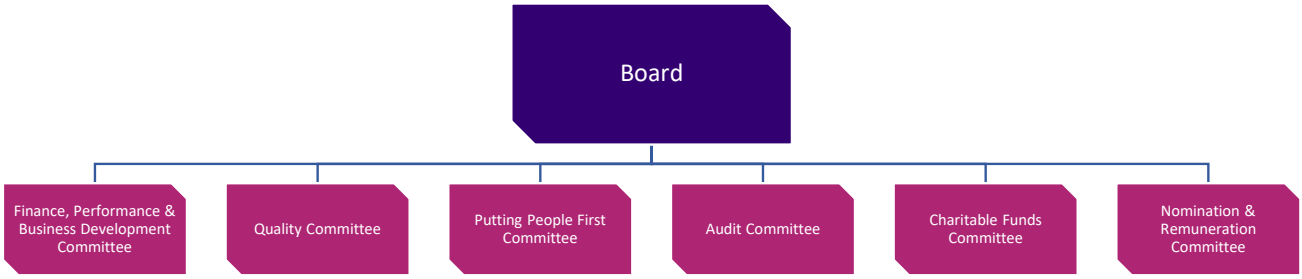
Liverpool Women's
NHS Foundation Trust

Trust Board

4 November 2021, 09.00am
Virtual Meeting



Liverpool Women's NHS Foundation Trust

Trust Board

Location	Virtual Meeting
Date	4 November 2021
Time	9am

AGENDA					
Item no. 21/22/	Title of item	Objectives/desired outcome	Process	Item presenter	Time
PRELIMINARY BUSINESS					
079	Introduction, Apologies & Declaration of Interest	Receive apologies & declarations of interest	Verbal	Chair	09.00 (5 mins)
080	Meeting Guidance Notes	To receive the meeting attendees' guidance notes	Written	Chair	
081	Minutes of the previous meeting held on 2 September 2021	Confirm as an accurate record the minutes of the previous meeting(s)	Written	Chair	
082	Action Log and matters arising	Provide an update in respect of on-going and outstanding items to ensure progress	Written	Chair	
083	Patient Story	To receive a patient story	Verbal	Chief Nurse & Midwife	09.05 (15 mins)
084	Chair's announcements	Announce items of significance not found elsewhere on the agenda	Verbal	Chair	09.20 (10 mins)
085	Chief Executive Report	Report key developments and announce items of significance not found elsewhere on the agenda	Written	Chief Executive	09.30 (10 mins)
QUALITY & OPERATIONAL PERFORMANCE					
086a	Maternity Voices Partnership	For information	Verbal	Chief Nurse & Midwife	09.40 (90 mins)
086b	Quality & Operational Performance Report	For assurance – To note the latest performance measures	Written	Chief Operating Officer	
086c	Cheshire & Merseyside Women's Health & Maternity Services Programme Update	For information	Presentation	Chief Operating Officer	
086d	Maternity Safety Self-Assessment Tool	For assurance	Written	Chief Nurse & Midwife	
086e	Guardian of Safe Working Hours Annual Board Report 2020 - 2021	To note	Written	Medical Director	

086f	Learning from Deaths Quarter 1, 2021/22	For assurance	Written	Medical Director	
086g	Gynaecology Inpatient Survey Results 2020	For information	Written	Chief Nurse & Midwife	
086h	Chair's Reports from the Quality Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	
BREAK – 10 mins					
PEOPLE					
087a	Workforce Performance Report	For assurance – To note the latest performance measures	Written	Chief People Officer	11.20 (20 mins)
087b	Supporting Staff Wellbeing: The North West Pledge	To approve	Written	Chief People Officer	
087c	Chair's Report from the Putting People First Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	
BREAK – 15 mins					
Board Thank You – 5 mins					
FINANCE & FINANCIAL PERFORMANCE					
088a	Finance Performance Review Month 6 2021/22	For assurance - To note the current status of the Trust's financial position	Written	Chief Finance Officer	12.00 (30 mins)
088b	Planning Update, October 2021 to March 2022	To note	Written / Presentation	Chief Finance Officer	
088c	Chair's Report from the Finance, Performance and Business Development Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	
088d	Chair's Report from the Audit Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	
088e	Chair's Report from the Charitable Funds Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	
BOARD GOVERNANCE					
089	Board Assurance Framework	For assurance	Written	Trust Secretary	12.30 (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.*					
090	Medical Revalidation Annual Report	For assurance	Written	Medical Director	Consent

091	Board Assurance - post-mortem facilities	For assurance	Written	Chief Nurse and Midwife	
CONCLUDING BUSINESS					
092	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair	12.40 (5 mins)
093	Chair's Log	Identify any Chair's Logs	Verbal	Chair	
094	Any other business & Review of meeting	Consider any urgent items of other business	Verbal	Chair	
Finish Time: 12.45					

Date of Next Meeting: 2 December 2021

12.45 – 12.55	*Questions raised by members of the public*	To respond to members of the public on matters of clarification and understanding.	Verbal	Chair

The Board of Directors is invited to adopt the following resolution:

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

Liverpool Women's NHS Foundation Trust

Meeting attendees' guidance

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

Before the meeting

- Consider the most appropriate format for your meeting i.e. physical, virtual or hybrid. There are advantages and disadvantages to each format, and some lend themselves to particular meetings better than others. Please seek guidance from the Corporate Governance Team if you are unsure.

General considerations:

- Submit any reports scheduled for consideration at least 8 days before the meeting to the meeting administrator. Remember to try and answer the 'so what' question and avoid unnecessary description. It is also important to ensure that items/papers being taken to the meeting are clear and provide a proposal/recommendation to reduce unnecessary discussion time at the meeting.
- Ensure your apologies are sent if you are unable to attend and *arrange for a suitable deputy to attend in your absence
- Prepare for the meeting in good time by reviewing all reports
- Notify the Chair in advance of the meeting if you wish to raise a matter of any other business

*some members may send a nominated representative who is sufficiently senior and has the authority to make decisions. Refer to the terms of reference for the committee/subcommittee to check whether this is permitted.

Virtual / Hybrid Meetings via Microsoft Teams and other digital platforms

- For the Chair / Administrators:
  - Ensure that there is a clear agenda with breaks scheduled if necessary
  - Make sure you have a list of all those due to attend the meeting and when they will arrive and leave.
  - Have a paper copy of the agenda to hand, particularly if you are having to host/control the call and refer to the rest of the meeting pack online.
  - If you are the host or leader for the call, open the call 10-15 minutes before the start time to allow everyone to join in an orderly way, in case there are any issues.
  - At the start of the call, welcome everyone and run a roll call/introduction - or ask the meeting administrator to do this. This allows everyone to be aware of who is present.
  - Be clear at the beginning about how long you expect the meeting to last and how you would like participants to communicate with you if they need to leave the meeting at any point before the end.

- General Participants
  - Arrive in good time to set up your laptop/tablet for the virtual meeting
  - Switch mobile phone to silent
  - Mute your screen unless you need to speak to prevent background noise
  - Only the Chair and the person(s) presenting the paper should be unmuted
  - Remember to unmute when you wish to speak

- Use headphones if preferred
- Use multi electronic devices to support teams.
- You might find using both mobile and laptops is useful. One for Microsoft teams and one for viewing papers

At the meeting

General Considerations:

- For the Chair:
  - The chair will assume that all members come prepared to discuss agenda items having read through supporting papers, this obviates the need for leads to take up valuable time presenting their papers.
  - The chair will allow a free ranging debate and steer discussions to keep members on track whilst at the same time not being seen to overly influence the outcome of the debate.
  - The chair will provide a brief summary following presentation and discussion of the paper, confirming any key risks and / or assurances identified and whether there are any matters for the Chair's log.
  - The chair will question leads when reports have not been submitted within the Trust's standard template or within the required timeframe.
  - Ensure that correct people are in the room to 'form the meeting' with other attendees invited to attend only when presenting their item.

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

Virtual / Hybrid Meetings via Microsoft Teams and other digital platforms

- For the Chair:
  - Make sure everyone has had a chance to speak, by checking at the end of each item if anyone has any final points. If someone has not said anything you might ask them by name, to ensure they have not dropped off the call or assist them if they have not had a chance to speak. In hybrid meetings, it can be useful to ask the 'virtual' participants to speak first.

    - Remember to thank anyone who has presented to the meeting and indicate that they can leave the meeting. It can be easy to forget this if you can't see them.

- General Participants:
    - Show conversation: open this at start of the meeting.
        - This function should be used to communicate with the Chair and flag if you wish to make comment
    - Screen sharing
        - If you wish to share a live document from your desktop click on share and identify which open document you would like others to view

Attendance

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

After the meeting

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

Standards & Obligations

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

13. Towards the end of the meeting, agendas should carry a standing item that requires members to collectively identify new risks to the organisation – it is the responsibility of the chair of the committee to ensure, follow agreement from the committee members, these risks are documented on the relevant risk register and scored appropriately

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

Page 129 Handbook to the NHS Constitution 26th March 2013

Liverpool Women's NHS Foundation Trust

Board of Directors

Minutes of the meeting of the Board of Directors held virtually at 09.00am on 2 September 2021

PRESENT

Robert Clarke	Chair
Kathryn Thomson	Chief Executive
Jenny Hannon	Chief Finance Officer
Gary Price	Chief Operating Officer
Louise Martin	Non-Executive Director
Lynn Greenhalgh	Medical Director
Dr Susan Milner	Non-Executive Director / SID
Ian Knight	Non-Executive Director
Tracy Ellery	Non-Executive Director
Tony Okotie	Non-Executive Director
Marie Forshaw	Chief Nurse & Midwife
Michelle Turner	Chief People Officer / Deputy Chief Executive

IN ATTENDANCE

Kim Clarke	Genetic Counsellor, Hewitt Centre (item 068 only)
Matthew O'Neill	Safeguarding Service Manager (item 071b only)
Kevin Robinson	Deputy Head of Patient Experience / Freedom to Speak Up Guardian (item 071c only)
Lesley Mahmood	Member of the public
Felicity Dowling	Member of the public
Kiran Jilani	Staff Governor
Mark Grimshaw	Trust Secretary (minutes)

APOLOGIES:

Prof Louise Kenny	Non-Executive Director
Jo Moore	Non-Executive Director / Vice Chair

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	✓	✓	✓	✓		A						
Tracy Ellery - Non-Executive Director	✓	✓	✓	A		✓						
Louise Martin - Non-Executive Director	✓	✓	✓	✓		✓						
Ian Knight - Non-Executive Director	✓	✓	✓	✓		✓						
Tony Okotie - Non-Executive Director	A	✓	✓	✓		✓						
Prof Louise Kenny - Non-Executive Director	✓		✓	✓		A						
Jenny Hannon – Chief Finance Officer	✓	✓	✓	✓		✓						
Marie Forshaw – Chief Nurse & Midwife	✓	A	✓	✓		✓						

Gary Price - Chief Operating Officer	✓	✓	✓	✓		✓						
Michelle Turner - Chief People Officer	✓	A	✓	✓		✓						
Dr Lynn Greenhalgh - Medical Director	✓	✓	✓	✓		✓						
Present (✓) Apologies (A) Representative (R) Non attendance (NA)												

21/22/	
064	**Introduction, Apologies & Declaration of Interest** The Chair welcomed everyone to the meeting. The Chair noted that item 075c related to a proposed amendment to the Constitution which would impact on the parameters for extension to the terms of office for Non-Executive Directors beyond a second three-year term. As the term of office of the Chair had recently been agreed to be extended beyond a second three-year term, the Chair noted a declaration of interest in this item. No action would be required as the item would be progressed through the consent agenda. The Chief Executive noted an interest in item 075f as she was a Director for Liverpool Health Partners. No action would be required as the item would be progressed through the consent agenda. Apologies were noted as above.
065	**Meeting guidance notes** The Board received the meeting attendees' guidance notes.
066	**Minutes of the previous meetings held on 1 July 2021** Subject to the following amendment, the minutes of the Board of Directors meetings held on 1 July 2021 were agreed as a true and accurate record: • Sentence "Non-Executive Director, Louise Kenny thanked Dr Timothy Neal for proactively engaging with water safety issues", amended to "Non-Executive Director, Louise Martin thanked Dr Timothy Neal for proactively engaging with water safety issues"
067	**Action Log and matters arising** Non-Executive Director, Tony Okotie, referenced action 21/22/50a, relating to the Trust's complaints target, and noted that measuring the number of complaints was a limited way of informing the Board of the feedback being received by patients / public. It was agreed that further thought was required in terms of the most appropriate metric / mechanism of reporting complaints performance and feedback to the Board and its Committees.
068	**Patient Story** Kim Clarke, Genetic Counsellor, attended to introduce a video recorded from a patient who described their experience of being supported by the Trust through testing for a potential Huntington's Disease diagnosis. It was noted that this had been a challenging time for the patient, their family and a parent who would have been impacted by any potential diagnosis. It was highlighted how the genetic counsellors had provided support throughout the whole process and the success of this had also encouraged the patient's parent to engage in the service in a similar way. Dr Lynn Greenhalgh, Medical Director, remarked that the importance of good communication was clear from the story, noting that poor communication was an issue raised in many of the complaints received by the Trust. It was stated that there was often the need to deliver bad news and how this was communicated could often make a significant difference to the patient's experience.

	The Chair queried whether the genetic counsellor team shared their learning with other parts of the organisation. It was noted that whilst there was a not a formal mechanism for this, opportunities would be explored. The Chair thanked the patient for sharing their story and the Genetic Counsellor team for their excellent work in supporting patients and their families through often difficult times in their lives. *Kim Clarke left the meeting*

069	**Chair's announcements**
	The Chair noted the following issues:
	• The Annual Member's Meeting was scheduled for 30 September 2021. This would be held virtually.
	• A Nomination & Remuneration Committee had been held on 1 July 2021. Issues considered included:
	  ○ The performance review of Executive Directors
	  ○ A review of the terms and conditions for Executive Directors
	  ○ Agreement for the Chief Information Officer to join the Executive Team and to be a non-voting member of the Board
	  ○ Agreement to allocate the Deputy Chief Executive role to Michelle Turner, Chief People Officer
	• The Council of Governors had met on 22 July 2021. Items considered included:
	  ○ Receiving the Annual Report and Accounts
	  ○ Receiving an update on Maternity Services
	  ○ Reviewing the Membership Strategy
	  ○ Receiving feedback on the performance of the Chair and Non-Executive Directors.
	  ▪ Non-Executive Director and Senior Independent Director, Susan Milner, noted that the Council of Governors had agreed to extend the Chair's term of office for an additional year (from February 2022 to February 2023).
	• There continued to be progress made in relation to the development of an Integrated Care System in Cheshire and Merseyside (C&M ICS). A recruitment process for a C&M ICS Chair and Chief Executive was currently underway.
	• There had been strong candidates interviewed in recent Consultant recruitment sessions which was encouraging for the Trust.
	• A process for Non-Executive Director recruitment was in progress with an outcome expected to the reported to the Council of Governors in November 2021.
	
	The Board noted the Chair's update.

070	**Chief Executive's report** The Chief Executive presented the report which detailed local, regional and national developments. The Chief Operating Officer reported that the Covid-19 pandemic continued to present significant operational challenges. The Trust remained subject to command-and-control structures and an updated Oversight Framework had been published by NHS Improvement / England (NHSI/E). This framework established expectations for performance in terms of post Covid-19 recovery. There had been capacity challenges in the Trust's maternity services and these had been replicated throughout the Cheshire & Merseyside system. In response, a Cheshire & Merseyside maternity cell had been established to provide clear escalation pathways to support patient safety. The Trust's ability to clear a backlog of benign gynaecology procedures had been impacted due to capacity issues, mainly driven by staff absence. There had been an increase in oncology referrals and whilst the Trust's two-week performance had been maintained, improvements were required in other areas.

	The Chair queried if there were any concerns about achieving the established recovery trajectories. The Chief Operating Officer noted that staff absence was the main concern as this had a direct impact on capacity. The Medical Director noted an increased need to work with partners to support the backlog challenges. The region had acute challenges with Gynaecology, and it would be important for the Trust to consider what support it could offer. **Chair's Log: For the Executive Team to consider and develop the Trust's 'system offer' in the context of recovery from the Covid-19 pandemic.** Non-Executive Director, Ian Knight, asked what could be done to support staff as there were significant demands in place as part of the recovery effort. The Chief Operating officer stated that this would be the most important aspect to achieving the recovery trajectories and that there needed to be different solutions for different groups. The Chief People Officer introduced the concept of 'personalised employment' and noted that leaders were being encouraged to have discussions with individuals about their needs. The Trust was exploring how best to embed psychological support in teams, and it was acknowledged that this would not be a 'quick fix'. The Chief Operating Officer continued to outline the work being undertaken with the Family Health Division as they were in a period of enhanced oversight by the Executive Team in line with the Performance Management Framework. The Board of Directors: • noted the Chief Executive update.
071a	**Quality & Operational Performance Report** The Board considered the Quality and Operational Performance Report. The Chief Operating Officer noted that it was encouraging that infection, prevention, and control performance remained strong. The performance report continued to develop to provide increased visibility of estates performance and work was also being undertaken to ensure that the metrics within the report aligned with the updated NHSI/E Oversight Framework. This would include reframing several metrics, including those related to Continuity of Carer. The Chief Executive highlighted that the 52 week wait position had the potential to deteriorate quickly and requested that this be reviewed in further detail at the Finance, Performance & Business Development Committee. **Chair's Log: For the Finance, Performance & Business Development Committee to review the Trust's 52 week wait performance in further detail.** Non-Executive Director, Louise Martin, drew attention to the Hard Facilities Management performance and remarked that the Trust's Planned Preventative Maintenance (PPM) programme was limited in that it could only consider known assets. It was suggested that the Trust explore commissioning an outside body to undertake a detailed asset survey. **Chair's Log: For the Finance, Performance & Business Development Committee to explore the commissioning of an outside body to undertake a detailed asset survey.** The Board of Directors: • Received and noted the Quality & Operational Performance Report. *Matthew O'Neill joined the meeting*
071b	**Safeguarding Annual Report 2020/21**

	The Safeguarding Service Manager attended to present the Safeguarding Annual Report 2020/21. It was noted that performance had been positive for the Trust and that the service had responded flexibly to the pandemic, changing practice when necessary to maintain safety. Some of these practices would be retained beyond the pandemic. It was noted however, that the impact of Covid-19 had created uncertainty with statutory partners and consequently, 'normal' service had been challenged. The number of referrals had also reduced in comparison to previous years, and this was attributable to the pandemic. A key focus for 2021/22 would be on domestic abuse with the service doing more work at the point of admission to counterbalance the reduction in other sources of intelligence. A safeguarding dashboard had also been developed which would report through the Trust's governance structure on a quarterly basis. Non-Executive Director, Louise Martin, noted that there had been challenges with training compliance and asked if there was an update on the recovery programme. The Safeguarding Service Manager acknowledged that the pandemic had impacted training compliance and alternative delivery methods had been required as well as additional sessions. The trajectory was predicting that the Trust would return to a 'green' level of compliance by the end of 2021. Whilst there had been a focus on increasing compliance, it was noted that this was not to the detriment to the quality of the training. The Chief Executive noted that despite a reduction in referrals during 2020/21, there was a longer-term trajectory of increased activity. It was asked whether the Trust was engaging in preventative work. The Safeguarding Service Manager noted that the opportunities for more preventative work had been diminished due to reduced / restricted capacity in the third sector, but opportunities were being sought as to how best to mainstream safeguarding activity in the Trust's operations. Attention was drawn to Appendix A which provided a reminder of the Board responsibilities for safeguarding arrangements. The Chief Nurse & Midwife noted her acknowledgement for the work carried out by the team, often in challenging circumstances. The Board of Directors: • Receive and approved the Annual Safeguarding Report 2020/21 *Matthew O'Neill left the meeting* *Kevin Robinson joined the meeting*
071c	Freedom to Speak Up *Whistleblowing / Freedom to Speak up Annual Report 2020/21* The Deputy Head of Patient Experience / Freedom to Speak Up Guardian presented the Whistleblowing / Freedom to Speak up Annual Report 2020/21 highlighting the following key issues: • There had been seven formal concerns raised with the Trust during the year • There had been a total of 72 contacts made to the Freedom to Speak up Guardian. This was an increase of 112 % (38) contacts compared to the previous year. It was asserted that the trend data indicated that staff continued to feel confident to raise concerns in their own name. • The main themes from issues raised related to change management (and how change was communicated) and HR processes and procedures. The Chief People Officer noted that a key positive related to the fact that the number of requests for issues to remain anonymous had reduced which was indicative of increased trust in the process. The

	significant increase of issues raised in 2020/21 could be attributed to the roll out of the Continuity of Carer model for midwifery. The Chief Operating Officer noted that the recent 'pause and reflect' phase for the roll out of the Continuity of Carer model had afforded the opportunity to improve planning and consultation ahead of moving forward with the next phase. The challenge continued to be in balancing effective change management processes with the pace that was required under command-and-control arrangements. The Chief Information Officer highlighted how feedback from the Freedom to Speak Up process had been important to learn lessons from the recent K2 Athena implementation and had led to the creation of 'digital midwife' roles. The following key actions for 2021/22 were outlined: • Launch the Freedom to Speak up Strategy • Conduct a refreshed Freedom to Speak Up review tool review for 2021 with the Board and work on any associated actions that result from this. The Chair queried whether the Freedom to Speak Up process was sufficiently resourced and that the current Champion vacancy would be recruited to. It was confirmed that the vacancy would be filled shortly and that the balance of work (front-facing and administrative) would be reviewed once the individual started in the role. The Chief People Officer noted that there had been a recommendation from the External Well-Le Review to develop a network of Freedom to Speak Up Champions. It was explained that the Trust would be utilising the existing 'staff supporter' network for this purpose. A model that provided dedicated time for the Freedom to Speak Up Guardians had also been considered but after consultation, it had been agreed to continue with flexible working. *Freedom to Speak Up Vision and Strategy 2021-24* The Chief People Officer introduced the strategy noting that it had been reviewed against national strategies and guidance to ensure alignment. The Board of Directors: • Accepted the assurance provided by the report and; • Approved the Freedom to Speak Up Vision and Strategy 2021-24 *Kevin Robinson left the meeting*
071d	Integrated Governance Report The Board received the Integrated Governance Assurance report which covered Quarter 1 of 2021/22. The report formed part of the regular reporting schedule of the Trust to ensure that there was oversight and assurance monitoring of Integrated Governance across the Trust. The Chair asked if blood sampling errors remained a concern for the Trust. The Chief Nurse & Midwife reported that quality improvement work on this issue had started and improvements would be closely monitored. If improvements were not forthcoming, more systemic issues e.g. no on-site laboratory, would need to be reviewed. The Board of Directors: • Accepted the assurance provided by the report.
071e	Bi-Annual Safer Staffing Paper; Nursing and Midwifery The Board received the Bi-Annual Safer Staffing Paper; Nursing and Midwifery which covered the period from January 2021 to June 2021. It was noted that the report had been reviewed in detail by the Putting People First Committee in July 2021. It was noted that the format of the report was being developed and would be improved for the next iteration. The Chief Executive stated the importance of referencing national guidance in the report.

	The Board of Directors: • Accepted the assurance of the current nurse/ midwife staffing levels • Noted the content of the report and the assurances, provided that nurse/midwife staffing levels agreed were safe and appropriate at present. • Noted the risk to the organisation of the number of nursing and midwifery staff > 50 years of age. • Noted the national shortage of nurses and midwives, current vacancies in Maternity and Theatres and actions being taken in the divisions
071f	**Chair's Reports from the Quality Committee** The Board considered the Chair's Reports from the Quality Committee meetings held on 26 July 2021 and the 23 August 2021. Non-Executive Director, Susan Milner chaired the August 2021 meeting and highlighted that an issue regarding HSIB investigations had been raised at the meeting. It was explained that the Trust undertook its own investigations in parallel to those carried out by the HSIB as these could often be completed with a quicker turnaround. There was the possibility that the Trust would be instructed not to duplicate HSIB investigations which could result in the pace of learning being slower. This issue would be monitored by the Committee. The Board of Directors: • Received and noted the Chair's Reports from the Quality Committee meetings held on 26 July 2021 and the 23 August 2021. In summarising the 'Quality and Operational Performance' section of the meeting, the Chair highlighted the following key issues: • There were opportunities for the Trust to offer system support in the post-pandemic recovery • A 'personalised approach' to staff wellbeing would be key to achieving recovery trajectories • A concern regarding maternity staffing levels remained • There was a potential need to enhance processes around the Trust's Planned Preventive Maintenance (PPM) programme • Whilst the Trust retained a quality Safeguarding service there were several external challenges impacting on delivery • The Freedom to Speak Up process was robust but remained in development.
072a	**Workforce Performance Report** The Board received the Workforce Performance Report. The Chief People Officer reported that work continued to improve mandatory training compliance with alternative delivery vehicles being utilised. Confidence was low that the 95% target would be met in the near future, but assurance was provided that risk stratification was in place to ensure that training efforts were targeted effectively to maintain patient safety. The Trust's sickness rate also remained a challenge with particularly high rates seen in the maternity service. Attempts were being made to build in opportunities for staff to access wellbeing offers during their working day. The Chair asked when it was likely for the Trust to see improvements. The Chief People Officer asserted that the current method of managing short term sickness was not resulting in improvements. A more personalised approach to managing sickness was being pursued but this would take time to produce results. The Chief Executive noted the importance of ensuring that the Trust was providing flexible working arrangements for its staff and suggested that senior leaders consider how best to account for the delivery of this to the Board. **Action: For consideration to be given to how senior leaders provide accountability to the Board regarding flexible working arrangements for staff.**

	Non-Executive Director, Louise Martin, asked how the first leadership forum had been received. It was noted that there had been 30 senior leaders in attendance from a mix of clinical and non-clinical areas. The focus of the sessions had been on the Trust strategy and how best to translate and embed it throughout the organisation. The Board of Directors: • Noted the Workforce Report.
072b	**Equality Diversity and Inclusion Update, including WRES and WDES 2021 Data** The Chief People Officer introduced the report which fulfilled the mandatory requirement for the Board to review the annual data relating to the Workforce Race Equality Standard (WRES) and the Workforce Disability Standard (WDES) (for the year ending 31st March 2021). It was noted that whilst the Trust benchmarked positively in these areas there was still significant scope for improvement. For instance, whilst progress had been made, the Trust's senior leadership cohort was not yet close to being representative of the communities served by the organisation. The experience from the Covid-19 pandemic had also identified inequalities for both patients and staff. The pandemic had, however, re-energised the diversity and inclusion agenda and it would now be important to maximise the opportunities this presented. The pandemic had also accelerated the use of digital technology which had widened participation in several ways. The Trust was also cognisant of digital inequalities and was exploring how best to mitigate this. Non-Executive Director, Louise Martin, sought clarification on a point in the report that suggested medical staff would be excluded from a commitment to treble the number of staff from ethnic minority backgrounds in leadership roles (Band 7 and above) by 2022. The Chief People Officer explained that there was already strong representation in medical leadership roles from clinicians with ethnic minority backgrounds. The Board of Directors: • Noted the report and the progress made in the last 12 months, and; • Noted that there was a sustained focus in place to meet the ED&I ambitions set out in the Trust Strategy
072c	**Chair's Report from the Putting People First Committee** The Board considered the Chair's Report from the Putting People First Committee meeting held on 19 July 2021. Non-Executive Director, Susan Milner chaired the meeting and highlighted the following issues: • The Committee had received a detailed assurance paper in relation to the clinical workforce in maternity. Immediate and short-term actions in place to improve the position and weekly executive oversight meetings to oversee progression against the actions were noted. The Committee had been moderately assured due to the residual risk. • The Committee was moderately assured by the Medical Workforce Assurance Report and agreed that an action plan should be developed to take forward actions to address the risks identified. • The Committee received limited assurance from the Corporate Services Workforce Assurance Report due to an inconsistent narrative via multiple authors. It was agreed that the narrative would be improved to ensure a consistent and unified report within the next iteration. The Board of Directors: • Received and noted the Chair's Report from the Putting People First Committee meeting held on 19 July 2021.
	Board Thank you

	Anne Bridson (Learning & Development Facilitator), Louise Smith (Administrative Supervisor), Rochelle Collins (Medical Workforce Manager), Jacob Clement-Jones (HR Assistant) and Claire Potter (Medical Rota Co-ordinator) joined the meeting. The Chief People Officer presented a 'thank you' to Louise Smith who had started her level 4 apprenticeship in Business and Professional Admin in June 2020. In April 2021, Anne Bridson had been sent an email about Louise by her college tutor, that said that she was one of the most outstanding apprentices they had worked with. The Medical Director presented a 'thank you' to the team involved with the electronic solution for medical rostering. This had been an example of effective team working that had made a significant difference to the Trust. *Anne Bridson (Learning & Development Facilitator), Louise Smith (Administrative Supervisor), Rochelle Collins (Medical Workforce Manager), Jacob Clement-Jones (HR Assistant) and Claire Potter (Medical Rota Co-ordinator) left the meeting.*
073a	Finance Performance Review Month 4 2021/22 The Chief Finance Officer presented the Month 4 position noting that to date the Trust was reporting a surplus of just under £0.3m, slightly behind the surplus plan. There was a small deficit target in month due to the phasing of Elective Recovery Fund. The Cost Improvement Programme (CIP) remained behind plan and this was being managed with divisions individually and via the Senior Management Team meeting, which was being refocussed to give greater time to CIP and Transformation. The Chair highlighted the CIP delivery gap and remarked that there was a steep increase in trajectory for delivery in the latter part of the year. The Chief Finance Officer noted that there was risk to delivery of the CIP programme, but it had been originally profiled with increased amounts being delivered towards the end of the year. Non-Executive Director, Tracy Ellery, asserted that it would be important to demonstrate grip on the CIP programme in order to maintain credibility in discussions for Half 2 2021/22 funding. The Chief Finance Officer acknowledged the importance of ensuring recurrent savings were delivered. Cash had reduced in Month 4 to £3.2m. Now that further system monies and a breakeven plan had been agreed, cash was less of a risk for Half 1 2021/22. Close monitoring of the cash position had been in place for some time and would continue; this included reviewing each payment run and detailed daily cashflow forecasts. In terms of Half 2 2021/22, trusts were expected to submit plans by 11 November 2021. This timetable would present some risk as the Trust would operationally already be into second half of the year. Non-Executive Director, Louise Martin noted the £2.2m variance on the capital expenditure programme and stated that this was significant at this point in the financial year. It was queried whether the plan required review and amendment. The Chief Finance Officer reported that it was expected that spend would be caught up on the most significant elements by year-end. However, some of the smaller value items were being reviewed and reprofiled if necessary. It was stated that the detail on the capital expenditure programme would be provided through the Finance, Performance & Business Development Committee. The Board of Directors: • Noted and received the Month 4 2021/22 Finance Performance Review
073b	Future Generations Programme: Expression of Interest to Build a New Liverpool Women's Hospital

	The Chief Finance Officer explained that in July 2021, the government announced a plan to build eight new hospitals in England, inviting expressions of interest from trusts who met specific criteria. It was reported that the Trust intended to submit an expression of interest to build a new Liverpool Women's Hospital, co-located with an adult acute site, in order to address the longstanding clinical safety and sustainability issues related to its current isolated location. If successful, the proposal would deliver a broad range of local and system-wide benefits. Non-Executive Director, Louise Martin, noted the importance of ensuring that the Trust's expression of interest submission was strong on of all the criteria established on the submission template. This included ensuring that the sustainability credentials of the proposal were robust. Non-Executive Director, Ian Knight, queried whether the Trust was able to detail future proposals for the Crown Street site in the submission. The Chief Finance Officer confirmed that reference to the Trust's on-going work to develop the Crown Street site (e.g. CT Scanner, Community Diagnostic Hub etc.) would be included to help to demonstrate the opportunities to re-purpose the facility. The Chair stated that it would be important to illustrate how a re-purposed site could be utilised to benefit the community and preventative health agenda, providing a genuine asset to the system and local population. It was noted that the deadline for submission was 9 September 2021. The Trust's template was being finalised and would be shared with the Board for final comment ahead of submission by the Chief Executive. **Action: To share the draft expression of interest template with the Board for final comment ahead of submission on 9 September 2021.** The Chair noted that this was the first stage in the process, and should the Trust be successful in progressing to the next stage, work would be undertaken to engage with the public and stakeholders. The Board of Directors: • approved the submission of an expression of interest to build one of eight new hospitals in England.
073c	**Chair's Report from Finance, Performance and Business Development Committee** The Board considered the Chair's Report from the Finance, Performance & Business Development Committee meetings held on 26 July 2021. Committee member and Non-Executive Director, Tracy Ellery highlighted that the Committee would be closely monitoring the risks relating to Half 2 2021/22 planning. The Committee continued to receive good assurances regarding treasury management. The Board of Directors: • Received and noted the Chair's Report from the FPBD Committee meeting held on 26 July 2021.
073d	**Chair's Report from the Audit Committee** The Board considered the Chair's Report from the Charitable Funds Committee meeting held on 22 July 2021. Non-Executive Director and Committee Chair, Tracy Ellery reported that the Divisional Presentation for Family Health had been deferred to the next meeting in October 2021 due to on-going pressures in the Division. It was stated that there remained a need for the Board to receive assurance on the how the challenges in the Division were being managed. The Committee had also been informed from the MIAA audit of the Trust's CQC action plan that 11 out of the 34 actions were only partially complete. An action was remitted to the Quality Committee to receive assurance regarding the close out of the 11 'partially complete' CQC actions and on the initial process for signing off completed actions. Attention was drawn to a Bribery Act 2010 & Trust Anti-Bribery Strategy briefing from the Trust's Anti-Fraud Specialist (included as an appendix to the Chair's Report) which provided a reminder to the Board on the Trust's anti-bribery arrangements.

	The Board of Directors: • Received and noted the Chair's Report from the Audit Committee meeting held on 22 July 2021. • Noted the Bribery Act 2010 & Trust Anti-Bribery Strategy briefing
074a	**Well-Led Governance Review – Action Plan** The Chair noted that the fieldwork for the external Well-Led review undertaken by Grant Thornton was completed in April 2021 and a final report had been shared with the Trust. The recommendations from the external review had been compiled into an action plan and combined with outstanding actions from the Trust's internal assessment. Grant Thornton had also undertaken a site visit to several clinical areas during April 2021 and several recommendations also flowed out of this process. These had also been captured into the overall action plan. Since presenting the combined action plan to the Board in July 2021, Executive leads have worked to close out the recommendations, liaising with Non-Executive leads where appropriate, either through Committee meetings, separate meetings or via email. Positive progress has been made against the identified actions with the majority either noted as being 'blue' (complete with evidence) or 'green' (evidence available that a plan for completion in line with the deadline is in place). Two main issues remained outstanding, and these cut across several of the 'amber' or 'red' areas: 1) There was a requirement to ensure that there is consistent practice at Divisional governance meetings so that risks were regularly checked, lessons learned, and feedback was effectively cascaded. The efficacy of Divisional governance arrangements had also been highlighted in recent Board Committee meetings where there had been discussions regarding the strength of challenge and the impact on the strength of assurances provided. Nevertheless, there was clear evidence that progress is being made Trust-wide in the practice of learning lessons – a key theme identified in the internal and external reviews. 2) Whilst progress had been made to improve the Trust's Quality Improvement process, there remained room for further development. In response to this, the Trust had engaged MIAA to provide additional support. It was noted that the sign off process of outstanding actions would continue between Executive and Non-Executive Leads by the end of calendar year. The Board of Directors: • Received the well-led action plan
074b	**Board Assurance Framework** The Board received the Board Assurance Framework (BAF). The Trust Secretary noted that since the report was last circulated and discussed at the Board, no new risks or strategic threats had been added to the BAF. There were however plans to discuss in further detail 1) the risk of the Trust running multiple clinical systems and 2) whether cyber security should be recognised on the BAF rather than the Corporate Risk Register. The outcome of these discussions would be reported to the respective Committees and through to the Board. The Board of Directors: • Noted the BAF

075a	**Research & Development Annual Report 2020/21** The Board noted the Research & Development Annual Report 2020/21.
075b	**Annual Health and Safety Report 2020/21** The Board noted the Annual Health and Safety Report 2020/21.
075c	**Constitution Amendment** The Board approved the suggested amendments to the Constitution.
075d	**Membership Strategy 2021-25** The Board approved the Membership Strategy 2021-25
075e	**Corporate Governance Manual – 2021 Update** The Board adopted the updated Corporate Governance Manual.
075d	**Updated LHP Members Agreement following formal dissolution of LHP Ltd.** The Board approved the CEO to sign the updated LHP members agreement and variation agreement.
076	**Review of risk impacts of items discussed** No new risks noted.
077	**Chair's Log** The following Chair's Logs were noted: • For the Executive Team to consider and develop the Trust's 'system offer' in the context of recovery from the Covid-19 pandemic. • For the Finance, Performance & Business Development Committee to review the Trust's 52 week wait performance in further detail. • For the Finance, Performance & Business Development Committee to explore the commissioning of an outside body to undertake a detailed asset survey.
078	**Any other business & Review of meeting** The Chair noted that it was the last Board meeting for Non-Executive Director Ian Knight and Chief Finance Officer Jenny Hannon before they leave the Trust. Thanks were extended to both for their commitment and hard work. **Review of meeting** No comments noted.

NHS
Liverpool Women's
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Action Log

Trust Board - Public
November 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
2 September 2021	21/22/ 73b	Future Generations Programme: Expression of Interest to Build a New Liverpool Women's Hospital	To share the draft expression of interest template with the Board for final comment ahead of submission on 9 September 2021.	Chief Finance Officer	Sept 21	Complete	Shared with the Board ahead of submission
2 September 2021	21/22/72a	Workforce Performance Report	For consideration to be given to how senior leaders provide accountability to the Board regarding flexible working arrangements for staff.	Chief People Officer	Dec 21	On track	The Trust is involved in a programme with NHSI/E to support this aim. Updates to be provide to the PPF Committee.
1 July 2021	21/22/57	Any other business & Review of meeting	To establish a Board working group to explore the Trust's role in 'place' and the Corporate Social Responsibility agenda.	Chief People Officer	Sept 21	Complete	Membership agreed. Date for first meeting set for 18th November 2021. Outputs to report to the Board in January / February 2022.
1 July 2021	21/22/50a	Quality & Operational Performance Report	To seek clarification on the setting of the Trust's complaints target.	Chief Nurse & Midwife	~~Sept 21~~ Dec 21	On track	Refreshed target to be reviewed alongside SOF update to performance reports.
6 May 2021	21/22/27b	Chair's Report from Finance, Performance and Business Development Committee	For a future Board workshop training on revised performance reports.	Chief Operating Officer	Oct 21	Complete	Session added to agreed Board Development Programme. This will be facilitated by NHSI/E. Date to be confirmed.
6 May 2021	21/22/26a	Staff Listening Events	For the Executive Team to consider attendance, staff engagement and meeting	Chief People Officer	Sept 21	Complete	Update provided to September 2021 PPF Committee. Improvements

			location of future Listening Events.				requested by the Committee to the 'Staff Engagement Report' that will be received on a regular basis with issues escalated to the Board via the Chair's Report.
			Board oversight of delivery against the 30/60/90 day actions as agreed at the Listening Event held in April 2021.	Chief People Officer	Sept 21		
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.	Chief Nurse & Midwife	Sept 21	On track	This item is scheduled for the November 2021 Board agenda.

Chair's Log

Received / Delegated	Meeting Date	Issue and Lead Officer	Receiving / Delegating Body	Action Deadline	RAG Open/Closed	Comments / Update
Delegated	02.09.2021	To explore the commissioning of an outside body to undertake a detailed asset survey. Lead Officer: Chief Operating Officer	Finance, Performance & Business Development Committee	November 2021	On track	FPBD informed in Oct 2021 that the Premises Assurance Group would be taking forward this action.
Delegated	02.09.2021	To review the Trust's 52 week wait performance in further detail. Lead Officer: Chief Operating Officer	Finance, Performance & Business Development Committee	November 2021	On track	Analysis provided in Recovery and Restoration presentation provided to Oct 2021 FPBD. 'Deep dive' to be undertaken in November 2021.
Delegated	02.09.2021	For the Executive Team to consider and develop the Trust's 'system offer' in the context of recovery from the Covid-19 pandemic.	Executive team	November 2021	Closed	Discussion held at Executive Team 27.10.2021

		Lead Officer: Executive team				
Delegated	01.07.2021	To explore the progression pathway and development opportunities for the midwifery role. Lead Officer: Chief Nurse and Midwife	Putting People First Committee	September 2021	Closed	Paper received at September 2021 PPF Committee
Delegated	01.07.2021	To review progress towards and potential challenges to reverting to pre-Covid-19 cancer pathways. Lead Officer: Chief Operating Officer	Quality Committee	September 2021	Closed	Paper received at September 2021 Quality Committee
Delegated	01.07.2021	For relevant Committee's to review the new Oversight Framework KPIs relevant to their area of oversight. Lead Officer: Committee Executive Leads	FPBD / QC / PPF	September 2021	Closed	Papers received at the PPF, FPBD and Quality Committee meetings in September 2021.
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	Closed	Paper received at September 2021 Quality Committee

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CEO Report

Trust Board
November 2021

Chief Executive Report

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.

Section A - *Internal*

Liverpool Women's among best performing Trusts in Gynaecology inpatients survey

Liverpool Women's Hospital has received its Gynaecology inpatients survey results for 2020, receiving an overall rating of 'better' in comparison to other Trusts in 6 of the 9 eligible categories of the survey. This shows Liverpool Women's to have performed among the best Trusts in the country across a range of categories.

A National Inpatients Survey is conducted each year looking at the experiences of over 73,000 NHS patients who received care in NHS hospitals between May - November 2020.

Of the 9 categories where an overall rating was published for the Trust, Liverpool Women's overall scores were 'much better' compared to other hospitals in 2 categories and 'better' in a further 4 categories. Across all categories the Trust was rated either better or in line with other NHS hospitals across the country.

Liverpool Women's scored particularly well in a number of areas of feedback including; being admitted into hospital, confidence and trust in doctors, care provided during operations and procedures, the support given when leaving the hospital, and the overall care and treatment provided.

Full details of the Liverpool Women's report are available on the CQC website and additional insight into the Trust's performance is available later in the agenda.

Black History Month

October was Black History Month and we had a selection of events taking place for all staff to learn more about equality, diversity and inclusion at LWH.

- Local born historian, Laurence Westgraph discussed Liverpool, Philanthropy and Slavery on 15 October to staff in the Blair Bell (also broadcast via Microsoft Teams)
- Laurence also undertook a 'Liverpool and Slavery Walking Tour' on 21 October

You an also watch this short video from Laurence, on Liverpool and Slavery, looking around 19-23 Abercromby Square here: 19 - 23 Abercromby Square –

https://www.youtube.com/watch?v=pPmvvyk9bJY

Chief Executive Report

Section A - *Internal*

NHS System Oversight Framework Segmentation
The new NHS System Oversight Framework (SOF), after a period of consultation, has now been implemented. The final SOF can be found here:

https://www.england.nhs.uk/publication/system-oversight-framework-2021-22/

Following consideration by the NHSE/I regional support group and national moderation, it has been agreed that the Trust should be placed into SOF segment 3 and mandated support provided. The drivers behind the segmentation and the implications of this are currently being reviewed and the Board (and its Committees) will kept up to date on progress.

Archbishop Beck Catholic College – Careers Video
Archbishop Beck Catholic College have produced a video on their career support processes which the Trust participates in.

https://www.youtube.com/watch?v=BficGZVVjsk

The relevant section starts at 3 minute 42 seconds.

Employee and Team of the Month – August 2021
Congratulations to Employee of the Month winner – Matt O'Neill for the successful delivery of the vaccination programme and Team of the Month winner – the Maternity Service for going above and beyond to provide safe care for women and their babies the past 18 months.

Medical Revalidation Annual Board Report and Statement of Compliance
There is a requirement for the Board to sign off the Trust's Medical Revalidation Annual Board Report and Statement of Compliance. Whilst this was reviewed by the Putting People First Committee on the 20th September 2021, the submission date (24th September 2021), was ahead of the next scheduled Board meeting date. Email approval was therefore sought and the Board is now asked to ratify this decision.

Section A - *Internal*

Quality Improvement update

The Board will be aware that that Quality Improvement had been identified as a challenge to the Trust in the most recent CQC inspection report and the External Well-Led Review. Issues specifically related to an inconsistent approach to Quality Improvement across the organisation and to an identified need to embed an agreed approach in 'business as usual' practices.

In response to this, the Trust has engaged Mersey Internal Audit Agency (MIAA) who will be providing LWH with expert support to review the existing quality improvement processes we have and develop a strategy for improvement. They will take stock, offer advice for enhancement, providing a formal programme of expert support to refresh, train, embed and sustain effective Quality Improvement arrangements and culture throughout the Trust.

Phil Bartley, Associate Director of Quality & Governance will lead to project, supported by Amanda Cringle, Quality Improvement Lead.

Current position

Communication was sent to senior managers on 18 October 2021 advising of the project with MIAA and an introductory meeting with them on 3 November 2021. The ask was for this to cascaded to their staff teams to allow for as many people to be involved in this project as possible. This will support LWH on its journey to achieve an outstanding rating with the Care Quality Commission. Further communication was sent to all staff encouraging their involvement in the weekly communications bulletin on 20 October 2021. As of 27 October 2021, 16 members of staff have accepted this invitation to the introductory meeting.

Next steps

1. Introductory meeting to be held with MIAA on 3 November 2021
2. Associate Director of Quality & Governance will continue to promote the project, working with staff to engage with 'buy in' of the process.
3. MIAA will be meeting with people who wish to be part of this project following the initial meeting as part of the newly formed Quality Improvement Action Group.
4. Associate Director of Quality & Governance and QI Lead will continue to meet with MIAA on a regular basis throughout the duration of the project and manage progress accordingly.
5. Weekly updates will be provided to the Executive team, to outline progress, risks and updates as per the terms of reference agreed with MIAA. Regular updates will also be provided to the Quality Committee
6. At the conclusion of the project the Associate Director of Quality & Governance will lead on the completion of the QI framework to under pin the clinical quality strategy 2021-25.

Section B - *Local*

Cheshire and Merseyside Health and Care Partnership – Chair Appointment Update

The statement below was received from the Partnership regarding the Chair role.

"Cheshire and Merseyside Health and Care Partnership did not appoint to the position of Chair of the ICS during the national recruitment process which has just been completed. This is a key leadership appointment and we all agree it is of paramount importance that we get the right candidate for our system. We are really pleased to confirm that David Flory, currently interim Chair, and substantive Chair of the Lancashire and South Cumbria ICS, has agreed to extend his interim contract with us until 31st March, 2022. David is a highly experienced and effective Chair and we welcome his continuing input and the stability this brings during our transition to an ICS. We will relaunch the recruitment process for a permanent Chair early in the new year."

Cheshire & Merseyside Gynaecological Cancer Services Review

Attached as Appendix A is a briefing note regarding the Cheshire & Merseyside Gynaecological Cancer Services Review, which will be undertaken by the NHS Transformation Unit.

Blackpool Teaching Hospitals – Freedom to Speak Up Case Review

The National Guardian's Office (NGO) provides support and challenge to the healthcare system in England on speaking up. The NGO leads, develops and supports Freedom to Speak Up Guardians, who support workers to speak up and work within their organisation to tackle barriers to speaking up. The NGO carries out reviews where it has information suggesting speaking up has not been handled following good practice. Reviews seek to identify learning, recognise innovation and support improvement. The review for Blackpool Teaching Hospitals can be found on the following link: https://nationalguardian.org.uk/wp-content/uploads/2021/10/Blackpool_Teaching_Hospitals_FT_case_review.pdf

The findings and recommendations are being reviewed with the Trust's Freedom to Speak Up Guardians and assurance / learning will report to the Putting People First Committee.

Section C - *National*

CQC State of Care Report: Key findings

The report looks at the quality of care in our health and social care system over the past year. CQC's assessment this year is that "The system has not collapsed – but the system is composed of individuals, both those who deliver and receive care, and the toll taken on many of these individuals has been heavy".

Unsurprisingly the report highlights the workforce challenges, with staff being exhausted and depleted after a difficult 18 months. In particular, CQC notes the real struggle within social care to retain staff with staff vacancy rates having increased steadily from 6% in April 2021 to 10.2% in September 2021. With the difficulty of recruiting nurses, more and more providers are closing their nursing care homes. CQC states that if social care funding is to have any impact, it must be on developing a clearly defined career pathway for social care staff, which is linked to training and consistent investment and better pay. Otherwise staffing problems will reduce capacity and choice, and poorer quality of care will result. The overall effect will ripple into the wider health and care system creating a risk of a "tsunami of unmet need".

https://www.cqc.org.uk/publications/major-report/state-care

2021/22 priorities and operational planning guidance: October 2021 – March 2022

This updated planning guidance for the second half of the year reflects the financial settlement for the NHS. The implications of this guidance has been reviewed at the Trust's Finance, Performance and Business Development Committee and will be discussed further by the Board. The Trust is required to submit a financial and operational plan for Half 2 2021/22 by 11 November 2021.

Cheshire and Merseyside full review of gynaecology cancer services Bulletin Oct 2021

1. Introduction

By working as a whole system, we have the opportunity to harness our expertise and resources to improve outcomes for the benefit of our patients.

The gynaecological cancer services in Cheshire and Merseyside are designed with the aim of improving outcomes and equity of access, and to significantly develop the clinical services and research opportunities for gynaecological cancer.

The Cheshire and Merseyside Cancer Alliance is undertaking a full review of gynaecology cancer services with the aim of securing a better understanding of how they operate, their challenges and more importantly best practice which can be shared/adopted across the system. The review will support the development of a long-term vision leading to a comprehensive improvement plan with short, medium and long-term goals.

The last network review took place over twenty years and therefore it opportune time to complete a fresh review. We want to conclude this review by February 2022. To help with this, we need the support and cooperation of the Unit Leads, clinicians and operational teams.

2. What can I do to help?

The NHS Transformation Unit (TU) will provide the capacity to deliver this review in partnership with you and the Cheshire and Merseyside Cancer Alliance. Below are some ways you can help the review to be a success:

a. Support Local Unit Visits

To enable an in depth understanding of the operation of the local diagnostic units, from both a patient and clinical perspective, the TU would like to visit each unit during a clinic in November/early December with Mr Kirwan and Dawn Valentine. During these visits they would like to speak to different clinicians to secure feedback on a range of questions and to map the patient journey. The TU will be in touch with Local Unit Leads to arrange these full or half day visits.

b. Facilitate service user engagement:

It is really important that we secure the views and feedback from service users, but it also fully appreciated that this must be done with sensitivity. So, to assist,

i. If you run an existing service user group which we could access, please could you send the organisers contact details to mlcsu.cancerprog@nhs.net

ii. If you have any current service users who you could approach for an informal interview, please send their contact details once you have secured their permission, to mlcsu.cancerprog@nhs.net

c. Structured interviews with stakeholders

Based on initial analysis more semi-structured interviews may need to take place. The TU will be seeking the support to go through a series of questions with an agreed list of stakeholders.

d. Review

Following the activities outlined in a, b & c, a report will be drafted which will include a variety of findings gathered from the stakeholder engagement and research to propose recommendations for service improvements. Please can we ask that people take the time to review the findings and provide feedback.

3. Review Principles

It is appreciated that there will be some anxiety created regarding this review. To provide some assurance about the process of the review activity and for developing recommendations, the following principles have been drafted:

- For all recommendations to be informed by evidence gathered from this review.
- To consider and account for the co-dependencies between cancer and non-cancer activity and stakeholders.
- To consider the operation of the whole gynae cancer system, to support future proof, sustainable recommendations.
- Meaningful engagement and communication with stakeholders.
- Build on audits and other research already completed and align to other linked service developments underway
- To focus on having the greatest impact in the timeframe, using the resources available.

If you have any questions or comments on this briefing,

please email mlcsu.cancerprog@nhs.net.

Liverpool Women's
NHS Foundation Trust

Trust Board

Operational Performance Summary
November 2021

Trust Board Performance Report

Executive Director: Gary Price, Chief Operating Officer
Report produced by Digital Services

Liverpool Women's NHS Foundation Trust

This report has been produced to provide an exception position against the Trust's key performance standards. It outlines the measures being undertaken to improve performance where required. The paper includes information on key workforce metrics and access targets.

Delivering high quality, timely and safe care is the key priority for the organisation. This report provides an overview of the Trust's performance against the key standards. It highlights those areas where the targets have not been met in month and subsequent actions taken to improve this position.

How to interpret the report:

Green: KPI **meeting** target
Red: KPI is **failing** against the target
Purple: KPI is **outside** of control limits
Black: KPI does not have a target set

Control limits are set using statistical process control. The standard deviation for each indicator is calculated based on the previous two financial years data unless recalculation is required due to service changes. the upper and lower control limits are two standard deviations above and below the mean performance level. Where appropriate data points will be removed and control limits recalculated if reasons for adverse performance are known and accepted.

Performance is reported one or two months in arrears depending on submission deadlines. The reporting month is highlighted against each specific KPI.

Data Quality Kitemark

The DQ Kitemark is included to identify the confidence levels around data quality. Each metric is measured using five domains: Source, Timeliness, Completeness, Granularity, Validation. Where KPIs do not meet the requirements for each of the domains an action plan will be included within the data health check section for detail around where improvements are required.

The Kitemark is a score out of 5 with compliance against each domain scoring 1.

Digital.Information Data Health Check

All denominators have been reviewed and there has been no unexpected variation in these. There are no KPIs where known data issues have affected performance.

Exec Lead	KPI	Month	Target	KPI Meeting Target	Denominator Check

WE SEE Summary

WE SEE Positive Developments

Workforce

Mandatory training Task and Finish Group chaired by the Chief Information Officer is progressing well with good engagement from divisional representatives

40 leaders at Bands 7 and 8, mainly from within nursing and midwifery are commencing the new LWH Leadership and Management Development Programme at the end of October

Efficient

As at Month 6, the Trust remained in line with the H1 2021/22 breakeven position

Safety

IPC performance continues to be strong for the Trust

Effective

Cancer 2 week performance has continued to be strong for the Trust

Experience

Positive feedback received on the 'Maternity Facts' infographic

WE SEE Areas of Challenge

Workforce

The Trust's sickness absence rate has increased slightly and remains significantly above the established target.

Efficient

Half 2 2021/22 planning will present several significant challenges to the Trust.

The Trust is behind on its Cost Improvement Programme (CIP) target

Safety

A verbal update will be provided on VTE performance which has deteriorated in recent months.

Effective

The Trust performance for 52 week position has plateaued, largely due to reduced planned theatre sessions due to sickness absence.

The Cancer 62 day target remains an ongoing challenge with the NHS Transformation Unit commissioned by the Cheshire and Mersey Cancer Alliance to address the regional optimal pathway improvements that need to be made

Experience

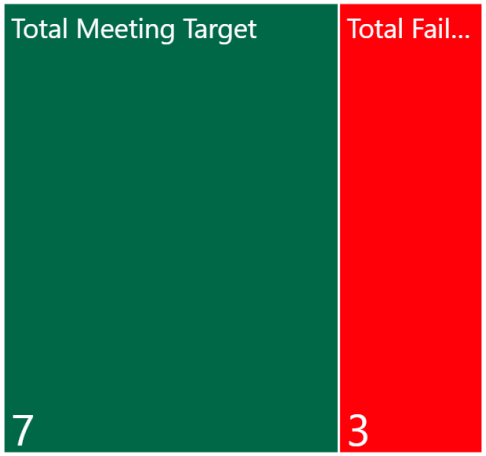
Complaints response rates continue to be challenged. This is due to the pressures within Divisions to release staff to complete investigations and subsequent availability of senior staff to review and sign off investigations once complete.

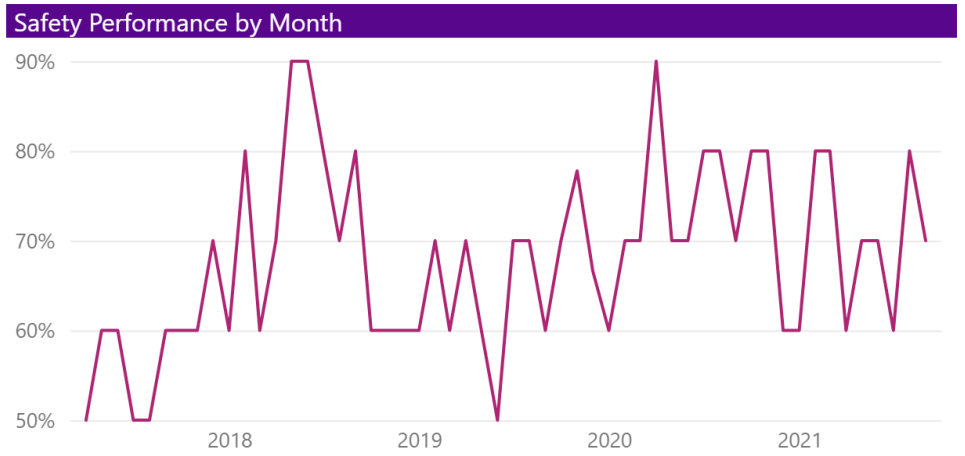
Liverpool Women's
NHS Foundation Trust

Operational & Quality Performance

Trust Board
November 2021

To deliver **Safe** services

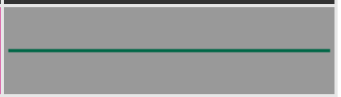
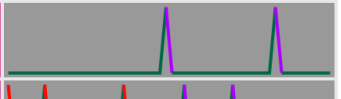
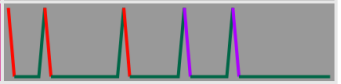
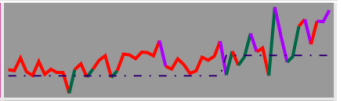
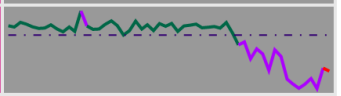




The majority of Safety indicators remained green in September. An explanation of VTE performance will be provided verbally at the meeting.

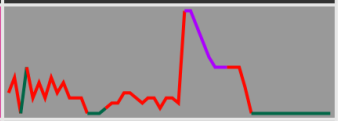
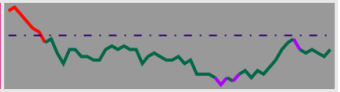
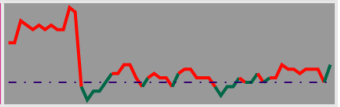
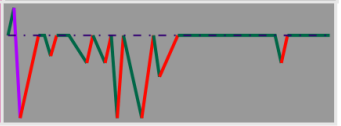
Detail on serious incidents is provided within the performance report.

To deliver Safe services

KPI Owner	KPI	As of Date	Current Value	KPI Status	Target	Denominator	DQ Kite Mark	Sparklines
Director of Nursing & Midwifery	NHSE / NHSI Safety Alerts Outstanding	September 2021	0	0				
Medical Director	Infection Control: Clostridium Difficile	September 2021	0	0				
	Infection Control: MRSA	September 2021	0	0				
	Never Events	September 2021	0	0			5	
Medical Director	Caesarean Section - Emergency Rate	September 2021	21.94%	+5.34%	16.60%	679	5	
	Venous Thromboembolism (VTE)	September 2021	87.96%	-7.04%	95.00%	1138		

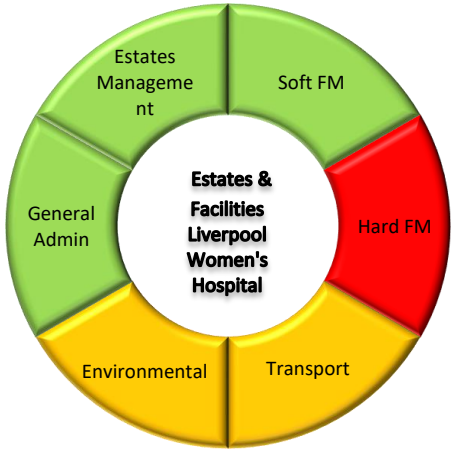
KPI	KPI Narrative
Caesarean Section - Emergency Rate	We are not a regional outlier for this metric. Review of CS metrics required as per HSCC report - need to use Robson criteria.
Venous Thromboembolism (VTE)	VTE assessment now principally undertaken by the medical team. Gynae noted a dip in compliance for July 2021.. E-mail for update and action sent to obstetric and gynaecology safety leads sent on 11/10/21

To deliver Safe services - Serious Untoward Incidents

KPI Owner	KPI	As of Date	Current Value	KPI Status	Target	Denominator	DQ Kite Mark	Sparklines
Director of Nursing & Midwifery	Serious Untoward Incidents: Number of SUI's with actions outstanding	September 2021	0	0				
	Serious Untoward Incindents: New (Rolling per year)	September 2021	20	-4	24			
	Serious Untoward Incindents: Open	September 2021	9	+4	5			
Director of Nursing & Midwifery	Serious Untoward Incidents: Number of SUI's reported to CCG within agreed timescales	September 2021	100.00%	0.00%	100.00%	4		

KPI	KPI Narrative

To deliver Safe Services – Estates and Facilities



Notes:
1. Excellent progress made this month with on water safety checks with >99% of scheduled checks completed.
2. Work continues building PPM system to generate jobs as required.
3. Work with Lifestyle continuing - since last month some other contracts have been awarded and schedules in place - Procurement team are supporting chasing others to be finalised.
4. Good progress made with fire PPMs - maintenance and service contract has been awarded. Fire door inspections commenced in September - report due in October. Fire Damper Inspections to commence in October.

Risk register:
2274 - water safety PPMs has impacted on existing resources which will cause increased backlog on reactive maintenance tasks.
2469 - allocation of resources to carry out water safety checks has not achieved full compliance - although in recent weeks significant improvement has been maintained with more than 99% achievement in August. Will continue to review if this level of compliance can be maintained.
2474 - PPM system not populated, regular maintenance not completed, equipment may breakdown more frequently - although good progress has been made in recent weeks to populate PPM system and schedule tasks to be completed.
All three risks have an impact on resource levels within the department. Paper is being completed to consider how this will be addressed going forward - due to present end of September.

To deliver Safe Services – Serious Incidents

Overview

There was one SI's reported in August and four reported in September making a total of 10 SI's reported for the year to date for 2021/22. Comparations to previous years are shown below.

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	2	3	0	1	4	-	-	-	-	-	-	10

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.

To deliver Safe Services – Serious Incidents

August 2021 Serious Incidents

Service	StEIS Ref.	Reported in Line with Policy	Summary
Gynaecology	2021-17138	Yes	Cardiac arrest nine days post debunking surgery for ovarian cancer. CPR was commenced, the patient was pronounced dead after 9 minutes of resuscitative efforts.

September 2021 Serious Incidents

Service	StEIS Ref.	Reported in Line with Policy	Summary
Gynaecology	2021-19164	Yes	The patient attended Gynaecology Emergency Department (GED) 6/52 post medical termination of pregnancy at 15/40, of twin pregnancy. A scan performed identified likely retained products of conception. It was identified that following the medical termination of pregnancy which took place on 11 July 2021, there was no documentation within the clinical or nursing notes that the patient received Anti D following this procedure.

Service	StEIS Ref.	Reported in Line with Policy	Summary
Maternity	2021-19505	Yes	High risk pregnancy with additional risk factors not escalated to senior obstetrician and discharged inappropriately. Guidelines not followed, positive PlGF repeated, fetal monitoring was not continued during the correction of ketosis. .

Service	StEIS Ref.	Reported in Line with Policy	Summary
Maternity	2021-19483	Yes	Diversion of Maternity services following escalation in accordance with the Cheshire and Merseyside Maternity Escalation and Divert Policy on two separate occasions.

Service	StEIS Ref.	Reported in Line with Policy	Summary
Maternity	2021-19486	Yes	31 day old baby admitted to ED with vomiting for 22hours.The baby had suffered a large intracranial bleed and required emergency surgery. Subsequently diagnosed with Haemorrhagic disease of the newborn.

To deliver Safe Services – Serious Incidents

HSIB Cases Reported and NHSR Early Notification Scheme

During July 2021 there was 1 case which met the HSIB criteria and has been reported to HSIB and NHSR as per procedure. During August, there were no cases. During September, there were 3 cases. The main themes 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	2	0	2	0	1	0	3	-	-	-	7

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

Duty of Candour was completed for the 1 Serious Incident declared in August, and the 4 incidents declared in September.

Overdue Actions for reported Sis

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

To deliver Safe services - Safer Staffing

Gynaecology: September Fill Rate

Fill-rate – The fill rates for both RN and HCA appear underfilled and overfilled, this is due to the roster template, the staffing establishment is under review, the band 4 AP was also rotated to night duty during September which increases the fill rate on nights for the HCA

Attendance/ Absence – for September 5.95%, 62% short term sickness, 38% Long term sickness, Covid related sickness amounted to 1.64% which takes the total for sickness to 7.34%. 4.23WTE Maternity leave

Vacancies – 4RN vacancies (under review) and 1 HCA vacancy, there were 2 new RN starters in September

Red Flags – 0 red flags

Bed Occupancy – Gynaecology inpatient ward 64.67% High Dependency Unit 38.96%

Neonates: September Fill Rate

Fill-rate – Throughout September the NICU has continued to maintain safe staffing and fill rates are reflective of acuity and occupancy. However, this has required increased use of Bank and the flexibility of staff swapping and changing shifts.

Attendance/Absence – September sickness ran at 7.25%, this was down from September by 1.65%. Short term sickness sits at 47% with long term sickness making up 53%. Covid sickness and covid special leave made up approximately 2.69% this is down by 0.5% from the previous month. The introduction of new isolation guidelines has supported this decrease. There continues to be 13 FTE on maternity leave and turnover sits at 7% well below the Trust target.

Vacancies – Band 5's and 6's recruited have all started in post. We will go out to recruit further staff at band 5 and 7.

Red Flags – No red Flags

Bed Occupancy – Unit occupancy has run at 85.6% just above the expected 80% and 10% up on last month. IC ran at 98.3%, HD 66.1%, LD 89.7%, and TC at 60%. This has been a very busy month for neonatal services.

Maternity: September Fill Rate

Fill-rate – Maternity continues to report high levels of sickness, within its midwifery and support staff groups. Noting a rate of increased absence due to Covid positive cases and absence linked to isolation requirements and childcare commitments also. Maternity continues to have high agency usage due to vacancy gaps and sickness rates. Due to sickness both long and short term the closure of MLU has been necessary within this reporting period. Clinical activity and staff rostered to MLU have been reallocated across other areas within maternity.

Attendance/Absence – sickness is reported at 8.19% a decrease on last month, which is split into 24% short term and 76% long term – please note these figures include all of maternity's staff groups including maternity administration, and non-direct clinical roles. Maternity have requested that future reports reflect maternity staff only. Maternity leave sits at 11%, a static position for maternity.

Vacancies – vacancy rate of 10% continues, noting a rise in staff requesting retirement, and a reduction in contractual. An active recruitment plan and rolling NHS job adverts remains in place.

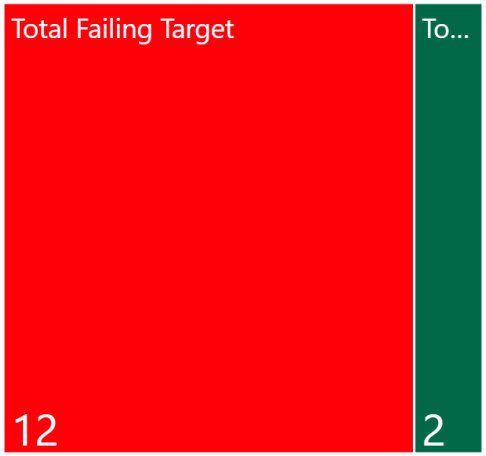
Red flags – Maternity has a positive reporting culture for red flags, noting a slight increase in red flag reporting this month. A thematic review of red flags has been undertaken and the rise is noted as, delays of elective procedures such as IOL, and delays or omissions in analgesia – each has an action plan and QI project registered against the area of concern.

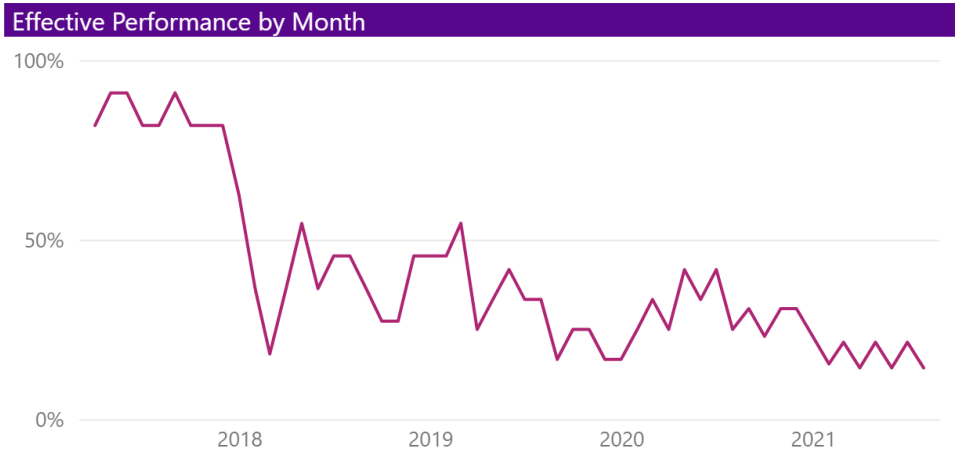
Bed Occupancy – Maternity continues to experience high levels of clinical activity and await the refreshed power BI occupancy report which will demonstrate the following: modality of birth, expected date of transfer to community services, length of stay and bed occupancy. Maternity saw two maternity diverts to other maternity services due to activity and staffing during this reporting period.

To deliver Safe services - Safer Staffing

WARD	Fill Rate Day%	Fill Rate Day %	Fill Rate Night %	Fill Rate Night %
	RN/RM	Care staff	RN/RM	Care staff
Gynae Ward	65.33%	110.00%	90.00%	206.67%
Induction&Delivery Suites	98.46%	95.00%	94.10%	90.00%
Maternity & Jeffcoate	76.19%	85.71%	63.81%	85.19%
MLU	35.83%	43.33%	55.00%	70.00%
Neonates (ExTC)	95.61%	65.00%	93.51%	83.33%
Transitional Care	96.67%	90.00%	156.67%	76.67%

To deliver the most **E**ffective outcomes





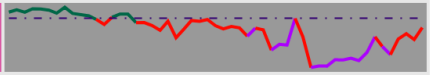
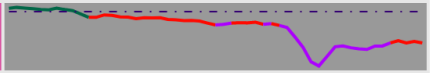
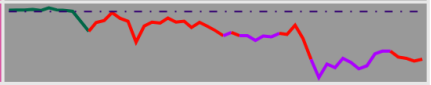
The Trust performance for 52 week position has plateaued, largely due to reduced planned theatre sessions due to sickness absence. This has been compounded by continued increases in 2 week urgent referrals. Whilst we continue to meet this urgent target to do so takes capacity from our routine day case.

Plans are in place to increase this capacity in H2. Elective priority is given to the most urgent cases.

A further additional compounding factor is the reduction of elective sessions for oncology at LUH due to their ongoing pressures.

The Cancer 62 day target remains an ongoing challenge with the NHS Transformation Unit commissioned by the Cheshire and Mersey Cancer Alliance to address the regional optimal pathway improvements that need to be made

To deliver the most Effective outcomes

KPI Owner	KPI	As of Date	Current Value	KPI Status	Target	Denomina...	DQ Kite Mark	Sparklines
Chief Operating Officer	18 Week RTT: Incomplete Pathway > 52 Weeks	August 2021	244	+244	0		+5	
Chief Operating Officer	18 Week RTT: Admitted Completed Pathways	August 2021	82.97%	-7.03%	90.00%	229	5	
	18 Week RTT: Incomplete Pathways	August 2021	67.41%	-24.59%	92.00%	11724	5	
	18 Week RTT: Non-Admitted Completed Pathways	August 2021	73.49%	-21.51%	95.00%	1841	5	

KPI Narrative

The gynaecology division has failed to reach this target during August with 244 52 week breaches.

The impact of Covid has led to long queues for new and FU patients. This has created increasing numbers of patients waiting over 52 weeks. The cessation of elective work in 2020 caused queues to increase whilst restrictions in activity following re-opening of elective work has led to on-going issues with waiting times.

During August 2021 we faced weekly reductions in theatre lists due to theatre staffing restrictions, therefore creating longer waiting times for patients. We continue to run Saturday WLI for daycase/non-complex patients to mitigate some of these restrictions.

The waiting time for ambulatory procedures continues to challenge. The ability to create additional capacity is hindered by estates space, clinician availability and nursing staff availability - all are being addressed:
- nurse recruitment ongoing in GOPD to create capacity to staff evening and weekend list.
- looking at estates to create capacity.

There is a lead-in time to this piece of work due to nursing staff availability and the building work required to develop estates.

Ongoing clinical review of queues continues to identify if patients can be triaged away from ambulatory.

Patients are prioritised against Federation of Surgical Specialties Association 'clinical guide to surgical prioritisation during coronavirus pandemic'.

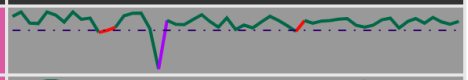
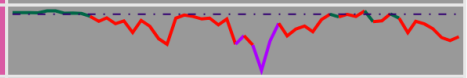
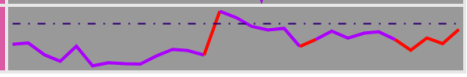
Regular review of long-waiting patients to ensure that any actions towards ensuring management/treatment is taken in a timely way.

Weekly PTL meetings reviewing all patient queues.

Regular WLI sessions planned through October - December 2021.

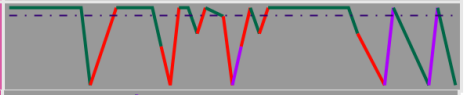
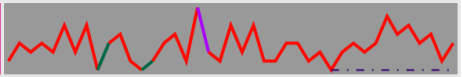
Careful monitoring of clinic utilisation to ensure all available appointments are filled.

To deliver the most Effective outcomes - Cancer Waiting Times

KPI Owner	KPI	As of Date	Current Value	KPI Status	Target	Previous Year Value	DQ Kite Mark	Sparklines
Chief Operating Officer	Cancer: 2 Week Wait	August 2021	96.42%	+3.42%	93.00%	279	5	
	Cancer: 31 Days from Diagnosis to 1st Definitive Treatment	August 2021	68.97%	-27.03%	96.00%	29	5	
	Cancer: 28 Day Faster Diagnosis	August 2021	71.12%	-3.88%	75.00%	232	5	

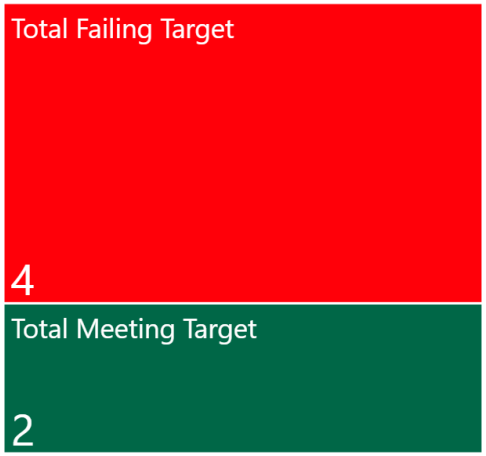
KPI	KPI Narrative
Cancer: 28 Day Faster Diagnosis	Performance 71% against a target of 75% and an improvement on the performance for July 2021. The main delays with the patient pathway continue to be caused by hysteroscopy capacity. A longer wait for hysteroscopy then delays the diagnosis or exclusion of cancer within 28 days. We continue to review hysteroscopy capacity to increase both for out-patient hysteroscopy and ambulatory hysteroscopy. The bigger delay sits with ambulatory procedure. We are exploring all areas where ambulatory capacity can be improved and continue with regular Saturday ambulatory sessions. Clinical sessions are being converted to out-patient hysteroscopy to create capacity and the impact can be seen by the improving percentage against target. We are following a number of routes to increase ambulatory capacity including extending sessions/converting rooms/ introducing new clinicians. We are also in the process of refining the patient pathway into ambulatory, particularly the route through pre-op clinics as there has been some identified delays in this part of the pathway. We have an ongoing review of the Rapid Access pathways with the intention of improving and streamlining the patient journey.
Cancer: 31 Days from Diagnosis to 1st Definitive Treatment	August 2021 - There has been a slight improvement against the target and achieved 69% against a KPI target of 96%. There are continued delays in accessing the investigations needed following pre-op assessment prior to surgical intervention. More patients are requiring ECHO and Spirometry which are all outsourced. There are also significant delays in accessing CT and MRI. The gynaecology division are looking at all internal process to ensure bottlenecks/delays are reduced eg) waiting time to pre-operative assessment. We are experiencing delays around investigations needed following pre-op assessment at LWH with a higher number of patients requiring Echocardiogram and spirometry which are all outsourced. There are issues with capacity within these organisations. There is also the continuing impact of the reduction in theatre sessions due to theatre staffing issues. Although every effort is taken to protect the oncology theatre sessions. During August we converted some benign theatre sessions to oncology theatre sessions and have continued to do this to create capacity. The cancer team, and particularly the early diagnosis support workers liaise regularly with local hospitals to escalate delays and to attempt to obtain earlier appointments. An escalation SOP is being utilised to strengthen communication between LWH and CBH.

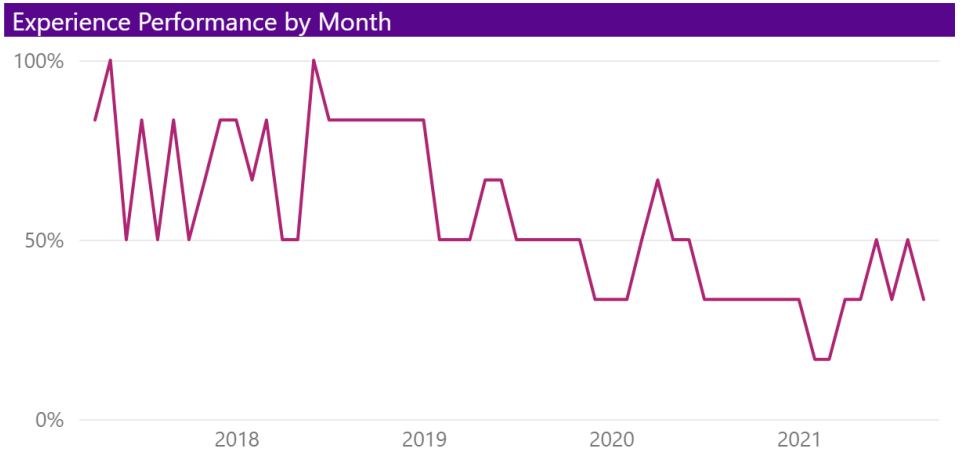
To deliver the most Effective outcomes - Cancer Waiting Times

KPI Owner	KPI	As of Date	Current Value	KPI Status	Target	Denominator	DQ Kite Mark	Sparklines
Chief Operating Officer	All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (After Re-allocation)	August 2021	16.22%	-68.78%	85.00%	19	5	
	Cancer: 62 Day Screening Referrals (Percentage)	July 2021	0.00%	-90.00%	90.00%	1	5	
Chief Operating Officer	Cancer: 62 Day Screening Referrals (Numbers)	August 2021	0	-5	5		5	
	Cancer: 104 Day Breaches	August 2021	3	+3	0		5	

KPI	KPI Narrative
All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (After Re-allocation)	There are continued delays in accessing the investigations needed following pre-op assessment prior to surgical intervention. More patients are requiring ECHO and Spirometry which are all outsourced. There are also significant delays in accessing CT and MRI. 2ww performance is still compliant despite increasing demand. The gynaecology division are looking at all internal process to ensure bottlenecks/delays are reduced eg) waiting time to pre-operative assessment. We are experiencing delays around investigations needed following pre-op assessment at LWH with a higher number of patients requiring Echocardiogram and spirometry which are all outsourced. There are issues with capacity within these organisations. There is also the continuing impact of the reduction in theatre sessions due to theatre staffing issues. Although every effort is taken to protect the oncology theatre sessions. During August we converted some benign theatre sessions to oncology theatre sessions and have continued to do this to create capacity. The cancer team, and particularly the early diagnosis support workers liaise regularly with local hospitals to escalate delays and to attempt to obtain earlier appointments. An escalation SOP is being utilised to strengthen communication between LWH and CBH.
Cancer: 104 Day Breaches	There were 3 x 104 day breaches in month. We continue to review the diagnostic pathways with with external stakeholders to optimise waiting times. There is a dependency as an organisation on external stakeholders for diagnostics such as MRI, CT, ECHO and Spirometry and pressure in achieving timely access. There are plans being actioned to implement a new referral form into oncology at LWH which requires the referring organisation to ensure that diagnostic tests are booked/arranged as part of the referral process to reduce pathway times. This has been agreed at gynae CQG. However some changes were requested via Cancer Managers in the C&M region. These are currently being actioned and this form is likely to be implemented in October/November 2021.

To deliver the best possible **E**xperience for patients and staff

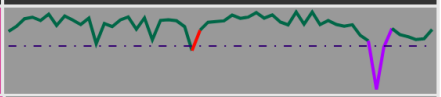
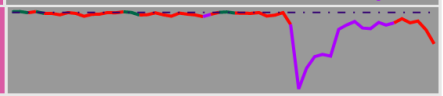




Complaints response rates continue to be challenged. This is due to the pressures within Divisions to release staff to complete investigations and subsequent availability of senior staff to review and sign off investigations once complete. The Trust is continuing to work closely with the complainants to try and provide realistic achievable timeframes and keep them updated of any delays and the reasons for this at the earliest opportunity. Weekly meetings are scheduled with the Deputy Chief Nurse & Midwife for the Divisions to provide updates on progress of their ongoing complaints and requirements for assistance for any identified blockages.

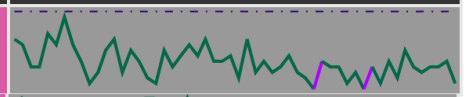
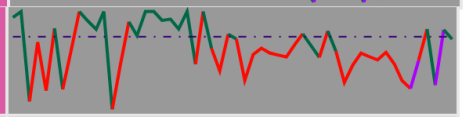
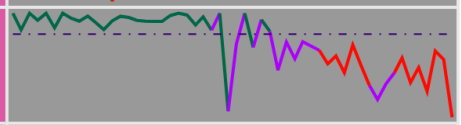
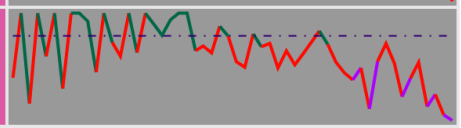
Positive feedback has been received via Social Media regarding the ‘Maternity Facts; infographic.

To deliver the best possible Experience for patients and staff

KPI Owner	KPI	As of Date	Current Value	KPI Status	Target	Denominator	DQ Kite Mark	Sparklines
Chief Operating Officer	A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge	September 2021	97.43%	+2.43%	95.00%	971	5	
Chief Operating Officer	Diagnostic Tests: 6 Week Wait	September 2021	69.65%	-29.35%	99.00%	794		

KPI	KPI Narrative
Diagnostic Tests: 6 Week Wait	Overall performance for each diagnostic area can be seen below: Ultrasound Numerator 614, Denominator 436 = 71.01%, Dexa Numerator 47, Denominator 47 = 100%, Cystoscopy Numerator 2, Denominator 5 = 40%, Urodynamics Numerator 68, Denominator 128 = 53.13% Reduced capacity within imaging has resulted in increased waiting times for patients and a failure to meet these targets for ultrasounds. Whilst figures for Cystoscopy and Cystometry have improved, capacity continues to remain an issue, with targets not met. Mitigating Actions?: The CSS Operational Services Manager is validating the PTL on a weekly basis and working with service leads / admin leads across the Trust to identify capacity and try to mitigate the number of month end breaches. Staff have returned from sickness, and a plan has been implemented for a fixed term member of staff, within imaging to help resolve the backlog and address the waiting times within imaging. How is this being fixed?: See above Additional capacity within gynaecology is also being identified by the Gynaecology Operational Team. When will target be achieved?: Q3; Why this timeframe?: Gynaecology consultant has been appointed to support additional capacity; Additional capacity in imaging due to staff returning from sickness and fixed term member of staff in post until December 2021.

To deliver the best possible Experience for patients and staff

KPI Owner	KPI	As of Date	Current Value	KPI Status	Target	Denominator	DQ Kite Mark	Sparklines
Director of Nursing & Midwifery	Complaints: Number Received	September 2021	2	-13	15		5	
Director of Nursing & Midwifery	Friends & Family Test: In-patient/Daycase % positive	September 2021	94.53%	-0.47%	95.00%	128	5	
	Friends & Family Test: A&E % positive	September 2021	75.00%	-20.00%	95.00%	36	5	
	Friends & Family Test: Maternity % positive	September 2021	76.28%	-18.72%	95.00%	156	5	

KPI	KPI Narrative
Friends & Family Test: A&E % positive	The matron and ward manager responsible for GED receive a weekly overview of FFT responses. They are reviewed and actioned in relation to the issues raised by patients. Any in relation to the medical team are escalated through the CD . The FFT findings are discussed at the monthly Divisional senior nurse meetings . patient experience Team will provide some up date training and inputting responses onto Power Bi to close the lop on any actions taken as a result of negative feedback. Each of the clinical /areas Departments have a You said we did board to display FFT feedback that both staff and patients can see.
Friends & Family Test: Maternity % positive	Narrative What is the reason for failure against this target?: Restrictions are still in place due to the National pandemic . This has affected women's experience of the Maternity pathway at all stages ; Mitigating Actions?: Review of guidance as restrictions change; How is this being fixed?: Monitor feedback and update websites and pathways as changes occur; Allowing partners on site for Outpatient appointments and scans . Being able to see women face to face especially for bookings When will target be achieved?: 31/12/2021; Why this timeframe?: Global Pandemic and restrictions;

September 2021 – Maternity Facts.

NHS Liverpool Women's NHS Foundation Trust

Thank you to all our families for choosing Liverpool Women's : Welcome to the world our September 2021 Babies.

680 Total Births

9 Vaginal Birth After CS

16 Home Births

Girls 338

342 Boys

1,404 Visits to Maternity Assessment Unit

2 Breech Births

Inductions of Labour . 219

8 Sets of Twins

Women Booked For Care 787

113 Elective C - Sections

148 Emergency C - Sections

Have you had a September 2021 Baby?
Why not send a picture to our Twitter or Facebook account.
We'd love to hear from you.
@LiverpoolWomens

Instrumental Births 81

Discharges from NICU 106

22 Pool Births

Heaviest Baby 11lb 5oz
Lightest Baby 1lb 7oz

Our busiest day for births this month: 17th September – 35 Births

KPI Lineage

Metric Description	Board	FPBD	Quality	PPF	Senate	Family Health Division	CSS Division	Gynaecology Division	Maternity Clinical	Neonates Clinical (MDT)
18 Week RTT: Admitted Completed Pathways	Y	Y	Y		Effective		Y	Y		
18 Week RTT: Incomplete Pathway > 52 Weeks	Y	Y	Y		Effective		Y	Y		
18 Week RTT: Incomplete Pathways	Y	Y	Y		Effective		Y	Y		
18 Week RTT: Non-Admitted Completed Pathways	Y	Y	Y		Effective		Y	Y		
A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge	Y	Y	Y		Experience			Y		
All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (After Re-allocation)	Y	Y	Y		Effective			Y		
Caesarean Section - Emergency Rate	Y				Safety				Y	
Cancer: 104 Day Breaches	Y	Y	Y		Effective			Y		
Cancer: 2 Week Wait	Y	Y	Y		Effective			Y		
Cancer: 28 Day Faster Diagnosis	Y	Y	Y		Effective		Y	Y		
Cancer: 31 Days for Subsequent Treatment (Surgery)	Y	Y	Y		Effective			Y		
Cancer: 31 Days from Diagnosis to 1st Definitive Treatment	Y	Y	Y		Effective			Y		
Cancer: 62 Day RTT Consultant upgrade (Non-urgent suspected cancer referrals)	Y	Y	Y		Effective			Y		
Cancer: 62 Day Screening Referrals (Numbers)	Y	Y	Y		Effective			Y		
Cancer: 62 Day Screening Referrals (Percentage)	Y	Y	Y		Effective			Y		
Clinical Mandatory Training Compliance	Y		Y	Y	Workforce					
Complaints: Number Received	Y		Y		Experience					

KPI Lineage

Metric Description	Board	FPBD	Quality	PPF	Senate	Family Health Division	CSS Division	Gynaecology Division	Maternity Clinical	Neonates Clinical (MDT)
Diagnostic Tests: 6 Week Wait	Y	Y			Experience		Y	Y		
Financial Sustainability Risk Rating: Overall Score	Y	Y			Efficient					
Friends & Family Test: A&E % positive	Y		Y		Experience			Y		
Friends & Family Test: In-patient/Daycase % positive	Y		Y		Experience			Y		
Friends & Family Test: Maternity % positive	Y		Y		Experience				Y	
Infection Control: Clostridium Difficile	Y		Y		Safety					
Infection Control: MRSA	Y		Y		Safety					
Intensive Care Transfers Out (Rolling 12 Month)	Y		Y		Effective					
Mandatory Training Compliance	Y		Y	Y	Workforce					
Never Events	Y		Y		Safety					
NHSE / NHSI Safety Alerts Outstanding	Y		Y		Safety				Y	
Serious Untoward Incidents: Number of SUI's reported to CCG within agreed timescale	Y		Y		Safety		Y			
Serious Untoward Incidents: Number of SUI's with actions outstanding	Y		Y		Safety		Y	Y		
Serious Untoward Incindents: New	Y				Safety		Y	Y	Y	
Serious Untoward Incindents: Open	Y		Y		Safety					
Sickness	Y		Y	Y	Workforce					
Turnover	Y			Y	Workforce					
Venous Thromboembolism (VTE)	Y				Safety					

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*2021/22/86d*		**Date: 04/11/2021**	
Report Title	**Maternity Services Self-Assessment Tool**			
Prepared by	***Family Health Division***			
Presented by	***Marie Forshaw, Chief Nurse & Midwife***			
Key Issues / Messages	**To outline the key highlights from the Maternity Services Self-Assessment Tool**			
Action required	**Approve ☐**	**Receive ☐**	**Note ☒**	**Take Assurance ☐**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	***To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it***	***For the intelligence of the Board / Committee without in-depth discussion required***	***To assure the Board / Committee that effective systems of control are in place***
	Funding Source (If applicable):			
	For Decisions - in line with Risk Appetite Statement – Y/N ***If no – please outline the reasons for deviation.***			
	The Trust Board is asked to note the contents of the report that seeks to formally update the board with progress against the National Maternity self-assessment tool.			
Supporting Executive:	***Marie Forshaw, Chief Nurse & Midwife***			

Equality Impact Assessment *(if there is an impact on E,D & I, an Equality Impact Assessment **MUST** accompany the report)*							
Strategy	☐	Policy	☐	Service Change	☐	Not Applicable	☒

Strategic Objective(s)			
To develop a well led, capable, motivated and entrepreneurial ***workforce***	☐	To participate in high quality research and to deliver the most ***effective*** Outcomes	☒
To be ambitious and ***efficient*** and make the best use of available resource	☐	To deliver the best possible ***experience*** for patients and staff	☐
To deliver ***safe*** services	☒		

Link to the Board Assurance Framework (BAF) / Corporate Risk Register (CRR)	
Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* 3.1 Failure to deliver an excellent patient and family experience to all our service users	Comment:
Link to the Corporate Risk Register (CRR) – CR Number:	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Quality Committee	**Oct 21**	**CNM**	**Recommended for further discussion at Board.**

EXECUTIVE SUMMARY

The Maternity Services Safety Self- assessment tool has been designed for NHS Maternity Services and private maternity providers to allow them to self-assess whether their operational service delivery meets national standards, guidance, and regulatory requirements. Organisations can use the tool to inform the Trusts maternity quality improvement and safety plan and so keep the Trust board and commissioners aware of their current position.

This is a useful bench marking tool to support the planning and delivery of maternity services to ensure they are safe effective and have service users and staff at the centre.

Liverpool Women's
NHS Foundation Trust

MAIN REPORT

Introduction

The maternity safety self-assessment tool has been developed in response to national review findings, and the recommendations for good safety principals within maternity services. The most up to date version of the national tool has been further influenced by the findings and recommendations of the Ockenden review, 7 features of safety culture and the emerging themes from services on the Safety Support Programme and the areas CQC found to be outstanding in reviews of maternity services across England.

This paper seeks to formally update the Board as to the progress within the Maternity Service System learning self-assessment tool, updated version July 2021. A Board development session took place regarding this on October 6th 2021.

The family health senior leadership met in September 2021, to undertake a full self-assessment of maternity's compliance and benchmark against the national tool. There are five areas of key lines of enquiry:

- Leadership and development
- Governance: Covers all pillars of good governance
- Quality improvement: application of methodology and tools
- National Standards and guidance: service delivery
- Safety culture: no blame, proactive, open and honest approach, psychological safety
- Patient voice: service user involvement and engagement through Co-production and Co-design, MVP and wider

Of the 161 named areas of improvement, maternity's initial assessment:

- 41 metrics red
- 71 Amber
- 52 green

Within the metrics, self-assessed as red, the key areas for mobilisation are –

- Workforce, including appointing to key leadership roles i.e. Director of Midwifery and additional key leadership roles. Job planning for Consultants including forecasting for the financial costs.
- Training including assurance that the requirements for the additional training for both Midwifery and Medical workforce are met. Capacity and demand planning will need to underpin this.
- A review of Governance assurance, including the flow of information from Ward to Board which includes service user engagement with the MVP, safety culture, staff well-being and quality improvement.

The senior leadership review allowed for discussion and challenge regarding the divisions performance and it outlined a positive level of progress across the self-assessment tool.

Scheme Management

- A detailed spreadsheet has been produced to identify key lines of enquiry. This spreadsheet has been shared with the relevant scheme stakeholders within the Family Health Division (FHD) and assurance will be provided to the FHD Board monthly.

- In the interests of the ability to share and collate evidence for scheme stakeholders, our colleagues in the Information team have developed a Microsoft Teams Channel. This will consist of each 'key area of improvement' action spreadsheet being held centrally with action owners given the ability to update and upload actions and evidence as the scheme progresses throughout the coming year. This will have oversight by the FHD Management Team and Quality committee at sub board level, with monthly board updates as requested by the Chief Nurse.

- Every action has been nominated a lead, with associated actions being given to action owners. Action Leads and owners will be responsible for ensuring their progress, challenges and completions are presented and overseen by the Family Health Divisional Board (FHDB).

- The FHDB meets monthly, chaired by the Clinical Director for the Family Health Division. This meeting provides updates and assurance to sub board committees and dependent on Key line of Enquiry, Quality committee, FPBD, and Safety and effectiveness senate may all require a formal update in the progress against this national safety plan. Assurance will also be sought from external regulators such as CQC, LMS, and the ICS. The Family Health Senior Leadership Team provide these assurance updates as requested.

- **Key Risks and matters for escalation to Board**

A good level of momentum has been developed and activities are now taking place and plans shared, the family health senior leadership team have considered what is required to take progress forward:

  - Key recruitments within the division
  - Refreshed governance structure within family health division including accountability framework
  - Operational delivery of the core competency framework for education
  - Operational delivery of 'safe maternity culture'
  - Delivery of a maternity specific strategy
  - Development of maternity transformation

Recommendation

The Trust Board is asked to:
Note the contents of the report and seeks to formally update the board with progress against the National Maternity self-assessment tool

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	***2021/22/086e***		**Date: 04/11/2021**	
Report Title	**Guardian of Safe Working Hours Annual Board Report 2020 - 2021**			
Prepared by	***Rochelle Collins, Medical Workforce Manager and Kat Pavlidi Guardian of Safe Working Hours***			
Presented by	***Kat Pavlidi, Guardian Safe Working Hours***			
Key Issues / Messages	**To present the Guardian of Safe Working Hours Annual Board Report 2020 - 2021**			
Action required	**Approve ☐**	**Receive ☐**	**Note ☒**	**Take Assurance ☐**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	***To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it***	***For the intelligence of the Board / Committee without in-depth discussion required***	***To assure the Board / Committee that effective systems of control are in place***
	Funding Source (If applicable):			
	For Decisions - in line with Risk Appetite Statement – Y ***If no – please outline the reasons for deviation.***			
	The Board is asked to read and note this report from the Guardian of Safe Working Hours.			
Supporting Executive:	***Lynn Greenhalgh, Medical Director***			

Equality Impact Assessment *(if there is an impact on E,D & I, an Equality Impact Assessment **MUST** accompany the report)*

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

To develop a well led, capable, motivated and entrepreneurial ***workforce***	☒	To participate in high quality research and to deliver the most ***effective*** Outcomes	☐
To be ambitious and ***efficient*** and make the best use of available resource	☐	To deliver the best possible ***experience*** for patients and staff	☒
To deliver ***safe*** services	☒		

Link to the Board Assurance Framework (BAF) / Corporate Risk Register (CRR)

Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* 1.2 Failure to recruit and retain key clinical staff	Comment:
Link to the Corporate Risk Register (CRR) – CR Number:	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Putting People First Committee	Sept 21	MD	Recommended to the Board for noting. Suggested that it would be useful to hear the perspective of a junior doctor.

Liverpool Women's
NHS Foundation Trust

EXECUTIVE SUMMARY

Under the 2016 terms and conditions for doctors and dentists in training introduced by the Department of Health nationally, there is a requirement for the Guardian of Safe Working Hours (GSWH) to submit a quarterly report to a sub board committee and an annual report to the Trust Board. The Putting People First Committee has received these reports quarterly.

The 2016 contract highlights three functions, which oversee the safety of doctors in the training and service delivery domains of their working experience:

a. The employer or host organisation designs schedules of work that are safe for patients and safe for doctors, and ensures that work schedules are adhered to in the delivery of services.

b. The Director of Medical Education (DME) oversees the quality of the educational experience.

c. The Guardian of Safe Working Hours provides assurances to the employer, and host organisation if appropriate on the compliance with safe working hours by the employer and the doctor.

The GWSH supports safe care for patients and the health and wellbeing of doctors in training through the management of exception reporting. The role ensures any issues of compliance with safe working are addressed as appropriate by the Trust. The guardian has the authority to impose sanctions such as a doctor taking time back in lieu of working additional hours or levy financial penalties against the departments where safe working hours are breached.

MAIN REPORT

Introduction

The Guardian is confident that doctors in training receive appropriate work schedules and compliant rotas. This is evident in the number of exception reports received by the Guardian in the reporting year, a total of 17 exception reports 16 were lodged by O&G trainees only, 14 of which were in Q4 and 1 by Neonates. There was 1 work schedule review request.

It is important for the committee to note that the 2016 terms and conditions was imposed on doctors in training, however, in July 2019, an agreement was reached between NHS Employers, the British Medical Association (BMA) and the Department of Health and Social Care (DHSC) on the amendments to the 2016 terms and conditions for doctors in training, The updated contract is referred to as 'Junior Doctors 2018 contract refresh'

The main themes negotiated were;

- Less than full-time, flexible working and equalities

- Pay structure
- Safety and wellbeing
- Workforce
- Training and education

In addition to the above, Health Education continues to fund a 'SuppoRTT Champion' and in July 2019 appointed Miss Cara Williams, a role which is now well-established. The role is designed to provide trainees of all specialties and their supervisors with guidance regarding the relevant policies and available resources to them returning to training. The role also ensures that trainees returning to training after a period of prolonged absence are fully supported and consider any upskilling/reskilling educational and training needs trainees may have to be fully confident to return to the workplace.

The agreement received ministerial clearance and an investment over a four year period (1 April 2019 to 31 March 2023) the investment will be used to support changes within the 2016 contract.
There has also been an agreed addition to the nodal points, with the introduction of Nodal point 5 in October 2020, which recognises the experience of junior doctors in later stages of their training, otherwise called 'senior decision makers'.
In 2020/21, there was a total investment of 2 per cent in the contract. In the subsequent year (2021/22-2022/23) there will be annual pay uplifts of 2 per cent and a further 1 per cent of additional investment (circa £90m) in other terms within the contract.

This additional investment has enabled the introduction of:

- A weekend allowance uplift to ensure those working the most frequent weekends are remunerated more fairly
- An enhanced rate of pay for shifts that finish after midnight and by 4am
- A new nodal pay point 5 (in place October 2020, as doctors in training are employed by the Lead Employer, this will be actioned by the employer rather than at Trust level)

The new terms and conditions of service were introduced in early August 2019, with the most updated version released in April 2021, with a phased implementation taking into account operational implications of the changes for employers.

All doctors in training successfully transitioned to the revised terms and conditions on the 5th February 2020. The Trust also made the decision to offer to move clinical fellows (now known as Locally Employed Doctors) to local T&C's that mirror the national terms and conditions.

Liverpool Women's NHS Foundation Trust

1. Report

During the first quarter of this reporting period, the services ran with a number of rota gaps. The O&G service received an increase of doctors in training resulting in the rotation being over established and the Anaesthetic service successfully recruited to gaps. Therefore, the services have seen a significant reduction in the number of shifts requiring locum coverage as detailed below;

Service	2018 – 2018 shifts requiring a locum	2019 – 2020 shifts requiring a locum	2020 – 2021 shifts requiring a locum	Percentage
O&G	398	145	82	-44%
Neonates	105	89	49	-45%
Anesthetics	123	21	93	+342%

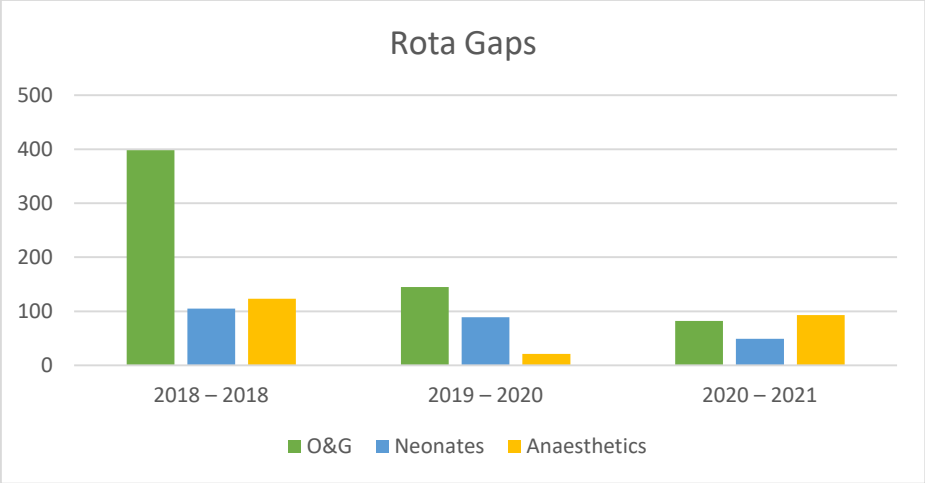


Chart 1: Detail of change in rota gaps over the last 3 years

The Guardian of Safe Working Hours is a requirement of the 2016 contract and is currently filled by Ms Kat Pavlidi (Consultant Gynaecologist) as of September 2021. The Guardian is responsible to the Medical Director and should not be involved in management roles within the Trust, but have a fully independent role with access to the Board as required.

The role of the Guardian is to;

- Act as a champion of safe working hours
- Record and monitor compliance of exception report management and review cases escalated by a doctor in training
- Escalate issues for action where not addressed locally
- Will request work schedule reviews to be undertaken where necessary

- Oversee safety-related exception reports and monitor compliance with the system
- Intervenes as required to mitigate safety risks
- Intervenes where issues are not being resolved satisfactory
- Provide assurances on safe working and compliance with TCS
- Submits a quarterly report to the Trust Board on the functioning of the contract and exception reporting

This report covers all of the above for the reporting period 1st April 2020 – 31st March 2021.

Work Schedules

NHS Employers recommend that doctors in training should be made aware of their next placement 12 weeks before commencement. They should receive work schedules 8 weeks prior to commencement and a finalised rota 6 weeks before. This is to ensure work life balance it also enables doctors to request annual leave 6 weeks in advance.

Although the majority of work schedules have been completed within the 8-week timeline, this has not always been possible due to conflicting information from Health Education inaccurate or missing information from the college tutors and/or changes in the rota due to unexpected gaps.

This information is currently reported quarterly to NHSI data collection but has been stood down during the COVID-19 pandemic.

There was one work schedule review request during this past year, which was granted after review of multiple exception reports for the F1 in O&G staying late after handover.

Rota compliance

All rotas are compliant with both 2002 and 2016 terms and conditions. This is relevant as previous to 5th February 2020, doctors training at the trust were on different terms and conditions, yet worked on the same rota. As of 2020, the currently locally employed doctors have been offered employment on the 2016 T&Cs allowing the rotas to remain compliant with both sets of terms and conditions.

Staffing Levels

In previous reports the GSWH has reported national shortages of junior doctors, and how this has been detailed on the trusts Risk Register for a number of years. The Trust continued to run with a number of gaps throughout quarter 1 of this report and

partially through quarter 2 until the new rotation in August 2020. These gaps were confounded by the COVID-19 pandemic, where staff had to quarantine frequently due to limited testing and family sickness. In addition, there were a number of junior doctors who had to shield either through chronic medical conditions, or due to being over 28 weeks pregnant, and therefore deemed higher risk of catching/being ill with COVID. With the introduction of the COVID vaccination programme and the Government's changes to the rules and regulations surrounding the pandemic, these gaps have decreased, although HEE are still advising those pregnant and over 28 weeks to not have patient facing roles.

During this time, the majority of gaps were in the majority covered as locum shifts by the cohort of doctors who were at the Trust in a training post.

As previously referenced in the Guardian quarterly reports, the number of gaps usually fluctuate throughout the 12 month rotation period due the number of times each specialty rotates, maternity leave, long-term absence and the completion of training (CCT). Therefore as the year progresses the services expect to work with increasing gaps. For context, the table below highlights the rotation months for each service. However, during quarter 3 and 4 of this report this has not been the case due to the O&G rotation being over established, Advance Neonatal Nurse Practitioners cross cover and excellent forward recruitment planning within Anaesthetics.

Rotations by month, specialty and grade.

Month	Specialty	Grade
August	O&G	F1 – ST7
	Anaesthetics*	CT2 – ST7
	Genetics	ST3 – ST7
September	Neonates	ST1 – ST7
November	Anaesthetics*	CT2 – ST7
December	O&G	F1 – F2
	Anaesthetics*	CT2 – ST7
February	O&G	GPST
	Anaesthetics*	CT2 – ST7
March	Neonates	ST1 – ST7
April	O&G	F1 – F2
May	Anaesthetics*	CT2 – ST7

*The Anaesthetic department trains doctors in higher obstetrics and these doctors rotate monthly. This is usually 1 -2 doctors at a time.

Obstetrics and Gynaecology

This workforce is predominately female; therefore as expected, there are usually a high number of gaps in this service due to maternity leave and less than full time working. The service runs with a 3 tier rota as described below.

- Tier one - doctors within the first 4 years of training most of which will have no or minimal experience in obstetrics and gynaecology. Usually GP, Foundation and ST1&2 O&G doctors.

- Tier two – Doctors who have a minimum of 2 years of experience working in Obstetrics and gynaecology working at an ST3 – ST5 who have a career plan to progress within O&G.

- Tier three – Experienced obstetricians and gynaecologists who have part 3 MRCOG and more than 5 years O&G experience working at an ST6 – ST7.

Trainees are given protected time to attend in house teaching organised by the college tutors for the last Wednesday afternoon of every month. The teaching is for ST1 to ST7 training grades. The teaching is facilitated mainly by internal speakers, with some external invited. However, during quarter 1 of this reporting period the service found it increasingly difficult to release trainees for teaching. This was raised at the junior doctor forum and the Director of Medical Education (DME) agreed to work with the college tutors to identify time when teaching may be 'paid back' to the trainees.

As previously noted, the service is familiar with issues around maintaining adequate staffing levels throughout the year, in particular, experienced staff on tiers 2 and 3 of the rota. This can potentially lead to patient safety issues. Throughout the year, the service attempts to mitigate this by employing a combination of Clinical Fellows and Research Fellows and more recently, International Training Fellows and Academic Clinical Fellows/Lecturers. Currently the Trust employs 7.8 WTE 'Locally employed' non-training doctors in addition to the doctors in training. The service also uses bank and doctors in training to cover out of hour rota gaps with agency doctors being sourced as a last resort.

The Trust works in partnership with Edge Hill University in recruiting International Training Fellows who work clinically at the Trust whilst completing a Masters. The doctors start on the Tier 1 rota and by quarter 3 progress to the Tier 2 rota as they become competent to work at a registrar level. The Trust has committed to employ two doctors per year for 3 years whilst the doctors undertake a Master's programme. However, given the over establishment of trainees in the O&G rotation this is currently under review.

The Trust continues to work in partnership with the University of Liverpool and the Tropical School of Medicine, jointly employing a clinical academic who will work 2.5 days clinical and 2.5 days academic.

In addition to the already mentioned Trust posts, the services was successful in submitting a business case for funding for a further 11 LWH (non-training) posts for the 2020-2021 rotation.

For context, during this reporting period the service required locum cover for 82 out of hour shifts to be covered by, Junior Doctors, bank doctors, agency doctors and consultants acting down. This, compared to last year's 145 gaps, is a 43% decrease in shifts requiring locum cover. During this reporting period 0 shifts were unfilled.

Genetics

Currently, there is no requirement for locum cover as genetic doctors do not work unsocial hours.

Anaesthetics

The Anaesthetic service runs with an average of 4 – 5 gaps per year. To mitigate the known gaps in the service, the service employs locally employed doctors, who are commonly referred to as Clinical Fellows. Also, the service at times, receives a trainee from Wales, the Welsh doctor has a Welsh training number and is therefore not included in Health Education England numbers. The Clinical Fellows are usually employed for a fixed term period of 3 to 6 months whilst they are preparing for exams and/or applying for ST3 rotation. This works extremely well as the majority of these doctors have previously worked at LWH as Core Trainees and therefore are well trained and familiar with the Trust and its complexities.

The service runs a 2 tier rota for on call work which equates to 4 x 12.5 hour shifts, 2 daytime and 2 at night. Therefore the service needs to cover both daytime and night time gaps with bank / lead employer doctors working locums. For reference, due to the training and specialist nature of the Trust, the service does not use agency doctors. The service has not reported any concerns with trainees being released for teaching. The main issue is the fact at times, the core trainee exam is scheduled on the same day as regional teaching for ST3 upwards. This can prove a difficult when trying to staff rotas. Occasionally, doctors may have their annual leave and or study leave refused. However, the service makes every effort to ensure this only happens in exceptional circumstances.

For context, during this reporting period the service required locum cover for 93 shifts to be covered by the following staff members, Junior Doctors and bank doctors. This, compared to 21 last year, this is an increase of 342% compared to the previous year. The majority of these gaps were noted during the first quarter, when gaps were covered due to colleagues being unable to attend work. This was increased by the fact that there was limited testing for COVID-19 and at the time, a 14 day quarantine

period. As the pool of junior doctors within the anaesthetic team is small, they were unable to implement a shadow rota as seen in the O&G and Neonates teams, which increased their gaps.

Neonates

The Neonatal service runs with an average of 2 gaps. During this reporting service, the service has not employed any Trust Grade Doctors as they are often reliant on Advanced Neonatal Nurse Practitioners (ANNP). Also due to the specialist nature of the service, the service does not use agency staff. To mitigate gaps in the rotation, the junior doctor workforce works alongside the ANNP's who are well established at LWH and are trained to work at registrar level.

The service has not reported any concerns with junior doctors and has highlighted GMC survey results for paediatric doctors (national survey) highlighted LWHFT's Neonatal unit as one of the best training sites within the country. The service has no issues with training or opportunities for teaching. The teaching takes place 5 mornings a week for 30 minutes and includes but not limited to, radiology, journal club, case presentations and consultants lead teaching. The Registrars (ST4 +) complete 1 week of teaching every 6 months in partnership with Arrowe Park Hospital. In the survey, local teaching and curriculum coverage was highlighted as excellent.

For context, during this reporting period the service required locum cover for 49 out of hour shifts to be covered by Junior Doctors and ANNP's. This, compared to 89 last year, this is a decrease of 45% of shifts requiring locum cover.

2. Key Findings

Exception Reporting

Doctors in training are expected to electronically submit exception reports via the doctors rostering system (DRS) detailing if they have worked over their scheduled hours, missed breaks or educational opportunities. These exceptions are managed by the doctor's educational supervisors, and where appropriate the GSWH and or the DME. As of August 2021, this exception reporting system has moved to Allocate/eRota.

As detailed in the table below, the number of exception reports has been minimal throughout Q1-3, with the majority of them being reported in Q4. This trend fits in with the fluctuating staffing levels in each specialty.

Numbers of exception reports recoded on the electronic reporting system are listed below;

Period	Specialty	Grade	Reason	No of exceptions	No: hours	Outcome
Quarter 1	N/A	N/A	N/A	0	N/A	
Quarter 2	Neonates	ST3	Hours	1	2	TOIL
Quarter 3	O&G	F1	Hours	2	4	Payment for hours worked
Quarter 4	O&G	F1	Hours	4	5	Payment for hours worked and a work schedule review
	O&G	ST6	Hours	10	N/A	See note *

*There was a number of exception reports submitted by the ST6 noted above. These exception reports were mainly to do with breaks and highlighted the issue with midwifery staffing shortage having an impact on the junior doctors. This led to doctors being asked to perform more clinical tasks that would normally be done by a midwife, difficulty in taking 3x30 minute breaks on a night shift, or being called out of the break room to do non-urgent tasks. This is currently being monitored, and juniors encouraged to exception report when similar issues occur.

Engagement of junior Doctors

The GSWH continues to attend doctor in training inductions and offers support to all doctors. The doctors are aware of the GSWH and the role. There is also an encouragement for doctors to complete exception reports as it is a useful tool when looking at workforce planning. Doctors are offered exception reporting training as and when they need it, however to date no one has taken up this offer nor advised the GSWH or HR of any issues when using the system.

All services continue to engage with junior doctors and offer supportive and safe environments for doctors to work. The doctors have access to the Guardian of Safe Working Hours and the Freedom to Speak up Guardian.
The doctors are also encouraged to discuss any issues relating to safe working, practices or behaviours with their educational supervisors.

As previously reported, the junior doctor forums were previously poorly attended; this was seen to be a trend across the region. However, the Trust has seen recently, an increase in the number of attendees and become a useful platform for the doctors to raise any concerns. The forum also gives the Trust the opportunity to address and issues.

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Fines

There are no fines to report.

3. Solutions / Actions

Issues for Consideration

The GSWH is no longer concerned about the number of rota gaps in O&G and the lack of research opportunities which had previously seen trainees apply for an out of programme period to complete research in neighbouring Trusts such as Manchester. The GSWH would like the Trust to consider the continuation of the Trust locally employed doctors to clinical fellow roles including research roles.

Although there are not many exception reports lodged, the GSWH believes that there is a trend for doctors not to report exceptions as they have advised in forums and outside of forums that they value the exposure and experience they gain from complex cases / patients. The Trust will continue to encourage doctors to submit exception reports.

The committee should note that the GSWH is no longer concerned about the doctors in training working in addition to their normal timetable and therefore reducing the risk of 'burnout' amongst the doctors.

The GSWH is concerned going forward that the main issues are lack of protected time for training (both for teaching sessions and special training) which has been made worse by the COVID-19 pandemic, such as with the stepping down of elective theatre lists, or increased staff sickness outside of the junior doctor workforce. This is in addition to lack of breaks due to frequent session changes during the day time hours. The GSWH continues to encourage doctors in training to submit exception reports and monitor staff working conditions.

Finally, the GSWH is concerned about the anecdotal increase in health professional burnout. This has affected and in turn is affected by, increased sickness within the junior doctor cohort and leads to gaps not only out of hours, but during day time working. This therefore decreases the amount of breaks and training opportunities that are available to the doctors. The trust has appointed a Mental health and wellbeing champion, Professor Andrew Weeks, who has been available for staff to speak to, and regularly updates the Trust with supportive emails and advice.

Fatigue and Facilities Charter

The committed is asked to note, the Trust has received funding of 30K as part of the BMA's 'fatigue and facilities charter'. The funding is to be used to make improvements to facilities for junior doctors as outlined in the charter. Any improvements must be made in conjunction with the junior doctor forum and a task and finish group. The charter has been presented to the Trusts space utilisation group and is highlighted as a priority for the forthcoming financial year. Currently, the funding is still unused and is going through further reviews of how it is to be allocated appropriately. The junior doctors forum and task and finish group have not been updated frequently and so this is still an issue requiring resolution. Junior doctors are very concerned as they do not feel the current mess is of acceptable condition and is not appropriately sited, leading to lack of space to take breaks. Further updates are to be given.

Actions Taken

Given the outbreak of COVID 19 in the UK in Q1 of 2020, the services had to take a proactive approach to workforce planning and the rostering of junior doctors in training. The proactive approach ensured and continues to ensure that the staffing levels remain safe and there is a robust plan in place should absences increase across the medical workforce. These rotas will be monitored regularly and flexed should there be a need to increase activity.

The Guardian of Safe Working Hours continues to work with the Educational Supervisors on how to address exception reports including specific timescales in line with the junior doctor Terms and Conditions of Service 2016. This will ensure all exceptions are responded to and resolved in good time and escalated where necessary.
The Guardian is continuing to engage with junior doctors at their scheduled forums and continues to promote the use of the exception reporting system.

The O&G and Anaesthetic service will continue to recruit to 'Clinical Fellow' (locally employed, Trust grade doctor) roles throughout the year.

To further improve workforce planning and rostering, the trust set forth a business case and a procurement process for the 'Allocate' e-rostering system, to replace DRS. This work commenced in May 2021 and went live in August 2021 for O&G. Exception reports are managed through the same system and will be further detailed in the next annual (2021-2022) annual board report.

4. Recommendations

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The Board is asked to read and note this report from the Guardian of Safe Working Hours.

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*2021/22/086f*		Date: 26/10/2021	
Report Title	**Learning from Deaths Quarter 1, 2021/22**			
Prepared by	*Allan Hawksey; Acting Associate Director of quality and Governance; Ai-Wei Tan, Consultant Obstetrician; Rebecca Kettle, Consultant Neonatologist and Andrew Drakeley, acting Deputy Medical Director.*			
Presented by	*Andrew Drakeley, acting Deputy Medical Director and Lynn Greenhalgh, Medical Director*			
Key Issues / Messages	The Board is asked to review the contents of the paper and take assurance that there is adequate processes and progress against the requirements laid out by the National Quality Board			
Action required	Approve ☐	Receive ☐	Note ☒	Take Assurance ☒
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable): N/A			
	For Decisions - in line with Risk Appetite Statement – Y *If no – please outline the reasons for deviation.*			
	a. The Board is asked to review the contents of the paper and take assurance that there is adequate process and progress against the requirements laid out by the National Quality Board b. Take assurance that there are effective processes in place to assure the Board regarding governance arrangements in place to drive quality and learning from the deaths of adults in receipt of care at the Trust. c. Be aware of the establishment of a Trust mortality review group. d. Note that a neonatal benchmarking project with St. Mary's, Manchester will report by Q4 of 2021/22. e. The rate of stillbirth will continue to be monitored. f. Parents continue to be at the centre of the investigation process. g. All stillbirths undergo a robust review process where learning is identified and shared. h. Issues identified at the reviews and recommendations made will now be tracked through the maternity clinical meeting. i. The Trust will comply with nationally mandated initiatives such as Saving Babies' Lives, CNST, PMRT and MBRRACE-UK.			
Supporting Executive:	Lynn Greenhalgh Medical Director			

Equality Impact Assessment *(if there is an impact on E,D & I, an Equality Impact Assessment **MUST** accompany the report)*					
Strategy ☐	Policy ☐	Service Change ☐	Not Applicable ☒		
Strategic Objective(s)					
To develop a well led, capable, motivated and entrepreneurial ***workforce***	☒	To participate in high quality research and to deliver the most ***effective*** Outcomes	☒		
To be ambitious and ***efficient*** and make the best use of available resource	☒	To deliver the best possible ***experience*** for patients and staff	☒		
To deliver ***safe*** services	☒				
Link to the Board Assurance Framework (BAF) / Corporate Risk Register (CRR)					
Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks*		Comment: N/A			

3.1 Failure to deliver an excellent patient and family experience to all our service users	
Link to the Corporate Risk Register (CRR) – CR Number:	Comment: No

EXECUTIVE SUMMARY

New development:
The Medical Director and the Deputy Director of Nursing and Midwifery have established a 'Mortality Review Group' which will meet quarterly prior to submission of quarterly mortality reports to the Quality Committee and prior to the Mortality and Morbidity meeting held as part of the GREAT day. The focus of the meeting is to learn from LWH based mortality as well as from outside the organisation. The key workstreams include:

i) Seek out learning from all deaths across the Trust.
ii) To ask families of those patients who passed away at LWH their opinion on what was done well and what could have been done better.
iii) Formalise structured judgement review of all adult deaths with two reviews using standard methodology. First by consultant in charge of the case and subsequently by Trust wide mortality review group.
iv) Review end of life framework.
v) Peer review of mortality e.g. by CHKS nationally benchmarked data.
vi) To share the learning from deaths at the quarterly mortality and morbidity discussion at Trust GREAT Day.
vii) Revise the Trust strategy for adult and extended perinatal mortality strategies.

The first meeting is scheduled for 1st November 2021

ADULT MORTALITY:

- There were 2 deaths within Gynaecology Oncology, on the ward. Both deaths were expected and there were no immediate deficiencies in care identified. Both have had mortality reviews completed by the gynaecology safety lead and governance manager and were deemed to have been appropriately managed.
- The Safety and Effectiveness Senate has overview of responsiveness to potential areas of risk to adult mortality.

PERINATAL MORTALITY:

- The stillbirth rate excluding TOP in the first quarter (Q1) of 2021/2022 is 4/1000.
- All stillbirths underwent a multidisciplinary review panel meeting utilising the PMRT tool.
- All parents were invited to be involved by submitting comments and questions for discussion at these reviews.
- The majority of stillbirths had appropriate antenatal care (Grade A).
- Adaption of care to telephone reviews due to Covid-19 played a role in the outcome of 1 case of stillbirth in Q1.
- Importance of adhering to the 'did not attend' policy, to ensure appropriate follow is available after a patient DNA's an appointment.
- Importance of face-to-face community midwifery reviews.
- To not give advice to patients that fetal movements are affected by placental site.

The Trust has implemented the K2 electronic patient record in January 2021, with a significant change to the documentation of maternal reviews and assessing important documents such as GROW charts and fetal medicine unit scan reports.

Through the PMRT process, data will also be collated on whether implementation of K2 has a role in the antenatal care provided in stillbirth cases, whether positive or negative.

Following previous reports, the Trust has now updated the guideline for serial growth scans to be fully compliant with recommendations from Saving Babies' Lives.

Neonatal mortality:

- The neonatal team have utilised the support of another unit to view its processes, as last year's mortality rates were higher than other units especially for the very premature babies. Q1 2021/22 mortality have improved.
- Having been highlighted as a network outlier for preterm mortality the neonatal team are in the process of a benchmarking project with St Mary's, Manchester independently chaired and hosted by the regional neonatal network. The review process in anticipated to take 6-7 months to complete and started in July 2021. Monthly meetings are being held to track the review but will not have a report of findings from the review until early 2022. The Executive team were sighted on this previously and signed off the TOR and proposal earlier in the 2021. The report will be presented to Quality Committee.

The review is looking at the following key areas:

1. Review of population and case-mix/clinical care practices
2. Workforce/organisation of care delivery
3. Cause/timing of deaths

- Q1 mortality rate for all LWH neonatal deaths is 3.1/1000 births.
- Q1 mortality for LWH inborn babies is 1.0/1000 births.

– 6/10 PMRT reviews completed, 3 LWH deaths, 3 non- NICU deaths.

Neonatal care:

Of the reviews held to date, care issues were identified in the neonatal care in 4 of 6 cases, however in all 4 they were issues or opportunities for improvement which would not have affected the outcome of the baby dying.

The issues identified which did not have affect the outcome for the baby (grade B) include:

- Non co-location with paediatric surgical services.
- Unplanned extubation / endotracheal tube dislodgement.
- Parent communication.
- Admission temperature.

Actions to address the above issues include:

- Ongoing development of the Liverpool Neonatal Partnership with AHCH, provisional opening of 2 NICU cots for Spring 2022 delayed due to concerns about variation in RSV season and estate being protected to manage paediatric admissions.
- Audit / QIP commenced on unplanned extubations in June 2021 this will be due to be reported at the end of 2021.
- Admission hypothermia remains under a rolling audit / review process.

Antenatal Care

Five of the six PMRT cases that have been reviewed received antenatal care in LWH. In 4 of these cases, there were no antenatal care issues identified and have been graded 'A'.

There was one case of a home birth where antenatal care has been graded C, due to an error in the referral triage process, and thus was not reviewed in the pre-term labour clinic in a timely manner. As a response, there is a planned discussion with the ultrasonography department of feasibility of listing scan reports and requests in a chronological manner to avoid a similar occurrence in the future.

Revised 21/22 CNST requirement targets

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

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

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

MAIN REPORT - DATA BY CATEGORY: ADULT, PERINATAL, NEONATAL

This is the quarter 1 mortality report for adults, perinatal and neonates. The report is part of the regular reporting schedule of the Trust to ensure that there is oversight and assurance monitoring of the mortality rates related to the clinical activity of the Trust. This is in accordance with recommendations by the National Quality Board and the Care Quality Commission. It outlines the work taking place within the department which is reported to the neonatal NWODN (North-West operational delivery network) and reviewed at CDOP (child death overview panel).

ADULT MORTALITY Q1

This report updates the Board regarding the Trust systems and processes to review and learn from deaths of patients under their care. This is in accordance with recommendations by the National Quality Board and the Care Quality Commission. It outlines the work taking place operationally and being overseen by the Safety and Effectiveness Sub - Committee and Quality Committee.

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

Obstetrics	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	TOTAL
Total Mortality	0	0	0										
Discharges	1938	1971	1851										5760

Table 2: Gynae-oncology mortality

Gynaecology (oncology)	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	TOTAL
Total Mortality	0	1	1										2
Discharges	65	70	58										193

Table 3: Benign Gynaecology

Gynaecology Oncology	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	TOTAL
Total Mortality	0	0	0										0
Discharges	547	601	640										1788

Out of hospital deaths 2021-22 Quarter 1

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

There were no reported out of hospital maternal deaths related to women who died within 12 months of delivering a baby at LWH in Q1.

No out of hospital Gynaecological deaths in Q1 were observed.

Mortality reviews and Key Themes

Table 4. Themes

Mortality reviews in Q1		
	Maternity (Direct)	Gynaecology
No of Adult Deaths	0	2
No of Mortality Reviews completed	0	completed
No of deaths requiring RCA's	0	0
No of deaths due to deficiencies in care	0	0
Mortality Themes	N/A	N/A
Progress v Smart Plans	N/A	N/A
Mortality Outcomes	N/A	N/A
Measures for ongoing scrutiny	N/A	N/A

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

There were no unexpected gynaecology deaths recorded in this quarter.

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

Risk Assurances in relation to mortality

As part of the Trusts assurances processes the Effectiveness and Safety Sub – Committee work to gain assurance as to actions taken in relation to Serious Incident reviews, Lessons Learnt, External Alerts and National guidance on Quality and Safety.

Horizon Scanning

Horizon Scanning Summary for guidance, reports and publications.

There were no updates of note for this reporting period.

PERINATAL MORTALITY Q1

Mortality Dashboard

Previous annual stillbirth rates excluding termination of pregnancy per 1000 births were: 2018/19 = 3.91; 2019/20 = 2.89 and 2020/21 = 3.4.

It has been agreed with the Clinical Lead for Obstetrics that this table, and a summary of cases discussed at PMRT will be an agenda item at the monthly Maternity Clinical Meeting so that the Stillbirth rate can be monitored, and relevant issues identified discussed.

Table 5: Stillbirths >24 weeks

STILLBIRTHS	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	**Apr-21**	**May-21**	**Jun-21**	**Q1 TOTAL 2021/22**
Total Stillbirths	2	3	1	4	1	2	4	0	1	3	6	4	13
Stillbirths (excluding TOP)	**2**	**2**	**1**	**2**	**1**	**2**	**3**	**0**	**3**	**3**	**3**	**2**	**8**
Births	658	677	681	669	605	605	604	615	650	639	672	696	2007
Overall Rate/1000 births	3.03	4.43	1.47	5.98	1.65	3.31	6.6	0	4.6	4.7	8.9	5.7	6.5

Rate (excluding TOP)/1000	3.03	2.95	1.5	1.47	1.65	3.31	4.9	0	4.6	4.7	4.5	2.9	4.0

Table 6: Stillbirth rate (excluding terminations) per quarter

Quarter	Rate 2019/2020	Rate 2020/2021	Rate 2021/2022
Q1	4.0	5.5	4.0
Q2	4.1	2.5	
Q3	1.5	2.7	
Q4	1.7	3.2	
ANNUAL	2.9	3.4	

Table 7: Gestation at diagnosis of Stillbirths and cause of death

Gestation at Stillbirth	Number (N=8)	Cause of death
<28 weeks	3	Extreme Prematurity Twin to twin transfusion Fetal Growth Restriction (FGR) / Placental insufficiency
28-34 weeks	1	FGR / Placental insufficiency
34-37 weeks	3	Lethal congenital anomaly Complex placental pathology (CHI) Placental insufficiency
> 37 weeks	1	FGR / Placental insufficiency

Mortality reviews and Themes

The methodology for review of stillbirths has been explained in previous reports and remains unchanged. The PMRT is completed and the antenatal and postnatal care a mother receives is graded in line with the MBRRACE-UK

grading system. The postnatal care is focused on the bereavement care the family receive, but also reviews care in relation to management of complications of labour and the postnatal period. Table 8 shows the criteria for grading.

Table 8: MBRRACE - UK Care Grading

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

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

All the stillbirths in Q1 have been reviewed, and the grading of care provided are as below.

Table 9: Grading of care for babies in Q1 of 2021-22

Grade	Care in antenatal period	Percentage (%)	Care in postnatal period	Percentage (%)
A	5	62.5	7	87.5
B	1	12.5	1	12.5
C	2	25	0	0
D	0	0	0	0
Total cases reviewed	8		8	

Table 10. Grading of ANTENATAL care where care issues were identified (B, C or D)

Gestation of SB	Grading of care	Cause of death	Issues	Actions	Lessons Learnt
35+1	B	Placental insufficiency	Comments conveyed to patient that there will be altered perception of fetal movement (FM) due to an anterior placenta	Lesson of the week (LOTW) to disseminate to all clinicians (doctors, midwives, sonographers) that perception of FM does not change with	Importance of not giving information to patient that are not evidence based

				placental site, and not to tell patient this	
28+2	C	Placental insufficiency Pre-eclampsia (PET)	Telephone appointments for community midwifery (CMW) due to Covid	CMW appointments to revert back to face-to-face reviews. ACTION COMPLETED	Importance of face-to-face reviews for CMW appointments to allow for routine observations and urine analysis to be done
36+1	C	Complex placental pathology (CHI) FGR	Did not attend (DNA) policy not followed, as lost to follow up in Obstetric Day Unit (ODU) for monitoring of PET; Not triaged appropriately at booking into high risk care	LOTW in midwifery assessment unit (MAU)/ODU on the importance of adhering to the DNA policy To monitor change to electronic patient records (EPR) and assess if provision of antenatal documentation is affected by it	Importance of ensuring patients have appropriate follow up if DNA appointments

Table 11. Grading of POSTNATAL care where care issues were identified (B, C or D)

Gestation of stillbirth	Grading of care	Cause of death	Issues	Actions	Lessons Learnt
24+4	B	Extreme prematurity	Lack of co-location of services and woman required 2 different transfers to LUHFT for CT scan and echocardiogram	An ongoing action in the trust to review availability of services in the trust	Single site issues well documented elsewhere

NEONATAL MORTALITY Q1

1. Mortality Dashboard

It has been agreed with the Head of Governance and Deputy Medical Director, that the following table showing the total mortality and the rate of death per 1000 births will be used as the mortality dashboard metric. Tables 12 and 13 refer to LWH NICU in-hospital mortality before discharge. The end of year annual neonatal mortality report will detail all neonatal deaths (<28 days), both on NICU and labour ward, all deaths before discharge, deaths at home or in another organisation after delivery and / or care in LWH neonatal unit.

Table 12: LWH Mortality

NICU	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Q1 Total
Discharges	102	108	91	94	98	90	91	92	89	100	97	106	303
Total Mortality	9	3	9	0	3	4	6	4	2	3	1	2	6
Births	658	677	681	669	605	605	610	618	658	622	654	673	1949
Mortality Rate per 1000 births	13.6	4.4	13.2	0	4.9	6.6	9.8	6.5	3.0	4.8	1.5	3.0	3.1

In Q1 of 21/22 we have seen a return to the mortality rates we are used to seeing in the years prior to 20/21, when we had a higher than normal mortality rate. There is an ongoing network collaborative review with another surgical NICU in the region looking at LWH preterm (<32 week) mortality, in addition to the cases themselves it also includes a wider review of service specification and population comparison to identify learning, changes or improvements that may be relevant to the higher than average mortality rates (MBRRACE 2018) we have been seeing in the last few years.

Figure 1. Neonatal mortality

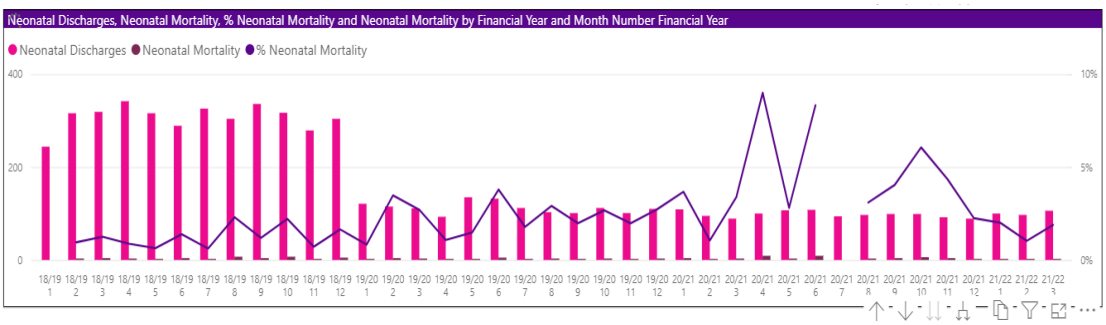


Figure 1 details over time, month by month from 18/19 to 21/22, the discharges and neonatal mortality as bar charts, with the percentage neonatal mortality as the purple line chart. This demonstrates the change we have seen over the last year in the neonatal mortality rates in LWH. The spikes we saw in mortality last year appear to

have settled over the last few months to previous rates. The lower rates are reassuring to see, although we will be monitoring to see if this is sustained.

Table 13 details the mortality for babies born in LWH only, excluding post-natal transfers. Tables 14 and 15 detail the breakdown of the deaths by gestation and cause. As a regional tertiary surgical and cardiac NICU we accept in-utero and post-natal transfers of high-risk babies requiring intensive care after birth and have an increased risk of mortality.

Table 13: NICU Mortality (inborn LWH)

NICU (LWH INBORN)	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Q1 Total
Discharges										100	97	106	303
Total Mortality										2	0	0	**2**
Births	658	677	681	669	605	605	610	618	658	622	654	673	1949
Mortality Rate per 1000 births										3.2	0	0	**1.0**

This tables details the inborn deaths in LWH, in May and June we had no deaths of babies born in LWH.

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

Table 14: Mortality *after* discharge from NICU

	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21
Alder Hey Children's Hospital			1 (LWH		3					2		

			booked)		(2 booked							
Hospice	1 (LWH booked)	1 (non-LWH booked)					2	1		1		
Repatriation to booking hospital												
Home											1	

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

In Q1, 4 babies died after transfer to another care setting, 2 babies died after transfer to AH for surgical management (1 term CDH and 1 extreme preterm with bowel perforation), 2 babies had inoperable complex congenital cardiac abnormalities and were on palliative care pathways 1 was transferred to hospice for end of life care and 1 baby went home for end of life care.

Table 15: All mortality by gestation Q1 21/22

	LWH INBORN mortality	**PNT mortality**	**All mortality**
Extremely preterm (<28 weeks)	2	3	**5**
Very preterm (28-32 weeks)		1	**1**
Moderate preterm (32-37 weeks)	1	1	**2**
Term (>37 weeks)	2		**2**

Table 16 details the breakdown by primary cause of death as stated on the death certificate, overall for Q1 the largest cause of death was congenital abnormalities accounting for 4 out of the 10 deaths this quarter, these included complex congenital cardiac anomalies, congenital diaphragmatic hernia and multi-cystic kidneys with pulmonary hypoplasia. There was also a rare case of Down Syndrome associated leukaemia in a preterm baby during this quarter.

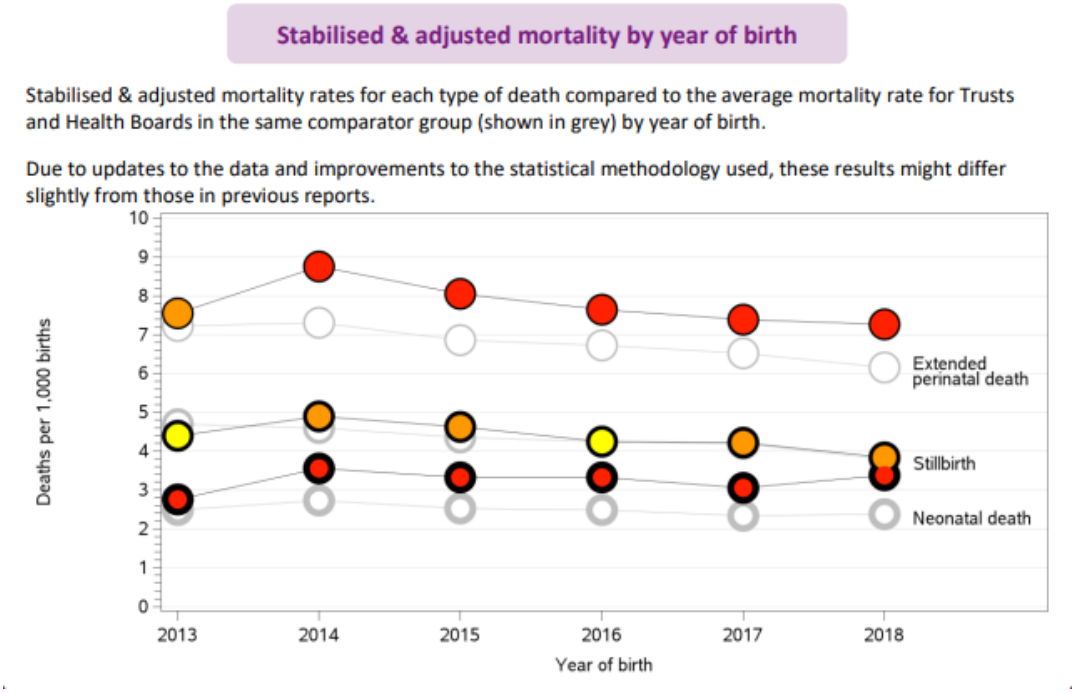
Table 16: All mortality by cause Q1 21/22

	LWH INBORN	Ex-utero transfers	Unbooked	Total
Prematurity	1	1		**2**
Infection		1		**1**
Hypoxic ischaemic encephalopathy				
Congenital abnormality	2	2		**4**
Respiratory				
Cardiovascular				
NEC	1			**1**
Neurological		1		**1**
Other		1		**1**

Benchmarking data

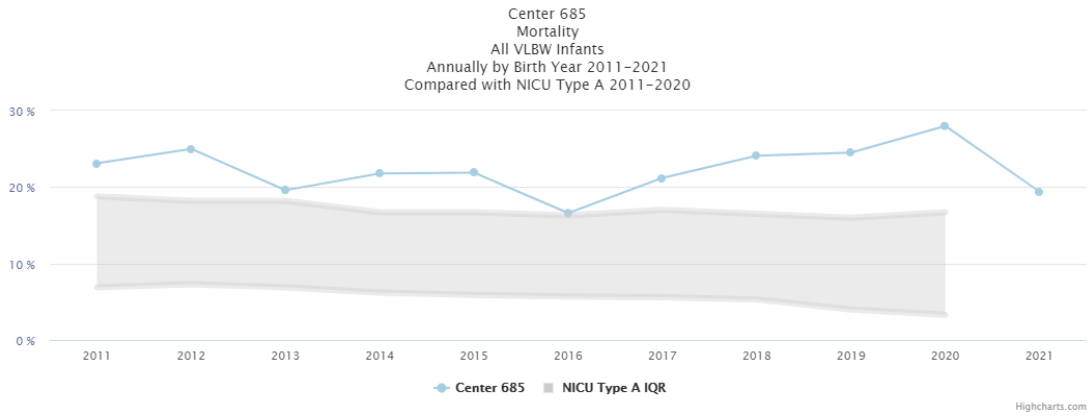
We benchmark our mortality through MBRRACE nationally and the international VON network. MBRRACE has reported most recently on 2018 data, figure 2 demonstrates mortality rates over time, the grey lines demonstrate UK average for the LWH comparator group i.e. other NICUs with neonatal surgery.

Figure 2.



We also benchmark through an international group VON, we can compare within the UK members of this network for various aspects of care, figure 3 is the mortality rates specifically for inborn, VLBW (<1500g) babies over time. The 2020 increase is a notable increase in the deviation away from the IQR over the last few years. Whilst reassuring to see 21/22 trend return towards the IQR, it is too soon to comment on this.

Figure 3



2. Neonatal mortality reviews

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

encompassing all aspects of care. Each case is then assigned a grade (A-D, see below) for each of the following areas: antenatal care, neonatal care and care after the baby has died.

Table 17. Perinatal mortality review tool (PMRT)

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

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

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

Table 18: 20/21 Neonatal Mortality Summary

	Q1	Q2	Q3	Q4	Total
All mortality	10				
NICU deaths	6				
LWH INBORN NICU deaths	**2**				
Mortality rate /1000 births	3.1				

LWH INBORN mortality rate / 1000 births	**1.0**
PMRT Reviews completed	6/10
No. of deaths where any care issues were identified (i.e. grades B/C/D)	
Antenatal	1
Neonatal	4
Care of mother after death of baby	1
No. of deaths where care issues may have or were likely to have affected the outcome (grade C/D)	
Antenatal	0
Neonatal	0
Care of mother after death of baby	0

Overall Recommendations

a. The Board is asked to review the contents of the paper and take assurance that there is adequate process and progress against the requirements laid out by the National Quality Board

b. Take assurance that there are effective processes in place to assure the Board regarding governance arrangements in place to drive quality and learning from the deaths of adults in receipt of care at the Trust.

c. Be aware of the establishment of a Trust mortality review group.

d. A neonatal benchmarking project with St. Mary's, Manchester will report by Q4 of 2021/22.

e. The rate of stillbirth will continue to be monitored.

f. Parents continue to be at the centre of the investigation process.

g. All stillbirths undergo a robust review process where learning is identified and shared.

h. Issues identified at the reviews and recommendations made will now be tracked through the maternity clinical meeting.

i. The Trust will comply with nationally mandated initiatives such as Saving Babies' Lives, CNST, PMRT and MBRRACE-UK.

Liverpool Women's NHS Foundation Trust

COVER SHEET

Agenda Item (Ref)	2021/22/86g		04.11.2021	
Report Title	Gynaecology Inpatient Survey Results 2020			
Prepared by	Diane Taylor Head of Nursing for Gynaecology and Fertility			
Presented by	Marie Forshaw – Chief Nurse & Midwife			
Key Issues / Messages	To celebrate positive the patient survey outcomes and note identified areas for improvement.			
Action required	Approve ☐	Receive ☐	Note ☒	Take Assurance ☐
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable):			
	For Decisions - in line with Risk Appetite Statement – Y/N *If no – please outline the reasons for deviation.*			
	To note the results from the Gynaecology Inpatient Survey 2020			
Supporting Executive:	Marie Forshaw – Chief Nurse & Midwife			

Equality Impact Assessment *(if there is an impact on E,D & I, an Equality Impact Assessment **MUST** accompany the report)*

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

To develop a well led, capable, motivated and entrepreneurial ***workforce***	☐	To participate in high quality research and to deliver the most ***effective*** Outcomes	☐
To be ambitious and ***efficient*** and make the best use of available resource	☐	To deliver the best possible ***experience*** for patients and staff	☒
To deliver ***safe*** services	☒		

Link to the Board Assurance Framework (BAF) / Corporate Risk Register (CRR)

Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* 2.2 Failure to develop our model of care to keep pace with developments and respond to a changing environment 3.1 Failure to deliver an excellent patient and family experience to all our service users	Comment:
Link to the Corporate Risk Register (CRR) – CR Number:	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome

N/A

EXECUTIVE SUMMARY

The National In-Patient Survey data was collected in November 2020. A total of 757 Gynaecology patients from Liverpool Women's Hospital Trust were invited to complete the survey. A total of 391 patients completed the survey, giving a response rate of 52%, which has increase from the previous year of (45%). The average response rate for the 75 'Picker' Trusts was 45%, meaning that as an organisation our response rate was higher than the average. This report includes a presentation on the detailed responses.

1. Key Findings

When compared to "Picker" average scores. LWH scored better than other Trust in a number of elements. The top five scores related to admission and discharge, being provided with written information about what to do or not to do on discharge, not having to wait long for a bed on the ward, patients were involved with decisions about their care and treatment and were not prevented from sleeping at night.

2. Solutions / Actions

Based upon the 2020 scores LWH have improved in 15 of the survey points. However, there are 5 areas where scores have declined from 2019 that require improvement.
The data demonstrates that our patients where not satisfied with the food we are providing them and the quality of care, patients said that they do not get enough help from staff to wash or keep clean.

An action plan has been devised to deliver improvements

3. Conclusion

The Division of Gynaecology have reviewed the entirety of the report and its findings. There are several key areas in which we need to focus attention and implement actions to improve our patient's experience of care. In addition to this there are several areas which should be celebrated and continued.

MAIN REPORT

Introduction
Picker is an international charity dedicated to ensuring the highest quality health and social care for all always.

There are 57 questions which make up the inpatient survey, which are designed to mirror the patient journey through the hospital.

The Picker survey enables the Trust to benchmark against other organisations. By reviewing the survey, the trust can monitor historical trends and themes, which enables focus on those areas. The results also enable the Trust to review areas where performance has improved, which supports assurance and evidence that the effects of any service improvements or change in practice have occurred.

Key improvements:
There have been significant improvements since 2019 survey. LWH have improved in respect of discharge planning and being provided with written information and advice on discharge, assistance with mealtimes improved as patients felt they received enough help from staff to eat meals.

League Table of Results
This year's League table of positive results LWH scores number 9th out of 75 Picker Trusts, last year the Trust were placed at 11th.

The historical league table demonstrates how LWH's overall positive score has changed from last year's survey and how this change compares to other organisations.

The Division is delighted to report that this has seen a significant improvement from 48th to 3rd position.

Historical trends of LWH
Utilising historical trends, the Trust can identify where we have improved or where performance has deteriorated over time.

Areas for Improvement
The areas for improvement noted in the report are as follows –

- Not enough help from staff to wash or keep clean
- Food was not particularly good or fairly good
- Patients did not receive adequate pain control
- Asked to give views on quality of care during stay
- Got enough support from health or social care professionals after discharge

On receipt of the embargoed report, immediate action commenced against the identified areas for improvement. There is an action plan which is monitored through the Matron's senior nurse meeting within the Gynaecology division; escalated to the divisional Governance meeting and discussed at the divisional Board. In addition, the Patient Experience sub-committee will receive the action plan and updates.

Action 1
Not enough help from staff to wash or keep clean

A daily audit is in place with the Ward Manager. All staff have been advised to offer support to all inpatients with regards to hygiene, regardless of the age of the patient.

Action 2
Food was not particularly good or fairly good

OCS have been informed of the survey results in relation to food. The issue is on the agenda for the November Nutrition Group.

Action 3
Patients did not receive adequate pain control

In relation to patients not receiving adequate pain control, a number of actions are in place. A pain assessment tool has been implemented, the audits of this are presented at the 'pain group'. A daily pain round is carried out by the anesthetist. Standard timing is in place for regular medication rounds. Patients prescribed controlled drugs are profiled at the huddle and the controlled drugs are administered first.

The divisional team have reflected on wat has taken place to have impacted on such a positive national inpatient survey. A number of improvement actions have been in place since the feedback of the CQC report of 2019; these include a period of oversight, support and scrutiny within the Executive team.

Change in leadership positions, improvement to support preceptorship, local inductions, training and education. The Gynaecology leadership have availed of the organisational development opportunity to support a change in culture and management capability across the division.

Action 4
Asked to give views on quality of care during stay

Staff are more focussed on encouraging patients to give feedback via friends and family test. In addition, the Manager will complete a daily walkaround, speaking to patients about their care. Matrons will also speak to patients during walkaround. Patient feedback has also been incorporated into the newly developed LWH service accreditation programme.

Action 5
Got enough support from health or social care professionals after discharge

The Matron for Gynaecology is leading on a review of the Trust discharge policy aligned to the newly published guidance.

Recommendation:
Trust Board to note the contents of the Gynaecology Inpatient Survey Results 2020.

Respondents:

Who took part in the survey?

This slide is included to help you interpret responses and to provide information about the population of patients who took part in the survey.

757 invited to take part

391 completed

20% urgent/emergency admission

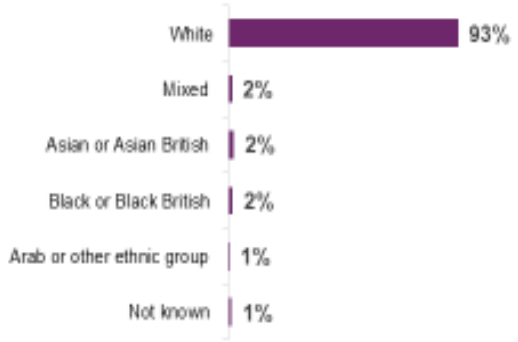
80% planned admission

52% response rate

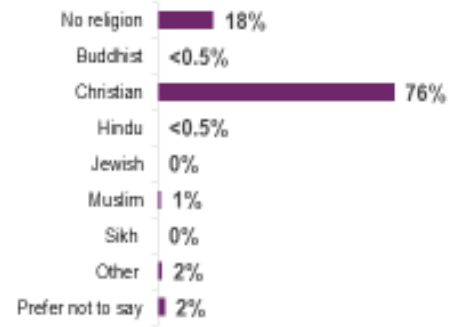
46% average response rate for all trusts

44% response rate for your trust last year

Ethnicity



Religion



Long-term conditions

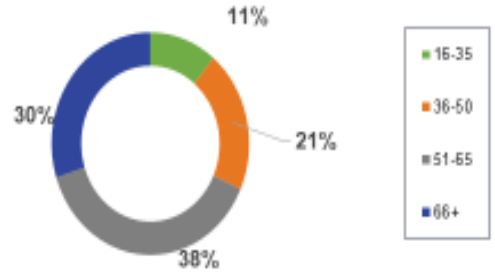
of participants said they have **physical or mental health conditions, disabilities or illnesses** that have lasted or are expected to last 12 months or more (excluding those who selected "I would prefer not to say").

Sex

At birth were you registered as...

1% of participants said their gender is different from the sex they were registered with at birth.

Age



Summary of findings for your trust

Comparison with other trusts

The **number of questions** at which your trust has performed better, worse, or about the same compared with all other trusts.

Comparison with last year's results

Results for the Adult Inpatient 2020 survey are not comparable with results from previous years. This is because of a change in survey methodology, extensive redevelopment of the questionnaire, and a different sampling month. More information on this is available in the survey development report.

The Adult Inpatient 2021 benchmark reports will include an overview of the number of questions at which your trust's performance has significantly improved, significantly declined, or not significantly changed compared with your result from the previous year.

For a breakdown of the questions where your trust has performed better or worse compared with all other trusts, please refer to the appendix section "comparison to other trusts".

Leaving hospital: Q38. Before you left hospital, were you given any written information about what you should or should not do after leaving hospital?

Results for your trust

Much worse than expected | Worse than expected | Somewhat worse than expected | About the same | Somewhat better than expected | Better than expected | Much better than expected

Your trust score compared with all other trusts:

This benchmarking compares the question score for your trust against all other trusts.

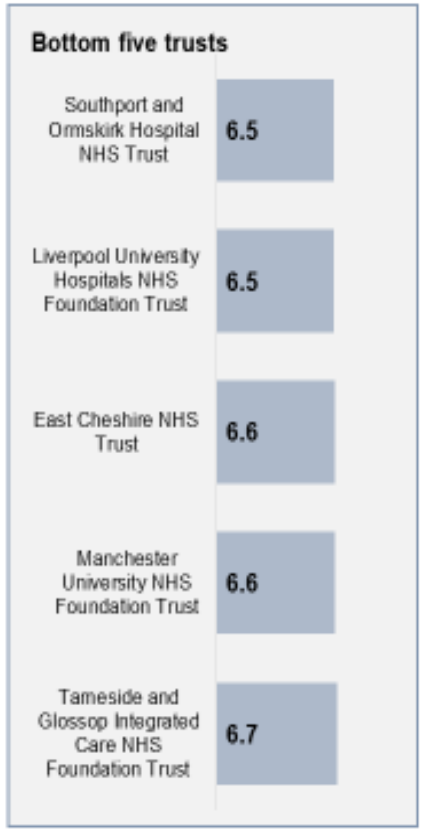
Breakdown of scores for sites within your trust:

This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

Site 1

Liverpool Women's Hospital (371)

Comparison with other trusts within your region



Doctors: Q17. When doctors spoke about your care in front of you, were you included in the conversation?

Results for your trust

Much worse than expected | Worse than expected | Somewhat worse than expected | About the same | Somewhat better than expected | Better than expected | Much better than expected

Your trust score compared with all other trusts:

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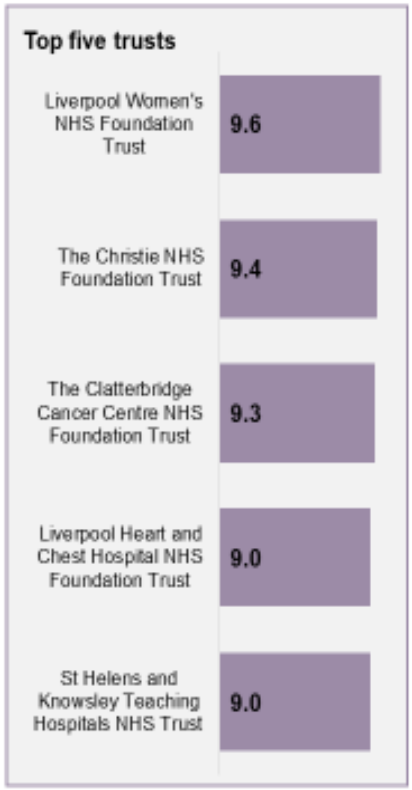
Breakdown of scores for sites within your trust:

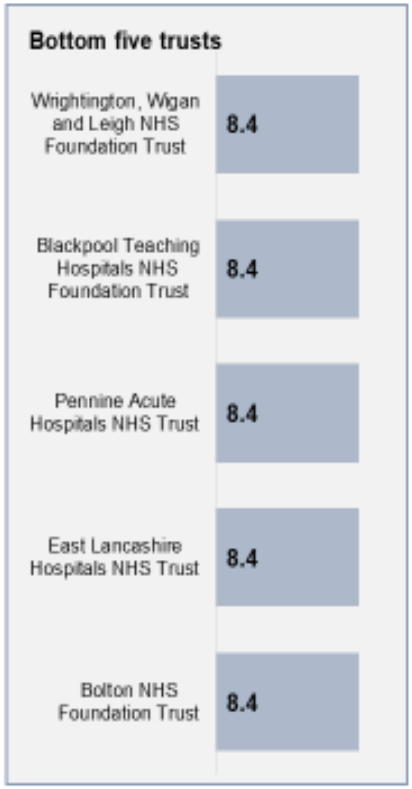
This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

Site 1

Liverpool Women's Hospital (387)

Comparison with other trusts within your region





The hospital and ward: Q5. Were you ever prevented from sleeping at night by noise from other patients?

Results for your trust

Your trust score compared with all other trusts:

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Breakdown of scores for sites within your trust:

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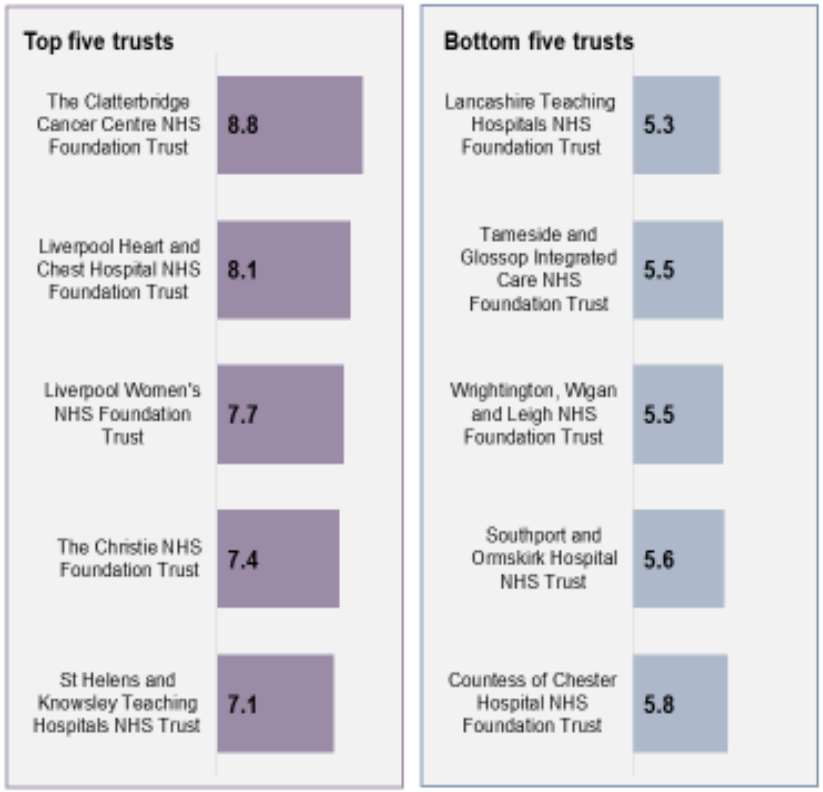
Comparison with other trusts within your region



Admission to hospital: Q3. How long do you feel you had to wait to get to a bed on a ward after you arrived at the hospital?

Results for your trust

Much worse than expected | Worse than expected | Somewhat worse than expected | About the same | Somewhat better than expected | Better than expected | Much better than expected

Your trust score compared with all other trusts:

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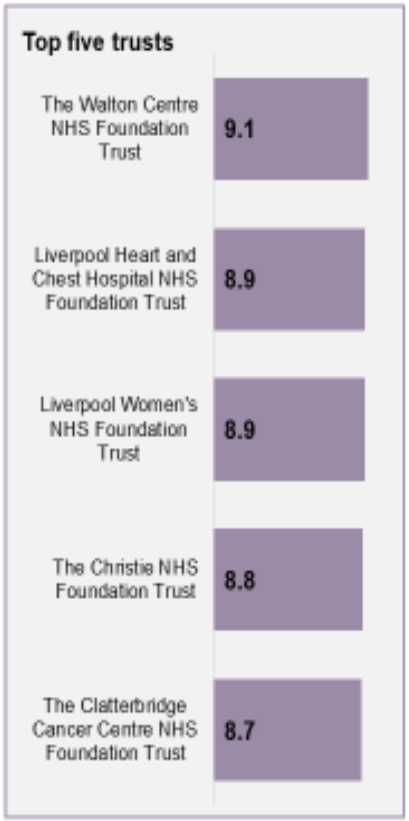
Breakdown of scores for sites within your trust:

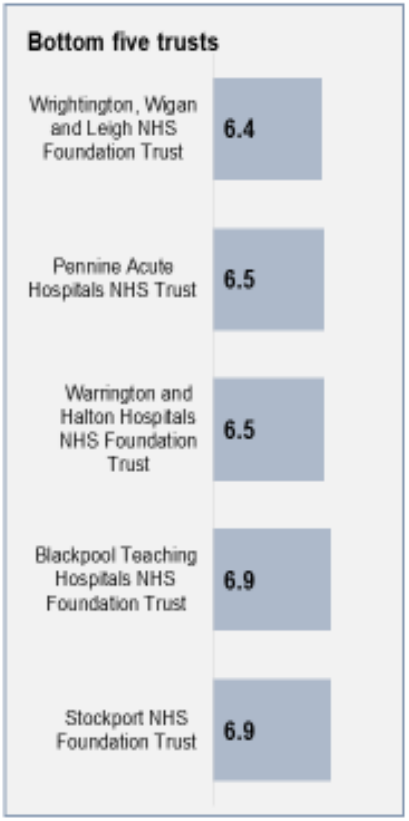
This benchmarking allows you to compare the results for sites within your trust with all other sites across trusts.

Site 1

Liverpool Women's Hospital (382)

Comparison with other trusts within your region





Leaving hospital: Q38. Before you left hospital, were you given any written information about what you should or should not do after leaving hospital?

Results for your trust

Much worse than expected | Worse than expected | Somewhat worse than expected | About the same | Somewhat better than expected | Better than expected | Much better than expected

Your trust score compared with all other trusts:

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Breakdown of scores for sites within your trust:

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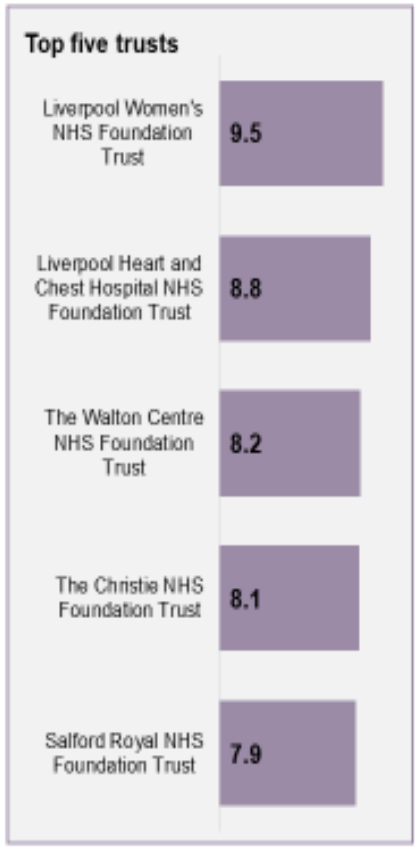
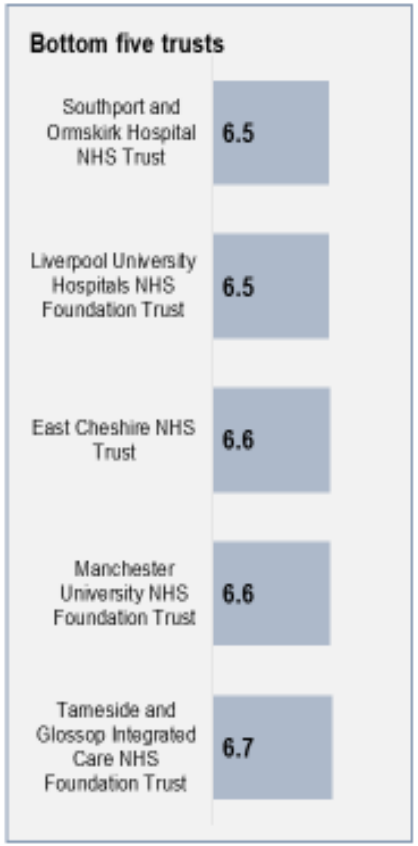
Site 1

Liverpool Women's Hospital (371)

Comparison with other trusts within your region





The hospital and ward: Q13. Did you get enough help from staff to eat your meals?

Results for your trust

Much worse than expected | Worse than expected | Somewhat worse than expected | About the same | Somewhat better than expected | Better than expected | Much better than expected

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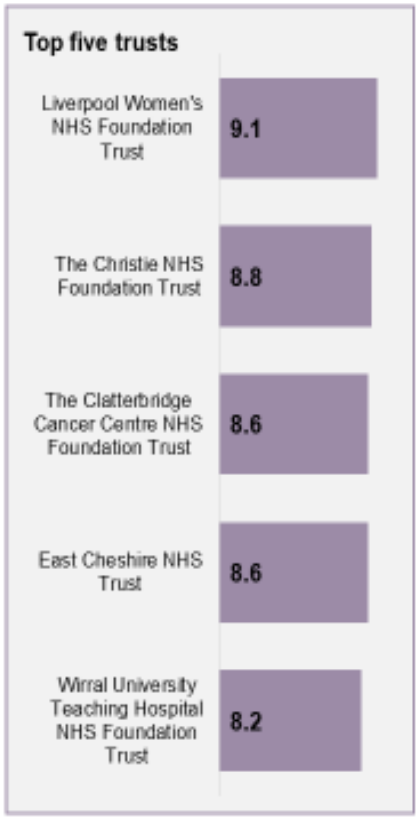
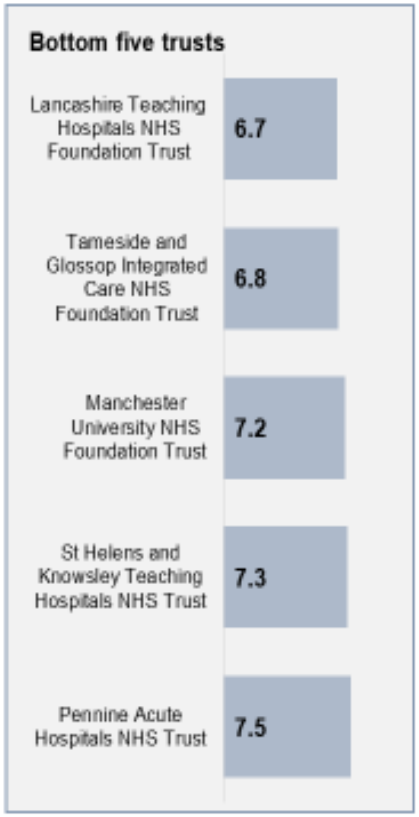
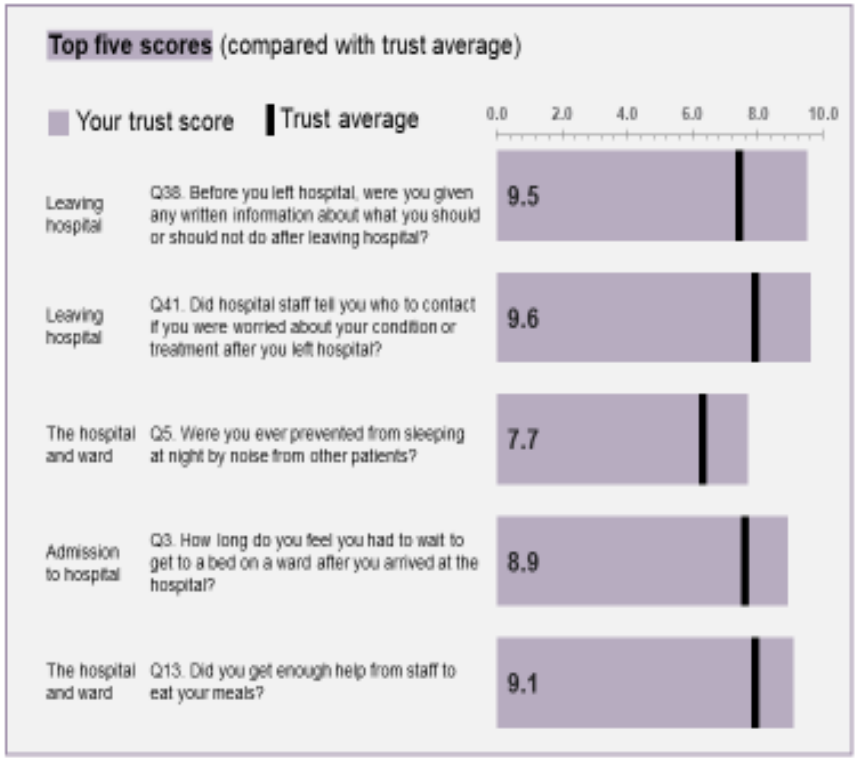




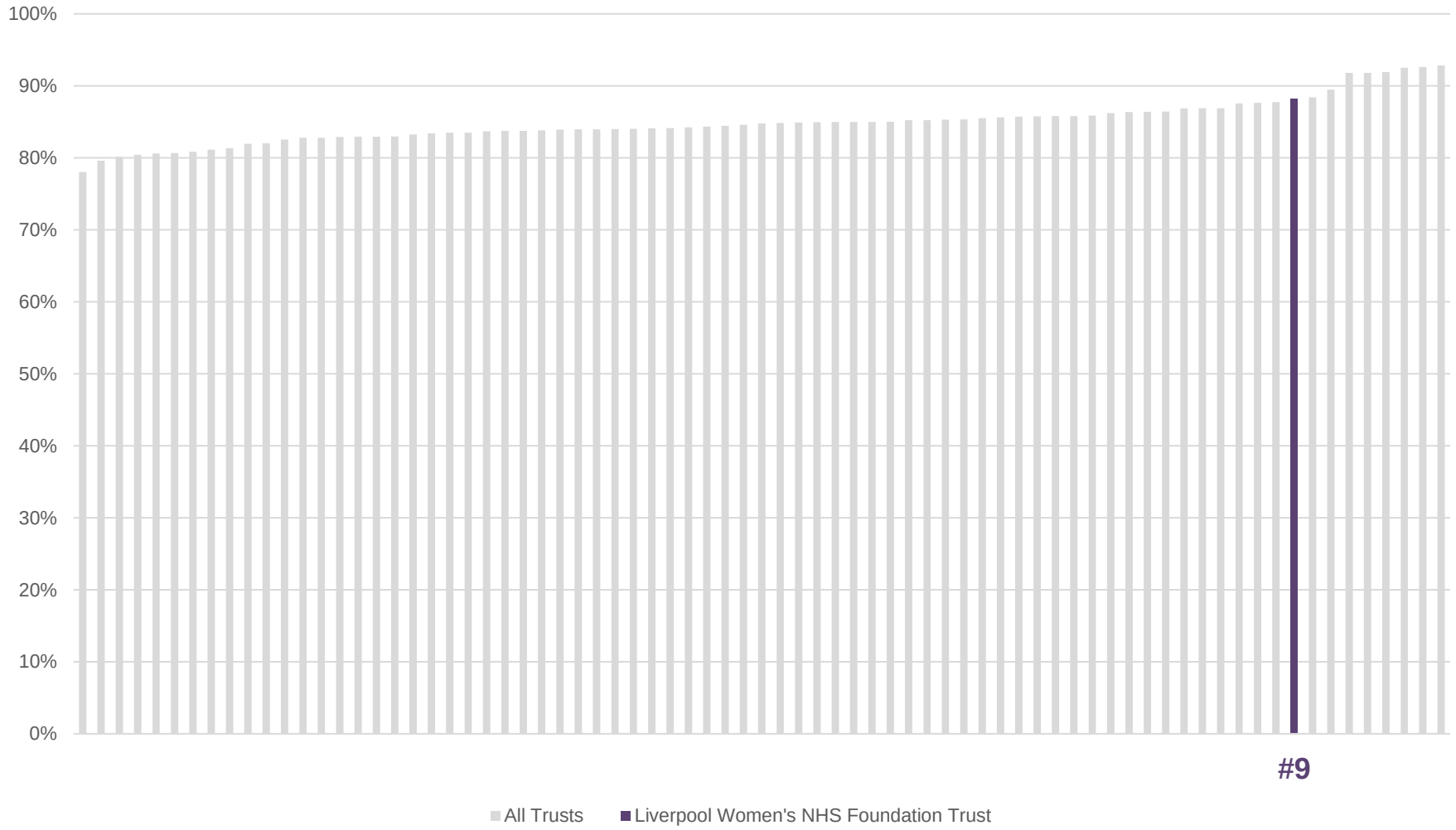
Best and worst performance relative to the trust average

These five questions are calculated by comparing your trust's results to the trust average.

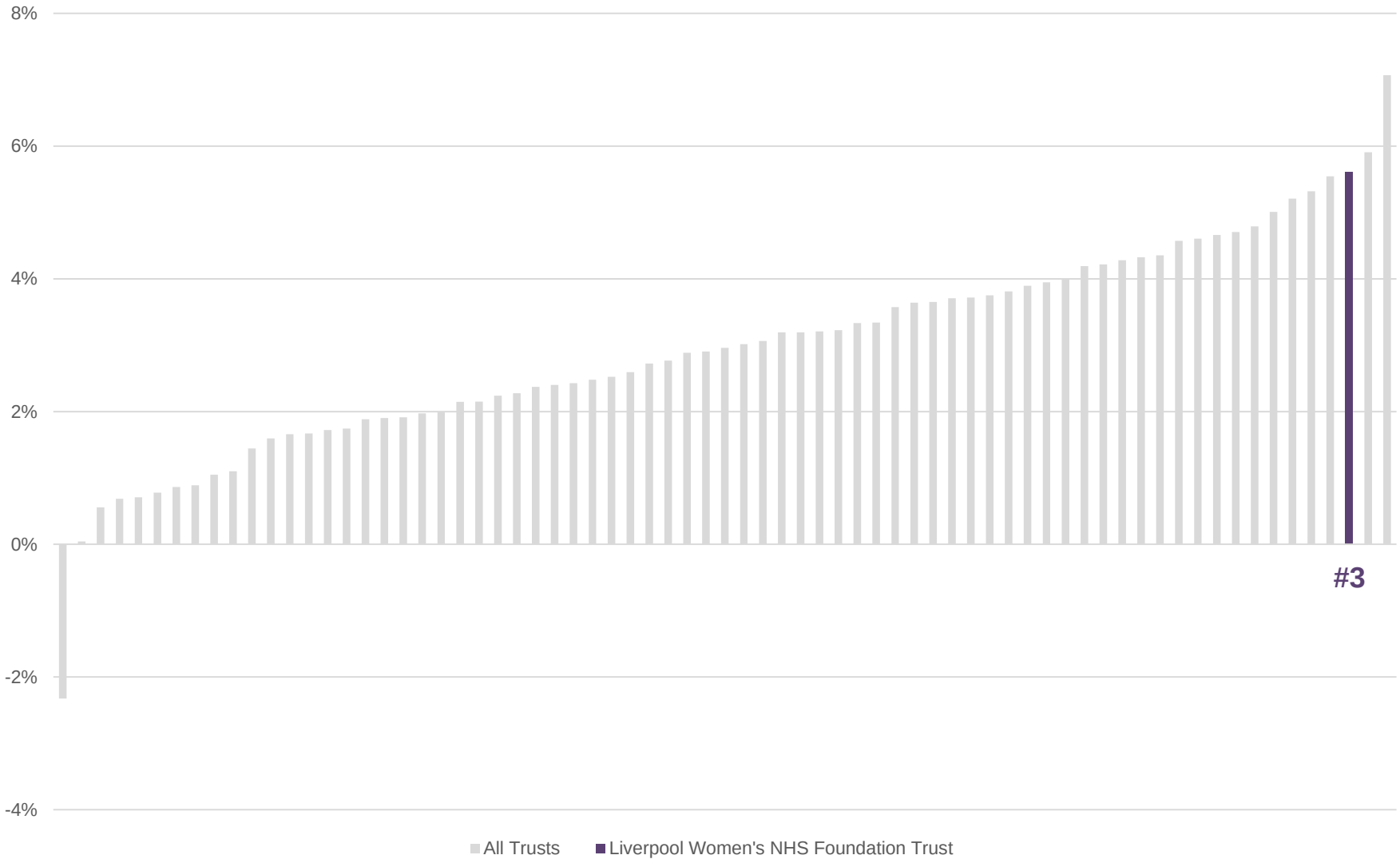
- **Top five scores**: These are the five results for your trust that are highest compared with the trust average. If none of the results for your trust are above the trust average, then the results that are closest to the trust average have been chosen, meaning a trust's best performance may be worse than the trust average.
- **Bottom five scores:** These are the five results for your trust that are lowest compared with the trust average. If none of the results for your trust are below the trust average, then the results that are closest to the trust average have been chosen, meaning a trust's worst performance may be better than the trust average.



Adult Inpatient Survey 2020: Overall Positive Score



Adult Inpatient Survey 2020: Overall Positive Score Change



Quality Committee Chair's Highlight Report to Trust Board
27 September 2021

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Although assured by Sub-Committee Chair Reports, the Committee requested further feedback on the Quality Improvement project on communication issues in Maternity, and noted the number of outdated policies requiring review and the escalation to the Executive Committee to focus on improvement. • The Committee noted that the Trust had been asked to restore Oncology activity levels during Q3 to 2019/20 Q3 levels. The biggest challenge to the Trust was achieving the 62-day target, late referrals and complex diagnostics being cited as the main causes of 62-day breaches. The importance of pathway work and mutual aid was noted to ensure healthcare was delivered to patients from across the Northwest. • Discussed the Clinical Audit Progress update 2021/22 noting the volume of remaining audits to be completed before year-end. The Medical Director confirmed that a rigorous process had been undertaken to review the content of the audit programme into 2021/22 and pull together a systematic timetable.	• Noted that the Trust was placed into direct monitoring by the CQC for maternity services in September 2021. A new intelligence led process whereby the CQC determine when services should be inspected following assessment of Trust responses to the CQC questionnaire. The Chief Nurse and Midwife had collated and submitted the Trust response to the CQC. • Noted developments against the Clinical Quality Strategy and the plans and processes in place to ensure delivery of the Clinical and Quality Strategy for 2021/22. • Following a period of consultation, NHSI/E had recently published the NHS System Oversight Framework 2021/22 which replaces the NHS Oversight Framework for 2019/20. The Trust already reports on many of the indicators listed within the System Oversight Framework and would include the new metrics within the Performance Reports as of September 2021.
Positive Assurances to Provide	**Decisions Made**
• Assured by the contents of the CQC Insight Tool report. Recommended that the report should be shared with divisions to review trends identified. • Assured by the operational report, noting that the Safety indicators remained green for August 2021 with the exception of the Continuity of Care (CoC) targets. Committee noted national discussions to potentially include an index of deprivation factor to the CoC pathway which would significantly impact the service need at this Trust. The link between consistent leadership and improving performance against metrics was noted. • Positively assured by the quality developments since the introduction of the Robotic Assisted Surgery, noting a positive impact on patient quality of care and experience. The dependency on the entire theatre team and not solely the consultant was noted, as was the training requirements. The Committee noted successful delivery of innovative change. • Committee received the Integrated Safeguarding Quality Assurance Report. It was assured by the contents of the quarterly report and agreed to receive a Safeguarding Performance Dashboard alongside the next report. • Assured by the Serious Incident and Learning quarterly report covering the period July and August 2021.	• Committee reviewed the Quality related BAF risks. No changes to existing risks were identified as a result of business conducted during the meeting. • Approved the Research Development & Innovation Sub Committee Terms of Reference. • Approved the Clinical Audit Annual Report 2020/21.

• Received and assured by the contents of the Mortality and Perinatal Report. The Committee was advised that a Mortality Workforce Group had been established to meet quarterly to review mortality across the Trust which would inform content of future quarterly reports. • Noted performance to date against the Corporate Objectives aligned to its terms of reference.	

Comments on Effectiveness of the Meeting / Application of QI Methodology

- Consider how to best capture and track evidence of positive projects and quality of care
- Effective timekeeping.

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
112.	Board Assurance Framework	Assurance	**120.**	Integrated Safeguarding Quality Assurance Report, Quarter 1 2021/22	Assurance
113.	Sub Committee Chair Reports	Assurance	**121.**	Serious Incident and Learning Monthly Update	Assurance
114.	Care Quality Commission Insight Tool	Information	**122.**	Mortality and Perinatal Report (Learning from Deaths)	Assurance
115.	Quality Performance Report Month 5, 2021/22	Assurance	**123.**	Clinical Quality Strategy Update	Information
116.	Progress and challenges to reverting to pre-Covid-19 cancer pathways	Information	**124.**	Clinical Audit Annual Report and Clinical Audit Progress	Assurance
117.	Robotic Assisted Surgery quality impacts	Information	**125.**	NHS System Oversight Framework 2021/22	Information
118.	Ockenden Report	Assurance	**126.**	Corporate Objectives: 6 monthly review	Information
119.	Lookback Review: Central monitoring of CTGs	Assurance			

3. 2021 / 22 Attendance Matrix

Core members	Apr		May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Tony Okotie, Chair	✓	✓	A	✓	✓	A	✓						
Susan Milner	✓	✓	A	✓	✓	✓	A						
Ian Knight	✓	✓	✓	✓	✓	✓	NON MEMBER						
Louise Kenny	✓	✓	✓	✓	✓	✓	A						
Marie Forshaw	✓	✓	✓	✓	✓	A	A						
Gary Price	✓	✓	A	✓	✓	✓	✓						

Lynn Greenhalgh	✓	✓	A	✓	A	✓	✓						
Jenny Hannon	✓	✓	A	✓	✓	✓	✓						
Michelle Turner	✓	✓	✓	✓	✓	✓	A						
Nashaba Ellahi	NON MEMBER			✓	✓	✓	✓						
Christopher Lube	✓	✓	✓	✓	NON MEMBER								
Philip Bartley	NON MEMBER						✓						
Present (✓) Apologies (A) Representative (R) Nonattendance (NA) *Non-quorate meetings highlighted in greyscale*													

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

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate

- Two items relating to the Family Health Division were required to be deferred to the next scheduled meeting. It was agreed that the November 2021 Committee meeting would focus on matters relating to the Family Health Division.
- An increase in incidents in the maternity service was reported and it was also noted that there had been delays in reviewing incidents due to capacity challenges. The maternity service is establishing a 'Perinatal Surveillance Team' to help coordinate reviewing incidents and triangulate learning.
- It was noted that there continued to be a high number of policies that had passed their review date. Targeted monthly meetings were being held with relevant areas to expedite the review and updating of policies.
- Performance for the 52 week wait position has plateaued, largely due to reduced planned theatre sessions as a result of sickness absence. The importance of increasing capacity to drive improvements in this area over the coming months was noted, particularly in the context that the Trust would not be subject to the same winter pressures as other acute trusts.
- The Cancer 62-day target remained a significant challenge. A task and finish group had bene established to identify immediate internal improvements whilst the NW cancer Alliance had commissioned a longer-term project to address the regional optimal pathway improvements.
- Noted that complaints response performance was below target. Work to process map was underway which was hoped to identify areas for improvement.
- Three issues were raised from the Maternity Safety Champion report and it was noted that these would be highlighted to the Board during the presentation of the Chair's Report:
    - Issues with K2 GROW Charts and the surveillance of fetal growth in pregnancy
    - Issues with timely review of clinical incidents
    - 1:1 Care in Labour

Major Actions Commissioned / Work Underway

- A discussion was held on how to receive assurance most effectively at the Committee regarding issues that required escalation from the Family Health Division (and other Divisions). The Committee requested particular assurance on the Family Health Executive Oversight arrangements at the November 2021 meeting.
- Noted that work continued to finalise the Maternity Safety Tool Assessment with outputs to be reported to the November 2021 Board.
- Noted that the Trust was placed into direct monitoring by the CQC for maternity services in September 2021. No response had been received to date following the submission made by the Trust.
- The Committee requested that further assurance be provided on the Trust's progress to strengthen its pathways for patients under the age of 18 (a need identified by the most recent CQC report).
- A discussion was held regarding the guidance that the Trust had given that only one investigation should be conducted led by HSIB for maternity incidents, despite this potentially resulting in delays to the identification of learning. It was agreed that a watching brief should be kept on the process to review how it embeds.

Positive Assurances to Provide

- The Committee received an outline of the process to complete the Trust's CNST Year 4 submission. Assurance was received that lessons had bene learned from the Year 3 submission.
- Progress against identified improvements for the Trust's medicine management processes was noted. It was requested that further improvements be made to the report to ensure that there was clarity on whether the issues identified by the CQC inspection had been fully closed down.

Decisions Made

- Committee reviewed the Quality related BAF risks. The Committee agreed to recommend to the Board the addition of a new BAF risk relating to Cyber-Security. There was agreement that whilst the impact of a cyber-attach would be wide-ranging the most acute issue would relate to patient safety.

Comments on Effectiveness of the Meeting / Application of QI Methodology
• No comments made

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
135.	Board Assurance Framework	Assurance	142.	Maternity Incentive Scheme (CNST) Year 4 – Scheme Release & Overview of Compliance Process	Information
136.	Sub Committee Chair Reports	Assurance	143.	Family Health Safety Champion Update	Information
137.	Quality Performance Report Month 6, 2021/22	Assurance	144.	Serious Incidents & Learning Report Quarter 2, 2021/22	Assurance
138.	Quality and Regulatory Update	Information	145.	Medicines Management Assurance Report Quarter 2, 2021/22	Assurance
139.	Maternity Safety Self-Assessment Tool	Information	146.	Legal Services	Assurance
140.	Lookback Review Central monitoring of CTGs	Deferred	147.	LocSSIPs Quarterly Assurance Report Q2	Assurance
141.	Never Events Update: Family Health	Deferred	148.	Seven Day Services Bi-Annual Update	Information

3. 2021 / 22 Attendance Matrix

Core members	Apr		May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Tony Okotie, Chair	✓	✓	A	✓	✓	A	✓	A					
Susan Milner	✓	✓	A	✓	✓	✓	A	✓					
Ian Knight	✓	✓	✓	✓	✓	✓	NON MEMBER						
Louise Kenny	✓	✓	✓	✓	✓	✓	A	✓					
Marie Forshaw	✓	✓	✓	✓	✓	A	A	✓					
Gary Price	✓	✓	A	✓	✓	✓	✓	✓					
Lynn Greenhalgh	✓	✓	A	✓	A	✓	✓	✓					
Jenny Hannon	✓	✓	A	✓	✓	✓	✓	Non-Member					
Eva Horgan	Non-Member							✓					
Michelle Turner	✓	✓	✓	✓	✓	✓	A	✓					
Nashaba Ellahi	NON MEMBER			✓	✓	✓	✓	A					
Christopher Lube	✓	✓	✓	✓	NON MEMBER								
Philip Bartley	NON MEMBER						✓	A					

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

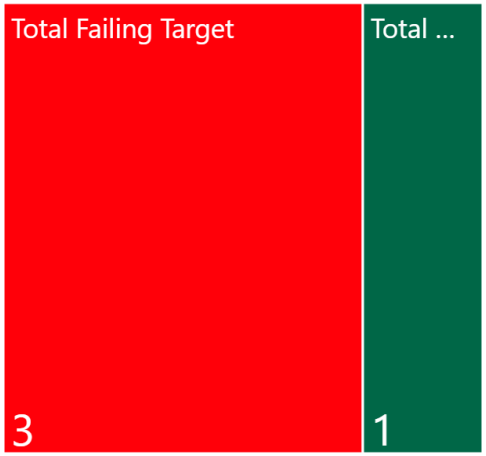
Liverpool Women's NHS Foundation Trust

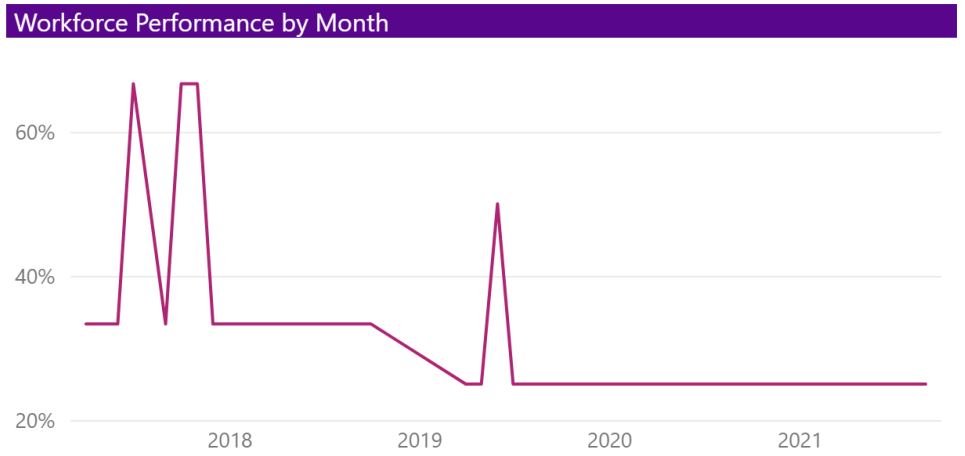
Workforce Performance

Trust Board

November 2021

To develop a well led, capable, motivated and entrepreneurial **W**orkforce



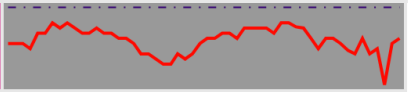
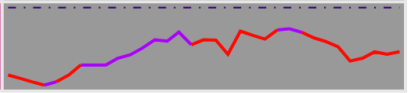


Mandatory Training
- Mandatory training Task and Finish Group chaired by the Chief Information Officer is progressing well with good engagement from divisional representatives
- Key areas of progress include all mandatory training now accessible from a single point of access, making it quicker and easier for staff

Absence
- New absence approach launches on 1st November 2021 and this is being supported by wellbeing coaching training for managers and part of a wider focus on wellbeing

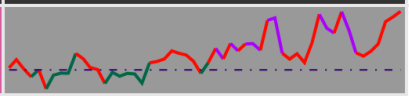
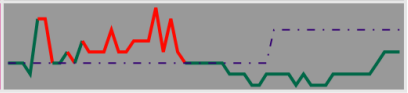
Leadership
- 40 leaders at Bands 7 and 8, mainly from within nursing and midwifery are commencing the new LWH Leadership and Management Development Programme at the end of October

To develop a well led, capable, motivated and entrepreneurial Workforce - Mandatory Training

KPI Owner	KPI	As of Date	Current Value	KPI Status	Target	Denominator	DQ Kite Mark	Trend
Chief People Officer	Mandatory Training Compliance	September 2021	89.00%	-6.00%	95.00%			
	Clinical Mandatory Training Compliance	September 2021	81.91%	-13.09%	95.00%			

KPI	KPI Narrative
Clinical Mandatory Training Compliance	The overall Trust clinical mandatory training compliance increased by 1% from 81% in month five, to 82% in month six. This is now 13% under the Trust's target rate of 95% and rated as amber. In the largest clinical areas, compliance increased by 3% in Gynaecology and by 1% Maternity, but fell by 2% in Neonates. At the divisional level, compliance increased by 3% in the Gynaecology Division, and by 2% in the Clinical Support Services, remained unchanged in Family Health, but fell by 2% in the Corporate Division. The HR and L&D teams continue to provide support, information, and training to managers across the Trust. A task and finish group, headed by the Chief Information Officer, has now been established to look at E-Learning as a whole, and try and identify ways of making it more accessible and effective, and to ensure that the associated data and reporting are accurate. As a result of the group's work, auto-enrolment will commence from 1st November, which will make enrolment easier and recording more accurate. Local mandatory training audits have commenced, as have annual reviews of each mandatory training course to ensure that they have the right content, and that requirements are correct in terms of which staff are mandated to complete the course. There have been some technical issues with medicine management and conflict resolution courses which have now been resolved. While every effort is being made to improve and maintain compliance rates, it is difficult to accurately predict when the target figure of 95% will be achieved, particularly in light of the continuing covid 19 global pandemic and the pressures it has created both operationally and in terms of staffing. High sickness levels will also be having an impact. Nevertheless, every endeavour continues to be made to bring the figure within Trust target through effective collaboration between line managers, Human Resources and Learning & Development.
Mandatory Training Compliance	The overall Trust mandatory training compliance increased by 1%, from 88% in month five, to 89% in month six. This is now only 6% under the Trust's target rate of 95% and rated as amber. In the largest clinical areas, compliance increased by 3% in Gynaecology, but fell by 1% in Maternity, and by 2% in Neonates. At the divisional level, compliance fell by 1% in Family Health, but increased by 2% in the Gynaecology Division, by 3% in Clinical Support Services, and by 2% in the Corporate Division. The HR and L&D teams continue to provide support, information, and training to managers across the Trust. A task and finish group, headed by the Chief Information Officer, has now been established to look at E-Learning as a whole, and try and identify ways of making it more accessible and effective, and to ensure that the associated data and reporting are accurate. As a result of the group's work, auto-enrolment will commence from 1st November, which will make enrolment easier and recording more accurate. Local mandatory training audits have commenced, as have annual reviews of each mandatory training course to ensure that they have the right content, and that requirements are correct in terms of which staff are mandated to complete the course. While every effort is being made to improve and maintain compliance rates, it is difficult to accurately predict when the target figure of 95% will be achieved, particularly in light of the continuing covid 19 global pandemic and the pressures it has created both operationally and in terms of staffing. Nevertheless, every endeavour continues to be made to bring the figure within Trust target through effective collaboration between line managers, Human Resources and Learning & Development.

To develop a well led, capable, motivated and entrepreneurial Workforce

KPI Owner	KPI	As of Date	Current Value	KPI Status	Target	Denominator	DQ Kite Mark	Trend
Chief People Officer	Sickness Absence Rate	September 2021	8.35%	+3.85%	4.50%	40660		
	Turnover Rate	September 2021	11.00%	-2.00%	13.00%			

KPI	KPI Narrative
Sickness Absence Rate	The single month sickness absence figure increased by 0.36%, from 7.99% in month five, to 8.35% in month six. This is now 3.85% above the Trust's target figure of 4.50% and is therefore rated as red. In the largest clinical areas, sickness absence increased by 1.94% in Maternity, but fell by 0.41% in Gynaecology, and by 1.60% in Neonates. At divisional level, sickness increased by 0.67% in Family Health, and by 0.94% in Clinical Support Services, but fell by 0.77% in the Gynae Division, and by 0.82% in the Corporate Division. Overall, the proportion of sickness that was short term went back up, from accounting for 28% in month five, to 33% in month six. In terms of diagnosis, the top three most common again remained unchanged: cold/cough/flu is the most prevalent diagnoses, followed by anxiety/stress/depression, and then gastrointestinal problems. The figure for sickness specifically resulting from covid 19 again continued to rise, reaching 2.37 % in month six (up from 1.94% in month five). In recognition that sickness, in particular short-term sickness are influenced by a number of wider work related factors, key actions are as follows: • Delivery of programme of wellbeing activities • Support for managers to have conversations with their staff about their health and wellbeing, this includes a day course for 20 line managers on wellbeing coaching • Annual wellbeing conversations for every staff member (supported by training) • Annual career conversations as part of PDR • Leadership Programme launched at the end of October • New retention and development roles focused on maternity and HCAS • Active review and management of LTS including temporary roles wherever possible • Planned recruitment of staff facing psychologist The programmes to deliver the covid booster vaccination and the flu vaccination began with an intensive week-long rollout from 4th October, walkaround sessions A fundamental revision of the Trust's Attendance Management Policy is underway, and the new policy will be launched next month, alongside an updated return to work form and monitoring process. Efforts to reduce sickness absence are on-going and individual divisions have developed trajectories for return to work of staff who have been absent long term. Covid-19 has exacerbated existing trends of high sickness absence in certain areas, hence sickness is being addressed through the wider lens of wellbeing.

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	***2021/22/087b***		**Date: 04/11/2021**	
Report Title	**Supporting Staff Wellbeing: The North West Pledge**			
Prepared by	**Rachel London, Deputy Director of Workforce**			
Presented by	**Michelle Turner, Chief People Officer and Deputy Chief Executive**			
Key Issues / Messages	**The North West NHS has developed a wellbeing pledge which all Trust Boards are being asked to sign up to**			
Action required	**Approve ☒**	**Receive ☐**	**Note ☐**	**Take Assurance ☐**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	***To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it***	***For the intelligence of the Board / Committee without in-depth discussion required***	***To assure the Board / Committee that effective systems of control are in place***
	Funding Source (If applicable): NA			
	For Decisions - in line with Risk Appetite Statement – Y ***If no – please outline the reasons for deviation.***			
	The Board is asked to sign the Pledge on behalf of LWH and support the ongoing work to enhance employee wellbeing at LWH.			
Supporting Executive:	**Michelle Turner, Chief People Officer / Deputy Chief Executive**			

Equality Impact Assessment *(if there is an impact on E,D & I, an Equality Impact Assessment **MUST** accompany the report)*							
Strategy ☐	Policy ☐	Service Change ☐	Not Applicable ☒				
Strategic Objective(s)							
To develop a well led, capable, motivated and entrepreneurial ***workforce***	☒	To participate in high quality research and to deliver the most ***effective*** Outcomes	☐				
To be ambitious and ***efficient*** and make the best use of available resource	☐	To deliver the best possible ***experience*** for patients and staff	☒				
To deliver ***safe*** services	☐						

Link to the Board Assurance Framework (BAF) / Corporate Risk Register (CRR)	
Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* 1.2 Failure to recruit and retain key clinical staff	Comment:

Link to the Corporate Risk Register (CRR) – CR Number:	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
N/A			

EXECUTIVE SUMMARY

This paper asks trust boards in the North West to sign up to a pledge of commitment in relation to employee wellbeing. The stated aim of the pledge is to 'shift the focus around health and wellbeing from the (approximately) 5% of staff in the North West who are off sick, to the 95% who are in work and contributing'.

The paper outlines the detail of the pledge commitments and, at a high-level benchmarks, LWH against best practice, whilst providing a brief overview of some of the Trust's activities within the wellbeing sphere to deliver the outcomes of the Putting People First Strategy.

Wellbeing of the workforce is one of the primary themes of the Trust's longstanding People Strategy; accordingly, there has been significant investment in wellbeing and recent recruitment to a senior leadership role to drive the agenda. The Trust has already an ambitious programme to support wellbeing which takes into account factors including environment, leadership, culture, recognition, involvement & psychological support.

It is recommended that the Board sign up to the Wellbeing Pledge as a clear statement of LWH's ongoing commitment to embedding a sustainable approach to staff wellbeing which places it at the heart of all people related activities and interventions.

The supporting delivery plan will be considered by PPF Committee in November 2021 and subsequently will be presented to the Board.

Liverpool Women's
NHS Foundation Trust

MAIN REPORT

INTRODUCTION

Through North West HR Directors Forum in partnership with NHS Employers, a Wellbeing Pledge for the region has been developed, which boards are asked to sign up to by the end of November, and by the end of December to agree an organisational action plan.

This paper provides an assessment of LWH's current position against the individual actions within the pledge, provides a reminder of the research evidence around wellbeing and a contextual update of other HWB interventions at LWH.

RESEARCH BASIS FOR HEALTH AND WELLBEING

Research undertaken by the RAND Foundation for NHS Employers have evidenced a clear link between low staff engagement and low productivity. They found that the costs of 'presenteeism', unproductive employees at work, was much greater than the costs of absence. Therefore, there is a need for organisations to focus attention more explicitly on the **95% of staff in work**, rather than the 5% who are absent

Key factors influencing both better mental health and increased productivity:

- Employees feel like they belong at work
- Their line manager cares about their wellbeing

The research concludes that despite the NHS as a whole having a extensive wellbeing offer, this offer is not sufficiently tailored to staff needs and is consequently not well utillised.

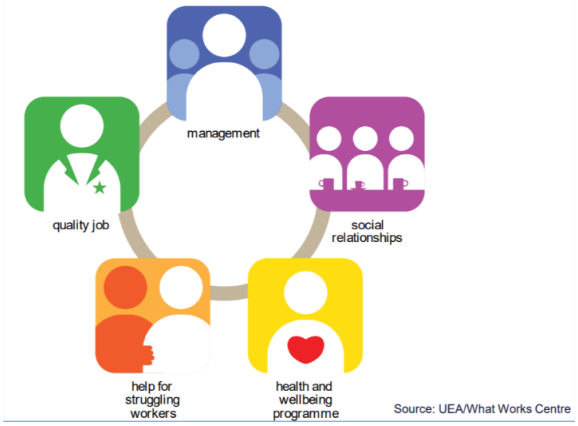
Putting health and wellbeing in the context of recovery, the NHS Confederation Report *'Putting People First, Supporting NHS Staff in the aftermath of Covid-19'* reached the following conclusions

- Addressing staff HWB means also addressing long standing vacancies and issues of bullying and discrimination
- Investment in HWB should consider on wellbeing hubs and restorative supervision but must be individualised
- Recognition and reward must continue
- Visible, compassionate leadership where staff can speak up and feel supported.
- Giving staff more control over how they organise their own work

It is clear that health and wellbeing interventions cannot sit in isolation but are part of a well-rounded approach to effective people management and engagement, which is outlined in the infographic (from RAND) below, and echoes the approach taken within the Putting People First Strategy.

Liverpool Women's NHS Foundation Trust

ASSESSMENT OF CURRENT PERFORMANCE

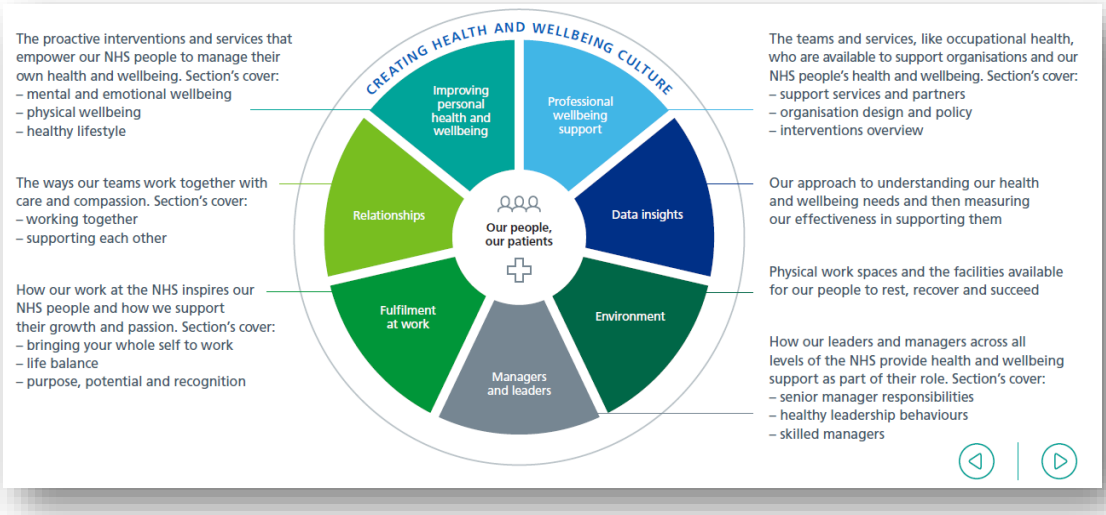


In considering health and wellbeing in a holistic context of overall good people leadership as recommended by the RAND research, LWH benchmarks as follows:

	Positive Indicators	Areas for Development
Management	Comprehensive leadership programme Access to coaching support Management Development offer Reciprocal mentoring	Stagnant staff survey scores around quality of line management
Social Relationships	Increased programme of team interventions using Ice Creates methodology (a team culture diagnostic tool) BE KIND programme linked to organisational values & behaviours	Score average or above on staff survey Capacity to deliver as many team interventions as we may want
Health and Wellbeing Programme	Developing a comprehensive offer under the WE CARE brand	Historically not been delivered on the clinical areas and hard for staff to access
Help for struggling workers	Counselling service provided by Mersey care, C&M Resilience Hub, on site resilience training, Mental health first aiders, REACT trained individuals (MH support programme), staff supporters, Professional Midwifery Advocates, Great Place to Work group	No current in house psychological support services but funding identified to recruit psychologist to head up staff support team
Quality Job	Revamped PDR approach including Career Conversation	Historically quality of appraisal rated low in staff survey.

Liverpool Women's
NHS Foundation Trust

The NHS has also developed a **Health and Wellbeing checklist** based on the evidence and insights gathered on staff health and wellbeing since the start of the COVID-19 pandemic in early 2020. LWH has been benchmarked against the recommendations and is on track to address them all. Progress against our ambitions will be monitored via a detailed Wellbeing action plan, regularly reviewed and tested by the Putting People First Committee.



Health and wellbeing organisational checklist

Environment	**LWH Response**
• Appropriate and accessible rest spaces • Access to appropriate PPE at all times • Accessible water points • Accessible toilet and changing facilities	• Water fountains to be installed in all clinical areas • Staff rooms in process of being upgraded • PPE all in place • Planned improvements to lockers • Green space (zen garden) & quiet staff only space provision (conservatory) • Rest pods in clinical areas • Improving healthy food offer (including out of hours)
Managers and leaders	
• Wellbeing Guardian appointed and helping to set HWB agenda by understanding Organisational priorities, informed by Model Health System	• Wellbeing Guardian was appointed, recent change to Board Member • Wellbeing Conversations commenced

• Health and wellbeing conversations promoted and encouraged • Role-modelling of high-quality wellbeing conversations	
Relationships	
• Development of wellbeing champions and opportunities to access proactive wellbeing activities and support	• Established Health and Wellbeing Committee, divisional representation recently been refreshed, chaired by Consultant Obstetrician • Refresh of organisational values & associated behaviours under the BE KIND banner
Improving personal health and wellbeing	
• Signposting to available HWB offers at local (e.g Occupational Health), ICS, regional (e.g. Mental Health Hubs) and national level (e.g access to financial support) • Active promotion of local Mental Health Hub • Emotional support that is culturally sensitive and meets the diverse needs of the workforce	• In place, C&M Resilience Hub have offered to do some team interventions • Development of psychological support offer ongoing
Professional wellbeing support	
• Annual leave policy ensures staff have regular time off for rest • Staff are encouraged to participate in health and wellbeing training and development opportunities, for individuals and for teams, and given the time to do so • A communications plan for HWB is in place, which includes regular information on the support available and progress being made • Effective and compassionate risk assessments for at risk staff (such as those who are clinically extremely vulnerable) • Occupational Health Service provider sharing how it can support teams and individuals • Support following distressing incidents/interactions e.g. through Compassionate Conversations	• Annual leave and e-roster policies support appropriate rest • 20 Ward Managers are currently being trained in wellbeing coaching • WE CARE branded programme of HWB activities and offer circulated to all staff with the 'Wellbeing Bags' • All staff risk assessed; ongoing risk assessment compliance being audited; wellbeing conversation to include identification of risk & response • Just Culture methodology being integrated into SI and de-briefing processes • Psychologist will also provide training and support following distressing incidents
Data insights	

• Engaging with staff to understand other support needed - e.g. childcare support and support for working carers	• Staff with caring responsibilities recorded on ESR • LWH engaged in national Flex for the Future programme looking at promoting even more opportunities for flexible working • Wellbeing conversation to identify non work factors impacting on health, performance, attendance

The establishment of a £100k Health and Wellbeing Budget (partly funded by charitable monies) has been instrumental in delivering some key wellbeing activities

- 15 days of 'Inspire Talkz', Rugby Players delivering face to face training and coachng around resilience which is already gaining positive feedback from 'hard to reach' groups including Delivery Suite
- Purchase of 3 sleep pods to aid rest and relaxation in the midst of busy clinical areas
- Upgrade of staff room facilities in clinical areas Trust wide
- Distribution of 'Wellbeing Bags' to every member of staff
- Promotion of wellbeing awareness days including talks with front line members of staff about mental health for mental health awareness day and talks, stands, promotions and events for Men's Health Week and Menopause Awareness Day.
- Refurbishment of conservatory and development of wildflower and zen gardens

It should be noted that neither of these two assessments take into account 'hygiene factors' of sufficient staff who are deployed efficiently. Without this, improvements in staff wellbeing will not be achieved. As a Trust, we are actively over-recruiting in key clinical services to take into account attrition, maternity leave, retirement intentions; the Trust is exploring international recruitment and undertaking a review of recruitment practice as a whole, including onboarding and testing experience at key points in an employee cycle.

THE PLEDGE

The overall pledge for the North West NHS, states a commitment to *shifting the well-being focus from the 5% to the 95%*

Specific pledges, which individual Trust Boards are asked to sign up to, are outlined below. It is recommended that LWH be at the forefront of promoting wellbeing and be a visible and enthusiastic signatory. The pledges are aligned with the work already being undertaken at LWH, specifically the changes to the Attendance Policy which come into effect in November, are reflected in the pledges below.

Preparing our Board for the change:

- Why presenteeism is of at least equal importance to sickness absence **At LWH we are starting to change the language, less focus on talking about absence and more about staff who are here and contributing, celebrating contribution & achievement.**
- Significant policy shift - from a focus on sickness absence to holistic well-being and from rigid attendance management to a more person centred & flexible approach **At LWH our updated sickness policy is to be launched in November including a move away from short term sickness stages to holistic wellbeing conversation to support staff**

- Considerations for ethics, equality, diversity and inclusion - moving away from treating everyone the same to more individualised and person-centred approaches
- How the approach aligns with embedding a just culture **At LWH, Wellbeing is overseen by the Head of Culture and Staff Experience who has a responsibility to co-ordinate both work plans**

Evidencing that well-being is a priority at our Trust Board by:

- Understanding the well-being of our people and how we are meeting their needs, giving staff a safe voice
- Showing how a well-being lens is applied to all decisions
- Understanding our organisation's culture, including what has been normalised, taking positive action to address the issues and support our People

Committing to the three NW themes of enabling work:

- Well-being services that support the 95%
- A new person-centred well-being and attendance management policy framework **As above the new Attendance Policy will be significantly different in tone and content.**
- Leadership development that supports managers in our new approach **LWH is part of a regional programme of wellbeing coaching for ward managers along with 2 other Trusts.**

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RECOMMENDATION

The Board is asked to

- sign the Pledge on behalf of LWH and support the ongoing work to enhance employee wellbeing at LWH.

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

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Maternity clinical mandatory training compliance raised as a continued area of concern. Committee noted the Maternity Oversight Group was working to drive improvements and requested a trajectory be included within the next workforce report from Family Health. • Committee remained concerned with findings from an audit of breaks of a sample of nurses and midwives. Further work including the Matrons was recommended with a report back to Committee. • The Committee was moderately assured by the Equality, Diversity and Inclusion (EDI) Update noting the volume of information provided and the difficulty to surmise assurance. It was noted that overall the Trust was not performing at the position it sought. The report would be developed with the support of the EDI Committee. • The Committee was assured that the Trust was appropriately focused on the objective to 'Involve and Empower our People' and noted the number of initiatives in place. However, it was not assured that the activities described had increased staff engagement and motivation. It was agreed that more work seeking staff views through existing groups e.g. Medical Staff Committee would be useful. It was noted that cultural change would not be quick to embed or evidence.	• Noted a Task and Finish Group chaired by the Chief Information Officer to review ESR and OLM systems with a focus to make system navigation as easy as possible to improve training rates. • Committee requested Trust Board support to develop and drive forward the business case for the Virtual Training Platform. • Following a period of consultation, NHSI/E had recently published the NHS System Oversight Framework 2021/22 which replaces the NHS Oversight Framework for 2019/20. The Trust already reports on many of the indicators listed within the System Oversight Framework and would include the new metrics within performance reporting as of September 2021.
Positive Assurances to Provide	**Decisions Made**
• Received a presentation on the Virtual Training Platform developed by the Trust. The platform had been developed within the Trust and through partnerships with external health education partners. The potential to grow across all clinical pathways and non-clinical and the potential for income generation was noted. The Committee acknowledged that the development team required support to drive the initiative forward and recommended that a Business Case be formed. • Noted funding identified to provide psychological support to staff as an important component of the staff wellbeing programme and designed to minimise psychological harm to staff and in turn reduce sickness absence. • Assured by the Corporate Response to Ockenden Recommendations. • Assured by the update on development and career pathways for the role of Midwife available at the Trust. The development pathways to progression were evidenced as active and successful based on internal promotions offered on an ongoing basis. • Assured by the contents of the Medical Appraisal and Revalidation Annual Report 2020/21 and the Pharmacy Revalidation Annual Report. • Committee received and noted the first Responsible Officer Quarterly Report as recommended by MIAA. • Noted the progress of the Leadership and Talent Strategic Framework and recommended actions to ensure the success of the leadership programme.	• Reviewed the PPF aligned BAF risks, no changes recommended. Consistency of narrative between the BAF and Corporate Risk Register was identified. • Approved the proposal to suspend the short-term stages of the Absence Management process for a period of 12 months. Updates to be provided within KPI reports. • On behalf of the Trust Board approved the 'statement of compliance' Annex D confirming that the organisation, as a designated body, is in compliance with the regulations and fulfilling all the requirements for revalidation. Annex D required CEO sign off following Board approval. • Committee ratified the policies received for approval.

• Accepted the assurance provided and supported the continued use of shared services, working in partnership with larger local NHS organisations, where they allow the Trust to provide effective and cost-efficient solutions. • Noted performance to date against the Corporate Objectives aligned to its terms of reference.	

Comments on Effectiveness of the Meeting / Application of QI Methodology

- There had been good challenge and robust discussion

2. Summary Agenda

No.	Agenda Item	Purpose	Rating	No.	Agenda Item	Purpose	Rating
49.	Board Assurance Framework (BAF): Workforce related risks	Assurance		58.	Equality, Diversity and Inclusion including WRES/WDES/Gender Pay Gap Update and ED&I Strategy and Workplan	Assurance	
50.	Virtual Training Platform	Information		59.	Staff Engagement Update	Assurance	
51.	Chief People Officer Report	Information		60.	Leadership & Talent Strategic Framework – An Update	Information	
52.	Workforce KPI Dashboard Report	Assurance		61.	Outsourced Services Contract Review	Assurance	
53.	Absence Management – Audit and proposed new approaches	Approval		62.	Policies for Approval	Approval	
54.	Development and career pathways for the role of Midwife	Assurance		63.	NHS System Oversight Framework 2021/22	Information	
55.	Nursing & Midwifery Framework (nee Strategy) Draft	Assurance		64.	Corporate Objectives 2020/21: Designated PPF Objectives First Review	Information	
56.	Breaks Audit Report	Assurance		65.	Subcommittee chairs reports	Assurance	
57.	Revalidation a) Medical Appraisal and Revalidation Annual Report 2020/21 b) Responsible Officer Quarterly Report Q1, 21/22 c) Pharmacy Revalidation Annual Report	Assurance					

3. 2021 / 22 Attendance Matrix

Core members	May	Jun	Sep	Nov	Jan	Mar
Jo Moore	✓	A	NM			
Dr Susan Milner	A	✓	✓			
Tracy Ellery	A	✓	✓			
Louise Martin	Non member	✓	✓			
Michelle Turner	✓	✓	✓			
Marie Forshaw	✓	✓	✓			

Gary Price	✓	✓	✓			
Claire Scott	A	✓	A			
Liz Collins	✓	✓	✓			
Dyan Dickins	Vacant	Vacant	✓			
Present (✓) Apologies (A) Representative (R) Nonattendance (NA) Non-Member (NM) *Non-quorate meetings highlighted in greyscale*						

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	**2021/22/88a**		**Date: 04/11/2021**	
Report Title	**Finance Performance Review Month 6 2021/22**			
Prepared by	***Claire Scott, Acting Deputy Chief Finance Officer***			
Presented by	***Eva Horgan, Chief Finance Officer***			
Key Issues / Messages	***To note the Month 6 financial position.***			
Action required	**Approve ☐**	**Receive ☐**	**Note ☒**	**Take Assurance ☐**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	***To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it***	***For the intelligence of the Board / Committee without in-depth discussion required***	***To assure the Board / Committee that effective systems of control are in place***
	Funding Source (If applicable): N/A			
	For Decisions - in line with Risk Appetite Statement – If no – please outline the reasons for deviation.			
	The Board is asked to note the Month 6 Financial Position			
Supporting Executive:	***Eva Horgan, Chief Finance Officer***			

Equality Impact Assessment *(if there is an impact on E,D & I, an Equality Impact Assessment **MUST** accompany the report)*							
Strategy	☐	Policy	☐	Service Change	☐	Not Applicable	☒

Strategic Objective(s)			
To develop a well led, capable, motivated and entrepreneurial ***workforce***	☐	To participate in high quality research and to deliver the most ***effective*** Outcomes	☐
To be ambitious and ***efficient*** and make the best use of available resource	☒	To deliver the best possible ***experience*** for patients and staff	☐
To deliver ***safe*** services	☐		

Link to the Board Assurance Framework (BAF) / Corporate Risk Register (CRR)	
Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks*	Comment:

4.1 Failure to ensure our services are financially sustainable in the long term	
Link to the Corporate Risk Register (CRR) – CR Number: N/A	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
N/A			

EXECUTIVE SUMMARY

The Trust has delivered its half year financial position against the April to September (H1) plan. However, this has been reliant on non-recurrent items due to shortfalls on the Cost Improvement Programme (CIP) and Elective Recovery Fund (ERF), as well as pay overspends. A full plan for the second half of the year (H2) has not yet been agreed but is in the process of being developed and agreed with the Cheshire and Merseyside Health and Care Partnership (HCP) in line with national guidance and timetables. This plan will be subject to Board sign off.

As at Month 6 the Trust achieved its H1 target. The cash position improved from the previous month however CIP and ERF remain behind plan. Capital spend is still considerably behind plan Year to Date (YTD) but is expected to increase. Note that NHSI/E plan to change metrics under the new System Operating Framework but the guidance for these have not yet been released.

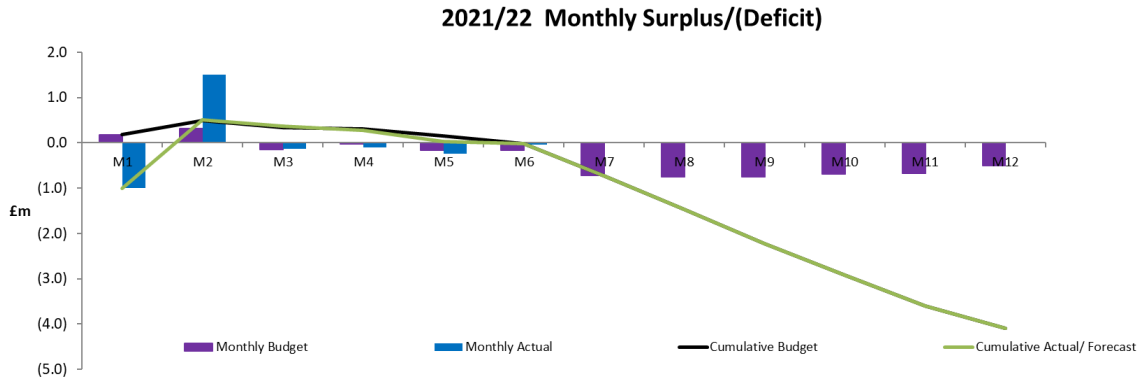
	Plan	Actual	Variance	RAG	*R*	*A*	*G*
H1 Surplus FOT	£0.0m	£0.0m	£0.0m	↔			
NHS I/E Rating	3	3	0	↔	*4*	*3*	*2+*
Cash	£4.5m	£4.2m	-£0.3m	↑	*<£1m*	*£1m-£4.5m*	*£4.5m+*
Total CIP Achievement	£0.7m	£0.5m	-£0.3m	↔	*>10% off plan*	*0-10% off plan*	*Plan or better*
Recurrent CIP Achievement	£0.7m	£0.4m	-£0.3m	↔	*>10% off plan*	*0-10% off plan*	*Plan or better*
Elective Recovery Fund (net)	£1.5m	£1.3m	-£0.3m	↔	*>10% off plan*	*0-10% off plan*	*Plan or better*
Non - Recurrent Items YTD	£0.0m	£1.7m	£1.7m	↓	*>£0*	-	*£0*
Capital Spend YTD	£4.5m	£2.0m	-£2.5m				

MAIN REPORT

1. Summary Financial Position

At Month 6 the Trust is reporting a Year to Date (YTD) deficit of £14k, against a £12k deficit plan, meaning that the Trust has delivered its (H1) plan. Note that the October to March (H2) budget as originally approved by the Board has not yet been revised, but planning with Cheshire & Merseyside is underway. This is subject to agreement at a C&M level and approval by the Trust Board.

Note that due to the financial challenges facing the Trust, a Financial Recovery Board has been set up, chaired by the Chief Finance Officer, which is reporting in to the Executive Team and Finance, Performance and Business Development Committee.



2. Divisional Summary Overview

In a change from 2020/21, divisions do now have income targets which are based on their agreed activity plans costed using Payment by Results (PbR) tariffs, although this is reconciled at a trust wide level to the blocks and top ups actually received.

Elective Recovery Fund (ERF) income has been estimated and included in the trust wide position but not at divisional level. No ERF is expected for Quarter Two either at LWH or across Cheshire & Merseyside as a whole.

The impact of the pay award YTD is included in the Month 6 position, in line with NHSI guidance.

Family Health: The division's position is now £573k overspent YTD in Month 6, a deterioration of £123k since Month 5. This is largely due to a significant pay overspend.

Gynaecology: The division is now £1.6m overspent YTD, primarily relating to activity and income being behind plan; this has been significantly impacted by reduced access to theatres (reduction of 25-30% compared to plan).

No ERF was earned in Quarter 2, as activity was below the threshold of 95% of 2019/20 activity.

Clinical Support Services: The Division have a YTD underspend of £254k. Agency spend in theatres remains high although this is offset by underspends on consultant anaesthetists.

Agency: Agency spend across the Trust is now a significant concern and is in danger of breaching the agency ceiling which has been re-introduced in NHSI/E monitoring. Total agency spend is now £1.1m YTD, of which £870k was in Quarter 2. Work is going on to resolve this on a number of fronts including the procurement team working on rates with agencies, the introduction of NHS Professionals to manage temporary staffing and divisions looking at usage to try to bring this down.

3. Elective Recovery Fund

The Elective Recovery Fund in H1 was been put in place to incentivise providers to undertake more elective activity and to pay for the additional costs associated with this. It is measured using a baseline of 2019/20 data and uses SUS[1] data which is not finally validated until three months after the activity is complete. The baseline increased in Month 4 to 95% of 2019/20 data. LWH have not achieved the increased target and therefore the YTD ERF is £1.2m, all due to Quarter 1 delivery. Note that the mechanism for ERF is changing in H2.

Note that the ERF is measured on a financial baseline not activity. Note also that the activity below is not adjusted for Termination of Pregnancy activity, although this is still being rigorously pursued with the national team and ICS.

A summary of the Trust's estimate for Month 6 YTD is given below. Further detail is given in the appendix.

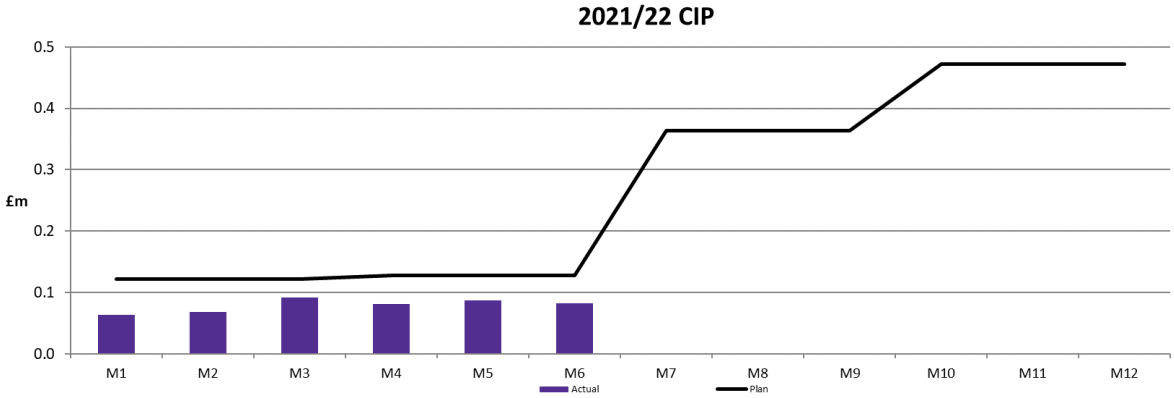
	2019/20		2021/22				
Point of Delivery	**Activity**	**Costed Activity £000**	**Activity**	**Costed Activity £000**	**ERF £000**	**% Activity**	**% Costed Activity**
Daycases	3,300	2,372	1,728	1,370	-146	52%	58%
Elective Inpatients	701	2,215	716	2,545	515	102%	115%
Outpatients	38,491	4,192	35,179	3,943	608	91%	94%
Outpatient Prcedures	9,999	2,161	10,580	1,863	342	106%	86%
Other					*-46*		
Total		**10,939**		**9,721**	**1,273**		**89%**

4. CIP

CIP is still behind plan and this is being managed with divisions individually and via the Senior Management Team meeting, which is being refocussed to give greater time to CIP and Transformation.

The graph below shows performance to Month 6.

[1] https://digital.nhs.uk/services/secondary-uses-service-sus



5. COVID-19

The Trust spent £677k on direct Covid-19 related costs YTD to Month 6, against a plan of £987k. A budget is in place for 2021/22 in line with the plan agreed with the HCP. Further detail is given in the Appendix.

6. Cash and Borrowings

The closing cash balance in Month 6 is £4.2m. This is now closer to plan. Additional temporary cash support via Cheshire & Merseyside and Liverpool CCG has been agreed from Quarter Three, pending agreement of the H2 plan, but the medium and long term position still remains a risk.

Close monitoring of the cash position has been in place for some time and will continue; this includes review of each payment run and detailed daily cashflow forecasts.

7. Capital Expenditure

Capital expenditure was relatively low again in month. It is expected to increase in coming months as expenditure under the Procure 22 Guaranteed Maximum Price (GMP) is now underway, and the works in relation to the Fetal Medicine Unit are now nearly complete.

8. BAF Risk

There are no proposed changes to the BAF score.

9. Conclusion & Recommendation

The Board is asked to note the position.

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

FINANCE REPORT: M6

YEAR ENDING 31 MARCH 2022

Liverpool Women's NHS Foundation Trust

Contents

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 1
NHS IMPROVEMENT RATIOS: M06
YEAR ENDING 31 MARCH 2022

USE OF RESOURCES RISK RATING	YEAR TO DATE Actual
CAPITAL SERVICING CAPACITY (CSC)	
(a) EBITDA + Interest Receivable	3,899
(b) PDC + Interest Payable + Loans Repaid	1,109
CSC Ratio = (a) / (b)	**3.51**
NHSI CSC SCORE	**1**
Ratio Score 1 = > 2.5 2 = 1.75 - 2.5 3 = 1.25 - 1.75 4 = < 1.25	
LIQUIDITY	
(a) Cash for Liquidity Purposes	(13,551)
(b) Expenditure	62,374
(c) Daily Expenditure	341
Liquidity Ratio = (a) / (c)	**(39.8)**
NHSI LIQUIDITY SCORE	**4**
Ratio Score 1 = > 0 2 = (7) - 0 3 = (14) - (7) 4 = < (14)	
I&E MARGIN	
(Surplus) / Deficit (Adjusted for donations and asset disposals)	13
Total Income	(66,272)
I&E Margin	**0.0%**
NHSI I&E MARGIN SCORE	**2**
Ratio Score 1 = > 1% 2 = 1 - 0% 3 = 0 - (-1%) 4 < (-1%)	
I&E MARGIN VARIANCE FROM PLAN	
I&E Margin (Actual)	0.00%
I&E Margin (Plan)	0.00%
I&E Variance Margin	**0.0%**
NHSI I&E MARGIN VARIANCE SCORE	**2**
Ratio Score 1 = > 0% 2 = (1) - 0% 3 = (2) - (1)% 4 = < (2)%	
Note: NHSI assume the score of the I&E Margin variance from Plan is a 1 for the whole year and year to date budget. This is because NHSI recognise the fact that an organisation would not "plan" to have a variance from plan and have not applied a calculated ratio to the budgeted columns of this metric.	
AGENCY SPEND	
YTD Providers Cap	894
YTD Agency Expenditure	1,081
	21%
NHSI AGENCY SPEND SCORE	**2**
Ratio Score 1 = < 0% 2 = 0% - 25% 3 = 25% - 50% 4 = > 50%	
Overall Use of Resources Risk Rating	**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: M6
YEAR ENDING 31 MARCH 2022

INCOME & EXPENDITURE	Month 6			YTD			YEAR
£'000	Budget	Actual	Variance	Budget	Actual	Variance	Budget
Income							
Clinical Income	(10,386)	(11,179)	794	(63,026)	(63,131)	105	(119,206)
Non-Clinical Income	(576)	(479)	(97)	(3,456)	(3,141)	(314)	(7,118)
Total Income	**(10,962)**	**(11,658)**	**696**	**(66,482)**	**(66,272)**	**(209)**	**(126,324)**
Expenditure							
Pay Costs	6,279	7,175	(895)	37,465	39,105	(1,640)	74,317
Non-Pay Costs	2,562	2,326	236	15,370	13,785	1,585	28,740
CNST	1,581	1,581	0	9,484	9,484	0	18,968
Total Expenditure	**10,422**	**11,081**	**(659)**	**62,319**	**62,374**	**(55)**	**122,025**
EBITDA	**(539)**	**(577)**	**38**	**(4,163)**	**(3,899)**	**(264)**	**(4,299)**
Technical Items							
Depreciation	501	462	39	2,985	2,803	182	6,022
Interest Payable	3	3	(0)	20	21	(2)	39
Interest Receivable	0	0	0	0	0	0	0
PDC Dividend	195	158	37	1,170	1,088	82	2,340
Profit/Loss on Disposal or Transfer Absorption	0	0	0	0	0	0	0
Total Technical Items	**699**	**623**	**76**	**4,174**	**3,913**	**262**	**8,401**
(Surplus) / Deficit	**160**	**46**	**114**	**12**	**14**	**(3)**	**4,102**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST **2a**
INCOME & EXPENDITURE HOSTED SERVICES: M6
YEAR ENDING 31 MARCH 2022

INCOME & EXPENDITURE £'000	Month 6 Budget	Month 6 Actual	Month 6 Variance	YTD Budget	YTD Actual	YTD Variance
Income						
Clinical Income	(544)	(289)	(256)	(1,533)	(720)	(813)
Non-Clinical Income	0	(20)	20	0	(20)	20
Total Income	**(544)**	**(308)**	**(236)**	**(1,533)**	**(740)**	**(793)**
Expenditure						
Pay Costs	176	66	110	538	277	260
Non-Pay Costs	368	240	128	995	459	536
Total Expenditure	**544**	**305**	**239**	**1,533**	**737**	**796**
(Surplus) / Deficit	**0**	**(3)**	**3**	**0**	**(3)**	**3**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 3
EXPENDITURE: M6
YEAR ENDING 31 MARCH 2022

EXPENDITURE £'000	MONTH Budget	MONTH Actual	MONTH Variance	YEAR TO DATE Budget	YEAR TO DATE Actual	YEAR TO DATE Variance	YEAR Budget
Pay Costs							
Board, Execs & Senior Managers	359	405	(45)	2,133	2,084	49	4,288
Medical	1,685	1,950	(265)	10,023	10,171	(148)	19,953
Nursing & Midwifery	2,682	3,199	(517)	16,002	17,077	(1,075)	31,754
Healthcare Assistants	483	101	382	2,904	2,442	462	5,565
Other Clinical	396	451	(55)	2,355	2,341	14	4,838
Admin Support	616	770	(154)	3,698	3,911	(212)	7,309
Agency & Locum	58	299	(241)	350	1,080	(730)	610
Total Pay Costs	**6,279**	**7,175**	**(895)**	**37,465**	**39,105**	**(1,640)**	**74,317**
Non Pay Costs							
Clinical Suppplies	775	729	46	4,612	4,408	204	8,219
Non-Clinical Supplies	589	591	(2)	3,552	3,181	370	6,897
CNST	1,581	1,581	0	9,484	9,484	0	18,968
Premises & IT Costs	710	516	194	4,270	3,861	409	7,994
Service Contracts	488	490	(2)	2,936	2,334	602	5,631
Total Non-Pay Costs	**4,143**	**3,906**	**236**	**24,854**	**23,268**	**1,585**	**47,708**
Total Expenditure	**10,422**	**11,081**	**(659)**	**62,319**	**62,374**	**(55)**	**122,025**

Note that the values above exclude £737k in relation to hosted services.

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 4
COVID EXPENDITURE: M6
YEAR ENDING 31 MARCH 2022

EXPENDITURE	MONTH			YEAR TO DATE		
£'000	Budget	Actual	Variance	Budget	Actual	Variance
Pay Costs						
Board, Execs & Senior Managers	0	0	0	0	1	(1)
Medical	0	0	0	0	4	(4)
Nursing & Midwifery	45	21	24	305	184	121
Healthcare Assistants	27	15	11	166	78	88
Other Clinical	0	0	(0)	0	2	(2)
Admin Support	21	29	(9)	134	156	(21)
Agency & Locum	15	9	6	90	58	32
Total Pay Costs	**107**	**74**	**33**	**695**	**482**	**213**
Non Pay Costs						
Clinical Suppplies	9	5	4	76	45	31
Non-Clinical Supplies	0	1	(1)	6	(7)	13
CNST	0	0	0	0	0	0
Premises & IT Costs	33	17	16	210	136	74
Service Contracts	0	5	(5)	0	20	(20)
Total Non-Pay Costs	**42**	**28**	**14**	**292**	**194**	**98**
Total Expenditure	**149**	**102**	**47**	**987**	**677**	**310**

Note that the values above include £7k YTD related to Vaccination and LAMP Testing expenditure which should both be reimbursed.

NHS
Liverpool Women's
NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 5
BUDGET ANALYSIS: M5
YEAR ENDING 31 MARCH 2022

INCOME & EXPENDITURE	MONTH			YEAR TO DATE			YEAR
£'000	Budget	Actual	Variance	Budget	Actual	Variance	Budget
Maternity							
Income	(4,000)	(4,549)	549	(24,002)	(24,325)	323	(48,003)
Expenditure	1,962	2,560	(598)	11,770	12,856	(1,087)	23,462
Total Maternity	**(2,039)**	**(1,990)**	**(49)**	**(12,232)**	**(11,469)**	**(763)**	**(24,541)**
Neonatal							
Income	(1,743)	(1,861)	118	(10,460)	(10,627)	167	(20,920)
Expenditure	1,240	1,432	(192)	7,440	7,416	24	14,851
Total Neonatal	**(503)**	**(429)**	**(74)**	**(3,020)**	**(3,210)**	**190**	**(6,069)**
Division of Family Health - Total	**(2,542)**	**(2,419)**	**(123)**	**(15,252)**	**(14,679)**	**(573)**	**(30,610)**
Gynaecology							
Income	(2,041)	(1,997)	(45)	(12,248)	(11,391)	(858)	(24,547)
Expenditure	1,110	1,349	(239)	6,653	7,210	(557)	13,225
Total Gynaecology	**(931)**	**(648)**	**(283)**	**(5,596)**	**(4,181)**	**(1,415)**	**(11,321)**
Hewitt Centre							
Income	(767)	(923)	156	(4,589)	(4,628)	40	(9,449)
Expenditure	699	847	(147)	4,196	4,397	(201)	8,140
Total Hewitt Centre	**(68)**	**(76)**	**8**	**(393)**	**(231)**	**(161)**	**(1,310)**
Division of Gynaecology - Total	**(999)**	**(724)**	**(275)**	**(5,988)**	**(4,412)**	**(1,576)**	**(12,631)**
Theatres							
Income	0	0	0	0	0	0	0
Expenditure	829	876	(46)	4,975	5,032	(57)	9,858
Total Theatres	**829**	**876**	**(46)**	**4,975**	**5,032**	**(57)**	**9,858**
Genetics							
Income	(13)	(10)	(3)	(75)	(40)	(35)	(150)
Expenditure	144	144	(0)	862	772	90	1,725
Total Genetics	**131**	**134**	**(3)**	**787**	**733**	**55**	**1,575**
Other Clinical Support							
Income	(367)	(549)	182	(2,203)	(2,513)	310	(4,451)
Expenditure	636	644	(8)	3,802	3,857	(54)	7,353
Total Clinical Support	**269**	**95**	**174**	**1,599**	**1,343**	**256**	**2,902**
Division of Clinical Support - Total	**1,229**	**1,105**	**125**	**7,361**	**7,108**	**254**	**14,335**
Corporate & Trust Technical Items							
Income	(2,574)	(2,077)	(497)	(14,438)	(13,489)	(949)	(22,336)
Expenditure	5,045	4,159	887	28,328	25,487	2,841	55,345
Total Corporate	**2,472**	**2,082**	**390**	**13,890**	**11,998**	**1,893**	**33,009**
(Surplus) / Deficit	**160**	**43**	**117**	**12**	**14**	**(2)**	**4,102**
Of which is hosted;							
Income	(544)	(308)	(236)	(1,533)	(740)	(793)	(3,533)
Expenditure	544	305	239	1,533	737	796	3,533
Total Corporate	**0**	**(3)**	**3**	**0**	**(3)**	**3**	**0**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 6
CIP: M6
YEAR ENDING 31 MARCH 2022

Scheme	Month 4 Target	Month 4 Actual	Month 4 Variance	YTD Target	YTD Actual	YTD Variance
Procurement and Non Pay	89	49	(41)	524	280	(245)
Estates Utilisation	0	0	0	0	0	0
Staffing and Skill Mix	17	17	0	101	101	0
Outpatients Utilisation	0	0	0	0	0	0
Medicines Management	0	0	0	0	0	0
Service Developments	21	16	(5)	122	95	(27)
Strategic Review	0	0	0	0	0	0
Theatre Efficiency	0	0	0	0	0	0
Technology Driven Efficiences	0	0	0	0	0	0
	127	**82**	**(46)**	**747**	**475**	**(272)**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 7
BALANCE SHEET: M06
YEAR ENDING 31 MARCH 2022

BALANCE SHEET £'000	YEAR TO DATE Opening	M06 Actual	Movement
Non Current Assets	90,086	89,371	(715)
Current Assets			
Cash	4,235	4,226	(9)
Debtors	4,976	8,936	3,960
Inventories	410	482	72
Total Current Assets	**9,621**	**13,644**	**4,023**
Liabilities			
Creditors due < 1 year - Capital Payables	(3,447)	(1,401)	2,046
Creditors due < 1 year - Trade Payables	(13,728)	(15,878)	(2,150)
Creditors due < 1 year - Deferred Income	(3,136)	(5,774)	(2,638)
Creditors due > 1 year - Deferred Income	(1,592)	(1,574)	18
Loans	(2,136)	(1,830)	306
Provisions	(4,090)	(3,820)	270
Total Liabilities	**(28,129)**	**(30,277)**	**(2,148)**
TOTAL ASSETS EMPLOYED	**71,578**	**72,738**	**1,160**
Taxpayers Equity			
PDC	62,927	64,101	1,174
Revaluation Reserve	7,522	7,522	0
Retained Earnings	1,129	1,115	(14)
TOTAL TAXPAYERS EQUITY	**71,578**	**72,738**	**1,160**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 8
CASHFLOW STATEMENT: M06
YEAR ENDING 31 MARCH 2022

CASHFLOW STATEMENT £'000	Actual
Cash flows from operating activities	1,095
Depreciation and amortisation	2,804
Impairments and reversals	0
Income recognised in respect of capital donations (cash and non-cash)	(17)
Movement in working capital	379
Net cash generated from / (used in) operations	**4,261**
Interest received	0
Purchase of property, plant and equipment and intangible assets	(4,092)
Proceeds from sales of property, plant and equipment and intangible assets	0
Net cash generated from/(used in) investing activities	**(4,092)**
PDC Capital Programme Funding - received	1,174
PDC COVID-19 Capital Funding - received	0
Loans from Department of Health Capital - repaid	(306)
Loans from Department of Health Revenue - received	0
Loans from Department of Health Revenue - repaid	0
Interest paid	(22)
PDC dividend (paid)/refunded	(1,024)
Net cash generated from/(used in) financing activities	**(178)**
Increase/(decrease) in cash and cash equivalents	**(9)**
Cash and cash equivalents at start of period	4,235
Cash and cash equivalents at end of period	**4,226**

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	(3,670)	1,830
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**	**(32,854)**	**1,830**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 9
CAPITAL EXPENDITURE: M06
YEAR ENDING 31 MARCH 2022

CAPITAL EXPENDITURE £'000	Year to Date			FOT		
	Plan	Actual	Variance	Plan	Actual	Variance
Estates - BAU	348	38	310	700	656	44
Crown Street Enhancements	3,058	1,251	1,807	4,520	4,520	0
Digital Projects	696	728	(32)	1,388	1,526	(138)
Medical Equipment	303	17	286	302	354	(52)
Other	99	12	87	101	87	14
Expected Mitigation	0	0	0	0	(132)	132
Grand Total	**4,504**	**2,046**	**2,458**	**7,011**	**7,011**	**(0)**

capital item by the Trust. This figure differs to the capital expenditure figure shown in the cashflow statement which is on a "Cash" basis.

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*2021/22/088b*		**Date: 04/11/2021**	
Report Title	**Planning Update, October 2021 to March 2022**			
Prepared by	*Eva Horgan, Chief Finance Officer*			
Presented by	*Eva Horgan, Chief Finance Officer*			
Key Issues / Messages	*To provide an update on planning for October 2021 to March 2022 (H2).*			
Action required	**Approve ☐**	**Receive ☐**	**Note ☒**	**Take Assurance ☐**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable): CDC Funding			
	For Decisions - in line with Risk Appetite Statement – Y *If no – please outline the reasons for deviation.*			
	The Trust Board is asked to note the contents of this report.			
Supporting Executive:	*Eva Horgan, Chief Finance Officer*			

Equality Impact Assessment *(if there is an impact on E,D & I, an Equality Impact Assessment **MUST** accompany the report)*							
Strategy ☐	Policy ☐	Service Change ☐	Not Applicable ☒				
Strategic Objective(s)							
To develop a well led, capable, motivated and entrepreneurial ***workforce***	☐	To participate in high quality research and to deliver the most ***effective*** Outcomes	☐				
To be ambitious and ***efficient*** and make the best use of available resource	☒	To deliver the best possible ***experience*** for patients and staff	☐				
To deliver ***safe*** services	☐						
Link to the Board Assurance Framework (BAF) / Corporate Risk Register (CRR)							

Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* 4.1 Failure to ensure our services are financially sustainable in the long term 4.2 Failure to 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	Comment:
Link to the Corporate Risk Register (CRR) – CR Number: N/A	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
FPBD	25/10/21	Eva Horgan	Summarise position to Trust Board

EXECTUTIVE SUMMARY

Both the Trust individually and organisations across Cheshire and Merseyside (C&M) are facing significant financial challenge for the second half of the financial year. At the time of writing, the Trust and most other organisations within the region did not have financially balanced plans for the second half of the financial year (H2). This paper updates the Board on some of the key points of national guidance and the local approach to planning and outlines next steps.

The Board will be required to formally approve the plan once it is finalised and provisionally agreed at a Cheshire and Merseyside level. This approval is likely to be required outside of a currently scheduled Board meeting due to the regional and national timetable.

Note that until approved otherwise by the Trust Board, the existing plan which was approved in April still stands.

MAIN REPORT

1. Introduction

This paper outlines the current situation regarding the financial and operational plans for the second half of the 2021/22 financial year.

2. National Guidance

Guidance has now been shared with Trusts and Systems[1] and was discussed at the Finance, Performance and Busines Development Committee. Substantively, the financial regime in the second half of the 2021/22 financial year will remain the same as in the first half of the year. However, key differences are as follows:

- Funding of the pay award.
- A further CIP requirement on trusts of 0.82%, bringing the total CIP requirement to 2.07%.
- A reduction in available system funding due to C&M being financially challenged.
- A change in methodology for earning Elective Recovery Fund (ERF) income.
- A reduction in Covid-19 funding.

3. Cheshire and Merseyside

Allocations and funding are being channelled through Integrated Care Systems (ICS's), although these are not currently legally constituted, so Liverpool CCG is acting as the host organisation for distribution and payments. With seventeen providers and nine CCGs in C&M, reaching agreement is a challenge.

The changes in the ERF funding are also significant. C&M collectively has achieved breakeven in the first half of 2021/22 (H1), but this was after receipt of £69m of ERF income. As things stand, the change in methodology means it is unlikely that either C&M or in fact the entire North West region will earn ERF due to being below the required threshold of waiting list clock stops (89%, C&M at 77%), which is how it will be earned. Clearly this will leave a significant financial gap. Funding has been made available nationally so discussions are ongoing between the regional NHSI/E team, ICS and the national team. This is particularly an issue given the impact of Covid-19 in the region.

In addition, providers are facing other financial pressures including winter pressures, ongoing covid impacts, staffing pressures and restoration. At present, providers (including LWH) have included restoration costs in financial plans and are planning to undertake as much activity as possible to clear backlogs. Although the national message has been to both breakeven financially and to deliver activity, no blocks are being put on expenditure to achieve recovery at this point, particularly as discussions are ongoing regarding the financial plans.

As a standalone organisation, LWH would be able to earn ERF.

4. LWH Process

Although the Trust did breakeven for H1, it was reliant on £1.7m of non-recurrent benefits as well as the £8.5m of system funding provided by C&M and £1.2m of Elective Recovery Fund income.

The plans for H2 have been based on realistic forecast spend incorporating the additional agency expenditure and staffing costs associated with pressures in maternity, theatres and for recovery. This has been developed on a bottom-up basis with divisions. Note that the Trust expects to breach its agency cap. It is also worth noting that the Trust only received £0.2m of the £1.3m Ockenden funding requested, and now has significant, unfunded pressures in Maternity.

Challenge is being put in place including requiring additional CIP to be identified and delivered, and expenditure above core budgets (which remain in place at a divisional level) to be controlled. A Financial Recovery Board reporting into the Executive Team and Finance, Performance and Business Development Committee has been put in place.

[1] https://www.england.nhs.uk/publication/guidance-on-finance-and-contracting-arrangements-for-h2-21-22/

5. Finalising Plans

Draft financial, activity and workforce plans, which have been prepared on a consistent basis, have been submitted with approval from relevant individual executives. It is clear and noted with C&M and NHSI/E that these do not constitute Board approved plans. The final allocations including system allocation have not been agreed so these are very much draft plans.

Discussions are ongoing between Chief Operating Officers regarding elective recovery and Chief Finance Officers re the financial position. A number of iterations of financial plans have been discussed and submitted. At the time of writing there was a significant gap at a C&M level which the ICS is trying to address.

6. Governance and Next Steps

The final plan has been requested on 11th November to C&M, prior to a national deadline for ICS submission on 16th November.

The Board will be kept updated on this timescale and approval for a final plan will be sought when possible.

Finance, Performance & Business Development Chair's Highlight Report to Trust Board
27 September 2021

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Shortfalls on the Cost Improvement Programme (CIP) and Elective Recovery Fund (ERF), as well as pay overspends were highlighted as matters of concern. The Committee noted that a Financial Recovery Board had been set up for further scrutiny and agree actions to improve the financial position. • The cash position had been raised to ICS, CCG and the national NHSI/E Financial Control Team to flag issues and explore solutions. • National planning guidance for H2 not yet released. To meet inevitably tight timelines planning had commenced at LWH using intelligence from national and regional CFO briefings. The Trust would continue to work towards the submission deadline of 11 November 2021. • The Recovery and Restoration presentation highlighted progress against H1 restoration requirements. The Committee noted that the Trust had been asked to restore Oncology activity levels during Q3 to 2019/20 Q3 levels. The biggest challenge to the Trust was achieving the 62-day target, late referrals and complex diagnostics being cited as the main causes of 62-day breaches. The importance of pathway work and mutual aid was noted to ensure healthcare was delivered to patients from across the Northwest.	• Supported the process route recommended in relation to the Soft Facilities Management contract. A Task and Finish Group would take forward and present the final proposal to the Board. • Received and accepted the findings of the Hewitt Fertility Centre Commercial and Strategic Review. Committee feedback would be added to the final version and recirculated. An action plan would be formed, including responsible Committees, as it was agreed that some of the recommendations sat outside of the FPBD remit and would require support from the wider governance structure. • Following a period of consultation, NHSI/E had recently published the NHS System Oversight Framework 2021/22 which replaces the NHS Oversight Framework for 2019/20. The Trust already reports on many of the indicators listed within the System Oversight Framework and would include the new metrics within the Performance Reports as of September 2021.
Positive Assurances to Provide	**Decisions Made**
• Assured by Month 5 finance position noting slightly behind track year to date but remained forecast to deliver the April to September (H1) plan. • Noted additional cash support provided by Liverpool CCG for Quarter 3 demonstrating positive and effective system working. • Enforcement Undertakings with NHSI/E (nee Monitor) had officially been lifted by NHSI/E stating that there were no longer reasonable grounds to suspect that the Trust was in breach of licence. • Assured by the operational report, noting Safety indicators remained green for August with the exception of the Continuity of Care (CoC) targets. The BAME CoC target continued to be met. The Committee noted national discussions to potentially include index of deprivation factor to the CoC pathway which would significantly impact the service needs at this Trust. • Positively assured by the quality developments since the introduction of the Robotic Assisted Surgery which had supported Trust aims to recruit and retain key clinical	• Reviewed the FPBD related BAF risks. The Committee considered plans to discuss in further detail 1) the risk of the Trust running multiple clinical systems and 2) whether cyber security should be recognised on the BAF rather than the Corporate Risk Register. The outcomes of these discussions would be reported to the October 2021 Committee for review ahead of recommendations to the Board in November 2021. No changes to existing risks related to FPBD were identified as a result of business conducted during the meeting.

staff, deliver excellent patient experience, and develop model of care to keep pace with developments.

- Works had progressed on site for Phase 1 (refurbishment of Rosemary Ward to create a new Fetal Medicine Unit). A Guaranteed Maximum Price (GMP) for the remainder of the scheme had been received and approved in accordance with SFIs, and instruction to proceed had been issued to Preferred Supply Chain Partners (PSCP) Tilbury Douglas.
- Positive assurance from progress within the programme activities underway for Meditech Expanse (EPR), Digital Maternity, and the GDE programme. The committee noted the Information Technology update provided.
- Noted performance to date against the Corporate Objectives aligned to its terms of reference.
- Assured by Sub-Committee Chair reports. Informed that the Performance Assurance Group should commence reporting up to the Finance Committee. Workplan & terms of reference would be adjusted.

Comments on Effectiveness of the Meeting / Application of QI Methodology

- Good discussion and challenge.
- Consider capturing and tracking evidence of positive action

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
87.	Board Assurance Framework Review	Assurance	94.	Robotic Assisted Surgery Post Implementation Review	Information
88.	Finance Performance Report Month 5 2021/22	Assurance	95.	Hewitt Fertility Centre Strategic and Commercial Review Report	Assurance
89.	Enforcement Undertakings	Information	96.	Crown Street Enhancements Programme	Assurance
90.	Update – Planning for October 2021 to March 2022 (H2)	Assurance	97.	Digital Services Update	Assurance
91.	Operational Performance Report Month 5 2021	Assurance	98.	NHS System Oversight Framework 2021/22	Information
92.	Recovery and Restoration Trajectory Update	Information	99.	Corporate Objectives 3-month review	Information
93.	Soft Facilities Management	Assurance	100.	Sub-Committee Chairs Reports	Assurance
70.	Planning and CIP Update	Information			

3. 2021 / 22 Attendance Matrix

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

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

Finance, Performance & Business Development Chair's Highlight Report to Trust Board
25 October 2021

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway

• Shortfalls on the Cost Improvement Programme (CIP) and Elective Recovery Fund (ERF), as well as a potential breach of the agency spend cap were highlighted as matters of concern. The Committee noted that the new Financial Recovery Board had met and was proving to be a useful forum to identify and progress actions.
• Capital spend is still considerably behind plan Year to Date (YTD) but is expected to increase as phasing for Crown Street enhancements had been finalised.
• Highlighted that improvements to Planned Preventative Maintenance compliance had plateaued. Options to increase resource in this area were being explored.
• Improvements to the Trust's 52 week wait performance have levelled off and this was attributed to staffing capacity challenges. Whilst two-week wait cancer performance was strong, 62-day performance remains significantly challenged. Short term actions are underway, together with a longer-term project, to review pathways across the C&M system.
• An update for H2 2021/22 planning was received by the Committee. This covered workforce, financial and operational aspects. A draft financial position for the 2021/22 year-end was outlined with a realistic deficit position explained, albeit with the potential for further mitigations noted. In this context, the Committee stressed the importance of progressing with the Trust's CIP programme and, wherever safe, reducing agency usage. The Trust would continue to work towards the submission deadline of 11 November 2021 with approval by the Trust Board required ahead of this point.
• An update on the development of the Community Diagnostic Centre was received. It was noted that further clarification on the capital monies available to support the project is awaited and it was acknowledged that Board approval for the project could not progress until sufficient assurances of capital financial support were received.
• It was noted that the Trust had received a segmentation rating of '3' under the updated NHSI/E Oversight Framework. The drivers behind the rating and the implications were being considered and would report back to the Committee.
	• The Committee requested to see further detail on the Financial Recovery Board, particularly in terms of targets and intended deliverables.
	• As the cash position continues to be challenged and inherently linked with overall financial performance, the Committee agreed to merge the Quarterly Treasury Management report with the standing Financial Performance report and receive monthly detailed updates on the cash position.
	• The Committee requested several improvements to the reporting of Estates issues:
	  ○ Ensuring that the frequency of reporting of items was identified correctly
	  ○ Reviewing the accuracy of the water testing compliance RAG rating
	  ○ Grouping of similar items to support better triangulation
	  ○ Ensuring that all relevant columns in the report were completed.
	• The Committee requested that the Premises Assurance Group Terms of Reference be reviewed to ensure that there was adequate senior representative from LWH staff as part of the membership of the meeting.

Positive Assurances to Provide	**Decisions Made**
• Assured by Month 6 finance position noting that the Trust had delivered its half year financial position against the April to September (H1) plan. The cash position had improved from the previous month and was now less of a concern in the short term. • Positive assurance regarding the steps to reduce debtors was noted by the Committee. • The Committee noted positive assurance regarding the post implementation process for CIP projects. That there had been no quality, safety or staff implications was highlighted as particularly encouraging. • Positive assurance from progress within the digital programme with activities underway for Meditech Expanse (EPR), Digital Maternity, and the GDE programme.	• Reviewed the FPBD related BAF risks. The Committee agreed to propose an increase to BAF risk 2.2 following a detailed review of the strategic threat relating to the Trust running multiple clinical systems.

• Progress to translate the Trust's Strategy into operational delivery was noted.	

Comments on Effectiveness of the Meeting / Application of QI Methodology

- Noted that the issues being discussed by the Committee carried significant risk to the Trust. The meeting duration is to be reviewed to ensure sufficient time is given to consider items.

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
109.	Board Assurance Framework Review	Assurance	**116.**	H2 Planning Update (October 2021 to March 2022)	For assurance
110.	Finance Performance Report Month 6 2021/22	Assurance	**117.**	Community Diagnostic Centre Update	For information
111.	Operational Performance Report Month 6 2021	Assurance	**118.**	Review of Strategic Progress	For assurance
113.	Recovery and Restoration Trajectory Update	For information	**119.**	Hewitt Fertility Centre Commercial and Strategic Action Plan – Update	For assurance
114.	Post Implementation Review of Cost Improvement Programme	For assurance	**120.**	Crown Street Enhancements Programme	For assurance
115.	Digital Services Update including Information Governance Update	For assurance	**121.**	Sub-Committee Chairs Reports	For assurance

3. 2021 / 22 Attendance Matrix

Core members	Apr	May	Jun	Jul	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Tracy Ellery	✓	✓	✓	✓	✓	✓					
Jo Moore	A	✓	✓	A	Non member						
Ian Knight	✓	✓	✓	✓	Non member						
Louise Martin	Non member		✓	✓	✓	✓					
Tony Okotie	Non member				✓	A					
Jenny Hannon	✓	✓	✓	✓	✓	Non member					
Eva Horgan	Non member					✓					
Kathryn Thomson	✓	✓	✓	✓	A	✓					
Gary Price	✓	✓	✓	✓	✓	✓					
Marie Forshaw	✓	✓	✓	✓	A	✓					

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

Audit Committee Chair's Highlight Report to Trust Board

21 October 2021

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• The Divisional Presentation for Family Health was received. Improvements made to the Division's Governance were highlighted whilst it was also noted that there continued to be further action required. The Division had developed a one-year plan for immediate required improvements and would then move into a more strategic five-year plan. It was noted that there were still improvements needed in relation to the escalation and flow of information from the Division through the Trust's governance framework and also feedback from Committees. The timing of monthly divisional meetings are being reviewed to line up better with the Committee meetings. • The Committee received a mid-year review of the Trust's Clinical Audit Programme. It was highlighted that there were inconsistencies across the Trust's service lines in terms of progress against 'must do' audits. The Medical Director had asked for this to be reviewed with audits prioritised accordingly. Key learning identified was to take a more bespoke approach to setting audit plans with service lines and aim for a more focused reduced number of audits which could be achieved in 2022/23.	• The Committee discussed the most effective way to track improvements with Divisional Governance Arrangements (the first 'cycle' of presentations from Divisions now completed). It was agreed that it would be important to establish clear criteria for establishing the maturity of Divisional governance arrangements and then re-start the cycle of presentations to assess against this. A paper setting out maturity criteria for Divisions was requested for January 2022.
Positive Assurances to Provide	**Decisions Made**
• Continued progress to close out internal and external audit recommendations in a timely way was noted with the internal auditor asserting that the Trust's processes were best in class. The Committee noted that seven actions had been deferred and the importance of setting realistic deadlines in the first place was stressed. • Four internal audit reports were received: o Financial Reporting & Integrity (High assurance) o Key Financial Systems (High assurance) o Absence Management (Moderate assurance) o Audit Committee Effectiveness Review (No assurance opinion) The Committee noted that the high assurance opinion on financial controls was encouraging. • The internal audit programme for 2021/22 was noted as being on track • The Committee was informed of continued awareness raising activity relating to anti-fraud. The Trust's Anti-Fraud Champion role would be assigned to the new Deputy CFO once in post. • Noted that there had been a reduction in average value of tender waivers being submitted which was an indication of robust controls and processes. • A mid-year review of the Trust's Assurance Framework was received. Noted as being good practice ahead of developing the Annual Governance Statement at Year-End.	• The Committee agreed that there would need to be a 'Plan A' and 'Plan B' in respect of the timelines for the Year-End sign off process. Details on deadlines and submission dates had yet to be made available. • The Committee reviewed the effectiveness of the internal and external auditor in July 2021. The Board is asked to note that a 2+2 year contract is in place with MIAA. The process for reviewing the procurement of an External Auditor is underway with Governor representation. It is expected that a recommendation will be made to the Council of Governors on 11 November 2021.
Comments on Effectiveness of the Meeting / Application of QI Methodology	
• The Chair noted that Non-Executive Director, Tony Okotie has joined the Committee, replacing Ian Knight.	

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
042	Follow up of Internal Audit and External Audit Recommendations	To receive and review an update of actions taken.	047	Clinical Audit Annual report 2020-21 & Interim Progress report 2021-22	To receive update
043	MIAA Internal Audit Reports a) Internal Audit Progress Report i. Financial Reporting & Integrity ii. Key Financial Systems iii. Absence Management iv. Audit Committee Effectiveness Review b) Anti-Fraud Progress Report 2021/22 c) Insight Update	To note the contents and any recommendations from the report.	048	Divisional Governance Arrangements – Family Health	To receive update
044	External Auditor Update	To receive update	049	Chairs reports of the Board Committees a) Finance, Performance and Business Development Committee b) Quality Committee c) Putting People First Committee d) Charitable Funds Committee	Review of Chair's Reports for overarching assurance.
045	Waivers Q2 Financial Year 2021/22	To note	050	Board Assurance Framework (BAF)	To receive assurance
046	Assurance processes, governance, risk management and internal control	For assurance			

3. 2021 / 22 Attendance Matrix

Core members	June	July	October	January	March
Tracy Ellery (Chair)	✓	✓	✓		
Ian Knight	✓	**A**			
Susan Milner	✓	✓	**A**		
Tony Okotie			✓		

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

Charitable Funds Committee Chair's Highlight Report to Trust Board
20 September 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 noted the interdebtedness between the Charity and the Trust as a result of payments the Trust had made on behalf of the Charity. As previously agreed, the Committee agreed to maintain the level of interdebt to allow the Charity a period of growth whilst closely monitoring and recovering payments on a monthly basis. It was requested that a repayment trajectory be agreed to progress further and allow the Committee to consider options. • The Committee noted at Month 4 the incoming resources were lower than the resources expended however the gain on investments of £56k in year supported the income position resulting in a net movement in funds of an increase of £49k. • Committee received an Impact Assessment review against the application of charitable funding across the Trust for staff and patients. The positive benefits demonstrated within the report was acknowledged. It was noted that a number of applicants had not submitted an impact review. It was also unknown whether there had been a reversal of any commitments made. It was agreed that a more robust and formal proposal process would also improve the post implementation review process. • Costings of the three projects forming the NHS Charities Together bid was discussed. • Noted a local appeal had gone live as of September 2021 which could pose a conflict of interest with Trust services and the Charity appeal. A meeting to discuss between both charities would be arranged.	• Noted primary appeals underway: FMU Refurb; Give for Gynae; and Honeysuckle Bereavement Suites. • Committee received a verbal update against the Charitable Funds Strategy. A written update highlighting progress against the priorities set would be provided at the next meeting. • The Committee was asked to note discussions towards the inclusion of the Charity within the remit of the wider Trust audit process. The Board would be asked to consider options as the Corporate Trustee.
Positive Assurances to Provide	**Decisions Made**
• Representatives from Investec presented a positive investment performance report demonstrating an increased capital value. It was agreed to maintain the current asset allocation. Future review of investment restrictions would be considered by the Committee. • The Committee was assured by the Benchmarking Exercise undertaken to consider Financial Services Support Costs charged to the Charity. • Noted positive fundraising activity during June – September 2021 despite Covid continuing to limit ability to fundraise at full potential. The Pink & Purple Pram Push, a new event launched in September 2021 had been successful and would become an annual event.	• Approved the identified fundraising risks to add to the Corporate Risk Register.

Comments on Effectiveness of the Meeting / Application of QI Methodology
• New Committee members require time to embed and receive and reflect on historic narrative of the Committee. • Good assurance received from Investec

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
17.	Investment Report	Assurance	21.	Charity Risk Assessments	Approval
18.	Finance position and Investment Report	Information	22.	Fundraising Update	Information
19.	CF Applications Impact Annual review	Assurance	23.	Charitable Funds Strategy Review	Information
20.	Benchmarking Exercise – Financial Services Support Costs	Information			

3. 2021 / 22 Attendance Matrix

Core members	June 2021	Sept 2021	Dec 2021	March 2022
Jo Moore (Chair until end Aug 2021)	✓	NM		
Tracy Ellery (Chair as of Sept 2021)	NM	✓		
Tony Okotie	✓	✓		
Louise Martin	A	✓		
Michelle Turner	✓	✓		
Jenny Hannon*	A	A		
Eva Horgan* (as nominated deputy)	✓	✓		
Marie Forshaw	✓	A		
Chris Gough	✓	A		
Kate Davis	✓	✓		

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	***21/22/89***		**Date: 04/11/2021**	
Report Title	**Board Assurance Framework**			
Prepared by	***Mark Grimshaw, Trust Secretary***			
Presented by	***Mark Grimshaw, Trust Secretary***			
Key Issues / Messages	***The report outlines any updates relating to the Board Assurance Framework and any key areas for consideration for the Board.***			
Action required	**Approve ☐**	**Receive ☐**	**Note ☐**	**Take Assurance ☒**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	***To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it***	***For the intelligence of the Board / Committee without in-depth discussion required***	***To assure the Board / Committee that effective systems of control are in place***
	Funding Source (If applicable): N/A			
	For Decisions - in line with Risk Appetite Statement – Y ***If no – please outline the reasons for deviation.***			
	The Board requested to review the BAF risks and agree their contents and actions.			
Supporting Executive:	***Mark Grimshaw, Trust Secretary***			

Equality Impact Assessment *(if there is an impact on E,D & I, an Equality Impact Assessment **MUST** accompany the report)*

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

To develop a well led, capable, motivated and entrepreneurial ***workforce***	☐	To participate in high quality research and to deliver the most ***effective*** Outcomes	☐
To be ambitious and ***efficient*** and make the best use of available resource	☐	To deliver the best possible ***experience*** for patients and staff	☐
To deliver ***safe*** services	☐		

Link to the Board Assurance Framework (BAF) / Corporate Risk Register (CRR)

Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* 5.2 Failure to fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership	Comment:
Link to the Corporate Risk Register (CRR) – CR Number: N/A	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome

BAF discussed at FPBD, PPF, Quality and Audit Committees since previous version presented to Board on 2 September 2021.

EXECUTIVE SUMMARY

The Board Assurance Framework (BAF) is a monitoring tool used by the Board to assess the organisation's capacity to achieve its strategic objectives, and to ensure it has appropriate oversight of the Trust's risk profile and risk management arrangements.

Board members will be aware that the BAF was updated to align with the Trust's 'Our Strategy' document and was discussed for the first time under the new format at the Board on 1 July 2021.

The BAF items are aligned to the Board's assurance committees and these were reviewed and discussed during September and October 2021. The outcomes of these discussions are detailed in the report below and on the BAF itself.

MAIN REPORT

Introduction

The following report provides an update to Board members on the latest review of the BAF items.

The report is intended to allow the members of the Board to review any proposed changes or additions and agree them moving forward. The report is also an opportunity for the Board to make informed judgements as to the level of assurance that they can take and to identify any further action required to improve the management of the identified risks.

Process for reviewing BAF areas during the meeting

As the Board works through the agenda, members are requested to consider the BAF areas contained in Appendix 1 and the associated interdependent 15 and above risks / CRR risks. Keeping these risks in mind should support consideration of whether any assurances provided through the reports received could contribute to mitigation (or escalation) of the BAF risks. These can be noted when the BAF itself is discussed.

In addition, members should consider whether as a result of the review of assurances and/or identification of risks, whether there is a need to commission additional assurance to be reported to future Board and / or Committee meetings. In particular, the Board needs to ask itself whether it is attaining adequate assurance against its highest scoring risks i.e., are these areas of risk driving the Board and Committee agendas? Any information that has been discussed in the meeting that needs to be shared with other corporate governance meetings should be included in the Chair's Log.

Changes to BAF

1.1 Failure to be recognised as one of the most inclusive organisations in the NHS with Zero discrimination for staff and patients (zero complaints from patients, zero investigations)
• No significant changes

1.2 Failure to recruit and retain key clinical staff

- No significant changes

2.1 Failure to progress our plans to build a new hospital co-located with an adult acute site

- This has been reviewed in line with the New Hospital Expression of Interest
- Potential for controls (and actions) to move to BAF Risk 2.3

2.2 Failure to develop our model of care to keep pace with developments and respond to a changing environment

- This risk has been reviewed by the Medical Director and CIO. Recognised that the Trust's multiple systems is one of the Trust's most significant risks and yet this was not reflected on the BAF. It has been suggested that the score is increased in response to this.

2.3: Failure to implement all feasible mitigations to ensure services delivered from the Crown Street site are as safe as possible, developing our facilities for the benefit of our patients as well as those across the system

- No significant changes to report.
- Potential to include the Community Diagnostic Hub development as a new control / source of assurance should it be approved.

2.4: Major and sustained failure of essential IT systems due to a cyber attack

- This is a proposed new risk
- Rationale as follows:
- The Trust's Digital Services department places cyber security management at the core of operational activities, ensuring it maintains its Cyber Essentials plus standard. Various controls are implemented that are considered effective and this reduces the likelihood of a cyber-attack impact. However, if a cyber-attack was successful the impact would likely be catastrophic to Trust services, likely rendering digital systems that clinical services are increasingly dependent on, unavailable for a period of time. The Digital Services department continue to strengthen controls through process refinement and the introduction of security technologies. On the basis of this, the impact is considered catastrophic and likelihood is considered as possible resulting in an overall score of 15.

3.1: Failure to deliver an excellent patient and family experience to all our service users

- Updated wording for the Strategic Threat
- Updated actions

BAF Risk 4.1: Failure to ensure our services are financially sustainable in the long term
• No significant changes to report.
BAF Risk 4.2: Failure to 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
• No significant changes to report.
5.1: Failure to progress our research strategy and foster innovation within the Trust
• No significant changes to report.
5.2: Failure to fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership
• Updating some of the language on strategic threats • Updating controls and assurances • Update of QI actions to reflect on-going MIAA led project

New Risks or Strategic Threats

Since the report was last circulated and discussed at the Board, a risk relating to Cyber Security has been suggested to be added to the BAF (detail noted above). It is likely that Risk 4.1 will require a significant review once the Half Two planning detail is available and understood.

Closed Risks or Strategic Threats

Since the report was last circulated and discussed at the Board, no risks closed on the BAF.

Conclusions

Board members are asked to comment on the current content and where required make further recommendation for change and agree the current BAF risks.

Recommendation

The Board requested to review the BAF risks and agree their contents and actions.

Liverpool Women's NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK 2021/2022

Trust Board – November 2021

Board Assurance Framework Key

Risk Rating Matrix (Likelihood x Consequence)					
Consequence	Likelihood				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic	5 Moderate	10 High	15 Extreme	20 Extreme	25 Extreme
4 Major	4 Moderate	8 High	12 High	16 Extreme	20 Extreme
3 Moderate	3 Low	6 Moderate	9 High	12 High	15 Extreme
2 Minor	2 Low	4 Moderate	6 Moderate	8 High	10 High
1 Negligible	1 Low	2 Low	3 Low	4 Moderate	5 Moderate

1 - 3	Low risk
4 - 6	Moderate risk
8 - 12	High risk
15 - 25	Extreme risk

Director Lead	
CEO	Chief Executive
CPO	Chief People Officer
COO	Chief Operating Officer
CFO	Chief Finance Officer
CIO	Chief Information Officer
CNM	Chief Nurse & Midwife
MD	Medical Director

Key to lead Committee Assurance Ratings	
	Green = Positive assurance: the Committee is satisfied that there is reliable evidence of the appropriateness of the current risk treatment strategy in addressing the threat or opportunity - no gaps in assurance or control AND current exposure risk rating = target OR - gaps in control and assurance are being addressed
	Amber = Inconclusive assurance: the Committee is not satisfied that there is sufficient evidence to be able to make a judgement as to the appropriateness of the current risk treatment strategy
	Red = Negative assurance: the Committee is not satisfied that there is sufficient reliable evidence that the current risk treatment strategy is appropriate to the nature and/or scale of the threat or opportunity
This approach informs the agenda and regular management information received by the relevant lead committees, to enable them to make informed judgements as to the level of assurance that they can take and which can then be provided to the Board in relation to each BAF Risk and also to identify any further action required to improve the management of those risks.	

Board Assurance Framework: Legend	
Strategic Priority	The 2021/25 strategic priority that the BAF risk has been aligned to.
BAF Risk:	The title of the strategic risk that threatens the achievement of the aligned strategic priority
Rationale for Current Risk Score:	This narrative is updated on a quarterly basis and provides a summary of the information that has supported the assessment of the BAF risk.
Strategic Threat:	What might cause the BAF risks to materialise
Provider Licence Compliance:	NHS Improvement provider licence conditions that align to the BAF risk providing assurance on compliance.
Controls:	The measures in place to reduce the risk likelihood or risk consequence and assist secure delivery of the strategic priority.
Assurances:	The measures in place to provide confirmation that the controls are working effectively in supporting the mitigation of the risk.
Gaps in Controls / Assurance:	Areas that require attention to ensure that systems and processes are in place to mitigate the BAF risk Areas where there is limited or no assurance that processes and procedures are in place to support the mitigation of the BAF risk.
Required Action:	Actions required to close the gap in control/ assurance
Lead:	The person responsible for completing the required action.
Implemented By:	Deadline for completing the required action.
Monitoring:	The forum that will monitor completion of the required action.
Progress:	A RAG rated assessment of how much progress has been made on the completion of the required action.

Risk Descriptors

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	Negligible	Minor	Moderate	Major	Catastrophic
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long- term incapacity/disabilit y Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day)	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days)	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff

			Low staff morale Poor staff attendance for mandatory/key training	Loss of key staff Very low staff morale No staff attending mandatory/ key training	No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10– 25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million

Service/business interruption **Environmental impact**	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Likelihood score (L)

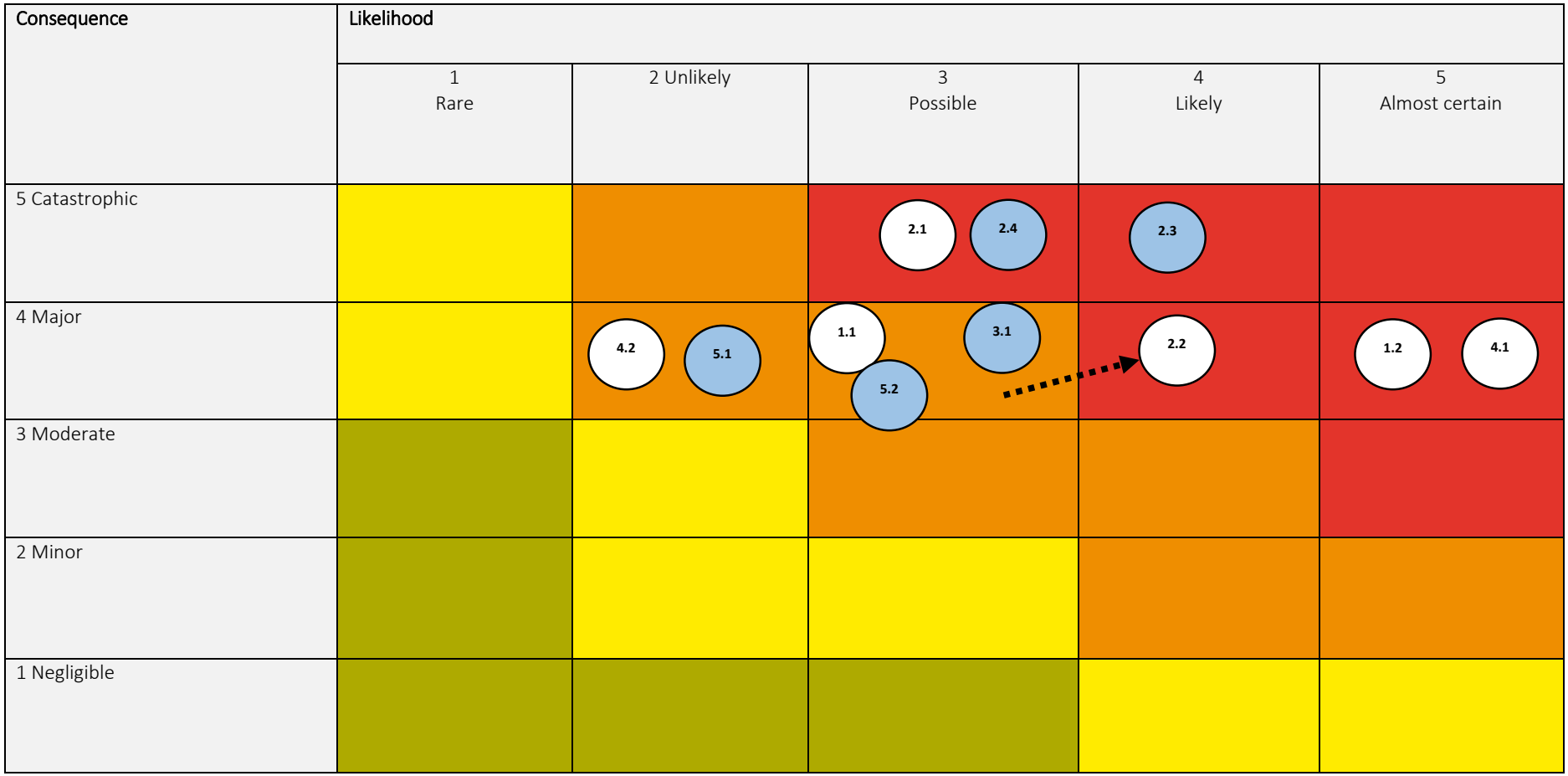
What is the likelihood of the consequence occurring?
The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

Board Assurance Framework Dashboard 2021/2022

SA	BAF Risk	Committee	Lead	July 2021	Q2	Q3	Q4	Q 2 Q movement	2021/22 Target
SA1 Workforce	1.1 Failure to be recognised as one of the most inclusive organisations in the NHS with Zero discrimination for staff and patients (zero complaints from patients, zero investigations)	PPF	CPO	12 (I3 x c4)	12 (I3 x c4)				8 (I2 x c4)
	1.2 Failure to recruit and retain key clinical staff	PPF	CPO	20 (I5 x c4)	20 (I5 x c4)				12 (I3 x c4)
SA2 Safe	2.1 Failure to progress our plans to build a new hospital co-located with an adult acute site	FPBD	MD	15 (I3 x c5)	15 (I3 x c5)				15 (I3 x c5)
	2.2 Failure to develop our model of care to keep pace with developments and respond to a changing environment	FPBD	COO	12 (I3 x c4)	16 (I4 x c4)				8 (I2 x c4)
	2.3 Failure to implement all feasible mitigations to ensure services delivered from the Crown Street site are as safe as possible, developing our facilities for the benefit of our patients as well as those across the system	Quality	COO	20 (I4 x c5)	20 (I4 x c5)				15 (I3 x c5)
	2.4 Major and sustained failure of essential IT systems due to a cyber attack	Quality	CIO	N/A	15 (I3 x c5)			N/A	12 (I2 x c5)
SA3 Experience	3.1 Failure to deliver an excellent patient and family experience to all our service users	Quality	CNM	12 (I3 x c4)	12 (I3 x c4)				8 (I2 x c4)
SA4 Efficient	4.1 Failure to ensure our services are financially sustainable in the long term	FPBD	CFO	20 (I5 x c4)	20 (I5 x c4)				16 (I4 x c4)
	4.2 Failure to 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	FPBD	CFO	8 (I2 x c4)	8 (I2 x c4)				8 (I2 x c4)
SA5 Effective	5.1 Failure to progress our research strategy and foster innovation within the Trust	Quality	MD	8 (I2 x c4)	8 (I2 x c4)				4 (I1 x c4)
	5.2 Failure to fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership	Quality	CNM	12 (I3 x c4)	12 (I3 x c4)				8 (I2 x c4)

BAF HEAT MAP


Consequence
Likelihood
1 Rare
2 Unlikely
3 Possible
4 Likely
5 Almost certain
5 Catastrophic
4 Major
3 Moderate
2 Minor
1 Negligible
2.1
2.4
2.3
4.2
5.1
1.1
3.1
5.2
2.2
1.2
4.1

Strategic Objective	SA1: To develop a well led, capable, motivated and entrepreneurial WORKFORCE
Committee:	Putting People First Committee
Risk Appetite:	Moderate

Principal risks (BAF)	Risk Score
1.1 Failure to be recognised as the most inclusive organisation in the NHS with Zero discrimination for staff and patients (zero complaints from patients, zero investigations)	12 (3 x 4)
1.2 Failure to recruit and retain key clinical staff	20 (4 x 5)

Ref	Corporate Risk Register / High Scoring (15+) Risks	Risk Score
2443	Inability to recruit specialised allied health professions in a timely manner	16
1705	Insufficient midwifery staffing levels as recognised by birth rate place plus.	20
2424	Unable to meet safe staffing levels in line with BAPM requirements	15
2087 **(CRR)**	Uncertainty about provision of a safe Maternity service able to give more effective interventions with 24/7 Consultant presence on Delivery suite and sufficient consultant cover for 10 elective caesarean lists per week and high-level MAU cover.	16
2244 **(CRR)**	The functions and assurances provided by the Resuscitation Team had stopped (or been partially completed on an ad hoc basis) since April 2016. Some ILS courses have been provided via Whiston Hospital; however, they could not deliver any further courses until January 2019 at the earliest. This has led to a depletion of certificated skills within the Trust's nursing and ODP staff.	9
2323 **(CRR)**	The Trust is currently non-compliant with standards 2,5,6 of the seven-day service standards (due to insufficient consultant numbers)	15
1704 (CCR)	Effective management systems are not in place or sufficient to ensure all employees complete and keep up to date with their mandatory training requirements.	12

Risk and Controls Summary

To outline changes to risk scores, new risks or closed risks.

2087 - Increase in risk score since last review from 12 to 16. Risk reviewed with Chris Dewhurst and agreement that the current obs cons staffing and pressures to the services required and increase to the level of risk. Last reviewed 15/06/21.

2244 - Last reviewed 06/07/21. Recruitment has been completed. Risk has now been removed.

2323 - No change in risk score since last review. Last reviewed 27/08/21

1704 - Given the decline in MT rates in clinical areas, risk has been increased to 12.

BAF Risk 1.1: Failure to be recognised as one of the most inclusive organisation in the NHS with zero discrimination for staff and patients (zero complaints from patients, zero investigations)	**Lead Director:** CPO **Op Lead:** Deputy Director of Workforce	**Review Date:**	**Ulysses Ref:**

Strategic Priority: SA1: To develop a well led, capable, motivated and entrepreneurial workforce

Lead Committee: Putting People First

Provider Licence Compliance link(s):

N/A

SCORE:

July 2021	Q2	Q3	Q4	Q 2 Q movement	2021/22 Target
12 (3 x 4)				⟷	8 (2 x 4)

Rationale for current risk score:

The Trust has several strong controls in place against this risk and can demonstrate effective performance in comparison with other NHS trusts. However, this is an ambitious aim within the Trust's 2021-25 strategy and will require significant cultural change to achieve together with a continued and unrelenting focus. The Trust can also make progress on the mechanisms that it has in place to hear the views and voices from its diverse staffing and patient communities and ensure that these voices have an impact on service improvement and development. Whilst there is evidence that the Trust has responded well to challenge that the pandemic has posed to the Trust in terms of patient and staff inequalities, this will continue to be a challenge over the year.

Strategic Threat *(what might cause this to happen)*	**Controls** *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Source of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Controls/Assurance** *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	**Overall Assurance Rating**
Unable to create a workforce representative of the community we serve	Monitoring of applications for employment within the Trust throughout the recruitment & selection process over a 12-month period via TRAC reporting	Monitored by the EDI Lead and reported through the ED&I Action Plan	None	
	Opportunities for all staff groups to attend/participate in 'shadow board'	Shadow Board attendance list and minutes.	None	
	Links with community leaders established to improve under-representation	PPF Strategy and action plan – monitored by PPF Committee	To ensure that there are robust processes in place to target advertising, work shadowing opportunities, pre-application training and offering career advice **(Actions 1.1 / 1 and 1.1 / 2)**	
	Annual review of all employee relation casework to determine if staff are reporting any form of discrimination and to ensure that process is fairly/consistently applied across all staff groups (benchmark against local and national data, where possible)	WRES submitted in September 2019 and reported a 100% reduction of BAME employees undergoing a formal process as at March 2019	None	
	All HR policies have up to date equality impact assessments at the point of review, in line with the policy schedule	Policy schedule is currently on track with EIA's being requested as required	None	
	HR policies reviewed in line with fair and just culture	Policy review process reported to PPF	None	
	WDES and WRES action plan delivery in line with timescales presented from NHS England	WDES and WRES Action Plan submissions	None	
	Demographic tracking for training access	In place and monitored by Head of L&D OD	None	
	Establishment of BAME and Disability Networks and work in collaboration with local Trusts to promote staff networks	Progress reported to PPF Committee	None	

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status	
1.1 / 1	Reciprocal mentoring scheme to be developed	Head of Culture, Inclusion, Wellbeing and Engagement	September 2021	E&D Sub-Committee		
1.1 / 2	Robust targeting of job adverts	Head of Culture, Inclusion, Wellbeing and Engagement	September 2021	E&D Sub-Committee		
1.1 / 3	Review of the current Equality Impact Assessment (EIA) process, simplification of document and sufficient guidance and education on how to complete, ensuring this is a meaningful form that is completed at the beginning stages of every project/transformation/CIP/Procedure	Head of Culture, Inclusion, Wellbeing and Engagement	December 2021	E&D Sub-Committee		
1.1 / 4	Extension of e-learning package to design and deliver specific EDI training and education to all LWH staff	Head of Culture, Inclusion, Wellbeing and Engagement	December 2021	E&D Sub-Committee		
1.1 / 5	Education and celebration of the key EDI events: Black History Month, Disability History Month, LGBT+ History Month and key faith observance days/festival	Head of Culture, Inclusion, Wellbeing and Engagement	December 2021	E&D Sub-Committee		
1.1 / 6	Exploration of how we attract local population to work at LWH, utilising widening participation programmes and alternative ways to advertise and promote our job opportunities	Head of Culture, Inclusion, Wellbeing and Engagement	December 2021	E&D Sub-Committee		
1.1 / 7	Ensure all BAME colleagues have a career conversation with their Manager	Head of Culture, Inclusion, Wellbeing and Engagement	November 2021	E&D Sub-Committee		
1.1. 8	Exploration and implementation of more diverse recruitment and selection processes including diverse interview panels and alternative recruitment methods	Head of Culture, Inclusion, Wellbeing and Engagement	March 2022	E&D Sub-Committee		

Strategic Threat *(what might cause this to happen)*	**Controls** *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Source of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Controls/Assurance** *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	**Overall Assurance Rating**

Unable to effectively engage with our patient and staff groups to understand further the needs of individuals with protected characteristics and respond proactively to identified needs	Patient stories on ED&I related matters being received by staff at Divisional Board, In the Loop etc	Divisional Board minutes, In the Loop recordings, other staff communications		Need to review internal communications and key Trust meetings to ensure that stories and the experience from under-represented groups is being heard, with action taken if necessary. **(Action 1.1 / 3)**	
	Patient information leaflets are up to date and accessible for all protected groups	Annual audit of patient leaflets to ensure accessibility and usability		To check where this assurance is currently being monitored and reported.	
	Enhanced communication and patient experience for people with disabilities coming for care at the Trust as part of Reasonable Adjustment activities	Personalised Maternity Care Budgets/ Maternity Early Adopter and Pioneer site – LMS Cheshire and Mersey Patients with learning difficulties, mental health or autism spectrum are allowed relatives to stay with them throughout their stay. Pro-active admissions for these groups with preadmission and discharge planning Admission procedures and assessments e.g. MUST /VTE/ FALLS / risk assessment Maternity Pre-operative assessments		None	
	Barriers removed to access/health inequalities to maternity services for all with specific focus to migrant and asylum-seeking women	Barriers identified and measures put in place to remove e.g. Presence of representatives from MRANG in the antenatal clinic to support asylum seekers		Further work required to ensure that the Trust is adequately engaging with its communities and understanding how best to deliver and tailor its services. For this feedback to generate actions to build trust. **(Actions 1.1 / 4 and 1.1 / 5)**	
	Gap Reference	**Required Action**	**Lead**	**Implement By**	**Monitoring**	**Status**
	1.1 / 9	Review internal communications and key Trust meetings to ensure that stories and the experience from under-represented groups is being heard, with action taken if necessary.	Head of Audit, Effectiveness and Patient Experience	September 2021	Patient Involvement & Experience Sub-Committee	
	1.1 / 10	Need to ensure that the Trust is adequately engaging with its communities and understanding how best to deliver and tailor its services. For this feedback to generate actions to build trust.	Head of Audit, Effectiveness and Patient Experience	September 2021	Patient Involvement & Experience Sub-Committee	
	1.1 /11	To review complaints data to explore trends relating to patients with protected characteristics	Head of Audit, Effectiveness and Patient Experience	September 2021	Patient Involvement & Experience Sub-Committee	
Strategic Threat *(what might cause this to happen)*	**Controls** *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Source of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*		**Gaps in Controls/Assurance** (*Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	**Overall Assurance Rating**
COVID-19 impact further increasing health inequalities for staff and patients	Staff working from home wherever possible, use of virtual meetings and enhanced IT provision Clear staff absence process and monitoring with increased flexibility Clear criteria as to elements of activity and types of patients the Trust can assist with Regular staff communications Listening Event for BAME staff completed to consider what further action the Trust could take to ensure BAME staff are protected as much as possible Risk Assessments undertaken for shielding & vulnerable staff including BAME, Pregnant workers, Age and Gender Comprehensive testing programme for symptomatic staff & household, antibody testing programme and have commenced asymptomatic testing for staff in high risk clinical areas Lateral Flow Testing at Home ongoing for all staff Trust offering vaccination reserve list to family members of staff who meet priority groups Staff Flu Vaccination Campaign completed within timeframe to required target level Covid - 19 Staff vaccination programme in place over 83% of staff have had vaccine.2nd dose programme to commence on 19th March 2021 Staff who have not had a first dose or have declined are being supported by local managers and HR in relation to any concerns about the vaccine Clear communication to patients via direct communications and social media. Review of national guidance re:activity delivery via Clinical Advisory Group Visiting Policy amended to reduce risk of spread PALS service continuing Family liaison service established to supplement PALS Service. Baby swabbing offer to new parents on leaving the hospital to provide assurance regarding hospital acquired infection. In patient swabbing in place monitored for completion at day 3 and day 5 as per national requirement Trust following National Guidance on Maternity partner support	Reduced footfall though the Trust - activity and visitors (comms) Close monitoring of guidelines and mandatory requirements with assurance reported to Extraordinary Board on 18 June 2020 Corporate BAU largely maintained despite remote working. Regular Covid-19 response reports to the Public Board EPRR Meetings continued Weekly monitoring of vaccine uptake in staff Weekly monitoring of swabbing of in patients		The age profile of individuals being infected with Covid-19 appears to be extending and there is an increase in the younger population with Covid-19. This includes the main age group of women attending maternity services. There is a possible increase in numbers of ladies and partners attending LWH who may be Covid-19 positive but asymptomatic. Impact on whole system during 'wave Three'	
	Gap Reference	**Required Action**	**Lead**	**Implement By**	**Monitoring**	**Status**
	1.1 / 6	Close working with Cheshire and Mersey procurement via Covid Supply Response (CSR)	Head of Procurement	September 2021	EPPR	

BAF Risk 1.2: Failure to recruit and retain key clinical staff

Lead Director: CPO
Op Lead: Deputy Director of Workforce

Review Date:

Ulysses Ref:

Strategic Priority: SA1: To develop a well led, capable, motivated and entrepreneurial workforce

Lead Committee: Putting People First

Provider Licence Compliance link:

N/A

SCORE:

July 2021	Q2	Q3	Q4	Q 2 Q movement	2021/22 Target
20 (4 x 5)				⟷	12 (3 x 4)

Rationale for current risk score:

Whilst the Trust has a significant number of controls and sources of assurance, the Trust does have acute and chronic staffing challenges in several areas and a higher than target sickness rate. The particularly acute issues with maternity staffing are the main driver behind this risk being scored a '5' for likelihood. There are also the following issues to consider: Insufficient numbers of doctors in training; ageing workforce; national shortage of nurses and midwives; isolated site and associated clinical risk impacting on recruitment and retention of specialist consultant staff; pension tax changes impacting on the retention of consultant medical staff (early retirement or reduction in working time).

There are examples of positive assurance in how the Trust has responded to the pandemic in relation to staff wellbeing but there remains some significant challenges during the 'recovery stage' and will require Board oversight and attention.

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust.	Appraisal policy, paperwork and systems for delivery and recording are in place for medical and non-medical staff.	Monthly KPI's for controls.	Quality of appraisal.	
	Behavioural framework developed in partnership with staff in 2021			
	Consultant revalidation process.	Outcomes reported to PPF and the Board	None	
	Reward and recognition processes linked to values.	Monthly KPI's for controls.	None	
	Pay progression linked to mandatory training compliance	Monthly KPI's for controls.	None	
	Targeted OD intervention for areas in need to support.	PPF Committee	Staff survey engagement score not improved in year Mandatory training currently below target. Sickness absence above target. **(Action 1.2 / 1)**	
	New Leadership Programme and Talent Management framework in place.	Leadership & Talent Strategy	Recommendation from Well-Led Review that additional measurables applied to this strategy to measure progress. Poor attendance at non-mandatory training e.g. leadership training. Requirement for further development of middle management	
	Programme of health and wellbeing initiatives.	Reported to PPF Committee	Ongoing challenges of engaging effectively with all staffing groups due to rota patterns.	
	All new starters complete mandatory PDR training as part of corporate induction ensuring awareness of responsibilities.	Monthly KPI's for controls.	None	
	Workforce planning processes in place to deliver safe staffing.	Divisional Board and Divisional Performance Reviews	Further evidence required that robust plans are being reviewed regularly at Divisional Board level	
	Shared decision making with JLNC and Partnership Forum.	Chair's Report to PPF Committee	None	
	Putting People First Strategy	Progress reported to PPF Committee	None	
	Guardian of Safe Working.	Report form Guardian of Safe Working	None	
	PDR training programme in place and PDR window for band 7 and above in N&M commenced in 2021	Monthly KPI's for controls.	None	
	Two Freedom to Speak Up Guardians	Bi-annual Speak Up Guardian Reports.	Consideration to be given to well-led review recommendation regarding development of a 'Champion's Network'.	
	Whistle Blowing Policy	Annual Report to PPF and Audit Committee	None	
	Engagement Tool Implemented.	Quarterly internal staff survey (Go Engage System)	None	

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
1.2 / 1	PPF deep dive into service level workface risks	Deputy Director of Workforce	On-going	PPF Committee	
1.2 / 3	Executive team and staff side walkabouts – to consider amending this process in line with recommendations from the Well-Led external review	Deputy Director of Workforce	1 September 2021	PPF Committee	
1.2 / 4	Fair & Just Culture Programme Delivery - Year 3 Action plan now developed and in place - key elements include training and engagement activities for colleagues at all levels.	Deputy Director of Workforce	30th June 2021	PPF Committee	
1.2 / 5	To respond to well-led review recommendation regarding additional measurables for talent & leadership programme	Deputy Director of Workforce	1 September 2021	PPF Committee	

	1.2 / 6	Consideration to be given to well-led review recommendation regarding development of a 'Champion's Network'. There is now a Great Place to Work Network	Deputy Director of Workforce	1 September 2021	PPF Committee		

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance (*Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
The Covid-19 pandemic has the potential to impact staff wellbeing, particularly in relation to morale and a result of changed ways of working.	Staff working from home wherever possible, use of virtual meetings and enhanced IT provision Clear staff absence process and monitoring with increased flexibility Clear criteria as to elements of activity and types of patients the Trust can assist with Regular staff communications Listening Event for BAME staff completed to consider what further action the Trust could take to ensure BAME staff are protected as much as possible Risk Assessments undertaken for shielding & vulnerable staff including BAME, Pregnant workers, Age and Gender	PPF Committee Feedback from staff side	'Staff recovery' will be as important as 'service recovery' post pandemic. This must remain as a key area of attention for the organisation.	

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance (*Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Insufficient numbers of clinical staff resulting in a lack of capability to deliver safe care and effective outcomes.	Annually agreed funding contract with HEE	PPF Committee, HEN Visit	None	
	Regional Training Programme Directors manage the junior doctor rotation programme and highlight shortages to the Lead Employer.	Lead Employer notifies the Trust of Gaps in local rotations, giving the Trust autonomy to recruit at a local level into these gaps	None	
	Effective electronic rota management system for AFC staff implemented with doctors implemented by early 2022	PPF Committee	Further utilisation of the rota management system. E-Roistering System not fully utilised	
	Director of medical Education (DME) to ensure training requirements are met, reporting to the Trust Medical Director and externally to HEN	Quarterly reporting by Guardian of Safe Working, GMC Survey	None	
	Guardian of Safe Working Hours appointed in 2016 under new Junior Doctor Contract.	Quarterly reporting by Guardian of Safe Working.	None	
	Acting down policy and process in place to cover junior doctor gaps	Quarterly reporting by Guardian of Safe Working.	None	
	National Revalidation process ensuring competent staff.	Revalidation report to PPF Committee	None	
	Shared decision making and review of risk with JLNC.	Chair's Report to PPF Committee	None	
	Succession Planning and Talent Programmes	PPF Committee	None	
	NHSE Retention Improvement Programme	PPF Committee	None	
	NHSI Sickness Improvement Programme	PPF Committee	None	
	NHSE/I leadership programme to reduce sickness	PPF Committee	None	
	Shared appointments with other providers	PPF Committee	None	
	Secured operating time at the LUH	PPF Committee	None	
	Increased consultant recruitment with incentives Neonatal Partnership	PPF Committee	None	
	Maternity introduction of ACP Midwives	PPF Committee	Maternity Staffing requirements require further analysis.	

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
1.2/1	Await outcome of Business case sent to NHSI to develop E-Rostering System Collaborative - The Trust has been successful in its business case and a procurement process has commenced and will be concluded by February 21 This will be concluded for O&G doctors by September, others by early 2022	Deputy Director of Workforce	September 2021	PPF Committee	
1.2 / 2	To provide evidence that robust workforce plans are being reviewed regularly at Divisional Board	Deputy Director of Workforce	1 September 2021	PPF Committee	
1.2 / 3	Robust Maternity Staffing plans to be developed	Head of Midwifery	1 September 2021	Quality Committee	

Strategic Objective	SA2: To deliver SAFE services
Committee:	Quality Committee & Finance, Performance & Business Development Committee
Risk Appetite:	Low

Principal risks (BAF)	Risk Score
2.1 Failure to progress our plans to build a new hospital co-located with an adult acute site	15 (3 x 5)
2.2 Failure to develop our model of care to keep pace with developments and respond to a changing environment	12 (3 x 4)
2.3 Failure to implement all feasible mitigations to ensure services delivered from the Crown Street site are as safe as possible, developing our facilities for the benefit of our patients as well as those across the system	20 (4 x 5)
2.4 Major and sustained failure of essential IT systems due to a cyber attack	15 (3 x 5)

Risk and Controls Summary

To outline changes to risk scores, new risks or closed risks.

2084 - No change in risk score since last review. Last reviewed 12/03/21

2085 - No change in risk score since last review. Last reviewed 08/09/2021

2086 - No change in risk score since last review. Last reviewed 12/05/21

2296 - No change in risk score since last review. Last reviewed 08/01/21

2321 - No change in risk score since last review. Last reviewed 06/09/21

Ref	Corporate Risk Register / High Level (15+) Risks	Risk Score
1961	Risk to patient safety, including risk of misdiagnosis, inaccurate reporting of imaging findings, and lack of evidence that imaging has been performed on PACS.	16
2397	Following a recent serious incident, there is a risk that patients will not be informed of abnormal imaging results from LWH or external organisations when the results are received at the Trust	16
2341	There is a risk that during the Covid-19 pandemic, adult patients who suffer a cardiac arrest will receive suboptimal resuscitation	16
2386	Risk of personal and sensitive information being compromised or being misused	15
2316	Risk of women needing to access emergency care with pregnancy complications and not being able to access advice or care at the point needed. Impact on the safety of patients, (physical/psychological harm)	16
2446	A number of patients who had been waiting for Gynaecology surgery (P4) and had pre-operative scans that were missed / not reviewed in time, subsequently had escalation of diagnosis and further management plan.	16
2084 **(CRR)**	Uncertainty of adequacy of 24/7 access to specialist input to support changing patient profiles and needs, new guidance and the Chief Medical Officer's recommendation of the specialist multidisciplinary team approach to treatment planning and co-ordination, including pre-operative, surgical and up to level 3 post-operative care for improved patient safety and improved outcomes.	6
2085 **(CRR)**	Uncertainty around access to dedicated diagnostic capacity and physiological measurement needed to support needs of a changing patient demographics and an increase in complex multiple comorbidities and meeting the pre-operative assessment standards of the AAGBI and the RCoA, to assess patients' clinical risk and plan for additional requirements for their safety and provide an optimal experience.	12
2086 **(CRR)**	Uncertainty about provision of adequate on-site Blood bank stocking all major blood products necessary to support the needs of the Maternity service.	9
2296 **(CRR)**	The LWH laboratory autoview analyser (the machine used to process Blood Group and Save samples on site) will no longer be supported as of 1st March 2020. This machine cannot continue to be used after this date.	16
2321 **(CRR)**	Due to the Trust not being located next to or with acute services, it is unable to meet the National Recommendations for Maternal Medicine	15

BAF Risk 2.1: Failure to progress our plans to build a new hospital co-located with an adult acute site	Lead Director: Medical Director Op Lead: Head of Transformation & Strategy	Review Date: Oct 21	Ulysses Ref: TBC

Strategic Priority: SA2: To deliver SAFE services

Lead Committee: Finance, Performance & Business Development Committee

Provider Licence Compliance link:

Integrated Care Condition

SCORE:

July 2021	Q2	Q3	Q4	Q 2 Q movement	2021/22 Target
15 (3 x 5)	15 (3 x 5)			⟷	15 (3 x 5)

Rationale for current risk score:

The Trust's services being located on an isolated site away from an acute centre, remains the most significant risk to the organisation. The Trust can demonstrate strong controls in relation to developing the clinical evidence base for the move and has achieved buy in from significant stakeholders. There remains however, a lack of system support outside of the C&M region to secure the capital case.

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Inability to effectively communicate the case for change with regulators, key partners and the local community and receive buy-in to move project forward.	Continuing dialogue with regulators	CEO and Chair maintaining on-going dialogue Support for Expression of Interest submitted 9th September 2021 from C&M. Trust has shared EOI with C&M partners, positive support received	Lack of system support outside of Cheshire and Mersey to secure the capital case H&CP submissions for capital bids not successful despite system agreement of clinical case	
	Future Generations Strategy Update	Available on the Trust website Future Generations Strategy has been included within refreshed overall corporate strategy and is a key supporting strategy within Trust strategic framework Future Generations Clinical Advisory Group has been reconstituted	None	
	Business case refresh	Refresh of business case is underway, informed by work of FGCAG. Work includes review of compliance against new clinical standards, counterfactual case refresh, future model of care, updated of clinical case for change (taking account of changes at LWH, in system and health and care landscape over last 5 years)	Business case refresh is led by Trust rather than commissioners as with previous case Public consultation required	
	Active management with all commissioners	Good meetings with CCG via Clinical Quality and Performance Group (CQPG) Relationships with key ICS stakeholders established Escalation of risks of isolated site to system level	None Transfer of commissioning arrangements from CCGs to ICS Potential change in ICS Board in April 2022	
	Progress being made in relation to building relationships with LUFT ***Proposed to move this control to BAF Risk 2.3**	Partnership Board meetings and involvement in wider Estates Strategy Mapping of requirements from and interdependencies with LUHFT across all Trust specialties	Establish task and finish groups to address key issues/relationships (to include any outstanding actions from clinical summit) Agreement/engagement from LUHFT Signed SLA	
	Future Generations project group established with the Trust	Reports to the Quality Committee	Only recently re-started.	
	External validation of case for change	Output from Clinical Summit report (2019)	Lobby systems and MPs for active support External review/testing of counterfactual case External review/testing of refreshed case for change, following completion of FGCAG work/business case refresh	

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
2.1/1	Management of Future Generations Strategy through Project Management Office	Head of Strategy and Transformation	August 2021	Board	On track
2.1/2	Submission of Expression of Interest for new hospital building	Head of Strategy and Transformation	September 2021	Board	Complete
2.1/3	Business case refresh – completion of refreshed case for change, including supporting evidence, clinical standards compliance, refreshed counterfactual case	Head of Strategy and Transformation	November 2021	Board	On track
2.1/4	Business case refresh – completion of options appraisal and refreshed model of care for future of women's and neonatal services	Head of Strategy and Transformation	December 2021	Board	On track

2.1/5	Business case refresh – refreshed estates modelling and schedule of accommodation for new build	Head of Strategy and Transformation	January 2022	Board	On track
2.1/6	Business case refresh – completion of financial modelling and LTFM	Head of Strategic Finance	February 2022	Board	On track
2.1/7	External validation of case for change and counterfactual case	Medical Director	January 2022	Board	On track
2.1/8	Longlisting of EOI (external control of this by NHSE/I)	Chief Finance Officer	December 2021	Board	On track
2.1/9	Approval of EOI (external control of this by NHSE/I)	Chief Finance Officer	April 2022	Board	On track
2.1/10	Commence public consultation (external control of this action by commissioners and NHSE/I)	Head of Communications and Marketing	July 2022	Board	On track
2.1/11	Development and completion of business case (OBC, FBC stages) through New Hospitals Building Programme approach (external control of this by NHSE/I)	Head of Strategy and Transformation	March 2024	Board	On track
2.1 / 3	Outcomes from the clinical summit to be actioned ***Proposed to move this action to BAF risk 2.3**	Head of Transformation & Strategy	August 2021	Board	On track
2.2 / 12	Lobby systems and MPs for active support	Head of Communications and Marketing	December 2021	Board	
2.2 / 13	Build relationships with key ICS personnel	Medical Director	December 2021	Board	On track

BAF Risk 2.2: Failure to develop our model of care to keep pace with developments and respond to a changing environment	**Lead Director:** COO **Op Lead:** Deputy COO	**Review Date:**	**Ulysses Ref:**

Strategic Priority: SA2: To deliver SAFE services

Lead Committee: Finance, Performance & Business Development Committee

Provider Licence Compliance link:

SCORE:

July 2021	Q2	Q3	Q4	Q 2 Q movement	2021/22 Target
12 (3 x 4)	16 (4 x 4)			↑	8 (2 x 4)

Rationale for current risk score:

The lack of an EPR (and as a corollary, having in place a disparate number of systems), remains a significant risk to the organisation because information is spread across disparate systems leading to information being incomplete, hard to find in a timely manner and a potential for inaccuracies due to manual transfer of information. However, there is evidence of pro-active mitigating controls and progress being made in the procurement and subsequent implementation of an integrated Meditech EPR system. The Trust can demonstrate evidence of being open and responsive to change in service development and delivery but further work can be done to strengthen the approach to horizon scanning and longer term, strategic planning at a Divisional level.

Strategic Threat *(what might cause this to happen)*	**Controls** *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Source of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Controls/Assurance** *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	**Overall Assurance Rating**
The Trust's current clinical records system (paper and Electronic) are sub-optimal.	Approved Digital Generations Strategy	Quarterly risk assessments completed	None	
	Approved Meditech Expanse Business Case	FPBD Committee overview and scrutiny	None	
	Maintenance of present system	Digital Hospital Committee oversight	None	
	Development of individual / service solutions e.g. PENs (Gynaecology) and Staff training	Approved EPR Business case which define clear direction and preferred solution.	Staff fatigue and loss of confidence. Ability of clinical staff to engage with the system development due to time and financial impact	
	Incident reporting	EPR programme board chaired by MD	None	
	Tactical solutions including the implementation of K2 Athena system	Independent lessons learnt Positive review	Optimisations to K2 system and refinements which are required	
	Exchange/LHCRE enables for patent information sharing	MIAA Critical Application Audit (rolling programme across trust systems) Reporting into Audit Committee and Digital Hospital Group	Not all Trust using LHCRE for patient information exchange	
	Virtual Desktop technology to aid staff working flexibly.		None	
	Additional network resilience for LUHFT supplied systems (K2/PENS/CRIS) to reduce risk of unplanned systems downtime		None	
	PACS upgrade removes a separate login for that system, reducing multiple systems issues.		None	
	Task and Finish group established to ensure that clinical investigation undertaken at external trusts have been actioned accordingly.	Safety and Effectiveness Sub-Committee	None	
	Appropriate task and finish groups established as required by Safety and Effectiveness sub-committee	Safety and Effectiveness Sub-Committee	None	

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
2.2 / 1	Develop staff communication plan for new system	CIO	December 2021	Digital Hospital Committee oversight	
2.2 / 2	Ongoing review of systems and mitigations quarterly (report to FPBD & QC)	CIO	February 2022	FPBD and Quality Committees	
2.2 / 3	Issue appropriate communication to all staff in relation to digital development by multiple means and forms	CIO	April 2022	Digital Hospital Committee oversight	
2.2 / 4	Develop a business case for appropriate digital training capabilities for the Trust	CIO	April 2022	Digital Hospital Committee oversight	
2.2 / 5	Develop a digital clinical leadership business case	CIO	September 2021	Digital Hospital Committee oversight	Complete
2.2 / 6	Implement required system optimisations as identified by Maternity and other Trust stakeholders	CIO	April 2022	Digital Hospital Committee oversight	
2.2 / 7	Task and Finish group to explore mitigations and identify new solutions to ensure the results of clinical investigations are reviewed and actioned. Ensuring documentation of this process can be provided	CIO	April 2022	Digital Hospital Committee oversight	

Strategic Threat *(what might cause this to happen)*	**Controls** *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Source of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Controls/Assurance** *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	**Overall Assurance Rating**
Clinical service strategies	Operational 'Plans on a page' for Divisions	Divisional Board meetings	To improve horizon scanning processes to constantly review and update plans on a page To understand commissioning priorities emerging from developing ICS	
	Operational planning process	Operational plans and budgets	None	

that do not sufficiently anticipate evolving healthcare needs of the local population and/or reduce health inequalities	Availability of data on service trends and demographics		Divisional Boards		To ensure that Divisions are fully utilising data to understand changing service demands	
	Workforce plans		Divisional Boards		To ensure that workforce plans are informed by trends and data led intelligence.	
	Gap Reference	**Required Action**	**Lead**	**Implement By**	**Monitoring**	**Status**
	2.2 / 8	Use of effective horizon scanning at Divisional Boards to review and update 'plans on a page' – to include emerging intelligence around commissioning priorities from developing ICS	Deputy COO	September 2021	Executive Team	
	2.2 / 9	To ensure that Divisions are fully utilising data to understand changing service demands	Deputy COO	September 2021	Executive Team	
	2.2 / 10	To ensure that workforce plans are informed by trends and data led intelligence.	Deputy COO	September 2021	Executive Team	

BAF Risk 2.3: Failure to implement all feasible mitigations to ensure services delivered from the Crown Street site are as safe as possible, developing our facilities for the benefit of our patients as well as those across the system	**Lead Director: Medical Director** **Op Lead:** Head of Strategy & Transformation	**Review Date: Oct 2021**	**Ulysses Ref: TBC**

Strategic Priority: SA2: To deliver SAFE services

Lead Committee: Quality Committee

Provider Licence Compliance link:

N/A

SCORE:

July 2021	Q2	Q3	Q4	Q 2 Q movement	2021/22 Target
20 (4 x 5)	20 (4 x 5)			⟷	15 (3 x 5)

Rationale for current risk score:

The Trust's services being located on an isolated site away from an acute centre, remains the most significant risk to the organisation and to patient safety. Good progress is being made on mitigating measures to make the Crown Street site safer with a number of significant capital projects either completed, underway or planned. It should be acknowledged that the impact of this risk cannot be fully mitigated whilst the Trust operates on an isolated site.

Strategic Threat *(what might cause this to happen)*	**Controls** *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Source of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Controls/Assurance** *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	**Overall Assurance Rating**
Location, size, layout and accessibility of current services do not provide for sustainable integrated care or safe and high-quality service provision.	Programme for a partnership in relation to Neonates with AHCH has been established.	Neonatal partnership updates provided to the Board	None	
	£15m capital investment in neonatal estate to address infection risk	IPC Reports	None	
	Transfer arrangements well established for neonates and adults	Transfers out monitored at HDU Group	None	
	Formal partnership and board established with Liverpool Universities Hospitals with respect to: -Diagnostics -Medical and surgical expertise -Intensive care facilities -Theatre access at Liverpool Universities Hospitals for women with Gynae cancers		Onsite and partnership mitigations cannot fully address the clinical risk - this can only be achieved through co-location	
	Blood product provision by motorised vehicle from nearby facility.	Serious incidents, should they occur are tracked and reported through the governance framework,	None	
	Investments in additional staffing inc. towards 24/7 cover	Staff Staffing levels reports to board	Emerging clinical standard leading to potential loss of services and increase in difficulty in relation to recruitment of consultants	
	Enhanced resuscitation training provision	Training compliance rates reported to PPF Committee	None	
	Crown Street Enhancement Group developed and has commenced meeting		Financial and workforce constraints for delivery of additional facilities on site. - No blood bank on site -No 24/7 cover on site - No CT	
	Divisional Operational Plans completed	Divisional Boards	None	

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
2.3 / 1	Divisional plans to be developed to support long term clinical sustainability via operational plan - Action in final stages of completion.	Head of Transformation & Strategy	July 2021	Trust Executive	
2.3 / 2	Agree funding for mitigations on site (Blood Bank, MRI, Diagnostics, CT and Staffing) for inclusion in 20/21 operational plan	Head of Transformation & Strategy	July 2021	FPBD Committee	
2.3 / 3	Project to establish 24/7 transfusion services, robotics surgical service and CT imaging at the Crown Street site. To include construction work and associated estate reconfiguration	Head of Transformation & Strategy	July 2021	FPBD Committee	

BAF Risk 2.4: Major and sustained failure of essential IT systems due to a cyber attack	Lead Director: CIO Op Lead: CIO	Review Date: Oct 2021	Ulysses Ref: TBC

Strategic Priority: SA2: To deliver SAFE services

Lead Committee: Quality Committee

Provider Licence Compliance link:

SCORE:

July 2021	Q2	Q3	Q4	Q 2 Q movement	2021/22 Target
N/A	15 (3 x 5)			N/A	12 (2 x 5)

Rationale for current risk score:

The Trust's Digital Services department places cyber security management at the core of operational activities, ensuring it maintains it's Cyber Essentials plus standard. Various controls are implemented that are considered effective and this reduces the likelihood of a cyber-attack impact. However, if a cyber-attack was successful the impact would likely be catastrophic to Trust services, likely rendering digital systems that clinical services are increasingly dependent on, unavailable for a period of time. The Digital Services department continue to strengthen controls through process refinement and the introduction of security technologies. On the basis of this, the impact is considered catastrophic and likelihood is considered as possible resulting in an overall score of 15.

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Ineffective cyber controls and technology, inadequate investment in systems and infrastructure, failure in skills or capacity of staff or service providers, poor end user culture regarding cyber security and IT systems use, inadequate contract management. **Consequence: Reduced quality or safety of services, financial penalties, reduced patient experience, loss of reputation, loss of market share / commissioner contracts.**	Microsoft Windows security and critical patches applied to all Trust servers on all servers\laptops and desktop devices on a monthly basis. Network switches and firewalls have firmware updates as and when required installed. Wifi network firmware patches applied for Controllers and Access points. Mobile end devices patched as and when released by the vendor. Externally managed network service provider to ensure network is a securely managed with underpinning contract. Robust carecert process to enact advice from NHS Digital regarding imminent threats. Network perimeter controls (Firewall) to protect against unauthorised external intrusion. Robust Information Governance training on information security and cyber security good practice. Regular staff educational communications on types of cyber threats and advice on secure working of Trust IT systems. Additional cybersecurity communications in relation to Covid phishing/ scams, advising diligence. Enhanced VPN solution including increased capacity to secure home working connections into the Trust. Review and updating of information security policies and home working IG guidance to support staff who are remote working. Malware protection identifies and removes known cyber threats and viruses within the Trust's network and at the network boundaries. Cyber Security Monitoring System identifies suspicious network and potential cyber threat behaviour. National CareCert alerts inform of known and imminent cyberthreats and vulnerabilities	Cyber Essentials Plus Standards/KPIs IMT Risk Management Meeting Digital Hospital Sub Committee MIAA Cyber Controls Review Cyber Essentials Plus Accreditation Cyber Penetration Test NHS Care Cert Compliance	Lack of Cyber Security strategy Lack of Network Access Controls within the physical network.	

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
2.4 / 1	Implement a Cyber Security strategy	CIO	Dec 2021	FPBD	
2.4 / 2	Procure and implement Network Access Control (NAC) solution	CIO	Mar 2022	DHSC	

Strategic Objective	SA3: To deliver the best possible EXPERIENCE for patients and staff
Committee:	Quality Committee
Risk Appetite:	Low

Principal risks (BAF)	Risk Score
3.1 Failure to deliver an excellent patient and family experience to all our service users	12 (3 x 4)

Risk and Controls Summary

To outline changes to risk scores, new risks or closed risks.

1966 - No change in risk score since last review. Last reviewed 07/09/2021.

2088 - No change in risk score since last review. Last reviewed 16/08/21

Ref	Corporate Risk Register / High Level (15+) Risks	Risk Score
2418	Lack of support and appropriate care for patients presenting with mental health conditions	16
2430	Network outlier for pre-term mortality - rate is higher than the national average	16
2427	Covid lockdown between March 2020 and July 2020 and then September 2020 and subsequently December 2020 to March 2021, resulting in prolonged wait for elective surgery for benign gynaecologic procedures	16
2350	Due to the need to reduce patient attendance / stop elective activity and adhere to social distancing as a result of Covid-19 a number of services within Gynaecology have had to cease or changes the way in which they are delivered	15
2304	Failure to achieve 31 day and 62 day national cancer targets, and having monthly 104 day breaches	16
1966 **(CRR)**	Risk of safety incidents occurring when undertaking invasive procedures	12
2088 **(CRR)**	Lack of on-site specialist paediatric care and support services Neonatal surgery provision and Level 3 neonatal intensive care unit and lack of on-site provision for CT & MRI scanning and Blood bank and Transfusion Lab.	12

BAF Risk 3.1: Failure to deliver an excellent patient and family experience to all our service users	**Lead Director: CN&M** **Op Lead:** Deputy Director of Nursing & Midwifery	**Review Date: Oct 2021**	**Ulysses Ref: TBC**

Strategic Priority: SA3: To deliver the best possible EXPERIENCE for patients and staff

Lead Committee: Quality Committee

Provider Licence Compliance link:

SCORE:

July 2021	Q2	Q3	Q4	Q 2 Q movement	2021/22 Target
12 (3 x 4)	12 (3 x 4)			⟺	8 (2 x 4)

Rationale for current risk score:

The Trust has strong evidence in relation to its response to the Covid-19 pandemic and continues to receive positive feedback from significant patient surveys. To improve further, it is imperative that the organisation ensures that it can listen to patient voices and the local community and ensure that services are responsive and can cater to differing needs. The evidence for how effective the organisation is undertaking this can be strengthened from the current position.

Strategic Threat *(what might cause this to happen)*	**Controls** *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Source of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Controls/Assurance** (*Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	**Overall Assurance Rating**
Unable to recover services to pre-Covid-19 levels and beyond	Commitment to deliver Business as Usual wherever possible	Situation continues to be monitored at Oversight and Scrutiny Group weekly and 3 times a week at the Command and Control meeting.	National mandates and what the Trust is required to recover and trajectories. Day case efficiency currently 70% backlog and ineffective in dealing with backlog. Insufficient Theatre staffing due to vacancies and not having a full complement of anaesthetists. Test, Track and Trace system impact on staffing	
	Corporate controls remain in place	Annual Governance Statement and performance reports		
	On-going regulatory compliance	As above		
	Recovery plans in development to include areas of good practice which should be maintained	Cancer services activity in Feb 2021 above activity in 2020		
	Maternity escalation and incineration process in place to support staff taking on back and extra shifts at times of short staffing	Safe Staffing report		

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status

Strategic Threat *(what might cause this to happen)*	**Controls** *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Source of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Controls/Assurance** (*Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	**Overall Assurance Rating**
Unable to adequately listen to patient voices and our local communities to ensure that services are responsive and cater to differing needs and are sensitive to the inclusion and diversity of the populations that we serve.	Patient Experience Strategy	Experience Senate (now Patient Involvement & Experience Sub-Committee)	Updated Strategy in development. There is a need to ensure that the Trust is adequately hearing from all demographic areas and ensuring that services are tailored to meet differing needs as much as is practicable. Improvements required in how Divisions utilise patient views and feedback to drive quality improvement.	
	Family Liaison Service	Experience Senate (now Patient Involvement & Experience Sub-Committee)		
	PALs and Complaints data	Experience Senate (now Patient Involvement & Experience Sub-Committee)		
	Friends and Family Test	Experience Senate (now Patient Involvement & Experience Sub-Committee)		
	National Patient Survey	Experience Senate (now Patient Involvement & Experience Sub-Committee)		
	Healthwatch feedback	Experience Senate (now Patient Involvement & Experience Sub-Committee)		
	Social media feedback	Experience Senate (now Patient Involvement & Experience Sub-Committee)		
	Membership feedback	Council of Governors		

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
3.1 / 1	To finalise updated Patient Experience Strategy – This is done and been approved, the Plan on a page has also been completed and is going to be displayed across the Trust as the previous one was.	Head of Audit, Effectiveness and Patient Experience	September 2021	Patient Involvement & Experience Sub-Committee	
3.1 / 2	To ensure that the Patient Involvement & Experience Sub-Committee monitors the objectives within the updated Patient Experience Strategy – This is complete and the newly developed PEX reviews for each service monitor the objectives at the sub-committee. This is also on the business cycle for the Committee to be discussed at each meeting.	Head of Audit, Effectiveness and Patient Experience	September 2021	Patient Involvement & Experience Sub-Committee	
3.1 / 3	To build relationships with local community leaders and mechanisms for hearing feedback on the Trust's services – This is the work that Dez has been doing and once the new Experience Matron starts this is part of her objectives going forward working with Dez.	Head of Audit, Effectiveness and Patient Experience	September 2021	Patient Involvement & Experience Sub-Committee	
3.1 / 4	To appoint a Non-Executive Director with a focus on community engagement	Trust Secretary	November 2021	Board	
3.1 / 5	To ensure that Divisions are adequately utilising patient feedback to drive quality improvement initiatives – All of the divisions get the Friends and Family data weekly, this gives the opportunity for the areas to see any feedback both good and bad.	Deputy COO	September 2021	Patient Involvement & Experience Sub-Commitee	

Strategic Objective	**SA4: To be ambitious and EFFICIENT and make the best use of available resources**
Committee:	**Finance, Performance and Business Development Committee**
Risk Appetite:	**Moderate**

Principal risks (BAF)	Risk Score
4.1 Failure to ensure our services are financially sustainable in the long term	20 (5 x 4)
4.2 Failure to 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	8 (2 x 4)

Ref	Corporate Risk Register / High Level (15+) Risks	Risk Score
None identified to date		

Risk and Controls Summary

To outline changes to risk scores, new risks or closed risks.

BAF Risk 4.1: Failure to ensure our services are financially sustainable in the long term	**Lead Director: DoF** **Op Lead:** Deputy Director of Finance	**Review Date: Oct 21**	**Ulysses Ref: TBC**

Strategic Priority: SA4: To be ambitious and EFFICIENT and make the best use of available resources

Lead Committee: Finance, Performance & Business Development Committee

Provider Licence Compliance link:

SCORE:

July 2021	Q2	Q3	Q4	Q 2 Q movement	2021/22 Target
20 (5 x 4)	20 (5 x 4)			⟷	16 (4 x 4)

Rationale for current risk score:

The Trust has a well-defined and evidence backed case that whilst it remains on a single site, long-term financial sustainability will be compromised. Progress has been made to identify strategic solutions to this issue, but these remain unresolved. Whilst plans are in place, there also remains significant on-going uncertainty regarding the financial regime, introduction of Integrated Care Systems and consequent change in commissioning landscape and the impact of changing clinical requirements with resource implications. That said, these changes could also present opportunities for the Trust that the Board should remain aware of. The Trust can demonstrate robust short-term and 'business as usual' financial controls – evidenced by feedback from internal and external audit.

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
The Trust is not financially sustainable in the long term	5 Year financial model produced giving early indication of issues	5 Year plan approved (BoD Nov 2014) Long Term Plan Submission Nov 19	Whilst plans are in place, there remains significant on-going uncertainty regarding the financial regime, introduction of Integrated Care Systems and consequent change in commissioning landscape and the impact of changing clinical requirements with resource implications. Model to be refreshed by December 2021.	
	Business case to Trust Board which identifies a solution which minimises deficit, including relocation to an acute site and merger	Future Generations Clinical Strategy and Business Plan (BoD Nov 15 – refreshed in 2020) Sustainability and Transformation Plan (FPBD, Jul 16) PCBC Approval (FPBD, Oct 16)	Implementation of business case is dependent on decision making external to the Trust (CCG, NHSE/I) National CDEL Issue Lack of capital nationally Time has now elapsed, and business case is in process of being refreshed.	
	Early and continuing dialogue with NHSE/I and Cheshire and Merseyside ICS	System top up agreed to achieve breakeven for Half One 2021/22.	Uncertainty re future settlement and regime.	
	Agreement for merger proposals with partner Trusts approve by three BoD's	Strategic Outline Case for merger approved by three Trust Boards (BoD, Jun 16) SOC for preferred option approved by Board - Sept 17	Merger dependent on external partners	
	Engagement in place with Cheshire and Mersey Partnership to review system solutions	Submission of Cheshire and Mersey STP capital bid Summer 2018 ranked no1 of schemes Active participation in C&M planning processes	Position potentially superseded by development of ICS	
	Clinical Engagement and support for proposals	Northern Clinical Senate Report supporting preferred option	None	
	Reduction in CNST Premium and achievement of Maternity Incentive Scheme.	Process in place regarding CNST MIS. Prior achievement of MIS. Engagement with NHS Resolution and learning from claims and incidents.	None	
	Reduction in back office overheads costs.	Oversight on costs at FPBD and Board Focus on benchmarking and efficiencies, including joint working where possible.	Requirement for resource in relation to recovery and covid.	
	Application for emergency capital for mitigations on site	Approved with work now underway	Supports safety on site but will impact on financial position re capital charges, staffing etc.	

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
4.1/1	Agree financial plan for H2 with NHSI/E and C&M	CFO	November 2021	FPBD Committee	
4.1/2	Agree financial plan for 2022/23 with NHSI/E and C&M	CFO	March 2022	FPBD Committee	
4.1/3	Work with regional team, commissioners and Local Maternity System to ensure staffing costs and pressures, particularly in relation to maternity, Ockenden and revised clinical standards are funded.	CFO	March 2022	FPBD Committee	
4.1 /4	Business Case 4 - Revision of SOC following unsuccessful STP capital bid - Target has been put back based on initial feedback from TU readiness assessment - system buy in to be initial focus ahead of SOC update	Deputy Director of Finance	June 2023	FPBD Committee	
4.1 /5	Business Case 2 - Public consultation by CCG following development of preferred option (Subject to capital bid)	CFO	June 2022	FPBD Committee	
4.1 /6	Business Case 3 - Decision making business case produced in partnership with CCG and final decision following outcome of public consultation required	CFO	December 2022	FPBD Committee	
4.1 / 7	Business case - to support the application for capital to support the relocation required	CFO	December 2021	FPBD Committee	
4.1 / 8	Merger – Explore options in relation to merger	CFO	December 2022	FPBD Committee	
4.1 / 9	Explore options for shared executive model with LUHFT.	CFO	December 2022	FPBD Committee	

	4.1/10	Procurement 1 - OJEU - Undertake most appropriate formal procurement process to appoint primary building contractor & architect	CFO	June 2023	FPBD Committee		
	4.1 /11	Procurement 2 - PQQ Stage - Procurement team to complete Pre Qualification Questionnaire stage	CFO	September 2023	FPBD Committee		
	4.1 / 12	Procurement 3 - ITPD Stage - Procurement team to complete Invitation to Participate in Dialogue stage	CFO	April 2024	FPBD Committee		
	4.1/13	Procurement 4 - Financial Close - Procurement team to complete financial close stage	CFO	July 2024	FPBD Committee		
	4.1/14	Procurement 5 - Contract Award - Trust to approve contract award	CFO	September 2024	FPBD Committee		
	4.1/15	Business Case 1 - Work in partnership with CCG to refresh PCBC document, including stakeholder engagement and refresh of data.	Head of Transformation & Strategy	December 2021	FPBD Committee		
	4.1/16	Business Case 5 - Approval for funding from NHSI/E based on refreshed SOC	CFO	April 2023	FPBD Committee		

Strategic Threat *(what might cause this to happen)*	**Controls** *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Source of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Controls/Assurance** (*Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	**Overall Assurance Rating**
Risk that the Trust will not deliver a breakeven position or have sufficient cash resources in the 2021/22 financial year	Monthly reporting and monitoring of position including taking corrective action where required. Sign off of budgets by budget holders and managers, and holding to account against those budgets Divisional performance reviews Working within ICS/system to ensure issues understood and Trust secures required amount of available funding.	FPBD Committee Internal Audit- high assurance for all finance related internal audit reports in 2020/21 and 2021/22. External Audit	Lack of contractual income position due financial framework in place following the Covid-19 pandemic, gap in baseline position and block payment compared to actual activity and cost, risk to CIP and income streams, timing of recovery and uncertainty over future regime.	

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
4.1/20	Ensure regular reporting in place and corrective action taken where needed	Deputy Director of Finance	March 2022	FPBD Committee	
4.1/21	Ensure full CIP programme in place with relevant QIAs etc	Deputy Director of Finance	March 2022	FPBD Committee	
4.1/22	Negotiate settlement for Half Two	CFO	November 2021	FPBD Committee	
4.1/23	Agree sufficient cash resource for Half Two	CFO	November 2021	FPBD Committee	

BAF Risk 4.2: Failure to 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	**Lead Director: COO** **Op Lead:** Deputy COO	**Review Date: Oct 21**	**Ulysses Ref: TBC**

Strategic Priority: SA4: To be ambitious and EFFICIENT and make the best use of available resources

Lead Committee: Finance, Performance & Business Development Committee

Provider Licence Compliance link:

Integrated Care

SCORE:

July 2021	Q2	Q3	Q4	Q 2 Q movement	2021/22 Target
8 (2 x 4)	8 (2 x 4)			⟷	8 (2 x 4)

Rationale for current risk score:

The Trust has well defined partnerships and relationships with a number of key stakeholders. These have been strengthened and added to during the Covid-19 pandemic response. The regulatory and system landscape remains uncertain and the Board will be looking for additional clarity on future arrangements (and the Trust's assured role in this) in order to mitigate this risk and work towards the target score and improve the overall assurance rating on the controls.

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance (*Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Conflicting priorities, financial pressures (system financial plan misalignment) and/or ineffective governance resulting in a breakdown of relationships amongst ICS and ICP partners and an inability to influence further integration of services across acute, mental, primary and social care	Robust engagement with ICS discussions and developments through CEO and Chair	CEO Report updates to the Board Board workshop discussion – June 2021	Governance arrangements are developing **(Action 4.2 / 1)**	
	Evidence of cash support for the Trust's H1 breakeven position	Interim Trust budget agreed by the Board	Developments for H2 currently unknown	
	Neonatal partnership in place with Alder Hey	Regular updates to the Board	None	
	Partnership Board in place with LUHFT and involvement in wider Estates Plan	Updates provided to the Quality Committee and Board	None	
	Positive and developing relationship with Merseycare NHS FT	Updates provided to the FPBD Committee	None	
	LMS Hosting Arrangement	Updates provided to the Board	Governance arrangements are developing **(Action 4.2 / 2)**	
	Finance Directors Group	Updates provides to the Executive Team and through the governance structure when appropriate	None	
	Health care partnership are using existing memorandum of understanding in relation to staff movement between local hospital at time of staffing need.	Agreed at Board	None	
	LWH have provided assistance to LUFT by taking over Non Obstetric Ultrasound scanning activity	Mutual aid reported through to the Quality Committee and Board	None	
	LWH identified as Gynaecology Oncology Hub for Cheshire and Mersey.		None	
	Theatre sessions provided at LWH for other Trusts such as Colorectal for LUFT		None	
	Provision of mutual aid to NWAST by supporting staff testing on LWH site for them		None	
	Provision of Mutual aid to NWAST for staff Covid-19 vaccinations		None	

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
4.2 / 1	Continue to provide updates to the Board regarding the development of the ICS, highlighting when decision points are likely	CEO	On-going	Board	
4.2 / 2	Development and embedding of governance arrangements for the LMS	COO	September 2021	Board	

Strategic Objective	SA5: To participate in high quality research in order to deliver the most EFFECTIVE outcomes
Committee:	Quality Committee
Risk Appetite:	High

Principal risks (BAF)	Risk Score
5.1 Failure to progress our research strategy and foster innovation within the Trust	8 (2 x 4)
5.2 Failure to fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership	12 (3 x 4)

Ref	Corporate Risk Register / High Scoring (15+) Risks	Risk Score
2336	There is risk to the Trust, as it is not currently meeting the CQC Regulations and national guidance in relation to the care of children aged 18 and below within the Gynaecology services	15
2232 **(CRR)**	There is a risk that due to a number of causes the Trust is unable to meet the safety requirements related to Blood Transfusion	15
2295 **(CRR)**	Inability to achieve and maintain regulatory compliance, performance and assurance.	8
2329 **(CRR)**	There is a risk to the Trust is not meeting it requirements for the safe and proper management of medicines	12

Risk and Controls Summary

To outline changes to risk scores, new risks or closed risks.

2232 - No change in risk score since last review. Last reviewed 12/07/21.

2295 - No change in risk score since last review. Last reviewed 07/09/2021

2329 - No change in risk score since last review. Last reviewed 06/09/21

BAF Risk 5.1: Failure to progress our research strategy and foster innovation within the Trust	**Lead Director: MD** **Op Lead:** Director of Research	**Review Date: Oct 2021**	**Ulysses Ref: TBC**

Strategic Priority: SA5: To participate in high quality research in order to deliver the most EFFECTIVE outcomes

Lead Committee: Finance, Performance & Business Development Committee

Provider Licence Compliance link:

N/A

SCORE:

July 2021	Q2	Q3	Q4	Q 2 Q movement	2021/22 Target
8 (2 x 4)	8 (2 x 4)			⟺	4 (1 x 4)

Rationale for current risk score:

The Trust has a well-established and successful research process and has been particularly active in the support provided to the wider system during Covid-19. To strengthen this area and further mitigate this risk, the Trust should look to widen participation in research across the organisation making links explicit with quality improvement activity. There is also an opportunity to further enhance the Trust's research profile in the local system but also nationally and internationally.

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
If high quality research staff cannot be engaged and retained, then research activities will not be fulfilled leading to withdrawal of funding or damage to reputation	Excellent support continues to be provided to medical staff in identifying and nurturing talent, ensuring projects suggested by new researchers are feasible and of high quality and establishing mentorship for individuals who wish to have a research component as part of their future career.	The Trust in-house research management infrastructure continues to operate in a robust and efficient manner. Its performance can be demonstrated via various internal and external reporting mechanisms.	Further support and development of the non-medical workforce in respect of research is required	

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
5.1 / 1	To explore methods of providing further support and development for the non-medical workforce in relation to the research agenda.	Medical Director	October 2021	Research and Development Sub-Committee	
5.1 / 2	To collaborate with the Professor of Midwifery	Medical Director	October 2021	Research and Development Sub-Committee	

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Continued engagement with the City-wide integrated approach to innovation is necessary in order to further promote, develop and innovation ideas from the Trust's workforce.	Engagement with Liverpool Health Partners	Regular innovative ideas are identified and supported, for example Life Start Trolley, Butterfly Pillow, Butterfly Shelf, parenteral nutrition product, speculum for the diagnosis of urogenital atrophy. Such ideas are supported in-house and via outsourced expert help and advice.	Further development of this strategic principle is required to enable the Trust to empower its staff in engaging with a City-wide integrated approach to innovation.	

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
5.1 / 3	To progress engagement with Liverpool Health Partners and other city-wide partners to further the Trust's research agenda	Medical Director	October 2021	Research and Development Sub-Committee	
5.1 / 4	Continue progress towards university hospital status application	Medical Director	October 2021	Research and Development Sub-Committee	
5.1 / 5	Continue Trust engagement with population health and longitudinal studies / workstreams	Medical Director	On-going	Research and Development Sub-Committee	

BAF Risk 5.2: Failure to fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership	**Lead Director: CN&M** **Op Lead:** Assoc. Director of Governance and Quality	**Review Date: Oct 2021**	**Ulysses Ref: TBC**

Strategic Priority: SA5: To participate in high quality research in order to deliver the most EFFECTIVE outcomes

Lead Committee: Quality Committee

Provider Licence Compliance link:

General Licence Condition 7

SCORE:

July 2021	Q2	Q3	Q4	Q 2 Q movement	2021/22 Target
12 (3 x 4)	12 (3 x 4)			⟷	8 (2 x 4)

Rationale for current risk score:

The Trust has a current rating of 'requires improvement' for well-led from the most recent CQC inspection and also received a warning notice regarding medicine management. Good assurance is in place regarding the Trust's response to this with only two actions remaining outstanding and the warning notice being withdrawn. Further work required to refine process and to ensure that the Trust remains 'inspection ready' at all times.

The Trust was subject to an external wee-led review and themes relating to effective lesson learning and establishing a quality improvement methodology were identified, mirroring findings from the CQC inspection and feedback from commissioners. Progress has been made in relation to both of these areas but this needs to go further to achieve the target score.

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
If the Trust fails to comply with the CQC fundamental standards and if actions arising from the CQC visit are not implemented at sufficient pace then clinical standards may not be met leading to significant patient harm, deterioration in patient outcomes, a failure to maintain a CQC rating of 'good' and a serious reputational risk to the Trust.	Action plan process in place with monthly review at Executive and Board level Widespread communication about CQC report and actions arising CQRG monitoring Majority of actions implemented with clear timeline in place for implementation of outstanding two actions	Quality Committee Executive Team oversight Divisional Board and performance review meetings MIAA internal audit report on CQC action plan	None	
			Further work required to refine ward accreditation process	
	Realignment of Governance Managers to demonstrate better accountability and ownership of risk	Monthly meetings with the divisions and Assoc. Director of Quality & Governance and Dep. Chief Nurse & Midwife to review the risk profile, ensuring we move at pace being able to evidence the work we are doing, including any learning from incidents/events etc		

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
5.2 / 1	To implement updated Ward Accreditation programme	Deputy Director of Nursing & Midwifery	October 2021	Quality Committee	

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Ineffective understanding and learning following significant events and evidencing improved practice and clinical outcomes.	Regular dialogue with regulators Incident reporting and investigation policies and procedures. MDT involvement in safety HR policies in relation to issues relating to professional and personal responsibility Mandatory training in relation to safety and risk Serious Incident Feedback form Serious Incident panels Safety is included as part of executive walk rounds. Risk Management Strategy	CQPG Meetings Reporting of incidents and management of action plans through Safety & Effectiveness Sub-Committee Reflection of risks and Corporate Risk Register and Board Assurance Framework CQC Assessment Annual Quality Account Report Monthly meetings with the divisions and Assoc. Director of Quality & Governance and Dep. Chief Nurse & Midwife to review the risk profile, ensuring we move at pace being able to evidence the work we are doing, including any learning from incidents/events etc	'Moderate Assurance' from recent MIAA Audit External criticism from regulators and commissioners Lack of testing of action plans following audits to ensure they lead embedded change Inconsistent completion and dissemination of actions and improvement plans Inconsistent implementation of lessons learnt and lack of evidence Pace of implementing change Lack of consistent between divisional governance meetings (noted in recent well-led report) Well-led external review recommendation regarding walkaround process	

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
5.2 / 2	To ensure that Divisional Governance meetings are consistent and seek evidence of actions / lessons being embedded	Deputy COO	September 2021	Safety & Effectiveness Sub-Committee	

	5.2 / 3	Develop better reporting from the Ulysses System There is a continuing commitment to improving reporting using Ulysses. A recent development has been the agreement to cross-tabulate incidents and complaints using Ulysses using a formal process.	Head of Governance & Quality	June 2021	Safety & Effectiveness Sub-Committee		
	5.2 / 4	Business case for the provision of Human Factors Training to be developed and submitted to education governance committee	Medical Ed Lead	September 2021	Safety & Effectiveness Sub-Committee		
	5.2 / 5	New risk management and patient safety training package to be developed	Head of Governance & Quality	June 2021	Safety & Effectiveness Sub-Committee		
	5.2 / 6	Root Cause Analysis training for staff to be reviewed and updated and to recommence via teams	Head of Risk	June 2021	Safety & Effectiveness Sub-Committee		
	5.2 / 7	Governance team to review current compliance level and to make changes to ensure trajectory is met	Head of Risk	July 2021	Safety & Effectiveness Sub-Committee		
	5.2 / 8	The governance team will work with the communications team to identify if it is possible to have a link on desktop of computer with a link to lesson learnt section of web page	Head of Risk	June 2021	Safety & Effectiveness Sub-Committee		
	5.2 / 9	The use of the action planning module is to be embedded across all divisions. Governance team to use weekly meeting for review actions and ensure shared. Governance team to ensure oversight and reporting of progress	Head of Risk	June 2021	Safety & Effectiveness Sub-Committee		
	5.2 / 10	Governance team to monitor compliance levels with risk management training and highlight staff who are non compliance to the Divisions and provide compliance update to Safety and Effectiveness Sub-committee.	Head of Risk	July 2021	Safety & Effectiveness Sub-Committee		

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance (*Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Ineffective and / or ill-defined quality improvement methodology will result in the Trust missing opportunities to improve the safety, effectiveness and experience of care.	Quality Improvement training materials available on Trust Intranet	Training levels reported to the Quality & Clinical Audit Group	Quality Improvement methodology document not finalised Opportunities to engage individuals in QI training limited, particularly during pandemic	
	Quality Improvement projects tracked	Safety & Effectiveness Sub-Committee	Evidence of QI projects being undertaken but not 'formalised'	
	Quality Account tracking key projects	Annual Quality Account	None	

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
5.2 / 11	Finalise and disseminate Quality Improvement Methodology document	Assoc. Director of Governance & Quality	December 2021	Quality Committee	
5.2 / 12	Increase levels of QI training	Assoc. Director of Governance & Quality	December 2021	Quality Committee	
5.2 / 13	Simplify process to encourage staff to record QI projects within formal framework	Assoc. Director of Governance & Quality	December2021	Quality Committee	

Liverpool Women's NHS Foundation Trust

Putting People First Committee

COVER SHEET

Agenda Item (Ref)	*21/22/57 A*		Date: 20/09/2021	
Report Title	Medical Appraisal and Revalidation Annual Report 2020/21			
Prepared by	Lynn Greenhalgh, Responsible Officer & MD Lynn Johnson, Revalidation Support Manager			
Presented by	Dr Lynn Greenhalgh			
Key Issues / Messages	1. Despite COVID 19 pandemic medical appraisal and revalidation processes were robust. 2. MIAA completed an audit concluded that the Board can take 'substantial assurance' from the medical appraisal and revalidation processes in the Trust. 3. Annex D was submitted for approval following email confirmation from the Board			
Action required	Approve ☐	Receive ☐	Note ☐	Take Assurance ☒
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable):			
	For Decisions - in line with Risk Appetite Statement – Y/N *If no – please outline the reasons for deviation.*			
	1. To receive the annual report and note that this will be shared with the higher Responsible Officer 2. Take assurance that despite COVID 19 there were effective medical appraisal and revalidation processes in place 3. To ratify the approval of the statement of compliance Annex D confirming that the organisation, as a designated body, is in compliance with the regulations			
Supporting Executive:	Dr Lynn Greenhalgh Medical Director			

Equality Impact Assessment *(if there is an impact on E,D & I, an Equality Impact Assessment **MUST** accompany the report)*							
Strategy ☐	Policy ☒	Service Change ☐	Not Applicable ☐				
Strategic Objective(s)							
To develop a well led, capable, motivated and entrepreneurial ***workforce***	☒	To participate in high quality research and to deliver the most ***effective*** Outcomes	☐				
To be ambitious and ***efficient*** and make the best use of available resource	☐	To deliver the best possible ***experience*** for patients and staff	☒				
To deliver ***safe*** services	☒						

Link to the Board Assurance Framework (BAF) / Corporate Risk Register (CRR)	
Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* 1.2 Failure to recruit and retain key clinical staff	Comment:
Link to the Corporate Risk Register (CRR) – CR Number:	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Putting People First Committee	Sept 21	MD	Recommended for approval by the Board – subsequently provided via email to ensure compliance with timescales.

EXECUTIVE SUMMARY

2020/21 Revalidation and Appraisal annual report

Revalidation is the General Medical Council's (GMC) way of regulating licensed doctors that will give extra confidence to patients that doctors are up to date and fit to practice.

The GMC requires that the designated body has nominated or appointed a responsible officer in compliance with the Responsible Officer (RO) Regulations. The RO is a licensed doctor who has been licensed continuously for the previous five years and continues to be licensed throughout the time they hold the role of responsible officer.

During this revalidation year April 2020 to March 2021, the team supporting revalidation for the Trust was: Dr Lynn Greenhalgh, Responsible Officer (RO),
Dr Janine Elson, Appraisal Lead,
Lynn Johnson Revalidation Support Manager and
a team of 19 trained appraisers who each will undertake between 4-7 appraisals/year.

Liverpool Women's NHS Foundation Trust as a designated body had 97 doctors with a prescribed connection in the revalidation year April 2020 to March 2021. All doctors were engaged with the process and all doctors were accounted for in terms of their participation.

Impact of the Covid-19 Pandemic on the appraisal and revalidation processes:

The time period covered by this report includes the suspension of appraisal and revalidation from March 2020-October 2020 as a consequence of the Covid-19 pandemic. During this time period doctors could ask to have their appraisal to be postponed.

As part of the framework for quality assurance and for the purpose of revalidation, NHS England requests an Annual Report together with the compliance statement (Annex D). This usually follows the completion of the Annual organisation Audit (AOA) exercise.

The Trust Board usually receives two papers for approval

Due to Covid-19 NHS England is not requiring either the AOA or Annex D and therefore neither need to be submitted for Board approval.

Providers have been advised that they may submit an annual report to their Boards and submit an Annex D compliance statement if they wish. The Trust's Annex D compliance statement has been completed and is attached as Appendix A.

This paper sets out the information usually submitted to the Trust Board within those papers to assure the Board that the Medical Appraisal and Revalidation processes continue to function well.

Revalidation recommendations:

6 doctors' revalidation date fell during this year. Five received a positive recommendation.

One recommendation was deferred due to the RO having insufficient evidence. This deferral was due to this doctor returning from a career break just months before their revalidation was due.

Governance and Quality Assurance:

The Appraisal and Revalidation policy has been updated in line with current national policy and with changes in personnel and is presented for ratification to this meeting. Please see Appendix B.

The Responsible Officer has provided quarterly assurance and an annual report to NHS England to demonstrate compliance with the Framework of Quality assurance for Responsible Officers and Revalidation.

Appraisal update training was suspended from March 2020 until August 2020 in line with the NHS England recommendations with regards suspension of appraisal and revalidation due to the Covid-19 pandemic. In house appraisal update training was delivered in September 2020 with regards use of the new Medical Appraisal Guide 2020 tools.

All new appraisers attend formal new appraiser training with update training being delivered twice yearly in house.

Internal quality assurance is performed by a peer review of a random sample of 10% of completed appraisals. For the year 2020/21 this will be done using the NHSE SUPPORT tool which is designed for use with the MAG 2020 appraisal form. This provides not only feedback to individual appraisers but also a learning and discussion opportunity for the reviewing appraisers. All appraisers are expected to attend at least one peer review session a year.

All appraisees complete a feedback questionnaire about the quality of their appraisal; this is included in an annual report to the appraisers to be included and discussed at their own appraisal.

The Appraisal Lead observes the quality of the appraisers undertaking an appraisal, at least once every 5 years. This information is used to provide evidence to the RO and designated body about the quality of the appraisal and used for feedback to the appraiser.

External Audit of Medical Appraisal and Revalidation processes:

MIAA conducted and audit into the Consultant Appraisal process in accordance with the requirements of the 2020/21 Internal Audit Plan, as approved by the Audit Committee. This audit found that the Trust had a good system of internal control designed to meet the system objectives and that controls are being applied consistently. The audit showed that the Trust can take ‘substantial Assurance’ from the Consultant Appraisal Process. The audit made three recommendations.

1. Policy: Key Document References - The Revalidation and Medical Appraisal Policy lacked a number of key references which have now been included in the policy.
2. Compliance Monitoring reporting – Although the RO and Appraisal Lead have oversight of the compliance monitoring process the Putting People First Committee do not review compliance monitoring.
3. Escalation Process – Review of the Revalidation and Medical Appraisal Policy identified that in the event the appraisal process indicates a doctor is in difficulty the appraiser must escalate this to the clinical director without delay. However, the policy does not state escalation processes within the Trust governance structures.

MAIN REPORT

1. Purpose of the paper

As part of the framework for quality assurance and for the purpose of revalidation, NHS England requests an Annual Report together with the compliance statement (Annex D). This usually follows the completion of the Annual organisation Audit (AOA) exercise. In April 2021, the AOA for 2020/21 was cancelled due to the Covid-19 pandemic but providers have been advised that they may submit an annual report to their Boards and submit an **Annex D** (Appendix A) compliance statement if they wish.

The paper is intended to fulfil the above and provide assurance to the Board that, in line with the self- and external assessments, the Trust is fulfilling all the requirements for revalidation.

2 Background

Revalidation was made statute on 3rd December 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving public safety and increasing public trust and confidence in the medical system. All doctors are allocated to a Designated Body through the GMC. Each Designated Body has a Responsible Officer, who is responsible for implementing appraisal and revalidation. Doctors in training are in the Deanery designated Body and therefore are not included in this report.

The GMC decides whether to revalidate a doctor based on the recommendation made to it by the Responsible Officer. A positive revalidation decision means the doctor's license to practice is extended for five years. Deferral is a neutral recommendation resulting in a new revalidation date being set. It does not impact on the doctor's license to practice. Non-engagement indicates a doctor's license is a risk of being withdrawn.

Liverpool Women's NHS Foundation Trust has a statutory duty to support the RO with sufficient funding and other resources necessary to enable them to discharge their duties under the Responsible Officer Regulations.

The RO oversees compliance by:

- Monitoring the frequency and quality of medical appraisals in their organisations;
- Checking there are effective systems in place for monitoring the conduct and performance of their doctors; ensuring that accurate records are kept of all relevant information, actions and decisions
- Ensures that the organisation's medical revalidation policies and procedures are in accordance with equality and diversity legislation
- Making timely recommendations to the GMC about the fitness to practice of all doctors with a prescribed connection in accordance with the GMC requirements and the GMC Responsible Officer Protocol
- Confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors

3 Governance Arrangements

The current Responsible Officer is Dr Lynn Greenhalgh. The Trust responsible Officer is appraised by an external appraiser nominated by NHS England. She has completed one appraisal in May 2021. She took over being RO in April 2021 after a period of 3 months acting as RO in an interim capacity.

The current Appraisal Lead is Dr Janine Elson. She is also currently appraised by an external appraiser nominated by NHS England and completed her last appraisal in January 2021.

Lynn Johnson was appointed to the post of Revalidation Support Manager in 2017, with the remit to provide support and advice to the RO and doctors on matters relating to appraisal and revalidation.

The Trust's Responsible Officer, Appraisal Lead and Revalidation Support Manager attend regular external Responsible Officer/Appraisal Lead Network meetings with other ROs and representatives from GMC and NHS England

The RO, Appraisal lead and Revalidation Support Manager meet regularly as a team, several times a month. Revalidation Team meetings have been established and meet at least twice a year. The purpose of the meeting is to provide appraiser peer support and to discuss any issues arising relating to the appraisal systems/processes as well as cascading any information provided but the NHSE/I Responsible Officer and Appraisal Lead meetings.

The Medical Appraisal/Revalidation Team reports to the Putting People First Committee and the minutes are formally recorded and submitted.

NHS England requests an Annual Report together with the compliance statement (Annex D). This usually follows the completion of the Annual organisation Audit (AOA) exercise. Due to Covid-19 the AOA has not been completed however it is suggested that providers might want to complete an Annex D compliance statement.

There is a process to support the appropriate transfer of information about a doctor's practice to and from the doctor's responsible officer. It is designed to be used to share information with the doctor's responsible officer in the following situations:

- When a doctor's prescribed connection changes
- When a concern arises about the doctor's practice in any place where the doctor is practising l

The Trust has an established team and system to record all incidents and complaints through the Risk and Safety Team.

The Trust also has a dedicated Audit team to assist the doctors and contribute to their clinical performance.

4 Policy and Guidance

The 2017 Medical Appraisal and Revalidation policy has been updated in line with current national policy and is presented for ratification to this meeting. (Appendix B).

5 Quality Assurance

All appraisees complete a feedback questionnaire about the quality of their appraisal; this is included in an annual report to the appraisers to be included and discussed at their own appraisal.

Internal quality assurance is performed by a peer review of a random sample of 10% of completed appraisals. For the year 2020/21 this will be done using the NHSE SUPPORT tool which is designed for use with the MAG 2020 appraisal form. This provides not only feedback to individual appraisers but also a learning and discussion opportunity for the reviewing appraisers. All appraisers are expected to attend at least one peer review session a year.

All appraisees complete a feedback questionnaire about the quality of their appraisal; this is included in an annual report to the appraisers to be included and discussed at their own appraisal.

The Appraisal Lead observes the quality of the appraisers undertaking an appraisal, at least once every 5 years. This information is used to provide evidence to the RO and designated body about the quality of the appraisal and used for feedback to the appraiser.

The contract for the current Equiniti Revalidation Management System used by the Trust is due for renewal in November 2021. Two other revalidation systems along with the updated Equiniti system are being evaluated with support from the Trust's Procurement Team. Two systems have been evaluated with the third evaluation due to be completed before the end of July. A decision will be made as to which system will be procured after all three systems have been scored.

The HLRO visit fulfils the Trust's requirement to have an external peer review of its appraisal and revalidation processes. HLRO annual visits have been cancelled due to the Covid-19 pandemic.

External Audit of Medical Appraisal and Revalidation processes:

MIAA conducted and audit into the Consultant Appraisal process in accordance with the requirements of the 2020/21 Internal Audit Plan, as approved by the Audit Committee. This audit found that the Trust had a good system of internal control designed to meet the system objectives and that controls are being applied consistently. The audit showed that the Trust can take 'substantial Assurance' from the Consultant Appraisal Process. The audit made three recommendations.

1. Policy: Key Document References - The Revalidation and Medical Appraisal Policy lacked a number of key references which have now been included in the policy.
2. Compliance Monitoring reporting – Although the RO and Appraisal Lead have oversight of the compliance monitoring process the Putting People First Committee do not review compliance monitoring.
3. Escalation Process – Review of the Revalidation and Medical Appraisal Policy identified that in the event the appraisal process indicates a doctor is in difficulty the appraiser must escalate this to the clinical director without delay. However, the policy does not state escalation processes within the Trust governance structures.

The full audit report has been included as Appendix C.

6 Medical Appraisals

Appraisal and Revalidation Performance Data

The Revalidation Support Manager maintains a database of all appraisal dates. Doctors receive timely notification and reminder emails with the request to undertake an annual appraisal, in accordance with

NHSE guidance.

The data on the appraisal is shown in the table below.

	Number	Completed appraisals	Incomplete/missed appraisal Authorised	Incomplete/missed appraisal Not Authorised
Consultant	78	27	50	1
Staff Grade, Associate Specialist Speciality Doctor	3	1	2	0
Temporary or Short-term Contract holders.	16	13	3	0
Total	97	41	55	1

Reasons for the incomplete/missed appraisal authorised were:

45 of the 50 incomplete or missed appraisals for consultants were due to Covid-19 deferral and 5 were due to maternity leave. All of the incomplete or missed appraisals for both Staff Grade and Associate specialist doctors and three temporary and short term contract holders were due to a Covid-19 deferral.

Reasons for the not authorised incomplete/missed appraisals were:

The overall rate of unauthorised missed/incomplete appraisal 1% which is the same as last year and that individual is now actively engaged with appraisal process.

The Revalidation team has a reminder letter system which now clarifies that discussion with the GMC liaison officer takes place regarding possible referral to the GMC as a consequence of unauthorised late appraisal.

7 Appraiser training

As part of the Revalidation process, every doctor will undergo a formal appraisal process each year facilitated by a trained appraiser. The Trust has 19 trained appraisers.

The GMC recommends that each appraiser perform a maximum of 8 appraisals, minimum 6 appraisals per year. Due to our size our appraisers undertake between 4-7 appraisals a year.

Appraisal update training was suspended from March 2020 until August 2020 in line with the NHS England recommendations with regards suspension of appraisal and revalidation due to the Covid 19 pandemic.

In house appraisal update training was delivered in September 2020 with regards use of the new Medical Appraisal Guide 2020 tools. All new appraisers attend formal new appraiser training with update training being delivered twice yearly in house.

8 Appraisee

Doctors upload documentation into a portfolio on RMS (Revalidation Management System) covering the GMC domains as outlined in Good Medical Practice. RMS requires the completion of pre-appraisal documentation by doctors regarding their own probity and health. Their PDP and Job plan are part of the portfolio. This portfolio is submitted to their appraiser prior to their appraisal meeting.

In each revalidation cycle, each doctor is obliged to gather patient and colleague feedback once. There is a system built into RMS to facilitate this, the feedback is discussed at appraisal, and feeds into the personal development plans.

Currently the Trust uses the Equiniti RMS (Revalidation Management System) as the system for doctors to upload their revalidation and appraisal evidence. The Trust have extended the contract (which expired in Jan 2020) for a further 12 months and are currently evaluating other options as well as how we fund the resources needed to facilitate ongoing training for appraisers and new appraises.

Appraisees that are new to the Trust as supported by the Revalidation Manager and the Appraisal Lead with training on the RMS and the expectations of the Trust with regards the supporting information necessary for appraisal submission.

9 Access, security and confidentiality

The Trust has an implemented framework of Information Governance to ensure all the information held on staff members are complaint with the Data protection and confidentiality, information security and information quality on an annual basis.

10 Issues for Board consideration

- The number of doctors with a prescribed connection and requiring appraisal has remained reasonably static at 97 doctors increased from 96 in 19/20.
- The team have worked hard to maintain the appraiser numbers as trained experienced appraisers have left the Trust. This is tracked by the Revalidation team.
- Appraiser time is accounted for within job plans with a currency of 0.25 PA. The Appraisal lead currency is 0.5 PA.
- The revalidation team has worked hard during the Covid-19 pandemic to ensure that during the appraisal pause (March to August 2020), all those doctors who wanted an appraisal could have one and that once the pause was lifted that all doctors were on track to completing their appraisal in a timely manner.
- The Revalidation Support Manager, Appraisal Lead and Appraisers have managed to support doctors through the appraisal system during the pandemic.

11 Conclusions

Medical Revalidation is in its second cycle. The Trust has seen a significant improvement in managing doctors who do not seek approval for late/incomplete appraisals. This is thanks to the efforts of the team and is reflected in the performance data.

During March to August 2020 the appraisal process was paused due to the Covid-19 pandemic. Doctors could seek deferral of their appraisal. This process was successfully tracked by the revalidation team.

The MIAA audit of Medical Appraisal and Revalidation gave high assurance that the Trust processes were fit for purpose.

7. Recommendations

- To receive the annual report and note that this will be shared with the higher Responsible Officer
- Take assurance that despite COVID 19 there were effective medical appraisal and revalidation processes in place
- To ratify the approval of the statement of compliance Annex D confirming that the organisation, as a designated body, is in compliance with the regulations

Appendix A – Annex D Statement of Compliance 2020/2021

Classification: Official

Publications approval reference: B0614

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1, July 2021

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

Annual Organisational Audit (AOA):

At the end of April 2021, Professor Stephen Powis wrote to Responsible Officers and Medical Directors in England letting them know that although the 2020/2021 AOA exercise had been stood down, organisations will still be able to report on their appraisal data and the impact of adopting the Appraisal 2020 model, for those organisations who have, in their annual Board report and Statement of Compliance.

Board Report template:

Following the revision of the Board Report template in June 2019 to include the qualitative questions previously contained in the AOA, the template has been further updated this year to provide organisations with an opportunity to report on their appraisal data as described in the letter from Professor Stephen Powis.

A link to the letter is below:

https://www.england.nhs.uk/coronavirus/publication/covid-19-and-professional-standards-activities-letter-from-professor-stephen-powis/

The changes made to this year's template are as follows:

Section 2a – Effective Appraisal

Organisations can use this section to provide their appraisal information, including the challenges faced through either pausing or continuing appraisals throughout and the experience of using the Appraisal 2020 model if adopted as the default model.

Section 2b – Appraisal Data

Organisations can provide high level appraisal data for the period 1 April 2020 – 31 March 2021 in the table provided. Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested is enough information to demonstrate compliance.

With these additional changes, the purpose of the Board Report template is to help the designated body review this area and demonstrate compliance with the responsible officer regulations. It simultaneously helps designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance.[1] This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). The intention is therefore to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. Bringing these two quality strands together has the benefits of avoiding duplication of recording and harnessing them into one overall approach.

The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

Statement of Compliance:

The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

Designated Body Annual Board Report

Section 1 – General:

The board of Liverpool Womens NHS Foundation Trust can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: N/A Comments: Dr Lynn Greenhalgh was appointed as interim RO form 4th January 2021 and then the substantive RO form the end of March 2021. Action for next year:

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes Action from last year: N/A Comments: The contract for the current revalidation system used (Equniti) is due to expire by the end of the calendar year. The revalidation team are assessing which platform to use moving forwards. Action for next year: To choose and procure the electronic revalidation system for the next 3 years.

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: Yes Comments: The revalidation manger completes this action Action for next year:

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

The MIAA audit recommended three actions – all of which are now complete.

i) Policy: Key Documentation References – The Revalidation and Medical Appraisal Policy lacked a key number of references which have now been included in the policy.
ii) Compliance Monitoring Report to Putting People First Committee– Although the RO and Appraisal Lead have oversight of the compliance monitoring process the Putting People First Committee do not review the compliance monitoring.
iii) Escalation Process – review of the Revalidation and Medical Appraisal Policy identified that in the event the appraisal process indicates a doctor is in difficulty the appraiser must escalate to the clinical director without delay. However, the policy does not state the escalation processes within the Trust governance structures, this has now been amended within the policy.

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

In July 2021 MIAA (external auditors) completed an audit of the medial revalidation and appraisal systems and concluded that the Board can take 'substantial assurance' from the processes in place. The audit recommended three actions:

i) Policy: Key Documentation References – The Revalidation and Medical Appraisal Policy lacked a key number of references which have now been included in the policy. ii) Compliance Monitoring Report to Putting People First Committee– Although the RO and Appraisal Lead have oversight of the compliance monitoring process the Putting People First Committee do not review the compliance monitoring. iii) Escalation Process – review of the Revalidation and Medical Appraisal Policy identified that in the event the appraisal process indicates a doctor is in difficulty the appraiser must escalate to the clinical director without delay. However, the policy does not state the escalation processes within the Trust governance structures, this has now been amended within the policy.

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: Comments: There were 21 short term doctors in the Trust 19 of whom were appraised and the other 19 had deferrals due to COVID 19. Action for next year: To continue to ensure that short term doctors have are supported with appraisal , revalidation, professional development and governance.

Section 2a – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical

outcomes. For organisations that have adopted the Appraisal 2020 model, there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet used the Appraisal 2020 model may want to consider whether to adopt the model and how they will do so.

Action from last year: to continue to actively manage the process of late appraisals Comments: The active monitoring of late appraisals as well as appraisals deferred due to COVID 19 has continued throughout this year Action for next year: to continue to actively manage the process of late appraisals

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: Comments: Yes Action for next year:

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: Comments: yes, some amendments have been made in line with recommendations from the MIAA audit and the policy is presented to Putting People First Committee for ratification. Action for next year:

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: Comments: yes Action for next year: The numbers decreased due to the retirement of a number of appraisers however we have managed to recruit appraisers to help support the appraisal process. Some of these new recruits have been appraisers at other Trusts and are therefore experienced..

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year: Comments: A system of peer review of appraisals has been established by the lead appraiser. The lead appraiser also attends appraisals for training and monitoring purposes. Action for next year: to embed the peer review process.

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: Comments: Yes Action for next year:

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation: Liverpool Womens NHS Foundation Trust	
Total number of doctors with a prescribed connection as at 31 March 2021	99
Total number of appraisals undertaken between 1 April 2020 and 31 March 2021	88
Total number of appraisals not undertaken between 1 April 2020 and 31 March 2021	1
Total number of agreed exceptions	10

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: N/A Comments: Timely recommendations are made Action for next year:

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: Comments: Yes Action for next year:

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: Comments: Yes the Trust uses the Ulysses system for adverse event reporting and triangulates with complaints and serious incidents Action for next year:

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: Comments: Yes such systems are in place Action for next year:

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year:

Comments: Yes the Trust uses the Maintaining High Professional Standards document to manage any concerns. Action for next year:

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

Action from last year: to work with the Director of HR to develop a QA process for this Comments: due to the ongoing COVID 19 pandemic and a change of Responsible Officer this has not been progressed and will be next year Action for next year: to work with the Director of HR to develop a QA process for this

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[4]

Action from last year: N/A Comments: Yes Action for next year:

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year:

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.
[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Comments: Yes. The trust is embedding a 'Fair and Just' culture Action for next year:

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: Comments: yes Action for next year:

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

- **General review of actions since last Board report:** **MIAA audit showed that the processes for medical revalidation and appraisal were working well**
- **Actions still outstanding:** to work with the Director of HR to develop a QA process for responding to concerns about a doctor in our organisation
- **Current Issues:** **The Responsible Officer and Appraisal Lead are both new in post and so are embedding within the Trust processes.**
- **New Actions:** **To ensure that the process of peer review for appraisers is embedded.**

Overall conclusion:

The MIAA audit showed that the Trust can take substantial assurance that the processes for medical appraisal and revalidation are robust.

Section 7 – Statement of Compliance:

The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: _ _ _ _ _ _ _ _ _ _ _ _

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _

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

This publication can be made available in a number of other formats on request.

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Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*2021/22/091*		Date: 04/11/2021	
Report Title	Board Assurance - post-mortem facilities			
Prepared by	*Phil Bartley, Associate Director of Quality & Governance*			
Presented by	*Marie Forshaw, Chief Nurse and Midwife*			
Key Issues / Messages	*It is recommended that the trust board note the contents of this paper and supports the future development of this report in the provision of assurance that the organisation is complying with the requirements of HTA or has appropriate arrangements in place to mitigate any risks.*			
Action required	Approve ☐	Receive ☐	Note ☐	Take Assurance ☒
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable):			
	For Decisions - in line with Risk Appetite Statement – Y/N *If no – please outline the reasons for deviation.*			
	To note the contents of this paper and supports the future development of this report in the provision of assurance that the organisation is complying with the requirements of HTA or has appropriate arrangements in place to mitigate any risks.			
Supporting Executive:	*Marie Forshaw, Chief Nurse and Midwife*			

Equality Impact Assessment *(if there is an impact on E,D & I, an Equality Impact Assessment **MUST** accompany the report)*							
Strategy ☐		Policy ☐		Service Change ☐		Not Applicable ☐	
Strategic Objective(s)							
To develop a well led, capable, motivated and entrepreneurial ***workforce***	☐		To participate in high quality research and to deliver the most ***effective*** Outcomes	☐			
To be ambitious and ***efficient*** and make the best use of available resource	☐		To deliver the best possible ***experience*** for patients and staff	☒			
To deliver ***safe*** services	☒						
Link to the Board Assurance Framework (BAF) / Corporate Risk Register (CRR)							
Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* 5.2 Failure to fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership			Comment:				
Link to the Corporate Risk Register (CRR) – CR Number:			Comment:				

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
N/A			

EXECUTIVE SUMMARY

NHS England and NHS Improvement (NHSEI) are requesting that Boards of organisations with either a mortuary or body store ensure they are compliant with existing guidance, and take additional steps set out in this letter.

The Human Tissue Authority (HTA) is the regulator which oversees the licensing and inspection of post-mortem facilities, including security arrangements. All Trusts should undertake a review of the HTA guidance and take steps to assure their Boards that they are compliant. OCS have been requested to ensure this takes place.

There are no overdue actions at the time of writing the report.

It is recommended that the trust board note the contents of this paper and supports the future development of this report in the provision of assurance that the organisation is complying with the requirements of HTA or has appropriate arrangements in place to mitigate any risks.

MAIN REPORT

NHSEI requires all Trusts with either a mortuary or body store to urgently review their practices and ensure the below actions are implemented. The governance team has reviewed the trusts position in relation to the above in liaison with the Estates and Facilities department and the Honeysuckle bereavement team. Each point responded to as follows;

1. Ensure all access points to the mortuary or body store are controlled by swipe card security access. Where this is not immediately possible, organisations must assure themselves that there is sufficient mitigation in place to ensure the facilities are secure and there is auditable access.

   The entrance to the corridor where the mortuary/body store is based is accessed by swipe card security access. The access to the mortuary/body store itself is via two sets of doors with a key coded lock for both doors. Assurance is provided that daily checks are conducted in relation to babies/their remains to ensure they have not been tampered with an auditable log of such is in place.

   However, it is noted that auditable access to the mortuary is not in place, but assurance is provided that arrangements have been made to ensure this happens both during and out of hours.

2. There must be effective CCTV coverage in mortuary areas and this should be reviewed on a regular basis by an appropriately trained and authorised individual. Specialist training and mental health support may be required to support staff to undertake this task.

   The corridor which leads to the mortuary is monitored by effective CCTV coverage although this is not continuously monitored. The mortuary/body store itself is not monitored by CCTV as consideration must be given to bereaved families who visit or accompany their baby to the suite following death. The mortuary/body store is then accessed via this area. The mortuary/body store is not set up the same way when benchmarked against larger acute trusts based on the services provided at LWH. Assurance is provided that all adult bodies are not stored here following death and are transferred to the mortuary at the Royal Liverpool Hospital.

3. A documented risk assessment of the facilities should be undertaken with regard to the operation, security and construction of the mortuary or body store area.

   A documented risk assessment is in place

4. Ensure there is consistent application of appropriate levels of DBS checks, disclosure and barring service for all Trust and contracted employees, specifically in line with requirements of the NHS Standard Contract. Employers are required to pay attention to the security features of a DBS certificate

   The trust has a contract with OCS Group UK Ltd for the use of its security staff. Assurance has been provided by OCS that all staff contracted to LWH have a standard DBS in place which is required under the terms of their licence with SIA. The trust awaits a further update from them in relation to the dates of their most recent DBS checks. This will be followed up and reported back to the trust board at the next meeting. All trust employees who have access to the mortuary/body store have enhanced DBS checks in place.

RECOMMENDATION

The Board may wish to consider if enhanced DBS checks are required for contracted security staff who accompany bereaved families to the mortuary/body store. Board Members are advised that this will be discussed at the Trust's Safeguarding Sub Committee.

It is recommended that the Trust Board note the contents of this paper and supports the future development of this report in the provision of assurance that the organisation is complying with the requirements of HTA or has appropriate arrangements in place to mitigate any risks. The current position for LWH in relation to this matter as outlined above can be submitted to NHSE/I by 16 November 2021 as per their request.