Liverpool Women's
NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

Board of Directors Meeting

PUBLIC

3 December 2020

Meeting of the Board of Directors
HELD ELECTRONICALLY
Thursday 3 December 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.					
209	Apologies for absence Declarations of interest	Receive apologies & declarations of interest	Verbal	Chair	
210	Meeting guidance notes	To receive the meeting attendees' guidance notes	Written	Chair	
211	Patient Story • ED&I • Endometriosis	To receive the patient story	Verbal	Chief Executive	1005 (20mins)
212	Minutes of the previous meeting held on 5 November 2020	Confirm as an accurate record the minutes of the previous meetings	Written	Chair	1025 (5mins)
213	Action Log and matters arising	Provide an update in respect of on-going and outstanding items to ensure progress	Written	Chair	
214	Chair's announcements	Announce items of significance not found elsewhere on the agenda	Verbal	Chair	1030 (5mins)
215	Chief Executive Report	Report key developments and announce items of significance not found elsewhere on the agenda	Written	Chief Executive	1035 (5mins)
BOARD COMMITTEE ASSURANCE					
216	Chair's Reports from Quality Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	1040 (5mins)
217	Chair's Reports from Finance, Performance and Business Development Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	1045 (5mins)
218	Chair's Report from Putting People First Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	1050 (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					
219	Covid-19 Pandemic: Trust Update	For assurance	Written	Chief Operating Officer	1055 (5mins)
220	Safer Nurse/Midwife Staffing Report M7 2020/21	For assurance and to note any escalated risks	Written	Acting Director of Nursing and Midwifery	1100 (10mins)
221	Care Quality Commission Update	For assurance	Written	Acting Director of Nursing and Midwifery	1110 (10mins)
222	Neonate Outcomes	For assurance	Written	Medical Director	1120 (10mins)
223	Saving Babies Lives Bi-Annual Report	For assurance	Written	Medical Director	1130 (15mins)

Item no. 2020/21/	Title of item	Objectives/desired outcome	Process	Item presenter	Time
BREAK – 5 mins					
224	Serious Incidents & Learning Reports	For assurance	Written	Acting Director of Nursing and Midwifery	1150 (10mins)
225	Key actions: infection prevention and control and testing	For assurance	Written	Acting Director of Nursing and Midwifery	1200 (5mins)
TRUST PERFORMANCE - TO DELIVER THE MOST EFFECTIVE OUTCOMES; TO BE EFFICIENT AND MAKE BEST USE OF AVAILABLE RESOURCES					
226	Operational Performance Report period M7, 2020/21	For assurance –To note the latest performance measures	Written	Chief Operating Officer	1205 (5mins)
227	Finance Report period M7, 2020/21	For assurance - To note the status of the Trust's financial position	Written	Director of Finance	1210 (5mins)
BOARD GOVERNANCE					
228	HFEA Licence Inspection	For assurance	Written	Medical Director	1215 (5mins)
229	Board Assurance Framework 2020/21	For assurance and approval	Written	Trust Secretary/ Executive Leads	1220 (5mins)
230	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair	1225 (5mins)
CONSENT AGENDA (all items 'to note' unless stated otherwise)					
231	Leadership & Talent Strategic Framework	For approval	Written	Chief People Officer	Consent
232	Lessons Learnt from Mortality Q2	For assurance	Written	Medical Director	Consent
233	Annual Quality Report 2019-20	For approval	Written	Acting Director of Nursing & Midwifery	Consent
234	2020/21 Corporate Objectives – six-month review	For assurance	Written	Chief Executive	Consent
HOUSEKEEPING					
235	Thank you's	To provide a Team thank you – above and beyond			1230 (5mins)
236	Any other business & Review of meeting	Consider any urgent items of other business	Verbal	Chair	

Date of next meeting

Board in Public: 4 February 2021

Meeting to end at 1225

12.35 – 12.45	***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

Page 129 Handbook to the NHS Constitution 26th March 2013

Liverpool Women's NHS Foundation Trust

Board of Directors

Minutes of the meeting of the Board of Directors held virtually at 10.00am on 5 November 2020

PRESENT

Mr Robert Clarke	Chair
Mrs Kathryn Thomson	Chief Executive
Mrs Michelle Turner	Chief People Officer
Mrs Jenny Hannon	Director of Finance
Dr Andrew Loughney	Medical Director & Deputy Chief Executive
Ms Gaynor Thomason	Interim Director of Nursing & Midwifery
Mr Gary Price	Chief Operating Officer
Mr Phil Huggon	Non-Executive Director
Mrs Tracy Ellery	Non-Executive Director
Dr Susan Milner	Non-Executive Director/SID
Mr Ian Knight	Non-Executive Director
Prof Louise Kenny	Non-Executive Director

IN ATTENDANCE

Mr Mark Grimshaw	Trust Secretary
Mrs Mary McDonald	Appointed Governor
Mrs Denise Richardson	Public Governor
Mrs Lesley Mahmood	Member of the Public
Dr Lynn Greenhalgh	Medical Director of the North West Genomics Laboratory Hub
Mrs Marie Forshaw	Director of Nursing & Midwifery (designate)
Mrs Michelle Corrigan	Observer – Insight Programme
Dr Bill Yoxall	Consultant, Neonates (item 169 only)
Mrs Kate Walsh	Physiotherapy manager/clinical lead (item 172 only)
Mrs Mandy McDonough	Associate Director of Nursing and Midwifery for Safeguarding (item 186 only)

APOLOGIES:

Ms Jo Moore	Non-Executive Director/Vice Chair
Mr Tony Okotie	Non-Executive Director

20/21/ 169	**Thank You** **Bill Yoxhall** – The Chief Executive stated the Board's thanks to Bill Yoxhall, Consultant Neonatologist, who was due to retire at the end of November 2020. The significant amount of work undertaken by Bill during his time at the Trust was noted, particularly in terms of supporting the development of the new Neonatal unit and establishing robust and effective partnerships across the city and wider region. **Gynaecology** – The Board extended thanks to the Gynaecology Service Clinical Leads for the leadership provided during the Covid-19 pandemic, particularly in relation to the flexibility and

	pragmatism that had been demonstrated. The team noted their thanks for the financial and moral support provided by the Board. **Marianne Hamer** – The Chief People Officer highlighted the significant contribution that Marianne Hamer, Clinical Lead for Imaging, had provided regarding the Trust's BAME Network and the leadership she had shown across the organisation to advance the Trust's aims to improve the experience of both staff and patients from under-represented groups. **Nancy Nicholas** – The Director of Finance extended thanks to Nancy Nicholas from the Redevelopment Team at Liverpool University Hospitals NHS Foundation Trust, for the advice and support provided for the development of plans for an enhanced imaging facility at the Crown Street site.
170	**Apologies** – as above **Declaration of Interests** – Ms Gaynor Thomason noted that she was a Non-Executive Director at Merseycare NHS Foundation Trust.
171	**Meeting guidance notes** The Board received the meeting attendees' guidance notes which had been updated to reflect 'virtual meetings'.
172	**Patient Story** Mrs Kate Walsh attended to present on the development of the Trust's physiotherapy service and on how this was benefitting the patient experience. The range of physiotherapy services provided was outlined and the development of a new patient pathway was explained. This had produced several 'quick wins' including improved efficiency and triaging. Mrs Kate Walsh continued to outline further ambitions for the service, noting that a key aim was to establish the Trust as an international centre providing specialist physiotherapy education. It was also hoped that a Liverpool-wide pelvic-floor service could be developed together with embedding physiotherapy into Multi-Disciplinary teams across the Trust – improving clinical outcomes and reducing pressure on other services. To achieve this, it was noted that there would be a need to expand the workforce and invest in the existing workforce. Several challenges were outlined but it was noted that the improvements to patient outcomes were such that it was worth working to overcome these. The Chair remarked that this presentation outlined the difference that aspirational leadership could provide to services and noted that this was an outstanding example of the Trust making a real difference to women's health outcomes and wellbeing – a key aim of the organisation. The Chief Executive stated that lessons could be learned from the experience of the Physiotherapy Service particularly in relation to unlocking a culture of change and improvement from existing staff. **Action: For the Physiotherapy manager/clinical lead to attend a future Executive Team meeting to outline the lessons learned in relation to initiating a culture change within a service.** The Board noted the presentation, thanking the Physiotherapy manager/clinical lead for their innovative working.
173	**Minutes of previous meeting** Subject to the addition of Mrs Tracy Ellery in the attendee list, the minutes of the Board of Directors meeting held on 3 September 2020 were agreed as a true and accurate record.
174	**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.
175	**Chair's Announcements** The Chair briefed the Board on events since the last meeting. There was an upcoming Council of Governors meeting on the 12 November 2020 and the respective sub-groups had continued to meet over the previous quarter. A Council of Governors Nomination & Remuneration Committee had met on 27 October 2020 to review the appraisals of the Chair and Non-Executive Directors and to also comment on the recruitment process for the upcoming 2021 Non-Executive Director vacancies. The Chair noted that due to the Covid-19 pandemic restrictions, the opening of the Neonatal Unit on the 7 November 2020 was unable to take place. Nevertheless, the completion of the project on time and to budget was a significant achievement and would make a difference to the lives of babies and their parents. The Chair had participated in walkabouts, including meeting with staff from the Aintree antenatal team and the community midwifery team. It was remarked that the enthusiasm and the commitment being shown by staff through a difficult time continued to be highly impressive. The Chair reported that a Nominations & Remuneration Committee had been held immediately prior to the Board. Items discussed had included the ratification of the appointment of the Director of Nursing & Midwifery and a discussion regarding the Executive pay ranges and salaries utilising available benchmarking data. The Board noted the Chair's update.
176	**Chief Executive's report** The Chief Executive presented the report which detailed local, regional and national developments. It was noted that the Trust continued to respond to the Covid-19 pandemic and thanks were extended to all staff for their on-going support and hard work, often going above and beyond. An update was provided on the appointment process for the Director of Nursing and Midwifery and Medical Director posts. In relation to the former, Marie Forshaw had been appointed. Marie was the current Interim Chief Nurse at Bolton NHS Foundation Trust and whilst it was likely that a formal starting point would be at the beginning of January 2021, Marie would be working in the Trust on a three day a week basis from December 2020 onwards. The Chief Executive extended thanks to Gaynor Thomason for her work as the Interim Director of Nursing & Midwifery. With regards to the Medical Director position, it was reported that Dr Lynn Greenhalgh had been appointed. Lynn was the current Medical Director of the North West Genomics Laboratory Hub and was due to formally start in the new role in January 2021. A handover period would commence with Dr Andrew Loughney over the coming weeks. The Chief Executive reported that due to the growing seriousness of the Covid-19 situation in Liverpool and the recent move into Tier 3 restrictions, the Trust had made the difficult decision to temporarily stop antenatal and postnatal visiting on the hospital wards for the time being. It was acknowledged that this decision would be disappointing for women and their families, but it had been made with safety of patients, staff and visitors as the Trust's number one priority. The decision would remain under regular review. The Trust's recent successes at the 2020 Health Tech Awards was highlighted. It was stated that this success demonstrated the excellent progress being made on the Digital agenda congratulations were

	extended to the Trust's Chief Information Officer, Matt Connor, the Digital Services team and the teams involved in the specific projects. Attention was drawn to the Trust's aspirations to achieve Teaching and University Hospital status by becoming part of the University Hospitals Association (UHA). The formal accreditation process was outlined, and it was noted that the Trust was working to close any gaps to meet the compliance specification. Reference was made to the Trust's ongoing flu campaign. The importance of the Trust reaching its compliance target was noted and work would continue prior to the year-end. The Board of Directors received and noted the Chief Executive's Report.
177	**Chair's Report from the Quality Committee** The Board considered the Chair's Reports from the Quality Committee meetings held on 21 September 2020 and 19 October 2020. The work to monitor the quality impact of the Covid-19 pandemic was highlighted. The Board of Directors: • Received and noted the Chair's Reports from the Quality Committee meetings held on 21 September 2020 and 19 October 2020.
178	**Chair's Report from Finance, Performance and Business Development Committee (FPBD)** Mr Phillip Huggon presented the Chair's Reports for the meetings of the Finance, Performance and Business Development Committee held on 22 September 2020 and 27 October 2020. Both meetings had considered the on-going impacts of the Covid-19 pandemic on the Trust's operational and financial performance. The October meeting had considered the detail of the changes to the NHS Provider financial funding regime from Month 7 onwards. This had resulted in a forecast deficit of c.£4.6m and the Committee was expecting to monitor the impacts of this during the 2020/21 financial year and beyond. The Committee had received robust assurance regarding the progress being made to close out actions from a cyber-security internal audit report and had also been encouraged by the process demonstrated by a business case post-implementation review report. The Board of Directors: • Received and noted the Chair's Reports from the FPBD Committee meetings held on 22 September 2020 and 27 October 2020
179	**Chair's Report from the Putting People First Committee** The Board considered the Chair's Report from the Putting People First Committee held on 21 September 2020. The work to progress and maintain progress on key workforce projects whilst also attempting to ensure that sufficient support and development was being provided to staff through the pandemic was noted. Particular attention was being given at the Committee to the support being provided to vulnerable groups of staff. The Board of Directors: • Received and noted the Chair's Reports from the PPF Committee meeting held on 21 September 2020.
180	**Chair's Report from the Audit Committee**

Mrs Tracy Ellery presented the Chair's Report for the meeting of the Audit Committee held on 29 October 2020. She briefed the Board on the content of the report noting that the Committee had received high assurance from recent internal audits into financial systems and processes. This was encouraging leading into the year-end process. The Committee had also considered the outputs from a Committee effectiveness review, facilitated by internal audit. Assurance had been provided that the Committee was operating from a strong baseline and the actions identified would help to yield further improvements. A number of the reports on the October 2020 agenda had already started to follow the recommendations.

The Board of Directors:

- Received and noted the Chair's Report from the Audit Committee meeting held on 29 October 2020.

181 **Chair's Report from the Charitable Funds Committee**

Mr Phillip Huggon presented the Chair's Report for the meeting of the Charitable Funds Committee held on 22 September 2020.

The Board of Directors:

- Received and noted the Chair's Reports from the Charitable Funds Committee meeting held on 22 September 2020.

182 **Covid-19 Pandemic: Trust Update**

The Chief Operating Officer reported that since the publication of the report, a nationally declared level four incident had been put into place resulting in NHS command and control arrangements being stepped up to a national level. Information relating to implications and mandated responses was expected. Due to high infection rates in the city, the Trust's internal command and control governance arrangements had remained in place throughout the pandemic.

Sickness absence had increased across all areas of the Trust during the second wave and posed a significant challenge to the day to day operational delivery of services. Sickness had risen to above 10% through October 2020 which had resulted in the 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 continued to offer a series of supportive measures to support both the physical and emotional health of its staff.

In line with national requirements the Trust continued to review waiting lists for those patients who have to wait longer for routine treatment due to the pandemic, specifically for benign gynaecology. From November the Trust would have a full complement of Gynaecology Consultants for the first time in over two years. Despite the challenges of Covid-19 the Trust was planning to establish a programme of efficiency review throughout November 2020 for benign gynaecology to ensure that the greatest benefit could be gained with the increased workforce.

The Trust had developed robust process for the procurement and management of required PPE and plans were also being developed for mutual aid across the system. This could include the provision of surgical activity for Liverpool University Hospitals NHS Trust. The Trust continued to ensure that it was taking an Infection Prevention & Control approach to its decision-making.

The Chair queried whether the stepping up of national command and control arrangement would impact plans for providing mutual aid for the system. The Chief Operating Officer stated that the Trust's major offer had remained surgical capacity at the Crown Street site. The on-going debate

	centred on the speciality that would be most appropriate for this. It was likely that this would be resolved shortly with plans put into action prior to the end of the calendar year. Mr Ian Knight asked whether the extensive Liverpool Covid-19 testing regime had required or would require resources from the Trust. The Chief Operating Officer noted that the Trust's overspill car park had been offered to support a testing centre but to date, the armed forces were managing the testing itself. Prof. Louise Kenny added that it was expected that the armed forces would be providing support for a period of four to six weeks. The Director of Finance made reference to the UK's exit of the European Union and noted that the potential impact of this on the Covid-19 response was being considered at a national and local level. The Board of Directors: • noted the report for information and assurance
183	**Equality Diversity and Inclusion: Update on WRES and WDES 2020 Data and overview of future strategy** The Chief People Officer noted that Equality, Diversity and Inclusion (ED&I) had been an area of attention for the Board over recent months and whilst it was recognised that some positive work had been undertaken in the area of ED&I, it was not currently sufficiently joined up, resourced and underpinned with an over-arching strategic aim. The Workforce Race Equality Scheme (WRES) and Workforce Disability Equality Scheme (WDES) data referenced in the report illustrated that whilst the Trust compared favourably with other trusts in many indicators, limited progress had been made to change the cultural make-up of the organisation. The Trust had 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 could demonstrate real benefits in terms of access to work for a diverse group. There was a clear crossover in terms of ED&I and the Patient Experience agenda with several examples of engaging with service users and the community to inform the way in which care was delivered. However, it was recognised that there was further work to be done with respect to Patient Experience from a diversity, equality and inclusion perspective that would 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 had accelerated actions in some areas as they had shone a particular spotlight on the experiences and health outcomes of ethnic minority colleagues. It was important, however, that focus also remained on improving inclusion more broadly. It had also identified that the Trust could be more ambitious in its ED&I agenda, beyond those objectives set out in the WRES and WDES. The Chief People Officer continued to outline a proposed strategic objective for Board approval; namely – "Be recognised as the most inclusive organisation in the NHS with Zero discrimination for staff and patients (zero complaints from patients, zero investigations)". Also outlined were a range of actions to inform the delivery of the existing Equality Objectives and a proposed process to develop an overarching Equality, Diversity & Inclusion Strategy and update the Equality Objectives. It was suggested that the Putting People First Committee would be tasked with maintaining oversight on progress with this agenda. The Chair stated the importance of ensuring that the ED&I agenda became 'business as usual' and was interwoven into the culture of the organisation. The Chief Executive asserted that the Trust could do more to identify and nurture talented colleagues with protected characteristics and this would be a challenge to all Executive Directors to progress – including those incoming Directors. The Chair

	added that the recruitment plans for the upcoming 2021 Non-Executive Director vacancies had made ensuring that candidates had a strong connection to the local community a priority. The Board of Directors: • noted the annual data pertaining to the Workforce Race Equality Standard (WRES) and the Workforce Disability Standard (WDES) • noted that the organisation had not become significantly more diverse over the last 12 months • noted the actions taken to support and connect with BAME colleagues during Covid-19. • approve the strategic objective as set out above • Considered the range of actions to inform the delivery of the existing Equality Objectives • approved the proposed process to develop an overarching Equality, Diversity & Inclusion Strategy and update the Equality Objectives
184	**Safer Nurse/Midwife Staffing Report, M5 & M6 2020/21** The Interim Director of Nursing & Midwifery presented a report which detailed Ward Staffing levels across all inpatient clinical areas during August and September 2020. The Board was briefed on the content of the report noting that there had been an increase in the number of 'red flag' events due to increased pressures as a result of sickness / Covid-19 related absence. This was noted as being a concern that would require careful monitoring and oversight. Emergency staffing plans had been developed and this was being supported by a skill mix review as it was recognised that existing resources could need to be re-deployed in priority areas if necessary. In relation to Allied Health Professional staffing, the Trust was impacted by a national shortage of sonographers, but it was hoped that there was a pipeline in place for students to take up posts when qualified. The Chair noted that it was encouraging to receive assurance that robust staffing contingencies had been developed. 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 staffing challenges relating to COVID-19 and the mitigating actions being put in place
185	**Care Quality Commission Update** The Interim Director of Nursing & Midwifery explained that the CQC Inspection from December 2019 had identified a number of 'Must Do' actions that had deadlines for the end of December 2020. The report outlined the progress made against the actions. It was noted that actions would only be identified as 'green' if evidence could be provided that it was fully embedded. Key areas to highlight were identified as follows: • Safe and proper management of medicines: Following the focused inspection on 28 July 2020 the warning notice had been lifted. Focused work continued to ensure actions were embedded. • Pathways for Under 18's / Deteriorating Child: This action remained RED. Work had been undertaken but progress did not have the required pace. Therefore, to support progress the Medical Director had established a task and finish group to help drive the improvements that were required.

- Actions related to waiting list and Referral to Treatment targets had been set pre-Covid-19 and would therefore be unlikely to be met.

The Interim Director of Nursing & Midwifery noted that the CQC had also discussed the Trust's Infection Prevention and Control measures and had noted their assurance.

The Board of Directors:

- noted the report for information and assurance

186 **Safeguarding Annual Report 2019/20**

The Associate Director of Nursing and Midwifery for Safeguarding attended to present the 2019/20 Annual Report outlining progress against the objectives set. It was noted that the Trust had received a reduced number of referrals over the period and this was attributed to a significant reduction in referrals from the police. It was noted that this was explained by a change of system utilised by the police and whilst referrals had reduced, it had resulted in more relevant cases being escalated. It was expected to see an increase in referrals during 2020/21 as a consequence of the pandemic. The Chief Executive queried if the pandemic had impacted the number of safeguarding disclosures from women. It was confirmed that there had been an increase in disclosures during the pandemic through routine enquiry at every contact.

The Chair drew attention to the Clinical Commissioning Group (CCG) Key Performance Indicator (KPI) Report, noting that there was an area of limited compliance regarding the adult and children safeguarding training. It was queried what improvement actions had been put into place. The Associate Director of Nursing and Midwifery for Safeguarding reported that LCCG had acknowledged and were satisfied that the Trust Safeguarding Team had a detailed recovery action plan and trajectory in place and that training programmes had continued to be reviewed with staff training compliance reported to Quality Committee via the Hospital Safeguarding Board. Whilst awaiting an increase in compliance and in order to provide assurance that the Trust's workforce had the knowledge, skills and awareness required, the Safeguarding Team had increased their 'Unannounced Safeguarding Inspections' to all the clinical areas.

The Medical Director noted that the possibility of moving level three safeguarding training on-line had been considered but not taken forward due to a concern regarding a reduction in the quality of the training. Mrs Tracy Ellery stated that level three compliance was a concern and suggested that utilising an alternative medium for providing the training be re-explored.

Action: For the Associate Director of Nursing and Midwifery for Safeguarding to explore an alternative mechanism to face-to-face delivery for level three safeguarding training to improve compliance.

The Chief People Officer also suggested that work be undertaken with the Divisions to risk assess non-compliant staff and to utilise this to prioritise training.

Mr Ian Knight, as Board Safeguarding Lead, noted that the Trust's Safeguarding Team was well regarded externally and that the Board should take assurance from the annual report.

The Board of Directors:

- noted an overview of safeguarding practice across the Trust and received assurance that systems and processes were in place to protect vulnerable Children and Adults
- received and approved the 2019/20 Annual Report.

187 **CNST – Maternity Incentive Scheme Year 3**

The Board received the report and noted the updated Clinical Negligence Scheme for Trusts (CNST) year 3 requirements published in October 2020. The Chief Operating Officer detailed the key changes

	in terms of reporting requirements and assurances required for Trust Board sign off in May 2021 for the scheme. Also outlined was the Trust's current compliance against the ten safety standards and attention was drawn to the role of the Board specifically in the sign off process. The Board of Directors • noted the evidence requirements in Appendix 2 to the report • noted that the Quality Committee would continue to receive regular updates, escalating issues when necessary.
188	Clinical Mandatory Training - Compliance The Chief People Officer provided an overview of the progress made against recovery plans in each of the Divisions in relation to clinical mandatory training, and highlighted areas of ongoing challenge and focus. It was reported that the increasing prevalence of COVID-19 in the community had impacted on the progress against trajectory due to staffing pressures, notably within midwifery staffing. Enhanced performance management had been put into place to support the Family Health division to an improved position of compliance within a reasonable timescale and to ensure that a risk-based approach to the prioritisation of training was in place. The Executive Team would continue to review progress on a weekly basis and the Putting People First Committee would retain oversight of performance against the KPI and provide assurance to the Board. Mr Ian Knight queried if timescales had been established for returning compliance to acceptable levels. The Chief People Officer noted that work was progressing with Divisions to set trajectories and to ensure that there was adequate forward planning in place to release staff for training. The Board of Directors: • noted the current challenges; and • took assurance from the enhanced performance management arrangements in place to oversee recovery and reduce risk.
189	Operational Performance Report period M6, 2020/21 The Chief Operating Officer presented the Operational Performance Report for Month 6 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. An increase in sickness and absence as a result of Covid-19 (both direct and indirect) provided a general context to performance challenges across the organisation. Despite the challenges posed during the Covid-19 pandemic the 2-week cancer performance remained strong and it was anticipated that this situation would not change with additional capacity in the coming months due to consultant recruitment. The oncology performance for 31-day DTT also remained strong. Moving forward it was anticipated that the Trust would see a continuation of improved performance compared to the past 24 months in 31 DTT target but face on-going challenges with the 62-day target due to Covid-19 priority 3 patient management. The Trust had started to see a slow rise in 18-week performance and a reduction in 52-week breaches as activity was restarted. However detailed work had identified the additional capacity required to deal with the increased backlog and this would only be achieved by increasing theatre staffing. Only then would a sustained reduction in the 52-week position be achievable. All 52-week breaches received a harm review. The 6-week diagnostic target, as a precursor to an improving 18-week position had seen significant improvement since the height of the first wave.

	The Chair queried if there was likely to be an impact on recovery trajectories from the second lockdown. The Chief Operating Officer stated that the Trust was working to remain on trajectory but this situation remained uncertain. The Chief Operating Officer noted that the Trust continued to work towards the NHS England target of 35% of women booked onto a Continuity of Care (CoC) pathway by March 2021. The Trust remained in consultation with maternity staff regarding, streams, workforce, and application of CoC across the maternity service. There had not been an extensive uptake from midwives on the workforce model and if this was not resolved by the end of November 2021, it was unlikely that the target would be met. Discussions continued to identify barriers and to explore ways of working that would resolve the issues. Dr Susan Milner sought clarification on whether there were additional costs involved for implementing the CoC model. It was stated that the Trust should be able to meet the initial 35% target with the existing workforce. The Chief Executive noted that there were examples of other trusts who were meeting the target without additional resource. The Chair queried whether lessons could be learned from those trusts. The Chief Operating Officer reported that the key aspect was empowering the midwifery teams to develop solutions that met local and individual needs. The Chief Executive noted that risks relating to this issue were being monitored and would be escalated through the Trust's risk management process. The Board of Directors: • Received and noted the Month 6 Operational Performance Report.
189a	**Assessment of Perinatal Mortality in Quarter 1 2020 in relation to COVID 19 – including figures for stillbirth in Q2** In response to a national review into an increase of still births during the Covid-19 pandemic, the Trust had undertaken a detailed review of stillbirths during quarter 1 and quarter 2 of 2020/21. The Medical Director reported that there were three potential reasons for an increase in stillbirths during the pandemic: 1) Infection directly impacting the pregnancy 2) Changes in Trust practice 3) Changes in the behaviour of pregnant women i.e. not presenting at hospital as readily due to infection concerns In assessing the Trust's own data, no correlation had been identified for the first two elements. Evidence for the latter reason was more challenging to identify. Prof. Louise Kenny noted that research was progressing in relation to the impact of Covid-19 on pregnancy but no high-quality peer reviewed papers were currently available. The Medical Director noted the importance on remaining vigilant on this issue and to ensure that all available surveillance systems were being triangulated to identify relevant data. The Chief Executive noted that it would be important to remain cognisant of the potential unintended negative impacts of infection prevention and control measures (i.e. restricting the access of partners) on behaviour change. The Chair stated the importance of the Trust being pro-active on this issue and to constantly review available data (both quantitative and qualitative) to ensure that all available action and mitigation was being taken. The Board of Directors: • Received and noted the report for information and assurance.

190	**Financial Report & Dashboard Month 6, 2020/21** The Director of Finance presented the Finance Report and Financial Dashboard for Month 6, 2020/21. She briefed the Board on the content of the report and advised that as at 30 September 2020, the Trust was reporting a breakeven position after an expected total cumulative top up of £8.4m. The Director of Finance noted that whilst having performed relatively well financially for the past two years and having had a balanced plan approved by the Board, 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. Whilst a strong working capital position would be retained for 2020/21, subsequent financial years would be more challenging without a further change to the financial regime. The Finance, Performance and Business Development Committee had reviewed BAF risk 2344 'risk to financial position in year 2020/21' and recommended to increase the likelihood to five taking the overall score of the risk to 20. The Chair noted the importance of maintaining close scrutiny of the developing financial position particularly in relation to the potential impact on future years. The Board of Directors: • Received and noted the Month 6 Financial Performance Report.
191	**Well-Led Self-Assessment Action Plan Update** The Board received the report. The Trust Secretary noted that the self-assessment (and action plan) was one part of the overall Well-Led framework process with there being a requirement to follow this with an external review. The procurement process was underway, and it was hoped that the review would begin in January 2021 with a final report received by the Board in April 2021. In the New Year, it would be important for actions in the self-assessment to be closed (where possible) and with evidence to be provided. It was 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 of Directors: • Received and noted the report for information and assurance.
192	**Board Assurance Framework** 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. Key updates were noted as follows: • The Quality Committee had recommended the de-escalation of BAF risk 2295: 'Inability to achieve and maintain regulatory compliance, performance and assurance' on to the Corporate Risk Register where it would be 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 Finance, Performance and Business Development Committee had reviewed BAF risk 2344 'risk to financial position in year 2020/21' and recommended to increase the likelihood to five taking the overall score of the risk to 20. The Board of Directors: • Noted the report for information and assurance • Approved the de-escalation of BAF risk 2295 to the Corporate Risk Register

	• Approved the increase of the overall score to 20 for BAF Risk 2344.
193	**Review of risk impacts of items discussed** The Board noted that the following risks had been discussed during the meeting: • The risks posed by Covid-19 to pregnancy, and the need to maintain effect surveillance systems and to consider the potential unintended consequences of decisions. • The likelihood of not achieving the CoC target and the challenges of managing the staffing issues • The challenge of maintaining safe staffing during the pandemic. *The following items were considered as part of the consent agenda*
194	**Medical Revalidation Annual Report 2019/20** The Board received the report and approved the signing of the 'statement of compliance' (Annex D) confirming that the organisation, as a designated body, was in compliance with the regulations.
195	**Guardian of Safe working Hours Annual Report 2019 - 2020** The Board noted the report for information and assurance.
196	**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 3 December 2020. **Exclusion of the Public** The Board of Directors resolved to exclude the press and public from the meeting at this point on the grounds that publicity of the matters being reviewed would be prejudicial to public interest, by reason of the confidential nature of business. Members of the public were requested to leave the meeting room at this point.

TRUST BOARD
3 December 2020
Action Plan

Meeting date	Minute Reference	Action	Responsibility	Target Dates	Status
5 November 2020	20/21/186	For the Associate Director of Nursing and Midwifery for Safeguarding to explore an alternative mechanism to face-to-face delivery for level three safeguarding training to improve compliance.	Associate Director of Nursing and Midwifery	Feb 21 In Progress	
5 November 2020	20/21/172	For the Physiotherapy manager/clinical lead to attend a future Executive Team meeting to outline the lessons learned in relation to initiating a culture change within a service.	Chief Operating Officer	Dec 20 In Progress	Invite to be extended for an Executive Team meeting during December 2020.
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	Feb 21 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 21 (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	
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	2020/21/215

MEETING	Board of Directors
PAPER/REPORT TITLE:	Chief Executive Report
DATE OF MEETING:	Thursday, 03 December 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

We are pleased to confirm two new appointments to the Board of Directors.

Director of Nursing & Midwifery
Following a competitive process and interviews at the end of October, Marie Forshaw has been appointed as Director of Nursing & Midwifery. Marie is currently Interim Chief Nurse at Bolton NHS Foundation Trust having joined the Trust in 2016 as Deputy Director of Nursing, Midwifery and AHPs. Marie is a trained general nurse, trained registered midwife and trained registered health visitor. We look forward to welcoming Marie to Liverpool Women's when she commences her role early in the new year.

Medical Director

Following a competitive process and interviews in November, Dr Lynn Greenhalgh has been appointed as Medical Director. Lynn is currently Consultant Clinical Geneticist at the Trust's Liverpool Centre for Genomic Medicine and also Medical Director of the North West Genomic Laboratory Hub. We look forward to Lynn commencing her role in the new year following Dr Andrew Loughney's departure.

HSJ Patient Safety Awards for 2020

The Trust's project "Using Virtual Reality as a Reasonable Adjustment", was 'highly commended' at the recent HSJ Patient Safety Awards 2020. This initiative is a great example of work to improve the safety and experience of patients and their Carers.

Health & Social Care Strategic Information Governance Award

In last month's report, the Trust's success in the Health Tech Newspaper 2020 Awards was highlighted. Since this point, the Trust's Head of Information Governance was announced on the 18th November 2020 as the winner of the "Information Governance Innovator of the Year" category at the Health & Social Care Strategic Information Governance Awards.

Liverpool Women's successful in securing £6.5m Capital Financing

We are pleased to confirm that Liverpool Women's has been successful in securing £6.5m capital financing.

The £6.5m support has been provided by the Department for Health and Social Care and will be spread over this year and next in order to address some of the clinical challenges we have on the current Liverpool Women's site.

This capital financing will allow us to bring a CT scanner and blood bank onsite, develop our colposcopy suite and invest in a surgical theatre robot, along with other associated estates works. As well as clear benefits for patients these new and innovative facilities will also help us to recruit and retain the best people.

The capital finance bid was submitted earlier this year by the Trust, with a proposal that was supported at a local and regional level, as well as by NHS England/Improvement.

Jenny Hannon, Director of Finance, has noted that: "We are delighted to secure this capital support, particularly during these challenging times. It will deliver significant benefits to our patients and staff as well as the wider region by providing much needed diagnostic capacity within the Trust. We look forward to progressing with our plans to make good use of this capital immediately with essential improvements to the hospital site, making our services even more safe and allowing us to provide an even higher quality of care."

Health Education England Quality Framework

The Health Education England Quality Framework identifies the standards that organisations are expected to have in place to provide a quality learning environment for the learners they have responsibility for. Every organisation is expected to have assessed which standards are fully or partially in place via the use of an annual self-assessment review (SAR). There is an expectation, via the Learning and Development Agreement (LDA), that organisations will refresh their SAR every year as good practice.

The review is usually sent to all organisations in January for submission in April. Due to COVID 19, the report had been suspended until 2021. However, it was then relaunched at the end of July with the deadline of completion for

30 September 2020. The Board reviewed and approved the SAR outside of Board meetings via email and this was submitted ahead of the deadline. The Board is now asked to ratify this approval.

2020 Flu Campaign Update

The holistic health and wellbeing of our valued workforce is of paramount importance to us. As part of this we want to mitigate the risk during the winter months of our staff becoming unwell due to the seasonal flu virus that is circulating within the community.

The Trust is continuing with its flu campaign delivery and at the 26 November 2020, the overall uptake stood at 70%.

The following measures have been put into place to support staff in accessing a flu vaccine:

Drop-in stand located near to the staff entrance - Monday-Friday between (7am-8:30am)
We have listened to staff feedback and have arranged for some earlier drop in slots to be set up each day for staff to get their flu jab before they start their morning shift and for those leaving after their night shift. The drop-in stand will be located by the lifts closest to the staff entrance.

Peer Vaccinator Ward/Departmental walk-arounds - Monday-Friday between (1:30pm-3:30pm)
The peer vaccinators have been visiting wards and all departments Monday-Friday between 1:30pm-3:30pm. Particular time requests have been considered and facilitated where possible.

Occupation Health Ward/Departmental Visits
The Trust's Occupational Health provider is also providing clinics and ward/departmental visits to vaccinate staff every Wednesday and Friday afternoon, they also have specific sessions for night and weekend staff.

If staff have received their vaccination from their GP/Pharmacist etc, a short form has been made available for them to inform the Trust.

CNST Compliance

In November 2020, the Board was informed of the updated Clinical Negligence Scheme for Trusts (CNST) year 3 requirements published in October 2020. Key changes in terms of reporting requirements and assurances required for Trust Board sign off in May 2021 for the scheme were outlined. The following highlights which sections of the agenda support the Board in demonstrating on-going compliance:

- Putting People First Committee Chair's Report – notes the percentage of O&G trainees in 2019 that reported whether they disagreed or strongly disagreed that educational / training opportunities are rarely lost due to gaps in the rota.
- Safe Staffing Report – notes the proportion of ACSA standards 1.7.2.5, 1.7.2.1 and 1.7.2.6 that have been met in relation to the Anaesthetic medical workforce.
- Saving Babies Lives Report – provides a bi-annual overview of the completed quarterly care bundle surveys for 2020/21.

SECTION B – Local

COVID-19 mass testing pilot reaches over 23,000 residents within first few days

Liverpool City Council revealed that more than 23,000 residents were tested for COVID-19 within the first four days of the city's mass testing pilot. The pilot is the first of its kind in the country and has received national and international

attention. Trust Staff who are residents of Liverpool have been encouraged to access the mass testing centres in their own time.

Local trust publishes Little Book of COVID-19 Best Practice

Cheshire and Wirral Partnership NHS Foundation Trust has published its 'Little Book of COVID-19 Best Practice'. The book is free to download and features case studies from the Trust which aim to demonstrate examples of leading clinical practice and facilitate the sharing of innovative ideas. It also includes examples of gold standard clinical practice within the fields of mental health, physical health and learning disability services.

https://issuu.com/cwp.essential/docs/little_20book_20of_20covid-19_20best_20practice

SECTION C – National

Asymptomatic home testing for NHS staff

Regular asymptomatic testing has been rolled out nationally (from 23rd November 2020) within NHS organisations to further control the risks associated with Covid-19, to reduce the spread of hospital acquired infection and to protect patients and staff.

Staff eligible for asymptomatic testing conduct self-administered tests twice a week from home with results being available within 20-30 minutes. These results are then be self-recorded via an online form. Members of staff with regular patient facing roles have be prioritised for home testing kits, starting with clinical members of staff.

Staff that have tested positive for Covid-19 within the last 90 days are not be eligible to take part in this home testing programme. Tests are not mandatory and are voluntary however all eligible members of staff have been strongly encouraged to take part to keep our women, babies and colleagues safe. Taking part in regular testing will also help the Trust to maintain its services safely through regular monitoring of staff who test negative and positive.

NHS begins work on coordination of mass vaccination programme

Whilst it is not expected that a COVID-19 vaccine will be widely available until 2021, the Government has asked the NHS to be ready to deliver a vaccination programme for England from December 2020, so that those who need it most will be able to access vaccinations as soon as they are available.

Detailed planning has been underway, both on a national and local level, building on the expertise and strong track record the NHS already has in delivering immunisations like the annual flu vaccination programme, to ensure that a COVID-19 vaccination programme does not impact on other vital services. These immunisations normally happen in settings like GP practices and community pharmacies and it is the intention that the COVID-19 vaccination will be delivered in a similar way.

The Joint Committee on Vaccination and Immunisation (JCVI) has published advice on the priority groups to receive the COVID-19 vaccine when it is ready, advising that vaccines should first be given to care home residents and staff, followed by people aged over 80 and health and social workers, before being rolled out to the rest of the population in order of age and risk.

To learn more about the COVID-19 vaccination programme, a stakeholder briefing from NHS England and NHS Improvement can be found on the following link: https://www.cheshireandmerseysidepartnership.co.uk/get-informed/meetings/293-201109-stakeholder-briefing-v1/file

November 2020 Spending Review

On the 25 November 2020, the Chancellor of the Exchequer, Rishi Sunak, delivered the 2020 Spending Review alongside the Office for Budget Responsibility (OBR)'s latest economic and fiscal outlook in the House of Commons. Although the government was due to hold a full Spending Review this year, the coronavirus pandemic has meant that the Chancellor decided the review would only cover 12 months from April 2021, with a full spending review to set multi-year budgets expected in 2021.

Department of Health and Social Care spending

Core revenue funding

- The Department of Health and Social Care's (DHSC's) core revenue budget will grow from £132.4bn in 2019/20 to £147.1bn in 2021/22 – a real terms increase of 3.5%
- This includes an NHS England budget of £136.1bn in 2021/22, with the government reaffirming its long-term commitment to increase the NHS funding to £148.5bn by 2023/24
- These figures suggest that the non-ringfenced DHSC core revenue budget, which includes money for Health Education England and Public Health England, has increased by approximately £400m
- The DHSC's administration budget is projected to remain at £2.5bn in 2021/22

Core capital funding

- The DHSC's core capital budget will grow from £7.0bn in 2019/20 to £9.4bn in 2021/22 – a real terms increase of 13.4%
- This includes £4.2bn in 2021/22 for NHS operational capital investment to allow hospitals to refurbish and maintain their infrastructure.
- The government also made two multi-year capital funding commitments, both of which will come out of DHSC core capital funding:
    - £3.7bn until 2024/25 to make progress on building 40 new hospitals by 2030
    - £1.7bn until 2024/25 for over 70 hospital upgrades to improve health infrastructure across the country over the long-term.

COVID-19 funding

- The government announced £20.3bn to help the NHS cover COVID-19 related costs in 2021/22, on top of the more than £50bn made available in 2020/21
- The 2021/22 funding includes £15bn for Test and Trace, £2.1bn to maintain and distribute stocks of personal protective equipment, and £163m for medicines and therapeutics
- It also includes £3bn for an 'NHS recovery package' and, as first announced on 22 November 2020, this will cover:
- Around £1bn to begin tackling the elective backlog
- Around £500m to address waiting times for mental health services
- Around £1.5bn to help ease existing pressures in the NHS caused by Covid-19

Health specific announcements

In addition to the recovery package set out above, the Chancellor also announced: £325m for the NHS to invest in new diagnostics equipment, such as MRI and CT scanners

- £260m for Health Education England to support the training and retention of the NHS workforce
- £559m to support the modernisation of technology across the health and care system
- £165m for the eradication of mental health dormitories
- £9.4m to improve maternity safety (the government will also publish a consultation next year aimed at improving patient safety and tackling the rising costs of clinical negligence)

- On public health, the government states that 'Local authority spending through the public health grant will continue to be maintained and the government will set out further significant action that it is taking to improve the population's health in the coming months'.

NHSE/I's policy paper 'Integrating Care'

NHSE/I have published a policy paper setting out their vision of the strategic direction of system working, 'Integrating Care: Next steps to building strong and effective integrated care systems across England'. It sets out a series of policy and legislative proposals to accelerate the development of Integrated Care Systems (ICSs), including a focus on the leadership role of providers within systems.

NHS Providers have published a briefing on the paper which can be found on the following link: https://nhsproviders.org/media/690574/201126-nhs-providers-on-the-day-briefing-integrating-care-final.pdf

NHSE/I are seeking views on the proposals and the Board will give this consideration in due course.

Liverpool Women's NHS Foundation Trust

Board of Directors

Committee Chair's report of Quality Committee meeting held 23 November 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 Effectiveness Senate, Experience Senate and the Hospital Safeguarding Board. The Committee also received and approved the Effectiveness Senate terms of reference noting a wider review of the function of the senates was underway which would potentially change future terms of reference of the Senates.
   - **Legal Services Annual Report and Lessons Learnt Workshop:** The Committee received a presentation detailing litigation cases including lessons learnt, triangulation with complaints/PALS/SI's, and the proactive approach undertaken to identify potential claims. The Committee noted that a deep dive thematic reviews based on an analysis of the available information into matters such as Cerebral Palsy cases had been completed or were planned. The Committee approved the Legal Services Annual report 20219/20.
   - **Monthly Quality Performance Review M7 2020/21:** The Committee received a report on Operational Performance at Month 7 2020/21. The Committee noted further actions undertaken to improve the falls metric which had consistently been underperforming – a 'deep dive' review into this issue was suggested for a future meeting. The Committee received a continuity of carer (CoC) update within the report in response to a Chairs action remitted from the Finance, Performance and Business Development Committee. The Committee noted a revised plan to achieve 30% of women booked under the CofC pathway by March 2021. It was noted that the regional continuity of carer team had reviewed and been satisfied with the Trust plan to implement CoC. A trajectory to meet the target would be shared at the next meeting. 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 plans.
   - **CQC Provider registration Statement of Purpose Update:** The Committee approved a revised Statement of Purpose following an agreement to provide mutual aid to Liverpool Universities Hospitals for the provision of theatre capacity for breast surgery. The Statement of Purpose would be submitted to the CQC.
   - **Integrated Governance Assurance Report Quarter 2:** The Committee received the assurance report in a revised format. The Committee noted continued difficulties to evidence learning as a recurring theme and recommended a focus on demonstrating learning across the Trust.
   - **Mortality and Perinatal Report (Learning from Deaths) Quarter 2:** The Committee received and noted the Learning from Deaths quarter 2 2020/21 report. The Committee was assured by processes in place to review all three types of death at the Trust: adult, neonatal and perinatal. The Committee noted further assurance provided within appendix 2 of the report, an assessment of Perinatal Mortality in Quarter 1 2020 in relation to Covid-19.
   - **Neonatal Preterm Mortality:** The Committee received a report on Neonatal Preterm Mortality in response to a spike in Neonatal deaths. It was noted that the Neonatal Senior Management Team had commissioned an external peer review led by Birmingham Women's Hospital. The Committee was assured by processes in place, the conclusion of the external review and commended the approach taken by the Neonatal Team to escalate and review the matter.

NHS

- **LocSSIPs Quarterly Assurance Report:** The Committee noted the contents of the report and was assured by the progress being made with implementing the required standards.
- **Safety issues raised by Maternity Safety Champion Meeting:** The NED responsible for Safety alerted the Committee to safety issues raised at the Maternity Safety Champion meeting. The Committee noted executive action taken in response to concerns.
- **Equality and Human Rights Goals 1&2 – progress report Q2:** The Committee noted the contents of the report and was assured by the progress being made.
- **National Patient Safety Strategy Annual Update:** The Committee received a position update noting action taken to implement the Strategy locally.
- **Half Year Committee Review against workplan:** The Committee reflected on Committee business conducted to date during the Covid-19 pandemic. It was noted that the Committee had worked broadly in line with the plan established at the beginning of 2020/21 and no additional risks as a result of the approach taken to meeting management since the pandemic began had been identified
- **Corporate Objectives six monthly review:** The Committee noted the performance to date against the Corporate Objectives aligned to its terms of reference.

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

   The Committee noted that BAF risk 2340 'overarching Covid-19 risk', had been updated and would continue to be reviewed and updated regularly to respond to the pandemic.

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
23 November 2020

Board of Directors

Committee Chair's report of Finance, Performance and Business Development Committee meeting held 24 November 2020

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

2. Agenda items covered
   - **Finance Performance Review Month 7 2020/21:** The Committee received a report on the Month 7 finance position noting that, as at 31 October 2020, the Trust was reporting a deficit of £0.7m for the month and year to date after receipt of system, Covid-19 and growth top up of £0.6m in month. The Committee noted that this deficit position had arisen from a change in the income being received for the second half of the year under the temporary finance regime. The Committee noted continued careful monitoring and recording with respect to Covid-19 related costs. The Committee noted that CIP projects continued to remain on track in Month 7 and that the Trust was delivering the highest level of CIP on a percentage basis across Cheshire and Merseyside. Assurance was given that the trade debtors position had reduced by a further £1.2m in month, leaving the overall debtor position at £2.4m. The Committee considered the additional cost to deliver a surgical robotic service against the improved quality of care and efficiencies that would be delivered. The Committee would receive the business case when completed.
   - **Operational Performance Month 7 2020/21:** The Committee received a report on Operational Performance as at Month 7 2020/21. Since the last meeting the Committee noted that the Continuity of Care (CoC) target set by NHS England had been considered by the Quality Committee and the Putting People First Committee to consider the workforce and patient quality implications. It was noted that rapid work had been undertaken to introduce CoC teams by March 2021. The Committee noted that cancer performance targets remained strong with a continuation of improved performance compared to the past 24 months but would continue to face ongoing challenges due to Covid-19 priority 3 patient management. The Trust had focussed on new patient appointments as a result of the pause caused during Wave 1 of Covid-19 but would need to allow for additional capacity for follow-up appointments going forward. The Trust continued to offer mutual aid to the wider system whilst ensuring that Trust services remained safe.
   - **Strategic Progress Update (Future–Generations):** The Committee received a verbal position update. The Committee noted that the Trust had been successful in securing £6.5m capital financing by the Department for Health and Social Care to address some of the clinical challenges faced on site.
   - **Cost Improvement Programme Planning Process:** The Committee was assured by the report detailing the process undertaken to identify CIP schemes including Quality Impact and Equality Impact assessments.
   - **Cost Improvement Programme 2020/21: Mid-Year Post Implementation Review:** The Committee noted that the Trust was forecasting £2.0m against a cost improvement programme target of £3.7m in 2020/21 of which £1.5m is recurrent. This equates to a recurrent saving equivalent to 1.2% of expenditure budgets. The Committee was assured by the contents of the report on the progress of the mid-year post implementation review exercise, undertaken in line with the Well-Led Review recommendations and as part of ensuring good governance and ensuring that lessons are learned from both successful and unsuccessful schemes.
   - **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. The Committee also received an update of developments to take

forward the K2 digital maternity project and the decision taken to defer the go live date from 13th November 2020 to January 2021. The deferral was chosen to ensure all actions had been completed and tested ahead of launching the system which had been delayed due to implications of Covid-19 on staffing.

- **EU Exit end of transitional period:** The Committee noted the report and the requirements for the exit response.
- **Corporate Objectives Six monthly review:** The Committee reviewed and noted the performance to date against the Corporate Objectives aligned to its terms of reference.
- **Mid-year Committee Review against workplan:** The Committee reflected on Committee business conducted to date during the Covid-19 pandemic. It was noted that the Committee had worked broadly in line with the plan established at the beginning of 2020/21 and no additional risks as a result of the approach taken to meeting management since the pandemic began had been identified.
- **Sub Committee Chairs report:** The Committee received and noted the Chair report from the Digital Hospital Subcommittee.

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

The Committee reviewed the risks that it was accountable for within the BAF. No changes to existing risks were identified as a result of business conducted during the meeting.

The Committee noted that BAF risk 2340 'overarching Covid-19 risk', had been updated and would continue to be reviewed and updated regularly to respond to the pandemic. The Committee also noted that BAF risk 2337 'the Trusts current clinical records system (paper and Electronic) are sub-optimal' had been reviewed and updated and 3 actions closed.

Based on earlier discussion it was noted that potential risk caused by the EU exit would be escalated through the Corporate Risk Register.

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

None

5. **Issues to highlight to Board**

The Committee wishes to highlight to the Board the £4.5m deficit forecast arising from the level of income allocation and reduction in top up payments for the second half of the year. The Committee raised concerns in relation to the impacts on income and activity for the following year, which was to be addressed during the 21/22 planning process.

6. **Action required by Board**

None

Phil Huggon, Committee Chair
FPBD Committee
24 November 2020

BOARD OF DIRECTORS

Chair's report of Putting People First Committee held on Monday 23 November 2020

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

2. **Agenda items covered:**
   - **Director of Workforce Report:** The Committee received the Director of Workforce report noting a detailed workforce position update in terms of Covid-19.
   - **COVID impacts regarding Medical Workforce and CNST:** The Committee received an in-depth report which detailed the impact Covid-19 had upon clinical staffing, educational training, and rota gaps. The report highlighted that obstetrics and gynaecology rota gaps was a significant patient safety consideration as part of CNST compliance. It was noted that 57.4% of O&G trainees in 2019 reported they disagreed or strongly disagreed that educational / training opportunities are rarely lost due to gaps in the rota. Actions taken to maintain safe rotas were outlined. Further analysis of the 2020 GMC Survey was to be undertaken and this would inform an updated action plan which was scheduled for consideration by the Committee in January 2021. To meet CNST requirements, this action plan will require Board approval.
   - **Workforce Key Performance Indicators (KPIs) including Resuscitation and Transfusion Training update:** The Committee noted a downward trend in relation to PDR and mandatory training compliance across a majority of departments and recognised the impact Covid-19 had caused on workforce ability to maintain compliance. A focused approach to develop e-learning and live web-based courses to replace face-to-face courses to maintain workforce training was noted.
   - **Staff Story: Maternity:** Angela Winstanley, Midwife presented her approach to implementing national initiatives at the Trust by developing a national forum to share learning and best practice. The Committee commended Angela for her proactive approach to network nationally to attain valuable benchmarking data and information sharing.
   - **Service Workforce Assurance & Risk Report: Neonatal Services:** The Committee received the Neonatal workforce assurance report and noted no risks escalated to committee attention. The Committee was assured that the neonatal workforce was safe and sustainable.
   - **Continuity of Carer Target:** The Committee received the report in response to a Chairs action remitted from the FPBD Committee. The Committee noted that there had been a lack of willingness of midwifery staff to embrace the new models of care despite engagement. The Committee received a revised proposal that would deliver 30% compliance with Continuity of Carer by March 2021 and noted that the 35% target would be achieved by introducing new starters to the continuity of carer team by June 2021.
   - **Fair and Just Culture Project Update:** The Committee received a verbal update detailing the progress to date with the Fair and Just Culture programme. It was noted that the Board of Directors had completed the Fair and Just training in October 2020 and a recorded version of the session would be shared with those not present.
   - **Widening Participation Update:** The Committee noted the current status of the Widening Participation programmes within the Trust and the intended future developments. The Committee noted the difficulties spending the apprenticeship levy and the perceived barriers of both recruiting apprenticeship roles and applying for an apprenticeship role.
   - **Leadership & Talent Strategic Framework Update:** The Committee received the draft Leadership & Talent Strategic Framework and noted the high-level engagement undertaken to underpin the Strategy. The Committee agreed that the appropriate structure had been developed.
   - **Guardian of Safe Working Hours (Junior docs) report Quarter 2 2020/21**: The Committee noted the contents of the 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. It was noted that the current Guardian of Safe Working Hours was retiring from the Trust and the position had been advertised.

- ~ **Corporate Objectives 2020/21: Designated PPF Objectives Six Monthly Review:** The Committee noted the performance to date against the Corporate Objectives aligned to its terms of reference. Consideration of the quality of PDR/Mandatory training within the corporate objectives would be undertaken within the next iteration.
- ~ **Mid-year Committee Review:** The Committee reflected on Committee business conducted to date during the Covid-19 pandemic. It was noted that the Committee had worked broadly in line with the plan established at the beginning of 2020/21 and no additional risks as a result of the approach taken to meeting management since the pandemic began had been identified.
- ~ **Subcommittee chairs reports and terms of reference:** The Committee received and noted the Chair's report from the Equality, Diversity and Inclusion Committee, Health and Wellbeing Group, Partnership Forum and the Nursing & Midwifery Professional Forum.

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 noted that BAF risk 2340 'overarching Covid-19 risk', had been updated and would continue to be reviewed and updated regularly to respond to the pandemic.

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 23 November 2020

Liverpool Women's NHS Foundation Trust

Agenda Item	20/21/219

MEETING	**Trust Board**
PAPER/REPORT TITLE:	**Covid-19 Pandemic: Trust Update**
DATE OF MEETING:	Thursday, 03 December 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):	3. This report will not be published under the Trust's Publication Scheme due to exemptions under S22 of the Freedom of Information Act 2000, because the information contained is intended for future publication	
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. December 2020 has seen the Liverpool city region move down into Tier 2 measures. There remain restrictions on 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. The Trust has responded to this pressure to date as part of the Cheshire and Mersey system response. The nationally declared level 4 incident was stepped up again in October 2020 in line with Wave 2.

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 November 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 October, however, anticipates November and December to be a challenge with the increased pressures of wave 2. Long waiting (52 week) patients are in line with our recovery trajectories however are likely to increase.

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.

In November the Trust commenced the testing of all asymptomatic staff through the national programme. All staff are offered a test twice a week for a 12-week period.

The Trust is preparing for the commencement of the Covid 19 Vaccine for all staff in December 2020

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. In November 2020 the Trust has worked with LUH colleagues to be able to deliver Breast surgery on the LWH site as part of supporting system oncology recovery. It is anticipated this will continue through Q4 at least.

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.

Agenda Item	2020/20/220

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Safer Nurse/Midwife Staffing Report, M7 2020/21**
DATE OF MEETING:	3rd December 2020
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	Janet Brennan, Acting Director of Nursing and Midwifery
AUTHOR(S):	Janet Brennan, Acting Director of Nursing and Midwifery
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** 1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☐ 2. To be ambitious and *efficient* and make the best use of available resource ☐ 3. To deliver *safe* services ☒ 4. To participate in high quality research and to deliver the most *effective* Outcomes ☐ 5. To deliver the best possible *experience* for patients and staff ☐
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust* ☒ ***2.*** *The Trust is not financially sustainable beyond the current financial year* ☐ ***3.*** *Failure to deliver the annual financial plan* ☐ ***4.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision* ☐ ***5.*** *Ineffective understanding and learning following significant events* ☐ ***6.*** *Inability to achieve and maintain regulatory compliance, performance and assurance* ☒ ***7.*** *Inability to deliver the best clinical outcomes for patients* ☒ ***8.*** *Poorly delivered positive experience for those engaging with our services* ☒
CQC DOMAIN	***Which Domain?*** ***SAFE-*** *People are protected from abuse and harm* ☐ ***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes,* ☐ *promotes a good quality of life and is based on the best available evidence.* ***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity* ☐ *and respect.* ***RESPONSIVE –*** *the services meet people's needs* ☐ ***WELL-LED -*** *the leadership, management and governance of the* ☐ *organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.* ***ALL DOMAINS*** ☒
LINK TO TRUST STRATEGY, PLAN AND	**1.** Trust Constitution ☐ **4.** NHS Constitution ☐ **2.** Operational Plan ☐ **5.** Equality and Diversity ☐ **3.** NHS Compliance ☒ **6.** Other: **NHS England Compliance**

EXTERNAL REQUIREMENT		
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 7 are as follows:

- Fill rate remains high at >90% for Registered Nurses & Midwives in Total.
- Gynaecology ward fill rates are lower this month (72%) for Registered Nurses during the day due to vacancies.
- Absence continues to fluctuate but this is due to Covid-19 related absence. Non-Covid related absence as of November 11th is 5.58%% for Nursing and Midwifery and 5.05%% for Medical staff and 0% for AHP's. Covid-19 related absence is 5.71% for Nursing and Midwifery, 4.04% for medical staff and 0% for AHP's.
- Nursing and Midwifery vacancies are 7% - M7 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.
- A business case is being presented to Divisional Board for increase in theatre scrub staff and HCSW to ensure midwives are not required to scrub.
- There were 9 red flags relating to staffing in Month 7.
- A cause group of midwives scrubbing in theatre has been added to the incident system to enable closer monitoring.

- 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. These will be completed by January.
- There are various staff support measures in place during Covid-19
- LWH is now part of an NHSE initiative working with a recruitment agency to support with HCSW recruitment.
- Twice weekly asymptomatic swabbing of all staff has commenced which may see a rise in covid-related absences. This is being monitored daily at the Command meetings.
- Plans are in place to ensure LWH staff are ready to implement mass vaccination programme.

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 9 Red Flags reported, 3 relating to staffing. 1 was relating to a second obstetric theatre having to be opened and a midwife having to scrub. 1 due to a delay in epidural and 1 due to a delay in transferring an induction of labour.
- A new cause group has been added to the Ulysses system to enable more effective monitoring of midwives having to scrub in theatre following an issue raised at the maternity safety champions meeting.

Safer staffing exception report

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

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 higher 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. Maternity have now filled all their vacancies following recent recruitment.

The Trust is now part of an NHSE initiative with Indeed recruitment agency to help support with HCSW vacancies. The HON for neonates is leading on this.

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.

AHP Staffing – overview and exceptions

- 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 2 vacancies and 0% sickness in Month 7.
- ODP's form part of the overall staffing for theatres. Currently there are 7 band 5 vacancies in theatre. As part of the theatre Quality improvement plan there has been a review of the leadership in theatres and a new model has been agreed by the theatre Executive Oversight committee. There are 2 ODP's in training. In view of the number of vacancies it is being explored if there are opportunities to accept more in training. A business case is being presented to increase the establishment of scrub staff and HCSW by 3 wte to ensure there is not a need for midwives to scrub. Plans are in place to cover these shortfalls with bank staff until the business case is approved following an issue raised at the maternity safety champions meeting.

Medical Staffing – overview and exceptions

The medical absence rate remains stable overall, reducing to around 3 % Covid related but rising to around 5% non Covid. Standard medical rotas remain in place for both the consultant and the trainee workforce and there have been no significant gaps to date. We remain vigilant.

Twice weekly symptomatic staff testing has now commenced but in comparison to earlier less optimistic estimates, pilot study data from elsewhere would suggest that an additional loss of no more than 2% of the medical workforce may result. The impact of staff vaccinations will not be seen until early 2021.

Of note, consultant recruitment has continued throughout the pandemic with the appointment of two new highly skilled laparoscopic gynaecological surgeons and one cancer surgeon. Three anaesthetic posts are being advertised in December 2020 / January 20201 jointly with LUHFT. This success reflects the Trust's determination to continue developing its vital core business despite the challenges presently at play.

Please see Appendix 2 for narrative to support that the Anaesthetic workforce meets ACSA standards as required by Maternity Incentive Scheme Safety Action 4.

Impact of Covid-19

Twice weekly asymptomatic swabbing has been rolled out to all staff across LWH on 19th November 2020. The impact of this is being monitored daily at the command meeting. Divisions have in place their business continuity plans if there is an increase in Covid -19 related absence.

The Trust is preparing and planning the implementation of the mass vaccination programme of which nurses and midwives will be asked to support delivering the vaccinations. Associate Director for Safeguarding is leading on this.

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.

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 and car sharing. 2 Trainee Nurse Associate's (TNA) commenced their programme with LJMU and LWH in September.

Conclusion and Recommendation

- Fill rate remains high at >90% for Registered Nurses & Midwives in Total.
- Gynaecology ward fill rates are lower this month (72%) for Registered Nurses during the day due to vacancies.
- Absence continues to fluctuate but this is due to Covid-19 related absence. Non-Covid related absence as at of November 11th is 5.58% for Nursing and Midwifery and 5.05% for Medical staff and 0% for AHP's. Covid-19 related absence is 5.71% Nursing and Midwifery, 4.04% Medical staff and 0% AHP's.
- Nursing and Midwifery vacancies are 6% - M7 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.
- A business case is being presented to Divisional Board for increase in theatre scrub staff and HCSW to ensure midwives are not required to scrub.
- There were 9 red flags relating to staffing in Month 7.
- A cause group of midwives scrubbing in theatre has been added to the incident system to enable closer monitoring.
- 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. These will be completed by January.
- There are various staff support measures in place during Covid-19
- LWH is now part of an NHSE initiative working with a recruitment agency to support with HCSW recruitment.
- Twice weekly asymptomatic swabbing of all staff has commenced which may see a rise in covid-related absences. This is being monitored daily at the Command meetings.
- Plans are in place to ensure LWH staff are ready to implement mass vaccination programme.

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 7

WARD	Fill Rate Day% RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff
Gynae Ward	72%	94%	108%	103%
Delivery suite	91%	102%	91%	92%
Mat Base/ Jeffcoate	88%	93%	95%	104%
MLU	87%	87%	79%	94%
Neo-nates	104%	68%	103%	100%
Transitional care	100%	97%	139%	55%
TOTAL	**93%**	**90%**	**97%**	**95%**

Appendix 2

The following information should provide assurance that the standards for ACSA and the Maternity Incentive Scheme are being met. All Rota and roster evidence is available should this be required and is stored with the Lead for Maternity Incentive Scheme.

Standard 1.7.2.5

Where there are elective caesarean section lists there are dedicated obstetric, anaesthesia, theatre and midwifery staff.

There is a dedicated anaesthetic consultant is assigned to elective caesarean section list who carries bleep 156. This arrangement is fulfilled in all elective episodes.

In the relevant time period, there are no gaps in rota provision that would lead to this standard not being met.

Standard 1.7.2.1

A duty anaesthetist is immediately available for the obstetric unit 24 hours a day. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patient in order to be able to attend immediately to obstetric patients. The rota should be seen to allow obstetrics to take priority where the duty anaesthetist has other responsibilities. A policy should be made available at staff induction regarding prioritising and junior staff should provide verbal confirmation that they have been inducted in this way. CNST, NHS Resolution or equivalent evidence and audits should also be provided.

There is always a trainee in anaesthetics available 24/7, who has no other responsibility but Obstetrics. They carried bleep 301. Anaesthetic trainees hand over, in person to the oncoming anaesthetist with bleep turn over. The trainee anaesthetists are directly supervised by a dedicated Consultant Anaesthetist during the day time Monday to Friday. A Consultant Anaesthetist is on call to provide support, supervision and if required will attend the hospital during out of hours.

In the relevant time period, there are no gaps in rota provision that would lead to this standard not being met.

Standard 1.7.2.6

The duty anaesthetist for obstetrics should participate in labour ward round. A copy of the rota to demonstrate duty consultant availability at a time when labour ward rounds are taking place.

A dedicated Consultant Anaesthetist (bleep holder 157) and a trainee anaesthetist (bleep holder 301) are available for obstetric ward round and all other delivery suite activities all five days a week. Out of hrs and over the weekend there is on site presence of trainee anaesthetists. On call consultant is available for distant supervision and for onsite if needed.

In the relevant time period, there are no gaps in rota provision that would lead to this standard not being met.

COVID-19 Impact

It is worth noting that the time period this report pertains to, was during the time of numerous COVID 19 lockdowns, restrictions and changes to guidance, policy and SOP. Reassuringly, COVID 19 sickness and absence did not have any significant impact on the provision of the anaesthetic service and the ACSA standards required to meet accreditation. Above and beyond what was required of anaesthetic cover, during the months of June and July 2020, Consultant Anaesthetist provision was increased to 24/7 on site cover. Providing assurance that at this critical time during COVID 19, senior attendance was available 24/7.

Conclusion.

The above arrangement of anaesthetic medical staff cover is a mandatory and minimum requirement for staffing of our rota. Further clinical and non-clinical activity and rota arrangements are completed only when we are assured that the above standards have been met. We are assured that in the six-month period this report pertains to that there are no occasions in which the above standards have not been met.

In event of any short term (on the day) sickness or absence, there is a volunteering back up rota in place to cover out of hrs commitment for Consultant cover. If a trainee is absent or sick, this voluntary arrangement would see a Consultant Anaesthetist steeping down to provide cover.

There are no requirements for any action plan to be signed off by the Board and reassuringly there are no actions to be taken as a result of this review and report. The Board is asked to take assurance that the ACSA and ultimately Maternity Incentive Scheme requirements are met with evidence available to support.

Agenda Item	20/21/221

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Care Quality Commission Update**
DATE OF MEETING:	Thursday, 03 December 2020
ACTION REQUIRED	**Assurance**
EXECUTIVE DIRECTOR:	Janet Brennan, Acting Director of Nursing and Midwifery
AUTHOR(S):	Janet Brennan, Acting Director of Nursing and Christopher Lube, Head of Governance and Quality
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** 1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☒ 2. To be ambitious and *efficient* and make the best use of available resource ☒ 3. To deliver *safe* services ☒ 4. To participate in high quality research and to deliver the most *effective* Outcomes ☒ 5. To deliver the best possible *experience* for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust…….* ☐ ***2.*** *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**	Quality Committee ***Click here to enter text.***		
	Date of meeting	Monday, 23 November 2020		

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 was 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**: Focused work continues to ensure actions are embedded and audit results are being monitored.
- **Pathways for Under 18's/ Deteriorating Child:** This action has been changed to amber as work has been undertaken and progress is being made and gaining some pace. A majority of actions will be completed from the action group, with a specific action around employment of paediatric nurses taking a longer than the specified completion date.
- **Resuscitation Equipment**: Compliance has improved 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, work uploading assessments is nearing completion which will allow for regular assurance reports to commence.
- **Gynaecology:** The Division have demonstrated improvements in Q2 following the safe and secure audits completed by the pharmacy team as reported to MMC. The improvement plan continues to be progressed with oversight by the executive team.
- **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 which is being monitored and actions taken when required, compliance has improved.
- **CSS:** All actions are on track to achieve within the timeframes and relevant audits are being monitored and actions taken as required. Overarching Theatre Improvement plan continues to progress with monitoring by the executive directors.

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 responded to the CQC with an action plan on 29 May 2020. It was 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 mostly 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 of actions

- **Safe and proper management of medicines**: Focused work continues to ensure actions are embedded and audit results are being monitored.
- **Pathways for Under 18's/ Deteriorating Child:** This action has been changed to amber as work has been undertaken and progress is being made and gaining some pace. The majority of actions will be completed from the action group, with a specific action around employment of paediatric nurses taking a longer than the specified completion date. The Policy for the Management of Children and Young Persons in Hospital is currently out for consultation with a plan to approve by end of December. A new document: Standards

of Vital Signs Monitoring, including a new Paediatric Early Warning Score (PEWS) chart, has been developed and recommended for implementation, this is out for consultation.

- **Resuscitation Equipment**: Compliance has improved however this remains amber until there are at least 6 months of audit results to demonstrate checks are embedded. Monitoring of compliance continues and any areas of concern are raised and manged by the relevant division.
- **Health and safety in relation to COSHH**: A new web-based management system in place to allow for greater management of risk assessments. Work has progressed with populating the system and is nearing completion which will allow for the implementation of regular assurance monitoring commencing.
- **Gynaecology:** The Division have demonstrated improvements in Q2 following the safe and secure audits completed by the pharmacy team as reported to MMC. The improvement plan continues to be progressed with oversight by the executive team.
- **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 which is being monitored and actions taken when required, compliance has improved.
- **CSS:** All actions are on track to achieve within the timeframes and relevant audits are being monitored and actions taken as required. Overarching Theatre Improvement plan continues to progress with monitoring by the executive directors.

Recommendation

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

.

Appendix 1- Updated action Plan November 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- Nov 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 August 2020 Added questions to weekly audits following focused inspection Quarterly audit being undertaken in July. All divisions presented actions to MMC- August. **November 20** Monitoring audit results

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. August 2020 Monthly compliance reports to Divisions and resus committee **November 20** Monitoring audit results

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 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)	1. Pathways for under 18's will be developed for each service. 2. Development of a trust-wide transfer policy 3. Quarterly report to safety senate on each pathway with Assurance to Quality Committee	DONM	Divisional Managers	DDONM		August 2020 October 2020 December 2020	Trust wide lead identified- HON, Gynae. Established Task and finish groups with representatives 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 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. 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. **November 20** Policy for Care of the Children and Young Persons in Hospital out for consultation Standards for Vital Signs monitoring in children and PEWS chart out for consultation Policy for Management of the Deteriorating Child and Young Person is in development An option paper on the use of Paediatric Nurses is going to executive meeting 02/12/20

No			Issue	Action	Executive Lead	Operational Manager	Operational Lead	RAG	Completion date	Progress Update
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 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)	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 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 **November 20** Web based COSHH system in final stage of being populated

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 as the time from diagnosis to treatment. Regulation 12 (2)	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 severely impacted its ability to meet current elective care standards (Which are under review). **<u>November 20</u>** In response to covid 19 the trust has responded in line with national policy and guidance. We are currently part way through the Clinical Validation Programme (please see embedded documents for information surround the programme and our submission to the national team). We have from the initial outbreak of Covid risk stratified all of our elective and oncology patients to treat patients on a priority basis rather than chronological wait where necessary. Whilst there have clearly been pressures nationally and regionally and whilst we are not compliant against previous waiting time standards, we are the top performing trust in the North West for the number of patients who have breached 52 weeks as the table below

No			Issue	Action	Executive Lead	Operational Manager	Operational Lead	RAG	Completion date	Progress Update
										demonstrates : -  Updates provided to CCG and CQC in performance and engagement meetings
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 **November 20** On track to introduce bi-annual reports

No			Issue	Action	Executive Lead	Operational Manager	Operational Lead	RAG	Completion date	Progress Update
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 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 areas 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	Monthly report of medicines audits to Divisional Governance meeting and Board. Monthly report to MMC. Quarterly audit will be shared with Division once completed (August MMC), action plans developed and monitored through MMC- completed in August August 2020 Nominated Consultant lead identified to support Medicines safety. Deep dive of medication incidents has been completed. Presented in Division, MMC and Safety Senate. **November 20** Monitoring audit results

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 towards improving performance against national standards such as the time from diagnosis to treatment. Regulation 12 (2)	1. Waiting times will be met in line with National Standards. 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	DOP	Divisional Managers	DDOP		(Awaiting national guidance following pandemic) September 2020 December 2020	The inspection was undertaken pre-covid, in response to the pandemic actions were taken in line with national guidance which severely impacted its ability to meet current elective care standards (Which are under review). In response to covid 19 the trust has responded in line with national policy and guidance. We are currently part way through the Clinical Validation Programme (please see embedded documents for information surround the programme and our submission to the national team). We have from the initial outbreak of Covid risk stratified all of our elective and oncology patients to treat patients on a priority basis rather than chronological wait where necessary. Whilst there have clearly been pressures nationally and regionally and whilst we are not compliant against previous waiting time standards, we are the top performing trust in the North West for the number of patients who have breached 52 weeks as the table below demonstrates : - 

No			Issue	Action	Executive Lead	Operational Manager	Operational Lead	RAG	Completion date	Progress Update
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 RSCN cover for under 18 patients **November 20** Monitoring

No			Issue	Action	Executive Lead	Operational Manager	Operational Lead	RAG	Completion date	Progress Update
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	August 2020 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. August 2020 SLA to be agreed with AHH, this is included within the gap analysis **November 20** Policy for care of the Children and Young Person in Hospital out for consultation Standards for Vital Signs monitoring in children and PEWS chart out for consultation Policy for management of the deteriorating patient in development Option paper on the use of Paediatric nurses going to excs meeting December 2nd 20

No			Issue	Action	Executive Lead	Operational Manager	Operational Lead	RAG	Completion date	Progress Update
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 and experience to keep them safe from avoidable harm. Regulation 12 (2) (c)	1. Review of national guidance and what training/ requirements are in scope 2. Training needs analysis will be undertaken. 3. Competencies required for the Nursing team. Identified timeframes with Assurance at PPF.	DONM	Divisional Managers	DDONM		August 2020 September 2020 December 2020	Training needs analysis completed Trust-wide competencies being developed for all Registered Nursing/ Midwifery staff- to be completed September 2020 as part of N&M strategy. **November 20** Monitoring
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 **November 20** Monitoring

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 **November 20** Monitoring Audit Results

No			Issue	Action	Executive Lead	Operational Manager	Operational Lead	RAG	Completion date	Progress Update
14	**Maternity SAFE**	**CQC report 23/04/2020 Must Do**	The service must ensure the proper and safe management of medicines, including the proper storage of medicines (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	Continual audit as part of maternity risk audit cycle, with final 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 **<u>November 20</u>** Monitoring Audit Results

No			Issue	Action	Executive Lead	Operational Manager	Operational Lead	RAG	Completion date	Progress Update
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 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 audit 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. Local audits reviewed and monitored through governance <u>August 2020</u> MyKit check monthly compliance reports monitored through divisional Board **<u>November 20</u>** Monitoring Audit Results

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. **November 20** Implementation of audits an assurance reports in progress
17	**Gynae**	**CQC report 23/04/2020 Should do**	The provider should ensure all staff completes their mandatory training.	1. All staff to complete their mandatory training within an agreed trajectory. 2. Quarterly reports with assurance to PPF	DONM	Divisional Manager	DDONM		June 2020-completed December 2020	Trajectory developed and monitored at Divisional Board and performance review **November 20** Monitoring compliance weekly

No			Issue	Action	Executive Lead	Operational Manager	Operational Lead	RAG	Completion date	Progress Update
18	**Gynae**	**CQC report 23/04/2020 Should do**	The provider should ensure all staff completes 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 August 2020 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. **November 20** Monitoring Compliance weekly AD Safeguarding reviewing delivery of L3 training method
19	**Gynae**	**CQC report 23/04/2020 Should do**	The provider should ensure they have a vision in place which is underpinned with values and a strategy	1. The Trust vision/values and strategy needs to be embedded across the services and services need to align their own strategy to this 2. Monthly reports to Divisional Board with Assurance at PPF quarterly	DONM	Divisional Managers	DDONM		September 2020 December 2020	Part of operational plan – strategy will form part of this and will be communicated across the division and visible in areas

No			Issue	Action	Executive Lead	Operational Manager	Operational Lead	RAG	Completion date	Progress Update
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 August 2020 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. **November 20** Monitoring
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 August 2020 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 August 2020 OD away days for Senior nurses in Division on 1st September. **November 20** Monitoring

No			Issue	Action	Executive Lead	Operational Manager	Operational Lead	RAG	Completion date	Progress Update
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 **November 20** New COSHH Web based system in final stages of being populated

No			Issue	Action	Executive Lead	Operational Manager	Operational Lead	RAG	Completion date	Progress Update
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. 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 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 matron and reported to senior ops meeting, MDT and Divisional Board **November 20** Monitoring Audit Results

No			Issue	Action	Executive Lead	Operational Manager	Operational Lead	RAG	Completion date	Progress Update
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

No			Issue	Action	Executive Lead	Operational Manager	Operational Lead	RAG	Completion date	Progress Update
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 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	DONM	Divisional Managers	DDONM		May 2020- completed August 2020 October 2020 December 2020	Stationary now placed in a locked cupboard Medicine audits twice weekly on NICU and weekly on LDU Quarterly pharmacy audits- action plan developed and monitored through MDT and MMC **November 20** Monitoring Audit Results

No			Issue	Action	Executive Lead	Operational Manager	Operational Lead	RAG	Completion date	Progress Update
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 **November 20** Monitoring Audit Results

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 **November 20** Assurance process for divisional board in progress
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 languages to meet their needs.	1. The information that is available to parents and their family's will be stated clearly that it can be requested in alternative languages and formats	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
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. **<u>November 20</u>** Monitoring Audit Results at Medicines Management Committee
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	**<u>November 20</u>** Roll out of system reviewed SOP updated and monitoring of audit results in progress

Agenda Item	**20/21/222**

MEETING	**Trust Board**
PAPER/REPORT TITLE:	**Neonatal Preterm Mortality Review (July 2015 – June 2018)**
DATE OF MEETING:	Thursday, 03 December 2020
ACTION REQUIRED	**Assurance**
EXECUTIVE DIRECTOR:	Andrew Loughney, Medical Director
AUTHOR(S):	Chris Dewhurst, Clinical Director Neonatology
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	☐	**4.** NHS Constitution	☒
	2. Operational Plan	☒	**5.** Equality and Diversity	☒
	3. NHS Compliance	☒	***6.*** Other: Click here to enter text.	
FREEDOM OF INFORMATION (FOIA):	3. This report will not be published under the Trust's Publication Scheme due to exemptions under S22 of the Freedom of Information Act 2000, because the information contained is intended for future publication			
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	The Board is requested to note the contents of the report for information and assurance.			
PREVIOUSLY CONSIDERED BY:	**Committee name**		Quality Committee	
	Date of meeting		23 November 2020	

Report

Neonatal Unit report

Division of Family Health

Report on Neonatal Preterm Mortality

July 2015 – June 2018

October 2020

Chris Dewhurst

Contents

1. Background

LWH reports and benchmarks neonatal data in several different fora. In August 2018, the North West Neonatal ODN highlighted data benchmarking preterm mortality (24+0 → 31+6 weeks gestational age). These data included babies with the following characteristics;

i. Born between 24+0 and 31+6 weeks gestational age and admitted into a neonatal unit
ii. Died before 44 weeks postmenstrual age
iii. Identified by place of first admission

These data demonstrated that Liverpool Women's Hospital had a mortality rate of 13.3% (54 of 406). The other level 3 units in the North west ODN had mortality rates 12.2%, 5.3% 8.1% 7.9% and 8.4.

The largest difference was in the population of 24-27 weeks GA. (27.9% cf. 21.7%, 13.1%, 18.6% 12.1, 6.7 and 16.7%)

	Total No Deaths # (%)	**24-27+6 weeks GA (% of admissions)**	**27+6 → 31+6 weeks GA (% of admissions)**
LWH	54/406 (13.3%)	27.9%	5.0%
Unit A	24/197 (12.2%)	21.7%	3.8%
Unit B	15/283 (5.3%)*	13.1%	1.1%
Unit C	22/272 (8.1%)*	18.6%	2.3%
Unit D	30/385 (7.9%)*	12.1%	7.9%
Unit E	8/210 (3.8%)*	6.7%	2.2%
Unit F	21/250 (8.4%)	16.7%	3.7%

#The denominators for this table is estimated from the data provided by ODN (only have number of deaths and %, not total number of admissions)

*Significant at $p<0.05$ level (Fishers exact) when cf LWH

Timing of death

- 20/54 (37%) babies died within the first 2 days of life. Further review of these babies is required but this is likely due to them being unwell from birth or conditions judged incompatible with life.
- 21/54 (39%) babies died after 2 weeks of life.

Sub-group analysis of 24 week infants

The provided data allowed LWH to determine that the difference in mortality was only seen in the 24-27+6 gestational age group. Further discussions with the ODN have provided further clarification that the difference is only observed in the most premature age group of 24 week infants. The ODN data has not yet been shared with LWH so we are unable to benchmark these data.

Gestation 24 weeks	**ODN data**	**LWH data**
Total number of deaths (N)	22	21
No. of babies born at 24 weeks	39	39
In-booked deaths (N)	14	13
In-booked births (N)	22	22
In-booked % (of all admissions at 24w)	56.4%	53.8%
Mortality – in-booked babies only	63.6%	59%
Mortality rate – all babies(%)	56.4%	56.4%
Booked elsewhere deaths (N)	8	8
No. booked elsewhere 24 weeks	17	17
Booked elsewhere or un-booked(all admissions at 24w)	43.6%	43.6%
Mortality – booked elsewhere	47%	47%

- 21/53 of the babies who died were born at 24 weeks (39.6% of all of deaths)
- The mortality amongst in-booked babies was 56.4% of babies vs 47% of those booked elsewhere. All of the in-booked babies had LWH postcodes.
- Birth weight median 650g (IQR 625-695)

- Within the 24 week infants there were the following congenital anomalies

- Congenital diaphragmatic hernia (LWH booked)
- Transposition of the Great Arteries (booked elsewhere)
- Pulmonary hypoplasia (booked elsewhere).

Grading of care

Two cases of suboptimal care were within this group

- Grade 3 = suboptimal care - different management would reasonably be expected to have MADE a difference to the outcome. This was an infant who had recurrent pneumothoraces. Insertion of a chest drain led to chest obstruction of bronchus and damage to pulmonary artery branch. This was an SI which led to changes in the insertion of chest drains
- Grade 2 outcome suboptimal care - different management MIGHT have made a difference to outcome. This related to a delay in administration of antifungal medication.

Timing of death

- 5/21 (22.7%) of the babies died within 2 days of birth.
- 11/21 (52.4%) of the babies died within 2 weeks

Details of birth

- 10/21 (47.6%) babies had a consultant in attendance at delivery
- All of the births without a consultant in attendance outside of resident-consultant hours. These had a senior ANNP or registrar in attendance. 6 deliveries had a core trainee in attendance.

Details of death

- 6/21 had sepsis as a cause or contributory cause of death
- 9/21 had extreme prematurity as their primary cause of death

2. Benchmarking of mortality data

VON network

Inborn 24 week survival over 10 year period at LWH. Comparison with VON data

Between 2009 and 2018 there have been 99 babies born at LWH and admitted to the neonatal unit. 61 of these babies (61.6% have died. The annual mortality rate has varied between 42% (2014) to 90% (2009) with a median annual mortality of 61%.

Chart 1 shows a comparison of the 24 week mortality rate with the whole VON network.

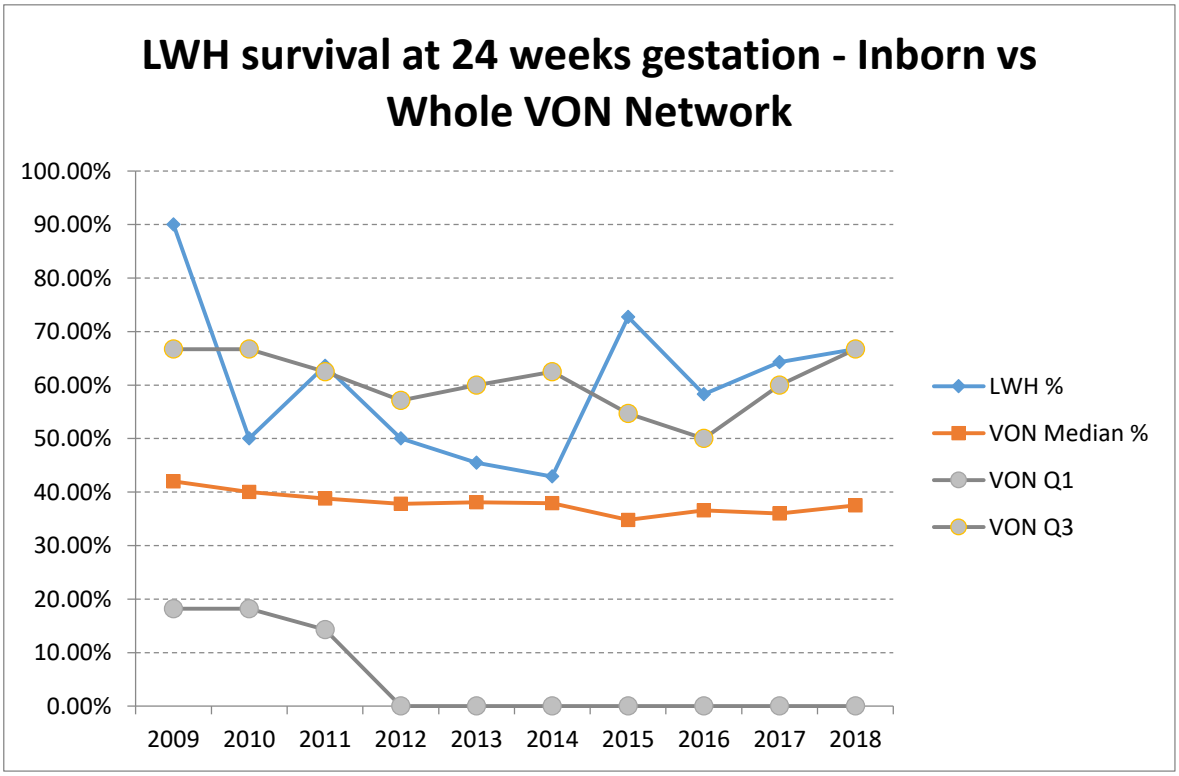
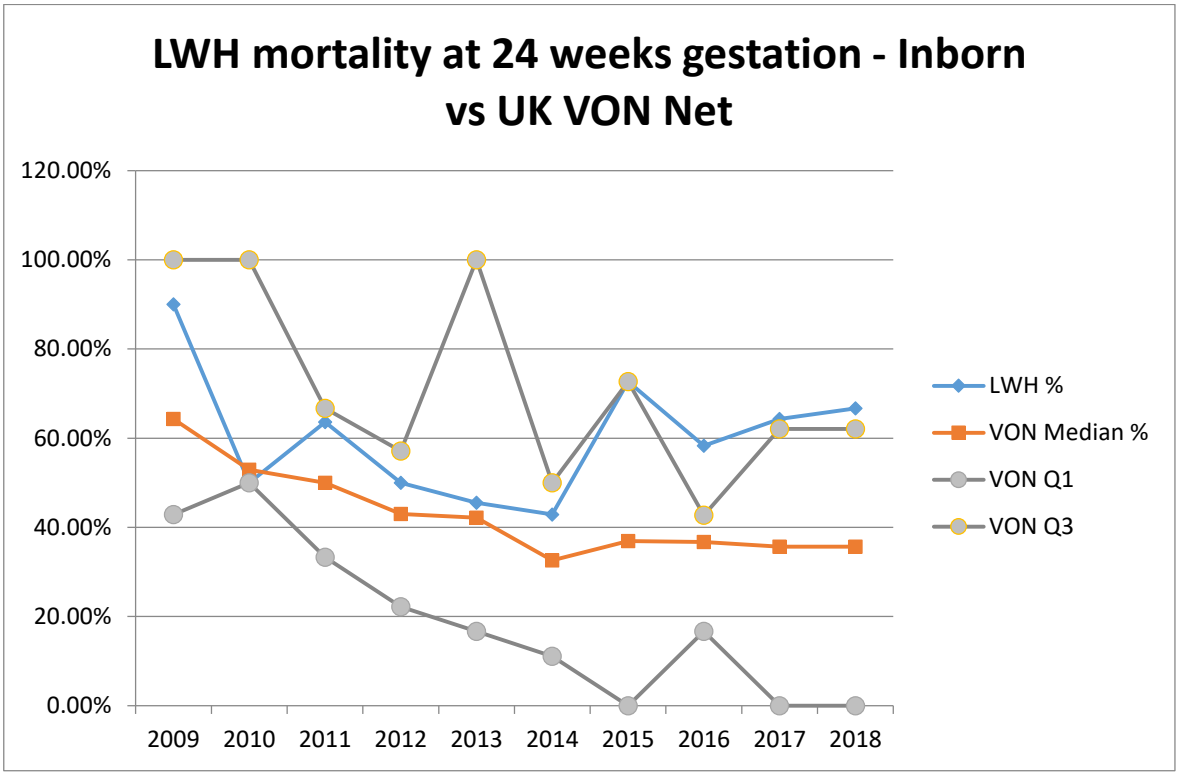


Chart 2 (next page) shows a comparison of the 24 week mortality rate with the UK VON network.



Comparison of data between Birmingham Women's Hospital and Liverpool Women's Hospital Inborn Babies 010715 to 300618. No difference in mortality rates

	Birmingham Women's			Liverpool Women's			p value
	Babies	**Death**	**Survival %**	**Babies**	**Death**	**Survival %**	
24	31	16	48%	39	22	44%	0.69
25	42	9	78%	27	9	67%	0.27
26	40	8	80%	48	6	88%	0.34
27	48	1	98%	32	4	88%	0.06
28	65	2	97%	47	3	94%	0.4
29	49	2	96%	49	3	94%	0.21
30	80	3	96%	71	2	97%	0.1
31	94	5	95%	91	4	96%	0.77
Total	**449**	**46**	**90%**	**404**	**53**	**87%**	0.19

3. Birmingham Women's Review

Neonatologists and an ANNP from Birmingham Women's Hospital were invited to undertake an external review of 10 randomly selected 24 week infants. Access to the notes on Neonatal BadgerNet was granted to the reviewers which allowed all contemporaneous notes to be reviewed, including investigation results, nursing observations and medications. The reviewers did not have access to imaging such as x-rays, or prescription charts, but this did not impact the review process.

Overview of Cases

10 cases were reviewed. 7 male and 3 female. The birth weight ranged from 580 to 745 grams with a mean of 647 grams. 7 babies were from singleton pregnancies, and 3 were from twin pregnancies. All babies received antenatal steroids, but one of these was an incomplete course due to timing of delivery. All mothers received antenatal magnesium sulphate. All of these babies were in-born, with 3 of them being transferred in-utero from within region.

The management at delivery and within the first hour was overall very good. The admission temperature was good, with 6 babies having temperature within the target range of 36.5 – 37.5oC. Only 2 babies were slightly cold (36.0oC and 36.3oC) and 2 babies were warm (37.6oC and 38.5oC). All babies were admitted to the neonatal unit for on-going management, and it appears that the "Golden Hour" was met in all cases including administration of antibiotics within the first hour.

The documentation about the delivery was sometimes in complete, with some lacking the information about who was present at delivery, and whether a consultant was present at birth.

The primary cause of death was noted to be renal failure in 3 babies, and E. coli sepsis in 3. Extreme prematurity, pulmonary hypoplasia and severe bronchopulmonary dysplasia were the other main causes of death.

Issues Identified

1. **Femoral arterial lines**

It was noted that femoral arterial lines were attempted in 5 of the cases. One of these attempts was unsuccessful with the femoral vein being cannulated instead. In all 4 babies who had a femoral arterial line, there were concerns with limb ischaemia with either pale, white limbs, or dusky limbs/digits distal to the line. Concerns were raised and documented by the nursing staff on these occasions, but the lines remained in situ, sometimes for many days with the use of GTN patches to aid perfusion. Although this did not affect any outcome, this practice is a concern due to the risk of whole limb ischaemia with permanent damage and loss of limb.

LWH Response

The use of femoral arterial lines has been previously identified in two recent SIs. The updated guidance has a weight cut off for those lines to be used in babies only > 1Kg. There is updated guidance on removal of these lines. It is likely that the lines apparently remaining in-situ after concerns were identified reflects a documentation issue on Badger, with lines removed but not being documented as this happening on Badger. An audit of femoral line use is nearing completion which will identify if this is correct (the lead clinician on the audit has provisionally confirmed the lines are removed but not documented until later).

2. **Liberal use of sodium bicarbonate**

In 7 of the cases there was liberal use of sodium bicarbonate. This is somewhat controversial practice as there is no evidence to support or refute this. However, in these cases there were multiple full corrections in a short period of time, sometimes with sodium bicarbonate boluses on an hourly basis with every blood gas on top of a background infusion. Often this occurred even if the metabolic acidosis was only mild. Rapid infusion of hypertonic sodium bicarbonate has been linked to intraventricular haemorrhages and potentially damaging changes in cerebral perfusion, and it can also cause a paradoxical intracellular acidosis. The large amounts of sodium bicarbonate resulted in

hypernatraemia, and in 2 patients the sodium was greater than 160 and in one patient was as high as 170 following multiple full corrections.

LWH Response

The drug datasheet and guidelines will be reviewed. The use of bicarbonate will be audited against previous collected data. (see action plan)

3. **Missed opportunity to palliate sooner.**

It is clear that Liverpool Women's Hospital has a very good bereavement and palliative care team and process, and the team should be proud of this. It was noted, however, that coming to the decision to re-orientate care to palliation could have happened earlier in 4 of the cases. Cardiac arrest is not common place on any neonatal unit, but 4 out of the 10 babies had cardiac arrests with full resuscitation. Some had more than one cardiac arrest. In Birmingham Women's Hospital it is common practice to put "Do Not Attempt Resuscitation" orders in place when extreme preterm infants who are sick have a continual deteriorating clinical course. This helps avoid futile cardiopulmonary resuscitation. These often will include withholding chest compressions and drugs of resuscitation should cardiac arrest occur as a result of the underlying pathology, but have the caveat of continued airway management in the event of a problem with the endotracheal tube. They are reviewed on a daily basis, and are withdrawn when appropriate.

LWH Response

We disagree that cardiac arrest is not common on any neonatal unit, but accept that not all neonatal unit will resuscitate babies who experience cardiac arrest. There are a spectrum of reasonable responses to a neonate who acutely deteriorates. We will review the need for do not resuciate orders and how these can be introduced onto the neonatal unit with an accompanying education programme. (see action plan)

4. **Tidal volumes to reduce ventilator induced lung injury.**

The data from BadgerNet seemed to suggest that very high tidal volumes were being delivered to the babies, sometimes more than 20 ml/kg when the target

would normally be 5 – 6ml/kg. We discussed the limitations of this information being pulled from the ventilators into BadgerNet, and the department now use volume controlled ventilation rather than pressure controlled. This will reduce this risk greatly, to the point of elimination.

LWH Response

See above. The data from the ventilators is piulled eonce/hour. The values fluctauate with each breath and therefore the data cnnot be used as an accurate relfection of the TVs being delivered. Since these cases, volume targeted ventilation has been introduced/ The TVs are limited by this mode of ventilation.

Specific Cases

1. One of the patients was born with presumed pulmonary hypoplasia following rupture of membranes and oligohydramnios from 19 weeks gestation. Very quickly the baby was ventilated on high frequency oscillatory ventilation. The starting mean airway pressure was very high at 26cm H2O, with a very high delta P of 50. There were problems with oxygenation and hypotension. In an extreme preterm with a weight of 600-700g, these high ventilation pressures will cause cardiac tamponade, reduced venous return, and poor gas exchange due to over distension of the lungs. This baby had 3 cardiac arrests, but there was no documentation of consideration of pneumothorax as being a cause, or about the high pressures affecting the clinical condition. There is also no documentation of a chest X-ray. It is possible that the ventilator settings and the high pressures contributed to the cardiac arrest, and a pneumothorax was a high risk.
   LWH response An SI has been initiated for this case.

2. There was one case when a baby was sent for a PDA ligation. When the baby arrived at Alder Hey Hospital, the PDA had already closed on scan. This meant there was an unnecessary, potentially destabilising transfer, and it may be that a repeat echo prior to transfer may have prevented this. This had no bearing on the outcome of the baby who later died from severe chronic lung disease.

LWH response We rarely send a baby for PDA ligation. Our practise is to repeat echocardiograms prior to transfer.

Action Plan

Action required for completion	By whom?	Target Date/ Completion date	Progress/Evidence	Update	RAG
1. Arrange session to discuss review findings with senior neonatal team.	Chris Dewhurst	Oct 30th 2020	Date set for 12th October for senior team to meet and discuss. Further actions may arise from this meeting.		
2. Review femoral line policy.	Bill Yoxall and Ben Shaw	Oct 30th 2020	Femoral line issues have already been identified from recent SIs. The guideline is now updated. Restriction to < 1000g to be included in guideline.		
3. Audit use of sodium bicarbonate in extreme premature infants .	Bala Palanisami Colin Morgan	Nov 30th 2020	To initiate audit proposal by this date		
4. Guidance on when to use Na HCO3. A. Review TPN guideline re:sodium bicarbonate indication. B. Review sodium bicarbonate formulary.	A Prof Morgan B Fauzia Paize	Nov 30th 2020			

5. Review use of DNRs on the neonatal unit and advice of when these should be initiated. Devleop education package around this.	**Fauzia Paize**	**Nov 30th 2020**			
6. Initiate SI for case 3.3.1	**Chris Dewhurst**	**Sept 30th**	**SI 2020/16403 initiated and review panel on 16th October**		
7. PMRT review of 24 week in 2019-20 to look for ongoing common themes relating to; Resuscitation		**Nov 30th 2020**			
8. Ward round documentation education and training	**Helen Chitty and Sue O Neill**	**Jan 30th 2021**			
9. Specific Guidance for extreme prematurity to be developed.	**Golden Hour and Resus Team. JH/RK/HC/FP**	**Jan 30th 2021**			
10. Develop a methodology for reviewing neonatal resuscitations on the NICU and at Delivery suite	**JH**	**Nov 30th 2021**			

BRAG Rating Key:

GREEN = Action Completed

Amber – Active and on track for completion

Red – Active with concerns for achievement or not achieved by target date

Agenda Item	20/21/223

MEETING	**Trust Board**
PAPER/REPORT TITLE:	**Bi-Annual Report Saving Babies Lives Version 2. October 2020**
DATE OF MEETING:	Thursday, 03 December 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.*** *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):	3. This report will not be published under the Trust's Publication Scheme due to exemptions under S22 of the Freedom of Information Act 2000, because the information contained is intended for future publication	
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	***The Board is asked to note the report and the key areas of compliance in respect of CNST.***	
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 Bi-Annual report provides a narrative on the progress made against full implementation the Saving Babies Lives Care Bundle 2 (SBLCBV2).

It provides details on progress made against the Trust Saving Babies Lives Action Plan in regard to each of the bundle's elements including smoking in pregnancy, Small for Gestational Age & fetal growth restriction, reduced fetal movements, effective fetal monitoring and preterm labour.

Receiving this report is required for the Board to demonstrate compliance against CNST Safety Action 6. The report will be supported by a presentation from the Quality & Safety Midwife that will identify the assurance that the Board can take in respect of the following areas:

- Evidence of the completed quarterly care bundle surveys for 2020/21
- Data from the organisation's Maternity Information System (MIS) evidencing compliance against the five elements.
- Specifically confirm that:
    - women with a BMI>35 kg/m2 are offered ultrasound assessment of growth from 32 weeks' gestation onwards
    - in pregnancies identified as high risk at booking uterine artery Doppler flow velocimetry is performed by 24 completed weeks gestation
    - There is a quarterly audit of the percentage of babies born <3rd centile >37+6 weeks' gestation.
    - 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.

SBL

Saving Babies' Lives Care Bundle

Version 2

Biannual report – October 2020

Previous Report June 2020.

Angela Winstanley RM

Quality & Safety Midwife

Dr Alice Bird

Consultant Obstetrician

Purpose

This paper provides an update on the implementation of the NHS England *Saving Babies' Lives Care Bundle Version 2* (SBLCBv2) at Liverpool Women's NHS Foundation Trust. Prior to this report, progress has been monitored via quarterly submissions of the national care bundle survey to the Strategic Clinical Network and the Local Maternity System. This report details each of the five elements of SBLCBv2 along with a progress narrative. Successes and challenges with implementation are highlighted. A separate action plan and tracker is available but has not been included in this report due to its length.

Background

Reducing perinatal morbidity and mortality rates remains a key priority for maternity services within the UK. The National Maternity Safety Ambition, launched in 2015 and updated in 2017, is to reduce the rates of stillbirth, neonatal deaths and brain injuries in babies that occur during or soon after birth by 50% by 2025 (in comparison to 2010 rates); and to reduce the national rate of preterm births from 8% to 6% by 2025 (*Safer maternity care*, 2016 and 2017). This ambition was reiterated in *The NHS Long Term Plan*. The 2017 Office for National Statistics (ONS) report showed a fall in stillbirth rates in England to 4.1 per 1000 total births, which represented an 18% reduction since 2010.

SBLCBv2 was produced to build on the achievements of SBLCBv1 (published in 2016) and to address the issues identified in the SPiRE evaluation of version 1. It aims to provide detailed information for providers and commissioners of maternity care on how to reduce perinatal mortality across England.

SBLCBv2 brings together five elements of care:

1. Reducing smoking in pregnancy
2. Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction
3. Raising awareness of reduced fetal movements
4. Effective fetal monitoring during labour
5. Reducing preterm birth

Lead healthcare professionals within Liverpool Women's NHS Foundation Trust have been allocated to each of the five elements. Alice Bird, consultant obstetrician, and Angela Winstanley, Quality & Safety Midwife, have overall responsibility for monitoring progress against SBLCBv2.

Element 1 leads	Gillian Diskin and Angela Winstanley Matron for Outpatients and Clinics; Quality & Safety Midwife
Element 2 lead	Mr Umber Agarwal Consultant in Maternal and Fetal Medicine (SGA/FGR lead)
Element 3 lead	Dr Alice Bird Consultant obstetrician (Intrapartum lead)
Element 4 leads	Alison Murray and Fiona Chandler Matron for High Risk Intrapartum Care and Fetal Surveillance Midwife
Element 5 lead	Dr Andrew Sharp Consultant obstetrician (Preterm Labour and Multiple Pregnancy lead)

Element 1: Reducing smoking in pregnancy

Description

This element and its associated interventions provide a practical approach to reducing smoking in pregnancy by following NICE guidance. Reducing smoking in pregnancy will be achieved by offering carbon monoxide (CO) testing for all women at the antenatal booking appointment, and as appropriate throughout pregnancy, to identify smokers (or those exposed to tobacco smoke) and offer them a referral for support from a trained stop smoking advisor. There are seven recommendations linked to this element, these are detailed with progress against each in the embedded action log below.

COVID-19

The COVID 19 pandemic brought about challenges to meeting the requirements for CO monitoring in pregnancy and subsequently ALL CO monitoring was suspended, both locally and nationally, in March 2020. This was disappointing, as the ceasing of CO screening came at a time when rates here at Liverpool Women's were consistently shown to be >95% at Booking. To ensure that CO screening can be implemented once again, when the recovery phase from COVID 19 commences and CO screening is once again nationally mandated, we have ensured that all CO monitors have been serviced, staff are trained in their use and that the consumables needed to complete CO screening are in ready supply.

Referrals to our Stop Smoking Partner, Solutions4Health did not alter during the pandemic, however face to face support from smoking cessation advisors and their presence at specialist clinics onsite at LWH also had to be ceased. The advisors had been a regular presence at the high risk antenatal clinics and had been providing cessation support to some of our most vulnerable women, especially those with pregnancies susceptible to fetal growth restriction.

Progress against SBLV2 Action log.

All actions on the Trust SBLCBV2 Action log with regards to Smoking in Pregnancy are monitored by the Quality & Safety Midwife and have a BRAG rating of Blue (action complete and embedded into practice) and Green (Active and on track), with the exception of two amber actions (described below).

There are two actions that remain Amber (active with minor concerns).

- Amber Action 1 - This concerns the process for feedback from the Stop Smoking Service. (Solutions4Health - S4H). Currently we cannot evidence a feedback loop from S4H to LWH, on a patient to patient basis, as the current system in place (Meditech) does not have an electronic solution for this. However, collaborative work is planned to introduce a feedback process, with regards to outcomes from referral to S4H at booking directly into the Trusts' new maternity electronic record - K2. This work will be included in the second scope of work for K2 and will enable S4H to input referral outcomes directly into the patient record. It will give the Community Midwifery Staff the ability to look at the outcome of the smoking referral at the 15/16 week appointment, enabling support and further advise to women on their stop smoking journey.
- Amber Action 2 – The second amber action is concerned with data collection with regards to the electronic recording of smoking status of women at 36 weeks. This historically has not been documented on Meditech, as the 36 week appointment proforma is contained within the hand held notes. There have been some changes to the Meditech System that now allow this data to be collated and going forward with the introduction of K2 this action should be Blue and embedded as the new K2 system has the capacity to accurately record smoking status at 36 weeks.

Successes with implementation

- Midwives who 'book' women for maternity care at LWH record the smoking status of every woman at the first booking appointment. Women who report they smoke or have recently quit, or those who have high CO levels, are referred to our partner smoking cessation service, Solutions4Health.
- Solutions for Health have reported that of the patient referrals sent this year, 83% have set a quit date – a great achievement and testament to the work around smoking cessation in pregnancy.
- All community midwifery staff now have access to their own CO monitor, with access to replacement consumables, CO screening rates at booking were consistently > 99% pre COVID 19 pandemic.
- An automatic referral system to the Stop Smoking Service is now in place for any woman who reports as a smoker or has recently quit, and this is completed at the time of booking. This is an opt out system.
- Pathway in place for referral to Stop Smoking Service with improved communication to Stop Smoking Service for inpatient referrals.
- CO screening is now undertaken on women who present with reduced fetal movements and very brief advice (VBA) is given on attendance. This is in accordance with the regional guideline for the management of reduced fetal movements. At present, this has been suspended due to COVID 9 restrictions.
- All outpatient areas within the hospital including Maternity Assessment Unit, Fetal Medicine Unit, Antenatal Clinic (Crown Street and Aintree) and the Day Assessment Unit at the Aintree Centre for Women's Health have access to a CO monitor.

- Maternity antenatal and postnatal inpatient ward areas now have access to a CO monitor and staff have received training in brief interventions and MECC (Making Every Contact Count) training.
- Smoking cessation advice training is delivered to midwifery staff on their clinical mandatory training days by a dedicated stop smoking advisor. This training includes use of the CO monitor and VBA.
- CO screening is now undertaken at the 36 week birth planning appointment in all settings and documented on the Meditech Information System.

Challenges with implementation

- Information system changes have been necessary to ensure that Meditech had the ability for midwives to record CO screening results at the booking appointment, 36 week visit and attendances with reduced fetal movements.
- Action plan has been developed in conjunction with Matrons for Community & ANC to ensure that ALL women have an appointment with their community midwife at 36 weeks, including those for whom receive Consultant Led/Hospital Based antenatal care (eg Multiple Pregnancy, Medical Disorders). Information around safe sleeping, CO screening and risk assessment for birth choice planning is discussed at the 36 week community midwifery visit and it is therefore essential that this is offered to all women.
- Cessation of CO screening due to COVID-19 pandemic – this has had a significant impact on the screening rates.
- Reliance on external provider of Stop Smoking services has resulted in some data gaps.

Element 2: Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction (FGR)

Element description

The previous version of this element has made a measurable difference to antenatal detection of small for gestational age (SGA) babies across England. It is however possible that by seeking to capture all babies at risk, interventions may have increased in women who are only marginally at increased risk of FGR related stillbirth. This updated element seeks to address this possible increase by focusing more attention on pregnancies at highest risk of FGR, including assessing women at booking to determine if a prescription of aspirin is appropriate. The importance of proper training of staff who carry out fundal height measurements, publication of detection rates and review of missed cases remain significant features of this element.

Action log

All actions for this element are either blue (completed and embedded) or green (active and on track for completion). However, some potential challenges have been identified and are detailed below.

Progress narrative

Implementation of some of the interventions within this element have been challenging. Concerns have been discussed at a national level about the feasibility of adopting this element in its entirety, given this, the care bundle allows for maternity services to deviate away from the recommendations set out. Liverpool Women's deviations away from SBLCBV2 and the pathways for women who may require a

uterine artery doppler, have both been submitted to both our CCG's and the NWC SCN (Clinical Network).

These deviations are summarised below:

Risk factor	SBLCB2 recommendation	LWH proposal
Previous small for gestational age	Growth scans 32/36/40	Growth scans 30/34/38
Previous stillbirth (non SGA)		Uterine artery Doppler assessment and growth scans every 2-4 weeks from 26-28 weeks until delivery (Rainbow Clinic)
Current smoker at booking (any)		Nil for women smoking ≤10/day Growth scans 30/34/38 for women smoking >10 day
Drug misuse		Growth scans 30/34/38
Women ≥40 at booking		Growth scans 30/34/38
Chronic kidney disease	Uterine artery Doppler assessment - If normal, growth scans every 2-4 weeks from 32 weeks until delivery - If abnormal but EFW ≥10th centile, growth scans every 2-4 weeks from 28 weeks until delivery - If abnormal and AC or EFW <10th centile, for discussion with fetal medicine	No uterine artery Doppler assessment Growth scans 30/34/38
Hypertension (outside of pregnancy)		No uterine artery Doppler assessment Growth scans 30/34/38
Autoimmune disease (SLE/APLS)		No uterine artery Doppler assessment Growth scans 30/34/38
Cyanotic congenital heart disease		Individualised plan regarding growth scans from 28 weeks until delivery (Cardiac Clinic/Fetal Medicine Unit)
Previous fetal growth restriction		Uterine artery Doppler assessment Individualised plan regarding growth scans from 26-28 weeks until delivery (Growth Clinic)
Hypertensive disease in a previous pregnancy		Uterine artery Doppler assessment if delivery <34 weeks due to pre-eclampsia with individualised plan regarding growth scans (Fetal Medicine Unit) Individualised plan for others (Hypertension Clinic)
Previous small for gestational age stillbirth		Uterine artery Doppler assessment and growth scans every 2-4 weeks from 26-28 weeks until delivery (Rainbow Clinic)
Papp-A <5th centile		LWH use <0.3 MoM as referral criteria rather than 5th centile Uterine artery Doppler assessment - If normal, growth scan at 28-30 and 36-37 - If abnormal, scan every 4 weeks from 24 weeks until delivery (Fetal Medicine Unit) - All get induction at 38 weeks
Echogenic bowel		Uterine artery Doppler assessment Individualised plan regarding growth scans (Fetal Medicine Unit)
Significant bleeding		Individualised plan (consultant obstetrician) Risk of missing women with 'significant' bleeding in early pregnancy so need to address this
Estimated Fetal Weight <10th centile (anomaly scan)		The EFW is not calculated at LWH anomaly scans. Fetal Medicine Unit referral if fetal biometry <5th centile
Body Mass Index ≥35	Growth scans 32/36/40	Growth scans 34 and 38 weeks
Body Mass Index ≤20		Growth scans 30/34 and 38 weeks.
Fibroids		Consultant ANC referral takes place if fibroid >5cm (or impinging on internal os) at dating or anomaly scan; individualised plan; proposal of a single scan at 38 weeks
We also offer women with a combination of risk factors (age ≥35/first pregnancy/IVF pregnancy) a uterine artery Doppler assessment		

Key

No deviations or care above that recommended by SBLCB2
Minor deviations from that recommended by SBLCB2
Major deviations from that recommended by SBLCB2

These deviations to the risk assessment pathway have now been accepted by both the CCG and the SCN Clinical Network and work has commenced on embedding this into practice. Meditech booking pages have been updated to reflect the changes and K2 now also reflects the pathway as above.

Successes with implementation

- All women at booking are risk assessed to determine if a prescription of aspirin is required. This risk assessment is fully in line with NICE Hypertension in Pregnancy guideline (NG133, 2019). We are currently working towards the introduction of a PGD for Aspirin for those women at risk of developing a pregnancy complicated by FGR.
- Use of customised fundal height measurement (GROW) charts in our low risk population is embedded into practice with current pathways for referral for growth ultrasound when deviation is recognised.
- The deviations away from the SBLCBV2 that LWH have put in place will allow easier identification of women who require a uterine artery Doppler in pregnancy without exponentially increasing the burden on the Ultrasound department. At booking, all women are now screened for their risk of having a pregnancy complicated by FGR, and this risk assessment is further reviewed at their 15 week visit where midwifery staff will be able to identify previous pregnancies complicated by SGA and FGR and ensure clinical pathways are correct.

Challenges with implementation

- With regards to the management of women with pregnancies confirmed affected by FGR and SGA, the development of an updated Small for Gestational Age and Fetal Growth Restriction guideline, encompassing any SBLCBv2 changes or those that require CCG/clinical network approval, has been delayed due to the anticipated release of multiple national guidelines on this subject during 2020, including the RCOG Green Top Guideline. We would want to incorporate any latest evidence from

this guideline in order to avoid making additional changes if it were to be updated now. It is anticipated that this guideline will be available for adoption by units across Cheshire and Merseyside, however this has not yet been confirmed. It is anticipated that the full SGA/FGR guideline will be updated and released after the publication of the RCOG guideline.

- One of the significant challenges we have identified going forward is the Trust moving to new electronic patient record system provided by K2MS. Unlike most other MIS providers, K2 are not willing to allow an interfacing back feed into their network from the Perinatal Institute for continued generation of GROW charts. This has been summarised in a document published by the Perinatal Institute: https://www.perinatal.org.uk/FetalGrowth/pdfs/K2_chart_analysis.pdf.
- The current statistical data provided by the Perinatal Institute and updated GROW-APP will include:
    - Use of a fully electronic chart – available on Desktop and Mobile devices
    - Interactive chart that will display the measurements as plots figures and trends
    - Auto-plotting with notifications of abnormal growth
    - Twin plotting and birth weight centiles
    - Mother version of the application for patient access
    - Integration with GAP-SCORE to allow review of missed cases of SGA/FGR
    - Enhanced reporting and identification in line with SBLCBV2

  The team at Liverpool Women's Hospital NHS Foundation Trust want to continue using GROW charts and the GROW-APP provided by the Perinatal Institute. We are unsure if the new K2 system will have same level of data extraction ability and ease of user interface.
- Until we have more clarity regarding integration of GROW and K2, we will continue to use GROW separately. Once the K2 system is introduced, women will have to carry a separate paper GROW chart. We feel that this will be a challenge as women may misplace this single piece of paper or

forget to bring it with them to appointments, which may lead to substandard care and the potential for adverse outcomes. There is also the possibility of duplication of GROW charts for these women which if not cancelled via Perinatal Institute would affect our annual delivery statistics.

- A quarterly audit of the proportion of babies born at <3rd centile at gestation of >37+6 weeks is challenging. Firstly there is a requirement at birth that the correct, PI calculated birthweight centile is entered into Meditech. These centiles can be then extracted from Meditech and enables the information team to provide the numbers of babies <3rd >37+6 with patient unit numbers. Unfortunately, the data quality is not always reliable, as the data entry at birth is not always correct for a number of reasons. This has been addressed with Midwifery staff with a plan to ensure that accurate data is being entered onto Meditech at the time of birth.
- The scope of work required to complete a full, case by case analysis and audit of babies born <3rd >37+6 with production of a report and thematic analysis is timely and current administrative support for the SGA/FGR lead to complete this is limited. The Head of Midwifery is currently exploring avenues to assist the SGA/FGR lead with the possibility of providing support to complete this piece of work.
- The Perinatal Institute produces quarterly reports for each provider which include these statistics, and these will be reviewed by the Trust Lead for FGR/SGA however, this does not provide patient level data. An annual audit will be undertaken by the Trust Lead for FGR/SGA, in addition to the quarterly review when the GAP-SCORE software is available from the Perinatal Institute. At the time of this report, we currently await feedback from PI with regards to the Trust data.

Element 3. Raising awareness of reduced fetal movement (RFM)

This element encourages awareness amongst pregnant women of the importance of detecting and reporting RFM, and ensuring providers have protocols in place, based on best available evidence, to manage care for women who report RFM. It recommends that induction of labour prior to 39 weeks gestation is only recommended where there is evidence of fetal compromise or other concerns in addition to the history of RFM.

Action Log

All actions for this element are either blue (completed and embedded) or green (active and on track for completion).

Progress narrative

Implementation of the interventions associated with this element is complete.

COVID-19

Throughout the COVID 19 pandemic, Liverpool Women's Hospital NHS Foundation Trust have strived to ensure that women continue to feel comfortable to contact and attend the hospital where they have concerns with fetal movements. Community Midwifery staff continue to discuss with women the importance of seeking help where they are worried. There has been no suspension of the ability for women to attend the MAU where fetal movements are concerned. A review of stillbirth cases of Q1 20/21 found no direct correlation with COVID 19 and women seeking help from our Maternity Service with regards to reduced fetal movements. The Trust continues to use social media to ensure messages are communicated to women and their families to seek help where required, along with maternity staff holding meaningful discussions with women about the importance of fetal movements.

Successes with implementation

- The Tommy's and NHS patient information leaflet on RFM has been adapted by Liverpool Women's Hospital NHS Foundation Trust to enable documentation of both initial and subsequent conversations held with women with regards to the importance of fetal movements in pregnancy.
- All handheld case notes are produced with this leaflet pre-printed and inserted and will be available from the first antenatal booking appointment.
- All maternity staff are directed to discuss fetal movements at every contact. The dates and times of these conversations can be documented on the adapted Tommy's RFM leaflet.
- The Tommy's RFM leaflet has also been translated into a number of alternative languages and can be used for women who are in the BAME population or who are non-English speaking. This is facilitated by our Enhanced and Link midwifery teams.
- Liverpool Women's Hospital NHS Foundation Trust uses a regionally developed and NWC Strategic Clinical Network approved guideline for the management of RFM and was co-authored by one of our consultant obstetricians. The guideline aligns with SBLCBv2 and includes the framework for performing risk assessments in women who attend with RFM and a checklist to ensure management is provided in line with the guidance.
- All women who attend with an episode of RFM are offered both a CO screen and a referral to our partner Smoking Cessation service if necessary, provided by Solutions4Health.

Challenges with implementation

- The need for increased ultrasound scans placed a requirement on the Trust to provide extra scanning provision for women who attend with reduced fetal movements and have an identified risk factor. A number of midwife sonographers have been trained to address this need and in

2019, we recruited midwives to the Advanced Clinical Practitioner training programme, which will further strengthen our ultrasound capacity.

- Increased capacity to provide inpatient inductions of labour. Threshold for induction of labour increased with the introduction of the new regional guideline for management of RFM, in line with SBLCBv2.

Element 4. Effective fetal monitoring during labour

Trusts must be able to demonstrate that all qualified staff who care for women in labour are competent to interpret cardiotocographs (CTGs), always use the buddy system and escalate accordingly when concerns arise, or risks develop. This element now includes use of a standardised risk assessment tool at the onset of labour and the appointment of a Fetal Monitoring Lead with the responsibility of improving the standard of fetal monitoring.

Action log

All actions for this element are either blue (completed and embedded) or green (active and on track for completion).

COVID-19

COVID-19 brought about the suspension of face to face training with regards to fetal surveillance and fetal heart rate monitoring. The K2 CTG Training package remained in place for staff to continue to use during the pandemic and compliance with this is closely monitored by the Fetal Surveillance Midwife. Working with the Maternity Education Team, the Trust Fetal Surveillance Midwife, now hold online CTG training sessions as part of the OBS 4 Mandatory Study Day on Microsoft Teams.

Progress narrative

Implementation of the interventions associated with this element are mostly complete. Staff completion of training remains the priority of the newly appointed fetal monitoring lead midwife, in order to fulfil the requirements of a 90% compliance rate in CTG training. There has been an introduction of a structured process to support staff who are unable to achieve the required 85% pass mark on the K2 Competency

Assessment Tool. This process gives staff the opportunity to have additional support and ensure a minimum 85% competency pass mark for all staff caring for women in the intrapartum area.

The re-instating of the Multi-Professional Maternity Emergency Training (MPMET) as a virtual training session, post COVID -19, is being facilitated with the purchase of the PROMPT training package. This will provide staff with the opportunity to continue to receive up to date, multi-professional training which covers topics such as human factors, situational awareness and obstetric CTG emergencies. All maternity staff must attend this on an annual basis and dates have been planned through the year for staff attendance.

Successes of implementation

- Successful bid to the LMS to secure funding for a full time, nominated, specialist midwife/clinician as a Fetal Monitoring Lead, to improve the standard of intrapartum risk assessment and fetal monitoring.
- The Fetal Monitoring lead is now in post with responsibility for updating fetal monitoring guidelines and providing a visible presence in both the low-risk and high-risk intrapartum areas.
- The Fetal Monitoring lead is also responsible for ensuring that fetal surveillance education is up to date and involves all the elements of fetal physiology, human factors, situational awareness in relation to CTG and intrapartum care and intermittent auscultation.
- Updated current Continuous CTG and Fetal Blood Sampling Guideline to ensure in line with NICE guideline CG190, with clear escalation pathways if concerns identified.
- The design and implementation of a risk assessment framework around place of birth and risk assessment has been registered as a Quality Improvement Project.
- The guideline which incorporates all the risk assessment requirements of SBL has now been successfully implemented, with staff now confident in its ability to assist in the recognition of a

changing clinical picture. This guideline and its risk assessment pathways are planned to be considered by our Strategic Clinical Network (SCN) and will be presented to the CCG when the SCN has approved.

- Building upon the 'Fresh Eyes' stickers, successfully implemented at Liverpool Women's NHS Foundation Trust in 2010, an audit was undertaken to assess the completion and use of the stickers. Based upon the audit findings, an updated fresh eyes sticker was designed, compliant with NICE guideline CG190 (2019). Additional education was provided to staff on the importance of ensuring full and accurate completion of fresh eyes stickers. The Fetal surveillance Midwife carries out weekly audits with regards to the use of the Fresh Eyes stickers.
- Successful introduction of an hourly review sticker to be used in the low risk intrapartum population when intermittent auscultation is the fetal monitoring of choice. This mandatory, hourly review sticker gives all grades of staff the opportunity to look at the whole clinical picture and supports escalation for senior review if required. This is supported by the updated guideline for fetal monitoring during normal labour.

Challenges with implementation

- A challenge brought about by COVID-19 restrictions is the inability of the Fetal Monitoring Lead and intrapartum staff to continue with fresh eyes reviews at the bedside, where the whole clinical picture can be assessed, and support provided. Remote review of intrapartum CTGs is facilitated presently with the K2 Guardian System.

Element 5. Reducing Preterm Birth

This is an additional element to version 2 of the care bundle, developed in response to The Department of Health's 'Safer Maternity Care' report which extended the 'Maternity Safety Ambition' to include reducing preterm births rate from 8% to 6%. This new element focuses on three intervention areas to improve outcomes which are prediction and prevention of preterm birth and better preparation when preterm birth is unavoidable.

Action Log

All actions for this element are either blue (completed and embedded) or green (active and on track for completion).

Progress narrative

Implementation of the interventions associated with this element is complete.

COVID-19

C0499-Appx-I-to-SB LCBv2-Reducing-pre

The embedded document above was distributed to Trusts in response to the data and evidence that women admitted to hospital with COVID 19 have an increased risk of pre-term birth. It is worth noting that a significant proportion of these births were brought about by an indication of intervention based on declining maternal health, rather than spontaneous preterm labour. The recommendations within this document are fully met at LWH; Risk assessment for PTL continued as part of routine midwifery assessment at booking, prevention strategies, availability of antenatal steroids and magnesium sulphate, USS capacity, cervical cerclage availability, telephone

consultations where required, screening for bacteriuria, smoking cessation, use of aspirin, fetal fibronectin are and remain available at Liverpool Women's Hospital NHS Foundation Trust.

Successes of Implementation.

- All women who attend a booking appointment have an assessment for their risk of preterm birth. Upon recognition of any risk factors referral is made on Meditech to the preterm birth clinic and placed on a risk based clinical pathway as determined within Saving Babies Lives.
- Management of multiple pregnancies is led by a Consultant in Fetal Medicine and is in line with NICE guidance. This clinic is supported by midwives with an interest in multiple pregnancies.
- Cervical length screening is performed in multiple pregnancies by the preterm birth service, which is not currently mandated by NICE, but as an extra service for this at risk group.
- LWH is an active participant in current research studies and is proudly involved in some that are looking at interventions for pre-term birth, namely; C-Stitch, C-Stitch2, Support, Craft and Encircle.
- Since publication of the last report, the Pre-Term labour and Fetal Centre Teams have now enabled the ability for ALL women with ANY history of LLETZ treatment to be referred to a Pre Term Labour Clinic.

Challenges to implementation

- The recommendation that all women who had a previous caesarean birth at full dilatation has not been implemented into the pathway for referral to the preterm birth clinic. However, this deviation from the SBLCBv2 has been considered by the Strategic Clinical Network and CCG and approved. The Trust is awaiting the publication of the Craft Study – a study looking at cervical cerlage after full dilatation caesarean section. The Trust is participating in this study as a recruiting site.

Conclusion.

This report details the progress made so far and the actions required to continue to work towards full and complete implementation of the whole of the Saving Babies Lives Care Bundle Version 2. Following the launch of the newly revised Maternity Incentive Scheme 2020, a focus on meeting the requirements with regards to Safety Action 6 continues. Audits are planned to provide assurance that Liverpool Women's Hospital NHS Foundation Trust are meeting the requirements of SBLCBv2 and to evidence compliance with the Maternity Incentive Scheme.

It is important to note, that the Trust continues to work closely with our regional partners at the SCN and the LMS, with completion and submission of the Care Bundle Surveys to the Regional Chief Midwife. Attendance at the Cheshire & Merseyside Stillbirth SIG and Safety SIG by the Trust Quality & Safety Midwife and two Consultant Obstetricians (one of whom is the Chair for the Stillbirth SIG) continues and provides an opportunity for the SBL progress to be discussed at a regional level.

Internally, Saving Babies Lives and its associated action plan are sighted across several maternity meetings, including maternity clinical, maternity risk and maternity quality. This report will also be sighted at the Family Health Divisional Board.

Regional Chief Midwife Surveys.

Survey 1. Submitted in November 2019

Copy of North West Coast REP v2 Survey

Survey 2. Submitted in March 2020

Copy of North West Coast REP v2 Survey

Survey 2.5, Submitted in July 2020

Copy of SBLCB Survey 2 (v2) Region

Survey 3. Submitted in October 2020

Copy of North West Coast REP v2 Survey

Liverpool Women's NHS Foundation Trust

Agenda Item	20/21/224

MEETING	**Trust Board**
PAPER/REPORT TITLE:	**Serious Incident Report – Quarter 2, 2020-21**
DATE OF MEETING:	Thursday, 03 December 2020
ACTION REQUIRED	**Assurance**
EXECUTIVE DIRECTOR:	Janet Brennan, Acting Director of Nursing and Midwifery
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:-….)***	It is recommended that the Board reviews the contents of this paper and takes assurance as to the robust process in place for the reporting and investigation of SI's and subsequent monitoring of actions.	
PREVIOUSLY CONSIDERED BY:	**Committee name**	Quality Committee (monthly report)
	Date of meeting	August, September and October Meetings 2020

Executive Summary

The following report relates to serious incidents reported during quarter 2 2020/21 and also includes completed investigations and information on the roots cause identified following the completion of the Serious Incident Investigation using Root Cause analysis and progress with actions.

There were 7 Serious Incidents (SI's) declared on the StEIS system as per Trust Policy in line with NHS England StEIS reporting criteria during Quarter 2 in 2020/21 period. The cases were identified in the following areas of the Trust; 1 for Clinical Support Services (Obstetric Theatre), 2 for Maternity, 3 for Neonatal, 1 for Gynaecology.

There were 5 Serious Incident final reports submitted to the CCG as in Quarter 2. The reports submission met the required timeframe (60 working days) as set out in the Trust Policy.

All of the Serious Incidents submitted to the CCG continue to be reviewed at the CCG SI Panel during the pandemic with meetings being held via a virtual Teams meeting from the summer of 2020. All reports reviewed have been well received with the panels commenting on the robustness of the investigations and the findings.

Duty of candour has been met in 100% of all SI cases and there are no overdue actions at the time of writing the report.

The report which has been presented, provides an update as to the number of SI's reported on StEIS and clearly demonstrates that the Trust continues to have an open culture of reporting and a robust process of investigation and provision of final investigation reports to the Clinical Commissioning Group, which provide clear root causes and lesson learnt. The Trust has been complimented by the CCG on numerous occasions as to the quality of the Trust Si investigations and associated reports which provides them with assurance.

It is therefore recommended that the Board note the contents of this paper and take assurance as to the robust process in place for the reporting and investigation of SI's.

Report

The agreed definition of a Serious Incident, both nationally and in the Trust Policy, is: "An accident or incident when a patient, member of staff, or member of the public suffers serious injury, major permanent harm or unexpected death, (or the risk of death or injury), on hospital, other health service premises or other premises where health care is provided and where actions of health service staff are likely to cause significant public / media concern".

The Trust follows NHS England's guidance in reporting Serious Incidents and carrying out investigations. This includes uploading all Serious Incidents onto StEIS (Strategic Executive Information System) for external review. Both our local commissioners and our regulators are informed of the Trust's Serious Incidents and monitor the outcomes.

Internally, Serious Incidents are managed operationally through the Safety Senate and through the Quality Committee.

In many cases it is immediately clear that a serious incident has occurred. If it is not clear whether an incident fulfils the definition of a Serious Incident, the Trust engages in open and honest discussions to agree the appropriate and proportionate response. Both NHS England and our local commissioners recognise that the best position is for us to discuss openly, to investigate proportionately and to let the investigation decide. It is nationally accepted that organisations that report more incidents usually have a better and more effective safety culture.

There were 7 Serious Incidents (SI's) declared on the StEIS system as per Trust Policy in line with NHS England StEIS reporting criteria during Quarter 2 in 2020/21 period. The cases were identified in the following areas of the Trust; 1 for Clinical Support Services (Obstetric Theatre), 2 for Maternity, 3 for Neonatal, 1 for Gynaecology.

There were 5 Serious Incident final reports submitted to the CCG as in Quarter 2. The reports submission met the required timeframe (60 working days) as set out in the Trust Policy.

There is 1 SI related to the neonatal unit which was classed as a near miss Never Event, which involved the administration of Potassium Acid Phosphate rather than Potassium Chloride. This was not declared as a Never Event as did not meet the definition within the National Framework for strong potassium. Potassium Acid Phosphate which was actually given is a lower strength of Potassium so did not meet the definition in the SI framework.

During a retrospective external review of 10 neonatal deaths from 2017, by Birmingham Womens Hospital Neonatal Team, there was one case which was identified where inappropriate use of ventilation setting on High Frequency Oscillation had been used. This was was considered too have potentially contributed to the baby's death and the case has been referred to the coroner. Since the time of this case, the policies, procedures, training and equipment in relation to the use and management of ventilation on the Neonatal unit has changed and this case could not occur again.

Due to an increase in serious incidents relating to imaging or where imaging has been a factor as part of the incident, the executive directors have requested that an external review of imaging is undertaken, this is currently in the process of being organised.

The table below provides a brief overview of the StEIS serious incidents reported in quarter 2.

Quarter 2 - July			
Service	**StEIS Ref.**	**Reported in Line with Policy**	**Summary**
Maternity	2020/13009	Yes	A primigravida with an uncomplicated pregnancy underwent routine induction of labour for post maturity/postdates. Instrumental delivery. The baby received a prolonged period of advanced resuscitation with subsequent intubation and adrenaline and transferred to neonatal unit for therapeutic cooling.

Immediate Action Taken:

- Support given to staff involved in the patient's care
- Statements requested by staff involved in patients care to allow further review
- Case reported to HSIB/EBC portal
- DOC to parents
- Review of instrumental trolley provision on DS
- CTG issues disseminated for learning72 hours review conducted:
- CTG issues disseminated for learning

Initial Lesson Learnt:

- Incorrect advice given when rang with reported spontaneous rupture of membranes
- On return and reinsertion of propess there was a lack of discussion regarding plan for artificial rupture of membranes and change of place of birth from home to inpatient
- At 15.20 VE at 8cm/rim a fetal heart deceleration was misinterpreted as loss of contact on the CTG
- At 16.20 Fetal blood sampling invoked no reactivity of the fetal heart and there was a lack of recognition of this being suspicious.
- Hyper stimulation was not recognised or managed appropriately with on-going IVI Syntocinon
- CTG categorised as suspicious on two occasions and there was no escalation to an ST6 or above
- An ST3 review was carried out instead and there was no plan made
- The pathological CTG and prolonged bradycardia was not recognized at the time and not escalated to the senior obstetrician ST6/7

Service	**StEIS Ref.**	**Reported in Line with Policy**	**Summary**
Maternity	2020/13448	Yes	12 day Post-natal admission to RLUH AED with Sepsis, transferred to ITU confirmed E-Coli. Identified in pregnancy, no record of treatment during acre or after discharge.

Immediate Action Taken:

- Obstetric medical and maternity staff statements to be requested.
- Escalation to Head of Midwifery and Clinical Director for consideration of STEISS reporting and completion of SI.
- Escalated to Head of Governance

Immediate Lesson Learnt:

- Asymptomatic bacteraemia pathway – not followed. Booking sample not repeated, test of cure following confirmed UTI treatment not obtained.
- UTI antibiotic treatment course not completed as an inpatient

- Midwife did not escalated abnormal clear loss PV to medical staff
- Several reviews for haematuria by junior staff, lack of escalation

Service	StEIS Ref.	Reported in Line with Policy	Summary
Neonatal	2020/14059	Yes	Near miss Never Event involving the administration of Potassium Acid Phosphate rather than Potassium Chloride Note: Not declared as a Never Event as did not meet the definition within the National Framework for strong potassium.

Immediate Actions Taken:

- Potassium acid phosphate and potassium chloride should be separated in the CD cupboard
- Pre-filled bags of potassium chloride to be sourced
- Once pre-filled bags are sourced, datasheets to be amended
- Process for CD key holder to be reviewed at Senior Nursing Operations meeting
- Medication incidents/SI's and Never events to be highlighted at unit meeting
- Review lighting in rooms

Initial Lesson identified

- Potassium chloride and potassium acid phosphate should not be stored beside each other in the controlled drugs cupboard
- Neonatal CD drug process introduces a third person by way of the key holder going to the CD cupboard
- Adequate lighting should be used to check drugs before administration

Quarter 2 - August

Service	StEIS Ref.	Reported in Line with Policy	Summary
CSS – Obstetric Theatres	2020/15123	Yes	**Unexpected admission to ITU following an Elective Caesarean Section** Diagnosis of anterior placenta praevia possible focal accreta at the left anterior uterine wall increased vascularity breech position evidence of placenta in bladder mucosa, Patient started bleeding +++ following delivery of baby, Placenta removed and patient was stabilising. Following closure of the abdomen concern patient was about to go into a cardiac arrest, patient collapsed and aortic compression where required including a total of 22 unit of blood. Decision made for a radical hysterectomy to be completed.

Immediate Action Taken:

- A radical hysterectomy to be completed.
- Patient stabilised and transferred to ITU at RLUH.

Initial Lesson Learnt:

- MDT antenatal approach to ensure the surgical and anaesthetic team are fully prepped for the case.
- Dedicated gynaecologists to support placenta accrete surgery
- Presence of gynaecologist at the surgical huddle and for the duration of the CS/surgery

Service	StEIS Ref.	Reported in Line with Policy	Summary
Neonatal	2020/16403	Yes	**Retrospective Incident from 2017 identified from an external review of cases of care provided to very preterm babies by neonatologists from Birmingham Women's.** Case of a 24 week twin, prolonged rupture of the membranes from 19 weeks with anhydramnios. After birth the baby had respiratory failure and commenced HFOV (powerful ventilation). This baby commenced on a MAP of 26cmH2O (according to several entries in the records). This level of MAP would never be used in a preterm infant. There was hypotension and poor cardiac output. There were frequent cardiorespiratory arrests and the baby died at 8 hours of age. This baby was high risk for not surviving but it is possible that the inappropriate high MAP was the cause of, or contributed to, her death.

Immediate Action Taken:

- None at this time as this is a retrospective review. Since 2017 there have been changes in ventilation guideline and there have been a series of focussed training sessions around a new ventilation policy. The unit has new ventilators and had staff have been trained on these. The mortality review process has changed and this issue would now be picked up if it occurred again.

On initial review it was identified that:

- The wrong level of MAP was used for the gestation of the baby.
- Practice has changed since the incident occurred

This case has been referred to the coroner and an inquest will take place in due course.
The family have had full disclosure and a full, discussion with Dr Yoxall who completed the SI investigation

Quarter 2 - September			
Service	**StEIS Ref.**	**Reported in Line with Policy**	**Summary**
Neonatal	2020/17398	Yes	The initial incident reported that "an adrenaline infusion was started during a resuscitation. The label on the infusion stated double strength, however quad strength was written in mls to be added to the infusion". This qualified as a medication prescribing error, which led to a drug administration error.

Immediate Action Taken:

- Statements were requested from staff involved
- The importance of following policy has been highlighted to the individuals involved and to staff via the unit meeting held on 14th September 20
- The incident was discussed at the neonatal medicines group on 15th September 20

Immediate Lesson Learnt:

- Medication and prescribing error due situational error

Service	**StEIS Ref.**	**Reported in Line with Policy**	**Summary**
Gynaecology	2020/18433		The patient was referred from GOPD to the Mirena Clinic for insertion of a Mirena Coil for heavy menstrual bleeding it was identified at the Mirena Clinic that there was a coil in the abdomen. **X-ray completed in March 2020 not reviewed**

Immediate Action Taken:

- The images from the ultrasound scan undertaken on 2 March 2020 have been reviewed by the Lead Sonographer and are all of good quality and show there is no evidence of an IUCD. The report also states that an X-ray is required due to the patient's symptoms.

Immediate Lesson Learnt:

- Vigilance required during Gynaecology Ward Round in relation to reviewing all investigations performed on the patient.

The Executive Directors have requested a formal external review of Imagining takes place which is currently being organised.

Lessons learnt from serious incidents submitted in Q2 2020/21

During the Q2 period a total of 5 SI's have had final reports submitted to the CCG for consideration.

Service	StEIS Ref.	Summary
Neonatal	2020/7022	An umbilical arterial catheter (UAC) had been removed and femoral arterial access inserted at 10:54am on 02/04/20 and removed at 9am on 03/04/20. The limb was documented as being pale/white and cool to touch on a number of occasions in the 24 hour period prior to the line being removed There were evolving ischaemic injuries to both legs resulting in an unsalvageable right leg and likelihood of below knee or through knee amputation to the left leg. The condition of Baby A deteriorated and on 12th April 2020, unfortunately baby passed away. Following the initial review, the panel felt there were missed opportunities to remove the line at an earlier opportunity, but stressed this may not have changed the outcome for this patient.

Root Cause:

- Failure to remove the femoral arterial line at an earlier opportunity due to this being a critical line

Learning from Investigation:

- Opportunities were missed and the line could have been removed earlier.
- Documentation of concerns about the condition of the leg should be specific.
- Communication about the condition of the leg should be specific with a plan put in place for reviews and further discussions with the consultant.

Recommendations:

- Undertake a review of incidents involving femoral arterial lines to be undertaken in order to identify trends/themes
- Review the decision making process in relation to insertion and removal of arterial and femoral lines.
  - Consider whether every other option has been exhausted before insertion. Consider whether this should be a two consultant decision?
  - Should the threshold for removal of these types of lines be lower? E.g. monitor for one hour and if no improvement, remove the line.
- Documentation should be specific with regards to:
  - decision to insert an arterial line
  - any concerns there may be about the line/limb
  - current status of line/limb
  - further plans to review/discuss the line/limb with consultant and action if limb deteriorates before
- Best practice re insertion of femoral lines to be communicated to neonatal consultants and guideline for femoral lines updated to include above points
- Escalation process for clinical concerns to be agreed and implemented
- Individual feedback to be given to staff involved
- Roll out human factors training to neonatal staff

Monitoring and Assurance

- All actions from the SI action plan are being monitored via the Neonatal MDT Group which reports up to the Divisional Board for Family Health.
- All overdue or outstanding actions are expectation reported to the Safety Senate and reviewed for progress and expected date of completion.
- All actions requiring an audit have been placed on the forward audit plan and will be monitored via ES

Service	StEIS Ref.	Summary
CSS – Obstetric Theatres	2020/9008	The incident involved a swab being left in the abdomen of the patient during a caesarean section. Surgery was completed and the initial swab count that was thought to be correct was discovered to be in error. The patient required a second spinal anaesthetic due to long duration of the original procedure as well as time taken to trying to locate the missing swab post procedure. The patient was reopened and the swab removed.

Root Cause:

- Lack of leadership, supervision and training of junior Theatre staff, leading to the inadequate distribution of staff for complex high risk case.

Learning from Investigation:

- A formal induction for new staff members, to integrate them into the department to help them understand the systems and procedures (policies and SOP's) used in Theatres.
- Newly qualified staff members should have a period preceptorship.
- Newly qualified staff members should have agreed upon time frames for achieving competencies and be provided with adequate mentorship and supervision to aid in achieving these goals.
- Newly qualified staff should be allocated to theatres where their experience and completed competencies are recognised to be suitable if expected to work independently.
- Students in theatre should have formal induction into the theatre department.
- Students in theatre should have designated responsible supervisors for each shift, and have pre-agreed upon roles and responsibilities within each case.
- "Best Practice" regarding swab use from theatre scrub protocols must become mandatory practice for all cases, namely in attaching Spencer Wells clamps to all 18x18 swab ribbons for placing within the open cavity to ensure swab identification at all times.
- Temporary cessation of activity by surgeons during swab counts to ensure adequate time and care without distraction is allocated to the swab count.
- Ongoing training and support for Theatre managers to enable them to complete duties commensurate with their role.
- In the event of equipment failure, situational awareness must be maintained by all members of the team and not allow it to become a distraction from the clinical case
- One senior trained nurse in Theatre at all times, when this is not possible the issue should be escalated to all senior staff/managers.
- A clear escalation policy is required in Theatres for when more staff are needed or we have concerns about the number of cases booked and their complexity
- A clear escalation policy is required in Theatres for when more staff are needed or there are concerns about the number of cases booked and their complexity.
- Feedback to Obstetric consultant body for list planning
- Evidence from the staff statements, and interviews demonstrated little or no support for the staff involved in the event
- Elective section lists should be filled appropriately so the correct amount of time and clinical care can be allocated to each case.

Recommendations:

- An induction programme to Theatres for all new staff and students
- Role specific competency assessments with time scales for all staff
- Development of a local mentorship programme for all new staff
- Review of current process for allocating staff and skill mix to theatre lists
- Review and update the Swabs, Needle and Instrument Check Policy to mandate attaching of a clamp to

the 18 X 18 swabs
- Review and update of Theatre Etiquette Policy to ensure
- Review of the elective caesarean section list
- Supporting of staff following a serious incident
- Ongoing training and support for Theatre managers to enable them to complete duties commensurate with their role.
- Review the themes from previous Never Events to ensure lessons learned have been embedded.

Monitoring and Assurance
- All actions from the SI action plan are being monitored via the CSS Divisional Governance Group which reports up to the Divisional Board for Clinical Support Services.
- All overdue or outstanding actions are expectation reported to the Safety Senate and reviewed for progress and expected date of completion.
- All actions requiring an audit have been placed on the forward audit plan and will be monitored via ES

Service	StEIS Ref.	Summary
Maternity	2020/9294	Antepartum stillbirth at 32+3 weeks while being managed as an in-patient following spontaneous rupture of membranes. Previous history of spontaneous onset of labour resulting in a 24 week birth. Previous obstetric history noted and pregnancy managed under the pre-term labour clinic at the fetal medicine unit.

Root Cause:
- Stillbirth following admission for management of premature pre labour rupture of membranes caused by chorioamnionitis infection as identified by placental histology.
- Exacerbation of poor patient experience by communication failure and missed opportunities to assess fetal wellbeing after identification of reduced fetal movements.

Learning from Investigation:
- Reduced fetal movements are an indication to commence a CTG immediately in the inpatient setting.
- Communication with women whose first language is not English must be improved with use of interpreting services used when assessing and providing patient care.

Recommendations:
- CTGs should be spaced evenly over a 24 hour period to provide reassurance of fetal wellbeing consistently.
- Communication with women whose first language is not English should occur via language line for admission, assessment and care planning.
- Evaluation of the LMS regional MEWS scoring tool.

Monitoring and Assurance
- All actions from the SI action plan are being monitored via the Maternity Risk Group which reports up to the Divisional Board for Family Health.
- All overdue or outstanding actions are expectation reported to the Safety Senate and reviewed for progress and expected date of completion.
- All actions requiring an audit have been placed on the forward audit plan and will be monitored via ES

Service	StEIS Ref.	Summary
Patient Administration	2020/1117	During a clinic appointment the consultant requested the patient was to be sent for an MRI scan with a six week follow up appointment. A six month appointment was made in error which resulted in the patient receiving the results of the MRI scan four and a half months late. The results showed a soft tissue mass in the left lower lobe of her lung.

Root Cause:

- Delay in diagnosis and treatment of lung cancer due to early missed diagnosis and error in setting follow up appointment, which resulted in further delay of diagnosis. CCC not flag abnormality. There is also currently no process in the LWH gynaecology department about reviewing Radiology reports from external organisations

Learning from Investigation:

- Use of paper outcome sheets and manual appointment making may increase the likelihood of human error
- All radiology reports (i.e. those with or without alert codes) from external organisations need to reviewed and acknowledged by referring clinicians in a timely fashion.
- Need to ensure that there is a system in place to allow and facilitate review and acknowledgement of all radiology reports from external organisations. This may involve IT or other manual systems.
- A clear escalation policy is required to alert external organisations about errors detected at LWH but occurring at the external organisation.

Recommendations:

- Complete implementation to paperless In Touch E-outcome system as soon as possible for ordering future clinic appointments. Functionality of e-outcome to include drop down menu i.e. using words instead of 1/12, 1/52.
- Create SOP outlining the process of making follow up appointments for all reception staff once E-outcome is in place
- Trust to order all scans referrals within the Meditech system, which allows radiology reports from external organisations to be fed back to Meditech and LWH CRIS. This may involve some reliance on working with partner organisations.
- Implement an IT solution, which alerts referring clinician to results and allows electronic acknowledgement of results.
- Set up a generic e-mail for the Clinical personal assistants to receive radiological results from external organisations forward on with read receipt functionality.
- Create local SOP for Gynaecology detailing how radiology examinations are requested on Meditech and how reports from external organisations will be referred, regularly reviewed and acknowledged by referring clinicians.
- Medical Director to discuss with senior Radiology Clinician at CCC whether ALL unexpected results from LWH can be flagged with an alert code.
- In lieu of an IT system which alerts the Consultant to results being available and which allows them to acknowledge results electronically, a manual system should be implemented. There should be a weekly manual check of all scans ordered. Once a report is available on the CRIS system this should be printed out and made available for the Consultant to review and to acknowledge receipt. This should be the responsibility of the Clinical PAs
- Acknowledgment of results should be audited annually and monitored through the Clinical Effectiveness Committee.
- CCC should conduct their own internal review of the early missed diagnosis and feedback the findings to LWH
- In the meantime, all recent orders for CT and MRI scans requested since the incident occurred should be

complied and reports manually checked on the CRIS system to ensure that reports have been reviewed. This will also act as a pilot for the manual weekly check recommended. • LWH should seek to acquire on site facilities for CT and MRI. This would ensure local control of processes and contribute to the clinical quality strategy.
Monitoring and Assurance • All actions from the SI action plan are being monitored via the Divisional Governance Group which reports up to the Divisional Board for Clinical Support Services. • All overdue or outstanding actions are expectation reported to the Safety Senate and reviewed for progress and expected date of completion. • All actions requiring an audit have been placed on the forward audit plan and will be monitored via ES

Service	StEIS Ref.	Summary
Neonatal	2020/12092	Baby was born following a spontaneous preterm labour at 23 weeks gestation with a birth weight of 630g. A non-occlusive aortic thrombus was noted on day 16. A femoral arterial line was inserted on day 20 of life, but he subsequently developed an irreversible ischaemic injury to his leg as a consequence of this.

Root Cause:

- The leg became ischaemic because a femoral arterial line was inserted in a baby with a non-occlusive aortic thrombosis.
- This occurred because of a failure in the handover of key information between two consultants.
- The injury was made irreversible by the delay in removing the line after evidence that the perfusion had been impaired by the line.

Learning from Investigation:

- Handover of key information needs to be improved.
- Contraindications to the insertion of femoral arterial lines should be listed in the relevant policy.
- Arterial lines should be removed immediately whenever there is evidence of distal ischaemia.
- Consultant should be informed immediately if the perfusion of a limb does not recover immediately on removal of an arterial line.
- Incidents should be reported at the time that they occur or as quickly as possible after that.
- Duty of candour should be followed in a timely manner.

Recommendations:

- Reflective discussions and feedback to be given to staff involved
- The policy for arterial line insertion is being amended to include:
  - a requirement for 2 consultants to review the decision to insert these lines.
  - rewording to state that a line should be removed immediately that there is any concern about limb perfusion, even in the absence of pallor.
  - Amendment to clearly state contraindications of arterial line insertion
- Staff to be reminded to report incidents when they occur
- Consultants to be reminded of the requirements of Duty of Candour
- The ongoing audit of femoral line insertion will be completed and may identify other contraindications to insertion that will be reflected in the policy.
- Review of system for entering Clinical reviews in the Badger system.

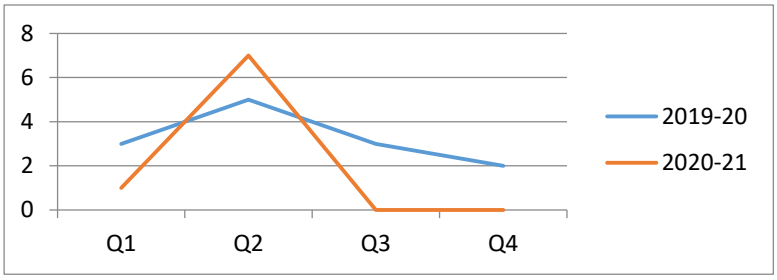
Monitoring and Assurance

- All actions from the SI action plan are being monitored via the Divisional Governance Group which reports up to the Divisional Board for Clinical Support Services.
- All overdue or outstanding actions are expectation reported to the Safety Senate and reviewed for progress and expected date of completion.
- All actions requiring an audit have been placed on the forward audit plan and will be monitored via ES

Overview

There were 7 SI's reported in Q2 making a total of eight SI's reported for the year to date for 2020/21. This is an increase as compared to the same period in 2019/20 where 5 SI's were reported. The following table shows the trend in SI's numbers in the Trust the all quarters in 2019/20 and the first 2 quarters in 2020/21

Year	Q1	Q2	Q3	Q4	Total
2019-20	3	5	3	2	11
2020-21	1	7	0	0	8



Duty of Candour

The Trust has a policy in place in relation to the completion of Duty of Candour which meets the requirements of the National Guidance and Regulation 20 of the Health and Social Care Regulations 2008 (Regulated Activities) Regulation 2014. The annual audit of duty of candour compliance is currently being completed by the Risk and Patient Safety Manager.

Since the last report the Risk and Patient Safety Manager and the Divisional Governance Managers and Facilitator have all completed a master class in relation to Duty of Candour to ensure there level of knowledge is up to date.

Overdue Actions for reported Sis

At the time of writing this report there are no actions from Serious Incidents which are overdue. This has improved following changes made within the Governance team and additional support from the Risk and Patient Safety Manager in relation to monitoring any overdue actions have and their competition. Implementation of improved and updated elements of the Ulysses Risk Management System has provided greater monitoring in the future and prevents actions becoming overdue.

Conclusion

The report which has been presented, provides an update as to the number of SI's reported on StEIS and clearly demonstrates that the Trust continues to have an open culture of reporting and a robust process of investigation and provision of final investigation reports to the Clinical Commissioning Group, which provide clear root causes and lesson learnt.

Recommendation

It is recommended that the Board reviews the contents of this paper and takes assurance as to the robust process in place for the reporting and investigation of SI's and subsequent monitoring of actions.

Agenda Item	20/21/225

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Key Actions: Infection Prevention and Control Testing** **NHSE/I Covid-19 Infection Control Board Assurance Framework - version 1.4.2 – Updated 19th November 2020**
DATE OF MEETING:	3rd December 2020
ACTION REQUIRED	**Assurance**
EXECUTIVE DIRECTOR:	Janet Brennan, Acting Director of Nursing and Midwifery
AUTHOR(S):	Janet Brennan, Acting Director of Nursing and Midwifery, Christopher Lube, Head of Governance and Quality, Tim Neal, Director of Infection Prevention and Control, AnnMarie Roberts, Infection Control Nurse
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):	3. This report will not be published under the Trust's Publication Scheme due to exemptions under S22 of the Freedom of Information Act 2000, because the information contained is intended for future publication	
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	The Board are requested to note the contents of the paper and take assurance that the Trust is taking all actions reasonably practicable to ensure it is working to meet it responsibilities for Infection Prevention and Control in relation to Covid-19.	
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

Board Assurance Framework

On the 26th October 2020 NHSE/I provided all Trusts with version 1.4 of the Infection control Board Assurance Framework which is to be used to further review compliance with IPC during Covid 19 pandemic. The aim of the framework is to provide the Trust with a method of assessing compliance and providing assurance to its Safety and Quality Committee. The updated framework poses 48 key line of enquiry in relation to compliance or non-compliance with national guidance, identification of gaps in assurance and identification of any mitigation for gaps.

Of the 48 questions posed, the Trust has been assessed as being compliant with 42 questions and is able to provide evidence to support the declaration of compliance. The 6-key line of enquiry (highlighted in yellow in **Appendix 1)** which have been identified as non-compliant are due to further information being required or a specific action needing to be completed, 3 of these have been addressed.

10 Key Actions- Boards responsibilities

On November 17th, 2020 NHSE/I published a document highlighting the Board's responsibilities for 10 Key actions **(Table 1):** Infection Prevention and Control and Testing. Of the 10 Key actions the address, 'Patient Testing - Those who test negative upon admission must have a second test 3 days after admission, and a third test 5-7 days post admission, 'is a significant change in practice compared to the previous guidance and is being confirmed by the DIPC as there has been a push back from this point nationally.

Both the IPC Board Assurance framework and the 10 Key actions have been signed off at Oversight and Scrutiny which meets weekly and is chaired by the CEO.

With the commencement of a new Director of Nursing and Midwifery there will be an opportunity to review practices with fresh eyes and identify any gaps not seen.

CQC Assurance

The Director of Nursing and Midwifery, Director of Infection Prevention and Control and the Head of Governance and Quality took part in a CQC Emergency Support Framework IPC Call 24 August 2020, which had been requested by the CQC. This is a process that the CQC is undertaking with all Trusts in England as part of their on-going assurance around Covid-19 and infection control compliance.

The Trust received a feedback report from the CQC in which they state: **We have found that the board is assured that the trust has effective infection prevention and control measures in place**

Recommendation
The Board is asked to note the contents of the paper and take assurance that the Trust is taking all actions reasonably practicable to ensure it is working to meet it responsibilities for Infection Prevention and Control in relation to Covid-19.

Report

Board Assurance Framework

On the 26th October 2020 NHSE/I provided all Trusts with version 1.4 of the Infection control Board Assurance Framework which is to be used to further review compliance with IPC during Covid 19 pandemic. The aim of the framework is to provide the Trust with a method of assessing compliance and providing assurance to its Safety and Quality Committee. The updated framework poses 48 key lines of enquiry in relation to compliance or non-compliance with national guidance, identification of gaps in assurance and identification of any mitigation for gaps.

Of the 48 questions posed, the Trust has been assessed as being compliant with 42 questions and is able to provide evidence to support the declaration of compliance. The 6-key line of enquiry (highlighted in yellow in **Appendix 1)** which have been identified as non-compliant are due to further information being required or a specific action needing to be completed, 3 of these have been addressed. These areas do not present any significant risk to the Trust and its overall compliance and safety for patients, visitors and staff. The initial areas of non-compliance are:

Systems and processes are in place to ensure:

- IPC measures in relation to COVID-19 should be included in all staff Induction and mandatory training – review of mandatory training element required – **Completed, added into training**
- There is clearly displayed and written information available to prompt patients' visitors and staff to comply with hands, face and space advice – check of public areas such as lifts **required – Completed, additional information being put up.**
- Areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand the different risk areas – **not able to put physical barriers in clinical areas due to patient safety apart from side rooms which are in use**
- A documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health **–** needs system updating **– Occupational Health element Ongoing**
- Following consideration of reasonable adjustments e.g. respiratory hoods, personal re- usable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal record and Occupational health service record – need system

updating - **Occupational Health element Ongoing**

- Boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care, this system should include a centrally held record of results which is regularly reviewed by the board – no direct report, needs to be considered – **Completed, a formal report now goes to Oversight and Scrutiny Group fortnightly with continued verbal update in between and at Command and Control Meetings.**

10 Key Actions- Boards responsibilities

On November 17th, 2020 NHSE/I published a document highlighting Board's responsibilities:

10 Key actions: Infection Prevention and Control and Testing.

Table 1

ACTION	ASSURANCE
1. Staff consistently practice good hand hygiene and all high touch surfaces and items are decontaminated multiple times everyday	• SOP's in place agreed at Oversight committee • IPC covid audits any non- compliance reported. Audit reports to IPCC and Oversight committee • Peer audits undertaken by matrons. Executive team to be part of peer audit teams in December • Cleaning records in place
2. Staff maintain social distancing in the workplace, when travelling to work and to remind staff to follow public health guidance outside of the workplace	• Assessment undertaken of each area for occupancy allowed and is visible in each room • IPC covid audits any non- compliance reported. Audit reports to IPCC and Oversight committee • Regular communications and updates following public health guidance signed off by Oversight Committee • Security walk rounds reminding staff of car sharing rules and use of facemasks.
3. Staff wear the right level of PPE when in clinical settings, including use of face masks in non- clinical settings	• SOP's in place • Posters in place in all areas • IPC Covid audits and peer audits immediate non-compliance reported. Audit reports to IPCC and Oversight committee
4. Patient are not moved until at least two negative test results are obtained, unless clinically justified	• SOP in place • All patients swabbed on or before admission • Patients only moved if clinically justified (includes the provision in care in different areas throughout labour)

5. Daily submissions signed off by CEO, MD of DON and the BAF is reviewed and evidence of reviews are available	• Information Department SOP in place regarding Covid-19 submissions • BAF monitored at Oversight and Quality Committee
6. High numbers of beds in bays must be risk assessed, where 2m cannot be achieved then segregation of patients to be considered and wards are effectively ventilated	• All bays have been assessed and 2m achieved • Opd areas chairs achieve 2m distance with reviews as part of covid audits • SOP's in place for segregated risk zones
7. Staff testing: a) Twice weekly lateral flow testing b) If high nosocomial rate additional targeting of NHS staff	• Rolled out 20/11/2020 • Only 1 transmission event on NICU- grandparents to baby. Actions put in place lessons learnt and follow up audit reported to Oversight Committee
8. Patient testing: a) All patients tested at emergency admission b) Those with symptoms must be retested at the point of symptoms arise after admission c) Those who test negative upon admission must have a second test 3 days after admission, and a third test 5-7 days post admission d) All patients must be tested 48 hours prior to discharge directly to a care home e) Elective patient testing must happen within 3 days before admission and patients must be asked to self-isolate from the day of the test until	• SOP's in place • Data which includes those tested and those declined presented at Oversight Committee with assurance from the divisions on actions • SOP in place, patient is zoned if symptomatic or awaiting test results until negative. Those declining are placed in the appropriate zone • Second test currently at day 5-7. Day 3 awaiting confirmation from DIPC • Local data has not identified positive patients at the 5 day swabbing point, suggesting that current processes are not missing positive patients • SOP in place. No breaches • SOP in place with patients isolating at home before admission

the day of admission	
9. Systems- Local systems must assure themselves with commissioners that the Trusts IPC interventions are optimal, the BAF is complete and agreed actions are being delivered 10. Review system performance and data; offer peer support and take steps to intervene as required.	• Daily systems call and Sit reps submitted • Monthly CQRM meeting with CCG • Tabletop review of BAF with CQC- letter of

CQC Assurance

The Director of Nursing and Midwifery, Director of Infection Prevention and Control and the Head of Governance and Quality took part in a CQC Emergency Support Framework IPC Call 24 August 2020, which had been requested by the CQC. This is a process that the CQC is undertaking with all Trusts in England as part of their on-going assurance around Covid-19 and infection control compliance.

As part of the call the DoN&M, DIPC and HOG&Q were required to answer a serious of questions in relation to the IPC Framework and what the Trust had put in place to protect patients, staff and visitors. The meeting lasted for 1hour and the questioning was very comprehensive and detailed.

The Trust received a feedback report from the CQC in which they state: **We have found that the board is assured that the trust has effective infection prevention and control measures in place.**

Oversight and Scrutiny

There is a daily command and control meeting chaired by the COO.

There is a three times weekly clinical advisory group chaired by the Medical Director.

There is a weekly oversight and scrutiny committee chaired by the CEO. There is an action and decision log evident. Any changes in Public Health, National or local guidance are presented discussed and acted on with an appropriate SOP put in place. All SOP's go through the trust process. The Oversight committee monitors any risks and incidents relating to Covid- 19. The IPC BAF is monitored through oversight and scrutiny and Quality committee. IPC Covid audits are presented at Oversight committee and IPC committee.

Recommendations

The Board is asked to note the contents of the paper and take assurance that the Trust is taking all actions reasonably

practicable to ensure it is working to meet it responsibilities for Infection Prevention and Control in relation to Covid-19.

Appendix 1

Publications approval reference: 001559

IPC

Infection prevention and control board assurance framework

15th October. Version 1.4

Foreword

NHS staff should be proud of the care being provided to patients and the way in which services have been rapidly adapted in response to the COVID-19 pandemic.

Effective infection prevention and control is fundamental to our efforts. We have developed this board assurance framework to support all healthcare providers to effectively self-assess their compliance with PHE and other COVID-19 related infection prevention and control guidance and to identify risks. The general principles can be applied across all settings; acute and specialist hospitals, community hospitals, mental health and learning disability, and locally adapted.

The framework can be used to assure directors of infection prevention and control, medical directors and directors of nursing by assessing the measures taken in line with current guidance. It can be used to provide evidence and as an improvement tool to optimise actions and interventions. The framework can also be used to assure trust boards.

Using this framework is not compulsory, however its use as a source of internal assurance will help support organisations to maintain quality standards.

Ruth May
Chief Nursing Officer for England

1. Introduction

As our understanding of COVID-19 has developed, PHE and related guidance on required infection prevention and control measures has been published, updated and refined to reflect the learning. This continuous process will ensure organisations can respond in an evidence-based way to maintain the safety of patients, services users and staff.

We have developed this framework to help providers assess themselves against the guidance as a source of internal assurance that quality standards are being maintained. It will also help them identify any areas of risk and show the corrective actions taken in response. The tool therefore can also provide assurance to trust boards that organisational compliance has been systematically reviewed.

The framework is intended to be useful for directors of infection prevention and control, medical directors and directors of nursing rather than imposing an additional burden. This is a decision that will be taken locally although organisations must ensure they have alternative appropriate internal assurance mechanisms in place.

2. Legislative framework

The legislative framework is in place to protect service users and staff from avoidable harm in a healthcare setting. We have structured the framework around the existing 10 criteria set out in the Code of Practice on the prevention and control of infection which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Health and Safety at Work Act 1974 places wide-ranging duties on employers, who are required to protect the 'health, safety and welfare' at work of all their employees, as well as others on their premises, including temporary staff, casual workers, the self-employed, clients, visitors and the general public. The legislation also imposes a duty on staff to take reasonable care of health and safety at work for themselves and for others and to co-operate with employers to ensure compliance with health and safety requirements.

Robust risk assessment processes are central to protecting the health, safety and welfare of patients, service users and staff under both pieces of legislation. Where it is not possible to eliminate risk, organisations must assess and mitigate risk and provide safe systems of work. In the context of COVID-19, there is an inherent level of risk for NHS staff that is treating

And caring for patients and service users and for the patients and service users themselves in a healthcare setting. All organisations must therefore ensure that risks are identified, managed and mitigated effectively.

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • infection risk is assessed at the front door and this is documented in patient notes	Previous Assurance provided in version 1.2.4	None Identified	
• patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission	Previous Assurance provided in version 1.2.4		
• compliance with the national guidance around discharge or transfer of COVID-19 positive patients	Previous Assurance provided in version 1.2.4		
• monitoring of IPC practices, ensuring resources are in place to enable compliance with IPC practice monitoring of compliance with PPE, consider implementing the role of PPE guardians/safety champions to embed and encourage best practice	Audits completed by IPC team in relation to Covid 19 and general IPC practices across all areas of the Trust Results go onto NICERS system, sent out to HoN/M and Matrons. Assurance provided at Infection Control Committee and Oversight and Scrutiny Group Monitoring for PPE is part of Covid ICC audits. Issues relating to PPE reported on Ulysses and highlighted at Control and Command meetings daily.	None Identified	

	Champions in place via IPC team and Covid leads for each area which are consultant and senior nurse level. PPE lead for Trust is the HOG&Q ICC link staff in all clinical areas.	None Identified	
• staff testing and self-isolation strategies are in place and a process to respond if transmission rates of COVID-19 increase	Full process in place for all staff that show symptoms of Covid, SOP in place, testing undertaken locally by staff. Process in place for identifying an outbreak and actions required by IPC team and senior managers BCP in place for staff levels	None identified	
• training in IPC standard infection control and transmission-based precautions are provided to all staff	All staff has a mandatory training requirement in relation to their clinical or non -clinical role. Targets in place for 95% compliance, monitored weekly by executive directors and at monthly divisional performance meetings. Link ICC undertake local updates as required for hand washing, general IPC, ANTT and as part of local induction.	None identified	
• IPC measures in relation to COVID-19 should be included in all staff Induction and mandatory training	PPE Donning and Doffing now included in local induction and corporate induction	Assurance as to level of covid-19 IC included in mandatory training required.	IPC Team to update to mandatory training required. IPC nurse to d/w HR –**Completed - IPC have developed a slide to be added to mandatory training, sent to added as soon as possible**.

• all staff are regularly reminded of the importance of wearing face masks, hand hygiene and maintaining physical distance both in and out of work	Weekly communications go out to all staff and regularly include information on requirements. IPC staff remind staff when out and about Discussed with staff when not compliant on Covid audit Signage place across Trust	None identified	
• all staff (clinical and non-clinical) are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to the PPE that protects them for the appropriate setting and context as per national guidance	All clinical staff at risk of contact with Covid positive patients has had clear face to face training on the use of PPE and donning and doffing. All, non-clinical staff have received clear information as how and when to use face masks. Posters have been issued across the organisation for both clinical and non-clinical PPE use.	None identified	

• national IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	IPC team and DIPC regularly review all guidance and ensure that any updates required are identified and included in any polices or SOPS. Updates are scrutinised at the weekly Oversight meeting and any immediate actions are raised at daily Command and Control.	None identified	
• changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	The DOO provides an update on all aspects of Covid to the Trust Board monthly as part of the trust performance report.	None identified	
• risks are reflected in risk registers and the board assurance framework where appropriate	All risks have been reviewed and Covid element added where required. All BAF risks have been Covid assessed and impact identified. An overarching BAF risk for Covid Pandemic has been developed and is updated every 2 – 4 weeks depending on current situation.	None identified	
• robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	Previous Assurance provided in version 1.2.4		

• that Trust CEOs or the executive responsible for IPC approve and personally signs off, all data submissions via the daily nosocomial sitrep. This will ensure the correct and accurate measurement and testing of patient protocols are activated in a timely manner**.**	This is reviewed weekly at Oversight and Scrutiny and at the daily command and control meetings All data collated through Power BI system and controlled by Head of Performance.	None identified None identified	
• ensure Trust Board has oversight of ongoing outbreaks and action plans.	DIPC provides reports to board as and when outbreaks occur and works with PHE and local staff to develop a robust action pan which is then monitored via the Weekly Oversight and Scrutiny meeting chaired by the CEO/Deputy CEO.	None identified	

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas	Previous Assurance provided in version 1.2.4	None identified	
• designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas	Previous Assurance provided in version 1.2.4		
• decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance	Previous Assurance provided in version 1.2.4		
• increased frequency at least twice daily of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance	Previous Assurance provided in version 1.2.4		

• cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses	Previous Assurance provided in version 1.2.4		
• Manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/disinfectant solutions/products as per national guidance	Previous Assurance provided in version 1.2.4		
• 'frequently touched' surfaces e.g. door/toilet handles, patient call bells, over bed tables and bed rails should be decontaminated more than twice daily and when known to be contaminated with secretions, excretions or body fluids	Previous Assurance provided in version 1.2.4		
• electronic equipment e.g. mobile phones, desk phones, tablets,	Previous Assurance provided in version 1.2.4		

desktops & keyboards should be cleaned a minimum of twice daily			
• rooms/areas where PPE is removed must be decontaminated, ideally timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily)	Previous Assurance provided in version 1.2.4	None identified	
• linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken	Previous Assurance provided in version 1.2.4		
• single use items are used where possible and according to single use policy	Previous Assurance provided in version 1.2.4		
• reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance	Previous Assurance provided in version 1.2.4		
• ensure cleaning standards and frequencies are monitored in non-clinical areas with actions in place to resolve issues in maintaining a clean environment	Cleaning is monitored in accordance with the National Specification for Cleanliness in a Healthcare Environment to the following targets by risk category using the 49 listed elements. Referred to in Trust Cleaning Policy.	None identified	

<table>
<tr>
<td>

- ensure the dilution of air with good ventilation e.g. open windows, in admission and waiting areas to assist the dilution of air

</td>
<td>

Non clinical areas, e.g. offices would be in the significant or low categories, unless they were offices within a clinical area then that frequency and target would apply.

<table>
<tr><th>Risk Category</th><th>Target</th><th>Frequency</th></tr>
<tr><td>Very High</td><td>98%</td><td>Weekly</td></tr>
<tr><td>High</td><td>96%</td><td>Monthly</td></tr>
<tr><td>Public areas</td><td>96%</td><td>Monthly</td></tr>
<tr><td>Significant</td><td>92%</td><td>Quarterly</td></tr>
<tr><td>Low</td><td>90%</td><td>6 monthly</td></tr>
</table>

Previous Assurance provided in version 1.2.4

</td>
<td>None identified</td>
<td></td>
</tr>
</table>

• there is evidence organisations have reviewed the low risk COVID-19 pathway, before choosing and decision made to revert to general purpose detergents for cleaning, as opposed to widespread use of disinfectants	Low risk Covid pathway not currently in use due to regional being at tier 3. DIPC has reviewed the guidance, but at this time there are no plans to change current cleaning standards	None identified	

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and process are in place to ensure: • arrangements around antimicrobial stewardship is maintained • mandatory reporting requirements are adhered to and boards continue to maintain oversight	Previous Assurance provided in version 1.2.4 Previous Assurance provided in version 1.2.4	None identified	
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion			
• **Key lines of enquiry**	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**

Systems and processes are in place to ensure: • implementation of national guidance on visiting patients in a care setting	All guidance is reviewed at oversight and scrutiny with a decision made in relation to local restrictions	None identified	
• areas in which suspected or confirmed COVID-19 patients are being treated in areas clearly marked with appropriate signage and have restricted access	Previous Assurance provided in version 1.2.4		
• information and guidance on COVID-19 is available on all trust websites with easy read versions	All Covid information is regularly updated on Trust site by communications team and via social media.	None identified	
• infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	The Trust has a specific Covid discharge SOP in place	None identified	
• there is clearly displayed and written information available to prompt patients' visitors and staff to comply with hands, face and space advice.	All areas have information available. Trust only has 2 entrances to building in use, both of which are staffed during the day and one entrance at night. At all times key information is provided.	Clarify on level, of information available in some areas required	IPC Staff to review lifts and general areas to review level of information available **Completed - Clinical areas ,entrances and exits reviewed and are compliant. No signage found in lifts therefore IPC will ask Comms and Patient facilities to add signage to these areas.**

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
• screening and triaging of all patients as per IPC and NICE Guidance within all health and other care facilities must be undertaken to enable early recognition of COVID-19 cases.	SOPs in place for all areas for elective and non- elective patients and requirements for screening Compliance monitored weekly at oversight meeting	None identified	
• front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate from Non Covid-19 cases to minimise the risk of cross-infection as per national guidance	Previous Assurance provided in version 1.2.4		
• staff are aware of agreed template for triage questions to ask	Template available by all key phone routes into trust	None identified	
• triage undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible	In key clinical areas where triage is in use such as MAU, GED, Bedford undertaken by trained clinical staff supported by relevant SOPS	None identified	
• face coverings are used by all outpatients and visitors	This requirement for anyone on entering the Trust building unless		

	individual identifies that they are exempt.	None identified	
• face masks are available for patients with respiratory symptoms	Face mask stations at front entrances and in all clinical areas which patients can access in all inpatient and outpatient areas if required.	None identified	
• provide clear advice to patients on use of face masks to encourage use of surgical facemasks by all inpatients in the medium and high-risk pathways if this can be tolerated and does not compromise their clinical care	Currently DIPC is reviewing medium and high risk pathways and requirements. Patients are currently required to wear if moving around or in a high risk area.	None identified	
• ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff.	Previous Assurance provided in version 1.2.4		
• for patients with new-onset symptoms, isolation, testing and instigation of contact tracing is achieved until proven negative	Previous Assurance provided in version 1.2.4		
• patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly	Previous Assurance provided in version 1.2.4		
• patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	Previous Assurance provided in version 1.2.4		

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
• separation of patient pathways and staff flow to minimise contact between pathways. For example, this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage, and restricted access to communal areas	All patient pathways are in place for inpatient and outpatient areas. Separate entrance for staff in to organisation use of red, amber and green zones in inpatient areas One way system in place in main corridors, stair ways and public areas	None identified None identified	
• all staff (clinical and non- clinical) have appropriate training, in line with latest national guidance to ensure their personal safety and working environment is safe	Previous Assurance provided in version 1.2.4		
• all staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to Don and Doff it safely	Previous Assurance provided in version 1.2.4		
• a record of staff training is maintained	Previous Assurance provided in version 1.2.4		
• appropriate arrangements are in place that any reuse of PPE in line with the MHRA CAS Alert is properly monitored and managed	Previous Assurance provided in version 1.2.4		

• any incidents relating to the re-use of PPE are monitored and appropriate action taken	Previous Assurance provided in version 1.2.4		
• adherence to PHE national guidance on the use of PPE is regularly audited	Previous Assurance provided in version 1.2.4		
• hygiene facilities (IPC measures) and messaging are available for all patients/individuals, staff and visitors to minimise COVID-19 transmission such as:	All patients have access to hygiene facilities in patient areas and communal areas; these are regularly monitored and cleaned. All patients receive information as part of appointment letter and text reminder of Covid requirements. Clear signage on entrance to building of requirements	None identified None identified	
• hand hygiene facilities including instructional posters	Previous Assurance provided in version 1.2.4		
• good respiratory hygiene measures	Previous Assurance provided in version 1.2.4		
• maintaining physical distancing of 2 metres wherever possible unless wearing PPE as part of direct care	Previous Assurance provided in version 1.2.4		
• frequent decontamination of equipment and environment in both clinical and non-clinical areas	Previous Assurance provided in version 1.2.4		

• clear advice on use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas	Previous Assurance provided in version 1.2.4		
• staff regularly undertake hand hygiene and observe standard infection control precautions • the use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance • guidance on hand hygiene, including drying should be clearly displayed in all public toilet areas as well as staff areas • staff understand the requirements for uniform laundering where this is not provided for on site • all staff understand the symptoms of COVID-19 and take appropriate action (even if experiencing mild symptoms) in line with PHE national guidance and other if they or a member of their household display any of the symptoms	Previous Assurance provided in version 1.2.4 Previous Assurance provided in version 1.2.4 Previous Assurance provided in version 1.2.4 Previous Assurance provided in version 1.2.4 Previous Assurance provided in version 1.2.4		

• a rapid and continued response through ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals)	DIPC provide IPC team with surveillance rates which includes Covid. CEO and DOO attending regional system meeting during the week and get update on local changes and identify any possible impact on Trust as part of Command and Control meetings Where required any changes are made in response to information gained and in line with regional guidance	None identified None identified None identified	
• positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported. • robust policies and procedures are in place for the identification of and management of outbreaks of infection	All Health Care Associated Infections are dealt with under local policy and procedures which meet notional guidance Any cases of an outbreak are reported as per national guidance and investigations led by DIPC linking in with PHE and NHSE/I Previous Assurance provided in version 1.2.4	None identified None identified	

7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: restricted access between pathways if possible, (depending on size of the facility, prevalence/incidence rate low/high) by other patients/individuals, visitors or staff	Separate entrances into organisation are in place, clear triage and reduction of patients on site for GED, Bedford and Maternity Assessment Unit by use of a triage system	None identified	
	Maternity base have implemented a red zone for which there is a separate entrance, which can be used.	None identified	
	Where possible every effort is made to ensure that positive patients do not cross with negative patients in clinical areas	None identified	

• areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand the different risk areas	Clear floor marking in place with signage All reception desks, shop, cafes and staff restaurant have screens in place.	Side room in use but no other physical barriers in place in clinical areas	None required, physical barriers would hinder clinical care and impact on patient safety **Completed - Signage is in place in clinical areas, audited to provide assurance.**
• patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate	The use of red amber and green zones in in-patient areas	None identified	
• areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance	In areas which are being used to co-hort patients beds have been removed to increase space to 2 meters between beds and chairs	None identified	
• patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	Previous Assurance provided in version 1.2.4		

8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
There are systems and processes in place to ensure:			
10. ensure screens taken on admission given priority and reported within 24hrs	Lab facilities are out sourced to LCL, swab result returns are monitored by weekly Oversight and Scrutiny group. Medial Director has had a number of conversation with LCL in relation to LWH requirements and the need to ensure LWH swabs are prioritised as the same as internal requirements for LUFT	None identified	
11. regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available	As above		
12. testing is undertaken by competent and trained individuals	Trust testing process are run by the clinical Support Division and this is supported by SOPs	None identified	
13. patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance	Previous Assurance provided in version 1.2.4		

14. regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data)	This is in line with national guidance of symptomatic Use of Power BI	None identified	
15. screening for other potential infections takes place	All screening of infections has continued as normal and following local policies and procedures.	None identified	

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that: • staff are supported in adhering to all IPC policies, including those for other alert organisms	This activity continues as per normal practice with full support from DIPC and IPC Team	None identified	
• any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	Previous Assurance provided in version 1.2.4		
• all clinical waste and linen/laundry related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance	Previous Assurance provided in version 1.2.4		
•			

• PPE stock is appropriately stored and accessible to staff who require it	Trust have moved to a dedicated portacabin which is set up as a main stock room and manned by procurement staff whop undertake weekly stock push to wards and departments. Emergency stock supply kept in main hospital for out of hour's access. Additional container storage is on site which feeds the main stock room. Clear stock levels are maintained by procurement staff and daily updates given to command and control meeting	None identified None identified None identified	
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Appropriate systems and processes are in place to ensure: • staff in 'at-risk' groups are identified using an appropriate risk assessment tool and managed appropriately including ensuring their physical and wellbeing is supported	Previous Assurance provided in version 1.2.4		

• that risk assessment(s) is (are) undertaken and documented for any staff members in an at risk or shielding groups, including Black, Asian and Minority Ethnic (BAME) and pregnant staff	The Trust actively assessed all BAME staff and put in place additional support where required.	None identified	
• staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained and held centrally	Previous Assurance provided in version 1.2.4		
• staff who carry out fit test training are trained and competent to do so	All staff carrying our Fit testing has received appropriate training to do so and any one of concern is reviewed by Risk and Patient Safety Manager.	None identified	
• all staff required to wear an FFP respirator have been fit tested for the model being used and this should be repeated each time a different model is used	The Trust has put in place a robust process for this, and all staff has a fit test for the mask they are using and if this changes they are re-fit tested.	None identified	
• a record of the fit test and result is given to and kept by the trainee and centrally within the organisation	A central record is kept by the corporate governance team	None identified	

• for those who fail a fit test, there is a record given to and held by trainee and centrally within the organisation of repeated testing on alternative respirators and hoods	All staff who are fit tested are provided with a copy of their test results and results maintained on control record.	None identified	
• for members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm	All staff who fail a fit test would be referred back to their line manager and if deemed fit the line manager can refer them for a respiratory hood fitting. If this is not appropriate for the role then a discussion on redeployment would be held with HR involvement.	None identified	
• a documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health	Record of discussion are held locally with line manager	Record not held as part of employment record or by Occupational Health	Review holding copy of record centrally and with Occupational Health of discussion with staff re: redeployment **– Ongoing**
• following consideration of reasonable adjustments e.g. respiratory hoods, personal re-usable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal record and Occupational health service record	All staff who fail a fit test would be referred back to their line manager and if deemed fit the line manager can refer them for a respiratory hood fitting. If this is not appropriate for the role then a discussion on redeployment would be held with HR involvement.	Record not held as part of employment record or by Occupational Health	Review holding copy of record centrally and with Occupational Health of discussion with staff re: redeployment - **Ongoing**

• boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board	The Trust has SOP in place and ensures that all staff who require fit testing have this completed. Reporting on fit testing provided to Command and control meeting and to Weekly Oversight and Scrutiny group verbally by Head of Governance and Quality, Trust lead for PPE and fit testing. Output form Oversight and Scrutiny reported to Trust board by CEO and in DOO Covid section of performance report.	Separate PPE report not provided to Trust board included in other reports.	Review need for a separate board report on PPE and fit testing. **Completed – Formal report fortnightly now presented at Oversight and Scrutiny Meeting with verbal updates in between continuing and at Command and control Meetings.**
• consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between planned/elective care pathways and urgent/emergency care pathways as per national guidance	Previous Assurance provided in version 1.2.4	None identified	
• all staff should adhere to national guidance on social distancing (2 metres) if not wearing a facemask and in non-clinical areas	Previous Assurance provided in version 1.2.4		
• health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone	All areas have had a Covid -19 risk assessment completed and where compliant have been issues with a Covid-19 secure certificate. These have been placed on the Trust intranet for all staff to access		

• staff are aware of the need to wear facemask when moving through COVID-19 secure areas.	All staff have been made fully aware via numerous communications and poster of the requirement to use a face masks when moving around. This is reinforced by the executive directors during In the Loop presentation and walk arounds.	None identified	
• staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing • staff who test positive have adequate information and support to aid their recovery and return to work	Update on staff absences are provided to the daily command and Control Meeting and at the Weekly Oversight and Scrutiny meeting Previous Assurance provided in version 1.2.4	None identified	

Agenda Item	20/21/226

MEETING	**Trust Board**
PAPER/REPORT TITLE:	**Performance Report**
DATE OF MEETING:	Thursday, 03 December 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 committee 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 performance for months 7 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

KPI ID	Source	Service ID	Target < or >	Target	Value	Trend	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
Sickness Absence Rate	Owner - Deputy Director of Workforce																	
KPI101T	NHSI	Trust	<=	4.5%	Numerator		2264	2532	2549	2229	3195	3148	2327	2108	2312	2043	2494	3375
					Denominator		39330	40809	40902	38492	41197	39757	41513	40457	41594	40995	39689	41383
					Performance		5.76%	6.21%	6.23%	5.79%	7.75%	7.92%	5.61%	5.21%	5.56%	4.98%	6.28%	8.16%
					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%	6.61%	6.61%	6.61%	6.23%	6.23%	6.23%	5.60%	5.60%	5.60%	8.16%
Mandatory Training Compliance	Owner - Deputy Director of Workforce																	
KPI095T	Quality Strategy	Trust	>=	95.0%	Numerator													
					Denominator													
					Performance		89.00%	91.00%	91.00%	91.00%	91.00%	90.00%	92.00%	92.00%	91.23%	91.00%	89.00%	87.00%
					Trend		▼	▲	▶	▶	▶	▼	▲	▶	▼	▼	▼	▼
					Target %		95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
					Qtrly Performance													

The single month sickness absence figure for month seven increased significantly by 1.88% from 6.28% to 8.16%. Sickness directly attributed to covid 19 again increased significantly from 1.02% in month six to 2.33% in month seven. The HR Department are continuing to provide support for managers in managing sickness absence and in supporting staff through this difficult time. A whole range of support for staff has been developed and communicated to all staff through the regular Coronavirus (COVID-19) staff briefings. Covid 19 Risk assessments have now been put in place for all staff. A coronavirus testing programme is in place for staff with suspected symptoms. The national programme of asymptomatic testing for all frontline staff will be rolled out in the next few weeks. The annual staff flu vaccination programme is also now well underway.

The overall Trust mandatory training compliance rate fell by 2%, from 89% in month six to 87% in month seven. This is now 8% under the Trust's target rate of 95% and rated as amber. In the largest clinical areas, compliance fell by 1% in Gynaecology and by 4% in Maternity, although it remained unchanged in Neonates. At the divisional level, compliance fell by 1% in the Gynaecology Division and by 3% in Family Health but remained unchanged in both Clinical Support Services and the Corporate Division.

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 worldwide Covid 19 pandemic and the current 'second wave' of the virus. In addition to higher sickness absence rates, the large-scale programme of asymptomatic testing both in the Liverpool Region, and for NHS frontline staff, and the return to shielding, will no doubt be factors that will continue to influence levels of mandatory training compliance. However, every endeavour is being made by line managers, with support from the Human Resources and L&D departments, to increase compliance

3. 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	Oct-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	94.2	95.0
	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	100.0	84.0
	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	42.9	52.0
	104d Referral to First Definitive Treatment	Count	0	Zero tolerance	7	2	1	5	2	5	1	1	3	3	1	2	0	2
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	64.4	65.5
	Incomplete Pathway > 52 Weeks	Count	0	Zero tolerance	1	3	5	1	0	0	0	2	5	11	29	32	22	26
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	87.23
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	97.9

Figures in grey are not validated 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 good.

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

Nationally and regionally there continues to be a rise in long waiting patients. The Trust continues to be on plan against recovery trajectory for those patients waiting longer than a year at LWH although it is anticipated this will rise due to challenges of the 2nd wave of Coronavirus.

The Trust continues to see a slow rise in 18-week performance 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.

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

The Trust had 26 52-week breaches for October which was a slight increase from the previous month but within trajectory. The 6-week diagnostic target, as a precursor to an improving 18-week position has seen improvement since the height of the first wave.

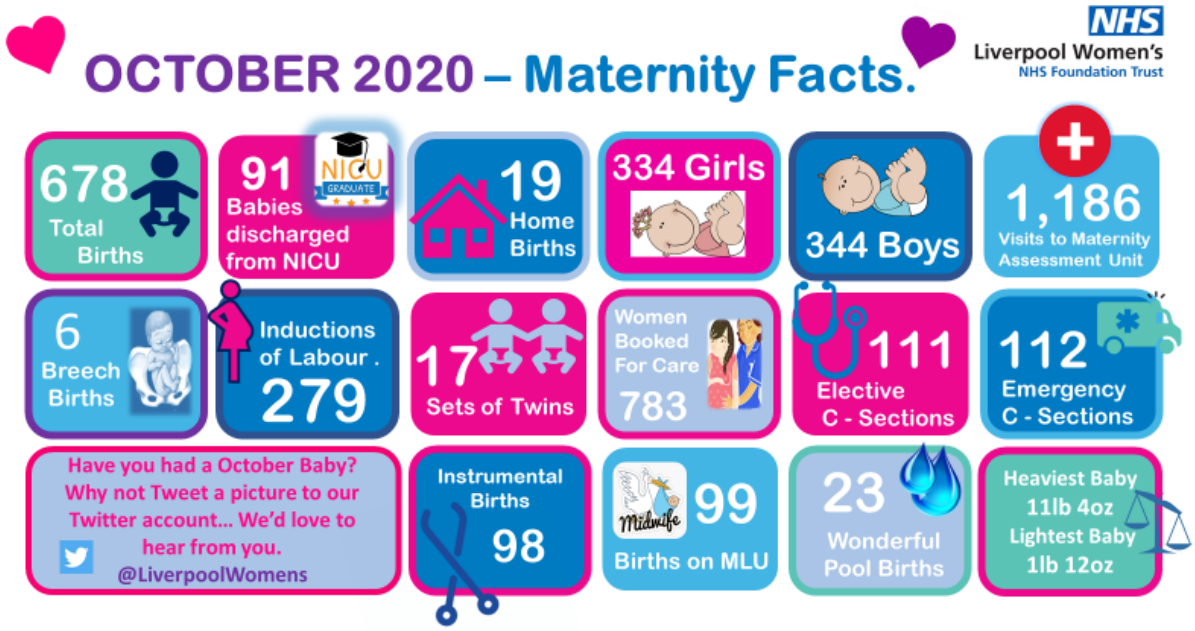
KPI ID	Source	Service ID	Target < or >	Target	Value	Trend	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
Diagnostic Tests: 6 Week Wait			Owner - Divisional Manager Clinical Support															
KPI204	NHSI	Trust	>=	99.0%	Numerator		516	436	464	421	165	35	195	326	332	284	328	328
					Denominator		522	456	481	426	188	127	415	565	555	488	394	376
					Performance		98.85%	95.61%	96.47%	98.83%	87.77%	27.56%	46.99%	57.70%	59.82%	58.20%	83.25%	87.23%
					Trend		▲	▼	▲	▲	▼	▼	▲	▲	▲	▼	▲	▲
					Target %		99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%
					Qtrly Performance		97.59%	97.59%	95.89%	95.89%	95.89%	50.23%	50.23%	50.23%	65.69%	65.69%	65.69%	87.23%

Maternity

The Trust has reviewed our Continuity of Care plans and worked with the North West Regional Maternity Team to develop these further. There is now a plan in place to deliver the standard of 35% in Q1 2021/22, however every effort is being made to accelerate this timescale. The trajectory will be monitored via the Quality Committee.

KPI ID	Source	Service ID	Target < or >	Target	Value	Trend	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-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	42
					Denominator		790	658	892	775	819	816	751	805	807	660	810	785
					Performance		31.65%	31.46%	13.12%	13.68%	17.34%	11.76%	13.45%	9.94%	9.29%	6.82%	8.02%	5.35%
					Trend			▼	▼	▲	▲	▼	▲	▼	▼	▼	▲	▼
					Target %		20%		35%	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%	5.35%

The below graphic illustrates the maternity activity in October 2020



4. 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 - November 2020

Data Included - Up to October 2020

Workforce

KPI ID	Source	Service ID	Target < or >	Target	Value	Trend	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
Sickness Absence Rate	**Owner - Deputy Director of Workforce**																	
KPI101T	NHSI	Trust	<=	4.5%	Numerator		2264	2532	2549	2229	3195	3148	2327	2108	2312	2043	2494	3375
					Denominator		39330	40809	40902	38492	41197	39757	41513	40457	41594	40995	39689	41383
					Performance		5.76%	6.21%	6.23%	5.79%	7.75%	7.92%	5.61%	5.21%	5.56%	4.98%	6.28%	8.16%
					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%	6.61%	6.61%	6.61%	6.23%	6.23%	6.23%	5.60%	5.60%	5.60%	8.16%
Mandatory Training Compliance	**Owner - Deputy Director of Workforce**																	
KPI095T	Quality Strategy	Trust	>=	95.0%	Numerator													
					Denominator													
					Performance		89.00%	91.00%	91.00%	91.00%	91.00%	90.00%	92.00%	92.00%	91.23%	91.00%	89.00%	87.00%
					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	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-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	3

Liverpool Women's NHS Foundation Trust

Safety

KPI ID	Source	Service ID	Target < or >	Target	Value	Trend	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
Never Events	**Owner - Head of Governance**																	
KPI181T	NHSI	Trust	=	0	Performance Value		0	0	0	0	0	0	1	0	0	0	0	0
					Trend		▶	▶	▶	▶	▶	▶	▲	▼	▶	▶	▶	▶
					Target Value		0	0	0	0	0	0	0	0	0	0	0	0
					Qtrly Performance Value		0	0	0	0	0	1	1	1	0	0	0	0
NHSE / NHSI Safety Alerts Outstanding	**Owner - Head of Governance**																	
KPI193	NHSI	Trust	=	0	Performance Value		0	0	0	0	0	0	0	0	0	0	0	0
					Trend		▶	▶	▶	▶	▶	▶	▶	▶	▶	▶	▶	▶
					Target Value		0	0	0	0	0	0	0	0	0	0	0	0
					Qtrly Performance Value		0	0	0	0	0	0	0	0	0	0	0	0
Infection Control: Clostridium Difficile	**Owner - Infection Control Lead**																	
KPI104T	Quality Schedule	Trust		0	Performance Value		0	0	0	0	0	0	0	0	0	0	0	0
					Trend		▶	▶	▶	▶	▶	▶	▶	▶	▶	▶	▶	▶
					Target Value		0	0	0	0	0	0	0	0	0	0	0	0
					Qtrly Performance Value		0	0	0	0	0	0	0	0	0	0	0	0
Infection Control: MRSA	**Owner - Infection Control Lead**																	
KPI105T	Quality Schedule	Trust		0	Performance Value		0	0	0	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	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
Intensive Care Transfers Out	**Owner - Clinical Director Gynaecology**																	
KPI107T	Trust Objectives	Trust			Performance Value		2	1	0	0	0	0	1	2	1	1	3	1
					Trend		▲	▼	▼	▶	▶	▶	▲	▲	▼	▶	▲	
					Target Value													
					Qtrly Performance Value		4	4	0	0	0	3	3	3	5	5	5	1

Liverpool Women's NHS Foundation Trust

Experience

KPI ID	Source	Service ID	Target < or >	Target	Value	Trend	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
18 Week RTT: Incomplete Pathways	**Owner - Divisional Manager Gynaecology**																	
KPI003T	NHSI	Trust	>=	92.0%	Numerator		5224	4971	5187	5152	5149	4657	4217	3443	3550	4428	5264	5120
					Denominator		6243	6061	6283	6349	6476	6476	6584	6549	7204	7799	8177	7877
					Performance		83.68%	82.02%	82.56%	81.15%	79.51%	71.91%	64.05%	52.57%	49.28%	56.78%	64.38%	65.00%
					Trend		▲	▼	▲	▼	▼	▼	▼	▼	▼	▲	▲	▲
					Target %		92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%
					Qtrly Performance		82.95%	82.95%	81.06%	81.06%	81.06%	62.81%	62.81%	62.81%	57.13%	57.13%	57.13%	65.00%
18 Week RTT: Incomplete Pathway > 52 Weeks	**Owner - Divisional Manager Gynaecology**																	
KPI002T	Quality Schedule	Trust	=	0	Performance Value		5	1	0	0	0	2	5	11	29	32	22	25
					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		374	230	192	196	170	123	79	90	118	114	134	143
					Denominator		453	283	290	278	243	137	104	169	217	210	227	243
					Performance		82.56%	81.27%	66.21%	70.50%	69.96%	89.78%	75.96%	53.25%	54.38%	54.29%	59.03%	58.85%
					Trend		▲	▼	▼	▲	▼	▲	▼	▼	▲	▼	▲	▼
					Target %		90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
					Qtrly Performance		79.92%	79.92%	68.80%	68.80%	68.80%	71.22%	71.22%	71.22%	55.96%	55.96%	55.96%	58.85%
18 Week RTT: Non-Admitted Completed Pathways	**Owner - Divisional Manager Gynaecology**																	
KPI004T	Trust Objectives	Trust	>=	95.0%	Numerator		1605	1490	1864	1766	1417	798	659	973	913	1042	1043	1235
					Denominator		1958	1774	2230	2073	1673	898	795	1325	1400	1461	1497	1672
					Performance		81.97%	83.99%	83.59%	85.19%	84.70%	88.86%	82.89%	73.43%	65.21%	71.32%	69.67%	73.86%
					Trend		▼	▲	▼	▲	▼	▲	▼	▼	▼	▲	▼	▲
					Target %		95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
					Qtrly Performance		83.35%	83.35%	84.45%	84.45%	84.45%	80.52%	80.52%	80.52%	68.79%	68.79%	68.79%	73.86%
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		4	4.5	4	4.5	9	6.5	4	5.5	9.5	7.5	3	
					Denominator		8.5	12	9	11.5	13.5	10	11.5	15	12.5	12.5	7	
					Performance		47.06%	37.50%	44.44%	39.13%	66.67%	65.00%	34.78%	36.67%	76.00%	60.00%	42.86%	
					Trend		▲	▼	▲	▼	▲	▼	▼	▲	▲	▼	▼	
					Target %		85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
					Qtrly Performance		34.92%	34.92%	51.47%	51.47%	51.47%	43.84%	43.84%	43.84%	62.50%	62.50%	62.50%	
Cancer: 62 Day Screening Referrals (Numbers)	**Owner - Divisional Manager Gynaecology**																	
KPI033	NHSI	Gynaecology	<=	5	Performance Value		2.0	0.0	1.0	1.0	1.0	1.0	0.5	0.0	2.0	1.0	0.0	
					Trend		►	▼	▲	►	►	►	▼	▼	▲	▼	▼	
					Target Value		5	5	5	5	5	5	5	5	5	5	5	5
					Qtrly Performance Value		4	4	3	3	3	1.5	1.5	1.5	3	3	3	0
Cancer: 62 Day Screening Referrals (Percentage)	**Owner - Divisional Manager Gynaecology**																	
KPI034	NHSI	Gynaecology	>=	90.0%	Numerator		2	0	1	1	1	1	0.5	0	2	1	0	
					Denominator		2	0	1	1	1	1	0.5	0	2	1.5	0	
					Performance		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%	85.71%	85.71%	85.71%	
Cancer: 104 Day Breaches	**Owner - Divisional Manager Gynaecology**																	
KPI352	Trust Objectives	Gynaecology	=	0	Performance Value		1	5	2	5	1	1	3	3	1	2	0	
					Trend		▼	▲	▼	▲	▼	►	▲	►	▼	▲	▼	
					Target Value		0	0	0	0	0	0	0	0	0	0	0	0
					Qtrly Performance Value		8	8	8	8	8	7	7	7	3	3	3	0

Liverpool Women's NHS Foundation Trust

Experience

KPI ID	Source	Service ID	Target < or >	Target	Value	Trend	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
Cancer: 28 Day Faster Diagnosis	**Owner - Divisional Manager Gynaecology**																	
KPI359	Trust Objectives	Gynaecology	>=	75.0%	Numerator		118	116	136	145	167	111	112	165	177	159	186	
					Denominator		249	246	258	253	296	208	134	208	242	225	259	
					Performance		47.39%	47.15%	52.71%	57.31%	56.42%	35.00%	83.58%	79.33%	73.14%	70.67%	71.81%	
					Trend		▼	▼	▲	▲	▼	▼	▲	▼	▼	▼	▲	
					Target %		75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%
					Qtrly Performance		47.58%	47.58%	55.51%	55.51%	55.51%	70.55%	70.55%	70.55%	71.90%	71.90%	71.90%	
Diagnostic Tests: 6 Week Wait	**Owner - Divisional Manager Clinical Support**																	
KPI204	NHSI	Trust	>=	99.0%	Numerator		516	436	464	421	165	35	195	326	332	284	328	328
					Denominator		522	456	481	426	188	127	415	565	555	488	394	376
					Performance		98.85%	95.61%	96.47%	98.83%	87.77%	27.56%	46.99%	57.70%	59.82%	58.20%	83.25%	87.23%
					Trend		▲	▼	▲	▲	▼	▼	▲	▲	▲	▼	▲	▲
					Target %		99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%
					Qtrly Performance		97.59%	97.59%	95.89%	95.89%	95.89%	50.23%	50.23%	50.23%	65.69%	65.69%	65.69%	87.23%
A&E: Total Time Spent in department (95th Percentile)	**Owner - Divisional Manager Gynaecology**																	
KPI012	Trust Objectives	Gynaecology	<=	240	Performance Value		215	210	214	218	222	208	199	213	231	223	232	233
					Trend		▼	▼	▲	▲	▲	▼	▼	▲	▲	▼	▲	▲
					Target Value		240	240	240	240	240	240	240	240	240	240	240	240
					Qtrly Performance Value		646	646	654	654	654	620	620	620	686	686	686	233
Complaints: Number Received	**Owner - Head of Audit, Effectiveness and Patient Experience**																	
KPI038T	NHSI / Quality Strate	Trust	<=	15	Performance Value		4	5	7	4	3	1	6	5	5	2	4	1
					Trend		▼	▲	▲	▼	▼	▼	▲	▼	▶	▼	▲	▼
					Target Value		15	15	15	15	15	15	15	15	15	15	15	15
					Qtrly Performance Value		15	15	14	14	14	12	12	12	11	11	11	1

Liverpool Women's NHS Foundation Trust

Agenda Item	20/21/227

MEETING	**Trust Board**
PAPER/REPORT TITLE:	Finance Performance Review Month 7 2020/21
DATE OF MEETING:	Thursday, 03 December 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):	2. This report will not be published under the Trust's Publication Scheme due to exemptions under S21 of the Freedom of Information Act 2000, because the information contained is reasonably accessible by other means			
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	***The Board is asked to note the Month 7 Financial Position.***			
PREVIOUSLY CONSIDERED BY:	**Committee name**	Finance Performance and Business Development Committee		
	Date of meeting	24/11/20		

Executive Summary

The Trust had produced a breakeven financial plan for 20/21, however operational and financial planning was paused at the onset of the Covid 19 pandemic and replaced with a new temporary financial regime. This financial regime was updated once more from October, with the removal of retrospective top up payments in place for the first half of the year which had allowed the Trust to breakeven in months 1 to 6.

At month 7 the Trust achieved its revised plan of a deficit of £0.7m for the month and year to date (YTD). This is after receipt of system, Covid-19 and growth top up of £0.6m in month.

This leaves the Trust on plan to deliver a revised £4.6m deficit for the year, as submitted to the Cheshire & Merseyside Health and Care Partnership (HCP).

The key areas of financial performance are summarised below.[1] Enhanced reporting has been put in place from Month 7 based on the revised deficit plan.

	Original Plan	Actual	Variance	RAG	*Revised Plan*	*Actuals*	*Variance v Revised Plan*	*RAG re Revised Plan*
Surplus/(Deficit) YTD	-£0.4m	-£0.7m	-£0.3m	↓	*-£0.7m*	*-£0.7m*	*£0.0m*	
Surplus/ (Deficit) FOT	£0.0m	-£4.6m	-£4.6m	↓	*-£4.6m*	*-£4.6m*	*£0.0m*	
NHS I/E Rating	3	3	0	↔	3	3	0	
Cash	£4.6m	£9.2m	£4.6m	↓	*£9.9m*	*£9.2m*	*-£0.8m*	
Total CIP Achievement YTD	£1.7m	£1.1m	-£0.6m	↓	*£0.2m* [2]	*£0.2m* [2]	*£0.0m*	
Recurrent CIP Achievement YTD	£1.7m	£1.0m	-£0.7m	↓	*£0.2m*	*£0.2m*	*£0.0m*	
Capital Spend YTD	£3.1m	£2.4m	-£0.7m		*£3.1m*	*£2.4m*	*-£0.7m*	

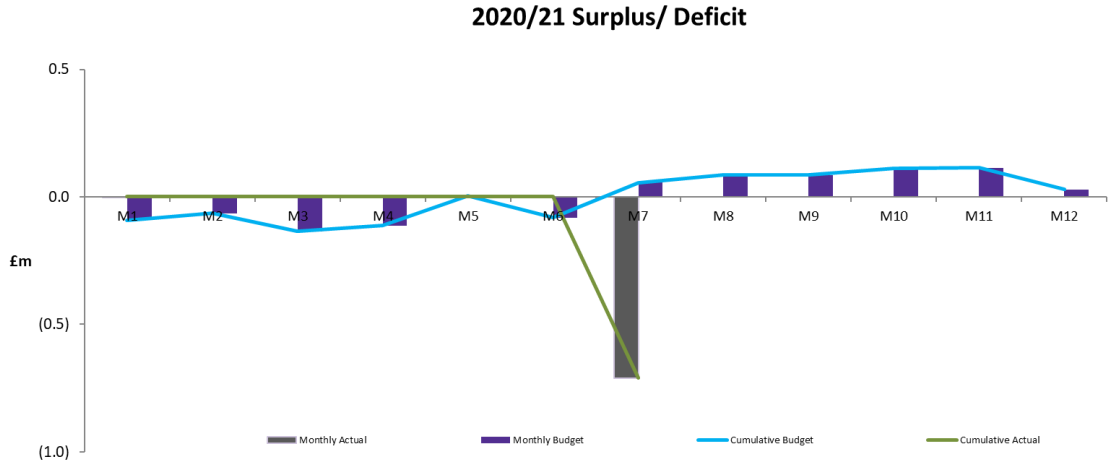
[1] NHS I/E Rating: Red is 4 or 5, Amber 3 and Green 2 or 1. Cash: Red is <£1m, Amber £1m-£4m and Green £4m+. Capital is not RAG rated. All other KPIs: Red is >10% off plan, Amber 0-10% off plan and Green at plan or better. Arrows denote movement from the prior month.

Monitoring will continue both against the Trust's internal plan, which aligns to budgets agreed by the divisions and signed off by the Board, and the revised NHSI/E plan, which is based on the revised forecast submitted to the HCP. Note that internal budgets will rollover into 2021/22 as the starting point for planning. Work continues with the HCP, NHSI/E and commissioners to resolve the income shortfall which is causing the deficit position.

Report

1. Summary Financial Position

At Month 7 the Trust is reporting a deficit of £0.7m, after total combined tops up of £9m YTD. Top up payments have reduced significantly in Month 7, causing the deficit position.



A retrospective top up is no longer paid; this had been on average £1.3m per month to Month 6, plus £99k per month projected top up and £25k MRET (marginal rate emergency rule payment), bringing the total to £1.4m. The total requirement versus amount provided by month and reason, is provided below.

[2] Note that the actual CIP figure shown against the revised plan relates to the achievement in month 7, when monitoring commenced by NHSI. This is measured against the revised forecast submit as part of the revised plan submission.

	M1 £000	M2 £000	M3 £000	M4 £000	M5 £000	M6 £000	M7 £000	YTD £000
Anticipated structural shortfall	780	780	780	780	780	780	780	**5,460**
Private Patient income shortfall	222	253	163	-10	63	-49	-85	**557**
Commercial income shortfall	56	51	49	47	7	55	38	**303**
CIP under delivery	49	50	48	73	73	107	205	**606**
Covid-19 costs	484	409	296	361	221	191	216	**2,178**
Activity related underspends - non pay	-174	-92	-106	-115	-193	-88	92	**-676**
Activity related underspends - pay	-116	-280	-75	-127	-70	10	163	**-496**
Trust settlements					260	109	0	**369**
Other Healthcare Income	42	140	-12	82	88	96	28	**464**
Medical pay award (YTD)						109	18	**127**
Other	-18	-170	16	105	92	340	-86	**279**
Total Retrospective	**1,325**	**1,140**	**1,159**	**1,196**	**1,322**	**1,661**	**1,369**	**9,172**
Projected	99	99	99	99	99	99	0	**592**
MRET	25	25	25	25	25	25	0	**147**
Total Required	**1,448**	**1,263**	**1,282**	**1,319**	**1,445**	**1,784**	**1,369**	**9,911**
Total Provided	**1,448**	**1,263**	**1,282**	**1,319**	**1,445**	**1,784**	**649**	**9,191**
Variance	**0**	**0**	**0**	**0**	**0**	**0**	**-720**	**-720**

The actual top up for Month 7 was £0.6m. The difference is the cause of the deterioration in the Trust's position in month as shown above.

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 (£9k) bringing the year to date (YTD) underspend to £246k. Midwifery spend overall remained static against prior year trend and bank spend remains similar to last month (£53k).

Gynaecology: The division overspent in month (£48k), reducing the YTD underspend to £746k. The in month overspend was largely related to drugs in Hewitt Fertility (£78k overspent), although self-funding income was significantly ahead of plan (£85k favourable) which accounts for some of this. Pay overall was close to plan in month but remains underspent YTD (£542k). This underspend is projected to be reduced by year end with additional medical and agency costs projected.

Activity increased in both Gynaecology directorate and the Hewitt Fertility Centre in month.

Clinical Support Services: The division was overspent in month (£42k), bringing the year underspend to £576k YTD, primarily related to an underspend on medical staffing (£583k) largely related to vacancies in anaesthetics. The in-month overspend was largely related to expenditure on theatre robotics (£61k).

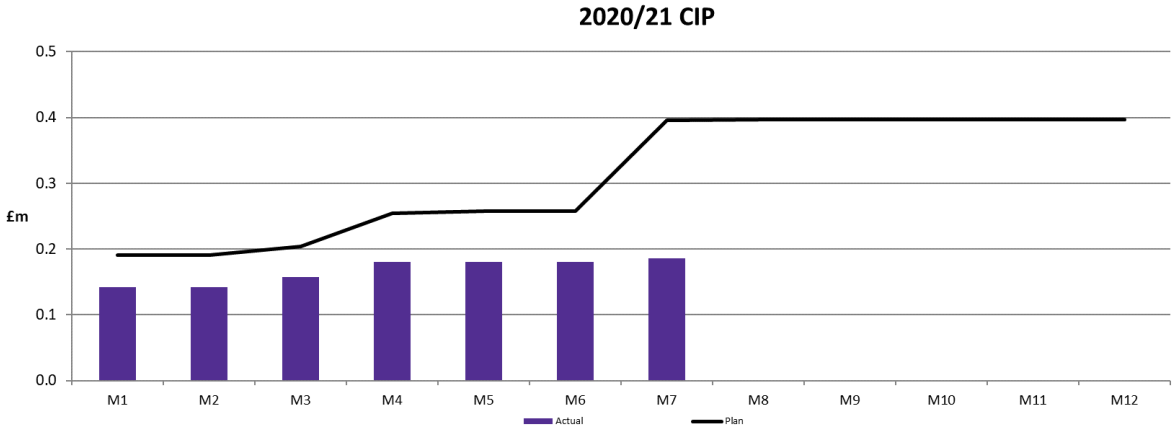
Agency: Total agency spend was £434k YTD, of which £274k was Covid-19 related.

Expenditure forecasts are kept under close review, noting the ever-evolving pandemic situation including offers of mutual aid by the Trust to Cheshire and Mersey partners and the impacts of mass testing. The Trust, along with other NHS organisations, is expected to submit a further forecast for the remainder of 20/21 to NHSI on 4 December 2020.

3. CIP

A revised CIP forecast has been used as the basis for a plan to NHSI/E and is reportable from Month 7 onwards. This is on track at Month 7 (£183k plan and actual delivery).

The Trust will also continue to monitor against the original plan, as shown in the graph below.



4. COVID-19

A total of £216k was spent on Covid-19 related costs in October.

	M1 £000	M2 £000	M3 £000	M4 £000	M5 £000	M6 £000	M7 £000	YTD £000
Bank costs to cover Covid-19 related vacancies	119	62	71	49	19	22	71	**413**
Student Nurses	0	40	49	34	17	0	0	**140**
Agency and WLI costs for medical cover	104	78	46	138	13	1	1	**381**
PPE and equipment (not including centrally purchased	69	24	13	73	61	23	10	**272**
Enhancements paid to staff off sick	58	26	13	19	18	16	31	**182**
Staff meals (after £15k charity contribution)	28	60	0	0	0	0	0	**88**
Other catering and cleaning	32	33	37	15	26	22	30	**195**
Swabbing Service					17	21	22	**61**
Additional corporate costs	9	22	27	18	11	17	24	**129**
Telephony						29	3	**31**
Other	67	62	41	15	39	40	25	**289**
Total	**486**	**408**	**296**	**361**	**221**	**191**	**216**	**2,180**

Costs in this area continue to be carefully monitored.

5. Cash and Borrowings

The cash balance remains strong, at £9.2m. This will be reduced over the coming months as the Trust moves into deficit. However, no additional revenue support is currently assessed to be required in this financial year. A full cashflow projection is given in the appendix. Cash will continue to be carefully monitored.

6. Capital Expenditure

The capital plan is behind plan YTD but a high level of spend is anticipated over the coming months. Divisions were informed that orders had to be placed by the end of October to be included in the expenditure for this financial year to avoid the risk of underspend. This has not happened for all items so some redistribution will be agreed through a reprioritisation exercise. The Trust is also working with the HCP to determine if any additional BAU 'business as usual' capital can be made available for further flexibility for expenditure.

The Trust has now been informed that the £6.5m capital bid to enhance facilities on-site has been approved and progress is underway to begin the enabling estates work and purchase of equipment.

7. Balance Sheet

Older debt continues to be cleared, with a further reduction in aged debt over 60 days of £1.2m, bringing the total over 60 day debt figure down to £2.4m.

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

8. BAF Risk

There are no further changes proposed to BAF risk 2344 (in-year financial position), which stands at 20 (likelihood at 5 – *almost certain* and severity at 4 - *major*).

9. Conclusion & Recommendation

The Trust is facing a deficit plan for the remainder of the financial year despite demonstrating sound grip and control across expenditure. The issues surrounding the adequacy of the income payments will continue to be flagged, particularly in light of the ongoing impact into future years.

The Board are asked to note the Month 7 financial position.

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

FINANCE REPORT: M7

YEAR ENDING 31 MARCH 2021

Contents

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 1
NHS IMPROVEMENT RATIOS: M7
YEAR ENDING 31 MARCH 2021

USE OF RESOURCES RISK RATING	YEAR TO DATE NHSI Plan	YEAR TO DATE Actual
CAPITAL SERVICING CAPACITY (CSC)		
(a) EBITDA + Interest Receivable	3,732	3,721
(b) PDC + Interest Payable + Loans Repaid	1,678	1,677
CSC Ratio = (a) / (b)	**2.22**	**2.22**
NHSI CSC SCORE	**2**	**2**
Ratio Score 1 = > 2.5 2 = 1.75 - 2.5 3 = 1.25 - 1.75 4 = < 1.25		
LIQUIDITY		
(a) Cash for Liquidity Purposes	(12,585)	(11,666)
(b) Expenditure	68,768	68,762
(c) Daily Expenditure	321	321
Liquidity Ratio = (a) / (c)	**(39.2)**	**(36.3)**
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)	707	710
Total Income	(72,500)	(72,483)
I&E Margin	**-0.97%**	**-0.98%**
NHSI I&E MARGIN SCORE	**3**	**3**
Ratio Score 1 = > 1% 2 = 1 - 0% 3 = 0 - (-1%) 4 < (-1%)		
I&E MARGIN VARIANCE FROM PLAN		
I&E Margin (Actual)		-1.00%
I&E Margin (Plan)		-1.00%
I&E Variance Margin	**0.00%**	**0.00%**
NHSI I&E MARGIN VARIANCE SCORE	**1**	**2**
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 year		
AGENCY SPEND		
YTD Providers Cap	1,043	1,043
YTD Agency Expenditure	438	434
	-58%	**-58%**
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

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 2
INCOME & EXPENDITURE: M7
YEAR ENDING 31 MARCH 2021

INCOME & EXPENDITURE	M7 - NHSI Plan			M7 - Internal Budget			YTD - NHSI Plan			YTD - Internal Budget			YEAR - NHSI Plan			YEAR - Internal Budget		
£'000	NHSI Plan	Actual	Variance	Budget	Actual	Variance	NHSI Plan	Actual	Variance	Budget	Actual	Variance	NHSI Plan	Forecast	Variance	Budget	Forecast	Variance
Income																		
Clinical Income	(9,296)	(9,337)	41	(9,379)	(9,337)	(42)	(68,482)	(68,522)	41	(65,461)	(68,522)	3,061	(115,160)	(115,160)	(0)	(112,354)	(115,160)	2,806
Non-Clinical Income	(564)	(506)	(58)	(699)	(506)	(193)	(4,019)	(3,961)	(58)	(4,843)	(3,961)	(881)	(6,840)	(6,840)	0	(8,339)	(6,840)	(1,499)
Total Income	**(9,860)**	**(9,843)**	**(17)**	**(10,078)**	**(9,843)**	**(235)**	**(72,500)**	**(72,483)**	**(17)**	**(70,304)**	**(72,483)**	**2,180**	**(122,000)**	**(122,000)**	**(0)**	**(120,693)**	**(122,000)**	**1,307**
Expenditure																		
Pay Costs	6,256	6,248	7	5,961	6,248	(287)	43,121	43,113	7	41,868	43,113	(1,245)	74,581	74,581	(0)	71,670	74,581	(2,912)
Non-Pay Costs	2,368	2,370	(2)	2,137	2,370	(233)	16,569	16,570	(1)	15,598	16,570	(973)	28,779	28,780	(0)	26,283	28,780	(2,496)
CNST	1,297	1,297	(0)	1,297	1,297	(0)	9,079	9,079	(0)	9,079	9,079	0	15,563	15,563	0	15,563	15,563	0
Total Expenditure	**9,921**	**9,915**	**5**	**9,395**	**9,915**	**(520)**	**68,768**	**68,762**	**6**	**66,544**	**68,762**	**(2,218)**	**118,924**	**118,924**	**(0)**	**113,516**	**118,924**	**(5,408)**
EBITDA	**60**	**72**	**(12)**	**(682)**	**72**	**(755)**	**(3,732)**	**(3,721)**	**(11)**	**(3,759)**	**(3,721)**	**(38)**	**(3,076)**	**(3,076)**	**(1)**	**(7,177)**	**(3,076)**	**(4,101)**
Technical Items																		
Depreciation	451	445	7	446	445	1	3,090	3,083	7	2,980	3,083	(103)	5,324	5,324	0	5,109	5,324	(215)
Interest Payable	5	4	1	43	4	38	31	30	1	285	30	255	56	56	0	488	56	432
Interest Receivable	0	0	0	(4)	0	(4)	0	0	0	(30)	0	(30)	0	0	0	(51)	0	(51)
PDC Dividend	191	191	(0)	142	191	(49)	1,341	1,342	(0)	951	1,342	(391)	2,301	2,301	0	1,630	2,301	(671)
Profit/Loss on Disposal or Transfer Absorption	0	0	0	0	0	0	(14)	(14)	0	0	(14)	14	(14)	(14)	0	0	(14)	14
Total Technical Items	**647**	**640**	**7**	**626**	**640**	**(14)**	**4,448**	**4,441**	**7**	**4,186**	**4,441**	**(254)**	**7,667**	**7,667**	**0**	**7,177**	**7,667**	**(490)**
(Surplus) / Deficit	**708**	**712**	**(5)**	**(56)**	**712**	**(769)**	**716**	**720**	**(4)**	**427**	**720**	**(293)**	**4,591**	**4,591**	**(0)**	**0**	**4,591**	**(4,591)**
Top-up Payments in position																		
Projected Top-Up			*0*	*(99)*		*(99)*	*(594)*	*(594)*	*0*	*(693)*	*(594)*	*(99)*	*(594)*	*(594)*	*0*	*(1,188)*	*(594)*	*(594)*
MRET			*0*	*(25)*		*(25)*	*(147)*	*(147)*	*0*	*(172)*	*(147)*	*(25)*	*(147)*	*(147)*	*0*	*(294)*	*(147)*	*(147)*
Retrospective Top-Up unvalidated M1-M6			*0*			*0*		*(1,851)*	*1,851*		*(1,851)*	*1,851*			*0*			*0*
Retrospective Top-Up validated M1-M6			*0*	*(531)*		*(531)*	*(7,654)*	*(5,803)*	*(1,851)*	*(3,718)*	*(5,803)*	*2,085*	*(7,654)*	*(7,654)*	*0*	*(6,373)*	*(7,654)*	*1,281*
System Top-Up M7-M12	*(307)*	*(307)*	*(0)*		*(307)*	*307*	*(307)*	*(307)*	*0*		*(307)*	*307*	*(1,840)*	*(1,840)*	*0*		*(1,840)*	*1,840*
Growth Top-Up M7-M12	*(62)*	*(62)*	*0*		*(62)*	*62*	*(62)*	*(62)*	*0*		*(62)*	*62*	*(373)*	*(373)*	*0*		*(373)*	*373*
Covid Top-Up M7-M12	*(280)*	*(280)*	*0*		*(280)*	*280*	*(280)*	*(280)*	*0*		*(280)*	*280*	*(1,683)*	*(1,683)*	*0*		*(1,683)*	*1,683*
Total Top-up	***(649)***	***(649)***	***0***	***(655)***	***(649)***	***(6)***	***(9,044)***	***(9,044)***	***0***	***(4,582)***	***(9,044)***	***4,462***	***(12,291)***	***(12,291)***	***0***	***(7,855)***	***(12,291)***	***4,436***
(Surplus)/Deficit excluding Top-up	***1,357***	***1,362***	***(5)***	***599***	***1,362***	***(763)***	***9,760***	***9,764***	***(4)***	***5,009***	***9,764***	***(4,755)***	***16,882***	***16,882***	***(0)***	***7,855***	***16,882***	***(9,027)***

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 3
EXPENDITURE: M7
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	333	(6)	2,291	2,414	(124)	3,927	4,195	(269)
Medical	1,556	1,625	(68)	10,893	10,908	(16)	18,673	19,070	(397)
Nursing & Midwifery	2,633	2,807	(174)	18,531	19,678	(1,147)	31,695	33,972	(2,277)
Healthcare Assistants	424	446	(23)	2,966	3,047	(81)	5,084	5,317	(233)
Other Clinical	376	362	14	2,153	1,948	205	4,517	4,231	287
Admin Support	136	138	(2)	955	934	21	1,637	1,710	(73)
Corporate Services	445	493	(48)	3,155	3,303	(148)	5,375	5,421	(46)
Agency & Locum	63	44	19	926	882	45	761	665	96
Total Pay Costs	**5,961**	**6,248**	**(287)**	**41,868**	**43,113**	**(1,245)**	**71,670**	**74,581**	**(2,912)**
Non Pay Costs									
Clinical Suppplies	623	535	88	1,898	1,777	122	7,502	7,502	0
Non-Clinical Supplies	555	680	(125)	13,964	14,084	(120)	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	360	515	(156)	3,117	4,117	(1,000)	4,915	6,729	(1,814)
Total Non-Pay Costs	**3,434**	**3,667**	**(233)**	**24,676**	**25,649**	**(973)**	**41,847**	**44,343**	**(2,496)**
Total Expenditure	**9,395**	**9,915**	**(520)**	**66,544**	**68,762**	**(2,218)**	**113,516**	**118,924**	**(5,408)**

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	YEAR Budget	YEAR Actual	YEAR Variance
Pay Costs									
Board, Execs & Senior Managers	0	5	(5)	0	32	(32)	0	24	(24)
Medical	0	1	(1)	0	190	(190)	0	219	(219)
Nursing & Midwifery	0	85	(85)	0	680	(680)	0	1,306	(1,306)
Healthcare Assistants	0	30	(30)	0	176	(176)	0	228	(228)
Other Clinical	0	0	(0)	0	3	(3)	0	3	(3)
Admin Support	0	19	(19)	0	34	(34)	0	72	(72)
Corporate Services	0	0	0	0	0	0	0	0	0
Agency & Locum	0	11	(11)	0	274	(274)	0	339	(339)
Total Pay Costs	**0**	**151**	**(151)**	**0**	**1,390**	**(1,390)**	**0**	**2,191**	**(2,191)**
Non Pay Costs									
Clinical Suppplies	0	9	(9)	0	124	(124)	0	196	(196)
Non-Clinical Supplies	0	(151)	151	0	368	(368)	0	503	(503)
CNST	0	0	0	0	0	0	0	0	(0)
Premises & IT Costs	0	207	(207)	0	294	(294)	0	369	(369)
Service Contracts	0	0	0	0	5	(5)	0	100	(100)
Total Non-Pay Costs	**0**	**65**	**(65)**	**0**	**792**	**(792)**	**0**	**1,168**	**(1,168)**
Total Expenditure	**0**	**216**	**(216)**	**0**	**2,181**	**(2,181)**	**0**	**3,360**	**(3,360)**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
BUDGET ANALYSIS: M7
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 - Internal Budget	YEAR - Internal Actual	YEAR - Internal Variance
Maternity									
Income	0	(2)	2	0	(26)	26	0	(46)	46
Expenditure	1,889	1,945	(56)	13,225	13,394	(169)	22,671	23,121	(450)
Total Maternity	**1,889**	**1,943**	**(54)**	**13,225**	**13,368**	**(143)**	**22,671**	**23,075**	**(404)**
Neonatal									
Income	0	(81)	81	0	(539)	539	0	(869)	869
Expenditure	1,127	1,145	(18)	7,887	8,036	(149)	13,520	13,773	(253)
Total Neonatal	**1,127**	**1,064**	**63**	**7,887**	**7,498**	**389**	**13,520**	**12,905**	**615**
Division of Family Health - Total	**3,016**	**3,007**	**9**	**21,112**	**20,866**	**246**	**36,191**	**35,979**	**212**
Gynaecology									
Income	0	0	0	0	0	0	0	0	0
Expenditure	1,033	999	34	7,231	6,961	270	12,397	12,274	123
Total Gynaecology	**1,033**	**999**	**34**	**7,231**	**6,961**	**270**	**12,397**	**12,274**	**123**
Hewitt Centre									
Income	0	0	0	0	(1)	1	0	(1)	1
Expenditure	690	773	(83)	4,848	4,373	475	8,296	8,220	76
Total Hewitt Centre	**690**	**773**	**(83)**	**4,848**	**4,372**	**476**	**8,296**	**8,219**	**77**
Division of Gynaecology - Total	**1,723**	**1,771**	**(48)**	**12,079**	**11,333**	**746**	**20,693**	**20,493**	**200**
Theatres									
Income	0	0	0	0	0	0	0	0	0
Expenditure	712	781	(69)	5,104	4,599	505	8,663	8,322	342
Total Theatres	**712**	**781**	**(69)**	**5,104**	**4,599**	**505**	**8,663**	**8,322**	**342**
Genetics									
Income	0	(12)	12	0	(106)	106	0	(148)	148
Expenditure	151	143	8	1,060	1,007	53	1,816	1,657	159
Total Genetics	**151**	**131**	**20**	**1,060**	**900**	**159**	**1,816**	**1,509**	**307**
Other Clinical Support									
Income	0	0	(0)	0	(0)	0	0	(0)	0
Expenditure	602	596	6	4,327	4,415	(88)	7,338	7,626	(288)
Total Clinical Support	**602**	**596**	**6**	**4,327**	**4,415**	**(88)**	**7,338**	**7,626**	**(288)**
Division of Clinical Support - Total	**1,466**	**1,508**	**(42)**	**10,490**	**9,914**	**576**	**17,817**	**17,456**	**361**
Corporate & Trust Technical Items									
Income	(10,078)	(9,748)	(329)	(70,304)	(71,811)	1,507	(120,693)	(120,935)	242
Expenditure	3,817	4,175	(358)	27,050	30,419	(3,368)	45,992	51,598	(5,606)
Total Corporate	**(6,261)**	**(5,573)**	**(687)**	**(43,253)**	**(41,392)**	**(1,861)**	**(74,701)**	**(69,337)**	**(5,364)**
(Surplus) / Deficit	**(56)**	**712**	**(769)**	**427**	**720**	**(293)**	**0**	**4,591**	**(4,591)**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
BUDGET ANALYSIS: M7
YEAR ENDING 31 MARCH 2021

INCOME & EXPENDITURE	MONTH - NHSI			YEAR TO DATE - NHSI			YEAR - NHSI		
£'000	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Actual	Variance
Maternity									
Income	0	(2)	2	0	(26)	26	0	(46)	46
Expenditure	1,961	1,945	16	13,410	13,394	16	23,137	23,121	16
Total Maternity	**1,961**	**1,943**	**18**	**13,410**	**13,368**	**42**	**23,137**	**23,075**	**63**
Neonatal									
Income	0	(81)	81	0	(539)	539	0	(869)	869
Expenditure	1,143	1,145	(1)	8,035	8,036	(1)	13,772	13,773	(1)
Total Neonatal	**1,143**	**1,064**	**80**	**8,035**	**7,498**	**537**	**13,772**	**12,905**	**867**
Division of Family Health - Total	**3,105**	**3,007**	**98**	**21,445**	**20,866**	**580**	**36,909**	**35,979**	**930**
Gynaecology									
Income	0	0	0	0	0	0	0	0	0
Expenditure	1,033	999	35	6,996	6,961	35	12,207	12,274	(67)
Total Gynaecology	**1,033**	**999**	**35**	**6,996**	**6,961**	**35**	**12,207**	**12,274**	**(67)**
Hewitt Centre									
Income	0	0	0	0	(1)	1	0	(1)	1
Expenditure	718	773	(55)	4,318	4,373	(55)	7,916	8,220	(304)
Total Hewitt Centre	**718**	**773**	**(55)**	**4,318**	**4,372**	**(54)**	**7,916**	**8,219**	**(303)**
Division of Gynaecology - Total	**1,751**	**1,771**	**(20)**	**11,314**	**11,333**	**(19)**	**20,123**	**20,493**	**(370)**
Theatres									
Income	0	0	0	0	0	0	0	0	0
Expenditure	679	781	(102)	4,496	4,599	(102)	7,960	8,322	(362)
Total Theatres	**679**	**781**	**(102)**	**4,496**	**4,599**	**(102)**	**7,960**	**8,322**	**(362)**
Genetics									
Income	0	(12)	12	0	(106)	106	0	(148)	148
Expenditure	132	143	(11)	996	1,007	(11)	1,646	1,657	(11)
Total Genetics	**132**	**131**	**1**	**996**	**900**	**95**	**1,646**	**1,509**	**137**
Other Clinical Support									
Income	0	0	(0)	0	(0)	0	0	(0)	0
Expenditure	626	596	30	4,445	4,415	30	7,721	7,626	96
Total Clinical Support	**626**	**596**	**30**	**4,445**	**4,415**	**30**	**7,721**	**7,626**	**96**
Division of Clinical Support - Total	**1,437**	**1,508**	**(71)**	**9,936**	**9,914**	**23**	**17,327**	**17,456**	**(129)**
Corporate & Trust Technical Items									
Income	(9,860)	(9,748)	(112)	(72,500)	(71,811)	(689)	(122,000)	(120,935)	(1,065)
Expenditure	4,276	4,175	101	30,520	30,419	101	52,231	51,598	633
Total Corporate	**(5,585)**	**(5,573)**	**(11)**	**(41,980)**	**(41,392)**	**(588)**	**(69,768)**	**(69,337)**	**(431)**
(Surplus) / Deficit	**708**	**712**	**(5)**	**716**	**720**	**(4)**	**4,591**	**4,591**	**(0)**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
CIP: M7
YEAR ENDING 31 MARCH 2021

SCHEME NAME	MONTH 7			YTD			Full Year		
	Original Target	Actual	Variance	Original Target	Actual	Variance	Original Target	Revised FOT	Variance
Procurement Savings	83	0	(83)	83	0	(83)	500	0	(500)
Contract Savings	38	38	0	266	266	0	456	456	0
Corporate savings	32	32	0	201	197	(3)	358	358	0
Maternity Skillmix	21	21	0	146	146	0	250	250	0
Bank Usage	17	17	0	117	117	0	200	200	0
Physiotherapy Productivity	14	0	(14)	99	0	(99)	169	0	(169)
IM&T Enabled Savings	13	0	(13)	88	0	(88)	150	0	(150)
Commissioning Changes	11	11	0	79	79	0	135	135	0
Rental Income	10	10	0	67	67	0	115	115	0
Estate Utilisation	11	0	(11)	44	0	(44)	100	0	(100)
HFC Strategic Review	25	13	(13)	69	18	(51)	195	90	(105)
Theatre Efficiency and Surgical Pathways Project	17	0	(17)	17	0	(17)	100	0	(100)
Full SLA review	11	11	0	44	44	0	100	100	0
TOPS Pathway	11	0	(11)	44	0	(44)	100	0	(100)
Theatre procurement Savings	10	10	0	50	50	0	100	50	(50)
Imaging Recharges	6	6	0	41	41	0	70	70	0
Imaging rota review	5	5	0	35	35	0	60	60	0
Pharmacy Ordering	4	4	0	14	14	0	32	32	0
Other Smaller Schemes	54	10	(43)	243	66	(177)	537	141	(396)
	391	**186**	**(205)**	**1,746**	**1,139**	**(607)**	**3,728**	**2,058**	**(1,669)**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 7
BALANCE SHEET: M7
YEAR ENDING 31 MARCH 2021

BALANCE SHEET £'000	YEAR TO DATE Opening	M07 Actual	Movement	YEAR TO DATE NHSI Plan	M07 Actual	Movement	YEAR TO DATE Internal Budget	M07 Actual	Movement
Non Current Assets	**92,282**	**91,517**	(765)	**92,457**	**91,517**	(940)	**93,179**	**91,517**	(1,662)
Current Assets									
Cash	4,647	9,185	4,538	9,943	9,185	(758)	4,600	9,185	4,585
Debtors	6,329	7,552	1,223	5,573	7,552	1,979	8,916	7,552	(1,364)
Inventories	432	401	(31)	432	401	(31)	452	401	(51)
Total Current Assets	**11,408**	**17,138**	**5,730**	**15,948**	**17,138**	**1,190**	**13,968**	**17,138**	**3,170**
Liabilities									
Creditors due < 1 year - Capital Payables	(2,809)	(850)	1,959	(953)	(850)	103	(266)	(850)	(584)
Creditors due < 1 year - Trade Payables	(15,314)	(13,321)	1,993	(13,481)	(13,321)	160	(18,359)	(13,321)	5,038
Creditors due < 1 year - Deferred Income	(2,918)	(12,513)	(9,595)	(11,924)	(12,513)	(589)	(3,471)	(12,513)	(9,042)
Creditors due > 1 year - Deferred Income	(1,623)	(1,605)	18	(1,623)	(1,605)	18	(1,597)	(1,605)	(8)
Loans	(17,359)	(2,442)	14,917	(2,442)	(2,442)	0	(17,117)	(2,442)	14,675
Provisions	(1,698)	(1,644)	54	(1,698)	(1,644)	54	(4,870)	(1,644)	3,226
Total Liabilities	**(41,721)**	**(32,375)**	**9,346**	**(32,121)**	**(32,375)**	**(254)**	**(45,680)**	**(32,375)**	**13,305**
TOTAL ASSETS EMPLOYED	**61,969**	**76,280**	**14,311**	**76,284**	**76,280**	**(4)**	**61,467**	**76,280**	**14,813**
Taxpayers Equity									
PDC	42,519	57,550	15,031	57,550	57,550	0	42,488	57,550	15,062
Revaluation Reserve	14,329	14,329	0	14,329	14,329	0	14,503	14,329	(174)
Retained Earnings	5,121	4,401	(720)	4,405	4,401	(4)	4,476	4,401	(75)
TOTAL TAXPAYERS EQUITY	**61,969**	**76,280**	**14,311**	**76,284**	**76,280**	**(4)**	**61,467**	**76,280**	**14,813**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 8
CASHFLOW STATEMENT: M7
YEAR ENDING 31 MARCH 2021

CASHFLOW STATEMENT	YEAR TO DATE		
£'000	NHSI Plan	Actual	Variance
Cash flows from operating activities	642	638	4
Depreciation and amortisation	3,089	3,083	6
Impairments and reversals	0	0	0
Income recognised in respect of capital donations (cash and non-cash)	0	0	0
Movement in working capital	6,920	5,034	1,886
Net cash generated from / (used in) operations	**10,651**	**8,755**	**1,896**
Interest received	0	0	0
Purchase of property, plant and equipment and intangible assets	(5,455)	(4,317)	(1,138)
Proceeds from sales of property, plant and equipment and intangible assets	14	14	0
Net cash generated from/(used in) investing activities	**(5,441)**	**(4,303)**	**(1,138)**
PDC Capital Programme Funding - received	428	428	0
PDC Funding received (Loans to PDC Conversion)	14,572	14,572	0
PDC COVID-19 Capital Funding - received	31	31	0
Loans from Department of Health Capital - repaid	(306)	(306)	0
Loans from Department of Health Capital - repaid (Loans to PDC Conversion)	(14,572)	(14,572)	0
Loans from Department of Health Revenue - received	0	0	0
Loans from Department of Health Revenue - repaid	0	0	0
Interest paid	(67)	(67)	0
PDC dividend (paid)/refunded	0	0	0
Net cash generated from/(used in) financing activities	**86**	**86**	**0**
Increase/(decrease) in cash and cash equivalents	**5,296**	**4,538**	**758**
Cash and cash equivalents at start of period	4,647	4,647	0
Cash and cash equivalents at end of period	**9,943**	**9,185**	**758**

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

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST **9**
CAPITAL EXPENDITURE: M7
YEAR ENDING 31 MARCH 2021

CAPITAL EXPENDITURE	Year to Date		
£'000	NHSI Plan	Actual	Variance
Neonatal New Building	1,159	709	450
Estates Schemes	155	238	(83)
IT Schemes	1,014	1,043	(29)
Medical Equipment	735	328	407
Critical Infrastructure Risk - PDC Funded	0	10	(10)
COVID-19 Items - PDC Funded	0	31	(31)
Total	**3,063**	**2,359**	**704**

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.

Liverpool Women's NHS Foundation Trust

Agenda Item	20/21/228

MEETING	**Trust Board**
PAPER/REPORT TITLE:	**HFEA Inspection Progress**
DATE OF MEETING:	Thursday, 03 December 2020
ACTION REQUIRED	**Assurance**
EXECUTIVE DIRECTOR:	Andrew Loughney, Medical Director
AUTHOR(S):	Dr Rachel Gregoire - Scientific Director & HFEA Person Responsible
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: **HFE Act (1990, 2008) compliance. HFEA treatment and storage licence renewal**
FREEDOM OF INFORMATION (FOIA):	3. This report will not be published under the Trust's Publication Scheme due to exemptions under S22 of the Freedom of Information Act 2000, because the information contained is intended for future publication	
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	***The Board is asked to note the 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

The HFEA inspect the Trust every four years ahead of renewing a licence. This report outlines the findings from the previous inspection (and progress against the findings), the preparation being undertaken for the lead in to upcoming inspection, the key areas of focus contained within the inspection and the Trust's current position against these, with any areas of challenge outlined.

Report

Introduction

The Human Fertilisation and Embryology Authority (HFEA) licence all fertility services in the UK who offer licensed fertility treatments and storage of eggs, sperm and embryos, under the Human Fertilisation and Embryology Act (1990, 2008). Each HFEA licensed clinic must be inspected every four years for their licence to be renewed and to continue to offer licensed treatments and storage. Two years into the licensed period an interim inspection must also take place.

The Hewitt Fertility Centre on Crown Street site (centre 0007) will be inspected to renew their HFEA licence in the next 12 months. The inspection was expected before October 2020 but due to COVID-19 restrictions the licensed period was extended until October 2021. Historically the HFEA issue a Self-Assessment Questionnaire (SAQ) 8 weeks prior to an inspection. This was issued and returned to the HFEA on 19th August 2020. Subsequently the HFEA issued guidance on future inspections due to COVID restrictions, and confirmed that imminent future inspections will be desk-based assessments with a one day onsite inspection following a 12 week notice period. This will allow evidence to be shared ahead of the inspection. The 12 week notice period has not yet been issued.

What does the HFEA look at during an inspection?

During a licence renewal inspection the HFEA will look at key areas of the service:

1. Compliance against the HFEA Code of Practice

All HFEA licensed clinics must provide fertility services compliant with the HFEA Code of Practice. There are 33 'Guidance Notes' within the Code of Practice which cover 'General Directions' and 'Licence Conditions' set by the HFEA. The Hewitt Centre will need to provide evidence of compliance at the inspection.

2. Medicines Management and Infection Control

The Care Quality Commission (CQC) and HFEA have what is known as a 'Memorandum of Understanding' in that the CQC do not inspect HFEA licensed clinics. Instead, the areas of healthcare routinely inspected by the CQC are covered by the HFEA when they inspect. This means the Hewitt Centre will be inspected on areas such as Medicines Management and Infection Control.

3. Clinical governance

The HFEA will look at how the Hewitt Centre manages incidents reported within the service but also those reported within the sector nationally and how they mitigate any risks highlighted within the service. They will also look at patient and staff feedback and how the Hewitt Centre responds to this. The HFEA will also consider non-compliances raised in previous inspections and lessons learned.

4. Current areas of interest for the HFEA

    a. The HFEA will want to consider our response to the COVID-19 pandemic and how we keep our patients and staff safe.
    b. With the End of the Transition Period approaching on the 31st December 2020, the HFEA will focus on our strategy for meeting any challenges caused by UK exit from the EU.

What the Hewitt Centre is doing to prepare for the inspection:

1. Compliance against the HFEA Code of Practice

We are auditing our processes and documentation against each of the 33 Guidance Notes within the Code of Practice. Every Licence Condition and General Direction is being checked to ensure the Hewitt Centre complies. Any findings are actioned before the audit can be closed.

- **Progress:**

9/33 audits have been closed once evidence of compliance with all aspects of the Code of Practice has been reviewed by the HFEA Person Responsible (PR).
11 more audits have been completed and are awaiting final review of the evidence by the PR before closing.
13 audits are underway and expected to be ready for review by the PR by end January 2021.

- **Identified risks/challenges:**

No risks or challenges highlighted in the 9 audits closed.
Due to the growth of donor conception treatment, the clinical processes for donation and surrogacy pathways are currently under review to ensure adequate support is given to provide these often complex treatments. This means that audits in these areas may take longer than expected to complete while the pathways are reviewed. It will therefore be challenging to complete and review the four audits against areas of the Code of Practice related to donation and surrogacy prior to inspection.

2. Medicines Management and Infection Control

- **Progress: medicines management**

HFC follow the Trusts audit process of a medicine audit being conducted on a twice weekly basis and a peer Matron audit once monthly.

Fridge temperatures and drugs cupboards are checked on a daily basis and signed off by the Ward Manager/ Matron on a weekly basis. Any discrepancies are reported via Ulysses (Trust incident reporting system) and actioned accordingly.

Monitoring is also conducted via the QSUS accreditation system.
A safe and secure audit is monitored on a quarterly basis alongside Pharmacy.
Medicine Management mandatory training is monitored closely via Power BI and local records.

- **Identified risks/challenges: medicines management**

A CD book audit has highlighted missing data (e.g. time of administration) and confirming new page numbers from bottom of one page to the top of the next page. An email has been sent to the Anaesthetist department highlighting the need for times to be entered into the CD book and a form has been constructed for the nurse in charge to check the book before the anaesthetist and ODP leave the department.

A matrix (Medication Prescribing/ administration assessment tool) has been constructed and will be trialled for any drug errors (this is taking into account that patients self -administer the majority of drugs used at the Hewitt centre)

- **Progress: Infection control**

Infection Control is monitored via the NICERS system and reports are accessible.
Mandatory training is monitored closely via Power BI.
Matrons 'SHINE' round is being reintroduced.
Daily decontamination records are available in each clinical area to provide assurance.
Monitoring is also conducted via QSUS accreditation scheme around infection prevention and control.

- **Identified risks/challenges: infection control**
  None

3. Clinical governance

a. Incident reporting and management

The Hewitt Centre has audited their incident reporting pathway to ensure compliance against the HFEA Code of Practice and no risks were identified. One finding of the audit highlighted that the Standard Operating Procedure (SOP) for incident reporting needed more detail to include HFEA scoring and Trust scoring of adverse events. The SOP also needed detail adding for the recall of products from clinical use if identified as involved in an adverse event (HFEA Licence Condition T122). The Hewitt Centre are active 'over-reporters' to ensure the HFEA is aware of incidents however small.

- **Progress:**
  Complete

- **Identified risks/challenges:**
  None

b. National trends for incident reporting and non-compliance

HFEA Clinical Governance update 2020 highlights the most common incidents reported to the HFEA from licensed clinics within the UK and the most common areas of non-compliance found at HFEA inspections in the previous 12 months. The Clinical Governance update has been reviewed by the HFEA PR and is used as part of every HFEA compliance audit to ensure to ensure compliance against the Code of Practice.

- **Progress:**
  Ongoing as HFEA compliance audits continue

- **Identified risks/challenges:**
  None

c. Non compliance in previous inspections

Licence inspection 14.06.2016:		Area of non-compliance
Critical area of non-compliance	1	Egg donor screening
Major area of non-compliance	2	QMS audits: counselling audit findings and actions not complet QMS audits: donor recruitment audit not done QMS audits: egg/embryo donation process not audited
	3	SLA for SSR premises not in place
	4	Sperm pots and pipettes not CE marked
	5	Incidents not reported to the HFEA
	6	CD discrepancies
	7	Late submission of data to HFEA

Other areas of non-compliance	8	CD drug book
	9	Validation of O/R pumps
Interim inspection 12.06.2018		Area of non-compliance
Critical area of non-compliance	0	
Major area of non-compliance	1	Success rates: ICSI
	2	Medicines management: CD book
Other areas of non-compliance	3	Screening: Ebola
	4	Website: LBR
	5	Infection control: boxes on floor
	6	Staff - lone working policy

All areas of non-compliance in both inspections were actioned and closed by previous HFEA Person Responsible (2016 full inspection) and current HFEA Person Responsible (2018 interim inspection).

- **Progress:**
  Complete

- **Identified risks/challenges:**
  None

4. Current areas of interest for the HFEA

    a. COVID-19 response

In May 2020 the Hewitt Centre submitted a 'Treatment Commencement self-assessment' to the HFEA to formally request to recommence fertility services following closure of services in March 2020 in compliance with General Direction 0014 version 1 (instructing all fertility services to stop providing treatment). The Hewitt Centre has a COVID-19 treatment strategy to keep staff and patients safe. The strategy outlines modified practice to allow services to continue safely and is reviewed and amended as guidelines change. No changes to the strategy have been needed as the Merseyside area moved to Tier 3 to national lockdown and back to Tier 2 as the Hewitt Centre is confident with the processes already in place. The Hewitt Centre continues to operate at 75% clinical capacity to ensure reduced footfall and continue to closely manage waiting times for treatment (currently 4-8 weeks).

- **Progress:**
  Complete

- **Identified risks/challenges:**
  None

b. End of Transition Period

The HFEA are seeking assurance that fertility services have considered the potential impact of the End of the Transition Period on 31st December 2019. The Hewitt Centre has risk assessed against the following areas:

- Workforce
- R&D
- Supply chain (consumables, gases, equipment and medicines, donor sperm)

The Hewitt Centre submitted their evidence of preparation to the HFEA on 20th November 2020.

- **Progress:**
  Complete

- **Identified risks/challenges:**
  None

Recommendation

The Board is asked to note the report for information and assurance.

Agenda Item	20/21/229

MEETING	**Trust Board Meeting**
PAPER/REPORT TITLE:	**Board Assurance Framework**
DATE OF MEETING:	Thursday, 03 December 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	October and November 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 risks 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 the following updates have been made.

- **2266 - Condition: Ineffective understanding and learning following significant events. Risk** reviewed by Medical Director and Head of Governance, the MIAA audit of Lesson Learnt from Incidents has commenced following a delay due to Covid-19 work being undertaken by MIAA. No change in risk score at this time.

- **2337 - Condition: The Trusts current clinical records system (paper and Electronic) are sub-optimal -** Review completed by CIO, actions updated and 3 actions closed.

- **2335 - Condition: Major and sustained failure of essential IT systems due to a cyber-attack -** Risk reviewed by CIO, no change in risk score. Current high level of Covid-19 related cyber threats / scams.

- **2340 - Overarching Covid-19 Trust Risk Version 4** - Risk under review by executive directors: additional areas of consideration are: Mutual Aid, Vaccine Development and roll out, Asymptomatic testing and Brexit Incident Response. No other changes required at this time.

- **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, FPBD approved increase in likelihood score to 5 from 4 increasing risk score to 20. This was due to the deficit plan for 2nd half of 2020/21 based on central income allocations.

The remaining risk did not have and changes made to them and the risk score remains the same.

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 Trust Board of the process and outcomes from Trust 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: November 2020

Please refer to appendix 1

2. Sub-Committee Changes to Risks

Since the last report to the Trust 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

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 the escalation of risk 2295 - Condition: Inability to achieve and maintain regulatory compliance, performance and assurance, has been discussed at the Corporate Risk Committee on the 25th November 2020 and accepted onto the Corporate Risk Register.

5. Conclusions

The report reflects the active review of BAF Risks by the Trust 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 November 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, No changes.
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 Workforce and Marketing and Head of Governance and Quality. No changes to the risk at this time.

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 Deputy Director of Workforce and Marketing and Head of Governance and Quality. No changes to the risk at this time.
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.

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	
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	Review completed by ICO, actions updated and 3 actions closed.
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	Risk reviewed by ICO, no change in risk score. Current high level of covid-19 related cyber threats / scams

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	
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 under review by executive directors: additional areas of consideration are: Mutual Aid, Vaccine Development and roll out, Asymptomatic testing and Brexit Incident Response. No other changes required at this time.
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, FPBD approved increase in likelihood score 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:** 17/11/2020 08:49:08

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:** 16/12/2020

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:** 10/11/2020 **Reviewed By:** Christopher Lube

Risk reviewed by Director of Finance and Head of Governance and Quality, No changes.

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 ----------	Ongoing	/ /

					Put back due to Covid-19 pandemic. Date Entered : 28/04/2020 14:05 Entered By : Eva Horgan ---------- Timescale TBC - requirements to be confirmed, subject to outcome of bid. Date Entered : 09/08/2019 14:18 Entered By : Christopher Lube		
11	Merger 1 - Agree in principle to proceed to merger	13/02/2020	30/03/2021	Eva Horgan	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 Date Entered : 28/04/2020 14:05 Entered By : Eva Horgan	Ongoing	/ /
12	Merger 2 - Establish Merger Project (internal group)	01/04/2020	30/03/2021	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.	Ongoing	/ /

					Date Entered : 08/10/2020 14:54 Entered By : Christopher Lube ---------- On hold due to Covid-19 pandemic. Date Entered : 28/04/2020 14:04 Entered By : Eva Horgan		
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	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. Date Entered : 28/04/2020 14:03 Entered By : Eva Horgan	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	External Strategic work on hold during pandemic. Date Entered : 08/10/2020 14:55 Entered By : Christopher Lube	Ongoing	/ /
27	Business Case 5 - Approval for funding from NHSI/E based on refreshed SOC	01/08/2022	31/10/2022	Eva Horgan		Ongoing	/ /

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

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

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

Listing For: 4. BAF | **Risk Register Level:** 4. BAF | **Directorate:** Governance | **Service / Department:** Governance | **Position at:** 17/11/2020 08:49:08

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:** 16/12/2020

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:** 12/11/2020 **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 ----------	Completed	01/07/2020

					Upgrades commencing to be rolled out to staff, review and close march 2020. Date Entered : 04/03/2020 13:23 Entered By : Christopher Lube ---------- Updates to the Ulysses system have been completed and a plan is in place to roll out by 1st Feb 2020. Some final testing to be completed and training. Date Entered : 11/01/2020 10:40 Entered By : Christopher Lube ---------- The Upgrade of the Ulysses system is progressing. A slight delay was encountered due to the 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	Ongoing	/ /

					Gov Comm. Date Entered : 03/10/2019 16:38 Entered By : Christopher Lube ---------- Update Received from Dr Hurst as to current position of Simulation Tranining. See Document section for further detail. Date Entered : 14/08/2019 14:19 Entered By : Elaine Eccles ---------- Initial paper presented to Ed Gov and Safety Senate, acting Medical Director requested further information Date Entered : 31/07/2019 11:01 Entered By : Christopher Lube			
7	New risk management and patient safety training package to be developed	01/04/2019	28/02/2021	Christopher Lube	Awaitng national syllubus to be published Date Entered : 16/11/2020 13:25 Entered By : 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	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	28/02/2021	Christopher Lube	2019-20. Date Entered : 31/07/2019 11:00 Entered By : Christopher Lube Audit delayed due to MIAA urgent work. Aduit recommenced Bov 2020. Date Entered : 16/11/2020 13:26 Entered By : 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:** 17/11/2020 08:49:08

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:** 16/12/2020

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:** 11/11/2020 **Reviewed By:** Christopher Lube

Risk reviewed by Deputy Director of Workforce and Marketing and Head of Governance and Quality. No changes to the risk at this time.

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	Ongoing	/ /

					Entered By : Christopher Lube --- 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:** 17/11/2020 08:49:08

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:** 16/12/2020

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:** 12/11/2020 **Reviewed By:** Christopher Lube

Risk reviewed by Deputy Director of Workforce and Marketing and Head of Governance and Quality. No changes to the risk at this time.

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 &	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

	vulnerable staff including BAME, Pregnant workers, 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	01/12/2020	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	Completed	12/11/2020

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 October respectively Date Entered : 08/10/2020 15:23 Entered By : Christopher Lube	Completed	15/06/2020
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:** Executive Office | **Position at:** 17/11/2020 08:49:08

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:** 16/12/2020

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:** 09/11/2020 **Reviewed By:** Christopher Lube

Risk reviewed by the Head of Strategy and 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	Ongoing	/ /

4	Divisional plans to be developed to support long term clinical sustainability via operational plan	01/04/2019	07/12/2020	Jennifer Huyton	Date Entered : 09/08/2019 13:41 Entered By : Christopher Lube 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	Ongoing	/ /

5	Outcomes from the clinical summit to be actioned.	27/09/2019	30/12/2020	Jennifer Huyton	Date Entered : 09/08/2019 13:46 Entered By : Christopher Lube 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 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.	Ongoing	/ /

					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.	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	Date Entered : 06/04/2020 12:06 Entered By : 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	Ongoing	/ /

					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 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	Ongoing	/ /	

					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.		
11	External review/testing of counterfactual case	01/04/2020	31/12/2020	Jennifer Huyton	Date Entered : 06/04/2020 12:03 Entered By : 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:** 17/11/2020 08:49:08

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:** 16/12/2020

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:** 03/11/2020 **Reviewed By:** Matt Connor

Risk reviewed by ICO, no change in risk score. Current high level of covid-19 related cyber threats / scams

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 ----------	Ongoing	/ /

3	Implement a Cyber Security strategy	01/04/2020	31/01/2021	Matt Connor	New network equipment has been delivered, configured and some of it racked. Part of the new network 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	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:** 17/11/2020 08:49:08

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:** 16/12/2020

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:** 03/11/2020 **Reviewed By:** Matt Connor

Review completed by ICO, actions updated and 3 actions closed.

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	03/11/2020
3	Develop staff communication plan for new system	24/03/2020	31/12/2020	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	Completed	03/11/2020

					Date Entered : 29/09/2020 11:27 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	Completed	30/09/2020

					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 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	Sample 360 ordering reviewed at DHSC and decision supported to focus this delivery within the Meditech Expanse project to avoid Trust staff fatigue Date Entered : 03/11/2020 10:51 Entered By : Matt Connor	No Further Action	03/11/2020
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:** 17/11/2020 08:49:09

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:** 16/12/2020

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:** 10/11/2020 **Reviewed By:** Christopher Lube

Risk under review by executive directors: additional areas of consideration are: Mutual Aid, Vaccine Development and roll out, Asymptomatic testing and Brexit Incident Response. No other changes required at this time.

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 Entered By : Christopher Lube			
5	Work with partners such as Liverpool University to develop alternative means to maintain the supply of PPE	01/04/2020	/ /	Christopher Lube	Full process in place with includes Co-operation and mutual aid with partner organisations cross Cheshire and Merseyside. Monitored via Covid Oversight and Scrutiny meeting weekly. Date Entered : 16/11/2020 13:43 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		Completed	02/11/2020
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:** 17/11/2020 08:49:09

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:** 16/12/2020

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:** 10/11/2020 **Reviewed By:** Christopher Lube

Risk reviewed by the Director of Finance and Head of Governance and Quality, FPBD approved increase in likelihood score 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	5 Almost	20

Target Assessment		
Severity	Likelihood	Risk Score
4 Major	2 Unlikely	8

Liverpool Women's NHS Foundation Trust

Agenda Item	20/21/231

MEETING	**Trust Board**
PAPER/REPORT TITLE:	**Leadership & Talent Strategic Framework**
DATE OF MEETING:	3 December 2020
ACTION REQUIRED	**For approval**
EXECUTIVE DIRECTOR:	Michelle Turner, Chief People Officer
AUTHOR(S):	Jeanette Chalk, Head of Talent & Culture
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 requested to approve the leadership & talent framework.***			
PREVIOUSLY CONSIDERED BY:	**Committee name**	Putting People First Committee		
	Date of meeting	23 November 2020		

Executive Summary

The purpose of this paper is to seek approval for the leadership and talent strategic framework. The draft was considered by the Putting People First Committee on the 23rd November 2020 with a recommendation for approval to the Board.

Report

The attached document seeks to provide the framework within which a key ambition defined within the LWH Putting People First Strategy will be delivered, namely *"To invest in the identification and development of emerging and existing leaders, and ensure that they are well equipped to care for their staff so their staff can care for patients and their families".*

The guiding principle underpinning this Framework is the recognition that, within the context of the unprecedented challenges being faced by the NHS at large, and the Trust's own clinical strategy 'Future Generations', which clearly sets out the vision for Liverpool Women's services for the future, there is a real need to invest in the Trust's current and future leaders, wherever they are within the organisation. Our leaders must be appropriately equipped and supported to successfully deliver the organisation's vision and strategic objectives, whilst also promoting and role-modelling the LWH values – Engage; Ambition; Care; Learn; Respect.

Conclusion

The outcomes associated with the successful implementation of the Framework will be manifested in different ways, at an organisation and an individual level, and across a range of stakeholder groups. Ultimately, the development of the organisation's leadership capacity and capability, which is rooted in a commitment to deliver collective and compassionate leadership, will benefit our patients, service users and staff.

Recommendations

The Board is requested to approve the leadership & talent framework.

Leadership & Talent – A Strategic Framework

Contents

1. Introduction

1.1 This document seeks to provide the framework within which a key ambition defined within the LWH Putting People First Strategy will be delivered, namely ***"To invest in the identification and development of emerging and existing leaders, and ensure that they are well equipped to care for their staff so their staff can care for patients and their families".***

1.2 The Putting People First (PPF) Strategy further identifies that the Trust will:

- Develop a Leadership Strategy which promotes collective, compassionate and visionary leadership.
- Develop our talent mapping processes – ensuring that through effective appraisal discussions talent and aspiration is identified and nurtured to ensure a pipeline of Liverpool Women's leaders in all areas and disciplines.
- Develop a multi-disciplinary Leadership Forum to aid self-development, peer support and networking across the organisation and across the system. This will include buddying and mentoring for new leaders and facilitated connections to wider networks including the National Leadership Academy.
- Develop and roll out a Coaching & Mentoring Programme with a mixture of formal coaching training, coaching behaviours and team coaching; and a focus on growing an internal cohort of mentors.
- Ensure that newly appointed line managers have access to support, training, development and mentoring for the first 12 months in the form of a personalised programme.

The guiding principle underpinning this Framework is the recognition that, within the context of the unprecedented challenges being faced by the NHS at large, and the Trust's own clinical strategy 'Future Generations', which clearly sets out the vision for Liverpool Women's services for the future, there is a real need to invest in the Trust's current and future leaders, wherever they are within the organisation. Our leaders must be appropriately equipped and supported to successfully deliver the organisation's vision and strategic objectives, whilst also promoting and role-modelling the LWH values – Engage; Ambition; Care; Learn; Respect.

1.3 The Trust's future approach to leadership and talent development recognises that traditional "command and control" models of leadership are no longer appropriate in the context of the aims set out within the PPF strategy, that is, to develop collective and compassionate leadership.

To achieve its aims, the Trust requires leadership practices which are based in inclusivity, influence and authenticity, rather than authority; and shared ownership, rather the responsibility vested in the few.
To lead the organisation forward the individuals are needed who are capable of:

- Creating a compelling vision and taking people with them;
- Leading across boundaries;
- Utilising high levels of emotional intelligence in order to influence through a shared mission or goal;
- Being in the present, but also horizon scanning;
- Promoting and developing distributed leadership (ie. leadership at all levels, not just at the "top");
- Embracing diversity, innovation and being open to alternative views;
- Demonstrating and promoting compassion for self and others, with a focus on improvement and accountability;
- Developing and getting the best from their teams – ensuring any barriers to development are removed so every colleague has the opportunity to fulfil their potential.
- Leading by example, demonstrating the application of fair & just methodologies at all times.

In doing so, our current and future leaders need to recognise talent all around.

1.4 Whilst everyone requires personal and professional development in one form or another, certain individuals will stand out as demonstrating high levels of talent (with talent being defined as being the product of current performance and potential). In order to benefit from this latent resource, the organisation must have mechanisms in place which both recognise talent and support individuals in achieving their potential in a systematic and timely way. Effective talent and career development is necessary for the sustained motivation and retention of employees, no matter what their level in the organisation, and must be a key leadership consideration.

1.5 It is recognised that, through the development and promotion of desired leadership qualities, the Trust must capitalise upon its strengths, progress opportunities to create a value-based fair & just culture and environment. The role of coaching and mentioning within such an environment and in the development of "authentic" leadership capability is considered within the context of establishing a "coaching culture".

Whilst it is correct to state that a true coaching culture should become 'part of the way we do things around here', it is equally important to note that a coaching culture is about delivering results, improving performance and making the most of people's potential. It's NOT about having coaching conversations for their own sake.

Our aims in developing a coaching culture can be outlined as:

- Senior leaders with a clear vision that coaching and mentoring are at the heart of how we operate.
- Managers looking for opportunities to help others to learn.
- Employees at all levels having open, honest and supportive conversations with one another - routinely giving one another feedback, both supportive and critical
- Managers coaching team members to help them develop, rather than just to tackle poor performance
- A pragmatic focus on delivering results and at the same time building the long-term capability of the organisation.

1.6 The outcomes associated with the successful implementation of the Framework will be manifested in different ways, at an organisation and an individual level, and across a range of stakeholder groups. Ultimately, the development of the organisation's leadership capacity and capability, which is rooted in a commitment to deliver collective and compassionate leadership, will benefit our patients, service users and staff.

2. Aims & Priorities

2.1 The overall aim of this Leadership and Talent Development Strategic Framework is to set the direction and establish a means by which the Trust will attract, identify, develop and retain leadership capability of the highest quality.

It is recognised that leadership which is shared, distributive and adaptive will underpin the Trust's ambition to deliver the best possible patient care and experience, delivered within a culture of kindness and compassion, with fairness at its heart.

2.2 In setting the direction, four priority areas have been defined:

Leadership Talent for Today – Developing our leadership teams to advance our strategic aims and to effectively lead the delivery of our corporate objectives - growing the specific management and leadership skills needed to implement effective ways of working;

Leadership Talent for Tomorrow – Building diverse future leadership pipelines, with appropriately developed people with the right values – internal succession and external acquisition;

Changing our Culture – Challenging our existing behaviours – culture change is required to ensure all of our leaders display kind and compassionate leadership and make decisions which are grounded in fair & just methodology. Authenticity and transparency will become the norm;

Equality, Diversity & Inclusion - Ensuring equal opportunity for development, career progression and promotion, removing barriers and engaging effectively with all colleagues; Ensuring barriers to diversity in recruitment are removed;

3. Our Approach to Future Leadership Development

To effect change across the priority areas noted above, and to develop robust processes and means of achieving the wider aims within this Framework, the Trust's approach to the future provision of leadership and talent development will focus on four key areas, as outlined below.

Progress in each of these areas will drive improvement in overall leadership capacity and capability, together with increased engagement and therefore patient care. The ongoing Fair & Just Culture programme will be woven in to all aspects of leadership performance and will feature in a variety of ways in the further development of this Framework.

Talent Acquisition	Developing our Capability	Performance Culture	Engaging Hearts & Minds
• Attract & retain the best people. • Develop a system/ approach for identifying & deploying the right people into the right jobs. • Actively seek diverse candidate pools for vacant leadership roles, ensuring selection processes encourage applicants from under represented groups.	• Develop our leaders to perform at their best – driving improvements in competence, skill and experience. • Develop a collaborative approach with other organisations to support leader development through secondment or project opportunities.	• Drive performance in the "how" as well as the "what". • Develop a culture of performance excellence through coaching and feedback. • Focus on the ability to identify and prioritise opportunities to improve the delivery of excellent patient care.	• Create a multi-disciplinary leadership forum to promote connectivity across the leadership population. • Develop a culture of transparent, 2-way communication & collaboration – ensuring accessibility & visibility of our leadership population.

3.1 Talent Acquisition

A variety of interlinked activities will be developed and undertaken to ensure we are able to deliver an effective approach to talent acquisition. These include:

- ***Workforce planning*** – the approach to workforce planning will be broadened to not only consider the numbers of people required to provide safe services, but to particularly focus on any skills gap in relation to current and future leadership capability. Furthermore, active planning for increasing the diversity of our workforce will become part of this process.
- ***External resourcing*** – diversity of candidate pools will be improved with job adverts reviewed to ensure the wording encourages applicants from under-represented groups. Selection processes will be continually reviewed to ensure shortlisting activities are inclusive and transparent. Values based recruitment will support our Fair & Just culture programme and ensure that those recruited into leadership positions will have the capability to lead by example in that environment.
- ***Internal resourcing*** – the introduction of annual talent management processes will support the identification of high performing individuals, ensuring that talent is spotted and developed at every level.
- ***Develop internal development roles/secondments*** – the talent management process will also have an active focus on the identification and creation of development roles/secondments, providing real opportunity to stretch and develop emerging leadership capability across the organisation. We will aim to develop a reputation for "being brilliant" at developing talent.
- ***Succession planning*** – critical roles and skills gaps will be identified and a succession planning process will be introduced to identify current and future leaders to fill those roles. Succession planning will form part of the overall approach to talent management and will be reviewed annually.
- ***Diversity and inclusion*** – all processes will be reviewed, and barriers identified and removed to ensure that all roles, secondments and development opportunities are open and accessible for all.

3.2 Developing Our Capability

- ***Leadership Programme*** – the LWH Leadership Programme will be refreshed - incorporating elements of NHS leadership development coupled with modules which bridge local skill gaps and/or organisational development needs. 360 degree development will become a standard part of the programme.

Additional elements of development and support will be offered to new leaders, including access to a mentor for the first 12 months in role.

- ***Individual Development Plans*** – IDP's will be introduced for our leadership population, capturing individual development needs which will support career aspirations, and potentially address skills gaps.
- ***Career conversations*** – a programme of career conversations will be developed and introduced, separate to the PDR process, but supporting the introduction of the IDP's.
- ***Collaboration*** - opportunities will be identified to forge partnerships with other local Trusts to develop a wider leadership cohort with a view to creating broader development opportunities within the region. Starting small and developing our reputation.

3.3 Performance Culture

- ***Behavioural Framework*** - a behavioural framework will be introduced across the Trust, which will allow leaders (and other colleagues) to be challenged and developed in "how" they perform and achieve their objectives, rather than just on "what" they do/achieve. This framework will support the embedding of the fair & just methodology into the everyday "how we do things around here". It is important to note that our Values will remain central to the behaviours expected and encouraged through the framework.
- ***Managing Performance*** – The PDR process will be refreshed for the leadership population, moving the emphasis on to the quality of the conversation, and not the paperwork. A "PDR Window" will be introduced to support the talent management/succession processes, and ensure development opportunities can be considered for high performers across all areas at the same time – ensuring equitable access.
- ***Coaching & Mentoring*** –Developing and embedding a coaching and mentoring network. Interventions will directly contribute to the development of an organisational culture that enables leaders to support teams to be motivated to deliver excellent healthcare, every time.
- ***Quality Improvement*** – an output of the Leadership Forum (detailed below) will be the introduction of "Quality Improvement Cells" where leaders will come together to drive improvement or resolve issues – across boundaries.

  This approach will be utilised to consolidate and embed learning and, where possible, those attending the Leadership Programme will:

  - Be required to undertake a service/quality improvement project within their own work area, or

- Be linked into a project in a different area, for example, undertaking a service improvement project outside of their own work area.

3.4 Engaging Hearts & Minds

- ***Leadership Forum*** – a key aim within the PPF Strategy, a multi-disciplinary Leadership Forum will be introduced which will afford the opportunity to align the leadership population by bringing all leaders together in one large group so that everyone hears and develops one message. An opportunity to "set the tone".

  It is envisaged that two or three Forums will be held each year, with the first one being in March, allowing the Board to share the organisational strategy, annual corporate objectives and set the expectations for the leadership populate for the year ahead. Additional Forums in the year will allow progress to be shared but also allow opportunities to invite external experts to share best practice etc.

- ***Strategic Input & Collaboration*** – An essential aspect of leadership development is the ability to contribute in a participative way to strategy development. It is envisaged that the Leadership Forum will also support this by integrating it within corporate planning process - the leadership population will be invited to give input/review/develop the corporate strategy– thereby enabling the sharing of a common understanding with their teams.

4. Building Effective Leaders

4.1 Leadership Programme

The Leadership Programme is currently being re-developed to support the developing Strategic Framework and will incorporate a number of facets required for building an effective leader.

More active use will be made of the leadership programmes available through the National Leadership Academy, where appropriate including the Edward Jenner, Mary Seacole, Rosalind Franklin, Elizabeth Garrett Anderson and Nye Bevan programmes. All of the Leadership Academy programmes are currently under review centrally and so further review of content and appropriateness will be undertaken when they are re-launched.

Alongside the Leadership Academy development programmes, the Leadership Programme will also seek to develop specific professional development routes, such as enhancing leadership skills within the clinical and medical professions.

The information shown on the following page demonstrates all of the building blocks that will be developed to form the overall leadership development offering for the Trust.

Some elements, such as mandatory training, are, of course, mandatory at every level. Other aspects, such as the generic management training will add individual and bespoke options to the identified pathways at all levels:

Building Effective Leaders

Generic Management Training	Coaching Conversations Workshop	Performance Management	Maintaining Positive Pressure	Communication Styles / Difficult Conversations	Finance for Non-Finance Managers	Time Management	Other as driven by annual TNA

ADDITIONAL OPTIONS FOR ALL

New Leaders (Band 6 / Above)	**Month 1 to 3** – Management Induction; Allocation of Mentor for Year 1	**Month 4 to 6** – First 100 day check in; Set interim objectives	**Month 7 to 9** – Initial career conversation	**Month 10 to 12** – 360 Assessment; Career Conversation; Individual Development Plan

ADDITIONAL OPTIONS FOR NEW LEADERS

Senior Leaders (Band 8c / Above)	360 Degree Assessment	Career Conversation & IDP	LWH Leadership Programme – Level 2 and/or Shadow Board	Accredited Programme/ Apprenticeship – eg. Nye Bevan Programme	Fair & Just Leader Programme	Individual Mentor or Coach	Member of the Leadership Forum
Middle Manager (Band 8a-8b)	360 Degree Assessment	Career Conversation & IDP	LWH Leadership Programme – Level 1	Accredited Programme/ Apprenticeship – eg. Elizabeth Garnett Anderson Programme	Fair & Just People Mgr Course	Individual Mentor or Coach	Member of the Leadership Forum
First Line Manager (Band 6-7)	360 Degree Assessment	Career Conversation & IDP	Self-Directed Learning – access to optional OLM eLearning packages & short courses	Accredited Programme/ Apprenticeship – eg. Mary Seacole Programme	Fair & Just People Mgr Course	Individual Mentor	Member of the Leadership Forum

MANDATORY FOR ALL

Mandatory Training	Core	Core Clinical (where appropriate)	Local

4.2 Fair & Just Culture Training

A key element of the F&J Culture Programme is the creation and implementation of appropriate training and awareness across the Trust. It will become essential training for all leaders, at two levels.

Both elements of training will be supplemented with locally driven activities such as focus groups and books clubs.

For Bands 8c and above it is expected that the ***Just Culture Certification*** training is successfully completed, at which point he/she will be designated as a Fair & Just Leader.

Details of this eight week programme, via e-learning, are shown below:

Just Culture Certification – via e-Learning
Phase 1 - weeks 1-3

- Two hours of introductory video learning. Presented by David Marx, the discussion will allow participants to appreciate Just Culture as model and methodology.
- Four hours of interactive, online learning. Participants begin with 16 self-paced, interactive introductory chapters that conclude with a 25-question test. Participants will finish this computer-assisted learning with a working vocabulary of Just Culture concepts and be ready to join the application and scenario-based learning in Phase 2.

Phase 2 - weeks 4-8

- Participants will join in five weekly one-hour, interactive, webinar-enabled sessions with The Just Culture Company's Advisor and a real-time peer group. Each session includes case-based scenarios, advanced strategies for conducting and using Threshold Investigations, and practice applying the Just Culture Algorithm.
- Each session concludes with an at-home assignment, designed to help participants assess and apply the Just Culture system to norms in our workplace. At-home assignments are estimated to require 40 minutes per week to complete.
- At the conclusion of Phase 2, participants are eligible to sit for the Just Culture Certification Exam. Individuals who pass the Just Culture Certification Exam may designate themselves as a Certified Just Culture Champion and for the Trust will be designated as a Fair & Just Leader.

allalllevels:

F&

First line managers ***(Band 6-7)*** and middle managers ***(Band 8a and 8b)*** will be expected to undertake the ***Just Culture Online Training for Managers***.

Just Culture Online Training for Managers

This online course contains the following 16 chapters and will take approximately four hours to complete, followed by an exam.

1. Introduction
2. Missions and Values
3. Duties, aspirations, and Expectations
4. The Five Behaviours
5. Role modelling, Mentoring, and Coaching
6. Severity Bias and the Role of Disciplinary Sanction
7. System Design
8. Learning
9. Introduction to the Three Duties and the Just Culture Algorithm
10. The Duty to Avoid Causing Unjustifiable Risk or Harm
11. The Duty to Follow Procedural Rules
12. The Duty to Produce Outcomes
13. Repetitive Human Errors
14. Repetitive At-Risk Behaviours
15. The Body of Work – Performance Evaluation
16. Mercy, Grave, and Forgiveness

The 25-question final exam requires a passing score. Passing the exam in this course with a score of 80% or better will provide participants with a certificate of completion.

5. What will success look like?

5.1 The successful implementation of the programmes and initiatives proposed within the Strategic Framework will be manifest on a number of levels and across a range of measures. Ultimately, improved leadership capacity and capability combined with the effective identification and support of talent, at every level of the organisation, will improve the staff experience (and thereby aid recruitment and retention) and have a direct and positive impact on patient care – these are the main drivers for investing leadership and talent development overall.

5.2 Broadly, at both an organisational and an individual level demonstrable evidence of success will include the following:

- A clear understanding of the leadership skills and behaviours needed to deliver organisational success and embed “collective, compassionate and visionary” in the provision of the highest standards of patient care;
- A growing leadership “community” which is recognised and appropriately supported (and which is self-sustaining);
- A greater level of devolved accountability and decision-making;
- Confident and authentic leavers, at every level, who are recognised as demonstrating and promoting the Trust’s core values;
- Improved multi-disciplinary team working;
- Improvement performance against patient experience metrics;
- Lower staff turnover rates;
- Continued improvement in performance against the range of staff engagement measures associated with the annual staff survey;
- Better quality candidates (both internal and external) applying for key roles within the Trust;
- Talent development and succession planning are recognised as being an essential part of effective day to day people management, and talent discussions included within the PDR process;
- The essential principles of coaching and mentoring are understood by leaders and applied to routine interactions with team members;
- A clear path for career progression and personal development for existing and future leaders is established and understood.

Agenda Item	**20/21/232**

MEETING	**Trust Board**
PAPER/REPORT TITLE:	**Lessons Learnt from Mortality Q2**
DATE OF MEETING:	Monday, 23 November 2020
ACTION REQUIRED	**Assurance**
EXECUTIVE DIRECTOR:	Andrew Loughney, Medical Director
AUTHOR(S):	Devender Roberts, Deputy Medical Director, Allan Hawksey, Risk and Patient Safety Manager, Louise Robertson, Consultant Obstetrician, Rebecca Kettle, Consultant Neonatologist
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):	3. This report will not be published under the Trust's Publication Scheme due to exemptions under S22 of the Freedom of Information Act 2000, because the information contained is intended for future publication	
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	The Board is asked to review the contents of the paper and take assurance that there is adequate process in place for learning from deaths.	
PREVIOUSLY CONSIDERED BY:	**Committee name**	Not Applicable
	Date of meeting	

Executive Summary

This is the 2020/21 Quarter 2 (Q2) learning from deaths report for the Trust.
There are processes in place for review in all three types of death at the Trust. Unlike other Trusts, **every** death in the Trust, including expected adult deaths, are reviewed.

Key areas the report addresses:

- All adult deaths, stillbirths & neonatal deaths have a mortality review conducted.
- No in-hospital or LeDeR related adult deaths occurred in Q2 of 2020/21.
- The Q2 stillbirth rate of 4.1/1000 (3.9/1000 excluding fetal abnormalities) is lower than reported in Q1.
- No cases were identified where care was adversely affected by COVID 19 related restrictions and/or amended guidance or due to mothers delaying accessing maternity healthcare
- The Neonatal mortality rate has spiked in Q2 but this is due to the high number of babies with cardiac abnormalities and in-utero transfers in this quarter.
- The overall standard of care in stillbirth and neonatal deaths was good.
- The Trust demonstrates a high level of learning from mortality reviews. Themes are identified and action plans in place to address issues that arise.

Learning from deaths 2020/21

Strategic context

Learning from the care provided to patients who die is a key part of clinical governance and quality improvement work (CQC 2016). In February 2017 the CQC set out new requirements for the investigation of deaths to run alongside the local existing processes. The National Quality Board has subsequently provided further guidance and recommendations for learning from deaths entitled 'National Guidance for Learning from Deaths – A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care'.

A quarterly Adult and Perinatal Mortality report is presented to the Quality Committee as a core requirement of the National Guidance for Learning from Deaths. This report is the 20/21 Q2 Board assurance report regarding compliance with review process and learning from deaths. **It is set within the context of the Coronavirus Covid-19 pandemic.**

Local context

The number of adult deaths in the Trust is low. Deaths are usually expected, end of life care related. Due to the low level of mortality numbers encountered and the complexity of the patients cared for by the Trust, adult mortality data is presented as pure data, not standardised mortality such as SHMI.

The use of pure data and not standardised mortality rates has been previously agreed with the CCG as the Trust's approach to monitoring adult mortality rates.
Stillbirths and neonatal mortality rates are reported in absolute numbers and /1000 births. Stillbirths are reported as overall rate and rate excluding terminations. Neonatal deaths are reported as overall rate and rate for in-booked babies.

Table 1. Overall mortality rate in the Trust 2020/21

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	TOTAL
ADULT	0	0	0	0	0	0							0
Obstetrics													
Gynaecology (Oncology)	0	0	0	0	1	1							0
Gynaecology (non-Oncology)	0	0	0	0	0	0							0
STILLBIRTHS													
Total stillbirths	1	5	4	2	3	1							16
Stillbirths (excl.terminations)	1	5	4	2	2	1							15
Births	597	582	639	658	677	681							3829
Overall Rate per 1000 births	1.67	8.59	4.27	3.0	4.1	1.5							4.1
Rate (excluding TOP) per 1000	1.67	8.59	4.27	3.0	3.0	1.5							3.9
NEONATAL MORTALITY	3	0	4	9	3	9							7
Total Mortality													
Deliveries	597	582	639	658	677	681							3829
Mortality Rate per 1000 Deliveries	5.1	0	6.3	13.6	4.4	13.2							7.4
Mortality for LWH in-booked babies	1	0	3	6	1	3							4

Mortality rate per 1000 LWH in-booked babies	1.7	0	4.7	9.1	1.5	4.4							3.7

1. ADULT DEATHS:

The Trust's policy for analysis after an adult death relies upon the following activities:

- Gathering detailed intelligence on all individual instances of adult mortality in the Trust
- Identifying local issues arising from each of those events individually
- Exploring themes that may be emerging from groups of events

Adult deaths - Mortality reviews Q2		
	Maternity (Direct)	**Gynaecology**
No of Adult Deaths	0	2
No of Mortality Reviews completed	0	2
No of deaths requiring RCA's	0	0
No of deaths due to deficiencies in care	0	0
Mortality Themes	N/A	N/A
Progress v Smart Plans	N/A	N/A
Mortality Outcomes	N/A	N/A
Measures for ongoing scrutiny	N/A	N/A

No care issues were identified in the 2 end of life deaths in Q2.

Out of hospital adult deaths 2020/21

Out of hospital deaths in Maternity are considered as Community deaths and not allocated to the Trust. The Trust does however, review care provided in all these cases to determine any thematic points for learning.

GYNAECOLOGY

There were no out of hospital Gynaecological deaths in Q2.

MATERNITY

The maternal death of suspected suicide at 10 weeks reported in Q1 is currently being investigated by HM Coroner. The Trust has commenced a review but had not provided any care for this lady immediately prior to her death.

There were no reported out of hospital maternal deaths related to women who died within 12 months of delivering a baby at LWH in Q2.

LEARNING FROM ADULT DEATHS

Due to the low level of adult death within the Trust, this report seeks to gain triangulation from the work of the Safety and Effectiveness Senates in reducing the risk of mortality. This is shown in Appendix 1.

2. PERINATAL DEATHS

All Perinatal deaths in the Trust are subject to review using the Perinatal Mortality Review Tool. The tool grades care as shown in the table below.

Table 2: MBRRACE - UK Care Grading

Care Grade	Description
Grade A	No improvements in care identified
Grade B	Improvements in care identified that would not have changed the outcome
Grade C	Improvements in care identified that **may** have changed the outcome
Grade D	Improvements in care provided that **would** have changed the outcome

Any cases graded D are automatically reported as a Serious Incident and added to StEIS. A root cause analysis, (RCA), investigation is completed, and the family are informed of the findings.

Stillbirth reviews and Key Themes

Table 3. Grading of antenatal care for babies in Q2 2020-21

Grade	Care in antenatal period
A	**3**
B	**1**
C	**0**
D	**0**
UNK	**1**

There were no cases graded C or D in this quarter. There were no cases identified where care was adversely affected by COVID 19 related restrictions and/or amended guidance or due to mothers delaying accessing maternity healthcare in relation to COVID 19 changes – see Appendix 2.

Table 4. Details of the deaths for this period and consequent actions taken

Gestation	Cause of death	Issues	Actions
25 weeks	Fetal Vascular malperfusion	No issues identified	NA
25 weeks	SGA no placental pathology	No Issues identified	NA
26 weeks	Placental abruption	No 16 or 25 week CMW appointment. Ability to book follow up CMW appointments at the booking visit – not currently possible	Discuss with Deputy HOM ability to do this with new K2 system
36 weeks	Cord accident with associated fetal vascular mal-perfusion	No issues identified	NA
30 weeks	PM outstanding	To be reviewed	To be reviewed

Actions taken to address the findings for Q2

Deputy HOM has confirmed that booking follow up CMW appointments at booking will not be possible with the new K2 system at present due to the primary care appointment booking systems.

Progress on previous actions

- SOP for management of thrombocytosis has been completed
- Covid policies for growth scans have been reviewed and were compliant with national guidance.
- Criteria for midwife referral to Consultant led clinic will be reviewed with the implementation of the new K2 system
- A service evaluation to ensure the service is meeting the needs of non-English speaking women with particular reference to interpreter services and communication is currently paused due to Covid-19.
- The RFM guideline is being updated to a timeframe for CTG when reduced fetal movements are reported as an inpatient.
- NEST team leader is linking with other specialist midwifery teams to evaluate language barrier solutions and present these findings at Maternity Risk meeting in December 2020. This will tie in with the overall action plan for improving the perinatal journey of non-English speaking and other vulnerable women.

Neonatal reviews and key themes Q2

The data provided in Table 1. refers to LWH NICU in-hospital mortality before discharge.

There have been a higher than usual number of deaths in July (9) and September (9) giving an overall rate of 7.4/1000 compared to 3.9/1000 in Q1 (see Table 1). No clear themes have been identified on initial review. All deaths will be reviewed through the PMRT process however at this point it is not possible to comment further as not all deaths have been reviewed to date.

Out of hospital neonatal deaths Q2 2020/21

Some babies who are born and / or cared for in NICU are subsequently transferred to Alder Hey for ongoing management. If a baby dies after transfer to AH the case is reviewed through the AH mortality review process by the hospital mortality review group with neonatal input from the LWHNSFT. If a baby is transferred to hospice for end of life care the case is reviewed through the LWH PMRT process. Table 5. shows the detail of these babies.

Table 5: Mortality after discharge from NICU

	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20
Alder Hey Children's Hospital	1 (non-LWH booked)	1 (non-LWH booked	1 (LWH booked)			1 (LWH booked)
Hospice				1 (LWH booked)	1 (non-LWH booked)	
Repatriation to booking hospital			1			
Home						

All deaths after transfer to Alder Hey in Q1 have been reviewed through AH HMRG (hospital mortality review group). All were prenatally known to have congenital cardiac anomalies. No specific neonatal issues were identified at AH mortality review.

In Q2, three babies died after transfer to a different care setting. One to Alder Hey with a prenatal diagnosis of congenital cardiac anomaly; two babies died after transfer to hospice for end of life care - One with severe hypoxic ischaemic encephalopathy and one baby born preterm with an inoperable cardiac anomaly.

Neonatal mortality is highly dependent on gestation at birth. See table 6 for mortality by gestation for all babies including the out of hospital deaths (n=24)

Table 6: All mortality by gestation Q2 20/21

	LWH booked mortality	Non-LWH booked mortality	All mortality
Extremely preterm (<28 weeks)	8	5	**13**
Very preterm (28-32 weeks)	1	2	**3**

Moderate preterm (32-37 weeks)	0	5 (including 1 unbooked)	**5**
Term (>37 weeks)	3	0	**3**

The highest mortality group are the extremely premature babies. Of the 8 deaths in the moderate preterm and term babies, six had congenital anomalies and two were due to hypoxic ischaemic encephalopathy.

Table 7 details the primary cause of death as stated on the death certificate. Overall for Q2 the highest group were congenital anomalies (9/24). One case this quarter was referred to the coroner and has been ruled as a natural cause of death with underlying congenital anomaly.

Table 7: All mortality by cause Q2 20/21

	LWH Booked	**In-utero transfers (non-LWH booked)**	**Ex-utero transfers (non-LWH booked)**	**Unbooked**	**Total**
Prematurity	5		2		**7**
Infection	2	1			**3**
Hypoxic ischaemic encephalopathy	1		1		**2**
Congenital abnormality	3	5		1	**9**
Respiratory					**0**
Cardiovascular		1			**1**
Abdominal / Renal	1				**1**
Neurological		1			**1**
Other					**0**

Number of reviews	
No. of Neonatal Deaths	21
No. of Mortality Reviews completed	10
No. of deaths were care issues may have or were likely to have affected the outcome (grade C/D)	
Antenatal	1 (D)
Neonatal	1 (C)
Care of the mother after death of baby	

Learning from Deaths

Of the 10 cases reviewed in Q2, five had neonatal care issues identified and five had antenatal care issues identified; there were 2 cases where care issues of the mother after the death of the baby were identified.

Neonatal care

Of the 5 cases with neonatal care issues identified 4 were graded B (care issues identified which would not have made a difference to the outcome), whilst through the detailed review process care issues have been identified and afford opportunities for learning and improvement, they have not impacted on the outcome for the babies.

Care issues identified which did not impact on the death of the baby included:

- Not achieving targets of initial management on admission
- Prolonged handling after admission in extreme preterm baby
- Multiple line insertions in a challenging baby, a necessary intervention however these were not fully documented and the parents found this experience particularly difficult – communication, documentation and support of the parents could have been improved.

- Multiple intubations for a baby on several occasions – care could have been improved with a better oversight and acknowledgement of the history and consideration of more experienced first intubator on the later occasions.
- Several hours of high peak pressures on the ventilator before consideration of optimising respiratory support with high frequency oscillation ventilation.
- Sub-optimal documentation – this was identified in several reviews but in different areas of documentation.

Actions proposed to address the issues above include:

- Working group to review of initial management of preterm babies on admission *(in development)*
- Include initial management and admissions procedures in Junior doctor induction 6 monthly with LOTW reminder *(induction session completed september 2020, LOTW pending)*
- Feedback to wider NICU team at clinical governance day regarding patient experience and importance of documentation *(November 2020)*
- LOTW for ventilation key points – for both medical and nursing staff *(pending)*
- LOTW for documentation *(w/c9/11/20)*

1 case was graded C (the care issue may have made a difference to the outcome) having identified that an extremely premature infant became hypothermic on NICU during the admission process. This will be looked into in more detail at a table top review to understand how this occurred and how to prevent similar issues in the future, however a review and optimisation of the initial management of preterm by a mutli-disciplinary working group is expected following an ongoing audit and feedback from the recent GIRFT review. A summary of the table-top findings and any actions will be included in the Q3 report.

Antenatal Care

Progress on action from Q1:

- A more detailed updated screening proforma for assessing risks for preterm labour has been introduced which specifically asks about types of cervical surgery and uterine anomaly. Referrals are made accordingly.
- The process for FU in the community will hopefully be improved by the K2 electronic patient record.
- LOTW on the use of partogram in the intrapartum management in preterm labour, initiation of MgS04 and IV antibiotics, and sending placental for histology.

Actions for findings from Q2:

- The neonatal case graded D for intrapartum care was an HSIB case. An SI investigation with full details of recommendations and actions has been completed. The HSIB report is currently awaited.
- The process for management of abnormal MSU including asymptomatic bacteriuria through ANC is in progress. An update will be provided in the next report.

Care after the death of the baby

For 2 families, we identified lack of Honeysuckle support in the first days after the death due to no cross cover for annual leave and delayed communication with a booking hospital regarding the death of the baby.

Action:

- Bereavement checklist to be reviewed and pathways of communication confirmed

Progress on actions from Q1

In Q1 mortality report we had identified concerns over femoral arterial lines, with 2 cases having been investigated as SIs. Both cases involved a known complication of an intensive care procedure, decision to insert and handover of key information were identified as issues along with subsequent escalation of perfusion concerns in a timely manner.

The recommendations following these reviews include:

- Reflective discussions and feedback to be given to staff involved
- The policy for arterial line insertion is being amended to include:
    - a requirement for 2 consultants to review the decision to insert these lines.
    - rewording to state that a line should be removed immediately that there is any concern about limb perfusion, even in the absence of pallor.
    - Amendment to clearly state contraindications of arterial line insertion
- Staff to be reminded to report incidents when they occur
- Consultants to be reminded of the requirements of Duty of Candour
- The ongoing audit of femoral line insertion will be completed and may identify other contraindications to insertion that will be reflected in the policy.
- Review of system for entering Clinical reviews in the Badger system.

Learning will be shared via senior nursing and MDT meetings and disseminated to the wider NICU team via the November clinical governance meeting.

Benchmarking

We continue to benchmark against NNAP (National neonatal audit programme) data for neonatal mortality, MBRRACE UK and internationally through the VON (Vermont Oxford Network) collaboration.

Following work done by the NWODN (North West neonatal operational delivery network) on preterm (24-31+6 weeks) mortality over the 3 year period July 2015- June 2018 we are working with the network to benchmark our mortality rates regionally and invited an external review looking specifically at the lower gestational ages in this time period. The external review included 10 randomly selected 24 week infants in the time period. The review has been presented to the department, key findings and themes identified at the review include:

1. Femoral arterial lines
2. Liberal use of sodium bicarbonate
3. Missed opportunities to palliate sooner
4. Tidal volumes to reduce ventilator induced lung injury

One case included in the review has been escalated to an SI based on findings of the external review, full report is pending.

A paper detailing the review in more detail has been prepared by Dr Dewhurst, Neonatal Clinical Director, including the LWH response to the issues identified and an action plan generated to address the themes. This is included as a separate item on the Trust Board agenda.

Conclusion:

The Board is asked to note that:

- All adult deaths, stillbirths & neonatal deaths have a mortality review conducted.
- No in-hospital or LeDeR related adult deaths occurred in Q2 of 2020/21.
- The Q2 stillbirth rate of 4.1/1000 (3.9/1000 excluding fetal abnormalities) is lower than reported in Q1.
- No cases were identified where care was adversely affected by COVID 19 related restrictions and/or amended guidance or due to mothers delaying accessing maternity healthcare
- The Neonatal mortality rate has spiked in Q2 but this is due to the high number of babies with cardiac abnormalities and in-utero transfers in this quarter.
- The overall standard of care in stillbirth and neonatal deaths was good.
- The Trust demonstrates a high level of learning from mortality reviews. Themes are identified and action plans in place to address issues that arise.

APPENDIX 1. Risk Assurances from Senates in relation to Mortality

During Quarter 2 the main issues which were discussed which contribute to safety were:

Safety Senate (last meeting 09 October 2020)

- Gynaecology Update -Recruited, so fully staffed from November. Transfer of the critically ill policy ratified. HDU handover now electronic
- Maternity Update - MEWS guideline to be reviewed by maternity clinical group. HDU trolleys planned Recent increase in major haemorrhage and transfers to be reviewed at next meeting
- Sepsis - All validations up to date and no Covid patients. Sepsis guidelines developed for both maternity and gynaecology need to be collated and ratified
- Lack of rapid infuser in obstetric theatres and access to appropriate ABG monitoring in major haemorrhage. Possibility of getting Belmont Rapid Infuser & ABG machine suitable for adult use being explored.
- Influenza PGD - The updated PHE PGD for the Inactivated Influenza Vaccine was approved. Regional procurement has been asked if we could increase our allocation of vaccines so that a significantly higher number of pregnant mothers can be immunised.
- Low reporting figures for medication incidents across Theatres & Anaesthesia – recently initiated Safety Huddles to address this issue.
- The Medicines Safety Bus was launched in September to educate staff on the importance of medication incident reporting and allow learning from incidents that have occurred across the Trust.
- Maternity Specialty Report Highlights

  · Significant reduction in medication incidents from 93 to 43.

  · Thematic review of PPHs >3L in progress. PPH rate is 2.9%, in line with national figures.

Effectiveness Senate (last meeting 16 October 2020)

- Discussion regarding the issue of HSIB projects and how they should be recorded & monitored with possibility of using the Ulysses 'Action' module.
- 'Quality Improvement Process Updates' is to be added as a standing agenda item in a monthly report by the Head of Governance.
    - Comparison with the last clinical audit year has shown that clinical audit activity in Q2 20/21 has **not** been affected as a result of the Covid-19 pandemic. Current figures appear very similar to those of this time last year with no impact on registering projects or receiving reports.

- The Clinical Audit Strategy will now be linked in with the wider Quality Improvement strategies moving forward. There will however continue to be a Clinical Audit Forward Plan and Clinical Audit Policy.
- The Quality Strategy for 2017-2020 had now been completed. Single outcome not achieved was zero never events.
- Shared learning - The Effectiveness Senate and the Chair are to consider other ways of sharing audit findings and actions using wider communication methods. Effectiveness Leads are to advise their auditing teams to produce a poster following completion of their clinical audit projects. Templates will be provided by the Clinical Audit & Effectiveness Team.

Appendix 2

Introduction

In response to a notable increase in the rate of stillbirths in the months of Q1 2020/21, the Deputy Medical Director, Head of Midwifery and Quality & Safety Midwife undertook a review of ten cases of perinatal mortality reported. All 10 cases of stillbirth from Q1 have been reported to the NWC Dashboard lead and have been through a thorough PMRT investigative review process with external representative.

A secondary review, was undertaken to provide assurance to both the Family Health Division at LWH and the NWC SCN that this increase in stillbirths did not have a direct correlation to the ongoing COVID-19 pandemic and the changes made in adaption of a number of maternity and obstetric guidelines and SOP's, see below. The review panel reviewed each stillbirth case with the aim to provide assurance that there were no causative factors in relation to the guidelines 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.

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.

Case Analysis from second 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.

Conclusion.

This review did not identify care issues that had a direct correlation to the changes implemented during the COVID 19 pandemic. The Trust declared one case as a Serious Untoward Incident, but this was also not in relation to the COVID 19 pandemic and centred around care of the woman as an inpatient on the ward and that no cases were graded as a 'D'. It was noted that all actions developed as part of the PMRT process were deemed appropriate.

Liverpool Women's NHS Foundation Trust

Agenda Item	20/21/233

MEETING	**Trust Board**
PAPER/REPORT TITLE:	**Annual Quality Report 2019-20**
DATE OF MEETING:	Thursday, 03 December 2020
ACTION REQUIRED	**Approve**
EXECUTIVE DIRECTOR:	Janet Brennan, Acting Director of Nursing and Midwifery
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):	2. This report will not be published under the Trust's Publication Scheme due to exemptions under S21 of the Freedom of Information Act 2000, because the information contained is reasonably accessible by other means			
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	The Board members are requested to review the contents of the report and provide final sign off for its publication.			
PREVIOUSLY CONSIDERED BY:	**Committee name**	Quality Committee Or type here if not on list: ***Click here to enter text.***		
	Date of meeting	Monday, 24 August 2020		

Executive Summary

Patients want to know they are receiving the very best quality of care. Providers of NHS healthcare are required to publish a quality account each year. These are required by the Health Act 2009, and in the terms set out in the National Health Service (Quality Accounts) Regulations 2010 as amended ('the quality accounts regulations'). Information on quality accounts can be found on the NHS Choices website.

NHS Improvement also requires all NHS foundation trusts to produce reports quality reports as part of their annual reports. Quality reports help trusts to improve public accountability for the quality of care they provide. The quality report incorporates all the requirements of the quality accounts regulations as well as our additional reporting requirements.

The quality report must contain (in the following order):

- Part 1: Statement on quality from the chief executive of the NHS foundation trust
- Part 2: Priorities for improvement and statements of assurance from the board
- Part 3: Other information and two annexes:
  - statements from NHS England or relevant clinical commissioning groups, local Healthwatch organisations, and overview and scrutiny committees
  - a statement of directors' responsibilities for the quality report.

The Trust completed the final year of the 2017-20 Quality Strategy with all goals being met apart from not achieving Zero Never Events with one Never Event occurring in the year.

Due to covid-19 Pandemic there are a number of National Targets which have not been met with monitoring by the CCG continuing.

This year's report the 11th Quality Report published by the Trust, but due to Covid-19 it publication has been delayed until December 2020.

Report

The Quality Report is intended for public consumption and due to the type of data can sometimes be difficult to penetrate. This year's document has been written with this in mind. It aims to ensure that the information contained within it is accessible and comprehensible and that any indicators included bear comparison to either past performance or the performance of relevant peers.

The Trust completed the final year of the 2017-20 Quality Strategy with all goals being met apart from not achieving Zero Never Events with one Never Event occurring in the year. The event was due to a retained swab in obstetric theatres, which has undergone a full investigation with a supporting action plan being developed and monitored via the Clinical Support Services Divisional board and the CCG. This incident has also lead at a full review of previous events and Serious Incidents and a Theatre Quality Improvement plan being developed and monitored by the executive directors.

Due to covid-19 Pandemic there are a number of National Targets which have not been met with monitoring by the CCG continuing.

At time of the report was presented to the Quality Committee for review and comment the CCG had not reviewed the report, commentary from the CCG has been received and are included in the report as well as commentary form Healthwatch. The Trust attended the CCG Quality Presentation day as required via a virtual meeting and was able to provide the attendees from each of the CCGs and Healthwatch a clear overview of what the trust has achieved in 2019-20 and what is planned as part of the new 2020-25 Clinical and Quality Strategy.

The audit of the Quality Report by KPMG has been cancelled due to Covid-19 and the inability of the auditors to be able to validate data included in the report due to restrictions.

To provide assurance around the continued provision of quality care during Covid-19 a section has been added in to part 3 of the report.

Please see Annual Quality Report

Recommendation

The Board members are requested to review the contents of the report and provide final sign off for its publication.

Liverpool Women's
NHS Foundation Trust

Dedicated to you

Quality Report
Liverpool Women's NHS Foundation Trust
2019-2020

Final Draft

Contents

Why publish a Quality Report?

The purpose of a Quality Report is to inform you, the public, about the quality of services delivered by Liverpool Women's NHS Foundation Trust. All providers of NHS Services in England are required to report annually on quality; the Quality Report enables us to demonstrate our commitment to continuous, evidence based quality improvement and to explain our progress to the public. The Quality Report forms an important part of the Trust's Annual Report. This is the Trust's 11th Quality Report.

Part 1

Statement from the Chief Executive

Welcome to Liverpool Women's NHS Foundation Trust's 9th annual Quality Report. This provides an opportunity for us to report on the quality of healthcare provided during 2019-2020, celebrate our achievements and to share with you the Trust's key priorities for quality in the next reporting year of 2020-21. This is a critically important document for us as it highlights our commitment to putting quality at the heart of everything we do.

By reporting to you annually through our Quality Report we demonstrate how the Trust has performed against the ambitious, specific targets we set ourselves each year. It is through striving to deliver each of these individual targets that we will be able to achieve the long-term objectives in our Quality Strategy. As well as reporting on performance 2019/20, the Quality Report also identifies our priorities for the coming year. These priorities range from nationally published measures through to our own locally selected issues.

The trust monitors data quality through a regular data quality sub-committee that reports through the information governance committee to FPBD and focusses on specific specialties to ensure regular representation from senior managers and clinicians. This provides a forum for informatics and operational staff to discuss issues and key data items relating to their specialty. Regular data quality reports, validations and audits are undertaken provides me with assurance that submitted data is representative of the Trust's activity.

I would like to take this opportunity to discuss some of our quality highlights of 2019-20. Each of them is an initiative or piece of work that we have either led or been involved with over the past 12 months that will change the lives of patients and their families for the better.

It will come as no surprise that towards the end of 2019-20, our services were heavily impacted by the global coronavirus (Covid-19) pandemic. Like all of the NHS, our services and workforce had to respond in

a way not seen in peace time. The response of our staff during this period has been astounding and the lengths that our teams have gone to, to keep not only our patients safe but those of the wider health system has been truly humbling.

This year has seen the continuation of our £15m project to upgrade and expand our existing Neonatal Unit which will help to keep our most vulnerable patients safe and will improve the facilities and comforts for families of babies being cared for on the unit. Part of the new unit opened in February 2020 and the send phase opening in August 2020. Having been on a number of tours of the new unit during the project, I can confirm that it is a truly fantastic environment that will keep our most vulnerable babies safe.

Following our recent CQC inspection in December 2019 and the Well Led element in February 2020 that Trust was rated 'Good' overall. This is a testament to the quality of our services and the commitment of our staff in demonstrating the excellent care that is delivered to our patients every day.

We continue to work hard to develop plans for the long term future of our services. This started with our Future Generations Strategy in 2015 and has continued through our work with Liverpool CCG and other stakeholders as part of the One Liverpool strategy, which we hope will lead to a public consultation on the future of our services in the near future. We continue to focus on our Future Generations Strategy with the long-term safety of our services and patients being our number one priority.

This report contains many more indicators as to the quality of the care and service provided by all of the staff here at Liverpool Women's and the above are just a small selection. I encourage you to read the report in full and to see the range of measures that are in place to continually improve and sustain quality by reducing harm, reducing mortality and improving the experiences of our patients and families.

In making this statement I can confirm that, to the best of my knowledge, the information contained in this Quality Report is accurate and there are no concerns regarding the quality of relevant health services that we provide or sub-contract.

Kathryn Thomson
Chief Executive


Liverpool Women's
AMBULANCE
EMERGENCY AMBULANCE
North West Ambulance Service NHS Trust
DK09 GAX
EMERGENCY
AMBULANCES ON

Part 2

Priorities for improvement and statements of assurance from the board

Part 2

Priorities for Improvement

The section of the report looks at the Trust's quality priorities, how we have performed against them during 2019-2020 and how we plan to monitor progress during the coming year.

These priorities are a combination of national and local issues and wherever possible are identified by as wide a range of stakeholders as possible; this includes patients, their families, the wider public, our staff and commissioners. The Trust's priorities can be summarised by our 3 goals: to reduce harm, reduce mortality and provide the best patient experience. The Trust priorities ensure that Safety, Effectiveness and Experience, set out by the Department of Health as the 3 central principles of quality healthcare, remain at the core of all activity at Liverpool Women's.

Reduce Harm

Safety is of paramount importance to our patients and is the bottom line for Liverpool Women's when it comes to what our services must be delivering.

Reduce Mortality

Effectiveness is providing the highest quality care, with world class outcomes whilst also being efficient and cost effective.

Provide the best Patient Experience

Our patients tell us that the **experience** they have of the treatment and care they receive on their journey through the NHS can be even more important to them than how clinically effective care has been.

Key
Level 0 – No action to date (red)
Level 1 – Process in place (amber)
Level 2 – Improvement in practice (blue)
Level 3 – Complete (green)

Quality and Safety Improvement Priority	Target	2019-2020	2018-19
Reducing Avoidable Harm (Safety)	Zero never events	Level 2	Level 2
	Reduce medication incidents resulting in harm	Level 3	Level 3
	100% sepsis screening	Level 3	Level 3
	Reduce avoidable admissions	Level 3	Level 2
	Reduce avoidable returns to theatre	Level 3	Level 2
	Reduce avoidable term neonatal admissions	Level 3	Level 3
Reducing Mortality - Achieve the best clinical outcome (Effectiveness)	Zero maternal deaths	Level 3	Level 3
	Zero unexpected deaths in women having gynaecological treatment	Level 3	Level 3
	Reduce avoidable stillbirth	Level 3	Level 3
	Reduce avoidable neonatal deaths	Level 3	Level 3
	Increase compliance with NICE Quality Standards	Level 3	Level 3
Providing the Best Patient Experience (Experience)	Increase the percentage of staff recommending the Trust as a place to work	Level 3	Level 3
	Increase the Trust's staff engagement score	Level 3	Level 3
	Reduce PALS contacts regarding patient access to triage systems	Level 3	Level 3
	Health & Wellbeing; to improve staff health and wellbeing	Level 3	Level 3

Reduce Avoidable Harm

This section of the report looks at how the Trust ensures Safety through the use of its first quality goal, "to reduce harm". Despite the best efforts of every healthcare professional, harm occurs every day to patients in every hospital. Catastrophic events are rare but we acknowledge that unintentionally a significant number of patients experience some harm in the course of their care. Given the nature of the services we provide, harm can sometimes result in lifelong consequences for women, babies and families.

As a specialist Trust, Liverpool Women's has thought carefully about the types of harm that are particularly relevant to the services we provide and the patients we care for. The priorities that have been selected are therefore specific to us and to the issues most relevant to you, our patients and families, and your safety. They give the best overview of how we are tackling harm and working hard to reduce it.

Our Priority Safety	Zero Never Events	Level 3 – Complete

What we said we'd do

The Trust takes extremely seriously its duty to prevent harm and provide care in a safe environment. This will be monitored via our Ulysses incident reporting system and reported to Safety Senate.

What the data shows

The Trust reported 1 'Never Events' in the period 01/04/2019-31/03/2020 and consequently did not meet this target.

An incident occurred on 13th August 2019 in the Obstetric theatres involving a patient undergoing an elective caesarean section. The incident involved a swab being left in the abdomen during a caesarean section. Suturing had been completed prior to the realisation that a swab was unaccounted for. The patient was reopened under the original spinal anaesthetic and the retained swab was removed. The patient was fully informed during and after the incident had occurred.

The incident and investigation has been referred to the Trust's Local Safety Standards for Invasive Procedures (LocSSIPs) working group for inclusion in their ongoing work to ensure the Trust meets the National Standards for Safer Invasive Procedures. The Trust reported 1 'Never Events' in the period 01/04/2019-31/03/2020 and consequently did not meet this target.

Financial Year	No. of Never Events per Financial Quarter				
	Q1	Q2	Q3	Q4	TOTAL
2016-17	0	0	2	1	3
2017-18	1	0	1	0	2
2018-19	0	1	1	0	2
2019-20	0	0	1	0	1

Data Source: Ulysses Risk Management System

What happens next?

Our ongoing aim is to ensure that no 'Never Events' occur and a key to this is staff vigilance as to what are 'Never Events'.

As part of the Trust Risk Management Strategy, the Governance team and the Trust LOcSSIPs working group will continue to work to raise the profile of what 'Never Events' are and the lesson learnt from any which may occur.

Where a 'Never Event' may occur we will continue to report them to the CCG and ensure a full investigation is completed and root causes and lesson learnt identified and disseminated across the organisation.

Our Priority Safety	**Reduce medication incidents resulting in harm**	**Level 3 – Complete**

What we said we'd do

Improving the reporting culture and having the correct processes to review and learn can have a positive impact on patient safety. This will be measured using data from the Trust's Ulysses system and reported to Safety Senate.

What the data shows

There were a total of 762 medication incidents reported during 2019/20 which is a significant increase in the total number from the previous year (583 for 2018/19) and continues to reflect a greater awareness for reporting medication incidents and near misses across the Trust.

Of these 762 incident reports 48 (6%) were recorded as near-misses, 602 (79%) caused no harm, and 111 (15%) were recorded as causing low harm. The Trust reported one medication related incident as causing moderate harm and no incidents relating to severe harm during this period, reflecting the position achieved consistently since 2016/17. As in 2018/19, the large majority of reported medication incidents caused no harm (79% and 80%) and the proportion of incidents causing low harm remained stable (15% and 15%). Low harm medication incidents are defined as 'any medication incident that required extra observation or minor treatment', even if the outcome of the monitoring was normal and there was no actual adverse effect caused by the incident. 2019/20 saw a slight increase in the proportion of near misses when compared to the previous year (6% vs. 5%). The single medication incident that caused moderate harm (Data Source: Ulysses Risk Management System)

What happens next?

Individual service areas across the Trust are responsible for managing medication related incidents and their medication safety programme, with support as required from the governance and pharmacy departments. The Trust's Medicines Management Committee receives bi-annual medication related incident reports from Divisions to increase assurance that key lessons learned from incidents are being disseminated and actioned across the areas. To improve oversight and organisational learning, the Medicines Management Committee has recently introduced a Medicines Safety Group to review medication related incidents on a weekly basis. The primary purpose of the Medicines Safety Group is to improve systems for safer medicines practice throughout the Trust and reduce harm from medication errors.

In the past year, the Medicines Management Committee reviewed the delivery of medicines management training to clinical staff, to provide a greater focus on medication safety and reporting. An interactive eLearning module was launched which highlighted key aspects of overarching medicines management policies and replaced the previous workbook that staff were asked to complete. All clinically-focused staff at Liverpool Women's Hospital must now complete this module upon induction, as well as every 2 years, as part of their mandatory training. In the coming year, the Medicines Management Committee will work with the Trust governance department to increase awareness of Adverse Drug Reactions (ADRs) & Yellow Card reporting. Encouraging ADR reporting is positive and shows that a healthcare team is committed to patient safety.

The Medicines Management Committee is a reporting group of the Trust's Safety Senate and has executive support from the Medical Director to enable it to deliver its work plan.

Our Priority Safety	**100% Sepsis Screening**	**Level 3 – Complete**

What we said we'd do

The Trust takes extremely seriously its duty to recognise and treat sepsis in a prompt and appropriate manner. Quarterly reports are prepared to check compliance with this target.

What the data shows

These data demonstrates that for all patients presenting to the Emergency room with suspected sepsis, and all hospital in-patients who developed symptoms, screening was undertaken in an appropriate manner and compared to previous years, we have seen 100% compliance maintained with our systems and processes of early interventions and diagnoses.

We are continually seeing low numbers of patients being seen and treated at Liverpool Women's Hospital suffering or showing symptoms of Sepsis. However these low numbers can impact on our performance by skewing the figures when benchmarking or comparing with our comparative hospital groups and peers. In all but two cases potentially lifesaving antibiotic therapy was administered within one hour in compliance with National Guidelines.

Timely Identification and Treatment	2016-17	2017/18	2018/19	2019/20
Timely Identification of Sepsis in ED	100%	100%	100%	100%
Timely treatment of Sepsis in ED	20%	93%	100%	100%
Timely identification of Sepsis in Inpatients	100%	100%	100%	100%
Timely treatment of Sepsis in Inpatients	100%	100%	100%	100%

Data Source: LWH IT Performance Team

What happens next?

Sepsis, its recognition and treatment remains a standing agenda item at monthly and quarterly Critical Care Meeting (CCM) meetings, with monthly CQUIN (Commissioning for Quality and Innovations) reporting in place. A rolling monthly audit on sepsis takes place to form the main quarterly report after review at the CCM.

Education on the importance of prompt recognition and management for new medical staff commencing in the Trust will continue. Sepsis awareness week and regular updates. Streamlining data collection process and analysis continues across the Trust. This regime of monitoring and training is providing effective outcomes and improved safety to patients.

To promote our safe service ethos, we will be benchmarking our Trust against other hospitals in our region, using NHS England and Sepsis Trust Data to assist us to maintain our high standards of care and aim to be outstanding.

Our Priority Safety	**Reduce avoidable readmissions**	Level 3 – Complete

What we said we'd do

Planning patient discharges as early as possible and ensuring clear discharge plans are in place leads to safer care. Targeted clinical audits to understand patient flow will be in place and reported to Safety Senate.

Each patient, is reviewed and individualised discharge planning commences at the point of admission. Discharge planning is flexible dependent upon which clinical pathway the patient takes which helps to support Expected Date of Discharges.

What the data shows

Data table demonstrating Readmissions 2019-20

KPI ID	Source	Service ID	Target < or >	Target	Value	Trend	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
A&E: Unplanned Reattendances within 7 days (Non Pregnancy Related)					Owner - Head of Nursing Gynaecology													
KPI014	Quality Schedule	Gynaecology	<=	7.0%	Numerator		20	32	28	30	23	19	36	28	19	32	21	35
					Denominator		350	375	340	375	349	304	391	341	275	355	371	263
					Performance		5.71%	8.53%	8.24%	8.00%	6.59%	6.25%	9.21%	8.21%	6.91%	9.01%	5.66%	13.31%
					Trend		▼	▲	▼	▼	▼	▼	▲	▼	▼	▲	▼	▲

Data Source: LWH IT Performance Team

What happens next?

Criteria nurse led discharge is in place for the majority of day case procedures, which is working well and supports enhanced patient flow. Consultant led ward rounds are completed 7 days per week which supports appropriate and timely decision making and discharge planning.

In 2019-20, performance against this metric will be monitored via a quarterly report to the Gynaecology Divisional Governance meeting. This report will also explore and themes or trends in un planned returns or admissions to hospital.

Our Priority Safety	Reduce avoidable returns to theatre	Level 3 – Complete

What we said we'd do

Monitoring and understanding why patients are returned to theatre unexpectedly including analysing variation as part of the revalidation process. Conducting root cause analysis and learning from these investigations will be reported to Safety Senate.

What the data shows

Looking at the details of the cases returned to theatre, obstetric cases related to management of complications of surgically assisted birth.

In Gynaecology, cases of return to theatre, the indications vary but primary causation is bleeding after major or laparoscopic surgery; post-operative bleeding after loop excision and after hysterectomy and required a further laparotomy.

The number of returns to theatre over the reporting year of gynaecological surgical procedures performed in theatres excludes incomplete surgical evacuation of uterus after miscarriage or termination of pregnancy (which might occur up to 4 weeks from original surgical evacuation procedure).

Returns to theatres in 2019-20

KPI ID	Source	Service ID	Target < or >	Target	Value	Trend	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Returns To Theatre (exc EVACS)	Owner - Clinical Director Gynaecology																	
KPI190a	Quality Strategy	Trust	<=	0.7%	Numerator		2	1	0	2	3	3	2	3	5	3	0	4
					Denominator		656	664	647	727	714	701	757	669	628	660	616	652
					Performance		0.30%	0.15%	0.00%	0.28%	0.42%	0.43%	0.26%	0.45%	0.80%	0.45%	0.00%	0.61%

Returns to Theatre figures excluded evacs from September 2018.

Data Source: LWH IT Performance Team

What happens next?

Following an analysis of the detailed information in relation to each return to theatre, are reviewed and reported individually via the Ulysses Risk Management Database. There will be ongoing monitoring of returns to theatre via monthly performance dashboard, scrutiny and overview at Gynaecology Divisional monthly meetings.

Our Priority Safety	**Reduce avoidable term neonatal admissions**	**Level 3 – Complete**

What we said we'd do

A key aim of the Trust and its staff is the safety and welfare of our patients. Minimising term admissions reduces potentially avoidable separation of mothers and babies, reduces unnecessary investigation and treatment and allows better utilisation of resources in the neonatal unit, means that mothers and babies are cared for together whenever possible and is a national priority area.

Reduce harm from avoidable admissions to the neonatal unit in infants born at term (≥ 37 weeks' gestation). A multidisciplinary clinical team from Maternity and Neonatal Services will review all admitted term babies on a case-by-case basis and decide whether or not their admission could have been prevented.

We will identify any learning opportunities and put actions in place to minimise the number of unnecessary admissions. We will monitor the frequency of such admissions and aim to reduce their occurrence.

What the data shows

This table shows the number of babies admitted at term whose admission was deemed to be 'potentially avoidable' has remained at this low level in 2019/20 at 4.1%.

Period	% of total admissions classified as potentially avoidable
2016/17	16.2%
2017/18	9.1%
2018/19	7.1%
2019/20	4.1%

Data Source: Neonatal Admissions Database

What happens next?

We will continue to monitor our overall term admission rates as well as those considered potentially avoidable.

We will continue to enable an admission criteria to try and allow more babies to be cared for in the postnatal wards, thus preventing unnecessary separation of mother and baby.

We will continue to enhance midwifery and neonatal training and education to support staff looking after babies in the postnatal areas.

Reducing Mortality

This section of the report considers how the Trust seeks to "achieve the best clinical outcomes", ensuring the effectiveness of our services for our patients. Given the nature of the services we provide at Liverpool Women's, such as looking after the very premature babies born or transferred here and providing end of life care for cancer patients, we do see deaths, many of which are expected. However, our quality goal is to reduce mortality and improve best clinical outcomes wherever possible.

As is explained on the right, the use of HSMR is not appropriate for this organisation; as it excludes a large number of our deaths, using it may give false concern or reassurance. This has been considered very carefully by the Trust and we have committed to monitoring our mortality by focussing on each clinical area separately. We will record our mortality rates in those areas and benchmark against national standards. To ensure effectiveness in the Trust is at the absolute forefront of practice, the Trust goes a step further than most other hospitals by ensuring that every case in which there is a death is reviewed individually so that any lessons regarding failures of care may be learned.

Do you use the Hospital Standardised Mortality Rate (HSMR)?
The government uses a standardised measurement to calculate mortality across the NHS. This ratio, HSMR, compares a hospital's actual mortality rate to the mortality rate that would be expected given the characteristics of the patients treated. This is not a useful tool for Liverpool Women's since maternal deaths, stillbirths and neonatal deaths are all excluded.

Our Priority Effectiveness	**Zero Direct Maternal Deaths**	**Level 3 – Complete**

What we said we'd do

A direct maternal death is one which is directly related to a complication of pregnancy (such as haemorrhage, pre-eclampsia or sepsis). We said we would keep this at zero level.

An adult mortality strategy was written and implemented in April 2017 and updated in April 2018.
The strategy prioritises up to date guidelines and audit in order to reduce the risk of adult mortality.

A process for reviewing all adult deaths, using an Adult Mortality Audit sheet which complies with recognised and validated methodology detailed in PRISM studies was implemented on Ulysses in 2017/18. A LeDeR policy was also written. (**National Guidance on Learning from Deaths. National Quality Board (2017) Available at www.england.nhs.uk) (**Learning Disabilities Mortality Review (LeDeR) Programme (2017) Available at **www.bristol.ac.uk/sps/leder)**

What the data shows

-No direct maternal deaths were recorded in 2019-20.

As well as assessing each individual case very closely, the Trust benchmarks using figures provided from MBRRACE-UK. The latest available MBRRACE-UK data shows a national rate of 9.2 direct maternal deaths per 100,000 of the population.
2019 (this report): Surveillance data on maternal deaths from 2015-17.

Direct Maternal Deaths		
2017-18	**2018-19**	**2019-20**
0	**0**	**0**

Data Source: Hospital Episode Submission Data (HES)

What happens next?

The Quality Committee will continue to receive a quarterly mortality report. From February 2019 until the funding runs out, any direct maternal death in the perinatal period (except suicide) will undergo a Health Safety Investigation Branch (HSIB) review.
https://www.hsib.org.uk/maternity/

Investigations will:

- identify the factors that may have contributed towards death or harm
- use evidence based accounts to establish what happened and why

HSIB can bring standardised approach to maternity investigations and will not attribute blame or liability. HSIB will set out the facts of what happened in each case and generate recommendations and aggregate the findings from reports and draw out wider learning for the whole system.

During 2019-20 the Trust has reported 17 cases to HSIB and has continued to be fully involved and support of the investigation process.

Our Priority Effectiveness	**Zero unexpected deaths in women having gynaecological treatment**	**Level 3 – Complete**

What we said we'd do

An unexpected death is one which is not related to an end of life condition or which occurs as a result of treatment received.

We measure using HES data and report mortality rates to the Quality Committee.

In 2019-20 there have been no unexpected death following Gynaecology treatment.

How we help and deal with our patients who have serious or terminal diseases is important both in our dealings with the clinical issues around their care, but also in terms of the support and assistance we give to the patients and their families during this time.

We committed in our Quality Strategy to offering palliative end of life care to Gynaecology cancer patients in the Liverpool Women's, and providing help and support for patients and their families whether their preferred place of death is the Liverpool Women's Hospital or home.

What the data shows

There were 7 expected oncology in hospital deaths in Gynaecology in 2018-19 and one death not related to an end of life condition.

Data Source: Hospital Episode Submission Data (HES)

What happens next?

All deaths within the hospital, whether cancer-related or not, are reviewed using the adult mortality tool to ensure the appropriate action was taken (see maternal death section above). The Trust benchmarks its mortality data against peer Trusts using the Capita Healthcare Knowledge System (CHKS).

We will continue to benchmark in this way to complement the close monitoring of our mortality data internally. The Trust's Quality Committee and ultimately the Board have an overview of the delivery of this work. The Trust published an Adult Mortality Strategy in 2017.

This priority will continue to be reported in the Quality Report but will be reported under the redefined priority of Adult Mortality.

Our Priority Effectiveness	Reduce avoidable still birth	Level 3 – Complete

What we said we'd do

We said we would reduce stillbirths due to small for gestational age (SGA) babies by 20% from the 2013 rate of 42.5%.

What the data shows

Following a year on year reduction since 2014, unfortunately for year 2018/19 the analysis shows that the contribution of undetected Small for Gestational Age towards stillbirth cases has increased to 25%. We acknowledge the increase in stillbirth rate due to undetected SGA, the stillbirth committee will review all these cases and report back if this is a true increase or an unexpected temporary deviation from a general trend in the coming financial year. Appropriate recommendations will then be made to address this. It is possible that this increase may be just an anomaly, or may reflect a true increase, as stillbirth is complex and multifactorial and not all causes are detectable or preventable antenatally.

In 2019/20, we have been implementing new recommendations of the Saving Babies Lives-2 and GAP-2 programmes which will address issues around undetected Small for Gestational Age. We will keep this figure under review as new recommendations are implemented, to ensure we provide assurances to our patients and the Trust.

The stillbirth rate for 2018-19 was 3.91/1000. In 2019/20, this rate has reduced to 2.89/1000 suggesting that the Trust is progressing in its aim to reduce stillbirth

- All babies undergo a multidisciplinary review panel meeting
- All parents are informed of the review process and are supported to submit questions through the Honeysuckle Bereavement Team
- The Perinatal Mortality Review Tool (PMRT) review panels have identified some relevant issues which have formed the basis of the action plan for 19/20 and 20/21
- When different care would have prevented the outcome a thorough level 3 investigation has been undertaken
- Adequate progress is being made on the action plan.

    - Screening for pre-term labour is now part of the Meditech booking questions
    - SOP for assessment of domestic violence risk is written, has been approved by safeguarding and is awaiting sign off at division
    - PGD for aspirin prescription and simplifying the aspirin prescription in pregnancy is under discussion
    - Pre-term labour guideline for counselling and management of extreme prematurity labour is on hold due to COVID 19
    - Junior doctor teaching is on hold for COVID – 19
    - Partogram in labour - a lesson of the week has gone out but as this is a culture change it will need consistent reinforcement from shift leaders and senior obstetricians

Stillbirth rate (excluding terminations) per quarter

Quarter	Rate
Q1	4.0
Q2	4.1
Q3	1.5
Q4	1.7

Stillbirths >24 weeks

501 - OBS	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	TOTAL
Total stillbirths	2	8	4	7	7	6	5	2	3	3	1	2	50
Stillbirths (excluding terminations)	1	5	2	4	2	3	1	1	1	1	1	1	23
Births	665	684	666	714	750	711	703	583	664	638	562	608	7949
Rate per 1000 births	3.0	11.7	6.0	9.8	9.3	8.4	7.1	3.4	4.5	4.7	1.8	3.3	6.29
Rate (excluding TOP) per 1000	1.5	7.3	3.0	5.6	2.7	4.2	1.4	1.7	1.5	1.6	1.8	1.6	2.89

What happens next?

The Trust has an action plan for the national Saving Babies Lives Care Bundle.

It will continue to monitor compliance against all elements of this care bundle. Alongside SBL-2 care bundle, we will also continue to implement the GROW/GAP-2 programme through Perinatal Institute Birmingham to align the saving babies lives bundle recommendations into our routine clinical practice

Cessation of Smoking in pregnancy remains a key area for improving outcomes with regards to reducing small for gestational age babies and reducing stillbirth rates and poor neonatal outcomes where a direct link to smoking in pregnancy can be made. This work, will be monitored at both a local and regional level via our dashboard figures and monitoring themes from PMRT reviews.

Our close links to our stop smoking services and local smoking commissioners and public health links will continue to build upon the work already completed within the trust. Work will continue to improve smoking in pregnancy rates by further engaging staff across the maternity division, improvements such as increasing training for midwives in very brief advice and implementing the BabyClear risk perception intervention.

Debrief process needs streamlining to ensure families are debriefed in a consistent and time appropriate manner. If parents do not wish a debrief, a letter should be offered. If parents decline the letter a plan for future pregnancy needs to be documented.

Co-ordination of appointments for non-English speaking women with medical disorders needs to come through the LINK clinic and NEST team. A service evaluation is required to ensure the service is meeting the needs of the women.

Our Priority Effectiveness	**To deliver our risk adjusted neonatal mortality within 1% of the national Neonatal Mortality Rate Level 3 – Complete**

What we said we'd do

Neonatal mortality rate (NNMR) is accepted to be a useful indicator of the effectiveness of a perinatal healthcare system and two-thirds of infant deaths occur in the neonatal period (<28 days). The neonatal service at Liverpool Women's cares for one of the largest populations of preterm babies in the NHS and it is extremely important that survival of these babies is monitored to ensure that the quality of the care that we are providing is maintained.

We benchmark our mortality against the national NMR published from the Office of National Statistics, having committed to remaining within 1% of the NMR and reported to Effectiveness Senate. Furthermore, we benchmark against mortality data from VON (Vermont-Oxford Network), a collaborative network of neonatal care providers both nationally and internationally, which is committed to improving the quality of new-born infant care.

What the data shows

The most recent data from the ONS states a UK national NMR of 2.8/1000 live births (2018), in 2019/20 for babies both booked and delivered at LWH the neonatal mortality rate is 2.4/1000 livebirths. The rate is similar to the previous year and remains lower than the NNMR. If we include babies born in LWH following ante-natal transfer for specialist care, including extreme prematurity and congenital abnormalities, the mortality rate is higher at 3.8/1000 live births.

The latest available data (2018) from the VON network for all infants <1500g, born in Liverpool Women's Hospital shows the mortality rate was 24.5%. Though this falls out with the interquartile range for units who participate in VON throughout the UK, it is notable that the data has not been adjusted to take account of the specialist care we provide. We are a regional referral centre for fetal medicine and neonatal intensive care, meaning we look after a large number of high-risk pregnancies. As a result, we would expect to have a higher mortality rate when compared with units that do not provide this same level of specialist care.

Data Source: Office for National Statistics (ONS), Vermont Oxford Network
Note: NMR is calculated as the number of deaths per 1,000 live births

What happens next?

The Trust will continue to benchmark against national data from the Office of National Statistics, annual data from Vermont-Oxford Network and MBRRACE-UK.

All neonatal deaths are reviewed using the national perinatal mortality review tool, with external representation and parental engagement; we will continue to ensure a high quality review process with a focus on learning, reporting and action to improve future care.

Our Priority Effectiveness	**Increase compliance with NICE Quality Standards** **Level 3 – Complete**

What we said we'd do

Demonstrate compliance with evidenced based practice and aim to be in the top performing 20% of trusts for anticipated critical outcomes by:

- Agreeing implementation plans for NICE Quality Standards in each division.
- Auditing compliance.
- Identifying a suite of clinical indicators for each division, establishing baseline data.
- Developing and implementing improvement plans for clinical indicators that fall outside the top 20% against appropriate peers.
- Increasing oversight of delivery via the Effectiveness Senate and Quality Committee.

What the data shows

The data shows that:

- Implementation plans for all relevant NICE Quality Standards in each division are agreed and recorded bi-monthly.
- All NICE Quality Standards released in 2019-20 have been considered for applicability to the Trust and where applicable, allocated appropriately.
- NICE Quality Standards which are recorded as being 'fully implemented / compliant' were considered for inclusion in the Annual Clinical Audit Forward Plan.
- In order to increase oversight of delivery of the Quality Standards, this is reported monthly to the Information Team via the Governance Databook and quarterly at both the Effectiveness Senate and the Quality Committee.
- Of the 9 NICE Quality Standards deemed applicable; 7 (78%) have completed baseline assessments, 5 (71%) of which we are fully compliant with, 2 (29%) have actions in progress in order for us to become fully compliant and 2 (22%) have baseline assessments in progress to establish compliance

Guidance ID	Guidance Title	Baseline Assessment complete Y/N	Guidance Status
QS183	Physical activity: encouraging activity in the community	Y	**Fully implemented / compliant**
QS187	Learning disability: care and support of people growing older	Y	**Fully implemented / compliant**
QS101 (updated from Oct 2015)	Learning disability: behaviour that challenges	Y	**Fully implemented / compliant**
QS35 (updated from Jul-13)	Hypertension in pregnancy	Y	**Fully implemented / compliant**
QS135 (updated from Oct-16)	Preterm labour and birth	Y	**Fully implemented / compliant**
QS15 (updated from Feb 2012)	Patient experience in adult NHS services	Y	**Fully implemented / compliant**
QS46 (updated from Sep-13)	Multiple pregnancy: twin and triplet pregnancies	Y	**Fully implemented / compliant**
QS190	Flu vaccination: increasing uptake	N	**Actions in progress – relates to 2020/21 winter season**
QS192	Intrapartum care: existing medical conditions and obstetric complications	N	**Fully implemented / compliant**

Data Source: NICE National Quality Standards

What happens next?

To continue with current processes and encourage audit of implemented Quality Standards.

Learning from Deaths

The following section of the report provides information as to how the trust learns from deaths.

The use of Hospital Standardised Mortality Rate (SHMI) is not appropriate for this organisation as it excludes a large number of our deaths. Using it may give false concern or reassurance. This has been considered very carefully by the Trust Board and we have committed to monitoring our mortality by focussing on each clinical area separately and using crude mortality data.

We record our mortality rates in those areas and benchmark against national standards. To ensure effectiveness in the Trust is at the absolute forefront of practice, the Trust goes a step further than most other hospitals by ensuring that every case in which there is a death is reviewed individually so that any lessons regarding quality of care may be learned.

The below table provides an overview of all reviews or investigations conducted for each adult and perinatal deaths within LWH. The quarterly percentage includes both adult and perinatal deaths, in total there were 40 deaths, of this 7 were expected gynaecological oncology patients on a palliative care pathway and the remaining 33 deaths were infants who died as a result of their serverity and/or complexity of their clinical condition

Overall deaths (adult and paediatric deaths)	%
Estimate of the number of deaths during reporting period 01 April 2019 – 31 March 2020 for which case review or investigation has been carried out	100%
Number of the patient deaths during the reporting period 01 April 2019 – 31 March 2020 are judged to be more likely than not to have been due to problems in the care provided to the patient	100%
Number of overall deaths as a percentage in Q1 (No of overall deaths 13)	32.5%
Number of overall deaths as a percentage in Q2 (No of overall deaths 11)	27.5%
Number of overall deaths as a percentage in Q3 (No of overall deaths 8)	20%
Number of overall deaths as a percentage in Q4 (No of overall deaths 8)	20%
A revised estimate of the number of deaths during the previous reporting period taking into account the deaths judged to be more likely than not to have been due to problems in the care provided to the patient.	100%

Neonatal

Since January 2019 all neonatal deaths on NICU have been reviewed using the standardised national perinatal mortality review tool (PMRT). There is a monthly multi-disciplinary review meeting with representation from neonatal, obstetrics, bereavement support and palliative care teams. Reviews are planned for 6-8 weeks after the baby has died. Where there has been an in-utero transfer for or a baby has been transferred post-natally for higher level care, the other hospitals or care providers involved are invited to the meeting to complete a joint review encompassing all aspects of care. If a joint review is not possible care at LWH is reviewed and the booking / delivery hospital is contacted and asked to complete a local review. Each case is then assigned a grade (A-D, see below) for each of the following areas: antenatal care, neonatal care and care after the baby has died.

A	No issues with care identified up to the point that the baby was confirmed as having died
B	Care issues which the panel considered would have made no difference to the outcome for the baby
C	Care issues which the panel considered may have made a difference to the outcome for the baby
D	Care issues which the panel considered were likely to have made a difference to the outcome for the baby

Cases where a grading of C or D has been assigned will be then reviewed further as a table-top review, or if deemed appropriate a formal review or serious incident. Local mortality review outcomes and learning are shared within the department and at the Clinical Effectiveness Group for Cheshire and Mersey NWODN. The PMRT outcomes are reported to the regional child death overview panel (CDOP).

The PMRT process encourages parental engagement, all parents are informed of the review process at the time the baby dies, a letter detailing the process and how they can engage is provided. Any comments / questions / concerns which the parents send in are addressed as part of the review and parents are provided a written response and offered an appointment to discuss the response thereafter.

19/20 Neonatal PMRT Summary

	Q1	Q2	Q3	Q4	Total
NICU deaths	9	10	7	8	34
LWH booked NICU deaths	**5**	**7**	**5**	**5**	**22**
Mortality rate /1000 deliveries	4.6	4.8	3.6	4.5	4.4
LWH booked mortality rate / 1000 deliveries	**2.5**	**2.9**	**3.1**	**2.8**	**2.9**
PMRT Reviews completed	9	10	7	6	32
No. of deaths were care issues were identified (grade B/ C/D)	5	6	4	2	18
No. of deaths were care issues may have or were likely to have affected the outcome (grade C/D)	1	0	0	0	1
Non-NICU deaths of babies cared for on NICU	*4*	*6*	*3*	*5*	*18*

Themes

For the year 2019/2020 themes which have emerged from neonatal PMRT reviews include:

- Access to paediatric sub-speciality services
- Unplanned extubation
- Umbilical line dislodgement
- Thermal management
- Timely involvement of palliative care
- Documentation
-

Actions which have been taken to address these themes include:

- Development of the Liverpool Neonatal Partnership
- All unplanned extubations to be reported and reviewed
- Thematic review of umbilical line incidents, in particular fixation of the lines
- Include umbilical line fixation training in junior doctor induction programme
- QIP for thermal management at birth
- Palliative care nurse specialist weekly attendance at ward rounds

Gynaecological (Oncology + Non-oncology) and Maternity (Adult Deaths)

All expected and unexpected adult deaths in the Trust, are reported on the Ulysses Risk management system as soon after death as practicable by the nurse or clinician providing care to the deceased patient.

They will thereafter, complete an Adult Mortality Review on Ulysses Risk Management System within 48 hours of the patient's death. This records performance against a predefined set of standards, using the recognised and validated methodology detailed in PRISM studies. In each clinical area, the Clinical Director provides feedback to clinicians if individual errors or omissions in care have been identified by use of this audit tool. The Risk and Patient Safety Manager and Deputy Medical Director analyse the data and identify any emerging Trust-wide themes. These are highlighted and reported in the Quarterly Adult Mortality Report.

If any deaths are graded as NCEPOD 5 or <3 (very poor/poor care) on structured judgement review then a second stage review will be performed according to the RCP SJR process.

For unexpected gynaecological deaths and all maternal deaths, either a Level 2 or a Level 3 Root Cause Analysis is performed. One of the main aims of the Root Cause Analysis is to identify case-specific errors and systematic flaws. All Root Cause Analyses are scrutinised by the Head of Governance and Quality and risk and Patient Safety Manager, who pool data and identifies any emerging Trust-wide themes.

The lessons learnt and the SMART Action Plans are highlighted in the Quarterly Adult Mortality Report.

Seven Day Hospital Services

Following instruction from NHSE, the Trust will submit its spring return on the seven day services Assurance Framework formally on 30th September 2020. This is a deferred return due to the novel Coronavirus (Covid-19) pandemic. The information describes the Trust's 7DS provisional status as of end March 2020 for assurance purposes.

This most recent survey has shown a significant increase in meeting the target for priority Standard 2. In spring 2020, the Trust reached a position of compliance against this standard for the first time, with 96% of emergency admissions meeting the target. Only one case - a miscarriage - was not seen by a Consultant within 14 hours but was reviewed by a Senior Trainee within 14 hours of admission. The data analysed for this submission pre-dates the 'lockdown' and pre-dates the changes made to rotas in response to the Covid-19 pandemic.

This improvement has come about because of an increasing frequency of Consultant ward rounds, reflected in job plans. Following a further successful round of Consultant recruitment to the Gynae Emergency Dept (GED) on 4th May 2020 we now expect this improved position to be maintained long term. This will also allow further development of the acute Gynaecology service model and the embedding of learning gained from the Covid-19 pandemic response, in terms of triage, efficiency of clinical pathways and the assimilation of new clinical techniques into normal practice.

One admission met the criteria for Standard 8 in the reporting period - management was compliant with requirements involving emergency surgery by a multi-disciplinary team with direct involvement from the acute Trust.

In contrast, there has been no significant progress against the requirements of Standards 5 & 6 as these ostensibly require co-location with an adult acute site to be fulfilled. The possibility of agreeing an over-

arching SLA with Liverpool University Hospitals NHS FT continues to be explored by Executive team, however, and LWH's reported performance against Standards 5 & 6 will then be reassessed.

STANDARD	SELF ASSESSMENT	SCORE
Priority Standard 2 – All emergency admissions must be seen by a suitable Consultant at the latest within 14 hours from time of admission (target >90%)	As per agreement with the 7DS assurance service and the CCG, hyperemesis has been excluded from this survey as patients are admitted for management on a defined pathway of rehydration and discharged, this not meeting the criteria for 7DS return. Most other women attending as emergencies are miscarriage related and as such do not necessarily need Consultant review as the process and pathways in GED support decision making to improve the patient pathway. However, in this report, it is clear that all have had review and decisions at senior level. Patients requiring thorough clinical assessment by a suitable Consultant were seen daily by a Consultant. The current job plans do not specifically make reference to 7DS but the on-call rotas cover Consultant ward rounds and emergency admissions. In this survey, 96% of admitted women were assessed in person by a Consultant within 14 hours of admission, a significant improvement and the first time the Trust has been compliant with the standard. Recent appointment of GED Consultants and learning from the changes made during the Coronavirus (Covid-19) pandemic response will help maintain compliance with this further.	Met
Priority Standard 5 – Hospital inpatients must have 7 day access to diagnostic services & Consultant directed diagnostics	No formal arrangements for this but there are pathways in place for ad hoc diagnostics. This access is not ring-fenced and clinicians spent a lot of time negotiating transfers and transport of patients to the acute site.	Not met
Priority Standard 6: Hospital inpatients must have 24 hr access to consultant delivered interventions on site or through formally agreed arrangements	Key consultant delivered interventions can be accessed but these are generally provided outside specialty specific guidance due to stand-alone site of LWH. No formal arrangements but there is an ad-hoc understanding with the acute sites. Feasibility for an over-arching SLA is being explored by the Finance Director for Strategy.	Not met
Priority Standard 8: All HDU patients have twice daily Consultant review and at least once every 24 hrs once a clear pathway has been agreed	100% return achieved with evidence of multi-disciplinary involvement including from adult acute Trust. Care is also provided off – site to women admitted in other hospitals e.g. RLBUHT/Aintree if needed. Increasingly LWH treats women assessed pre-operatively as potentially needing ITU care in the post-operative period at the acute Trust rather than on the stand-alone site.	Met

Providing the Best Patient Experience

We have discussed already our priorities for ensuring our patients are safe and receive effective care. However at Liverpool Women's we also know that the experience that our patients have whilst under our care is of great importance. We understand that many of our patients have contact with us at some of the most significant times in their lives; with that in mind it is our ambition to make the experience of everyone who steps through our doors the best that it can possibly be. We also know that this goal of a great patient experience can only be delivered by a workforce who are engaged, competent and motivated to deliver high quality care.

Our Priority Experience	**Increase the percentage of staff recommending the Trust as a place to work** **Level 3 - Complete**

What we said we'd do

Aim to increase the number of staff who would recommend the Trust as a place to work and increase overall levels of engagement as measured by the Staff Survey.

Actions to improve engagement are varied and include our health and wellbeing strategy, our approach to leadership development, engaging and involving our staff through varied communications channels and ensuring we reward and recognise our workforce.

What the data shows

2019 staff survey results saw a statistically significant increase in the number of staff recommending the Trust as a place to work. Over the last 12 months the link between place to work and place to have treatment has been explored through focus groups and listening events and it is positive to note that both have improved.

LWH Staff Survey Results

Would you recommend as a place to work? (Staff Survey)

2016	2017	2018	2019
56%	61%	60%	67%

Would you recommend as a place to have treatment? (Staff Survey)

2016	2017	2018	2019
81%	80%	78%	81%

Data Source: NHS Staff Survey (Picker Institute)

What happens next?

Progress against these indicators will be tracked via the Year Two action plan of the Putting People First strategy.

All Division and Corporate service have been tasked with and engagement with staff to understand issues developing an action plan to support staff in the workplace and any concerns they have. These will be monitored via the Putting People Frist Committee

Our Priority Experience	**Increase the Trust's staff engagement score**	Level 3 - Complete

What we said we'd do

There are well evidenced links between staff engagement and good outcomes for patients. By supporting our staff to develop, listening to their feedback and involving them in decision –making we aim to improve both staff and patient experience. It is measured via the engagement score in the annual staff survey and reported to Experience Senate.

What the data shows

Since 2016 the engagement trend has been positive and 2019 saw a statistically significant improvement in the engagement score which reflects a period of iterative work where staff engagement has been a focus through the Putting People First strategy.

Overall engagement score (Staff Survey- out of a maximum of 10)

2016	2017	2018	2019
6.9	7.0	7.0	7.2

Data Source: NHS Staff Survey (Picker Institute)

What happens next?

Actions will be tracked through Divisional People Plans and Trust wide actions through the Year 2 Action Plan of the Putting People First strategy.

Action areas are in line with last year in and include investment in leadership training, embedding a talent management process, improving quality of Personal Development Reviews (PDRs) and objectives, continuing with robust workforce planning and succession planning processes.

Our Priority Experience	**We will promote a positive experience that allows the trust to deliver a high quality carer and family experience - Level 3 – Complete**

What we said we'd do

Respond to themes from PALS, Complaints and Feedback and surveys. This will begin with improving patient access to telephone triage systems and will be reported to Experience Senate.

What the data shows

The data shows that **5.7%** of the Patient Advisory and Liaison Service (PALs) contacts for **2019/20** involved an element of telephone calls not being answered in the Trust. This is down from **9.7%** in **2018/19**. 70% of these concerns relate to trying to access the administration and admissions teams. These issues were identified throughout the previous year and steps were put in place to address these. Actions have continued to be taken to increase the staff numbers and bolster the systems. System limitations, such as no engaged tone, IVR messages or queue information, are being addressed which has had an effect of decreasing the issues escalated to the PALS team.

As it was identified that the Friends and Family Test (FFT) response rates continued to require improvement, steps have been taken over the last year to assist with this. We have continued to push this message to staff and provided instructions about the feedback collection methods to ensure all areas understand their responsibilities within this process.

To support the improvement needed in response rates we expanded the roll out of a text message service. This provides patients with a web link to complete, via their mobile phone or other device, the F&F Test once they have had an appointment or contact with the hospital. Roll out this year has continued within Maternity and has been introduced for Gynaecology patients and people using the Genetics service.

This change has already seen a considerable increase in response rates from 5821 in 2018/19 to 18,584 in 2019/20. This will only increase as the Text Service roll out continues into other services in the hospital such as Neonatal, Imaging and Physiotherapy services during 2020/21.

PALS relating to Telephone calls not being answered		FFT Responses	
2018/19	**2019/20**	**2018/19**	**2019/20**
9.7%	↓ 5.1%	5821	↑ 18584

Data Source: Power Bi

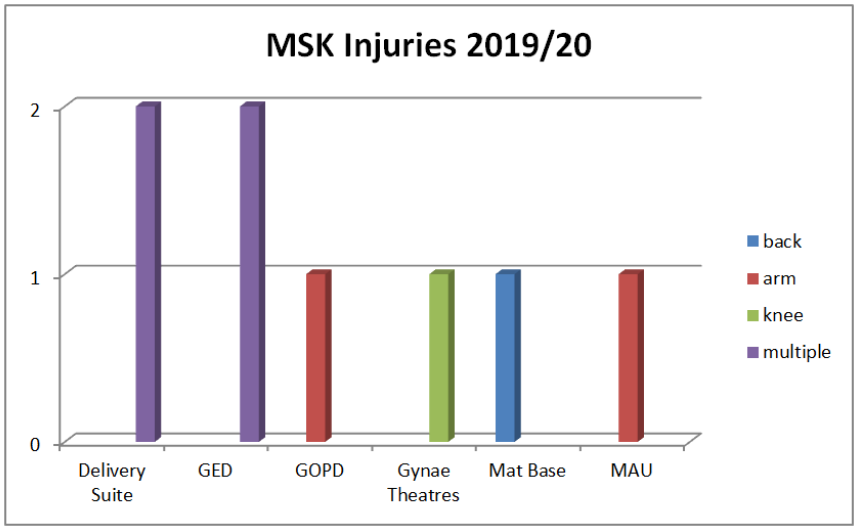
What happens next?

Telephony improvements will continue to be monitored to ensure they are having the desired impact on patient experience. Friends and Family Test text service roll out will continue into other services in the hospital such as Neonatal, Imaging and Physiotherapy services during 2020/21. Focus for 2020/21 will move away from response rates and focus on the improvements made from feedback and how this is shared across the Trust and the patient population. The progress of these issues will continue to be monitored via the patient experience senate.

Our Priority Experience	**Health & Wellbeing; to improve staff health and wellbeing (HWB) Level 3 – Completed**
What we said we'd do	We will strive to create a workforce that is aware of and takes ownership of how to maintain its physical and psychological welfare. This includes a culture in which leadership is focused on the wellbeing of its staff. There will be a range of accessible and utilised facilities, information and resources to support individuals and leaders to maintain a culture of wellbeing.
What the data shows	Staff Survey results over the last 3 years for health and wellbeing remain stable. The significant focus on health and wellbeing over the last year has not resulted in an improvement in staff's overall perception that the organisation takes health and wellbeing seriously. The health and wellbeing committee continues to be very active and has new objectives aligned to those in the Putting People First strategy. There is now an annual programme of health and wellbeing activities and monthly public health campaigns. The Trust has made progress in achieving more elements of the Workplace Wellbeing Charter and has embedded its team of Mental Health First aiders.

MSK Reported Injuries

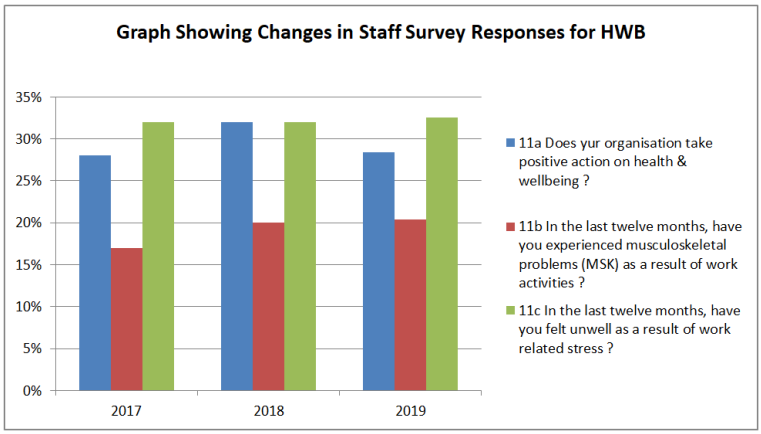
Interrogation of the Ulysses incident reporting system showed that neight incidents of musculoskeletal injuries were reported in the 2019/20 period compared to nine the previous year. This is significantly lower than the comparator group. High compliance rates with mandatory training and early referral to occupational health have supported this.



LWH Staff Survey Health & Well Being Results

Question	LWH	average for acute specialist trusts	average for acute trusts	national average
11a Does yur organisation take positive action on health & wellbeing ?	28%	34%	29%	30%
11b In the last twelve months, have you experienced musculoskeletal problems (MSK) as a result of work activities ?	20%	25%	29%	27%
11c In the last twelve months, have you felt unwell as a result of work related stress ?	33%	36%	40%	40%

Data Source: NHS Staff Survey



Data Source: NHS Staff Survey

What happens next?

All managers now have health and wellbeing objectives as part of their PDRs and the effectiveness of these objectives will be audited.

There are ongoing challenges of taking health and wellbeing activities to the clinical areas. The Covid-19 situation has demonstrated how well mental health, wellbeing and resilience sessions on clinical area have worked. The going home checklists have been another positive way in which staff have been supported.

Mental health first aiders have been working with other staff as part of a wider staff support network and this has proved effective and a wider 'staff support network' will be established once Covid-19 has passed.

The NHS Employers tool *How Are you Feeling Today?*, tool which identifies stress hotspots will be rolled out in other areas. This will be supported by the quarterly online and paper surveys which will be rolled out in Summer 2020 and will include health and wellbeing questions. Follow up interventions will be targeted in areas based on the results of both tools.

HWB will be embedded in the new Leadership Strategy and will support the Fair and Just Culture

Priorities for Improvement in 2020-25

As has been outlined in the report so far, the Trust has 3 clearly defined quality goals; to reduce harm, to reduce mortality and to provide the best patient experience. You have seen already how we have performed during 2019-20; the tables below set out what our priorities will be in the coming 5 years with the new quality and clinical combined strategy.

Our priorities are a combination of national and local issues and wherever possible are identified by as wide a range of stakeholders as possible as well as by the Trust. This includes patients, their families, the wider public, our staff and commissioners. We have held listening events and engagement sessions to allow all our stakeholders the opportunity to assist in choosing this year's priorities. The priorities are driven by the Trust's Quality Strategy and will allow us to achieve our vision of being the recognised leader in healthcare for women, babies and their families

Our Ambitions for Quality Improvement

In keeping with the wider NHS, we use a three-part definition of quality, described in the 2008 Darzi NHS Next Stage Review (Department of Health 2008) as:

- Patient Safety
- Clinical Effectiveness
- Patient Experience.

Three of our Trust aims map directly to our definition of quality, however, we also recognise that work streams within *each* of our five aims have an impact on quality and our ability to improve quality within our clinical services.

At Liverpool Women's, our vision is to become the recognised leader in healthcare for women, babies and their families. We have developed a set of ambitions aligned to our aims, which set the long term direction for our organisation; creating the momentum and mind-set we need to become outstanding in everything we do. Our ambitions help create an environment where we are constantly reaching for excellence and where continuous improvement in quality is always at the top of our agenda.
Our extensive engagement work in preparing this strategy culminated in the identification of a number of key priorities for delivering quality improvement in the first years of this strategy, moving us towards achieving our ambitions and realising our vision. We will monitor, review and refresh where needed these priorities, to make sure we are still firmly on track to deliver outstanding care in all of our services, all of the time.

Quality improvement is a part of everything we do; naturally then some of this work is described elsewhere within our strategies and plans; where this is the case, we have made this clear. We will not duplicate work; we strive to be efficient in how we approach quality improvement throughout our organisation.

WORKFORCE

AMBITION

WE WILL BE AN OUTSTANDING EMPLOYER

- We will value and care for our staff
- We will listen to our staff and act accordingly
- We will welcome staff and volunteers from all parts of our community
- We will attract outstanding people to deliver outstanding care to our patients
- We will invest in our staff to develop them
- We will promote research and foster innovation amongst our teams

QUALITY PRIORITY

Create a Fair & Just Culture

At Liverpool Women's, we are undertaking a long-term programme of cultural change to ensure we embed a culture where the focus is on clear accountability, supporting each other and learning from events, where staff are empowered to act and speak out in the interests of safety. Successful delivery of this programme will have a clear impact on both quality improvement and safety; creating an open environment where we can extract the best learning from incidents and complaints.

Implementation of this work stream is part of the Putting People First Strategy and is monitored by the Putting People First Committee.

Deliver Comprehensive Human Factors Training

Human Factors is an established scientific discipline used in many safety critical industries. It offers an integrated, evidenced and coherent approach to patient safety, quality improvement and clinical excellence. Embedding Human Factors approaches within our clinical services will allow us to deliver optimum outcomes, through better understanding the behaviour of individuals, their interactions with each other and with their complex clinical environments.

Implementation of this work stream is part of the Quality Improvement Strategy and will be monitored by Effectiveness Senate

Supporting Strategies and Plans

Putting People First, Nursing Midwifery & AHPs, Quality Improvement, Leadership and Talent

EFFICIENT

AMBITION

MAXIMUM EFFICIENCY, OPTIMUM USE OF RESOURCES

- We will value the time of every person using or providing our services
- We will make best use of all our resources

QUALITY PRIORITY

Adopt Relevant Tested Interventions

The National Patient Safety Strategy recognises that ensuring the adoption and spread of tested methodologies has a material impact on safety and quality within clinical services. In our Quality Improvement Strategy, we outline our methodology for ensuring that all relevant, tested interventions will be implemented.

Implementation of this work stream is part of the Quality Improvement Strategy and will be monitored through the Effectiveness Senate

Deliver National Targets in the Context of COVID Recovery

National targets provide key benchmarks against which we compare our performance. Meeting national targets is vital to ensure we are achieving both the best outcomes and experience for our women, babies and their families. Performance against national targets has worsened significantly across the NHS as we respond to COVID-19; it is imperative that we retain our focus on meeting these targets as we recover from the pandemic and bring services back online.

Implementation of this work stream is monitored through our Operational Plan and Performance Reports

Supporting Strategies and Plans

Digital.Generations, Operational Plan, LTFM, Nursing, Midwifery & AHPs

SAFE

AMBITION

THE SAFEST CARE FOR OUR WOMEN, BABIES AND THEIR FAMILIES

- We will develop services with safety at their core
- We will learn from the mistakes of ourselves and others

QUALITY PRIORITY

Create a Culture of Safety

The National Patient Safety Strategy sets out what the NHS will do to continuously improve patient safety. It features two key strands; embedding a patient safety culture and a patient safety system. We will develop a local implementation plan to ensure this national strategy is delivered at Liverpool Women's and that staff feel supported and empowered to act and speak out, enabling us to achieve our ambition of zero never events.

Deliver Outstanding Medicines Safety

We will deliver a robust system for ensuring the safe and secure management of medicines across all areas of the Trust to protect patients from harm, meet regulatory requirements and avoid medicines safety errors. We will participate in the national Medicines Safety Improvement Programme, focusing on high risk drugs, situations and vulnerable patients.

Deliver Outstanding Maternity and Neonatal Safety

We will participate in the national Improvement Programme for Maternity and Neonatal Safety, aiming to deliver the goals set out in the national patient safety strategy; reducing the rate of stillbirths, neonatal deaths and asphyxial brain injury by 50% by 2025.

Supporting Strategies and Plans

Putting People First, Nursing Midwifery & AHPs, Risk Management

EFFECTIVE

AMBITION

OUTSTANDING OUTCOMES

- We aim to deliver the 3 zeros - zero stillbirth, zero maternal deaths, zero never events
- We will achieve world leading cancer outcomes

QUALITY PRIORITY

Improve Adult Mortality

Our isolation from other acute adult services at Liverpool Women's Hospital increases the risk to our adult patients in maternity and in gynaecology. It is vital that we maintain the highest possible quality of care at all times, across all of our medical, midwifery and nursing specialties. We will strive to achieve zero maternal deaths, zero unexpected deaths in women having gynaecological treatment and high quality care for women dying as an expected result of gynaecological cancer.

Reduce Still Birth, and Deaths in the First 28 Days of Life

The death of a baby before or after birth is a devastating event. We will strive to ensure there are no avoidable deaths of babies before or after their birth.

Deliver All Possible NICE Quality Standards

At Liverpool Women's NICE Quality Standards are used to review current services and to show that high quality care or services are being provided and highlight areas for improvements. We will demonstrate compliance with evidenced based practice where feasible (some standards are unachievable due to the separation from other services).

Supporting Strategies and Plans

Putting People First, Nursing Midwifery & AHPs, Risk Management, Research and Development Strategy

EXPERIENCE

AMBITION

EVERY PATIENT WILL HAVE AN OUTSTANDING EXPERIENCE

- Service users will be partners in decisions about their care
- We will be accountable to our community, members and governors
- We will be inclusive of all members of our community
- We will seek your views and listen to what you say

QUALITY PRIORITY

Accountability to Our Community

Shared decision making, at both individual and collective levels, leads to better decisions and a better experience. We want to empower our community to inform what we do and shape our services for the future, so that we become as accountable to the community that we serve as we are to our regulators. We will build on our existing relationships and seek out best practice so that we become more accountable to our community.

Learning from Patient Experience

At Liverpool Women's we recognise that we will only deliver the highest quality care and best patient experience when our patients are equal partners in decision making about their care, and when we listen to and act on what patients tell us about their experiences of our services. We will learn from what each of our patients tells us about their experience.

Implementation of this work stream is monitored through the Patient Experience and Nursing, Midwifery and AHPs Strategies

Supporting Strategies and Plans

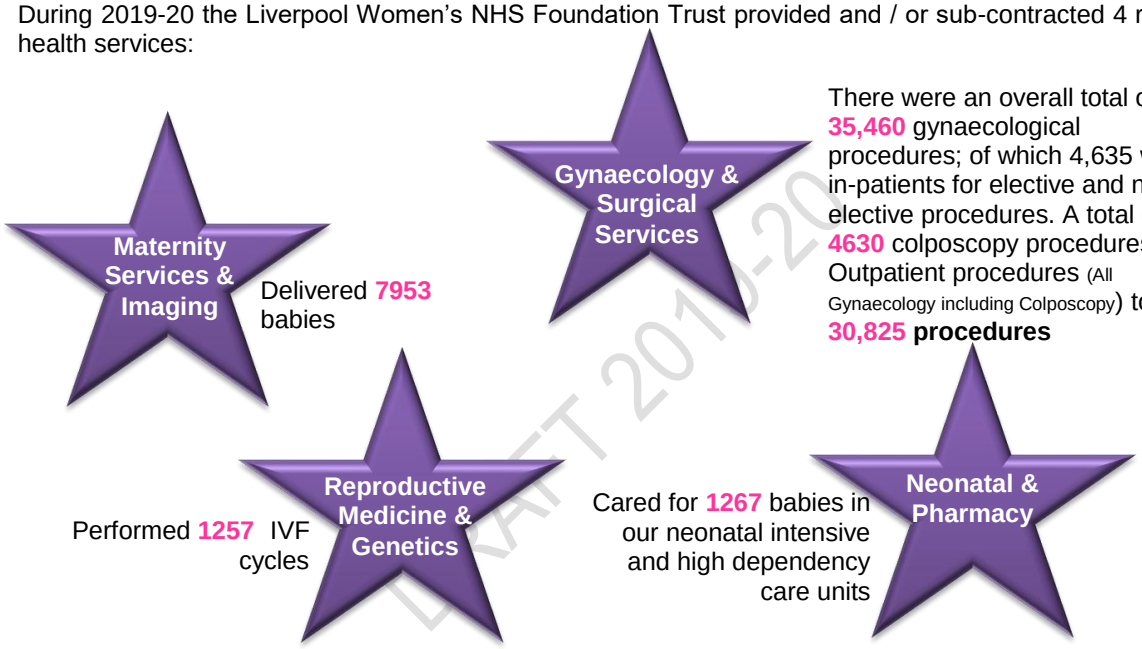
Putting People First, Nursing Midwifery & AHPs, Patient Experience, Communications

Statements of Assurance

The Trust is required to include statements of assurance from the Board. These statements are nationally requested and are common across all NHS Quality Accounts.

Review of Services

During 2019-20 the Liverpool Women's NHS Foundation Trust provided and / or sub-contracted 4 relevant health services:



The Liverpool Women's NHS Foundation Trust has reviewed all the data available to them on the quality of care in all of these relevant health services.

Participation in Clinical Audit

During 2019-20 8 national clinical audits and 2 national confidential enquiries covered relevant health services that Liverpool Women's NHS Foundation Trust provides. During 2019-20 Liverpool Women's NHS Foundation Trust participated in 100% of national clinical audits and 100% of national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Liverpool Women's NHS Foundation Trust participated in, and for which data collection was completed during 2019-20, are listed below alongside the percentage of the number of registered cases required by the terms of that audit or enquiry.

Relevant National Clinical Audits	Did the Trust participate?	Cases Submitted
Neonatal Intensive and Special Care (NNAP)	✓	**100%**
National Comparative Audit of Blood Transfusion Programme – Massive haemorrhage	✓	**100%**
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK) – Perinatal Mortality	✓	**100%**
National Pregnancy in Diabetes Audit (NPID)	✓	**100%**
National Maternity and Perinatal Audit (NMPA)	✓	**100%**
Learning Disability Mortality Review Programme (LeDeR)	**No cases to submit**	
National audit of the Management of Maternal Anaemia	✓	**100%**
Serious Hazards of Transfusion (SHOT) *(actions to be included in annual Bedside Transfusion Audit report)*	✓	**100%**

Relevant National Confidential Enquiries	Did the Trust participate?	Cases Submitted
Maternal, New-born and Infant Clinical Outcome Review Programme (MBRRACE-UK) – Maternal Deaths	✓	**100%**
Acute Bowel Obstruction	✓	**N/A** *(Organisational Questionnaire returned. No Casenotes requested).*

The reports of 2 national clinical audits were reviewed by the provider in 2019-20 and the remaining reports are expected later in 2020 and Liverpool Women's NHS Foundation Trust intends to take relevant actions to improve the quality of healthcare provided.

National Clinical Audits	Actions Taken
Neonatal Intensive and Special Care (NNAP)	National report in the process of being reviewed prior to provision of local report and action plan.
National Comparative Audit of Blood Transfusion Programme – Massive haemorrhage	Interim National Report received. No local actions required at this time. Awaiting National Report.

Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK) – Stillbirth	National report in the process of being reviewed prior to provision of local report and action plan.
National Pregnancy in Diabetes Audit (NPID) 2019	As a result of the most recent National Report received which looked at 2017 and 2018 deliveries, a local report including action plan was developed and the following actions are in progress: Promote pre-pregnancy counselling clinics in Aintree and RLUH to patients and primary care. Change format of discharge letters to GP after delivery to emphasise need for pre pregnancy counselling, HbA1c target of <48mmol/mol and 5mg folic acid. Incorporate educational sessions on Continuous Glucose Monitoring (CGM) and diabetes issues in ward based teaching sessions. Audit to explore reasons for higher preterm delivery and large for gestational age (LGA >90th centile) babies in pre-existing diabetes to assess the utility of VRIII for Ante Natal steroids and in labour in adherence to LWH guidelines, specifically looking at compliance to CBG monitoring, timing of administration of steroids, utility of insulin and pregnancy outcomes in these cases. Create an electronic database with the assistance of the I.T. department, for collecting future NPID data.
National Maternity and Perinatal Audit (NMPA)	As a result of the most recent National Report received regarding 2016-17 data the following actions were completed: Due to the lack of understanding of the intrapartum factors associated with variations in the 5 Minute Apgar score, performance metrics were developed and monthly trend analysis are conducted. As a result of higher than expected 5 Minute Apgar scores not being investigated, a Root Cause Analysis (qualitative and quantitative) was conducted. Due to inaccuracy of the Apgar scoring system, an expanded Apgar scoring sheet was developed and implemented. An evaluation of the use of expanded Apgar scoring sheet is to take place including a trend analysis of 5 Minute Apgar scores in Term singleton babies. Awaiting next National Report.
Learning Disability Mortality Review Programme (LeDeR)	Although we planned to participate in this project, we had no cases to submit.

National Audit of the Management of Maternal Anaemia	Awaiting National Report.
Serious Hazards of Transfusion (SHOT) *(actions to be included in annual Bedside Transfusion Audit report)*	Awaiting Final Local Bedside Transfusion Audit Report.

The reports of 49 local clinical audits were reviewed by the provider in 2019-20 and Liverpool Women's NHS Foundation Trust has either already taken or intends to take the following actions to improve the quality of healthcare provided. This is a selection of key actions that have improved healthcare or made a difference to patients as a result of local clinical audit; they are those we feel are most relevant from our Clinical Audit programme this year.

Audit on reporting of radiology images by on-call neonatal consultant
Although the proportion of images with a documented review by any clinician has increased since the previous audit, it is still lower than our standard of 100%. As a result of this, individual feedback is now sent to consultants. A SOP has been modified to include the morning handover as a time when imaging studies from the previous night are performed. This has also been incorporated into the Badger system's induction training. A Lesson of the week for medical trainees and ANNPs about the need to record the consultant's name when they are entering the results of an x-ray review was circulated. Change request forms have been submitted to suppliers of the Badger system to improve the electronic form used to record radiology reviews with prompts for the name of the reviewing consultant.

Information provision on safer sleeping
Following a review of this audit against the January 2019 audit, there has been a significant improvement in all the standards. There is now an option on Meditech to record that a visit is a 36 week visit. All midwives are now recording the antenatal discussion of the safe sleep messages and completing the 36 week check list. The findings of this audit also demonstrated that all of the 54 records reviewed had the antenatal, intranatal and postnatal records, scanned into EDMS. All community midwives are now using the updated 36 week check list. Furthermore patient action plans completed are now being revisited at discharge from the community.

Bladder Care After TVT/Surgery
This audit highlighted that improvement in compliance with the Trial Without Catheter (TWOC) guideline was required.

Following this audit, a printed and laminated copy of the TWOC pathway has been made available to all staff working on the Gynaecology Ward. The full guideline is now also accessible via the Trust Intranet. A flowchart has been created on the Patient Electronic Notes System (PENS) to aid with robust documentation of bladder care following TWOC and gynaecological surgery; Staff on the Gynaecology Ward have also been informed of how to use this document correctly. The current guideline has been reviewed and updated based on findings of this audit and Nursing Staff on the Gynaecology Ward have been informed of the standards outlined in the current guideline.
A re-audit following the introduction of the updated guideline will take place in the 2020-2021 audit year.

Patient Information Process
The results of this audit demonstrated that there is a good process in place with regards to Patient information leaflets within the Trust.

The accessibility of Patient leaflets caters for all and leaflets can also be printed supporting those who may not have access to the internet etc. as Staff can print off required documentation at the time of an appointment or inpatient episode if necessary.

It was identified from this audit that 3 of the Trust leaflets did not receive patient involvement when being produced which is crucial in the development of a Patient leaflet. As a result, the checklist for creating a Patient leaflet has now been amended to include Patient involvement as a mandatory section when being compiling the document.

Audit to Assess Compliance with the Ionising Radiation (Medical Exposure) Regulations 2017
The need to ensure that x-ray examinations are reported on within a set time frame and that a plan is in place to make certain this is happening was noted as a result of this audit. There is currently a standard of practice in place but this will be updated to include a time-frame so that it is clearly documented when the reports should be completed. As a fail safe to ensure that requests are not missed in future, a system will be put in place which assesses x-ray requests weekly to determine whether there is a report on the system. Radiographers will sign a document weekly to confirm that they have assessed all of the requests for the past two weeks to ensure there is a report. If there is not a report on the system, Radiologists will be contacted in a timely manner and advised that this should be completed. A spot check will be performed 6 months following this audit to assess compliance with these new implementations.

Auditing the compliance against Domestic Abuse Protocol/Procedure
This audit found that compliance remains high in respect of routine enquiry and that Staff clearly demonstrate awareness of when it is not safe to complete routine enquiry and that there is understanding and adherence to internal safeguarding referral processes.

With regards to actions for improvement as a result of this audit, Level 3 Children/Adult and also bespoke Safeguarding training will be reviewed to ensure this will improve competence and confidence in understanding the dynamics of domestic abuse and levels of need in respect of children and families. The Safeguarding Team will create an additional essential training competency for Staff required to be able to complete Safe Lives DASH risk assessments. There will be specific training needs analysis (TNA) for areas where there is a known higher likelihood of disclosure. The Safeguarding Team will also work with IT systems to increase Safeguarding prompts within various pathways/assessments.

Re-Audit to assess compliance with new patient triage criteria in Clinical Genetics
The results of this audit found that the majority of referrals are triaged correctly and in line with the triage criteria. This means that the right Patient is seeing the right Clinician, at the right time. The weekly referral meeting catches most of the small number incorrectly triaged but they cannot catch the inappropriate clinics. The findings of this audit were presented and circulated to all relevant Staff and all Clinicians were sent reminders of the triage guidelines via email. As a 'safety-net, Principal Genetic Counsellors were encouraged to challenge any triages that they deemed incorrect moving forward.

Assess effectiveness of the Hewitt Centres Multiple Birth Minimisation Strategy (MBMS)
This audit identified within a limited data-set, potential trends and findings which if confirmed by future work, provide evidence based methods for revising the current MBMS. Standardisation of data recording and accurate policy documentation has been improved as a direct result of this audit. Conversations were also stimulated with senior Scientific Staff, as to the next moves in terms of both updating the MBMS and exploring options for better embryo selection tools. The results and conclusions of this audit were discussed with the Scientific Director and Lead Embryologists and the data was used for the review and update of the MBMS and local Standard Operating Procedure (SOP) in relation to MBMS.

Bedside Transfusion Re-audit
We have maintained or improved upon the compliance for the majority of the standards for this audit. This includes 100% compliance with patient identification, consent, transfusion episode complete within 4 hours, traceability and fating of blood components.

There were some areas of improvement identified from this audit and appropriate actions have been drawn up to ensure these areas are addressed. Audit findings are to be communicated to all Staff involved in delivering blood transfusions in clinical practice. Relevant department/ward Managers will be advised of the

improvements needed and that all Staff are required to be compliant and up to date with their mandatory training and competency assessments. It will be requested that ward/department Managers identify potential Staff from key areas to be prioritised for cascade training and that this continues to be monitored monthly. Relevant Staff will be informed of any areas of documentation requiring improvement whilst highlighting the importance of this. The Serious Hazards of Transfusion (SHOT) report and review of incident will be circulated alongside the findings of the audit to all of the relevant Staff. The data collection tool for this audit will also be reviewed ahead of the future audit to ensure it is fit for purpose and user friendly.

What is Clinical Audit?
Clinical audit is a quality improvement cycle that involves measurement of the effectiveness of healthcare against agreed and proven standards for high quality, and taking action to bring practice in line with these standards so as to improve the quality of care and health outcomes.

New Principles of Best Practice in Clinical Audit (Healthcare Quality Improvement Partnership, January 2011)

?

The Trust annually prepares a Clinical Audit Programme. This programme prioritises work to support learning from serious incidents, risks, patient complaints and to investigate areas for improvement. The results of all audits, along with the actions arising from them, are published in the Trust Clinical Audit Annual Report and on the Trust's intranet to ensure all staff are able to access and share in the learning.

Participation in Clinical Research

The Trust is continually striving to improve the quality of its services and patient experience. Research is recognised by the organisation as being pivotal to this ambition.

During 2019/20 we have continued our efforts to contribute to quality National Institute for Health Research (NIHR) studies and to maintain our subsequent numbers of NIHR recruitment accruals. We also continue to focus our efforts on collaborative research with academic partners to ensure the research we conduct is not only of high quality, but is translational, providing clinical benefit for our patients in a timely manner.
Our commitment to conducting clinical research demonstrates our dedication to improving the quality of care we offer and to making our contribution to wider health improvements. Our healthcare providers stay up to date with new and innovative treatment options and are able to offer the latest medical treatments and techniques to our patients.

The number of patients receiving relevant health services provided or sub-contracted by Liverpool Women's NHS Foundation Trust in 2019/20 that were recruited during that period to participate in research approved by a research ethics committee was 1,458 of which, 840 were recruited into NIHR portfolio studies.

Liverpool Women's was involved in conducting 109 clinical research studies across our speciality areas of maternity, neonates, gynaecology oncology, general gynaecology, reproductive medicine, anaesthetics and genetics during 2019/20. At the end of 2019/20 a further 25 studies were in set up, including 6 industry studies.

There were approximately 189 clinical staff contributing to research approved by a research ethics committee at Liverpool Women's during 2018/19. These staff contributed to research covering a broad spectrum of translational research from basic research at the laboratory bench, through early and late clinical trials, to health systems research about healthcare delivery in the community.

Our research has contributed to the evidence-base for healthcare practice and delivery, and in the last year, 75 publications have resulted from our involvement in research, which shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS.

Key research achievements during 2019/20 can be summarised as follows:

- A new collaborative world-leading programme of research focused on improving the health and wellbeing of children and their families within the Liverpool City Region (LCR) has been awarded funding from Wellcome. The 'Children Growing-up in Liverpool (C-GULL)' research study and data resource will be used to better understand and improve the lives of LCR children and their families. This will be the first newly established longitudinal birth cohort to be funded in the UK for almost 20 years.

  Currently, Liverpool ranks highly in terms of the highest rates of child mortality and conditions such as asthma, type 2 diabetes, epilepsy and risk factors for poor health such as obesity, poor nutrition and low levels of physical activity. To help develop a better understanding of these issues, researchers will collect information from 10,000 babies and their families, starting in pregnancy and over the first years of life, allowing changes in their health and development to be monitored and recorded over time. The information gathered will provide important evidence for policy, practice and research that will ultimately help improve child health and development in the area.

  C-GULL will launch at Liverpool Women's Hospital next year bringing together citizens, researchers and clinicians across the Liverpool City Region and wider to make one of the largest family studies in the UK.

- In June 2019, had the Trust had the privilege of hosting the annual meeting of the European Network for Individualised Treatment of Endometrial Cancer (ENITEC). ENITEC is a pan-European academic Network for Translational Researchers in Gynaecological Oncology, who gather together to share their expertise in uterine cancer research, with a particular focus on integration of molecular studies to improve and individualize patient care. The ultimate goal of the Network is to improve and individualize treatment of women with uterine cancers by integrating the best science in state of the art clinical care, and enabling every patient to access benefits from translational research.

- Research led by Dr Colin Morgan has led to the development of an idea for a new parenteral nutrition product that comprises a specific amino acid formulation concentration. During 2019/20 the research team, together with the R&D Department and a team of expert patent attorneys have undertaken further work to protect the IP by formally submitting an international patent. This has allowed the team to publish the preliminary data without other parties (especially commercial) using the information for commercial gain whilst additional scientific analysis is undertaken.

- During 2019/20, the Trust was awarded approximately £341,765 by the NIHR Health Technology Assessment programme. The funding will support delivery of the FERN – Intervention or Expectant Management for Early Onset Selective Fetal Growth Restriction in Monochorionic Twin Pregnancy research study. It is anticipated that the clinical research study will commence during 2020/21.

- During 2019/20 the Trust commenced collaborative discussions with the TMRW Group. The TMRW Group, based in New York, have developed an integrated system for automated, software guided embryology and cryo-management. The Hewitt Fertility Centre will be the first in Europe to test out this new cryogenic storage solution during 2020/21.

- The Trust was a finalist in the "Excellence in Commercial Life Science Research" award at the North West Coast Research and Innovation Awards 2020, for its participation in a clinical trial researching effective treatments for premenstrual dysphoric disorder (PMDD). PMDD has a negative effect on a woman's daily life and relationships. No treatments have been developed specifically for the treatment

of PMDD, antidepressants are often prescribed with moderate effect and tolerability. The aim of the study was to evaluate the effect of Sepranolone on premenstrual symptoms, provide further understanding of dose-confirmation and evaluate the safety and effectiveness of this potential new medication for PMDD – leading to the development of better treatment for this debilitating condition. Due to the hard work of the research team comprising, Dr Paula Briggs, Consultant Nurse Kathie Cooke and Research Nurse Pamela Corlett, LWH achieved top UK site status for both consented and randomised participants, and second highest recruitment site according to randomisation across all countries

Use of the Commissioning for Quality and Innovation (CQUIN) Payment Framework

A proportion of Liverpool Women's NHS Foundation Trust's income in 2019/20 was conditional upon achieving quality improvement and innovation goals agreed between Liverpool Women's NHS Foundation Trust and any other person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. The main areas covered by the framework are:

- Staff Flu Vaccinations
- Three High impact Falls
- Alcohol & Tobacco – Screening and Advice
- Neonatal Staffing

Further details of the agreed goals for 2019/20 and for the following 12 month period are available electronically at: www.liverpoolwomens.nhs.uk/About_Us/Quality_and_innovation.aspx.

The total monetary value of the income in 2019/20 conditional upon achieving quality improvement and innovation goals was £1,042,774. The monetary total for the actual payment in 2019/20 was ,£950,291 (Please note – CQUIN targets reduced between financial years as half of overall CQUIN value is now reimbursed via tariff

Care Quality Commission

Liverpool Women's NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is "registered without conditions".

The Care Quality Commission has not taken enforcement action against Liverpool Women's NHS Foundation Trust during 2019/20.

Liverpool Women's NHS Foundation Trust has not participated in special reviews or investigations by the Care Quality Commission during the reporting period.

What is the Care Quality Commission?
The Care Quality Commission (CQC) undertakes checks to ensure that Trusts are Safe, Caring, Responsive, Effective and Well-led. All NHS Trusts are required to register with them. If the CQC has concerns about a Trust it can issue a warning notice or even suspend or cancel a Trust's registration.

When Liverpool Women's was last formally inspected, in 3rd to 5th December 2019 for core services and 14th to 16th January 2020, the CQC rated it as **GOOD**. Full results are shown in the table that follows:

Safe	Effective	Caring	Responsive	Well-led	Overall
Good →← Apr 2020	Good →← Apr 2020	Good →← Apr 2020	Good →← Apr 2020	Requires improvement ↓ Apr 2020	Good →← Apr 2020

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for Liverpool Women's Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity	Good →← Apr 2020	Good →← Apr 2020	Good →← Apr 2020	Outstanding →← Apr 2020	Good →← Apr 2020	Good →← Apr 2020
Gynaecology	Requires improvement ↓ Apr 2020	Requires improvement ↓ Apr 2020	Good →← Apr 2020	Requires improvement →← Apr 2020	Requires improvement →← Apr 2020	Requires improvement →← Apr 2020
Neonatal services	Good ↓ Apr 2020	Good →← Apr 2020	Good →← Apr 2020	Good →← Apr 2020	Good →← Apr 2020	Good →← Apr 2020
End of life care	Good May 2015	Good May 2015	Good May 2015	Good May 2015	Good May 2015	Good May 2015
Outpatients	Good Mar 2020	Not rated	Good May 2020	Good May 2020	Good May 2020	Good May 2020
Overall*	Good →← Apr 2020	Good →← Apr 2020	Good →← Apr 2020	Good →← Apr 2020	Good →← Apr 2020	Good →← Apr 2020

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

The Trust received an overall rating of 'Good' with a 'Requires improvement' for Well- Led.

- Maternity received an overall 'Good' with **'Outstanding'** for Responsiveness
- Gynaecology received an overall 'Requires improvement' with 'Good' for Caring
- Neonatal services received an overall 'Good'.

During the Core Services inspection conducted 3-5 December 2019, the CQC issued the Trust with a warning notice 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 10 January 2020 deadline, noting the immediate steps that had been taken to ensure patient safety was not compromised. An immediate action taken was to implement twice weekly audits of medicine management with any resulting issues escalated as appropriate.

The trust internal audits have demonstrated ongoing compliance with the failings identified by the CQC warning notice. Following a focused inspection in relation to the warning notice the Trust has been informed that the warning notice has been lifted.

Liverpool Women's agreed an Action Plan with the CQC to address the Regulatory Breaches and those areas that the CQC had made recommendations and the Trust felt could be further enhance the care of our patients. The action plan has been monitored monthly via the Trust Quality Committee.

Data Quality

Liverpool Women's NHS Foundation Trust continues to hold regular data quality subcommittees to support the improvement of the data available to clinicians and senior managers within the Trust. These focus on specific specialties and have representation from key decision makers within the Divisions.

The establishment of these meetings has led to an increase in the number of data quality reports available to clinical areas to support the quality of data being provided and identifies key areas for additional training requirements.

The Trust continues to follow an internal programme of audit of important data sets and selected key performance measures and reports a high standard of completeness in the results of these audits.

The Trust recently commissioned an external audit of its RTT and Cancer data in line with NHSI IST guidance. Results showed 100% accuracy for cancer pathways and over 95% for RTT data. The Trust will continue to commission external audits focussing on RTT and Cancer Waiting Times data.

The Trust maintains a high score on the DQMI (%) as measured by NHSD throughout 2019/20, as reported below.

	Apr 19	May 19	June 19	July 19	Aug 19	Sept 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20
AE	99.0	99.2	98.9	99.2	98.2	98.3	97.9	98.1	98.7	98.4	98.5	97.9
APC	99.9	99.9	99.9	99.9	99.9	99.9	99.9	99.9	99.9	99.9	99.9	99.9
OP	99.9	99.9	99.9	99.9	99.9	99.8	99.8	99.6	99.9	99.7	99.7	99.7
MSDS	99.9	99.9	99.9	99.9	99.9	99.8	99.8	99.8	99.8	99.8	99.7	99.9
DID	99.1	99.1	99.3	99.2	99.2	99.2	99.1	99.1	99.1	99.2	99.0	99.0

Date source: https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/data-quality

The DQMI is a monthly publication about data quality in the NHS, which provides data submitters with timely and transparent information.

The percentage of records in the published data which included the patient's valid General Medical Practice Code was:

- 99.1% for admitted patient care
- 99.7% for Outpatient
- 99.5% for accident and emergency

This is important because the patient NHS number is the key identifier for patient records while accurate recording of the patient's General Medical Practice Code is essential to enable the transfer of clinical information about the patient from a Trust to the patient's General Practitioner.

Information Governance

In March 2020, the Trust was faced with the operational challenges of responding to the Covid-19 virus outbreak, which caused disruption in almost every area of the Trust. In response to the outbreak, the requirements for reporting against the Data Security and Protection (DSP) Toolkit were relaxed, meaning that a delay in reporting because of having to manage the outbreak was accepted, if Trusts felt that it was necessary to do so.

Whilst Covid-19 had caused some disruption, it was felt that the Trust was sufficiently prepared for the end of year submission that is was decided to submit the Trust position, as expected, in March 2020. The submitted Trust position was "Standards Met".

In the weeks prior to the DSP Toolkit submission, the Trust was subject to independent audit, which gave an assurance opinion of "Significant Assurance".

There still remain some areas that require review and further development, namely: reviewing the management and central control of computer systems and other information assets; ensuring the continued development of IG compliant processes; reviewing and renewing the trust central registers to ensure they are accurate and up to date; and taking steps to improve the compliance with Information Governance training.

During 2019/2020, the Trust has had no new incidents of sufficient seriousness to require reporting to the Information Commissioner's Office (ICO) but there was one incident that was first identified during the 2018/2019 reporting period that remained under active investigation and carried over into the current reporting period.

That incident, which involved unauthorised use of Trust information for research purposes, has now concluded. The ICO took no action against the Trust having been satisfied that he Trust had taken appropriate actions, had an ethical policy in place at the time and that these were the actions of an individual employee acting in isolation.

Clinical Coding

Liverpool Women's NHS Foundation Trust commissioned an external clinical coding audit in 2019-20 in line with the Data Security & Protection Toolkit guidelines. This found the overall accuracy of clinical coding to be of a high standard, meeting 'Standards Exceeded' level for DSPT. Good practice was noted in relation to the structure of the Clinical Coding department, which was found

to provide a supportive working environment with good channels for professional progression within the structure. The audit reported well-structured policies and procedures that effectively support the running of the department with active engagement from clinical staff. The Trust has a high level of assurance that the clinical coded data submitted is accurate and complete, supporting patient care and contributing to effective management.

Duty of Candour

The Francis Inquiry report into Mid Staffordshire NHS Foundation Trust recommended that a statutory duty of candour be introduced for health and care providers. This is further to the contractual requirement for candour for NHS bodies in the standard contract, and professional requirements for candour in the practice of regulated activity.

In interpreting the regulation on the duty of candour Liverpool Women's NHS Foundation Trust use the definitions of openness, transparency and candour used by Robert Francis in his report. The thresholds and harm definitions of moderate and severe harm are consistent with existing National Reporting and Learning System (NRLS) definitions, including prolonged psychological harm. The Trust records all specified instances in which it applies duty of candour on its Ulysses Risk Management system.

Duty of Candour requirements are covered by the Care Quality Commission's (CQC) Regulation 20. Trust Management are keen to confirm compliance with key aspects of Regulation 20, where they are aware that an incident has arisen requiring a Duty of Candour response.

A Duty of Candour Trust Audit completed in In September 2019 demonstrated that the Trust was 100% compliant with the Regulatory requirement for Duty of Candour. The audit examined the Trust policy and procedures and reviewed all incident where Duty of Candour Applied to identify if all requirements had been completed.

Gosport and Freedom to speak up processes

The Trust is committed to developing and maintaining an open and constructive culture whereby all staff feel comfortable in raising any concerns in the knowledge that they will be taken seriously, that their concerns will be addressed, and without any fear of reprisal of detriment. The ways in which staff can raise a concern are incorporated in the LWH Whistleblowing Policy & Procedure.

As well as the formal roles of the Senior Independent Non-Executive Director and the Freedom to Speak up Guardian, there are a range of other peer supporter roles including Mental Health First Aiders and Dignity at Work Advisors which are currently being amalgamated into one Staff Supporter role, that provide a further avenue for staff to raise concerns. These are supplemented by regular Trust wide Listening Events and smaller focus groups as required, plus quarterly internal staff surveys. The national staff survey shows an improving trend between 2015-2019 where staff confidence to report unsafe clinical practice increased from 67% to 75%.

In the twelve months April 2019 to March 2020, no formal concerns were raised under the Trust's Whistleblowing Policy. In the last 12 months a total of 34 contacts were made to the Freedom to Speak up Guardian (F2SUG). During 2019/20 the Board also completed the 'Freedom to Speak Up Review Tool for NHS Trusts'.

Fair and Just Culture

A Fair and Just (F&J) Steering Committee has been created for the 15 F&J trained leaders and others across the Trust to develop an operational plan and focus on staff and patient engagement. Policies have been reviewed to incorporate Fair & Just principles and processes. The steering committee continue to review areas where the use of F&J framework can be most beneficial to staff and the Trust. One area where this has become evident relates to individuals who continue not to follow medicines policies are in receipt of appropriate management using a fair and just culture approach.

Summary of Picker Inpatient Survey 2019 – Gynaecology Inpatients

Picker is an international charity dedicated to ensuring the highest quality health and social care for all always.

The National In-Patient Survey data was collected in July 2019. A total of 835 Gynaecology patients from Liverpool Women's Hospital Trust were invited to complete the survey. A total of 362 patients completed the survey, giving a response rate of 45%, which has decreased from the previous year (49%). The average response rate for the 74 'Picker' Trusts was 44%, meaning that as an organisation our response rate is lower than the average.

There are 62 questions which make up the inpatient survey, which are designed to mirror the patient journey through the hospital. The Picker survey enables the Trust to review its historical results from previous surveys and also allows the Trust to benchmark against other organisations. By reviewing the survey results the Trust is able to monitor historical trends and themes, which enables focus on those areas. The results also enable the Trust to review areas where performance has improved, which supports assurance and evidence that the effects of any service improvements or change in practice have occurred.

Respondents:

Of those who responded 15% accessed the Gynaecology service via an urgent or emergency pathway, the remaining patients (83%) were admitted on the elective pathway. The age range of the patients who responded were between 16-and 80+ with the majority of responses (60% coming from patients who were aged 40-69). The reported ethnic group of the patients were predominantly white (96%), other ethnic groups

Results

Key improvements:

There have been a number of significant improvements since 2018's survey. LWH have improved in respect of planned admissions, where the admission date was not changed by the hospital. Our patients have reported that during their inpatients stay there is always or nearly enough nurses on duty. During the admission process more patients reported that they did not have to wait long before they were allocated a bed on the ward. In addition to these improvements, patients also reported that staff helped with their care needs within a reasonable time. Patient also reported that they were told what to expect following their procedure or operation.

Compared to other "Picker" Trusts:

When compared to "Picker" average scores. LWH scored better than other Trust in a number of elements. The top five scores were mainly around admission and discharge processes. As mentioned in the previously patients reported that they did not have to wait long before they were allocated a bed on the ward. Regarding discharge patient reported that they were provided with written / printed documentation explaining what they should do /or not do following their discharge. The patients also reported that they were advised of danger signs to look for and they also reported that they were counselled regarding side effects of medications. Patients also reported that Doctors did not talk in front of them as if they were not there.

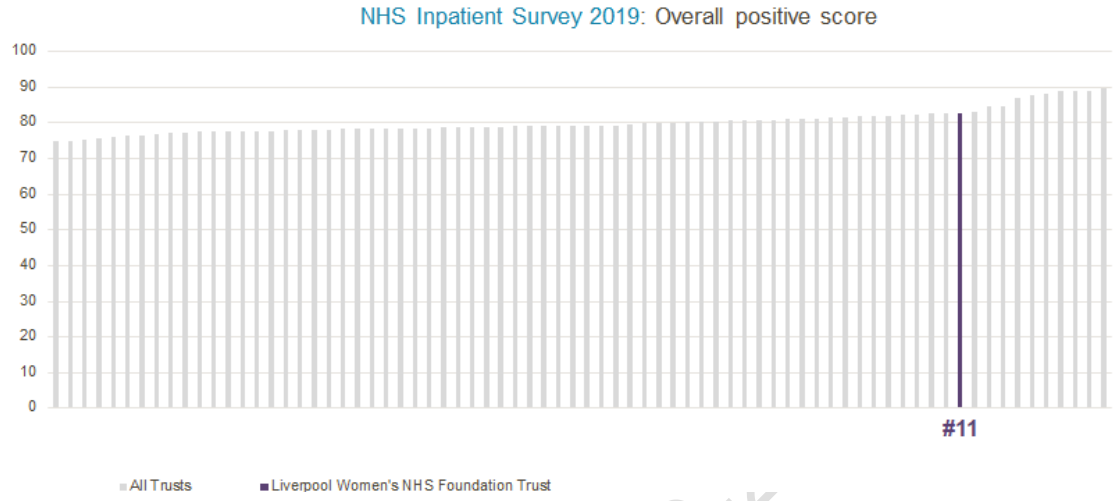
Least Improved from last Survey:

Of the five least improved elements from the survey, four domains related to the discharge of patients from the ward. Patients reported that staff did not discuss the need for additional

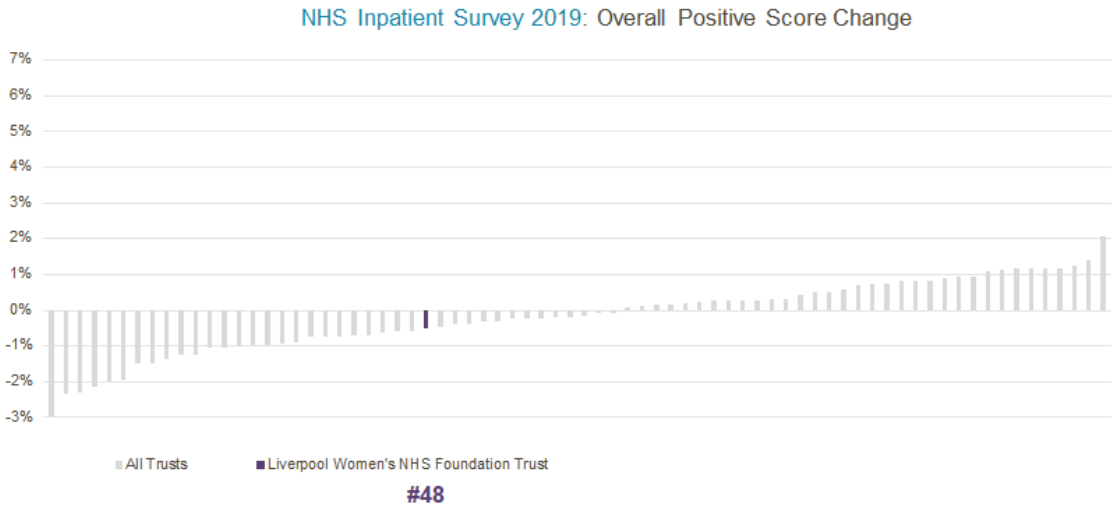
equipment, that expected care and support was available if it was needed. Specifically around discharge, patients also reported that staff did not discuss the need for further health and social care support or that they actually got enough support from health or social care professionals.

League Table of Results

This year's League table of positive results LWH scores number 11th out of 74 Picker Trusts, last year the Trust were placed at 11th.



The historical league table demonstrates how LWH's overall positive score has changed from last year's survey and how this change compares to other organisations. The Division is delighted to report that this has seen a significant improvement from 77th to 48th.



Historical trends of LWH

Utilising historical trends the Trust is able to identify where we have improved or performance has deteriorated over time. Based upon the 2019 scores LWH have improved in 28 of the survey points, as opposed to improving in only 5 areas in 2019, this is a considerable improvement. Key areas of improvement in scores relate to the care which our patients are given and in relation to nursing staff.

Based upon 2019 scores LWH have deteriorated in 26 areas within the survey compared to 50 areas in 2018. Demonstrating that although LWH have seen a drop in some scores this has not been as significant as the previous year.

Key Themes

Within the data it is quite clear that there are key themes, where we need to focus on improvement. The data demonstrates that our patients are not satisfied with both the food we are providing them nor are we supporting the patients during mealtimes. Patients have also identified that they do not get enough help from staff to wash or keep clean, and access to take their own medications is not supported.

The hospital & ward (part 2 of 2)

		Historical					Organisation type	
		2015	2016	2017	2018	2019	Average	Organisation
Q17+	Hospital: got enough help from staff to wash or keep clean	-	92%	90%	85%	84%	90%	84%
Q18+	Hospital: able to take own medication when needed to	-	92%	85%	84%	82%	79%	82%
Q19+	Hospital: food was very good or good	69%	67%	64%	62%	56%	59%	56%
Q20	Hospital: offered a choice of food	96%	96%	95%	95%	94%	94%	94%
Q21+	Hospital: got enough help from staff to eat meals	92%	88%	92%	79%	73%	82%	73%
Q22	Hospital: got enough to drink	-	-	93%	93%	94%	91%	94%

The other area where a clear theme has been identified is within the discharge from hospital process. Although some of our data evidences that we perform better in some areas than other Trust, this is the area where we have deteriorated the most since the 2018. It is not entirely clear on review why this area has deteriorated since the last report, however the ward has made improvements to the process prior to release of this survey.

Leaving hospital (part 1 of 2)

		Historical					Organisation type	
		2015	2016	2017	2018	2019	Average	Organisation
Q48+	Discharge: felt involved in decisions about discharge from hospital	90%	92%	91%	90%	91%	84%	91%
Q49	Discharge: given enough notice about when discharge would be	93%	94%	94%	92%	93%	87%	93%
Q50	Discharge: was not delayed	75%	79%	73%	71%	73%	60%	73%
Q52	Discharge: delayed by no longer than 1 hour	24%	27%	12%	14%	11%	12%	11%
Q54+	Discharge: got enough support from health or social care professionals	76%	77%	79%	74%	68%	78%	68%
Q55+	Discharge: knew what would happen next with care after leaving hospital	-	89%	90%	88%	85%	84%	85%
Q56	Discharge: patients given written/printed information about what they should or should not do after leaving hospital	87%	93%	90%	87%	84%	63%	84%
Q57+	Discharge: told purpose of medications	98%	97%	98%	97%	96%	91%	96%
Q58+	Discharge: told side-effects of medications	72%	78%	79%	75%	73%	57%	73%

Leaving hospital (part 2 of 2)

		Historical					Organisation type	
		2015	2016	2017	2018	2019	Average	Organisation
Q59+	Discharge: given clear written/printed information about medicines	91%	94%	95%	93%	91%	85%	91%
Q60+	Discharge: told of danger signals to look for	82%	86%	88%	86%	81%	64%	81%
Q61+	Discharge: family or home situation considered	86%	89%	89%	85%	86%	82%	86%
Q62+	Discharge: family, friends or carers given enough information to help care	67%	76%	81%	75%	74%	76%	74%
Q63+	Discharge: told who to contact if worried	94%	95%	96%	93%	91%	76%	91%
Q64+	Discharge: staff discussed need for additional equipment or home adaptation	70%	72%	84%	72%	56%	79%	56%
Q65+	Discharge: staff discussed need for further health or social care services	81%	82%	83%	80%	74%	81%	74%
Q66+	Discharge: expected care and support were available when needed	-	-	-	86%	79%	81%	79%

The Division of Gynaecology have reviewed the entirety of the report and its findings. There are a number of key areas in which we need to focus attention and implement actions to improve our patient's experience of care. In addition to this there are a number of areas which should be celebrated and continued.

Junior Doctor Staffing

In forward planning for the junior doctor workforce for year 19 – 20, the Trust agreed to fund an additional 11 WTE junior doctor posts within obstetrics and gynaecology as in previous years there has been a number of gaps / vacancies within this workforce.

The gaps were expected to continue in 19 – 20, however this has not been the case within O&G. The service received a full rotation resulting in the service being over established. This has enabled the service to run a shadow rota during out of hours giving doctors more support during out of hours from senior junior doctors.

Due to the over establishment in the workforce the Trust is relying less on agency and consultants to cover gaps in the rotas. Although other services are not over established they continue to achieve full staffing with minimal gaps and rota usage.

The trust continues to see under reporting in exception reporting although it is encouraged and the guardian of safe working has not issued any fines to services as all exceptions are settle with TOIL. There has also been an increase in the number of junior doctors able to attend teaching as the services are well staffed. However, there is an issue with ST3 trainees in O&G gaining competencies as the service received an increased number of ST3 trainees in quarter 2 of 2019.

It is important to note that, during this reporting year, 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 refreshed contract focuses on safety, wellbeing, training, education and includes an investment to support the changes and support an uplift in pay.

The number of gaps fluctuated throughout the year. The highest number of gaps in O&G was 3.5 for a period of 5 months. Anaesthetics, ran with 0.6 – 1 WTE gap over a 9 month period. Neonates gaps were between 1 – 2.8 WTE over a period of 11 months and genetics continued to run with 1 WTE gap. In the main, these gaps were related to maternity leave and long term sickness.

NHS Staff Survey

The Trust is committed to listening to the views of our staff and recognising their achievements on a regular basis. We believe that motivated and engaged staff deliver better outcomes for our patients and our on-going aspiration is to improve levels of staff engagement on a year on year basis, as measured by the NHS Staff Survey. Improving levels of involvement and engagement is one of four priority areas in our five-year Putting People First Strategy and underpins all of our HR, OD and L&D activity.

The NHS Staff Survey is a core tool for the Trust to engage consistently with our staff each year to identify what is important to them and then take action to address identified issues. In 2019, we continued to opt for a full survey of all our staff, included for the first-time electronic surveys and received a positive response rate of 61%, far exceeding the national average.

The table below indicates how the Trust compares to its benchmarking group (Specialist Acute Trusts):

Theme	2019		2018		2017		2016	
	Trust	Benchmarking Group	Trust	Benchmarking Group	Trust	Benchmarking Group	Trust	Benchmarking Group
Equality, diversity & inclusion	**9.4**	9.2	**9.5**	9.3	**9.4**	9.3	**9.5**	9.3
Health & wellbeing	**6.4**	6.3	**6.3**	6.3	**6.3**	6.3	**6.3**	6.3
Immediate managers	**6.9**	7.1	**6.8**	7	**6.7**	6.9	**6.7**	6.9
Morale	**6.3**	6.4	**6.1**	6.3	**---**	---	**---**	---

Quality of care	**7.6**	7.9	**7.6**	7.8	**7.6**	7.7	**7.6**	7.8
Safe environment – Bullying & harassment	**8.7**	8.3	**8.6**	8.2	**8.3**	8.4	**8.4**	8.3
Safe environment – Violence	**9.9**	9.8	**9.9**	9.7	**9.8**	9.7	**9.9**	9.7
Safety culture	**6.9**	7.0	**6.7**	6.9	**6.7**	6.9	**6.6**	6.9
Staff engagement	**7.2**	7.5	**7**	7.4	**7**	7.4	**6.9**	7.5
Team working	**6.6**	6.9	**---**	---	**---**	---	**---**	---

Overall the picture was one of improvement and we improved compared to last year in two overall 'themes' – *safety*, and *staff engagement*. We did not see a statistically significant decline in any of the eleven overall themes. We have moved closer towards the average or exceeded the average for Specialist Acute Trusts over a number of indicators. Areas where we remain further from the average include team working, immediate managers and quality of appraisals. The quality of appraisals has been highlighted as an issue for the last three years and the system will be reviewed in its entirety in 2020.

Analysis of key themes equality

Diversity & Inclusion
Although there was a minor drop from 9.5 in 2018 to 9.4 in 2019 (not statistically significant), this is still comfortably above the national average for our comparison group of 9.2.

Health & Wellbeing
There was a minor **increase** from 6.3 to 6.4 (not statistically significant) which is now above the national average of 6.3. For the specific question regarding whether staff have felt unwell as a result of work-related stress, the Trust figure of 32.2% in considerably lower than the national average for acute specialist Trusts of 36.6%.

Immediate Managers
There was a minor **increase** from 6.8 to 6.9 (not statistically significant) although this remains slightly below the national average of 7.1. It is encouraging that for the six questions that make up this theme, all saw improvements from our 2018 scores.

Morale
This figure **increased** from 6.1 to 6.3 (not statistically significant), which is now just below the national average of 6.4. It is notable that the specific question regarding involving staff in deciding changes that affect them saw an increase from 49.5% in 2018 to 57.2% in 2019. It should also be noted that the three questions regarding any intention to leave the Trust all saw improved scores.

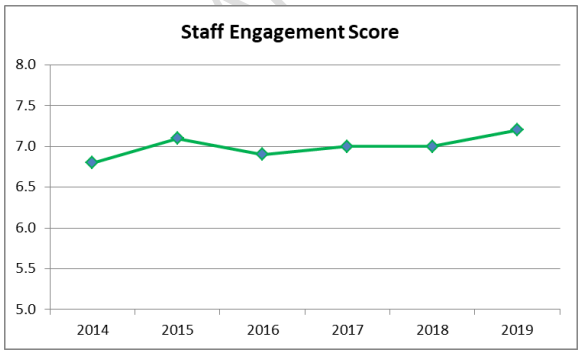
Quality of Care
This score **increased** from 7.5 in 2018 to 7.6 in 2019 (not statistically significant), while the national average remained unchanged at 7.9. The score for the specific question regarding staff being able to deliver the care they aspire to rose from70.7% in 2018 to 74.0% in 2019.

Safe Environment - Bullying & Harassment
This score **increased** from 8.6 to 8.7 (not statistically significant), which is markedly better than the national average of 8.3, and matches the best score nationally for acute specialist trusts. In particular, the score for the specific question regarding bullying by managers fell from 10.9% in 2018 to 7.9% in 2019 (having previously fallen from 15.5% in 2017).

Safe Environment - Violence
Our score remained unchanged at 9.9. This is better than the national average of 9.8, and matched the best score in our comparison group.

Safety Culture
This score **increased** from 6.7 to 6.9 and is now just 0.1 off the national average score of 7.0. Of particular note, the specific question concerning the Trust treating staff who are involved in incidents & near misses fairly saw an improvement from 50.5% in 2018 to 58.5% in 2019, and the number of staff said they would feel secure in raising concerns rose from 69.1% to 73.3%.

Staff Engagement
Our score **increased** from 7.0 in 2018 to 7.2 2019, although this is still below the national average of 7.5. Nevertheless, all nine questions that constitute this theme saw improvements.



Team Working
Our score remained unchanged at 6.6, as did the national average at 6.9. There were no significant changes in the scores for either of the specific questions that make up this theme.

It should also be noted that the scores for staff recommending the Trust as both a *place to receive treatment*, and as *a place to work*, reversed the fall in both these scores seen in the previous year. The significant rise in the score for recommending the Trust as a place to work is particularly encouraging.

Local results have been drilled down to division, directorate and ward/department level, and summaries have been distributed to the respective divisional management teams. They have been tasked with identifying key actions for their areas which will be signed off and monitored by the Divisional Boards. The local summaries also include a simple “you said /we did” pro- forma for local managers to use in sharing the results with their staff.

The results will also be used to refine and enhance the Putting People First Strategy Year 2 Action Plan which is performance managed via the sub-board level ‘Putting People First Committee’. Key Trust wide activities will include the implementation of a revised leadership strategy and the implementation of a talent mapping process. The local internal staff survey process will also be revised and a new paper based and electronic survey mirroring the key themes of the staff survey and other local priorities will be rolled out.

Reporting against Core Indicators

All NHS Trusts contribute to national indicators that enable the Department of Health and other organisations to compare and benchmark Trusts against each other. As a specialist Trust, not all of them are relevant to Liverpool Women's. This section of the report gives details of the indicators that are relevant to this Trust with national data included where it is available for the reporting year.

28 Day Readmission Rates

The first category of patients benchmarked nationally is those aged 0-15. The Trust admits fewer than 10 patients in this age category each year and so benchmarking of readmissions with other Trusts is not of any meaning.

The table below shows the percentage of patients aged 16 and above who were readmitted within 28 days:

Trust 2019/20	Trust 2018/19	National Average 2017/18 figures
3.04%	9.85%	13.8%

Liverpool Women's considers that this data is as described for the following reasons: readmission rates can be a barometer of the effectiveness of all care provided by a Trust. Liverpool Women's is committed to providing effective care .

Liverpool Women's intends to take the following actions to improve this indicator and so the quality of its services: continue to monitor the effectiveness of surgical and post-operative care using this indicator.

Trusts Responsiveness to Personal Needs of Patients

One of the care goals of the Liverpool Women's NHS Foundation Trust is to provide the best patient experience. We use the information provided from our patients to tell us that the experience they have of the treatment and care they receive on their journey through the NHS and how we can be even more important to them than how clinically effective care has been.

To be able to achieve this we work to ensure that all patient individual personal needs are identified and dealt with in the most appropriate manner. Working with patients in partnership is key to a good patient experience which can have a significant impact on their maternity experience and the birth of their baby, experience of the gynaecology services throughout patients department and inpatient ward and their recovery or a peaceful death.

In relation to Neonatal care a close relationship is built up with parents who have babies on the neonatal unit no matter how short a time that may be to ensure not only that the parent scan be involved in their babies care as much as they are able but to also allow them to form a key essential bond with their baby. This has been even further evidenced by the successful completion of the new Neonatal Unit, the design of which was influenced by engagement with the parents of babies who have been on the Unit.

Within the Gynaecology in patient service all patients have an individualised care plans in place form when they are admitted, which are updated as the patient condition changes. These are reviewed by the Matrons and Head of Nursing to ensure that they are of a high quality and meet the patient's needs. There is a close working relationship with eh safeguarding team in relation to ensuring that patient with Learning disabilities have reasonable adjustments in place prior to coming into hospital and for patients with Mental health issues is that there are process and procedures in place to support them whilst in the hospital environment.

Also within the unit there is a process of intentional rounding completed by the ward staff, ward manager and matrons to ensure that core care requirements are being met. This process is monitored via the use of ward nursing metrics system. The gynaecology ward had also introduced a daily huddle to clearly identify patients' needs and where applicable additional support if required.

In relation to the maternity service, all women have an individualised birth plans which is developed during their pregnancy, to ensure that as far as is possible during the woman's maternity care she has the best experience she would like to have to meet with her own personal needs. Birth plans are viewed by one of the Matrons to ensure that the plans are appropriate and written to meet the personal needs of the individual women.

NHS Trusts are required to have robust processes in place to ensure that essential standards of quality and safety are maintained in line with standards set by the Care Quality Commission (CQC) and Health and Social Care Act (2008). The desired outcome is that a patient's experience of care is safe, positive and clinically effective.

The process of Ward Accreditation has been introduced by the Director of Nursing and Midwifery which is a system of assessment of clinical environments to ensure that the highest standards of care and environmental safety are achieved. Where there are issue then an action plan is put in place to address these with oversight by the Quality Committee. One assessed the ward or departments are given an award level, Gold, Siler, Bronze and White. From the first round of assessment Neonatal Unit was given a gold award, Delivery Suite was given a silver award, Midwifery lead Unit was given and Siler award as was Maternity base and the Gynaecology Unit was given a white award.

Staff who would recommend the Trust to their family or friends

All Trusts are asked to record the percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the trust as a provider of care to their family or friends. The table below shows how Liverpool Women's compares with other specialist Trusts nationally:

Recommend as a place to receive treatment:

LWH 2019	LWH 2018	Benchmark Average (2019)
80.9%	77.5%	90.0%

Liverpool Women's considers that this data is as described for the following reasons: although below the national average when measured against Specialist Trusts, Liverpool Women's performs more favourably if grouped with other Acute Trusts

The increase in staff recommending as a place to receive treatment is a positive increase which is in line with the overall increase in the engagement score.

Venous Thromboembolism (VTE)

All Trusts are asked to record the number of patients receiving a VTE assessment expressed as a percentage of eligible 'ordinary' admissions. The table below shows how Liverpool Women's compares nationally:

2019-20	2018-19	2017-18	2016-17	National Target
97%	97%	98%	98%	90%

Liverpool Women's considers that this data is as described for the following reasons: the Trust has well established processes for assessing patients' risk of VTE and consistently performs above average.

Liverpool Women's intends to take the following actions to improve this indicator and so the quality of its services: the Liverpool Women's VTE guidelines have been updated in light of the NICE guidance NG98 2018 Venous thromboembolism in the over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism. The Trust will conduct 6 monthly audits of compliance with VTE guidelines.

Clostridium Difficile

All Trusts are asked to record the rate of Trust apportioned C.difficile per 100,000 bed days. The table below shows how Liverpool Women's compares nationally:

LWFT	LWFT 2018-19	LWFT 2017-18	National Average
0	0	0	N/A

Liverpool Women's considers that this data is as described for the following reasons: the Trust takes extremely seriously its duty to prevent infection and provide care in a safe environment.

Liverpool Women's intends to take the following actions to improve this indicator and so the quality of its services: all cases will continue to be reported to the infection control team, will have a root cause analysis and will be reported nationally. The Trust will also review its range of interventions to ensure they remain fit for purpose.

Patient Safety Incidents

All Trusts are asked to record their number and rate of patient safety incidents per 1,000 bed days. The table below shows this data for Liverpool Women in the period 2019-20:

	LWFT 2019-20*
No. PSIs	**4479**
Total Bed days 2019-20	**88991**
Rate /1000 Bed Days	**50.33**

*Local unmoderated data PSI only data

The Trust considers that this data is as described accurately for the following reasons:

The data for this and the following Severe Harm and Death incidence measure is taken from the Trust's Incident reporting database used in combination with bed days activity data monitored nationally. The Trust has a strong culture of incident reporting giving confidence in incident capture.

The risk team continue to support staff in the reporting of incidents to keep relevant managers and executives aware and involved in the management of incidents ensuring that appropriate action is taken where necessary.

Liverpool Women's intends to take the following actions to improve this indicator and so the quality of its services:

The latest available benchmarking data to March 2020 is not available.

The Trust continues to work positively with the Clinical Commissioning Group and HSIB and values the potential to further improve the effectiveness of its incident management processes and responsiveness of appropriate actions taken.

All Acute Trusts are asked to record the number and proportion of reported incidents that result in severe harm or death in the reporting period. The table below shows this data for Liverpool Women's during 2019-20:

Indicator	LWFT 2019-20*
No. PSIs	**4479**
No. Severe Harm or Death incidents	**1**
Severe Harm and Death incidents as % PSIs	**0.0002%**

* Local unmoderated data

Part 3

Other Information

Performance against Key National Priorities and National Core Standards

NHS improvement sets out their approach to overseeing NHS Foundation Trusts' compliance with the governance and continuity of service requirements of the Foundation Trust licence. This section of the report shows our performance against the indicators NHS Improvement set out in this framework, unless they have already been reported in another part of this report.

Last year was a particularly challenging one for the NHS; all trusts were expected to provide the highest standards of care while achieving demanding efficiency savings. The trust continued to provide safe, high quality care to our patients. With the exception of Referral to Treatment and 62 Day Cancer, the trust continued to deliver the national targets. Alongside this, in a climate where many providers have struggled to achieve their financial plan, the trust has continued to deliver its financial performance.

Details of the national targets that are required to achieve are set out below, together with our actual performance:

Indicator Name	Target	Performance 2019/20	
A&E Clinical Quality - Total Time in A&E under 4 hours (accumulated figure)	95%	**98.86%**	**Achieved**
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral) - post local breach re-allocation (accumulated figure)	90%	**88%**	**Not Achieved**
Cancer 31 day wait for second or subsequent treatment – surgery (accumulated figure)	94%	**77%**	**Not Achieved**
Cancer 31 day wait from diagnosis to first treatment (accumulated figure)	96%	**71%**	**Not Achieved**
Cancer 2 week (all cancers) (accumulated figure)	93%	**95.38%**	**Achieved**
Clostridium difficile due to lapses in care (accumulated figure)	0	**0**	**Achieved**
Never Events	0	**1**	**Not Achieved**
Incidence of MRSA bacterium	0	**1**	**Not Achieved**
Referral to treatment time, 18 weeks in aggregate, incomplete pathways	92%	**82.43%**	**Not Achieved**
Cancer 62 Day Waits for first treatment (from urgent GP referral) - post local breach re-allocation (accumulated figure)	85%	**43.2%**	**Not Achieved**
Maximum 6-week wait for diagnostic procedures	99%	**97.50%**	**Not Achieved**

Overall, the Trust performed well against a range of national standards during the year but failed to achieve the key standards for Referral to Treatment, Cancer 31 day wait from diagnosis to first treatment and Cancer 62-day performance.

For Referral to Treatment, including diagnostics, the Trust has ensured that longest waiting patients are cared for appropriately to mitigate risk of harm where standards are not achieved, and we have worked productively throughout the year with commissioners and partners to effect improvements in performance.

Performance against the Cancer standards has been impaired by clinical capacity and challenges in recruiting consultant staff in shortage specialties. We have worked collaboratively with the Cheshire and Mersey Cancer Alliance to ensure a pan-regional to address challenges associated with the Cancer standard and improve performance. This work has proved successful in identifying areas for further collaboration and facilitated a renewed focus on streamlined models of care and access to diagnostic services.

We were disappointed to record a Never Event during 2019/20 which related to a retained swab following completion of an elective caesarean section procedure. The incident was promptly investigated in accordance with local policy and national guidance and the investigation identified a root cause of both human error and system failure. The Trust responded quickly to address the operational issues raised by the incident and ensured rigorous monitoring to ensure that resultant changes in practice were embedded. Both commissioners and regulators were kept informed at each stage of the process.

Novel Coronavirus (Covid-19) Pandemic: Implications on Quality of Care

The current Novel Coronavirus (Covid-19) Pandemic is affecting most aspects of life in the UK and all aspects of healthcare. For some NHS Trusts, providing treatment for acute Covid-19 presentations is the focus whereas for others such as Liverpool Women's NHS FT (LWH), it is a matter of dealing with the many significant direct and indirect consequences of the pandemic. In this high level summary, the challenges facing LWH are described together with the Trust's responses on behalf of its patients.

Mandated suspension versus continuation of workstreams
LWH has a limited clinical portfolio but provides tertiary level care in each of its specialties. The suspension or continuation of services has been mandated by NHSE on a specialty by specialty basis since the pandemic's arrival in the UK, as follows:

- Maternity – continuation of all aspects of high and low risk care but with altered pathways of care
- Neonatology – continuation of all aspects of care
- Gynaecological Cancers – continuation of services but with altered pathways of care and postponed investigations and treatment if no likely physical impact upon outcomes
- Acute Gynaecology – continuation of all aspects of care
- Benign non-acute gynaecology – suspension of services requiring review in person
- Fertility – suspension of services other than on-going maintenance of laboratory facilities
- Termination of Pregnancy – continuation of all aspects of care but with altered pathways of care
- Genetics / Genomics – suspension of services requiring review in person
- Anaesthetics – key supporting role switching away from elective towards acute care provision.
- Continued workstreams – altering the working model to keep patients and staff safe

The risk of patients and staff passing the coronavirus on to one another has been reduced by an incremental increase in the use of personal protective equipment (PPE) in the Trust in keeping with national guidance from Public Health England and under the guidance of the Trust's own Director of Infection Prevention and Control (DIPC). The availability of PPE has been an area of focus for the Trust and nationally, but to date all necessary equipment has been available at its point of need. The Trust remains vigilant in this respect. Oversight is provided at the Trust's daily Command and Control meetings.

The requirement for rigorous PPE usage has provided an obstacle to rapid clinical response in hyper-acute scenarios such a category one caesarean section (common at LWH) and cardiac arrest (uncommon at LWH). A systematic increased in the use of clinical drills has therefore been implemented across the Trust, lead by the Trust's clinical and resuscitation leads.

With the suspension of several benign workstreams, some staff members have been released from their usual duties and have therefore been able to support other clinical areas in the Trust. This has been important because Covid-related staff absences on clinical rotas have to be covered if acute care is to be provided at normal safe standards. To date, all medical, nursing and midwifery rotas have been covered successfully without compromising clinical care.

The reduction in some clinical services previously described has allowed for the formation of resilience rotas in obstetrics, gynaecology and anaesthetics, giving greater (direct) clinical support and (indirect) psychological support to medical trainees, nursing staff and midwives in those specialties. In obstetrics and anaesthetics, consultant presence on-site has been provided on a 24/7 basis throughout and in gynaecology, a split consultant rota has allowed for a significant increase in the presence of consultant gynaecologists in the Gynaecology Emergency Department.

Suspended workstreams – vigilance for harm
The key areas requiring vigilance for harm have been those subject to suspension including some parts of the gynaecological cancer service and all of the non-acute benign gynaecological services. To maintain safety a number of new measures have been introduced:

- Consultant Gynaecologists are now available by video link to GPs for advice and guidance
- All suspended cases at potential risk of harm are reviewed on paper by consultant gynaecologists
- Women at risk of clinically significant deterioration are contacted for review by a consultant
- If the level of risk is increasing, a proposal for review and / or surgery is put to CAG (see below)
- If surgery is agreed by CAG on clinical grounds, liaison takes place with anaesthetics and theatres

The clinical criteria for surgical intervention include the development of severe pain uncontrollable by other means, the advent of bleeding requiring blood transfusion which is uncontrollable by other means and / or an increased risk of a malignancy developing in a pre-malignant condition.

To date, no harm has been detected in women being cared for in the Trust's suspended services but this remains an area of focus.

Performance
The Trust has continued to monitor all key aspects of its performance despite the suspension of some of its services and despite the unique pressures of the pandemic. Performance will continue to be reported separately to the Quality Committee.

Incident Reporting
A fall in the overall incident reporting rates on Ulysses has been noted during the pandemic. Data concerning incident reporting, serious incidents and never events are provided to the Quality Committee under separate over.

Covid-19 Infection Prevention and Control (IPC) Assurance Framework
An NHSE IPC Covid-19 board assurance framework has been included separately on the agenda. It provides greater detail of the Trust's response to Covid-19 from an IPC perspective.

Workforce Issues
The national response to Covid-19 has thrown up multiple workforce issues including the need:

- to risk assess staff who may be at increased risk of contracting the disease

- to risk assess staff who are more likely to have a poor outcome if they become infected
- to offer swab testing for symptomatic staff and their household members
- potentially to offer swab testing for asymptomatic staff as a screening tool
- to minimise the risk of staff contracting the disease
- to respond in line with all national directives.

The oversight of workforce issues is provided through the Trust's Putting People First Committee so no additional detail is provided in this report.

Governance
A governance structure was created in the Trust at the outset of the pandemic to ensure that an optimal response was provided to the challenges ahead. The system's structure remains intact although the frequency of meetings (other than Command and Control) has reduced slightly as the pace of change has reduced.

The Executive Group meets once weekly (previously twice) in a Covid-specific capacity to provide oversight and to consider material discussed at regional and national forums of relevance to Covid-19. It informs and assures the Trust's Board of Directors.

Command and Control meets daily to note and ensure the enactment of externally mandated changes to service. It is the key operational group. It reports into the Executive Group.

The Clinical Advisory Group meets three times weekly (previously seven) to provide clinical advice and interpretation and to assist with the enactment of changes to service. Its advice is considered by both the Executive Group and Command and Control.

The Huddle predates Covid-19. It takes place daily, shortly before the Command and Control meeting, and is an effective forum for the provision of clinically and operationally relevant information, for the dissemination of information and for the enactment of change.

Our recent successes

Our last Quality Strategy had three key areas of focus; reducing avoidable harm, reducing mortality and providing the best patient experience. We have successfully delivered material improvements in each area we set out to change; improving safety and outcomes, as well as staff and patient experience. The detail behind our performance is reported in our annual quality reports.

As well as our ambitious plans to build a new co-located hospital, our Future Generations Strategy also set out priorities for each service, focused on improving quality and safety while we remain in our current location. While approval to build a new hospital remains out of our control, we have successfully delivered significant improvements across all of our services over the last five years. We have heavily invested in our workforce; increasing our numbers of midwives, specialist nurses and consultants to help us deliver the safest care possible. We have also invested in developing our people; initiating a Fair and Just Culture programme to ensure our staff feel supported and empowered to speak out in the interests of their patients.

We have established formal partnerships across Liverpool; unique quality-driven interactions leading the drive to join up services across the whole city, targeting the specific clinical needs of our population, improving outcomes and helping to reduce health inequalities across our system. We have established the Liverpool Neonatal Partnership in conjunction with Alder Hey NHS FT, ensuring families with babies requiring surgical services experience consistent, trusted and familiar care throughout their whole journey, and we have developed complex gynaecology pathways in partnership with Liverpool University Hospitals NHS FT, delivering safer are and improved outcomes for women.

Neonatal Unit

In 2020 building work completed on our new Neonatal Unit. This 3 year, £15m project was established to address significant concerns regarding the existing Neonatal estate. Part of our planned programme of major enhancements at Crown Street, the unit provides state of the art facilities from which our clinicians can deliver world class tertiary care for our babies and their families.

Successful Partnerships

In recent years we have established a number of successful formal partnerships to improve our patient experience while mitigating some of the clinical risks that arise from our isolated site. We work in partnership to deliver maternal medicine, neonatal, genomics and complex gynaecology services.

Investing in Our Workforce

We have invested in our staff to improve safety, outcomes and experience for our patients. Over the last 5 years we have increased our numbers of midwives, increased consultant numbers in maternity, neonatology, gynaecology and anaesthetics as we aim to provide 24/7 consultant cover, and invested in Advanced Neonatal Nurse Practitioner roles.

Annex 1: Statements from our Partners

Liverpool Women's shares its Quality Report with commissioners, local Health watch organisations and Local Authority Overview and Scrutiny Committees. This section of the report details the responses and comments we have received from them.

Sefton Clinical Commissioning Group is leading on the response this year

NHS South Sefton Clinical Commissioning Group

NHS Liverpool Clinical Commissioning Group

NHS Southport and Formby Clinical Commissioning Group

NHS Knowsley Clinical Commissioning Group

1 Quality Account Statement – Liverpool Women's Hospital NHS Foundation Trust.

South Sefton CCGs hosted a Quality Accounts Day on Friday 9th October 2020. Providers were invited to present their accounts and stakeholders were asked to provide feedback. Stakeholders included:

(1) South Sefton and Southport and Formby CCGs
(2) Liverpool CCG
(3) Knowsley CCG
(4) Healthwatch Sefton, Liverpool and Knowsley
(5) Health Education England
(6) NHS England/Improvement
(7) Sefton MBC
(8) NHSE Specialised Commissioning
(9) CQC

The Stakeholders appreciate the Trust's focus on quality and safety at a time of a global pandemic. They recognise this has required different ways or working during the COVID 19 period and is reflected in the accounts.

The stakeholders welcomed the opportunity to jointly comment on Liverpool Women's Hospital NHS Foundation Trust's Quality Account for 2019/20. The CCGs have worked closely with the Trust throughout 2019/20 to gain assurances that the services delivered were safe, effective and personalised to service users. The CCGs share the fundamental aims of the Trust and supports their strategy to deliver high quality, harm free care.

It is noted that the Quality Account that is being reviewed is a draft version and the stakeholders look forward to receiving the finalised account. The work the Trust has undertaken and described within this Quality Account continues to promote patient safety and the quality of patient experience and endorses the Trust's commitment to promote safety and quality of care.

The Commissioners acknowledge the Quality Account for 2019/20 and the continued focus of work on the following elements:

- Development of a well led, capable, motivated and entrepreneurial workforce
- To be ambitious and efficient and best use of available resources
- Deliver safe services and best experience for patients and staff.

Stakeholders agree with priorities discussed and the Trust's commitment to extending on developing further national and regional priorities relating to Saving Babies Lives and Continuity of Carer. They welcomed the continuing priorities for reducing harm, reducing mortality & providing the best patient experience.
It was noted that:

- The learning from Serious Incident RCAs was open, transparent and honest. The Trust demonstrated a good process for dissemination and implementations of actions as well as organisational shared learning. It showed that there were processes in place to utilise learning from serious incidents in order to action service improvements and to ensure safer services.

- In relation to Freedom to Speak Up. The Trust demonstrated commitment to developing and maintaining an open and constructive culture for staff to raise any concerns including a whistleblowing policy.

- The Trust demonstrated good evidence for meeting quality standards, including zero direct maternal deaths in 2019/20.

The stakeholders note the commitment to improving breastfeeding rates but it would be helpful if they could expand on the Trust plans to progress UNICEF accreditation and how they will work collaboratively with other partners e.g. public health and health visiting, to address continuation rates.

The Trust has successfully completed their 3 year quality strategy 2017-2020 and stakeholders note that the new strategy 2020-2025 is currently in development.

This is a comprehensive report that clearly demonstrates progress within the Trust. It identifies where the organisation has done well, where further improvement is required and the ambitions moving forward. We understand the Trust's Quality Strategy has a number of individual workstreams that will take into account patient feedback on progress made.

Commissioners are aspiring through strategic objectives to develop an NHS that delivers positive outcomes, now and for future generations. This means reflecting the government's objectives for the NHS set out in their mandate to us, adding our own stretching ambitions for improving health and delivering better services to go even further to tailor care to the local health economy. Providing high quality care and achieving excellent outcomes for our patients is the central focus of our work and is paramount to our success.

It is felt that the priorities for improvement identified for the coming year are reflective of how the Trust will further improve services to address the current issues across the health economy.

We acknowledge the actions the Trust is taking to improve the quality as detailed in this Quality Account. It is felt that the priorities for improvement identified for the coming year are both challenging and reflective of the current issues across the health economy. We therefore commend the Trust in taking account of new opportunities to further improve the delivery of excellent, compassionate and safe care for every patient, every time.

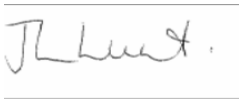
2 South Sefton and Southport & Formby CCGs

Signed

Fiona Taylor, Chief Officer Date: 16th November 2020

3 Liverpool CCG

Signed



Jane Lunt, Chief Nurse Date: 19th November 2020

Signed

Dianne Johnson, Chief Executive Date: 10th November 2020

Health watch Liverpool

Liverpool Women's Hospital Quality Account 2019-20 commentary

Healthwatch Liverpool welcomes the opportunity to comment on the 2019-20 Quality Account for the Liverpool Women's Hospital NHS Foundation Trust.

We base our commentary on the Quality Account report itself, our engagement with the Trust, and feedback and enquiries that we receive throughout the year. Due to the Covid-19 pandemic our annual Listening Event at the Trust could not take place.

The Quality Account highlights the conclusion of the 5-year plan (2015-2020). We are pleased to see that most of the targets the Trust had set itself over 5 years were met, and many improvements achieved.

Although most patient experience priorities focused on staff, it is positive to see that there were increases in the number of staff who recommended the Trust as a place to work and as a place for friends and family to receive treatment. Improved phone systems in reaction to patient feedback are also most welcome.

The Trust has progressed with 7-day working consultant cover, and is exploring a service level agreement with Liverpool University Hospitals Trust (LUFT) to be able to improve this. We believe that increased partnership work between the two Trusts will promote better outcomes for patients.

Other achievements include the opening of the new neonates department which the Trust is rightly proud of, and which should improve the experience of families using these facilities during a difficult time.

Lessons learnt from clinical audits are clearly explained in the report, and examples given of the clinical research the Trust has participated in. We particularly welcome the 'Children Growing-up in Liverpool' research project, which aims to improve child health, and may help to prevent future health inequalities.

We are pleased to note that the Trust once again was rated better than average for overall patient experience in the National Inpatient Survey, which covers patients discharged in July 2019. We look forward to seeing the actions the Trust will take on the themes that were identified for improvement.

At its most recent inspection the Care Quality Commission (CQC) rated most of the Trust as 'good', and it was positive to see that the responsiveness of maternity was rated 'outstanding'. We note that the Trust has been working hard to address those issues identified by the CQC as 'requiring improvement'.

The final quarter of 2019-20 brought rapid changes to services due to the Covid-19 pandemic, and we are pleased to see that the quality account document reflects this. It was particularly reassuring that the Trust has managed to maintain staff rota cover throughout.

However, although the Trust has been working to address cancer treatment waiting times, it is concerning that it was far from meeting several of the national targets. Even with minimal clinical impacts for the patients concerned, the overall effect on their experience is likely to be detrimental. An added concern is that the Covid-19 pandemic has the potential to extend waiting times further.

Future priorities have been set out to cover the next 5 years, in line with the Trust's overall 2020-25 clinical and quality strategy. We are pleased to note that this includes priorities addressing the effects of the Covid-19 pandemic, and others focusing on patient experience and community engagement. We look forward to learning what practical steps will be taken to progress these priorities in 2020-21.

Due to the pandemic there has been less regular engagement from the Trust, and we are working to try and re-establish this. At the current time we can't visit Trust sites to meet patients and visitors face to face and capture their feedback. We are working in different and new ways, for example by planning and facilitating online focus groups, one of which will be about maternity care.

We look forward to working with Liverpool Women's Hospital in 2020-21, helping to ensure that patients' voices continue to be central in celebrating good practice, and in feeding back if and where improvements could be made.

Inez Bootsgezel
Information and Project Officer- Engagement
2nd November 2020

Commentary from Local Authority Overview & Scrutiny Committees (OSCs)

Knowsley Council - Requested but not received.

Annex 2: Statement of Directors' Responsibilities

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

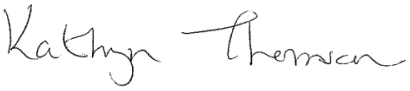
In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the *NHS foundation trust annual reporting manual 2019/20* and supporting guidance *Detailed requirements for quality reports 2019/20*
- the content of the quality report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2019 to May 2020
  - papers relating to quality reported to the board over the period April 2019 to May 2020
  - feedback from commissioners dated 19/11/2020
  - feedback from governors dated 12/11/2020
  - feedback from local Healthwatch organisations dated 02/11/2020
  - feedback from overview and scrutiny committee not provided
  - the trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 20/07/2020
  - the Gynaecology national patient survey July 2020
  - the national staff survey May 2020
  - the Head of Internal Audit's annual opinion of the trust's control environment dated 21/05/2020
  - CQC inspection report dated 22/04/2020
- the quality report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the quality report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice

- the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review

- the quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.



Robert Clarke
Chair
Date

Kathryn Thomson
Chief Executive
Date

Annex 3: External Auditor's Limited Assurance Report

Independent Auditors' Limited Assurance Report to the Council of Governors of Liverpool Women's Hospital NHS Foundation Trust on the Annual Quality Report

N.B – not required due to Covid-19.

Annex 4: Glossary of Terms

Assisted Conception	The use of medical procedures to produce an embryo.
CCG	Clinical Commissioning Group – Local groups of GP practices commissioned health services from the Trust for their patients.
Epidural	Form of regional analgesia used during childbirth.
Established Labour	The period from when a woman is 4 cms dilated and contracting regularly.
Gynaecology	Medical practice dealing with the health of the female reproductive system.
Gynaecological Oncology	Specialised field of medicine that focuses on cancers of the female reproductive system.
Haemorrhage	The flow of blood from a ruptured blood vessel.
HES	Hospital Episodes Submission.
HFEA	Human Fertilisation & Embryology.
HIE	Hypoxic Ischaemic Encephalopathy is an acute disturbance of brain function caused by impaired oxygen delivery and excess fluid in the brain.
HSCIC	Health and Social Care Information Centre.
Intraventricular Haemorrhage	Bleeding within the ventricles of the brain.
Intrapartum	Occurring during labour and delivery.
LWFT (sometimes LWH)	Liverpool Women's NHS Foundation Trust.
Maternity	The period during pregnancy and shortly after childbirth.
MBRRACE -UK	Mother and Baby Reducing Risks through Audits & Confidential Enquiries across the UK.
Neurological	The science of the nerves, the nervous system and the diseases affecting them.
Neonatal	Of or relating to newborn children.
NICE	National Institute for Health and Care Excellence.
NIHR	National Institute for Health Research.
NNAP	National Neonatal Audit Project.
NMR / NNMR	Neonatal Mortality Rate; Deaths of infants in the newborn period.
NRLS	National Reporting & Learning System.
ONS	Office for National Statistics.
PALS	Patient Advice & Liaison Service.
Perinatal	The period surrounding birth.
Periventricular Leukomalacia	A form of brain injury involving the tissue of the brain known as 'white matter'.
PHE	Public Health England.
Postnatal	Term meaning 'After Birth'.
Post-operative	Period immediately after surgery.
Pre-eclampsia	A condition involving a number of symptoms including increased maternal blood pressure in pregnancy and protein in the urine.
RCOG	Royal College of Obstetrics & Gynaecology.
Root Cause Analysis	A method of problem solving used for identifying the root causes of faults or problems.
SGA	Small for Gestational Age.
Tissue Viability	Tissue Viability is about the maintenance of skin integrity, the management of patients with wounds and the prevention and management of pressure damage.
Ultrasound	Sound or other vibrations having an ultrasonic frequency, particularly

	as used in medical imaging.
VTE	Venous Thrombo-embolism; this describes a fragment that has broken away from a clot that had formed in a vein.
VLBW	Very Low Birth Weight - babies born weighing less than 1500 grams
VON	Vermont Oxford Neonatal Network.
WHO	World Health Organisation.

Liverpool Women's NHS Foundation Trust

Agenda Item	20/21/234

MEETING	**Trust Board**
PAPER/REPORT TITLE:	**Corporate Objectives 2020/21: Six Monthly Review**
DATE OF MEETING:	Thursday, 03 September 2020
ACTION REQUIRED	**Assurance**
EXECUTIVE DIRECTOR:	Executives
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:	
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 position to date against the 2020/21 Corporate Objectives.			
PREVIOUSLY CONSIDERED BY:	**Committee name**		Not Applicable	
	Date of meeting			

Executive Summary

The Board of Directors reviewed the corporate objectives 2020/21 at its meeting on 7 May 2020 and formally approved them.

The cycle of periodic review usually involves the Committees and the Board reviewing progress on the Corporate Objectives on a six-monthly basis. In light of the Covid-19 pandemic, and to ensure that the objectives remain feasible and deliverable, it was agreed that the 2020/21 objectives be reviewed in three months and then again at six months. This report provides the six-month position.

Consideration of the corporate objectives have been given by each of the Board Committees, and they are now presented to the Board for noting.

Recommendation

The Board is asked to note the position to date against the 2020/21 Corporate Objectives.

Report

The Vision Aims and Values have been developed over a long period of time with input from the Board, Staff, Governors and Stakeholders.

Our vision:		To be the recognised leader in healthcare for women, babies and their families
Our strategic aims – WE SEE:	W	To develop a well led, capable, motivated and entrepreneurial Workforce;
	E	To be ambitious and Efficient and make best use of available resources;
	S	To deliver Safe services;
	E	To participate in high quality research in order to deliver the most Effective outcomes;
	E	To deliver the best possible Experience for patients and staff.
Our values – We CARE and we LEARN:		Caring – we show we care about people; Ambition – we want the best for people Respect – we value the differences and talents of people; Engaging – we involve people in how we do things; LEARN – we learn from people past, present and future.

To develop a Well Led, capable, motivated and entrepreneurial Workforce

Proposed Corporate Objective	Executive Lead	Relevant Strategy	Board Committee	6 month review comments
Improving the Health & Wellbeing of the workforce by moving to upper quartile performance for % sickness absence and stress related absence incrementally between 2019-2021 as measured by the Annual Staff Survey	CPO	People Strategy	Putting People First	This remains a key area of focus for the Trust and has been further emphasised as a priority issue in the context of Covid. We are currently reviewing all mental health & psychological support provision for staff and a team of 20 plus 'Staff Supporters' has recently launched.
Improving the organisation's climate and increasing the overall staff engagement score (as measured by Annual Staff Survey & the Staff Friends & Family Test) to upper quartile for acute specialist Trusts incrementally between 2019-2021	CPO	People Strategy	Putting People First	This remains a key area of focus and feature of Divisional People Plans. Wellbeing was a key driver of staff engagement as outlined in the NHS People Plan and this, along with the launch of the LWH leadership strategy will be a focus for the next 12 months. LWH is also contributing to regional workstreams emanating from the NHS People Plan.
Expanding the Trust's reach into its communities through extending its work experience, work training, guaranteed interview and apprenticeship schemes	CPO	People Strategy	Putting People First	Schools have been offered a programme of virtual careers events. A functional skills programme to support staff to achieve the qualifications required to enrol in nursing/ midwifery degrees has recently launched.
Shaping workforce to meet operational needs through effective workforce planning and partnerships	CPO	People Strategy	Putting People First	Workforce plans for LWH were submitted into the regional workforce plan in September. Further work is ongoing between N&M, finance and HR to ensure a coherent workforce planning cycle which responds to internal and external requirements.

To be ambitious and Efficient and make best use of available resources

Corporate Objective – Proposed update	Executive Lead	Relevant Strategy	Board Committee	6 month review comments
Deliver the financial plan for 2020/21, achieving quarterly targets and optimising the opportunities for financial recovery funding through system working.	DoF	Operational Plan 2020/21	FPBD	The Trust agreed an annual 'breakeven' plan for 20/21 however the COVID pandemic led to operational and financial planning regimes to be paused and replaced with a temporary finance regime. For the first half of the year this allowed the Trust to breakeven through a series of retrospective top ups, however for the second half of the year the level of retrospective top us has been significantly reduced and the Trust is now planning a net deficit of £4.6m. The deficit is driven by an inadequate block income payment allocated to the Trust based on historical data and the Trust will continue to pursue this. There are a significant number of other providers in the system with planned deficits and the C&M HCP organisations will continue to work together to achieve the best possible outcomes in the context of the ongoing pandemic.
Deliver the operational plan for 2020/21, achieving quarterly targets and ensuring that appropriate actions are in place to respond to areas of underperformance.	COO	Operational Plan 2020/21	FPBD	Whilst an Operational Plan for 2020/21 was not agreed (due to national requirement being removed), the Trust has worked to ensure that reporting processes have been maintained, even in areas where external reporting has been paused. Performance reports have been received by the Board Committees and issues have been escalated through the Board performance report. The Covid-19 pandemic has had an impact on Trust performance and where this has applied, the reasons have been outlined with the attendant actions described.

				Whilst the achievement of the Trust's performance targets will continue to be challenged, this remains a valid objective and there will be a focus on ensuring that assurance is provided on the efficacy of the recovery actions being applied.
Demonstrate the effective use of resources in providing high quality, efficient and sustainable care, maintaining robust grip and control and ensuring that opportunities for improved working arising from the COVID-19 response are realised.	DoF	Operational Plan 2020/21	FPBD	CIP delivery is not required nationally for the first half of the year and was not reportable to NHSI. The Trust had £3.7m of schemes identified before delivery was paused and will be well positioned to move forward with this when possible. While a number of planned schemes have been paused during the pandemic, those schemes which could safely proceed have done so, delivering CIP of £1.1m to month 7. Costs relating to Covid-19 expenditure continue to be carefully monitored. All non-pay costs are approved by the Deputy Director of Finance or Director of Finance through a separate cost centre. All pay costs are approved either by the weekly vacancy control panel or at the Covid-19 Oversight Group. Work has been undertaken to capture the lessons learned from the initial Covid-19 response and are supporting the 'second wave' This will remain an important objective throughout 2020/21, particularly in relation to planned and required service developments.

To deliver **S**afe services

Corporate Objective – Proposed update	Executive Lead	Relevant Strategy	Board Committee	6 month review comments
Maintain regulatory confidence & compliance	CEO	All	All	Whilst some reporting regimes were paused or stood down during Covid-19, the Trust has maintained internal processes and has remained cognisant of changing and updated guidance, particularly through the Covid-19 oversight and scrutiny group. The BAF risk score relating to this objective was increased in June 2020. This was in recognition that there may be issues in meeting the Health and Safety Executive requirements for supporting staff returning to the work environment, due to the current estate layout and capacity i.e. social distancing. This issue was monitored closely and the BAF risk was subsequently de-escalated and agreed to be removed from the BAF in the November 2020 Board. This objective remains achievable.
Delivery of in-year Quality Strategy objectives including the delivery of a Quality Improvement Strategy	MD	Quality Strategy	Quality	The Clinical and Quality Strategy was approved by the Board in September 2020. An update on delivery against the objectives is scheduled for the December 2020 Quality Committee. A Quality Improvement Strategy (Methodology) remains in development and should be approved by the Executive Team prior to the end of the calendar year.
Deliver the objectives defined in the Trust LocSSIP Group's Terms of Reference	MD	Quality Strategy	Quality	The Quality Committee received assurance on progress being made on LocSSIP compliance. Whilst progress was recognised, the Committee agreed to monitor compliance on a quarterly basis.
Begin to embed ward accreditation across clinical areas during 2020/21	DoN&M	Quality Strategy	Quality	The following was reported to the July 2020 Quality Committee: Following initial baseline audits the plan was to undertake the full accreditation in the baseline 5 areas 6 months later. This has

				now been completed but not within the timeframes initially identified due to CQC and Covid-19. Neo-Nates achieved Gold Status, MLU Silver, Delivery Suite, Silver, Maternity Base, Silver. Gynaecology ward is awaiting validation. A further 6 areas (Bedford, Hewitt x 2, Theatres, Gynae opd and GED) have now been trained on the Quality metrics (monthly audits) and have commenced in May. They will be fully accredited after 6 months. The remaining areas will join the programme in a phased approach with all being included by the end of 2021.
Development of Clinical Strategy to ensure robust recovery plans following COVID-19 and that lessons are learned.	MD	Clinical Strategy	Quality	The Clinical and Quality Strategy was approved by the Board in September 2020. This includes references to how lessons from Covid-19 have informed the strategy.
Successfully deliver the final phase of the Neonatal new build time and to budget, as well as develop further capital investments into infrastructure which will enhance the safety of the service (blood bank, diagnostic, robotics). Develop relationships with other system providers to ensure estate utilisation and development takes into account the relevant needs of local partners.	COO/ DoF	Future Generations	FPBD	The Neonatal unit has been completed on time and to budget. The Trust has developed an additional emergency capital submission to help enhance the safety of the service while on this site while awaiting approval of the capital for the long-term preferred option. During the year, the Board approved a change to the profile moving £1.6m of expenditure into 2021/22 to support achievement of the wider Cheshire & Merseyside system plan. However, the ongoing delay in this capital approval jeopardises the ability to spend the plan in year as well as delays safety enhancements. The Trust is however currently piloting robotics via a lease while the capital bid remains outstanding.
Working in partnership with providers and commissioners to ensure quality safe services are delivered to the population of the region and to ensure operational recovery post COVID-19. This will include working closely with the following:-	COO / MD	Operational Plan	FPBD	The Trust has been working under a command and control structure since the Covid-19 outbreak and within this has ensured that support to other partners has been offered and provided when appropriate e.g. step-down beds provided for LUHFT, gynaecological hub for C&M and continuing progression

• Cheshire and Merseyside Health & Care Partnership (STP) to develop and influence regional strategy • Liverpool Provider Alliance in supporting the One Liverpool Plan • Alder Hey to implement the Neonatal Single Service on two sites • LUHFT to strengthen existing partnerships				of the neonatal partnership. Mutual aid has also been developed and offered through the second wave of the pandemic. Engagement specific to the stated objectives has continued. Active partnership working is likely to continue to be a vital way of operating throughout 2020/21 and beyond. The Board has been receiving regular updates on various aspects of partnership working.
Electronic Patient Record project delivery - Identify, procure and begin to install a new record which meets the requirements of the organisation	MD	EPR Project Plan	FPBD / Quality	The Board agreed the EPR business plan in July 2020. The programme is progressing and is being monitored by the FPBD Committee.
Develop IM&T as a strategic enabler ensuring that clinical systems are fit for purpose, forward focussed and embrace the wider strategic view of the health economy	DoF	IT Strategy	FPBD	The Trust has developed and launched an updated IM&T Strategy that focuses on technology underpinning improvements in services and experience for both patients and staff. There are a number of developments in place that can demonstrate positive impacts across the organisation and the Trust continues to work with the HCP on the longer-term system strategic developments.
Maintain appropriate staffing levels for the level required to maintain patient safety.	DoN&M	Quality & People Strategies	Putting People First	PPF Committee continues to review Safe staffing levels and take assurance from the director of Nursing & Midwifery
To implement the in-year objectives of the Fair & Just Culture Programme	CPO	People Strategy	Putting People First	Year 3 objectives are in progress. Project will be integrated into the new role of Head of Inclusion, Culture and Engagement when current post holder leaves.

To participate in high quality research in order to deliver the most Effective outcomes				
Proposed Corporate Objective	**Executive Lead**	**Relevant Strategy**	**Board Committee**	**6 month review comments**
Develop closer working relationships with University of Liverpool with respect to research and innovation	MD	R&D	Quality	Covid-19 research has provided a common focus and central research command and control process. LWH participated in this with the University of Liverpool and Liverpool Health Partners leading. The Trust is also looking to progress University Hospital Status.
Successful implementation of the Trust's Research and Development Strategy to enhance the Research and Innovation capabilities of the Trust	MD	R&D	Quality	Progress remains positive and the objective remains achievable.
Work in partnership with the University of Liverpool to prepare for implementation of the Children Growing Up in Liverpool (C-GULL) programme in 2021/22	MD	R&D	Quality	The Trust continues to work with the University of Liverpool to prepare for implementation of the Children Growing Up in Liverpool (C-GULL) programme in 2021/22. The objective remains feasible.

To deliver the best possible Experience for patients and staff				
Proposed Corporate Objective	**Executive Lead**	**Relevant Strategy**	**Board Committee**	**6 month review comments**
Providing a patient focused experience, seeking feedback to further enhance our service provision whilst taking account of the pressures experienced by services.	DoN&M	Patient Experience Strategy	Quality	Detailed report provided to the June 2020 Quality Committee on how Liverpool Women's NHS Foundation Trust has responded to the Covid-19 Pandemic and the Patient Experience. The objective remains feasible and achievable.

Delivery of the Future Generations Strategy				
Proposed Corporate Objective	**Executive Lead**	**Relevant Strategy**	**Board Committee**	**6 month review comments**
Support Commissioners and Regulators to agree strategic direction for Trust services, commencing with public consultation and Commissioner Decision Making Business Case.	CEO	Future Generations	Board specific	Whilst progress against this objective has been limited during the pandemic, this remains a key focus for the Trust. Recommencement of activity in this area was planned for September 2020, however the second wave of the pandemic meant that this was not possible. This is now planned to commence in Q4 of the year.

Work jointly with other providers and regulators to consider options for future collaborations and organisational form.	DoF	Future Generations	Board specific	The Trust has continued to work closely with other providers in a number of existing partnership arrangements, and the Trust continues to engage in conversations with partners across Cheshire and Mersey to consider where these partnerships could be expanded or strengthened. During the pandemic the Trust has been able to support other providers by delivering mutual aid.
Retain Public and Staff Confidence through an effective Communications and Engagement Strategy	CPO	Future Generations	Board specific	Future Generations Strategy summary document produced and approved by the Board for external circulation Work is planned to engage with stakeholders e.g. members via surveys and focus groups for the development of new strategy. Workshop held with the Council of Governors in November 2020. The Board workshop scheduled in January 2021 will consider further the most effective mechanisms for communicating the Trust strategy to staff and external stakeholders.