Liverpool Women's
NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

Board of Directors Meeting

PUBLIC

1 April 2021

Liverpool Women's NHS Foundation Trust

Trust Board

Location	Virtual Meeting
Date	1 April 2021
Time	9am

AGENDA					
Item no. 21/22/	Title of item	Objectives/desired outcome	Process	Item presenter	Time
PRELIMINARY BUSINESS					
001	Introduction, Apologies & Declaration of Interest	Receive apologies & declarations of interest	Verbal	Chair	09.00 (5 mins)
002	Meeting Guidance Notes	To receive the meeting attendees' guidance notes	Written	Chair	
003	Minutes of the previous meetings held on 4 February 2021 and 4 March 2021	Confirm as an accurate record the minutes of the previous meeting(s)	Written	Chair	
004	Action Log and matters arising	Provide an update in respect of on-going and outstanding items to ensure progress	Written	Chair	
005	Patient Story	To receive a patient story	Verbal	Director of Nursing & Midwifery	09.05 (15 mins)
006	Chair's announcements	Announce items of significance not found elsewhere on the agenda	Verbal	Chair	09.20 (10 mins)
007	Chief Executive Report	Report key developments and announce items of significance not found elsewhere on the agenda	Written	Chief Executive	09.30 (15 mins)
QUALITY & OPERATIONAL PERFORMANCE					
008a	Performance Report	For assurance – To note the latest performance measures	Written	Director of Operations	09.45 (60 mins)
008b	Lessons learnt from mortality, Q3 2020/21	For assurance	Written	Medical Director	
008c	Chair's Reports, Annual Report & Terms of Reference from the Quality Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	
PEOPLE					
009a	2020 Staff Survey Results Summary	For information	Written	Chief People Officer	10.50 (30 mins)
009b	Chair's Report, Annual Report & Terms of Reference from Putting People First Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	

BREAK – 20 mins					
Board Thank You – 10 mins					
FINANCE & FINANCIAL PERFORMANCE					
010a	Finance Performance Review Month 11 2020/21	For assurance - To note the current status of the Trusts financial position	Written	Director of Finance	11.50 (50 mins)
010b	2021/22 Operational Plan and Budget Update	For assurance	Presentation	Director of Finance	
010c	Digital – Annual Review	For assurance	Written	Director of Finance	
010d	Chair's Reports, Annual Report & Terms of Reference from Finance, Performance and Business Development Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	
010e	Chair's Report & Terms of Reference from Audit Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	
010f	Chair's Report, Annual Report & Terms of Reference from Charitable Funds Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	
BOARD GOVERNANCE					
011a	Corporate Objectives 2020/21: Year-End Review	For approval	Written	Chief Executive	12.40 (15 mins)
011b	Revised Risk Management Strategy for 2021-22	For approval	Written	Director of Nursing & Midwifery	
011c	Proposed Risk Appetite Statement 2021-22	For approval	Written	Director of Nursing & Midwifery	
CONSENT AGENDA (all items 'to note' unless stated otherwise) *All these items have been read by Board members and the minutes will reflect recommendations, unless an item has been requested to come off the consent agenda for debate; in this instance, any such items will be made clear at the start of the meeting.*					
012	Emergency Preparedness Resilience and Response Annual Board Report	For assurance	Written	Chief Operating Officer	CONSENT
013	Trust Board Terms of Reference	For approval	Written	Trust Secretary	CONSENT
014	Board Assurance Framework	For assurance	Written	Trust Secretary	CONSENT
CONCLUDING BUSINESS					
015	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair	12.55 (5 mins)
016	Chair's Log	Identify any Chair's Logs	Verbal	Chair	
017	Any other business & Review of meeting	Consider any urgent items of other business	Verbal	Chair	
Finish Time: 13.00					

Date of Next Meeting: 6 May 2021

13.00 – 13.10	*Questions raised by members of the public*	To respond to members of the public on matters of clarification and understanding.	Verbal	Chair

Liverpool Women's

Meeting attendees' guidance using Microsoft Teams

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

Before the meeting

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

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

Microsoft Teams

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

At the meeting

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

Attendance

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

After the meeting

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

Standards & Obligations

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

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

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Liverpool Women's NHS Foundation Trust

Action Log

Trust Board
1 April 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
4 March 2021	20/21/298	Trust Corporate Strategy	For a future Board workshop to consider the potential impact of system level changes to the delivery of the Corporate Strategy.	Director of Finance	Jun 21	On track	Item to be scheduled as part of the next Trust workshop session.
4 February 2021	20/21/275	Operational Performance Report period M8 & M9, 2020/21	For future performance reports to differentiate between Covid-19 and non-Covid-19 drivers of underperformance.	Chief Operating Officer	Apr 21	Completed	Operational Performance Report provides a commentary on the impact of Covid-19 on performance.
4 February 2021	20/21/272	Bi-Annual Safer staffing paper Nursing and Midwifery	For a future Board workshop session to consider longer-term horizon scanning relation to Trust-wide staffing requirements	Chief People Officer	June 21	On track	Item to be scheduled as part of the next Trust workshop session.
4 February 2021	20/21/270	Ockenden Report Update	For the MVP Chair to be invited to attend a future Board meeting to discuss the patient's perspective on maternity services.	Director of Nursing & Midwifery	May 21	On track	Invite to be extended following agenda setting process for the May 2021 Board.
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,	Medical Director and Director of Nursing & Midwifery	Apr 21	On track	Verbal update to be provide at the meeting.

			reporting back to the April 2021 Board.				
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	Complete	Physiotherapy manager / clinical lead attended an Executive Team meeting on 24 March 2021.
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 May 2021 to await the consideration of results from an internal audit report at the April 2021 Quality Committee.
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)	Complete	Session received at 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	04.03.2021	For the quality impacts of robotic assisted surgery to be monitored by the Quality Committee within six months from implementation. Lead Officer: Chief Operating Officer	Quality Committee	September 2021	Open	Remitted to Quality Committee for action
Delegated	04.02.2021	For the Charitable Funds Committee to explore fundraising ideas for specific projects. Lead Officer: Head of Fundraising	Charitable Funds Committee	March 2021	Completed	Please see March 2021 Chair's Report.
Delegated	03.12.2020	Gynaecology staffing challenges 'deepdive' Lead Officer: Chief People Officer / Director of Nursing & Midwifery	Putting People First Committee	May 2021	Open	Scheduled for the PPF Committee in May 2021.

Liverpool Women's NHS Foundation Trust

Board of Directors

Minutes of the meeting of the Board of Directors held virtually at 10.00am on 4 February 2021

PRESENT

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

IN ATTENDANCE

Mr Mark Grimshaw	Trust Secretary
Mrs Michelle Corrigan	Observer – Insight Programme
Mrs Mary McDonald	Appointed Governor
Ms Kate Hindle	Lead Governor
Mrs Denise Richardson	Public Governor
Mrs Jackie Sudworth	Public Governor
Mrs Christine Malone	Matron, Hewitt (Item 259 only)
Dr Rachel Gregoire	Scientific Director, Hewitt (Item 259 only)
Mrs Gillian Hathaway	Ovum Donation Co-ordinator, Hewitt (Item 259 only)
Mrs Felicity Dowling	Member of the public
Mrs Lesley Mahmood	Member of the public
Mrs Tracy Cooper	Member of the public
Mrs Sionadh Curtis	Observer - CQC
Mrs Sue Corden	Observer - Grant Thornton, Well-Led

APOLOGIES:
None noted

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

259	**Patient Story** Christine Malone (Matron, Hewitt), Dr Rachel Gregoire (Scientific Director, Hewitt) and Gillian Hathaway (Ovum Donation Co-ordinator, Hewitt) attended to introduce a patient video showing the treatment that had been provided by the Hewitt Centre and the subsequent care provided by the maternity service. The patient remarked upon the personal care that she had been afforded and the compassion that had been shown throughout her journey. The Medical Director noted that a key issue identified by the recent Ockenden Report related to a lack of compassion shown to some women and their families and stated that it was encouraging to hear directly from a patient that they had been treated with kindness whilst at the Trust. Non-Executive Director Ian Knight queried if there was any further support that the fertility service required from the Board. The Scientific Director, Hewitt, remarked that the service was exploring plans to expand and would therefore potentially require additional administrative support. The Chief Executive and Director of Finance explained that fertility service was currently being reviewed and further resource requirements would be identified as part of this as well as through the annual planning process that was underway. The Board of Directors: • Noted the patient story • Expressed thanks to the patient and the staff for providing their time to share the story with the Board.
260	**Minutes of previous meeting** Subject to the following amendments, the minutes of the Board of Directors meeting held on 3 December 2020 were agreed as a true and accurate record: • Item 227 - Financial Report & Dashboard Month 7, 2020/21 – change of "The Director of Finance stated that the Trust was part of a system funding envelope and was therefore unlikely to receive a specific response" to "The Director of Finance stated that this had been flagged and noted but as the Trust was part of a wider system funding envelope it was unlikely to receive a specific adjustment to its individual allocation." • For the following to be identified as attending the meeting for item 211; Dr Dharani Hapangama (Consultant, Gynaecology), Dr Arshad Ilyas (Consultant, Gynaecology) and Dr Manou Kaur (Consultant, Gynaecology) The minutes of the Extraordinary Board of Directors meeting held on 7 January 2021 were agreed as a true and accurate record.
261	**Matters arising and action log.** The Chair drew attention to the Patient Story received in December 2020 and queried whether the suggested links between the endometriosis and genomics services had been made. The Medical Director confirmed that a meeting had been arranged with Dr Dharani Hapangama (Consultant, Gynaecology) to discuss how to progress this. The Chair noted that the Black, Asian and Minority Ethnic strategic advisory committee (the Assembly) had written to all Trusts with the draft Vision and Mission statements with Objectives with a request for comment in November 2021 and queried whether the Trust had responded. The Chief People Officer confirmed that this would be checked. With regards to the action log, the Medical Director outlined the strengthened medicine management processes implemented by the Trust and whilst the MIAA internal audit report on lesson learning was awaited, there was confidence that the interventions put into place were being effective (action 20/21/221).

The Medical Director continued to report that meetings had been held with colleagues from Liverpool University Hospitals NHS Foundation Trust (LUHFT) to explore the establishment of a Service Level Agreement (SLA) that would help the Trust to meet the requirements for Priority Standards Five and Six in the Seven Day Services self-assessment. It was noted that a similar SLA had been agreed between LUHFT and Clatterbridge Cancer Centre that could be replicated for the Trust.

262 **Chair's Announcements**

The Chair briefed the Board on events since the last meeting. It was noted that there was a Council of Governors meeting scheduled for the 11 February 2021 that would be focusing on the Ockenden Report and seeking the views of the governors on the priority areas established by the Board.

Interviews had taken place for Non-Executive Directors on the 28 January 2021. The panel had recommended the appointment of two candidates and this would be considered by the Council of Governors at their aforementioned meeting.

The Shadow Board had met on 3 February 2021 and there had been a number of productive discussions. The Chief Executive remarked that there had been an increase in confidence levels of the individuals attending the meetings and the Chief People Officer noted that the Shadow Board would be aligned with the actions in the leadership strategy going forward.

The Chair reported that he had recently met with the Trust's Fundraising Team. They had identified recent success from targeted fundraising activity to support specific schemes and had asked that the Trust continue to identify ideas for projects.

Chair's Log: For the Charitable Funds Committee to explore fundraising ideas for specific projects.

The Board noted the Chair's update.

263 **Chief Executive's report**

The Chief Executive presented the report which detailed local, regional and national developments. The following key points were highlighted:

- 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 had worked with Public Health England in relation to this. Whilst no patients had come to harm related to this issue, the Trust was reviewing the event in line with incident management policies to establish any further learning.
- The Trust had been in receipt on an updated Covid-19 Infection, Prevention and Control Board Assurance Framework and work was underway to update the Trust's compliance position.
- Although the staff vaccination programme had been an unprecedented logistical challenge, the clinic had been well received by staff and data sourced from the Trust's Business Intelligence system on 22nd January 2021 showed 70% of Trust staff had been vaccinated (including 76% of our BAME staff and 72% of staff classed as clinically vulnerable).
- The Trust had initiated Schwartz Rounds as an additional staff support mechanism
- On Tuesday 19th January, the Trust launched 'K2 Athena' - an electronic Patient Health Record System (PHR), which would be replacing patient's handheld notes in the Maternity division. The Chairman noted that whilst there remained some issues to resolve with the system, feedback from staff during a recent walkabout had been positive.

The Board noted the Chief Executive update.

264	**Chair's Reports from the Quality Committee** The Board considered the Chair's Reports from the Quality Committee meetings held on 21 December 2020 and the 25 January 2021. Non-Executive Director, Tony Okotie noted the updated format of the Chair's Reports that had been utilised for the January 2021 report. It was noted that the Committee was currently focusing on seeking assurance regarding the Trust's approach to lesson learning and an internal audit report on this issue from Mersey Internal Audit Association (MIAA) was awaited. The Committee was also tracking performance against the Continuity of Carer metric and had requested further assurance on performance trajectories and their attendant risks to a future meeting. The Chief Executive added that the Putting People First Committee also had a role to play in understanding the on-going workforce challenges in relation to the Continuity of Carer model, particularly understanding the concerns of staff. The Chief People Officer added that the role out of the Continuity of Carer model had demonstrated that the Trust needed to review its change management processes to ensure that staff were fully engaged with and owing the proposed changes. The Board of Directors: • Received and noted the Chair's Reports from the Quality Committee meeting held on 21 December 2020 and the 25 January 2021
265	**Chair's Report from Finance, Performance and Business Development Committee (FPBD)** Non-Executive Director, Phillip Huggon presented the Chair's Report for the meetings of the Finance, Performance and Business Development Committee held on 22 December 2020 and 26 January 2021. The Committee had been informed that the roll-out of the K2 maternity records system had taken place in January 2021 and lessons would be learned from this ahead of a more comprehensive EPR implementation over the next couple of years. The Committee had requested that an overall digital update be provided at the year-end. Updates on the Crown Street enhancement programme continued to be received and the Committee was seeking assurances regarding value for money and the clinical case. The Chair queried if assurance could be provided that the Trust would be able to spend the allocated £4.9m of emergency capital ahead of year-end. The Director of Finance noted that risks remained attached the delivery of the plan, particularly around estates. A robust governance structure had been put into place to monitor and track delivery with assurance reported to the Committee. Non-Executive Director, Phillip Huggon continued to highlight that a significant area of attention for the Committee was the likely financial pressures during the 2021/22 financial year. The Committee had requested to receive scenario plans at the next meeting and was intending to monitor the position closely. The Board of Directors: • Received and noted the Chair's Reports from the FPBD Committee meeting held on 22 December 2020 and 26 January 2021 • Noted assurance provided to the Committee that the Trust remained compliant with the Information Standards Notice following implementation of K2 in January 2021 and that it was currently compliant with Maternity Services Data Set (MSDS)v2 Information Standards Notice, DCB1513 and 10/2018, supported by the latest NHS Digital MSDS scorecard.
266	**Chair's Report from the Putting People First Committee** The Board considered the Chair's Report from the Putting People First Committee held on 25 January 2021. The Committee had received an update on mandatory training and positive assurance had been received from a staff story which related to how the resus training manager had adapted training during the pandemic to improve compliance rates. The Committee awaited an internal audit report regarding mandatory training and would consider the recommendations once it was available. The Committee was informed that the Trust's sickness absence rate remained above target (even when not taking Covid-19 related sickness into consideration). Action being taken by the Trust was noted

	and the Committee had recommended that the relevant BAF risk score be increased (increased 'impact' score from three to four). The Committee had been appraised of pressures within the Medical Anaesthetic workforce and challenges relating to clinical training during the pandemic. On the latter point, the Committee had agreed to receive a staff story from a GP trainee at a future meeting. A shared remit to monitor progress against the Ockenden Report with the Quality Committee was noted and a deepdive review was commissioned to explore the cultural themes identified. The Chair noted that staffing level pressures in maternity appeared to high and queried what action the Trust was taking in response to this. The Director of Nursing & Midwifery highlighted several mechanisms to track safe staffing levels and escalate issues for action. The Board of Directors: • Received and noted the Chair's Report from the PPF Committee meeting held on 25 January 2021.
267	**Chair's Report from Audit Committee** Non-Executive Director, Tracy Ellery, presented the Chair's Report for the meeting of the Audit Committee held on 26 January 2021. The Committee had received several reports relating to preparations for the year-end process and had been informed that whilst there was confidence that the audit would progress without significant issues, the Finance Team might be required to undertake the 2021/22 planning process at the same time as the audit, due to delays in Nationally mandated timescales, potentially resulting in resource implications. The Director of Finance noted that planning work was currently progressing where possible to avoid a duplication of workload later in the year. Several positive assurances had been received at the meeting with 'substantial assurance' being provided in two internal audit reports; Effective Rotas and Payroll/Recruitment. The Trust's Assurance Framework had also been found to meet requirements. The Committee had agreed a change to the internal audit plan to consider a review of the Trust's CQC action plan and assurance had been provided that the internal auditor would be able to provide a Head of Internal Audit opinion within the expected timescales. The Committee had also been updated on progress to enhance the Trust's processes to identify, monitor and follow-up on external inspections and accreditations. Non-Executive Director, Tracy Ellery noted that post 31 March 2021, the Audit Committee would be reduced to two Non-Executive members as Ian Knight's term of office was ending. This would result in quoracy issues for the Committee, and as a result Non-Executive Director Jo Moore had agreed to join the Committee to cover meetings relating to the year-end process. The Board of Directors: • Received and noted the Chair's Report from the Audit Committee meeting held on 26 January 2021. • Noted that Jo Moore would replace Ian Knight on the Audit Committee from 1 April 2021 onwards.
268	**Chair's Report from the Charitable Funds Committee** The Board considered the Chair's Report from the Charitable Funds Committee held on 15 December 2020. It was noted that the majority of items from the Committee were reported to the Extraordinary Board held on 7 January 2021. The Director of Finance confirmed that the 2019/20 Charitable Funds Annual Report and Accounts were submitted to the Charities Commission ahead of the deadline. The Board of Directors:

- Received and noted the Chair's Report from the Charitable Funds Committee meeting held on 15 December 2020.

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

The Chief Operating Officer reported that following the country being placed in a national lockdown, the Trust had responded 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. The Trust had maintained fertility services throughout this lockdown.

The Chair drew attention to the Covid-19 outbreak referenced in item 272 and queried whether the resulting staff absences had put increased pressure on maternity services. The Director of Nursing & Midwifery confirmed that meetings had been held with the senior leadership team in midwifery to understand staffing pressures and to ensure that staff support mechanisms were available and being accessed. Non-Executive Director, Ian Knight, asked whether the donations for staff support measures seen during the first lockdown were still available for staff. The Chief People Officer confirmed that a number of support measures remained in place, although there had been a slight reduction in the donations received compared to earlier in the pandemic. Work was taking place with the fundraising team to develop a consistent stream of funding for staff support measures.

Referring to the staff vaccine programme, Non-Executive Director, Phil Huggon asked whether the Trust had a target for staff take-up. The Director of Nursing & Midwifery confirmed that the Trust was aiming for 100% take-up and would continue to work towards that target.

The Medical Director confirmed that the mutual aid being offered by the Trust was helping to develop relationships that would be beneficial in a post-Covid-19 landscape. Non-Executive Director, Tony Okotie, asked whether the Trust was recouping costs incurred for providing mutual aid. The Director of Finance explained that cross-charging was not being implemented due to system working but costs were being tracked for value for money considerations.

The Board of Directors:

- Noted the report for information and assurance

270 **Ockenden Report Update**

The Director of Nursing & Midwifery noted that at the Extraordinary Board meeting held on 7 January 2021, a response to the Ockenden Board Assurance Assessment Tool (BAAT) had been reviewed ahead of the 15 January 2021 submission date. 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 was now 15th February 2021 with the LMS requiring oversight of the Trust response by the 8th February 2021. This revised date had enabled the Trust to review and further update its response to the BAAT.

The Board was informed that the actions required in order to meet Immediate and Essential Action 6 (Fetal Wellbeing) had been completed, following the appointment of a Named Consultant Obstetrician to compliment the role of the Fetal Surveillance Midwife. This had been marked as 'partial compliance' in the January 2021 update. The Board was assured by the establishment of an Ockenden governance framework to ensure that the actions from the report would be actioned and embedded in the Trust. The Board was also encouraged to hear that this framework would be used to revisit and test that the Kirkup recommendations remained actioned and embedded within current services. On this latter point, the Board emphasised that the findings in the Ockenden Report were not 'novel' and indeed should be recognised as 'business as usual' practice and linked to existing improvement work.

	Non-Executive Director, Ian Knight, referenced current staffing challenges in maternity services and queried whether these would challenge the Trust's response to the Ockenden recommendations. The Chief Executive noted that the Trust did invest in maternity staffing eighteen months previously and as birth rates had decreased, staffing numbers had remained constant. Acute challenges were being driven by higher than expected sickness levels and these were being managed through flexing the workforce to meet peak demand through effective rostering. This was being supported via a well trained and resourced temporary staffing workforce. The Board was assured that the Maternity Voices Partnership (MVP) Chair would be further involved in the Trust's listening processes and it was suggested that they attend a Board meeting in the near future. **Action: For the MVP Chair to be invited to attend a future Board meeting to discuss the patient's perspective on maternity services.** The Board of Directors: • Noted the report for information and assurance
271	**Safer Nurse/Midwife Staffing Report, M8 & 9 2020/21** The Director of Nursing & Midwifery presented a report which detailed Ward Staffing levels across all inpatient clinical areas during November & December 2020. The Board was briefed on the content of the report and it was noted that Gynaecology ward fill rates were lower in M8 & 9 (67 % and 68%) for Registered Nurses during the day due to vacancies., however the daily staffing huddle ensured appropriate staff were moved to support areas with staffing shortfalls. Attention was drawn to a review of neo-natal staffing that was required for the Trust's CNST compliance requirements. Following a Neo-natal medical staffing review (Appendix 2) assurance was provided that the Trust met Safety Action 4 of the Maternity Incentive Scheme 2020 (aka CNST) with regards to Neonatal Medical Workforce. The review concluded that the British Association of Perinatal Medicine (BAPM) standards required to meet the optimal arrangements for neonatal intensive care medical staffing were in place and that there was no requirement for a Trust Board approved action plan. A Neo-natal Nurse staffing review was undertaken by the Head of Nursing for Neonates in September 2020. The majority of the BAPM standards were met, but this was in relation to cot side nursing and did not consider the other roles required within a tertiary service. There had been a reduction in activity which had enabled the Neonatal unit to move towards being BAPM compliant. The review recommended the appointment of another Band 7 nurse within budget to ensure on-going CNST compliance and this was in progress. The Director of Nursing & Midwifery highlighted that the presentation of the report was being reviewed to ensure that it was focused on the key assurance requirements of the Board. 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 BAPM standards required to meet the optimal arrangements for neonatal intensive care medical staffing were in place and that there was no requirement for a Trust Board approved action plan.
- Noted the assurance that the majority of BAPM standards for Neonatal nurse staffing were being met and that progress was being made to close out the staffing gap identified by the most recent review.

272 **Bi-Annual Safer staffing paper Nursing and Midwifery**

The Board considered the bi-annual comprehensive report which detailed 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. The Director of Nursing & Midwifery noted that staffing levels were reviewed regularly at a divisional level with issues escalated as necessary.

The Director of Nursing and Midwifery acknowledged that improvements were required to the format of the report, with greater emphasis provided on themes, action taken and key exceptions. Non-Executive Director, Louise Kenny, remarked that achieving the correct balance of detail in bi-annual staffing papers was difficult as the methodology could very often be a 'blunt tool' that looked solely at staffing numbers and did not take into consideration issues such as skill mix and long-term staffing challenges.

The Board agreed that it would be beneficial to review the Trust's longer-term horizon scanning in relation to staffing requirements.

Action: For a future Board workshop session to consider longer-term horizon scanning relation to Trust-wide staffing requirements

The Trust Secretary referenced the risk to the organisation of the number of nursing and midwifery staff over 50 years of age and queried whether fatigue post pandemic could result in a number of staff accelerating retirement. The Chief People Officer noted that this was a possibility and the Trust continued to explore methods to shift the age profile downwards, referencing work that had been undertaken recently with the neo-natal staffing cohort.

The Board of Directors:

- Noted the content of the report and the assurances provided that nurse/midwife staffing levels were safe and appropriate at present.
- Noted the risk to the organisation of the number of nursing and midwifery staff over 50 years of age.
- Noted the national shortage of nurses and midwives.

273 **Serious Incident Report – February 2021**

The Director of Nursing & Midwifery presented the report noting that following the publication of the Ockenden Report, it was now a requirement that the Board receive a Serious Incident report at each Board meeting. It was acknowledged that the report 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 Medical Director noted that it would be challenging to provide a balance between providing the requisite level of detail on a monthly basis whilst also effectively reporting on longer-term themes that would not change significantly on a report to report basis. A solution was being developed and it was aimed to have an updated reporting mechanism in place from April 2021 onwards.

	The Director of Finance noted that the Board had been informed of an increase in still births during quarter one of 2020/21 and queried whether this trend had continued. The Chief Executive reported that the Deputy Medical Director had been requested to produce a thematic review for 2020/21. The Board of Directors: • Received the report for information but noted that only limited assurance could be taken from the report in its current format.
274	**Review of Disciplinary Policy and Practice** The Board considered the report which was intended to provide assurance that the Trust had 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. It was reported that the Trust had reviewed its disciplinary policy against the fair and just principles, guidance and against Imperial College Healthcare NHS Trust's revised Disciplinary Policy. It had been concluded that whilst the Disciplinary Policy was fit for purpose, there were improvements that could be made, and these would be completed before 1st April 2021 when the policy would be published on the website. The Board of Directors: • note the contents of the paper for information and assurance • approved the suggested amendments to the Trust's Disciplinary Policy
275	**Operational Performance Report period M8 & M9, 2020/21** The Chief Operating Officer presented the Operational Performance Report for Month 8 & 9 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. Non-Executive Director, Ian Knight, queried if there was an improvement plan in place for mandatory training performance. The Chief People Officer noted that this issue was reviewed regularly at the Putting People First Committee and performance improvement trajectories would be provided going forward. It was explained that there had been some issues with high volume training at the beginning of the financial year and more robust training delivery programmes (including on-line training) were now in place as a mitigation. Non-Executive Director, Tracy Ellery, highlighted that a significant number of the Trust's performance metrics were rated as 'red'. Whilst it was understood that the drivers behind this performance were predominantly related to the pandemic, it was suggested that it was still important for the Board to have sight of trajectories and performance against these. **Action: For future performance reports to differentiate between Covid-19 and non-Covid-19 drivers of underperformance.** The Board of Directors: • Received and noted the Month 8 & 9 Operational Performance Report.
276	**Finance Report period M9, 2020/21** The Director of Finance presented the Finance Report and Financial Dashboard for Month 9, 2020/21. She briefed the Board on the content of the report and advised that at month 9 the Trust was slightly ahead of this revised plan with an adjusted deficit of £0.8m for the month and £2.4m year to date (YTD). This was after receipt of system, Covid-19 and growth top up of £0.6m per month in month's 7-9 (compared with an average of £1.4m per month in months 1-6). This meant that the Trust was on plan to deliver a revised £4.6m adjusted deficit as submitted to the Cheshire & Merseyside Health and Care Partnership (HCP).

	The cash balance improved in month 9 despite the Trust generating a deficit. This was largely due to the reduction in debtors and was above the minimum amount planned for (c£4.5m). This would be reduced over the coming months as the Trust continued to generate a deficit. However, no additional revenue support was currently assessed to be required in the financial year. Cash would continue to be carefully monitored. Work continued to deliver the capital plan and following the confirmation that the emergency capital bid was approved, progress was being made to ensure the £4.9m phased into 2020/21 would be spent. This would be a challenge, but it had been made clear that unspent funds could not be carried over, so work was focused on achieving this. The Board of Directors: • Received and noted the Month 9 Financial Performance Report.
277	**Well-Led Self-Assessment Action Plan Update** The Board considered the update to the Well-Led Self-Assessment Action Plan. The Trust Secretary remarked that progress had been made against a significant number of the actions and those identified as 'red' relating to Quality Improvement were expected to be closed out shortly following the finalisation of the Trust's Quality Improvement methodology document. The Trust Secretary explained that the Trust's self-assessment (and action plan) was one part of the overall Well-Led framework process with there being a requirement to follow this with an external review. This process was currently underway with a final report scheduled to be received by the Board in April 2021. This report would likely result in a number of improvement recommendations / actions and it would 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 of Directors: • Received and noted the report for information and assurance.
278	**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. At the PPF Committee in January 2021 a recommendation was made that the Board increase risk 2294 (Condition: Insufficient numbers of clinical staff resulting in a lack of capability to deliver safe care and effective outcomes) to 20 (5 x 4) on the basis that: • The Trust's sickness absence rates were amongst the highest in the NW region, particularly amongst Nursing & Midwifery staff • The Trust had specific challenges in accessing registered temporary staff in neonatal and maternity • The Trust's absence was in excess of 5% before the Covid-19 pandemic The Board of Directors: • Noted the report for information and assurance • Agreed to increase the likelihood score from three to four for BAF risk 2294.
279	**Review of risk impacts of items discussed** The Board noted that the following risks had been discussed during the meeting: • The Trust continuing to track and monitor Continuity of Carer performance against set trajectories • Challenges in relation to sickness absence rates

	• The need review long-term workforce challenges, taking into consideration a system-wide approach • Maintaining compliance with the Ockenden Report recommendations and wider considerations. • Ensuring that the Board was receiving adequate assurance regarding lesson learning from serious incidents • That the Board had an understanding of underperformance, particularly when it was not related to the Covid-19 pandemic. • The need to maintain close monitoring of the Trusts ongoing financial and planning risks. *The following items were considered as part of the consent agenda*
280	**CNST Junior Doctors Rota Gaps Action Plan** The Board of Directors • Noted the information provided for assurance of safe staffing levels in the Trust, and; • approved the submission of the action plan to the Royal College of Obstetricians and Gynaecologists (RCOG).
281	**Board Thank You's** The Trust Secretary provided an overview of the Board thank you's made to the following teams: • Infection, Prevention & Control team • Staff Vaccine Programme team • Business Intelligence team Videos showing the respective teams receiving thank you's from Executive Directors were circulated to the Board via email.
282	**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 1 April 2021. **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 4 March 2021 Virtual Meeting

PRESENT

Mr Robert Clarke	Chair
Mrs Kathryn Thomson	Chief Executive
Ms Jo Moore	Non-Executive Director/Vice Chair
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
Mr Phil Huggon	Non-Executive Director
Dr Susan Milner	Non-Executive Director/SID
Prof Louise Kenny	Non-Executive Director
Mr Ian Knight	Non-Executive Director
Mrs Tracy Ellery	Non-Executive Director

IN ATTENDANCE

Mrs Jen Huyton	Head of Strategy and Transformation (item 298 only)
Mr Andrew Duggan	Head of Communications (item 298 only)
Mr Mark Grimshaw	Trust Secretary
Mrs Cynthia Dowdle	Appointed Governor
Mrs Jackie Sudworth	Public Governor
Ms Kate Hindle	Staff/Lead Governor
Mr Peter Norris	Public Governor
Mr Yaroslav Zhukovskyy	Public Governor

APOLOGIES:

Mr Tony Okotie	Non-Executive Director

20/21/	
294	**Apologies** – as above **Declaration of Interests** – None noted
295	**Meeting guidance notes** The Board received the meeting attendees' guidance notes which had been updated to reflect 'virtual meetings'.
296	**Chair's announcements** None noted.
297	**Chief Executive Report**

No issues noted.

Jen Huyton and Andrew Duggan joined the meeting

298 **Trust Corporate Strategy**

The Chair noted that the process to update the Trust's Corporate Strategy ('Strategy') had been progressing over several months, with consultations undertaken with internal and external stakeholders as well as the Board through workshop sessions. The final draft of the Strategy had been included within the meeting pack for Board approval.

The Head of Strategy and Transformation provided an overview of the engagement undertaken to date and asserted that the key elements of the strategy had been well socialised with both internal and external stakeholders. Following feedback from the February 2021 private Board discussion, further engagement with external partners had taken place, most notable with the Maternity Voices Partnership (MVP) Chair. Comments received stated that the Strategy was an accessible and easy-to-read document with agreement noted for the key areas of focus and appreciation of the level of ambition expressed. The Head of Strategy and Transformation noted that due to Covid-19 restrictions, the amount of external engagement with the Strategy had been limited and noted that a six-month review was planned in which patients and service users would have a central role.

The Head of Communications presented the communications plan for the Strategy. It was noted that it would be designed utilising the updated Trust branding and would be launched digitally with other recently updated strategy documents e.g. Clinical & Quality Strategy. The communications approach would utilise an on-going series of messages with key themes selected for focus. The Strategy would be given a high-profile launch with staff, with all current internal communication channels utilised to highlight the key elements and themes. An important part of the communications plan was to embed the Strategy so that it would have an impact on influencing staff behaviours. The Strategy would therefore have alignment to the following:

- Divisional processes and operational planning
- Board Assurance Framework
- Corporate Objectives
- Personal Development Reviews (PDRs)

In relation to PDRs, the Head of Communications stated that there were plans to align the strategy with 'real life' examples for particular professions and groups of staff so that there was clarity on how day-to-day activity directly impacted on the Trust realising the strategic aims.

The Chief Executive commented on the importance of linking with public and patient groups when reviewing the Strategy and stated that it would be important to consider the impact that potential system level changes could have on the delivery of the Strategy.

Action: For a future Board workshop to consider the potential impact of system level changes to the delivery of the Corporate Strategy.

The Chair remarked that it would be important for the Board to remain cognisant of emerging challenges to the delivery of the Strategy.

The Board of Directors:

- Approved the Trust Corporate Strategy

Jen Huyton and Andrew Duggan left the meeting

299	**NHSE/I Covid-19 Infection Control Board Assurance Framework** The Director of Nursing & Midwifery reported that on the 26th October 2020 NHSE/I provided all Trusts with version 1.4 of the Infection, Prevention and Control (IPC) Board Assurance Framework which was to be used to further review compliance with IPC during the Covid-19 pandemic. The aim of the framework was to provide the Trust with a method of assessing compliance and provide assurance to the Board. The updated framework posed 43 new key lines of enquiry in relation to compliance or non-compliance with national guidance, identification of gaps in assurance and identification of any mitigation for gaps. The Trust provided a return in November 2020 declaring compliance with all bar six of the new standards. A further request was made by NHSE for a review of the novel elements of the BAF and the Trust made a return on February 11th 2021 citing compliance with all the new standards. The Chair referenced that a detailed evidence document had been made available that Board members could access to seek assurance against the compliance statements. The Chief Executive stated that it would be important for the Board to received assurance on the status of other IPC issues beyond Covid-19. The Trust Secretary noted that the IPC Annual Report was scheduled for consideration at the July 2021 Board. The Board of Directors: • Note the report • Took assurance that the Trust was taking all actions reasonably practicable to ensure it was working to meet its responsibilities for Infection Prevention and Control in relation to Covid-19.
300	**Robotic Assisted Surgery Business Case** Non-Executive Director Phillip Huggon Chair of the Finance, Performance and Business Development (FPBD) Committee, outlined the anticipated strategic and clinical benefits as well as the projected financial impact of the business case. He reported that the business case had been reviewed by the (FPBD) Committee, and it had been recommended to approve the purchase of a theatre robot in order to establish a permanent robotic assisted surgical service at Liverpool Women's Hospital. The Chief Operating Officer noted his thanks to the Board for the on-going support, particularly through the approval of a trial period for the robotic assisted surgery and for a full complement of gynaecology consultants. Following an issue being identified at FPBD Committee, it was confirmed that maintenance fees were included within the business case and were not additional costs. The Director of Finance noted that whilst only capital funding had been received, the Trust would recognise the on-going revenue costs in the accounts. Non-Executive Director, Prof. Louise Kenny, queried if the Trust would continue to calculate other cost benefits of robotic assisted surgery over the medium and long term. The Chair noted it was important to capture any direct and indirect cost mitigations to the increased revenue / running costs of a robotic service. The Director of Finance noted that a 12-month post implementation review would be undertaken and would capture this element. The Chair suggested that it would also be important for the quality impacts to also be monitored. **Chair's Log: For the quality impacts of robotic assisted surgery to be monitored by the Quality Committee within six months from implementation.** The Board of Directors: • Approved the Robotic Assisted Surgery business case and associated capital purchase.
301	**Any other business & Review of meeting**

	No comments noted. **Date of next meeting** The Chair reported that the next meeting of the Board of Directors in public would be held on 1 April 2021.

Agenda Item	2021/22/007

MEETING	Board of Directors
PAPER/REPORT TITLE:	Chief Executive Report
DATE OF MEETING:	Thursday, 01 April 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

Covid-19 Update

In February and March 2021, the Trust continued our staff vaccination programme with 84% now vaccinated. Sickness absence rates have improved although they remain high in some areas. We have been able to restart routine elective work and are working as part of the Cheshire and Mersey system as we develop recovery trajectories. There is a range of staff support available including increasing executive and senior team sessions with all staff groups.

The Trust continues under regional command and control arrangements with weekly executive lead oversight.

Perfect Week

The division of CSS are planning a 'Perfect Week' project with the aim to improve the patient pathway and theatre efficiency and utilisation. Part of the project will involve following the patient through from admission to discharge from theatres by observing and documenting all elements of the patient/ journey. The project is planned for the week of the 12th April for 5 days AM and PM and is supporting the Trust's approach to quality improvement.

Freedom to Speak Up Guardians

At Liverpool Women's Hospital we want to have a healthy culture of raising or reporting concerns. We have recently strengthened our Freedom to Speak process through the recruitment of an additional Guardian. Marianne Hamer (Clinical Lead for Imaging) became a Freedom to Speak up Guardian in March 2021 joining Kevin Robinson (Deputy Head of Patient Experience).

Maternity incentive scheme – year three

NHS Resolution published the final iteration of the Maternity Incentive Scheme Year Three Conditions during March 2021. The Trust has reviewed these and continues to form its evidence base ahead of sign off by the Board in July 2021.

Cheshire & Merseyside Local Maternity System

Local Maternity Systems (LMS) were established across the country in response to NHS England's Better Births report which set out a vision for safer, more personalised maternity care that reflects women's choices and offers continuing joined-up care. NHS organisations, Healthwatch and local councils, work together as a Local Maternity System (LMS) to design and implement improvements in maternity and neonatal services.

There is a Cheshire & Merseyside LMS that had previously been hosted by Liverpool CCG as part of the Cheshire and Mersey Women and Children's Programme, with myself as Chair from the middle of 2020 onwards. From 1 April 2021, the Cheshire & Merseyside LMS will be hosted by the Trust. Work is underway on developing the underpinning governance structures of the hosting arrangement and this will include how best to keep the Board updated of progress.

We welcome the new staff to the Trust.

Cheshire & Merseyside Health and Care Partnership Memorandum

The Board provided confirmation to the Cheshire & Merseyside Health and Care Partnership of its intention to sign up to the Partnership Memorandum via email ahead of the 12 March 2021 deadline. *The Board is asked to formally ratify this decision.*

Trust Seal

In line with paragraph 118 of the Trust's Standing Orders, there is a requirement to report all sealings to the Board of Directors on an annual basis. The report should contain details of the seal number, the description of the document and date of sealing. The Trust Seal was not used during the 2020/21 financial year.

SECTION B – Local

New chief nurse for the North West appointed by NHS England and NHS Improvement

Hayley Citrine, the current Chief Executive for The Walton Centre NHS Foundation Trust, has been appointed by NHS England and NHS Improvement as the new chief nurse for the North West regional team.

Hayley replaces Jackie Bird, who retired as chief nurse at the beginning of this year.

Hayley joined The Walton Centre in 2014 as Executive Director of Nursing and Quality and in February 2018 she took up the position of Chief Executive. Hayley's career in the NHS started in 1985 and she has worked as Deputy Director and Associate Director of Nursing for a number of years following previous experience in a variety of clinical posts at

the former South Manchester University Hospitals Trust, Salford Royal Foundation Trust, Warrington and Halton Hospitals Foundation Trust and East Lancashire NHS Trust.

Speaking of her new appointment Hayley said: "In one respect I am immensely sorry to leave The Walton Centre, yet also absolutely delighted to be appointed as Chief Nurse for the North West and I look forward to working with patients, colleagues and volunteers throughout the region. During the pandemic I have been working as one of the CEOs as part of the in-hospital cell in Cheshire and Merseyside and enjoyed working in partnership across the region, so to have the opportunity to build on that further on a wider footprint is one I'm really looking forward to.

"There is a significant amount of change happening both within and external to the NHS that will influence the way we deliver future services so it's imperative that this has the clinical professions at its heart and ensures equity and excellence across organisational boundaries for our patients and populations health and care. It's imperative we consider the workforce required for this - the right staff with the right skills with the right support to deliver the ambitions, so to be able to play a part in that is something I'm really looking forward to in the role, as well as working with the regional team and colleagues across the North West."

Update from the Cheshire & Merseyside Partnership Board – Edition 3

This update provides the highlights from the issues discussed at the February 2021 Partnership Board. The Department of Health and Social Care White Paper on Health and Social Care was discussed at length during the meeting and details are included in the update. The Partnership Board also heard the latest position with regard to Covid and vaccination and the establishment of Integrated Care Partnerships at our nine Places.

https://www.cheshireandmerseysidepartnership.co.uk/wp-content/uploads/2021/03/Partnership-Board-Briefing-Edition-3-final.pdf

SECTION C – National

NHS Providers publishes regulation survey report

A new report by NHS Providers on trusts' experience of NHS regulation highlights strengths and weaknesses in the approaches taken by Care Quality Commission (CQC) and NHS England and NHS Improvement in response to the COVID-19 pandemic. Based on findings from its annual regulation survey, it concludes that both organisations implemented welcome changes in response to the onset of the pandemic, scaling back their activity to allow trusts to concentrate their full efforts on patient care.

https://nhsproviders.org/reconsidering-the-approach-to-regulation

Update on CQC's regulatory approach

The three Chief Inspectors have published a statement about the CQC's future approach, outlining changes that will take effect from April 2021, and what they mean for providers from all sectors.

Throughout the pandemic, the CQC's regulatory role has not changed. Their core purpose to ensure that the public receive safe, effective, compassionate and high-quality care has remained at the centre of our activities – and this will continue.

The CQC has stated that they want to have an active role in encouraging system-wide recovery and as we move into the spring, they are looking to the future and how they can support this. The CQC will continue responding to risk to keep people safe from harm and protect their human rights by proactively seeking out and addressing safety and quality concerns.

For hospital services (including independent health and mental health services), they will be continuing with their current risk-based approach to regulation, undertaking inspection activity where there is a clear risk to safety. They will also:

- return to inspect and rate NHS trusts and independent healthcare services that are rated as inadequate or requires improvement, or where new risks have come to light, and develop plans to review ratings for all hospital providers to make sure they are still appropriate based upon our latest assessment of risk
- carry out some core service with well-led inspections of mental health trusts and independent mental health providers
- prioritise high risk independent healthcare services for inspection, for example, cosmetic surgery services, independent ambulance services, and those where closed cultures may exist
- closely monitor how hospitals are ensuring robust infection prevention and control and carry out focused IPC inspections where we have concerns about a provider's oversight of infection risk
- conduct Mental Health Act (MHA) monitoring visits to ensure the rights of vulnerable people are protected
- carry out focused inspection activity in emergency departments where our data monitoring and local intelligence indicates that increased pressure is having a direct impact on the quality and safety of care
- roll out a programme of focused inspections of safety in NHS maternity services where data and local intelligence identifies concerns about the quality of care; these inspections will look closely at issues such as teamworking and culture, and experiences of staff and patients.

The full statement can be found on the following link: https://www.cqc.org.uk/news/stories/update-cqcs-regulatory-approach

Agenda Item	21/22/8a

MEETING	**Trust Board**
PAPER/REPORT TITLE:	**Performance Report**
DATE OF MEETING:	Thursday, 01 April 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):	*Choose an item.*	
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**	*Choose an item.* Or type here if not on list: *Click here to enter text.*
	Date of meeting	*Click here to enter a date.*

Executive Summary

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

The report also incorporates the Trust's Safe Staffing position and the monthly update on Serious Incidents.

Report

1. Introduction

Delivering high quality, timely and safe care are the key priorities for the organization. This report provides an overview of the Trust's performance. 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 Board dashboard is included as an appendix to this paper which includes all the indicators that have been achieved or not.

2. Workforce

2.1 Sickness Absence

KPI ID	Source	Service ID	Target < or >	Target	Value	Trend	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
Sickness Absence Rate	Owner - Deputy Director of Workforce																	
KPI101T	NHSI	Trust	<=	4.5%	Numerator		3195	3148	2327	2108	2312	2043	2494	3375	2911	2880	3466	2689
					Denominator		41197	39757	41513	40457	41594	40995	39689	41383	40186	41591	41637	37996
					Performance		7.75%	7.92%	5.61%	5.21%	5.56%	4.98%	6.28%	8.16%	7.24%	6.92%	8.32%	7.08%
					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%	6.23%	6.23%	6.23%	5.60%	5.60%	5.60%	7.44%	7.44%	7.44%	7.73%	7.73%

Sickness reduced in February 2021. The greatest pressure has been seen in Maternity and Theatres. Maternity has been placed into weekly Executive oversight in order to improve sickness absence and support the service.

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 pulled together and communicated to all staff through the regular Coronavirus (COVID-19) staff briefings. Covid 19 Risk assessments are in place for all staff. A coronavirus testing programme is in place for staff (and family members) with suspected symptoms, and asymptomatic testing continues to be available to staff.

The Covid vaccination programme is also now well underway with 84% of staff having had their first vaccination

3. Continuity of Carer (CoC)

KPI ID	Source	Service ID	Target < or >	Target	Value	Trend	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
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		142	96	101	80	75	45	65	42	44	78	412	186
					Denominator		819	816	751	805	807	660	810	785	779	843	1121	910
					Performance		17.34%	11.76%	13.45%	9.94%	9.29%	6.82%	8.02%	5.35%	5.65%	9.25%	36.75%	20.44%
					Trend		▲	▼	▲	▼	▼	▼	▲	▼	▲	▲	▲	▼
					Target %		35%	35%	35%	35%	35%	35%	35%	35%	35%	35%	35%	35%
					Qtrly Performance		14.68%	11.68%	11.68%	11.68%	8.12%	8.12%	8.12%	6.81%	6.81%	6.81%	29.44%	29.44%

CoC was just over 20% in February and has seen a steady rise since the review of the programme in November 20. A 5th Team is due to go live in March. Revised trajectories in line with staffing challenges will be taken through quality committee.

4. Access Standards

INDICATOR		METRIC	THRESHOLD		ACTUALS Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
Cancer	2WW for suspected cancer	%	≥93%	Higher values are better	96.7	95.7	96.5	96.7	97.3	97.0	95.0	94.2	95.0	97.0	97.7	93.9	
	31 Days from Diagnosis to 1st Definitive Treatment	%	≥96%	Higher values are better	81.8	75.0	89.7	96.0	92.9	96.0	93.3	100.0	87.1	88.1	96.4	91.3	
	62 Days for First Treatment from urgent GP Referral **(After re-allocation)** Final Reported Position	%	≥85%	Higher values are better	39.1	66.7	65.0	34.8	36.7	76.0	60.0	42.9	64.3	61.5	47.4	41.7	
	104d Referral to First Definitive Treatment	Count	0	Zero tolerance	5	1	1	3	3	1	2	0	2	3	2	3	
RTT	RTT Incomplete Pathways <18 weeks	%	≥92%	Higher values are better	81.1	79.5	71.9	64.0	52.6	49.0	56.8	64.4	65.0	63.6	62.8	62.3	64.0
	Incomplete Pathway > 52 Weeks	Count	0	Zero tolerance	0	0	2	5	11	29	32	22	25	47	51	103	190
Diagnostics	Diagnostic Tests: 6 week wait	%	≥99%	Higher values are better	98.83	87.80	27.60	47.00	57.70	59.82	58.20	83.25	87.23	90.53	84.43	83.87	89.67
A&E	A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge	%	95%	Higher values are better	98.5	98.1	100.0	98.2	100.0	98.1	98.7	98.2	97.9	98.1	96.6	95.8	88.6

(Cancer data is reported 2 months after month end)

4.1 ED attendances

For February 21 a breach analysis was undertaken which demonstrated a clear issue in achieving 4-hour performance out of normal working hours. There was a combination of factors which impacted this

The following actions have been initiated and daily performance has subsequently improved.

- Introduction of a 10-10 GED specialist nurse provision
- Reviewed hospital out of hours provision for the medical workforce led by Medical Director
- Implemented a new escalation policy within GED
- Change of breach analysis form to provide greater data to enable more informed decision making.

4.2 Referral to Treatment

The Trust continues to see a sustained level in 18-week performance and an increase in 52-week breaches.

Regionally and nationally theatre staffing continues to be challenged due to the pandemic. The key factors continue to be

1) Cancellation of elective theatres in support of the regional response
2) Sickness absence across all staff groups
3) Increased theatre time for cases due to IPC measures
4) Patients choosing to defer due to Covid concerns
5) Reprioritisation of patients against developing national criteria

All 52-week breaches receive a harm review.

Work on recovery has been commenced with the Cheshire and Mersey System with a priority on providing operation dates for those deemed highest clinical priority.

4.3 Cancer

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

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

Priority level 1a

• Emergency: operation needed within 24 hours to save life

Priority level 1b

• Urgent: operation needed with 72 hours

Priority level 2

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

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

- urgency of symptoms

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

- 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 3 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.

4.4 Diagnostic wait

KPI ID	Source	Service ID	Target <or>	Target	Value	Trend	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
Diagnostic Tests: 6 Week Wait		Owner - Divisional Manager Clinical Support																
KPI204	NHSI	Trust	>=	99.0%	Numerator		165	35	195	326	332	284	328	328	344	282	312	382
					Denominator		188	127	415	565	555	488	394	376	380	334	372	426
					Performance		87.77%	27.56%	46.99%	57.70%	59.82%	58.20%	83.25%	87.23%	90.53%	84.43%	83.87%	89.67%
					Trend		▼	▼	▲	▲	▲	▼	▲	▲	▲	▼	▼	▲
					Target %		99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%
					Qtrly Performance		95.89%	50.23%	50.23%	50.23%	65.69%	65.69%	65.69%	87.52%	87.52%	87.52%	86.97%	86.97%

The 6-week diagnostic wait increased in February and has performed generally well in the context of the pandemic. It is likely that this will increase as sickness absence reduces.

5. Safe Staffing

The key areas to highlight for Month 10 and 11 are as follows:

Maternity:

- **Fill-rate –** within maternity we are presently reporting fill rates of above 75%, with non direct care giving midwifery roles being utilised to address the shortfall, night shifts are reporting a higher fill rate of greater than 80%, maternity is utilising external agency to address short and long term gaps within rotas. Maternity has a comprehensive escalation policy in relation to staffing/acuity/activity; activity is reviewed every four hours within maternity services.
- **Attendance/Absence -** Maternity has reported high levels of sickness absence for this reporting period, including a high level of extremely clinically vulnerable staff who have required shielding/working from home. Work has been ongoing within the division to expand our 'working from home remit' for midwifery staff, this will also now be used to support return from LTS for midwifery staff.
- **Vacancies –** Maternity presently has 17.04wte vacancies (6.48wte) is required maternity leave cove recruitment is ongoing within maternity to address this; we also await the qualification of our student midwifery team, to address this recruitment gap.
- **Red flags -** Maternity has reported 25 red flags within this reporting period, the emerging theme are delays in clinical activity such as IOL, due to staffing pressures. Maternity red flags are reviewed locally and themes fed into governance and divisional board.

Neonates:

- **Fill- rate –** within the NICU we have good fill rate both with registered and unregistered staff. As our non-registered are counted in our care delivery numbers this gives flex on the fill rates. At all times the minimum safer staffing levels are maintained with the NICU.
- **Attendance/ Absence -** Sickness absence for the unit has sat around 12/13% over January and February, 7.5% of this is accounted for in covid absences. In January we had a 40% short term sickness rate and 60% long term sickness rate, this changed in February to 20% short term sickness and 80% long term sickness. The main issues around long-term sickness are cancers and stress and anxiety. We have on average 11 wte on maternity leave and 8 wte shielding. The impact of shielding and earlier maternity shielding has had an impact on bank usage.
- **Vacancies -**Currently we have no vacancies at Band 7/6, we have just completed a successful round of band 5 interviews and have recruited to the 11.58 registered vacancies we have 5.62 unregistered vacancies
- **Red Flags -** We have no red flags

Gynaecology:

- **Fill – rate -** RN fill rate has been low due to vacancy and sickness. We have been monitoring staffing twice daily and redeploy across the Division to support safe staffing levels. The Division have also increased care staff hours to support.
- **Attendance/ Absence -** There are currently 3 staff on Covid shielding and we have two trained staff on LTS which has impacted on staffing. Matrons and managers meet monthly with HR to ensure absence has been managed appropriately.
- **Vacancies -** The ward has seen significant turnover of staff and 12 month turnover is currently 30%. Active recruitment (including over recruiting 3 RN's) has taken place, and there are 5 staff awaiting start dates, with a further 3.4 vacancies (this includes the over establishment)
- **Red Flags -** Non raised

Month 10

WARD	Fill Rate Day% RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff
Gynae Ward	74%	104%	98%	118%
Delivery suite	80%	88%	85%	82%
Mat Base/ Jeffcoate	73%	89%	81%	97%
MLU	68%	86%	75%	68%
Neo-nates	99%	84%	100%	77%
Transitional care	86%	79%	107%	46%

Month 11

WARD	Fill Rate Day% RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff
Gynae Ward	75%	105%	98%	126%
Delivery suite	82%	87%	91%	88%
Mat Base/ Jeffcoate	73%	79%	72%	96%
MLU	67%	81%	74%	84%
Neo-nates	95%	76%	97%	93%
Transitional care	97%	106%	123%	68%

6. Serious Incidents

There were three Serious Incidents (SI's) relating to Maternity care declared on the StEIS system as per Trust Policy in line with NHS England StEIS reporting criteria in February and March 2021.

The table below provides a brief overview of the StEIS serious incidents reported in February and March 2021.

Service	StEIS Ref.	Reported in Line with Policy	Summary
Maternity	2021-3919	Yes	Unexpected admission to Neonatal Intensive Care for Therapeutic Cooling.

Service	StEIS Ref.	Reported in Line with Policy	Summary
Maternity	2021-3920	Yes	Unexpected / potentially avoidable death at 28+ weeks.

Service	StEIS Ref.	Reported in Line with Policy	Summary
Maternity	2021-6065	Yes	Wrong blood in Transfusion blood sample tube – SHOT reportable.

Overview

The three SI's reported in February and March made a total of 25 SI's reported for the year to date for 2020/21. Compared to 2019/20 period the Trust has had an increase on the previous 3 years of reporting as can be seen below but has a similar reporting level compared to 4-5 years ago.

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	2	1	25

The number of Serious Incidents which occur in any given year can vary considerably as shown above for LWH data only. Due to SI data from trusts not being published we are not able to benchmark this area. It is important to note that LWH has a clear process for the identification and investigation of SIs and has an open and honest approach to this.

There are a number of aspects which can influence an SI occurring such as, increased activity and acuity, reduced staffing levels, complexity of patient condition and human error. A deep dive into the increased number of SIs reported in 2020/21 period has been requested by the Quality committee for review in April 2021.

A key theme identified in SIs reported by the Trust, relates to Human Factors. This has been recognised nationally and internationally increasingly over the past few years as the main factor affecting incidents occurring and the identification of lessons. This element has been recognised as part of the National Patient Safety Strategy (2019) where it is a clear goal for improvement. As part of the Trust Patient Safety Implementation plan and Clinical and Quality Strategy (2020-2025) work is currently progressing to clearly identify the type and amount of Human Factors Training which is required for all staff levels. It is the current intention to have a full training programme in place and running by the end of August 2021. This plan is fully supported by the Trust Education Governance Committee who will monitor progress and implementation.

HSIB Cases Reported and NHSR Early Notification Scheme

During February and March 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	1	0	-	-	-	-	-	-	-	-	-	2

The main theme of cases being related to cooled babies in the main is due to the Trust having a very low threshold for commencing therapeutic cooling as compared to other neonatal units. A majority of babies are discharged in a short period with no ongoing neurological deficits or harm having occurred.

Duty of Candour

All Serious Incidents which have been declared in February and March 2021 have had full duty of candour completed in line with Trust policy. The results of the 20-21 audit of duty of candour which is being completed by the Risk and Patient Safety Manager are awaited.

Overdue Actions for reported Sis

At the time of writing this report there are no actions from Serious Incidents which are overdue.

7. Conclusion

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

During 2020/21 the unpredictable sickness absence related to Covid on top of normal absence has been the most significant factor affecting operational performance throughout the whole year.

Out of the services that were prioritised nationally, Cancer services maintained previous performance and demonstrated some improvement as the Consultant workforce increased throughout the year. Maternity services maintained essential services and despite the challenges related to staffing demonstrated significant improvement in the Continuity of Care Target, although there remains work to do to achieve the 35%. Neonatal services maintained operational performance

Of the services that were nationally mandated to step down, benign gynaecology has seen the greatest effect on performance with a significant increase in long waiting patients. Genetics services saw a decline although this has returned to normal performance. Fertility services were stepped down and have also returned to normal performance. Staff from the clinical services that were stepped down were used to support the nationally prioritised services listed earlier, in addition they supported Covid related operational services such as swabbing and screening.

Liverpool Women's NHS Foundation Trust

Board Performance Report

Published Month - March 2021

Data Included - Up to February 2021

Workforce

KPI ID	Source	Service ID	Target < or >	Target	Value	Trend	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
Sickness Absence Rate	**Owner - Deputy Director of Workforce**																	
KPI101T	NHSI	Trust	<=	4.5%	Numerator		3195	3148	2327	2108	2312	2043	2494	3375	2911	2880	3466	2689
					Denominator		41197	39757	41513	40457	41594	40995	39689	41383	40186	41591	41637	37996
					Performance		7.75%	7.92%	5.61%	5.21%	5.56%	4.98%	6.28%	8.16%	7.24%	6.92%	8.32%	7.08%
					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%	6.23%	6.23%	6.23%	5.60%	5.60%	5.60%	7.44%	7.44%	7.44%	7.73%	7.73%
Mandatory Training Compliance	**Owner - Deputy Director of Workforce**																	
KPI095T	Quality Strategy	Trust	>=	95.0%	Numerator													
					Denominator													
					Performance		91.00%	90.00%	92.00%	92.00%	91.23%	91.00%	89.00%	87.00%	89.00%	89.00%	88.00%	86.64%
					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	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
Financial Sustainability Risk Rating: Overall Score					**Owner - Deputy Director of Finance**													
KPI087	NHSI	Trust	<=	3	Performance Value		3	3	3	3	3	3	3	3	3	3	3	3
					Trend		▶	▶	▶	▶	▶	▶	▶	▶	▶	▶	▶	▶
					Target Value		3	3	3	3	3	3	3	3	3	3	3	3
					Qtrly Performance Value		9	9	9	9	9	9	9	9	9	9	6	6

Liverpool Women's NHS Foundation Trust

Safety

KPI ID	Source	Service ID	Target < or >	Target	Value	Trend	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
Never Events	**Owner - Head of Governance**																	
KPI181T	NHSI	Trust	=	0	Performance Value		0	0	1	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	1	1	1	0	0	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	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
Intensive Care Transfers Out	**Owner - Clinical Director Gynaecology**																	
KPI107T	Trust Objectives	Trust			Performance Value		0	0	1	2	1	1	3	1	1	0	0	1
					Trend		▶	▶	▲	▲	▼	▶	▲	▼	▶	▼	▶	▲
					Target Value													
					Qtrly Performance Value		0	3	3	3	5	5	5	2	2	2	1	1

Liverpool Women's NHS Foundation Trust

Experience

KPI ID	Source	Service ID	Target < or >	Target	Value	Trend	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
18 Week RTT: Incomplete Pathways	**Owner - Divisional Manager Gynaecology**																	
KPI003T	NHSI	Trust	>=	92.0%	Numerator		5149	4657	4217	3443	3550	4428	5264	5120	4982	5283	5501	5762
					Denominator		6476	6476	6584	6549	7204	7799	8177	7877	7834	8419	8832	8874
					Performance		79.51%	71.91%	64.05%	52.57%	49.28%	56.78%	64.38%	65.00%	63.59%	62.75%	62.28%	64.93%
					Trend		▼	▼	▼	▼	▼	▲	▲	▲	▼	▼	▼	▲
					Target %		92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%
					Qtrly Performance		81.06%	62.81%	62.81%	62.81%	57.13%	57.13%	57.13%	63.76%	63.76%	63.76%	63.61%	63.61%
18 Week RTT: Incomplete Pathway > 52 Weeks	**Owner - Divisional Manager Gynaecology**																	
KPI002T	Quality Schedule	Trust	=	0	Performance Value		0	2	5	11	29	32	22	25	47	51	103	190
					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		170	123	79	90	118	114	134	143	148	94	103	140
					Denominator		243	137	104	169	217	210	227	243	246	161	160	184
					Performance		69.96%	89.78%	75.96%	53.25%	54.38%	54.29%	59.03%	58.85%	60.16%	58.39%	64.38%	76.09%
					Trend		▼	▲	▼	▼	▲	▼	▲	▼	▲	▼	▲	▲
					Target %		90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
					Qtrly Performance		68.80%	71.22%	71.22%	71.22%	55.96%	55.96%	55.96%	59.23%	59.23%	59.23%	70.64%	70.64%
18 Week RTT: Non-Admitted Completed Pathways	**Owner - Divisional Manager Gynaecology**																	
KPI004T	Trust Objectives	Trust	>=	95.0%	Numerator		1417	798	659	973	913	1042	1043	1235	1072	939	1083	1383
					Denominator		1673	898	795	1325	1400	1461	1497	1672	1488	1358	1536	1821
					Performance		84.70%	88.86%	82.89%	73.43%	65.21%	71.32%	69.67%	73.86%	72.04%	69.15%	70.51%	75.95%
					Trend		▼	▲	▼	▼	▼	▲	▼	▲	▼	▼	▲	▲
					Target %		95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
					Qtrly Performance		84.45%	80.52%	80.52%	80.52%	68.79%	68.79%	68.79%	71.85%	71.85%	71.85%	73.46%	73.46%
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		9	6.5	4	5.5	9.5	7.5	3	9	8	4.5	5	
					Denominator		13.5	10	11.5	15	12.5	12.5	7	14	13	9.5	12	
					Performance		66.67%	65.00%	34.78%	36.67%	76.00%	60.00%	42.86%	64.29%	61.54%	47.37%	41.67%	
					Trend		▲	▼	▼	▲	▲	▼	▼	▲	▼	▼	▼	
					Target %		85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
					Qtrly Performance		51.47%	43.84%	43.84%	43.84%	62.50%	62.50%	62.50%	58.90%	58.90%	58.90%	41.67%	41.67%
Cancer: 62 Day Screening Referrals (Numbers)	**Owner - Divisional Manager Gynaecology**																	
KPI033	NHSI	Gynaecology	<=	5	Performance Value		1.0	1.0	0.5	0.0	2.0	1.0	0.0	0.0	0.0	1.0	0.0	
					Trend		▶	▶	▼	▼	▲	▼	▼	▶	▶	▲	▼	
					Target Value		5	5	5	5	5	5	5	5	5	5	5	5
					Qtrly Performance Value		3	1.5	1.5	1.5	3	3	3	1	1	1	0	0
Cancer: 62 Day Screening Referrals (Percentage)	**Owner - Divisional Manager Gynaecology**																	
KPI034	NHSI	Gynaecology	>=	90.0%	Numerator		1	1	0.5	0	2	1	0	0	0	1	0	
					Denominator		1	1	0.5	0	2	1.5	0	0	0.5	1	0	
					Performance		100.00%	100.00%	100.00%		100.00%	66.67%			0.00%	100.00%		
					Trend		▶	▶	▶			▼				▲		
					Target %		90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
					Qtrly Performance		100.00%	100.00%	100.00%	100.00%	85.71%	85.71%	85.71%	66.67%	66.67%	66.67%		
Cancer: 104 Day Breaches	**Owner - Divisional Manager Gynaecology**																	
KPI352	Trust Objectives	Gynaecology	=	0	Performance Value		1	1	3	3	1	2	0	2	3	2	3	
					Trend		▼	▶	▲	▶	▼	▲	▼	▲	▲	▼	▲	
					Target Value		0	0	0	0	0	0	0	0	0	0	0	0
					Qtrly Performance Value		8	7	7	7	3	3	3	7	7	7	3	3

Experience

KPI ID	Source	Service ID	Target < or >	Target	Value	Trend	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
Cancer: 28 Day Faster Diagnosis	**Owner - Divisional Manager Gynaecology**																	
KPI359	Trust Objectives	Gynaecology	>=	75.0%	Numerator		167	111	112	165	177	159	186	169	206	248	173	
					Denominator		296	208	134	208	242	225	259	285	321	355	266	
					Performance		56.42%	35.00%	83.58%	79.33%	73.14%	70.67%	71.81%	59.30%	64.17%	69.86%	65.04%	
					Trend		▼	▼	▲	▼	▼	▼	▲	▼	▲	▲	▼	
					Target %		75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%
					Qtrly Performance		55.51%	70.55%	70.55%	70.55%	71.90%	71.90%	71.90%	64.83%	64.83%	64.83%	65.04%	65.04%
Diagnostic Tests: 6 Week Wait	**Owner - Divisional Manager Clinical Support**																	
KPI204	NHSI	Trust	>=	99.0%	Numerator		165	35	195	326	332	284	328	328	344	282	312	382
					Denominator		188	127	415	565	555	488	394	376	380	334	372	426
					Performance		87.77%	27.56%	46.99%	57.70%	59.82%	58.20%	83.25%	87.23%	90.53%	84.43%	83.87%	89.67%
					Trend		▼	▼	▲	▲	▲	▼	▲	▲	▲	▼	▼	▲
					Target %		99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%
					Qtrly Performance		95.89%	50.23%	50.23%	50.23%	65.69%	65.69%	65.69%	87.52%	87.52%	87.52%	86.97%	86.97%
A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge					**Owner - Divisional Manager Gynaecology**													
KPI008	NHSI	Gynaecology	>=	95.0%	Numerator		830	1156	1207	748	684	702	746	750	839	787	882	816
					Denominator		846	1156	1229	748	697	711	760	766	855	815	921	921
					Performance		98.11%	100.00%	98.21%	100.00%	98.13%	98.73%	98.16%	97.91%	98.13%	96.56%	95.77%	88.60%
					Trend		▼	▲	▼	▲	▼	▲	▼	▼	▲	▼	▼	▼
					Target %		95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
					Qtrly Performance		98.80%	99.30%	99.30%	99.30%	98.34%	98.34%	98.34%	97.54%	97.54%	97.54%	92.18%	92.18%
Complaints: Number Received	**Owner - Head of Audit, Effectiveness and Patient Experience**																	
KPI038T	NHSI / Quality Strate	Trust	<=	15	Performance Value		3	1	6	5	5	2	4	1	5	2	6	3
					Trend		▼	▼	▲	▼	▶	▼	▲	▼	▲	▼	▲	▼
					Target Value		15	15	15	15	15	15	15	15	15	15	15	15
					Qtrly Performance Value		14	12	12	12	11	11	11	8	8	8	9	9

Agenda Item	21/22/8b

MEETING	**Trust Board**
PAPER/REPORT TITLE:	**Lessons learnt from mortality, Q3 2020/21**
DATE OF MEETING:	Thursday, 01 April 2021
ACTION REQUIRED	**Assurance**
EXECUTIVE DIRECTOR:	Lynn Greenhalgh, Medical Director
AUTHOR(S):	Andrew Drakeley, Acting Deputy Medical Director, Allan Hawksey, Risk and Patient Safety Manager, Louise Robertson, Consultant Obstetrician, Ai-Wei Tang, Consultant Obstetrician and Rebecca Kettle, Consultant Neonatologist
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** **1.** To develop a well led, capable, motivated and entrepreneurial ***workforce*** ☒ **2.** To be ambitious and ***efficient*** and make the best use of available resource ☐ **3.** To deliver ***safe*** services ☒ **4.** To participate in high quality research and to deliver the most ***effective*** Outcomes ☒ **5.** To deliver the best possible ***experience*** for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust…….* ☒ ***2.*** *Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have sufficient numbers of clinical staff with the capability and capacity to deliver the best care. ……* ☒ ***3.*** *The Trust is not financially sustainable beyond the current financial year……* ☐ ***4.*** *Failure to deliver the annual financial plan ……* ☐ ***5.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision ……* ☒ ***6.*** *Ineffective understanding and learning following significant events……* ☒ ***7.*** *Inability to achieve and maintain regulatory compliance, performance and assurance……* ☒ ***8.*** *Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) ……* ☐
CQC DOMAIN	***Which Domain?*** ***SAFE-*** *People are protected from abuse and harm* ☒ ***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☒ ***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☒ ***RESPONSIVE –*** *the services meet people's needs.* ☒

	WELL-LED** - the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.* ☒ ***ALL DOMAINS ☒	
LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution ☒ **2.** Operational Plan ☒ **3.** NHS Compliance ☒	**4.** NHS Constitution ☒ **5.** Equality and Diversity ☒ ***6.*** Other: Click here to enter text.
FREEDOM OF INFORMATION (FOIA):	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 Committee members are asked to review the contents of the paper and Take assurance that there is adequate processes and progress against the requirements laid out by the National Quality Board	
PREVIOUSLY CONSIDERED BY:	**Committee name**	*Choose an item.* Or type here if not on list: Quality Committee
	Date of meeting	Monday, 01 February 2021

Executive Summary

This is the 2020/21 Quarter 3 (Q3) learning from deaths report for the Trust. There are processes in place for review in all three types of death at the Trust. Every death in the Trust, including expected adult deaths, is reviewed.

Key areas the report addresses:

- All adult deaths, stillbirths & neonatal deaths have a mortality review conducted.
- One in-hospital related adult death occurred in Q3 of 2020/21.
- The Q3 stillbirth rate of 4.0/1000 (3.5/1000 excluding fetal abnormalites) was lower than Q2 (4.1 and 3.9/1000 respectively).
- One neonatal case was identified where care could have been adversely affected by COVID 19 related restrictions and/or amended guidance or due to mothers delaying accessing maternity healthcare. This has been escalated to a serious incident and is being investigated. Full report to follow.
- The overall standard of care in stillbirth and neonatal deaths was good.
- The Trust demonstrates a high level of learning from mortality reviews. Themes are identified and action plans in place to address issues that arise.

Learning from deaths 2020/21

Strategic context

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

Learning from Deaths – A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care'. A quarterly Adult and Perinatal Mortality report is presented to the Quality Committee as a core requirement of the National Guidance for Learning from Deaths.

This report is the 20/21 Q3 Board assurance report regarding compliance with review process and learning from deaths. It is set within the context of the Coronavirus Covid-19 pandemic.

Local context

The number of adult deaths in the Trust is low. Deaths are usually expected, end of life care related. Due to the low level of mortality numbers encountered and the complexity of the patients cared for by the Trust, adult mortality data is presented as pure data, not standardised mortality such as SHMI. The use of pure data and not standardised mortality rates has been previously agreed with the CCG as the Trust's approach to monitoring adult mortality rates. Stillbirths and neonatal mortality rates are reported in absolute numbers and /1000 births. Stillbirths are reported as overall rate and rate excluding terminations. Neonatal deaths are reported as overall rate and rate for in-booked babies.

Data is presented for adults, maternity/perinatal and neonatal deaths:

1. Adult:

The Trust's policy for analysis after an adult death relies upon the following activities:
• Gathering detailed intelligence on all individual instances of adult mortality in the Trust
• Identifying local issues arising from each of those events individually
• Exploring themes that may be emerging from groups of events

The report is part of the regular reporting schedule of the Trust to ensure that there is oversight and assurance monitoring of the mortality rates related to the clinical activity of the Trust.

The data contained in this report is pure data and is not standardised mortality data such as SHMI, due to the low level of mortality numbers encountered and the complexity of the patients cared for by the Trust.

The use of pure data and not standardised mortality rates has been previously agreed with the CCG as the Trusts approach to monitoring mortality rates.

Key findings:

- There were 2 deaths within Gynaecology Oncology for Q3. Both were subject to Mortality Reviews. 1 was declared as a Serious Incident. In the other case, there were no issues identified with the end-of-life care provided.
- The Safety and Effectiveness Senates have clear overview of and show evidence of responsiveness to potential areas of risk to adult mortality.

Table 1: Obstetric Mortality
This includes all obstetric activity in-hospital.

Obstetrics	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	TOTAL
Total Mortality	0	0	0	0	0	0	0	0	0				0
Discharges	1490	1632	1689	1835	1921	1806	1850	1690	1684				15597

Table 2: Gynaecology Mortality (non-oncology)

Gynaecology (non oncology)	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	TOTAL
Total Mortality	0	0	0	0	0	0	0	0	0				0
Discharges	258	203	293	470	546	554	614	637	478				4053

Table 3: Gynaecology Oncology

Gynaecology Oncology	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	TOTAL
Total Mortality	0	0	0	0	1	1	1	0	1				4
Discharges	70	60	66	76	72	65	67	64	62				408

<u>Out of hospital deaths 2020-21 Quarter 3</u>

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

There were no reported out of hospital maternal deaths related to women who died within 12 months of delivering a baby at LWH in Q3.

There was a lady who sadly passed away at 10 weeks pregnant (reported in Q1), prior to having her 12 weeks scan. It was a suspected suicide; however, remains subject to ongoing investigation by HM Coroner. The Trust had not provided any care for this lady immediately prior to her death. The Trust review was completed in November 2020 and has been submitted to HM Coroner. The recommendations were as follows:

- Gynaecology Emergency Department to develop a Standard Operating Procedure for follow-up of non-attendance of appointments to include a review of PENS. Relevant information to be shared with named midwife and obstetrician in the case of ongoing pregnancy.
- Review findings to be shared with Liverpool University Hospitals (who had had direct contact on a number of occasions with the patient relating to their mental health).

There were no out of hospital Gynaecological deaths in Q3.

Table 4 Mortality reviews and Key Themes

Mortality reviews in Q3		
	Maternity (Direct)	**Gynaecology**
No of Adult Deaths	0	2
No of Mortality Reviews completed	0	2
No of deaths requiring RCA's	0	1
No of deaths due to deficiencies in care	0	0
Mortality Themes	N/A	N/A
Progress v Smart Plans	N/A	N/A
Mortality Outcomes	N/A	N/A
Measures for ongoing scrutiny	N/A	N/A

Unexpected adult gynaecology deaths trigger a 72- hour report and are recorded on Ulysses (Trust risk management and incident recording system).

There was 1 unexpected gynaecology death recorded in this quarter (December). Pre-operatively, the patient was noted to have potential endometrial cancer and associated infection. Post-operatively the patient declined very quickly and sadly passed away. The Trust are currently undertaking a Serious Incident investigation to identify if there are any opportunities for learning. The post-mortem results have indicated natural causes with no concerns raised by HM Coroner that the Trust have caused or contributed to the patient's death. Report submitted to the CCG in December 2020.

All **direct maternal deaths** trigger serious incident investigation. No direct maternal deaths were recorded in this quarter.

2. Maternity / perinatal

Table 5. perinatal deaths

PERINATAL DEATHS

	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	TOTAL
ADULT Obstetrics	0	0	0	0	0	0	0	0	0				0
STILLBIRTHS Total stillbirths	1	5	4	2	3	1	4	1	2				23
Stillbirths (excl. terminations)	1	5	4	2	2	1	2	1	2				20
Births	596	579	638	658	677	681	669	605	605				5708
Overall Rate per 1000 births	1.68	8.63	6.27	3.03	4.43	1.47	5.98	1.65	3.31				4.0
Rate (excluding TOP) per 1000	1.68	8.63	6.27	3.03	2.95	1.5	1.47	1.65	3.31				3.5

All Perinatal deaths in the Trust are subject to review using the Perinatal Mortality Review Tool. The tool grades care as shown in the table below. This report encompasses all babies >23+6 weeks.

Table 6: MBRRACE - UK Care Grading

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

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

All our parents are invited to submit questions for the review panel to answer through the Honeysuckle team.

Stillbirth reviews and Key Themes

Table 7. Grading of antenatal care for babies in Q3 2020-21

Grade	Care in antenatal period
A	**2**

B	**1**
C	**0**
D	**0**
UNK	**2**

One baby has been escalated to an SI as the death occurred in the unit. This mother had recently been positive for COVID 19. This mother's care was possibly adversely affected by COVID 19. This will be addressed through the SI investigation process.

Table 8. Details of the deaths for this period and consequent actions taken

Gestation	Cause of death	Issues	Actions	Parental involvement
30 weeks (Outstanding from Q2 report)	Placental abruption	No issues identified	None	No questions submitted
37 weeks	Massive perivillious fibrin deposition in the placenta. Covid positive mum and evidence of covid in placenta	Death of baby occurred between MAU and delivery suite. COVID policies not adhered to	Escalated to SI	Questions submitted
40 weeks	Fetal Vascular thrombosis and chornagiosis	No Issues identified	NA	Questions submitted
25 weeks	Maternal vascular under perfusion in placenta	No issues identified	NA	Questions submitted
31 weeks	Feta anomaly (cardiac) and fetal vascular malperfusion	No formal referral process for FMU when a mother moves in pregnancy. There was no fetal information leaflet in the notes in a language the woman's own language	Booking trust were involved in the review. We have shared our link to FM leaflets (Tommy's website) Formal process of referral when women who are high risk FMU move in pregnancy	No questions submitted
24 weeks	To be reviewed 3/3/21 awaiting investigations	To be reviewed	To be reviewed	Questions submitted

Actions taken to address the findings for Q3

- Share link to Tommy's website with Northwick Park for non-English speaking women
- FMU to develop a referral system when a woman relocates in pregnancy
- Await SI report and embed actions into stillbirth action plan

Progress on previous actions

- K2 system, online live notes system in place as of January 2021.
- A service evaluation to ensure the service is meeting the needs of non-English speaking women, with particular reference to interpreter services and communication. A meeting between the stillbirth team and NEST leads is being organised to outline the issues and identify solutions.
- Update to guidance on reduced fetal movements whilst an inpatient has been chased (March 2021).

Revised Feb 2021 CNST requirement targets

The trust was in receipt of the revised maternity invective scheme guidance which has included updated timescales and deadlines for the reporting and reviewing of stillbirths and neonatal deaths.

The stillbirth PMRT team are aware of the changes to the guidance and can provide assurance that standards required will be met.

This quarterly report (and previous quarterly reports) will continue to be discussed with the maternity safety champion.

3. Neonates

This section updates the Board regarding the Trust systems and processes to review and learn from deaths of neonates under their care. This is in accordance with recommendations by the National Quality Board and the Care Quality Commission. It outlines the work taking place within the department which is reported to the neonatal NWODN (North West operational delivery network) and reviewed at CDOP (child death overview panel).

Key findings:

- Q3 mortality rate for all LWH neonatal deaths is 3.7 /1000 births
- Q3 mortality for LWH booked babies is 2.1 /1000 births
- 20/21 year to date mortality rate for all LWH neonatal deaths is 6.1/1000 births
- 20/21 year to date mortality for LWH booked babies is 3.0/1000 births

1. Mortality Dashboard

It has been agreed with the Head of Governance and Deputy Medical Director, that the following table showing the total mortality and the rate of death per 1000 births will be used as the mortality

dashboard metric. Tables 9 and 10 refer to LWH NICU in-hospital mortality before discharge. The end of year annual neonatal mortality report will detail all neonatal deaths (<28 days), both on NICU and labour ward, all deaths before discharge, deaths at home or in another organisation after delivery and / or care in LWH neonatal unit.

Table 9: NICU Mortality

NICU	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Total
Discharges	110	99	78	102	108	91	94	98	90	870
Total Mortality	3	0	4	9	3	9	0	3	4	35
Births	584	572	631	658	677	681	669	605	605	5708
Mortality Rate per 1000 births	5.1	0	6.3	13.6	4.4	13.2	0	4.9	6.6	6.1

There were a higher than usual number of deaths in July and September 2020. On initial review there were no clear themes and all will be reviewed through the PMRT process, however at this point it is not possible to comment further as not all deaths have been reviewed to date. Tables 12 and 13 detail the breakdown of the deaths by gestation and cause. As a regional tertiary surgical and cardiac NICU we accept in-utero and post-natal transfers of high-risk babies requiring intensive care after birth and have an increased risk of mortality. Table 10 details the mortality for babies booked at LWH only, excluding in-utero and post-natal transfers.

Table 10: NICU Mortality (booked LWH)

NICU (LWH BOOKED)	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Total
Discharges	110	99	78	102	108	91	94	98	90	588
Total Mortality	1	0	3	6	1	3	0	2	2	17
Births	584	572	631	658	677	681	669	605	605	5712
Mortality Rate per 1000 births	1.7	0	4.8	9.1	1.5	4.4	0	3.3	1.5	3.0

Some variation is to be expected month on month, however July was noted to be higher than usual. There was an initial overview of the cases for any clear themes, pending full review through the PMRT process for issues and identifiable themes.

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

Table 11: Mortality ***after*** discharge from NICU

	Apr 20	**May 20**	**Jun 20**	**Jul 20**	**Aug 20**	**Sep 20**	**Oct 20**	**Nov 20**	**Dec 20**			
Alder Hey Children's Hospital								3 (2 booked)				
Hospice												
Repatriation to booking hospital												
Home												

The 3 babies who died after transfer to AH in Q3 will be reviewed through the LWH PMRT process which will then feed into the AH HMRG (hospital mortality group) for a complete review of the mother and babies' care.

In Q3, 3 babies died after transfer to another care setting: 1 baby was transferred to AH for surgical management of necrotising enterocolitis (NEC), the other 2 babies were transferred for ENT assessment of airway after difficulty intubating. Both had multiple congenital anomalies.

Table 12: All mortality by gestation Q3 20/21

	LWH booked mortality	**Non-LWH booked mortality**	**All mortality**
Extremely preterm (<28 weeks)	3	4	**7**

Very preterm (28-32 weeks)			
Moderate preterm (32-37 weeks)	1	1	**2**
Term (>37 weeks)	1		**1**

The highest mortality group remains the extremely premature babies. Of the 3 deaths in the moderate and term babies, all 3 had congenital anomalies: 1 congenital diaphragmatic hernia and 2 had multiple congenital abnormalities without a unifying diagnosis and died after transfer to AH for specialist intervention.

Table 13 details the breakdown by primary cause of death as stated on the death certificate. Overall, for Q3 the majority of deaths were due to prematurity, accounting for 5 out of the 10 deaths this quarter. There were also a significant proportion of deaths attributable to congenital anomalies, which is similar to the proportion seen in the last quarter, although the overall number was higher.

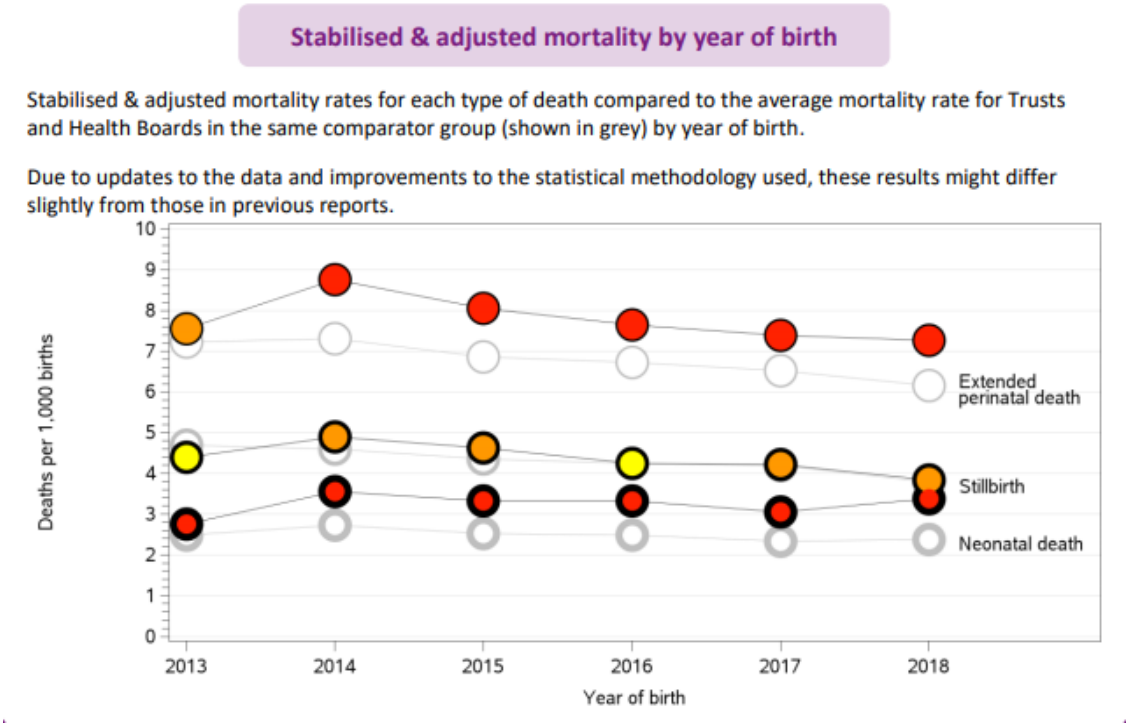
Table 13: All mortality by cause Q3 20/21

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

Benchmarking data

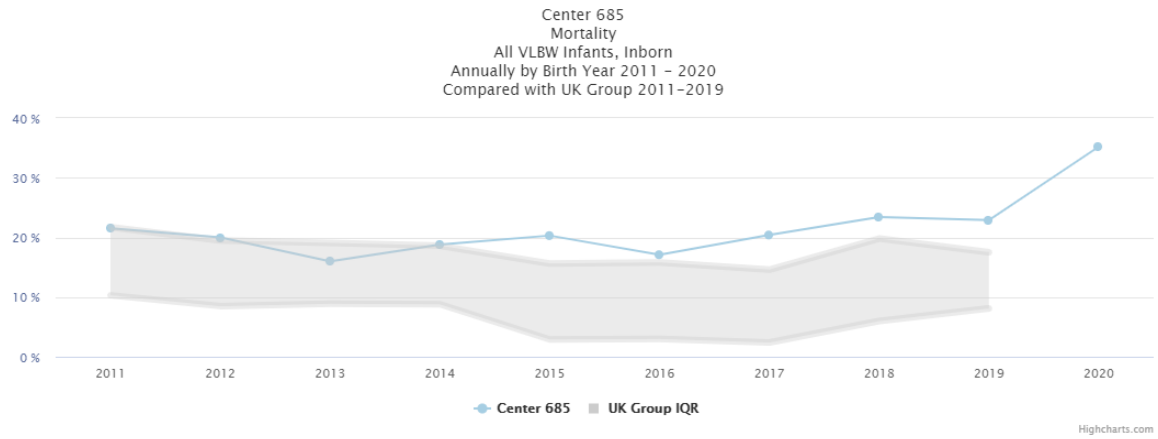
We benchmark our mortality through MBRRACE nationally and the international VON network. MBRRACE has reported most recently on 2018 data, figure 1 demonstrates mortality rates over time, the grey lines demonstrate UK average for the LWH comparator group e.g. other NICUs with neonatal surgery.

Figure 1.



We also benchmark through an international group VON. We can compare within the UK members of this network for various aspects of care, figure 2 is the mortality rates specifically for those born, VLBW (<1500g) babies over time. The 2020 increase is notable, there is yet to be a trend analysis for the whole comparator group for 2020, this is usually available in June of the following year. We have remained at the upper end of or above the interquartile range for mortality but have mostly followed the trend.

Figure 2



2. Mortality reviews

All neonatal deaths on NICU are reviewed using the standardised national perinatal mortality review tool (PMRT). There is a monthly multi-disciplinary review meeting with representation from neonatal, obstetrics, bereavement support and palliative care teams. Reviews are planned for 6-8 weeks after the baby has died. Where there has been an in-utero transfer or a baby has been transferred post-natally for higher level care, the hospital of booking and or/ birth along with other care providers involved are invited to the meeting to complete a joint review encompassing all aspects of care. Each case is then assigned a grade (A-D, see below) for each of the following areas: antenatal care, neonatal care and care after the baby has died.

Table 14. perinatal mortality review tool

A	no issues with care identified up to the point that the baby was confirmed as having died
B	care issues which the panel considered would have made no difference to the outcome for the baby
C	care issues which the panel considered may have made a difference to the outcome for the baby
D	care issues which the panel considered were likely to have made a difference to the outcome for the baby

Cases where a grading of C or D has been assigned will be then reviewed further as a table-top review, or if deemed appropriate a formal review or serious incident. Local mortality review outcomes and learning are shared within the department and at the Clinical Effectiveness Group for Cheshire and Mersey NWODN. The PMRT outcomes are reported to the regional child death overview panel (CDOP).

The PMRT process encourages parental engagement. All parents are informed of the review process at the time the baby dies, followed up with a letter detailing the process and how they can engage. Any comments, questions or concerns which the parents send in are addressed as part of the review. Parents are offered an appointment to discuss the response thereafter and a letter detailing the PMRT outcome is provided following the appointment.

Table 15: 20/21 Neonatal Mortality Summary

	Q1	Q2	Q3	Q4	Total
NICU deaths	7	21	7		
LWH booked NICU deaths	**5**	**10**	**4**		
Mortality rate /1000 births	3.9	10.4	3.7		
LWH booked mortality rate / 1000 births	**2.2**	**4.7**	**2.1**		
PMRT Reviews completed	7	21	7		
No. of deaths where any care issues were identified (i.e. grades B/ C/D)					
Antenatal	*6*	*6*	*3*		
Neonatal	*6*	*14*	*6*		
Care of mother after death of baby	*2*	3	*1*		
No. of deaths where care issues may have or were likely to have affected the outcome (grade C/D)					
Antenatal	*1*	*1(D)*	*1(C) 2*		
Neonatal	*1*	*1(C)*			
Care of mother after death of baby					
Non-NICU deaths of babies cared for on NICU	4	3	*3*		

Learning from Deaths from Q2 – all reviews completed

In Q2 only 10 out of 21 cases had been reviewed at the time of the Q2 report. All 21 have now had a full PMRT review. 13 of the 21 had been graded B, 1 grade C or D, below is a complete list of the Q2 issues identified.

Neonatal care

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

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

- Not achieving targets of initial management on admission
- Prolonged handling after admission in extreme preterm baby

- Multiple line insertions in a challenging baby. A necessary intervention however these were not fully documented and the parents found this experience particularly difficult: communication, documentation and support of the parents could have been improved.
- Multiple intubations for a baby on several occasions. Care could have been improved with a better oversight and acknowledgement of the history and consideration of more experienced first intubator on the later occasions.
- Several hours of high peak pressures on the ventilator before consideration of optimising respiratory support with high frequency oscillation ventilation.
- Sub-optimal documentation – this was identified in several reviews but in different areas of documentation.
- Fluid management.
- Delayed blood gases.
- Admission temperature low – although reasonable interventions used.
- Diagnostic testing – investigating early for congenital infections in the context of symmetrical IUGR.
- Medication error.
- Delayed administration of surfactant afterbirth – local District General Hospital.
- Delayed antibiotic administration at birth due to IV access issues – referring hospital.
- Use of language line / interpreter for difficult and pertinent conversations.
- Accidental extubation.

Actions proposed to address the issues above include:

- Working group to review of initial management of preterm babies on admission
    - 09/03/2021 update: group is meeting regularly and working towards an education and launch package for the new processes.
- Include initial management and admissions procedures in junior doctor induction 6 monthly with lesson of the week (LOTW) reminder (induction session completed September 2020, LOTW pending).
    - 04/03/2021: Induction session completed for new rotation of junior doctors.
- Feedback to wider NICU team at clinical governance day regarding patient experience and importance of documentation.
    - November 2020: completed.
- LOTW for ventilation key points – for both medical and nursing staff (pending).
    - 03/03/2021: Ventilation induction for new junior doctors.

- LOTW for documentation.
    - 09/11/2020: Complete.
- Fluid guideline reviewed and updated including LOTW.
    - Jan 2021: complete.
- Nursing education in fluid balance documentation
    - Awaiting update from nurse education team.
- Medication error – has been through medicine management processes, utilising shift leader in managing nursing staff and task delegation during resuscitations.
    - Complete.

Antenatal Care

There were no antenatal care issues identified in the majority of cases reviewed. There was a case of an un-booked pregnancy and further review of the reason for not booking the pregnancy did not raise any concerns. Antenatal care issues identified that were not considered to have changed the outcome include (Grade B):

- Lack of use of partogram in preterm labour.
- Inadequate communication with community midwifery teams regarding diagnosis of fetal abnormality from fetal medicine unit (FMU).
- Lack of record of telephone triage and advice given to patients.
- Failure to FU when patient did not attend for ODU appointment.
- Delay in reviews and keeping patients informed of abnormal urine (MSU) results such as recurrent contamination and asymptomatic bacteriuria and need for the appropriate follow-up with repeated samples.

To address some of these issues, the following has been carried out and completed:

- Sharing of LOTW to Obstetric staff on intrapartum management of preterm labour that includes utility of partogram, consideration of magnesium sulphate, IV antibiotics and steroids, depending on the gestation of the pregnancy.
- Reminder sent by midwifery assessment unit (MAU) manager to MAU team on importance of follow up on patients who do not attend ODU appointments.
- Agreed process of sharing FMU reports with the community teams on the new K2 Athena electronic patient records which include attaching all reports onto K2.
- The letter sent to patients informing them on the need to repeat urine samples now include instructions on how to avoid contamination, with diagrams included. Pharmacy is also now involved in contacting patients if they fail to attend to collect their antibiotic treatment for asymptomatic bacteriuria or UTI.

Both lack of documentation of telephone triage and management of abnormal MSU are known recurrent antenatal care issues and have been escalated and are currently on the risk register and regularly assessed.

Of all the cases reviewed, there was 1 case where antenatal care was graded D (where care issues identified were considered by the panel to likely to have made a difference to the outcome of the baby). This case was also reviewed through the HSIB process and investigated in LWH as a serious incident. Safety recommendations have been advised, with a plan put in place to ensure continued CTG training for staff working in the intrapartum area, and training for all staff on Situational Awareness in an multidisciplinary manner.

Care after the death of the baby

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

Action:

- Bereavement checklist to be reviewed and pathways of communication confirmed
    - Dec 2021: complete

Learning from Deaths Q3 – 7/7 All reviews completed

All of the 7 reviews have been completed 6 of the 7 identified care issues which would not have affected the outcome for the baby (B). The issues identified include:

- Sub-optimal admission documentation.
- Unplanned extubation in 2 babies
- Inappropriate grade of staff performing procedures.
- Subcapsular haematoma – awaiting review through incident process.
- Hypothermia after being out for skin to skin.
- Emergency buzzer inaudible in neonatal seminar room.
- ETT fixation in delivery room suboptimal allowing slippage and necessitating re-intubation .

Actions planned to address the above issues:

- Admission documentation QIP
    - Ongoing – report to be circulated after completion
- Unplanned extubation audit to identify themes and rates of incidence
    - Registered as an audit in 21/22 Neonatal Audit Programme
- Extreme preterm pathway working group in progress of reviewing and creating a targeted package of care for this group of infants – to include guidance around skin to skin and grades of staff to be involved in practical procedures.
    - 09/03/2021 update: group is meeting regularly and working towards an education and launch package for the new processes.

- Emergency buzzer pager always carried by senior member of staff, consultant when on site and senior ANNP / trainee overnight.
    - Complete.
- ETT fixation in delivery room suboptimal allowing slippage and necessitating re-intubation
    - This was managed appropriately.

Antenatal Care

Of these 7 reviews, 2 of these cases were graded B, (where care issues identified did not change the outcome). These issues include not sending the placenta for histology and a delay in review of MSU results, which have been addressed above. Both the LOTW and changes in communication to patient regarding repeat urine samples were completed in January 2021.

There was one case where care issues identified may have affected the outcome (Grade C), involving the screening process for preterm labour. We are currently not offering women with previous 2nd stage Caesarean section cervical length screening for preterm labour, which is a deviation from national recommendations. A formal review is in process of being arranged with the preterm labour team to discuss an alternative pathway to manage this group of high-risk women.

Care after the death of the baby

For 1 of these families, we identified factors that we could have made to improve their care, which included the use of bereavement / baby loss lanyards to identify the issue without parents having to explain to staff. These are available in maternity but have not been introduced in neonatal unit.

Action:

- Bereavement team to link with neonatal bereavement nursing staff on NICU and supply lanyards to be used when needed.

Learning and action plans from quarterly reports to be reported through monthly neonatal MDT.

Revised Feb 2021 CNST requirement targets

The trust was in receipt of the revised maternity invective scheme guidance which has included updated timescales and deadlines for the reporting and reviewing of stillbirths and neonatal deaths.

The neonatal PMRT team are aware of the changes to the guidance and can provide assurance that standards required will be met.

This quarterly report (and pervious quarterly reports) will continue to be discussed with the maternity safety champion.

Overall summary: Learning from Deaths

There have been 2 Gynaecology Oncology deaths, 1 expected and 1 unexpected, reported in Q3 and subject to a Mortality Review. There were no issues identified with the end-of-life care in relation to the expected death. The unexpected death case remains subject to an ongoing investigation. There were no non-oncology patient deaths.

There have been no maternal deaths.

There were 5 stillbirths in Q3, fewer than Q1/2, with one possibly Covid-19 related.

NICU experienced 7 deaths in Q3, which was lower than Q2 and the same as Q1. There were 3 additional deaths for babies transferred to Alder Hey, all with underlying congenital abnormalities.

As part of the Trusts assurance processes, the Safety and Effectiveness Senates work to gain assurance as to actions taken in relation to serious incident reviews, lessons learnt, external alerts and national guidance on quality and safety. The Effectiveness Senate also has oversight and scrutinises clinical and effectiveness audits and service evaluations.

The Board members are asked to review the contents of the paper and take assurance that there are adequate processes and progress against the requirements laid out by the National Quality Board and to take assurance that there are effective processes in place to assure the Board, regarding governance arrangements to drive quality and learning from deaths in receipt of care at the Trust.

Liverpool Women's NHS Foundation Trust

Quality Committee Chair's Highlight Report to Trust Board
22 February 2021

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• The Safety Senate highlighted concern of the volume of blood sampling errors and the risk posed to the Trust as a standalone site. The Safety Senate had commissioned a quality improvement project for blood sampling. The Committee noted further risks linked to blood sampling errors articulated within the Integrated Governance Report received. • Compliance against the Continuity of Carer (CoC) pathway target had improved in month however it was noted that the national target of 35% would not be achieved during quarter 1 as projected without organisational change. The Trust was due to receive a feedback report from the regional North West Midwifery team following review of Trust plans. The Committee chair log noted the Putting People First Committee to have oversight of the potential workforce change required to achieve the national target. • Deteriorating quality performance metrics. Concern specifically for high sickness levels, unplanned reattendance, epidural rates and prevention of ill health smoking as the pandemic continued. The Trust continued to be restricted by local and national system rules and requirements to deliver clinical services. • Limited assurance taken from the LocSSIPs report.	• Content / Presentation of BAF report under review and to be aligned with the revised Corporate Strategy • Content / Presentation of Performance report under review, to go live May 2021. Draft report to be presented to Committee for comment. • Quality Improvement Project to assess and improve blood sampling errors. • Formal review of progress and implementation of LocSSIPs to date and forward planning to be presented back to Committee in March 2021.
Positive Assurances to Provide	**Decisions Made**
• Noted submission of the Trust response against the Ockenden Review to NHSE/I. The Committee agreed the proposed role of the Committee to oversee continued progress. • Assured by the report and progress made to achieve the CNST maternity safety actions. It noted that NHSR had issued the revised guidance for 2020/21 on 01 February 2021 and that targets remain on track to be achieved for submission in July 2021. • Integrated Governance Report quarter 3 was received and provided assurance. The report would be developed further to strengthen lessons learnt, serious incidents and trends as an opportunity to improve assurance to the Committee. • Assured by Learning from Deaths report quarter 3 that adequate processes were in place and appropriate progress against the requirements laid out by the National Quality Board.	• 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 Integrated Governance Report to improve assurances to the Committee. • Deferred consideration of the Theatre Never Event Review report until March 2021.

Comments on Effectiveness of the Meeting / Application of QI Methodology
• Benefitted from a shorter agenda to focus on key matters. • New members of the Committee provided a fresh outlook.

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
191.	Board Assurance Framework: Review of Quality related risks October 2020/21	Assurance	198.	Mortality and Perinatal Report Quarter 3	Assurance
192.	Subcommittee Chair's reports	Information	199.	Progress of LocSSIPs Implementation Group Quarter 3	Assurance
193.	Ockenden Review of Maternity Services: LWH Trust Response	Information			
194.	Clinical Negligence Scheme for Trusts (CNST) Update Year 3	Assurance			
195.	Performance Report Month 10 2020/21	Assurance			
196.	Integrated Governance 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	✓	A	

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

Quality Committee Chair's Highlight Report to Trust Board
22 March 2021

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Compliance against the Continuity of Carer (CoC) pathway target was at 21% in February 2021 with a trajectory set to achieve 35% in Autumn. The Committee agreed with the proposed next steps to pause and prepare, to embed the existing teams, share learning from the new teams, upskill the workforce, review safe staffing levels and prepare for formal consultation with staff to progress providing COC model for all eligible patients. The Committee would receive regular position updates to ensure the pathway was being developed and implemented proficiently.	• Deep dive into serious incidents would be considered by the Quality Committee Learning Session in April 2021. • It was noted that the Quality Committee Learning session in April 2021 would also receive the formal review of progress and implementation of LocSSIPs and the Theatre Never Event Review. • Amendments to the underpinning quality governance structure was highlighted by the Committee Annual Review. The Executive Team had reviewed and agreed with the proposed amendments.
Positive Assurances to Provide	**Decisions Made**
• Received a verbal update of divisional engagement to respond to the Ockenden Review recommendations. Recognition that additional resources would likely be required but had not been quantified. Careful adoption of the Board NED champion role would be required to ensure that it did not develop into an operational role. • Assured that robust processes are in place to report and investigate serious incidents. • Positively assured by the post implementation review against the Research Strategy and noted excellent progress against the eight strategic principles during the first three years of the five-year strategy. Continuation of work to develop non-medical research and continue engagement with the citywide integrated approach was noted. • A Clinical Investigation Task and Finish Group has been formed to develop an interim electronic solution to strengthen the clinical investigations process until the Meditech Expanse is operational. The Committee was assured by steps undertaken to mitigate the risk and requested oversight via the responsible sub-committee. • The Committee was assured that activities to achieve the aims of the Clinical and Quality Strategy had continued, including developing a robust operational plan. It was agreed that the Committee should undertake deep dive reviews into key parts of the Strategy during 21/22. • Assured by performance against the 2020/21 Corporate Objectives. • Assured that the Committee had achieved its objectives during 2020/21.	• Committee reviewed the Quality related BAF risks. No changes to existing risks were identified as a result of business conducted during the meeting. • Committee reviewed the Risk Management Strategy and recommended Trust Board approval to adopt the Risk Management Strategy for 2021/22 subject to minor iterations. • Committee reviewed its risk appetite and level and recommended Trust Board approval as follows: 'To deliver safe services' risk appetite for safety is low; 'To participate in high quality research and to deliver the most effective outcomes' risk appetite for effective is moderate; 'To deliver the best possible experience for patients and staff' risk appetite for experience is low. • Confirm achievement against the 2020/21 Corporate Objectives aligned to the Quality Committee to the Trust Board for final review. • Recommend Trust Board approval of the Quality Committee Annual Report, Terms of Reference and workplan.
Comments on Effectiveness of the Meeting / Application of QI Methodology	
• Support to undertake an additional Committee meeting in April to focus on Lessons Learnt	

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
209.	Board Assurance Framework	Assurance	**215.**	Process to manage Abnormal Clinical Investigation Results	Assurance
210.	Sub Committee Chair Reports	Information	**216.**	Annual Review of Risk Management Strategy	Approval
211.	Ockenden Review of Maternity Services: LWH Trust Response	Information	**217.**	Risk Appetite Statement – Quality Committee	Approval
212.	Serious Incidents & Learning Monthly Report	Assurance	**218.**	Progress Report – Clinical and Quality Strategy 2020-2025	Information
213.	Quality Performance Report Month 11 2020/21	Assurance	**219.**	Corporate Objectives year-end review	Assurance
214.	Research and Innovation Strategy Review	Assurance	**220.**	Annual Committee Effectiveness Review	Approval

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	✓	✓	A
Gary Price	✓	✓	✓	✓	✓	A	✓	✓	✓	✓	✓	✓
Andrew Loughney (until end Dec 2020)	✓	✓	✓	✓	✓	✓	✓	✓	A	Non member		
Lynn Greenhalgh (as of Jan 2021)	Non member								✓	✓	✓	A
Jenny Hannon	✓	✓	✓	✓	✓	✓	A	✓	✓	✓	✓	✓
Michelle Turner	✓	A	✓	A	✓	✓	✓	✓	✓	✓	✓	A
Christopher Lube	✓	✓	✓	✓	✓	✓	✓	✓	A	✓	A	✓

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

Liverpool Women's NHS Foundation Trust

Quality Committee Annual Report 2020/21

Quality Committee

This report covers the period April 2020 to March 2021. There were 12 meetings held during this period.

Introduction

The Quality Committee is responsible for receiving assurance that the Trust has in place effective governance systems, risk management and quality improvement arrangements, and providing assurance to the Board of Directors that this is achieved as required by the organisation.

In discharging these duties, the Committee is responsible for:

Strategy and Performance

a) Oversee the development and implementation of the Quality Strategy with a clear focus on upholding the tenants of quality (Governance, safety, patient experience and clinical effectiveness).
b) Ensure that the Quality Strategy and performance are consistent with the Trust's; Vision and strategic objectives and oversee any initiatives undertaken by the Trust that relates to the development and implementation of the Quality Strategy.
c) Review trends in patient safety, experience and outcomes (effectiveness) to provide assurance to the Board on performance and commission 'deep dives' as appropriate.
d) To receive assurance that action plans arising from in-patient, out-patient and other care related surveys are being undertaken and make recommendations to the Board as appropriate.
e) Oversee the implementation of key national reports and inquiries recommendations and provide assurance to the Board on its delivery.

Governance

f) Oversee the effectiveness of the clinical systems developed and implemented to ensure they maintain compliance with the Care Quality Commission's Fundamental Standards in relation to Quality (Safety, Experience and Effectiveness).
g) Obtain assurance of the Trust's ongoing compliance with the Care Quality Commission registration.
h) Review the controls and assurance against relevant quality risks on the Board Assurance Framework and provide assurance to the Board that risks to the strategic objectives relating to quality and safety are being managed and facilitate the completion of the Annual Governance Statement at year end.
i) Obtain assurance that the Trust is compliant with guidance from NICE (through receipt of an Annual Report) and other related bodies.
j) Consider external and internal assurance reports and monitor action plans in relation to clinical governance resulting from improvement reviews / notices from NHSI, the Care Quality Commission, the Health and Safety Executive and other external assessors.
k) Receive the annual clinical audit programme and provide assurance to the Board that clinical audit supports the Trust to provide safe and clinically effective patient care and obtain assurance that there is delivery against agreed annual clinical audit programme.
l) Implement and monitor the process for the production of the Trust's year end Quality Report before it is presented to the Trust Audit Committee and Board for formal approval.
m) Undertake an annual review of the Quality and Risk Management Strategies to ensure that they reflect all required priorities.
n) To have oversight of the Committees performance measures to ensure they are appropriate and provide assurance of compliance and escalate exceptions to Trust Board.

o) To review the proposed internal audit plan for all functions areas within the Committees remit e.g. Clinical Audit, Safety, Experience and Effectiveness.

p) Review the Trust's Research and Development Strategy and Innovation Strategy prior to their recommendation it to the Board of Directors.
q) Approving the terms of reference and memberships of its subordinate committees.

Overall

r) To approve any matters that, due to time constraints, could not be approved by the Board within the scope of the Committees areas of responsibility.
s) Referring relevant matters for consideration to other Board Committees as appropriate.
t) Considering relevant matters delegated or referred to it by the Board of Directors or referred by any of the Board Committees.
u) Escalating matters as appropriate to the Board of Directors.

Constitution

The Quality Committee is accountable to the Board of Directors. Membership during the year comprised:

- Non-Executive Director (Chair)
- Two additional Non-Executive Directors
- Medical Director
- Director of Nursing and Midwifery
- Director of Finance
- Director of Workforce and Marketing
- Director of Operations
- Committee Chairs of the Safe, Experience and Effectiveness Senates
- Deputy Director of Nursing and Midwifery
- Head of Governance

Meetings were also attended by other executives and senior management staff as appropriate.

The Committee's constitution allows for members to participate by two-way audio link on occasion where appropriate which is deemed to constitute presence in person per the Committee's Terms of Reference. Due to the Covid-19 pandemic, all meetings during 2020/21 have been held virtually utilising Microsoft Teams.

The Terms of Reference requires that all members of the committee attend a minimum of 75% of the meetings held. The table at appendix 1 lists the names of the members of the Committee and the meetings they attended during 2020/21 together with the names of senior management who were invited to attend during the year. The majority of members attended 75% or more of the meetings during 2020/21. This appendix will be updated post meeting so that a full 2020/21 picture can be provided to the Board.

Following comments made at the June 2020 meeting, the Terms of Reference of the Committee were reviewed in September 2020 and then again in December 2020, prior to being approved by the Board in January 2021.

Key Achievements / Activity

The key items discussed and reviewed by the Committee during 2020/21 were as follows:

Covid-19

At the beginning of the pandemic, the Committee received in-depth position updates with regards to the planning and management of patient services in relation to coronavirus and potential impact on quality. The Committee noted the Trust decision to maintain internal monitoring despite a national pause in the requirement to provide external monitoring. It also noted that currently wards were safely staffed. Further updates were provided throughout the year via the Quality Performance Report with assurance provided that there were active

surveillance measures in place for all patients that had a cancelled / deferred operation to prevent causing harm as well as other quality implications.

The Committee sought assurance that the Trust was undertaking Equality Impact Assessments and where there was evidence that protected groups could incur a disadvantage, mitigating actions had been put in place.

In June 2020, the Committee received and noted an in-depth report detailing the impact of Coronavirus on Patient Experience.

NHSE/I Covid-19 Infection Control Assurance Framework

As part of the Committee's role for overseeing the quality impacts of the Covid-19 pandemic, assurance was provided on how the Trust had completed its review against the national framework provided by NHSE/I and the level of compliance against the 48 questions. An updated version of this framework, and the Trust's response against this, was considered later in the year.

Board Assurance Framework (BAF)

The Committee regularly reviewed the Board Assurance Framework risks assigned in line with the business cycle of activities. The Committee held discussions over the rating of specific risks attributable to the Committee noting that they were being managed appropriately. The Committee reported all changes to the BAF at the next following Board of Directors meeting for approval.

CQC Action Plan

In the early part of the year, the Committee gave particular attention to the Warning Notice that had been received from the CQC regarding Medicines Management. Assurance was sought on the actions that had been put into place to respond to the Warning Notice and ensure patient safety. This included the addition of a quarterly medicine management assurance report on the 2020/21 Committee work programme. As the year progressed, the Committee received regular reports on the CQC action plan and progress made to close out the key recommendations into embedded practice.

Corporate Objectives 2020/21

The Committee received a three month and six month progress update against the Corporate Objectives aligned to the Committee. The March 2021 meeting is scheduled to receive a final outturn position.

Clinical & Quality Strategy 2020-25 & Annual Quality Report 20219/20

The Committee has been a key forum throughout the year for informing and helping to shape the updated Clinical & Quality Strategy 2020-25.

The production of the Annual Quality Report was deferred due to the impact of Covid-19 and the changing regulatory requirements on the document. A draft was considered and approved by the Committee in August 2020.

Clinical Negligence Scheme for Trusts (CNST)

Whilst there have been several amendments to CNST requirements and timescales throughout 2020/21, the Committee has continued to monitor compliance and progress against the 10 safety standards. This was in recognition that working towards the safety standards was an important quality objective and not just a compliance matter.

Contract Quality Schedule Assurance Report

This item was a new addition to the Committee's workplan during 2020/21 and was put into place to provide assurance of work undertaken to achieve targets set within the quality contract agreed with the CCG. This report was received on a quarterly basis.

Clinical Audit Work Programme 2020/21

The Committee approved the work programme for 2020/21 in April 2020. It was acknowledged that items would require prioritisation in the context of COVID-19. Committee requested that the workplan remain an iterative document, flexing to the developing situation. A mid-year review was received in November 2020.

Local Safety Standards for Invasive Procedures (LocSSIPs)

Whilst it was acknowledged that LocSSIPs could be perceived as an operational issue, the Committee made the decision to continue to receive quarterly updates until the requisite progress could be evidenced.

Mortality Reporting and Learning from Deaths

The Committee received quarterly reports and improvements were made throughout the year on ensuring that the reports provided the appropriate level of detail and evidence of lesson learning for the purposes and aims of the Committee.

In November 2020, the Committee received a report on Neonatal Preterm Mortality in response to a spike in Neonatal deaths. It was noted that the Neonatal Senior Management Team had commissioned an external peer review led by Birmingham Women's Hospital. The Committee was assured by processes in place, the conclusion of the external review and commended the approach taken by the Neonatal Team to escalate and review the matter.

Paterson Report: LWH review against recommendations

The Committee received the internal review against the Paterson report recommendations. The Committee noted Trust compliance with 14 out of the 15 recommendations and was informed that the aspect of non-compliance related to written communication between consultants and the patients following clinic reviews. The Committee was informed that discussions were underway with divisions to establish a proactive change to local practice. The Committee was assured by the processes in place in relation to the recommendations applicable to LWH.

Health and Safety Annual Report 2019/20

The Committee received the annual Health and Safety report and was assured by the overview of compliance and governance assurance regarding the Health and Safety arrangements, activities, performance and improvements illustrated within the annual report.

Quarterly Integrated Governance Assurance Reports 2019/20 and Learning from Serious Incidents Reports 2019/20

The Committee routinely considered safety, effectiveness and experience of patients through a Quarterly Integrated Governance Assurance Report and a Quarterly Serious Incidents and Learning Report. The report provided the Committee with assurance regarding the clinical governance arrangements in place and that staff were being open by reporting incidents, clinical and non-clinical, to ensure patients and staff safety is maintained. Throughout the year, the Committee identified a need to ensure that these reports provide improved assurance that lessons were being learned from incidents / feedback and that changed practice could be evidenced.

To support this aim, the Committee received verbal case studies from staff members representing each of the three divisions, Gynaecology, Family Health and Clinical Support Services in December 2020. This will be an area of continued focus during 2021/22.

Never Event Thematic Assurance Report

The Committee received a report in September 2020 detailing a deep dive review undertaken of all Never Events that had occurred in Theatres since 2017 to date. The Committee was informed that a Theatres Review had been commissioned in response to these concerns. The outputs from this review are expected to be reported in 2021/22.

Research & Development Annual Report

The Committee received the annual Research and Development report and was assured by the overview of compliance and governance assurance related to research activity. Whilst Covid-19 research had been conducted effectively, the performance and delivery of research not related to COVID-19 during quarter 4 of the year had been severely impacted by the Covid-19 pandemic.

Counterfactual Case Update: Managing clinical risks and mitigations Future Generations Update
The Committee received an in-depth update report which detailed the short, medium- and long-term clinical risks posed by operating as a single site Trust and the mitigations in place to manage the identified risks.

Legal Services Annual Report and Lessons Learnt Workshop
The Committee received a presentation detailing litigation cases including lessons learnt, triangulation with complaints/PALS/SI's, and the proactive approach undertaken to identify potential claims.

Safety issues raised by Maternity Safety Champion Meeting
The NED responsible for Maternity Safety alerted the Committee in November 2020 to safety issues raised at the Maternity Safety Champion meeting. The Committee noted the executive action taken in response to concerns.

Deepdive Review: Falls deep dive detailing quality implications
Following a trend identified from previous performance reports, the Committee received a report on the fall prevention interventions led by the Gynaecology nursing team.

Deepdive Review: Continuity of Carer (CoC) Trajectory
The Continuity of Carer target was monitored closely during 2020/21 via the performance report and a 'deepdive' was received in December 2020 outlining work to date and proposed next steps to achieve the projected target. A further position update was provided in February 2021 and this will continue to be an area of attention moving into 2021/22.

Ockenden Review of Maternity Services at Shrewsbury and Telford Hospital NHS Trust: LWH Trust Response to initial report
From December 2020, the Committee received regular reports on the Trust's response to the Ockenden Review. The Committee's fundamental role has been to ensure compliance against the recommendations but to also consider wider issues such as effective lesson learning and patient involvement and engagement.

Review of Risk Management Strategy & Review of Risk Appetite Statement 2020/21
The Committee reviewed and approved the Risk Management Strategy of the Trust.

The Committee performed a review of the Risk Appetite Statements for 2021/22 that related to the Committees sphere of responsibility: to deliver safe services; to participate in high quality research and to deliver the most effective outcomes; and to deliver the best possible experience for patients and staff. The Committee reviewed the risk appetite for each objective and agreed that for 'Safe Services,' 'Effective Outcomes' and 'Patient Experience' the level of risk appetite was appropriate and would not change from the risk appetite in 2020/21.

Mid-Year Review
The Covid-19 pandemic has increased pressures across the NHS and on 28th March 2020 NHSE/I, issued guidance regarding 'Reducing burden and releasing capacity at NHS providers to manage the COVID-19 pandemic'. This provided advice regarding governance, meetings, reporting and assurance, among other issues. There were several recommendations contained within this guidance which mainly related to the streamlining of governance arrangements to ensure that there was a focus of resources onto front-line clinical care. At the time, there was agreement that the Trust had sufficient capacity to continue with existing governance arrangements but to also explore mechanisms to streamline agendas and items for discussion either through deferment or the use of a 'consent agenda'. This was mainly with the intention of wanting to reduce the burden on front line staff but was also in recognition of the limitations of virtual meetings. When this decision was taken, it was agreed that the Board's Committees would review their practice at a six-monthly interval to consider whether any amendments

were required and to identify whether there were any risks posed by items that had been deferred or not considered.

This review was undertaken in November 2020 and concluded that the Quality Committee had worked broadly in line with the plan established at the beginning of 2020/21 and no additional risks as a result of the approach taken to meeting management since the pandemic began have been identified. In reaching this conclusion, it was noted that no meetings had been cancelled in the year and that no risks had been posed by items that had been removed or deferred. This has continued to be the case for the second half the year. There were a number of areas for improvement outlined in the mid-year review and these have been further developed and are outlined in the section below.

Areas for Development

The Committee recognised early during the Covid-19 pandemic that there would be a challenge of discharging the identified business set out in the 2020/21 work programme and undertook to streamline business through a) identifying items that could be discharged elsewhere in the governance structure and b) utilising a consent agenda. The consent agenda has operated effectively throughout the year, and an option has always been made available to bring an item into the main agenda, should it require further scrutiny and challenge.

Whilst there was some success to streamlining the agendas, this ultimately presented a challenge at each meeting and two additional meetings (held in August 2020 and December 2020) were also required. For the first time, an effectiveness survey was circulated to members of the Committee seeking feedback on the activity of the Committee during 2020/21. On the whole, the responses received were positive – the full results can be seen in Appendix 2. One narrative comment was received and this stated that the Committee brief remained too large and the sub-committee structure required strengthening to enable the effective devolving of responsibilities. This has been an area of improvement identified by the Medical Director and Director of Nursing & Midwifery, and a number of amendments to the underpinning governance structure are suggested as part of this review. These are as follows:

- Combination of the 'Effectiveness Senate' and 'Safety Senate' to form a Clinical Governance Sub-Committee. The rationale for this is that there are several items that overlap the two meetings but due to the two meetings having a different membership, business can often be duplicated.
- Robust oversight will be maintained around the business of this meeting to ensure that it is receiving appropriate items aligned to the terms of reference.
- Part of this will be supported by the establishment of a Quality Improvement and Clinical Audit Group which will undertake detailed reviews and report assurance through to the Sub-Committee.
- Refocusing the 'Experience Senate' to become the 'Patient Involvement and Experience Sub-Committee'.
- To reallocate some of the reporting lines into the sub-committees to achieve a greater balance
- Moving the Research and Development Group to become a sub-Committee of the Quality Committee in recognition of the strategic importance of research to the Trust. There remains a longer-term aim of creating a Research and Development Committee of the Board to support the Trust's ambition to achieve university teaching hospital status.

The previous and proposed meeting structures can be found in Appendix 3.

Strengthening the underpinning governance structure will also support the timing of Annual Reports to ensure that they are received by their respective reporting body by the end of July at the latest.

One area that has been explored during 2020/21 has been the use of 'deepdives' either into performance areas of particular concern or into themes identified as important to the Committee. These have worked effectively, and it is aimed to provide space on agendas during 2021/22 to undertake further 'deepdive' reviews.

Proposed Amendments to the Terms of Reference

The Committee last reviewed its Terms of Reference in March 2020 and were approved by the Board in April 2020. No amendments are proposed apart from updates to the reporting groups.

The draft Terms of Reference is included at Appendix 4.

Proposed Amendments to the Committee Business Cycle

Each of the Committees established by the Board of Directors has an annual business cycle which is subject to review each year. The business cycle forms the 'core' agenda for Committee meetings throughout the year with scheduled business ensuring that the Committee discharges its responsibilities as set out in the Terms of Reference.

The Quality Committee last reviewed its annual business cycle in March 2020 and is therefore scheduled to complete a further review in order to set the business cycle for 2021/22.

All members of the Quality Committee had the opportunity to participate in the annual review and propose any amendments to the business cycle and terms of reference during February 2021 by completing the committee effectiveness survey. The Committee members who responded did not make any suggested amendments to the business cycle or terms of reference.

In addition to the survey, discussions between the Committee Chair, Director of Nursing & Midwifery, Medical Director and Trust Secretary to consider the means to enhance Committee effectiveness resulted in the following suggested amendments to the business cycle:

- Inclusion of an Ockenden Update Report – monthly
- Inclusion of a Safety Champion Update – quarterly
- Deletion of National Patient Surveys – to be presented via Sub-Committee Chair reports and escalated on an 'as required' basis
- Deletion of PLACE Annual Report and bi-annual action plan ((to be devolved to the Patient Involvement & Experience Sub-Committee)
- Deletion of Equality and Human Rights Goals 1&2 (to be devolved to the Patient Involvement & Experience Sub-Committee)
- Realignment of receipt of annual reports towards the beginning of the reporting schedule

It is likely that key areas of attention during 2021/22 will be as follows:

- To support development and monitor progress against the Clinical & Quality Strategy for 2020/25;
- To review and recommend to the Board of Directors the 2020/21 Quality Report;
- Review and scrutinise the risks assigned to the Committee in the BAF and agree annual risk appetite statement;
- To ensure that there are effective and robust processes in place for lesson learning and that changes in practice can be evidenced;
- To receive assurance that the Trust is adequately mitigating the quality impacts during recovery from the Covid-19 pandemic;
- To receive assurance that the Trust has robust IPC measures in place to manage the Covid-19 pandemic;
- To ensure that the Trust is demonstrating compliance against the recommendations in the Ockenden Report;

- To ensure that there are effective processes in place for ensuring patient involvement and engagement in the development and improvement of Trust Services;
- To receive assurance that the Trust has robust Quality Improvement processes in place and that a clear methodology is embedded across the organisation;
- To monitor progress against the Trust's 'ZERO' commitments included within the Trust Strategy.

The draft Business Cycle is included at Appendix 5.

Conclusion

In the final analysis, it is concluded that the Quality Committee has achieved its objectives for the Financial Year 2020/21.

Tony Okotie CHAIR
Quality Committee
April 2021

Quality Committee **Attendance at Committee: April 2020 – March 2021** **Appendix 1**

Committee Member	Job Title	April 2020	May 2020	June 2020	July 2020	Aug 2020	Sept 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	March 2021	% attendance
Susan Milner	Non-Executive Director (Chair until end Aug 2020)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	100
Tony Okotie	Non-Executive Director (**Chair as of Sept 2020**)	**Non Member (NM)**				✓	✓	✓	✓	✓	✓	✓	✓	100
Phil Huggon	Non-Executive Director (member until end Aug 2020)	✓	✓	✓	✓	✓	**NM**							100
Ian Knight	Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	100
Louise Kenny	Non-Executive Director	✓	**apols**	✓	✓	✓	**apols**	✓	✓	✓	✓	✓	✓	83
Gaynor Hales	Interim Director of Nursing & Midwifery (April–end Oct 2020)	✓	✓	✓	✓	**apols**	**apols**	✓	**NM**					75
Caron Lappin	Director of Nursing & Midwifery (until end August 2020)				✓	**apols**	**NM**							
Marie Forshaw	Director of Nursing & Midwifery (as of Jan 2021)	**NM**									✓	✓	✓	
Janet Brennan	Deputy Director of Nursing & Midwifery	✓	✓	✓	✓	✓	✓	**apols**	✓	**apols**	✓	✓	**NM**	82
Gary Price	Chief Operating Officer	✓	✓	✓	✓	✓	**apols**	✓	✓	✓	✓	✓	✓	92
Andrew Loughney	Medical Director (until end Dec 2020)	✓	✓	✓	✓	✓	✓	✓	✓	**apols**	**NM**			83
Lynn Greenhalgh	Medical Director (as of Jan 2021)	**NM**								✓	✓	✓	**apols**	
Jenny Hannon	Director of Finance	✓	✓	✓	✓	✓	✓	**apols**	✓	✓	✓	✓	✓	92
Michelle Turner	Chief People Officer	✓	**apols**	✓	**apols**	✓	✓	✓	✓	✓	✓	✓	**apols**	75
Christopher Lube	Head of Governance	✓	✓	✓	✓	✓	✓	✓	✓	**apols**	✓	**apols**	✓	83

Appendix 2

Quality Committee Effectiveness Survey

6	01:15	Active
Responses	Average time to complete	Status

1. I understand the duties of the committee.

Strongly Agree	3
Agree	3
Disagree	0
Strongly disagree	0
Unable to answer	0

2. I believe the committee receives sufficient assurance to conclude upon its areas of responsibility

Strongly Agree	0
Agree	6
Disagree	0
Strongly disagree	0
Unable to answer	0

3. I am confident that the committee effectively monitors and scrutinises progress against the aligned strategies.

Strongly Agree	0
Agree	5
Disagree	1
Strongly disagree	0
Unable to answer	0

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4. I am content that the committee is delivering the right level of assurance to the Board / Committee.

Strongly Agree	0
Agree	6
Disagree	0
Strongly disagree	0
Unable to answer	0

5. I believe that the committee effectively seeks assurance that the Trust complies with its own policies, all relevant external regulation and standards of governance and risk management.

Strongly Agree	2
Agree	4
Disagree	0
Strongly disagree	0
Unable to answer	0

6. I feel that the committee has the right balance of experience, attendance, knowledge and skills to fulfil its role.

Strongly Agree	2
Agree	4
Disagree	0
Strongly disagree	0
Unable to answer	0

7. The committee has structured its agenda and work plan to cover its key responsibilities.

Strongly Agree	1
Agree	5
Disagree	0
Strongly disagree	0
Unable to answer	0

Appendix 2

8. The committee is effectively chaired.

Strongly Agree	4
Agree	2
Disagree	0
Strongly disagree	0
Unable to answer	0

9. All members of the committee are able to participate effectively.

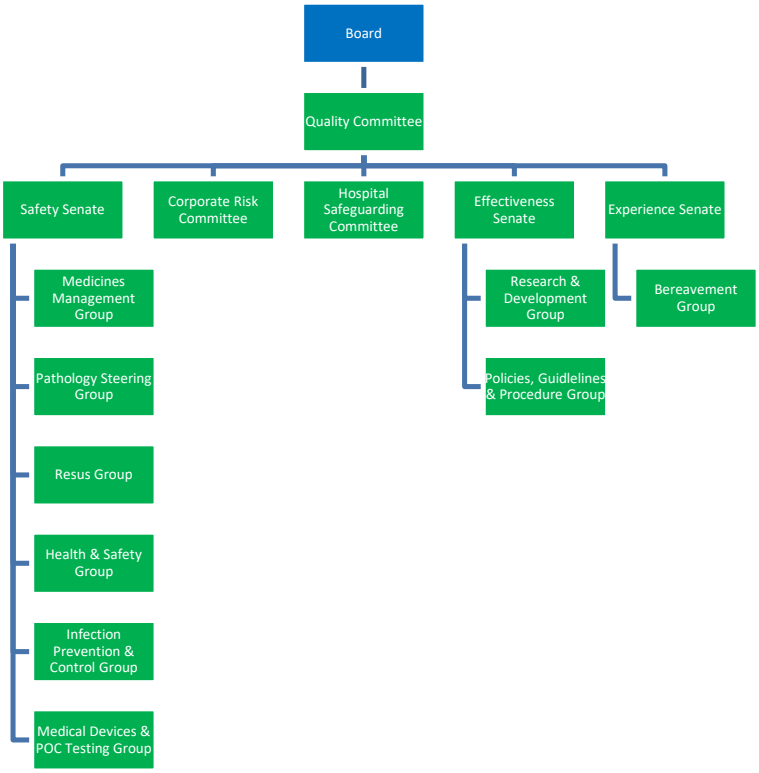
Strongly Agree	5
Agree	1
Disagree	0
Strongly disagree	0
Unable to answer	0

10. There is clarity in relation to the work of the committee and its interaction and alignment with other committees.

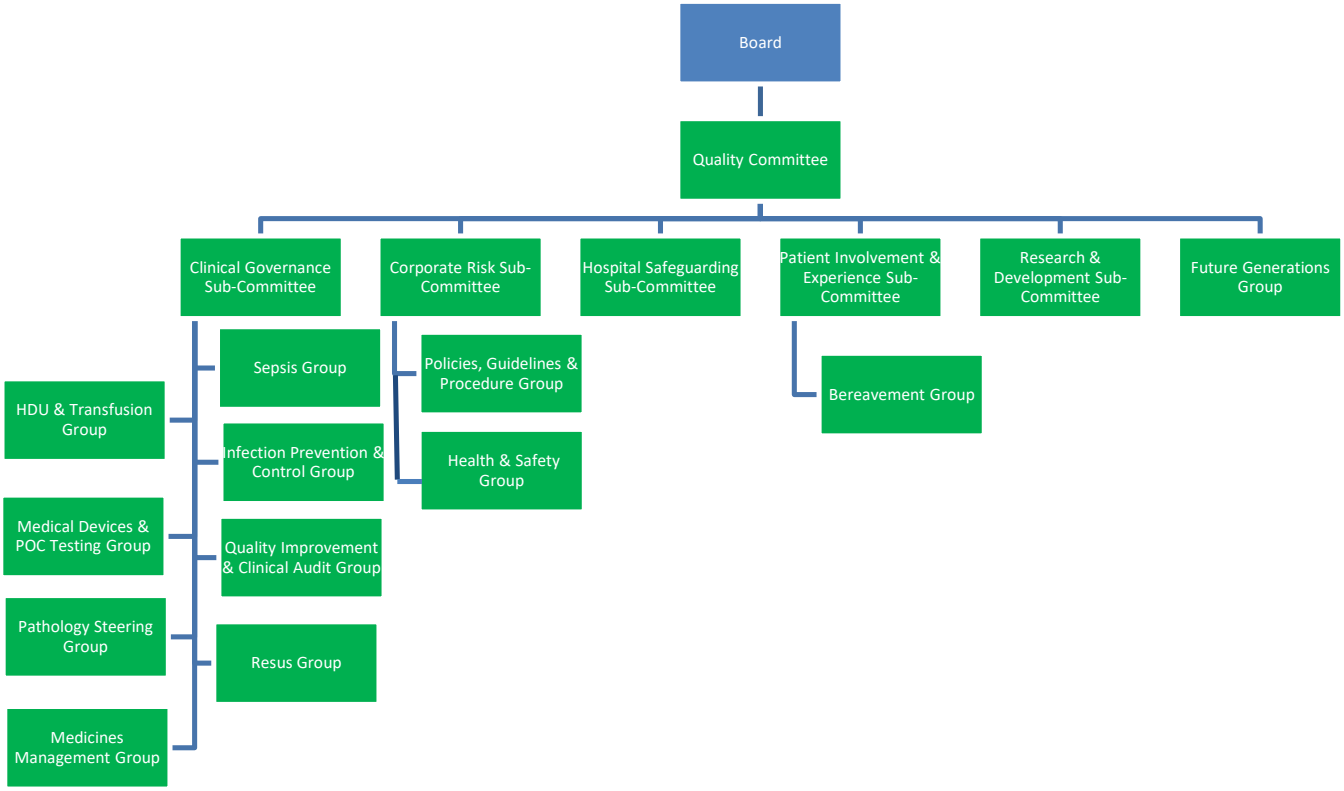
Strongly Agree	2
Agree	4
Disagree	0
Strongly disagree	0
Unable to answer	0

Appendix 3

Current Reporting Structure



Proposed Reporting Structure



Appendix 4

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

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

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

Appendix 4

	experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities. The Committee is authorised to approve those policies and procedures for matters within its areas responsibility.
Accountability and reporting arrangements:	The Quality Committee will be accountable to the Board of Directors. A Chair's Report will be submitted to the next following Board of Directors for assurance. Approved minutes will be made available to all Board members. The Committee will report to the Board annually on its work and performance in the preceding year. Trust standing orders and standing financial instructions apply to the operation of the Committee.
Reporting Committees/ Groups	The sub committees/groups listed below are required to submit the following information to the Committee: a) Chairs Report; and b) Annual Report setting out the progress they have made and future developments. The following sub committees/groups will report directly to the Committee (See appendix 1): • Clinical Governance Sub-Committee • Patient Involvement & Experience Sub-Committee • Corporate Risk Sub-Committee • Hospital Safeguarding Sub-Committee • Research and Development Sub-Committee • Future Generations Project Group
Monitoring effectiveness:	The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements.
Review:	These terms of reference will be reviewed at least annually by the Committee.
Reviewed by Quality Committee	22 March 2021
Approved by Board of Directors:	[01 April 2021]
Review date:	March 2022
Document owner:	Mark Grimshaw, Trust Secretary, Email: mark.grimshaw@lwh.nhs.uk Tel: 0151 702 4033

Appendix 5

Work Programme

Quality Committee			WORKPLAN 2021/22											
			Quarter 1			Quarter 2			Quarter 3			Quarter 4		
	Executive/ Senior Owner	⇧ to Board	26 April 2021	24 May 2021	21 June 2021	26 July 2021	23 Aug 2021 TBC	27 Sept 2021	25 Oct 2021	22 Nov 2021	20 Dec 2021 TBC	24 Jan 2022	21 Feb 2022	28 Mar 2022
Standing Items														
Minutes of Previous meeting	TS		✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Actions/Matters Arising	TS		✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Chairs Report - Verbal	Chair		✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Monthly Quality Performance Report	COO	✓	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Review of BAF risks	DNM	✓	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Quality and Regulatory update – internal reviews (CQC assessments) and External guidelines, statute best practice etc. to be reported by exception	DDNM		✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Review of risk impacts of items discussed	Chair		✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Any other business	Chair		✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Review of meeting	Chair		✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Annual Reports & Strategies														
Infection Prevention and Control Annual Report	DNM	✓			✓									
Annual Safeguarding Report	DNM	✓				✓		~~✓~~						
Annual Health & Safety Report	DNM	✓			✓									
Research & Development Annual Report	MD	✓			✓	~~✓~~								
Research and Innovation Strategy and Review	MD	✓			✓	~~✓~~								✓
Complaints Annual Report	DNM				~~✓~~	✓								
Security Management Annual Report	COO			✓				~~✓~~						
Legal Services Annual Report	DDNM								✓					
Review of Annual Quality Report (prior to AC/Board)	MD	✓		✓										

Appendix 5

Quality Committee			WORKPLAN 2021/22											
			Quarter 1			Quarter 2			Quarter 3			Quarter 4		
	Executive/ Senior Owner	⇧ to Board	26 April 2021	24 May 2021	21 June 2021	26 July 2021	23 Aug 2021 TBC	27 Sept 2021	25 Oct 2021	22 Nov 2021	20 Dec 2021 TBC	24 Jan 2022	21 Feb 2022	28 Mar 2022
Review of Quality Strategy (Quarterly)	MD		√(Q4)			√(Q1)				√ (Q2)			√ (Q3)	
NICE Annual Report	MD					√								
Patient														
~~National Patient survey/s provisional: In patient – Gynaecology~~	DNM													
~~In patient – Maternity~~			√					√						
~~In patient - Cancer~~												√		
										√				
Serious Incidents & Learning Report	DNM	√	√ (Q4)	√	√	√ (Q1)		√	√ (Q2)	√		√ (Q3)	√	√
Mortality and Perinatal Report (Learning from Deaths)	MD	√		√(Q4)				√(Q1)		√(Q2)			√(Q3)	
Integrated Governance Assurance Report	DNM			√(Q4)		√(Q1)				√(Q2)			√(Q3)	
Medicines Management Assurance Report	MD			√ (Q4)		√ (Q1)			√ (Q2)			√(Q3)		
LocSSIPs Quarterly Assurance Report	MD			√ (Q4)		√(Q1)			√(Q2)				√ (Q3)	
~~PLACE Annual Report (inc. review of actions from previous year) and PLACE Annual Plan~~	DNM							√ (AR)						√(AP)
Seven Day Working Board Assurance – 6 monthly	MD			√					√					
Ockenden Report Update	DNM		√	√	√	√		√	√	√		√	√	√
Safety Champion Update (quarterly)	NED SC		√			√			√			√		
~~COVID-19 Update: Quality of Care matters~~	DNM													
Risk														
Annual Review of Risk Management Strategy	DNM	√												√
Risk Appetite Statement – Quality Committee	DNM	√												√

Appendix 5

Quality Committee			WORKPLAN 2021/22											
			Quarter 1			Quarter 2			Quarter 3			Quarter 4		
	Executive/ Senior Owner	⇧ to Board	26 April 2021	24 May 2021	21 June 2021	26 July 2021	23 Aug 2021 TBC	27 Sept 2021	25 Oct 2021	22 Nov 2021	20 Dec 2021 TBC	24 Jan 2022	21 Feb 2022	28 Mar 2022
General Governance Arrangements														
Ward Accreditation Scheme - annually	DNM				√									
~~Equality and Human Rights Goals 1&2 – progress report~~	DNM			√(Q4)		√(Q1)				√(Q2)			√(Q3)	
Contract Quality Schedule Assurance Report	DDNM		√(Q4)			√(Q1)			√(Q2)			√(Q3)		
CNST Progress Report	DNM		√	√	√	√						√	√	√
Clinical Audit work plan & annual report	MD		√ (WP)					√ (AR)						
Corporate Objectives: 6 monthly and year-end review & Objective Setting	TS	√	√ (OS)					√						√
Terms of reference review and business cycle	TS													√
QC Committee Annual Report	TS													√
Subcommittee chairs reports and Terms of Reference • Clinical Governance Sub-Committee • Patient Involvement & Experience Sub-Committee • Corporate Risk Sub-Committee • Trust Safeguarding Sub-Committee • Research and Development Sub-Committee • Future Generations Project Group														

Q=Quarter WP=Work plan AR=Annual Report AP=Annual Plan OS=Objective Setting

Liverpool Women's NHS Foundation Trust

Agenda Item	21/22/9a

MEETING	**Trust Board**
PAPER/REPORT TITLE:	**2020 Staff Survey Results Summary**
DATE OF MEETING:	Thursday, 01 April 2021
ACTION REQUIRED	**Information**
EXECUTIVE DIRECTOR:	Michelle Turner, Chief People Officer
AUTHOR(S):	Simon Davies, HR Manager Rachel London, Deputy Director of Workforce
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** 1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☒ 2. To be ambitious and *efficient* and make the best use of available resource ☒ 3. To deliver *safe* services ☒ 4. To participate in high quality research and to deliver the most *effective* Outcomes ☐ 5. To deliver the best possible *experience* for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust…….* ☒ ***2.*** *Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have sufficient numbers of clinical staff with the capability and capacity to deliver the best care. ……* ☐ ***3.*** *The Trust is not financially sustainable beyond the current financial year……* ☐ ***4.*** *Failure to deliver the annual financial plan ……* ☐ ***5.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision ……* ☐ ***6.*** *Ineffective understanding and learning following significant events……* ☐ ***7.*** *Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) ……* ☐
CQC DOMAIN	***Which Domain?*** ***SAFE****- People are protected from abuse and harm* ☐ ***EFFECTIVE*** *- people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☐ ***CARING*** *- the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☐ ***RESPONSIVE –*** *the services meet people's needs.* ☐ ***WELL-LED*** *- the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.* ☐ ***ALL DOMAINS*** ☒

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

Executive Summary

This paper provides an overview of the results for the 2020 NHS Staff Survey results. It explains that the key theme scores have remained largely unchanged, with only minor variations (both positive and negative) which are not deemed to be statistically significant.

The overall staff engagement score is 7.1 out of 10 and this has remained static over the last few years. As an organisation our aim is to bring our score closer in line with the average for acute specialist Trusts (7.4).

The results have been broken down and shared with management teams across the Trust. Each division is being asked to pick a key theme from the results to focus on for improvement, with each ward/department being asked to identify a sub-theme and then follow through with an action plan to address the issues/barriers/problems within that sub-theme. Successes will then be shared across divisions and throughout the Trust as a whole, as examples of best practice.

The Staff Survey will be used as part of the data set to support the cultural diagnostic work will shortly commence. 1-1 and group discussions will explore some of the key indicators in the staff survey which are linked to culture and build on the existing Trust values with the objective of creating a Trust wide behavioural framework.

Report

1) Introduction

The 2020 National Staff Survey was conducted from October to December 2020, with the results being published nationally on 11th March 2021. Clearly, the survey period coincided with the covid 19 pandemic, and it is possible that this might have had an effect of some of the results.

The survey is carried out by all NHS organisations using a nationally agreed set of questions. As in previous years, the Trust surveyed all its staff rather than just the required minimum sample, and the survey was undertaken by Quality Health, one of the DH approved contractors. Also as in previous years, our comparator group is 'specialist acute Trusts' which is made up of fourteen trusts across the country, although in reality, our services are more akin to those provided by a (general) acute Trust.

The survey itself contains a total of 31 questions, many with multiple parts, but for the nationally published results, these are statistically analysed grouped & weighted, and presented as ten key themes: equality diversity & inclusion, health & wellbeing, immediate managers, morale, quality of care, safe environment (bullying & harassment), safe environment (violence), safety culture, staff engagement, and team working (last year there was also a separate 'theme' for quality of appraisals). The results are presented as a score out of ten for each theme.

2) Issues for Consideration

Overall Theme Scores

The results of the national staff survey are now headlined as ten key themes. The nationally published reports display these showing comparisons against other similar Trusts (we are classed as an acute specialist trust, for which the comparator group includes 14 organisations), and against our previous years' scores. The tables below represent a summary of these comparisons:

Comparisons Against Other Acute Specialist Trusts:

equal to best	1	equality, diversity & inclusion
above average	1	safe environment – bullying & harassment
equal to average	3	health & wellbeing safe environment – violence team working
below average	1	morale
equal to worst	4	immediate managers quality of care safety culture staff engagement

Comparisons Against Our 2019 Survey Results:

improved	3	equality, diversity & inclusion (9.4⇨9.5) health & wellbeing (6.4⇨6.5) team working (6.6⇨6.8)
unchanged	4	morale quality of care safe environment – bullying & harassment safety culture
deteriorated	3	immediate managers (6.9⇨6.8) safe environment – violence (9.9⇨9.8) staff engagement (7.2⇨7.1)

However, it should be noted that **none of the changes** in our overall theme scores were deemed to be **statistically significant**:

Theme	2019 score	2019 respondents	2020 score	2020 respondents	Statistically significant change?
Equality, diversity & inclusion	**9.4**	822	**9.5**	788	Not significant
Health & wellbeing	**6.4**	830	**6.5**	796	Not significant
Immediate managers †	**6.9**	826	**6.8**	790	Not significant
Morale	**6.3**	814	**6.3**	789	Not significant
Quality of care	**7.6**	746	**7.6**	681	Not significant
Safe environment - Bullying & harassment	**8.7**	819	**8.7**	788	Not significant
Safe environment - Violence	**9.9**	822	**9.8**	790	Not significant
Safety culture	**6.9**	826	**6.9**	792	Not significant
Staff engagement	**7.2**	831	**7.1**	789	Not significant
Team working	**6.6**	816	**6.8**	776	Not significant

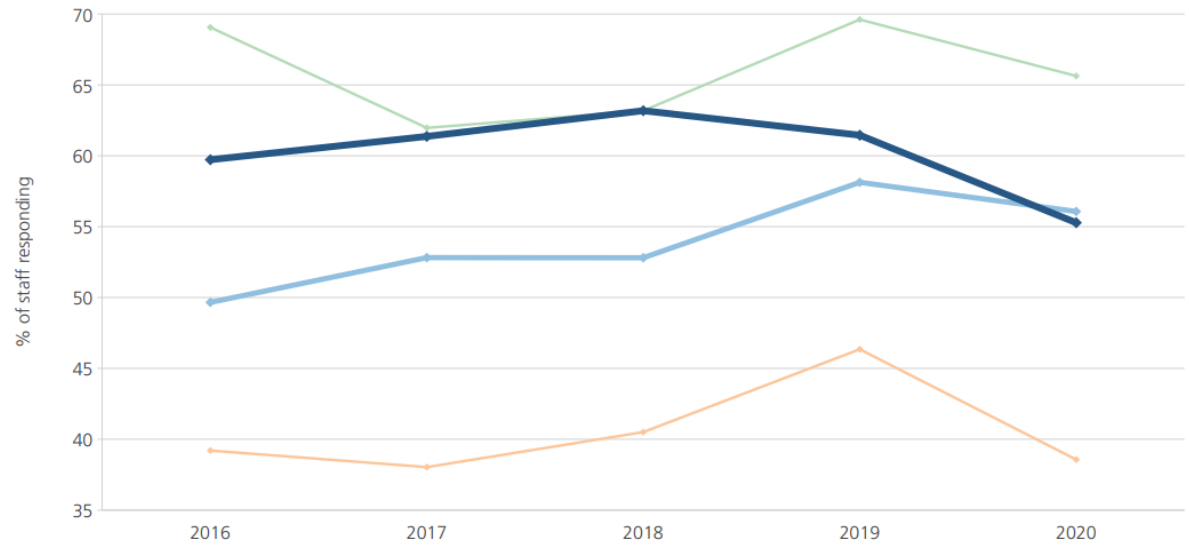
Response Rate

The table below shows that although our response rate didn't manage to reach the same level as previous years, this was reflected across our comparator group. The same pattern of lower response rates was also seen nationally, and is likely to be a result of the survey being conducted during the covid 19 pandemic, when staff and services faced vastly increased pressures and challenges:

Survey Coordination Centre

2020 NHS Staff Survey Results > Appendices > Response rate

NHS England

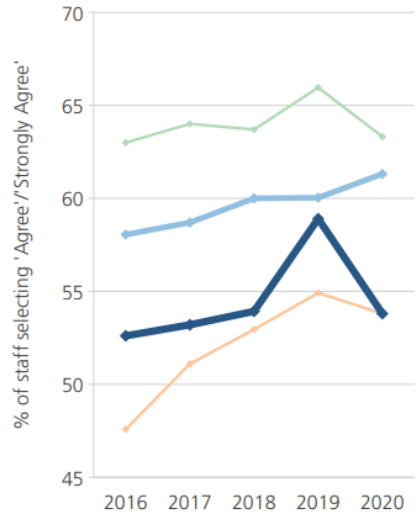


	2016	2017	2018	2019	2020
Best	69.1%	62.0%	63.2%	69.6%	65.6%
Your org	59.7%	61.4%	63.2%	61.5%	55.3%
Median	49.7%	52.8%	52.8%	58.1%	56.1%
Worst	39.2%	38.0%	40.5%	46.3%	38.6%

Individual Question Scores:

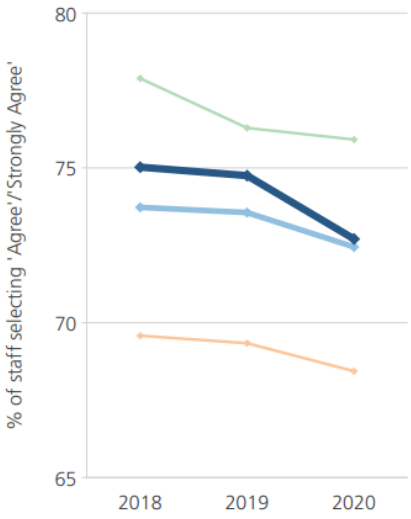
The published reports also provide more detail in relation to individual questions. Whilst the overall pattern of little or no change is also reflected at the individual question level, there are some that stand out as issues that would bear closer examination:

Q8d
My immediate manager asks for my opinion before making decisions that affect my work



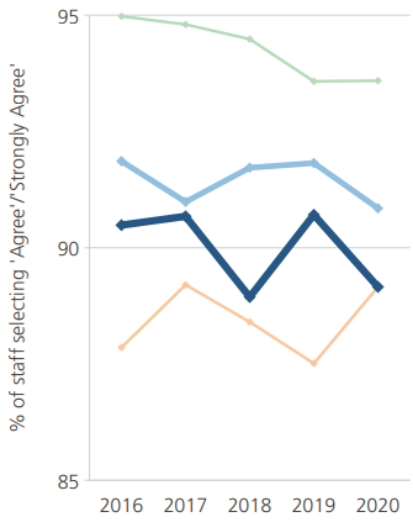
	2016	2017	2018	2019	2020
Best	63.0%	64.0%	63.7%	66.0%	63.3%
Your org	52.6%	53.2%	53.9%	58.9%	53.8%
Average	58.1%	58.7%	60.0%	60.0%	61.3%
Worst	47.6%	51.1%	52.9%	54.9%	53.8%

Q4j
I receive the respect I deserve from my colleagues at work



	2018	2019	2020
Best	77.9%	76.3%	75.9%
Your org	75.0%	74.7%	72.7%
Average	73.7%	73.6%	72.4%
Worst	69.6%	69.3%	68.4%

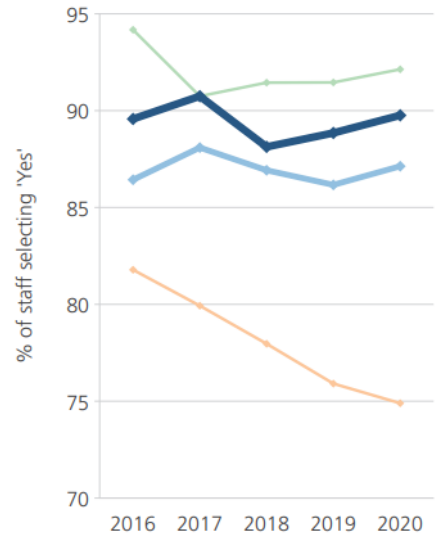
Q7b
I feel that my role makes a difference to patients / service users



Best	95.0%	94.8%	94.5%	93.6%	93.6%
Your org	90.5%	90.7%	88.9%	90.7%	89.2%
Average	91.9%	91.0%	91.7%	91.8%	90.8%
Worst	87.9%	89.2%	88.4%	87.5%	89.2%

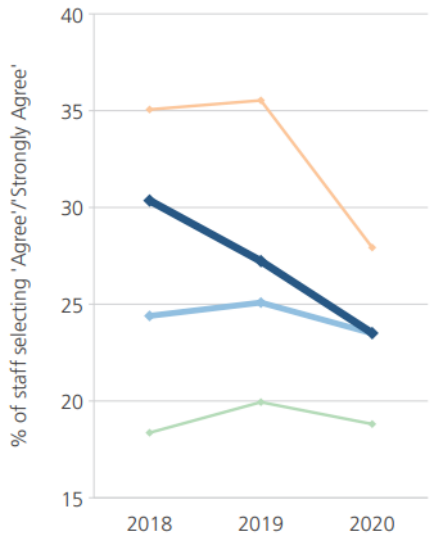
Equally, there are also some that stand out as cause for optimism/celebration:

Q14
Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?



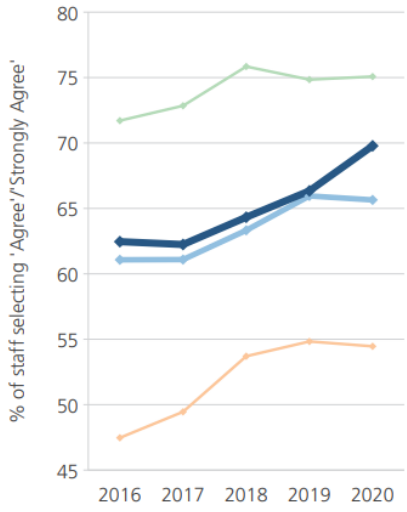
Best	94.2%	90.7%	91.4%	91.5%	92.1%
Your org	89.6%	90.7%	88.1%	88.8%	89.8%
Average	86.4%	88.1%	86.9%	86.2%	87.1%
Worst	81.8%	79.9%	78.0%	75.9%	74.9%

Q19a
I often think about leaving this organisation



Worst	35.1%	35.5%	27.9%
Your org	30.4%	27.2%	23.5%
Average	24.4%	25.1%	23.5%
Best	18.4%	19.9%	18.8%

Q16d
We are given feedback about changes made in response to reported errors, near misses and incidents



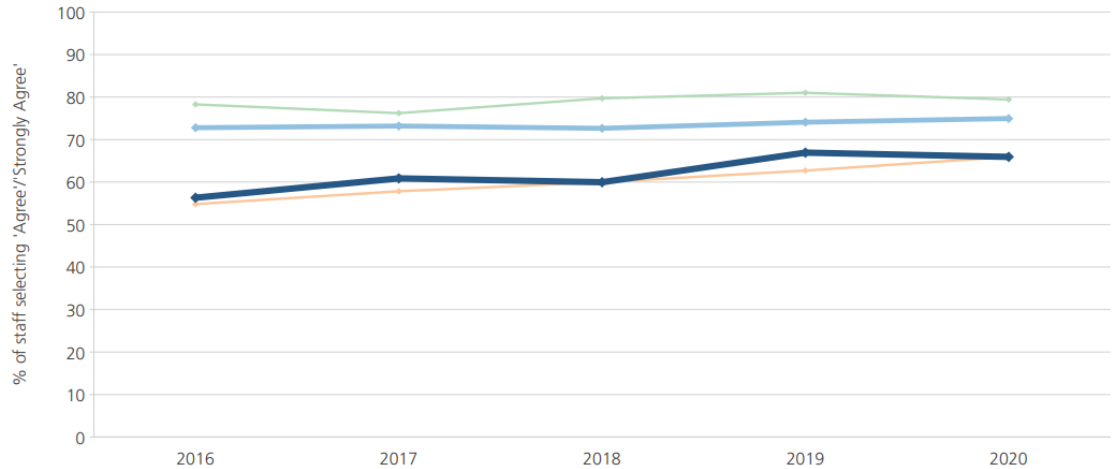
Best	71.7%	72.8%	75.8%	74.8%	75.1%
Your org	62.5%	62.2%	64.3%	66.3%	69.8%
Average	61.1%	61.1%	63.3%	66.0%	65.6%
Worst	47.5%	49.5%	53.7%	54.8%	54.5%

For the two key questions regarding recommending the Trust as either a place to work or receive treatment, the changes from last year's scores were minimal:

Survey Coordination Centre

2020 NHS Staff Survey Results > Question results > Your organisation > Q18c > I would recommend my organisation as a place to work

NHS England

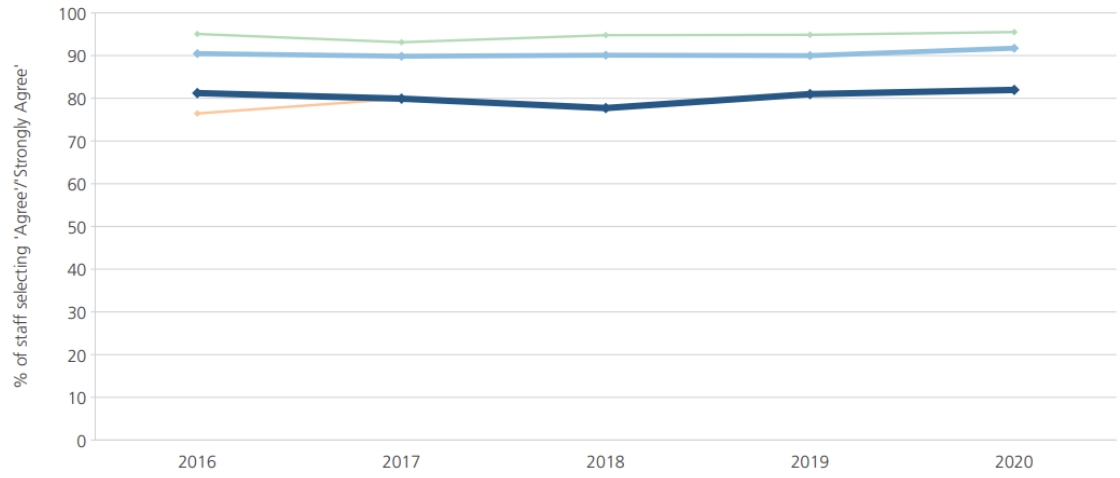


Best	78.3%	76.2%	79.7%	81.0%	79.4%
Your org	56.3%	60.9%	60.0%	66.9%	65.9%
Average	72.8%	73.2%	72.6%	74.1%	75.0%
Worst	54.8%	57.8%	60.0%	62.7%	65.9%
Responses	841	863	866	820	790

Survey Coordination Centre

2020 NHS Staff Survey Results > Question results > Your organisation > Q18d **>** If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation

NHS England



	2016	2017	2018	2019	2020
Best	95.1%	93.1%	94.8%	94.9%	95.5%
Your org	81.2%	79.9%	77.7%	81.0%	82.0%
Average	90.5%	89.9%	90.1%	90.0%	91.7%
Worst	76.5%	79.9%	77.7%	81.0%	82.0%
Responses	841	864	861	820	793

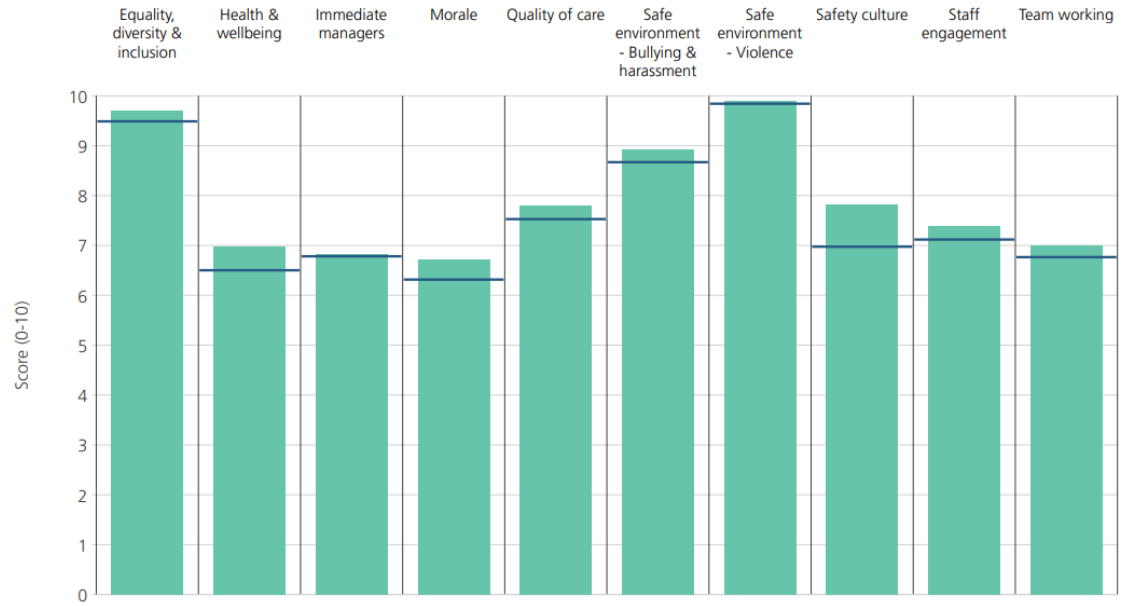
Divisional & Staff Group Results

Below are some of the examples of the variation in scores across the divisions:

Survey Coordination Centre

2020 NHS Staff Survey Results > Directorates 1 > Neonates

NHS England



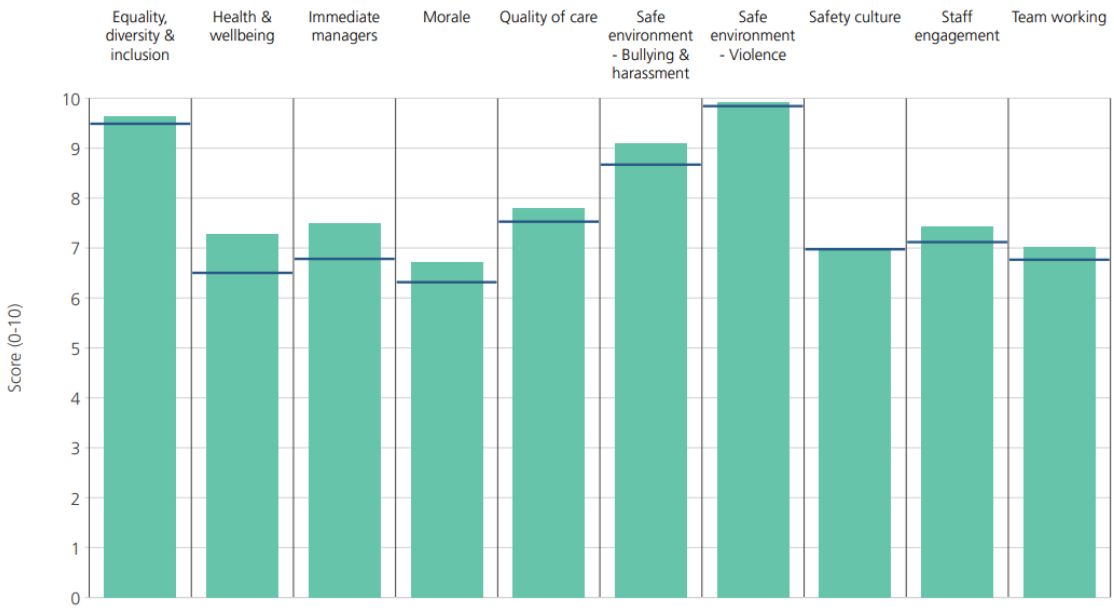
	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Directorate	9.7	7.0	6.8	6.7	7.8	8.9	9.9	7.8	7.4	7.0
Your org	9.5	6.5	6.8	6.3	7.5	8.7	9.8	7.0	7.1	6.8
Responses	143	144	144	144	143	142	141	144	143	142

And across the different staff groups:

Survey Coordination Centre

2020 NHS Staff Survey Results > Directorates 2 > Administrative and Clerical

NHS England

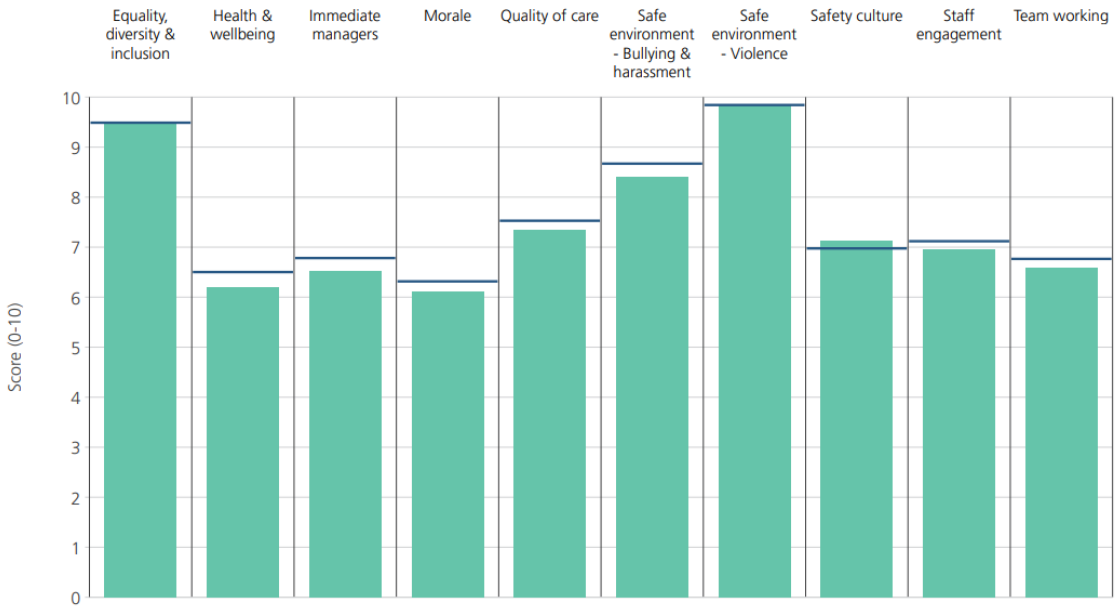


	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Directorate	9.6	7.3	7.5	6.7	7.8	9.1	9.9	7.0	7.4	7.0
Your org	9.5	6.5	6.8	6.3	7.5	8.7	9.8	7.0	7.1	6.8
Responses	214	218	217	217	119	216	218	216	217	211

Survey Coordination Centre

2020 NHS Staff Survey Results > Directorates 2 > Nursing and Midwifery Registered

NHS England



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Directorate	9.5	6.2	6.5	6.1	7.3	8.4	9.8	7.1	6.9	6.6
Your org	9.5	6.5	6.8	6.3	7.5	8.7	9.8	7.0	7.1	6.8
Responses	335	337	335	335	330	336	335	337	334	330

Full comparisons for all divisions and staff groups are included in the nationally published directorate report (attached). These reports are being included with the feedback given at division and directorate levels so that

local management can see where they stand in relation to the bigger Trust wide picture, and therefore identify specific local issues that need addressing.

Nationally Published Reports
All figures/charts taken from the nationally published reports:


NHS_staff_survey_2020_REP_summary.pdf


NHS_staff_survey_2020_REP_full.pdf


NHS_staff_survey_2020_REP_directorate.pc

Benchmarking with other local Trusts

At North West level 5 out of 20 Acute Trusts were on or above the national benchmark on all 10 themes within the survey. STHK were above on all 10 9. Bolton and East Lancashire also performed well.

All acute specialist organisations achieve above average in all 10 themes **except LWH where we fell below in 6 of the 10 national themes.**

As usual, we perform less favourably than other (specialist) Trusts in the region on the key score of **Staff Engagement.**

Liverpool University Hospitals Trust	6.9
Birmingham W&C NHS Foundation Trust	7.2
Liverpool Women's NHS Foundation Trust	**7.2**
Alderhey NHS FT	7.4
STHK	7.6
Walton Centre	7.6
Liverpool Heart and Chest Hospitals	7.6

Let's Talk Survey Results
In parallel to the national staff survey, the rust also runs a quarterly local survey under the strapline "Let's Talk". The most recent of these was completed in December 2020, and a summary of the results is available on request.

This summary has been shared with local managers along with their staff survey results to help them establish a wider evidence base to inform the development of their action plans.

3) Conclusions/Next Steps
Overall, there has been little change in this year's staff survey results. While on the one hand it is disappointing that more progress has not been made in key areas, it is also apparent that the continuing covid 19 pandemic is likely to have had an effect on the results, and on some of the key issues that are measured by the survey.

The results have been drilled down to division, directorate and ward/department level, and summaries have been distributed to the divisional management teams. The divisions are being asked to pick a key theme from the results to focus on for improvement, with each ward/department being asked to identify a sub-theme and then follow through with an action plan to address the issues/barriers/problems within that sub-theme. Successes will then be shared across divisions and throughout the Trust as a whole as examples of best practice, thereby maximising the impact of changes driven by the staff survey results.

It is important that the Staff Survey data and key themes are used to inform the objectives within the Trust's Putting People First action plan and specific workstreams emanating from that including

- Health and wellbeing strategy
- Cultural diagnostic programme
- Roll out of Fair and Just Culture training to 200 managers over next 3-6 months
- Leadership and Talent strategy
- How we learn from the lessons of covid and move forward towards recovery

Our newly appointed Head of Culture, Inclusion, Engagement and Wellbeing will lead on utilising the staff survey results to inform plans for cultivating and developing staff engagement across the Trust (both local and Trust-wide levels) and in taking forward the work to embed Fair & Just Culture into everything that we do.

While the current covid pandemic presents certain challenges to achieving these goals, it also offers the opportunity to be more creative and imaginative in coming up with solutions, building on some of the excellent work done during the pandemic around agile working, flexible support for staff and alternative delivery methods for learning and teaching.

4) Recommendations

The Board is asked to note the contents of this paper and endorse the 'next steps' described above.

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

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• The downward trend in mandatory training compliance remained a concern, including decline in both corporate and clinical departments. Further detail requested to explain the corporate position. • Sickness absence continued to be above the Trust target although it was noted that there would be an improved position in relation to special leave moving towards 2021/22 M1 as staff return from shielding. Careful transition of staff back into the workforce was recommended. • A verbal update from the CSS Clinical Director to inform of action taken to address the pressures faced by the medical anaesthetic workforce, including the introduction of joint posts with a local hospital Trust, improve medical student experience to maintain a trained workforce, and further appeal to the international workforce. • The Freedom to Speak Up Guardian national survey recommended the introduction of F2SU training as mandatory. The Committee noted potential further stetch on the mandatory training programme and headroom of the workforce. • Staff Survey results 2020/21: Trust achieved 7.1 out of 10 for the overall engagement score (average score for acute trusts being 7.4). The results remained static from previous years which was disappointing and did not reflect the resource allocation to improve staff engagement. A progress update against the staff survey action plan would be received in six months.	• In response to the Quality Committee Chair action to review cultural failings identified by the Ockenden report, it was noted that a 'cultural diagnostic' would be conducted using the NHSI Culture Improvement Framework. It would be implemented in the Maternity Service initially. • The Committee remained concerned by the risk within the medical anaesthetic workforce and requested that the Executive Committee consider the options further and provide a structured approach within a paper to the next PPF meeting.
Positive Assurances to Provide	**Decisions Made**
• Received a positive staff story from a junior doctor anaesthetist's experience of taking the decision to shield and returning to work. • Positive assurance from the National Freedom to Speak Up Survey • Received assurance from the Gynaecology Division that the workforce was safe and sustainable. It was recognised that the progression to strengthen the workforce had put the division in a strong position to support the recovery phase post covid-19. • The Equality and Diversity Annual Report provided improved oversight and assurance of the position against the Equality, Diversity and Inclusion Strategy and the Committee approved the proposed actions for 2021/22. (See Appendix 1 of Chair report) • Trust forecast to spend the full CPD allocation for 20/21. Although training/courses had been cancelled due to Covid-19 the Trust had successfully reallocated the funding appropriately to other resources to support the CPD of each nurse, midwife and AHP. Planning guidance for 21/22 had not yet been issued. • The Guardian for Safe Working Hours position had been filled with an interim post holder and a permanent member undertaking the role in August 2021.	• Reviewed the PPF related BAF risks. No changes to existing risks were identified as a result of business conducted during the meeting. • Staff Survey Report to be presented up to Trust Board for assurance. • The Committee approved the Communications, Marketing & Engagement Strategy. • Committee reviewed its risk appetite and level and recommended Trust Board approval as follows: 'To develop a well-led, capable and motivated workforce' a Moderate risk appetite. • Achievement against the 2020/21 Corporate Objectives aligned to the PPF Committee had been met and would be presented to the Trust Board for final review. • Recommend Trust Board approval of the PPF Committee Annual Report, Terms of Reference and workplan.
Comments on Effectiveness of the Meeting / Application of QI Methodology	
• PPF had trialled an 'Assurance pilot' throughout the meeting to consider papers referenced as for assurance and consider how well that assurance had been provided. The Committee agreed that it had provided focus and created discussion.	

2. Summary Agenda

No.	Agenda Item	Purpose	Rating	No.	Agenda Item	Purpose	Rating
115.	Board Assurance Framework (BAF): Workforce related risks	Information		123.	Equality & Diversity Annual Report	Assurance	
116.	Chief People Officer Report	Information		124.	Continuing Professional Development Spend and Planning	Information	
117.	Workforce KPI Dashboard Report	Assurance		125.	Communications, Marketing & Engagement Strategy	Approval	
118.	Staff Story: Junior Doctor	Information		126.	Review of Risk Appetite Statement	Approval	
119.	Service Workforce Assurance & Risk Report: Gynaecology & Hewitt Division	Assurance		127.	Corporate Objectives 20/21 Year-end Review	Assurance	
120.	Clinical Support Services follow-up assurance report	Assurance		128.	Committee Effectiveness Review	Approval	
121.	Freedom to Speak Up Guardian National & Local Update	Assurance		129.	Subcommittee chairs reports	Information	
122.	Safe Survey Results	Information					

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	✓	✓	✓	✓	✓	A
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	✓	✓	✓	✓	✓	A

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

Equality & Diversity Annual Report 2021

Executive Summary

*Full report for Board members can be found in the Supporting Documents in Teams and on Virtual Boardroom

Context

The Trust has five over-arching Equality Objectives in our action plan for the period 2019 - 2023;

- Create a workforce representative of the community we serve*
- Ensure that we meet the communication needs of our patients*
- Ensure that staff training & development promotes the values of inclusion and tolerance for all, whilst meeting the needs of all staff groups
- Develop the EDI agenda into the culture of existing meetings and committees
- Continue to engage with our patient and staff groups to understand further the needs of individuals with protected characteristics and respond proactively to identified needs

* The objectives highlighted above will be areas for continued focus in 2021/22

The Trust Equality Objectives action plan (2019/23) can be found on the Trusts website (https://www.liverpoolwomens.nhs.uk/diversity-inclusion-human-rights/).

Activity in 2019/20

Key actions included:

- Delivering Inclusion throughout COVID-19
- Supporting BAME colleagues during COVID-19
- Mental Health First Aiders (MHFA)
- Widening Participation
- Black History Month
- Colleague Inclusion Networks
- Supporting patients with a disability
- Supporting patients who do not speak English as a first language
- Matron review for all patients with additional needs
- Visiting times on the neonatal unit

Measures & Objectives

Gender Pay Gap Report (2020)

Gender pay gap reporting regulations require UK employers in the public sector with 250+ employees to disclose workforce details in relation to their gender pay gap based on a single date each year, namely 31 March. As such, the gender pay gap report gives a snapshot of the gender balance within an organisation. It measures the difference between the average earnings of all male and female employees, irrespective of their role and/or seniority.

The full 2020 Gender Pay Gap report for the Trust can be found on the Trust website (https://www.liverpoolwomens.nhs.uk/diversity-inclusion-human-rights/).

Workforce Race Equality Standard (WRES)

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

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

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

Specifically, 15% of all applications from April 19 to March 20 were from BAME staff. 36 BAME applicants were shortlisted and 15 were appointed. The relative likelihood of a white member of staff being appointed from shortlisting stage increased to 1.35 compared to 0.8 in 2019. This evidences that fewer BAME staff are being appointed compared to white staff relative to those who reach interview stage.

In terms of our BAME colleagues at work;

- 88% feel there are equal opportunities for career progression, this is in line with 2019 Staff Survey results and an increase of 10% compared to 2018 results of 78%. This is better than the national average for BAME staff of 76%
- 33% stated they have experienced bullying, harassment or abuse from a colleague, compared to 17% of white staff (the national average for specialist Trusts is 29%)

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

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

- On-going Listening events on topic of Bullying & Harassment
- Review of ED&I training provision, introduction of cultural awareness training to be piloted in maternity
- Career clinics for BAME staff
- Mentoring and reverse mentoring schemes are in development
- Specific targets for BAME representation in leadership roles to be devised
- On-going recruitment audits, positive targeting of applicants via community groups, on-going widening participation work

A WRES action plan for the coming year is available to view which takes into account the above noted key findings from the latest WRES submission and this can be found at on the Trust website (https://www.liverpoolwomens.nhs.uk/diversity-inclusion-human-rights/).

Workforce Disability Equality Standard (WDES)

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

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

In terms of band distribution, there are no disabled staffs above 8a in non-clinical roles however there are two individuals at 8a and 8b respectively, in clinical roles. There are no medical staffs with a disclosed disability.

In terms of recruitment, non- disabled candidates are 2.32 times more likely to be appointed from shortlisting stage than disabled candidates. 32 disabled staff applied for a job at the Trust in 2019/20 and 8 were appointed; an appointment rate of 25%.

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

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

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

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

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

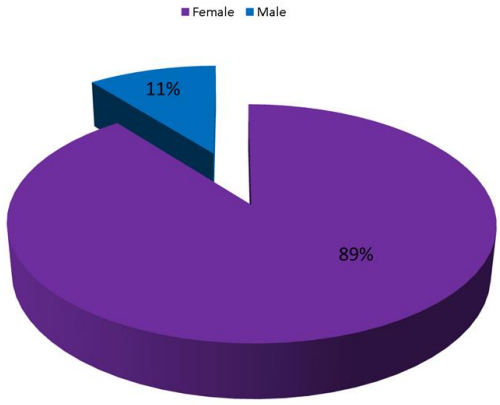
The Trust WDES action plan can be found on the Trust website (https://www.liverpoolwomens.nhs.uk/diversity-inclusion-human-rights/).

Staff Profiles

Headcount for the workforce as of December 2020 stood at 1516 which is a decrease of 65 staff from 2019.

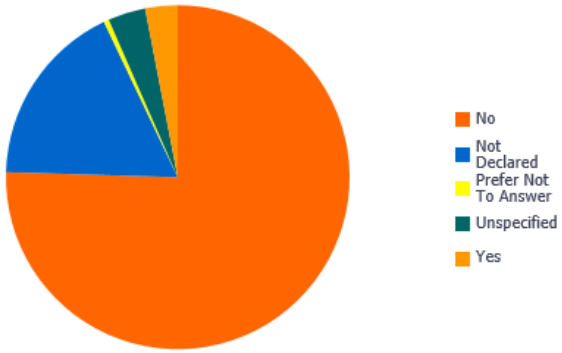
Staff Profile - Gender

Liverpool Women's NHS Foundation Trust has an 89% female workforce which equates to 1349 colleagues and this is a 1% drop based colleague profiles as reported in 2019.



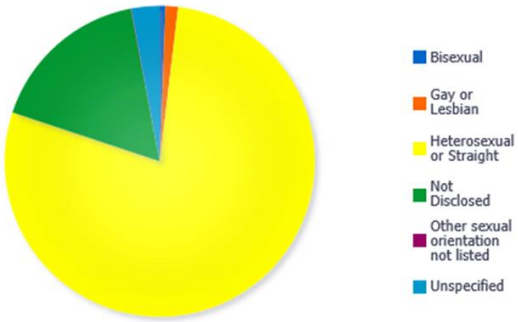
Of the workforce, 760 are in the Nursing and Midwifery staff group; 99.7% of this group are female.

Staff profile - Disability



The figures relating to disability declarations remain as per those reported in 2019 namely 75.5% of colleagues state they do not have a disability and 3% state that they do. 17.5% of colleagues declined to provide an answer to the question and so, the above does not provide a full representation of disability within our colleague base. Further information can be found in the Trust WDES report which can be found via https://www.liverpoolwomens.nhs.uk/diversity-inclusion-human-rights/

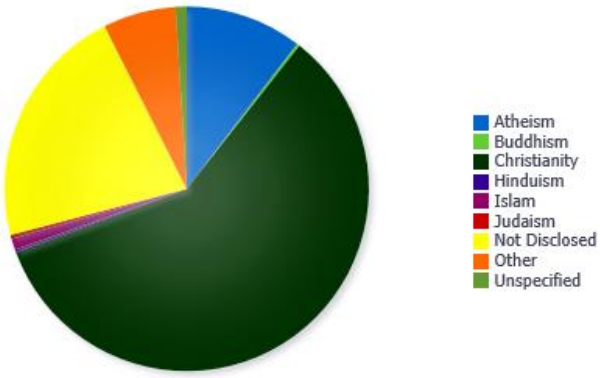
Staff profile – Sexual Orientation



78% of colleagues define their sexual orientation as Heterosexual; this remains comparative to last year in which 77.87% of colleagues identified as such. Those identifying as Gay or Lesbian is 1.3%.

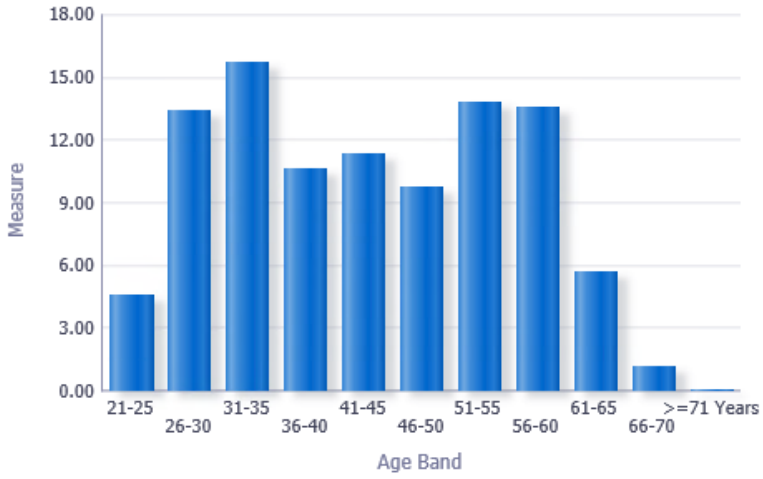
As with disability declarations, the above does not provide a full representation of colleagues orientation as 16.9% declined to provide an answer.

Staff profile – Religion



The information reported on religion remains comparable to 2019; those not wishing to disclose their religious belief has further reduced to 0.98%.

Staff profile – Age



Between the ages of 26 – 60 are mainly equal percentages with the younger and older workforce being smaller numbers; this is comparable to 2019.

Plans for 2021/22

This report has provided an update on many of the activities and actions that have taken place in 2019/20 across the Trust.

There is board level commitment to review the Trust approach to Equality, Diversity and Inclusion in its entirity following events of the past 12 months; the Trust has an ambition to be amongst the best Trusts in the UK in creating an inclusive culture that harnesses and encourages diverse leadership at all levels in the organisation.

Specific plans are outlined below and will form part of the revised set Equality Objectives (currently in place until 2023)

- Positive discrimination at shortlisting stage
- Diverse interview panels for posts above B6
- Enhanced training offer and career coaching for under-represented groups
- Commitment to appoint % of senior staff to under -represented groups
- Commitment to create a developmental NED role and appoint from an under represented group
- Every senior leader to be offered as a mentor to under-represented groups
- Pilot reverse mentoring
- Approach other Trusts to offer their BAME leaders as mentors for our staff
- Second F2SU guardian from a diverse group
- Colleague networks for other groups
- Colleague supporters network inclusive of diverse members

Conclusion

This annual report collates some of the activities that have taken place in the last 12 months at the Trust. There is clear direction with regards to the Equality, Diversity and Inclusion strategy, with the Trust seeking to further develop the overall approach in 2021/22.

Whilst it is important to note the positive work that continues to take place for both patient/service-user and colleague groups, it is equally important to recognise that this journey for the Trust is ever moving and changing to ensure the best possible experience for all. To support this development, it is vital to work in partnership with stakeholders including our local community in a collaborative approach to address the areas for improvement as highlighted in this report.

As a final word, the Trust is confident that the Equality Objectives (2019/23) as set out are achievable in order to reach the overall ambition of being a great place to work.

Liverpool Women's NHS Foundation Trust

Putting People First Committee Annual Report 2020/21

Putting People First Committee

This report covers the period April 2020 to March 2021. There were six meetings held during this period.

Introduction

The Committee is responsible for:

a) Developing and overseeing implementation of the Trust's People Strategy (integrated workforce, wellbeing and organisational development strategy) and plan and providing assurance to the Board of Directors that this is being delivered in line with the annual planning process
b) Oversight of the strategic implementation of multi-disciplinary education and training and gaining assurances that the relevant legislative and regulatory requirements are in place (Education Governance Committee)
c) Approving, monitoring and reviewing policies, procedures and guidance documents relating to the management of the Trust's workforce
d) Monitoring and reviewing workforce key performance indicators to ensure achievement of the Trust's strategic aims and escalate any issues to the Board of Directors
e) Reviewing any changes in practice required following any internal enquiries that significantly impact on workforce issues
f) Oversight of the strategic implementation and monitoring of staff engagement levels as evidenced by the results of the national and any other staff surveys
g) Reviewing and approving partnership agreements with staff side
h) Ensuring that the Trust fulfils all legislative and regulatory requirements pertaining to workforce and organisational development issues
i) Monitor and evaluate compliance with the public sector equality duty and delivery of equality objectives to improve the experience of staff with protected characteristics
j) Approving the terms of reference and membership of its reporting groups and overseeing the work of those groups, receiving reports from them for consideration and action as necessary and routinely receiving the minutes of their meetings
k) Receipt and review of relevant risks (including those referred from other Committees or subcommittees) concerned with workforce and organisational development matters as identified through the Board Assurance Framework. Monitor progress made in mitigating those risks, identifying any areas where additional assurance is required, escalating to the Board of Directors as required.
l) Receiving and considering issues from other Committees when appropriate and taking any necessary action.

Constitution

The Putting People First Committee is accountable to the Board of Directors.

Membership during the year comprised:

- Non-Executive Director (Chair)
- Two other Non-Executive Directors
- Director of Workforce & Marketing
- Director of Nursing & Midwifery
- Director of Operations
- Staff Side Chair
- Medical Staff Committee representative
- Senior Finance Manager

Meetings were also attended by other executives and senior management staff as appropriate.

The Committee's constitution allows for members to participate by two-way audio link on occasion where appropriate which is deemed to constitute presence in person per the Committee's Terms of Reference. Due to the Covid-19 pandemic, all meetings during 2020/21 have been held virtually utilising Microsoft Teams.

The Terms of Reference requires that all members of the committee attend a minimum of 75% of the meetings held. The table at appendix 1 lists the names of the members of the Committee and the meetings they attended during 2020/21 together with the names of senior management who were invited to attend during the year. The majority of members attended 75% or more of the meetings during 2020/21. This appendix will be updated post meeting so that a full 2020/21 picture can be provided to the Board.

Key Achievements / Activity

The key items discussed and reviewed by the Committee during 2020/21 were as follows:

Covid-19 Update

At the beginning of the pandemic, the Committee received an in-depth position update with regards to supporting and managing the workforce in response to the coronavirus situation. Confirmation was provided that safe staffing levels were being maintained and it was noted that the workforce had responded positively to the challenges and demonstrated high levels of flexibility and cross-team working.

Subsequent meetings also received assurance regarding the Trust's response to the pandemic. In June 2020, the Committee was assured by compliance checks undertaken against the MIAA People Governance Checklist and noted the significant action undertaken to support and respond to concerns raised by the BAME workforce.

In November 2020, The Committee received an in-depth report which detailed the impact Covid-19 had upon clinical staffing, educational training, and rota gaps.

Putting People First Strategy 2019/24 Annual Review

The Committee was assured by the in-depth appraisal of achievements against the putting people first strategy during its first year. The Committee endorsed the proposed approach for 2020/21.

NHS Staff Survey 2019 Results and Action plan

The Committee considered the Annual Staff Survey results and subsequent action plans. The Committee supported a focus for 2020/21 regarding the quality of appraisals.

Workforce Key Performance Indicators (KPIs)

The Committee receives a regular report on the Workforce KPIs. Work has progressed throughout the year to improve the report to ensure that it better aligns with the key areas of focus within the workforce domain.

The key areas of attention during 2020/21 related to mandatory training compliance (particularly clinical safety issues) and sickness absence. A detailed review on the latter which included mitigating strategies was received in January 2021.

Service Workforce Assurance Risk Report: Corporate Services

In June 2020, the Committee received a workforce assurance report from corporate services, including Estates & facilities, Finance, HR, Governance and IT & Information teams. Following a request, the Committee received a 'deepdive' review into recurring themes within this area in September 2020.

Whistleblowing Annual report

The Committee was assured by the update provided by the Freedom to speak up guardian. For the 2020/21 report, the Committee suggested a broader focus that includes whistleblowing received following other procedures, e.g. to the Senior Independent Director; to external regulators etc.

Bi-Annual Safe Staffing Review nursing and midwifery

The Committee received the bi-annual report in June 2020 and January 2021 which provided assurance that nurse/midwife staffing levels were safe and appropriate.

Director of Medical Education Annual Report

The Committee was assured that the Trust was compliant with NICE guidelines and standards.

Communications, marketing and Engagement Strategy Action plan 2020/21

The Committee noted action being undertaken to achieve strategy objectives during 2020/21.

Fair and Just Culture Project Update

In June 2020, the Committee received an in-depth update detailing the progress made into year 3 of the project. The Committee noted the link between the Fair and Just Culture Project with other initiatives, e.g. Freedom to Speak up guardian role; and the Leadership Strategy.

Overview of PPF Year 2 Strategy and Correlation with the NHS People Plan

The Committee noted the alignment between the NHS People Plan and the PPF Strategy and was assured that the Trust was meeting the requirements of the NHS People Plan.

Staff Stories

The Committee continued to receive regular staff stories at meetings to provide a 'first hand' insight of the staff experience.

Update on EDS2, WRES and WDES Data including Covid BAME lookback

The Committee received a detailed report noting that WRES and WDES data illustrated that the Trust compared favourably in many indicators compared with other Trusts, however limited progress had been made to change the cultural make-up of the organisation. This would be an area of focus for the organisation.

A review of Staff Engagement Methods and Outcomes at LWH

The Committee noted the ongoing work in respect to staff engagement and was assured that action was being focused in the correct areas.

Leadership & Talent Strategic Framework Update:

The Committee approved the initial proposals in relation to the development of the Leadership and Talent Strategic Framework to support the achievement of the PPF Strategy.

Medical Appraisal & Revalidation Annual Report 2019/20

The Committee noted the report and approved the statement of compliance confirming that the organisation as a designated body was in compliance with the regulations.

Pharmacy Revalidation Annual Report

The Committee noted the report and was assured that revalidation in the pharmacy department was in line with the requirements of the relevant professional body.

Analysis of Disciplinary, Grievance and DAW Cases for 2019/20

The Committee noted the report and was assured that disciplinary, grievance and dignity at work matters are dealt with appropriately in the Trust.

Guardian of Safe Working Hours (Junior docs) Annual Report 2019/20

The Committee noted the contents of both the annual report and was assured that doctors in training at Liverpool Women's NHS FT were safely rostered and enabled to work hours that are safe and in compliance with their contract. Quarterly update reports were received throughout the year.

Outsourced Services Contract Review

The Committee approved the continued use of shared services, working in partnership with larger local NHS organisations which provide effective and cost-efficient solutions.

Service Workforce Assurance & Risk Report: Neonatal Services:

The Committee received the Neonatal workforce assurance report and noted no risks escalated to committee attention. The Committee was assured that the neonatal workforce was safe and sustainable.

Mid-Year Review

The Covid-19 pandemic has increased pressures across the NHS and on 28th March 2020 NHSE/I, issued guidance regarding 'Reducing burden and releasing capacity at NHS providers to manage the COVID-19 pandemic'. This provided advice regarding governance, meetings, reporting and assurance, among other issues. There were several recommendations contained within this guidance which mainly related to the streamlining of governance arrangements to ensure that there was a focus of resources onto front-line clinical care. At the time, there was agreement that the Trust had sufficient capacity to continue with existing governance arrangements but to also explore mechanisms to streamline agendas and items for discussion either through deferment or the use of a 'consent agenda'. This was mainly with the intention of wanting to reduce the burden on front line staff but was also in recognition of the limitations of virtual meetings. When this decision was taken, it was agreed that the Board's Committees would review their practice at a six-monthly interval to consider whether any amendments were required and to identify whether there were any risks posed by items that had been deferred or not considered.

This review was undertaken in November 2020 and concluded that the Putting People First Committee had worked broadly in line with the plan established at the beginning of 2020/21 and no additional risks as a result of the approach taken to meeting management since the pandemic began have been identified. In reaching this conclusion, it was noted that no meetings had been cancelled in the year and that no risks had been posed by items that had been removed or deferred. This has continued to be the case for the second half the year.

Areas for Development

For the first time, an effectiveness survey was circulated to members of the Committee seeking feedback on the activity of the Committee during 2020/21. On the whole, the responses received were positive – the full results can be seen in Appendix 2. One narrative comment received noted the importance of continually reviewing the quality of the reports received by the Committee, particularly in relation to the assurance provided. This work will form part of a wider effort across the Trust to strengthen reporting within both the performance management and assurance frameworks.

One area that has been explored during 2020/21 has been the use of 'deepdives' either into performance areas of particular concern or into themes identified as important to the Committee. These have worked effectively, and it is aimed to provide space on agendas during 2021/22 to undertake further 'deepdive' reviews.

Proposed Amendments to the Terms of Reference

The Committee last reviewed its Terms of Reference in March 2020 and were approved by the Board in April 2020. It is proposed that the frequency of meetings increase from five to six a year. This enables a meeting in March to be held which aligns the Committee with other Board level Committees and supports the year-end reporting process.

The draft Terms of Reference is included at Appendix 3.

Proposed Amendments to the Committee Business Cycle

Each of the Committees established by the Board of Directors has an annual business cycle which is subject to review each year. The business cycle forms the 'core' agenda for Committee meetings throughout the year with scheduled business ensuring that the Committee discharges its responsibilities as set out in the Terms of Reference.

The Putting People First Committee last reviewed its annual business cycle in March 2020 and is therefore scheduled to complete a further review in order to set the business cycle for 2021/22.

All members of the Putting People First Committee had the opportunity to participate in the annual review and propose any amendments to the business cycle and terms of reference during February 2021 by completing the committee effectiveness survey. The Committee members who responded did not make any suggested amendments to the business cycle or terms of reference.

In addition to the survey, discussions had been held between the Committee Chair, Chief People Officer, Deputy Director of Human Resources and Trust Secretary to consider means to enhance Committee effectiveness.

The Committee members suggested the following amendments to the business cycle:

- Inclusion of Medical Workforce as a reporting service to provide workforce assurance and staff story – annual
- Inclusion of HEE Quality Framework Annual Assessment in replacement of HENW Educational Standards Audit - annual
- Inclusion of staff listening events update – bi-annual
- Inclusion of Flu Campaign update – annual
- Amalgamation of the Whistleblowing annual report with the Freedom to Speak Up Guardian annual report – annual
- Improved alignment of Equality, Diversity and Inclusion reports

It is likely that key areas of attention during 2021/22 will be as follows:

- To continue to support the five-year People Strategy and seek progress reports on a regular basis.
- To analyse trend data arising from the monthly KPI data and workforce planning reviews and again identify and mitigate any risks.
- To seek assurance that staff remained supported during the Covid-19 recovery
- To seek assurance that progress is being made to improve the Trust's sickness absence rates
- To seek assurance that the actions identified from the 2020 Staff Survey are being progressed
- Seek assurance that the Trust is making progress against its Equality, Diversity and Inclusion objectives
- To support the Trust's response to the Ockenden Report by seeking assurance that the Trust can identify any negative cultural issues and take any necessary action in response
- To support the Trust's progress against achieving the Continuity of Carer target through providing assurance on related workforce issues.

The draft Business Cycle is included at Appendix 4.

Conclusion

In the final analysis, it is concluded that the Putting People First Committee has achieved its objectives for the Financial Year 2020/21.

Jo Moore CHAIR
Putting People First Committee
April 2021

Appendix 1

Putting People First Committee, Attendance at Committee: April 2020 – March 2021

Committee Member	Job Title	April 2020	June 2020	Sep 2020	Nov 2020	Jan 2021	March 2021	% attendance
Tony Okotie	(CHAIR) Non-executive director (until Aug 2020)	✓	✓	NM				
Jo Moore	(CHAIR) Non-executive director (as of Sept 2020)	✓	✓	✓	✓	✓		
Dr Susan Milner	Non-executive director	✓	✓	✓	✓	✓		
Tracy Ellery	Non-Executive director (joined Sept 2020)	NM		✓	✓	✓		
Michelle Turner	Chief People Officer	✓	✓	✓	✓	✓		
Caron Lappin	Director of Nursing & Midwifery (until Aug 2020)	Ap	Ap	NM				
Gaynor Hales	Interim Director of Nursing & Midwifery (from April 2020 – Nov 2020)	✓	✓	AP	NM			
Marie Forshaw	Director of Nursing & Midwifery (as of Jan 2021)	NM				✓		
Gary Price	Chief Operating Officer	✓	✓	AP	✓	✓		
Dan Nash*	General Manager (Representing COO)			✓				
Claire Scott	Senior Finance Manager	✓	Ap	AP	AP	✓		
Kathryn Wooder*	Finance (Representing finance member)			✓	✓			
Victoria McKay	Medical Staff Committee Chair	✓	✓	✓	✓	AP		
Liz Collins	Staff Side Chair	✓	✓	✓	✓	✓		

Appendix 2

Putting People First Committee Effectiveness Survey

5	02:31	Active
Responses	Average time to complete	Status

1. I understand the duties of the committee.

Strongly agree	4
Agree	1
Disagree	0
Strongly disagree	0
Unable to answer	0

2. I believe the committee receives sufficient assurance to conclude upon its areas of responsibility.

Strongly agree	0
Agree	5
Disagree	0
Strongly disagree	0
Unable to answer	0

3. I am confident that the committee effectively monitors and scrutinises progress against the aligned strategies.

Strongly agree	0
Agree	5
Disagree	0
Strongly disagree	0
Unable to answer	0

Appendix 2

4. I am content that the committee is delivering the right level of assurance to the Board / Committee.

Strongly agree	0
Agree	5
Disagree	0
Strongly disagree	0
Unable to answer	0

5. I believe that the committee effectively seeks assurance that the Trust complies with its own policies, all relevant external regulation and standards of governance and risk management.

Strongly agree	1
Agree	4
Disagree	0
Strongly disagree	0
Unable to answer	0

6. I feel that the committee has the right balance of experience, attendance, knowledge and skills to fulfil its role.

Strongly agree	1
Agree	4
Disagree	0
Strongly disagree	0
Unable to answer	0

7. The committee has structured its agenda and work plan to cover its key responsibilities.

Strongly agree	3
Agree	2
Disagree	0
Strongly disagree	0
Unable to answer	0

Appendix 2

8. The committee is effectively chaired.

Strongly agree	1
Agree	4
Disagree	0
Strongly disagree	0
Unable to answer	0

9. All members of the committee are able to participate effectively.

Strongly agree	2
Agree	3
Disagree	0
Strongly disagree	0
Unable to answer	0

10. There is clarity in relation to the work of the committee and its interaction and alignment with other committees.

Strongly agree	1
Agree	4
Disagree	0
Strongly disagree	0
Unable to answer	0

Appendix 3

PUTTING PEOPLE FIRST COMMITTEE
TERMS OF REFERENCE

Constitution:	The Committee is established by the Board of Directors and will be known as the Putting People First Committee (the Committee).
Duties:	The Committee is responsible for: a. Developing and overseeing implementation of the Trust's People Strategy (integrated workforce, wellbeing and organisational development strategy) and plan and providing assurance to the Board of Directors that this is being delivered in line with the annual planning process b. Oversight of the strategic implementation of multi-disciplinary education and training and gaining assurances that the relevant legislative and regulatory requirements are in place (Education Governance Committee) c. Approving, monitoring and reviewing policies, procedures and guidance documents relating to the management of the Trust's workforce d. Monitoring and reviewing workforce key performance indicators to ensure achievement of the Trust's strategic aims and escalate any issues to the Board of Directors e. Reviewing any changes in practice required following any internal enquiries that significantly impact on workforce issues f. Oversight of the strategic implementation and monitoring of staff engagement levels as evidenced by the results of the national and any other staff surveys g. Reviewing and approving partnership agreements with staff side h. Ensuring that the Trust fulfils all legislative and regulatory requirements pertaining to workforce and organisational development issues i. Monitor and evaluate compliance with the public sector equality duty and delivery of equality objectives to improve the experience of staff with protected characteristics j. Approving the terms of reference and membership of its reporting groups and overseeing the work of those groups, receiving reports from them for consideration and action as necessary and routinely receiving the minutes of their meetings k. Receipt and review of relevant risks (including those referred from other Committees or subcommittees) concerned with workforce and organisational development matters as identified through the Board Assurance Framework. Monitor progress made in mitigating those risks, identifying any areas where additional assurance is required, escalating to the Board of Directors as required.

	l. Receiving and considering issues from other Committees when appropriate and taking any necessary action.
Membership:	The Committee membership will be appointed by the Board of Directors and will consist of: • Non-Executive Director (Chair) • 2 other Non-Executive Director • *Chief People Officer • *Director of Nursing & Midwifery • *Chief Operating Officer • Staff Side Chair • Medical Staff Committee representative • Senior Finance Manager *or their nominated representative who will be sufficiently senior and have the authority to make decisions. Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. The Board of Directors will appoint a Non-Executive Director as Chair of the Committee. Should the Chair be absent from a meeting of the Committee, the Committee may appoint a Chair of the meeting from amongst the Non-Executive Directors present.
Quorum:	A quorum shall be four members including: • The Chair or at least one other Non-Executive Director • At least one from either Director of Workforce and Marketing or Director of Nursing and Midwifery • Director of Operations or their Deputy • Either Staff Side Chair or Medical Staff Committee representative
Voting:	Each member will have one vote with the Chair having a second and casting vote, if required. Should a vote be necessary a decision will be determined by a simple majority.
Attendance:	**a. Members** Members will be required to attend a minimum of 75% of all meetings. **b. Officers** HR & OD Senior Team, Education Governance Chair, and a representative from the Nursing & Midwifery Board shall normally attend meetings.

	Members may send a nominated representative to attend meetings on their behalf when they are not available, provided they are sufficiently senior and have the authority to make decisions. Other executive directors, officers and staff of the Trust will be invited to attend the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed. Representatives from partner organisations or other external bodies may be invited to attend as appropriate. Such representatives will not have voting rights.
Frequency:	Meetings shall be held at least 6 times per year. Additional meetings may be arranged from time to time, if required, to support the effective functioning of the Trust.
Authority:	The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of representatives from partner organisations or other external bodies or organisations with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities.
Accountability and reporting arrangements:	The Putting People First Committee will be accountable to the Board of Directors. A Chair's Report will be submitted to the subsequent Board of Directors for assurance. Approved minutes will be made available to all Board members upon request. Approved chairs reports will also be circulated to members of the Audit Committee. The Committee will report to the Board annually on its work and performance in the preceding year. Trust standing orders and standing financial instructions apply to the operation of the Putting People First Committee.
Reporting Committees and Groups	The sub committees/groups listed below are required to submit the following information to the Committee: a) Chairs Report; b) an Annual Report setting out the progress they have made and future developments;

Appendix 3

	c) Terms of reference The following sub committees/groups will report directly to the Committee: • Diversity & Inclusion Committee • Health & Wellbeing Committee • Partnership Forum • Nursing & Midwifery Professional Forum • Educational Governance Committee • Joint Local Negotiating Committee
Monitoring effectiveness:	The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements.
Review:	These terms of reference will be reviewed at least annually by the Committee.
Reviewed by Putting People First Committee:	22 March 2021
Approved by Board of Directors:	*[01 April 2021]*
Review date:	March 2022
Document owner:	Mark Grimshaw, Trust Secretary Email: mark.grimshaw@lwh.nhs.uk Tel: 0151 702 4033

Appendix 4

Work Programme

Putting People First Committee				WORKPLAN 2021/22				
			Quarter 1	Quarter 2		Quarter 3	Quarter 4	
	Executive / Senior Owner	Reports up to Board	17 May 2021	19 July 2021	20 Sept 2021	15 November 2021	17 January 2022	21 March 2022
Standing Items								
Minutes of Previous meeting	TS		✓	✓	✓	✓	✓	✓
Actions/Matters Arising	TS		✓	✓	✓	✓	✓	✓
Chairs Report - Verbal	Chair		✓	✓	✓	✓	✓	✓
Review of risk impacts of items discussed	Chair		✓	✓	✓	✓	✓	✓
Any other business	Chair		✓	✓	✓	✓	✓	✓
Review of meeting	Chair		✓	✓	✓	✓	✓	✓
Review of BAF risks: Workforce related risks	CPO	✓	✓	✓	✓	✓	✓	✓
Workforce KPI Dashboard Report	DDoW		✓	✓	✓	✓	✓	✓
Director of Workforce Report	CPO		✓	✓	✓	✓	✓	✓
Policies for Approval & Policy Audit Update	DDoW		✓	✓	✓	✓	✓	✓
To develop a well led, capable, and motivated workforce								
Service Workforce Assurance & Staff Story	DoO / DDoW		Medical workforce	Corporate		Family Health	Clinical Support Services	Gynaecology & Hewitt
Talent Management & Leadership Development Review	DDoW			✓				
HEE Quality Framework Annual Assessment	Head of Learning / DoME				✓			
Director of Medical Education Annual Report	DoME							✓

Medical Appraisal & Revalidation Annual Report	MD	✓			✓			
Pharmacy Revalidation Annual Report	MD				✓			
Freedom to Speak Up Guardian Update	F2SUG				✓			✓
Staff Listening Events Report (to Board)	DDoW	✓		✓				✓
Flu Campaign	DDoW	✓			✓			
To be efficient and make best use of available resources								
Review of External Contracts	DDoW				✓			
Disciplinary and Grievance processes annual review	DDoW			✓				
Workforce Planning Return	DDoW							✓
Freedom to Speak Up Guardian Annual Report including Whistleblowing	F2SUG	✓						✓
Bi-Annual Safer Staffing Review	DoNM	✓		✓			✓	
To deliver the most effective outcomes								
Equality, Diversity and Inclusion Annual Report inlcuding Equality Objectives	DDoW	✓						✓
Equality, Diversity and Inclusion including WRES/WDES/Gender Pay Gap	DDoW			✓		✓		✓
Putting People First Strategy 2019-2024 Annual Review (including Volunteer workforce)	DDoW	✓						✓
Communications, Marketing and Engagement Strategy Annual Review	CPO							✓
Nursing, Midwifery & AHP Framework Annual Review	DoNM	✓						✓
To deliver the best possible experience for patients and our staff								
Staff Engagement and NHS Staff Survey Annual Results & Action Plan	Head of Culture, Inclusion, Wellbeing & Engagement	✓ (annual)			✓ (bi-annual)			✓ (annual)

Appendix 4

Fair and Just Culture Update	Head of Culture, Inclusion, Wellbeing & Engagement				✓			✓
Guardian of Safe Working Hours (Junior Doctors) Quarterly Report	MD / G4SWH	✓	✓ (Q4 AR)		✓ (Q1)	✓ (Q2)	✓ (Q3)	
GOVERNANCE								
Review of Risk Appetite Statement	DoNM	✓						✓
Annual review of Corporate Objectives aligned to PPF & Objective setting	CPO	✓			✓ (bi-annual)			✓ (annual & OS)
PPF Terms of reference review	TS	✓						✓
PPF Committee Annual Report	CPO / TS	✓			✓ (bi-annual)			✓
PPF Business Cycle	CPO / TS							✓
Subcommittee chairs reports and Terms of reference: • Diversity & Inclusion Committee • Health & Wellbeing Committee • Partnership Forum • Nursing & Midwifery Professional Forum • Educational Governance Committee • Joint Local Negotiating Committee			✓	✓	✓	✓	✓	✓

Liverpool Women's NHS Foundation Trust

Agenda Item	21/22/010a

MEETING	**Trust Board**
PAPER/REPORT TITLE:	Finance Performance Review Month 11 2020/21
DATE OF MEETING:	Thursday, 01 April 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):	1. This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting	
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	***The Board is asked to take assurance from the Month 11 position.***	
PREVIOUSLY CONSIDERED BY:	**Committee name**	Finance Performance and Business Development Committee
	Date of meeting	23/03/2021

Executive Summary

The Trust initially produced a breakeven plan for 20/21; this was paused at the outset of the pandemic. During the first half of the year, breakeven was achieved as costs were covered by block payments and "top up" income which matched expenditure. For the second half of the year, these top ups have reduced and are a fixed value, leading to an agreed Trust plan of a £4.6m deficit.

At month 11 the Trust is slightly ahead of this revised plan with an adjusted deficit[1] of £0.4m for the month and £3.6m year to date (YTD). The in-month improvement related largely to the receipt of £0.4m of income to cover the loss of non-NHS education income from NHSI/E. This position is after receipt of system, Covid-19 and growth top up of £0.6m per month in months 7-11 (compared with an average of £1.4m per month in months 1-6), plus a further £0.4m one off top up related to loss of non-NHS income accounted for in months 11 and 12. The forecast has improved from an adjusted deficit of £4.6m in line with plan to an adjusted deficit of £4.4m.

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

[1] The actual deficit is £3.4m YTD and forecast £4.2m 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 £3.6m YTD and £4.4m 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.

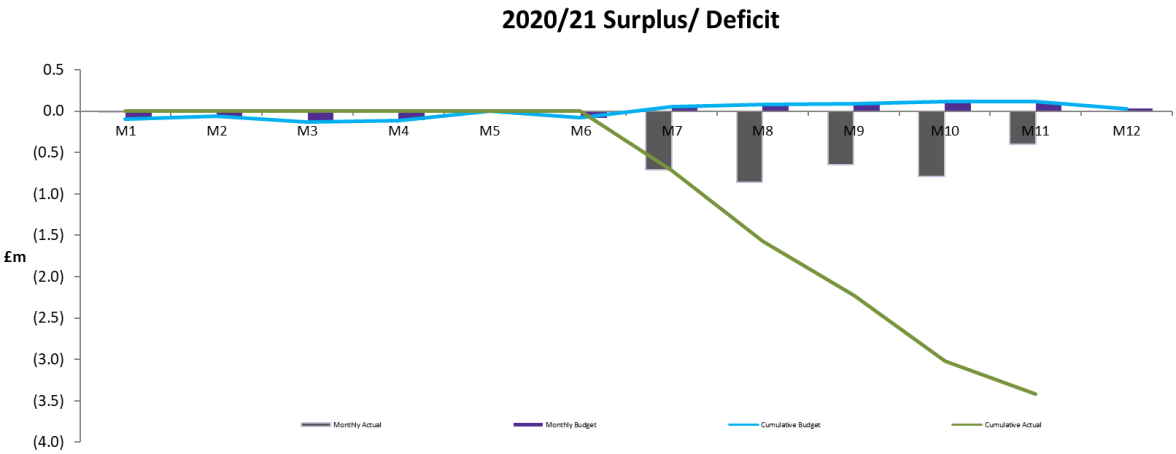
	Original Plan	Actual	Variance	RAG	*Revised Plan*	*Actuals*	*Variance v Revised Plan*	*RAG re Revised Plan*
Surplus/(Deficit) YTD	-£0.0m	-£3.6m	-£3.6m	↑	*-£4.0m*	*-£3.6m*	*£0.4m*	↑
Surplus/ (Deficit) FOT	£0.0m	-£4.4m	-£4.4m	↑	*-£4.6m*	*-£4.4m*	*£0.2m*	↑
NHS I/E Rating	3	3	0	↔	3	3	*£0.0m*	↔
Cash	£4.6m	£12.7m	£8.1m	↑	*£11.9m*	*£12.7m*	*£0.8m*	↑
Total CIP Achievement YTD	£3.3m	£1.9m	-£1.5m	↓	*£0.9m*	*£0.9m*	*-£0.0m*	↔
Recurrent CIP Achievement YTD	£3.0m	£1.5m	-£1.5m	↓	*£0.8m*	*£0.6m*	*-£0.2m*	↓
Capital Spend YTD	£3.5m	£4.0m	£0.5m		*£3.7m*	*£4.0m*	*£0.4m*	

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 agreed with the Health and Care Partnership (HCP).

Report

1. Summary Financial Position

At month 11 the Trust is reporting an actual deficit of £3.6m YTD, after total combined tops up of £11.6m YTD.



The top up has reduced to a fixed £0.6m per month in quarters three and four against an average of £1.4m per month in quarters one and two, plus a one of non-NHS income top up of £0.4m, accounted for as £0.3m in month 11 and forecast £0.1m in month 12. 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	M10 £000	M11 £000	YTD £000
Anticipated structural shortfall	780	780	780	780	780	780	780	780	780	780	780	**8,580**
Private Patient income shortfall	222	253	163	-10	63	-49	-85	23	12	16	-42	**566**
Commercial income shortfall	56	51	49	47	7	55	38	41	47	47	49	**488**
CIP under delivery	49	50	48	73	73	107	205	205	205	227	219	**1,462**
Covid-19 costs	484	409	296	361	221	191	216	175	126	300	249	**3,028**
Activity underspends - non pay	-174	-92	-106	-115	-193	-88	92	42	239	82	-404	**-717**
Activity underspends - pay	-116	-280	-75	-127	-70	10	163	136	-51	23	173	**-215**
Trust settlements					260	109	0	0	0	0	0	**369**
Other Healthcare Income	42	140	-12	82	88	96	28	57	40	47	59	**667**
Medical pay award (YTD)						109	18	18	18	18	18	**200**
Other	-18	-170	16	105	92	340	-86	32	73	-92	259	**551**
Total Retrospective	**1,325**	**1,140**	**1,159**	**1,196**	**1,322**	**1,661**	**1,369**	**1,509**	**1,490**	**1,448**	**1,359**	**14,978**
Projected	99	99	99	99	99	99	0	0	0	0	0	**592**
Total Required	**1,424**	**1,239**	**1,258**	**1,295**	**1,421**	**1,760**	**1,369**	**1,509**	**1,490**	**1,448**	**1,359**	**15,570**
Total Provided	**1,424**	**1,239**	**1,258**	**1,295**	**1,421**	**1,760**	**649**	**649**	**649**	**649**	**963**	**11,954**
Variance	**0**	**0**	**0**	**0**	**0**	**0**	**-720**	**-860**	**-841**	**-799**	**-396**	**-3,616**

The actual top up for month 11 was £1m, compared to a requirement of £1.4m, in line with previous months. The position was supported in month 11 by additional top up related to lost income.

2. Divisional Summary Overview

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 slightly overspent in month (£8k), bringing the YTD underspend to £272k.

Gynaecology: The division overspent in month (£64k), reducing the YTD underspend to £477k.

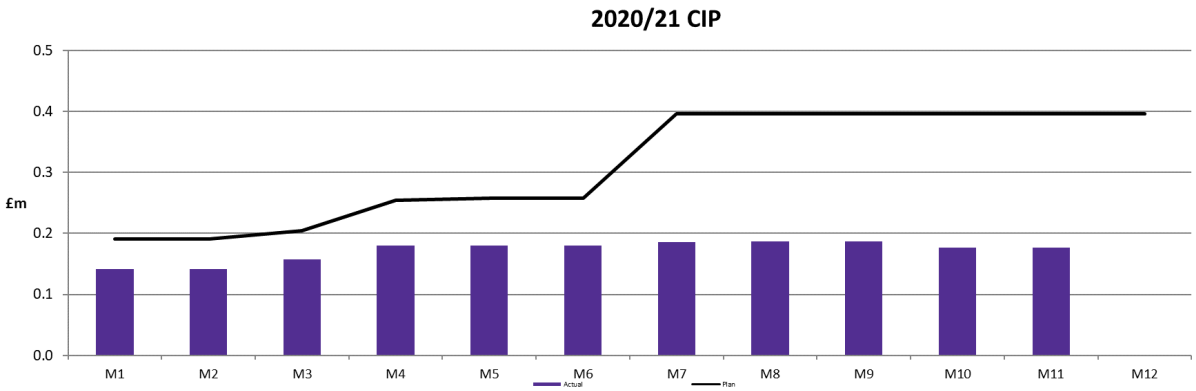
Clinical Support Services: The division was underspent in month (£85k), bringing the underspend to £580k YTD.

Agency: Total agency spend was £638k YTD, of which £325k was Covid-19 related.

3. CIP

A revised CIP forecast has been used as the basis for a plan to NHSI/E and has been reportable from month 7 onwards. This is close to plan at month 11 (£177k delivery against a revised plan of £187k) and is forecasting delivery just below the revised plan (£1,092k against a revised half-year plan of £1,103k).

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



4. COVID-19

A total of £249k was spent on Covid-19 related costs in month 11, 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	M10 £000	M11 £000	YTD £000
Bank costs to cover Covid-19 related vacancies	119	62	71	49	19	22	71	52	19	111	116	**711**
Student Nurses	0	40	49	34	17	0	0	0	0	0	0	**140**
Agency and WLI costs for medical cover	104	78	46	138	13	1	1	1	3	-32	15	**369**
PPE and equipment (excluding centrally purchased)	69	24	13	73	61	23	10	5	6	1	3	**288**
Enhancements paid to staff off sick	58	26	13	19	18	16	31	23	17	35	25	**281**
Staff meals (after £15k charity contribution)	28	60	0	0	0	0	0	0	0	0	0	**88**
Other catering and cleaning	32	33	37	15	26	22	30	30	28	21	24	**298**
Swabbing, Lateral Flow and Vaccination Costs					17	21	22	23	27	71	39	**220**
Additional corporate costs	9	22	27	18	11	17	24	13	14	60	0	**216**
Telephony						29	3	3	3	3	3	**41**
LUHFT - Breast Surgery								3	6	2	2	**13**
Other	67	62	41	15	39	40	25	23	2	27	21	**362**
Total	**486**	**408**	**296**	**361**	**221**	**191**	**216**	**175**	**124**	**300**	**249**	**3,027**

Costs in this area continue to be carefully monitored.

5. Cash and Borrowings

Cash increased in month 11 to £12.7m, despite the Trust being in deficit. No cash support is required in the current financial year despite the deficit position, and with the year end cash forecast standing at nearly £10m, the Trust has a good level of resilience at least for the first months of 2021/22.

6. Capital Expenditure

The capital plan is on plan year to date and at present is forecast to deliver on plan for the full year. There will be significant spend in March; a number of large items have been ordered and arrangements are in place to secure ownership of equipment including the surgical robot.

7. Balance Sheet

Debtors reduced again with continued work on the aged debt position. Attention has also been placed on settling creditor disputes. A number of accounts have been settled or largely settled including some long-standing issues.

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.

8. Forecast

The forecast moved to be slightly ahead of plan in month 11, to and actual deficit of £4.2m and an adjusted deficit, against which the Trust is measured, of £4.4m.[4]

The reasons for this improvement are that the annual leave accrual has increased by £0.2m, but this is offset by funding for loss of non-NHS income by NHSI/E of £0.4m.

9. BAF Risk

There are no changes proposed to BAF risk 2344 (in-year financial position), which stands at 20 (likelihood at 5 – almost certain and severity at 4 - major). At this stage the Trust is achieving its revised plan and the risk of further deterioration is small, however the position will be a deficit against the original breakeven plan.

10. Conclusion & Recommendation

At this stage in the year there is little risk to achievement of the year end position, and the Trust expects to end the year slightly ahead of the revised plan with an adjusted deficit of £4.4m. Work is clearly focussed on planning for 2021/22.

The Board is asked to note the position and take assurance from it.

[4] This largely relates to donated asset income and depreciation which are adjusted out by NHSI/E when monitoring financial performance.

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

FINANCE REPORT: M11

YEAR ENDING 31 MARCH 2021

Liverpool Women's NHS Foundation Trust

Contents

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 1
NHS IMPROVEMENT RATIOS: M11
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	2,971	3,570
(b) PDC + Interest Payable + Loans Repaid	2,466	2,465
CSC Ratio = (a) / (b)	**1.20**	**1.45**
NHSI CSC SCORE	**4**	**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	(14,908)	(13,455)
(b) Expenditure	108,962	108,705
(c) Daily Expenditure	326	325
Liquidity Ratio = (a) / (c)	**(45.7)**	**(41.3)**
NHSI LIQUIDITY SCORE	**4**	**4**
Ratio Score 1 = > 0 2 = (7) - 0 3 = (14) - (7) 4 = < (14)		
I&E MARGIN		
Deficit (Adjusted for donations and asset disposals)	4,043	3,591
Total Income	(111,934)	(112,275)
I&E Margin	**-3.6%**	**-3.2%**
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)		-3.20%
I&E Margin (Plan)		-3.60%
I&E Variance Margin	**0.00%**	**0.40%**
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	1,639	1,639
YTD Agency Expenditure	619	638
	-62%	**-61%**
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: M11
YEAR ENDING 31 MARCH 2021

INCOME & EXPENDITURE £'000	M11 - NHSI Plan			M11 - Internal Budget			YTD - NHSI Plan			YTD - Internal Budget			YEAR - NHSI Plan			YEAR - Internal Budget		
	NHSI Plan	Actual	Variance	Budget	Actual	Variance	NHSI Plan	Actual	Variance	Budget	Actual	Variance	NHSI Plan	Forecast	Variance	Budget	Forecast	Variance
Income																		
Clinical Income	(9,292)	(9,706)	414	(9,379)	(9,706)	328	(105,658)	(106,062)	404	(102,975)	(106,062)	3,086	(115,160)	(116,186)	1,025	(112,354)	(116,186)	3,832
Non-Clinical Income	(564)	(615)	51	(699)	(615)	(84)	(6,276)	(6,214)	(62)	(7,640)	(6,214)	(1,426)	(6,840)	(6,713)	(127)	(8,339)	(6,713)	(1,626)
Total Income	**(9,856)**	**(10,322)**	**465**	**(10,078)**	**(10,322)**	**244**	**(111,934)**	**(112,275)**	**342**	**(110,615)**	**(112,275)**	**1,660**	**(122,000)**	**(122,898)**	**898**	**(120,693)**	**(122,898)**	**2,205**
Expenditure																		
Pay Costs	6,257	6,378	(121)	5,960	6,378	(418)	68,323	68,098	226	65,709	68,098	(2,389)	74,581	74,743	(161)	71,670	74,743	(3,073)
Non-Pay Costs	2,425	2,398	27	2,137	2,398	(261)	26,373	26,341	32	24,146	26,341	(2,195)	28,779	29,174	(395)	26,283	29,174	(2,891)
CNST	1,297	1,297	(0)	1,297	1,297	(0)	14,266	14,266	(0)	14,266	14,266	(0)	15,563	15,563	(0)	15,563	15,563	(0)
Total Expenditure	**9,979**	**10,073**	**(94)**	**9,394**	**10,073**	**(679)**	**108,962**	**108,705**	**257**	**104,122**	**108,705**	**(4,583)**	**118,924**	**119,480**	**(557)**	**113,516**	**119,480**	**(5,964)**
EBITDA	**123**	**(249)**	**372**	**(684)**	**(249)**	**(435)**	**(2,971)**	**(3,570)**	**599**	**(6,494)**	**(3,570)**	**(2,923)**	**(3,076)**	**(3,418)**	**342**	**(7,177)**	**(3,418)**	**(3,759)**
Technical Items																		
Depreciation	447	453	(6)	406	453	(47)	4,881	4,875	6	4,644	4,875	(231)	5,324	5,332	(8)	5,109	5,332	(222)
Interest Payable	5	4	1	39	4	35	51	46	5	443	46	398	56	50	6	488	50	438
Interest Receivable	0	0	0	(4)	0	(4)	0	0	0	(46)	0	(46)	0	0	0	(51)	0	(51)
PDC Dividend	192	191	1	129	191	(61)	2,109	2,113	(4)	1,482	2,113	(632)	2,301	2,306	(4)	1,630	2,306	(675)
Profit/Loss on Disposal or Transfer Absorption	0	0	0	0	0	0	(14)	(39)	25	0	(39)	39	(14)	(39)	25	0	(39)	39
Total Technical Items	**644**	**647**	**(3)**	**570**	**647**	**(77)**	**7,027**	**6,995**	**32**	**6,523**	**6,995**	**(472)**	**7,667**	**7,648**	**19**	**7,177**	**7,648**	**(471)**
(Surplus) / Deficit before Adjusting Items	**767**	**398**	**368**	**(114)**	**398**	**(512)**	**4,056**	**3,425**	**631**	**29**	**3,425**	**(3,396)**	**4,591**	**4,230**	**361**	**0**	**4,230**	**(4,230)**
Remove Income from donated assets	0	0	0	0	0	0	0	189	(189)	0	189	(189)	0	189	(189)	0	189	(189)
Add back depreciation on donated assets	(1)	(3)	2	(0)	(3)	2	(14)	(23)	9	(4)	(23)	19	(15)	(25)	10	(4)	(25)	21
Remove gain on disposable assets variance	0	0	0	0	0	0	0	25	(25)	0	39	(39)	0	25	(25)	0	39	(39)
(Surplus) / Deficit as per NHSI	**766**	**396**	**370**	**(114)**	**396**	**(510)**	**4,042**	**3,616**	**426**	**25**	**3,630**	**(3,604)**	**4,576**	**4,419**	**157**	**(4)**	**4,433**	**(4,437)**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 3
EXPENDITURE: M11
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	344	(17)	3,599	3,718	(119)	3,927	4,068	(141)
Medical	1,555	1,626	(70)	17,116	17,337	(220)	18,673	19,149	(476)
Nursing & Midwifery	2,633	2,885	(252)	29,062	31,055	(1,992)	31,695	34,025	(2,330)
Healthcare Assistants	424	466	(42)	4,661	4,849	(188)	5,084	5,323	(239)
Other Clinical	376	364	13	3,383	2,966	416	4,517	4,095	422
Admin Support	136	127	9	1,501	1,452	49	1,637	1,581	56
Corporate Services	444	523	(78)	4,931	5,316	(385)	5,375	5,812	(437)
Agency & Locum	63	43	20	1,456	1,405	51	761	689	72
Total Pay Costs	**5,960**	**6,378**	**(418)**	**65,709**	**68,098**	**(2,389)**	**71,670**	**74,743**	**(3,073)**
Non Pay Costs									
Clinical Suppplies	623	535	88	1,898	1,777	122	7,502	7,502	0
Non-Clinical Supplies	555	706	(151)	26,262	26,928	(665)	6,665	7,333	(668)
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	517	(158)	4,555	6,232	(1,677)	4,915	7,138	(2,223)
Total Non-Pay Costs	**3,434**	**3,695**	**(261)**	**38,412**	**40,607**	**(2,195)**	**41,847**	**44,738**	**(2,891)**
Total Expenditure	**9,394**	**10,073**	**(679)**	**104,122**	**108,705**	**(4,583)**	**113,516**	**119,480**	**(5,964)**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 4a
COVID EXPENDITURE: M11
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	2	(2)	0	36	(36)	0	50	(50)
Medical	0	2	(2)	0	169	(169)	0	170	(170)
Nursing & Midwifery	0	126	(126)	0	1,051	(1,051)	0	1,201	(1,201)
Healthcare Assistants	0	25	(25)	0	290	(290)	0	328	(328)
Other Clinical	0	1	(1)	0	7	(7)	0	7	(7)
Admin Support	0	28	(28)	0	152	(152)	0	173	(173)
Corporate Services	0	0	0	0	0	0	0	0	0
Agency & Locum	0	15	(15)	0	325	(325)	0	340	(340)
Total Pay Costs	**0**	**198**	**(198)**	**0**	**2,029**	**(2,029)**	**0**	**2,268**	**(2,268)**
Non Pay Costs									
Clinical Suppplies	0	2	(2)	0	117	(117)	0	119	(119)
Non-Clinical Supplies	0	3	(3)	0	404	(404)	0	413	(413)
CNST	0	0	0	0	0	0	0	0	(0)
Premises & IT Costs	0	45	(45)	0	472	(472)	0	513	(513)
Service Contracts	0	0	0	0	5	(5)	0	5	(5)
Total Non-Pay Costs	**0**	**50**	**(50)**	**0**	**998**	**(998)**	**0**	**1,050**	**(1,050)**
Total Expenditure	**0**	**249**	**(249)**	**0**	**3,027**	**(3,027)**	**0**	**3,318**	**(3,318)**

Note that the values above include £51k YTD and £97k in the FOT related to Vaccination expenditure and £2k YTD and £3k in the FOT for Nightingale incremental costs which should both be reimbursed.

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 4b
COVID EXPENDITURE: M11
YEAR ENDING 31 MARCH 2021

Type	Description	£'s April	£'s May	£'s June	£'s July	£'s August	£'s September	£'s October	£'s November	£'s December	£'s January	£'s February	Details
Pay Related Costs													
	3rd Year Students	0	40,272	48,783	33,639	17,080	0	0	0	0	0	0	Ceased August 2020
	Agency Medical	44,366	37,886	43,360	52,618	10,555	0	0	0	0	0	0	Ceased August 2020
	Agency Sonographer	840	3,575	2,658	0	0	0	0	0	0	0	0	Ceased June 2020
	Agency IT Staff	2,717	5,083	15,470	12,966	9,732	8,809	10,935	11,070	11,070	11,379	14,560	Additional staff to support working from home and virtual requirements
	Bank costs	119,698	63,063	70,802	49,242	19,240	21,627	71,173	51,747	19,028	110,922	116,310	To backfill Covid related absences.
	Corporate Support	3,149	8,098	5,085	7,089	1,304	261	12,682	2,157	2,478	48,362	9,522	Estates, Admin, HR, Finance, Operational Management and Procurement
	Enhancements	58,338	26,368	12,544	19,019	18,485	15,931	30,818	22,608	17,113	35,082	24,895	Paid to staff isolating/off-sick as per NHS Employers guidance.
	Infection Control Team	5,608	5,022	2,405	2,406	2,240	2,427	2,247	2,258	2,207	2,207	2,207	Additional measures
	Junior Doctors	45,027	33,606	0	73,472	(0)	(0)	0	885	(0)	(35,670)	138	Additional support and annual leave payments
	Medical Staffing - Sickness Cover	16,256	2,930	2,400	11,860	2,058	1,356	1,404	300	3,000	3,971	654	WLI payments within Anaesthetics and Neonates
	Other Pay	3,688	3,283	88	0	0	0	134	541	222	637	372	Overtime and additional support
Non-Pay Related Costs													
	Accommodation - NICU Parents	17,250	17,250	12,144	0	0	0	0	0	0	0	0	Hotel accomodation. Ceased June 2020
	Accommodation - Staff	1,775		1,720	28	0	143	(71)	0	0	0	0	Staff accomodation
	Drug Costs	0	0	0	30,000	0	0	0	0	4,342	10,460	5,352	Due to changes in legislation
	Estates Work	975	0	1,140	3,995	19,378	5,612	698	7,721	2,897	(1,110)	3,065	Building works and various equipment
	IT Equipment	(5,282)	7,542	8,272	2,966	6,316	186	3,303	842	961	(845)	0	Equipment to assist with remote and virtual working
	OCS (Free food for Staff)	28,034	60,131	0	0	0	0	0	0	0	0	0	Ceased May 2020
	OCS (Security)	0	0	0	8,689	5,095	13,750	8,217	8,815	9,860	14,342	11,006	To support front door cover
	OCS (Decontamination)	31,741	32,575	24,437	26,423	11,620	11,930	13,168	17,981	9,127	17,475	14,861	Additional cleaning requirements
	OCS (Other)	3,414	5,703	12,764	(19,819)	8,809	(3,615)	9,043	3,523	8,839	(10,837)	9,270	Healthy snack for patients
	PPE & Equipment	82,751	24,952	17,345	32,322	59,303	23,256	9,511	4,452	(7,231)	(9,458)	(3,408)	Various PPE and procurement
	PPE Storage/Gazebo Covid testing station	69	0	2,936	14,312	9,308	17,653	18,583	12,376	12,359	27,170	6,847	PPE Storage Hire and rental units
	Public Advisory	0	0	50	0	0	8,162	0	0	0	0	0	Public information/advice
	Systems to support remote patient access	0	0	0	0	3,475	6,000	0	0	0	0	0	Vcreate & Intouch App
	Telephony Charges	0	0	0	0	0	28,782	2,500	2,500	2,500	2,500	2,500	Telephony costs to support wfh
	Travel - NICU Parents	0	222	32	0	0	0	0	0	0	0	0	NICU parents
	Other	1,899	751	0	0	0	0	0	0	(45)	0	0	Training
Other													
	Vaccination Costs	0	0	0	0	0	0	0	0	0	46,882	3,668	Vaccination programme costs
	Swabbing & Lateral Flow	0	0	0	0	17,225	21,160	22,006	22,507	26,093	23,489	23,380	Swabbing Service & Lateral Flow Team established
	Nightingale	0	0	0	0	0	0	0	0	0	548	1,095	Incremental costs of backfill from W.C 16th Feb
	Mutual Aid (other Trusts)	0	0	0	0	0	0	0	2,960	5,577	2,416	2,209	Breast and Colorectal support
	Crown Ward	1,110	834	1,018	0	1,053	206	0	0	0	0	0	Capacity to support geriatric referrals from LUHFT
	Royal Ward	20,985	29,412	10,715	50	137	0	0	0	0	0	0	Capacity to support geriatric referrals from LUHFT
TOTAL		**484,409**	**408,556**	**296,169**	**361,276**	**222,414**	**183,637**	**216,351**	**175,243**	**130,396**	**299,922**	**248,503**	

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 5
BUDGET ANALYSIS: M11 as per ledger
YEAR ENDING 31 MARCH 2021

INCOME & EXPENDITURE £'000	MONTH Budget	MONTH Actual	MONTH Variance	YEAR TO DATE Budget	YEAR TO DATE Actual	YEAR TO DATE Variance	YEAR - Internal Budget	YEAR - Internal Actual	YEAR - Internal Variance
Maternity									
Income	0	(4)	4	0	(45)	45	0	(49)	49
Expenditure	1,889	1,918	(29)	20,782	21,069	(288)	22,671	22,991	(320)
Total Maternity	**1,889**	**1,914**	**(25)**	**20,782**	**21,024**	**(243)**	**22,671**	**22,942**	**(271)**
Neonatal									
Income	0	(81)	81	0	(869)	869	0	(948)	948
Expenditure	1,127	1,191	(64)	12,394	12,748	(355)	13,520	13,954	(433)
Total Neonatal	**1,127**	**1,110**	**17**	**12,394**	**11,879**	**514**	**13,520**	**13,006**	**514**
Division of Family Health - Total	**3,016**	**3,024**	**(8)**	**33,175**	**32,903**	**272**	**36,191**	**35,948**	**244**
Gynaecology									
Income	0	0	0	0	0	0	0	0	0
Expenditure	1,033	1,109	(76)	11,364	11,284	80	12,397	12,384	13
Total Gynaecology	**1,033**	**1,109**	**(76)**	**11,364**	**11,284**	**80**	**12,397**	**12,384**	**13**
Hewitt Centre									
Income	0	0	(0)	0	(1)	1	0	(1)	1
Expenditure	689	677	12	7,606	7,210	396	8,296	7,979	317
Total Hewitt Centre	**689**	**677**	**12**	**7,606**	**7,209**	**397**	**8,296**	**7,978**	**318**
Division of Gynaecology - Total	**1,722**	**1,787**	**(64)**	**18,970**	**18,492**	**477**	**20,693**	**20,361**	**331**
Theatres									
Income	0	0	0	0	0	0	0	0	0
Expenditure	712	640	72	7,951	7,544	407	8,663	8,294	369
Total Theatres	**712**	**640**	**72**	**7,951**	**7,544**	**407**	**8,663**	**8,294**	**369**
Genetics									
Income	0	(13)	13	0	(160)	160	0	(178)	178
Expenditure	151	141	10	1,665	1,579	86	1,816	1,722	94
Total Genetics	**151**	**128**	**24**	**1,665**	**1,419**	**246**	**1,816**	**1,545**	**272**
Other Clinical Support									
Income	0	(0)	0	0	0	(0)	0	0	(0)
Expenditure	602	613	(11)	6,736	6,808	(72)	7,338	7,428	(90)
Total Clinical Support	**602**	**613**	**(11)**	**6,736**	**6,808**	**(72)**	**7,338**	**7,428**	**(90)**
Division of Clinical Support - Total	**1,466**	**1,380**	**85**	**16,352**	**15,772**	**580**	**17,817**	**17,266**	**551**
Corporate & Trust Technical Items									
Income	(10,078)	(10,223)	146	(110,615)	(111,200)	585	(120,693)	(121,722)	1,029
Expenditure	3,760	4,431	(671)	42,147	47,457	(5,310)	45,992	52,377	(6,385)
Total Corporate	**(6,318)**	**(5,792)**	**(525)**	**(68,468)**	**(63,743)**	**(4,725)**	**(74,701)**	**(69,346)**	**(5,356)**
(Surplus) / Deficit	**(114)**	**398**	**(512)**	**29**	**3,425**	**(3,396)**	**0**	**4,230**	**(4,230)**
Adjusting Items	(0)	(3)	2	(4)	205	(209)	(4)	203	(207)
(Surplus) / Deficit	**(114)**	**396**	**(510)**	**25**	**3,630**	**(3,604)**	**(4)**	**4,433**	**(4,437)**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
BUDGET ANALYSIS: M11 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)	(4)	0	(45)	(45)	1	(49)	(49)	1
Expenditure	1,936	1,918	18	21,200	21,069	131	23,134	22,991	143
Total Maternity	**1,932**	**1,914**	**18**	**21,156**	**21,024**	**132**	**23,085**	**22,942**	**144**
Neonatal									
Income	(66)	(81)	15	(726)	(869)	143	(792)	(948)	156
Expenditure	1,148	1,191	(42)	12,616	12,748	(132)	13,764	13,954	(190)
Total Neonatal	**1,082**	**1,110**	**(27)**	**11,890**	**11,879**	**11**	**12,972**	**13,006**	**(34)**
Division of Family Health - Total	**3,014**	**3,024**	**(10)**	**33,046**	**32,903**	**142**	**36,058**	**35,948**	**110**
Gynaecology									
Income	0	0	0	0	0	0	0	0	0
Expenditure	1,037	1,109	(72)	11,114	11,284	(170)	12,149	12,384	(235)
Total Gynaecology	**1,037**	**1,109**	**(72)**	**11,114**	**11,284**	**(170)**	**12,149**	**12,384**	**(235)**
Hewitt Centre									
Income	0	0	(0)	(1)	(1)	0	(1)	(1)	0
Expenditure	718	677	41	7,195	7,210	(15)	7,917	7,979	(62)
Total Hewitt Centre	**718**	**677**	**41**	**7,194**	**7,209**	**(15)**	**7,916**	**7,978**	**(62)**
Division of Gynaecology - Total	**1,755**	**1,787**	**(32)**	**18,308**	**18,492**	**(184)**	**20,065**	**20,361**	**(296)**
Theatres									
Income	0	0	0	0	0	0	0	0	0
Expenditure	694	640	54	7,333	7,544	(211)	8,027	8,294	(267)
Total Theatres	**694**	**640**	**54**	**7,333**	**7,544**	**(211)**	**8,027**	**8,294**	**(267)**
Genetics									
Income	(7)	(13)	7	(248)	(160)	(88)	(254)	(178)	(77)
Expenditure	129	141	(12)	1,525	1,579	(54)	1,654	1,722	(68)
Total Genetics	**122**	**128**	**(6)**	**1,278**	**1,419**	**(142)**	**1,399**	**1,545**	**(145)**
Other Clinical Support									
Income	0	(0)	0	0	0	(0)	(0)	0	(0)
Expenditure	636	613	23	6,960	6,808	153	7,596	7,428	169
Total Clinical Support	**636**	**613**	**23**	**6,960**	**6,808**	**152**	**7,596**	**7,428**	**168**
Division of Clinical Support - Total	**1,452**	**1,380**	**71**	**15,571**	**15,772**	**(200)**	**17,023**	**17,266**	**(244)**
Corporate & Trust Technical Items									
Income	(9,779)	(10,223)	444	(110,914)	(111,200)	286	(120,904)	(121,722)	818
Expenditure	4,325	4,431	(106)	48,045	47,457	588	52,349	52,377	(28)
Total Corporate	**(5,454)**	**(5,792)**	**338**	**(62,869)**	**(63,743)**	**873**	**(68,555)**	**(69,346)**	**791**
(Surplus) / Deficit	**767**	**398**	**368**	**4,056**	**3,425**	**631**	**4,591**	**4,230**	**361**
Adjusting Items	(1)	(3)	2	(14)	191	(205)	(15)	189	(204)
(Surplus) / Deficit	**765**	**396**	**370**	**4,042**	**3,616**	**426**	**4,576**	**4,419**	**157**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 6
CIP: M11 as per ledger/original plan
YEAR ENDING 31 MARCH 2021

SCHEME NAME	MONTH 11			YTD			Full Year		
	Original Target	Actual	Variance	Original Target	Actual	Variance	Original Target	Revised	Variance
Procurement Savings (Trust-wide)	83	0	(83)	417	0	(417)	500	0	(500)
Genetics contribution to overheads	38	38	0	418	418	0	456	456	0
Corporate savings	32	32	0	327	325	(2)	358	357	(1)
Maternity HCA vacancies	21	21	0	229	229	0	250	250	0
NHSP Savings (subject to Business Case)	17	17	0	183	183	0	200	200	0
Additional Pysiotherapy activity within existing resource	14	0	(14)	155	0	(155)	169	0	(169)
GDE Revenue Savings	13	0	(13)	138	0	(138)	150	0	(150)
Genetics Commissioning Changes (Sendaway Tests)	11	11	0	124	124	0	135	135	0
Estates Rental income - UNIVERSITY	10	10	0	105	105	0	115	115	0
Aintree Estate Utilisation	11	0	(11)	89	0	(89)	100	0	(100)
HFC Strategic Review	25	13	(13)	170	68	(102)	195	80	(115)
Theatre Efficiency and Surgical Pathways Project	17	0	(17)	83	0	(83)	100	0	(100)
Full SLA review	11	11	0	89	89	0	100	100	0
MVA Business Case income generation (net of pay costs)	11	0	(11)	89	0	(89)	100	0	(100)
Theatre procurement Savings	10	0	(10)	90	70	(20)	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	64	64	0	70	70	0
Additional Fertility offering Macclesfield	0	0	0	0	0	0	0	0	0
Imaging rota review	5	5	0	55	55	0	60	60	0
Pharmacy Ordering	4	4	0	28	28	0	32	32	0
Other Smaller Schemes	59	11	(48)	478	110	(368)	537	121	(416)
	396	**177**	**(219)**	**3,331**	**1,869**	**(1,463)**	**3,728**	**2,047**	**(1,681)**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 7
BALANCE SHEET: M11
YEAR ENDING 31 MARCH 2021

BALANCE SHEET £'000	YEAR TO DATE Opening	M11 Actual	Movement	YEAR TO DATE NHSI Plan	M11 Actual	Movement	YEAR TO DATE Internal Budget	M11 Actual	Movement
Non Current Assets	**92,282**	**91,497**	(785)	**91,438**	**91,497**	59	**92,483**	**91,497**	(986)
Current Assets									
Cash	4,647	12,699	8,052	11,920	12,699	779	4,600	12,699	8,099
Debtors	6,329	2,935	(3,394)	4,273	2,935	(1,338)	8,353	2,935	(5,418)
Inventories	432	464	32	432	464	32	452	464	12
Total Current Assets	**11,408**	**16,098**	**4,690**	**16,625**	**16,098**	**(527)**	**13,405**	**16,098**	**2,693**
Liabilities									
Creditors due < 1 year - Capital Payables	(2,809)	(757)	2,052	(953)	(757)	196	(266)	(757)	(491)
Creditors due < 1 year - Trade Payables	(15,314)	(14,734)	580	(16,481)	(14,734)	1,747	(17,675)	(14,734)	2,941
Creditors due < 1 year - Deferred Income	(2,918)	(11,865)	(8,947)	(11,924)	(11,865)	59	(3,471)	(11,865)	(8,394)
Creditors due > 1 year - Deferred Income	(1,623)	(1,595)	28	(1,623)	(1,595)	28	(1,585)	(1,595)	(10)
Loans	(17,359)	(2,442)	14,917	(2,442)	(2,442)	0	(16,791)	(2,442)	14,349
Provisions	(1,698)	(1,630)	68	(1,698)	(1,630)	68	(4,870)	(1,630)	3,240
Total Liabilities	**(41,721)**	**(33,023)**	**8,698**	**(35,121)**	**(33,023)**	**2,098**	**(44,658)**	**(33,023)**	**11,635**
TOTAL ASSETS EMPLOYED	**61,969**	**74,572**	**12,603**	**72,942**	**74,572**	**1,630**	**61,230**	**74,572**	**13,342**
Taxpayers Equity									
PDC	42,519	58,547	16,028	57,550	58,547	997	42,488	58,547	16,059
Revaluation Reserve	14,329	14,329	0	14,329	14,329	0	14,503	14,329	(174)
Retained Earnings	5,121	1,696	(3,425)	1,063	1,696	633	4,239	1,696	(2,543)
TOTAL TAXPAYERS EQUITY	**61,969**	**74,572**	**12,603**	**72,942**	**74,572**	**1,630**	**61,230**	**74,572**	**13,342**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 8
CASHFLOW STATEMENT: M11
YEAR ENDING 31 MARCH 2021

CASHFLOW STATEMENT	YEAR TO DATE		
£'000	NHSI Plan	Actual	Variance
Cash flows from operating activities	(1,912)	(1,305)	(607)
Depreciation and amortisation	4,880	4,875	5
Impairments and reversals	0	0	0
Income recognised in respect of capital donations (cash and non-cash)	0	(189)	189
Movement in working capital	10,452	10,755	(303)
Net cash generated from / (used in) operations	**13,420**	**14,136**	**(716)**
Interest received	0	0	0
Purchase of property, plant and equipment and intangible assets	(6,247)	(6,090)	(157)
Proceeds from sales of property, plant and equipment and intangible assets	14	48	(34)
Net cash generated from/(used in) investing activities	**(6,233)**	**(6,042)**	**(191)**
PDC Capital Programme Funding - received	428	1,425	(997)
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**	**(42)**	**128**
Increase/(decrease) in cash and cash equivalents	**7,273**	**8,052**	**(779)**
Cash and cash equivalents at start of period	4,647	4,647	0
Cash and cash equivalents at end of period	**11,920**	**12,699**	**(779)**

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: M11
YEAR ENDING 31 MARCH 2021

CAPITAL EXPENDITURE £'000		Year to Date Plan	Year to Date Actual	Year to Date Variance	FOT Plan	FOT Actual	FOT Variance
Estates	Estates - Business as Usual	270	42	228	300	141	159
	Estates - Critical Infrastructure	0	199	(199)	364	379	(15)
	Estates Total	**270**	**241**	**29**	**664**	**520**	**144**
Capital Projects	Neonatal Development	759	727	32	759	727	32
	Crown Street Enhancements		345	(345)	3,618	1,233	2,385
	CT Scanner		0	0	0	597	(597)
	Surgical Robot		53	(53)	1,291	1,462	(171)
	Capital Projects Total	**759**	**1,125**	**(366)**	**5,668**	**4,019**	**1,649**
IM&T	IM&T - Business as Usual	629	822	(193)	1,148	1,205	(57)
	K2 Athena	198	198	0	0	214	(214)
	360 Blood and Milk	217	217	0	286	286	0
	EPR	313	313	0	0	384	(384)
	Homeworking Equipment	49	49	0	0	49	(49)
	Video Consultation		8	(8)	0	20	(20)
	IM&T Total	**1,406**	**1,607**	**(201)**	**1,434**	**2,158**	**(724)**
Medical Equipment	Medical Equipment - Neonates	176	0	176	361	357	4
	Medical Equipment - Maternity	391	391	0	462	419	43
	Medical Equipment - HFC	404	404	0	332	648	(316)
	Medical Equipment - Theatres	19	19	0	100	49	51
	Medical Equipment - Imaging	228	228	0	440	832	(392)
	Medical Equipment Total	**1,218**	**1,042**	**176**	**1,695**	**2,305**	**(610)**
Other	Genetics Software		5	(5)	0	10	(10)
	Patient Lift System		10	(10)	0	10	(10)
	Fridge Temperature Check		0	0	0	36	(36)
	Workforce Development System		0	0	0	206	(206)
	Other		8	(8)	0	586	(586)
	Total Other	**0**	**23**	**(23)**	**0**	**848**	**(848)**
Grand Total		**3,653**	**4,038**	**(385)**	**9,461**	**9,851**	**(390)**

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.
A number of items have been brought forward from the 21/22 plan in order to utilise available funding.
The total overspend has been funded and is agreed with the HCP/NHSI/E.

Interim Revenue and Capital Budgets 2021/22 and Liverpool Women's Charity Budgets 2021/22

Board of Directors, 01/04/2021
Jenny Hannon, Director of Finance

Revenue and Capital Budgets 2021/22

Liverpool Women's

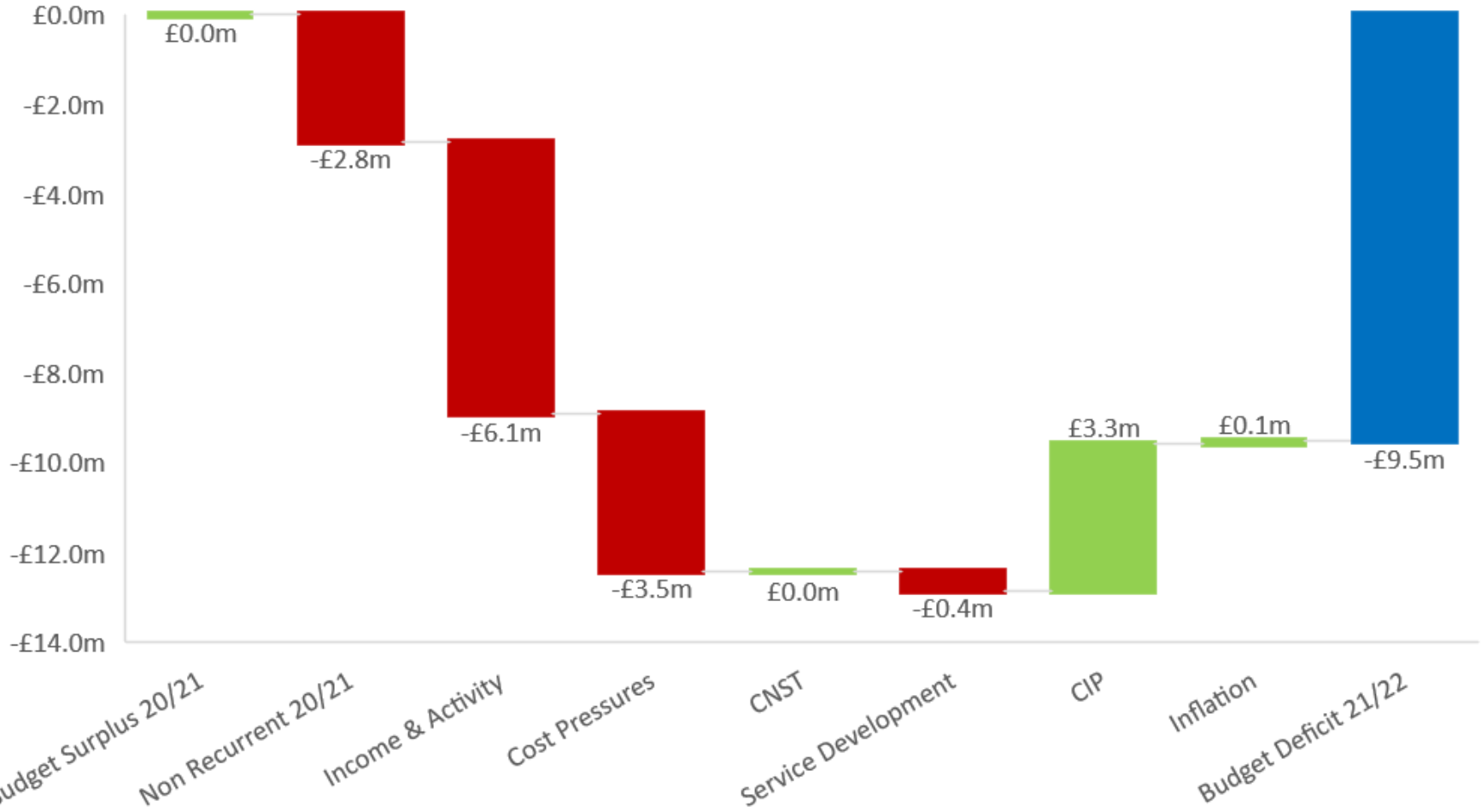
- Trust budgets were **reviewed in detail at Finance, Performance and Business Development Committee (FPBD)** and at a separate deep dive session for Board members in March 2021.
- **Approved at divisional level** and reviewed by Executive Team and Senior Management Team.
- This presentation highlights **key areas to report** and is an opportunity for **question, comment and discussion** in addition to the detailed scrutiny ahead of formal approval.
- The Board will be asked to **approve the interim budget**.
- This is still subject to **agreement at a C&M level** with national guidance and allocations only recently released.
- There may be **opportunities** to improve the position presented following system discussions, regular updates and detail will be provided to Board.

Movements from FPBD review

- Recent guidance (26 March 21) has informed the following amendments from the FPBD review
- Applies to the first six months of the year (H1) only but extrapolated to H2

	H1	H2	21/22 FY
FPBD Budget Deficit	**-£7.2m**	**-£5.9m**	**-£13.1m**
Inflation Uplift to Blocks	£0.2m	£0.2m	£0.5m
Non Pay inflation	-£0.2m	-£0.2m	-£0.4m
Indicative System Top Up	£1.8m	£1.8m	£3.7m
Other Changes (net)	£0.0m	£0.0m	£0.0m
Revised Interim Deficit	**-£5.4m**	**-£4.1m**	**-£9.5m**

Interim Revenue Budget



Planning Guidance and National Approach

- National Guidance
  - National planning guidance and confirmation of the financial framework for the first half of 2021/22 (only)
- Planning Assumptions
  - Block contracts, inflation, pay award, CQUIN
- Elective Recovery Fund
  - Supporting activity recovery
- Cancer Recovery
  - Cancer alliances & plans to recover cancer performance
- Maternity Recovery and Transformation
  - Resource being made available nationally to improve maternity safety

System Approach to planning

- System approach even more embedded in 2021/22 with plans, narrative and financial settlements being agreed and submitted by HCPs
- Balanced position expected overall
- Additional C&M distributions of resource:
  - Covid funding
  - System Top Up
  - CNST funding
  - Non-NHS Income

Revenue Budgets

- Income
  - Indicative block payment & top up not sufficient to break even
- CIP and Efficiency
  - Trust has identified a CIP programme in excess of the national requirement. The Trust's overall programme currently represents 2.7% of turnover (£3.2m). Schemes are subject to Quality end Equality impact assessment before initiation.
- Cost Pressures
  - Crown Street enhancements, digital investments, capacity related and unavoidable costs (£3.5m in year effect)
- Additional Maternity considerations
  - Birth Rate Plus, Ockenden, Delivery Numbers & Acuity, Continuity of Carer
- Long Term Financial Planning
  - Long term sustainability plan

Cash & Balance Sheet

- Likely to require cash support if deficit ongoing
- Level required will be determined when final deficit agreed across Cheshire & Merseyside HCP
- Mechanism in place to allow this via Public Dividend Capital (3.5% dividend is payable)

Capital Plan Summary 2021/22

Plan has been prioritised and agreed within the Trust. Whilst subject to agreement at a system level, indication from the HCP has been that no changes will be required, as the plan is within the Trust's affordability through internally-generated or previously approved Public Dividend Capital (PDC).

	£m
Crown Street Enhancements	5.3
Estates requirements	0.7
Medical Equipment	0.3
Digital Services	1.4
Other	0.1
Anticipated Rebate	-0.8
Grand Total	**7.0**

Charity Budget Summary 2021/22

The Charitable Funds Committee has reviewed the Charity Budget 2021/22 and recommended it for Board approval

	£000
Planned Income	**380**
Running Costs	-137
Big Tiny Steps Appeal	-60
Neonatal Flat Refurbishment	-70
Honeysuckle	-20
Staff Welfare	-50
Other	-43
Total Expenditure	**-380**
Net Income/Expenditure	**0**
Forecast Reserves 31st March 2021 & 2022	*475*

Next Steps

- Planning Submissions at C&M Level – May (Draft) & June (Final)
- Half 2 (H2) Plans to be determined in line with further information later in the financial year
- Monthly reporting to Board within regular finance and performance reports with detailed monitoring against agreed position.

Recommendation

Following detailed review and recommendation the Board is asked to approve:

- **Interim revenue budgets for 2021/22**, *(as recommended by the Finance, Performance & Business Development Committee)* to be reviewed/revised at H2
- **Delegation of approval of the final planning submissions for H1 to Finance Committee (FPBD)**, with regular reporting into Board
- **Capital Plan 2021/22** *(as recommended by the Finance Performance & Business Development Committee)*

- **Charity Budget 2021/22** *(as recommended by the Charitable Funds Committee).*

Liverpool Women's NHS Foundation Trust

Agenda Item	21/22/010c

MEETING	**Trust Board**
PAPER/REPORT TITLE:	**Digital Services – Annual Review**
DATE OF MEETING:	Thursday, 01 April 2021
ACTION REQUIRED	**Assurance**
EXECUTIVE DIRECTOR:	Jenny Hannon, Director of Finance
AUTHOR(S):	Matthew Connor, Chief Information 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.*** *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):	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 review and note the achievements and delivery of the Digital Services department.***	
PREVIOUSLY CONSIDERED BY:	**Committee name**	*Choose an item.* Or type here if not on list: Click here to enter text.
	Date of meeting	*Click here to enter a date.*

Executive Summary

This report provides a review of key digital activities over the last 12 months and places this within the context of digital programme, business as usual commitments and the impact of Covid-19. The report describes what's on the horizon as key digital priorities to come and provides a summary of the progress achieved.

Report

1. Introduction

The last 12 months have been very challenging due to the impact of the Covid-19 pandemic. The Digital Services department has played a significant role in supporting the Trust's response to Covid-19.

Prior to the start of each year, Digital Services management and wider Trust key stakeholders formulate the digital programme which sets out the deliverables to meet the Trust's strategic and operational priorities. During this process, consideration is made to any wider NHS regulatory or other local system requirements. The Digital Programme placed focus on developing a new Digital Strategy, developing an Electronic Patient Record (EPR) business case, delivering a new Digital Maternity system, and continuing with the implementation of projects commissioned under the Global Digital Exemplar (GDE) Programme. It was during the commencement of the digital programme when the Covid-19 Pandemic impacted the UK. New challenges were faced, which resulted in a rapid deployment of new technologies to support remote working and providing care services in a virtual manner where required. Throughout the year, it was important to balance the priorities of the digital programme with the Trusts response to the Pandemic. This report reflects on the activities undertaken by the Digital Services department over the last 12 months.

Digital Delivery: A look back at 2020-21

The Digital Services (IM&T) department is a diverse set of functions and teams comprising of approximately seventy staff. The services delivered include:

Function / Team	Responsibilities include
Information and Performance	Contractual / statutory reporting. Power BI Divisional reporting to aid operational and performance related decision making.
Information Technology	End User IT Support, End User Computing through to Network & Infrastructure. Cyber Security, compliance, and project delivery support.
Patient Records	Provision of timely clinical records in paper & electronic format.
Digital Programme Management Office	Management of the digital programme, governance, and benefits realisation. Programme risks and issues management.
Information Governance	Compliance, standards, and information asset security.
Digital Systems	Support, maintain and develop clinical systems. Provide end user training on clinical systems use.
Clinical Coding	Translation of medical terminology into coded format for Trust performance and activity monitoring and income payments.

The staff that make up these functions are responsible for delivering the digital programme and what we term Business-as-Usual (BAU) activities. The digital programme typically consists of 'new things' such as implementing a new system, major upgrade or change that requires dedicated resources to implement. These 'new things' often impact and affect wider parts of the Trust and as such careful consideration to the change impact, or transition as well as benefits realisation is required. This major component is referred to as Business Change or Business Transformation and will consist of staff within the Digital Programme Management Office, IT, Digital System, IG, Information and key stakeholders such as Clinical, Midwifery and Nursing Leads to support the implementation and adoption. The term BAU refers to the everyday activities that are required to be fulfilled to ensure that operational services are maintained and are robust. These include (but not limited to): -

- That good data quality is maintained across the Trust.
- That information reporting commitments (both internal and external) are fulfilled.
- That information security principles are applied and monitored through Information Governance oversight.
- That clinical and corporate systems are managed to ensure they function correctly.
- That core network, server and data storage infrastructure is maintained to ensure it is resilient, performant and has the capacity required.
- That cyber security and data backup activities are routinely under-taken to address new cyber threats and keep the Trust's data and systems safe.
- Manage processes to manage end user incidents relating to IT and wider digital issues
- Undertake routine administration activities to provide network accounts for new staff, provide access to data repositories.
- Ensure clinical coding activities are fulfilled to reflect accurate activities and clinical outcomes.

At the start of the new financial year Digital Services also welcomed Dr Natalie Canham, Consultant Geneticist as the new Chief Clinical Information Officer (CCIO).

BAU activities are essential and during the last year all the above and many more responsibilities have been discharged in addition to the Covid-19 pandemic response, and the wider commitment to delivering the digital programme. The Digital Services department successfully delivered on the BAU commitments which included responding to external audit recommendations and cyber security needs.

At the start of the year, there were two strategic objectives to deliver.

- **Identify a clear direction of travel for the procurement of a suitable Electronic Patient Record**

  The EPR business case was successfully approved in July 2020 which allowed the procurement, legal and contractual activities to commence. The procurement process concluded successfully, and the new EPR contract was signed at the end of September with Meditech UK. From November the EPR Programme Board (Meditech Expanse) has been implemented along with the required project governance and resources to undertake the implementation of the Meditech Expanse EPR system, which is due for go-live April 2022.

- **Develop a Digital (IM&T) Strategy**

  The Digital Strategy was successfully launched in September 2020. The development of the strategy placed staff engagement at fore, and through several virtual workshops, key themes were identified which shaped the objectives of the strategy.

Initial activities during the start of the year were focussed on responding to the start of Covid-19 pandemic. In terms of Digital, this meant that the Trust had to be equipped to work remotely and to be able to deliver services for patients in a different way.

Mobile end user IT equipment such as laptops, cameras and speakers had to be procured and provided to staff at scale and quickly, in some cases this meant that traditional desktop computers were re-purposed enabling them to work from home. Collaboration technologies such as Microsoft Teams had to be implemented at pace and configured to support remote meetings. This incurred a significant training burden as the Trust mobilised and adjusted to working differently all within a space of weeks. The increased volume of remote workers placed greater burden on the Trusts network and remote access infrastructure which resulted in the Information Technology team upgrading the connectivity bandwidth and optimising the Remote Access systems (Citrix & VPN). This placed unprecedented demand on the Digital Services team to support staff. Throughout the year a number of other Covid-19 related digital activities have been undertaken; namely implementing the required national dataset reporting, patient and staff testing reporting and aiding the rollout of the vaccine through the use of IT systems, technology and information reporting.

To aid the Trust to deliver clinical services differently Virtual Clinics were implemented using Attend Anywhere and some clinics were set up for Telephone consultations. The Digital Systems and Information and Performance teams updated the Trusts Patient Administration System (PAS) and Information Reporting system to reflect the new ways of clinic delivery. During this time, clinical services within the Trust would actively re-design to meet the needs of their patients, and this is reflected in the work that the Neonatal Partnership undertook with Digital Services to deliver Telemedicine Robots to enable remote consultations and ward rounds. This proved to be highly effective and well received by patients and staff.

During the first quarter of 2020/21 and in parallel to the Covid-19 digital response, activities commenced on the strategic objectives. Firstly, several Designing Digital virtual workshops were undertaken to engage with Trust staff on the development of the Digital.Generations strategy. This work would ultimately conclude with an approved strategy that was launched in September. Secondly, there was an emphasis to build a robust EPR business case for consideration, to allow for a Trust decision on the way forward prior to the expiration (end of September 2020) of the incumbent supplier contract.

The Trust was identified as Global Digital Exemplar (GDE) Fast Follower (FF) in 2018 and during the last year, there have been a number of projects delivered as part of this programme. These include Paper Free, e-Xchange, Virtual

Desktop (Hewitt Fertility Centre) and Virtual Reality Tours. There are some projects which are ongoing and are referenced in the next section of the report.

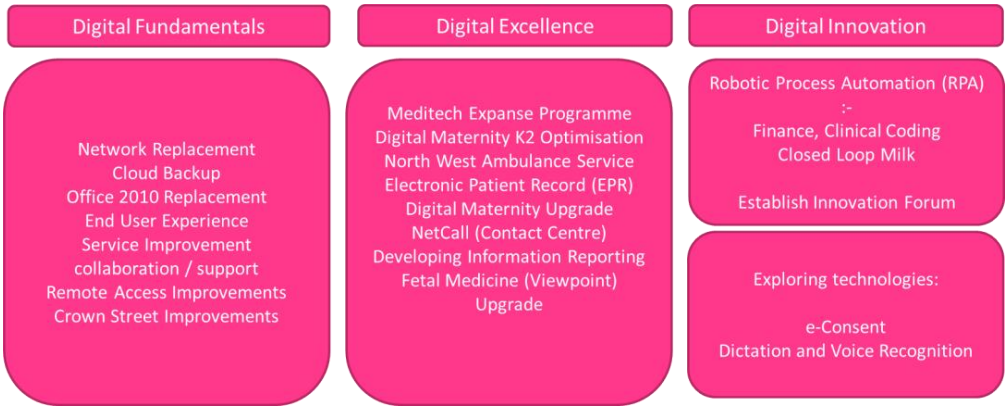
The Digital Services department also undertook a number of critical infrastructure projects which resulted in the complete replacement of the Trusts Telephony system, included a major upgrade to the Picture Archive & Communication System (PACS), implementation of Virtual Smart Cards as well as commencing projects on the Data Network replacement and replacement of Windows 7 computers.

A significant achievement relates to the successful go-live of the Digital Maternity (K2) system. This project commenced at the start of the year and the Trust went live in January. The project delivered a fully digital maternity care record which covers intrapartum and postpartum care across acute and community settings. There are over 880 users of the system and this is considered a Trust-wide deployment. The project was complex and required significant time and resource investment from Maternity and Digital Services during the project phase and post go-live.

The Trust was recognised in October through four external Health Technology News (HTN) awards; 'Highly Commended' for Major Project Go-Live (Paper Free), 'Highly Commended' for Technology Project of the Year (Neonatal Telemedicine) and Winner for Best Digital Project (Virtual Reality Tours). The Trusts Head of Information Governance won 'Information Governance Innovator of the Year' under the National Health and Social Care Strategic Information Governance Network Awards 2020. During February 2021, the Digital Services successfully renewed their Cyber Essentials Plus accreditation. A graphical roadmap of what has been delivered is available in the appendix.

Digital Delivery: the road ahead

Several of the projects that were commenced during this year will continue as key priorities into the next year. The Data Network Replacement project had been delayed due to Covid-19 because the necessary downtime periods to enable the core network replacement would have incurred a significant operational impact on the Trust at the height of Covid-19 wave 2 and this was rightfully deferred. Remote Access improvements continue as do additional phases to the Digital Maternity Programme (optimisation and upgrade). Digital Services will implement a new Cloud based data backup solution and continue with the exciting Meditech Expanse EPR Programme. Following on from the Telephony System replacement Digital Services will deliver enhanced 'Contact Centre' capabilities through NetCall which will primarily introduce robust call queuing functionality.



The remaining projects within the GDE programme which relate to the Robotic Process Automation (RPA) project and the Blood Transfusion and Closed Loop Milk (Sample 360) initiatives will be delivered. Digital Services will explore learning locally and tap into the innovative minds of Trust staff with the intention of implementing an Innovation Forum; this will be linked to the Trust's Service Improvement plan. Planned programme activities are aligned to the key themes within the Digital Generations strategy. The implementation of the digital programme is monitored regularly through Digital Hospital Sub Committee (DHSC) and the Digital Generations strategy reviewed bi-annually at Finance, Performance and Business Development (FPBD) Committee.

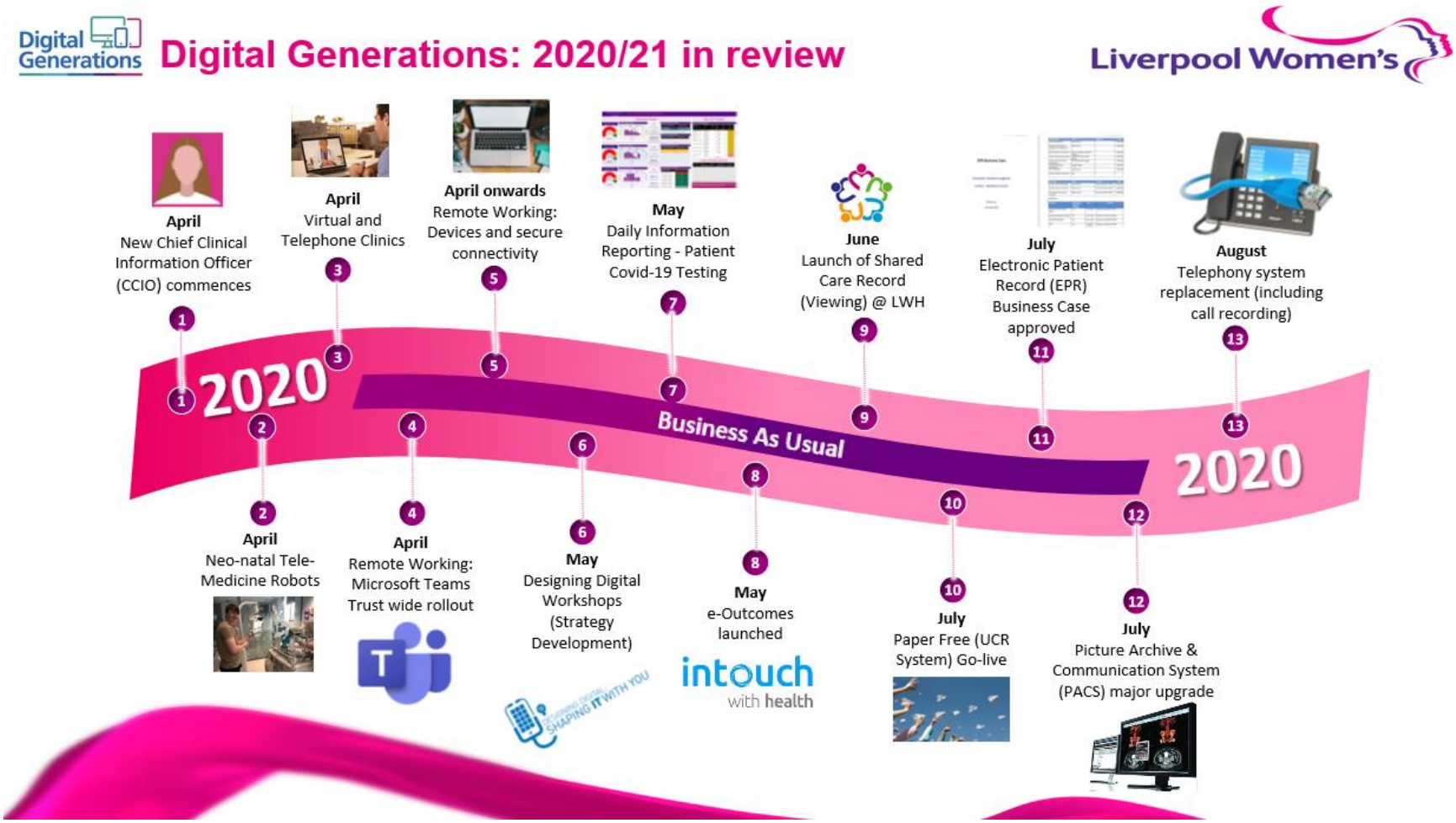
Summary

It has truly been a unique year; one which has placed new challenges before the Trust, requiring all departments to support a collective response to the Covid-19 Pandemic. Within Digital Services, this placed a rapid and significant demand on new ways of working, technologies, collaboration tools and additional reporting demands. Despite all of this, the department has continued to deliver on its intended programme of work, and whilst some projects have been impacted through Covid-19 (such as the network replacement project) many have concluded successfully or progressed as intended. The department also delivered on its two strategic objectives by delivering a new Digital Strategy and an approved EPR Business Case. In addition to all of this, the department has cohesively worked well as a team and delivered on its business as usual activities to ensure operational services are maintained. Whilst this year has been challenging, it has also been rewarding.

Recommendation

The Board is asked to review and note the achievements and delivery of the Digital Services department.

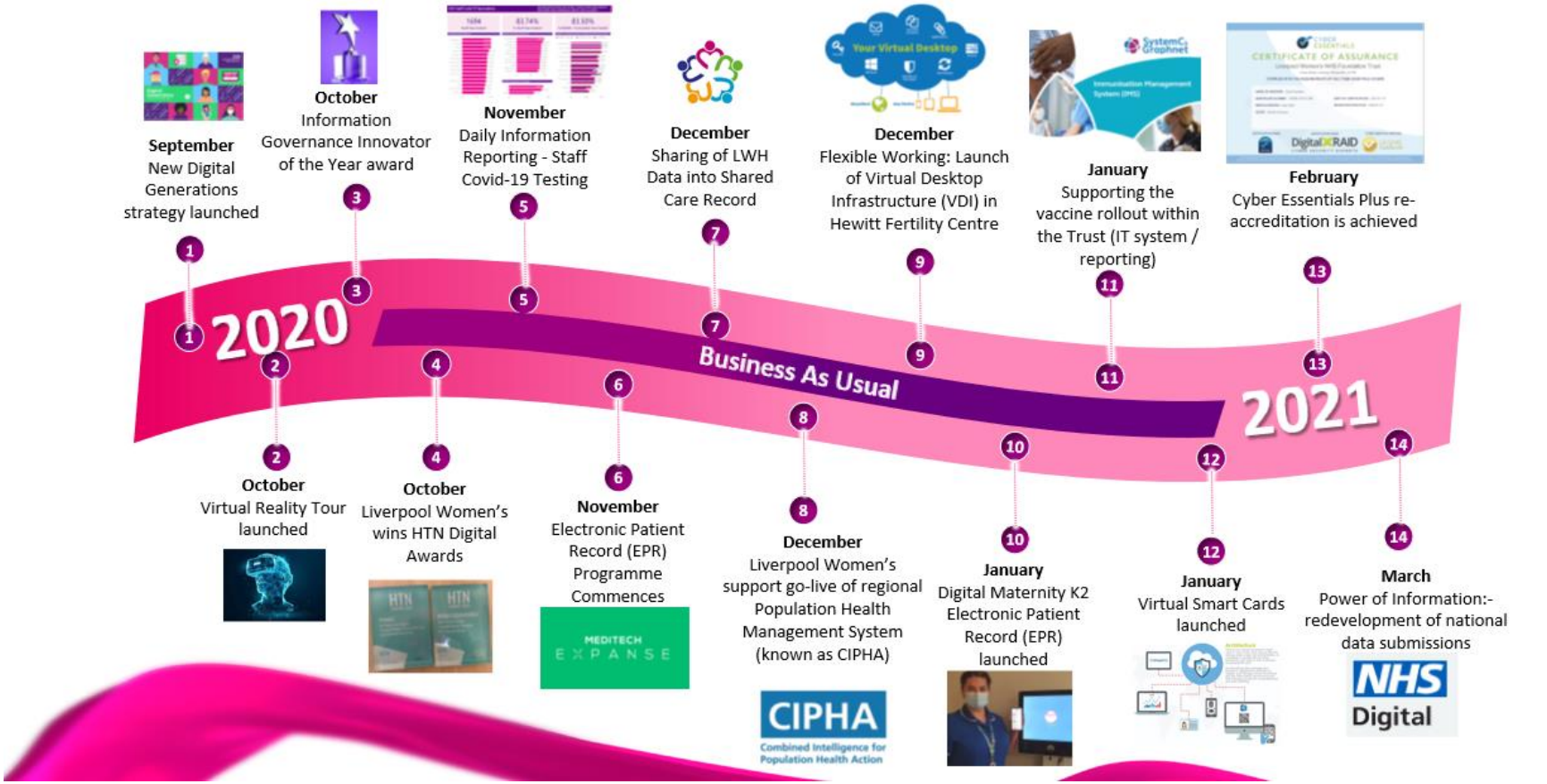
Appendix – Digital Generations: 2020/21 in review



Liverpool Women's NHS Foundation Trust

Digital Generations: 2020/21 in review

Liverpool Women's



Finance, Performance & Business Development Chair's Highlight Report to Trust Board
23 February 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 uncertainty and risk related to financial planning 2021/22. • Performance targets remain a challenge as a direct impact of Covid-19 on performance measures including sickness absence and access targets remain. • Increasing backlog of long waiters due to Covid-19 as essential services only are being delivered within national command and control arrangements. The Committee received a detailed presentation highlighting the impact of Covid-19 and the planned recovery against the elective care standards. It was anticipated that a regional approach would be undertaken to commence recovery. • Difficulties posed by Planning Process 2021/22 undertaken within the Covid-19 landscape. Despite the difficulties to plan without a clear set of parameters and national guidance, significant progress had been made with a high level of engagement from the clinical divisions. The Committee requested sight of scenario planning and additional saving options in addition to the CIP plan due to the recurrent downward trend. • A risk that the full Emergency Public Dividend Capital (PDC) would not be spent in-year and any un-utilised funds would not be available in future years. To utilise the funding whilst ensuring appropriateness of spend, value for money and adhering to procurement rules, it was agreed to revise the capital plan for 2020/21 and 2021/22. The Board would be asked to approve the amendments to the Capital Plan.	• Noted a Commercial Review was underway and the Committee would receive the final report • Further Planning 2021/22 assumption scenarios to be considered by the Committee in March • 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 • The Trust Corporate Strategy had been approved by the Board of Directors in February 2021. The Strategy would be formally launched in April 2021. A review and refresh of underpinning strategies would be undertaken to ensure alignment. • Assured that the Trust implementation of K2 had continued to be successful since its launch in January 2021 and that a post project review would be utilised to inform other IMT developments. • Continued progression to develop the EPR Programme and GDE Programme noted. • Assured by the activity and assurance demonstrated by the Emergency Preparedness, Resilience and Response (EPRR) annual report and noted compliance to NHSE/I EPRR Core Standards.	• Reviewed BAF risks mindful of the deficit position. Agreed to maintain current risk score and narratives. It was noted that a detailed review of the BAF would be undertaken to align the BAF with the revised Corporate Strategy. • Recommend Board approval of the amendments to the Capital Plan for 2020/21 noting the risk to delivery within the timescales • Recommend Board approval of the commencement of the Estates element of the Crown Street Enhancement works, noting the implications for the Capital Plan 2021/22 • Recommend Board approval of the Robotic Assisted Surgery Business Case and the associated capital in accordance with SFIs
Comments on Effectiveness of the Meeting / Application of QI Methodology	
• Papers considered adequately and in a timely manner.	

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
162.	Board Assurance Framework Review	Assurance	168.	Theatre Robotic Assisted Surgery Business Case	Approval
163.	Finance Performance Report Month 10 2020/21	Assurance	169.	Digital Service Update Report	Assurance
164.	Operational Performance Report Month 10 2020/21	Assurance	170.	Emergency Planning Resilience and Response Annual Review	Assurance
165.	Review of Strategic Progress Update	Assurance	171.	Sue Committee Chair Reports	Assurance
166.	Planning 2021/22 Update	Assurance			
167.	Capital Update 2020/21 including Crown Street Enhancements	Approval			

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

Finance, Performance & Business Development Chair's Highlight Report to Trust Board
23 March 2021

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Noted a continued planned deficit for the year. At month 11 the Trust was reporting an actual deficit of £3.6m year to date (YTD), after total combined tops up of £11.6m YTD. • Performance targets remain a challenge as a direct impact of Covid-19 on performance measures including sickness absence and access targets. • The Committee noted that the Continuity of Carer target was above 20% in month 11 and was informed that the Quality Committee had approved the next steps to pause and prepare to review progress to date and prepare to progress with the next phase of implementation. Monthly compliance against the planned trajectory would be kept under review by this Committee. • National planning process for 2021/22 remained under review. Continued risks due to national uncertainties to the revenue and capital budgets were noted.	• Noted that a Finance and Sustainability Strategy and associated Long Term Financial Model would be developed to support the overarching Trust Strategy. • Final Findings report from the Hewitt Fertility Centre Strategic and Commercial Review to be completed. • Noted ongoing works in relation to the Crown Street Enhancement programme.
Positive Assurances to Provide	**Decisions Made**
• Continued internal monitoring of financial and performance metrics despite national pauses. • Positive evidence of system transactions working collaboratively. • The Cheshire and Merseyside Elective Recovery Plan was shared with the Committee. Positive assurance was given that the trajected plans for the Trust was achievable. • A Planning Assumption meeting had been held on 18th March 2021 for FPBD Committee members to consider the revenue and capital budget 2021/22 in greater detail. Despite the risks identified the Committee was assured by the planning scenarios presented and the Trust's grip and control of the internal budgeting process. • Key strategic developments included the finalisation of the corporate strategy, development of supporting strategies and plans, and the Hewitt Fertility Centre Strategic Review. • Assured by continued progress of the Crown Street Enhancements Programme. • Assured by progress against three significant digital programmes: the EPR programme (Meditech Expanse), Digital Maternity (K2) and the GDE Programme. • It was noted that the Digital Hospital Sub-Committee had an improved clinical focus.	• Reviewed BAF risks mindful of the deficit position. No changes to existing risks were identified as a result of business conducted during the meeting. Appropriate scoring of risk 1986 was discussed. It was confirmed that recalibration of risk scores would be part of the overall BAF review. • Recommend Board approval of the Interim budget setting position for 2021/22. Subject to the release of the financial framework and final income values. • Confirmed achievement against the 2020/21 Corporate Objectives aligned to the FPBD Committee and recommend submission to the Trust Board for final review. • Committee reviewed its risk appetite and risk level and recommended Trust Board approval as follows: 'To be ambitious and efficient and make the best use of available resources' as a moderate risk appetite. • Recommend Trust Board approval of the FPBD Committee Annual Report, Terms of Reference and workplan 2021/22.
Comments on Effectiveness of the Meeting / Application of QI Methodology	
• Papers considered adequately and in a timely manner.	

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
181.	Board Assurance Framework Review	Assurance	187.	Crown Street Enhancements Programme Update	Assurance
182.	Finance Performance Report Month 11 2020/21	Assurance	188.	Digital Services Update	Assurance
183.	Operational Performance Report Month 11 2020/21	Assurance	189.	Corporate Objectives 2020/21 Year-end review	Assurance
184.	Revenue and capital budget for 2021/22 & CIP 2021/22 programme	Assurance	190.	Risk Appetite Statement – FPBD Committee	Assurance
185.	Review of Strategic Progress	Assurance	191.	FPBD Committee Review	Approval
186.	Hewitt Fertility Centre Strategic and Commercial Review – Draft Findings	Information	192.	Sub-Committee Chairs Reports	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

NHS
Liverpool Women's
NHS Foundation Trust

Finance, Performance & Business Development Committee Annual Report 2020/21

Finance, Performance & Business Development Committee

This report covers the period April 2020 to March 2021. There were 11 meetings held during this period.

Introduction

The Finance, Performance & Business Development Committee operates under the broad aims of reviewing financial and operational planning, performance and business development.

The Committee's responsibilities fall broadly into the following two areas:

Finance and performance

a) Receive and consider the annual financial and operational plans and make recommendations as appropriate to the Board.
b) Review progress against key financial and performance targets
c) Review on behalf of the Board, financial submissions (as reported in the Financial Performance Report) or others, as agreed by the Board, to NHS Improvement for consistency on financial data provided.
d) Review the service line reports for the Trust and advise on service improvements
e) Provide oversight of the cost improvement programme
f) Oversee external financing & distressed financing requirements
g) Oversee the development and implementation of the information management and technology strategy
h) Examine specific areas of financial and operational risk and highlight these to the Board as appropriate through the Board Assurance Framework
i) To undertake an annual review of the NHS Improvement Enforcement Undertaking.
j) To review and receive assurance on the appropriateness of the Trust's Emergency Planning Resilience & Response processes and procedures.

Business planning and development

k) Advise the Board and maintain an overview of the strategic business environment within which the Trust is operating and identify strategic business risks and opportunities reporting to the Board on the nature of those risks and opportunities and their effective management
l) Advise the Board and maintain an oversight on all major investments, disposals and business developments.
m) Advise the Board on all proposals for major capital expenditure over £500,000
n) Develop the Trust's marketing & communications strategy for approval by the Board and oversee implementation of that strategy

Constitution

The Finance, Performance & Business Development Committee is accountable to the Board of Directors.

Membership during the year comprised:

- Non-Executive Director (Chair)
- Two additional Non-Executive Directors
- Chief Executive
- Director of Finance
- Director of Operations
- Director of Nursing and Midwifery

Meetings were also attended by other executives and senior management staff as appropriate.

The Committee's constitution allows for members to participate by two-way audio link on occasion where appropriate which is deemed to constitute presence in person per the Committee's Terms of Reference. Due to the Covid-19 pandemic, all meetings during 2020/21 have been held virtually utilising Microsoft Teams.

The Terms of Reference requires that all members of the committee attend a minimum of 75% of the meetings held. The table at appendix 1 lists the names of the members of the Committee and the meetings they attended during 2020/21 together with the names of senior management who were invited to attend during the year. The majority of members attended 75% or more of the meetings during 2020/21. This appendix will be updated post meeting so that a full 2020/21 picture can be provided to the Board.

Key Achievements / Activity

The key items discussed and reviewed by the Committee during 2020/21 were as follows:

Covid-19 Response

Early in 2020/21, the Committee received an in-depth position update on the Covid-19 pandemic including the operational, financial and strategic impacts, governance implications, IM&T and the work being undertaken on recovery planning. The Committee noted the Trust decision to maintain internal monitoring despite a national pause on the requirement to provide external monitoring.

The impacts of Covid-19 on operational performance were included within the monthly operational performance report throughout 2020/21. On occasion, more detailed reports on Covid-19 recovery measures were provided to the Committee.

Financial Performance

The Committee reviewed financial performance throughout the year in line with submissions to the regulator, noting areas of under and over performance. Until Month 7, the Trust was tracking in line with an established breakeven position but due to the calculation methodology used by NHSI/E to inform income, the Trust was required to establish a revised deficit position. This revised position was monitored closely by the Committee with assurance sought that internal financial controls were as robust as possible. This included the close tracking of Covid-19 related expenditure and whilst not required by the regulators, the progress made against the Trust's CIP programme. As the financial year came to an end, the Committee's attention became focussed on the potential impacts on the 2021/22 financial position and the longer-term financial health of the organisation. An additional Committee session was held in March 2021 which provided an outline of several financial scenarios and the options available for the Trust.

Whilst national guidance was delayed, the Committee also received updates on the process for financial and operational planning for 2021/22.

Operational Performance

The Committee reviewed operational performance on a monthly basis. The Committee was assured by the actions being taken to address improvement of the performance metrics but was mindful of the continued potential impact on performance metrics caused by Covid-19.

Analytical Review – Annual Accounts 2019/20

The Committee received a detailed paper summarising the key financial statements and an analytical review undertaken on the key differences between the 2018/19 and 2019/20 accounts.

Cost Improvement Programme 2019/20 Full Year Post Implementation Review

The Committee noted that the full year post implementation review exercise had been undertaken in line with the Well-Led Review recommendations and was part of ensuring good governance and ensuring that lessons learnt from both successful and unsuccessful schemes.

Business Case Post Implementation Review

As part of ongoing quality and process improvement, the Committee received the output from a Business Case Post Implementation Review for all cases from the 2019/20 financial year.

Commercial and Strategic Review of the Hewitt Centre

The Committee approved a commercial and strategic review of the Hewitt Fertility Centre to provide an evidence base and framework from which the Hewitt Centre could develop a divisional strategy aligned with the Trust's overarching strategic direction.

Trust Strategy

Throughout the year, the Committee has been involved in the development of the Trust Corporate Strategy.

IM&T

The Committee played a key role in the development of the Trust's Digital Strategy and has also sought assurance throughout the year on the Trust's progress to move forward with an Electronic Patient Record solution, progress against Global Digital Exemplar (GDE) objectives (and benefits realisation) and cyber-security readiness.

Neonatal Capital Programme Build

The Committee provided oversight during the year on the neonatal build which was completed to schedule and on budget. The Committee requested a follow up benefits realisation update after a 12 month period.

NHS Enforcement Undertakings Update

The Committee received a position update in relation to the Enforcement Undertakings with Monitor (the statutory body which now operates as NHS Improvement). It was confirmed that all actions had been completed and/or breaches are no longer in place.

Treasury Management

The Committee received quarterly reports which provide assurance on the strength of financial controls.

One to one midwives update

The Committee was kept updated throughout 2020/21 on the administration and the investigation process. Assurance was provided that the Trust was fully co-operating with the investigation process.

Update on Communications, Marketing and Engagement Action Plan 2020-21

The Committee received an update on the marketing, communications and engagement action plan established in April 2020. It was agreed that the Communications Team had performed well in supporting the Trust through a challenging period as a result of the Covid-19 pandemic.

EU Exit end of transitional period

The Committee was kept updated throughout the year on the potential impacts on the Trust and received assurance that adequate preparations were being made.

Business Assurance Framework (BAF)

The Committee regularly reviewed the Board Assurance Framework risks assigned in line with the business cycle of activities. The Committee held discussions over the rating of specific risks attributable to the Committee noting that they were being managed appropriately. The Committee reported all recommended changes to the BAF at the following Board of Directors meeting for approval.

Corporate Objectives Outturn 2020/21 and Corporate Objectives 2020/21

The Committee reviewed the performance for the year against the Corporate Objectives 2020/21 aligned to its terms of reference

Review of Risk Appetite Statement 2021/22

The Committee performed a review of the Risk Appetite Statements for 2021/22 that related to the Committees sphere of responsibility: to be ambitious and efficient and make the best use of available resources. The Committee reviewed the risk appetite for this objective and agreed that the level of risk appetite was appropriate and would not change from the risk appetite in 2020/21.

Crown Street Enhancement Programme

In December 2020, 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.

Mid-Year Review

The Covid-19 pandemic has increased pressures across the NHS and on 28th March 2020 NHSE/I, issued guidance regarding 'Reducing burden and releasing capacity at NHS providers to manage the COVID-19 pandemic'. This provided advice regarding governance, meetings, reporting and assurance, among other issues. There were several recommendations contained within this guidance which mainly related to the streamlining of governance arrangements to ensure that there was a focus of resources onto front-line clinical care. At the time, there was agreement that the Trust had sufficient capacity to continue with existing governance arrangements but to also explore mechanisms to streamline agendas and items for discussion either through deferment or the use of a 'consent agenda'. This was mainly with the intention of wanting to reduce the burden on front line staff but was also in recognition of the limitations of virtual meetings. When this decision was taken, it was agreed that the Board's Committees would review their practice at a six-monthly interval to consider whether any amendments were required and to identify whether there were any risks posed by items that had been deferred or not considered.

This review was undertaken in November 2020 and concluded that the Finance, Performance & Business Development Committee had worked broadly in line with the plan established at the beginning of 2020/21 and no additional risks as a result of the approach taken to meeting management since the pandemic began have been identified. In reaching this conclusion, it was noted that no meetings had been cancelled in the year and that no risks had been posed by items that had been removed or deferred. This has continued to be the case for the second half the year.

Areas for Development

For the first time, an effectiveness survey was circulated to members of the Committee seeking feedback on the activity of the Committee during 2020/21. On the whole, the responses received were positive – the full results can be seen in Appendix 2. One narrative comment received noted that the Committee would have a key role moving into 2021/22 to provide the Board with assurance on financial and operational performance recovery.

One area that has been explored during 2020/21 has been the use of 'deepdives' either into performance areas of particular concern or into themes identified as important to the Committee. These have worked effectively, and it is aimed to provide space on agendas during 2021/22 to undertake further 'deepdive' reviews.

Proposed Amendments to the Terms of Reference

The Committee last reviewed its Terms of Reference in March 2020 and were approved by the Board in April 2020. No amendments are proposed apart from updates to the reporting groups.

The draft Terms of Reference is included at Appendix 3.

Proposed Amendments to the Committee Business Cycle

Each of the Committees established by the Board of Directors has an annual business cycle which is subject to review each year. The business cycle forms the 'core' agenda for Committee meetings throughout the year with scheduled business ensuring that the Committee discharges its responsibilities as set out in the Terms of Reference.

The Finance, Performance & Business Development Committee last reviewed its annual business cycle in March 2020 and is therefore scheduled to complete a further review in order to set the business cycle for 2021/22.

All members of the Finance, Performance & Business Development Committee had the opportunity to participate in the annual review and propose any amendments to the business cycle and terms of reference during February 2021 by completing the committee effectiveness survey. The Committee members who responded did not make any suggested amendments to the business cycle or terms of reference.

In addition to the survey, discussions between the Committee Chair, Director of Finance and Trust Secretary to consider means to enhance Committee effectiveness resulted in the following suggested amendments to the business cycle:

- Inclusion of a Crown Street Enhancement Progress Review - monthly
- Inclusion of a Neonatal Capital Programme Build benefits realisation report - annual
- Inclusion of Business Case Post Implementation Reviews - annual
- Inclusion of Post Implementation Review of Cost Improvement Programme (CIP) – annual
- Inclusion of Crown Street Enhancement Programme Board Chairs report - monthly

It is likely that key areas of attention during 2021/22 will be as follows:

- To provide oversight to the Trust's on-going financial management of a deficit position, providing guidance and scrutiny to the actions available to the organisation
- To closely monitor organisational performance, particularly as the Trust continues to recover from the Covid-19 pandemic
- To continue to monitor progress against the Trust's Strategy, particularly seeking assurance that it has been embedded within the organisation and well understood by staff and stakeholders
- Maintain oversight of the capital improvements to the Crown Street site.
- Continue to monitor all business developments and key service changes
- Continue to oversee the EPR project and monitor risks associated with delivery

The draft Business Cycle is included at Appendix 4.

Conclusion

In the final analysis, it is concluded that the Finance, Performance & Business Development Committee has achieved its objectives for the Financial Year 2020/21.

Phillip Huggon CHAIR
Finance, Performance & Business Development Committee
April 2021

Appendix 1

Finance, Performance & Business Development Committee **Attendance at Committee: April 2020 – March 2021**

MEMBERS	**JOB TITLE**	April 2020	May 2020	June 2020	July 2020	Sept 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	% attendance
Jo Moore	Non-Executive CHAIR (until end Aug 2020)	✓	✓	✓	✓	✓	Apols	Apols	Apols	✓	✓	✓	73
Ian Knight	Non-Executive	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	100
Phil Huggon	Non-Executive CHAIR (as of Sept 2020)	✓	✓	✓	✓	✓	Apols	✓	✓	✓	✓	✓	91
Tracy Ellery	Non-Executive	✓	apols	✓	✓	✓	✓	✓	Apols	✓	✓	✓	82
Jenny Hannon	Director of Finance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	100
Kathryn Thomson	Chief Executive Officer	✓	✓	✓	✓	Apols	✓	✓	✓	Apols	✓	✓	82
Gary Price	Chief Operational Officer	✓	✓	✓	✓	Apols	✓	✓	✓	✓	✓	✓	91
Caron Lappin	Director of Nursing & Midwifery (until end August 2020)	apols	apols	apols	✓	NM							91
Gaynor Hales	Interim Director of Nursing & Midwifery (from April – end Oct 2020)	✓	✓	✓	✓	✓	Apols	NM					
Janet Brennan	Acting Director of Nursing & Midwifery (Nov – Dec 2020)							✓	✓				
Marie Forshaw	Director of Nursing & Midwifery (from Jan 2021)									✓	✓	✓	

Appendix 2

Finance, Performance and Business Development Committee Effectiveness Survey

4	01:54	Active
Responses	Average time to complete	Status

1. I understand the duties of the committee.

Strongly agree	3
Agree	1
Disagree	0
Strongly disagree	0
Unable to answer	0

2. I believe the committee receives sufficient assurance to conclude upon its areas of responsibility

Strongly agree	3
Agree	1
Disagree	0
Strongly disagree	0
Unable to answer	0

3. I am confident that the committee effectively monitors and scrutinises progress against the aligned strategies.

Strongly agree	2
Agree	2
Disagree	0
Strongly disagree	0
Unable to answer	0

Appendix 2

4. I am content that the committee is delivering the right level of assurance to the Board / Committee.

Strongly agree	3
Agree	1
Disagree	0
Strongly disagree	0
Unable to answer	0

5. I believe that the committee effectively seeks assurance that the Trust complies with its own policies, all relevant external regulation and standards of governance and risk management.

Strongly agree	2
Agree	2
Disagree	0
Strongly disagree	0
Unable to answer	0

6. I feel that the committee has the right balance of experience, attendance, knowledge and skills to fulfil its role.

Strongly agree	2
Agree	2
Disagree	0
Strongly disagree	0
Unable to answer	0

7. The committee has structured its agenda and work plan to cover its key responsibilities.

Strongly agree	3
Agree	1
Disagree	0
Strongly disagree	0
Unable to answer	0

Appendix 2

8. The committee is effectively chaired.

Strongly agree	2
Agree	2
Disagree	0
Strongly disagree	0
Unable to answer	0

9. All members of the committee are able to participate effectively.

Strongly agree	3
Agree	1
Disagree	0
Strongly disagree	0
Unable to answer	0

10. There is clarity in relation to the work of the committee and its interaction and alignment with other committees.

Strongly agree	2
Agree	2
Disagree	0
Strongly disagree	0
Unable to answer	0

Appendix 3

FINANCE, PERFORMANCE AND BUSINESS DEVELOPMENT COMMITTEE TERMS OF REFERENCE

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

	j. To review and receive assurance on the appropriateness of the Trust's Emergency Planning Resilience & Response processes and procedures. **Business planning and development** The Committee will: k. Advise the Board and maintain an overview of the strategic business environment within which the Trust is operating and identify strategic business risks and opportunities reporting to the Board on the nature of those risks and opportunities and their effective management l. Advise the Board and maintain an oversight on all major investments, disposals and business developments. m. Advise the Board on all proposals for major capital expenditure over £500,000 n. Develop the Trust's marketing & communications strategy for approval by the Board and oversee implementation of that strategy
Membership:	The Committee membership will be appointed by the Board of Directors and will consist of: • Non-Executive Director (Chair) • Two additional Non-Executive Directors • Chief Executive • Director of Finance • Director of Operations • Director of Nursing and Midwifery Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. The Board of Directors will appoint a Non-Executive Director as Chair of the Committee. Should the Chair be absent from a meeting of the Committee, the Committee may appoint a Chair of the meeting from amongst the Non-Executive Directors present.

Appendix 3

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

Appendix 3

	Trust standing orders and standing financial instructions apply to the operation of the Finance, Performance and Business Development Committee.
Reporting Committees and Groups	The sub committees/groups listed below are required to submit the following information to the Committee: a) Chairs Report; and b) an Annual Report setting out the progress they have made and future developments. The following sub committees/groups will report directly to the Committee (see appendix 1): • Emergency Planning Resilience & Response Committee • Digital Hospital Sub-Committee
Monitoring effectiveness:	The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements.
Review:	These terms of reference will be reviewed at least annually by the Committee.
Reviewed by Finance, Performance & Business Development Committee:	23 March 2021
Approved by Board of Directors:	
Review date:	March 2022
Document owner:	Mark Grimshaw, Trust Secretary Email: mark.grimshaw@lwh.nhs.uk Tel: 0151 702 4033

Appendix 4

Work Programme

Finance, Performance and Business Development Committee	Report up to Board	Exec Lead	WORKPLAN 2021/22											
			Quarter 1			Quarter 2			Quarter 3			Quarter 4		
			21 April	19 May	23 June	21 July	25 Aug TBC	22 Sept	20 Oct	24 Nov	22 Dec TBC	26 Jan	23 Feb	23 Mar
Standing Items														
Minutes of Previous meeting		TS	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Actions/Matters Arising		TS	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Chairs Report - Verbal		Chair	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Review of Board Assurance Framework Risks	✓	DOF	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Subcommittee Chairs reports & Terms of Reference: Emergency Planning Resilience & Response Committee Digital Hospital Sub-Committee Crown Street Enhancement Programme Board		COO CIO DoF	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Review of risk impacts of items discussed		DoF	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Any other business		Chair	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Review of meeting		Chair	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
MATTERS FOR DISCUSSION & BOARD ACTION/DECISION														
To be ambitious and efficient and make best use of available resources														
Monthly Finance Performance review (Incl CIP review)	✓	DOF	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Monthly Operational Performance review	✓	COO	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
NHSI Enforcement Undertaking Review		DOF	✓			✓								
Review of unaudited Annual Accounts (prior Audit)	✓	DOF		✓										

Review of Strategic Progress		DOF	✓			✓			✓			✓		
Crown Street Enhancement Progress Review		DOF	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Neonatal Capital Programme Build benefits realisation		DOF							✓					
Annual Business Case Post Implementation Reviews		DOF							✓					
Post Implementation Review of Cost Improvement (CIP)		DOF		✓					✓					
Review Marketing Strategy		CPO							✓					
Digital Services Update - implementation of business case		DOF	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Digital Generations Strategy 2020-2024 Bi-annual review		DOF				✓						✓		
Information Governance Update		SIRO	✓			✓			✓			✓		
Revenue and capital budget for 2022/23	✓	DOF												✓
Operational Planning: Six monthly review (2021/22) and Operational Planning (2022/23)	✓	COO							✓ **(R)**					✓
Corporate Objectives Bi-annual (R) & Year-end review (AR)	✓	TS/Exec						✓ **(R)**						✓**(AR)**
Corporate Objectives Setting for 2021/22	✓	TS/Exec	✓											
Treasury Management Quarterly Report		DOF	✓			✓			✓			✓		
Emergency Planning Resilience & Response Annual review	✓	COO											✓	
General Governance Arrangements														
Review of Risk Appetite Statement 2022/23	✓	DNM												✓
FPBD Committee Effectiveness Annual Report	✓	DOF												✓
FPBD Terms of Reference	✓	TS												✓

FBPD Business Cycle		TS												✓

Audit Committee Chair's Highlight Report to Trust Board

23 March 2021

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• No key risks or matters of concern identified.	• The Committee agreed that whilst the MIAA report into learning from serious incidents report had yet to be received by the Committee, it would be germane for the Quality Committee to review at the Extraordinary Quality Committee scheduled in April 2021. • The Committee reviewed the draft Clinical Audit programme. It was agreed to provide a Chair's Log to the Quality Committee to review the Clinical Audit Programme alongside the Internal Audit Programme to ensure synergy and alignment. The Committee also requested that the clinical audit programme take lessons from the internal audit tracking system to 'close the loop' and ensure that actions were embedded. • The Committee requested that the Trust Secretary review and strengthen the Trust's in-year processes for identifying conflicts of interest – reporting back to the Committee in July 2021. • It was agreed to undertake a training needs analysis for the Committee (in line with the Terms of Reference).
Positive Assurances to Provide	**Decisions Made**
• The Committee noted that requested amendments to the Trust's internal audit recommendation tracking process had been implemented to ensure that there were consistent lists between the Trust's own system and that of MIAA. The achievement of maintaining progress against audit recommendations during the pandemic was acknowledged. • Three internal audit reports were received 1) Medicines Management (Neonatal) (High Assurance) 2) Global Digital Exemplar (GDE) Programme (Substantial Assurance), and 3) Data Security & Protection Toolkit (no issues highlighted). The Committee remarked that the high assurance for medicine management in neonates was particularly positive and it was noted that learning could be taken for other areas in the Trust. • A draft Head of Internal Audit Opinion was noted. This provided a draft substantial assurance opinion. • The Committee noted the MIAA Internal Audit Charter • The Committee received an anti-fraud progress update. Noted that the Trust was on track to receive a 'green rating' in the year-end report.	• The Committee approved the MIAA Internal Audit Plan for 2021/22. It was agreed that the 2022/23 plan would be circulated to all Non-Executive Directors for input as part of the process in early 2022. • The Committee approved the 2021/22 Anti-Fraud work plan • The Committee approved Policy for Use of External Auditors to Undertake Non-Audit Work. Noted that this would be reviewed at the beginning of the procurement process for external auditors. • The Committee approved the areas of judgements in the accounts. • The Committee recommended the approval of the Risk Management Strategy 2021/22 to the Board. • The Committee agreed to write off £108k of debt for the 2020/21 financial year. A significant portion of this debt related to overseas patients (unplanned care) and all avenues of collection had been exhausted. • The Committee agreed to publish the Trust's Registers of Interest • The Committee reviewed and recommended for approval to the Board the updated Terms of Reference and 2021/22 work programme.

• Noted that the interim external audit had been completed. No significant control issues highlighted although a higher sample would be taken in relation to private patient income at the Hewitt Centre. Highlighted that as no Financial Recovery Fund money would be allocated to Trusts, the recognition of income had been removed as a substantial risk area. Work progressed on the audit and no issues were foreseen for completing within the identified timescales. The external auditor highlighted that the requirement for a long form audit report had been removed which would impact the information provided to the Council of Governors. It was likely that the full ISA260 report would be utilised to communicate with governors at year-end. • The Committee received a presentation from the CSS Division regarding their developing governance processes.	
Comments on Effectiveness of the Meeting / Application of QI Methodology	
• No comments made	

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
20/21/85	Follow up of Internal Audit and External Audit Recommendations	To receive assurance of actions implemented on a timely basis.	20/21/91	Clinical Audit Forward Plan 2021-22	For approval / information
20/21/86	**MIAA Internal Audit Reports** a) Internal Audit Progress Report b) Final Audit Reports c) Draft Head of Internal Audit Opinion 2020/21 d) Internal Audit Work Plan 2021/22 e) Internal Audit Charter **Anti-Fraud** f) Progress Report 2020/21 g) Anti-Fraud Work Plan 2021/22 **Insight** h) Insight Update	To note the contents and any recommendations from the report.	20/21/92	Divisional Governance Presentation	For assurance
20/21/87	KPMG – External Audit Technical Update & Interim Audit Update	To note the contents and any recommendations from the report.	20/21/93	Debt Write Off Report	For approval

20/21/88	Policy for Use of External Auditors to Undertake Non-Audit Work	For approval	20/21/94	Managing Conflicts of Interests	For assurance
20/21/89	Areas of Judgement in the Accounts	For approval	20/21/95	Review of Committee Terms of Reference & Business Cycle 2021/22	For approval.
20/21/90	Risk Management Strategy Review	For assurance	20/21/96	Chairs reports of the Board Committees a) Finance, Performance and Business Development Committee b) Quality Committee c) Putting People First Committee Charitable Funds Committee	Review of Chairs' reports for overarching assurance.
			20/21/97	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

AUDIT COMMITTEE
TERMS OF REFERENCE

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

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

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

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

b. Internal audit

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

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

c. External audit

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

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

annual audit plan and ensure coordination with internal auditors and with other external auditors

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

d. Other assurance functions

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

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

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

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

e. Counter fraud

The Audit Committee will satisfy itself that the Trust has adequate arrangements in place for countering fraud and will approve the

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

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

	A Chair's Report will be submitted to the next following Board of Directors for assurance. Approved minutes will be made available to all Board members. The Committee will report to the Board annually on its work and performance in the preceding year and, as part of this report, will provide commentary in support of the Annual Governance Statement (AGS), specifically dealing with the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the Trust, the integration of governance arrangements and the appropriateness of the evidence compiled to demonstrate fitness to register with the Care Quality Commission and the robustness of the processes behind the quality accounts. In providing this commentary in support of the AGS the Committee will seek relevant assurance from the Chair of the Board's Quality Committee. Trust standing orders and standing financial instructions apply to the operation of the Audit Committee.
Monitoring effectiveness:	The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements.
Review:	These terms of reference will be reviewed at least annually by the Committee.
Reviewed by Audit Committee:	23 March 2021
Approved by Board of Directors:	01 April 2021
Review date:	March 2022
Document owner:	Mark Grimshaw, Trust Secretary Email: mark.grimshaw@lwh.nhs.uk Tel: 0151 702 4033

Liverpool Women's NHS Foundation Trust
Audit Committee Business Cycle 2021-22

Item	Exec lead	10 June 2021	22 July 2021	21 October 2021	20 January 2022	24 March 2022
MATTERS FOR APPROVAL/DECISION						
Standing Items						
Minutes of Previous meeting	TS		✓	✓	✓	✓
Actions/Matters Arising	TS		✓	✓	✓	✓
Chairs Report - Verbal	Chair		✓	✓	✓	✓
Board Assurance Framework	TS		✓	✓	✓	✓
Review of risk impacts of items discussed			✓	✓	✓	✓
Any other business			✓	✓	✓	✓
Review of meeting			✓	✓	✓	✓
MATTERS FOR DISCUSSION & COMMITTEE ACTION/DECISION						
Data Assurance Report	CIO					✓
Follow up of Internal and External Audit Recommendations	DF		✓	✓	✓	✓
Register of waivers of standing orders	DF		✓	✓	✓	
Areas of Judgement in the Annual Accounts	DF					✓
Losses and special payments	DF					✓
Raising staff concerns arrangements	DW&M		✓			
Settlement agreements annual report	DW&M		✓			
Bribery Act compliance	TS			✓		
Review of Board, Governor and Staff register of interests	TS					✓
Review of Board, Governor and staff register of gifts and hospitality	TS					✓
Corporate governance manual review	TS		✓			
Review of assurances processes:	TS					
• Integrated governance				✓		
• risk management						✓
Counter fraud						
Counter fraud progress report	IA		✓	✓	✓	✓
Counter fraud annual report 2019/20	IA	✓				
~~Counter fraud annual report 2020/21 (draft)~~	IA					✓
Counter fraud work plan 2021/22	IA					✓
Internal audit						
Head of Internal Audit's opinion and annual report Draft/Final	IA	✓				✓
Internal Audit Work Plan 2021/22	IA					✓
Internal audit progress report	IA		✓	✓	✓	✓

Liverpool Women's NHS Foundation Trust
Audit Committee Business Cycle 2021-22

Review of Internal Audit Charter	IA					✓
Annual Review of effectiveness of Internal audit	Chair		✓			
External audit						
External audit findings (ISA 260) and management letter	EA	✓				
External Audit Technical Update (formerly progress report)	EA		✓	✓	✓	✓
External Audit Plan	EA				✓	
Review of effectiveness of external audit	Chair		✓			
Financial Reporting						
Annual Governance Statement	TS	✓				
Annual report, quality report and financial accounts (to include Code of Governance compliance & Salient Features)	DF/MD/TS	✓				
Audit Committee Annual Report	TS/DF	✓				
Code of Governance Compliance & NED indpendance Dec's	TS	✓				
Other Assurance Functions						
Review of Board Committee Annual Reports	TS		✓			
Review of Divisional Governance Arrangements (rota)			✓	✓	✓	✓
Review of Chair reports of Board Committee meetings • Finance, Performance and Business Development Committee	TS		✓	✓	✓	✓
• Quality Committee			✓	✓	✓	✓
• Putting People First Committee			✓	✓	✓	✓
Clinical Audit Forward plan	MD					✓
Clinical Audit Annual Report & Mid Year Update	MD			✓		
General Governance Arrangements						
Review of Audit Committee effectiveness	TS/DF		✓	✓		
Review of Committee terms of reference	TS					✓
Committee business cycle 2021/22	TS					✓
Private discussion with auditors (internal and external) when required	Chair		✓	✓	✓	✓

Charitable Funds Committee Chair's Highlight Report to Trust Board
16 March 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 approved the draft budget proposal for 2021/22 whilst mindful of the uncertainty caused by the ongoing impact of the pandemic. The Committee agreed to the following principles: primarily that expenditure should not exceed income in year, agree to maintain investments and confirm the priorities and financial principles for future fundraising. The Committee would recommend Board approval of the Budget Setting 2021/22.	• Work progressing to enable the introduction of additional payment mechanisms into the Charity, e.g. Direct Debit / Standing Order payments. It was recommended that GDPR compliance was reviewed with the Information Governance Team to ensure donor data compliance. • The Committee formally approved the following primary fundraising campaigns: Endometriosis Appeal; FMU & MLU refurbishment; Neonatal Big Tiny Steps Appeal – Refurbishment of parental accommodation; Bereavement Suite (Gynae & Delivery); Breast Pumps for Community team and neonatal; and Covid Recovery Appeal.
Positive Assurances to Provide	**Decisions Made**
• The Committee noted the current financial position as at the end of January 2021. The positive impact on the financial position of monies donated via NHS Charities Together was noted. It was confirmed that expenditure of the NHS Charities Together funding would be achieved by the end of 2020/21 as required. • Positive increase of new fundraising activity commencing demonstrated by new Just Giving pages and fundraising challenges. • Proactive steps taken towards introducing new donation platforms e.g. Facebook Donate. • Assured by the Charity's first and successful bid applying for a research grant. • The Committee was supportive of the proposed awareness raising campaign alongside the fundraising for Endometriosis. • The Charity priorities and income generation action plan 2021/22 was noted. • Assured by the Committee Annual Effectiveness Review and believed better clarity of the purpose of the committee had been achieved towards the end of 2020/21.	• Approved two charitable funding applications from the Neonatal Fund. • Approved the Committee Workplan and terms of reference for 2021/22. Recommend formal adoption of the terms of reference (TOR) to the Board of Directors in April 2021. • Submit the Committee Effectiveness Annual Report to the Board of Directors for assurance that the Committee was fulfilling its duties as set within the TORs.
Comments on Effectiveness of the Meeting / Application of QI Methodology	
• Benefitted from a focussed agenda • Proposed introduction of risks towards the charity noted as a positive step to further improve meeting reports.	

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
57.	Finance report YTD spend and income	Information			
58.	Budget 2021/22	Information			
59.	Fundraising Update	Information			
60.	Fundraising Operational Plan	Information			
61.	Potential Fundraising Priorities	Approval			
62.	Committee Annual Effectiveness Review	Approval			

3. 2020 / 21 Attendance Matrix

Core members	June 2020	Sept 2020	Dec 2020	March 2021
Phil Huggon	✓	✓	✓	✓
Jo Moore	✓	✓	ap	ap
Tony Okotie	✓	✓	ap	✓
Michelle Turner	✓	✓	✓	ap
Eva Horgan	✓	✓	✓	✓
Caron Lappin	Ap			
Gaynor Thomason	✓	✓	nm	
Janet Brennan	nm		✓	✓
Marie Forshaw	nm			ap
Chris Gough				
Kate Davis				

Liverpool Women's NHS Foundation Trust

Charitable Funds Committee Annual Report 2020/21

Charitable Funds Committee

This report covers the period April 2020 to March 2021. There were four meetings held during this period.

Introduction

The Committee has been established to exercise the Foundation Trust's functions as sole corporate trustee of the Liverpool Women's Charity (registered charity number 1048294).

The Trust Board is regarded as having responsibility for exercising the functions of the Trustee. The Trust Board delegates these functions to the Committee, within any limits set out in these terms of reference and the sections of the standing financial instructions pertaining to charitable funds.

In discharging these duties, the Committee is responsible for:

Compliance

a. Manage the affairs of the Liverpool Women's Charity in accordance with appropriate legislation and ensure statutory compliance with the Charity Commission regulations.
b. Ensure systems and processes are in place to receive, account for, deploy and invest charitable funds in accordance with charity law.
c. Scrutinise requests for use of charitable funds to ensure that any such use is in accordance with the aims and purposes of any charitable fund or donation and are clinically and ethically appropriate. Committee members will bear in mind due diligence to Charity Commission and Trust guidance regarding the ethical use of funds and acceptance of donations.

Budget, Income & Expenditure

d. Review and approve an Annual Business plan and budget
e. Receive and approve periodic income and expenditure statements, ensuring that performance is in line with the Charity's budget and plan.
f. Receive and consider the Annual Accounts including the Annual Report from the auditors, before submission to the Board of Directors for approval.

Fundraising

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

Investment Management

m. Consider and agree an investment strategy for the safe and secure investment of funds not immediately required for use, taking into account any appropriate ethical considerations.
n. Appoint and review external investment advisors and operational fund managers.
o. Review the performance of investments on a regular basis (utilising comparator information) with the external investment advisors to ensure the optimum return from surplus funds.

This remit is achieved through the Committee being appropriately constituted and complying with the duties delegated by the Board of Directors through its terms of reference.

Constitution

The Charitable Funds Committee is accountable to the Board of Directors. Membership during the year comprised:

- Chairman (Non-executive director)
- Two other Non-executive Directors
- Director of Finance
- Deputy Director of Finance
- Director of Workforce and Marketing
- Director of Nursing and Midwifery
- Financial Accountant
- Head of Fundraising

Meetings were also attended by other executives and senior management staff as appropriate.

At the beginning of the financial year, the Committee was scheduled to meet twice. After agreement at the June 2020 meeting, it was agreed to increase the frequency to quarterly. Meetings in September 2020 and March 2021 were subsequently added to the schedule.

The Committee's constitution allows for members to participate by two-way audio link on occasion where appropriate which is deemed to constitute presence in person per the Committee's Terms of Reference. Due to the Covid-19 pandemic, all meetings during 2020/21 have been held virtually utilising Microsoft Teams.

The Terms of Reference requires that all members of the committee attend a minimum of 75% of the meetings held. The table at appendix 1 lists the names of the members of the Committee and the meetings they attended during 2020/21 together with the names of senior management who were invited to attend during the year. The majority of members attended 75% or more of the meetings during 2020/21. This appendix will be updated post meeting so that a full 2020/21 picture can be provided to the Board.

Following comments made at the June 2020 meeting, the Terms of Reference of the Committee were reviewed in September 2020 and then again in December 2020, prior to being approved by the Board in January 2021.

Key Achievements / Activity

The key items discussed and reviewed by the Committee during 2020/21 were as follows:

- The impact of the Covid-19 pandemic on the Trust's fundraising plans and capability. Assurance has been provided throughout the year on how the fundraising team has continued to adapt to the challenges posed by the pandemic. This included involvement with the NHS Charities Together.
- Regular investment updates have been received from the Charity's Fund Manager. Assurance has been provided on the delivery of fund performance despite the market volatility brought about by the pandemic.
- Regular reports have been received on the financial performance of the charity
- The Charity's Fundraising Strategy was received and reviewed by the Committee together with specific updates on progress against major appeals e.g. Big Tiny Steps. The Committee has also started to receive reports on future fundraising priorities, and this is something that the Committee wishes to develop further into 2021/22 (more below in 'Areas for Development' section).
- Updates received on progress with the Volunteer Strategy and particularly on the volunteer recovery plan post Covid-19.

- The Committee reviewed and agreed a proposal to create a lottery to raise additional funds.
- On request, the Committee undertook a formal review of the Investment policy taking into account ethical considerations and a review of the Charity risk appetite and capacity for loss in relation to its investments. The amendments suggested were subsequently reported to and approved by the Board.
- Review of the Annual Report and Accounts and recommendation for approval by the Board.
- A review of the Committee's purpose and how this is reflected in its Terms of Reference and work programme has been undertaken at each meeting during 2020/21. Further detail on this can be found in the 'Areas for Development' section.

Areas for Development

For the first time, an effectiveness survey was circulated to members of the Committee seeking feedback on the activity of the Committee during 2020/21. On the whole, the responses received were positive – the full results can be seen in Appendix 2. There was a small degree of divergence against the following questions:

- I believe the Committee receives sufficient assurance to conclude upon its areas of responsibility
- I am confident that the Committee effectively monitors and scrutinises progress against the aligned strategies
- The Committee has structured its agenda and workplan to cover its key responsibilities
- There is clarity in relation to the work of the Committee and its interaction and alignment with other committees

There were also narrative comments received which suggested that the Committee needed to be more strategic focussed, seeking high level assurance rather than receiving detailed updates on the operational performance of the fundraising team.

These comments and areas for development largely reflect the discussions that have taken place at the Committee during 2020/21. In reviewing the Terms of Reference from June 2020 onwards, the Committee requested that they be updated to greater reflect the role of overseeing the fundraising function and to clarify the Committee's role in relation to the strategy and expenditure. Additional references were also added to include the internal and external legislative framework that impacts on the role and function of the Committee.

Fundamentally the Committee is evolving from a bi-annual meeting that predominantly focussed on reviewing the financial and fiduciary performance of the Charity and its investments to a meeting that takes a more regular look at the Trust's fundraising strategy and priorities and how these align with the overarching direction of the organisation. This change of direction is reflected in the proposed work programme set out in the relevant section below and in Appendix 4.

Proposed Amendments to the Terms of Reference

The Committee last reviewed its Terms of Reference in December 2020 and were approved by the Board (with some small amendments in January 2021). No further amendments are proposed and the Terms of Reference can be located in Appendix 3.

Proposed Amendments to the Committee Business Cycle

Each of the Committees established by the Board of Directors has an annual business cycle which is subject to review each year. The business cycle forms the 'core' agenda for Committee meetings throughout the year with scheduled business ensuring that the Committee discharges its responsibilities as set out in the Terms of Reference.

The Charitable Funds Committee last reviewed its annual business cycle and terms of reference on 18 December 2019 and is therefore scheduled to complete a further review in order to set the business cycle for 2021/22.

All members of the Charitable Funds Committee had the opportunity to participate in the annual review and propose any amendments to the business cycle and terms of reference during February 2021 by completing the committee effectiveness survey. As noted above, one comment suggested that the Committee should focus on higher level strategy and assurance and less on the operational performance of the strategy.

The Committee also agreed changes to the business cycle during meetings held on 22 September 2020 and 15 December 2020. These changes were:

- Inclusion of a Revenue & Capital Budget for 2021/22 – annual
- Inclusion of review against identified risks related to the Charity – quarterly
- Increase business cycle to a quarterly cycle

Apart from the amendments listed above, the areas of focus for the 2021/22 business cycle are less additional / new items and rather a required change of focus of existing items. For instance, the regular fundraising update should provide a high-level strategic focus of how the Trust's fundraising activity is supporting the Trust's strategic aims and objectives rather than detailing operational level issues.

Conclusion

In the final analysis, it is concluded that the Charitable Funds Committee has achieved its objectives for the Financial Year 2020/21.

Phillip Huggon CHAIR
Charitable Funds Committee
April 2021

Appendix 1

Charitable Funds Committee, Attendance at Committee: April 2020 – March 2021

Committee Member	Job Title	June 2020	Sept 2020	Dec 2020	Mar 2021	% Attendance
Phil Huggon	Non-Executive (Committee Chair)	✓	✓	✓	✓	100
Jo Moore	Non-Executive	✓	✓	AP	AP	50
Tony Okotie	Non-Executive	✓	✓	AP	✓	75
Michelle Turner	Chief People Officer	✓	✓	✓	AP	75
Eva Horgan	Deputy Director of Finance	✓	✓	✓	✓	100
Caron Lappin	Director of Nursing & Midwifery / General Purpose Fund Holder (until Aug 2020)	AP	NM			75
Gaynor Thomason	Interim Director of Nursing & Midwifery (April – Oct 2020)	✓	✓	NM		
Janet Brennan	Acting Director of Nursing & Midwifery (Nov-Dec 2020 only)	NM		✓	✓	
Marie Forshaw	Director of Nursing & Midwifery / General Purpose Fund Holder (as of Jan 2021)	NM			AP	
Chris Gough	Financial Accountant	✓	✓	✓	✓	100
Kate Davis	Head of Fundraising	✓	✓	✓	✓	100

Appendix 2

Charitable Funds Committee Effectiveness Review

6	01:33	Active
Responses	Average time to complete	Status

1. I understand the duties of the committee.

Strongly agree	4
Agree	2
Disagree	0
Strongly disagree	0
Unable to answer	0

2. I believe the committee receives sufficient assurance to conclude upon its areas of responsibility.

Strongly agree	1
Agree	4
Disagree	1
Strongly disagree	0
Unable to answer	0

3. I am confident that the committee effectively monitors and scrutinises progress against the aligned strategies.

Strongly agree	0
Agree	5
Disagree	1
Strongly disagree	0
Unable to answer	0

4. I am content that the committee is delivering the right level of assurance to the Board / Committee.

Strongly agree	0
Agree	6
Disagree	0
Strongly disagree	0
Unable to answer	0

5. I believe that the committee effectively seeks assurance that the Trust complies with its own policies, all relevant external regulation and standards of governance and risk management.

Strongly agree	1
Agree	5
Disagree	0
Strongly disagree	0
Unable to answer	0

6. I feel that the committee has the right balance of experience, attendance, knowledge and skills to fulfil its role.

Strongly agree	1
Agree	4
Disagree	0
Strongly disagree	0
Unable to answer	0

7. The committee has structured its agenda and work plan to cover its key responsibilities.

Strongly agree	1
Agree	4
Disagree	1
Strongly disagree	0
Unable to answer	0

8. The committee is effectively chaired.

Strongly agree	1
Agree	5
Disagree	0
Strongly disagree	0
Unable to answer	0

9. All members of the committee are able to participate effectively.

Strongly agree	2
Agree	4
Disagree	0
Strongly disagree	0
Unable to answer	0

10. There is clarity in relation to the work of the committee and its interaction and alignment with other committees.

Strongly agree	1
Agree	4
Disagree	1
Strongly disagree	0
Unable to answer	0

Appendix 3

CHARITABLE FUNDS COMMITTEE
TERMS OF REFERENCE

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

	h. ensure systems and processes are in place to receive, account for, deploy and invest funds raised in accordance with charity law; i. ensure systems, processes and communication are in place around fundraising, staff engagement and funding commitments; j. ensure a cohesive policy around external media and communication; k. encourage a culture of fundraising and raise the profile of the Charity within the Trust and with external partner organisations l. ensure effective communication regarding 'whistleblowing' relating to fundraising, donations or subsequent use of funds. **Investment Management** m. Consider and agree an investment strategy for the safe and secure investment of funds not immediately required for use, taking into account any appropriate ethical considerations. n. Appoint and review external investment advisors and operational fund managers. o. Review the performance of investments on a regular basis (utilising comparator information) with the external investment advisors to ensure the optimum return from surplus funds.
Membership:	The Committee membership shall consist of the following: • A Chairman who shall be a Non-executive director • Two other Non-executive Directors • Director of Finance (or nominated deputy) • Director of Workforce and Marketing • Director of Nursing and Midwifery • Financial Accountant • Head of Fundraising Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. The Board of Directors will appoint a Non-Executive Director as Chair of the Committee. Should the Chair be absent from a meeting of the Committee, the Committee may appoint a Chair of the meeting from amongst the Non-Executive Directors present.

Quorum:	A quorum shall be three members which must include one Executive Director and one Non-Executive Director.
Voting:	Each member will have one vote with the Chair having a second and casting vote, if required. Should a vote be necessary a decision will be determined by a simple majority.
Attendance:	**a. Members** Members will be required to attend a minimum of 75% of all meetings. **b. Officers** The non-executive Chairman shall normally attend meetings. Other Board members shall also have right of attendance subject to invitation by the Chairman of the Committee. The Fundraiser to attend as required at request of the Committee. Other officers and staff of the Trust will be invited to attend the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed. Representatives from partner organisations or other external bodies may be invited to attend as appropriate. Such representatives will not have voting rights.
Frequency:	Meetings shall be held on a quarterly basis. Additional meetings may be arranged from time to time, if required, to support the effective functioning of the Trust.
Authority:	The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of representatives from partner organisations or other external bodies or organisations with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities. This includes seeking the advice of specialists from within and outside the NHS as appropriate.
Accountability and reporting arrangements:	The minutes of the Charitable Funds Committee shall be formally recorded and a Chair's Report will be submitted to the subsequent Board of Directors for assurance. Approved minutes will be made available to all Board members upon request.
Reporting Committees/Groups	The Charitable Funds Committee has no reporting committees / groups.
Monitoring effectiveness:	The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements.

Review:	These terms of reference will be reviewed at least annually by the Committee.
Reviewed by: Charitable Funds Committee:	15 December 2020 16 March 2021
Approved by: Board of Directors	January 2021 [01 April 2021]
Review date:	March 2022
Document owner:	Mark Grimshaw, Trust Secretary Email: mark.grimshaw@lwh.nhs.uk Tel: 0151 702 4033

APPENDIX 4

Charitable Funds Committee	WORKPLAN 2021/22					
			Quarter 1	Quarter 2	Quarter 3	Quarter 4
	Exec / Senior Owner	To Board	14 June 2021	20 Sept 2021	13 Dec 2021	21 March 2022
Standing Items						
Minutes of Previous meeting	Trust Secretary		✓	✓	✓	✓
Actions/Matters Arising	Trust Secretary		✓	✓	✓	✓
Chairs Report - Verbal	Chair		✓	✓	✓	✓
Review of risk impacts of items discussed	Chair		✓	✓	✓	✓
Any other business	Chair		✓	✓	✓	✓
Review of meeting	Chair		✓	✓	✓	✓
Review of BAF risks: CFC related risks	Chief People Officer		✓	✓	✓	✓
MATTERS FOR DISCUSSION & COMMITTEE ACTION/DECISION						
Charitable Funds Strategy Review	Chief People Officer		✓	✓	✓	
Quarterly Financial Position Report	Director of Finance		✓	✓	✓	✓
Revenue & Capital Budget for 2022/23	Director of Finance					✓
CF Applications Impact Annual review	Director of Finance		✓			
Fundraising Update	Chief People Officer		✓	✓	✓	✓
Approval of Annual Report and Accounts (draft)	Director of Finance	✓			✓	
Investment Report	Investec			✓	✓	✓
Authorisation of funding applications expenditure (as required)	Director of Finance		✓		✓	
Volunteer Strategy Achievements	Chief People Officer		✓			
Review of Fund Signatories'	Director of Finance				✓	
MATTERS FOR APPROVAL / DECISION						
CFC Terms of Reference	Trust Secretary	✓				✓
CFC Business Cycle	Trust Secretary					✓

Liverpool Women's NHS Foundation Trust

Agenda Item	21/22/11a

MEETING	**Trust Board**
PAPER/REPORT TITLE:	**Corporate Objectives 2020/21: Year-End Review**
DATE OF MEETING:	Thursday, 01 April 2021
ACTION REQUIRED	**Receive**
EXECUTIVE DIRECTOR:	Executives
AUTHOR(S):	Mark Grimshaw, Trust Secretary
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** 1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☐ 2. To be ambitious and *efficient* and make the best use of available resource ☒ 3. To deliver *safe* services ☒ 4. To participate in high quality research and to deliver the most *effective* Outcomes ☒ 5. To deliver the best possible *experience* for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust…….* ☐ ***2.*** *Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have sufficient numbers of clinical staff with the capability and capacity to deliver the best care. ……* ☒ ***3.*** *The Trust is not financially sustainable beyond the current financial year……* ☐ ***4.*** *Failure to deliver the annual financial plan ……* ☐ ***5.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision ……* ☒ ***6.*** *Ineffective understanding and learning following significant events……* ☒ ***7.*** *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):	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 performance against the 2020/21 Corporate Objectives***			
PREVIOUSLY CONSIDERED BY:	**Committee name**	Quality Committee, FPBD Committee, PPF Committee		
	Date of meeting	March 2021		

Executive Summary

The Board of Directors reviewed the corporate objectives 2020/21 at its meeting on 7 May 2020 and formally approved them.

The cycle of periodic review usually involves the Committees and the Board reviewing progress on the Corporate Objectives on a six-monthly basis. In light of the Covid-19 pandemic, and to ensure that the objectives remained feasible and deliverable, it was agreed that the 2020/21 objectives be reviewed in three months and then again at six months. This report provides the final outturn position.

Consideration of the corporate objectives have been given by each of the Board Committees, and they are now presented to the Board for noting.

It is intended to report the draft Corporate Objectives for 2021/22 at the April 2021 Committees (Putting people First via email) ahead of Board approval in May 2021. In discussing the 2020/21 objectives with the Committees, there was agreement that the 2021/22 objectives would benefit from being SMART with clear linkages made to the updated Corporate Strategy whilst avoiding objectives already in place in other strategies and frameworks.

Recommendation

The Board is asked to note performance against the 2020/21 Corporate Objectives.

Report

The Vision Aims and Values have been developed over a long period of time with input from the Board, Staff, Governors and Stakeholders.

Our vision:		To be the recognised leader in healthcare for women, babies and their families
Our strategic aims – WE SEE:	W	To develop a well led, capable, motivated and entrepreneurial **W**orkforce;
	E	To be ambitious and **E**fficient and make best use of available resources;
	S	To deliver **S**afe services;
	E	To participate in high quality research in order to deliver the most **E**ffective outcomes;
	E	To deliver the best possible **E**xperience for patients and staff.
Our values – We CARE and we LEARN:		Caring – we show we care about people; Ambition – we want the best for people Respect – we value the differences and talents of people; Engaging – we involve people in how we do things; LEARN – we learn from people past, present and future.

To develop a Well Led, capable, motivated and entrepreneurial Workforce				
Proposed Corporate Objective	**Executive Lead**	**Relevant Strategy**	**Board Committee**	**Outturn Position**
Improving the Health & Wellbeing of the workforce by moving to upper quartile performance for % sickness absence and stress related absence incrementally between 2019-2021 as measured by the Annual Staff Survey	CPO	People Strategy	Putting People First	The Trust continues to enact its health and wellbeing strategy. Following a recent discussion at Trust Board it has been agreed that Sleep will be a major theme in 2021/22. Health and wellbeing will be integrated into our Trust behavioural framework currently in development. Funding is also being identified to establish a small budget for HWB events and programmes. The staff survey score for HWB in 2020 remained static and we are focused on ensuring that the 'basics' such as effective rostering, breaks and staffing are in place in our clinical areas, especially maternity as without these, HWB interventions will have minimal impact. We are currently engaging in national and regional discussions about incorporating wellbeing into recovery plans.
Improving the organisation's climate and increasing the overall staff engagement score (as measured by Annual Staff Survey & the Staff Friends & Family Test) to upper quartile for acute specialist Trusts incrementally between 2019-2021	CPO	People Strategy	Putting People First	The staff engagement score remained static at 7.1 out of 10 (against an average score of 7.4 for acute specialist Trusts) This remains a key area of focus and feature of Divisional People Plans. Wellbeing was a key driver of staff engagement as outlined in the NHS People Plan and this, along with the launch of the LWH leadership strategy will be a focus for the next 12 months. LWH is also contributing to the regional staff engagement workstream emanating from the NHS People Plan.

Expanding the Trust's reach into its communities through extending its work experience, work training, guaranteed interview and apprenticeship schemes	CPO	People Strategy	Putting People First	Pre-employment programmes will restart in the Summer and the Trust is working with the Princes Trust and Kickstart to offer more placements to young people. Careers events and partnering with schools for mentoring is now focusing on schools in our local area to create opportunities for those young people who may not have considered a career at LWH
Shaping workforce to meet operational needs through effective workforce planning and partnerships	CPO	People Strategy	Putting People First	HR Business Partners continue to input into the Operational Planning and Budget setting processes and support the utilisation of workforce planning tools such as the forthcoming Birthrate Plus review.

To be ambitious and Efficient and make best use of available resources

Corporate Objective – Proposed update	Executive Lead	Relevant Strategy	Board Committee	Outturn Position
Deliver the financial plan for 2020/21, achieving quarterly targets and optimising the opportunities for financial recovery funding through system working.	DoF	Operational Plan 2020/21	FPBD	The Trust agreed an annual 'breakeven' plan for 20/21 however the COVID pandemic led to operational and financial planning regimes to be paused and replaced with a temporary finance regime. For the first half of the year this allowed the Trust to breakeven through a series of retrospective top ups, however for the second half of the year the level of retrospective top up has been significantly reduced and the Trust is now predicting a net deficit of £4.6m for 20/21.

				The deficit is driven by an inadequate monthly block income payment allocated to the Trust based on historical data which the Trust has regularly flagged to the wider system. Strong financial controls remain in place within the organisation and C&M HCP organisations have worked well together to achieve the best possible outcomes in the context of the pandemic.
Deliver the operational plan for 2020/21, achieving quarterly targets and ensuring that appropriate actions are in place to respond to areas of underperformance.	COO	Operational Plan 2020/21	FPBD	The North West experienced 3 waves of the Covid-19 Pandemic in 2021/22 For large parts of the year the NHS mandated routine work be paused and only the highest priority work to continue Cancer work was prioritised, the Trust maintained delivery of the 2-week referral target and demonstrated achievement of the 31-day target. The Trust worked as part of the Cheshire and Mersey Cancer Alliance to achieve this. Reprioritization of patients meant the 62-day target was not achieved. The Trust experienced an increase in routine 52 week waits in line with the whole of the NHS due to the national pauses in elective surgery. The 4 Hr urgent care target was achieved for the year The Continuity of Carer target showed progress towards the later part of the year
Demonstrate the effective use of resources in providing high quality, efficient and sustainable care, maintaining robust grip and control and ensuring that opportunities for improved working arising from the COVID-19 response are realised.	DoF	Operational Plan 2020/21	FPBD	Good grip was maintained during the pandemic supported by 'High Assurance' internal audit outcomes in the year across financial systems and reporting.

				Costs relating to Covid-19 expenditure were carefully managed, recorded and monitored within the Trust. Lessons learned from the initial Covid-19 response were used to support subsequent waves. Organisations across Cheshire and Merseyside worked together optimise use of available resources across the wider geography. CIP delivery was not required nationally for the first half of the year. However, the Trust had £3.7m of schemes identified before delivery was paused. While a number of planned schemes were paused as a result of the pandemic, those schemes which could safely proceed have done so, delivering CIP of £1.1m from month 7 and £2m in total for the year.

To deliver Safe services				
Corporate Objective – Proposed update	**Executive Lead**	**Relevant Strategy**	**Board Committee**	**Outturn Position**
Maintain regulatory confidence & compliance	CEO	All	All	Whilst some reporting regimes were paused or stood down during Covid-19, the Trust has maintained internal processes and has remained cognisant of changing and updated guidance, particularly through the Covid-19 oversight and scrutiny group. The BAF risk score relating to this objective was increased in June 2020. This was in recognition that there may be issues in meeting the Health and Safety Executive requirements for supporting staff returning to the work environment, due to the current estate layout and capacity i.e. social distancing. This issue was monitored closely and the BAF risk was subsequently de-escalated and agreed to be removed from the BAF in the November 2020 Board.

Delivery of in-year Quality Strategy objectives including the delivery of a Quality Improvement Strategy	MD	Quality Strategy	Quality	The Clinical and Quality Strategy was approved by the Board in September 2020. An update on delivery against the objectives is scheduled for the March 2021 Quality Committee. Outline of key methodologies for use in QI across LWH had been developed with associated training programme and key documents. New Quality Improvement web page has been developed on the Trust intranet which all staff can access. The GREAT day on the 30th April 2021 will be dedicated to Quality Improvement.
Deliver the objectives defined in the Trust LocSSIP Group's Terms of Reference	MD	Quality Strategy	Quality	The Quality Committee received assurance on progress being made on LocSSIP compliance. Whilst progress was recognised, the Committee agreed to monitor compliance on a quarterly basis.
Begin to embed ward accreditation across clinical areas during 2020/21	DoN&M	Quality Strategy	Quality	All areas have now joined the ward accreditation programme. In early 2021/22 it is planned to undertake an external review of the Trust's ward accreditation programme. The outcomes from this review will be utilised to identify improvements in the Trust's processes.
Development of Clinical Strategy to ensure robust recovery plans following COVID-19 and that lessons are learned.	MD	Clinical Strategy	Quality	The Clinical and Quality Strategy was approved by the Board in September 2020. This includes references to how lessons from Covid-19 have informed the strategy.
Successfully deliver the final phase of the Neonatal new build time and to budget, as well as develop further capital investments into infrastructure which will enhance the safety of the service (blood bank, diagnostic, robotics). Develop relationships with other system providers to ensure estate utilisation and development takes into account the relevant needs of local partners.	COO/ DoF	Future Generations	FPBD	The Neonatal unit has been completed on time and to budget. The Trust was successful in securing £6.5m additional Public Dividend Capital (PDC) to help enhance the safety of the service while on Crown Street and while awaiting approval of the capital for the long-term preferred option. The Trust continues to work with partners across Cheshire and Merseyside to ensure that

				these capital enhancements deliver the best solutions and value to the wider system.
Working in partnership with providers and commissioners to ensure quality safe services are delivered to the population of the region and to ensure operational recovery post COVID-19. This will include working closely with the following:- • Cheshire and Merseyside Health & Care Partnership (STP) to develop and influence regional strategy • Liverpool Provider Alliance in supporting the One Liverpool Plan • Alder Hey to implement the Neonatal Single Service on two sites • LUHFT to strengthen existing partnerships	COO / MD	Operational Plan	FPBD	The Trust has been working under a command and control structure since the Covid-19 outbreak and within this has ensured that support to other partners has been offered and provided when appropriate e.g. step-down beds provided for LUHFT, gynaecological hub for C&M and continuing progression of the neonatal partnership. Mutual aid has also been developed and offered through the second wave of the pandemic. Engagement specific to the stated objectives has continued. Active partnership working is likely to continue to be a vital way of operating throughout 2020/21 and beyond. The Board has been receiving regular updates on various aspects of partnership working.
Electronic Patient Record project delivery - Identify, procure and begin to install a new record which meets the requirements of the organisation	MD	EPR Project Plan	FPBD / Quality	The Board agreed the EPR business plan in July 2020. The programme is now underway with regular updates provided to the FPBD Committee.
Develop IM&T as a strategic enabler ensuring that clinical systems are fit for purpose, forward focussed and embrace the wider strategic view of the health economy	DoF	IT Strategy	FPBD	The Trust has developed and launched an updated IM&T Strategy that focuses on technology underpinning improvements in services and experience for both patients and staff. There are a number of developments in place that demonstrate positive impacts across the organisation and the Trust continues to work with the HCP on the longer-term system strategic developments.
Maintain appropriate staffing levels for the level required to maintain patient safety.	DoN&M	Quality & People Strategies	Putting People First	PPF Committee continues to review Safe staffing levels and take assurance from the Director of Nursing & Midwifery

To implement the in-year objectives of the Fair & Just Culture Programme	CPO	People Strategy	Putting People First	Year 3 objectives are in progress. Project will be integrated into the new role of Head of Inclusion, Culture and Engagement. Key focus for 2021 is the delivery of F&J training to 200 managers.

To participate in high quality research in order to deliver the most Effective outcomes				
Proposed Corporate Objective	**Executive Lead**	**Relevant Strategy**	**Board Committee**	**Outturn Position**
Develop closer working relationships with University of Liverpool with respect to research and innovation	MD	R&D	Quality	Covid-19 research has provided a common focus and central research command and control process. LWH participated in this with the University of Liverpool and Liverpool Health Partners leading. The Trust is actively looking to progress to University Hospital Status and is looking to expand the number of clinical academics within the Trust to facilitate this.
Successful implementation of the Trust's Research and Development Strategy to enhance the Research and Innovation capabilities of the Trust	MD	R&D	Quality	A post implementation review of the strategy has shown that the aims and objectives were largely achieved. A refresh of the Strategy is planned for 2021-2022.
Work in partnership with the University of Liverpool to prepare for implementation of the Children Growing Up in Liverpool (C-GULL) programme in 2021/22	MD	R&D	Quality	The Trust continues to work with the University of Liverpool to prepare for implementation of the Children Growing Up in Liverpool (C-GULL) programme in 2021/22. The objective remains feasible. Progress has been slowed due to COVID 19.

To deliver the best possible Experience for patients and staff				
Proposed Corporate Objective	**Executive Lead**	**Relevant Strategy**	**Board Committee**	**Outturn Position**

Providing a patient focused experience, seeking feedback to further enhance our service provision whilst taking account of the pressures experienced by services.	DoN&M	Patient Experience Strategy	Quality	The Experience Senate has reviewed the patient experience throughout 2020/21 with particular attention given to the impact of Covid-19 on service users. The Trust is in the process of reviewing and updating its patient experience strategy and is currently undertaking an assessment against NHSE's patient experience framework to establish a baseline. The 'Experience Senate' is also being refreshed to provide an enhanced focus on patient involvement.

Delivery of the Future Generations Strategy				
Proposed Corporate Objective	**Executive Lead**	**Relevant Strategy**	**Board Committee**	**Outturn Position**
Support Commissioners and Regulators to agree strategic direction for Trust services, commencing with public consultation and Commissioner Decision Making Business Case.	CEO	Future Generations	Board specific	Whilst progress against this objective has been limited during the pandemic, this remains a key focus for the Trust. Activities in this area recommenced in Q4 of the period and will continue into 2021/22
Work jointly with other providers and regulators to consider options for future collaborations and organisational form.	DoF	Future Generations	Board specific	The Trust has continued to work closely with other providers in a number of existing partnership arrangements, and the Trust continues to engage in conversations with partners across Cheshire and Mersey to consider where these partnerships could be expanded or strengthened. During the pandemic the Trust has been able to support other providers by delivering mutual aid and will continue to work closely with providers and regulators to explore possibilities for future collaborations.
Retain Public and Staff Confidence through an effective Communications and Engagement Strategy	CPO	Future Generations	Board specific	A summary Future Generations document was produced and published for staff and the wider public which set out the longer term plans for the services. Engagement with stakeholders (patients, governors members, staff) via surveys and focus groups supported the

				development and production of a refreshed corporate strategy 'Our Strategy' finalised in March 2021 which also references 'Future Generations' progress. This is being launched to staff and external stakeholders through a number of mediums with ongoing stakeholder engagement planned.

	Agenda Item 21/22/011b
MEETING	**Trust Board**
PAPER/REPORT TITLE:	**Revised Risk Management Strategy for 2021-22**
DATE OF MEETING:	Thursday, 01 April 2021
ACTION REQUIRED	**For Approval**
EXECUTIVE DIRECTOR:	Marie Forshaw, Director of Nursing and Midwifery
AUTHOR(S):	Allan Hawksey Risk and Patient Safety Manager and Christopher Lube, Head of Governance and Quality
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** 1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☒ 2. To be ambitious and *efficient* and make the best use of available resource ☒ 3. To deliver *safe* services ☒ 4. To participate in high quality research and to deliver the most *effective* Outcomes ☒ 5. To deliver the best possible *experience* for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust* ☒ ***2.*** *The Trust is not financially sustainable beyond the current financial year* ☒ ***3.*** *Failure to deliver the annual financial plan* ☒ ***4.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision* ☒ ***5.*** *Ineffective understanding and learning following significant events* ☒ ***6.*** *Inability to achieve and maintain regulatory compliance, performance and assurance* ☒ ***7.*** *Inability to deliver the best clinical outcomes for patients* ☒ ***8.*** *Poorly delivered positive experience for those engaging with our services* ☒
CQC DOMAIN	***Which Domain?*** ***SAFE-*** *People are protected from abuse and harm* ☒ ***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☒ ***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☒ ***RESPONSIVE –*** *the services meet people's needs.* ☒ ***WELL-LED -*** *the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.* ☒ ***ALL DOMAINS*** ☐
LINK TO TRUST STRATEGY, PLAN AND	**1.** Trust Constitution ☒ **4.** NHS Constitution ☒ **2.** Operational Plan ☒ **5.** Equality and Diversity ☒

EXTERNAL REQUIREMENT	**3.** NHS Compliance ☒	***6.*** Other: **Click here to enter text.**
FREEDOM OF INFORMATION (FOIA):	2. This report will not be published under the Trust's Publication Scheme due to exemptions under S21 of the Freedom of Information Act 2000, because the information contained is reasonably accessible by other means	
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	The Trust Board members are requested to review and approve the recommended Risk Management Strategy for 2021/22.	
PREVIOUSLY CONSIDERED BY:	**Committee name**	Quality Committee Audit Committee
	Date of meeting	March 2021

Executive Summary

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

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

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

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

Report

The following report provides a review of the current Risk Management Strategy (last reviewed in 2020) and provides an updated proposed Risk Management Strategy for 2021/22, which identifies changes which are required to maintain it as a live document.

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

Proposed Risk Management Strategy for 2021/22

The Risk Management Strategy (version 14 proposed for 2021 onwards) has undergone a number of amendments and additions to reflect developments in the Trust's approach to assessment, management and mitigation of risk as follows:

- Reviewed statement of intent from the Chief Executive (subject to finalisation by the Chief Executive)
- Update regarding the role of the Risk and Patient Safety Manager

- Introduction of the roles of 3 Patient Safety Specialists (additional responsibilities in exisiting roles) from the Patient Safety Strategy 2020
- Update wording regarding the underpinning of the BAF by Key Corporate Risks. This is in recognition that whilst the BAF is supported by the risk management framework, it is not a risk register in itself.
- Addition of the NHS key Fraud Risks and the EPRR and Major Incident Recovery Plan
- Risk team profile (and key contacts) including divisional governance management structure

Conclusion

The updates and changes which have been made to the attached proposed Risk Management Strategy for 2021/22 relate to measures implemented to continue to improve the Trust's assessment, management and mitigation of risk to ensure that risk is mitigated as much as is practicable, in accordance with the Trust's risk appetite.

The proposed Risk Management Strategy for 2021-22 was presented to the Quality Committee on the 22nd March with a request to review and a proposal to recommend the strategy to the Trust Board for approval. The Quality Committee were in full agreement with the revised strategy and recommended its approval to the Trust Board.

The recommended Risk Management Strategy Version 14.0 for review and approval is attached

Recommendation

The Trust Board members are requested to review and approve the recommended Risk Management Strategy for 2021/22.

Risk Management Strategy

Liverpool Women's NHS Foundation Trust

Version 14.0
March 2021

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

1 Foreword : Trust Risk Statement (statement to be reviewed and agreed by the Chief Executive)

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

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

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

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

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

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

Kathryn Thomson
Chief Executive

2 Introduction

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

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

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

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

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

2.1 The Core Elements of the Strategy

Risk Management Process

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

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

The identification of risk is the essential element of any risk management strategy or process. There needs to be a fully identified and supported approach to this element of risk management which includes formal risk assessment generated for incidents, claims, complaints etc. the identification of any new risks as part of normal business of meetings from papers or concerns raised is beneficial. The use of horizon scanning which is in built into the agendas of a number of committee, sub-committee and groups within the Trust provides a solid foundation in supporting robust discussions within the meeting and the identification of new risk on the horizon. This key element needs to be developed and embedded further within the divisional boards and sub groups to ensure there is a Trust wide approach to identifying risks on the horizon.

Governance Structure to Support Risk Management

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

- Board of Directors
- Executive Management Team

Divisional Governance Management supported (since April 2019) by divisional governance managers, who work as part of the senior management team within each division.

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

1. **The Board Assurance Framework (BAF)** sets out the strategic objectives, identifies key underpinning risks in relation to each strategic objective along with the controls in place and assurances available on their operation. The BAF is cross-referenced with, and contains all risk within the Corporate Risk Register. The BAF can be used to drive the board agenda. The BAF highlights national key Fraud risks for the Trust and Covid Emergency Planning and Major Incident Recovery Plans.

2. **The Corporate Risk Register (CRR)** is the corporate high level operational risk register used as a tool for managing risks and monitoring actions and plans against them. Used correctly it demonstrates that an effective risk management approach is in operation within the Trust.
3. **Divisional and Local risk registers** are for recording and managing risks to the routine daily activities of each service. Local risks are discussed at team meetings, risks that cannot be managed at the local level may be escalated to the CRR

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

2.2 Aim

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

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

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

2.3 Risk Appetite and Statement

Risk Appetite

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

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

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

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

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

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

Risk Appetite Statement

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

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

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

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

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

2.4 Responsibility and Accountability

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

- Identifying risk owners that have the accountability and authority to manage risks.
- Identifying who is accountable for the development, implementation and maintenance of the framework for managing risk.
- Identifying other responsibilities of people at all levels in the organisation for the risk management process.
- Establishing performance measurement and external/internal reporting and escalation processes; and
- Ensuring appropriate levels of recognition.

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

2.5 Individual Responsibilities

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

Chief Executive

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

Director of Finance

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

Director of Nursing and Midwifery

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

Head of Governance and Quality

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

Trust Secretary

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

Medical Director

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

Executive Directors

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

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

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

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

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

Heads of Corporate Services

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

Patient Safety Specialists

Patient Safety Specialists are new roles identified within the Patient Safety Strategy, of which the Trust has 3 nominated specialists. They are the patient safety experts within the Organisation to provide leadership, visibility and expert support to patient safety work. They are expected to:

- Support the development of a patient safety culture and safety systems.
- Engage directly with the executive team.
- Lead, oversee or support patient safety improvement and ensure that systems thinking, human factors understanding and just culture principles are embedded in all patient safety processes.
- Promote patient safety thinking beyond things going wrong to why things routinely go right healthcare and the systems approach to patient safety.
- Implement the rollout out of the new Patient Safety Incident Response Framework expected from Spring 2022.

Senior Managers

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

- Identify risks to the safety, effectiveness and quality of services, finance, delivery of objectives and reputation- drawing on the knowledge of front line colleagues.
- Identify risk owners with the seniority to influence and be accountable should the risk materialise.
- Assess the rating of individual risks looking at the likelihood that they will happen, and the consequence if they do.
- Identify the actions needed to reduce the risk and assign action owners.
- Record risks on the risk register.

- Check frequently on action progress, especially for high severity risks.
- Apply healthy critical challenge, without blaming others for identifying and highlighting risks, or consider that they are being unduly negative in doing so.
- Implement a process to escalate the most severe risks, and use it.

Risk and Patient Safety Manager

The Risk and Patient Safety Manager will be responsible for ensuring that the systems and processes for risk management are monitored and maintained for their effectiveness. They:

- Will lead on effective operational risk management across the Trust as the Governance Lead reporting to the Head of Governance and Quality
- Have oversight of all risk within the Trust
- Triangulates all trust risks through quarterly Integrated Governance Reports to Quality Committee
- Ensure risk is being managed proactively and effectively, ensuring escalation or de-escalation where required.
- Ensure the Ulysses Risk Management system is being fully utilised effectively
- Ensure risk and risk actions are regularly reviewed within required timescales
- Report to the Corporate Risk Committee regarding new risks, closed risk assurance and the effectiveness of risk management across the Trust bi-monthly.
- Plan and undertake provisional underpinning work for the new Patient Safety Incident Response Framework and identify key performance indicators, once operational, for the forthcoming 12 month period.

All Staff

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

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

2.6 Committee Duties and Responsibilities

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

Board of Directors

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

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

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

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

Audit Committee

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

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

Finance, Performance and Business Development Committee

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

Quality Committee

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

Putting People First Committee

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

Trust Executive Team

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

2.7 Clinical Services and Corporate Risk Management Arrangements

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

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

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

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

Corporate Risk Committee

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

3 Process for Managing Risk

Stage 1 – Clarifying Objectives

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

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

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

Stage 2 – Identifying Risks to Objectives

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

- Do you know what all of the risks to the delivery of your objectives or work are, especially those that impact on delivering high quality, safe services?
- What could happen, and what could go wrong?
- How and why could this happen?
- What is depended upon for continued success?
- Is there anyone else who might provide a different perspective on your risks?
- Is it an operational risk or a risk to a strategic objective?

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

Stage 3 – Defining and Recording Risks

Once the risk has been identified then:

- Undertake a comprehensive risk assessment
    - Describe the risk, so that others understand what the risk is in relation to the description of condition, cause and consequence, being clear for each one.
    - Complete an initial risk assessment score so that the risk is appropriately escalated to management where required
    - Assign an owner to the risk who will oversee the risk management and review the initial score
    - List the key controls (actions) being taken to reduce the likelihood of the risk happening, or reduce the impact.

- If it is a severe risk (use risk matrix Appendix A) then consider what the contingency action plan is, i.e. what will you do should the risk happen.
- Rate the likelihood of the risk materialising.
- Rate the consequence of the risk happening.

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

Stage 4 – Risk Register(s)

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

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

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

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

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

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

2. Source of, how or where the risk was identified. This could include:
   - Business planning.
   - Clinical audit.
   - Complaints/PALS.
   - External audit.
   - External review.
   - Incident.
   - Internal audit.
   - Legislation.
   - Litigation.
   - National risks such as financial fraud
   - NICE guidance.
   - Regulatory standard.
   - Risk Assessment.
3. Risk description as the name suggests, allows the risk to be described. It is important that risks are clearly articulated. If not, then it is difficult to put effective controls, or actions, in place to reduce the risk materialising and contingency plans. Using the following subheadings will help to clearly describe risk:
   - Condition
   - Cause
   - I Consequence

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

Getting this right is important as the key controls relate directly to the description of the risk. Key controls are the measures put in place as preventative measures to lessen or reduce the likelihood or consequence of the risk happening and/or the severity if it does. You must ensure that each control (or action where a gap in control has been identified) has an owner and target completion date.

These must describe the practical steps that need to be taken to manage and control the risk. Without this stage, risk management is no more than a paper based or bureaucratic process.

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

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

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

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

Stage 5 – Escalation and De-escalation of Risks

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

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

For example: a service risk scoring high or extreme should only be escalated to the corporate risk register if it is **not** manageable within the service. If the risk **is** manageable within the service then it remains on the service risk register. In a case whereby the risk is to be escalated to the corporate risk register, options for controls or mitigation must be offered. The risk owner should discuss and seek approval from their manager before risk escalation to the next level. Once an escalated risk has reached the Corporate Risk Register, the Corporate Risk Committee will consider the risk control options advised and make recommendations for action, the risk will then be de- escalated and returned to the risk owner for implementation. Where a risk is de-escalated this must be communicated to the management level below, and the risk monitored at the appropriate management level and risk forum.

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

Stage 6 - Closure of Risk

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

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

All closed risks will be archived and not deleted

3.1 Risk Profile

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

3.2 Horizon Scanning

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

By implementing formal mechanisms to horizon scanning the Trust will be better able to respond to changes or emerging issues in a planned structured and co-ordinated way. Issues identified through horizon scanning should link into and inform the business planning process. As an approach it should consider ongoing risks to services.

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

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

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

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

4 Training

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

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

All new staff undertake risk management training as part of their Corporate Induction. Training is mandated for all other staff.

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

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

5 Evidence Base

- Home Office Risk Management Policy and Guidance, Home Office (2011).
- A Risk Matrix for Risk Managers, National Patient Safety Agency (2008).
- NHS Audit Committee Handbook, Department of Health (2011).
- UK Corporate Governance Code, Financial Reporting Council (2010).
- 'Taking it on Trust: A Review of How Boards of NHS Trusts and Foundation Trusts Get Their Assurance', Audit Commission (2009).
- The Orange Book (Management of Risk – Principles and Concepts), HM Treasury (2004).
- Risk Management Assessment Framework, HM Treasury (2009).
- Understanding and Articulating Risk Appetite, KPMG (2008).
- Risk Appetite Frameworks- how to spot the genuine article, Deloitte (2013).
- Defining Risk Appetite and Managing Risk by Clinical Commissioning Groups and NHS Trusts, Good Governance Institute (2012).
- Good Practice Guide: Managing Risks in Government, National Audit Office (2011).
- Risk Management – principles and guidelines ISO 31000 (2009).
- Patient Safety Strategy (2020)

6 Monitoring Compliance and Audit

The Trust risk team, led by the Head of Governance oversee all risks recorded on the Ulysses risk management system. The team review all new, closed and outstanding risks and quality assures every risk assessment whether ongoing or completed. The team re-open closed risks if necessary, where it is deemed appropriate action has not been taken and audit risks exceeding timescales, escalating to the appropriate management level where necessary,
This strategy will be reviewed annually.

The Trust Risk Team, which includes the divisional governance managers, are always for available for operational advice / support when required and are contactable as follows:

Name	Role	Extension
Chris Lube	Head of Governance	1383
Allan Hawksey	Risk and patient safety manager	4437
Elaine Eccles	Governance support officer	4292
Jenny Lamble	Governance support officer	4489
Laura Thorpe	Divisional Governance Manager (maternity)	4433

Julie Connor	Divisional Governance Manager (gynaecology / Hewitt Centre)	1048
Heather Watterson	Divisional Governance Manager (Neonatal)	1015

7 Dissemination, Implementation and Access to the Document

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

8 Key Performance Indicators

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

					& Midwifery)
Risk management training mandatory for all staff at Corporate induction	100%		Corporate Risk Committee	Annual Report	Head of Governance and Quality (Exec Lead: Director of Nursing & Midwifery)
Risk management training mandatory for all staff as part of their mandatory training	100%		Corporate Risk Committee	Annual Report	Head of Governance and Quality (Exec Lead: Director of Nursing & Midwifery)
Staff compliance with the risk management standard operating procedure (SOP)	100%		Corporate Risk Committee	Annual Report	Head of Governance and Quality (Exec Lead: Director of Nursing & Midwifery)

9 Appendices

Appendix A - Risk Descriptors and Grading

Risk Descriptors

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

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

Likelihood score (L)

What is the likelihood of the consequence occurring?

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

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

Risk scoring = consequence x likelihood (C x L)

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

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

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

The risk matrix above can be used to provide an initial breakdown of the hazards into 4 Categories as follows:

Low Risk	Acceptable risk requiring no immediate action Review annually Place on the appropriate section of the Risk Register
Moderate Risk	Action planned within one month to reduce risk Commenced within 3 months Place on the appropriate section of the Risk Register
High Risk	Actions planned immediately Review Monthly Place on the appropriate section of the Risk Register
Extreme Risk	Immediate Actions required Reviewed weekly by ET Placed on the Corporate Risk Register

Appendix B - Initial Equality Impact Assessment

Name of policy/ business or strategic plans/CIP programme:	**Risk Management Strategy v 14**	
Does the proposal, service or document affect one group more or less favourable than another on the basis of:	**No**	**Justification/evidence and data source**
Age	No	No discrimination / inequality identified, the document sets out the Trust's approach and framework for Risk Management, ensuring this is systematic and objective and applied without prejudice or favour.
Disability: including learning disability, physical, sensory or mental impairment.	No	
Gender reassignment	No	
Marriage or civil partnership	No	
Pregnancy or maternity	No	
Race	No	
Religion or belief	No	
Sex	No	
Sexual orientation	No	
Human Rights – are there any issues which might affect a person's human rights?	**No**	**Justification/evidence and data source**
Right to life	No	No impact on human rights, the document sets out the Trust's approach and framework for Risk Management, ensuring this is systematic and objective and applied without prejudice or favour. The aim being to reduce risks to the organisation, its services and the safety and well-being of patients, visitors, staff and the wider public.
Right to freedom from degrading or humiliating treatment	No	
Right to privacy or family life	No	
Any other of the human rights?	No	

Assessment carried out by: **Christopher Lube**
Date: **15th March 2021**

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

Appendix C – Glossary

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

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

Liverpool Women's NHS Foundation Trust

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

Good Governance Institute

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

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

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Liverpool Women's NHS Foundation Trust

Agenda Item	21/22/011c

MEETING	**Trust Board Meeting**
PAPER/REPORT TITLE:	**Proposed Risk Appetite Statement 2021-22**
DATE OF MEETING:	**1st April 2021**
ACTION REQUIRED	**For Approval**
EXECUTIVE DIRECTOR:	Marie Forshaw, Director of Nursing and Midwifery
AUTHOR(S):	Christopher Lube, Head of Governance and Quality
STRATEGIC OBJECTIVES:	***Which Objective(s)?***
	To develop a well led, capable, motivated and entrepreneurial *workforce* **X**
	To be ambitious and *efficient* and make the best use of available resource **X**
	To deliver *safe* services **X**
	To participate in high quality research and to deliver the most *effective* Outcomes **X**
	To deliver the best possible *experience* for patients and staff **X**
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?***
	Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust **X**
	The Trust is not financially sustainable beyond the current financial year **X**
	Failure to deliver the annual financial plan **X**
	Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision **X**
	Ineffective understanding and learning following significant events **X**
	Inability to achieve and maintain regulatory compliance, performance and assurance **X**
	Inability to deliver the best clinical outcomes for patients **X**
	Poorly delivered positive experience for those engaging with our services **X**
CQC DOMAIN	***Which Domain?***
	SAFE- *People are protected from abuse and harm* ☐
	EFFECTIVE - *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☐
	CARING - *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☐
	RESPONSIVE – *the services meet people's needs.* ☐
	WELL-LED - *the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.* ☐
	ALL DOMAINS **X**

LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution **2.** Operational Plan **3.** NHS Compliance	**x** **x** **x**	**4.** NHS Constitution **5.** Equality and Diversity ***6.*** Other: Click here to enter text.	☐ **x**
FREEDOM OF INFORMATION (FOIA):	2 . This report will not be published under the Trust's Publication Scheme due to exemptions under S21 of the Freedom of Information Act 2000, because the information contained is reasonably accessible by other means			
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	The Board is requested to receive the recommendations of its sub-committees regarding risk appetite and risk tolerance levels for 2021-22 and approve the Risk Appetite Statement for 2021-22.			
PREVIOUSLY CONSIDERED BY:	**Committee name**		Quality Committee Putting People First Committee Finance, Performance and Business Development Committee	
	Date of meeting		March 2021	

1. Executive Summary

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

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

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

What is the Process?
The Liverpool Women's Risk Management Strategy describes the process as follows:

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

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

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

The Board is requested to receive the recommendations of its sub-committees regarding risk appetite and risk tolerance levels for 2021-22 and approve the Risk Appetite Statement for 2021-22.

2. Report

Risk Appetite Levels

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

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

Proposal for 2021-22 Risk Appetite Statement

Following review and discussion at sub –committees of the board the following Risk Appetite Statement for 2021-22 is proposed for review by the Trust Board.

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

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

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

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

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

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

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

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

Liverpool Women's NHS Foundation Trust supports **Moderate** risk against this objective. Whilst this objective was not aligned to the Finance, Performance & Business Development Committee (it was discussed at the Quality Committee), members of the meeting suggested that this should be reviewed and considered to be a **High** risk appetite. It was asserted that a level of service redesign to improve patient outcomes that requires innovation, creativity, and clinical research are considered by Liverpool Women's NHS Foundation Trust to be an essential part of the risk profile of the Trust.

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

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

3. Conclusion

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

The Board's sub-committees, QC, PPF and FPBD have met and agreed the parts of the statement for which they are operationally responsible. As noted above, the FPBD Committee has made a suggestion regarding the risk appetite for research. The Board are now asked to review the statement in its entirety and agree its publication.

4. Recommendations

The Board of Directors is asked to:

a) Receive the recommendations of its sub-committees regarding risk appetite and risk tolerance levels for 2021-22
b) Approve the Risk Appetite Statement for 2021-22.

5. Appendix

Liverpool Women's NHS Foundation Trust

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

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

Good Governance Institute

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

Liverpool Women's NHS Foundation Trust

Agenda Item	21/22/012

MEETING	Trust Board
PAPER/REPORT TITLE:	Emergency Preparedness Resilience and Response Annual Board Report
DATE OF MEETING:	Tuesday, 23 February 2021
ACTION REQUIRED	Assurance
EXECUTIVE DIRECTOR:	Gary Price, Chief Operating Officer
AUTHOR(S):	Lorraine Thomas, Emergency Planning & Business Continuity Manager
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** 1. To develop a well led, capable, motivated and entrepreneurial ***workforce*** ☒ 2. To be ambitious and ***efficient*** and make the best use of available resource ☒ 3. To deliver ***safe*** services ☒ 4. To participate in high quality research and to deliver the most ***effective*** Outcomes ☐ 5. To deliver the best possible ***experience*** for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust*..... ☐ ***2.*** *Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have sufficient numbers of clinical staff with the capability and capacity to deliver the best care.* ..... ☒ ***3.*** *The Trust is not financially sustainable beyond the current financial year*..... ☐ ***4.*** *Failure to deliver the annual financial plan* ..... ☐ ***5.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision* ..... ☐ ***6.*** *Ineffective understanding and learning following significant events*..... ☒ ***7.*** *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: Legal duties.
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:-….)***	*Report for noting.*	
PREVIOUSLY CONSIDERED BY:	**Committee name**	FPBD Committee
	Date of meeting	Tuesday, 23 February 2021

Executive Summary

- This Emergency Preparedness, Resilience and Response (EPRR) Annual Report provides a summary of EPRR activities and achievements in 2020/21. The EPRR strategy implemented by the EPRR Committee aims to support the trust to meet its duties under the Civil Contingencies Act 2004. These duties are supported by compliance to the NHSE/I EPRR Core Standards. It should be noted that due to the Covid 19 Incident response the NHSE/I assessment and assurance process for September 2020 was significantly reduced, however the trust returned positive responses against all criteria.

- In view of the above it should be noted that the Trust Covid 19 incident response led by the Chief Operating Officer / Emergency Accountable Officer and EU Exit Preparedness led by the Director of Finance for 2020/21 required completion of actions identified at national and regional level and submission of situation reports and assurances across numerous aspects of EPRR.

- EPRR work-streams remain focused on achieving and maintaining a high level of compliance to the NHSE EPRR Core Standards for 2021.

Report

Introduction

As a category 1 responder under the Civil Contingencies Act 2004 the trust is required to prepare for emergency and business continuity incidents and ensure that the organisation has the capacity and capability to effectively respond to incidents. Whilst managing emergency situations the trust is required to maintain business continuity, as far as is reasonably practicable, prioritising critical service delivery when necessary.

The trust aims to meet the above duties within a framework that is safe, effective, caring, responsive and well-led. The EPRR agenda is led by the EPRR Accountable Emergency Officer (Chief Operating Officer) supported by the Emergency Planning & Business Continuity Manager and the EPRR Committee. In order to meet its legal duties the trust holds a portfolio of emergency plans and is required to review and test those plans. The process for plan validation includes testing of alerting and escalation procedures, rehearsal of key roles within live incidents and emergency planning exercises and identification of lessons learned for incorporation within subsequent training and incident response.

The trust is required to work in cooperation with other category 1 responders including other NHS Trusts and the emergency services, in relation to both emergency planning and incident response. The trust is represented at the Merseyside Local Health Resilience Partnership. The forum led by NHSE /I aims to coordinate and direct cooperative working including in relation to risk management, review of regional plans and sharing and implementation of lessons learned from exercises and incidents.

EPRR work streams continue to focus on compliance to the NHSE EPRR Core Standards in order to support preparedness for emergency incidents and ensure a high level of compliance in external assurance and audit processes. EPRR objectives for 2020 were detailed within the EPRR Annual Board Report 2019 as below. This report aims to demonstrate the meeting of these objectives.

- High level discussion of the EPRR priorities via the EPRR Committee;
- Review of EPRR Risks;
- Review of Trust emergency plans and arrangements;
- Business continuity planning for scheduled service disruption;
- Provision of EPRR training;
- Working in cooperation with other healthcare responders;
- Effective incident response.

Risk Review

EPRR risks are regularly reviewed and updated including consultation at the EPRR Committee and Corporate Risk Committee. Covid 19 was added to the risk management system in February 2020. Actions and arrangements in relation to this remain in progress.

Trust Emergency & Business Continuity Plans

The trust holds a portfolio of emergency plans which are subject to a process of review as directed by trust governance procedures and as required by changing national, regional and local structures, priorities or lessons learned.

Emergency & Business Continuity Plans	Review Date
EPRR Trust Strategy	October 2023
Major Incident Plan	September 2022
Business Continuity SOP	March 2021
Adverse Weather Plan	February 2024
CBRN Plan	January 2022
Communications / Media Action Card	May 2021
High Profile Patient SOP	April 2021
Fuel Shortages Plan	February 2021 (under review)
Pandemic Influenza Plan	September 2021
Security Lockdown Plan	September 2021
UK International Threat Level Action Card	May 2021
Winter Plan	October 2022

Emergency and business continuity plans revision status is demonstrated above. All plans are subject to consultation and approval via the EPRR Committee and as required submitted to Policy Group in order to ensure trust governance procedures. In addition to the above the Hospital Evacuation Strategy is managed by the Fire Safety Team.

Departmental Business Continuity Plans Review

Departmental business continuity plans were reviewed by service leads for 2020/21.

External Audit and Assurance

The trust was required to submit EPRR assurance to NHSE/I October 2020, including reporting on any actions identified from the NHSE/I EPRR Core Standards assurance process 2019, completion of a Covid 19 mid-term review and confirmation of embedded learning from the mid-term review, including application of Covid 19 response measures to winter preparedness.

Hospital Incident Control Centre Activations

Covid 19 Incident Response

The trust Incident Control Centre (ICC) has been operational throughout the Covid 19 incident response with a virtual approach. The trust response is aligned to national and regional directives and guidance and is led by the trust command and control structure. Trust Strategic Command / Executive Oversight Group provides an escalation route for the Tactical Command Group (TCG) led by the Chief Operating Officer. Senior leaders have attended NHSE/I national and regional fora which aim to support the local response by facilitation of information sharing, interpretation of guidance and benchmarking.

The TCG has been supported by key services leads in order to ensure an effective trust wide response. The Covid 19 incident response included;

- Daily monitoring of capacity, demand and staffing levels;
- Prioritisation of clinical services based on national guidance;
- Enhanced Infection Prevention and Control measures
- Controlled hospital access including review of visiting arrangements;
- Programme of FFP3 mask fit-testing / refresher training;
- Personal Protective Equipment (PPE) supply and issue arrangements;
- Implementation of national and regional guidance;
- Provision of communications and support for trust staff including shielding staff;
- Collaborative working with partner organisations including provision of mutual aid;
- Delivery of Covid 19 testing programme;
- Delivery of Covid 19 vaccination programme;
- Compliance to national and regional reporting arrangements.

EU Exit Preparedness

The Director of Finance is the designated Senior Responsible Officer (SRO) for EU Exit. The EPRR service supports EU Exit preparations and assurance including monitoring via the existing trust command and control arrangements. National preparations for the end of the EU Exit transition period were stepped-up from October 2020 with reintroduction of NHS reporting arrangements and delivery of national webinars. The trust conducted a review of actions and compliance across the seven key areas. NHSE/I webinars were attended by trust leads and situation reports were submitted as required with positive responses to all enquiries.

Borehole Anomaly Incident

The Hospital Incident Control Centre was activated 16 October 2020 in relation to a Borehole Anomaly Incident due to location of potential unexploded ordnance (UXO) on the hospital site. The borehole anomaly was identified during drilling of exploratory bore holes to support construction works. Specialist contractors had been commissioned to provide a survey and advice and in acknowledgement of the increased potential for UXO within the local area a further sub-contractor had been commissioned to provide specialist support including risk assessment.

Incident response in relation to the borehole anomaly was led by the Chief Operating Officer supported by the Chief Executive. The incident was escalated to the emergency services and NHSE/I NW (Cheshire & Merseyside). As indicated by review of the method statement and risk assessment the trust commissioned an intrusive magnetometer survey which was conducted within 24 hours and concluded that the unidentified metal object was not UXO related.

The above incident did not impact on hospital services. An incident debrief report including action plan was presented to the EPRR Committee and Executive Team.

Business Continuity Planning

The trust developed business continuity plans to support the following planned 'incidents'. Management of these plans provided the opportunity to test strategic, tactical and operational business continuity arrangements including rehearsing incident response roles, alerting arrangements and communications.

- Planned electrical shutdown to facilitate electrical infrastructure upgrade scheduled for 15th October 2020 and 14th January 2021.
- Planned telephony services downtime to facilitate telephony upgrade scheduled for 20th June 2020 and 18th September 2020.

External notification in relation to the above included NHSE/I Cheshire & Merseyside, Liverpool Clinical Commissioning Group, local NHS Trusts, North West Ambulance Services and Merseyside Fire & Rescue Service. No impact was anticipated in relation to emergency services.
Lessons learned identified via debrief procedures were incorporated within subsequent planning arrangements.

Training

EPRR training delivered throughout 2020 is detailed below. In some instances training was delivered on a reduced basis due to the impact of Covid 19:

- EPRR Induction training for executives and senior managers joining the on-call rota. Sessions provide information on aspects of EPRR incident response including legal duties, accountability, command and control, escalation and communication, emergency plans and resources.
- Business continuity plans and arrangements were 'live tested' within the Covid 19 incident response in relation to a range of aspects as discussed above and were also tested within the business continuity plans for planned infrastructure upgrades as detailed above.
- Chemical, Biological, Radiological, Nuclear (CBRN) / Hazardous Materials (HazMat) decontamination training is currently being re-designed to further support staff in the emergency areas and senior managers participating in the on-call rota.
- Fire Warden training sessions delivered by Fire Safety Advisors. Reduced nominations are currently accepted for each session due to Covid 19 IPC requirements.
- Fire Evacuation simulations delivered within wards/ departments by the Fire Safety Advisor.

Conclusion / Recommendation

EPRR activities and achievements discussed within this report demonstrate that the Trust remains focused on continuing to meet its duties under the CCA 2004. The Trust EPRR strategy aims to continue to maintain a high level of compliance to the NHSE EPRR Core Standards for 2021.

Agenda Item	21/22/13

MEETING	**Board**
PAPER/REPORT TITLE:	**Board Terms of Reference**
DATE OF MEETING:	Thursday, 01 April 2021
ACTION REQUIRED	**Approve**
EXECUTIVE DIRECTOR:	Mark Grimshaw, Trust Secretary
AUTHOR(S):	Mark Grimshaw, Trust Secretary
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** **1.** To develop a well led, capable, motivated and entrepreneurial ***workforce*** ☒ **2.** To be ambitious and ***efficient*** and make the best use of available resource ☒ **3.** To deliver ***safe*** services ☒ **4.** To participate in high quality research and to deliver the most ***effective*** Outcomes ☒ 5. To deliver the best possible ***experience*** for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust…….* ☐ ***2.*** *Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have sufficient numbers of clinical staff with the capability and capacity to deliver the best care. ……* ☐ ***3.*** *The Trust is not financially sustainable beyond the current financial year……* ☐ ***4.*** *Failure to deliver the annual financial plan ……* ☐ ***5.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision ……* ☐ ***6.*** *Ineffective understanding and learning following significant events……* ☐ ***7.*** *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:*** • ***Review and if deemed appropriate approve the terms of reference included as appendix 1***	
PREVIOUSLY CONSIDERED BY:	**Committee name**	N/A
	Date of meeting	

Executive Summary

The Trust approved a Board Terms of Reference at its meeting held on 7 May 2021. Whilst it is not a requirement to have a Board Terms of Reference, it is considered good practice and had been highlighted as a development point in the Trust's NHS Improvement Well-Led Framework Self-Assessment.

No amendments are proposed but it is good practice to annually review the Terms of Reference.

Recommendation

The Board is asked to:

- Review and if deemed appropriate approve the terms of reference included as appendix 1

Appendix 1:

BOARD OF DIRECTORS
TERMS OF REFERENCE

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

The general responsibilities of the Board are:

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

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

LEADERSHIP

The Board provides active leadership to the organisation by:

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

STRATEGY

The Board:

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

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

CULTURE, ETHICS AND INTEGRITY

The Board:

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

GOVERNANCE

The Board:

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

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

RISK

The Board:

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

COMMUNICATION

The Board:

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

FINANCIAL AND QUALITY SUCCESS

The Board:

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

RESPONSIBILITIES OF BOARD MEMBERS

All Members of the Board:

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

Role of the Trust Chair:

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

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

Role of the Chief Executive

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

Role of Executive Directors (EDs)

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

Role of Non-Executive Directors (NEDs)

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

- Scrutinise the performance of the executive management in meeting agreed goals and objectives, receive adequate information and monitor the reporting of performance. NEDs should satisfy themselves as to the integrity of financial, clinical and other information, and make sure that financial and clinical quality controls, and systems of risk management and governance, are robust and implemented.
- To take an active role in providing advice, support and encouragement to Executive Directors.

Role of the Senior Independent Director (SID)

- Is a Non-Executive Director appointed by the Board in consultation with the Council of Governors to undertake the role. Normally the SID will not be the Vice Trust Chair although this may be the case if the Board deems it necessary.
- Will be available to members of the Foundation Trust and to Governors if they have concerns which, contact through the usual channels of the Trust Chair, Chief Executive, Deputy Chief Executive, Director of Finance and Trust Secretary, has failed to resolve or where it would be inappropriate to use such channels.
- Has a key role in supporting the Trust Chair in leading the Board and acting as a sounding board and source of advice for the Trust Chair. The SID has a role in supporting the Trust Chair in his/her role as Trust Chair of the Council of Governors.

In addition to the duties described here, the SID has the same duties as the other Non-Executive Directors.

Role of the Trust Secretary

The Trust Board shall be supported by the Trust Secretary whose duties in this respect will include:

- agreement of the agenda, for Board and Board committee meetings, with the relevant Chair, in consultation with the Chief Executive;
- collation of reports and papers for Board and committee meetings;
- ensuring that suitable minutes are taken, keeping a record of matters arising and issues to be carried forward;
- ensuring that board procedures are complied with;
- supporting the Chair in ensuring good information flows within and between the Board, its committees, the Council of Governors and senior management;
- advising the Board and Board committees on governance matters;
- supporting the chair on matters relating to induction, development and training for directors

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

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

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

Monitoring effectiveness:	The Board will undertake an annual review of its performance against its duties in order to evaluate its achievements.
Review:	These terms of reference will be reviewed at least annually by the Board.
Reviewed by Board of Directors:	*1 April 2021*
Approved by Board of Directors:	*TBC*
Review date:	April 2022
Document owner:	Mark Grimshaw, Trust Secretary Email: mark.grimshaw@lwh.nhs.uk Tel: 0151 702 4033

Liverpool Women's NHS Foundation Trust

Agenda Item	21/22/014

MEETING	**Trust Board Meeting**
PAPER/REPORT TITLE:	**Board Assurance Framework**
DATE OF MEETING:	Thursday, 01 April 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.*** *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 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	March 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.

There are currently 9 risks on the Trust Board Assurance Framework aligned to each of the committees of the board; Finance and Business Development Committee (inc. overarching Trust Cvoid-19 risk) four risks, Quality Committee three risks and Putting People First Committee two risks. Since the last report to the Board, the executive directors and Trust board committees have reviewed each of the BAF risks and the following being the main update:

Two risks 2266 and 2297 received a number of updates in relation to updates to controls measures, assurance and progress of actions, none of these changes has an impact on the current risk scores which remain the same (see main report). The remaining risk did not have and changes made to them and the risk score remains the same.

- **2266 - Condition: Ineffective understanding and learning following significant events –** Reviewed by Medical Director and Head of Governance and Quality. MIAA report received, reviewed and agreed, recommendations add into BAF action section. Moderate assurance provided therefore agreed not for consideration for de-escalation at this time until actions completed. Revisit in July 2021.

- **2297 - Condition: Location, size, layout and accessibility of current services do not provide for sustainable integrated care or safe and high quality service provision** - Reviewed by Medical Director and Head of Governance and Quality. Minor updates made to controls in place: Crown Street Enhancement Group, Divisional Operational Plans and Relationships with LUFT. No change to risk or risk score at this time

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: March 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.

Liverpool Women's NHS Foundation Trust

Appendix 1 – BAF Dashboard March 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	Reviewed by Medical Director and Head of Governance and Quality. Current Serious Incident Report format being reviewed for all levels of meetings to ensure assurance is provided on lessons learnt. New format is to include review of closed action plans from SI's Medical Director is to introduce a new weekly Safety check in meeting for all staff but especially Jr Drs, with input from all Safety Leads.

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	Risk reviewed , no changes to the risk or risk actions 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	
2297	Quality Committee	**Condition:** Location , size, layout and accessibility of current services do not provide for sustainable integrated care or safe and high quality service provision. **Cause:** Lack of on site multidisciplinary provision, no ITU or Blood bank on site, very limited diagnostic imaging on site; Failure to meet multiple clinical standards; Senior staff recruitment and retention very difficult, lack of co-located paediatric surgical support. **Consequence:** Patient harm, poor continuity of care, poor patient experience due to transfer away for booking location. **Covid-19 impact:** The pandemic has increased the challenge of providing additional services within the current Crown street site due to the need for additional space to maintain current services. No change in risk score at this time. Focus on project relating to relocation has been reduced during pandemic	5	5	25	25	⟺	Y	Y	Y	Risk reviewed by the Head of Strategy. Currently no change to the risk or action completion dates. Progress updates recorded against actions as appropriate.
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 7** **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	Reviewed by Medical Director and Head of Governance and Quality. Minor updates made in relation to wave three responses, such as vaccination programme and mutual aid and assurances. Three actions closed as have become part of normal business via command and control and oversight meetings.

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 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:** 15/03/2021 10:12:06

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:** 14/03/2021

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:** 15/03/2021 **Reviewed By:** Christopher Lube

No changes to the risk or risk actions 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							/
6							/
7							/
8							/

					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

Cur ent 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:** 15/03/2021 10:12:06

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:** 10/04/2021

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:** 11/03/2021 **Reviewed By:** Christopher Lube

Reviewed by Medical Director and Head of Governance and Quality. MIAA report received ,reviewed and agreed, recommendations add into BAF action section. Moderate assurance provided therefore agreed not for consideration for de-escalation at this time until actions completed, Revisit in July 2021.

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	01/06/2021	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 Awaiting new national programme due spring 21 Date Entered : 11/03/2021 12:27 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 - - - - - -	Ongoing	/ /

					Work is ongoing, plan for completion Nov 19 Date Entered : 03/10/2019 16:39 Entered By : Christopher Lube - - - - - - Head of Governance in planning stages. May be affected by new national training system and curriculum which is due to be published in 2019-20. Date Entered : 31/07/2019 11:00 Entered By : Christopher Lube			
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	MIAA draft report received, reviewed and final report to be published. Actions added to BAF. Date Entered : 11/03/2021 11:34 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	Completed	11/03/2021
9	Root Cause Analysis training for staff to be reviewed and updated and to recommence via teams	11/03/2021	30/06/2021	Allan Hawksey		Ongoing	/ /
10	Governance team to review current compliance level and to make changes to ensure trajectory is met.	11/03/2021	30/04/2021	Allan Hawksey		Ongoing	/ /
11	The governance team will work with the communications team to identify if it is possible to have a link on desk top of computer with a link to lesson learnt section of web page.	11/03/2021	30/06/2021	Allan Hawksey		Ongoing	/ /
12	The use of the action planning module is to be embeded across all divisions. Governance team to use weekly meeting for review actiosn and ensure shared. Governance team to ensure oversight and reporting of progress to safety senate	11/03/2021	30/06/2021	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:** 15/03/2021 10:12:07

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:** 14/03/2021

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:** 15/03/2021 **Reviewed By:** Christopher Lube

No changes to the risk or risk actions 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:** 15/03/2021 10:12:07

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:** 15/04/2021

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:** 15/03/2021 **Reviewed By:** Christopher Lube

No changes to risk , risk actions or risk score at this time

Control	Control Description	Gaps in Control	Effectiveness	Internal Assurance	External Assurance	Gaps in Assurance	Adequacy of Assurance
Prevent	Annually agreed funding contract with HEN. Regional Training Programme Directors manage the junior doctor rotation programme and highlight shortages to the Lead Employer. Lead Employer notifies the Trust of Gaps in local rotations, giving the Trust autonomy to recruit at a local level into these gaps. Effective electronic rota management system implemented. Director of medical Education (DME) to ensure training requirements are met, reporting to the Trust Medical Director and externally to HEN. Guardian of Safe Working Hours appointed in 2016 under new Junior Doctor Contract. Acting down policy and process in place to cover junior doctor gaps. National Revalidation process ensuring competent staff. Shared decision making and review of risk with JLNC. Putting People First Strategy. Quality Strategy. Strategic Workforce Group established. Aspirational Ward Manager Programme. Succession Planning and Talent Programme NHSE Retention Improvement Programme NHSI Sickness Improvement Programme Shared appointments with other providers Secured operating time at the LUH Increased consultant recruitment with incentives Neonatal Partnership Maternity introduction of ACP Midwives Policy to mitigate impact on LTA and AA on senior staff in place	Further utilisation of the rota management system. E-Roistering System not fully utilised	Effective	Quarterly reporting by Guardian of Safe Working. Strategic Workforce reporting to PPF. Leadership Development programme Review (annual to PPF). Exception Reporting System and process working effectively. Junior Medical Staff GMC survey reporting to Education Governance and PPF - No concerns areas of specific concerns identified. Clinical and nursing roles being developed and enhanced to mitigate the gas in junior doctor workforce. Roles include: Physicians Assistants, Surgical assistants, ANP's, Consultant Nurses, ER Practitioners.	DME reports to HEN on an annual basis in relation to junior doctor training. Annual GMC Survey. Annual Staff survey NHS Ed SAR. DME Annual Report GMC Revalidation Process HEN Visit - Regular (next due 2019 due to satisfactory report in 2016) GMC Medical Staff survey - annual.	None identified at this time	Positive
Detect	GMC Survey 018 - action plan in place						
Covid 19	Staff are required to social distance (2 meters) in all area where this is possible Staff are required to wear PPE in the clinical environment as per PHE guidance All staff re required to wear a face covering in all public areas and in offices where they are unable to social distance (2 meters) All areas have clear signage, including floor signage All staff entering the Trust are required to use one entrance and have a temperature check and provided with a face mask to use Listening Event for BAME staff - 24th June 2020 to consider what further action the Trust could take to ensure BAME staff are protected as much as possible. Risk Assessments undertaken for shielding &	The risk is staff do not comply with social distancing and/or PPE.	Not Effective	Trust has completed the NHSE/I IPC Assurance Framework and presented to the Quality Committee Controls monitored daily at Command meeting and weekly at Oversight and Scrutiny meeting Requirements being managed by senior staff clinical and cooperate.	None at this time	Issue with staff with staff to complying with social distancing and use of face mask as required.	Inconclusive

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

Action	Action Description:	Start Date	Target Date	Person Responsible	Progress	Status	Date Completed
4	Await outcome of Business case sent to NHSI to develop E-Rostering System Collaborative	16/11/2019	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	3 Possible	15

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

Listing For: 4. BAF | **Risk Register Level:** 4. BAF | **Directorate:** Governance | **Service / Department:** Executive Office | **Position at:** 15/03/2021 10:12:07

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:** 10/04/2021

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:** 11/03/2021 **Reviewed By:** Christopher Lube

Reviewed by Medical Director and Head of Governance and Quality. Minor updates made to controls in place: Crown Street Enhancement Group, Divisional Operational Plans and Relationships with LUFT.

No change to 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	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 Crown Street Enhancement Group developed and has commenced meeting Progress being made in relation to building relationships with LUFT Divisional Operational Plans completed	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	Will keep target date under review in light of COVID impacts Date Entered : 11/02/2021 22:09 Entered By : Jennifer Huyton - - - - - - 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	Ongoing	/ /

2	Agree Business Case for new build	01/04/2019	29/04/2022	Jennifer Huyton	Date Entered : 09/08/2019 13:40 Entered By : Christopher Lube Proposal and timeline for PCBC development approved by Executive Committee 10.02.21 Date Entered : 11/02/2021 22:02 Entered By : 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	01/04/2021	Jennifer Huyton	Date Entered : 09/08/2019 13:41 Entered By : Christopher Lube Action reviewed by the Head of Strategy and Transformation. No submission date has been provided by NHSI/E, however Trust operational plans will be complete and signed off by the Board on 01.04.21, therefore the target date for this action has been adjusted accordingly. Operational planning is progressing well with all plans in line with Trust strategy. Date Entered : 26/02/2021 11:04 Entered By : Jennifer Huyton Operational planning is in process, with divisions ensuring that plans are in line with overall Trust strategy as well as Clinical and Quality Strategy Date Entered : 11/02/2021 22:14 Entered By : Jennifer Huyton 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	Ongoing	/ /

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
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

5	Outcomes from the clinical summit to be actioned.	27/09/2019	30/04/2021	Jennifer Huyton	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 SLA drafted for agreement with LUHFT in order to formalise pathways within existing reciprocal service provision. Date Entered : 11/02/2021 22:13 Entered By : 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 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,	Ongoing	/ /

although funding approval is yet to be received. The Trust has submitted a bid for additional capital funds to provide a mobile CT scanner on site, should the emergency capital bid not be approved. The case for swift approval of our capital bid has been put to Cheshire and Mersey HCP.

Date Entered : 08/07/2020 17:41
Entered By : Jennifer Huyton
- - - - - -
The Trust is now developing a clinical and quality strategy to complement a refreshed future generations strategy, to be completed by the end of 2020. This will include divisional plans. The funding for on site developments has been requested but remains out of the Trust's control. The lobbying of MPs has been paused during the covid crisis.

Date Entered : 06/07/2020 14:42
Entered By : Rowan Davies
- - - - - -
Target date amended due to response to COVID19. Good progress had been made towards implementation of actions. Partnership Board established with LUHFT. Work now paused due to COVID19 but will remain under regular review.

Date Entered : 06/04/2020 12:09
Entered By : Jennifer Huyton
- - - - - -
CT scanner and Blood Bank provision has been added to the draft operational plan, which is awaiting approval.

Date Entered : 04/03/2020 07:27
Entered By : Christopher Lube
- - - - - -
Target date amended following development of MoU with LUH. Detailed plan is in place (to be attached) actions are in progress

Date Entered : 10/01/2020 14:18
Entered By : Jenny Hannon
- - - - - -
Acting Medical Director working with Strategic Finance Manager on reviewing summit outcomes.

Date Entered : 27/09/2019 08:43
Entered By : Christopher Lube

7	Management of Future Generations Strategy through Project Management Office	16/11/2019	31/08/2021	Jennifer Huyton	FG Strategy articulated in draft corporate strategy, agreed by Trust Board in Feb 21. Corporate strategy features co-location as a key strategic objective. Date Entered : 11/02/2021 22:11 Entered By : Jennifer Huyton Action completion date amended to reflect revised plan outlined below Date Entered : 04/02/2021 14:14 Entered By : Jennifer Huyton Recruitment to Trust PMO office was paused during the pandemic, but was re-established in December 2020 using bank staff to retain flexibility. Manger now recruited to support FG programme through the PMO office. Agreed with Medical Director that the FG Project Group will be re-established in Feb/March 2021 with a view to refreshing the Trust's PCBC over a 6 month period, in conjunction with divisional teams. Programme of work is currently undergoing refresh and milestones will be established during February and reported through the FG Project Group, which was established by the Quality Committee. Date Entered : 04/02/2021 14:13 Entered By : Jennifer Huyton Remains postponed due to covid-19 Date Entered : 31/08/2020 11:06 Entered By : Christopher Lube The Trust is now developing a clinical and quality strategy to complement a refreshed future generations strategy, to be completed by the end of 2020. This will include divisional plans. The funding for on site developments has been requested but remains out of the Trust's control. The lobbying of MPs has been paused during the covid crisis. Date Entered : 06/07/2020 14:43 Entered By : Rowan Davies	Ongoing	/ /

					- - - - - - Reviewed 26 March 2020 by J Huyton: Project Manager recruitment completed in March 2020; post successfully appointed. Start date anticipated June 2020. Majority of FG programme paused during response to COVID19; work remains under regular review by PMO team. Date Entered : 06/04/2020 12:06 Entered By : Jennifer Huyton		
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	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 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	Completed	01/12/2020

					------ The Trust is now developing a clinical and quality strategy to complement a refreshed future generations strategy, to be completed by the end of 2020. This will include divisional plans. The funding for on site developments has been requested but remains out of the Trust's control. The lobbying of MPs has been paused during the covid crisis. Date Entered : 06/07/2020 14:43 Entered By : Rowan Davies ------ Reviewed 26 March 2020 by J Huyton: Application for emergency capital funding submitted to NHSI/E in Feb 2020 with decision originally expected early April. Revised guidance now expected from NHSE/I regarding emergency capital in light of response to COVID19. Guidance will be reviewed once released and target completion dates amended accordingly. Date Entered : 06/04/2020 12:00 Entered By : Jennifer Huyton			
10	Lobby systems and MP's for active support	16/11/2019	30/04/2021	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	Ongoing	/ /	

					Reviewed 26 March 2020 by JHuyton: This work is ongoing but paused at present due to response to COVID19. Action completion dates will remain under regular review as situation develops. Date Entered : 06/04/2020 12:03 Entered By : Jennifer Huyton		
11	External review/testing of counterfactual case	01/04/2020	30/04/2021	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.		/ /
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 : 31/08/2020 11:10 Entered By : Christopher Lube Counterfactual case developed and ready for external review, challenge and testing. Process likely to be delayed due to response to COVID19. Target completion dates will be reviewed regularly as response develops. Date Entered : 06/04/2020 11:55 Entered By : Jennifer Huyton Delivery group established for CT, project plan in place. Purchase of CT equipment approved by FPBD. Delivery group partially established for blood bank, key membership agreed. Robot business case complete and submitted to FPBD for review and approval. Good progress in robotic surgical cases as part of pilot. Case for FMU 'enabling' works agreed by Executive Committee. Options appraisal re estate options completed. Continued good progress towards GMP. Date Entered : 11/02/2021 22:08 Entered By : Jennifer Huyton Project Board established 04.12.20. Delivery groups for workstreams to be established during December (FMU, Colp, CT, Transfusion).	Ongoing	/ /

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

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:** 15/03/2021 10:12:07

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:** 14/03/2021

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:** 15/03/2021 **Reviewed By:** Christopher Lube

No changes to the risk or risk actions 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							/
2							/

3	Implement a Cyber Security strategy	01/04/2020	31/03/2021	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:** 15/03/2021 10:12:07

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:** 10/04/2021

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:** 11/03/2021 **Reviewed By:** Christopher Lube

Reviewed by Medical Director and Head of Governance and Quality. 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	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	30/04/2021	Matt Connor	This will be captured under the Digital Generations newsletter, Date Entered : 27/01/2021 13:32 Entered By : 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 Date Entered : 04/05/2020 12:54 Entered By : Matt Connor	Completed	03/11/2020
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/ 1/2022	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	Completed	30/09/2020

					be managed through the change control procedures in place for PENS documentation. ECDS data being submitted from PENS and regular data quality reports are monitored by ED and Digital.Information staff. Date Entered : 08/10/2020 06:52 Entered By : Richard Strover - - - - - - PENS is now in use within the GED. Attendances are still recorded on Meditech to ensure a record of the attendance but all clinical documentation has been moved over to PENS. Work is ongoing to remap all data 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:** 15/03/2021 10:12:07

Risk Number: 2340 **Version:** 8 **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:** 10/04/2021

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:** 11/03/2021 **Reviewed By:** Christopher Lube

Reviewed by the Medical Director and Head of Governance and Quality, no significant changes at this time to the risk or risk actions.

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 reduced to meet once 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 for FFP3 masks, Half Face respirators and respiratory hoods 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, 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'	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 Weekly monitoring of vaccine uptake in staff Weekly monitoring of swabbing of in patients	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 20-2. 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 ongoing for all staff Staff Flu Vaccination Campaign completed within timeframe to required target level Covid - 19 Staff vaccination programme in place over 83% of staff have had vaccine.2nd dose programme to commence on 19th March 2021 Staff who have not had a first dose or have declined are being supported by local managers and HR in relation to any concerns about the vaccine. Trust offering vaccination reserve list to family members of staff who meet priority groups. 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 Colorectal for LUFT 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 Covid -19 Expenditure Financial analysis of the trusts expenditure during the pandemic has been completed and presented to the Oversight and Scrutiny Group. Discussions as to ongoing financial impact undertaken.	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. Cancer services activity in Feb 2021 above activity in 2020		Inconclusive

4	Close working with Cheshire and Mersey procurement via Covid Supply Response (CSR)	01/04/2020	31/03/2021	Amy Noble	Close working continues between Trust procurement and regional teams. No PPE issues on site at this time. Continue to monitor. Date Entered : 12/02/2021 14:34 Entered By : Christopher Lube - - - - - - 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	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:** 15/03/2021 10:12:07

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:** 14/03/2021

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:** 15/03/2021 **Reviewed By:** Christopher Lube

No changes to the risk or risk actions 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