Liverpool Women's
NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

Board of Directors Meeting

PUBLIC

4 February 2021

Meeting of the Board of Directors
HELD ELECTRONICALLY
Thursday 4 February 2021 at 1000hrs
VIRTUAL MEETING

Item no. 2020/21/	Title of item	Objectives/desired outcome	Process	Item presenter	Time
PLEASE NOTE – Due to the Covid-19 pandemic, the Board is utilising a 'consent agenda'. It will be assumed that all of these items have been read by Board members and the minutes will reflect recommendations, unless an item has been requested to come off the consent agenda for debate. In this instance, it is requested that the Trust Secretary be notified prior to the meeting and this will be made clear at the start of the meeting.					
257	Apologies for absence Declarations of interest	Receive apologies & declarations of interest	Verbal	Chair	
258	Meeting guidance notes	To receive the meeting attendees' guidance notes	Written	Chair	
259	Patient Story • Hewitt Centre	To receive the patient story	Verbal	Director of Nursing & Midwifery	1005 (15mins)
260	Minutes of the previous meetings held on 3 December 2020 and 7 January 2021	Confirm as an accurate record the minutes of the previous meetings	Written	Chair	1020 (5mins)
261	Action Log and matters arising	Provide an update in respect of on-going and outstanding items to ensure progress	Written	Chair	
262	Chair's announcements	Announce items of significance not found elsewhere on the agenda	Verbal	Chair	1025 (5mins)
263	Chief Executive Report	Report key developments and announce items of significance not found elsewhere on the agenda	Written	Chief Executive	1030 (5mins)
BOARD COMMITTEE ASSURANCE					
264	Chair's Reports from Quality Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	1035 (5mins)
265	Chair's Reports from Finance, Performance and Business Development Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	1040 (5mins)
266	Chair's Report from Putting People First Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	1045 (5mins)
267	Chair's Report from Audit Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	1050 (5mins)
268	Chair's Report from Charitable Funds Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	1055 (5mins)
TO DEVELOP A WELL LED, CAPABLE AND MOTIVATED WORKFORCE; TO DELIVER SAFE SERVICES; TO DELIVER THE BEST POSSIBLE EXPERIENCE FOR OUR PATIENTS AND OUR STAFF					
269	Covid-19 Pandemic: Trust Update	For assurance	Written	Chief Operating Officer	1100 (10mins)
270	Ockenden Report Update	For assurance	Written	Director of Nursing & Midwifery	1110 (15mins)

Item no. 2020/21/	Title of item	Objectives/desired outcome	Process	Item presenter	Time
271	Safer Nurse/Midwife Staffing Report, M8 & 9 2020/21	For assurance	Written	Director of Nursing and Midwifery	1125 (5mins)
272	Bi-Annual Safer staffing paper Nursing and Midwifery	For assurance and to note any escalated risks	Written	Director of Nursing and Midwifery	1130 (10mins)
		BREAK – 5 mins			
273	Serious Incident Report – February 2021	For assurance	Written	Director of Nursing and Midwifery	1145 (10mins)
274	Review of Disciplinary Policy and Practice	For review and approval	Written	Chief People Officer	1155 (10mins)
TRUST PERFORMANCE - TO DELIVER THE MOST EFFECTIVE OUTCOMES; TO BE EFFICIENT AND MAKE BEST USE OF AVAILABLE RESOURCES					
275	Operational Performance Report period M8 & M9, 2020/21	For assurance –To note the latest performance measures	Written	Chief Operating Officer	1205 (5mins)
276	Finance Report period M9, 2020/21	For assurance - To note the status of the Trust's financial position	Written	Director of Finance	1210 (5mins)
BOARD GOVERNANCE					
277	Well-Led Self-Assessment Action Plan Update	For assurance	Written	Trust Secretary	1215 (5mins)
278	Board Assurance Framework 2020/21	For assurance and approval	Written	Trust Secretary/ Executive Leads	1220 (5mins)
279	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair	1225 (5mins)
CONSENT AGENDA (all items 'to note' unless stated otherwise)					
280	CNST Junior Doctors Rota Gaps Action Plan	To approve	Written	Trust Secretary	Consent
HOUSEKEEPING					
281	Thank you's	To provide a Team thank you – above and beyond			1230 (5mins)
282	Any other business & Review of meeting	Consider any urgent items of other business	Verbal	Chair	

Date of next meeting

Board in Public: 1 April 2021

Meeting to end at 12.35pm

12.35 – 12.45	***Questions raised by members of the public submitted in advance of the meeting.***	To respond to members of the public on matters of clarification and understanding.	Verbal	Chair

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

Liverpool Women's

Meeting attendees' guidance using Microsoft Teams

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

Before the meeting

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

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

Microsoft Teams

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

At the meeting

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

Attendance

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

After the meeting

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

Standards & Obligations

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

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

Page 129 Handbook to the NHS Constitution 26th March 2013

Liverpool Women's NHS Foundation Trust

Board of Directors

Minutes of the meeting of the Board of Directors held virtually at 10.00am on 3 December 2020

PRESENT

Mr Robert Clarke	Chair
Mrs Kathryn Thomson	Chief Executive
Mrs Michelle Turner	Chief People Officer
Mrs Jenny Hannon	Director of Finance
Mrs Janet Brennan	Acting Director of Nursing & Midwifery
Mr Gary Price	Chief Operating Officer
Mr Phil Huggon	Non-Executive Director
Mr Tony Okotie	Non-Executive Director (from item 216)
Dr Susan Milner	Non-Executive Director/SID
Mr Ian Knight	Non-Executive Director
Prof Louise Kenny	Non-Executive Director

IN ATTENDANCE

Mr Mark Grimshaw	Trust Secretary
Dr Lynn Greenhalgh	Medical Director of the North West Genomics Laboratory Hub / Medical Director (designate)
Mrs Michelle Corrigan	Observer – Insight Programme
Mr Yaroslav Zhukovsky	Public Governor
Mrs Mary McDonald	Appointed Governor
Ms Kate Hindle	Lead Governor
Mrs Denise Richardson	Public Governor
Dr Kiran Jilani	Consultant Obstetrician / Staff Governor (item 211 only)
Mrs Angela Winstanley	Quality & Safety Midwife (item 223 only)
Dr Rachel Gregoire	Scientific Director & HFEA Person Responsible (item 228 only)
Dr Alice Bird	Consultant Obstetrician (item 230 only)
Mrs Esther Steel	Member of the Public

APOLOGIES:

Ms Jo Moore	Non-Executive Director/Vice Chair
Mrs Tracy Ellery	Non-Executive Director
Dr Andrew Loughney	Medical Director & Deputy Chief Executive

20/21/	
209	**Apologies –** as above. **Declaration of Interests –** None.
210	**Meeting guidance notes** The Board received the meeting attendees' guidance notes which had been updated to reflect 'virtual meetings'.
211	**Patient Story**

	Equality, Diversity & Inclusion Dr Kiran Jilani attended to outline the work that she had recently become involved in relating to raising awareness of implicit bias and the impacts that this was having on the Trust's patients and staff. Both Dr Kiran Jilani and Prof Louise Kenny reported incidents where they had treated women who had been subjected to Female Genital Mutilation (FGM). In both of these incidents, the importance of understanding the language of ethnicity was stated, and the need for Trust staff to be aware of the verbal and non-verbal communication impacts on the patient and their experience. The Chief People Officer agreed that it was vital for the Trust to engage positively with the lived experience of the patient. It was noted that it would be useful for Dr Kiran Jilani to work with the Trust on this issue and to explore how training and awareness could be implemented for all relevant staff. *Endometriosis* Dr Dharani Hapangama, Dr Arshad Ilyas and Dr Manou Kaur attended to outline the improvements that had been recently been made to the Endometriosis service and the further work that was planned. Dr Dharani Hapangama noted that whilst the disease was common, it required an operation for a diagnosis. At that point, it was likely that medical interventions had been exhausted and surgery was required. The surgery needed to be precise to avoid damaging implications to patients and it was noted that the recent appointment of highly skilled surgeon's Dr Arshad Ilyas and Dr Manou Kaur had enhanced the service and was providing a much-improved patient experience. In terms of next steps, Dr Dharani Hapangama noted the importance of research to better understand the nature of the disease and improve interventions and treatments for patients. A member of the team had recently been awarded as a MSRC Research Fellow which would further enhance a vibrant research culture at the Trust. It was also important to maintain the high-level surgical skills in the team, and therefore a focus was being placed on training to ensure that this could be maintained. In summary, Dr Dharani Hapangama asserted that the Trust had a unique opportunity to build and maintain a high-quality and long-term legacy for the service. The Chair stated that it was encouraging to see a positive turnaround in the service and the impact that this was having on patients. The Chief Executive noted that it was encouraging that the Trust had been able to attract and recruit such high calibre surgeons. It was suggested that the service could link more closely with the Trust's genomic service to explore whether there could be opportunities for research collaboration. Dr Lynn Greenhalgh added that it would be useful to consider how the service could be positioned externally as a leader in this area of practice. The Director of Finance noted that it would be helpful to engage with commissioners and look to receive 'buy-in' for the proposed direction of the service. The Board of Directors: • Noted the ED&I and Endometriosis presentations
212	**Minutes of previous meeting** The minutes of the Board of Directors meeting held on 5 November 2020 were agreed as a true and accurate record.
213	**Matters arising and action log.** There were no matters arising. The Board of Directors reviewed the Action Log and noted that there were no overdue actions.
214	**Chair's Announcements**

	The Chair briefed the Board on events since the last meeting. It was noted that the Council of Governors had met on the 12 November 2020 in which a detailed review of how the Trust was receiving assurance of the patient and staff experience during the Covid-19 pandemic was considered. The Council of Governors Nomination & Remuneration Committee had met on the 29 October 2020 and had discussed in detail the outputs of the Chair and Non-Executive Director (NED) appraisals, recommending that these be considered at the full Council of Governors meeting. The recruitment process for the upcoming 2021 NED vacancies (three) was also considered and agreed with applications from people with a range of personal and professional experiences from a diversity of backgrounds and community connections being targeted. The application window was due to close on 6 December 2020. The Shadow Board (development programme for Trust senior leaders), paused due the pandemic, had recommenced meeting on 4 November 2020. This had been a successful meeting and further consideration was being given to how to most effectively feed back the views of the Shadow Board to the Trust Board. The Nominations & Remuneration Committee had been held immediately prior to the Board meeting. Items discussed included cost of living pay increases for Very Senior Managers (VSM), the ratification of the Medical Director appointment and changes to Public Sector Exit Payment Regulations and the impact on notice periods for Executive Directors. The North West NHS had taken the decision to establish a Black, Asian and Minority Ethnic strategic advisory committee (the Assembly). The ambition for the Assembly was for the NHS in the North West to be Anti-Racist and at the forefront of challenging and tackling racism and the health inequalities faced and experienced by people in our communities, brought into stark relief by the coronavirus pandemic. A smaller working group had been progressing the identification of a set of priorities, which would form the basis of the committee's programme. The Assembly chairs had written to all Trusts with the draft Vision and Mission statements with Objectives with a request for comment. It was noted that it was the Medical Director's last Board meeting at the Trust. The Chair wished the Medical Director well and noted thanks for his contribution and work with the Trust. The Board noted the Chair's update.
215	Chief Executive's report The Chief Executive presented the report which detailed local, regional and national developments. The Trust had been successful at the HSJ Patient Safety Awards 2020 in which the "Using Virtual Reality as a Reasonable Adjustment" project was 'highly commended'. It had also been announced on the 18 November 2020 that the Trust's Head of Information Governance was the winner of the "Information Governance Innovator of the Year" category at the Health & Social Care Strategic Information Governance Awards. It was confirmed that the Trust had been successful in securing £6.5m capital financing from the Department for Health and Social Care. This capital financing would allow the Trust to bring a CT scanner and blood bank onsite, develop the colposcopy suite and invest in a surgical theatre robot, along with other associated estates works. As well as clear benefits for patients these new and innovative facilities would also help the Trust to recruit and retain the best people.

	In November 2020, the Board was informed of the updated Clinical Negligence Scheme for Trusts (CNST) year 3 requirements published in October 2020. Key changes in terms of reporting requirements and assurances required for Trust Board sign off in May 2021 for the scheme were outlined. The Chief Executive highlighted which sections of the agenda would support the Board in demonstrating on-going compliance. Regular asymptomatic testing had been rolled out nationally (from 23rd November 2020) within NHS organisations to further control the risks associated with Covid-19, to reduce the spread of hospital acquired infection and to protect patients and staff. To date, approximately 1000 testing kits had been given to Trust staff. In response to a query from Mr Ian Knight, Non-Executive Director, the Chief Executive confirmed that no positive tests had been received to date. The Chief Executive noted that NHSE/I had published a policy paper setting out their vision of the strategic direction of system working. This set out a series of policy and legislative proposals to accelerate the development of Integrated Care Systems (ICSs), including a focus on the leadership role of providers within systems. **Action: For the Board to discuss and consider the implications of the NHSE/I policy paper regarding ICSs at the January 2021 workshop.** It was highlighted that the Board had reviewed and approved via email an annual self-assessment review (SAR) stating that standards that organisations were expected to have in place to provide a quality learning environment were being met. The Board was asked to ratify this approval. The Board of Directors received and noted the Chief Executive's Report and ratified the SAR for the Health Education England Quality Framework. *Mr Tony Okotie joined the meeting*
216	**Chair's Report from the Quality Committee** The Board considered the Chair's Report from the Quality Committee meeting held on 23 November 2020. The Committee had received assurance regarding how the Trust was managing the quality implications of not currently meeting the Continuity of Carer target but requested further information at the next meeting regarding a trajectory of expected improvement. A deterioration in falls performance was also noted and a 'deep dive' into the quality impact was requested for the December 2020 meeting. The Committee had received a detailed presentation on the legal services annual report and received assurance on how the Trust utilising lessons learned. The Board of Directors: • Received and noted the Chair's Report from the Quality Committee meeting held on 23 November 2020.
217	**Chair's Report from Finance, Performance and Business Development Committee (FPBD)** Mr Phillip Huggon presented the Chair's Report for the meetings of the Finance, Performance and Business Development Committee held on 24 November 2020. Despite there being evidence of strong controls (performance against CIP and aged debtors), the Committee was continuing to monitor the impact of the Trust's projected deficit for 2020/21. Whilst assurance had been provided that the Trust had sufficient cash to manage the 2020/21 position, potential challenges for the 2021/22 financial year had been identified. The Committee had resolved to continue to seek assurance that options were being developed. Positive assurance had been received regarding the governance and programme arrangements for the EPR programme. The Committee had been informed that the roll-out of the K2 maternity records system had been deferred to January 2021

	with assurance provided on the rationale for delay. Mr Tony Okotie, Non-Executive Director, asked regarding the level of confidence that the K2 system would be launched in January 2021. The Director of Finance confirmed that the system was in place, with the roll out delayed to a lack of testing by the initial launch date. This was being rectified and there was confidence that the system would be in place in January 2021. The Board of Directors: • Received and noted the Chair's Report from the FPBD Committee meeting held on 24 November 2020.
218	**Chair's Report from the Putting People First Committee** The Board considered the Chair's Report from the Putting People First Committee held on 23 November 2020. The work to progress and maintain progress on key workforce projects whilst also attempting to ensure that sufficient support and development was being provided to staff through the pandemic was noted. Particular attention was being given at the Committee to the support being provided to vulnerable groups of staff. The Committee noted a downward trend in relation to PDR and mandatory training compliance across a majority of departments and recognised the impact Covid-19 had caused on workforce ability to maintain compliance. A focused approach to develop e-learning and live web-based courses to replace face-to-face courses to maintain workforce training was reported to the Committee. The Board of Directors: • Received and noted the Chair's Report from the PPF Committee meeting held on 23 November 2020.
219	**Covid-19 Pandemic: Trust Update** The Chief Operating Officer reported that despite the city being placed in tier 2 restrictions, the Trust remained on high alert and the protective measures and governance arrangements had been maintained. Work continued to listen to staff needs and concerns and grip was being maintained on business as usual standards. The Chair questioned whether risk assessments for vulnerable staff had been reviewed. The Chief People Officer stated that the aim was to maintain staff risk assessments as a live process. A particular focus had been contacting those staff who had been required to shield and regular conversations were being held with BAME staff to listen to their views. Non-Executive Director, Mr Ian Knight, queried whether there were any concerns relating to PPE supplies post 31 December 2020 should there be a 'no deal' exit from the European Union. The Director of Finance stated that she was not aware of any issues and Business Continuity Plans had been subjected to desk top tests with no risks identified. The Board of Directors: • Noted the report for information and assurance
220	**Safer Nurse/Midwife Staffing Report, M7 2020/21** The Acting Director of Nursing & Midwifery presented a report which detailed Ward Staffing levels across all inpatient clinical areas during October 2020. The Board was briefed on the content of the report and it was noted that there were challenges in the Gynaecology team regarding recruitment and retention. It was stated that plans were in place to make improvements in this area. Following a theatre review (initiated after an identified theme from serious incidents), an updated workforce model had been developed and was scheduled to be actioned.

The Acting Director of Nursing & Midwifery reported that Nursing and Midwifery vacancies were at 7% (not 6% as stated in the report). Despite this, the fill rate during the month remained high at 90%.

The Chief Executive referenced the challenges highlighted in the Gynaecology team and queried whether the Trust needed to be mindful of this when in discussions regarding a mutual aid offer as part of the Covid-19 response. The Acting Director of Nursing & Midwifery confirmed that this would be require on-going monitoring. The Chair noted that on a recent walkabout, nursing staff in the area had noted that they were looking forward to an increased variety in their workload.

Chair's Log: For the Putting People First Committee to undertake a 'deepdive' review into gynaecology staffing challenges.

The Chair referenced an issue raised by the Non-Executive Director Maternity Safety Champion (Prof. Louise Kenny) regarding the on-going practice of midwives being required to undertake tasks which in another context were usually performed by other professionals e.g. scrub assistant. It was queried why this practice was continuing when a business case to remove the requirement had been approved in 2018 by the Board. The Chief Executive noted that whilst the business case had been approved, it had not been enacted upon until recently by the respective division. The Medical Director had not been made aware of the issue and this therefore highlighted a lesson to be learned by the Trust in relation to the close out and tracking of approved business cases. The Chief Executive noted that this incident had highlighted the importance of the Maternity Safety Champion in flagging relevant issues for action.

The Board of Directors:

- Noted the content of the report and the assurances that appropriate information was being provided to meet the national and local requirements
- Noted that the organisation had the appropriate number of nursing & midwifery staff on its inpatient wards to manage the current clinical workload as assessed by the Acting Director of Nursing & Midwifery
- Noted staffing challenges relating to COVID-19 and the mitigating actions being put in place
- Noted the assurance that the Anaesthetic workforce met the ACSA standards as required by Maternity Incentive Scheme Safety Action 4 and that no action plan was required.

221 **Care Quality Commission Update**

The Acting Director of Nursing & Midwifery explained that the CQC Inspection from December 2019 had identified a number of 'Must Do' actions that had deadlines for the end of December 2020. The report outlined the progress made against the actions. It was noted that actions would only be identified as 'green' if evidence could be provided that it was fully embedded.

Key areas to highlight were identified as follows:

- Pathways for Under 18's/ Deteriorating Child: This action had been changed to 'amber' (from 'red' in the November 2020 update) as work had been undertaken and progress was being made. The majority of actions would be completed from the action group, with a specific action around employment of paediatric nurses taking a longer than the specified completion date. The Policy for the Management of Children and Young Persons in Hospital was currently out for consultation with a plan to approve by end of December 2020. Overall, it was expected that the action would be complete by March 2021.
- It had been noted at the November 2020 Board meeting that the actions related to waiting list and Referral to Treatment targets were unlikely to be met as they had been set pre-Covid-19. The Chief Operating Officer stated that it was possible that this action would be identified as 'green' due to the work undertaken to ensure that all available mitigations had

	been enacted from a quality perspective. The Chief People Officer suggested that the description of the assurances included in the action tracker required strengthening in relation to how the Trust was managing waiting lists from the perspective of minimising harm to patients. Non-Executive Director, Dr Susan Milner, noted the assurances provided in the action tracker that the Trust had strengthened its medicine management processes and queried if it was a concern that the Trust was still experiencing a number of medicine management related incidents. The Chief People Officer stated that whilst it was not realistic to aim for zero medicine management incidents, improvements were still required to identify themes and patterns to help pinpoint underlying issues that required intervention. The Chief Executive noted that she shared the same concern as Dr Susan Milner and suggested that the newly appointed Director of Nursing & Midwifery and Medical Director review the interventions put in place by the Trust to provide a view on their effectiveness. The outcome of this would be included within the 'lesson learning' report scheduled for February 2021. **Action: For the Director of Nursing & Midwifery and Medical Director to review the medicine management interventions put in place by the Trust to provide a view on their effectiveness with the outcomes reported in the 'lesson learning' report scheduled for February 2021.** The Board of Directors: • noted the report for information and assurance
222	**Neonatal Preterm Mortality Review (July 2015 – June 2018)** The Board considered the report that detailed the outcome of an external review that had been commissioned by the Neonatal team into an identified increase in the pre-term mortality rate during 2015-2018. The Medical Director (designate) noted that the review had confirmed the increase but had not provided an explanation. The Neonatal team was now undertaking work to explore the underlying reasons (considering data up until 2020). Of the 10 cases reviewed externally, one incident had been identified in which the Trust's practices had contributed to the death of the baby. A Serious Incident had been raised and the learning would be taken to improve practice. Attention was drawn to the action plan developed following the review which remained a live document. Non-Executive Director Prof. Louise Kenny stated that there could be complex reasons behind the increase in mortality that would not solely be as a result of Trust practice. It was asserted that socio-economic issues could potentially be causal factors that would need to be considered as part of the review. It was suggested that the Neonatal team explore a potential collaboration with the University of Liverpool who would be able to provide the requisite skills and resources to support the review. The Board of Directors: • noted the report for information and assurance.
223	**Bi-Annual Report Saving Babies Lives Version 2. October 2020** The Board received the Bi-Annual report which provided detail on the progress made against the Trust's Saving Babies Lives (SBL) Action Plan in regard to each of the bundle's elements including smoking in pregnancy, Small for Gestational Age & fetal growth restriction, reduced fetal movements, effective fetal monitoring and preterm labour. The Quality and Safety Matron noted that receiving the report was required for the Board to demonstrate compliance against CNST Safety Action 6. The Quality and Safety Matron continued to present on the key elements of the SBL bundle, highlighting levels of implementation and key challenges. The Board was asked to particularly note:

- the completed quarterly care bundle surveys were embedded within the October 2020 Bi-Annual Report (Safety Action 6a).
- not all data from the Information Team via the Maternity Information System to confirm compliance across the bundle elements was in place. Audits were planned to provide evidence against the five elements and results from this would be included in the April 2021 Bi annual report - to be presented at Trust Board 6th May 2021. It was highlighted that the imminent K2 maternity data system would assist with the data gaps identified. (Safety Action 6 Evidential Requirements)
- Trust policy supported women with a BMI >35 to have ultrasound assessments of growth from 32 weeks (Safety Action 6 Evidential requirements)
- Quarterly audits of the percentage of babies born <3rd centile >37+6 weeks were planned and ongoing with the GAPSCORE (audit tool provided by Perinatal Institute) assisting with this. The outcomes would be presented in the April 2021 Bi Annual Report (Safety Action 6 Evidential requirements)
- Women at high risk of preterm birth had access to the specialist preterm birth clinic when transvaginal ultrasound (TVUS) was provided. The Trust's Preterm (PT) birth clinic was well embedded with a Consultant Specialist Lead. Screening at booking for preterm birth was completed on all women and those at risk were referred to PT birth clinic.

The Board of Directors

- noted the report and the key areas of compliance in respect of CNST Safety Standards.

224 **Serious Incident Report – Quarter 2, 2020-21**

The Acting Director of Nursing & Midwifery presented the report noting that it included detail of the serious incidents reported during quarter 2 2020/21 and an outline of completed investigations and information on the root cause identified following the completion of the Serious Incident Investigation.

It was asserted that the report demonstrated that the Trust continued 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 provided clear root causes and lessons learnt. Duty of candour had been met in 100% of all SI cases and there were no overdue actions at the time of writing the report.

The Chair stated that the report was a useful source of information but could be strengthened and improved by identifying other sources of information for triangulation purposes and by identifying themes and evidence of lesson learning being embedded. The Chief People Officer acknowledged that these improvements were required, and the report was being reviewed alongside the Integrated Governance Report (received by the Quality Committee) to ensure that the correct level of assurance was being provided at Board and Committee level.

The Board of Directors:

- noted the report for information and assurance.

225 **Key actions: infection prevention and control and testing**

The Acting Director of Nursing & Midwifery outlined the Trust's level of compliance against the latest NHSE/I Infection Control Board Assurance Framework and the 10 key Board responsibilities for Infection Prevention and Control and Testing. With regards the latter, it was highlighted that the Board was not compliant with action eight but had taken action from the day of the Board meeting to implement the three-day follow up patient test following admission.

Reference was made to a feedback report from the CQC in which they had stated "We have found that the board is assured that the trust has effective infection prevention and control measures in place".

The Board of Directors:

- note the contents of the paper
- took assurance that the Trust was taking all actions reasonably practicable to ensure it was working to meet it responsibilities for Infection Prevention and Control in relation to Covid-19.

226 **Operational Performance Report period M7, 2020/21**

The Chief Operating Officer presented the Operational Performance Report for Month 7 2020/21. He briefed the Board on the content of the report and provided an overview of performance against key national standards as detailed at section two of the report.

An increase in sickness and absence as a result of Covid-19 (both direct and indirect) provided a general context to performance challenges across the organisation. Despite the challenges posed during the Covid-19 pandemic 18-week performance remained on trajectory and there had been a continued reduction in 52-week breaches. However, the cancellation of elective activity at the beginning of the pandemic would start to result in an additional number of 52-week breaches over the coming months. Work was also being planned for the potential impact of a third Covid-19 wave. National expectations for performance during 2021/22 was awaited and this would be considered as part of the operational planning process.

Attention was drawn to Continuity of Care (CoC) performance and it was noted that whilst compliance against the 35% target would not be met for March 2021, plans were in place to achieve this by the end of quarter 1 2021/22. Non-Executive Director, Mr Ian Knight, queried whether the workforce issues that had contributed to the CoC challenge had been overcome. The Chief Operating Officer reported that engagement with the midwifery workforce remained on-going. Concerns had been listened to and the Trust had been clear regarding expectations. This had resulted in additional staff volunteering to work under the required staffing model. It was noted that the December 2020 Quality Committee had requested a 'deep dive' review into the CoC performance trajectory.

The Board of Directors:

- Received and noted the Month 6 Operational Performance Report.

227 **Financial Report & Dashboard Month 7, 2020/21**

The Director of Finance presented the Finance Report and Financial Dashboard for Month 7, 2020/21. She briefed the Board on the content of the report and advised that as at 31 October 2020, the Trust was reporting a deficit of £0.7m after receipt of system, Covid-19 and growth top up of £0.6m in month. This meant that the Trust was on plan to deliver a revised £4.6m deficit for the year, as submitted to the Cheshire & Merseyside Health and Care Partnership (HCP).

The cash position for 2020/21 remained robust but would become an increasing challenge into 2021/22 should the funding deficit not be resolved. The 2021/22 planning process had started but guidance regarding the levels of expected delivery were still awaited.

Non-Executive Director, Mr Ian Knight, asked whether the Trust had received a response regarding the questions posed on the funding allocation. The Director of Finance stated that the Trust was part of a system funding envelope and was therefore unlikely to receive a specific response. Non-Executive Director, Mr Philip Huggon referenced the ICS proposals discussed in item 215 and noted that the potential impact on funding would need to be considered for future years' financial planning. The

	Board noted the additional focus on the issue by the Finance, Performance and Business Development Committee. The Board of Directors: • Received and noted the Month 7 Financial Performance Report.
228	**HFEA Licence Inspection** The Scientific Director & HFEA Person Responsible explained that the Human Fertilisation and Embryology Authority (HFEA) inspected the Trust every four years ahead of renewing a licence. They outlined the findings from the previous inspection (and progress against the findings), the preparation being undertaken for the lead in to upcoming inspection, the key areas of focus contained within the inspection and the Trust's current position against these, with any areas of challenge outlined. The Chief Executive noted the need to ensure that the HFEA Person Responsible was supported and that the licence process was considered as part of the Trust's governance framework. The Chief People Officer added that the Gynaecology Divisional Board would have a role to have oversight of progress. An overall map of external inspections and accreditations was due to be considered by the Trust's Audit Committee in January 2021. The Board of Directors: • Received and noted the report for information and assurance.
229	**Board Assurance Framework** The Trust Secretary presented the Board Assurance Framework 2020/21. Since the last report to the Board, the executive directors and Board Committees had reviewed each of the BAF risks and several updates had been made, mainly to actions. There were no proposed changes to the scores for the Board to consider. The Board of Directors: • Noted the report for information and assurance
230	**Board Thank You's** *Alice Bird – Consultant Obstetrician* The Chief People Officer reported that when the Covid-19 pandemic hit the Communications Team at the hospital worked closely with Alice Bird, Consultant Obstetrician to produce a series of short video messages following the immediate changes to Maternity services due to Covid-19. Responding to questions from mothers to be on social media in an interactive way, Ask Alice provided reassurance to pregnant women and families at an anxious time through a friendly and knowledgeable face. Thanks were extended to Alice for her commitment, skill and flexibility in producing the videos. *Maternity Team* The Board viewed a video in which the Chief Operating Officer thanked Angela Winstanley (Quality & Safety Midwife), Rachel McFarland (consultant obstetrician) and Karinn Farquharson (Junior Doctor) for producing the maternity infographics. These were being used to explain the activity of the Trust to a wide audience both internally to the Trust and externally via social media.
231	**Review of risk impacts of items discussed** The Board noted that the following risks had been discussed during the meeting: • The continuing need to ensure that the experiences of the Trust's BAME staff and patients were being considered and necessary actions being taken • The uncertainty in relation to guidance for operational and financial planning for 2021/22 • Workforce challenges in relation to:

	○ On-going requirement to monitor the well-being and morale of staff ○ Safe staffing challenges in gynaecology ○ Mandatory training compliance • The issues raised regarding neonatal outcomes and the additional exploratory work required in collaboration with the University of Liverpool *The following items were considered as part of the consent agenda*
232	**Leadership & Talent Strategic Framework** The Board approved the Leadership & Talent Strategic Framework.
233	**Lessons Learnt from Mortality Q2** The Board noted the assurance that there were adequate processes in place for learning from deaths.
234	**Annual Quality Report 2019-20** The Board approved the Quality Report for publication on the Trust and NHS England website.
235	**2020/21 Corporate Objectives – six-month review** The Board noted the report for information and assurance.
236	**Any other business & review of meeting** None noted.
	Date of next meeting The Chair reported that the next meeting of the Board of Directors in public would be held on 4 February 2020.
	Exclusion of the Public The Board of Directors resolved to exclude the press and public from the meeting at this point on the grounds that publicity of the matters being reviewed would be prejudicial to public interest, by reason of the confidential nature of business. Members of the public were requested to leave the meeting room at this point.

Liverpool Women's NHS Foundation Trust

Board of Directors

Minutes of the meeting of the Extraordinary Board of Directors held in public at 0930 on 7 January 2021 Virtual Meeting

PRESENT

Mr Robert Clarke	Chair
Mrs Kathryn Thomson	Chief Executive
Mrs Michelle Turner	Chief People Officer
Mrs Jenny Hannon	Director of Finance
Dr Lynn Greenhalgh	Medical Director
Mrs Marie Forshaw	Director of Nursing & Midwifery
Mr Gary Price	Chief Operating Officer
Dr Susan Milner	Non-Executive Director/SID
Prof Louise Kenny	Non-Executive Director
Mr Phil Huggon	Non-Executive Director
Mr Ian Knight	Non-Executive Director
Mrs Tracy Ellery	Non-Executive Director

IN ATTENDANCE

Mr Mark Grimshaw	Trust Secretary (minutes)
Mrs Mary McDonald	Appointed Governor
Mrs Denise Richardson	Public Governor
Ms Kate Hindle	Staff Governor
Mrs Jackie Sudworth	Public Governor
Mr Yaroslav Zhukovskyy	Public Governor
Mrs Felicity Dowling	Member of the public

APOLOGIES:

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

20/21/	
249	**Apologies** – as above **Declaration of Interests** – Mrs Kathryn Thomson noted that she was the Senior Responsible Officer for the Cheshire & Merseyside Local Maternity System which was responsible for assessing compliance levels against the Ockenden Assurance Tool referenced in item 251
250	**Meeting guidance notes** The Board received the meeting attendees' guidance notes which had been updated to reflect 'virtual meetings'.
250a	**Chief Executive's Announcements** Whilst it was not scheduled on the agenda, the Chair noted that it would be useful for the Board to be updated considering the Government's escalated response to the Covid-19 pandemic following the Christmas period.

The Chief Operating Officer reported that a new Covid-19 strain(s) had and were continuing to significantly increase infections nationally and locally and this had resulted in a national lockdown. It was noted that the Trust had well-established governance mechanisms and the benefit of learning from previous waves which would support its response. However, it was recognised that the impact on staff throughout the year had been significant and it would be vital to continue to offer support. This included an effective and efficient roll out of the vaccine. It was also noted that the Trust would continue to take an infection, prevention and control led approach to maintaining safety both for staff and patients.

The Chair queried if there were any additional or different actions that the Board would need to take to support the Trust's response. The Medical Director stated that it would be important to maintain effective listening mechanisms with staff and patients and to be responsive to concerns or ideas when appropriate. Mrs Marie Forshaw noted that she had been impressed with the co-ordination, oversight and connection between the Executive team and staff since joining the Trust.

251 **Ockenden Report – Trust Response**

The Medical Director reported that following the publication of Ockenden Interim Report on 10 December 2020, NHS England had requested that maternity services implement all seven Immediate and Essential Actions (IEAs) described in the document. In addition, 12 urgent clinical priorities had been identified from the seven IEAs. All maternity services had been asked to provide assurance that they complied 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 the Trust had provided thorough and robust evidence to demonstrate their self-assessment of ratings. Out of the 12 urgent clinical priorities. The Trust had rated six as partially compliant and six as fully compliant. The partially compliant areas were outlined, and attention was drawn to appendix 1 to the report that provided additional detail.

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

- Review of the Ockenden report and the seven IEA's using the assurance assessment tool (Appendix 2). It was a requirement that the Ockenden report be 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 publication of the Ockenden report the Trust had established an Ockenden governance framework to ensure that the actions from the report would be actioned and embedded in the Trust. The Trust would also use this framework to revisit and test that the Kirkup recommendations (from the 2015 report) remained actioned and embedded within current services.

The Chair thanked the Executive team for presenting the report and noted that whilst it would be important to monitor the specific compliance points within the action plans, the challenge for the Board would be to consider how to consistently deliver the best maternity services for the communities served by the Trust. The Chief People Officer noted that a theme within the report related to culture and asserted that it would be important for the Board to challenge whether it adequately understood its culture and whether the right interventions were in place. The Chair

	highlighted the Trust's on-going cultural improvement programmes and noted their importance in this supporting this aim. The Chief Executive stated that she would welcome the views of the newly appointed directors on whether the Trust's cultural programmes were correctly targeted and effective. **Action: For the Medical Director and Director of Nursing & Midwifery to reflect on whether the Trust's cultural programmes were correctly targeted and effective, reporting back to the April 2021 Board.** The Director of Nursing & Midwifery noted the close connection between culture and communications and highlighted the importance of ensuring that there were adequate communications with the maternity team. The Chair remarked that whilst the Trust had stated a position of compliance against actions relating to effectively engaging with women and understanding their views – mainly through the Maternity Voices Partnership (MVP) – this was an area that could be further strengthened. It was stated that it would be useful to improve the connection of the MVP to the Board (possibly through the Safety Champion route) and to also identify other mechanisms that were being or could be utilised to effectively engage with women and their families. The Chair added that it would be vital to ensure that a diversity of voices was being heard that was representative of the communities served by the Trust. Non-Executive Director, Prof. Louise Kenny noted that the report demonstrated the importance of the Board being assured that lesson learning from incidents had been fully embedded and has resulted in improved practice. The Medical Director added that there was an opportunity for the lessons from the Ockenden Report to be expanded across the whole organisation and not limited to solely maternity services. Non-Executive Director, Dr Susan Milner stated that the Trust's response to the Ockenden Report should not be seen as a 'one-off' compliance exercise but instead become part of the Trust's overall continuous improvement efforts to ensure that the longer term aim of being the leading provider for women and their families was realised. **Chair's Log: Quality Committee to receive a report on Ockenden.** The Board of Directors: • Noted the report and the assurance regarding the action taken to demonstrate compliance against the seven IEAs and 12 urgent clinical priorities • Requested that a further report be received in February 2021 that would outline how the Trust would start to work against the longer-term actions identified in the report and from the Board's discussion.
252	**Serious Incident Report – Quarter 3 2020-21** The Medical Director presented the serious incidents report quarter 3 2020/21 highlighting the number of completed investigations and information on the root cause identified following the completion of the Serious Incident Investigation and progress with actions. It was noted that in response to the Ockenden Report, the frequency of reporting would increase from quarterly to every Board meeting. The Chief People Officer explained that future reports would have an increased focus on the identification of themes and lesson learning recognising the importance of identifying and exploring commonalities rather than providing detail on each individual incident.

	Non-Executive Director, Dr Susan Milner, added that this principle could be applied across a number of Board and Committee papers and asserted that it would be important to ensure that the appropriate level of information was reported to suit the purpose of the meeting as part of the Trust's on-going governance development programme. The Board of Directors: • Noted the contents of the report and took assurance that there was a robust process in place for the reporting and investigation of Serious Incidents.
253	**Approval of Charitable Funds Annual Report and Accounts 2019/20** Non-Executive Director, Phillip Huggon presented the Liverpool Women's NHS Foundation Trust Charity Annual Report and Accounts for the 2019/20 financial year noting that they had been reviewed by the Charitable Funds Committee on the 15th December 2020. Approval was required by the Board of Directors, in its role as the Corporate Trustee of the charity before they could be filed with the Charity Commission before the end of January 2021. The Chair queried if the Charitable Funds Committee had discussed the income stream challenges for the Charity during 2020. Non-Executive Director, Phillip Huggon confirmed this to be the case. The Chief People Officer added that whilst it had been a challenging year for the fundraising team, they had responded well and had undertaken several innovative projects. The Director of Finance confirmed that there had been no concern raised on the accounts from the independent examiner. The Chair highlighted that the incorrect signature had been applied adjacent to the picture of the Chair of the Charitable Funds Committee. The Board of Directors: • Subject to the correct signature being applied adjacent to the picture of the Chair of the Charitable Funds Committee, approved the Charitable Funds Annual Report and Accounts 2019/20 ahead of submission to the Charities Commission. • *Post Meeting Note: Approved the signing of the Letter of Representation via email (28th January 2021).*
254	**Charitable Funds Committee – Terms of Reference** The Trust Secretary reported that the Charitable Funds Committee had reviewed the Terms of Reference and had recommended them for approval by the Board. Non-Executive Director, Tracy Ellery, suggested the following additional amendments: • Membership section – "Deputy Director of Finance (or nominated deputy)" to be replaced with "Director of Finance (or nominated deputy)" • Quorum section changed to "A quorum shall be three members which must include one Executive Director and one Non-Executive Director" The Board of Directors: • Subject to the suggested amendments being applied, approved the Charitable Funds Terms of Reference.
255	**Charitable Funds Investment Policy Amendments** The Board of Directors approved the amendments to the Charitable Funds Investment Policy.
256	**Any other business & Review of meeting** None noted.

	Date of next meeting The Chair reported that the next meeting of the Board of Directors in public would be held on 4 February 2021.

Liverpool Women's NHS Foundation Trust

Action Log

Trust Board
4 February 2021

Key	Complete	On track	Risks identified but on track	Off Track

Meeting Date	Ref	Agenda Item	Action Point	Owner	Action Deadline	RAG Open/Closed	Comments / Update
7 January 2021	20/21/251	Ockenden Report – Trust Response	For the Medical Director and Director of Nursing & Midwifery to reflect on whether the Trust's cultural programmes were correctly targeted and effective, reporting back to the April 2021 Board.	Medical Director and Director of Nursing & Midwifery	Apr 21	On track	
3 December 2020	20/21/221	Care Quality Commission Update	For the Director of Nursing & Midwifery and Medical Director to review the medicine management interventions put in place by the Trust to provide a view on their effectiveness with the outcomes reported in the 'lesson learning' report scheduled for February 2021.	Medical Director and Director of Nursing & Midwifery	Feb 21	On track	With the lesson learning report being deferred to April 2021, the MD and DoN&M to provide a verbal update to the meeting.
3 December 2020	20/21/215	Chief Executive Report	For the Board to discuss and consider the implications of the NHSE/I policy paper regarding ICSs at the January 2021 workshop.	Chief Executive	Jan 21	Completed	Discussion held at January 2021 workshop
5 November 2020	20/21/186	Safeguarding Annual Report 2019/20	For the Associate Director of Nursing and Midwifery for Safeguarding to explore an alternative mechanism to face-to-face delivery for level three	Associate Director of Nursing and Midwifery	Feb 21	Completed	The Safeguarding Team have revised the delivery model for level 3 Child & Adult SGT by including the use of e-learning. Face to face scenarios have been

			safeguarding training to improve compliance.				retained. Evaluations of this element have been positive. The offer of full non face to face delivery including the potential for a virtual scenario will be explored with the CQC in the next relationship meeting to gain a view
5 November 2020	20/21/172	Patient Story	For the Physiotherapy manager/clinical lead to attend a future Executive Team meeting to outline the lessons learned in relation to initiating a culture change within a service.	Chief Operating Officer	Dec 20	Off track	Owing to capacity at Executive team meetings, the invite has been deferred to a meeting during February 2021.
3 September 2020	20/21/164	7 Day services – self – assessment against priority standards	For focused improvement work to be undertaken for Priority Standards Five and Six and for this to be captured within the next self-assessment (Autumn 2020).	Medical Director	Feb 21	On track	Verbal Update to be provided by the Medical Director at the 4 February 2021 Board.
3 September 2020	20/21/155	Serious Incident Report – Quarter 1, 2020-21	A report on the processes for learning lessons and embedding updated practice to be tabled at the November 2020 Board meeting.	Chief People Officer	Feb 21 (Nov 20)	Off track	Work continues to identify evidence for the Trust effectively learning lessons. A comprehensive report on this has been deferred until April 2021 as the Trust is awaiting the results of an internal audit report.
3 September 2020	20/21/155	Serious Incident Report – Quarter 1, 2020-21	For the Board to review Serious Incident definition tolerances at the January 2021 Board workshop.	Medical Director	Mar 21 (Jan 21)	Off track	Deferred to March 2021 Workshop

Liverpool Women's NHS Foundation Trust

Chair's Log

Received / Delegated	Meeting Date	Issue and Lead Officer	Receiving / Delegating Body	Action Deadline	RAG Open/Closed	Comments / Update
Delegated	03.12.2020	Gynaecology staffing challenges 'deepdive' Lead Officer: Chief People Officer / Director of Nursing & Midwifery	Putting People First Committee	March 2021	Open	Scheduled for the PPF Committee in March 2021.
Delegated	07.01.2021	Ockenden report: Quality Committee to receive a report on Ockenden. Lead Officer: Medical Director / Director of Nursing & Midwifery	Quality Committee	January 2021	Completed	On Quality Committee agenda for discussion 25 January 2021, agenda item 20/21/175.

Agenda Item	2020/21/263

MEETING	Board of Directors
PAPER/REPORT TITLE:	Chief Executive Report
DATE OF MEETING:	Thursday, 04 February 2021
ACTION REQUIRED	Information
EXECUTIVE DIRECTOR:	Kathy Thomson, Chief Executive
AUTHOR(S):	Mark Grimshaw, Trust Secretary
STRATEGIC OBJECTIVES:	*Which Objective(s)?* 1. To develop a well led, capable, motivated and entrepreneurial ***workforce*** ☒ 2. To be ambitious and ***efficient*** and make the best use of available resource ☒ 3. To deliver ***safe*** services ☒ 4. To participate in high quality research and to deliver the most ***effective*** Outcomes ☒ 5. To deliver the best possible ***experience*** for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	*Which condition(s)?* *1. Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust…….* ☒ *2. Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have sufficient numbers of clinical staff with the capability and capacity to deliver the best care. ……* ☒ *3. The Trust is not financially sustainable beyond the current financial year……* ☒ *4. Failure to deliver the annual financial plan ……* ☒ *5. Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision ……* ☒ *6. Ineffective understanding and learning following significant events……* ☒ *7. Inability to achieve and maintain regulatory compliance, performance and assurance……* ☒ *8. Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) ……* ☒
CQC DOMAIN	*Which Domain?* ***SAFE-*** *People are protected from abuse and harm* ☐ ***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☐ ***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☐ ***RESPONSIVE –*** *the services meet people's needs.* ☐ ***WELL-LED -*** *the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.* ☐

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

Executive Summary

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

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

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

Report

SECTION A – Internal

Cluster of Covid-19 cases among LWH staff

In late 2020 a small number of staff were part of an event outside of work. This resulted in a number of COVID-19 transmissions and the Trust has worked with Public Health England in relation to this. Due to the emergence of a subsequent transmission this was then declared as a nosocomial outbreak to NHSI/E and has been managed in accordance with the agreed processes. No patients have come to harm related to this issue. All staff have been reminded about the need to follow Infection, Prevention and Control guidance in and out of work. The Trust is reviewing this event in line with our incident management policies to establish any further learning.

Staff Vaccine

On the 30th December 2020, the COVID-19 vaccine developed by Oxford University/AstraZeneca was given regulatory approval by the Medicines and Healthcare products Regulatory Agency (MHRA) after meeting the required safety, quality and effectiveness standards. The Trust received a delivery of the Oxford/AstraZeneca on the 6th January 2021 and commenced a soft roll-out on Friday 8th January 2021, in preparation for a full clinic launch on Monday 11th January 2021.

Although the vaccination programme has been an unprecedented logistical challenge, the clinic has been well received by staff and data sourced from the Trust's Business Intelligence system on 22nd January 2021 showed 70% of Trust staff have been vaccinated (including 76% of our BAME staff and 72% of staff classed as clinically vulnerable).

The Trust is currently, via line managers, contacting all staff who did not access a vaccine to establish any concerns or anxieties, to inform targeted communications or to arrange for 1:1s with an appropriate professional to address any issues. The Trust is already committed to commence the second phase of the Vaccination Programme in March 2021.

Schwartz Rounds

The COVID-19 pandemic has resulted in unprecedented challenges for the NHS and I continue to be very grateful to all of our staff for the tremendous amount of work they have been doing, and will continue to do, to help contain the spread and provide high quality services. The Trust recognises that it is important to continue to explore mechanisms to provide support during and after the pandemic.

Schwartz Rounds are one of these support mechanisms and provide a confidential forum for all staff to come together once a month to reflect on the non-clinical aspects of caring for patients – that is the emotional and social experiences associated with their work.

At each round, two to three people share an experience from their work. The story is told from an employee perspective

Schwartz Rounds help with:

- Normalising emotions
- Creating a culture of openness
- Promoting connectedness and increasing insight
- Role modelling
- Changing narratives

K2 Athena

On Tuesday 19th January, the Trust launched 'K2 Athena' - an electronic Patient Health Record System (PHR), which will be replacing patient's handheld notes in the Maternity division.

All maternity care will be documented in Athena from booking, to discharge, to health visits, with the exception of the GROW & HDU charts. Women will be able to access their records through any mobile device via a secure website, keeping their data safer.

Maternity clinical data is captured once, and once only; contemporaneously at the point of care during the patient interaction, even in emergency situations. There is no need to rely on retrospective entry away from the patient. K2 Athena facilitates patient consultation, captures interaction, enhances clinical oversight and communication, helping multi-disciplinary teams plan future care.

Benefits of the new system include:

- Reduction in the amount of paper used, thus improving the Trust's carbon footprint
- Safer storage of patient records
- Provides a live auditable digital footprint, enhancing confidentiality and security of Patients records
- K2 Athena interfaces with our current K2 Guardian system, reducing duplication of data entry
- Clinicians have access to a patient case notes at the touch of a button 24/7

Continuity of Carer

We are delighted to announce we have started to roll out a new way of working within our Maternity Services – known as 'Continuity of Carer'. This new model of care will enable the same team of midwives to care for our mums before, during and after their baby's birth.

Allowing for seamless support from booking right through to labour and postnatal care, and most importantly it will help build strong relationships between our midwives, women and their families. The women will always have a midwife who they know and trust, rather than seeing a different face at every appointment.

Following the National Maternity review – Better Births, it is clear that models of care where women know the midwife who is caring for them throughout their maternity journey, have a positive impact on improving safety, clinical outcomes, as well as a better birth experience. Continuity models of care also have an impact on reducing pre term births, hospital admissions and the need for intervention in labour. Relationship continuity maternity models have also been shown to improve job satisfaction and a sense of autonomy for midwives that practice in these models and improve trust and effective collaboration between care providers.

Initially there will be four teams of Midwives delivering the service to Mums registered with local GPs, the new model will then be gradually rolled out right across Merseyside. However, even at this early stage it is our aim to offer the service to the majority of women booking to have their care at Liverpool Women's.

CNST Compliance

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

- In December 2020, the Board noted the percentage of O&G trainees in 2019 that reported whether they disagreed or strongly disagreed that educational / training opportunities are rarely lost due to gaps in the rota. Included on the agenda is an action plan, outlining how the Trust intends to make improvements in this area. The Board is required to approve this action plan ahead of its submission to the Royal College of Obstetricians and Gynaecologists (RCOG)
- Maternity Services Data Set – Assurance provided through the Finance, Performance and Business Development Committee that the Trust remained compliant with the Information Standards Notice following implementation of K2 in January 2021 and that it is currently compliant with Maternity Services Data Set (MSDS)v2 Information Standards Notice, DCB1513 and 10/2018, supported by the latest NHS Digital MSDS scorecard. As part of the CNST Incentive scheme, the Board are asked to note the assurance received by the FPBD Committee in relation to safety action 2 and refer to Appendix 1 of the Chair report.
- Safe Staffing paper – The Board is asked to note that the Neonatal medical and nursing workforce meet the requirements of CNST safety action 4 with no action plan required.

SECTION B – Local

University of Liverpool – 2020 Year in Review

Professor Dame Janet Beer (Vice-Chancellor) has noted that the impact of Covid-19 has been felt in every aspect of the University's work - from the nature of the research they do, the way in which they teach and support their students, to how they navigate and occupy their campus. The following video has been produced to capture the challenges and innovations during the year -

https://www.liverpool.ac.uk/feature/an-extraordinary-year/?utm_source=emt&utm_campaign=EndofYearFilmCG&utm_medium=email&utm_term=2021&utm_content=AnExtraordinaryYear

Cheshire and Merseyside Health and Care Partnership – Update from the Partnership Board

The Partnership Board met for the last time in 2020 on 23rd December. There were four substantial items of business and more detail on these can be found on the link below. In addition, a draft Memorandum of Understanding (MoU) regarding the Partnership's future working arrangements was shared with trusts and other partners during December 2020. The Board reviewed the draft MoU at its workshop in January 2021 and noted support for the direction of travel outlined. A final version of the MoU is expected in the coming weeks.

https://www.cheshireandmerseysidepartnership.co.uk/news-and-publications/update-from-the-partnership-board/

Discover LHP's achievements of the last six months

Liverpool Health Partners' Half Year Review provides a round-up of achievements and developments over the last six months. In the review, you'll find:

- New programme strategies that are set to have a positive impact on the city region
- The STOP-COVID webinar series and working groups
- New collaborations across our network with partners
- New appointments to bolster the LHP offering
- The anticipated launch of their new brand and identity
- LHP SPARK's reach during the pandemic and beyond

https://liverpoolhealthpartners.org.uk/landmark-moments-in-healthcare-from-lhp-and-its-partners-our-half-year-review/

SECTION C – National

NHSE/I's policy paper 'Integrating Care'

It was reported at the December 2020 Board that NHSE/I had published a policy paper setting out their vision of the strategic direction of system working, 'Integrating Care: Next steps to building strong and effective integrated care systems across England'. This set out a series of policy and legislative proposals to accelerate the development of Integrated Care Systems (ICSs), including a focus on the leadership role of providers within systems. NHS Providers have published a briefing on the paper which can be found on the following link: https://nhsproviders.org/media/690574/201126-nhs-providers-on-the-day-briefing-integrating-care-final.pdf

The Trust contributed to a Liverpool Integrated Care Partnership Group response that was submitted on the 8th January 2021 as part of the consultation. The Board will be kept up-to-date of further developments.

EU Exit

The transitional period following the exit from the EU ended on 31 December 2020. A trade deal was secured, and NHSI/E have kept trusts appraised of what they need to do in response, which is primarily a "business as usual" approach. The Director of Finance is the EU exit SRO and will work closely with the Chief Operating Officer and EPRR lead to continue to take any required actions are taken, such as:

- Ensuring the Board is sighted on the process and made aware of any issues
- Testing and updating business continuity plans (in the revised context of the global pandemic)
- Revisiting of guidance and actions and addressing any outstanding issues
- Ensuring local risk assessments are up to date
- Ensuring effective communication to managers and frontline staff is maintained.

Liverpool Women's NHS Foundation Trust

Board of Directors

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

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

2. **Agenda items covered**
   - **Deepdive Review: Falls deep dive detailing quality implications:** The Committee noted the fall prevention interventions led by the Gynaecology nursing team. It was recognised that the small numbers reported at the Trust could cause large variations and might not provide an accurate representation of performance, improvement or deterioration. The Chief Operating Officer advised that the metric was being discussed with the Clinical Commissioners as part of the CQUIN negotiations for 2021/22.
   - **Deepdive Review: Continuity of Carer (CoC) Trajectory:** The Matron for Community provided a presentation to the Committee outlining work to date and proposed next steps to achieve the projected target by March 2021. The Committee would continue to receive position updates against this target to monitor the risk.
   - **Lesson Learning front line view: Practical process and change in practice case studies:** The Committee received verbal case studies from staff members representing each of the three divisions, Gynaecology, Family Health and Clinical Support Services. The Committee noted a key issue identified within all case studies was that staff had felt empowered by the development and opportunity to raise concerns in an appropriate way.
   - **Monthly Quality Performance Review M8 2020/21:** The Committee received a report on Operational Performance at Month 8 2020/21. The Committee was assured by the actions being undertaken to improve the performance position in relation to key quality indicators.
   - **Ockenden Review of Maternity Services at Shrewsbury and Telford Hospital NHS Trust: LWH Trust Response to initial report:** The Committee noted that that the Trust had undertaken a review of evidence of compliance against the 12 urgent clinical priorities as set within the Ockenden Report and was assured that there was a clear process for the review of the Ockenden report and the actions contained within it.

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

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

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

6. **Action required by Board**
   None

Tony Okotie
Chair of Quality Committee
21 December 2020

NHS

Liverpool Women's NHS Foundation Trust

Quality Committee Chair's Highlight Report to Trust Board
25 January 2021

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• The Safety Senate highlighted concern of management of abnormal scan findings in response to a number of incidents. A long-term solution had been identified by Meditech Expanse however an interim measure was required. Safety Senate had commissioned the divisional management teams to provide a solution and assurance. Committee noted further risks linked to abnormal scan findings articulated within the Serious Incident Report received. • Two actions remained open on the CQC action plan which related to Pathways for under 18's and RTT compliance. The former would be completed by end March 2021. Challenges regarding the RTT Compliance action remain as it was set pre-Covid-19. In response to the pandemic, actions taken in line with national guidance had severely impacted the Trust's ability to meet current elective care standards. The Committee recommended a discussion with the CQC Relationship Manager. • Deteriorating quality performance metrics directly related to Covid-19. Concern specifically for 52-week breaches and increasing risk of harm to patients as the pandemic continued. The Trust was restricted by local and national system rules and requirements but had focused on internal planning to enable an immediate restart. • Sustained high levels of sickness absence and the consequential impact on quality performance was noted as a concern. Committee noted that the Putting People First Committee would receive a detailed paper on the sickness position at its meeting 25.01.21. • Quality Contract with the CCG: Noted one of the 42 requirements was amber and related to mental health act compliance. This requirement of the contract had been a long-term challenge for the Trust to declare compliance. Work was ongoing with Mersey Care in relation to crisis service cover for LWH site and administration support for Deprivation of Liberties process. The Committee recommended that the requirement be added to the Corporate Risk Register and escalated to Executive Committee for formal support.	• MIAA internal audit of learning from significant events: audit delay from MIAA noted due to Covid-19. • Imminent review of Patient Experience Strategy noted and a refresh of the terminology of 'strategies' to become framework/plan to fit within the revised Corporate Strategy structure. • Committee requested a focussed assurance report on the two-remaining open CQC action plan actions: Under 18's pathway and RTT. • Recommended an MIAA audit be commissioned to audit completion of the CQC action plan. • Assurance report commissioned in relation to the interim abnormal scan result process.

Positive Assurances to Provide	Decisions Made
• Noted work underway to provide a Trust response to the Ockenden Review. A task and finish group would provide oversight. Assurance will continue via QC and TMB. • Assured by the CQC update report and sustained progress to achieve actions within timescales. • Assured by the report and divisional representation at the meeting of progress made to achieve the CNST maternity safety actions. It noted that NHSR had revised the submission timeframe to July 2021 and supported the Trust approach to work towards completion against the original timeframe of 20 May 2021. • Continuity of Carer (CoC) pathway target had improved and four new teams established in January 2021. A CoC organisational risk and trajectory update would be provided at the next meeting. • Serious Incident quarter 3 report: assured that the correct process of reporting SI's was in place but limited assurance in relation to the process of lessons learnt. • Committee was assured by the strengthened governance process to recognise and respond to medicine management issues both locally and nationally and appropriate duties were being undertaken following the CQC visit in December 2019.	• Committee reviewed the Quality related BAF risks. No changes to existing risks were identified as a result of business conducted during the meeting. • Agreed to develop the serious incident report to ensure that the appropriate level of detail was reported at Senate, Committee, and Board level.

Comments on Effectiveness of the Meeting / Application of QI Methodology

- Shared learning from the Ockenden report to be communicated across all Board Committees and divisional groups.
- A gap of divisional representation at Quality Committee was noted. Wider attendance to be considered by Executive Team.
- Paused consent agenda for this meeting allowed discussion and airtime to regular reports which had not been considered throughout 2020/21.

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
173.	Board Assurance Framework: Review of Quality related risks October 2020/21	Assurance	180.	Serious Incidents & Learning Reports Quarter 3	Assurance
175.	Ockenden Review of Maternity Services: LWH Trust Response	Information	181.	Medicines Management Assurance Report Quarter 3	Assurance
176.	Care Quality Commission (CQC) 2019 Inspection Update (including Action Plan)	Assurance			
177.	Clinical Negligence Scheme for Trusts (CNST) Update Year 3	Information			
178.	Performance Report Month 8 2020/21 including Continuity of Carer (CoC) Update	Assurance			
179.	Quality Contract Assurance Report Quarter 3	Assurance			

3. 2020 / 21 Attendance Matrix

Core members	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Susan Milner Chair until Aug 2020	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Tony Okotie Chair as of Sept 2020	Non member				✓	✓	✓	✓	✓	✓		
Phil Huggon	✓	✓	✓	✓	✓	Non member						
Ian Knight	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Louise Kenny	✓	A	✓	✓	✓	A	✓	✓	✓	✓		
Gaynor Hales (until end Oct 2020)	✓	✓	✓	✓	A	A	✓	Non member				
Marie Forshaw (as of Jan 2021)	Non member									✓		
Janet Brennan	✓	✓	✓	✓	✓	✓	A	✓	A	✓		
Gary Price	✓	✓	✓	✓	✓	A	✓	✓	✓	✓		
Andrew Loughney (until end Dec 2020)	✓	✓	✓	✓	✓	✓	✓	✓	A	Non member		
Lynn Greenhalgh (as of Jan 2021)	Non member								✓	✓		
Jenny Hannon	✓	✓	✓	✓	✓	✓	A	✓	✓	✓		
Michelle Turner	✓	A	✓	A	✓	✓	✓	✓	✓	✓		
Christopher Lube	✓	✓	✓	✓	✓	✓	✓	✓	A	✓		

Present (✓) Apologies (A) Representative (R) Nonattendance (NA) *Non-quorate meetings highlighted in greyscale*

Board of Directors

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

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

2. **Agenda items covered**
   - **Finance, Performance and Planning - 2021/22 Planning – CNST premium (and Ockenden report):** The Committee was informed that the Trust's Clinical Negligence Scheme for Trusts (CNST) premium requirement for 2021/22 from NHS Resolution was increasing to £20.5m in 2021/22 from £16.8m in 2020/21. It was noted that in recent years, movements to premiums had been funded through tariff, control totals, STF/PSF/FRF or top ups. Under the financial regime that had been enacted in response to the Covid-19 pandemic, there was uncertainty on how this would be reflected in the Trust's future income and this was identified as a risk to financial planning for 2021/22. An analysis of claims data had been undertaken together with evidence such as strengthened staffing models and a reduction in activity and this would be used to inform discussions with the Trust's regulators and commissioners regarding the level of the premium and funding to be received. The Committee also acknowledged that the Trust's ongoing clinical quality work, whilst primarily undertaken to improve safety, could also have a beneficial impact on reducing the amount and level of claims. The recently published Ockenden Report and its attendant actions was noted as being highly relevant in this context.

   - **Crown Street Enhancement Programme:** The Committee received the output of an options appraisal on the best way to progress the with the £6.5m capital allocation for enhancements with the Crown Street site. The Committee sought and were provided assurances regarding the project governance in place and the strategic alignment, affordability and deliverability of the preferred option. The Committee noted that they would be informed in a timely way of any relevant changes to the agreed way forward.

   - **Finance Performance Report Month 8 2020/21:** The Committee noted the Month 8 2020/21 financial position.

   - **Operational Performance Report Month 8 2020/21:** The Committee noted the Month 8 2020/21 operational performance report.

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

4. **Issues to highlight to Board**
   The Committee wishes to highlight an increased risk to the 2021/22 financial planning as a result of the increased CNST premium.

5. **Action required by Board**
   None

Phil Huggon, Committee Chair
FPBD Committee
22 December 2020

Finance, Performance & Business Development Chair's Highlight Report to Trust Board
26 January 2021

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Trust on plan to deliver a revised £4.6m adjusted deficit as submitted and approved by the Cheshire & Merseyside Health and Care Partnership (HCP). The Committee raised concern of the risk posed by the deficit position moving into 2021/22 and the impact on financial and operational planning. • Increasing risk to deliver CIP targets in 2021/22. • Performance targets remain a challenge as a direct impact of Covid-19 on performance measures including sickness absence, mandatory training, 62-day target remain. • Increasing backlog of long waiters due to Covid-19 as essential services only are being delivered within national command and control arrangements. • Difficulties posed by Planning Process 2021/22 undertaken within the Covid-19 landscape. Dialogue will continue with the HCP, NHSI/E, CCGs, Specialised Commissioning and other local providers in order to ensure that LWH issues are understood as well as possible. The income position was noted as a key risk.	• Planning 2021/22 assumption scenarios to be received by Committee in February • Corporate Strategy nearing completion and would be presented to Board • Theatre Robotic Business Case to be received by Committee in February • Work is ongoing in relation to the Crown Street enhancement program
Positive Assurances to Provide	**Decisions Made**
• Continued internal monitoring of financial and performance metrics despite national pauses • Continuity of Carer: continued to improve the position within the Trust. • Assurance was given that the trade debtors position had reduced by a further £1.2m in month, leaving the overall debtor position at £2.4m • Noted positive progress within all four projects currently overseen by the Programme Board: construction, CT Imaging, 24/7 Transfusion and Robotic Assisted Surgery. • Assured that the Trust remained compliant with the Information Standards Notice following implementation of K2 in January 2021 and that it is currently compliant with Maternity Services Data Set (MSDS)v2 Information Standards Notice, DCB1513 and 10/2018, supported by the latest NHS Digital MSDS scorecard. As part of the CNST Incentive scheme, the Board are asked to note the assurance received by the FPBD Committee in relation to safety action 2 and refer to Appendix 1 of the Chair report. • No significant impacts at LWH due to EU Exit. • Noted a positive introduction of the new Digital Generations Strategy since its official launch in September 2020.	• Recommend Board approval to purchase CT Scanner • Recommend a year-end digital services update to be presented to Board • Reviewed BAF risks mindful of the deficit position. Agreed to maintain current risk score and narratives but agreed to review the narrative of the in-year financial BAF risk in response to the changing landscape
Comments on Effectiveness of the Meeting / Application of QI Methodology	
• Treasury management becoming increasingly important as the Trust continues to report a deficit position and therefore will not be considered in the consent agenda.	

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
140.	Finance Performance Report Month 9 2020/21	Assurance	147.	Digital Generations Strategy 2020-2024 Review	Assurance
141.	Operational Performance Report Month 9 2020/21	Assurance	148.	Maternity Services Data Set assurance report	Approval
142.	Planning 2021/22 Update	Information	149.	Treasury Management Quarterly Report	Assurance
143.	Strategic Progress Update (Future Generations)	Assurance	150.	EU Exit end of transitional period	Assurance
145.	Crown Street Enhancements Program	Assurance	151.	One to one midwives update	Information
146.	Digital Service Report: includes Electronic Patient Record & Information Governance updates	Assurance	152.	Board Assurance Framework Review	Assurance

3. 2020 / 21 Attendance Matrix

Core members	Apr	May	Jun	Jul	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Phil Huggon	✓	✓	✓	✓	✓	A	✓	✓	✓		
Jo Moore	✓	✓	✓	✓	✓	A	A	A	✓		
Ian Knight	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Tracy Ellery	✓	A	✓	✓	✓	✓	✓	A	✓		
Jenny Hannon	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Kathryn Thomson	✓	✓	✓	✓	A	✓	✓	✓	A		
Gary Price	✓	✓	✓	✓	A	✓	✓	✓	✓		
Marie Forshaw	Non member								✓		
Gaynor Hales	✓	✓	✓	✓	✓	A	Non member				
Janet Brennan							✓	✓	Non member		

Present (✓) Apologies (A) Representative (R) Nonattendance (NA)
Non-quorate meetings highlighted in greyscale

APPENDIX 1: NHS DIGITAL MSDS V2 MONTHLY SCORECARD

This is an extract from the most recent NHSD scorecard, highlighting full compliance for Liverpool Women's. 11 is currently the highest achievable score. It has been filtered to North West Trusts only for ease of viewing.

			Criteria Achieved by provider by month				
Org.Code	Organisation Name (Provider)	Region	May 2020	Jun 2020	Jul 2020	Aug 2020	Sep 2020
REP	Liverpool Womens NHS Foundation Trust	North West	9	9	10	11	11
RXN	Lancashire Teaching Hospitals NHS Foundation Trust	North West	10	9	9	11	11
RBL	Wirral University Teaching Hospital NHS Foundation Trust	North West	9	10	10	10	11
RJR	Countess of Chester Hospital NHS Foundation Trust	North West	4	4	5	8	9
R0A	Manchester University NHS Foundation Trust	North West	4	4	4	9	9
RTX	University Hospitals of Morecambe Bay NHS Foundation Trust	North West	8	8	8	9	9
RMC	Bolton NHS Foundation Trust	North West	5	6	6	8	8
RXR	East Lancashire Hospitals NHS Trust	North West	4	4	5	6	8
RW6	Pennine Acute Hospitals NHS Trust	North West	7	7	7	8	8
RWJ	Stockport NHS Foundation Trust	North West	7	7	7	8	8
RMP	Tameside and Glossop Integrated Care NHS Foundation Trust	North West	7	7	7	8	8
RWW	Warrington and Halton Hospitals NHS Foundation Trust	North West	6	7	7	8	8
RRF	Wrightington, Wigan and Leigh NHS Foundation Trust	North West	6	6	6	7	8
RXL	Blackpool Teaching Hospitals NHS Foundation Trust	North West	6	7	6	8	7
RBT	Mid Cheshire Hospitals NHS Foundation Trust	North West	3	3	3	7	6
RY2	Bridgewater Community Healthcare NHS Foundation Trust	North West	4	4	4	4	5
RJN	East Cheshire NHS Trust	North West	4	4	4	5	5
RVY	Southport and Ormskirk Hospital NHS Trust	North West	4	4	4	5	5
RBN	St Helens and Knowsley Teaching Hospitals NHS Trust	North West	4	4	4	7	5

Putting People First (PPF) Committee Chair's Highlight Report to Trust Board
25 January 2021

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Mandatory training compliance remained a concern. High levels of sickness absence and special leave due to Covid-19 was a recognised impact however it was believed that further enablers would improve compliance. • Sickness absence rate highlighted as a negative outlier compared to local and national rates. PPF was assured that appropriate internal action had been taken and absence management processes had been followed however raised concern that an operational risk remained. PPF reviewed the associated BAF risk 2294 and recommended to increase the risk score to 20. • Pressures noted within the Medical Anaesthetic workforce – attributed to the following factors; recruitment to vacant posts had been challenging, deanery changes in how trainee anaesthetists are rotated had caused a negative impact, and fatigue in the substantive anaesthetic staff due to continued sickness issues and covering sabbatical gaps. PPF requested that the Clinical Director for CSS attend a meeting to provide assurance. • GMC Survey: it was noted that those on the GP programme had indicated that improvements could be made in their experience. It was suggested that a junior doctor should be invited to provide a staff story to share their experiences. • Lack of an identified Guardian for safe working hours since the last post holder resigned. The newly appointed Medical Director was addressing the requirement with the senior leadership team.	• Noted a shared remit to monitor progress against the Ockenden review with the Quality Committee. PPF commissioned a deepdive in Maternity services in response to cultural themes highlighted by the Ockenden review. • MIAA mandatory training audit report underway. • Noted progress made against Year 1 implementation of the Nursing, Midwifery & Allied Health Professional (NMAHP) Strategy. A refresh of the terminology 'strategy' to become a framework to fit within the revised Corporate Strategy structure. A refreshed Nursing, Midwifery & AHP framework would be provided to the Committee.
Positive Assurances to Provide	**Decisions Made**
• Successful roll out of the Oxford / Astrazeneca vaccine to Trust staff. 70% staff had been vaccinated. • Awarded National Funding to support HCA recruitment to attract candidates from outside the NHS into HCA roles. • Received assurance from the Clinical Support Service that the workforce was safe and sustainable. No risks escalated to committee attention with the exception of the anaesthetic workforce (as described above) • Assured by action taken to revise the Resuscitation Training package provided and offer greater flexibility to increase staff attendance whilst meeting mandatory requirements. • GMC Survey conducted in August 2020 provided assurance that overall educational supervision was well maintained with generally positive results for educational supervision and curriculum delivery and communication.	• Reviewed the PPF related BAF risks. Recommend Board approval to increase risk score of BAF risk 2294 from (5x3) 15 to (5x4) 20. • Agreed to modify the Bi-Annual Safe Staffing report ahead of review by the Trust Board.

• Assured that the current nurse/ midwife staffing levels were safe and appropriate, and noted the national shortage of nurses and midwives and the continued impact of COVID-19 on staffing.	

Comments on Effectiveness of the Meeting / Application of QI Methodology

- Successful interconnection of key workforce risks identified across the reports received.
- Staff story: it had been beneficial to hear from a new member of staff and a fresh pair of eyes resolving a prolonged issue.

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
95.	Board Assurance Framework (BAF): Workforce related risks	Information	101.	GMC Survey and Action Plan	Assurance
96.	Chief People Officer Report	Information	102.	Safe Staffing review	Assurance
97.	Current absence rates and mitigating strategies report	Assurance	103.	Nursing, Midwifery and AHP Strategy Annual Review	Information
98.	Workforce KPI Dashboard Report	Assurance	104.	Guardian of Safe Working Hours (Junior docs) Quarter 3 report	Assurance
99.	Staff Story: Clinical Support Service	Information	105.	Subcommittee chairs reports	Information
100.	Service Workforce Assurance & Risk Report: Clinical Support Services	Assurance			

3. 2020 / 21 Attendance Matrix

Core members	Apr	Jun	Sep	Nov	Jan	Mar
Tony Okotie (Chair until Aug 2020)	✓	✓	Non member			
Jo Moore (Chair as of Sept 2020)	✓	✓	✓	✓	✓	
Dr Susan Milner	✓	✓	✓	✓	✓	
Tracy Ellery (as of Sept 2020)	Non member		✓	✓	✓	
Michelle Turner	✓	✓	✓	✓	✓	
Gaynor Hales (until Nov 2020)	✓	✓	A	Non member		
Marie Forshaw (as of Jan 2021)	Non member				✓	
Gary Price	✓	✓	A	✓	✓	
Dan Nash (R)			✓ R			
Claire Scott	✓	A	A	A	✓	
Victoria McKay	✓	✓	✓	✓	A	
Liz Collins	✓	✓	✓	✓	✓	

Present (✓) Apologies (A) Representative (R) Nonattendance (NA) *Non-quorate meetings highlighted in greyscale*

Audit Committee Chair's Highlight Report to Trust Board

26 January 2021

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• The Committee received the audit plan from the External Auditor. There was confidence that the audit would progress without significant issues although it was noted that the Finance Team might be required to undertake the 2021/22 planning process at the same time as the audit, potentially resulting in resource implications.	• The Committee requested an amendment to the Trust's internal audit recommendation tracking process to ensure that there were consistent lists between the Trust's own system and that of MIAA • The Committee requested that MIAA undertake an audit on the Trust's CQC action plan. • In relation to the 'ISA 540 (revised) Auditing Accounting Estimates and Related Disclosures – Enhancing Evidence' requirements, the Committee agreed to receive a report at the March 2021 meeting setting out the Trust's approach to estimates. • The Committee considered a Policy for Use of External Auditors to Undertake Non-Audit Work. The External Audit referenced recently updated NAO guidance and it was agreed to review the draft policy against this ahead of finalising at the next scheduled meeting. • The Committee received an outline map of external inspections and accreditations. It was agreed that this should also outline reviews / inspections in which the Trust was an ancillary party and also the Trust's response to relevant and significant external reports. • The Committee noted continued developments of the Trust's Board Assurance Framework
Positive Assurances to Provide	**Decisions Made**
• The Committee noted a continued reduction in the number of outstanding internal audit recommendations. • Whilst some internal audits had been delayed due to Covid-19, the Committee was assured that MIAA were on track to provide their Head of Internal Audit Opinion • Good progress had been made with the Anti-Fraud programme and the Committee was assured that anti-fraud training was being provided via the Trust's on-line induction (an issue that had previously been raised as a concern). • Substantial assurance had been provided in two internal audit reports; Effective Rotas and Payroll/Recruitment. The Trust's Assurance Framework had also been found to meet requirements. • The number of tender waivers continued to track downwards, demonstrating increased grip and awareness across the organisation.	• The Committee noted the external audit fees for the 2020/21 audit • The Committee agreed to move the 21 May 2021 meeting date to closer to the 15 June 2021 annual report and accounts deadline. • The Committee agreed a small debt write off.

Comments on Effectiveness of the Meeting / Application of QI Methodology
• The Committee received a presentation from the Gynaecology Division regarding their governance processes. It was agreed that this was a useful exercise and divisions would continue to attend on a rota basis. It was suggested that future presentations provide an outline of the development of governance processes.

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
20/21/62	Follow up of Internal Audit and External Audit Recommendations	To receive assurance of actions implemented on a timely basis.	20/21/68	Areas of Judgement in the Accounts	For assurance
20/21/63	**MIAA Internal Audit Reports** a) Follow Up Audit Recommendations b) Internal Audit Progress Report i. Effective Rotas ii. Payroll/Recruitment iii. Assurance Framework (AF) **Anti-Fraud** c) Progress Report 2020/21 **Insight** d) Insight Update	To note the contents and any recommendations from the report.	20/21/69	Debt Write-Off Report	For assurance
20/21/64	External Audit Plan	For agreement	20/21/70	Divisional Governance Presentation	For assurance
20/21/65	External Audit Technical Update	To note the contents and any recommendations from the report.	20/21/71	Update on the Review of Process for external reviews / inspections of the Trust	For assurance
20/21/66	Policy for Use of External Auditors to Undertake Non-Audit Work	For agreement	20/21/72	Chairs reports of the Board Committees a) Finance, Performance and Business Development Committee b) Quality Committee c) Putting People First Committee d) Charitable Funds Committee	Review of Chairs' reports for overarching assurance.
20/21/67	Audit Waiver Report Quarter Three 2020/21	The Committee is asked to note the Register of waivers and receive assurance that contracts requiring a waiver are managed appropriately within the Trust's SFI's.	20/21/73	Board Assurance Framework (BAF)	For assurance

3. 2020 / 21 Attendance Matrix

Core members	May	July	October	January	March
Tracy Ellery	✓	✓	✓	✓	
Ian Knight	✓	✓	✓	✓	
Tony Okotie (until Sept 20)	✓	✓			
Susan Milner (from Sept 20)			✓	✓	

Present (✓) Apologies (A) Representative (R) Nonattendance (NA) *Non-quorate meetings highlighted in greyscale*

Liverpool Women's NHS Foundation Trust

Board of Directors

Committee Chair's report of Charitable Funds Committee meeting held 15 December 2020

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

2. Agenda items covered
   - **Monthly Financial Position & Investment Report – 2020/21:** The Committee noted the current financial position as at the end of November 2020. The positive impact on the financial position of monies donated via NHS Charities Together was noted. The Committee approved an update to the authorised signatories.
   - **Charity Investment Policy Review:** The Committee reviewed the Investment policy taking into account ethical considerations and reviewed the Charity risk appetite and capacity for loss in relation to its investments. In relation to the ethical considerations the Committee agreed to exclude Armaments from its investment portfolio. The Committee approved the updated policy and agreed to maintain a medium risk appetite level.
   - **Investment Market:** The Committee received a presentation update from the Investment Director. The Committee approved the recommendation to adjust the asset allocation to gain increased exposure to long term global growth.
   - **Approval of Annual Report and Accounts (draft):** The Committee reviewed and approved the draft annual report and accounts. The Charity Annual Report and Accounts would be submitted to the Board of Directors in January 2021 for approval ahead of submission to the Charities Commission on the 31st January 2021.
   - Fundraising Update: The Committee noted that all planned fundraising events had been reviewed in line with Covid-19 guidance, which had greatly reduced the number of fundraising events planned for the year. The Committee noted Pro Bono support received by the Charity particularly in relation to online developments which had provided valuable cost savings.
   - **Big Tiny Steps Appeal Update: Flats appeal video:** The Committee noted that additional funds donated to the Big Tiny Steps Appeal would be used to refurbish the parent accommodation.
   - Covid-19 Recovery Appeal Video: The Committee approved the option to launch a Covid-19 recovery appeal video in 2021.
   - Liverpool Women's Charity Fundraising Guide: The Committee noted the guide for information.
   - Charitable Funds Committee Terms of reference & Work plan: The Committee received and approved the terms of reference and workplan. The Committee supported the approach to review the content of the Corporate Governance Manual to ensure improved user access by the Charity.

3. Board Assurance Framework (BAF) risks reviewed
   The Chief People Officer noted that no risk related to the Charity was on the risk register and requested that a risk be added to the Corporate Risk Register.

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

5. Issues to highlight to Board
   None

6. Action required by Board
   - To approve the updated Investment Policy as Corporate Trustee of the charity.
   - To approve the Charity Annual Report and Accounts as Corporate Trustee of the charity ahead of submission to the Charities Commission on the 31st January 2021.

NHS

Phil Huggon
Chair of Charitable Funds Committee
15 December 2020

Liverpool Women's NHS Foundation Trust

Agenda Item	20/21/269

MEETING	**Trust Board**
PAPER/REPORT TITLE:	**Covid-19 Pandemic: Trust Update**
DATE OF MEETING:	Thursday, 04 February 2021
ACTION REQUIRED	**Assurance**
EXECUTIVE DIRECTOR:	Gary Price, Chief Operating Officer
AUTHOR(S):	Gary Price, Chief Operating Officer
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** 1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☐ 2. To be ambitious and *efficient* and make the best use of available resource ☒ 3. To deliver *safe* services ☒ 4. To participate in high quality research and to deliver the most *effective* Outcomes ☐ 5. To deliver the best possible *experience* for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust…….* ☐ ***2.*** *Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have sufficient numbers of clinical staff with the capability and capacity to deliver the best care. ……..* ☒ ***3.*** *The Trust is not financially sustainable beyond the current financial year……* ☐ ***4.*** *Failure to deliver the annual financial plan ……* ☐ ***5.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision ……* ☐ ***6.*** *Ineffective understanding and learning following significant events……* ☒ ***7.*** *Inability to achieve and maintain regulatory compliance, performance and assurance……* ☐ ***8.*** *Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) ……* ☐
CQC DOMAIN	***Which Domain?*** ***SAFE-*** *People are protected from abuse and harm* ☐ ***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☐ ***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☐ ***RESPONSIVE –*** *the services meet people's needs.* ☐ ***WELL-LED -*** *the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care,* ☐

	supports learning and innovation, and promotes an open and fair culture. ***ALL DOMAINS*** ☒	
LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution ☐ **2.** Operational Plan ☒ **3.** NHS Compliance ☒	**4.** NHS Constitution ☐ **5.** Equality and Diversity ☐ ***6.*** Other: Click here to enter text.
FREEDOM OF INFORMATION (FOIA):	3. This report will not be published under the Trust's Publication Scheme due to exemptions under S22 of the Freedom of Information Act 2000, because the information contained is intended for future publication	
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	***The Board is asked to note this report for information and assurance***	
PREVIOUSLY CONSIDERED BY:	**Committee name**	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

This paper provides an update on the Trust's ongoing response to the Covid 19 Pandemic. January 2021 has seen another national lockdown. There remain restrictions on society and significant pressures on the NHS.

Report

1. Introduction

The pandemic outbreak of Covid 19 continues to place significant demands on the whole of the NHS. The Trust has responded to this pressure to date as part of the Cheshire and Mersey system response. The country is in another national lockdown and the Trust has had to respond appropriately in order to maintain safety for our staff and our patients. In January 2021 the Trust was required to step down routine elective surgery along with other trusts in Cheshire and Mersey to support the pandemic response.

2. Governance: Command and Control

The Trust remains under command and control via the Cheshire and Merseyside (C&M) in and out of hospital cells. The C&M system hosts a daily Gold Command call to ensure a collaborative approach to managing the pandemic, in addition there is a 3 x weekly Liverpool system call. There are regular Cheshire and Mersey calls for all Directors portfolios. This structure is overseen throughout the week with system CEO calls. This structure has overseen the management of the pandemic to date.

Internally the Trust has maintained its Coronavirus oversite and scrutiny arrangements since March 2020 which has allowed us to be responsive to the ever-changing demands and deliver safe services. The Trust has a daily

command and control session which oversees our operational response to the pandemic, this is overseen by the weekly Executive lead Oversight and Scrutiny Committee that reports to the Finance, Performance & Business Development Committee. The Trust has a Covid Clinical Advisory Group that allows us to ensure senior clinical and Infection Prevention Control (IPC) input to all our decisions.

3. Sickness absence

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

4. Infection Prevention and Control

The Trust has commenced its Covid-19 staff vaccination programme in January 2021 with over 75% staff vaccinated to date and over 70% BAME staff vaccinated. Work is underway to improve this further and to develop the role of the Trust in the wider mutual aid offer to vaccinate the population.

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

In late 2020 a small number of staff were part of an event outside of work. This resulted in a number of COVID transmissions and the Trust has worked with Public Health England in relation to this. Due to the emergence of a subsequent transmission this was then declared as a nosocomial outbreak to NHS I /E and has been managed in accordance with the agreed processes. No patients have come to harm related to this issue. All staff have been reminded about the need to follow IPC guidance in and out of work. The Trust is reviewing this event in line with our incident management policies to establish any further learning.

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

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

Ward areas have reviewed their bed space to ensure IPC compliance, this has resulted in the requirement to open increased capacity in maternity to ensure compliance with social distancing. The Trust has an established swabbing service which sits under the management of Clinical Support Division. This service is for symptomatic staff and for elective patients and supports our overall management of the pandemic response.

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

5. Mutual Aid

The Trust is engaged with the wider Cheshire and Mersey system to understand what mutual aid can be provided during the pandemic. Through early January the Trust provided medical step-down beds to Liverpool University Hospitals. In addition, the Trust has provided theatre, staffing and ward space to support the Cheshire and Mersey Cancer Alliance and Liverpool University Hospitals to deliver with Breast and Colorectal cancer surgeries.

6. Recovery and Restoration

In line with national requirements the Trust continues to review our waiting lists for those patients who have to wait longer for routine treatment due to the pandemic, specifically for benign gynaecology. All referrals have clinical triage, patients on the admitted pathway have all had Consultant review to prioritise patients. The Trust has met required recovery trajectories for outpatients and elective activity to date, however, anticipates future challenges with long waiting (52 week) patients.

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

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

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

7. Conclusion

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

Liverpool Women's NHS Foundation Trust

Agenda Item	20/21/270

MEETING	**Trust Board of Directors**
PAPER/REPORT TITLE:	**Ockenden Report Update**
DATE OF MEETING:	Thursday, 04 February 2021
ACTION REQUIRED	**Assurance**
EXECUTIVE DIRECTOR:	Marie Forshaw, Director of Nursing & Midwifery
AUTHOR(S):	Angela Winstanley. Rachel McFarland.
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.*** *The Trusts current clinical records system (paper and electronic) are sub-optimal……* ☐ ***8.*** *Major and sustained failure of essential IT systems due to a cyber attack ….* ☐ ***9.*** *Failure to - a) maintain pre-Covid-19 level of service for our patients due to the outbreak of the Covid-19 pandemic; b) protect staff, patients and visitors from infection; c) effectively manage increased demands and provide support to the wider system; and d) failure to recover to pre-Covid-19 service levels following the pandemic and be sufficiently resilient to manage a potential 'second wave' of infection* ☐
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**	*Choose an item.* Or type here if not on list: **Click here to enter text.**
	Date of meeting	***Click here to enter a date.***

Executive Summary

This Paper is to update the Board of Directors in progress made with regards to the Family Health Division response to the Ockenden Report. It will outline the actions taken to date to enable the Family Health Division to provide assurance that the full implementation of the Ockenden Essential and Urgent recommendations are underway.

In January 2021, the Board of Directors received a **Board Assurance Assessment Tool** (BAAT) that required completion and submission to NHS England & NHS Improvement Regional team via the LMS by 15th January 2021.

This BAAT was completed in conjunction with the Family Health Head of Midwifery, Divisional Manager of Operations and Quality & Safety Midwife with oversight from the Deputy Director of Nursing and Midwifery, Head of Governance and the Medical Director. The aim of the BAAT was to provide assurance and evidence of compliance against each of the essential and urgent clinical priorities.

Since the submission of the BAAT in January to the Board of Directors, an update was received by the Trust in relation to an extension of the submission deadline. The requirement now is that the BAAT is submitted to NHS England & NHS Improvement Regional team by the **15th February 2021** with oversight of the Trust response supplied to the Local Maternity System by the 8th February 2021.

This has given the FHD Clinical Leads for Ockenden a further opportunity to review the BAAT and update where required.

This paper will outline the key changes to the BAAT to enable submission to the LMS on 15th February 2021. This BAAT will be reviewed at the Ockenden Task & Finish Group Meeting on the 1st of February 2021.

Report

Introduction.

The Board Assurance Assessment Tool (BAAT) was received by the Trust on 14th December 2021. It was expected that this tool was to be completed and sighted at a Public Trust Board and submitted to the NHS England & NHS Improvement Regional team LMS by January 15th 2021 via the LMS. A Paper was submitted to the Trust Board of Directors on 07th January 2021 outlining the full requirements of the Ockenden Report, the Immediate and Essential actions with all the urgent clinical priorities. The Paper appendices a DRAFT version of BAAT and from this the Trust Board provided feedback.

Since this submission, all NHS maternity providers via their CEO received a letter outlining a revised submission date of the BAAT. The revised date of submission to the NHS England & NHS Improvement Regional team is now 15th February 2021 with the LMS requiring oversight of the Trust response by the 8th February 2021. This extension was announced in light of the sustained pressures that organisations are facing due to staff sickness, shielding and its disruption and impact on service provision.

This additional time has enabled the following to take place:

- Review and response of the Trust Board of Directors' comments and feedback from the initial draft submission.
- Reassessment and revision of the Board Assurance Assessment Tool by the nominated Family Health Divisional Leads for Ockenden.
- Review and analysis of the Perinatal Clinical Quality Surveillance Framework.
- DRAFT development of a Family Health Divisional Action Plan in response to Ockenden with SMART actions embedded of which will be agreed at the Family Health Divisional Board and the Task & Finish Group
- Development of DRAFT action plan to implement the Trust responsibilities with regards to the principles described in the Perinatal Clinical Quality Surveillance Framework of which will be agreed at the Family Health Divisional Board and the Task & Finish Group
- Ockenden Task and Finish Group development and meetings diarised.
- Revised consideration of Ockenden Action plan being a standard agenda item at the Maternity Risk Meeting. The action plan will be instead sighted at the Maternity Clinical Meeting where there is a wider clinical audience, including the Obstetric Clinical Lead (TBC) to provide feedback and support of the actions required. This will also enable a process for escalation of concerns to the Family Health Divisional Board.

Board Assurance Assessment Tool (BAAT) Update. (Updated BAAT can be found in Appendix1)

The BAAT has been updated to include the following:

- Each of the responses to the 12 Immediate and Essential Actions have been streamlined within the tool to follow a more easily readable format.
- Each of the 11 urgent clinical priorities, as laid out in the BAAT, have been referenced and linked to the Immediate and Essential Actions, including further narrative around the Perinatal Clinical Quality Assurance

Framework, information supporting clarification of the requirements of a senior, independent advocate role and LMS external validation of supporting evidence.

- As the Trusts' new K2 Athena Maternity Information System has since 'Gone Live' since the BAAT Draft was submitted, some of the immediate actions and the evidential audit requirements have been updated to reflect that the Trust will be in a position to provide evidence via an audit and review process.
- Additional narrative around the use of Personalised Care & Support Plans in Maternity, this was only minimally referenced in the DRAFT submission.
- Additional narrative to support the recent appointment of a named Consultant Obstetrician to work with and support the Fetal Surveillance Midwife.
- Information and narrative relating to the required Midwifery Leadership Statement.

Board Feedback from 7th January 2021.

It is pertinent to note the comments that the Board of Directors offered after receiving the DRAFT BAAT tool and the divisional responses. Responses to these comments have been formulated by the Head of Governance, Head of Midwifery and Family Health Division Ockenden Leads and any actions from these will be embedded in the Family Health Divisional Action Plan.

How the Board gets assurance that when an incident is raised, the loop is properly closed and evidence provided that practice has changed (recognised that this isn't just a concern re: maternity but Trust wide)

The Quarterly Serious Incident report is moving to monthly schedule and has been redesigned to provide the Quality Committee and the Trust Board with further detailed assurance as to how lessons will be learnt and are implemented. This monthly report will identify to the Trust Board when an Action Plan associated with a serious incident is completed. It will detail how this action plan has supported change and how the changes have and will continue to be evidenced. This process has not been undertaken in previous reports and heralds the start of change to disseminating how as a Trust we learn from incidents, change clinical practice and support quality improvement.
The actions required to support this process will be included in the Ockenden Action Plan and further with the Trust Serious Incident SOP update. Further detail and actions outlining the improvements to be made with regards to lessons learnt is provided in the assurance tool.

How the Board gets to hear the 'voice' of the patient and their families regarding their experiences. There was some doubt as to whether MVP is enough and/or whether the MVP should have a more visible presence at Board and its Committees.

To formalise this further, the Family Health Division will also strengthen the links between the Maternity Voices Partnership and the Board Level Safety Champion. This may include the attendance of the Board Level Safety Champion at formal MVP meetings, where escalation to the Board can be supported. In particular views will be sought of young people who use the services of the Trust. The MVP chair has undertaken listening events with vulnerable service users who find some of our services hard to reach and BAME women. This work will continue throughout 2021.
The introduction of the planned independent advocate role (EA2) would further support how the Board hears the voices of Women and Families. We currently wait further guidance in relation to this from NHSE. The introduction of the planned senior independent advocate role (EA2) would further support how the Board hears the voices of Women and Families, and whilst we await further guidance on this from NHSE, we remain positive that Women's voices are heard, listened to and acted upon by the other pathways and processes in place.

How the Trust can take the lessons from Ockenden and apply across the organisation?

The Ockenden report has been disseminated across the organisation through the Safety Senate. The Safety Leads for each Division and their departments have been asked to consider how the report is applicable to their service.

Divisional safety leads should engage with the Family Health Division to ensure quality improvements, enhanced clinical care and support can be put in place to support a Trust wide response. The Medical Director should ensure that the C.S.S and Gynaecology Divisions and their departments can provide assurance to the Safety Senate that they have taken forward any applicable lessons from the Ockdenen report.

Maternity Workforce Planning.

A Maternity workforce gap analysis was requested and has been completed in January 2021 to determine compliance to maternity staffing and confirm plans in place to meet the Birthrate Plus (BR+) standard by 31 January 2021 confirming timescales for implementation.

The Liverpool Women's commissioned Birth rate plus to undertake a systematic assessment of workforce requirements and received this report in July 2018. The analysis received was based on 8200 births and utilising an uplift of 21.4%. 67.8% of the births were identified as be category IV and V representing the highest level of care required and is reflective of the increased caesarean section, induction of labour rates, complexities of the women receiving maternity care within LWH and being a tertiary referral Maternity service.

For the financial year 2020/21, the Maternity establishment budget was set in line with the Birthrate plus recommendations and the staffing initially compliant in accordance with the identified establishment.

The Birth rate plus assessment findings noted a shortfall in non-direct care giving staff given the size of the maternity service. LWH has recruited a Deputy Head of Midwifery and an additional maternity matron since the Birth rate plus assessment. Plans for 2021 include the recruitment of a second Consultant midwife with a lead and focus on Continuity of carer, additional midwifery resource within the education team and the permanent role of the fetal surveillance midwife.

Monthly budget establishment meetings occur between finance and the maternity managers and matrons and continual review of staffing is undertaken. Maternity workforce is and reviews are included in the Bi Annual staffing paper presented to Trust Board.

The consistent monitoring and recognition of vacancies when they have fallen below Birthrate plus since budget setting have resulted in three successful recruitments in 2020. 22.06 WTE midwives were appointed in totality due to unprecedented high levels of current and forthcoming maternity leave, staff leavers and retirements.
A additional recruitment is currently in progress. The current deficit in comparison to Birthrate plus findings as of the 31st January 2021 is 4.66WTE midwives which if successfully recruited to will enable the staffing to comply with Birthrate plus and align to this years funded establishment

The Maternity service is currently experiencing high levels of sickness predominantly due to long term sickness and the effects of the COVID pandemic. The Maternity service continually works alongside HR to ensure sickness management is undertaken in line with Trust policy. Use of bank hours is undertaken to fill gaps in rotas due to sickness and the maternity escalation policy is utilised accordingly

The undertaking of a full Birth rate plus assessment is required to be considered due to significant clinical changes within the Maternity service, a reduction in bookings and births and increased activity with the Maternity assessment Unit. A quotation for a full assessment has been received at a cost of £9,800.00 inclusive of all expenses; and exclusive of VAT.
This full assessment will enable analysis of current activity aligned to required staffing and will include the introduction of current Continuity of carer teams and projections for proposed staffing as the Maternity service continues to introduce additional continuity of carer teams and safe levels of core staffing based on activity and acuity.

Compliance/Non Compliance update.

Since the review of the BAAT by the FHD Ockenden Leads, we can confirm compliance and assurance that the actions required in order to meet Immediate and Essential Action 6 (Fetal Wellbeing) have been completed, following the appointment of a Named Consultant Obstetrician to compliment the role of the Fetal Surveillance Midwife.

Conclusion.

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 updated BAAF assessment tool in the immediate term and what longer term actions are required to provide assurance going forward.

Appendix 1 - Maternity services assessment and assurance tool

Appendix 2 – Maternity Staffing Gap Analysis

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 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.** 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. 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), Safety Specialist Interest Group, Obstetrics and Gynaecology Clinical Network, Maternity Clinical Experts' Group, Cheshire and Merseyside Head of Midwifery and North West Coast Head of Midwifery meetings. • **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.** External reviewers, from out of the Trust but within the region, 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. In the event of a maternal death, external representation would be sought through the Clinical Network. Review of maternal deaths that have not occurred in our Trust, but may have accessed our service within the pregnancy, have all been undertaken to include external representation. • **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.** See narrative in Clinical Priority B. **Clinical Priority A** **A plan to implement the Perinatal Clinical Quality Surveillance Model.** The Trust is currently reviewing and is committed to following the Perinatal Clinical Quality Surveillance Model. This model has been designed by NHS England and seeks to provide a consistent and methodical oversight of all services, specifically including maternity services. It was developed to gather ongoing learning and insight, to inform improvements in the delivery of perinatal services. This framework consists of five principles. There are two principles (Principle 1 and 5) that require attention by the Trust. Principle One concerns strengthening trust level oversight for quality. Principle Five is concerned with identifying concerns, taking proportionate action and triggering escalation. The remaining Principles require Cheshire and Merseyside LMS attention and further guidance should be issued to the Trust. A GAP analysis to be undertaken and action plan to address requirements as outlined in Principles One and Five is underway and currently in draft form – To be reviewed by the Task & Finish Group. **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.

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 and will be uploaded onto the evidence portal when available:

- **Managing Incidents- Serious Incident Policy**
- **Trust Board reports - Serious Incidents Quarterly Report.**
- **Trust Board reports – Serious Incidents Monthly Report (From February 2021)**
- **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?	• **Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.** **and:** • **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.** The Trust is currently awaiting guidance from NHS England with regards to this essential action. NHS England is developing a national model for a network of advocates. Ensuring we get the right people into these roles is essential to improving maternity services in line with the Ockenden report. We know that the training, skills and credibility of the advocates will be key therefore co-producing a framework, including a standard JD, training package and principles for establishing a network. We will develop a clear process so that women and families know how to contact the advocates. This will also include mechanisms for contracting advocates so they remain independent and how these will be funded. • **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.** See Narrative below in Clinical Priority B. **Clinical Priority 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.** 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

	Clinical Priority 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.** 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: Service user attendance at Experience Senate 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 Board Level 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 Board Safety 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. This is yet to be developed by NHS England. 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. There is requirement to reinstate the formal MVP meetings, this will need to be virtually and minuted to enable formal evidence of discussions held. 3. The Maternity Safety Champions to liaise with the Chair of the MVP and invite to Safety Champions meeting on a Quarterly Basis.
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. 3. Maternity Safety Champions to liaise with the Chair of the MVP and set up meetings for MVP Chair to be invited to the Safety Champions meeting on a quarterly basis.
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?	To ensure that the views and concerns of patients involved in serious incidents, cases of intra-uterine fetal death and babies who undergo therapeutic cooling treatment a full Duty of Candour discussion with a Consultant is held and comments and queries are encouraged to be submitted to either the Divisional Governance Lead or the Quality & Safety Midwife. The women who sadly are affected by a stillbirth or a neonatal death, that require a PMRT review are supported by the Honeysuckle Team to submit comments to be considered as part of the PMRT review process. These comments are addressed within the PMRT report and are feedback to Women and their families at their Consultant De-brief. All HSIB investigations are independently reviewed and women and their families have the opportunity to discuss their care and highlight any concerns or questions with the HSIB Investigatory team. These comments are addressed and form part of the final HSIB report. Consideration for the Patient Experience Team to support families as an advocate requires further exploration.

Evidence considered and is available for review and will be uploaded onto the evidence portal when available:

- **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?	• **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.** 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). External validation of the evidence that Trusts have embedded multi-disciplinary training will require further guidance from the LMS with a process in place to support the Trust, however the Trust will liaise with the LMS in order to support the LMS where necessary. • **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.** 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 suite. 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. • **Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.** 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. In anticipation of a successful CNST 20/21/22 submission, the Finance Team have been asked to provide assurance that any maternity scheme refunds will be ring-fenced for use within maternity services. **Clinical Priority A** **Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.** See narrative above. Data to confirm compliance with this clinical priority has commenced. **Clinical Priority 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** See narrative above. The Trust will await this further guidance and complete a GAP analysis of the requirements versus the current Trust training schedule.
What are our monitoring mechanisms?	Data collation ongoing with regards to evidencing that the Consultant Ward Rounds are performed twice daily. 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, Maternity Quality Meeting and at the Family Health Divisional Board.

Where will compliance with these requirements be reported?	Compliance is monitored through Educational Governance, Divisional Clinical and Divisional Board Meetings. The Simulation Committee (a Sub group of Educational Governance) reviews the requirements for simulation within the Trust. 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. Update and amalgamation of two obstetric staffing guidelines to ensure that twice daily Consultant Led ward rounds are referenced and the framework to support MDT Ward round is in place. 3. 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. 4. 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. 5. LWH will incorporate the required training compliance into our own reporting schedules to the LMS three times per year. 6. Provide the Regional Chief Midwife with the updated Maternity Training Needs Analysis. 7. Embed a 'Service User Story' into MMPET training days to provide ensure user voice is heard.
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. 2. 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. 3. 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. 4. LWH will respond to the reporting schedule by the LMS. 5. LWH will incorporate MPET training into our own reporting schedules to the LMS three times per year from January 2021. 6. Service User Story – Maternity Education Team aware and are planning to work in collaboration with MVP Chair.
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 and will be uploaded onto the evidence portal when available:

- **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?	• **Women with complex pregnancies must have a named consultant lead.** 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. Following the introduction of K2 Athena on the 18th of January 2021 this information is now in an accessible format and will be audited to provide evidence of compliance. • **Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team** Where complex pregnancies are identified referrals are made and triaged by the Obstetric Consultant leads for tertiary maternal medicine clinics or by an Obstetric consultant when an intrapartum concern has been highlighted. Early specialist involvement is undertaken in all the tertiary maternal medicine clinics. The process for referral and allocation to specific clinic is now fully auditable through the K2 Athena system. The Trust are planning to audit against these actions within the next 6 months now the K2 Athena system is active. Standardised care plans for specific maternal medicine clinics which had been agreed between the woman and the team were previously included in the maternity handheld records. These care plans for the most high risk women are shared to the wider MDT at a monthly maternal medicine meeting. Care plans are now incorporated into the K2 Athena system and can be viewed by both the woman (through the My Pregnancy Notes portal) and by clinical staff. **Clinical Priority A** **All women with complex pregnancy must have a named Consultant Lead, and mechanisms to regularly audit compliance must be in place** 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 experienced 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. **Clinical Priority B** **Understand what further steps are required by your organisation 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. Further information to be added to this by DOF.
What are our monitoring mechanisms?	The required named Consultant for complex pregnancies can be effectively monitored following the implementation of the K2 Athena patient records. Risk Register: Maternal Medicine Risks highlighted and reviewed at regular intervals
Where is this reported?	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 is planned to commence. We are aware that the requirement for the audit to be completed was by January 2021. The Trust recognised that the hand held maternity records would not provide assurance with the recommendation for named consultant for women with complex pregnancy. The Trust is assured that referral process and risk assessments are in place to identity women with complex pregnancies and that these women have a named Consultant. From 18th January 2021 the Trust have implemented an EPR (K2 Athena) which will resolve many of the limitations of hand held records and provide the evidence required by this safety action.
Who and by when?	Audit to commence in February 2021 and facilitated by Medical Student or Obstetric Trainee. DONM will clarify the requirement from the Executive Team with regards to the audit detail.
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. The Trust believe we are compliant, and this can now be audited following the successful implantation of the K2 Athena system.

Evidence considered and is available for review and will be uploaded onto the evidence portal when available:

- **NICE annual report 2019/20**
- **Maternal medicine risks**
- **NMNS Annex D- Network submission**
- **NMMS- service specification**
- **Family Health Division Saving Babies Lives Action plan**
- **SBL Bi Annual Reports**
- **SBLCBv2 Quarterly Surveys.**

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.

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) 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.

What do we have in place currently to meet all requirements of IEA 5?	• **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** LWH are in the process of implementing Electronic Patient Records with the introduction of K2 Athena. The K2 Athena system went live on the 18th January 2021. Prior to the implementation of the K2 Athena formal assessments of risk were undertaken at booking, 36 weeks and the onset of labour or when women commence IOL, documented and recorded in the hand held maternity notes . An informal assessment has historically been completed at each antenatal visit but is inconsistently documented. With the implementation of the K2 Athena, a formal risk assessment will be completed at each antenatal contact allowing continued review of risk factors and escalation to the most appropriately trained professional as required and/or review of the intended place of birth. Once the system has been fully implemented audits are to be undertaken to provide assurance that these assessments are embedded into clinical practice. The Trust will commit to the implementation of the guideline for National Antenatal assessment risk process when this is finalised and released. When LWH is in receipt of this, it will be reviewed by the clinical teams and embedded in practice where appropriate. It is encouraging that The Trust Consultant Midwife has had early involvement in the development of this framework and will support its implementation in due course. • **Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.** Following the recommendations made by the 2018 Each Baby Counts report, HSIB Reports and as part of the Trust commitment to implement 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. This will be auditable through the recently implemented K2 Athena system. **Clinical Priority 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 (PCSP). Regular audit mechanisms are in place to assess PCSP compliance.** The personalised care and support plan are discussed at the booking appointment (choice of place of birth discussion) and have previously been documented within our electronic system (Meditech). Documentation of the PCSP will be with the K2 Athena system from the 18th of January. Risk assessment completed and recorded, place of birth discussion and audit in place to assess PSCP compliance. Current audit and review of the PCSP compliance is well embedded. Compliance is monitored by the Lead for Continuity of Care and is reported to the LMS on a monthly basis. This data is to be added to a performance dashboard enable review by the Family Health Division. The Cheshire & Merseyside Women and Children's Partnership are currently developing a supporting leaflet with regards to PCSP and information available to women. This will be adopted by LWH, incorporated in to the K2 Athena when finalised.
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. This is recorded and reported to the LMS. This will be added to a LWH performance dashboard – to be finalised and monitored through the FHD Board.
Where is this reported?	These figures are reported monthly to the LMS by the Continuity of Care Lead.
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 Athena electronic documentation system which went live on the 18th January 2021. An audit of these 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 Jan 2021, we will add to the second scope of work that documentation field at the end of every antenatal contact assessment, that includes intended place of birth in added. This assessment will then be electronically auditable. 3. Add PCSP figures to performance dashboard for Maternity oversight at Family Health Divisional Board.

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. Targets to be agreed as to percentage of women having risk assessments undertaken. 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. 3. PCSP figures to be added to performance dashboard for Maternity/FHD oversight.
What resources or support do we need?	Additional scoping of any further costs required for new work to be identified. The K2 digital midwife is currently in post and will oversee the new scope of work and the subsequent audit. We will need further support from our Information Team. We will need the ongoing support of the K2 Athena Implementation Team.
How will we mitigate risk in the short term?	These risk assessments are completed at every contact with a midwife. The process for documentation of these risk assessments is neither robust nor standardised. With the abolishment of hand held records and the implementation of K2 Athena, documentation that these risk assessments at each antenatal contact will be supported. 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 are currently documented in the paper maternity health records or on Meditech when telephone/virtual consultations take place.

Evidence considered and is available for review and will be uploaded onto the evidence portal when available :

- **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?	• **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 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. The Fetal Surveillance Midwife will utilise her knowledge and expertise in CTG interpretation to embed training, learning lessons from Maternity SIs where CTG interpretation has been a contributing factor. 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 Lead for SBL. The Trust has now also a named Consultant Lead for Fetal Surveillance and Well Being who will support the Fetal Surveillance Midwife. **Clinical Priority 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.** In addition to the fetal surveillance midwife, the Clinical Director for FHD has appointed a Consultant Obstetrician to work with the Midwife to deliver the expectations associated with this action. In addition to this, the Quality & Safety Midwife is the lead for SBLCBv2 and maintains a whole oversight and action plan for all the SBLCBv2. .
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 Evaluation forms to be developed and utilised at weekly CTG Review Sessions providing feedback on the effectiveness of the CTG Sessions.
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. Implement a plan to ensure that CTG Training continues in the case of Fetal Surveillance Midwife absence – Plan to be developed by Family Health Division.
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.

Evidence considered and available for review and will be uploaded onto the evidence portal when available

- Fetal Surveillance Midwife Job Description
- Training figures for K2 CTG Training Package.
- Saving Babies Lives Action Plan.

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?	• **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 the 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. • **Women must be enabled to participate equally in all decision-making processes and make informed choices about their care.** 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. Options for 'place of birth' are formally revisited at the midwifery 36-week assessment where this 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 that deviates from 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. • **Women's choices following a shared and informed decision-making process must be respected** The Trust recognises that women may choose to deviate from local and national guidance with respect to the choices they make about their care and pregnancy. Women who choose to deviate away from clinical guidance and protocol are offered a consultation with the Consultant MW or Obstetrician. Following this consultation and care plan reflecting the women's choices is created and shared with the multi-disciplinary team. Women are supported to receive care within a framework that meets their informed choices whilst ensuring care is delivered in safe and caring way. It is not a common phenomenon that women deviate from care pathways, evidence of where women have been supported in this way can be provided with individualised care plans. **Clinical Priority 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.** See narrative above.
Where and how often do we report this?	
How do we know that our processes are effective?	The Trust receives information via multiple sources including the Friends and Family Test, NHS surveys and PALS service within the Trust. This monitored by the Patient Experience Team and the Experience Senate, with actions formulated where concerns are identified. Positive feedback is disseminated to staff.
What further action do we need to take?	1. Undertake a full review all website information for patients to ensure all 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 Februaryy 2021
What resources or support do we need?	Internal resource: Clinical resources to support the updating of information. Administrative and IT support for the on going EPR, Internet and web based resources.
How will we mitigate risk in the short term?	Face to face interaction Review of the approach to trust wide information uploads.

Evidence considered and available for review and will be uploaded onto the evidence portal when available:

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?	**<u>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.</u>** 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 Trust Board in February 2021. 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. Birth Rate Plus was undertaken with a report received in July 2018. The funded establishment set for the 2020/21 was in line with Birth rate plus and the staffing was initially compliant in accordance with the identified establishment. The Birth rate plus assessment findings noted a shortfall in non-direct care giving staff given the size of the maternity service. LWH has recruited a Deputy Head of Midwifery and an additional maternity matron since the Birth rate plus assessment. Plans for 2021 include the recruitment of a second Consultant midwife with a lead and focus on Continuity of carer, additional midwifery resource within the education team and the permanent role of the fetal surveillance midwife. Monthly budget establishment meetings occur between finance and the maternity managers and matrons and continual review of staffing is undertaken. Maternity workforce is and reviews are included in the Bi Annual staffing paper presented to Trust Board. The monitoring and recognition of vacancies below Birthrate plus since budget setting have resulted in three successful recruitments in 2020, where 22.06 WTE midwives were appointed in totality due to unprecedented high levels of current and imminent maternity leave, staff leavers and retirements. A further recruitment is in progress. The current deficit in comparison to Birthrate plus findings as of the 31st January 2021 is 4.66WTE midwives which if successfully recruited to will enable the staffing to comply with Birthrate plus and this years funded establishment. Maternity work force Gap analysis paper undertaken and submitted to the Trust Board in February 2021. 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. **<u>CNST Workforce Analysis: Obstetric Medical, Neonatal Medical and Anaesthetic Medical Workforce.</u>** - 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.

How have we assured that our plans are robust and realistic?	Family Health Divisional Board sign off Director of Nursing and Midwifery sign off. Monitored monthly at Divisional performance reviews with KPI's. Benchmark against agreed national standards. Bi- Annual Staffing paper to Putting People First Committee and Trust 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. Monthly establishment meetings with maternity management and finance to enable monitoring of current vacancies and projected deficits in staffing. Vacancies discussed at Divisional board and submitted via the Trust vacancy control panel with executive sign off and agreement for recruitment.
What further action do we need to take?	Continued monitoring of monthly funded staffing establishment by maternity management and finance. Vacancies and deficits in staffing discussed at Divisional Board with vacancies submitted via the Trust vacancy control panel with Executive sign off for agreement for recruitment. Further recruitment currently in progress. The current deficit in comparison to Birthrate plus findings, as of the 31st January 2021 is 4.66WTE midwives. If successfully recruited to will enable the staffing to comply with Birth-rate plus and this years funded establishment. Recruitment of a second Consultant Midwife with a lead and focus on Continuity of Carer Further additional midwifery resource within the Maternity Education Team Permanent role of the Fetal Surveillance Midwife. Maternity work force Gap analysis paper undertaken and submitted to the Trust Board in February 2021. Consideration for a further Birthrate plus assessment. The funded establishment set for the 2020/21 was set in line with a Birth rate plus refresh assessment in 2018 against 8200 births. Due to significant clinical changes within the Maternity service, a reduction in bookings and births and increased activity with the Maternity Assessment Unit; Birth rate plus has been contacted by the Deputy Head of Midwifery in relation to undertaking a full Birth rate assessment as soon as possible in 2021. This full assessment will enable analysis of current activity aligned to required staffing and will include the introduction of current Continuity of Carer teams and projections for proposed staffing as the Maternity service continue to introduce additional continuity of carer teams and safe levels of core staffing based on activity and acuity. The costings have been received and submitted to the Director of Nursing and Midwifery and Deputy Director of Finance for consideration and action if approval given.
Who and by when?	Job Description required for Consultant Midwife role to be completed February 2021. Head of Operations for Family Health and Head of Midwifery. Executive approval for recruitment of a second Consultant Midwife with a lead and focus on Continuity of Carer, additional midwifery resource within the education team and the permanent role of the fetal surveillance midwife. To be agreed in February 2021 Executive approval to commence a full Birth rate plus assessment. February 2021 Assessment would be undertaken by Birth-rate plus. Contact has been made with Birth-rate plus by the Deputy Head of Midwifery and costings received. Once agreement given to undertake the assessment Birthrate plus will be able to formally clarify their availability to undertake an assessment which is anticipated to be early summer
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. Birth rate plus has advised a minimum of 0.6 WTE midwife would be required for a least 3 months in order to provide the required data.
How will we mitigate risk in the short term?	Workforce planning constantly under review by The Trust and the Family Health Division. The current vacancies aligned to the funded establishment are 4.66WTE midwives and recruitment is in progress, however the Maternity service is currently experiencing high levels of sickness which are predominantly due to long term sickness and the effects of the COVID pandemic with a direct effect on the daily staffing levels. The Maternity service continually works alongside HR to ensure sickness management is undertaken in line with Trust policy. Use of bank hours is undertaken to fill gaps in rotas due to sickness and the maternity escalation policy is utilised accordingly

Evidence considered and is available for review:

- **Anaesthetic Medical workforce review**
- **CNST neonatal medical workforce review**
- **Covid impact regarding medical workforce for Obstetrics and Neonates**
- **Maternity Bi Annual staffing paper December 2020**
- **Maternity workforce gap analysis paper January 2021**

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

Strengthening Midwifery Leadership: A Manifesto for better maternity care was produced by the Royal College of Midwives in August 2019. This manifesto laid out seven steps to strengthening midwifery leadership:

Liverpool Women's Trust has appointed a Director of Nursing & Midwifery who commenced in post on the on 1st January 2021. The post holder is a RGN & RM and has within the job description and portfolio the responsibility for the strategic development, planning, leadership, advice and to act as an advocate for women including the expert voice of the patient. The Head of Midwifery focuses on the operational delivery and supports the Director of Nursing and Midwifery to deliver the wider elements of the role. The Head of Midwifery is accountable to the Director of Nursing and Midwifery. The post older is located within a Division and is supported by Operational Lead and a Clinical Lead.

The Family Health Division have plans to recruit an additional Consultant midwife to the Maternity service to support and lead on the Continuity of Carer initiative, this is in addition to the already in post Consultant Midwife for Low Risk Midwifery Care.

The Trust has several specialist midwifery roles throughout the organisation:

- Perinatal Mental Health Midwife with additional 0.4 WTE support seconded into this service due to current activity - which requires review to determine additional level of support required in this service..
- Dedicated Safeguarding Team and Safeguarding Midwives
- Honeysuckle Bereavement Service, contains two Midwives and administrative support
- Infant Feeding Team Midwife Lead 1.0 WTE, supported by BAMBIS Infant Feeding Team.
- Uro-Dynamic Midwife provides support to the Trust Uro-Dynamic Service and provide a FGM Service.
- The Maternity Education Team currently consists of 1.4 WTE midwives and 1.0 WTE seconded Fetal Surveillance Midwife. Plans for 2021 are for the fetal surveillance role to be permanent role and an additional 1 WTE midwife to be appointed to the education team.
- Antenatal Screening Co-ordinator.
- Research Midwives (not within FHD establishment)
- Infection Control Specialist Midwife
- Fetal Centre Specialist Midwives including Multiple Pregnancy Support Midwives.

Within the FHD there are Four Maternity Matrons, two of whom have attended the Aspiring Head of Midwifery Programme, all of whom have also attended leadership and managerial courses both in house and externally. There are six Band 7 Managers who provide managerial support in ANC/Fetal centre, High Risk Intrapartum, Low Risk Intrapartum, Community and postnatal care. Band 7 midwives have attended leadership programmes that include developing, mentoring, and coaching including the Mary Seacole programme.

There is currently no midwifery specialist roles for providing support to women with Substance misuse, SGA/FGR (GROW), Diabetes or Smoking.

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 co-ordinated centrally through our Clinical Audit and Effectiveness Team who support the Effectiveness Leads (Consultants) within the Divisions to undertake a review of the NICE 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. All Maternity Guidelines go through a robust ratification process with Multi-Disciplinary Team allowing discussion for deviations from NICE and inclusion of non evidence based guidance with appropriate clinical justification. . It is recognised that variations from NICE Guidelines may be required due to clinical situations and the tertiary level patients under the care of LWH.
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 is received by 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?	The Obstetric Clinical Lead for Effectiveness senate will undertake a formal review of all maternity guidelines to ensure that evidence is available where deviations from guidelines exist for clinical purposes. This will enable to the Trust to take assurance that all clinical deviations from NICE Guidance are justified and evidenced.
Who and by when?	Consultant Lead for Effectiveness will undertake a review and aim to be completed May 2021.
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?	The established process for the regular review of clinical guidelines through Effectiveness Senate and following RCOG recommendations will continue.

Appendix 2

Maternity Staffing Gap Analysis – January 2021

Introduction.

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. The report described important findings from the significant concerns raised from these reviews and their associated actions for all Maternity Units in England.

NHS England requested that maternity services implement all 7 Immediate and Essential Actions (IEAs) described in the document and identified 12 urgent clinical priorities from these 7 IEAs.
LWH reviewed evidence of compliance with the 12 urgent clinical priorities and assurance was submitted to the Local Maternity System (LMS) on Friday 18 December 2020. Out of the 12 urgent clinical priorities LWH rated 6 as partially compliant and 6 as fully compliant.

Following review of the regional submissions further evidence has been requested from NHSEI and an Assurance Assessment Tool requires completion and submission to the LMS by the 8th February 2021.

One element of this evidence is the requirement to undertake a maternity work force gap analysis and 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.

Gap Analysis
Liverpool Women's commissioned Birth rate plus to undertake a systematic assessment of workforce requirements and received the report in July 2018.

The analysis received was based on 8200 births and utilising an uplift of 21.4%. 67.8% of the births were identified as be category lV and V representing the highest level of care required and is reflective of the increased caesarean section, induction of labour rates, complexities of the women receiving maternity care within LWH and being a tertiary referral Maternity service.

The assessment identified that the Maternity service required 313.34 WTE direct care staff for the core maternity areas of Delivery suite, MLU, MAU, ANC including the fetal medicine unit, community midwifery and the Maternity ward including midwifery hours needed to undertake Examination of the Newborn assessments.

Birth rate plus methodology in the calculation of total clinical establishments does not include the following midwifery roles:

- Head of Midwifery & Matrons.
- Midwifery Practice Development roles
- Clinical Governance role
- Midwifery input towards Baby Friendly Initiative.
- Additional hours for antenatal screening over & above the time provided in actual clinics
- Coordination for such work as Safeguarding Children
- Any PMAs (A-Equip)

The assessment findings noted that there appeared to be a significant shortfall in non-direct care giving staff given the size of the maternity service at Liverpool Women's hospital, and also in comparison to organisations of a similar size. Since receipt of the report, LWH has made several additions to the non-direct clinical care roles which included

the Deputy Head of Midwifery and an additional maternity matron. Plans for 2021 include the recruitment of a second Consultant midwife with a lead and focus on Continuity of carer, additional midwifery resource within the education team and the permanent role of the fetal surveillance midwife.

The funded establishment set for the 2020/21 was in line with Birth rate plus and which additionally included the Non direct clinical care midwifery roles, Band 2 Health care support workers, Housekeepers and administration staffing WTE requirements.

Since the finalisation of budget setting in March 2020, 2.76 WTE midwives were appointed in June 2020. The Maternity service subsequently experienced an unprecedented high level of maternity leave and recruitment was approved and interviews undertaken on 25th August where 11.22 WTE midwives were appointed who commenced substantive employment in September/ October 2020.

A further recruitment for 9.19 WTE was undertaken on 17th November 2020 due to leavers and retirements. 9.05 WTE midwives were appointed with 1.84WTE midwives commencing in January 2021, 0.92 commencing in Feb and the remainder due to commence early March 2021. 0.96 WTE withdrew in January 2021 at short notice and the 0.14 under recruitment totalled a remaining vacancy of 1.06.

Further recruitment is currently in progress for 4.66 WTE midwives that includes 1.06 WTE from the previous under recruitment and new vacancies which if staff are appointed fully will achieve the funded midwifery establishment 20/21 in line with Birthrate plus recommendations.

Throughout 2020, reviews of the health care support care staff have been undertaken to ensure that the appropriate Band 2 and Band 3 staff are aligned to the appropriate clinical areas specific and dependent to their job descriptions and to enable the required midwifery to support staff ratios in the non-intrapartum areas. Work will be undertaken in early 2021 to review the roles of the 5.03 WTE Band 4 support staff roles. Recruitment to Band 3 staff is currently in progress.

The midwifery workforce bi- annual review has been completed and is included in the Trust wide bi-annual staffing paper which has been presented to Putting People First Committee on 25th January and subsequently to the Trust Board in February 2021.

The Maternity service is currently experiencing high levels of sickness which are predominantly due to long term sickness and the effects of the COVID pandemic that are currently affecting the daily staffing levels.

Conclusion

For the financial year 2020/21, the establishment budget was set in line with the Birthrate plus recommendations and the staffing initially compliant in accordance with the identified establishment.

The Birth rate plus assessment findings noted a shortfall in non-direct care giving staff given the size of the maternity service. LWH has recruited a Deputy Head of Midwifery and an additional maternity matron since the Birth rate plus assessment. Plans for 2021 include the recruitment of a second Consultant midwife with a lead and focus on Continuity of carer, additional midwifery resource within the education team and the permanent role of the fetal surveillance midwife.

Monthly budget establishment meetings occur between finance and the maternity managers and matrons and continual review of staffing is undertaken. Maternity workforce is and reviews are included in the Bi Annual staffing paper presented to Trust Board.

The monitoring and recognition of vacancies below Birthrate plus since budget setting have resulted in three successful recruitments in 2020, where 22.06 WTE midwives were appointed in totality due to unprecedented high levels of current and imminent maternity leave, staff leavers and retirements. A further recruitment is in progress. The current deficit in comparison to Birthrate plus findings as of the 31st January 2021 is 4.66WTE midwives which if successfully recruited to will enable the staffing to comply with Birthrate plus and align to this years funded establishment

The Maternity service is currently experiencing high levels of sickness predominantly due to long term sickness and the effects of the COVID pandemic. The Maternity service continually works alongside HR to ensure sickness management is undertaken in line with Trust policy. Use of bank hours is undertaken to fill gaps in rotas due to sickness and the maternity escalation policy is utilised accordingly

Issues for Consideration

The funded establishment set for the 2020/21 was set in line with the Birth rate plus 2018 refresh assessment against 8200 births. Due to significant clinical changes within the Maternity service, a reduction in bookings and births and increased activity with the Maternity assessment Unit; Birth rate plus has been contacted by the Deputy Head of Midwifery in relation to undertaking a full Birth rate assessment as soon as possible in 2021. A quotation for a full assessment has been received at a cost of £9,800.00 inclusive of all expenses; and exclusive of VAT. This full assessment will enable analysis of current activity aligned to required staffing and will include the introduction of current Continuity of carer teams and projections for proposed staffing as the Maternity service continues to introduce additional continuity of carer teams and safe levels of core staffing based on activity and acuity.

The costings have been received and submitted to the Director of Nursing and Midwifery and Deputy Director of Finance for consideration and action if approved.

Agenda Item	2020/20/271

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Safer Nurse/Midwife Staffing Report, M8 & 9 2020/21**
DATE OF MEETING:	4th February 2021
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	Marie Forshaw, Director of Nursing and Midwifery
AUTHOR(S):	Janet Brennan, Deputy Director of Nursing and Midwifery
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** 1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☐ 2. To be ambitious and *efficient* and make the best use of available resource ☐ 3. To deliver *safe* services ☒ 4. To participate in high quality research and to deliver the most *effective* Outcomes ☐ 5. To deliver the best possible *experience* for patients and staff ☐
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust* ☒ ***2.*** *The Trust is not financially sustainable beyond the current financial year* ☐ ***3.*** *Failure to deliver the annual financial plan* ☐ ***4.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision* ☐ ***5.*** *Ineffective understanding and learning following significant events* ☐ ***6.*** *Inability to achieve and maintain regulatory compliance, performance and assurance* ☒ ***7.*** *Inability to deliver the best clinical outcomes for patients* ☒ ***8.*** *Poorly delivered positive experience for those engaging with our services* ☒
CQC DOMAIN	***Which Domain?*** ***SAFE-*** *People are protected from abuse and harm* ☐ ***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes,* ☐ *promotes a good quality of life and is based on the best available evidence.* ***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity* ☐ *and respect.* ***RESPONSIVE –*** *the services meet people's needs* ☐ ***WELL-LED -*** *the leadership, management and governance of the* ☐ *organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.* ***ALL DOMAINS*** ☒
LINK TO TRUST STRATEGY, PLAN AND	**1.** Trust Constitution ☐ **4.** NHS Constitution ☐ **2.** Operational Plan ☐ **5.** Equality and Diversity ☐ **3.** NHS Compliance ☒ **6.** Other: **NHS England Compliance**

EXTERNAL REQUIREMENT		
FREEDOM OF INFORMATION (FOIA):	1. This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting	
RECOMMENDATION: *(eg: The Board/Committee is asked to:-….)*	The Board is asked to note: • The content of the report and be assured appropriate information is being provided to meet the national and local requirements • The organisation has the appropriate number of nursing & midwifery staff on its inpatient wards to manage the current clinical workload as assessed by the Director of Nursing & Midwifery • Staffing challenges relating to COVID-19 and the mitigating actions being put in place	
PREVIOUSLY CONSIDERED BY:	Committee name	Not Applicable Or type here if not on list: Click here to enter text.
	Date of meeting	

Executive Summary

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

The key areas to highlight for Month 8 & 9 are as follows:

- Fill rate is starting to fluctuate for Registered Nurses & Midwives.
- Gynaecology ward fill rates are lower in M8 & 9 (67 % and 68%) for Registered Nurses during the day due to vacancies., however the daily staffing huddle ensures appropriate staff are moved to support areas with staffing shortfalls.
- Absence continues to fluctuate. Total absence in December is 7.50% for Nursing and Midwifery. Covid-19 related absence is 2.18% for Nursing and Midwifery.
- Nursing and Midwifery vacancies are 5% - M9 which are in line with the previous 12 months but there is an increase in vacancies in Gynaecology. HR are working with the HON for Gynaecology to improve recruitment and retention.
- There were 8 red flags relating to staffing in Month 8 & 9. 3 relating to staffing shortages
- There are various staff support measures in place during Covid-19
- LWH is now part of an NHSE initiative working with a recruitment agency to support with HCSW recruitment.
- Vaccination of staff is ongoing.
- Plans to start lateral flow testing for women and support partners for FMU, EPAU and 12- and 20-week scans are in place which will require staffing support.

- Neonatal medical workforce staffing – The BAPM standards required to meet the optimal arrangements for neonatal intensive care medical staffing are in place at LWH and that there is no requirement for a Trust Board approved action plan.
- Neonatal nurse staffing - The majority of the BAPM standards are met, but this is in relation to cot side nursing and does not consider the other roles required within a tertiary service. It is recommended that another Band 7 is recruited within budget which is in progress.

Main Report

Introduction

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

Processes for monitoring safe staffing and escalating issues

- Daily Staffing Huddle – There are twice daily staffing huddles with representatives from all divisions. The purpose of these huddles is to ensure safe staffing across the Trust and appropriate escalation as required.
- Staffing is monitored across maternity every 2 hours by the 104-bleep holder who has an overview of the whole of maternity service. Staff are moved between areas depending on activity. The Neo-natal unit uses an acuity model of staffing which is used every 12 hours.
- Each division undertake workforce reviews bi- annually which are signed off by the DONM. Competencies have now been developed for Nursing and Midwifery staff. A review has been undertaken of band 2,3 & 4 and will form part of the divisional workforce reviews in December. A skill set review is also being undertaken in each area to ensure those staff being required to rotate or work across areas have the necessary skills and training to do so.
- A review of the housekeeper role is about to be undertaken.
- There were 8 Red Flags reported, 3 relating to staffing. 2 in maternity and 1 in gynaecology. All resulting in no harm.

Safer staffing exception report

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

Fill rate fluctuates. Gynaecology RN fill rates are below 70% for day shifts which corresponds with their current vacancies. Their support worker rates are higher to support the shortfall in RN's. The twice daily staffing huddle supports the movement of staff to ensure each area is safe based on the acuity of each area.

Maternity fill rates have been variable with MLU having the lowest fill rate particularly in December. As part of maternity safer staffing the 104 bleep holder monitors staffing and acuity every 2 hours and staff are moved to support areas when required. Maternity have now filled all their vacancies following recent recruitment.

The Trust is now part of an NHSE initiative with Indeed recruitment agency to help support with HCSW

vacancies. LWH has been given 81k to support with this initiative.

Safer Staffing – Allied Health Professional (AHP)

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

AHP Staffing – overview and exceptions

- Sonographers – Currently 5.85 vacancies, shifts are being filled by staff doing bank shifts. There are 2 students who when qualify will fill 2 posts.
- Physiotherapy – Currently 2.03 vacancies.
- ODP's form part of the overall staffing for theatres. Currently there are 5 band 5 vacancies in theatre. As part of the theatre Quality improvement plan there has been a review of the leadership in theatres and a new model has been agreed by the theatre Executive Oversight committee. There are 2 ODP's in training. In view of the number of vacancies it is being explored if there are opportunities to accept more in training.

Neo-Natal staffing review

Medical

Following a Neo-natal medical staffing review (Appendix 2) assurance can be given that Liverpool Women's NHS Foundation Trust meets Safety Action 4 of the Maternity Incentive Scheme 2020 (aka CNST) with regards to Neonatal Medical Workforce.

Safety Action 4 – ''The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing. If this is not met an action plan to address deficiencies is in place and agreed at Board Level'.

The content of report details the standards required and its supporting evidence to meet the BAPM framework or neonatal medical staffing

It concludes that the BAPM standards required to meet the optimal arrangements for neonatal intensive care medical staffing are in place at LWH and that there is no requirement for a Trust Board approved action plan.

Neo-natal Nurse staffing

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

Impact of Covid-19

Twice weekly lateral flow testing has been rolled out to all staff across LWH on 19th November 2020. The impact of this is being monitored daily at the command meeting with an emphasis on those not completing their tests. Divisions have in place their business continuity plans if there is an increase in Covid -19 related absence.

The trust has rolled out vaccinations for the workforce.

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

- Staff Support Team

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

- Leader Support

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

- Staff Relaxation Areas

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

- Schwarz Rounds

The first round has taken place on 14th January, which was very well received

Mental Health First Aiders

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

- Resilience Sessions

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

Horizon Scanning and Forward Look

National information

There is no nationally agreed measure of the shortfall in the nursing and midwifery workforce in England, however, Health Education England state that there are circa 43 ,000 nursing vacancies and 2,500 midwives in the NHS in England.

Students continue with their placements. Third year nursing students and third year medical students can become part of the band 2/3 workforce as trusts require.

The main impact of Covid-19 has been on community placements due to the changes in service provision and car sharing.

Conclusion and Recommendation

- Fill rate is starting to fluctuate for Registered Nurses & Midwives.
- Gynaecology ward fill rates are lower in M8 & 9 (67 % and 68%) for Registered Nurses during the day due to vacancies., however the daily staffing huddle ensures appropriate staff are moved to support areas with staffing shortfalls.
- Absence continues to fluctuate. Total absence in December is 7.50% for Nursing and Midwifery. Covid-19 related absence is 2.18% for Nursing and Midwifery.
- Nursing and Midwifery vacancies are 5% - M9 which are in line with the previous 12 months but there is an increase in vacancies in Gynaecology. HR are working with the HON for Gynaecology to improve recruitment and retention.
- There were 8 red flags relating to staffing in Month 8 & 9. 3 relating to staffing shortages
- There are various staff support measures in place during Covid-19
- LWH is now part of an NHSE initiative working with a recruitment agency to support with HCSW recruitment.
- Vaccination of staff is ongoing.
- Plans to start lateral flow testing for women and support partners for FMU, EPAU and 12- and 20-week scans are in place which will require staffing support.
- Neonatal medical workforce staffing – The BAPM standards required to meet the optimal arrangements for neonatal intensive care medical staffing are in place at LWH and that there is no requirement for a Trust Board approved action plan.
- Neonatal nurse staffing - The majority of the BAPM standards are met, but this is in relation to cot side nursing and does not consider the other roles required within a tertiary service. It is recommended that another Band 7 is recruited within budget which is in progress.

The Board is asked to note:

- The content of the report and be assured appropriate information is being provided to meet the national and local requirements.
- The organisation has the appropriate number of nursing & midwifery staff on its inpatient wards to manage the current clinical workload as assessed by the Director of Nursing & Midwifery
- Staffing challenges relating to COVID-19 and the mitigating actions being put in place
- The Neonatal medical and nursing workforce meet the requirements of CNST safety action 4 with no action plan required.

Appendix 1

Month 8

WARD	Fill Rate Day% RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff
Gynae Ward	67%	88%	92%	120%
Delivery suite	89%	90%	86%	88%
Mat Base/ Jeffcoate	88%	86%	94%	91%
MLU	93%	83%	83%	90%
Neo-nates	99%	58%	98%	87%
Transitional Care	52%	70%	100%	27%

Month 9

WARD	Fill Rate Day% RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff
Gynae Ward	68%	100%	92%	97%
Delivery suite	85%	97%	86%	81%
Mat Base/jeffcoate	83%	86%	88%	87%
MLU	75%	90%	79%	94%
Neo-nates	99%	65%	98%	76%
Transitional Care	126%	61%	135%	45%

APPENDIX 2

Introduction.

Now in its third year, the Maternity Incentive Scheme supports the delivery of safer maternity care through an incentive element to trusts contributions to the CNST. The scheme, rewards trusts that meet ten safety actions designed to improve the delivery of best practice in maternity and neonatal services.

In the third year, the scheme will further incentivise the ten maternity safety actions from the previous year with some further refinement. As part of the updated Maternity Incentive Scheme (aka CNST) 2020 a requirement of Safety Action 4 is that Trusts can demonstrate an effective system of clinical workforce planning to the required standards across Obstetrics, Anaesthesia, Midwifery, Neonatal Nursing and Neonatal Medical Workforces

Below, are the requirements, as referenced within the Maternity Incentive Scheme specifically for Neonatal Medical Workforces:

Revised safety actions - updated 30 September 2020

Safety action 4: Can you demonstrate an effective system of clinical* workforce planning to the required standard?

Neonatal medical workforce
• The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing. If this is not met, an action plan to address deficiencies is in place and agreed at board level

Neonatal medical workforce
The Trust is required to formally record in Trust Board minutes whether it meets the recommendations of the neonatal medical workforce training action. If the requirements are not met, an action plan should be developed to meet the recommendations and should be signed off by the Trust Board.

Neonatal medical workforce	
Six month period between Wednesday 1 January 2020 and Thursday 20 May 2021.	
Do you meet the BAPM national standards of junior medical staffing depending on unit designation?	If no, please submit a Trust board approved action plan to the Neonatal ODN. There should also be an indication whether the standards not being met is due to insufficient funded posts or no trainee or/suitable applicant for the post (rota gap). There should also be a record of the rota tier affected by the gaps.

The following information and narrative provides assurance that LWH meet the recommendations for both the BAPM standards and the requirements for the Maternity Incentive Scheme.

Compliance with BAPM Medical Staffing Standards for Maternity Incentive Scheme (CNST).

Reference is made to the current BAPM Framework for Practice:

"Optimal Arrangements for Neonatal Intensive Care Units in the UK including guidance on their Medical Staffing" (2014) https://www.bapm.org/resources/31-optimal-arrangements-for-neonatal-intensive-care-units-in-the-uk-2014

Adherence to the following criteria is made by reference to and evidenced by staffing rotas (Appendix 1) for the six-month period September 2020 – February 2021.

Criterion 3.2.1: Minimum NICU resident out-of-hours care should comprise one tier 1 clinician (ANNP/ST1-3 junior doctor), *and* a tier 2 clinician (appropriately-trained specialty doctor/ANNP/ST4-8 junior doctor.

*LWH Response - At Liverpool Women's Hospital NICU, out-of-hours staffing (*i.e. *beyond 1700, and overnight), there will be a minimum of two tier 2 clinicians (comprised of ST4-5 paediatric trainees, and Band 8 ANNPs/neonatal grid trainees) and two tier 1 clinicians (comprised of ST1-3 paediatric trainees/Band 7/8 ANNPs).*

No actions required to meet this standard: Fully Compliant

Criterion 3.2.3: NICUs with more than 2500 intensive care days *per annum* should double tier 2 cover at night by adding a second experienced junior doctor ST4-8 or appropriately trained specialty doctor or ANNP.

LWH Response: In view of intensive care days at Liverpool Women's Hospital NICU exceeding >2500 per annum *(~3500), the tier 2 cover has been accordingly doubled from the minimum outlined in criterion 3.2.1. (one tier 2 clinician out-of-hours) to that described above (two tier 2 clinicians).*

No actions required to meet this standard: Fully Compliant.

Criterion 3.2.4: NICUs co-located with a maternity service delivering more than 7000 deliveries per year should augment their tier 1 cover at night by adding a second junior doctor, an ANNP and/or by extending nurse practice.

In view of deliveries at Liverpool Women's Hospital exceeding ~8000 per annum*, the tier 1 cover has been accordingly doubled from the minimum outlined in criterion 3.2.1. (one tier 1 clinician out-of-hours) to that described above (two tier 1 clinicians).*

No actions required to meet this standard: Fully Compliant

Criterion 3.2.5: It is recommended that all NICUs seek to extend consultant presence on the unit to at least 12 hours per day.

LWH Response: At Liverpool Women's Hospital NICU, on-unit Consultant Neonatalogist presence is from 0815 (0830 weekends) until 2300.

No actions required to meet this standard: Fully Compliant.

Criterion 3.2.6: NICUs undertaking more than 4000 intensive care days *per annum* with onerous on call duties should consider having a Consultant present and immediately available 24 hours per day.

LWH Response: *Not currently applicable on the NICU at Liverpool Women's Hospital as NICU Intensive care days equal to 3,500.*

No actions required to meet this standard: Not applicable to LWH.

Criterion 3.2.7: NICUs undertaking more than 2500 intensive care days *per annum* should consider the presence of at least 2 consultant-led teams during normal daytime hours.

LWH Response: At Liverpool Women's Hospital NICU, care is delivered on a mixed acuity basis, where babies receiving intensive-level care are cared for in the same clinical area as those receiving high-dependency-level care. After progressing to special-level care, babies will be transferred to the adjacent Low Dependency Unit. In the mixed acuity area (capacity 24 cots), care is delivered by two consultant-led teams, with a third consultant leading on the Low Dependency Unit.

No actions required to meet this standard: Fully Compliant.

Criterion 3.2.8: NICUs undertaking more than 4000 intensive care days *per annum* should consider the presence of three consultant-led teams during normal daytime hours.

LWH Response: Not currently applicable on the NICU at Liverpool Women's Hospital.

No actions required to meet this standard: Not applicable to LWH.

Additional Evidence to Support Neonatal Medical Workforce Requirements.

In addition, reference is made to the 2010 document detailing: Service Standards for Hospitals Providing Neonatal Care, which provides additional guidance on medical staffing levels.

https://www.nna.org.uk/assets/bapm_standards_final_aug2010.pdf

Criterion 5.4.1: All staffing roles should be limited to neonatal care at all levels, i.e. no cross cover with general paediatrics.

It is anticipated that teams at each tier will be made up from the following groups:

• Tier 1: Staffing can be from paediatric ST1-3, ENNPs or ANNPs, specialty doctors.

• Tier 2: Staffing from paediatric ST4-8, specialty doctors, other non-training grade doctors, ANNPs (with appropriate additional skills and training), resident neonatal consultants.

• Tier 3: Consultant neonatologists. There will be 24/7 availability of a consultant neonatologist for Tier 3.

LWH Response: At Liverpool Women's Hospital NICU, all staff work solely on the neonatal unit, with no general paediatric service located on site.

Roles on the tier 1 rota are fulfilled by ST1-3 paediatric trainees, and Band 7/8 ANNPs.

*Roles on the tier 2 rota are fulfilled by ST4-5 paediatric trainees, and Band 8a ANNPs. Additionally, the rota is organised so that at all periods where a consultant is not required to be on-site (*i.e. *night shifts post-2300), the most senior clinician on site is a senior Band 8a+ ANNP or neonatal grid trainee.*

Tier 3 requirements : Consultant neonatologists are available for attendance 24/7/365, and will be physically on-site from 0815 (0830 at weekends/bank holidays) until 2300.

No actions required to meet this standard: Fully Compliant.

Criterion 5.4.2: Recommended numbers of staff for a Neonatal Intensive Care Unit:

• Tier 1: Separate neonatal rotas with a minimum of 8 staff.

• Tier 2: Separate neonatal rota with a minimum of 8 staff.

• Tier 3: A minimum of 7 consultants on the on call rota with resident consultants on the tier 2 rota additional to this number. All tier 3 consultants should be identified neonatal specialists.

LWH Response: The tier 1 rota in the specified period is comprised of 11 ST1-3 doctors, working 10.6 working time equivalents (WTE). Additionally, roles within the tier 1 rota are supplemented by a group of 10 junior ANNPs (9.92 WTE) who undertake the same roles across the neonatal unit, on a separate but complementary rota.

The tier 2 rota in the specified period is comprised of 9 ST4-5 doctors, working 7.0 WTE on a separate rota; and 2 neonatal grid trainees (1.2 WTE) and 14 senior ANNPs (12.45 WTE), who work on a pattern to enable the aforementioned experienced cover on nights

No actions required to meet this standard: Fully Compliant.

Criterion 5.4.3: For larger NICUs, special consideration should be given to the number of staff required at each tier throughout the 24 hours and giving due consideration to the time required at each handover. With increasing size, at some point, essentially the whole of the staffing structure described in 5.4.2 should be doubled.

LWH Response: In recognition of the number of cots and deliveries at Liverpool, as recommended by BAPM, the staffing levels have been essentially doubled from baseline, with 20.52 WTE tier 1 clinicians (ST1-3 doctors and Band 7/8a ANNPs); 20.65 WTE tier 2 clinicians (ST4-5 doctors, neonatal grid trainees and ANNPs), and 14 consultants.

No actions required to meet this standard: Fully Compliant.

Conclusion.

The neonatal medical workforce and the staffing of the neonatal unit complies with the BAPM standards.

The requirements for CNST 2020 are fully met and can be evidenced with rota spreadsheets.

There is no requirement for an action plan to be formulated and signed off by the Trust Board.

Agenda Item	20/21/272

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Bi-Annual Safer staffing paper Nursing and Midwifery**
DATE OF MEETING:	Thursday, 04 February 2021
ACTION REQUIRED	**Assurance**
EXECUTIVE DIRECTOR:	Marie Forshaw, Director of Nursing and Midwifery.
AUTHOR(S):	Janet Brennan, DDONM
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** 1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☒ 2. To be ambitious and *efficient* and make the best use of available resource ☒ 3. To deliver *safe* services ☒ 4. To participate in high quality research and to deliver the most *effective* Outcomes ☐ 5. To deliver the best possible *experience* for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust…….* ☐ ***2.*** *Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have sufficient numbers of clinical staff with the capability and capacity to deliver the best care. ……* ☒ ***3.*** *The Trust is not financially sustainable beyond the current financial year……* ☐ ***4.*** *Failure to deliver the annual financial plan ……* ☐ ***5.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision ……* ☐ ***6.*** *Ineffective understanding and learning following significant events……* ☐ ***7.*** *Inability to achieve and maintain regulatory compliance, performance and assurance……* ☒ ***8.*** *Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) ……* ☐
CQC DOMAIN	***Which Domain?*** ***SAFE-*** *People are protected from abuse and harm* ☐ ***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☐ ***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☐ ***RESPONSIVE –*** *the services meet people's needs.* ☐ ***WELL-LED -*** *the leadership, management and governance of the* ☐

	organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture. ***ALL DOMAINS*** ☒			
LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution	☒	**4.** NHS Constitution	☐
	2. Operational Plan	☐	**5.** Equality and Diversity	☐
	3. NHS Compliance	☒	***6.*** Other: Click here to enter text.	
FREEDOM OF INFORMATION (FOIA):	3. This report will not be published under the Trust's Publication Scheme due to exemptions under S22 of the Freedom of Information Act 2000, because the information contained is intended for future publication			
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	The Board of Directors is asked to: 1. *Accept the assurance of the current nurse/ midwife staffing levels* 2. *Note the content of the report and the assurances provided that nurse/midwife staffing levels are safe and appropriate at present.* 3. *Note the risk to the organisation of the number of nursing and midwifery staff > 50 years of age.* 4. *Be cited on the national shortage of nurses and midwives.*			
PREVIOUSLY CONSIDERED BY:	**Committee name**		PPF	
	Date of meeting		Monday, 25 January 2021	

Executive Summary

The bi-annual Nursing and Midwifery staffing report is provided to the Board of Directors through the Putting People First (PPF) Committee. The report sets out the LWH position in the context of the National Nursing and Midwifery workforce challenges. This report covers the period from June 2020 to December 2020. The report provides assurance that there are robust systems and processes in place throughout the year to monitor and manage nursing & midwifery staffing requirements. This report also includes AHP staffing. As part of this report a section on the impact on staffing of COVID- 19 is also included.

The report has been presented and discussed at Putting People First Committee (PPF) where the key issues reported were:

- Sickness rates were discussed as part of another workforce report to PPF
- 32% of registered nurses and midwives ae over 50 years of age
- Turnover rates are at 9% however to note gynaecology is at 11%
- LWH supports 122 midwifery students as the home trust and supports ODP, Physio and nursing students
- Actual versus planned staffing shows: Fill rate has fluctuated over the last 6 months, with some figures being skewed by COVID-19 and changes in services. (Appendix 1).
- Vacancy rates are below the national picture. National (11.6%) Cheshire and Mersey (9.3%) LWH (5%) for Registered Nurses and Midwives. The vacancy rate has increased from previous reports.
- The Age profile for LWH is 32 % of the Nursing and Midwifery workforce are > 50 years of age. This remains the same as the previous report.

- LWH are part of a national programme which supports HCSW recruitment and retention.
- Staff have worked flexibly during the pandemic and supported each area as required daily.

PPF acknowledged the reference to other workforce reports (sickness) but advised that more triangulation was required with patient experience and patient feedback which will be part of the report going forward.

Report

1.0 Introduction

Getting the right numbers of nurses, midwives and care staff in place is essential for the delivery of safe and effective patient care. It is a requirement for the Executive Nurse Director, on behalf of the Board of Directors to review the nursing and midwifery staffing numbers twice per year.

NHSI have developed recommendations to support Trusts in making informed, safe and sustainable workforce decisions (October 2018). The document builds on the National Quality Board's (NQB) guidance (2013, 2016). NQB's guidance states that providers:

- Must deploy sufficient suitable qualified competent, skilled and experienced staff to meet the care and treatment needs safely and effectively.
- Should have a systematic approach to determining the number of staff and range of skills required to meet the needs of the people using the service and keep them safe at all times.
- Must use an approach that reflects current legislation and guidance where it is available.

In 2017 the NQB published an improvement resource to achieve safe, sustainable and productive staffing of maternity services. The guidance endorses Birth-rate plus as a tool to ensure staff are deployed in the right place whilst NICE guidance supports 1:1 care in labour.

In March 2020 the National Audit Office provided a report to The Department of Health and Social Care on the NHS Nursing workforce.

LWH reports the following in line with NQB recommendations:

- 6 monthly Trust Board report: Bi- annual Nursing & Midwifery Staffing Review.
- Monthly Board level reporting detailing planned and actual staffing for the previous month, including the impact of COVID-19.
- Monthly staffing report to Unify (paused initially during the COVID-19 pandemic) and published on the Trust's website, and the NHS Choices website.
- Nursing/ Midwifery staffing levels each shift (planned and actual) displayed at ward level.
- Evidence based tools, professional judgement and outcomes are used in the safe staffing processes.
- Updated annual workforce plan that is signed off by the Executives.
- Any service change, including skill mix change has a full quality impact assessment review signed off by the DONM and MD.

1.1 This bi-annual comprehensive report is provided to the Board of Directors on Nursing and Midwifery staffing. The report details the Trust's position against the requirements of the National Institute of Health Care Excellence (NICE) guidance for adult wards issues in July 2014, the National Quality Board (NQB) Safer Staffing Guidance 2016 and the NQB speciality staffing improvement guidance documents published by NHSI in January 2018.

1.2 The report will provide analysis of the Trusts workforce position at the end of December 2020 and the actions being taken to mitigate and reduce the vacant position.

1.3 Workforce planning is currently being undertaken prior to budget setting by each division and each. This will be signed off by the Executive team.

1.4 Each Division has undertaken a review of their workforce.

1.5 The staffing and acuity measures are modelled based on activity and professional judgement. Birth- rate plus and professional judgements are used to determine appropriate midwifery staffing. In addition, the maternity delivery suite utilises an acuity tool every two hours to assist with staffing. Following the initial findings of the Ockenden Report a gap analysis of the maternity workforce is required to be reported to Board.

1.6 The Neo-natal unit utilises an acuity model of staffing, which is reviewed 12 hourly and staffing flexed in accordance with patient need. British Association of Perinatal Medicine (BAPM) standards have been utilised to provide the benchmark for staffing within the Neo-natal Unit. Theatre staffing review is based on AFPP (Association of peri-operative practitioners) guidelines. The SCNT (Safe care Nursing tool) which is a measure of acuity is unable to provide an accurate measurement of acuity in Gynaecology due to the mix of day-case patients with in- Patients. The tool is not suitable for day- case patients.

1.7 In the review of establishments, the ongoing monitoring of nursing and midwifery quality indicators, red flags, patient survey results, friends and family feedback, reported incidents and complaints have all been considered to assess whether the nursing and midwifery needs of patients are being met. These are presented monthly at Board and relevant senates and demonstrate good compliance.

1.8 The introduction of LWH accreditation across 5 areas in April 2020(Maternity Base, Gynaecology Ward, Neo-nates, Delivery and MLU) reviews staffing as part of the accreditation process. These 5 areas have been re- accredited at the end of 2020. Six other areas (GED, OPD, Hewitt, Knutsford, Bedford and LWH and Theatres have started audits as part of the accreditation programme and will be fully accredited in February/ March 2021. Roll out of accreditation is on track to be completed by end of 2021.

2.0 National Context

2.1 The shortfall in nurse numbers and midwives across the UK is well- recognised. Although there is no nationally agreed measure of the shortfall in the nursing in England, recent figures presented by National Audit office- September 2019 data (March 2020 report) suggest the number is 43,590 vacancies (12%). The national midwife shortage continues, with the NHS in England short of the equivalent of almost 2,500 full-time midwives. That is according to the latest RCM analysis of birth figures published in June 2020 by the Office for National Statistics (ONS).

2.2 There has been a 20% increase in nurses and midwives leaving the profession; The National Audit office report (March 2020) stated that between September 2017 and September 2018, 31, 000 nurses left the NHS, compared to a similar number who joined. In September 2020 the CNO for England announced funding available to restart the international nurse recruitment following a pause during COVID-19 and to fund significant expansion. Out of the 13,000 nurses and midwives who had signed up to the temporary coronavirus register 6000 had completed the checks to practice.

2.3 Despite the government's efforts to increase the number of nurses and AHP's in training by up to 10,000 success has yet to be seen. The number of applicants fell by 21% in 2017. Since 2017 the number of nursing places have not increased as anticipated. (National Audit office- March 2020). The Government have committed to train 3,000 more midwives in England over the next three years, and hundreds of extra student midwives began their training in 2019.

2.4 The people plan sets out areas of focus for the future nursing and midwifery workforce which includes:

- Increasing the pipeline supply
- Reducing vacancies (target 5% by 2028)
- Career development and progression
- Expanding the nursing workforce (including nursing associate role and International Recruitment)

2.5 HEE modelling forecasts that approximately 41,000 nurses or 13% of the workforce, will retire between 2018 and 2024.

2.6 Nationally the proportion of midwives in their fifties and sixties (with a handful in their seventies) is 32%.

2.7 Cheshire and Mersey Vacancy position is 9.5% and the national position is 11.6%.

2.8 The NHS people plan recognises the significant shortfalls in nursing and midwifery and has put in a number of actions to enable the NHS to grow the nursing workforce by >40,000 by 2024 and reducing vacancy levels to 5% by 2028.

3.0 LWH Nursing and Midwifery Workforce position

3.1 At the end of November 2020 there were a total of 31.46 wte registered nursing, midwifery, and ODP vacancies across LWH. With a vacancy rate of 5% compared to Cheshire and Mersey (9.5%) and the national picture (11.6%) This is an increase of 2% from the previous report.

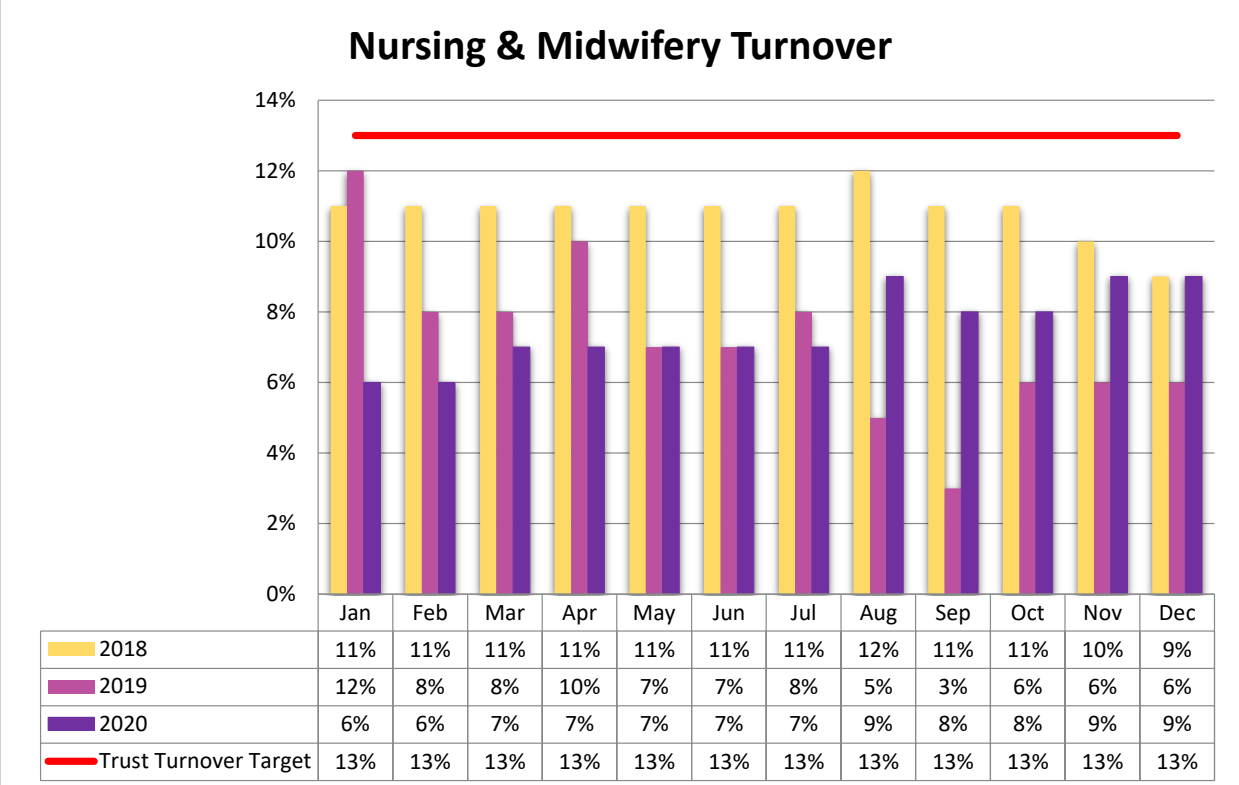
3.2 The tables below illustrate the vacancies (finance data), by division (December 2020).

RN&M / ODP vacancies	Establishment	In Post	Vacancies	Vacancy rate %
Maternity	288.62	284.72	3.9	1%
Gynaecology	103.7	97.05	6.65	6%
Neonates	175.63	159.08	16.55	9%
Hewitt	33.36	31.91	1.45	4%
Genetics	11.4	9.6	1.8	16%
Theatres	59.26	54.25	5.01	8%
Total	**671.97**	**636.61**	**35.36**	**5%**

HCSW vacancies	Establishment	In Post	Vacancies	Vacancy rate %
Maternity	80.98	63.36	17.62	22%
Gynaecology	43.39	39.76	3.63	8%
Neonates	19.42	13.03	6.39	33%
Hewitt	13.48	9.72	3.76	28%
Genetics	0	0	0	0%
Theatres	22.72	16.49	6.23	27%
Total	**179.99**	**142.36**	**37.63**	**21%**

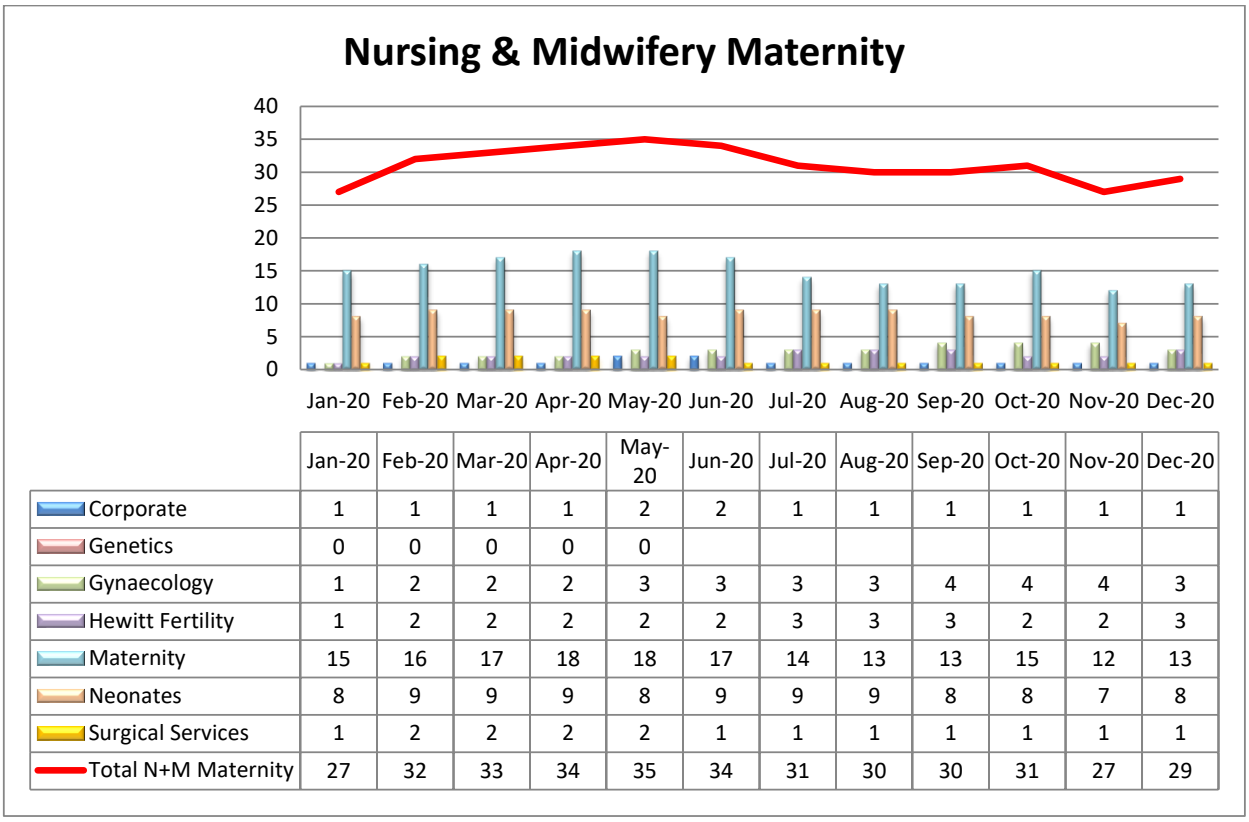
	Establishment	In Post	Vacancies	Vacancy rate %
Imaging	21.97	16.12	5.85	27%
Physio	5.62	3.59	2.03	36%

3.3 The table below demonstrates that Nursing and Midwifery turnover is 9 % at the end of December 2020 which has seen a gradual increase in the last 6 months.



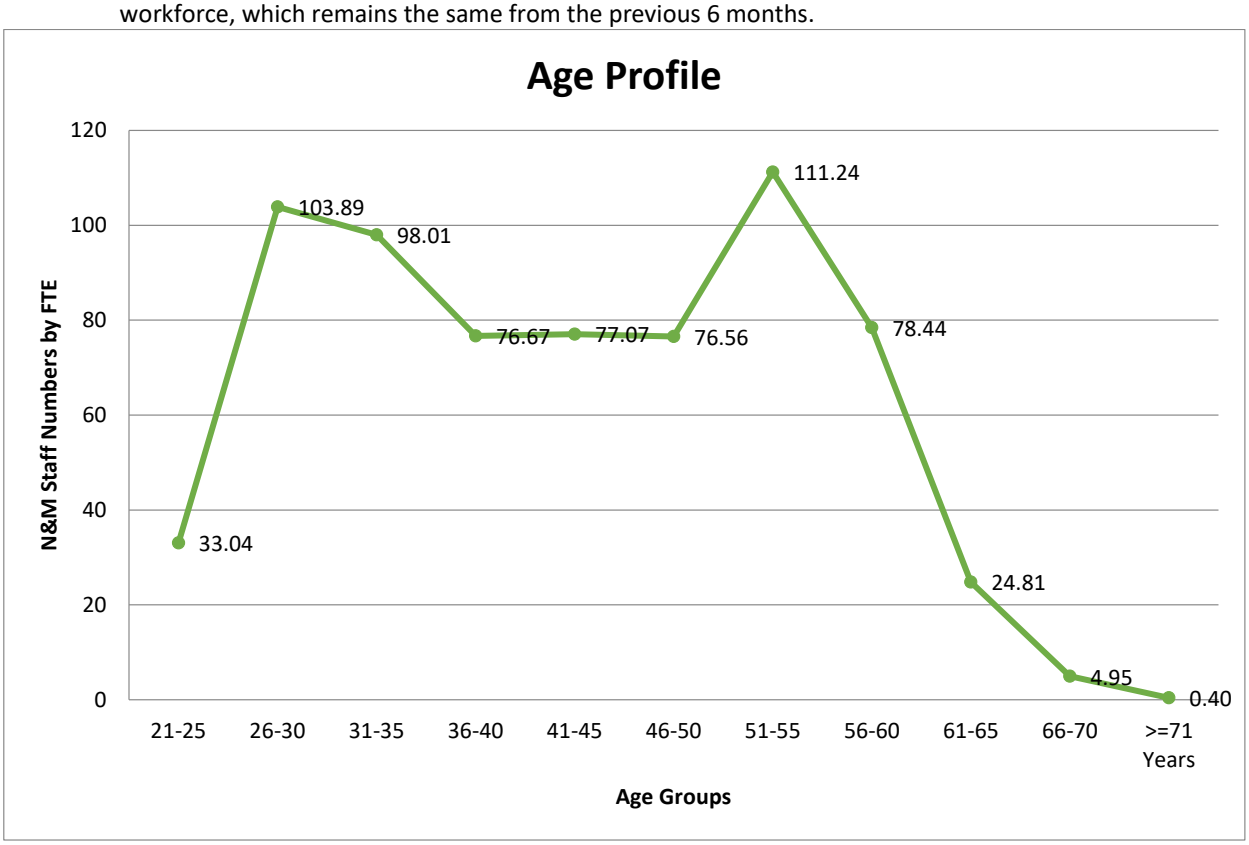
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2018	11%	11%	11%	11%	11%	11%	11%	12%	11%	11%	10%	9%
2019	12%	8%	8%	10%	7%	7%	8%	5%	3%	6%	6%	6%
2020	6%	6%	7%	7%	7%	7%	7%	9%	8%	8%	9%	9%
Trust Turnover Target	13%	13%	13%	13%	13%	13%	13%	13%	13%	13%	13%	13%

3.4 The graph below demonstrates a slight decrease in Maternity leave, Maternity leave is not funded in budgets but where possible maternity leave is recruited to, particularly in maternity who have the largest number on maternity leave.

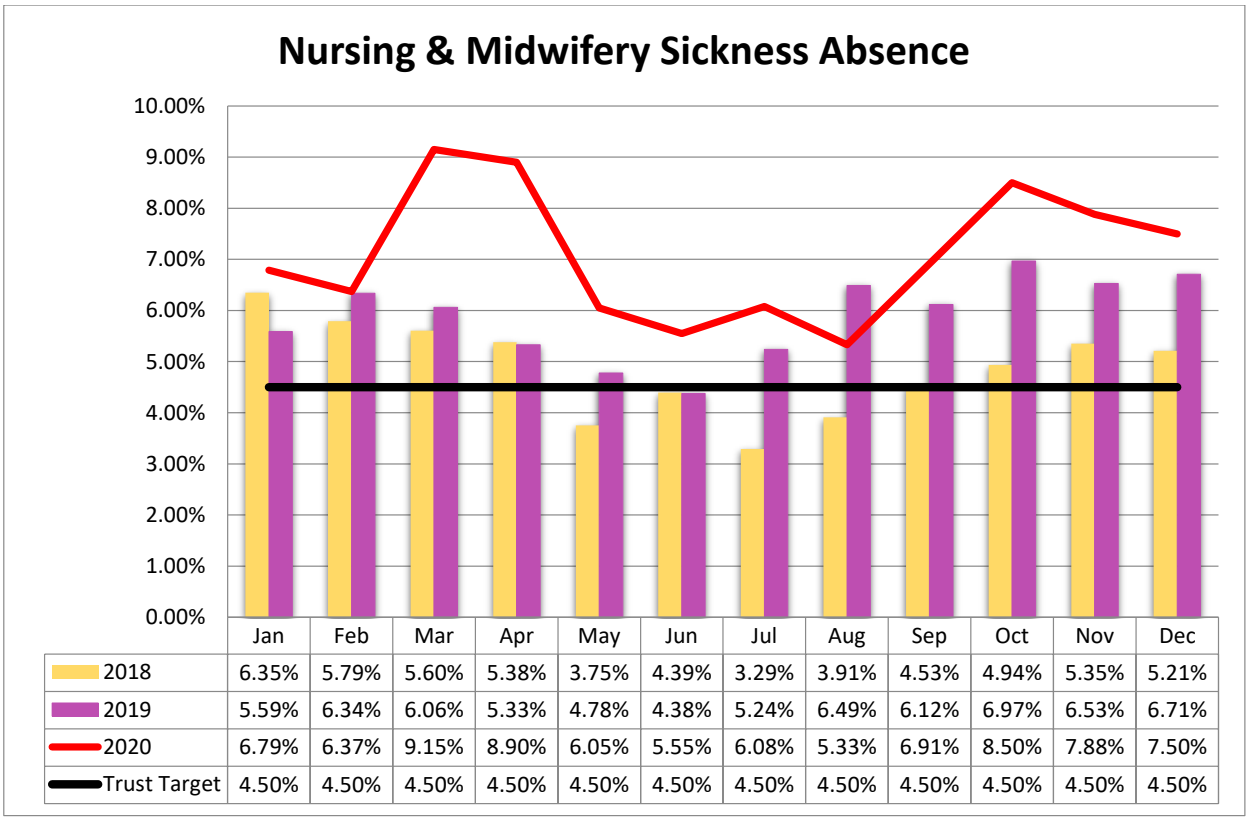


	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
Corporate	1	1	1	1	2	2	1	1	1	1	1	1
Genetics	0	0	0	0	0							
Gynaecology	1	2	2	2	3	3	3	3	4	4	4	3
Hewitt Fertility	1	2	2	2	2	2	3	3	3	2	2	3
Maternity	15	16	17	18	18	17	14	13	13	15	12	13
Neonates	8	9	9	9	8	9	9	9	8	8	7	8
Surgical Services	1	2	2	2	2	1	1	1	1	1	1	1
Total N+M Maternity	27	32	33	34	35	34	31	30	30	31	27	29

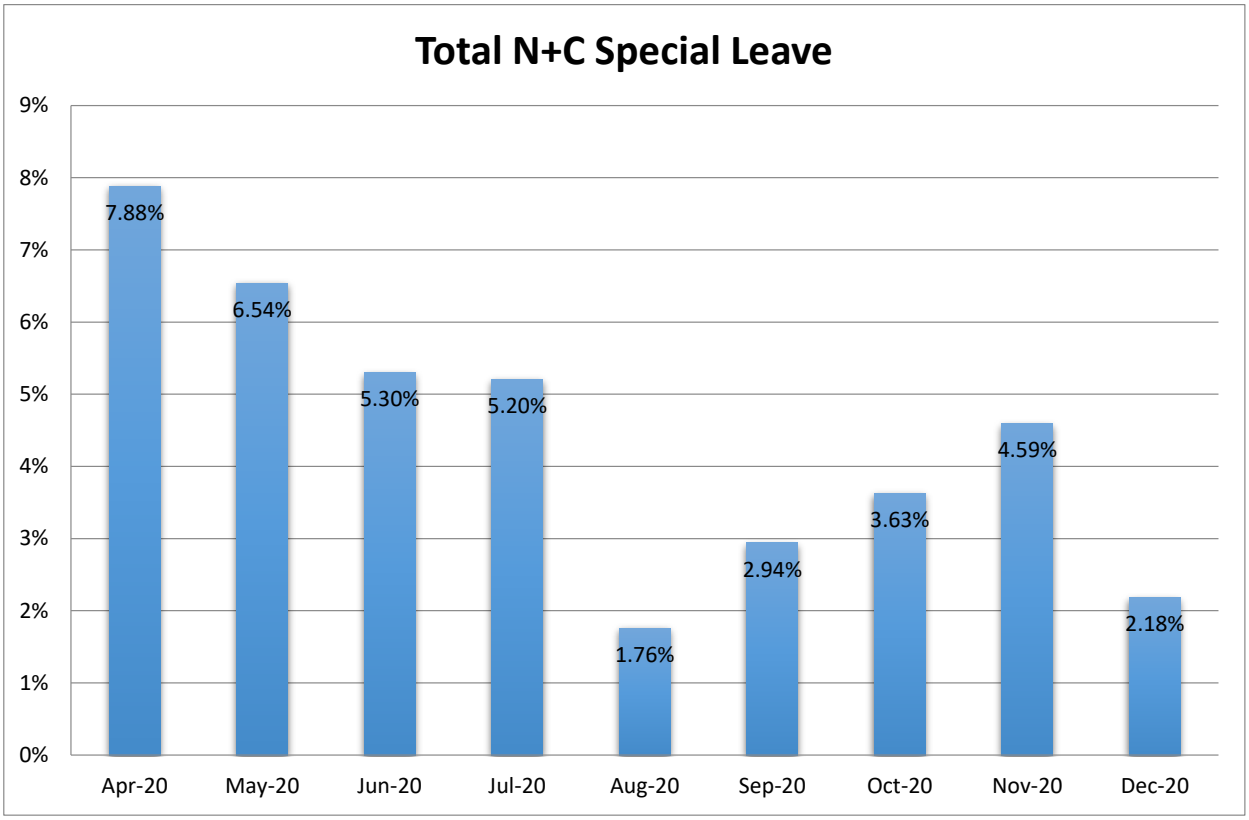
3.5 Age Profile - the graph below illustrates the age profile of Nurses and Midwives across LWH. 219.84 wte of our N&M workforce are >50 years of age which equates to 32% of LWH workforce, which remains the same from the previous 6 months.



3.6 Absence rate – including COVID-19 related and the third table shows N&M absences in December 2020 by short term and long-term sickness demonstrating a higher percentage of long-term sickness.



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2018	6.35%	5.79%	5.60%	5.38%	3.75%	4.39%	3.29%	3.91%	4.53%	4.94%	5.35%	5.21%
2019	5.59%	6.34%	6.06%	5.33%	4.78%	4.38%	5.24%	6.49%	6.12%	6.97%	6.53%	6.71%
2020	6.79%	6.37%	9.15%	8.90%	6.05%	5.55%	6.08%	5.33%	6.91%	8.50%	7.88%	7.50%
Trust Target	4.50%	4.50%	4.50%	4.50%	4.50%	4.50%	4.50%	4.50%	4.50%	4.50%	4.50%	4.50%



	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
	Absence %	Absence %	Absence %	Absence %	Absence %	Absence %	Absence %
159 Genetics L3	0.00%	0.00%	0.00%	0.00%	0.00%	3.47%	0.00%
159 Surgical Services L3	13.97%	14.12%	5.09%	2.59%	0.71%	10.20%	0.57%
159 Integrated Governance L3	4.82%	3.24%	0.00%	3.42%	8.36%	0.87%	0.00%
159 Maternity L3	5.42%	5.33%	1.68%	2.56%	3.42%	4.17%	1.81%
159 Neonates L3	5.05%	5.55%	2.71%	3.66%	4.29%	5.30%	3.24%
159 Gynaecology L3	3.15%	2.70%	0.08%	3.48%	2.83%	3.89%	2.42%
159 Hewitt Fertility L3	3.48%	1.89%	0.00%	2.83%	6.72%	3.27%	3.77%
Total N+C Special Leave	**5.30%**	**5.20%**	**1.76%**	**2.94%**	**3.63%**	**4.59%**	**2.18%**

	Short Term	Long Term
NMC Total	40%	60%

Org L2	Short Term	Long Term
159 Clinical Support Services L2	30%	70%
159 Corporate L2	100%	0%
159 Family Health L2	38%	62%
159 Gynaecology L2	51%	49%
159 Operational Support Services L2	0%	0%

Org L3	Short Term	Long Term
159 Genetics L3	0%	100%
159 Imaging L3	100%	0%
159 Surgical Services L3	32%	68%
159 Integrated Governance L3	100%	0%
159 Maternity L3	31%	69%
159 Neonates L3	56%	44%
159 Gynaecology L3	68%	32%
159 Hewitt Fertility L3	13%	87%
159 Operational Support Services L3	0%	0%

4.0 Summary of outcomes from Divisional reviews.

4.1 Gynaecology services

Summary

The Gynaecology Nursing team currently incorporates:

- A twenty-four-hour Gynaecology Emergency Department (GED).
- An Early Pregnancy Assessment Unit (EPAU).
- A combined 24 bedded inpatient ward.
- A 2 bedded High Dependency Unit, which provides complex post-operative care.
- A 6 trolley Day Surgery area.
- A large Outpatient department based on Crown Street and at Aintree.
- The Bedford unit.
- A Colposcopy and Hysteroscopy unit both on site and at Aintree.
- A large fertility unit on two sites; Crown Street and Knutsford.

The workforce within the Gynaecology Division consists of both registered and non-registered nurses (64%/36% split). The registered staff are made up of Registered Nurses, Specialist Nurses, Consultant Nurses, Emergency and Nurse Practitioners, Healthcare Support Workers, additionally there are 3 Trainee Advanced Nurse Practitioners. The Division from September 2020 are supporting two trainee nurse associates, this is the first cohort at Liverpool Women's Hospital. The Gynaecology service has had a successful year in relation to nurse recruitment and succession planning with some key appointments.

As of November 2020, the Division reported an 8.19% sickness absence level (8.54% in gynaecology and 7.70% in Hewitt).

These figures include sickness absence due to coronavirus which fluctuates month on month, reporting at 2.79% in October and 1.59% in November 2020. Absence due to self-isolation and shielding is in addition to the sickness absence percentage.

The proportion of long term sickness absence has fluctuated across the last 12 months and within services, with the teams working to support multiple returns in the summer months of those who had been previously been absent due to long term sickness, the impact of which can be seen in the single month figure above.

The previous 12 months have clearly been challenging for the team, with absence levels being higher than in 2019/20. The team have continued to support people through the absence management processes, to benefit from the health and wellbeing offer available and putting adjustments in place to support timely returns.

Turnover in the Hewitt Centre remains well below the Trust target figure at 5%. In contrast, turnover in gynaecology has seen a steady increase across this financial year especially, peaking at 13% in August 2020, reducing to 11% in the November. Within this, the Bedford Clinic and Inpatient Ward have been identified as areas of higher turnover, with the Bedford Clinic being a smaller area that has benefited from the internal promotion of members of the team. To understand the situation on the Inpatient Ward, the recently commenced Ward Based Matron has been undertaking work to identify the key themes impacting this and putting plans in place to address them, including actions around an increase in support for new starters, for example which have commenced and received positive feedback. Forward planning for 2021/2022 include a business case for succession planning in specialist nursing teams

across Gynaecology, the Introduction of a CNS in Children's who will work across the Trust and the introduction of educator post in HFC to support fertility training.

Challenges identified and actions to address:

Reduction in hours and age profile of some specialist nurses:

- Review of service needs and lead in times for training.
- Business case to be developed to increase staffing in specialist nurse cohort.

Recruitment:

- Continue with proactive recruitment
- Consider Divisional recruitment
- Implement rotational post for Band 5 across gynaecology.
- Engage and work with local university to develop a L6 Gynaecology Nursing module.

Career Progression /Succession Planning:

- Implement the talent pool process
- Formalise the use of competencies at all levels (currently only for Matron / Band 5/ and Band 7)
- Actively develop future leaders from within
- Promote academic development
- Encourage research involvement

4.2 Clinical Support Services

Summary

Theatres

Staffing within in theatres comprises of Registered Nurses, Operational Department Practitioners, there are 3 Registered Nurses with advanced skills working as Surgical First Assistants and 1 Surgical Care Practitioner educated at master's Level. Current Vacancies within theatres are 3.11 WTE in the theatre scrub team and 1.1 WTE in theatre recovery .1 WTE band 7 theatre coordinator currently in the recruitment phase. A business case has recently been approved to recruit further Theatre scrub and Healthcare support workers to open a 2nd theatre out of hours for Obstetrics theatres. Further Apprentices are being recruited for ODP training.

Imaging

The Imaging department provides a patient centred service with the facility to provide diagnostic Scanning services for women requiring Gynaecology and Obstetrics appointments. There are currently 3.31 WTE vacancies for Sonographers within the Imaging Department. Recruitment continues, there are two Trainees who have now completed their qualification and will progress into Band 7 roles form December. Two more trainees will be recruited, reducing the vacancies in the Team further. There are currently 2 WTE sonographers on Maternity leave. There is currently a workforce review being undertaken within the Imaging Department which will assess the current workforce issues, along with looking at what will be required from a staffing perspective once the development of the CT Scanner is complete and also the impact of the repatriation of the Aintree SLA. These should link into capacity and demand and the most recent GIRFT review.

Genetics

The Merseyside and Cheshire Clinical Genetics Service is primarily involved with the diagnosis and genetic counselling of families with possible or known inherited disorders. There are also 1.8 WTE vacancies within the Genetic Counsellor team, recruitment into these vacancies is to commence in the near future.

Sickness absence in the service has seen fluctuations throughout the year. As of the end of November 2020, the Division reported a 10.26% sickness absence level. This is a decrease from 11.78% in October and an increase from 10.16% in September and 7.69% in August. Sickness absence due to Covid-19 accounts for 0.66%, down from 1.44% in October 2020. In addition, absence due to COVID-19 special Leave (typically isolation following contact tracing) adds an additional 3.87% absence across the division, with this figure being higher within theatres and pre-op at 8.47%, increased from 1.57% in October primarily due to the reintroduction of shielding.

The reported turnover figure provides a rolling 12-month position, and is based on 'avoidable' turnover, so excludes retirements and dismissal from the calculation, for example. As evident below, the turnover figure has remained above the 13% target, with no new starters or leavers reported in month. Turnover is high in physiotherapy following significant changes in the team previously. Further to this, 3 of the 7 team members have handed in their notice, so we anticipate this figure increasing again.

Those in the age bands of 56 and over equates to 14% of the workforce. Given the distribution of ages within the service, the service must encourage new entrants, and this enables cross working/learning from the experienced workforce to allow the transfer of skills and this also supports succession planning.

Future in CSS – a skill mix review in pharmacy is being undertaken to allow for a prescribing pharmacist in Hewitt centre. The successful bid for the CT scanner and Blood Bank will require a staffing review which is in the planning stage and will be completed by March 2021.

4.3 Maternity

The maternity service at LWH had 6908 births for the period of 1st Jan 20 – 30th Nov 20 and 8156 births for the preceding 12-month period. The service offers a wide range of tertiary maternity services to the women of Liverpool and beyond. These services include Antenatal, FMU, intrapartum, post-partum, community and high-risk specialist services. The 2020-21 Maternity staffing WTE budgets were set in line with the agreed ward/service level rotas which were updated in early 2020; The resultant overall WTE budget was also reviewed using the Birth Rate Plus findings to ensure that the workforce was in line with Birth Rate Plus (BRP) based on 8,200 deliveries, as per divisional sign off.

There is a funded establishment of 381.93 wte across the whole service and 287.62 wte midwives and 79.65 maternity support workers. The senior leadership team is made up of the Head of Midwifery (HOM), Deputy Head of Midwifery (DHOM) and 4 matrons across the service. The maternity service also has 1 consultant midwife. This year has seen the development of Advanced Midwifery Practitioners and the service has 7 midwives in training. Birth-rate plus is the only validated National tool for calculating midwifery staffing levels and is endorsed by the RCM to ensure appropriate staffing ratios based on activity and acuity. The report findings are based on data collected retrospectively and prospectively The Birth-rate plus tool is designed to calculate the required WTE of midwives needed arising from the clinical needs of women encompassing maternity care from initial contact in pregnancy until final discharge in the puerperium by community midwives. The Birth rate plus tool calculates the number of WTE hospital and community maternity staff that are required to undertake the defined workload based on the levels of dependency and activity. A review Birth Rate Plus (BRP) in line with the proposed new birth rate of 7700 is in the process of being completed. A formal review by BRP is also being considered.

In July 2020 several actions were agreed by the Head of Midwifery relating to the Maternity Establishment. Permanent recruitment of 11.22 WTE midwives to cover maternity leave. Agreement to "hold recruitment" for 8.6 WTE existing vacancies pending completion of further staffing/activity analysis being undertaken.

COVID-19 has had a huge impact on staffing within maternity service both on registered and unregistered professional. Sickness within Maternity has remained a challenge throughout the year, some progress was made in the spring and summer months however there was a significant increase in sickness absence in October which was predominately due to an increase in COVID-19 cases within Maternity. Long term sickness has also shown an upward trajectory with 31 cases in October and anxiety, stress, depression the most common reason for absence. Staff supporters continued to be visible and in place to support staff, resilience sessions were held to provide further support to staff and a wobble room was introduced for all staff to take some time away if needed. Sickness absence has continued to be managed and supported.

There has been a step change in service in the numbers being seen and the acuity of the patients being cared so therefore a full formal birthrate plus review is recommended. This will give clarity on the current position and have a clear focus going forward, especially with the introduction of continuity of carer, and recommendations from the Ockenden report.

As part of the operational planning for 2021/2022 there will be a focus on development of the education team. This team requires investment to ensure that standards are achieved and maintained. This will require appointment to the education team of at least 2 wte. The nurse consultant roll also requires investment, money has been identified to start this development and this would see a nurse consultant appointment to support the CoC. Additional admin support is required to support the leadership team. This has been identified within the current establishment and will commence in Jan 2021

A staffing paper that meets the requirements of CNST will be produced and present to board in early spring.

4.4 Neonatal Services

The workforce within the Neonatal Intensive Care Unit (NICU) comprises of both registered and non-registered nurses (74%/16% split). The registered staff are made up of Advanced Neonatal Nurse Practitioners (ANNP) and Neonatal Nurses from a range of backgrounds including Adult, Children, and midwifery training. Over 70% of the nurses on the unit have completed a speciality course in the care the preterm and sick babies; this allows them to be registered as nurses who are qualified in speciality (QIS).

The majority of ANNP's have studied to master's level qualification over a two-year period to complete and gain required competencies. The ANNP's will have also completed a non-medical prescribing course. The level of training received by ANNP's allows them to work on the Tier 1 and Tier 2 of the medical rotas. This is fully supported by BAPM standards.

The Neonatal Service at Liverpool Women's Hospital (LWH) has had a very successful year and has had successful recruitment at all levels of practice. While internal promotion has been used for some of the more senior roles, nurses with previous neonatal experience and those with the QIS have also been recruited from outside the Trust.

Sickness absence in the service has seen fluctuations throughout the year. This has been very much distorted by the COVID-19 absence during the pandemic. The 12-month rolling sickness absence rate for the service stands at 4.85%, compared with 5.29% last year, with the addition of COVID-19 absence this increases to over 8% on average. This is just slight above the Trust target of 4.5% and the reason for this reasonably split between long term and short-term

sickness. Long term sickness absence in the service are being managed within the timeframes as detailed in the Attendance Management policy i.e. any cases over 6 months are managed by exception only.

Turnover has over the last year at 6%. There are no concerns to highlight that have been seen in the last 12 months with regards to this metric. To maintain low levels of turnover and to support new entrants to the service, there has been great leadership by the team leaders, in ensuring staff are encouraged and prepared for internal promotion.

Those in the age bands of 55 and over equates to 22% of the workforce. Given the distribution of ages within the service, the service encourages new entrants, and this enables cross working/learning from the experienced workforce to allow the transfer of skills and this also supports succession planning.

Proactive recruitment happens twice a year with adhoc recruitment as needed. This has ensured that vacancies are covered in a timely manner and training needs are met. We have successfully recruited a further 4 trainee ANNP's who will work as part of the Liverpool Neonatal Partnership. This will bring total ANNP/Trainee ANNP team to 32 wte.

5.0 Recruitment

5.1 Trust wide proactive recruitment campaigns continue to attract experienced nurses and midwives as well as newly qualified Nurses and Midwives. The Trust utilises links with Universities and social media as part of recruitment strategies. The HON/ M have introduced keep in touch strategies for those in the recruitment process. There is a regional drive to improve HCSW recruitment with support from NHSE. LWH are part of this programme to fill all HCSW vacancies by March 2021.

5.2 LWH continues to support Student placements and is committed to increasing placements as appropriate to support succession planning for the future. The Trust currently takes 20 student nurses on placement and 122 midwives as the home trust. Opportunities to accept more ODP students on the apprentice scheme will be agreed by March 2021. All students have recommenced placements. As part of the workforce review it has been identified a further PEF is required to support the increase in student capacity. Funding is currently being explored to support this.

5.3 Trainee Nursing associates commenced in September 2020 who will complete their training on June 2022. They are current healthcare support workers who are undertaking a foundation degree and will become a Band 4 Registrant at the end of their training. They have been supported by the gynaecology division as part of their recruitment and succession planning for the future.

6.0 Retention and Turnover

6.1 Retention is a key element of the workforce plans for the Trust. At the end of December 2020, the Nursing and Midwifery turnover rate was 9%. This is a 2% increase from the last report. Specifically of note Gynaecology is increasing which is of concern especially on the gynaecology ward. The Head of Nursing for Gynaecology is working with HR to develop strategies to improve retention.

6.2 To support staff, competency frameworks have been developed for Bands 8C- Band 5 and a matron's development programme is to commence in February 2021.

6.3 Cheshire and Mersey have developed frameworks for preceptorship, CPD and a charter for nurses and midwives. This is being rolled out in January in the Trust.

7.0 Health Care support workers

7.0 There are 37.64 wte health care support worker vacancies across the Trust (December 2020) however, in maternity some of these vacancies are managed within the clinical teams whilst a review of establishment has been undertaken due to the drop-in births.

7.1 LWH is part of a national programme to recruit to HCSW vacancies with support from NHSE. 81k funding has just been secured to support with the recruitment, training and pastoral support. The DDONM, Deputy Head of HR and finance are leading on this programme.

8.0 Care Hours Per Patient Per Day (CHPPD)

8.1 In May 2014, guidance was published from NHSE that required all Trusts to publish staff fill rates by hours (Actual versus Planned) via the unify report. From April 2016 all Trusts were required to report monthly staff fill rates and Care Hours per Patient Day (CHPPD) via unify.

8.2 CHPPD was introduced as a measure for the deployment of nursing, midwifery and healthcare support staff on acute and acute specialist inpatient wards. CHPPD is now the national principal measure.

8.3 CHPPD is calculated by taking all the shift hours worked over the 24-hour period by Registered nurses/ midwives and nursing assistants and dividing this by the number of patients occupying a bed at midnight. The data is aggregated each day over the month. In maternity only, the mothers are included in the census.

8.4 It is important to note that the use of CHPPD will only capture the care hours provided to each bed and does not capture all the activity on the ward such as the turnover of patients through that bed within the 24-hour period or recognise the acuity of the patient receiving the care.

8.5 The lack of national CHPPD benchmarks limits the validity of the data to inform safer staffing decisions at present.

8.6 Whilst CHPPD is a simple measure, this must be reviewed alongside patient acuity and dependency data as CHPPD is not a metric to neither determine registered nurse/ midwife requirements not provide assurance for safe staffing.

8.7 Appendix 2 illustrates CHPPD level from Jun- December 2020 in Gynaecology.

9.0 Safe Care-Planned versus actual

9.1 Planned versus actual staffing levels are reported monthly via Unify. Currently the data is gathered manually. There are plans for this to be reported via Health Roster in 2021.

9.2 Appendix 1 shows the planned versus actual figures from Jun 2020- Dec 2020. The data shows that the fill rate is good. Averages for RN/M is on average 81% or above, which is a decrease from previous reports. It must be noted that some months are skewed due to COVID-19 and closing of beds and redeploying staff.

10.0 Safe care-Acuity and dependency

10.1 The previous results of the Safer Care Nursing Staffing tool (SCNT) were unable to define the correct establishment needed for the gynaecology ward due to the mix of day cases and in patients but gave an indication for the HON to use as part of the workforce review.

10.2 The tool is not designed to capture acuity and dependency data from wards with less than 16 beds, day case rates, maternity areas or departments.

11.0 Red Flags and escalation and patient experience

Where a shortfall in Registered Nurses/ Midwives occurs, the Trust has a process to mitigate in real time through interventions by senior nurses/ midwives in line with an escalation process to enable the delivery of safe and effective patient care.

11.1 NICE guidance recommends that the trust have a mechanism to capture "red flag" events. The trust has incorporated these into the Trust incident reporting system. Incidents can be reviewed against acuity and dependency, planned and actual staffing levels for the day. Triangulation of data assists in informed decision making related to staffing. LWH participates in and publishes data relating to NHS Safety Thermometer Classic and Maternity.

11.2 From June 2020- December 2020 a total of 105 Red flags were raised. Of these 20 were incidents reported as staffing shortfalls. No Serious incidents or RCA's were declared relating to staffing levels.

11.3 The top reporting areas were delivery suite, MAU and Gynaecology Ward and GED.

11.4 There were no specific complaints about staffing levels from June – December 2020. There were 16 friends and family responses which mentioned staffing levels. 12 out of the 16 were relating to the Maternity Base

11.5 Staffing levels are also triangulated with complaints and adverse incidents to provide assurance on patient safety and are reported through the appropriate senates. Staff are encouraged to complete an incident report when staffing levels are below the required parameters. Each division puts plans in place when staffing falls below the required parameters with oversight by the Head of Nursing/ Midwifery. Daily staffing huddles take place for the site to review staffing levels and oversee the support required for the shortfalls and escalation as necessary.

12.0 E-Roster

12.1 The Trust has rolled out Health Roster, there is still some work to do with embedding usage of the system. Health roster challenge meetings have commenced with DDON/M, monitoring the roster performance KPI's with the HON/M and matrons. This is now led by the divisions and will be discussed as part of the divisional performance reviews. Monthly meeting with DDONM, DDOPF and DDOHR and the divisions has recommenced.

13.0 Temporary staffing

13.1 Currently the Trust uses its own internal Bank system. A scoping exercise is currently being undertaken looking at the feasibility and cost of utilising other bank methods. A business case has been presented at Senior management team previously for the Trust to adopt NHSP however, following further scope other options are available and an updated business case will be finalised by March 2021.

14.0 COVID-19

14.1 A number of measures have been put in place to support the workforce during COVID-19:

- Staff support team
- Leader support
- Staff relaxation areas
- Schwarz rounds
- Mental Health first aiders
- Resilience sessions

14.2 Staffing has had to respond to a number of initiatives from command and control during COVID-19

- Mutual aid
- Swabbing of symptomatic staff and asymptomatic elective patients and support partners
- Monitoring of temperatures of staff and visitors on entrance to the Trust.
- Staff have worked flexibly and supported each area daily as required.

15.0 Summary

15.1 LWH can demonstrate safe staffing levels through workforce reviews, actual versus planned data, CHPPD, acuity tools and professional judgement.

15.2 Vacancy rate for Registered N&M at LWH is 5 % compared to the national picture of 11.6 %. And Cheshire and Mersey 9.3%. Although it should be noted that the vacancy rate is higher than in previous reports.

15.3 9% turnover in December compared to 15% across Cheshire and Mersey. However, it is to be noted that Gynaecology is at 11%.

15.4 32% of the Nursing and Midwifery workforce are > 50 years of age therefore recruitment and retention need to remain a high focus.

15.5 There has been a steady increase in sickness rates in the last 6 months.

15.6 COVID-19 related absence has steadily increased since August with a spike in November but a reduction in December.

15.7 The Divisional triumvirate structure will ensure workforce is monitored through KPI's at performance reviews.

15.8 Staff have worked flexibly during COVID-19 and supported each area as required daily.

16.0 Conclusion / Recommendations

The Board of Directors are asked to:

16.1 *Accept the assurance of the current nurse/ midwife staffing levels*

16.2 *Note the content of the report and the assurances provided that nurse/midwife staffing levels are safe and appropriate at present.*

16.3 *Note the risk to the organisation of the number of nursing and midwifery staff > 50 years of age.*

16.4 *Be cited on the national shortage of nurses and midwives.*

16.5 *Note the impact of COVID-19 on staffing*

APPENDIX 1 - Fill Rate

June 2020

WARD	Fill Rate Day% RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff
Gynae Ward *	73.9%	108.9%	94.4%	103.3%
Delivery suite	95.4%	118.3%	94%	94.4%
Mat Base	98.6%	132.1%	96.2%	118.5%
MLU	86.7%	93.3%	99.3%	90%
Neo-nates	128.5%	71.7%	124.8%	86.7%
Jeffcoate **	71.9%	62.5%	71.4%	57.1%

***Skewed due to COVID-19**

****Skewed due to opening and closing of unit**

July 2020

WARD	Fill Rate Day % RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff
Gynae ward *	61.9%	111.3%	80.6%	109.7%
Delivery suite	86.5%	95.2%	91%	80.6%
Mat Base	87.1%	108.6%	88.5%	94%
MLU	79.4%	80.6%	73.5%	83.9%
Neo-nates	125%	80.6%	121.2%	91%
Jeffcoate **	112.5%	50%	100%	71.4%

- *Skewed due to COVID-19
- ** skewed due to opening and closing of the unit

August 2020

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

September 2020

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

October 2020

WARD	Fill Rate Day% RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff
Gynae Ward	72%	94%	108%	103%
Delivery suite	915	102%	91%	92%
Mat Base/ Jeffcoate	88%	93%	95%	104%
MLU	87%	87%	79%	94%
Neo-nates	104%	68%	103%	100%
Transitional Care	100%	97%	139%	55%

November 2020

WARD	Fill Rate Day% RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff
Gynae Ward	67%	88%	92%	120%
Delivery suite	89%	90%	86%	88%
Mat Base/ Jeffcoate	88%	86%	94%	91%
MLU	93%	83%	83%	90%
Neo-nates	99%	58%	98%	87%
Transitional Care	52%	70%	100%	27%

December 2020

WARD	Fill Rate Day% RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff
Gynae Ward	68%	100%	92%	97%
Delivery suite	85%	97%	86%	81%
Mat Base/jeffcoate	83%	86%	88%	87%
MLU	75%	90%	79%	94%
Neo-nates	99%	65%	98%	76%
Transitional Care	126%	61%	135%	45%

Appendix 2

CHPPD hrs

	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
Gynae Ward	8.6	6.2	7.0	9.4	7.1	9.0	8.8

Appendix 3

Percentage of women receiving 1:1 Care in Labour

All	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov - 20	Dec- 20
Yes	482	526	523	511	505	468	455
No	8	19	21	30	30	29	23
Total	500	545	544	541	535	497	478
% Yes	96.40%	96.51%	96.14%	94.45%	94.39%	94.16%	95.2%
Trust Target	90%	90%	90%	90%	90%	90%	90%

Liverpool Women's NHS Foundation Trust

Agenda Item	20/21/273

MEETING	**Trust Board**
PAPER/REPORT TITLE:	**Serious Incident Report – February 2021**
DATE OF MEETING:	Thursday, 04 February 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):	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:-….)***	It is recommended that the Board notes the contents of this paper and supports the future development of this report in the provision of assurance that the organisation is learning and embedding the learning from Serious Incidents.			
PREVIOUSLY CONSIDERED BY:	**Committee name**			
	Date of meeting			

Executive Summary

On the 2nd July 2019 at the HSJ Patient Safety Congress in Manchester, Aiden Fowler the NHS National Director of Patient Safety published the NHS Patient Safety Strategy. Safer culture, safer systems, safer patients. The strategy has been developed following a request from the Secretary of State for the development of a new Strategy for Patient Safety as a 'golden thread' running through healthcare.

The strategy commences with a quote from John F Kennedy in 1960 *' We are not here to curse the darkness, but to light the candle that can guide us through the darkness to a safe and sane future'.*

The strategy goes on to state 'Too often in healthcare we have sought to blame individuals, and individuals have not felt safe to admit errors and learn from them or act to prevent recurrence. The willingness to support the development of this strategy, however, has amply demonstrated people's desire to make the NHS safer'.

Patient safety is about maximising the things that go right and minimising the things that go wrong for people experiencing healthcare. It is integral to the NHS's definition of quality in healthcare, alongside effectiveness and patient experience. This strategy describes how the NHS will continuously improve patient safety over the next five to ten years.

This strategy sits alongside the NHS Long Term Plan (LTP) and the LTP Implementation Framework. Local system plans to deliver the LTP will include local elements of the strategy: opportunities to improve patient safety are greatest at the point of care. NHS England and NHS Improvement regional teams will support delivery.

Addressing these challenges will enable the NHS to achieve its safety vision; **to continuously improve patient safety**. To do this the NHS will build on two foundations: a **patient safety culture** and a **patient safety system**. Three strategic aims will support the development of both:

- improving understanding of safety by drawing intelligence from multiple sources of patient safety information (**Insight**)

• equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system (**Involvement**)

• designing and supporting programmes that deliver effective and sustainable change in the most important areas (**Improvement**).

The new Patient Safety Incident Reporting Framework which will replace the current Serious Incident Reporting Framework identified the following areas as key changes:

A broader scope: describing principles, systems, processes, skills and behaviours for incident management as part of a broader system approach, providing and signposting guidance and support for preparing for and responding to patient safety incidents in a range of ways, moving away from a focus on current thresholds for 'Serious Incidents'.

Transparency and support for those affected: setting expectations for informing, involving and supporting patients, families, carers and staff affected by patient safety incidents.

A risk-based approach: Organisations should develop a patient safety incident review and investigation strategy to allow them to use a range of proportionate and effective learning responses to incidents. The proposal is to explore basing the selection of incidents for investigation on the opportunity they give for learning; and ensuring that providers allocate sufficient local resources to implement improvements that address investigation findings.

Purpose: reinforcing the purpose of patient safety investigation and insulating it against scope creep and inappropriate use, so that safety investigations are no longer asked to judge 'avoidability', predictability, liability, fitness to practise or cause of death.

Governance and oversight: taking a different approach to the oversight and assurance provided by commissioners, emphasising instead the role of provider boards and leaders in overseeing individual investigations.

The following report relates to serious incidents reported during January 2021, reported numbers of SIs back to 2016 and the number of incident reported to HSIB since 2019. The report also highlights some themes identified from the SIs reported in January in relation to previous SIs reported.

Following a recommendation from the Ockenden Report (2020), Enhanced Safety 1b, relating to the reporting of Serious Incidents to the Trust Board, it recommends that SI's are reported on a monthly basis. Historically SIs have been reported to the Trust Board on a quarterly basis, following discussion it has been agreed that this report will move to being reported on a monthly basis. The report will also have a revised format following comments from the Trust Board members. For completeness and transparency the report will contain all Serious Incidents reported in month across the Trust.

The details of the incidents which have been reported in January 2021 can be found in the main body of the report, three cases in total.

The Trust submits all final Serious Incident reports to the Clinical Commissioning Group, which provides clear root causes and lesson learnt. The CCG have fed back to the Trust at the Clinical, Quality Reporting Meeting (CQRM) in relation to the completed SI reports submitted as being robust and transparent in their findings with clear action plans, which provides them with assurance.

Following the introduction of investigations into a set group of maternity incidents by HSIB, the Trust commenced reporting maternity incidents February 2019 and has continued to date. Further details of this process and number of incidents submitted can be found in the main body.

It is recommended that the Board notes the contents of this paper and supports the future development of this report in the provision of assurance that the organisation is learning and embedding the learning from Serious Incidents.

Report

The agreed definition of a Serious Incident, both nationally and in the Trust Policy on the Management of Incident and Serious Incidents , 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), in 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. As identified above the current approach is changing following the publication in July 2019 a new National Patient Strategy was published, which identified the need to restructure the national approach to patient safety and ensure there was a national framework for all organisations to follow. Part of the new strategy was the updating of the current National Serious Incident Framework which is to become the Patient Safety Incident Response Framework. The new approach will see a move away from Root Cause Analysis into system analysis and failures with the approach of investigating themes. The approach is also about a more compassionate approach to investigating incidents and supporting staff involved in incidents. The early adopters are currently piloting the new framework with a planned national rollout in 2022.

In many cases it is immediately clear that a serious incident has occurred, and as further information emerges and reviewed, and as part of this approach 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 with executive directors, senior managers and clinicians including at time advice from the CCG. Both NHS England and our local commissioners recognise that the best position is for us to discuss openly, to investigate proportionately. It is nationally accepted that organisations that report more incidents usually have a better and more effective safety culture.

As part of the current Trust policy for the Management of Incidents and Serious Incidents all incidents which are reported as serious incidents have a 72hr review completed which aims to identify if there are any immediate actions required to keep our patients safe whilst the investigation is being completed. These are clearly documented and submitted to the CCG and CQC for assurance.

New Serious Incident Reported to CCG in January 2021

There were 3 Serious Incidents (SI's) declared on the StEIS system as per Trust Policy in line with NHS England StEIS reporting criteria during January 2021. The cases were identified in the following areas of the Trust, 2 for Maternity and 1 for Gynaecology.

Maternity:

StEIS Number 2021/800 - Unexpected Intrapartum Intrauterine Death whilst in hospital within 5 hours of admission to MAU. Identified as an SI as part of a PMRT review on the 6th January 2021

StEIS number 2021/808 - Notification of a number of COVID positive staff members within Maternity, with further impact noted due to the requirement for other staff members to self-isolate as per IPC guidance. All positive cases have been linked to an attendance at an external gathering.

After a number of staff had to self-isolate this had an impact on the continued service provision. Safety of service has been maintained by utilising all resources and active management of the situation with multiple meetings each day with the senior team.

Gynaecology

StEIS number 2021/1415 - On 29 December 2019 the patient underwent surgery was discharged and subsequently admitted to a neighbouring Trust where sadly the patient passed away.

Following the 72hr review of StEIS Number 2021/800 maternity incident it has been identified that there are similar themes which have been identified in previous completed maternity Serious Incidents investigations, which have occurred in the past:

- Antenatal CTG stickers not used to aid categorisation of CTG
- Delay in transfer to DS related to MW staffing, but 1:1 care provided on MAU.
- Delay in escalation of pathological CTG

Following each of the previous SIs specific actions have been taken in relation to updating of policies and procedures such as the Continuous Electronic Fetal Heart Rate Monitoring, Scalp Sampling Guideline, Maternity Escalation Guideline, issuing a lesson of the week in relation to a subject such as Intrapartum care and the timing and interpretation of CTGs, in training sessions such as CTG intrapartum and use of record stickers in notes, use of VE stickers in notes, 1:1 support and guidance for midwives on key subjects such as clear communication and escalation of concerns.

As part of the CNST safety actions the issues identified above from SI investigations are included in the current trust action plan and to demonstrate compliance require regular audits to be completed. These audits will provide information as to whether changes made are being embedded and if not look to identify why. The CNST action plan in place is monitored via Family Health Board, Quality Committee and Trust Board.

HSIB Cases Reported and NHSR Early Notification Scheme

During January 2021 there has been 1 case which met the HSIB criteria and has been reported to HSIB and NHSR as per procedure. The main theme of the incidents reported is in relation to; cooled babies, there have been small numbers of neonatal death and Hypoxic Ischaemic Encephalopathy (HIE):

	Jan	Feb	Mar	April	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Total
2019	0	3	1	0	3	1	2	0	0	0	1	2	13
2020	1	3 (1 rejected)	1 rejected	0	0	0	4 (3 rejected)	0	0	2	3 (2 rejected)	0	14
2021	1												

Overview

During January 2021 there were 3 SI's reported making a total of 22 SI's reported for the financial year to date for 2020/21. This is an increase as compared to the same period in 2019/20 where 13 SI's were reported.

Total SIs reported by month compared by year

The following table shows the trend in SI numbers in the Trust for all months since April 2016 to date. As can be seen there has been a decrease in reported SI's between 2017-18 and 2019-20 with an increase occurring in 2020-21 period.

Year Comparison

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	Total
2016-17	1	2	4	2	2	2	5	3	5	3	1	0	30
2017-18	2	4	1	0	0	1	2	4	1	0	5	0	20
2018-19	1	1	1	0	3	2	1	5	0	0	1	2	17
2019-20	2	4	0	0	3	1	1	2	2	0	0	0	13
2020-21	2	2	2	3	2	2	1	3	2	3			22

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. The audit is due to be completed by the end of February 2021and will be submitted to the Safety Senate and Effectiveness senate for review. The audit completed in 2020 demonstrated that there was 100% compliance.

Overdue Actions for reported SIs

At the time of writing this report there are no actions from Serious Incidents which are overdue. The number of overdue actions has reduced over the past 12 months, following increased monitoring by the Risk and Patient Safety Manager on a weekly basis in relation to the progress of actions. This is further supported by weekly oversight with the Divisional Governance Managers within the Divisions. Implementation of improved and updated elements of the Ulysses Risk Management System will provide greater monitoring in the future and prevent actions becoming overdue.

Conclusion

The report provides an update as to the number of SI's reported on StEIS and provision of final investigation reports to the Clinical Commissioning Group, which provide clear root causes and lessons learnt. Moving forward the report will provide further information in relation to the trends being identified and how lesson learnt are being embedded in the Trust.

Recommendation

It is recommended that the Board notes the contents of this paper and supports the future development of this report in the provision of assurance that the organisation is learning and embedding the learning from Serious Incidents.

Liverpool Women's NHS Foundation Trust

Agenda Item	20/21/274

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Review of Disciplinary Policy and Practice**
DATE OF MEETING:	Thursday, 04 February 2021
ACTION REQUIRED	**Approve**
EXECUTIVE DIRECTOR:	Michelle Turner, Chief People Officer
AUTHOR(S):	Rachel London, Deputy Director of Workforce Angela Hughes, HR Business Partner
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:-….)***	It is recommended that Board of Directors review the contents of this report and give approval for how they wish to proceed in terms of considerations.			
PREVIOUSLY CONSIDERED BY:	**Committee name**			
	Date of meeting			

Executive Summary

This paper is intended to provide the Trust Board with assurance that LWH has adhered to the recommendations of the NHS Advisory group, established following the death in 2015 of an employee involved in a disciplinary process at another NHS Trust.

The board is asked to take assurance that the LWH Disciplinary policy has been reviewed against the guidance and against Imperial College Healthcare NHS Trust's revised Disciplinary Policy

It concludes that whilst the Disciplinary Policy is fit for purpose, there are improvements which can be made, which will be completed before 1st April when the policy will be published on the website.

Report

Background

Imperial Healthcare NHS Trust and Dido Harding

In May 2019 a review was commissioned by Baroness Dido Harding in response to a tragic event that occurred at Imperial College Healthcare NHS Trust in 2015 when a nurse Amin Adbullah who at the time was the subject of an investigation and disciplinary procedure, tragically took his own life.

An investigation was conducted by an appointed advisory group and this group made a series of recommendations.

In December 2019 the NHS Chief People Officer wrote to all NHS organisations requesting them to reflect on their disciplinary procedures to ensure

- Trusts enable a fair and compassionate culture
- Trusts review on a yearly basis and by the end of this financial year, all disciplinary procedures against the recommendations
- Trusts make their disciplinary policy available on the organisations public website by the end of financial year.

Following the letter in December 2019 a review has been undertaken of our current disciplinary policy in line with the Imperial College Healthcare policy to establish any recommendations that need to be considered and implemented.

Review of our Policy in comparison to Imperial's policy and recommendations of the NHS Advisory Group

1. Adhering to best practice

a) The development and application of local investigation and disciplinary procedures should be informed and underpinned by the provisions of current best practice, principally that which is detailed in the Acas 'code of practice on disciplinary and grievance procedures' and other non-statutory Acas guidance; the GMC's 'principles of a good investigation'; and the NMC's 'best practice guidance on local investigations' (when published).

b) All measures should be taken to ensure that complete independence and objectivity is maintained at every stage of an investigation and disciplinary procedure, and that identified or perceived conflicts of interest are acknowledged and appropriately mitigated (this may require the sourcing of independent external advice and expertise).

LWH response: a) the LWH policy is in line with the ACAS code of practice. b) We always identify any potential conflicts of interest when appointing Investigating Officers though have a smaller pool to choose from being a small Trust. We also commission external investigating officers where required.

2. Applying a rigorous decision-making methodology

a) Consistent with the application of 'just culture' principles, which recognise that it is not always appropriate or necessary to invoke formal management action in response to a concern or incident, a comprehensive and consistent decision-making methodology should be applied that provides for full and careful consideration of context and prevailing factors when determining next steps.

b) In all decision-making that relates to the application of sanctions, the principle of plurality should be adopted, such that important decisions which have potentially serious consequences are very well informed, reviewed from multiple perspectives, and never taken by one person alone.

LWH response a) The HR Team do adhere to these principles but formal training in Fair and Just Culture is required and is planned for the next 6 months. b) Such decisions are taken by panels, with HR advice and where necessary legal advice.

3. Ensuring people are fully trained and competent to carry out their role

Individuals should not be appointed as case managers, case investigators or panel members unless they have received related up to date training and, through such training, are able to demonstrate the aptitude and competencies (in areas such as awareness of relevant aspects of best practice and principles of natural justice, and appreciation of race and cultural considerations) required to undertake these roles.

LWH Areas for improvement: We recognise that we need to train additional investigating officers and this is in progress for 2021.

4. Assigning sufficient resources

Before commencing investigation and disciplinary procedures, appointed case managers, case investigators and other individuals charged with specific responsibilities should be provided with the resources that will fully support the timely and thorough completion of these procedures. Within the overall context of 'resourcing', the extent to which individuals charged with such responsibilities (especially members of disciplinary panels) are truly independent should also be considered.

LWH response: Investigations are sometimes delayed due to operational pressures of investigating officers who have a day job. A clear outline of the time required should be explored and where possible, backfill considered.

5. Decisions relating to the implementation of suspensions/exclusions

Any decision to suspend/exclude an individual should not be taken by one person alone, or by anyone who has an identified or perceived conflict of interest. Except where immediate safety or security issues prevail, any decision to suspend/exclude should be a measure of last resort that is proportionate, timebound and only applied when there is full justification for doing so. The continued suspension/exclusion of any individual should be subject to appropriate senior-level oversight and sanction.

LWH Any decision to suspend is reviewed by senior managers and signed off by the Deputy Director of Workforce

6. Safeguarding people's health and wellbeing

a) Concern for the health and welfare of people involved in investigation and disciplinary procedures should be paramount and continually assessed. Appropriate professional occupational health assessments and intervention should be made available to any person who either requests or is identified as requiring such support.
b) A communication plan should be established with people who are the subject of an investigation or disciplinary procedure, with the plan forming part of the associated terms of reference. The underlying principle should be that all communication, in whatever form it takes, is timely; comprehensive; unambiguous; sensitive; and compassionate.
c) Where a person who is the subject of an investigation or disciplinary procedure suffers any form of serious harm, whether physical or mental, this should be treated as a 'never event' which therefore is the subject of an immediate independent investigation commissioned and received by the board. Further, prompt action should be taken in response to the identified harm and its causes.

LWH Response a) The availability occupational health and counselling support is always shared with the staff member b) This is an area for improvement. Anyone involved in a formal disciplinary process should be assigned a buddy and a communication plan agreed. In practice this does not always happen in a timely fashion and will be reiterated in the Disciplinary Policy. C) This has thankfully never happened but would be treated as a never event.

7. Board-level oversight

Mechanisms should be established by which comprehensive data relating to investigation and disciplinary procedures is collated, recorded, and regularly and openly reported at board level. Associated data collation and reporting should include, for example: numbers of procedures; reasons for those procedures; adherence to process;

justification for any suspensions/exclusions; decision-making relating to outcomes; impact on patient care and employees; and lessons learnt.

LWH response: The Putting People First Committee receive an annual review of all disciplinary and grievances and discussion takes place within the Committee with assurance reported through to the Board via the Chair's Report.

Review of LWH disciplinary policy against Imperial College Disciplinary Policy

Whilst the LWH policy meets the ACAS code of good practice, there are a number of areas for improvement and LWH can take on board some areas of good practice within Imperial's policy

- Tone and style: policy is formal in tone with complex language. The Imperial policy uses more accessible language which is preferable to aid understanding.
- Add to policy that suspension will be reviewed every 5 days with the caveat that most investigations should be concluded within two weeks of suspension, there are no suspension timescales in the Trust policy.
- Consider of increasing panel membership to 3 for cases which may result in dismissal
- Increasing diversity of panel members at disciplinary hearings
- Considering external panel members at disciplinary hearings

Imperial College Healthcare NHS Trust have introduced a team of trained investigators, trained managers who hear cases at formal hearings and expanded pastoral support for employees, following the introduction of these measures they have reduced formal disciplinary investigations and hearings by a third. Liverpool Women's disciplinary policy states that all Managers involved in investigating and conducting hearings and appeals will receive specific training to assist in undertaking their role but as articulated earlier in the paper, additional training for managers at LWH is required.

Context of our Disciplinary Policy within a Fair and Just Culture

Following training of the HR team, the Disciplinary Policy will be reviewed holistically through the Fair and Just culture lens and the following questions for HR teams and commissioning managers included, to ensure that any potential disciplinary action is fully considered, resourced and actioned.

- Is there sufficient understanding of the issues or concerns, and the circumstances relating to them, to justify the initiation of formal action?
- Considering the circumstances, in the eyes of your organisation and others external to it, would the application of a formal procedure represent a proportionate and justifiable response (i.e. have other potential responses and remedies, short of formal intervention, been fully assessed before being discounted)?
- If formal action is being or has been taken, how will appropriate resources be allocated and maintained to ensure it is conducted fairly and efficiently; how are you ensuring that independence and objectivity is maintained at every stage of the process? ▪ What will be the likely impact on the health and wellbeing of the individual(s) concerned and on their respective teams and services, and what immediate and ongoing direct support will be provided to them? Further, how will you ensure the dignity of the individual(s) is respected at all times and in all communications, and that your duty of care is not compromised in any way, at any stage.
- For any current case that is concluding, where it is possible that a sanction will be applied, are similar questions being considered?

Conclusion

The Board can take assurance that LWH is responding to the recommendations of the review and by 1st April 2021 will make some improvements to the Disciplinary Policy which will be published on our external facing website.

Appendices

1. **Dido Harding Letter to Chairs and CEOs May 2019**

2. **Letters from NHS Chief People Officer asking all organisations to reflect on our disciplinary processes**

3. **Annual Review of Disciplinary and Grievances Processes presented to PPF in September 2020**

   Included in the 'Supporting Documents' folder for Directors on Teams and Virtual Boardroom.

Chief Executive and Chair's Office
Wellington House
133-155 Waterloo Road
London SE1 8UG

Tel: 020 3747 0000

To:
NHS trust and NHS foundation trust chairs and chief executives

24 May 2019

Dear colleagues

Learning lessons to improve our people practices

I am writing to share with you the outcomes of an important piece of work recently undertaken in response to a very tragic event that occurred at a London NHS trust three years ago.

In late 2015, Amin Abdullah was the subject of an investigation and disciplinary procedure. The protracted procedure culminated in Amin's summary dismissal on the grounds of gross misconduct. Tragically, in February 2016 just prior to an arranged appeal hearing, Amin took his own life. This triggered the commissioning of an independent inquiry undertaken by Verita Consulting, the findings of which were reported to the board of the employing Trust and to NHS Improvement in August 2018. The report concluded that, in addition to serious procedural errors having been made, throughout the investigation and disciplinary process Amin was treated very poorly, to the extent that his mental health was severely impacted. Verita's recommendations were accepted by the Trust, in full, and have largely been implemented.

Subsequently, NHS Improvement established a 'task and finish' Advisory Group to consider to what extent the failings identified in Amin's case are either unique to this Trust or more widespread across the NHS, and what learning can be applied. Comprising of multi-professional stakeholders and subject matter experts representing both the NHS and external bodies, together with an advocate for Amin's partner, the Group conducted an independent analysis of both the Verita findings and several historical disciplinary cases, the outcomes of which had attracted criticism in Employment Tribunal proceedings and judgements. HR directors of provider organisations were advised of the Group's activity and invited to share details of any local experiences and/or examples of measures being taken to improve the management of employment issues.

The analysis highlighted several key themes associated with the Verita inquiry which were also common to other historical cases considered. Principal among these were: poor framing of concerns and allegations; inconsistency in the fair and effective

application of local policies and procedures; lack of adherence to best practice guidance; variation in the quality of investigations; shortcomings in the management of conflicts of interest; insufficient consideration and support of the health and wellbeing of individuals; and an over-reliance on the immediate application of formal procedures, rather than consideration of alternative responses to concerns.

The NHS England and NHS Improvement People Committees in Common received a detailed report on the outcomes of the Advisory Group's activities, which included recommendations that aim to ensure the captured learning is used to best effect in informing positive changes across the NHS. The Committees recognised that, sadly, Amin's experiences are far from unique and acknowledged there needs to be greater consistency in the demonstration of an inclusive, compassionate and person-centred approach, underpinned by an overriding concern to safeguard people's health and wellbeing, whatever the circumstances. This view certainly echoed many of the comments we have received from across the NHS during our recent People Plan engagement.

Some of the proposed recommendations will require further discussion with key stakeholders, including regulatory and professional bodies (in particular, I am keen that consideration and assessment of the 'health' of organisational culture, including aspects relating to the management of workplace issues, is given more prominence in the 'well-led' assessment domain). The majority, though, can be immediately received and applied.

Enclosed with this letter is additional guidance relating to the management and oversight of local investigation and disciplinary procedures which has been prepared based on the Advisory Group's re-commendations. You will recognise the guidance as representing actions characteristic of responsible and caring employers and which reflect our NHS values. I would ask that you, your HR team and your Board review them and assess your current procedures and processes in comparison and, importantly, make adjustments where required to bring your organisation in line with this best practice. I would draw your attention to item 7 of the guidance and ask you to consider how your Board oversees investigations and disciplinary procedures. Further, with respect to any cases currently being considered and all future cases, I would ask you to review the following questions (and, where necessary, take corrective action in response):

- Is there sufficient understanding of the issues or concerns, and the circumstances relating to them, to justify the initiation of formal action?

- Considering the circumstances, in the eyes of your organisation and others external to it, would the application of a formal procedure represent a proportionate and justifiable response (i.e. have other potential responses and remedies, short of formal intervention, been fully assessed before being discounted)?

- If formal action is being or has been taken, how will appropriate resources be allocated and maintained to ensure it is conducted fairly and efficiently; how are you ensuring that independence and objectivity is maintained at every stage of the process?

- What will be the likely impact on the health and wellbeing of the individual(s) concerned and on their respective teams and services, and what immediate and ongoing direct support will be provided to them? Further, how will you ensure the dignity of the individual(s) is respected at all times and in all communications, and that your duty of care is not compromised in any way, at any stage.

- For any current case that is concluding, where it is possible that a sanction will be applied, are similar questions being considered?

In highlighting these issues, which I know will be important to you and your teams, I would like to thank all those colleagues who directly contributed to and informed the work completed by the Advisory Group. I would particularly like to acknowledge the endeavours of Amin's partner Terry Skitmore and his advocate Narinder Kapur, without whose dedication and sacrifices the Amin Abdullah inquiry and subsequent development work by NHS Improvement would not have taken place.

I know that we are all keen to ensure we treat our people fairly and protect their wellbeing. Implementing the attached guidance consistently well across the NHS will contribute to that goal. It is tragic that we are learning these lessons after Amin's death, but we owe it to him and the others who have suffered in similar circumstances to act now.

Thank you for your attention to these vital issues.

Best wishes

Baroness Dido Harding
Chair, NHS Improvement

Enclosure:

Additional guidance relating to the management and oversight of local investigation and disciplinary procedures

Copies:

Chair, Care Quality Commission
Chair, NHS Providers
Chair, Nursing and Midwifery Council
Chief Executive, NHS Employers

Additional guidance relating to the management and oversight of local investigation and disciplinary procedures

1. Adhering to best practice

a) The development and application of local investigation and disciplinary procedures should be informed and underpinned by the provisions of current best practice, principally that which is detailed in the Acas 'code of practice on disciplinary and grievance procedures' and other non-statutory Acas guidance; the GMC's 'principles of a good investigation'; and the NMC's 'best practice guidance on local investigations' (when published).

b) All measures should be taken to ensure that complete independence and objectivity is maintained at every stage of an investigation and disciplinary procedure, and that identified or perceived conflicts of interest are acknowledged and appropriately mitigated (this may require the sourcing of independent external advice and expertise).

2. Applying a rigorous decision-making methodology

a) Consistent with the application of 'just culture' principles, which recognise that it is not always appropriate or necessary to invoke formal management action in response to a concern or incident, a comprehensive and consistent decision-making methodology should be applied that provides for full and careful consideration of context and prevailing factors when determining next steps.

b) In all decision-making that relates to the application of sanctions, the principle of plurality should be adopted, such that important decisions which have potentially serious consequences are very well informed, reviewed from multiple perspectives, and never taken by one person alone.

3. Ensuring people are fully trained and competent to carry out their role

Individuals should not be appointed as case managers, case investigators or panel members unless they have received related up to date training and, through such training, are able to demonstrate the aptitude and competencies (in areas such as awareness of relevant aspects of best practice and principles of natural justice, and appreciation of race and cultural considerations) required to undertake these roles.

4. Assigning sufficient resources

Before commencing investigation and disciplinary procedures, appointed case managers, case investigators and other individuals charged with specific responsibilities should be provided with the resources that will fully support the timely and thorough completion of these procedures. Within the overall context of 'resourcing', the extent to which individuals charged with such responsibilities (especially members of disciplinary panels) are truly independent should also be considered.

5. Decisions relating to the implementation of suspensions/exclusions

Any decision to suspend/exclude an individual should not be taken by one person alone, or by anyone who has an identified or perceived conflict of interest. Except where immediate safety or security issues prevail, any decision to suspend/exclude should be a measure of last resort that is proportionate, timebound and only applied when there is full justification for doing so. The continued suspension/exclusion of any individual should be subject to appropriate senior-level oversight and sanction.

6. Safeguarding people's health and wellbeing

a) Concern for the health and welfare of people involved in investigation and disciplinary procedures should be paramount and continually assessed. Appropriate professional occupational health assessments and intervention should be made available to any person who either requests or is identified as requiring such support.

b) A communication plan should be established with people who are the subject of an investigation or disciplinary procedure, with the plan forming part of the associated terms of reference. The underlying principle should be that all communication, in whatever form it takes, is timely; comprehensive; unambiguous; sensitive; and compassionate.

c) Where a person who is the subject of an investigation or disciplinary procedure suffers any form of serious harm, whether physical or mental, this should be treated as a 'never event' which therefore is the subject of an immediate independent investigation commissioned and received by the board. Further, prompt action should be taken in response to the identified harm and its causes.

7. Board-level oversight

Mechanisms should be established by which comprehensive data relating to investigation and disciplinary procedures is collated, recorded, and regularly and openly reported at board level. Associated data collation and reporting should include, for example: numbers of procedures; reasons for those procedures; adherence to process; justification for any suspensions/exclusions; decision-making relating to outcomes; impact on patient care and employees; and lessons learnt.

4 November 2019

NHS Improvement & NHS England

Prerana Issar
NHS Chief People Officer
Skipton House
80 London Road
London SE1 6LH
Prerana.issar@nhs.net

www.england.nhs.uk
www.improvement.nhs.uk

Dear Colleague,

You may well be aware of an important piece of work completed by NHS England and NHS Improvement in response to a tragic event that occurred at Imperial College Healthcare NHS Trust (ICHT) three years ago. Details of this work, conducted by an appointed Advisory Group, together with the reasons for its commission, are provided in the enclosed letter that was personally issued by Baroness Harding to all NHS trust and NHS foundation trust chairs and chief executives in May of this year.

The Advisory Group made a series of recommendations, many of which were used as the basis for the provision of additional guidance to provider organisations (also at the enclosure). The purpose in issuing this guidance was to encourage all NHS staff, and in particular boards and HR teams, to reflect on its contents. Boards were further asked to review and assess their respective procedures and processes relating to the management of investigatory and disciplinary matters against the guidance, and to make any adjustments required to bring their organisation in line with best practice. Feedback from the provider community suggests that the guidance was well-received and recognised as representing actions characteristic of responsible and caring employers, while also reflecting our NHS values.

Acknowledging the importance of promoting good practice in the management and conduct of local investigations and disciplinary procedures across the Service, a broader recommendation made by the Advisory Group was that: 'Healthcare regulatory and professional bodies should consider reviewing their respective guidance and standards issued to their registrants, which relate to the management and conduct of local investigations and disciplinary procedures, to ensure fairness, consistency and alignment'. Therefore, I am seeking the support of all healthcare professional and regulatory bodies in undertaking an examination of any such guidance that might already have been provided to members and registrants, or might be developed, to ensure it addresses the issues highlighted above. The General Medical Council already has in place guidance relating to the management and leadership functions of its registrants ('Leadership and management for all doctors' - 2012) and this is commended as being an example of good practice.

In conducting such an examination, respective bodies may also wish to consider offering guidance on a range of specific issues that are relevant to management responsibilities exercised by members and registrants. These could include, for

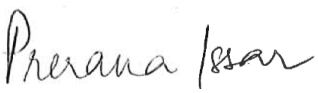
example: expectations regarding high standards of personal conduct and behaviour towards staff; the duty to always act with honesty, compassion, fairness, impartiality and discretion; avoiding, unless in exceptional circumstances, the use of 'some other substantial reason' (SOSR) to dismiss staff; and to ensure that management interventions and actions prioritise the welfare of individuals above any self-interest. Similarly, it is a duty of individuals undertaking management responsibilities to immediately challenge when contra-behaviours and actions are observed in others. In developing guidance, consultation with members and registrants is likely to highlight other considerations and potential remedies which may help to prevent and/or resolve future issues.

In the interests of promoting consistency of approach, NHS England and NHS Improvement would be keen to be consulted on, and to provide support in the development and/or revision of any new or existing guidance. In the first instance, the principal point of contact for this purpose is my office.

Lastly, a further recommendation of the Advisory Group was that the procedures established by 'Maintaining High Professional Standards in the Modern NHS' (a framework for the initial handling of concerns relating to doctors and dentists) should inform the development and implementation of a common management framework for handling concerns relating to all NHS Staff, regardless of profession, role or the type of NHS organisation within which they work. Soundings taken from the HR Director community suggests there is an appetite for the development of a common framework and some scoping work has begun. Clearly, in pursuing this work, there will need to be extensive engagement with all stakeholders, but at this early stage any initial thoughts you may wish to share would be gratefully received.

Thank you in anticipation of your support.

Yours Sincerely,



Prerana Issar
NHS Chief People Officer

Enclosure:

Learning lessons to improve our people practices - Letter from Baroness Harding to all NHS trust and NHS foundation trust chairs and chief executives, 24 May 2019.

Classification: Official

Publication approval reference: PAR293

Prerana Issar

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

01 December 2020

To:

- NHS trust CEOs, HR directors, workforce directors
- NHS foundation trust CEOs, HR directors, workforce directors

Dear Colleagues,

Re: Sharing good practice to improve our people practices

I hope you are doing well in these challenging times.

In May 2019 we shared with you an important piece of work in response to a tragic event that occurred at Imperial College Healthcare NHS Trust (ICHT) four years ago. Sadly, Amin Abdullah, a nurse who at the time was the subject of an investigation and disciplinary procedure, tragically took his own life. Details of the investigation, conducted by an appointed advisory group, together with the reasons for its commission, are provided in the enclosed letter (enclosure 1).

The advisory group made a series of recommendations, many of which were used as the basis for the provision of additional guidance to provider organisations (also at the enclosure). In addition, in November 2019, I wrote to healthcare professionals and regulatory bodies, encouraging review and examination of any guidance and standards provided to members and registrants to address the issues highlighted to support compassionate leadership and improvement across the healthcare system (enclosure 2).

Since Amin's passing, ICHT has worked collaboratively with Amin's partner Terry Skitmore and his advocate Narinder Kapur, alongside other stakeholders, to create a revised policy for handling staff related concerns or complaints. I am writing to share this with you as an example of good people practice, albeit arising from such tragic circumstances (enclosure 3).

The shared learning from Amin's experience has demonstrated the need for us to work continuously and collaboratively, to ensure that our people practices are inclusive, compassionate and person-centred, with an overriding objective as to the safety and wellbeing of our people. These values are central to our recently published People Plan and People Promise.

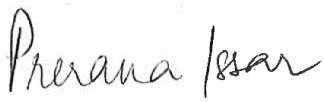
Our collective goal is to ensure we enable a fair and compassionate culture in our NHS. I urge you to honestly reflect on your organisation's disciplinary procedures, review the recommendations we issued in May 2019 and the attached example of good practice, and consider what has worked well and what could be further improved.

Where action is required, I urge NHS organisations to commit to tangible and timely action to review on a yearly basis and by the end of this financial year, all disciplinary procedures against the recommendations and that these are formally discussed/minuted at a **Public** Board or equivalent. We will continue work with the CQC to embed the learning from these reviews to form part of the formal oversight framework. I would also like to suggest your policy is made available on your organisation's public website by the end of the financial year.

As we prepare for the second wave of COVID-19, our staff should feel supported in every sense, including demonstrating a sensitive and compassionate approach to colleagues throughout the disciplinary procedure and process.

Many thanks for everything you are doing to provide services during this challenging time.

Best wishes,



Prerana Issar
NHS Chief People Officer

Enclosure

1. Learning lessons to improve our people practices – Letter to all NHS trust and NHS foundation trust chairs and chief executives, 24 May 2019.

2. Guidance and standards for registrants in relation to local investigations and disciplinary procedures - Letter from Prerana Issar to healthcare professional and regulatory bodies, 04 November 2019.

3. Imperial College Healthcare NHS Trust - Disciplinary Policy and Procedure, July 2020.

Liverpool Women's NHS Foundation Trust

Agenda Item	20/21/275

MEETING	**Trust Board**
PAPER/REPORT TITLE:	**Operational Performance Report period M8 & M9, 2020/21**
DATE OF MEETING:	Thursday, 04 February 2021
ACTION REQUIRED	**Assurance**
EXECUTIVE DIRECTOR:	Gary Price, Chief Operating Officer
AUTHOR(S):	Gary Price, Chief Operating Officer
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** 1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☐ 2. To be ambitious and *efficient* and make the best use of available resource ☒ 3. To deliver *safe* services ☒ 4. To participate in high quality research and to deliver the most *effective* Outcomes ☐ 5. To deliver the best possible *experience* for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust…….* ☐ ***2.*** *Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have sufficient numbers of clinical staff with the capability and capacity to deliver the best care. ……* ☒ ***3.*** *The Trust is not financially sustainable beyond the current financial year……* ☐ ***4.*** *Failure to deliver the annual financial plan ……* ☒ ***5.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision ……* ☐ ***6.*** *Ineffective understanding and learning following significant events……* ☐ ***7.*** *Inability to achieve and maintain regulatory compliance, performance and assurance……* ☒ ***8.*** *Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) ……* ☐
CQC DOMAIN	***Which Domain?*** ***SAFE-*** *People are protected from abuse and harm* ☐ ***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☐ ***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☐ ***RESPONSIVE –*** *the services meet people's needs.* ☐ ***WELL-LED -*** *the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.* ☐ ***ALL DOMAINS*** ☒

LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution ☐ **2.** Operational Plan ☒ **3.** NHS Compliance ☒	**4.** NHS Constitution ☐ **5.** Equality and Diversity ☐ ***6.*** Other: Click here to enter text.
FREEDOM OF INFORMATION (FOIA):	3. This report will not be published under the Trust's Publication Scheme due to exemptions under S22 of the Freedom of Information Act 2000, because the information contained is intended for future publication	
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	***The Board is asked to note the contents of this paper for assurance***	
PREVIOUSLY CONSIDERED BY:	**Committee name**	Finance Performance and Business Development Committee Quality Committee *Click here to enter text.*
	Date of meeting	Monday, 25 January 2021

Executive Summary

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

Report

1. Introduction

Delivering high quality, timely and safe care are the key priorities for the organisation. This report provides an overview of the Trust's performance for months 8 and 9 20/21 against the key quality standards. It highlights those areas where the targets have not been met in the most recent month and subsequent actions taken to improve this position. The full dashboard is included as an appendix to this paper which includes all the indicators that have been achieved or not.

2. Workforce

KPI ID	Source	Service ID	Target < or >	Target	Value	Trend	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
Sickness Absence Rate	Owner - Deputy Director of Workforce																	
KPI101T	NHSI	Trust	<=	4.5%	Numerator		2549	2229	3195	3148	2327	2108	2312	2043	2494	3375	2911	2880
					Denominator		40902	38492	41197	39757	41513	40457	41594	40995	39689	41383	40186	41591
					Performance		6.23%	5.79%	7.75%	7.92%	5.61%	5.21%	5.56%	4.98%	6.28%	8.16%	7.24%	6.92%
					Trend		▲	▼	▲	▲	▼	▼	▲	▼	▲	▲	▼	▼
					Target %		4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%
					Qtrly Performance		6.61%	6.61%	6.61%	6.23%	6.23%	6.23%	5.60%	5.60%	5.60%	7.44%	7.44%	7.44%
Mandatory Training Compliance	Owner - Deputy Director of Workforce																	
KPI095T	Quality Strategy	Trust	>=	95.0%	Numerator													
					Denominator													
					Performance		91.00%	91.00%	91.00%	90.00%	92.00%	92.00%	91.23%	91.00%	89.00%	87.00%	89.00%	89.00%
					Trend		▶	▶	▶	▼	▲	▶	▼	▼	▼	▼	▲	▶
					Target %		95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
					Qtrly Performance													

The single month sickness absence figure fell by 0.32% from 7.24% in month eight to 6.92% in month nine. This remains significantly above the Trust's target figure of 4.50% and is therefore rated as 'red'.

The HR Department is continuing to provide support for managers in managing sickness absence and in supporting staff through this difficult time. A range of support for staff has been developed and communicated to all staff through the regular Coronavirus (COVID-19) staff briefings. Covid 19 Risk assessments have now been put in place for all staff. A coronavirus testing programme is in place for staff (and family members) with suspected symptoms, and asymptomatic testing is now also available to staff. The Covid vaccination programme is now underway and is open to all staff.

The overall Trust mandatory training compliance rate remained unchanged at 89%. This is still 6% under the Trust's target rate of 95% and rated as 'amber'. Local managers continue to monitor the training compliance of their staff, to ensure that patient safety and the quality of the service provided are maintained.

3. Continuity of Care

KPI ID	Source	Service ID	Target < or >	Target	Value	Trend	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
Maternity Services: Proportion of relevant service users who are booked onto a continuity of carer pathway					Owner - Head of Midwifery													
KPI356	Quality Schedule	Maternity	>=	35.0%	Numerator		117	106	142	96	101	80	75	45	65	42	44	78
					Denominator		892	775	819	816	751	805	807	660	810	785	779	843
					Performance		13.12%	13.68%	17.34%	11.76%	13.45%	9.94%	9.29%	6.82%	8.02%	5.35%	5.65%	9.25%
					Trend		▼	▲	▲	▼	▲	▼	▼	▼	▲	▼	▲	▲
					Target %		35%	35%	35%	35%	35%	35%	35%	35%	35%	35%	35%	35%
					Qtrly Performance		14.68%	14.68%	14.68%	11.68%	11.68%	11.68%	8.12%	8.12%	8.12%	6.81%	6.81%	6.81%

The continuity of care performance increased to over 9% in December 2020 with nearly double the number of women booked this way than the previous month. In January 2021 four new teams will go live in line with the agreed plan to increase this target further.

4. Maternity

The below graphic illustrates the maternity activity in December 2020:

5. Access Standards

INDICATOR		METRIC	THRESHOLD		ACTUALS											
					Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
Cancer	2WW for suspected cancer	%	≥93%	Higher values are better	92.6	96.7	95.7	96.5	96.7	97.3	97.0	95.0	94.2	95.0	97.0	
	31 Days from Diagnosis to 1st Definitive Treatment	%	≥96%	Higher values are better	78.3	81.8	75.0	89.7	96.0	92.9	96.0	93.3	100.0	87.1	88.1	
	62 Days for First Treatment from urgent GP Referral **(After re-allocation)** Final Reported Position	%	≥85%	Higher values are better	44.4	39.1	66.7	65.0	34.8	36.7	76.0	60.0	42.9	64.3	61.5	
	104d Referral to First Definitive Treatment	Count	0	Zero tolerance	2	5	1	1	3	3	1	2	0	2	3	
RTT	RTT Incomplete Pathways <18 weeks	%	≥92%	Higher values are better	82.6	81.1	79.5	71.9	64.0	52.6	49.0	56.8	64.4	65.0	63.6	62.8
	Incomplete Pathway > 52 Weeks	Count	0	Zero tolerance	0	0	0	2	5	11	29	32	22	25	47	51
Diagnostics	Diagnostic Tests: 6 week wait	%	≥99%	Higher values are better	96.47	98.83	87.80	27.60	47.00	57.70	59.82	58.20	83.25	87.23	90.53	84.43
A&E	A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge	%	95%	Higher values are better	99.6	98.5	98.1	100.0	98.2	100.0	98.1	98.7	98.2	97.9	98.1	96.6

Referral to Treatment

The Trust continues to see a sustained level in 18-week performance and an increase in 52-week breaches and is beginning to see the impact of lost activity in Q4 last year and Q1 this year for long waiting patients. As outlined last month a detailed review of 52-week patients and our trajectory in performance demonstrated that we could only sustain our long waiting performance if additional theatre capacity could be sourced. Regionally and nationally theatre staffing continues to be challenged. All 52-week breeches receive a harm review.

The Trust had 47 52-week breaches for November. RTT performance decreased to 63.6%. The 6-week diagnostic target, as a precursor to an improving 18-week position has seen improvement since the height of the first wave.

Cancer

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

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

Priority level 1a

- Emergency: operation needed within 24 hours to save life

Priority level 1b

- Urgent: operation needed with 72 hours

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

Priority level 2

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

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

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

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

Priority level 3

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

The 2-week performance remains strong and it is anticipated that this situation will not change despite significant increases in referral number for the past three months compared to the same time period last year (up to 126%), which was expected following a significant reduction in 2ww referrals earlier this year. The oncology performance for 31-day DTT remains good. Moving forward it is anticipated that we see a continuation of improved performance compared to the past 24 months in 31 DTT target but face on-going challenges with our 62-day target due to Covid priority 3 patient management.

Diagnostics

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

KPI ID	Source	Service ID	Target < or >	Target	Value	Trend	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
Diagnostic Tests: 6 Week Wait		Owner - Divisional Manager Clinical Support																
KPI204	NHSI	Trust	>=	99.0%	Numerator		464	421	165	35	195	326	332	284	328	328	344	282
					Denominator		481	426	188	127	415	565	555	488	394	376	380	334
					Performance		96.47%	98.83%	87.77%	27.56%	46.99%	57.70%	59.82%	58.20%	83.25%	87.23%	90.53%	84.43%
					Trend		▲	▲	▼	▼	▲	▲	▲	▼	▲	▲	▲	▼
					Target %		99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%
					Qtrly Performance		95.89%	95.89%	95.89%	50.23%	50.23%	50.23%	65.69%	65.69%	65.69%	87.52%	87.52%	87.52%

6. Conclusion

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

Liverpool Women's NHS Foundation Trust

Board Performance Report

Published Month - January 2021

Data Included - Up to December 2020

Workforce

KPI ID	Source	Service ID	Target < or >	Target	Value	Trend	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
Sickness Absence Rate	**Owner - Deputy Director of Workforce**																	
KPI101T	NHSI	Trust	<=	4.5%	Numerator		2549	2229	3195	3148	2327	2108	2312	2043	2494	3375	2911	2880
					Denominator		40902	38492	41197	39757	41513	40457	41594	40995	39689	41383	40186	41591
					Performance		6.23%	5.79%	7.75%	7.92%	5.61%	5.21%	5.56%	4.98%	6.28%	8.16%	7.24%	6.92%
					Trend		▲	▼	▲	▲	▼	▼	▲	▼	▲	▲	▼	▼
					Target %		4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%	4.5%
					Qtrly Performance		6.61%	6.61%	6.61%	6.23%	6.23%	6.23%	5.60%	5.60%	5.60%	7.44%	7.44%	7.44%
Mandatory Training Compliance	**Owner - Deputy Director of Workforce**																	
KPI095T	Quality Strategy	Trust	>=	95.0%	Numerator													
					Denominator													
					Performance		91.00%	91.00%	91.00%	90.00%	92.00%	92.00%	91.23%	91.00%	89.00%	87.00%	89.00%	89.00%
					Trend		▶	▶	▶	▼	▲	▶	▼	▼	▼	▼	▲	▶
					Target %		95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
					Qtrly Performance													

Efficient

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

Liverpool Women's NHS Foundation Trust

Safety

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

Effective

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

Liverpool Women's NHS Foundation Trust

Experience

KPI ID	Source	Service ID	Target < or >	Target	Value	Trend	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
18 Week RTT: Incomplete Pathways	**Owner - Divisional Manager Gynaecology**																	
KPI003T	NHSI	Trust	>=	92.0%	Numerator		5187	5152	5149	4657	4217	3443	3550	4428	5264	5120	4982	5283
					Denominator		6283	6349	6476	6476	6584	6549	7204	7799	8177	7877	7834	8419
					Performance		82.56%	81.15%	79.51%	71.91%	64.05%	52.57%	49.28%	56.78%	64.38%	65.00%	63.59%	62.75%
					Trend		▲	▼	▼	▼	▼	▼	▼	▲	▲	▲	▼	▼
					Target %		92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%
					Qtrly Performance		81.06%	81.06%	81.06%	62.81%	62.81%	62.81%	57.13%	57.13%	57.13%	63.76%	63.76%	63.76%
18 Week RTT: Incomplete Pathway > 52 Weeks	**Owner - Divisional Manager Gynaecology**																	
KPI002T	Quality Schedule	Trust	=	0	Performance Value		0	0	0	2	5	11	29	32	22	25	47	51
					Trend													
					Target Value		0	0	0	0	0	0	0	0	0	0	0	0
18 Week RTT: Admitted Completed Pathways	**Owner - Divisional Manager Gynaecology**																	
KPI001	Trust Objectives	Trust	>=	90.0%	Numerator		192	196	170	123	79	90	118	114	134	143	148	94
					Denominator		290	278	243	137	104	169	217	210	227	243	246	161
					Performance		66.21%	70.50%	69.96%	89.78%	75.96%	53.25%	54.38%	54.29%	59.03%	58.85%	60.16%	58.39%
					Trend		▼	▲	▼	▲	▼	▼	▲	▼	▲	▼	▲	▼
					Target %		90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
					Qtrly Performance		68.80%	68.80%	68.80%	71.22%	71.22%	71.22%	55.96%	55.96%	55.96%	59.23%	59.23%	59.23%
18 Week RTT: Non-Admitted Completed Pathways	**Owner - Divisional Manager Gynaecology**																	
KPI004T	Trust Objectives	Trust	>=	95.0%	Numerator		1864	1766	1417	798	659	973	913	1042	1043	1235	1072	939
					Denominator		2230	2073	1673	898	795	1325	1400	1461	1497	1672	1488	1358
					Performance		83.59%	85.19%	84.70%	88.86%	82.89%	73.43%	65.21%	71.32%	69.67%	73.86%	72.04%	69.15%
					Trend		▼	▲	▼	▲	▼	▼	▼	▲	▼	▲	▼	▼
					Target %		95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
					Qtrly Performance		84.45%	84.45%	84.45%	80.52%	80.52%	80.52%	68.79%	68.79%	68.79%	71.85%	71.85%	71.85%
All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (After Re-allocation)	**Owner - Divisional Manager Gynaecology**																	
KPI030	NHSI	Gynaecology	>=	85.0%	Numerator		4	4.5	9	6.5	4	5.5	9.5	7.5	3	9	8	
					Denominator		9	11.5	13.5	10	11.5	15	12.5	12.5	7	14	13	
					Performance		44.44%	39.13%	66.67%	65.00%	34.78%	36.67%	76.00%	60.00%	42.86%	64.29%	61.54%	
					Trend		▲	▼	▲	▼	▼	▲	▲	▼	▼	▲	▼	
					Target %		85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
					Qtrly Performance		51.47%	51.47%	51.47%	43.84%	43.84%	43.84%	62.50%	62.50%	62.50%	62.96%	62.96%	62.96%
Cancer: 62 Day Screening Referrals (Numbers)	**Owner - Divisional Manager Gynaecology**																	
KPI033	NHSI	Gynaecology	<=	5	Performance Value		1.0	1.0	1.0	1.0	0.5	0.0	2.0	1.0	0.0	0.0	0.0	
					Trend		▲	▶	▶	▶	▼	▼	▲	▼	▼	▶	▶	
					Target Value		5	5	5	5	5	5	5	5	5	5	5	5
					Qtrly Performance Value		3	3	3	1.5	1.5	1.5	3	3	3	0	0	0
Cancer: 62 Day Screening Referrals (Percentage)	**Owner - Divisional Manager Gynaecology**																	
KPI034	NHSI	Gynaecology	>=	90.0%	Numerator		1	1	1	1	0.5	0	2	1	0	0	0	
					Denominator		1	1	1	1	0.5	0	2	1.5	0	0	0.5	
					Performance		100.00%	100.00%	100.00%	100.00%	100.00%		100.00%	66.67%			0.00%	
					Trend			▶	▶	▶	▶			▼				
					Target %		90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
					Qtrly Performance		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	85.71%	85.71%	85.71%	0.00%	0.00%	0.00%
Cancer: 104 Day Breaches	**Owner - Divisional Manager Gynaecology**																	
KPI352	Trust Objectives	Gynaecology	=	0	Performance Value		2	5	1	1	3	3	1	2	0	2	3	
					Trend		▼	▲	▼	▶	▲	▶	▼	▲	▼	▲	▲	
					Target Value		0	0	0	0	0	0	0	0	0	0	0	0
					Qtrly Performance Value		8	8	8	7	7	7	3	3	3	5	5	5

Experience

KPI ID	Source	Service ID	Target < or >	Target	Value	Trend	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
Cancer: 28 Day Faster Diagnosis	**Owner - Divisional Manager Gynaecology**																	
KPI359	Trust Objectives	Gynaecology	>=	75.0%	Numerator		136	145	167	111	112	165	177	159	186	169	206	
					Denominator		258	253	296	208	134	208	242	225	259	285	321	
					Performance		52.71%	57.31%	56.42%	35.00%	83.58%	79.33%	73.14%	70.67%	71.81%	59.30%	64.17%	
					Trend		▲	▲	▼	▼	▲	▼	▼	▼	▲	▼	▲	
					Target %		75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%
					Qtrly Performance		55.51%	55.51%	55.51%	70.55%	70.55%	70.55%	71.90%	71.90%	71.90%	61.88%	61.88%	61.88%
Diagnostic Tests: 6 Week Wait	**Owner - Divisional Manager Clinical Support**																	
KPI204	NHSI	Trust	>=	99.0%	Numerator		464	421	165	35	195	326	332	284	328	328	344	282
					Denominator		481	426	188	127	415	565	555	488	394	376	380	334
					Performance		96.47%	98.83%	87.77%	27.56%	46.99%	57.70%	59.82%	58.20%	83.25%	87.23%	90.53%	84.43%
					Trend		▲	▲	▼	▼	▲	▲	▲	▼	▲	▲	▲	▼
					Target %		99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%
					Qtrly Performance		95.89%	95.89%	95.89%	50.23%	50.23%	50.23%	65.69%	65.69%	65.69%	87.52%	87.52%	87.52%
A&E: Total Time Spent in department (95th Percentile)	**Owner - Divisional Manager Gynaecology**																	
KPI012	Trust Objectives	Gynaecology	<=	240	Performance Value		214	218	222	208	199	213	231	223	232	233	236	237
					Trend		▲	▲	▲	▼	▼	▲	▲	▼	▲	▲	▲	▲
					Target Value		240	240	240	240	240	240	240	240	240	240	240	240
					Qtrly Performance Value		654	654	654	620	620	620	686	686	686	706	706	706
Complaints: Number Received	**Owner - Head of Audit, Effectiveness and Patient Experience**																	
KPI038T	NHSI / Quality Strate	Trust	<=	15	Performance Value		7	4	3	1	6	5	5	2	4	1	5	2
					Trend		▲	▼	▼	▼	▲	▼	▶	▼	▲	▼	▲	▼
					Target Value		15	15	15	15	15	15	15	15	15	15	15	15
					Qtrly Performance Value		14	14	14	12	12	12	11	11	11	8	8	8

Liverpool Women's NHS Foundation Trust

Agenda Item	20/21/276

MEETING	**Trust Board**
PAPER/REPORT TITLE:	Finance Performance Review Month 9 2020/21
DATE OF MEETING:	Thursday, 04 February 2021
ACTION REQUIRED	**Assurance**
EXECUTIVE DIRECTOR:	Jenny Hannon, Director of Finance
AUTHOR(S):	Eva Horgan, Deputy Director of Finance Claire Scott, Head of Financial Management
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** **1.** To develop a well led, capable, motivated and entrepreneurial ***workforce*** ☐ **2.** To be ambitious and ***efficient*** and make the best use of available resource ☒ **3.** To deliver ***safe*** services ☐ **4.** To participate in high quality research and to deliver the most ***effective*** Outcomes ☐ **5.** To deliver the best possible ***experience*** for patients and staff ☐
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust…….* ☐ ***2.*** *Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have sufficient numbers of clinical staff with the capability and capacity to deliver the best care. ……* ☐ ***3.*** *The Trust is not financially sustainable beyond the current financial year……* ☒ ***4.*** *Failure to deliver the annual financial plan ……* ☒ ***5.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision ……* ☐ ***6.*** *Ineffective understanding and learning following significant events……* ☐ ***7.*** *The Trusts current clinical records system (paper and electronic) are sub-optimal……* ☐ ***8.*** *Major and sustained failure of essential IT systems due to a cyber attack ….* ☐ ***9.*** *Failure to - a) maintain pre-Covid-19 level of service for our patients due to the outbreak of the Covid-19 pandemic; b) protect staff, patients and visitors from infection; c) effectively manage increased demands and provide support to the wider system; and d) failure to recover to pre-Covid-19 service levels following the pandemic and be sufficiently resilient to manage a potential 'second wave' of infection* ☐
CQC DOMAIN	***Which Domain?*** ***SAFE-*** *People are protected from abuse and harm* ☐ ***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☐ ***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☐

	RESPONSIVE – *the services meet people's needs.* ☐ ***WELL-LED*** *- the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.* ☒ ***ALL DOMAINS*** ☐	
LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution ☐ **2.** Operational Plan ☒ **3.** NHS Compliance ☒	**4.** NHS Constitution ☐ **5.** Equality and Diversity ☐ ***6.*** Other: **Click here to enter text.**
FREEDOM OF INFORMATION (FOIA):	2. This report will not be published under the Trust's Publication Scheme due to exemptions under S21 of the Freedom of Information Act 2000, because the information contained is reasonably accessible by other means	
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	***The Board is asked to note the Month 9 Financial Position.***	
PREVIOUSLY CONSIDERED BY:	**Committee name**	Not Applicable
	Date of meeting	

Executive Summary

The Trust had produced a breakeven financial plan for 20/21, however operational and financial planning was paused at the onset of the Covid 19 pandemic to be replaced with a new temporary financial regime. This financial regime was updated once more from October, with the removal of retrospective top up payments in place for the first half of the year which had allowed the Trust to breakeven in months 1 to 6. So whilst expenditure has not changed significantly in the second half of the year, the reduction in income has led to the Trust being in a deficit position.

At month 9 the Trust is slightly ahead of this revised plan with an adjusted deficit[1] of £0.8m for the month and £2.4m year to date (YTD). This is after receipt of system, Covid-19 and growth top up of £0.6m per month in months 7-9 (compared with an average of £1.4m per month in months 1-6).

This leaves the Trust on plan to deliver a revised £4.6m adjusted deficit as submitted to the Cheshire & Merseyside Health and Care Partnership (HCP). There remains an overall financial gap across organisations at an HCP level however this has been reducing over recent months.

The key areas of financial performance are summarised below.[2]

[1] The actual deficit is £2.2m YTD and forecast £4.4m but this includes income from donated assets of £0.2m, which is adjusted out in the I&E for NHSI/E comparison purposes leaving the adjusted deficit against which the Trust is monitored at £2.4m YTD and £4.6m forecast.

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

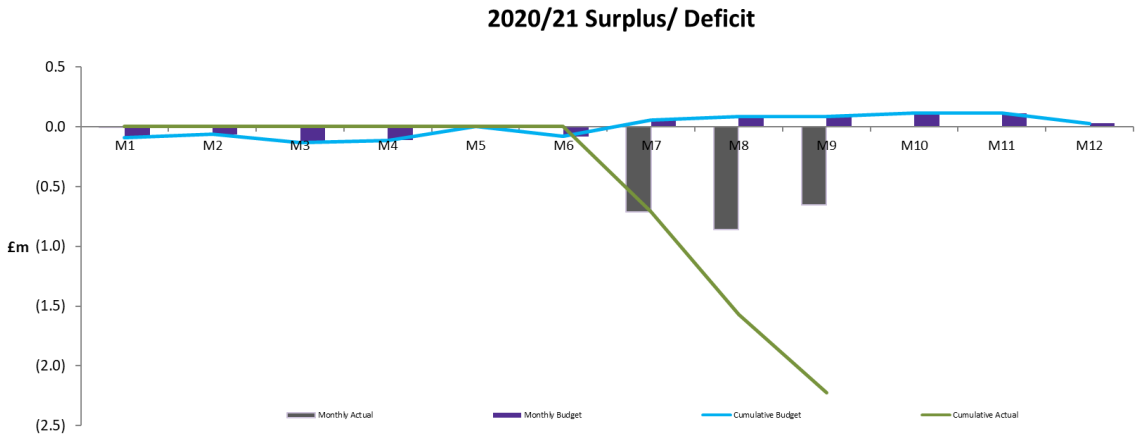
	Original Plan	Actual	Variance	RAG	*Revised Plan*	*Actuals*	*Variance v Revised Plan*	*RAG re Revised Plan*
Surplus/(Deficit) YTD	-£0.3m	-£2.2m	-£2.0m	↓	*-£2.4m*	*-£2.2m*	*-£0.2m*	↑
Surplus/ (Deficit) FOT	£0.0m	-£4.6m	-£4.6m	↔	*-£4.6m*	*-£4.4m*	*-£0.2m*	↑
NHS I/E Rating	3	3	0	↔	3	3	0	↔
Cash	£10.8m	£8.4m	-£2.4m	↓	*£10.4m*	*£8.4m*	*-£1.9m*	↑
Total CIP Achievement YTD	£2.5m	£1.5m	-£1.0m	↓	*£0.6m*	*£0.6m*	*£0.0m*	↔
Recurrent CIP Achievement YTD	£2.3m	£1.3m	-£1.0m	↓	*£0.5m*	*£0.5m*	*£0.0m*	↔
Capital Spend YTD	£3.4m	£3.4m	£0.0m		*£3.3m*	*£3.4m*	*£0.0m*	

Monitoring will continue both against the Trust's internal plan, which aligns to budgets agreed by the divisions and signed off by the Board, and the revised NHSI/E plan, which is based on the revised forecast submitted to the HCP.

Report

1. Summary Financial Position

At month 9 the Trust is reporting an actual deficit of £2.2m YTD, after total combined tops up of £10.4m YTD. Top up payments have reduced significantly in the last quarter, causing the deficit position.



Top up has reduced to a fixed £0.6m per month in quarter three against an average of £1.4m per month in quarters one and two. The total requirement versus amount provided by month and reason, is provided below.

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

	M1 £000	M2 £000	M3 £000	M4 £000	M5 £000	M6 £000	M7 £000	M8 £000	M9 £000	YTD £000
Anticipated structural shortfall	780	780	780	780	780	780	780	780	780	**7,020**
Private Patient income shortfall	222	253	163	-10	63	-49	-85	23	12	**592**
Commercial income shortfall	56	51	49	47	7	55	38	41	47	**392**
CIP under delivery	49	50	48	73	73	107	205	205	205	**1,016**
Covid-19 costs	484	409	296	361	221	191	216	175	131	**2,484**
Activity related underspends - non pay	-174	-92	-106	-115	-193	-88	92	42	239	**-395**
Activity related underspends - pay	-116	-280	-75	-127	-70	10	163	136	-51	**-411**
Trust settlements					260	109	0	0	0	**369**
Other Healthcare Income	42	140	-12	82	88	96	28	57	40	**561**
Medical pay award (YTD)						109	18	18	18	**164**
Other	-18	-170	16	105	92	340	-86	32	68	**379**
Total Retrospective	**1,325**	**1,140**	**1,159**	**1,196**	**1,322**	**1,661**	**1,369**	**1,509**	**1,490**	**12,171**
Projected	99	99	99	99	99	99	0	0	0	**592**
MRET	25	25	25	25	25	25	0	0	0	**147**
Total Required	**1,448**	**1,263**	**1,282**	**1,319**	**1,445**	**1,784**	**1,369**	**1,509**	**1,490**	**12,910**
Total Provided	**1,448**	**1,263**	**1,282**	**1,319**	**1,445**	**1,784**	**649**	**649**	**649**	**10,489**
Variance	**0**	**0**	**0**	**0**	**0**	**0**	**-720**	**-860**	**-841**	**-2,421**

The actual top up for month 9 was £0.6m, compared to a requirement of £1.5m. The difference is the cause of the deterioration in the Trust's position in month as shown above. Note also that the Trust anticipates £60k funding towards lateral flow testing plus some additional funding towards vaccination costs in year (to be agreed), but this will be minimal.

2. Divisional Summary Overview

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

Family Health: The division was marginally underspent in month (£10k) bringing the YTD underspend to £255k. Midwifery bank spend remains similar to last month (£53k) despite additional measures to reduce this, meaning the overspend on midwives in total increased £74k in month to £539k YTD.

Gynaecology: The division overspent in month (£60k), reducing the YTD underspend to £647k.

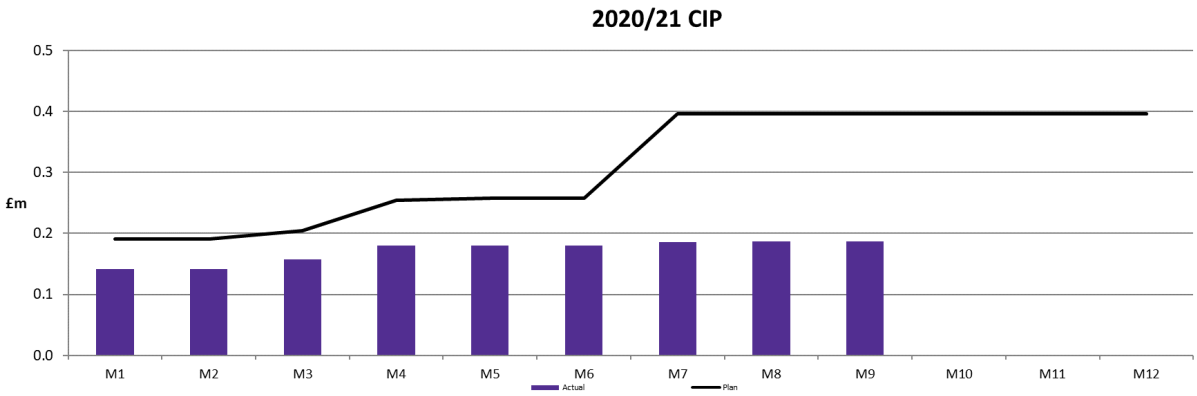
Clinical Support Services: The division was overspent in month (£59k), bringing the underspend to £448k YTD.

Agency: Total agency spend was £549k YTD, of which £298k was Covid-19 related.

3. CIP

A revised CIP forecast has been used as the basis for a plan to NHSI/E and is reportable from month 7 onwards. This is on track at month 8 (£187k plan and actual delivery in month, £559k YTD).

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



4. COVID-19

A total of £131k was spent on Covid-19 related costs in December, which is shown in the table below with further detail in the appendix.

	M1 £000	M2 £000	M3 £000	M4 £000	M5 £000	M6 £000	M7 £000	M8 £000	M9 £000	YTD £000
Bank costs to cover Covid-19 related vacancies	119	62	71	49	19	22	71	52	19	**484**
Student Nurses	0	40	49	34	17	0	0	0	0	**140**
Agency and WLI costs for medical cover	104	78	46	138	13	1	1	1	3	**385**
PPE and equipment (not including centrally purchased items)	69	24	13	73	61	23	10	5	6	**283**
Enhancements paid to staff off sick	58	26	13	19	18	16	31	23	17	**221**
Staff meals (after £15k charity contribution)	28	60	0	0	0	0	0	0	0	**88**
Other catering and cleaning	32	33	37	15	26	22	30	30	28	**253**
Swabbing, Lateral Flow and Vaccination Costs					17	21	22	23	27	**110**
Additional corporate costs	9	22	27	18	11	17	24	13	14	**156**
Telephony						29	3	3	3	**36**
LUHFT - Breast Surgery								3	6	**9**
Other	67	62	41	15	39	40	25	23	9	**321**
Total	**486**	**408**	**296**	**361**	**221**	**191**	**216**	**175**	**131**	**2,486**

Costs in this area continue to be carefully monitored.

5. Cash and Borrowings

The cash balance actually improved in month 9 despite the Trust generating a deficit. This was largely due to the reduction in debtors and is well above the minimum amount planned for of c£4.5m. This will be reduced over the coming months as the Trust continues to generate a deficit. However, no additional revenue support is currently assessed to be required in this financial year. Cash will continue to be carefully monitored.

6. Capital Expenditure

The capital plan is on plan. Due to underspend of capital at an HCP level, LWH has taken the opportunity to increase capital expenditure and allow items previously held back to be funded, meaning there is a planned full year overspend of £250k. This is still within the Trust's individual Capital Resource Limit and is affordable from a cash perspective. There is no funding e.g. PDC associated with this so additional spend is being kept to critical items only.

In addition to this, the Trust has been successful in securing additional PDC to fund an e-rostering system (£97k).

Following the confirmation that the emergency capital bid was approved, work continues to ensure the £4.9m phased into 2020/21 will be spent. This will be a challenge, but it has been made clear that unspent funds cannot be carried over so work is focused on achieving this.

7. Balance Sheet

Overall debtors reduced again to £2.3m from £3.6m in month eight. Deferred income remains high due to the cash receipt in April of two months' worth of block payments. This will reduce in month 12 when the additional payment is clawed back. The Trust also received payment for the majority of the prior months' top up from NHSI/E.

8. BAF Risk

There are no further changes planned to BAF risk 2344 (in-year financial position), which stands at 20 (likelihood at 5 – *almost certain* and severity at 4 - *major*). The deficit plan is now agreed at a HCP level, so it was agreed at the Finance, Performance and Business Development Committee that the severity score will now be reviewed.

9. Conclusion & Recommendation

The Trust is facing a deficit plan for the remainder of the financial year despite demonstrating sound grip and control across expenditure. The issues surrounding the adequacy of the income payments will continue to be flagged, particularly in light of the ongoing impact into future years. The Trust is considering the impact this may have on financial stability in 2021/22.

The Board are asked to note the month 9 financial position.

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 1
NHS IMPROVEMENT RATIOS: M9
YEAR ENDING 31 MARCH 2021

USE OF RESOURCES RISK RATING	YEAR TO DATE NHSI Plan	YEAR TO DATE Actual
CAPITAL SERVICING CAPACITY (CSC)		
(a) EBITDA + Interest Receivable	3,317	3,453
(b) PDC + Interest Payable + Loans Repaid	2,072	2,064
CSC Ratio = (a) / (b)	**1.60**	**1.67**
NHSI CSC SCORE	**3**	**3**
Ratio Score 1 = > 2.5 2 = 1.75 - 2.5 3 = 1.25 - 1.75 4 = < 1.25		
LIQUIDITY		
(a) Cash for Liquidity Purposes	(13,937)	(13,562)
(b) Expenditure	88,904	88,629
(c) Daily Expenditure	323	322
Liquidity Ratio = (a) / (c)	**(43.1)**	**(42.1)**
NHSI LIQUIDITY SCORE	**4**	**4**
Ratio Score 1 = > 0 2 = (7) - 0 3 = (14) - (7) 4 = < (14)		
I&E MARGIN		
Deficit (Adjusted for donations and asset disposals)	2,409	2,385
Total Income	(92,221)	(92,082)
I&E Margin	**-2.6%**	**-2.6%**
NHSI I&E MARGIN SCORE	**4**	**4**
Ratio Score 1 = > 1% 2 = 1 - 0% 3 = 0 - (-1%) 4 < (-1%)		
I&E MARGIN VARIANCE FROM PLAN		
I&E Margin (Actual)		-2.60%
I&E Margin (Plan)		-2.60%
I&E Variance Margin	**0.00%**	**0.00%**
NHSI I&E MARGIN VARIANCE SCORE	**1**	**1**
Ratio Score 1 = > 0% 2 = (1) - 0% 3 = (2) - (1)% 4 = < (2)%		
Note: NHSI assume the score of the I&E Margin variance from Plan is a 1 for the whole year and year		
AGENCY SPEND		
YTD Providers Cap	1,341	1,341
YTD Agency Expenditure	529	548
	-61%	**-59%**
NHSI AGENCY SPEND SCORE	**1**	**1**
Ratio Score 1 = < 0% 2 = 0% - 25% 3 = 25% - 50% 4 = > 50%		
Overall Use of Resources Risk Rating	**3**	**3**

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

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
INCOME & EXPENDITURE: M9
YEAR ENDING 31 MARCH 2021

INCOME & EXPENDITURE	M9 - NHSI Plan			M9 - Internal Budget			YTD - NHSI Plan			YTD - Internal Budget			YEAR - NHSI Plan			YEAR - Internal Budget		
£'000	NHSI Plan	Actual	Variance	Budget	Actual	Variance	NHSI Plan	Actual	Variance	Budget	Actual	Variance	NHSI Plan	Forecast	Variance	Budget	Forecast	Variance
Income																		
Clinical Income	(9,296)	(9,281)	(15)	(9,379)	(9,281)	(98)	(87,074)	(87,034)	(40)	(84,218)	(87,034)	2,816	(115,160)	(115,361)	201	(112,354)	(115,361)	3,007
Non-Clinical Income	(564)	(700)	136	(699)	(700)	1	(5,147)	(5,048)	(100)	(6,241)	(5,048)	(1,194)	(6,840)	(6,645)	(195)	(8,339)	(6,645)	(1,694)
Total Income	**(9,860)**	**(9,981)**	**121**	**(10,078)**	**(9,981)**	**(97)**	**(92,221)**	**(92,082)**	**(139)**	**(90,460)**	**(92,082)**	**1,622**	**(122,000)**	**(122,006)**	**6**	**(120,693)**	**(122,006)**	**1,313**
Expenditure																		
Pay Costs	6,303	6,166	138	5,960	6,166	(206)	55,756	55,495	260	53,789	55,495	(1,707)	74,581	74,538	44	71,670	74,538	(2,868)
Non-Pay Costs	2,466	2,550	(83)	2,137	2,550	(412)	21,476	21,461	15	19,872	21,461	(1,589)	28,779	28,705	75	26,283	28,705	(2,421)
CNST	1,297	1,297	(0)	1,297	1,297	(0)	11,672	11,672	(0)	11,673	11,672	0	15,563	15,563	(0)	15,563	15,563	0
Total Expenditure	**10,067**	**10,012**	**54**	**9,394**	**10,012**	**(618)**	**88,904**	**88,629**	**275**	**85,333**	**88,629**	**(3,296)**	**118,924**	**118,806**	**118**	**113,516**	**118,806**	**(5,289)**
EBITDA	**206**	**31**	**175**	**(684)**	**31**	**(715)**	**(3,317)**	**(3,453)**	**136**	**(5,127)**	**(3,453)**	**(1,674)**	**(3,076)**	**(3,200)**	**124**	**(7,177)**	**(3,200)**	**(3,976)**
Technical Items																		
Depreciation	448	444	4	426	444	(18)	3,985	3,967	18	3,832	3,967	(135)	5,324	5,299	25	5,109	5,299	(190)
Interest Payable	5	4	1	41	4	37	41	38	3	366	38	328	56	50	6	488	50	438
Interest Receivable	0	0	0	(4)	0	(4)	0	0	0	(38)	0	(38)	0	0	0	(51)	0	(51)
PDC Dividend	192	199	(7)	136	199	(63)	1,725	1,721	5	1,223	1,721	(498)	2,301	2,294	7	1,630	2,294	(664)
Profit/Loss on Disposal or Transfer Absorption	0	(25)	25	0	(25)	25	(14)	(39)	25	0	(39)	39	(14)	(39)	25	0	(39)	39
Total Technical Items	**645**	**621**	**23**	**598**	**621**	**(23)**	**5,737**	**5,686**	**51**	**5,383**	**5,686**	**(303)**	**7,667**	**7,604**	**63**	**7,177**	**7,604**	**(427)**
(Surplus) / Deficit before Adjusting Items	**851**	**652**	**199**	**(86)**	**652**	**(738)**	**2,420**	**2,233**	**187**	**256**	**2,233**	**(1,977)**	**4,591**	**4,403**	**188**	**0**	**4,403**	**(4,403)**
Remove gain on disposable assets	0	25	(25)	0	25	(25)	14	39	(25)	0	39	(39)	14	39	(25)	0	39	(39)
Remove Income from donated assets	0	169	(169)	0	169	(169)	0	169	(169)	0	169	(169)	0	169	(169)	0	169	(169)
Add back depreciation on donated assets	(1)	(5)	4	(0)	(5)	5	(12)	(17)	5	(3)	(17)	14	(15)	(22)	7	(4)	(22)	18
(Surplus) / Deficit as per NHSI	**850**	**841**	**8**	**(86)**	**841**	**(928)**	**2,422**	**2,425**	**(3)**	**253**	**2,425**	**(2,172)**	**4,590**	**4,590**	**0**	**(4)**	**4,590**	**(4,594)**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 3
EXPENDITURE: M9
YEAR ENDING 31 MARCH 2021

EXPENDITURE £'000	MONTH Budget	MONTH Actual	MONTH Variance	YEAR TO DATE Budget	YEAR TO DATE Actual	YEAR TO DATE Variance	YEAR Budget	YEAR Actual	YEAR Variance
Pay Costs									
Board, Execs & Senior Managers	327	310	17	2,945	3,044	(99)	3,927	4,059	(132)
Medical	1,555	1,610	(55)	14,004	14,191	(186)	18,673	19,109	(436)
Nursing & Midwifery	2,633	2,781	(148)	23,797	25,250	(1,453)	31,695	33,927	(2,232)
Healthcare Assistants	424	429	(5)	3,813	3,918	(104)	5,084	5,224	(140)
Other Clinical	376	349	27	2,768	2,503	264	4,517	4,186	332
Admin Support	136	139	(3)	1,228	1,200	28	1,637	1,605	32
Corporate Services	444	482	(38)	4,043	4,270	(227)	5,375	5,754	(379)
Agency & Locum	63	65	(1)	1,191	1,121	70	761	674	87
Total Pay Costs	**5,960**	**6,166**	**(206)**	**53,789**	**55,495**	**(1,707)**	**71,670**	**74,538**	**(2,868)**
Non Pay Costs									
Clinical Suppplies	623	535	88	1,898	1,777	122	7,502	7,502	0
Non-Clinical Supplies	555	811	(256)	20,113	20,529	(416)	6,665	7,563	(898)
CNST	1,297	1,297	0	3,891	3,891	0	15,563	15,563	0
Premises & IT Costs	600	640	(40)	1,806	1,780	26	7,202	7,202	0
Service Contracts	360	564	(204)	3,836	5,157	(1,320)	4,915	6,438	(1,523)
Total Non-Pay Costs	**3,434**	**3,847**	**(412)**	**31,544**	**33,134**	**(1,589)**	**41,847**	**44,268**	**(2,421)**
Total Expenditure	**9,394**	**10,012**	**(618)**	**85,333**	**88,629**	**(3,296)**	**113,516**	**118,806**	**(5,289)**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 4a
COVID EXPENDITURE: M9
YEAR ENDING 31 MARCH 2021

EXPENDITURE £'000	MONTH Budget	MONTH Actual	MONTH Variance	YEAR TO DATE Budget	YEAR TO DATE Actual	YEAR TO DATE Variance	YEAR Budget	YEAR Actual	YEAR Variance
Pay Costs									
Board, Execs & Senior Managers	0	0	0	0	25	(25)	0	25	(25)
Medical	0	5	(5)	0	198	(198)	0	209	(209)
Nursing & Midwifery	0	34	(34)	0	775	(775)	0	1,069	(1,069)
Healthcare Assistants	0	14	(14)	0	221	(221)	0	261	(261)
Other Clinical	0	1	(1)	0	5	(5)	0	5	(5)
Admin Support	0	18	(18)	0	63	(63)	0	119	(119)
Corporate Services	0	0	0	0	0	0	0	0	0
Agency & Locum	0	12	(12)	0	298	(298)	0	337	(337)
Total Pay Costs	**0**	**85**	**(85)**	**0**	**1,583**	**(1,583)**	**0**	**2,025**	**(2,025)**
Non Pay Costs									
Clinical Suppplies	0	(2)	2	0	113	(113)	0	113	(113)
Non-Clinical Supplies	0	6	(6)	0	395	(395)	0	411	(411)
CNST	0	0	0	0	0	0	0	0	(0)
Premises & IT Costs	0	41	(41)	0	383	(383)	0	511	(511)
Service Contracts	0	0	0	0	5	(5)	0	5	(5)
Total Non-Pay Costs	**0**	**45**	**(45)**	**0**	**895**	**(895)**	**0**	**1,040**	**(1,040)**
Total Expenditure	**0**	**130**	**(130)**	**0**	**2,479**	**(2,479)**	**0**	**3,065**	**(3,065)**

Note that the values above include £3k YTD and £86k in the FOT related to Vaccination expenditure which may be reimbursed, this will be moved out of Covid costs into a separate section in M10 if that is the case.

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 5
BUDGET ANALYSIS: M9 as per ledger
YEAR ENDING 31 MARCH 2021

INCOME & EXPENDITURE	MONTH			YEAR TO DATE			YEAR - Internal		
£'000	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Actual	Variance
Maternity									
Income	0	(2)	2	0	(37)	37	0	(49)	49
Expenditure	1,889	1,907	(18)	17,003	17,229	(226)	22,671	23,025	(354)
Total Maternity	**1,889**	**1,905**	**(15)**	**17,003**	**17,192**	**(189)**	**22,671**	**22,975**	**(304)**
Neonatal									
Income	0	(94)	94	0	(725)	725	0	(996)	996
Expenditure	1,127	1,195	(68)	10,140	10,421	(281)	13,520	13,933	(413)
Total Neonatal	**1,127**	**1,101**	**26**	**10,140**	**9,696**	**444**	**13,520**	**12,938**	**583**
Division of Family Health - Total	**3,016**	**3,006**	**10**	**27,143**	**26,888**	**255**	**36,191**	**35,913**	**278**
Gynaecology									
Income	0	0	0	0	0	0	0	0	0
Expenditure	1,033	1,047	(14)	9,297	9,086	211	12,397	12,333	64
Total Gynaecology	**1,033**	**1,047**	**(14)**	**9,297**	**9,086**	**211**	**12,397**	**12,333**	**64**
Hewitt Centre									
Income	0	0	0	0	(1)	1	0	(1)	1
Expenditure	689	735	(46)	6,227	5,793	434	8,296	8,060	236
Total Hewitt Centre	**689**	**735**	**(46)**	**6,227**	**5,791**	**435**	**8,296**	**8,059**	**237**
Division of Gynaecology - Total	**1,722**	**1,782**	**(60)**	**15,524**	**14,877**	**647**	**20,693**	**20,391**	**301**
Theatres									
Income	0	0	0	0	0	0	0	0	0
Expenditure	712	786	(74)	6,527	6,195	332	8,663	8,557	106
Total Theatres	**712**	**786**	**(74)**	**6,527**	**6,195**	**332**	**8,663**	**8,557**	**106**
Genetics									
Income	0	(11)	11	0	(135)	135	0	(189)	189
Expenditure	151	142	9	1,362	1,299	63	1,816	1,747	69
Total Genetics	**151**	**132**	**20**	**1,362**	**1,164**	**198**	**1,816**	**1,559**	**258**
Other Clinical Support									
Income	0	0	(0)	0	0	(0)	0	0	(0)
Expenditure	602	608	(5)	5,531	5,614	(83)	7,338	7,485	(147)
Total Clinical Support	**602**	**608**	**(6)**	**5,531**	**5,614**	**(83)**	**7,338**	**7,485**	**(147)**
Division of Clinical Support - Total	**1,466**	**1,525**	**(59)**	**13,421**	**12,973**	**448**	**17,817**	**17,601**	**216**
Corporate & Trust Technical Items									
Income	(10,078)	(9,875)	(203)	(90,460)	(91,183)	723	(120,693)	(120,771)	78
Expenditure	3,788	4,214	(426)	34,627	38,677	(4,050)	45,992	51,269	(5,277)
Total Corporate	**(6,290)**	**(5,661)**	**(628)**	**(55,833)**	**(52,506)**	**(3,327)**	**(74,701)**	**(69,502)**	**(5,199)**
(Surplus) / Deficit	**(86)**	**652**	**(738)**	**256**	**2,233**	**(1,977)**	**0**	**4,403**	**(4,403)**
Adjusting Items	(0)	189	(189)	(3)	192	(195)	(4)	186	(190)
(Surplus) / Deficit	**(86)**	**841**	**(928)**	**253**	**2,425**	**(2,172)**	**(4)**	**4,590**	**(4,594)**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
BUDGET ANALYSIS: M9 as per revised NHSI Plan
YEAR ENDING 31 MARCH 2021

INCOME & EXPENDITURE £'000	MONTH - NHSI			YEAR TO DATE - NHSI			YEAR - NHSI		
	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Actual	Variance
Maternity									
Income	(4)	(2)	(2)	(37)	(37)	1	(49)	(49)	1
Expenditure	1,960	1,907	53	17,331	17,229	102	23,134	23,025	110
Total Maternity	**1,956**	**1,905**	**51**	**17,294**	**17,192**	**102**	**23,085**	**22,975**	**110**
Neonatal									
Income	(66)	(94)	28	(594)	(725)	131	(792)	(996)	204
Expenditure	1,148	1,195	(46)	10,319	10,421	(102)	13,764	13,933	(169)
Total Neonatal	**1,082**	**1,101**	**(19)**	**9,725**	**9,696**	**29**	**12,972**	**12,938**	**35**
Division of Family Health - Total	**3,039**	**3,006**	**33**	**27,019**	**26,888**	**131**	**36,058**	**35,913**	**145**
Gynaecology									
Income	0	0	0	0	0	0	0	0	0
Expenditure	1,055	1,047	8	9,043	9,086	(43)	12,149	12,333	(183)
Total Gynaecology	**1,055**	**1,047**	**8**	**9,043**	**9,086**	**(43)**	**12,149**	**12,333**	**(183)**
Hewitt Centre									
Income	0	0	0	(1)	(1)	0	(1)	(1)	0
Expenditure	718	735	(17)	5,759	5,793	(34)	7,917	8,060	(143)
Total Hewitt Centre	**718**	**735**	**(17)**	**5,758**	**5,791**	**(33)**	**7,916**	**8,059**	**(143)**
Division of Gynaecology - Total	**1,773**	**1,782**	**(9)**	**14,801**	**14,877**	**(76)**	**20,065**	**20,391**	**(326)**
Theatres									
Income	0	0	0	0	0	0	0	0	0
Expenditure	702	786	(83)	5,945	6,195	(250)	8,027	8,557	(530)
Total Theatres	**702**	**786**	**(83)**	**5,945**	**6,195**	**(250)**	**8,027**	**8,557**	**(530)**
Genetics									
Income	(11)	(11)	(0)	(234)	(135)	(99)	(254)	(189)	(66)
Expenditure	132	142	(10)	1,268	1,299	(31)	1,654	1,747	(94)
Total Genetics	**121**	**132**	**(10)**	**1,034**	**1,164**	**(130)**	**1,399**	**1,559**	**(159)**
Other Clinical Support									
Income	0	0	(0)	0	0	(0)	(0)	0	(0)
Expenditure	631	608	23	5,694	5,614	80	7,596	7,485	111
Total Clinical Support	**631**	**608**	**23**	**5,694**	**5,614**	**80**	**7,596**	**7,485**	**111**
Division of Clinical Support - Total	**1,454**	**1,525**	**(71)**	**12,673**	**12,973**	**(300)**	**17,023**	**17,601**	**(578)**
Corporate & Trust Technical Items									
Income	(9,780)	(9,875)	95	(91,355)	(91,183)	(173)	(120,904)	(120,771)	(133)
Expenditure	4,364	4,214	150	39,282	38,677	605	52,349	51,269	1,080
Total Corporate	**(5,415)**	**(5,661)**	**246**	**(52,074)**	**(52,506)**	**432**	**(68,555)**	**(69,502)**	**947**
(Surplus) / Deficit	**850**	**652**	**198**	**2,420**	**2,233**	**187**	**4,591**	**4,403**	**188**
Adjusting Items	(1)	189	(190)	2	192	(190)	(1)	186	(187)
(Surplus) / Deficit	**849**	**841**	**8**	**2,422**	**2,425**	**(3)**	**4,590**	**4,590**	**0**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 6
CIP: M9
YEAR ENDING 31 MARCH 2021

SCHEME NAME	MONTH 9			YTD			Full Year		
	Original Target	Actual	Variance	Original Target	Actual	Variance	Original Target	Revised	Variance
Procurement Savings (Trust-wide)	83	0	(83)	250	0	(250)	500	0	(500)
Genetics contribution to overheads	38	38	0	342	342	0	456	456	0
Corporate savings	32	32	0	264	260	(3)	358	358	0
Maternity HCA vacancies	21	21	0	188	188	0	250	250	0
NHSP Savings (subject to Business Case)	17	17	0	150	150	0	200	200	0
Additional Pysiotherapy activity within existing resource	14	0	(14)	127	0	(127)	169	0	(169)
GDE Revenue Savings	13	0	(13)	113	0	(113)	150	0	(150)
Genetics Commissioning Changes (Sendaway Tests)	11	11	0	101	101	0	135	135	0
Estates Rental income - UNIVERSITY	10	10	0	86	86	0	115	115	0
Aintree Estate Utilisation	11	0	(11)	67	0	(67)	100	0	(100)
HFC Strategic Review	25	13	(13)	119	43	(77)	195	80	(115)
Theatre Efficiency and Surgical Pathways Project	17	0	(17)	50	0	(50)	100	0	(100)
Full SLA review	11	11	0	67	67	0	100	100	0
MVA Business Case income generation (net of pay costs)	11	0	(11)	67	0	(67)	100	0	(100)
Theatre procurement Savings	10	10	0	70	70	0	100	70	(30)
P2P Activity above budget 19/20	0	0	0	0	0	0	0	0	0
Imaging recharges for scanning - full review (AH Consultant)	6	6	0	53	53	0	70	70	0
Additional Fertility offering Macclesfield	0	0	0	0	0	0	0	0	0
Imaging rota review	5	5	0	45	45	0	60	60	0
Pharmacy Ordering	4	4	0	21	21	0	32	32	0
Other Smaller Schemes	59	11	(48)	360	88	(273)	537	121	(416)
	396	**187**	**(209)**	**2,539**	**1,513**	**(1,025)**	**3,728**	**2,048**	**(1,680)**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
BALANCE SHEET: M9
YEAR ENDING 31 MARCH 2021

BALANCE SHEET £'000	YEAR TO DATE Opening	M09 Actual	Movement	YEAR TO DATE NHSI Plan	M09 Actual	Movement	YEAR TO DATE Internal Budget	M09 Actual	Movement
Non Current Assets	**92,282**	**91,829**	(453)	**92,105**	**91,829**	(276)	**92,834**	**91,829**	(1,005)
Current Assets									
Cash	4,647	8,483	3,836	10,791	8,483	(2,308)	4,600	8,483	3,883
Debtors	6,329	7,161	832	4,873	7,161	2,288	9,476	7,161	(2,315)
Inventories	432	467	35	432	467	35	452	467	15
Total Current Assets	**11,408**	**16,111**	**4,703**	**16,096**	**16,111**	**15**	**14,528**	**16,111**	**1,583**
Liabilities									
Creditors due < 1 year - Capital Payables	(2,809)	(381)	2,428	(953)	(381)	572	(266)	(381)	(115)
Creditors due < 1 year - Trade Payables	(15,314)	(13,162)	2,152	(14,981)	(13,162)	1,819	(18,698)	(13,162)	5,536
Creditors due < 1 year - Deferred Income	(2,918)	(13,944)	(11,026)	(11,924)	(13,944)	(2,020)	(3,471)	(13,944)	(10,473)
Creditors due > 1 year - Deferred Income	(1,623)	(1,600)	23	(1,623)	(1,600)	23	(1,591)	(1,600)	(9)
Loans	(17,359)	(2,442)	14,917	(2,442)	(2,442)	0	(17,117)	(2,442)	14,675
Provisions	(1,698)	(1,644)	54	(1,698)	(1,644)	54	(4,870)	(1,644)	3,226
Total Liabilities	**(41,721)**	**(33,173)**	**8,548**	**(33,621)**	**(33,173)**	**448**	**(46,013)**	**(33,173)**	**12,840**
TOTAL ASSETS EMPLOYED	**61,969**	**74,767**	**12,798**	**74,580**	**74,767**	**187**	**61,349**	**74,767**	**13,418**
Taxpayers Equity									
PDC	42,519	57,550	15,031	57,550	57,550	0	42,488	57,550	15,062
Revaluation Reserve	14,329	14,329	0	14,329	14,329	0	14,503	14,329	(174)
Retained Earnings	5,121	2,888	(2,233)	2,701	2,888	187	4,358	2,888	(1,470)
TOTAL TAXPAYERS EQUITY	**61,969**	**74,767**	**12,798**	**74,580**	**74,767**	**187**	**61,349**	**74,767**	**13,418**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 8
CASHFLOW STATEMENT: M9
YEAR ENDING 31 MARCH 2021

CASHFLOW STATEMENT	YEAR TO DATE		
£'000	NHSI Plan	Actual	Variance
Cash flows from operating activities	(668)	(513)	(155)
Depreciation and amortisation	3,984	3,967	17
Impairments and reversals	0	0	0
Income recognised in respect of capital donations (cash and non-cash)	0	(169)	169
Movement in working capital	8,736	7,378	1,358
Net cash generated from / (used in) operations	**12,052**	**10,663**	**1,389**
Interest received	0	0	0
Purchase of property, plant and equipment and intangible assets	(6,008)	(5,836)	(172)
Proceeds from sales of property, plant and equipment and intangible assets	14	48	(34)
Net cash generated from/(used in) investing activities	**(5,994)**	**(5,788)**	**(206)**
PDC Capital Programme Funding - received	428	428	0
PDC Funding received (Loans to PDC Conversion)	14,572	14,572	0
PDC COVID-19 Capital Funding - received	31	31	0
Loans from Department of Health Capital - repaid	(306)	(306)	0
Loans from Department of Health Capital - repaid (Loans to PDC Conversion)	(14,572)	(14,572)	0
Loans from Department of Health Revenue - received	0	0	0
Loans from Department of Health Revenue - repaid	0	0	0
Interest paid	(67)	(67)	0
PDC dividend (paid)/refunded	0	(1,125)	1,125
Net cash generated from/(used in) financing activities	**86**	**(1,039)**	**1,125**
Increase/(decrease) in cash and cash equivalents	**6,144**	**3,836**	**2,308**
Cash and cash equivalents at start of period	4,647	4,647	0
Cash and cash equivalents at end of period	**10,791**	**8,483**	**2,308**

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

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST **9**
CAPITAL EXPENDITURE: M9
YEAR ENDING 31 MARCH 2021

CAPITAL EXPENDITURE	Year to Date		
£'000	NHSI Plan	Actual	Variance
Neonatal New Building	759	753	6
Estates Schemes	220	292	(72)
IT Schemes	1,211	1,239	(28)
Medical Equipment	1,218	1,063	155
Critical Infrastructure Risk - PDC Funded	0	30	(30)
COVID-19 Items - PDC Funded	0	31	(31)
Total	**3,408**	**3,408**	**0**

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

Agenda Item	20/21/277

MEETING	**Board**
PAPER/REPORT TITLE:	**Well-Led Framework Self-Assessment – Action Plan**
DATE OF MEETING:	Thursday, 04 February 2021
ACTION REQUIRED	**Receive**
EXECUTIVE DIRECTOR:	Mark Grimshaw, Trust Secretary
AUTHOR(S):	Mark Grimshaw, Trust Secretary
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** **1.** To develop a well led, capable, motivated and entrepreneurial ***workforce*** ☒ **2.** To be ambitious and ***efficient*** and make the best use of available resource ☒ **3.** To deliver ***safe*** services ☒ **4.** To participate in high quality research and to deliver the most ***effective*** Outcomes ☒ 5. To deliver the best possible ***experience*** for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust…….* ☐ ***2.*** *Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have sufficient numbers of clinical staff with the capability and capacity to deliver the best care. ……* ☐ ***3.*** *The Trust is not financially sustainable beyond the current financial year……* ☐ ***4.*** *Failure to deliver the annual financial plan ……* ☐ ***5.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision ……* ☐ ***6.*** *Ineffective understanding and learning following significant events……* ☐ ***7.*** *Inability to achieve and maintain regulatory compliance, performance and assurance……* ☒ ***8.*** *Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) ……* ☐
CQC DOMAIN	***Which Domain?*** ***SAFE-*** *People are protected from abuse and harm* ☐ ***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☐ ***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☐ ***RESPONSIVE –*** *the services meet people's needs.* ☐ ***WELL-LED -*** *the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.* ☒

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

Executive Summary

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

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

The action plan has been updated by the Executive Team and these are reflected in the 'comments' section. A file structure has been established in the 'Trust Board Teams' room in which Board members can review the identified evidence for assurance purposes.

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

1. *To ensure that the Trust's strategy is well understood by all staff and external stakeholders and that there are clear links between the Trust's short- and medium-term plans to the overarching strategy.*

   Work has progressed to develop the Trust's strategy and strategic aims with regular updates provided to the Finance, Performance and Business Development Committee and the Board. The views of governors, staff and the public have been gathered and a draft strategy has been produced for consideration by the Board on the private agenda. The draft document has recognised the need to ensure that the Trust's short- and medium-term objectives are fully outlined. A discussion took place at the Board's workshop on 7 January 2021 and it was recognised that key to the strategy's success would be ensuring 'buy in' from all staff groups. Methods for gaining this 'buy in' remain in development but are seen as a core part of the success of the updated strategy. Plans also remain to link the strategy and strategic aims to the updated appraisal process.

2. *The requirement for a defined approach to Continuous Improvement that is recognised and utilised throughout the organisation so that it becomes a demonstrable 'improvement mindset'.*

   As can be seen from the action plan, several actions have been taken to move forward the Trust's approach to Quality Improvement (QI) and examples of this were reported to the Board in November 2020. There is now a recognised structure and process for the establishment and monitoring of QI projects via the Effectiveness Senate.

   Work has continued on an overarching document summarising the Trust's approach and this is close to completion and will be progressed through the Executive Team. The challenge going forward will be to ensure that Quality Improvement becomes fully embedded as a 'mindset' for the organisation and to be able to evidence its effective use in day-to-day operations.

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

   Whilst progress has been made to enhance the Trust's approach to lesson learning, and body of evidence is being compiled, further work is required to ensure that lessons are being effectively utilised to drive changes in practice that become fully embedded and demonstrable. The Quality Committee has been scheduled to receive a 'deep dive' on lesson learning since prior to the Christmas period but this has been deferred until an internal audit report on lesson learning has been finalised (expected in early March 2020). The Quality Committee and then Board will then receive a comprehensive report on the Trust's approach, it's maturity and areas for improvement. This is likely to have synergies with the work the Trust will be undertaking in its response to the Ockenden report, a key theme from which the Board has identified as the effective learning of lessons and evidencing of improved practice.

The Trust's self-assessment (and action plan) is one part of the overall Well-Led framework process with there being a requirement to follow this with an external review. This process is currently underway with a final report scheduled to be received by the Board in April 2021. This report will likely result in a number of improvement recommendations / actions and it will be the intention to take forward the Trust's own identified actions (yet to be closed or not duplicated) within an updated action plan.

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

Well-Led Self-Assessment Action Plan

KLOE 1. Is there the leadership capacity and capability to deliver high quality, sustainable care?						
Lead Executive: Chief Executive Management Lead: Trust Secretary NED Lead: Trust Chair						
Action Ref	Action	**Timescale**	**Lead**	Progress	Comments	Evidence
K1/1.1	Development of a Board Terms of Reference to provide additional clarity on roles and responsibilities	May-20	TS		Complete	Terms of Reference included within Corporate Governance Manual
K1/1.2	Ensure that an annual declaration against the Code of Conduct is completed by Board members	Sep-20	TS		Complete	Outputs of this process reported to the Nomination & Remuneration Committee in September 2020. Individual records reviewed by both Chair and CEO (and Deputy CEO and SID for Chair and CEO)
K1/1.3	Ensure that safeguarding issues are highlighted more prominently in Board and Committee papers	Apr-21 (Jan-21)	TS / Chair / Committee Chairs		Rather than including the highlighting of both safeguarding issues in the regular 'review of risks' item on Board and Committee agendas, it is proposed that Safeguarding metrics be developed and for these to be reported to the relevant assurance meeting for visibility (Quality Committee and Board). These will form part of the Integrated Performance Report that will launch in April 21.	
K1/1.4	Although the gender balance is good there are further opportunities to improve the diversity of the Board to ensure that it mirrors the population that the Trust serves. This should feature in future succession plans.	Nov-20	TS / Chair		Attempts were made during the most recent NED recruitment process to increase the diversity of candidates. This involved the use of a video clip via social media to encourage applications from individuals who might not have considered applying previously. Adverts were also targeted at national and local community organisations. The outcome from the recruitment process can be reported verbally to the meeting. A reflection piece will be undertaken to consider whether the Trust could have improved the recruitment process to further strengthen the diversity of the Board going forward. This will feature on future succession plans.	Link to video and candidate pack
K1/1.5	To share findings from the external well-led review once complete and ensure that progress against the action plan is reported through the public Board.	Apr-21	TS		The external well-led review is underway and is scheduled to report to the April 2021 Board.	
K1/1.6	To seek Committee feedback into the effectiveness reviews from all members – take into consideration the recommendations from the MIAA Audit Committee Effectiveness Review.	Mar-21	TS		The 2021 Committee Effectiveness Review will mirror the effectiveness review process undertaken by the Audit Committee in Oct 2020.	
K1/1.7	Consider how to formalise feedback from the Shadow Board process	~~Oct 20~~ Apr-21	TS / Chair		Representative from the Shadow Board to attend immediately prior to the Trust Board to provide a verbal update.	
K1/1.8	Effective assurance minute writing guidance to be produced for all relevant administrative staff.	Nov-20	TS		This will be incorporated into the Governance and Performance Framework (currently in development). This will be supported by group training delivered by the Corporate Governance team. Training has been undertaken for the majority of administrative staff during December 2020.	Training presentation Governance and Performance Framework (draft)
K1/1.9	To develop Leadership & Organisational Development Strategy	Dec-20 (Sep-20)	CPO		Leadership & Development Strategy approved by the Board in December 2020.	December 2020 Board pack
KLOE 2. Is there a clear vision and a credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?						
Lead Executive: Director of Finance Management Lead: Strategic Finance Manager NED Lead: Jo Moore						
Action Ref	Action	Timescale	Lead	Progress	Comments	Evidence

K2/2.1	Strategy re-fresh to be undertaken with public facing document also produced. This will be socialised with the public, stakeholders, and staff. Strategy to ensure that it; a) References operational priorities – e.g. RTT, GIRFT b) is aligned to newly published Long-Term Plan; c) Clearly articulates short- and medium-term plans linked to overarching strategy, and; d) Shows how it has used NHSI Strategy tool	Apr-21	DoF / CPO		Update on the Strategy was provided to the January 2021 Board workshop and a draft version is scheduled for consideration in February 2021. The final version is scheduled for approval in April 2021.	
K2/2.2	Ensuring there is a clear link to strategy when producing annual service plans	Apr-21 (Sep-20)	DoF		Annual Service Plans were paused due to the Covid-19. It is not expected that this can be achieved for the 2020-21 financial year but will be factored into the planning for 2021-22.	
K2/2.3	To undertake testing on whether more junior staff in all areas can articulate the Trust strategy	Jul-21 (Oct-20)	CPO		Once the strategy has been launched following approval in April 2021 – testing will be undertaken on the effectiveness of the campaign.	
K2/2.4	Re-establish robust patient engagement mechanisms regarding the Trust Strategy with reporting through to the Experience Senate	Nov-20 (Sep-20)	DoN&M		Patient and public engagement sought during November and December 2020 and this has fed into the development of the Trust Strategy. The Trust's overarching strategic framework recognises the contributory factor of underpinning strategies and the Patient Experience Strategy is currently being renewed. This will align with the priorities established in the overarching corporate strategy. The updated Membership Strategy (in development) will also recognise the importance of utilising membership to explain the Trust's strategic direction 9and seek input into	Patient Engagement feedback provided to January 2021 workshop.
K2/2.5	Ensure that there are documented links from overarching strategy to individual performance target levels	Apr-21 (Sep-20)	CPO		PDR review underway. PDR window to be introduced in line with publication of the Trust corporate objectives, creating a 'golden thread'. To be introduced 2021/22 Q1.	
K2/2.6	To ensure that there is a post implementation review process for strategy	Apr-21 (Jun-21)	DoF		A formal process is being introduced for annual strategy post implementation reviews to be scrutinised and reported through the relevant Board Committee structures. This is to be added as part of the annual workplan for each committee. The overarching corporate strategy will further be aligned to the Board's review of the setting of and performance against the Trust's annual Corporate Objectives. The Trust's Digital Strategy has recently undergone its first review of progress – this will form a model for reviewing strategies going forward.	Digital Strategy review – reported to FPBD in January 2021.
K2/2.7	Clear links to strategy in divisional priorities with references to strategy delivery in Divisional Performance meetings	Apr-21 (Oct-20)	COO		This was intended to be achieved with the plans on a page, however Covid-19 affected the practicalities of completing this. For 2021/22 each division will update their plans on a page (and corporate services) and they will be the tools for linking strategy to performance from then on. In the meantime, the performance reviews will be updated to reflect links to strategic aims.	

KLOE 3. Is there a culture of high quality, sustainable care?

Lead Executive: Director of Nursing & Midwifery Management Lead: Deputy Director of Nursing NED Lead: Tony Okotie

Action Ref	Action	Timescale	Lead	Progress	Comments	Link with CQC Action Plan
K3/3.1	Quality improvement work needs to be more focused with clear demonstration of training, projects identified with robust evaluations. Although to some extent this is demonstrated through audit and effectiveness (service evaluations) further work needs to be done with the evidencing of QI projects and sustainability specifically in clinical areas. To be a focus in the quality strategy 2020-2025.	Nov-20	MD		The Clinical & Quality Strategy was approved by the Board in September 2020 and the final version is now live on the Trust website. The Trust's use of Quality Improvement is referenced within the document. There is an established process for the approval, monitoring and reflection on QI projects – all quality improvement projects and clinical audits are now registered on Ulysses with active management of action plans. This is relatively new so there is a lot of support required for staff to upload their projects and monitor them QI Lead has retrospectively put on all projects from April 1st 2020 onward. We are encouraging staff at the Effectiveness senate (in minutes) to use QI to support the actions from their audits. We are also asking the effectiveness senate members to bring to the senate lessons learnt from Audits and QI and we actively ask them at the end of the senate to report back Evidence of QI projects reported to the November 2020 Board.	Clinical & Quality Strategy QI Methodology and process November 2020 Board minutes (private)

K3/3.2	It is recognised and evidenced through the staff survey that the quality of appraisals needs improving. A review of appraisal process and documentation / conversation needs to happen with a talent management conversation as a separate discussion. To start in September 2020.	Apr-21 (Mar-21)	CPO		- see k2/2.5	
K3/3.3	Focus areas remain incident reporting / learning from incidents (safety culture) where we have improved year on year but below average and the best performing Trusts. Embedding learning from incidents/ complaints is a key part of N, M& AHP strategy and the Quality strategy with focused actions to achieve this. Continued and improved recognition awards both internal and external.	Apr-21 (Sep-20)	DoN&M		Report scheduled for February 2021 outlining how the Trust can improve lesson learning and the identification of themes from Serious Incidents. A broader review of lesson learning across the organisation is scheduled for March's Quality Committee and through to the Board in April 2021.	
K3/3.4	LWH still receive some complaints from staff via CQC, there are some complex dignity at work investigations. To improve there needs to be a more consistent approach across all teams needs to be evident utilising the fair and just culture approach.	Mar-21	CPO		Fair and Just project embedded in substantive role of Head of Talent and Culture. Work progressing accordance with work-plan including integration within HR policies and procedures.	
K3/3.5	There needs to be more evidence of embedding lessons learnt and sharing across the trust. There is evidence of divisional lessons learnt but lack of Trust wide evidence and utilising quality improvement methodology to sustain this	Apr-21 (Sep-20)	MD		- see k3/3.3 We are expecting the results of the MIAA audit into lessons learnt. At the end of each senate the MD asks each representative what they have learnt from the senate and what they are going to feedback to their clinical area. The next step will be asking them to evidence they have done that (MD to start to do this in a few months' time)	
K3/3.6	More work needs to be undertaken with the reporting of incidents. Although staff do speak out regarding concerns to CQC, Freedom to speak up more needs to be done to give staff the confidence to report incidences internally and that they have feedback regarding the issues raised.	Apr-21 (Sep-20)	DoN&M		The Risk and Patient Safety Manager continues to work with the Governance managers on ways in which we can improve incident reporting levels. It is recognised that staff need more support to feel that they are safe and supported to report incidents at all levels of the organisation and from each other. The Risk and Patient Safety Manger has developed some information leaflets for all staff about the importance of reporting incidents and explanations to refute the above comments. The Serious Incident process includes a feedback process to staff. Further thought will be given to this issue following consideration of outputs from the 2020 Staff Survey.	
K3/3.7	Although there are some effective systems and processes in place for documenting lessons learnt/ action plans this is not readily available for teams in an electronic format (reminder) for them to monitor out of date actions. Also, lessons learnt is not embedded at 'shop floor' level.	Apr-21 (Sep-20)	DoN&M		The Head of Governance has purchased an action planning module for the Ulysses system which will ensure all actions are centralised and action plans and reports can be extracted from the system. This also allows for all evidence in relation to an action to be attached to the action and in Ulysses and stored centrally. The Head of Governance and arranged for a weekly report to be generated for the Head of Nursing in relation to all actions currently open for their services and their current status. Overdue actions will be escalated via the appropriate monitoring group or committee. This is already done in relation to actions from Serious Incidents via the Divisional Governance Groups, Safety Senate , Quality Committee and the Trust Board. On the Trust Intranet there is a lesson learnt section which all staff can access which has lessons from incidents uploaded into a simple one page format for Maternity, Gynaecology, Neonatal and Theatres. This has been recently updated to include Covid-19 and is to be developed further to cover all areas. The Governance team are planning an update to the risk management intranet page which will also holds information on lesson learnt which all staff can access. The Risk and Patient Safety manager and Quality Improvement Lead are currently completing a piece of work to identify if we can learn for other organisation who have achieved outstanding in QC as to how they share and embed lessons. Comprehensive evidence report scheduled for the Board in Apr-21.	

K3/3.8	To ensure that there is a clear mechanism for the triangulation of information to inform the Trust's Training Needs Analysis and that the Educational Governance Group provides sufficient oversight.	Apr-21 (Sep-20)	CPO		The divisional structure is providing improved input and oversight regarding the Trust's Training Needs Analysis (TNA). To be explored whether lesson learning can be used to help inform the TNA. Comprehensive evidence report scheduled for the Board in Apr-21.	
K3/3.9	Training and appraisal performance needs to be consistently above 95% in all areas	Nov-20	COO & CPO		Robustly monitored via Divisional Board and Divisional Performance Review. Compliance trajectories in place. This is being monitored closely at the Putting People First Committee	
K3/3.10	A need to provide evidence of supporting under-represented groups into senior roles	Nov-20	CPO		A Head of Culture, Inclusion, Wellbeing and Engagement has also been appointed, this new role will drive forward the F&J agenda and enable us to achieve our corporate objectives to become a truly inclusive employer. The recent NED recruitment round had a particular focus on ensuring that the reach of the job advert went to all areas of the communities served by the Trust. Proposed to close the action on this tracker and this has bene added as part of the Trust's wider E&DI agenda.	NED Recruitment process
KLOE 4. Are there clear responsibilities, roles and systems of accountability to support good governance and management?						
Lead Executive: Chief Executive Management Lead: Trust Secretary NED Lead: Tracy Ellery						
Action Ref	Action	Timescale	Lead	Progress	Comments	Evidence
K4/4.1	To hold a Board Development session on Duties of Directors	Oct-20	TS		Took place at October 2020 Board workshop.	Presentation slides
K4/4.2	The level of challenge between Governors and Non-Executive Directors can be strengthened in order for the former to demonstrate discharge of holding to account responsibilities.	Mar-21 (Jan-21)	TS		Effective challenge and questioning session provided to the Board of Directors (Oct 2020). Session to be arranged for the Council of Governors (March 2021).	
K4/4.3	A review of Board agendas from 2017-2020 demonstrates that there is an imbalance in the Board time allocated to current performance and the time allocated to strategic discussion during meetings held in public. Whilst this is developing in right direction, further emphasis can be given to strategic discussion.	Apr-21 (Jan-21)	TS		Whilst the on-set of Covid-19 has required a focus on operational matters, the Board has maintained a view on strategic matters and this will be increased during phase 3 of the Covid-19 response. View to be taken from the external well-led review on the balance of Board focus and time.	
KLOE 5. Are there clear and effective processes for managing risks, issues and performance?						
Lead Executive: Chief Operating Officer Management Lead: Head of Governance & Quality NED Lead: Susan Milner						
Action Ref	Action	Timescale	Lead	Progress	Comments	Evidence
K5/5.1	Whilst processes are in place further work is required with senior managers to ensure that they fully understand and can articulate the mechanisms for managing risks and performance (link with Accountability Framework)	Oct-20	DoN&M		In March 2019 the Head of Governance and Quality put in place a new Standard Operating Procedure for the Management of Risk and Risk Registers. As part of this process awareness sessions were provide in the safety senate and Corporate Risk Committee. On an annual basis the Head of Governance undertakes a training session with the Executive Directors in relation to their responsibilities for risk and Health and Safety in the organisation. Maternity, Gynaecology and Neonatal services have a Governance Manager in place. Clinical Support Services currently have a Governance Facilitator in place supported by the Head of Governance. The governance staff in the divisions are working closely with all the responsible managers for risk to ensure that the identification and	

					management if risk meets the Trust SoP and is as robust as it can be. This is an on-going process. A part of the corporate induction the Head of Governance provides a session on risk and risk management to all new staff. A similar session is provided to all new junior medical staff when they commence in the Trust. The Risk and Patient Safety Manager is currently developing a new training package for all levels of staff on risk and incident management. Nov 20 – Whilst further work is required to strengthen the 'feedback loop' for an individual, the Executive feel that there is sufficient evidence for this item to be closed.	
K5/5.2	Further work required to formalise horizon scanning processes at operational level.	Jan-21 (Oct-20)	COO		This is being undertaken at divisional level (reported through review meetings) and at the Effectiveness Senate. This will be further strengthened as part of the updated Divisional Board agenda pack from April 2021.	Divisional Board agendas
K5/5.3	Further work required to embed the 'follow up' process to business case implementation. Need to clearly define approach to developing and delivering CIPs.	Oct-20	DoF		The Trust's approach to developing and delivering CIPs has been formalised into a document which will be presented at FPBD in October 20 alongside the scheduled CIP mid-year post implementation review and ahead of the formal work up for the 21/22 planning round. The formal follow up process for business cases will also be presented at this committee. Nov-20 - Reports received and embedded – agreed to be closed.	
KLOE 6. Is appropriate and accurate information being effectively processed, challenged and acted on?						
Lead Executive: Director of Finance Management Lead: Chief Information Officer NED Lead: Ian Knight						
Action Ref	Action	Timescale	Lead	Progress	Comments	Evidence
	No actions identified					
KLOE 7. Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?						
Lead Executive: Chief People Officer Management Lead: Deputy Director of Workforce NED Lead: Phil Huggon						
Action Ref	Action	Timescale	Lead	Progress	Comments	Evidence
K7/7.1	Consider how to evidence that staff at all levels are involved in the planning and delivery of service developments and give due regard to the public sector equality duty.	Feb-21 (Nov-20)	DoF & CPO		Quality Improvement framework will provide structured mechanisms for staff to engage with service change and transformation. Leadership strategy focuses on effective engagement and consultation with staff. PSED observed in internal and external consultation regarding changes to services. Robust EIQA process in place – agreed to collate these for evidence purposes. Evidenced engagement with all staff in relation to the 2021/22 planning round and CIP identification.	FPBD Report on 2021/22 planning QI reports to Effectiveness Senate
K7/7.2	To consider how best to receive and analyse 360-degree feedback from system leaders.	Dec-20 (Sep-20)	DoF / CEO		Readiness Assessment performed in Autumn 2019 proved a useful tool to understand the views of stakeholders. Further approaches via direct contact and use of governance structures during development and implementation of the refreshed strategy will support an updated view. Further independent review to be considered. Snapshot information will be provided through the quarterly partnership report (referenced in K7/7.3). Further evidence of this provided through Chair, CEO and Exec Director appraisals.	CEO Reports Quarterly partnership

					Involvement in system meetings and activity to be captured in future CEO reports.	
K7/7.3	To evidence that the Trust is involved in pooled activities in the local health economy.	Dec-20 (Oct-20)	COO		As above.	

KLOE 8. Are there robust systems and processes for learning, continuous improvement and innovation?

Lead Executive: Medical Director Management Lead: Deputy Medical Director NED Lead: Louise Kenny

Action Ref	Action	Timescale	Lead	Progress	Comments	Link with CQC Action Plan
K8/8.1	The Trust requires strengthened articulation of a quality improvement preferred methodology and strategy either within the existing quality strategy or in a new QI strategy.	Nov-20 (Sep-20)	MD		The approach to QI is referenced within the Clinical & Quality Strategy. The Trust's QI methodology is set out in a package on the Trust's intranet and is available to all staff. A consolidated QI document remains in development and requires approval by the Executive team. Expected by the middle of February 2021.	
K8/8.2	Theme of Quality Improvement to be used for a 'Great Day' to help communicate the Trust's agreed approach from the Quality Improvement Strategy.	Feb-21	MD		A meeting is being arranged between QI lead, clinical audit lead and DON and MD to discuss the agenda for the QI 'Great Day'	
K8/8.3	Review of the work-plan of the Divisional partnership board meetings, Senates and Board committees to ensure that learning from external sources is reflected.	Apr-21 (Sep-20)	TS/MD		Outline of process of external inspections and accreditations to be considered by the Audit Committee in January 2021. Updated Divisional Board agendas will ensure that action plans from such inspections are considered.	
K8/8.4	Board and its Committees to find a process by which they can reflect upon their successes and failures; review how quality, financial and operational information has resulted in actions that have successfully improved performance; articulate the same and plan for improvement.	Nov-20	TS		Mid-year review process undertaken by Committees. Board survey in place after Board meetings – feeds back into informal NED meetings and Executive meetings.	Board Survey Mid-year Committee reviews.
K8/8.5	Governance team to evidence activity around improvement using PDSA cycles being discussed and supported in Divisions and Senates and develop a training and implementation plan if one is needed.	Jan-21 (Sep-20)	DoN&M		The Quality Improvement lead has developed a new Quality Improvement intranet site which will allow all QI training information and improvement updates to be available to all staff. QI approval section in the Effectiveness Senate agenda. QI Methodology document will incorporate a training plan.	
K8/8.6	Board development session to provide learning and discussion around improvement methodologies.	Jun-20	MD/TS		QI Session at June 2020 Board Workshop – completed.	June 2020 workshop minutes
K8/8.7	Governance department to produce a co-ordinated planned roll-out of improvement methodology teaching to encompass all key groups as agreed with the executive group	Jan-21 (Oct-20)	DoN&M		Training has been offered but with low turn out due to Covid-19 pressures. QI Methodology document will incorporate a training plan.	
K8/8.8	Documentation of skill sharing demonstrated by delivery of improvement methodology events by a broader group of staff	Oct-20	DoN&M		All QI training sessions are run as a multi-disciplinary process so there is mix of staff from different background and skills.	
K8/8.9	Strengthened evidence required that the Senates record issues on internal and external reviews and can robustly identify assurance.	Jan-21 (Oct-20)	TS/MD/DoN&M		Outline of process of external inspections and accreditations to be considered by the Audit Committee in January 2021.	
K8/8.10	Senior leaders in each profession to consider how 'timely and balanced feedback' against personal objectives can be delivered. Is this simply an annual event, a response to an adverse event or something more nuanced?	Mar-21 (Oct-20)	All		To be considered as part of the appraisal process update. The governance team provide information in relation to Incidents, claims, audit activity for the doctor revalidation process. Executive Team to consider how best to evidence progress against this.	

Agenda Item	20/21/278

MEETING	**Trust Board Meeting**
PAPER/REPORT TITLE:	**Board Assurance Framework**
DATE OF MEETING:	Thursday, 04 February 2021
ACTION REQUIRED	**Assurance**
EXECUTIVE DIRECTOR:	Mark Grimshaw, Trust Secretary
AUTHOR(S):	Christopher Lube, Head of Governance and Quality
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** 1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☒ 2. To be ambitious and *efficient* and make the best use of available resource ☒ 3. To deliver *safe* services ☒ 4. To participate in high quality research and to deliver the most *effective* Outcomes ☒ 5. To deliver the best possible *experience* for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust…….* ☒ ***2.*** *Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have sufficient numbers of clinical staff with the capability and capacity to deliver the best care. ……* ☒ ***3.*** *The Trust is not financially sustainable beyond the current financial year……* ☒ ***4.*** *Failure to deliver the annual financial plan ……* ☒ ***5.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision ……* ☒ ***6.*** *Ineffective understanding and learning following significant events……* ☒ ***7.*** *Inability to achieve and maintain regulatory compliance, performance and assurance……* ☒ ***8.*** *Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) ……* ☒
CQC DOMAIN	***Which Domain?*** ***SAFE-*** *People are protected from abuse and harm* ☒ ***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☒ ***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☒ ***RESPONSIVE –*** *the services meet people's needs.* ☒ ***WELL-LED -*** *the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care,* ☒

	supports learning and innovation, and promotes an open and fair culture. ***ALL DOMAINS*** ☐			
LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution ☒ **2.** Operational Plan ☒ **3.** NHS Compliance ☒		**4.** NHS Constitution ☒ **5.** Equality and Diversity ☒ ***6.*** Other: **Click here to enter text.**	
FREEDOM OF INFORMATION (FOIA):	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 Trust Board members are requested to review the contents of the paper and gain assurance as to the BAF management process and identify any changes they consider necessary for consideration by the sub-committees.			
PREVIOUSLY CONSIDERED BY:	**Committee name**	The Committees of: Finance, Performance and Business Development, Putting People First Quality Committee		
	Date of meeting	January 2021		

Executive Summary

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

The BAF is based on based on seven key elements:

- Clearly defined Key Priorities for 2020/21 (aligned to the Trust Strategic Aims)
- Clearly defined principle risks to the key priorities together with an assessment of their potential impact and likelihood.
- Key controls by which these risk can be managed.
- Potential and positive assurance that risk are being reasonably managed.
- Board reports detailing how risk are being managed and objectives met, together with the identification of gaps in assurances and gaps in control.
- Risk reduction plans, for each risk, which ensures the delivery of the objectives, control of risk and improvements in assurances.
- A target risk rating.

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

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

Since the last report to the Board, the executive directors and Trust board committees have reviewed each of the BAF risks and the following updates have been made.

- **2294 - Condition: Insufficient numbers of clinical staff resulting in a lack of capability to deliver safe care and effective outcomes.** At the PPF committee in January 2021 a decision was made to increase risk 2294 to 20 (5 x4) on the basis that:
    - Our sickness absence rates are amongst the highest in the NW region, particularly amongst N&M staff
    - We have specific difficulties in accessing registered temporary staff in neonatal and maternity
    - Our absence was in excess of 5% before Covid-19 pandemic

- **2340 - Overarching Covid-19 Trust Risk Version 5 -** Risk Reviewed by Chief Operating Officer and Head of Governance and Quality. Changes made due to change in Medical Director. Updates made in relation to controls, gaps in control and contingency control due to changes in Covid Pandemic situation since last review. Noted in 'Wave Three' and use of Lateral Flow testing and introduction of Covid 19 Vaccination programme.

The remaining risks did not have any changes made to the risk or the risk score at this time.

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

Report

1. Introduction

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

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

BAF Dashboard: January 2021

Please refer to appendix 1

2. Sub-Committee Changes to Risks

Since the last report to the Trust Board, the sub-committees have further reviewed the risks within their remit and there have been some minor changes or alterations completed to a number of risks

3. New Risks

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

4. Closed Risks

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

5. Conclusions

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

6.Recommendation

The Trust Board members are requested to review the contents of the paper and gain assurance as to the BAF management process and identify any changes they consider necessary for consideration by the sub-committees.

Appendix 1 – BAF Dashboard January 2021 v1.0

Risk No.	Assurance Committee	Description	Current risk score			Target	Assurance				Proposed Changes, Additions & Removals
			Severity	Likelihood	Risk Score	Risk Score by 31/03/2021	Status	Controls identified	Gap in Controls Identified	Assurances identified	
1986	Finance, Performance and Business Development Committee	**Condition:** The Trust is not financially sustainable beyond the current financial year **Cause:** On-going requirement for annual CIPs; Significant CNST premium; Overhead costs; Impact of service change; reduction in activity and income; declining birth rates. **Consequence:** Lack of financial stability, invocation of NHSI sanctions, special measures. Continued borrowing to meet operational expenses resulting in significant debt. **Covid-19 Impact:** There is an impact on this BAF risk. Although the Trust is currently in a block contract, the pandemic will have an impact on the efficiency and capacity of the Trust in how we deliver our services. There is also an uncertain future commissioning/funding landscape. This situation will require close monitoring. No proposed change to risk score.	5	5	25	25	⟷	Y	Y	Y	No change to the risk or risk scores at this time
2266	Quality Committee	**Condition:** Ineffective understanding and learning following significant events **Cause:** Failure to identify root cause, system structures and process, failure to analyse thematically, failure to respond proportionately. **Consequence:** Patient harm, failure to learn and improve the quality of service and experience, poor quality services, loss of income and activity, reputational damage, increased staff turnover. **Covid-19 Impact:** There is no impact on the BAF risk as the Trust has not reduced governance oversight or activity at divisional and corporate level during this pandemic. No change in the current risk score.	4	3	12	6	⟷	Y	Y	Y	No change to the risk or risk scores at this time

Risk No.	Assurance Committee	Description	Current risk score			Target	Assurance				Proposed Changes, Additions & Removals
			Severity	Likelihood	Risk Score	Risk Score by 31/03/2021	Status	Controls identified	Gap in Controls Identified	Assurances identified	
2293	Putting People First Committee	**Condition:** Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust. **Cause:** Poor staff morale, lack of clarity around objectives, lack of ability to influence in the workplace, lack of organisational/job security, lack of leadership, behaviour contrary to the Trust values. **Consequence:** Failure to deliver high quality, safe patient care, impact on recruitment and retention, failure to achieve strategic vision, potential for regulatory action and reputational damage. **Covid-19 Impact:** The Covid-19 pandemic has the potential to impact staff wellbeing, particularly in relation to morale and a result of changed ways of working. There are also increased risk to staff mental health. No proposed change to the current risk score.	4	2	8	6	⟷	Y	Y	Y	No change to the risk or risk scores at this time
2294	Putting People First Committee	**Condition:** Insufficient numbers of clinical staff resulting in a lack of capability to deliver safe care and effective outcomes. **Cause:** Insufficient numbers of doctors in training; Ageing workforce; National shortage of nurses and midwives; Isolated site and associated clinical risk impacting on recruitment and retention of specialist consultant staff; pension tax changes impacting on the retention of consultant medical staff (early retirement or reduction in working time). **Consequence:** Gaps on junior doctor rotas; Loss of highly experienced nursing staff due to retirement; Impact on the quality of junior doctors in training; This may result in unsafe patient care and less effective outcomes, status of teaching hospital and impact on retention of specialist services. **Covid-19 Impact:** The pandemic will have an impact on this BAF risk. Impact on education and training; the potential loss of experienced staff due to retirement; reduced student places; potential requirement for supervised re-introduction in some job related roles due to reduced exposure to 'normal work'; more staff required to deliver same amount of care. There is also a related to the introduction of Test, Track & Trace and the potential number of staff from teams being asked to isolate at short notice for 14 days due to contact with a positive case. No change in the current risk score.	5	4	20	10	↑	Y	Y	Y	At the PPF committee in January 2021 a decision was made to increase risk 2294 to 20 (5 x 4) on the basis that: • Our sickness absence rates are amongst the highest in the NW region, particularly amongst N&M staff • We have specific difficulties in accessing registered temporary staff in neonatal and maternity • Our absence was in excess of 5% before Covid-19 pandemic

Risk No.	Assurance Committee	Description	Current risk score			Target	Assurance				Proposed Changes, Additions & Removals
			Severity	Likelihood	Risk Score	Risk Score by 31/03/2021	Status	Controls identified	Gap in Controls Identified	Assurances identified	
2297	Quality Committee	**Condition:** Location , size, layout and accessibility of current services do not provide for sustainable integrated care or safe and high quality service provision. **Cause:** Lack of on site multidisciplinary provision, no ITU or Blood bank on site, very limited diagnostic imaging on site; Failure to meet multiple clinical standards; Senior staff recruitment and retention very difficult, lack of co-located paediatric surgical support. **Consequence:** Patient harm, poor continuity of care, poor patient experience due to transfer away for booking location. **Covid-19 impact:** The pandemic has increased the challenge of providing additional services within the current Crown street site due to the need for additional space to maintain current services. No change in risk score at this time. Focus on project relating to relocation has been reduced during pandemic	5	5	25	25	⟷	Y	Y	Y	Risk reviewed and change to risk score.
2337	Quality Committee	**Condition:** The Trusts current clinical records system (paper and Electronic) are sub-optimal. **Cause:** Failure to upgrade present Electronic Patient Records system in recent years and failure of 3 Trust electronic Patient Records to deliver on time. **Consequence:** There is potential impact on patient safety, quality, experience and negative effect on staff, Staff are unable to work effectively and safely. Reporting requirements will be impacted if systems fail. There is a financial cost of replacement and penalties to the Trust, of withdrawal from three way electronic Patient record **Covid-19 impact:** There may be an impact due to the pandemic in relation to an increased challenge to staff engaging in the development of the EPR system. No change in current risk score proposed.	5	4	20	20	⟷	Y	Y	Y	Risk reviewed and change to risk score.

Risk No.	Assurance Committee	Description	Current risk score			Target	Assurance				Proposed Changes, Additions & Removals
			Severity	Likelihood	Risk Score	Risk Score by 31/03/2021	Status	Controls identified	Gap in Controls Identified	Assurances identified	
2335	Finance, Performance and Business Development Committee	**Condition:** Major and sustained failure of essential IT systems due to a cyber attack **Cause:** ineffective cyber controls and technology, inadequate investment in systems and infrastructure, failure in skills or capacity of staff or service providers, poor end user culture regarding cyber security and IT systems use, inadequate contract management. **Consequence:** Reduced quality or safety of services, financial penalties, reduced patient experience, loss of reputation, loss of market share/ commissioner contracts. **Covid-19 Impact:** The Covid-19 pandemic has increased the Trust's risk to cyber attack. Whilst there have been several communications circulated to staff advising them of the risks, there are increased vulnerabilities due to different ways of working and particularly home working.	5	4	20	10	⟺	Y	Y	Y	No change to the risk or risk scores at this time
2340	Finance, Performance and Business Development Committee	**Overarching Covid-19 Trust Risk Version 4** **Condition:** Failure to - a) maintain pre-Covid-19 level of service for our patients due to the outbreak of the Covid-19 pandemic; b) protect staff, patients and visitors from infection; c) effectively manage increased demands and provide support to the wider system; and d) failure to recover to pre-Covid-19 service levels following the pandemic and be sufficiently resilient to manage a potential 'third wave' of infection. **Cause:** Reduction of a number of elective services to focus capacity and reduction of efficiency due to infection, prevention and prevention measures. Increased number of staff absent due to Covid-19 health restrictions **Consequence:** Lack of service provision to Liverpool Womens Hospital patient groups, reduced services in some areas, life altering impact on some patients, reduced patient experience, impact on patient safety and potential loss of reputation and inability to recover service provision in the future.	4	4	16	8	⟺	Y	Y	Y	Risk Reviewed by Chief Operating Officer and Head of Governance and Quality. Changes made due to change in Medical Director. Updates made in relation to controls, gaps in control and contingency control due to changes in Covid Pandemic situation since last review. Noted in 'Wave Three' and use of Lateral Flow testing and introduction of Covid 19 Vaccination programme.

Risk No.	Assurance Committee	Description	Current risk score			Target	Assurance				Proposed Changes, Additions & Removals
			Severity	Likelihood	Risk Score	Risk Score by 31/03/2021	Status	Controls identified	Gap in Controls Identified	Assurances identified	
2344	Finance, Performance and Business Development Committee	**Condition:** There is a risk that the Trust will not deliver a breakeven position or have sufficient cash resources in the 2020/21 financial year. **Cause:** Lack of contractual income position due to the Covid-19 pandemic, gap in baseline position and block payment compared to actual activity and cost, risk to CIP and income streams, timing of recovery and uncertainty over future regime. **Consequence**: Potential for insufficient operational cash reserves and non-compliance with regulations. **Covid-19 Impact:** The impact of Covid-19-19 is inherent in the risk description. No further issues identified. No changes required.	4	5	20	8	⟷	Y	Y	Y	No change to the risk or risk scores at this time

Listing For: 4. BAF | **Risk Register Level:** 4. BAF | **Directorate:** Financial Services | **Service / Department:** Finance | **Position at:** 28/01/2021 12:31:10

Risk Number: 1986 **Version:** 7 **Domain:** Finance Including Claims **Linked Risks:**

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

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

Risk Appetite: 3.Moderate

Assurance Committee: Finance, Performance & **Review Due:** 13/02/2021

Risk Description:

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

Cause: Ongoing requirement for annual CIPs; Significant CNST premium; Overhead costs; Impact of service change; reduction in activity and income; declining birth rates.

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

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

Last Review Narrative: **Date:** 14/01/2021 **Reviewed By:** Christopher Lube

Following review by Director of Finance, no changes required at this time

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

Action	Action Description:	Start Date	Target Date	Person Responsible	Progress	Status	Date Completed
4	Business Case 4 - Revision of SOC following unsuccessful STP capital bid Target has been put back based on initial feedback from TU readiness assessment - system buy in to be initial focus ahead of SOC update.	02/05/2022	29/07/2022	Eva Horgan	Work ongoing Date Entered : 09/08/2019 14:11 Entered By : Christopher Lube	Ongoing	/ /
6	Business Case 2 - Public consultation by CCG following development of preferred option (Subject to capital bid)	01/07/2021	29/10/2021	Eva Horgan	Dependent on external influences and agencies Date Entered : 09/08/2019 14:14 Entered By : Christopher Lube	Ongoing	/ /
7	Business Case 3 - Decision making business case produced in partnership with CCG and final decision following outcome of public consultation required	01/11/2021	29/04/2022	Eva Horgan	Closely linked to other actions and external influences Date Entered : 09/08/2019 14:16 Entered By : Christopher Lube	Ongoing	/ /
8	Business case - to support the application for capital to support the relocation required	01/04/2019	30/03/2021	Eva Horgan	External Strategic work on hold during pandemic. Date Entered : 08/10/2020 14:52 Entered By : Christopher Lube ----------	Ongoing	/ /

					Put back due to Covid-19 pandemic. Date Entered : 28/04/2020 14:05 Entered By : Eva Horgan ---------- Timescale TBC - requirements to be confirmed, subject to outcome of bid. Date Entered : 09/08/2019 14:18 Entered By : Christopher Lube		
11	Merger 1 - Agree in principle to proceed to merger	13/02/2020	30/03/2021	Eva Horgan	External Strategic work on hold during pandemic. Date Entered : 08/10/2020 14:53 Entered By : Christopher Lube ---------- Put back due to Covid-19 pandemic Date Entered : 28/04/2020 14:05 Entered By : Eva Horgan	Ongoing	/ /
12	Merger 2 - Establish Merger Project (internal group)	01/04/2020	30/03/2021	Eva Horgan	External Strategic work on hold during pandemic. Date Entered : 08/10/2020 14:53 Entered By : Christopher Lube	Ongoing	/ /
13	Merger 3 - Develop Strategic case working with external organisations	01/07/2020	31/03/2021	Eva Horgan		Ongoing	/ /
14	Merger 4 - Develop and complete business case in conjunction with external organisations	01/04/2021	30/11/2021	Eva Horgan		Ongoing	/ /
15	Merger 5 - Merger / acquisition approval process with external organisation	01/12/2021	30/03/2023	Eva Horgan	External Strategic work on hold during pandemic. Date Entered : 08/10/2020 14:54 Entered By : Christopher Lube	Ongoing	/ /
16	Shared Exec Model 1 - Develop Shared Exec Model - Work in partnership with external body (LUHFT) in order to develop and assess options for a shared executive model which will deliver financial savings	01/07/2020	31/03/2021	Eva Horgan		Ongoing	/ /
17	Shared Exec Model 2 - Agree Model - Review and agree preferred model in conjunction with external organisation (LUHFT)	01/04/2021	30/06/2021	Eva Horgan		Ongoing	/ /
18	Shared Exec Model 3 - Implement Shared Exec Model - Detailed implementation plan to be developed in conjunction with external organisation (LUHFT) to implement agreed shared exec model.	01/10/2021	31/12/2021	Eva Horgan		Ongoing	/ /
19	Procurement 1 - OJEU - Undertake most appropriate formal procurement process to appoint primary building contractor & architect	03/10/2022	30/12/2022	Eva Horgan		Ongoing	/ /
20	Procurement 2 - PQQ Stage - Procurement team to complete Pre Qualification Questionnaire stage	02/01/2023	31/03/2023	Eva Horgan		Ongoing	/ /
21	Procurement 3 - ITPD Stage - Procurement team to complete Invitation to Participate in Dialogue stage	03/04/2023	31/10/2023	Eva Horgan		Ongoing	/ /
22	Procurement 4 - Financial Close - Procurement team to complete financial close stage	01/08/2023	31/01/2024	Eva Horgan		Ongoing	/ /
23	Procurement 5 - Contract Award - Trust to approve contract award	01/02/2024	29/03/2024	Eva Horgan		Ongoing	/ /
24	Short term investment through operational plan to ensure safety on site	06/01/2020	31/12/2021	Eva Horgan	Target date updated to 31 Mar 21 (see above narrative)	Ongoing	/ /

					Date Entered : 06/01/2021 14:46 Entered By : Jenny Hannon ---------- Capital to invest on site secured Dec 2020. Operational and Financial planning implications of this will be factored into next plan submission (likely March 21) and included in next LTFM refresh Date Entered : 06/01/2021 14:45 Entered By : Jenny Hannon ---------- External Strategic work on hold during pandemic. Date Entered : 08/10/2020 14:54 Entered By : Christopher Lube ---------- On hold due to Covid-19 pandemic. Date Entered : 28/04/2020 14:04 Entered By : Eva Horgan			
25	Emergency capital funding application - submit emergency capital funding application to NHSI/E regarding new build and refurbishment work to house mitigations designed to reduce clinical risk on isolated site	06/01/2020	/ /	Jennifer Huyton	Capital bid submitted to NHSI, was due for review in April. Covid-19 pandemic means this is on hold at least until the summer. There is a lack of clarity on the national capital allocation process. Likely to be managed by STP but no detail available as of April 2020. To be further reviewed once detail about the regime is available. Date Entered : 28/04/2020 14:03 Entered By : Eva Horgan		Completed	31/07/2020
26	Business Case 1 - Work in partnership with CCG to refresh PCBC document, including stakeholder engagement and refresh of data	01/01/2020	30/03/2021	Jennifer Huyton	External Strategic work on hold during pandemic. Date Entered : 08/10/2020 14:55 Entered By : Christopher Lube		Ongoing	/ /
27	Business Case 5 - Approval for funding from NHSI/E based on refreshed SOC	01/08/2022	31/10/2022	Eva Horgan			Ongoing	/ /

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

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

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

Listing For: 4. BAF | **Risk Register Level:** 4. BAF | **Directorate:** Governance | **Service / Department:** Governance | **Position at:** 14/01/2021 12:31:11

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

Executive Lead: Lynn Greenhalgh **Operational Lead:** Christopher Lube

Strategic Objective: To Deliver SAFE Services

Risk Appetite: 2.Low

Assurance Committee: Quality Committee **Review Due:** 10/02/2021

Risk Description:

Condition: Ineffective understanding and learning following significant events

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

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

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

Last Review Narrative: **Date:** 11/01/2021 **Reviewed By:** Christopher Lube

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

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

Action	Action Description:	Start Date	Target Date	Person Responsible	Progress	Status	Date Completed
1	Introduction of Fair and Just Culture process	01/04/2019	31/10/2024	Rachel London	Initial stages of training staff via book clubs in progress. Mapping exercise of SI ongoing Date Entered : 31/07/2019 10:57 Entered By : Christopher Lube	Ongoing	/ /
3	Develop better reporting from the Ulysses System There is a continuing commitment to improving reporting using Ulysses. A recent development has been the agreement to cross-tabulate incidents and complaints using Ulysses using a formal process.	01/04/2019	05/06/2020	Christopher Lube	Development and upgrade of Ulysses system complete and final roll put being undertaken Date Entered : 01/07/2020 16:58 Entered By : Christopher Lube ---------- There is a continuing commitment to improving reporting using Ulysses. A recent development has been the agreement to cross-tabulate incidents and complaints using Ulysses using a formal process. Date Entered : 06/05/2020 09:13 Entered By : Rowan Davies ----------	Completed	01/07/2020

					Upgrades commencing to be rolled out to staff, review and close march 2020. Date Entered : 04/03/2020 13:23 Entered By : Christopher Lube ---------- Updates to the Ulysses system have been completed and a plan is in place to roll out by 1st Feb 2020. Some final testing to be completed and training. Date Entered : 11/01/2020 10:40 Entered By : Christopher Lube ---------- The Upgrade of the Ulysses system is progressing. A slight delay was encountered due to the need to move to a new server. Date Entered : 30/10/2019 14:47 Entered By : Christopher Lube ---------- Governance team currently working with Ulysses to develop the current system and implement new modules to support RCA investigation, Action Planning and CQC compliance monitoring, Audit module to come later in year. Date Entered : 31/07/2019 10:56 Entered By : Christopher Lube		
6	Business case for the provision of Human Factors Training to be developed and submitted to education governance committee	01/04/2019	30/04/2021	Linda Watkins	Preparation of case ongoing. Date Entered : 11/01/2021 13:14 Entered By : Christopher Lube ---------- Work on hold due to Covid 19 Date Entered : 08/05/2020 12:16 Entered By : Christopher Lube ---------- Business case for sim lead developed. Need to identify funding. As a result of feedback need to develop simulation strategy for the trust to present to ed gov. Delay as DME has been supporting colleague on mat leave as well as the acting specialty tutor for O&G after Specialty tutor resigned. Date Entered : 29/01/2020 17:57 Entered By : Linda Watkins ---------- Discussions are ongoing via Ed Gov Committee Date Entered : 11/01/2020 10:44	Ongoing	/ /

7	New risk management and patient safety training package to be developed	01/04/2019	28/02/2021	Christopher Lube	Entered By : Christopher Lube --- There is currently no lead for SIM Training in Trust, Lead for action has been changed to Chair of Ed Gov Comm. Date Entered : 03/10/2019 16:38 Entered By : Christopher Lube --- Update Received from Dr Hurst as to current position of Simulation Tranining. See Document section for further detail. Date Entered : 14/08/2019 14:19 Entered By : Elaine Eccles --- Initial paper presented to Ed Gov and Safety Senate, acting Medical Director requested further information Date Entered : 31/07/2019 11:01 Entered By : Christopher Lube Awaitng national syllubus to be published Date Entered : 16/11/2020 13:25 Entered By : Christopher Lube --- Due to Covid-19 this has been delayed. Still awaiting new national SI framework. Date Entered : 01/07/2020 16:59 Entered By : Christopher Lube --- Work on this development has been delayed due to need to deal with Covid19 situation. Date Entered : 04/04/2020 13:42 Entered By : Christopher Lube --- Work on Risk Training Package is ongoing with the appointment of new Risk and Patient Safety Manager. RCA training dates are available for staff to book on, bespoke training continues to be available and Risk Management is part of Cooperate induction and Annual Mandatory Training, Date Entered : 11/01/2020 10:48 Entered By : Christopher Lube --- Work is ongoing, plan for completion Nov 19 Date Entered : 03/10/2019 16:39 Entered By : Christopher Lube ---	Ongoing	/ /

8	MIAA have been commissioned to undertake an audit of the current processes in place for the dissemination of lessons learnt across the trust	20/07/2020	28/02/2021	Christopher Lube	Head of Governance in planning stages. May be affected by new national training system and curriculum which is due to be published in 2019-20. Date Entered : 31/07/2019 11:00 Entered By : Christopher Lube Audit delayed due to MIAA urgent work. Aduit recommenced Bov 2020. Date Entered : 16/11/2020 13:26 Entered By : Christopher Lube ---------- Audit lead from MIAA has meet with Head of Governance and identified documentation required as part of the audit. Information has been provided to audit lead. Date Entered : 28/08/2020 08:36 Entered By : Christopher Lube		Ongoing	/ /

Initial Assessment		
Severity	Likelihood	Risk Score
4 Major	5 Almost	20

Current Assessment		
Severity	Likelihood	Risk Score
4 Major	3 Possible	12

Target Assessment		
Severity	Likelihood	Risk Score
3 Moderate	2 Unlikely	6

Listing For: 4. BAF | **Risk Register Level:** 4. BAF | **Directorate:** Human Resources | **Service / Department:** HR | **Position at:** 14/01/2021 12:31:11

Risk Number: 2293 **Version:** 5 **Domain:** HR/Organisational Development/ **Linked Risks:**

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

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

Risk Appetite: 3.Moderate

Assurance Committee: Putting People First **Review Due:** 13/02/2021

Risk Description:

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

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

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

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

Last Review Narrative: **Date:** 14/01/2021 **Reviewed By:** Christopher Lube

No change in risk or risk score at this time

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

Action	Action Description:	Start Date	Target Date	Person Responsible	Progress	Status	Date Completed
1	PPF deep dive into service level workface risks	01/04/2019	30/09/2021	Rachel London	To be completed on a monthly basis Date Entered : 08/08/2019 11:31 Entered By : Christopher Lube	Ongoing	/ /
2	Aspirant managers programme in place - this will be incorporated into the Trust Leadership strategy	29/01/2021	01/12/2020	Rachel London	Leadership Strategy to be presented to PPF in Nov 20 Date Entered : 30/09/2020 17:27 Entered By : Rachel London ---------- Aspirant managers programme in place and 1st cohort have completed with 2nd cohort to commence. Date Entered : 16/11/2019 12:04	Completed	27/11/2020

					Entered By : Christopher Lube --- To be monitored monthly Date Entered : 08/08/2019 11:33 Entered By : Christopher Lube			
3	Executive team and staff side walkabouts	01/04/2019	30/09/2020	Rachel London	New programme of exec and staff side walkabouts commenced in September 2020 Date Entered : 30/09/2020 17:27 Entered By : Rachel London --- To be monitored monthly Date Entered : 08/08/2019 11:35 Entered By : Christopher Lube		Completed	30/09/2020
4	In 2018 the Trust began its Fair & Just Culture Programme - our journey to developing a different type of organisational culture. This is a five year programme which moved into Year 3 in April 2020.	01/04/2019	30/06/2021	Jeanette Chalk	Year 3 Action plan now developed and in place - key elements include training and engagement activities for colleagues at all levels. Date Entered : 16/07/2020 10:40 Entered By : Jeanette Chalk --- Year 1 completed on timescale in accordance with project plan. Date Entered : 16/11/2019 12:04 Entered By : Christopher Lube --- Initial development work and staff training in progress Date Entered : 09/08/2019 15:24 Entered By : Christopher Lube		Ongoing	/ /

Initial Assessment		
Severity	Likelihood	Risk Score
5 Catastrophic	5 Almost	25

Current Assessment		
Severity	Likelihood	Risk Score
4 Major	2 Unlikely	8

Target Assessment		
Severity	Likelihood	Risk Score
3 Moderate	2 Unlikely	6

Listing For: 4. BAF | **Risk Register Level:** 4. BAF | **Directorate:** Human Resources | **Service / Department:** HR | **Position at:** 14/01/2021 12:31:11

Risk Number: 2294 **Version:** 8 **Domain:** HR/Organisational Development/ **Linked Risks:**

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

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

Risk Appetite: 3.Moderate

Assurance Committee: Putting People First **Review Due:** 13/02/2021

Risk Description:

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

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

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

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

Last Review Narrative: **Date:** 14/01/2021 **Reviewed By:** Christopher Lube

At the PPF committee in January 2021 a decision was made to increase risk 2294 to 20 (5 x4) on the basis that:

- Our sickness absence rates are amongst the highest in the NW region, particularly amongst N&M staff
- We have specific difficulties in accessing registered temporary staff in neonatal and maternity
- Our absence was in excess of 5% before Covid-19 pandemic

Control	Control Description	Gaps in Control	Effectiveness	Internal Assurance	External Assurance	Gaps in Assurance	Adequacy of Assurance
Prevent	Annually agreed funding contract with HEN. Regional Training Programme Directors manage the junior doctor rotation programme and highlight shortages to the Lead Employer. Lead Employer notifies the Trust of Gaps in local rotations, giving the Trust autonomy to recruit at a local level into these gaps. Effective electronic rota management system implemented. Director of medical Education (DME) to ensure training requirements are met, reporting to the Trust Medical Director and externally to HEN. Guardian of Safe Working Hours appointed in 2016 under new Junior Doctor Contract. Acting down policy and process in place to cover junior doctor gaps. National Revalidation process ensuring competent staff. Shared decision making and review of risk with JLNC. Putting People First Strategy. Quality Strategy. Strategic Workforce Group established. Aspirational Ward Manager Programme. Succession Planning and Talent Programme NHSE Retention Improvement Programme NHSI Sickness Improvement Programme Shared appointments with other providers Secured operating time at the LUH Increased consultant recruitment with incentives Neonatal Partnership Maternity introduction of ACP Midwives Policy to mitigate impact on LTA and AA on senior staff in place	Further utilisation of the rota management system. E-Roistering System not fully utilised	Effective	Quarterly reporting by Guardian of Safe Working. Strategic Workforce reporting to PPF. Leadership Development programme Review (annual to PPF). Exception Reporting System and process working effectively. Junior Medical Staff GMC survey reporting to Education Governance and PPF - No concerns areas of specific concerns identified. Clinical and nursing roles being developed and enhanced to mitigate the gas in junior doctor workforce. Roles include: Physicians Assistants, Surgical assistants, ANP's, Consultant Nurses, ER Practitioners.	DME reports to HEN on an annual basis in relation to junior doctor training. Annual GMC Survey. Annual Staff survey NHS Ed SAR. DME Annual Report GMC Revalidation Process HEN Visit - Regular (next due 2019 due to satisfactory report in 2016) GMC Medical Staff survey - annual.	None identified at this time	Positive
Detect	GMC Survey 018 - action plan in place						
Covid 19	Staff are required to social distance (2 meters) in all area where this is possible Staff are required to wear PPE in the clinical environment as per PHE guidance All staff re required to wear a face covering in all public areas and in offices where they are unable to social distance (2 meters) All areas have clear signage, including floor signage All staff entering the Trust are required to use one entrance and have a temperature check and provided with a face mask to use Listening Event for BAME staff - 24th June 2020 to consider what further action the Trust could take to ensure BAME staff are protected as much as possible. Risk Assessments undertaken for shielding &	The risk is staff do not comply with social distancing and/or PPE.	Not Effective	Trust has completed the NHSE/I IPC Assurance Framework and presented to the Quality Committee Controls monitored daily at Command meeting and weekly at Oversight and Scrutiny meeting Requirements being managed by senior staff clinical and cooperate.	None at this time	Issue with staff with staff to complying with social distancing and use of face mask as required.	Inconclusive

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

Action	Action Description:	Start Date	Target Date	Person Responsible	Progress	Status	Date Completed
4	Await outcome of Business case sent to NHSI to develop E-Rostering System Collaborative	16/11/2019	28/02/2021	Rachel London	The Trust has been successful in its business case and a procurement process has commenced and will be concluded by February 21 Date Entered : 30/12/2020 13:19 Entered By : Rachel London ---------- The Trust was unsuccessful in bidding for national funds to purchase the Allocate doctors rostering system. This system would not address the shortage in certain specialties but would be a more efficient means to roster the medical workforce. A business case will be developed to purchase the system ourselves, this has been delayed due to Covid-19 issues and will be developed by Autumn 2020. Date Entered : 14/04/2020 14:51 Entered By : Rachel London	Ongoing	/ /
5	Medical Workforce Recruitment and Retention process being developed	01/11/2019	02/11/2020	Rachel London	As above- divisions have been asked to produce their own medical workforce plans for the next divisional performance review Date Entered : 27/08/2020 11:04 Entered By : Rachel London ---------- There are a number of workstreams around identifying and developing talent in the medical workforce at junior doctor level and developing pathways to consultant level. A bespoke leadership programme for consultants has also been developed to deliver a pipeline of talent for future clinical director roles.	Completed	12/11/2020

					These plans need to be co-ordinated into an overall medical recruitment and retention plan. This has been delayed due to Covid-19 and will be developed by the summer. Date Entered : 14/04/2020 14:54 Entered By : Rachel London			
6	Need to recruit Gynae Oncologists to ensure service is viable and able to provide level of service to patients.	22/04/2020	/ /	Rachel London	Recruitment of two Gynae Oncologists took place in April- 1 FTC and 1 Permanent contract due to commence in June and October respectively Date Entered : 08/10/2020 15:23 Entered By : Christopher Lube		Completed	15/06/2020
7	In relation to Social Distancing and use of face masks, regular communication and senior staff and managers are required to continually remind individuals of their responsibilities and highly visible reminders around the workplace. Encourage and empower staff to challenge peers when not complying with requirements.	17/06/2020	31/03/2021	Rachel London			Ongoing	/ /

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

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

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

Listing For: 4. BAF | **Risk Register Level:** 4. BAF | **Directorate:** Governance | **Service / Department:** Executive Office | **Position at:** 14/01/2021 12:31:11

Risk Number: 2297 **Version:** 6 **Domain:** Impact On The Safety Of Patien **Linked Risks:**

Executive Lead: Lynn Greenhalgh **Operational Lead:** Jennifer Huyton

Strategic Objective: To Deliver SAFE Services

Risk Appetite: 2.Low

Assurance Committee: Quality Committee **Review Due:** 10/02/2021

Risk Description:

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

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

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

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

Last Review Narrative: **Date:** 11/01/2021 **Reviewed By:** Christopher Lube

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

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

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

4	Divisional plans to be developed to support long term clinical sustainability via operational plan	01/04/2019	26/02/2021	Jennifer Huyton	Date Entered : 09/08/2019 13:41 Entered By : Christopher Lube The Clinical and Quality Strategy was finalised in October 2020 and included long term plans to mitigate clinical risk in the medium term while LWH remans on the Crown Street site.The Trust is also in the process of refreshing its overall strategy, which includes a specific objective regarding the mitigation of clinical risk on the Crown Street site. The operational planning process began in November 2020, with a clear brief that all operational plans will support delivery of both the overall Trust strategy as well as clinical service priorities set out in the Clinical and Quality strategy. A separate project board has been established with associated delivery groups in order to oversee the implementation of additional mitigations, including CT, transfusion services, migration of colposcopy and FMU and the robotic surgical service. Divisional plans will reflect this work. Action completion date amended to reflect operational planning timescales. Date Entered : 09/12/2020 10:44 Entered By : Jennifer Huyton ---------- Clinical and Quality Strategy contains divisional plans for development to support long term clinical, sustainability back and this will inform he operational plan when due for submission Date Entered : 31/08/2020 10:59 Entered By : Christopher Lube ---------- The Trust is now developing a clinical and quality strategy to complement a refreshed future generations strategy, to be completed by the end of 2020. This will include divisional plans. The funding for on site developments has been requested but remains out of the Trust's control. The lobbying of MPs has been paused during the covid crisis. Date Entered : 06/07/2020 14:41	Ongoing	/ /

					Entered By : Rowan Davies --- This has been impacted by Covid19 but a revised schedule for production of a short to medium term clinical strategy for the trust has been proposed, with input from each specialty and which will account for the changes that Covid19 hasbrought. Date Entered : 06/05/2020 09:14 Entered By : Rowan Davies --- Target date amended due to response to COVID19. Draft divisional plans presented to Senior Management Team in Feb/March 2020. Completion of final versions currently paused due to operational response to COVID19. Target completion date will remain under regular review. Date Entered : 06/04/2020 12:16 Entered By : Jennifer Huyton --- Operational plans under development but not due until March 20. Target date amended to March 20. Date Entered : 10/01/2020 14:18 Entered By : Jenny Hannon --- Work ongoing in Divisions Date Entered : 09/08/2019 13:46 Entered By : Christopher Lube			
5	Outcomes from the clinical summit to be actioned.	27/09/2019	30/04/2021	Jennifer Huyton	Capital funding awarded December 2020 to enable delivery of CT and 24/7 transfusion services on site. Programme Board established to oversee projects. Project group set up in progress. Work to agree GMP for construction element has recommenced. Date Entered : 14/01/2021 10:58 Entered By : Jennifer Huyton --- Due to pressure from third wave of Covid-19, to be revisited April 2021 Date Entered : 13/01/2021 13:57 Entered By : Rowan Davies --- Planning progress has been made in relation to the location of the CT scanner on site, but capitol is still not yet confirmed. Similarly capital for the blood bank. Partnership	Ongoing	/ /	

Board with LUFT remains functioning.

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

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

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

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

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

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

Date Entered : 06/04/2020 12:09
Entered By : Jennifer Huyton

CT scanner and Blood Bank provision has been added to the draft operational plan, which is awaiting approval.

Date Entered : 04/03/2020 07:27
Entered By : Christopher Lube

Target date amended following development of MoU with LUH. Detailed plan is in place (to be attached) actions are in progress

7	Management of Future Generations Strategy through Project Management Office	16/11/2019	29/01/2021	Jennifer Huyton	Date Entered : 10/01/2020 14:18 Entered By : Jenny Hannon ---------- Acting Medical Director working with Strategic Finance Manager on reviewing summit outcomes. Date Entered : 27/09/2019 08:43 Entered By : Christopher Lube Remains postponed due to covid-19 Date Entered : 31/08/2020 11:06 Entered By : Christopher Lube ---------- The Trust is now developing a clinical and quality strategy to complement a refreshed future generations strategy, to be completed by the end of 2020. This will include divisional plans. The funding for on site developments has been requested but remains out of the Trust's control. The lobbying of MPs has been paused during the covid crisis. Date Entered : 06/07/2020 14:43 Entered By : Rowan Davies ---------- Reviewed 26 March 2020 by J Huyton: Project Manager recruitment completed in March 2020; post successfully appointed. Start date anticipated June 2020. Majority of FG programme paused during response to COVID19; work remains under regular review by PMO team.	Ongoing	/ /
9	Agree funding for mitigations on site (Blood Bank, MRI, Diagnositics, CT and Staffing) for inclusion in 20/21 operational plan	31/03/2020	30/12/2020	Jennifer Huyton	Date Entered : 06/04/2020 12:06 Entered By : Jennifer Huyton Capital funding to develop a CT service, transfusion service and robotics theatre service at Crown Street was approved in November 2020. A Project Board has been established to provide oversight of these developments and will be chaired by the Director of Finance. Delivery groups for each individual workstream are in the process of being established and will be operational during December. Revenue costs will be worked up through the delivery groups and built into the operational plan. The Trust will continue to explore	Completed	01/12/2020

options for further mitigations on site (such as MRI and Interventional Radiology) through the project board.

Action complete.

Date Entered : 09/12/2020 10:36
Entered By : Jennifer Huyton

Awaitiing ourcome

Date Entered : 31/08/2020 11:07
Entered By : Christopher Lube

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

Date Entered : 08/07/2020 17:44
Entered By : Jennifer Huyton

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

Date Entered : 06/07/2020 14:43
Entered By : Rowan Davies

Reviewed 26 March 2020 by J Huyton:
Application for emergency capital funding submitted to NHSI/E in Feb 2020 with decision originally expected early April. Revised guidance now expected from NHSE/I regarding emergency capital in light of response to COVID19. Guidance will be reviewed once released and target completion dates amended accordingly.

Date Entered : 06/04/2020 12:00

10	Lobby systems and MP's for active support	16/11/2019	30/04/2021	Jennifer Huyton	Entered By : Jennifer Huyton Due to pressure from third wave of Covid-19, to be revisited April 2021 Date Entered : 13/01/2021 13:57 Entered By : Rowan Davies ---------- Has been devolved to exec level with a plan being considered by Trust secretary to match Board members with key targets for lobbying Date Entered : 31/08/2020 11:08 Entered By : Christopher Lube ---------- The Trust is now developing a clinical and quality strategy to complement a refreshed future generations strategy, to be completed by the end of 2020. This will include divisional plans. The funding for on site developments has been requested but remains out of the Trust's control. The lobbying of MPs has been paused during the covid crisis. Date Entered : 06/07/2020 14:41 Entered By : Rowan Davies ---------- Reviewed 26 March 2020 by JHuyton: This work is ongoing but paused at present due to response to COVID19. Action completion dates will remain under regular review as situation develops.	Ongoing	/ /
11	External review/testing of counterfactual case	01/04/2020	30/04/2021	Jennifer Huyton	Date Entered : 06/04/2020 12:03 Entered By : Jennifer Huyton Due to third wave of Covid-19, to revisit this action in April 2021 Date Entered : 13/01/2021 13:56 Entered By : Rowan Davies ---------- Presently on pause, with a plan to bring back into play Sept-De 2020. Date Entered : 31/08/2020 11:10 Entered By : Christopher Lube ---------- Counterfactual case developed and ready for external review, challenge and testing. Process likely to be delayed due to response to COVID19. Target completion dates will be reviewed regularly as response develops.		/ /

12	Project to establish 24/7 transfusion services, robotics surgical service and CT imaging at the Crown Street site. To include construction work and associated estate reconfiguration.	04/12/2020	01/04/2022	Jennifer Huyton	Date Entered : 06/04/2020 11:55 Entered By : Jennifer Huyton Project Board established 04.12.20. Delivery groups for workstreams to be established during December (FMU, Colp, CT, Transfusion). Stage 2 design work complete with good progress towards completion of Stage 3 and agreement of GMP. Options appraisal re estate options scheduled for 17.12.20. Date Entered : 09/12/2020 11:15 Entered By : Jennifer Huyton	Ongoing	/ /

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

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

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

Listing For: 4. BAF | **Risk Register Level:** 4. BAF | **Directorate:** IM & T | **Service / Department:** IM & T | **Position at:** 14/01/2021 12:31:11

Risk Number: 2335 **Version:** 4 **Domain:** Impact On The Safety Of Patien **Linked Risks:**

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

Strategic Objective: To Deliver SAFE Services

Risk Appetite: 2.Low

Assurance Committee: Finance, Performance & **Review Due:** 13/02/2021

Risk Description:

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

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

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

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

Last Review Narrative: **Date:** 14/01/2021 **Reviewed By:** Christopher Lube

No change to the risk or risk scores at this time

Control	Control Description	Gaps in Control	Effectiveness	Internal Assurance	External Assurance	Gaps in Assurance	Adequacy of Assurance
Prevent	1. Microsoft Windows security and critical patches applied to all Trust servers on all servers\laptops and desktop devices on a monthly basis. 2. Network switches and firewalls have firmware updates as and when required installed. Wifi network firmware patches applied for Controllers and Access points. 3. Mobile end devices patched as and when released by the vendor. 4. Externally managed network service provider to ensure network is a securely managed with underpinning contract. 5. Robust carecert process to enact advice from NHS Digital regarding imminent threats. 6. Network perimeter controls (Firewall) to protect against unauthorised external intrusion. 7. Robust Information Governance training on information security and cyber security good practice. 8. Regular staff educational communications on types of cyber threats and advice on secure working of Trust IT systems. 9. Additional cyber security communications in relation to Covid phishing/ scams, advising diligence. 10. Enhanced VPN solution including increased capacity to secure home working connections into the Trust. 11. Review and updating of information security policies and home working IG guidance to support staff who are remote working.	Lack of Cyber Security strategy	Effective	Cyber Essentials Plus Standards/KPIs IMT Risk Management Meeting Digital Hospital Sub Committee Finance, Performance & Business Development	MIAA Cyber Controls Review Cyber Essentials Plus Accreditation Cyber Penetration Test NHS Care Cert Compliance	None known at this time	Positive
Detect	1. Malware protection identifies and removes known cyber threats and viruses within the Trusts network and at the network boundaries. 2. Cyber Security Monioring System identifies suspicious network and potential cyber threat behaviour. 3. National CareCert alerts inform of known and imminent cyber threats and vulnerabilities.	1. Lack of Network Access Controls within the physical network.	Effective	Cyber Essentials Plus Standards/KPIs IMT Risk Management Meeting Digital Hospital Sub Committee Finance, Performance & Business Development	MIAA Cyber Controls Review Cyber Essentials Plus Accreditation Cyber Penetration Test NHS Care Cert Compliance	None Known at this tiime	Positive
Contingency	1. Departmental Business Continuity Plans being invoked. 2. Enactment of the IMT Dept. Disaster Recovery (DR) Plan 3. Seek C&M system wide support in recovery.	None known at this time	Not Yet Tested	~~EPRR~~	MIAA Audit on BCP and DR C&M Cyber Security workstream C&M Digital Leadership forum	None known at this time	Inconclusive

Action	Action Description:	Start Date	Target Date	Person Responsible	Progress	Status	Date Completed
1	Implementation of the MIAA Cyber Security audit action	12/03/2020	31/03/2021	Philip Moss	Work continuews on enhancing the Trusts Cyber security cabailities. Work includes - End User Education - Monthly End User Security Emails SIEM - Enhancement of the Trusts Pervade working in Athena Cyber security developing a unified monitoring dashboard Network Refresh Project - replacement of the Trust legacey network, once completed this will Trust Policies - Enhancement of Trusts Policy Security patching Demarc - working to fully implementing DEMARC for Email CareCerts - reponding to NHS security alerts Date Entered : 27/08/2020 16:51 Entered By : Philip Moss		/ /
2	Implementation of new network will introduce enhanced security capabilities.	13/03/2020	28/02/2021	Philip Moss	Planned installation of new network core for 17th Oct 2020 has been deferred due to the impact on staffing through Covid-19. This will be implemented in the new year as all focus turns to the go-live of K2 Digital Maternity in November. Action due date therefore updated. Date Entered : 09/10/2020 09:10 Entered By : Matt Connor ---------- Work continuews on enhancing the Trusts Cyber security cabailities. Work includes - End User Education - Monthly End User Security Emails SIEM - Enhancement of the Trusts Pervade working in Athena Cyber security developing a unified monitoring dashboard Network Refresh Project - replacement of the Trust legacey network, once completed this will Trust Policies - Enhancement of Trusts Policy Security patching Demarc - working to fully implementing DEMARC for Email CareCerts - reponding to NHS security alerts Date Entered : 27/08/2020 16:55 Entered By : Philip Moss ----------	Ongoing	/ /

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

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

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

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

Listing For: 4. BAF | **Risk Register Level:** 4. BAF | **Directorate:** IM & T | **Service / Department:** Executive Office | **Position at:** 14/01/2021 12:31:11

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

Executive Lead: Lynn Greenhalgh **Operational Lead:** Matt Connor

Strategic Objective: To Deliver SAFE Services

Risk Appetite: 2.Low

Assurance Committee: Quality Committee **Review Due:** 10/02/2021

Risk Description:

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

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

Consequence: There is potential impact on patient safety, quality, experience and negative effect on staff, Staff are unable to work effectively and safely.Reporting requirements will be impacted if systems fail. There is a financial cost of replacement.

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

Last Review Narrative: **Date:** 11/01/2021 **Reviewed By:** Christopher Lube

Risk reviewed and change to risk score.

Control	Control Description	Gaps in Control	Effectiveness	Internal Assurance	External Assurance	Gaps in Assurance	Adequacy of Assurance
Prevent	Approved Digital Generations Strategy Approved Meditech Expanse Business Case Signed Meditech Expanse contract with clear direction to implement a robust integrated EPR solution. Maintenance of present system Development of individual / service solutions e.g. PENs (Gynaecology) and Staff training Development and deployment of ADT Whiteboard system to reduce risk of multiple systems. Implementation of contextual links into ADT Whiteboard system to reduce multiple logins. Incident reporting Quarterly risk assessments reported to FPBD Tactical solutions including planned implementation of K2 Athena system Single Sign on review/ optimise, upgrade improvements. Exchange/LHCRE enables for patent information sharing Desktop refresh with dual screen configuration (where required) to improve system performance and simplify multiple systems use. Virtual Desktop technology to aid staff working flexibly. Microsoft Teams rolled out trust wide to aid collaboration. Additional network resilience for LUHFT supplied systems (ADT/PENS/CRIS) to reduce risk of unplanned systems downtime. PACS upgrade removes a separate login for that system, reducing multiple systems issue. approved EPR Business case which define clear direction and preferred solution.	Staff fatigue and loss of confidence. Not all Trust using LHCRE for patient information exchange Ability of clinical staff to engage with the system development due to time and financial impact	Effective	Quarterly risk assessments completed Quality Committee oversight and scrutiny FPBD Committee overview and scrutiny Digital Hospital Committee oversight	Independent lessons learnt review	Reactive rather than proactive identification and approach to problems caused by current sub optimal Electronic Patient Record, including patient risk and staff experience.	Positive

Action	Action Description:	Start Date	Target Date	Person Responsible	Progress	Status	Date Completed
1	Terms of Reference for leadership group to be formalised	24/03/2020	/ /	Andrew Loughney	Governance structure has been identified and placed in contract. ToR is being drafted. Date Entered : 29/09/2020 11:25 Entered By : Matt Connor	Ongoing	03/11/2020
3	Develop staff communication plan for new system	24/03/2020	31/01/2021	Matt Connor	The project team are arranging to attend the GREAT Day event in January Date Entered : 18/12/2020 16:20 Entered By : Matt Connor ---------- Communication plan to be aligned with procurement, contract and implementation plan activities.		/ /

					Date Entered : 04/05/2020 12:57 Entered By : Matt Connor		
4	Develop plan for system development and implementation	24/03/2020	/ /	Matt Connor	Project planning will commence in detail following contract sign off/ procurement and establishment of project team Date Entered : 29/09/2020 11:27 Entered By : Matt Connor ---------- The business case includes part of the plan i.e. resources, governance model. However a full implementation plan will be developed with supplier as part of the procurement. Therefore plan date changed in accordance with contract renewal timescales. Date Entered : 04/05/2020 12:56 Entered By : Matt Connor ---------- Business case has been developed	Completed	03/11/2020
					Date Entered : 04/05/2020 12:54 Entered By : Matt Connor		
5	Procurement of new system following evaluation	24/03/2020	/ /	Matt Connor	Contract sign off concluded 29th September 2020 Date Entered : 29/09/2020 11:27 Entered By : Matt Connor ---------- Procurement is underway. Specifics are being addressed regarding leasing arrangements in-line with funding requirements. Contracts are being drafted and procurement expected to complete by Sept. Date Entered : 04/08/2020 16:08 Entered By : Matt Connor	Completed	29/09/2020
6	Ongoing review of systems and mitigations quarterly (report to FPBD & QC)	24/03/2020	31/01/2021	Matt Connor			/ /
7	Development of an Information Management And Technology Strategy	24/03/2020	/ /	Matt Connor	Draft Digital Strategy approved. It will be launched, socialised in September. Date Entered : 04/08/2020 16:10 Entered By : Matt Connor	Completed	29/09/2020
8	Implement PENS forms in Gynae ED to capture clinical documentation to reduce paper burden and simplify digital systems use. Gynae ED will solely be using PENS.	08/06/2020	/ /	Richard Strover	PENS is now live for clinical staff to record clinical documentation for both A&E attendances and outpatient follow ups. Any development to current forms will be managed through the change control procedures in place for PENS documentation. ECDS data being submitted from PENS and regular data quality	Completed	30/09/2020

					reports are monitored by ED and Digital.Information staff. Date Entered : 08/10/2020 06:52 Entered By : Richard Strover ---------- PENS is now in use within the GED. Attendances are still recorded on Meditech to ensure a record of the attendance but all clinical documentation has been moved over to PENS. Work is ongoing to remap all data for reporting the daily ECDS from Meditech to PENS with completion anticipated by mid June. All data will be retrospectively submitted as agreed with Liverpool CCG. The automated GP letter has been re-mapped from Meditech to PENS and these are now being sent to GPs electronically the day after attendance. Date Entered : 08/06/2020 16:47 Entered By : Richard Strover			
9	Implement electronic ordering from ICE to replace a multi-system process through Meditech.	08/06/2020	/ /	Richard Strover	Sample 360 ordering reviewed at DHSC and decision supported to focus this delivery within the Meditech Expanse project to avoid Trust staff fatigue Date Entered : 03/11/2020 10:51 Entered By : Matt Connor		No Further Action	03/11/2020
10	Upgrade PACS to integrate fully into the network and remove a seperate system login feature.	08/06/2020	/ /	Paula Brennan			Completed	04/08/2020
11	Implement Virtual Smartcards which will allow clinical staff who access the national e-referral system system or the summary care record to log on without the need for a physical smart card or password.	08/06/2020	/ /	Paula Brennan			Completed	29/09/2020

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

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

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

Listing For: 4. BAF | **Risk Register Level:** 4. BAF | **Directorate:** EPRR | **Service / Department:** Executive Office | **Position at:** 14/01/2021 12:31:12

Risk Number: 2340 **Version:** 6 **Domain:** Impact On The Safety Of Patien **Linked Risks:**

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

Strategic Objective: To Deliver SAFE Services

Risk Appetite: 2.Low

Assurance Committee: Finance, Performance & **Review Due:** 10/02/2021

Risk Description:

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

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

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

Last Review Narrative: **Date:** 11/01/2021 **Reviewed By:** Christopher Lube

Risk Reviewed by Chief Operating Officer and Head of Governance and Quality. Changes made due to change in Medical Director. Updates made in relation to controls, gaps in control and contingency control due to changes in Covid Pandemic situation since last review. Noted in 'Wave Three' and use of Lateral Flow testing and introduction of Covid 19 Vaccination programme.

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

	Lateral Flow Testing at Home introduced for all staff Staff Flu Vaccination Campaign completed within timeframe to tom required target level PATIENTS Clear communication to patients via direct communications and social media. Review of national guidance re:activity delivery via Clinical Advisory Group PALS service continuing Visiting Policy amended to reduce risk of spread Family liaison service established to supplement PALS service. All staff, patients and visitors required to wear masks whilst on site. Baby swabbing offer to new parents on leaving the hospital to provide assurance regarding hospital acquired infection. In patient swabbing in place monitored for completion at day 3 and day 5 as per national requirement Trust following National Guidance on Maternity partner support				
Contingency	BUSINESS AS USUAL, RECOVERY and RESILIENCE Commitment to deliver Business as Usual wherever possible Executive lead assigned to manage Business as Usual Corporate controls remain in place On-going regulatory compliance Recovery plans in development to include areas of good practice which should be maintained Maternity escalation and incineration process in place to support staff taking on back and extra shifts at times of short staffing. Health care partnership are using existing memorandum of understanding in relation to staff movement between local hospital at time of staffing need. Previous staffing skills audit refreshed to ensure up to date and ensure information available to allow for staff to be moved into an appropriate support role if required. LWH have provided assistance to LUFT by taking over Non Obstetric Ultrasound scanning activity LWH identified as Gynaecology Oncology Hub for Cheshire and Mersey. Theatre sessions provided at LWH for other Trusts such as Breast surgery for LUFT Provision of mutual aid to LUFT via provision of 8 step down beds Provision of mutual aid to NWAST by supporting staff testing on LWH site for them Provision of Mutual aid to NWAST for staff Covid 19 vaccinations BREXIT- Executive Director of Finance is SRO, procurement team actively involved in preparations	National mandates and what the Trust is required to recover and trajectories. Day case efficiency currently 70% backlog and ineffective in dealing with backlog. Insufficient Theatre staffing due to vacancies and not having a full compliment of anaesthetists. Test, Track and Trace system impact on staffing	Not Yet Tested	Situation continues to be monitored at Oversight and Scrutiny Group weekly and 3 times a week at the Command and Control meeting. BREXIT - No issues have been identified to date. Situation reviewed weekly at Oversight meeting and at FPBD.	Inconclusive

Action	Action Description:	Start Date	Target Date	Person Responsible	Progress	Status	Date Completed
1	Ongoing dialogue with partners and consideration of mitigating arrangements to be introduced on site via Clinical Advisory Group - CAG is up and running and is a functional group	01/04/2020	01/02/2021	Lynn Greenhalgh	CAG remains functional and providing advice to the Trust Covid-19 Oversight and Scrutiny Group Reduced meetings to 2 times a week. Date Entered : 01/07/2020 17:07 Entered By : Christopher Lube ---------- CAG is up and running and is a functional group Date Entered : 04/05/2020 08:59		/ /

					Entered By : Rowan Davies			
3	Ongoing review of directives across national, regional and local forums	01/04/2020	31/03/2021	Lynn Greenhalgh	All guidance continues to be reviewed at command and control meetings during the week and at the Covid oversight and scrutiny weekly meetings. Directors all linked into relevant regional and national meetings and feedback. All CAS alerts related to Covid are dealt with through normal trust processes and monitored via oversight. Date Entered : 07/12/2020 13:11 Entered By : Christopher Lube ---------- Review of all guidance and directives completed at Control and command and Oversight and Scrutiny Groups of the Trust. Also reviewed and discussed at Executive Directors Meetings. Date Entered : 01/07/2020 17:10 Entered By : Christopher Lube			/ /
4	Close working with Cheshire and Mersey procurement via Covid Supply Response (CSR)	01/04/2020	31/03/2021	Amy Noble	No changes in situation, continue to link into local regional and national meetings via procurement and director level. Mentored via oversight weekly meeting and command and control meetings. Date Entered : 07/12/2020 13:14 Entered By : Christopher Lube ---------- Head of Procurement has worked closely with procurement colleagues and other partner organisations to maintain supply of PPE linking in with national systems. Date Entered : 01/07/2020 17:16 Entered By : Christopher Lube			/ /
6	The Trust needs ensure that it is keeping up to date with local, regional and national Covid-19 guidance and policy, ensuring review and implement at pace.	03/08/2020	02/08/2021	Christopher Lube	All local, regional and national guidance is review within then Trust and reported back to Command and Control and Weekly Oversight and Scrutiny Group. Where required the Trust reports back out of the Trust as required. Date Entered : 11/01/2021 13:45 Entered By : Christopher Lube		Ongoing	/ /

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

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

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

Listing For: 4. BAF | **Risk Register Level:** 4. BAF | **Directorate:** Financial Services | **Service / Department:** Finance | **Position at:** 14/01/2021 12:31:12

Risk Number: 2344 **Version:** 6 **Domain:** Finance Including Claims **Linked Risks:**

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

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

Risk Appetite: 3.Moderate

Assurance Committee: Finance, Performance & **Review Due:** 13/02/2021

Risk Description:

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

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

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

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

Last Review Narrative: **Date:** 14/01/2021 **Reviewed By:** Christopher Lube

Following review by Director of Finance, no changes required at this time

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

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

Initial Assessment		
Severity	Likelihood	Risk Score
4 Major	5 Almost	20

Current Assessment		
Severity	Likelihood	Risk Score
4 Major	5 Almost	20

Target Assessment		
Severity	Likelihood	Risk Score
4 Major	2 Unlikely	8

Liverpool Women's NHS Foundation Trust

Agenda Item	20/21/280

MEETING	**Putting People First Committee**
PAPER/REPORT TITLE:	**CNST Junior Doctors Rota Gaps Action Plan**
DATE OF MEETING:	4 February 2021
ACTION REQUIRED	**Assurance**
EXECUTIVE DIRECTOR:	Mark Grimshaw, Trust Secretary
AUTHOR(S):	Linda Watkins, Director of Medical Education
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: **CNST**	☒ ☒
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:-….)***	***Note the information provided for assurance of safe staffing levels in the Trust and approve the submission of the action plan to the Royal College of Obstetricians and Gynaecologists (RCOG)***			
PREVIOUSLY CONSIDERED BY:	**Committee name**		Putting People First Committee	
	Date of meeting		25th January 2021	

Executive Summary

This paper is to complete the actions for CNST regarding the Trust's management of rota gaps.

Rota gaps and staffing particularly in Obstetrics have been highlighted as a key area of risk as part of the Clinical Negligence scheme for Trusts (CNST).

Report

Introduction

Work force is a key component to be able to provide adequate educational opportunities. This is recognised by the clinical negligence scheme for trusts (CNST) who have included a requirement for this year to formally record at board level the proportion of trainees who felt educational opportunities have been lost due to rota gaps in 2019 with an action plan.

Staffing of junior doctors rotas in O&G had been raised as a concern by rota leads in O&G and medical staffing in 2017-18. This led to the development of a business case to allow over establishment of the junior doctor rota in O&G which was approved in January 2019. This was fully implemented by August 2019.

Doctors in training

Clinical Negligence Scheme for Trusts (CNST)

There is a requirement for CNST compliance that we do the following:

- *All boards should formally record in their minutes the proportion of obstetrics and gynaecology trainees in their trust who responded 'Disagreed or /Strongly disagreed' to the 2019 General Medical Council (GMC) National Trainees Survey question: 'In my current post, educational/training opportunities are rarely lost due to gaps in the rota.'*
  This was reported to Board in the Putting People First Chairs report in December 2020.

- *Furthermore, there should be an agreed strategy and an action plan with deadlines produced by the Trust to address these lost educational opportunities due to rota gaps. The Royal College of Obstetricians and Gynaecologists (RCOG) has examples of trust level innovations that have successfully addressed rota gaps available to view at www.rcog.org.uk/workforce*
  The purpose of this paper.

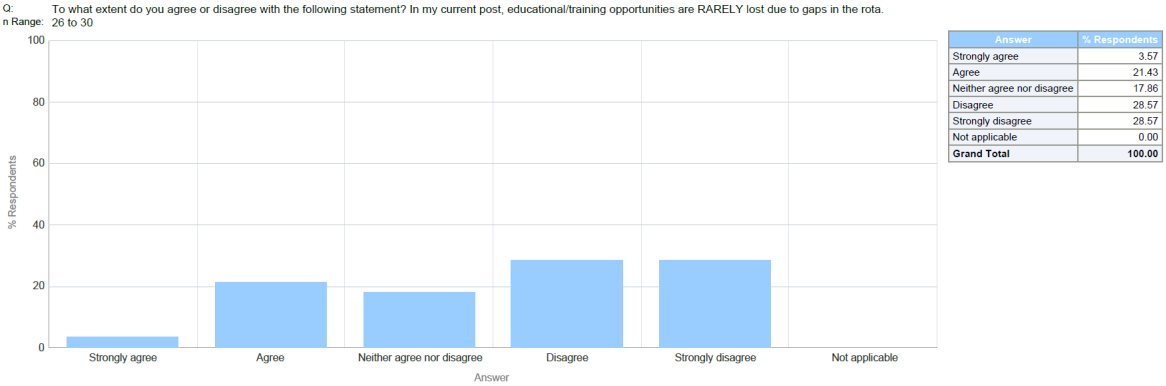
- *The action plan should be signed off by the trust Board and a copy (with evidence of Board approval) submitted to the RCOG at workforce@rcog.org.uk*

Strategic Workforce Business case for Obstetrics and Gynaecology

The business case for workforce for O&G is a detailed document which analysed rota gaps in O&G and proposed over establishment of the rota with clinical and research fellow posts. CNST maternity incentive scheme was used to help support this business case for over establishment of the O&G rotas.

GMC National training survey 2019 and rota gaps

57.4% of O&G trainees in 2019 reported they disagreed or strongly disagreed that educational / training opportunities are rarely lost due to gaps in the rota.



Answer	% Respondents
Strongly agree	3.57
Agree	21.43
Neither agree nor disagree	17.86
Disagree	28.57
Strongly disagree	28.57
Not applicable	0.00
Grand Total	**100.00**

The figure above includes all trainees in O&G from GP/F2 up to ST7.

The other GMC questions and LWH O&G responses interrogating rota design are included in the rota design document.

When benchmarked against other trusts we came out as second quartile for rota design for all trainees and an outlier for rota design (bottom 25%) for Specialist trainees in O&G. At that time we carried several gaps within the tier 2 and 3 rota. This was addressed as part of the action plan included in the GMC feedback report.

Although we noted that by August 2019 the rotas were over established this was in line with the business case. In August 2019 we received slightly more trainees than expected. This was due to HEENW increasing the numbers of training numbers in their attempt to mitigate for the nationally high levels of drop out in the training programme and rota gaps in O&G due to flexible working.

We noted over establishing rotas requires on-going monitoring and the need to monitor clinical experience/ learning opportunities. There is the possibility of losing educational opportunities when a rota is over established.

Junior doctor rota gaps are reported to PPF by the guardian of safe working. We plan to continue to monitor training experience using our in house temperature checks and future GMC surveys.

Medical staffing budget and rotas gaps are also closely monitored in a quarterly meeting between the Clinical Directors for O&G, the DME, medical staffing and finance.

Action plan to address lost educational opportunities in for O&G trainees due to rota gaps

Concern	Actions & Evidence	Who by	By when	Completed	Comments
Educational opportunity will be lost due to rota gaps.	Develop a strategic work force business case for over establishment of junior doctors rotas to counter anticipated rota gaps  Strategic work force Business Case for Oa	DME Medical staffing manager	March 2019	Submitted and approved Jan 2019	This action preceded the 2019 GMC survey
	Implementation of additional posts as per business plan	Medical staffing manager Finance leads for O&G	Jan 2019	August 2019	Posts include; International medical fellows Trust Clinical fellows Trust research fellows in conjunction with University of Liverpool
	Continue to monitor O&G trainee rota gaps via quarterly finance meetings  Junior Doctor Budget Review 23.10	DME, Finance lead for Workforce in O&G, CD for Gynaecology, CD for Family health and Medical staffing lead	Quarterly	On going	DME meets with relevant CDs and Finance lead and Medical staffing manager on a quarterly basis to monitor rotations and Gaps. Approval for new posts is authorised via this group.
	Continue to monitor impacts of rota gaps and also over establishment of rotas	Guardian of safe working DME	Quarterly	Ongoing	Guardian of safe working submits regular detailed reports to PPF

	via exception reports  82 PPF - Guardian of Safe Working (Jul - S 2020				
	Complete review of 2020 GMC survey to include updated action plan  GMC survey feedback 2020 for ed	DME	Jan 2021	Complete	This year's GMC survey was limited due to covid 19 and did not ask specific questions regarding rota gaps. This action plan will go into updated GMC survey action plan. Paper tabled for Jan 21 PPF and March 21 Education Governance.
	Continue to monitor impacts of rota gaps and over establishment of rota gaps by review of GMC survey 2021	DME Speciality tutors	Annual Oct 2021	Annual	Ongoing monitoring of impacts of managing rota gaps.