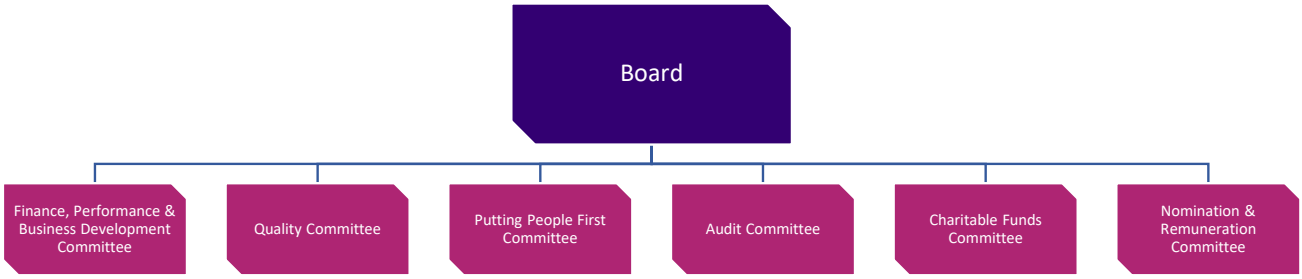
Liverpool Women's
NHS Foundation Trust

Trust Board

3 February 2022, 09.30am
Virtual Meeting, via Teams



Liverpool Women's
NHS Foundation Trust

Trust Board

Location	Virtual Meeting
Date	3 February 2022
Time	9.30am

AGENDA					
Item no. 21/22/	Title of item	Objectives/desired outcome	Process	Item presenter	Time
PRELIMINARY BUSINESS					
153	Introduction, Apologies & Declaration of Interest	Receive apologies & declarations of interest	Verbal	Chair	0930 (5 mins)
154	Meeting Guidance Notes	To receive the meeting attendees' guidance notes	Written	Chair	
155	Minutes of the previous meeting held on 6 January 2022	Confirm as an accurate record the minutes of the previous meeting	Written	Chair	
156	Action Log and matters arising	Provide an update in respect of on-going and outstanding items to ensure progress	Written	Chair	
157	Patient Story	To receive a patient story	Verbal	Chief Nurse & Midwife	0935 (25 mins)
158	Chair's announcements	Announce items of significance not found elsewhere on the agenda	Verbal	Chair	1000 (5 mins)
159	Chief Executive Report	Report key developments and announce items of significance not found elsewhere on the agenda	Written	Chief Executive	1005 (10 mins)
QUALITY & OPERATIONAL PERFORMANCE					
160a	Quality & Operational Performance Report	For assurance – To note the latest performance measures	Written	Chief Operating Officer	1015 (70 mins)
160b	CNST Assurance • **Saving Babies Lives – Biannual Update** • **Perinatal Surveillance Dashboard Quarterly Update**	For assurance	Written	Chief Nurse & Midwife	
160c	Birthrate Plus / Maternity Staffing	For approval	Written	Chief Nurse & Midwife	
160d	Learning from Deaths – Quarter 2 2021/22	For assurance	Written	Medical Director	

160e	Chair's Reports from the Quality Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	
BREAK – 10 mins					
Board Thank You – 5 mins					
PEOPLE					
161a	Workforce Performance Report	For assurance – To note the latest performance measures	Written	Chief People Officer	1140 (30 mins)
161b	Vaccination as a Condition of Deployment (VCOD)	For assurance	Written	Chief People Officer	
161c	Chair's Reports from the Putting People First Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	
FINANCE & FINANCIAL PERFORMANCE					
162a	Finance Performance Review Month 9 2021/22	To note the current status of the Trust's financial position and review approval requests	Written	Chief Finance Officer	1210 (25 mins)
162b	Chair's Reports from the Finance, Performance and Business Development Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	
162c	Chair's Report from the Audit Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	
162d	Chair's Report from the Charitable Funds Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	
BOARD GOVERNANCE					
163a	Green Plan	For approval	Written	Chief Operating Officer	1235 (20 mins)
163b	Well-Led Action Plan	For assurance	Written	Trust Secretary	
163c	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.*					
164	Guardian of Safe Working Hours (Junior Doctors) Quarterly Report Q1- Q3 2021/22	For assurance	Written	Chief People Officer	Consent
CONCLUDING BUSINESS					
165	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair	1255 (5 mins)

166	Chair's Log	Identify any Chair's Logs	Verbal	Chair	
167	Any other business & Review of meeting	Consider any urgent items of other business	Verbal	Chair	
Finish Time: 1300					

Date of Next Meeting: 7 April 2022

1300 - 13010	***Questions raised by members of the public***	To respond to members of the public on matters of clarification and understanding.	Verbal	Chair

Liverpool Women's NHS Foundation Trust

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 via Teams at 09.30am on 6 January 2022

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
Dr Susan Milner	Non-Executive Director / SID
Tracy Ellery	Non-Executive Director / Vice-Chair
Gloria Hyatt MBE	Non-Executive Director
Zia Chaudhry MBE	Non-Executive Director
Sarah Walker	Non-Executive Director
Tony Okotie	Non-Executive Director
Prof. Louise Kenny CBE	Non-Executive Director
Marie Forshaw	Chief Nurse & Midwife

IN ATTENDANCE

Matt Connor	Chief Information Officer
Dianne Brown	Interim Associate Director (item 145a only)
Rachel London	Deputy Director of Workforce
Nashaba Ellahi	Deputy Director of Nursing & Midwifery (item 145b only)
Dr Alice Bird	Consultant Obstetrician and Clinical Lead for Maternity (item 149 only)
Lesley Mahmood	Member of the public
Felicity Dowling	Member of the public
Peter Norris	Public Governor
Mark Grimshaw	Trust Secretary (minutes)

APOLOGIES:

Michelle Turner	Chief People Officer / Deputy Chief Executive

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 / Vice-Chair	✓	✓	✓	A		✓		A	✓	✓		
Louise Martin - Non-Executive Director	✓	✓	✓	✓		✓		✓	✓	✓		
Ian Knight - Non-Executive Director	✓	✓	✓	✓		✓	Non-member					
Tony Okotie - Non-Executive Director	A	✓	✓	✓		✓		✓	A	✓		

Prof Louise Kenny - Non-Executive Director	✓		✓	✓		A		✓	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	✓	✓		✓		✓	✓	A		
Dr Lynn Greenhalgh - Medical Director	✓	✓	✓	✓		✓		✓	✓	✓		
Zia Chaudhry – Non-Executive Director	Non-member								✓	✓		
Gloria Hyatt – Non-Executive Director	Non-member								✓	✓		
Sarah Walker – Non-Executive Director	Non-member								✓	✓		
Present (✓) Apologies (A) Representative (R) Non attendance (NA)												

21/22/	
140	**Introduction, Apologies & Declaration of Interest** The Chair welcomed everyone to the meeting. It was explained that this meeting had been convened to receive a number of time sensitive items and did not therefore include the standard monthly review items. No declarations of interest were made, and apologies were noted as above. There was agreement that item 149 'Roles and Responsibilities of the Consultant providing Acute Care in Obstetrics and Gynaecology – Summary of Workforce Report' would be taken out of the consent agenda and instead subject to Board discussion.
141	**Meeting guidance notes** The Board received the meeting attendees' guidance notes.
142	**Minutes of the previous meetings held on 2 December 2021** Subject to the following amendments, the minutes of the Board of Directors meetings held on 2 December 2021 were agreed as a true and accurate record: • Item 123a – 'Finance Performance Review Month 7 2021/22' o 2nd paragraph – amended to – "It was explained that the mechanism for ERF was changing in H2 2021/22, to be based on completed referral to treatment (RTT) pathway activity rather than total costed activity which was used in H1. The Trust and Cheshire & Merseyside System as a whole would need to achieve a completed referral to treatment (RTT) pathway activity above a 2019/20 89% threshold to achieve ERF payment. It was noted that there was a risk to this delivery, particularly taking into account winter pressures across the system. o 5th paragraph – amended to – "The Chair queried whether the change in mechanism for the ERF funding was beneficial for the Trust and whether the risk profile had changed. The Chief Finance Officer stated that the mechanism did not take into account levels of complexity which would be negative for the Trust, with an average pathway price in place regardless of complexity, in a change from H1. Whilst the change to being based on RTT would make the threshold theoretically easier to achieve were the Trust a standalone organisation, there was significant risk that Cheshire & Merseyside as a whole would not be able to achieve the 89% of 19/20. o 7th paragraph – first sentence amended to – "The Chief Executive suggested that it would be useful to reflect on the spend that had been committed to meet emergent issues and whether this could have been avoided or reduced with better financial planning within the Family Health Division"

143	**Action Log and matters arising** Discussions were held on the following actions: • 21/22/88c – Noted that this had been marked as 'complete' due to the issue in question being tabled for receipt in a Board development session scheduled for 6 January 2022. Due to operational pressures, this session had been postponed and therefore the action remained open. • 21/22/72a – Noted that the issue relating to the Trust's approach to developing flexible working for staff needed to be received by the future Putting People First Committee.
144	**Chair and CEO announcements** The Chair noted congratulations for Prof. Louise Kenny who had been awarded a CBE for services to research in the NHS. The Chief Operating Officer provided an outline of the operational challenges that the Trust had experienced over the Christmas period and were anticipating over the coming weeks. It was reported that Covid-19 related staff absences had averaged 10-15 staff per day throughout the pandemic. During the previous fortnight, this had increased to over 100 staff per day. The Trust had enacted business continuity plans and enhanced command control processes and oversight. This had included the cancelling of non-essential services and the redeployment of staff where appropriate in line with the *in extremis* staffing plans. Community midwives had been consolidated into community hubs rather than operating out of individual GP practices. The pace of the Omicron wave had been unprecedented, and the Trust had taken part in wider systems calls, participating in responding to requests for mutual aid. The offer from the Trust particularly related to gynae-oncology patients. The Chief Executive added that the average number of Covid-19 positive patients on site had increased from approximately one per day to an average of 10. These patients required staff to don additional Personal Protective Equipment (PPE), adding to the operational challenges. Non-Executive Director, Tracy Ellery, queried if there had been any issues with PCR testing. The Chief Nurse & Midwife noted that there had been an increase in demand which had necessitated a rapid quality improvement process, resulting in the Trust moved to a self-swabbing approach which had improved efficiency. The Chair asked if there was confidence that there was sufficient resilience in core services should the situation deteriorate further. The Chief Operating Officer noted that the Trust's elective programme had continued, and this could be reduced to provide capacity elsewhere in the organisation if required. The Board noted the Chair and CEO update. *Dianne Brown joined the meeting*
145a	**Major Incident Update** The Board received an update on the learning and ongoing actions from the major incident which occurred in November 2021. It was noted that there had been positive feedback received from all stakeholders in relation to the Trust response to the major incident. It was reported that there had been immediate and ongoing support from system partners, across health, social care, Merseyside Police, Merseyside Fire and Rescue and the Regional Counter Terrorism Unit. Following de-escalation of the major incident, oversight and governance of the incident had been managed through the Restoration and Recovery Group. Immediate and longer-term actions identified through learning events which had engaged with over 60 Trust staff directly

	involved, and all staff through an 'all staff' survey. It was highlighted that no formal complaints had been received to the Trust from patients or their families. One informal concern had been addressed by the Chief Nurse & Midwife personally. The Trust had reported into a regional debrief led by the NHSE/I Regional EPPR Lead held on the 13.12.2021. The Interim Associate Director continued to outline the immediate actions taken and highlighted that there were three main areas of focus for on-going actions: • Security • Communication • Major Incident Policy review and testing. Assurance was provided on the mechanisms in place for sharing learning and embedding change. Non-Executive Director, Dr Susan Milner, sought further clarification on the proposal to increase the security resource on site, particularly in terms of whether this would provide a value for money solution. Non-Executive Director, Louise Martin, added caution that increasing security staffing numbers was not always the best way to improve the security of a site and queried whether technological solutions had also been explored. The Interim Associate Director confirmed that independent external security advice had been sought and they had made recommendations on a range of options. The increase of security staffing was just one part of the solution but was necessary to ensure that there were sufficient staff to manage the switchboard whilst ensuring that two members of staff could attend an incident. The Board of Directors: • received the update • noted the actions taken to date in response to the incident, and • noted the approach to on-going learning and reporting. *Dianne Brown left the meeting* *Nashaba Ellahi joined the meeting*
145b	**Winter 2021 Preparedness: Nursing and Midwifery Safer Staffing** The Deputy Director of Nursing & Midwifery explained that on 12th November 2021, Provider Chief Nurses and Trust Single Point of Contact (SPOCS) were sent the BW1068 – Staffing Assurance framework for Winter 2021 preparedness to review and consider. The accompanying request was for Trust SPOCS to share the publication with Trust Boards to support Trust Board members in their collective responsibilities for workforce planning, practice, and safeguards. The Deputy Director of Nursing and Midwifery had led a review of the publication to enable a comprehensive Trust position to be captured (Appendix 5 of the report). This review was supported by the Heads of Nursing, Midwifery and AHP with contribution from Workforce, Risk and Governance, Emergency Planning Manager, Deputy Director of Operations and Trust Secretary. Following the completion of the document, two areas of further development had been identified: • The need to undertake an annual review and refresh of Business Continuity Plans in line with the cycle of business in emergency planning. • For the Quality Committee to receive information on system wide solutions in place to mitigate risks to patients due to staffing challenges. The Chair noted that the Trust's staffing preparedness plans were currently being heavily tested and queried if the relevant learning was being identified and captured. The Deputy Director of Nursing & Midwifery confirmed that staffing was monitored formally twice a day and was part of an on-going

	process in which pinch points were identified and staff redeployed / agency staff deployed as required. This process was in constant review and refinement. Non-Executive Director, Dr Susan Milner, suggested that the redeployment of staff could have a deleterious impact on staff morale and queried whether action was in place to mitigate this. The Deputy Director of Nursing & Midwifery asserted that how the Trust conducted itself when asking staff to be redeployed was vital as was the 'welcome' provided when staff joined the new ward. The Board of Directors: • Noted the assurances provided within the report. *Nashaba Ellahi left the meeting*
146	**Wellbeing Pledge – Action Plan** The Deputy Director of Workforce reminded the Board that there had been agreement in November 2021 to commit to an NHS Employers North West pledge to shift the wellbeing focus from the 5% sickness to the 95% attendance. The actions underpinning this pledge were outlined within the report. Non-Executive Director, Louise Martin, stated that the Trust was effective in making externally contracted staff feel part of the organisation, and suggested that these efforts should be recognised within the Trust wellbeing offer. It was asserted however, that more actions could be taken to improve the wellbeing offer for staff who did not work at the Crown Street site e.g. community based staff. Non-Executive Director, Gloria Hyatt, queried if diversity and inclusion had been considered as factors to the wellbeing offer. The Deputy Director of Workforce confirmed that the content in the paper related in the main to the response to the requirements of the NHS Employers North West pledge but noted that the Trust had other actions underway to improve the experience of work for staff with protected characteristics. Non-Executive Director, Zia Chaudhry, highlighted that there was a significant focus on wellbeing activities for maternity staff and asked whether this could leave other areas feeling aggrieved. It was acknowledged that there was a focus on maternity staff, but it was asserted that there was a specific need in this area that required a pro-active approach. The Chief Executive stated that often the most influential factor on an individual's wellbeing at work was their relationships with their direct team and line manager. **Chair's Log: For the Putting People First Committee to receive an update on the progress with wellbeing actions, particularly those that provide guidance for line managers to support their direct reports.** The Board of Directors: • Agreed that the wellbeing achievements to date and proposals fulfilled the action plan requirements for the NHS England North West Wellbeing Pledge
147a	**Approval of the Liverpool Women's NHS Foundation Charitable Trust Annual Report and Accounts 2020/21** The Chief Finance Officer reported that the Charity Annual Report and Accounts for the 2020/21 financial year were reviewed by the Charitable Funds Committee on the 13 December 2021. The Charitable Funds Committee had recommended their approval by the Trust Board in its role as Corporate Trustee of the charity.

	It was noted that there had been minimal changes to the documents since review by the Charitable Funds Committee, but any amendments had been detailed in the covering report. Key headlines for the 2020/21 year were noted as follows: • There has been an increase in the Investments value compared to the prior year, which had largely been due to the unrealised gain on investments of £141k. • Work progressed to reduce the debt owed between the charity and the Trust and this would continue during 2022/23 to a position of total close out. • The proportion of spend on overheads was being reviewed with a view to reducing this where possible. The Chair highlighted that 'neonatal services' was missing from the list of Trust services in the Chair's Introductory statement in the Annual Report. It was confirmed that this would be amended ahead of submission. Non-Executive Director, Gloria Hyatt, noted that the Annual Report could be improved by including increased reference to the impact of charitable fund investments. The Chief Finance Officer confirmed that this would be taken into account for the 2021/22 report. Non-Executive Director, Tracy Ellery, confirmed that the timetable of producing the Charity's Annual Report and Accounts would be brought forward to be closer to the year-end point. The Board of Directors: • Approved the 2020/21 Charitable Funds Annual Report and Accounts in its role as the Corporate Trustee of the Charity • Noted that the Charitable Funds Annual Report and Accounts would be filed with the Charity Commission for England and Wales before the deadline of the 31 January 2022.
147b	Community Diagnostic Centre Update & Mobile CT Proposal The Board received a general update on progress with implementing the Community Diagnostic Centre (CDC) and a proposal for the hiring of a mobile CT scanner in February / March 2022 for a 9-month period. The Chair sought assurance on how the proposals regarding the establishment of the CDC were being formulated. The Chief Finance Officer reported that expert advice was being sought from Liverpool University Hospitals NHS Foundation Trust and from the imaging network. Individuals from these organisations were engaging with the Trust's architects and contractors. It was noted that patients and the public would also be engaged with ahead of the finalisation of the finish and artwork in the centre. Once formed, proposals were considered by the Crown Street Enhancement Board and decisions escalated in line with standing financial instructions where necessary. The Chair queried if there will be a separate entrance for non-Trust patients accessing the CDC. It was confirmed that access would be through the main Crown Street entrance but once in the centre, there would be no patient mixing. Non-Executive Director, Dr Susan Milner, queried if there were any anticipated issues with car parking with additional patient groups accessing the site. It was confirmed that options involving the Mulgrave Street car park were being explored. Dr Susan Milner suggested that different patient groups accessing the Crown Street site could change the perception of the building as a women's hospital and asked if this had been considered. The Chief Finance Officer noted that the CDC would be clearly branded as a separate entity to the Trust and would have its own identity. The Chief Executive acknowledged that it would be worthwhile exploring the equality aspects of accessing the Crown Street site and the potential impact of the CDC on this aspect. The Chief Finance Officer continued to outline the rationale for procuring a mobile CT scanner for a temporary period. The Chair queried if the risk ownership of the CDC including aspects such as the

	management of appointments had been considered. The Chief Finance Officer explained that whilst not all risks relating to the CDC could be fully mitigated, it remained the correct option for Trust patients, local community, and wider system. Work continued with partners on developing effective patient pathways. Non-Executive Director, Zia Chaudhry sought clarification on the reasons behind the CDC not being open out of regular hours. The Chief Finance Officer explained that this was due to staffing availability, but it remained a longer term aim to provide out of hours availability. The Board of Directors: • noted the overall progress in delivering the CDC, including the work which had taken place to finalise the MRI design. • noted the risks in respect of agreeing pathways and referrals and the dependency on partner organisations to ensure capacity was fully utilised • approved a cost envelope of up to £850k to enable hiring a mobile CT scanner in February/March 2022 for a 9-month period and noted that the final decision to progress with the mobile CT would be taken by the CDC Oversight Group on 14 January 2022, subject to the following: o Successful confirmation of appropriate reporting arrangements and sufficient demand from referring organisations, and; o Receipt of refreshed quotations in line with or lower than the approved funding envelope.
148	Cyber Security Update The Board received an update regarding the recently identified high severity cyber security known as Apache Foundation Log4j 2 vulnerability (CVE-2021-44228 / CC-3989). The Chief Information Officer explained that a vulnerability has been found within "Log4j". Log4j was used by software developers as they created applications and to process logs of activity on systems. It was embedded into many systems that may have been developed internally by local and national NHS organisations as well as systems developed by many different suppliers. The Chief Information Officer outlined the action the Trust had taken following the identification of the vulnerability and the Trust had responded to the direction provided by NHS Digital. The Chair queried if there would be any resource issues in the Trust's efforts to respond to the identified vulnerability. The Chief Information Officer confirmed that existing systems and processes were being utilised and to date, the response had been effective and in line with national requirements. The Board of Directors: • noted the assurance on the remediation approach and steps taken by the Trust. *Dr Alice Bird joined the meeting*
149	Roles and Responsibilities of the Consultant providing Acute Care in Obstetrics and Gynaecology – Summary of Workforce Report The Board received the report that summarised the obstetric elements of the consultant workforce report published by the Royal College of Obstetricians & Gynaecologists (RCOG) in June 2021. The report detailed the wide-ranging roles and responsibilities of the obstetrics and gynaecology consultant. It was noted that the Family Health Division was working towards full compliance against the recommendations in the report and this would be supported by the introduction of twilight shifts from April 2022 (corrected from 2021 noted in the report) and 24/7 resident obstetric consultant cover. It was explained that Safety Action 4 of the NHS Resolution Maternity Incentive Scheme (Year 4) required the obstetric consultant and maternity senior management teams to

	acknowledge and commit to incorporating the principles outlined in the RCOG workforce report into the service. Non-Executive Director, Prof. Louise Kenny, sought clarification on whether the Trust had previously implemented twilight shifts and stopped. The Consultant Obstetrician and Clinical Lead for Maternity explained that the Trust had undertaken a pilot of implementing twilight shifts and 24/7 cover but noted that it had been challenging to accurately report the impacts and manage the rota. Improved informatics was now in place, together with an increased number of consultants so it was expected that the implementation of twilight shifts would now have a greater chance of success. Challenges remained with the implementation of 24/7 consultant cover due to staffing numbers. There was agreement that the Putting People First Committee would review the staffing requirements and potential issues of implementing twilight shifts and 24/7 consultant cover. The Chief Executive added that an investment plan was in place as part of the Future Generations strategy to increase the number of consultants. **Chair's Log: For the Putting People First Committee to explore the potential staffing barriers to implementing obstetric twilight shifts and 24/7 consultant cover.** Non-Executive Director, Louise Martin, requested that future iterations of the report provide a clearer outline of the Trust's level of compliance against the RCOG recommendations. The Board of Directors: • Received and noted the report • Noted that an update on the report would be provided to the Board in six months (September 2022).
150	**Review of risk impacts of items discussed** The Chair identified the following risk items and positive assurances: Risks: • Continued operational and staffing pressures resulting from the most recent Covid-19 wave. On which the Board noted its thanks for the dedication and flexibility of all staff and leaders and the hard work put in to manage the situation. • On-going challenges with staff wellbeing, and the need to continue to support leaders at all levels.
151	**Chair's Log** The following Chair's Logs were noted: • For the Putting People First Committee to receive an update on the progress with wellbeing actions, particularly those that provide guidance for line managers to support their direct reports. • For the Putting People First Committee to explore the potential staffing barriers to implementing obstetric twilight shifts and 24/7 consultant cover.
152	**Any other business & Review of meeting** None noted. The meeting had been effective at giving Directors opportunity to examine a smaller number of agenda items and gave rise to some reflection on the focus and time allocations for future meetings. **Review of meeting** No comments noted. The Chair closed the meeting and provided an opportunity for members of the public to ask questions of the Board.

Liverpool Women's
NHS Foundation Trust

Action Log

Trust Board - Public
February 2022

Key	Complete	On track	Risks identified but on track	Off Track

Meeting Date	Ref	Agenda Item	Action Point	Owner	Action Deadline	RAG Open/Closed	Comments / Update
2 December 2021	21/22/121f	Integrated Governance Assurance Report 2021/22 – Quarter 2	For the Board to receive a report on the work to mitigate the blood sampling errors issue.	Medical Director	Apr 22	On track	
2 December 2021	21/22/121e	Perinatal Quality Assurance	Board to receive an overview of the CNST Year 4 Assurance process at its February 2022 meeting.	Chief Nurse & Midwife	Feb 22	Complete	Included as item 160b.
2 December 2021	21/22/121a	Quality & Operational Performance Report	To ensure that the narrative in the Safe Staffing section provides context to explain any potential or perceived anomalies.	Chief Nurse & Midwife	Feb 22	Complete	Included in item 160a
2 December 2021	21/22/118	Patient Story	For the Board to receive an overview of the work being undertaken by the Patient Experience Matron in April 2022.	Chief Nurse & Midwife	April 22	On track	
2 December 2021	21/22/118	Patient Story	For the Board to receive an Endometriosis Service update in February 2022.	Medical Director	Feb 22	Complete	To be provided as part of the patient story in the February 2022 Board.
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	March 22	On track	On the agenda for the March 22 Board Development Session. Initial report received by January FPBD Committee.

Liverpool Women's NHS Foundation Trust

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	
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	March 22	On track	The Trust is involved in a programme with NHSI/E to support this aim. Update to be provide to the March 22 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	Proposal for target / method of reporting to be outlined at the meeting.

Chair's Log

Received / Delegated	Meeting Date	Issue and Lead Officer	Receiving / Delegating Body	Action Deadline	RAG Open/Closed	Comments / Update
Delegated	06.01.22	To explore the potential staffing barriers to implementing obstetric twilight shifts and 24/7 consultant cover. Lead Officer: CPO	PPF	March 2022	On track	
Delegated	06.01.22	To receive an update on the progress with wellbeing actions, particularly those that provide guidance for line managers to support their direct reports. Lead Officer: CPO	PPF	March 2022	On track	
Delegated	02.12.21	To receive a review of the learning from the Major Incident and its implications for the Trust's EPRR arrangements.	FPBD	February 2022	On track	

		Lead Officer: Chief Operating Officer				
Delegated	02.12.21	To receive assurance on how capital expenditure was being mobilised. Lead Officer: Chief Finance Officer	FPBD	January 2022	Complete	Received at January 2022 FPB Committee.
Delegated	02.12.21	To receive trajectories against access targets with blockages against achievement identified. Lead Officer: Chief Operating Officer	Quality Committee and FPBD	January 2022	Complete	Received at both January 2022 Committee meetings.
Delegated	02.12.21	To maintain a regular item on their agenda to provide oversight on learning from the major incident. Lead Officer: Chief Operating Officer	FPBD	February 2022	On track	
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	Complete	Received at January's QC.

Liverpool Women's
NHS Foundation Trust

CEO Report

Trust Board
February 2022

Chief Executive Report

Executive Summary:

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

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

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

Chief Executive Report

Section A - *Internal*

Vaccine a Condition of Deployment (VCOD)
Following the amendment to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ("the 2014 Regulations"), with effect from the 1st April 2022, the COVID19 vaccination will become a condition of deployment for roles that are considered to be within scope of the regulations. The Trust has been providing multiple opportunities for staff to access a vaccine and to receive information and assurance on any particular concerns. Further information on the Trust's response and implications for the organisation are provided later in the agenda.

Liverpool Women's Hospital bereavement Support Officer Sarah Martin running for National Award
Our very own bereavement support officer Sarah Martin has been nominated for an Our Health Heroes Award in recognition of her work supporting parents and their families whose baby has died as a result of molar, ectopic, early/late miscarriage and stillbirth or just after birth.

Our Health Heroes Awards, delivered by Skills for Health, celebrates the thousands of unsung heroes working behind the scenes in the NHS. The Operational Support Worker of the Year Award 2022 is sponsored by UNISON.

Support Sarah's nomination and cast your vote for Sarah before 4th February 2022 by visiting: https://bit.ly/3EZ0kXo

Congratulations to our Employee/Team of the Month winners for December

Lee Berryman, Theatre HCA obstetrics won the award for assisting the team who responded to an emergency bleep that delivered specialised care and treatment in a difficult and an unusual setting. He constantly proves he is a very valued member of the team but he went above and beyond in numerous ways.

Testing and Surveillance Team. The response from the COVID Testing & Surveillance Door and Admin teams in supporting the response to the major incident was outstanding and they went above and beyond to support other staff and our patients and visitors to make them feel safe and secure. They worked additional hours and offered to support everywhere they could.

Review Body on Doctors' and Dentists Remuneration (DDRB) Letter

The Trust was visited by DDRB members and secretariat on 13 October 2021. A letter of thanks can be found as an appendix to this report

Robotic First

The Trust's robotic program continues to go from strength to strength and is leading to cutting edge developments for the Trust. One recent highlight has been Ms. Manou Kaur completing what we believe are the UK's first Robotic Trans Abdominal Cerclages on the 20.1.22. It is great to see the ambition and drive from everyone to embrace & deliver the benefits of Da Vinci surgery to our patients.

Chief Executive Report

Section A - *Internal*

Charity Update

Bollywood Dinner 26th March 2022
The fantastic group "Women Conquering Cancer" are hosting a Bollywood Dinner @ the Florrie to raise funds to support the purchase of the Mona Lisa Laser. The Laser will provide a new treatment for women suffering from menopausal symptoms. If you would like to show your support please book using the following Eventbrite link: https://www.eventbrite.co.uk/e/214768316817

It will be a fantastic evening.

Abseil Anglican Cathedral 9 & 16 July 2022
We need your help ! We have secured 20 places for our staff to fundraise for Liverpool Women's Hospital Charity, by abseiling down the Anglican Cathedral. If you have ever wanted to do this, now is the time, you will be ably supported by professionals from Pennine Events and you will have a fantastic experience. Please email: fundraising@lwh.nhs.uk to secure your place – first come first served.

We have 2 days available, on the 9 July – 16 July.

Fashion Show 14th of April 2022
On Thursday the 14th of April we are hosting a fashion show, organised by Paula Johnson of Sparkle Studios Boutique, hosted by comedian Pauline Daniels. Money raised will contribute towards the Gynaecology Unit fund to refurbish the Mulberry and Orchid palliative care rooms. We are in need of 3-5 more people to volunteer to model an outfit each for this event, this could be LWH staff members, volunteers, past patients or support group members – anyone willing to get involved for a good cause.

Please contact Hattieella.brignal@lwh.nhs.uk for details.

There will be food, drinks, music and laughter – all for a very good cause! Ticket sales to be announced soon, keep an eye on our social media.

Section B - *Local*

Improving hospital stroke care

The NHS in Knowsley, Liverpool, South Sefton, Southport & Formby, and West Lancashire has been looking at how it can improve local hyper-acute stroke services – 'hyper-acute' is the care you receive in the first 72-hours after having a stroke. Between 22 November 2021 and 14 February 2022, Liverpool CCG are holding a public consultation about proposals for a Comprehensive Stroke Centre at Aintree University Hospital, which would bring together the hyper-acute care currently provided at Aintree, the Royal Liverpool, and Southport hospitals.

For more details about these proposals and why they are being made, please read **this information booklet**

You can share your views by filling out this questionnaire: **https://www.smartsurvey.co.uk/s/SB2ZWZ/**

Walton Centre Board Appointments

Professor Paul May and Ray Walker began in their posts early in the New Year.

Professor May has recently retired from The Walton Centre, where he spent 30 years as a Consultant Neurosurgeon. He remains the National Clinical Lead for Adolescent and Paediatric Neurosurgery in the GIRFT programme too.

Mr Walker, who is a Registered Nurse, has over 40 years' experience working in a diverse number of roles including the NHS and Higher Education. He has held a number of senior positions including Chief Nurse for the North of England at Health Education England.

Cheshire & Merseyside Radiology Imaging Network Newsletter

The January 2022 edition can be found on the following link - CAMRIN - Cheshire & Merseyside Health & Care Partnership (cheshireandmerseysidepartnership.co.uk)

Section B - *Local*

Stakeholder Update from Graham Urwin, CEO of Cheshire and Merseyside Health & Care Partnership

Key points from the update provided on 23 December 2021, outlined below:

- Go-live date for Integrated Care Boards has been delayed to 1 July 2022
- Delay does not affect the priorities and the actions underway to achieve a smooth transition of staff and functions. Work towards organisational redesign will continue at pace.
- Latest step towards developing NHS Cheshire and Merseyside Integrated Care Board has seen four key leadership roles advertised: Assistant Chief Executive Officer; Director of Performance and Planning; Chief People Officer; and Director of Communications and Empowerment
- Focus remains on four broad priorities:
    - Delivering today, including our Covid response, mass vaccination programme and transition to a statutory Integrated Care Board
    - Recovery and restoration of our services so we continue to provide health and care to everyone who needs it
    - Collaboration and integration – working together with all our partners to do more for our population
    - Tackling inequalities and influencing the wider determinants of health so we can prevent ill-health wherever possible
- In the process of making permanent senior appointments to the Integrated Care Board, including executive and non-executive directors. Recruitment to the position of Independent Chair is also now under way and they will soon begin appointing to the key positions of the nine place leads. Stakeholders are involved with the process for all appointments and the place leads will either be joint appointments with the local authority or, where this is not yet possible, appointments will be made to the ICB with local authority input to the decision.

The January 2022 edition of 'Connect' the C&M HCP publication can be found on the following link: https://issuu.com/cheshireandmerseysidehcp/docs/connect_44

Vice-Chancellor announces retirement from December 2022

On 4 January 2022, Professor Dame Janet Beer, Vice-Chancellor of the University of Liverpool, announced that she will be retiring from her role in December 2022. An outstanding researcher in the field of late 19th and early 20th century American literature and culture, and an established leader in the higher education sector nationally, Professor Beer joined the University in February 2015 as its first woman Vice-Chancellor.

Under her leadership, the University has made enormous progress in the representation of women at senior levels in the organisation. 64% of the University's Senior Leadership Team and 44% of senior leaders are now women and all academic schools and institutes have an Athena Swan award. Professor Beer has also overseen significant improvement in the University of Liverpool's work to widen student participation, working in partnership with schools and colleges to provide opportunities to huge numbers of young people from traditionally under-represented groups and low participation neighbourhoods.

The process to appoint a new Vice-Chancellor for the University of Liverpool will now commence and the intention is that an appointment will be made with ample time to ensure a smooth transition.

Section B - *Local*

LHP SPARK Shortlisted for the 2022 HSJ Partnership Awards

Liverpool Health Partners (LHP) recently announced that the LHP SPARK Response to COVID has been shortlisted for Best Healthcare Provider Partnership with the NHS at the HSJ Partnership Awards 2022.

LHP SPARK is the Single Point of Access to Research and Knowledge and is a joint research service which brings together Liverpool Health Partners' NHS and Universities research support functions to facilitate and deliver world-class health research. It acts as a single point of access for investigators and research teams. The nomination recognises the outstanding contribution to healthcare in response to COVID – in what has been an exceptional and challenging period across the sector.

In March 2020, LHP SPARK pivoted to tackle the COVID pandemic stewarding the research workforce across the eight NHS organisations with NIHR CRN North West Coast, developing efficient and streamlined single processes, reporting and shared strategic decision making. This allowed for the efficient setup and rapid recruitment to NIHR Urgent Public Health (UPH) studies, COVID vaccine studies and local strategic research.

A reflection on the previous year from LHP CEO, DR Dawn Lawson, can be found on the following link - https://liverpoolhealthpartners.org.uk/if-you-want-to-go-fast-go-alone-if-you-want-to-go-far-go-together-our-ceo-on-the-progress-of-lhp/

LHP new Chief Operating Officer, Prof. Nicola Wilson, started in her role in January 2022 – her blog post can be found on the following link - https://liverpoolhealthpartners.org.uk/who-are-we-we-are-liverpool-health-partners-read-our-new-coos-first-blog/

INTERIM REPORT - Building Back Fairer in Cheshire and Merseyside: Evidence for action and key approaches

In 2021 the Institute of Health Equity (IHE) was commissioned by the Population Health Board of the Cheshire and Merseyside Health and Care Partnership (HCP) to support work to reduce health inequalities through action on the social determinants of health and to Build Back Fairer from COVID-19.

The report can be found on the following link: https://www.cheshireandmerseysidepartnership.co.uk/wp-content/uploads/2021/12/Interim-report-Final-November.pdf

Section B - *Local*

Cheshire & Merseyside Cancer Inequality Report January 2022

Please see in appendix 2 for the second 6 monthly report on inequalities in cancer for our region for you to share at your Boards or relevant meetings.

Key messages:

- The inequality variation is more evident in referrals than for first treatments, but overall both referrals and first treatments for cancer have rebounded
- We are seeing a flattening out of the inequalities that we saw 6 months ago
- Variation in referrals are greater in men, those living in the most deprived areas and by older people
- First treatments showed no significant inequity in terms of age, deprivation, gender or ethnicity but there was variation across our places with Liverpool showing the lowest number of first treatments and Southport and Formby showing the highest level.
- There is no evidence of a statistically significant change in stage at diagnosis

Section C – *National*

Update from CQC Chief Inspectors on their regulatory approach

In an update in December 2021, the CQC confirmed that they did not currently plan to return to routine frequency-based inspections. Alongside their risk-based inspection activity the CQC will continue their ongoing monitoring of services. They'll use this to identify risk and signal where they may need to take further action to ensure that people are receiving safe care and offer support for providers.

What this means for providers
Across all services the CQC will:

- Continue ongoing monitoring of services, including a monthly review of the information they hold about a service to identify any risk to quality and safety.
- Use their independent voice to amplify the urgency for immediate support for services under pressure and for the development of new models of care. Making the case for services designed around local need so that people get the right service in the right place at the right time. Delivered by a workforce who are valued and supported.
- Prioritise registration activity where they can support the creation of extra capacity in the system.
- Use information to determine where registration activity needs to be focused.
- Deliver a more co-ordinated approach to inspecting urgent and emergency care pathways this winter. Where they identify risk they will look at how services across a system are working together. To identify improvements that could benefit people using services and staff delivering care.
- Monitor and assess where there is a risk of a closed culture developing. This includes monitoring and acting on information of concern about blanket bans on visiting. Their monitoring will also show them where they need to look at services they've had limited or no contact or information from over a period of time.

Hospital services (These include independent health and mental health services).
They will:

- Inspect services in NHS Trusts and independent health providers where there is a clear risk to safety.
- Conduct Mental Health Act (MHA) monitoring visits to ensure the rights of people are protected.
- Prioritise high risk independent healthcare services for inspection. For example, cosmetic surgery services, independent ambulance services, and those where closed cultures may exist.

Section C – *National*

NHS Planning Guidance 2022/23

NHS Planning Guidance for 2022/23 was published on 24 December 2021. The objectives set out in this document are based on a scenario where COVID-19 returns to a low level and the NHS is able to make significant progress in the first part of next year as it continues to rise to the challenge of restoring services and reducing the COVID backlogs.

Building on the progress seen during 2021/22, this means significantly increasing the number of people the NHS can diagnose, treat and care for in a timely way. This will depend on the NHS doing things differently, accelerating partnership working through integrated care systems (ICSs) to make the most effective use of the resources available across health and social care, and ensure reducing inequalities in access is embedded in the approach. As part of this, and when the context allows it, the NHS will need to find ways to eliminate the loss in non-COVID output caused by the pandemic.

Securing a sustainable recovery will depend on a continued focus on the health, wellbeing and safety of our staff. ICSs will also need to look beyond the immediate operational priorities and drive the shift to managing the health of populations by targeting interventions at those groups most at risk and focusing on prevention as well as treatment.

In light of the pressures from COVID-19, the planning timetable has been extended until the end of April 2022 and will be kept under review.

Ockenden review of maternity services – one year on

In a letter dated 25 January 2022 NHS Improvement and England have requested that the Trust discuss progress against the Ockenden Report at a public Board meeting before the end of March 2022. The discussion is expected to cover:

- Progress with implementation of the 7 IEAs outlined in the Ockenden report and the plan to ensure full compliance,
- Maternity services workforce plans

Review Body on Doctors' and Dentists' Remuneration

Review Body on Doctors' and
Dentists Remuneration
3rd Floor, Windsor House
42-50 Victoria Street
London
SW1H 0TL

Kathryn Thompson MCIPD
Chief Executive, Liverpool Women's
NHS Foundation Trust
Crown Street
Liverpool
L8 7SS
16 December 2021

Dear Kathryn,

I am writing on behalf of the DDRB and its secretariat to extend our sincere thanks to you and the team at Liverpool Women's Hospital for hosting DDRB members and secretariat for a visit on 13 October.

The discussions that were had with you and your management team, as well as medical staff at the Trust gave us essential insight into the present reality for doctors and dentists and the NHS and will be very important in helping us understand the issues that we will be discussing during the upcoming pay round.

These visits are highly valued by the Review Body as a chance to hear from its remit group directly about their experiences and concerns about pay and pay-related issues, and they provide insights into the realities of NHS working which are not always conveyed by the written evidence that the Review Body receives as part of its formal evidence-taking process. Under the present circumstances, we are particularly grateful that you accommodated us in-person, enabling DDRB members to meet with doctors and dentists face-to-face. We appreciate that everyone is very busy, and it can be difficult to secure attendees for such meetings. Please pass on our thanks to all those involved for making the visit a success, especially Jan Owen, whose support, both during, and in the run-up to the visit, was particularly valuable.

Thank you again to you and your staff for taking the time.

Yours sincerely,

Chris Pilgrim
Chair, Review Body on Doctors' and Dentists' Remuneration

Cheshire & Merseyside Cancer Alliance

Cancer Inequalities in Cheshire and Merseyside: *Second Report*

January 2022

Version 1

Contents

Section I: Introduction

Cheshire and Merseyside Cancer Alliance published its first report on the impact of COVID-19 on cancer health inequalities in July 2021. That report explored available data to assess the impact of the pandemic on suspected cancer referrals and treatments for new cancers in the 12 months following the start of the first national lockdown, analysed by geography, tumour group, age, gender, deprivation and ethnicity. It showed that there had been a significant increase in inequities particularly in relation to a reduction in referrals from the most deprived neighbourhoods and amongst the elderly.

This second report considers an additional six months' worth of data, and includes new intelligence, such as data relating to the stage of disease at the time of diagnosis, which was not mature enough to be considered in the first report. It shows that many of the inequities highlighted in the first report are still evident, but the impact is flattening out as time progresses.

This new report also looks to the future, setting out in more detail the Alliance's approach to tackling health inequalities in cancer, including those inequalities that existed before the impact of COVID-19.

The impact of COVID-19 on cancer inequalities - Summary

In Cheshire and Merseyside:

- The impact of the COVID-19 pandemic has been greater on referrals than first treatments.
- Referral and first treatment rates have rebounded and are now above pre-pandemic levels.
- However, the cumulative impact on both referrals and treatments is still evident.
- The impact upon referrals was disproportionate in terms of gender, deprivation and age:
  - Men more affected than women
  - People living in the most deprived neighbourhoods more affected than those in less deprived neighbourhoods
  - Older people more affected than younger people
- First treatments showed no significant inequity in terms of age, deprivation, gender or ethnicity.
- Routes to diagnosis have returned to pre-pandemic norms.
- There is currently no evidence of a statistically significant shift in the stage of disease at diagnosis.

Section II:

The impact of COVID-19 on cancer inequalities

Cheshire & Merseyside Cancer Alliance

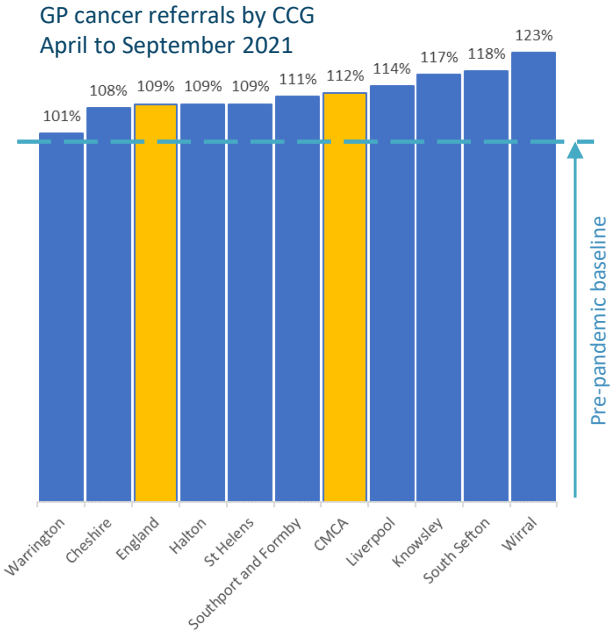
In this section we compare data relating to urgent suspected cancer referrals, treatments for new cancers, and the stage of disease at the point of diagnosis in the period immediately before the COVID-19 pandemic with data from various periods in the 18 months thereafter.

Cancer referrals

Urgent suspected cancer referrals reduced by over 70% in the first weeks of the first national lockdown but then fully recovered by September 2020. The number of patients seen following an urgent suspected cancer GP referral more recently, between April and September 2021 was 12% higher than between April and September 2019. This was a larger increase than in England as a whole, where referrals rose by 9%.

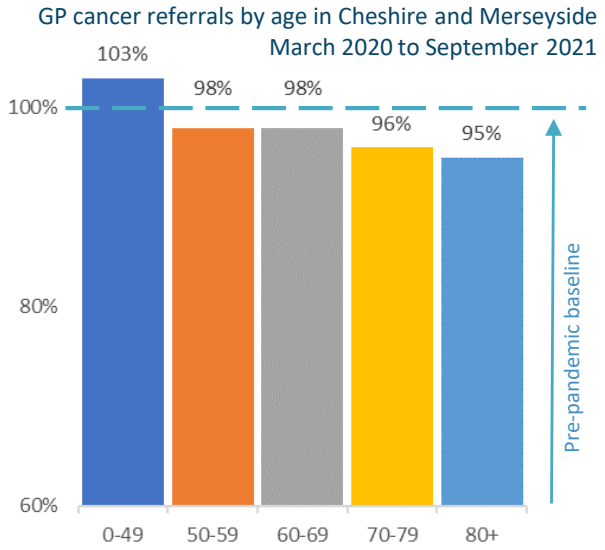
However, there was variation by CCG area, with Wirral seeing the greatest rise in referrals (23%) and Warrington witnessing little change (1% increase).

Halton CCG, which experienced the largest reduction in referrals in the first 12 months of the pandemic (between April 2020 and March 2021) of all Cheshire and Merseyside CCGs, saw referrals rise by 9% (the same as the national average) during April and September 2021 above the same period in 2019.



Variation was also seen at tumour level. Urgent GP referrals for suspected urological, lung and haematological cancers in the first six months of 2021/22 were 8 to 9% below the numbers received in the first six months of 2019/20. All other common tumour groups had referrals above pre-pandemic levels. The greatest rise in referral levels were for suspected lower and upper gastrointestinal cancers (increases of 23% and 19% respectively).

The cumulative impact of the pandemic can be seen through a comparison of the period from March 2020 to September 2021 to a pre-pandemic baseline period (using the equivalent months from March 2019 to February 2020). This shows that the impact (cumulative reduction) of referrals was greatest in the most deprived areas (Quintile 5). Referrals have now increased above pre-COVID-19 levels for all deprivation quintiles.



The cumulative impact on referrals increased with age. Between March 2020 and September 2021, referrals for patients under 50 rose by 3%, whereas there was a 5% reduction in referrals for patients 80+ compared with the pre-pandemic baseline.

Between March 2020 and September 2021 the cumulative impact on referrals for males was significantly greater than for females. Compared with the pre-pandemic baseline, male referrals fell by 5%, but female referrals rose by 1%.

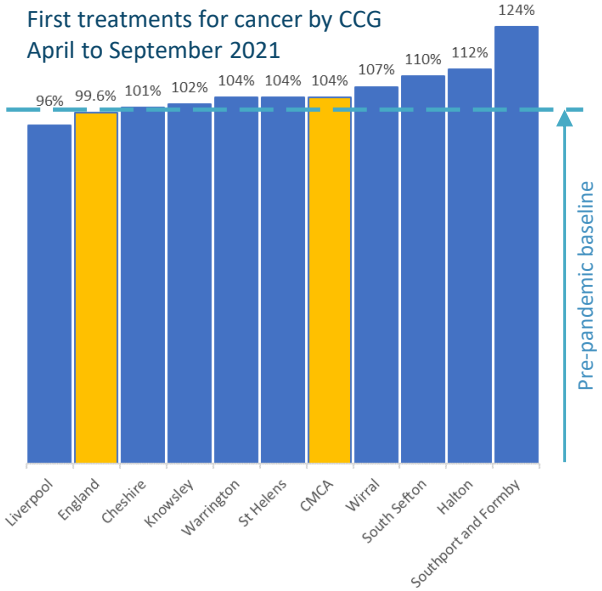
The impact of the pandemic on referrals for patients from different ethnic backgrounds is more difficult to assess due to small numbers in some communities. The cumulative impact during the period March 2020 to September 2021 was a 2% reduction in referrals for individuals identifying as white British, compared to a 3% increase in referrals for patients from diverse ethnic groups.

Whilst the impact of the pandemic is still evident in these cumulative data, referrals have now increased above pre-pandemic levels for all ages, gender, and all ethnic groups. Over time, the inequalities exacerbated by the pandemic are being flattened out.

First treatments

The number of patients treated for a new cancer in Cheshire and Merseyside was 3.9% higher in April to September 2021, compared to April to September 2019. This is in contrast to England as a whole, where the number of first treatments was 0.4% lower than before.

There was variation at CCG-level, with the greatest rise being in Southport and Formby (24%). Only Liverpool CCG saw a reduction in first treatments between April and September 2021 compared to the same period in 2019 (4% reduction).



During the same period, first treatments for skin, lower gastrointestinal and gynaecological cancers were significantly higher (21%, 16% and 9% respectively), whereas treatments for urological, head & neck and breast cancers were lower (by 5%, 4% and 4% respectively).

Cheshire & Merseyside Cancer Alliance

The referral routes leading to a first treatment between April and September 2021 were very similar to those between April and September 2019. In both periods, half of all treatments were the result of an urgent GP cancer referral. In the first few months of the crisis, most cancer screening programmes were paused, but data from April to September 2021 show that referrals from the screening programmes accounted for 7% of first treatment, which is the same proportion as was seen in 2019.

From April 2021 onwards, first treatment level have been similar to pre-pandemic levels across all deprivation quintiles. However the legacy of the early phase of the crisis can still be seen in the cumulative data from March 2020 to September 2021, which shows a disproportionate impact upon patients from the most deprived neighbourhoods. Curiously, patients from the second most deprived neighbourhoods were impacted the least. However, it should be noted that the differences between the quintiles in Cheshire and Merseyside are not statistically significant.

As of September 2021, the proportional impact of the pandemic on first treatments shows no clear pattern in relation to age, gender or ethnicity.

Stage of disease

Outcomes for patients treated for early stage cancers are significantly better than for those whose disease has progressed. The NHS Long Term Plan ambition for cancer is for 75% of cancers to be diagnosed at an early stage (stage I or II) by 2028. Nationally published staging data is currently available up to and including 2018. At that time, 53.0% of patients in Cheshire and Merseyside were diagnosed at stages I or II compared with 53.9% for England as a whole.

Unpublished, rapid cancer registration data (RCRD) is now available up to and including 2020 to NHS staff to assist with assessing the impact of the COVID-19 pandemic. These data are provisional, and have not been through the rigorous quality checks required for publication. When the Cancer Alliance produced its first report into the impact of COVID-19 in July 2021 the RCRD was too incomplete to be appropriately interpreted. Six months on, the dataset has matured and, albeit tentatively, conclusions can be drawn.

RCDC data for Cheshire and Merseyside suggest that the proportion of patients diagnosed at an early stage in 2020 was statistically similar to 2018 and 2019.

Section III:

Our approach to addressing cancer inequalities in Cheshire and Merseyside

Cheshire & Merseyside Cancer Alliance

Cheshire & Merseyside Cancer Alliance brings together organisations, patients and others affected by cancer to drive improvements in clinical outcomes and patients' experience of the care and treatment they receive.

We aim to achieve:

- **Better cancer services**, by providing access to expertise and learning; leading change in care pathways, and in piloting new scientific innovations.
- **Better cancer care**, by sharing and building on good patient experience practice.
- **Better cancer outcomes**, by increasing early detection, early diagnosis, enabling early access to cancer services and pathways, and ensuring cancer patients have access to the support they need to live long fulfilling lives beyond cancer.

To achieve these three aims it is essential that we are focussed on, and committed to, addressing health inequalities on all levels.

We know that there are health inequalities when comparing Cheshire and Merseyside's cancer outcomes with other regions in England. Our population has higher rates of cancer incidence and mortality that the England average, and there is a need to speed up our rate of improvement to close the gap. We also know that there are inequalities within our own population, with deprivation being not the only, but probably the biggest, pre-existing (i.e. pre-COVID) cause of variation.

Over the course of the last 18 months, the Cancer Alliance has developed its thinking and approach to addressing inequalities. We are now clear that we will not close the gap by simply addressing inequalities at the point of access to health services, as has been, perhaps, the traditional NHS approach. We need to work with communities and partner organisations to address – indeed prevent – inequalities upstream, as well as when they are observed in NHS services.

With support from Macmillan, the Cancer Alliance has established a new team focussing specifically on patient experience and health inequalities. The team members are facilitators, supporting and enabling others to identify and resolve inequalities, rather than being solely responsible themselves. This approach will help to embed a culture of awareness throughout the Alliance's work programme. Ultimately, all decisions that the Alliance makes on the deployment of resources should be made on the basis of reducing inequity.

WE ARE MACMILLAN. CANCER SUPPORT

Improvement is all about partnerships. Coordinated action, based on sound evidence and informed by people from within the communities themselves, is key. The Alliance works closely with the Directors of Public Health through the Champs Public Health Collaborative, and is a key stakeholder in developing the C&M Marmot Community.

Marmot Community

In 2021, University College London's Institute of Health Equity, headed by Professor Sir Michael Marmot, was commissioned by the Cheshire and Merseyside Health & Care Partnership and the Directors of Public Health to support the reduction of health inequalities through action on the social determinants of health.

Cheshire and Merseyside Cancer Alliance has been closely involved in the development of the Marmot Community from the outset and is represented on the Advisory Board.

The Community involves organisations outside the health care system which have an impact on health – including local government, public services, business, the voluntary and community sector, and the public. These partnerships are vital for reducing health inequalities but are often difficult to establish and sustain, due to different priorities, lack of resources, and different ways of working. Aligning different sectors and organisations' priorities, budgets, levers, and incentives is an essential next step for Cheshire and Merseyside and there is great ambition to achieve this. The development of the Integrated Care Board in Cheshire and Merseyside provides an opportunity to forge a system which generates greater health equity in the region based on partnerships with other sectors.

https://www.champspublichealth.com/wp-content/uploads/2021/10/Briefing-Note-Institute-of-Health-Equity-FINAL.pdf

In parallel to our involvement in the Marmot Community and focus on the wider determinants of health, the Cancer Alliance has developed a comprehensive health inequalities strategy based around nine locally-developed pillars, namely:

1. Understanding health inequity
2. Building confidence and awareness amongst staff
3. Adapting processes
4. Accessibility to information
5. Building a community against cancer
6. Sharing individual experience
7. Sharing group experience
8. Making health inequalities everyone's business
9. Creating and sharing resources

These CMCA pillars are described in the appendix. In short, the aims are to make inequalities visible (we can't tackle what we can't see), and ensure that everyone has the skills, confidence and commitment to address them on a daily basis.

The Alliance has set aside a dedicated budget to support the delivery of its health inequalities strategy.

Appendix: The Nine Pillars of CMCA's Health Inequalities Strategy

1. Understanding Health Inequity

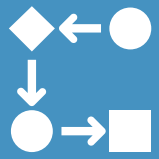
Ensuring access to good quality intelligence so we can 'see' and understand inequity in order to address it.

We will build a greater range of reliable data sources and link in with initiatives such as CIPHA.

2. Building Confidence and Awareness

Delivering a mandatory three hour workshop to all CMCA staff to shift perception. Possible offer to roll out to other NHS organisations. Will form part of the Cancer Academy to ensure HI awareness is built into all training programmes. Training on HI added to advance communications skills for cancer support workers.

3. Adapting Process



Adapting the Alliance's programme management office (PMO) and governance frameworks to ensure that all projects and programmes are 'hard wired' to address inequalities.

4. Accessibility to Information

Ensuring all patient/public facing materials from the Alliance are accessible, including being available in five languages, easy read and British Sign Language. The Alliance has set aside a budget to support this.

5. Building a Community Against Cancer

Working with over 200 organisations in Cheshire and Merseyside to become affiliated through a *foundation of engagement.* This community against cancer asks community groups to commit to a range of offers, from sharing social media to co-producing services.

6. Sharing Individual Experience

Recording the stories of individuals whose lives have been impacted by cancer to form a patient experience library. From one minute statements, to whole stories, podcasts and quotes, we will bring the experience of patients and their carers to life.

7. Sharing Group Experience

Developing a resource of experiences shared by groups with protected characteristics, through videos made by local communities and support groups.

8. Making Health Inequalities Everyone's Business

The Alliance's Health Inequalities Team work as facilitators, encouraging and skilling staff to listen to communities, patients and support groups, and to work with them to address inequity.

9. Creating and Sharing Resources

https://www.cmcanceralliance.nhs.uk/work/patient-experience-and-health-inequalities

The Alliance will maintain a library of resources. Current examples:

- National Cancer Patient Experience Survey Toolkit
- Quality of Life Survey Toolkit
- Religion and Cancer Reference
- Barriers by Protected Characteristic
- Resources by Protected Characteristic

Online resources

Online resources designed to support healthcare professionals in tackling health inequality can be found on the Cheshire and Merseyside Cancer Alliance website.

www.cmcanceralliance.nhs.uk

Acknowledgements:
Jenny Hampson, Performance Information Analyst, CMCA
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Cheshire and Merseyside Cancer Alliance is an NHS organisation that brings together NHS providers, commissioners, patients, cancer research institutions and voluntary & charitable sector partners to improve cancer outcomes for our local population.

Liverpool Women's
NHS Foundation Trust

Trust Board

Performance Report
February 2022

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.

WE SEE Summary

WE SEE Positive Developments

Workforce

The leadership Programme is up and running with positive evaluation following the first cohort.

Efficient

CIP is on track to deliver against the revised plan.

Safety

IPC performance continues to be strong for the Trust

Effective

A clinically lead cancer task and finish group has lead on significant improvements in performance in this area for Q3 and these improvements will continue in Q4

Experience

The Trust continues to see a strong performance in A&E waits and an improvement in the waits for routine diagnostics

WE SEE Areas of Challenge

Workforce

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

Efficient

The YTD trust wide position has worsened in month due to increasing pay cost pressures in relation to agency and other cover for rising sickness and staff absence figures, predominantly due to Covid-19.

Safety

Staffing levels have been significantly challenged over the previous month

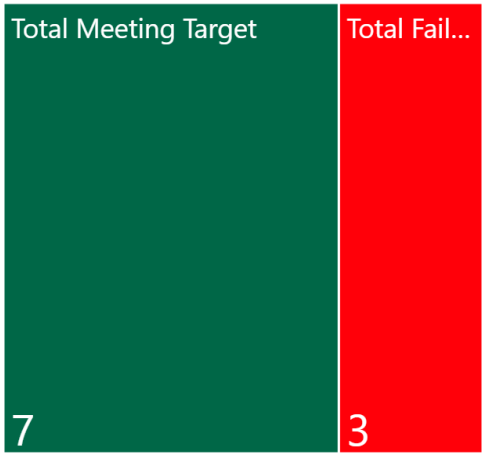
Effective

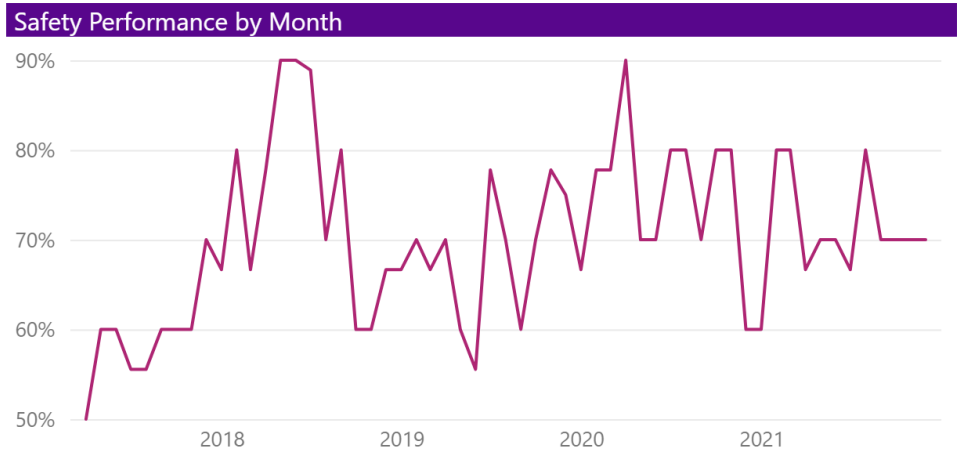
Focus through December has continued on the highest priority patients which has resulted in an increase in patients waiting over 52 weeks

Experience

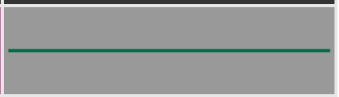
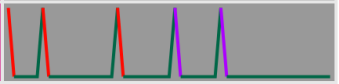
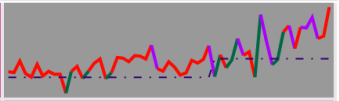
Continued dissatisfaction in some areas due to on-going Covid-19 restrictions.

To deliver **Safe** services



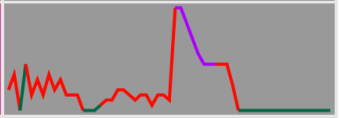
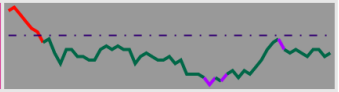
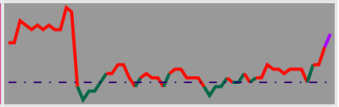
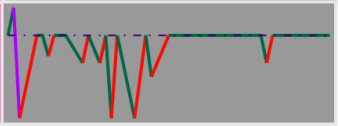


To deliver Safe services

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	December 2021	0	0				
Medical Director	Infection Control: Clostridium Difficile	December 2021	0	0				
	Infection Control: MRSA	December 2021	0	0				
	Never Events	December 2021	0	0			5	
Medical Director	Caesarean Section - Emergency Rate	December 2021	23.27%	+6.67%	16.60%	623	5	
	Venous Thromboembolism (VTE)	December 2021	86.39%	-8.61%	95.00%	1029		

KPI	KPI Narrative
Venous Thromboembolism (VTE)	New VTE policy now ratified. Gynae & Maternity risk leads emailed to table a discussion on their relevant governance meetings as this KPI is regularly breached.
Caesarean Section - Emergency Rate	The information team are currently developing a presentation of CS data according to the Robson Criteria. There is potentially some mis categorisation of category 3 sections (emergencies) that may affect this reporting

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	December 2021	0	0				
	Serious Untoward Incindents: New (Rolling per year)	December 2021	19	-5	24			
	Serious Untoward Incindents: Open	December 2021	16	+11	5			
Director of Nursing & Midwifery	Serious Untoward Incidents: Number of SUI's reported to CCG within agreed timescales	December 2021	100.00%	0.00%	100.00%	3		

KPI	KPI Narrative

To deliver Safe Services – Serious Incidents

Overview

There was four SI's reported in November 2021 and three in December 2021 making a total of 18 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	4	3	-	_	_	18

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

November 2021 Serious Incidents

Service	StEIS Ref.	Reported in Line with Policy	Summary
Maternity	2021-24256	Yes	Booked with another Trust with a twin pregnancy. Booking scan at 11 weeks at Trust 1 appeared to show a Dichorionic Diamniotic Twin Pregnancy. Referred to FMU. Patient subsequently elected a termination of pregnancy. Post procedure checks showed twin 2 fetal heart present immediately and at 50 mins post procedure. Unable to auscultate fetal heart, intrauterine death of twin 2 confirmed on scan. **Immediate Action Taken:** Review of FMU referral process (into LWH) **Immediate Lesson Learnt:** Communication issues – referral process Human factors – confirmation bias from initial report of DCDA twin pregnancy
Maternity	2021-24381	Yes	High risk multiple pregnancy. Counselled diagnosis and scan findings discussed. Weekly review and discussion of management options. Further weekly scans. Repeat scan arranged for 2-3 weeks, but rescheduled due to Consultant sickness for a further 2 weeks. 29+2 weeks scan no FH detected and intrauterine death confirmed **Immediate Action Taken:** PMRT review. Immediate escalation for consideration of an SUI. **Immediate Lesson Learnt:** High risk multiple pregnancy must have adherence to plan of fetal surveillance
Gynaecology	2021-24358	Yes	Diagnostic delay for pelvic mass **Immediate Action Taken:** Patient to be seen in high-risk anaesthetic clinic and an urgent EUA and biopsy. Support from the CNS. **Immediate Lesson Learnt:** Earlier referral to the Gynecology Specialist MDT in a patient who presents with bilateral ureteric obstruction. This can be for radiology review of imaging or for second opinion
Trust Wide	2021-24462	Yes	Major Incident at the Trust. Actions and learning detailed in report to the January 2022 Board.

To deliver Safe Services – Serious Incidents

December 2021 Serious Incidents

Service	StEIS Ref.	Reported in Line with Policy	Summary
Maternity	2021 - 24637	Yes	Postponed induction of labour at maternal request against medical advice. Induction commenced and issues during labour identified regarding the lack of Consultant input into an intrapartum high-risk pregnancy with deviation from medical advice and missed opportunities to escalate abnormalities on CTG requiring medical review. **Immediate Action Taken:** Staff statements to be obtained and reviewed to identify any additional immediate learning **Immediate Lesson Learnt:** Lack of Consultant input into an intrapartum high-risk pregnancy with deviation from medical advice (Escalation)
Maternity	2021 - 25049	Yes	Developed pre eclampsia - opportunities for escalation to senior review missed. **Immediate Action Taken:** Pre-eclampsia management to be discussed at departmental teaching **Immediate Lesson Learnt:** Missed opportunities to review whole clinical picture and escalate abnormal blood results MAU and IOL suite
Maternity	2021- 25830	Yes	A postpartum haemorrhage followed which required transfer to theatre. One vaginal pack was left behind and was identified when the patient mobilised for the first time. This was removed immediately. **Immediate Action Taken:** Addition to the policy to mandate two person checks when packs are removed with verification of numbers and documentation of this for audit purposes. **Immediate Lesson Learnt:** Addition to Guideline: When intentionally retained items are removed there should be a two-person check documenting the numbers of items removed against the numbers of wristbands.

To deliver Safe Services – Serious Incidents

HSIB Cases Reported and NHSR Early Notification Scheme

During November there were 3 cases and 1 in December 2021 which met the HSIB criteria and has been reported to HSIB

	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	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.

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

To deliver Safe services - Safer Staffing

Gynaecology: December Fill Rate

Fill-rate – The underfill for RN continues to appear low in December due to the change in establishment requirements/roster requirements, where RN requirements on nights based on acuity and dependency is being reduced. Following review and trialling the change has been agreed in December by ward manager and Matron with approval from Head of Nursing/Divisional SMT. The overfill of HCAs includes the Band 4 Assistant Practitioner who assumes a hybrid role and functions that sit between RN and HCA, however, cannot be placed in RN fill rate as remain unregistered. Safe staffing was maintained throughout December, monitored twice daily in staffing huddles and by divisional senior nursing team.

Attendance/ Absence – sickness and absence decreased in December to 5.9% from 7.18% in November, short-term sickness accounted for 83% absence in the month and 17% Long-term, Covid related absence contributed to the increase in short -term sickness in December

Vacancies – Currently there are no Nursing vacancies on the inpatient area, the ward is over established by 5.59 WTE, the band 7 ward manager has now been recruited to substantive post.

Red Flags – There were no red flags reported in December

Bed Occupancy – 56%

Neonates: December Fill Rate

Fill-rate –December has continued to be a busy month on the NICU. Staffing has been challenged with increased covid absence; however, the team have continued to maintain safe staffing and fill rates are reflective of acuity and occupancy. There has been a continued high use of Bank, the flexibility of staff swapping and changing shifts and non-cot side staff working clinically.

Attendance/Absence – December sickness ran at 11.19%, this was up from November by 4.86%. Short term sickness sits at 44% with long term sickness making up 56%. Covid sickness and covid special leave made up approximately 5% this is up by 3.57% on the previous month. Maternity leave has reduced to 11.06 FTE and turnover sits at 9% well below the Trust target.

Vacancies –Adverts out for Band 5 posts with planned interviews mid-January with good responses to advert and expecting all positions to be filled. One leaver has asked to return to their post. Band 7 posts (non-education) have been put out for secondment and will be filled with internal candidates to allow for development. Band 7 education post will be advertised in January.

Red Flags – No red Flags

Bed Occupancy – Unit occupancy has run at 84% this continues to run above the expected 80%. IC ran at 80.9%, HD 90.9%, LD 81.8%, and TC at 65.1%. December while quieter than November has continued to be a busy month for the neonatal service.

To deliver Safe services - Safer Staffing

Maternity: December 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, to allow a consolidation of midwifery staffing to one clinical area. Clinical activity and staff rostered to MLU have been reallocated across the first floor of Maternity Services, to maintain safe midwifery care. Maternity undertakes a 4-hourly activity /acuity review, which allows senior midwifery staff to maintain safety by rotating staff to the areas of highest clinical need. Midwifery managers and senior managers have been rostered into clinical rota gaps to support safe staffing, during this period; senior midwifery staff have increased on calls to support staff both clinically and professionally as a response to Maternity experiencing 30-50% staff unavailability and enacting Business Continuity Plans.

Attendance/Absence – Maternity sickness is reported at 10.63% which is a combination of clinical, non-clinical and administration staff, this monthly rate has decreased from previous month (12.63%), and maternity is demonstrating a downward trend for sickness absence. Maternity has seen a decrease in sickness rates with staff resuming from LT sick, short term and covid sickness however isolation requirements have increased during this reporting period. Maternity have requested that reports should be reviewed, and clinical staff reported separately to the overall division's sickness absence rate. Maternity sickness has a higher rate of LT sickness than ST sickness (31%STS versus 69%LTS). Ward managers/matrons have individual sickness reviews, and maternity are planning return to work programmes with all LT employees to support returns to work. Maternity has a comprehensive sickness review programme overseen by the HRBP and HOM on a weekly basis.

Vacancies – Current vacancy rate of 6%, for midwifery staff, 4% for support staff (band 2-4), the division continues to note a rise in staff requesting retirement and requests for contractual hours to be reduced. Maternity maintains an active recruitment plan with a rolling NHS jobs advert. Maternity is currently implementing an International Recruitment programme and in early discussions with HEE to introduce a RTP (Return to Practise programme) at LWH to support maternity's staffing programme/approach.

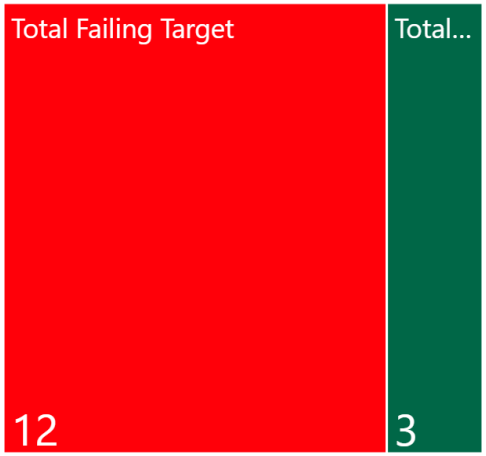
Red flags – Maternity have a positive reporting culture for red flags, noting a slight increase in red flag reporting in month. A thematic review of red flags has been undertaken and the rise is reflective of delays in elective procedures, such as Induction of Labour and delays or omissions in analgesia. 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. Due to midwifery staffing MLU has been closed for a substantial part of this reporting period, women have been offered home births as a low-risk option, all maternity admissions for inpatient intrapartum care have been admitted to Delivery Suite.

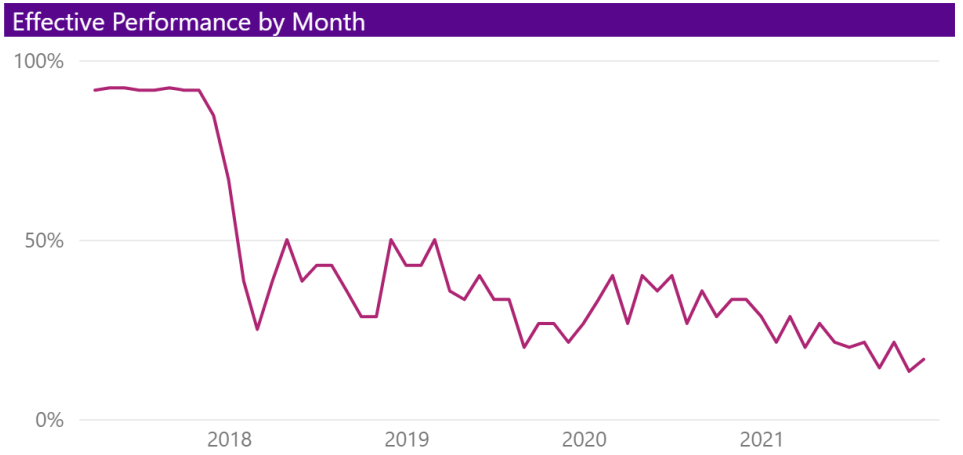
Bed Occupancy – Maternity continues to experience high levels of clinical activity. Maternity awaits a refreshed power BI occupancy report which will demonstrate both modality of birth, expected date of transfer to community services, length of stay, as well as bed occupancy. There has been no requirement to divert maternity services during this reporting period. The urgent requirement of this work has been escalated to the interim Divisional Manager.

To deliver Safe services - Safer Staffing

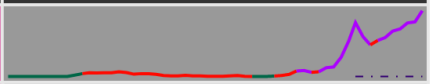
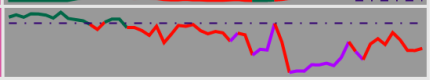
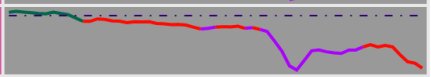
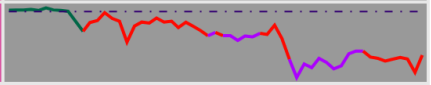
December 2021					
WARD	Fill Rate Day % RN/RM *	Fill Rate Day % Care staff **	Fill Rate Night % RN/RM *	Fill Rate Night % Care staff **	Supporting narrative (RN/RM = *; Care staff = **)
Gynae Ward	66.45%	80.65%	79.57%	167.74%	*The RN under fill rates reflect the roster review and change in establishment requirement due to change in service requirements and the bed occupancy. Safe staffing has been maintained throughout **The over fill rate of Care staff on nights is reflective of the review of the roster establishment and the Band 4 AP who is counted in the care staff numbers
Induction & Delivery Suites	87.10%	100.00%	86.10%	80.65%	*/** as per narrative below and within controls
Maternity & Jeffcoate	64.06%	71.55%	56.22%	88.29%	Jeffcoate remains permanently closed due to maternity staffing and the low-risk maternity offer. *Maternity Base has experienced high levels of maternity sickness. This shortfall is covered with use of agency staff. Safe staffing has been maintained.
MLU	72.58%	41.94%	68.55%	58.06%	MLU is reviewed on a daily basis to agree if MLU is to open or closed based on the current Covid-19 situation to ensure safe staffing. **The staffing fill rate affecting care staff is reduced however this is reflective of MLU closure for significant periods. The area was staffed safely when opened.
Neonates (ExTC)	94.91%	98.39%	94.57%	88.71%	*/ ** while fill rate are less than 100% safe staffing has been maintained when triangulated with acuity and occupancy.
Transitional Care	70.97%	106.45%	83.87%	74.19%	* RN fill rates are reflective of occupancy and acuity and safe staffing was maintained throughout. ** Care staff rates of 106.45% are reflective of the use of non-registered staff instead of registered staff, this is appropriate and safe in the TC environment. The lower rate will be reflective of occupancy and acuity on the TC, safe staffing will have been maintained throughout.

To deliver the most **E**ffective outcomes





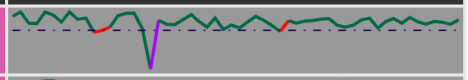
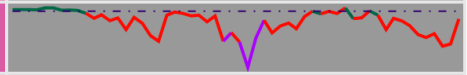
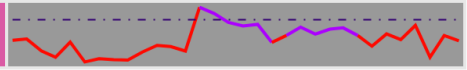
To deliver the most Effective outcomes

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	December 2021	354	+354	0		+5	
Chief Operating Officer	18 Week RTT: Admitted Completed Pathways	December 2021	71.19%	-18.81%	90.00%	236	5	
	18 Week RTT: Incomplete Pathways	December 2021	50.75%	-41.25%	92.00%	12864	5	
	18 Week RTT: Non-Admitted Completed Pathways	December 2021	75.32%	-19.68%	95.00%	1771	5	

KPI Narrative

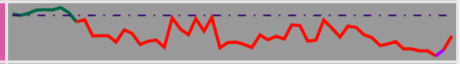
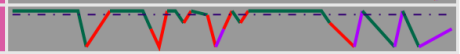
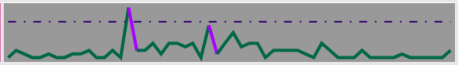
18 week position is failing nationally due to Covid - main priorities are cancer, urgent and patients waiting over 52 weeks

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	November 2021	97.04%	+4.04%	93.00%	338	5	
	Cancer: 31 Days from Diagnosis to 1st Definitive Treatment	November 2021	86.67%	-9.33%	96.00%	30	5	
	Cancer: 28 Day Faster Diagnosis	November 2021	60.50%	-14.50%	75.00%	362	5	

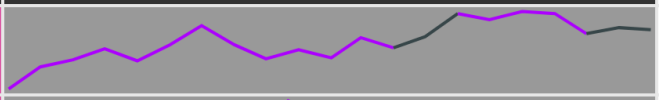
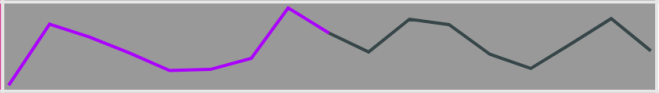
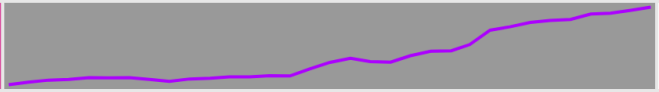
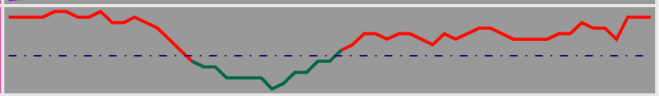
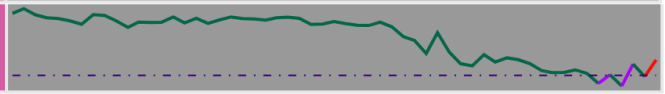
KPI	KPI Narrative
Cancer: 28 Day Faster Diagnosis	Target continues to fail due to significant increase referrals. Main pressure point is diagnostics as there is currently a 3 week wait for an appointment. Additional weekend activity is being planned but staff sickness is preventing this. Additional scopes are on order to help provide capacity within theatres.
Cancer: 31 Days from Diagnosis to 1st Definitive Treatment	Unvalidated position for November is currently 81%. Significant increase from previous month. Recovery action plan implemented and delivering.

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)	November 2021	44.83%	-40.17%	85.00%	15	5	
	Cancer: 62 Day Screening Referrals (Percentage)	November 2021	50.00%	-40.00%	90.00%	2	5	
Chief Operating Officer	Cancer: 62 Day Screening Referrals (Numbers)	November 2021	1	-4	5		5	
	Cancer: 104 Day Breaches	November 2021	3	+3	0		5	

KPI	KPI Narrative
Cancer: 104 Day Breaches	3 patients treated during November 2021. 7 patients are currently over 104 days with those fit for surgery all dated in the near future.
All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (After Re-allocation)	62 day performance continues to improve with performance now achieving 44%. The cancer and oncology teams have worked significantly hard to improve the position during October and November and the division are expecting this position to be maintained and improve moving forward.

To deliver the most Effective outcomes

KPI Owner	KPI	As of Date	Current Value	Target	Denominator	DQ Kite Mark	Sparklines
Chief Operating Officer	Advice and Guidance	December 2021	88				
	Diagnostic Activity Levels	December 2021	1589				
	Overall size of Elective Waiting List	December 2021	13017				
Medical Director	Intensive Care Transfers Out (Rolling 12 Months)	December 2021	15	8			
Chief Operating Officer	Proportion of patient activity with an ethnicity code	December 2021	96.80%	96.00%	13116		

To deliver the most Effective outcomes - Estates

Planned Preventative maintenance

Compliant | partial compliant | Non Compliant

PPM Description	Responsibility/ Contractor	HTM/HBN Reference	Frequency				Comments
			Annual	6-Monthly	Quarterly	Monthly	
FIRE							
Fire Alarm Testing (W, 3M)	Tailored Fire						
Fire Doors (M)	Estates						Links to overall fire startegy - Leviathan have provided compartmentalisation drawings - CLC to commence "Find & Fix" works 24.01.22 and will include fire doors within compartmentation sections identified on drawings.
Fire Damper Inspection Test	VSS & Swegon						Contracts now in place and schedules progressing. Some restricted access being addressed.
Fire Fighting Equipment (12m)	Tailored Fire						
Dry Risers (12M)	Tailored Fire						
Fire Hydrants (12M)	Tailored Fire						
Emergency Light test (M,12M)	Estates						Now on PPM system so more acurate visibility as to compliance - still some areas to pick up.
WATER							
Water Treatment (M) (heating and cooling)	Aquaserv						
Water Tank Cleaning (12M)	Aquaserv						
Water Sampling (M)	Aquaserv						
Water Safety PPMs	Estates						Resource to maintain compliance is the issue - some improvement this month - contractor engaged from 10.01.22 - B3 out to advert interviews 17.01.22.
SECURITY							
Access Control System (3M)	Clarion						
CCTV (3M)	HESIS						Contract now in place and works scheduled. Security review being undertaken following MI
Intruder Alarm (6M)	Clarion						
Baby Tagging System (3M)	Xtag						
LIFTS							
Passengers & Goods Lift (M, 12M)	Rubax						
Ladder & Access Platforms (6M)	Ladder Safety Services						
ELECTRICAL							
Commercial Dishwashers (6M)	JLA						Contract now in place
Commercial Washing Machine Dryers (6M)	JLA						Contract now in place
Electric Boilers (12M)	JLA						Contract now in place
Kitchen Equipment (6M)	JLA						Contract now in place
Portable Appliances Testing (12M)	OCS						
Food Trolleys (6M)	Socomel						
Weighing Equipment (3M)	Accurate weight						
Fixed Appliance Testing (12M)	Parr group						
Bed Pan Washers service (6M)	Dekomed						
Bed Pan Washers Testing (3M)	Dekomed						
Nurse Calling System (3M)	Austco						
External Light Cleaning (12M)	Estates						No resource available to complete when scheduled
Internal Light Cleaning (12M)	Estates						No resource available to complete when scheduled
Lightning Protection (12 M)	PTSG						
Generator Testing (W,M,6M,12M)	Ingrams/Estates						
Trend Building Management System (M)	BTS						Some isues with software being addressed by IT.
LV Distribution System (12M)	Estates						
HV Distribution System (12M)	Ipsum						
Refridgeration (6M) Catering/Domestic	Effective Air						Contract now in place

To deliver the most Effective outcomes - Estates

MEDICAL GASES							
Medical Gases (3M)	Medigas Services						Work continuing with present incumbent but awating contract award
HVAC (Heating, ventilation and air conditioning)							
Boiler Burners (6M)	Engie						
Pressure Units (6M)	Engie						
Main chiller unit (6M)	Engie						
Air conditioning (6M)	Effective Air						Contract now in place but awaiting PO and work to be scheduled
Ventilation System(6M) (AHU)	Estates						All 39 AHU's in date, Extract fan AHU 12 for ANC failed, new one on order 5-6 weeks. AHU 2 needs new frost coil, on order 5-6 weeks
NICU Chiller Units (3M)	Carrier						
Ceiling Grills Extract Fans (6M)	Estates						Now on PPM system and schedule to complete identified and on going.
OTHER							
Car Park Pay & Display (6M)	Newpark						
Grass Cutting and Grounds Maintenance	Rice lane landscapes						Monthly during March - October
Windows maintenance (12M)	Fenestral						Schedule in place and work has commenced.

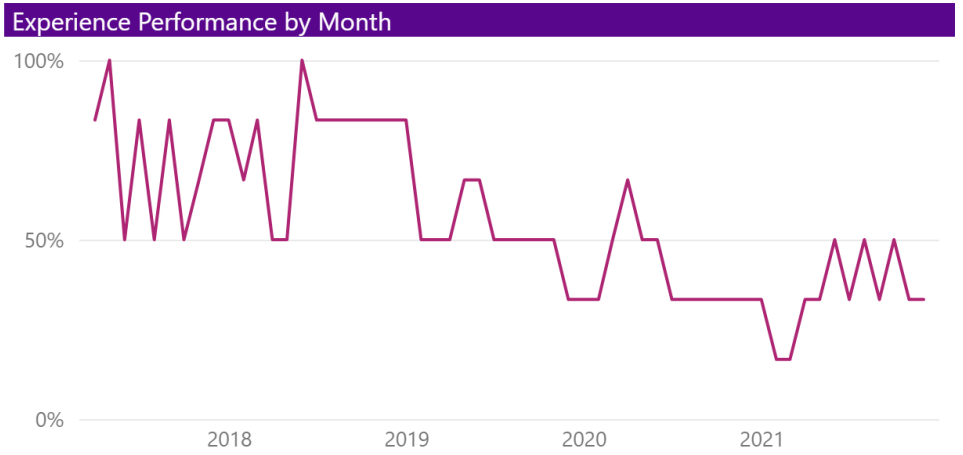
To deliver the best possible **E**xperience for patients and staff

Total Failing Target

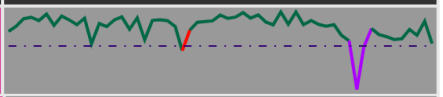
4

Total Meeting Target

2

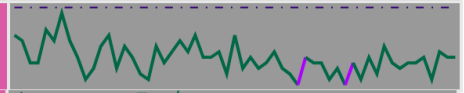
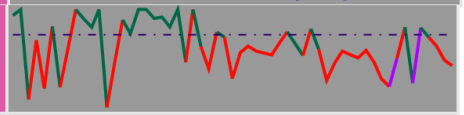
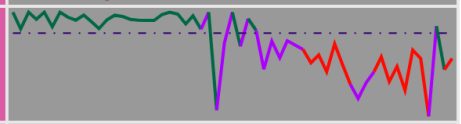
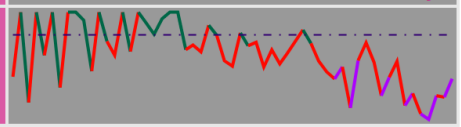


To deliver the best possible Experience for patients and staff

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	December 2021	95.36%	+0.36%	95.00%	969	5	
Chief Operating Officer	Diagnostic Tests: 6 Week Wait	December 2021	90.13%	-8.87%	99.00%	628		

KPI	KPI Narrative
Diagnostic Tests: 6 Week Wait	Overall performance for each diagnostics area can be seen below: Dexa - Numerator 49, Denominator 54, Achievement 90.74% / Total Non Obs Ultrasound - Numerator 456, Denominator 471, Achievement 96.82% / RMU – Numerator 115, Denominator 117, Achievement 98.29% / US – Numerator 341, Denominator 354, Achievement 96.33% / Cystoscopy – 2 breaches Improvement in figures can be seen for RMU ultrasounds and cystoscopy. Compliance is being monitored by Divisional Teams. Cystometry capacity continues to remain an issue, with targets not met. Mitigating actions?: CSS Divisional Team is monitoring and validating the PTL for Dexa, Gynae Imaging and Cystoscopy, whilst the Gynaecology Divisional Team are monitoring and validating the PTL for Cystometry and RMU Imaging. Work is being undertaken to ensure patients show correctly on reporting / waiting lists. Work continues to review and identify capacity. How is this being fixed?: See above. Additional capacity within gynaecology to be identified. When will target be achieved?: Q4 Why this timeframe?: Gynaecology to identify additional capacity. Imaging capacity (gynaecology) capacity has improved, with improvement seen in figures.

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	December 2021	6	-9	15		5	
Director of Nursing & Midwifery	Friends & Family Test: In-patient/Daycase % positive	December 2021	88.89%	-6.11%	95.00%	108	5	
	Friends & Family Test: A&E % positive	December 2021	88.89%	-6.11%	95.00%	36	5	
	Friends & Family Test: Maternity % positive	December 2021	85.27%	-9.73%	95.00%	129	5	

KPI	KPI Narrative
Friends & Family Test: Maternity % positive	There continues to be reduced satisfaction due to continuing COVID restrictions in place. Reduced staffing continues due to vacancy and increased sickness absence which is also affecting experience. Recruitment has taken place and Maternity are awaiting the birth rate plus report with staffing levels required for the service. Restrictions under review as per National and local guidance

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		
18 Week RTT: Incomplete Pathway > 52 Weeks	Y	Y	Y		Effective			Y		
18 Week RTT: Incomplete Pathways	Y	Y	Y		Effective			Y		
18 Week RTT: Non-Admitted Completed Pathways	Y	Y	Y		Effective			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		
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)	*21/22/160b*		Date: 03/02/2022	
Report Title	Maternity Incentive Scheme (CNST) Year 4 - Assurance			
Prepared by	*Loraine Turner – Director for Transformation and Improvement* *Angela Winstanley – Maternity Quality & Safety Matron* *Clare Fitzpatrick – Head of Midwifery*			
Presented by	*Marie Forshaw, Chief Nurse & Midwife*			
Key Issues / Messages	This report provides an outline of the CNST requirements for year 4, the Trust's current governance arrangements for compliance and outlines specific information relating to the Saving Babies Lives Care Bundle 2 (safety action 6) and the perinatal surveillance dashboard. This is to support the Board's discussions on and oversight of maternity safety intelligence.			
Action required	Approve ☐	Receive ☐	Note ☐	Take Assurance ☒
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth,* *noting the implications for the Board / Committee or Trust* *without formally* *approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable):			
	For Decisions - in line with Risk Appetite Statement – Y *If no – please outline the reasons for deviation.*			
	The Board is asked to note the report for assurance and ensure that discussions are held regarding maternity safety intelligence.			
Supporting Executive:	***Marie Forshaw, Chief Nurse and Midwife***			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☐

Strategic Objective(s)

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

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

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

3.1 Failure to deliver an excellent patient and family experience to all our service users	
Link to the Corporate Risk Register (CRR) – CR Number:	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Quality Committee	Jan 22	Maternity Quality & Safety Matron	Committee noted the report.

EXECUTIVE SUMMARY

This purpose of this report is to update the Trust Board with the recently published (09.08.2021) and the further version released in October 2021, Maternity Incentive Scheme for Year Four (2021-2022).

It outlines the scheme requirements for compliance required to achieve all ten safety actions and their associated standards for the Maternity Incentive Scheme Year 4 and the governance arrangements put into place following lessons learned from the Year 3 scheme.

Also outlined is specific information relating to the Saving Babies Lives Care Bundle 2 (safety action 6) and the perinatal surveillance dashboard. This is to support the Board's discussions on and oversight of maternity safety intelligence.

MAIN REPORT

Introduction

NHS Resolution is operating year four of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care. The maternity incentive scheme applies to all acute Trusts that deliver maternity services and are members of the CNST.

As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund. As in year three, the scheme incentivises ten maternity safety actions. Trusts that can demonstrate they have achieved all ten safety actions and will recover the element of their contribution relating to the CNST maternity incentive fund, and will receive a share of any unallocated funds.

Trusts that do not meet the ten-out-of-ten threshold will not recover their contribution to the CNST maternity incentive fund but may be eligible for a small discretionary payment from the scheme to help them to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the incentive fund

In order to be eligible for payment under the scheme, Trusts must submit their completed Board declaration form to NHS Resolution by **12 noon** on **30 June 2022**. However, it should be noted there has been an imposed submission deferral issued on the 23 December 2021. It is anticipated, by the Family Health Division that the submission date will be three months post the original deadline of 30 June 2022. The Family Health Senior Leadership team have agreed to continue as is and maintain progress as a means of preparedness and the Executive Team have supported this approach.

Scheme Safety Actions

The table below outlines the ten safety actions for Year four of the scheme, that replicate the year 3 requirements:

- **Safety action 1**: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
- **Safety action 2**: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?
- **Safety action 3**: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?
- **Safety action 4**: Can you demonstrate an effective system of clinical workforce planning to the required standard?
- **Safety action 5**: Can you demonstrate an effective system of midwifery workforce planning to the required standard?
- **Safety action 6**: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?
- **Safety action 7**: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?
- **Safety action 8**: Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4? In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4?
- **Safety action 9**: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?
- **Safety action 10**: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) scheme for 2021/22?

Reflection CNST Year Three Process

Full implementation of the CNST standards was a lengthy and detailed process. Numerous updates to the standards and the scheme guidance since its inception in December 2019 had created additional challenges to the work required to fulfil compliance. Operational responsibility for full compliance of the CNST standards was set with the Divisional Operations manager, with updates to Quality Committee.

The year three scheme, had more than 100 lines of enquiry and work/evidential requirements, ranging from audits, implementation of new processes and guidance, submission of data to external sources, reports and assurance processes for medical, midwifery and neonatal nursing staffing.

Lessons Learnt from Year Three Scheme

- Family Health Divisional Oversight – Within the Family Health Division, a strengthened senior management framework will enable a more consistent approach to the oversight of compliance. This oversight will be led by the Clinical Director, Clinical Lead, Head of Midwifery, Head of Neonatal Nursing and the Director of Transformation and Improvement.

- Assurance of compliance and/or escalation of concerns will be provided to the Quality Committee and/or Trust Board by the Clinical Director for the Family Health Division via the Chairs Report. To this end, the Governance structure has been reviewed and the Director of Transformation and Improvement is now leading the process.

- Board Level Requirements – The Maternity Incentive Scheme, historically and within the new update, requires Trust Board level oversight of the whole scheme and its associated workstreams. In anticipation of this, the Family Health Division plan to give assurance to the Trust Board, via the Family Health Divisional Board, with key specific actions attributed to a wider team of clinicians and individuals.

- In the previous years there were often short notice revised and updated scheme guidance to Trusts in Year Three which made the governance process sometimes unclear impacting Family Health Divisional Board sign off. However, a new governance structure has been designed to support this. The Family Health Division will continue to be vigilant in keeping the Quality Committee and Trust Board updated.

Scheme Management

- In the interests of the ability to share and collate evidence for scheme stakeholders, the Information Team have developed a Microsoft Teams Channel. This will consist of each Safety action spreadsheet being held centrally with action owners given the ability to update and upload actions and evidence as the scheme progresses throughout the coming year. This will have oversight by the Family Health Division Management Team and CNST Oversight Committee.

- Every action has been nominated a lead, with associated actions being given to action owners. Action Leads and owners will be responsible for ensuring their progress, challenges and completions are presented and overseen by the FHD CNST Oversight Committee. This fortnightly meeting, chaired by the Director of Transformation and Improvement will provide assurance to the FHD Board, with assurance to Quality Committee and Trust Board from the associated assurance paper.

- It must be acknowledged that the current pressure faced by the Family Health Divisional Board in relation to staffing and the operational pressure by the COVID 19 pandemic does pose a challenge to the overall delivery of the Maternity Incentive Scheme. This has been highlighted through divisional board and at recent

executive oversight meeting. The challenges are managed and escalated through the family health divisional board.

Safety Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives Care Bundle Version 2

The Saving Babies' Lives care bundle aims to provide detailed information for providers and commissioners of maternity care on how to reduce perinatal mortality. The second version of the care bundle brings together five elements of care:

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

There are key areas that require strict oversight from the Family Health Division to ensure full compliance. These are:

- CO screening rates at booking and 36 weeks
- Recording of the fetal growth restriction risk assessment at the time of the mid-trimester anomaly scan
- Ultrasound capacity – uterine artery Doppler assessment and cervical length screening
- Attendance at local multi-professional fetal monitoring training

The Executive Team received an interim report in late January 2022, and this has identified potential challenges to meeting several of the Safety Action 6 compliance targets, particularly relating to CO (carbon monoxide) screening rates at booking and 36 weeks. Whilst these measures demonstrate an upward trajectory, they remain off target and will require improvement in order to meet the 80% ave. over a six-month reporting period target. The Chief Nurse & Midwife has met with the Safety Action leads to seek additional assurances on the trajectories and on the immediate actions being taken in response. This will be closely monitored, and an overall Safety Action 6 assurance report will be provided to the April 2022 Board (first bi-annual update of the reporting period).

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

https://www.england.nhs.uk/wp-content/uploads/2020/12/implementing-a-revised-perinatal-quality-surveillance-model.pdf

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. The 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.

The first iteration of this dashboard was received in December 2021 (October 2021 data) and it was agreed that further iterations would be received on a quarterly basis. An updated dashboard can be located in Appendix 1.

It should be noted that 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.

Maternity Perinatal Quality Surveillance Model: December 2021.

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CQC MATERNITY RATINGS	Overall	Safe	Effective	Caring	Well Led	Responsive
LAST REPORT – 22/04/2020	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 Flag	37 Midwifery Red Flags in November.
Most reported Red Flag -	Delay in >2 Hours between Admission and Induction.
Actions Taken:	Escalated to 104 Bleep Holder. Managed appropriately at the time. Patient safety maintained; patient experience affected Apologies offered to patient . Maternity Red Flag reported reviewed and monitored through Maternity Risk Committee, with escalation to Senior Leadership Team with any safety issues.

Appendix 1

	Comments	Actions
MVP/Service User Feedback	Discussions with MVP chair surrounding estate -additional male bathroom facilities request with baby changing and additional parent and child car park spaces. Request to review K2 and the Honeysuckle logo, following some feedback from service users. LWH have requested some support from the MVP in relation to community groups to support LWH with its vision and strategy	Requests escalated to Estates – part of ongoing upgrades to front entrance. K2 issue will be resolved with next phase implementation. Community engagement planned by MVP chair
Safety Champions Feedback	Issues escalated to Safety Champions and noted at QC: Ongoing issues with GROW Charts – Integrated digital solution Expected in April 2022. Patient flow, staffing and skill mix affecting Maternity Base, issues with TTOs and ward based pharmacological support. Walk abouts continue with Board Levels and Divisional Safety Champion attendance. Ward to Board to Ward feedback continues ia Safety Champions Check in – Video to be uploaded to Intranet. Safety & Governance Boards now in all Maternity areas.	Maternity Ward Action Plan developed which will address escalated estates and environment issues.
Excellence Reports and/or Employee/Team of Month	Maternity Shining Star awarded to Danuta Morris, Community Midwife, nominated by Team Leader and will be nominated for employee of the month. *"Congratulations to Danuta for receiving Decembers Shining Star ⭐ nominated by Sally Haymes and agreed by all Maternity Managers* *'Since joining our team, Danuta has been amazing! She is really organised, unfazed and is happy to help across the service were needed always with a smile on her face. Since joining Community she has care for a caseload with a lot of complexity which has been challenging- but she has taken this in her stride and used as a learning opportunity. We all recognize that she is an asset to NEST and LWH and are so pleased that she has chosen to begin her Midwifery career here with us.'*	Employee of the Month nomination.

Appendix 1

Appendix 1

<table>
<tr><th>Number of HSIB Referrals.</th><th>PMRT Reviews.</th><th>Key Themes Identified</th><th colspan="2">Safety Incidents Reported in Month</th></tr>
<tr><td rowspan="2">Number of Therapeutic Cooled: 3

Two cases reported to HSIB:

One Therapeutic Cooled Baby returned for local investigation as normal neonatal MRI.

One case of Intrapartum SB reported to HSIB:

Attended with absent FM and found to be in labour. Both cases have had 72 hr reports and escalated to Exec Wednesday Harm Meeting.</td><td>Number of NND

Perinatal Deaths

Reviews Completed:

Q3 Neonatal deaths = 3

Q2 PMRT reviews = 11</td><td rowspan="2">Importance of sending placenta for analysis.</td><td>Number of Mod/Serious Harm Incidents? D.O.C Completed?</td><td>Moderate Harm Closed in Nov - 3

One case of cooled baby – HSIB reported, returned due to no safety issues – Placental Abruption.

CS Hysterectomy 6.7L - Placenta Acreta.

Cooled Baby – Declined IOL, IOL delayed due to Terrorist attack.

Serious Harm – Closed in November – 1

Post CS, Bowel perforation, resection, bowel resection.</td></tr>
<tr><td>Number of Stillbirth

Perinatal Deaths

Reviews Completed:

Q3 of Stillbirths = 10

Q2 PMRT reviews = 8</td><td>Importance of sending placenta for analysis and postnatal investigations

Ensuring GROW charts are present in the Maternity notes</td><td>Actions from Moderate/Serious Harm Incidents include:</td><td>All action plans associated with closed moderate and/or harm incidents are monitored through the Maternity Clinical Risk committee.

All actions from SUI closed in November are monitored through Maternity Risk and are submitted to the CCG.</td></tr>
<tr><td colspan="3"></td><td>Number of STEISS Incidents (Non HSIB) : 2</td><td>MCDA Pregnancy – Fetocide and Intrauterine Death – Misidentification of Chorionicity

MCMA – TRAPP sequence, Fetocide at 21wks in T1. IUD of twin 2.

Prolonged USS interval of 5wks due to Covid sickness on Cons Team.</td></tr>
</table>

Appendix 1

Ockenden Update:	The FHD continue to work on the full implementation of the immediate and essential Ockenden actions: IEA 1, 2, 3 and 6 - Completed. All evidence submitted to Portal. CSU and Office of Regional Chief Midwife Validated. IEA 4 – On track to launch as a Maternal Medicine Centre (MMC) in April 2022. Pathways are being agreed across the North West Maternal Medicine Network with the two other MMCs (St Mary's Hospital (Manchester University NHS Foundation Trust) and Royal Preston Hospital (Lancashire Teaching Hospitals NHS Foundation Trust)). An electronic referral system has been built and is undergoing testing. The governance process around the regional maternal medicine MDTs and provision of advice is being developed. All women with complex pregnancies will have a named consultant lead. The Cheshire & Merseyside Maternal Mental Health Service is planning to launch at the end of February 2022. IEA 5 – Audit of Personalised care and Support Plans outstanding – will be completed with guidance from Regional LMS Teams. IEA 7 - Ongoing work to enable women to participate equally in all decision-making processes, use of BRAIN tool and associated audit requirements.
Maternity Risk Register.	Extreme Risks: 20 High Risks:10 Moderate Risks: 4 Low Risk: 1
Progress against CNST **10 Standards**	Progress against the Year 4 Maternity Incentive Scheme (CNST): 1. PMRT – Trust Board receives perinatal mortality reports quarterly. 87% of cases review started, needs 95% for compliance. 100% of families aware of PMRT review and asked to contribute. 2. MSDS – Digital Hospital Sub Committee in Jan will receive paper and into QC in February that outlines current position. 3. ATAIN – Head of Nursing strengthening teams to ensure all workstreams and actions are completed. 4. Clinical Workforce – Obs workforce paper submitted in January. Neo Nursing and Medical workforce paper to be submitted in Feb QC. 5. Midwifery Workforce – Detailed staffing paper to Trust Board outlining Birth Rate Plus assessment requirements and further scheme detail. 6. SBLCBv2 –- PTL Risk assessment to be updated. 20 Weeks FGR Risk assessment to be embedded into pregnancy journey. 7. MVP – Continued close working relationship with MVP and MVP/LWH Strategy under development. 8. Mandatory MPMET and Neonatal Resus Training – MPMET Training session reinstated in face-to-face capacity. Target of 90% of all staff groups to attend by scheme end. 9. Safety Champions – Safety Issues continue to be escalated. BLSC sighted on Perinatal Clinical dashboard and submitted monthly. 10. HSIB and NHSR Notifications – No issues identified. All HSIB and D.O.C duties completed to date.

Appendix 1

	Metric	Standard National standard/Average where available.	Running Total/ average	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct 21	Nov- 21	Dec 21
Perinatal RS	1:1 Care in Labour	100% (CNST)			99.6%	99.3%	99.2%	98.6%	99.6%	99.4%	98.1%
	Stillbirth Number >24wk (Adjusted)	Actual Number			2	7	3	1	2	5	2
	Stillbirth Rate >24wk (Adjusted) (Quarterly)	<4.4/1000		4.0		5.3			5.1		
	Apgar <7 @ 5 Min (>37weeks)	<1.2%			0.8%	0.6%	1.3%	0.8%	05.%	1.15%	1.28%
	Term Admission to NICU	<6%			3.54%	4.01%	4.91%	5.1%	4.52%	7.69%	5.46%
	Women in receipt of Continuity of Care	100%			15.35%	14.49%	16.67%	19.91%	17.85%	20.52%	20.52%
	BAME in receipt of Continuity of Care	100%			29.41%	31.63%	39.81%	47.96%	39.60%	41.58%	37.89%
	Social Depravation Continuity of Care				18.18%	19.89%	24.21%	26.40%	22.26%	24.78%	23.62%
	Provision of Epidural in Labour.	Actual Number			15.1%	20.3%	19.4%	20.3%	22.82%	17.78%	16.78%
	Obstetric Haemorrhage >1.5L				4.28%	3.96%	3.77%	4.14%	3.37%	4.26%	2.96%
	Coroner Reg 28 Made to Trust				0	0	0	0	0	0	0
	HSIB Actions Returned				1	0	0	1	1	1	0
Workforce CF/RR/AB/LD	Super Numerary DS Shift Leader.	100% (CNST)	100%		100%	100%	100%	100%	100%	100%	100%
	Midwifery Sickness	% of workforce			10.13%	12.28%	12.17%	14.11%	13.31%	12.63%	15.26%

Appendix 1

	Midwifery Sickness	WTE			36.6	44.6	43.7	50.7	NA	NA	NA
	Midwife to Birth Ratio (in Post)	>1.30			30	31	31	32	NA	NA	NA
	Midwifery Vacancy	% of workforce			2.40%	1.40%	4.40%	3.30%	5.32%	8.72%	7.84%
	Midwifery Vacancy	WTE			7.01	4.13	12.76	9.74	NA	NA	NA
	Rostered Cons on DS (Hrs per Wk)	>60 hrs			91	91	91	91	91	91	91
Feedback CF/AW	**Number of Formal Complaints**	Actual Number			2	2	1	2	3	2	2
	Number of Maternity Incidents over 30 Days	Actual Number			188	261	89	161	376	97	119
	FFT Response Rate	>50%			<10%	<10%	<10%	<10%	<10%	<10%	<10%
	Number of PALS/PALS+	Actual Number			74	66	67	46	52	44	32
Training AM	**Fetal Surveillance Training: IP Staff**	100%			95%	95%	95%	95%	95%	95%	95%
	MPMET Training Compliance (Overall)	90% (by June 2022)			76.0%	81.0%	84.1%	81.0%	77%	84.9%	82%

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	***21/22/160c***		**Date: 03/02/2022**	
Report Title	**Birthrate Plus / Maternity Staffing**			
Prepared by	***Clare Fitzpatrick, Head of Midwifery, Alison Murray Deputy Head of Midwifery, Clare Scott Deputy Director of Finance***			
Presented by	***Marie Forshaw, Chief Nurse & Midwife***			
Key Issues / Messages	***The Maternity Staffing Oversight Report outlines the requirements of Maternity Incentive Scheme Safety Action 5 and details LWH current position.*** ***This paper includes the final report of the commissioned Birth Rate Plus systematic workforce review and associated action plans. This forms the required evidential standard for submission to Trust Board***			
Action required	**Approve ☐**	**Receive ☒**	**Note ☐**	**Take Assurance ☐**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	***To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it***	***For the intelligence of the Board / Committee without in-depth discussion required***	***To assure the Board / Committee that effective systems of control are in place***
	Funding Source (If applicable):			
	For Decisions - in line with Risk Appetite Statement – Y/N ***If no – please outline the reasons for deviation.***			
	It is recommended that the Board accepts the information in this paper.			
Supporting Executive:	***Marie Forshaw, Chief Nurse & Midwife***			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

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

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

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

REPORT DEVELOPMENT:

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

EXECUTIVE SUMMARY

The Maternity Staffing Oversight Report outlines the requirements of Maternity Incentive Scheme Safety Action 5 and details LWH current position.

This paper includes the final report of the commissioned Birth Rate Plus systematic workforce review and associated action plans. This forms the required evidential standard for submission to Trust Board

It is recommended that the Board accepts the information in this paper.

MAIN REPORT

INTRODUCTION

The Maternity Incentive Scheme (MIS) Year 4 Safety Action 5, 16092021-MaternityIncentiveSchemeYEAR4-Revised-timeframe-October-2021-updated.pdf (resolution.nhs.uk) requires that trusts demonstrate an effective system of midwifery workforce planning to the required standard detailed below:

a) A systematic, evidence-based process to calculate midwifery staffing establishment is completed.
b) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service
c) All women in active labour receive one-to-one midwifery care
d) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year four reporting period

This report comprises of evidence to support a, b and progress towards achieving c with an associated action plan detailing this. In order to meet the expected evidential standards, the report provides:

- A clear breakdown of Birth Rate Plus or equivalent calculations to demonstrate how the required establishment has been calculated
- Details of planned versus actual midwifery staffing levels. To include evidence of mitigation/escalation for managing a shortfall in staffing.
- An action plan to address the findings from the full audit or table-top exercise of Birth Rate+ or equivalent undertaken, where deficits in staffing levels have been identified.
- Maternity services should detail progress against the action plan to demonstrate an increase in staffing levels and any mitigation to cover any shortfalls.
- The midwife to birth ratio
- The percentage of specialist midwives employed and mitigation to cover any inconsistencies. Birth Rate Plus accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.
- Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator status and the provision of one-to-one care in active labour. Must include plan for mitigation/escalation to cover any shortfalls.

In response to the National Maternity Transformation agenda, the Local Maternity System commissioned a workforce analysis for Cheshire and Merseyside Maternity Services. The regional emerging clinical picture from local intelligence and clinical dashboards including midwife to birth ratio and vacancy, suggested that whilst births were reducing, complexity and staffing requirements to align to national safety standards were increasing. On review of LWH data there had been an increase in complexity at booking, an increase in unscheduled attendances to the Maternity Assessment Unit, and rising rates of Induction of Labour. The demographic of the population within the greater Liverpool area has seen significant challenges in relation to social deprivation, safeguarding and an ever-increasing public health demand which has increased the requirements for midwifery staffing.

Birth Rate Plus is an approved systematic evidence-based process to calculate Midwifery staffing establishment requirements in line with clinical activity and demographic data.

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Birth Rate Plus

Birth Rate Plus (BR+) is a framework for workforce planning and strategic decision-making and has been in variable use in UK maternity units since 1988, with periodic revisions as national maternity policies and guidance are published. It is based upon an understanding of the total midwifery time required to care for women and on a minimum standard of providing one-to-one midwifery care throughout established labour. The principles underpinning the BR+ methodology are consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings and have been endorsed by the RCM and RCOG. The RCM strongly recommends using BR+ to undertake a systematic assessment of workforce requirements, since BR+ is the only recognised national tool for calculating midwifery staffing levels. Whilst birth outcomes are not influenced by staff numbers alone, applying a recognised and well-used tool is crucial for determining the number of midwives and support staff required to ensure each woman receives one-to-one care in labour.

In addition, it caters for the various models of providing care, such as traditional, community-based teams and continuity caseload teams. It is responsive to local factors such as demographics of the population; socio-economic needs; rurality issues; complexity of associated neo-natal services, etc. The methodology remains responsive to changes in government policies on maternity services and clinical practices.

An individual service produces a case mix based on clinical indicators of the wellbeing of the mother and infant throughout labour and birth. Each of the indicators has a weighted score designed to reflect the different processes of labour and birth and the degree to LWH deviations from obstetric normality. Five different categories are created - the lower the score the more normal are the processes of labour and birth. Other categories classify women admitted to the delivery suite for other reasons than for labour and delivery. Together with the case mix, the number of midwife hours per patient/client category based upon the well-established standard of one midwife to one woman throughout labour, plus extra midwife time needed for complicated Categories III, IV & V, calculates the clinical staffing for the annual number of women delivered.

Included in the workforce assessment is the staffing required for antenatal inpatient and outpatient services, ante and postnatal care of women and babies in community birthing in either the local hospital or neighbouring ones. The method works out the clinical establishment based on agreed standards of care and specialist needs and then includes the midwifery management and specialist roles required to manage maternity services. Adjustment of clinical staffing between midwives and competent & qualified support staff is included. The recommendation is to provide total care to women and their babies throughout the 24 hours 7 days a week inclusive of the local % for annual, sick & study leave allowance and for travel in community

LWH commenced our workforce analysis with Birth Rate Plus in Summer 2021.

Additional considerations

In view of an increase in the requirements of Maternity workforce training to adherence to the newly devised core competency framework to meet MIS and Ockenden evidential requirements, Maternity services have completed a deep dive recognising the shortfall in allocated hours for Mandatory

training requirements for Midwifery staff. On recognition of this, a paper has been developed regarding operational delivery with a recommendation to increase the overall establishment headroom to 23%, specifically the training proportion which is currently 1.9% to 3.5%. This is in line with the benchmarking from 'Mind the Gap Report' which was a National review of Maternity Training Provision and Investment, completed in summer 2021. This addition would ensure the correct allocated study days per person, per annum to undertake all corporate, clinical and local training. This is pending financial and executive agreement.

Maternity Training Needs Analysis available for the Board in the Microsoft Teams folder.

Liverpool Women's Hospital NHSFT Birth Rate Plus Report Jan 2022

Birthrate plus Report available for the Board in the Microsoft Teams folder.

Birth Rate Plus Analysis

Maternity has a 372.60 WTE funded establishment for all midwifery staff including support workers inclusive of a headroom factor of 21.4%.

Table one below splits the 372.60 WTE into posts that are directly included in the Birth Rate Plus (BR+) ratio and posts that are not included in the ratio. The posts not included in the ratio are Band 2 & 3 working on delivery suite, maternity wards and in outpatient clinics where professional judgement of the numbers is required per shift rather than a clinical dependency method.

Table 1	LWH Current Funded Establishment	BR+ Recommendation 23%	Variance to budget
Total Clinical Staff	266.20		
Contribution from Specialist Midwives	7.70		
Total Direct Care-giving Midwives	273.90	283.22	-9.32
Non-direct care giving (non-clinical)	19.05	34.64	-15.59
Total Registered Midwives	**292.95**	**317.86**	**-24.91**
MSW's included in BR+ (Community & Mat Ward)	34.27	31.73	2.54
Total MSW's	**34.27**	**31.73**	**2.54**
Total Posts included in BR+ ratio	**327.22**	**349.59**	**-22.37**
Band 2 not directly included in the BR+ ratio	17.9		
Band 3 not directly included in the BR+ ratio	27.48		
Total Midwifery Establishment	**372.60**		

Of the 372.60 WTE funded budget; 327.22 WTE are included in the BR+ ratio. BR+ recommend that the Trust should have 349.59 WTE staff in post to be fully BR+ compliant. This is a net increase against funded establishment of 22.37 WTE. The increase is split between Midwifery numbers of 24.91 WTE and a reduction of Midwifery Support Workers (MSW) numbers by 2.54 WTE. It would be expected that the small reduction in MSW would be achieved through natural attrition rates however this would be subject to a professional judgement review of the support staff posts not included in the BR+ ratio.

Table Two below shows actual WTE in post as of 30th November 2021 compared to the BR+ recommendation and is split between midwifery and support staff.

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Table 2	Establishment in Post 30.11.21	BR+ Recommendation 23%	Variance to actual
Total Clinical Staff	276.28		
Contribution from Specialist Midwives	7.20		
Total Direct Care-giving Midwives	283.48	283.22	0.26
Non-direct care giving (non-clinical)	28.55	34.64	-6.09
Total Registered Midwives	**312.03**	**317.86**	**-5.83**
MSW's included in BR+ (Community & Mat Ward)	32.85	31.73	1.12
Total MSW's	**32.85**	**31.73**	**1.12**
Overall Variance to Actual Staff in Post	**344.88**	**349.59**	**-4.71**

Based on actual staff in post in November, the overall variance against the BR+ recommendation inclusive of 23% headroom is 4.71 WTE (1.3% vacancy rate against BR+ recommended figure).

Maternity have been staffing at a higher level than the current funded establishment all year. This includes a number of posts, particularly non-direct care giving midwives which will require substantive funding as outlined in the BR+ review. These posts include Preceptorship midwives, Quality and Safety Lead Midwives and additional breastfeeding support of which substantive staff in post.

Maternity had received agreement which has allowed the division to recruit to non- direct midwifery care roles to ensure compliance in line with national safety standards such as SBLv2, and to reflect the trusts standalone isolated status. In responding to the national call to increase recruitment and retention within the newly qualified preceptorship period, we have developed bespoke midwifery roles to provide 'by the bedside teaching', assessing and mentoring, combined with managerial and pastoral support. This is combination with Professional Midwifery Advocate roles to strengthen our wellbeing offer for Midwifery staffing. This has been widely recognised as an exemplar of good practice by NHSE/I and LWH innovation and commitment has been shared nationally.

Due to the changing landscape of Maternity governance we have been required to strengthen the Maternity Governance team with the inclusion of two Quality and Safety Midwifery roles.

The above roles require 34.64wte which is 11% of the clinical total WTE, which brings us in line with the MIS recommendation of specialist and non-direct care giving midwives.

Our 2021 Birth Rate plus report, and professional judgement, we are confident that workforce planning has been undertaken in sufficient detail to address workforce requirements across maternity answering the required standard of MIS SA5.

On receipt of this report LWH are not currently Birth Rate Plus compliant with the current budgeted establishment.

As part of the review of the report the senior management team have produced an action plan highlighting the deficits and requirements for the recruitment of midwifery staff to revised BR+ establishments. Going forward, the action plan when agreed by Trust board, will be updated and demonstrate the mitigation that the maternity service delivers to cover any shortfalls. This action plan will be monitored through FHDB to Quality Committee with final review and sign off at Trust board.

Birthrate Plus action plan available for the Board in the Microsoft Teams folder.

Maternity Staffing Planned vs Actual

Maternity has a process for daily review of planned vs actual staffing, this information is fed into both the Trust staffing safety huddle and the overall senior manager safety huddles twice daily basis. This safety huddle consists of senior managers and the trust senior manager on call. LWH has recently procured the services of NHS Professionals to support temporary staffing shortfalls which if required includes cascade of vacant shifts to agencies. Planned staffing fill rates are highlighted and approval gained in weekly meetings by the Deputy HoM and Deputy COO to ensure consistent safe staffing levels. This work forms part of the NHS I staffing return.

Maternity has a clear escalation policy, to review maternity staffing and acuity every 4 hours. Midwives and MSW undertake a rotational training programme, allowing midwives to rotate between all clinical areas, ensuring we have a moveable workforce and midwifery staff can be redeployed to the areas of highest clinical demand. The Maternity Bleep holder consistently reviews staffing and has the ability to redeploy non- direct care givers to address spikes in clinical activity to maintain a safe clinical staffing ratio.

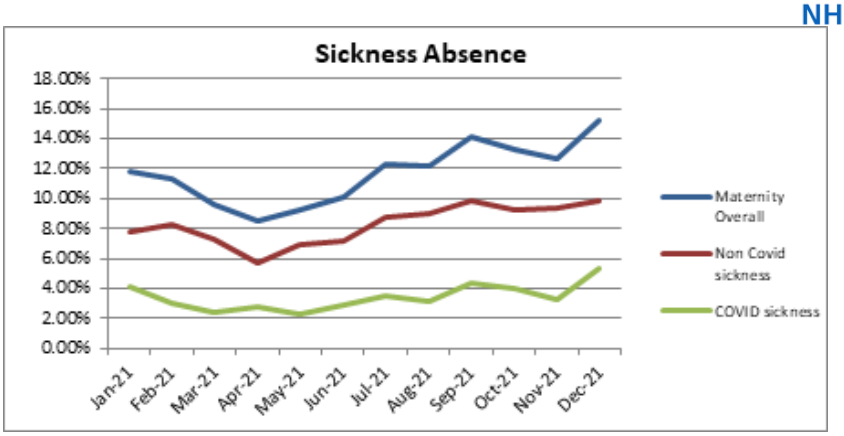
Maternity Escalation guideline available for the Board in the Microsoft Teams folder.

Maternity Sickness 2021

Sickness absence is a continuing challenge in the service with both ongoing pressures from Covid-19 infections/diagnoses and colleagues reporting burn-out. The 12-month rolling sickness absence rate for the service stands at 12.28% compared with 10.63% last year (December 2020). The division has been above the Trust target of 4.50% for the last 12 months with the split of absence weighted towards long term cases at 69%. The service reviews their sickness cases (short and long term) on a weekly basis and any long term cases are managed in accordance with the current Attendance Management policy.

In terms of long term sickness, within Maternity, there is an evidenced downward trend of active cases with weekly monitoring taking place jointly between HR and Maternity Management; a return to work trajectory has been developed which is reported to Family Health Divisional Board and this data shows that 24 colleagues have been welcomed back during Q3 via supported/phased return to work plans. Equally, the service is able to evidence that the prominent length of absence with between 0-3 months showing active management does take place. The service has 6 long Covid cases that are managed in line with policy and national guidance; this number is a reduction to previous months as the team welcomed back two colleagues who had reported long Covid-19 and had been absent for over 9 months.

For all absences, Occupational Health are fully engaged (as required) and support information for the C&M Resilience Hub is regularly accessed/part of welfare conversations.



Turnover

Staff turnover within maternity is currently reported at 13% in December 2021, within the reporting period it has never exceeded the 13%, which is the Trust target. Maternity has seen a gradual increase in staff turnover which reflects the national picture. The HOM /Deputy HOM have reviewed all leavers in the last 6 months and attrition is mainly due to staff relocating to be closer to home and family due to the COVID pandemic. Early retirement requests stating burn out and the pandemic have been received. Recently LWH has attracted and successfully recruited leavers from the trust back into the organisation within the same job role.

Maternity Staff Turnover					
Jul 21	**Aug 21**	**Sep 21**	**Oct 21**	**Nov 21**	**Dec 21**
11%	**12%**	**12%**	**13%**	**12%**	**13%**

Midwife to Birth Ratio

National recommendations suggest a 1:28 midwife to birth ratio, this ratio is monitored monthly through the maternity dashboard and published externally as part of our SCN (Strategic Clinical Network) dashboard,

At present we are currently reporting a ratio of 1:30 which is reflective of Midwifery turnover and current vacancy. Work is ongoing within NHSE to review maternity staffing and how 'safe' is demonstrated, early indications have highlighted that boards should use Birth rate plus, and not the 1:28 midwife to birth ratio, we await NHSE final recommendations.

Midwife to Birth					
Jul 21	**Aug 21**	**Sep 21**	**Oct 21**	**Nov 21**	**Dec 21**
1:31	**1:32**	**1:32**	**1:30**	**1:29**	**1:30**

Midwifery Red Flags

A midwifery red flag event is a warning sign and an early indicator that midwifery staffing ratios maybe incorrect at that given time. If a midwifery red flag event occurs, the midwife in charge of the service should be notified. The midwife in charge (Maternity Bleep Holder) should determine whether midwifery staffing is the cause, and the action that is needed which may include redeployment of staffing to meet acuity or appropriate skill mix, as per escalation policy.

Midwifery Red Flags are:

- Delayed or cancelled time critical activity.
- Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing).
- Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication).
- Delay of more than 30 minutes in providing pain relief.
- Delay of 30 minutes or more between presentation and triage.
- Full clinical examination not carried out when presenting in labour.
- Delay of 2 hours or more between admission for induction and beginning of process.
- Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output).
- Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour.

Midwifery Red Flags reported					
Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21
28	62	39	19	37	39

A monthly midwifery 'Red Flag Report' is tabled at maternity risk and clinical meeting, monitoring themes and trends of red flags in the previous month. The report is compiled from data derived from the live reporting system, completed by the maternity bleep holder. Any themes or actions required are escalated to the senior midwifery team, maternity safety champions, and to our Family Health Divisional Board. Within the six period captured in this report, maternity identified 224 red flag incidents demonstrating a positive reporting culture. Our most frequently reported red flags in this period were Delay of 30 minutes or more between presentation and triage, and Delay of 2 hours or more between admission for induction and beginning of process.

Supernumerary Shift Coordinator Labour Ward

Supernumerary Shift Coordinator					
Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21
100%	100%	100%	100%	100%	100%

Within LWH Labour Ward, we consistently maintain compliance of 100% of a supernumerary shift co-coordinator. This role is pivotal in providing a total oversight into all birth activity within the first floor and provides a helicopter view of all staffing/workforce requirements as well as birth activity. The band 7 midwifery co-ordinator is rostered independently from the core midwifery staff; therefore we achieve 100% compliance against this target. This evidence is live via the e-Roster system with a distinct marker against the shift coordinator indicating supernumerary status.

1:1 Care in Labour

NICE guidance supports one to one care in established labour, as one of the indicators of effective midwifery workforce planning. LWH has consistently across our intrapartum areas, of MLU (midwifery led unit), and our Labour Ward (consultant high risk care), achieved a compliance rate of 98.9% in this reporting period.

MIS SA5 requires organisations to produce an action plan when compliance is less than 100%. As part of the review of the non-compliance to this required standard, each case were 1:1 care is not achieved has been reviewed to ensure no adverse clinical outcome have occurred. The common themes identified for non-compliance include midwifery sickness, vacancy and the nature of maternity services which may include precipitate labour or presentation of a woman about to birth imminently.

1:1 Care in Established Labour					
Jul 21	**Aug 21**	**Sep 21**	**Oct 21**	**Nov 21**	**Dec 21**
99.3%	**98.6%**	**98.6%**	**99.6%**	**99.4%**	**98.1%**

1 to 1 action plan available for the Board in the Microsoft Teams folder.

This action plan is monitored at Maternity Risk and Clinical Meetings again reviewed as part of our assurance process to the FHDB upwardly reporting to safety and effectiveness senate, as well as external reporting to our local LMS and SCN.

Covid 19 staffing update:

Covid-19 staffing absence is presently not a Maternity Red Flag but is robustly monitored within the trust at the Executive chaired Covid Oversight Committee. This includes all aspects including illness, isolation, shielding and special leave.

Maternity absence increased during the pandemic period, due to positive cases of COVID 19 which required isolation and the requirements of isolation pending results. The impact of external pressures such as school opening resulted in additional staff requiring isolation periods, at no time during the pandemic have maternity staff that hold a Registered Midwifery, or dual qualification, or additional skill set been relocated to a differing clinical location or a differing trust as part of a mutual aid request.

In line with gaps in midwifery rotas due to COVID pressures, on occasions were required to review the core midwifery care offer within agreed business continuity plans, ensuring that all available midwives are providing direct midwifery care, and all non-direct care midwives are readily available. This

resulted in operational changes including the conversion of some face to face community antenatal and postnatal elements being rationalised on a risk stratification basis, and conversion to telephone contacts if appropriate. In order to maintain the requirements to fulfil 1:1 care, Midwives from the postnatal ward have on occasion been moved to provide Intrapartum Care and replaced by registered nurses to provide post-operative surgical care. We as a division recognise that by rationalising midwifery staffing to our Intrapartum departments to support 1:1 Care in labour may have affected women's experience of postnatal care.

Recruitment

Active recruitment has been undertaken to address vacancy gaps. Maternity has seen in the past 2 years a change in the demographic of its midwifery and support worker age profiles, bringing an increase in retire and return requests, a reduction on overall hours and an increase in maternity leave. This is monitored on a monthly basis by the senior midwifery team and HRBP; we have Trust board approval to over recruit to negate this risk, however there have been challenges noted locally, regionally and nationally with maternity workforce recruitment. To address this Maternity has a comprehensive recruitment plan for student midwives, which involve collaboration with HEIs to support LWH student recruitment programme. We have also engaged with international recruitment successfully recruiting directly from the Republic of Ireland and we presently await Midwives from our successful submission as part of a Northwest Collaboration for global recruitment.

Continuity

Nationally Continuity of Carer remains within a "pause and reflect phase" due to the pandemic. LWH continues to plan the operational delivery of CoC. Birth Rate Plus is devised on a traditional Midwifery case loading model and not CoC. There are ongoing discussions between national CoC leads and the ICS regarding the applicability of Birth Rate Plus in the operational delivery using the systematic evidence tool for CoC.

Delivering Maternity CoC at Full scale (B0961 Delivering-midwifery-continuity-of-carer-at-full-scale.pdf (england.nhs.uk) NHSE 2021) highlights *"There is no evidence that MCoC requires extra midwifery time on an ongoing basis when deployed at scale, but all services need to be fully established for safe care. Women are more likely to experience MCoC in a well-established service"*

As part of the CoC project plan Maternity are working collaboratively with finance to devise costings associated with the operational delivery of Phase 2. Early indication has revealed a cost pressure of midwifery staffing

Recommendation

It is recommended that Trust board receive and the note the information provided in this paper.

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*21/22/160d*		Date: 03/02/2022	
Report Title	**Learning from Deaths Quarter 2, 21/22**			
Prepared by	*Julie Connor, gynaecology risk lead; Ai-Wei Tan, Consultant Obstetrician; Rebecca Kettle, Consultant Neonatologist and Chris Dewhurst, Deputy Medical Director.*			
Presented by	*Lynn Greenhalgh, Medical Director*			
Key Issues / Messages	The Board members are asked to review the contents of the paper and take assurance that there is adequate processes and progress against the requirements laid out by the National Quality Board			
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.*			
	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 when learning from deaths. In addition, as per the Learning from Deaths framework requirements the Board is requested to note: • ***number of deaths in our care*** • ***number of deaths subject to case record review*** • ***number of deaths investigated under the Serious Incident framework*** • ***number of deaths that were reviewed/investigated and as a result considered due to problems in care*** • ***themes and issues identified from review and investigation*** • ***actions taken in response, actions planned and an assessment of the impact of actions taken.***			
Supporting Executive:	Lynn Greenhalgh Medical Director			

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

Liverpool Women's NHS Foundation Trust

5.2 Failure to fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership	
Link to the Corporate Risk Register (CRR) – CR Number:	Comment: No

EXECUTIVE SUMMARY

This "Learning from Deaths" paper presents the mortality data for quarter 2. The "Learning from deaths" information is included for quarter 1 (stillbirths and neonatal deaths) and adult deaths (quarter 2).

In quarter 2 there were the following deaths:

Adult deaths	2
Stillbirths	11 (rate 5.3/1000)
Neonatal deaths	11 (7 inborn, 4 transferred in) (rate 3.4/1000 inborn births)

All Q1 deaths have been reviewed using the appropriate review tools and methodology;

- The review of stillbirths and neonatal deaths are subject to a multidisciplinary review panel meeting with external professionals utilising the Perinatal Mortality Review Tool (PMRT). All cases invited parents to be involved in the review by submitting comments and questions for discussion.
- An expected adult death was reviewed within an internal mortality review. The unexpected death is being reviewed under the Serious Untoward Incident (SUI) framework. This SUI will be included in the Q3 paper.

Lessons learnt and actions taken are presented in this paper. There were no common themes from the quarter 1 reviews.

Changes in clinical care due to the covid pandemic may have played a role in the outcome of 1 case of stillbirth. There was no impact on any other deaths.

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 when learning from deaths. In addition, as per the Learning from Deaths framework requirements the Board is requested to note:

- number of deaths in our care
- number of deaths subject to case record review
- number of deaths investigated under the Serious Incident framework
- number of deaths that were reviewed/investigated and as a result considered due to problems in care
- themes and issues identified from review and investigation

- actions taken in response, actions planned and an assessment of the impact of actions taken.

MAIN REPORT

This is the quarter 2 mortality report for adults, perinatal and neonates. The report is part of the regular reporting schedule of the Trust to ensure that there is oversight and assurance monitoring of the mortality rates related to the clinical activity of the Trust. This is in accordance with recommendations by the National Guidance on Learning From Deaths (National Quality Board).

The data presented relates to quarter 2, 2021-22. The data is presented in the embedded papers. The learning from stillbirths and neonatal deaths relate to deaths occurring in Q1 (due to the MDT review of deaths not occurring in the quarter when the death occurred).

The data contained in this report is not adult standardised mortality data such, due to the low level of deaths of adult patients cared for by the Trust. The use of pure data and not standardised mortality rates has been previously agreed with the CCG as the Trusts approach to monitoring mortality rates.

1 Adult Mortality Q2

1.1 Obstetric Mortality

There were no obstetric deaths in quarter 2. There have been no obstetric deaths in 2021-22.

Out of hospital deaths in Maternity are considered as community deaths and not allocated to the Trust. The Trust does however, review care provided in all these cases to determine any thematic points for learning. There were no reported out of hospital maternal deaths related to women who died within 12 months of delivering a baby at LWH in Q2.

1.2 Gynaecology Mortality

There were 2 deaths within Gynaecology Oncology. (total for 2021-2 = 4 deaths). No "out of hospital" gynaecological deaths in Q2 were observed.

1.3 Learning from Q2 Adult deaths

An expected adult death was reviewed within an internal hospital mortality review with appropriate care provided. An unexpected death was subject to a 72-hour review with a decision made to proceed to a serious untoward incident. The results of this SUI will be presented in the Q3 report.

The reviews of Adult deaths in Q1 identified/initiated the following:

- Learning related to the use of the National Early Warning Score (NEWS). This has been updated with an SBAR incorporated
- The NEWS audit has been updated to reflect the actions taken and outcome. This audit is now electronic with data presented on power BI
- Lessons from a previous SUI included the need for rapid antimicrobial therapy. This has been presented at the Gynaecology Oncology Morbidity & Mortality meeting and included in the newly developed Gynaecology emergencies study day.

2 Stillbirths

There were 11 stillbirths (excluding Termination of pregnancy (TOP)) in the Q2 2021/2022, giving a stillbirth rate of 5.3/1000 (4/1000 in Q1). There were 3 babies (excluding TOP) born between 22-24 weeks gestation who were included in the PMRT process.

There were 7 stillbirths in July. There was no clear indication for this apparent "spike" in stillbirths but the learning from these will be presented in Q3s report.

Table 1 Stillbirths > 24 weeks

STILLBIRTHS	**Apr 21**	**May 21**	**Jun 21**	**Jul 21**	**Aug 21**	**Sep 21**	**TOTAL 2021/22**
Total Stillbirths	3	6	4	7	4	2	26
Stillbirths (excluding TOP)	**3**	**3**	**2**	**7**	**3**	**1**	**19**
Births	639	672	696	692	695	684	4078
Overall Rate/1000 births	4.7	8.9	5.7	10.1	5.8	2.9	6.4
Rate (excluding TOP)/1000	**4.7**	**4.5**	**2.9**	**10.1**	**4.3**	**1.5**	**4.6**
Rate/quarter (excluding TOP) /1000 births	**4.0**			**5.3**			

Previous annual stillbirth rates excluding termination of pregnancy per 1000 births were: 2018/19 = 3.91; 2019/20 = 2.89 and 2020/21 = 3.4. The current data suggest that the still birth rate in 2021/22 will be higher than the previous 2 years. This will be reviewed with Q3 data with a more detailed analysis of stillbirth data.

2.1 Learning from Q1 Stillbirths (n=8)

5/8 cases had appropriate care, 2 cases identified learning that did not impact upon the outcome and 1 case identified learning that may have impacted upon the outcome**.** Learning included**:**

- Changes in clinical care due to the Covid pandemic may have played a role in the outcome of 1 case of stillbirth.
- Importance of compliance with the DNA policy and to ensure appropriate follow up is offered to women after a DNA appointment. Update provided by Lesson of the week (LOTW)
- Importance of face-to-face appointments for booking and CMW reviews. Action complete
- To not give advice to patients that FM is affected by placental site. Update provided by LOTW.
- Guideline updated in relation to monitoring growth to be compliant with recommendations from 'Saving Babies Lives v2'. Complete.

3. Neonatal Deaths

Neonatal deaths can be reported in several ways. The population can include in-born babies only, LWH booked pregnancies or all babies cared for in LWH (including babies transferred to LWH from other care providers). Deaths may be those within 28 days or those prior to discharge from the NICU and may include or exclude babies with congenital anomalies.

It has previously been agreed with the Head of Governance and Deputy Medical Director, that the total mortality and the rate of deaths per 1000 LWH births will be used as the mortality dashboard metric. In quarter 2 there were 11 neonatal deaths in this category. (table 9). Of those who were born at LWH, there were 7 deaths.

Table 9: LWH All Neonatal Mortality

NICU	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	21/22 total
Discharges	94	98	90	91	92	89	100	97	106	93	119	113	628
Total Mortality	0	3	4	6	4	2	3	1	2	5	3	3	18
Births	669	605	605	610	618	658	622	654	673	692	695	684	4020
Mortality Rate per 1000 births	0	4.9	6.6	9.8	6.5	3.0	4.8	1.5	3.0	8.6	4.3	4.3	4.4

3.1 Lessons learnt from Q1 neonatal deaths (n=10)

In 5/10 cases care issues were identified which would not have affected the outcome. Two cases identified antenatal care issues that may have affected the outcome.

- One case identified care issues which may have made a difference to the outcome, related to care received prior to transfer to LWH. The referring hospital is reviewing their referral pathways to the LWH fetal medicine unit.

- The second case identified that a referral to the preterm labour clinic was rejected in error due to reading a historical ultrasound report rather than one from the index pregnancy. Learning and action now means that the most recent ultrasound scan reports are reviewed for FMU by those who receive the referral.

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

- Non co-location with paediatric surgical services, (2 babies). The LNP development will ameliorate this issue.
- Unplanned extubation / ETT dislodgement, 2 babies. A QI project for unplanned extubation is being developed.
- Parent communication. Alder Hey bereavement team reminded to inform LWH's Honeysuckle bereavement team to notify them on the death of a neonate.
- This is monitored through the NNAP and LNP board.
- Admission temperature. There is an ongoing QI for admission hypothermia.
- Genetics not sent on a congenital cardiac anomaly.
- Late antibiotic administration on admission. A preterm pathway is now in place to further standardise the management of extreme preterm infants.

Recommendations

It is it is requested that the members of the quality committee review the contents of the paper and take assurance that there are adequate governance processes in place when learning from deaths. In addition, as per the Learning from Deaths framework requirements the board are requested to note:

- number of deaths in our care
- number of deaths subject to case record review
- number of deaths investigated under the Serious Incident framework
- number of deaths that were reviewed/investigated and as a result considered due to problems in care
- themes and issues identified from review and investigation
- actions taken in response, actions planned and an assessment of the impact of actions taken.

Appendix – Learning from deaths – additional data

Available for Board members in the Microsoft Teams folder

Quality Committee Chair's Highlight Report to Trust Board
20 December 2021

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Ageing midwifery workforce within the Fetal Medicine Unit noted as a risk. Action in relation to the midwifery workforce and how best to utilise skills to maintain a competent workforce across all midwifery units was identified.	• Received the Family Health review of actions from the Theatre Never Events and noted the lack of cross-divisional working to ensure that actions identified from the initial review undertaken by the CSS division be undertaken and embedded across all divisions. It was agreed that a key focus during 2022 should be to improve cross divisional working which would have a positive impact on several workstreams. • Supportive of the Fetal Medicine Unit aspirations to deliver a North Fetal Medicine Network. Discussions to be undertaken with commissioners to take the aspiration forward noted as priority. It was clarified that this development would not undermine the Future Generations programme. • The Committee noted the work underway to progress the divisional five-year transformation plans, the request to take forward discussions with commissioners (FMU) and external providers to strengthen co-dependent working (telemedicine). It was recommended that a combined report be shared with the Trust Board to note quality impacts, commissioning needs and the wider system which support the Trusts key strategic items.
Positive Assurances to Provide	**Decisions Made**
• The Committee noted continued positive progress against the planned trajectory for the Continuity of Carer pathway. • Assured by the continued focus to increase activity and reduce waiting times for patients on the cancer pathways. • Supportive of the Trusts approach to provide clinical support to external clinical services within Cheshire and Merseyside that have identified workforce gaps. • Received a virtual tour and noted the successful relocation of the Fetal Medicine Unit to a newly refurbished unit. • The Committee received a positive presentation in relation to the Maternal Medicine Service and the planned future use of telemedicine to strengthen services for those patients with maternal medicine issues. It was clarified that the work supported the Future Generations workstream.	• Committee reviewed the Quality related BAF risks. It was noted that BAF risk 2.3 had been significantly updated with the addition of a number of actions towards reducing the risk rating. Although not yet added as a control measure it was noted that progress against the Community Diagnostic Centre would support mitigations against this risk.
Comments on Effectiveness of the Meeting / Application of QI Methodology	
• A positive meeting • Tangible ambition demonstrated to develop and grow services	

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
177.	Board Assurance Framework	Assurance	**180.**	Maternal Medicine Service	Information
178.	Quality Performance Report Month 8, 2021/22	Assurance	**181.**	Fetal Medicine Unit Centre and Service Delivery Plans	Assurance
179.	Family Health Review of actions from Theatre Never Events	Assurance			

3. 2021 / 22 Attendance Matrix

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

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

Quality Committee Chair's Highlight Report to Trust Board
24 January 2022

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Vacant standalone posts (or those with an incumbent who is absent) noted as a significant risk. The Committee generated a Chair action to the Putting People First Committee to review standalone positions and mitigations in place. • A high number of out of date policies noted. Corporate Risk Sub-Committee was sighted on the issue and Executives had been tasked to drive improvement within their portfolios. • Safeguarding training compliance below requirement despite actions in place to flex the training programme. The Committee was informed that Divisions had been asked to apply a targeted approach to mandatory training by identifying the most critical elements contributable to patient safety and ensure compliance against these, of which it was felt Safeguarding would be a critical module. • Received a presentation which detailed trajectory against target. Noted the Trust was ahead of trajectory for the 62 day pathway though the gap was increasing across Cheshire and Merseyside. The 52 week position was also worsening but should improve at the Trust as theatre sessions increased. Action to continue to achieve the trajectories against the target were noted, including a review of outpatient pathways and a review of inappropriate primary care referrals. The recent Audit recommendations regarding waiting list management would also be progressed.	• Positive work on the Research, Development and Innovation Strategy and noted the Trust Board would discuss the strategy in a Board development session ahead of finalisation. • The Committee received a position update against the Maternity Incentive Scheme (CNST) Year 4. The Committee tested assurance in relation to one of the metrics related to the peri-natal dashboard and agreed to discuss further at Executive Committee. • Received the outcome of the Imaging external review in response to concerns raised. A number of actions had been identified which related to management and leadership, communication and cultural engagement, and recruitment and retention. The Committee noted the issues identified but requested more information and assurance on how and when the issues would be resolved.
Positive Assurances to Provide	**Decisions Made**
• Committee received a positive update of a review undertaken against the use of Keillands forceps at the Trust in response to the Poppy Harris Case. • The C-Gull pilot had been completed and the project continued towards a go-live date of May/June 2022. • Noted a grant received to enhance the voluntary service. Plans to attract volunteers with skills that could enhance provision for patients e.g. hairdressing and a wish to develop the volunteer workforce to become more representative of the community it is part of noted. • The Committee noted positive progress with the Quality Improvement Engagement and Refresh Project. An external assessment of the process had been undertaken and feedback provided to the Committee. The challenge to embed QI within usual practice as opposed to 'in addition' was noted. New posts within divisions to	• Committee reviewed the Quality related BAF risks. No changes to risks scores or narrative was recommended. The Committee noted a planned review of BAF risk 5.1, Failure to progress our research strategy and foster innovation within the Trust.

support a focus on QI was noted as a positive action. The QI Framework would be shared with the Committee at its next meeting.

- Noted that the National Planning Guidance had been published. The metrics would be reviewed against the planning guidance. Committee noted the continued work to develop and enhance the new template performance report.
- Noted a positive continuation of services throughout December 2021, cancelling only 1 theatre session despite the workforce challenges due to the Omicron variant.
- Committee noted positive impact of the Quality Safety Audit Programme.
- Committee was positively assured by the Family Health Division Safety Champions Update. Issues raised by the Safety Guardians included:
    - 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
    - Issues on Maternity Base affecting patient flow, experience, and staff morale
    - Staff redeployment around the Maternity Division.
- The Committee received assurance of action taken in response to the Ockenden recommendations. The Committee commented on the number of national reports requiring a response from the Family Health division in addition to the pandemic.
- The Committee received and noted positive assurance from the Serious Incidents & Learning Report Quarter 3, 2021/22; Medicines Management Assurance Report Quarter 3; CQC Insight Tool; and the Maternity Services Self-assessment tool.

Comments on Effectiveness of the Meeting / Application of QI Methodology

- A positive meeting
- Level of discussion had been operationally focussed and required more focus on assurance.
- Report authors should be reminded to provide an effective executive summary as per the template.

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
190.	Board Assurance Framework	Assurance	**199.**	Ockenden Response Update	Assurance
191.	Sub-committee Chair Reports	Assurance	**200.**	Imaging External Review	Information
193.	Quality Performance Report Month 9, 2021/22	Assurance	**201.**	Serious Incidents & Learning Report Quarter 3, 2021/22	Assurance
194.	Trajectories against targets update	Assurance	**202.**	Medicines Management Assurance Report Quarter 3	Assurance
195.	Quality Improvement Engagement and Refresh Project Update	Assurance	**203.**	CQC Insight Tool	Assurance

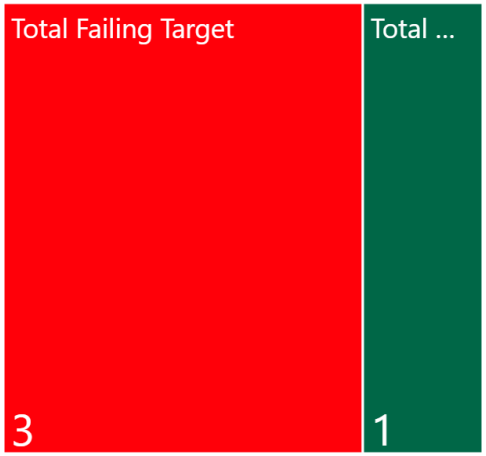
196.	Quality Safety Audit Programme	Information	**204.**	Maternity Services Self-Assessment Tool	Information
197.	Maternity Incentive Scheme (CNST) Year 4 – Scheme Update	Assurance	**205.**	Review use of Keillands forceps at LWH in response to the Poppy Harris Case	Information
198.	Family Health Division Safety Champions Update	Information			

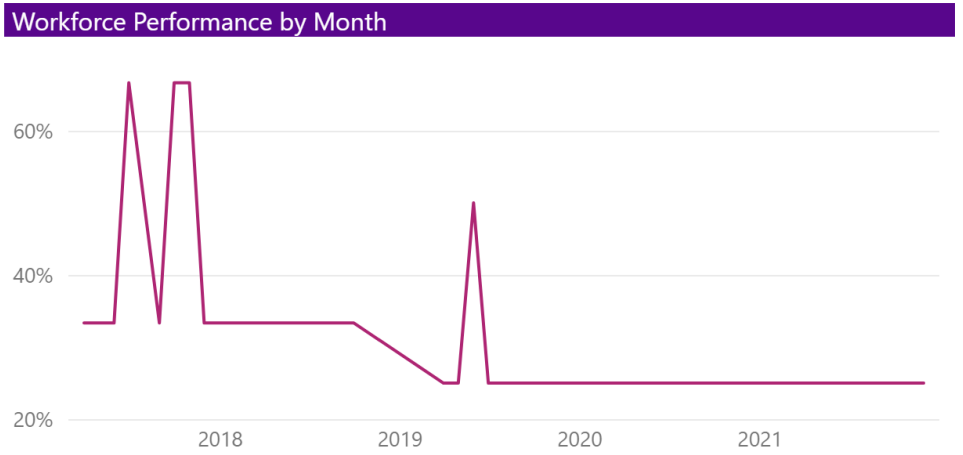
3. 2021 / 22 Attendance Matrix

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

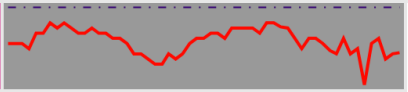
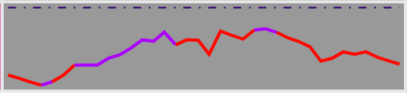
Present (✓) Apologies (A) Representative (R) Nonattendance (NA) *Non-quorate meetings highlighted in greyscale*

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



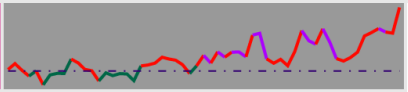
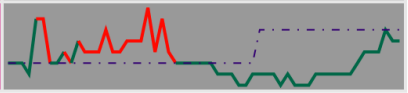


To develop a well led, capable, motivated and entrepreneurial Workforce - Mandatory Training

KPI Owner	KPI	As of Date	Current Value	KPI Status	Target	Denominator	DQ Kite Mark	Trend
Chief People Officer	Mandatory Training Compliance	December 2021	86.23%	-8.77%	95.00%			
	Clinical Mandatory Training Compliance	December 2021	78.26%	-16.74%	95.00%			

KPI	KPI Narrative
Clinical Mandatory Training Compliance	Narrative The overall Trust clinical mandatory training compliance fell by 1% from 79% in month eight, to 78% in month nine. This is now 17% under the Trust's target rate of 95%. In the largest clinical areas, compliance fell by 2% in Maternity, and by 2% in Gynaecology, but remained unchanged in Neonates. At the divisional level, compliance fell by 1% in the Gynaecology Division, and by 1% in Family Health, but increased by 1% in Clinical Support Services, and by 2% in Corporate Division. The HR and L&D teams continue to provide support, information, and training to managers across the Trust. Positive work is on-going with the OLM task and finish group, which has seen improvements with the accessibility of training with automatic enrolments to e-learning packages, which has already seen a marked reduction in monthly queries being highlighted to the L&D team. Bi-monthly training validation has now been completed; the validation meetings are an opportunity to discuss the large volume of local training courses and determine what is mandatory and must be recorded on OLM. This is then validated through Education Governance, the next round are currently planned for April 22, future work is being planned on the method of accessing OLM with a view to further implementing virtual smartcards to easy access not only to OLM & ESR but other clinical systems, there will no longer be a plastic card to carry around and allows for staff to reset their own passwords if they forget them. 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	Narrative The overall Trust mandatory training compliance maintained at 86% for month eight and nine and is now 9% under the Trust's target rate of 95% and rated as amber. In the largest clinical areas, compliance decreased by 2% in Maternity, and by 2% in Gynaecology, while Neonates increased by 4% to 88%. At the divisional level, compliance increased by 1% in Family Health, by 4% in Corporate Division, but fell by 1% in Clinical Support Services, and by 1% in Gynaecology. The HR and L&D teams continue to provide support, information, and training to managers across the Trust. Positive work is on-going with the OLM task and finish group, which has seen improvements with the accessibility of training with automatic enrolments to e-learning packages, which has already seen a marked reduction in monthly queries being highlighted to the L&D team. Bi-monthly training validation has now been completed; the validation meetings are an opportunity to discuss the large volume of local training courses and determine what is mandatory and must be recorded on OLM. This is then validated through Education Governance, the next round are currently planned for April 22, future work is being planned on the method of accessing OLM with a view to further implementing virtual smartcards to easy access not only to OLM & ESR but other clinical systems, there will no longer be a plastic card to carry around and allows for staff to reset their own passwords if they forget them. 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	December 2021	10.26%	+5.76%	4.50%	43341		
	Turnover Rate	December 2021	12.00%	-1.00%	13.00%			

KPI	KPI Narrative
Sickness Absence Rate	Narrative The single month sickness absence figure increased by 2.33%, from 7.93% in month eight, to 10.26% in month nine. This is now 5.76% above the Trust's target figure of 4.50% and is therefore rated as red. In the largest clinical areas, sickness absence increase by 2.63% in Maternity, 2.47% in Gynaecology and 3.92% in Neonates. At divisional level, sickness increased by 2.96% in Family Health, 4.31% in Clinical Support Services, 2.72% in Gynaecology, but decreased by 0.08% in the Corporate Division, although it increased by 2.19% in Gynaecology. Overall, the proportion of sickness that was short term increased by 10% from 30% in month eight to 40% in month nine, which in turn decreased long term sickness by 10% from 70% in month eight to 60% in month nine. 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 increased by 1.73% from 1.84% in month eight to 3.57% in month nine. 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 which is now mandatory for all staff. The programmes to deliver the COVID booster vaccination and the flu vaccination are both now well underway. 74.12% of staff have now had their COVID booster, and 57.46% of staff have had their flu vaccination. 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 shortly. 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)	***21/22/161b***		**Date: 03/02/2022**	
Report Title	**Vaccination as a Condition of Deployment (VCOD)**			
Prepared by	***Michelle Turner, Chief People Officer/Deputy CEO***			
Presented by	***Michelle Turner, Chief People Officer/Deputy CEO***			
Key Issues / Messages	***To detail the steps taken to ensure the Trust is able to meet the requirements of the legislation brought in by Government in January 2022 with regard to Vaccination as a Condition of Deployment for staff in health and social care.***			
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:	**Michelle Turner, Chief People Officer/Deputy CEO**			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

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

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

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

REPORT DEVELOPMENT:

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

EXECUTIVE SUMMARY

The Government announced new regulations, made on 6 January 2022, on mandatory vaccination of staff in health and social care aged 18 or over, who are employed or engaged in the provision of a CQC regulated activity and who have direct, face to face contact with patients, unless medically exempt.

There are some roles, albeit few within the Trust, which do not fall within scope and to which the regulations do not apply. In order to be fully vaccinated staff must have received their first dose of vaccine by 3 February 2022 and the second dose by 31 March 2022. Staff who fall within scope but who fail to take up their vaccine by that date (other than those who are exempt) will be issued with termination of employment notices accordingly.

MAIN REPORT

The Government announced new regulations, made on 6 January 2022, on mandatory vaccination of staff in health and social care aged 18 or over, who are employed or engaged in the provision of a CQC regulated activity and who have direct, face to face contact with patients, unless medically exempt. There are some roles, albeit few within the Trust, which do not fall within scope and to which the regulations do not apply.

In order to be fully vaccinated, if staff choose, they must have received their first dose of vaccine by 3 February 2022 and the second dose by 31 March 2022.

The Trust is required to comply with legislation. There is no discretion to depart from the regulations. The Trust will not pressure or coerce staff to be vaccinated. This is a personal choice for each individual employee and one which the Trust respects. Nevertheless, it is the case that if individuals make the decision not to have the vaccine, the Trust will need to take decisions about their employment if they are, as a result of their choice, not permitted by law to carry out the duties of their role. Where the Trust cannot adjust a role or redeploy an individual, their employment will be terminated. It is important to highlight that the potential to redeploy staff within the Trust will be extremely limited.

Process to date

The Trust has actively promoted uptake of the vaccine to staff since it became available in December 2020. The Trust has provided the opportunity for staff to receive both doses of the vaccine and the booster in the workplace. There have a been a number of vaccination opportunities for staff. A significant communications programme has run alongside the offer, including comprehensive on-line resources, which is regularly updated as information on the vaccine programme has become available. Staff with specific concerns, such as pregnancy, fertility, allergy etc have had the opportunity to be connected to an appropriate health professional to speak about their concerns or anxieties. Managers have held one to one conversations with staff within teams to address vaccine hesitancy or anxiety. The Trust offered its last Vaccine clinic for staff on 19 January. Staff are now signposted to community vaccination provision.

Scope

The regulations refer to individuals being within scope due to the nature of their role or the work they do. When determining whether individuals are in scope or not, consideration must be given to both the duties that are being performed and the location duties are performed in. Clearly, most if not all clinical roles in the Trust, are within scope. However, many corporate and ancillary roles also fall within scope due either their location within the organisation or the requirement of their role to spend time in patient areas.

The Trust has adopted a framework to assess roles against in order to make judgements regarding scope (see Appendix 1). This will also provide evidence of the rationale for deeming a post within scope should that decision by challenged by the employee.

The Trust delivers fertility services. This service is not regulated by the CQC but is regulated by the Human Fertilisation & Embryology Authority (HFEA). However, it is clear that the majority of staff who work in that service at Liverpool Women's and its associated sites do meet the second test of the legislation which relates to direct, face to face contact with patients. For that reason, at Liverpool Women's, it is proposed to include the roles that meet that second test within scope.

New recruitment activity will require the recruiting manager to assess whether, for the safe and effective functioning of the service, any new appointee to the role would require to be vaccinated as a condition of their employment.

Current position

This is a very dynamic situation and the figures given below are correct as at the time of writing the report (26.01.22) but are likely to be out of date by the date of meeting.

Current figures show of LWH directly employed staff (plus doctors in training), 93% of staff are compliant with the regulations. Within the number that are yet to either start or complete their vaccination requirement, there are a number of staff who are either exempt due to pregnancy or other medical reasons.

The Trust is working hard to encourage staff to commence or complete their vaccinations. Individual conversations continue with those staff to understand and hopefully address issues that may be influencing an employee's decision.

The Trust's staff side partners have worked closely with the Trust to encourage and support staff to take up the vaccination and understand the implications of not doing so where their post has been deemed to be within scope.

To date, unvaccinated staff have received two letters from the Chief Nurse/ Medical Director emphasising the importance of vaccination and the majority have accepted the offer of a 1-1 discussion with their line manager or Head of Nursing / Midwifery. A further letter is to be issued from the Chief People Officer highlighting the potential implications for their contract of employment should they continue to fail to access vaccination.

For staff not directly employed by LWH eg facilities, volunteers, agency, bank, students, it is the responsibility of the employing organisation or institution to confirm to the Trust whether individuals have been vaccinated.

Organisational Risks

The Trust is sighted on its organisational risks associated with VCOD. The Chief Operating Officer, through the divisional management structure, has identified a range of potential case scenarios, the impact on service delivery and the action required to mitigate that impact.

Timeline

In accordance with the national guidance, the earliest date that notice of termination of contract will be issued is 3rd February 2022, with the earliest date of dismissal being 31st March 2022.

The categories are as follows:-

1. Those who have not had their vaccination by 3rd February 2022 and therefore cannot meet the requirements of the regulations
2. Those who have had their first vaccination by 3rd February 2022 but have indicated they do not intend to have the second dose by 31st March 2022
3. Those who have had their first vaccination by 3rd February 2022 (being the last date for first vaccinations to meet the regulation requirements) and have indicated their intention to have second vaccination by 31st March 2022

Employees with temporary exemptions will be grouped into a fourth category and appropriate action taken on a case by case basis at the point at which their exemption ends.

4. Those with temporary exemptions e.g., unable to have COVID-19 vaccination due to recent COVID-19 infection, maternity leave or short-term medical exemptions

Employees who refuse to provide evidence of the vaccination status will be grouped into a fifth group:

5. Those who fail or refuse to provide evidence of their vaccination status

Wellbeing support will be available and actively promoted to staff who are going through this process.

Redeployment and adjustments to role

Should employees continue to remain unvaccinated, or not have a second dose vaccination, consideration will be given to adjustments that could be made to the role in the first instance to move the individual out of scope. Consideration will need to be given to availability of accommodation and the impact of any change in location or duties on both the effective delivery of service and the impact on other team members and their roles.

There is a responsibility for individuals who are identified in scope, and who do not meet the exemption criteria, to propose changes or adjustments that they believe could be implemented to take them out of scope for consideration. Managers will also pro-actively consider what adjustments could be made. Any adjustments to duties must be agreed between the line manager and the employee and must not negatively impact on the safe and effective functioning of the service.

Adjustments are likely to fall into two categories:

1. Accommodation changes
2. Changes to contractual duties
    a. Not attending clinical areas
    b. Moving to telephone or virtual service delivery

Redeployment under VCOD could be to a position in the substantive band or any lower band. Pay protection will not apply as redeployment is not the result of organisational change.

The Trust will not create additional positions to support VCOD.

The potential for redeployment is limited.

Recommendation

1. The Board is asked to support the decision to include roles within the Fertility Service (a HFEA regulated activity), that meet the test of direct, face to face contact with patients within scope (other than for the medically exempt).

2. The Board is asked to take assurance that there are clear and effective processes in place to

    - actively promote vaccination to the workforce & address individual concerns
    - identify roles within scope
    - engage with unvaccinated staff to address concerns relating to vaccination
    - require evidence of vaccination compliance from partner organisations
    - understand and mitigate the potential operational impact of staff opting to not have the vaccine
    - meet the requirement of the legislation by 1 April 2022

APPENDIX 1

FRAMEWORK TO ASSESS WHETHER A ROLE FALLS WITHIN SCOPE

Duties	Location	Scope
Duties requiring face to face contact with patients (regardless of frequency)	Any location	In scope
Duties that are performed via telephone or other virtual mechanisms	Work location is in / access is through or adjacent to a clinical area	In scope
Duties that are performed via telephone or other virtual mechanisms	Work location is not in / access is not through or adjacent to a clinical area	Out of scope
Duties that are not patient facing	Work location is in / access is through or adjacent to a clinical area	In scope
Duties that are not patient facing	Work location is not in / access is not through or adjacent to a clinical area	Out of scope
Duties that do not involve contact with patients, but do require contact with staff who have face to face contact with patients	Work location is in / access is through or adjacent to a clinical area	In scope
Duties that do not involve contact with patients, but do require contact with staff who have face to face contact with patients	Work location is not in / access is not through or adjacent to a clinical area	Out of scope
Requirement to participate in an on-call or hot week rota	May require attendance in a clinical area	In scope
Requirement to participate in an on-call or hot week rota	Does not require attendance in a clinical area	Out of scope

Putting People First (PPF) Committee Chair's Highlight Report to Trust Board
17 January 2022

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Maternity core and clinical mandatory training compliance continued to be a matter of concern. • Committee received a detailed Workforce Assurance report from Family Health. The position in relation to the culture, training, and sickness was noted and partial assurance received. It was agreed that a recovery report detailing how the division would manage and improve the position would be provided at a future meeting. • Noted the highest rate of sickness to-date for the Trust during Month 9. Daily absence returns and Covid-19 absence input continued as HR worked closely with all areas to ensure government guidelines adhered to. • The Committee noted a downward trend against turnover compliance currently at 12% across the Trust (1% below the Trust target). HR was monitoring exit interviews and cascaded information back to departments to implement changes. The Committee would receive further update against retention activity within a Flexible Working Update. It was recommended that a Board Workshop session discuss retention to share innovation and experience of Board members from other sectors. • Received the results of the GMC survey noting difficulties related to anaesthetic and GP trainees however overall the Trust had performed well compared to the national benchmark. Committee reviewed the action plan developed in response to the survey and shared with the Trust Board as per CNST requirements. • Received a report into GP rotational training specifically focussed on clinical supervision and induction. A number of incidents had been raised by GP trainees during the recent rotation and escalated within the GMC survey. The recent rotation had highlighted a significant change in practice in relation to the O&G training programme and experience provided within UK Medical Degrees and the practical experience of GP trainees prior to placement at the Trust due to the pandemic and potentially working in a virtual setting during the past 12 months. The Committee noted an action plan had been put in place to address the risks identified and better support the GP Trainees going forward.	• Positive progress to implement the Continuity of Care model received. Proposed changes towards a geographical community hub model for maternity care away from the GP model and the partnership work required to implement the change was noted. • The Mandatory Vaccination Regulations (VCOD) had been enacted in legislation, enforcing a legal requirement for anyone within patient facing roles to be vaccinated against Covid-19 by 01 April 2022, unless exempt. It was reported that approximately 100 members of the workforce had not completed the vaccination programme. A comprehensive update would be provided to the Trust Board in February 2022.
Positive Assurances to Provide	**Decisions Made**
• Received the Freedom to Speak Up Guardian update. Noted a second FTSUG had been appointed, Srinivasarao Babarao (Shri), Neonatal Consultant, who commenced this role as of October 2021. • The Committee noted the Responsible Officer Quarterly Report for Quarter 2 and Q3 2021/22. • Received and assured by the Guardian of Safe Working Hours (Junior Doctors) Quarterly Report Q1 - Q3 2021/22.	• Reviewed the PPF aligned BAF risks, no changes recommended. It was noted that the assurance rating for the strategic threat 'Insufficient numbers of clinical staff resulting in a lack of capability to deliver safe care and effective outcomes' had been moved from an 'amber' rating to 'red' (BAF risk 1.2). It was agreed to maintain the overall risk score of '20' and amend the narrative to accurately reflect the risks. • Approved the Terms of Reference of the Workforce Sub-Committee's.

• Assured by the governance framework in place in relation to the revised Attendance Policy. The outstanding audit action in relation to return-to-work interviews was noted and would be addressed. • Received assurance that the Trust is seeking to implement and embed a Culture of positive behaviours and Just Culture at LWH. • Noted the embargoed results of the Staff Survey 2021 and plans to receive a detailed analysis against the staff survey results at the next Committee meeting. • Noted a review undertaken of Education Governance within the Trust against the HEE Quality framework 2019/20 and planned actions	• Noted Committee e-approval had been sought for 'policies to be approved' and the 'Committee Corporate Objectives 2021/22' in lieu of the November 2021 meeting which had been cancelled due to the major incident.

Comments on Effectiveness of the Meeting / Application of QI Methodology

- There had been good challenge and robust discussion

2. Summary Agenda

No.	Agenda Item	Purpose	Rating	No.	Agenda Item	Purpose	Rating
74.	Board Assurance Framework (BAF): Workforce related risks	Assurance		82.	HENW GMC survey feedback report and action plan	Assurance	
75.	Family Health Workforce Assurance Report	Assurance		83.	Report into GP rotational training at Liverpool Women's Hospital	Information	
76.	Continuity of Care Reflection	Assurance		84.	Education Governance Quality Framework (HEE Quality Framework Annual Assessment)	Information	
77.	Chief People Officer Report	Information		85.	Revised Attendance Policy – Governance Framework	Assurance	
78.	Workforce KPI Dashboard Report	Assurance		86.	Responsible Officer Report (Medical Revalidation) Quarter 2 and Q3 2021/22	Information	
79.	Freedom to Speak Up Guardian Update	Information		87.	Guardian of Safe Working Hours (Junior Doctors) Quarterly Report Q1- Q3 2021/22	Assurance	
80.	LWH People Promise (and Just Culture Approach)	Assurance		88.	Subcommittee chairs reports & Terms of reference	Assurance	
81.	Staff Survey Update	Assurance					

3. 2021 / 22 Attendance Matrix

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

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

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	**21/22/162a**		**Date: 03/02/2022**	
Report Title	**Finance Performance Review Month 9 2021/22**			
Prepared by	***Claire Scott, Acting Deputy Chief Finance Officer***			
Presented by	***Eva Horgan, Chief Finance Officer***			
Key Issues / Messages	***To note the Month 9 financial position.*** ***To approve*** - ***The award of the Linen and Laundry contract.*** - ***The award of the Clinical Waste contract.***			
Action required	**Approve ☒**	**Receive ☐**	**Note ☒**	**Take Assurance ☐**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	***To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it***	***For the intelligence of the Board / Committee without in-depth discussion required***	***To assure the Board / Committee that effective systems of control are in place***
	Funding Source (If applicable): N/A			
	For Decisions - in line with Risk Appetite Statement – ***If no – please outline the reasons for deviation.***			
	The Board is asked to note the Month 9 Financial Position and approve - ***The award of the Linen and Laundry contract.*** - ***The award of the Clinical Waste contract.***			
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)							

Liverpool Women's NHS Foundation Trust

Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* 4.1 Failure to ensure our services are financially sustainable in the long term	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

At Month 9, the Trust is reporting a £1.7m deficit Year to Date (YTD) against a £0.3m deficit plan, and a breakeven forecast in line with the revised Board approved plan. The YTD trust wide position has worsened in month due to increasing pay cost pressures in relation to agency and other cover for rising sickness and staff absence figures, predominantly due to Covid-19.

Whilst the Cost Improvement Programme (CIP) continues to deliver, Elective Recovery Fund (ERF) income is significantly behind plan, with the year to date position reflecting the risk relating to Cheshire & Merseyside (C&M) delivery. Capital spend is behind plan but expected to increase.

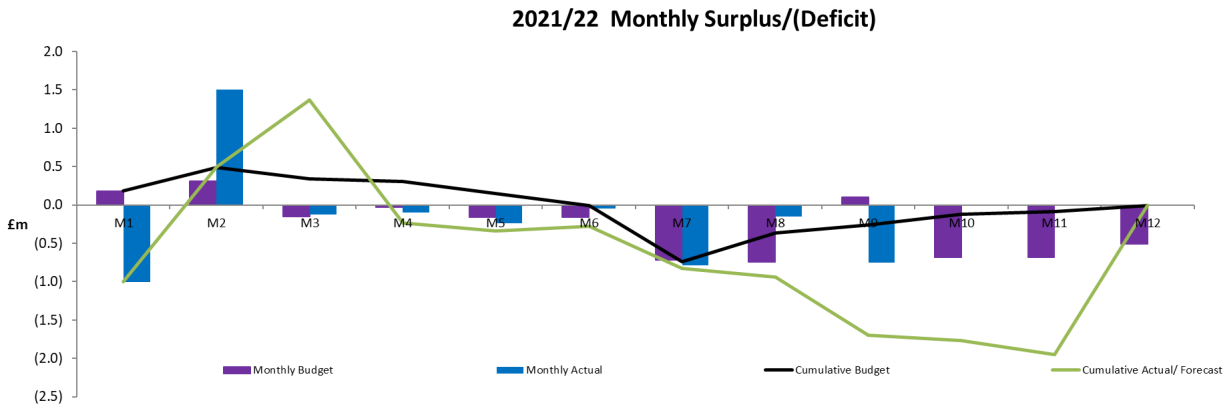
	Plan (Revised)	Actual	Variance	RAG	*R*	*A*	*G*
Surplus/(Deficit) YTD	-£0.3m	-£1.7m	-£1.4m	↓	*>10% off plan*	*Plan*	*Plan or better*
I&E Forecast	£0.0m	£0.0m	£0.0m	↔	*>10% off plan*	*Plan*	*Plan or better*
NHS I/E Rating	3	3	0	↔	*4*	*3*	*2+*
Cash	£4.2m	£5.6m	£1.4m	↓	*<£1m*	*£1m-£4.5m*	*£4.5m+*
Total CIP Achievement	£0.9m	£1.0m	£0.1m	↑	*>10% off plan*	*Plan*	*Plan or better*
Recurrent CIP Achievement	£0.9m	£0.8m	-£0.1m	↑	*>10% off plan*	*Plan*	*Plan or better*
Elective Recovery Fund (net)	£2.4m	£1.3m	-£1.2m	↑	*>10% off plan*	*Plan*	*Plan or better*
Non-Recurrent Items YTD	£0.0m	£2.4m	£2.4m	↓	*>£0*		*<£0*
Capital Spend YTD	£5.8m	£3.5m	-£2.3m				

Liverpool Women's NHS Foundation Trust

MAIN REPORT

1. Summary Financial Position

At Month 9 the Trust is reporting a Year to Date (YTD) deficit of £1.7m, against a £0.3m deficit plan per the revised budget. The graph below shows the forecast against the revised plan.



2. Divisional Summary Overview

Financial performance remains a concern for Family Health and Gynaecology divisions in particular with increasing pay pressures across services. Divisions continue to be monitored against their original agreed positions with the balance to the agreed trust plan held centrally, other than in relation to the pay award funding which has been devolved to divisions.

Agency spend across the Trust is now £2.2m YTD, and the forecast increased to £3.0m full year although work is ongoing to reduce this, particularly in maternity.

3. Community Diagnostic Centre

Expenditure and income in relation to the Community Diagnostic Centre is included in the forecast. As this was not budgeted it shows as a variance against budget. In totality, the Trust is expecting to spend the full revenue allocation of £2.4m. This is kept under close review and is managed via the CDC Oversight Group.

4. Elective Recovery Fund

The Trust and Cheshire & Mersey as a whole need to achieve a completed referral to treatment (RTT) pathway activity above a 2019/20 89% threshold to achieve ERF payment in the second half of the year. Cheshire & Mersey have achieved 89.2% of total weighted activity for October, against the threshold of 89% so receiving a total payment of just £174k across the region. The Trust is one of five providers who achieved activity above the 89% threshold in October. The £174k has been weighted across the five providers ERF achievement, equating to £1k for the Trust.

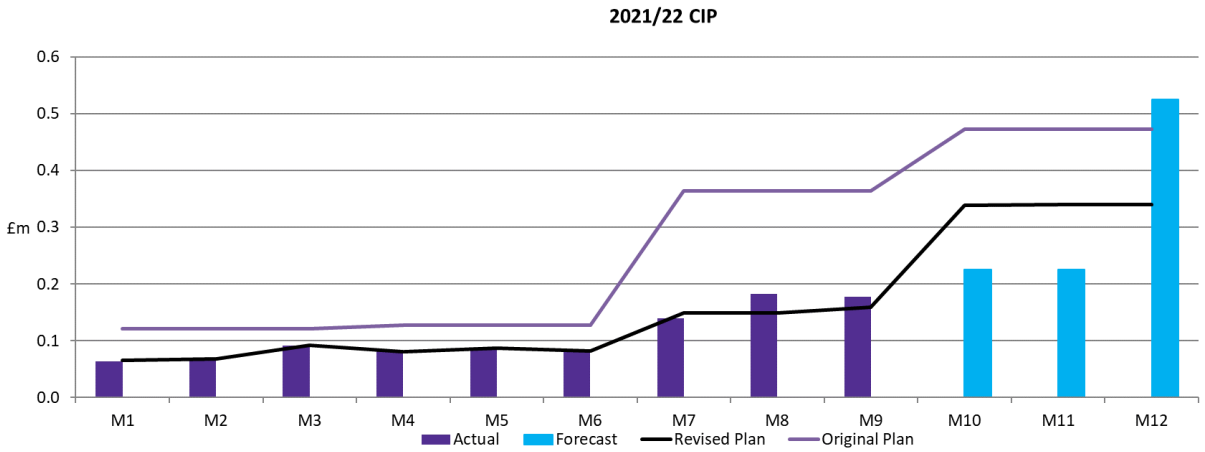
Note that the activity has not been adjusted for Termination of Pregnancy pathway changes which impact on the ERF, although this is still being rigorously pursued with the national team and ICS.

The Trust would have earned nearly £1m of ERF income in Quarter Three alone, if the baseline adjustment had been made, as a standalone organisation.

5. CIP

The CIP plan was revised as part of the H2 planning process and approval. Monitoring against the original agreed CIP plans continues as well as against the revised target. CIP is on track to deliver against the revised plan.

The graph below shows both the original and revised plans and the forecast.



6. Improving Me

A budget for Improving Me, the hosted service which incorporates the Local Maternity System, has been set for the 2021/22 financial year based on project deliverables and other funding plans agreed in approved business cases and bids.

At Month 9, Improving Me are forecasting to spend in line with the funding envelope. Income is released in line with expenditure incurred. In terms of spend to date against the planned budget, Improving Me are £0.5m ahead of plan.

7. COVID-19

The Trust spent just under £1m on direct Covid-19 related costs YTD to Month 9.

8. Cash and Borrowings

The closing cash balance in Month 9 is £5.6m. Additional cash support via Cheshire & Merseyside and Liverpool CCG which was agreed for Quarter Three is now being returned, but the medium and long term position still remains a risk.

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

9. Capital Expenditure

Capital expenditure was relatively low again in month. It is expected to increase in coming months as a number of large purchases including an MRI scanner are being processed, however there is still some risk that this will not be

achieved. A capital working group, led by the Deputy Chief Operating Officer, has been set up internally to ensure expenditure is monitored and progressed.

10. Board Approval

As per Trust Standing Financial Instructions, Board approval is required for recommending contract awards with a value over £500k. The following items have been through a full procurement process and are recommended for Board approval.

- **Award of Linen and Laundry contract:** LWH's linen and laundry contract is due to expire on 31st March 2022. The Cheshire & Merseyside Health and Care Partnership undertook a Further Competition for the provision of a linen and laundry contract for trusts who were out of contract or expiring within the next 12 months. The Further Competition was conducted using the Countess of Chester Hospital NHS Foundation Trust Healthcare Laundry & Linen Services Dynamic Purchasing System, a compliant procurement route in line with Public Contract Regulations 2015.
  Liverpool Women's were lotted in a geographically determined lot with other in-scope trusts in Liverpool. The contract length procured was three years with optional extension of up to two years to align contract end dates of the trusts involved. Bids were evaluated on priced and non priced elements, with a 60% weighting to quality and 40% to price, and a successful bidder has been identified following evaluation.

  The total proposed contract value has been shared with the Board. This represents a recurrent saving of c£9k against the current contract and meets the needs and specification supplied by LWH.

  The Board is recommended to approve the contract award noting the process followed.

- **Award of Clinical Waste contract:** LWH's clinical waste contract is due to expire on 22nd April 2022. As part of the regional procurement work, in line with the Carter at Scale agenda, clinical waste services were procured using a regional lotted approach. Liverpool Women's were lotted in Lot 1 along with acute trusts whose contracts all expire in April, with community and mental health trusts in Lot 2. HealthTrust Europe, a framework provider, were engaged to carry out the open tender on behalf of Cheshire and Merseyside cluster for a five year contract initial term with an optional two year extension. Bids were evaluated on price and quality with a 60% weighted to quality (with a number of pass/fail requirements and specific weighted requirements within that) and 40% on price.

  The bidders have now been evaluated and the Board is recommended to make an award to the top scoring bidder. Note that despite the quality weighting, this was also the lowest cost bid. The total contract value and proposed length has been shared with the Board. This represents a £40k per annum cost pressure. This is due to the current contract being below market standard and costs. Whilst the Trust does have the option to withdraw and conduct a separate standalone procurement process, given the process already followed this is unlikely to yield further savings.

  The Board is recommended to approve this contract award, noting the partnership approach across C&M and full tender process followed.

11. BAF Risk

There are no proposed changes to the BAF score.

Liverpool Women's NHS Foundation Trust

12. Conclusion & Recommendation

The Board is asked to note the position and is recommended to approve the linen and laundry and clinical waste contract awards as outlined above.

Liverpool Women's
NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

FINANCE REPORT: M9

YEAR ENDING 31 MARCH 2022

NHS
Liverpool Women's
NHS Foundation Trust

Contents

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 1
NHS IMPROVEMENT RATIOS: M09
YEAR ENDING 31 MARCH 2022

USE OF RESOURCES RISK RATING	YEAR TO DATE Actual
CAPITAL SERVICING CAPACITY (CSC)	
(a) EBITDA + Interest Receivable	4,275
(b) PDC + Interest Payable + Loans Repaid	1,497
CSC Ratio = (a) / (b)	**2.86**
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	(14,875)
(b) Expenditure	95,519
(c) Daily Expenditure	347
Liquidity Ratio = (a) / (c)	**(42.8)**
NHSI LIQUIDITY SCORE	**4**
Ratio Score 1 = > 0 2 = (7) - 0 3 = (14) - (7) 4 = < (14)	
I&E MARGIN	
(Surplus) / Deficit (Adjusted for donations and asset disposals)	1,694
Total Income	(99,794)
I&E Margin	**-1.70%**
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)	-1.70%
I&E Margin (Plan)	-0.30%
I&E Variance Margin	**-1.4%**
NHSI I&E MARGIN VARIANCE SCORE	**3**
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	1,341
YTD Agency Expenditure	2,218
	65%
NHSI AGENCY SPEND SCORE	**4**
Ratio Score 1 = < 0% 2 = 0% - 25% 3 = 25% - 50% 4 = > 50%	
Overall Use of Resources Risk Rating	**3**

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

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
INCOME & EXPENDITURE: M9
YEAR ENDING 31 MARCH 2022

INCOME & EXPENDITURE	Month 9			YTD			YEAR		
£'000	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Forecast	Variance
Income									
Clinical Income	(10,624)	(10,585)	(39)	(94,870)	(94,848)	(22)	(126,035)	(129,040)	3,006
Non-Clinical Income	(571)	(544)	(27)	(5,188)	(4,946)	(242)	(6,943)	(8,451)	1,508
Total Income	**(11,196)**	**(11,129)**	**(66)**	**(100,058)**	**(99,794)**	**(264)**	**(132,978)**	**(137,491)**	**4,514**
Expenditure									
Pay Costs	6,709	7,100	(391)	57,942	60,034	(2,092)	77,976	80,785	(2,809)
Non-Pay Costs	2,148	2,509	(360)	22,010	21,259	751	27,917	29,765	(1,848)
CNST	1,581	1,581	(0)	14,226	14,226	(0)	18,968	18,968	(0)
Total Expenditure	**10,437**	**11,189**	**(752)**	**94,178**	**95,519**	**(1,341)**	**124,861**	**129,518**	**(4,657)**
EBITDA	**(758)**	**60**	**(818)**	**(5,880)**	**(4,275)**	**(1,605)**	**(8,117)**	**(7,973)**	**(144)**
Technical Items									
Depreciation	471	460	10	4,386	4,188	198	5,821	5,618	203
Interest Payable	3	3	(0)	29	30	(2)	38	39	(2)
Interest Receivable	0	0	0	0	0	0	0	0	0
PDC Dividend	183	219	(36)	1,727	1,772	(45)	2,275	2,355	(80)
(Profit) / Loss on Disposal of assets	0	0	0	0	(20)	20	0	(20)	20
Total Technical Items	**656**	**682**	**(26)**	**6,141**	**5,971**	**170**	**8,134**	**7,993**	**141**
(Surplus) / Deficit	**(102)**	**742**	**(844)**	**261**	**1,696**	**(1,435)**	**17**	**20**	**(2)**

Note that the deficit forecast and variance is in relation to the treatment of technical items within the position.

Liverpool Women's
NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST **2a**
INCOME & EXPENDITURE HOSTED SERVICES (Improving Me): M9
YEAR ENDING 31 MARCH 2022

INCOME & EXPENDITURE £'000	Month 9 Budget	Month 9 Actual	Month 9 Variance	YTD Budget	YTD Actual	YTD Variance
Income						
Clinical Income	(213)	(678)	466	(2,171)	(2,662)	491
Non-Clinical Income	0	0	0	0	(20)	20
Total Income	**(213)**	**(678)**	**466**	**(2,171)**	**(2,682)**	**511**
Expenditure						
Pay Costs	102	53	49	844	422	421
Non-Pay Costs	111	625	(514)	1,327	2,259	(932)
Total Expenditure	**213**	**678**	**(466)**	**2,171**	**2,682**	**(511)**
(Surplus) / Deficit	**0**	**0**	**0**	**0**	**0**	**(0)**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 3
EXPENDITURE: M9
YEAR ENDING 31 MARCH 2022

EXPENDITURE £'000	MONTH Budget	MONTH Actual	MONTH Variance	YEAR TO DATE Budget	YEAR TO DATE Actual	YEAR TO DATE Variance	YEAR Budget
Pay Costs							
Board, Execs & Senior Managers	348	349	(1)	3,176	3,107	69	4,252
Medical	1,774	1,820	(45)	15,237	15,531	(294)	20,615
Nursing & Midwifery	2,987	2,880	107	25,041	25,841	(801)	33,906
Healthcare Assistants	479	450	28	4,338	3,837	501	5,774
Other Clinical	412	424	(12)	3,591	3,555	36	4,827
Admin Support	611	695	(84)	5,524	5,945	(421)	7,356
Agency & Locum	98	481	(384)	1,035	2,218	(1,182)	1,245
Total Pay Costs	**6,709**	**7,100**	**(391)**	**57,942**	**60,034**	**(2,092)**	**77,976**
Non Pay Costs							
Clinical Suppplies	753	670	83	6,838	6,911	(72)	9,099
Non-Clinical Supplies	288	499	(211)	4,622	4,266	356	5,527
CNST	1,581	1,581	(0)	14,226	14,226	(0)	18,968
Premises & IT Costs	708	877	(169)	6,418	6,313	105	8,543
Service Contracts	399	462	(63)	4,132	3,769	363	4,749
Total Non-Pay Costs	**3,729**	**4,089**	**(360)**	**36,236**	**35,485**	**751**	**46,885**
Total Expenditure	**10,437**	**11,189**	**(752)**	**94,178**	**95,519**	**(1,341)**	**124,861**

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.

NHS
Liverpool Women's
NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 4
COVID EXPENDITURE: M9
YEAR ENDING 31 MARCH 2022

EXPENDITURE	MONTH			YEAR TO DATE		
£'000	Budget	Actual	Variance	Budget	Actual	Variance
Pay Costs						
Board, Execs & Senior Managers	0	0	0	0	1	(1)
Medical	0	4	(4)	0	13	(13)
Nursing & Midwifery	43	32	11	458	266	192
Healthcare Assistants	11	7	4	200	98	102
Other Clinical	0	1	(1)	1	4	(3)
Admin Support	32	23	9	232	221	11
Agency & Locum	0	0	0	90	70	20
Total Pay Costs	**86**	**67**	**19**	**981**	**673**	**308**
Non Pay Costs						
Clinical Suppplies	8	5	3	100	60	40
Non-Clinical Supplies	0	3	(3)	6	(4)	10
CNST	0	0	0	0	0	0
Premises & IT Costs	14	20	(6)	252	197	55
Service Contracts	0	3	(3)	0	33	(33)
Total Non-Pay Costs	**22**	**32**	**(10)**	**358**	**285**	**73**
Total Expenditure	**109**	**99**	**10**	**1,339**	**958**	**381**

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

NHS Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 5
BUDGET ANALYSIS: M9
YEAR ENDING 31 MARCH 2022

INCOME & EXPENDITURE	MONTH			YEAR TO DATE			YEAR		
£'000	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Actual	Variance
Maternity									
Income	(4,000)	(3,817)	(183)	(36,002)	(36,076)	74	(48,003)	(47,937)	(66)
Expenditure	1,998	2,454	(456)	18,056	19,889	(1,833)	24,049	26,569	(2,520)
Total Maternity	**(2,003)**	**(1,363)**	**(639)**	**(17,946)**	**(16,187)**	**(1,759)**	**(23,954)**	**(21,368)**	**(2,586)**
Neonatal									
Income	(1,743)	(1,767)	24	(15,690)	(15,575)	(115)	(20,920)	(20,799)	(122)
Expenditure	1,271	1,334	(63)	11,435	11,463	(28)	15,217	15,265	(48)
Total Neonatal	**(473)**	**(433)**	**(40)**	**(4,255)**	**(4,112)**	**(143)**	**(5,703)**	**(5,533)**	**(169)**
Division of Family Health - Total	**(2,475)**	**(1,796)**	**(679)**	**(22,201)**	**(20,300)**	**(1,902)**	**(29,657)**	**(26,902)**	**(2,755)**
Gynaecology									
Income	(2,041)	(1,913)	(128)	(18,372)	(16,849)	(1,523)	(24,547)	(22,518)	(2,029)
Expenditure	1,149	1,207	(59)	10,217	10,935	(719)	13,663	14,475	(813)
Total Gynaecology	**(893)**	**(706)**	**(187)**	**(8,156)**	**(5,914)**	**(2,242)**	**(10,884)**	**(8,043)**	**(2,842)**
Hewitt Centre									
Income	(778)	(641)	(136)	(6,948)	(6,674)	(274)	(9,449)	(9,330)	(119)
Expenditure	671	665	6	6,292	6,596	(304)	8,305	8,692	(387)
Total Hewitt Centre	**(107)**	**24**	**(131)**	**(657)**	**(78)**	**(578)**	**(1,145)**	**(639)**	**(506)**
Division of Gynaecology - Total	**(999)**	**(682)**	**(317)**	**(8,813)**	**(5,992)**	**(2,820)**	**(12,029)**	**(8,681)**	**(3,347)**
Theatres									
Income	0	0	0	0	0	0	0	0	0
Expenditure	828	920	(92)	7,549	7,789	(240)	10,041	10,389	(348)
Total Theatres	**828**	**920**	**(92)**	**7,549**	**7,789**	**(240)**	**10,041**	**10,389**	**(348)**
Genetics									
Income	(13)	(10)	(3)	(113)	(47)	(65)	(150)	(75)	(75)
Expenditure	147	120	28	1,327	1,146	181	1,769	1,545	224
Total Genetics	**135**	**110**	**25**	**1,214**	**1,099**	**116**	**1,619**	**1,470**	**149**
Other Clinical Support									
Income	(367)	(391)	24	(3,305)	(3,404)	99	(4,451)	(4,604)	152
Expenditure	645	548	97	5,738	5,681	57	7,673	7,273	400
Total Clinical Support	**278**	**157**	**120**	**2,434**	**2,277**	**156**	**3,222**	**2,670**	**552**
Division of Clinical Support - Total	**1,240**	**1,187**	**53**	**11,198**	**11,165**	**32**	**14,881**	**14,528**	**353**
Corporate & Trust Technical Items									
Income	(2,466)	(3,268)	803	(21,798)	(23,849)	2,051	(28,990)	(35,693)	6,703
Expenditure	4,599	5,302	(703)	41,876	40,672	1,204	55,812	56,767	(955)
Total Corporate	**2,133**	**2,034**	**99**	**20,078**	**16,823**	**3,255**	**26,821**	**21,073**	**5,748**
(Surplus) / Deficit	**(102)**	**742**	**(844)**	**261**	**1,696**	**(1,435)**	**17**	**19**	**(2)**
Of which is hosted;									
Income	(213)	(678)	466	(2,171)	(2,682)	511	(3,533)	(3,465)	(68)
Expenditure	213	678	(466)	2,171	2,682	(511)	3,533	3,464	69
Total Corporate	**0**	**0**	**0**	**0**	**0**	**(0)**	**0**	**(1)**	**1**

Liverpool Women's
NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 6
CIP: M9
YEAR ENDING 31 MARCH 2022

Scheme	Month 9			YTD		
	Target	Actual	Variance	Target	Actual	Variance
Procurement and Non Pay	85	121	36	516	571	56
Estates Utilisation	0	0	0	0	0	0
Staffing and Skill Mix	33	33	0	201	201	0
Outpatients Utilisation	0	0	0	0	0	0
Medicines Management	5	5	0	15	15	0
Service Developments	19	19	(0)	151	151	(0)
Strategic Review	17	0	(17)	50	58	8
Theatre Efficiency	0	0	0	0	0	0
Technology Driven Efficiences	0	0	0	0	0	0
	159	**178**	**19**	**932**	**996**	**64**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 7
BALANCE SHEET: M09
YEAR ENDING 31 MARCH 2022

BALANCE SHEET £'000	YEAR TO DATE Opening	M09 Actual	Movement
Non Current Assets	90,086	89,428	(658)
Current Assets			
Cash	4,235	5,621	1,386
Debtors	4,976	8,481	3,505
Inventories	410	464	54
Total Current Assets	**9,621**	**14,566**	**4,945**
Liabilities			
Creditors due < 1 year - Capital Payables	(3,447)	(1,099)	2,348
Creditors due < 1 year - Trade Payables	(13,728)	(17,998)	(4,270)
Creditors due < 1 year - Deferred Income	(3,136)	(6,948)	(3,812)
Creditors due > 1 year - Deferred Income	(1,592)	(1,572)	20
Loans	(2,136)	(1,830)	306
Provisions	(4,090)	(3,065)	1,025
Total Liabilities	**(28,129)**	**(32,512)**	**(4,383)**
TOTAL ASSETS EMPLOYED	**71,578**	**71,482**	**(96)**
Taxpayers Equity			
PDC	62,927	64,527	1,600
Revaluation Reserve	7,522	7,522	0
Retained Earnings	1,129	(567)	(1,696)
TOTAL TAXPAYERS EQUITY	**71,578**	**71,482**	**(96)**

NHS
Liverpool Women's
NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 8
CASHFLOW STATEMENT: M09
YEAR ENDING 31 MARCH 2022

CASHFLOW STATEMENT £'000	Actual
Cash flows from operating activities	86
Depreciation and amortisation	4,188
Impairments and reversals	0
Income recognised in respect of capital donations (cash and non-cash)	(34)
Movement in working capital	2,722
Net cash generated from / (used in) operations	**6,962**
Interest received	0
Purchase of property, plant and equipment and intangible assets	(5,844)
Proceeds from sales of property, plant and equipment and intangible assets	20
Net cash generated from/(used in) investing activities	**(5,824)**
PDC Capital Programme Funding - received	1,600
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	**248**
Increase/(decrease) in cash and cash equivalents	**1,386**
Cash and cash equivalents at start of period	4,235
Cash and cash equivalents at end of period	**5,621**

LOANS SUMMARY £'000	Loan Principal Drawndown	Loan Principal Repaid	Loan Principal Outstanding
Loans from Department of Health - Capital (ITFF) - 2.0% Interest Rate	5,500	(3,670)	1,830
Loans from Department of Health - Capital (Neonatal) - 2.54% Interest Rate	14,572	(14,572)	0
Loans from Department of Health - Revenue - 1.50% Interest Rate	14,612	(14,612)	0
Total	**34,684**	**(32,854)**	**1,830**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST **9**
CAPITAL EXPENDITURE: M09
YEAR ENDING 31 MARCH 2022

CAPITAL EXPENDITURE	Year to Date			FOT		
£'000	Plan	Actual	Variance	Plan	Actual	Variance
Estates	**522**	181	**341**	700	584	**116**
Capital Projects	**3,787**	2,151	**1,636**	7,374	5,317	**2,057**
IM&T	**1,044**	1,012	**32**	2,653	2,048	**605**
Medical Equipment	**303**	132	**171**	302	608	**(306)**
Other	**99**	21	**78**	101	729	**(628)**
Additional Items				0	1,844	**(1,844)**
Total	**5,755**	**3,497**	**2,258**	**11,130**	**11,130**	**0**

Finance, Performance & Business Development Chair's Highlight Report to Trust Board
20 December 2021

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Elective Recovery Fund income is significantly behind plan, with nothing recognised in the H2 position due to risk relating to Cheshire & Merseyside delivery as well as the Termination of Pregnancy baseline adjustment not being agreed. Cheshire and Merseyside (C&M) HCP is working with the national team around accessing funding set aside for ERF. In addition, work is ongoing by organisations within C&M to identify and release flexibility across the region. • Additional challenge caused by the Omicron variant was noted as an impact on workforce and wider system pressures. • The Committee received a presentation detailing the operational planning process undertaken for 2022/23. It was noted that it is an operationally and clinically driven process. The key risks and opportunities were highlighted. The Committee considered the process and approach. It was noted that additional funding would likely be required for gynaecology and maternity. Although agreement would be needed with C&M, it is the Trust Board which would be asked to sign off the plan and budgets in April 2022. The Committee would be kept updated with progress on a monthly basis. • In relation to the EPR Programme the Committee noted that a trust had identified several issues with the EPMA (TTO) functionality. In response workshops had been held with all Meditech UK customers. The development was reviewed and supported and Meditech had scheduled the development work commencing in December 2021. Meditech had now finalised the plan for the delivery of the development and it would be in three main phases during December 2021, March 2022, and May 2022. A workshop would be scheduled for Liverpool Women's Pharmacy Team to review the detail of the development and determine the impact of each item for the Trust. This was expected to occur in January 2022. At a minimum the Trust would require software development due to be delivered in May 2022 which would likely alter the date of the planned proposed Go-Live date of June 2022.	• The Committee received an update in relation to the Community Diagnostic Centre (CDC) noting positive progress and engagement with the other partner trusts. Clarification with regards to the costs of securing and removing portacabins would be provided to the Committee subsequent to the meeting. [NB: This was followed up by email directly after the meeting; these costs are included.] • The Committee received an update from the Crown Street Enhancements Programme noting that Phase 2 works (CT and MR imaging and colposcopy) had commenced. Work had been paused temporarily following the major incident which occurred on 14 November 2021, however this had recommenced with good progress made. • Committee noted work undertaken towards delivering a Net Zero NHS and development of a Trust Green Plan. The Trust Green plan would be submitted for approval to the Trust Board in January 2022 (later deferred to February 2022) and launched in March 2022. It was clarified that the schemes had been identified against the national requirements and measurables against each would be provided within the next report. It was recommended that reference to the Future Generations plan be included.
Positive Assurances to Provide	**Decisions Made**
• The Committee noted a breakeven plan had been approved for the full year. At the time of approval of the plan for the second half of the year (H2), a number of risks had been noted, particularly in relation to Elective Recovery Fund (ERF) income and CIP. Against the revised plan, CIP is now improved, with the shortfall of unidentified CIP closed. There had also been improvements in the pay run rate compared to the H2 plan following concerted focus through the efforts of divisions and actions taken through Financial Recovery Board and at other forums. • Noted positive operational performance during Month 8 despite the major incident. • Continued consistent delivery of activity against cancer performance targets, noting improvements against the 31 DTT, 62 day, and maintained performance in 2 week waits. The	• Reviewed the FPBD related BAF risks. The Committee was asked to consider the capability of the organisation to manage competing projects as an increasing challenge. The Committee agreed to receive a proposal at the next meeting. • Approved the Crown Street Enhancements Programme Board Terms of Reference, subject to clarity with regards to external membership of the Programme Board.

Committee commended the progress made. It was suggested that trajectories could be utilised for other aspects of the performance report as a way to better inform the Committee. • Committee supported the Trust approach to provide clinical support to external clinical providers within Cheshire and Merseyside. • Positive assurance from progress within the digital programme with activities underway for Digital Maternity, and the GDE programme. The Committee discussed the capacity of the team and maintaining progress against the workstreams alongside competing pressures within the divisions and workforce.	

Comments on Effectiveness of the Meeting / Application of QI Methodology

- Positive meeting.

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
150.	Board Assurance Framework Review	Assurance	156.	Crown Street Enhancements Programme	Information
151.	Finance Performance Report Month 8 2021/22	Assurance	157.	Delivering a Net Zero NHS and Trust Green Plans	Information
152.	Operational Performance Report Month 8 2021	Assurance	158.	Digital Services Update	Assurance
153.	Recovery and Restoration	Assurance	159.	Modern Slavery Act 2015 – Trust Statement	Approval
154.	2022/23 Planning Update	Assurance	140.	Sub-Committee Chairs Reports	Assurance
155.	Community Diagnostic Centre Update	Information	141.		

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	✓	✓	A			

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

Finance, Performance & Business Development Chair's Highlight Report to Trust Board
24 January 2022

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Month 9, the Trust is reporting a £1.7m deficit Year to Date (YTD) against a £0.3m deficit plan, and a breakeven forecast in line with the revised Board approved plan. The YTD Trust wide position had worsened in month due to increasing pay cost pressures in relation to rising sickness and staff absence figures predominantly due to Covid-19. The Committee requested sight of scenario planning and potential risks to the breakeven position as we move towards the end of H2. • Elective Recovery Fund (ERF) income is significantly behind plan, with the year to date position reflecting the risk relating to Cheshire & Merseyside (C&M) delivery as well as ongoing uncertainty regarding the Termination of Pregnancy baseline adjustment. • Noted a significant amount of Capital Expenditure to spend over the coming months and some risk that this would not be achieved. The Committee noted that a capital working group had been set up internally to ensure expenditure is monitored and progressed. • Increasing pay pressures and significant increased agency spend, particularly in Maternity. • Moderate assurance received regarding the current position of third-party service provider controls in place at the Trust. It was noted that the risk would be moved off the Finance Risk Register and added to the Corporate Risk Register. Quarterly updates would be received by the Committee for assurance. • Update received on Meditech Expanse and functionality of the electronic prescribing module. Development work required to resolve EPMA issues indicate a minimal delay of two months from previously reported timescale. Anticipate an end Quarter 3 Go-live date to be considered feasible. The Committee raised concern in relation to a potential rise in costs due to project delays beyond the original timetable.	• The Committee received a detailed presentation on the Planning position for 2022/23. The Committee was assured by the process undertaken to put in place robust planning whilst noting the considerable challenges expected during 2022/23. The pressure on elective recovery alongside the introduction of national initiatives, e.g. Continuity of Carer, BirthRate Plus and associated additional costs to achieve these aims was noted. The importance of effective communication and further work with primary care partners and commissioners was highlighted. • Committee received a Payments update and noted the risks to the Trust as identified within the report. The Committee noted that both legal and tax advice would be sought in respect of the Trust position and agreed with the proposed next steps. A further update would be presented to the Committee at a later date. • It was noted that the Future Generations business case is scheduled to be complete (in draft form) by April 2022. The Counterfactual Case was currently being refreshed and would be taken through Executive Committee and Quality Committee. The Committee recommended the engagement of health economists at this stage.
Positive Assurances to Provide	**Decisions Made**
• Noted that the Cost Improvement Programme (CIP) continues to deliver, since Month 7 there was no longer any unidentified CIP in the forecast position and a number of additional CIP schemes had been identified. • Covid vaccine and Covid booster staff uptake had been added to the performance report to monitor compliance as vaccination as a condition of employment becomes enforced. • The impact of Covid-19 pandemic during Month 9 and increasing referrals had impacted upon patient pathways and operational performance. It was positively noted that the Trust had maintained services and cancelled only one theatre session despite significant pressures on staffing during Month 9. Received demonstrable evidence of improved and sustained cancer performance targets on a quarterly basis. • Received an Information Governance Update and noted confirmation of registration with NHS Digital of Eva Horgan, Chief Finance Officer as the Trust Senior Information Risk Owner (SIRO).	• Reviewed the FPBD related BAF risks. A comprehensive discussion was held in relation to the risk score of BAF Risk 2.1: Failure to progress our plans to build a new hospital co-located with an adult acute site. The risk would continue to be reviewed against implementation of site projects as they developed and during the preparation of the counterfactual case. • It was agreed to change the executive ownership of BAF Risk 2.1 from the Medical Director to the Chief Finance Officer and BAF Risk 4.2 from the Chief Finance Officer to the Medical Director. • Committee received an overview report detailing how the Trust balanced Financial and Quality Risks. It was agreed that the report should be discussed at a Board workshop.

• Positive assurance of strategic developments which included progress towards delivery of the Future Generations strategy; development of underpinning strategies and plans to date; and next steps for strategy development. • The Committee received an update from the Crown Street Enhancements Programme noting that Phase 2 works (CT and MR imaging and colposcopy) had commenced and is due to complete in December 2022. The design for the MR imaging suite had been finalised and approved, and work is progressing well.	

Comments on Effectiveness of the Meeting / Application of QI Methodology

- Good contributions throughout the meeting.
- Adjust timings of agenda items to provide sufficient time for discussion, challenge and debate.

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
169.	Board Assurance Framework Review	Assurance	175.	Review of Strategic Progress	Information
170.	Finance Performance Report Month 9 2021/22	Assurance	176.	Balancing Financial and Quality Risks	Information
171.	Operational Performance Report Month 9 2021	Assurance	177.	Planning 2022/23 Update	Information
172.	Recovery and Restoration	Assurance	178.	Assurance regarding third party service provider controls	Assurance
173.	Digital Services Update including Information Governance Update	Assurance	179.	Sub-Committee Chairs Reports	Assurance
174.	Payments Paper	Information	180.	Crown Street Enhancements Programme	Information

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	✓	✓	A		
Jenny Hannon	✓	✓	✓	✓	✓	Non member					
Eva Horgan	Non member					✓	✓	✓	✓		
Kathryn Thomson	✓	✓	✓	✓	A	✓	✓	✓	✓		
Gary Price	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Marie Forshaw	✓	✓	✓	✓	A	✓	✓	A	✓		

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

Audit Committee Chair's Highlight Report to Trust Board
20 January 2022

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• The Committee received the draft audit plan from the external auditor. No matters of concern were highlighted but the key areas of risk that would be focussed on were outlined as follows: o Valuation of land and buildings – noted that there were a number of areas of judgment within this area and management that would be assessed. o Expenditure recognition – noted that controls and the follow up of controls would be reviewed. o Management override of controls – review required in adherence to professional standards.	• The Committee sought clarification on the necessary requirements for the recommendation to be actioned regarding the extension of reporting of patients awaiting a follow up appointment in the Quality Committee and Finance, Performance and Business Development (FPBD) Committee meeting Dashboards. • Agreed to highlight the 'NHS report: The future of NHS human resources and organisational development report' (flagged in the MIAA Insight report) to the Putting People First Committee. • First iteration of the areas of judgement in the accounts report received. Noted that a final version would be presented to the March 2022 Committee meeting. This would help to provide assurance to the external auditor on the approach taken by management. • During the discussion about the holiday pay accrual, an action was remitted to the Putting People First Committee to monitor the impact of staff annual leave not taken at the end of 2020/21.
Positive Assurances to Provide	**Decisions Made**
• Continued progress to close out internal and external audit recommendations in a timely way was noted with the internal auditor asserting that the Trust's processes were best in class. The Committee discussed the eight actions that had been deferred and the importance of setting realistic deadlines was reiterated. Assurance was provided that the actions would be closed ahead of the financial year-end and that work was on-going to ensure that achievable deadlines were set. • Two internal audit reports were received: o Waiting List Management (Moderate assurance) o Conflicts of Interest (Substantial Assurance) The Committee highlighted the fact that the main improvement theme from the waiting list management report related to data quality. A comprehensive management action plan has been prepared. • Whilst there had been some delays to the internal audit programme for 2021/22, progress was being made and there was confidence that a Head of Internal Audit Opinion could be delivered for Year-End. • The Committee was informed of continued awareness raising activity relating to anti-fraud. The Trust's Anti-Fraud Champion role would be assigned to the new Deputy CFO once in post. A new test module was to be launched as part of the anti-fraud training provided during corporate induction. • Noted that there had been a reduction in average value of tender waivers being submitted from the previous year which was an indication of improved controls and processes.	• The Committee noted that the deadline for submitting accounts had been notified as the 22 June 2022. It was therefore agreed to schedule an Audit Committee and Board meeting for the 16 June 2022 to provide final approval. • The Committee agreed a debt write off total of £11,303.40

• A review of the Trust's governance arrangements in the context of Covid-19 was received (an updated version of a report received in October 2020). It was noted that, on the whole, the Trust had continued with business as usual.	

Comments on Effectiveness of the Meeting / Application of QI Methodology

- In preparation for two Committee members leaving the Trust in summer 2022, the three newly appointed NEDs attended the meeting to support succession planning and continuity.

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
060	Follow up of Internal Audit and External Audit Recommendations	To receive and review an update of actions taken.	065	Areas of Judgement in the Accounts	For assurance
061	MIAA Internal Audit Reports a) Internal Audit Progress Report i. Waiting List Management ii. Conflicts of Interest b) Follow-Up of Audit recommendations c) Anti-Fraud Progress Report 2021/22 d) Insight Update	To note the contents and any recommendations from the report.	066	Debt write-off	To approve
062	External Audit Plan	To receive update	067	Governance in the context of Covid-19	For assurance
063	External Auditor Technical Update	To receive update	068	Board Assurance Framework (BAF)	To receive assurance
064	Waivers Q3 Financial Year 2021/22	For assurance	069	Chairs reports of the Board Committees a) Finance, Performance and Business Development Committee b) Quality Committee c) Charitable Funds Committee	Review of Chair's Reports for overarching assurance.

3. 2021 / 22 Attendance Matrix

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

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

Liverpool Women's NHS Foundation Trust

Charitable Funds Committee Chair's Highlight Report to Trust Board
13 December 2021

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Noted that the Head of Fundraising would meet with their counterpart at Alder Hey Children's Hospital to discuss the potential impact and difficulties upon the existing Trust neonatal fundraising campaign caused by Alder Hey's new neonatal appeal. The Committee requested to receive a progress update. • The Committee discussed the expenditure split between the total spend on fundraising against the total spend on patient welfare, staff welfare and research collectively. The Committee noted that the Board of Trustees had considered the matter thoroughly and had agreed in order to develop the Charity further and to significantly increase income would require additional funding from the onset. The impact of the pandemic had set the plan off track to significantly increase income. As the level remained high and disproportionate the Chief Finance Officer recommended a refocus to recover and align to the original plan. It was agreed that the Committee should actively review this position going forward. • The Trust had applied for emergency funding from NHS Charities Together following the major incident. As this was unprecedented it was being considered by the NHS Charities Together Board. • The Committee was informed that a number of projects that had received fundraising monies had not been implemented. This could present difficulties to the Charity when applying for grant funding. The matter was escalated to the Executive Committee to review all outstanding charitable fund schemes and ensure Trust support to provide project management at time of implementation. • The Committee received a report detailing the charity priorities and income generation action plan for 2021/22. It was noted that the action to provide the Committee with a written update highlighting progress against the priorities set had not been fully addressed. The Head of Fundraising agreed to update the report and recirculate as opposed to delaying the action until March 2022.	• Commissioned a review to consider the portfolio position and subsequent impact on current investments if adopting Green aims within the investment portfolio. The Committee requested a recommendation be provided to the next meeting in March 2022. • Committee received a draft version of the Charity Annual Report and Accounts. The independent review by the external examiners was currently underway although no material changes to the figures within the accounts provided to the Committee was expected. The Committee would be informed if there were any subsequent changes required by the independent examiner. It was noted that there had been a delay in the production of the accounts. It was agreed that a review of timetabling would be undertaken to ensure that a final version of the Charitable annual report and accounts would be provided timely to the Committee ahead of the Trust Board. • A decision as to the appropriate Board Trustee to sign off the statement of trustee's responsibilities within the Charity Annual report and account would be provided ahead of sign off.
Positive Assurances to Provide	**Decisions Made**

• Representatives from Investec presented a positive investment performance report demonstrating an increased capital value. It was agreed to maintain the current asset allocation. • Noted that the total incoming resources had improved at £146k in 2021/22 compared to the prior year (2020/21) of £86k (excluding NHS Charities Together). At Month 7 the incoming resources had been higher than resources expended and there had been a gain on investments of £57k in year. The closing fund balance was at £597k. • The Committee noted a repayment had been made to the Trust to reduce the interdebtedness between the Charity and the Trust. It was clarified that this would reduce the level of interdebtedness but would not remove it. • Noted positive fundraising activity during September to December 2021 despite Covid continuing to limit ability to fundraise at full potential. The Give for Gynae appeal was progressing positively and demonstrated the importance of a tangible appeal to influence donors.	• It was agreed that an annual review of investments should be added to the workplan. • The Committee approved the charity fund signatories. • The Committee recommended approval of the Charity Annual report and Accounts 2020/21 to the Board of Trustees at the Trust Board meeting to be held 06 January 2022 ahead of filing with the Charity Commission in advance of 31 January 2022. The Trust Board was asked to note that the Committee had reviewed a draft version ahead of the external examiners opinion.

Comments on Effectiveness of the Meeting / Application of QI Methodology

- Timetabling of annual report and accounts for Committee to receive final version.
- Newer Trust Board members required time to receive and reflect on the historic narrative of the Charity as a Trustee of the Charity.

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
32.	Investment Report	Assurance	**35.**	Fundraising Update	Information
33.	Monthly Financial Position & Investment report 2021/22 including Annual Review of Fund Signatories	Information	**36.**	Charitable Funds Operational Plan 2021/22	Information
34.	Approval of Annual Report and Accounts (draft)	Approval			

3. 2021 / 22 Attendance Matrix

Core members	June 2021	Sept 2021	Dec 2021	March 2022
Jo Moore (Chair until end Aug 2021)	✓	NM		
Tracy Ellery (Chair as of Sept 2021)	NM	✓	✓	
Tony Okotie	✓	✓	✓	
Louise Martin	A	✓	✓	
Michelle Turner	✓	✓	A	
Jenny Hannon*	A	A	NM	

Eva Horgan* (as nominated deputy. CFO as of Oct 2021)	✓	✓	✓	
Marie Forshaw	✓	A	✓	
Chris Gough	✓	A	✓	
Kate Davis	✓	✓	✓	

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	***21/22/163a***		**Date: 03/02/2022**	
Report Title	**Green Plan**			
Prepared by	***The Trusts Green Plan Task and Finish Group***			
Presented by	***Gary Price: Chief Operating Officer***			
Key Issues / Messages	***All NHS Trusts are mandated to ensure that Trust Boards have sight on their organizations Green Plan to support the national NHS net zero carbon ambition by 2045***			
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 multi-disciplinary approach involving staff groups to develop this plan. Progress will be monitored by a Green Plan steering Group and reported to FPBD quarterly and Trust Board annually			
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* 2.2 Failure to develop our model of care to keep pace with developments and respond to a changing environment	Comment:
Link to the Corporate Risk Register (CRR) – CR Number:	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Trust Board	**Jan 21**	**Gary Price**	**Comments received from first draft**

EXECUTIVE SUMMARY

The NHS Net Zero ambition sets out a challenge for the NHS to significantly reduce its carbon footprint by the year 2045. Individual Trusts are required to produce a Green Plan to identify objectives towards supporting this goal.

Through Autumn 2021 a Trust task and finish group comprising clinical, operational, and corporate representatives have identified key actions to undertake through 2022/23 and beyond to support our response to the Net Zero Ambition. The appendix in the plan sets out those areas of focus and the process by which these initiatives will be monitored. The Trust Board is asked to note this approach and will receive updates on progress annually**.**

1. Delivering a Net Zero NHS

The Delivering a Net Zero NHS strategy 2020 sets out ambitious carbon reduction targets for the NHS. Greener NHS » Delivering a 'Net Zero' National Health Service (england.nhs.uk)**.** It recognised that identifying a trajectory to net zero emissions for a complex, highly specialised system as large as the NHS is particularly challenging. A net zero target for the NHS has emerged from this process: This target is that by 2045 for the NHS Carbon Footprint an ambition for an 80% reduction (compared with a 1990 baseline). NHS Trusts have been tasked to produce a green plan to identify how they can support this ambition.

2. Producing the Plan

In autumn 2021 a multidisciplinary task and finish group comprising staff from all areas of the Trust has come together to identify schemes that aim to improve the Trust green footprint and contribute towards carbon reduction.

The Trust sought external facilitation in developing this plan through support of the 2030 hub, this is a Local United Nations (UN) hub with a focus on UN sustainability goals. The areas of focus identified are:

- Communications, workforce, and system leadership
- Sustainable models of care
- Informatics
- Travel and Transport
- Estates and facilities
- Medicines
- Supply chain and procurement
- Food and Nutrition

The key areas of work identified by our staff are in Appendix 1 of the plan. They will be overseen via a Green Plan steering group that will produce a quarterly summary of progress. One of the first key areas will be to complete the annual Sustainability and Development Assessment Tool (SDAT) to benchmark our Carbon footprint then review annually against progress of the areas identified.

3. Recommendations

The Board is asked to note the multi-disciplinary approach involving staff groups to develop this plan. Progress will be monitored by a Green Plan steering Group and reported to FPBD quarterly and Trust Board annually

NHS
Liverpool Women's
NHS Foundation Trust

Our Green Plan

Creating a greener Liverpool Women's

Our Green Plan

The NHS National Greener Programme “Delivering a net zero National Health Service” highlights that left unabated climate change will disrupt care, with poor environmental health contributing to major diseases, including cardiac problems, asthma, and cancer.

The report set out trajectories and actions for the entire NHS to significantly reduce carbon emissions by 2040 for the emissions it controls directly, and 2045 for those it can influence (such as those embedded within the supply chain).

This green plan details the contribution Liverpool Women’s NHS Foundation Trust can make towards to that ambition.

Creating a greener Liverpool Women’s

1. Introduction

1.1 Each year Liverpool Women's Hospital comprising of a team of approximately 1,300 people, takes care of more than 50,000 patients from Liverpool, the surrounding areas and across the UK. As well as delivering care within the hospital we work in the heart of the community, providing care for patients at various clinics across the city.

1.2 Climate change is now viewed as one of the most serious threats to the continued health and wellbeing of millions of people worldwide. The worst aspects of climate change will inevitably impact greatest on those within society who are most vulnerable and least able to cope. It is therefore vital that action is taken at all levels to implement effective strategies not only to reduce carbon emissions, but also apply the broader principles of sustainable development and healthcare.

The NHS has set a target to reduce carbon emissions. This plan responds to these targets and other requirements placed on the Trust to manage and reduce our environmental impact.

1.3 Caring for our patients in a sustainable manner and being aware of the social impacts of our actions will help achieve the goals of caring for the environment, reducing long term expenditure, and building a supportive base in the society in which we operate.

1.4 Through Autumn 2021 a multidisciplinary team of LWH staff have developed this green plan to outline the steps we can take together as an organization to make LWH a greener place. The detail in this plan will not be exhaustive and time has been allocated in the governance of the programme detailed moving forwards to continue to develop our approach and response to the green agenda.

1.7 This Green Plan outlines projects and activities which should evidence continual improvement in sustainability performance throughout the Trust, covering areas such as staff awareness and engagement, through to projects aimed specifically at reducing the carbon emissions associated with our service delivery and operating our estate.

2 . Areas of Focus

2.1 The following areas of focus will form the basis of our Green Plan.

1. Workforce and System Leadership
2. Sustainable Models of care
3. Digital Transformation
4. Travel and Transport
5. Estates and facilities
6. Medicines
7. Supply Chain and Procurement
8. Food and Nutrition
11. Our People our Culture

3 Reporting

3.1 The structure of this Green Plan has been aligned to that of the Greener NHS Sustainable Development Assessment Tool (SDAT). This has been done for ease of measurement, monitoring and reporting. The Green Plan actions make a commitment to benchmark our own performance year on year but also benchmark ourselves against other providers through completing the Greener NHS SDAT on an annual basis. SDAT was paused in 2021 and will be relaunched following an upgrade in 2022.

3.2 Progress against the objectives detailed in the Action Plan is to be reported to the Trust on an annual basis. Objectives will be reviewed and updated annually. This approach will ensure that continual improvement is made in our environment and sustainability performance, which is reflective of the evolving nature of our service provision.

3.3 The Trusts Annual Report is to include a section on sustainability that provides an overview of activities undertaken during the previous financial year.

4. Governance

4.1 A Green Plan Steering Group has been established to co-ordinate the implementation of the Green Plan.

4.2 The steering group is comprised of the following members:

- Chief Operating Officer (Chair)
- Estates Manager
- Health and Safety
- Procurement and Finance
- HR
- Clinical representation including Pharmacy
- Patient Experience
- Communications
- Health Informatics

4.3 The steering group will meet quarterly and provide updates to the Trusts FPBD through the production of a chairs report and annually to Trust Board. The steering group will annually review and update the objectives based on progress and identification of new initiatives and feedback received.

Green Plan Objectives: 2022-2023

Category	Objective	Lead	Timescale
Communications and System Leadership	Develop a Communications Plan specifically for the promotion of the Green Plan sustainable developments to staff, patients, and service users.	Communications	Q1 2022/23
	Complete the NHS Sustainable Development Assessment Tool (SDAT) annually to benchmark Performance.	Estates	Q1 2022/23
	As per the 2021/22 NHS Standard Contract: Every trust to ensure a board member is responsible for their Green Plan. Similarly, every ICS is asked to designate a board-level lead to oversee the development of their own Green Plan.	Chief Operating Officer	Q4 2021/22
Category	***Objective***	***Lead***	***Timescale***
Sustainable Models of Care	Develop a framework to ensure that existing and new models of care can demonstrate their environmental impact and be assessed against it	Chief Operating Officer	Q2 2022/23
Category	***Objective***	***Lead***	***Timescale***
Informatics	To reflect the Green Plan ambition in the End User Devices Strategy including • Single device Policy • Staff Profile: Right device for right role • Shift to mobile working low power devices • Power management policy: Investment in technology to reduce digital power usage according to usage profiles • Virtual desktop Infrastructure: enable better home working, reduce the need for traditional computers	Chief Information Officer	In line with the existing timescales in 2022/23 for the end user device strategy
	As per the 2021/22 NHS planning guidance Where outpatient attendances are clinically necessary, at least 25% of outpatient activity should be delivered remotely, resulting in direct and tangible carbon reductions.	Chief Operating Officer	In line with 2022/23 annual plan

	.		
Category	***Objective***	***Lead***	***Timescale***
Travel and Transport	Develop a Trust approved Travel Plan	Environmental Manager	Q2 2022/23
	Investigate the use of NHS Health Outcomes Travel Tool (HOTT) to identify opportunities to quantify and reduce carbon and health impacts	Environmental Manager	Q2 2022/23
	Expand the provision of Electric Vehicle charging points across the Trust	Estates	Q2 2022/23
	Organisation's salary sacrifice scheme for vehicles must allow for the purchase of only ultra-low or zero emissions	HR / Procurement	Q2 2022/23
	Organisation to purchase or lease solely cars that are Ultra-Low Emission Vehicles (ULEV) or zero emission vehicles (ZEV)?	HR / Procurement	Q4 2022/23
Category	***Objective***	***Lead***	***Timescale***
Estates and Facilities	Ensure the Trust Estate strategy in explicit in the requirements to reduce energy demand including baselining the electricity and gas consumption volumes as CO_2e and repeat annually to monitor change.	Estates	Q2 2022/23
	Develop a Trust-wide strategy to reduce water demand	Estates	Q3 2022/23
	Deliver an annual energy awareness campaign and baseline the electricity and gas consumption volumes as CO_2e and repeat annually to monitor change.	Estates	Q4 2022/23
	Purchase Renewable sourced electricity only.	Procurement	Q4 2022/23
	Develop a Waste Strategy to improve waste management and save costs Baseline waste generation as tonnage and develop a carbon metric, repeat each year to measure change	Estates	Q4 2022/23
Category	***Objective***	***Lead***	***Timescale***
Medicines	Investigate more environmentally friendly medicine delivery (i.e., use of e-scooters and bikes) – potentially look to involve volunteering teams	Deputy Chief Pharmacist	Q1 2022/23
	Work with medicine suppliers and wholesalers to understand and improve their carbon emissions & delivery schedules.		Q2 2022/23
	Encourage more thorough conversations with patients around which medicines they may already have at home which can be brought into hospital before dispensing new medication.		Q1 2022/23 Q4 2022/23
	Medicines to be dispensed in paper packaging rather than plastic.		Q1 2022/23

	Establish one-stop dispensing to reduce wastage from repeat dispensing.		Q2 2022/23
	Education for staff, making them aware of impact of certain medicine usage in the environment.		Q2 2022/23
	Continue to increase usage of total intravenous anaesthesia (TIVA) in Theatres to minimise the impact of anaesthetic gases on the environment.		Q2 2022/23
Category	**Objective**	**Lead**	**Timescale**
Supply Chain and Procurement	Instigate a waste generation survey	Procurement	Q2 2022/23
	Reduce use of single use plastic items		Q3 2022/23
	Increase use of SME's (Small and Medium Enterprises) and locally sourced goods and services		Q2 2022/23
	Review and update LWH Sustainable Procurement Policy		Q2 2022/23
Category	**Objective**	**Lead**	**Timescale**
Food and Nutrition	Regularly meet Government Buying Standards for food and catering services	Procurement	Q2 2022/23
	Instigate a plant based menu that is readily available for patients and staff throughout the year	Facilities Manager	Q2 2022/23
Category	**Objective**	**Lead**	**Timescale**
Our People and Culture	Complete a scoping exercise and develop a framework to support staff to undertake volunteering and other activities as part of the Trusts commitment to CSR (Corporate Social Responsibility)	HR	Q2 2022/23
	Develop staff communications to improve understanding of the Trusts sustainability agenda through recruitment, selection, induction and appraisal	HR	Q2 2022/23

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*2021/22/163b*		Date: 03/02/2022	
Report Title	Well-Led Framework – Action Plan			
Prepared by	*Mark Grimshaw, Trust Secretary*			
Presented by	*Mark Grimshaw, Trust Secretary*			
Key Issues / Messages	*This report presents an update on the combined action plan from the internal and external well-led inspections. Areas that remain outstanding are highlighted with proposed actions outlined.*			
Action required	Approve ☐	Receive ☒	Note ☐	Take Assurance ☐
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable):			
	For Decisions - in line with Risk Appetite Statement – Y *If no – please outline the reasons for deviation.*			
	The Board is asked to ***• Note the update on the combined well-led framework action plan.*** ***• Agree that the annual internal well-led review will commence from July 2022.***			
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: The Trust's progress against the NHSI well-led framework will be a key source of information for a future CQC well-led inspection.
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
Trust Board	Several times	Trust Secretary	Since April 2020, the Board has received updates regarding the Trust's progress against the well-led framework
Committees	July 2021	Trust Secretary	FPBD, Quality and PPF Committees all considered the well-led actions during their July 2021 meetings.

EXECUTIVE SUMMARY

This report presents an update on the combined action plan from the internal and external well-led inspections. Areas that remain outstanding are highlighted with proposed actions outlined.

MAIN REPORT

INTRODUCTION

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

The fieldwork for the external Well-Led review undertaken by Grant Thornton was completed in April 2021 and a final report was shared with the Trust in June 2021 and with the Board ahead of the July 2021 meeting.

The high-level output from the external review was as follows:

NHSI Well-Led framework			
#	Question	Trust rating 2020	GT rating 2021
1	Is there the leadership capacity and capability to deliver high quality, sustainable care?		
2	Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?		
3	Is there a culture of high quality sustainable care?		
4	Are there clear responsibilities, roles and systems of accountability to support good governance and management?		
5	Are there clear and effective processes for managing risk, issues and performance?		
6	Is appropriate and accurate information being effectively processed, challenged and acted on?		
7	Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?		
8	Are there robust systems and processes for learning continuous improvement and innovation?		

Grant Thornton also undertook a site visit to several clinical areas during April 2021 and several recommendations also flowed out of this process. These, together with the actions from the external and internal assessment were combined into an overall action plan.

KEY ISSUES

Since presenting the combined action plan to the Board in July 2021, a further update was provided in September 2021. Executive leads have continued to close out the recommendations, liaising with aligned

Non-Executive leads where appropriate, either through Committee meetings, separate meetings or via email.

The full action plan has been made available to the Board via the Trust Board file on Microsoft Teams. Positive progress has been made against the identified actions with the majority (83% (61 of 73 actions)) noted as being 'blue' (complete with evidence). Detail on the outstanding actions is outlined below:

Action / Recommendation	Timescale	Lead	Comments
The level of challenge between Governors and Non-Executive Directors can be strengthened in order for the former to demonstrate discharge of holding to account responsibilities.	February 2022	TS	There has been a planned session with NEDs and Governors to discuss effective challenge and work through case studies. It has been agreed that this would be better suited to a face-to-face meeting which has been limited by COVID-19 IPC restrictions.

Action / Recommendation	Timescale	Lead	Comments
The Divisions should ensure that adequate time is timetabled to allow a regular and thorough review of their risk registers.	September 2021 Updated timescale – March 2022	COO	Improvements have been made to the risk management process through the year and this is demonstrated at the Trust's Corporate Risk Committees. However, an inconsistent approach remains across the Divisions and the Trust Secretary is working with the Assoc. Director of Quality to make further improvements. The outputs of this are scheduled to be reported to the March 2022 Audit Committee and therefore this action does not yet have sufficient evidence to close out.

Action / Recommendation	Timescale	Lead	Comments
Milestones and measures to demonstrate achievement should be documented as part of the Leadership and Talent Strategic Framework. Progress should be presented to the PPF Committee.	September 2021 Updated timescale – March 2022	CPO	Progress impacted by Covid 19 resulting in delay to launching leadership programme (now launched) with good engagement. Leadership & Talent Management Framework in place with supporting workplan. PPF have oversight of Leadership & Talent Management Strategy and receive regular updates for assurance purposes against agreed Annual Workplan to allow for identification of progress/slippage Further work required on monitoring uptake/impact. KPIs and reporting through to PPF Committee. Update due to March 22 meeting of PPF Committee.

Action / Recommendation	Timescale	Lead	Comments
The NED aligned to the FTSU agenda should access the FTSU training available from the National Guardian's Office to maximise the support offered to the FTSU Guardians	September 2021 Updated timescale – March 2022	CPO	Training invitation extended.

Action / Recommendation	Timescale	Lead	Comments
The Chair should work with the Lead Governor to establish activities that will gain useful information on patient experience. The following activities should be established as soon as Covid-19 restrictions are eased. • A buddy scheme whereby a Governor and NED pair up and meet informally could enhance the ability of the Council in its role in holding the NEDs, individually and collectively, to account for the performance of the Board of Directors. • 'Meet the Governor' or Governor drop in sessions could be scheduled once Covid-19 restrictions allow to gather valuable patient/visitor feedback for the Trust to consider to improve/transform its services. • The nationally available Governor training should be made available to all Governors.	October 2021 Updated timescale – April 2022	TS	Nationally available training as been circulated and booked onto for governors e.g. finance training. The value of a NED/Governor 'buddy scheme' has been considered and it is felt that there are alternative options to develop the relationship between NEDs and Governors to enhance the holding to account role. This includes 1) exploring options to strengthen the processes at Governor sub-group meetings 2) holding an 'informal session' at the end of the year for governors and NEDs to discuss key priorities and strategic issues 3) joint training sessions The opportunity to realise some of these ideas has been restricted by COVID-19 and will need to be taken forward once IPC arrangements allow.

Action / Recommendation	Timescale	Lead	Comments
The Quality Improvement Framework document should be progressed to publication as soon as possible. It should include detailed milestones, monitoring of achievement against the milestones and reporting arrangements for assurance on direction of travel and outcomes	July 2021 Updated timescale – February 2022	CNM	This document has been developed and is scheduled to report to the February 2022 Quality Committee
The Trust needs to develop its training plan and increase and record the pace of training for the roll out of its PDSA model. Training rates should be reported to the Quality Committee.	July 2021 Updated timescale – April 2022	CNM	Detailed update on this issue provided to the January 2022 Quality Committee – paper has been made available to Board members in the Teams folder.
The Trust should consider how to and publicise to staff the outcomes of the completed QI projects. This will raise confidence in the approach and reaffirm the use of the PDSA model.	July 2021 Updated timescale – April 2022	CNM	Detailed update on this issue provided to the January 2022 Quality Committee – paper has been made available to Board members in the Teams folder.
Following the CCG learning panel event the Trust should establish and	July 2021	CNM	Evidence of this approach is captured in the Trust's Integrated Governance Report but will also form part

document its plans to embed the way it learns incidents throughout its services, from front-line service areas through to the Board	Updated timescale – March 2022		of the aforementioned work regarding improving the approach in Divisions to their governance processes.
The Trust requires strengthened articulation of a quality improvement preferred methodology and strategy either within the existing quality strategy or in a new QI strategy.	July 2021 Updated timescale – April 2022	CNM	Detailed update on this issue provided to the January 2022 Quality Committee – paper has been made available to Board members in the Teams folder.
Governance team to evidence activity around improvement using PDSA cycles being discussed and supported in Divisions and Senates and develop a training and implementation plan if one is needed.	July 2021 Updated timescale – April 2022	CNM	Detailed update on this issue provided to the January 2022 Quality Committee – paper has been made available to Board members in the Teams folder.
Governance department to produce a co-ordinated planned roll-out of improvement methodology teaching to encompass all key groups as agreed with the executive group	July 2021 Updated timescale – April 2022	CNM	Detailed update on this issue provided to the January 2022 Quality Committee – paper has been made available to Board members in the Teams folder.

Next Steps

Work will continue to close out the outstanding actions by the updated timescales. Grant Thornton have also offered to undertake a follow up visit and discussion with the Board in Spring 2022. This will help to provide assurance on the Trust's progress and also identify areas for continued development.

The Trust is required by the NHS Code of Governance to undertake an external well-led review at least every three years. It is also recommended that the Trust undertakes an internal annual review against the well-led framework. It is therefore suggested that the Trust begins this process once the 2021/22 year-end undertakings have been completed at the end of June 2022. Whilst part of this will be reviewing and seeking assurance on the 2021/22 action plan, this should also present an opportunity to look ahead and identify updated areas for development.

RECOMMENDATION

The Board is asked to

- Note the update on the combined well-led framework action plan.
- Agree that the annual internal well-led review will commence from July 2022.

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	***21/22/163c***		**Date: 03/02/2022**	
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, Putting People First and Quality Committees since previous version presented to Board on 2 December 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 January 2022. 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)

- General Housekeeping updates
- Reference to recent inclusivity benchmarking success but not felt sufficient to reduce overall score as work remains on-going.
- No suggested change to Q3 score.

1.2 Failure to recruit and retain key clinical staff

- Updated references in the rationale to the increase in staff absences due to the Omicron variant and also the currently unknown impact of the mandatory staff Covid-19 vaccine.
- The assurance rating for the strategic threat 'Insufficient numbers of clinical staff resulting in a lack of capability to deliver safe care and effective outcomes' has been moved from an 'amber' rating to 'red'. The overall score of the BAF item remains unchanged at '20'. It was agreed at the Putting People First Committee that it was appropriate to not escalate this risk to a '25' but it was accepted that the level of risk had escalated and that the Board should be cognisant of this.
- No suggested change to Q3 score.

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

- Suggested that the ownership of this risk changes from the MD to the CFO – this is considering where responsibility for the majority of controls sit.
- No further changes to report since December 2021.
- No suggested change to Q3 score although the FPBD Committee did request additional time at the next review to allow for a discussion of risk score ratings.

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

- Significant work is currently being undertaken regarding clinical and divisional strategies both for 2022/23 and the next five years. Updates will be presented to the Committee and to the Board in the Spring and this strategic threat will be reviewed in this context.
- No suggested change to Q3 score.

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

- This has been significantly updated following discussion with Medical Director and Head of Strategy and Transformation (reported through to December's Quality Committee) – see track changes.
- No suggested change to Q3 score.

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

- No changes to report.
- No suggested change to Q3 score.

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

- Additional control added to reflect the appointment of the Patient Experience Matron.
- No suggested change to score for Q3

BAF Risk 4.1: Failure to ensure our services are financially sustainable in the long term
• Updated in light of H2 2021/22 information (see track changes) • No suggested change to Q3 score.
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
• Suggested that the ownership of this risk changes from the CFO to the MD – this is considering where responsibility for the majority of controls sit. • No significant changes to report but discussion held at January 2022 FPBD Committee on whether there is a need for the increased reporting on the Trust's partnership / network / hosting arrangements and the most appropriate space/(s) for this. To be considered by the Executive Team in early February and inform next review. • No suggested change to Q3 score.
5.1: Failure to progress our research strategy and foster innovation within the Trust
• Updates to actions (highlighted in yellow) • Potential for score to be reduced to target score by the end of the Q4 2021/22 but no suggestion to amend score for Q3.
5.2: Failure to fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership
• Updates to actions (highlighted in yellow) • No suggested change to score for Q3

New Risks or Strategic Threats

Since the report was last circulated and discussed at the Board, there has not any new risks or strategic threats identified.

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 – February 2022

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)	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)	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~~ CFO	15 (I3 x c5)	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)	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)	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)	15 (I3 x c5)		⟷	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)	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)	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~~ MD	8 (I2 x c4)	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)	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)	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)

Risk and Controls Summary

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

2087 - No change in risk score since last review. Last reviewed 09/11/2021

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 – No change in risk score since last review. Last reviewed 03/11/2021.

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

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)	12 (3 x 4)	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. The Trust also recently benchmarked within the top 50 inclusive places to work. 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 and LGBTQ Network to be launched in 2022 ~~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~~ December 2021	E&D Sub-Committee	
1.1 / 2	Robust targeting of job adverts – engagement in health and careers fairs with local community groups for example Pakistani Centre, Al Ghazali Centre~~Robust targeting of job adverts~~	Head of Culture, Inclusion, Wellbeing and Engagement	September 2021 (ongoing)	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~~February 2022	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*	Overall Assurance Rating

			evidence as to effectiveness of the controls or negative assurance)	
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 Development of a Supporting Patients with Additional Needs Strategy	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)	20 (4 x 5)	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. In the short term, this issue is being exacerbated by significant absences as a result of the Omicron Covid-19 variant and the in the medium term there is a concern about the potential loss of staff if they do not accept the mandatory Covid-19 vaccine. 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). Whilst the severity of this issue is not sufficient to rate this risk at '25', the Board should be cognisant that this risk presents one of the most acute challenges to the organisation.

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.	
	LWH 'People Promise' to launch in 2022 – bringing together key strands of people strategy including behavioural framework	PPF	None	
	Behavioural framework developed in partnership with staff in 2021	PFF Committee, In the Loop, Great Place to Work Group	None	
	Great Place to Work Group Launched as a cross section of staff committed to improving staff experience and a source of two way communication	Great Place to work minutes to PPF	None	
	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 including launch of LWH Staff Support Service, recruitment of LWH Psychologist and Wellbeing Coaches~~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~~	
	Regular Local Staff Surveys	Quarterly internal staff survey (In the Loop)	None	
	Regular Listening Events	Listening events increased to bi-monthly	Nnone	

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~~ February 202~~1~~	PPF Committee		
	1.2 / 4	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 in early 2022~~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~~March 2022	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.	
	Work underway to ensure that the number of staff without a Covid-19 vaccine is minimised	PPF Committee	There remains a small number of staff in this cohort – advice is being sought from the centre and the Trust is responding to national guidance and working with the staff in question.	

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
1.2/1	E-rostering system for doctors - Allocate is implemented for O&G and work commenced for other specialties~~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 29/10/21

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

2469 – new risk added - Rationale for escalation – This is a statutory compliance issue where the Trust are non-complaint. Resourcing issues within estates and facilities have impacted on compliance. Resourcing is currently under review.

2470 – new risk added - This is a statutory compliance issue where the Trust are non-complaint. There is potentially an engineering project issue regarding pipework

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
2469 **(CRR)**	Allocation of resources to carry out water safety checks and maintenance has failed to achieve required targets despite prioritising this work and reducing resources for other tasks	9
2470 **(CRR)**	Water cold water temperatures in the new NICU build are being recorded as 2% higher than hospital cold water temperatures.	9

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~~ CFO Op Lead: Head of Transformation & Strategy	Review Date: December 2021	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)		⟷	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	
	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: Jan 22**	**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)	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		None	
	Maintenance of present system	FPBD Committee overview and scrutiny	None	
	Development of individual / service solutions e.g. PENs (Gynaecology) and Staff training	Digital Hospital Committee oversight	Staff fatigue and loss of confidence. Ability of clinical staff to engage with the system development due to time and financial impact	
	Incident reporting	Approved EPR Business case which define clear direction and preferred solution.	None	
	Tactical solutions including the implementation of K2 Athena system	EPR programme board chaired by MD	Optimisations to K2 system and refinements which are required	
	Exchange/LHCRE enables for patent information sharing	Independent lessons learnt Positive review	Not all Trust using LHCRE for patient information exchange	
	Virtual Desktop technology to aid staff working flexibly.	MIAA Critical Application Audit (rolling programme across trust systems) Reporting into Audit Committee and Digital Hospital Group	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 that do not sufficiently anticipate evolving healthcare needs of the	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	
	Availability of data on service trends and demographics	Divisional Boards	To ensure that Divisions are fully utilising data to understand changing service demands	

local population and/or reduce health inequalities	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: Chief Operating Officer
Op Lead: Head of Strategy & Transformation

Review Date: Dec 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)	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	Transfers out monitored by Partnership	None	
	Transfer arrangements for adults	Transfers out monitored at HDU Group	Transfers are often subject to delay due to the Trust being considered a 'place of safety'. Transfer of adults requires accompanying clinical staff, which can lead to staffing pressures on the ward. Action 2.3/4	
	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 -Provision of maternity expertise at LUHFT sites -Provision of Gynaecology expertise at LUHFT sites -Placenta accreta service, including specialist imaging and supervision of review from Sheffield Teaching Hospitals NHS FT		Onsite and partnership mitigations cannot fully address the clinical risk - this can only be achieved through co-location. Arrangements not formally agreed and underpinned by detailed SLA. Actions 2.3/5, 2.3/6	
	Blood product provision by motorised vehicle from nearby facility, with protocols in place to prioritise transport of blood products.	Serious incidents, should they occur are tracked and reported through the governance framework,	Lack of 24/7 transfusion laboratory on site leads to delay in patients receiving transfusion. Action 2.3/7, 2.3/8	
	nvestments in additional staffing inc. towards 24/7 cover - Maternity	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 Twilight cover to be in place from April 2022 Action 2.3/9	
	Investments in additional staffing inc. towards 24/7 cover - Anaesthetics	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 24/7 cover required but not yet in place Action 2.3/9	
	Investments in additional staffing inc. towards 24/7 cover – Gynaecology, including additional investment in ANP roles within GED	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 24/7 cover not required Action 2.3/9	
	Investments in additional staffing inc. towards 24/7 cover - Neonates	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 24/7 cover in place from January 2022 Action 2.3/9	
	Enhanced resuscitation training provision - Paediatric	Training compliance rates reported to PPF Committee	Full provision for paediatric resus cover not in place Action 2.3/10	
	Enhanced resuscitation training provision - Adult	Training compliance rates reported to PPF Committee	None	

Crown Street Enhancements Programme Board established to oversee: -Construction work required to accommodate new FMU, colposcopy suite, CT & MR Imaging suites (ongoing) -Implementation of Robotic Assisted Surgery (complete) -Implementation of 24/7 transfusion laboratory on site (ongoing) -Decant into and new ways of working within FMU (complete) -Decant into and new ways of working within colposcopy (ongoing)	Crown Street Enhancements Programme progress reviewed monthly at FPBD	Financial and workforce constraints for delivery of additional facilities on site. Action 2.3 / 2 Construction works not yet complete – due to complete December 2022 Action 2.3/11 24/7 transfusion laboratory not yet established – aim for completion September 2022 Action 2.3/7 Colposcopy decant not yet complete – aim for completion June 2022 Action 2.3/12
Community Diagnostic Centre established at Crown Street, to include the following diagnostics with access for LWH patients: -Imaging – CT, MR, X-ray, ultrasound -Physiological – ECHO, ECG, BP monitoring, Spiro, FeNO, Sleep studies -Pathology	Community Diagnostic Centre Oversight Group reviews progress on a fortnightly basis. Progress also reported to and monitored by regional CDC Programme Board.	Services not yet implemented Action 2.3 / 13
Divisional Operational Plans completed	Divisional Boards	5 Year Service Transformation Plans under development – CSS Division plan not yet in place 2022/23 Divisional operational plans not yet developed Action 2.1 / 1
Use of telemedicine to facilitate consultations both at Crown Street and other sites	Divisional Boards	Implemented for Neonatal Partnership Expansion to cover other Trusts Expansion to cover maternity services
Historic controls still in place include: -Use of cell salvage -Expanded role of anaesthetists to cover HDU patients -Existing informal links with partner organisations -ANP roles -Transfer of patients for urgent imaging and critical care -Theatre slots at LUHFT -ACHD Partnership	Quality Committee	None
Progress being made in relation to building relationships with LUFT ***Moved this control from BAF Risk 2.1**	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

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 Strategy and Transformation/ Deputy Chief Operating Officer	March 2022	Trust Executive	
2.3 / 2	Agree funding for all mitigations on site are included operational planning	Deputy Chief Finance Officer	March 2022	FPBD Committee	
2.3 / 3	Project to establish robotics surgical service - COMPLETE	Deputy Chief Operating Officer	July 2021	FPBD Committee	
2.3 / 4	Provision of staffed and dedicated ambulance to facilitate transfer of adult patients to be explored.	Deputy Chief Operating Officer	TBC	Quality Committee	
2.3 / 5	Task and finish groups to be established, reporting into the Partnership Board with LUHFT, to formally agree and set out arrangements for partnership working across all four LWH and LUHFT sites	Head of Transformation & Strategy	March 2022	Partnership Board	
2.3 / 6	Detailed agreements to form part of SLA with LUHFT, clearly explaining routes of access and expectations of both organisations.	Deputy Chief Finance Officer	September 2022	Partnership Board, TBDG	
2.3 / 7	Project to establish 24/7 transfusion laboratory on site at Crown Street	Head of AHPs	September 2022	Crown Street Enhancements Programme Board, FPBD	
2.3 / 8	Implement remote issue of blood products to minimise delay in transfusion	Head of AHPs	April 2022	Crown Street Enhancements Programme Board, FPBD	
2.3 / 9	Complete job planning and feed into operational planning process for 2022/23 to facilitate move towards 24/7 consultant cover	Clinical Directors	January 2022	TBDG	
2.3 / 10	Clear SOP to be implemented for paediatric resus provision	Deputy Medical Director	January 2022	Quality Committee	
2.3 / 11	Complete construction of colposcopy, CT & MR imaging suites	Head of Strategy and Transformation	December 2022	Crown Street Enhancements Programme Board, FPBD	

	2.3 / 12	Project to manage decant and new ways of working within colposcopy	Deputy Divisional Manager for Gynaecology	June 2022	Crown Street Enhancements Programme Board, FPBD		
	2.3 / 13	Deliver CDC project plan to establish CDC services: -Imaging – CT, MR, X-ray, ultrasound -Physiological – ECHO, ECG, BP monitoring, Spiro, FeNO, Sleep studies -Pathology	Head of Strategy and Transformation/ Deputy Chief Operating Officer	December 2022	CDC Oversight Group, FPBD		
	2.3 / 14	Project to expand use of telemedicine technology across more providers for neonatal services and implement within maternity	Divisional Manager for Family Health	March 2022	Trust Executive		

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)	15 (3 x 5)		⟷	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 09/11/2021

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: Jan 2022**	**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)	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~~ Women, babies and their families experience strategy 2021 - 2026	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		
	Patient Experience Matron in place providing clinical view into patient experience team	Reports Patient Involvement and Experience Sub-Committee and attends CoG Comms and Engagement Group		

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~~ March 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-Committee	

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: CFO** **Op Lead:** Deputy CFO	**Review Date: Dec 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)	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. However, a number of cost increases have been approved in relation to quality and safety (including maintaining safety on site and the Clinical Case for Change, investment in maternity services, and service developments such as Robotic Surgery). The Trust has also delivered lower levels of recurrent CIP in 2020/21 and 2021/22 than in previous years. The underlying financial position has therefore deteriorated. This increases the challenge for the Trust; however, this is also coupled with additional funding routes being made available, particularly in relation to Maternity.

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~~March 2022.	
	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. This will be a Strategic Outline Case. There remains uncertainty as to where and by who this will be assessed Additional work being undertaken to quantify financial benefits of co-location.	
	Early and continuing dialogue with NHSE/I and Cheshire and Merseyside ICS	System top up agreed to achieve breakeven for Half One 2021/22 and also Half Two 2021/22, meaning a breakeven plan is in place for 2021/22.	Uncertainty re future settlement and regime. Level of current financial system support provided sets a precedent going forward.	
	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. Not actively being pursued at present. However co-location and new build will allow for increased efficiency and reduced cost.	
	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 Trust Expression of Interest as part of New Hospital Programme has not been prioritised by Cheshire and Merseyside in 2021 but was mentioned as (joint) second priority in feedback.	Position potentially superseded by development of ICS Feedback to both ICS and North West region provided.	
	Clinical Engagement and support for proposals	Northern Clinical Senate Report supporting preferred option	Further work programme in place including further Clinical Senate Review of 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. Direct engagement with NHS Resolution. Increased resource in Maternity to manage this.	~~None~~ Potential resourcing issues to manage this.	
	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.	
	~~Financial risk in relation to~~Development of Community Diagnostic Centre.	Upfront capital and revenue funding provided. Letter of comfort from ICS.	Significant revenue implications on an ongoing basis, not directly related to LWH patients. No definitive ongoing revenue funding source in place (although national programme and letter of comfort from ICS provided).	

	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		
	4.1/17	Agree ongoing funding model for Community Diagnostic Centre	CFO	March 2022	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 Mitigations being worked up in case of identified risks materialising	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. Reliance on Cheshire & Merseyside position and NHS Improvement/England national team to support proposed baseline adjustment for Elective Recovery Funding.	

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		
4.1/224.1/21	Negotiate settlement for Half TwoEnsure full CIP programme in place with relevant QIAs etc	CFODeputy Director of Finance	November 2021March 2022	FPBD CommitteeFPBD Committee		
4.1/234.1/22	Agree sufficient cash resource for Half TwoNegotiate settlement for Half Two	CFOCFO	November 2021November 2021	FPBD CommitteeFPBD Committee		
4.1/243	Agree sufficient cash resource for Half TwoMitigations to be worked up in case Elective Recovery Fund income note earned.	CFO	November 2021March 2022	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: Medical Director** **Op Lead:** Deputy COO	**Review Date: Jan 22**	**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)		⟷	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 18/10/2021

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: January 2022**	**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:

N/A

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)		⇔	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. Note – Nursing, Midwifery & AHP Research Talent Pipeline report scheduled for R&D Sub-Committee in February 2022.	Medical Director	~~October 2021~~ Feb 2022	Research and Development Sub-Committee	
5.1 / 2	To collaborate with the Professor of Midwifery Update – Three Prof. of Midwifery attend Trust's RD&I Sub-Committee Research midwife now in post (joint appointment).	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 Update – Regular attendance at RD&I sub-committee by LHP theme leads	Medical Director	~~October 2021~~ On-going	Research and Development Sub-Committee	
5.1 / 4	Continue progress towards university hospital status application	Medical Director	~~October 2021~~ October 2022	Research and Development Sub-Committee	
5.1 / 5	Continue Trust engagement with population health and longitudinal studies / workstreams Update – C-Gull programme scheduled to start in Q1 22/23 – Trust is engaged.	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: Jan 22**	**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)	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	February 2022	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	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 Discussions with staff on walk arounds conducted by the Director of Nursing & Midwifery and senior clinical staff. Shared learning page now live on the intranet	'Moderate Assurance' from recent MIAA Audit – actions remain in progress but improved processes in place.	
	Incident reporting and investigation policies and procedures.		External criticism from regulators and commissioners – recent position is improving with feedback more positive.	
	MDT involvement in safety		Lack of testing of action plans following audits to ensure they lead embedded change – will be supported by ward accreditation once in place.	
	HR policies in relation to issues relating to professional and personal responsibility		Inconsistent completion and dissemination of actions and improvement plans – signs of improvement but with further work required.	
	Mandatory training in relation to safety and risk		Inconsistent implementation of lessons learnt and lack of evidence - clinical walkarounds by execs and clinical staff capture this now. Further improvements required re blood sampling errors which is now being managed by the pathology steering group	
	Serious Incident Feedback form		Pace of implementing change	
	Serious Incident panels		Lack of consistent between divisional governance meetings (noted in recent well-led report) – now improving	
	Safety is included as part of executive walk rounds.		Well-led external review recommendation regarding walkaround process	
	Risk Management Strategy			

	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~~ February 2022	Safety & Effectiveness Sub-Committee		
	5.2 / 5	New risk management and patient safety training package to be developed	Head of Governance & Quality	April 2022	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 Update - Significant improvements and updates to CQC action plans are evident. The position is much better compared to July 2021	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~~ On-going	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	February 2022	Quality Committee	
5.2 / 12	Increase levels of QI training	Assoc. Director of Governance & Quality	April 2022	Quality Committee	
5.2 / 13	Simplify process to encourage staff to record QI projects within formal framework	Assoc. Director of Governance & Quality	April 2022	Quality Committee	

Liverpool Women's NHS Foundation Trust

Trust Board

Agenda Item	*21/22/164*	Date: 03/02/2022		
Report Title	Guardian of Safe Working Hours Quarterly Report – Q1, 2 and 3 2021/22			
Prepared by	*Kat Pavlidi, Guardian of Safe Working Hours*			
Presented by	*Kat Pavlidi, Guardian of Safe Working Hours*			
Key Issues / Messages	The report presents the findings of the Guardian of Safe Working			
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 this report from the Guardian of Safe Working Hours.			
Supporting Executive:	*Lynn Greenhalgh, Medical Director*			

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

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

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Putting People First	**Jan 22**	**MD**	**Report was noted.**

EXECUTIVE SUMMARY

The Board is advised:

- rota establishment continues to fluctuate throughout the year with robust processes in place to mitigate the use of high cost agency locums wherever possible by using internal bank, doctors in training and ANNPs
- From June 2020 to December 2021 there has not been a requirement to change working patterns due to the ongoing Covid situation
- This however changed over the Christmas/New Year period as the ongoing Covid situation increased and a back-up rota was created.
- the services continue to complete some work remotely, virtually and via telephone
- the impact of staff required to shield during this reporting period had minimal impact on the services as there were 3 junior doctors continued to work remotely due to shielding/pregnancy.

Exception reports continued to be submitted; however the Board should be advised that the old system of exception reporting (DRS) is no longer available to view and therefore is no update on the number of reports submitted for the first two quarters. The GSWH and the HR lead are both looking to resolve this issue imminently and the Committee will be updated regarding this number in the next quarterly report.

This issue is the same with regards to WTE rota gaps and with regards to annual leave that was not able to be taken at the end of some juniors' placements as the DRS system was not accessible at the time of writing the report.

There were two exception reports in relation to educational issues in these three quarters.

The Guardian of Safe Working advises the Board that in her view the hours and templates are safe and compliant in each service and in line with the junior doctor contract.

Staffing levels across the services has resumed mostly to normal levels, although there is still an element of remote and virtual working. Trainees are still able to gain training experiences via virtual clinics and consultations, although these are not as useful as F2F working. Doctors in training continue to staff areas such as delivery suite, GED and theatres to the same level as pre-covid working.

Medical Staffing continues to actively support the educational supervisors and trainees with the exception reporting system, ensuring the system is managed appropriately. The lack of a GSWH has been discussed at JLNC and it was agreed Medical staffing could oversee the process until a replacement is appointed, with the HR lead overseeing this role until September 2021 when a new GSWH was appointed.

REPORT

1. Introduction

The 2016 contract requires the Guardian of Safe Working to report to the Trust Board and Sub Board Committee on a quarterly basis, with the following information;

- Aggregated exception reports including outcomes
- Details of fines levied
- Data on rota gaps
- Data on locum usage
- Other relevant data
- Qualitative narrative highlighting areas of good practice or persistent concern

This report covers all of the above for the reporting period and relates to the first three quarters of the year. It is an aggregate report as many themes were seen to carry on from Q1 to Q2 to Q3.

- Q1 1st April – 30th June,
- Q2 1st July 2021 – 30th September 2021.
- Q3 1st October 2021 – 31st December 2021.

2. Background

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

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

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

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

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

As noted in previous reports, NHS Employers, the British Medical Association (BMA) and the Department of Health and Social Care (DHSC) have jointly agreed the amendments to the 2016 terms and conditions for doctors in training. The updated contract is referred to as ‘Junior Doctors 2018 contract refresh’.

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

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

Medical HR continue to work alongside the services to ensure all rotas are compliant with 'Good Rostering Guidance' which is contractual. In the main, good rostering affects Less than full time (LTFT) trainees, as LTFT trainees can no longer be asked to work on non-working days which affects the current block of nights in rosters and the updated Terms and Conditions. So far, this has been managed well alongside input from the DME and it is anticipated that there will be no further issues with rostering as this becomes normal practice. However, the committee should note, that some trainees choose to work on non-working days but are not rostered to work on these days by the organisation.

The Board is asked to note that the updated Terms and Conditions of service focuses heavily on the Exception Reporting process, timescales and payment. It seeks to provide greater clarity on the types of activity that can be exception reported.

All doctors have access to the exception reporting system and HR continues to support those who need help with accessing the system. However, currently the trend for exception reporting is mainly within the O&G cohort.

3. Guardian Report

3.1 Aggregated exception reports including outcomes

During the reporting period of 1st April – 30th June, and 1st July – 31st August 2021, the accurate number of exception reports are unable to be noted in this report.

From the 1st September – 31st December 2021, exception reports were made on a new Allocate eRota system and are accurate and up to date.

There were 21 exception reports made, all from O&G trainees.

Period	Specialty	Grade	Reason	#exceptions	No: hours	Out come
Q2 (1st Sep onwards)	O&G	F1	Hours	5	4.5	TOIL
	O&G	ST2	Hours	2	2.5	TOIL
	O&G	ST5	Education	2		Rota review
Q3	O&G	ST2	Hours and natural breaks	2	1	Payment for extra hour

	O&G	ST1	Hours and natural breaks	3	5	TOIL
	O&G	ST7	Hours and natural breaks	4	3	TOIL and payment for extra hour
	O&G	GP	Hours	1	1	Payment for extra hour
	O&G	ST6	Hours	2	5	Payment

Three junior doctors put exception reports in for the Extra hour worked due to the clocks going back in October.

In the previous annual report, there was a significant increase in the number of exception reports which highlighted the lack of breaks that was made worse by the crisis in midwifery staffing. This was not reflected anecdotally in the exception reports received in Q1 and Q2 of 2021-2022 but will continue to be monitored. The Committee is asked to note this is a perceived decrease as the actual number is unable to be reviewed currently due to the old exception report system (DRS) being inaccessible.

3.2 Details of fines levied

To date, the Guardian has not issued any fines in these three quarters.

3.3 Data on rota gaps

As referenced in previous reports, the number of gaps requiring locum cover fluctuate throughout the year due the number of times the specialty rotates, maternity leave, long-term absence and completion of training (CCT). Therefore, as the year progresses, the services expect to work with increasing gaps. With the continuing COVID-19 pandemic, this increase in gaps has been noted, with addition of a number of trainees either shielding for medical reasons, or for pregnancy after 28 weeks.

As mentioned before in this report, due to not having access to the old DRS system, the Guardian is unable to report on the detailed data on rota gaps within each specialty for the first 2 quarters.

The Trust received a full rotation for all doctors in training and the rotation continues to be supported by fixed term research posts and locally employed doctors who are either out of programme or in between training. In April and August, the O&G GP doctors, and in May and August the anaesthetic doctors all rotated; the Neonates doctors rotated in March and September.

Although the rotations received have been full, there is still a need to cover unexpected absences such as sickness and or isolation due to Covid symptoms. The majority of these gaps are mainly covered by locum shifts from the current cohort of doctors in training, trust employed doctors and ANNPs.

Within these three quarters, the number of shielding junior doctors due to medical or pregnancy reasons was 4 – one in Anaesthetics, and 3 in O&G.

Anaesthetics

As in previous quarters, the Anaesthetic division mitigated gaps by workforce planning enabling the service to either recruit or extend the contracts of Locally Employed Doctors (previously known as clinical fellows), who are usually employed for a fixed term period of 3 to 6 months whilst they are preparing for exams and/or applying for ST3 rotation. This works extremely well as the majority of these doctors have previously worked at LWH as Core Trainees and therefore are well trained and familiar with the Trust and its complexities. The Locally Employed Doctors continued to support the May rotation.

The service runs a 2 tier rota for on call work which equates to 4 x 12.5 hour shifts, 2 daytime and 2 at night. Therefore the service needs to cover both daytime and night time gaps with bank/lead employer doctors working locums. For reference, due to the training and specialist nature of the Trust, the service does not use agency doctors. The service has not reported any concerns with trainees being released for teaching.

Neonates

The neonatal service uses no agency staff and therefore to mitigate gaps in the rotation, the junior doctor workforce works alongside the Advanced Neonatal Nurse Practitioners (ANNP) who are well established at LWH and are trained to work at registrar level. However, due the number of ANNP's in training, there is a risk that the ANNP's training may take away training opportunities from junior doctors. The service is aware of this and is putting processes in place to manage the risk.

The service has no concerns with junior doctors as the GMC survey results for paediatric doctors (national survey) continues to be high with LWHFT Neonatal unit reported as one of the best training sites within the country. The service has no issues with training or opportunities for teaching, with the survey highlighting the local teaching and curriculum coverage as excellent.

Obstetrics and Gynaecology

This workforce is predominately female; therefore as expected, there are usually a high number of gaps in this service due to maternity leave and less than full time working. The service runs with a 3 tier rota as described below. Currently, the service does not cover daytime gaps, with locum doctors covering only 17:00 – 08:30 gaps.

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

- Tier two – Doctors who have a minimum of 2 years of experience working in Obstetrics and gynaecology working at an ST3 – ST5 who have a career plan

to progress within O&G.

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

Trainees are given protected time to attend in-house teaching organised by the college tutors for the last Wednesday afternoon of every month. The teaching is for ST1 to ST7 training grades. The teaching is facilitated mainly by internal speakers. Anecdotally (again as the DRS system is inaccessible and the GWSH is unable to comment on juniors who were unable to attend weekly teaching) there is an increase in the number of trainees who are unable to attend teaching due to service provision requirements. This is significantly more a problem for O&G Tier 2 and 3 trainees, less so for Tier 1 trainees, and significantly less so for the GP and Foundation trainees.

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

The Trust continues to work in partnership with the University of Liverpool and the Tropical School of Medicine, jointly employing 4 clinical academics who work 2.5 days clinical and 2.5 days academic.

Trainees requiring extra support (TRES)

The service is also supporting a number of trainees requiring extra support (previously known as DID – doctors in difficulty). The additional locally employed doctors within this year's workforce allows for flexibility within rostering, ensuring these doctors are fully supported with a 'buddy' during out-of- hours working.

During all three quarters, there has been at least 1 TRES doctor within the O&G service. All have been noted to require extra support from concerns that there was little senior assistance for Tier 1 doctors at night when covering gynaecology services, mainly due to the workload for maternity. This has led to the gynaecology division moving an ENP (emergency nurse practitioner) onto nights within the Gynaecology Emergency Department (GED), both to help support the Tier 1 junior doctors on shift and to support the service to prevent patient breaches. Within the 3rd quarter, this has largely been stepped down, due to increasing ENP gaps.

3.4 Data on locum usage

The below tables give context to the number of unsocial shifts requiring a doctor or ANNP to work, the number of gaps in each month and who covered the shift.

Anaesthetics

Month	Number of unsociable shifts	Number of shift gaps	Dr's in training/bank/ trust Dr cover	Consultant cover	Unfilled
Apr 21	120	1	1	0	0
May 21	120	7	7	0	0
Jun 21	120	2	2	0	0
Jul 21	120	2	2	0	0
Aug 21	120	0	0	0	0
Sep 21	120	1	1	0	0
Oct 21	120	6	6	0	0
Nov 21	120	0	0	0	0
Dec 21	120	0	0	0	0

Of the 10 locum shifts in Q1, 3 in Q2, and 6 in Q3, all were covered by current junior doctors for unexpected sickness absence, isolation and quarantine period cover. The number of gaps in this reporting period has decreased compared to the previous quarter. In the main the gaps are a consequence of the current covid situation / shielding.

Neonates

Month	Number of unsociable shifts	Number of shift gaps	Dr's in training Dr's/ANNPs cover	Consultant cover	Unfilled
Apr 21	168	4	4	0	0
May 21	168	3	3	0	0
Jun 21	168	3	3	0	0
Jul 21	168	6	6	0	0
Aug 21	168	11	11	0	0
Sep 21	168	0	0	0	0

Oct 21	168	11	11	0	0
Nov 21	168	14	14	0	0
Dec 21	168	5	5	0	0

Of the 10 locum shifts in Q1, 17 in Q2, and 30 in Q4 in neonates, the majority were covered by Advanced Neonatal Nurse Practitioners and the remaining by junior doctors. The number of gaps in this reporting period has increased compared to Q4 of the previous year. In the main the gaps are a consequence of the current covid situation/shielding.

Genetics

Currently, there is no requirement for locum cover as genetic doctors do not work unsocial hours. There was one vacancy given one trainee was on maternity leave and due to return to work in July.

Obstetrics and Gynaecology

Month	Number of unsociable shifts	Number of shift gaps	Dr's in training/bank/trust Dr cover	Agency Locum cover	Consultant cover	Unfilled
Apr 21	252	11	11	0	0	0
May 21	252	16	16	0	0	0
Jun 21	252	27	27	0	0	0
Jul 21	252	15	15	0	0	0
Aug 21	252	26	26	0	0	0
Sep 21	252	13	12	0	0	1
Oct 21	252	19	19	0	0	0
Nov 21	252	12	12	0	0	0
Dec 21	252	28	28	0	0	0

Of the 54 locum shifts in Q1, 54 in Q2, and 59 in Q3, all shifts were covered by the current junior doctor cohort undertaking additional shifts, bank doctors, and Trust doctors. During this reporting period, 1 shifts remained uncovered due to short term mid-shift sickness. There was no patient or doctor safety concerns given that there were extra doctors on shift that day. The gaps were mainly a consequence of Covid with sickness/isolation periods. The number of gaps in this reporting period has increased compared to the last quarter of the previous year.

The use of locums is being closely monitored by the service and HR as locums should only be sought for unexpected absence such as sickness, although there is a trend to cover planned maternity leave, and trainees leaving for Out of Programme training or experience.

Two junior doctors were on long-term sick through this period the report covers.

As predicted all services saw an increase in absences due to covid and in particular the need to isolate awaiting test results for with staff or staff family members.

During the Christmas/New Year period, there was a need to set up a back-up rota to mitigate for the increasing numbers of staff isolating with COVID/awaiting PCR tests, especially given the number of days that needed covering (25-28/12/21 and 1-2/1/22). This was organised over two weeks prior to the bank holidays, with a back-up person available for each shift.
7 gaps were covered in this two-week period, with some junior doctors coming out of their annual leave at short notice to help cover.

4. Other relevant data

There are no other issues, concerns or particular data sets to report at this point.

5. Qualitative narrative highlighting areas of good practice or persistent concern

All services continue to cover locum shifts within the junior doctor and ANNP workforce to reduce the need for agency staff. Only one shift went unfilled within Q2 due to mid-shift illness.

All services continue to engage with junior doctors and offer supportive and safe environments for doctors to work. The doctors have access to the Guardian of Safe Working Hours/Medical Staffing and the Freedom to Speak up Guardian.

There was a concern that work schedules did not reach the junior doctor workforce in time for the August rotations, with the trainees receiving them at 4 weeks, rather than the mandatory 8 weeks. Although the majority of work schedules have been completed within the 8-week timeline, this has not always been possible due to conflicting

information from Health Education inaccurate or missing information from the college tutors and/or changes in the rota due to unexpected gaps.

Currently, the concern around the junior medical workforce (and mostly within O&G) is the lack of access to regular local teaching due to service provision from gaps made worse due to the COVID pandemic. This is being monitored by HR and all juniors have been encouraged to exception report when training opportunities are lost.

6. Conclusion

The Board is advised:

- The revised 2016 contract is now fully implemented
- the number of gaps has increased compared to Q4 of the previous reported year (2020-2021).
- should the rota establishment fluctuate throughout the year there are robust processes in place to mitigate the use of high cost agency locums wherever possible by using internal bank, doctors in training and ANNPs
- There are several gaps expected from Q4 of 2021-2022 (due to trainees obtaining CCT or leaving for Out of Programme training/experiences) and some fixed-term clinical fellow posts have been planned for to mitigate these gaps. These will be looked at in the next Quarter and reported on accordingly.
- The data regarding exception reports and WTE rota gaps will be reported on in due course when the lack of access to DRS is resolved.

This report advises the Board that doctors in training are safely rostered and enabled to work hours that are safe and in compliance with their contract. It is also important to recognise that the doctors continue to be supported during their time at LWH.

7. Recommendations

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