Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

Board of Directors Meeting

PUBLIC - HELD ELECTRONICALLY

6 May 2021

Liverpool Women's NHS Foundation Trust

Trust Board

Location	Virtual Meeting
Date	6 May 2021
Time	9.30am

AGENDA					
Item no. 21/22/	Title of item	Objectives/desired outcome	Process	Item presenter	Time
PRELIMINARY BUSINESS					
018	Introduction, Apologies & Declaration of Interest	Receive apologies & declarations of interest	Verbal	Chair	09.30 (5 mins)
019	Meeting Guidance Notes	To receive the meeting attendees' guidance notes	Written	Chair	
020	Minutes of the previous meeting held on 1 April 2021	Confirm as an accurate record the minutes of the previous meeting(s)	Written	Chair	
021	Action Log and matters arising	Provide an update in respect of on-going and outstanding items to ensure progress	Written	Chair	
022	Patient Story	To receive a patient story	Verbal	Director of Nursing & Midwifery	09.35 (15 mins)
023	Chair's announcements	Announce items of significance not found elsewhere on the agenda	Verbal	Chair	09.50 (10 mins)
024	Chief Executive Report	Report key developments and announce items of significance not found elsewhere on the agenda	Written	Chief Executive	10.00 (10 mins)
QUALITY & OPERATIONAL PERFORMANCE					
025a	Performance Report	For assurance – To note the latest performance measures	Written	Director of Operations	10.10 (50 mins)
025b	Lesson Learning	For assurance	Written	Executive Team	
025c	CNST Compliance Position Statement	For assurance	Written	Director of Nursing & Midwifery	
025d	Chair's Report from the Quality Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	
PEOPLE					

026a	Staff Listening Events	For information	Presentation	Chief People Officer	11.00 (15 mins)
BREAK – 15 mins					
Board Thank You – 10 mins					
FINANCE & FINANCIAL PERFORMANCE					
027a	Finance Performance Review Month 12 2020/21	For assurance - To note the current status of the Trusts financial position	Written	Director of Finance	11.40 (20 mins)
027b	Chair's Report from the Finance, Performance and Business Development Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	
BOARD GOVERNANCE					
028	Corporate Objectives 2021/22	For approval	Written	Chief Executive	12.00 (10 mins)
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.*					
None noted.					
CONCLUDING BUSINESS					
029	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair	12.10 (5 mins)
030	Chair's Log	Identify any Chair's Logs	Verbal	Chair	
031	Any other business & Review of meeting	Consider any urgent items of other business	Verbal	Chair	
Finish Time: 12.15					

Date of Next Meeting: 1 July 2021

12.15 – 12.25	*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 NHS Foundation Trust

Board of Directors

Minutes of the meeting of the Board of Directors held virtually at 09.00am on 1 April 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
Ms Jo Moore	Non-Executive Director/Vice Chair
Mrs Tracy Ellery	Non-Executive Director
Mrs Louise Martin	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 Phil Huggon	Former Non-Executive Director (from 1 April 2021)
Mr Mark Grimshaw	Trust Secretary
Mrs Jackie Sudworth	Public Governor
Mrs Felicity Dowling	Member of the public
Mrs Lesley Mahmood	Member of the public
Mrs Teresa Williamson	Member of the public
Mrs Marie Kelleher	Bereavement Midwife (item 005 only)
Claire Arnold	Ward Manager (NICU) (Board Thank you only)
Tracy McNulty	Theatre Service Improvement Manager (Theatres / CSS) (Board Thank you only)
Danielle Ahmed	Staff Nurse (Gynaecology) (Board Thank you only)
Rachel Mavers	Team Leader Community Midwife (Maternity) (Board Thank you only)
Mr Matt Connor	Chief Information Officer (item 010c only)

APOLOGIES:

Mr Tony Okotie	Non-Executive Director

Core members	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Robert Clarke - Chair	✓											
Kathryn Thomson - Chief Executive	✓											
Dr Susan Milner - Non-Executive Director / SID	✓											
Jo Moore - Non-Executive Director / Vice Chair	✓											
Tracy Ellery - Non-Executive Director	✓											
Louise Martin - Non-Executive Director	✓											
Ian Knight - Non-Executive Director	✓											

Tony Okotie - Non-Executive Director	A											
Prof Louise Kenny - Non-Executive Director	✓											
Jenny Hannon - Director of Finance	✓											
Marie Forshaw - Director of Nursing & Midwifery	✓											
Gary Price - Chief Operating Officer	✓											
Michelle Turner - Chief People Officer	✓											
Dr Lynn Greenhalgh - Medical Director	✓											
Present (✓) Apologies (A) Representative (R) Non attendance (NA)												

21/22/	
001	**Apologies –** as above. **Declaration of Interests –** None.
002	**Meeting guidance notes** The Board received the meeting attendees' guidance notes which had been updated to reflect 'virtual meetings'.
003	**Minutes of the previous meetings held on 4 February 2021 and 4 March 2021** The minutes of the Board of Directors meetings held on 4 February 2021 and 4 March 2021 were agreed as a true and accurate record.
004	**Action Log and matters arising** In response to the action relating to efficacy of the Trust's cultural improvement programmes, the Director of Nursing & Midwifery noted that she had requested that the Divisions undertake a review of culture, utilising the findings from the Ockenden Report as a reference tool. The Putting People First Committee would be retaining Trust-wide oversight of this work. The Chair referenced the action relating to lesson learning which had been identified as being 'off track'. The Trust Secretary explained that an additional Quality Committee had been established to consider issues relating to 'lesson learning' later in the month. This would include the review of a recent internal audit report which in draft form, had provided 'moderate assurance' in relation to the Trust's processes for learning lessons from Serious Incidents. Non-Executive Director, Tracy Ellery, noted that whilst the Audit Committee had yet to review the report, it had been felt germane to enable the Quality Committee to include the draft findings as part of their wider review. It was expected that an output report would be provided to the Board in May 2021.
005	**Patient Story** Mrs Marie Kelleher, Bereavement Midwife, attended to introduce a video of a mother who had experienced a miscarriage at 15 weeks. The mother shared details of their antenatal care, care whilst they were an inpatient and the continued support by The Honeysuckle Team. It was noted that the care provided throughout the process had been excellent, particularly in terms of bereavement support. Reference was made to a difficult period when the mother was required to wait alone in a ward for a period after being informed of the miscarriage, ahead of further intervention. Whilst it was acknowledged that this had been required for medical reasons, there was agreement that it would be best practice, and in line with recommendations from the Ockenden Report, that psychological support be provided during this stage. Mrs Marie Kelleher, Bereavement Midwife, stated that outreach work by the Honeysuckle Team had been initiated in the wards to provide psychological and bereavement support at an earlier point in the process.

	Action: For the Executive Team to receive assurance regarding the progress of the outreach work in the Trust's wards by the Honeysuckle Team. Mrs Tracy Ellery, Non-Executive Director, queried what support had been provided to the father. It was confirmed that bereavement support was provided to the whole family and that there were specific support groups for fathers that the team signposted to. The Chair stated his thanks to Marie Kelleher and the Honeysuckle Team remarking on the commendable work being undertaken. The Board noted the presentation and agreed to provide a written thank you to the family who had shared their story.
006	**Chair's announcements** The Chair reported that a Council of Governors meeting had been held on 11 February 2021. At the meeting, approval had been provided to appoint Louise Martin and Joanne Anderson to the roles of Non-Executive Directors with a start date set of 1 April 2021. Louise Martin was welcomed to the Board. After this decision, Joanne Anderson had been selected as the Labour Party candidate for the role of Liverpool Mayor. Considering this, the Council of Governors had agreed to defer Joanne's start date until the outcome of the election was known. The Council of Governors had also agreed to extend the tenure of Non-Executive Ian Knight for a period of up to six months to provide on-going capacity in the interim. The Chair had undertaken several site visits and walkabouts since the previous update to the Board. A discussion held with the neonatal team was highlighted in which positive feedback had been received relating to staff development. Several health care assistants had noted that they had been encouraged to enrol on nursing courses by the nursing leadership. The Chair remained involved in regional and national discussions regarding the development of Integrated Care Systems; an issue that would be discussed in more detail at a forthcoming Board workshop. There had been positive developments in relation to integration at a Liverpool Integrated Care Partnership level to date. The Board noted the Chair's update.
007	**Chief Executive's report** The Chief Executive presented the report which detailed local, regional and national developments. The following key points were highlighted: • The Chief Executive had been involved in the ASPIRE-COVID19 UK study. This was being led by the University of Central Lancashire and was researching what lessons could be learned from how maternal and neonatal care providers had responded to the Coronavirus pandemic. It was noted that there would be lessons to be learned from the study that would be applicable to the Trust. • As part of the Trust's quality improvement processes, the division of Clinical Support Services (CSS) were planning a 'Perfect Week' project in April 2021 with the aim to improve the patient pathway and theatre efficiency and utilisation. • The Trust had recently strengthened its 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). • From 1 April 2021, the Cheshire & Merseyside Local Maternity System (LMS) that had previously been hosted by Liverpool CCG as part of the Cheshire and Mersey Women and Children's Programme, would be hosted by the Trust. Work was underway on developing the

	underpinning governance structures of the hosting arrangement led by the Chief Operating Officer. The LMS staff were welcomed to the Trust. • The Board was reminded that confirmation had been provided via email to the Cheshire & Merseyside Health and Care Partnership of the Trust's intention to sign up to the Partnership Memorandum ahead of the 12 March 2021 deadline. The Board formally ratified this decision. • It was noted that Liverpool Health Partners (LHP) had recently appointed a new Chair – Elliot Foster. Close working relationships with LHP would be retained. The Board noted the Chief Executive update.
008a	Performance Report The Chief Operating Officer presented the report highlighting the following key points: • The Trust's sickness absence rate continued to be a challenge, however a significant number of staff who had been shielding during the pandemic had returned or were due to. • The staff vaccination programme was progressing well with the second injection phase commencing towards the end of March 2021. The Trust was also in the process of transitioning from twice weekly lateral flow tests for staff to weekly Loop-mediated isothermal amplification (LAMP) tests. • The National Incident Level for the pandemic had been stepped down from level four to level three at the end of March 2021. Despite this, extensive oversight arrangements remained in place regionally and within the Trust. • Whilst there had been a high level of sickness in maternity, progress had been made in relation to Continuity of Carer performance, particularly since November 2020. However, further work was required to achieve the trajectories set by the Trust. As the maternity department was going through a period of challenge, a decision had been made to 'pause and reflect' on increasing continuity of carer teams to ensure that the quality and safety of wider maternity services could be maintained. • In relation to Access Standards, a deep dive had been undertaken into the February 2021 A&E four-hour target underperformance. Initial findings had found some areas for improvement regarding out of hours provision. Clear planning guidance for 2021/22 had recently been received and there was to be a focus on working across health systems to prioritise and progress patients. To support the recovery from the pandemic, work was being undertaken to explore efficiency gains in theatres. • Despite a challenging year, cancer performance had been maintained. However, there had been a recent increase in referrals which would start to have an impact on the Trust. The Director of Nursing & Midwifery drew attention to the safe staffing section of the report. It was noted that the majority of 'red flags' had been reported in the maternity department. Whilst close oversight was being maintained it was asserted that it was positive that there continued to be an active reporting culture that enabled review and escalation of issues. The Chief Operating Officer provided an overview of the impact of the Covid-19 pandemic on the Trust's performance. It was noted that to some extent, all services had been impacted by the pandemic. Areas that had been prioritised nationally e.g. cancer and essential services such as maternity and neonatal care had been maintained throughout the pandemic. Benign gynaecology services had been impacted and work was progressing to recover and improve performance relating to waiting lists. Thanks were extended to staff who had been flexible and accommodating when asked to support maintained services if their usual area had been temporarily stood down. Non-Executive Director, Louise Martin queried where items of statutory compliance were reported e.g. measures relating to estates and health and safety. The Chief Operating Officer explained that there was a Health and Safety Group which monitored progress and provided assurance and/or matters for escalation to the Quality Committee. Other estates issues received oversight from the

	Finance, Performance and Business Development Committee. It was acknowledged that these items would be considered as part of the on-going performance report refresh. **Action: To review the reporting of areas of statutory compliance as part of the refresh of the Trust's Performance Report.** The Board of Directors: • Received and noted the Month 11 Performance Report.
008b	**Lessons learnt from mortality, Q3 2020/21** The Medical Director presented the report noting that it provided assurance that there were processes in place to ensure that all adult deaths, stillbirths & neonatal deaths had a mortality review conducted. One in-hospital related adult death occurred in Q3 of 2020/21. This was subject to a Serious Incident review. The Quarter 3 stillbirth rate of 4.0/1000 (3.5/1000 excluding fetal abnormalities) was lower than Quarter 2 (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 had been escalated to a serious incident and was being investigated. The Medical Director highlighted that the Trust's neonatal mortality rate remained higher than expected, a trend that had been in place for several years. This was subject to an on-going review and it was expected that the drivers behind the higher rate would be complex and multi-factorial. Whilst the Trust was taking action to ensure that internal processes and standards of care were at the expected level (e.g. engaging external bodies to review and benchmark), socio-economic factors were also being explored. The Chair asked whether the Trust was taking action to target resource into early intervention. The Chief Executive confirmed that the number of neonatal consultants had been recently increased and the Neonatal Partnership was making progress to connect with the Starting Well agenda. The Board of Directors: • Noted the report • Took assurance that there were adequate processes for reviewing mortality and progress against the requirements laid out by the National Quality Board.
008c	**Chair's Reports, Annual Report & Terms of Reference from the Quality Committee** The Board considered the Chair's Reports from the Quality Committee meetings held on 22 February 2021 and the 22 March 2021. Non-Executive Director, Prof. Louise Kenny, highlighted that the Committee continued to track progress against the trajectories set for Continuity of Carer compliance, with risks of not achieving the 35% target by autumn 2021 discussed. An additional Quality Committee had been scheduled in April 2021 to focus on issues relating to the Trust's processes for learning lessons. The Committee continued to receive regular updates relating to Ockenden Report and Prof. Louise Kenny (as Maternity Safety Champion – NED), the Director of Nursing & Midwifery and the Chief Executive remained involved in local and national initiatives to progress the recommendations. The Chair queried whether the Committee was reviewing the quality implications of the Trust's sickness absence rate. It was confirmed that this had been a key consideration in the Committee agreeing with the proposals to enter a 'pause and reflect' period in the roll out of additional Continuity of Carer teams. It was noted that a further expansion would potentially impact the safety and quality of maternity services due to current workforce challenges. The Chief Executive suggested that the Quality Committee should undertake a reflective exercise on the roll out of Continuity of Carer to ensure that key lessons were identified.

	Chair's Log: For the Quality Committee to undertake a reflective exercise on the roll out of Continuity of Carer to ensure that key lessons were identified (May 2021). Attention was drawn to the Committee's 2020/21 Annual Report, updated Terms of Reference and 2021/22 work programme. The Trust Secretary noted that the most significant update to the Terms of Reference related to a change to the underpinning reporting structure. A discussion was held regarding the main themes identified during the Quality and Operational Performance section of the meeting. It was noted that there was a clear requirement for the Trust to refine its approach to learning lessons. The importance of the Trust actively and effectively engaging with the 'Starting Well' agenda was also highlighted. **Action: For the Research & Development Sub-Committee to consider how the Trust is engaging with the 'Starting Well' agenda.** The Board of Directors: • Received and noted the Chair's Reports from the Quality Committee meetings held on 22 February 2021 and the 22 March 2021 • Received and noted the 2020/21 Committee Annual Report and 2021/22 work programme • Approved the updated Quality Committee Terms of Reference.
009a	**2020 Staff Survey Results Summary** The Chief People Officer introduced the report noting that the response rate for the 2020 Staff Survey had reduced slightly from 2019 (55% compared to 61.5%) – this was in line with a national trend. The Chief People Officer reported that the key theme scores had remained largely unchanged, with only minor variations (both positive and negative) which were not deemed to be statistically significant. The overall staff engagement score was 7.1 out of 10 and this had remained static over the last few years. The aim remained to bring the score closer in line with the average for acute specialist Trusts (7.4), although it was asserted that there were limitations to the utility of this benchmarking cohort. The results had been broken down and shared with management teams across the Trust. Each division had been asked to pick a key theme from the results to focus on for improvement, with each ward/department requested to identify a sub-theme and then follow through with an action plan. Successes would then be shared across divisions and throughout the Trust as a whole, as examples of best practice. The Staff Survey would be used as part of the data set to support the cultural diagnostic work, due to commence in April 2021. The Putting People First Committee would retain oversight of progress against the identified actions, with a substantial review undertaken in the autumn. Non-Executive Director, Ian Knight, queried whether a deterioration in the score for '…I receive respect from my colleagues…' was related to the pandemic. The Chief People Officer stated that whilst this had been a consistent theme across the NHS, further work was required to understand the key drivers. The cultural diagnostic work would support this and would identify recommendations to strengthen leadership behaviours. The Chair identified that the '…recommend the Trust as a place to work / have treatment…' measure had not moved significantly for a number of years. The Chief People Officer stated that this measure was often a signifier of organisational culture and therefore took time to move, positively or negatively, in a significant way. The Director of Nursing & Midwifery added that staff would be encouraged to undertake secondments in neighbouring trusts to gain an understanding of the positive and negative aspects of other organisational cultures. Non-Executive Director, Louise Martin queried whether the data enabled the Trust to understand whether there were any divergences in views between staff working day and night shifts. The Chief

	People Officer noted that whilst the Trust did not have a significant number of staff on fixed night shifts, this would be a useful issue for the Divisions to explore. The Chief Executive stated that often the most important influence on staff morale was the relationship with an immediate line manager and peer group. In recognition of this, work was progressing to support line managers to demonstrate and embody the Trust's cultural values. This would be monitored via the appraisal process. The Board of Directors: • Noted the contents of this paper, and • Endorsed the 'next steps' as described in the report.
009b	**Chair's Report, Annual Report & Terms of Reference from Putting People First Committee** The Board considered the Chair's Report from the Putting People First Committee meeting held on 22 March 2021. Non-Executive Director, Jo Moore highlighted the following key issues: • The Committee continued to monitor mandatory training compliance, undertaking 'deep dives' in particular 'hot spots' when necessary • Close attention had been provided to the Trust's sickness absence rate which was showing signs of improvement. • A position update had been given from the Clinical Support Services (CSS) Clinical Director regarding the recruitment challenges in the medical anaesthetic workforce and the actions being undertaken in response. • Assurance received 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 Committee 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. Attention was drawn to the Committee's 2020/21 Annual Report, updated Terms of Reference and 2021/22 work programme. The Trust Secretary noted that the most significant update to the Terms of Reference related to a change to the frequency of the meetings (moving from five to six per year). A discussion was held regarding the main themes identified during the People section of the meeting. The Chair noted that the use of Personal Development Reviews (PDR) would be key to unlocking a number of desired improvements outlined in discussions. It was suggested that the Putting People First Committee receive an update on the efficacy of the upcoming PDR window in September 2021. **Chair's Log: For the Putting People First Committee receive an update on the efficacy of the upcoming PDR window in September 2021.** The Board of Directors: • Received and noted the Chair's Report from the Putting People First Committee meeting held on 22 March 2021 • Received and noted the 2020/21 Committee Annual Report and 2021/22 work programme • Approved the updated Putting People First Committee Terms of Reference.
	Board Thank you *Claire Arnold, Ward Manager (NICU), Tracy McNulty, Theatre Service Improvement Manager (Theatres / CSS), Danielle Ahmed, Staff Nurse (Gynaecology) and Rachel Mavers, Team Leader Community Midwife (Maternity) joined the meeting.*

	The Chief Executive explained that the Board wished to recognise the work that had been undertaken by ward managers during the pandemic. It was acknowledged that the decisions made by the Board often had a direct impact on ward managers and their teams and they had been key to implementing a number of challenging actions throughout the pandemic. *Claire Arnold, Ward Manager (NICU), Tracy McNulty, Theatre Service Improvement Manager (Theatres / CSS), Danielle Ahmed, Staff Nurse (Gynaecology) and Rachel Mavers, Team Leader Community Midwife (Maternity) left the meeting.*
010a	Finance Performance Review Month 11 2020/21 The Director of Finance noted that the Trust initially produced a breakeven plan for 2020/21; 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 had reduced and were a fixed value, leading to an agreed Trust plan of a £4.6m deficit. At month 11 the Trust was slightly ahead of this revised plan with an adjusted deficit 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 was 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 had improved from an adjusted deficit of £4.6m in line with plan to an adjusted deficit of £4.4m. Non-Executive Director, Ian Knight, remarked that it was important to recognise the work that the Trust had undertaken throughout the year to reduce aged debtors significantly. The Board of Directors: • Noted and received the Month 11 2020/21 Finance Performance Review
010b	2021/22 Operational Plan and Budget Update The Director of Finance reported that Trust budgets had been reviewed in detail at the Finance, Performance and Business Development Committee (FPBD) and at a separate deep dive session for Board members in March 2021. The budgets had also been reviewed at divisional level, by the Executive Team and the Senior Management Team. It was important to note that the Board was being asked to approve an interim budget position as it was still subject to agreement at a Cheshire & Merseyside level with national guidance and allocations only recently released. Regular updates and detail would be provided to Board in due course. The Director of Finance outlined the interim revenue budget, noting that there was a planned deficit of £9.5m. This had improved from the position reported to the FPBD Committee in March 2021 (£13.1m). It was explained that the Trust would be likely to require cash support if a deficit position remained on-going throughout 2021/22. The level of this support would be determined when the final deficit was agreed across the Cheshire & Merseyside Health and Care Partnership. The Trust's Capital Plan and Charity Budget were also outlined. The next steps for the budget would be submit planning submissions at a regional level (May – draft, June – final) with the Half two (of 2021/22) plans to be determined in line with further information later in the year. Non-Executive Director, Ian Knight noted the falling birth rate trend and queried whether the Trust could explore the reduction of expenditure. The Director of Finance stated that maternity resources would be reviewed in line with Birthrate Plus, Ockenden and Continuity of Carer requirements, with any available adjustments made accordingly. The Trust would also be working to influence an appropriate level of maternity tariff in national conversations. Non-Executive Director, Tracy Ellery, noted her support for the interim budget approach and stated that it would be important for the

	Trust to demonstrate recovery plans in order to access cash support. The Director of Finance agreed that demonstrating the long-term view on the Trust's financial sustainability would be important. In relation to the Charity Budget, Non-Executive Director, Tracy Ellery queried what would happen if the Charity could not raise the funds to meet the planned expenditure. Former Chair of the Charitable Funds Committee, Phillip Huggon noted that income would be required to exceed expenditure ahead of committing funds. The Director of Finance explained that the income target was seen as 'conservative' and contingency had been factored. The Chief People Officer highlighted that regular monthly meetings were held with the Charity team to track income generation and expenditure. The Chair remarked that whilst it was clear that financial uncertainties remained, the Board could take assurance that the uncertainties had been identified and understood. The Board of Directors approved: • Interim revenue budgets for 2021/22, to be reviewed/revised at H2 • Delegation of approval of the final planning submissions for H1 to FPBD, with regular reporting into Board • Capital Plan 2021/22 • Charity Budget 2021/22 *Matt Connor, Chief Information Officer, joined the meeting*
010c	**Digital – Annual Review** The Board received a review of key digital activities over the last 12 months and this was placed within the context of the digital programme, business as usual commitments and the impact of Covid-19. The Chief Information Officer also described the upcoming key digital priorities. The Chair stated that the speed of roll out from concept to business as usual for several digital solutions had been invaluable during the pandemic and he commended the digital team for their work. The Board of Directors: • Received the report and noted the achievements and delivery of the Digital Services department. *Matt Connor, Chief Information Officer, left the meeting*
010d	**Chair's Reports, Annual Report & Terms of Reference from Finance, Performance and Business Development Committee** The Board considered the Chair's Reports from the FPBD Committee meetings held on 23 February and 23 March 2021. Former Chair and Non-Executive Director, Phillip Huggon highlighted the following key issues: • The Committee continued to monitor the Trust's financial deficit position for 2020/21 and considered the impacts on the 2021/22 financial year and beyond. • Assurance received regarding the governance and oversight arrangements for the Crown St capital works. • The Committee had received an update on the commercial strategy for the Hewitt Centre and had requested that further work be undertaken ahead of reporting back to a future meeting.

	Attention was drawn to the Committee's 2020/21 Annual Report, updated Terms of Reference and 2021/22 work programme. The Trust Secretary noted that the only change to the Terms of Reference related to an update to the reporting groups (inclusion of the Crown St Programme Group). The Board of Directors: • Received and noted the Chair's Reports from the FPBD Committee meetings held on 23 February 2021 and 23 March 2021 • Received and noted the 2020/21 Committee Annual Report and 2021/22 work programme • Approved the updated FPBD Committee Terms of Reference.
010e	Chair's Report & Terms of Reference from Audit Committee The Board considered the Chair's Report from the Audit Committee meeting held on 23 March 2021. Non-Executive Director, Tracy Ellery highlighted the following key issues: • The draft Head of Internal Audit Opinion was indicating that a 'substantial' assurance rating would be provided • High assurance had been received regarding medicine management in the Neonatal department following an internal audit report. It was requested that best practice be shared across the organisation. • The Trust remained on track to receive a 'green' rating for anti-fraud activity • The external audit process was progressing in line with the expected timetable. Attention was drawn to the Committee's 2020/21 updated Terms of Reference and 2021/22 work programme. It was noted that the Committee's Annual Report was produced as part of the year-end documentation. No changes were proposed to the Terms of Reference. The Board of Directors: • Received and noted the Chair's Report from the Audit Committee meetings held on 23 March 2021 • Received and noted the 2021/22 work programme • Approved the updated Audit Committee Terms of Reference.
010f	Chair's Report, Annual Report & Terms of Reference from Charitable Funds Committee The Board considered the Chair's Report from the Charitable Funds Committee meeting held on 16 March 2021. Former Chair and Non-Executive Director, Phillip Huggon noted thanks to the Head of Fundraising and the wider team for making significant progress on a number of issues despite challenges caused by the pandemic. Attention was drawn to the Committee's 2020/21 Annual Report, updated Terms of Reference and 2021/22 work programme. The Trust Secretary noted that no changes were proposed to the Terms of Reference The Board of Directors: • Received and noted the Chair's Report from the Charitable Funds Committee meeting held 16 March 2021 • Received and noted the 2020/21 Committee Annual Report and 2021/22 work programme • Approved the updated Charitable Funds Committee Terms of Reference.
011a	Corporate Objectives 2020/21: Year-End Review The Board received the final outturn position statements for the 2020/21 Corporate Objectives. The Chief Executive asserted that review had highlighted that the Trust had achieved a significant amount despite unprecedented challenges. Thanks were extended to the Executive Team for continuing to deliver against the corporate objectives.

	The Trust Secretary noted that a process was underway to develop the corporate objectives for 2021/22. Feedback from recent Committee meetings had requested that the objectives be aligned to the strategic aims, be SMART / measurable, and ensure that they do not duplicate objectives in other strategies / plans. The draft 2021/22 objectives would be reviewed by the Committee ahead of being submitted for approval by the Board in May 2021. The Board of Directors: • Noted performance against the 2020/21 Corporate Objectives.
011b	**Revised Risk Management Strategy for 2021-22** The Board received the report which provided a review of the current Risk Management Strategy (last reviewed in 2020). An updated proposed Risk Management Strategy for 2021/22 was tabled for consideration by the Board. The Trust Secretary identified the most significant change as being clarification in the Strategy that the Board Assurance Framework was not part of the hierarchy of risk registers but rather was a separate document that was informed by the Trust's risk profile. A discussion was held regarding the frequency of reviewing the Risk Management Strategy. It was agreed that whilst an update on progress against the established key performance indicators should take place annually, a full review of the Strategy could take place bi-annually. The Board of Directors: • Approved the Risk Management Strategy for 2021/22 • Agreed that the Strategy would be subject to bi-annual reviews rather than annual reviews.
011c	**Proposed Risk Appetite Statement 2021-22** The Board discussed a proposed risk appetite statement which set out the Trust's tolerance levels for risk in relation to the key strategic aims. The statement would define the Trust's appetite for risk to the achievement of strategic aims for the current financial year and had been reviewed by the Board's Committees during March 2021. During the FPBD discussion, it had been queried whether the risk appetite for the 'To participate in high quality research and to deliver the most effective outcomes' strategic aim would be better articulated as a 'High' risk appetite rather than as a 'Moderate' risk appetite. It had been asserted that a level of service redesign to improve patient outcomes would require innovation, creativity, and clinical research and the Trust should be ambitious in this area. The Board agreed that assigning a 'High' risk appetite to this aim would be a signifier of intent. The Board of Directors: • Subject to the amendment outlined above, approved the Risk Appetite Statement for 2021-22. *The following items were taken as part of the consent agenda.*
012	**Emergency Preparedness Resilience and Response Annual Board Report** The Board of Directors: • Noted the Emergency Preparedness, Resilience and Response (EPRR) Annual Report
013	**Trust Board Terms of Reference** The Board of Directors: • Approved the Trust Board Terms of Reference

014	**Board Assurance Framework** The Board of Directors: • Noted the Board Assurance Framework
015	**Review of risk impacts of items discussed** In summarising the meeting, the Chair highlighted the following key considerations: • Whilst operational and financial recovery would be vital, it would be important to also consider the recovery of the workforce from a challenging year. • The importance of the Trust engaging with the 'Starting Well' agenda. • The need for the Trust to improve its processes for 'learning lessons' • Ensuring that actions from the staff survey assigned to the Divisions were being effectively monitored.
016	**Chair's Log** The following Chair's Logs were noted: • For the Quality Committee to undertake a reflective exercise on the roll out of Continuity of Carer to ensure that key lessons were identified (May 2021). • For the Putting People First Committee receive an update on the efficacy of the upcoming PDR window in September 2021.
017	**Any other business & Review of meeting** The Chair extended thanks to Phillip Huggon who had left the Trust as a Non-Executive Director on 31 March 2021. The Chair particularly remarked on Phillip's flexibility and commitment to the role and the support that he had given to the Trust's fundraising team.

Liverpool Women's NHS Foundation Trust

Action Log

Trust Board
6 May 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
1 April 2021	21/22/008c	Chair's Reports, Annual Report & Terms of Reference from the Quality Committee	For the Research & Development Sub-Committee to consider how the Trust is engaging with the 'Starting Well' agenda.	Medical Director	Jul 21	On track	MD meeting with the Starting Well Theme leads on 7th May 2021 to explore how LWH can help to support the theme.
1 April 2021	21/22/008a	Performance Report	To review the reporting of areas of statutory compliance as part of the refresh of the Trust's Performance Report.	Chief Operating Officer	Jul 21	On track	This action remains on track. As part of the updated performance report to July Board statutory estates and H&S metrics will be included.
1 April 2021	21/22/005	Patient Story	For the Executive Team to receive assurance regarding the progress of the outreach work in the Trust's wards by the Honeysuckle Team.	Director of Nursing & Midwifery	July 21	On track	Scheduled for a future Executive Team meeting ahead of deadline.
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	20/21/272	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	July 21	On track	Invite to be extended following agenda setting process for the July 2021 Board.
3 September 2020	20/21/155	Serious Incident Report – Quarter 1, 2020-21	A report on the processes for learning lessons and embedding updated practice to be tabled at the November 2020 Board meeting.	Chief People Officer	Feb 21 (Nov 20)	Complete	Item scheduled for the May 2021 Board.

Chair's Log

Received / Delegated	Meeting Date	Issue and Lead Officer	Receiving / Delegating Body	Action Deadline	RAG Open/Closed	Comments / Update
Delegated	01.04.2021	For the Putting People First Committee receive an update on the efficacy of the upcoming PDR window in September 2021.	Putting People First Committee	Sept 21	Open	Scheduled for the September 2021 PPF Committee.
Delegated	01.04.2021	To undertake a reflective exercise on the roll out of Continuity of Carer to ensure that key lessons were identified (May 2021). Lead Officer: Director of Nursing & Midwifery	Quality Committee	May 2021	Open	This is on the scheduled agenda for the May 2021 Quality Committee.
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	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.

Agenda Item	2021/22/024

MEETING	Board of Directors
PAPER/REPORT TITLE:	Chief Executive Report
DATE OF MEETING:	Thursday, 06 May 2021
ACTION REQUIRED	Information
EXECUTIVE DIRECTOR:	Kathy Thomson, Chief Executive
AUTHOR(S):	Jenny Hannon, Director of Finance
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

The Covid-19 staff vaccination programme continues with good uptake. Asymptomatic staff have also been offered regular at home LAMP (Loop-mediated isothermal amplification) testing. The Trust has welcomed back those staff who have been shielding and each of those has a risk assessment to ensure they are supported back into work. The Trust continues its oversight of the response to the pandemic with an increasing focus on restoration.

Perfect Week

During the week of 19th -23rd April the Trust undertook a Gynaecology Theatre 'Perfect Week' which is an established national NHS improvement programme. The purpose of the programme is to identify improvements that can be made to the surgical pathway from booking, through the day of theatre and time in theatre, through to discharge. The session saw daily feedback to the Trust to identify actions to improve patient experience and efficiency. Over 30 staff who wouldn't normally be involved in theatres and the surgical patient journey supported during the week to help monitor the journey and experience of each patient.

An update on recent changes to senior management roles

There have been the following recent changes to senior management roles.

- Dan Nash was recently appointed to the new role of Deputy Chief Operating Officer. Responsibilities for Dan's previous role of Divisional Manager for Gynaecology have been shared across a number of individuals whilst the recruitment process takes place for a permanent appointment.
- Deputy Director of Nursing & Midwifery, Janet Brennan, has recently retired. Nashaba Ellahi will soon join the Trust as the new Deputy Director of Nursing & Midwifery. Responsibilities of the Deputy Director of Nursing & Midwifery role have been shared across the senior nursing and midwifery team until Nashaba joins us.

'Our Strategy' Launch

The Trust is proud to be able to share our new plan for the next five years; **Our Strategy**. Our Strategy was written in collaboration with our staff, patients, governors, members and our wider community. It sets out our ambitions for Liverpool Women's for the next five years, and will be our guide to the decisions we make on our journey to becoming outstanding in everything we do and delivering our vision of being the recognised leader in healthcare for women, babies and their families. Listening to the views of our staff, patients and community really shaped our plans, and encouraged us to be bold in our renewed focus of making sure we have the best people, giving the safest care, providing outstanding experiences.

Our Strategy will be available to download from our website from 6th May.

https://www.liverpoolwomens.nhs.uk/about-us/corporate-documents/

Future Generations

Our ambitions for Liverpool Women's Hospital over the next five years are set out in our 'Our Strategy'. However the **Future Generations** strategy within that sets out the clinical challenges associated with our isolated site. We are clear that those challenges can be addressed with a relocation of Liverpool Women's adjacent to an adult acute hospital in the city, ensuring access to the full range of clinical expertise and facilities to provide safer and more sustainable care for the future generations of women in Liverpool and beyond. We are planning to reinvigorate and refresh our work and engagement in this area.

SECTION B – Local

New Chair of Liverpool Health Partners (LHP)

Liverpool Health Partners has announced the appointment of its new Chair, Professor Eliot Forster. Prof Forster officially took up his post at the Academic Health Science System for Cheshire and Merseyside this month, following the decision by Dr Neil Goodwin, CBE to stand down as Chair as part of his move into retirement. Prof Forster was the Founding Chairman of MedCity, which represents the life sciences cluster of London and the south east of England and is a Board member of the Office for the Strategic Coordination of Health Research. He has 30 years of experience in the pharmaceutical and biotechnology industry. An alumnus of Liverpool University, where he is a Visiting Professor, he is also a Visiting Professor University of Pavia in Italy and a Fellow of the Royal Society of Medicine.

Appointment of New Chair of South Sefton CCG

Following the stepping down of Dr Craig Gillespie on the 31st March 2021, the CCG membership have approved Dr Peter Chamberlain as the new Chair of the CCG. The Clinical vice chair remains as Dr John Wray with Alan Sharples continuing in the role as deputy chair-Lay member for Governance.

One Liverpool Strategy

Developed by Liverpool City Council, the local NHS and key partners, the **One Liverpool Strategy** sets out a clear vision for a healthier, happier, fairer Liverpool for all. Following a period of focus on the COVID-19 response, work in this area is being restarted. Liverpool Women's has CEO representation on the program. Professor Louise Kenny, Executive Pro-

Vice-Chancellor of the Faculty of Health and Life Sciences Liverpool University (and non-executive director at the Trust) is also a key contributor.

SECTION C – National

Women's Health Strategy: Call for Evidence

The Department for Health and Social Care (DHSC) is seeking views to help inform the development of the government's Women's Health Strategy. There is strong evidence of the need for greater focus on women's health and to recognise and act on the inequalities. With the ambition of improving health and wellbeing of women across the country, the Trust will be co-ordinating a response as the leading provider of women's healthcare in Liverpool and beyond. Individuals are also encouraged to complete the consultation.

Women's Health Strategy: Call for Evidence - GOV.UK (www.gov.uk)

Policy paper - Integration and innovation: working together to improve health and social care for all

The Department for Health and Social Care (DHSC) has set out its legislative proposals for a Health and Care Bill aiming to build on the collaborations seen through COVID. The proposals address working together more collaboratively, reducing bureaucracy, improving accountability and other measures to support social care, public health and the NHS.

Integration and innovation: working together to improve health and social care for all (HTML version) - GOV.UK (www.gov.uk)

NHS System Oversight approach

NHS England and NHS Improvement (NHSE/I) have prepared proposals for a new approach to NHS system oversight. The proposed approach aligns with the vision set out for Integrated Care Systems (ICS) in Integrating Care and in the Government's White Paper, Integration and Innovation: working together to improve health and social care for all.

b0381-consultation-on-a-new-nhs-system-oversight-framework-2021-22.pdf (england.nhs.uk)

NHS 2021/22 priorities and operational planning guidance

NHS England and NHS Improvement (NHSE/I) published priorities and operational planning guidance for 2021/22 on 25 March 2021. This overarching document sets out six priorities for the year ahead and asks systems to develop fully triangulated plans across activity, workforce and money for the next six months. These arrangements are supported by an additional £8.1bn of funding to reflect the ongoing impact of COVID-19.

https://nhsproviders.org/media/691146/next-day-briefing-2021-22-planning-guidance-final.pdf

2021/22 National Tariff Payment System Consultation

On 22 March 2021 NHS England published a statutory consultation notice for the 2021/22 National Tariff Payment System (NTPS). The Trust has prepared a response to these proposals ahead of the deadline of 30 April 2021.

Liverpool Women's NHS Foundation Trust

	Agenda Item 21/22/25a
MEETING	**Trust Board**
PAPER/REPORT TITLE:	**Performance Report**
DATE OF MEETING:	Thursday, 06 May 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 on improving performance.***	
PREVIOUSLY CONSIDERED BY:	**Committee name**	*Choose an item.* Or type here if not on list: *Click here to enter text.*
	Date of meeting	*Click here to enter a date.*

Executive Summary

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

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 for months 11 and 12 20/21 against the key standards. It highlights those areas where the targets have not been met in the most recent month and subsequent actions taken to improve this position. The full dashboard is included as an appendix to this paper which includes all the indicators that have been achieved or not.

2. Workforce

2.1 Sickness Absence

KPI ID	Source	Service ID	Target < or >	Target	Value	Trend	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Sickness Absence Rate	Owner - Deputy Director of Workforce																	
KPI101T	NHSI	Trust	<=	4.5%	Numerator		3148	2327	2108	2312	2043	2494	3375	2911	2880	3466	2689	2395
					Denominator		39757	41513	40457	41594	40995	39689	41383	40186	41591	41637	37996	42558
					Performance		7.92%	5.61%	5.21%	5.56%	4.98%	6.28%	8.16%	7.24%	6.92%	8.32%	7.08%	5.63%
					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		6.23%	6.23%	6.23%	5.60%	5.60%	5.60%	7.44%	7.44%	7.44%	7.00%	7.00%	7.00%

The single month sickness absence figure again fell significantly, this month by 1.45%, from 7.08% in month eleven, to 5.63% in month twelve. This is still 1.13%above the Trust's target figure of 4.50%. Sickness absence fell in all the largest clinical areas, by 1.99% in Gynaecology, 1.66% in Maternity, and by 1.30% in Neonates

The HR Department are continuing to provide support for managers in managing sickness absence and in supporting staff. A range of support for staff is available and communicated to all staff through management and communications channels. Specific Covid 19 actions are in place including risk assessments for all staff, on-site coronavirus testing programme for staff (and family members) with suspected symptoms. Asymptomatic testing is now available to all staff (the new LAMP testing process replaced the previous lateral flow testing from 15th March). The Covid vaccination programme (available to all staff) continues, with second doses being administered from 22nd March onwards. 86.26% of staff have now had at least their first vaccination.

3. Safety

3.1 Serious Untoward Incidents (SUI)

KPI ID	Source	Service ID	Target < or >	Target	Value	Trend	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Serious Untoward Incindents: Open		Owner - Head of Governance																
KPI198T	Trust Objectives	Trust	<=	5	Performance Value		4	4	6	5	5	7	5	6	6	9	8	8
					Trend		▲	▶	▲	▼	▶	▲	▼	▲	▶	▲	▼	▶
					Target Value		5	5	5	5	5	5	5	5	5	5	5	5
					Qtrly Performance Value		14	14	14	17	17	17	17	17	17	25	25	25

For the end of March there were 8 SI's. Sis continue to be reviewed to identify trends, themes and learning. Since the last report the Trust has submitted a case to the CCG and declared a new SI, hence no change in the numbers

1 case has had an extension approved by the CCG following Executive Panel to enable some further enquiries to be completed. All immediate actions have been completed as a result of the 72-hour reviews, and there are no overdue actions from any SI's at present.

2 cases have recently been heard at CCG panel. 2 further are awaiting the next available panel.

3.2 Continuity of Care

KPI ID	Source	Service ID	Target < or >	Target	Value	Trend	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-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		96	101	80	75	45	65	42	44	78	412	186	129
					Denominator		816	751	805	807	660	810	785	779	843	1121	910	886
					Performance		11.76%	13.45%	9.94%	9.29%	6.82%	8.02%	5.35%	5.65%	9.25%	36.75%	20.44%	14.56%
					Trend		▼	▲	▼	▼	▼	▲	▼	▲	▲	▲	▼	▼
					Target %		35%	35%	35%	35%	35%	35%	35%	35%	35%	35%	35%	35%
					Qtrly Performance		11.68%	11.68%	11.68%	8.12%	8.12%	8.12%	6.81%	6.81%	6.81%	24.92%	24.92%	24.92%

The CoC % decreased in March. It will increase in April with the introduction of a 5th team. Progress has been a significant challenge in 2020 due to the pandemic and staffing levels, however increased performance from January 21 can be seen with a most recent quarterly performance of just under 25%. Approximately 10 teams are required to meet the 35% target and 15 teams for the 50% target in March 22. Following a period of "Pause and Prepare" to

review the COC plans The Family Health Division will continue to formally engage with staff in May and June to continue to move the maternity service to this model of working.

4. Effectiveness:

4.1 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	Mar-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	96.4	
	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	73.9	
	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	26.3	
	104d Referral to First Definitive Treatment	Count	0	Zero tolerance	5	1	1	3	3	1	2	0	2	3	2	3	6	
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	64.9	65.0
	Incomplete Pathway > 52 Weeks	Count	0	Zero tolerance	0	0	2	5	11	29	32	22	25	47	51	103	190	290
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	87.13
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	94.8

Referral to Treatment

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

As anticipated in March there was a deterioration in performance with 52-week breaches. The performance has been significantly impacted by the national stepdown of routine surgery and provision of mutual aid in the last 12 months. In addition, the national clinical validation programme meaning patients validated as higher priority are being treated ahead of other patients whose treatment is not as urgent but who have been waiting a longer time period.

It is anticipated that performance against this metric will improve in April as elective services increase.

All 52-week breeches receive a harm review.

As part of the Trusts recovery plans, we have a trajectory to eliminate 52-week breeches by March 2022

April 21	May 21	June 21	July 21	Aug 21	Sept 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22
199	147	120	118	91	64	37	13	23	16	8	0

Towards the end of March 21, the Trust began to restore our elective programme. Following successful recruitment in our theatre services we are able to maximise a 38-session week from mid-May which allows the service to address the long wait backlog. Consultant Anaesthetic provision however remains a challenge with LWH and LUH currently advertising for joint appointments. The service intends to keep in regular contact with those long waiting patients as we did during the national clinical validation programme towards the end of 2020.

Urgent Care

The 4-hour performance improved significantly in March and the weekly performance from mid-March has been achieved. The Trust has invited ESIST (The Emergency Services Intensive Support Team) to the Trust to develop our pathways against the CQC Patient First guidance.

Cancer

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

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

Priority level 1a

• Emergency: operation needed within 24 hours to save life

Priority level 1b

• Urgent: operation needed with 72 hours

Priority level 2

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

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

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

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

Priority level 3

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

The Cheshire and Mersey Cancer Alliance has commissioned work through Q1&2 this year to review the optimal gynaecology cancer pathway. This will aim to address the challenges of ensuring appropriate referrals and completion of diagnostics in a timely manner.

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

Diagnostic wait

KPI ID	Source	Service ID	Target < or >	Target	Value	Trend	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Diagnostic Tests: 6 Week Wait		Owner - Divisional Manager Clinical Support																
KPI204	NHSI	Trust	>=	99.0%	Numerator		35	195	326	332	284	328	328	344	282	312	382	352
					Denominator		127	415	565	555	488	394	376	380	334	372	426	404
					Performance		27.56%	46.99%	57.70%	59.82%	58.20%	83.25%	87.23%	90.53%	84.43%	83.87%	89.67%	87.13%
					Trend		▼	▲	▲	▲	▼	▲	▲	▲	▼	▼	▲	▼
					Target %		99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%
					Qtrly Performance		50.23%	50.23%	50.23%	65.69%	65.69%	65.69%	87.52%	87.52%	87.52%	87.02%	87.02%	87.02%

The 6-week diagnostic wait reduced slightly, however despite the pandemic has maintained fair performance. It is likely that this will increase as sickness absence reduces. The focus now for diagnostics is on cytometry and cystoscopy to improve this indicator. It is anticipated this indicator will be green end Q1 2021/22 as a results of capacity pressures easing.

5. Estates, Health and Safety

The Trust reported no RIDDOR events in March and none outstanding for the end of 2021/22.

Most recent water flushing compliance was 93% which is recognised by the Director of Infection, Prevention and Control as good performance in line with peers.

The Trust is reviewing our performance reporting of the Estate and facilities function in relation to Key Performance Indicator visibility at Trust Board and subcommittee level. Moving forward this will include

- Compliance with planned preventative maintenance
- Performance of Hard and Soft Facilities Management Functions
- Assurance on any estates risk.

This will be supported by benchmarking against the national NHSE Premises Assurance Tool.

6. Serious Incidents

StEIS Serious incidents reported in April 2021

There were no serious incidents declared in April 2021 and reported on StEIS

Lessons learnt from serious incidents submitted in April 2021

During April 2021 a total of 1 SI had its final report submitted to the CCG for consideration and request to close the incident on the StEIS system.

Service	StEIS Ref.	Summary
Maternity	2021-808	There was a notification that a number of staff members within Maternity had tested positive for Covid-19. There was further impact noted, due to the requirement for other staff members to self-isolate, as per Infection Prevention and Control guidance. All positive cases had been linked to an attendance at an external gathering on 22 December 2020. Following the number of staff that had to self-isolate, this had an impact on the continued service provision within Maternity.

Root Cause:

- There was a significant Covid-19 transmission event as a result of the external gathering and the measures taken by those in attendance were insufficient to manage the transmission risk.

Learning from Investigation:

Staff must ensure that they have a clear understanding of Government guidance within The Health Protection (Coronavirus Restrictions) (All Tiers) (England) Regulations 2020 to ensure that any external activity planned and undertaken is compliant with the Government guidance at the relevant time.

Staff must adhere to social distancing guidelines at all times and wear appropriate Personal Protective Equipment where necessary. They should ensure that any necessary risk assessments are completed either by the lead organiser of any event or the venue premises manager where it is required by the relevant legislation.

Recommendation

The staff directly involved should undertake a reflective account in order to demonstrate their understanding of the impact of the Serious Incident.

Actions Before final Report Published:

The Trust has re-iterated the importance of social distancing and wearing of PPE in respect of attending any external events where current government guidance permits. (This has been completed via the Trust In The Loop video message dated 24/02/2021, a Video Message from the Medical Director on 25/02/2020, and 2 further emails providing guidance on attending the funeral of a colleague, dated 10/03/2021 and 15/03/2021 respectively. The Head of Communications and Investigating Officer believe that sufficient communications have been disseminated across the Trust and no further action is required.).

Recommendations and Actions:

Two recommendations were identified from the investigation and developed into an action plan approved at the Maternity Risk Committee. To date 1 action has been completed in the required timeframe. The remaining action is due to be completed in April 2021 and is currently on track.

Monitoring and Assurance

This should be coordinated with the HOM and DON&M. This should be completed before the end of April 2021. The Director of Nursing and Midwifery will receive this reflection to ensure it considers the professional responsibilities and accountabilities of Midwives and other staff.

Overview

There was no SI's reported in April making a total of 0 SI's reported for the year to date for 2021/22. Compared to 2020/21 period the Trust has had a decrease 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
2021-22	0	-	-	-	-	-	-	-	-	-	-	-	0

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.

HSIB Cases Reported and NHSR Early Notification Scheme

During April 2021 there have been 0 cases which met the HSIB criteria and have 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	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 April 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.

Month 12 Safe Staffing Figures

WARD	Fill Rate Day% RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff
Gynae Ward	67%	102%	99%	126%
Delivery suite	71%	90%	78%	86%
Mat Base/ Jeffcoate	66%	75%	75%	84%
MLU	56%	62%	62%	81%
Neo-nates	98%	60%	96%	76%
Transitional care	71%	97%	152%	32%

Liverpool Women's NHS Foundation Trust

Board Performance Report

Published Month - April 2021

Data Included - Up to March 2021

Workforce

KPI ID	Source	Service ID	Target < or >	Target	Value	Trend	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Sickness Absence Rate	**Owner - Deputy Director of Workforce**																	
KPI101T	NHSI	Trust	<=	4.5%	Numerator		3148	2327	2108	2312	2043	2494	3375	2911	2880	3466	2689	2395
					Denominator		39757	41513	40457	41594	40995	39689	41383	40186	41591	41637	37996	42558
					Performance		7.92%	5.61%	5.21%	5.56%	4.98%	6.28%	8.16%	7.24%	6.92%	8.32%	7.08%	5.63%
					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		6.23%	6.23%	6.23%	5.60%	5.60%	5.60%	7.44%	7.44%	7.44%	7.00%	7.00%	7.00%
Mandatory Training Compliance	**Owner - Deputy Director of Workforce**																	
KPI095T	Quality Strategy	Trust	>=	95.0%	Numerator													
					Denominator													
					Performance		90.00%	92.00%	92.00%	91.23%	91.00%	89.00%	87.00%	89.00%	89.00%	88.00%	86.64%	86.00%
					Trend		▼	▲	▶	▼	▼	▼	▼	▲	▶	▼	▼	▼
					Target %		95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
					Qtrly Performance													

Efficient

KPI ID	Source	Service ID	Target < or >	Target	Value	Trend	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-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	9	9

Safety

KPI ID	Source	Service ID	Target < or >	Target	Value	Trend	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Never Events	**Owner - Head of Governance**																	
KPI181T	NHSI	Trust	=	0	Performance Value		0	1	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		1	1	1	0	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	1	0	0	0
					Trend		▶	▶	▶	▶	▶	▶	▶	▶	▲	▼	▶	▶
					Target Value		0	0	0	0	0	0	0	0	0	0	0	0
					Qtrly Performance Value		0	0	0	0	0	0	1	1	1	0	0	0

Effective

KPI ID	Source	Service ID	Target < or >	Target	Value	Trend	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Intensive Care Transfers Out	**Owner - Clinical Director Gynaecology**																	
KPI107T	Trust Objectives	Trust			Performance Value		0	1	2	1	1	3	1	1	0	0	1	0
					Trend		▶	▲	▲	▼	▶	▲	▼	▶	▼	▶	▲	▼
					Target Value													
					Qtrly Performance Value		3	3	3	5	5	5	2	2	2	1	1	1

Liverpool Women's NHS Foundation Trust

Experience

KPI ID	Source	Service ID	Target < or >	Target	Value	Trend	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
18 Week RTT: Incomplete Pathways	**Owner - Divisional Manager Gynaecology**																	
KPI003T	NHSI	Trust	>=	92.0%	Numerator		4657	4217	3443	3550	4428	5264	5120	4982	5283	5501	5762	6109
					Denominator		6476	6584	6549	7204	7799	8177	7877	7834	8419	8832	8874	9405
					Performance		71.91%	64.05%	52.57%	49.28%	56.78%	64.38%	65.00%	63.59%	62.75%	62.28%	64.93%	64.95%
					Trend		▼	▼	▼	▼	▲	▲	▲	▼	▼	▼	▲	▲
					Target %		92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%
					Qtrly Performance		62.81%	62.81%	62.81%	57.13%	57.13%	57.13%	63.76%	63.76%	63.76%	64.08%	64.08%	64.08%
18 Week RTT: Incomplete Pathway > 52 Weeks	**Owner - Divisional Manager Gynaecology**																	
KPI002T	Quality Schedule	Trust	=	0	Performance Value		2	5	11	29	32	22	25	47	51	103	190	290
					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		123	79	90	118	114	134	143	148	94	103	140	164
					Denominator		137	104	169	217	210	227	243	246	161	160	184	238
					Performance		89.78%	75.96%	53.25%	54.38%	54.29%	59.03%	58.85%	60.16%	58.39%	64.38%	76.09%	68.91%
					Trend		▲	▼	▼	▲	▼	▲	▼	▲	▼	▲	▲	▼
					Target %		90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
					Qtrly Performance		71.22%	71.22%	71.22%	55.96%	55.96%	55.96%	59.23%	59.23%	59.23%	69.93%	69.93%	69.93%
18 Week RTT: Non-Admitted Completed Pathways	**Owner - Divisional Manager Gynaecology**																	
KPI004T	Trust Objectives	Trust	>=	95.0%	Numerator		798	659	973	913	1042	1043	1235	1072	939	1083	1383	1512
					Denominator		898	795	1325	1400	1461	1497	1672	1488	1358	1536	1821	1961
					Performance		88.86%	82.89%	73.43%	65.21%	71.32%	69.67%	73.86%	72.04%	69.15%	70.51%	75.95%	77.10%
					Trend		▲	▼	▼	▼	▲	▼	▲	▼	▼	▲	▲	▲
					Target %		95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
					Qtrly Performance		80.52%	80.52%	80.52%	68.79%	68.79%	68.79%	71.85%	71.85%	71.85%	74.80%	74.80%	74.80%
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		6.5	4	5.5	9.5	7.5	3	9	8	4.5	5	2.5	
					Denominator		10	11.5	15	12.5	12.5	7	14	13	9.5	12	9.5	
					Performance		65.00%	34.78%	36.67%	76.00%	60.00%	42.86%	64.29%	61.54%	47.37%	41.67%	26.32%	
					Trend		▼	▼	▲	▲	▼	▼	▲	▼	▼	▼	▼	
					Target %		85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
					Qtrly Performance		43.84%	43.84%	43.84%	62.50%	62.50%	62.50%	58.90%	58.90%	58.90%	34.88%	34.88%	34.88%
Cancer: 62 Day Screening Referrals (Numbers)	**Owner - Divisional Manager Gynaecology**																	
KPI033	NHSI	Gynaecology	<=	5	Performance Value		1.0	0.5	0.0	2.0	1.0	0.0	0.0	0.0	1.0	0.0	0.0	
					Trend		▶	▼	▼	▲	▼	▼	▶	▶	▲	▼	▶	
					Target Value		5	5	5	5	5	5	5	5	5	5	5	5
					Qtrly Performance Value		1.5	1.5	1.5	3	3	3	1	1	1	0	0	0
Cancer: 62 Day Screening Referrals (Percentage)	**Owner - Divisional Manager Gynaecology**																	
KPI034	NHSI	Gynaecology	>=	90.0%	Numerator		1	0.5	0	2	1	0	0	0	1	0	0	
					Denominator		1	0.5	0	2	1.5	0	0	0.5	1	0	0	
					Performance		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%	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	3	3	1	2	0	2	3	2	3	6	
					Trend		▶	▲	▶	▼	▲	▼	▲	▲	▼	▲	▲	
					Target Value		0	0	0	0	0	0	0	0	0	0	0	0
					Qtrly Performance Value		7	7	7	3	3	3	7	7	7	9	9	9

Experience

KPI ID	Source	Service ID	Target < or >	Target	Value	Trend	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Cancer: 28 Day Faster Diagnosis	**Owner - Divisional Manager Gynaecology**																	
KPI359	Trust Objectives	Gynaecology	>=	75.0%	Numerator		111	112	165	177	159	186	169	206	248	173	204	
					Denominator		208	134	208	242	225	259	285	321	355	266	298	
					Performance		35.00%	83.58%	79.33%	73.14%	70.67%	71.81%	59.30%	64.17%	69.86%	65.04%	68.46%	
					Trend		▼	▲	▼	▼	▼	▲	▼	▲	▲	▼	▲	
					Target %		75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%
					Qtrly Performance		70.55%	70.55%	70.55%	71.90%	71.90%	71.90%	64.83%	64.83%	64.83%	66.84%	66.84%	66.84%
Diagnostic Tests: 6 Week Wait	**Owner - Divisional Manager Clinical Support**																	
KPI204	NHSI	Trust	>=	99.0%	Numerator		35	195	326	332	284	328	328	344	282	312	382	352
					Denominator		127	415	565	555	488	394	376	380	334	372	426	404
					Performance		27.56%	46.99%	57.70%	59.82%	58.20%	83.25%	87.23%	90.53%	84.43%	83.87%	89.67%	87.13%
					Trend		▼	▲	▲	▲	▼	▲	▲	▲	▼	▼	▲	▼
					Target %		99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%
					Qtrly Performance		50.23%	50.23%	50.23%	65.69%	65.69%	65.69%	87.52%	87.52%	87.52%	87.02%	87.02%	87.02%
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		1156	1207	748	684	702	746	750	839	787	882	816	1009
					Denominator		1156	1229	748	697	711	760	766	855	815	921	921	1064
					Performance		100.00%	98.21%	100.00%	98.13%	98.73%	98.16%	97.91%	98.13%	96.56%	95.77%	88.60%	94.83%
					Trend		▲	▼	▲	▼	▲	▼	▼	▲	▼	▼	▼	▲
					Target %		95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
					Qtrly Performance		99.30%	99.30%	99.30%	98.34%	98.34%	98.34%	97.54%	97.54%	97.54%	93.15%	93.15%	93.15%
Complaints: Number Received	**Owner - Head of Audit, Effectiveness and Patient Experience**																	
KPI038T	NHSI / Quality Strate	Trust	<=	15	Performance Value		1	6	5	5	2	4	1	5	2	6	3	8
					Trend		▼	▲	▼	▶	▼	▲	▼	▲	▼	▲	▼	▲
					Target Value		15	15	15	15	15	15	15	15	15	15	15	15
					Qtrly Performance Value		12	12	12	11	11	11	8	8	8	17	17	17

Liverpool Women's NHS Foundation Trust

Agenda Item	21/22/25b

MEETING	**Trust Board**
PAPER/REPORT TITLE:	**Lesson Learning**
DATE OF MEETING:	Thursday, 06 May 2021
ACTION REQUIRED	**Assurance**
EXECUTIVE DIRECTOR:	Executive Team
AUTHOR(S):	Executive Team
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 note the report, the assurances provided, and the future actions identified.***			
PREVIOUSLY CONSIDERED BY:	**Committee name**	Not Applicable		
	Date of meeting			

Executive Summary

Identifying lessons that can be learnt from the experiences we have, either positive or negative, within our working environment, is extremely important in the Trust's goal of becoming the 'recognised leader in healthcare for women, babies and their families'. They help us in preventing unwanted reoccurrences and in continuing to improve the services we provide.

This report outlines some of the challenges that the Trust has experienced in ensuring that there are effective and robust processes for learning lessons, with findings and comments from external partners e.g. the Care Quality Commission (CQC), Liverpool Clinical Commissioning Group (LCCG), and Mersey Internal Audit Agency (MIAA) highlighted. The report continues to note the Trust's current processes and vehicles for learning and sharing learning, drawing attention to some of the improvements that have been seen, illustrated through examples and good practice. The report concludes with identifying the additional steps that the Trust is planning to take to strengthen its processes to maximise the opportunities that effective lesson learning provides.

Report

Introduction

Identifying lessons that can be learnt from the experiences we have, either positive or negative, within our working environment, is extremely important in the Trust's goal of becoming the 'recognised leader in healthcare for women, babies and their families'. They help us in preventing unwanted reoccurrences and in continuing to improve the services we provide.

The Trust is cognisant of recent comments by the most recent CQC inspection which noted that "The managers investigated incidents, however lessons learned were not consistently shared within teams and the wider service". Papers from the March 2021 LCCG Board made the following comment regarding the Trust, asserting that "There has been limited assurance in relation to triangulation of learning from previous never events and serious incidents" and

a recent internal audit report from MIAA provided 'moderate assurance' regarding the Trust's processes for learning from serious incidents. This is an area of improvement that the Trust has been aware of and there has been the following item "Ineffective understanding and learning following significant events" on the Trust's Board Assurance Framework for the last couple of years. Lesson learning has been a topic that has been discussed on several occasions by the Trust's Quality Committee, and a specifically focussed meeting on the topic was held on 19 April 2021.

Outlined in the report are the Trust's current processes for learning lessons and examples are provided to demonstrate that the Trust has made progress in strengthening its arrangements, particularly over the past 12 months. Whilst there is an understandable focus on learning lessons from serious incidents, the Trust's approach aims to be wider than this, incorporating other opportunities for learning, some non-clinical. Whilst improved processes are important, ultimately for the Trust to improve its approach to lesson learning this will require a cultural shift to ensure that it is embedded in the day-to-day practice of all staff. This is explored in more detail towards the end of the report.

Current Processes

Process for learning from Serious Incidents / Never Events

As part of the Trust policy for the Management of Incidents and Serious Incidents, we currently use the Root Cause Analysis process which has built into the investigation process the identification of key areas where lessons can be learnt. This is completed initially in the 72hr review where immediate actions which are required are identified with the aim of protecting patients and staff whilst the main investigation is ongoing. During the main investigation the Investigating officer will identify areas where lesson can be learnt in relation to each of the key contributory factors, such as communication and environment. From the identification of these lessons, recommendation and actions are clearly identified and placed in an action plan. The final report, recommendations and action plan are reviewed and either agreed at the executive SI review panel. These are then shared with Liverpool Clinical Commissioning Group and the Care Quality Commission.

The final reports will now go to the appropriate Divisional Governance Groups and Divisional Board to take ownership of the action plan and its completion along with collating associated evidence.

Lesson from SI are shared with staff in a number of ways, via local newsletter, Lesson of the week, month posters, in staff safety huddles, in ward and department meetings and at formal meetings.

As part of developments during Covid-19 pandemic, the Risk and Patient Safety manager set up a virtual learning clinic. This was a success and other clinics are being rolled out on a monthly basis.

Learning from Never Events has also been shared at a 'GREAT Day' and in local safety meetings in Theatres.

Most recent learning event to be established is the Friday Morning 'Safety Check In' which has been established by the Medical Director and involves the Deputy Chief Pharmacist raising any issues with Medicines Safety and one of the divisional safety leads reviewing an Incident or SI which has occurred.

Process for learning from Complaints, Compliments etc.

Complaints are a valuable source of information on the quality of service the Trust is providing. The Trust looks at complaints to understand the factors that may lead to them, what can be done to address these factors, and whether the Trust's response to complaints can be deemed to be both appropriate and sufficient. The Trust uses information from complaints ('lessons learnt') to inform and help shape our future service delivery.
Making a complaint is never easy and it is important that there is an effective and sympathetic process for dealing with complaints. Those who complain should feel that they have been listened to and that learning has taken place. The Trust continues to work hard to ensure that its complaint process is personal and responds to the needs of the

individual to ensure that their experience is listened to and put right simply and quickly. This philosophy aligns with the Health Service Ombudsman's Principles of Good Complaints Handling which promotes a customer focused complaints system. Repairing relationships is the primary focus of complaint handling. An investigation is concerned with establishing the facts in order to reach a judgment in the matter of complaint and organisational learning is a by-product of the activity. The trust is committed to implementing the learning and recommendations from every complaint where improvements have been identified and recommended.

The Experience Senate (now the Patient Involvement and Experience Sub-Committee) receives quarterly and annual complaints reports detailing complaint themes, recommendations, actions taken and lessons learned. The Senate is attended by members of all divisions with the expectation that this information is taken back and shared. All complaint investigations are signed off by the Divisional Managers, so they have sight of all of the recommendations made by the investigator to address the lessons learnt. It is expected that these are shared at the divisional meetings, although there is no assurance that this is done consistently.

All actions taken to address the issues identified are recorded on Ulysses, with automatic reminders going to the action owner and responsible person when the action is assigned, due for completion and at regular intervals if it becomes overdue. Progress is recorded against the action directly onto Ulysses by the action owner until it is completed. This information is accessible for all areas using Ulysses, although currently there are no standard automatic reports for this information being utilised.

Learning from complaints is also shared externally via the Integrated Governance Report and the Quality Schedule.

Examples of shared learning from complaints:

- Issues were identified in concerns raised by women following discharge after a C- Section about the lack of pain relief provided. As a result, this was picked up by the Medical Team in Maternity who, in conjunction with Patient Experience, conducted surveys of C section women in relation to pain relief provision. As a result, new PN analgesia packs have been introduced to address this issue.
- Concerns were identified from people unhappy they were having extended wait to get in contact with GED. As a result, a second phone line was introduced to assist with the call capacity when volume increases.

Compliments

Compliments received by the Trust, that are notified to the Patient Experience Team, are recorded on the Ulysses system. If the staff member(s) is identifiable in the compliment that they are notified directly of the praise and their area/department manager is included in this email notification. If there is not an identifiable person, the compliment is sent to the area(s) or department(s) identified. It is expected that these are then shared more widely within the division, but we have no assurance that this happens on a regular basis.

The number of compliments is reported to the Experience Senate on a quarterly basis.

Process for triangulation e.g. Integrated Governance Report

Over the past 2 ½ years the Head of Governance and Quality has been developing the current Integrated Governance Report which is a quarterly report used to provide a clear over view of all incident, complaints, claims, clinical audits, risks and leaning which have occurred to the Quality Committee and our commissioners. This report is also shared with Liverpool Clinical Commissioning Group as part of our Quality Contract Evidence.

The report has been through a period of development and has been an iterative process with feedback from the Quality Committee members and the Commissioners which has been taken on board and changes made. The Head of Governance has benchmarked this report with other organisations, and it has developed well, there continues to be further development on the assurance around the embedding of lesson learnt.

The aim of the report is not only to provide information as what has happened, when and the numbers which have occurred, it is also a process of triangulation of the key findings and trends identified. The Head of Governance and Quality and the Risk and Patient Safety Manager review the information provided for the report and look to identify the trends in each section, (incidents, claims complaints etc.) and they look to identify if there is any trends in these sections and if there is any correlation between the sections, if so, what these are and if there have been any actions out in place. These are then cross-referenced with the risks on the corporate risk register and the BAF to identify if the key issues identified have been identified as risks.

The report is also used to stimulate discussion at the Quality Committee and encourage the committee members to examine a challenge the contents and actions.

One of the next steps is to commence sharing this report with the Divisional Governance Group and Divisional Boards to support the identification of trends and any triangulation across divisions which can support improvement and development and reduce silo working.

Quality Improvement

The process for Quality Improvement at LWH has been growing and developing over the past 2 years, with clear recognition that this was an area which required focus and drive. This was also an area of focus for the Care Quality Commission in the Trust 2018/19 inspection where lack of clarity about the trust approach to quality improvement was identified. The Trust has had a Quality Strategy in place since 2013 with the latest for 2020-2025 being the most significant development as a Clinical and Quality Strategy. The Quality Strategy is monitored via the Quality Committee on a quarterly basis with a clear indication of progress and actions where progress is off trajectory.

The development of the Clinical and Quality Strategy for 2020-25 has occurred due to clear drive from the organisation to ensure that we have an integrated approach to quality improvement which is driven from the ground up and not top down.

As part of the review and restructure of the trusts meeting structure a new Quality Improvement Group has been established which reports into the newly combined Safety and Effectiveness Sub-committee. The group will be chaired by the Deputy Medical Director with a clear membership which includes effectiveness leads from each of the divisions and corporate staff. The establishment of a dedicated operational group for Quality improvement which will include Clinical Audit and Effectiveness will allow for a greater degree of engagement and scrutiny of projects and their outcomes. It is envisaged that this group will help in providing focus and drive, energising the Trusts work around and in relation to improvement.

A Quality Improvement new web page and Quality Improvement Framework have been developed by the Trust Quality Led which provides clear information as to the methodology used for QI by the Trust and how staff are to receive training and support on OI and the implementation of this in all areas of the Trust. As part of this approach the Trust has moved to logging and monitoring all Quality Improvement and Service Evaluation projects on the new action plan module in Ulysses, which is also used for all action plans across the Trust. This will allow for the central monitoring of progress and collation of evidence and actions which are developed from projects. The Trust Lead for Quality Improvement will use this module to management, monitor and report on projects and their progress to the Quality Improvement Group.

Learning form QI projects including service evaluation are shared within the services and divisions and where there is learning across the organisation, this shared via the use of the great day, weekly Safety check ins, QI web page.

Learning is shared outside of the organisation in the form of the Trust annual Quality Report which is structured around national framework as although is written as a spate report is part of the Trusts annual report. The Quality

Report is also shared with Health Watch and Merseyside CCGs to review and provide comment on as part of the report.

Further work is required with the development of a QI page in the staff bulleting and the potential use of the new staff app as has been done with learning form incidents.

Clinical Audit

Clinical Audit is a recognised methodology that can be used to inform and stimulate clinical quality improvement. The main purpose of Clinical Audit is to deliver improvements in clinical practice. Where the results of a Clinical Audit indicate sub-optimal practice, an Action Plan is produced. Action Plans should be specific, measurable and achievable/realistic. They should have clear prioritised implementation timescales with identified leads for each action. Action Plans should also be considered within Specialty/Divisional Governance meetings and actions discussed, reviewed and approved as appropriate. This is to ensure that Clinical Audit activity is embedded in the routine management and quality improvement activities of Specialties. Clinical services are responsible to ensure that identified changes where necessary are integrated into relevant business plans as appropriate. The Clinical Audit Annual report lists all of the changes made as a result of Clinical Audit and where the trust has learnt lessons and made a change. Below is an example lessons learnt and changes made to improve.

2020/022: Covid-19; an audit into triage standards in the Gynaecology Emergency Department

Lesson Learnt: Patient triage was not always performed within 15 minutes of arrival to the GED department, the GED escalation process was unsuitable and the physical relocation of the triage area was not suitable.

Changes made:
The triage process has been reviewed and staff training is underway to ensure the escalation of any delays and identification of high priority patients to Senior Staff. GED has physically relocated to allow for the initial assessment to be performed within the expected 15 minutes of arrival with a more in-depth nursing assessment carried out following this.

Lessons Learnt: There was a lack of clear escalation pathway within both the 'Continuous fetal monitoring' and 'Fetal blood sampling' guidelines. Medical staff were not consistently documenting fresh eyes assessments.

Changes made: Both guidelines were updated to include more robust guidance. A lesson of the week was circulated and a short training course was implemented for all midwifery staff. Fetal monitoring interpretation packages were reviewed and a fetal surveillance mid-wife has been appointed to support the fetal monitoring programme.

Process for learning from Freedom to Speak Up

The Freedom to Speak Up Guardians attend the Trust's Putting People First Committee (PPF) and provide regular reports on themes emerging from concerns. In addition, the Guardian submits twice yearly updates to the Board of Directors, including the Annual Report, which again provides an opportunity to highlight themes and identify learning. The concerns raised with Guardians are also captured in the annual Raising Concerns reports which goes to the Audit Committee. The Guardian is also active in the regional and national networks, which provides an opportunity for sharing learning and identifying themes across organisations and geography.

Work is underway to promote and raise the profile of the Guardians, including extending the knowledge of the team of Staff Supporters with respect to signposting staff with concerns to the Guardians. Further work is also being undertaken to connect the feedback from the Guardian service to the wider sharing of learning processes currently being refreshed within the organisation.

Covid-19 / IPC learning

The Covid-19 pandemic has been the greatest test of our business continuity arrangements and emergency planning as it has for the whole NHS. The pandemic has resulted in sustained levels of sickness absence of up to 20% that business continuity plans under normal times would not have anticipated. Business continuity plans, specifically winter and flu plans have not previously accounted for such long periods of sickness absence. This has resulted in the plans being updated to include allowing for this. The lessons learnt include:

- More regular refresh of skills audit to see how skills can be utilized across the divisions
- Updating in extremis staffing level ratios as in a pandemic mutual aid from other trusts is limited for our specialist and essential services.
- The creation of SOPs for providing mutual aid to other Trusts on a more consistent basis
- The creation of SOPs for virtual clinics as these will be business as usual moving forward
- Reviewing how we communicate with patients who are waiting longer than they normally would for an appointment/ procedure
- Review of clinical estate to reflect social distancing requirements
- Review of working from home arrangements including IT and infrastructure

HR Processes

The HR function records all disciplinary, grievance, dignity at work, recruitment & selection activity – looking at issues such as compliance with policy, by protected characteristic, by role/grade etc. An annual review is undertaken of that data through a range of processes, including e.g. WRES, WDES, to identify any areas of practice that may identify inequity and an annual report is submitted to the Board's PPF Committee to provide assurance and outline learning identified/actions taken.

With respect to Employment Relations processes, there are quarterly reviews undertaken within the HR team to allow for the identification of improvement/learning and feedback to investigating managers/HR professionals.

Learning from both activities outlined above are built into ongoing training processes such as local manager training and specialised training such as Investigator training.

In the rare circumstances of a complex, lengthy employee relations case, there are formal debriefs and learning events – e.g. a complex medical workforce case involving multiple individuals and differing employment policies resulted in the Trust commissioning legal expertise to come and deliver a learning session to the wider consultant body as part of a GREAT day.

Finance Processes

The finance function also learns and shares lessons in a number of ways. Through regular audits, recommendations and implementation of improvement actions the team maintain consistent challenge and improvement. Where Cost Improvement Programs (CIP) are developed, the team will conduct post implementation reviews on all schemes at six months and again at the end of the financial year to ensure that they are delivering as planned, and if not what are the causes of this. This is achieved by asking four key questions;

- Did the scheme achieve its objectives (positive impact)?
- Did the scheme have an adverse impact on quality?
- Did the scheme unduly affect the working lives of staff?
- Did the scheme elevate any other risks?

The outcomes of this are captured and reported through Trust governance structures to help understand and shape future approaches to schemes. The team also conduct post implement reviews on significant Trust Business Cases with the same intention.

The team also seek feedback on their performance and outputs through an annual budget holder survey, which is used to both celebrate areas of success but also reflect on what could be done even better going forward. Informal

meetings and discussions also support learning and best practice as well as sharing and networking across other departments and organisations.

The culture in the department it that of continuous learning. Engaging in national and local initiatives allows the team to develop appropriate skills, maintain accreditation and be fit for the future. This includes programs such as Future Focussed Finance, Finance Skills Development and participating in the Value Makers programme which aims to create a network of staff from across the country, representing all levels of the NHS Finance function. Sharing ideas, information and supporting one another.

There are areas for improvement in relation to the wider finance function being able to spend more time with the services, which has been difficult during the pandemic. In doing so the team can better understand the challenges within the divisions and other corporate areas to provide optimum levels of support.

Current vehicles for sharing learning

The sharing of learning via the governance team occurs in several ways on differing levels.

The Head of Governance and Quality and the Risk and Patient Safety Manager are both members of corporate groups such as Quality Committee, Safety and Effectiveness Sub-committee, Medicines Management Group etc. where they can provide feedback on lessons learnt to the membership and ask that this is shared within their areas.

The Head of Governance and Quality and the Risk and Patient Safety Manager review all incident each day (Mon-Fri) and look to identify any serious incidents, trends or key incidents which need a rapid review. They join the daily safety huddle and share this with the senior staff present. The Divisional Governance Managers also review all the incidents reported in their division on a daily basis to identify any key incidents or issues. The daily incident report is also shared with all senior staff, matrons, Director of Nursing and Midwifery, Medical Director and more recently all Executive directors and deputies.

The Divisional Governance Managers are key within the division as members of the senior management team, not only their support and participation in their divisional governance groups, but also divisional boards and their direct contact with clinical and non- clinical staff on the ground floor. They are also instrumental in ensuring the completion of robust incident, serious incident and complaint investigations and assisting in identifying the key lessons and supporting how these are shared across their division.

The Head of Governance and Quality assists in coordinating lessons learnt across the divisions with the governance managers to work towards reducing silo working and ensuring that lessons which are applicable to multiple areas are shared as such. This is an area requiring on going development to ensure any relevant learning is shared across the organisation.

The governance team are in the process of producing a new newsletter for staff starting the beginning of May 2021, which will share lesson learnt and identify where there is wider learning and have arranged to have a section on the new staff app which will also provide updates on key issues and lesson learnt.

The Clinical Audit And Effectiveness team play a key role in supporting staff to complete robust audits which may have been identified as a areas for review from an incidents, serious incidents, risk assessments or national guidance.

The Quality Improvement Lead is part of the Governance team and plays a key role in the development of Quality Improvement across the organisation suing an agreed approach for the Trust supported by training for staff. Working has been ongoing to assist in identifying QI projects from Incident's, SI, complaints, audits etc. This is underpinned by the Trust Clinical and Quality Strategy 2020-2025.

Areas for Improvement

Consistency / Standardisation of approach at divisional level
There is an opportunity to enhance the standardisation of learning through the cascade of information through the Divisional Boards. Moving forward this will be a standard agenda item.

Responding to MIAA Audit
The MIAA audit has been received by the Quality Committee and the Safety and Effectiveness Sub-committee and once received by the Audit committee will be shared with the divisions. Work on the four identified actions is ongoing with focus on increasing the number of staff who have completed their mandatory Risk Management Module. The remaining three actions are being progressed and are within agreed timescale.

HR Processes

Areas for improvement centre around the effective interpretation of the Supporting Staff Policy and the application of Fair & Just Culture methodology, with a focus on supporting and recovering staff, coaching behaviours and wider sharing of identified learning.

Closing the loop – Developing a learning culture
The Trust is using many ay in which to share learning with staff as previously identified above and as shown continues to plan improvements and different mean by which learning can be shared across the divisions but also across the organisation as a whole.

The biggest change is linked to the development of the safety and learning culture of the organisation, to engage staff in the learning process and to have clear understanding that learning is not just relevant from local events but events form across the Trust.

Another key element is the development and introduction of Human Factors Training which will, be in line with the requirements of the National Patient Safety Strategy. Work on developing a business case for this has commenced with input form a University specialist lecture in Human Factors who is also part of the NHSE/I team developing the new national patient safety training programme.

A key area which requires further development is the process of gaining assurance that learning has been adopted in and embedded into practice. The ongoing development of Service Evaluation and Quality Improvement projects is important along with the ongoing use of clinical audits, staff mentorship and supervision.

An example of the effective use of clinical audit can be seen from the formal line incidents which occurred on the neonatal unit in 2020. These were declared and investigated as serious incidents with a result of the investigation identifying that an audit of practice was required. The audit clearly identified inconsistencies in practice up to and including consultant level in relation to the insertion and removal of lines. From this audit practice and new policies and procedures have been developed and implemented. A re-audit is planned for 6 months to identify if the practice change has occurred.

Strengthening vehicles for sharing learning

- Bulletins – circulated to all staff on a bi-monthly basis, including good practice regarding patient safety and experience sharing. First edition being written now, section on new staff app also agreed and information will be available from launch date.

- Learning Lessons sessions – held monthly and available to all staff. Dates are in the diary for staff to book onto.

- Learning Lessons Leads – development of a virtual group of 50+ staff in the Trust to establish a culture of learning and development based on national and international dissemination of knowledge.

- Debriefing sessions – following incidents for both staff and patients to support understanding and learning. There is a need to ensure that these are consistently utilised.

Conclusion and Recommendation

The Trust has several mechanisms in place for learning lessons and these have been outlined in the report. The next steps need to focus on ensuring that there is evidence that improved practice has been put into place and embedded. A key vehicle for this will be the Trust's Divisional structure and the further development of a 'learning culture' throughout the organisation. Work is progressing on these aspects and improvements are visible although it is acknowledged that it will take time to provide assurance through the Trust's governance framework.

The Board is asked to note the report, the assurances provided, and the future actions identified.

Agenda Item	21/22/25c

MEETING	**Trust Board of Directors**
PAPER/REPORT TITLE:	**Maternity Incentive Scheme (CNST) Position Paper**
DATE OF MEETING:	Thursday, 06 May 2021
ACTION REQUIRED	**Assurance**
EXECUTIVE DIRECTOR:	Gary Price, Director of Operations
AUTHOR(S):	Angela Winstanley – Quality & Safety Midwife
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** **1.** To develop a well led, capable, motivated and entrepreneurial ***workforce*** ☐ **2.** To be ambitious and ***efficient*** and make the best use of available resource ☒ **3.** To deliver ***safe*** services ☒ **4.** To participate in high quality research and to deliver the most ***effective*** Outcomes ☒ **5.** To deliver the best possible ***experience*** for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust*..... ☐ ***2.*** *Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have sufficient numbers of clinical staff with the capability and capacity to deliver the best care.* ..... ☐ ***3.*** *The Trust is not financially sustainable beyond the current financial year*..... ☐ ***4.*** *Failure to deliver the annual financial plan* ..... ☐ ***5.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision* ..... ☐ ***6.*** *Ineffective understanding and learning following significant events*..... ☐ ***7.*** *Inability to achieve and maintain regulatory compliance, performance and assurance*..... ☐ ***8.*** *Failure to deliver an integrated EPR against agreed Board plan (Dec 2016)* ..... ☐
CQC DOMAIN	***Which Domain?*** ***SAFE-*** *People are protected from abuse and harm* ☒ ***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☒ ***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☒ ***RESPONSIVE –*** *the services meet people's needs.* ☒ ***WELL-LED -*** *the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.* ☒ ***ALL DOMAINS*** ☐
LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution ☐ **2.** Operational Plan ☐ **3.** NHS Compliance ☐ **4.** NHS Constitution ☐ **5.** Equality and Diversity ☐ ***6.*** Other: **Click here to enter text.**
FREEDOM OF INFORMATION (FOIA):	

RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	***The Board is asked:*** ***To note the current, to date compliance across each of the Maternity Incentive Scheme Safety Actions.*** ***To note the highlighted requirements for the Trust Board as found in the updated March 2021 guidance.***	
PREVIOUSLY CONSIDERED BY:	**Committee name**	Not Applicable
	Date of meeting	

Executive Summary

This report is to be used to update the Trust Board on progress to date with compliance required to achieve all ten safety actions and their associated standards for the Maternity Incentive Scheme Year Three. The scheme offers a financial rebate of up to 10% of the maternity premium for Trusts that are able to demonstrate progress against the scheme.

Report

Introduction

In response to the ongoing, significant pressures and strains on all NHS Services, including maternity, it was announced that a revision of the Maternity Incentive Scheme 20-21 (CNST Year Three) would be published in early 2021. In order to support Trusts to continue to work towards improving quality and safety during the pandemic, and to reduce the administrative burden, multiple safety actions and standards have been revised or removed.

The Trust received a further revision to the guidance for the 2020-2021 Maternity Incentive Scheme on 1st March 2021 (Appendix D), which was a further change to the update received in January 2021 (Appendix C). The Trust CNST Action Log/Action plan has been updated with the changes and work continues to progress towards full compliance (available upon request).

For the Trust to be eligible for payment under the scheme, Trusts are now required to submit their completed active board declaration to NHS Resolution, which must be signed by the Trust Chief Executive, between the dates of **12th July and Noon 15th July 2021.** Submission after 1200hrs on 15th July 2021 will **not** be considered, notification of results will be given to the Trust by end of November 2021.

Liverpool Women's are required to comply with the following conditions:

- The Trust **must** achieve all ten maternity safety actions.
- The Board declaration form must be signed and dated by the Trust Chief Executive to confirm that:
  - The Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required standards as set out in the safety actions and technical guidance documents
  - The content of the Board declaration form has been discussed with the commissioner (s) of the Trust's maternity service.
- The Board must give their permission to the Chief Executive to sign the Board declaration form prior to submission to NHS Resolution.
- The submission must be discussed with local Clinical Commissioning Groups.

Update and Position as of 29th April 2021.

- There are several reports and actions, noted throughout the guidance, that require sight at a Divisional Level. The Family Health Divisional Board meeting addresses any Divisional requirements and signs off any requirements that are not required for sighting at Trust Board level. To date – all divisional reports and papers have been sighted at the Family Health Divisional Board Meeting and have thus far met the requirements needed to evidence assurance of completion.
- Throughout the MIS guidance, there are several safety actions that require Trust Board sight, these requirements are presently up to date and a pathway and plan for presentation to the Board has been formulated by the Trust Secretary and Quality and Safety Midwife. These Board requirements and pathway can be found in Appendix B.

CNST Compliance as of April 28th 2021.

The Family Health Division would like to provide assurance that progress continues against compliance for all safety actions, with assurance and compliance in place for all safety actions, other than those detailed below.

Safety Action Point	Description	Board or Divisional Requirements needed for Compliance.	Status RAG
SA.1	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	Standard Ai, Aii, B and C – Compliance Met re PMRT Deadlines (Appendix G) **Outstanding:** Standard D) Q4/End of Year Perinatal Mortality Report is currently under development and requires sight at Trust Board in July 1st 2021.	**Partial** Compliance and ongoing.
SA.2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Compliance achieved with this action in its entirety. All requirements for each standard have been met, with evidence embedded into Trust action log. Confirmation received from regional Chief Midwife that confirms LWH (and all Trusts in the region) met the requirements for this action.	**Compliant.**
SA.3	Can you demonstrate that you have transitional care services to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?	Standards A, B and C removed in March update. Compliance achieved with this action in its entirety. All requirements for each standard have been met, with evidence embedded into Trust action log.	**Complaint.**
SA.4	Can demonstrate an effective system of clinical workforce planning to the required standard?	Standards pertaining to Obstetric Workforce removed in March 2021 update. Compliance achieved with this action in its entirety. All requirements for each standard have been met, with evidence embedded into Trust action log.	**Compliant**

SA.5	Can demonstrate an effective system of midwifery workforce planning to the required standard?	Midwifery workforce paper submitted in January 2021 as part of the bi-annual staffing paper. **Outstanding:** Midwifery workforce paper to be submitted to Board in July 2021 - This will cover all requirements of the Maternity Incentive Scheme and will include an action plan that will include a commitment to a further BirthRate+ assessment in Summer. 2021.	**Partial** compliance and Ongoing
SA.6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	Compliance achieved with this action in its entirety. All requirements for each standard have been met, with evidence embedded into Trust action log. A further bi-annual Saving Babies Lives progress report is included in the appendices of this paper, as there is a requirement for Trust Board consideration of how its organisation is complying with SBLCBV2 (Appendix E). It is worth noting that the deviations submitted for the Saving Babies Lives Care Bundle, still require sign off by the Cheshire and Merseyside Strategic Clinical Network. The SCN have developed a process for expert review of these deviations and will provide a response to the Trust in course, decision anticipated to be May 2021. LWH deviations centre around the pathway for the management of women at risk of developing a growth restricted fetus. They have been reviewed extensively by the Family Health Division and our in house experts. These deviations will be submitted to the Board Level Safety Champion for further information and have been described in the Bi-Annual SBL Reports in Appendix E	**Compliant.**
SA.7	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?	Compliance achieved with this action in its entirety. All requirements for each standard have been met, with evidence embedded into Trust action log. Chair of MVP now invited to Safety Champions Meetings as a further opportunity to provide Trust feedback of women's and their families voices. MVP meeting re-instated post Covid-19 pandemic and future collaborative projects planned. Up to date Terms of Reference for MVP requested- doesn't affect ability to meet standard.	**Compliant**
SA.8	Can you evidence that at least 90% of each maternity unit staff group attendance an 'in-house' multi-professional maternity emergencies training session within the last year.	Previous concerns with this action (risk of declaring non-compliance with this Safety Action due to significant staffing pressures across maternity/midwifery and achievement of the 90% training compliance) have now been removed as there are no attendance compliance rates that the Trust must meet. The MPMET days will continue in order to evidence that staff have access to COVID 10 e-learning training, as this training is embedded into the study day agenda. **Outstanding:** Requirement from the Trust Board to facilitate ongoing, in person MMPET training sessions including fetal monitoring training when permitted and this must be reflected in the Trust Board Minutes. This evidence will be embedded into CNST action log when available.	**Partially Compliant** and ongoing
SA.9	Can you demonstrate that the Trust Safety Champions (obstetrician, neonatology, and Midwife) are meeting bi-monthly with Board level champions to escalate local identified issues?	Compliance with progress in meeting the Continuity of Carer targets and action plan continues. Board Level Safety Champion MF has attended one MatNeoSIP engagement events, commitment made to attend next event in November 2021. **Outstanding:** Score Survey Results to be utilised as part of Trust and Maternity Improvement – Evidence is required that this has been completed.	**Partially Compliant** and ongoing.
SA.10	Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only)	Email confirmation from NHSR stating that the Trust have complied with all requirements for reporting of 2019-2020 cases that fit the NHSR Early Notification Scheme.	**Compliant.**

	reported to NHS Resolution's Early Notification (EN) scheme?	The Trust Board is asked to consider the paper in Appendix F, that provides evidence and oversight of the requirements to meet this safety action.	

Conclusion.

- Safety Action 1, 2, 3, 4, 6, 7, 9 and 10 – Compliant. Evidence embedded into Trust Action Log. Evidence log to be scrutinised and discussed with CCG by COO.
- The Trust Board is asked to note the requirements in Safety Action 8 and 10 (highlighted in red).
- Deviations from the Saving Babies Lives Care Bundle V2 require strategic clinical network sign off - Deviations submitted – SCN now have a process in place for deviation sign off – awaiting decision, anticipated in June 2021.
- Work continues to meet the last requirements prior to the sign off date of 15th July 2021.
- The Trust Board should take assurance that to date all requirements have been met and evidence is available to demonstrate our position.

Appendix.

Appendix A - Revised CNST Guidance Issued 01.02.2021

Available for Board members via the Document Library on Virtual Boardroom and on Microsoft Teams.

Appendix B - Trust Board Requirements and Progress.

Available for Board members via the Document Library on Virtual Boardroom and on Microsoft Teams.

Appendix C – CNST Revision Guide – Issued 01.02.2021

https://resolution.nhs.uk/wp-content/uploads/2020/02/Maternity-Incentive-Scheme-Y3-Change-guide.docx

Appendix D – Revised CNST Guidance Issued 01.03.2021

https://resolution.nhs.uk/wp-content/uploads/2021/03/Maternity-Incentive-Scheme-year-3-March-2021-FINAL.pdf

Appendix E – Saving Babies Lives Bi-Annual Report: May 2021.

Below

Appendix F – Maternity Incentive Scheme: Safety Action 10. Compliance Report/Governance Records for HSIB/NHSr and DOC (redacted)

Below

Appendix G – PMRT Compliance with regards to CNST Deadlines (redacted).

Available for Board members via the Document Library on Virtual Boardroom and on Microsoft Teams.

Liverpool Women's NHS Foundation Trust

	Agenda Item
MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Saving Babies Lives Care Bundle 2 – Bi Annual Report May 2021**
DATE OF MEETING:	Thursday, 06 May 2021
ACTION REQUIRED	**Information**
EXECUTIVE DIRECTOR:	Lynn Greenhalgh, Medical Director
AUTHOR(S):	Angela Winstanley – Quality & Safety Midwife/Saving Babies Lives Lead Midwife
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** 1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☐ 2. To be ambitious and *efficient* and make the best use of available resource ☐ 3. To deliver *safe* services ☒ 4. To participate in high quality research and to deliver the most *effective* Outcomes ☐ 5. To deliver the best possible *experience* for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust…….* ☐ ***2.*** *Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have sufficient numbers of clinical staff with the capability and capacity to deliver the best care. ……* ☐ ***3.*** *The Trust is not financially sustainable beyond the current financial year……* ☐ ***4.*** *Failure to deliver the annual financial plan ……* ☐ ***5.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision ……* ☐ ***6.*** *Ineffective understanding and learning following significant events……* ☐ ***7.*** *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):	*Choose an item.*	
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	***The Board is asked to receive and take assurance from this report. Its primary aim is to inform the Board on the challenges, successes and actions required to ensure successful implementation of Version 2 of the Saving Babies Lives Care Bundle.***	
PREVIOUSLY CONSIDERED BY:	**Committee name**	*Choose an item.* Or type here if not on list: Click here to enter text.
	Date of meeting	*Click here to enter a date.*

Executive Summary

This paper provides an update on the implementation of the NHS England *Saving Babies' Lives Care Bundle Version 2* (SBLCBv2) at Liverpool Women's NHS Foundation Trust.

Prior to this report, progress has been monitored via quarterly submissions of the national care bundle survey to the Strategic Clinical Network and the Local Maternity System. This report details each of the five elements of SBLCBv2 along with a progress narrative.

Successes and challenges with implementation are highlighted. A separate action plan and tracker is available but has not been included in this report due to its length.

This report is important and forms evidence to meet the requirements of the Maternity Incentive Scheme, Safety Action 6, intervention A – Trust Board level consideration of how its organization is complying with the Saving Babies Lives care bundle version 2

Liverpool Women's NHS Foundation Trust

Report

Saving Babies' Lives Care Bundle

Version 2

Biannual report – May 2021

Previous Report October 2020.

Angela Winstanley RM

Quality & Safety Midwife

Dr Alice Bird

Consultant Obstetrician

Purpose

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

Background

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

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

SBLCBv2 brings together five elements of care:

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

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

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

Element 1: Reducing smoking in pregnancy

Description

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

COVID-19

The COVID 19 pandemic brought about challenges to meeting the requirements for CO monitoring in pregnancy and subsequently ALL CO monitoring was suspended, both locally and nationally, in March 2020. This was disappointing, as the ceasing of CO screening came at a time when rates here at Liverpool Women's were consistently shown to be >95% at Booking.

Referrals to our Stop Smoking Partner, Solutions4Health did not alter during the pandemic, however face to face support from smoking cessation advisors and their presence at specialist clinics onsite at LWH also had to be ceased. The advisors had been a regular presence at the high-risk antenatal clinics and had been providing cessation support to some of our most vulnerable women, especially those with pregnancies susceptible to fetal growth restriction. Given the current easing of lockdown restrictions, we will be requesting that this service be re-introduced as soon as possible.

The Family Health Division now plans to recommence the CO Screening programme in the post COVID recovery plans, and as such will be:

- Risk assessing clinical areas to ensure safe and adequate space.
- Ensuring all clinical areas and community staff have access to a working, serviced CO monitor.
- Purchase of further CO monitors to ensure Continuity of Care Team Midwives have access to a CO Monitor and replace those monitors now decommissioned or out of service.
- Updated smoking cessation training, which will contain information on the safe re-introduction of CO screening and the most up to date advice midwives are to supply to women as part of the VBA (Very Brief Advice) intervention.
- Introduction of a Smoking Cessation Midwife (7.5hrs per week) commissioned by Liverpool CCG.

Progress against SBLV2 Action log.

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

- Amber Action 1 - This concerns the process for feedback from the Stop Smoking Service. (Solutions4Health - S4H). Currently we cannot evidence a feedback loop from S4H to LWH, on a patient to patient basis. However, collaborative work is planned to introduce a feedback process, with regards to outcomes from referral to S4H at booking directly into the Trusts' new maternity electronic record - K2. This work will be included in the second scope of work for K2 and will enable S4H to input referral outcomes directly into the patient record. It will give the Community Midwifery Staff the ability to look at the outcome of the smoking referral at the 15/16 week appointment, enabling support and further advise to women on their stop smoking journey.

Since the last report, an amber action has been addressed and closed – K2 Athena has now given LWH the ability to electronically document CO reading and smoking status at the 36 week appointment – previously not possible with the Meditech system

Successes with implementation

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

- All outpatient areas within the hospital including Maternity Assessment Unit, Fetal Medicine Unit, Antenatal Clinic (Crown Street and Aintree) and the Day Assessment Unit at the Aintree Centre for Women's Health have access to a CO monitor.
- Maternity antenatal and postnatal inpatient ward areas now have access to a CO monitor and staff have received training in brief interventions and MECC (Making Every Contact Count) training.
- Smoking cessation advice training is delivered to midwifery staff on their clinical mandatory training days by a dedicated stop smoking advisor. This training includes use of the CO monitor and VBA.
- CO screening is now undertaken at the 36 week birth planning appointment in all settings and documented on the Meditech Information System.

Challenges with implementation

- Information system changes have been necessary to ensure that Meditech had the ability for midwives to record CO screening results at the booking appointment, 36 week visit and attendances with reduced fetal movements – however this data hasn't been reliable. K2 Athena now has the ability to document CO reading at all appointments with it being mandatory at the 36 week appointment.
- Action plan has been developed in conjunction with Matrons for Community & ANC to ensure that ALL women have an appointment with their community midwife at 36 weeks, including those for whom receive Consultant Led/Hospital Based antenatal care (eg Multiple Pregnancy, Medical Disorders). Information around safe sleeping, CO screening and risk assessment for birth choice planning is discussed at the 36 week community midwifery visit and it is therefore essential that this is offered to all women.
- Cessation of CO screening due to COVID-19 pandemic – this has had a significant impact on the

screening rates.

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

Element description

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

Action log

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

Progress narrative

Implementation of some of the interventions within this element have been challenging. Concerns have been discussed at a national level about the feasibility of adopting this element in its entirety, given this, the care bundle allows for maternity services to deviate away from the recommendations set out.

Liverpool Women's deviations away from SBLCBV2 and the pathways for women who may require a uterine artery doppler, have both been submitted to both our CCG's and the NWC SCN (Clinical Network).

The deviations are set out in the embedded document in the document below.

LWH Saving Babies Lives Deviations Upc

This document was updated and re-sent to the SCN in February 2021 to reflect the evidence and rational behind each deviation we are requesting. These deviations to the risk assessment pathway have now been accepted by the CCG and we are awaiting approval from our SCN Clinical Network colleagues, however work has commenced on embedding this into practice. Meditech booking pages have been updated to reflect the changes and K2 now also reflects the pathway as above.

Presently (April 2021), the Strategic Clinical Network for Cheshire & Merseyside are developing a process for review and ratification of SBLCBV2 deviations submitted from providers across the region. LWH was the first Trust in the region to submit deviations (back in 2020) and remain optimistic that they will be accepted.

Successes with implementation

- All women at booking are risk assessed to determine if a prescription of aspirin is required. This risk assessment is fully in line with NICE Hypertension in Pregnancy guideline (NG133, 2019). We are currently working towards the introduction of a PGD for Aspirin for those women at risk of developing a pregnancy complicated by FGR.

- Use of customised fundal height measurement (GROW) charts in our low risk population is embedded into practice with current pathways for referral for growth ultrasound when deviation is recognised.
- The deviations away from the SBLCBV2 that LWH have put in place will allow easier identification of women who require a uterine artery Doppler in pregnancy without exponentially increasing the burden on the Ultrasound department. At booking, all women are now screened for their risk of having a pregnancy complicated by FGR, and this risk assessment is further reviewed at their 15 week visit where midwifery staff will be able to identify previous pregnancies complicated by SGA and FGR and ensure clinical pathways are correct.
- An audit to review the percentage of babies born <3rd centile at >37+6 weeks will be completed and has been registered with the Trust Audit and Effectiveness Department. This audit will be conducted by the Trust Lead for FGR/SGA and the Quality & Safety Midwife and will use the GAP-SCORE audit tool provided by the Perinatal Institute.

Challenges with implementation

- With regards to the management of women with pregnancies confirmed affected by FGR and SGA, the development of an updated Small for Gestational Age and Fetal Growth Restriction guideline, encompassing any SBLCBv2 changes or those that require CCG/clinical network approval, has been delayed due to the anticipated release of multiple national guidelines on this subject during 2020, including the RCOG Green Top Guideline. Presently, April 2021, we are await the publication of the updated RCOG Green Top Guidance for the management of SGA/FGR pregnancies We would want to incorporate any latest evidence from this guideline in order to avoid making additional changes if it were to be updated now. It is anticipated that this guideline will be available for adoption by units across Cheshire and Merseyside, however this has not yet been confirmed. It is anticipated

that the full SGA/FGR guideline will be updated and released after the publication of the RCOG guideline.

- One of the significant challenges we have identified going forward is the Trust moving to new electronic patient record system provided by K2MS. Unlike most other MIS providers, K2 are not willing to allow an interfacing back feed into their network from the Perinatal Institute for continued generation of GROW charts. The team at Liverpool Women's Hospital NHS Foundation continue using GROW charts and the GROW-APP provided by the Perinatal Institute.
- Until we have more clarity regarding integration of GROW and K2, we will continue to use GROW separately. Once the K2 system is introduced, women will have to carry a separate paper GROW chart. We feel that this will be a challenge as women may misplace this single piece of paper or forget to bring it with them to appointments, which may lead to substandard care and the potential for adverse outcomes. There is also the possibility of duplication of GROW charts for these women which if not cancelled via Perinatal Institute would affect our annual delivery statistics.

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

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

Action Log

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

Progress narrative

Implementation of the interventions associated with this element is complete.

COVID-19

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

are communicated to women and their families to seek help where required, along with maternity staff holding meaningful discussions with women about the importance of fetal movements.

Successes with implementation

- The Tommy's and NHS patient information leaflet on RFM has been adapted by Liverpool Women's Hospital NHS Foundation Trust to enable documentation of both initial and subsequent conversations held with women with regards to the importance of fetal movements in pregnancy.
- This leaflet has been uploaded to the patient user side of the new K2 Athena System and is accessible by all patients registered for use of the app.
- All maternity staff are directed to discuss fetal movements at every contact. The dates and times of these conversations can be documented on the adapted Tommy's RFM leaflet.
- The Tommy's RFM leaflet has also been translated into a number of alternative languages and can be used for women who are in the BAME population or who are non-English speaking. This is facilitated by our Enhanced and Link midwifery teams.
- Liverpool Women's Hospital NHS Foundation Trust uses a regionally developed and NWC Strategic Clinical Network approved guideline for the management of RFM and was co-authored by one of our consultant obstetricians. The guideline aligns with SBLCBv2 and includes the framework for performing risk assessments in women who attend with RFM and a checklist to ensure management is provided in line with the guidance.
- All women who attend with an episode of RFM are offered both a CO screen and a referral to our partner Smoking Cessation service if necessary, provided by Solutions4Health.

Challenges with implementation

- The need for increased ultrasound scans placed a requirement on the Trust to provide extra scanning provision for women who attend with reduced fetal movements and have an identified risk factor. A number of midwife sonographers have been trained to address this need and in 2019, we recruited midwives to the Advanced Clinical Practitioner training programme, which will further strengthen our ultrasound capacity.
- Increased capacity to provide inpatient inductions of labour. Threshold for induction of labour increased with the introduction of the new regional guideline for management of RFM, in line with SBLCBv2.

Element 4. Effective fetal monitoring during labour

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

Action log

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

COVID-19

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

Progress narrative

Implementation of the interventions associated with this element are mostly complete. Staff completion of training remains the priority of the newly appointed fetal monitoring lead midwife, in order to fulfil the requirements of a 90% compliance rate in CTG training. There has been an introduction of a structured

process to support staff who are unable to achieve the required 85% pass mark on the K2 Competency Assessment Tool. This process gives staff the opportunity to have additional support and ensure a minimum 85% competency pass mark for all staff caring for women in the intrapartum area.

The Trust in response to the Ockenden Report published in December 2020, have appointed a dedicated Consultant Obstetrician Lead for Fetal Monitoring and surveillance as well as securing a full time position for a fetal surveillance midwife.

The re-instating of the Multi-Professional Maternity Emergency Training (MPMET) as a virtual training session, post COVID -19, has being facilitated with the purchase of the PROMPT training package.

Successes of implementation

- Successful bid to the LMS to secure funding for a full time, nominated, specialist midwife/clinician as a Fetal Monitoring Lead, to improve the standard of intrapartum risk assessment and fetal monitoring. This post is now a full-time substantiative role within the Trust.
- The Fetal Monitoring lead MW & Obstetrician are now in post with responsibility for updating fetal monitoring guidelines and providing a visible presence in both the low-risk and high-risk intrapartum areas.
- The Fetal Monitoring lead MW && Obstetrician are also responsible for ensuring that fetal surveillance education is up to date and involves all the elements of fetal physiology, human factors, situational awareness in relation to CTG and intrapartum care and intermittent auscultation.
- Updated current Continuous CTG and Fetal Blood Sampling Guideline to ensure in line with NICE guideline CG190, with clear escalation pathways if concerns identified.

- The design and implementation of a risk assessment framework around place of birth and risk assessment has been registered as a Quality Improvement Project.
- The guideline which incorporates all the risk assessment requirements of SBL has now been successfully implemented, with staff now confident in its ability to assist in the recognition of a changing clinical picture. This guideline and its risk assessment pathways are planned to be considered by our Strategic Clinical Network (SCN) and will be presented to the CCG when the SCN has approved.
- Building upon the 'Fresh Eyes' stickers, successfully implemented at Liverpool Women's NHS Foundation Trust in 2010, an audit was undertaken to assess the completion and use of the stickers. Based upon the audit findings, an updated fresh eyes sticker was designed, compliant with NICE guideline CG190 (2019). The use of these stickers has now been replaced with the use of an electronic review on the K2 Athena system.

Element 5. Reducing Preterm Birth

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

Action Log

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

Progress narrative

Implementation of the interventions associated with this element is complete.

COVID-19

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

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

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

Successes of Implementation.

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

Challenges to implementation

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

Conclusion.

This report details the progress made so far and the actions required to continue to work towards full and complete implementation of the whole of the Saving Babies Lives Care Bundle Version 2. Following the launch of the newly revised Maternity Incentive Scheme 2020, a focus on meeting the requirements with regards to Safety Action 6 continues. Audits have been undertaken to provide assurance that Liverpool Women's Hospital NHS Foundation Trust are meeting the requirements of SBLCBv2 and to evidence compliance with the Maternity Incentive Scheme. This audit and its findings are planned to be reported at the newly combined Effectiveness and Safety Senate in May/June 2021.

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

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

Regional Chief Midwife Surveys.

Since the last bi-annual report was submitted to Board in October 2020, a further regional survey has been completed and submitted to the SCN and the LMS. Survey number 4 can be found embedded within this report.

Survey 1. Submitted in November 2019

Copy of North West Coast REP v2 Survey

Survey 2. Submitted in March 2020

Copy of North West Coast REP v2 Survey

Survey 2.5, Submitted in July 2020

Copy of SBLCB Survey 2 (v2) Region

Survey 3. Submitted in October 2020

Copy of North West Coast REP v2 Survey

Survey 4. Submitted March 2021.

Copy of North West Coast REP v2 Survey

Appendix F - Maternity Incentive Scheme: Safety Action 10. Compliance Report.

Executive Summary

This paper provides evidence and narrative to support the Family Health Divisions progress with meeting the requirements for Safety Action 10 of the 2020-2021 Maternity Incentive Scheme. This report seeks to assure the Trust Board that we have reported 100% of qualifying cases to HSIB and to NHS Resolutions' Early Notification scheme.

Report

Introduction

The national Maternity Safety Strategy set out the Department of Health and Social Care's ambition to reward Maternity Trusts who have taken action to improve maternity safety. NHS Resolution in 2021 updated and published ten safety actions of which Trusts must be able to demonstrate they have fully embedded.

Safety Action 10, refers to the Trusts ability to having to have reported **all** qualifying cases to the Healthcare Safety Investigation Branch and for those births in 2019-2020 they have been reported to NHSr. This report will include evidence, for the Trust Board to consider, of reported cases in the timescales required in order to assure that all required cases have been declared.

Cases that Qualify for HSIB Referral:

Cases that Qualify for HSIB Referral:
There are set criteria that would necessitate a referral by the Trust to HSIB. The criteria are as follows:

- All births must be of ≥37+0 completed weeks of gestation, following labour, that resulted in severe brain injury diagnosed in the first seven days of life. These are any babies that fall into the following categories:

  o Was diagnosed with Grade III Hypoxic Ischaemic Encephalopathy (HIE)
  [OR]
  o Was Therapeutically Cooled (active cooling only)
  [OR]
  o Had decreased central tone AND was comatose AND had seizures of any kind.

- Any Intrapartum Stillbirth – where the baby was thought to be alive at the start of labour but was born with no signs of life (as per Each baby Counts definition of labour) .

- Any early neonatal death within 7 days of birth (≥37+0, excluding congenital abnormalities)

- Direct or Indirect Maternal Deaths up to and within 42 days of the end of pregnancy (excluding suicide and homicide).

Pause in reporting to NHSr due to COVID:

In order to reflect the significant impact of the COVID 19 pandemic on Trusts, reporting to NHS Resolution, was paused from the 1st April 2020. There remains an ongoing requirement that Trusts continue to report all cases that meet the criteria to the Healthcare Safety Investigation Branch (HSIB) for investigations to take be undertaken.
HSIB took on the responsibility for reporting potential eligible Early Notification cases to NHS Resolution for further consideration from a legal perspective. In April 2021, the Trust received communication from NHSr that this pause in

reporting will continue until further notice, the communication is embedded in the document below and received via our legal department.

NHSR pause in reporting COVID19 .

Since the COVID-19 pandemic began HSIB changed their investigation criteria. Referrals continued but cases where a baby was diagnosed with a normal MRI and where no concerns have been raised by the Trust or parents would not be progressed to full investigation. The mandatory reporting of all cooled babies has continued pending MRI results and any initial concerns raised by the parents or from the Trust. The letter from HSIB which details their new criteria for investigation and the additional written information for parents during the COVID-19 pandemic are embedded below. Cases where a normal MRI US have been referred back to the Trust have undergone a concise investigation with external clinician review facilitated at the LWH Perinatal Mortality and Morbidity review meetings.

HSIB COVID 19 criteria.docx

HSIB family info sheet during COVID

Governance Records pertaining to Required Standard A:

Reporting of all outstanding qualifying cases for the year 2019/20 to *NHS Resolution's EN scheme.*

Reporting period: Monday 1 April 2019 to Tuesday 31 March 2020.

15 cases were reported to NHSR in the reporting period, of these one was closed as the baby died prior to seven days of life and therefore was no longer a qualifying case.

Name	Baby W	DOB	Registration	Eligibility	HSIB	EN/NHSR Number
[redacted]		21/04/2019	YES	COOLED	YES	M19CT320/005
		20/04/2019	YES	COOLED	NO	M19CT320/002
		02/05/2019	YES	COOLED	YES	M19CT320/003
		09/06/2019	YES	COOLED	YES	M19CT320/006
		29/06/2019	YES	COOLED	YES	M19CT320/008
		13/07/2019	YES	COOLED / NND	YES	M19CT320/005 Closed as NND before 7 days
		20/07/2019	YES	COOLED	YES	M19CT320/010
		10/11/2019	yes	COOLED	YES	M19CT320/019
		29/11/2019	Yes	COOLED	YES	M19CT320/024
		02/12/2019	YES	COOLED	YES	M19CT320/025
		09/12/2019	YES	COOLED	YES	M19CT320/020
		11/01/2020	YES	Cooled	YES	M19CT320/039
		29/01/2020	YES	Cooled	Yes	M19CT320/029
		03/02/2020	YES	Cooled	Yes	M19CT320/028
		27/02/2020	YES	Cooled	YES	M19CT320/037

The Trust Board can be assured that the above cases have been cross referenced with NHSr . Confirmation that the Trust have complied with this standard has been provided scheme lead, Elita Mazzocchi (Maternity Incentive Scheme Clinical Lead for NHSr) to Angela Winstanley Quality & Safety Midwife on 6th April 2021.

Email confirmation embedded below.

re Safety Action 10
A. Early Notification.

Governance Records pertaining to Required Standard B:

Reporting of all qualifying cases to the *Healthcare Safety Investigation Branch (HSIB) for 2020/21*

Reporting period: Wednesday 1 April 2020 to Wednesday 31 March 2021.

Name	Baby W	DOB	Eligibility	HSIB	Number
		06/01/2020	NND - anomaly	Yes	2002-1722
		11/01/2020	Cooled	Yes	2001-1633
		29/01/2020	Cooled	Yes	2002-1739
		03/02/2020	Cooled	Yes	2002- 1740
		27/02/2020	Cooled	Yes	2003-1803
		30/06/2020	Cooled	Yes	2007-2227
		01/07/2020	Cooled	Yes	2007-2226
		05/07/2020	Cooled	Yes	2007-2225
		14/07/2020	Cooled	Yes	2007-2288
		04/10/2020	Cooled	Yes	2010-2572
		06/10/2020	Cooled	Yes	2010-2571
		19/10/2020	Cooled	Yes	2010-2571
		06/11/2020	Cooled	Yes	2011-2678
		04/01/2021	Cooled	Yes	MI-003102
		22/12/2020	Cooled	Yes	MI-003107
		02/02/2021	Cooled	Yes	MI-003267
		25/03/2021	Cooled	Yes	MI-003389
		28/03/2021	Cooled	Yes	MI-003390

All eligible cases, that required HSIB referral, have been reported. This will be cross-referenced by NHSr against the HSIB database and the National Neonatal Research Database, post Board declaration for the Maternity Incentive Scheme.

Governance Records pertaining to Required Standard C:

Qualifying cases which have occurred during the period 1 October 2020 to 31 March 2021 the Trust Board are assured that:

1.The family have received information on the role of HSIB and the EN scheme.

2.There has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.

Name	Mum W Number.	Badger ID	DOB	Eligibility	Duty of Candour & Information Letter
[redacted]			04/10/2020	Cooled	05/10/2020
			06/10/2020	Cooled	07/10/2020
			19/10/2020	Cooled	21/10/2020
			06/11/2020	Cooled	09/11/2020
			04/01/2021	Cooled	06/01/2021
			22/12/2020	Cooled	06/01/2021
			02/02/2021	Cooled	05/02/2021
			25/03/2021	Cooled	25/03/2021
			28/03/2021	Cooled	30/03/2021

Information has been provided to all parents in all cases relating to and requiring reporting to NHSR and HSIB. Parents are provided with a Duty of Candour letter that described the role of HSIB and NHSr. This letter is supplied to the parents along with a full and in-depth duty of candour conversation with a Consultant Obstetrician/Duty of Candour Lead, prior to discharge from the hospital with full explanation as to the review and referral process. HSIB have also produced patient information leaflets that are provided to all parents where a referral has been necessary.

An example of the HSIB DOC letter, Trust DOC leaflet and HSIB Information can be found below:

HSIB_Maternity_Family_Information_Fe

DOCHSIBNHSR-Example.docx

duty-of-candour-leaflet-lwh.pdf

Conclusion.

The Trust Board should take assurance from the evidence and information provided in this paper that the required standards to confirm compliance with Safety Action 10 of the Maternity Incentive Scheme have been fulfilled.

Quality Committee Chair's Highlight Report to Trust Board
19 April 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 agreed with the plan to undertake a Trust wide service evaluation and quality improvement project to review blood sampling errors. The risk of not providing an onsite phlebotomy service was noted. The Committee was supportive of a service evaluation and consideration to the provision of onsite phlebotomy services and training. • The Trust is undertaking an internal review of systems and processes to explore whether there are any issues of concern that require rectification with regards to neonatal mortality. The Committee acknowledged the importance of this but also stated that there may be external, socio-demographic factors to be aware of, which a review of the Trust's own processes and practice may not be able to answer.	• Commissioned a follow up report on Never Events to be presented in six months. • Chair action to PPF to focus divisions on the quality and continuation of shared learning actions. • It was recommended that the Divisional Governance Meetings needed to be strengthened to focus on demonstrating improvements and lesson learning to deliver assurances up to the Committee. • Commission divisional position update reports against the medicines management action plan to test whether compliance had been sustained. • Introduction of a Trust Governance and Learning Newsletter. • Chair action to Executive Committee to have oversight over key issues raised within the Learning Session, including organisational maturity to sustain learning and embedding Fair and Just culture aims.
Positive Assurances to Provide	**Decisions Made**
• Assured that a comprehensive thematic review and deep dive had been undertaken into never events which occurred in the Gynaecology and Obstetrics Theatres. Evidence of positive impact of changes made demonstrated within Gynaecology Theatres. Actions continued to be implemented to work towards improvements particularly within an emergency Obstetric Theatres setting. • Positively assured that a process of compliance monitoring was in place for LocSSIPs Wave 1 and that Wave 2 implementation was underway. Evidence of high levels of compliance demonstrated by weekly observational audits. Reliance on IT systems to be fit for purpose noted and a critical aspect for implementation of new IT systems to avoid difficulties. • Considered Mersey Internal Audit Agency (MIAA) review into learning from serious incidents and never events. MIAA had issued moderate assurance as the outcome. • Noted a total of 25 serious incidents (SI's) recorded during 2020/21, comparable to past annual total data. An overview against the main themes identified from the 25 SI's was provided. The planned development of Human Factors training was noted as a recurring theme affecting incidents and lessons.	• Approved the Terms of Reference of the Independent Mortality Overview.

Comments on Effectiveness of the Meeting / Application of QI Methodology
• Positive meeting to consider evidence and assurances of lesson learning within the Trust. • It was recommended that the divisional senior management teams undertake a similar exercise.

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
03.	North West Operational Delivery Network review of Mortality at LWH proposal and Terms of Reference	Approval	**06.**	Report on Blood Sampling Errors	Assurance
04.	Review of actions from Theatres Never Events	Assurance	**07.**	MIAA Learning from Serious Incidents and Never Events Review Final Assignment Report 2020/21	Assurance
05.	Progress of the LocSSIPs Implementation Group Q4 2020/21	Assurance	**08.**	Report on Serious Incidents, Quarter 4 2020/21, including year-end overview of reported SI's	Assurance

3. 2021 / 22 Attendance Matrix

Core members	Apr		May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Tony Okotie Chair	✓												
Susan Milner	✓												
Ian Knight	✓												
Louise Kenny	✓												
Marie Forshaw	✓												
Gary Price	✓												
Lynn Greenhalgh	✓												
Jenny Hannon	✓												
Michelle Turner	✓												
Christopher Lube	✓												

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

Quality Committee Chair's Highlight Report to Trust Board
26 April 2021

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Sickness levels had improved overall, however remained high in Maternity. Currently these sickness levels were no longer attributed to covid-19 as a cause and would be monitored by weekly executive oversight and the Putting People First Committee. • The worsening Friends and Family test score in Family Health was raised. The position would be considered by the Patient Involvement & Experience Sub-Committee commissioned to oversee an improvement. • The risk to manage patients on multiple clinical systems and on long waiting lists was raised within the Gynaecology deepdive report. A quarterly review of non-cancer patients on waiting lists continued although was not mandated. It was recommended that the risk should be reflected on the risk register.	• The Local Maternity System had requested that all maternity providers undertake an internal audit of the Continuity of Carer pathway. • Consider development of a Maternity Strategy with the output of wider actions identified by Family Health from the Ockenden review.
Positive Assurances to Provide	**Decisions Made**
• Noted the chairs report from the first Safety and Effectiveness Sub-Committee. The undertaking of a lookback exercise of cerebral palsy legal claims to identify any themes was noted as a constructive lesson learning review. • Received a deepdive review from Gynaecology which detailed responsive care through Covid-19. The Committee was assured that Gynaecology services had responded safely to support patients during 2020/21 and appropriately followed business continuity plans. • Assured by progress with remaining open actions on the CQC action plan. • Positively assured by Family health division progress implementing the Ockenden review essential and urgent recommendations. It was noted that additional action had been taken beyond the recommendations of the initial report. • Recommended that corporate departments should also consider the Ockenden review in terms of own processes/teams and of supporting clinical divisions. • Assured by robust leadership to ensure compliance against the maternity incentive scheme (CNST) within the revised timescales. • Received a Safety Champion update noting Trust implementation of the framework. • Noted the Quality Contract Assurance self-assessment for Quarter 4. Out of 42 requirements, 41 green and 1 amber which was being resolved.	• Committee reviewed the Quality related BAF risks. No changes to existing risks were identified as a result of business conducted during the meeting. Additional actions to mitigate 'Risk 2337, current clinical systems are suboptimal' was noted however no change to risk score of 20. The new EPR system was on plan for delivery by Summer 2022. • Approved the Clinical Audit Forward Plan 2021/22. • Agreed the Corporate Objectives 2021/22 aligned to the Quality Committee and would recommend approval by the Trust Board.
Comments on Effectiveness of the Meeting / Application of QI Methodology	
• The additional session held in April 2021 supported the discussion of items at this meeting. • Open and productive debate.	

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
17.	Board Assurance Framework	Assurance	**23.**	CNST Progress Report	Assurance
18.	Sub Committee Chair Reports	Information	**24.**	Family Health Division: Safety Champion Update	Information
19.	Quality Performance Report Month 12 2020/21	Assurance	**25.**	Clinical Audit Forward Plan 2021/22	Approval
20.	Gynaecology Update through Covid: Responsive Care	Assurance	**26.**	Contract Quality Schedule Assurance Report Quarter 4	Assurance
21.	CQC Regulatory Update	Assurance	**27.**	Corporate Objective Setting 2021/22	Approval
22.	Ockenden Report Update	Information			

3. 2021 / 22 Attendance Matrix

Core members	Apr		May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Tony Okotie Chair	✓	✓											
Susan Milner	✓	✓											
Ian Knight	✓	✓											
Louise Kenny	✓	✓											
Marie Forshaw	✓	✓											
Gary Price	✓	✓											
Lynn Greenhalgh	✓	✓											
Jenny Hannon	✓	✓											
Michelle Turner	✓	✓											
Christopher Lube	✓	✓											

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

Liverpool Women's NHS Foundation Trust

Agenda Item	21/22/27a

MEETING	**Trust Board**
PAPER/REPORT TITLE:	Finance Performance Review Month 12 2020/21
DATE OF MEETING:	Thursday, 06 May 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 note the Month 12 Financial Position***	
PREVIOUSLY CONSIDERED BY:	**Committee name**	Finance Performance and Business Development Committee
	Date of meeting	26/04/2021

Executive Summary

The Trust's unaudited year end position is an adjusted deficit[1] of £4.2m, a favourable variance of £0.4m against the adjusted plan.

Initially the Trust had planned to breakeven in 20/21 but the planning round 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. The Trust improved against this plan through securing additional non-NHS income from NHSI/E of £0.4m. It was also confirmed in Month 12 that the movement in the annual leave accrual would be met in full (£0.45m up from £0.2m forecast). This has led to an improvement from the Month 11 forecast.

[1] The actual deficit is £4m but this includes income from donated assets of £0.2m, which is adjusted out in the I&E for NHSI/E comparison purposes.

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

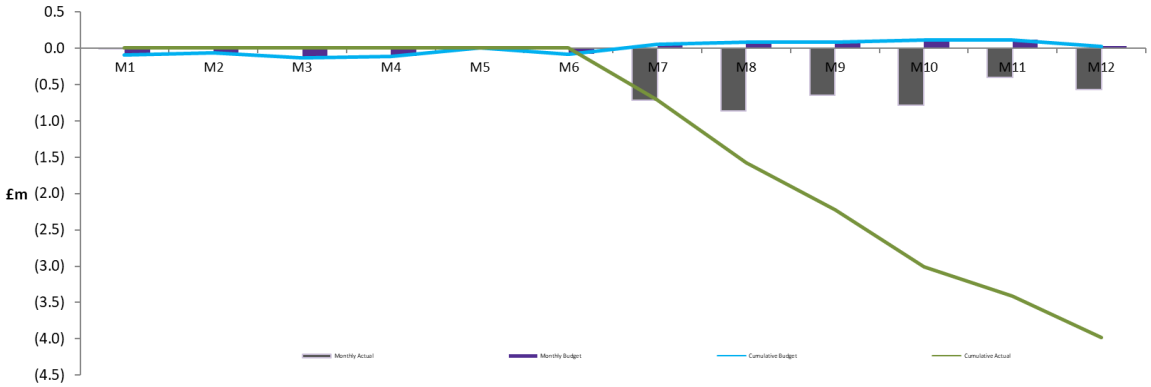
	Original Plan	Actual	Variance	RAG[2]	*Revised Plan*	*Actual*	*Variance v Revised Plan*	*RAG re Revised Plan*[2]
Surplus/(Deficit) Adjusted	-£0.0m	-£4.2m	-£4.2m	↑	*-£4.6m*	*-£4.2m*	*£0.4m*	↑
NHS I/E Rating	3	3	0	↔	3	3	*0*	↔
Cash	£4.6m	£4.2m	-£0.4m	↓	*£4.6m*	*£4.2m*	*-£0.4m*	↓
Total CIP Achievement	£3.7m	£2.0m	-£1.7m	↔	*£1.1m*	*£1.1m*	*-£0.0m*	↔
Recurrent CIP Achievement	£3.4m	£1.7m	-£1.7m	↔	*£0.9m*	*£0.9m*	*-£0.0m*	↔

Report

1. Summary Financial Position

At Month 12 the Trust is reporting an actual deficit for the full year of £4m (£4.2m adjusted) after total combined tops up of £12.8m.

2020/21 Surplus/ Deficit



Top up has reduced to a fixed £0.6m per month in the second half of the year against an average of £1.4m per month in quarters one and two, plus a one off non-NHS income top up of £0.4m, accounted for as £0.3m in Month 11 and £0.1m in Month 12. The total requirement versus amount provided by month and reason, is provided below.

[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.

	M1 £000	M2 £000	M3 £000	M4 £000	M5 £000	M6 £000	M7 £000	M8 £000	M9 £000	M10 £000	M11 £000	M12 £000	YTD £000
Anticipated structural shortfall	780	780	780	780	780	780	780	780	780	780	780	780	**9,360**
Private Patient income shortfall	222	253	163	-10	63	-49	-85	23	12	16	-42	-90	**476**
Commercial income shortfall	56	51	49	47	7	55	38	41	47	47	49	42	**530**
CIP under delivery	49	50	48	73	73	107	205	205	205	227	219	219	**1,681**
Covid-19 costs	484	409	296	361	221	191	216	175	126	300	249	204	**3,231**
Activity underspends - non pay	-174	-92	-106	-115	-193	-88	92	42	239	82	-404	186	**-531**
Activity underspends - pay	-116	-280	-75	-127	-70	10	163	136	-51	23	173	72	**-143**
Trust settlements					260	109	0	0	0	0	0	0	**369**
Other Healthcare Income	42	140	-12	82	88	96	28	57	40	47	59	-429	**238**
Medical pay award (YTD)						109	18	18	18	18	18	18	**218**
Other	81	-71	114	203	191	439	-86	32	73	-92	259	95	**1,237**
Total Required	**1,424**	**1,239**	**1,257**	**1,294**	**1,421**	**1,760**	**1,369**	**1,509**	**1,490**	**1,448**	**1,359**	**1,097**	**16,667**
Total Provided	**1,424**	**1,239**	**1,257**	**1,294**	**1,421**	**1,760**	**649**	**649**	**649**	**649**	**963**	**719**	**12,673**
Variance	**0**	**0**	**0**	**0**	**0**	**0**	**-720**	**-860**	**-841**	**-799**	**-396**	**-378**	**-3,994**

The actual top up for Month 12 was £0.7m, compared to a requirement of £1.1m.

2. Divisional Summary Overview

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

Family Health: The division ended the year £239k underspent. The Neonatal service was underspent by £527k offset by an overspend of £288k in Maternity.

Gynaecology: The division was £381k underspent for the year, driven by medical and nursing vacancies earlier in the year. Run rate has now returned to a slight overspend as vacancies have been recruited to.

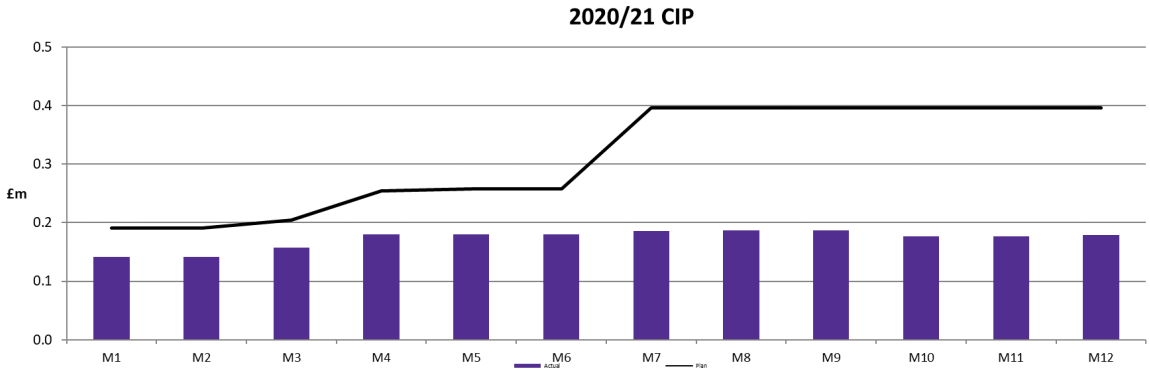
Clinical Support Services: The division was underspent by £493k for the year.

Agency: Total agency spend was £688k for the year, of which £337k 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. The Trust largely delivered this target achieving £1.1m of CIP against a revised plan of £1.1m for the second half of the year, of which £0.2m was non-recurrent.

The Trust has also monitored against the original plan, as shown in the graph below, and has achieved over £2m of CIP in the financial year.



4. COVID-19

The Trust spent £3.2m on costs directly related to Covid-19 in 2020/21, as shown in the table below, with £204k in Month 12.

	M1 £000	M2 £000	M3 £000	M4 £000	M5 £000	M6 £000	M7 £000	M8 £000	M9 £000	M10 £000	M11 £000	M12 £000	YTD £000
Bank costs to cover Covid-19 related vacancies	119	62	71	49	19	22	71	52	19	111	116	125	**836**
Student Nurses	0	40	49	34	17	0	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	16	**385**
PPE and equipment (excluding centrally purchased)	69	24	13	73	61	23	10	5	6	1	3	20	**308**
Enhancements paid to staff off sick	58	26	13	19	18	16	31	23	17	35	25	21	**302**
Staff meals (after £15k charity contribution)	28	60	0	0	0	0	0	0	0	0	0	0	**88**
Other catering and cleaning	32	33	37	15	26	22	30	30	28	21	26	-25	**276**
Swabbing, Lateral Flow and Vaccination Costs					17	21	22	23	27	71	39	40	**260**
Additional corporate costs	9	22	27	18	11	17	24	13	14	60	10	7	**233**
Telephony						29	3	3	3	3	3	-13	**29**
LUHFT - Breast Surgery								3	6	2	2	0	**13**
Other	67	62	41	15	39	40	25	23	2	27	9	12	**363**
Total	**486**	**408**	**296**	**361**	**221**	**191**	**216**	**175**	**124**	**300**	**249**	**204**	**3,231**

5. Cash and Borrowings

Cash reduced to £4.2m at year end, with a number of payments including the PDC dividend payment and loan repayment due in Month 12. There are also significant capital creditors (£3.8m) at year end due to extensive capital purchasing in March. The Trust will keep the cash position under close review moving into 21/22.

6. Capital Expenditure

The capital plan ended slightly below forecast and revised plan, due to the late delivery of a number of items particularly in relation to IM&T. However, this was only a small underspend at £132k above the original plan (before successfully achieving additional allocation and PDC funding of £0.4m) and £258k behind the Month 11 forecast.

7. Balance Sheet

Debtors over 60 days reduced again to £1.1m, of which £0.5m relates to the unpaid balance with One to One Midwives.

Deferred income has reduced as there were no block payments in March as anticipated to reflect the dual payment made in April 20 at the early part of the pandemic.

8. Year End Position

Overall, subject to audit, the Trust has been able to deliver against its agreed plans and support the Cheshire and Merseyside Health and Care Partnership (HCP) in delivery of the system-wide position.

Note that the Trust is reporting a £6.9m reduction in the revaluation reserve following the annual year end valuation of land and buildings.

9. BAF Risk

The financial BAF risks for 21/22 will be fully reviewed once planning for 21/22 is complete and agreed with the HCP. However an interim review will be performed to ensure that the risks in relation to the financial position are well articulated. The Finance, Performance and Business Development Committee approved reducing the score for the in-year financial position (risk 2344) to its target 8 (likelihood of 2, impact of 4) as the Trust has (subject to audit) achieved a favourable position against the agreed plan.

10. Conclusion & Recommendation

The Board is asked to note the Month 12 financial position and agree the reduction of the BAF score in relation to the in-year financial position to its target score of 8 (noting that this will be reviewed and rearticulated for 2021/22).

Appendix 1 – Finance Pack

Finance Pack M12 - Board.xlsx

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

FINANCE REPORT: M12

YEAR ENDING 31 MARCH 2021

Contents

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 1
NHS IMPROVEMENT RATIOS: M12
YEAR ENDING 31 MARCH 2021

USE OF RESOURCES RISK RATING	YEAR TO DATE NHSI Plan	YEAR TO DATE Actual
CAPITAL SERVICING CAPACITY (CSC)		
(a) EBITDA + Interest Receivable	3,076	3,529
(b) PDC + Interest Payable + Loans Repaid	2,969	2,846
CSC Ratio = (a) / (b)	**1.04**	**1.24**
NHSI CSC SCORE	**4**	**4**
Ratio Score 1 = > 2.5 2 = 1.75 - 2.5 3 = 1.25 - 1.75 4 = < 1.25		
LIQUIDITY		
(a) Cash for Liquidity Purposes	(15,391)	(15,329)
(b) Expenditure	118,924	121,749
(c) Daily Expenditure	326	334
Liquidity Ratio = (a) / (c)	**(47.2)**	**(46.0)**
NHSI LIQUIDITY SCORE	**4**	**4**
Ratio Score 1 = > 0 2 = (7) - 0 3 = (14) - (7) 4 = < (14)		
I&E MARGIN		
Deficit (Adjusted for donations and asset disposals)	4,576	4,161
Total Income	(122,000)	(125,278)
I&E Margin	**-3.8%**	**-3.3%**
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)		-3.30%
I&E Margin (Plan)		-3.80%
I&E Variance Margin	**0.00%**	**0.50%**
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	1,788	1,788
YTD Agency Expenditure	664	687
	-63%	**-62%**
NHSI AGENCY SPEND SCORE	**1**	**1**
Ratio Score 1 = < 0% 2 = 0% - 25% 3 = 25% - 50% 4 = > 50%		
Overall Use of Resources Risk Rating	**3**	**3**

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

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 2
INCOME & EXPENDITURE: M12
YEAR ENDING 31 MARCH 2021

INCOME & EXPENDITURE	M12 - NHSI Plan			M12 - Internal Budget			YTD - NHSI Plan			YTD - Internal Budget			YEAR - NHSI Plan			YEAR - Internal Budget		
£'000	NHSI Plan	Actual	Variance	Budget	Actual	Variance	NHSI Plan	Actual	Variance	Budget	Actual	Variance	NHSI Plan	Forecast	Variance	Budget	Forecast	Variance
Income																		
Clinical Income	(9,502)	(12,533)	3,031	(9,379)	(12,533)	3,155	(115,160)	(118,595)	3,435	(112,354)	(118,595)	6,241	(115,160)	(118,595)	3,435	(112,354)	(118,595)	6,241
Non-Clinical Income	(564)	(470)	(94)	(699)	(470)	(229)	(6,840)	(6,684)	(156)	(8,339)	(6,684)	(1,655)	(6,840)	(6,684)	(156)	(8,339)	(6,684)	(1,655)
Total Income	**(10,066)**	**(13,003)**	**2,937**	**(10,078)**	**(13,003)**	**2,925**	**(122,000)**	**(125,278)**	**3,279**	**(120,693)**	**(125,278)**	**4,586**	**(122,000)**	**(125,278)**	**3,279**	**(120,693)**	**(125,278)**	**4,586**
Expenditure																		
Pay Costs	6,258	7,651	(1,393)	5,961	7,651	(1,691)	74,581	75,755	(1,174)	71,670	75,755	(4,085)	74,581	75,755	(1,174)	71,670	75,755	(4,085)
Non-Pay Costs	2,406	4,148	(1,741)	2,137	4,148	(2,010)	28,779	30,484	(1,704)	26,283	30,484	(4,200)	28,779	30,484	(1,704)	26,283	30,484	(4,200)
CNST	1,297	1,244	53	1,297	1,244	53	15,563	15,511	52	15,563	15,511	53	15,563	15,511	52	15,563	15,511	53
Total Expenditure	**9,961**	**13,043**	**(3,082)**	**9,395**	**13,043**	**(3,648)**	**118,924**	**121,749**	**(2,826)**	**113,516**	**121,749**	**(8,233)**	**118,924**	**121,749**	**(2,826)**	**113,516**	**121,749**	**(8,233)**
EBITDA	**(105)**	**40**	**(145)**	**(683)**	**40**	**(723)**	**(3,076)**	**(3,529)**	**453**	**(7,177)**	**(3,529)**	**(3,648)**	**(3,076)**	**(3,529)**	**453**	**(7,177)**	**(3,529)**	**(3,648)**
Technical Items																		
Depreciation	443	451	(8)	465	451	14	5,324	5,327	(3)	5,109	5,327	(217)	5,324	5,327	(3)	5,109	5,327	(217)
Interest Payable	5	3	2	45	3	42	56	49	7	488	49	439	56	49	7	488	49	439
Interest Receivable	0	0	0	(5)	0	(5)	0	0	0	(51)	0	(51)	0	0	0	(51)	0	(51)
PDC Dividend	192	72	120	149	72	77	2,301	2,185	116	1,630	2,185	(555)	2,301	2,185	116	1,630	2,185	(555)
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	**640**	**526**	**114**	**654**	**526**	**128**	**7,667**	**7,521**	**146**	**7,177**	**7,521**	**(344)**	**7,667**	**7,521**	**146**	**7,177**	**7,521**	**(344)**
(Surplus) / Deficit before Adjusting Items	**535**	**566**	**(30)**	**(29)**	**566**	**(595)**	**4,591**	**3,992**	**599**	**0**	**3,992**	**(3,992)**	**4,591**	**3,992**	**599**	**0**	**3,992**	**(3,992)**
Remove Income from donated assets	0	6	(6)	0	6	(6)	0	194	(194)	0	194	(194)	0	194	(194)	0	194	(194)
Add back depreciation on donated assets	(1)	(3)	2	(0)	(3)	2	(15)	(26)	11	(4)	(26)	22	(15)	(26)	11	(4)	(26)	22
(Surplus) / Deficit as per NHSI	**534**	**569**	**(34)**	**(29)**	**569**	**(598)**	**4,576**	**4,161**	**415**	**(4)**	**4,161**	**(4,165)**	**4,576**	**4,160**	**416**	**(4)**	**4,160**	**(4,164)**
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	**534**	**569**	**(34)**	**(29)**	**569**	**(598)**	**4,576**	**4,186**	**390**	**(4)**	**4,200**	**(4,204)**	**4,576**	**4,186**	**390**	**(4)**	**4,200**	**(4,204)**

Note that the values above excluded net neutral adjustments in the accounts to income/expenditure for donated Personal Protective Equipment (£2.3m) and additional employer pension contributions (£2.9m) as advised by the Department of Health and Social Care.

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 3
EXPENDITURE: M12
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	162	165	3,927	3,880	46	3,927	3,880	46
Medical	1,556	2,109	(553)	18,673	19,446	(773)	18,673	19,446	(773)
Nursing & Midwifery	2,633	3,415	(782)	31,695	34,469	(2,774)	31,695	34,469	(2,774)
Healthcare Assistants	424	942	(518)	5,084	5,791	(706)	5,084	5,791	(706)
Other Clinical	376	327	50	3,690	3,202	488	4,517	4,060	457
Admin Support	136	142	(6)	1,637	1,594	43	1,637	1,594	43
Corporate Services	444	505	(61)	5,375	5,827	(452)	5,375	5,827	(452)
Agency & Locum	63	50	14	1,588	1,546	43	761	688	73
Total Pay Costs	**5,961**	**7,651**	**(1,691)**	**71,670**	**75,755**	**(4,085)**	**71,670**	**75,755**	**(4,085)**
Non Pay Costs									
Clinical Suppplies	623	830	(207)	7,502	7,688	(186)	7,502	7,688	(186)
Non-Clinical Supplies	555	2,602	(2,047)	6,665	8,536	(1,871)	6,665	8,536	(1,871)
CNST	1,297	1,244	53	15,563	15,511	53	15,563	15,511	53
Premises & IT Costs	600	562	37	7,202	7,879	(678)	7,202	7,879	(678)
Service Contracts	360	153	206	4,915	6,381	(1,466)	4,915	6,381	(1,466)
Total Non-Pay Costs	**3,434**	**5,392**	**(1,958)**	**41,847**	**45,994**	**(4,148)**	**41,847**	**45,994**	**(4,148)**
Total Expenditure	**9,395**	**13,043**	**(3,648)**	**113,516**	**121,749**	**(8,233)**	**113,516**	**121,749**	**(8,233)**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 4
COVID EXPENDITURE: M12
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	1	(1)	0	38	(38)	0	38	(38)
Medical	0	4	(4)	0	173	(173)	0	173	(173)
Nursing & Midwifery	0	129	(129)	0	1,180	(1,180)	0	1,180	(1,180)
Healthcare Assistants	0	32	(32)	0	322	(322)	0	322	(322)
Other Clinical	0	1	(1)	0	8	(8)	0	8	(8)
Admin Support	0	26	(26)	0	178	(178)	0	178	(178)
Corporate Services	0	0	0	0	0	0	0	0	0
Agency & Locum	0	12	(12)	0	337	(337)	0	337	(337)
Total Pay Costs	**0**	**206**	**(206)**	**0**	**2,235**	**(2,235)**	**0**	**2,235**	**(2,235)**
Non Pay Costs									
Clinical Suppplies	0	4	(4)	0	121	(121)	0	121	(121)
Non-Clinical Supplies	0	(11)	11	0	394	(394)	0	394	(394)
CNST	0	0	0	0	0	0	0	0	(0)
Premises & IT Costs	0	4	(4)	0	476	(476)	0	476	(476)
Service Contracts	0	0	0	0	5	(5)	0	5	(5)
Total Non-Pay Costs	**0**	**(2)**	**2**	**0**	**996**	**(996)**	**0**	**996**	**(996)**
Total Expenditure	**0**	**204**	**(204)**	**0**	**3,231**	**(3,231)**	**0**	**3,231**	**(3,231)**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
BUDGET ANALYSIS: M12 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	(20)	20	0	(65)	65	0	(65)	65
Expenditure	1,889	1,955	(66)	22,671	23,024	(354)	22,671	23,025	(354)
Total Maternity	**1,889**	**1,935**	**(46)**	**22,671**	**22,959**	**(288)**	**22,671**	**22,959**	**(288)**
Neonatal									
Income	0	(100)	100	0	(969)	969	0	(969)	969
Expenditure	1,127	1,214	(87)	13,520	13,962	(442)	13,520	13,962	(442)
Total Neonatal	**1,127**	**1,114**	**13**	**13,520**	**12,993**	**527**	**13,520**	**12,993**	**527**
Division of Family Health - Total	**3,016**	**3,049**	**(33)**	**36,191**	**35,953**	**239**	**36,191**	**35,953**	**239**
Gynaecology									
Income	0	0	0	0	0	0	0	0	0
Expenditure	1,033	1,096	(63)	12,397	12,380	17	12,397	12,380	17
Total Gynaecology	**1,033**	**1,096**	**(63)**	**12,397**	**12,380**	**17**	**12,397**	**12,380**	**17**
Hewitt Centre									
Income	0	0	0	0	(1)	1	0	(1)	1
Expenditure	690	723	(33)	8,296	7,933	363	8,296	7,933	363
Total Hewitt Centre	**690**	**723**	**(33)**	**8,296**	**7,932**	**364**	**8,296**	**7,932**	**364**
Division of Gynaecology - Total	**1,723**	**1,819**	**(96)**	**20,693**	**20,311**	**381**	**20,693**	**20,311**	**381**
Theatres									
Income	0	0	0	0	0	0	0	0	0
Expenditure	712	847	(135)	8,663	8,391	272	8,663	8,391	272
Total Theatres	**712**	**847**	**(135)**	**8,663**	**8,391**	**272**	**8,663**	**8,391**	**272**
Genetics									
Income	0	22	(22)	0	(138)	138	0	(138)	138
Expenditure	151	47	105	1,816	1,626	190	1,816	1,626	190
Total Genetics	**151**	**69**	**82**	**1,816**	**1,488**	**328**	**1,816**	**1,488**	**328**
Other Clinical Support									
Income	0	(2)	2	0	(1)	1	0	(1)	1
Expenditure	602	638	(36)	7,338	7,446	(108)	7,338	7,446	(108)
Total Clinical Support	**602**	**637**	**(34)**	**7,338**	**7,445**	**(107)**	**7,338**	**7,445**	**(107)**
Division of Clinical Support - Total	**1,466**	**1,553**	**(87)**	**17,817**	**17,324**	**493**	**17,817**	**17,324**	**493**
Corporate & Trust Technical Items									
Income	(10,078)	(12,904)	2,826	(120,693)	(124,104)	3,411	(120,693)	(124,104)	3,411
Expenditure	3,844	7,049	(3,205)	45,992	54,508	(8,516)	45,992	54,507	(8,516)
Total Corporate	**(6,234)**	**(5,855)**	**(379)**	**(74,701)**	**(69,596)**	**(5,105)**	**(74,701)**	**(69,596)**	**(5,105)**
(Surplus) / Deficit	**(29)**	**566**	**(595)**	**0**	**3,992**	**(3,992)**	**0**	**3,992**	**(3,992)**
Adjusting Items	(0)	3	(3)	(4)	208	(212)	(4)	208	(212)
(Surplus) / Deficit	**(29)**	**569**	**(598)**	**(4)**	**4,200**	**(4,204)**	**(4)**	**4,200**	**(4,204)**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
BUDGET ANALYSIS: M12 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)	(20)	16	(45)	(65)	21	(49)	(65)	17
Expenditure	1,936	1,955	(19)	21,200	23,024	(1,824)	23,134	23,025	109
Total Maternity	**1,932**	**1,935**	**(3)**	**21,156**	**22,959**	**(1,804)**	**23,085**	**22,959**	**126**
Neonatal									
Income	(66)	(100)	34	(726)	(969)	243	(792)	(969)	177
Expenditure	1,148	1,214	(66)	12,616	13,962	(1,346)	13,764	13,962	(198)
Total Neonatal	**1,082**	**1,114**	**(32)**	**11,890**	**12,993**	**(1,103)**	**12,972**	**12,993**	**(21)**
Division of Family Health - Total	**3,014**	**3,049**	**(35)**	**33,046**	**35,953**	**(2,907)**	**36,058**	**35,953**	**105**
Gynaecology									
Income	0	0	0	0	0	0	0	0	0
Expenditure	1,037	1,096	(59)	11,114	12,380	(1,266)	12,149	12,380	(231)
Total Gynaecology	**1,037**	**1,096**	**(59)**	**11,114**	**12,380**	**(1,266)**	**12,149**	**12,380**	**(231)**
Hewitt Centre									
Income	0	0	0	(1)	(1)	0	(1)	(1)	0
Expenditure	718	723	(5)	7,195	7,933	(738)	7,917	7,933	(16)
Total Hewitt Centre	**718**	**723**	**(5)**	**7,194**	**7,932**	**(738)**	**7,916**	**7,932**	**(16)**
Division of Gynaecology - Total	**1,755**	**1,819**	**(64)**	**18,308**	**20,311**	**(2,004)**	**20,065**	**20,311**	**(246)**
Theatres									
Income	0	0	0	0	0	0	0	0	0
Expenditure	694	847	(153)	7,333	8,391	(1,058)	8,027	8,391	(364)
Total Theatres	**694**	**847**	**(153)**	**7,333**	**8,391**	**(1,058)**	**8,027**	**8,391**	**(364)**
Genetics									
Income	(7)	22	(29)	(248)	(138)	(110)	(254)	(138)	(117)
Expenditure	129	47	82	1,525	1,626	(101)	1,654	1,626	28
Total Genetics	**122**	**69**	**53**	**1,278**	**1,488**	**(211)**	**1,399**	**1,488**	**(89)**
Other Clinical Support									
Income	0	(2)	2	0	(1)	1	(0)	(1)	1
Expenditure	636	638	(3)	6,960	7,446	(486)	7,596	7,446	150
Total Clinical Support	**636**	**637**	**(1)**	**6,960**	**7,445**	**(484)**	**7,596**	**7,445**	**151**
Division of Clinical Support - Total	**1,452**	**1,553**	**(101)**	**15,571**	**17,324**	**(1,753)**	**17,023**	**17,324**	**(301)**
Corporate & Trust Technical Items									
Income	(9,989)	(12,904)	2,915	(120,981)	(124,104)	3,123	(120,904)	(124,104)	3,200
Expenditure	4,325	7,049	(2,724)	58,647	54,508	4,139	52,349	54,507	(2,158)
Total Corporate	**(5,664)**	**(5,855)**	**191**	**(62,334)**	**(69,596)**	**7,262**	**(68,555)**	**(69,596)**	**1,042**
(Surplus) / Deficit	**557**	**566**	**(9)**	**4,591**	**3,992**	**599**	**4,591**	**3,992**	**599**
Adjusting Items	(1)	3	(4)	(15)	194	(209)	(15)	194	(209)
(Surplus) / Deficit	**555**	**569**	**(13)**	**4,576**	**4,186**	**390**	**4,576**	**4,186**	**390**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 6
CIP: M12
YEAR ENDING 31 MARCH 2021

SCHEME NAME	MONTH 12			YTD			Full Year		
	Original Target	Actual	Variance	Original Target	Actual	Variance	Original Target	Revised	Variance
Procurement Savings	83	0	(83)	500	0	(500)	500	0	(500)
Contract Savings	38	38	0	456	456	0	456	456	0
Corporate savings	32	34	2	358	358	0	358	358	0
Maternity Skillmix	21	21	0	250	250	0	250	250	0
Bank Usage	17	17	0	200	200	0	200	200	0
Physiotherapy Productivity	14	0	(14)	169	0	(169)	169	0	(169)
IM&T Enabled Savings	13	0	(13)	150	0	(150)	150	0	(150)
Commissioning Changes	11	11	0	135	135	0	135	135	0
Rental Income	10	10	0	115	115	0	115	115	0
Estate Utilisation	11	0	(11)	100	0	(100)	100	0	(100)
HFC Strategic Review	25	13	(13)	195	80	(115)	195	80	(115)
Theatre Efficiency and Surgical Pathways Project	17	0	(17)	100	0	(100)	100	0	(100)
Full SLA review	11	11	0	100	100	0	100	100	0
TOPS Pathway	11	0	(11)	100	0	(100)	100	0	(100)
Theatre procurement Savings	10	0	(10)	100	70	(30)	100	70	(30)
Maternity Income	0	0	0	0	0	0	0	0	0
Imaging Recharges	6	6	0	70	70	0	70	70	0
Fertility Service Development	0	0	0	0	0	0	0	0	0
Imaging rota review	5	5	0	60	60	0	60	60	0
Pharmacy Ordering	4	4	0	32	32	0	32	32	0
Other Smaller Schemes	59	11	(48)	537	121	(416)	537	121	(416)
	396	**179**	**(217)**	**3,728**	**2,048**	**(1,680)**	**3,728**	**2,048**	**(1,680)**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
BALANCE SHEET: M12
YEAR ENDING 31 MARCH 2021

BALANCE SHEET £'000	YEAR TO DATE Opening	YEAR TO DATE M12 Actual	YEAR TO DATE Movement	YEAR TO DATE NHSI Plan	YEAR TO DATE M12 Actual	YEAR TO DATE Movement	YEAR TO DATE Internal Budget	YEAR TO DATE M12 Actual	YEAR TO DATE Movement
Non Current Assets	**92,282**	**90,086**	(2,196)	**96,355**	**90,086**	(6,269)	**98,816**	**90,086**	(8,730)
Current Assets									
Cash	4,647	4,235	(412)	4,647	4,235	(412)	4,600	4,235	(365)
Debtors	6,329	4,627	(1,702)	3,989	4,627	638	7,042	4,627	(2,415)
Inventories	432	410	(22)	432	410	(22)	452	410	(42)
Total Current Assets	**11,408**	**9,272**	**(2,136)**	**9,068**	**9,272**	**204**	**12,094**	**9,272**	**(2,822)**
Liabilities									
Creditors due < 1 year - Capital Payables	(2,809)	(3,817)	(1,008)	(2,809)	(3,817)	(1,008)	(266)	(3,817)	(3,551)
Creditors due < 1 year - Trade Payables	(15,314)	(13,490)	1,824	(16,557)	(13,490)	3,067	(15,680)	(13,490)	2,190
Creditors due < 1 year - Deferred Income	(2,918)	(3,991)	(1,073)	(2,918)	(3,991)	(1,073)	(3,471)	(3,991)	(520)
Creditors due > 1 year - Deferred Income	(1,623)	(1,592)	31	(1,623)	(1,592)	31	(1,582)	(1,592)	(10)
Loans	(17,359)	(2,136)	15,223	(2,136)	(2,136)	0	(22,994)	(2,136)	20,858
Provisions	(1,698)	(2,753)	(1,055)	(1,698)	(2,753)	(1,055)	(4,870)	(2,753)	2,117
Total Liabilities	**(41,721)**	**(27,779)**	**13,942**	**(27,741)**	**(27,779)**	**(38)**	**(48,863)**	**(27,779)**	**21,084**
TOTAL ASSETS EMPLOYED	**61,969**	**71,579**	**9,610**	**77,682**	**71,579**	**(6,103)**	**62,047**	**71,579**	**9,532**
Taxpayers Equity									
PDC	42,519	62,927	20,408	62,823	62,927	104	42,488	62,927	20,439
Revaluation Reserve	14,329	7,523	(6,806)	14,329	7,523	(6,806)	14,503	7,523	(6,980)
Retained Earnings	5,121	1,129	(3,992)	530	1,129	599	5,056	1,129	(3,927)
TOTAL TAXPAYERS EQUITY	**61,969**	**71,579**	**9,610**	**77,682**	**71,579**	**(6,103)**	**62,047**	**71,579**	**9,532**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 8
CASHFLOW STATEMENT: M12
YEAR ENDING 31 MARCH 2021

CASHFLOW STATEMENT	YEAR TO DATE		
£'000	NHSI Plan	Actual	Variance
Cash flows from operating activities	(2,248)	(1,798)	(450)
Depreciation and amortisation	5,324	5,327	(3)
Impairments and reversals	0	0	0
Income recognised in respect of capital donations (cash and non-cash)	0	(194)	194
Movement in working capital	4,649	1,951	2,698
Net cash generated from / (used in) operations	**7,725**	**5,286**	**2,439**
Interest received	0	0	0
Purchase of property, plant and equipment and intangible assets	(11,617)	(8,584)	(3,033)
Proceeds from sales of property, plant and equipment and intangible assets	14	48	(34)
Net cash generated from/(used in) investing activities	**(11,603)**	**(8,536)**	**(3,067)**
PDC Capital Programme Funding - received	5,701	5,805	(104)
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	(612)	(612)	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	(91)	(91)	0
PDC dividend (paid)/refunded	(1,151)	(2,295)	1,144
Net cash generated from/(used in) financing activities	**3,878**	**2,838**	**1,040**
Increase/(decrease) in cash and cash equivalents	**0**	**(412)**	**412**
Cash and cash equivalents at start of period	4,647	4,647	0
Cash and cash equivalents at end of period	**4,647**	**4,235**	**412**

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	(3,364)	2,136
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**	**(32,548)**	**2,136**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 9
CAPITAL EXPENDITURE: M12
YEAR ENDING 31 MARCH 2021

CAPITAL EXPENDITURE £'000		Full Year Plan	Actual	Variance
Estates	Estates - Business as Usual	300	175	125
	Estates - Critical Infrastructure	364	393	(29)
	Estates Total	**664**	**568**	**96**
Capital Projects	Neonatal Development	759	754	5
	Crown Street Enhancements	3,618	959	2,659
	CT Scanner	0	596	(596)
	Surgical Robot	1,291	1,444	(153)
	Capital Projects Total	**5,668**	**3,753**	**1,915**
IM&T	IM&T - Business as Usual	1,148	1,061	87
	K2 Athena	0	217	(217)
	360 Blood and Milk	286	217	69
	EPR	0	378	(378)
	Homeworking Equipment	0	85	(85)
	Video Consultation	0	8	(8)
	IM&T Total	**1,434**	**1,966**	**(532)**
Medical Equipment	Medical Equipment - Neonates	361	357	4
	Medical Equipment - Maternity	462	723	(261)
	Medical Equipment - HFC	332	652	(320)
	Medical Equipment - Theatres	100	49	51
	Medical Equipment - Imaging	440	781	(341)
	Medical Equipment Total	**1,695**	**2,562**	**(867)**
Other	Genetics Software	0	10	(10)
	Patient Lift System	0	10	(10)
	Fridge Temperature Check	0	36	(36)
	Workforce Development System	0	206	(206)
	Other	0	482	(482)
	Total Other	**0**	**744**	**(744)**
Grand Total		**9,461**	**9,593**	**(132)**

Note that the plan was increased in-year to £9,851k following additional PDC and HCP allocations. Agaisnt this plan the Trust was £258k underspent.

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

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• The NHSI Enforcement Undertaking Review position remained unchanged due to processes within NHSI/E. A request to formally resolve had been re-escalated to NHSI/E. • Performance targets remain a challenge as a direct impact of Covid-19 on performance measures particularly with access targets. • The Committee received an annual estates and facilities compliance report. Due to compliance levels demonstrated within the report the Committee was not assured that the Trust was meeting all statutory and mandatory requirements. The Committee referred an action to the Executive Committee to review the report and monitor compliance. It was noted that the revised Performance Report would include estates performance and risks metrics for the Committee to review on a regular basis.	• A full analytical review based on the unaudited accounts would be presented to the May Committee ahead of full review of the Annual Accounts at the Audit Committee. • Further submissions of activity, finance and workforce plans to the HCP are required. The Committee and Board would be kept updated. • The Local Maternity System (LMS) had requested that maternity providers undertake an internal audit on Continuity of Carer and CNST. Both would be added to the MIAA workplan 2021/22. • The Trust had been asked to develop working models to support the system gynaecology recovery by the Senior Responsible Officer for Cheshire & Merseyside.
Positive Assurances to Provide	**Decisions Made**
• Overall, subject to audit, at year-end the Trust had delivered against its agreed financial plans and supported the Health and Care Partnership (HCP) in delivery of the system-wide position. • Assured that good treasury management processes were in place • Noted the timelines in relation to the national planning process for 2021/22. The Committee noted the challenges to working within a system environment but was encouraged by positive working across the Health and Care Partnership. • The opportunity to bid for additional maternity transformation funding was noted. • Encouraged by key strategic developments including the finalisation of the corporate strategy and development of supporting strategies and plans. • Assured by continued progress of the Crown Street Enhancements Programme, noting delivery group updates related to CT imaging and a 24/7 blood bank. • Assured by progress against three significant digital programmes: the EPR programme (Meditech Expanse), Digital Maternity (K2) and the GDE Programme. The Committee noted the advantageous support provided by the Digital Midwife and the Senior Clinical Information Officer roles. The CIO and Family Health were reviewing resource requirements to ensure required support would be available to fulfil future delivery. • The Committee noted the Operational Plan on a page for 2021/22.	• Reviewed BAF risks. It was agreed to amend the in-year financial delivery risk 2344 to its target of 8 given the out-turn position (subject to audit). The revised BAF was planned for launch in June 2021. During the interim it was agreed that the FPBD BAF risks should be rearticulated for 2021/22 as an interim position noting that a further change would occur in June 2021. This was an approach to be recommended to the other Committees. • Committee approved the Terms of Reference of both the Crown Street Enhancements Programme Board and the Emergency Preparedness, Resilience and Response (EPRR) Committee. • Agreed the 2021/22 Corporate Objectives aligned to the FPBD Committee and recommend Trust Board approval.

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
06.	Board Assurance Framework Review	Information	12.	Review of Strategic Progress	Assurance
07.	Finance Performance Report Month 12 2020/21	Assurance	13.	Crown Street Enhancements Programme Update	Assurance
08.	Treasury Management Quarterly Report, Q4	Assurance	14.	Digital Services Update	Assurance
09.	NHSI Enforcement Undertaking Review	Information	15.	Operational Plan 2021/22	Information
10.	Operational Performance Report Month 12 2020/21	Assurance	16.	Corporate Objectives Setting 2021/22	Review
11.	Annual Estates and Facilities Compliance Report	Assurance	17.	Sub-Committee Chairs Reports / Terms of reference	Assurance Approval

3. 2021 / 22 Attendance Matrix

Core members	Apr	May	Jun	Jul	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Tracy Ellery	✓										
Jo Moore	A										
Ian Knight	✓										
Jenny Hannon	✓										
Kathryn Thomson	✓										
Gary Price	✓										
Marie Forshaw	✓										

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

Liverpool Women's NHS Foundation Trust

Agenda Item	21/22/28

MEETING	**Trust Board**
PAPER/REPORT TITLE:	**Corporate Objectives 2021/22**
DATE OF MEETING:	Thursday, 06 May 2021
ACTION REQUIRED	**Approve**
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 approve the 2021/22 Corporate Objectives***	
PREVIOUSLY CONSIDERED BY:	**Committee name**	Quality Committee, FPBD Committee, PPF Committee
	Date of meeting	April 2021

Executive Summary

Consideration of the Corporate Objectives 2021/22 have been given by each of the Board Committees, and they are now presented to the Board for approval.

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 approve the 2021/22 Corporate Objectives.

Report

Liverpool Women's NHS Foundation Trust

Corporate Objectives

2021 – 2022

Liverpool Women's NHS Foundation Trust

Our Vision

To be the recognised leader in healthcare for women, babies and their families

Our shared vision at Liverpool Women's is simple and has withstood the test of time. It is underpinned by a shared set of values based around the needs of our people. We encourage these behaviours in all our staff, partners and volunteers to make sure our values are delivered in the same way, every day, to every person we care for.

Our Values	Care	Ambition	Respect	Engage	Learn

We have a set of five strategic aims which are central to all of our strategies and plans, and through working with patients, staff, governors and our partners we have developed a series of ambitions to push those aims one step further, helping us create the mind-set we need to achieve our vision and be outstanding in everything we do:

Our Aims	To develop a well led, capable, motivated and entrepreneurial workforce.	To be ambitious and efficient and make best use of available resources.	To deliver safe services.	To participate in high quality research to deliver the most effective outcomes.	To deliver the best possible experience for patients and staff.
Our Ambitions	We will be an outstanding employer.	We will deliver maximum efficiency in our services.	Our services will be the safest in the country.	Outcomes will be best in class.	Every patient will have an outstanding experience.

Our partnerships with other providers and organisations across the city are central to delivering our aims; we know we need to work together to make this happen.

To develop a Well Led, capable, motivated and entrepreneurial Workforce				
Strategic Aim	**Proposed Corporate Objective**	**Executive Lead**	**Relevant Strategy**	**Board Committee**
Be recognised as the most inclusive organisation in the NHS with Zero discrimination for staff and patients (zero complaints from patients, zero investigations)	Treble the number of staff from BAME backgrounds in leadership roles (Band 7 and above) by 2022	CPO	PPF Strategy	PPF
	Working as an active partner with health, education and the Liverpool Race Equality Task Force, increase the overall % of employees from a BAME background, and specifically to increase the % of staff who live in the Riverside Ward by at least 10%	CPO	PPF Strategy	PPF
Recruit and retain key clinical staff	Demonstrate improvement from the 2020 NHS Staff survey in relation to staff engagement measures.	CPO	PPF Strategy	PPF
	Make progress to grow the consultant workforce to achieve 24/7 consultant cover by 2023	CPO	PPF Strategy	PPF
	Train 200 managers in Fair & Just processes	CPO	PPF Strategy	PPF
	Develop and launch a Behavioural Framework	CPO	PPF Strategy	PPF
	Launch LWH Leadership Programme and talent management process	CPO	PPF Strategy	PPF

To deliver Safe services				
Strategic Aim	**Proposed Corporate Objective**	**Executive Lead**	**Relevant Strategy**	**Board Committee**
Progress our plans to build a new hospital co-located with an adult acute site	Complete refresh of business case for a new Liverpool Women's Hospital to reflect evolving models of care and system developments.	DoF	Future Generations Strategy	FPBD
	Contribute to the development and delivery of the Liverpool-wide estates plan during 2021, building on strategic partnerships for optimal outcomes.	DoF	Estates Strategy	FPBD
Develop our model of care to keep pace with developments and respond to a changing environment	Review Future Generations model of care for all services, taking account of all post-COVID learning and changes to care delivery models by 2021	MD	Future Generations Strategy	QC
	Deliver the Quality and Clinical strategy year one objectives	MD	Clinical & Quality Strategy	QC
	Deliver the launch of Trust's EPR programme in line with established timescales (April 2022)	MD	Digital.Generations Strategy	QC
	Provide our hospital with the best digital capabilities and embed a digital first culture through delivering the Digital.Generations strategy through to 2025.	DoF	Digital.Generations Strategy	FPBD
Implement all feasible mitigations to ensure services delivered from the	Deliver the Crown Street enhancement work program (including CT and blood bank services) to time and to budget working with	DoF	Estates Strategy	FPBD

Crown Street site are as safe as possible, developing our facilities for the benefit of our patients as well as those across the system	system partners to ensure optimal patient benefit across the wider Cheshire and Mersey system.			
	Maximise the clinical workforce to deliver timely, safe and effective care to our patients.	MD	Clinical & Quality Strategy	PPF

To deliver the best possible Experience for patients and staff				
Strategic Aim	**Proposed Corporate Objective**	**Executive Lead**	**Relevant Strategy**	**Board Committee**
Deliver an excellent patient and family experience to all our service users	Make progress towards achieving Bliss baby charter accreditation by 2023	DONM	Clinical & Quality Strategy	QC
	Make progress towards achieving the Unicef Baby Friendly Initiative by 2025	DONM	Clinical & Quality Strategy	QC
	Develop and begin to implement the Patient Experience Framework	DONM	Clinical & Quality Strategy	QC
	Pro-actively seek the views of diverse communities to inform the design of our services for the future, ensuring we champion the voices of our future service users	DONM	Clinical & Quality Strategy	QC
	Deliver the Continuity of Care (COC) priorities in 2021/22	DONM	Clinical & Quality Strategy	QC

	Deliver on the Ockenden recommendations	DONM	Clinical & Quality Strategy	QC
	Deliver CNST year 3	DONM	Clinical & Quality Strategy	QC

To be ambitious and Efficient and make best use of available resources				
Strategic Aim	**Proposed Corporate Objective**	**Executive Lead**	**Relevant Strategy**	**Board Committee**
Ensure our services are financially sustainable in the long term	Ensure efficient and effective use of all available resources, meeting agreed financial targets and working across the Cheshire and Mersey system for optimum outcomes for the region.	DoF	Finance & Sustainability 2021-2025	FPBD
	Ensure the Trust has an updated, long term financial plan in place during 2021/22 to reflect recent and proposed regime changes, with clear views and actions in place in relation to long term sustainability.	DoF	Finance & Sustainability 2021-2025	FPBD
	Develop the Trust's commercial strategy during 2021 and pursue appropriate opportunities to maximise Trust income for the benefit of our patients	DoF	Finance & Sustainability 2021-2025	FPBD
	Appraise options for future organisational form (up to and including merger) by 2022	CEO	Future Generations Strategy	FPBD

	Look for opportunities to maximise use of the Crown Street estate for the benefit of our patients and the whole of Liverpool and C&M	COO	Estates Strategy	FPBD
	Ensure post Covid-19 recovery including: • Eliminating 52 week waits • Deliver 100% of 2019/20 activity by November 2021 • Restore all cancer services in Q1 and return to pre pandemic performance levels. • Achieve the 75% faster diagnostic target in Q3	COO	Our Strategy	FPBD

To participate in high quality research in order to deliver the most Effective outcomes				
Strategic Aim	**Proposed Corporate Objective**	**Executive Lead**	**Relevant Strategy**	**Board Committee**
Expand our existing partnerships, building on learning and partnership working throughout the COVID-19 pandemic, playing a key role in establishing any ICP or ICS	Maintain and develop the following key partnerships during 2021, ensuring robust governance structures are in place: • The Cheshire and Mersey LMS • Our Local MVP and other user groups • Liverpool Place and Liverpool Provider Alliance • Liverpool University Hospitals • The Liverpool Neonatal Partnership and the NWNODN • The Cheshire and Mersey Cancer Alliance • The North West Genomics Partnership • Liverpool University and LHP	COO	Our Strategy	FPBD

	Support the developing ICS for C&M and working with the system to improve outcomes for Women's Health including Maternal and Neonatal care.	CEO	Our Strategy	FPBD
Progress our research strategy and foster innovation within the Trust	Make progress to achieve university hospital status by March 2023	MD	Research & Innovation Strategy	QC
	Provide clear evidence of senior nursing & midwifery research leadership, as per the Trust R&D strategy by March 2021	MD	Research & Innovation Strategy	QC
	Demonstrate full recovery of the RD&I activities by July 2021 following the COVID-19 pandemic	MD	Research & Innovation Strategy	QC
	Provide clear evidence of the Trust's R&D response to COVID-19 pertaining to the specific needs of the Liverpool population	MD	Research & Innovation Strategy	QC
	Commence refresh of R&D strategy by engagement with stakeholders	MD	Research & Innovation Strategy	QC
	Ensure active engagement with the 'Starting Well' agenda	MD	Research & Innovation Strategy	QC
Fully implement the CQC well-led framework	Achieve a well-led 'good' rating by 2021	DONM	Clinical & Quality Strategy	QC

throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership	Ensure all wards and key areas have ward accreditation in Q1 and 2	DONM	Clinical & Quality Strategy	QC