021.

SECTION C – National

Changes to Regulation

Changes to regulation during the COVID-19 pandemic have been a catalyst for an acceleration in longer term changes to the two main regulators' approach to regulating providers. Both CQC and NHS England and Improvement have signalled their plans to transform the way they regulate services in response to increased system working, and in the context of COVID-19 and the impact it has had on how the NHS operates.

CQC

The CQC is currently rolling out its transitional regulatory approach following the first wave of the COVID-19 outbreak. This will move away from their previous approach, and function as a 'prototype' model ahead of the implementation of their new strategy from summer 2021. The intention is that there will be a greater emphasis on safety, access and leadership, and regulation will be more intelligence led, with more work done offsite than in the prior inspection-led model. The CQC has also been clear that they acknowledge the burden of the inspection regime and plan to move to a leaner approach.

In early October 2020, the CQC published its draft strategy setting out its plans for regulation over the next five years. The draft strategy identifies four key areas of focus, which set out how CQC plans to change its approach to regulation. A common thread runs throughout of the need to review health and care systems and how they're working together to reduce health inequalities. The strategy describes an intention to take a more dynamic approach to regulation, moving away from relying on a set schedule of inspections to a more flexible approach using all regulatory methods, tools and techniques to assess quality continuously. Local teams will have a more regular view of the services they manage and ratings will be updated more regularly. As part of the emphasis on systems, CQC has indicated it is seeking powers to regulate systems as part of the new NHS legislation, leading to further questions about the future of Integrated Care Systems as a potential new statutory layer in the system architecture. CQC will engage informally on this draft strategy during the autumn, with plans to launch the statutory consultation early in 2021. The strategy will come into effect from April 2021.

NHS England and Improvement

NHS England and Improvement (NHSE/I) continue to progress plans to move towards system oversight with the development of a new system oversight framework, which will replace the current single oversight framework (SOF) and seek to align system working objectives with oversight arrangements. The framework will include local priorities as part of the key oversight metrics and measurement of performance at a system level.

As part of this, NHSE/I have signalled an intention to coordinate support requirements across systems, CCGs and providers, ensuring support and interventions align so that issues are tackled in the right place, involving the right parties. While timings have yet to be confirmed for the publication of the new oversight framework, it is believed by NHS Providers that NHSE/I hope to secure some alignment with the publication of the planning guidance for 2021/22.

Public Sector Exit Payments - Regulations in force 4 November 2020

The Regulations introducing a £95,000 cap on public sector exit payments have now passed through Parliament and will come into force on 4 November 2020.

The Regulations provide that any relevant authority must not make an exit payment to a person which exceeds the exit payment cap in respect of a relevant public sector exit. The exit payment cap is currently £95,000, although the Government has indicated that it intends to keep this figure under review. Importantly the Regulations will apply to all payments made on or after the 4 November 2020, even if the payment relates to contractual arrangements made before that date.

Further detail and any potential implications of these regulations will be reported to the Trust's Nomination & Remuneration Committee.

Liverpool Women's NHS Foundation Trust

Board of Directors

Committee Chair's report of Quality Committee meeting held 21 September 2020

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

2. Agenda items covered
   - **Subcommittee Chairs reports**: The Committee received and noted the Chair's report from the Safety Senate, Effectiveness Senate, Experience Senate, and Corporate Risk Committee. Following an issue being escalated from the Safety Senate, the Committee requested further assurance regarding the Trust's processes for the effective filing of patient records. It was noted that the subcommittee chair templates would be reviewed to improve assurance reporting up to Board Committees.
   - **Monthly Quality Performance Review M5 2020/21:** The Committee received a report on Operational Performance at Month 5 2020/21. The Committee noted that the staff sickness absence rate had improved however this was likely to increase due to the further impact of Covid-19. It was noted that Covid-19 continued to pose challenges for Referral to Treatment (RTT) performance due to restrictions in capacity and activity. The Committee was assured by the actions being undertaken to address the deterioration in performance.
   - **Care Quality Commission (CQC) 2019 Inspection Update:** The Committee was assured by the CQC Update report received and updated action plan. The Committee was assured by the Head of Midwifery of the rigour undertaken to ensure evidence of compliance before an action was declared as complete. The Committee noted that the Trust was developing the CQC Action Plans to be on-going as Quality Improvement Action Plans which would generate several quality improvement projects.
   - **Updated Covid-19 IPC Framework:** The Committee noted that the Trust had taken part in a CQC Emergency Support Framework IPC interview in relation to the IPC Framework. The Committee was assured by the formal response received from the CQC in which they had stated "we (CQC) have found that the Board is assured that the Trust has effective infection prevention and control measures in place."
   - **Never Event Thematic Assurance Report:** The Committee received a report for assurance, detailing a deep dive review undertaken of all Never Events that had occurred in Theatres since 2017 to date. The Committee noted that the main themes identified included leadership/management and communication/culture, both of which had been highlighted as areas of concern within recent Board reports. The Committee was informed that a Theatres Review had been commissioned in response to these concerns. The subsequent report would be shared with the Committee. The Committee was assured by the contents of the report and was supportive of the further action taken to review the department.
   - **Lessons learnt from Mortality: Quarter 1 2020/21:** The Committee reviewed the quarterly update and was assured that there was an adequate process in place to ensure learning from deaths (adult, perinatal and neonatal). The Committee noted that a slight deterioration in the still-birth rate and requested that this be investigated and reported back in the next scheduled quarterly report.
   - **Research & Development Annual Report & Strategy Review 2019/20:** The Committee received the annual Research and Development report and was assured by the overview of compliance and governance assurance related to research activity. The Committee noted that Covid-19 research had been conducted effectively. It was also noted that performance and delivery of research not related to COVID-19 during quarter 4 of the year had been severely impacted by the Covid-19 pandemic.
   - **Trust Annual Statement against the Francis Report:** The Committee received the current Trust

response to the Francis Report recommendations and noted that the Trust continued to remain compliant against each recommendation with exception of recommendation 244: EPR. The Committee approved publication on the Trust website.

~ **Security Management Annual Report 2019/20:** The Committee received and noted the Security Management Annual Report 2019/20.

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

The Committee reviewed the Quality related BAF risks. The Committee recommended that BAF risk 2340 'overarching Covid-19 risk', be rearticulated to better reflect the current position and mitigations in place. The Committee would recommend a review to FPBD Committee as the responsible committee for risk 2340.

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

The Committee highlighted continued 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**

None

Tony Okotie
Chair of Quality Committee
21 September 2020

Liverpool Women's NHS Foundation Trust

Board of Directors

Committee Chair's report of Quality Committee meeting held 19 October 2020

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

2. Agenda items covered
   - Subcommittee Chairs reports: The Committee received and noted the Chair's report from the Safety Senate and the Effectiveness Senate. In particular, it was highlighted that a thematic review of Imaging Serious Incidents was underway which would be presented back through Executive Committee with a potential decision to commission an external review.
   - Monthly Quality Performance Review M6 2020/21: The Committee received a report on Operational Performance at Month 6 2020/21. The Committee noted that the current spike in Covid-19 cases locally had impacted on performance standards, notably workforce attendance and access standards. The Committee noted the efforts to identify underperforming quality performance metrics directly related to Covid-19 and those that were not. The Committee was assured by the actions being undertaken to address the deterioration in performance.
   - Care Quality Commission (CQC) 2019 Inspection Update: The Committee was assured by the CQC update report and updated action plan. It was noted that as the CQC inspection and subsequent action plan had been created pre-Covid-19, additional information related to Covid-19 command and control rules had been added to the action plan.
   - Clinical Negligence Scheme for Trusts (CNST) Update Year 3: The Committee noted that the pause on the CNST scheme due to Covid-19 had been lifted and requirements to complete year 3 of the CNST scheme would resume and conclude with final Board sign off in May 2021. The potential associated financial benefit to achievement of the scheme in terms of a rebate of up to 10% on the CNST premium in financial year 2021/22 was also noted.
   - Counterfactual Case Update: Managing clinical risks and mitigations Future Generations Update: The Committee received an in-depth update report which detailed the short, medium and long term clinical risks posed by operating as a single site Trust and the mitigations in place to manage the identified risks. The Committee considered the associated BAF risk and agreed that the risk score should remain at the highest score of 25. The Committee was assured by the update and supported continued development of the counterfactual clinical case in the Covid-19 environment. The Committee recommended further consideration at a private Board meeting to allow all Board members to receive the report and review the position.
   - Serious Incidents & Learning Reports Quarter 2: The Committee received and noted the quarter 2 2020/21 Serious Incident and Learning report. The Committee raised concern regarding the repeated serious incidents related to reporting and acting on results and noted that the serious incidents would be included within the Imaging thematic review. The Committee requested that future reports focus more on evidencing that learning was taking place.
   - Medicines Management Assurance Report Quarter 2: The Committee received and noted the quarter 2 2020/21 Medicines Management Assurance Report. The Committee was assured that the Trust remained focussed on embedding actions from the CQC action plan. The Committee challenged the decrease in medicine incident reporting and was assured that this was an actual reduction in incidents rather than as a result of a lower rate of reporting.
   - Seven-day services bi-annual update: The Committee received and was assured by the Autumn 2020 provision of seven-day services. It was noted due to the impact of Covid-19 the regional seven-day service team had cancelled the requirement of a Trust submission this year. It was unknown how collection of data would be requested in the future.

NHS

- **Contract Quality Schedule Assurance Report Quarter 2:** The Committee noted the assessment and assurance levels of information submitted by the Trust to the Clinical Commissioning Group in relation to the Quality Schedule.
- **Clinical Audit Annual Report:** The Committee was assured that appropriate work had been undertaken towards supporting and completing the Clinical Audit Programme during 2019/20.
- **National Institute for Health and Care Excellence (NICE) Annual report:** The Committee received an amended version to formally approve following recommendations made by the Quality Committee at its meeting held in July 2020.

3. **Board Assurance Framework (BAF) risks reviewed**
   The Committee reviewed the Quality related BAF risks. The Committee agreed to recommend to the Board the de-escalation of BAF risk 2295: Inability to achieve and maintain regulatory compliance, performance and assurance on to the Corporate Risk Register, monitored by the Corporate Risk Committee (CRC). The Committee was assured by the processes in place but recommended close monitoring by the CRC with respect to potential secondary impact caused by Covid-19.

   The Committee considered further BAF risk 2340: Overarching Covid-19 with respect to recent local changes and the impact on quality of services. The Committee noted that decisions were based on patient safety as a priority which might negate quality. The additional comments would be included within the reiteration of BAF risk 2340 (overseen by the Finance, Performance & Business Development Committee).

4. **Escalation report to the Board on Performance Measures**
   The Committee highlighted continued 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**
   None

Tony Okotie
Chair of Quality Committee
19 October 2020

Liverpool Women's NHS Foundation Trust

Board of Directors

Committee Chair's report of Finance, Performance and Business Development Committee meeting held 22 September 2020

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

2. Agenda items covered
   - ~ Finance Performance Review Month 5 2020/21: The Committee received a report on the Month 5 finance position noting that, as at 31 August 2020, the Trust was reporting a breakeven position after an expected total cumulative top up of £6.6m. The Committee noted continued careful monitoring and recording with respect to Covid-19 related costs. The Committee was informed NHS England and NHS Improvement (NHSI/E) had given further details of the financial arrangements for the rest of 2020/21, including how system-level funding envelopes have been calculated. The allocation that had been communicated to the Trust would represent a funding shortfall and this case was being made to NHSI/E. The Committee noted the importance of maintaining oversight of this potential shortfall and monitoring the areas of expenditure that the Trust retained control over. A financial plan for the remainder of 2020/21 was due to be submitted at the end of September 2020 and the Committee agreed to receive an overview via email, with the drivers of the deficit clearly articulated.
   - ~ Operational Performance Month 5 2020/21: The Committee received a report on Operational Performance as at Month 5 2020/21. The Committee noted the challenging position particularly in relation to theatre efficiency. In order to reduce a patient backlog, it was likely that theatres would require either additional staffing or available working hours – measures that had a cost implication. It was also highlighted that missed operational targets could result in financial penalties. The Committee noted the further potential impact on staffing and activity caused by Covid-19 outbreaks amongst the workforce. The Committee was assured by the action being taken to address improvement of the performance metrics but was mindful of the continued potential impact on performance metrics caused by Covid-19.
   - ~ Review of Strategic Progress: The Committee noted the Strategic progress report. The Committee noted key strategic developments undertaken during August 2020 including completion of the Clinical and Quality Strategy and estates development work.
   - ~ Neonatal Capital Programme Build Update: The Committee noted that the neonatal build project substantially completed on 27 July 2020. Unit decant took place on 3 August 2020 and the unit was now fully clinically operational. Final outturn costs for the project are expected to be £14.77m which was below the projected budget envelope set at £15m.
   - ~ Electronic Patient Record (EPR) Programme Report: The Committee received a detailed update of developments undertaken to take forward the EPR programme. The Committee was assured by the recommendations proposed.
   - ~ GDE Benefits Realisation: The Committee received a presentation noting the benefits achieved, benefits to be assessed and benefits to be delivered as an output from the GDE programme. It was noted that further consideration would be given at the Board Workshop in October 2020.
   - ~ EU Exit Update: The Committee noted the position is relation to EU Exit preparations.
   - ~ One to One Midwives Update: The Committee noted that the independent investigation continued to be undertaken.
   - ~ National Cost Collection Update: The Committee noted the position relating to the National Cost Collection exercise 2019/20.
   - ~ Sub Committee Chairs report: The Committee received and noted the Chair's report from the Digital Hospital Subcommittee, Information Governance Committee and EPRR Committee. The

NHS

Committee approved the terms of reference of the Information Governance Committee and EPRR Committee.

3. Board Assurance Framework (BAF) risks reviewed

The Committee reviewed the risks that it was accountable for within the BAF. The Committee noted recommendations from both the Quality Committee and the Putting People First Committee to formally review BAF risk 2340 'overarching Covid-19 risk' to more accurately reflect the current position, risk and mitigation being encountered. The PPF Committee recommended an increase of the risk score to 20. The Committee agreed to formally review the risk and receive an update within the next report. The Committee also suggested further review of BAF risk 2344 'risk to financial position in year 2020/21' due to the current financial position.

4. Escalation report to the Board on Performance Measures

The Committee highlighted continued 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

None

Phil Huggon
Chair of FPBD Committee
22 September 2020

Board of Directors

Committee Chair's report of Finance, Performance and Business Development Committee meeting held 27 October 2020

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

2. Agenda items covered
   - **Finance Performance Review Month 6 2020/21:** The Committee received a report on the Month 6 finance position noting that, as at 30 September 2020, the Trust was reporting a breakeven position after an expected total cumulative top up of £8.4m. The Committee noted continued careful monitoring and recording with respect to Covid-19 related costs. Assurance was provided that Quality Impact Assessments continued to be undertaken for CIP projects that were being progressed and that trade debtors had reduced by another £1.5m in month, leaving the overall debtor position less than £3m. The Committee noted the importance of maintaining a focus on improving the debtor position to maintain a strong cash position in the context of a likely deficit in year.
   - **Operational Performance Month 6 2020/21:** The Committee received a report on Operational Performance as at Month 6 2020/21. A challenge regarding staff absence rates (10% compared to 6% at the beginning of September 2020) was reported and noted as being a consequence of the Covid-19 pandemic. The Trust had started to see a small increase in the 18-week access target although an improvement in diagnostic performance was hoped to have a positive impact on this. The Trust was working to increase elective activity to 2019/20 levels and despite progress, this was being challenged by theatre efficiency issues as a result of Covid-19. Cancer performance remained strong and was expected to be further supported by a robust consultant staffing position. The Committee was informed of a challenge to meet the 35% by March 2021 Continuity of Care (CoC) target set by NHS England. Discussions were continuing with staff regarding developing models of care to help meet the target. Further assurance on this issue is planned for discussion at the November 2020 Board. The Trust continued to offer mutual aid to the wider system whilst ensuring that Trust services remained safe.
   - **Financial Planning Update:** The Committee noted that whilst having performed relatively well financially for the past two years and having had a balanced plan approved by the Board in March 2020, the Trust faced a significant deficit for the second half of 2020/21 due to the calculation methodology used by NHSI/E to inform income for the remainder of the financial year. The Committee was informed that the finance team continued to work with partners and regulators to make the case for a financial envelope more representative of the Trust's costs. The Committee was informed that work was underway with the respective divisions and corporate areas to determine the longer-term consequences of this shortfall as part of the development of future financial plans.
   - **Business Case Post Implementation Review:** As part of ongoing quality and process improvement, The Committee received the output from a Business Case Post Implementation Review for all cases from the 2019/20 financial year. The Committee was assured by the process outlined in the paper and remarked that it was positive evidence of the Trust developing a learning culture that effectively pursued continuous improvement. An annual review would continue to be undertaken and reported to the Committee.
   - **Strategic Progress Update (Future-Generations):** The Committee noted the Strategic progress report. The Committee noted that the Trust was seeking further detail following a recent DHSC capital funding announcement that referenced resources to fund eight further new hospital schemes.

- ~ **Neonatal Capital Programme Build Update:** The Committee received the final update report following the close out of the project. The build had finished within the planned timescales and budget envelope and was delivering a significant number of benefits including the material reduction of clinical risk in the unit. The Committee requested that a follow up benefits realisation report be provided in 12 months.
- ~ **Treasury Management Quarterly Report, Quarter 1 2020/21:** The Committee received assurance regarding the positive cash position for 2020/21, supported by the reduction in aged debt and noted the transfer to Public Dividend Capital (PDC) for the Neonatal project.
- ~ **Update on Communications, Marketing and Engagement Action Plan 2020-21:** The Committee received an update on the marketing, communications and engagement action plan established in April 2020. It was agreed that the Communications Team had performed well in supporting the Trust through a challenging period as a result of the Covid-19 pandemic.
- ~ **Electronic Patient Record (EPR) Programme Report:** The Committee received a detailed update of developments undertaken to take forward the EPR programme. The Committee was assured by the progress outlined.
- ~ **MIAA Cyber Security Audit Progress Report:** The Committee received an update regarding progress to close out outstanding actions from the audit. Assurance was provided that key outstanding risks would be completed by the end of October 2020.
- ~ **Information Governance Update:** The Committee noted that there had been no ICO reportable incidents in the period.
- ~ **Sub Committee Chairs report:** The Committee received and noted the Chair's report from the Digital Hospital Subcommittee, Information Governance Committee and EPRR Committee. The Committee approved the updated terms of reference of the Digital Hospital Sub-Committee.

3. **Board Assurance Framework (BAF) risks reviewed**
   The Committee reviewed the risks that it was accountable for within the BAF. The Committee noted the updated position of BAF risk 2340 'overarching Covid-19 risk' to more accurately reflect the current position, risk and mitigation being encountered. Following discussion at the September 2020 meeting, BAF risk 2344 'risk to financial position in year 2020/21' had been reviewed with a recommendation to increase the likelihood to 5 taking the overall score of the risk to 20. This was as a result of the effects of the deficit plan for the 2nd half or 2020/21 being based on the central income allocations which was outside of the Trust control.

4. **Escalation report to the Board on Performance Measures**
   The Committee issued a 'Chair's Log' to the Quality Committee and the Putting People First Committee to explore the issues underpinning the Continuity of Carer performance.

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

6. **Action required by Board**
   None

Tracy Ellery (Chairing in place of Phil Huggon)
FPBD Committee
27 October 2020

BOARD OF DIRECTORS

Chair's report of Putting People First Committee held on Monday 21 September 2020

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

2. **Agenda items covered:**
   - **Director of Workforce Report:** The Committee received the workforce update, noting the workforce position in terms of Covid-19, continued progress to introduce Schwartz Rounds, and changes to the internal DBS process.
   - **Workforce Key Performance Indicators (KPIs) including Resuscitation and Transfusion Training update:** The Committee took assurance from action being taken to address delivery of mandatory training within Covid-19 restrictions and a potential reduction of workforce. It noted compliance of the clinical workforce despite the current working pressures. The Committee would receive a further update in relation to delivery of Resuscitation training at the next meeting.
   - **Overview of PPF Year 2 Strategy and Correlation with the NHS People Plan:** The Committee noted the alignment between the NHS People Plan and the PPF Strategy and was assured that the Trust was meeting the requirements of the NHS People Plan.
   - **Neonatal Unit Staff Story:** Daniella Davies, Neonatal Nurse presented an insight into her experiences as a Neonatal Nurse and a NICU bereavement link working during the Covid-19 lockdown. She described how the team strived to continue delivering high quality bereavement care by effective communication, teamwork and challenging current practice by different ways of working whilst upholding Covid-19 restrictions.
   - **Staff Survey update for Estates, IM&T and Governance:** The Committee noted that all three business areas were working towards improving team working, morale and leadership. It was anticipated that these workstreams would improve the working culture of these teams and result in improved 2020 staff survey results.
   - **Freedom to Speak Up Guardian Update:** The Committee was assured by the update provided by the Freedom to Speak up Guardian and the contents of the report. It was noted that the next Board Self-assessment in relation to Freedom to Speak Up would be undertaken in early 2021 following the publication of the Strategy.
   - **Fair and Just Culture Project Update:** The Committee received an update detailing the progress to date with the Fair and Just Culture programme which was in the third year of a five-year programme. It was noted that the Board of Directors had signed up to receive Fair and Just training in October 2020.
   - **Update on EDS2, WRES and WDES Data including Covid BAME lookback:** The Committee received a detailed report noting that WRES and WDES data referenced in the paper illustrated that LWH compared favourably in many indicators compared with other Trusts, however limited progress had been made to change the cultural make-up of the organisation. It was noted that a Board development session on EDI had been arranged to take place on 1 October 2020.
   - **A review of Staff Engagement Methods and Outcomes at LWH:** The Committee noted the ongoing work in respect to staff engagement and was assured that action was being focused in the correct areas.
   - **Leadership & Talent Strategic Framework Update:** The Committee approved the initial proposals in relation to the development of the Leadership and Talent Strategic Framework to support the achievement of the PPF Strategy.
   - **Policies for approval update:** The Committee approved the following policies: E-Rostering Policy; Establishment Control SOP; Overpayments, Underpayments & Incorrect Payments

Policy; Secondary Employment Policy and Procedure; Volunteer Policy; Whistleblowing Policy; Medical Appraisal & Revalidation Policy.

- **Medical Appraisal & Revalidation Annual Report 2019/20:** The Committee noted the report and approved the statement of compliance confirming that the organisation as a designated body was in compliance with the regulations.
- **Pharmacy Revalidation Annual Report:** The Committee noted the report and was assured that revalidation in the pharmacy department was in line with the requirements of the relevant professional body.
- **Analysis of Disciplinary, Grievance and DAW Cases for 2019/20:** The Committee noted the report and was assured that disciplinary, grievance and dignity at work matters are dealt with appropriately in the Trust.
- **Guardian of Safe Working Hours (Junior docs) Annual Report 2019/20 and Quarter 1 2020/21:** The Committee noted the contents of both the annual report and Quarter 1 report and was assured that doctors in training at Liverpool Women's NHS FT are safely rostered and enabled to work hours that are safe and in compliance with their contract.
- **Outsourced Services Contract Review:** The Committee approved the continued use of shared services, working in partnership with larger local NHS organisations which provide effective and cost-efficient solutions.
- **Subcommittee chairs reports and terms of reference:** The Committee received and noted the Chair's report from the Diversity and Inclusion Committee, JLNC, Health and Wellbeing Group, and the Nursing & Midwifery Professional Forum. The Committee approved the Terms of Reference of the Education Governance Committee. The Committee also received the chairs report from the Education Governance Committee held 17.09.20 via email following the meeting.

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

The Committee reviewed the PPF related BAF risks. No changes to existing risks were identified as a result of business conducted during the meeting.

The Committee recommended that BAF risk 2340 'overarching Covid-19 risk', be rearticulated to better reflect the current risk and recommended an increase of the risk score to 20, severity 5 by likelihood 4. The Committee would recommend a review to FPBD Committee as the responsible committee for risk 2340.

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

None

5. **Issues to highlight to Board**

None

6. **Action required by Board**

None

Jo Moore
Chair of Putting People First Committee
Date 21 September 2020

2020/21/180

Board of Directors
Committee Chair's report of Audit Committee meeting held 29 October 2020

1. Meeting Quorate: Yes

2. Agenda items covered

~ **Follow up of Internal Audit and External Audit Recommendations:** The Committee received an updated position on audit recommendations. It was noted that audit implementation rates had improved with no recommendations currently overdue. The Committee was informed of the recommendations that remained outstanding including those relating to a Cyber-Security audit. Reference was made to a recent assurance report received by the Finance, Performance and Business Development Committee which outlined how the risks had been managed and the actions progressed. It was noted that lessons would be learned from the cyber-security audit, particularly in relation to the 'cohorting' of actions to support their management.

~ **Internal Audit Progress Reports and follow up:** The Committee noted that two reports had been finalised since the last update in July 2020. These were as follows:

- Financial Reporting and Integrity Review Assignment Report 2020/21 – High Assurance
- Financial Systems Key Controls Review Assignment Report 2020/21 – High Assurance

With the financial challenges facing the Trust, the Committee noted that it was highly encouraging that the internal systems of control had been demonstrated to be robust.

The Committee was informed that due to the Covid-19 pandemic, amendments to the original internal audit plan had been made to reprioritise and re-order to reflect lockdown conditions. The internal auditor noted that whilst a number of audits were backloaded to quarter four, it was still expected that the audit programme would be delivered for the year. The Committee noted a requirement to monitor progress closely.

~ **Anti-Fraud Progress Report 2020/21:** The Committee received the Anti-Fraud Progress Report 2020/21. It was noted that the face-to-face anti-fraud awareness sessions by the AFS had been paused due to the moratorium on corporate inductions. These were expected to re-start virtually during November 2020. The Committee discussed a national trend relating to a drop in anti-fraud reporting and whilst this had not impacted the Trust's referral rate, there was agreement to place this on the risk register for monitoring purposes.

~ **Audit Committee Effectiveness Review:** The Committee received the outcome from the effectiveness review which had been informed by the HFMA Audit Committee good practice guidance and local intelligence from the internal auditor. In considering the resulting action plan, the Committee noted assurance from the internal auditor that the Committee had a strong existing baseline performance, with the actions identified to further enhance processes rather than to meet gaps in practice.

~ **External Audit Technical Update**: The Committee received the Health Sector Technical Update from the Audit Partner. A revision to value for money reporting arrangements was highlighted and it was noted that discussions were being held with the finance team regarding the implications for the Trust.

~ **Audit Waiver Report Quarter Two 2020/21:** The Committee received the Audit Waiver Report Quarter Two 2020/21 which showed a significant reduction in waivers from the same period in 2019/20. Whilst this was partly explained by a reduction in non-pay expenditure, the Committee was assured that processes had also been strengthened.

- ~ **Assurance processes, governance, risk management and internal control:** The Committee received an outline of the Trust's systems and processes for internal control. Whilst the Trust could demonstrate robust processes and systems, the Committee was informed that improvements were required to progress the Trust from an organisation rated 'good' to a rating of 'outstanding'. Actions to make these improvements were outlined and the Committee re-iterated its plans to receive assurance on Divisional governance arrangements at future meetings.
- ~ **Clinical Audit Annual Report 2019-20 & Interim Progress Report 2020-21:** The Committee received the Clinical Audit Annual Report for 2019/20 and a mid-year report for 2020/21. The Committee was assured by the progress made during 2020/21 despite pressures from Covid-19 and noted that processes were in place for prioritising audits when required.
- ~ **External Inspections & Accreditations - Process:** The Committee was informed that work was being undertaken to map the Trust's external inspections and accreditations and strengthen the processes for the centralization of actions to reduce duplication and to support lesson learning. A further report on this is scheduled for January 2021.
- ~ **Governance in the context of COVID-19:** The Committee received assurance that the Trust had robust governance arrangements in place to manage the requirements of an effective response to the Covid-19 pandemic.
- ~ **Chairs Reports**: The Committee received and reviewed the Chairs reports for each of the Board Committees.
- ~ **Board Assurance Framework:** The Committee was assured of the processes in place to review the BAF and the developing work to ensure that it was being utilized as a dynamic tool to drive the assurance agenda of the organisation.

3. Escalation report to the Board on Audit Performance Measures
   - ~ None

4. Issues to highlight to Board
   - ~ The following risks were identified:
     - The need for close monitoring of the delivery of the 2020/21 internal audit plan

5. Action required by Board
   - ~ None

Tracy Ellery
Chair of Audit Committee
October 2020

Liverpool Women's NHS Foundation Trust

Board of Directors

Committee Chair's report of Charitable Funds Committee meeting held 22 September 2020

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

2. **Agenda items covered**
   - **Monthly Financial Position & Investment Report – 2020/21 (August 2020):** The Committee noted the current financial position as at the end of August 2020. The positive impact on the financial position of monies donated via NHS Charities Together was noted.
   - **Budget Expectation:** The Committee noted the negative impact of Covid-19 on the budget forecast for the remainder of 2020/21 and for 2021/22. The Committee agreed that any further expenditure be matched with additional income. A more detailed budget setting exercise would be completed for 2021/22.
   - **Fundraising Update:** The Committee noted that all planned fundraising events had been reviewed in line with Covid-19 guidance, which had greatly reduced the number of fundraising events planned for the year.
   - **Health Care Financial Management (HFMA) Guidance for NHS Charities:** The Committee received the HFMA guidance as a reminder of their Trustee responsibilities in relation to good governance and risk management & control of the Charity.
   - **Charitable Funds Committee Terms of reference & Work plan:** The Committee requested further amendments to the Committee terms of reference responsibilities to clarify the Committee's role in relation to the strategy and expenditure.
   - **Unity Lottery:** The Committee approved the request to apply for a small society lottery licence to run a lottery for Liverpool Women's Hospital Charity to raise funds and add a new income stream.
   - **NHS Charities Together:** The Committee noted that application to stage 2 monies was open however the Trust could not submit a direct application as each STP/ICS area had to appoint a lead charity to apply for funds on behalf of others. Currently the Cheshire and Merseyside STP haven't agreed a lead Charity. The Committee agreed that this should be escalated to Chief Executive and Chair forums to resolve.
   - **Volunteer Recovery Plan:** The Committee noted the continued disruption that Covid-19 had caused on the Volunteer workforce. It was noted that the Trust was reviewing roles to support the Covid-19 recovery phase that the volunteer workforce could support.
   - **Future Fundraising Priorities:** The Committee agreed the proposed future fundraising priorities.

3. **Board Assurance Framework (BAF) risks reviewed**
   None

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

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

6. **Action required by Board**
   None

Phil Huggon
Chair of Charitable Funds Committee
22 September 2020

NHS

Liverpool Women's NHS Foundation Trust

Agenda Item	20/21/182

MEETING	**Trust Board**
PAPER/REPORT TITLE:	**Covid-19 Pandemic: Trust Update**
DATE OF MEETING:	Thursday, 05 November 2020
ACTION REQUIRED	**Assurance**
EXECUTIVE DIRECTOR:	Gary Price, Chief Operating Officer
AUTHOR(S):	Gary Price, Chief Operating Officer
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 Board is asked to note this report for information and assurance***			
PREVIOUSLY CONSIDERED BY:	**Committee name**		*Choose an item.* Or type here if not on list: *Click here to enter text.*	
	Date of meeting		*Click here to enter a date.*	

Executive Summary

This paper provides an update on the Trusts ongoing response to the Covid 19 Pandemic. October 2020 has seen the Liverpool city region move into Tier 3 measures with increased restrictions in society and pressures on the NHS.

Report

1. Introduction

The pandemic outbreak of Covid 19 continues to place pressure on the whole of the NHS. Liverpool Women's NHS FT has responded to this pressure to date as part of the Cheshire and Mersey system response. The nationally declared level 4 incident was maintained throughout April, May and June 2020. The level of incident had been stepped down in July 2020 to a level 3, however the Trust remains under command and control. In October the Liverpool city region move into new Tier 3 measures with increased restrictions in society and pressures on the NHS.

2. Governance: Command and Control

The Trust remains under command and control via the Cheshire and Merseyside in and out of hospital cells, the C&M system hosts a daily Chief Operating Officer system call to ensure a collaborative approach to managing the pandemic, in addition there is a 3 x weekly Liverpool system call. There are regular Cheshire and Mersey Medical Director, Director of Nursing and Director of Finance sessions. This structure is overseen throughout

the week with system CEO calls. This structure has overseen the management of the response to the second wave being experienced across the North West of England most acutely.

Internally the Trust has maintained its Coronavirus oversite and scrutiny arrangements since March 2020 which has allowed us to be responsive to the ever-changing demands and deliver safe services. The Trust has a daily command and control session which oversees our operational response to the pandemic, this is overseen by the weekly Executive lead Oversite and Scrutiny Committee that reports to FPBD. The Trust has a Covid Clinical Advisory Group that allows us to ensure senior clinical and Infection Prevention Control (IPC) input to all our decisions.

3. Sickness absence

Sickness absence has increased across all areas of the Trust during the second wave and poses a significant challenge to the day to day operational delivery of our services. Sickness has risen to above 10% at times through October 2020 which has resulted in activation of Business Continuity Plans, specifically in Maternity where sickness absence has risen to 12% at times. All staff have had a Covid 19 risk assessment and the Trust continues to offer a series of supportive measures to support both the physical and emotional health of our staff.

4. Recovery and Restoration

In line with national requirements the Trust continues to review our waiting lists for those patients who have to wait longer for routine treatment due to the pandemic, specifically for benign gynaecology. All referrals have clinical triage, patients on the admitted pathway have all had Consultant review to prioritise patients. The Trust has met required trajectories for outpatients and elective activity for September, however, anticipates October and November to be a challenge with the increased pressures of wave 2. Long waiting (52 week) patients are in line with our recovery trajectories.

From November the Trust will have a full compliment of Gynaecology Consultants for the first time in over 2 years, despite the challenges of Covid the Trust will establish a programme of efficiency review through November for benign gynaecology to ensure that the greatest benefit can be gained with the increased workforce.

The Trust now regularly delivers over 2000 non face to face appointments per month (virtual or telephone) which assists greatly with recovery. The non-obstetric ultrasound diagnostic backlog caused by wave 1 has been eliminated as part of recovery plans.

Gynaecology Oncology services have been prioritised again in wave 2 and the Trust continues to be able to deliver our oncology services in line with the national clinical prioritisation and support the Cheshire and Mersey region for Gynaecology.

The Trust continues to review our visiting arrangements as part of recovery on a regular basis, Decisions around visiting are taken with the latest Infection Prevention and Control advice and where possible service user groups such as the Maternity Voices Partnership. Restricting any aspect of visiting is not something that the Trust would wish to do but is done so in the best interests of our patients and staff

5. Personal Protective Equipment (PPE) and Swabbing

The Trust reviews all PPE and equipment requirements daily and has been able to respond positively to the demands of the pandemic. The finance and procurement teams lead this aspect of managing our response to the pandemic.

All work-based areas (clinical and non-clinical) have risk assessments to ensure Covid secure compliance plus all rest areas, e.g. staffrooms and break areas. One-way systems are in operation across the Trust as is promotion of working from home wherever possible.

Staff and patients are provided with masks, sanitising hand gel and temperature checks at the front door. Sanitising stations are available across the Trust. In addition, patients are screened for Covid symptoms on arrival. For planned patient care, prior to arrival at the Trust, patients are given relevant information to not attend the Trust if they are symptomatic but to phone for advice. Wherever possible unplanned attendances, e.g. Gynae ED/ MAU are required to telephone in advance to manage footfall. All elective admissions are swabbed before there attendance and shield before any procedure.

Ward areas have reviewed their bed space to ensure IPC compliance, This has resulted in the requirement to open increased capacity in maternity to ensure compliance with social distancing.

The Trust has an established swabbing service which sits under the management of Clinical Support Division. This service is for symptomatic staff and for elective patients and supports our overall management of the pandemic response.

6. Mutual Aid

The Trust is engaged with the wider Cheshire and Mersey system to understand what mutual aid can be provided during the pandemic

Mutual aid was provided in wave 1

- 10 medical step down beds were made available to LUH
- Staffed elective cancer lists were given adhoc to the Cheshire and Mersey system for priority patients
- Offer for buddying up with regional maternity units
- Joint Neonatal Ward rounds with Alder Hey

In wave 2 the below has been offered

- A full staffed day elective operating to LUH
- Staffed elective cancer lists adhoc to the Cheshire and Mersey system for priority patients
- Non obstetric ultrasound capacity given to system to support backlog from November 2020
- Offer of support from corporate services, e.g. Safeguarding from LWH to free up capacity at LUH

7. Conclusion

The Trusts response to the Coronavirus pandemic is ongoing. Measures are regularly reviewed with the latest IPC advice to ensure that our key services remain able to care for the most vulnerable patients and that we are able to develop increased capacity for planned recovery. Our staff are our greatest asset in our response to the pandemic and the Trust constantly reviews its measures for staff support during this time.

8. Recommendation

The Board is asked to note this report for information and assurance

	20/21/183

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Equality Diversity and Inclusion: Update on WRES and WDES 2020 Data and overview of future strategy**
DATE OF MEETING:	Thursday, 05 November 2020
ACTION REQUIRED	**Assurance**
EXECUTIVE DIRECTOR:	Michelle Turner, Chief People Officer
AUTHOR(S):	Rachel London, Deputy Director of Workforce
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 annual data pertaining to the Workforce Race Equality Standard (WRES) and the Workforce Disability Standard (WDES) • note that the organisation has not become significantly more diverse over the last 12 months • note the actions taken to support and connect with BAME colleagues during Covid-19. • Approve the strategic objective as set out • Consider the range of actions to inform the delivery of the existing Equality Objectives • Approve the proposed process to develop an overarching Equality, Diversity & Inclusion Strategy and update the Equality Objectives			
PREVIOUSLY CONSIDERED BY:	**Committee name**	Putting People First Committee		
	Date of meeting	23 September 2020		

Executive Summary

This paper:

- presents the annual data pertaining to the Workforce Race Equality Standard (WRES) and the Workforce Disability Standard (WDES)
- identifies that the organisation has not become significantly more diverse over the last 12 months
- appraises the Board of actions taken to support and connect with BAME colleagues during Covid-19.
- sets out the proposed strategic objective for Board approval
- identifies a range of actions to inform the delivery of the existing Equality Objectives
- describes the proposed process to develop an overarching Equality, Diversity & Inclusion Strategy and update the Equality Objectives

Report

Introduction

A diverse workforce at all levels is good news for NHS organisations as it enables access to a wider range of skills and talents; good news for patients as a diverse workforce is better equipped to meet the needs of our diverse communities; and good news for staff wellbeing as they enjoy greater workplace opportunities, increased job satisfaction and are better rewarded for their contribution to the NHS.

At LWH we recognise that some positive work is undertaken in the area of ED&I but this is not currently sufficiently joined up, resourced and underpinned with an over-arching strategic aim. The Workforce Race Equality Scheme and Workforce Disability Equality Scheme data referenced in this paper illustrate whilst LWH compares favourably in many indicators compared with other Trusts, limited progress has been made to change the cultural make-up of the organisation. The WDES and WRES are helpful drivers to identify disparities and take action.

The Trust has some strengths particularly in terms of its inclusion activities, with strong links with education providers at all levels in the city and with the DWP and can demonstrate real benefits in terms of access to work for a diverse group.

There is a clear crossover in terms of Equality, Diversity & Inclusion and the Patient Experience agenda with again many great examples of engaging with our service users and community to inform the way in which we deliver care. However, it is recognised that there is further work to be done with respect to Patient Experience from a diversity, equality and inclusion perspective that will contribute to the Trust achieving its vision of being the leading provider of healthcare for women, babies and their families.

Both Covid-19 and the Black Lives Matter campaign have accelerated actions in some areas as they have shone a particular spotlight on the experiences and health outcomes of ethnic minority colleagues. It is important, however, that focus also remains on improving inclusion more broadly

ED&I during Covid-19

The national focus and research studies pertaining to the poorer health outcomes of BAME individuals has been something of a 'wake up call' for the NHS as a whole and has provided a much needed focus via the NHS People Plan on creating real change in how we create a more diverse workforce from board to ward level. For LWH in particular, Covid has been the catalyst to set up a BAME staff network (for which previously there had been limited interest in uptake). This group, along with a BAME representative on Covid Oversight Committee and some key consultants with a passion for the ED&I agenda, is enabling the voice of BAME staff to be better heard at board level, who are being appraised of the key themes coming from the network. During Covid a staff survey and listening event was conducted with BAME employees specifically. BAME staff were also offered Vitamin D testing. The overall message was that staff generally felt very well supported by the Trust (80%), but many felt anxious about the Covid situation as a whole. Other issues raised included:

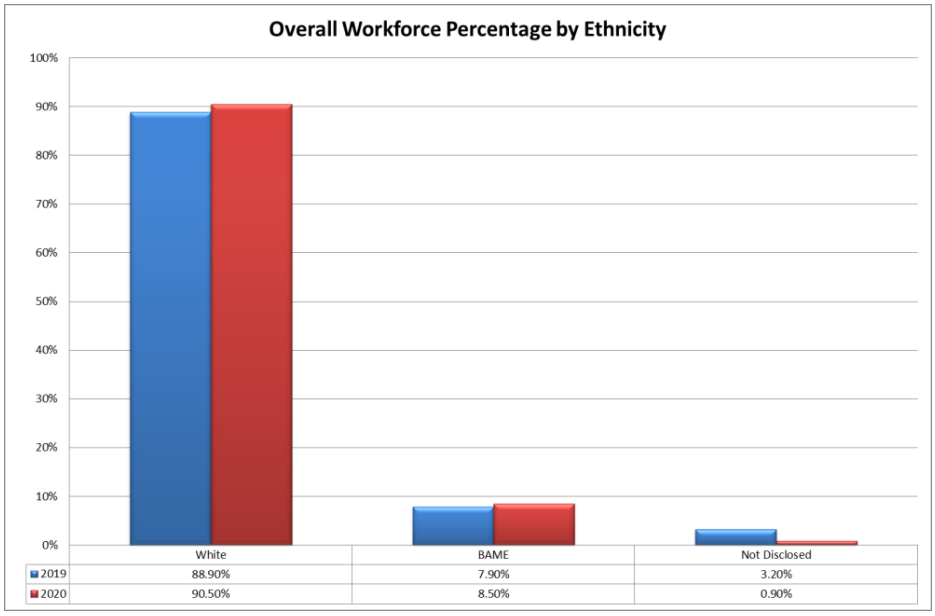
- Some concerns with PPE in the very early part of Covid for those staff who required different types of masks etc which have since resolved with improved supply flow nationally; ppe availability and any associated issues are reviewed daily at the Command meeting
- Quality of risk assessments was variable and was dependent on the person carrying them out which was addressed through education of managers and standardisation of documentation

- It was felt BAME staff should be prioritised for testing; the Trust now has on site testing for symptomatic staff and any symptomatic household member with quick turnaround times and no significant issues with respect to access for any group of staff
- Awareness of managers around the specific issues for BAME staff needed to increase; this has been addressed through ongoing education and will continue to be reviewed through listening events and the network.

WRES

The Workforce Race Equality Standard (WRES) was most recently submitted to NHS England on 30th August 2020, in line with the national deadline.

In summary from the latest submission, it can be evidenced that the workforce remains largely static in relation to the demographics of employees, with a marginal increase from 7.9% to 8.5% of BAME employees, in reality this is most likely due to more people correctly recording their ethnicity.



Band distribution has also not changed with the majority of BAME staff holding clinical Band 5, Band 6 and Band 7 posts. The highest banded non-clinical role remains the same as 2019, one individual at Band 8a. The highest banded clinical role (excluding medics) remains one individual at Band 8b.

The relative likelihood of a white member of staff being appointed from shortlisting stage increased to 1.35 compared to 0.8 in 2019. This evidences that fewer BAME staff are being appointed compared to white staff relative to those who reach interview stage.

88% of BAME staff feel there are equal opportunities for career progression, this is in line with 2017 Staff Survey results and an increase of 10% compared to 2018 results of 78%. This is better than the national average for BAME staff of 76%.

33% of BAME staff have stated they have experienced bullying, harassment or abuse from a colleague, compared to 17% of white staff 29% of BAME staff as the national average for specialist Trusts and needs to better understood, utilising the BAME network.

For the last 2 years there have been no BAME staff entering the formal disciplinary process.

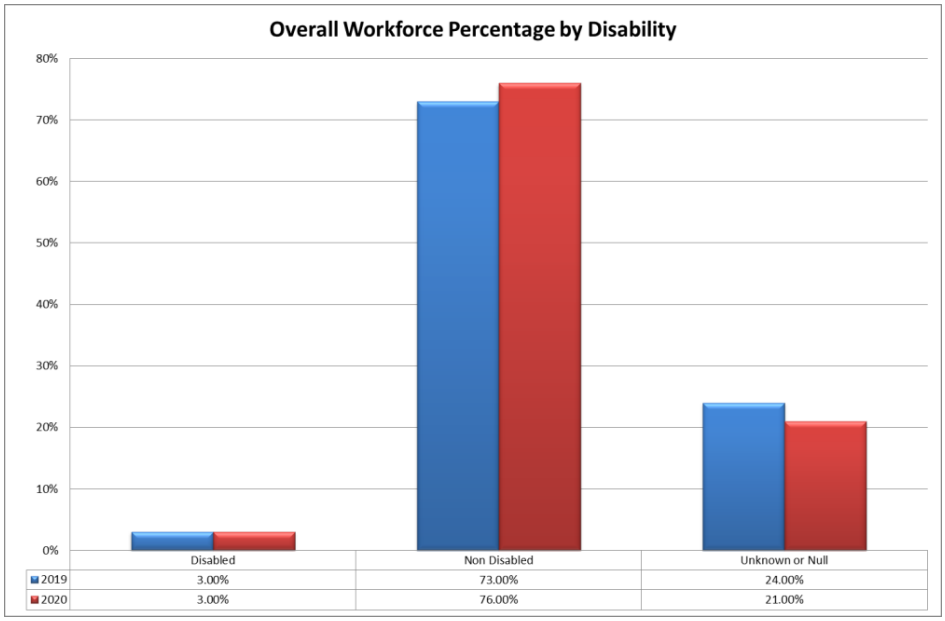
In terms of responding to the data, the WRES action plan is currently being reviewed in the context of the wider review of all E&D activity. Key actions include

- Ongoing listening events on topic of B&H
- Review of ED&I training provision, introduction of cultural awareness training to be piloted in maternity this quarter.
- Career clinics for BAME staff – commencing October 2020
- Mentoring and reverse mentoring schemes – in development
- Specific targets for BAME representation in leadership roles
- Ongoing recruitment audits, positive targeting of applicants via community groups, ongoing widening participation work.

WDES

The Workforce Disability Equality Standard (WDES) was introduced in 2019 and entails a set of 10 specific measures/metrics that will enable NHS organisations to compare the experiences of disabled and non-disabled staff. The deadline for this data submission was successfully met on 31st August 2020.

The data shows that the overall number of disabled staff in the Trust has not changed at 3%. There remains an important issue of staff not wishing to disclose a disability when they commence in post on ESR, though the position has improved slightly since 2019. This remains the topic of ongoing communication.



In terms of band distribution, there are no disabled staff above band 8a in non-clinical roles, but 2 individuals at Band 8a and Band 8b respectively, in clinical roles. There are no disabled medical staff.

In terms of recruitment, non- disabled candidates are 2.32 times more likely to be appointed from shortlisting stage than disabled candidates. 32 disabled staff applied for a job at the Trust in 19/20 and 8 were appointed.

No-one with disability entered into a formal disciplinary process in the 12 months prior to 31st March 2020.

It is concerning that more than double the number of disabled staff (23%) stated in the 2019 Staff Survey that they have experienced bullying, harassment or abuse in the workplace from other colleagues (13%), though this is lower than the national average for disabled staff (27%). Disabled staff are slightly more likely to report it (56%) than non-disabled (51%).

83% of disabled staff believes the Trust provides equal opportunities for career progression compared to 90% of non-disabled employees.

Specific WDES actions in the action plan include

- Expanding programme of internships for disabled staff via widening participation scheme
- Offering career coaching to this cohort of staff
- Ongoing recruitment audits
- Training for managers on reasonable adjustments and supportive approach to attendance management.
- Encouraging staff to declare their disability

Next Steps

Strategic Objective

The Board has previously stated its desire to strengthen the Trust's approach to ED&I in its entirety and set a strategic objective that articulates LWH ambition to be an outstanding organisation in the UK in creating an inclusive culture with diverse leadership at all levels of the organisation.

Following the recent Executive team workshop and the subsequent Board Workshop, the following strategic objective is now proposed.

Be recognised as the most inclusive organisation in the NHS with Zero discrimination for staff and patients (zero complaints from patients, zero investigations)

Equality Objectives

The Trust currently has a set of Equality Objectives which, following the Board's approval of the overarching strategic objective, will be refreshed.

The following actions are already in progress to support delivery of the existing Equality Objectives. The actions have been identified through a range of Workshops, engagement & listening events.

- Treble number of BAME staff in leadership roles (Band 7 and above) by 2022
- Ensure our workforce matches the ward of Riverside in terms of % of BAME staff by 2025
- Positive action at shortlisting stage

- Diverse interview panels for all advertised posts above B6
- Enhanced training offer and career coaching for under-represented groups
- Commitment to appoint % of senior staff to under-represented groups
- Commitment to create a developmental NED role and appoint from an under represented group
- Every senior leader to be offered as a mentor to under-represented groups
- Pilot reverse mentoring
- Approach other Trusts to offer their BAME leaders as mentors for our staff
- Appoint a second Freedom to Speak Up guardian from a diverse group
- Establish staff networks for other groups
- Expand the staff supporters network to proactively recruit diverse members
- Identify partnerships within the city to work collaboratively towards achievement of the strategic objective

The refresh of the Patient Experience Strategy which is due to commence in early 2021 will provide an opportunity to review and refresh the patient related Equality Objectives in the context of the overarching Strategic Objective Equality, Diversity & Inclusion Strategy

Equality, Diversity & Inclusion Strategy

The Putting People First Committee will have oversight of the development and implementation of an Equality, Diversity & Inclusion Strategy for the Trust which will come to the Board for approval by March 2021.

Recommendations

The Board is asked to

- note the annual data pertaining to the Workforce Race Equality Standard (WRES) and the Workforce Disability Standard (WDES)
- note that the organisation has not become significantly more diverse over the last 12 months
- note the actions taken to support and connect with BAME colleagues during Covid-19.
- Approve the strategic objective as set out
- Consider the range of actions to inform the delivery of the existing Equality Objectives
- Approve the proposed process to develop an overarching Equality, Diversity & Inclusion Strategy and update the Equality Objectives

Agenda Item	2020/20/184

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Safer Nurse/Midwife Staffing Report, M5 & M6 2020/21**
DATE OF MEETING:	5th November 2020
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	Gaynor Thomason, Interim 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 EXTERNAL REQUIREMENT	**1.**	Trust Constitution	☐	**4.** NHS Constitution	☐
	2.	Operational Plan	☐	**5.** Equality and Diversity	☐
	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 organisation 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 • Staffing challenges relating to COVID-19 and the mitigating actions being put in place	
PREVIOUSLY CONSIDERED BY:	Committee name	Not Applicable Or type here if not on list: Click here to enter text.
	Date of meeting	

Executive Summary

In response to the National Quality Board (NQB) publication 'Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time: Safe, sustainable and productive staffing (2016)', the report provides assurance regarding the effective use of current Nursing & Midwifery resources for all inpatient clinical areas. The need to consider the wider multidisciplinary team when looking at the size and composition of staff for any setting is recognised, particularly during the Covid-19 pandemic and therefore the report also provides assurance on other relevant staffing groups.

The key areas to highlight for Month 5 & 6 are as follows:

- Fill rate remains high at >90% for Registered Nurses & Midwives
- Absence continues to fluctuate but this is due to Covid-19 related absence. Non-Covid related absence is 3.95% for Nursing and Midwifery and 1.02% for Medical staff and 0% for AHP's
- Nursing and Midwifery vacancies are 6% - M5 and 7%- M6 which are in line with the previous 12 months but there is an increase in vacancies in Gynaecology. HR are working with the HON for Gynaecology to improve recruitment and retention.
- There were 17 red flags relating to staffing in Month 5 & 6.
- Workforce reviews being undertaken will include a skill set review to ensure those rotating to other areas will have the necessary skills and training to do so.
- There are various staff support measures in place during Covid-19
- The neonatal staffing review highlights the majority of BAPM standards are met.
- LWH has now recommenced student placements

Main Report

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.

Processes for monitoring safe staffing and escalating issues

- Daily Staffing Huddle – There are twice daily staffing huddles with representatives from all divisions. The purpose of these huddles is to ensure safe staffing across the Trust and appropriate escalation as required.
- Staffing is monitored across maternity every 2 hours by the 104-bleep holder who has an overview 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.
- Each division undertake workforce reviews bi- annually which are signed off by the DONM. Competencies have now been developed for Nursing and Midwifery staff. A review has been undertaken of band 2,3 & 4 and will form part of the divisional workforce reviews in December. A skill set review is also being undertaken in each area to ensure those staff being required to rotate or work across areas have the necessary skills and training to do so.
- There were 17 Red Flags reported, 14 relating to staffing. 1 of these incidents was classed as a near miss but on investigation appropriate care was given and no harm occurred. All other red flags were low/minor, or no harm and all investigations identified appropriate care was given.

Safer staffing - Exceptions

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.

Fill rates remain good overall. Gynaecology RN fill rates are below 80% for day shifts which corresponds with their current vacancies. Their support worker rates are >100% to support the shortfall in RN's. The twice daily staffing huddle supports the movement of staff to ensure each area is safe based on the acuity of each area.

Maternity fill rates have been variable with MLU having the lowest fill rate. As part of maternity safer staffing the 104 bleep holder monitors staffing and acuity every 2 hours and staff are moved to support areas when required. 11 red flag staffing incidents were raised in maternity with no harm identified.

Safer Staffing – Allied Health Professional (AHP) and Medical

Whilst safer staffing guidance is predominantly focused upon the nursing establishment, the need to consider the wider multidisciplinary team when looking at the size and composition of staff for any setting is noted as being important, particularly during the Covid-19 pandemic. The following section therefore provides a view of the AHP and Medical staffing positions.

<u>AHP Staffing – overview and exceptions</u>

- Sonographers – Currently 5 vacancies, shifts are being filled by staff doing bank shifts. There are

2 students who when qualify will fill 2 posts.
- Physiotherapy – Currently 0 vacancies and 0% sickness in Months 5 & 6.

Medical Staffing – overview and exceptions

The Trust continues to increase its elective activity despite the pressures of the second wave of Covid, whilst adhering to Tier Three requirements and the more general pandemic restrictions. This has been possible because to date, the medical absence rate has remained stable at around 5 % Covid related and 2% non Covid.

Standard medical rotas remain in place for both the consultant and the trainee workforce, but alternative rota plans have been worked through in case staffing levels fall to task critical levels as a result of illness or track and trace isolations. Of note, asymptomatic testing has not yet been reintroduced into the Trust by the regional command bodies but when it is, the loss of around an additional 7% of the medical workforce may be anticipated. The Trust's daily command group, three times weekly clinical advisory group and weekly executive oversight group all remain vigilant in this respect.

Impact of Covid-19

Given the rising Covid-19 incidence Cheshire and Mersey have produced a ward staffing paper (available as a supporting document for the Board) that recognises that at times during the pandemic staffing is likely to go below minimum to a critical level. This has been agreed by C&M DON and the in-hospital cell and is for each trust consideration and local adaptation.

Each Division at LWH has reviewed the paper and produced as part of their Business Continuity Plans a critical staffing level. This has been discussed and agreed at the Covid-19 oversight and scrutiny committee with a request that it also include the skills assessment and a plan for upskilling of appropriate staff. At the start of Covid-19 a skills assessment was undertaken across the Trust to understand what competencies staff had if needed to support areas. This is currently being re-visited and will be completed by mid-November.

A number of measures have been put in place to support the workforce:

- Staff Support Team

There is a new dedicated team for staff support. Training has taken place for the team around listening and signposting. The team has also been recommended to attend the REACT Psychological first aid training offered by Our NHS People to enable them to identify any potential staff issues and how to deal with them.

- Leader Support

Manager Peer Support Network sessions have taken place. There have been 8 sessions in total to support leaders during the pandemic. These sessions enabled leaders from different areas to come together to discuss any issues or problems and to also share good practice.

- Staff Relaxation Areas

Charitable funds have enabled a revamp of the conservatory for staff relaxation, including landscaping of the outside area to encourage staff to sit in the fresh air.

- Schwarz Rounds

The first round is planned for 14th January. Facilitators are due to complete their training in the coming weeks; administrator training is complete.

- Mental Health First Aiders

There are MHF Aiders ready to support staff. More colleagues have been trained virtually to add to the team.

- Resilience Sessions

Resilience sessions have been offered bespoke to teams if needed. Maternity areas, admin areas and Neonatal have taken advantage of this offer. There are also resilience workshops available for staff who would like to attend independently of their team.

Horizon Scanning and Forward Look

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 2,500 midwives in the NHS in England.

During August LWH agreed to take a number of second year students who due to covid had paused some of their training. This was to enable them to complete the necessary placements to commence their third year. This was supported by the HEI and was successful. From September LWH have on placement 19 student nurses and 92 midwifery students with a further 26 to commence in January.
The main impact of COVID-19 has been on community placements due to the changes in service provision. 2 Trainee Nurse Associate's (TNA) commenced their programme with LJMU and LWH in September.

Neonatal Staffing Review

A staffing review was undertaken by HON for Neonates in September 2020. BAPM has set clear standards around the minimum number of nurses required. The majority of the BAPM standards are met, but this is in relation to cot side nursing and does not consider the other roles required within a tertiary service. There has been a reduction in activity which has enabled the Neonatal unit to move towards being BAPM compliant. The review recommended the appointment of another Band 7 within budget to ensure CNST compliance. The Band 7's will also be required to rotate within the partnership to build the expertise and confidence. Due to completion of the new unit there is physical capacity and within the establishment to accept further activity which is currently in the network.

Conclusion and Recommendation

- Fill rate remains high at >90% for Registered Nurses & Midwives
- Absence continues to fluctuate but this is due to Covid-19 related absence. Non-Covid related absence is 3.95% for Nursing and Midwifery and 1.02% for Medical staff and 0% for AHP's
- Nursing and Midwifery vacancies are 6% - M5 and 7%- M6 which are in line with the previous 12 months but there is an increase in vacancies in Gynaecology. HR are working with the HON for Gynaecology to improve recruitment and retention.

- There were 17 red flags relating to staffing in Month 5 & 6.
- Workforce reviews being undertaken will include a skill set review to ensure those rotating to other areas will have the necessary skills and training to do so.
- There are various staff support measures in place during Covid-19
- The Neonatal staffing review highlights the majority of BAPM standards are met.
- LWH has now recommenced student placements

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 organisation 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
- Staffing challenges relating to COVID-19 and the mitigating actions being put in place

Appendix 1

Month 5

WARD	Fill Rate Day% RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff
Gynae Ward	75%	100%	102%	113%
Delivery suite	92%	98%	92%	95%
Mat Base	93%	83%	102%	96%
MLU	92%	65%	92%	100%
Neo-nates	102%	85%	100%	82%
Transitional care	81%	74%	106%	55%
TOTAL	**94%**	**87%**	**97%**	**92%**

Month 6

WARD	Fill Rate Day% RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff
Gynae Ward	76%	113%	112%	113%
Delivery suite	87%	97%	96%	99%
Mat Base	85%	91%	95%	95%
MLU	79%	73%	77%	90%
Neo-nates	105%	97%	103%	108%
Transitional Care	90%	90%	120%	60%
TOTAL	**92%**	**95%**	**98%**	**97%**

Liverpool Women's NHS Foundation Trust

Agenda Item	20/21/185

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Care Quality Commission Update**
DATE OF MEETING:	Thursday, 05 November 2020
ACTION REQUIRED	**Assurance**
EXECUTIVE DIRECTOR:	Gaynor Thomason, Interim Director of Nursing and Midwifery
AUTHOR(S):	Janet Brennan, Deputy Director of Nursing
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 and gain assurance of the updated action plans.* .	
PREVIOUSLY CONSIDERED BY:	**Committee name**	Not Applicable ***Click here to enter text.***
	Date of meeting	***Click here to enter a date.***

Executive Summary

The Care Quality Commission (CQC) carried out an unannounced inspection of the Trust from 3 - 5 December 2019 and an announced 'well-led' inspection from 14-16 January 2020.

During the Core Services inspection conducted 3-5 December 2019, the CQC issued the Trust with a warning notice on 13th December 2019 which stated a failure to ensure that systems and processes were effectively established to ensure the proper and safe management of medicines.

The Trust developed an action plan to address these points. The trust has responded to the CQC with an action plan on 29 May 2020. It is envisaged all the actions will be completed by December 2020. The Divisions were asked to develop their own action plans in response to the trust action plan and have further developing their action plans to include Quality improvements. The overarching updated action plan is reported monthly to the Quality Committee. (Appendix 1)

All current action plans are monitored by the Director of Nursing and Midwifery and the Deputy Director of Nursing & Midwifery and Head of Governance & Quality monthly with the divisions; assurance on progress is also provided as part of the divisional performance reviews.

The key areas to highlight are:

- **Safe and proper management of medicines**: Following the focused inspection on 28 July 2020 the warning notice has been lifted. Focused work continues to ensure actions are embedded.
- **Pathways for Under 18's/ Deteriorating Child:** This action remains RED. Work has been undertaken but progress is slow. Therefore, to support progress the Medical Director has established a task and finish group to help drive the improvements that are required.
- **Resuscitation Equipment**: Compliance is improving however this remains amber until there are at least 6 months of audit results to demonstrate checks are embedded.

- **Health and safety in relation to COSHH**: A new web-based management system in place to allow for greater management of Risk assessments
- **Gynaecology:** No issues were raised relating to gynaecology at the focused inspection in July. The Division have demonstrated improvements in Q2 following the safe and secure audits completed by the pharmacy team as reported to MMC. Issues have been raised at the Ward accreditation and now form part of the improvement plan.
- **Family Health**: All actions achieved or on track to achieve within the timeframes. An additional concern was raised on the focused inspection regarding fridge monitoring.
- **CSS:** All actions are on track to achieve within the timeframes.

Report

The Care Quality Commission (CQC) carried out an unannounced inspection of the Trust from 3 - 5 December 2019 and an announced 'well-led' inspection from 14-16 January 2020. During the Core Services inspection conducted 3-5 December 2019, the CQC issued the Trust with a warning notice on 13th December 2019 which stated a failure to ensure that systems and processes were effectively established to ensure the proper and safe management of medicines. The Trust responded to the warning notice by the deadline noting the immediate steps that had been taken to ensure patient safety was not compromised.

The Trust developed an action plan to address these points. The Trust has responded to the CQC with an action plan on 29 May 2020. It is envisaged all the actions will be completed by December 2020. The Divisions were asked to develop their own action plans in response to the trust action plan and are further developing their action plans to include Quality improvements. The overarching updated action plan is on track and is reported monthly to the Quality Committee.

A further focused inspection was carried out on 28th July 2020. 3 days prior notice was given. Specific data was requested to be available on the day and a request for interviews with specific staff. The area of focus were the issues raised in the warning notice. Several areas were visited.

Further information was requested following the inspection. This information was sent to the CQC in the required timeframe. The trust received the final report and the CQC were satisfied that the trust had actioned issues identified in the warning notice.

All current action plans are monitored by the Director of Nursing and Midwifery and the Deputy Director of Nursing & Midwifery and Head of Governance & Quality monthly with the divisions; assurance on progress is also provided as part of the divisional performance reviews.

Update on actions

- **Safe and proper management of medicines**: Following the focused inspection on 28 July 2020 the warning notice has been lifted. The CQC were satisfied with the actions the Trust had taken regarding the warning notice. The focused inspection identified an issue with the escalation of out of range fridge temperatures. Actions have been undertaken to address this and is part of the Divisional action plans. Focused work continues to ensure actions are embedded.
- **Pathways for Under 18's/ Deteriorating Child:** This action remains RED. This is in the relation to the development of an escalation policy for the deterioration of people under 18. The escalation policy is underway, and several positive mitigations have been implemented to support the safer care for patients under the age of 18. Work has been undertaken but progress is slow. Therefore, to support progress the Medical Director has established a task and finish group to help drive the improvements that are required.

- **Resuscitation Equipment**: Compliance is improving however this remains amber until there are at least 6 months of audit results to demonstrate checks are embedded.
- **Health and safety in relation to COSHH**: A new web-based management system in place to allow for greater management of Risk assessments
- **Gynaecology:** No issues raised relating to gynaecology at the focused inspection in July. The Division have demonstrated improvements in Q2 following the safe and secure audits completed by the pharmacy team as reported to MMC. Issues have been raised at the Ward accreditation and now form part of the improvement plan. The Divisional management team attend a weekly oversight meeting with executives to monitor actions and to provide any support required in achieving the actions.
- **Family Health**: All actions achieved or on track to achieve within the timeframes. An additional concern was raised on the focused inspection regarding fridge monitoring.
- **CSS:** All actions are on track to achieve within the timeframes.

Recommendation

The Board is asked to note and gain assurance of the updated action plans.

Appendix 1- Updated action Plan October 2020

Improvement plan post CQC inspection 2020

Introduction

The Trust has received the CQC Inspection report and returned the factual accuracy response. The CQC report includes 1 warning notice 16 requirements and 23 recommendations under the headings shown below:

1. Safe
2. Caring
3. Responsive
4. Effective
5. Well led

The action plan has been developed to ensure compliance with all the recommendations within the report. It is expected that the action plan will be monitored through the Quality Committee monthly, then to Trust Board by exception.

- Executive Sponsor
- Operational Manager
- Operational Lead
- Issue Description
- Action description with responsible assurance committee
- RAG rating
- Target date for completion of the formulated action.
- Progress update

Red actions have not yet started	Amber actions are actively in progress	Green actions have been completed

2020 inspection- OCT UPDATE

No			Issue	Action	Executive Lead	Operational Manager	Operational Lead	RAG	Completion date	Progress Update
1	**Trust-wide** **SAFE**	**CQC report 23/04/2020 Must Do**	Proper and safe management of medicines, including ensuring that there is a robust process in place for the monitoring of emergency medicines stored on the resuscitation trolleys to make sure that medicines do not exceed the manufacturers recommended expiry dates and are safe to use when needed. (Regulation 12 (1) (2) (g)	1. Develop and embed governance processes in all areas by ensuring area are audited monthly. 2. Quarterly audit by pharmacy of each area. 3. Monthly report to MMC with assurance to Quality Committee	DONM	Divisional Managers	DDONM		August 2020 October 2020 December 2020	Weekly audits which are reviewed at medicines group- reports to MMC. Weekly audits are on power BI- sent to Divisional teams **<u>August 2020</u>** **Added questions to weekly audits following focused inspection** **Quarterly audit being undertaken in July. All divisions presented actions to MMC- August.**

No			Issue	Action	Executive Lead	Operational Manager	Operational Lead	RAG	Completion date	Progress Update
2	**Trust-wide** **SAFE**	**CQC report 23/04/2020 Must Do**	The trust must ensure the equipment used is safe for its intended purpose and ensure all resuscitation equipment is checked regularly and there are appropriate systems to monitor compliance with this. (Regulation 12 (1) (2) (e)	1. All resuscitation equipment will be checked in line with SOP 2. Monthly report to resuscitation committee with assurance to Quality committee	DONM	Divisional Managers	DDONM		August 2020 December 2020	My Kit check is in place trust wide. 100 % compliance reported 08/07/2020. Formal report to be put in place to resus committee by August 2020. SOP completed. For approval at resus committee August 2020. New Clinical Resus Lead in place July 2020. **<u>August 2020</u> Monthly compliance reports to Divisions and resus committee**
3	**Trust-wide SAFE**	**CQC report 23/04/2020 Must Do**	The trust must ensure that their systems and processes operate effectively across all areas	1. Pathways for under 18's will be developed for each service.	DONM	Divisional Managers	DDONM		August 2020 October 2020	Trust wide lead identified- HON, Gynae. Established Task and finish groups with representatives

No			Issue	Action	Executive Lead	Operational Manager	Operational Lead	RAG	Completion date	Progress Update
			of the trust to ensure that they assess, monitor and improve the quality and safety of all services provided and assess, monitor and mitigate the risks to the health, safety and welfare of service users and others who may be at risk. Regulation 17 (2) (a and b)	2. Development of a trust-wide transfer policy 3. Quarterly report to safety senate on each pathway with Assurance to Quality Committee					December 2020	from each Division. The group also involves the Consultant Medic and Nurse for adolescent Gynaecology, a gynaecology specialist nurse from Alder Hey. The group are current working through the Standards for Children's Surgery 2013 to provide a Trust gap analysis which will be completed and an options appraisal by end of July. A paediatric pain tool is about to be introduced in Gynaecology to support patients under

No			Issue	Action	Executive Lead	Operational Manager	Operational Lead	RAG	Completion date	Progress Update
										the age of 18, this will also be helpful for patient who may have a cognitive impairment. Matron Review tool is in place in Gynaecology to ensure all patients under the age of 18 have a senior nurse review. Patient experience survey for use in patients under the age of 18 has been developed and about to be piloted in GOPD. Adult Resuscitation policy currently being reviewed and updated to include children under the age of 18.

No			Issue	Action	Executive Lead	Operational Manager	Operational Lead	RAG	Completion date	Progress Update
										August 2020 **HON met with MD- paper to execs following gap analysis with an options appraisal** **New resus policy has been updated to reflect paediatric resus.**
4	**Trust-wide** **SAFE**	**CQC report 23/04/2020 Must Do**	The trust must ensure that their systems and processes operate effectively across all areas of the trust to ensure that they assess, monitor and improve the quality and safety of all services provided and assess, monitor	1. Health and Safety COSHH risk assessments will be in place and chemicals stored appropriately. 2. Bi- Annual audits reported to Safety senate with Assurance to Quality Committee	DONM	Divisional Managers	DDONM		August 2020 December 2020	COSHH is part of weekly audits The annual COSHH audit/risk assessments were due by 29th June 2020, however, due to Covid those risk assessments have taken priority so will be completed

No			Issue	Action	Executive Lead	Operational Manager	Operational Lead	RAG	Completion date	Progress Update
			and mitigate the risks to the health, safety and welfare of service users and others who may be at risk. Regulation 17 (2) (a and b)							by August 2020. Roll out of the COSHH Management System in August. This system won't require an annual audit, on-going compliance and dashboards will be readily available and automatic reminders will be system generated when a risk assessment requires update or review
5	**Trust-wide**	**CQC report 23/04/2020 Must Do**	The trust must ensure that patients receive care in a timely way and work towards improving performance against national standards such	1. Waiting times will be met in line with National Standards. 2. Monthly monitoring at Access Board with Assurance to FPBD	DOP	Divisional Managers	DDOP		(Awaiting national guidance following pandemic)	The inspection was undertaken pre-covid, in response to the pandemic actions were taken in line with national guidance which

No			Issue	Action	Executive Lead	Operational Manager	Operational Lead	RAG	Completion date	Progress Update
			as the time from diagnosis to treatment. Regulation 12 (2)							severely impacted its ability to meet current elective care standards (Which are under review).
6	**Trust-wide** **EFFECTIVE**	**CQC report 23/04/2020 Must Do**	The trust must ensure that their audit and governance systems remain effective. Regulation 17 (2)(f)	1. The Trust Audit plan will ensure all national guidance is taken account of with a Risk assessment. 2. Bi- Annual reports to Effectiveness senate with Assurance to Quality Committee	MD	Divisional Managers	DMD		September 2020 December 2020	Forward audit plan completed and agreed at QC
7	**Gynae/ CSS** **SAFE**	**CQC report 23/04/2020 Must Do**	The service must ensure the proper and safe management of medicines, including ensuring that there is a robust process in place for the monitoring of	1. Develop and embed governance processes in all areas by ensuring areas are audited monthly. 2. Quarterly audit by pharmacy of each area.	DONM	Divisional Managers	DDONM		August 2020 October 2020 December 2020	Monthly report of medicines audits to Divisional Governance meeting and Board. Monthly report to MMC.

No			Issue	Action	Executive Lead	Operational Manager	Operational Lead	RAG	Completion date	Progress Update
			emergency medicines stored on the resuscitation trolleys to make sure that medicines do not exceed the manufacturers recommended expiry dates and are safe to use when needed. (Regulation 12 (1)(2)(g)	3. Monthly report to MMC with assurance to Quality Committee						Quarterly audit will be shared with Division once completed (August MMC), action plans developed and monitored through MMC- completed in August **<u>August 2020</u>** **Nominated Consultant lead identified to support Medicines safety. Deep dive of medication incidents has been completed. Presented in Division, MMC and Safety Senate.**
8	**Gynae/ CSS** **SAFE**	**CQC report 23/04/2020 Must Do**	The service must ensure that patients receive care in a timely way and work	1. Waiting times will be met in line with National Standards.	DOP	Divisional Managers	DDOP		(Awaiting national guidance following pandemic)	The inspection was undertaken pre-covid, in response to the pandemic

No			Issue	Action	Executive Lead	Operational Manager	Operational Lead	RAG	Completion date	Progress Update
			towards improving performance against national standards such as the time from diagnosis to treatment. Regulation 12 (2)	2. Benchmark with other TOP services and provide a report to effectiveness senate with Assurance to Quality Committee. 3. Monthly monitoring of waiting times at Access Board with Assurance to FPBD					September 2020 December 2020	actions were taken in line with national guidance which severely impacted its ability to meet current elective care standards (Which are under review).
9	**Gynae** **EFFECTIVE**	**CQC report 23/04/2020 Must Do**	The service must ensure they have enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment on the ward. Regulation 18(1)(2)(a)	1. Training needs analysis will be undertaken. 2. Competencies will be developed for the Nursing team. Identified timeframes with Assurance at PPF 3. Medical staff will be appointed	DONM	Divisional Managers	DDONM		September 2020 October 2020 December 2020	Training needs analysis completed Trust-wide competencies being developed for all Registered staff 2 further Consultants appointed in Gynaecology June 2020. **August 2020**

No			Issue	Action	Executive Lead	Operational Manager	Operational Lead	RAG	Completion date	Progress Update
										RSCN cover for under 18 patients
10	**Gynae** **SAFE**	**CQC report 23/04/2020 Must Do**	The service must ensure that there is a system in place to manage the deterioration of a poorly young person between the age of 16 and 18 years old. Regulation 12(1)(2) (c	1. Pathways for under 18's will be developed for each service. 2. An escalation policy will be developed for the deterioration of people under 18 3. Quarterly report to safety senate on each pathway with Assurance to Quality Committee	DONM	Divisional Managers	DDONM		August 2020 October 2020 December 2020	**<u>August 2020</u> News 2 has been identified as suitable for aged 16 and over.** Use of PEWS is being considered the task and finish group. Deteriorating patient policy to be updated to include 16-18 and under. **<u>August 2020</u> SLA to be agreed with AHH, this is included within the gap analysis**
11	**Gynae** **EFFECTIVE**	**CQC report 23/04/2020 Must Do**	The service must ensure staff looking after young people have the right qualifications, skills, training	1. Review of national guidance and what training/ requirements are in scope	DONM	Divisional Managers	DDONM		August 2020 September 2020	Training needs analysis completed Trust-wide competencies being developed for

No			Issue	Action	Executive Lead	Operational Manager	Operational Lead	RAG	Completion date	Progress Update
			and experience to keep them safe from avoidable harm. Regulation 12 (2) (c)	2. Training needs analysis will be undertaken. 3. Competencies required for the Nursing team. Identified timeframes with Assurance at PPF.					December 2020	all Registered Nursing/ Midwifery staff- to be completed September 2020 as part of N&M strategy.
12	**Gynae** **WELL-LED**	**CQC report 23/04/2020 Must Do**	The provider must ensure leaders of the service are familiar with and understand the risks to the service.	1. Education of all staff will be undertaken of the risk register and risks associated with the service. 2. Knowledge and understanding of this will be checked monthly and reported to Divisional Board with Assurance at Quality Committee	DONM	Divisional Managers	DDONM		August 2020 September 2020	Governance on a page shared monthly at senior nurse and governance meeting. All managers share with teams including risks

No			Issue	Action	Executive Lead	Operational Manager	Operational Lead	RAG	Completion date	Progress Update
13	**Neo-nates** **SAFE**	**CQC report 23/04/2020 Must Do**	The service must ensure the proper and safe management of medicines, including ensuring that there is a robust process in place for the monitoring of emergency medicines stored on the resuscitation trolleys to make sure that medicines do not exceed the manufacturers recommended expiry dates and are safe to use when needed. (Regulation 12 (1) (2) (g) (e)	1. Develop and embed governance processes in all areas by ensuring area are audited monthly. 2. Monthly checks by resus officers with a report to resus committee quarterly with Assurance to Quality committee 3. Quarterly audit by pharmacy of each area. 4. Monthly report to MMC with assurance to Quality Committee	DONM	Divisional Managers	DDONM		August 2020 December 2020 October 2020 December 2020	New SOP in place for checking Resus equipment New lockable resus trolleys in place New checklist which includes expiry dates Monthly report to MDT and Divisional Board Quarterly pharmacy audits- action plan developed and monitored through MDT and MMC
14	**Maternity** **SAFE**	**CQC report 23/04/2020 Must Do**	The service must ensure the proper and safe management of	1. Develop and embed governance processes in all areas by ensuring	DONM	Divisional Managers	DDONM		August 2020	Continual audit as part of maternity risk audit cycle, with final

No			Issue	Action	Executive Lead	Operational Manager	Operational Lead	RAG	Completion date	Progress Update
			medicines, including the proper storage of medicines (Regulation 12 (1) (2) (g)	area are audited monthly. 2. Quarterly audit by pharmacy of each area. 3. Monthly report to MMC with assurance to Quality Committee					October 2020 December 2020	assurance submitted monthly to Family Health Divisional Board Spot checks completed as well as weekly audits Revised forceps trolley checklist Lesson of the week developed and circulated in various ways Quarterly pharmacy audits- action plan developed and monitored through Governance and MMC
15	**Maternity** **SAFE**	**CQC report 23/04/2020 Must Do**	The service must ensure the equipment used is safe for its intended purpose and ensure all	1. All resuscitation equipment will be checked in line with SOP	DONM	Divisional Managers	DDONM		August 2020	My Kit check is in place trust wide. 100 % compliance reported 08/07/2020.

No			Issue	Action	Executive Lead	Operational Manager	Operational Lead	RAG	Completion date	Progress Update
			resuscitation equipment is checked regularly and there are appropriate systems to monitor compliance with this. (Regulation 12 (1) (2) (e)	2. Monthly audit report to resuscitation committee with assurance to Quality committee .					December 2020	Formal report to be put in place to resus committee by August 2020. SOP completed. For approval at resus committee August 2020. Local audits reviewed and monitored through governance **<u>August 2020</u>** **MyKit check monthly compliance reports monitored through divisional Board**

No			Issue	Action	Executive Lead	Operational Manager	Operational Lead	RAG	Completion date	Progress Update
16	**Gynae**	**CQC report 23/04/2020 Should do**	The provider should ensure there is appropriate tool to assess pain.	1. Pain assessment tool will be developed, implemented and audited. 2. Quarterly audits reported to Effectiveness senate with assurance to Quality committee	DONM	Divisional Manager	DDONM		August 2020	Pain tool developed and in use however doesn't include a visual Q for those under 18. Alder Hey Tool under review Monthly audits of use of pain tool and monitored at Gynae senior nurse meeting **August 2020** **Tool and associated SOP to come to Gynaecology Governance meeting in August for ratification.**
17	**Gynae**	**CQC report 23/04/2020 Should do**	The provider should ensure all staff complete their mandatory training.	1. All staff to complete their mandatory training within an agreed trajectory.	DONM	Divisional Manager	DDONM		June 2020-completed December 2020	Trajectory developed and monitored at Divisional Board and performance review

No			Issue	Action	Executive Lead	Operational Manager	Operational Lead	RAG	Completion date	Progress Update
				2. Quarterly reports with assurance to PPF						
18	**Gynae**	**CQC report 23/04/2020 Should do**	The provider should ensure all staff complete their safeguarding training.	1. All staff to complete their safeguarding training within an agreed trajectory 2. Quarterly reports with assurance to PPF	DONM	Divisional Manager	DDONM		June 2020- completed December 2020	Trajectory completed and compliance monitored at Gynae senior nurse and Divisional Board **<u>August 2020</u>** **SGA below compliance due to application of Band 5 to SGA L3. Compliance to be reached by December 2020. To mitigate any risk, all band 6, Band 7 and Matrons have been trained in SGA L3.**
19	**Gynae**	**CQC report 23/04/2020 Should do**	The provider should ensure they have a vision in place which is	1. The Trust vision/values and strategy needs to be embedded	DONM	Divisional Managers	DDONM		September 2020	Part of operational plan – strategy will form part of this and

No			Issue	Action	Executive Lead	Operational Manager	Operational Lead	RAG	Completion date	Progress Update
			underpinned with values and a strategy	across the services and services need to align their own strategy to this 2. Monthly reports to Divisional Board with Assurance at PPF quarterly					December 2020	will be communicated across the division and visible in areas
20	**Gynae**	**CQC report 23/04/2020 Should do**	The provider should ensure they support the needs of dementia patients or patients with any other protected characteristics.	1. Pathways for patients with protected characteristics will be developed. 2. Audit of pathway to be completed with report to patient experience committee with assurance to Quality Committee.	DONM	Divisional Managers	DDONM		September 2020 December 2020	Review commenced **<u>August 2020</u>** **Dementia Champions to be identified within the ward.** **EDI lead identified for the Division. We will use EDS2 as a framework for evidence of how the Division support patients with protected characteristics.**

No			Issue	Action	Executive Lead	Operational Manager	Operational Lead	RAG	Completion date	Progress Update
21	**Gynae**	**CQC report 23/04/2020 Should do**	The provider should ensure the leadership structure is stabilised.	1. Divisional leadership and ward leadership will be developed and stabilised.	DONM	Divisional Managers	DDONM		September 2020	Substantive matron now in post Senior team OD support sought **<u>August 2020</u>** **Ward manager returned from absence comprehensive support package has been in place during phased return**. Matron and ward manager competencies being developed Trust- wide Survey implemented for Staff- how they feel today Listening events held with Divisional manager and HON **<u>August 2020</u>** **OD away days for Senior nurses in**

No			Issue	Action	Executive Lead	Operational Manager	Operational Lead	RAG	Completion date	Progress Update
										Division on 1st September.
22	**Neo-nates**	**CQC report 23/04/2020 Should do**	The service should consider implementing a staffing board on the low dependency unit so that it is visible to the public.	1. Staffing board will be placed on the low dependency unit	DONM	Divisional Managers	DDONM		July 2020	Completed
23	**Neo-Nates**	**CQC report 23/04/2020 Should do**	The service should ensure that cleaning products which are hazardous to health are consistently stored securely to prevent potential risk to patients and visitors in line with national patient safety alert requirements. Regulation 12(2)(b)	1. Health and Safety COSHH risk assessments will be in place and chemicals stored appropriately. 2. Bi- Annual audits reported to Safety senate with Assurance to Quality Committee	DONM	Divisional Managers	DDONM		September 2020	Secure unit in place for all COSHH products COSHH risk assessments completed
24	**Neo-Nates**	**CQC report 23/04/2020 Should do**	The service should consider a review of its governance processes for the monitoring of daily resuscitation equipment checks to make sure that equipment is safe and ready for use.	1. All resuscitation equipment will be checked in line with SOP 2. Monthly audit report to resuscitation committee with assurance to	DONM	Divisional Managers	DDONM		August 2020 December 2020	SOP in place for checking Resus equipment My Kit check (trust wide) in place Equipment checked daily by shift co-ordinator and monthly by

No			Issue	Action	Executive Lead	Operational Manager	Operational Lead	RAG	Completion date	Progress Update
			Regulation 12(1) (2) (e	Quality committee						matron and reported to senior ops meeting, MDT and Divisional Board
25	**Neo-nates**	**CQC report 23/04/2020 Should do**	The service should consider a review of the arrangements for the storage of emergency equipment so that it is clear to staff what should be included, so that missing sundries can be easily identified during the regular checks. Regulation 12(1) (2) (e	1. All resuscitation equipment will be checked in line with SOP 2. Monthly audit report to resuscitation committee with assurance to Quality committee	DONM	Divisional Manager	DDONM		August 2020 December 2020	New lockable trolleys in all rooms New checklists in place Daily monitoring by shift co-ordinator and monthly by Matron
26	**Neo-nates**	**CQC report 23/04/2020 Should do**	The service should ensure that medicines related stationery is stored securely and cannot be accessed by unauthorised persons	1. All medicines related stationery will be kept in a secure place and only accessed by authorised personnel	DONM	Divisional Managers	DDONM		May 2020-completed August 2020	Stationary now placed in a locked cupboard Medicine audits twice weekly on NICU and weekly on LDU

No			Issue	Action	Executive Lead	Operational Manager	Operational Lead	RAG	Completion date	Progress Update
				2. Develop and embed governance processes in all areas by ensuring area are audited monthly. 3. Quarterly audit by pharmacy of each area. 4. Monthly report to MMC with assurance to Quality Committee					October 2020 December 2020	Quarterly pharmacy audits- action plan developed and monitored through MDT and MMC
27	**Neo-nates**	**CQC report 23/04/2020 Should do**	The service should consider a review of the monitoring process for the recording of medication storage temperatures so that documentation reflects action staff have taken when temperatures have exceeded the maximum range.	1. Develop and embed governance processes in all areas by ensuring areas are audited monthly 2. Monthly report to MMC with assurance to Quality Committee	DONM	Divisional Managers	DDONM		September 2020 December 2020	Appropriate monitoring documentation in place Weekly checks by ward manager Audit added to monthly medicines report

No			Issue	Action	Executive Lead	Operational Manager	Operational Lead	RAG	Completion date	Progress Update
28	**Neo-nates**	**CQC report 23/04/2020 Should do**	The service should consider a review of its guidelines and policies so that expected review dates are clearly visible to staff.	1. All guidelines and policies to include review dates. 2. Ensure education of all staff on the policies. 3. Knowledge and understanding of this will be checked monthly and reported to Divisional Board with Assurance at Quality Committee	DONM	Divisional Managers	DDONM		September 2020 September 2020 November 2020	All policies have a review date and are accessed via Badger All staff have and know how to access policies Policies are reviewed weekly by Consultants and minuted in Consultant meetings
29	**Neo-nates**	**CQC report 23/04/2020 Should do**	The service should consider a review of the information available to parents and their families on the units so that it can be requested it in alternative formats or	1. The information that is available to parents and their family's will be stated clearly that it can be requested in alternative	DONM	Divisional Managers	DDONM		July 2020-Completed	Poster now in place to ensure parents are aware that resources are available in different languages and formats.

No			Issue	Action	Executive Lead	Operational Manager	Operational Lead	RAG	Completion date	Progress Update
			languages to meet their needs.	languages and formats						
30	**Trust-wide**	**Focused inspection 28 July 2020**	Some inconsistent practice in relation to the monitoring of medicines stored in fridges	1. SOP to be reviewed and ratified at MMC 2. Questions relating to fridge temperatures to be added to weekly audits and Monthly LWH accreditation audits and monitored through divisional boards. 3. Compliance with SOP to form part of safe and secure medicines audit 4. Business case for electronic fridge temperature monitoring	DONM	Divisional Managers	DDONM		December 2020	**<u>September 2020</u>** SOP ratified Questions now included in weekly audits and monthly accreditation audits Business case agreed.

No			Issue	Action	Executive Lead	Operational Manager	Operational Lead	RAG	Completion date	Progress Update
31	**Trust-wide**	**Focused inspection 28 July 2020**	Inconsistent roll out of My Kit Check	1. Development of SOP for MyKITCheck. 2. Monthly compliance report to divisional boards and resuscitation committee with assurance to Quality committee	DONM	Divisional Managers	DDONM		December 2020	

Liverpool Women's NHS Foundation Trust

Agenda Item	20/21/186

MEETING	**Trust Board**
PAPER/REPORT TITLE:	**Safeguarding Annual Report 2019/20**
DATE OF MEETING:	**Thursday, 05 November 2020**
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	**Gaynor Thomason** **Interim Director of Nursing and Midwifery**
AUTHOR(S):	**Mandy McDonough, Associate Director of Nursing and Midwifery for Safeguarding**
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	☐	**4.** NHS Constitution	☐
	2. Operational Plan	☐	**5.** Equality and Diversity	☐
	3. NHS Compliance	☒	***6.*** Other:	
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 is requested to • note an overview of safeguarding practice across the Trust and receive assurance that systems and processes are in place to protect vulnerable Children and Adults • receive and approve the Annual Report.			
PREVIOUSLY CONSIDERED BY:	**Committee name**	Hospital Safeguarding Board		
	Date of meeting	Tuesday, 13 October 2020		

Executive Summary

The Safeguarding Annual Report for Children, Young People and Adults is to provide an overview of Safeguarding activity within the Trust for the period 1st April 2019 – 31st March 2020 and to assure our Board of Directors that the Trust has effective systems and processes in place to safeguard patients who access services provided within Liverpool Women's NHS Foundation Trust.

Safeguarding remains a fundamental component of all care within the Trust and we have again this year ensured that we respond effectively and efficiently to the challenges of safeguarding both our patients and our staff.

The Hospital Safeguarding Board (HSB) and Safeguarding Operational Group (SOG), continue to provide the Board of Directors, Clinical Commissioning Group (CCG) and External Safeguarding Boards with assurance of our ability to respond effectively and demonstrate accountability, for all aspects of safeguarding Children, Young People and Adults.

The report will outline the key priorities for the coming 12 months which are central to supporting core safeguarding activities and demonstrate the organisations compliance with Section 11 of the Children Act (2004) and the Care Act (2014).

Board Approval

The Trust Board is requested to

- note an overview of safeguarding practice across the Trust and receive assurance that systems and processes are in place to protect vulnerable Children and Adults
- receive and approve the Annual Report.

Once approved the report will be submitted to the Liverpool, Sefton and Knowsley Safeguarding Children's Board's and the combined Pan-Merseyside Safeguarding Adult Board and become a composite with other partner organisations.

Contents

Introduction

Liverpool Women's NHS Foundation Trust (LWH) understands and acknowledges that safeguarding is everybody's business and everyone working in health care has a responsibility to help prevent abuse and to act quickly and proportionately to protect children, young people and adults when abuse is suspected.

Maintaining the function and quality of all aspects of safeguarding practice across the Trust is essential; with a particular focus on ensuring effective strategic Safeguarding leadership is in place.

This year the Safeguarding Team have continued to implement relevant Safeguarding processes; establishing robust governance and assurance processes and embedding a continually developing Safeguarding Strategy.

National Context

Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework (2019) which is now referred to as the Safeguarding Accountability and Assurance Framework (SAAF); clearly sets out the safeguarding roles and responsibilities of all individuals working in providers of NHS funded care settings and NHS commissioning organisations.

It is the first joint NHS England and NHS Improvement Safeguarding Accountability and Assurance Framework and strengthens the NHS commitment to promoting the safety, protection and welfare of children, young people and adults.

The framework provides guidance and minimum standards but should not be seen as constraining the development of effective local safeguarding practice and arrangements in line with the underlying legal duties. The responsibilities for safeguarding form part of the core functions for each organisation and must therefore be discharged within agreed baseline funding.

Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children' (2018) is the government's statutory guidance for all organisations and agencies who work with, or carry out work related to, children and young people -agency working and for promoting the welfare of children from all backgrounds, in all settings.

Summary of Current Position

A number of key areas of priority were identified and outlined in the 2018/19 Safeguarding Annual Report:

Number	Objective	RAG Status
1	Ensure the newly embedded Safeguarding Adults Intercollegiate (August 2018) guidance is assessed via the unannounced inspection programme for 2019/20	
2	Ensure that all safeguarding processes currently in place are replicated robustly within electronic health records and enable greater confidential sharing of safeguarding information across the workforce (EPR)	
3	Continue to develop enhanced data-sets for specific Trust safeguarding agendas to assist strategic direction for resource allocation and improve the ability of external partners to present an accurate picture of the local safeguarding landscape	
4	Building on the recognised good practice of Liverpool Women's when recognising and responding to domestic abuse as a healthcare issue; plan and host a multi-agency event aimed at Commissioners, managers and other professionals working in the NHS, Police, Social Care / Local Authorities and the wider public, private, voluntary and community sectors to showcase the Trust as an exemplar	
5	Complete a full self-assessment against the new Section 11 standards detailed within the new Working Together 2018 guidance	
6	Complete a full self-assessment against the new Learning Disability improvement standards detailed within the NHS Improvement guidance (July 2018)	

7	Review the current established processes and arrangements for patients, detained under the Mental Health Act 1983 with a view as to providing further assurance that the Trust are meeting its statutory obligations	
8	Develop a 'Voice of the Child Practice Guidance' for Liverpool Women's Health Professionals and Midwives to ensure the ability to capture the unborn	

Throughout the reporting period for 2019/20, significant progress has been made with the safeguarding children, young people and adult's work plans ensuring that the Trust is able to meet the overall objective to:

Ensure that Liverpool Women's NHS Foundation Trust safeguarding arrangements are statutory compliant with appropriate legislation and national/local guidance in respect of those identified as at risk

The key objectives for 2020/21 will be summarised at the end of this report.

Safeguarding Arrangements at Liverpool Women's

Liverpool Women's takes care of more than 50,000 patients from Liverpool, the surrounding areas and across the UK. Along with hospital based contact, delivering around 8,500 babies and performing some 10,000 gynaecological procedures annually; we provide care for patients within the community and at the Aintree Centre for Women's Health, which is based at Aintree University Hospitals NHS Foundation Trust.

Supporting that activity, the Safeguarding Team is an established, fully integrated, multi professional service, comprising of Senior Health and Social Care Professionals with experience in Midwifery, A&E, Critical Care, Elderly and Social Care; and who are able to act both strategically and operationally in preventing and investigating potential abuse.

The Associate Director of Nursing and Midwifery for Safeguarding (ADN), with executive leadership from the Director of Nursing and Midwifery, ensures safeguarding expertise and clinical/strategic safeguarding leadership is available within Liverpool Women's for children and adults.

The following diagram reflects the scope of Liverpool Women's Safeguarding Service and the statutory partners we work alongside to ensure we are able to provide specialist support and safeguard children, young people and families as appropriate.

Safeguarding Service Scope and Statutory Partners

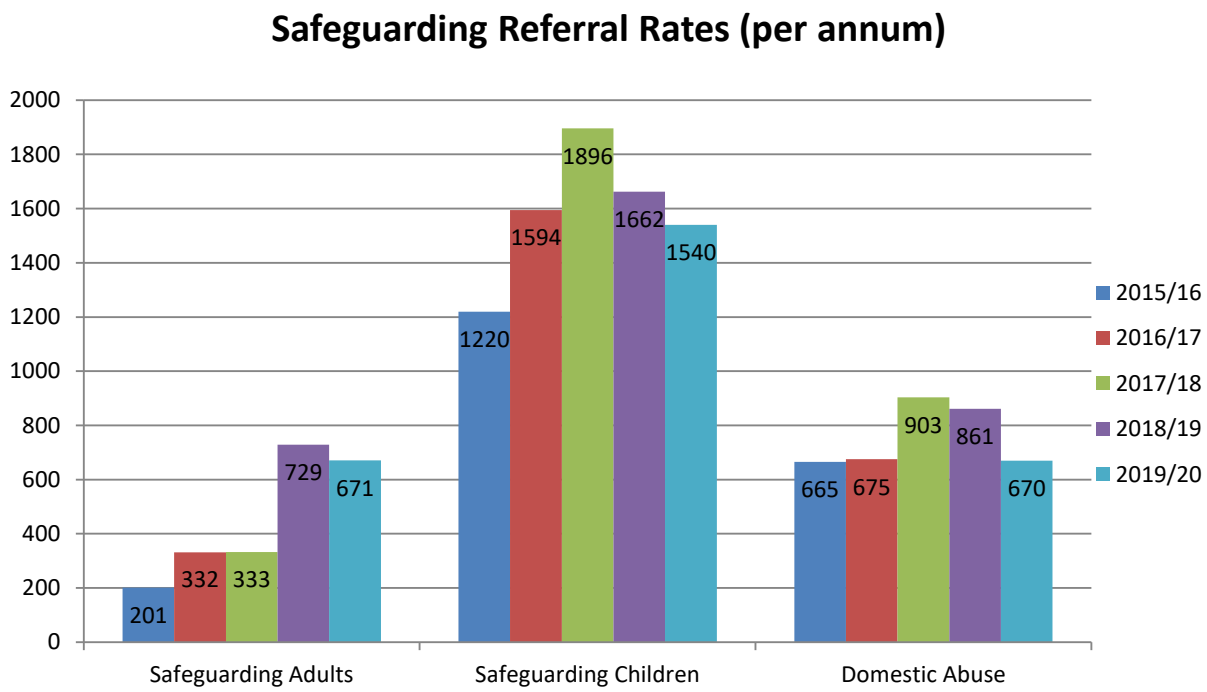
Safeguarding Children

- Child Sexual Exploitation
- Child Criminal Exploitation
- Fabricated Induced Illness
- Serious Case Reviews
- NAI
- Looked After Children
- Neglect

Safeguarding Adults

- Mental Capacity
- DoLS
- Forced Marriage
- Honour Based Violence
- Female Genital Mutilation
- Restraint
- Learning Disabilities
- Dementia
- Neglect
- Modern Slavery
- Allegations Against Staff
- Human Trafficking
- Domestic Abuse
- Prevent Duty

Safeguarding Performance Data Overview



For the first time in five years there has not been an increase in operational workload and the amount of Safeguarding referrals received by the service has decreased (371 less than in 2018/19).

Compared to previous years the amount of domestic abuse and safeguarding children referrals has noticeably decreased. This can be attributed to staff learning from the feedback process which is firmly embedded into the referrals, alongside the changes made to the Safeguarding Children Level 3 Training; which now includes more specific training around applying the 'Levels of Need' for a child. The slight reduction in Safeguarding Adult referrals can be attributed to the embedding of the Safeguarding Adults Intercollegiate Document (*now ratified*).

Also this year we have delivered more bespoke training to individual clinical areas and added specific scenarios for the professionals attending the individual sessions; which will account for an increased knowledge.

Whilst it is acknowledged that a reduction may be attributed to an improved staff understanding and subsequent improved quality in referrals; the largest reduction

identified has been Merseyside Police Referrals. We believe this is attributed to the revised processes implemented force wide last year around structural changes to their workforce and some of their administrative function. This was centralised and standardised across the force, combining much of the workload into one locality to provide support and dedicated resources on a Pan-Merseyside basis.

Alongside this, the software Police use to create their referrals (VPRF1) was updated, in order to gather more safeguarding history automatically and incorporate it into the information shared along with the referral. In order to comply with new General Data Protection Regulation (GDPR) regulations and the new Data Protection Act 2018, the “Levels of Need” were applied to their referrals, to ensure consent processes are adhered to. This change was in order to improve agencies ability to make decisions on the information provided. It was envisioned that the changes would also result in a better quality of referral in terms of information shared. Although perhaps reduced, it was hoped that referrals would be more appropriate.

The revised processes are now firmly embedded Force wide which will account for a reduction in referrals to us. More importantly, as forecast, there has been an improvement in the quality of referrals this year which is less of an impact on our capacity when gathering appropriate and relevant information.

Safeguarding Children

As all NHS health services, including Foundation Trusts are required to identify a Named Doctor and Named Professional for Safeguarding Adults and Children and a Named Midwife (if the organisation provides maternity services); Liverpool Women's continues to support the statutory requirements with the roles of the Associate Director of Nursing and Midwifery for Safeguarding who is the Trust's Named Nurse and Midwife for Safeguarding Children and Dr Helen Chitty who is the current Named Doctor for Safeguarding Children.

As reported in last year's Annual Report, the revised Working Together to Safeguard Children (2018) set out a number of changes required to support the new system of multi-agency safeguarding arrangements established by the Children and Social Work Act (2017).

The changes required were around Multi-Agency Safeguarding Arrangements (MASAC), Child Death Reviews (previously Child Death Overview Panel) and National and Local Safeguarding Reviews (previously Serious Case Reviews); and have now been implemented.

Although the new arrangements are very much in the early stages, as a statutory partner of Liverpool, Sefton and Knowsley Safeguarding Children Boards, Liverpool Women's has continued in our commitment to those boards, fulfilling our role in relation to safeguarding practices.

National and Local Safeguarding Reviews (previously Serious Case Reviews)

The Child Safeguarding Practice Review Panel are responsible for identifying and overseeing the review of serious child safeguarding cases and raise issues that are complex or of national importance.

In this reporting period, the Trust has provided information and been involved in two reviews; one commissioned by Liverpool Local Authority and one commissioned by Sefton Local Authority.

Although Liverpool Women's featured in both reviews; there were no single agency actions or recommendations for the Trust from either review. This highlights appropriate, effective processes in place within the Trust.

Child Exploitation (CE)

All staff must be alert and vigilant to the possibility of Child Sexual/Criminal Exploitation when caring and in contact with under 18 year olds. If it is suspected the child must be referred to the Trust Safeguarding Team and the appropriate Local Authority. Staff can refer to the Pan-Merseyside Multi-Agency Protocol for Child Exploitation for further guidance.

Regardless of whether exploitation is suspected, if a child is under the age of 13, is known to be sexually active and accesses services from Liverpool Women's, a referral should be made to children's Social Care. The concerns should be reported immediately to the Safeguarding Team as consideration will need to be made around making a Police referral.

Bespoke enhanced CSE/CE Training is delivered by the Safeguarding Team to the Trust's unplanned care settings such as Bedford Clinic and the Gynaecology Emergency Room.

Early Help Assessment Tool (EHAT)

The Early Help Assessment Tool (EHAT) is used for identifying children/young people and families who would benefit from the provision of additional services and where universal services do not meet any identified needs. The assessment promotes a coordinated service response to meet those needs and to significantly improve the outcomes for the child.

Historically Liverpool Women's have had some difficulties in the completion of Early Help documentation in relation to the information required and have explored many different options including whether a midwifery reduced version or pre-EHAT would be more appropriate.

This has now been agreed and a 12 month pilot of the process change will be starting in September 2020. Midwifery Services will be able to make referrals to the Early Help service using the pre EHAT form for families that are in need of an Early Help assessment and Team around the Family plan. This will enable all midwifery staff to record vital information and observations obtained through routine midwifery care and share with external partners/agencies. It will also reduce possible referrals that do not meet the appropriate level of need going through to Children's Services.

The progress of this pilot will be monitored via the Hospital Safeguarding Board and our external Multi-Agency Safeguarding Arrangements (MASAC).

Looked After Children (LAC)

A 'Looked after Child' (LAC) is a child who has been in the care of their Local Authority for more than 24 hours. They are also referred to as 'Children in Care' or 'Care Experienced'. In England, the legal definition of a looked after child is derived from the Children Act 1989, whereby a child is legally defined as 'looked after' by a Local Authority if he or she:

- ✓ is provided with accommodation for a continuous period for more than 24 hours
- ✓ is subject to a care order; or
- ✓ is subject to a placement order

Healthcare services have a responsibility to keep children safe. Therefore if a LAC accesses the Trust via unscheduled care, staff can access the Child Protection Information Sharing (CP-IS); which connects Local Authority Children's Social Care systems with those used by NHS unscheduled care settings and Maternity Units. Access to information is instant and enables vulnerable children to be identified wherever they are cared for in England.

Staff are asked to notify the Safeguarding Team of this young person's admission or attendance in order for any relevant information sharing with the relevant Social Worker and Local Authority.

Voice of the Child

Failure to listen to children and ensure that their views are taken into account in child protection cases has been highlighted in many Serious Case Review (SCR) findings.

Actively involving children to communicate their experiences of care, with a particular emphasis on how a service has helped to improve their health and wellbeing, is essential in ensuring that the care we provide is improving children's lives and keeping them safe. However, this can be difficult in a provider organisation which predominantly delivers healthcare to adults and babies.

However an unborn is perceived to be 'at risk' when there are known Safeguarding concerns and agencies involved in any direct care have a key role in representing their interests. If the concerns relate to any present and/or future risk, in accordance with statutory guidance (Section 17, of the Children Act 1989, 2004) they must make a Child Protection Referral to Children's Social Care. This referral process is 'acting by proxy' as the voice of the child for the unborn.

In the Trust's unplanned and/or specialist care setting, we treat young adults under 18 years of age. In this instance, we are able to capture their views with our patient feedback cards.

As such Liverpool Women's can evidence compliance with the Voice of the Child agenda.

Domestic Abuse

Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality; is referred to as domestic abuse.

Last year we reported the successful appointment to the Team of an Independent Domestic Violence Advocate (IDVA), who is also a qualified Children's Social Worker. This has been a positive appointment and has heightened awareness and assisted in the appropriate identification, referrals and support for our patients who disclose domestic abuse. It is also in line with national guidance, evidence based research around best practice and the Trusts vision and values, to be a recognised as dedicated to the delivery of excellent healthcare and safe services, in a safe environment.

As we have previously reported, this year has seen a reduction in domestic abuse referrals which is mainly in the amount of referrals from Merseyside Police. However, the enhanced training and other staff members greater understanding of the types of abuse and indeed what constitutes abuse, will also have an effect of what is referred to the Team.

Domestic Abuse and the LGBTQ Community

The definition of domestic abuse specifically includes reference to same sex couples to recognise that domestic abuse does occur in LGBTQ relationships.

Research into the prevalence of domestic abuse with LGBTQ members shows that prevalence rates are equal or at a higher rate compared to heterosexual couples. As such Liverpool Women's advocate the use of Routine and Selective Enquiry regardless of a patient's sexuality/identification.

Liverpool Women's offer support and provide the relevant support numbers to LGBTQ members to enable them to make a choice as to which service to access; including the specific same sex support services that are available.

Multi-Agency Risk Assessment Conference's (MARAC)

All healthcare providers are required to provide health information relevant to cases being discussed for all MARAC meetings and attend the meetings where victims who have been referred by the individual Trusts are being discussed.

Liverpool Women's continues to work in collaboration with our external statutory partners by referring and attending when required at the MARAC; enabling maximum information sharing between relevant agencies within an agreed protocol. This ensures that those identified as most at risk from violence and abuse, are managed jointly with a management plan that provides a professional, co-ordinated approach to reducing the perceived risk.

The Trust continues to provide all appropriate health information/intelligence to Liverpool (North and South), Sefton and Knowsley MARAC's; attending as required.

Domestic Homicide Reviews (DHRs)

Liverpool Women's have been involved in DHR processes since they were established on a statutory basis in April 2011, under section 9 of the Domestic Violence, Crime and Victims Act (2004).

In this reporting period, the Trust has had no DHR involvement. However, in a previous review (DHR 11), which was also a Joint Safeguarding Adults Review (SAR), the Home Office appointed Independent Author, outlined a number of good practice points for Liverpool Women's.

"The way this disclosure of domestic abuse was managed by staff at Liverpool Women's was exemplary."

"Examples of good practice being providing an opportunity for initial disclosure, conducting and accurately recording a robust risk assessment enabling appropriate referrals based on the high-risk assessment and involvement of the Safeguarding Team, who have the specific training and skill set for this role"

With the recommendation to:

- Share good practice from Liverpool Women's NHS Foundation Trust staff to ensure that learning is shared across the organisation and with other wider health colleagues and agencies

As such in October 2019, Liverpool Women's Safeguarding Team organised and hosted a Domestic Abuse Master-class for all staff and external partners.

Expert speakers included Nazir Afzal OBE former Chief Prosecutor for the Crown Prosecution Service (CPS) and subject of the BBC three-part drama 'Three Girls', based on the Rochdale sexual exploitation scandal; and Laura Richards, a British Psychologist, Criminal Behavioural Analyst with the FBI and former New Scotland Yard. Laura, an international expert on domestic violence, stalking, sexual violence and risk assessment; is the founder of the world's first National Stalking Advocacy Service and developed the DASH (Domestic Abuse, Stalking and Harassment) Risk Assessment that we use within the Trust to identify women at risk from abuse.

The objective of the day was to hear expert opinions on real murder cases, deconstructing each of the cases in detail in order to inform us of ways in which abuse can be prevented. Our aim for this approach to learning was for the attendees to understand the importance of professional curiosity around abuse and highlight the potential outcome if agencies simply choose to do nothing when abuse is suspected.

Opened by our Chief Executive, Mrs Kathryn Thomson and Merseyside Police Chief Constable Andy Cook; the day was attended by over 100 people, including representation from external partner agencies and was extremely well received.

The 'Protecting Vulnerable People Agenda'

The Pan Merseyside Harmful Practices Group meet on a quarterly basis and lead on raising awareness among professionals and practitioners of harmful practice; such as Forced Marriage, Honour Based Violence and Female Genital Mutilation. The Safeguarding Team represent Liverpool Women's at that meeting in order to share good practice and disseminate any local and national learning.

Human Trafficking / Modern Slavery

Liverpool Women's continue to work closely with Merseyside Police Human Trafficking Team and have robust processes in place as standard; which includes 'real time' access to operational data and intelligence.

This enables timely identification of individuals involved and ensures vulnerable victims are safeguarded as appropriate; and outcomes can be evidenced.

Our work with Merseyside Police also gives us the information and knowledge around the particulars of 'trafficked' cases, leading to the appropriate challenge around Local Authority decision making; ensuring Liverpool Women's advocate for this vulnerable cohort of women.

Safeguarding Adults

This year has seen a slight reduction in the number of safeguarding adult referrals received. The majority of referrals relate to adults with additional needs or have on-going mental health needs and require specialist advice and support during their admission; or a review of their established package of care to facilitate a safe discharge.

The numbers of referrals that progress to further enquiries being made by Merseyside Police or the Local Authority, remain minimal.

In addition, there has been a reduction in referrals requesting support to identify appropriate reasonable adjustments for patients in compliance with the Equality Act (2010).

This reduction demonstrates a greater awareness from front line staff around the diverse nature of safeguarding adults and the importance of recognising potential vulnerabilities and seeking specialist advice to ensure compliance with the statutory guidance. Staff awareness can be attributed to embedding the skills required to complete the assessments with key groups such as the Enhanced Midwifery Team and the Pre-Operative Assessment staff in Gynaecology.

Regardless of this year's slight reduction, the Safeguarding Team have continued to take a proactive approach to working collaboratively with both the patient and external partner agencies in agreeing appropriate safeguarding arrangements in line with statutory guidance.

Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (2009) (MCA & DoLS)

As in previous years for this reporting period, the Trust has been able to demonstrate through audit, full compliance with the following:

- When assessing capacity, all patients deemed to lack capacity to consent met the legal standard for deeming a person to lack capacity to make the required decision
- Prior to establishing a lack of capacity there was evidence to show all practicable steps to support the patient in demonstrating capacity had been taken without success and there was evidence as to how the judgement was reached
- All Deprivations of Liberty (DoLS) were assessed and the appropriate safeguards completed within the statutory timeframes and all authorisations were shared with the Care Quality Commission, using the appropriate template, following discharge

However this year there has been a reduced compliance in the decision to proceed with the proposed investigation and or treatment in accordance with Section 1(4) of the Act (Best Interest). The audit highlighted that there was no evidence that the opinions of those interested in the welfare of the person deemed to lack capacity (relatives/friends) had been taken into account.

A key contributor to this may have been the reduced compliance with staff trained in MCA and therefore a lack of appreciation as to the statutory importance of documenting the views of both the patient and those interested in their welfare. In response all Clinical Divisions were requested to promote the need to complete the online training MCA (Advanced) module to the relevant identified staff groups.

With regard to complex and potentially challenging cases, the Safeguarding Team continue to provide expert support to clinicians across both Gynaecology and Maternity; working in close collaboration with external service providers to ensure compliance with the Act.

The majority of these cases predominantly feature known behaviour that challenges healthcare delivery and the potential or actual need to use restrictive practices or restraint to ensure the safety of the person deemed to lack capacity, hence the required support from the Safeguarding Team.

This year also saw the Safeguarding Team commence planning for the proposed implementation of the Liberty Protection Safeguards (LPS), contained in the Mental Capacity (Amendment) Act 2019. This is due to be implemented in October 2020, however at the time of writing, as a potential consequence of the start of the COVID-19 pandemic, the Government look set to delay the implementation. In response Safeguarding continues to monitor the progress of this in readiness for any required changes to be implemented.

Learning Disabilities & Dementia

Liverpool Women's continue to work in collaboration with external health providers and service users to improve the experiences of patients with additional needs including Learning Disabilities, Autism & Dementia.

In June 2018, NHS Improvement launched the '*National Learning Disability Improvement Standards'* for NHS Trusts; designed to drive rapid improvement of patient experience and equity of care. The findings from our participation in the pilot benchmarking exercise, published this year, identified areas of good practice within the Trust; namely the embedding and application of Reasonable Adjustments, ensuring those caring for patients with a Learning Disability or Autism are appropriately trained to recognise individual needs of both the patient and those involved in their care, access to specialist advice/support and the application of the Mental Capacity Act in clinical practice.

However, nationally, concerns were raised by participating NHS Trusts regarding the methodology of the pilot and subsequent findings. Therefore, following a review of the methodology for the 2020/21 national audit, it is hoped a clearer picture is available to provide assurance that Trusts have the right structures, processes, workforce and skills to deliver the outcomes that people with Learning Disabilities and Autism, receive the care their families and carers expect and deserve. Moving forward we await the findings to inform a review of Trust strategy.

In the interim the Safeguarding Team have delivered training around the completion of the Reasonable Adjustments Risk Assessment to the Enhanced Midwifery Service and Pre-Operative Assessment staff.

Safeguarding continue to provide support to clinicians when completing assessments and care planning for complex admissions involving patients with Learning Disabilities, Dementia and Autism. This training has improved access to assessments and in turn equality in access to care.

We know from the Confidential Inquiry into the Premature Deaths of People with Learning Disabilities (CIPOLD), that the Department of Health and other statutory agencies require Trusts to implement appropriate strategies to overcome barriers to accessing healthcare.

For people with Learning Disabilities and their carers, going into hospital can be frightening, confusing and stressful as they are often unsure of what to expect or how they will cope. They may have difficulty in adjusting to the hospital environment and Trust routines and this has been seen as a contributing factor for patients with a Learning Disability to die 20 years sooner than patients without a Learning Disability.

Therefore in accordance with Trust policy, we identify and ensure professionals complete Reasonable Adjustments Risk Assessments for this patient group. Without these assessments we would regularly come across patients who can exhibit behaviour that challenges the delivery of healthcare and therefore lead to an inequality in health provision as well as the inappropriate use of restraint and sedation to facilitate admission.

A key trigger for this behaviour can be their unfamiliarity with the hospital environment and our internal processes. In order to mitigate this we currently employ an array of strategies including an information booklet about the Trust sent to the patient and or carers prior to their admission in an Easy read format and supervised ‘walk arounds’ of the Trust often out of hours due to the need for reduced stimuli prior to their elective admission date.

In this reporting period, in partnership with the Trust IM&T Department the Safeguarding Team commenced a piece of work to develop a Virtual Reality (VR) Programme. The programme would allow users to experience a sense of presence in the Trust via a computer-generated three-dimensional environment.

In addition the programme will include a 'voice over' component explaining key aspects of the patient journey as they move through the Trust which will support those patients who have difficulty reading and therefore comply with the Accessible Information Standard.

To date VR has not been used as a de-sensitisation strategy for patients who may find hospital admissions challenging. However extensive research has been published regarding the benefits of VR for patients who experience difficulty with imagining or visualisation as part of de-sensitisation programmes.

This is an innovative programme and far more comprehensive and informative than the current information booklet, enabling our patients with additional needs an ability to prepare for their admission in the familiar surroundings of their own home.

Mental Health Act

The Trust has a statutory obligation to ensure that its service users, detained under the Mental Health Act (1983) as amended by the Mental Health Act (2007) are treated lawfully.

In response to concerns being raised regarding a perceived lack of clarity or access to direct support when managing complex Mental Health cases accessing the Trust, the Safeguarding Team have completed a review of existing processes in the Trust.

The review clarified the relevant policies, guidance and proposed governance developed in 2018; were still relevant. However the requirement for a Service Level Agreement with a Mental Health provider to underpin compliance with the Act unfortunately had not been successfully secured.

In response the Safeguarding Team commenced discussions with a Mental Health provider with a view that once agreed they would embed the required policies, guidance and governance as well as roll out the required training to key individuals.

In the interim and whilst awaiting an agreed way forward, the Safeguarding Team have continued to provide guidance and support on a case by case basis.

Safeguarding Governance

Risk

Safeguarding Risk Register

During 2019/20 there were two service level risks identified within the Safeguarding Service:

1. Risk ID 2302 - Safeguarding training below target compliance
2. Risk ID 2308 – Reduction in Safeguarding Service staffing

Risk 2302

At Septembers Hospital Safeguarding Board it was agreed that as the Trust had not achieved the internal and commissioning training compliance targets for an extended period of time the Safeguarding Service completed a risk assessment. The group agreed with the score of 10 (2*5), as well as the controls in place and the risk was added to the Risk Register (Service Level). Risk controls continued to be facilitated and tested to ensure the risk was managed appropriately however, despite an increase, the Safeguarding compliance rates never achieved internal or commissioning targets in 2019/20.

Risk 2308

Prior to our impending CQC Inspection the Safeguarding Team agreed to second a member of the Team to assist and support another division (Gynaecology) for a 3 month period. Due to the reduced staffing and potential service impact, Safeguarding completed a risk assessment. At Septembers Hospital Safeguarding Board the group agreed the score of 10 (2*5) as well as the controls in place and the risk was added to the Risk Register (Service Level). In December 2019, it was agreed to extend the secondment for a further 3 months and until the end of the financial year. In order to further assist the Gynaecology division.

Performance

Clinical Commissioning Group (CCG) Key Performance Indicator (KPI) Reports

For 2019/20 Liverpool Clinical Commissioning Group (LCCG) provided an overall limited assurance rating to the Trust Safeguarding Service. Similar to the previous year the only area of limited compliance was the adult and children safeguarding training. All other areas of Safeguarding again achieved significant assurance.

LCCG acknowledged and were satisfied that the Trust Safeguarding Team had a detailed recovery action plan and trajectory in place that had oversight from the Director of Nursing and Midwifery, that training programmes have continued to be reviewed and staff training compliance is reported to Quality Committee via the Hospital Safeguarding Board.

Whilst awaiting an increase in compliance, in order to provide assurance that our workforce have the knowledge, skills and awareness required, the Safeguarding Team increased their 'Unannounced Safeguarding Inspections' to all the clinical areas. The inspections were in order to identify potential risks or gaps in knowledge and were recorded within Risk 2302.

LWH	Q1 (2019/20) Assurance rating			Q2 (2019/20) Assurance rating			Q3 (2019/20) Assurance rating			Q4 (2019/20) Assurance rating
Training			↔			↔			↔	Due to COVID-19 there was an agreement with all Providers for the KPI Framework not to be followed for
Local Authority Children			↔			↔			↔	
Local Authority Adults			↔			↔			↔	
MCA / DoLS			↔			↔			↔	
Commissioning Standards			↔			↔			↔	

										Quarter 4.		
Overall			↔			↔			↔			↔

Merseyside Safeguarding Group Section 11 Audit

Following the changes to safeguarding arrangements in 2018/19, Liverpool, Knowsley, Sefton and St Helens Safeguarding Children's Partnerships (Boards) utilised a Pan-Merseyside approach based on one single Section 11 submission.

The stages of the process were as follows:

October 2019	The newly formed Merseyside Safeguarding Children's Board distributes online workforce survey asking LWH staff to complete review against Trust self-assessment
November 2019	Merseyside Safeguarding Children's Board undertakes assessment of returned all audits from NHS Trusts on behalf of the all local boards.
November 2019	Cross Merseyside agencies complete audit for 2019/20 consideration.
December 2019	Board representatives from across Merseyside will meet to consider scrutiny requirements to address standards deemed not sufficiently evidenced.
December 2019	Front Line visit (FLV) will be scheduled and inform the decision to proceed to scrutiny panel.
January 2020	LWH receive frontline visit by two members of Merseyside Safeguarding Children's Boards (MSCB)
April 2020	LWH FLV report received and informed they do not require a scrutiny panel

- **2019/20 Section 11 – LWH Self-Assessment**

Section 11 requirements are divided in to 13 auditable standards and these are based on the guidance in Working Together to Safeguard Children (2018) which came into effect in April 2019. For the first time this audit did not require a submission of documentary evidence however a workforce survey (WFS) would be conducted in October 2019 and a Pan Mersey Scrutiny Panel would be convened to assess agencies submissions. Below are the standards and the Trusts self-assessment ratings for 2019/20.

	Working Together 2018 Standards	**LWH Self-Assessment**
1	A senior board level lead with the required knowledge, skills and expertise or sufficiently qualified and experienced to take leadership responsibility for the organisation's/agency's safeguarding arrangements	
2	Clear whistleblowing procedures, which reflect the principles in Sir Robert Francis' Freedom to Speak Up Review and are suitably referenced in staff training and codes of conduct, and a culture that enables issues about safeguarding and promoting the welfare of children to be addressed	
3	Clear escalation policies for staff to follow when their child safeguarding concerns are not being addressed within their organisation or by other agencies	
4	A designated practitioner (or, for health commissioning and health provider organisations/agencies, designated and named practitioners) for child safeguarding. Their role is to support other practitioners in their organisations and agencies to recognise the needs of children, including protection from possible abuse or neglect. Designated practitioner roles should always be explicitly defined in job descriptions. Practitioners should be given sufficient time, funding, supervision and support to fulfil their child welfare and safeguarding responsibilities effectively	

5	A clear line of accountability for the commissioning and/or provision of services designed to safeguard and promote the welfare of children	
6	A culture of listening to children and taking account of their wishes and feelings, both in individual decisions and the development of services	
7	Appropriate supervision and support for staff, including undertaking safeguarding training	
8	Safe recruitment practices and on-going safe working practices for individuals whom the organisation or agency permit to work regularly with children, including policies on when to obtain a criminal record check	
9	Arrangements which set out clearly the processes for sharing information, with other practitioners and with safeguarding partners	
10	Creating a culture of safety, equality and protection within the services they provide	
11	Employers are responsible for ensuring that their staff are competent to carry out their responsibilities for safeguarding and promoting the welfare of children and creating an environment where staff feel able to raise concerns and feel supported in their safeguarding role	
12	Staff should be given a mandatory induction, which includes familiarisation with child protection responsibilities and the procedures to be followed if anyone has any concerns about a child's safety or welfare	
13	All practitioners should have regular reviews of their own practice to ensure they have knowledge, skills and expertise that improve over time	

- **Merseyside Safeguarding Children's Board Section 11 – LWH Workforce Survey**

The workforce survey (*facilitated online*) requested staff to complete responses to 16 questions, the full compliance target was 90% positive responses, LWH received this rating (or higher) in nine of the questions, whereas the following seven questions received lower scores:

1. Do you know who your agency's representative for the MASA (multi-agency safeguarding arrangements) is? (42% aware)
2. Are you familiar with the local descriptions of need, or thresholds document? (38%)
3. Are you made aware of multi-agency safeguarding training? (66%)
4. Do you receive regular reflective supervision, or debrief when needed? (58%)
5. Do you receive briefings, information about Serious Case Reviews, opportunities to attend seminars etc (44%)
6. Are you aware of your agency's Safer Recruitment policy? (34%)
7. Are you aware of the multi-agency escalation procedure? (49%)

Through discussion with Liverpool LSCP regarding feedback from the Workforce Survey and potential areas for improvement in future audits, it was agreed that certain terminologies (e.g. Safer Recruitment Policy) potentially confused Trust staff. It was also agreed that the questions within the survey made it difficult for the Scrutiny Panel to ascertain compliance; this increased the need for Frontline Visits to be conducted.

Following the survey the Safeguarding Team made some changes to our Safeguarding Children Training programmes, for example expanded the LSCP roles and procedures for staff to have a better understanding.

- **Merseyside Safeguarding Children's Board - Section 11 Scrutiny Panel**

In December 2019, the Merseyside Safeguarding Group provided the Trust with the results from the Section 11 Audit Scrutiny Panel. The Panel found the following:

Topic 1 – Policies, Procedures and Thresholds			
Q	**Standard**	**Panel is Assured Y/N**	**Panel Comments**
2	**1.2** Does your organisation have a senior board level lead with the required knowledge, skills, and experience who has responsibility for Safeguarding?	**Y**	
3	**1.3** Is there a named lead and deputy for safeguarding children and child protection in your organisation that have a clearly defined role and responsibility for championing children?	**Y**	
4	**1.4** Does your organisation publish a clear statement of the commitment to safeguard children and young people?	**Y**	
5	**1.5** Has your organisation published a safeguarding policy?	**Y**	
6	**1.6** What are the dates of the most recent and next planned review of this policy?	**Y**	Good practice to review annually
7	**1.7** Are all staff aware of safeguarding procedures/policies including multi-agency safeguarding procedures and how to access them?	**Y**	
8	**1.8** How do you ensure children and young people are listened to, and their wishes and feelings taken account for in both individual decisions and the development of services?	**Y**	FLV to evaluate how children's wishes and feelings are listened to and acted on in cases where an expectant mother is a child, and how the wishes of children of patients are listened to and acted on

9	**1.9** Are safeguarding policies/procedures accessible to children, young people and their families?	**Y**	Recommendation – this should be made available to everyone
10	**1.10** How does your organisation test the use and awareness of policies and procedures amongst staff in your agency?	**Y**	
11	**1.11** Does your organisation have a clear procedure for sharing information with other professionals, agencies and the MASAs?	**Y**	
12	**1.12** Do staff understand the Descriptions of Need and know when and how to refer concerns into Children's Social Care?	**N**	FLV to evaluate: WFS does not support this finding
13	**1.13** Do all staff know what to do within the organisation if they have safeguarding concerns about a child/young person?	**Y**	
14	**1.14** How does your organisation monitor rates and outcomes of referrals to Children's Social Care completed by your staff?	**Y**	
15	**1.15** If your organisation commissions services, are you assured of the services arrangements to safeguard and promote the welfare of children and young people?	**Y**	
Topic 2 – Skilled Workforce (Training)			
Q	**Standard**	**Panel is Assured Y/N**	**Panel Comments**
16	**2.1** Do all new staff have a mandatory induction that includes familiarisation with child protection responsibilities and agency safeguarding procedures/policy?	**Y**	
17	**2.2** Have all staff (including volunteers)	**Y**	Percentage of

	received or attended training in line with their safeguarding responsibilities?		compliance with training requirements to be gained at FLV
18	**2.3** Is multi-agency training advertised and promoted to staff in line with the competency framework?	**Y**	
19	**2.4** How does your organisation identify who requires training and which courses are most suitable?	**Y**	
20	**2.5** How does your organisation ensure and test professionals' level of understanding and learning following attendance at training?	**N**	FLV to clarify how this is completed
21	**2.6** Do staff in your agency have the opportunity to receive reflective supervision?	**Y**	
22	**2.7** Does your organisation have a designated person who monitors attendance at training and ensures all staff are trained to the appropriate level with refreshers when required?	**Y**	What do compliance reports say? Request prior to FLV
23	**2.8** Do you provide/commission single agency safeguarding training for your own staff?	**Y**	
24	**2.9** Does your agency have a lead officer who disseminates additional learning (information about Serious Case Reviews, 7 minute briefings, opportunities to attend seminars etc)?	**Y**	FLV to determine the efficacy of dissemination
25	**2.10** What are your agency's priorities with regard to safeguarding training for the next 12 months??	**Y**	
Topic 3 – Skilled Workforce (Recruitment)			

Q	Standard	Panel is Assured Y/N	Panel Comments
26	**3.1** Does your agency have a safer recruitment policy in place which all staff are aware of?	**Y**	
27	**3.2** Has a senior member of staff in your agency received Safer Recruitment training?	**Y**	
28	**3.3** Do recruitment adverts include your agencies' commitment to safeguarding children?	**Y**	Panel felt was an exemplary answer
29	**3.4** Do all staff have DBS checks or evidence of checks from a relevant agency?	**Y**	
Topic 4 – Skilled Workforce (Complaints, Escalation, Whistleblowing and Allegations Management)			
Q	**Standard**	**Panel is Assured Y/N**	**Panel Comments**
30	**4.1** Does your organisation have a whistleblowing policy and systems in place for professionals and members of the public?	**Y**	
31	**4.2** Does your organisation have a complaints policy and systems in place for professionals, young people and their families?	**Y**	
32	**4.3** How does your agency promote the use of the multi-agency escalation procedure?	**Y**	
33	**4.4** Does your organisation have a clear policy for dealing with allegations against professionals?	**Y**	

Topic 5 – Key Issues
Please note this section is not evaluated via Scrutiny A

Due to needing further particular information from the submission and Workforce Survey; a Frontline Visit was required and was arranged for the next quarter.

- **Merseyside Safeguarding Children's Board - Section 11 Front Line Visit (FLV)**

On 29th January 2020, a representative from Merseyside Police and Education respectively conducted the Section 11 Front Line Visit. They interviewed members of the Trust Safeguarding Team as well as staff in Antenatal Clinic, Gynaecology and Maternity.
Overall findings from the Frontline Visit were:

- The staff were very welcoming and open towards the visit and forthcoming with the relevant information
- Evidence was provided that demonstrated assurance of the standards outlined in this document
- Descriptions of need and referral mechanisms were understood by senior staff and operational staff that were spoken with. It was felt that this question may not have been answered correctly in the audit due to the terminology used as staff refer to levels of need or the windscreen model
- The staff provided reassurance regarding safeguarding training that was taking place was a high standard and governance was in place to monitor through the Safeguarding Seam. They felt they were given appropriate guidance and support from the Safeguarding Team
- Voice of the child and the unborn child was being captured well by the midwives and evidence of this was presented in the form of an initial contact form which displayed good evidence of capturing the voice of the child throughout

- An enhanced service, which is a specific pathway is offered to teenage girls. There was evidence of the 'voice of the child' being captured in safeguarding records relating to a teenage girl. This was embedded throughout the text although consideration should be given to adapting the form to have a discrete 'voice of the child' box where the child's views can be summarised
- It was agreed that there was some confusion with the terminology used in the audit questions. The Trust were able to assist in providing further evidence to support the audit and could have expanded further on their initial responses to promote their on-going work
- Practitioners had a good knowledge of Levels of Need and the windscreen model. They spoke favourably about the MARF, being easy to access and use with good links
- Staff were positive in relation to the training provided in a variety of different ways to encourage learning
- Training included key themes including Domestic abuse, FGM, Trafficking, CSE etc
- Staff had good knowledge and understanding of voice of the child and the unborn child, including all vulnerability and teenage pregnancy
- They are aware of how to make a referral to children's services directly and how to seek support from the Safeguarding Team
- Voice of the child and the unborn child was being captured well by the midwives and evidence of this was presented
- Very evident young person's views are captured in a lot of detail for individual service design
- It was thought there was some evidence lacking to demonstrate how this information was used to shape future services
- 89% completion rate for Level 1 & 2 refresher training at the time of visit
- 82% completion rate for Level 3 Safeguarding Children refresher at the time of the visit
- Level of need refresher training completed with staff, this includes a test following completion. There are also unannounced inspections to front line staff by the Safeguarding Teams to test colleagues understanding. Reports go through safeguarding board and CCG have sight of.

- Staff spoke about the MARF being easy to access and submit and were really positive about this at a strategic and operational level. MARFs from Sefton are quality assured by the Safeguarding Team and feedback is offered to the frontline colleague when required
- Updated training re FGM and submission of the MARF. None English speaking team assist with Language barriers, including work with the Human Trafficking Team within the Police (Operation Sanctuary)
- Training given to staff around the Emergency Room and other higher risk areas around CSE
- The board has a TNA and plan to ensure all training is completed

The Report from the Frontline Visit was received and agreed at Decembers Hospital Safeguarding Board.

Policies

Following publication of updated legislation and national guidance, the Safeguarding Team ensures all safeguarding policies are compliant and accurate. Although the Trusts policy is to ensure 3 yearly reviews; Safeguarding policies are reviewed every 12 months due to the regular changes in guidance and law.

Updated documents in 2019/20:

1. Corporate Safeguarding Strategy
2. Safeguarding Training Strategy
3. Safeguarding Children Policy
4. Safeguarding Adults Policy
5. MCA/DoLS Policy
6. Domestic Abuse Policy
7. Supporting Patients with a Disability Policy
8. Managing Allegations for People Working with Children Adults and Vulnerable Adults
9. Safeguarding Supervision Policy

10. Prevent Policy
11. Missing Child Guideline
12. LeDeR Guideline

Main changes to policy for 2019/20 were:

- ✓ Inclusion of the recommendations from the new Working Together to Safeguard Children (2018) publication within the Safeguarding Children Policy

- ✓ The updated definition and process around stalking and harassment and support for the LGBTQ Community; within the Trust Domestic Abuse Policy

Audits

Forward Plan No.	Title	Auditor / Audit Supervisor	Changes in practice / Improvements
2019-010	Trust compliance with the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS)	Carl Griffiths Matt O'Neill	Very high standard of compliance with policy and procedures. However for the first time in three audit years there was a reduction in compliance in respect to the decision to proceed with the proposed investigation and or treatment in accordance with Section 1(4) of the Act (best Interest).

2019/032	Safeguarding children procedures in accordance with statutory guidance audit	Maria Clegg Matt O'Neill	Very high standard of compliance with policy and procedures. In particular the identification of concerns and the swiftness this was referred to the Trust Safeguarding Team was a big positive, another being the management of discharges under safeguarding procedures. One area of improvement noted was the importance of the timely referrals to the Local Authority at the point of documented concerns.
2019/023	Auditing the compliance against Domestic Abuse Protocol/Procedure	Jayne Reid/ Matt O'Neill	High standard of compliance with policy and procedures. It was identified that staff clearly knew when it was safe to conduct routine enquiry and also ensured that partners details where obtained. In MAU, Bedford Clinic and GED; all midwives/nurses to be trained to complete Co-ordinated Action Against Domestic Abuse - Domestic Abuse, Stalking and 'Honour'-based violence (CAADA-DASH) risk assessments for patients who disclose domestic abuse. This will improve the resilience and increase support for victims.

Assurance

Hospital Safeguarding Board (HSB)

The HSB ensures that all safeguarding arrangements within the Trust are regularly reviewed, providing assurance to the Trust Board that the Trust is meeting its statutory obligations and locally agreed objectives.

The HSB Terms of Reference include representation from the Designated Nurses (LCCG), Non-Executive Director (Safeguarding Champion) and is chaired by the Director of Nursing and Midwifery and/or the Associate Director of Nursing and Midwifery for Safeguarding. The Board provides strategic overview and scrutiny across all aspects of Safeguarding.

In this reporting period, the HSB has had much focus on the monitoring of progress against the training compliance and the recovery plan. We have also completed a review of the Terms of Reference in which the body of work encompassed within the HSB was clarified ensuring the following items are continually discussed and monitored:

- Partnership Working
- Risks & Serious Incidents
- Legislation and National / Local guidance changes
- Training
- Serious Case Reviews (SCRs) & Domestic Homicide Reviews (DHRs)
- CCG Key Performance Indicators (KPIs)
- Governance
- Assurance
- Effectiveness
- Performance

Safeguarding Operational Group (SOG)

The Safeguarding Operational Group (SOG) supports the HSB, with the primary purpose to ensure that safeguarding children and adults is a Trust wide priority.

Again this year, through monitoring compliance with training, incident trends, Safeguarding Unannounced Inspection Reports, Serious Case Review findings and Safeguarding performance and activity; the group have been able to provide assurance to the HSB that safeguarding arrangements within the Trust are continually developed and implemented and are compliant with appropriate legislation and national/local guidance in respect of Safeguarding Children and Adults.

Meetings are quarterly and have full divisional representation, which again has been noted as positive and consistent.

Care Quality Commission (CQC)

Between 03 December to 05 December 2020, the CQC completed an inspection of the services at Liverpool Women's. During the inspection the CQC found that staff were able to identify potential safeguarding risks, involving the relevant professionals and had appropriate systems in place to manage any safeguarding concerns.

They were satisfied that community staff were supported and made prompt and timely referrals for women and babies identified as vulnerable. They were provided with evidence of close working arrangements between the Safeguarding Team, the Enhanced Midwifery Team, Police and Children's Services.

As the Trusts mandatory safeguarding training compliance rates were low at the time of inspection, the Inspectors completed a full review of the Safeguarding Training Strategy, Training Action Plan and Trajectory. They were assured that staff had the relevant knowledge with the Safeguarding Unannounced Inspections Report and were satisfied that we had a plan in place to manage the low compliance.

They were further assured that Safeguarding practice was supported with a Trust wide Safeguarding Team that staff could access for advice and support. However they did highlight the approach to certain elements of Safeguarding in some clinical areas required further development. This will be a priority for the Safeguarding Team to support in the coming 12 months.

Safeguarding Training

At the end of the reporting period for 2019/20, the Trusts compliance levels for Safeguarding training are:

Session	CCG Compliance Threshold (%)	Compliance as of April 2020 (%)
Safeguarding Children Level 1	90%	**89.69%**
Safeguarding Children Level 2	90%	**89.69%**
Safeguarding Children Level 3	90%	**85.74%**
Safeguarding Children Level 4	90%	**100%**
Safeguarding Adults Level 1	90%	**89.69%**
Safeguarding Adults Level 2	90%	**89.69%**
Safeguarding Adults Level 3	90%	**80.43%**
Safeguarding Adults Level 4	90%	**100%**
MCA & DoLS (Advanced) **	90%	**52.08%**
Prevent (Basic Awareness)	90%	**89.69%**
Prevent (WRAP)	90%	**89.0%**

***following the removal of LCCG funding for MCA/DoLS Level 2 training and no programme available locally/nationally, Liverpool Women's created a bespoke package of training which was launched early 2020 to all staff via eLearning. Compliance was reset to zero.*

As previously reported, due to the lack of regulatory compliance, Risk 2302 was raised with controls embedded to provide assurance; alongside actions to support the clinical divisions to increase compliance.

Key Objectives for 2020/21

2019/20 has been another year of activity but more so than ever significant scrutiny. Throughout this time, the Trust has successfully demonstrated that robust mechanisms remain in place to safeguard children, young people and adults from abuse.

That said as approaches to Safeguarding continually evolve and the complexity of decision making increases around newly recognised forms of harm and abuse, structures and process need to continually develop in response.

Therefore, aside from further embedding of existing overall process, the following key areas / objectives for improvement have been identified in the priorities for 2020/21:

1. Ensure that all safeguarding processes currently in place are replicated robustly within electronic health records (K2/PENS) and enable greater confidential sharing of safeguarding information across the workforce

2. Building on the recognised good practice of Liverpool Women's when recognising and responding to domestic abuse as a healthcare issue; plan and host a series of Webinars aimed at Commissioners, managers and other professionals working in the NHS, Police, Social Care / Local Authorities and the wider public, private, voluntary and community sectors

3. Complete a full review and update the Corporate Safeguarding strategy (2017-2020)

4. Complete an annual full self-assessment against the Section 11 standards detailed in Working Together (2018)

5. Complete a further full self-assessment against the Learning Disability improvement standards detailed within the NHS Improvement guidance (July 2018) and develop a standalone Strategy for Supporting Patients with Additional Needs with an embedded operational work plan.

6. Progress the arrangements for patients, detained under the Mental Health Act 1983 with a view as to providing further assurance that the Trust are meeting its statutory obligations

7. The Mental Capacity (Amendment) Act (2019) is due to be implemented in October 2020. If Government delay the implementation, due to COVID-19, Safeguarding will be required to monitor the progress of this in readiness for any required changes around the Liberty Protection Safeguards; then complete a scoping exercise and develop an implementation plan.

Liverpool Women's NHS Foundation Trust

Agenda Item	20/21/187

MEETING	**Trust Board**
PAPER/REPORT TITLE:	**Clinical Negligence Scheme for Trusts Update Year 3**
DATE OF MEETING:	Thursday, 05 November 2020
ACTION REQUIRED	**Assurance**
EXECUTIVE DIRECTOR:	Gary Price, Chief Operating Officer
AUTHOR(S):	Gary Price, Chief Operating Officer
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:	
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 evidence requirements in Appendix 2 noting that the Quality Committee will continue to receive regular updates, escalating issues when necessary.***			
PREVIOUSLY CONSIDERED BY:	**Committee name**	Not Applicable		
	Date of meeting			

Executive Summary

The purpose of this paper is to inform the Board of the updated Clinical Negligence Scheme for Trusts (CNST) year 3 requirements published October 2020. It details the key changes in terms of reporting requirements and assurances required for Trust Board sign off in May 2021 for the scheme. The report outlines the Trust's current compliance against the ten safety standards and draws attention to the role of the Board specifically in the sign off process.

Report

1. Introduction

The national Clinical Negligence Scheme for Trusts (CNST) had been paused due to the Covid-19 pandemic. The Trust had committed to meeting these actions despite the pause as they were recognised as indicators of a high-quality service and has been progressing against the original standards. Updates have been presented to the Quality Committee and the Board throughout 2020.

On October 2nd 2020, the Trust received final clarification on the requirements for completion of the year 3 scheme which concludes with final Trust Board sign off in May 2021. There will, in the financial year 2021/22 be associated financial benefit to achievement of the scheme in terms of a rebate of up to 10% on the CNST premium.

2. Year 3 update

An update on the scheme was received October 2nd 2020 https://resolution.nhs.uk/resources/maternity-incentive-scheme-year-three/

Appendix 1 details the letter received by trusts. This highlights the new reporting requirements and a challenge to Trusts to ensure that they have visibility at Board level of sign off for achievement against the key standards.

The Trust is required to complete a thorough declaration form against the standards to conclude the sign off process in May 2021. Notes detailing current compliance against the ten safety standards and the role of the Board specifically in the sign off process is detailed in Appendix 2.

The updated scheme is challenging, with a focus on Neonates as well as Maternity. In addition, there are updated timescales for reporting and specific focus on learning from Covid-19.

3. Proposal for oversight

The Chief Operating Officer will have Executive oversight of progression of the scheme to date with support from the Head of Midwifery and the broader Divisional leadership team for Family Health.

The Quality Governance Midwife will take operational lead on collating evidence against the key standards. The Trust secretary will ensure that timetables of committees reflect appropriate time for scrutiny of evidence that needs to be provided to assure Trust Board sign off in May 2021.

Many of the original timescales for the year 3 scheme are still relevant and have been achieved. Originally these were due to conclude in September 2020 but were paused and have now been extended to May 2021 to reflect the challenges of the pandemic.

4. Conclusion and Recommendation

The year 3 CNST clarification has been received and The Trust is required to have complete sign off May 2021. Year 3 will be a challenge with significant work required (Appendix 2).

The Board is asked to note the evidence requirements in Appendix 2 noting that the Quality Committee will continue to receive regular updates, escalating issues when necessary.

1 October 2020

Dear Colleagues

Relaunch of year three of the maternity incentive scheme

We are pleased to announce the re-launch of year three of the maternity incentive scheme from 1 October 2020. Please note that the deadline for submissions will be **12 noon on Thursday 20 May 2021**.

The maternity incentive scheme supports the Maternity Safety Ambition by incentivising ten essential actions designed to improve the delivery of best practice in maternity and neonatal services. Improving safety for women and their babies remains our priority during the current phase of the Covid-19 response. In light of Covid-19 pressures on the NHS and maternity services, the maternity incentive scheme Collaborative Advisory Group (CAG)[1] has been working to review the ten maternity incentive scheme safety actions to include additional elements that ensure key learning from important emerging Covid-19 themes are considered and implemented by NHS maternity services. In addition, revisions to the training requirements have also been made.

We would like to draw your attention to the importance of achieving all safety actions as a whole, and in particular reporting to data to the NHS Digital Maternity Services Data Set (MSDS). The majority of the requirements for safety action 2 (Are you submitting data to MSDS to the required standard?) will be assessed on the trusts' MSDS submission for December 2020 made by 28 February 2021.

[1] Royal College of Obstetricians and Gynaecologists, Royal College of Midwives MBRRACE-UK, NHS England & Improvement, the Care Quality Commission, NHS Resolution and the Healthcare Safety Investigation Branch (HSIB)

We have also made revisions to action ten (reporting 100% of qualifying cases to the Health Safety Investigation Branch (HSIB) and further standards have been added relating to assurance of compliance with the duty of candour for 2019/20 births and ensuring families have received information on the role of HSIB and the NHS Resolution's Early Notification Scheme.

You will be aware that there were a small number of trusts that had mis-certified their maternity incentive scheme declaration for years one and two. As result of this, the trusts involved have been required to repay the funding awarded. The Department of Health and Social Care, NHS England and relevant NHS Improvement regional directors and the Deputy Chief Midwifery Officer and relevant Regional Chief Midwife have been notified of these cases which been also escalated to the Care Quality Commission to consider whether any further steps should be taken. In view of this, we have further strengthened the conditions of the scheme, and recommend that trusts familiarise themselves with the revised conditions of the scheme, and also the ten safety actions, paying particular attention to the requirements outlined within the technical guidance.

The declaration form has been revised to include details of all safety actions' sub-requirements and this will be shared with trusts in the forthcoming months. In the meantime, please refer to the PDF version of the declaration form available on NHS Resolution website as initial guide.

A series of recorded webinars has been developed to support trusts in understanding the requirements for the each of the maternity incentive scheme safety actions.

The webinars are available on the NHS Resolution website.

We encourage trusts to submit any queries in relation to the safety actions to: MIS@resolution.nhs.uk

We would like to thank you for all your hard work, both with the ongoing situation and in working towards achieving the highest standards of care in maternity and neonatal services.

Yours sincerely

Helen Vernon
Chief Executive
NHS Resolution

Dr Matthew Jolly
National Clinical Director
National Maternity Safety Champion

Prof Jacqueline Dunkley-Bent
Chief Midwifery Officer
National Maternity Safety Champion

Safety Action	Position as of 27.10.2020	Evidence Required by Board.	Validation
1.PMRT	**Partial Compliance.** Currently, element leads have no concerns with achieving the standards within this element. Work continues to complete PMRT reports into all perinatal deaths via MDT meetings and meet the deadlines and timeframes within the scheme. Extraordinary meetings are planned to ensure neonatal deaths are reviewed in the timeframes required. Safety Action Leads plan to meet on 10.11.2020 to ensure understanding of all requirements. The Trust are now able to track compliance and status of cases with the use of the MBRRACE data reporting spreadsheet – of which map the deadlines and current compliance.	Notifications must be made and surveillance forms completed using the MBRRACE-UK reporting website. The perinatal mortality review tool must be used to review the care and draft reports should be generated via the PMRT. A report has been received by the Trust Board each quarter from Thursday 1 October 2020 onwards that includes details of the deaths reviewed and the consequent action plans. The report should evidence that the PMRT has been used to review eligible perinatal deaths and that the required standards a), b) and c) have been met	Self-certification by Board. Cross referenced with MBRRACE/ PMRT.
2.MSDS	**Non- Compliant.** Two people are registered to submit data by Friday October 30th – Compliant (RS & HM) Webinar attendance in Jan/Feb 2020– Compliant (confirmed within the CNST document, as all Trusts attended). Richard Strover is providing a paper based on difficulties in achieving this standards deadlines due to introduction of K2 and deadlines for individual data submissions.	NHS Digital will issue a monthly scorecard to data submitters (Trusts) that can be presented to the Board. It will help Trusts understand the improvements needed in advance of the assessment. The scorecard will be used by NHS Digital to assess whether each MSDS data quality criteria has been met All 13 criteria are mandatory. Items 1, 2, 4-13 will be assessed by NHS Digital and included in the scorecard. Item 3 will be reported to NHS Resolution. Item 14 related to the Maternity Record Standard has been removed from the MIS safety action two.	Self-certification by Board. Cross-referenced against NHS Digital data.
3.ATAIN.	**Partial Compliance.** Safety Action Leads planning to meet to ensure all standards can be evidenced – planned for 9th November 2020 – pending attendance acceptance.	Local policy available which is based on principles of British Association of Perinatal Medicine (BAPM) transitional care where: **Evidence for standard a) to include:** •There is evidence of neonatal involvement in care planning •Admission criteria meets a minimum of HRG XA04 but could extend beyond to BAPM transitional care framework for practice •There is an explicit staffing model •The policy is signed by maternity/neonatal clinical leads •The policy has been fully implemented and monthly audits of compliance with the policy are conducted. **Evidence for standard b) to include:** •Audit findings are shared with the neonatal safety champion. Where barriers to achieving full implementation of the policy are encountered, an action plan should be agreed, and progress overseen by both the board and neonatal safety champions. **Evidence for standard c) to include:** •Data is available (electronic or paper based) on transitional care activity (regardless of place - which could be a TC, postnatal ward, virtual outreach pathway etc.) and which has been recorded as per XA04 2016 NCCMDS. **Evidence for standard d) to include:** •As and when requested, commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2 are shared with the Local Maternity System (LMS), ODN or commissioner. Evidence for standard e) to include:	Self-certification by Board.

Safety Action	Position as of 27.10.2020	Evidence Required by Board.	Validation
	Review of Term Admissions 01.03.2020 – 31.08.2020 report planned to be completed by Consultant Neonatologist and ANNP. Formulation of revised ATAIN action plan to be completed, meeting planned for 19th November by ATAIN Team champion. *Where is the best place for this to be sited? Given the requirement for Board oversight?*	•An audit trail is available which provides evidence that a review of term admissions during the period Sunday 1 March 2020 – Monday 31 August 2020 has been undertaken •Evidence that the review specifically considered the impact of changes to parental access; staff redeployment, closure or reduced TC capacity and changes to postnatal visits on admission rates including those for jaundice, weight loss and poor feeding . **Evidence for standard f) to include:** •An audit trail is available which provides evidence and rationale for developing the agreed action plan to address local findings from ATAIN reviews. •Evidence of an action plan to address identified and modifiable factors for admission to transitional care. •Evidence that the action plan has been revised in the light of learning from term admissions during Covid-19. Where no changes have been made, the rationale should be clearly stated. •Evidence that the action plan has been shared and agreed with the neonatal safety champion and Board level champion. Evidence for standard g) to include: •Evidence that progress with the revised ATAIN action plan has been shared with the neonatal safety champion and Board level champion.	
4.Clinical Workforce	**Partially Compliant** Email sent to Safety action leads for update on evidence gathering across all divisions. Anaesthesia have reported they are compliant with their requirements (RK). Requested evidence of Trust Board Minutes.	**Obstetric medical workforce** Proportion of trainees formally recorded in Board minutes and an action plan to address lost educational opportunities should be signed off by the Trust Board. The plan must also include an agreed strategy with dates, to address their rota gaps. A copy of the tool must be submitted to the RCOG at workforce@rcog.org.uk **Anaesthetic medical workforce** Trust Board minutes formally recording the proportion of ACSA standards 1.7.2.5, 1.7.2.1 and 1.7.2.6 that are met. Where Trusts did not meet these standards, they must produce an action plan (ratified by the Trust Board) stating how they are working to meet the standards. **Neonatal medical workforce** The Trust is required to formally record in Trust Board minutes whether it meets the recommendations of the neonatal medical workforce training action. If the requirements are not met, an action plan should be developed to meet the recommendations and should be signed off by the Trust Board. **Neonatal nursing workforce** The Trust is required to formally record to the Trust Board minutes the compliance to the service specification standards annually using the neonatal clinical reference group nursing workforce calculator. For units that do not meet the standard, an action plan should be developed to meet the standards and should be signed off by the Trust board and a copy submitted to the Royal College of Nursing (Fiona.Smith@rcn.org.uk) and Neonatal Operational Delivery Network (ODN).	Self-certification by Board.
5.Midwifery Workforce	**Partially Complaint.** Head of Midwifery and Deputy Head of Midwifery will need to review this safety action in light of the additions made due to COVID 19. Unable to provide accurate update (27.10.2020) due to HOM sickness and DHOM annual leave.	The bi-annual report submitted will comprise evidence to support a, b and c progress or achievement. It should include: •A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated •Details of planned versus actual midwifery staffing levels. To include evidence of mitigation/escalation for managing a shortfall in staffing. •An action plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified. •Maternity services should detail progress against the action plan to demonstrate an increase in staffing levels and any mitigation to cover any shortfalls. •The midwife: birth ratio. (Regular reviews and have plans to flexibly adjust midwife to woman ratio if needed due to Covid-19) •The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives. •Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator status and the provision of one-to-one care in active labour. Must include plan for mitigation/escalation to cover any shortfalls. •Did Covid-19 cause impact on staffing levels? -Was the staffing level affected by the changes to the organisation to deal with Covid-19?	Self-certification by Board.

Safety Action	Position as of 27.10.2020	Evidence Required by Board.	Validation
		-How has the organisation prepared for sudden staff shortages in terms of demand, capacity and capability during the pandemic and for any future waves?	
6.SBLCBV2	**Partially Compliant** All Quarterly Care bundle surveys have been included in the Bi-Annual Report(October 2020) . All quarterly care bundle surveys have been completed. They are embedded in the October 2020 Saving Babies Lives Bi-Annual Report, not yet submitted to Board. *How do we feel this would be best to be sighted?* Audits to demonstrate compliance against this safety element are ongoing: No concerns noted at present time.	Evidence of the completed quarterly care bundle surveys for 2020/21 should be submitted to the Trust board. **Element one:** •Recording of carbon monoxide reading for each pregnant woman on Maternity Information System (MIS) and inclusion of these data in the providers' Maternity Services Data Set (MSDS) submission to NHS Digital. •Percentage of women where Carbon Monoxide (CO) measurement at booking is recorded. •Percentage of women where CO measurement at 36 weeks is recorded. Note: The relevant data items for these indicators should be recorded on the provider's Maternity Information System (MIS) and included in the MSDS submissions to NHS Digital in an MSDSv2 Information Standard Notice compatible format. The Trust board should receive data from the organisation's MIS evidencing 80% compliance. If a virtual booking appointment is performed, then CO monitoring at booking can be carried out at the time of the first trimester scan. If CO monitoring is suspended or if there is a delay in the provider trust MIS's ability to record these data at the time of submission an in-house audit of 40 consecutive cases using locally available data or case records should have been undertaken to assess compliance with this indicator. If CO monitoring is suspended due to Covid-19 the audit described above needs to be based on the percentage of women asked whether they smoke at booking and at 36 weeks. The Very Brief Advice and referral to smoking cessation services remain part of the pathway. The timing of the audit is at the Trust's discretion but should include the dates when women booked, and reference to the national CO testing policy at that time. A threshold score of 80% compliance should be used to confirm successful implementation. •If the process metric scores are less than 95% Trusts must also have an action plan for achieving >95%. **Element two:** •Percentage of pregnancies where a risk status for fetal growth restriction (FGR) is identified and recorded at booking. Note: The relevant data items for these indicators should be recorded on the provider's Maternity Information System (MIS) and included in the MSDS submissions to NHS Digital in an MSDSv2 Information Standard Notice compatible format. The Trust board should receive data from the organisation's MIS evidencing 80% compliance. If there is a delay in the provider Trust MIS's ability to record these data at the time of submission an in house audit of 40 consecutive cases using locally available data or case records should have been undertaken to assess compliance with this indicator. A threshold score of 80% compliance should be used to confirm successful implementation. If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%. In addition the Trust board should specifically confirm that within their organisation: 1)women with a BMI>35 kg/m2 are offered ultrasound assessment of growth from 32 weeks' gestation onwards 2)in pregnancies identified as high risk at booking uterine artery Doppler flow velocimetry is performed by 24 completed weeks gestation 3)There is a quarterly audit of the percentage of babies born <3rd centile >37+6 weeks' gestation. If Trusts have elected to follow Appendix G due to staff shortages related to the Covid-19 pandemic Trust Boards should evidence they have followed the escalation guidance for the short term management of staff (https://www.england.nhs.uk/publication/saving-babies-lives-care-bundle-version-2-Covid-19-information/). They should also specifically confirm that they are following the modified pathway for women with a BMI>35 kg/m2. If this is not the case the Trust board should describe the alternative intervention that has been agreed with their commissioner (CCG) and that their Clinical Network has agreed that it is acceptable clinical practice. **Element three:** a)Percentage of women booked for antenatal care who had received leaflet/information by 28+0 weeks of pregnancy. b)Percentage of women who attend with RFM who have a computerised CTG. Note: The SNOMED CT code is still under development for RFM and therefore an in-house audit of two weeks' worth of cases or 20 cases whichever is the smaller to assess compliance with the element three indicators. A threshold score of 80% compliance should be used to confirm successful implementation. If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%. **Element four:** •Percentage of staff who have received training on fetal monitoring in labour in line with the requirements of Safety Action eight, including: intermittent auscultation, electronic fetal monitoring, human factors and situational awareness.	Self-certification by Board. Shadow validation MSDS data for the month of December 2020 at the latest. The December data will be published by NHS Digital by the end of March 2021. Shadow validation by the NHS E/I national team drawing on self-reported position using the SBLCB survey if available.

Safety Action	Position as of 27.10.2020	Evidence Required by Board.	Validation
		•Percentage of staff who have successfully completed mandatory annual competency assessment. Note: An in-house audit should have been undertaken to assess compliance with these indicators. The compliance required is the same as safety action eight i.e. 90% of maternity staff which includes 90% of each of the following groups: •Obstetric consultants •All other obstetric doctors (including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota •Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives). Maternity theatre midwives who also work outside of theatres. **Element 5:** •Percentage of singleton live births (less than 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth. •Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior birth. •Percentage of women who give birth in an appropriate care setting for gestation (in accordance with local ODN guidance). Note: The relevant data items for these indicators should be recorded on the provider's Maternity Information System (MIS) and included in the MSDS submissions to NHS Digital in an MSDSv2 Information Standard Notice compatible format. The Trust board should receive data from the organisation's MIS evidencing 85% compliance. If there is a delay in the provider Trust MIS's ability to record these data at the time of submission an in-house audit of a minimum of four weeks' worth of consecutive cases up to a maximum of 20 cases to assess compliance with the element five indicators. Completion of the audits should be used to confirm successful implementation. If the process indicator scores are less than 85% Trusts must also have an action plan for achieving >85%. In addition, the Trust board should specifically confirm that within their organisation: •women at high risk of pre-term birth have access to a specialist preterm birth clinic where transvaginal ultrasound to assess cervical length is provided. If this is not the case the board should describe the alternative intervention that has been agreed with their commissioner (CCG) and that their Clinical Network has agreed is acceptable clinical practice. an audit has been completed to measure the percentage of singleton live births (less than 34+0 weeks) occurring more than seven days after completion of their first course of antenatal corticosteroids.	
7.MVP	**Partially Compliant.** Evidence gathering continues.	Evidence should include: •Terms of Reference for your MVP •Minutes of MVP meetings demonstrating explicitly how feedback is obtained and the consistent involvement of Trust staff in coproducing service developments based on this feedback •Evidence of service developments resulting from coproduction with service users •Written confirmation from the service user chair that they are being remunerated for their work and that they and other service user members of the Committee are able to claim out of pocket expenses •Evidence that the MVP is prioritising hearing the voices of women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation, as a result of UKOSS 2020 coronavirus data.	Self-certification by Board.
8.MDT Training	**Non- Complaint.** MMPET Virtual Training day re-commences on November 23rd 2020. Action lead will report monthly progress against meeting the compliance requirements of 90% for each staff group. Ongoing work – Training sessions and dates now planned with support from Educational Team. Action Lead plans to report training figures on a monthly basis and plot trajectory. It is anticipated that 90% of relevant staff will have attended a MMPET session by the end of March – April 2020.	Evidence to your Trust Board that you have met the threshold of 90% for each of the staff groups before Thursday 20 May 2021. Trusts should evidence that multi-professional system testing occurs in the clinical area at least once in the MIS reporting period, and it is attended by the anaesthetic, maternity and neonatal teams. Risks and issues identified within the clinical environment are addressed accordingly.	Self-certification by Board.

Safety Action	Position as of 27.10.2020	Evidence Required by Board.	Validation
	Some concerns voiced about ability of clinical obstetric consultants to deliver regular SIMS training and continue with clinical commitments. There is currently no allocation within Consultant Job Plans for delivering SIMS training.		
9.Safety Champions	**Non-Compliant.** *Requirements needed:* *-Administrative support to continue with minutes, action log and agenda planning. Current administrative support seconded to another role.* *-Safety Action Lead questions whether the pathway needs revisiting to ensure we are meeting the requirements. Can we re-visit this with the appointment of the new Board Level Safety Champion?* *-Named Board level Safety Champions (CL & AL) have either left the Trust or are in the process leaving the Trust. There is a requirement for a Board level safety champion to be nominated and understand the complexity and requirements of this safety action.* *-Executive sponsor/Board Level Safety Champion for MATNEOSIP – Clarification needed on whom this is and how they intend to support the divisions in attending and facilitating QI through the MatNeoSIP.* *- Support to utilise SCORE survey results – Trust undertook the SCORE survey in 2018, despite yielding little results, there was no action plan generated. The SCORE survey will need to be utilised in order to meet this requirement. Is this something that HR can assist the Safety Champions with?* *Meeting planned with AL and RMcF to review this safety action – 3rd November 2020.* *I am concerned about this Safety action, there seems to be a much larger onus on the Safety Champions in the newly released guidance, with more complex, evidential requirements.*	a) Evidence of a written pathway which describes how frontline midwifery, neonatal, obstetric and Board safety champions share safety intelligence between a) each other, b) the Board, c) the LMS and d) Patient Safety Networks. b) Evidence that a clear description of the pathway and names of safety champions are visible to maternity and neonatal staff. c) Evidence that discussions regarding safety intelligence, concerns raised by staff and service users in relation to, but not exclusively, the impact of Covid-19 on maternity and neonatal services; progress and actions relating to the local improvement plan(s) and QI activity are reflected in the minutes of Board, LMS and Patient Safety Network meetings. Minutes should also include discussions on where efforts should be positively recognised. d) Evidence of a safety dashboard or equivalent, visible to both maternity and neonatal staff which reflects action and progress made on identified concerns raised by staff and service users. This should include concerns relating to the Covid-19 pandemic. e) Evidence that Board level safety champions have reviewed their continuity of carer action plan in light of Covid-19. Plans should reflect how the Trust will continue or resume continuity of carer models so that at least 35% of women booking for maternity care are being placed onto continuity of carer pathways. In light of the increased risk facing, women from Black, Asian and minority ethnic backgrounds and women from the most deprived areas, local systems should consider bringing forward enhanced continuity of carer models primarily targeting these groups. f) Evidence of Board level oversight and discussion of progress in meeting the revised continuity of carer action plan. g) Evidence that the frontline and Board safety champions have reviewed local outcomes as set out in d) above and are addressing relevant learning, drawing on insights and recommendations from the two named reports and undertaking the requirements within the letter targeting perinatal support for Black, Asian and Minority Ethnic groups. h) Evidence of how the Board has supported staff involved in the four key areas outlined in part e) of the required standard and specifically to: •work with Patient Safety Networks, local maternity systems, clinical networks, commissioners and others on Covid-19 and non Covid-19 related challenges and safety concerns •active participation in contributing to the delivery of the collective aims of the Patient Safety Network and undertaking of improvement work aligned to the MatNeoSIP national driver diagram and key enablers •utilise SCORE culture survey results to inform local quality improvement plans •engage in relevant improvement/capability building initiatives nationally, regionally or via Patient Safety Networks •maintain oversight of improvement outcomes, learning and ensure intelligence is actively shared with key system stakeholders.	Self-certification by Board.
10.NHS Resolution Reporting.	**Compliant.** All notifiable cases have been reported to NHSR by LWH in the time frame 01.04.2019-31.03.2020	Trust Board sight of Trust legal services and maternity clinical governance records of qualifying Early Notification incidents and numbers reported to HSIB and the NHS Resolution Early Notification team. Trust Board sight of evidence that the families have received information on the role of HSIB and EN scheme.	Self-certification by Board.

Safety Action	Position as of 27.10.2020	Evidence Required by Board.	Validation
	All HSIB reportable cases have continued to be reported to HSIB in timeframe 01.04.2020 – date. Governance Team and Leads across the Trust have attended up to date duty of candour training. Duty of Candour letter/HSIB letter provided to parents meets with the statutory duty of candour requirements and has been approved by Head of Governance and Quality.	Trust Board sight of evidence of compliance with the statutory duty of candour.	Cross reference HSIB database and the National Neonatal Research Database.

Liverpool Women's NHS Foundation Trust

Agenda Item	20/21/188

MEETING	**Board**
PAPER/REPORT TITLE:	**Clinical Mandatory Training - Compliance**
DATE OF MEETING:	Thursday, 05 November 2020
ACTION REQUIRED	**Assurance**
AUTHOR(S):	Andrew Loughney, Medical Director Michelle Turner, Chief People Officer
EXECUTIVE DIRECTOR:	As above
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 ☒			
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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 take note of the current challenges and take assurance from the enhanced performance management arrangements now in place to oversee recovery and reduce risk.***			
PREVIOUSLY CONSIDERED BY:	**Committee name**	Not Applicable Or type here if not on list: ***Click here to enter text.***		
	Date of meeting	***Click here to enter a date.***		

Executive Summary

The purpose of this report is to provide an overview of the progress made against recovery plans in each of the Divisions in relation to clinical mandatory training, and to highlight areas of ongoing challenge and focus.

The increasing prevalence of COVID 19 in the community has impacted on the progress against trajectory due to staffing pressures, notably within midwifery staffing. The paper described the implementation of weekly performance management to support the division to an improved position of compliance within a reasonable timescale and to ensure that a risk-based approach to the prioritisation of training is in place.

Staffing issues in Resuscitation and Blood Competencies have been addressed providing for more stability and resilience, with the Clinical Support Services Division responsible for ensuring that is maintained and further strengthened.

The Executive Team will continue to review progress on a weekly basis. The Putting People First Committee will retain oversight of performance against the KPI and provide assurance to the Board of Directors.

Report

Family Health:

In summary, the position in relation to clinical mandatory training is as follows:

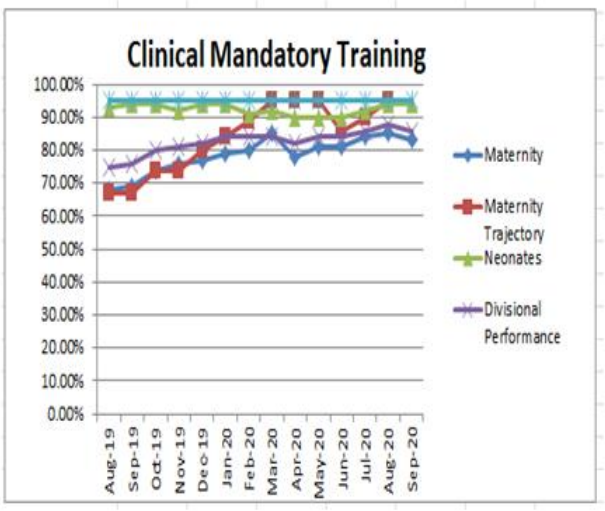
Clinical Mandatory Training	Jun-20	Jul-20	Aug-20	Sept-20
Maternity	81%	84%	85%	83%

Medical Staff - Maternity	73%	74%	76%	78%
Neonates	90%	92%	94%	94%
Medical staff - Neonates	83%	75%	87%	85%
Division (exc Medical)	84%	86%	88%	86%
Trust	85%	81%	88%	87%

It can be noted from the September data above that whilst compliance continues to increase month by month for the medical workforce in Maternity, compliance for other Maternity staff has declined by 2%. Significant staffing challenges have been experienced in Maternity during this period, which will have impacted the ability to complete training – these challenges have been largely related to Covid-19 related absence.

In Neo the reverse can be seen, with compliance for the medical workforce slipping back by 2% whilst compliance for other Neo staff remained steady.

Below is an overview of the clinical mandatory training position in Family Health across the past 12 months, alongside the September compliance by module, excluding the medical workforce:



In September 2020, the modules with compliance of less than 75% at a Divisional Level are:

- Patient Handling – 55.40%
- Safeguarding Adults Level 3 – 66.67%
- Adult Basic Life Support – 70.07%

The trajectory and recovery plan previously reported upon, to reach compliance in August, was not achieved. Maternity reached 88% and missed the trajectory target of 95% by 7%. As at October, the trajectory has not been refreshed. Staffing is the key challenge in maternity at this point in time.

Neonatal have continued to increase compliance rates month on month and have remained at 94% over the last two months.

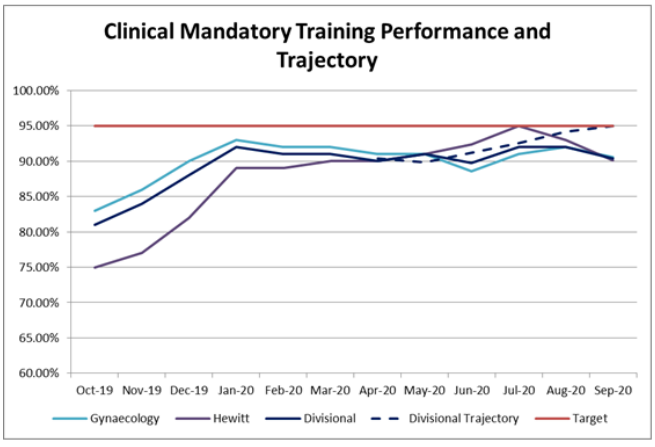
Gynaecology:

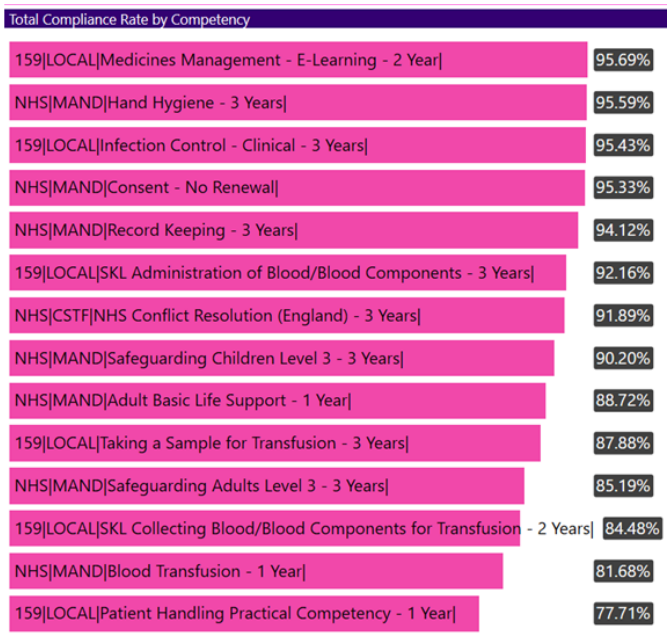
In summary, the position in relation to clinical mandatory training is as follows:

Clinical Mandatory Training	Jun-20	Jul-20	Aug-20	Sept-20
Gynae	89%	91%	92%	91%
Medical Staff - Gynae	84%	87%	88%	85%
Hewitt	92%	95%	93%	90%
Medical staff - Hewitt	96%	94%	90%	90%
Division (exc Medical)	90%	92%	92%	90%
Trust	85%	81%	88%	87%

Clinical mandatory training dipped to 90% compliance in month, meaning that the trajectory agreed earlier this year has not been met. This is in part due to the fluctuating staffing situation placing additional pressure on our clinical teams. If the current staffing pressures continue, it is not anticipated that the 95% compliance target will be met in this calendar year.

Below is an overview of the clinical mandatory training position in Gynaecology across the past 12 months, alongside the September compliance by module, excluding the medical workforce:





As of the end of September 2020, the modules with compliance of less than 75% at a Divisional Level are:

Medical Gynaecology
- BLS - 70.38%
- Safeguarding Adults L3 - 68.18%

Medical Hewitt
- Safeguarding Adults L3 - 66.67%

Whilst there has been noticeable improvement in the clinical mandatory training in the medical workforce across the past 12 months, with both areas reporting a compliance level below 75% in October 2019, progress has slowed.

Resuscitation training has continued to be a focus. As anticipated, this increased slightly in month to 70.38%, with 4 more Consultants/SAS known to have completed the training in October 2020, leaving 3 outstanding. The medical workforce in the Hewitt Centre are 100% compliant with resuscitation training. All resuscitation training is currently reported under the Adult Basic Life Support competency in OLM.

As reported previously, the Clinical Educator role within the Division had been vacant; the interim postholder has since started in post, commencing at the end of September 2020.

Clinical Support Services (CSS):

In summary, the position in relation to clinical mandatory training is as follows:

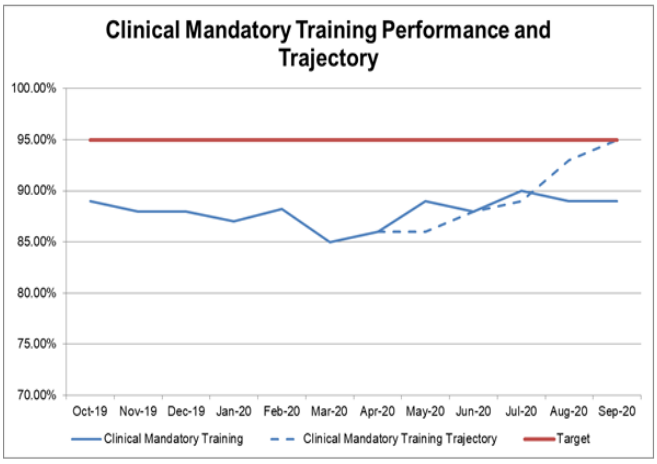
Clinical Mandatory Training	Jun-20	Jul-20	Aug-20	Sept-20
Theatres & Pre-Op (Surgical Services)	86%	90%	88%	88%
Patient Access, Clinical Admin & Reception (Integrated Admin)	87%	81%	81%	80%*
Genetics	97%	97%	98%	97%
Imaging	92%	94%	94%	92%
Pharmacy	97%	86%	90%	92%
Anaesthetics - Medical	79%	89%	96%	96%
Genetics - Medical	96%	98%	98%	96%
Physiotherapy	67%	73%	69%	69%
Division (exc Medical)	88%	90%	89%	89%
Trust	85%	81%	88%	87%

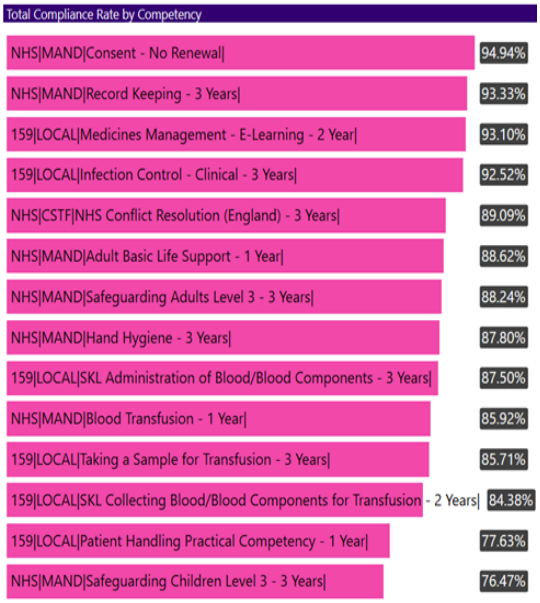
*Management of the Clinical PAs for Family Health and Gynaecology has now moved to their divisions

Clinical mandatory training compliance held at 89%, and from August, has not met the trajectory set in May of this year.

Recent staffing pressures related to short notice sickness absence and isolation due to Covid-19, in addition to vacant posts within theatres have had a significant impact on this, as the clinical mandatory training compliance in CSS is largely dependent on the compliance within theatres. If the current staffing pressures continue, it is not anticipated that the 95% compliance target will be met in this calendar year.

Below is an overview of the clinical mandatory training position in CSS across the past 12 months, alongside the





September compliance by module, excluding the medical workforce:

As of the end of September 2020 there were no modules with compliance of less than 75% at a Divisional Level, though there are 2 with compliance of less than 80% as can be seen above.

As can be seen in the table, it is worth noting that the *Anaesthetics - Medical Staff* mandatory training has been on a successful improvement journey in recent months, now reporting 96% compliance with clinical mandatory training. Within this, 3 of the 4 blood competencies and resuscitation training reporting a 90.91% compliance, with just one person outstanding; 100% have completed the blood transfusion workbook.

Previously blood transfusion training in theatres was reported as a challenge; whilst not yet at the required level, compliance has improved from 77.14% in July to 85.71% as of the end of September 2020.

Conclusion

It can be noted from the above data that overall compliance with clinical mandatory training at Trust level remains challenging, especially in relation to maternity services.

It is concerning to note that recovery plans refreshed in the summer, with clear aims to reach compliance before this point, have not been met and, furthermore, current staffing pressures now being highlighted mean that it is unlikely that compliance will be achieved in the short term.

Divisional focus remains around all aspects of mandatory training however some significant focus is now also being placed around the staffing pressures - largely related to absence driven by Covid-19.

A risk-based approach to recovery will be overseen by weekly performance management meetings with the Executive team.

Recommendation

The Board is asked to take note of the current challenges and take assurance from the enhanced performance management arrangements now in place to oversee recovery and reduce risk.

Liverpool Women's NHS Foundation Trust

	Agenda Item 20/21/189
MEETING	**Trust Board**
PAPER/REPORT TITLE:	**Performance Report**
DATE OF MEETING:	Thursday, 05 November 2020
ACTION REQUIRED	**Assurance**
EXECUTIVE DIRECTOR:	Gary Price, Chief Operating Officer
AUTHOR(S):	Gary Price, Chief Operating Officer
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 Board is asked to note the contents of this paper for assurance on improving performance***			
PREVIOUSLY CONSIDERED BY:	**Committee name**		*Choose an item.* Or type here if not on list: *Click here to enter text.*	
	Date of meeting		*Click here to enter a date.*	

Executive Summary

This report has been produced to provide a position against the Trusts key performance standards and outline the measures being undertaken to improve performance where required by exception. It also highlights where the Covid 19 pandemic has impacted on these measures.

Report

1. Introduction

Delivering high quality, timely and safe care is a key priority for the organization. This report provides an overview of the Trust's quality performance for month 6 20/21 against the key standards. It highlights those areas where the targets have not been met in the most recent month and subsequent actions taken to improve this position. The full dashboard is included as an appendix to this paper which includes all the indicators that have been achieved or not.

2. Workforce

The single month sickness absence figure for month six increased significantly by 1.30% from 4.98% to 6.28%. The figure increased in all three of the largest clinical areas, by 1.81% in both Gynaecology and Maternity, and by 1.57% in Neonates.

Sickness directly attributed to Covid 19 increased significantly from 0.35% in month five to 1.02% in month six.

Local managers continuously monitor sickness absence and adjust rotas and work schedules as appropriate. The HR Department are continuing to provide support for managers in managing sickness absence and in supporting staff through this difficult time. A range of support for staff has been pulled together and communicated to all staff

through the regular coronavirus (COVID-19) staff briefings. A coronavirus testing programme is in place for symptomatic staff (and family members). Covid 19 Risk assessments have now been put in place for all staff.

The overall Trust mandatory training compliance rate fell by 2%, from 91% in month five to 89% in month six. This is now 6% under the Trust's target rate of 95% and rated as amber. In the largest clinical areas, compliance fell by 1% in Gynaecology, by 4% in Maternity and by 2% in Neonates.

While every effort is being made to improve and maintain compliance rates, it is difficult to accurately predict when the target figure of 95% will be achieved, particularly in light of the continuing uncertainty around the Covid 19 pandemic and the current 'second wave' of the virus. However, every endeavour is being made by line managers, with support from the Human Resources and L&D departments, to increase compliance.

KPI ID	Source	Service ID	Target < or >	Target	Value	Trend	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
Sickness Absence Rate	Owner - Deputy Director of Workforce																	
KPI101T	NHSI	Trust	<=	4.5%	Numerator		2499	2264	2532	2549	2229	3195	3148	2327	2108	2312	2043	2494
					Denominator		40070	39330	40809	40902	38492	41197	39757	41513	40457	41594	40995	39689
					Performance		6.24%	5.76%	6.21%	6.23%	5.79%	7.75%	7.92%	5.61%	5.21%	5.56%	4.98%	6.28%
					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		6.07%	6.07%	6.07%	6.61%	6.61%	6.61%	6.23%	6.23%	6.23%	5.60%	5.60%	5.60%
Mandatory Training Compliance	Owner - Deputy Director of Workforce																	
KPI095T	Quality Strategy	Trust	>=	95.0%	Numerator													
					Denominator													
					Performance		90.00%	89.00%	91.00%	91.00%	91.00%	91.00%	90.00%	92.00%	92.00%	91.23%	91.00%	89.00%
					Trend		▶	▼	▲	▶	▶	▶	▼	▲	▶	▼	▼	▼
					Target %		95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

3. Maternity performance

The graphics below detail the key maternity facts for September 2020. This was an extremely busy month for the service against a backdrop of challenging staffing due to high sickness levels and the service should be commended for the performance.


SEPTEMBER 2020 – Maternity Facts.
NHS
Liverpool Women's
NHS Foundation Trust
665 Total Births
60% Breast Feeding Initiation
16 Home Births
337 Girls
328 Boys
40 Term Admissions to NICU
1 Set of Triplets.
Inductions of Labour. 284
11 Sets of Twins
1.4% 3rd Degree Tears
110 Elective C - Sections
105 Emergency C - Sections
Have you had a September Baby? Why not Tweet a picture to our Twitter account... We'd love to hear from you. @LiverpoolWomens
Instrumental Births 83
119 MLU Births
25 Pool Births
Heaviest Baby 10lb 6oz
Lightest Baby 1lb 5oz


MIDWIFE
AT HOME TEAM
NHS
Liverpool Women's
NHS Foundation Trust
SEP 2020
79% Breast Fed
17 Home Births
52% WATER BIRTHS
2 WOMAN Transferred in labour
HEAVIEST BABY 9lb 6oz
Natural placenta delivery (no medication) 45%
39 NEW REFERRALS
If you would like to find out more about Home Birth please contact the Team on 07976835735
home.birth@lwh.nhs.uk.

KPI ID	Source	Service ID	Target < or >	Target	Value	Trend	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
Maternity Services: Proportion of relevant service users who are booked onto a continuity of carer pathway					Owner - Head of Midwifery													
KPI356	Quality Schedule	Maternity	>=	35.0%	Numerator			250	207	117	106	142	96	101	80	75	45	65
					Denominator			790	658	892	775	819	816	751	805	807	660	810
					Performance			31.65%	31.46%	13.12%	13.68%	17.34%	11.76%	13.45%	9.94%	9.29%	6.82%	8.02%
					Trend				▼	▼	▲	▲	▼	▲	▼	▼	▼	▲
					Target %			20%		35%	35%	35%	35%	35%	35%	35%	35%	35%
					Qtrly Performance			31.56%	31.56%	14.68%	14.68%	14.68%	11.68%	11.68%	11.68%	8.12%	8.12%	8.12%

Continuity of Care

LWH continues to review its response to the NHS E call for a maternity pathway to provide women with continuity of care (COC). The target is *Booked onto a COC pathway, (with plans to implement intrapartum care)*, 35% target by March 2021, with movement at pace to have the majority of women in receipt of COC by March 2022. BAME targets have also been reviewed with a target of 75% of this patient group by 2024.

LWH maternity services remain in consultation with our maternity staff regarding, streams, workforce, and application of COC across the maternity service, for LWH to reach the target of 35%, we will be required to start the teams in which ever clinical format by November 2020.

LWH is also reviewing with other national tertiary level maternity providers, the operational delivery of COC, and can the required metric be operationally delivered in a high-risk obstetric model and can COC be delivered in a differing manner in high risk, high acuity, high patient volume.

4. Access Standards

INDICATOR		METRIC	THRESHOLD		ACTUALS											
					Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
Cancer	2WW for suspected cancer	%	≥93%	Higher values are better	96.2	98.3	96.7	94.8	92.6	96.7	95.7	96.5	96.7	97.3	97.0	95.0	93.0
	31 Days from Diagnosis to 1st Definitive Treatment	%	≥96%	Higher values are better	28.6	93.6	85.2	70.0	78.3	81.8	75.0	89.7	96.0	92.9	96.0	93.3	96.0
	62 Days for First Treatment from urgent GP Referral **(After re-allocation)** Final Reported Position	%	≥85%	Higher values are better	28.6	22.7	47.1	37.5	44.4	39.1	66.7	65.0	34.8	36.7	76.0	60.0	37.0
	104d Referral to First Definitive Treatment	Count	0	Zero tolerance	7	2	1	5	2	5	1	1	3	3	1	2	1
RTT	RTT Incomplete Pathways <18 weeks	%	≥92%	Higher values are better	83.3	83.1	83.7	82.0	82.6	81.1	79.5	71.9	64.0	52.6	49.0	56.8	62.0
	Incomplete Pathway >52 Weeks	Count	0	Zero tolerance	1	3	5	1	0	0	0	2	5	11	29	32	24
Diagnostics	Diagnostic Tests: 6 week wait	%	≥99%	Higher values are better	98.3	98.1	98.85	95.61	96.47	98.83	87.80	27.60	47.00	57.70	59.82	58.20	83.25
A&E	A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge	%	95%	Higher values are better	99.1	99.2	99.9	99.1	99.6	98.5	98.1	100.0	98.2	100.0	98.1	98.7	98.2

(Data in Grey is unvalidated at the time of producing the report)

Cancer

Cancer services have been prioritised in the Covid-19 pandemic with the Trust named as the regional gynaecology hub for Cheshire and Merseyside. A priority clinical order has been established which takes precedent over the mandated normal cancer rules.

As per the national guidance[1] cancer multidisciplinary teams (MDTs) must categorise all cancer surgical patients into one of the following priority levels. Trusts should create a single list of the patients in prioritised order.

Priority level 1a

• Emergency: operation needed within 24 hours to save life

Priority level 1b

• Urgent: operation needed with 72 hours

Priority level 2

Elective surgery with the expectation of cure, prioritised according to:

within 4 weeks to save life/progression of disease beyond operability based on

- urgency of symptoms
- complications such as local compressive symptoms
- biological priority (expected growth rate) of individual cancers based on:

Local complications may be temporarily controlled, for example with stents if surgery is deferred and /or interventional radiology.

Priority level 3

Elective surgery can be delayed for 10-12 weeks with have no predicted negative outcome.

The 2-week performance remains strong and it is anticipated that this situation will not change with additional capacity in the coming months due to consultant recruitment. The oncology performance for 31-day DTT remains strong.

Moving forward it is anticipated that we see a continuation of improved performance compared to the past 24 months in 31 DTT target but face on-going challenges with our 62-day target due to Covid priority 3 patient management.

Referral to Treatment

The Trust has started to see a slow rise in 18-week performance and a reduction in 52-week breeches as we restart activity. However detailed work has identified the additional capacity required to deal with the increased backlog and this will only be achieved by increasing theatre staffing as we look to recover lost activity in q3 and q4. Only then will a sustained reduction in the 52-week position be achievable. All 52-week breeches receive a harm review.

The Trust had 24 52-week breaches for September which was a reduction from the previous month. RTT performance increased again to 62% (unvalidated)

The 6-week diagnostic target, as a precursor to an improving 18-week position has seen significant improvement since the height of the first wave.

[1] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/specialty-guide-acute-treatment-cancer-23-march-2020.pdf

5. Conclusion

This paper highlights the key performance 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 - October 2020

Data Included - Up to September 2020

Workforce

KPI ID	Source	Service ID	Target < or >	Target	Value	Trend	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
Sickness Absence Rate	**Owner - Deputy Director of Workforce**																	
KPI101T	NHSI	Trust	<=	4.5%	Numerator		2499	2264	2532	2549	2229	3195	3148	2327	2108	2312	2043	2494
					Denominator		40070	39330	40809	40902	38492	41197	39757	41513	40457	41594	40995	39689
					Performance		6.24%	5.76%	6.21%	6.23%	5.79%	7.75%	7.92%	5.61%	5.21%	5.56%	4.98%	6.28%
					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		6.07%	6.07%	6.07%	6.61%	6.61%	6.61%	6.23%	6.23%	6.23%	5.60%	5.60%	5.60%
Mandatory Training Compliance	**Owner - Deputy Director of Workforce**																	
KPI095T	Quality Strategy	Trust	>=	95.0%	Numerator													
					Denominator													
					Performance		90.00%	89.00%	91.00%	91.00%	91.00%	91.00%	90.00%	92.00%	92.00%	91.23%	91.00%	89.00%
					Trend		►	▼	▲	►	►	►	▼	▲	►	▼	▼	▼
					Target %		95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
					Qtrly Performance													

Efficient

KPI ID	Source	Service ID	Target < or >	Target	Value	Trend	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-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	9	9

Safety

KPI ID	Source	Service ID	Target < or >	Target	Value	Trend	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
Never Events	**Owner - Head of Governance**																	
KPI181T	NHSI	Trust	=	0	Performance Value		0	0	0	0	0	0	0	1	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	1	1	1	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	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

Effective

KPI ID	Source	Service ID	Target < or >	Target	Value	Trend	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
Intensive Care Transfers Out		**Owner - Clinical Director Gynaecology**																
KPI107T	Trust Objectives	Trust			Performance Value		1	2	1	0	0	0	0	1	2	1	1	3
					Trend		▼	▲	▼	▼	▶	▶	▶	▲	▲	▼	▶	▲
					Target Value													
					Qtrly Performance Value		4	4	4	0	0	0	3	3	3	5	5	5

Liverpool Women's NHS Foundation Trust

Experience

KPI ID	Source	Service ID	Target < or >	Target	Value	Trend	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
18 Week RTT: Incomplete Pathways	**Owner - Divisional Manager Gynaecology**																	
KPI003T	NHSI	Trust	>=	92.0%	Numerator		5324	5224	4971	5187	5152	5149	4657	4217	3443	3550	4428	5264
					Denominator		6405	6243	6061	6283	6349	6476	6476	6584	6549	7204	7799	8177
					Performance		83.12%	83.68%	82.02%	82.56%	81.15%	79.51%	71.91%	64.05%	52.57%	49.28%	56.78%	64.38%
					Trend		▼	▲	▼	▲	▼	▼	▼	▼	▼	▼	▲	▲
					Target %		92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%
					Qtrly Performance		82.95%	82.95%	82.95%	81.06%	81.06%	81.06%	62.81%	62.81%	62.81%	57.13%	57.13%	57.13%
18 Week RTT: Incomplete Pathway > 52 Weeks	**Owner - Divisional Manager Gynaecology**																	
KPI002T	Quality Schedule	Trust	=	0	Performance Value		3	5	1	0	0	0	2	5	11	29	32	22
					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		359	374	230	192	196	170	123	79	90	118	114	134
					Denominator		469	453	283	290	278	243	137	104	169	217	210	227
					Performance		76.55%	82.56%	81.27%	66.21%	70.50%	69.96%	89.78%	75.96%	53.25%	54.38%	54.29%	59.03%
					Trend		▼	▲	▼	▼	▲	▼	▲	▼	▼	▲	▼	▲
					Target %		90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
					Qtrly Performance		79.92%	79.92%	79.92%	68.80%	68.80%	68.80%	71.22%	71.22%	71.22%	55.96%	55.96%	55.96%
18 Week RTT: Non-Admitted Completed Pathways	**Owner - Divisional Manager Gynaecology**																	
KPI004T	Trust Objectives	Trust	>=	95.0%	Numerator		1589	1605	1490	1864	1766	1417	798	659	973	913	1042	1043
					Denominator		1888	1958	1774	2230	2073	1673	898	795	1325	1400	1461	1497
					Performance		84.16%	81.97%	83.99%	83.59%	85.19%	84.70%	88.86%	82.89%	73.43%	65.21%	71.32%	69.67%
					Trend		▲	▼	▲	▼	▲	▼	▲	▼	▼	▼	▲	▼
					Target %		95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
					Qtrly Performance		83.35%	83.35%	83.35%	84.45%	84.45%	84.45%	80.52%	80.52%	80.52%	68.79%	68.79%	68.79%
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		2.5	4	4.5	4	4.5	9	6.5	4	5.5	9.5	7.5	
					Denominator		11	8.5	12	9	11.5	13.5	10	11.5	15	12.5	12.5	
					Performance		22.73%	47.06%	37.50%	44.44%	39.13%	66.67%	65.00%	34.78%	36.67%	76.00%	60.00%	
					Trend		▼	▲	▼	▲	▼	▲	▼	▼	▲	▲	▼	
					Target %		85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
					Qtrly Performance		34.92%	34.92%	34.92%	51.47%	51.47%	51.47%	43.84%	43.84%	43.84%	68.00%	68.00%	68.00%
Cancer: 62 Day Screening Referrals (Numbers)	**Owner - Divisional Manager Gynaecology**																	
KPI033	NHSI	Gynaecology	<=	5	Performance Value		2.0	2.0	0.0	1.0	1.0	1.0	1.0	0.5	0.0	2.0	1.0	
					Trend		▲	▶	▼	▲	▶	▶	▶	▼	▼	▲	▼	
					Target Value		5	5	5	5	5	5	5	5	5	5	5	5
					Qtrly Performance Value		4	4	4	3	3	3	1.5	1.5	1.5	3	3	3
Cancer: 62 Day Screening Referrals (Percentage)	**Owner - Divisional Manager Gynaecology**																	
KPI034	NHSI	Gynaecology	>=	90.0%	Numerator		2	2	0	1	1	1	1	0.5	0	2	1	
					Denominator		2	2	0	1	1	1	1	0.5	0	2	1.5	
					Performance		100.00%	100.00%		100.00%	100.00%	100.00%	100.00%	100.00%		100.00%	66.67%	
					Trend		▲	▶			▶	▶	▶	▶			▼	
					Target %		90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
					Qtrly Performance		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	85.71%	85.71%	85.71%
Cancer: 104 Day Breaches	**Owner - Divisional Manager Gynaecology**																	
KPI352	Trust Objectives	Gynaecology	=	0	Performance Value		2	1	5	2	5	1	1	3	3	1	2	
					Trend		▼	▼	▲	▼	▲	▼	▶	▲	▶	▼	▲	
					Target Value		0	0	0	0	0	0	0	0	0	0	0	0
					Qtrly Performance Value		8	8	8	8	8	8	7	7	7	3	3	3

Experience

KPI ID	Source	Service ID	Target < or >	Target	Value	Trend	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
Cancer: 28 Day Faster Diagnosis	**Owner - Divisional Manager Gynaecology**																	
KPI359	Trust Objectives	Gynaecology	>=	75.0%	Numerator		139	118	116	136	145	167	111	112	165	177	159	
					Denominator		289	249	246	258	253	296	208	134	208	242	225	
					Performance		48.10%	47.39%	47.15%	52.71%	57.31%	56.42%	35.00%	83.58%	79.33%	73.14%	70.67%	
					Trend		▲	▼	▼	▲	▲	▼	▼	▲	▼	▼	▼	
					Target %		75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%
					Qtrly Performance		47.58%	47.58%	47.58%	55.51%	55.51%	55.51%	70.55%	70.55%	70.55%	71.95%	71.95%	71.95%
Diagnostic Tests: 6 Week Wait	**Owner - Divisional Manager Clinical Support**																	
KPI204	NHSI	Trust	>=	99.0%	Numerator		468	516	436	464	421	165	35	195	326	332	284	328
					Denominator		477	522	456	481	426	188	127	415	565	555	488	394
					Performance		98.11%	98.85%	95.61%	96.47%	98.83%	87.77%	27.56%	46.99%	57.70%	59.82%	58.20%	83.25%
					Trend		▼	▲	▼	▲	▲	▼	▼	▲	▲	▲	▼	▲
					Target %		99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%
					Qtrly Performance		97.59%	97.59%	97.59%	95.89%	95.89%	95.89%	50.23%	50.23%	50.23%	65.69%	65.69%	65.69%
A&E: Total Time Spent in department (95th Percentile)	**Owner - Divisional Manager Gynaecology**																	
KPI012	Trust Objectives	Gynaecology	<=	240	Performance Value		221	215	210	214	218	222	208	199	213	231	223	232
					Trend		▲	▼	▼	▲	▲	▲	▼	▼	▲	▲	▼	▲
					Target Value		240	240	240	240	240	240	240	240	240	240	240	240
					Qtrly Performance Value		646	646	646	654	654	654	620	620	620	686	686	686
Complaints: Number Received	**Owner - Head of Audit, Effectiveness and Patient Experience**																	
KPI038T	NHSI / Quality Strate	Trust	<=	15	Performance Value		6	4	5	7	4	3	1	6	5	5	2	4
					Trend		▲	▼	▲	▲	▼	▼	▼	▲	▼	▶	▼	▲
					Target Value		15	15	15	15	15	15	15	15	15	15	15	15
					Qtrly Performance Value		15	15	15	14	14	14	12	12	12	11	11	11

Liverpool Women's NHS Foundation Trust

Agenda Item	20/21/189a

MEETING	**Board of Directors.**
PAPER/REPORT TITLE:	**Assessment of Perinatal Mortality in Quarter 1 2020 in relation to COVID 19 – including figures for stillbirth in Q2.**
DATE OF MEETING:	Thursday, 05 November 2020
ACTION REQUIRED	**Assurance**
EXECUTIVE DIRECTOR:	Andrew Loughney, Medical Director
AUTHOR(S):	Angela Winstanley Quality & Safety Midwife.
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 of Directors is asked to note the contents of this report and to take assurance that although understandable concerns have been raised around the relationship of covid with stillbirth: • there is a heightened vigilance around cases of stillbirth at LWH and regionally • rapid identification of cases takes place and a detailed analysis of care then follows • to date, no clear covid related local impact has been identified either directly or indirectly • nevertheless, heightened vigilance will continue throughout the pandemic and will include wider aspects of care, including maternal and extended neonatal outcomes.	
PREVIOUSLY CONSIDERED BY:	**Committee name**	*Choose an item.* Or type here if not on list: *Click here to enter text.*
	Date of meeting	*Click here to enter a date.*

Report

Process

Whenever a stillbirth is encountered at Liverpool Women's NHS FT (LWH) a rapid tabletop review takes place so that any immediate safety issues can be addressed without delay. Escalation is to the Head of Midwifery and the Clinical Director for Obstetrics if any immediate safety issues are identified.

Each case then goes through a thorough regional PMRT (Perinatal Mortality Review Tool) investigative review process. LWH cases are prepared for the PMRT review by the Trust's Quality &

Safety Midwife and the Consultant Lead for Stillbirth. An external expert sits on each review panel and questions specific to covid are now included on the investigation proforma.

Actions arising from the PMRT reviews are developed with the SMART objectives in mind and are allocated a named lead within the Trust. This action log is addressed at the Maternity Quality Meeting and the Maternity Clinical Meeting.

Recent Activity

Ten cases of stillbirth were identified at LWH in Q1 of 2020/2021, indicating a rise compared to recent years. This roughly coincided with the arrival of the covid pandemic in the North West of England. Each case went through the initial in-house process and the external PMRT process as detailed above.

A further additional review of these ten cases was undertaken by in-house lead obstetric and midwifery clinicians to determine whether this increase in stillbirths had resulted either from the direct effects of a covid infection or from a covid-related change in clinical practice. This secondary review included testing the cases against current versions of key clinical guidelines as listed below:

- Management of PPROM.
- Antenatal Referrals and Consultations.
- Maternity Admissions Screening and Management of Diabetes/GDM
- Changes to ultrasound provision for surveillance of fetal growth.
- Management of women with low PAPP-A Screening.
- Provision of Community Midwifery Care
- Care of the placenta after pregnancy loss during COVID-19.
- Maternity Admissions COVID -19.

The present paper provides information around stillbirth rates in Q1 and Q2 (Table 1) with the previously discussed rise in Q1 being balanced by a fall in Q2, back to levels matching 2019-2020 performance. A detailed table of findings against Q1 cases (Table 2) is also included.

In summary, despite national concern around UK stillbirth rates during the pandemic, no clear and sustained correlation can yet be seen in LWH cases. A high degree of vigilance is, however, being maintained.

Conclusions and Limitations

Despite concerns raised nationally and the apparent local rise in cases of stillbirth in Q1, this review did not identify a sustained change in rates of stillbirth. Neither did it identify cases of stillbirth resulting directly or indirectly from covid. The authors recognise that changes in an individual pregnant woman's behaviour could increase the risk of her suffering a stillbirth, for example if she were reluctant to seek help when developing significant symptoms, and that such subtle differences could be difficult to pick up on case review. The authors also recognise that ongoing detailed surveillance is going to be necessary throughout the pandemic.

Next Steps in reporting

A wider review of morbidity in maternity and neonatal care is now being produced for the Board's attention at LWH. In this review, reference will be made to the latest available National Perinatal Epidemiology Unit (NPEU) UK Obstetric Surveillance System (UKOSS) covid data and its relevance to activity at LWH will be discussed.

Recommendations

The Board of Directors is asked to note the contents of this report and to take assurance that although understandable concerns have been raised around the relationship of covid with stillbirth:

- there is a heightened vigilance around cases of stillbirth at LWH and regionally
- rapid identification of cases takes place and a detailed analysis of care then follows
- to date, no clear covid related local impact has been identified either directly or indirectly
- nevertheless, heightened vigilance will continue throughout the pandemic and will include wider aspects of care, including maternal and extended neonatal outcomes.

Table 1: Stillbirth Rates (Non-Termination) 2017 – 2020.

The table below demonstrates the annual stillbirth rates per quarter since 2017 with the exclusion of terminations of pregnancy. It maps the natural variation shown across each financial year and that the LWH stillbirth rate (Non-Termination) has seen a progressive improvement from **4.1/**1,000 births to **2.89/**1,000 births in the last three years. The data below shows a reassuring decrease in the stillbirth rate in Q2 2020/21.

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Overall Year Ending Total
2017-2018	2184 Births	2193 Births	2077 Births	1977 Births	**8431 Births**
Number of Stillbirths (Non TOP)	5	9	13	7	**34**
% per 1,000 births.	2.28%	4.10%	6.25%	3.54%	**4.1%**
2018-2019	2030 Births	2127 Births	2089 Births	1942 Births	**8188 Births**
Number of Stillbirths (Non TOP)	7	7	11	7	**32**
% per 1,000 births	3.44%	3.29%	5.26%	3.6%	**3.91%**
2019-2020	2015 Births	2175 Births	1950 Births	1808 Births	**7948 Births**
Number of Stillbirths (Non-TOP)	8	9	3	4	**23**
% per 1,000 births	3.9%	4.1%	1.5%	1.7%	**2.89%**
2020-2021	1783 Births	1717 Births*			
Number of Stillbirths (Non-TOP)	10	5	TBC	TBC	**TBC**
% per 1,000 births	5.6%	2.91%	TBC	TBC	**TBC**

*Data on births to date 23.09.2020.

Table 2: Case Analysis from second-look review on 17.09.2020.

Case details.	PMRT Grading	Care issue identified at 1st PMRT and Actions Taken.	Impact of COVID-19.
Antenatal Stillbirth at 32 weeks.	Grade B	Incorrectly plotted estimated fetal weights from USS. This has been discussed with the staff involved via the USS department lead.	No COVID 19 related issues at second review.
Antenatal Stillbirth at 39 weeks.	Grade C	Transfer booking from another provider. Noted to have accelerated growth on SFH measurement and a query around polyhydramnios. The MW referred the woman to the Main USS for a growth US. Some concern was expressed at this review as to whether the Growth US in main department was rejected due to COVID-19 altered pathways but this would not have made a difference to the outcome. Actions:- Explore ways to introduce a failsafe system for rejected Growth US scans. -Discussion with Community Midwife re process for referral for? Poly /Accelerated Growth. - LOTW and clearer pathway information.	No COVID 19 related issues at second review. Further review has identified a different, well embedded pathway for Polyhydramnios should have been employed. The referral for Growth USS should have been made LWH ODU/MAU.
Antenatal Stillbirth at 31 weeks.	Grade A	No care issues identified. Triplet pregnancy – Demise of Triplet with extreme FGR and is a recognised complication of multiple pregnancy.	No COVID 19 related issues at second review.
Antenatal Stillbirth at 32 weeks.	Grade C	Declared as Trust SUI. Actions taken from SUI Report and monitored via Safety Senate and Divisional Safety Leads.	No COVID 19 related issues at second review.
Antenatal Stillbirth at 28 weeks	Grade B	Undiagnosed Trisomy 21. Ultrasound imaging did not identify congenital abnormality – feedback to USS department completed.	No COVID 19 related issues at second review.
Antenatal Stillbirth at 34 weeks.	Grade B	DNA attend for 1st GTT appointment – Attended on 2nd GTT – was not due to any changes due to COVID-19 pathway changes.	No COVID 19 related issues at second review.
Antenatal Stillbirth at 26 weeks.	Grade A	No care issues identified. Areas of good practice include appropriate referral for growth USS as previous child born <10th centile.	No COVID 19 related issues at second review.

Antenatal Stillbirth at 25 weeks	Grade B	Fetal abnormality – IUD.	No COVID 19 related issues at second review.
Antenatal Stillbirth at 35 weeks	Grade B	Booked late. Appropriate referral for growth US at 37 weeks as per late booker guidance. IUD was diagnosed prior to 37 week USS. Normally grown birth weight.	No COVID 19 related issues at second review.
Antenatal Stillbirth at 31 weeks.	Grade C	High risk antenatal patient. Managed as Outpatient for Preeclampsia. No referral back to FMU with raised PI. Missed opportunity for MDT discussion around risk of SB.	No COVID 19 related issues at second review.

Agenda Item	20/21/190

MEETING	**Trust Board**
PAPER/REPORT TITLE:	Finance Performance Review Month 6 2020/21
DATE OF MEETING:	Thursday, 05 November 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 6 Financial Position.***	
PREVIOUSLY CONSIDERED BY:	**Committee name**	Finance, Performance and Business Development Committee
	Date of meeting	27/10/2020

Executive Summary

Month 6 is the last month of the temporary financial regime whereby trusts are supported to breakeven with a retrospective top up. As such the Trust is reporting a breakeven position for the month and year to date, position after an expected cumulative top up of £8.4m.

The NHS provider payment regime from Month 7 onwards does not include a retrospective top up. As a result a plan of a net £4.6m deficit for Month 7 to Month 12 has been submitted to the Cheshire & Merseyside Health and Care Partnership (HCP), who are collating the plans at a system wide level. This deficit is as a result of the monthly baseline income allocation being below what is required for 20/21.

The key areas of financial performance are summarised below.[1] There is no requirement currently to deliver or report on Cost Improvement Plans (CIP), however where it has been deemed safe to do so the Trust has initiated those schemes that would not negatively impact during the current situation. Work is ongoing to develop additional CIP for the latter part of the year.

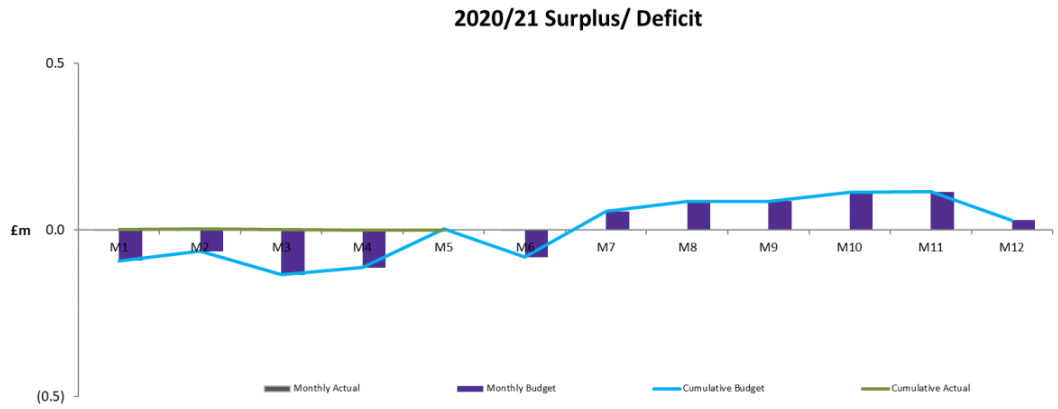
	Plan	Actual	Variance	RAG
Surplus/(Deficit) YTD	-£0.5m	£0.0m	£0.5m	↑
NHS I/E Rating	3	3	0	↔
Cash	£4.6m	£9.8m	£5.2m	↑
Total CIP Achievement YTD	£1.4m	£1.0m	-£0.4m	↓
Recurrent CIP Achievement YTD	£1.4m	£0.8m	-£0.5m	↑
Capital Spend YTD	£2.6m	£1.8m	-£0.8m	

[1] NHS I/E 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 6 the Trust is reporting a breakeven position, after £8.4m top up.



The Retrospective Top Up is comprised as follows; there is an additional £592k which has been received as a Projected Top Up.

	M1 £000	M2 £000	M3 £000	M4 £000	M5 £000	M6 £000	YTD £000
Anticipated structural shortfall	780	780	780	780	780	780	4,680
Private Patient income shortfall	222	253	163	-10	63	-49	642
Commercial income shortfall	56	51	49	47	7	55	265
CIP under delivery	49	50	48	73	73	107	401
Covid-19 costs	484	409	296	361	221	191	1,962
Activity related underspends - non pay	-174	-92	-106	-115	-193	-88	-768
Activity related underspends - pay	-116	-280	-75	-127	-70	10	-659
Trust settlements					260	109	369
Other Healthcare Income (Wales, IoM etc)	42	140	-12	82	88	96	436
Medical pay award (YTD)						109	109
Other	-18	-170	16	105	92	340	365
Total	**1,325**	**1,140**	**1,159**	**1,196**	**1,322**	**1,661**	**7,803**

2. Divisional Summary Overview

Note that whilst activity and notional income under payment by results (PbR) is still being recorded and monitored, it does not impact on the Trust's NHS clinical income position which is comprised of block payments and top ups. There are no clinical income targets at divisional level so the positions below relate to expenditure only. All Covid-19 costs are recorded separately and not contained within divisional positions.

Family Health: The division was underspent in month (£54k) bringing the year to date (YTD) underspend to £237k. Midwifery spend overall remained static against prior year trend and bank spend remains similar to last month (£48k).

Gynaecology: The division overspent in month (£51k), reducing the YTD underspend. This was primarily related to medical overspends. There are also significant activity related underspends on non pay (£251k YTD) and nursing (£196k YTD).

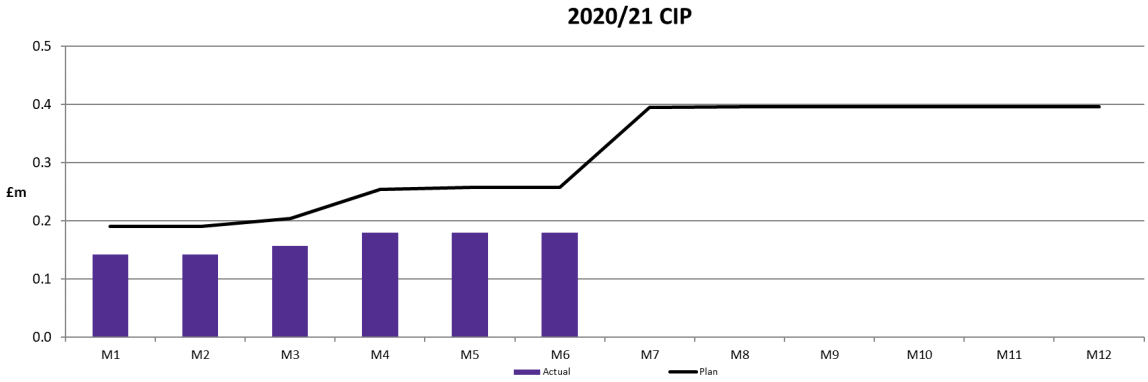
Clinical Support Services: The division was underspent in month (£10k), bringing the year to date position to an underspend of £618k YTD, primarily related to an underspend on medical staffing (£501k) largely related to vacancies in anaesthetics.

Agency: Total agency spend was £390k YTD, of which £263k was Covid-19 related.

3. CIP

CIP delivery is not required nationally at this time and is not reportable to NHSI, although this may change in later months. A number of schemes have been paused during the pandemic. However, those schemes which could safely proceed have done so, delivering CIP of £171k in month. The Trust had £3.7m of schemes identified before delivery was paused and will be well positioned to move forward with this when possible. A full forecast has been undertaken at Month 6, and the Trust is still on track to deliver £2m of this plan by year end, which is similar to the value anticipated at the beginning of the pandemic.

The graph below shows current performance and plan.



4. COVID-19

A total of £191k was spent on Covid-19 related costs in September, a reduction on previous months, although clearly there is a risk this could increase in Month 7 given the rapid increase in cases in the area. There are some underspends within divisions as a result as resources have been diverted to Covid-19, although this is starting to reduce. Key components of this cost are given below.

	M1 £000	M2 £000	M3 £000	M4 £000	M5 £000	M6 £000	YTD £000
Bank costs to cover Covid-19 related vacancies	119	62	71	49	19	22	**342**
Student Nurses	0	40	49	34	17	0	**140**
Agency and WLI costs for medical cover	104	78	46	138	13	1	**379**
PPE and equipment (not including centrally purchased items)	69	24	13	73	61	23	**263**
Enhancements paid to staff off sick	58	26	13	19	18	16	**151**
Staff meals (after £15k charity contribution)	28	60	0	0	0	0	**88**
Other catering and cleaning	32	33	37	15	26	22	**164**
Swabbing Service					17	21	**38**
Additional corporate costs	9	22	27	18	11	17	**105**
Telephony						29	**29**
Other	67	62	41	15	39	40	**264**
Total	**486**	**408**	**296**	**361**	**221**	**191**	**1,964**

Costs in this area continue to be carefully monitored. Further guidance on allowable expenditure has been received and reviewed and the Trust has been in contact with others in the region to ensure consistency.

5. Cash and Borrowings

The cash balance at the end of month 6 was £9.8m, significantly above the plan of £4.6m. The transfer of £14.6m of borrowings to Public Dividend Capital (PDC) related to the Neonatal Redevelopment loan, was transacted in September. This has had a significant impact on the Trust's reported balance sheet. Any further capital bids will be in the form of PDC rather than loans.

6. Capital Expenditure

The capital plan is behind plan YTD but a high level of spend is anticipated over the coming months.

Overall the Trust expects to spend its allocation and will be able to spend more should there be further availability of capital cover at a Cheshire & Merseyside level.

The Trust still awaits approval on the capital bid submitted to DHSC in relation to the enhancements to Crown Street.

7. Balance Sheet

Trade debtors reduced overall by another £1.5m in month on top of the £1.4m reduction in the previous month, and trade debtors are now below £3m.

Deferred income remains high due to the cash receipt in April of two months' worth of block payments received at the beginning of the pandemic.

Most other items including trade and capital creditors remained broadly in line with previous months, but note that other debtors increased due to an increase in prepayments and release of accrued credit notes.

8. BAF Risk

The Finance. Performance and Business Development Committee approved the increase of the score in relation to BAF risk 2344 in relation to the in-year financial position is increased to 20 (likelihood at 5 – *almost certain* and severity at 4 - *major*) from 16 (likelihood 4 – *likely* and severity at 4)

Severity score may be reduced in year, noting that there are obvious structural issues contributing to the deficit forecast and that a positive cash flow is expected to be maintained. This will be kept under review.

9. Conclusion & Recommendation

The Board are asked to note the Month 6 financial position including the increased BAF risk score.

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

FINANCE REPORT: M6

YEAR ENDING 31 MARCH 2021

Contents

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 1
NHS IMPROVEMENT RATIOS: M6
YEAR ENDING 31 MARCH 2021

USE OF RESOURCES RISK RATING	YEAR TO DATE Budget	YEAR TO DATE Actual
CAPITAL SERVICING CAPACITY (CSC)		
(a) EBITDA + Interest Receivable	3,102	3,792
(b) PDC + Interest Payable + Loans Repaid	1,051	1,176
CSC Ratio = (a) / (b)	**2.95**	**3.22**
NHSI CSC SCORE	**1**	**1**
Ratio Score 1 = > 2.5 2 = 1.75 - 2.5 3 = 1.25 - 1.75 4 = < 1.25		
LIQUIDITY		
(a) Cash for Liquidity Purposes	(14,300)	(11,248)
(b) Expenditure	57,149	58,848
(c) Daily Expenditure	312	322
Liquidity Ratio = (a) / (c)	**(45.8)**	**(35.0)**
NHSI LIQUIDITY SCORE	**4**	**4**
Ratio Score 1 = > 0 2 = (7) - 0 3 = (14) - (7) 4 = < (14)		
I&E MARGIN		
Deficit (Adjusted for donations and asset disposals)	483	0
Total Income	(60,226)	(62,640)
I&E Margin	**-0.80%**	**0.0%**
NHSI I&E MARGIN SCORE	**3**	**2**
Ratio Score 1 = > 1% 2 = 1 - 0% 3 = 0 - (-1%) 4 < (-1%)		
I&E MARGIN VARIANCE FROM PLAN		
I&E Margin (Actual)		0.00%
I&E Margin (Plan)		-0.80%
I&E Variance Margin	**0.00%**	**0.80%**
NHSI I&E MARGIN VARIANCE SCORE	**1**	**1**
Ratio Score 1 = > 0% 2 = (1) - 0% 3 = (2) - (1)% 4 = < (2)%		
Note: NHSI assume the score of the I&E Margin variance from Plan is a 1 for the whole year and		
AGENCY SPEND		
YTD Providers Cap	894	894
YTD Agency Expenditure	570	389
	-36%	**-56%**
NHSI AGENCY SPEND SCORE	**1**	**1**
Ratio Score 1 = < 0% 2 = 0% - 25% 3 = 25% - 50% 4 = > 50%		
Overall Use of Resources Risk Rating	**3**	**3**

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

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
INCOME & EXPENDITURE: M6
YEAR ENDING 31 MARCH 2021

INCOME & EXPENDITURE	M6 - NHSI Plan			M6 - Internal Budget			YTD - NHSI Plan			YTD - Internal Budget			YEAR		
£'000	NHSI Plan	Actual	Variance	Budget	Actual	Variance	NHSI Plan	Actual	Variance	Budget	Actual	Variance	Budget	Forecast	Variance
Income															
Clinical Income	(8,501)	(8,658)	157	(8,723)	(8,658)	(64)	(51,006)	(50,937)	(69)	(52,302)	(50,937)	(1,365)	(104,793)	(102,948)	(1,845)
Top Up inc MRET	(124)	(1,760)	1,636	(655)	(1,760)	1,105	(742)	(8,395)	7,653	(3,930)	(8,395)	4,465	(8,749)	(12,291)	3,542
Non-Clinical Income	(672)	(507)	(165)	(668)	(507)	(161)	(4,034)	(3,308)	(726)	(3,993)	(3,308)	(686)	(7,151)	(6,693)	(458)
Total Income	**(9,297)**	**(10,925)**	**1,628**	**(10,045)**	**(10,925)**	**879**	**(55,782)**	**(62,640)**	**6,858**	**(60,226)**	**(62,640)**	**2,414**	**(120,693)**	**(121,932)**	**1,239**
Expenditure															
Pay Costs	5,897	6,251	(354)	5,984	6,251	(267)	35,382	36,865	(1,483)	35,907	36,865	(958)	71,670	74,570	(2,900)
Non-Pay Costs	1,668	2,719	(1,051)	2,220	2,719	(499)	10,008	14,201	(4,193)	13,460	14,201	(741)	26,283	28,747	(2,464)
CNST	1,201	1,297	(96)	1,297	1,297	0	7,206	7,782	(576)	7,782	7,782	0	15,563	15,563	0
Total Expenditure	**8,766**	**10,267**	**(1,501)**	**9,501**	**10,267**	**(766)**	**52,596**	**58,848**	**(6,252)**	**57,149**	**58,848**	**(1,699)**	**113,516**	**118,880**	**(5,364)**
EBITDA	**(531)**	**(658)**	**127**	**(544)**	**(658)**	**114**	**(3,186)**	**(3,792)**	**606**	**(3,077)**	**(3,792)**	**715**	**(7,177)**	**(996)**	**(6,181)**
Technical Items															
Depreciation	363	441	(78)	446	441	5	2,178	2,638	(460)	2,535	2,638	(104)	5,109	5,324	(215)
Interest Payable	28	4	24	43	4	38	168	26	142	242	26	216	488	56	432
Interest Receivable	(5)	0	(5)	(4)	0	(4)	(30)	0	(30)	(25)	0	(25)	(51)	0	(51)
PDC Dividend	145	214	(69)	142	214	(71)	870	1,150	(280)	809	1,150	(342)	1,630	2,275	(644)
Profit/Loss on Disposal or Transfer Absorption	0	0	0	0	0	0	0	(14)	14	0	(14)	14	0	(14)	14
Total Technical Items	**531**	**659**	**(128)**	**626**	**659**	**(33)**	**3,186**	**3,801**	**(615)**	**3,560**	**3,801**	**(240)**	**7,177**	**7,640**	**(464)**
(Surplus) / Deficit	**0**	**1**	**(1)**	**82**	**1**	**81**	**0**	**8**	**(8)**	**483**	**8**	**475**	**0**	**4,589**	**(4,589)**
Break-even adjusting items															
Depn on donated assets		*(1)*	*1*		*(1)*	*1*		*(8)*	*8*		*(8)*	*8*		*(15)*	*15*
Breakeven Position	***0***	***0***	***(0)***	***82***	***0***	***82***	***0***	***(0)***	***0***	***483***	***(0)***	***484***	***0***	***4,574***	***(4,574)***
Provider Top-up funding from NHSI/E															
Block projected Top-up	*99*	*99*	0	*99*	*99*	0	*592*	*592*	0	*592*	*592*	0	*1,188*	*592*	(596)
Retrospective Top-Up validated (inc. MRET)	*25*	*25*	(1)	*25*	*25*	(1)	*150*	*6,141*	5,991	*150*	*5,928*	5,778	*7,561*	*7,803*	242
Retrospective Top-Up unvalidated		*1,637*	1,637	*531*	*1,637*	1,106	*0*	*1,662*	1,662	*3,188*	*1,874*	(1,314)		*0*	0
System Top-Up M7-M12		*0*	0		*0*	0		*0*	0		*0*	0		*3,896*	3,896
Variance against Trust planned budget	***124***	***1,760***	***1,637***	***655***	***1,760***	***1,105***	***742***	***8,395***	***7,653***	***3,930***	***8,395***	***4,464***	***8,749***	***12,291***	***3,542***

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 3
EXPENDITURE: M6
YEAR ENDING 31 MARCH 2021

EXPENDITURE £'000	MONTH Budget	MONTH Actual	MONTH Variance	YEAR TO DATE Budget	YEAR TO DATE Actual	YEAR TO DATE Variance	YEAR Budget	YEAR Actual	YEAR Variance
Pay Costs									
Board, Execs & Senior Managers	327	361	(34)	1,963	2,081	(118)	3,927	4,195	(269)
Medical	1,555	1,676	(121)	9,336	9,284	53	18,673	19,070	(397)
Nursing & Midwifery	2,650	2,755	(106)	15,898	16,870	(973)	31,695	33,973	(2,277)
Healthcare Assistants	424	425	(1)	2,542	2,601	(59)	5,084	5,317	(233)
Other Clinical	376	356	20	1,845	1,681	164	4,517	4,222	296
Admin Support	136	129	7	819	795	23	1,637	1,672	(35)
Corporate Services	452	509	(57)	2,710	2,810	(100)	5,375	5,457	(82)
Agency & Locum	63	40	24	794	742	52	761	665	96
Total Pay Costs	**5,984**	**6,251**	**(267)**	**35,907**	**36,865**	**(958)**	**71,670**	**74,570**	**(2,900)**
Non Pay Costs									
Clinical Suppplies	623	535	88	1,898	1,777	122	7,502	7,502	0
Non-Clinical Supplies	555	793	(237)	10,890	10,933	(43)	6,665	7,347	(682)
CNST	1,297	1,297	0	3,891	3,891	0	15,563	15,563	0
Premises & IT Costs	600	640	(40)	1,806	1,780	26	7,202	7,202	0
Service Contracts	443	752	(309)	2,757	3,603	(845)	4,915	6,697	(1,782)
Total Non-Pay Costs	**3,517**	**4,016**	**(499)**	**21,242**	**21,983**	**(741)**	**41,847**	**44,310**	**(2,464)**
Total Expenditure	**9,501**	**10,267**	**(766)**	**57,149**	**58,848**	**(1,699)**	**113,516**	**118,880**	**(5,364)**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 4a
COVID EXPENDITURE: M6
YEAR ENDING 31 MARCH 2021

EXPENDITURE £'000	MONTH Budget	MONTH Actual	MONTH Variance	YEAR TO DATE Budget	YEAR TO DATE Actual	YEAR TO DATE Variance
Pay Costs						
Board, Execs & Senior Managers	0	8	(8)	0	27	(27)
Medical	0	1	(1)	0	189	(189)
Nursing & Midwifery	0	33	(33)	0	595	(595)
Healthcare Assistants	0	16	(16)	0	146	(146)
Other Clinical	0	0	(0)	0	2	(2)
Admin Support	0	13	(13)	0	15	(15)
Corporate Services	0	0	0	0	0	0
Agency & Locum	0	9	(9)	0	263	(263)
Total Pay Costs	**0**	**80**	**(80)**	**0**	**1,238**	**(1,238)**
Non Pay Costs						
Clinical Suppplies	0	9	(9)	0	115	(115)
Non-Clinical Supplies	0	105	(105)	0	519	(519)
CNST	0	0	0	0	0	0
Premises & IT Costs	0	(4)	4	0	87	(87)
Service Contracts	0	2	(2)	0	5	(5)
Total Non-Pay Costs	**0**	**112**	**(112)**	**0**	**727**	**(727)**
Total Expenditure	**0**	**192**	**(192)**	**0**	**1,965**	**(1,965)**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 5
BUDGET ANALYSIS: M6
YEAR ENDING 31 MARCH 2021

INCOME & EXPENDITURE £'000	MONTH Budget	MONTH Actual	MONTH Variance	YEAR TO DATE Budget	YEAR TO DATE Actual	YEAR TO DATE Variance	YEAR Budget
Maternity							
Income	0	(4)	4	0	(24)	24	0
Expenditure	1,889	1,942	(53)	11,335	11,449	(114)	22,671
Total Maternity	**1,889**	**1,938**	**(49)**	**11,335**	**11,425**	**(89)**	**22,671**
Neonatal							
Income	0	(128)	128	0	(458)	458	0
Expenditure	1,127	1,151	(25)	6,760	6,892	(131)	13,520
Total Neonatal	**1,127**	**1,024**	**103**	**6,760**	**6,434**	**326**	**13,520**
Division of Family Health - Total	**3,016**	**2,962**	**54**	**18,096**	**17,859**	**237**	**36,191**
Gynaecology							
Income	0	0	0	0	0	0	0
Expenditure	1,033	1,063	(30)	6,198	5,963	236	12,397
Total Gynaecology	**1,033**	**1,063**	**(30)**	**6,198**	**5,963**	**236**	**12,397**
Hewitt Centre							
Income	0	0	0	0	(1)	1	0
Expenditure	692	714	(21)	4,158	3,600	558	8,296
Total Hewitt Centre	**692**	**714**	**(21)**	**4,158**	**3,599**	**559**	**8,296**
Division of Gynaecology - Total	**1,725**	**1,777**	**(51)**	**10,356**	**9,562**	**795**	**20,693**
Theatres							
Income	0	0	0	0	0	0	0
Expenditure	729	619	110	4,392	3,818	574	8,663
Total Theatres	**729**	**619**	**110**	**4,392**	**3,818**	**574**	**8,663**
Genetics							
Income	0	88	(88)	0	(94)	94	0
Expenditure	151	133	18	908	863	45	1,816
Total Genetics	**151**	**221**	**(70)**	**908**	**769**	**139**	**1,816**
Other Clinical Support							
Income	0	(0)	0	0	(0)	0	0
Expenditure	602	632	(30)	3,724	3,819	(95)	7,338
Total Clinical Support	**602**	**632**	**(30)**	**3,724**	**3,819**	**(95)**	**7,338**
Division of Clinical Support - Total	**1,482**	**1,472**	**10**	**9,024**	**8,406**	**618**	**17,817**
Corporate & Trust Technical Items							
Income	(10,045)	(10,881)	836	(60,226)	(62,063)	1,837	(120,693)
Expenditure	3,904	4,672	(768)	23,233	26,245	(3,011)	45,992
Total Corporate	**(6,142)**	**(6,209)**	**68**	**(36,993)**	**(35,818)**	**(1,175)**	**(74,701)**
(Surplus) / Deficit	**82**	**1**	**81**	**483**	**8**	**475**	**0**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 6
CIP: M6
YEAR ENDING 31 MARCH 2021

SCHEME NAME	SCHEME NAME	MONTH 6			YTD			Full Year		
		Original Target	Actual	Variance	Original Target	Actual	Variance	Original Target	Revised	Variance
Procurement Savings	Procurement Savings (Trust-wide)	0	0	0	0	0	0	0	0	0
Contract Savings	Genetics contribution to overheads	38	38	0	228	228	0	456	456	0
Maternity Skillmix	Maternity HCA vacancies	21	21	0	125	125	0	250	0	(250)
Estate Utilisation	Aintree Estate Utilisation	0	0	0	0	0	0	0	0	0
Bank Usage	NHSP Savings (subject to Business Case)	17	17	0	100	100	0	200	0	(200)
Physiotherapy Productivity	Additional Pysiotherapy activity within existing resource	0	0	0	0	0	0	0	0	0
IM&T Enabled Savings	GDE Revenue Savings	0	0	0	0	0	0	0	0	0
Commissioning Changes	Genetics Commissioning Changes (Sendaway Tests)	11	11	0	68	68	0	135	135	0
Rental Income	Estates Rental income - UNIVERSITY	10	10	0	58	58	0	115	115	0
HFC Strategic Review	HFC Strategic Review	0	0	0	0	0	0	0	0	0
Theatre Efficiency and Surgical Pathways Project	Theatre Efficiency and Surgical Pathways Project	0	0	0	0	0	0	0	0	0
Full SLA review	Full SLA review	11	11	0	33	33	0	100	100	0
TOPS Pathway	MVA Business Case income generation (net of pay costs)	0	0	0	0	0	0	0	0	0
Theatre procurement Savings	Theatre procurement Savings	0	0	0	0	0	0	0	0	0
Transformation Team Efficiences	Transformation Team review of all pay budgets/structures	8	8	0	50	50	0	100	100	0
HR Team Efficiencies	HR review of all pay budgets/structures	7	7	0	40	40	0	79	79	0
Maternity Income	P2P Activity above budget 19/20	0	0	0	0	0	0	0	0	0
Imaging Recharges	Imaging recharges for scanning - full review (AH Consultant)	6	6	0	35	35	0	70	70	0
Fertility Service Development	Additional Fertility offering Macclesfield	0	0	0	0	0	0	0	0	0
Imaging rota review	Imaging rota review	5	5	0	30	30	0	60	60	0
Fertility Pathway Efficiencies	TESE	0	0	0	0	0	0	0	0	0
Other Smaller Schemes	Other Smaller Schemes	124	38	(86)	589	187	(402)	2,162	933	(1,229)
		257	**171**	**(86)**	**1,355**	**953**	**(401)**	**3,728**	**2,049**	**(1,679)**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 7
BALANCE SHEET: M6
YEAR ENDING 31 MARCH 2021

BALANCE SHEET £'000	YEAR TO DATE Opening	YEAR TO DATE M06 Actual	YEAR TO DATE Movement	YEAR TO DATE Budget	YEAR TO DATE M06 Actual	YEAR TO DATE Movement
Non Current Assets	**92,282**	**91,439**	(843)	**93,354**	**91,439**	(1,915)
Current Assets						
Cash	4,647	9,790	5,143	4,600	9,790	5,190
Debtors	6,329	5,973	(356)	8,636	5,973	(2,663)
Inventories	432	380	(52)	452	380	(72)
Total Current Assets	**11,408**	**16,143**	**4,735**	**13,688**	**16,143**	**2,455**
Liabilities						
Creditors due < 1 year - Capital Payables	(2,809)	(653)	2,156	(266)	(653)	(387)
Creditors due < 1 year - Trade Payables	(15,314)	(12,731)	2,583	(18,232)	(12,731)	5,501
Creditors due < 1 year - Deferred Income	(2,918)	(11,924)	(9,006)	(3,471)	(11,924)	(8,453)
Creditors due > 1 year - Deferred Income	(1,623)	(1,608)	15	(1,600)	(1,608)	(8)
Loans	(17,359)	(2,442)	14,917	(17,117)	(2,442)	14,675
Provisions	(1,698)	(1,660)	38	(4,870)	(1,660)	3,210
Total Liabilities	**(41,721)**	**(31,018)**	**10,703**	**(45,556)**	**(31,018)**	**14,538**
TOTAL ASSETS EMPLOYED	**61,969**	**76,564**	**14,595**	**61,486**	**76,564**	**15,078**
Taxpayers Equity						
PDC	42,519	57,122	14,603	42,488	57,122	14,634
Revaluation Reserve	14,329	14,329	0	14,503	14,329	(174)
Retained Earnings	5,121	5,113	(8)	4,495	5,113	618
TOTAL TAXPAYERS EQUITY	**61,969**	**76,564**	**14,595**	**61,486**	**76,564**	**15,078**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 8
CASHFLOW STATEMENT: M6
YEAR ENDING 31 MARCH 2021

CASHFLOW STATEMENT	YEAR TO DATE		
£'000	Budget	Actual	Variance
Cash flows from operating activities	307	1,154	(847)
Depreciation and amortisation	2,601	2,638	(37)
Impairments and reversals	0	0	0
Income recognised in respect of capital donations (cash and non-cash)	0	0	0
Movement in working capital	1,186	5,645	(4,459)
Net cash generated from / (used in) operations	**4,094**	**9,437**	**(5,343)**
Interest received	25	0	25
Purchase of property, plant and equipment and intangible assets	(2,784)	(3,966)	1,182
Proceeds from sales of property, plant and equipment and intangible assets	0	14	(14)
Net cash generated from/(used in) investing activities	**(2,759)**	**(3,952)**	**1,193**
PDC Capital Programme Funding - received	0	0	0
PDC Funding received (Loans to PDC Conversion)	0	14,572	(14,572)
PDC COVID-19 Capital Funding - received	0	31	(31)
Loans from Department of Health Capital - received	428	0	428
Loans from Department of Health Capital - repaid	(631)	(306)	(325)
Loans from Department of Health Capital - repaid (Loans to PDC Conversion)	0	(14,572)	14,572
Loans from Department of Health Revenue - received	0	0	0
Loans from Department of Health Revenue - repaid	0	0	0
Interest paid	(213)	(67)	(146)
PDC dividend (paid)/refunded	(919)	0	(919)
Net cash generated from/(used in) financing activities	**(1,335)**	**(342)**	**(993)**
Increase/(decrease) in cash and cash equivalents	**0**	**5,143**	**(5,143)**
Cash and cash equivalents at start of period	4,600	4,647	(47)
Cash and cash equivalents at end of period	**4,600**	**9,790**	**(5,190)**

LOANS SUMMARY £'000	Loan Principal Drawndown	Loan Principal Repaid	Loan Principal Outstanding
Loans from Department of Health - Capital (ITFF) - 2.0% Interest Rate	5,500	(3,058)	2,442
Loans from Department of Health - Capital (Neonatal) - 2.54% Interest Rate	14,572	(14,572)	0
Loans from Department of Health - Revenue - 1.50% Interest Rate	14,612	(14,612)	0
Total	**34,684**	**(32,242)**	**2,442**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 9
CAPITAL EXPENDITURE: M6
YEAR ENDING 31 MARCH 2021

CAPITAL EXPENDITURE	Year to Date		
£'000	Budget	Actual	Variance
Neonatal New Building	1,159	690	469
Estates Schemes	130	75	55
IT Schemes	924	731	193
Medical Equipment	408	283	125
COVID-19 Items	0	31	(31)
Total	**2,621**	**1,810**	**811**

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	20/21/191

MEETING	**Board**
PAPER/REPORT TITLE:	**Well-Led Framework Self-Assessment – Action Plan**
DATE OF MEETING:	Thursday, 05 November 2020
ACTION REQUIRED	**Receive**
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 asked to receive the well-led assessment action plan, noting updates where appropriate.***			
PREVIOUSLY CONSIDERED BY:	**Committee name**	N/A		
	Date of meeting			

Executive Summary

The Trust undertook a self-assessment against the Well-Led Framework during Jan-Mar 2020. This resulted in an overall view of performance which was agreed by the Board in April 2020. The next step was to develop an action plan and work against this ahead of the procurement of an external review during 2020/21. This action plan was agreed in July 2020 and it was noted that regular updates on progress would be provided to the Board.

The action plan below provides an outline of the specific actions against the KLOE headings.

The action plan was subject to a thorough review by the Executive Team on the 28th October 2020. These updates are reflected in the 'comments' section. On occasion, the timescale has been refined to reflect a more accurate position as the implications of the Covid-19 pandemic have become clearer over time. These are shown utilising strikethroughs and parentheses (for showing updates to timescales).

In addition to the specific actions, key themes were identified from the self-assessment in April 2020. Updates against these are as follows:

1. 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.

   Work has progressed to develop the Trust's strategy and strategic aims with regular updates provided to the Finance, Performance and Business Development Committee and the Board. There are plans to gather the views of governors, staff and the public prior to the end of the calendar year, finalise the strategy in the New Year and launch a campaign to ensure that the key messages are well understood by staff and stakeholders. This will involve linking the strategy and strategic aims to the updated appraisal process.

2. 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'.

Continuous or Quality Improvements projects have progressed and examples of these will be reported to the November 2020 Board. To date, the Effectiveness Senate has taken a lead in considering and approving quality improvement projects. Quality improvement will be embedded in the developing performance management framework with the exception report template including prompts to outline how the Trust's quality improvement methodology is being utilised in day-to-day operations. An overarching document, summarising the Trust's approach is close to completion and will be progressed through the Executive Team prior to the end of the calendar year.

3. To ensure that there is a consistent approach to 'lesson learning' throughout the organisation

   Whilst progress has been made to enhance the Trust's approach to lesson learning, and body of evidence is being compiled, further work is required to ensure that lessons are being effectively utilised to drive changes in practice that become fully embedded and demonstrable. The Quality Committee is scheduled to receive a 'deep dive' in November 2020 on how lessons from the Legal Services Annual Report can be utilised to inform better practice. A comprehensive report on the Trust's approach to lesson learning is scheduled for the February 2021 Board.

The Trust's self-assessment (and action plan) is one part of the overall Well-Led framework process with there being a requirement to follow this with an external review. The procurement process is underway, and it is hoped that the review will begin in January 2021 with a final report received by the Board in April 2021.

In the New Year, it will be important for actions in the self-assessment to be closed (where possible) and with evidence to be provided. It is planned to hold sessions with the Executive Lead, Operational Lead and NED Lead for each KLOE to gain detailed assurance of the underpinning assurance prior to reporting back to the full Board.

The Board is asked to receive the well-led assessment action plan, noting updates where appropriate.

Well-Led Self-Assessment Action Plan

KLOE 1. Is there the leadership capacity and capability to deliver high quality, sustainable care?						
Lead Executive: Chief Executive Management Lead: Trust Secretary NED Lead: Trust Chair						
Action Ref	Action	**Timescale**	**Lead**	Progress	Comments	Link with CQC Action Plan
K1/1.1	Development of a Board Terms of Reference to provide additional clarity on roles and responsibilities	May-20	TS		Complete	
K1/1.2	Ensure that an annual declaration against the Code of Conduct is completed by Board members	Sep-20	TS		Complete	
K1/1.3	Ensure that safeguarding issues are highlighted more prominently in Board and Committee papers	Jan-21 (Sep-20)	TS / Chair / Committee Chairs		Rather than including the highlighting of both safeguarding issues in the regular 'review of risks' item on Board and Committee agendas, it is proposed that Safeguarding metrics be developed and for these to be reported to the relevant assurance meeting for visibility (Quality Committee and Board).	
K1/1.4	Although the gender balance is good there are further opportunities to improve the diversity of the Board to ensure that it mirrors the population that the Trust serves. This should feature in future succession plans.	Nov-20	TS / Chair		A discussion on Board succession planning took place September 2020 Board which identified key skills required going forward (including diversity and community representation). This will be discussed and agreed with the Council of Governors prior to the recruitment process being finalised in November 2020.	
K1/1.5	To share findings from the external well-led review once complete and ensure that progress against the action plan is reported through the public Board.	Apr-21	TS		The Trust is planning to procure and complete the external review prior to the financial year-end.	
K1/1.6	To seek Committee feedback into the effectiveness reviews from all members – take into consideration the recommendations from the MIAA Audit Committee Effectiveness Review.	Mar-21	TS		Committee Effectiveness process is being reviewed and will take into consideration the recommendations from the MIAA Audit Committee Effectiveness Review (scheduled to report in October 2020)	
K1/1.7	Consider how to formalise feedback from the Shadow Board process	~~Oct 20~~ Dec 20	TS / Chair		The Shadow Board process, paused due to Covid-19, is scheduled to re-start from December 2020 with consultations on key items before this point. Once reconvened, a process will be agreed for providing formalised feedback to the Board. This will support the Board's Continuous Improvement aims. A suggestion is that a representative from the Shadow Board will be asked to attend prior to the full Board to provide feedback to inform Board discussions.	
K1/1.8	Effective assurance minute writing guidance to be produced for all relevant administrative staff.	Nov-20	TS		This will be incorporated into the Governance and Performance Framework (currently in development). This will be supported by group training delivered by the Corporate Governance team.	
K1/1.9	To develop Leadership & Organisational Development Strategy	Dec-20 (Sep-20)	CPO		First draft of Leadership Strategy is going to PPF in November 2020. Depending on the extent of amendments required, this will then be received by the Board in December 2020 or February 2021.	
KLOE 2. Is there a clear vision and a credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?						
Lead Executive: Director of Finance Management Lead: Strategic Finance Manager NED Lead: Jo Moore						
Action Ref	Action	Timescale	Lead	Progress	Comments	Link with CQC Action Plan

K2/2.1	Strategy re-fresh to be undertaken with public facing document also produced. This will be socialised with the public, stakeholders, and staff. Strategy to ensure that it; a) References operational priorities – e.g. RTT, GIRFT b) is aligned to newly published Long-Term Plan; c) Clearly articulates short- and medium-term plans linked to overarching strategy, and; d) Shows how it has used NHSI Strategy tool	Apr-21	DoF / CPO		Strategy refresh is underway which applies the methodology of NHSI strategy development tool and will link to national, local and Trust priorities. Full engagement is planned as part of the development.	SHOULD DO #19
K2/2.2	Ensuring there is a clear link to strategy when producing annual service plans	Feb-21 (Sep-20)	DoF		Annual Service Plans were paused due to the Covid-19. It is not expected that this can be achieved for the 2020-21 financial year but will be factored into the planning for 2021-22.	SHOULD DO #19
K2/2.3	To undertake testing on whether more junior staff in all areas can articulate the Trust strategy	Feb-21 (Oct-20)	CPO		Once the strategy has been launched in the New Year – testing will be undertaken on the effectiveness of the campaign.	SHOULD DO #19
K2/2.4	Re-establish robust patient engagement mechanisms regarding the Trust Strategy with reporting through to the Experience Senate	Nov-20 (Sep-20)	DoN&M		Update on patient engagement plans with the Trust Strategy outlined in the Trust Strategy item on the September 2020 Board agenda. Engagement sessions planned for November and December 2020.	SHOULD DO #19
K2/2.5	Ensure that there are documented links from overarching strategy to individual performance target levels	Apr-21 (Sep-20)	CPO		PDR review underway. PDR window to be introduced in line with publication of the Trust corporate objectives, creating a 'golden thread'. To be introduced Q1.	SHOULD DO #19
K2/2.6	To ensure that there is a post implementation review process for strategy	Mar-21 (Jun-21)	DoF		A formal process is being introduced for annual strategy post implementation reviews to be scrutinised and reported through the relevant Board Committee structures. This is to be added as part of the annual workplan for each committee. The overarching corporate/Future Generations strategy would further be aligned to the Board's review of the setting of and performance against the Trust's annual Corporate Objectives.	SHOULD DO #19
K2/2.7	Clear links to strategy in divisional priorities with references to strategy delivery in Divisional Performance meetings	Apr-21 (Oct-20)	COO		This was intended to be achieved with the plans on a page, however Covid-19 affected the practicalities of completing this. For 2021/22 each division will update their plans on a page (and corporate services) and they will be the tools for linking strategy to performance from then on. In the meantime, the performance reviews will be updated to reflect links to strategic aims.	SHOULD DO #19
KLOE 3. Is there a culture of high quality, sustainable care?						
Lead Executive: Director of Nursing & Midwifery	Management Lead: Deputy Director of Nursing		NED Lead: Tony Okotie			
Action Ref	Action	Timescale	Lead	Progress	Comments	Link with CQC Action Plan
K3/3.1	Quality improvement work needs to be more focused with clear demonstration of training, projects identified with robust evaluations. Although to some extent this is demonstrated through audit and effectiveness (service evaluations) further work needs to be done with the evidencing of QI projects and sustainability specifically in clinical areas. To be a focus in the quality strategy 2020-2025.	Nov-20	MD		The draft quality strategy is timetabled for ratification at Board in September 2020. It references the QI processes of the Trust (separate QI Strategy in development). The Divisional Boards are now being instructed to include QI as one if their key agenda items and oversight is provided by the Effectiveness Senate.	
K3/3.2	It is recognised and evidenced through the staff survey that the quality of appraisals needs improving. A review of appraisal process and documentation / conversation needs to happen with a talent management conversation as a separate discussion. To start in September 2020.	Apr-21 (Mar-21)	CPO		Review underway- see k2/2.5	
K3/3.3	Focus areas remain incident reporting / learning from incidents (safety culture) where we have improved year on year but below average and the best performing Trusts. Embedding learning from incidents/ complaints is a key part of N, M& AHP strategy and the Quality strategy with focused actions to achieve this. Continued and improved recognition awards both internal and external.	Feb-21 (Sep-20)	DoN&M		Up until 2018 the NRLS produced an annual report for all trusts in England comparing the levels of incident reporting and timeliness of this. During this period LWH were identified as the highest reporter in our specialist group. From 2019 the NRLS has discouraged benchmarking, instead placing emphasis on internal trends. The Head of Governance produces a quarterly Governance report which includes cumulative data on the number of incidents reported benchmarked against the previous year. This has shown that although there has been a dip in reporting during Covid-19 the Trust is continuing to report more incidents each year. There are two key areas of the	

					organisation where incident reporting is below what is expected, that being Gynaecology and Theatres, and these areas will continue to be an area of focus. Currently each division has a process in place for the sharing of lessons learnt in their specialisms and where required, the forward planning of audits, especially in relation to Serous Incident actions. This is completed via different methods such as posters, information at staff huddles, ward handover, staff meetings. In line with the lesson learnt risk on the Trust BAF work has been on-going by the Governance department to upgrade the Ulysses system to ensure lessons learnt and recommendations are captured form incident reviews. Lessons learnt is part of in the Loop session for key message across the Trust. The Governance team are developing a new lesson learnt section for the monthly staff briefing. A patient safety week is being planned for September 2020 to coincide with the World Patient Safety Day. As part of the National Patient Safety Strategy the Trust Risk and Patient Safety manager is developing a local implementation plan. As part of the National Patient Safety Strategy each organisation is to have patient safety specialist(s) who will have national training and be linked into regional patient safety teams to lead and support improvements across the Trust and share across the region. It has previously been agreed that the Head of Governance and the Risk and Patient Safety manager would take on these roles. The Trust Risk Management Strategy and Policy for the Management of Incidents and Serious Incident both have requirements set out for the dissemination of learning. With the embedding of Governance Groups in the new divisions the identification and dissemination of lessons can be improved with support from the Governance team to identify cross organisational learning and how this can be implemented and embedded.	
K3/3.4	LWH still receive some complaints from staff via CQC, there are some complex dignity at work investigations. To improve there needs to be a more consistent approach across all teams needs to be evident utilising the fair and just culture approach.	Mar-21	CPO		Fair and Just project embedded in substantive role of Head of Talent and Culture. Work progressing accordance with work-plan including integration within HR policies and procedures.	
K3/3.5	There needs to be more evidence of embedding lessons learnt and sharing across the trust. There is evidence of divisional lessons learnt but lack of Trust wide evidence and utilising quality improvement methodology to sustain this	Feb-21 (Sep-20)	MD		An assurance paper regarding recurrent never events has been requested by safety senate with a focus on common themes and our apparent failure to learn lessons across the Trust. The MD, DoNM and Head of Governance are meeting separately to consider how better functionality can be achieved wrt lessons learnt. Comprehensive evidence report scheduled for the Board in Feb-21.	
K3/3.6	More work needs to be undertaken with the reporting of incidents. Although staff do speak out regarding concerns to CQC, Freedom to speak up more needs to be done to give staff the confidence to report incidences internally and that they have feedback regarding the issues raised.	Jan-21 (Sep-20)	DoN&M		Please refer to K3/3.3 The Risk and Patient Safety Manager is working with the Governance managers on ways in which we can improve incident reporting levels. One issue which is evident from reviews and investigations is that a number of staff still view incident reporting as 'telling tales' and there is a perception that reports will not always be followed through. There is a	

					cultural issue which needs to be addressed in line with the Fair and Just Culture work which is on-going. Visibility from the senior governance team is an element which is being explored, but in line with restrictions with Covid-19. It is recognised that staff need more support to feel that they are safe and supported to report incidents at all levels of the organisation and from each other. The Risk and Patient Safety Manger has developed some information leaflets for all staff about the importance of reporting incidents and explanations to refute the above comments. Evidence to be provided of improvements via raw 2020 Staff Survey data (available in Jan 21)	
K3/3.7	Although there are some effective systems and processes in place for documenting lessons learnt/ action plans this is not readily available for teams in an electronic format (reminder) for them to monitor out of date actions. Also, lessons learnt is not embedded at 'shop floor' level.	Feb-21 (Sep-20)	DoN&M		The Head of Governance has purchased an action planning module for the Ulysses system which will ensure all actions are centralised and action plans and reports can be extracted from the system. This also allows for all evidence in relation to an action to be attached to the action and in Ulysses and stored centrally. The Head of Governance and arranged for a weekly report to be generated for the Head of Nursing in relation to all actions currently open for their services and their current status. Overdue actions will be escalated via the appropriate monitoring group or committee. This is already done in relation to actions from Serious Incidents via the Divisional Governance Groups, Safety Senate , Quality Committee and the Trust Board. On the Trust Intranet there is a lesson learnt section which all staff can access which has lessons from incidents uploaded into a simple one page format for Maternity, Gynaecology, Neonatal and Theatres. This has been recently updated to include Covid-19 and is to be developed further to cover all areas. The Governance team are planning an update to the risk management intranet page which will also holds information on lesson learnt which all staff can access. The Risk and Patient Safety manager and Quality Improvement Lead are currently completing a piece of work to identify if we can learn for other organisation who have achieved outstanding in QC as to how they share and embed lessons. Comprehensive evidence report scheduled for the Board in Feb-21.	
K3/3.8	To ensure that there is a clear mechanism for the triangulation of information to inform the Trust's Training Needs Analysis and that the Educational Governance Group provides sufficient oversight.	Feb-21 (Sep-20)	~~MD~~ CPO		The divisional structure is providing improved input and oversight regarding the Trust's Training Needs Analysis (TNA). To be explored whether lesson learning can be used to help inform the TNA. Comprehensive evidence report scheduled for the Board in Feb-21.	
K3/3.9	Training and appraisal performance needs to be consistently above 95% in all areas	Nov-20	COO & CPO		Robustly monitored via Divisional Board and Divisional Performance Review. Compliance trajectories in place.	
K3/3.10	A need to provide evidence of supporting ~~BAME~~ under-represented groups into senior roles	Nov-20	CPO		Review of E&D objectives and overall approach underway. Work with Trust Board to develop more ambitious Inclusion Strategy.	
KLOE 4. Are there clear responsibilities, roles and systems of accountability to support good governance and management?						
Lead Executive: Chief Executive Management Lead: Trust Secretary NED Lead: Tracy Ellery						
Action Ref	Action	Timescale	Lead	Progress	Comments	Link with CQC Action Plan
K4/4.1	To hold a Board Development session on Duties of Directors	Oct-20	TS		Took place at October 2020 Boar workshop.	

K4/4.2	The level of challenge between Governors and Non-Executive Directors can be strengthened in order for the former to demonstrate discharge of holding to account responsibilities.	Jan-21	TS		Effective challenge and questioning session to be provided to both the Board of Directors (Oct 2020) and the Council of Governors (date tbc).	
K4/4.3	A review of Board agendas from 2017-2020 demonstrates that there is an imbalance in the Board time allocated to current performance and the time allocated to strategic discussion during meetings held in public. Whilst this is developing in right direction, further emphasis can be given to strategic discussion.	Jan-21	TS		Whilst the on-set of Covid-19 has required a focus on operational matters, the Board has maintained a view on strategic matters and this will be increased during phase 3 of the Covid-19 response.	
KLOE 5. Are there clear and effective processes for managing risks, issues and performance?						
Lead Executive: Chief Operating Officer Management Lead: Head of Governance & Quality NED Lead: Susan Milner						
Action Ref	Action	Timescale	Lead	Progress	Comments	Link with CQC Action Plan
K5/5.1	Whilst processes are in place further work is required with senior managers to ensure that they fully understand and can articulate the mechanisms for managing risks and performance (link with Accountability Framework)	Oct-20	DoN&M		In March 2019 the Head of Governance and Quality put in place a new Standard Operating Procedure for the Management of Risk and Risk Registers. As part of this process awareness sessions were provide in the safety senate and Corporate Risk Committee. On an annual basis the Head of Governance undertakes a training session with the Executive Directors in relation to their responsibilities for risk and Health and Safety in the organisation. Maternity, Gynaecology and Neonatal services have a Governance Manager in place. Clinical Support Services currently have a Governance Facilitator in place supported by the Head of Governance. The governance staff in the divisions are working closely with all the responsible managers for risk to ensure that the identification and management if risk meets the Trust SoP and is as robust as it can be. This is an on-going process. A part of the corporate induction the Head of Governance provides a session on risk and risk management to all new staff. A similar session is provided to all new junior medical staff when they commence in the Trust. The Risk and Patient Safety Manager is currently developing a new training package for all levels of staff on risk and incident management. Nov 20 – Whilst further work is required to strengthen the 'feedback loop' for an individual, the Executive feel that there is sufficient evidence for this item to be closed.	MUST Do #12
K5/5.2	Further work required to formalise horizon scanning processes at operational level.	Jan-21 (Oct-20)	COO		This is being undertaken at divisional level (reported through review meetings) and at the Effectiveness Senate. COO to work with Head of Strategy to develop a formal one side operational planning template to link to horizon scanning to be included as part of the updated Divisional reporting process.	
K5/5.3	Further work required to embed the 'follow up' process to business case implementation. Need to clearly define approach to developing and delivering CIPs.	Oct-20	DoF		The Trust's approach to developing and delivering CIPs has been formalised into a document which will be presented at FPBD in October 20 alongside the scheduled CIP mid-year post implementation review and ahead of the formal work up for the 21/22 planning round. The formal follow up process for business cases will also be presented at this committee.	

					Nov-20 - Reports received and embedded – agreed to be closed.	
KLOE 6. Is appropriate and accurate information being effectively processed, challenged and acted on?						
Lead Executive: Director of Finance Management Lead: Chief Information Officer NED Lead: Ian Knight						
Action Ref	Action	Timescale	Lead	Progress	Comments	Link with CQC Action Plan
	No actions identified					
KLOE 7. Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?						
Lead Executive: Chief People Officer Management Lead: Deputy Director of Workforce NED Lead: Phil Huggon						
Action Ref	Action	Timescale	Lead	Progress	Comments	Link with CQC Action Plan
K7/7.1	Consider how to evidence that staff at all levels are involved in the planning and delivery of service developments and give due regard to the public sector equality duty.	Feb-21 (Nov-20)	DoF & CPO		Quality Improvement strategy will provide structured mechanisms for staff to engage with service change and transformation. Leadership strategy focuses on effective engagement and consultation with staff. PSED observed in internal and external consultation regarding changes to services. Robust EIQA process in place – agreed to collate these for evidence purposes.	
K7/7.2	To consider how best to receive and analyse 360-degree feedback from system leaders.	Dec-20 (Sep-20)	DoF / CEO		Readiness Assessment performed in Autumn 2019 proved a useful tool to understand the views of stakeholders. Further approaches via direct contact and use of governance structures during development and implementation of the refreshed strategy will support an updated view. Further independent review to be considered. Snapshot information will be provided through the quarterly partnership report (referenced in K7/7.3). Further evidence of this provided through Chair, CEO and Exec Director appraisals. Involvement in system meetings and activity to be captured in future CEO reports.	
K7/7.3	To evidence that the Trust is involved in pooled activities in the local health economy.	Dec-20 (Oct-20)	COO		As above.	
KLOE 8. Are there robust systems and processes for learning, continuous improvement and innovation?						
Lead Executive: Medical Director Management Lead: Deputy Medical Director NED Lead: Louise Kenny						
Action Ref	Action	Timescale	Lead	Progress	Comments	Link with CQC Action Plan
K8/8.1	The Trust requires strengthened articulation of a quality improvement preferred methodology and strategy either within the existing quality strategy or in a new QI strategy.	Nov-20 (Sep-20)	MD		The approach to QI is referenced within the Clinical & Quality Strategy. A separate QI document is being developed and will be agreed by the Executive team.	
K8/8.2	Theme of Quality Improvement to be used for a 'Great Day' to help communicate the Trust's agreed approach from the Quality Improvement Strategy.	Feb-21	MD		This has been proposed as a theme for a Great Day. A revised schedule for Great Days is being created with the use of digital technologies to account for the limitations imposed by Covid-19.	
K8/8.3	Review of the work-plan of the Divisional partnership board meetings, Senates and Board committees to ensure that learning from external sources is reflected.	Sep-20	TS/MD		Governance and Performance Framework in development and likely to be finalised during September 2020.	

K8/8.4	Board and its Committees to find a process by which they can reflect upon their successes and failures; review how quality, financial and operational information has resulted in actions that have successfully improved performance; articulate the same and plan for improvement.	Nov-20	TS		As referenced in K1/1.6, the Committee Effectiveness process is being reviewed. Proposal to undertake a mid-year review to reflect on the Board and Committee response to the Covid-19 pandemic and whether lessons can be learned for the rest of the financial year.	
K8/8.5	Governance team to evidence activity around improvement using PDSA cycles being discussed and supported in Divisions and Senates and develop a training and implementation plan if one is needed.	Jan-21 (Sep-20)	DoN&M		The Deputy Medical Director is currently developing a Quality Improvement Strategy which outlines the methods used in the trust, the training provided and support from the Quality Improvement lead. Part of this QI Strategy is a training plan for the next 5 years. The Quality Improvement lead has developed a new Quality Improvement intranet site which will allow all QI training information and improvement updates to be available to all staff. QI approval section in the Effectiveness Senate agenda	
K8/8.6	Board development session to provide learning and discussion around improvement methodologies.	Jun-20	MD/TS		QI Session at June 2020 Board Workshop – completed.	
K8/8.7	Governance department to produce a co-ordinated planned roll-out of improvement methodology teaching to encompass all key groups as agreed with the executive group	Jan-21 (Oct-20)	DoN&M		See K8/8.5	
K8/8.8	Documentation of skill sharing demonstrated by delivery of improvement methodology events by a broader group of staff	Oct-20	DoN&M		All QI training sessions are run as a multi-disciplinary process so there is mix of staff from different background and skills.	
K8/8.9	Strengthened evidence required that the Senates record issues on internal and external reviews and can robustly identify assurance.	Jan-21 (Oct-20)	TS/MD/DoN&M		All Internal and external reviews are reported to the Safety Senate with associated action plans included. All action plans moving forward will be placed on Ulysses as previously identified above. This will allow the senates to review any actions which are overdue or outstanding. The safety senate has received reports on Gosport and Patterson and are due to receive a report on the Cumberlege report in September. Each of these reports identify what is relevant to the trust, assess position against recommendation and any actions required. Update report on this issue scheduled for the Audit Committee in Oct 20 with the final output scheduled for Jan 21.	
K8/8.10	Senior leaders in each profession to consider how 'timely and balanced feedback' against personal objectives can be delivered. Is this simply an annual event, a response to an adverse event or something more nuanced?	Jan-21 (Oct-20)	All		To be considered as part of the appraisal process update. The governance team provide information in relation to Incidents, claims, audit activity for the doctor revalidation process. Executive Team to consider how best to evidence progress against this.	

Agenda Item	20/20/192

MEETING	**Trust Board Meeting**
PAPER/REPORT TITLE:	**Board Assurance Framework**
DATE OF MEETING:	Thursday, 05 November 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.			
PREVIOUSLY CONSIDERED BY:	**Committee name**	The Committees of: Finance, Performance and Business Development, Putting People First Quality Committee		
	Date of meeting	September and October 2020		

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 risk on the BAF are set out under strategic aims.

The BAF is based on based on seven key elements:

- Clearly defined Key Priorities for 2020/21 (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.

The Head of Governance and Quality continues to meet with each of the Executive Director leads on a monthly basis to ensure the BAF is maintained as a live document.

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.

Since the last report to the Board, the executive directors and Trust Board committees have reviewed each of the BAF risks and out of the 10 risk currently on the BAF 9 have had updates have been made, with only 1 not requiring any updates. There are two risk of note:

It is proposed by the Director of Nursing and Midwifery supported by the Quality committee, to de-escalate the risk 2295 - Condition: Inability to achieve and maintain regulatory compliance, performance and assurance, to the corporate risk register, as it is deemed that sufficient controls are in place which have enabled the risk to achieve it target score of 8 and therefore it does not need to remain on the BAF

Following review by FPBD, risk 2344 - Condition: There is a risk that the Trust will not deliver a breakeven position or have sufficient cash resources in the 2020/21 financial year, the risk overall score has been increased to 20, as the likelihood aspect has been increased to 5 from 4, due to the deficit plan for 2nd half of 2020/21 based on central income allocations and outside of the Trust control.

The report reflects the process of 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.

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.

BAF Dashboard: September 2020

Please refer to appendix 1

Full BAF Register – September 2020:

Please refer to appendix 2

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 some minor changes or alterations completed to a number of risks:

1986 - Condition: The Trust is not financially sustainable beyond the current financial year -Risk reviewed by Director of Finance and Head of Governance and Quality; some actions have had their target dates extended due to external strategic work being on hold during the pandemic

2266 - Condition: Ineffective understanding and learning following significant events - Reviewed by Head of Governance and Quality. No change to current risk or actions, awaiting MIAA audit results.

2294 - Condition: Insufficient numbers of clinical staff resulting in a lack of capability to deliver safe care and effective outcomes - Risk reviewed by Director of Workforce and Marketing and Head of Governance and Quality, Additional controls for contingency have been added and following review at PPF decision made to increase likelihood to 4 from 3 due to increased prevalence of Covid-19 locally, impact from school and child care not being available and the implementation of Test, Track and Trace on staffing levels due to staff having to self-isolate significantly impacting on staffing numbers.

2295 - Condition: Inability to achieve and maintain regulatory compliance, performance and assurance - Risk reviewed by the Director of Nursing and Midwifery and the Head of Governance and Quality. There is a robust system currently in place and the ability to provide robust evidence to external regulators as and when required. The Trust has regular monitoring via the Senates and Quality committee who receive papers for scrutiny and assurance on key risks and issues which has proved to be robust and effective in providing assurance and to highlight any further work which may be required. The Trust Corporate Risk Committee is functioning to the level required with assurance being provided to the chair of the committee (CEO) and provide opportunity for scrutiny of the cooperate and divisional risks and actions. Assurance papers and evidence available from groups and committees as required. **It is therefore proposed that the risk target of 8 (C Major x L Unlikely) has been achieved and the risk can be deescalated to the corporate risk register for monitoring for a period of 6 months and then deescalated to divisional level for ongoing monitoring.**

2337 - Condition: The Trusts current clinical records system (paper and Electronic) are sub-optimal - Reviewed risk and updated controls reflecting the approved Digital Strategy and signed Meditech Expanse contract. No changes to the overall risk score.

2335 - Condition: Major and sustained failure of essential IT systems due to a cyber attack - Review of risk, controls and actions complete. Some actions have been deferred in relation to the network implementation delay (impacted by Covid19), no change to overall risk score.

2340 - Overarching Covid-19 Trust Risk Version 4 - Risk reviewed with Executive Directors. Additional information added into controls section under contingency. Relates to staffing levels and impact of Test, Track and Trace and need to be able to flex staffing levels using bank and additional payments.

2344 - Condition: There is a risk that the Trust will not deliver a breakeven position or have sufficient cash resources in the 2020/21 financial year - Risk reviewed by the Director of Finance and Head of Governance and Quality, proposal to go to FPBD for likelihood score to be increased to 5 from 4 due to deficit plan for 2nd half of 2020/21 based on central income allocations.

3. New Risks

Since the last report to the Trust Board no new risks have been added to the BAF.

4. Closed Risks

Since the last report to the Trust Board no new risks have been closed to the BAF.

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.

Appendix 1 – BAF Dashboard September 2020 v1.0

Risk No.	Assurance Committee	Description	Current risk score			Target	Assurance				Proposed Changes, Additions & Removals
			Severity	Likelihood	Risk Score	Risk Score by 31/03/2021	Status	Controls identified	Gap in Controls Identified	Assurances identified	
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; reduction in activity and income; declining birth rates. **Consequence:** Lack of financial stability, invocation of NHSI sanctions, special measures. Continued borrowing to meet operational expenses resulting in significant debt. **Covid-19 Impact:** There is an impact on this BAF risk. Although the Trust is currently in a block contract, the pandemic will have an impact on the efficiency and capacity of the Trust in how we deliver our services. There is also an uncertain future commissioning/funding landscape. This situation will require close monitoring. No proposed change to risk score.	5	5	25	25	⟺	Y	Y	Y	Risk reviewed by Director of Finance and Head of Governance and Quality, Some actions have had their target dates extended due to external strategic work being on hold during the pandemic
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. **Covid-19 Impact:** There is no impact on the BAF risk as the Trust has not reduced governance oversight or activity at divisional and corporate level during this pandemic. No change in the current risk score.	4	3	12	6	⟺	Y	Y	Y	Reviewed by Head of Governance and Quality. No change to current risk or actions, awaiting MIAA audit results.
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. **Covid-19 Impact:** The Covid-19 pandemic has the potential to impact staff wellbeing, particularly in relation to morale and a result of changed ways of working. There are also increased risk to staff mental health. No proposed change to the current risk score.	4	2	8	6	⟺	Y	Y	Y	Risk reviewed by Deputy Director of HR, no actions required

Risk No.	Assurance Committee	Description	Current risk score			Target	Assurance				Proposed Changes, Additions & Removals
			Severity	Likelihood	Risk Score	Risk Score by 31/03/2021	Status	Controls identified	Gap in Controls Identified	Assurances identified	
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; Ageing 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. **Covid-19 Impact:** The pandemic will have an impact on this BAF risk. Impact on education and training; the potential loss of experienced staff due to retirement; reduced student places; potential requirement for supervised re-introduction in some job related roles due to reduced exposure to 'normal work'; more staff required to deliver same amount of care. There is also a related to the introduction of Test, Track & Trace and the potential number of staff from teams being asked to isolate at short notice for 14 days due to contact with a positive case. No change in the current risk score.	5	3	15	10	⟺	Y	Y	Y	Risk reviewed by Director of Workforce and Marketing and Head of Governance and Quality, Additional controls for contingency have been added and following review at PPF decision made to increase likelihood to 4 from 3 due to increased prevalence of Covid-19 locally, impact from school and child care not being available and the implementation of Test, Track and Trace on staffing levels due to staff having to self isolate significantly impacting on staffing numbers.
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, reputation damage, loss of commissioner and patient confidence in provision of services. **Covid-19 Impact -** There may be impact in relation to the Trust not being able to meet the Health and Safety Executive requirements for supporting staff retuning to the work environment, due to the current estate layout and capacity i.e. social distancing. There is also an impact due to the H&S staff not being able to be on site during the pandemic, oversight and support from home working H&S Manager and HoG on site.	4	4	16	8	⟺	Y	Y	Y	Risk reviewed by the Director of Nursing and Midwifery and the Head of Governance and Quality. There is a robust systems currently in place and the ability to provide robust evidence to external regulators as and when required. The Trust has regular monitoring via the Senates and Quality committee who receive papers for scrutiny and assurance on key risks and issues which has proved to be robust and effective in providing assurance and to highlight any further work which may be required. The Trust Corporate Risk Committee is functioning to the level required with assurance being provided to the chair of the committee (CEO) and provide opportunity for scrutiny of the cooperate and divisional risks and actions. Assurance papers and evidence available from groups and committees as required. It is therefore proposed that the risk target of 8 (C Major x L Unlikely)has been achieved and the risk can be deescalated to the cooperate risk register for monitoring for a period of 6 months and then to divisional level.

Risk No.	Assurance Committee	Description	Current risk score			Target	Assurance				Proposed Changes, Additions & Removals
			Severity	Likelihood	Risk Score	Risk Score by 31/03/2021	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 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. **Covid-19 impact:** The pandemic has increased the challenge of providing additional services within the current Crown street site due to the need for additional space to maintain current services. No change in risk score at this time. Focus on project relating to relocation has been reduced during pandemic	5	5	25	25	⟺	Y	Y	Y	Risk reviewed by the Head of Governance and Quality, currently there is no change in the risk or actions.
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 **Covid-19 impact:** There may be an impact due to the pandemic in relation to an increased challenge to staff engaging in the development of the EPR system. No change in current risk score proposed.	5	4	20	20	⟺	Y	Y	Y	Reviewed risk and updated controls reflecting the approved Digital Strategy and signed Meditech Expanse contract. No changes to the overall risk score.

Risk No.	Assurance Committee	Description	Current risk score			Target	Assurance				Proposed Changes, Additions & Removals
			Severity	Likelihood	Risk Score	Risk Score by 31/03/2021	Status	Controls identified	Gap in Controls Identified	Assurances identified	
2335	Finance, Performance and Business Development Committee	**Condition:** Major and sustained failure of essential IT systems due to a cyber attack **Cause:** ineffective cyber controls and technology, 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. **Covid-19 Impact:** The Covid-19 pandemic has increased the Trust's risk to cyber attack. Whilst there have been several communications circulated to staff advising them of the risks, there are increased vulnerabilities due to different ways of working and particularly home working.	5	4	20	10	⟺	Y	Y	Y	Review of risk, controls and actions complete. Some actions have been deferred in relation to the network implementation delay (impacted by Covid19), no change to overall risk score.
2340	Finance, Performance and Business Development Committee	**Overarching Covid-19 Trust Risk Version 4** **Condition:** Failure to - a) maintain pre-Covid-19 level of service for our patients due to the outbreak of the Covid-19 pandemic; b) protect staff, patients and visitors from infection; c) effectively manage increased demands and provide support to the wider system; and d) failure to recover to pre-Covid-19 service levels following the pandemic and be sufficiently resilient to manage a potential 'second wave' of infection. **Cause:** Reduction of a number of elective services to focus capacity and reduction of efficiency due to infection, prevention and prevention measures. Increased number of staff absent due to Covid-19 health restrictions **Consequence:** Lack of service provision to Liverpool Womens Hospital patient groups, reduced services in some areas, life altering impact on some patients, reduced patient experience, impact on patient safety and potential loss of reputation and inability to recover service provision in the future.	4	4	16	8	⟺	Y	Y	Y	Risk reviewed with Executive Directors. Additional information added into controls section under contingency. Relates to staffing levels and impact of Test, Track and Trace and need to be able to flex staffing levels using bank and additional payments.
2344	Finance, Performance and Business Development Committee	**Condition:** There is a risk that the Trust will not deliver a breakeven position or have sufficient cash resources in the 2020/21 financial year. **Cause:** Lack of contractual income position due to the Covid-19 pandemic, gap in baseline position and block payment compared to actual activity and cost, risk to CIP and income streams, timing of recovery and uncertainty over future regime. **Consequence:** Potential for insufficient operational cash reserves and non-compliance with regulations. **Covid-19 Impact:** The impact of Covid-19-19 is inherent in the risk description. No further issues identified. No changes required.	4	5	20	8	↑	Y	Y	Y	Risk reviewed by the Director of Finance and Head of Governance and Quality, proposal to go to FPBD for likelihood score to be increased to 5 from 4 due to deficit plan for 2nd half of 2020/21 based on central income allocations.

Listing For: 4. BAF | **Risk Register Level:** 4. BAF | **Directorate:** Financial Services | **Service / Department:** Finance | **Position at:** 12/10/2020 08:58:09

Risk Number: 1986 **Version:** 7 **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:** 07/11/2020

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; reduction in activity and income; declining birth rates.

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

Covid-19 Impact: There is an impact on this BAF risk. Although the Trust is currently in a block contract, the pandemic will have an impact on the efficiency and capacity of the Trust in how we deliver our services. There is also an uncertain future commissioning/funding landscape. This situation will require close monitoring. No proposed change to risk score.

Last Review Narrative: **Date:** 08/10/2020 **Reviewed By:** Christopher Lube

Risk reviewed by Director of Finance and Head of Governance and Quality, Some actions have had their target dates extended due to external strategic work being on hold during the pandemic.

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	30/03/2021	Eva Horgan	External Strategic work on hold during pandemic. Date Entered : 08/10/2020 14:52 Entered By : Christopher Lube ---------- Put back due to Covid-19 pandemic.	Ongoing	/ /

					Date Entered : 28/04/2020 14:05 Entered By : Eva Horgan ---------- Timescale TBC - requirements to be confirmed, subject to outcome of bid.		
11	Merger 1 - Agree in principle to proceed to merger	13/02/2020	30/03/2021	Eva Horgan	Date Entered : 09/08/2019 14:18 Entered By : Christopher Lube External Strategic work on hold during pandemic. Date Entered : 08/10/2020 14:53 Entered By : Christopher Lube ---------- Put back due to Covid-19 pandemic	Ongoing	/ /
12	Merger 2 - Establish Merger Project (internal group)	01/04/2020	30/03/2021	Eva Horgan	Date Entered : 28/04/2020 14:05 Entered By : Eva Horgan External Strategic work on hold during pandemic. Date Entered : 08/10/2020 14:53 Entered By : Christopher Lube	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	30/03/2023	Eva Horgan	External Strategic work on hold during pandemic. Date Entered : 08/10/2020 14:54 Entered By : Christopher Lube	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	31/12/2020	Eva Horgan	External Strategic work on hold during pandemic. Date Entered : 08/10/2020 14:54 Entered By : Christopher Lube ---------- On hold due to Covid-19 pandemic.	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	/ /	Jennifer Huyton	Date Entered : 28/04/2020 14:04 Entered By : Eva Horgan Capital bid submitted to NHSI, was due for review in April. Covid-19 pandemic means this is on hold at least until the summer. There is a lack of clarity on the national capital allocation process. Likely to be managed by STP but no detail available as of April 2020. To be further reviewed once detail about the regime is available.	Completed	31/07/2020
26	Business Case 1 - Work in partnership with CCG to refresh PCBC document, including stakeholder engagement and refresh of data	01/01/2020	30/03/2021	Jennifer Huyton	Date Entered : 28/04/2020 14:03 Entered By : Eva Horgan External Strategic work on hold during pandemic.	Ongoing	/ /
27	Business Case 5 - Approval for funding from NHSI/E based on refreshed SOC	01/08/2022	31/10/2022	Eva Horgan	Date Entered : 08/10/2020 14:55 Entered By : Christopher Lube	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:** 12/10/2020 08:58:10

Risk Number: 2266 **Version:** 3 **Domain:** Impact On The Safety Of Patien **Linked Risks:**

Executive Lead: Andrew Loughney **Operational Lead:** Christopher Lube

Strategic Objective: To Deliver SAFE Services
Risk Appetite: 2.Low

Assurance Committee: Quality Committee **Review Due:** 11/11/2020

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.

Covid-19 Impact: There is no impact on the BAF risk as the Trust has not reduced governance oversight or activity at divisional and corporate level during this pandemic. No change in the current risk score.

Last Review Narrative: **Date:** 12/10/2020 **Reviewed By:** Christopher Lube

Reviewed by Head of Governance and Quality. No change to current risk or actions, awaiting MIAA audit results.

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	Jeanette Chalk	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 There is a continuing commitment to improving reporting using Ulysses. A recent development has been the agreement to cross-tabulate incidents and complaints using Ulysses using a formal process.	01/04/2019	05/06/2020	Christopher Lube	Development and upgrade of Ulysses system complete and final roll put being undertaken Date Entered : 01/07/2020 16:58 Entered By : Christopher Lube ---------- There is a continuing commitment to improving reporting using Ulysses. A recent development has been the agreement to cross-tabulate incidents and complaints using Ulysses using a formal process. Date Entered : 06/05/2020 09:13 Entered By : Rowan Davies ---------- Upgrades commencing to be rolled out to staff, review and close	Completed	01/07/2020

					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 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	30/11/2020	Linda Watkins	Work on hold due to Covid 19 Date Entered : 08/05/2020 12:16 Entered By : Christopher Lube ---------- 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	Ongoing	/ /

					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		
7	New risk management and patient safety training package to be developed	01/04/2019	01/11/2020	Christopher Lube	Due to Covid-19 this has been delayed. Still awaiting new national SI framework. Date Entered : 01/07/2020 16:59 Entered By : Christopher Lube ---------- Work on this development has been delayed due to need to deal with Covid19 situation. Date Entered : 04/04/2020 13:42 Entered By : Christopher Lube ---------- Work on Risk Training Package is ongoing with the appointment of new Risk and Patient Safety 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	Ongoing	/ /
8	MIAA have been commissioned to undertake an audit of the current processes in place for the dissemination of lessons learnt across the trust	20/07/2020	30/10/2020	Christopher Lube	Audit lead from MIAA has meet with Head of Governance and identified documentation required as part of the audit. Information has been provided to audit lead. Date Entered : 28/08/2020 08:36 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
3 Moderate	2 Unlikely	6

Listing For: 4. BAF **Risk Register Level:** 4. BAF **Directorate:** Human Resources **Service / Department:** HR **Position at:** 12/10/2020 08:58:10

Risk Number: 2293 **Version:** 5 **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:** 08/11/2020

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.

Covid-19 Impact: The Covid-19 pandemic has the potential to impact staff wellbeing, particularly in relation to morale and a result of changed ways of working. There are also increased risk to staff mental health.No proposed change to the current risk score.

Last Review Narrative: **Date:** 09/10/2020 **Reviewed By:** Rachel London

Risk reviewed no actions required

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	30/09/2021	Rachel London	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 - this will be incorporated into the Trust Leadership strategy	29/01/2021	01/12/2020	Rachel London	Leadership Strategy to be presented to PPF in Nov 20 Date Entered : 30/09/2020 17:27 Entered By : Rachel London ---------- 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 ----------	Ongoing	/ /

					To be monitored monthly Date Entered : 08/08/2019 11:33 Entered By : Christopher Lube			
3	Executive team and staff side walkabouts	01/04/2019	30/09/2020	Rachel London	New programme of exec and staff side walkabouts commenced in September 2020 Date Entered : 30/09/2020 17:27 Entered By : Rachel London ---------- To be monitored monthly Date Entered : 08/08/2019 11:35 Entered By : Christopher Lube		Completed	30/09/2020
4	In 2018 the Trust began its Fair & Just Culture Programme - our journey to developing a different type of organisational culture. This is a five year programme which moved into Year 3 in April 2020.	01/04/2019	30/06/2021	Jeanette Chalk	Year 3 Action plan now developed and in place - key elements include training and engagement activities for colleagues at all levels. Date Entered : 16/07/2020 10:40 Entered By : Jeanette Chalk ---------- 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**
4 Major	2 Unlikely	8

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:** 12/10/2020 08:58:10

Risk Number: 2294 **Version:** 8 **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:** 07/11/2020

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; Ageing 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.

Covid-19 Impact: The pandemic will have an impact on this BAF risk. Impact on education and training; the potential loss of experienced staff due to retirement; reduced student places; potential requirement for supervised re-introduction in some job related roles due to reduced exposure to 'normal work'; more staff required to deliver same amount of care. There is also a related to the introduction of Test, Track & Trace and the potential number of staff from teams being asked to isolate at short notice for 14 days due to contact with a positive case.No change in the current risk score.

Last Review Narrative: **Date:** 08/10/2020 **Reviewed By:** Christopher Lube

Risk reviewed by Director of Workforce and Marketing and Head of Governance and Quality, Additional controls for contingency have been added and following review at PPF decision made to increase likelihood to 4 from 3 due to increased prevalence of Covid-19 locally, impact from school and child care not being available and the implementation of Test, Track and Trace on staffing levels due to staff having to self isolate significantly impacting on staffing numbers.

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						
Covid 19	Staff are required to social distance (2 meters) in all area where this is possible Staff are required to wear PPE in the clinical environment as per PHE guidance All staff re required to wear a face covering in all public areas and in offices where they are unable to social distance (2 meters) All areas have clear signage, including floor signage All staff entering the Trust are required to use one entrance and have a temperature check and provided with a face mask to use Listening Event for BAME staff - 24th June 2020 to consider what further action the Trust could take to ensure BAME staff are protected as much as possible. Risk Assessments undertaken for shielding & vulnerable staff including BAME, Pregnant workers,	The risk is staff do not comply with social distancing and/or PPE.	Not Effective	Trust has completed the NHSE/I IPC Assurance Framework and presented to the Quality Committee Controls monitored daily at Command meeting and weekly at Oversight and Scrutiny meeting Requirements being managed by senior staff clinical and cooperate.	None at this time	Issue with staff with staff to complying with social distancing and use of face mask as required.	Inconclusive

	Age and Gender. Comprehensive testing programme for symptomatic staff & household, antibody testing programme and have commenced asymptomatic testing for staff in high risk clinical areas					
Contingency	Maternity escalation and incineration process in place to support staff taking on back and extra shifts at times of short staffing. Health care partnership are using existing memorandum of understanding in relation to staff movement between local hospital at time of staffing need. Previous staffing skills audit refreshed to ensure up to date and ensure information available to allow for staff to be moved into an appropriate support role if required.	Test, Track and Trace system	impact on staffing	Effective	Monitored via weekly Oversight and Scrutiny and 3 times a week at command and control meetings.	None at this time	Inconclusive

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	31/10/2020	Rachel London	The Trust was unsuccessful in bidding for national funds to purchase the Allocate doctors rostering system. This system would not address the shortage in certain specialties but would be a more efficient means to roster the medical workforce. A business case will be developed to purchase the system ourselves, this has been delayed due to Covid-19 issues and will be developed by Autumn 2020. Date Entered : 14/04/2020 14:51 Entered By : Rachel London	Ongoing	/ /
5	Medical Workforce Recruitment and Retention process being developed	01/11/2019	02/11/2020	Rachel London	As above- divisions have been asked to produce their own medical workforce plans for the next divisional performance review Date Entered : 27/08/2020 11:04 Entered By : Rachel London ---------- There are a number of workstreams around identifying and developing talent in the medical workforce at junior doctor level and developing pathways to consultant level. A bespoke leadership programme for consultants has also been developed to deliver a pipeline of talent for future clinical director roles. These plans need to be co-ordinated into an overall medical recruitment and retention plan. This has been delayed due to Covid-19 and will be developed by the summer. Date Entered : 14/04/2020 14:54 Entered By : Rachel London	Ongoing	/ /
6	Need to recruit Gynae Oncologists to ensure service is viable and able to provide level of service to patients.	22/04/2020	/ /	Rachel London	Recruitment of two Gynae Oncologists took place in April- 1 FTC and 1 Permanent contract due to commence in June and	Completed	15/06/2020

October respectively

Date Entered : 08/10/2020 15:23
Entered By : Christopher Lube

7	In relation to Social Distancing and use of face masks, regular communication and senior staff and managers are required to continually remind individuals of their responsibilities and highly visible reminders around the workplace. Encourage and empower staff to challenge peers when not complying with requirements.	17/06/2020	31/03/2021	Rachel London			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:** 12/10/2020 08:58:10

Risk Number: 2295 **Version:** 2 **Domain:** Impact On The Safety Of Patien **Linked Risks:**

Executive Lead: Gaynor Thomason **Operational Lead:** Christopher Lube

Strategic Objective: To Deliver SAFE Services

Risk Appetite: 2.Low

Assurance Committee: Quality Committee **Review Due:** 11/11/2020

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, reputation damage, loss of commissioner and patient confidence in provision of services.

Covid-19 Impact - There may be impact in relation to the Trust not being able to meet the Health and Safety Executive requirements for supporting staff retuning to the work environment, due to the current estate layout and capacity i.e. social distancing. There is also an impact due to the H&S staff not being able to be on site during the pandemic, oversight and support from home working H&S Manager and HoG on site. Proposed to increase likelihood score to 4.

Last Review Narrative: **Date:** 12/10/2020 **Reviewed By:** Christopher Lube

Risk reviewed by the Director of Nursing and Midwifery and the Head of Governance and Quality. There is a robust systems currently in place and the ability to provide robust evidence to external regulators as and when required. The Trust has regular monitoring via the Senates and Quality committee who receive papers for scrutiny and assurance on key risks and issues which has proved to be robust and effective in providing assurance and to highlight any further work which may be required.

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
Covid 19	Impacts of Covid-19 identified for this BAF risk	Reduction of staff time on site to support direct actions for compliance	Not Yet Tested	Monitoring of compliance with regulations	External regulatory visits and reports	Ability to achieve action plans	Negative

Action	Action Description:	Start Date	Target Date	Person Responsible	Progress	Status	Date Completed
1	Provide assurance to QC in relation to risk with appropriate information	01/04/2019	/ /	Christopher Lube	CQC actions plan reports tabled monthly at QC for assurance on progress and escalation of issues. Date Entered : 12/10/2020 08:15 Entered By : Christopher Lube ---------- Compliance module roll out delayed as above with a significant impact on progress. Target date to be extended by 2 months and to be reviewed by HoG. Date Entered : 15/09/2020 09:49 Entered By : Allan Hawksey ---------- New CQC compliance module roll out has been delayed due to	Completed	12/10/2020

					Covid19 situation. As soon as able this will be commenced. Date Entered : 04/04/2020 13:39 Entered By : 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		
2	Ward accreditation to be rolled out following completion of pilot	01/04/2019	/ /	Janet Brennan	Pilot completed and implementation of ward accreditation approved to move forward. Date Entered : 12/10/2020 08:17 Entered By : Christopher Lube ---------- Ward Accreditation programme being reviewed by Interim DoN&M. Date Entered : 28/08/2020 08:41 Entered By : Christopher Lube ---------- Ward accreditation process across the Trust is back on track following a delay due to Covid-19. Date Entered : 11/08/2020 08:48 Entered By : Christopher Lube ---------- Due to the current Covid19 situation the roll out of ward accreditation has been delayed. Date Entered : 04/04/2020 13:31 Entered By : Christopher Lube ---------- Meeting with Ward Accreditation providers due on 08/08/19. Progress on pilot to be discussed and review of software to log data.	Completed	12/10/2020
5	Undertake intermittent deep dive reviews into specialist services	01/04/2019	/ /	Christopher Lube	Date Entered : 08/08/2019 15:00 Entered By : Christopher Lube Deep dives commissioned by QC or safety Senate as required either internally or by MIAA. Date Entered : 12/10/2020 08:18 Entered By : Christopher Lube ---------- This is a long term ongoing action which will be completed as and when a deep dive is required. Action put onto annual review basis Date Entered : 04/04/2020 13:38 Entered By : Christopher Lube ---------- Reviews to be completed as and	Completed	12/10/2020

					when identified by sub-committee of the board or at divisional board level. Date Entered : 08/08/2019 15:08 Entered By : Christopher Lube			
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	/ /	Christopher Lube	System roll out commenced. Date Entered : 12/10/2020 08:16 Entered By : Christopher Lube ---------- Plan to roll out new CQC module in September 2020. Date Entered : 11/08/2020 08:49 Entered By : Christopher Lube ---------- New module due to roll out but has been delayed slightly due to COovid19 situation. Date Entered : 04/04/2020 13:29 Entered By : 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	Completed	12/10/2020

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:** 12/10/2020 08:58:10

Risk Number: 2297 **Version:** 6 **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:** 11/11/2020

Risk Description:

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 on site multidisciplinary provision, no ITU or Blood bank on site, very limited diagnostic imaging on site; Failure to meet multiple clinical standards; Difficulties encountered with senior staff recruitment and retention, lack of co-located paediatric surgical support.

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

Covid-19 impact: The pandemic has increased the challenge of providing additional services within the current Crown street site due to the need for additional space to maintain current services. No change in risk score at this time. Focus on project relating to relocation has been reduced during pandemic

Last Review Narrative: **Date:** 12/10/2020 **Reviewed By:** Christopher Lube

Risk reviewed by the Head of Governance and Quality, currently there is no change in the risk or actions.

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	Ongoing	/ /

					Entered By : Christopher Lube		
4	Divisional plans to be developed to support long term clinical sustainability via operational plan	01/04/2019	07/12/2020	Jennifer Huyton	Clinical and Quality Strategy contains divisional plans for development to support long term clinical, sustainability back and this will inform he operational plan when due for submission Date Entered : 31/08/2020 10:59 Entered By : Christopher Lube ---------- The Trust is now developing a clinical and quality strategy to complement a refreshed future generations strategy, to be completed by the end of 2020. This will include divisional plans. The funding for on site developments has been requested but remains out of the Trust's control. The lobbying of MPs has been paused during the covid crisis. Date Entered : 06/07/2020 14:41 Entered By : Rowan Davies ---------- This has been impacted by Covid19 but a revised schedule for production of a short to medium term clinical strategy for the trust has been proposed, with input from each specialty and which will account for the changes that Covid19 has brought. Date Entered : 06/05/2020 09:14 Entered By : Rowan Davies ---------- Target date amended due to response to COVID19. Draft divisional plans presented to Senior Management Team in Feb/March 2020. Completion of final versions currently paused due to operational response to COVID19. Target completion date will remain under regular review. Date Entered : 06/04/2020 12:16 Entered By : 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 from the clinical summit to be actioned.	27/09/2019	30/12/2020	Jennifer Huyton	Planning progress has been made in relation to the location of the CT scanner on site, but capitol is still not yet confirmed. Similarly capital	Ongoing	/ /

for the blood bank. Partnership Board with LUFT remains functioning.

Date Entered : 31/08/2020 11:04
Entered By : Christopher Lube

Work to implement additional mitigations within Crown Street estate is progressing. Stage 2 design phase has commenced, although funding approval is yet to be received. The Trust has submitted a bid for additional capital funds to provide a mobile CT scanner on site, should the emergency capital bid not be approved. The case for swift approval of our capital bid has been put to Cheshire and Mersey HCP.

Date Entered : 08/07/2020 17:41
Entered By : Jennifer Huyton

The Trust is now developing a clinical and quality strategy to complement a refreshed future generations strategy, to be completed by the end of 2020. This will include divisional plans. The funding for on site developments has been requested but remains out of the Trust's control. The lobbying of MPs has been paused during the covid crisis.

Date Entered : 06/07/2020 14:42
Entered By : Rowan Davies

Target date amended due to response to COVID19. Good progress had been made towards implementation of actions. Partnership Board established with LUHFT. Work now paused due to COVID19 but will remain under regular review.

Date Entered : 06/04/2020 12:09
Entered By : 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			
7	Management of Future Generations Strategy through Project Management Office	16/11/2019	29/01/2021	Jennifer Huyton	Remains postponed due to covid-19 Date Entered : 31/08/2020 11:06 Entered By : Christopher Lube ---------- The Trust is now developing a clinical and quality strategy to complement a refreshed future generations strategy, to be completed by the end of 2020. This will include divisional plans. The funding for on site developments has been requested but remains out of the Trust's control. The lobbying of MPs has been paused during the covid crisis. Date Entered : 06/07/2020 14:43 Entered By : Rowan Davies ---------- Reviewed 26 March 2020 by J Huyton: Project Manager recruitment completed in March 2020; post successfully appointed. Start date anticipated June 2020. Majority of FG programme paused during response to COVID19; work remains under regular review by PMO team. Date Entered : 06/04/2020 12:06 Entered By : 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	30/12/2020	Jennifer Huyton	Awaitiing ourcome Date Entered : 31/08/2020 11:07 Entered By : Christopher Lube ---------- Work to implement additional mitigations within Crown Street estate is progressing. Stage 2 design phase has commenced, although funding approval is yet to be received. The Trust has submitted a bid for additional capital funds to provide a mobile CT scanner on site, should the emergency capital bid not be approved. The case for swift approval of our capital bid has been put to Cheshire and Mersey HCP. Date Entered : 08/07/2020 17:44 Entered By : Jennifer Huyton ---------- The Trust is now developing a clinical and quality strategy to complement a refreshed future	Ongoing	/ /

					generations strategy, to be completed by the end of 2020. This will include divisional plans. The funding for on site developments has been requested but remains out of the Trust's control. The lobbying of MPs has been paused during the covid crisis. Date Entered : 06/07/2020 14:43 Entered By : Rowan Davies ---------- Reviewed 26 March 2020 by J Huyton: Application for emergency capital funding submitted to NHSI/E in Feb 2020 with decision originally expected early April. Revised guidance now expected from NHSE/I regarding emergency capital in light of response to COVID19. Guidance will be reviewed once released and target completion dates amended accordingly. Date Entered : 06/04/2020 12:00 Entered By : Jennifer Huyton		
10	Lobby systems and MP's for active support	16/11/2019	30/12/2020	Jennifer Huyton	Has been devolved to exec level with a plan being considered by Trust secretary to match Board members with key targets for lobbying Date Entered : 31/08/2020 11:08 Entered By : Christopher Lube ---------- The Trust is now developing a clinical and quality strategy to complement a refreshed future generations strategy, to be completed by the end of 2020. This will include divisional plans. The funding for on site developments has been requested but remains out of the Trust's control. The lobbying of MPs has been paused during the covid crisis. Date Entered : 06/07/2020 14:41 Entered By : Rowan Davies ---------- Reviewed 26 March 2020 by JHuyton: This work is ongoing but paused at present due to response to COVID19. Action completion dates will remain under regular review as situation develops. Date Entered : 06/04/2020 12:03 Entered By : Jennifer Huyton	Ongoing	/ /
11	External review/testing of counterfactual case	01/04/2020	31/12/2020	Jennifer Huyton	Presently on pause, with a plan to bring back into play Sept-De 2020.		/ /

Date Entered : 31/08/2020 11:10
Entered By : Christopher Lube

Counterfactual case developed and ready for external review, challenge and testing. Process likely to be delayed due to response to COVID19. Target completion dates will be reviewed regularly as response develops.

Date Entered : 06/04/2020 11:55
Entered By : Jennifer Huyton

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:** 12/10/2020 08:58:11

Risk Number: 2335 **Version:** 4 **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:** 08/11/2020

Risk Description:

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

Cause: ineffective cyber controls and technology, 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.

Covid-19 Impact: The Covid-19 pandemic has increased the Trust's risk to cyber attack. Whilst there have been several communications circulated to staff advising them of the risks, there are increased vulnerabilities due to different ways of working and particularly home working. Proposal to increase the 'likelihood' score by 1.

Last Review Narrative: **Date:** 09/10/2020 **Reviewed By:** Matt Connor

Review of risk, controls and actions complete. Some actions have been deferred in relation to the network implementation delay (impacted by Covid19), no change to overall risk score.

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. 9. Additional cyber security communications in relation to Covid phishing/ scams, advising diligence. 10. Enhanced VPN solution including increased capacity to secure home working connections into the Trust. 11. Review and updating of information security policies and home working IG guidance to support staff who are remote working.	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 Monioring 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	31/03/2021	Philip Moss	Work continuews on enhancing the Trusts Cyber security cabailities. Work includes - End User Education - Monthly End User Security Emails SIEM - Enhancement of the Trusts Pervade working in Athena Cyber security developing a unified monitoring dashboard Network Refresh Project - replacement of the Trust legacey network, once completed this will Trust Policies - Enhancement of Trusts Policy Security patching Demarc - working to fully implementing DEMARC for Email CareCerts - reponding to NHS security alerts Date Entered : 27/08/2020 16:51 Entered By : Philip Moss		/ /
2	Implementation of new network will introduce enhanced security capabilities.	13/03/2020	28/02/2021	Philip Moss	Planned installation of new network core for 17th Oct 2020 has been deferred due to the impact on staffing through Covid-19. This will be implemented in the new year as all focus turns to the go-live of K2 Digital Maternity in November. Action due date therefore updated. Date Entered : 09/10/2020 09:10 Entered By : Matt Connor ---------- Work continuews on enhancing the Trusts Cyber security cabailities. Work includes - End User Education - Monthly End User Security Emails SIEM - Enhancement of the Trusts Pervade working in Athena Cyber security developing a unified monitoring dashboard Network Refresh Project - replacement of the Trust legacey network, once completed this will Trust Policies - Enhancement of Trusts Policy Security patching Demarc - working to fully implementing DEMARC for Email CareCerts - reponding to NHS security alerts Date Entered : 27/08/2020 16:55 Entered By : Philip Moss ---------- New network equipment has been delivered, configured and some of it racked. Part of the new network	Ongoing	/ /

					has been implemented alongside the legacy network. NICU 2 has been connected to the new network. A rollout plan is being developed and implemented. Work ongoing through Sept and Oct. Date Entered : 04/08/2020 15:55 Entered By : Matt Connor			
3	Implement a Cyber Security strategy	01/04/2020	31/01/2021	Matt Connor			Ongoing	/ /

Initial Assessment		
Severity	**Likelihood**	**Risk Score**
5 Catastrophic	4 Likely	20

Current Assessment		
Severity	**Likelihood**	**Risk Score**
5 Catastrophic	4 Likely	20

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

Listing For: 4. BAF | **Risk Register Level:** 4. BAF | **Directorate:** IM & T | **Service / Department:** Executive Office | **Position at:** 12/10/2020 08:58:11

Risk Number: 2337 **Version:** 4 **Domain:** Impact On The Safety Of Patien **Linked Risks:**

Executive Lead: Andrew Loughney **Operational Lead:** Matt Connor

Strategic Objective: To Deliver SAFE Services
Risk Appetite: 2.Low

Assurance Committee: Quality Committee **Review Due:** 08/11/2020

Risk Description:

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

Cause: Due to current legacy nature of clinical systems, resulting in lack of integration of patient records and clinical information.

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.

Covid-19 impact: There may be an impact due to the pandemic in relation to an increased challenge to staff engaging in the development of the EPR system. No change in current risk score proposed.

Last Review Narrative: **Date:** 09/10/2020 **Reviewed By:** Matt Connor

Reviewed risk and updated controls reflecting the approved Digital Strategy and signed Meditech Expanse contract. No changes to the overall risk score.

Control	Control Description	Gaps in Control	Effectiveness	Internal Assurance	External Assurance	Gaps in Assurance	Adequacy of Assurance
Prevent	Approved Digital Generations Strategy Approved Meditech Expanse Business Case Signed Meditech Expanse contract with clear direction to implement a robust integrated EPR solution. 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. Implementation of contextual links into ADT Whiteboard system to reduce multiple logins. Incident reporting Quarterly risk assessments reported to FPBD Tactical solutions including planned implementation of K2 Athena system Single Sign on review/ optimise, upgrade improvements. Exchange/LHCRE enables for patent information sharing Desktop refresh with dual screen configuration (where required) to improve system performance and simplify multiple systems use. Virtual Desktop technology to aid staff working flexibly. Microsoft Teams rolled out trust wide to aid collaboration. Additional network resilience for LUHFT supplied systems (ADT/PENS/CRIS) to reduce risk of unplanned systems downtime. PACS upgrade removes a separate login for that system, reducing multiple systems issue. approved EPR Business case which define clear direction and preferred solution.	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	Reactive rather than proactive identification and approach to problems caused by current sub optimal Electronic Patient Record, including patient risk and staff experience.	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	29/10/2020	Andrew Loughney	Governance structure has been identified and placed in contract. ToR is being drafted. Date Entered : 29/09/2020 11:25 Entered By : Matt Connor	Ongoing	/ /
3	Develop staff communication plan for new system	24/03/2020	30/11/2020	Matt Connor	Communication plan to be aligned with procurement, contract and implementation plan activities. Date Entered : 04/05/2020 12:57 Entered By : Matt Connor		/ /
4	Develop plan for system development and implementation	24/03/2020	30/10/2020	Matt Connor	Project planning will commence in detail following contract sign off/ procurement and establishment of project team Date Entered : 29/09/2020 11:27	Ongoing	/ /

					Entered By : Matt Connor ---------- The business case includes part of the plan i.e. resources, governance model. However a full implementation plan will be developed with supplier as part of the procurement. Therefore plan date changed in accordance with contract renewal timescales. Date Entered : 04/05/2020 12:56 Entered By : Matt Connor ---------- Business case has been developed Date Entered : 04/05/2020 12:54 Entered By : Matt Connor		
5	Procurement of new system following evaluation	24/03/2020	30/09/2020	Matt Connor	Contract sign off concluded 29th September 2020 Date Entered : 29/09/2020 11:27 Entered By : Matt Connor ---------- Procurement is underway. Specifics are being addressed regarding leasing arrangements in-line with funding requirements. Contracts are being drafted and procurement expected to complete by Sept. Date Entered : 04/08/2020 16:08 Entered By : Matt Connor	Completed	29/09/2020
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	30/09/2020	Matt Connor	Draft Digital Strategy approved. It will be launched, socialised in September. Date Entered : 04/08/2020 16:10 Entered By : Matt Connor	Completed	29/09/2020
8	Implement PENS forms in Gynae ED to capture clinical documentation to reduce paper burden and simplify digital systems use. Gynae ED will solely be using PENS.	08/06/2020	15/10/2020	Richard Strover	PENS is now live for clinical staff to record clinical documentation for both A&E attendances and outpatient follow ups. Any development to current forms will be managed through the change control procedures in place for PENS documentation. ECDS data being submitted from PENS and regular data quality reports are monitored by ED and Digital.Information staff. Date Entered : 08/10/2020 06:52 Entered By : Richard Strover ---------- PENS is now in use within the GED. Attendances are still recorded on Meditech to ensure a record of the attendance but all clinical documentation has been moved over to PENS. Work is ongoing to remap all data	Completed	30/09/2020

					for reporting the daily ECDS from Meditech to PENS with completion anticipated by mid June. All data will be retrospectively submitted as agreed with Liverpool CCG. The automated GP letter has been re-mapped from Meditech to PENS and these are now being sent to GPs electronically the day after attendance. Date Entered : 08/06/2020 16:47 Entered By : Richard Strover		
9	Implement electronic ordering from ICE to replace a multi-system process through Meditech.	08/06/2020	31/12/2020	Richard Strover			/ /
10	Upgrade PACS to integrate fully into the network and remove a seperate system login feature.	08/06/2020	30/09/2020	Paula Brennan		Completed	04/08/2020
11	Implement Virtual Smartcards which will allow clinical staff who access the national e-referral system system or the summary care record to log on without the need for a physical smart card or password.	08/06/2020	30/09/2020	Paula Brennan		Completed	29/09/2020

Initial Assessment		
Severity	**Likelihood**	**Risk Score**
5 Catastrophic	4 Likely	20

Current Assessment		
Severity	**Likelihood**	**Risk Score**
5 Catastrophic	4 Likely	20

Target Assessment		
Severity	**Likelihood**	**Risk Score**
5 Catastrophic	4 Likely	20

Listing For: 4. BAF | **Risk Register Level:** 4. BAF | **Directorate:** EPRR | **Service / Department:** Executive Office | **Position at:** 12/10/2020 08:58:11

Risk Number: 2340 **Version:** 4 **Domain:** Impact On The Safety Of Patien **Linked Risks:**

Executive Lead: Kathryn Thomson **Operational Lead:** Gary Price

Strategic Objective: To Deliver SAFE Services

Risk Appetite: 2.Low

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

Risk Description:

Condition: Failure to - a) maintain pre-Covid-19 level of service for our patients due to the outbreak of the Covid-19 pandemic; b) protect staff, patients and visitors from infection; c) effectively manage increased demands and provide support to the wider system; and d) failure to recover to pre-Covid-19 service levels following the pandemic and be sufficiently resilient to manage a potential 'second wave' of infection.

Cause: Reduction of a number of elective services to focus capacity and reduction of efficiency due to infection, prevention and prevention measures.Increased number of staff absent due to Covid-19 health restrictions

Consequence: Lack of service provision to Liverpool Womens Hospital patient groups, reduced services in some areas, life altering impact on some patients, reduced patient experience, impact on patient safety and potential loss of reputation and inability to recover service provision in the future.

Last Review Narrative: **Date:** 12/10/2020 **Reviewed By:** Christopher Lube

Risk reviewed with Executive Directors. Additional information added into controls section under contingency. Relates to staffing levels and impact of Test, Track and Trace and need to be able to flex staffing levels using bank and additional payments.

Control	Control Description	Gaps in Control	Effectiveness	Internal Assurance	External Assurance	Gaps in Assurance	Adequacy of Assurance
Prevent	RESPONSE Command and Control arrangements in place led by Executive Directors Regional Director of Nursing and Medical Directors groups meeting to discuss issues and develop assistance. Cheshire and Mersey Coordinated response including Chief executive Officer briefings and Hospital Cell approach Weekly oversight and scrutiny meetings chaired by Chief Executive Officer (internal) Daily incident meetings to support and respond to challenges Planning and monitoring of activity on a daily basis by Divisional Managers Partnership working with Liverpool University Hospitals, Alder Hey Hospital and wider Cheshire and Mersey network for coordinated provision of support Clear and on-going communication with the Clinical commissioning Group and Specialist Commissioners Working as part of the regional Local Resilience Forum Business Continuity Plans in place Pandemic plan in place and being followed Daily safety huddle Clinical Advisory Group (CAG) meetings meets 3 times a week . STAFFING Staff working from home wherever possible, use of virtual meetings and enhanced IT provision. Clear staff absence process and monitoring with increased flexibility. Taking steps to review work schedules including start and finish times/shift patterns, working from home etc. to reduce number of workers on site at any one time. Also relocating workers to other tasks. Enhanced well being support for staff Strict supply and demand process for Personal Protective Equipment in place. Fit testing process in place fro FFP3 masks Clear criteria as to elements of activity and types of patients the Trust can assist with. Close working with Director of Infection Control and Infection Control team. Regular staff communications Listening Event for BAME staff completed to consider what further action the Trust could take to ensure BAME staff are protected as much as possible. Risk Assessments undertaken for shielding & vulnerable staff including BAME, Pregnant workers, Age and Gender, to include all staff by 31st August 2020 Comprehensive testing programme for symptomatic staff & household, antibody testing programme and have commenced asymptomatic testing for staff in high risk clinical areas	External pressures on neighbouring Trust beds and services, impacting on ability of the LWH Trust to access critical care and other services. Ability to control PPE deliveries from centre Unknown staffing and service impact of potential 'second wave' Unknown length of time to return to pre Covid-19 service levels Trust is required to meet national target in relation to flu vaccinations, but this needs to be completed in a short time period to provide the best protection for staff. The revised requirements increases the protected groups to include all staff over 50 years of age and more may yet be confirmed. Issues with supply may also create a challenge with meeting targets. The Trust has an understanding of the scale of the recovery / re-set challenge, the guidance on how to engage in this process have yet to be released. The age profile of individuals being infected with Covid-19 appears to be extending and there is an increase in the younger population with Covid-19. This includes the main age group of women attending maternity services. There is a possible increase in numbers of ladies and partners attending LWH who may be Covid-19 positive but asymptomatic.	Effective	Weekly Operations and Oversight meetings are effective Board Committee meetings continuing (although adjustments made). Maintenance of assurance reporting (performance metrics etc.) - identification of key performance measures. Reduced footfall though the Trust - activity and visitors (comms) Close monitoring of guidelines and mandatory requirements with assurance reported to Extraordinary Board on 18 June 2020 Corporate BAU largely maintained despite remote working. Regular Covid-19 response reports to the public Board EPRR Meetings continued	Daily Regional command meetings Oversight by NHSE/I Oversight by Commissioners Audit of financial accounts National Health Service Resolution. Internal procedures in line with regional guidance, planned and undertaken	External audit activity suspended for Quality Account Internal normal business audits have stopped due to workload Reduction in some external performance measurement due to pressures Lack of covid-19 testing for staff. Internal audit programme anticipated to be completed on time as per plan from 20-21, if there is a second wave or increase in Coivd-19 restriction this may prevent the programme completing on time. The Trust is struggling to access benchmarking information on what is good practice in terms of the Trust's response.	Positive

	PATIENTS Clear communication to patients via direct communications and social media. Review of national guidance re:activity delivery via Clinical Advisory Group PALS service continuing Visiting Policy amended to reduce risk of spread Family liaison service established to supplement PALS service. All staff, patients and visitors required to wear masks whilst on site. Baby swabbing offer to new parents on leaving the hospital to provide assurance regarding hospital acquired infection.				
Contingency	BUSINESS AS USUAL, RECOVERY and RESILIENCE Commitment to deliver Business as Usual wherever possible Executive lead assigned to manage Business as Usual Corporate controls remain in place On-going regulatory compliance Recovery plans in development to include areas of good practice which should be maintained Maternity escalation and incineration process in place to support staff taking on back and extra shifts at times of short staffing. Health care partnership are using existing memorandum of understanding in relation to staff movement between local hospital at time of staffing need. Previous staffing skills audit refreshed to ensure up to date and ensure information available to allow for staff to be moved into an appropriate support role if required.	National mandates and what the Trust is required to recover and trajectories. Day case efficiency currently 70% backlog and ineffective in dealing with backlog. Insufficient Theatre staffing due to vacancies and not having a full compliment of anaesthetists. Test, Track and Trace system impact on staffing	Not Yet Tested	Situation continues to be monitored at Oversight and Scrutiny Group weekly and 3 times a week at the Command and Control meeting.	Inconclusive

Action	Action Description:	Start Date	Target Date	Person Responsible	Progress	Status	Date Completed
1	Ongoing dialogue with partners and consideration of mitigating arrangements to be introduced on site via Clinical Advisory Group - CAG is up and running and is a functional group	01/04/2020	01/02/2021	Andrew Loughney	CAG remains functional and providing advice to the Trust Covid-19 Oversight and Scrutiny Group Reduced meetings to 2 times a week. Date Entered : 01/07/2020 17:07 Entered By : Christopher Lube ---------- CAG is up and running and is a functional group Date Entered : 04/05/2020 08:59 Entered By : Rowan Davies		/ /
3	Ongoing review of directives across national, regional and local forums	01/04/2020	01/12/2020	Andrew Loughney	Review of all guidance and directives completed at Control and command and Oversight and Scrutiny Groups of the Trust. Also reviewed and discussed at Executive Directors Meetings. Date Entered : 01/07/2020 17:10 Entered By : Christopher Lube		/ /
4	Close working with Cheshire and Mersey procurement via Covid Supply Response (CSR)	01/04/2020	01/12/2020	Amy Noble	Head of Procurement has worked closely with procurement colleagues and other partner organisations to maintain supply of PPE linking in with national systems. Date Entered : 01/07/2020 17:16		/ /

5	Work with partners such as Liverpool University to develop alternative means to maintain the supply of PPE	01/04/2020	01/12/2020	Christopher Lube	Entered By : Christopher Lube Via the Head of Procurement and Head of Governance work has been undertaken with partner organisation and the LRF to ensure the supply of PPE via mutual aid. Date Entered : 01/07/2020 17:14 Entered By : Christopher Lube		/ /
6	The Trust needs ensure that it is keeping up to date with local, regional and national Covid-19 guidance and policy, ensuring review and implement at pace.	03/08/2020	02/08/2021	Christopher Lube		Ongoing	/ /

Initial Assessment		
Severity	**Likelihood**	**Risk Score**
5 Catastrophic	4 Likely	20

Current Assessment		
Severity	**Likelihood**	**Risk Score**
4 Major	4 Likely	16

Target Assessment		
Severity	**Likelihood**	**Risk Score**
2 Minor	4 Likely	8

Listing For: 4. BAF | **Risk Register Level:** 4. BAF | **Directorate:** Financial Services | **Service / Department:** Finance | **Position at:** 12/10/2020 08:58:12

Risk Number: 2344 **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:** 07/11/2020

Risk Description:

Condition: There is a risk that the Trust will not deliver a breakeven position or have sufficient cash resources in the 2020/21 financial year.

Cause: Lack of contractual income position due to the Covid-19 pandemic, gap in baseline position and block payment compared to actual activity and cost, risk to CIP and income streams, timing of recovery and uncertainty over future regime.

Consequence: Potential for insufficient operational cash reserves and non-compliance with regulations.

Covid-19 Impact: The impact of Covid-19-19 is inherent in the risk description. No further issues identified. No changes required.

Last Review Narrative: **Date:** 08/10/2020 **Reviewed By:** Christopher Lube

Risk reviewed by the Director of Finance and Head of Governance and Quality, proposal to go to FPBD for likelihood score to be increased to 5 from 4 due to deficit plan for 2nd half of 2020/21 based on central income allocations.

Control	Control Description	Gaps in Control	Effectiveness	Internal Assurance	External Assurance	Gaps in Assurance	Adequacy of Assurance
Contingency	Working with system including NHSI/E and commissioners to ensure Trust position is understood.	Uncertainty re financial regime.	Not Yet Tested				
Prevent	Breakeven draft plan agreed by Board demonstrating ability to meet targets	uncertainty re COVID-19 impacts and recovery	Not Yet Tested		MIAA assurance over budgetary controls	Lack of clarity over operational planning regime nationally	Inconclusive
Prevent	CIP schemes fully worked up with PIDs, QIAs and EIAs with post evaluation reviews	Delays due to COVID-19	Not Yet Tested				
Prevent	Budgetary sign off by divisional leaders		Not Yet Tested				Inconclusive
Detect	Monthly reporting and review of position against national regime and internally approved plan	Operational impacts of COVID-19	Not Yet Tested	FPBD scrutiny Track record of delivery	MIAA audit assurance re adequacy of budgetary controls and CIP NHSI/E top up system for trusts and Distressed Financing available as last resort		Inconclusive
Detect	Divisional performance reviews	Operational impacts of COVID-19	Not Yet Tested				Inconclusive
Prevent	Robust budget setting process	lack of contingency in budgets	Not Yet Tested				

Action	Action Description:	Start Date	Target Date	Person Responsible	Progress	Status	Date Completed
1	Budgets uploaded to ledger. Regular reporting to divisions and FPBD/Board. Financial management processes to continue.	01/04/2020	31/03/2021	Eva Horgan			/ /
2	Full set of CIP mandates completed with QIAs, EIAs etc. Some schemes paused as not possible to implement during Covid-19 pandemic.	01/04/2020	31/03/2021	Eva Horgan			/ /
3	Regular communication with NHSI/E and Commissioners, plus other providers, to ensure position is clear and understood.	01/04/2020	31/03/2021	Eva Horgan			/ /

Initial Assessment		
Severity	Likelihood	Risk Score
4 Major	5 Almost	20

Current Assessment		
Severity	Likelihood	Risk Score
4 Major	4 Likely	16

Target Assessment		
Severity	Likelihood	Risk Score
4 Major	2 Unlikely	8

Liverpool Women's NHS Foundation Trust

Agenda Item	20/21/194

MEETING	**Trust Board**
PAPER/REPORT TITLE:	**Medical Appraisal and Revalidation Annual Report 2019/20**
DATE OF MEETING:	Thursday, 05 November 2020
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	Andrew Loughney, Medical Director
AUTHOR(S):	Devender Roberts, Responsible Officer & Deputy MD Lynn Johnson, Revalidation Support Manager
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: **NHS Medical revalidation**
FREEDOM OF INFORMATION (FOIA):	*Choose an item.*	
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	The Board is asked to receive the report and approve the signing of the 'statement of compliance' (Annex D) confirming that the organisation, as a designated body, is in compliance with the regulations.	
PREVIOUSLY CONSIDERED BY:	**Committee name**	Putting People First Committee
	Date of meeting	21 September 2020

Executive Summary

(Please note: the time period covered by this report pre-dates the suspension of appraisal and revalidation from March 2020-October 2020 as a consequence of the Covid-19 pandemic)

Revalidation is the General Medical Council's (GMC) way of regulating licensed doctors that will give extra confidence to patients that doctors are up to date and fit to practice.

The GMC requires that the designated body has nominated or appointed a responsible officer in compliance with the Responsible Officer (RO) Regulations. The RO is a licensed doctor who has been licensed continuously for the previous five years and continues to be licensed throughout the time they hold the role of responsible officer.

During this revalidation year April 2019 to March 2020, the team supporting revalidation for the Trust was:
Dr Devender Roberts, Responsible Officer (RO),
Dr Bill Yoxall Appraisal Lead,
Lynn Johnson Revalidation Support Manager and
a team of 13 + 4 newly trained appraisers who each will undertake between 4-7 appraisals/year.

Liverpool Women's NHS Foundation Trust as a designated body had 96 doctors with a prescribed connection in the revalidation year April 2019 to March 2020. All doctors were engaged with the process and all doctors were accounted for in terms of their participation.

Revalidation recommendations:

12 doctors' revalidation date fell during this year. Nine received a positive recommendation.

Three recommendations were deferred due to the RO having insufficient evidence; one of these subsequently had a positive recommendation within the year. One of the remaining doctors has since moved Trust and all available information forwarded to the new designated body, and one deferral is still on-going.

Governance and Quality Assurance:

The Appraisal and Revalidation policy has been updated in line with current national policy and is presented for ratification to this meeting.

The Responsible Officer has provided quarterly assurance and an annual report to NHS England to demonstrate compliance with the Framework of Quality assurance for Responsible Officers and Revalidation.

Twice yearly appraisal update training has been provided by MIAD up till now. All future appraisal training will be delivered in-house with invited speakers to meet the requirements for keeping appraisers up to date with current issues and methodologies in appraisal and revalidation.

Internal quality assurance is performed by reviewing a random sample of 10% of completed appraisals. In the year 2019/20 this was done using the NHSE ASPAT tool. Following a recent Higher-Level Responsible Officer visit in January 2020, the recommendation was that the Trust moves to using the Excellence QA tool. This will commence in autumn 2020.

The Trust returned an 8.8% unapproved missed appraisal rate in 2018/19 which resulted in a Higher-Level RO visit in January 2020. The purpose of these visits is to understand and aid Trusts in meeting the requirements for appraisal and revalidation. The notes from the visit and action plan are appended to this paper and have been presented at the July Trust Board meeting for assurance. The HLRO visit fulfils the Trust's requirement to have a peer review of its appraisal and revalidation processes.

Recommendation:

The Board is asked to receive the report and approve the signing of the 'statement of compliance' (Annex D) confirming that the organisation, as a designated body, is in compliance with the regulations.

Report

1. Purpose of the paper

As part of the framework for quality assurance and for the purpose of revalidation, NHS England requests an Annual Report together with the compliance statement (Annex D). This usually follows the completion of the Annual organisation Audit (AOA) exercise. In April 2020, the AoA for 2019/20 was cancelled due to the Covid-19 pandemic but providers have been advised that they may submit an annual report to their Boards and submit an Annex D compliance statement if they wish.

The paper is intended to fulfil the above and provide assurance to the Putting People First Committee that, in line with the self- and external assessments, the Trust is fulfilling all the requirements for revalidation.

2. Background

Revalidation was made statute on 3rd December 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving public safety and increasing public trust and confidence in the medical system. All doctors are allocated to a Designated Body through the GMC. Each Designated Body has a Responsible Officer, who is responsible for implementing appraisal and revalidation. Doctors in training are in the Deanery designated Body and therefore are not included in this report.

The GMC decides whether to revalidate a doctor based on the recommendation made to it by the Responsible Officer. A positive revalidation decision means the doctor's license to practice is extended for five years. Deferral is a neutral recommendation resulting in a new revalidation date being set. It does not impact on the doctor's license to practice. Non-engagement indicates a doctor's license is a risk of being withdrawn.

Liverpool Women's NHS Foundation Trust has a statutory duty to support the RO with sufficient funding and other resources necessary to enable them to discharge their duties under the Responsible Officer Regulations.

The RO oversees compliance by:

- Monitoring the frequency and quality of medical appraisals in their organisations;
- Checking there are effective systems in place for monitoring the conduct and performance of their doctors; ensuring that accurate records are kept of all relevant information, actions and decisions
- Ensures that the organisation's medical revalidation policies and procedures are in accordance with equality and diversity legislation
- Making timely recommendations to the GMC about the fitness to practice of all doctors with a prescribed connection in accordance with the GMC requirements and the GMC Responsible Officer Protocol
- Confirming that feedback from patients is sought periodically so that their views can inform the

appraisal and revalidation process for their doctors

3. Governance Arrangements

The current Responsible Officer is Dr Devender Roberts. The Trust responsible Officer is appraised by an external appraiser nominated by NHS England. She has completed two appraisals and is due a third one in autumn 2020.

The current Appraisal Lead is Dr Bill Yoxall.

Lynn Johnson was appointed to the post of Revalidation Support Manager in 2017, with the remit to provide support and advice to the RO and doctors on matters relating to appraisal and revalidation.

The Trust's Responsible Officer and Revalidation Support Manager attend regular external Responsible Officer/Appraisal Lead Network meetings with other ROs and representatives from GMC and NHS England

The RO and Revalidation Support Manager meet regularly. Revalidation Team meetings have been established and meet twice a year. The purpose of the meeting is to provide appraiser peer support and to discuss any issues arising relating to the appraisal systems/processes.

The Medical Appraisal/Revalidation Team reports to the Putting People First Committee and the minutes are formally recorded and submitted.

The RO provides a Statement of Assurance to NHS England Regional Revalidation team via E-mail on a quarterly basis and completes an Annual Organisational Audit (AOA).

There is a process to support the appropriate transfer of information about a doctor's practice to and from the doctor's responsible officer. It is designed to be used to share information with the doctor's responsible officer in the following situations:

- When a doctor's prescribed connection changes
- When a concern arises about the doctor's practice in any place where the doctor is practising I

The Trust has an established team and system to record all incidents and complaints through the Risk and Safety Team.

The Trust also has a dedicated Audit team to assist the doctors and contribute to their clinical performance.

4. Policy and Guidance

The 2017 Medical Appraisal and Revalidation policy has been updated in line with current national policy and is presented for ratification to this meeting.

5. Quality Assurance

All appraisees complete a feedback questionnaire about the quality of their appraisal; this is included in an annual report to the appraisers to be included and discussed at their own appraisal.

The Appraisal Lead observes the quality of the appraisers undertaking an appraisal, at least once every 5 years. This information is used to provide evidence to the RO and designated body about the quality of the appraisal and used for feedback to the appraiser. The Appraisal lead has introduced a process for peer review of appraisals using the NHSE ASPAT tool. This shows that in general the quality of appraisals in the Trust are good. The areas for improvement centre around the appraisees submitting high quality supporting information and the appraisers providing appropriate challenge to drive quality. The area of providing and receiving constructive challenge during appraisal will feature in future training for appraisers and appraisees.

With regards to the amount of time required to prepare for appraisal, the team is in the process of evaluating revalidation systems other than the current Equiniti Revalidation Management System used by the Trust.

In 2018/19 the Trust returned an 8.8% (n=6) unauthorised late appraisal rate on the Annual Organisational Audit. This resulted in a visit from the Higher Level RO in January 2020. The purpose of these visits is to understand and aid Trusts in meeting the requirements for appraisal and revalidation. The notes from the visit and action plan are appended to this paper and have been presented at the July Trust Board meeting for assurance. The actions from the meeting and their status is as follows:

- Better alignment of the Trust Medical revalidation policy with NHSE/I guidance and more clarity re: process
  This has been completed and the policy is presented at this PPF meeting for ratification
- QA tools for assurance of appraisal other than ASPAT
  A new QA excellence tool has been introduced
- Relationship building with other local providers
  Meeting with the combined RO team at LUFT took place on 30th July 2020. Both Revalidation teams agreed to share resources and maintain a reciprocal relationship
- GMC Effective Clinical Governance Handbook and self-assessment
  Self-assessment meeting with Director of HR took place on 10th July 2020. Further actions to be agreed at PPF

The HLRO visit fulfils the Trust's requirement to have an external peer review of its appraisal and revalidation processes.

6. Medical Appraisals

Appraisal and Revalidation Performance Data

The Revalidation Support Manager maintains a database of all appraisal dates. Doctors receive timely notification and reminder emails with the request to undertake an annual appraisal, in accordance with NHSE guidance.

The data on the appraisal is shown in the table below.

	Number	Completed	Incomplete/missed appraisal	Incomplete/missed appraisal Not

		appraisals	Authorised	Authorised
Consultant	79	70	8	1
Staff Grade, Associate Specialist Speciality Doctor	3	2	1	0
Temporary or Short-term Contract holders.	17	17	0	0
Total	99	89	9	1

Reasons for the not authorised incomplete/missed appraisals were:

One doctor requested postponement of appraisal after they missed their original appraisal date. In order to have an approved late appraisal, they are required to request postponement prior to the appraisal date.

The overall rate of of unauthorised missed/incomplete appraisal 1%. This marks a significant improvement from the previous year and is under the 2.1% reported in 18/19 for other same sector organisations. There is no national benchmark for 19/20 due to the cancellation of the Annual Organisational reports in March 2020.

The Revalidation team has tightened up the reminder letter system which now clarifies that discussion with the GMC liaison officer takes place regarding possible referral to the GMC as a consequence of unauthorised late appraisal.

7. Appraiser training

As part of the Revalidation process, every doctor will undergo a formal appraisal process each year facilitated by a trained appraiser. The Trust has 14 + 3 newly trained appraisers.

The GMC recommends that each appraiser perform a maximum of 8 appraisals, minimum 6 appraisals per year. Due to our size our appraisers undertake between 4-7 appraisals a year. Training by accredited external providers has been provided for all new appraisers and refresher training is provided twice a year.

All appraisers have attended required training, two workshops occur each year which provide appraisal update training by an accredited external agency. This is followed by a meeting where the annual audit and individual experience is shared and standards are set for the next appraisal cycle.

All appraisers are required to have refresher training annually. This has been provided bi-annually by MIAD. Although the quality of the training in the past has been well evaluated, the revalidation team received feedback that the MIAD training had not adapted to deliver the level of in-depth appraiser training required for the post-implementation revalidation frameworks.

Future training will be delivered in-house with invited speakers to cover areas relevant to appraisers and their development.

8. Appraisee

Doctors upload documentation into a portfolio on RMS (Revalidation Management System) covering the GMC domains as outlined in Good Medical Practice. RMS requires the completion of pre-appraisal documentation by doctors regarding their own probity and health. Their PDP and Job plan are part of the portfolio. This portfolio is submitted to their appraiser prior to their appraisal meeting.

In each revalidation cycle, each doctor is obliged to gather patient and colleague feedback once. There is a system built into RMS to facilitate this, the feedback is discussed at appraisal, and feeds into the personal development plans.

Currently the Trust uses the Equiniti RMS (Revalidation Management System) as the system for doctors to upload their revalidation and appraisal evidence. The Trust have extended the contract (which expired in Jan 2020) for a further 12 months and are currently evaluating other options as well as how we fund the resources needed to facilitate ongoing training for appraisers and new appraises.

9. Access, security and confidentiality

The Trust has an implemented framework of Information Governance to ensure all the information held on staff members are complaint with the Data protection and confidentiality, information security and information quality on an annual basis.

10. Issues for Board consideration

- The HLRO meeting in January 2020 completes the Trust requirement for independent verification once every revalidation cycle for each designated body as described in the Framework of quality Assurance for Responsible Officers and Revalidation. The team were satisfied that the processes were in place and made minor suggestions for improvement. The HLRO meeting notes and action plan was presented to the Board. All actions are now complete but further work on some areas of the GMC Governance Framework will be needed.

- The number of doctors with a prescribed connection and requiring appraisal has increased from ~70 to 96 in 19/20. The team have worked hard to maintain the appraiser numbers to support the increase. Progress against this is tracked by the Revalidation team.

- The resources required for training appraisers and new appraises has developed significantly with the introduction of ‘Top Tips’ by the Appraisal Lead. The appointment of an Appraisal Lead has led to significant improvement in the appraisal process and this is reflected in the performance data for 19/20. Appraiser time is accounted for within job plans with a currency of 0.25 PA. The Appraisal lead currency is 0.5 PA.
- Continued funding to support the training including the Trust ambition to improve it by having higher quality and invited speakers is essential to ensure compliance with the GMC Governance framework.

- In the 2018/19 report; strengthening assurance where doctors work in multiple locations was an area of key focus for the team. This includes private practice and doctors on short-term contracts. In

2019/20, all short-term contract holders with a prescribed connection to LWH were accounted for and appraised. Doctors are also more aware now that they are appraised on their whole scope of practice which includes academic and private work.

11. Conclusions

Medical Revalidation is in its second cycle. The Trust has seen a significant improvement in managing doctors who do not seek approval for late/incomplete appraisals. This is thanks to the efforts of the team and is reflected in the performance data.

A review of the revalidation system for doctors and the training for appraisers and appraisees is being undertaken to improve the service and lighten the burden on doctors.

12. Recommendations

The Board is asked to receive the report and approve the signing of the ‘statement of compliance’ (Annex D) confirming that the organisation, as a designated body, is in compliance with the regulations.

Liverpool Women's NHS Foundation Trust

Statement of Compliance -Annex D

Designated Body Annual Board Report

Section 1 – General:

The board–of Liverpool Women's NHSFT can confirm that:

1. The Annual Organisational Audit (AOA) for this year has been submitted.

Date of AOA submission: 2020 submission cancelled Action from last year: None Comments: Proportion of missed/unauthorised appraisals has significantly improved from 8.8% (n=6) to 1% in 19/20. Action for next year: Continue to monitor and actively manage late appraisals

2. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Yes

3. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes

4. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Yes

5. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Yes

6. A peer review has been undertaken of this organisation's appraisal and revalidation processes.

Action from last year: As the Responsible Officer and Lead Appraiser were newly appointed in December 2019 and January 2020, an independent review was proposed for 2020/2021 year. Comments: An HLRO visit triggered by the 8.8% late appraisals in 18/19 took place in January 2020. This fulfils the criteria for an externally validated peer review. All actions are complete Action for next year: -

7. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: To keep the direct channels with HR open regarding informing the revalidation team when locum or short-term doctors are appointed to the organisation

Comments: 100% achieved this year

Action for next year: to maintain the process

Section 2 – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year: to actively manage late appraisals

Comments: Yes

Action for next year: to continue active management of the process

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year:

Comments: Yes

Action for next year:

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: -

Comments: Yes the olicy has been revised to bring it more in line with NHSI/E guidance and is presented to the PPF for ratification in September 2020

Action for next year: -

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: - Comments: Yes. The number of appraisers was increased to support the increase in prescribed connections Action for next year: Continue to actively monitor numbers as appraisers come and go due to retirement etc.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent).

Action from last year: Comments: Yes Action for next year:

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Comments: Yes

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Comments: Yes

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Comments: Yes

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: Comments: Yes the Trust uses the Ulysses system for adverse event reporting and triangulates with complaints and serious incidents Action for next year:

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Comments: Yes

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Comments: Yes the Trust uses MHPS for this

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors[2].

Action from last year: to formalise the quality assurance process for the system for responding to concerns about a doctor Comments: This has not been performed due to the Coronavirus pandemic but is reported directly to the GMC Employment Liaison Officer who triangulates concerns data with the GMC database. This continued during the pandemic Action for next year: to work with the Director of HR to develop a QA process for this

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance

[4]This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation[3].

Action from last year: Comments: Yes Action for next year:

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: Comments: Yes Action for next year:

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year:

2. Comments: Yes RO and Medical Staffing Officer work closely to ensure pre-employment checks are fully undertaken. Medical Staffing informs the Revalidation Officer of all newly appointed doctors including locum and short-term doctors to ensure they are allocated appraisers

Action for next year:

Section 6 – Summary of comments, and overall conclusion

Issues for consideration

- The HLRO meeting in January 2020 completes the Trust requirement for independent verification once every revalidation cycle for each designated body as described in the Framework of quality Assurance for Responsible Officers and Revalidation. The team were satisfied that the processes were in place and made minor suggestions for improvement. The HLRO meeting notes and action plan was presented to the Board. All actions are now complete but further work on some areas of the GMC Governance Framework will be needed.

[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

- The number of doctors with a prescribed connection and requiring appraisal has increased from ~70 to 96 in 19/20. The team have worked hard to maintain the appraiser numbers to support the increase. Progress against this is tracked by the Revalidation team.

- The resources required for training appraisers and new appraises has developed significantly with the introduction of 'Top Tips' by the Appraisal Lead. The appointment of an Appraisal Lead has led to significant improvement in the appraisal process and this is reflected in the performance data for 19/20. Appraiser time is accounted for within job plans with a currency of 0.25 PA. The Appraisal lead currency is 0.5 PA.
- Continued funding to support the training including the Trust ambition to improve it by having higher quality and invited speakers is essential to ensure compliance with the GMC Governance framework.

- In the 2018/19 report; strengthening assurance where doctors work in multiple locations was an area of key focus for the team. This includes private practice and doctors on short-term contracts. In 2019/20, all short-term contract holders with a prescribed connection to LWH were accounted for and appraised. Doctors are also more aware now that they are appraised on their whole scope of practice which includes academic and private work.

Conclusions

Medical Revalidation is in its second cycle. The Trust has seen a significant improvement in managing doctors who do not seek approval for late/incomplete appraisals. This is thanks to the efforts of the team and is reflected in the performance data.

A review of the revalidation system for doctors and the training for appraisers and appraisees is being undertaken to improve the service and lighten the burden on doctors.

Section 7 – Statement of Compliance:

The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: _ _ _ _ _ _ _ _ _ _ _

Name: _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _

Liverpool Women's NHS Foundation Trust

Agenda Item	20/21/195

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Guardian of Safe working Hours Annual Report 2019 - 2020**
DATE OF MEETING:	Thursday, 05 November 2020
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	Andrew Loughney, Medical Director
AUTHOR(S):	Rochelle Collins, Medical Workforce Manager
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 junior medical 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)* ☐ ***9.*** *Inability to deliver the best clinical outcomes for patients* ☐ ***10.*** *Potential for 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):	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:-….)***	***Read and note this report***	
PREVIOUSLY CONSIDERED BY:	**Committee name**	Putting People First Committee
	Date of meeting	Monday, 21 September 2020

Executive Summary

Under the 2016 terms and conditions for doctors and dentists in training introduced by the Department of Health nationally, there is a requirement for the guardian of safe working hours (GSWH) to submit a quarterly report to a sub board committee Putting People First Committee and an annual report to the Trust Board.

The 2016 contract highlights three functions, which oversee the safety of doctors in the training and service delivery domains of their working experience:

a. The employer or host organisation designs schedules of work that are safe for patients and safe for doctors, and ensures that work schedules are adhered to in the delivery of services.

b. The Director of Medical Education (DME) oversees the quality of the educational experience.

c. The Guardian of Safe Working Hours provides assurances to the employer, and host organisation if appropriate on the compliance with safe working hours by the employer and the doctor.

The GWSH supports safe care for patients and the health and wellbeing of doctors in training through the management of exception reporting. The role ensures any issues of compliance with safe working are addressed as appropriate by the Trust. The guardian has the authority to impose sanctions such as a doctor taking time back in lieu of working additional hours or levy financial penalties against the departments where safe working hours are breached.

The Guardian is confident that doctors in training receive appropriate work schedules and compliant rotas. This is evident in the number of exception reports received by the Guardian in the reporting year, a total of 6 exception reports were lodged by O&G trainees only. There were no work schedules review requests.

It is important for the Board to note that the 2016 terms and conditions was imposed on doctors in training, however, in July 2019, an agreement was reached between NHS Employers, the British Medical Association (BMA) and the Department of Health and Social Care (DHSC) on the amendments to the 2016 terms and conditions for doctors in training, The updated contract is referred to as 'Junior Doctors 2018 contract refresh'

The main themes negotiated were;

- Less than full-time, flexible working and equalities
- Pay structure
- Safety and wellbeing
- Workforce
- Training and education

In addition to the above, Health Education continues to fund a 'SuppoRTT Champion' and in July 2019 appointed Miss Cara Williams into the role. The role is designed to provide trainees of all specialties and their supervisors with guidance regarding the relevant policies and available resources to them returning to training. The role also ensures that trainees returning to training after a period of prolonged absence are fully supported and consider any upskilling / reskilling educational and training needs trainees may have to be fully confident to return to the workplace.

The agreement received ministerial clearance and an investment over a four year period (1 April 2019 to 31 March 2023) the investment will be used to support changes within the 2016 contract.
In 2019/20, there was a total investment of 2.3 per cent in the contract. In each of the subsequent years (2020/21-2022/23) there will be annual pay uplifts of 2 per cent and a further 1 per cent of additional investment (circa £90m) in other terms within the contract.

This additional investment has enabled the introduction of:

- A weekend allowance uplift to ensure those working the most frequent weekends are remunerated more fairly
- An enhanced rate of pay for shifts that finish after midnight and by 4am
- A new nodal pay point 5 from October 2020 for grades ST6 and above

The new terms and conditions of service were introduced in early August 2019 with a phased implementation taking into account operational implications of the changes for employers.

All doctors in training transitioned to the revised terms and conditions on the 5th February 2020. Where applicable, a number of doctors are currently pay protected as arranged by the Lead Employer. However, locally employed doctors, commonly referred to as Clinical Fellows whose service is not recognised towards training remained on the 2002 pay conditions. This is currently being looked across the region and it is anticipated that Locally Employed Doctors will be offered the 2016 terms and conditions and associated pay scale from 4th August 2020.

During the first quarter of this reporting period, the services ran with a number of rota gaps until August 2019. The O&G service received an increase of doctors in training resulting in the rotation being over established and the Anaesthetic service successfully recruited to gaps. Therefore, the services have seen a significant reduction in the number of shifts requiring locum coverage as detailed below;

Service	2018 – 2019 shifts requiring a locum	2019 – 2020 shifts requiring a locum	Percentage
O&G	398	145	-64%
Neonates	105	89	-15%
Anaesthetics	123	21	-83%

Report

Introduction

The Guardian of Safe Working Hours is a requirement of the 2016 contract and is currently filled by Mr Geoff Shaw (Consultant Obstetrician), however, the Board is asked to note that Mr Shaw intends to retire from the Trust in November 2020. Therefore, the Medical Director will seek a replacement. The Guardian is responsible to the Medical Director and should not be involved in management roles within the Trust, but have a fully independent role with access to the Board as required.

The role of the Guardian is to;

- Act as a champion of safe working hours
- Record and monitor compliance of exception report management and review cases escalated by a doctor in training
- Escalate issues for action where not addressed locally
- Will request work schedule reviews to be undertaken where necessary
- Oversea safety-related exception reports and monitor compliance with the system
- Intervenes as required to mitigate safety risks
- Intervenes where issues are not being resolved satisfactory
- Provide assurances on safe working and compliance with TCS
- Submits a quarterly report to the Trust Board on the functioning of the contract and exception reporting

Work Schedules

NHS Employers recommend that doctors in training should be made aware of their next placement 12 weeks before commencement. They should receive work schedules 8 weeks prior to commencement and a finalised rota 6 weeks before. This is to ensure work life balance it also enables doctors to request annual leave 6 weeks in advance.

Although the majority of work schedules have been completed within the 8-week timeline, this has not always been possible due to conflicting information from Health Education inaccurate or missing information from the college tutors and / or changes in the rota due to unexpected gaps. The increase in less than full time working may at times affect the sharing of work schedules in good time as these rota can be complex. This information is currently reported quarterly to NHSI data collection.

Rota compliance

All rotas are compliant with both 2002 and 2016 terms and conditions. This is relevant as previous to 5th February 2020 doctors training at the trust were on different terms and conditions yet work on the same rota. Also, the currently locally employed doctors are employed on the 2002 TCs. Therefore, it is paramount that all rotas remain compliant with both sets of terms and conditions. However, due to the change in February 2020, the need for rotas to be compliant with both terms and conditions will phase out due to all doctors transitioning to one set of terms and conditions.

Staffing Levels

In previous reports the GSWH has reported national shortages of junior doctors, and how this has been detailed on the trusts Risk Register for a number of years. The Trust continued to run with a number of gaps throughout quarter 1 of this report and partially through quarter 2 until the new rotation in August 2019. During this time, the majority of gaps were in the main covered as locum shifts by the cohort of doctors, at the Trust in a training post.

As previously referenced in the Guardian quarterly reports, the number of gaps usually fluctuate throughout the 12 month rotation period due the number of times each specialty rotates, maternity leave, long-term absence and the completion of training (CCT). Therefore as the year progresses the services expect to work with increasing gaps. For context, the table below highlights the rotation months for each service. However, during quarter 3 and 4 of this report this has not been the case due to the O&G rotation being over established, Advance Neonatal Nurse Practitioners cross cover and excellent forward recruitment planning within Anaesthetics.

Rotations by month, specialty and grade.

Month	Specialty	Grade
August	O&G	F1 – ST7
	Anaesthetics*	CT2 – ST7
	Genetics	ST3 – ST7
September	Neonates	ST1 – ST7
November	Anaesthetics*	CT2 – ST7
December	O&G	F1 – F2
	Anaesthetics*	CT2 – ST7
February	O&G	GPST
	Anaesthetics*	CT2 – ST7
March	Neonates	ST1 – ST7
April	O&G	F1 – F2
May	Anaesthetics*	CT2 – ST7

*The Anaesthetic department trains doctors in higher obstetrics and these doctors rotate monthly. This is usually 1 -2 doctors at a time.

Obstetrics and Gynaecology

This workforce is predominately female; therefore as expected, there are usually a high number of gaps in this service due to maternity leave and less than full time working. During quarter 1 of this report, the service ran with an average of 3.5 gaps across the 3 rotas. The service runs with a 3 tier rota as described below.

- Tier one - doctors within the first 4 years of training most of which will have no experience in obstetrics and gynaecology. Usually GP, Foundation and ST1&2 O&G doctors.

- Tier two – Doctors who have a minimum of 2 years of experience working in Obstetrics and gynaecology working at an ST3 – ST5 who have a career plan to progress within O&G.

- Tier three – Experienced obstetricians and gynaecologists who have part 3 MRCOG and more than 6 years O&G experience working at an ST6 – ST7.

Trainees are given protected time to attend in house teaching organised by the college tutors for the first week of every month. The teaching is for ST1 to ST7 training grades. The teaching is facilitated by external and internal speakers. However, during quarter 1 of this reporting period the service found it increasingly difficult to release trainees for teaching. This was raised at the junior doctor forum and the Director of Medical Education (DME) agreed to work with the college tutors to identify time when teaching may be 'paid back' to the trainees.

Trainees are also invited to attend quarterly meeting with the college tutors and HR on a Friday morning 'early bird' session to discuss issues and concerns as well as updates about their rota and training needs.

Historically, all three rotas have carried gaps up to 5 WTE for a number of years. This has particularly impacted the Tier 2 and Tier 3 rota therefore the Trust has mitigated these gaps by employing a combination of Clinical Fellows, Research Fellows and International Training Fellows and Academic Clinical Fellows/Lecturers in addition to the doctors in training. The service also uses bank and doctors in training to cover out of hour rota gaps with agency doctors being sourced as a last resort. However, since August 2019, the service has been fully staffed with an increase in ST3 doctors and the service anticipates this will also be the case in August 2020. The Board is asked to note, that although Health Education has sent a full complement of doctors in training it is recognised that it is advisable to maintain the Locally Employed posts to attract a cohort into these non-training posts. These posts ensure the Trust continues to complete research and enable doctors to apply for sub-specialist training in the future.

The Trust works in partnership with Edge Hill University in recruiting International Training Fellows who work clinically at the Trust whilst completing a Masters. The doctors start on the Tier 1 rota and by quarter 3 progress to the Tier 2 rota as they become competent to work at a registrar level. Although the Trust had committed to employing two doctors per year for three years, it has become evident that the Trust cannot employ a further two international training fellows in year 2020 - 2021. This is in the main due to the over establishment of trainees in the O&G rotation. Therefore, it was agreed for the Trust to not appoint International Training Fellows into year 3 2020 – 2021.

The current partnership with the University of Liverpool continues to work well through the joint appointment of clinical academics who will work 2.5 days clinical and 2.5 days academic. The Trust is keen to ensure the service continues to work in collaboration with the University of Liverpool with particular focus on research and development.

In addition to the already mentioned Trust posts, the services was successful in submitting a business case for funding for a further 4 LWH (non-training) posts for the 2019 – 2020 rotation. Again, these posts will be reviewed at the beginning of the next financial year.

For context, during this reporting period the service required locum cover for 145 out of hour shifts to be covered by, Junior Doctors, bank doctors, agency doctors and consultants acting down. This, compared to last year 398 is a 64% decrease in shifts requiring locum cover. During this reporting period 2 shifts were unfilled. However, it should be noted, that at no point did the Trust consider the staff levels to be in adequate as the unfilled shifts were during the hours on 17:00 – 21:00 when there was senior medical representatives on site.

Anaesthetics

The Anaesthetic service runs with an average of 4 – 5 gaps per year. To mitigate the known gaps in the service, the service employs locally employed doctors, who are commonly referred to as Clinical Fellows. Also, the service at times, receives a trainee from Wales, the Welsh doctor has a Welsh training number and is therefore not included in Health Education England numbers. The Clinical Fellows are usually employed for a fixed term period of 3 to 6 months whilst they are preparing for exams and / or applying for ST3 rotation. This works extremely well as the majority of these doctors have previously worked at LWH as Core Trainees and therefore are well trained and familiar with the Trust and its complexities.

The service runs a 2 tier rota for on call work which equates to 4 x 12.5 hour shifts, 2 daytime and 2 at night. Therefore the service needs to cover both daytime and night time gaps with bank / lead employer doctors working locums. For reference, due to the training and specialist nature of the Trust, the service does not use agency doctors. The service has not reported any concerns with trainees being released for teaching. The main issue is the fact at times, the core trainee exam is scheduled on the same day as regional teaching for ST3 upwards. This can prove a difficult when trying to staff rotas. Occasionally, doctors may have their annual leave and or study leave refused. However, the service makes every effort to ensure this only happens in exceptional circumstances.

For context, during this reporting period the service required locum cover for 21 shifts to be covered by the following staff members, Junior Doctors and bank doctors. This, compared to 123 last year, this is a decrease of 83% compared to the previous year.

Neonates

The Neonatal service runs with an average of 2 gaps. During this reporting service, the service has not employed any Trust Grade Doctors as they are often reliant on Advanced Neonatal Nurse Practitioners (ANNP). Also due to the specialist nature of the service the service does not use agency staff. To mitigate gaps in the rotation, the junior doctor workforce works alongside the ANNP's who are well established at LWH and are trained to work at registrar level.

The service has not reported any concerns with junior doctors and has highlighted GMC survey results for paediatric doctors (national survey) highlighted Liverpool Women's NHS Foundation Trust Neonatal unit as one of the best training sites within the country. The service has no issues with training or opportunities for teaching. The teaching takes place 5 mornings a week for 30 minutes and includes but not limited to, radiology, journal club, case presentations and consultants lead teaching. The Registrars (ST4 +) complete 1 week of teaching every 6 month in partnership with Arrowe Park. In the survey local teaching and curriculum coverage was highlighted as excellent.

For context, during this reporting period the service required locum cover for 89 out of hour shifts to be covered by Junior Doctors and ANNP's. This, compared to 105 last year, this is a decrease of 15% of shifts requiring locum cover.

Exception Reporting

Doctors in training are expected to electronically submit exception reports via the doctors rostering system (DRS) detailing if they have worked over their scheduled hours, missed breaks or educational opportunities. These exceptions are managed by the doctor's educational supervisors, and where appropriate the GSWH and or the DME.

As detailed in the table below, the number of exception reports has been minimal with the majority of them being reported in quarter 1 and quarter 4. This trend fits in with the fluctuating staffing levels in each specialty.

Numbers of exception reports recoded on the electronic reporting system are listed below;

Period	Specialty	Grade	Reason	No of exceptions	No: hours	Out come
Quarter 1	O&G	ST2	Education	1	N/A	Teaching session rescheduled for another day
	O&G	ST2	Education	1	N/A	Teaching session rescheduled for another day
	O&G	ST1	Hours	1	N/A	TOIL
Quarter 2	N/A	N/A	N/A	0	N/A	
Quarter 3	N/A	N/A	N/A	0	N/A	
Quarter 4	O&G	ST3	*Education	1	N/A	See note
	O&G	ST3	*Education	1	N/A	See note
	O&G	ST4	Hours	1	2.5	TOIL

*Due to the number of ST3 trainees on the O&G rotation, there has been an issue with ST3 staff acquiring the relevant training opportunities as on some days, an area may be staffed heavily with ST3 doctors all wanting the same training opportunities / competency sign off.

Engagement of junior Doctors

The GSWH continues to attend doctor in training inductions and offers support to all doctors. The doctors are aware of the GSWH and the role. There is also an encouragement for doctors to complete exception reports as it is a useful tool when looking at workforce planning. Doctors are offered informal exception reporting training as and when they need it. The Trusts Junior Doctor BMA rep has raised a point of some trainees reporting they do not have a log in for the system. This has been addressed by HR who has assurance that all eligible trainees have been sent a log in to the system and this will continue to be monitored.

All services continue to engage with junior doctors and offer supportive and safe environments for doctors to work. The doctors have access to the Guardian of Safe Working Hours and the Freedom to Speak up Guardian.
The doctors are also encouraged to discuss any issues relating to safe working, practices or behaviours with their educational supervisors.

As previously reported, the junior doctor forums were poorly attended; this was seen to be a trend across the region. However, the Trust has seen an increase in the number of attendees and become a useful platform for the doctors to raise any concerns. The forum also gives the Trust the opportunity to address and issues.

Fines

There are no fines to report.

Issues for Consideration

The GSWH is no longer concerned about the number of rota gaps in O&G and the lack of research opportunities which had previously seen trainees apply for an out of programme period to complete research in neighbouring Trusts such as Manchester. The GSWH would like the Trust to consider the continuation of the Trust locally employed doctors to clinical fellow roles including research roles.

Although there are not many exception reports lodged the GSWH believes that there is a trend for doctors not to report exceptions as they have advised in forums and outside of forums that they value the exposure and experience they gain from complex cases / patients. The Trust will continue to encourage doctors to submit exception reports.

The Board should note that the GSWH is no longer concerned about the doctors in training working in addition to their normal timetable and therefore reducing the risk of 'burnout' amongst the doctors as raised in previous reports.

Fatigue and Facilities Charter

The Board is asked to note, the Trust has received funding of 30K as part of the BMA's 'fatigue and facilities charter'. The funding is to be used to make improvements to facilities for junior doctors as outlined in the charter. Any improvements must be made in conjunction with the junior doctor forum and a task and finish group. The charter has been presented to the Trusts space utilization group and is highlighted as a priority for the forthcoming financial year. However, given the below mentioned COVID 19 pandemic the implantation of this charter will remain on hold until further notice.

Actions Taken

Given the outbreak of COVID 19 in the UK, mid quarter 4 of this report, the services had to take a proactive approach to workforce planning and the rostering of junior doctors in training. The proactive approach ensured and continues to ensure that the staffing levels remain safe and there is a robust plan in place should absences increase across the medical workforce. These rotas will be monitored regularly and flexed should there be a need to increase activity.

The Guardian of Safe Working Hours continues to work with the Educational Supervisors on how to address exception reports including specific timescales in line with the junior doctor Terms and Conditions of Service 2016. This will ensure all exceptions are responded to and resolved in good time and escalated where necessary.

The Guardian is continuing to engage with junior doctors at their scheduled forums and continues to promote the use of the exception reporting system.

The O&G and Anaesthetic service will continue to recruit to 'Clinical Fellow' (locally employed, Trust grade doctor) roles throughout the year.

Recommendation

The Board is asked to read and note this report from the Guardian of safe Working Hours.