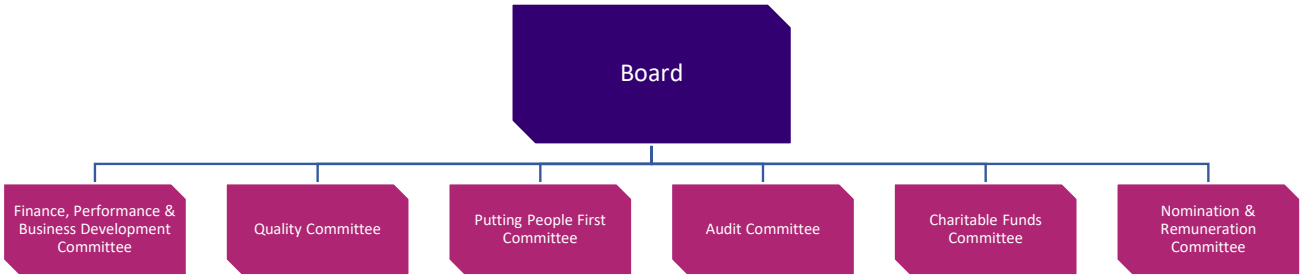
Liverpool Women's
NHS Foundation Trust

Trust Board

2 December 2021, 09.30am
Blair Bell Lecture Theatre / Virtual Meeting



Liverpool Women's NHS Foundation Trust

Trust Board

Location	Blair Bell Lecture Theatre and Virtual Meeting
Date	2 December 2021
Time	9.30am

AGENDA					
Item no. 21/22/	Title of item	Objectives/desired outcome	Process	Item presenter	Time
PRELIMINARY BUSINESS					
114	Introduction, Apologies & Declaration of Interest	Receive apologies & declarations of interest	Verbal	Chair	0930 (5 mins)
115	Meeting Guidance Notes	To receive the meeting attendees' guidance notes	Written	Chair	
116	Minutes of the previous meeting held on 4 November 2021	Confirm as an accurate record the minutes of the previous meeting	Written	Chair	
117	Action Log and matters arising	Provide an update in respect of on-going and outstanding items to ensure progress	Written	Chair	
118	Patient Story	To receive a patient story	Verbal	Chief Nurse & Midwife	0935 (15 mins)
119	Chair's announcements	Announce items of significance not found elsewhere on the agenda	Verbal	Chair	0950 (5 mins)
120	Chief Executive Report	Report key developments and announce items of significance not found elsewhere on the agenda	Written	Chief Executive	0955 (10 mins)
QUALITY & OPERATIONAL PERFORMANCE					
121a	Major Incident Update	For assurance	To Follow	Chief Executive	1005 (70 mins)
121b	Quality & Operational Performance Report	For assurance – To note the latest performance measures	Written	Chief Operating Officer	
121c	Liverpool Neonatal Partnership Update	For information	Presentation	Medical Director	
121d	Maternity Executive Oversight Update	For assurance	Written	Chief Operating Officer	
121e	Perinatal Quality Assurance	For information	Written	Chief Nurse & Midwife	

121f	Integrated Governance Assurance Report 2021/22 – Quarter 2	For assurance	Written	Chief Nurse & Midwife	
121g	Chair's Reports from the Quality Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	
PEOPLE					
122	Workforce Performance Report	For assurance – To note the latest performance measures	Written	Chief People Officer	1115 (10 mins)
BREAK – 15 mins					
Board Thank You – 5 mins					
FINANCE & FINANCIAL PERFORMANCE					
123a	Finance Performance Review Month 7 2021/22	For assurance - To note the current status of the Trust's financial position	Written	Chief Finance Officer	1145 (20 mins)
123b	Chair's Report from the Finance, Performance and Business Development Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	
BOARD GOVERNANCE					
124a	2020/21 Corporate Objectives – six-month review	For assurance	Written	Trust Secretary	1205 (15 mins)
124b	Board Assurance Framework	For assurance	Written	Trust Secretary	
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.*					
125	Emergency Preparedness, Resilience & Response Annual Assurance Report	For assurance	Written		Consent
CONCLUDING BUSINESS					
126	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair	1220 (5 mins)
127	Chair's Log	Identify any Chair's Logs	Verbal	Chair	
128	Any other business & Review of meeting	Consider any urgent items of other business	Verbal	Chair	
Finish Time: 1225					

Date of Next Meeting: 4 February 2022

1225 - 1235	*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 4 November 2021

PRESENT

Robert Clarke	Chair
Kathryn Thomson	Chief Executive
Eva Horgan	Chief Finance Officer
Gary Price	Chief Operating Officer
Louise Martin	Non-Executive Director
Dr Lynn Greenhalgh	Medical Director (until item 087c)
Dr Susan Milner	Non-Executive Director / SID
Prof Louise Kenny	Non-Executive Director
Tony Okotie	Non-Executive Director
Marie Forshaw	Chief Nurse & Midwife
Michelle Turner	Chief People Officer / Deputy Chief Executive

IN ATTENDANCE

Matt Connor	Chief Information Officer
Susan Roberts	Matron, Community Midwifery (item 083 only)
Clare Fitzpatrick	Head of Midwifery (items 086a to 086d)
Catherine McClennan	Programme Director, C&M Local Maternity System (item 086c only)
Rochelle Collins	Medical Workforce Manager (item 085e only)
Kat Pavlidi	Gynaecology Consultant / Guardian of Safe Working Hours (item 085e only)
Lucy Dobson	Junior Doctor (item 085e only)
Lesley Mahmood	Member of the public
Jackie Sudworth	Public Governor
Peter Norris	Public Governor
Mark Grimshaw	Trust Secretary (minutes)

APOLOGIES:

Tracy Ellery	Non-Executive Director

Core members	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Robert Clarke - Chair	✓	✓	✓	✓		✓		✓				
Kathryn Thomson - Chief Executive	✓	✓	✓	✓		✓		✓				
Dr Susan Milner - Non-Executive Director / SID	✓	✓	✓	✓		✓		✓				
Jo Moore - Non-Executive Director / Vice Chair	✓	✓	✓	✓		A	Non-member					
Tracy Ellery - Non-Executive Director	✓	✓	✓	A		✓		A				
Louise Martin - Non-Executive Director	✓	✓	✓	✓		✓		✓				
Ian Knight - Non-Executive Director	✓	✓	✓	✓		✓	Non-member					
Tony Okotie - Non-Executive Director	A	✓	✓	✓		✓		✓				
Prof Louise Kenny - Non-Executive Director	✓		✓	✓		A		✓				
Jenny Hannon – Chief Finance Officer	✓	✓	✓	✓		✓	Non-member					

Eva Horgan – Chief Finance Officer	Non-member							✓				
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/	
079	**Introduction, Apologies & Declaration of Interest** The Chair welcomed everyone to the meeting. No declarations of interest were made, and apologies were noted as above.
080	**Meeting guidance notes** The Board received the meeting attendees' guidance notes.
081	**Minutes of the previous meetings held on 2 September 2021** The minutes of the Board of Directors meetings held on 2 September 2021 were agreed as a true and accurate record.
082	**Action Log and matters arising** The Action Log was noted.
083	**Patient Story** Susan Roberts, Matron, Community Midwifery, attended to introduce a video recorded from a patient who described their experience of being supported by the Trust's Continuity of Carer midwifery model. The advantages of being cared for under this model were outlined and it was particularly noted that having familiar faces throughout the pregnancy had resulted in the patient developing trust with her midwives and feeling that her needs were being listened to. The Chair noted that it was encouraging to hear a positive story about the Continuity of Carer model and queried when more teams would be implemented. The Chief Nurse and Midwife noted that the model had been refreshed and further national guidance was awaited. Until the Trust was in receipt of this it was challenging to provide timescales. The Chair thanked the patient for sharing their story and Susan Roberts for her work in developing and delivering the Trust's Continuity of Carer approach. *Susan Roberts left the meeting*
084	**Chair's announcements** The Chair noted the following issues: • Non-Executive Director, Jo Moore, had resigned from the Trust during September 2021. Thanks were extended to Jo for all her hard work and commitment to the Trust • A process for Non-Executive Director recruitment was in progress with the outcome from interviews held on 18th and 19th October to be reported to the Council of Governors meeting scheduled for 11 November 2021. • A Nomination & Remuneration Committee had been held on 7 October 2021. The main issue considered related to Executive Director succession planning. • The Trust's Annual Member's Meeting took place on 30th September 2021. The recording and presentation slides would be made available on the Trust website.

	The Board noted the Chair's update.
085	**Chief Executive's report** The Chief Executive presented the report which detailed local, regional and national developments. It was reported that the new NHS System Oversight Framework (SOF), after a period of consultation, had now been implemented. Following consideration by the NHSE/I regional support group and national moderation, it had been agreed that the Trust be placed into SOF segment 3 and mandated support provided. The drivers behind the segmentation and the implications of this were currently being reviewed and the Board (and its Committees) would kept up to date on progress. Congratulations were extended 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. The Chief Nurse & Midwife drew attention to the Quality Improvement update. A meeting had been held with senior managers about the intended approach and there had been good engagement. There was an intention to keep the Board well informed of Quality Improvement projects and the extent to which it was becoming an embedded approach within the organisation. The Chief Operating Officer noted that a Cheshire & Merseyside Gynaecological Cancer Services Review was underway, being led by the NHS Transformation Unit. There was an expectation that the review would identify improvements to cancer pathways. The Chair asked if the review would take into consideration future opportunities in addition to current challenges. The Chief Operating Officer confirmed that the review would take a whole system approach and recognise that events had developed since current pathways had been established. The Chief Executive noted that there was a requirement for the Board to approve 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 had therefore been sought and the Board was asked to ratify this decision. The Board of Directors: • noted the Chief Executive update. • Ratified the approval of the Medical Revalidation Annual Board Report and Statement of Compliance *Clare Fitzpatrick joined the meeting*
086a	**Maternity Voices Partnership** The Board received a video from the Liverpool Maternity Voices Partnership (MVP) Chair. This outlined the role of the MVP and the work they undertook to co-produce change relating to maternity services either through social media engagement or feedback from service user representatives. It was noted that the MVP held a quarterly meeting with service users to provide an update on activities within the period, feedback to Trust professionals and deliver training. Examples of co-produced change were described, with particular attention given to a recent 'you said, we did' project on postnatal pain relief. The Chief Nurse and Midwife remarked that the support of the MVP was invaluable in driving improvements in maternity services and noted that they were invited to the quarterly maternity safety champion meetings.

	The Chief Executive, from the perspective of the Local Maternity System, noted that the MVP model was developing with some CCG footprints having a more mature offer than others across the wider Cheshire and Merseyside system. It was asserted that it would be vital for the Trust to continue to pursue effective engagement with MVPs across the system to ensure that service users were being actively listened to. The Chief Operating Officer noted the important role that MVPs had played during the pandemic to help to communicate often complex and challenging updates to women and their families. The Board of Directors noted the update.
086b	Quality & Operational Performance Report The Board considered the Quality and Operational Performance Report. The Chief Nurse and Midwife noted encouraging progress in relation to safe staffing numbers and reported that the Deputy Chief Nurse and Midwife was providing increased focus on roster management. The Chief Operating Officer highlighted that Planned Preventative Maintenance (PPM) compliance had been RAG rated as 'red'. A new system had been implemented to monitor compliance and additional resource had put into place. It was expected that there would be improved performance over the next reporting period. The Chief Operating Officer continued to outline the Trust's cancer performance. Whilst 2-week cancer performance remained strong, there had been challenges during Quarter 2 2021/22 in the 31-day performance. The Chair queried if the drivers behind the challenged performance for the 31 day and 62-day cancer targets was the same. The Chief Operating Officer explained that the 31-day position was largely within the Trust's control and was predominantly due to reduced theatre capacity during the summer months. A clinically led task and finish group had been formed and the backlog had now been cleared. Whilst the internal capacity issues had impacted 62-day performance, other factors such as access to diagnostics and late referrals had also been significant. In relation to the latter, the work of the NHS Transformation Unit to the review of Cheshire & Merseyside Gynaecological Cancer Services was expected to deliver improved pathways. The Chair acknowledged the long-term systemic challenges but queried why there had been a significant recent reduction in performance. The Medical Director noted that theatre staffing capacity challenges had been significant during the summer months and the Chief Executive added that access to other clinical sites in the city for complex surgery had also been an issue. This had been escalated to the relevant individuals with suggestions made for pathway improvements. The Chair asked if the Trust was assessing potential patient harm. It was confirmed that all patients had received a harm review. The Medical Director added that the Trust had been required to undertake additional work to ready patients for surgery as individuals had become sicker during the pandemic. It was noted that the Trust could provide this service to other parts of the system if resources were made available. Action: To provide additional detail to the December 2021 Board on the 31-day and 62-day cancer targets in terms of number and length of breaches. The Trust performance for the 52-week position had plateaued, largely due to reduced planned theatre sessions due to sickness absence. This had been compounded by continued increases in 2-week urgent referrals. Whilst the Trust continued to meet this urgent target to do so took capacity from the routine day case. The Chair queried the increase in the emergency caesarean section rate. The Chief Nurse and Midwife confirmed that this had been flagged a concern in a recent Maternity Safety Champion meeting. The Head of Midwifery noted that there had been increased activity through the delivery suite and an additional complexity of patients during the reporting period. A thematic review was planned that would report initially to the Family Health Divisional Board. Non-Executive Director, Louise Kenny, stated that emergency caesarean section rates were limited without context and suggested that they

	should be viewed alongside the Robson caesarean classification. The Chief Executive noted that a recent Coroner's report regarding the inappropriate use of Kielland's forceps had been published. It was agreed that it would be useful to review the report for learning opportunities. **Chair's Log: For the Quality Committee to review a Coroner's report regarding the inappropriate use of Kielland's forceps to identify potential learning opportunities.** The Board of Directors: • Received and noted the Quality & Operational Performance Report. *Catherine McClennan joined the meeting*
086c	**Cheshire & Merseyside Women's Health & Maternity Services Programme Update** The Chief Operating Officer introduced the item noting that whilst the Local Maternity System (LMS) was independent from the Trust, it had been operating under a hosting arrangement since 1 April 2021. It had therefore been considered germane for the Board to receive an update on the work of the LMS and the planned future direction. The LMS Programme Director reported that the LMS had established a 'case for change' for maternity services in Cheshire and Merseyside in 2017, citing issues such as unsustainable financial arrangements and an inability to comply with national guidance. The progress since that point was outlined and it was explained that the programme had been renamed as the Women's Health & Maternity Services Programme (WHaM). The current priorities of the WHaM were detailed, and these included ensuring that the system was responding adequately to the findings of the Ockenden Report. The LMS Programme Director outlined how performance across the footprint was monitored and identified risks to delivering the WHaM priorities were highlighted. An updated 'case for change' was being developed with a significant focus being provided to ensuring that there were appropriate models of care in place. The Chair stated that it was useful for the Board to receive an insight into the LMS hosting arrangement and queried whether there was commitment for system change amongst key stakeholders. The LMS Programme Director stated that there was a clear desire to improve maternity services and that momentum had been created by a national recognition of the current challenges. It was noted that it was important for the LMS to monitor progress whilst being solution focussed and taking opportunities to drive improvement when they became available. The Chief Executive added that there had been a muted response to the programme roadshows when undertaken in 2019 but the recent emphasis on collaboration and the outputs of the Ockenden Report had provided renewed focus on maternity services. There would be opportunities to ensure that this focus was maintained during the establishment of Provider Collaboratives under the Integrated care System structure. The Chief Nurse & Midwife requested that a risk to the resilience of midwifery staff be acknowledged in the programme key priorities. The LMS Programme Director confirmed that listening events with maternity staff were planned. Non-Executive Director, Susan Milner, asked how the LMS was responding the challenge of health inequalities, particularly as these had become increasingly evident during the pandemic. The LMS Programme Director confirmed that an engagement team was in place and suggested that a further update be provided to the Board on the programme's equity strategy. **Action: For the April 2022 Board to receive an update on the work undertaken by the Women's Health & Maternity Services Programme to reduce health inequalities.** The Board of Directors: • Received and noted the Women's Health & Maternity Services Programme update *Catherine McClennan left the meeting*

086d	**Maternity Safety Self-Assessment Tool** The Chief Nurse and Midwife explained that the Maternity Services Safety Self- assessment tool had been designed for NHS Maternity Services and private maternity providers to allow them to self-assess whether their operational service delivery met national standards, guidance, and regulatory requirements. It was noted that it was a useful bench marking tool to support the planning and delivery of maternity services to ensure they were safe, effective and had service users and staff at the centre. The family health senior leadership team met in September 2021, to undertake a full self-assessment of maternity's compliance and benchmark against the national tool. The key themes identified from the review were outlined together with the processes for taking forward and monitoring actions. There was acknowledgment that workforce issues, including appointing to key leadership roles and ensuring that appropriate training was being undertaken, were particularly vital in ensuring improved compliance. The Board of Directors: • Noted the contents of the report and • Received the update on progress against the National Maternity self-assessment tool *Clare Fitzpatrick left the meeting* *Rochelle Collins, Kat Pavlidi and Lucy Dobson joined the meeting*
086e	**Guardian of Safe Working Hours Annual Board Report 2020 - 2021** The Board received the Guardian of Safe Working Hours Annual Board Report 2020 – 2021 noting that the detail had been considered at the Putting People First Committee. In considering the report, the Committee had recommended that the Board invite a junior doctor to provide their perspective on the process. Lucy Dobson, Junior Doctor, noted that she was an obstetrics and gynaecology trainee and that this area of practice had been slower to adapt to the culture of exception reporting, mainly due to the period of training tending to last a long period than other disciplines. Despite this, progress was being made to reach acceptance that exception reporting was an important mechanism for maintaining staff and patient safety. The Chair asked if junior doctors could access senior leaders in the organisation. It was confirmed that no concerns had been raised. Whilst there remained some uncertainty regarding the process with consultants, they remained overall supportive. Non-Executive Director, Louise Martin, noted that the report highlighted that missed breaks had been an issue and this had been exacerbated by clinical time being impacted by midwifery staffing shortages. It was asked if this had been resolved. The Medical Workforce Manager stated that this was an example of exception reporting helping to identify an issue which was in turn escalated to the Clinical Director of the Family Health Division. Work was underway to resolve the issue which included educated all staff to ensure that breaks were maintained. Non-Executive Director, Louise Martin, also highlighted that the £30k received by the Trust to improve the doctor's mess facilities had yet to be utilised and asked when this would be progressed. The Chief Operating Officer explained that there were restrictions with the estate and moving the doctor's mess would involve vacating an alternative space. Work continued to resolve the issue. The Board of Directors: • Noted the report from the Guardian of Safe Working Hours *Rochelle Collins, Kat Pavlidi and Lucy Dobson left the meeting*
086f	**Learning from Deaths Quarter 1, 2021/22** The Board received the Quarter 1, 2021/22 Learning from Deaths report. It was noted that the Medical Director and the Deputy Chief Nurse and Midwife had established a 'Mortality Review

	Group' which would 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 would be to learn from Trust based mortality as well as from outside the organisation. The Medical Director highlighted that neonatal mortality rate had improved from the previous quarter and the position would continue to be monitored to identify a potential downward trend. Having been highlighted as a network outlier for preterm mortality the neonatal team were in the process of a benchmarking project with St Mary's, Manchester independently chaired and hosted by the regional neonatal network. The review process was anticipated to take 6-7 months to complete and started in July 2021. Monthly meetings were being held to track the review but a report of findings from the review would not be available until early 2022. Non-Executive Director, Louise Martin, asked about the level of confidence that the benchmarking project would support the Trust's hypothesis that its outlier status was mainly as a result of socio-economic factors. The Medical Director explained that the report would only provide an external view of whether improvements could be made to the Trust's internal practice. A wider review of the impact of social determinants required an extensive research project that was being undertaken by a PhD candidate. The Board of Directors: • took assurance that there was an adequate process against the requirements laid out by the National Quality Board and that there were 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. • Noted the establishment of a Trust mortality review group. • Noted that a neonatal benchmarking project with St. Mary's, Manchester would report by Q4 of 2021/22. • Noted that the rate of stillbirth would continue to be monitored. • Noted that parents continued to be at the centre of the investigation process. • Noted that all stillbirths underwent a robust review process where learning was identified and shared. • Noted that issues identified at the reviews and recommendations made would be tracked through the maternity clinical meeting. • The Trust was complying with nationally mandated initiatives such as Saving Babies' Lives, CNST, PMRT and MBRRACE-UK.
086g	Gynaecology Inpatient Survey Results 2020 The Board received the 2020 Gynaecology Inpatient Survey Results noting that the Trust had scored 'better' than other trusts in several elements. Comparing to the previous year (2019), the service had improved in 15 of the survey points. There were however, five areas where scores had declined from the 2019 results and subsequently required improvement. The actions being taken in response were outlined. The Board acknowledged the highly encouraging result, noting the improvement journey since the previous survey and the findings from the most recent CQC inspection report. Non-Executive Director, Louise Martin, sought confirmation that the improvement actions relating to the food offer were aligned with the existing work being undertaken by the Chief Operating Officer on the Trust's Soft Facilities Management contract. The Chief Nurse and Midwife confirmed that the actions were being progressed and monitored by the Nutrition and Food Group and it was hoped that improvements would be evident in the 2021 survey results. The Board of Directors noted the Gynaecology Inpatient Survey Results 2020.

086h	**Chair's Reports from the Quality Committee** The Board considered the Chair's Reports from the Quality Committee meetings held on 27 September 2021 and the 25 October 2021. Non-Executive Director, Susan Milner chaired the October 2021 meeting and highlighted that 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. Three issues were raised from the Maternity Safety Champion report and it was noted that these would be highlighted to the Board: • 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 The progress against these issues would report to the next scheduled quarterly maternity safety champion meeting. The Board of Directors: • Received and noted the Chair's Reports from the Quality Committee meetings held on 27 September 2021 and the 25 October 2021. In summarising the 'Quality and Operational Performance' section of the meeting, the Chair highlighted that it was clear that workforce issues were closely entwined with quality and operational challenges.
087a	**Workforce Performance Report** The Board received the Workforce Performance Report. The Chief People Officer noted that the Trust continued to report a significantly challenged position against key workforce metrics. A mandatory training Task and Finish Group chaired by the Chief Information Officer was progressing well with good engagement from divisional representatives. Key areas of progress included all mandatory training being made accessible from a single point of access, making it quicker and easier for staff. The Chief People Officer noted that the work being undertaken to review rotas would also support staff by strengthening the ability to plan for staff to be released for training. It was reported that a new absence approach launched on 1st November 2021 and this was being supported by wellbeing coaching training for managers and part of a wider focus on wellbeing. The Board of Directors: • Noted the Workforce Report.
087b	**Supporting Staff Wellbeing: The North West Pledge** The Chief People Officer explained that trust boards in the North West had been asked to sign up to a pledge of commitment in relation to employee wellbeing. The stated aim of the pledge was to 'shift the focus around health and wellbeing from the (approximately) 5% of staff in the North West who were off sick, to the 95% who were in work and contributing'. The Chief People Officer continued to outline the detail of the pledge commitments and, at a high-level, benchmark the Trust 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. Non-Executive Director, Louise Martin, requested that staff working in the community be included in wellbeing initiative and activities. The Chief People Officer acknowledged this and confirmed that community staff would be included.

	The Board of Directors: • Approved the signing of the Supporting Staff Wellbeing: The North West Pledge; and • Noted the ongoing work to enhance employee wellbeing at LWH. *Lynn Greenhalgh left the meeting*
087c	**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 20 September 2021. Non-Executive Director, Susan Milner chaired the meeting and highlighted the following issues: • The Committee had noted moderate assurance against two reports, mainly as a result of the way the information was presented rather than due to the content. • Positive assurance had been received in relation to the development of a Virtual Training Platform. The Board of Directors: • Received and noted the Chair's Report from the Putting People First Committee meeting held on 20 September 2021.
	Board Thank you *Kathy Smith (Medical & Undergraduate Education Centre Manager), Diane Taylor (Head of Nursing, Gynaecology) and Debbie Pink (Access Centre Manager) joined the meeting.* The Chief People Officer presented a 'thank you' to Kathy Smith who ensured that junior doctors had a good experience at the Trust. It was noted that Kathy was well respected by the medical workforce and was also undertaking an innovative project to help to develop the Virtual Training Platform. The Chief Nurse and Midwife presented a 'thank you' to Diane Taylor and Debbie Pink for the work undertaken by the Gynaecology Division to achieve a great result in the Gynaecology Inpatient Survey. *Kathy Smith (Medical & Undergraduate Education Centre Manager), Diane Taylor (Head of Nursing, Gynaecology) and Debbie Pink (Access Centre Manager) left the meeting.*
088a	**Finance Performance Review Month 6 2021/22** The Chief Finance Officer presented the Month 6 2021/22 finance performance report which detailed the Trust's financial position as of 30 September 2021. The Committee noted a Year-to-Date deficit of £14k, against a £12k deficit plan, meaning that the Trust had broadly delivered its half year financial position against the April to September (H1) plan. The Chief Finance Officer informed the Committee that shortfalls on the Cost Improvement Programme (CIP) and Elective Recovery Fund (ERF), as well as a potential breach of the agency spend cap were the key matters of concern. It was explained that the Trust was working to convert agency usage to fixed-term and bank roles, tapering down any areas of double-running. The Chief Finance Officer noted that the main driver for agency usage had been a national shortage of midwives and it was stated that the use of agency staff had been exercised in a targeted and managed way to ensure that safe staffing levels were maintained. It was expected that the use of agency midwives would reduce once newly recruited midwives, who started at the Trust in September and October 2021 became embedded. Due to the scale of the Trust's financial challenges, a Financial Recovery Board (FRB) had been established to provide further scrutiny and agree actions to improve the financial position. The FRB had met in October 2021 and was proving to be a useful forum to identify and progress actions.

	Whilst not able to attend the meeting, the Chair reported that Non-Executive Director, Tracy Ellery, had wished to convey the message that whilst H1 delivery was a success, the Trust could not be complacent about the significant challenges facing the organisation for the second half of the year. The Board of Directors: • Noted and received the Month 6 2021/22 Finance Performance Review
088b	Planning Update, October 2021 to March 2022 The Board received the report that outlined the current situation regarding the financial and operational plans for the second half of the 2021/22 financial year. It was noted that a draft plan had been shared with the Finance, Performance and Business Development Committee in October 2021 and that a final plan would need to be formally approved by the Board ahead of submitting to the Cheshire & Merseyside Integrated Care System. The deadline for the submission remained fluid but it was likely that an Extraordinary Board meeting would need to be called to consider and approve the finalised plan. The Chair noted that whilst he was assured regarding the Trust's processes for developing the H2, 2021/22 plan, it was likely that the outcome, and delivery requirements against this, would present a significant risk to the organisation. The Board of Directors noted the Planning Update, October 2021 to March 2022.
088c	Chair's Reports from Finance, Performance and Business Development Committee The Board considered the Chair's Reports from the Finance, Performance & Business Development Committee meetings held on 27 September and 25 October 2021. Committee Chair and Non-Executive Director, Louise Martin, reiterated the point that delivery of the H2, 2021/22 plan would present significant challenges to the Trust. With this in mind, the time allocated to the Committee meetings would be increased and a December 2021 meeting would take place. Louise Martin continued to assure the Board that the Committee was also retaining a focus on operational performance, particularly the recovery of services post pandemic. The Chief Executive suggested that it would be useful to hold a Board Development session on the effective and appropriate balance of quality and financial risks. Action: To hold a Board Development session on the effective and appropriate balance of quality and financial risks in the New Year. The Board of Directors: • Received and noted the Chair's Reports from the FPBD Committee meeting held on 27 September and 25 October 2021.
088d	Chair's Report from the Audit Committee The Board considered the Chair's Report from the Audit Committee meeting held on 21 October 2021. Non-Executive Director and Committee member, Tony Okotie highlighted the following key issues: • The Committee discussed the most effective way to track improvements with Divisional Governance Arrangements (the first 'cycle' of presentations from Divisions being 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. • 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 was asked to note that a 2+2 year contract is in place with MIAA. The process for reviewing the procurement of an External Auditor was underway with Governor representation. It was expected that a recommendation would be made to the Council of Governors on 11 November 2021. The Board of Directors: • Received and noted the Chair's Report from the Audit Committee meeting held on 21 October 2021. • Noted that a 2+2 year contract for internal audit services was in place with MIAA
088e	**Chair's Report from the Charitable Funds Committee** The Board considered the Chair's Report from the Charitable Funds Committee meeting held on 20 September 2021. Non-Executive Director and Committee member, Tony Okotie highlighted that the Committee had 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 were acknowledged. It was noted that a number of applicants had not submitted an impact review and 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 improve the post implementation review process. The Board of Directors: • Received and noted the Chair's Report from the Charitable Funds Committee meeting held on 20 September 2021.
089	**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, a discussion had been held at the Quality Committee regarding the potential addition of a new BAF risk relating to Cyber-Security. There was agreement that cyber-security should be a BAF level risk item, with the risk to patient safety, amongst other impacts, noted. A debate was held as to the most appropriate Committee alignment. Whilst it was accepted that the impact of the risk materialising would impact the areas within the purview of the Quality Committee, a significant number of the identified controls and assurances reported through to the Finance, Performance and Business Development Committee. For this reason, it was agreed that the Cyber Security BAF risk would be aligned to the Finance, Performance and Business Development Committee. It was reported that BAF Risk 2.2 'Failure to develop our model of care to keep pace with developments and respond to a changing environment' and particularly the underpinning strategic threat relating to multiple clinical systems had been underscored following review by the Medical Director and Chief Information Officer. As this represented one of the most significant risks to the Trust, there was agreement to increase the score from 12 to 16. The Board of Directors: • Noted the BAF • Agreed to the addition of BAF risk 2.4 'Major and sustained failure of essential IT systems due to a cyberattack' and for this to be aligned to the FPBD Committee • Approved the increase of score for BAF Risk 2.2 to 16 from 12. *The following items were received under the 'Consent Agenda'*
090	**Medical Appraisal and Revalidation Annual Report 2020/21** The Board of Directors:

	• received the annual report and noted that this would be shared with the higher Responsible Officer • Took assurance that despite COVID19 there were effective medical appraisal and revalidation processes in place • ratified the approval of the statement of compliance Annex D confirming that the organisation, as a designated body, was in compliance with the regulations
091	**Board Assurance - post-mortem facilities** The Board of Directors: • noted the contents of the report • noted support for the future development of the report in the provision of assurance that the organisation was complying with the requirements of HTA or has appropriate arrangements in place to mitigate any risks.
092	**Review of risk impacts of items discussed** The Chair identified the following risk items and positive assurances: Risks: • Concerns relating to 31-day and 62-day cancer performance • Continued workforce pressures • The significant financial risks from the H2, 2021/22 planning • The addition of a new cyber-security BAF risk and escalation of scoring relating to the risk of the Trust's multiple systems. Positive assurances: • Positive feedback regarding the Continuity of Carer model • Positive feedback from the MVP Chair Overall, the Chair identified an overarching theme of challenge relating to the Family Health Division. It was requested that an overview of the Executive team oversight work with the Division be provided to the next scheduled Board meeting. **Action: To provide an overview of the Executive team oversight work with the Family Health Division for the December 2021 Board meeting.**
093	**Chair's Log** The following Chair's Log was noted: • For the Quality Committee to review a Coroner's report regarding the inappropriate use of Kielland's forceps to identify potential learning opportunities.
094	**Any other business & Review of meeting** None noted. **Review of meeting** No comments noted.

Liverpool Women's
NHS Foundation Trust

Action Log

Trust Board - Public
December 2021

Key	Complete	On track	Risks identified but on track	Off Track

Meeting Date	Ref	Agenda Item	Action Point	Owner	Action Deadline	RAG Open/Closed	Comments / Update
4 November 2021	21/22/92	Review of risk impacts of items discussed	To provide an overview of the Executive team oversight work with the Family Health Division for the December 2021 Board meeting.	Chief Operating Officer	Dec 21	Complete	On the agenda – item 121d
4 November 2021	21/22/88c	Chair's Reports from Finance, Performance and Business Development Committee	To hold a Board Development session on the effective and appropriate balance of quality and financial risks in the New Year.	Trust Secretary	Jan 22	On track	
4 November 2021	21/22/86c	Cheshire & Merseyside Women's Health & Maternity Services Programme Update	For the April 2022 Board to receive an update on the work undertaken by the Women's Health & Maternity Services Programme to reduce health inequalities.	Chief Operating Officer	Apr 22	On track	
4 November 2021	21/22/86b	Quality & Operational Performance Report	To provide additional detail to the December 2021 Board on the 31-day and 62-day cancer targets in terms of number and length of breaches.	Chief Operating Officer	Dec 21	Complete	On the agenda – item 121b
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	Jan 22	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	21/22/50a	Quality & Operational Performance Report	To seek clarification on the setting of the Trust's complaints target.	Chief Nurse & Midwife	~~Sept 21~~ Feb 22	On track	Refreshed target to be reviewed alongside SOF update to performance reports.

Chair's Log

Received / Delegated	Meeting Date	Issue and Lead Officer	Receiving / Delegating Body	Action Deadline	RAG Open/Closed	Comments / Update
Delegated	04.11.2021	To review a Coroner's report regarding the inappropriate use of Kielland's forceps to identify potential learning opportunities. Lead Officer: Medical Director	Quality Committee	January 2022	On track	
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	Closed	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	Closed	Analysis provided in Recovery and Restoration presentation provided to Oct 2021 FPBD. 'Deep dive' undertaken in November 2021.

Liverpool Women's
NHS Foundation Trust

CEO Report

Trust Board
December 2021

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.

Chief Executive Report

Section A - *Internal*

Recent incident at Liverpool Women's Hospital

The time since the incident on the 14th November 2021 has been extremely upsetting and traumatising for everyone associated with Liverpool Women's.

I'd firstly like to say thank you to our patients and visitors for your co-operation and patience during this time. We know that it has been a very traumatic experience for you and we appreciate your understanding and support to allow us, working with others in the community, to manage this incident appropriately and safely.

I am so proud to be Chief Executive of Liverpool Women's Hospital and to have so many brave and dedicated colleagues who have worked during the most upsetting of circumstances to keep our patients safe - in particular, the members of staff and public who were first at the scene of the incident and came to people's aide.

Thank you also to Merseyside Police, Merseyside Fire & Rescue Service and all other emergency services and agencies who have supported the Trust throughout this incident and helped to keep everyone safe.

We have also sent our best wishes to the taxi driver who was involved in the incident and wish him a speedy recovery – Liverpool Women's is thinking of you.

As a Trust we have been so grateful for the messages of solidarity and support at this difficult time from everyone across the city, the country, and beyond. We have lost count of the kind messages of support we have received and we want to say thank you for being with us.

I just wanted to draw attention to a particular story from a patient who was with us from the 9th November 2021 until they were discharged on the 20th November 2021:

My pregnancy was straightforward until the very last moment when I was diagnosed with pre-eclampsia after labour had started and I was in MAU. From the moment we arrived at the Women's at 9am on 9th November to the moment we left on Saturday night, I have been astonished by the standard of care. I feel as though I stayed at a very clean hotel with unusual beds, bins for every occasion and staff in variety of uniforms…

…Things were already hard and then of course there was the attack on Remembrance Sunday. I didn't see the attack, but I heard the explosion. I have anxiety and terrorism is a major trigger for me, so to say that I fell apart on the Tuesday after would be an understatement. A combination of hormones and all the events going on physically and in the carpark caused me to unravel. The staff on Matbase couldn't have been any better with me. I could see how busy they were doing their daily jobs and there's no mistaking the unsustainable pressure they seem to be under, but in no time had organised for me to get the support I needed and moved me into a side room. I don't know her surname, but I believe the midwife assigned to TC that day was called Emma and she was brilliant. I felt much better once on the sideward as it allowed me to think a bit more clearly. I'm also not great when surrounded by people so after a week nearly on a ward, I was so glad to be alone. I think it gave me the chance to process what had happened without everyone else's chatter setting off further anxiety.

The purpose of this communication is to let you know how glad I am that I chose Liverpool Women's for my maternity care. I didn't like staying in hospital so long, but who knows what the outcome would have been 50 years ago without the interventions given to us. Liverpool Women's ensured that my child didn't leave hospital until she was ready to and did the very best for me while we were with you. I'm beyond shocked that your wonderful hospital was attacked, I'm relieved that no one else was harmed… We'll all be processing it differently and some will be more affected than others, I'm accessing counselling tomorrow, again, this is through a service that the perinatal mental health midwives referred me to.

I'd like to mention specifically the nurses on the TC ward who taught me mothering skills when my own mother couldn't be with me. They looked after my daughter with tenderness and helped me to feel less alone, I was glad to come home, but sad to say goodbye to them. My daughter's birth and the after events has been the most challenging of my life, for someone who's spent a lifetime dealing with anxiety and depression this is saying something. Had I not received such a high standard of support, I don't know how I'd have managed it.

Section A - *Internal*

Recent incident at Liverpool Women's Hospital

We will be continuing to work with Merseyside Police and other agencies as part of this ongoing investigation and therefore we would appreciate that our staff, patients and visitors continue to be given respect and space during the period ahead. Please also be kind to one another at this difficult time. There is a report on today's agenda that outlines the process that the Trust is going through to identify learning from the incident and future actions to be taken.

We are pleased to say that despite the understandable continued security and Police presence on our site at the moment, our services are back to running as close to normal as can be expected, allowing us to do what we do best which is looking after our women, babies and families at Liverpool Women's.

For the latest updates and advice on accessing the hospital please go to: https://www.liverpoolwomens.nhs.uk/news/ongoing-incident-at-liverpool-women-s-hospital/

Thank you again for your continued heartfelt support, it means so much to everyone at Liverpool Women's NHS Foundation Trust. The following video just pulls together some of the messages that we have received:

https://fb.watch/9wCTCCmrl5/

2021 Flu Campaign Update

The holistic health and wellbeing of our valued workforce is of paramount importance to us. As part of this we want to mitigate the risk during the winter months of our staff becoming unwell due to the seasonal flu virus that is circulating within the community.

The Trust is continuing with its flu campaign delivery and at the 25 November 2021, the overall uptake stood at 43%.

Sessions have been available which have been delivered through a mix of peer vaccinators and OH colleagues from LUHT, a mixture of drop in clinics and walkarounds at different times in all clinical areas. Flu was delivered in conjunction with the booster clinics and will be offered again at the booster clinics on 30th, 1st and 2nd December 2021.

If staff have received their vaccination from their GP/Pharmacist etc, this can be captured by informing HR

Section A - *Internal*

Award for Estates and Facilities Team of the Year
WINNER 2021: Tilbury Douglas and Liverpool Women's Hospital estates team for the neonatal unit project.

In partnership with Tilbury Douglas, Liverpool Women's successfully completed work on a brand new £15m Neonatal Unit in August 2020. Despite the impact of COVID-19, we completed the project on time and on budget, bringing significant benefits to our babies, families and our staff. In recognition of this highly successful project, Liverpool Women's Hospital estates and facilities project team and Tilbury Douglas were recently recognised as the Estates and Facilities Team of the Year, as part of the Building Better Healthcare Awards 2021.

Clinical Audit Leadership Summit 2021: Success for LWH
The Clinical Audit & Effectiveness Team at LWH are proud to announce that three of our local Clinical Audit projects have been selected for presentation at Health Care Conferences UK (HCCUK) 'Clinical Audit Leadership Conference 2021'.

HCCUK advised a large volume of abstracts were submitted this year, with ours being in the top third of all of those received! Well done to everyone involved!

The successful projects are:
- Clinical Audit Reference 2019/020 - Hewitt Fertility Centre: 'Patient Access to Fertility Preservation Treatment Re-audit'
- Clinical Audit Reference 2020/025 - Neonates: 'Reporting of radiology images by on-call neonatal consultant Re-audit'
- Clinical Audit Reference 2020/019 - Safeguarding: 'Trust Compliance with the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) 2020-21'

The Clinical Audit Leadership Summit, held virtually on Friday 26th November 2021 and in association with the Clinical Audit Support Centre, the conference shared good practice and leadership in Clinical Audit.

The summit focused on Clinical Audit for Improvement with a particular emphasis on the development of effective local clinical audit leading to audit recommendations that change practice and improve patient care. Key speakers in attendance will include representatives from NHS England and NHS
Improvement and Care Quality Commission.

Community Diagnostic Centre
At its meeting in November 2021, the Board approved the building of a Community Diagnostic Centre at the Crown St site. There will be five community diagnostic centres located across the Cheshire and Merseyside region and they will form part of a wider national initiative, that'll see over 100 community diagnostic centres backed by Government investment launch across England, to make services more accessible and convenient for patients. The centres will achieve this by providing patients with quick and easy access to various diagnostic tests, such as blood tests, X-rays, ultrasound, CT scans, and endoscopy, in one place. Enabling patients to visit a hub, or 'one stop shop' as they're referred to, closer to home, in order to get multiple tests completed at the same time, helping them to get diagnosed earlier, ultimately sparing more patients and families the pain and trauma of disease, and saving lives by allowing interventions to start sooner.

Section A - *Internal*

Promoting NHS Finance Careers
As part of Black History Month and Liverpool Women's Hospital initiative in "Promoting NHS Finance Careers" Bassey Orok, Management Accountant visited Kingsley Community Primary School.

The school wanted someone to explain what they do and how they got to where they are. This coincided with LWH initiative to promote the vast range of careers available in the NHS to students of all ages as they are our future workforce. As a local school over the road from LWH, it was an opportunity Bassey could not miss.

There were other speakers from various professions e.g., Pharmacist, Engineer, a poet/writer, boxer, lawyer, and local business entrepreneur.

Bassey addressed the assembly and explained the role of Finance in NHS and the support we give to front line medical staff and patients. The children and teachers wanted to know how Accountants fit into NHS hospitals as their perception of hospitals is Doctors and Nurses.

At the end of the assembly the head teacher thanked the speakers for coming and sharing their career experiences with the children. She said "you are all role models".

Bassey said "It was interesting as the children asked interesting questions. I explained where we get our funding from and how it is used. I had to break it down to money. Some of the children expressed a career interest in Finance because of money, some wanted to know if am paid lots of money, another wanted to know how long it took to count the money and if wished I had all that money. It was interesting seeing the children engaged and showing interest in what goes on in NHS beyond front line medical staff. I thoroughly enjoyed interacting with children and teachers."

The feedback from Kingsley Community Primary School is that "the children loved it and are still talking about the assembly!"

Section B - *Local*

Designate Chief Executive of the Cheshire and Merseyside Integrated Care Board (ICB)

The Cheshire and Merseyside Health and Care Partnership has confirmed that, following a robust recruitment process, Graham Urwin has been appointed to the position of Designate Chief Executive of the Cheshire and Merseyside Integrated Care Board (ICB).

Graham joins from his current role as Director of Performance and Improvement at NHS England North West, a role with responsibility for system leadership and oversight of NHS commissioners and providers in the North West region. Graham has a finance background in both local government and the NHS and has worked at local, regional and national level. He has also worked across both commissioning and provider organisations. Graham has also been the Regional Incident Director throughout the Covid-19 pandemic.

David Flory, Interim Chair of Cheshire and Merseyside Health and Care Partnership, said: “The confirmation of Graham in this role is a significant step in the development of integrated care in Cheshire and Merseyside and the establishment of an NHS Integrated Care Board which, subject to legislation, will hold a substantial budget for commissioning high quality patient care, and have the authority to establish performance arrangements to ensure this is delivered.

“I am sure our partners will join me in welcoming Graham and continuing to work with him and other colleagues on improving care for the people of Cheshire and Merseyside.”

The next step will be to recruit non-executive members and executive directors to the ICB over the coming weeks. Updates will be shared as this work progresses.

Section C - *National*

Widening access to Health Inequalities Improvement Dashboard

The Health Inequalities Improvement Dashboard is an important deliverable for the National Health Inequalities Improvement Programme, which builds on learning from the COVID-19 pandemic around the importance of good quality data to provide insights to drive improvements in tackling health inequalities. Whilst several individual tools exist, the Health Inequalities Improvement Dashboard provides key strategic indicators relating to health inequalities all in one place. This will help the NHS to meet its vision of 'exceptional quality healthcare for all, through ensuring equitable access, excellent experience and optimal outcomes'. The dashboard will measure, monitor, and inform actionable insight to make improvements to narrow health inequalities. It covers the 5 priority areas for narrowing health inequalities in the 2021-22 planning guidance. It will also cover data relating to the five clinical areas in our Core20PLUS5 approach. By providing data cut by ethnicity and deprivation, the dashboard will enable the NHS to take concerted action to improve health inequalities.

The new process to access the dashboard will be through the Equality and Health Inequalities Network – FutureNHS Collaboration Platform. If you click on the Health Inequalities Dashboard tab, you will be able to see a process for instructions of how to access the dashboard (an NHS.net or nhs.uk email address is required).

https://future.nhs.uk/EHIME/grouphome

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	***2021/22/121a***		**Date: 02/12/2021**	
Report Title	**Major Incident Update Report**			
Prepared by	***Dianne Brown – Interim Associate Director***			
Presented by	***Dianne Brown – Interim Associate Director***			
Key Issues / Messages	***This paper outlines the immediate response that the Trust has taken through the escalation of the Major Incident policy. The update describes the ongoing actions taken to mitigate risk, maintain patient safety and access to services and support staff, patients, and visitors. The paper also outlines next steps in terms of debrief, restoration, learning and subsequent reporting.***			
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): TBC			
	For Decisions - in line with Risk Appetite Statement – N/A ***If no – please outline the reasons for deviation.***			
	Recommendation: *The Board is asked to receive the update provided within the report into the Major Incident that occurred at the Liverpool Women's site on 14.11.2021. The Board is also asked to note the actions taken to date in response to the incident, and note the approach to debrief, learning and reporting*			
Supporting Executive:	**Gary Price – Chief Operating 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:

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

On 14 November 2021, at approximately 10:59 am, an explosion occurred inside a taxi as it arrived in front of the main entrance of the hospital on the Crown Street site. The driver left the vehicle seconds later and ran to safety, supported by Trust staff. There was an ongoing fire in the vehicle and Trust security operatives attended to extinguish the flames using appropriate equipment. An immediate "999" call was made to summon help from emergency services.

Police immediately attended along with the North West Ambulance Service and Merseyside Fire and Rescue who dealt with the imminent risk of the fire. Initial first aid was provided to the taxi driver by staff within the Gynaecology Emergency Department and he was subsequently transferred by North West Ambulance to Aintree Hospital.

Appropriate internal escalations through onsite leadership and management teams were made to the executive on call. The Chief Operating Officer, Chief Executive and Chief People Officer / Deputy Chief Executive all made their way to the site.

A major Incident was subsequently declared at 12.07 by the Chief Operating Officer and initially the site was locked down with no access or exit allowed as per policing policy. During this time a decision was made in conjunction with clinical colleagues to divert patients from the Trust and appropriate alternative care was provided in collaboration with North West Ambulance. Access to the site was significantly affected and access directed by police and counter terrorism colleagues.

In a meeting between Merseyside Police and the CEO the incident was declared a terrorist incident at 15.00 hours on the 14.11.2021. The site at the main entrance and main carpark remained cordoned off and under the control of Merseyside police and the North West Counter Terrorism Unit, supported by the Royal logistics Corps' Bomb Squad until Monday 22 November 2021.

The major Incident policy and associated oversight remained in situ until Wednesday 24.11.2021 whereby a Trust decision to deescalate took place. This followed the decision of the Strategic Command Group to de-escalate the system wide and policing major Incident.

Support mechanisms were immediately provided and continue for all staff in the Trust. Patients and families have been supported in accordance with best practice and communications have worked to support the key messages needed through both internal and external stakeholders.

A full debrief and After Incident Review will now take place and the Trust will report finding through to the Merseyside Resilience Forum

This paper outlines the immediate response that the Trust has taken through the escalation of the Major Incident policy. The update describes the ongoing actions taken to mitigate risk, maintain patient safety and access to services and support staff, patients, and visitors. The paper also outlines next steps in terms of debrief, restoration, learning and subsequent reporting.

MAIN REPORT

Immediate actions taken on the day of the incident

On the 14th November 2021 at approximately 10:59 the Trust was subject to a Terrorist Incident at the main entrance. Immediate actions were taken to alert emergency services and summon help. Trust staff acted in accordance to Trust policy and escalated the incident though the on-call management system.

A major Incident was declared at 12.07 by the Chief Operating Officer who had arrived on site.

Subsequently, Executive directors led by the CEO attended site and led the major incident command room. All decisions made where made in conjunction with Merseyside police and co-ordinated through on-site leaders and managers using the Major Incident Policy. This was a significantly dynamic period with Trust Executives working closely with and to the instructions of North West Counter Terrorism Police and Merseyside Police.

Immediate actions were taken to identify additional resources required to support the Major Incident this included the need for additional security and switchboard operatives to support police and security activity The Patient Facilities Manager attended site and co-ordinated security and switchboard operations as part of the team. Security guards on site supported emergency services with direction and access throughout the site. Access to visitors and staff was restricted and appropriate communications were led by the Head of communications who also attended site and provided invaluable links to internal and external stakeholders, working in conjunction with police communication teams to align messaging. Regular updates were added to the Trust website for patients and visitors and social media channels used to signpost to the relevant websites. Appropriate escalations to external bodies and regulators were made through the Executive team.

A decision was made to instigate the internal and CM regional maternity divert policy. In total 5 women were transferred to alternative providers of maternity care to reduce footfall and access to the site and recue the workload of staff internally. They have since had appropriate follow- up as defined by the policy by the Trust and appropriate support offered.

Some elective and outpatient activity was cancelled within Gynaecology and these have been reported appropriately through the incident management system. Further analysis is ongoing relating to any harm incurred. Any future identified harm will be reported and investigated through the incident reporting system and duty of candour considered as required.

Staff Support

Immediately on the day of the incident a counsellor was made available for the afternoon providing immediate support to affected staff. Executive teams ensured a full 24-hour on-site presence for several days and feedback from staff has been positive. Immediately following the incident, several Executive Team members including CEO, Deputy CEO and COO conducted numerous walkarounds of all areas of the hospital to ensure staff were aware of the incident and to try to provide reassurance and advice.

Best practice guidance has been sought form professional bodies and colleagues at Mersey Care to ensure that the staff support offer meets the needs of staff. Formal debrief is being considered when appropriate

and clinically advised. There have been several opportunities to access counselling and support, and these are summarised below.

- 2 weeks of face to face listening and signposting from counsellors and psychologists from Merseycare / C&M Resilience Hub including Saturdays with counsellors based within clinical areas at the request of staff
- Ongoing counselling support available and promoted
- Inspire Talkz (2 ex rugby players) delivered planned sessions on resilience and Mental Health as well as ad hoc support in areas as required
- Literature for managers and staff about supporting staff after trauma distributed and discussed
- Listening event open to all staff to reflect on incident on 25/11
- Ongoing signposting to specialist support in relation to terror / trauma, e.g. Peace foundation

It is recognised that ongoing support may be required for some staff for some time, and this will be overseen by the workforce group and Deputy Chief People Officer. In addition, the following is in development to ensure ongoing support.

- Employment of 1.0wte 8c Staff Support Psychologist which was already planned and will be advertised next week
- Extension of the support provided by inspire Talkz
- 'Walk and Talk' sessions as an opportunity for multi-disciplinary staff to get together and support each other
- Continuation of OD work with teams led by LWH OD lead, using culture mapping diagnostic tools

As we move into the restoration and recovery phase it is recognised that some staff may have concerns regarding the impact of the incident that occurred on the 14.11.2021. Advice and support have been received from the local Community policing team who are maintaining an on-site presence via a mobile police station manned by a police officer offer for 12 hours a day. The local community policing team are also working with the Trust to develop plans to host some on site and in person police surgeries to offer advice, support, and reassurance to staff. In addition, we are reviewing our on-site security measures to ensure that there is an increased presence of the security team on all entrances. Finally Prevent training and education is being reviewed and considered as part of the work of the workstream reporting into the Restorations and Recovery Group.

Every effort has been made to ensure that opportunities are maximised to provide every appropriate element of support to protect the longer-term health and wellbeing of staff. Feedback from staff has been extremely positive about the approach the Trust has taken. Finally following the period of reflection and learning there is a need to recognise and celebrate the outstanding actions of Trust staff during the incident this will be considered in depth as appropriate and led by the Chief People Officer.

Patient and Family Support

Support on the day of the incident for inpatients and their families was provided by the clinical teams on site. Heads of service have also been available in the clinical areas to offer support and signposting on an individual basis, with maternity patients receiving the support of community midwives visiting with a referral to PNMH services if required.

In addition, the Executive team provided a highly visible presence for staff and patients visiting each clinical area several times each day. Any patients discharged on the day of 14 and 15 November were supported within 24 hours with a phone call from the PALS team. In total over 50 patients that were discharged on those dates were contacted. Follow up letters have been sent to all patients providing information and sign

posting to support services and contact number of the hospital teams reiterated. Additional support has been sought from Liverpool CCG and the primary Care networks, the following has been agreed and in place:

- Mersey Care FT will accept any patients who seek support following the incident as fast track referrals
- Agreement that LWH can refer to MCFT who will be prioritised and seen quickly

In addition, correspondence was drafted and sent to GPs to advise them of the services and support groups available to enable appropriate advice and support to be given to patients should any patient access their services post discharge.

Additionally, a patient helpline has commenced via the Patient advice team, and access to support has been advertised widely. Information leaflets that detail the support available have been produced and shared with every area and are handed out at the man entrance. The website has a specific area that highlights support available from specialist teams and patients have been advised to contact this before any appointment by text messaging. Consideration is being made to the development of some group sessions for patients and their families supported by the Peace Foundation.

Operational Impact

Operational impact of the major incident has been minimal in respect of cancellations and/or disruption to patient activity. Some Outpatients and Inpatient procedures, for Gynaecology, were cancelled on Monday 15th November. This was enacted on Sunday 14th as an immediate major incident response. This did not include Oncology, Obstetrics or Neonates. In line with the Major Incident policy, it was further agreed to convert as many clinics as possible on the Crown St site to either a telephone where possible, or transfer to the Aintree site, this minimised the loss of activity significantly. All Oncology activity continued to run and was delivered on the Crown St site. No elective admissions were cancelled from Tuesday 16th November onwards. Activity commenced as normal from w/c 29th November.

The Access Team are leading on the rebooking of all patients that were cancelled on the day. This will be monitored as part of the operational workstream. It is anticipated that all patients will be rebooked by the 30.11.2021

Clinicians will be asked to comment on the impact of delay on individual patient cases. If necessary, any identified harm or consequence will be reported through the incident reporting system clinical care for each patient in terms of their clinical care.

Estate Implications

Constraints to the access of the site continued throughout the period of the major incident. The main entrance and ambulance bay specifically affected. The retail areas remained closed and extended operating hours offered from the staff dining room to support staff.

Alternative access was made available and communicated to staff, patients, and key agencies. Risk's assessments have been completed and monitored in terms of impact.

Additional security has been deployed across the site providing extended support and cover to entrances 24/7. It is anticipated that this additional cover will be extended for the forthcoming weeks. Additional security will remain in place pending review and recommendations by Local Security Management Specialist (LSMS) and Patient Facilities Manager (PFM)

The After Incident Review has been completed with the security guards and learning will feedback into the final report. Support has been offered and accepted by the team from both the Trust and OCS.

A formal structural engineer's report has been commissioned and completed. Initial verbal feedback is positive with no issues identified. At the time of writing this report we await the formal written report. Following handover of the estate to the Trust on the 22.11.2021 the following actions have been taken to ensure that the main entrance and car park can reopen safely and with minimal impact.

- Road maintenance and repair attended and completed
- Painter/decorator works to the main entrance
- Grounds & Gardens maintenance contractor attended
- Repair of windows

Prior to the full opening of the main entrance the Oversight Group will ensure that a full safety checklist is completed including review of the electronic door access, ventilation, and fire systems.

A longer-term review of the site access and entrances will be considered following the feedback from the Counter Terrorism Unit who have offered to support the Trust in a review of security. This will enable to trust to minimise and mitigate risk as much as possible. The review will be overseen by the Restoration and Recovery Group and reported through the executive team and relevant governance committees.

Communications

The Head of Communications attended site on day of the incident to support the response following call from the Chief Operating Officer. There was immediate all staff communications sent on the afternoon on the day of the incident. This was then established as a daily briefing to provide regular updates in terms of the incident and to reinforce support available for staff. This was supported by a Dedicated website alert and accompanying news page with latest information established as our 'go to' resource from day of incident onwards A press conference was arranged with CEO alongside Merseyside Police and Fire & Rescue Service on day of the incident (3 hours post incident) attended by regional and national media.

The Head of communications has met daily with all agency partners to ensure an aligned communications approach and strategy. In addition, the following actions were undertaken with system wide positive recognition for the approach of the communications from Liverpool Women's

- A letter of thanks from CEO published on social media and website 24 hours post-incident resulting in extensive media coverage
- Be Kind banner shared digitally and imminent installation on hospital site thanking people for their support
- A pooled interview with CEO through BBC North West's Andy Gill following the event which was shared on BBC NW, BBC Radio Merseyside and Granada Reports
- Video message from Deputy CEO asking for kindness in response to reports of hate crimes following incident – picked up by Granada Reports and Liverpool Echo
- Reassurance messages from clinical staff posted on social media encouraging patients to attend as normal
- Letter of reassurance and support for patients/visitors developed with PALs Team and offered to everyone coming into the hospital
- Social media posts encouraging photos/positive stories from patients who were in LWH care during incident and aftermath. These were posted by Merseyside Police and Liverpool City Council as part of an open letter to the city a week after the incident.

We recognise however that the communication and engagement with stakeholders, patients and staff needs to continue and further actions are planned. These will be monitored through the communications work stream and reported accordingly. Focus will remain on post-incident communication updates with clear information regarding the recovery, a particular focus of this work will be when the Police leave the site entirely and the main entrance re-opens as we know this will be challenging for some.

Financial Implications

There will be associated additional financial costs for the trust because of the Major Incident. These relate to additional staffing costs, specifically relating to security and some clinical workforce required to cover sickness and absence. Estate remedial works have commenced at pace as described to ensure business continuity; final costs will not be fully understood until works are complete. There has been an identified budget code and financial lead identified so that any associated costs can be verified and recorded. The Trust is represented within the financial recovery sub cell of the Regional Recovery Group and will submit a funding request to central Government as part of the group to request support and reimbursement for any costs incurred.

Initial discussions have also been held with NHSR regarding potential claims through the Trust indemnity and Insurance scheme. Once understood fully any financial implications will be reported through financial governance and the appropriate Board Committee.

Legal and potential risk

Advice and support have been received from local legal teams and NHS Resolution. NHS Resolution have been informed and are aware of the potential of future claims and possible Trust liabilities. Any subsequent claims and complaints will be monitored through the Trust complaints and litigation process and managed in accordance with advice received.

A full review of risks associated with the incident will be undertaken at the meeting of the Corporate Risk Committee in December 2021. The Board Assurance framework will be considered during the month of December in appropriate Board Committees.

Governance

The Trust continues to be represented in the strategic oversight of the incident through the multi-agency, and local authority led Recovery Co Ordinating Group (Operation Kipling) and appropriate subgroups. The purpose of this group is to promote the restoration and activity in the aftermath of an incident and to implement an action plan to mitigate and minimise the impact of risks identified.

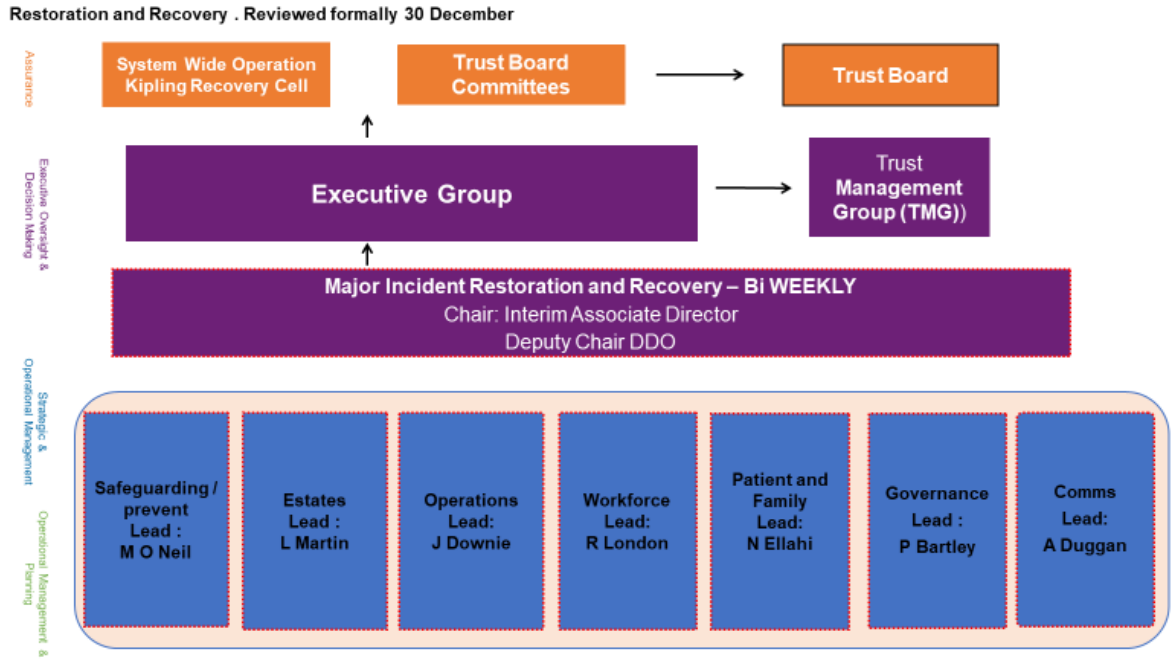
To support the ongoing management of the incident a Trust recovery and restoration oversight group has been convened to oversee the transition phase and ensure appropriate steps are taken across all areas impacted by the Major Incident. An overview of the terms of reference are highlighted below.

Major Incident Recovery and Restoration Terms of Reference summary.

- Providing Oversight Governance and Assurance to the Board of Directors and external Regulators regarding the oversight and management of the Major Incident
- Acting as SPOC for Incident Management
- Make informed decisions relating to resumption of Business as usual
- Responsible for identifying and reporting learning internally and to strategic bodies and regulators
- Ensure compliance with current Major Incident Policy and post incident review of policy.
- Oversee the process for Incident Debrief – (After Action Review)

- Ensure option appraisal completed for estates and security
- Oversee development of repository of evidence relating to the incident
- Be time limited and action focussed
- Identify opportunities for celebration and reflection

The reporting of the oversight group is as follows.



In addition to the declaration of the Major Incident an incident report has been submitted through the NHSE/I Incident reporting system (Steis) notifying of the major incident. The maternity divert will also be reported in this way as per local policy, and any identified patient harm will be reported through the Trust incident reporting system and appropriate level of investigation completed. Individual incidents are currently under review at the time of this report being compiled and further analysis of the level of harm will be reported in due course once investigations are complete. The Trust has received advice from the Health and Safety Executive and this incident is nor RIDDOR Reportable, however any staff absences of longer than three days are reportable under the RIDDOR framework. early indications are that there is one staff member who would meet that criteria. Relevant support from Occupational Health and the Psychology teams are in place.

Learning and next steps

It is important to ensure there is an evaluation of the implementation and actions undertaken during the period of the major incident to capture any learning and issues ensuring that these are documented and actioned appropriately. This in new territory and that there is no precedent in terms of learning from previous Terror incidents within NHS settings. It is vital that due attention is paid to each step of the response to enable not only our learning but learning that can be shared across the NHS and health care system. The methodology used for this learning process has been directed by the Merseyside Resilience Forum and is called, After-Action Review. The reviews will be led by the Interim Associate Director and supported by the Governance team.

An After-Action Review (AAR) is a structured facilitated discussion of an event, the outcome of which enables the individuals involved in the event to understand why the outcome differed from that which was

expected and what learning can be identified to assist improvement. AAR is intervention that is undertaken soon after the incident occurs that seeks to understand the expectations and perspectives of all those staff involved. It generates insight from the various perspectives of the multidisciplinary team, enables lessons learned to be identified and leads to greater safety awareness, changes to team behaviours and assists in identifying actions required to support safety improvement.

The AAR meetings are planned to take place week commencing the 29 November and will include the following staff groups

- Executive Teams
- Security Teams
- Clinical staff
- Non-Clinical Staff (porters, domestics, and admin)
- The opportunity for all staff to contribute to the feedback through an online survey

On completion of the AAR a desk top review will be completed to consider all the information available to the team, including the full chronology of events, outputs from the AAR, and any other intelligence available to ensure a detailed report of learning including recommendations and actions can be completed. Once complete the report will be shared through the Merseyside Resilience Forum and will be reported to the Board of Directors in January 2022.

Conclusion and Recommendation

The Trust has responded effectively, operating in extremely unprecedented and dynamic circumstances to maintain safe and accessible services throughout the implementation of the major incident policy. A review of the effectiveness of the implementation of the major incident policy will now be undertaken and reported with recommendations to the Board of Directors in January 2022. The report will also be shared through the Merseyside Resilience Forum and other relevant strategic groups

The Board is asked to receive this report and take assurance from the actions taken to the Major Incident that occurred on the 14.11.2021.

Liverpool Women's
NHS Foundation Trust

Trust Board

Operational Performance Summary
December 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

New absence policy and approach launches in November 2021 to move the focus from absence to wellbeing

Efficient

Breakeven plan for H2 2021/22 submitted.

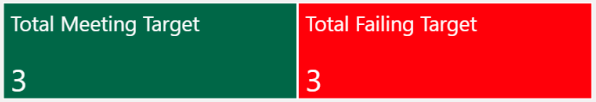
Safety

IPC performance continues to be strong for the Trust

Effective

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

Experience



Strong A&E Performance

WE SEE Areas of Challenge

Workforce

The Trust's sickness absence rate remains significantly above the established target.

Efficient

Half 2 2021/22 presents several significant challenges to the Trust.

The Trust is behind on its Cost Improvement Programme (CIP) target and overspent on agency usage.

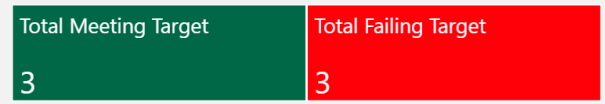
Safety

Whilst VTE performance has shown a recent improvement, it remains below target.

Effective

Cancer 31 day and 62 day performance significantly below target.

Experience



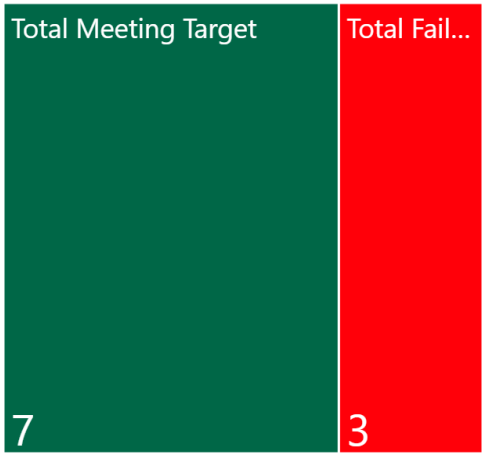
Continued challenges with Friends and Family performance in Maternity

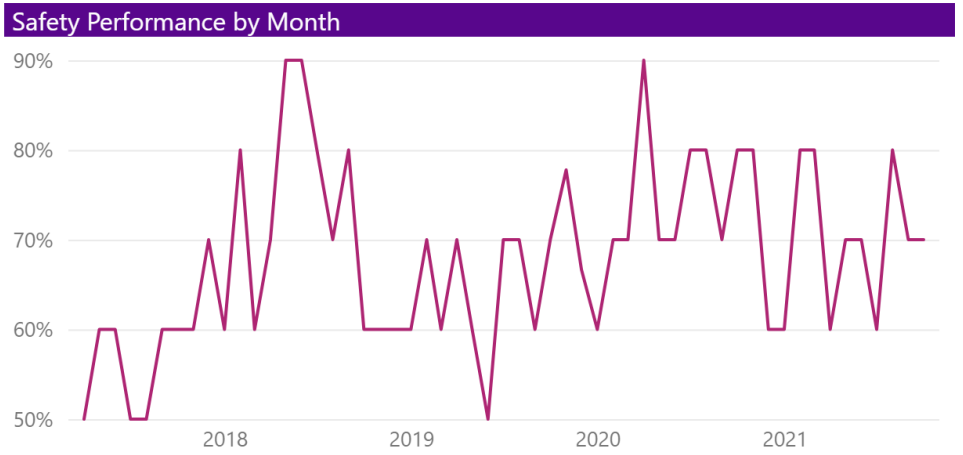
Liverpool Women's
NHS Foundation Trust

Operational & Quality Performance

Trust Board
December 2021

To deliver **Safe** services

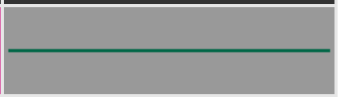
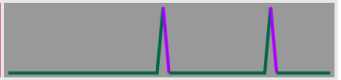
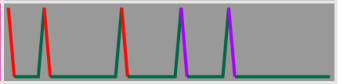
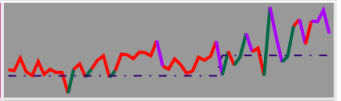
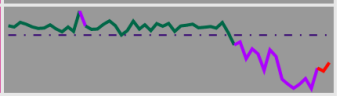




The majority of Safety indicators remained green in October 2021.

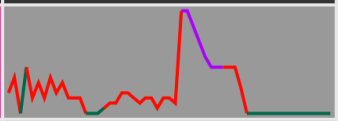
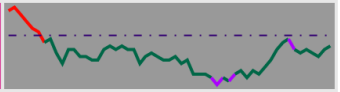
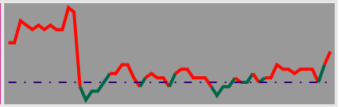
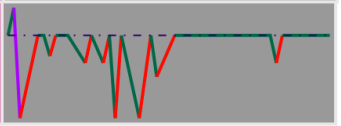
Detail on serious incidents is provided within the performance report.

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	October 2021	0	0				
Medical Director	Infection Control: Clostridium Difficile	October 2021	0	0				
	Infection Control: MRSA	October 2021	0	0				
	Never Events	October 2021	0	0			5	
Medical Director	Caesarean Section - Emergency Rate	October 2021	19.21%	+2.61%	16.60%	656	5	
	Venous Thromboembolism (VTE)	October 2021	89.62%	-5.38%	95.00%	1118		

KPI	KPI Narrative
Venous Thromboembolism (VTE)	A new Trust Guideline for VTE thromboprophylaxis and anticoagulation for gynaecological inpatients has been written. It is tabled for the next gynae governance meeting and after approval and ratification at the subsequent gynaecology board meeting will be disseminated widely to the Division.
Caesarean Section - Emergency Rate	We are not a regional outlier for elective/emergency/overall CS rates. Review of CS metrics required as per HSCC report - need to use Robson criteria.

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	October 2021	0	0				
	Serious Untoward Incindents: New (Rolling per year)	October 2021	21	-3	24			
	Serious Untoward Incindents: Open	October 2021	12	+7	5			
Director of Nursing & Midwifery	Serious Untoward Incidents: Number of SUI's reported to CCG within agreed timescales	October 2021	100.00%	0.00%	100.00%	2		

KPI	KPI Narrative

To deliver Safe Services – Serious Incidents

Overview

There was one SI's reported in October making a total of 11 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	1	-	-	-	-	-	11

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

October 2021 Serious Incident

Service	StEIS Ref.	Reported in Line with Policy	Summary
Gynaecology	2021-21803	Yes	The patient attended Gynaecology Outpatient Clinic on 16 September 2021, during this appointment it was identified that the patient underwent a Vaginal Hysterectomy and posterior repair on 23 March 2018 and was discharged on 25 March 2018.

To deliver Safe Services – Serious Incidents

HSIB Cases Reported and NHSR Early Notification Scheme

During October there was 1 case which met the HSIB criteria and has been reported to HSIB as referenced above steis ref 2021-20999

	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	1	-	-	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 Serious Incidents and HSIB cases declared in October.

Overdue Actions for reported Sis
At the time of writing this report there are no actions from Serious Incidents which are overdue.

Conclusion
The report which has been presented provides an update as to the number of SI's and HSIB qualifying cases reported on StEIS during October was 3 in total.

To deliver Safe services - Safer Staffing

Gynaecology: October Fill Rate

Fill-rate – The underfill rates for RN appear low due to the change in establishment requirements/roster requirements which is due to change on the 20th December. This is following a review by the ward manager and Matron, with approval of changes made by Head of Nursing and SMT. The same applies to the overfill of HCAs noted, which includes the band 4 AP.

Attendance/ Absence – 3.36% for October improvement from September 7.64%

Vacancies – 1.0WTE B6 Sister on maternity leave, with secondment opportunity advertised. 3.23WTE B5 vacancies (1 post advertised with 2 posts appointed to awaiting start dates). 1 further HCA vacancy to be progressed in lieu of notice.

Red Flags – none

Bed Occupancy – 63.2%. The bed occupancy is at the highest through the day where in month it has been at 69% based on 24 inpatient beds

Neonates: October Fill Rate

Fill-rate – Occupancy and acuity throughout October in the NICU has continued to run at high rates, however, safe staffing has been maintained and fill rates are reflective of acuity and occupancy. This has required an increased use of Bank and the flexibility of staff swapping and changing shifts with use of incentives. There have been occasions where the escalation policy has been used. This was implemented in collaboration with maternity colleagues, ensuring that occupancy, acuity and staffing were considered.

Attendance/Absence – October sickness ran at 6.94%, this was down for a third consecutive month. Short-term sickness is at 64% with long-term sickness making up 36%. Long-term sickness continues to reduce month on month. Covid sickness and covid special leave made up approximately 1.62% which is down by 1.0% from the previous month. The introduction of new isolation guidelines continues to support this decrease. Maternity leave is down from 13 FTE to 12.59 FTE and turnover sits at 8% well below the Trust target.

Vacancies – Vacancies at Band 5 are out to advert.

Red Flags – No red Flags

Bed Occupancy – Unit occupancy has run at 80.9% just above the expected 80% and 4.6% down on last month. IC ran at 98.9%, HD 74.2%, LD 74.2%, and TC at 41.9%. October has continued to be a very busy month for neonatal services.

Maternity: October 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 within the staff groups. Covid sickness and covid special leave is linked to isolation and childcare arrangements. High agency usage continues due to vacancy gaps and sickness rates. Due to both long and short-term sickness Maternity has been required to close MLU during this reporting period. Clinical activity and staff rostered to MLU have been reallocated across the first floor of Maternity Services.

Attendance/Absence – sickness is reported at 10.55%, which is a combination of clinical and non-clinical, administration staff. Maternity have requested that reports should be reviewed, and clinical staff reported separately to the overall division's sickness absence rate. Sickness and absence rates are declining in division; sickness is reported as short term (32%), long term (68%) with a slight increase noted in maternity leave in month.

Vacancies – Current vacancy rate of 10.88%. The division note a rise in staff requesting retirement and requests for contractual hours to be reduce. Maternity maintains an active recruitment plan and a rolling NHS jobs advert.

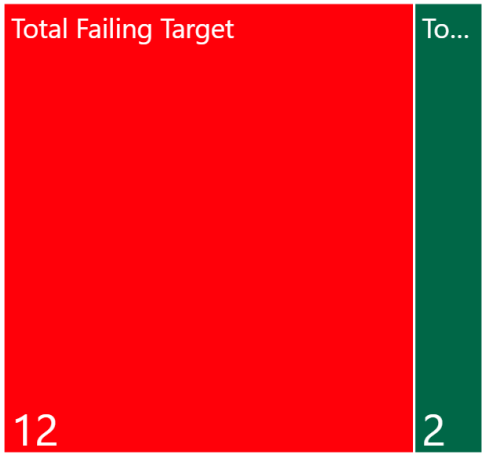
Red flags – Maternity have a positive reporting culture for red flags, noting a slight increase in red flag reporting in month. A thematic review of red flags has been undertaken and the rise is reflective of delays in elective procedures, such as Induction of Labour and delays or omissions in analgesia. Each has an action plan and QI project noted against the area of concern. Maternity is reporting closures of beds as part of the daily safety huddle.

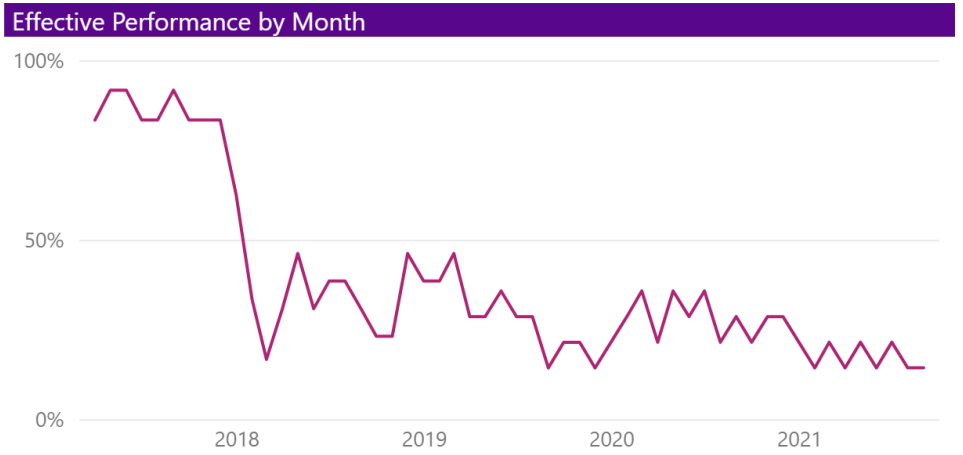
Bed Occupancy – Maternity continues to experience high levels of clinical activity. Maternity awaits a refreshed power BI occupancy report which will demonstrate both modality of birth, expected date of transfer to community services, length of stay, as well as bed occupancy. There has been no requirement to divert maternity services 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	67.7%	111.3%	89.2%	183.9%
Induction&Delivery Suites	96.3%	101.6%	95.0%	92.5%
Maternity & Jeffcoate	67.7%	92.1%	53.5%	91.7%
MLU	39.5%	48.4%	56.5%	54.8%
Neonates (ExTC)	96.1%	69.4%	93.9%	77.4%
Transitional Care	90.3%	87.1%	83.9%	41.9%

To deliver the most **E**ffective outcomes





In Q2 there were 38 breaches of the 31 Day DTT metric. 11 of the 38 breaches (29%) were due to lack of surgical capacity to treat these women. In Q2 surgical wait times exceeded 31 days at times meaning achieving the metric was a challenge. To date we have reduced surgical wait times down to 18 days, this in turn has seen an improvement in performance with the current unvalidated position for November 78% a significant improvement from Q2's position of 60.58%.

To continue this improvement we have an internal target of 13 days surgical wait times to ensure our women are treated in a timely fashion. Work continues with external stakeholders related to delays in access to diagnostics for ECHO, Spirometry, CT and MRI.

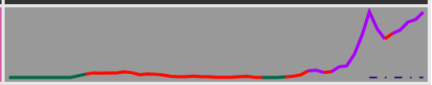
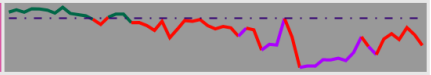
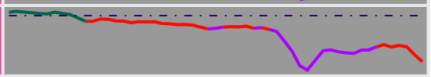
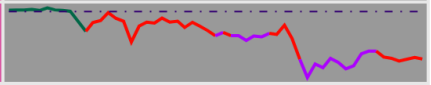
.

For the 62 day target In Q2 our denominator was 50 (61 Patients), with 6.5 (7 Patients) treated within 62 days once reallocated breaches had been transferred back to the referring trusts.

A significant contributor to the decline in performance is the increase in surgical wait times. 54 patients breached the target in Q2, 12 (22.2%) were directly attributable to surgical wait times. As outlined above the reduction in surgical wait times has seen an improvement in November

It is clear that a continuation in improvement is required beyond current performance levels but timely diagnostic intervention is a theme which continues to provide challenge. 33 (61.1%) of breaches are directly attributable to delay in access to MRI, CT, ECHO and Spirometry. The CDC is the long term solution to the challenges faced with this but will not immediately resolve the challenges we are facing with some external stakeholders.

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	October 2021	288	+288	0		+5	
Chief Operating Officer	18 Week RTT: Admitted Completed Pathways	October 2021	69.71%	-20.29%	90.00%	274	5	
	18 Week RTT: Incomplete Pathways	October 2021	55.82%	-36.18%	92.00%	12312	5	
	18 Week RTT: Non-Admitted Completed Pathways	October 2021	73.58%	-21.42%	95.00%	2188	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'.

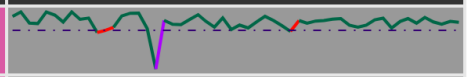
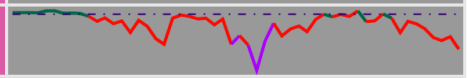
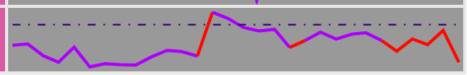
Regular review of long-waiting patients to ensure that any actions towards ensuring management/treatment is taken in a timely way.

Weekly PTL meetings reviewing all patient queues.

Regular WLI sessions planned through October - December 2021.

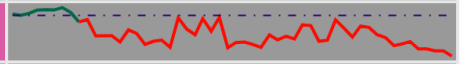
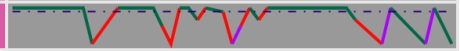
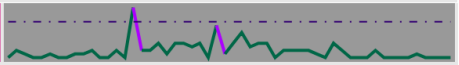
Careful monitoring of clinic utilisation to ensure all available appointments are filled.

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	September 2021	96.06%	+3.06%	93.00%	279	5	
	Cancer: 31 Days from Diagnosis to 1st Definitive Treatment	September 2021	54.05%	-41.95%	96.00%	37	5	
	Cancer: 28 Day Faster Diagnosis	September 2021	49.12%	-25.88%	75.00%	397	5	

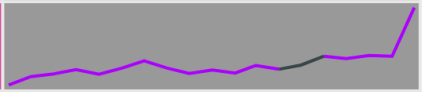
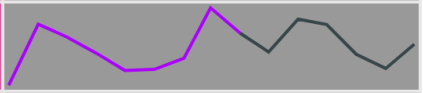
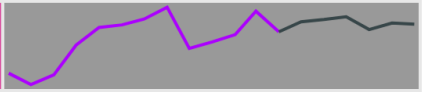
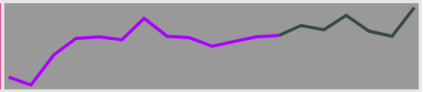
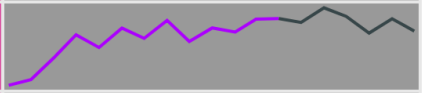
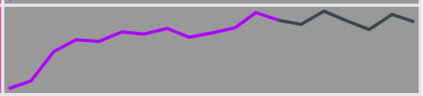
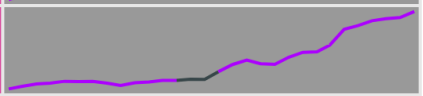
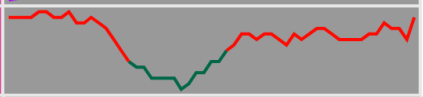
KPI	KPI Narrative
Cancer: 28 Day Faster Diagnosis	September 2021 shows a worsening of performance - 49% against a target of 75% (October data shows an improvement against the target of 65%). The main delays with the patient pathway continue to be caused by ambulatory hysteroscopy capacity. A longer wait 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. We have protected slots within out-patient hysteroscopy to reduce waiting time. However, the bigger delay sits with the ambulatory procedure. We are exploring all areas where ambulatory capacity can be improved and continue with regular Saturday ambulatory sessions. Additional scopes are on order to allow for sessions to take place on Sunday. We are exploring 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	Narrative September 2021 - There has been a drop against the target with the gynaecology division achieving 54% 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 have made changes to the booking out processes to reduce these delays, the ops team closely manage the wait for pre-op assessment and anaesthetic assessment and intervene if delays are considered excessive. 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. We continue to convert benign theatre sessions to oncology theatre sessions to create oncology theatre capacity. In September 8 additional lists were converted to oncology in an attempt to see patients quickly and avoid breaches. The gynaecology ops team are also exploring the possibility of 3 session theatre days for oncology, however at the moment restrictions within the theatre team are impacting on this. 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

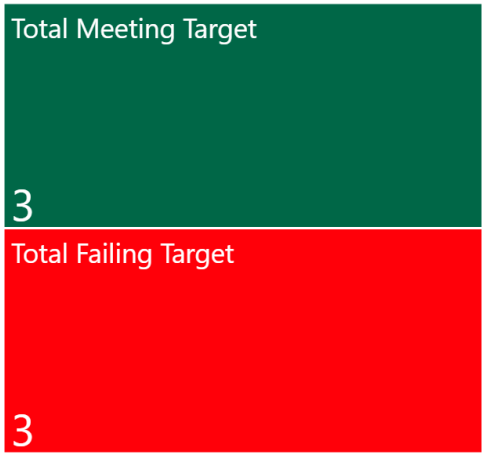
KPI Owner	KPI	As of Date	Current Value	KPI Status	Target	Denominator	DQ Kite Mark	Sparklines
Chief Operating Officer	All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (After Re-allocation)	September 2021	6.06%	-78.94%	85.00%	17	5	
	Cancer: 62 Day Screening Referrals (Percentage)	July 2021	0.00%	-90.00%	90.00%	1	5	
Chief Operating Officer	Cancer: 62 Day Screening Referrals (Numbers)	September 2021	0	-5	5		5	
	Cancer: 104 Day Breaches	September 2021	5	+5			5	

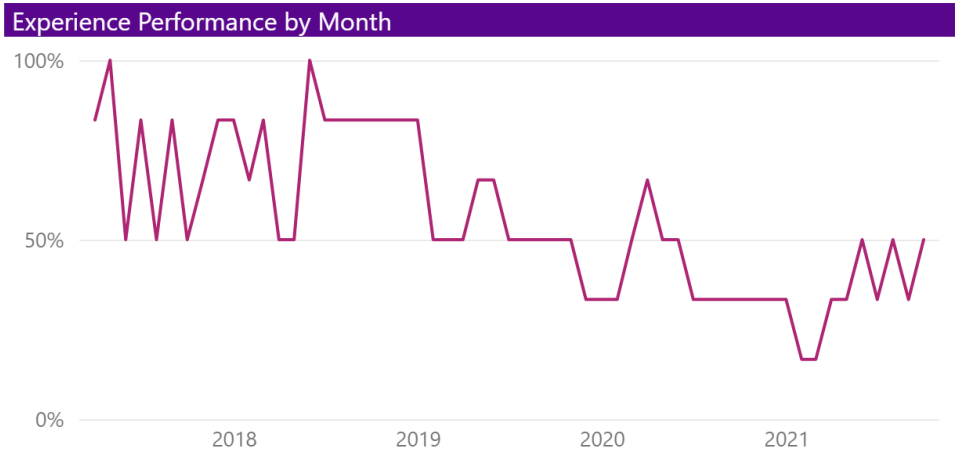
KPI	KPI Narrative
Cancer: 104 Day Breaches	Narrative September 2021 - There 5 104 day breaches in month. 3 patients required extensive external diagnostic investigations that created delays. 1 patient had an extremely complex pathway 1 patient was delayed in her referral between Trusts. There are continued 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, with delays noted in reporting on these investigations. These delays are escalated through the LWH in an attempt to speed up these external processes. The gynaecology division are looking at all internal process to ensure bottlenecks/delays are reduced eg) waiting time to pre-operative assessment. We have made changes to the booking out processes to reduce these delays, the ops team closely manage the wait for pre-op assessment and anaesthetic assessment and intervene if delays are considered excessive. 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. We continue to convert benign theatre sessions to oncology theatre sessions to create oncology theatre capacity. In September 8 additional lists were converted to oncology in an attempt to see patients quickly and avoid breaches. The gynaecology ops team are also exploring the possibility of 3 session theatre days for oncology, however at the moment restrictions within the theatre team are impacting on this. 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.
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

To deliver the most Effective outcomes

KPI Owner	KPI	As of Date	Current Value	KPI Status	Target	Denominator	DQ Kite Mark	Sparklines
Chief Operating Officer	Advice and Guidance	October 2021	231	231				
	Diagnostic Activity Levels	October 2021	1632	1632				
	Elective activity levels - Daycase	October 2021	424	424				
	Elective activity levels - Inpatient	October 2021	163	163				
	Elective activity levels - Outpatient Follow Up	October 2021	4461	4461				
	Elective activity levels - Outpatient New	October 2021	3364	3364				
	Overall size of Elective Waiting List	September 2021	12389	12389				
Medical Director	Intensive Care Transfers Out (Rolling 12 Months)	October 2021	15	7				
Chief Operating Officer	Proportion of patient activity with an ethnicity code	October 2021	96.58%	96.58%		14525		

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

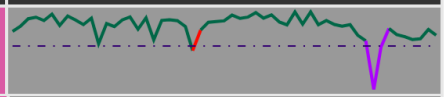
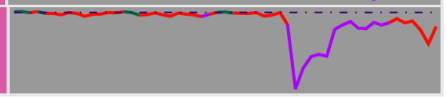




Complaints response rates continue to be challenged. This is due to the pressures within Divisions to release staff to complete investigations and subsequent availability of senior staff to review and sign off investigations once complete. The Trust is continuing to work closely with the complainants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

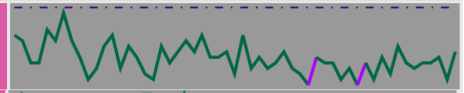
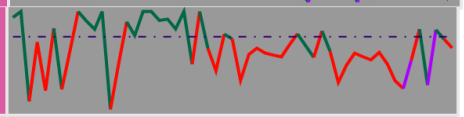
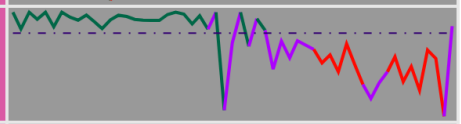
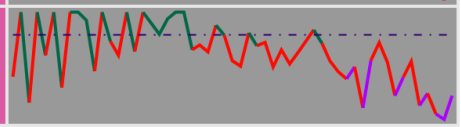
Positive feedback has been received regarding the Trust's response to the Major Incident.

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	October 2021	96.58%	+1.58%	95.00%	1052	5	
Chief Operating Officer	Diagnostic Tests: 6 Week Wait	October 2021	85.81%	-13.19%	99.00%	747		

KPI	KPI Narrative
Diagnostic Tests: 6 Week Wait	The gynaecology division has not met the diagnostic test (6ww) target - performance 52.6% against a target of 99.%. There has been a slight improvement in performance from August 2021. Cystometry capacity has been reviewed within the urogynaecology team in an attempt to increase available appointments. There is an issue with high DNA rates and this is being addressed to reduce this number and therefore increase patient throughput. This impact will be evident from November onwards.

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	October 2021	7	-8	15		5	
Director of Nursing & Midwifery	Friends & Family Test: In-patient/Daycase % positive	October 2021	92.79%	-2.21%	95.00%	111	5	
	Friends & Family Test: A&E % positive	October 2021	96.67%	+1.67%	95.00%	30	5	
	Friends & Family Test: Maternity % positive	October 2021	81.52%	-13.48%	95.00%	184	5	

KPI	KPI Narrative
Friends & Family Test: Maternity % positive	What is the reason for failure against this target?: Some restrictions remain l in place in Maternity due to the National pandemic . This has affected women's experience of the Maternity pathway at all stages ; Staffing levels have been compounded by sickness and recruitment challenges locally and Nationally. Mitigating Actions?: Review of guidance as restrictions change; A large recruitment of new midwives has taken place in October who are being supported by new preceptorship roles. How is this being fixed?: Monitor feedback and update websites and pathways as changes occur; Allowing partners on site for Outpatient appointments and scans . Introducing face to face appointments in community settings When will target be achieved?: 31/12/2021; Why this timeframe?: Global Pandemic and restrictions;

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)	***2021/22/121d***		**Date: 02/12/2021**	
Report Title	**Maternity Executive Oversight Update**			
Prepared by	***Gary Price, Chief Operating Officer***			
Presented by	***Gary Price, Chief Operating Officer***			
Key Issues / Messages	***In summer 2021 Maternity services were under considerable pressure due to staffing challenges. As a result, the Executive team provided additional support to Maternity services via the Executive oversight process. This is an established governance process to support services who may be experiencing extraordinary multifactorial challenges over and above business as usual.***			
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 – N/A ***If no – please outline the reasons for deviation.***			
	The Board is asked to note the report for assurance			
Supporting Executive:	***Gary Price, Chief Operating 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* 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			

Liverpool Women's
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EXECUTIVE SUMMARY

In summer 2021 Maternity services were under considerable pressure due to staffing challenges. As a result, the Executive team provided additional support to Maternity services via the Executive oversight process. This is an established governance process to support services who may be experiencing extraordinary multifactorial challenges over and above business as usual.

MAIN REPORT

In summer 2021 Maternity services experienced acute staffing challenges. These staffing challenges were manifesting in increased sickness absence (Covid and Non Covid) plus vacancies. These challenges reflected the national picture in Maternity services however for a Specialist Women's Trust were being acutely felt at LWH. In addition, there was no clear Cheshire and Mersey Maternity escalation structure that accounted for the increase in system operational pressures.

As well as pressures on operational delivery of services the staffing challenges resulted in

- Increased incidents being reported relating to staffing and raising of concerns
- Increased use of agency and non-core spend
- Poor staff retention
- Poor mandatory training and appraisal rates

In addition, the service was having to deal with significant national and local agendas requiring specific focus

- Continuity of Care implementation
- Embedding of K2 informatics system
- Ongoing operational challenges of Covid 19
- Increase in requirements to respond to national quality and safety initiatives, e.g., Ockenden, CSNT etc

Following the Executive oversight process and in partnership with the Family Health Division the following developments have been implemented to support our Maternity services.

1. The system response: Cheshire and Mersey Maternity Escalation Cell

During 2021 there has been an increase in regional Maternity services having to enact their escalation and divert processes. Many of the Cheshire and Mersey Trusts look to LWH for support and mutual aid as the largest provider in region. The challenges at LWH meant that we were not consistently able to offer that support, in fact on a small number of occasions LWH required mutual aid from other Trusts.

This was escalated via the Cheshire and Mersey Gold Command infrastructure. As a result of these system pressures the Cheshire and Maternity escalation policy was reviewed and updated and a system Maternity Cell was established that LWH now holds the Chair of. This has resulted in increased system collaboration and ensured that the system position for Maternity services is visible to all partners as it is for Urgent Care, Critical Care and Paediatrics. The data from the Cell can now support regional strategic decisions relating to Maternity services

2. Workforce Update: Strategic and Divisional Management

During the oversight period additional leadership support has been allocated to support the Division of Family Health to strengthen strategic and operational leadership. This will continue to support divisional accountability and progress towards increased divisional autonomy.

To provide strategic and Transformational Leadership A Transformation Lead has been in place in from October 21 to March 22 and a new Director of Midwifery post is currently being recruited to. To support operational challenges the deputy Chief Operating Officer was allocated to support the service and additional Operational Support roles have been established including a patient flow manager.

The Midwifery Management Structure has also been reviewed with an increase in development of Matrons in Maternity services through a formal programme of personal development.

3. Workforce Update: Increasing Midwifery Workforce

The Maternity workforce has been increased to support the challenges. The division will now need to sustain this with ongoing recruitment based on predictive planning. This is, however, against a backdrop of a national maternity shortages and novel approaches will need to be undertaken that support LWH and the system.

The service commenced an enhanced recruitment drive in July 2021 with bespoke offers to keep in touch with those that were offered jobs prior to their commencement dates to improve their "on-boarding" experience

A Cohort of 27 new midwives are now in week 8 of employment, after 2 weeks consolidated training in the classroom an orientation. 2 Preceptor Lead Midwives covering 7 days per week ensure that they are supported, assisting with clinical skills, and providing expert bedside clinical advice, building confidence in this new staff group.

We also have experienced midwives returning to LWH, and band 5 recruits transferring their preceptorship to LWH from maternity units inside and outside of the CM region. To provide additional support from a Professional Midwifery Advocate (PMA) perspective external funds have been awarded to LWH, to enhance our PMA offer to all midwives and support staff.

Strengthening community services in relation to recruitment into vacant team leader post has been successful, there has been an additional band 7 post recruited into to support the clinical and operational delivery of COC, an additional digital lead midwife has commenced in post to support the embedding and further implementation of k2, as well as the recruitment of the critical care outreach midwife.

International recruitment has commenced within maternity – presently there are 2 midwives from the Republic of Ireland in super training. The Trust is are awaiting confirmation of start dates for our worldwide international programme, we have 8 midwives commencing with LWH as part of the national recruitment drive from HEE/NHSE/I.

Maternity now has an active recruitment process, with a rolling job advert on NHS jobs, social media campaigns, the service awaits its review of birth rate plus staffing assessment in December, that may require further staffing changes, in line with updated birth acuity data and the continued roll out of COC.

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4. Workforce Update – Medical

In addition to enhancing our maternity workforce the medical workforce has been increased:3 new Obstetric consultants appointed and from April 2022 this will allow increased evening Consultant presence

Furthermore 2 new Foetal Medicine consultants have been appointed, One a Professorial post.

The current Job Plan process will allow for an increase in leadership roles amongst the Consultant workforce to support the multi professional approach to patient care. This will include leads for

- Maternity Assessment Unit
- Maternity Base
- Safety Champion
- HSIB
- Infection/Sepsis
- Abnormally Invasive placenta
- SIM lead
- Patient experience

5. People Metrics and Wellbeing

Long term sickness within the service has predominantly been linked to stress and anxiety. All staff on long term sick have a support plan in place with offers of flexible working solutions to support staff back to work. Covid absences have seen a decline since the oversight process was commenced however short-term sickness remains high.

Appraisal rates for staff have improved during the oversight period due to the introduction of new approaches including team appraisals and use of Microsoft Teams. However mandatory training rates have not significantly improved and remain an area of focus

The Trust has invested in additional wellbeing coaches with a focus on maternity services and increased signposting to the Cheshire and Mersey resilience hub

6. Patient Flow and increased use of informatics

With the addition of a patient flow manager the service now has live performance tools on Power BI including Bed Flow and Estimated Date of delivery prediction and Induction of Labour Planning.

Since their introduction and the introduction of new staff the service has had fewer periods of escalation and patient flow is managed better, there are however still further improvements to be made including a review of Maternity Base to ensure appropriate senior leadership in our highest volume clinical area to maintain patient flow and improve experience.

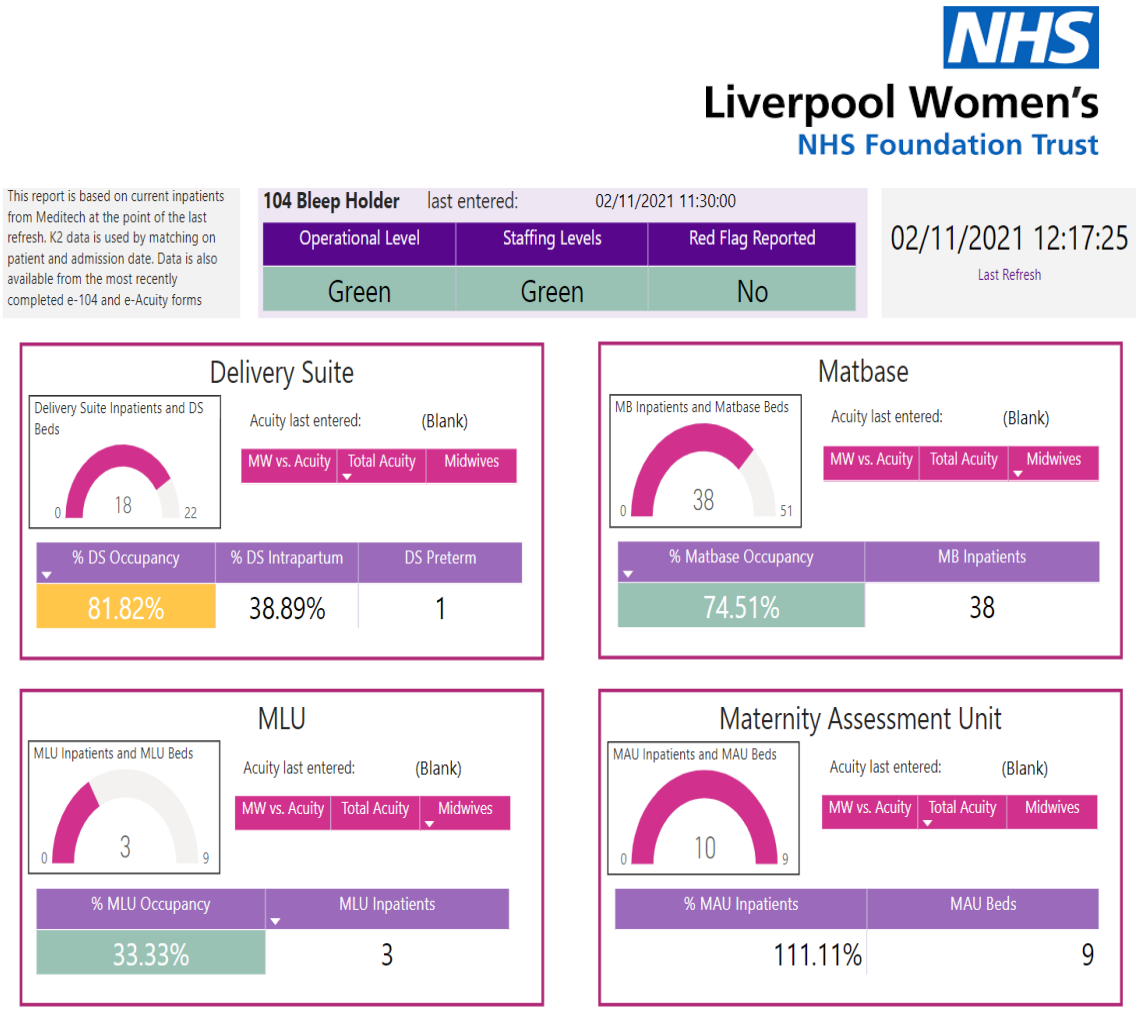

Fig 1

Oversight reporting and Power BI dashboards have been co-developed with Maternity and Operational leaders, providing insight into performance and service requirements. These are used daily within a maternity management context and also within the oversight forum. We expect additional requirements and refinements to come through to strengthen the use of the reports.

Throughout the period of Executive Oversight, the k2 optimisation programme continues, with a host of new improvements implemented on the 1 November 2021 bringing the following improvements

- Antenatal risk assessments – Improved risk assessments, including recommendations from the Ockendon report, mean we can ensure all women have a personalised antenatal/intrapartum and postnatal care and support plans through thorough risk assessment at each contact, and are at the centre of their care.
- The Birmingham Triage (BSOSTS) functionality has been implemented, which will hopefully lead to an improved and more efficient triaging system within maternity.
- Covid-19 risk assessments have been added, as well as Covid-19 vaccine status, allowing midwives to better discuss and share Covid-19 information with women.
- Various improvements to forms and data collection fields (i.e. mandatory fields, simplify referral and discharge processes) to reduce data missed during entry leading to improved data quality

7. Financial Position

The measures taken have come at a financial cost. Despite being funded for more activity than is likely to be delivered, the directorate is forecast to overspend by £2.7m. An active decision was taken to provide additional support into the division and to ensure that immediate staffing pressures were resolved. This should allow a period of stabilisation to be completed and additional management capacity to resolve some of the longstanding and more recent issues. This has been partially successful as outlined above but there is further work to do.

The biggest component of this overspend are agency staffing (forecast at a £1.6m overspend, although work is ongoing to reduce this)- this should be completely removed once staffing and sickness are fully stabilised- and bank spend (forecast at £0.9m). Again, it would be expected that this will be managed downwards significantly once other staffing measures are reduced.

However, it should be noted that investment has been made in a number of fixed term and permanent positions above budget in addition to these costs, including additional midwifery management, the Preceptorship Lead Midwives as noted above, Surgical Nurse Support posts and other posts. The total full year impact of permanent posts is in excess of £0.7m; this will need to be managed through budget setting and planning into 2022/23. There are also a number of fixed term posts which will need to be reviewed and managed.

Income for maternity services is also likely to change significantly; it will be important that the Trust can demonstrate the necessity and value for money of this investment in providing safe maternity care.

8. Conclusion and Next steps

With additional staffing and improved line of sight at all levels on daily operational pressures maternity services have been able to function without the need for external escalation or divert. In addition, there has been significant investment in leadership within the service and at a strategic level.

Whilst the acute challenges have been addressed there remains ongoing challenges relating to

1) Ensuring sustainability and consistency in Divisional Management and leadership to return Maternity services to business as usual

2) An increased requirement to focus on improving sickness rates and Mandatory Training rates

3) A focus on Maternity Base as our area of high patient throughput

These challenges will now be a focus of Executive oversight of Maternity services moving forward with key performance metrics monitored to drive improvements.

It is anticipated these improvements can be in place in Q4. For the Executive oversight process to be concluded the Division of Family Health will need to sustain improvements based on the 3 points above.

In addition to this the DoN&M will continue to lead a programme to develop resilience in the Maternity leadership team as we continue to face a national shortage in this area.

9. Recommendation

The Board is asked to note the report for assurance.

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	***2021/22/121e***		**Date: 02/12/2021**	
Report Title	**Perinatal Quality Assurance**			
Prepared by	***Clare Fitzpatrick – Head of Midwifery*** ***Angela Winstanley – Quality & safety Matron***			
Presented by	***Marie Forshaw, Chief Nurse & Midwife***			
Key Issues / Messages	***This paper will identify the requirements that the Trust Board must implement in order to be assured that they are sighted on issues relating to maternity, neonatal and perinatal quality surveillance***			
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 receive the proposed Perinatal Surveillance Tool and consider any further amendment ahead of final adoption.			
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* 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			

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EXECUTIVE SUMMARY

This paper will identify the requirements that the Trust Board must implement in order to be assured that they are sighted on issues relating to maternity, neonatal and perinatal quality surveillance.

MAIN REPORT

Background

In December 2020, following the publication of the Ockenden Report, Trusts were mandated to plan and implement a new quality surveillance model.

implementing-a-revised-perinatal-quality-surveillance-model.pdf (england.nhs.uk)

This model proactively seeks to identify trusts that require support before serious issues arise. Implementation of a new quality surveillance model seeks to provide for consistent and methodical oversight of all services, specifically including maternity services. The model has also been developed to gather ongoing learning and insight, to inform improvements in the delivery of perinatal services.

Provider Trusts and their Boards, supported by the senior maternity and neonatal triumvirate and the board-level perinatal safety champion at its centre, ultimately remain responsible for the quality of the services provided and for ongoing improvement to these. As the commissioners of maternity care, CCGs also have a statutory role to improve quality, safety and outcomes for their patients. The quality model supports trusts and CCGs to discharge their duties, while providing a safety net for any emerging concerns, trends or issues that are not quickly identified and addressed.

As part of the guidance, the development of a locally agreed dashboard was mandated to include, as a minimum, the measures set out within the screenshot below. This enables the drawing out of locally collected intelligence to monitor maternity and neonatal safety at board meetings. This dashboard should form part of the discussion held at Board Level with respect to maternity and neonatal safety issues, as set out within the national guidance.

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Select Trust:

CQC Maternity Ratings	Overall	Safe	Effective	Caring	Well-Led	Responsive
	Select Rating:	Select Rating:	Select Rating:	Select Rating:	Select Rating:	Select Rating:

Maternity Safety Support Programme	Select Y / N:	If No, enter name of MIA

	2021											
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Findings of review of all perinatal deaths using the real time data monitoring tool												
Findings of review all cases eligible for referral to HSIB.												
Report on: •The number of incidents logged graded as moderate or above and what actions are being taken •Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training •Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite , gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively.												
Service User Voice feedback												
Staff feedback from frontline champions and walk-abouts												
HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust												
Coroner Reg 28 made directly to Trust												
Progress in achievement of CNST 10												

Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment (Reported annuallly)	
Proportion of specialty trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how would they would rate the quality of clinical supervision out of hours (Reported annually)	

Liverpool Women's NHS Foundation Trust

Maternity Incentive Scheme Year 4 2021

The requirement for trust boards to implement this locally agreed dashboard, also comes as a required standard for the Maternity Incentive Scheme (MIS) (October 2021). This dashboard should be presented to the Trust Board by the Board Level safety Champions, on a quarterly basis. Evidential requirements as laid out within the MIS guidance require that discussions surrounding safety intelligence are taking place at Board level.

It should be noted that the key information within the tool has regularly been reported to the Board either through separate reports or through the overarching performance report. The adoption of a surveillance tool will strengthen the visibility of the information and enable enhanced triangulation.

Actions take to date

The Family Health Division have developed a structured and enabled perinatal quality surveillance dashboard which will be presented for assurance at Trust Board monthly as set out in the national requirements.

This dashboard will then be presented to frontline, clinical staff in a variety of methods, utilising social media platforms, safety huddles, governance, dashboard and ward and divisional manager, ward and matron meetings. This initiative will be led by the Quality & Safety Matron, supported by Maternity and Neonatal safety champions.

Conclusion

The Family Health Division are currently awaiting formal conformation of the regional assurance and governance pathway led by the LMS, in order to work collaboratively with Regional leaders including the regional chief midwife. The Head of Midwifery has escalated the requirements of this framework and a response is anticipated. This process will formalise how trust-level intelligence will be shared to ensure early action and support for areas of concern. The Trust Board are asked to accept this dashboard as information and assurance of site of perinatal quality safety issues in maternity and neonatal.

Recommendation

To receive the proposed Perinatal Surveillance Tool and consider any further amendment ahead of final adoption.

Maternity Perinatal Quality Surveillance Model: Sept 2021.

Liverpool Women's NHS Foundation Trust

CQC MATERNITY RATINGS LAST REPORT – 22/04/2020	Overall	Safe	Effective	Caring	Well Led	Responsive
	Good	Good	Good	Good	Good	Outstanding

Staff Survey Results:	Update Date	Results
Proportion of midwives responding with agree/strongly agree on whether they would recommend LWH as a place to work or receive treatment (reported annually).	Report 2020.	41%
Proportion of Speciality Trainees in Obstetrics responding with 'excellent or good' on how they would rate the quality of clinical supervision out of hours (reported annually)	Report 2020	41.3%

Midwifery Red Flags	**40** Closed in September
Most reported Red Flag	**15** Delay >30 Mins Between Pr And Triage
Actions Taken:	Ongoing planning for the introduction of BSOTS Triage and Assessment System Revision of Escalation Policy

Number of HSIB Referrals.	PMRT Reviews.	Key Themes Identified	Safety Incidents Reported in Month	
Number of Therapeutic Cooled: 2 - CTG not commenced in IOL Suite - Delayed IOL - Hyperstimulation - Hypertension unrecognised - 2nd Case returned Trust.	Number of NND Perinatal Deaths Reviews Completed: **4**	No themes identified – All cases reviewed through PMRT with external validation of grading.	**Number of Mod/Serious Harm Incidents? D.O.C Completed?**	4 x Moderate and DOC Completed, Family provided with HSIB and NHSr information.
	Number of Stillbirth Perinatal Deaths Reviews Completed: **4**	September PMRT meeting saw the completion of reviews of 4 Babies born through June & July 2021. All cases graded with external validation and parental comments obtained All cases reported to MBRRACE A – No care issues identified x 2 C – Care issues identified may have may have change outcome x 2 Issues with identification of women with clinical risk factors requiring extra USS.	**Actions from Mod/Serious Harm Incidents include:**	Escalated to formal review or PMRT. Escalated to HOM/CD Staff statements requested. No immediate safety concerns.
			Number of STEISS Incidents (Non HSIB) **3**	Haemorrhagic disease of the new-born Service diversion. 32 wk diabetic – HIE diagnosis

	Comments	Actions
MVP/Service User Feedback	You Said, We Did: In co-production with the MVP the development of enhanced postnatal pathway.	Fortnightly meetings with HOM. Next MVP Meeting - 06/12/2021 at 19.30pm and service users welcome.
Safety Champions Feedback	The safety Champions received a full update on the implementation of the Continuity of Care project with a update planned to go to Board. There was no safety issues escalated to the BLSC.	No Actions required.
Excellence Reports and/or Employee/Team of Month	There have been **11** Excellence Reports received by the Maternity Division, with numerous staff members recognised.	**Recognition to staff:** For going the extra mile, good communication and team work.: Nuooral Abidin, Carmel Doyle, Susan Roberts, Clair Roberts, Aimi Hodgson, Chinedu Obu, Fran Wood, Ben Choo, Paul Jackson, Nicola O Connor, Danuta Morris, Michelle Dower, Laura Blair, Michelle Taylor & Erin Davies

Ockenden Update:	The FHD continue to work on the full implementation of the immediate and essential Ockenden actions and await feedback from the National Teams with regards the evidence submitted to the Portal. IEA 1 – Implemented all actions. IEA 2 – Development of MVP Strategy and continued development work. IEA 3 – MDT Training strategy completed with detailed TNA developed. IEA 4 - Management of complex pregnancies involves LWH being a maternal medicine specialist hub – Clinical Lead for Obstetrics working with regional teams to design this service. IEA 5 – Pregnancy Risk Assessments – K2 Updates developed to aid documentation of risk status at each antenatal contact IEA 6 – Fetal Wellbeing – Training and upskilling of staff ongoing, fetal surveillance MW and Consultant now in Post. IEA 7 – Structured decision making tools for patient consent (BRAIN tool) under development. The second, larger Ockenden Report is due for publication in December 2021, this will be shared with the teams upon receipt.
Maternity Risk Register.	Extreme Risks: 8. High Risks : 19. Moderate Risks: 5. Low Risk: 1. Maternity risks continue to be monitored via Maternity Risk and development of quarterly staff visual for display in clinical areas for clinical staff awareness of current divisional risks.
Progress against CNST 10 Standards	Progress against the Year 3 Maternity Incentive Scheme (CNST): 1. PMRT – Compliance achieved. 2. MSDS – Compliance achieved. 3. ATAIN – Compliance achieved. 4. Clincal Workforce – Compliance achieved. 5. Midwifery Workforce – Compliance achieved 6. SBLCBv2 – Work ongoing – Updating guideline for FGR/SGA/SBL 7. MVP -Compliance achieved 8. Mandatory MPMET and Neonatal Resus Training – Compliance achieved 9. Safety Champions – Compliance achieved. 10. HSIB and NHSR Notifications – Compliance achieved.

	Metric	Standard National standard/Average where available.	Running Total/ average	Apr – 21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Perinatal	1:1 Care in Labour	100% (CNST)				99.6%	99.3%	99.2%	98.6%
	Stillbirth Number >24wk (Adjusted)	Actual Number	19			2	7	3	1
	Stillbirth Rate >24wk (Adjusted) (Quarterly)	<4.4/1000		3.95%			4.85%		
	Apgar <7 @ 5 Min (>37weeks)	<1.2%				0.8%	0.6%	1.3%	0.8%
	Term Admission to NICU	<6%				3.54%	4.01%	4.91%	5.1%
	Women in receipt of Continuity of Care	100%				15.35%	14.49%	16.67%	19.91%
	BAME in receipt of Continuity of Care	100%				29.41%	31.63%	39.81%	47.96%
	Social Depravation Continuity of Care					18.18%	19.89%	24.21%	26.40%
	Provision of Epidural in Labour.	Actual Number				15.1%	20.3%	19.4%	20.3%
	Obstetric Haemorrhage >1.5L					4.28%	3.96%	3.77%	4.14%
	Coroner Reg 28 Made to Trust					0	0	0	0
	HSIB Actions Returned					1	0	0	1
Workforce	Super Numerary DS Shift Leader.	100% (CNST)	100%			100%	100%	100%	100%
	Midwifery Sickness	% of workforce				10.13%	12.28%	12.17%	14.11%
	Midwifery Sickness	WTE				36.6	44.6	43.7	50.7
	Midwife to Birth Ratio (in Post)	>1.30				30	31	31	32
	Midwifery Vacancy	% of workforce				2.40%	1.40%	4.40%	3.30%
	Midwifery Vacancy	WTE				7.01	4.13	12.76	9.74
	Rostered Cons on DS (Hrs per Wk)	>60 hrs				91	91	91	91
Feedback	Number of Formal Complaints	Actual Number				5	2	1	2
	Number of Maternity Incidents over 30 Days	Actual Number				188	261	89	161
	FFT Response Rate	>50%				<10%	<10%	<10%	<10%
	Number of PALS/PALS+	Actual Number				0	1	1	1
Training	Fetal Surveillance Training: IP Staff	100%				95%	95%	95%	95%
	MPMET Training Compliance (Overall)	90% (by June 2022)				76.0%	81.0%	84.1%	81.0%

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*21/22/121f*		Date: 02/12/2021	
Report Title	**Integrated Governance Assurance Report 2021/22 – Quarter 2**			
Prepared by	***Phil Bartley, Associate Director of Quality and Governance***			
Presented by	***Phil Bartley, Associate Director of Quality and Governance***			
Key Issues / Messages	Report provides information of oversight and assurance monitoring of Integrated Governance and highlights key risks to the Trust.			
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.*			
	It is requested that the Trust Board review the contents of the paper and take assurance that there are adequate governance processes in place and the positive progress in managing risk has been made with Senior Management having oversight of such risks.			
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 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:

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REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Quality Committee	Nov 21	CN&M	Recommended for review by the Board. Noted that further improvements to the layout of the report would be taken forward for Q3, particularly in relation to highlighting the key issues and concerns.

EXECUTIVE SUMMARY

The following Integrated Governance Assurance report covers Quarter 2 of 2021/22. The report is part of the regular reporting schedule of the Trust to ensure that there is oversight and assurance monitoring of Integrated Governance across the Trust.

Key findings in this report:

- There has been an increase in the total number of incidents reported during Quarter 2 was 1813, an increase of 122 since Q1.
- The no harm category has 508 (28%) of incidents, Low harm/minor 596 (33%) there are currently 647 (36%) unreviewed incidents in Q2 21/22 in the web holding file which would alter the amount of no harm incidents
- Investigations (282) is the highest cause group for reported incidents with inadequately labelled sample as the highest with 153, Incorrect Details On Report – Investigations with 26, Haemolysed Sample – 21.
- There remains a continued issue relating to blood sampling errors, with samples not being processed due to inadequate / inappropriate labelling. The Trust Transfusion practitioner in continuing to undertake a weekly safety round in all clinical areas on the subject as well as discussing errors with individual staff. An updated Standard Operating Procedure has also been published which should allow for further improvement.
- Lessons learned remain a priority for the Governance Team who are actively working to continue to develop an evolving system of dissemination in order to improve quality, reduce risk and develop staff engagement through use of engagement and learning events, the Trust Wide shared learning desktop icon and the roll out of the new staff app which is expected to be fully functional as a priority.

Dashboard of key figures relating to Incidents, complaints and claims Q2

- Increase of 122 compared to 279 incidents in Quarter 4 – Increase of 425 incidents compared to Q2 20-21
- The no harm category has 508 (28%) of incidents, there are currently 647 (36%) unreviewed incidents in Q2 21/22 in the web holding file which would alter the amount of no harm incidents.
- Overall increase in total number of patient safety incidents due to increased incident reporting
- 10 controlled drug incidents.

Key themes and issues highlighted:

- Clinical management – treatment procedures / delays
- RTT 52 week breaches – reduced Trust capacity
- Investigations – blood labelling sampling errors
- Admission / discharge / transfers – ability to discharge, admit patients and transfer internally
- Staffing levels – Covid impact and sickness

- 13 (no change) formal complaints
- 14 complaints closed down (-1)
- 660 (-58) PALS contacts

Key risks to the Trust:

- At the time of writing this report the key risks to the organisation relate to the continued impact of Covid-19 and on Trust capacity to treat patients appropriately within 52 week performance targets.
- Blood sampling continue to be reported relating to inappropriate and insufficient labelling errors and other errors associated with obtaining such samples. However, we would expect improvements to be made in this area for Q3 as the Trust transfusion lead has been working with staff to support and educate them in improving standards. Furthermore, an updated Standard Operating Procedure has been published in late October 2021 which will support further improvement in this area. This has been discussed with senior managers on the 'daily huddle' to ensure this is appropriately cascaded to their staff teams.
- There have also been numerous incidents in relation to specimens due to be sent to the RLUH for analysis, this is also including the transportation of such specimens. As such as task and finish group has been commenced to review this issue with outcomes and new procedures expected to be in place by mid-November 2021 to allow for significant improvement in this area.
- The key areas, which continue to be part of the themes and trends throughout incident and complaints continues to be, clinical treatment / management and communication. Similar to the above, this has been discussed at daily huddles to ensure we improve in this area with a particular focus on conversations to enable areas evidentially demonstrate how they are learning from such incidents. Furthermore, the Associate Director of Quality & Governance and the Deputy Director of Nursing have begun meeting with the senior management team from each division to focus on their governance arrangements, including how complaints are managed within divisions.

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Achieved

- Engagement of staff
- Improved compliance with Safe and Secure Storage of Medicines
- Improved medicines compliance
- Safety and Governance in relation to Covid-19
- Continued availability and use of PPE
- Fit Testing staff for FFP3 mask completed for all nominated clinical staff. Job spec in place for recruitment of FFP3 tester.
- Increase in incident reporting over the year
- Gynae inpatient survey – great results.

Requires Improvement

- Lesson learnt from Complaint's / PAL's need to be implemented in a more timely manner
- Verbal communication and accuracy documentation
- Full use of Ulysses system in progress
- Lack of learning being disseminated Trust wide
- Risk register content continues to require improvement and development but is progressing
- Care of the 16-17 year old
- Asymptomatic testing for staff.

Risks

- Lack of learning being disseminated divisionally and Trust wide
- Poor verbal and written communication
- Multiple IT systems – Managed risk
- Non - compliance with Medicines Safe and Secure Requirements
- Lack of adherence to recommendations, requiring further education of staff
- Medicines Safety
- Clinical management and treatment

- Governance work on greater dissemination of lessons learnt has significantly progressed with the continuation of Trust Wide learning and engagement events, the introduction of a Trust Wide Shared Learning icon on all staff computers (which is regularly updated) and a section on the new staff app called Learning Together which is due to launch imminently. Furthermore, the Associate Director of Quality & Governance and the Deputy Director of Nursing have begun meeting with the senior management team from each division to focus on their governance arrangements. Divisional Governance Managers have moved into the divisions to focus on areas for improvements and drive improvement
- The Trust has continued to ensure safe care of our patients during Covid-19 period and second wave and lining in with local and regional control groups
- Asymptomatic testing for staff has been made mandatory which will now be monitored for improvements in our performance for this area.

Recommendation: It is it is requested that the members of the Board review the contents of the paper and take assurance that there are adequate governance processes in place and the positive progress in managing risk has been made with Senior Management having oversight of such risks.

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MAIN REPORT

The following report provides information in relation to five key aspects of an integrated Governance structure, Incidents, Complaints, Clinical Audit, Claims and triangulation of themes.

Incidents

Total incidents

- 1813 reported in total
- Increase of 122 incidents compared to 279 incidents in Quarter 4 21/22 – Increase of 425 incidents compared to Q2 20-21

Top 5 cause groups

- Investigations – 282 (+118)
- Clinical Management – 261 (+67)
- 52 week breaches – 188 (+14)
- Communication – 137 (+11)
- Staffing Levels – 136

Top 5 Incident locations

- Maternity – 950 (+187)
- Gynaecology – 415 (+35)
- Neonatal – 107 (-46)
- Theatres and Anaesthesia – 87 (-12)
- Patient Administration – 155 (+86)

Total number of incidents reported across Q1 and Q2 - 2021/22 compared with 2020/21.

2020-21	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Total	214	224	343	428	505	459	396	404	385	466	412	534	**4770**
Quarterly	781(<331)			1392 (>611)			1185 (<207)			1412 (>227)			(<321)
2021-22	Apr	May	Jun	Jul	Aug	Sep							
Total	557	636	498	510	468	835							
Quarterly	1691(>279)			1813 (>122)									

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Patient Safety Incidents

Total Patient Safety Incidents

- 1710 reported in total (+306 from Q1) reported in total
- No harm 472 (-65)
- Low / minor harm – 572 (+127)
- Moderate harm 13 (+6)– Joint highest cause groups: Clinical management (6) Admission / discharge / transfer (4), Medication (1) Unexpected Death (1) and Diagnosis (1)
- 611 unreviewed incidents in the Q2 21-22.

Investigation Incidents

Investigation Incidents

- Highest cause group Q2
- 281 Incidents reported in total
- Inadequately labelled sample (153)
- Incorrect Details On Report – Investigations (25)
- Haemolysed Sample (21)
- Insufficient Sample (19)
- Test Not Performed (12)

Top 5 Location Investigation Incidents

- Delivery Suite (76)
- Community (63)
- Antenatal LWH (31)
- MAU - Maternity Assessment Unit (18)
- Neonatal Unit (15)

Impact of Investigation Incidents

- Near miss (1)
- No harm (94)
- Low harm (103)
- Unreviewed (83)

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Medication Incidents

Medication Incidents

- 80 (-38) incidents reported in total.
- 10 (-2) related to a controlled drug (CD).
- 4 CD incidents within Delivery Suite
- 2 occurred within Pharmacy
- 2 occurred on Maternity Base
- 2 occurred within Gynae Unit
- 3 medication incidents assessed as near miss
- 22 as no harm.
- 36 as low / minor
- 1 incident assessed as moderate harm.

Serious Incidents

Serious Incidents

- 5 (no change) serious incidents reported
- 4 (no change) serious incidents submitted to the CCG
- No never events
- All incidents requiring duty of Candour have been completed
- New serious incidents relate to 3 Maternity cases and 2 Gynae cases – 1 x divert, 1 x death following cardiac arrest, 1 x high risk pregnancy with risks not escalated to senior consultant, 1 x omission of Vitamin K and 1 x failure to provide Anti-D

Complaints and PAL's

Complaints and PALS

- 13 (no change) formal complaints
- Clinical Treatment and Communication are the key themes
- 14 complaints closed down
- 660 (-58) PALS contacts
- Communications, appointments and access to treatment or drugs remain key themes
- PALS+ 10 (-1) contacts
- Patient care, values and behaviours (staff) and communication are key themes

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Effectiveness and Audit

Effectiveness and Audit

- 5 audits completed in Q2

Themes across Quarter 2 Clinical Audit Projects:

- Improvement is required with regards to documentation; both paper and electronic.
- Shared learning and continual education via communication, dissemination of results, teaching, as well as linking across departments is paramount in highlighting findings and risks identified.
- Appropriate sharing of findings locally, regionally, and nationally can assist with change and improvements on a wider scale.
- It is essential to have robust policies, procedures and pathways in place that are regularly reviewed and adhered to. These should be communicated as relevant to both staff and service users (via presentations, leaflets etc.)
- Development around performing and/or recording systemic enquiry and checklists requires improvement.
- Identifying issues and collaborating with I.T. and Coding departments will improve data output from electronic systems, including further development of K2 system, to enable provision of additional reports e.g. 6-monthly reports to ensure accurate recording of cord clamping time.
- Timely organisation of meetings across departments is important for discussing projects e.g. the implementation of Life start Trolleys.

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Claims cases and Inquests

Legal

- 4 clinical negligence claims in Q2
- Decrease of 6 from Q1 21/22
- 5 clinical negligence claims were settled in Q2
- No claims were raised as a result of any Serious Incident investigations
- No new public liability of employer liability claims
- The trust has been involved in 2 inquests. One was a successful conclusion for LWH, the other due in Dec 21.

2020/21	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Total
Month				3	5	4	1	1	2	1	6	3	
Total	8			7			6			25			46
2021/22	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec	
Month	1	3	3	2	3	5	1	2	1				
Total	7			10			4						

Legal update: July – September

There were 4 new clinical claims in total:

- 1 in July (gynaecology claim),
- 2 in August (both gynaecology) , and
- 1 in September (Mesh)

In addition;

- 1 New EL claim.
- 1 New ENS claim

July

1 gynaecology claim settled on a litigation risk basis following Hill Dickinson and Trust investigations.

August

A Rowland case settled and awaits costs to be finalised.

A genecology claim was settled following a joint settlement meeting pre-trial with the Claimant.

A birth injury claim was settled at a joint settlement meeting pre-trail with the Claimant. This settlement figure was a substantial amount under the anticipated figure and deemed a success for the Trust in those circumstances.

September

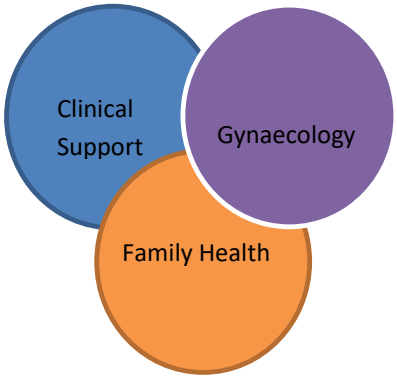
A genecology claim was settled in good faith following the service of a Letter of Response which contained admissions following an internal and external investigation by Trust solicitors.

Inquests

An inquest concluded which heard the patient died of natural causes, this was deemed a successful conclusion for the Trust following extensive investigations, both internal and external review

We have been asked to give evidence at another inquest that the Coroner is investigating regarding a lady that was operated on at the Trust under an arrangement with another local Trust listed for December 2021.

Triangulation and key trends



- Blood sampling errors relating to Inappropriate or insufficient labelling across all divisions (as per Q1)
- Communication issues both with patients and with the teams across all divisions (as per Q1)
- Clinical treatment / management and communication remain the highest categories of formal complaints and a significant proportion of PALS contacts.
- Risk 2329 (Pharmacy) on the Corporate Risk Register relates to the safe and proper management of medicines – Owned by the Medical Director and managed by the Deputy Chief Pharmacist
- Risk 2232 (Pathology) on the Corporate Risk Register relates to the safety requirements regarding blood transfusion including sample labelling – Owned by the Trust Transfusion Lead (Consultant) and managed by the Trust Transfusion Practitioner.

Quality Improvement Projects

Mersey Internal Audit Agency (MIAA) 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. The terms of reference agreed with MIAA.

The Chief Nurse & Midwife will lead the project supported by the Associate Director of Quality & Governance and by the Quality Improvement Lead.

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 would support LWH on its journey to achieve an outstanding rating with the Care Quality Commission. 23 People attended the initial meeting.

The QI lead had been absent from work for a period of over two months before their return on 17 October 2021. During this time, there was an embargo on any new QI projects being registered as there were approximately 60 projects on hold within the Ulysses database. The QI lead had been the single lead for this role across the organisation and had previously requested support to develop this role and increase buy in across the organisation.

There is an inconsistent approach across the organisation in relation to knowledge and the application of QI. There has been some unnecessary time spent on what could have been "everyday QI / Just do it " .

The QI lead is supporting people to progress projects and update Ulysses to reflect the current position with any new or on-going projects. As such the embargo on any new projects being registered has now be removed. The use of the Ulysses system for QI work will be reviewed through this project.

The governance department are reviewing roles and responsibilities within its management team to ensure there isn't a single point of failure for any pieces of work going forwards, including QI.

The QI lead is meeting with MIAA on a weekly basis to keep track on any progress of the project, providing them with any materials and information requested.

Next steps

1. Introductory meeting to be held with MIAA on 3 November
2. The AD Quality & Governance will continue to promote the project, working with staff to engage with 'buy in' of the process and showcasing the work we do across the trust.
3. The QI project lead from 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. The integrated Governance team 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.
6. At the conclusion of the project the AD Quality & governance y will lead on the completion of the QI framework to under pin the clinical quality strategy 2021-25.
7.

CONCLUSION

This report is to provide assurance as to the Governance System in place in LWH and that staff are being open by reporting incidents, clinical and non-clinical, to ensure patients and staff safety is maintained.

The report which has been presented has clearly identified themes within incidents and complaints and the triangulation of these across the divisions.

RECOMMENDATIONS

It is it is requested that the members of the Board review the contents of the paper and take assurance that there are adequate governance processes in place and the positive progress in managing risk has been made with Senior Management having oversight of such risks.

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

Liverpool Women's NHS Foundation Trust

1. Highlight Report

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

• The Safety and Effectiveness Sub-Committee raised a risk in relation to the Liverpool Centre for Genomic Medicine and an increase in incidents regarding genomic testing relating to the number of rapid changes to the genomics laboratory. There are issues with trying to resolve these incidences with respect to joint working and investigation. The Safety and Effectiveness Sub-Committee had commissioned a report from the Genomics Service to respond to the issue and the process of investigating and learning from incidents between the clinical and the laboratory services.
• A Cancer improvement task and finish group had been established to improve Cancer Performance in Q3 from the Q2 position. The results on this would be presented to the Finance Performance and Business Development (FPBD) Committee along with a 52-day trajectory in line with the H2 planning round.
• Noted a continued issue relating to blood sampling errors, with samples not being processed due to inadequate / inappropriate labelling. The Trust Transfusion practitioner continued to undertake a weekly safety round in all clinical areas as well as discussing errors with individual staff. An updated Standard Operating Procedure had also been published which should allow for further improvement. Clarification was sought that blood sampling training was part of the clinical mandatory training programme within the Transfusion training competency. It was agreed that the Safety and Effectiveness Sub-Committee should review the position.
• Committee received the impact review on the central CTG monitoring system used on the Delivery Suite. It was acknowledged by the clinical team that whilst centralised monitoring was a routine component of care and had several benefits it was unlikely, in isolation, to positively impact upon the incidence of hypoxic ischaemic encephalopathy and/or cerebral palsy. The Committee noted the recommendations and requested that the Family Health Division monitor completion against the suggested recommendations. Remote access to the CTG monitoring was considered, particularly in the absence of 24/7 consultant onsite presence. The Chief Operating Officer agreed to review the option of K2 remote access.
• Learning from Deaths for the period Quarter 2, 2021/22 received:
  ○ The Committee noted the rise in still birth rates and the recommendation to undertake a thematic review of all stillbirths in 2021-22 due to the rising trend. This would be undertaken by the Family Health Division and overseen by the Safety and Effectiveness Sub-Committee. Cross reference with previous Trust reports reviewing stillbirth was requested.
  ○ Chair action to the Family Health Division and the Digital Hospital Sub-Committee to consider whether the implementation of K2 has had a role in the antenatal care provided in stillbirth cases.
	• Reflected on the major incident at the Trust on 14.11.21 and noted the professionalism and resilience demonstrated by the workforce and the support received regionally and nationally.
	• A discussion was held on the maternity KPIs focussing on the purpose of the metric, the interpretation and the positioning of Trust maternity metrics against other providers nationally. A chair action on the safety and effectiveness of the Maternity KPIs was remitted to the Safety & Effectiveness Sub-Committee.
	• An accreditation programme in the process of being put into place and embedded trust wide. This would enable the Trust to develop a comprehensive overview of the programme plan to ensure safe and effective patient care and patient experience and to make sure that all actions plans are up to date.
	• Noted the CQC Insight Liverpool Women's report as published on 20 September 2021. It was noted that no response had been received from the CQC following its Direct Monitoring Call in September 2021.
	• The governance processes within the Trust continue to be strengthened, aligning to divisions with a common approach to good governance which will enable improved outcomes for people and operational performance. The governance team continue to horizon scan and would update the Committee in relation to any changes to CQC's regulatory approach.
	• Received the monthly serious incident report for October 2021, noting one SI declared on StEIS and one incident reported under HSIB criteria but not as an SI. Additional narrative would be provided in future reports to provide clarity on SI escalation criteria.
	• Noted that the latest 'Mind the Gap' report was due to be published on 23rd November 2021; it was anticipated that the Family Health Division would perform a review of maternity training needs in response to this.
	• Continued progress against the clinical priorities to achieve the aims of the 2020-25 Clinical and Quality Strategy. Five-year Transformation plans which integrate the clinical priorities set out in the Clinical and Quality Strategy would be finalised by January 2022 with the operational and workforce plans to be developed in January 2022.

Positive Assurances to Provide	Decisions Made
• The RDI Sub-Committee reported that the Trust had been invited to input into the Living Well programme led by Liverpool Health Partners. The Trust was already inputting into the Starting Well programme. • The Committee was informed that the Continuity of Carer trajectory had been updated following national directives and that a red RAG rating was not reflective of current performance. This updated measure would be included within the next iteration of the performance report. • The Committee received a position update in relation to the clinical pathway offered to Children and Young People patients following an issue identified in the most recent CQC inspection report. Assurance was received that action had been taken and a range of initiatives put in place to improve the experience and safety across Trust services for children and young people. • The Committee received assurance that the outstanding actions from the Trust wide CQC Action Plan identified by Mersey Internal Audit Agency (MIAA) had been completed and closed by MIAA. • Positively assured by the results of the gynaecology inpatient survey 2020. • Assured by the contents of the Integrated Governance Assurance report for the period Quarter 2 of 2021/22, demonstrating oversight and assurance monitoring of Integrated Governance across the Trust. It was suggested that the narrative of the IGA Report should be linked to the H2 report. • Assured by the clinical services self-assessment against the Essential Actions in the Ockenden report. Progress against outstanding actions would be monitored through the Safety and Effectiveness Sub Committee. The Committee noted that this demonstrated an effective response beyond the initial ask from maternity.	• Committee reviewed the Quality related BAF risks. It was noted that the Trust Board had considered the introduction of the new BAF risk relating to Cyber Security and recommended and approved that it be aligned to the Finance, Performance and Business Development (FPBD) Committee as the controls and assurances to respond to the risk of cyber security was held by FPBD. • Approved the Corporate Objectives 2021/22 aligned to the Quality Committee.

Comments on Effectiveness of the Meeting / Application of QI Methodology

- No comments made

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
157.	Board Assurance Framework	Assurance	163.	Integrated Governance Assurance Report Q2, 2021/22	Assurance
158.	Sub Committee Chair Reports	Assurance	164.	Lookback Review: Central Monitoring of CTG recordings on Delivery Suite	Information
159.	Quality Performance Report Month 7, 2021/22	Assurance	165.	Divisional Reviews against the Ockenden Report	Assurance
160.	Quality and Regulatory Update • Children and Young People's Report • MIAA CQC Action Plan Update • CQC Insight Tool	Information	166.	Clinical Quality Strategy Update	Information

161.	Gynaecology Inpatient Survey results 2020	Information	**167.**	Learning from Deaths (Mortality and Perinatal) Report Q2 2021/22	Assurance
162.	Serious Incidents & Learning Report (monthly report)	Assurance	**168.**	Corporate Objectives 2021/22: Designated Quality Objectives Six Month Review	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	A				
Christopher Lube	✓	✓	✓	✓	NON MEMBER								
Philip Bartley	NON MEMBER						✓	A	✓				

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

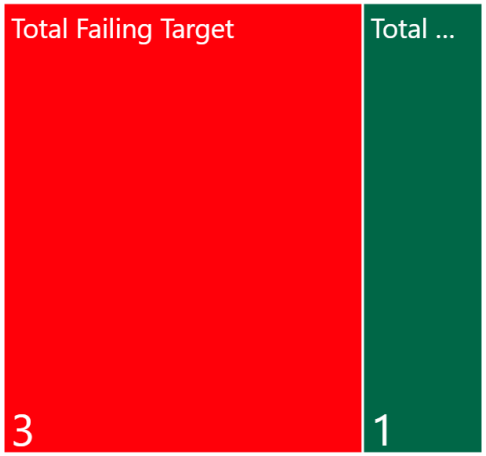
Liverpool Women's NHS Foundation Trust

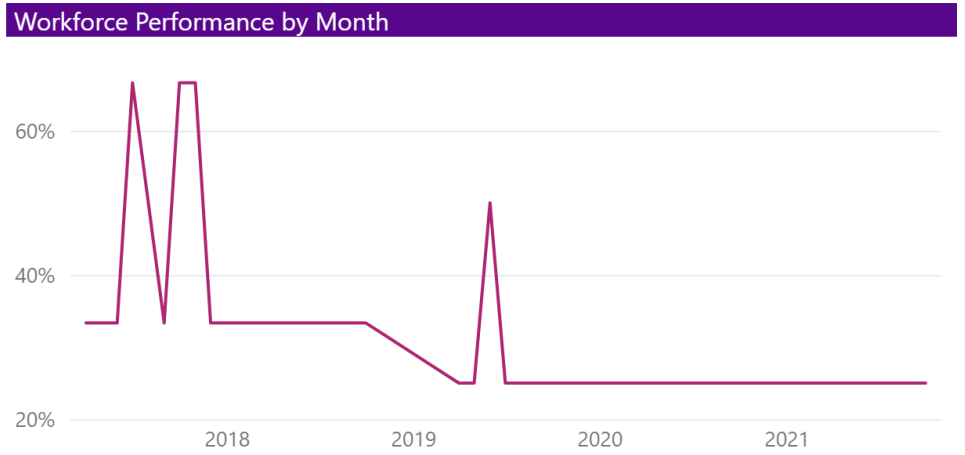
Workforce Performance

Trust Board

December 2021

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



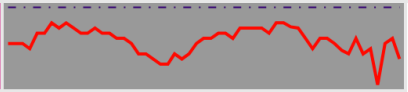
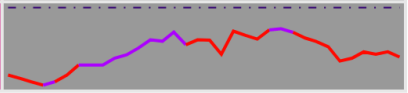


Mandatory Training
Key developments in OLM to improve mandatory training access for staff include 1. Accessing mandatory training from a single point of access on the front page of ESR 2. Auto enrolment in place so staff just need to click 'play'. HR/OD have supported managers with additional inputting of local training and there have been a number of improvements including 100% compliance in theatres.

Absence
New absence policy and approach launches in November 2021 to move the focus from absence to wellbeing. Wellbeing conversations are also taking place Trust wide and 20 managers are taking part in a regional training programme on attendance management. LWH's first Staff Support psychologist is out for recruitment and we have delivered a wellbeing and resilience programme, fronted by two ex rugby players with personal experience of mental health issues. Schwartz rounds continue into 2022

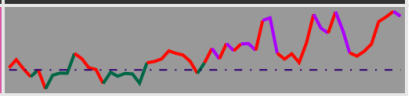
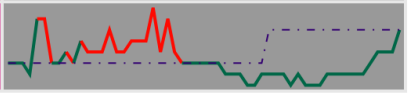
Leadership
40 leaders at Bands 7 and 8, mainly from within nursing and midwifery have commenced on the new LWH Leadership and Management Development Programme. Coaching and mentoring training continues Trust wide.

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	October 2021	85.00%	-10.00%	95.00%			
	Clinical Mandatory Training Compliance	October 2021	80.35%	-14.65%	95.00%			

KPI	KPI Narrative
Clinical Mandatory Training Compliance	The overall Trust clinical mandatory training compliance fell by 2% from 82% in month six, to 80% in month seven. This is now 15% under the Trust's target rate of 95% and rated as amber. In the largest clinical areas, compliance fell by 1% in Gynaecology, by 3% Maternity, and by 3% in Neonates. At the divisional level, compliance fell by 1% in the Gynaecology Division, but increased by 2% in Family Health, by 3% in Clinical Support Services, and by 1% 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 be introduced from 30th 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. 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 fell by 4%, from 89% in month six, to 85% in month seven. This is now 10% under the Trust's target rate of 95% and rated as amber. In the largest clinical areas, compliance fell by 1% in Gynaecology, by 8% Maternity, and by 4% in Neonates. At the divisional level, compliance fell by 1% in both the Gynaecology Division and the Corporate Division. It remained unchanged in Clinical Support Services, but increased by 2% in Family Health. 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 be introduced from 30th 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	October 2021	8.03%	+3.53%	4.50%	42925		
	Turnover Rate	October 2021	13.00%	0.00%	13.00%			

KPI	KPI Narrative
Sickness Absence Rate	The single month sickness absence figure fell by 0.32%, from 8.35% in month six, to 8.03% in month seven. This is now 3.53% above the Trust's target figure of 4.50% and is therefore rated as red. In the largest clinical areas, sickness absence fell by 0.67% in Gynaecology, by 0.80% in Maternity, and by 0.31% in Neonates. At divisional level, sickness fell by 0.85% in the Gynae Division and by 0.64% in Family Health, but increased by 0.33% in Clinical Support Services, and by 0.26% in the Corporate Division. Overall, the proportion of sickness that was short term again went up, from accounting for 33% in month six, to accounting for 37% in month seven. 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 fell to 2.16% in month seven, compared to 2.37 % in month six. The HR Department are continuing to provide support for managers in managing sickness absence and in supporting staff through this difficult time. A range of measures are in place specifically to address the situation with regards to covid 19. These are available to all staff and include risk assessments, on-site testing for staff (and family members) with suspected symptoms, and asymptomatic testing (with a choice of LAMP or Lateral Flow tests available). From 15th November, asymptomatic testing will become mandatory for all staff. The programmes to deliver the covid booster vaccination and the flu vaccination are both now well underway. A lot of work has also been done in pulling together and communicating to staff a whole range of available support, with a particular focus on health and wellbeing. A new updated Return To Work Form has now been launched with more of a focus on health and wellbeing rather than short term policy stages, together with a new recording process that will allow the completion of return to work meetings to be accurately monitored. A fundamental revision of the Trust's Attendance Management Policy whereby the short term stages for managing attendance will be removed, will be launched this month. Efforts to reduce sickness absence are on-going, but it is difficult to accurately predict when the target figure of 4.50% 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 Occupational Health.

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	**2021/22/123a**		**Date: 02/12/2021**	
Report Title	**Finance Performance Review Month 7 2021/22**			
Prepared by	***Claire Scott, Acting Deputy Chief Finance Officer***			
Presented by	***Eva Horgan, Chief Finance Officer***			
Key Issues / Messages	***To take assurance from the Month 7 finance 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 Committee is asked to note the Month 7 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

National guidance has been to split the financial year into two halves with the first half (H1) being a continuation of the system of blocks and top ups from the previous year, supplemented with an Elective Recovery Fund (ERF).

The Trust had an adjusted breakeven target for H1 which was achieved. However, this was reliant on non-recurrent items due to shortfalls on the Cost Improvement Programme (CIP) and ERF, as well as pay overspends.

For the second half of the year (H2) the system of blocks and top ups will remain in place along with the ERF incentive however the basis of achievement of ERF has been adjusted. A deficit plan was approved by the Trust Board on 10th November; the Board also delegated final approval to the Finance, Performance and Business Development Committee if a breakeven plan was possible. This was the case and the Committee approved a breakeven plan on 22nd November. This was agreed with Cheshire & Merseyside Health and Care Partnership and submitted to NHS Improvement on 25th November.

Although the Trust now has a breakeven plan for the whole of 2021/22, this was not the case at the time of preparing the Month 7 management accounts. The system funding and other items such as bids were not clear at this time. For Month 7, the Trust was working to its original plan which was a deficit of £4.1m for the full year. The table below measures against the Trust's internal plan but this will be updated in Month 8.

The cash position is less of a concern for Quarter Three as temporary support is being provided by Liverpool CCG. This is being carefully monitored as the temporary support will be removed in Quarter Four, but other income is now expected and will be applied into the cashflow for Month 8 reporting.

CIP and ERF are still behind plan; further detail is in section 3 and 5 below. 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.

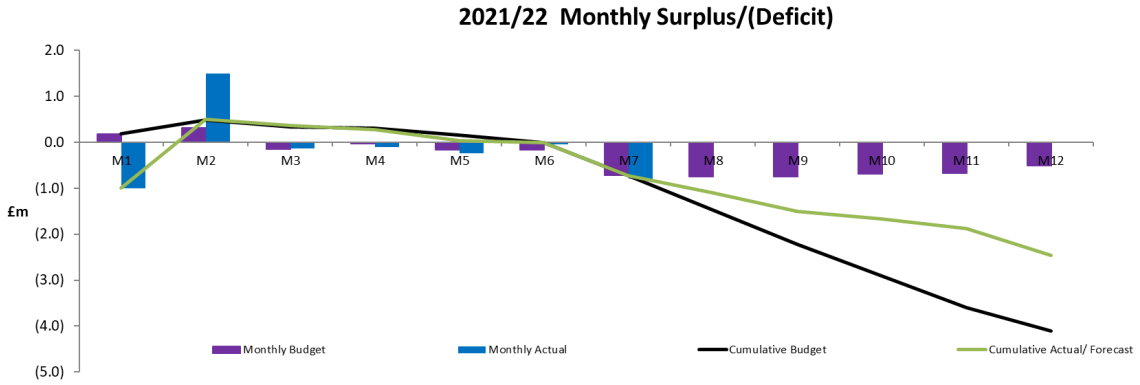
Liverpool Women's NHS Foundation Trust

	Plan	Actual	Variance	RAG	R	A	G
Surplus/(Deficit)	-£0.7m	-£0.8m	-£0.1m	↓	*plan*	*Plan*	*better*
NHS I/E Rating	3	3	0	↔	*4*	*3*	*2+*
Cash	£4.5m	£6.4m	£1.9m	↑	*<£1m*	*£1m-£4.5m*	*£4.5m+*
Total CIP Achievement	£0.9m	£0.6m	-£0.3m	↔	*plan*	*Plan*	*better*
Recurrent CIP Achievement	£0.9m	£0.5m	-£0.4m	↔	*plan*	*Plan*	*better*
Elective Recovery Fund (net)	£1.5m	£1.3m	-£0.3m	↓	*plan*	*Plan*	*better*
Non - Recurrent Items YTD	£0.0m	£1.7m	£1.7m	↔	*>£0*	-	*£0*
Capital Spend YTD	£4.9m	£2.7m	-£2.3m				

MAIN REPORT

1. Summary Financial Position

At Month 7 the Trust is reporting a Year to Date (YTD) deficit of £0.8m, against a £0.7m deficit plan per the original budget. This budget will be revised in line with the plan agreed on 22nd November for Month 8 reporting. The forecast at the time of preparation of the Month 7 position was a £2.5m deficit, this will be revised at Month 8 in line with the additional items and income agreed as part of the planning process to get to a subsequently agreed breakeven plan.



2. Divisional Summary Overview

The divisional positions remain broadly in line with prior months. Covid costs are separately recorded and do not impact divisional positions.

Family Health: The division's position has worsened again, to £646k overspent YTD in Month 7, a deterioration of £73k since Month 6. This is largely due to a significant pay overspend, largely due to continued expenditure on agency midwives. The Maternity directorate is under Executive oversight and a Maternity Transformation Board is in place.

Gynaecology: The division is now £1.8m overspent YTD, primarily relating to activity and income being behind plan as well as pay overspends.

Clinical Support Services: The Division have a YTD underspend of £194k. Agency spend in theatres remains high although this is offset by underspends on consultant anaesthetists.

Agency: Agency spend across the Trust is now £1.4m YTD. This continues to be a significant concern and is almost certain to breach the agency ceiling. The Trust are keeping the regional team informed of the specific issues driving the increase above the ceiling including the actions being taken to address it.

Financial Recovery Board: Due to the scale of the Trust's financial challenges, particularly in Maternity, Gynaecology and Fertility, a Financial Recovery Board (FRB) has been set up. The purpose of the FRB is to give further scrutiny and agree actions to improve the financial position, focussing on grip and control and process.

3. Elective Recovery Fund

The Elective Recovery Fund was put in place during H1 to incentivise providers to undertake more elective activity and to pay for the additional costs associated with this. For H1 it was measured using a baseline of 2019/20 data. LWH achieved ERF in Quarter 1 however the baseline increased to 95% of 2019/20 data in Quarter 2 and neither the Trust, nor Cheshire & Mersey were able to achieve this target. Note that baseline activity was not adjusted for Termination of Pregnancy activity. This is still being rigorously pursued with the national team.

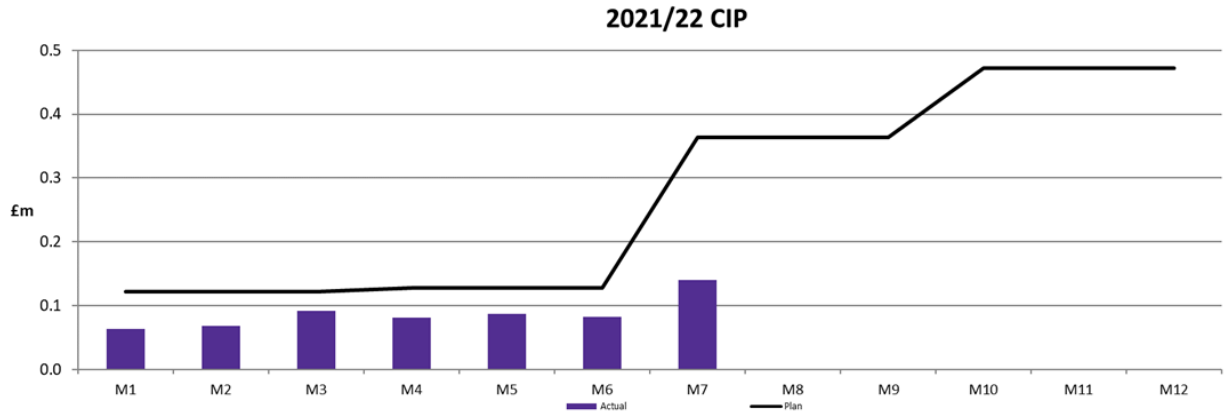
The mechanism for ERF is changing in H2, this will be focussed on completed referral to treatment (RTT) pathway activity rather than total cost weighted activity which was used in H1. The ERF threshold has been recalculated so that it is on a comparable basis to the 95% threshold for the ERF in Q2.

The Trust and Cheshire & Mersey as a whole will need to achieve a completed referral to treatment (RTT) pathway activity above a 2019/20 89% threshold to achieve ERF payment. This will then be funded at 100% of tariff between 89% and 94%, and 120% of tariff for activity above 94%. This will be applied to the ERF baselines for October to March which were issued in H1.

At Month 7, no ERF is included in the position whilst this situation is clarified but a catch up will be put into Month 8 if it is agreed that Cheshire & Merseyside expect to achieve ERF.

4. CIP

At Month 7, CIP continues to remain behind the original board approved plan. Note that the October to March (H2) target as approved by the Board has not yet been revised in the Month 7 position but will be updated in Month 8 now that a revised plan is in place. This is a reduced target of just under £2m full year against the original plan of £3.3m.



CIP continues to be managed with divisions individually and via the Senior Management Team meeting, which has been refocussed to give greater time to CIP and Transformation.

5. COVID-19

The Trust spent £747k on direct Covid-19 related costs YTD to Month 7. Further detail on spend is in the Appendix.

6. Cash and Borrowings

The closing cash balance in Month 7 is £6.4m. This is due to revised system top-up and block payments inclusive of the pay award being received. Additional cash support via Cheshire & Merseyside and Liverpool CCG has also been agreed but the medium and long term position still remains a risk. The Trust's finance team continue to run a number of scenarios and closely monitor the situation.

7. Capital Expenditure

Expenditure under the Procure 22 Guaranteed Maximum Price (GMP) is underway, and the works in relation to the Fetal Medicine Unit are complete.

Business as usual expenditure on Estates and Medical Equipment is behind plan. This is being monitored with divisions individually and via the Senior Management Team meeting. The Finance and Procurement teams are working closely with departments to ensure that expenditure is planned in as soon as possible. Purchase orders have been raised for the majority of items and we expect to see this spend increase in line with forecast.

IM&T are over-spent due to prior year items which could not be delivered in time for year end. There are a number of bids that have been submitted to support Digital recovery and innovation.

NHSI have now confirmed that the Trust will be in receipt of £2.9m in relation to the Community Diagnostic Centre. The letter of agreement has now been signed and PDC drawdown is expected to begin in December.

This increase in funding will need to be closely managed.

8. Balance Sheet

Debtors over 60 days reduced again by £0.2m to £1.2m, and work continues to clear the remaining debt.

Performance against the Better Payment Practice Code improved to 90% by value in Month 7, compared to 87% at year end 2020/21.

By removing non-NHS invoices that have been held in a form of dispute, the BPPC overall would remain at 90% by value. The performance by invoice count would improve by 2% to 84%.

9. BAF Risk

There are no proposed changes to the BAF score but this is under review.

10. Conclusion & Recommendation

The Board is asked to note the position.

NHS
Liverpool Women's
NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

FINANCE REPORT: M7

YEAR ENDING 31 MARCH 2022

Liverpool Women's NHS Foundation Trust

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NHS
Liverpool Women's
NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 1
NHS IMPROVEMENT RATIOS: M07
YEAR ENDING 31 MARCH 2022

USE OF RESOURCES RISK RATING

	Actual
CAPITAL SERVICING CAPACITY (CSC)	
(a) EBITDA + Interest Receivable	3,764
(b) PDC + Interest Payable + Loans Repaid	998
CSC Ratio = (a) / (b)	**3.77**
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	(14,194)
(b) Expenditure	73,405
(c) Daily Expenditure	343
Liquidity Ratio = (a) / (c)	**(41.4)**
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)	802
Total Income	(77,169)
I&E Margin	**-1.04%**
NHSI I&E MARGIN SCORE	**4**

Ratio Score 1 = > 1% 2 = 1 - 0% 3 = 0 - (-1%) 4 < (-1%)

I&E MARGIN VARIANCE FROM PLAN	
I&E Margin (Actual)	-1.00%
I&E Margin (Plan)	-0.90%
I&E Variance Margin	**-0.1%**
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	1,043
YTD Agency Expenditure	1,397
	34%
NHSI AGENCY SPEND SCORE	**3**

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.

NHS
Liverpool Women's
NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 2
INCOME & EXPENDITURE: M7
YEAR ENDING 31 MARCH 2022

INCOME & EXPENDITURE £'000	Month 7 Budget	Actual	Variance	YTD Budget	Actual	Variance
Income						
Clinical Income	(9,355)	(10,276)	921	(72,381)	(73,407)	1,026
Non-Clinical Income	(576)	(621)	45	(4,032)	(3,762)	(270)
Total Income	**(9,931)**	**(10,897)**	**966**	**(76,413)**	**(77,169)**	**757**
Expenditure						
Pay Costs	6,120	6,805	(685)	43,586	45,911	(2,325)
Non-Pay Costs	2,240	2,646	(406)	17,610	16,429	1,180
CNST	1,581	1,581	0	11,065	11,065	0
Total Expenditure	**9,941**	**11,032**	**(1,091)**	**72,260**	**73,405**	**(1,145)**
EBITDA	**10**	**135**	**(125)**	**(4,153)**	**(3,764)**	**(388)**
Technical Items						
Depreciation	505	464	41	3,490	3,267	223
Interest Payable	3	3	0	23	24	(2)
Interest Receivable	0	0	0	0	0	0
PDC Dividend	195	191	4	1,365	1,279	86
Profit/Loss on Disposal or Transfer Absorption	0	0	0	0	0	0
Total Technical Items	**703**	**658**	**45**	**4,878**	**4,571**	**307**
(Surplus) / Deficit	**714**	**793**	**(79)**	**725**	**806**	**(81)**

Note that the budget is as per the Original Board approved plan for 2021/22.

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST **2a**
INCOME & EXPENDITURE HOSTED SERVICES: M7
YEAR ENDING 31 MARCH 2022

INCOME & EXPENDITURE £'000	Month 7 Budget	Month 7 Actual	Month 7 Variance	YTD Budget	YTD Actual	YTD Variance
Income						
Clinical Income	(213)	(431)	219	(1,745)	(1,151)	(594)
Non-Clinical Income	0	0	0	0	(20)	20
Total Income	**(213)**	**(431)**	**219**	**(1,745)**	**(1,171)**	**(574)**
Expenditure						
Pay Costs	102	43	59	640	321	319
Non-Pay Costs	111	388	(278)	1,106	847	258
Total Expenditure	**213**	**431**	**(219)**	**1,745**	**1,168**	**577**
(Surplus) / Deficit	**0**	**0**	**(0)**	**0**	**(3)**	**3**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 3
EXPENDITURE: M7
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
Pay Costs						
Board, Execs & Senior Managers	359	321	38	2,492	2,405	87
Medical	1,665	1,741	(76)	11,688	11,912	(224)
Nursing & Midwifery	2,617	2,954	(337)	18,619	20,030	(1,411)
Healthcare Assistants	443	466	(23)	3,348	2,909	439
Other Clinical	396	351	45	2,750	2,692	59
Admin Support	597	656	(59)	4,295	4,567	(272)
Agency & Locum	43	316	(273)	393	1,396	(1,003)
Total Pay Costs	**6,120**	**6,805**	**(685)**	**43,586**	**45,911**	**(2,325)**
Non Pay Costs						
Clinical Suppplies	606	843	(237)	5,218	5,251	(33)
Non-Clinical Supplies	564	558	6	4,116	3,739	377
CNST	1,581	1,581	0	11,065	11,065	0
Premises & IT Costs	621	765	(144)	4,891	4,626	264
Service Contracts	449	479	(30)	3,385	2,813	572
Total Non-Pay Costs	**3,821**	**4,226**	**(406)**	**28,674**	**27,494**	**1,180**
Total Expenditure	**9,941**	**11,032**	**(1,091)**	**72,260**	**73,405**	**(1,145)**

Note that the budget is as per the Original Board approved plan for 2021/22. And that the values above exclude £1,168k in relation to hosted services.

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 4a
COVID EXPENDITURE: M7
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
Pay Costs						
Board, Execs & Senior Managers	0	0	0	0	1	(1)
Medical	0	1	(1)	0	5	(5)
Nursing & Midwifery	0	23	(23)	305	207	98
Healthcare Assistants	0	11	(11)	166	88	78
Other Clinical	0	(0)	0	0	2	(2)
Admin Support	0	19	(19)	134	174	(40)
Agency & Locum	0	10	(10)	90	69	21
Total Pay Costs	**0**	**64**	**(64)**	**695**	**546**	**149**
Non Pay Costs						
Clinical Suppplies	0	4	(4)	76	49	27
Non-Clinical Supplies	0	0	(0)	6	(7)	13
CNST	0	0	0	0	0	0
Premises & IT Costs	0	17	(17)	210	153	57
Service Contracts	0	4	(4)	0	24	(24)
Total Non-Pay Costs	**0**	**26**	**(26)**	**292**	**220**	**72**
Total Expenditure	**0**	**89**	**(89)**	**987**	**766**	**221**

Note that the values above include £18k YTD related to Vaccination and LAMP Testing expenditure which should both be reimbursed.

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 5
BUDGET ANALYSIS: M7
YEAR ENDING 31 MARCH 2022

INCOME & EXPENDITURE £'000	MONTH Budget	MONTH Actual	MONTH Variance	YEAR TO DATE Budget	YEAR TO DATE Actual	YEAR TO DATE Variance
Maternity						
Income	(4,000)	(4,086)	86	(28,002)	(28,411)	410
Expenditure	1,949	2,233	(284)	13,719	15,090	(1,371)
Total Maternity	**(2,051)**	**(1,853)**	**(198)**	**(14,283)**	**(13,322)**	**(961)**
Neonatal						
Income	(1,743)	(2,001)	257	(12,203)	(12,627)	424
Expenditure	1,240	1,372	(132)	8,680	8,789	(109)
Total Neonatal	**(503)**	**(628)**	**125**	**(3,523)**	**(3,839)**	**315**
Division of Family Health - Total	**(2,555)**	**(2,482)**	**(73)**	**(17,807)**	**(17,161)**	**(646)**
Gynaecology						
Income	(2,041)	(1,991)	(50)	(14,290)	(13,382)	(908)
Expenditure	1,095	1,253	(157)	7,748	8,462	(714)
Total Gynaecology	**(946)**	**(738)**	**(208)**	**(6,542)**	**(4,919)**	**(1,622)**
Hewitt Centre						
Income	(804)	(837)	33	(5,393)	(5,465)	72
Expenditure	657	695	(38)	4,853	5,092	(239)
Total Hewitt Centre	**(147)**	**(142)**	**(5)**	**(540)**	**(373)**	**(167)**
Division of Gynaecology - Total	**(1,093)**	**(880)**	**(213)**	**(7,081)**	**(5,293)**	**(1,789)**
Theatres						
Income	0	0	0	0	0	0
Expenditure	812	892	(80)	5,787	5,924	(137)
Total Theatres	**812**	**892**	**(80)**	**5,787**	**5,924**	**(137)**
Genetics						
Income	(13)	11	(23)	(88)	(29)	(59)
Expenditure	144	128	16	1,006	900	106
Total Genetics	**131**	**139**	**(7)**	**919**	**871**	**47**
Other Clinical Support						
Income	(367)	(423)	56	(2,570)	(2,937)	366
Expenditure	592	620	(28)	4,394	4,477	(83)
Total Clinical Support	**225**	**197**	**28**	**1,824**	**1,540**	**284**
Division of Clinical Support - Total	**1,168**	**1,228**	**(59)**	**8,530**	**8,335**	**194**
Corporate & Trust Technical Items						
Income	(1,174)	(2,000)	826	(15,612)	(15,489)	(123)
Expenditure	4,367	4,927	(560)	32,696	30,413	2,282
Total Corporate	**3,193**	**2,927**	**266**	**17,083**	**14,924**	**2,159**
(Surplus) / Deficit	**714**	**793**	**(79)**	**725**	**806**	**(81)**
Of which is hosted;						
Income	(213)	(431)	219	(1,745)	(1,171)	(574)
Expenditure	213	431	(219)	1,745	1,168	577
Total Corporate	**0**	**0**	**(0)**	**0**	**(3)**	**3**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 6
CIP: M7
YEAR ENDING 31 MARCH 2022

Original Target	H1			H2			FOT/H2 Plan		
Scheme	Target	Actual	Variance	Target	FOT	Variance	Target	FOT	Variance
Procurement and Non Pay	524	280	(245)	1,033	563	(470)	1,557	843	(715)
Estates Utilisation	0	0	0	200	0	(200)	200	0	(200)
Staffing and Skill Mix	101	101	0	394	201	(194)	495	301	(194)
Outpatients Utilisation	0	0	0	50	0	(50)	50	0	(50)
Medicines Management	0	0	0	240	30	(210)	240	30	(210)
Service Developments	122	95	(27)	204	112	(92)	326	207	(119)
Strategic Review	0	0	0	100	151	51	100	151	51
Theatre Efficiency	0	0	0	110	0	(110)	110	0	(110)
Technology Driven Efficiences	0	0	0	177	0	(177)	177	0	(177)
Unidentified	0	0	0	0	420	420	0	420	420
	747	**475**	**(272)**	**2,508**	**1,476**	**(1,032)**	**3,255**	**1,952**	**(1,304)**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 7
BALANCE SHEET: M07
YEAR ENDING 31 MARCH 2022

BALANCE SHEET £'000	YEAR TO DATE Opening	M07 Actual	Movement
Non Current Assets	90,086	89,522	(564)
Current Assets			
Cash	4,235	6,412	2,177
Debtors	4,976	11,949	6,973
Inventories	410	397	(13)
Total Current Assets	**9,621**	**18,758**	**9,137**
Liabilities			
Creditors due < 1 year - Capital Payables	(3,447)	(1,188)	2,259
Creditors due < 1 year - Trade Payables	(13,728)	(16,773)	(3,045)
Creditors due < 1 year - Deferred Income	(3,136)	(10,960)	(7,824)
Creditors due > 1 year - Deferred Income	(1,592)	(1,572)	20
Loans	(2,136)	(1,830)	306
Provisions	(4,090)	(3,767)	323
Total Liabilities	**(28,129)**	**(36,090)**	**(7,961)**
TOTAL ASSETS EMPLOYED	**71,578**	**72,190**	**612**
Taxpayers Equity			
PDC	62,927	64,345	1,418
Revaluation Reserve	7,522	7,522	0
Retained Earnings	1,129	323	(806)
TOTAL TAXPAYERS EQUITY	**71,578**	**72,190**	**612**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 8
CASHFLOW STATEMENT: M07
YEAR ENDING 31 MARCH 2022

CASHFLOW STATEMENT

£'000	Actual
Cash flows from operating activities	497
Depreciation and amortisation	3,268
Impairments and reversals	0
Income recognised in respect of capital donations (cash and non-cash)	(17)
Movement in working capital	3,290
Net cash generated from / (used in) operations	**7,038**
Interest received	0
Purchase of property, plant and equipment and intangible assets	(4,927)
Proceeds from sales of property, plant and equipment and intangible assets	0
Net cash generated from/(used in) investing activities	**(4,927)**
PDC Capital Programme Funding - received	1,418
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	**66**
Increase/(decrease) in cash and cash equivalents	**2,177**
Cash and cash equivalents at start of period	4,235
Cash and cash equivalents at end of period	**6,412**

LOANS SUMMARY

£'000	Loan Principal Drawndown	Loan Principal Repaid	Loan Principal Outstanding
Loans from Department of Health - Capital (ITFF) - 2.0% Interest Rate	5,500	(3,670)	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**

Finance, Performance & Business Development Chair's Highlight Report to Trust Board
22 November 2021

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Agency spend highlighted as a significant concern, currently at £1.4m YTD. The Trust was keeping the regional team informed of the specific issues driving the increase above the ceiling including the actions being taken to address it. NHSI/E advised that the metrics are currently being reviewed on a case-by-case basis and at this point, there was no further action. • An update for H2 2021/22 planning was received by the Committee, noting a breakeven position for H2 2021/22. Key risks and mitigations against the breakeven position and significant amount of work to be undertaken as part of 2022/23 planning was highlighted. The achievement of the Elective Recovery Fund (ERF) was highlighted as the biggest risk to the H2 plan. • Since approval of Community Diagnostic Centre (CDC) funding from NHSI/E national teams, the Trust had continued to make good progress in establishing programme governance, recruiting key staff to deliver the programme and establishing a detailed programme plan to enable delivery. Work is progressing to determine financial impacts. The risk of identifying sufficient activity was raised to the Committee as was the reliance on external partners to be successful. It was agreed that the CDC should be reflected on the BAF.	• The Committee was assured by the Business Case Post Implementation Review. It was noted that several lessons from implementation had been identified the previous year. The Senior Management Team had been asked to ensure that recommendations are followed going forward. • The Committee received an update from the Crown Street Enhancements Programme. Phase 1 works (Fetal Medicine Unit (FMU) enabling works) completed on 1 November 2021. Phase 2 works (Colposcopy/Imaging) are due to commence 8 November 2021 following decant of relevant clinical areas. Forecast costs for the programme (excluding MRI costs) was currently on budget and remain at the agreed guaranteed maximum price of £5.7m, although there was a possibility of slippage between financial years which was being closely monitored and managed by the CSE Board.
Positive Assurances to Provide	**Decisions Made**
• Received a deep dive presentation on the Trust's 52 week wait performance which included four scenarios listed from worst case to best case of planned activity by March 2022. Significant improvements in activity delivery during the last 8 weeks was noted and the importance to sustain activity delivery to reach projected forecasts. A continued focus on theatre staff recruitment would be maintained. The Committee was assured by the grip and control demonstrated despite the challenges. • Positive assurance from progress within the digital programme with activities underway for Meditech Expanse (EPR), Digital Maternity, and the GDE programme. The Committee also received assurance from Information and Performance update. • Assured by the Neonatal Capital Programme Build benefits realisation review. The programme had successfully mitigated clinical and estate risk, and delivered material benefits for staff, babies and families. • Committee received a summary report detailing the Trust's compliance to the NHSE/I Emergency Preparedness, Resilience and Response (EPRR) Core Standards based on a self-assessment. The Committee was assured by the EPRR annual assurance outcome of 'Substantial Compliance' which demonstrated the Trust remained focused on continuing to meet its duties under the Civil Contingencies Act 2004.	• Reviewed the FPBD related BAF risks. The Committee noted the new BAF risk related to Cyber-Security had been assigned to the Committee to oversee. • The Committee on behalf of the Trust Board approved the breakeven position for H2 2021/22 for submission to NHSI/E. • Approved the corporate objectives 2021/22 aligned to the Committee.

Comments on Effectiveness of the Meeting / Application of QI Methodology
• Positive meeting.

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
130.	Board Assurance Framework Review	Assurance	136.	Annual Business Case Post Implementation Review	Assurance
131.	Finance Performance Report Month 7 2021/22	Assurance	137.	Crown Street Enhancements Programme	Information
132.	Operational Performance Report Month 7 2021 including Deep dive on 52 week waits	Assurance	138.	Community Diagnostic Centre Update	Information
133.	H2 Planning Update (October 2021 to March 2022)	Assurance	139.	EPRR Annual Assurances Board report	Assurance
134.	Digital Services Update	Assurance	140.	Corporate Objectives 6-month review	Information
135.	Update Neonatal Capital Programme Build benefits realisation	Assurance	141.	Sub-Committee Chairs Reports	Assurance

3. 2021 / 22 Attendance Matrix

Core members	Apr	May	Jun	Jul	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Tracy Ellery	✓	✓	✓	✓	✓	✓	A				
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*

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*2021/22/124a*		Date: 02/12/2021	
Report Title	Corporate Objectives 2021/22: Six Month Review			
Prepared by	***Mark Grimshaw, Trust Secretary***			
Presented by	Executives			
Key Issues / Messages	***The report provides a six month position for the 2021/22 Corporate Objectives.***			
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 Board is asked to note the performance / progress to date against the 2021/22 Corporate Objectives.			
Supporting Executive:	Executive Team			

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

REPORT DEVELOPMENT:

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

EXECUTIVE SUMMARY

The Board of Directors reviewed the corporate objectives 2020/21 at its meeting on 6 May 2021 and formally approved them.

The cycle of periodic review usually involves the Committees and the Board reviewing progress on the Corporate Objectives on a six-monthly basis. During 2020/21, in light of the Covid-19 pandemic, and to ensure that the objectives remained feasible and deliverable, the 2020/21 objectives were reviewed in three months and then again at six months. It was agreed to continue this process for 2021/22 and this report provides the six-monthly position.

Recommendation

The Board is asked to note the performance / progress to date against the 2021/22 Corporate Objectives.

MAIN REPORT

Liverpool Women's
NHS Foundation Trust

Corporate Objectives

2021 – 2022

Liverpool Women's
NHS Foundation Trust

Our Vision

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

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

Our Values	**Care**	**Ambition**	**Respect**	**Engage**	**Learn**

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

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

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

Liverpool Women's NHS Foundation Trust

Key	Complete	On track	Risks identified but on track	Off Track

To develop a Well Led, capable, motivated and entrepreneurial Workforce						
Strategic Aim	**Proposed Corporate Objective**	**Executive Lead**	**Relevant Strategy**	**Board Committee**	**6 month update**	**Progress Rating**
Be recognised as the most inclusive organisation in the NHS with Zero discrimination for staff and patients (zero complaints from patients, zero investigations)	Treble the number of staff from BAME backgrounds in leadership roles (Band 7 and above) by 2022	CPO	PPF Strategy	PPF	WRES data from March 2021 showed that LWH employed no non-clinical staff from a BAME background above a Band 8a, where there was one member of staff. As part of the focused commitment to increase the number of staff in leadership roles there have been a number of appointments including - ED&I manager - Deputy Director of N&M - Head of Finance - Ward Manager Bedford The process to have members of the BAME network sitting on	

					interview panels for senior roles is commencing and was reflected in the interview process for the NED roles, where diverse candidates were successfully appointed.	
	Work as an active partner with health, education and the Liverpool Race Equality Task Force, increase the overall % of employees from a BAME background	CPO	PPF Strategy	PPF	Joint working between the Widening Participation Manager and ED&I lead has already made positive links with the Somali, Caribbean and Pakistani communities. LWH continues to work closely with partner organisations including local schools, colleges and Liverpool City Council. An updated on WP is provided in the CPO report for November PPF.	
Recruit and retain key clinical staff	Demonstrate improvement from the 2020 NHS Staff survey in relation to staff engagement measures.	CPO	PPF Strategy	PPF	The 'Let's Talk Survey' from July demonstrated similar themes to the national staff survey. Ongoing feedback is being gathered from the Lets Talk Survey 3 times a year – along with regular qualitative feedback from	

					the monthly Great Place to Work group, ad hoc surveys and focus groups.	
	Make progress to grow the consultant workforce to achieve 24/7 consultant cover by 2023	CPO	PPF Strategy	PPF	The Medical Director will present the Medical Workforce Plan to PPF in early 22.	
	Train 200 managers in Fair & Just processes	CPO	PPF Strategy	PPF	Training scheduled and must be completed by the end of January 2022. Progress is being monitored and overseen by the Just Culture Leaders group who will hold regular 'communities of practice' sessions to support mangers with decisions as well as co-ordinate regular communications	
	Develop and launch a Behavioural Framework	CPO	PPF Strategy	PPF	Engagement has taken place through the Great Place to Work Group, Leadership Forum and Listening Events and the behavioural framework is tabled at November PPF	
	Launch LWH Leadership Programme and talent management process	CPO	PPF Strategy	PPF	Launched – the first stage was to carry out PDRS for all N&M leaders at Band 7 and above to prioritise for the Leadership	

					Programme. The Leadership Programme commenced in October 21. The first session with 2 cohorts (1 band 7 and 1 Band 8 and above) was received positively.	

To deliver Safe services						
Strategic Aim	**Proposed Corporate Objective**	**Executive Lead**	**Relevant Strategy**	**Board Committee**	**6 month update**	**Progress Rating**
Progress our plans to build a new hospital co-located with an adult acute site	Complete refresh of business case for a new Liverpool Women's Hospital to reflect evolving models of care and system developments.	CFO	Future Generations Strategy	FPBD	Expression of Interest (EOI) for Capital submitted. Future Generations Program relaunched and Clinical Advisory Group underway. Long term financial model being refreshed. LWH not prioritised by C&M but yet to undertake regional or national assessment. Meeting requested with regional colleagues to discuss.	
	Contribute to the development and delivery of the Liverpool-wide estates plan during 2021, building on	CFO	Estates Strategy	FPBD	Membership of C&M Strategic Estates Group. LWH plans (EOI) presented to C&M and	

	strategic partnerships for optimal outcomes.				Liverpool place strategic estates boards Sept 21.	
	Provide our hospital with the best digital capabilities and embed a digital first culture through delivering the Digital.Generations strategy through to 2025.	CIO	Digital.Generations Strategy	FPBD	The EPR Programme is progressing broadly in-line with plan and on-schedule for May 22 go-live. The current focus is on design, build and testing earlier system prototypes. Digital Maternity system is embedding well with optimisations underway. Brilliant fundamentals delivering robust digital infrastructure with strong progress within the network replacement,	
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	Deliver the Crown Street enhancement work program (including CT and blood bank services) to time and to budget working with system partners to ensure optimal patient benefit across the wider Cheshire and Mersey system.	CFO	Estates Strategy	FPBD	Schemes are underway with oversight from the Crown Street Enhancements Board. Guaranteed Maximum Price agreed and Tilbury Douglas engaged to commence building works. FMU now completed. CT scanner works likely to be delayed due to successful bid for	Impacted by the CDC and the major incident at the hospital. Full impact being assessed but likely to be some delay.

					Community Diagnostic Centre (CDC). Impact of major incident at LWH yet to be assessed but likely to lead to some delays in building work.	
	Maximise the clinical workforce to deliver timely, safe and effective care to our patients.	MD	Clinical & Quality Strategy	PPF	The Medical Director will present the Medical Workforce Plan to PPF in November 21 Longer Term Strategic Workforce Planning will be included as an agenda item on SMT going forward.	
Develop our model of care to keep pace with developments and respond to a changing environment	Review Future Generations model of care for all services, taking account of all post-COVID learning and changes to care delivery models by 2021	MD	Future Generations Strategy	QC	Future Generations Clinical Advisory Group held a workshop on 20th September to review the future models of care. There was good attendance and engagement by senior LWH clinical staff.	
	Deliver the Quality and Clinical strategy year one objectives	MD	Clinical & Quality Strategy	QC	Update to QC 22nd November on progress.	

	Deliver the launch of Trust's EPR programme in line with established timescales (April 2022)	MD	Digital Generations Strategy	QC	This work is ongoing with good progress and is monitored through the Meditech Expanse Board meeting. There has been some slippage in the timelines but there has not yet any decision to extend the timescale.	

To deliver the best possible Experience for patients and staff						
Strategic Aim	**Corporate Objective**	**Executive Lead**	**Relevant Strategy**	**Board Committee**	**6 month update**	**Progress Update**
Deliver an excellent patient and family experience to all our service users	Make progress towards achieving Bliss baby charter accreditation by 2023	DONM	Clinical & Quality Strategy	QC	The NNU are not progressing with formal accreditation due to the financial costs.	
	Make progress towards achieving the Unicef Baby Friendly Initiative by 2025	DONM	Clinical & Quality Strategy	QC	The NNU are currently at stage 1 in the UNICEF accreditation. The infant feeding team in the process of completing the application. Stage 2 of the process is about embedding the standards that will allow the Trust to demonstrate that staff are confident with standards expected.	

					This will require the infant feeding to deliver a comprehensive teaching programme and to audit that the standards are embedded. The planning application towards achieving continues.	
	Develop and begin to implement the Patient Experience Framework	DONM	Clinical & Quality Strategy	QC	Our ambition at Liverpool Women's NHS Foundation Trust is to ensure that every patient will have an outstanding experience. To do this the Trust has undertaken a review of the Patient Experience Improvement Framework developed by NHS Improvement and has identified improvements that are needed and have incorporated these into the Women, Babies and their Families Experience Strategy 2021 – 2026 objectives. Patient Experience Reviews are received from Divisions at the Patient Involvement and	

					Experience Sub Committee which monitor progress against strategy objectives.	
	Pro-actively seek the views of diverse communities to inform the design of our services for the future, ensuring we champion the voices of our future service users	DONM	Clinical & Quality Strategy	QC	The Trust hosted a Women's and Health Day at the local Pakistani Centre on 23 September 2021 to engage with our local female population from ethnic backgrounds on how we can improve access to our services. The women's health day demonstrated LWH commitment to engage with communities and learn from our patients. Maternity Voices Project is a focus group commencing 11 November to consider how we improve our support for patients with additional needs. Proposal for LWH to be involved in engaging with local community on how we improve access to services at the Families	

					and Women health event Spring in 2022.	
	Deliver the Continuity of Care (COC) priorities in 2021/22	DONM	Clinical & Quality Strategy	QC	Evidence from research and the experiences of women in England in the CQC Maternity Service survey has shown that Continuity of Carer is essential to improving the safety, equity and experience of Maternity care. The vision for Liverpool Women`s Hospital is to be an exemplar in delivering national targets for Continuity of Care and address unwanted variation for all women receiving care at LWH. As a Trust we remain committed to ensuring women are in receipt of Continuity of Care as set out in the NHS - long term plan, and have made progress to ensure women of Black, Asian and Minority Ethnic	

					backgrounds and those living in the most deprived LLSOAs are prioritised in our plans to deliver Continuity of Care. Further priorities for the Trust are to review the action plan which describes how the maternity service will work towards Continuity of Care being the default model of care by 2023, ensuring agreed timescales for implementation, prioritising those women from BAME backgrounds and those living in the most deprived LLSOAs, whilst ensuring transitional arrangements and support are in place to uphold the safety of care of all women across the service. A workforce review by Birth rate plus has recently been commissioned across Cheshire and Merseyside LMS to specifically understand the midwifery	

					workforce requirements needed to achieve the Continuity of Carer requirements, as well as address activity and acuity. Following the outcome of the Birth rate plus audit a review of the midwifery establishment will be undertaken to ensure that the service is supported with the requisite number of midwives delivering directly clinical care and the requirements of national transformation / inquiry outcomes.	
	Deliver on the Ockenden recommendations	DONM	Clinical & Quality Strategy	QC	The work continues to deliver on the Ockenden recommendations. Initial feedback on the original submission has been received, we await formal feedback.	
	Deliver CNST year 3	DONM	Clinical & Quality Strategy	QC	The Trust Board signed off the submission of CNST Year 3.	

To be ambitious and Efficient and make best use of available resources						
Strategic Aim	**Proposed Corporate Objective**	**Executive Lead**	**Relevant Strategy**	**Board Committee**	**6 month update**	**Progress rating**
Ensure our services are financially sustainable in the long term	Ensure efficient and effective use of all available resources, meeting agreed financial targets and working across the Cheshire and Mersey system for optimum outcomes for the region.	CFO	Finance & Sustainability 2021-2025	FPBD	H1 position delivered. Deficit plan submitted to C&M; approved by Board. Work continuing with C&M to agree position.	
	Ensure the Trust has an updated, long term financial plan in place during 2021/22 to reflect recent and proposed regime changes, with clear views and actions in place in relation to long term sustainability.	CFO	Finance & Sustainability 2021-2025	FPBD	Work is underway to refresh the long term financial plan however this is still impacted by future uncertainty with the financial regime.	
	Develop the Trust's commercial strategy during 2021 and pursue appropriate opportunities to maximise Trust income for the benefit of our patients	CFO	Finance & Sustainability 2021-2025	FPBD	Largely paused due to Covid. However this will be picked up through H2 with some additional resource identified to support with this.	
	Appraise options for future organisational form (up to and including merger) by 2022	CEO	Future Generations Strategy	FPBD	This will be reviewed as part of the later Future Generations work and financial modelling.	

	Look for opportunities to maximise use of the Crown Street estate for the benefit of our patients and the whole of Liverpool and C&M	COO	Estates Strategy	FPBD	Bid has been submitted for Community Diagnostic Hub to increase the clinical offer from LWH for Liverpool and Wider Cheshire and Merseyside. FMU, blood bank and CT scanner development in progress and overseen through Crown Street Enhancements Group. Update November: The bid has been successful and implementation group established to deliver on this through Q4 2021/22 to Q2 2022/23	
	Ensure post Covid-19 recovery including: • Eliminating 52 week waits • Deliver 100% of 2019/20 activity by November 2021 • Restore all cancer services in Q1 and return to pre pandemic performance levels. • Achieve the 75% faster diagnostic target in Q3	COO	Our Strategy	FPBD	The Trust 52-week position has plateaued in Q2 after an initial reduction in Q1. This is due to reduced theatre and clinical capacity and a need to focus on high priority P2 patients and reduction in planned clinical capacity due to sickness absence and challenges in theatre recruitment. H2 planning will address the increased	

					capacity required to deal with the backlog. (New and Inpatient activity is on plan Follow up and Day case activity is behind plan) Cancer services have been fully restored in Q1. The C&M cancer alliance has commissioned a C&M Gynae Optimal pathway cancer review to address the challenges of late referrals and will report in for Q3. November update: The national H2 ask is to "reduce" 52 week waiters. The Trust is reprofiling to eliminate 52 week waits through summer 2022/23 however at present this is subject to H2 planning confirmation and associated bids. A reduction in overdue follow ups has been seen and no further significant	

					increase in the 52 week position	

To participate in high quality research in order to deliver the most Effective outcomes						
Strategic Aim	**Proposed Corporate Objective**	**Executive Lead**	**Relevant Strategy**	**Board Committee**	**6 month update**	**Progress Rating**
Expand our existing partnerships, building on learning and partnership working throughout the COVID-19 pandemic, playing a key role in establishing any ICP or ICS	Maintain and develop the following key partnerships during 2021, ensuring robust governance structures are in place: • The Cheshire and Mersey LMS • Our Local MVP and other user groups • Liverpool Place and Liverpool Provider Alliance • Liverpool University Hospitals • The Liverpool Neonatal Partnership and the NWNODN • The Cheshire and Mersey Cancer Alliance • The North West Genomics Partnership • Liverpool University and LHP	COO	Our Strategy	FPBD	The Trust has taken over the hosting of the LMS for C&M in Q1. The Trust is leading the C&M Maternal Medicine Transformation Programme. Through the Maternal Medicine Transformation Programme, the Trust is actively engaged with LUHFT on ensuring clinical pathways are clear and an SLA with LUHFT of the services deliver in partnership is being developed. The Trust has seen an increase in pregnant ladies in LUHFT due to Covid related challenges and works actively with LUHFT teams to support	

					these ladies in partnership. The trust also holds the C&M Maternity escalation Cell chair to support with the tactical response to Covid. The Trust remains committed to working alongside the MVP for Liverpool and C&M and regularly meets to understand feedback and address challenges. The Trust has the clinical lead post on reviewing the Cheshire and Mersey Gynae Optimal Pathway for C&M which will be complete in Q3. The Trust is represented on the Liverpool Place "Complex Lives" Programme which has been established to address the system challenges of this group	

	Support the developing ICS for C&M and working with the system to improve outcomes for Women's Health including Maternal and Neonatal care.	CEO	Our Strategy	FPBD	The CEO hold the SRO role for the C&M Women's Programme In April 2021 the Trust took over the hosting of the Cheshire and Mersey LMS from Liverpool CCG in order to support enhanced care and outcomes for Women's Health. The LMS has now developed a suite of KPIs and is working across the C&M system supported by the infrastructure Of LWH with several LWH clinicians holding posts in the LMS. The Trust has commenced the Chair of the Maternal Medicine working group for C&M and is working as part of the North West system to develop this.	
Progress our research strategy and foster innovation within the Trust	Make progress to achieve university hospital status by March 2023	MD	Research & Innovation Strategy	QC	The main barrier in achieving this is the number of University employed staff who deliver clinical sessions at	

					LWH. There has been a retirement of one academic member of staff and another has left the Trust. There have been a number of approaches to the UoL by individuals who want to hold an academic post at UoL/LWH and the MD and other senior members of staff have engaged with showing them LWH and encouraging them to apply for an academic post.	
	Provide clear evidence of senior nursing & midwifery research leadership, as per the Trust R&D strategy by March 2021	MD	Research & Innovation Strategy	QC	There are now 2 professors of midwifery who sit on the RD&I sub-committee. They have presented to the Nursing and Midwifery forum regarding opportunities for these staff groups for research. The Deputy Director of nursing, Medical Director and Director of Research are meeting to scope out a talent pipeline for nursing, midwifery and allied health professional	

					staff the first draft of which will be presented to RD&I sub committee in January.	
	Demonstrate full recovery of the RD&I activities by July 2021 following the COVID-19 pandemic	MD	Research & Innovation Strategy	QC	For months 1-4 of this year recruitment to open studies at LWH was above that of 20-21 and 19-20. Due to the COVID-19 pandemic the NIHR Clinical Research Network has set Trysts High Level Objectives (HLOs) to aid recovery. LWH has been set 3 HLOs 1) Efficient Study Delivery – New Commercial Studies 2) Efficient Study Delivery – Commercial Managed Recovery 3) Efficient Study Delivery – Non-Commercial Managed Recovery The Trust is meeting all of its obligations in the 3 HLOs The Trust is now recruiting to NIHR studies at pre pandemic levels	

					and this is increasing above that..	
	Provide clear evidence of the Trust's R&D response to COVID-19 pertaining to the specific needs of the Liverpool population	MD	Research & Innovation Strategy	QC	The LWH RD&I department provided mutual aid to COVID -19 specific research teams across Liverpool. That mutual aid is no longer required but could be mobilised if the situation arises.	
	Commence refresh of R&D strategy by engagement with stakeholders	MD	Research & Innovation Strategy	QC	Engagement with both internal and external stakeholders has taken place and that information collated. Further work is needed to write the first draft of the Strategy which is to be presented at the January RD&I sub committee.	
	Ensure active engagement with the 'Starting Well' agenda	MD	Research & Innovation Strategy	QC	'Starting Well' is a standard agenda item on the RD&I sub committee agenda. There is to be a 'Starting Well' conference in Spring 2022.	
Fully implement the CQC well-led framework throughout the Trust, achieving maximum	Achieve a well-led 'good' rating by 2021	DONM	Clinical & Quality Strategy	QC	MIAA Audit of the Trust Action Plan is progressing. The 'Must and Should do's' have been formally closed off.	

compliance and delivering the highest standards of leadership					Planning and preparation in the organisation continues.	
	Ensure all wards and key areas have ward accreditation in Q1 and 2	DONM	Clinical & Quality Strategy	QC	Work has been underway, led by the Corporate Nurse on streamlining and updating the suite of KPIs and ward/dept accreditation programme. It is anticipated that in December 2021 that the KPIs will be implemented Trust-wide. The accreditation programme will be trialled in December 2021 and thereafter rolled out through the organisation during Q4 and Q1 in 2022.	

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	***21/22/124b***		**Date: 02/12/2021**	
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 and Quality Committees since previous version presented to Board on 4 November 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.

The BAF items are aligned to the Board's assurance committees and these were reviewed and discussed during November 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
• 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
• No significant changes
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.
2.4: Major and sustained failure of essential IT systems due to a cyber attack
• No significant changes to report
3.1: Failure to deliver an excellent patient and family experience to all our service users
• No significant changes to report
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

- No significant changes to report

New Risks or Strategic Threats

Since the report was last circulated and discussed at the Board, there has not been any significant changes to report. However, in discussions at the Quality and FPBD Committees, there was agreement that the following issues would require reflection in the next significant quarterly update:

- CDC funding and delivery risks
- Half 2 2021/22 financial and operational planning risks
- Major Incident and learning

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 – December 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	FPBD	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			2.1 2.4	2.3	
4 Major		4.2 5.1	1.1 3.1 5.2	2.2	1.2 4.1
3 Moderate					
2 Minor					
1 Negligible					

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: FPBD 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 / 3	To build relationships with local community leaders and mechanisms for hearing feedback on the Trust's services	Head of Audit, Effectiveness and Patient Experience	January 2022	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	Deputy COO	January 2022	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

Trust Board

COVER SHEET

Agenda Item (Ref)	*2021/22/125*		Date: 02/12/2021	
Report Title	Emergency Preparedness, Resilience & Response Annual Assurance Report			
Prepared by	Lorraine Thomas Emergency Planning & Business Continuity Manager			
Presented by	Gary Price Chief Operating Officer / Accountable Emergency Officer			
Key Issues / Messages	***This report provides a summary of the Trust's compliance to the NHSE/I Emergency Preparedness, Resilience and Response (EPRR) Core Standards based on a self-assessment conducted October 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/N *If no – please outline the reasons for deviation.*			
	The Board are requested to note this report.			
Supporting Executive:	Gary Price Chief Operating Officer / Accountable Emergency 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* 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
FPBD	Nov 21	COO	Recommended for approval to the Board

EXECUTIVE SUMMARY

1. This report provides a summary of the Trust's compliance to the NHSE/I Emergency Preparedness, Resilience and Response (EPRR) Core Standards based on a self-assessment conducted October 2021.

2. As a category 1 responder under the Civil Contingencies Act (CCA) 2004 the Trust is required to prepare for emergency and business continuity incidents and ensure that it has the capacity and capability to respond to emergency situations. Whilst managing emergency situations the Trust must as far as is reasonably practicable maintain continuity of services, prioritising critical service delivery when necessary.

3. The NHSE/I EPRR Core Standards support the requirements of the CCA and are utilised as an audit tool to measure compliance rates for NHS funded organisations. The NHSE/I EPRR annual assurance process for 2021/22 took the form of a self-assessment against the EPRR Core Standards including additional 'deep dive' criteria.

4. The Trust achieved a rating of substantial compliance against the NHSE/I EPRR Core Standards for 2021/22.

5. An action plan is in place to support monitoring and implementation of outstanding core standards and deep dive criteria.

MAIN REPORT

INTRODUCTION

NHS organisations were required to complete a self-assessment of compliance against the NHSE/I EPRR Core Standards. NHS Specialist Trusts were required to self-assess against 38 Standards. In addition, NHS organisations were required to self-assess against 7 'deep dive' criteria. For 2021/22 the deep dive criteria related to management of oxygen supplies. Compliance against the deep dive criteria does not contribute to the overall compliance rating.

The NHSE/I EPRR Core Standards assessment process was conducted by the Emergency Planning and Business Continuity Manager in consultation with the Accountable Emergency Officer. Responses were based on activities monitored and implemented via the EPRR Committee. EPRR Committee standing agenda items, including development and revision of emergency and business continuity plans and arrangements, delivery of training and monitoring of the EPRR risk register directly support the EPRR annual assurance requirements.

ANALYSIS

Of the 38 EPRR Core Standards applicable to Specialist NHS Trusts the Trust met 34 standards with a rating of 'Green'. Four standards were partially met and therefore rated as 'Amber'. Based on this outcome the Trust submitted an overall rating to NHSE/I of 'Substantial Compliance' against the EPRR Core Standards for 2021/22. The deep dive standards were assessed with a rating of amber. On

conclusion of the national assurance process which includes facilitation of a confirm and challenge process conducted by NHSE/I, the Trust will receive confirmation of the assessment outcome.

Please see Appendix 1 for the Statement of Compliance.

CONCLUSION

An integral part of the EPRR annual assurance process is the development of an action plan to ensure achievement of compliance against any outstanding core standards. Actions have been identified and submitted to NHSE/I NW and have be formulated into an action plan including actions to support the deep dive criteria. The action plan (Appendix 2) will be monitored via the EPRR Committee.

EPRR activities going forward will focus on meeting the outstanding core standards and deep dive criteria and aim to maintain a high level of compliance to the NHSE/I EPRR Core Standards 2022/23 and other EPRR audits and assurances.

The EPRR annual assurance outcome of 'Substantial Compliance' against the NHSE/I EPRR Core Standards demonstrates the Trust remains focused on continuing to meet its duties under the Civil Contingencies Act 2004.

RECOMMENDATION

The Board is requested to note this report.

Cheshire and Merseyside Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance 2021-2022

STATEMENT OF COMPLIANCE

The Liverpool Women's Hospital NHS Foundation Trust has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool v1.0

Where areas require further action, the Liverpool Women's Hospital will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Substantial compliance against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

Number of applicable standards	Standards rated as **Red**	Standards rated as **Amber**	Standards rated as **Green**
38	**0**	**4**	**34**
Acute providers: **46** Specialist providers: **38** Community providers: **37** Mental health providers:**37** CCGs: **29**			

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.

Signed by the organisation's Accountable Emergency Officer

30/09/2021

Date signed

22/11/2021	02/12/2021	30/05/2022
Date of Board/governing body meeting	Date presented at Public Board	Date published in organisations Annual Report

EPRR Core Standards Action Plan 2021-22

October 2021

EPRR Core Standards							
No	**Standard**	**Compliance**	**Status**	**Action**	**Progress**	**Responsibility**	**Target Date**
1	**Governance / Senior Leadership**		EPRR AEO identified. EPRR Committee meets regularly. EPRR Reports submitted to Board.	Non-executive board member or suitable alternative to be identified to support AEO role.		Gary Price Chief Operating Officer	March 2022
20	**Shelter & Evacuation Procedures**		The Trust Evacuation Strategy is currently under review by Fire Safety Advisors due to change to fire strategy. The Trust has delivered simulation exercises to test evacuation procedures. Trained Fire Wardens in place (x116)	Trust Evacuation Strategy to be approved. Fire Simulation of Neonatal Unit Further Fire Wardens to be trained to ensure across site cover.		Fire Safety Advisors Fire Safety Advisors Tracy Bryning Health & Safety Manager	December 2021 December 2021 March 2022
53	**BCP Audit**		The Trust has a process for internal audit. A BCP audit has not been completed for 2020-21.	BCP Audit to be completed		Lorraine Thomas via EPRR Committee	December 2021

68	**CBRN / HazMat Awareness & Training**		Management of patients involved in CBRN incidents including the requirement for isolation detailed within CBRN /HazMat Plan. Plan includes Action Cards to support key roles. Designated CBRN /HazMat decontamination room.	CBRN / HazMat Plan / Action Cards - awareness raising		Lorraine Thomas Linda Martin Patient Facilities Manager	December 2021

October 2021

EPRR Core Standards - Deep Dive – Medical Oxygen Supply Criteria							
No	**Standard**	**Compliance**	**Status**	**Action**	**Progress**	**Responsibility**	**Target Date**
1	**Medical gasses - governance**		Medical Gasses Policy states responsible committee is Medicines Management Committee/Safety Senate and includes key responsibilities. Safety Senate provides point of escalation for any issues with medical oxygen supplies.	Develop and implement oxygen management action plan including specific actions to be monitored via Estates with oversight via EPRR Committee.		Paul Aitcheson Estates Manager	March 2022
2	**Medical gasses - planning**		Liquid stock levels are remotely monitored by BOC automated system to minimum agreed levels based on usage. During potential escalation situations BOC would provide additional deliveries.	Develop and implement oxygen management action plan including specific actions to be monitored via Estates with oversight via EPRR Committee.		Paul Aitcheson Estates Manager	March 2022
3	**Medical gasses - planning**		Agreed levels of liquid oxygen maintained in VIE. Staff trained in accepting cylinder deliveries. VIE de-iced	Develop and implement oxygen management action plan including specific		Paul Aitcheson Estates Manager	March 2022

			weekly or as required. PPM 6 monthly schedule on VIE and reserve manifold from BOC including the alarms.	actions to be monitored via Estates with oversight via EPRR Committee.			
4	**Medical gasses - workforce**		Authorised Person in place with 2nd second AP available via SLA with LUHFT. Competent Persons x3 within the Estates Department. Trained designated Porters for deliveries. Quality Control Pharmacist available via LUHFT (Quality Control North West).	Develop and implement oxygen management action plan including specific actions to be monitored via Estates with oversight via EPRR Committee.		Paul Aitcheson Estates Manager	March 2022
5	**Oxygen systems - escalation**		Oxygen levels monitored and submitted during Covid 19 response oxygen demand was noted to reduce. Additional liquid and cylinder deliveries are available via BOC order line.	Develop and implement oxygen management action plan including specific actions to be monitored via Estates with oversight via EPRR Committee.		Paul Aitcheson Estates Manager	March 2022
6	**Oxygen systems**		Orginal as fitted drawings and service reports in place.	Develop and implement oxygen management action plan including specific		Paul Aitcheson Estates Manager	March 2022

				actions to be monitored via Estates with oversight via EPRR Committee.			
7	**Oxygen systems**		Oxygen daily usage monitored and submitted during the pandemic. This was found to be reduced against pre pandemic normal levels.	Develop and implement oxygen management action plan including specific actions to be monitored via Estates with oversight via EPRR Committee.		Paul Aitcheson Estates Manager	March 2022