Liverpool Women's
NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

Extraordinary Board of Directors Meeting

PUBLIC

7 January 2020

Extraordinary Meeting of the Board of Directors
HELD IN PUBLIC
Thursday 7 January 2021 at 0930
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.					
249	Apologies for absence Declarations of interest	Receive apologies	Verbal	Chair	0930 (5 mins)
250	Meeting guidance notes	To receive the meeting attendees' guidance notes	Written	Chair	
BOARD GOVERNANCE					
251	Ockenden Report – Trust Response	To receive for information and assurance	Written	Medical Director	0935 (45mins)
252	Serious Incident Report – Quarter 3 2020-21	To receive for information and assurance	Written	Director of Nursing & Midwifery	1020 (10mins)
253	Approval of Charitable Funds Annual Report and Accounts 2019/20	To approve the signing of the relevant documents	Written	Director of Finance	1030 (5mins)
CONSENT AGENDA (all items 'to note' unless stated otherwise)					
254	Charitable Funds Committee – Terms of Reference	To approve	Written	Trust Secretary	Consent
255	Charitable Funds Investment Policy Amendments	To approve	Written	Director of Finance	Consent
HOUSEKEEPING					
256	Any other business & Review of meeting	Consider any urgent items of other business	Verbal	Chair	1035 Meeting ends

Date of next meeting
4 February 2021

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

Agenda Item	20/21/251

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Ockenden Report into Maternity Care at Shrewsbury and Telford NHS Trust – Board Assurance**
DATE OF MEETING:	Thursday, 07 January 2021
ACTION REQUIRED	**Assurance**
EXECUTIVE DIRECTOR:	Lynn Greenhalgh, Medical Director Marie Forshaw, Director of Nursing and Midwifery.
AUTHOR(S):	Janet Brennan, Deputy Director of Nursing and Midwifery Lynn Greenhalgh, Medical Director Chris Lube, Head of Governance
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):	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:-….)***	It is recommended that Board of Directors review the contents of this report and gain assurance that the issues relating to the Ockenden report have been considered. The Board is asked to note what has been done so far, what is required to achieve compliance with the assessment tool in the immediate term and what longer term actions are required to provide assurance going forward.	
PREVIOUSLY CONSIDERED BY:	**Committee name**	
	Date of meeting	

Executive Summary

On 10 December 2020 the first report from Donna Ockenden was published following clinical review of the first 250 cases where concerns had been raised over the care the patients received from the maternity unit at The Shrewsbury and Telford Hospital NHS Trust. (https://www.gov.uk/government/publications/ockenden-review-of-maternity-services-at-shrewsbury-and-telford-hospital-nhs-trust) The report describes important findings from the significant concerns raised from these reviews and their associated actions for all Maternity Units in England.

The report states: 'After reviewing 250 cases and listening to many more families, this first report identifies themes and recommendations for immediate action and change, both at The Shrewsbury and Telford Hospital NHS Trust and across every maternity service in England' (p vi).

NHS England have requested that maternity services implement all 7 Immediate and Essential Actions (IEAs) described in the document and they have identified 12 urgent clinical priorities from these 7 IEAs. All maternity services have been asked to provide assurance that they comply with these 12 urgent clinical priorities.

Following a review of evidence of compliance with the 12 urgent clinical priorities assurance was submitted to the Local Maternity System (LMS) on Friday 18 December 2020. A meeting took place on Monday 21 December 2020 where each Trust presented their assurance ratings to the LMS. Following this meeting all Trusts were asked to review their ratings and re- submit in light of this challenge. This was then submitted to NHSE/I. Feedback from the LMS was that LWH had provided thorough and robust evidence to demonstrate their self- assessment of ratings. Out of the 12 urgent clinical priorities LWH rated 6 as partially compliant and 6 as fully compliant.

Partially compliant areas were:

- A plan to implement the Perinatal Clinical Quality Surveillance Model
- All Maternity SI's are shared with Trust Boards at least monthly and the LMS, in addition to reporting as required to HSIB (Healthcare Safety Investigation Branch)
- All women with complex pregnancy must have a named Consultant lead, and mechanisms to regularly audit compliance must be in place
- A risk assessment must be completed and recorded at every contact
- A Lead Midwife and Consultant Obstetrician for Fetal wellbeing
- All pathways of care clearly described in written formats on the trust website.

These are set out in more detail in Appendix 1

The Trust also submitted a position statement to the LMS on 22 December in relation to the Kirkup report, which was a review into Maternity Care at Morecambe bay NHS Trust in 2015. (https://www.gov.uk/government/publications/morecambe-bay-investigation-report). In 2015 an action plan from the Kirkup report was created and monitored through the LWH Clinical Governance Committee (CGC) which reported to Governance and Clinical Assurance Committee (now Quality Committee), which is a subcommittee of the Board. It was noted in the minutes of CGC in November 2015 that the organisation did not have any outstanding actions.

In addition, there are a number of further requirements with evidence of implementation to be provided to the LMS by 15 January 2021. These reflect the following:

- Review of the Ockenden report and the 7 IEA's using the assurance assessment tool (Appendix 2). It is a requirement that the Ockenden report is reviewed at public board using this assessment tool.
- Nice Guidance relating to maternity
- Compliance against the CNST safety actions
- Current workforce gap analysis

Following the Ockenden report the Trust has established an Ockenden governance framework to ensure that the actions from the report will be actioned and embedded in the Trust. The Trust will also use this framework to revisit and test that the Kirkup recommendations remain actioned and embedded within current services.

This paper is intended to provide the Trust Board with assurance that the Ockenden Report has been reviewed and the maternity services provided by the Trust have been assessed for compliance of the 12 urgent clinical priorities and that there is a plan in place for the maternity services to reach full compliance against the IEAs. The Board is asked to review the assurance assessment tool and gain assurance that the Trust has provided sufficient evidence to

demonstrate compliance or that the appropriate actions are identified to achieve full compliance. It should also be noted that these immediate actions will form part of a much wider response to ensure that maternity services are safe and provide a high standard of care on an ongoing basis.

Report

Introduction

In the summer of 2017, following a letter from bereaved families, raising concerns where babies and mothers died or potentially suffered significant harm whilst receiving maternity care at The Shrewsbury and Telford Hospital NHS Trust, the former Secretary of State for Health and Social Care, Jeremy Hunt, instructed NHS Improvement to commission a review assessing the quality of investigations relating to new-born, infant and maternal harm at The Shrewsbury and Telford Hospital NHS Trust.

The first terms of reference in 2017 were written for a review comprising 23 families. They were amended in November 2019 to encompass a much larger number of families.

Between June 2018 and the summer of 2020, a further 900 families directly contacted the review team raising concerns about the maternity care and treatment they had received at the Trust. These included a number of maternal and baby deaths and many cases where babies suffered brain damage possibly as a result of events that took place around the time of their birth.

Direct contact from families together with the Trust's referrals led to reporting in July 2020 that the review numbers had increased to encompass 1,862 families. The investigation team were made aware that a number of families had made multiple attempts, sometimes over many years to raise concerns with the Trust, but at this stage they were unable to say whether all of the poor outcomes reported to them occurred as a result of poor care.

It is likely that, when completed, this review of 1,862 families will be the largest number of clinical reviews undertaken relating to a single service, as part of an inquiry, in the history of the NHS. The majority of cases are from the years 2000 to 2019. However, where families contacted the investigation team directly with concerns preceding the year 2000, they agreed to review those cases where records exist as per the revised terms of reference. Throughout the review, the care and treatment provided, and the quality of any internal reviews, investigations and learning undertaken by the Trust will be considered with reference to the guidance and standards of the day by experienced clinicians who were in clinical practice at the time.

As well as undertaking the clinical review the investigation has also reviewed the following key areas:

- Turnover of Executive leadership at The Shrewsbury and Telford Hospital NHS Trust impacting organisational knowledge and memory
- What the Care Quality Commission (CQC) said about the Trust CQC Reports - 2015, 2018 and 2020
- MBRRACE (Mothers and Babies - Reducing Risk through Audits and Confidential Enquiries)
- Overview of MBRRACE reports: perinatal mortality rates at the Trust 2013-2017
- Clinical Commissioning Group (CCG) oversight of the Trust

- The role of the Local Supervisory Authority and statutory supervision of midwives at the Trust
- Internal Trust Review of Maternity Services 2007- 2017

The report makes several Local Actions for Learning and seven Immediate and Essential Actions (IEAs) to improve care and safety in Maternity Services.

Initial response to the findings

NHS England requested that maternity services implement all 7 Immediate and Essential Actions (IEAs) and identified 12 urgent clinical priorities and asked for assurance of compliance by 21 December 2020. The LMS asked for all maternity services within the region for assurance that these priorities have been assessed and for detail of actions to be taken if partially or non- compliant by 18 December 2020. This assurance was reviewed at an LMS meeting on the 21 December2020.

The maternity team at LWH collated evidence regarding compliance against the clinical priorities described and these were then reviewed by the Acting Director of Nursing and Midwifery and Incoming Medical Director with support from the Director of Finance, and the level of assurance scored accordingly. The Executive team reviewed this prior to submission. This assurance was submitted with a covering letter from the Chief Executive (see Appendix 3) to the LMS on Friday 18 December 2020. The Quality Committee was appraised of the Ockenden report, compliance and associated actions on 21 December 2020 along with Finance, Performance and Business Development Committee on 22 December, noting the potential impact on CNST.

Following the LMS assurance review meeting on 21 December all Trusts were asked to review their ratings and re-submit. The LMS then confirmed the assurance ratings given and then submitted the paper to NHSE. Feedback from the LMS was that LWH had provided thorough and robust evidence to demonstrate their self- assessment of ratings. Out of the 12 urgent clinical priorities LWH rated 6 as partially compliant and 6 as fully compliant following the LMS review.

Areas of partial compliance from the initial LMS Submission are as follows:

1. **Implementation of the Perinatal Clinical Quality surveillance model-** The trust already has robust processes for surveillance, reviewing and reporting of perinatal deaths. A full review of compliance and development of an action plan against the model has taken place and has been received by the Acting Director of Nursing and Midwifery (18.12.2020). The initial review indicates partial compliance. The maternity division will review this through the maternity risk group and Divisional Board and report to the Quality Committee by **January 2021**.
2. **All maternity SI's are shared with Trust Boards at least monthly and the LMS, in addition to reporting to HSIB**- the Trust current process is to report all SI to the Trust Board on a quarterly basis, this will move to monthly/each meeting from January 2021. All Board members are notified of individual SI's as they are identified. The Trust has robust processes in place for the identification and referral of all SIs which meet the HSIB investigation criteria. The acting Head of Midwifery is arranging to put in place a process for sharing of final SI reports with the LMS from **January 2021**
3. **All women with complex pregnancies must have a named consultant lead-** This is in place but without audit evidence. An audit has commenced in Jan 2021 and will be completed by **March 2021**

4. **A Risk assessment must be completed and recorded at every contact**- As K2 (Maternity electronic record system) is implemented this will be added to the scope or work which will then be electronically auditable by **June 2021 Currently each contact is recorded but not auditable.**
5. **Every unit has a lead Midwife and obstetrician lead for fetal monitoring-** the current seconded midwife post is to become substantive- this has been agreed by Executive team. The Obstetrician Lead role will be reviewed by the divisional leadership team, with a view to immediate action by **January 2021**
6. **Pathways of care clearly described, in written information format on the Trust website**- All information leaflets are available however to be reviewed for completeness by **January 2021**

There is much positive evidence and action demonstrated through the submission. The detail of this is submission is set out in Appendix 1

Maternity services assessment and assurance tool
NHSE have provided all Trusts with a maternity unit an additional assessment and assurance tool in relation to the 7 IEAs which has been completed in draft (Appendix 2) providing evidence and assurance to the Trust Board to enable them to assess the Trust current position. This assurance tool is required to be submitted to the LMS by 15 January 2021.

The tool now factors in other considerations taking the urgent actions further and overlaying it with other factors which include NICE Guidance, CNST 10 Safety Actions and Maternity Workforce Planning.

The tool provides a structured approach to enable the Board to critically evaluate the Trusts current position and identify further actions and any support requirements. The assessment and assurance tool (Appendix 2) has been completed by the Family Health Divisional team which demonstrates the evidence for assurance for compliance.

a. Urgent Clinical Priorities

As noted, the Trust is fully compliant with 6 of the 12 urgent clinical priorities. The remaining 6 demonstrate the evidence as to why they are partially compliant with actions and time frames to achieve full compliance. This evidence has been reviewed by Medical Director, Director of Finance and Deputy Director of Nursing and Midwifery. The assessment and assurance tool is now developing into an action plan where any gaps have been identified. The action plan will be monitored by a Task and Finish group led by the Medical Director and Director of Nursing and Midwifery.

b. NICE guidance relating to maternity

The Trust has a process whereby all NICE guidance and Quality Standards are coordinated centrally through the Clinical Audit and Effectiveness team who support the effectiveness leads (consultants) within the specialties to undertake a review of the guidance or standards and identify relevance and compliance. Where there is compliance this is evidenced and where non-compliance is identified, then an action plan is developed to achieve compliance in a specified timetable.

There is a set template format which is used to undertake the review and identify compliance; this is to ensure that there is a standardised approach and response format. All Compliance reviews and action plans are reported to the Trust Effectiveness Senate, which is a subgroup of the Quality committee at each meeting. The group is chaired by the Medical Director and has representation from all specialities through the clinical effectiveness leads and senior clinical staff.

An annual report is produced and presented to the Quality Committed for review; this information is also included in the Annual Quality Report as mandated. So far, the review has not highlighted any issues in this area.

c. Compliance against CNST safety actions

The 10 CNST safety actions are monitored monthly at Family Health Divisional Board and at Quality Committee as well reported to Board. While not without challenge and with further work required, the actions are on target for completion and submission to NHS Resolution in July 2021, however these are under constant review. These reviews are well documented though the Trust Governance process. There is a comprehensive action plan in place, clearly outlining Divisional roles and responsibilities, including escalation framework to the Executive Board.

d. Maternity Workforce Planning

As part of the Assessment tool there is a requirement to undertake a maternity workforce analysis and to have a plan in place to meet the Birth-rate plus (or equivalent) by 31 January, and to confirm timescales for implementation. As part of CNST there is a requirement to undertake a bi- annual workforce reviews, this is in progress and will form part of the overall Bi- annual staffing review presented to Putting People First (PPF) committee on the 25th January 2021 and to Board in February. Operational planning is undertaken annually with predicted levels of activity. Clinical workforce requirements are discussed with clinical leads and signed off by the Divisions. There has been significant investment in the maternity workforce in recent years.

Birth rate plus was undertaken with a report received in 2018. The funded establishment set for the 2020/21 was in line with Birth rate plus. Due to the changes in activity in maternity, a local review of Birth rate plus assessment is to be continued. Consideration of a further formal assessment of Birth rate plus is being discussed. There are no significant issues identified in this area.

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Governance & Next Steps

This assessment and review is still ongoing and there is further work required in relation to the development of the action plan ahead of the final submission to the LMS on 15 January 2021. The final submission will have Executive sign off with any significant variations reported to the Board, although significant variations are not expected.

In order to enable a robust and complete review of the maternity service against the Ockenden report and previous reports i.e. Kirkup report and CNST safety actions, and to implement the recommendations LWH will also:

- Establish a task and finish group to support progression of all actions with senior executive oversight.
- Create a standing agenda item on monthly maternity risk meeting to review the progress of action plans.
- Regular reports to Family Health Divisional Board for oversight and challenge against compliance.
- Monthly reports to Quality Committee for assurance, these will include consideration of cultural issues and qualitative factors as well as progress against actions
- Quarterly reports to Safety Senate for assurance.
- Provide monthly updates to CCG and the CQC for assurance through CQRM meetings.
- Work closely with the LMS to ensure that all actions are robustly in place and embedded

Boards are asked to ask themselves whether they know that mothers and babies are safe in their maternity units.

It is also advised that providers utilise internal audit functions to provide independent assurance that the process of assessment and evidence is rigorous. This will be factored in to the MIAA audit plan.

Regional teams (LMS) will also work with providers to understand the gaps and provide additional support.

Recommendation

It is recommended that Board of Directors review the contents of this report and gain assurance that the issues relating to the Ockenden report have been considered. The Board is asked to note what has been done so far, what is required to achieve compliance with the assessment tool in the immediate term and what longer term actions are required to provide assurance going forward.

Ockenden Review December 2020: 12 Urgent Clinical Priorities

APPENDIX 1

Trust Name:	Liverpool Women's NHS FT
Tool completed by - Name:	Janet Brennan
Role:	Acting Director of Nursing & Midwifery
Contact email address:	janet.brennan@lwh.nhs.uk

Essential Action		Action required	**Current status -** compliant, partially compliant, not compliant *(drop down box available)*	Action to be taken if partially or not compliant	Lead	Timescale for completion
Enhanced safety: Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.	1a)	A plan to implement the Perinatal Clinical Quality Surveillance Model, further guidance will be published shortly	Partially Compliant	The Trust has robust processes for the surveillance, reviewing and reporting of all perinatal deaths. A review of compliance and development of an action plan against the Perinatal Clinical Quality Surveillance Model will take place now this has been received (18.12.2020). Initial review indicates partial compliance.	Medical Director	Dec 20/Jan 21
	1b)	All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB	Partially Compliant	The Trust has a policy in place for the Management of Incidents and Serious Incidents (SI's) which follows the National guidance on the Management of Serious Incidents. As part of this process, when an SI is declared a notification email is sent to all Executive Directors, Non-Executive Directors, Senior staff and external regulators and commissioners. On a monthly basis the Safety Senate receives a report on all SI's which have been declared in the last month, which includes immediate lessons identified and immediate action taken. This report also includes all SI's which have had their investigation completed and been submitted to the CCG, which includes the root cause, lesson identified, recommendations and actions taken. The report also includes information on any actions which are overdue or outstanding. Note: The Safety Senate is chaired by the Medical Director and the Director of Nursing and Midwifery is in attendance as Deputy Chair. Safety Senate then reports to the Quality Committee. **Final reports and findings will be sent to the LMS.** On a quarterly basis, the Quality Committee (a sub-committee of the Trust board) and the Trust Board receives a Serious Incident Report which provides information on the incidents which have occurred, lessons identified, learning and actions taken. Whilst SI's are reported to Board members as they are raised, it will be recommended that all SIs are formally discussed at every public board rather than quarterly. The Trust and Maternity service have been actively reporting all maternal cases to HSIB as required since February 2019 and have quarterly meeting with the Regional and local team on progress and lessons identified. To this date, HSIB have not identified any significant risks, concerns or issues which the Trust's own internal Investigation process had not already found. Note: As part of adopting the HSIB referral process, the Trust agreed to continue with our internal investigation process, as we wanted to ensure that we identified any issues promptly, implementing any actions and learning, due to HSIB investigation reports taking approx. 6 months to report back on any findings.	Head of Midwifery	Jan-21
Listening to Women and their Families: Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.	2a)	Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services	Compliant	The Liverpool Maternity Voices Partnership (MVP) was established in 2018. The group was previously called PRAMS and involved regular meetings with service users and representatives from provider organisations of the Maternity services. The purpose of the MVP is to improve services for women and their families involved with Maternity services and to ensure that women's voices are heard. Quarterly meetings were scheduled with an agreed terms of reference. The chair is a recent service user of the Maternity service and the group needs to have a % of mothers present at meetings. Liverpool Women's works closely with our Maternity Voices Partnership (MVP) and the MVP chair to ensure the voice of service users are at the core of commissioning, monitoring and continuous improvement of maternity services including service re-design and/ or re-structure along with any decision making involving maternity services. Since the start of the COVID pandemic, face to face meetings have not been possible however communication and collaboration has been maintained. We have had two virtual meetings and two forums have with a focus on infant feeding and induction of labour experience during the pandemic. Two listening events with service users have been undertaken with one being a focus on the impact of COVID on BAME and vulnerable women. All of the virtual forums have been well attended with positive feedback. Additionally from onset of wave 1 of COVID, fortnightly calls were undertaken reducing to monthly with ad hoc calls or Email correspondence as required between the MVP chair and the Deputy Head of Midwifery to ensure communication and partnership working continues enabling service user feedback to shape and enhance woman-centred care. A collaborative approach has been used to co-produce COVID-19 SOP's including screening for COVID and accompanying patient information leaflets, information available to women and their families during COVID, the impact of visiting restrictions and expectations of women attending the maternity service whilst in a pandemic.		

	2b)	In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard. Further guidance will be shared shortly.	Compliant	There is a named Non-Executive Director supporting Board Safety Champion. As per the Maternity Incentive Scheme (previously known as CNST) Safety Action 9, we have a dedicated pathway for escalation of all safety issues. Concerns raised from staff are escalated through the Safety Champions. Information related to accessing the safety champions is visible to staff and prior to the COVID-19 Pandemic, regular walkabouts were performed by the safety champions to talk with staff. Service users (Neo parents) are invited to provide feedback through a questionnaire system in Neonatology and formal sessions with parents are arranged to ensure actions are taken and service users are kept informed. Service users are also included in research with in the Trust through the Patient and Service Users involvement groups Other examples of obtaining service user feedback is as follows:		
Staff training and working together: Staff who work together must train together.	3a)	Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.	Compliant	There is a MDT Consultant Led Ward round at least twice a day on the high risk intrapartum area. There is also a Consultant Led MDT ward round daily on the antenatal and postnatal ward. There is ratified guideline in place, Medical Staffing Delivery Suite Change over (embedded), that outlines the process for handover and when MDT Consultant ward rounds should take place. All handovers are documented electronically and recorded and can be used for audit purposes if required. The current guideline is being updated following increased resident consultant cover in the delivery suite. Obstetric consultants remain on site between 08.30 and midnight. In response to the recent HSIB report (Delays in intervention once fetal compromise is suspected) published in Nov 2020, the Trust has created an action plan addressing the questions raised. Please refer to the embedded document. LWH are aiming to commence a QI project, with a named task & finish group, based on the NHSI framework (embedded) to focus on safety huddles and handovers in addition to the MDT wards rounds. This will improve the over sight of cases, activity and staffing across the intrapartum area and will include Clinicians from across Midwifery, Neonatal, Obstetrics and Anaesthetics. This has been discussed with the Intrapartum Working Group on 11th December and will be discussed further in January 2021.		
	3b)	The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented, In the meantime we are seeking assurance that a MDT training schedule is in place.	Compliant	In the Year ending 2019, LWH successfully demonstrated that 90% of all staff groups had attended a MDT training session that incorporated CTG, human factors, situational awareness. As part of the Trust requirements to successfully implement all the training safety actions from the Maternity Incentive Scheme (Safety Action 8) 2020-2021, there is MDT training sessions scheduled to take place with a mandatory requirement that at least 90% of all staff groups attend. Each of these training sessions (MMPET/OBS1) are and will be attended by Midwifery, Obstetric and Anaesthetic Clinicians. In addition to this training, and somewhat due to COVID 19 restrictions affecting face to face training, the Trust purchased online PROMPT training resource to support MDT training and this is completed on mandatory training sessions. For year ending 2021, there are training dates scheduled for all relevant staff groups to attend, these training sessions commenced on 23rd November and the Education Lead for Maternity will be sending a compliance report to the CNST Lead to ensure that training trajectory is being met. This 1st report is due in January 2021. There are currently two Consultant Clinical leads for simulation – across the Family Health Division, one Consultant Obstetrician and a Consultant Neonatologist, who are supported by the practice education leads from across all divisions, including midwifery, gynaecology, critical care and neonatology. There is currently a simulation group, a sub-group of educational governance, that reports to PPF Committee and is chaired by the Director of Medical Education (DME) The DME is in the process of finalising a simulation strategy to be implemented across the Trust. This includes business case for financial commitment to appointment a Trust wide simulation lead.		

	3c)	Confirmation that funding allocated for maternity staff training is ringfenced and any CNST Maternity Incentive Scheme (MIS) refund is used exclusively for improving maternity safety	Compliant	The Trust did not achieve the CNST MIS in year one (2018/19), declaring non-compliance in relation to one action- Safety Action Eight (training). An action plan was submitted to NHSR and funding was made available to the Trust in line with this action plan (£170k). This was ring fenced and released into maternity budgets to facilitate training. This action was subsequently achieved in 2019/20. The Trust did achieve the CNST MIS in year two (2019/20) and the contribution made of £962k was returned to the Trust. Investments in excess of £1m on a full year basis were made into maternity budgets in 2019/20, primarily in order to fund investment in Birth Rate Plus and to ensure that headroom was sufficient to allow CNST training requirements to be met.		
Managing complex pregnancy: There must be robust pathways in place for managing women with complex pregnancies. Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.	4a)	All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place	Partially Compliant	A risk assessment at booking is undertaken to identify complex pregnancies. All complex pregnancies are referred to a Consultant Led ANC and assigned a Consultant lead. The Trust provides tertiary level maternal medicine services which combine input from medical clinicians and experience obstetric consultants. The Trust has a dedicated clinic for diabetes, hypertension, inflammatory bowel disease, cardiology, rheumatology, endocrinology, multiple pregnancy and neurology. These specialist clinics have a dedicated Consultant with a special interest in obstetric medicine to support the named obstetric consultant. There is also a regional monthly meeting for women with HIV and syphilis attended by both obstetric clinicians and Genito-Urinary Medicine Consultants. The Trust has implemented a monthly MDT meeting, reviewing all complex pregnancies that are nearing delivery to improve communications for intrapartum and neonatal care. Audits are undertaken to review compliance against local and National guidance for Maternal medicine conditions. The Effectiveness Senate at LWH receive all new NICE guidance and quality standards. These are allocated for review by appointed staff within the Trust. The monitoring of compliance and the progress following gap analysis is reviewed through the effectiveness senate. **There is a requirement for an audit to be undertaken to ensure compliance that all women have a named consultant where a complex pregnancy is identified.**	Clinical Director - Family Health	Audit will begin in January 21 for Completion March 21
	4b)	Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres	Compliant	Liverpool Women's NHS Trust is a tertiary referral centre for maternal and neonatal medicine. We regularly review our services with regards to maternal and neonatal medicine against the National service specification. The Trust has been working with partners across the North West of England, submitting a joint proposal in 2019 regarding plans to establish Networked Maternal Medicine Services. The proposal covers three LMS areas (Greater Manchester, Lancashire and South Cumbria, and Cheshire and Mersey). A jointly agreed phased approach is planned. Greater Manchester and Eastern Cheshire will develop the first maternal medicine centre in the region, with a with a clear vision to connect all maternal medicine services across the region and support the development of two additional maternal medicine centres (including one based at LWH) over the next 1-2 years. The Trust has assessed compliance against the service specification for NMM services, noting some required derogation from the specification in respect of issues caused by the configuration and physical location of acute services within Liverpool. The Trust has a series of mitigations in place with further planned (for example establishing a CT imaging and 24/7 transfusion service on site), and is working with system partners to minimise clinical risk as far as possible.		
Risk assessment throughout pregnancy: Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.	5a)	A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance	Partially Compliant	Following the recommendations made by the 2018 Each Baby Counts report, HSIB Report Recommendations and as part of the Trust commitment to implement full Saving Babies Lives Care Bundle 2, a risk assessment guideline 'Place of Birth assessment and choice' was updated. This guideline provides a framework for risk assessment which will take place during pregnancy, when labour commences and throughout labour and birth; to assist decision making and care planning regarding appropriate place of birth. The personalised care and support plan is discussed at the booking appointment and documented within our electronic documentation system (Meditech). Monthly compliance audits are undertaken and findings monitored. **As we implement the Trusts new K2 Athena electronic documentation system in 2021, we will add to the scope of work a documentation field at the end of every antenatal contact a assessment of intended place of birth which will be electronically auditable**	Deputy Head of Midwifery	Jun-21

Monitoring fetal wellbeing: All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.	6a)	Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.	Partially Compliant	The Trust currently has 1.0 WTE Fetal Surveillance and Monitoring Lead Midwife, who provides regular training to all staff. She leads on CTG review cases and provides support to all cohorts of staff. There is a dedicated Saving Babies Lives Care Bundle Lead Midwife, who maintains oversight of all actions including Element 4, along with a named Consultant. The additional requirement of a named Consultant Lead for fetal monitoring is currently supported by the Intrapartum Consultant Lead. However, this support does not include the additional requirements to provide fetal monitoring training. **This has been escalated to the Clinical Director and the Medical Director noting that an Obstetric Consultant lead for fetal monitoring is required - this will be reviewed with a view to immediate action.** **Seconded Fetal Surveillance Midwife Post to become a substantive post: this has been agreed by the Performance Review meeting on 16.12.2020 and will be actioned by the DHOM.**	Clinical Director - family Health / Deputy Head of Midwifery	Jan-21
Informed consent: All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.	7a)	Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.	Partially Compliant	All consent forms are available on the hospital intranet, and can be made available in paper version for all users of the service. As part of the consent process, all consent forms are completed in clinic with the patient present, discussing risks, benefits of procedure etc. The patient is then re-consented on admission, as per Trust policy and National guidance. It is at this point that the appropriate patient information leaflet is provided so the patient can go away and consider what has been discussed. If a patient attends as an emergency, consent is obtained prior to procedure. **All patient information leaflets are available on the Trust's Web Site. However this will be reviewed for completeness and best practice**	Patient Experience Matron	Jan-21

Appendix 2
Maternity services assessment and assurance tool

We have devised this tool to support providers to assess their current position against the 7 Immediate and Essential Actions (IEAs) in the Ockenden Report and provide assurance of *effective* implementation to their boards, Local Maternity System and NHS England and NHS Improvement regional teams. Rather than a tick box exercise, the tool provides a structured process to enable providers to critically evaluate their current position and identify further actions and any support requirements. We have cross referenced the 7 IEAs in the report with the urgent clinical priorities and the ten Maternity incentive scheme safety actions where appropriate, although it is important that providers consider the full underpinning requirements of each action as set out in the technical guidance.

We want providers to use the publication of the report as an opportunity to objectively review their evidence and outcome measures and consider whether they have *assurance* that the 10 safety actions and 7 IEAs are being met. As part of the assessment process, actions arising out of CQC inspections and any other reviews that have been undertaken of maternity services should also be revisited. This holistic approach should support providers to identify where existing actions and measures that have already been put in place will contribute to meeting the 7 IEAs outlined in the report. We would also like providers to undertake a maternity workforce gap analysis and set out plans to meet Birthrate Plus (BR+) standards and take a refreshed view of the actions set out in the Morecambe Bay report. We strongly recommend that maternity safety champions and Non-Executive and Executive leads for Maternity are involved in the self-assessment process and that input is sought from the Maternity Voices Partnership Chair to reflect the requirements of IEA 2.

Fundamentally, boards are encouraged to ask themselves whether they really know that mothers and babies are safe in their maternity units and how confident they are that the same tragic outcomes could not happen in their organisation. We expect boards to robustly assess and challenge the assurances provided and would ask providers to consider utilising their internal audit function to provide independent assurance that the process of assessment and evidence provided is sufficiently rigorous. If providers choose not to utilise internal audit to support this assessment, then they may wish to consider including maternity audit activity in their plans for 2020/21.

Appendix 2
Maternity services assessment and assurance tool

Regional Teams will assess the outputs of the self-assessment and will work with providers to understand where the gaps are and provide additional support where this is needed. This will ensure that the 7 IEAs will be implemented with the pace and rigour commensurate with the findings and ensure that mothers and their babies are safe.

Section 1

Immediate and Essential Action 1: Enhanced Safety

Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.

- Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months.
- External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.
- All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months

Link to Maternity Safety actions:

Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
Action 2: Are you submitting data to the Maternity Services Dataset to the required standard?
Action 10: Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification scheme?

Link to urgent clinical priorities:

(a) A plan to implement the Perinatal Clinical Quality Surveillance Model
(b) All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB

What do we have in place currently to meet all requirements of IEA 1?	**Clinical Priority A). A plan to implement the Perinatal Clinical Quality Surveillance Model.** The Trust is currently reviewing the Perinatal Clinical Quality Surveillance Model. A Gap analysis to be undertaken and action plan to be formulated to address requirements identified in gap analysis this will be completed by end of January 2021.

	The Trust has a robust process for the surveillance, reviewing and reporting of all perinatal deaths. The Perinatal Mortality Review Tool (PMRT) process for the review of all >22week gestation stillbirths (SB) and neonatal deaths (NND). Parental involvement in the review of care provided is achieved in consultation with the Honeysuckle Team and use of the PMRT parental engagement tools. Quarterly reporting on perinatal deaths (SB & NND) are sighted at Quality Committee, where lessons learnt, action plans and safety actions are identified. External reviewers are requested to attend both stillbirth and neonatal PMRT review meetings. This is supported by the Clinical Network Co-ordinator for Maternity & Perinatal Mental Health as part of the North West Coast Clinical Network. **Clinical Priority B). Maternity SI's are shared with Trust Boards at least monthly and the LMS, in addition to HSIB.** The Trust has a policy in place for the Management of Incidents and serious incidents (SI's) which follows the National guidance on the Management of serious incidents. As indicated in the policy all Level 3 investigations are reported to our commissioners and an external investigator (from another Trust) is identified as a member of the investigation team. As part of this process, when an SI is declared a notification email is sent to all Executive Directors, Non-Executive Directors, senior staff and external regulators and commissioners. On a monthly basis the Safety Senate receives a report on all SI's which have been declared in the last month, which includes immediate lessons identified and immediate action taken. This report also includes all SI's which have had their investigation completed and been submitted to the CCG, which includes the root cause, lesson identified, recommendations and actions taken. The report also includes information on any actions which are overdue or outstanding. **Note:** The Safety Senate is chaired by the Medical Director and the Director of Nursing and Midwifery is in attendance as Deputy Chair. The Safety Senate then reports to the Quality Committee. On a quarterly basis, the Quality Committee (a sub-committee of the Trust board) and the Trust Board receives a serious incident report which provides information on the incidents which have occurred, lessons identified, learning and actions taken. The Trust and Maternity service have been actively reporting all maternal cases to HSIB as required since February 2019 and have quarterly meeting with the regional and local team on progress and lessons identified. To this date, HSIB have not identified any significant risks, concerns or issues which the Trusts own internal Investigation process had not already found. **Note:** As part of adopting the HSIB referral process, the Trust agreed to continue with our internal investigation process, as we wanted to ensure that we identified any issues promptly, implementing any actions and learning, due to HSIB investigation reports taking approx. 6 months to report back on any findings. All cases 'rejected' for review by HSIB, and cases that are <37weeks, but otherwise meet the HSIB criteria are subject to an internal formal investigation. These cases are presented at the Maternity PMRT (1st Wed of every month) where an external reviewer (external from the Trust) is present. Final reports and findings are shared with families throughout and post completion of investigations.

	LWH use the National Perinatal Mortality Review Tool as required in Maternity Safety action 1. We submit data to the Maternity Services Dataset to the required standard each month as indicated in Maternity safety action 2 and have reported 100% of qualifying cases to HSIB (for 2019/20 births only) and reported to NHS Resolution's Early Notification scheme as required in Maternity safety action 10. Clinical changes that are required to be implemented are discussed in a variety of meetings both internally and externally. The Maternity service has a monthly Maternity Clinical and Maternity Risk meetings where the Maternity dashboard is presented, and clinical changes are discussed and monitored, and additionally clinical changes are discussed at the Trust CAG (Clinical Advisory Group) and Safety Senate. LWH participates in many Cheshire and Merseyside meetings to enable collaboration with other Trusts and share lessons learnt, these include the Stillbirth Speciality Interest Group (SIG), Obstetrics and Gynaecology Clinical Network, Maternity Clinical experts' group, C+M HOM and NW HOM meetings.
Describe how we are using this measurement and reporting to drive improvement?	The identification of incident and serious incidents as part of an overarching policy and procedures allows the Trust to identify as part of the investigation any areas where improvement can be made and whether there are aspects of care and treatment where staff training, education and development is required. This process also allows the Trust to identify if there are any specific trends in relation to types of incidents locations, times etc. and identify once again if any improvements are required. The outcomes of investigations are reported at many levels in the organisation and where appropriate across the organisation. The initial sharing of learning is by means of lessons of the week and monthly posters and newsletters, one to one meeting with key staff involved, feedback at team meeting and safety huddles and used as examples on training days. Training materials are updated with any identified lessons learnt and/or any changes to practice. Reports on incidents are presented to the Divisional governance groups and Divisional Board and are used as part of the monthly performance review with the Executive Directors. Organisation wide they are fed back into the Trust Safety Senate on a monthly basis, which reports up to the Quality Committee and to the Board. The Safety Senate is chaired by the Medical Director and its membership consists of all the Clinical Safety leads and key senior staff. The Quality Committee and Board receive a quarterly report on all Serious Incident's which have occurred which also identifies completed incidents, Root Causes and lesson learnt.

How do we know that our improvement actions are effective and that we are learning at system and trust level?	From the incident investigation it is identified if changes in practice, policy etc. are required and if so when an audit of these actions is due to take place. If the audits are to be competed in the current year then then a request is made for the audit to be added to the current audit schedule for the division. If these audits are required to take place in the following audit year then they are placed on the Trust forward Audit Plan. As well as the identification of audits, lesson learnt can be identified as a quality Improvement project or a service evaluation which can either be completed in year or as part of a plan for the following year as above with audits. All audits, service elevations and quality improvement outcomes are reported to the Trust Effectiveness Senate which is chaired by the Medical Director and whose membership includes Clinical Effectiveness Leads for all areas. All service evaluations and quality improvement projects are supported by the Trust Quality Improvement Lead that will also monitor progress and outcomes. Training and education are carried out across the Trust following any learning requirements from incidents for example on the Trust wide Great Day (protected learning for clinical staff) which is held quarterly.
What further action do we need to take?	1. In relation to the timing of serious incidents reported to the Trust Board, this has been on a quarterly basis however from January 2021 this will now be reported on a monthly basis. The January Board will receive the Q3 report earlier than planned to bring them up to date and monthly reports will commence from February 2021. 2. The Trust is awaiting the outcome of an Internal Audit by MIAA on lessons learnt from serious incidents to identify if further improvement for the sharing of learning across the organisation can be identified and taken forward. 3. Introduction of Governance notice boards across the Trust in clinical areas 4. Introduction of Quality Improvement and Effectiveness page in staff newsletter 5. Introduction of Quarterly lesson learnt forum meetings via Teams 6. The Trust is in year 3 of a cultural change programme with the objective of developing a Fair and Just learning culture. Training of key managers is the priority for this year to ensure they have the ability to make people management decisions through the lens of this culture. 7. Maternity Serious Incident (SI) reports must be presented to the LMS at least every three months

Who and by when?	1. Monthly Serious Incident report to be provided from February 2021 to the Trust Board by the Head of Governance and Quality. 2. The MIAA audit report is due early February 2021 and actions from this will be taken forward by the Head of Governance and Quality 3. To further enhance how information is shared with staff in relation to governance, patient safety and lessons learnt all clinical areas are to have dedicated information boards which will be managed by the appropriate Divisional Governance Manager. Boards will be in place by 31st Jan 2021 4. The introduction of a Quality Improvement and Effectiveness page on the staff newsletter to commence in January 2021 and will be led by Deputy Manager for Clinical Audit and Effectiveness and Quality Improvement Lead. 5. Following a successful Lessons Learnt Forum, which was undertaken as part of the Patient Safety Week in September 2020, quarterly lessons learnt forums are to be established from Jan 2021 by the Risk and Patient Safety Manager. Each forum highlights a subject which has been a key theme in the previous quarter from incidents and lessons learnt. 6. The Trust is in year 3 of a cultural change programme with the objective of developing a Fair and Just learning culture. Training of key managers is the priority for this year to ensure they have the ability to make people management decisions through the lens of this culture. This is led by the Deputy of HR. 7. Maternity SI reports will be presented to the LMS quarterly from January 2021.
What resource or support do we need?	None identified at this time.
How will mitigate risk in the short term?	All the actions identified are to further enhance the current safe systems in the Trust. Any specific risk associated with an incident and actions required are risk assessed and placed onto an appropriate risk register for monitoring at service, divisional, corporate and BAF level if required.

Evidence considered and is available for review:

- **Managing Incidents- Serious Incident Policy**

- **Board reports Serious Incidents**
- **Serious incidents combined reports**
- **Pathway for review of HSIB incidents**
- **HSIB action log**
- **CQRM minutes**
- **Being Open and Duty of Candour Policy.**

Immediate and essential action 2: Listening to Women and Families
Maternity services must ensure that women and their families are listened to with their voices heard.

- Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.

- The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.
- Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.

Link to Maternity Safety actions:
Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?
Action 9: Can you demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?

Link to urgent clinical priorities:

(a) Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services.
(b) In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard.

What do we have in place currently to meet all requirements of IEA 2?	**MVP.** The Liverpool Maternity Voices Partnership (MVP) was established in 2018. The group was previously called PRAMS and involved regular meetings with service users and representatives from provider organisations of the Maternity services. The purpose of the MVP is to improve services for women and their families involved with Maternity services and to ensure that women's voices are heard. Quarterly meetings were scheduled with an agreed term of reference. The chair is a recent service user of the Maternity service and the group needs to have a % of mothers present at meetings. Liverpool Women's Hospital works closely with our Maternity Voices Partnership (MVP) and the MVP chair to ensure the voice of service users are at the core of commissioning, monitoring and continuous improvement of maternity services including service re-design and/ or re-structure along with any decision making involving maternity services. Since the start of the COVID pandemic, face to face meetings have not been possible however communication and collaboration has been maintained. We have had two virtual meetings and two forums have taken place with a focus on infant feeding and induction of labour experience during the pandemic. Two listening events with service users have been undertaken with one being a focus on the impact of COVID on BAME and vulnerable women. All the virtual forums have been well attended with positive feedback. Additionally, from onset of wave 1 of COVID, fortnightly calls were undertaken reducing to monthly with ad hoc calls or Email correspondence as required between the MVP Chair and the Deputy Head of Midwifery to ensure communication and partnership working continues enabling service user feedback to shape and enhance woman-centred care. A collaborative approach has been used to co-produce COVID-19 SOP's including screening for COVID and accompanying patient information leaflets, information available to women and their families during COVID, the impact of visiting restrictions and expectations of women attending the maternity service whilst in a pandemic. The MVP have been involved in the re design of the Midwifery Led Unit with LWH including the creation of pathways, one being, the Liverpool Tongue Tie pathway in conjunction with Alder Hey Hospital. The MVP has undertaken dad's engagement groups events, 'WHOSE SHOES' and a 15 Steps review to ensure that women's views and feedback is listened to and encompassed within the service to facilitate improvements. The MVP is working currently with LWH on our: • BAME action plan and further listening events are planned that will be included in this action plan. • Implementation of our continuity of carer models of care • Review of the recent NHS documentation for 'Supporting pregnant women using maternity services during the COVID pandemic: Actions for NHS providers report • Ockenden report and associated action plans

	Executive & Non-Executive for Maternity. The Executive Director with responsibility for Maternity Services is the Director of Nursing and Midwifery (DONM) There is a named Non-Executive Director who supports the Board Maternity Safety Champion and attends the Maternity Safety meetings. As per the Maternity Incentive Scheme (previously known as CNST) Safety Action 9, we have a dedicated pathway for escalation of all safety issues and the Safety champions meet Bimonthly with the Non-executive Director. Concerns raised from staff are escalated through the Divisional Safety Champions. Information related to accessing the safety champions is visible to staff and prior to the COVID-19 Pandemic, regular walkabouts were performed by the safety champions to talk with staff. Other examples of obtaining service user feedback is as follows: Friends and Family Test (FFT) – A text is sent to all users after attending the Trust, with users directed to a website to complete a questionnaire. The responses are collated and available through the hospital business intelligence system (Power BI) allowing our heads of service, matrons and managers to have an opportunity to respond and action any of the comments. Patients can also access the FFT directly from the Trust website to give any feedback at any time. National Maternity Survey - This is an annual survey with a report sent through to the Trust, with an action plan devised and monitored within the Family Health Division. The report and action plan are also reviewed and discussed at the Experience Senate. The Experience Senate has a varied attendance including Trust Governors, Patient Representatives and Healthwatch. The Chair of the MVP reports any formal and informal feedback that she receives which is actioned Divisionally or escalated if required to the Safety champions. Service users (Neo parents) are invited to provide feedback through a questionnaire system in Neonatology and formal sessions with parents are arranged to ensure actions are taken and service users are kept informed. Service users are also included in research within the Trust through the Patient and Service Users involvement groups Complaints, PALS, PALS+ – all concerns raised (email, telephone, written) are actioned and responses to women and their families are provided in whatever response method the family determine with a report generated and submitted to Experience Senate, including lessons learnt. Patient Experience team (PEX) walkabouts – The PEX team undertake ‘walk about’ to support with any patient concerns or views, with a view to resolve as quickly as possible. Care Opinion – Users can post on Care Opinion about their experience at Liverpool Women’s, with action taken by the Trust to respond. Social Media – The Trust will act on any feedback received through social media regarding a concern, which is sent via the PEX team to investigate. Local surveys are monitored out in the areas through the Experience Senate. The independent annual Picker survey provides the Trust with the opportunity to receive women’s views on the care that they receive and compare the findings to previous surveys in order to monitor improvement. An action plan is produced and monitored at the Patient experience senate. In 2020, despite COVID, LWH participated in in an

	electronic pilot of the survey. Initial feedback has been reported as favourable however the final report is awaited and once received will be presented to the Patient experience senate.

How will we evidence that we are meeting the requirements?	Feedback from MVP meetings and service users Feedback to Board from Non- exec champion Feedback through patient experience senate report.
How do we know that these roles are effective?	The Trust needs clarity on the action that each Trust must create an independent senior advocate role which reports to both the Trust and the LMS Boards. The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome. Currently there is no role at the Trust that describes this although there is as described a robust MVP. Despite the COVID pandemic, collaboration and communication with the chair of the MVP has increased with positive feedback received alongside the ability to be provided with service users views for consideration. The non-executive director safety champion has demonstrated their role effectively by raising safety issues directly to the Quality Committee with effective outcomes.
What further action do we need to take?	1. There is currently no independent senior advocate role that reports to the Trust Board and the LMS or whom is available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome. Clarification relating to the 'independent' meaning of this action as to if independent means external to the Trust or external to the Division has been sought from the NW Regional Chief midwife and a response is awaited. Response received from the Deputy Regional maternity lead on 04.01.20 who advised that guidance regarding the independent advocate role is awaited from the National team. 2. 2021 the requirement to reinstate virtually the formal MVP meetings
Who and by when?	1. Once clarification has been received regarding the meaning of an independent senior advocate, a proposal to Board will be made as to how this could be implemented as the requirement would need to be more than one individual by the Deputy Director of Nursing/ HOM 2. Reinstatement of the formal MVP meeting virtually. This action is required to be undertaken by the Chair of the MVP by March 2021.
What resource or support do we need?	1. The response from the NW Regional Chief midwife will determine the resources needed. If independent relates to staff external to the Division, a consideration for the Patient experience team to support families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed,

	particularly where there has been an adverse outcome may be an option alongside the identification of a senior advocate reporting to the Board and LMS and consideration to who reports to the Board and LMS If the requirement is external to the Trust further consideration as to how this could be implemented.
How will we mitigate risk in the short term?	Currently to ensure the voices of families involved in serious incident, PMRT reviews are heard, the Divisional Governance manager, senior clinician or Maternity Quality and Safety Midwife liaise with the families to ensure that their views, opinions or any questions that may have are included in the investigation. All HSIB investigations are independently reviewed and women and their families have the opportunity to discuss their care and highlight any concerns or questions that will be addressed within their report findings. Consideration for the Patient Experience Team to support families as an advocate requires further exploration.

Evidence considered and is available for review:

- **Terms of Reference MVP**
- **MVP Minutes**
- **Patient experience reports**
- **Patient experience agenda**
- **Maternity overview for experience senate**

Immediate and essential action 3: Staff Training and Working Together Staff who work together must train together • Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year. • Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward. • Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.	
Link to Maternity Safety actions: **Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?** **Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?**	
Link to urgent clinical priorities: (a) Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week. (b) The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place	
What do we have in place currently to meet all requirements of IEA 3?	**Consultant Led Ward Rounds.** There is a MDT Consultant Led Ward round at least twice a day on the high-risk intrapartum area. There is also a Consultant Led MDT ward round daily on the antenatal and postnatal ward. There is ratified guideline in place, Medical Staffing Delivery Suite Change over, that outlines the process for handover and when MDT Consultant ward rounds should take place. All handovers are documented electronically and recorded and can be used for audit purposes if required. The current guideline is being updated following increased resident consultant cover in the delivery suit. Obstetric consultants remain on site between 08.30 and midnight. The updated guideline is due for ratification in January 2021. In response to the recent HSIB report (Delays in intervention once fetal compromise is suspected) published in Nov 2020, the Trust has created an action plan addressing the questions raised. LWH are aiming to commence a QI project, with a named task & finish group, based on the NHSI framework to focus on safety huddles and handovers in addition to the MDT wards rounds. This will improve the oversight of cases, activity, acuity and staffing across

	the intrapartum area and will include Clinicians from across Midwifery, Neonatal, Obstetrics and Anaesthetics. This has been discussed with the Intrapartum Working Group on 11th December and will be discussed further in January 2021. **MDT Training.** In the Year ending 2019, LWH successfully demonstrated that 90% of all staff groups had attended a MDT training session that incorporated CTG, human factors and situational awareness. As part of the Trust requirements to successfully implement all the training safety actions from the Maternity Incentive Scheme (Safety Action 8) 2020-2021, there is MDT training sessions scheduled to take place with a mandatory requirement that at least 90% of all staff groups attend. Each of these training sessions (MMPET/OBS1) are and will be attended by Midwifery, Obstetric and Anaesthetic Clinicians. In addition to this training, and somewhat due to COVID 19 restrictions affecting face to face training, the Trust purchased the online PROMPT training resource to support MDT training and this is completed on mandatory training sessions. For the year ending 2021, there are training dates scheduled for all relevant staff groups to attend, these training sessions commenced on 23rd November 2020 and the Education Lead for Maternity monitors training compliance and will send a compliance report to the CNST Lead to ensure that training trajectory is being met as evidence. This 1st report is due in January 2021. It is important to remember that this training sessions starts from a 0% compliance of all staff groups each year and requires allocated time to Consultants to enable the faculty to run these training sessions. There are currently two Consultant Clinical leads for simulation – across the Family Health Division, one Consultant Obstetrician and one Consultant Neonatologist, who are supported by the Practice Education Leads from across all divisions, including midwifery, gynaecology, critical care and neonatology. There is currently a simulation group, a sub-group of Educational Governance, that reports to Putting People First Committee (PPF) and is chaired by the Director of Medical Education (DME).
	CNST Ring fenced funding for Maternity Training. The Trust did not achieve the CNST MIS in year one (2018/19), declaring non-compliance in relation to one action- Safety Action Eight (training). An action plan was submitted to NHSR and funding was made available to the Trust in line with this action plan (£170k). This was ring fenced and released into maternity budgets to facilitate training. This action was subsequently achieved in 2019/20. The Trust did achieve the CNST MIS in year two (2019/20) and the contribution made of £962k was returned to the Trust. Investments in excess of £1m on a full year basis were made into maternity budgets in 2019/20, primarily in order to fund investment in Birth Rate Plus and to ensure that headroom was sufficient to allow CNST training requirements to be met.
What are our monitoring mechanisms?	Spot check audits of consultant led ward rounds to be undertaken by Delivery Suite shift leaders. MMPET Training trajectory developed and monitored by the Intrapartum matron and Midwifery lead for education to ensure compliance with CNST requirements. Compliance is monitored at the Maternity Clinical Meeting and at the Family Health Divisional Board.
Where will compliance with	Divisional Clinical and Divisional Board Meetings.

these requirements be reported?	Multidisciplinary training and working must be externally validated through the LMS 3 times a year
What further action do we need to take?	1. Audit of evidence of the twice per day Consultant led ward rounds required to evidence the undertaking of them. 2. Finalisation of Trust Wide Simulation Strategy and identification of financial resource. The Trust wide simulation leads will have dedicated time within their job plan and other participating consultants from the workforce to deliver training. 3. The LMS is required to develop a reporting mechanism for the validation of Trusts MPET training in order to meet the external validation requirement three times per year. 4. LWH will incorporate the required training compliance into our own reporting schedules to the LMS three times per year.
Who and by when?	1. Documentary evidence to commence in January 2021 to enable audit of twice daily Consultant led ward rounds by Consultant lead for Delivery suite. Spot check of twice daily Consultant led wards rounds to be undertaken by Delivery suite shift leaders in January 2021 followed by Audit of documentation of twice daily Consultant led rounds to be undertaken by Quality and Safety midwife in February 2021. 2. Finalisation of Trust Wide Simulation Strategy by the Director of Medical Education with a Trust wide Lead for Simulation to be in post by 1st April 2021. 3. LWH will respond to the reporting schedule by the LMS. 4. LWH will incorporate MPET training into our own reporting schedules to the LMS three times per year from January 2021.
What resource or support do we need?	Clinical time to develop, organise and deliver the simulation training.
How will we mitigate risk in the short term?	None required

Evidence considered and is available for review:

- **SIM group agenda**
- **Minutes Sim group**
- **Agenda MPET**
- **CNST- Safety and training report**
- **MPET training schedule**

Immediate and essential action 4: Managing Complex Pregnancy There must be robust pathways in place for managing women with complex pregnancies Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre. • Women with complex pregnancies must have a named consultant lead • Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team	
Link to Maternity Safety Actions: **Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?**	
Link to urgent clinical priorities: a) All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place. b) Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres.	
What do we have in place currently to meet all requirements of IEA 4?	**A) Complex Pregnancies & Named Consultant Lead and mechanisms to regularly audit compliance.** A risk assessment at booking is undertaken to identify women with complex pregnancies. All complex pregnancies are referred to a Consultant Led ANC and assigned a Consultant lead. The Trust provides tertiary level maternal medicine services which combine input from medical clinicians and experience obstetric consultants. The Trust has dedicated clinics for women with diabetes, hypertension, inflammatory bowel disease, cardiology, rheumatology, endocrinology, perinatal mental health, multiple pregnancy and neurology. These specialist clinics have a dedicated Consultant with a special interest in obstetric medicine to support the named obstetric consultant. At these clinics, specific management plans are made and agreed in conjunction with the woman. There is also a regional monthly meeting for women with HIV and syphilis attended by both obstetric clinicians and Genito-Urinary Medicine Consultants. The Trust has implemented a monthly MDT meeting, reviewing all complex pregnancies that are nearing delivery to improve communications for intrapartum and neonatal care. Audits are undertaken to review compliance against local and National guidance for Maternal medicine conditions. The Effectiveness Senate at LWH receive all new NICE guidance and quality standards. These are allocated for review by

	appointed staff within the Trust. The monitoring of compliance and the progress following gap analysis is reviewed through the effectiveness senate. B) **Understand what steps the organisation has to take to support development of maternal medicine specialist centres**. Liverpool Women's NHS Trust is a tertiary referral centre for maternal and neonatal medicine. We regularly review our services with regards to maternal and neonatal medicine against the National service specification. The Trust has been working with partners across the North West of England, submitting a joint proposal in 2019 regarding plans to establish Networked Maternal Medicine Services. The proposal covers three LMS areas (Greater Manchester, Lancashire and South Cumbria, and Cheshire and Mersey). A jointly agreed phased approach is planned. Greater Manchester and Eastern Cheshire will develop the first maternal medicine centre in the region, with a with a clear vision to connect all maternal medicine services across the region and support the development of two additional maternal medicine centres (including one based at LWH) over the next 1-2 years. The Trust has assessed compliance against the service specification for NMM services, noting some required derogation from the specification in respect of issues caused by the configuration and physical location of acute services within Liverpool. The Trust has a series of mitigations in place with further planned (for example establishing a CT imaging and 24/7 transfusion service on site) and is working with system partners to minimise clinical risk as far as possible. At LWH we have an SBL action plan that monitors our progress and compliance to the 5 elements.
What are our monitoring mechanisms?	The SBL action plan is maintained by the quality and safety midwife and the Consultant lead for Delivery suite and is monitored at the Maternity clinical and Maternity quality meetings. A Biannual report is completed detailing progress and evidence of areas of compliance. The October 2020 report was presented to the Board in December 2020. SBL is additionally incorporated into the CNST action plan that is monitored at the family Health Divisional board and the Trust Quality committee All audits are presented at Effectiveness senate which reports into to Quality Committee.
Where is this reported?	a) Audits of compliance will be reported to Divisional Board, Effectiveness senate to Quality Committee and to Trust Board
What further action do we need to take?	The requirement to undertake an audit to demonstrate that all women with complex pregnancies are allocated to a named consultant and that early specialist involvement and management plans agreed between the woman and the team are developed

Who and by when?	Audit to commence in February 2021 and facilitated by the ANC manager
What resources or support do we need?	Additional audit resource to facilitate review.
How will we mitigate risk in the short term?	Women are currently allocated a named consultant and attend the designated high-risk clinics where management plans are developed in conjunction with the woman and clinicians external to the Trust as required. We believe we are compliant which will be confirmed by audit.

Evidence considered and is available for review:

- **NICE annual report 2019/20**
- **Maternal medicine risks**
- **NMNS Annex D- Network submission**
- **NMMS- service specification**

<table>
<tr><td colspan="2">Immediate and essential action 5: Risk Assessment Throughout Pregnancy
Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.

• All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional

• Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.</td></tr>
<tr><td colspan="2">Link to Maternity Safety actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?</td></tr>
<tr><td colspan="2">Link to urgent clinical priorities:

a) A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance.</td></tr>
<tr><td>What do we have in place currently to meet all requirements of IEA 5?</td><td>A) Risk assessment completed and recorded, place of birth discussion and audit in place to assess PSCP compliance.
Following the recommendations made by the 2018 Each Baby Counts report, HSIB Report Recommendations and as part of the Trust commitment to implement full Saving Babies Lives Care Bundle 2, a risk assessment guideline 'Place of Birth assessment and choice' was updated. This guideline provides a framework for risk assessment which will take place during pregnancy, when labour commences and throughout labour and birth; to assist decision making and care planning regarding appropriate place of birth.

These assessments are formal assessments and documented within the woman's health records. At each other antenatal contact a risk assessment is undertaken however these are not formally recorded. If there are any changes to the level of clinical care required, the midwife refers for medical input. Changes in care affect the intended place of birth and any changes will be discussed with the woman and documented in the health records. There are plans in place to introduce formal monthly reporting/ recording of contacts in K2.

The personalised care and support plan are discussed at the booking appointment and documented within our electronic documentation system (Meditech). Monthly compliance audits are undertaken, and findings monitored.</td></tr>
</table>

What are our monitoring mechanisms and where are they reported?	The information team report on the PCSP compliance for the offer of choice of place of birth at booking monthly.
Where is this reported?	
What further action do we need to take?	1. The booking, 36 week and onset of labour risk assessment has already been built into the new K2 Athens electronic documentation system which is due to go live on 18th January 2021. An audit of these 3 elements will be scheduled. This will be reported to family health divisional board and to performance review. 2.As we implement the Trusts new K2 Athena electronic documentation system in 2021, we will add to the scope of work a documentation field at the end of every antenatal contact assessment of intended place of birth which will be electronically auditable.
Who and by when?	1. The booking, 36 week and onset of labour risk assessment audit to commence in March 2021 undertaken by the K2 Digital midwife. 2. Audit of the risk assessment of every antenatal contact including intended place of birth will be electronically auditable from June 2021 and facilitated K2 Digital midwife.
What resources or support do we need?	Additional scoping of any further costs required for new scope of work to be identified. The K2 digital midwife is currently in post and will oversee the new scope of work and the subsequent audit.
How will we mitigate risk in the short term?	Every woman at each antenatal contact has a full clinical evaluation to determine if her level of care remains the same or requires escalation which would necessitate a referral and review of the most appropriate place of birth. These referrals and discussion to be documented in the health records.

Evidence considered and is available for review:

- **Place of Birth assessment and choice SOP**

Immediate and essential action 6: Monitoring Fetal Wellbeing

All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.

The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: -

- Improving the practice of monitoring fetal wellbeing –
- Consolidating existing knowledge of monitoring fetal wellbeing –
- Keeping abreast of developments in the field –
- Raising the profile of fetal wellbeing monitoring –
- Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported –
- Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.
- The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training.
- They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice. •
- The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.

Link to Maternity Safety actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?
Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?

Link to urgent clinical priorities:

a) Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.

What do we have in place currently to meet all requirements of IEA 6?	The Trust currently has 1.0 WTE Fetal Surveillance and Monitoring Lead Midwife, who has the responsibility to provide regular training to all staff, monitoring of fetal surveillance training compliance, consolidating existing knowledge and raising the profile of monitoring fetal wellbeing. She leads on CTG review cases and provides support to the multi-disciplinary team of staff.

	There is a dedicated Saving Babies Lives Care Bundle Lead Midwife, who maintains oversight of all actions including Element 4, along with a named Consultant.
How will we evidence that our leads are undertaking the role in full?	The fetal surveillance midwife is an integral role within the Maternity Education Team, who is manged by the Intrapartum Matron and lead for Maternity education. Compliance with the teaching and training elements of this requirement will be monitored by the Matron. Ensuring the fetal surveillance midwife is present at all SI reviews, rapid reviews, formal reviews, HSIB reviews, PMRT reviews providing expert advice on fetal monitoring issues. The Saving Babies Lives Care Bundle Lead Midwife is visible within the Division and the Trust. Action plans, reports and presentations are developed and submitted to the Family Health Divisional Board and the Trust Board. Minimum Bimonthly meeting with the Maternity and neonatal safety champions and the non-executive Board level safety champion.
What outcomes will we use to demonstrate that our processes are effective?	CTG and Fetal Surveillance Training compliance. Assurance to the Board of progress to the SBL2 care bundle
What further action do we need to take?	The currently seconded Fetal Surveillance Midwife Post to become a substantive post: this has been agreed at the Performance Review meeting on 16.12.2020 and will be actioned by the DHOM. There is an additional requirement of a specific named Consultant Lead for fetal monitoring. Currently this remit is undertaken by the Intrapartum Consultant Lead, however, this support does not include the additional requirements to provide fetal monitoring training. This has been escalated to the Clinical Director and the Medical Director noting that an Obstetric Consultant lead for fetal monitoring is required.
Who and by when?	The Clinical Director for Family Health will identify the requirement for a fetal monitoring lead by January 2021. The Deputy Head of Midwifery will enact the substantive position of the fetal Surveillance Midwife Post in Jan 2021.
What resources or support do we need?	Financial support to ensure seconded MW post is developed into a substantive role. Named Consultant to have identified time in their job plan to support requirements of fetal surveillance midwife.

How will we mitigate risk in the short term?	Seconded midwife already in post supported by Consultant for Delivery suite covering the required roles. Plans developed to ensure the sustainability of these roles and requirements. The role is currently undertaken by the intrapartum Consultant Lead

Immediate and essential action 7: Informed Consent
All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.

- All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care
- Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care
- Women's choices following a shared and informed decision-making process must be respected

Link to Maternity Safety actions:

Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?

Link to urgent clinical priorities:

a) Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.

What do we have in place currently to meet all requirements of IEA 7?	**A) Pathways of Care clearly described, consistent with NHS policy and posted on Trust Website.** As part of the consent process, all consent forms for elective procedures are completed in clinic with the patient present, discussing risks, benefits of procedure etc. The patient is then re-consented on admission, as per Trust policy and National guidance. It is at this point that the appropriate patient information leaflet is provided so the patients leave the appointment and have time to consider what has been discussed. If a patient attends as an emergency, consent is obtained prior to procedure. **All Maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of Maternity care throughout the antenatal, intrapartum and postnatal periods of care.**

	Information is currently available on the Trust website, but this requires reviewing to ensure all patient information leaflets are available including links to National leaflets to ensure they are in line with NHS Policy. Some information is available in various formats and languages. Care pathways are not available on the Trust website. Consent forms are not currently available on the Trust website. The consent form has patient information within it, and this is discussed and explained to women when form is first signed. This information is reviewed, and any questions answered on admission when the consent is signed for a 2nd time prior to an elective procedure. Following the introduction of the new electronic K2 documentation system patient information will be available including a list of leaflets and relevant National guidance. Women will have access to these leaflets via the patient portal "My pregnancy notes." once K2 Athena is implemented. **<u>Women must be enabled to participate equally in all decision-making processes and make informed choices about their care.</u>** The midwife formally assesses the pregnancy risk at booking. This is reviewed informally throughout pregnancy and again formally at 36 weeks gestation. Women are given information regarding aspects of their care as clinically required. Choice of place of birth is discussed and recorded at booking and women are signposted to information "Where to have my baby' at this appointment and against discussed at the 36-week assessment when place of birth is discussed and documented again. An individual risk assessment is completed on both occasions to assist the women in making their decisions. A link is available which can be printed to the RCOG guidance "Choosing to have a caesarean section'. Any woman who is requesting a caesarean section will be referred to the Consultant or Consultant Midwife. Women's choices following a shared and informed decision-making process are respected. If a woman makes a decision or choice in deviance to Trust or National guidance a referral will be made to the Consultant Midwife or Consultant for further discussion. Women's choices are respected, and a risk assessment and plan of care will be put in place as required and shared with all members of the multi-disciplinary team.
Where and how often do we report this?	

How do we know that our processes are effective?	Feedback from women, friends and family test, NHS choices, pals
What further action do we need to take?	1. Undertake a full review all website information for patients to ensure all available information and National links are available to women and their families 2. Implementation of K2 Athena electronic documentation system will introduce the facility of links to local and National information and the women will be signposted to these by the midwife and will have access though the portal "My pregnancy notes " 3. A Trust wide approach for regular review of patient information available on the website including a process for updating, monitoring and uploading 4. The trust will commence to use a decision-making tool "BRAIN" in 2021 to support women making decisions regarding choices for induction of labour. This tool is being supported by the Maternity Voices partnership. 5. Introduce a link on the website for women to access the NHSE video Choices for birth available on the Improving Me Cheshire and Mersey website.
Who and by when?	Executive ownership by DONM, oversight to be completed by June 2021 and monitored through Experience senate. 1. Full review of all website information for patients to ensure all available information and National links are available to women and their families to be undertaken by the Maternity Matron and PEX for patient experience in January 2021 2. Implementation of K2 Athena electronic documentation system will introduce the facility of links to local and National information and the women will be signposted to these by the midwife and will have access though the portal "My pregnancy notes "This will be implemented on the 18.01.21 3. Implement a Trust wide approach for regular review of patient information available on the website including a process for uploading. PEX to work with divisional teams. 4. The Trust will commence to use a decision-making tool "BRAIN" (Benefits, Risks, Alternatives, intuition and Nothing) in 2021 to support women making decisions regarding choices for induction of labour. This will be enacted by the Consultant midwife. 5. Introduce a link on the website for women to access the NHSE video Choices for birth available on the Improving Me Cheshire and Mersey website. This will be undertaken by the Maternity matron for patient experience in January 2021
What resources or support do we need?	Internal resource- administration resource to undertake this that will support the review of patient information.

How will we mitigate risk in the short term?	Face to face interaction Review of the approach to trust wide information uploads.

Section 2	
MATERNITY WORKFORCE PLANNING	
Link to Maternity safety standards: **Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard** **Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?**	
We are asking providers to undertake a maternity work-force gap analysis, to have a plan in place to meet the Birthrate Plus (BR+) (or equivalent) standard by the 31st January 2020 and to confirm timescales for implementation.	
What process have we undertaken?	**Obstetric Medical, Neonatal Medical and Anaesthetic Medical Workforce.** - The Clinical Director for Anaesthetics performed a review and provided assurance to the Board that the required standards to meet both the ACSA and Maternity Incentive Scheme are currently being met. This Paper will be submitted to the scheduled Putting People First Committee in Jan 2021 and will provide assurance that all anaesthetic safe staffing standards are currently being met and that no further actions or completion of an action plan is required. This will need to be formally recorded in the February Board minutes that ASCA standards 1.7.2.5/1.7.2.1 and 1.7.2.6 are fully met. - The Clinical Director for Family Health Division will be submitting the following paper to the Acting Director of Nursing and Midwifery. This paper is to be noted and added as an appendix as part of the Safe Staffing Paper that will be submitted to the Putting People First Committee in January 2021. This paper provides assurance that all requirements for the safe medical staffing requirements of the neonatal unit are being met and as such the Maternity Incentive Scheme requirements are also satisfied. - The Director of Medical Education submitted the embedded paper (below) to Putting People First in November 2020, it provided an overview of how educational opportunities for clinical staff have been managed during Covid-19 and considers how the workforce challenges during COVID have impacted on staffing and training. It

	provides an update as to the current position from the Annual DME report presented in June 2020. This paper addressed the rota gaps in 2019 with the action plan formulated to address the rota gaps. The Maternity Incentive Scheme 2020 requirement that the *"Board formally record in their minutes the proportion of obstetrics and gynaecology trainees in their Trust who responded disagreed or strongly disagreed to the 2019 GMC national trainees survey",* this will be addressed at Board in February 2021. Midwifery workforce bi- annual review will be part of the Trust wide bi-annual staffing paper which will go to PPF 25th January and to Board, February. Operational planning is undertaken annually with predicted levels of activity. Clinical workforce requirements are discussed with clinical leads and signed off by the Divisions. There has been significant investment in the workforce. There is a twice-yearly review of safe staffing which is reported to board. Birthrate plus was undertaken with a report received in 2018. The funded establishment set for the 2020/21 was in line with Birth rate plus. The implementation of Continuity of carer will change the workforce framework and a further Birth rate plus reassessment has been proposed for 2021. The Trust did not achieve the CNST MIS in year one (2018/19), declaring non-compliance in relation to one action- Safety Action Eight (training). An action plan was submitted to NHSR and funding was made available to the Trust in line with this action plan (£170k). This was ring fenced and released into maternity budgets to facilitate training. This action was subsequently achieved in 2019/20. The Trust did achieve the CNST MIS in year two (2019/20) and the contribution made of £962k was returned to the Trust. Investments in excess of £1m on a full year basis were made into maternity budgets in 2019/20, primarily in order to fund investment in Birth Rate Plus and to ensure that headroom was sufficient to allow CNST training requirements to be met
How have we assured that our plans are robust and realistic?	Divisional Board sign off DONM sign off. Monitored monthly at divisional performance reviews with KPI's. Benchmark against agreed national standards Bi- annual staffing paper to PPF and Board.
How will ensure oversight of progress against our plans going forwards?	6 monthly review of planning progress Business intelligence paper to PPF. Monthly staffing paper to board

What further action do we need to take?	Local review of Birth rate plus assessment to be continued. Consider a formal assessment of a Birth rate plus.
Who and by when?	Assessment would be undertaken by Birthrate plus. Contact has been made with Birthrate plus to ascertain their availability to undertake an assessment- Lead, Head of Midwifery
What resources or support do we need?	Additional internal midwifery resources would be required to undertake the required work and data needed to be submitted to the Birth rate plus team. If a formal review was undertaken.
How will we mitigate risk in the short term?	Workforce planning which is under constant review.
Evidence considered and is available for review: • **Anaesthetic Medical workforce review** • **CNST neonatal medical workforce review** • **Covid impact regarding medical workforce**	

MIDWIFERY LEADERSHIP **Please confirm that your Director/Head of Midwifery is responsible and accountable to an executive director and describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in** Strengthening midwifery leadership: a manifesto for better maternity care

NICE GUIDANCE RELATED TO MATERNITY	
We are asking providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Where non-evidenced based guidelines are utilised, the trust must undertake a robust assessment process before implementation and ensure that the decision is clinically justified.	
What process do we have in place currently?	The Trust has a process whereby all NICE guidance and Quality Standards are coordinated centrally through our Clinical Audit and Effectiveness team who support the Effectiveness Leads (Consultants) within the specialties to undertake a review of the guidance or standards and identify relevance and compliance. Where there is compliance this is evidenced and where non-compliance then an action plan is developed to achieve this in a specified timetable. There is a set template format which is used to undertake the review and identify compliance to ensure that there is a standardised approach and response format.
Where and how often do we report this?	All Compliance reviews and action plans are report to the Trust Effectiveness Senate, which is a subgroup of the corporate Quality committee at each meeting. During 2020 this has been bi-monthly but was previously and is once again going to be monthly. The group is chaired by the Medical Director and have representation form al specialities by the Clinical Effectiveness leads and senior relevant staff. An annual report is produced and presented to the trusts Quality Committed for review; this information is also included in the Annual Quality Report s as mandated.
What assurance do we have that all our guidelines are clinically appropriate?	All guidance which comes into the Trust is reviewed at the Effectiveness Senate to identify if it is relevant to the Trust and if so, this is then sent to the appropriate effectiveness lead for a full review. Effectiveness senate is a sub-group of the Quality Committee and is multidisciplinary which is chaired by the Medical Director and has as its membership the Deputy Medical Director, Clinical Effectiveness Leads (Consultants), and senior key staff including the Head of Governance and Quality.

What further action do we need to take?	None identified at the time of completing this report
Who and by when?	None identified at the time of completing this report
What resources or support do we need?	None identified at the time of completing this report
How will we mitigate risk in the short term?	None identified at the time of completing this report

Liverpool Women's NHS Foundation Trust

Agenda Item	20/21/252

MEETING	**Trust Board**
PAPER/REPORT TITLE:	**Serious Incident Report – Quarter 3, 2020-21**
DATE OF MEETING:	Thursday, 07 January 2021
ACTION REQUIRED	**Assurance**
EXECUTIVE DIRECTOR:	Marie Forshaw, 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
	Date of meeting	November and December Meetings 2020

Executive Summary

The following report relates to serious incidents reported during quarter 3 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 5 Serious Incidents (SI's) declared on the StEIS system as per Trust Policy in line with NHS England StEIS reporting criteria during Quarter 3 in 2020/21 period. The cases were identified in the following areas of the Trust; 1 for Maternity, 4 for Gynaecology. There are two themes, medicines management policies not being following and delay in treatment due to diagnostic results not being reviewed.

There were 5 Serious Incident final reports submitted to the CCG as in Quarter 3. 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.

New Serious Incident Reports declared to the CCG

There were 5 Serious Incidents (SI's) declared on the StEIS system as per Trust Policy in line with NHS England StEIS reporting criteria during Quarter 3 in 2020/21 period. The cases were identified in the following areas of the Trust ;), 1 for Maternity, 4 for Gynaecology.

There were 5 Serious Incident final reports submitted to the CCG as in Quarter 3. The reports submission met the required timeframe (60 working days) as set out in the Trust Policy.

Of the three incidents related to Gynaecology, 2 relate to a delay in treatment due to the patient diagnostic results not being reviewed and acted upon, therefore delaying treatment. These are similar to incidents reported in the last quarter relating to imaging results not being reviewed. A task and finish group is being established in January 2021 by the Head of Governance and Quality to review all the Serious Incidents related to Imaging and diagnostic results review delays, and identify themes, trends and key actions to prevent further occurrence in the long term. Following the Root Cause Analysis investigations specific actions have or are being put in place to mitigate this risk until the Task and Finish group is able to undertake it's reviewed and identify any long terms actions required.

The last incident to be reported relates to an unexpected death of a patient following a day case procedure. This case in currently under investigation, but initial review has not identified any significant concerns or actions required.

Completed RCA Reports Submitted to the CCG

Of the 4 completed RCA reports submitted to the CCG there are to neonatal incidents which relate to medication errors. Both relate to staff not following Trusts policies and procedures, but one (adrenaline overdose) had the added element of loss of situational awareness during a stressful resuscitation. Actions have been put in place relating to specific elements of each outcome and there has been a re-introduction of simulation training on the unit involving Human Factors training.

Overview

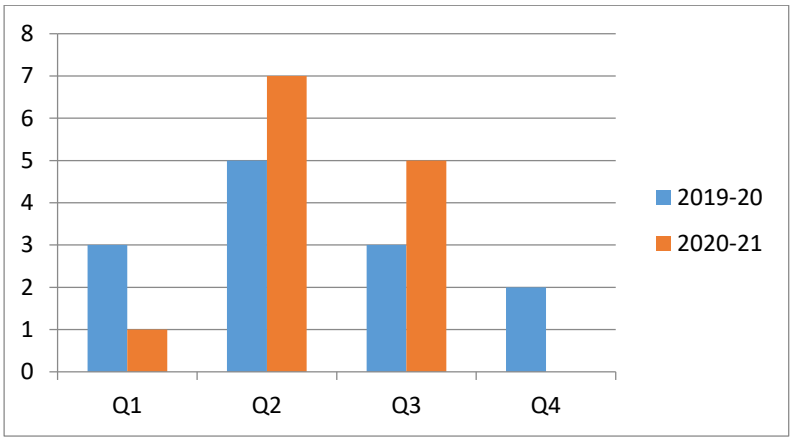
The following section of the report provide more detail in relation to each of the Serious incidents declared and RCA reports submitted including lessons identified, recommendations and actions.

During Quarter 3 there were 5 SI's reported making a total of 13 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 11 SI's were reported.

Total SIs reported by quarter compared by year

The following table shows the trend in SI's numbers in the Trust the all quarters in 2019/20 and the first 3 quarters in 2020/21

Year	Q1	Q2	Q3	Q4	Total
2019-20	3	5	3	2	11
2020-21	1	7	5	0	13



Serious Incidents Reported to the CCG in October, November and December 2020 (Q3)

The table below provides a brief overview of the 5 StEIS serious incidents reported to the CCG in quarter 3, including initial lesson identified and actions taken prior to the full RCA being completed.

Quarter 3 – October			
Service	**StEIS Ref.**	**Reported in Line with Policy**	**Summary**
Gynaecology	2020/19433	Yes	The patient was seen Gynaecology Outpatient Department in February 2020 with post menopausal bleeding and was receiving HRT treatment. Following this appointment the patient had an ultrasound scan on 29 February 2020 at LWH. The findings from which were abnormal, thickened endometrium and adnexal mass. Unfortunately no action was taken following the scan being reported and the patient was on the benign gynaecology pathway and was listed for routine ambulatory procedure and attended for this on 1 October 2020.

Immediate Action Taken:

- An urgent rescan was requested and this was performed on 1 October 2020.
- Ambulatory treatment took place on 1 October 2020 and an urgent histology sample was sent, which has now confirmed Endometrial Cancer.

Initial Lesson Learnt:

- To ensure that the patient was on the correct pathway.
- Review the process for escalating abnormal reports.

Quarter 3 - November

Service	StEIS Ref.	Reported in Line with Policy	Summary
Gynaecology	2020/20945	Yes	The patient was referred to Liverpool Women's Hospital in October 2019 with a history of peri-menopausal bleeding and was seen in Ambulatory Clinic on 21 November 2019, ultrasound scan identified endometrial polyp and complex cyst and a hysteroscopy was performed. Subsequently the patient had tumour markers taken (CA125) and was booked for myosure polypectomy which took place on 30 November 2019. There was no further clinical activity with the patient until September 2020 when the patient was referred to the Rapid Access Clinic with significantly enlarged ovarian mass and a raised CA125. The patient underwent surgery on 15 October 2020 and was discharged home on 18 October 2020. On 24 October 2020, 11 days post-surgery the patient was admitted to the Royal Liverpool University Hospital with sepsis which resulted from a bowel injury sustained from the surgery performed at LWH on 15 October 2020. Histology reported on 29 October 2020 confirmed Stage 1a Borderline mucinous ovarian tumour.

Immediate Action Taken:

- Patient was seen in Joint Clinic on 19 September 2019.
- Further imaging was requested.
- Subsequently seen in Gynaecology on 7 October 2020 and booked for surgery.

Initial Lesson Learnt:

- Robust system required to link radiology with follow up gynaecology clinics

Service	StEIS Ref.	Reported in Line with Policy	Summary
Maternity	2020/22259	Yes	Anti D omission post-natal. Identified on readmission at 9 days, not identified on post-natal home visits on day 5 and 8.

Immediate Action Taken:

- Immediate communication via email and handovers was given to all band 7 shift leaders that Anti D follow up must be actioned daily.
- For patient to be offered follow up with haematologist and obstetrician to discuss implications for future pregnancies.
- A Keilhauer was taken and Anti D 1500 IU given on 19/11/20 after discussion with medics.
- Immediate communication via email and handovers was given to all band 7 shift leaders that Anti D follow up must be actioned daily.
- An immediate addition to the shift leaders daily checklist has been made to include Anti D follow up.
- The Anti D book has been checked and there are no further outstanding Anti D follow ups.

Initial Lesson Learnt:

- All mandatory daily checks should be included on the daily checklist for shift leaders.

Quarter 3 – December			
Service	**StEIS Ref.**	**Reported in Line with Policy**	**Summary**
Gynaecology	2020/22952	Yes	Drug error- wrong medication given to patient. On handing over to night staff explained that I was unable to manage pain and nausea all day and stated the last dose of Oramorph was green. The nurse questioned why it was green; this resulted in checking the Oramorph in the controlled drug cupboard, where it was identified that the bottle inside the Oramorph box was Methadone. instead if 5mls Oramorph being given 5mls of Methadone was given.

Immediate Action Taken:

Short

- Methadone to be stored separately from Oramorph
- Training and support to be put in place for staff involved
- Review of CD checking process at change of shift
- Staff to be reminded about good housekeeping and removing empty boxes etc.
- Controlled liquids to be dispensed in their usual bottle with accompanying box
- Put escalation process in place to alert senior staff on the ward if there are any concerns with the patient.
- Reported to CDLIN
- Review of medication competency training for all
- Structure to be put in place for medicines round
- Put escalation process in place for calling the on-call Consultant and on call Pharmacist to make them aware of any serious issues on the ward and ask for advice as the potential for complications can be high.
- Senior staff to be developed to take a proactive approach to mentor and supervise new and junior staff

Immediate Lesson Learnt:

- No escalation process in place or not used for notifying on call Consultant and / or on call Pharmacist in the event of a medication error.
- Staff involved did not adhere to the medicines administration policy
- No supervision from senior staff on duty.
- No process in place for medicine round

Service	StEIS Ref.	Reported in Line with Policy	Summary
Gynaecology	2020/25044	Yes	Unexpected death of a patient following day surgery. The patient was admitted on 15 December 2020 and underwent examination under anaesthetic, diagnostic hysteroscopy and endometrial biopsy on 16 December 2020. Potential underlying endometrial cancer with associate pyometra (infection in the uterus) was noted at the time of the procedure and the decision was made for day case care with antibiotic cover.

Immediate Action Taken:

- Immediate medical review took place following identification of acute shortness of breath and low saturations following surgery.
- The patient was transferred to HDU and discussions were held with LUFT around level 3 care. However this was not thought to be appropriate.
- MDT discussion and discussion with ITU at RLUH to agree management plan.
- DNACPR form was signed
- Family were informed and invited to visit the patient
- All relevant information communicated with family members and support was offered.

Immediate Lesson Learnt:

None identified at this time, awaiting outcome of full RCA

Lessons learnt from serious incidents RCA Reports submitted in Q3 2020/21

During the Q3 period a total of 4 SI's have had final reports submitted to the CCG for consideration.

Service	StEIS Ref.	Summary
Neonatal	2020/14059	Near miss NE involving the administration of Potassium Acid Phosphate rather than Potassium Chloride NB: Sodium Acid Phosphate is a lower strength the Strong Potassium therefore does not meet NE criteria.
Root Cause: • When removing drugs from the controlled drug cupboard, the Management of controlled drugs policy was not adhered to.		
Learning from Investigation: • Staff to be reminded of the correct procedures to be followed when handling controlled drugs • Two types of potassium are not to be stored next to each other in the drugs cupboard • Three person check/involvement of controlled drugs made the process more complicated **Recommendations:** • Staff to be reminded of the correct procedures to be followed when handling controlled drugs • Potassium acid phosphate and potassium chloride should be separated in the controlled drugs cupboard • Pre-filled bags of potassium chloride to be sourced • Once pre-filled bags are sourced, datasheets to be updated • Process for CD key holder to be reviewed • Medication incidents/SI's and Never events to be discussed at neonatal unit meeting • Medication education and training programme to be launched, to include competencies relating to controlled drugs • Increase lighting in rooms		
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 Effectiveness Senate		

Service	StEIS Ref.	Summary
Neonatal	2020/16403	The Neonatal team at LWH requested that neonatologists from Birmingham Women's Hospital to review 10 cases of 24 week infant deaths from 2016. The retrospective review identified one case where further investigation was required. This was a twin (twin 2) born with a birthweight of 630g on 28/11/2016. There had been spontaneous preterm rupture of the fetal membranes with subsequent oligohydramnios/anhydramnios since 19 weeks gestation. There was a spontaneous labour at 24+6 weeks gestation, followed by a normal vaginal delivery. The baby was intubated and then transferred to the Neonatal

		Intensive Care Unit (NICU). The case notes record that a mean airway pressure of 26 was used with an amplitude of 50 – this is a much higher setting than would normally be used. The baby died of severe refractory respiratory failure a few hours after birth.

Root Cause:
There was loss of situational awareness by the consultant managing the team who were caring for this baby. This was a consequence of the high work load with both twins being critically ill at the same time, during the Monday morning ward round in a particularly busy shift. The babies were being managed by a consultant who had only just returned to work from a period of sick leave. Her loss of situational awareness led to an error in attempting to provide HFOV support with inappropriately high pressures. The relative lack of experience in the rest of the team meant that the error was not identified or corrected. The planned peer support that was intended to help the consultant on duty was ineffective.

Learning from Investigation:

- Nurse staffing on the neonatal unit in 2016 was inadequate and there was a need to either increase nurse staffing levels or reduce activity.
- The workload of the ITU consultant on the unit in 2016 could be extremely high and this could become a risk. There was a need to increase consultant staffing and to review work patterns to make the workload safer. There was a need to encourage members of the consultant team to ask for peer support more readily.
- More staff training on ventilation was required.
- Better support for clinicians returning from sick leave is required.
- Inappropriately high ventilator settings were used during the period of HFOV. This occurred and was not corrected due to loss of situational awareness. This patient had a more than 50% chance of death, but if the HFOV had been used appropriately, it is possible that she may have survived.
- In view of this, the case was referred to HM Coroner for review. The underlying causes of the incident relate to staffing and workload issues. These have already been addressed by the service.
- Simplification of the ventilation strategy, with the use of a single device for both modes of support, and an improved ventilation training package should also have mitigated some the future risk.

Actions taken since the incident prior to being identified in the review

- Many of the concerns identified in this incident review were already recognised by the department in 2016 and actions were underway to mitigate them.
- Increased funding for the service was successfully obtained in negotiations with NHSE and there has been an increase in nurse staffing numbers, ANNP numbers and consultant numbers so that we are now fully compliant with all national standards.
- Consultants returning from periods of sick leave recently have been able to have a slower phased return with better support.
- The babies on the unit are no longer divided into ITU and HDU rooms. They are cared for in 'mixed acuity' rooms which contain both ITU and HDU babies. The consultant work pattern has now been altered so that each of the 2 consultants on duty looks after a group of mixed acuity rooms, so the work load experienced by the ITU consultant previously is no longer experienced.
- The two 'acute' consultants on duty now share a 'hot' office on the unit and are aware of whether or not their colleague requires support.
- The unit now uses a Drager ventilator which is able to provide both conventional ventilation and HFOV. The staff only have to become familiar with one device. There is an extensive training package for the use of this ventilator which all members of the clinical staff receive.

Recommendations:

- Feedback to relevant staff
- Inform HM Coroner

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 Effectiveness Senate

Service	StEIS Ref.	Summary
Maternity	2020/13448	4th repeated LUSCS. Frank haematuria was noted in the postnatal period but this was not escalated. There was a repeated presence of E-coli on MSSU during pregnancy and the last confirmed UTI was treated with a course of antibiotics which were not completed.
Root Cause: • Failure to adequately treat the patient's urinary tract infection • Delay in identifying bladder injury/complication in the immediate postpartum period		
Learning from Investigation: • A requirement to review how patients with asymptomatic bacteriuria in pregnancy are managed and subsequently followed up. • Need to ensure patients with ongoing problems in the postnatal period are reviewed by a senior member of the obstetric team • Need to educate staff on the complications associated with a patient who has had repeated caesarean sections and their potential clinical presentation. To facilitate timely investigation and management. **Recommendations:** • Audit asymptomatic bacteriuria in pregnancy guideline to assess adherence • Following the initial audit asymptomatic bacteriuria should go on the clinic audit forward plan to be repeated in one year to ensure that any recommendations are embedded in practice • Institute a policy on the postnatal ward that any patient who has required three reviews by a junior members of staff and has ongoing problems/concerns should be reviewed by a senior member of the obstetric team (Senior Registrar or Consultant). This escalation can be made by a junior doctor or a Midwife. • Standardisation of medication administration times to minimise omission of medication or to ensure there is a record of why they have been withheld or omitted. • Learning lessons template to be shared with staff via the intranet and in clinical areas.		
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
Neonatal	2020/17398	Medication error - prescription incomplete and incorrect dose of adrenaline prescribed and administered. Policy not followed

Root Cause:

- Drug prescribing policy was not followed
- Drug administration policy was not followed

Learning from Investigation:

- Staff need to be mindful of high pressure environments not contributing to errors by not following policy
- A senior nurse should have an overview of the clinical setting directing the care being delivered by the nurses in a high pressure environment

Recommendations:

- Prescribers to be reminded that each and every part of a prescription must be completed prior to giving to a nurse for administration
- A senior nurse will have a helicopter view during resuscitations as well as a consultant to increase awareness of what the nursing staff are doing
- Education team to re-train nursing staff on safe handling and administration of medications
- Neonatal ANNPs to access training & support and attend the formal sessions that are ongoing within the trust
- Nursing staff to be reminded that they are not to complete any part of a prescription
- Prescribers to be reminded that nursing staff are not to be expected to complete any part of a prescription
- Datasheets should be available electronically on Badgernet
- Lessons learned from this incident to be shared with other non-medical prescribers within the Trust

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 Effectiveness Senate

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.

Liverpool Women's NHS Foundation Trust

Agenda Item	20/21/253

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	Charitable Funds Annual Report and Accounts - 2019/20
DATE OF MEETING:	Thursday, 07 January 2021
ACTION REQUIRED	**Approve**
EXECUTIVE DIRECTOR:	Jenny Hannon, Director of Finance
AUTHOR(S):	David Dodgson, Financial Controller
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 of Directors on behalf of the Corporate Trustee, Liverpool Women's NHS Foundation Trust, are asked to review and approve the Charities annual report and accounts for 2019/20 so they can be submitted to the Charity Commission.	
PREVIOUSLY CONSIDERED BY:	**Committee name**	Not Applicable Or type here if not on list: Click here to enter text.
	Date of meeting	*Click here to enter a date.*

Executive Summary

Liverpool Women's NHS Foundation Trust Charity Annual Report and Accounts for the 2019/20 financial year have been approved by the Charitable Funds Committee on the 15th December 2020. They require further approval by the Board of Directors, in its role as the Corporate Trustee of the charity before they can be filed with the Charity Commission before the end of January 2021

Report

Charitable Funds Corporate Trustee - Background

The Liverpool Women's NHS Foundation Trust is the sole Corporate Trustee of the Charity. The Corporate Trustee is managed through its Board of Directors (the Board) which consists of executive and non-executive directors. The Board established a committee, known as the Charitable Funds Committee, reporting to the Board on the 8th February 2005.

The role of the Charitable Funds Committee is to oversee the management of the affairs of the Charitable Fund. This is a delegated duty carried out on behalf of the Corporate Trustee. The role is to ensure that the Charity acts within the terms of its declaration of trust and appropriate legislation, and to provide information to the Audit Committee to enable it to provide assurance to the Board that the Charity is properly governed and well managed across its full range of activities.

The Director of Workforce and Marketing of the Liverpool Women's NHS Foundation Trust, under a scheme of delegated authority approved by the Corporate Trustee, has day to day responsibility for the management of the Charitable Funds and is the principal charitable fund advisor to the Board.

The Chair of the Charitable Funds Committee participates in the induction of new board directors and the Director of Workforce and Marketing ensures that the board of directors is informed of its responsibilifor charitable funds. The Corporate Trustee is kept informed of the discussions of the Charitable Funds Committee through briefings at its Board meetings.

Charitable Funds Accounts Overview

Liverpool Women's NHS Foundation Charitable Trust Annual Report and Accounts for the year ended 31st March 2020 are presented for review and approval.

Total Incoming resources for the 2019/20 financial year was £260k and total resources expended was £444k. There was also a realised and unrealised loss on investments of £76k, which means that the net movement in funds for 2019/20 was a decrease of £260k (2018/19: £76k decrease).

Key Features: Statement of Financial Activities (SOFA)

	2019/20 £'000	2018/19 £'000
Donations and legacies	**202**	174
Other trading activities (stall income)	**23**	45
Investment Income	**35**	36
Total Incoming Resources	**260**	255
Expenditure on Raising Funds	**79**	165
Charitable Activities	**365**	221
Total Resources Expended	**444**	386
Realised and unrealised (loss) / gains on investments	**(76)**	55
Net Movement in Funds	**(260)**	(76)

Key Features: Balance Sheet

	2019/20 £'000	2018/19 £'000
Investments	**752**	1,215
Total Fixed Assets	**752**	1,215
Debtors	**6**	7
Short term investments and deposits	**51**	22
Cash at bank and in hand	**6**	7
Total Current Assets	**63**	36
Creditors	**(476)**	(652)
Net Current Liabilities	**(413)**	(616)
Total Charity Funds	**339**	599

- There has been a reduction in the Investments value compared to the prior year, which is largely due to the sale of Investments of £285k and an unrealised loss on investments of £156k, which has been recognised in the SOFA.
- The creditor balance is significantly lower than the prior year due to the charity repaying the Trust £600k in 2019/20. Of the £476k creditors figure only £122k of it relates to the interdebtedness with the Trust i.e. payments made on behalf of the charity by the Trust, the other £354k relates to accrued but not yet expensed commitments of the charity.
- The charity is currently in a position of net current liabilities which means that it cannot repay the balance owed to the Trust of £122k without liquidating some investments.
- The net movement in funds in 2019/20 is a decrease of £260k, with the closing fund balance being £339k.

Key Features: Expenditure:

	2019/20 £'000	2018/19 £'000
Staging fundraising events	**5**	26
Fundraising managers	**63**	128
Investment management costs	**11**	11
Total expenditure on raising funds	**79**	165
Patient welfare	45	58
Staff welfare	0	14
Equipment	286	58
Research	34	91
Total expenditure on charitable activities	**365**	221
Total Expenditure	**444**	386

Review of the Annual Report & Accounts

The Annual Report & Accounts are included below for Board review. They have been subject to an independent review by the external examiners and have also been approved by the Charitable Funds Committee on the 15th December 2020. They require further approval by the Board of Directors, in its role as the Corporate Trustee of the charity before they can be filed with the Charity Commission before the end of January 2021.

Recommendation

The Charitable Funds Committee recommends that the Board of Directors reviews and formally approves the 2019/20 annual report and accounts in its role as the Corporate Trustee of the charity.

The charity annual report and accounts will then be filed with the Charities Commission before the deadline of the 31st January 2021.

Liverpool Women's NHS Foundation Charitable Trust

Trustee's Annual Report and Financial Statements For the year ended 31st March 2020

The Liverpool Women's NHS Foundation Charitable Trust
Registered Charity No. 1048294

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Chair's Statement

Welcome to the Liverpool Women's NHS Foundation Charitable Trust Annual Report and Accounts for the financial year 1st April 2019 to 31st March 2020.

Putting patients first is at the heart of everything we do. Our aim is to support the work of Liverpool Women's NHS Foundation Trust in providing the best possible healthcare for its patients, and to support research that will benefit patients here and elsewhere. Alongside that main aim we also help to fund research and staff welfare initiatives as well as providing greater access to training and development opportunities.

Liverpool Women's NHS Foundation Trust is a specialist trust providing maternity, gynaecology and genetics services in Liverpool and the North Mersey conurbation. It is also the recognised specialist provider in Cheshire and Merseyside of high risk maternity care including fetal medicine, the highest level of neonatal care, complex surgery for gynaecological cancer, reproductive medicine and laboratory and medical genetics. It is the largest hospital in Europe to exclusively care for the health needs of women.

Our support for the Liverpool Women's NHS Foundation Trust helps the hospital to deliver best possible services and facilities to our patients, families and our dedicated staff, and as a charity we continue to support a wide range of charitable and health related activities during 2019/20, focussing on four key areas:

- **Patient welfare and amenities** to help improve the experience of patients and their families, including the continued provision of on-site parental accommodation;
- Support for pioneering **research** into seeking new treatment for our patients;
- Investment in new **equipment** to enable the hospital to harness latest technologies; and
- **Staff education and welfare** to provide important support for our hospital's committed staff.

The Charity works hard to raise funds on behalf of the Trust to enhance overall patient experience by providing services and equipment above what is normally funded by the NHS. These enhancements make a big difference to the comfort and well-being of our patients. At the time of writing this report, COVID-19 has dominated the year but for the year ahead, we hope to see a further Big Tiny Steps appeal focusing on refurbishment of parental accommodation for our neo-natal families and a range of other fundraising activities to support the work of Liverpool Women's NHS Foundation Trust. On the following pages you will see a selection of highlights and achievements from this past year.

Trustee's Annual Report

Liverpool Women's Hospital Charity - Who we are:

Putting patients first is at the heart of everything we do. Liverpool Women's Charity is registered with the Charity Commission for England and Wales – registration number 1048294. The charity works hard to raise funds on behalf of the Trust to enhance overall patient experience by providing services and equipment above what is normally funded by the NHS. These enhancements make a big difference to the comfort and wellbeing of our patients.

Our charitable programmes fully support the entire range of patient services. The aim of the Liverpool Women's Charity is to support the care given to patients and their families. Alongside that main aim we also help to fund research and staff welfare initiatives as well as providing greater access to training and development opportunities.

How LWH Charity Fundraises

We adhere to the Fundraising code of practice. All campaigns are managed by the Charity's staff. In April 2019 LWH Charity commissioned Impact fundraising consultancy to undertake the launch of the Big Tiny Steps Appeal for an interim period, until December 2019. During the year LWH Charity did not receive any complaints about its fundraising approach and process.

LWH Charity was not involved in any social investment over the past 12 months

LWH Charity and grant making

LWH Charity was not involved in making any grants to external organisations over the last 12 months, but it did make grants to internal projects as per our aims and objectives.

Trustee's Annual Report

LWH Charity donated goods and services

COVID 19 Gifts in Kind

LWH Charity was overwhelmed by the generosity of the community and local corporates at the start of the Covid 19 pandemic. Up until the end of March 2020 we received donations of toiletries and food and drink, which was distributed to our staff across the site to support welfare and wellbeing

Public Benefit

LWH NHS Trust Foundation is the main beneficiary of the Charity and is a related party by virtue of being a corporate Trustee of the Charity. By working in partnership with the Trust, the charitable funds are used to the best affect for the benefit of the public served by the Trust. When deciding upon the most beneficial way to use the charitable funds, the corporate trustee has to take into regard the main objectives, strategic plans of the Trust, whilst ensuring that the grants reflect the wishes of patients and staff.

Our Fundraising Highlights 2019 -2020

Over the past 12 months we have been incredibly grateful to all our supporters, who have committed themselves to fundraising for LWH Charity, helping us to raise funds to make a difference to the women and babies.
In 2019 -2020 we launched the "Big Tiny Steps Appeal" to support the development of a new neonatal unit.

Liverpool has always led the way in maternity and neonatal care. As a centre of excellence in Neonatal care we launched fundraising campaign to raise £250k in added extras for the unit. These included reclining chairs and cot side comforts, an outdoor space and playground as well as a bereavement suite and improved family areas. The differences made by this appeal will enhance clinical practice and improve a families neonatal journey.

Other key highlights:

- Providing the latest state of the art equipment for our medical teams
- Supporting research education and training and the provision of grants to purchase new equipment, enable attendance at seminars and training
- Staff welfare and wellbeing support

Trustee's Annual Report

How our supporters have helped

Liverpool Passport Office

The Liverpool Passport Office fundraising team called 'club 101' chose the Honeysuckle Team as their charity of the year. As a team they were able to raise a fantastic £1,000. We also had 9 members of their staff volunteer to help out at the Christmas Winter Wonderland fayre.

The Batt family

Phil and Karen Batt's daughter, Betty, was at 23 weeks and weighed 650 grams. Due to the special care of the doctors and nurses at the Liverpool Women's Neonatal Intensive Care Unit, Betty was able to go home when she was 13 months old. The Batt family asked their local community to get involved by hosting a 'Go Neon for Neonatal' asking both staff and students to wear Neon and donate to the appeal. This took place at St Monica's Catholic Primary School and Cardinal Newman Catholic High School in Warrington, where they raised a fantastic total of £1,528!

Trustee's Annual Report

Laura Martindale and family

Laura and her family fundraised for 3D heart models to show complex issues that babies may be born with. Laura found out during her pregnancy that her son Finley had a hole in his diaphragm that meant his intestines were putting pressure on his lungs and heart. Having benefited from the expertise and technology at the Fetal Medicine Unit, they wanted to give something back.

They raised £8,392.50 and a further £2500 was received from Wasps Legends Charitable Foundation.
Dr Umber Agarwal, quotes "Dr Lim and myself and entire FMU are very grateful to Laura and her family for raising the funds and kindly agreeing for us to use them for care of unborn babies with complex heart defects. I am sure that prospective parents will be also very grateful with all their heart when we explain things to them via these models."

Colour dash challenge event

Sarah Fearon, Shona O'Neill, Rachel Riley, Michelle Meredith, Tanya Fluskey, Linzi Wood and Sally Daniels raised a fantastic £2,785.85 for the Honeysuckle bereavement team. These amazing ladies wanted to give something back to the support and help they received from the Honeysuckle Team

Trustee's Annual Report

Ruth Eardley & Paul Eddy

Ruth and Paul decided to set themselves 5 challenges throughout the year – thye undertook the Liverpool 5K Santa Dash, Chester 10K, Coast Half Marathon
Marathon, Liverpool Rock 'n' Roll Marathon, and the Colour run 5k.
They raised a fantastic £3,629.67. Their nephew, Noah Gleeson was born at just 24 weeks. He weighed a tiny 1lb 4oz They decided we wanted to do something to thank the staff at Liverpool Women's and to help other premature babies like Noah in the future.

How you can get involved

You can get involved with LWH Charity by contacting the team on 0151 702 4044 or email us on fundraising@lwhcharity.nhs.uk

There are so many things you can do:

- Show your support by making a donation in the post online or by calling the team
- Volunteer - you can help at events, in our little woollens shop and by acting as an ambassador showing people around the hospital.
- Nominate us as your companies charity of the year
- Take on a challenge in aid of LWH Charity
- Hold an event to raise funds

Trustee's Annual Report

Our achievements – what has been made possible

- £78,369 for additional Neonatal Equipment

- £17,959 for the purchase of 4 PC Systems to be used with the Picture Archiving Communication system in Radiology

- £8,096 for the provision of a Baby Loss Awareness Event

- £6,252 for the purchase of 4 breast pumps on stands
- £4,896 for the purchase of 6 porter chairs and 2 bariatric wheelchairs

- £3,575 for the provision of iPads for a Baby Diary Project

Trustee's Annual Report

Our Financial Achievements

£344,000 grants awarded on charitable activities

2% increase in Incoming Resources

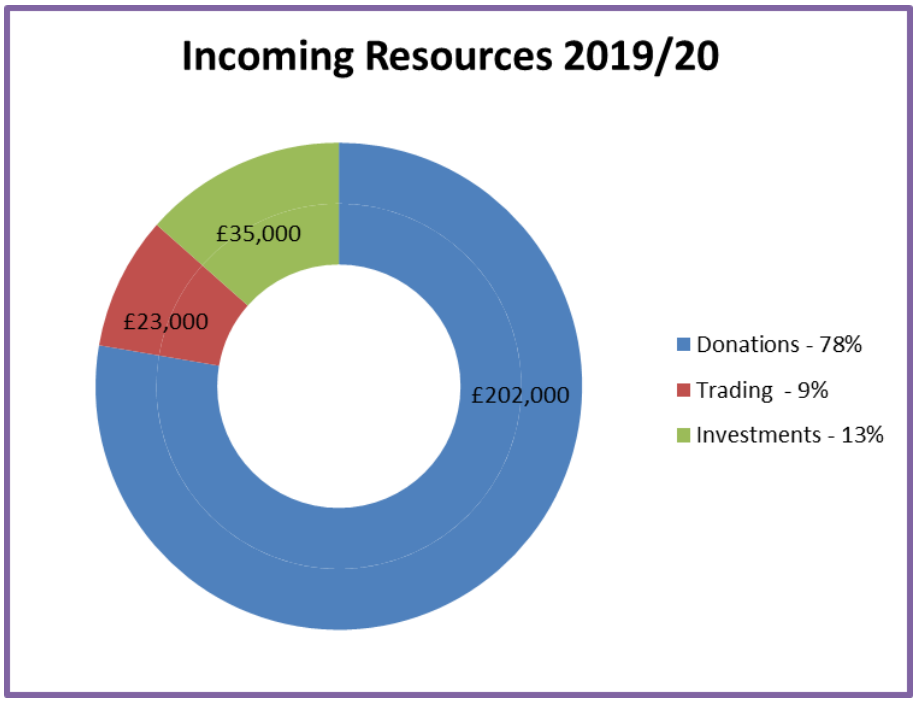
£14,000 stall income generated

£31,000 legacy income received

60% reduction in creditor balance

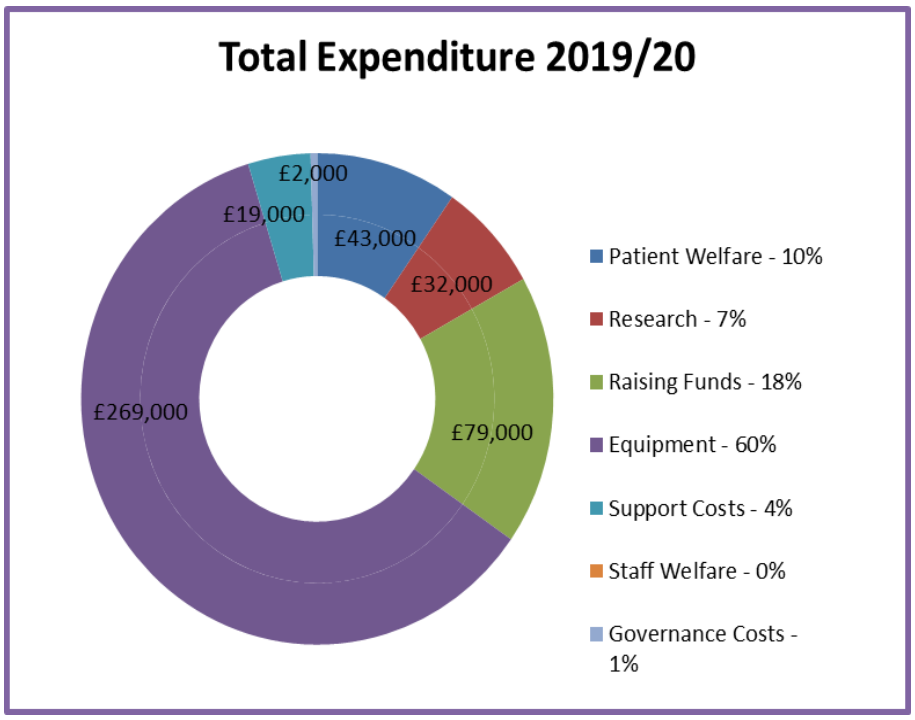
Trustee's Annual Report

Our Financial Achievements



Donations represent 78% of the total incoming resources enabling us to maintain our charitable activities for the hospital.

Trading activities includes knitting stall income.



Total expenditure of £444,000 during the year included over £344,000 (77%) on charitable activities, which included Patient welfare £43,000, Equipment £269,000 and Research £32,000.

Trustee's Annual Report

How you can get involved

You can get involved with LWH Charity by contacting the team on 0151 702 4044 or email us on fundraising@lwh.nhs.uk. There are so many things you can do:

- Show your support by making a donation in the post, online or by calling the team
- Volunteer - you can help at events, in our little woollens shop and by acting as an ambassador showing people around the hospital.
- Nominate us as your companies charity of the year
- Take on a challenge in aid of LWH Charity
- Hold an event to raise funds

Nominate Liverpool Women's Charity within your company

Many large companies work on a system where employees nominate charities and then the workforce vote as to who will be the winner. If you, or somebody you know, works for a company that chooses a charity of the year, please ask them to nominate Liverpool Women's Charity and help us continue to enhance our patient experience.

Legacies and in memory offerings

In November 2013 the Charity launched its legacy giving appeal. There has been £31,000 legacy income received in the year. If you are planning to leave a gift to Liverpool Women's Charity in your will, please let us know so we can thank you during your lifetime.

To most people who leave a legacy this will be the largest donation they ever make to a charity, and one that will make a lasting difference to many people, it is indeed your lasting legacies to those you leave behind.

If you would like to know more about leaving a donation in your will please contact Kate Davis on 0151 702 4044 or Rhianna McDermott on 0151 702 4194 or email fundraising@lwh.nhs.uk. You can also write to Liverpool Women's Charity, Liverpool Women's, Crown Street, Liverpool, L8 7SS

Trustee's Annual Report

Volunteers

Our volunteers here at the hospital provide a precious and much appreciated service to patients and their families, staff and visitors to the Liverpool Women's NHS Foundation Trust.

Some of the activities undertaken by volunteers include:

- greeting and welcoming patients and their relatives when they arrive at the ward
- assisting staff in ensuring rooms are ready for new patients and during the admittance procedure
- talking to and befriending patients
- making nurses and other staff aware of any patient concerns
- assisting in transferring patients to other departments
- supporting mothers who are having 'skin to skin' contact with their babies
- running the weekly knitting stall

We have around 300 volunteer knitters who help to raise money for the Neonatal Fund. These volunteers kindly donate their time to knit baby items, which are then sold on our weekly knitting stall in the hospital main reception. During the year the knitting stall raised over £14,000 for the Neonatal Fund.

Donate

"We are extremely grateful for every single donation, no matter how small, because of the benefits it allows us to bring to the patients and families of Liverpool and those who come from further afield"
- Liverpool Women's Charity

Every penny counts and goes towards improving the care provided to patients and their families. By supporting Liverpool Women's Charity, you will help us in a big way and we thank you enormously. Donations give us a reliable and much needed source of funding and help us to prioritise where it is needed the most. There are lots of ways you can donate:

- **Online:** You can make a secure donation online at **'Just Giving'.** Enter your details and the amount you wish to donate and click **'donate'.**
- **In person:** You can visit our Fundraising Office located opposite main reception
- **Via the ward or clinic:** Official donation envelopes are available from any ward, department or the main reception, 24 hours a day. Simply complete the details on the envelope and hand it to a member of staff to pass on to our finance department.
- **By credit/debit card**: You can make a donation by credit or debit card by contacting 0151 702 4044
- **By cheques**: These should be made payable to 'Liverpool Women's Hospital Charity' and can be sent to:

Rhianna McDermott
Liverpool Women's Hospital Charity
Liverpool Women's NHS Foundation Trust
Crown Street
Liverpool
L8 7SS

Trustee's Annual Report

Via BACS: If you would like to make a donation via BACS, please contact 0151 702 4044 for Liverpool Women's Charity's bank details.

By standing order: If you would like to set up a regular standing order or require any other information regarding charitable funds please contact 0151 702 4044.

Please include the name of your nominated fund with all donations so we can ensure your gift goes towards your chosen cause

You can also support us by giving your loose change to one of our spinner donation units located in the main reception and restaurant.

The Charity has also set up several SMS text donation services via Just Giving and uses social media to promote this method of donating to the Charity.

The Charity continues to raise money to improve all areas of the hospital.

smile.amazon.co.uk

You can now also raise money for the hospital charity whilst shopping on Amazon.co.uk. AmazonSmile is a website operated by Amazon that lets you enjoy the same wide selection of products & makes a 0.5% donation to our Charity.

Newsletter

The newsletter continues to be popular among our supporters and the staff at the Trust. It is filled with inspirational stories of why the Charity means so much to our followers.

If you wish to receive a copy of the newsletter please do not hesitate to contact our fundraising team.

Also please follow us on Facebook www.facebook.com/Liverpool-Womens-Charities

Our future plans

For the coming year we aim to strengthen our current corporate partnerships whilst pursuing new corporate partnerships.

We are aiming to develop a more active pipeline to Trusts and Foundations applications in order to widen our income sources.

We aim to engage, more proactively, with local community organisations in order to encourage support, whilst also raising awareness of the charity and its brand and continue to engage with grateful patients, families and visitors as well as developing relationships with new supporters.

The Corporate Trustee plans to continue the key activities of the Charity, and seek further opportunities to enhance the support offered to the patients and families of Liverpool Women's NHS Foundation Trust.

Trustee's Annual Report

BIG thank you

On behalf of the patients, relatives and staff who have benefitted from improved services due to donations and fundraising, the Corporate Trustee would like to thank all patients and relatives and staff who have made charitable donations or have given your time.

The backing of all of our supporters is fundamental to the success of our charity, and I would like to take this opportunity to thank each and every one of you for your continued support over the last year.

Having read all about us, we invite you to consider supporting the work of our charity. If you would like to know more about how to make a donation please contact either Kate Davis or Rhianna McDermott, our Charity Fundraisers on 0151 702 4044/4194, and "like" our Facebook page www.facebook.com/Liverpool-Womens-Charities for regular news and updates.

Phil Huggon
Chair of the Charitable Funds Committee

Trustee's Annual Report

Structure and governance

The Corporate Trustee presents the Charitable Funds Annual Report together with the Financial Statements for the year ended 31st March 2020.

The Charity's Annual Report and Accounts for the year ended 31st March 2020 have been prepared by the Corporate Trustee in accordance with the accounting policies set out in note 1 to the accounts, the Charities Act 2011 and Accounting and Reporting by Charities: Statement of Recommended Practice applicable to Charities preparing their accounts in accordance with the Financial Reporting Standard 102. The Charity's report and accounts include all the separately established funds for which Liverpool Women's NHS Foundation Trust is the sole beneficiary.

The Charitable Funds are registered as an umbrella charity, in accordance with the Charities Act 2011 using a model Declaration of Trust as approved by the Commission.

Reference and administrative details

The Liverpool Women's NHS Foundation Charitable Trust is an independent registered charity, which exists to raise, receive, manage and distribute donations for the benefit of the charitable purposes of the Liverpool Women's NHS Foundation Trust.

As a result of achieving Foundation Trust status in April 2005 the main umbrella charity changed its name from "Liverpool Women's Hospital Charitable Trust" to "The Liverpool Women's NHS Foundation Charitable Trust". This name change was approved by the Corporate Trustee on 2nd September 2005 and subsequently approved by the Charity Commission.

The Charity adopted a working name, "Liverpool Women's Charity", which was approved by the Charity Commission on 16th September 2009.

The Charity **has 11 individual** subsidiary registered funds as at the 31st March 2020 (2019:11) and the notes to the accounts distinguish the types of fund held and disclose separately all material funds (note 17)

Charitable funds received by the Charity are accepted, held and administered as funds and property held on trust for charitable purposes relating to the health service. The funds are held in accordance with the National Health Service Act 1977 and the National Health Service and Community Care Act 1990 and these funds are held on trust by the Corporate Body.

The Liverpool Women's NHS Foundation Trust (the NHS Foundation Trust) is the Corporate Trustee of the Charitable Funds governed by the law applicable to Trusts, principally the Trustee Act 2000 and the Charities Act 2011.

Trustee

The Corporate Trustee of the Charity is the Liverpool Women's NHS Foundation Trust and acts through the members of the Board of Directors. The members of the Board of Directors who served during the financial year and those in post as at the 7th January 2021 are set out on pages 22 and 23.

The Corporate Trustee devolved responsibility for the on-going management of funds to the Charitable Funds Committee, which administers the funds on behalf of the Corporate Trustee.

Trustee's Annual Report

This Charitable Funds Committee was formed on 8th February 2005. The names of those people who served as agents for the Corporate Trustee, as permitted under regulation 16 of the NHS Trusts (Membership and Procedures) Regulations 1990, are disclosed in the table on pages 22 and 23.

Principal charitable fund advisor to the Board

The Director of Workforce and Marketing of the Liverpool Women's NHS Foundation Trust, under a scheme of delegated authority approved by the Corporate Trustee, has day to day responsibility for the management of the Charitable Funds.

The Charitable Funds Committee continues to develop the arrangements for delegation to nominated fund holders who manage the funds on an everyday basis.

Structure

The Charity's unrestricted fund was established using the model declaration of trust, and all funds held on trust as at the date of registration are part of this fund. Subsequent donations and gifts received by the Charity are added to the fund balance. The fund covers a number of designations which have their own objectives and hold donations where a particular area or activity of the hospital was nominated by the donor at the time their donation was made. Whilst their nomination is not binding on the Corporate Trustee, the designated funds reflect these nominations.

The Corporate Trustee fulfils its legal duty by ensuring that funds are spent in accordance with the objectives of each fund and by the use of designated funds the Corporate Trustee respects the wishes of our generous donors.

Designated funds

A list of designated funds held during 2019/20 is set out below:

Trustee's Annual Report

Reserves policy

Charitable reserves are identified as income which becomes available to the Charity and is to be spent at the Corporate Trustee's discretion in furtherance of any of the Charity's objects, but which is not yet spent, committed or designated. As at 31st March 2020 the General Purpose reserves are £104,000 (2019: £105,000) which represents the net free reserves.

The reserves policy has the objective of ensuring the Charity has sufficient funds available to honour commitments.

The Corporate Trustee has a requirement to hold funds in order to support grants which will provide benefits for staff and funding for fixed term salaried posts such as the volunteer manager post.

The Corporate Trustee regularly reviews the level of reserves to ensure that commitments and spending plans are protected against falls in the Charity's income and investment values. The Corporate Trustee is mindful of the duty towards the Charity's current and future beneficiaries, and fulfils this responsibility by careful monitoring of expenditure and accessible money to guarantee day-to-day expenditure and ongoing commitments.

Grant making policy

All grants are made from the Charity's unrestricted funds – these funds comprise two elements:

The **General Purpose Fund** - this fund is constituted of gifts received by the Charity where no particular preference as to its expenditure has been expressed by donors.

Designated (Earmarked) Funds – these usually contain donations where a particular part of the hospital, activity or research was nominated by the donor at the time their donation was made. Whilst their nomination is not binding on the Corporate Trustee, the designated funds reflect these nominations.

The designated funds are overseen by fund holders who can make recommendations on how to spend the money within their designated area.

Governance

The Liverpool Women's NHS Foundation Trust is the sole Corporate Trustee of the Charity. The Corporate Trustee is managed through its Board of Directors (the Board) which consists of executive and non-executive directors. The Board established a committee, known as the Charitable Funds Committee, reporting to the Board. The role of the Committee is to oversee the management of the affairs of the Charitable Fund. This is a delegated duty carried out on behalf of the Corporate Trustee. The role is to ensure that the Charity acts within the terms of its declaration of trust and appropriate legislation, and to provide information to the Audit Committee to enable it to provide assurance to the Board that the Charity is properly governed and well managed across its full range of activities.

The Corporate Trustee executive directors are subject to recruitment by a Remuneration and Nominations Committee whose membership comprises of the Chair, Chief Executive and non-executive directors of the Corporate Trustee. Non-executive directors of the Board are appointed by the Corporate Trustee's Council of Governors.

The Chair of the Charitable Funds Committee participates in the induction of new board directors and the Director of Workforce and Marketing ensures that board directors are informed of their responsibilities for charitable funds. The Corporate Trustee is kept informed of the discussions of the Charitable Funds Committee through briefings at its Board meetings.

In addition, the Board of the Corporate Trustee keeps the skill and development requirements of its individual directors under review and directors attend training events and meetings, hosted by a variety of external organisations, which provide the opportunity to enhance their skills and knowledge.

Trustee's Annual Report

Management of funds

Each designated fund has a nominated fund holder(s) who, acting under delegated authority from the Charitable Funds Committee, and supported by detailed procedural instructions, is responsible for ensuring that expenditure is incurred in accordance with the charitable objectives of each fund.

Acting for the Corporate Trustee, the Charitable Funds Committee is responsible for the overall management of the Charitable Fund. The Committee is required to:

- Control, manage and monitor the use of the fund's resources including approval of all proposals for expenditure in excess of £40,000 for the General Purpose Fund and £30,000 for other designated funds.
- Provide support, guidance and encouragement for all its income raising activities, whilst managing and monitoring the receipt of all income.
- Ensure that 'best practice' is followed in the conduct of all its affairs and fulfilling all of its legal responsibilities.
- Ensure that the Investment Policy approved by the Board of Directors as Corporate Trustee is adhered to and that performance is continually reviewed whilst being aware of ethical considerations.
- Keep the Board of Directors fully informed on the activity, performance and risks of the Charity.

The accounting records and the day-to-day administration of the funds are dealt with by the Liverpool Women's NHS Foundation Trust's finance department. The Charitable Funds Committee meets on a quarterly basis and examines all expenditure approved by fund holders.

Risk management

The Corporate Trustee has a duty to identify the risks to which the Charity is exposed, to keep these under review and establish systems to mitigate these risks.

The Charitable Funds Committee believes that the internal control systems in place are sufficiently embedded and that managers and staff are aware of their responsibility for internal control as part of their accountability for achieving objectives.

The Charitable Funds Committee has identified the major risks to the Charity's objects, commitments and future spending plans and the most significant risk is considered to be the potential losses arising from a fall in the value of investments.

The Charitable Funds Committee has considered this risk carefully and have established procedures to review the investment portfolio regularly, ensuring that the Charity's investments are spread over a wide and varied portfolio and are not concentrated in one particular investment or commercial sector. The Charitable Funds Committee meets with Investment Managers, monitors performance and receives regular reports on the portfolio.

The Corporate Trustee is mindful of the need to ensure spending plans and firm financial commitments are matched with income.

Trustee's Annual Report

Partnership working and networks

The role of the Charity in supporting Liverpool Women's NHS Foundation Trust continues to go from strength to strength and in order to meet our objectives effectively, we have continued to invest in our fundraising activities and our partnerships working with three independent charities.

The NHS Foundation Trust is closely associated with two independent charities that are based at the hospital:

- We are grateful for the generous work of the volunteers of the **League of Friends of the Liverpool Women's Hospital (charity registration number 512162)**, who raise funds each year for the Liverpool Women's NHS Foundation Trust. Fundraising activities range from small events, to more substantial fundraising through the shop and trolley service.

- Liverpool Women's NHS Foundation Trust has developed a partnership with a large maternity hospital in Kampala, Uganda with a view to sharing educational resources through exchange visits by medical, nursing and midwifery staff. **The Liverpool Mulago Partnership (charity registration number 1135219).**

Objectives and strategy

The objectives of the umbrella charity require the Corporate Trustee to hold the fund upon trust and to apply the income and the capital for any charitable purpose or purposes relating to the National Health Service. These wide objectives were agreed with the Charity Commission to give flexibility to allow the Corporate Trustee to use funds without being subject to any specific restriction. In practice, all expenditure has been, and will continue to be, related to services provided by the Liverpool Women's NHS Foundation Trust. Each designated fund has its own charitable objectives in support of the overarching objective of the umbrella charity.

We seek to use the charitable funds to improve the vital care and support we give to our patients and their families. This enables our staff to gain access to training and development activities, to conduct appropriate research and to augment staff welfare, focusing on areas not covered or fully supported by central NHS funds.

Making our vision happen involves all our partners, the Liverpool Women's Hospital League of Friends staff, patients, carers and the community.

Public benefit

The Corporate Trustee has a duty to comply with Section 17 of the Charities Act 2011 to have due regard to the Charity Commission's general guidance on public benefit. The Corporate Trustee can confirm that it has fulfilled the public benefit requirement and that this requirement is strongly embedded within the procedures for approving grants and spending plans.

The Charitable Funds Committee, on behalf of the Corporate Trustee, ensures that all grants and spending plans contain identifiable public benefits that are clear and meet the objects of the Charity funds. This is achieved by the Corporate Trustee keeping spending plans under review throughout the year.

Trustee's Annual Report

A Review of our finances and performance

The net funds held, after taking account of current assets and liabilities, at 31st March 2020 were £339,000 (2019: £599,000). This represents an overall net decrease of £260,000 (2019 decrease: £76,000). This arises from an excess of expenditure over income of £184,000 (2019: £131,000) with net losses on investments of £76,000 (2019: £55,000 investment gains).

Review of income

The Charity relies on donations, fundraising events and investment income as the main sources of income. Total incoming resources of £260,000 were higher than those of 2019 (£255,000).

Donations totalling £171,000 (2019: £169,000) were received from grateful patients, their families, friends and other supporters in acknowledgement of the high standard of care provided. Trading activities income of £23,000 (2019: £45,000) includes income from the knitting stall of £14,000 (2019: £26,000)

The Corporate Trustee recognises the importance of the care provided throughout the NHS Foundation Trust and appreciates the donations and kind words from donors.

Legacy income

There was £31,000 of legacy income during the year (2019: £5,000). Legacy income is only accrued when there is a reasonable certainty of receipt. This is based on notifications provided by the representatives of the estates concerned. The Charity's officers liaise with solicitors to ensure that specific wishes are carried out.

Review of expenditure

From the total resources expended of £444,000 (2019: £386,000), charitable expenditure on direct charitable activity, was £344,000 (2019: £201,000) across a range of programmes.

Fund balances

Fund balances at 31st March 2020 were £339,000 (2018: £599,000).

Gift aid

Gift aid provides a great opportunity for donors to increase the value of their donation to our Charity. Provided the donor is a taxpayer, our Charity can claim from HM Revenue & Customs the basic rate tax paid on the gift. This increases donations by approximately 25%, so a gift of £10.00 is worth £12.50 to our charity.

Trustee's Annual Report

Investments

For investment purposes the Charity 'pools' its individual sub funds available, to maximise the returns on investments, whilst operating in accordance with the Board's agreed risk appetite. The funds are operated as a single investment fund under an official pooling scheme which was registered with the Charity Commission on 1st January 1999.

Investments are managed by Investec Wealth and Management on behalf of the Charity through an approved investment policy which includes an ethical restriction on investments in tobacco. The funds of the Charity are invested in a wide range of investments with the objective of maximising long term returns within a medium risk profile including UK equities and fixed interest securities, overseas equities held via collectives and cash.

The performance of the fund is reported by Investec Wealth and Management on a quarterly and annual basis against the benchmark set by the Corporate Trustee, the WM Unconstrained Universe, which is widely used by the charity sector. The members of the Charitable Funds Committee meet annually with the Investment Manager to discuss performance and to review the investment strategy. The investment markets remain volatile and the Charity's investments continue to be actively managed.

During the year the Charity's investment moved to a fund value of £752,000 as at 31st March 2020 from £1,215,000 at 31st March 2019.

Trustee's Annual Report

Administrative Details

Name of Charity
The Liverpool Women's NHS Foundation Charitable Trust
Registered charity number 1048294

Principal Office
Financial Accountant,
Finance Department,
Liverpool Women's NHS Foundation Trust
Crown Street
Liverpool
L8 7SS
Tel: 0151-708-9988

Fundraising
Fundraising Office
Email: fundraising@lwh.nhs.uk
Tel: 0151-702-4044

Bankers
Barclays Bank PLC
48b & 50 Lord Street
Liverpool
L2 1TD

Internal Auditors
Merseyside Internal Audit Agency
Regatta Place,
Brunswick Business Park,
Summers Road,
Liverpool L3 4BL

Independent Examiners
Beever and Struthers
St Georges House
215-219 Chester Road
Manchester
M15 4JE

Solicitors
Hill Dickinson
No. 1, St. Paul's Square,
Liverpool
L3 9SJ

Investment Fund Managers
Investec Wealth and Management
2 Gresham Street
London
EC2V 7QN

Trustee's Annual Report

Corporate Trustee Board of Directors – Non-Executive Directors

Name	Position held	Member of Charitable Funds Committee	1ST April 2019 to 31st March 2020	As at 7th January 2021
Non-Executive Directors				
Robert Clarke	Chair	No	In post	In post
Phil Huggon	Non-Executive Director, Chair of Charitable Funds Committee	Yes	In post	In post
Tony Okotie	Non-Executive director, Senior Independent Director	Yes	In post	In post
Jo Moore	Non-Executive Director	Yes	In post	In post
Ian Knight	Non-Executive Director	No	In post	In post
Susan Milner	Non-Executive Director	No	In post	In post
Tracy Ellery	Non-Executive Director	No	In post	In post
Louise Kenny	Non-Executive Director	No	In post	In post

Trustee's Annual Report

Corporate Trustee Board of Directors – Executive Directors

Name	Position held	Member of Charitable Funds Committee	1ST April 2019 to 31st March 2020	As at 7th January 2021
Executive Directors				
Kathryn Thomson	Chief Executive	No	In post	In post
Michelle Turner	Director of Workforce and Marketing & Deputy Chief Executive *	Yes	In post *fulfilled the additional role of Deputy Chief Executive from the 8th March 2019 to the 30th September 2019	In post
Devender Roberts	Acting Medical Director*	No	In post *fulfilled the role of Acting Medical Director from the 8th March 2019 to the 30th September 2019	Not in post
Andrew Loughney	Medical Director and Deputy Chief Executive*	No	In post *Reprised the roles of Medical Director and Deputy Chief Executive from the 1st October 2019.	Not In post
Caron Lappin	Director of Nursing and Midwifery	Yes	In post	Not In post
Gaynor Thomason	Interim Director of Nursing and Midwifery	Yes	In post from the 31st March 2020	Not In post
Gary Price	Director of Operations	No	In post from the 29th July 2019	In post
Jennifer Hannon	Director of Finance	No	In post	In post
Marie Forshaw	Director of Nursing & Midwifery	Yes	Not In post	In post from 4th January 2021
Lynn Greenhalgh	Medical Director	No	Not In post	In post from 4th January 2021

Statement of Trustee's responsibilities

The Corporate Trustee is responsible for preparing a Trustee's Annual Report and financial statements in accordance with applicable law and United Kingdom Accounting Standards (United Kingdom Generally Accepted Accounting Practice) including the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS102)

The law applicable to charities in England and Wales requires the Charity Trustee to prepare financial statements for each financial year which give a true and fair view of the state of affairs of the Charity and of its incoming resources and application of resources, of the Charity for that period.

In preparing the financial statements, the Trustee is required to:

a. select suitable accounting policies and then apply them consistently;
b. observe the methods and principles of the Charity SORP;
c. make judgements and accounting estimates that are reasonable and prudent;
d. state whether applicable United Kingdom accounting standards have been followed, subject to any material departures disclosed and explained in the financial statements; and
e. prepare the financial statements on the going concern basis unless it is inappropriate to presume that the Charity will continue to operate.

The Corporate Trustee is responsible for keeping proper accounting records that disclose with reasonable accuracy at any time the financial position of the Charity and enable it to ensure that the financial statements comply with the Charities Act 2011, the applicable Charities (Accounts and Reports) Regulations, and the provisions of the Trust Deed. It is also responsible for safeguarding the assets of the Charity and taking reasonable steps for the prevention and detection of fraud and other irregularities.

The Corporate Trustee is responsible for the maintenance and integrity of the Charity and financial information included on the Charity's website. Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

Approved by the Corporate Trustee on the 7th January 2021 and signed on its behalf by:

Name: Phil Huggon

Date: 7th January 2021

Independent Examiners Report

I report on the accounts of the charity for the 12 months ended 31 March 2020 which are set out on pages 26 to 40.

Respective responsibilities of trustee's and examiner

The charity's trustee is responsible for the preparation of the accounts. The charity's trustee considers that an audit is not required for this year under section 144(2) of the Charities Act 2011 (the 2011 Act) and that an independent examination is needed.

It is my responsibility to:

- examine the accounts under section 145 of the 2011 Act;
- follow the procedures laid down in the general Directions given by the Charity Commission under section 145(5)(b) of the 2011 Act; and
- state whether particular matters have come to my attention.

Basis of independent examiner's report

My examination was carried out in accordance with the general Directions given by the Charity Commission. An examination includes a review of the accounting records kept by the charity and a comparison of the accounts presented with those records. It also includes consideration of any unusual items or disclosures in the accounts, and seeking explanations from you as trustee concerning any such matters. The procedures undertaken do not provide all the evidence that would be required in an audit and consequently no opinion is given as to whether the accounts present a "true and fair view" and the report is limited to those matters set out in the statement below.

Independent examiner's statement

Since the charity's gross income exceeded £250,000 your examiner must be a member of a body listed in section 145 of the Act. I confirm that I am qualified to undertake the examination because I am member of the Institute of Chartered Certified Accountants which is one of the listed bodies.

In connection with my examination, no matter has come to my attention:

1 which gives me reasonable cause to believe that, in any material respect, the requirements:

- to keep accounting records in accordance with section 130 of the 2011 Act; and
- to prepare accounts which accord with the accounting records and comply with the accounting requirements of the 2011 Act

have not been met; or

2 to which, in my opinion, attention should be drawn in order to enable a proper understanding of the accounts to be reached.

Sue Hutchinson FCCA
Independent Examiner
Beever and Struthers
St George's House
215-219 Chester Road
Manchester
M15 4JE

Statement of Financial Activities for the year ended 31st March 2020

	Note	Unrestricted Funds 2020 £000	Restricted Funds 2020 £000	Total Funds 2020 £000	Total Funds 2019 £000
Incoming resources:	4				
Income and endowments from:					
Donations and legacies		202	0	**202**	174
Other trading activities		23	0	**23**	45
Investments	13	35	0	**35**	36
Other income		0	0	**0**	0
Total incoming resources		**260**	**0**	**260**	255
Resources expended:	7				
Expenditure on:					
Raising funds		79	0	**79**	165
Charitable activities		365	0	**365**	221
Total resources expended		**444**	**0**	**444**	386
Net expenditure before investment gains		**(184)**	**0**	**(184)**	(131)
Net (loss) / gain on investments - unrealised	12	(156)	0	**(156)**	24
Net gains on investments - realised		80	0	**80**	31
Net (expenditure)/income		**(260)**	**0**	**(260)**	(76)
Extraordinary items		0	0	**0**	**0**
Net movement in funds		**(260)**	**0**	**(260)**	(76)
Reconciliation of Funds:					
Fund balances brought forward 1st April		599	0	**599**	675
Fund balances carried forward 31st March		**339**	**0**	**339**	599

Balance Sheet as at 31st March 2020

	Note	Unrestricted Funds 2020 £000	Total Funds 2020 £000	Total Funds 2019 £000
Fixed assets:				
Investments	12	752	**752**	1,215
Total fixed assets		**752**	**752**	1,215
Current assets:				
Debtors	14	6	**6**	7
Cash at bank and in hand	15	57	**57**	29
Total current assets		**63**	**63**	36
Liabilities:				
Creditors and commitments falling due within one year	16	(416)	**(416)**	(508)
Creditors and commitments due greater than one year		(60)	**(60)**	(144)
Net current assets/(liabilities)		**(413)**	**(413)**	(616)
Total assets less current liabilities		**339**	**339**	599
The funds of the charity:				
Unrestricted funds	17	339	**339**	599
Total charity funds		**339**	**339**	599

The notes following the primary statements, numbered 1 to 20 form part of these accounts.

The financial statements contained within these accounts were approved by the Board of Directors on the 7th January 2021 and signed on its behalf by:

Name: Phil Huggon

Statement of Cash Flows for the year ended 31st March 2020

	Note	Total Funds 2020 £000	Total Funds 2019 £000
Cash flows from operating activities:			
Net cash provided by operating activities	18	**(394)**	(673)
Cash flows from investing activities:			
Dividends and interest from investments	4	**35**	36
Proceeds from sale of investments		**429**	103
Purchase of investments	12	**(59)**	(112)
Net cash provided by/(used in) investing activities		**405**	27
Change in cash and cash equivalents in the reporting period		**11**	(646)
Cash and cash equivalents at the beginning of the reporting period		**55**	701
Total cash and cash equivalents at the end of the reporting period	19	**66**	55

Notes to the accounts

1. Accounting Policies

1.1 Legal Status

The Liverpool Women's NHS Foundation Charitable Trust is an unincorporated charity registered with the charity commission. The address is Crown Street, Liverpool, L8 7SS.

1.2 Basis of preparation

The financial statements have been prepared under the historic cost convention, with the exception of investments which are included at fair value. The financial statements have been prepared in accordance with the Statement of Recommended Practice: Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS102) issued on July 2014, and the Financial Reporting Standard applicable in the United Kingdom and Republic of Ireland (FRS102) and the Charities Act 2011 and UK Generally Accepted Practice as it applies from 1 January 2019.

The trustee's consider that there are no material uncertainties about the Charity's ability to continue as a going concern. There are no material uncertainties affecting the current year's accounts. As a result of the COVID-19 pandemic there was a downturn in the financial markets and the Charity incurred an unrealised loss on investments of £156k in the 2019/20 financial year. However, the financial markets have since bounced back and the Charity incurred an unrealised gain on investments in the first 6 months of 2020/21 of £96k. The Charity has recently reviewed its Investment policy thoroughly with its Investment advisors Investec Wealth and Management and will continue to monitor and react accordingly to the changes in the financial markets. The forecast for the 2020/21 financial year is a closing fund balance of £197k.

The Charity constitutes a public benefit entity as defined by FRS 102. The financial statements are prepared in sterling which is the functional currency of the entity.

1.3 Funds structure

Unrestricted funds comprise those funds which the Trustee is free to use for any purpose in furtherance of the charitable objects. Restricted funds comprise those funds where the donor has provided for the donation to be spent in furtherance of a specified charitable purpose.

The funds held are disclosed in note 17.

1.4 Incoming resources

All incoming resources are recognised once the Charity has entitlement to the resources, it is probable that the resources will be received and the monetary value of incoming resources can be measured with sufficient reliability.

Where there are terms or conditions attached to incoming resources, particularly grants, then these terms or conditions must be met before the income is recognised as the entitlement condition will not be satisfied until that point. Where terms or conditions have not been met or uncertainty exists as to whether they can be met then the relevant income is not recognised in the year but deferred and shown on the balance sheet as deferred income.

1.5 Incoming resources from legacies

Legacies are accounted for as incoming resources either upon receipt or where the receipt of the legacy is probable. Receipt is probable when:

- Confirmation has been received from the representatives of the estate that probate has been granted
- The executors have established that there are sufficient assets in the estate to pay the legacy, and
- All conditions attached to the legacy have been fulfilled or are within the charity's control

If there is uncertainty as to the amount of the legacy and it cannot be reliably estimated then the legacy is shown as a contingent asset until all of the conditions for income recognition are met.

Notes to the accounts continued

1.6 Resources expended and irrecoverable VAT

All expenditure is accounted for on an accruals basis and has been classified under headings that aggregate all costs relating to each category of expense shown in the Statement of Financial Activities. Expenditure is recognised when the following criteria are met:

- There is a present legal or constructive obligation resulting from a past event
- It is more likely that not… that a transfer of benefits (usually a cash benefit) will be required in settlement
- The amount of the obligation can be measured or estimated reliably

Grants payable are payments made to the Liverpool Women's NHS Foundation Trust which is classed as a related party, in furtherance of the charitable objectives of the funds held on trust. In the case of an unconditional grant offer this is accrued once the recipient has been notified of the grant award. The notification gives the recipient a reasonable expectation that they will receive the one-year or multi-year grant.

Irrecoverable VAT is charged against the category of resources expended for which it was incurred.

1.7 Allocation of support costs

Support costs are those costs which do not relate directly to a single activity. These include some staff costs, costs of administration and independent examination costs. The analysis of support costs and the bases of apportionment applied are shown in note 7.

1.8 Fundraising costs

The costs of generating funds are those costs attributable to generating income for the charity, other than those costs incurred in undertaking charitable activities or the costs incurred in undertaking trading activities in furtherance of the charity's objectives. The costs of generating funds represent fundraising costs together with investment management fees. Fundraising costs include expenses for fundraising activities and a fee paid to related party, Liverpool Women's NHS Foundation Trust, which is used to cover the costs of the hospital's fundraising office salaries and overheads.

1.9 Charitable activities

Costs of charitable activities comprise all costs incurred in the pursuit of the charitable objects of the Charity. These costs comprise direct costs and an apportionment of overhead and support costs as shown in note 7.

1.10 Governance costs

Governance costs comprise all costs incurred in the governance of the charity. These costs include costs related to the independent accounts examination.

1.11 Fixed asset investments

Investments are a form of basic financial instrument. Fixed asset investments are initially recognised at their transaction value and are subsequently measured at their fair (market value) as at the balance sheet date. The statement of Financial Activities includes the net gains and losses arising on revaluation and disposals throughout the year. Quoted stocks and shares are included in the Balance Sheet at the current market value quoted by the investment analyst.

The main form of financial risk faced by the charity is that of volatility in equity markets and investment markets due to wider economic conditions, the attitude of investors to investment risk and changes in settlement concerning equities and within particular sectors or sub sectors. Further information on the investments can be found in note 12.

1.12 Realised gains and losses

All gains and losses are taken to the Statement of Financial Activities as they arise. Realised gains and losses on investments are calculated as the difference between sales proceeds and opening market value (purchase date if later). Unrealised gains and losses are calculated as the difference between the market value at the year end and opening market value (or purchase date if later).

Notes to the accounts continued

1.13 Pensions

The Charity is a grant making charity and has no employees.

1.14 Debtors

Debtors are amounts owed to the charity. They are measured at transaction price, less any impairment.

1.15 Cash and cash equivalents

Cash is represented by cash in hand and deposits with financial institutions repayable without penalty on notice of not more than 24 hours. Cash equivalents are highly liquid investments that mature in no more than three months from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

1.16 Creditors

Amounts owed to group companies due within one year are measured at the undiscounted amount of the cash or other consideration expected to be paid. All other creditors are measured at transaction price.

1.17 Financial instruments

A financial asset or a financial liability is recognised only when the entity becomes a party to the contractual provisions of the instrument.

Basic financial instruments are initially recognised at the transaction price, unless the arrangement constitutes a financing transaction, where it is recognised at the present value of the future payments discounted at a market rate of interest for a similar debt instrument.

Debt instruments are subsequently measured at amortised cost.

Other financial instruments are initially recognised at fair value, unless payment for an asset is deferred beyond normal business terms or financed at a rate of interest that is not a market rate, in which case the asset is measured at the present value of the future payments discounted at a market rate of interest for a similar debt instrument.

Other financial instruments are subsequently measured at fair value, with any changes recognised in the Statement of Financial Activities.

Financial assets that are measured at cost or amortised cost are reviewed for objective evidence of impairment at the end of each reporting date. If there is objective evidence of impairment, an impairment loss is recognised in the Statement of Financial Activities immediately.

Any reversals of impairment are recognised in the Statement of Financial Activities immediately, to the extent that the reversal does not result in a carrying amount of the financial asset that exceeds what the carrying amount would have been had the impairment not previously been recognised.

Notes to the accounts continued

2. Related party transactions

The Corporate Trustee of the Liverpool Women's NHS Foundation Charitable Trust (the Charity) is the Liverpool Women's NHS Foundation Trust (the Trust). The Charity delivers its charitable objectives by making grants to the Trust. Grants made to the Trust in the year were £383,000 (2019: £201,000).

The amount owed to the Trust as at 31 March 2020 was £124,000 (2019: £306,000) (see note 16). During the year the Charity made a payment of £600,000 (2019 £865,000) to the Trust.

None of the members of the Trust Board, Charitable Funds Committee, senior Trust staff, or parties related to them were beneficiaries of the Charity, and none of these individuals have undertaken any material transactions within the Charity during the year.

The Charity employed no direct employees during the year to 31st March 2020 (2019: none). During the year the Trust recharged £91,000 fundraising salary costs (2019: £128,000) to the Charity.

3. Purposes of unrestricted and material designated funds

The purposes of unrestricted and material designated funds are:

Fund	Purpose
The Women's Hospital General Purpose Fund	Any charitable purpose(s) relating to the NHS wholly or mainly for the Liverpool Women's Hospital.
Liverpool Women's Cancer Charity	To further the advancement of scientific and medical education and research into topics related to cancer research.
Community Midwifery	Promoting the efficient performance of their duties by the midwives of the NHS Foundation Trust.
Reproductive Medicine Fund	To further the advancement of scientific and medical education and research into topics related to infertility, miscarriage and menopause.
Medical Education Fund	To further the advancement of scientific and medical education and research into topics related to the field of obstetrics and gynaecology.
Fetal Centre Research and Development	The investigation into causes of sickness in the unborn child and the prevention, treatment, cure and defeat of this sickness.
Neonatal Fund	The investigation into the causes of sickness in the newborn child and the prevention, treatment, cure and defeat of this sickness and to further the cause of premature newborn babies at the NHS Foundation Trust and to further the advancement of scientific and medical education and research into topics related to sickness in the newborn child.

Other Funds:

Fund	Purpose
Women's Hospital Staff Welfare Fund	For the relief of sickness by promoting the efficient performance of their duties by the staff of the Liverpool Women's Hospital.
Training and Development Fund	To further the advancement of scientific and medical education and research into topics relating to pregnancy and problems associated with giving birth and gynaecological problems.
Women's Assisted Conception Fund	To further the advancement of scientific and medical education into topics related to infertility in women.
Cytogenetics Fund	To further the advancement of scientific and medical education and research into topics related to cytogenetics.

Notes to the accounts continued

4. Analysis of income

	2020 Unrestricted Funds £000	2020 Restricted Funds £000	2020 Total Funds £000	2019 Total Funds £000
Donations and legacies:				
Donations and gifts	**171**	0	**171**	169
Legacies	**31**	0	**31**	5
Total donations and legacies	**202**	**0**	**202**	174
Other trading activities:				
Stall income	**14**	0	**14**	27
Hire of birthing pools	**4**	0	**4**	1
Training Events	**0**	0	**0**	4
Fundraising events	**5**	0	**5**	13
Total other trading activities	**23**	**0**	**23**	45
Income from investments:				
Dividend income	**35**	0	**35**	36
Total income from investments	**35**	**0**	**35**	36
Other income:	0	0	**0**	0
Total other income	**0**	**0**	**0**	0
Total Income	**260**	**0**	**260**	255

All income in the prior year was unrestricted.

5. Donated Goods

	2020 Unrestricted Funds £000	2020 Restricted Funds £000	2020 Total Funds £000	2019 Total Funds £000
Included within other trading activities:				
Sale of donated items	**14**	0	**14**	26
Other stall income	**0**	0	**0**	1
Total stall income included within other trading activities	**14**	**0**	**14**	27

Donated knitted items for resale are not recognised on receipt. Instead the value to the charity of the donated goods sold is recognised as income when sold. The proceeds of sale are categorised as “Income from other trading activities” in the Statement of Financial Activities and included within the stall income of £14,000.

Notes to the accounts continued

6. Role of volunteers

The Charity is reliant on a team of volunteers who perform two main roles:

- **Knitting** – there are approximately 300 volunteer knitters who donate their time to knit baby items which are then sold a weekly knitting stall in the main reception of the Liverpool Women's Hospital which is also run by volunteers. During the year the knitting stall raised almost £14,000 for the hospital's neonatal unit (2019: £26,000).

- **Fundraisers** – the Charity has many local volunteers who actively fundraise by hosting events such as garden parties, charity nights, participating in local and national events and being involved with bucket collections.

7. Allocation of support costs and overheads

All financial services costs provided by the Liverpool Women's NHS Foundation Trust have been treated as support costs and Independent examination fees have been treated as governance costs. Both support costs and governance costs have been apportioned across charitable activities expenditure proportionate to the expenditure level.

7.1 Support & Governance Costs

	2020 Unrestricted Funds £000	2020 Restricted Funds £000	2020 Total Funds £000	2019 Total Funds £000
Support Costs: Financial Services provided by Liverpool Women's NHS Foundation Trust	**19**	0	**19**	18
Governance Costs: Independent Examination Fees	**2**	0	**2**	2
Total	**21**	**0**	**21**	20

The Trustee does not receive any remuneration nor were any expenses paid to the Trustee in the year ending 31 March 2020 or the preceding financial year.

7.2 Apportionment of Support & Governance Costs across Charitable Activities

	Patient welfare £000	Staff welfare £000	Equipment £000	Research £000	Total £000
Support Costs: Financial Services provided by Liverpool Women's NHS Foundation Trust	2	0	15	2	**19**
Governance Costs: Independent Examination Fees	0	0	2	0	**2**
Total	**2**	**0**	**17**	**2**	**21**

Notes to the accounts continued

7.3 Analysis of expenditure

	2020 Unrestricted Funds	2020 Unrestricted Funds Support & Governance Costs	2020 Restricted Funds	2020 Total	2019 Total
	£000	£000	£000	£000	£000
Expenditure on raising funds:					
Staging fundraising events	**5**	**0**	**0**	**5**	26
Fundraising managers	**63**	**0**	**0**	**63**	128
Investment management costs	**11**	**0**	**0**	**11**	11
Total expenditure on raising funds	**79**	**0**	**0**	**79**	**165**
Expenditure on charitable activities:					
Patient welfare	**43**	**2**	**0**	**45**	58
Staff welfare	**0**	**0**	**0**	**0**	14
Equipment	**269**	**17**	**0**	**286**	58
Research	**32**	**2**	**0**	**34**	91
Total expenditure on charitable activities	**344**	**21**	**0**	**365**	**221**
Total Expenditure	**423**	**21**	**0**	**444**	**386**

Overhead and support costs including governance costs, volunteer costs, fundraising costs, finance and independent examination fees have been apportioned across charitable activities on the basis of the value of the fund. The expenditure above includes released commitments, which has thereby reduced current year expenditure in comparison with the prior year in the following categories; staging fundraising events £12k, fundraising managers £8k, Patient Welfare £6k, Staff welfare £5k, Equipment £11k and Research £11k.

8. Independent examination and audit fees

	2020 Unrestricted Funds	2020 Restricted Funds	2020 Total	2019 Total
	£000	£000	£000	£000
Fees for examination of the accounts:				
Independent examiner's fees	**2**	**-**	**2**	1
Total fees	**2**	**0**	**2**	**1**

The Independent examination fee is shown in the above note excluding VAT in accordance with guidance, however, the VAT element is not recoverable making the overall Governance costs £2k as shown in note 7.1.

9. Analysis of staff costs

The Charity did not directly employ any staff during 2019/20 (208/19: nil).

The Charity instead received services from the Liverpool Women's NHS Foundation Trust, for example financial services and fundraising for which a recharge is made by the Trust to the Charity.

Notes to the accounts continued

10. Analysis of grants

The Charity does not make grants to individuals or third parties. All grants are made to the Liverpool Women's NHS Foundation Trust to provide for the care of our NHS patients in the furtherance of our charitable aims. The total cost of making grants, including support costs, is disclosed on the face of the Statement of Financial Activities. The standing orders and standing financial instructions of the NHS Foundation Trust include the directions of the Trustee for the management of charitable funds and recognise that management processes may overlap with those of the NHS Foundation Trust.

The Trustee operates a scheme of delegation for the majority of charitable funds, under which fund holders manage the day to day disbursements on their projects in accordance with the standing orders and standing financial instructions of the NHS Foundation Trust. Please refer to the Trustee's Annual report to the Account for additional information on the grant making activities performed during the year to 31st March 2020.

11. Transfers between funds

There were no transfers between funds during 2019/20 (2018/19: £nil).

12. Fixed asset investments Movement in fixed asset investment	2020 Total £000	2019 Total £000
Market Value brought forward	1,189	1,125
Add: additions to investment at cost	59	112
Less: disposals at carrying value	(349)	(72)
Add: net (loss) / gain on revaluation - unrealised	(156)	24
Market Value as at 31 March	**743**	**1,189**
Cash held as part of investment portfolio	**9**	**26**
Total investment value as at 31 March	**752**	**1,215**
Historic Cost as at 31 March	638	942

Fixed asset investments by type	2020 Total £000	2019 Total £000
Investments listed on a recognised Stock Exchange:		
UK Equities	**331**	517
European equities	**25**	52
North American equities	**121**	201
Japanese equities	**17**	37
Far East and Australasian equities	**19**	31
Emerging economies	**7**	18
International equities	**8**	0
Property	**53**	72
Alternative Assets	**31**	47
Other investments:		
UK fixed interest	**131**	214
Cash held as part of the investment portfolio	**9**	26
Total fixed asset investments	**752**	**1,215**

Notes to the accounts continued

13. Total gross income from investments and cash on deposit

	2020 Total £000	2019 Total £000
Investments listed on a recognised Stock Exchange:		
UK Equities	**22**	19
European equities	**1**	1
Overseas and emerging equities	**2**	3
Other investments:		
UK fixed interest	**6**	8
UK Property	**3**	3
Alternative Assets	**1**	2
Total	**35**	36

14. Analysis of current assets

	2020 Total £000	2019 Total £000
Debtors under one year		
Investment income receivable	**6**	7
Total	**6**	7

15. Analysis of cash and deposits

	2020 Total £000	2019 Total £000
Short term investments and deposits	**51**	22
Cash at bank and in hand	**6**	7
Total	**57**	29

16. Analysis of liabilities and commitments

	2020 Total £000	2019 Total £000
Creditors & commitments under one year		
Amounts due to Liverpool Women's NHS Foundation Trust	**122**	306
Commitments	**292**	198
Other accruals	**2**	4
Total	**416**	508

Notes to the accounts continued

	2020 Total £000	2019 Total £000
Creditors & commitments over one year		
Commitments	**60**	144
Total	**60**	144

Amounts owed to Liverpool Women's NHS Foundation Trust relate to grants paid out by the Trust on behalf of the Charity.

Movements in funding commitments during the period

	2020 Total £000	2019 Total £000
Balance at the start of the reporting period	342	290
Amounts added in current period	383	159
Amounts charged against commitments in the current period	(320)	(107)
Unused amounts reversed during the period	(53)	0
Balance at the end of the reporting period	**352**	**342**

17. Unrestricted funds

Analysis of unrestricted and material designated funds	Funds brought forward at 01-Apr-19 £000	Incoming resources £000	Resources expended £000	Loss on investments £000	Funds carried forward at 31-Mar-20 £000
General Purpose	105	85	(64)	(22)	104
Liverpool Women's Cancer Charity	88	7	(20)	(13)	62
Community Midwifery	33	6	(9)	(5)	25
Reproductive Medicine Fund	5	0	(2)	(1)	2
Medical Education	67	5	(14)	(11)	47
Fetal Centre Research & Development Fund	53	20	(23)	(9)	41
Neonatal Fund	231	109	(300)	(7)	33
Other Funds	17	28	(12)	(8)	25
Total	**599**	**260**	**(444)**	**(76)**	**339**

Notes to the accounts continued

Analysis of unrestricted and material designated funds	Funds brought forward at 01-Apr-18	Incoming resources	Resources expended	Gains on investments	Funds carried forward at 31-Mar-19
	£000	£000	£000	£000	£000
General Purpose	95	103	(104)	11	105
Liverpool Women's Cancer Charity	166	12	(101)	11	88
Community Midwifery	36	5	(10)	2	33
Reproductive Medicine Fund	7	0	(2)	0	5
Medical Education	73	3	(13)	4	67
Fetal Centre Research & Development Fund	49	7	(7)	4	53
Neonatal Fund	232	117	(139)	21	231
Other Funds	17	8	(10)	2	17
Total	**675**	**255**	**(386)**	**55**	**599**

The purposes of the funds are given in note 3.

18. Reconciliation of net movement in funds to net cash flow from operating activities

	2020 Total £000	2019 Total £000
Net movement in funds	**(184)**	(131)
Adjustments for:		
Dividends and interest on investments	**(35)**	(36)
(Increase) / decrease in debtors	**1**	0
Increase / (decrease) in creditors	**(176)**	(506)
Total	**(394)**	(673)

19. Analysis of cash and cash equivalents

	2020 Total £000	2019 Total £000
Cash and deposits:		
Short term investments and deposits	**51**	22
Cash in hand	**6**	7
	57	29
Cash held as part of the investment portfolio	**9**	26
	66	55

Notes to the accounts continued

20. Financial Instruments

The financial instruments are analysed as follows:

	2020 Total £000	2019 Total £000
Financial assets:		
Investments	**752**	1,215
Debtors	**6**	7
Cash at bank and in hand	**57**	29
Total	**815**	1,251
Financial Liabilities:		
Creditors falling due within one year	**(416)**	(508)
Creditors due greater than one year	**(60)**	(144)
Total	**(476)**	(652)

Liverpool Women's NHS Foundation Trust

Agenda Item	20/21/254

MEETING	**Charitable Funds Committee**
PAPER/REPORT TITLE:	**Charitable Funds Committee – Terms of Reference**
DATE OF MEETING:	Thursday, 07 January 2021
ACTION REQUIRED	**Approve**
EXECUTIVE DIRECTOR:	Mark Grimshaw, Trust Secretary
AUTHOR(S):	Mark Grimshaw, Trust Secretary
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** 1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☐ 2. To be ambitious and *efficient* and make the best use of available resource ☒ 3. To deliver *safe* services ☐ 4. To participate in high quality research and to deliver the most *effective* Outcomes ☐ 5. To deliver the best possible *experience* for patients and staff ☐
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust…….* ☐ ***2.*** *Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have sufficient numbers of clinical staff with the capability and capacity to deliver the best care. ……* ☐ ***3.*** *The Trust is not financially sustainable beyond the current financial year……* ☐ ***4.*** *Failure to deliver the annual financial plan ……* ☐ ***5.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision ……* ☐ ***6.*** *Ineffective understanding and learning following significant events……* ☐ ***7.*** *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 requested to review and approve the updated Terms of Reference following a recommendation from the Charitable Funds Committee.***	
PREVIOUSLY CONSIDERED BY:	**Committee name**	Charitable Funds Committee
	Date of meeting	15 December 2020

Executive Summary

The terms of reference were previously considered at the September 2020 Charitable Funds meeting. These had been updated to greater reflect the role of overseeing the fundraising function and to note that the Committee would be meeting quarterly rather than bi-annually.

The Committee requested further amendments to the responsibilities to clarify the Committee's role in relation to the strategy and expenditure. The Committee also suggested the addition of Financial Planning/Budget to be included on the workplan.

The terms of reference attached as appendix A have been amended to reflect these suggestions. Following feedback from Non-Executive Directors, additional references have also been added to include the internal and external legislative framework that impacts on the role and function of the Committee.

The Charitable Funds Committee considered the terms of reference at its meeting on the 15 December 2020 and recommended them for approval by the Board.

Recommendation

The Board is requested to review and approve the updated Terms of Reference following a recommendation from the Charitable Funds Committee.

Appendix A

Liverpool Women's NHS Foundation Trust

CHARITABLE FUNDS COMMITTEE
TERMS OF REFERENCE

Constitution:	The Committee has been established to exercise the Foundation Trust's functions as sole corporate trustee of the Liverpool Women's Charity (registered charity number 1048294). The Trust Board is regarded as having responsibility for exercising the functions of the Trustee. The Trust Board delegates these functions to the Committee, within any limits set out in these terms of reference and the sections of the standing financial instructions pertaining to charitable funds. ~~The Board hereby resolves to establish a Committee of the Board of Directors to be known as the Charitable Funds Committee (the Committee)~~
Duties:	The Committee's responsibilities fall broadly into the following areas: **~~Charitable Legislation~~Compliance** a. Manage the affairs of the Liverpool Women's Charity in accordance with appropriate legislation and ensure statutory compliance with the Charity Commission regulations. b. Ensure systems and processes are in place to receive, account for, deploy and invest charitable funds in accordance with charity law. c. Scrutinise requests for use of charitable funds to ensure that any such use is in accordance with the aims and purposes of any charitable fund or donation and are clinically and ethically appropriate. Committee members will bear in mind due diligence to Charity Commission and Trust guidance regarding the ethical use of funds and acceptance of donations. ~~a. To ensure funds are managed in accordance with the latest legislation and regulations pertaining to charities.~~ **Budget, Income & Expenditure ~~Income & Expenditure~~** a. Review and approve an Annual Business plan and budget b. Receive and approve periodic income and expenditure statements, ensuring that performance is in line with the Charity's budget and plan. c. Receive and consider the Annual Accounts including the Annual Report from the auditors, before submission to the Board of Directors for approval. ~~b. To review the fund's performance and ensure all expenditure is in line with the charitable objectives of the fund.~~

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Fundraising

a. Ensure a fundraising strategy is prepared and monitored which complies with Charity Commission guidance and legislation and which includes appropriate communication and marketing plans;
b. ensure systems and processes are in place to receive, account for, deploy and invest funds raised in accordance with charity law;
c. ensure systems, processes and communication are in place around fundraising, staff engagement and funding commitments;
d. ensure a cohesive policy around external media and communication;
e. encourage a culture of fundraising and raise the profile of the Charity within the Trust and with external partner organisations
f. ensure effective communication regarding 'whistleblowing' relating to fundraising, donations or subsequent use of funds.

~~c. To oversee fundraising activities and approve all plans for the expenditure of the fund.~~
~~d. To receive a periodical and annual fundraising reports.~~

Investment Management

a. Consider and agree an investment strategy for the safe and secure investment of funds not immediately required for use, taking into account any appropriate ethical considerations.
b. Appoint and review external investment advisors and operational fund managers.
c. Review the performance of investments on a regular basis (utilising comparator information) with the external investment advisors to ensure the optimum return from surplus funds.
~~e. To oversee the performance of the fund managers, compare with peer groups and periodically review the fund management function.~~

~~**Reports**~~

~~f. To receive periodical and annual reports regarding fundraising.~~
~~g.~~d. ~~To review and approve Trust Annual Report & Accounts~~.

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	~~**Strategy**~~ ~~h. To set the strategy regarding Charitable Funds~~
Membership:	The Committee membership shall consist of the following: • A Chairman who shall be a Non-executive director • Two other Non-executive Directors • Deputy Director of Finance (or nominated deputy) • Director of Workforce and Marketing • Director of Nursing and Midwifery • Financial Accountant • Head of Fundraising Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. The Board of Directors will appoint a Non-Executive Director as Chair of the Committee. Should the Chair be absent from a meeting of the Committee, the Committee may appoint a Chair of the meeting from amongst the Non-Executive Directors present.
Quorum:	A quorum shall be three members which must include one Non-executive director.
Voting:	Each member will have one vote with the Chair having a second and casting vote, if required. Should a vote be necessary a decision will be determined by a simple majority.
Attendance:	**a. Members** Members will be required to attend a minimum of 75% of all meetings. **b. Officers** The non-executive Chairman shall normally attend meetings. Other Board members shall also have right of attendance subject to invitation by the Chairman of the Committee. The Fundraiser to attend as required at request of the Committee.

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	Other officers and staff of the Trust will be invited to attend the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed. Representatives from partner organisations or other external bodies may be invited to attend as appropriate. Such representatives will not have voting rights.
Frequency:	Meetings shall be held on a ~~bi-annual~~ quarterly basis. Additional meetings may be arranged from time to time, if required, to support the effective functioning of the Trust.
Authority:	The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of representatives from partner organisations or other external bodies or organisations with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities. This includes seeking the advice of specialists from within and outside the NHS as appropriate.
Accountability and reporting arrangements:	The minutes of the Charitable Funds Committee shall be formally recorded and a Chair's Report will be submitted to the subsequent Board of Directors for assurance. Approved minutes will be made available to all Board members upon request.
Reporting Committees/Groups	The Charitable Funds Committee has no reporting committees / groups.
Monitoring effectiveness:	The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements.
Review:	These terms of reference will be reviewed at least annually by the Committee.
Reviewed by: Charitable Funds	15~~8~~ December 2020~~19~~

Committee Subcommittee:	
Approved by: Board of Directors	~~July 2020~~February 2021
Review date:	March 2021
Document owner:	Mark Grimshaw, Trust Secretary Email: mark.grimshaw@lwh.nhs.uk Tel: 0151 702 4033

Liverpool Women's NHS Foundation Trust

Agenda Item	20/21/255

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Charitable Funds Investment Policy Amendments**
DATE OF MEETING:	Thursday, 07 January 2021
ACTION REQUIRED	**Approve**
EXECUTIVE DIRECTOR:	Jenny Hannon, Director of Finance
AUTHOR(S):	David Dodgson, Financial Controller
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:-….)***	To review and approve the recommended Charitable Funds Investment Policy amendments.			
PREVIOUSLY CONSIDERED BY:	**Committee name**		Not Applicable Or type here if not on list: **Click here to enter text.**	
	Date of meeting		***Click here to enter a date.***	

Executive Summary

At the Charitable Funds Committee on the 15th December the potential for Investment risk and ethical Investment considerations were discussed and the following amendments in relation to the Investment policy were agreed by members:

- Ethical exclusions should be expanded to also include armaments – the updated list of ethical exclusions would then be Tobacco companies and armaments.
- The Investment policy should remain at the current Medium risk level portfolio
- The Benchmark of the portfolio should be amended taking into account the proposals of the Investment advisors, Investec Wealth and Investment

It is recommended that the Board of Directors approves these amendments to the Investment Policy in its role as the Corporate Trustee of the charity.

Report

Introduction

At recent Charitable Funds Committee meetings, it was agreed that the committee should consider the attitude to risk and capacity for loss in relation to its Investments. It was also agreed that a formal review of the Investment policy should take place taking into account ethical considerations.

As background, investments are managed by Investec Wealth and Management on behalf of the Charity through an approved investment policy which includes an ethical restriction on investments in tobacco. The funds of the Charity are invested in a wide range of investments with the objective of maximising long term returns within a medium risk profile including UK equities and fixed interest securities, overseas equities held via collectives and cash.

Attitude to risk and capacity for loss

The charity's Investment portfolio with Investec was a "High to Medium" risk portfolio but following a Charitable Funds Committee meeting in May 2013 it was decided that the charity had become less risk tolerant and it was amended to a "Medium" risk portfolio. The investment portfolio has been a Medium risk portfolio ever since and the below shows the performance of the Investments over the last 5 years:

Category	2015/16 £000's	2016/17 £000's	2017/18 £000's	2018/19 £000's	2019/20 £000's	Total Movement (over 5 year Period) £000's	Average Movement per Year £000's
Investment Income	24	28	32	36	35	155	31
Unrealised gain / (loss)	(9)	66	(17)	24	(156)	(92)	(18)
Realised gain / (loss)	(38)	94	21	31	80	188	38
Total Investment Impact on SOFA	**(23)**	**188**	**36**	**91**	**(41)**	**251**	

	2015/16 £000's	2016/17 £000's	2017/18 £000's	2018/19 £000's	2019/20 £000's
Closing 31st March Investment Balance	872	1,176	1,170	1,215	752

The total impact of the Investments on the Statement of Financial Activities (SOFA) is a £251k gain over the last 5 years. Therefore there has been an increase in available charitable funds of £251k over these years as a direct result of the Investment portfolio's performance.

Total Investment Income gained has been £155k over the last 5 years with an average of £31k earned each year.

The realised gain on Investments relates to Investments which have already been physically sold for a higher value than their purchase price and a realised gain has occurred. The value of realised gains is £188k over the last 5 years with an average of £38k earned each year.

The unrealised loss on Investments relates to Investments which have decreased in value from their purchase price but have not yet been sold and is therefore unrealised. The unrealised loss on Investments is £92k over the last 5 years, however, it must be noted that this loss is largely due to the large unrealised loss of £156k which occurred at the end of 2019/20 as a result of market fluctuations in response to the COVID pandemic. It is also worth noting that in the first 2 quarters of 2020/21 the portfolio performance has bounced back again and the unrealised gain is **£**115k at the end of quarter 2.

In the June Charitable Funds Committee, Investec recommended that the charity should answer a series of standard questions related to attitude to risk and capacity for loss to help Investec advise the charity on how much risk it should perhaps include in its Investment portfolio. They would also us their knowledge of the charity's past Investment portfolio decisions and performance and knowledge of the charity's circumstances to inform this advice. The Chair requested that finance colleagues review the position and bring forward a recommendation for the Committee to consider. Therefore, these questions have been completed and the questions and answers along with the rationale responses are contained in appendix 1.

Investec have reviewed this response and advised that the responses are consistent with a medium risk balanced portfolio and so would not advise a change to the current medium risk quoted within the charities Investment Policy and in use in the Investec Investment policy.

This was discussed by Charitable Funds Committee members and it was agreed to not make any amendments to the current Investment Portfolio risk level of Medium.

Ethical Investment Consideration

Section 4 (1) of the Trustee Act 2000 states that the following should be considered when reviewing the suitability of Investments:

- Consideration of the size and risk of the investment
- Ethical stances consideration i.e. the kind of Investments that are appropriate for the charity to make

Charity Commission guidance makes clear that when investing, trustees have a duty to do so in a way that furthers the aims and objectives of the charity. This would normally require them to obtain the best possible direct financial returns from an investment. Ethical investment may well be consistent with this. However, careful consideration is needed because excluding some types of investment or preferring others on ethical grounds may detract from trustees' duty to obtain the best financial return.

Trustees can pursue an ethical investment policy provided a balance is struck with the different considerations involved including their obligation to obtain the best direct financial return. However, a charity's trustees must be able to justify why it is in the charity's best interest to invest ethically. The law permits the following reasons:

- Avoiding investment in a particular business that conflicts with the aims of the charity.
- Avoiding investments that might hamper the charity's work – for example, by making potential beneficiaries unwilling to be helped or by alienating supports of the charity.
- There is no "significant financial detriment".

Currently the charity's Investment policy only has one ethical consideration which is the exclusion of Investments related to Tobacco. Discussions at past committees made reference to potentially considering excluding the following Investments categories on ethical grounds:

- Armaments
- Alcohol
- Formula Breast Milk
- Mining

Investec assured that they can assist with adding any of the above ethical restrictions to the charity's Investment portfolio. Investec stressed that it is important to consider if the ethical restrictions are aligned with the aims and objectives of the charity and also to be mindful that the more restrictions the charity adds, the greater the potential impact on performance.

This was discussed by Charitable Funds Committee members and it was agreed to also exclude the Investing in Armaments from the Investment Policy. The Committee members would then keep this ethical consideration under review going forwards.

Investment Portfolio Benchmarks

The Investment advisors, Investec Wealth and Investment suggested the below changes to the Investment Policy benchmarks.

	Your Portfolio %	Benchmark %	Ranges	Proposed Benchmark %	Proposed Ranges %	Indices
Bonds	**15.5**	20	15 – 25	20	15– 25	FTA Government All Stocks
UK Equities	**38.6**	45	35 – 55	**35**	**25 – 45**	FTSE All Share
Overseas Equities	**34.2**	25	15 – 35	**35**	**25 – 45**	FTSE All World (ex UK)
Property	**5.6**	6	0 – 10	**4**	**0 – 10**	IPD Monthly
Alternatives	**5.8**	1	0 – 6	**3**	**0 – 10**	B of E Base Rate +2%
Cash	**0.3**	3	0 - 15	3	0 - 10	B of E Base Rate - 0.5%
Total	**100**	**100**		**100**		

Investec made this proposal based on their view that the UK market has become increasingly narrow over the last decade and so have proposed adjusting the benchmarks to gain increased exposure to long term global growth and full details of Investec's proposed changes are detailed in Appendix 2.

The Committee requested that the proposed benchmark changes be sent to members to allow time for a full review and this was duly considered by members and it was decided to accept the proposed changes to the benchmarks.

Recommendations

As a result of the Charitable Funds Committee meeting held on the 15th December, the Investment Policy of the charity has been updated so that ethical exclusions have been expanded to also include armaments.

The Investment Policy of the charity has also been updated to change the proposed benchmarks of the Investment portfolio. The amended Investment policy is detailed at Appendix 3.

The Board of Directors is asked to formally approve the amendments to the Investment Policy in its role as Corporate Trustee of the charity.

Liverpool Women's NHS Foundation Trust

Appendix 1

Capacity for loss

These "standard" questions help Investec determine, along with their other knowledge of the charity's circumstances, how much risk the charity can take in the portfolio.

Question	Possible Responses	Liverpool Women's Hospital Charity Response & Reasoning
How much of your total funds does this portfolio represent?	a) All	(A) All of the charities available funds are invested in this portfolio. The only other liquid assets of the Trust relates to cash in commercial bank accounts which is already earmarked to repay the creditor balance owing to the Trust.
	b) Half	
	c) A small part	
If the capital value of your portfolio fell by 25% in one year, what would be the impact on you?	a) Significant	
	b) Adjust plans	(B) Based on recent history where the UK market fell by approx 25% in February / March of this year, the Charity was able to tolerate this loss and wait until the portfolio recovered in value. The charity would most likely want to review its Investment portfolio plans.
	c) No impact	
If the income produced by your portfolio fell by 25% in one year, what impact would this have on you?	a) Significant	
	b) Adjust plans	(B) The Investment Income in 19/20 was £33k and a reduction of 25% would be £8k. This would not have a significant impact on the financing of the charity, but the charity may want to review its Investment portfolio.
	c) None	
If you plan to withdraw large sums of capital, when would this be?	a) Within 3 years	(A) The charity has to meet its creditors and in order to do so will most likely have to liquidate some of its investment assets in the range of £100k to £200k within 3 years
	b) 3-5 years	
	c) 5-10 years	
	d) 10+ years	

Liverpool Women's NHS Foundation Trust

Appendix 1

Attitude to risk

These questions focus on the charity's views on risk, for example tolerance for risk in practice rather than the theory of the capacity for loss questions.

Question	Possible Responses	Liverpool Women's Hospital Charity Response & Reasoning
What percentage loss would make you consider taking funds from the portfolio and putting them elsewhere in cash?	a)5% b)10% c)20%	
	d)Would not move money	(D) The charity is of the view that capital Investments are held for the long term and recognises that although a fall of 20% would constitute approx. a significant £171k fall in available funds. It recognises that converting these capital funds into cash turns the unrealised loss into a "realised" loss. The approach taken by the charity would be to hold onto the capital investments until the markets recover and the unrealised loss has substantially reduced before making any decisions on converting the capital investment to cash.
If your portfolio fell in value, would you consider making any changes to the portfolio and over what timeframe?	a)Sell immediately b)Sell after a year	
	c)Would not make changes	(C) As above the charity is of the view that capital Investments are held for the long term and recognises that converting capital funds into cash turns the unrealised loss into a "realised" loss. The approach taken by the charity would be to hold onto the capital investments until the markets recover and the unrealised loss has substantially reduced before making any decisions on converting the capital investment to cash.
How do you view the risks of investing in terms of balancing losses and gains? Which is more important?	a)Safety is key b)Temporary losses more concerning than possible gains	
	c)Temporary losses tolerable for long term gains	(C) The charity is of the view that capital Investments are held for the long term and that temporary losses are tolerable for long term gains. This is based on past history of portfolio performance and how Investec have managed the portfolio, given that the equity market can be volatile and experience temporary losses.

Appendix 2 – Investec Benchmark Proposal

Available to Board members in the 'Supporting Documents' folder.

Appendix 3 – Amended Investment Policy Document

Available to Board members in the 'Supporting Documents' folder.