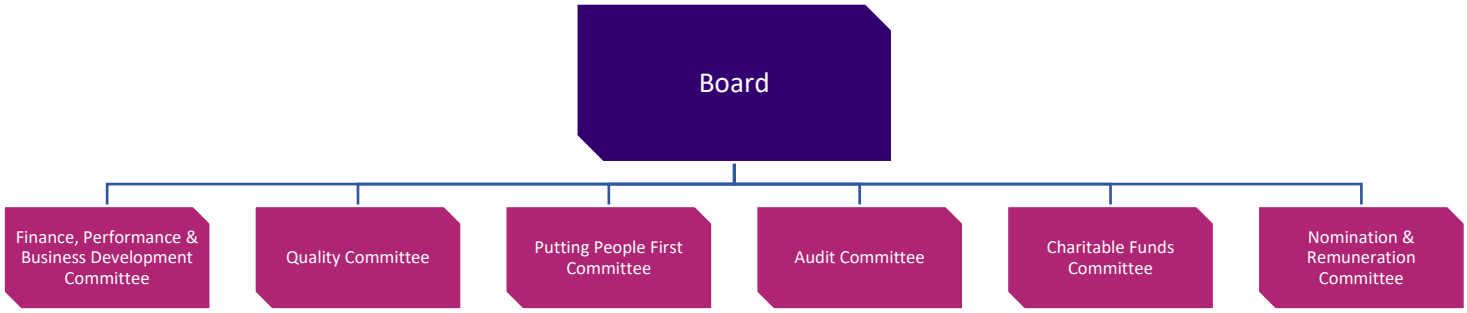
Liverpool Women's NHS Foundation Trust

Trust Board

7 July 2022, 09.00am

Boardroom, LWH & Virtual, via Teams



Liverpool Women's
NHS Foundation Trust

Trust Board

Location	Boardroom & Virtual via Teams
Date	7 July 2022
Time	9.00am

Item no. 22/23/	Title of item	Objectives/desired outcome	Process	Item presenter	Time
PRELIMINARY BUSINESS					
066	Introduction, Apologies & Declaration of Interest	Receive apologies & declarations of interest	Verbal	Chair	0900 (5 mins)
067	Meeting Guidance Notes	To receive the meeting attendees' guidance notes	Written	Chair	
068	Minutes of the previous meeting held on 5 May 2022	Confirm as an accurate record the minutes of the previous meeting	Written	Chair	
069	Action Log and matters arising	Provide an update in respect of on-going and outstanding items to ensure progress	Written	Chair	
070	Service Outline – Patient Experience Matron	To receive service outline	Presentation	Medical Director	0905 (15 mins)
071	Patient Story	To receive a patient story	Presentation	Chief Nurse & Midwife	0920 (15 mins)
072	Chair's announcements	Announce items of significance not found elsewhere on the agenda	Verbal	Chair	0935 (5 mins)
073	Chief Executive Report	Report key developments and announce items of significance not found elsewhere on the agenda	Written	Chief Executive	0940 (5 mins)
MATERNITY					
074a	Ockenden Final Report Self-Assessment	For assurance	Written	Chief Nurse & Midwife	0945 (5 mins)
074c	Maternity Incentive Scheme (CNST) Year 4 – Scheme Update	To receive	Written	Chief Nurse & Midwife	0950 (10mins)
QUALITY & OPERATIONAL PERFORMANCE					
075a	Chair's Reports from the Quality Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	1000 (60 mins)
075b	Quality & Operational Performance Report	For assurance – To note the latest performance measures	Written	Chief Operating Officer	

075c	Standalone Site - Update on Quality and Safety Risks	For noting	Written	Medical Director	
075d	Integrated Governance Report Quarter 4 2021/22	For assurance	Written	Chief Nurse & Midwife	
075e	Guardian of Safe Working Hours (Junior Doctors) Q4 / Annual Report	For assurance	Written	Medical Director	
075f	Learning from Deaths Quarter 4 2021/22	For assurance	Written	Medical Director	
BREAK – 10 mins					
Board Thank You – 5 mins					
PEOPLE					
076a	Chair's Report from the Putting People First Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	1115 (30 mins)
076b	Workforce Performance Report	For assurance – To note the latest performance measures	Written	Chief People Officer	
076c	'Big Conversation' Feedback	For assurance	Written	Chief People Officer	
FINANCE & FINANCIAL PERFORMANCE					
077a	Chair's Report from the Finance, Performance and Business Development Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	1145 (20 mins)
077b	Chair's Report from the Charitable Funds Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	
077c	Finance Performance Review Month 2 2021/22	For assurance - To note the current status of the Trust's financial position	Written	Chief Finance Officer	
BOARD GOVERNANCE					
078	Board Assurance Framework	For assurance	Written	Trust Secretary	1205 (5 mins)
CONSENT AGENDA (all items 'to note' unless stated otherwise) *All these items have been read by Board members and the minutes will reflect recommendations, unless an item has been requested to come off the consent agenda for debate; in this instance, any such items will be made clear at the start of the meeting.*					
079	Director of Infection Prevention and Control Annual Report 2021/22 & IPC BAF	For assurance	Written	Chief Nurse & Midwife	Consent
080	Health & Safety Annual Report 2021/22	For assurance	Written	Chief Operating Officer	
CONCLUDING BUSINESS					

080	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair	1210 (5 mins)
081	Chair's Log	Identify any Chair's Logs	Verbal	Chair	
082	Any other business & Review of meeting	Consider any urgent items of other business	Verbal	Chair	
083	Jargon Buster	For reference	Written	Chair	

Date of Next Meeting: 1 September 2022

1215 - 1225	*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 in the Boardroom and Virtually via Teams at 09.30am on 5 May 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 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
Tony Okotie	Non-Executive Director
Prof. Louise Kenny CBE	Non-Executive Director
Dr Lynn Greenhalgh	Medical Director

IN ATTENDANCE

Matt Connor	Chief Information Officer
Dianne Brown	Interim Associate Director
Rachel London	Deputy Director of Workforce
Nashaba Ellahi	Deputy Chief Nurse & Midwife
Chris Dewhurst	Deputy Medical Director
Alison Murray	Interim Head of Midwifery (items 47a and 47b only)
Angela Winstanley	Maternity Quality and Safety Matron (items 47a and 47b only)
Gillian Walker	Patient Experience Matron (item 044 only)
Dr Alice Bird	Clinical Lead, Maternity (item 043 only)
Lesley Mahmood	Member of the public
Felicity Dowling	Member of the public
Mark Grimshaw	Trust Secretary (minutes)

APOLOGIES:

Jackie Bird MBE	Non-Executive Director
Sarah Walker	Non-Executive Director
Marie Forshaw	Chief Nurse & Midwife
Michelle Turner	Chief People Officer / Deputy Chief Executive

Core members	**Jun 21**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May 22**
Robert Clarke - Chair	✓	✓		✓		✓	✓	✓	✓	✓	✓	
Kathryn Thomson - Chief Executive	✓	✓		✓		✓	✓	✓	✓	✓	✓	
Dr Susan Milner - Non-Executive Director / SID	✓	✓		✓		✓	✓	✓	✓	✓	✓	
Tracy Ellery - Non-Executive Director / Vice-Chair	✓	A		✓		A	✓	✓	✓	✓	✓	

Louise Martin - Non-Executive Director	✓	✓		✓		✓	✓	✓	✓	✓	✓	
Tony Okotie - Non-Executive Director	✓	✓		✓		✓	A	✓	✓	✓	✓	
Prof Louise Kenny - Non-Executive Director	✓	✓		A		✓	A	✓	A	A	A	
Eva Horgan – Chief Finance Officer	Non-member					✓	✓	✓	✓	✓	✓	
Marie Forshaw – Chief Nurse & Midwife	✓	✓		✓		✓	✓	✓	✓	✓	✓	
Gary Price - Chief Operating Officer	✓	✓		✓		✓	✓	✓	✓	✓	✓	
Michelle Turner - Chief People Officer	✓	✓		✓		✓	✓	A	✓	✓	✓	
Dr Lynn Greenhalgh - Medical Director	✓	✓		✓		✓	✓	✓	✓	A	A	
Zia Chaudhry – Non-Executive Director	Non-member						✓	✓	✓	✓	✓	
Gloria Hyatt – Non-Executive Director	Non-member						✓	✓	✓	✓	✓	
Sarah Walker – Non-Executive Director	Non-member						✓	✓	✓	✓	✓	
Jackie Bird MBE – Non-Executive Director	Non-member										✓	

22/23/	
039	**Introduction, Apologies & Declaration of Interest** The Chair welcomed everyone to the meeting. No declarations of interest were made, and apologies were noted as above. No items proposed to be removed from the consent agenda.
040	**Meeting guidance notes** The Board received the meeting attendees' guidance notes.
041	**Minutes of the previous meetings held on 7 April 2022** The minutes of the Board of Directors meeting held on 7 April 2022 were agreed as a true and accurate record. It was noted that at the April 2022 meeting, the Board had noted the specific updates in relation to the Neonatal Nursing workforce and the Neonatal Medical Workforce. To ensure clarity on this point the Board wished to formally record that a) assurance had been provided that the recommendations of the neonatal medical workforce had been met and b) that the neonatal nursing workforce was compliant to the service specification standards (set annually by the neonatal clinical reference group nursing calculator)
042	**Action Log and matters arising** The Action Log was noted.
043	**Service Outline – Still Births** Dr Alice Bird, Clinical Lead, Maternity attended to present on still births, explaining reporting categories and trend data for the previous three years. It was reported that there had been a rising rate from 2019/20, with the reason for this unclear. Further exploration of this issue would be undertaken once the 2021/22 cases had been reviewed in detail. There had been no obvious concerns flagged by available benchmarking data.

	Prof. Louise Kenny, Non-Executive Director, remarked that the concerning still birth trend was not correlating with relatively stable quality-of-care indicators and queried what the explanation might be for this. Dr Alice Bird suggested that the answer was likely to be multifaceted and involve issues relating to medical complexity, deprivation and potentially issues emerging from the pandemic. The Chair queried the process in place for reviewing still birth rates and if a holistic approach was being implemented. Dr Alice Bird confirmed that a longer-term review would be put into place, and this would involve an action plan with clear ownership and the tracking of delivery. It was suggested that the Trust may see further increases in the still birth rate as the Trust was taking complex cases from across the region. Prof. Louise Kenny, Non-Executive Director, sought further information on how the Trust was benchmarking against its usual comparator group. It was confirmed that, from the data available, the Trust was not an outlier. Further contact with St Mary's in Manchester and Birmingham Women and Children's hospital was being made. The Deputy Medical Director stated that the Trust had a significant cohort of women presenting to the Trust in the most deprived deciles nationally and whilst there was a clear need to continue to review the quality of care provided, there was a strong hypothesis that the high deprivation levels were a factor. The Chief Executive referenced previous work undertaken on this issue, particularly relating to low BMI and outcomes, and suggested that the findings from this be included in the wider review. Non-Executive Director, Louise Martin, asked if the Trust could identify avoidable still births. Dr Alice Bird explained that the numbers involved were small which made it challenging to undertake effective data analysis unit by unit. Ensuring that there was well resourced ultrasound workforce would be a key action as this could help the Trust to adapt screening practices to align with risk factors such as deprivation levels. The Chair suggested that it would be important for the Board to receive a cohesive and overarching plan to move towards achieving the national target for still birth rates when it was available. Action: For the Board to receive a cohesive and overarching plan to move towards achieving the national target for still birth rates The service outline was noted.
044	Patient Story Gillian Walker, Patient Experience Matron noted that the week commencing 2 May was deaf awareness week and introduced Janice (Community Liaison Officer- Merseyside Society for Deaf People) and her access to work British Sign Language interpreter Norah. Janice provided an overview of her role within the Merseyside Deaf community and continued to outline the key themes around communication issues that patients, relatives, and British sign language interpreters encounter and the small things that would make a difference in improving their experience when they use Trust services. The key lessons learned from patient experience included: • That there were many different types of hearing loss/deafness • The difficulties that the deaf community have in their voice being heard • The challenge of maintaining the privacy and dignity of patients when not using their access to work interpreter. • The need to establish robust mechanisms/processes of how British sign language interpreters could be arranged both in hours and out of hours and ensuring that appointment times are maintained accurately so that the interpreter resource was utilised efficiently.

	Gillian Walker reported that the Trust action plan in relation to patients/service users attending from the deaf community was being reviewed. An access audit was to be undertaken to look at how the environment for deaf patients/service users could be improved so that it was more inclusive of others with additional characteristics. This would be undertaken in conjunction with the findings from the site assessments following the November 2021 Major Incident. Noting that the deaf community could often have challenges with written communication, the Medical Director asked how the Trust could improve appointment letters. Janice suggested that plain English should be used and asserted that the ideal situation would be a QR code to a translation in British Sign Language. The Chief Information Officer noted that it would be germane to explore digital options to support the access to services from the deaf community and the overall experience. It was acknowledged however, that human contact would always remain paramount. The Chief Executive committed to explore what improvements the Trust could make and report back to the Merseyside Society for Deaf People when appropriate. It was suggested that the Quality Committee retain oversight on progress. Chair's Log: For the Quality Committee to retain oversight of the improvements the Trust makes in relation to patient access and experience for the deaf community. The Board noted the patient story and thanked Janice and Norah for their time and insight. *Gillian Walker left the meeting*
045	Chair's announcements The Chair reminded the Board that the period (previously known as 'purdah') leading up to the 2022 local government elections remained in effect and asked that members continue to be mindful of the requirement to maintain political impartiality in carrying out public duties. The Chair noted that he had attended a recent 'Liverpool against racism' conference that had been highly informative. It had made clear that the Trust still had work to do to support this agenda and a specific equality, diversity and inclusion session had been arranged for the next Board workshop. The Council of Governors were next scheduled to meet on the 12 May 2022. Key items for consideration would be the Trust's response to the Ockenden report, an outline of the year-end process and outputs from the Chair/NED appraisals. The Council of Governors would also be asked to support several changes to Non-Executive Director responsibilities (Committee membership and champion roles) and approve the appointment of Prof. Louise Kenny as Senior Independent Director once Dr Susan Milner left the Trust. The Board supported this recommendation to the Council of Governors. The Board noted the Chair's update.
046	Chief Executive's report The Chief Executive presented the report which detailed local, regional and national developments. The following key points were highlighted: • Tributes were paid to renowned gynaecologist and obstetrician, Bob Atlay who had passed away • To acknowledge International Day of the Midwife, it was noted that it had been a challenging year and thanks were extended to the midwives working at the Trust.

	• Two new permanent senior leadership appointments to support the Family Health Division had been made.
	  o Yana Richens had been appointed to the role of Director of Midwifery. This was a new Trust leadership role reporting to the Chief Nurse and Midwife. Yana's current role was Director of Midwifery at Whittington Health NHS Trust in London.
	  o Heledd Jones had been appointed to the vacant role of Head of Midwifery. Heledd's current role was Head of Midwifery and Gynaecology Nursing in Betsi Cadwaladr University Health Board, North Wales.
	• The Trust had been successful in securing a successful bid for Liverpool to host the British Gynaecological Cancer Society Annual Scientific Meeting in 2024. Congratulations were noted to Mr Mohamed Mehasseb and his team for putting together an excellent application.
	
	The Board of Directors:
	• noted the Chief Executive update.
	
	Alison Murray and Angela Winstanley joined the meeting

047a	Ockenden Final Report The Board received an update on the Trust's progress relating to the Ockenden Interim Report and outline the immediate steps taken after the publication of the Ockenden Final Report in March 2022, providing a comparison between the key areas of focus between the Interim and Final Reports. An outline of the process and assurance mechanisms for managing the Trust's response to the Final Report was outlined. Non-Executive Director, Zia Chaudhry MBE, noted that the feedback from the visit on 12 April 2022 from the Regional Chief Midwife (RCMW) team and the Cheshire and Mersey Local Maternity System representatives (LMNS) had suggested that the Trust had been overly 'self-critical' on occasion when demonstrating compliance with the Interim Ockenden Report. It was queried if this approach had been a hindrance to progressing with actions. The Interim Head of Midwifery asserted that actions had not been closed until evidence was in place that practice had been embedded. However, it was acknowledged that the service could improve its approach to celebrating achievements and good practice. The Interim Head of Midwifery noted that a gap analysis was now underway to understand the Trust's current compliance against the recommendations in the Ockenden Final Report. The Board of Directors: • noted the assurances provided in the report.
047b	Maternity Incentive Scheme (CNST) Year 4 – Scheme Update The Maternity Quality and Safety Matron outlined 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 Trust's status against this. It was noted that specific information was required to be noted by the Board. This related to the following: • Safety Action 9 - Perinatal Surveillance Dashboard Update (Appendix A) • Safety Action 4 – Anaesthetic Workforce paper (Appendix B) Non-Executive Director Louise Martin raised the following queries: • What action was being taken to improve the proportion (41%) of midwives responding with agree/strongly agree on whether they would recommend the Trust as a place to work or receive treatment (reported annually in the staff survey). • What action was being taken to improve the Friends and Family Response rate for maternity (currently 10%)

	• Whether staffing pressures could impact on the Trust's compliance with the MIS CNST Year 4 scheme. The Deputy Chief Nurse & Midwife acknowledged that the staff survey result was disappointing, and that work was underway to understand the reasons behind this through in-depth discussions with staff. A retention midwife had been identified and this provided a dedicated resource to speak with and listen to staff. It was also acknowledged that the friends and family response rate required significant improvements and the Family Health Division had been asked to consider alternative mechanisms for engaging with patients. This was being overseen by the Patient Involvement and Experience Sub-Committee. The Maternity Quality and Safety matron explained that the risk to MIS CNST Year 4 compliance related to the requirement for staff to receive training. Low staffing levels resulted in challenges for staff to be released to attend the training. Trajectories were being closely monitored with interventions planned should they be required. Non-Executive Director, Tracy Ellery, remarked that MIS CNST Year 4 non-compliance also posed a financial risk to the Trust. The Chief Finance Officer explained that a provision had been held in the 2022/23 accounts in the event of non-compliance and should it be achieved, it would be viewed as a benefit. This treatment had been discussed with the external auditors. Chief Operating Officer, Gary Price, highlighted that MIS CNST Year 4 remained in a period of 'pause' and updated guidance and timelines would be imminent. The Board of Directors: • Received the current position in relation to CNST Year 4 • Noted the specific updates in relation to: o Anaesthetic Workforce Paper o Perinatal Quality Safety Dashboard.
048a	Chair's Report from the Quality Committee The Board considered the Chair's Report from the Quality Committee meeting held on 25 April 2022. Chair of the Committee, Tony Okotie, noted that there had been several positive assurances received which, it was asserted, was an indication of a growing maturity of the Committee and the underpinning governance structure. The Committee had been particularly encouraged by the presentation outlining the new CQC preparedness framework. In terms of issues to escalate it was noted that the performance report had indicated that the 2-week performance remained a challenge with increasing referrals. Capacity had been reviewed to address this challenge and an improvement was expected in April 2022. The Committee had also noted continued issues with the telephone triage process, particularly within GED and MAU as escalated by the Patient Involvement & Experience Sub-Committee. The Committee requested that the Executive Team consider the issues as a matter of priority and identify timescales and report back to the next Committee. The Board of Directors: • Received and noted the Chair's Report from the Quality Committee meeting held 25 April 2022.
048b	Quality & Operational Performance Report The Board considered the Quality and Operational Performance Report. The Chief Operating Officer noted that for 2021/22 the Trust had presented a mixed picture of performance during the year, with the most challenged areas reflecting long existing pressures in the wider health system around Referral to Treatment and Cancer. The NHS now faced a unique challenge

	of recovering its services back to pre-pandemic levels whilst managing significant backlogs that had built up over the last couple of years. The Chief Operating Officer outlined the Trust's cancer performance noting that there had been challenges in relation to the 2-week wait metric during January 2022 and February 2022, mainly because of the Omicron variant on staffing and patient availability. Whilst there had been an improvement during March 2022, performance had deteriorated during April 2022, mainly due to staff sickness absence. An improved position was expected in May 2022 with a 'deep dive' review planned to reflect on the main drivers of the performance issues seen in 2022 to date. The Medical Director reported that an audit had been undertaken on 2-week wait cancer referrals and 50% of the referrals had not met the NICE criteria. A triage process had been implemented which was supporting the management of any immediate referral issues. A longer-term project would be required to ensure women were being placed on the most appropriate care pathway. Non-Executive Director Dr Susan Milner queried if feedback had been provided to referring GPs. It was confirmed that communications had been made with the Primary Care Women's Health Hub and it was acknowledged that more pro-active discussions would be helpful. The Chief Executive suggested providing enhanced GP access to specialists would build confidence in appropriate referrals. The Board of Directors: • Received and noted the Quality & Operational Performance Report.
048c	Operational Plan 2022/23 The Chief Operating Officer outlined the key performance priorities emerging from the updated operational planning guidance for 2022/23. These included the following: • RTT - Eliminate 104+ week waits by July 2022 • RTT - Eliminate 78+ week waits by April 2023 • RTT - Eliminate 52+ week waits by March 2025 • Cancer - Reduce the number of patients waiting beyond 62 days for treatment, to pre-pandemic levels by March 2023 • Cancer – compliance with the 75% Faster Diagnosis Standard (FDS) target by March 2024 • Diagnostics – 95% compliance against DM01 standards by March 2025 It was noted that it was a Trust objective to eliminate 78 week waits in year with a plan to reduce the current number of patients waiting longer than 52 weeks by 50%, by March 2023. Actions to support elective recovery aims were also outlined. Key challenges and risks were highlighted as follows: • Workforce – there could be potential issues with the Trust's ability to recruit where other provider organisations were also managing similar staff shortages. Staff burnout and resilience to deliver additional activity was also a risk. • Ultrasound workforce and diagnostic capacity in partner organisations was challenged. • Cancer referrals in 2021/22 were 15-20% above pre-pandemic levels and this was expected to continue in 2022/23 • Meditech Expanse rollout was scheduled during 2022/23 and this could have an impact on operational delivery The Board noted the presentation.
	Board Thank you *Julie Copeland, Sarah Moss, Noma Hashe, Dawn Valentine-Gray, Wendy Gerrard, Michaela Mayor, Danielle Smith, Nicola Grierson Laura Middlehurst (representatives from the Gynaecology Division), Wahiba Abdo (Urogynae Link Midwife) and Sarah Orok (Gynaecology Outpatients) joined the meeting* The Chief Operating Officer introduced representatives from the Gynaecology Division noting that they had all volunteered for being model at a recent fashion show that had been held to raise funds for the gynaecology services.

	The Deputy Director of Nursing & Midwifery noted that she had received a letter of commendation from an obstetric consultant regarding Wahiba Abdo. It was explained that a woman who first language was Arabic had lost their baby at full term. The Consultant had wished to discuss with her a lot of intimate details about post fetal death investigations including post-mortem. There had been a challenge with the virtual translator. Wahiba had been approached for advice and she then chose to come to the hospital whilst on leave to translate but to also provide emotional and spiritual support to the women and her husband. This helped the shared decision making, future planning and post-natal care to a great degree.
049a	Workforce Performance Report The Board received the Workforce Performance Report. The Chief People Officer noted sickness rates continued to be a challenge and that there had not been the expected traction towards the target in relation to mandatory training compliance. Additional investments had been made to provide additional corporate support to the Divisions and training was being prioritised in line with clinical need and acuity. In response to the Ockenden Report, human factors training had been developed and would be rolled out following consultation with the Liverpool Maternity & Neonatal System. Non-Executive Director, Tony Okotie queried if the Trust was an outlier in terms of mandatory training compliance rates. Chair's Log: Putting People First Committee to receive benchmarking information on mandatory training compliance. Non-Executive Director Louise Martin expressed a concern regarding the staff turnover rate and stated that future meetings should receive enhanced narrative on the reasons and the action being taken. Action: For future workforce performance reports to include enhanced narrative on the staff turnover rate explaining underpinning reason and corrective actions. The Board discussed the efficacy of the current approach to managing sickness absence and the Chief Executive suggested that one of the most significant factors for staff wellbeing was the relationship between a direct report and their line manager. There was agreement that each manager should have personal objectives regarding their management responsibilities, including use of exit interviews and undertaking return to work interviews. The Board of Directors: • Noted the Workforce Report.
049b	National Staff Survey Results 2021 The Deputy Director of Workforce introduced the report noting that the results of the staff survey highlighted that being a member of staff had been particularly challenging over the last 12 months. The Trust was a negative outlier in its comparator group and average in terms of acute trusts. The key issues raised were being addressed at both a divisional and Trust wide level and would inform the development of plans owned by local teams, to drive improvement. Local plans would be integrated into Divisional People Plans monitored by Divisional Boards and a summary of the plans, and the outputs from the Listening Events would be provided as an update at the next Putting People First Committee. The Chair acknowledged that the results were disappointing and that they gave reason to reflect on whether the initiatives utilised during the preceding year to support staff had been the right ones or if they had been deployed correctly. The Chief Executive noted that it would be important to ensure

	that listening events were more targeted in approach as it had been challenging to achieve buy in and engagement for Trust wide events. Non-Executive Director, Prof Louise Kenny CBE, noted that the comparative data and overall trends were concerning and stated that poor staff morale often impacted a range of quality and experience metrics. It was stated that understanding the key drivers of the results would be important to ensure that actions put into place would improve underlying long-term concerns rather than being seen as peripheral offers and short-term fixes. Non-Executive Director, Louise Martin, asserted that it would be important for staff to be assured that the Board acknowledged the level of dissatisfaction being expressed and that it was taking the issue seriously. The recent video produced by the Chief People Officer to all staff was provided as a good example of an open and honest approach that was not complacent about the amount of improvement required. Despite the positive results from the recent WRES report, Non-Executive Director Zia Chaudhry MBE, remarked that the Trust had still seen some deterioration in some measures. It was stated that these issues should be made integral to the staff survey response and actions. **Chair's Log: Putting People First Committee to reflect on the impact and efficacy of the previous interventions to improve staff experience.** The Chief Executive identified that results from the Nursing and Midwifery cohorts had been particularly concerning and suggested that separate meetings should be held with team leaders to discuss the most appropriate actions. **Action: Chief Nurse & Midwife and Chief People Officer to meeting with nursing and midwifery team leaders to discuss the most appropriate actions in response to the staff survey results.** The Board of Directors: • received the report. • Agreed that limited assurance could be taken regarding the response to the staff survey results outlined in the report.
050a	**Chair's Report from Finance, Performance and Business Development Committee** The Board considered the Chair's Report from the Finance, Performance & Business Development Committee meetings held on 25 April 2022. Committee Chair and Non-Executive Director, Louise Martin, noted that the majority of the Board had attended the meeting (beyond the usual membership) as the main business pertained to the year-end accounts and the 2022/23 budget. The Board of Directors: • Received and noted the Chair's Report from the FPBD Committee meeting held on 25 April 2022.
050b	**Finance Performance Review Month 12 2021/22** The Chief Finance Officer presented the Month 12 2021/22 finance performance report which detailed the Trust's financial position as of 31 March 2022. At Month 12, the Trust was reporting a £34k surplus for the year against a £17k deficit plan. This equated to a breakeven position within the Cheshire and Merseyside Integrated Care System (C&M ICS) after technical adjustments to financial performance were taken into account. The Year to Date (YTD) Trust wide position had improved in month due to non-recurrent benefits, such as additional system funding, improved ERF income and additional Health Education England (HEE) allocations. This had been offset by the ongoing pressures in agency staffing, gas and electricity prices. The Cost Improvement Programme (CIP) had delivered savings above the £2.0m target which was noted as a significant achievement.

	Looking ahead to the 2022/23 financial plan, the Chief Finance Officer explained that discussions remained on-going with the C&M ICS with the current position being a £5m deficit. Representations were being made to request that the increase in costs relating to the Trust's CNST premium and Ockenden compliance requirements were recognised. The Board of Directors: • Noted and received the Month 12 2021/22 Finance Performance Review
050c	Digital Annual Review The Board received an outline on the Digital Services Department activities during 2021-2022 financial year to underpin the Trust's Corporate objectives. It was stated that there had been positive examples throughout the year in relation to engaging clinical leadership in digital programmes including both Meditech Expanse and the Digital Maternity System (K2). Demonstrable progress had been made towards the Trust's key digital programmes, often requiring challenges to be navigated. The 2021/22 full year position for Digital Services department was a £29k deficit against an overall budget of £5,569,000 (0.5% of overall budget). The Trust received non-recurrent revenue bid income of £225k to offset specific project costs without which the full year position was a £256k deficit reflecting a 4% variation from planned budget. Looking ahead to 2022/23, it was reported that the key priorities would be to try and reducer the BAF risks relating to the digital agenda (multiple systems and cyber security) through the strengthening of controls and mitigations, begin the roll out of key programmes such as Meditech Expanse and continue to enhance the digital offer across a range of services. The Board of Directors: • Received and noted the report. • Took assurance that the delivery of the digital programme, and the operational performance had resulted in meeting the corporate objective to provide our hospital with the best digital capabilities and embed a digital first culture through delivering the Digital.Generations strategy through to 2025.
051a	Proposed Corporate Objectives 2022/23 The Board received the proposed Corporate Objectives 2022/23 which had been considered by each of the Board Committees. Most of the objectives had been recommended to the Board without comment, but the Quality Committee requested that two proposed objectives be amended to reduce the element of subjectivity as much as possible to ensure that there was clarity at the end of the year on whether the objectives had been achieved (or not). The Board received the final outturn position on the 2021/22 Corporate Objectives on 7 April 2021. On review, it was suggested that a position statement should be provided on the 2021/22 objectives either not complete or not being taken forward as a 2022/23 corporate objective. This had been provided in Appendix 1 to the report. Non-Executive Director Louise Martin noted that was a misalignment between the Trust's strategic aim to be 'the most inclusive NHS organisations' and the BAF risk which stated 'one of the most inclusive NHS organisations'. There was agreement that the Trust strategy should be amended to align with the language utilised in the BAF. Action: For the strategic aim 'to be the most inclusive NHS organisation' be amended to 'one of the most inclusive NHS organisations.

	The Board of Directors: • Approved the 2022/23 Corporate Objectives.
051b	**Revised Risk Management Strategy for 2022-23** The Board received the draft Risk management Strategy for 2022/23. This had been updated from the version tabled in April 2022 to provide additional clarity on the roles, responsibilities, and escalation routes for statutory compliance risks. The Board of Directors: • Approved the Risk Management Strategy for 2022-23.
051c	**Board Assurance Framework** The Board of Directors received the Board Assurance Framework. The Trust Secretary explained that the BAF items were aligned to the Board's assurance committees, and these were reviewed and discussed during April 2022. Reviews during April were significant with scores for the end of 2021/22 year discussed, target scores for 2022/23 proposed and amendments to the BAF risks themselves considered. There were two new strategic threats proposed for BAF risk 2.1 – instead of one strategic threat, the proposal was to separate this into the following three areas: • Inability to effectively communicate the case for change with regulators and key partners and receive buy-in to move project forward. • Inability to effectively communicate the case for change with the local community and receive buy in to move project forward. • Failure to secure capital funding to progress our plans to build a new hospital co-located with an adult acute site Under BAF Risk 3.1, the strategic threat 'Unable to recover services to pre-Covid-19 levels and beyond', was proposed to be removed as the issues within this threat had been subsumed into other areas. In its place, two new strategic threats had been identified under this BAF risk: • Unable to adequately listen to patient voices and our local communities • Failure to act on the feedback provided by patients, carers, and the local communities. The Board of Directors: • Reviewed the BAF Risks • Agreed the proposed amendments, 2021/22 outturn scores and 2022/23 target scores. *The following item was considered as part of the consent agenda*
052	**Emergency Planning Resilience and Response Annual Board Report** The Board of Directors noted the Emergency Planning Resilience and Response Annual Board Report.
053	**Review of risk impacts of items discussed** The Chair identified the following risk items: Risks: • Staffing issues and the need to better understand drivers behind high absence rates and low morale • The need to understand the diversity of patient groups and ensure that the Trust is effectively listening and responding to need • The Trust's financial position and long-term sustainability

054	Chair's Log The following Chair's Logs were noted: • For the Quality Committee to retain oversight of the improvements the Trust makes in relation to patient access and experience for the deaf community. • Putting People First Committee to receive benchmarking information on mandatory training compliance. • Putting People First Committee to reflect on the impact and efficacy of the previous interventions to improve staff experience.
055	Any other business & Review of meeting The Chair and the rest of the Board noted thanks to Dr Susan Milner whose second three-year term of office will come to an end on 31 May 2022. It was noted that Susan had provided a breadth of expertise and played a significant role in the development of the Quality Committee. Susan had also been a highly effective Senior Independent Director for over a year. Review of meeting No comments noted.
056	Jargon Buster Noted.

Liverpool Women's
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Action Log

Trust Board - Public
7 July 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
5 May 2022	22/23/51a	Proposed Corporate Objectives 2022/23	For the strategic aim 'to be the most inclusive NHS organisation' be amended to 'one of the most inclusive NHS organisations.	Chief Finance Officer	July 2022	Completed	Amendments being made to Trust's strategic documents
5 May 2022	22/23/049b	National Staff Survey Results 2021	To meet with nursing and midwifery team leaders to discuss the most appropriate actions in response to the staff survey results.	Chief Nurse & Midwife and Chief People Officer	July 2022	Completed	Dates for meetings have been scheduled
5 May 2022	22/23/049a	Workforce Performance Report	For future workforce performance reports to include enhanced narrative on the staff turnover rate explaining underpinning reason and corrective actions.	Chief People Officer	July 2022	Completed	Please see item 076a for narrative
5 May 2022	22/23/043	Service Outline – Still Births	For the Board to receive a cohesive and overarching plan to move towards achieving the national target for still birth rates	Medical Director	September 2022	On track	
7 April 2022	22/23/010b	Equality, Diversity and Inclusion Annual Report	Board development session to utilised to support the drafting of an ED&I Strategy	Chief People Officer	June 22	Complete	This was held on 16 June 2022
7 April 2022	22/23/009e	Bi-annual staffing paper, July-December 2021 (Q2 & Q3)	To include mandatory training compliance trajectories in future bi-annual staffing papers.	Chief Nurse & Midwife	Nov 22	On track	

7 April 2022	22/23/009c	Learning from Deaths Quarter 3, 2021/22	For the Board to receive a report on the Trust's stillbirth rate	Medical Director	~~July 22~~ September 2022	Risks identified	Learning from Deaths Report (item 076f) provides a preliminary analysis – this will be followed by a more extensive report in September 2022. Proposed that date is amended to September 2022. Potential to be superseded by action 22/23/043a.
7 April 2022	22/23/009a	Quality & Operational Performance Report	To explore the impact on the patient experience due to the closure of the MLU.	Chief Nurse & Midwife	July 22	On track	This action has been remitted to the Patient Involvement & Experience Sub-Committee. Outcomes will report through to the Quality Committee in July 2022.
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	July 22	On track	Scheduled on the July 22 agenda
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	~~July 22~~ September 2022	Risks identified	Due to availability of WHaM Programme Director, it is proposed that this item be moved to September 2022.

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Chair's Log

Received / Delegated	Meeting Date	Issue and Lead Officer	Receiving / Delegating Body	Action Deadline	RAG Open/Closed	Comments / Update
Delegated	05.05.2022	To reflect on the impact and efficacy of the previous interventions to improve staff experience. Lead Officer: CPO	PPF	July 2022	On track	
Delegated	05.05.2022	To receive benchmarking information on mandatory training compliance. Lead Officer: CPO	PPF	July 2022	On track	
Delegated	05.05.2022	To retain oversight of the improvements the Trust makes in relation to patient access and experience for the deaf community. Lead Officer: CN&M	Quality	Sept 2022	On track	
Delegated	07.04.2022	To review the deterioration in VTE performance Lead Officer: CN&M	Quality	May 2022	Closed	Additional narrative received by the June 2022 Quality Committee.
Received	24.03.22	To receive a proposed method of assessing the maturity of Divisional Governance arrangements to support the Audit Committee in undertaking reviews. Lead Officer: TS	Audit	~~July 2022~~ September 2022	Risks identified	Owing to the additional items produced by NHS England around NHS Governance, this item is proposed to be deferred to September 2022.
Delegated	03.02.22	To review the development of a business case for an expanded endometriosis service. Lead Officer: CFO	FPBD	October 2022	On track	To be progressed through the Divisional Operational Planning process with an update provided to the FPBD Committee as part of the six month review of progress.
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.	PPF	May 2022	Closed	Received at the May 2022 Putting People First Committee

		Lead Officer: CPO				

Liverpool Women's
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CEO Report

Trust Board
July 2022

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*

Senior Leadership Changes

I would like to update you on some recent Leadership changes.

As you will be aware we recently announced that our Chief Nurse & Midwife, Marie Forshaw has taken the decision to retire. Marie was appointed as Chief Nurse & Midwife at LWH in 2020 and her decision to retire follows a successful 35 year NHS career as a nurse, midwife and health visitor.

Following this decision we have appointed Dianne Brown to take up the role of Interim Chief Nurse for an initial period of nine months, during which time we will begin a formal recruitment process to appoint to the role permanently.

Dianne Brown was previously Director of Nursing & Midwifery at Liverpool Women's before moving on to the role of Chief Nurse at Aintree University Hospital and later Liverpool University Hospitals NHS Foundation Trust following the merger with the Royal Liverpool Hospital. Dianne returned to Liverpool Women's in 2021 on an interim basis to support the Trust with a number of projects. During this period of transition for Liverpool Women's and following a successful tenure at the Trust during her 10+ year career here previously, we are delighted to welcome Dianne back in a board level capacity for the next few months.

Marie will still be with LWH for the next few weeks and will now begin a period of handover with Dianne between now and August.

COVID-19 Staff Briefing: Changes to mask wearing guidance and opening of entrances

UK Health Security Agency (UKHSA) and NHS England have announced changes to their infection control guidance, including the COVID-19 protective measures for healthcare settings. Gary Price, Chief Operating Officer shares an update with you here: **https://tinyurl.com/GaryPriceIPCChangesJune2022** (you can watch the video by clicking on or typing the link into your browser either on your work or personal device.)

Guidance for patients

Inpatients with suspected or confirmed COVID-19 will be provided with a facemask on admission. This should be worn in multi-bedded bays and communal areas, e.g.: waiting areas for diagnostics, if this can be tolerated and is deemed safe for the patient. They are not usually required in single rooms, unless, e.g.: a visitor enters

- All other inpatients are not required to wear a facemask unless this is a personal preference
- Patients with suspected or confirmed COVID-19 transferring to another area should wear a facemask, if tolerated, to minimise the dispersal of respiratory secretions and reduce environmental contamination
- Outpatients with respiratory symptoms who are required to attend for emergency treatment should wear a facemask/covering, if tolerated, or offered one on arrival
- All other outpatients are not required to wear a facemask unless this is a personal preference.

For visitors:

- In inpatient settings visitors may be asked to wear a face mask when visiting patients with COVID-19, (or similar infections) or vulnerable patients. Visitors may choose to wear a face mask/covering if that is their preference
- Visitors and individuals accompanying patients to outpatient appointments, or the emergency department are not required to wear a facemask unless this is a personal preference.

Opening of entrances

From early June 2022 entrances open as normal, including the antenatal entrance for patients and staff, the Gynaecology Outpatient entrance will remain closed due to building works.

Section A - *Internal*

Future Generations Update

Please see a link to the latest Future Generations message from Medical Director, Lynn Greenhalgh. You can watch the video by clicking on or typing the following link into your browser either on your work or personal device:

https://tinyurl.com/FutureGenerationsupdateMay22

A more detailed update on issues relating to Future Generations can be found later in the agenda (single site risks report).

Mobile CT scanner has now seen over 1,500 patients on-site at Liverpool Women's (new

As many will be aware the Trust took delivery of a Mobile CT Scanner located near the front of the hospital in February this year and saw its first patient on 7th March. Since then the CT scanner has seen over 1,500 patients. The mobile CT unit is part of the development of a new Community Diagnostic Centre (CDC) onsite at the hospital. To view image of the scanner click here.

Not only will the new Community Diagnostic Centre (CDC) enable thousands of additional scans to be undertaken every year for patients in the region, it will also help to reduce risk for some of our most seriously ill patients, who at the moment are transferred across the city when they need urgent scans. This development started as part of the *Crown Street Enhancements Programme* but has now been significantly expanded. The CDC at Liverpool Women's is one of five in Cheshire and Merseyside.

The Liverpool Women's is working with partner organisations such as Liverpool University Hospitals (LUHFT), Liverpool Heart and Chest (LHCH) and The Clatterbridge Cancer Centre (CCC) as this Mobile CT will increase overall CT capacity for LWH and other patients in the area.

The new Community Diagnostic Centre at Liverpool Women's will deliver other tests for local people, such as non-obstetric ultrasounds, MRI and cardiac and respiratory diagnostics.

The work to establish a Community Diagnostic Centre at Crown Street is progressing as part of the Crown Street Enhancements Programme to create a new colposcopy suite, CT, and MRI imaging facilities. This work is going well and is on track for completion on time; the colposcopy suite and respiratory service is due to be completed in June 2022, with permanent CT and MRI due for completion in December 2022.

This programme is part of a national programme, for which LWH has been awarded an initial £5.2m. There are other CDCs in the region and in the area. More information is available here: *https://www.gov.uk/government/news/40-community-diagnostic-centres-launching-across-england*

Section A - *Internal*

Liverpool Women's 'In the News'

Dr Paula Briggs, Chair Elect of British Menopause Society and Consultant in Sexual and Reproductive Health at Liverpool Women's Hospital discusses her concerns and unpicks the potential impact of using testosterone

Woman's Hour podcast - 04/05/2022 Woman's Hour podcast (player.fm)

BBC Radio 4 - Woman's Hour - BBC Radio 4 - Woman's Hour, 04/05/2022

The Women's View – June / July 2022

The Women's View is now available for download

Use your Freedom to Speak Up – short video from our F2SU Guardians

Our Freedom to Speak Up Guardians are available to speak to any member of staff safely and confidentially whenever there are concerns that someone wants to raise. We hope staff have the confidence to do this in an open way so we can discuss any concerns in detail.

Our Guardians, Kevin Robinson and Srinivasarao Babarao have done a short video for you on why speaking up is important and the different ways you can do this. **You can watch the video here: https://tinyurl.com/F2SUGVideo**

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Section A - *Internal*

Dedicated to Excellence Awards 2022

The Trust's Dedicated to Excellence Awards took place on Thursday 30 June 2022 at St George's Hall. This was a fantastic event and it was great to see everyone there after the previous two years events being either cancelled or recorded due to the COVID-19 pandemic.

Well done to all the winners and nominees – we are proud of you and all of our staff.

LWH's BIG Conversation

From 8am Wednesday 15th June 2022 to 8am Thursday 16th June LWH's BIG Conversation took place.

The **Big Conversation** involved members of the Executive Team, senior managers and clinicians out and about the organisation for 24 hours, talking to staff in their place of work to listen. Further details on this process and the outcomes is included later in the agenda.

Born at Liverpool Women's (or working here) – Proud to Serve my Country

As part of Armed Forces week the Trust invited Armed Forces personnel who were born at Liverpool Women's to a lunch on Wednesday 22 June at 12 noon in the Blair Bell at the Liverpool Women's Hospital

Section B - *Local*

NHS Cheshire and Merseyside Becomes Statutory Organisation

NHS Cheshire and Merseyside has entered its first day as a statutory organisation on 1 July 2022 – in a move which will transform health and care for all of its 2.7 million residents.

The milestone means that Cheshire and Merseyside becomes one of 42 Integrated Care Systems (ICS) in the country, which are now on a legal footing. It also signals the closure of all nine Clinical Commissioning Groups (CCG) in Cheshire and Merseyside.

Further information can be found here - https://www.cheshireandmerseysidepartnership.co.uk/nhs-cheshire-and-merseyside-becomes-statutory-organisation/

NHS Cheshire and Merseyside Integrated Care Board meeting

NHS Cheshire and Merseyside Integrated Care Board meeting:

Date of meeting: Friday, July 1st 2022

Time: 10:30am-12:30pm

Venue: Boardroom, Lewis's Building, 2 Renshaw Street, Liverpool, L1 2SA

https://www.cheshireandmerseysidepartnership.co.uk/wp-content/uploads/2022/06/220701-ICB-Papers.pdf

Video: Cheshire & Merseyside ICS on developing an outcome-focused ICS strategy

You can watch the full webinar here: https://vimeo.com/710812553?embedded=true&source=video_title&owner=101128743

Section B - *Local*

Change of NHS England North West Regional Director

Amanda Doyle has been appointed to the role of National Director for Primary Care and Community Services for NHS England and NHS Improvement, responsible for the Primary Care, Community Services and Discharge and Personalised Care groups.

Amanda will be taking up the role inn June 2022 and Richard Barker, Regional Director for North East and Yorkshire, will take lead responsibility for the North West region. Both the North East and Yorkshire and the North West will continue to operate as separate regions under his overall leadership.

New Regional Appointments

Two appointments have been made to our regional leadership team in the roles of Regional Chief Nurse and Regional Medical Director.

Following formal recruitment processes, Dr Michael Gregory has been appointed to the position of Medical Director, and Jackie Hanson to the Chief Nurse post as a part-time job share with Hayley Citrine.

Liverpool Health Partners

The Partner organisations that make up Liverpool Health Partners have conducted a review into LHP's operating model after concerns were raised that the subscription costs were high and perhaps not value for money. A workshop was held on the 9th June 2022 with the Partners and facilitated by Neelam Patel (CEO of MedCity) and a preferred way forwards was suggested and then confirmed at an extraordinary LHP Board meeting on the 1st July. This preferred way forwards will now be communicated with LHP staff members and an implementation plan will be drawn up to transition from the current form to the new organisational form. More details will follow in due course.

Section B - *Local*

91% of Liverpool's research rated as world leading or internationally excellent

The University of Liverpool has reinforced its place as a world leading research institution in the results of the independent **Research Excellence Framework (REF 2021)**.

91% of the University's research is classed as world leading or internationally excellent as part of the national exercise to assess the quality and impact of research at every UK university.

The University's sector position for research quality and quantity has improved across the board since the last assessment in 2014, with particular progress in research impact. Nine Liverpool research units achieved a top ten ranking for their outstanding impact and 94% of the University's research impact is now considered 'outstanding' or 'very considerable', recognising the wide-reaching benefits of Liverpool experts' work in areas of health, culture, policy, business, sustainability and more.

Make your Views Heard - Liverpool City Council Consultation

Residents and stakeholders in Liverpool are being asked for their views on how the city is governed from 2023. A letter has been sent to households in the city, with all residents – aged over 18 – being urged to answer the question: "How would you like Liverpool City Council to be run?"

More info here https://liverpoolourwayforward.com/

The closing date is Monday 20 June.

Section C – *National*

NHS Providers Chief Executive

The chief executive of NHS Providers, Chris Hopson, is leaving after nearly a decade in the role to become chief strategy officer at NHS England and NHS Improvement.

Saffron Cordery who, as deputy chief executive, has worked in close partnership with Chris to lead NHS Providers, will take over as interim chief executive while the board determines the process for a permanent appointment.

Chris will leave NHS Providers on Friday 10 June 2022, at which point Saffron will become interim chief executive.

Publication of NHS Resolution's Strategy 2022-25

NHS Resolution has published a new corporate strategy 'Advise, Resolve and Learn: Our strategy to 2025' and 2022-23 business plan.

There are four priority areas in their new strategy:
1. Deliver fair resolution
2. Share data and insights as a catalyst for improvement
3. Collaborate to improve maternity outcomes
4. Invest in our people and systems to transform our business.

These priorities build on their work since 2017 to deliver fair resolution without the need for formal processes. Their primary aim is to ensure all that we do supports the delivery of safe healthcare to patients.

Over the next three years they will be focusing on increasing the use of their data and insights to reduce the risk of harm to patients. They will concentrate on working where they can have the greatest impact and so **maternity** is now a standalone strategic priority. To deliver this, they will build up their corporate capacity and capabilities internally.

Their corporate strategy will contribute to:

- A reduction in harm to patients;
- A reduction in distress caused to both patients and healthcare staff involved when a claim or concern arises;
- A reduction in the cost required to deliver fair resolution, thereby releasing public funds for other priorities, including healthcare;
- Ensuring indemnity arrangements are a driver for positive change across the healthcare system.

They have created a short animation which gives a brief overview of the key points in the strategy – this can be found on Our Strategy webpage. The 2022-23 business plan explains in detail how they will deliver their priorities and how the impact of their activities will be measured.

Section C – *National*

Donna Ockenden to chair Nottingham maternity review

Donna Ockenden will lead the independent review of maternity services at Nottingham University Hospitals NHS Trust. This was announced yesterday in a letter to the families affected.

Corporate Governance Consultations

Consultations on draft guidance to support trusts to work effectively in systems and adopt the latest governance best practice have been published.

Trust and system leaders, including chairs, company secretaries, and NHS foundation trust governors, are asked to give their views by **Friday 8 July** to shape the final versions.

Summary of statutory board meetings: CQC and HEE, May 2022

May's summary includes updates on Care Quality Commission's operations and the Health and Care Act 2022. Health Education England's update included updates on workforce training following the Ockenden report and final budget allocations.

https://nhsproviders.org/media/693697/summary-of-statutory-board-meetings-cqc-and-hee-may-2022.pdf

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	***22/23/76a***		Date: 07/07/2022	
Report Title	**Ockenden Final Report Self-Assessment**			
Prepared by	*Alison Murray, Interim Head of Midwifery*			
Presented by	**Marie Forshaw, Chief Nurse & Midwife**			
Key Issues / Messages	To note the self- Assessment outcomes			
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 assurances provided in the report.			
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* Choose an item.	Comment:
Link to the Corporate Risk Register (CRR) – CR Number:	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Quality Committee	**June 22**	**CN&M**	**The Committee noted the self-assessment which was submitted to the LMNS ahead of 30th June 2022 and approved the proposed governance process of overseeing the 15 essential actions.**

EXECUTIVE SUMMARY

This report outlines the Intermediate and Essential Actions (IEAs) following the completion of the Ockenden gap analysis tool that has been provided to LWH by the regional maternity team via the Local Maternity and Neonatal System (LMNS). The Regional Team have not asked that this is returned to them as they await the outcome of the East Kent Maternity Service review. The LMNS requested that this gap analysis be returned to them by 30 June 2022 – this was completed post review undertaken by the Quality Committee.

This report describes how the actions within the final Ockenden Report will be monitored and overseen with assurance reports into Safety & Effectiveness Sub-Committee and to Quality Committee and onward to Trust Board.

The self-assessment gap analysis indicates that currently the LWH within the 15 Essential Actions can demonstrates compliance with 53 of the 92 sub-sections, 25 which are amber, 3 which are red. The 11 sub-sections not self-assessed are for national action.

The June 2022 Quality Committee was asked to note the gap analysis and to approve the proposed plan to oversee and monitor progress against the 15 essential actions. The Committee accepted both recommendations whilst highlighting the importance of ensuring that various regulatory requirements around maternity services were triangulated and streamlined to avoid unnecessary duplication.

MAIN REPORT

The interim Ockenden Report was published on the 10th December 2020 following a clinical review of 250 cases. The report raised significant concerns at The Shrewsbury and Telford Hospital NHS Foundation Trust. (https://www.gov.uk/government/publications/ockenden-review-of-maternity-services-at-shrewsbury-and-telford-hospital-nhs-trust). The final report following Donna Ockenden's independent review was published on the 30th March 2022 (OCKENDEN REPORT - FINAL (ockendenmaternityreview.org.uk).

The independent review was originally commissioned in 2017 with the aim of reviewing The Shrewsbury and Telford Hospital NHS Trusts internal processes relating to 1592 clinical incidents involving mothers and babies. The review reviewed the maternity care received by a total of 1486 families, some with multiple incidents which ranged from 2009 – 2019. The priority of the review was to ensure that the families impacted by maternity services are heard and allow their understanding of the events and importantly, that lessons are learned to avoid the same mistakes for other families.

A key element of the final Ockenden report is the inclusion of 15 Immediate and Essential Actions (IEAs) to improve safer maternity care within the United Kingdom (U.K.). The IEAs build on the actions following the first report and their implementation are supported by NHSE&I. A paper detailing progress against those was presented to board in March 2022.

This paper aims to set out a framework and approach to the findings from the Ockenden Final Report which highlights LWH position following the Ockenden gap-analysis tool which was returned to the LMS ahead of the **30th June 2022**. The self-assessment gap analysis indicates that currently the LWH within the 15 Essential Actions can demonstrates compliance with 53 of the 92 sub-sections, 25 which are amber, 3 which are red. The 11 sub-sections not self-assessed are for national action.

A letter from NHSE&I to all NHS Trusts dated 1st April 2022 stipulates the requirement for local Boards duty to prevent further failings as found at The Shrewsbury and Telford Hospital NHS Trusts.

In order to manage the actions in the final Ockenden report the Maternity Transformation Board (MTB) meetings will become monthly occurring in the first week of each month from July 2022. The terms of reference are being revised and in recognition of the importance and value of the four pillars identified in the Ockenden report the agenda will be structured to reflect these which are as follows.

1. Safe staffing levels
2. A well-trained workforce
3. Learning from incidents
4. Listening to families

The Chairs report from the Maternity Transformation Board will go to Safety & Effectiveness and Quality Committee and will be shared with the three divisions at LWH. The Maternity Transformation Board will be chaired by the Director of Midwifery. It is important to note the Final Ockenden Report and 15 Essential Actions related not to the Family Health Division but are Trust Wide. The membership of the Transformation Board will need to reflect this.

As an organisation, LWH recognises the requirement to celebrate and share best practices and oversight of progression. Therefore, it is planned that LWH will host bi-annual Quality Maternity summit demonstrating progress against the essential actions. The attendance of such summits will importantly include staff and services users including the MVP, Transformation Board members, LMS members, Integrated Care Board (ICB) members, Regional Chief Midwife, Non-Executive Directors and Executive Directors

Appendix 1: Gap Analysis

Provided to Board members via the Supporting Documents folder in Admin Control.

Recommendation

The Board is asked to note the assurances provided in the report.

NHS
Liverpool Women's
NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	22/23/76b	**Date: 07/07/2022**
Report Title	Maternity Incentive Scheme (CNST) Year 4 – Scheme Update	
Prepared by	***Angela Winstanley – Maternity Quality & Safety Matron*** ***Gary Price - COO***	
Presented by	***Gary Price – COO***	
Key Issues / Messages	This report 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 Trust's current status against this. Specific information is required to be highlighted for the June 2022 Quality Committee meeting and the July 2022 Board meeting. This relates to the following: • Safety Action 6 - Paper for SBLCBv2 (Appendix A) • Safety Action 4 – RCOG Action Plan (Appendix B) • Safety Action 9 - Perinatal Surveillance Dashboard Update (Appendix C)	

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*

For Decisions - in line with Risk Appetite Statement – Y

The Quality Committee and Trust Board is asked to:

- ***Receive the current position in relation to CNST Year 4***
  - ***Note the Paper for SBLCBv2 in the Appendix***
  - ***Receive the Paper for Perinatal Quality Surveillance Dashboard (May Data)***
  - ***Receive the Paper For the Obstetric Workforce Action Plan.***

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

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

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Quality Committee	Monthly	DoN&M	Monthly updates to be provides to the Committee and where required, issues will be escalated to the Board for formal noting and assurance.
Divisional CNST Oversight Committee	Twice Monthly	COO	Twice monthly progress updates from scheme safety action leads.
Family Health Divisional Board	Monthly	Clinical Director for Family Health	Monthly updates to be provided to the FHDB and where required, issues for non compliance to be escalated and resolved.

EXECUTIVE SUMMARY

This report 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 Trust's current status against this. Specific information is required to be highlighted for the July 2022 Trust Board meeting and these include:

- Paper for SBLCBv2 (Appendix A)
- Receive the Paper concerning the Obstetric Workforce Review and associated action plan (Appendix B).
- Receive the Paper for Perinatal Quality Surveillance Dashboard (May Data) (Appendix C)

This paper has been received and noted at the June 2022 Quality Committee, with discussions relating to enhancement of information contained within the report and further detailed analysis of any risks identified that may pose a risk to achieving full compliance. Particularly these discussions, centred around the expected trajectory of multi-disciplinary training (MPMET – Multi-Professional Mandatory Emergency Training) compliance requirements within Safety action 8. Further detailed information pertaining to MPMET training compliance data and anticipated trajectory can be found in the Perinatal Quality Surveillance Dashboard paper.

Areas within this month's paper, highlighted in GREEN, are new scheme requirements, published in the May CNST 2022 update.

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

December 2021.

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 was an imposed submission deferral issued on the 23rd December 2021. 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.

May 2022.

In May 2022, NHS Resolution introduced a re-launch of the scheme, after the scheme pause, with the publication of full up to date guidance, with a new submission date of the Board Declaration form by **Thursday 5th January 2023.**

Conditions of the scheme.

The Quality Committee and ultimately, the Trust Board must also be aware of the conditions of the scheme, some have been added and are detailed in the May 2022 update. These are as follows:

- Trusts must achieve all ten maternity safety actions
- The declaration form must be submitted to Trust Board with an accompanying joint presentation detailing maternity safety actions by the Head of Midwifery and Clinical Director for Maternity Services (May 2022)

- The Board declaration form must be signed and dated by the Trust's **Chief Executive Officer** (CEO) to confirm that:

  - The Trust Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required safety actions' sub-requirements as set out in the safety actions and technical guidance document.

  - There are no reports covering either this year (2021/22) or 2022/23 that relate to the provision of maternity services that may subsequently provide conflicting information to our declaration (e.g. Care Quality Commission (CQC) inspection report, Healthcare Safety Investigation Branch (HSIB) investigation reports etc.). All such reports should be brought to the MIS team's attention before 5th January 2023.

The Board must give their permission to the CEO to sign the Board declaration form prior to submission to NHS Resolution. Trust Board declaration form must be signed by the Trust's CEO. If the form is signed by another Trust member this will not be considered.

- In addition, The CEO of the Trust will ensure that the Accountable Officer (AO) for their Clinical Commissioning Group/Integrated Care System (CCG/ICB) is apprised of the MIS safety actions' evidence and declaration form. The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the evidence to be submitted to NHS Resolution

  Note: CCG functions will be subsumed into integrated care systems, with CCGs ceasing to exist as statutory organisations by July 2022.

- Trust submissions will be subject to a range of external validation points, these include cross checking with: ---
  - MBRRACE-UK data (safety action 1 standard a, b and c),
  - NHS England & Improvement regarding submission to the Maternity Services Data Set (safety action 2, standard 2 to 7 inclusive),
  - National Neonatal Research Database (NNRD)
  - HSIB for the number of qualifying incidents reportable (safety action 10, standard a).
  - Trust submissions will also be sense checked with the CQC, and for any CQC visits undertaken within the time period, the CQC will cross-reference to the maternity incentive scheme via the key lines of enquiry.

- The Regional Chief Midwives will provide support and oversight to Trusts when receiving Trusts' update at Local Maternity System (LMS) and regional meetings, focusing on themes highlighted when Trusts have incorrectly declared MIS compliance in previous years of MIS.

- NHS Resolution will continue to investigate any concerns raised about a Trust's performance either during or after the confirmation of the maternity incentive scheme results. Trusts will be asked to consider their previous MIS submission and reconfirm if they deem themselves to be compliant. If a Trust re-confirm compliance with all of the ten safety actions then the evidence submitted to Trust Board will be requested by NHS Resolution for review. If the Trust is found to be non-compliant (self-declared non-compliant or declared non-compliant by NHS Resolution), it will be required to repay any funding received and asked to review previous years' MIS submissions.

- NHS Resolution will publish the outcomes of the maternity incentive scheme verification process, Trust by Trust, for each year of the scheme (updated on the NHS Resolution Website).

Scheme Safety Actions.

The table below outlines the ten safety actions for Year four of the scheme.

- **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?

Family Health Division Scheme Management and Leadership.

- 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 FHD 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 meeting, now twice monthly, is chaired by the Chief Nurse and Midwife will provide assurance to the FHD Board, with assurance to Quality Committee and Trust Board from the associated assurance paper.

Current Position for Year 4 against the updated May 2022 scheme update

RAG Rating Guidance	Description.
	All workstreams/safety actions on target. Evidence collated to demonstrate compliance.
	Workstreams ongoing, forecasted compliance expected with some evidence collated.
	Risk of Non-Compliance/Safety Action requiring escalation/No evidence to support compliance.

Safety Action Point	Description	Issue / Update for consideration	Status RAG
SA.1	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard? Leads: Ae Wei Tang – Obstetrics Rebecca Kettle – Neonates Sarah Howard – Midwifery	All eligible births and deaths, from 6th May 2022 must meet the following conditions: A. i) 100% all deaths have been reported to MBRRACE within the seven working day timeframe with 100% of deaths having surveillance completed within one month to date from 6th May 2022. Three cases reported to MBRRACE – 100% Compliance. ii) 95% of all deaths of babies, suitable for PMRT Review, will have had their case started within TWO MONTHS of the deaths from 6th May 2022. Three cases reported to MBRRACE – 100% Compliance. B. 50% of deaths of all babies who are born and die within the Trust, from 6th May 2022. All reports are either in: - Draft format within four months - Fully published within six months. On track for completion. C. 95% of families have been informed and offered involvement in the review of their care and that of their baby. 100% Compliance D. Quarterly reports submitted to Trust Board from 6th May 2022. 100% Compliant Q3 21/22 Learning from Deaths Report. - Submitted to QC Feb 21 - Submitted to Board May 2022 Q4 21/22 Learning from Deaths Report - Submitted to QC May 2022 - Submitted to Board July 2022	
SA.2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard? Leads: Richard Strover & Hayley McCabe	New requirement for a digital maternity to align with trust digital strategy -this is underway, and a working task and finish group has been developed with leadership from Richard Strover. The aim is that this strategy will be signed off at Trust Board in September. MSDS data for July 2022 data will be submitted in September 2022. Data quality reports from NHDS Digital relating to the	

		CNST standards are reviewed monthly and the Trust is current compliant against all requirements based on May 2022 data.	
SA.3	Can you demonstrate that you have transitional care services to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme? Leads: Anna Paweletz– Neonates Sarah Kildare – Neonates Paula Nelson – Neonates Sarah Howard – Maternity	A) Pathways of care into TC jointly agreed – Completed B) Pathways of care into TC are audited quarterly and shared with Neonatal Safety Champion, LMNS, Commissioner and ICS Quality Surveillance – Ongoing C) Data recording process (electronic/paper based) capturing all term babies admitted to NICU – Completed using BadgerNet. D) Data recording process for capturing all TC activity has been embedded – Completed - using BadgerNet E) Commissioner returns are available to be shared on request from LMNS/ODN and ICS – Returnable on request. F) Quarterly review of all babies admitted to NICU and shared with BLSC, LMNS and ICS Quality Surveillance Meeting – Ongoing - LWH hold weekly reviews with quarterly reporting G) Action Plan from TC and ATAIN audit agreed with Mat, Neo and Board Level Safety Champion – Completed and Ongoing. H) Progress with ATAIN action plan shared with Mat, Neo, Board Level Safety Champion and the LMNS and ICS Quality Surveillance Meeting – Completed January 2022. All workstreams completed or on track for completion. All Transitional Care and ATAIN audits are on track, Q4 21-22 Audits have been submitted to the Maternity Safety Champion and will be reviewed at the next Safety Champion Meeting in July 2022.	
SA.4	Can demonstrate an effective system of clinical workforce planning to the required standard? Leads: Alice Bird – Obstetrics Christopher Dewhurst – Neonates Neonatal Nursing – Jen Deeney Anaesthetic Workforce – Rakesh Parikh	Obstetric Workforce – Paper submitted to Trust Board in December 2020, outlining the current obstetric position as outlined in the RCOG Workforce document. Update paper required as per May 2022 requirements – **Trust Board to receive update paper and action plan in July 2022 with full update paper to Board in September 2022 (please see section below).** Anaesthetic Medical Workforce – Complete. Workforce review submitted to Quality Committee April 2022. Neonatal Nursing Workforce – Complete – Workforce review submitted to Trust Board April 2022. Board Mins to reflect requirements within scheme guidance. Neonatal Medical Workforce – Complete – Workforce review submitted to Trust Board April 2022. Board Mins to reflect requirements within scheme guidance.	

SA.5	Can demonstrate an effective system of midwifery workforce planning to the required standard? Leads: Alison Murray – Interim Head of Midwifery	Full Birth-rate Plus and Maternity Staffing paper received at Trust Board in February 2022. Trust Board paper covered all aspects of the evidential requirements. A further detailed midwifery staffing analysis should be expected to **Quality Committee in August and Trust Board in September 2022**, with detailed Trust Board Minutes being made available to the MIS scheme leads, that confirm the following: - Trust Boards must provide evidence of funded establishment being compliant with the outcomes of BirthRate+… and/if (MIS, 2022) - Trust Boards are not compliant with a funded establishment based on BirthRate+, Trust Board minutes must show the agreed plan, including timescales for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls. An added requirement in the May 2022 guidance, is the plan to address the findings of the full audit or tabletop exercise of BirthRate+, where deficits in staffing levels have been identified, must be shared with local commissioners (MIS, 2022)	
SA.6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives Care Bundle Version 2? Leads: Alice Bird – Obstetrics Angela Winstanley – Midwifery	Trust Board level consideration of how the organisation is complying with the SBLCBV2 and evidence that the quarterly care bundle surveys have been submitted to Trust Board. - SBLCBV2 Quarterly Care Bundle survey (Appendix 1) submitted to Trust Board in June 2022. An identified risk of the lack of compliance to the CO screening in pregnancy programme at 36 weeks has been rectified. In the May 2022 scheme update, Trusts will be required to evidence an average of 80% compliance across any four consecutive month period in the MIS scheme timeframe (August 2021 – December 2022). This is achievable and data compliance is being monitored closely the Head of Information, COO, Chief Nurse and Midwife and CNST Assurance meeting. - February 87.55% - March 82.85% - April 81.75% - May 80.5% A previously identified risk with this safety action was the implementation of a formal risk assessment of fetal growth restriction at the 20-week anomaly USS. The MIS requires compliance of 80% of completed risk assessment. The Clinical Lead for Maternity escalated the difficulties within this action and requested clarification from the National Safety Champion, Matthew Jolly. The DoF and Clinical Lead for Maternity have now received clarification of the Clarification notes that the risk assessment is the completion of a uterine artery doppler (UAD) US in those women deemed high risk at booking. The Digital MW and the Quality & Safety Matrons with the Clinical Lead for Maternity are currently undertaking this audit.	

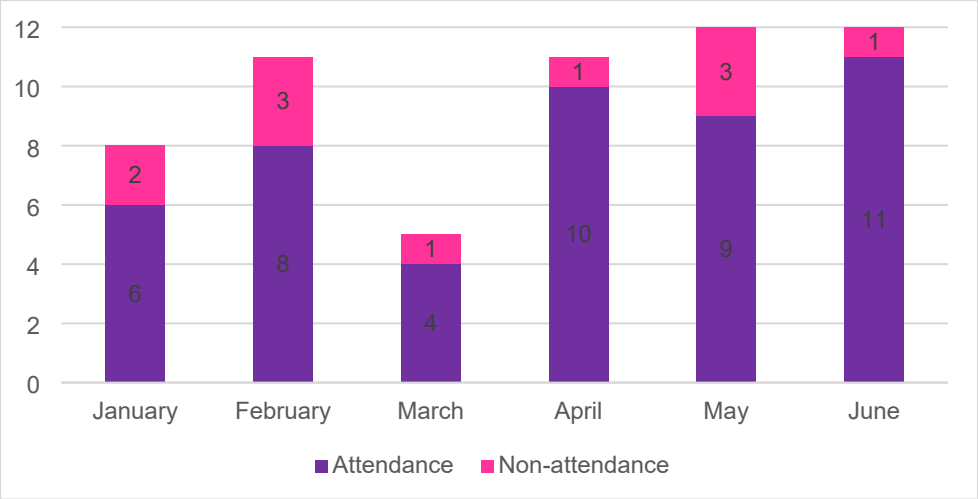
SA.7	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services? Leads: Gill Diskin – Midwifery Alison Murray – Midwifery Vacant – MVP Chair.	A risk to this safety action at present is the lack of a substantiative MVP Chair being in post. Current vacant post is out to advert and interviews are planned for 12th July 2022 should suitable candidates be shortlisted. Safety Action Leads continue to work with the Interim MVP Chair, after resignation of MVP Chair, to collate required evidence to demonstrate compliance with safety standards. The Chief Nurse and Midwife has contacted the LMS Lead to request assurance in relation to the MVP work plan and strategy. Assurance has been provided to the Chief Nurse and Midwife that the continue collaborative work between LWH and the MVP will support this strategy. The Interim MVP Chair, attended the Maternity Risk & Governance meeting on 27.05.2022 and will continue to be invited to all future meetings.	
SA.8	Can you evidence that at least 90% of each maternity unit staff group attendance an 'in-house' multi-professional maternity emergencies training session within the last year. Leads: Alison Murray – Midwifery Jonathon Hurst – Neonatal	There is a formal maternity training plan which incorporates all the requirements of the Core Competency Framework in accordance with this safety action. This has been tabled and approved by the FHDB and acknowledgment given to recognise the staffing shortages during COVID have disrupted progress. We are endeavouring to meet full compliance prior to the new submission date of 6th January 2023 with the acknowledgment that staffing, and sickness absence are risk to the 90% compliance target. Full further detail and analysis of current compliance data can be found in the Perinatal Quality Surveillance Dashboard Paper. The LWH Maternity Training Needs Analysis (TNA) has been shared with the Cheshire & Merseyside LMNS and it has been confirmed that we are compliant with training requirements and have a validated training programme. Owing to the quality of the maternity TNA provided by LWH the LMNS have asked for this to be used as a template for the maternity providers within the Cheshire & Merseyside region.	
SA.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? Leads: Rachel McFarland – Obs Safety Champion Angela Winstanley – Midwifery Safety Champion Fauzia Paize – Neonatal Safety Champion.	There are robust processes in place feeding perinatal safety information into the Trust Board and Quality Committee monthly via the Perinatal Clinical Quality Dashboard. The scheme relaunch in May 2022 provides updated timescales within this safety action. Maternity Continuity of Carer and its implementation plan, specifically prioritising those service users most likely to experience poor outcomes, 75% BAME, and 10% of deprived neighbourhoods. Board Level oversight and discussion of the CoC plan must be evidenced. The Board received a full paper in June 2022, this followed on from the Non-Executive Board Level Safety Champion meeting on 31st May 2022 with the DONM, Dep HOM and COC Leads where the CoC plan was discussed in-depth the specific details. All Board Level and Frontline Safety Champion exercises continued throughout the scheme pause.	

SA.10	Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification (EN) scheme? Leads: Incoming Maternity and Neonatal Governance Managers. Interim Lead: Angela Winstanley	All cases required have been reported to HSIB. All families have had information on HSIB and Early Notification/NHSR Scheme All Duty of Candour duties undertaken. Information pertaining to HSIB reporting is included in the Perinatal Quality Surveillance Paper as well as the Trust Board Performance Report. A full breakdown of all activity pertaining to HSIB, Duty of Candour will be presented to QC and Trust Board in December 2022.	

Obstetric Workforce Review and associated action plan

Safety Action 4 of the NHS Resolution Maternity Incentive Scheme (Year 4) requires compliance of consultant attendance for the clinical situations listed in the RCOG 'Roles and Responsibilities of the Consultant' document to be monitored, and shared with the Trust Board, the Board-level safety champions and the LMS at least every 6 months. An action plan must be implemented to prevent further non-attendance to the clinical situations listed in the document.

There was consultant attendance in 81% (48/59) of identified cases between 1st January 2022 and 30th June 2022:



Data includes caesarean birth for major placenta praevia/women with a BMI >50/<28/40; twins <30/40; 4th degree perineal tear repair; unexpected intrapartum stillbirth; eclampsia; PPH >2L. Does not currently capture high levels of activity; return to theatre; team debrief requested; if requested to do so; early warning score where HDU/ITU care is likely to become necessary; maternal collapse – septic shock/placental abruption.

Analysis of the 11 cases where there was no documented evidence of consultant attendance did not identify any key areas of concern:

- 5 cases occurred when the consultant was resident – they would have been available if required and this may have been appropriate due to level of trainee and move towards independent practice
- 2 cases where consultant not informed – due to rapid delivery
- 2 cases where consultant was concurrently managing another emergency
- 2 cases where women had a booking BMI of <50 but when they were reweighed (for accurate VTE prophylaxis) in the 3rd trimester, their BMI was >50; the Division are currently reviewing the guideline for this situation so that management is clear

There were no complications that occurred because of consultant non-attendance.

There are some data quality improvements to be made but there will be some cases from the mandated attendance list that we will not be able to identify electronically. It has been requested that an incident form is completed if the consultant does not attend in these circumstances, and none have been submitted to date.

Please see the action plan in Appendix B.

Conclusion

The Trust Board is asked to note the current position in relation to CNST Year 4 and our current positive position, along with the associated papers found within the appendix.

It is asked that the Trust Board takes note of the associated risks to the scheme compliance as detailed within the narrative of this paper specifically the MDT training requirements outlined in the perinatal quality surveillance dashboard.

Appendix

Saving Babies Lives Care Bundle 2 Survey 6 (App A)
RCOG Workforce Action Plan (App B)
Perinatal Quality Surveillance Dashboard (App C)

Access to SBLCB v2 Survey

In order to reduce the burden that this survey has on the submitter's time, we have pre-populated this survey with your provider's responses from the last survey.

In the case that the status of your provider has not changed since completion of the last survey, the first question of each element will still need updating.

Please tick the box below to confirm that you understand the pre-population process and that the survey responses will need to be updated to reflect the current status of your organisation.

☑ I understand that the survey has been pre-populated with the responses from the last SBLCB v2 survey and needs to be updated with the current status of my organisation.

NB: Please ensure that you select 'enable content' when prompted by the security dialog box at the top. Without enabling macros, you will not be able to access the survey.

NEW: Saving Babies Lives Care bundle Version 2 - A care bundle for reducing perinatal mortality

This brief assurance survey is designed to gather information on progress towards full implementation of the Saving Babies' Lives Care Bundle Version 2, published March 2019. The results of this semi-qualitative self-assessment will enable NHS England, commissioners and providers to identify common problems and barriers to implementation and share effective solutions. Please base your responses on your assessment of how much of your current activities match the requirements of the care bundle.

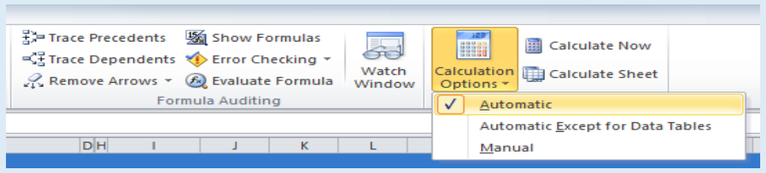
Full implementation of the care bundle and completion of the quarterly care bundle implementation survey will be included in the revised 2022/23 CNST incentive scheme, although the final details are yet to be agreed. We expect compliance with the CNST maternity incentive scheme standard to be primarily assessed using objective data submitted as part of a provider's MSDS submission, however this survey will also provide supporting information in relation to some aspects of implementation.

The technical specification available in the appendix provides guidance to help providers submit the data that will be used to assess compliance with the CNST maternity incentive scheme standard.

During the Covid-19 pandemic it has been difficult to implement some elements of SBLCB and in particular element one as carbon monoxide testing has been suspended. Compliance with element 1 will therefore require an audit based on the percentage of women asked whether they smoke at booking and at 36 weeks gestation if carbon monoxide testing has not been reinstated.

The action planning template is designed to complement the survey and is optional to complete.

Please note:
The calculation setting for this workbook should be set to 'Automatic' in order for all of the functions to work correctly. In order to check this setting, please click:
-> 'Formulas' in the top ribbon
-> 'Calculation Options' to the right
-> 'Automatic' from the dropdown menu.



Saving babies Lives Version 2 - A care bundle for reducing perinatal mortality

Survey Collection Schedule

Survey 1 Collection Round: October 2019
Circulate: 4th October 2019
Collect: 5th November 2019

Survey 2 Collection Round: December 2019
Circulate: 19th December 2019
Collect: 28th January 2020

Survey 3 Collection Round: September 2020
Circulate: 22nd September 2020
Collect: 20th October 2020

Survey 4 Collection Round: January 2021
Ciculate: 20th January
Collect: 17th February

Survey 5 Collection Round: April 2021
Ciculate: 30th April
Collect: 28th May

Survey 6 Collection Round: April 2022
Circulate: week commencing 18th April

TRUE

Update Report

NHS England

Communications:

Thank you for your ongoing support to reduce the tragedy of stillbirth for families in England. This questionnaire has been designed to reflect version 2 of the Saving Babies Lives Care Bundle (SBLCB v2) published in March 2019. The main purpose of the questionnaire will be as a tool to identify areas most in need of support as maternity services work to deliver full implementation on SBLCB v2 in accordance with the associated planning guidance deliverable and condition in the standard contract. Update September 2020: The survey questions for elements 1, 2 and 5 have been amended to reflect the additional SBLCBv2 gudiance which was issued in response to the COVID-19 pandemic as described here:

https://www.england.nhs.uk/publication/saving-babies-lives-care-bundle-version-2-covid-19-information/

The optional additional 'Case Study' and 'Action Planning' sections in the questionnaire for version 1 of the care bundle were well received and have therefore been retained in the questionnaire.

Programme Developments:

The Saving Babies' Lives Project Impact and Results Evaluation (SPiRE) was commissioned by NHS England and delivered by the Tommy's Centre for Stillbirth Research within the Faculty of Biology, Medicine and Health Sciences at the University of Manchester. The evaluation report, published in July 2018, confirmed the challenges and successes of implementation, the impact on maternity services and perinatal outcomes and the key factors that might affect implementation. The full report is available to download from The University of Manchester University website via the following link:

https://www.manchester.ac.uk/discover/news/download/573936/evaluationoftheimplementationofthesavingbabieslivescarebundleinearlyadopternhstrustsinenglandjuly2018-2.pdf

Version two of the Saving Babies' Lives Care Bundle (SBLCBv2), was developed to build on the achievements of version one and to address the learnings identified in the SPiRE evaluation. It aims to provide detailed information for providers and commissioners of maternity care on how to reduce perinatal mortality across England. The second version of the care bundle brings together five elements of care that are widely recognised as evidence-based and/or best practice:

1. Reducing smoking in pregnancy

This element provides a practical approach to reducing smoking in pregnancy by following NICE guidance. Reducing smoking in pregnancy will be achieved by offering carbon monoxide (CO) testing for all women at the antenatal booking appointment and as appropriate throughout pregnancy, to identify smokers (or those exposed to tobacco smoke) and offer them a referral for support from a trained stop smoking advisor.

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

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

3. Raising awareness of reduced fetal movement (RFM)

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

4. Effective fetal monitoring during labour

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

5. Reducing preterm birth

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

From the care bundle team.

Key Dates:

Survey 5 Collection Round: April 2021
Circulate: 30th April
Collect: 28th May

Survey 6 Collection Round: April 2022
Circulate: week commencing 18th April
Collect: week commencing 16th May

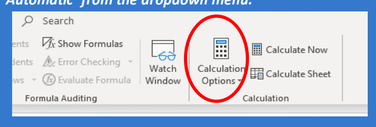
The purpose of this survey is to gather information on how much of current standard practice aligns with the interventions that make up the Saving Babies' Lives Care Bundle v2. Each intervention is made up of improvement activities. Improvement activities are the actions that make up the elements of the care bundle.

Collecting this survey allows monitoring of progress towards full implementation of the Care Bundle elements as standard practice and more importantly the identification of areas most in need of additional support with implementation. Please base your responses on your assessment of how much of your current activities match the requirements of the care bundle.

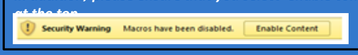
PLEASE CLICK THE ARROW TO USE THE DROP DOWN MENU TO SELECT YOUR ANSWERS.

IF THE CELL IS HIGHLIGHTED IN RED IT MEANS THE CELL IS LOCKED. PLEASE CHANGE YOUR ANSWERS TO THE QUESTIONS ASKING IF ANYTHING HAS CHANGED SINCE LAST SURVEY OR IF YOU HAVE MET ALL REQUIREMENTS OF THE ELEMENT AND THE CELLS SHOULD UNLOCK.

Please note:
The calculation setting for this workbook should be set to 'Automatic' in order for all of the functions to work correctly. In order to check this setting, please click:
-> 'Formulas' in the top ribbon
-> 'Calculation Options' to the right
-> 'Automatic' from the dropdown menu.



In addition, please ensure that you select 'enable content' when prompted by the security dialog box at the top



Survey Number	6th
Survey Date	Apr-22
Reducing Stillbirths Care Bundle Elements	
Element 1: Reducing smoking in pregnancy by carrying out a Carbon Monoxide (CO) test at booking to identify smokers (or those exposed to tobacco smoke) and referring to stop smoking service/specialist as appropriate	
Have any of your responses to the below questions 1aii. to 1f. changed since the last survey? *If "yes", answer question 1ai and make your changes below. If "no" answer question 1ai and then go to Element 2.*	No
1ai. Are you meeting all requirements of the modified version Element 1 of the care bundle, which was changed due to the COVID-19 pandemic? *Irrespective of your answer please ensure section 1 is completed on the basis of your Standard Operating Procedure once recovery from COVID has been instigated.*	Yes
1aii Once CO testing is re-introduced, will your trust meet all the requirements of Element 1 of the care bundle? *If changed to "yes", the questions below will be automatically populated on dropdown selection. If "no", please complete all questions below.*	**Yes**
1b. Are you carrying out any improvement activity designed to reduce smoking in pregnancy? *If "yes", please go to question 1c, If "no", please go to question 1f.*	**Yes**
1c. Does your standard operating procedure (e.g. guidelines) include the following:	
i. CO monitoring at booking and additional CO testing throughout pregnancy including the 36 week antenatal appointment, with the outcome recorded?	**Yes**
ii. Referring expectant mothers, with elevated CO levels (4ppm or above), to a trained stop smoking specialist, based on an opt out system with a pathway that includes feedback and follow up processes?	**Yes**
1d. Do the improvement activities include training all maternity staff on the use of the CO monitor and having a brief and meaningful conversation with women about smoking?	**Yes**
1e. Have all recorded outcomes of CO testing in pregnancy relating to element 1 activities been recorded on your MIS enabling their submission in MSDS v2.0 monthly submissions?	Yes
1f. If you answered "no" to question 1b, are you planning on introducing this type of intervention / improvement activity?	**Not Applicable**
Please use the free text box below to detail any barriers your maternity service is experiencing in implementing element 1 of SBLCBv2 or submitting the required data to MSDSv2; and to provide details of any learning developed as a result of the implementation.	
Element 2: Identification and surveillance of pregnancies with fetal growth restriction	
Have any of your responses to questions 2aii to 2j below changed since the last survey? *If "yes", answer question 2ai and make your changes below. If "no" answer question 2ai and then go to Element 3.*	No
2ai. Are you meeting all requirements of the modified version Element 2 of the care bundle, which was changed due to the COVID-19 pandemic? NB The modified version of element 2 should only be implemented in the case of significant COVID-19 related staff shortages. *Irrespective of your answer please ensure section 2 is completed on the basis of your Standard Operating Procedure i.e. once recovery from COVID has been instigated.*	Yes
2aii. In the case of you having no significant COVID related staff shortages, do you meet all requirements of Element 2 of the care bundle? *If changed to "yes", the questions below will be automatically populated on dropdown selection. If "no", please complete all questions below.*	**Yes**
2b. Are you carrying out any improvement activity designed to risk assess and manage babies at risk of Fetal Growth Restriction (FGR)? *If "yes", go to question 2c. If "no", please go to question 2j.*	**Yes**
2c. Does your standard operating procedure (e.g. guidelines) include the following:	
i. Assessing women at booking to determine if a prescription of aspirin is appropriate using the algorithm given in Appendix C of the care bundle or an alternative which has been agreed with local commissioners (CCGs) following advice from the provider's Clinical Network?	**Yes**
ii. Risk assessment and surveillance of women at increased risk of FGR, with triage of women at increased risk of FGR into an appropriate clinical pathway?	**Yes**
iii. Risk assessment and management of growth disorders in multiple pregnancy in compliance with NICE guidance or a variant agreed locally following advice from the provider's Clinical Network?	**Yes**
2d. Regarding women not undergoing serial ultrasound scan surveillance of fetal growth does your standard operating procedure (e.g. guidelines) include assessment performed using antenatal symphysis fundal height (SFH) charts by clinicians trained in their use?	**Yes**
2e. Does your standard operating procedure (guidelines) include differentiation between the management of the SGA and growth restricted fetus in accordance with the pathways and guidance outlined in version 2 of the Saving Babies Lives Care Bundle?	**Yes**
2f. Does your standard operating procedure (e.g. guidelines) include the following:	
i. Following recommended guidance on the frequency of ultrasound review of estimated fetal weight (EFW) when SGA is detected, in accordance with appendix D of SBLCBv2 or a variant agreed locally following advice from the provider's Clinical Network?,	**Yes**
ii. Maternity care providers caring for women with FGR identified prior to 34+0 weeks having an agreed pathway for management which includes network fetal medicine input (for example, through referral or case discussion by phone)?	**Yes**
2g. Accepting the proviso that all management decisions should be agreed with the mother in the cases of fetuses <3rd centile and with no other concerning features does your standard operating procedure (e.g. guidelines) include the following principles: •⍰ Initiation of labour and/or delivery should occur at 37+0 weeks and no later than 37+6 weeks gestation. •⍰ Delivery <37+0 weeks can be considered if there are additional concerning features, but these risks must be balanced against the increased risk to the baby of birth at earlier gestations.	**Yes**
2h. Does your standard operating procedure (e.g. guidelines) include individualised care of fetuses between 3rd – 10th centile using a risk assessment including Doppler investigations, assessment for the presence of any other high risk features such as recurrent reduced fetal movements, and the mother's wishes ; and in the absence of any high risk features the offer of delivery or the initiation of induction of labour at 39+0 weeks?	**Yes**
2i. Have all findings of small for gestational age fetuses been recorded on your MIS enabling their submission in MSDS v2.0 monthly submissions?	Yes
2j. If you answered "no" to 2b, are you planning on introducing this type of intervention / improvement activity?	**Not Applicable**
Please use the free text box below to detail any barriers your maternity service is experiencing in implementing element 2 of SBLCBv2 or submitting the required data to MSDSv2; and to provide details of any learning developed as a result of the implementation.	
Element 3: Raising awareness amongst pregnant women of the importance of detecting and reporting reduced fetal movement (RFM), and ensuring providers have protocols in place, based on best available evidence, to manage care for women who report RFM	
Have any of your responses to the below questions in Element 3 changed since the last survey? *If "yes", make your changes below. If "no", go to Element 4.*	No
3a. Are you meeting all requirements of Element 3 of the care bundle? *If changed to "yes", the questions below will be automatically populated on dropdown selection. If "no", please complete all questions below.*	**Yes**
3b. Are you carrying out any improvement activity designed to raise awareness among pregnant women of the importance of Reduced Fetal Movement (RFM)? *If "yes", please go to question 3c. If "no", please go to question 3h.*	**Yes**
3c. Do the improvement activities include providing pregnant mothers with information and an advice leaflet on reduced fetal movement based on current evidence, best practice and clinical guidelines,?	**Yes**
3d. Do the improvement activities include giving pregnant mothers this information by 28 weeks of pregnancy at the latest?	**Yes**
3e. Do the improvement activities include discussing RFM with pregnant mothers at every subsequent contact?	**Yes**
3f. Do the improvement activities include making use of an approved checklist to manage the care of pregnant woman who report reduced fetal movement, in line with national evidence-based guidance?	**Yes**
3g. Have all findings of reduced fetal movement been recorded on your MIS enabling their submission as Coded Clinical Entry in MSDS v2.0 monthly submissions?	Yes
3h. If you answered "no" to 3b, are you planning on introducing this type of intervention / improvement activity?	**Not Applicable**
Please use the free text box below to detail any barriers your maternity service is experiencing in implementing element 3 of SBLCBv2; and to provide details of any learning developed as a result of the implementation.	

Element 4: Effective fetal monitoring during labour	
Have any of your responses to the below questions in Element 4 changed since the last survey? **If "yes", make your changes below. If "no", go to Element 5.**	No
4a. Are you meeting all requirements of Element 4 of the care bundle? ***If changed to "yes", the questions below will be automatically populated on dropdown selection. If "no", please complete all questions below. Please take extra care to ensure your percentage of trained staff in question 4d is up to date.***	**Yes**
4b. Are you carrying out any improvement activities designed around effective fetal monitoring during labour? ***If "yes", go to question 4c. If "no", please go to question 4h.***	**Yes**
4c. Do your improvement activities include annual multidisciplinary training and competency assessment on cardiotocograph (CTG) interpretation and use of auscultation for staff who care for women in labour? ***If "yes", go to question 4d. If "no", please go to question 4e.***	**Yes**
4d. What is the percentage of staff who care for women in labour that have undertaken this training in the last 12 months?	Yes 80% to 89%
4e. Do you have a system that, irrespective of place of birth, assesses risk at the onset of labour to determine the most appropriate fetal monitoring method, as described in SBLCBv2?	**Yes**
4f. Do your improvement activities include a review at least every hour of fetal well-being incorporating the following:	
i. CTG or Intermittent Auscultation;	**Yes**
ii. reassessment of fetal risk factors	**Yes**
iii. a fresh eyes/buddy system	**Yes**
iv. clear guideline for escalation if concerns are raised through the use of a structured process?	**Yes**
4g. Do your improvement activities include identifying a Fetal Monitoring Lead for a minimum of 0.4WTE per consultant led unit during which time it is their responsibility to improve the standard of intrapartum risk assessment and fetal monitoring?	**Yes**
4h. If you answered "no" to 4b, are you planning on introducing this type of intervention / improvement activity?	**Not Applicable**
Please use the free text box below to detail any barriers your maternity service is experiencing in implementing element 4 of SBLCBv2; and to provide details of any learning developed as a result of the implementation.	

Element 5: Reducing preterm births	
Have any of your responses to questions 5aii to 5g changed since the last survey? ***If "yes", answer question 5ai and make your changes below. If "no" answer question 5ai and then complete the final section.***	Yes
5ai. If you are using the modified version of element 5 of the care bundle, are you meeting all of the requirements? ***Irrespective of your answer please complete the rest of section 5 on the basis of your SOP once recovery from COVID has been instigated.***	Yes
5aii. Are you meeting all requirements of Element 5 of the care bundle? ***If changed to "yes", the questions below will be automatically populated on dropdown selection. If "no", please complete all questions below.***	Yes
5b. Are you carrying out any improvement activity designed around reducing the number of preterm births and optimising care when preterm delivery cannot be prevented? ***If "yes", go to question 5c. If "no", please go to question 5g.***	**Yes**
5c. Does your standard operating procedure (e.g. guidelines) include the following:	
i. Assessing all women at booking for the risk of preterm birth and stratifying to low, intermediate and high-risk pathways as per the criteria in Appendix F of the SBLCB v2 of the care bundle document; or an alternative which has been agreed with local commissioners (CCGs) following advice from the provider's Clinical Network?	**Yes**
ii. Assessing women with a history of preterm birth to determine whether this was associated with placental disease and a discussion about prescribing aspirin with the woman based upon her personalised risk assessment?	**Yes**
iii. All women being offered testing for asymptomatic bacteriuria by sending off a midstream urine (MSU) for culture and sensitivity at booking, and a repeat MSU to confirm clearance following any positive culture?	**Yes**
iv. Having access to transvaginal cervix scanning (TVCS) and a clinician with an interest in preterm birth prevention with a clinical pathway for women at risk of preterm birth that is agreed with local commissioners (CCGs) following advice from the provider's clinical network (for example, UK Preterm Clinical Network guidance or NICE guidance)?	**Yes**
5d. Does your standard operating procedure (e.g. guidelines) include risk assessment and management in multiple pregnancy compliant with NICE guidance or a variant that has been agreed with local commissioners (CCGs) following advice from the provider's clinical network?	**Yes**
5e. Does your standard operating procedure (e.g. guidelines) include the following:	
i. every provider having referral pathways to tertiary prevention clinics for the management of women with complex obstetric and medical histories including access to clinicians who have the expertise to provide high vaginal (Shirodkar) and transabdominal cerclage?	**Yes**
ii. women at imminent risk of preterm birth being offered transfer to a unit with appropriate and available neonatal cot facilities when safe to do so and as agreed by the relevant neonatal Operational Delivery Network (ODN)?	**Yes**
iii. offering Antenatal corticosteroids to women between 24+0 and 33+6 weeks, optimally at 48 hours before a planned birth?	**Yes**
iv. offering Magnesium Sulphate to women between 24+0 and 29+6 weeks of pregnancy; and considering offering Magnesium Sulphate for women between 30+0 and 33+6 weeks of pregnancy, who are in established labour or are having a planned preterm birth within 24 hours?	**Yes**
v. ensuring the neonatal team are involved when a preterm birth is anticipated, so that they have time to discuss options with parents prior to birth and to be present at the delivery?	**Yes**
vi. holding a multidisciplinary discussion before birth between the neonatologist, obstetrician and the parents about the decision to resuscitate the baby for women between 23 and 24 weeks of gestation?	**Yes**
5f. Have all instances of maternal antenatal administration of corticosteroids for fetal lung maturation been recorded on your MIS enabling its submission as in MSDS v2.0 monthly submissions?	Yes
5g. If you answered "no" to 5b, are you planning on introducing this type of intervention / improvement activity?	**Not Apllicable**
Please use the free text box below to detail any barriers your maternity service is experiencing in implementing element 5 of SBLCBv2 or submitting the required data to MSDSv2; and to provide details of any learning developed as a result of the implementation.	

Please fill in the following details	
Name of person completing the form	angela winstanley
Job Title	quality & safety matron
Hospital Name	liverpool womens hospital
Trust Name	LIVERPOOL WOMEN'S NHS FOUNDATION
Trust Code	REP
SCN Area	North West Coast
Please provide information here if the drop-down boxes do not include the correct information for your trust	Free Text Box

Saving Babies Lives - Updates & Action Planning

The implementation survey gives a good insight into implementation trends but does not in itself increase levels of implementation of the care bundle. This action planning section is designed to complement the survey and support an increase in the levels of implementation by encouraging the development of explicit actions that outline how progress will be made and address the specific barriers faced by a particular trust.

Action Plan

R	Red: Immediate remedial action required to progress this activity
A	Amber: Action required for successful delivery of this activity
G	Green: Activity on target
B	Black: Completed activity

Recommendation Number	Recommendation	Action plan to address recommendation	Action progress against plan	Action priority 1 = Critical (Under 1 Month) 2 = Essential (1-3 Months) 3 = Recommended (over 3 months)	Action owner	Baseline date	Forecast date	Closure date	Current status
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									

Appendix: Technical Specification

The technical specification attached provides guidance to help providers submit the data that will be used to assess compliance with the CNST Incentive scheme standard.

SBLCBv2 MSDS v2.0
Technical Glossary
(for publication)

Action Plan: Roles and Responsibilities of the Consultant (RCOG)

This action plan was generated in response to a paper presented to Board in December 2021 summarising the RCOG Roles and Responsibilities of the Consultant Workforce Report.

Number	Action	Lead	Target completion	Status	Progress
1	Review of the 'Obstetricians Staffing Levels Guideline' to ensure compliance with RCOG report	Kate Alldred	April 2022		Guideline ratified in April 2022 and issued on intranet May 2022. This date was decided due to the commencement of the twilight rota and to prevent multiple revisions. The list of mandated attendance was shared with the team following the report publication, prior to April 2022 (see action 2).  Obstetricians Staffing Levels Guid
2	Communication regarding change in guideline to obstetric consultants, obstetric trainees, midwifery shift leaders and theatre teams	Kate Alldred	April 2022		Discussed at Obstetric Consultants meeting and Maternity Clinical meeting. Teams channel used to communicate key changes:

					 RCOG mandatory consultant attendance  RCOG consultant attendance dependinç  RCOG consultant attendance request fo
3	Develop process with the Information Team for monthly monitoring of consultant attendance in accordance with this guideline; an action plan will be developed to review any areas of non-attendance	Alice Bird/Richard Strover	January 2022		Power BI report produced: Consultant Attendance at Delivery Reports - Power BI The above report includes unverified data. AB has verified this as per the action 4 summary report.
4	Report to evidence position regarding consultant attendance to be shared with the Trust Board level safety champions and submitted to the Trust Board and LMS at least every 6	Alice Bird	July 2022		Due to be presented at Trust Board July 2022; will be submitted to LMS QSSG following this.

	months; next planned July 2022				
5	Development of a matrix of middle grades' competencies for the clinical scenarios outlined in the RCOG report	Linda Watkins and Kiran Jilani	September 2022		MS Forms survey currently in progress to establish the views of postgraduate doctors in training regarding the best way to communicate this and ensure it remains up to date. Matrix will be in place for August cohort.
6	Make progress with the QI project re implementation of Safety Huddles and MDT ward rounds	Alice Bird	September 2022		Following discussion with the QI team, a decision was made to implement the MDT ward rounds and safety huddles and not complete a QI project. This has been included in the guideline evidenced in action 1. This action will be revised to include an audit of the MDT ward rounds and safety huddles.
7	Explore resources available within the RCOG/RCM/Civility Saves Lives Workplace Behaviours Toolkit to promote a positive working environment for all	Alice Bird	September 2022		Awareness of the Workplace Behaviours Toolkit will be included in the August 2022 postgraduate doctors in training induction – Linda Watkins.

					This needs to be a priority for the Division over the next 6 months and additional support will probably be required. AB to discuss whether there should be a Trustwide approach to this.
8	Engage with the Digital team to explore options for tools to improve handover/huddle processes	Kate Alldred	September 2022		Maternity Overview Power BI report has been developed: Maternity Overview - Power BI BirthRate Plus app due to be implemented by October – includes acuity, staffing, red flag reporting; access to regional information. Huddle process needs formalising.
9	Use the Cappuccini Test (Modified) audit tool to review supervision arrangements/processes	Helen Bradshaw	September 2022		Audit completed by Medical Student. Date for presentation TBC.
10	Await publication of the Certificate of Eligibility for Locums, which will provide a standardised	Rachel Reeves/Rochelle Collins	September 2022		Not yet published.

	competency matrix which will allow roles to be matched against technical proficiency for short-term locums (less than 2 weeks)				
11	Implementation of twilight consultant rota in April 2022	Alice Bird	April 2022		Twilight consultant rota successfully implemented 29/4/22.

The Trustwide recommendations in relation to Human Factors Training and Mentorship have not been included as they are outside of the remit of the Family Health Division

Liverpool Women's
NHS Foundation Trust

Maternity Perinatal Quality Surveillance Model: June 2022 (May 22 Data)

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

Staff Survey Results:	Update Date	Results
Proportion of midwives responding with agree/strongly agree on whether they would recommend LWH as a place to work or receive treatment (reported annually).	Report 2020.	**41%**
Proportion of Specialty 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:

There was a total of 22 red flags closed in May within Maternity. A slight increase from previous months reporting. The red flags incidents investigated and closed closed in May were all reported in the same month, previous reports have shown a lag time of up to three months for closure.
The most reported red flag incident, this month related to difficult and delay in the provision of ongoing induction of labour process.

- 10 incidents - delay in ongoing process of induction >4 hours
- 4 Incidents - delay >2 Hours Between Admission and Induction
- 2 Incidents- Delay in postnatal suturing of perineum (known delay as pool birth) & failure to provide 1:1 care in labour.

All staff are encouraged to recognise and report midwifery red flags using the Ulysses System and the maternity managers strive to close incidents in a timely fashion.

Midwifery Red flags are monitored two hourly by the Midwifery 104 Bleep holder, with data And governance oversight maintained through the Divisional Maternity Governance and Risk Committee

Red Flag Incidents Closed.	February	March	April	May	June	July
1:1 Support Not Provided During Established Labour	1	3	0	2		
Acuity/ Capacity	1	1	0	0		
Delay >2 Hours Between Admission and Induction	3	19	0	4		
Delay in ongoing process of induction >4 hours	6	28	0	10		
Delay >30 Mins Between Presentation and Triage	0	0	1	0		
Delay in Transfer - Antenatal or Postnatal	1	5	0	0		
Delay or Cancellation of Activity	0	1	0	2		
Inability to Provide Epidural	0	1	0	0		
Medication error – drug not given	0	1	0	0		
Shortfall in Staffing	0	1	0	1		
Staffing Problem – Levels	0	10	3	1		
Wait for more than 60 mins for sutures post delivery	0	1	1	2		
Other	0	3	0	0		
Total	**12**	**75**	**5**	**22**		

Midwifery Red Flag Actions Taken:

- Insufficient Midwifery Staffing on Divisional Risk Register, extreme risk Number 1705, HOM Lead.
- Weekly and Daily Roster Oversight Management by HOM, Matrons and Managers.
- Exec Led E-Roster Challenge sessions.
- Proactive management of staff sickness and RTW

	- Use of Escalation and Divert Policy where required, including use of non-clinical registrants
	  - NHSP and Agency use – with incentiviced scheme developed and agreed by Senior Leadership Team.
	  - Medical Review, DOC/apologies and Escalation of delay to Senior Obstetrician and 104 Bleep Holder.
	  - Ongoing recruitment and retention programme.
	  - Compliance to Birth Rate Plus Report (Jan 2022)

MVP Feedback.	MVP Chair Interviews scheduled for 12th July 2022, LWH will be represented on interview panel by Richard Haines Consultant Obstetrician and Joan Holloway Inpatient Matron We have not received any feedback from the MVP this month. We have a temporary MVP Chair in the Interim, who is providing support and has attended the Maternity Risk & Governance Meeting in May 2022.
HSIB Referral Details:	The Family Health Division referred ONE any case to HSIB in the month of May. - Newborn infant requiring therapeutic hypothermia treatment (cooling) after spontaneous vaginal birth with a subsequent normal MRI. 72 Hour review has completed with presentation and review at Trust Weekly Harm Meeting – No escalation to SUI required and case will be subject to full external HSIB investigation.
Maternity Serious Safety Incidents	The Family Health Division reported TWO serious incidents to STEISS/CCG in May 2022: 1. Maternal Death within the Community at six weeks postnatal. On 30th November 2021, Liverpool Women's Trust via the Safeguarding Team were made aware from the Coroner of a Maternal Death within the Community. A post-mortem examination was undertaken by the Coroner and the results and cause of death withheld until histology and toxicology results were available. A review of the maternity and Obstetric care was undertaken. Some communication issues were identified. Subsequent delay in investigation due to HM Coroner involvement. HM Coroner subsequently provided authority for the trust to undertake an investigation in addition to an investigation being undertaken by an external Trust. 2. Baby born on 19th April 2022. Antenatally found to have right sided unilateral hydronephrosis, right sided ureteric dilatation and bladder ureterocele. In accordance with LWH neonatal guideline this baby should have been on prophylactic antibodies (Trimethoprim). The LWH guideline states: NEONATAL MEDICAL TEAM Will prescribe Trimethoprim 2mg/kg once daily for all babies with ureteric dilatation. These were not commenced and baby was sent home. Baby admitted to Alder Hey Children's Hospital on 28th April, day 11 of life for attendance for routine postnatal ultrasound as stipulated by our guideline and found to have pyelonephritis. Admitted for 14 days antibiotics and needed a long line inserted into a vein. Had to go to theatre for draining of pus from the bladder ureterocoele. Has grown pseudomonas from urine culture which would not have been sensitive to Trimethoprim. Baby is now on IV ciprofloxacin. This incident is bring investigated jointly across the Family Health Division with representation from Obstetrics and neonates identified. - Short, Medium and Long Term actions have been identified. - Completed investigations submitted to the CCG are detailed in the Associate Director of Governance Serious Incident Report.

Perinatal Mortality.	Number of Neonatal Perinatal Deaths in **May 2022: 5** Number of Stillbirth Perinatal Deaths in **May 2022: 4** All perinatal deaths in May 2022 have been reported to MBRRACE and will be subject to a full MDT review with an external panel member. Details and actions plans of every death are detailed in the Quarterly Mortality Report presented by the Deputy Medical Director at Quality Committee and Trust Board.
Ockenden	On the 29th April 2022, the Family Health Division received formal feedback from NHSe and NHSi who informed the Trust of full compliance against the seven immediate and essential actions published in the emerging findings from 1ST report. The QC received an update on the GAP analysis against IEAS as published in the second and final Ockenden report. Details of which are tabled for discussion at Trust Board in July 2022.
FHD Risk Register.	Current risk status for the Family Health Division. Extreme Risks: 11 High Risks: 24 Moderate Risks: 4 Low Risk: 1
Maternity Incentive Scheme Progress Year 4.	**Progress against the Year 4 Maternity Incentive Scheme (CNST):** 1. PMRT – Full details of the Trusts progress against the standards in this element are detailed in the quarterly learning from deaths report prepared by the Deputy Medical Director. All deaths have been reported as per the scheme guidance. 2. MSDS – No reported problems. Requirement for maternity digital strategy – linking to trustwide digital strategy. 3. ATAIN – Trust Board have received the ATAIN Action Plan, and this has been shared with the LMNS. Divisional Leads have been updated, named Cons Obstetrician and Midwife planned to take ownership of obstetric and midwifery requirements. 4. Clinical Workforce – Obs workforce paper submitted in January 2022. Neo Nursing and Medical workforce paper to be submitted to Board. 5. Midwifery Workforce – Detailed staffing paper against Birth Rate Plus Report of 2021 has been sighted at Trust Board. 6. SBLCBv2 – All workstreams currently on track for completion. The Trust Board should consider how the organisation is Complying with the SBLCBV2 and as per the MIS scheme requirements, the completed quarterly care bundle survey version 6.0 is appedixed to this paper. The Maternity Risk and Family Health Divisional Board have approved this survey response and it was returned to the LMNS on 25.05.2022. 7. MVP – Continued close working relationship with MVP and MVP/LWH Strategy under development. MVP Chair recruitment ongoing. 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. See further details below 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. Details to Trust Board in May 2022. ***A detailed paper is sighted at both Quality Committee and Trust Board where compliance with the MIS scheme is discussed and noted.***

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MIS - Safety Action 8 - MDT Training.	Staff Group	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Maternity & Neonatal MIS Training Narrative. May 2022.
SA 8b. MPMET	Midwives	13%	19%	22%	38%	61%	Maternity Training Needs Analysis: Liverpool Women's NHS trust (LWHT) is committed to the vision of the National Maternity Review Better Births Report to become safer, more personalized care with women and families receiving high quality care. Robust education and training are key components of providing safe care and contribute to creating a supportive learning environment where all staff are able to learns from incidents and concerns to continuously improve the care we are providing to women, families and babies. The Maternity training needs analysis (TNA) has been developed and identifies the training required to underpin our commitment. It includes the training required to meet the Core Competency Framework for maternity staff. To support this, LWHT maternity has successfully bid for Health Education England funding for safety training. Following publication of the CNST MIS Year 4 in August 2021, the TNA was reviewed and revised further to ensure compliance to CNST Safety Action 8. Updates in relation to the Midwifery Preceptorship programme and have also been included in v1.1 of this document to reflect current practices. The LWH Maternity TNA has been shared with the Local Maternity System Lead Midwife for Quality & Safety, ratified, and agreed and is currently being utilised as a template for other maternity providers within the region as a benchmarking tool. All managers, clinical leads and rota co-ordinators have been contacted and have ensured that staff are booked onto applicable course sessions that are planned and diarised. To note, Anaesthetic trainees are a small cohort of staff (average number 12) who complete a short three-month rotation to Obstetric Anaesthesia at LWH and therefore the compliance figure fluctuates dramatically for this group at the rotation times through the year. The Maternity Education Team have developed an excellent relationship with the rota coordinators who ensures that all obstetric consultant and trainees attend a MPMET session during their placement to achieve compliance. ** Midwifery and neonatal nurse compliance data is based on the one year in house update and does not include and reflect those clinicians who have at reg course and therefore this would supersede annual update. This will require manual verification later. This data has been sighted at the Trust Resuscitation Committee. Fetal Surveillance Training days commenced in January 2022 to include all elements of the Saving Babies Lives Care Bundle, in addition to the fetal monitoring training requirements. An increased number of courses have been arranged from March 2022, with an increased capacity for attendance. A trajectory is in place to ensure that we meet this requirement. Fetal Surveillance Training prior to January had been completed to a compliance rate of 90%.
	Maternity HCA	10%	19%	21%	30%	49%	
	Cons Obstetrician				62%	71%	
	Trainee Obstetrician					91%	
	Cons Anaesthetist						
	Trainee Anaesthetist						
SA 8c. Fetal Surveillance	Midwives	2%	7%	19%	28%	53%	
	Cons Obstetrician	1%	10%	20%	35%	60%	
	Trainee Obstetrician	0%	13%	39%	67%	63%	
SA 8d. NLS	Midwives	13%	19%	22%	39%	62%	
	Cons Neonatologist	94%	94%	94%	94%	100%	
	Trainee Neonatologist	95%	95%	100%	100%	100%	
	ANNPs	62%	85%	88%	88%	96%	
	Neonatal Nurses	80%	84%	89%	89%	89%	

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	Metric	Standard/ National Standard	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Perinatal	1:1 Care in Labour	100% CNST 95% CCG	99.60%	99.30%	99.20%	98.60%	99.60%	99.40%	98.10%	98.30%	98.90%	96.50%	98.97%	99.20%
	Stillbirth Number >24 weeks (Adjusted)	Actual Number	2	7	3	1	2	5	2	5	0	5	1	4
	Apgar <7 @ 5 Minutes (>37wks)	<1.6%	0.80%	0.60%	1.30%	0.80%	0.50%	1.15%	1.28%	0.51%	0.59%	1.15%	0.37%	0.45%
	Term Admission to NICU	<6%	3.54%	4.01%	4.91%	5.10%	4.52%	7.69%	5.46%	5.90%	5.70%	6.70%	3.40%	8.90%
	Women in reciept of CoC	100%	15.35%	14.49%	16.67%	19.91%	17.85%	20.52%	20.52%	18.7%	25.20%	16.90%	18.50%	TBC
	BAME in recipet of CoC	100%	29.41%	31.63%	39.81%	47.96%	39.60%	41.58%	37.89%	37.20%	59.46%	37.70%	41.90%	TBC
	Social Depravation of CoC	No standard	18.18%	19.89%	24.21%	26.40%	22.26%	24.78%	23.62%	21.70%	28.90%	23.30%	22.10%	TBC
	Provision of Epidural in Labour	No standard	15.1%	20.3%	19.4%	20.3%	22.82%	17.78%	16.78%	18.97%	18.70%	19.20%	19.35%	19.10%
	Obstetric Haemorrhage >1.5l	<2.7%	4.28%	3.96%	3.77%	4.14%	3.37%	4.26%	2.96%	3.2%	4.54%	3.74%	4.58%	3.60%
	Coroner Reg 28 Made to Trust	Actual Number	0	0	0	0	0	0	0	0	0	0	0	0
Workforce	HSIB Reports Returned	Actual Number	1	0	0	1	1	1	0	1	0	0	1	1
	Supernamary Shift Leader	100% CNST	100%	100%	100%	100%	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%	16.37%	11.45%	9.64%	9.69%	9.65%
	Midwife to Birth Ratio (in Post)	>1.30	30	31	31	32	30	29	30	30	30	30	28	31
	Midwifery Vacancy	% of Workforce	2.40%	1.40%	4.40%	3.30%	5.32%	8.72%	7.84%	2.46%	2.00%	4.10%	13.2%*	13.20%
Feedback	Rostered Cons Hrs on DS	Actual Number	91	91	91	91	91	91	91	91	91	91	106.5**	106.5
	Number of Formal Complaints	Actual Number	2	2	1	2	3	2	2	2	0	2	3	2
	Number of Maternity Incidents over 30 days	Actual Number	188	261	89	161	376	97	119	121	120	234	221	273
	Number of PALS/PALS +	Actual Number	74	66	67	46	52	44	32	44	42	31	27	26

Conclusion

The Family Health Division ask the Board to note this paper as assurance that perinatal quality safety is a key priority within the division and its compliance against the implementation of a perinatal quality dashboard and framework. The data that supports this paper is monitored at the Family Health Divisional Board and includes review of all WE SEE KPIs, as developed within the maternity Power BI dashboard. Further to this a review of the Cheshire & Merseyside Variance and Outliers status is undertaken by the Clinical Lead for Maternity at the FHDB. And outlier comments supplied to the LMNS from the Clinical Lead.

Quality Committee Chair's Highlight Report to Trust Board
23 May 2022

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• The performance report indicated continued challenges to meet the 2-week performance targets due to the number of referrals onto the pathway. It was confirmed that capacity within the Trust had improved, and regional pathways had been agreed with the Cheshire & Merseyside Cancer Alliance which should also support improvements. A recognised improvement against the cancer 31-day performance was noted.	• Noted that the Safety & Effectiveness Sub-Committee had commissioned a full review of Medicines storage across the organisation. The programme of work will be agreed and managed via the Medicine's Management Committee. • The Committee noted that the Birthrights inquiry into racial injustice in maternity care report had been published. The findings of which would be reviewed by the EDI Committee. • Further assurance was requested in response to the Cancer Pathway access (NICE Guidance) as highlighted within the Performance Report. The Committee to receive divisional update as reported to Safety & Effectiveness Sub-Committee. • The Committee discussed the Clinical Case for Change and the Counterfactual Case. Feedback from the Clinical Senate regarding the areas of high risk was considered. The Committee noted the next steps to consider preparation for a discussion in public in July 2022. • The Committee received the Security Management Annual Report 2021/22. It was noted that the management of the LSMS contract had returned to the Trust as of January 2022. Consideration of future reporting and governance arrangements to be agreed as part of the security review workstream. • The Committee received an update against CNST Level 4. The new submission date of 05 January 2023 for Board declaration and signoff was noted. The Committee noted the workstreams underway to deliver against CNST requirements.
Positive Assurances to Provide Identify in brackets should the assurance provide evidence against the CQC Key Questions – SAFE | EFFECTIVE | CARING | RESPONSIVE | WELL LED	**Decisions Made**
• Noted the appointment of a Maternity Project Manager to support the significant number of maternity projects underway to meet the Trust, regional and national maternity transformation agenda. • Positively assured by the CQC Insight Tool update noting that any areas of concern detailed within the Trust and Core Service Analysis were known and actions in place to address these issues. • The Committee received the monthly Serious Incident report for April 2022, noting 0 serious incidents declared, 3 final reports submitted to the CCG, and 0 overdue actions. The Committee requested further clarity in relation to the recommendations,	• The Committee reviewed the draft Annual Quality Report 2021/22. The Committee approved the contents of the report and noted that it would be submitted to Audit Committee and Trust Board for ratification on 16th June 2022. An abridged public summary document was recommended. The Committee agreed to receive a mid-year Quality Report to support future reporting.

interventions and outcome for each incident to provide background to better support assurance for Committee members.

- The Committee was assured by the approach undertaken to address the issues in response to the Maternity Survey 2021. The Committee appreciated the triangulation undertaken and noted the realistic timescales and owner responsibility assigned within the action plan.
- Annual review of the Robotic Assisted Surgery since its introduction. The Committee was assured that the Trust had met the planned trajectory and noted patient choice in relation to requesting use of the robot. The level of learning and development required from the Theatres Team to have implemented the process so efficiently was acknowledged.
- Received positive assurance from the Learning from Deaths Quarter 4 report. It was noted that the learning data was from reviews undertaken during Quarter 3 to provide learning from the formal processes. The review of stillbirths and neonatal deaths are subject to a multidisciplinary review panel meeting with external professionals.
- The Committee noted the Medicines Management Assurance Report for Quarter 4, 2021/22.
- The Committee noted the ongoing work in relation to implementation of LocSSIPs during Quarter 4, 2021/22.

Summary of BAF Review Discussion (Board Committee level only)

- The Committee reviewed the Quality related BAF risks. No changes to risk scores were recommended. No risks closed on the BAF for Quality Committee.

Comments on Effectiveness of the Meeting / Application of QI Methodology

- Appropriate discussion time dedicated to identified reports
- Satisfactory reports and sighted on the most appropriate issues

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
25.	Board Assurance Framework	Assurance	32.	Robotic Assisted Surgery Update	Information
26.	Sub-committee Chair Reports	Assurance	33.	Future Generations Case for Change and Counterfactual Case	Information
27.	Quality & Regulatory Update: CQC Insight Tool	Assurance	34.	Security Management Annual Report	Assurance
28.	Quality Performance Report Month 1, 2022/23	Assurance	35.	CNST Year 4 Assurance	Information
29.	Serious Incidents & Learning Report (monthly update)	Assurance	36.	Mortality and Perinatal Report (Learning from Deaths) Quarter 4	Assurance

30.	Review of Annual Quality Report (prior to AC/Board)	Information	**37.**	Medicines Management Assurance Report Quarter 4	Assurance
31.	Maternity Picker Survey Update	Information	**38.**	LocSSIPs Quarterly Assurance Report Quarter 4	Assurance

3. 2022 / 23 Attendance Matrix

Core members	April	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Tony Okotie, Chair	✓	✓										
Susan Milner	✓	**A**										
Louise Kenny	**A**	✓										
Sarah Walker	**NM**	✓										
Gloria Hyatt	**NM**	✓										
Jackie Bird	**NM**	✓										
Marie Forshaw	✓	✓										
Gary Price	✓	✓										
Lynn Greenhalgh	✓	✓										
Eva Horgan	✓	✓										
Michelle Turner	✓	✓										
Nashaba Ellahi	✓	✓										
Philip Bartley	✓	✓										

Quality Committee Chair's Highlight Report to Trust Board
27 June 2022

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• A general theme regarding training compliance was identified through several of the agenda items and incorporated areas such as fit mask testing and safeguarding level 3 training. • A presentation was received outlining the quality impacts of the recovery and restoration work post pandemic. Whilst the Committee was assured by the grip demonstrated by the Operations Team (and improvements in several areas), there was a concern expressed that key waiting time / access metrics continued to deteriorate. Actions to improve the position were outlined and it was expected that the position would plateau in Q3 2022/23. A recommendation was made to ensure that this issue was visible on the BAF (see below). There was acknowledgement that the drivers behind this issue were multifaceted and would require oversight from the Putting People First Committee, Finance, Performance & Business Development Committee together with the Quality Committee. • It was noted that whilst HSIB investigation timescales remained a concern, a preliminary review against the Trust's internal investigation processes had found that similar conclusions had been reached.	• In response to the issue identified regarding training compliance, the Committee sought further assurance at a future meeting regarding the effective prioritisation of mandatory training compliance from a patient safety perspective. • Noting that a pilot 'interpreter on wheels' initiative had received positive feedback, the Committee identified a need to seek feedback on the post-natal experience from non-English speaking patients. • The Committee requested that the monthly serious incident report be strengthened by enhancing the evidence that lessons had been learned and embedded. • The Committee received the Integrated Governance Report for Q4 2021/22. Whilst assurance was noted in relation to the level of activity described in the report, it was noted that the triangulation between areas and themes could be further strengthened.
Positive Assurances to Provide Identify in brackets should the assurance provide evidence against the CQC Key Questions – SAFE | EFFECTIVE | CARING | RESPONSIVE | WELL LED	**Decisions Made**
• Noted that performance for the 4hr A&E target had improved and that the target would likely be met for June 2022. Work was now underway to ensure sustained performance (RESPONSIVE) • Positively assured by the Imaging Review Update. Whilst it was acknowledged that further work was required, the service had made significant improvements, particularly in relation to the team dynamic and culture. (WELL-LED) • The Committee received the bi-annual clinical and quality strategy update. It was noted that through receiving updates twice a year, this would support the development of the Trust's Quality Account at year-end. It was noted that positive feedback on the Trust's 2021/22 Quality Account had been received from the Trust's Commissioners (ALL) • The Committee was assured by the Trust's approach to infection, prevention and control as outlined in the annual report for 2021/22. Positive assurance was noted in relation to the level of compliance demonstrated against the Covid-19 IPC Board Assurance Framework tool.	• The Committee remitted a Chair's Log to the Putting People First Committee to consider the training issues identified through several items on the agenda.

- Assurance was noted from the 2021/22 Health and Safety Report. Issues relating to health and safety training and fit mask testing were highlighted (picked up elsewhere on the agenda). (SAFE)
- Assurance received in relation to the Research, Development and Innovation Annual Report. Noted that the Trust's research activity had and would continue to play a key role in improving patient outcomes and support recruitment and retention of staff. The Committee noted the annual report could be strengthened by referencing the RD&I strategy objectives and progress made against them. (EFFECTIVE)
- Noted that the Trust was progressing against the CNST Year 4 requirements as expected. (SAFE)
- The Committee was informed of the Trust's self-assessment response to the Ockenden Report requirements. Also outlined was a proposed governance arrangement for embedding Ockenden actions into the Maternity Transformation Board (the terms of reference and chairing of which were under review to ensure appropriate clinical leadership). (WELL LED).

Summary of BAF Review Discussion (Board Committee level only)

- The Committee reviewed the Quality related BAF risks. A discussion was held regarding the Trust's position in relation to performance against key access targets. There was agreement that this was a key risk to the Trust achieving its strategic aims and it therefore needed to be reflected on the BAF. An action was taken to articulate this as a 'strategic threat' and bring back for approval to the next scheduled Committee meeting.

Comments on Effectiveness of the Meeting / Application of QI Methodology

- Appropriate discussion time dedicated to identified reports
- Noted that with a number of new Committee members, the opportunity would be taken to review the effectiveness of the Committee and seek improvements. Feedback was invited from Committee members.
- A potential issue relating to quoracy for the scheduled meeting in July 2022 was discussed. There was agreement that a meeting should progress, and workaround options would be found.
- The Committee thanked the outgoing Chair (Tony Okotie) for all his hard work and efforts to improve the Committee effectiveness.

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
47.	Board Assurance Framework	Assurance	54.	Annual Report of the Director of Infection Prevention & Control & IPC BAF	Assurance
48.	Sub-committee Chair Reports	Assurance	55.	Annual Health & Safety Report	Assurance
49.	Quality Performance Report Month 2, 2022/23	Assurance	56.	Research & Development Annual Report	Assurance

50.	Imaging External Review	Assurance	**57.**	Maternity Incentive Scheme (CNST) Year 4 – Scheme Update June 2022	Information
51.	Review of Clinical and Quality Strategy (bi-annual)	Information	**58.**	Ockenden Final Report Self-Assessment	Information
52.	Serious Incidents & Learning Report (monthly update)	Assurance	**59.**	Safeguarding Quarterly Report, Q4	Assurance
53.	Integrated Governance Assurance Report Quarter 4	Assurance			Assurance

3. 2022 / 23 Attendance Matrix

Core members	April	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Tony Okotie	✓	✓	✓									
Susan Milner	✓	**A**	**NM**									
Louise Kenny	**A**	✓	✓									
Sarah Walker, Chair	**NM**	✓	✓									
Gloria Hyatt	**NM**	✓	✓									
Jackie Bird	**NM**	✓	✓									
Marie Forshaw	✓	✓	✓									
Gary Price	✓	✓	✓									
Lynn Greenhalgh	✓	✓	✓									
Eva Horgan	✓	✓	✓									
Michelle Turner	✓	✓	✓									
Nashaba Ellahi	✓	✓	✓									
Philip Bartley	✓	✓	✓									

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	**22/23/77b**		**Date: 07/07/2022**	
Report Title	**Quality & Operational Performance Report**			
Prepared by	***Gary Price, Chief Operating Officer, Dr Lynn Greenhalgh, Medical Director and Marie Forshaw, Chief Nurse & Midwife***			
Presented by	***Gary Price, Chief Operating Officer***			
Key Issues / Messages	***For assurance – To note the latest performance measures***			
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 assurances within the Month 2 Quality and Operational Performance Report.			
Supporting Executive:	***Gary Price, Chief Operating Officer***			

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

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: N/A	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Finance, Performance and Business Development Committee	June 22	COO	The Committee noted the report.
Quality Committee	June 22	COO	The Committee noted the report.

Liverpool Women's
NHS Foundation Trust

Trust Board Performance Report

This report has been produced to provide an exception position against the Trust's key performance standards. This page is designed to help readers interpret the report and understand the process for KPI selection and review.

Report Layout:

WE SEE Summary - this provides a breakdown of the number of KPIs that are meeting / failing targets for the most recent month of reported data.

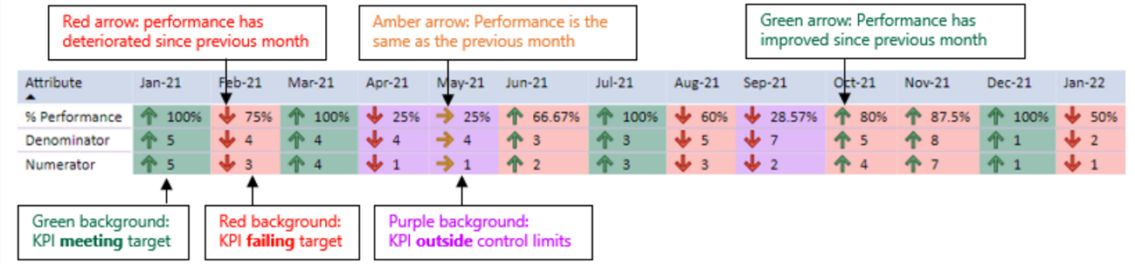
Cover Sheets - these provide an overview of performance with over arching narrative for each of the WE SEE values. In addition a selection of KPIs will be selected for a more in depth review. These are selected based on whether the KPI meets one or more of the following criteria:
•Outside of a control limit, having previously been within control limits
•A consecutive deterioration of performance over a quarter, which is not insignificant
•A significant drop in performance over the space of a month
•A consecutive improvement in performance over a quarter, which is not insignificant
•A significant increase in performance over the space of a month
•KPIs, that following specific analysis require review, or where a change in measurement or data production require escalation

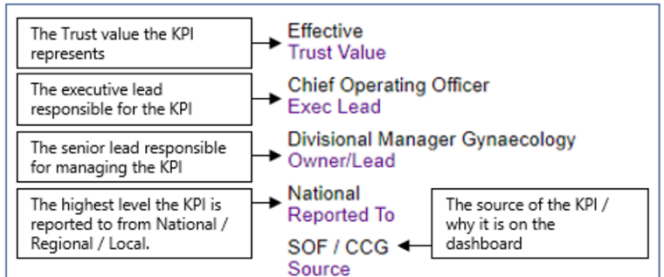
Data Sheets - these provide detailed information for each specific KPI measured. This includes data values for the previous 13 months, a sparkline included performance dating back to April 2018 where available. The sparkline graph includes the performance, target and control limits for the specific KPI. Within the data table the arrows represent whether performance has increased, decreased or remained the same. The colour coding is based on the target type as to whether this movement is positive or negative. All arrows apply to the performance and not other data items. In addition the target, target type, executive lead, operational / clinical owner / lead, source (why are we leasuring the KPI) and data quality kite mark (1 least confidence to 5 highest confidence). Narrative submitted by the KPI owner for the most recent month is included if provided.

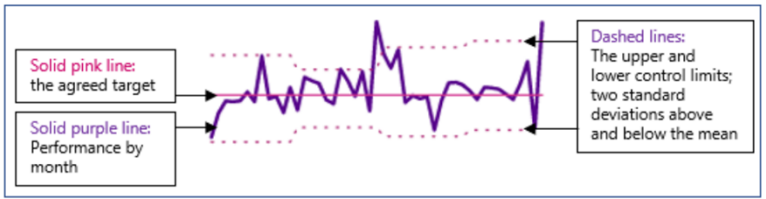
Data Health Check - highlights where KPIs have denominators outside of control limits along with a summary of the data quality kite mark scores for each KPI.

KPI Lineage - shows for each committee / meeting that KPI is included within the performance dashboard

How to interpret the report:







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.

Liverpool Women's
NHS Foundation Trust

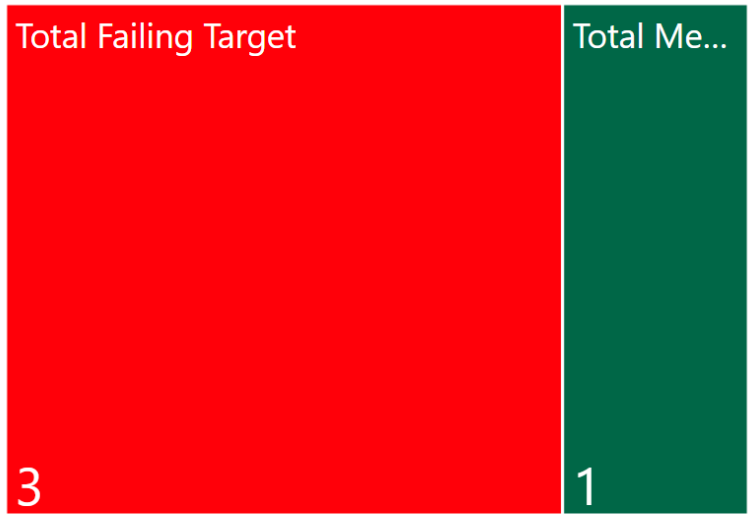
Trust Board

Performance Report

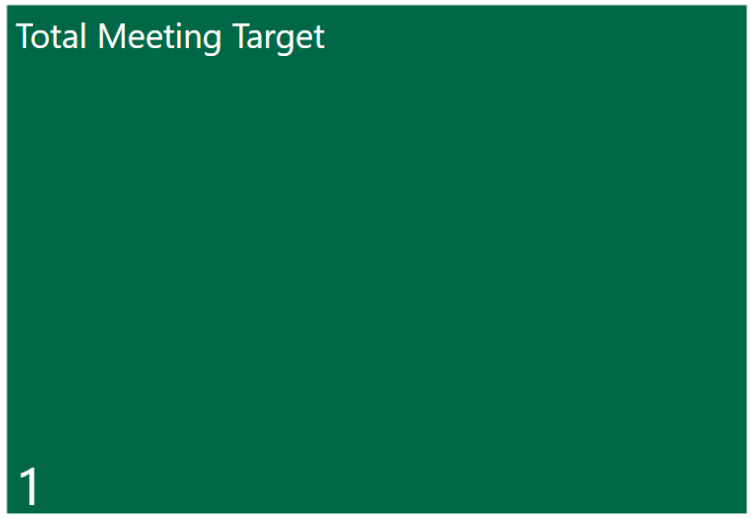
June 2022

WE SEE Summary

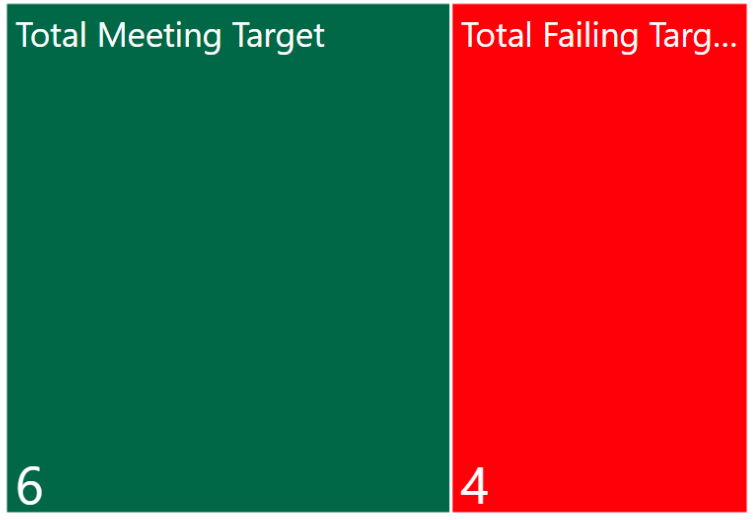
Workforce



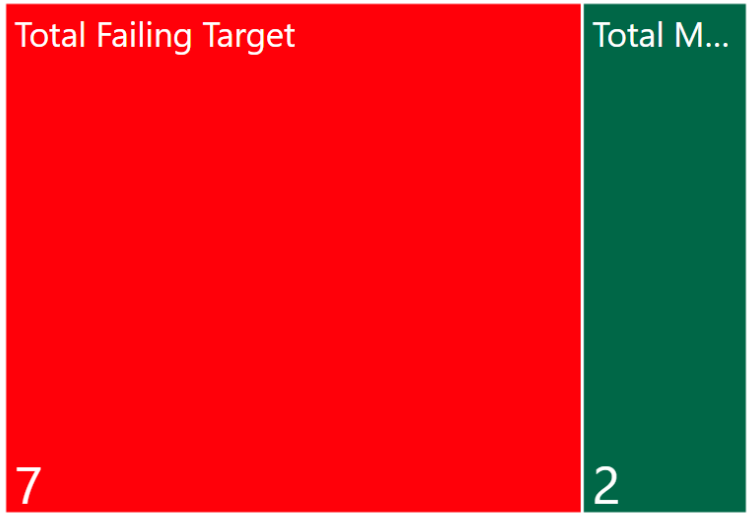
Efficient



Safety

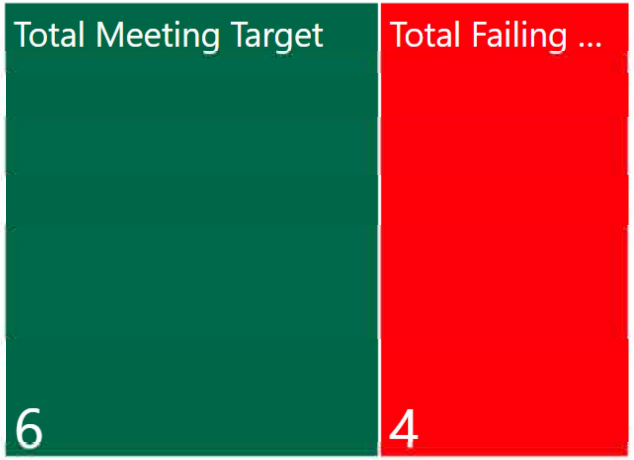


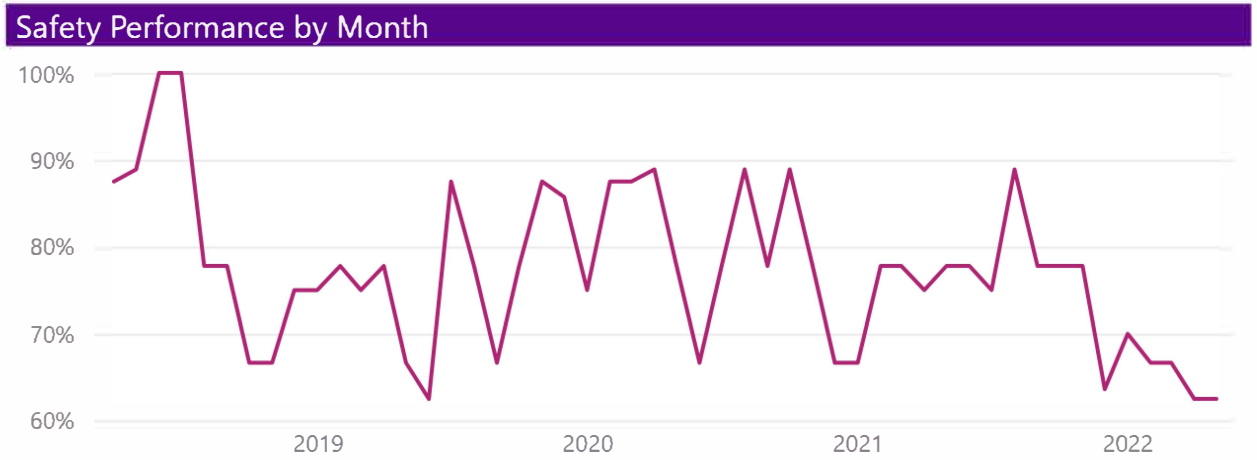
Effective



Experience

To deliver **Safe** services





Positive Developments

30 people have undertaken training in relation to Route Cause Analysis/SI's throughout May and June 2022. This provides the trust with a much larger pool of Investigative Officers which will allow investigations to be commenced and completed in a more timely way. There are no longer any outstanding actions for review with processes now in place to avoid a repeat of this.

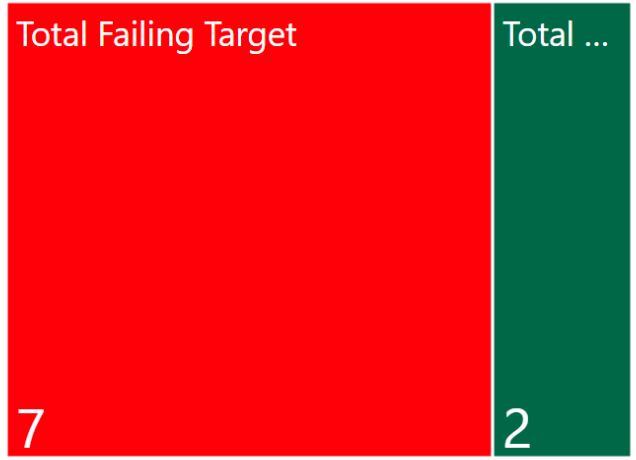
Areas of Challenge

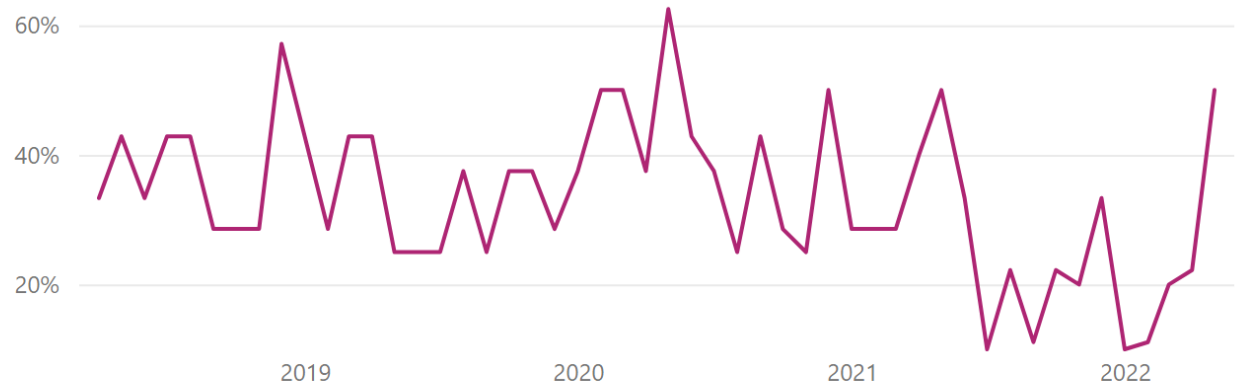
There have been Governance Manager vacancies trust wide over the last few months which may have impacted on the timely progression of SI's within divisions. These posts have now been recruited to and it's therefore expected to see improvements in this area. It has not always been evident that learning has been embedded as repeating themes and trends within our SI's have been identified. The Corporate Governance team are starting to develop processes to strengthen the triangulation of incidents claims and complaints to drive change and improvement.

KPI	May 2021	June 2021	July 2021	August 2021	September 2021	October 2021	November 2021	December 2021	January 2022	February 2022	March 2022	April 2022	May 2022
Serious Untoward Incidents: Number of SUI's with actions outstanding	0	0	0	0	0	0	0	0	0	0	1	1	1
Serious Untoward Incindents: Open	8	8	8	5	9	9	13	16	19	19	17	14	13
Venous Thromboembolism (VTE)	85.39%	86.51%	84.58%	88.55%	87.96%	90.64%	86.25%	86.39%	84.16%	85.86%	86.38%	89.11%	89.5%

These KPIs have been highlighted for the current reporting month based on the criteria highlighted in the report guidance

To deliver the most **E**ffective outcomes





Positive Developments

The Trust continues to report 0 104 week waits in line with the national recovery trajectory. 78 week waits are in line with trajectory.

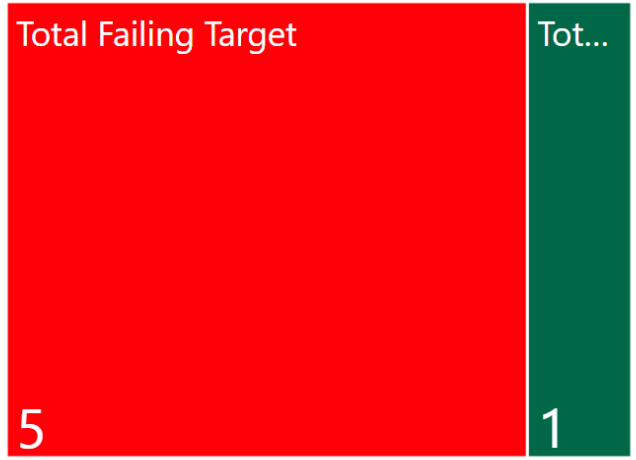
Areas of Challenge

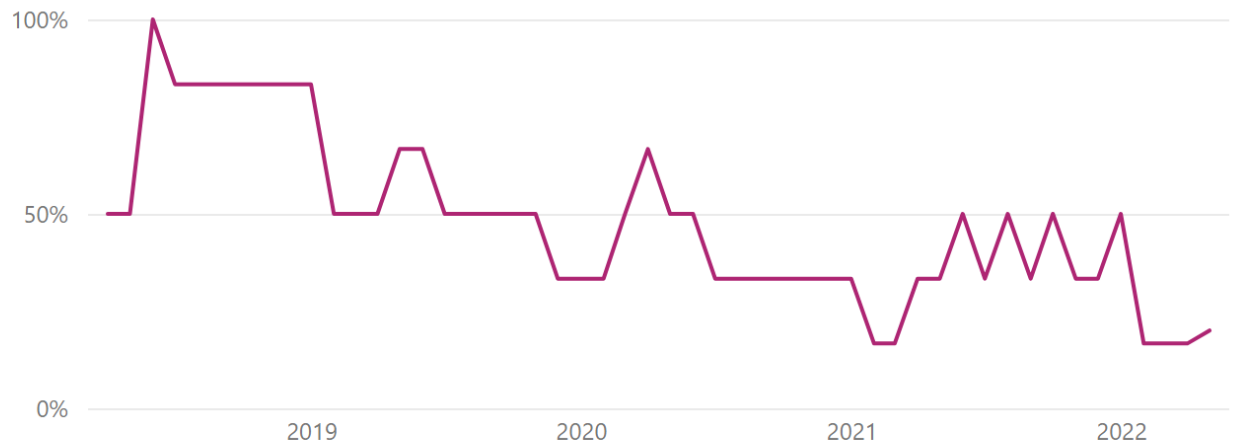
The 52 week wait continues to be an area of challenge. Additional capacity has been identified and will come into place through Q2 with anticipated plateau in Q2/3 and reduction in Q4. This supports the national trajectory to eliminate 52 week waiters by March 2025.
The 2 week cancer target saw a significant decline in April due to unexpected staffing challenges and continued increase in referrals. Following review and immediate action the May performance has increased and the June performance is in line with pre-pandemic levels.

KPI	May 2021	June 2021	July 2021	August 2021	September 2021	October 2021	November 2021	December 2021	January 2022	February 2022	March 2022	April 2022	May 2022
18 Week RTT: Incomplete Pathway > 52 Weeks	170	194	209	244	256	288	294	354	406	479	544	816	1145
18 Week RTT: Incomplete Pathway > 78 Weeks	0	4	4	12	39	21	3	3	11	12	12	26	29
All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (After Re-allocation)	20%	20%	16.13%	16.22%	6.06%	18.18%	44.83%	54.55%	34.78%	47.06%	18.75%	26.92%	
Cancer: 104 Day Breaches	3	4	1	3	5	3	3	3	2	2	2	4	
Cancer: 2 Week Wait	97.92 %	96.2%	95.32%	96.42%	96.06%	95.33%	97.04%	95.31%	76.65%	81.91%	67.87%	11.9%	

These KPIs have been highlighted for the current reporting month based on the criteria highlighted in the report guidance

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





Positive Developments

The 4 hr Emergency Department Target improved in May as workforce numbers stabilized. A new department lead commenced in post in May to lead on further improvements.

Areas of Challenge

In April the 6 week diagnostic wait was challenged due to a reduction in imaging capacity. This has been addressed in the short term and recruitment is under way for additional posts

KPI	May 2021	June 2021	July 2021	August 2021	September 2021	October 2021	November 2021	December 2021	January 2022	February 2022	March 2022	April 2022	May 2022
A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge	96.67% ↓	96.37% ↓	95.95% ↓	96.06% ↑	97.43% ↑	96.58% ↓	98.64% ↑	95.36% ↓	97.02% ↑	94.11% ↓	89.73% ↓	90.94% ↑	91.75% ↑
Diagnostic Tests: 6 Week Wait	93.16% ↑	89.3% ↓	90.95% ↑	82.73% ↓	69.65% ↓	85.81% ↑	87.25% ↑	90.13% ↑	83.08% ↓	94.39% ↑	88.32% ↓	71.08% ↓	
Friends & Family Test: A&E % positive	86.96% ↑	81.25% ↓	90.91% ↑	88.89% ↓	75% ↓	96.67% ↑	86.21% ↓	88.89% ↑	85.71% ↓	80.77% ↓	85.71% ↑	83.08% ↓	85.37% ↑

These KPIs have been highlighted for the current reporting month. In depth detail and narrative is included in the reporting pack

May 2022 – Maternity Facts

NHS
Liverpool Women's
NHS Foundation Trust

Thank you to all our families for choosing Liverpool Women's : Welcome to the world our May 2022 Babies.

656 Babies Born

11 Vaginal Birth After CS

18 Home Births

Girls 318

337 Boys

1469 Visits to Maternity Assessment Unit

1 Breech Births

Spontaneous Vaginal Births 316

13 Sets of Twins

206 Inductions of labour

98 Elective C - Sections

164 Emergency C - Sections

Have you had a May 2022 Baby? Why not send a picture to our Twitter or Facebook account. We'd love to hear from you. @LiverpoolWomens

Births on MLU 52

Instrumental Births 76

Women Booked For Care 742

19 Pool Births

Heaviest Baby 10lb 15oz
Lightest Baby 1lb 6oz

Eid al Fitr 2nd May: 13 Births.

Our busiest day: 26th May: 30 Births.

To deliver Safe Services – Serious Incidents

Overview

There were zero SI's reported in April 2022 and two in May 2022 making a total of two SI's reported for the year to date for 2022/23. 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	4	3	3	28
2022-23	0	2											2

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

May 2022 Serious Incidents

Service	StEIS Ref.	Reported in Line with Policy	Summary
Maternity	2022 - 9734	Yes	On 30th November 2021, Liverpool Women's Trust via the Safeguarding Team were made aware from the Coroner of a Maternal Death within the Community. A post-mortem examination was undertaken by the Coroner and the results and cause of death withheld until histology and toxicology results were available. A review of the maternity and Obstetric care was undertaken. Some communication issues were identified. Subsequent delay in investigation due to HM Coroner involvement. HM Coroner subsequently provided authority for the Trust to undertake an investigation in addition to an investigation being undertaken by an external Trust. **Immediate Action Taken:** No short-term actions required. Medium- & Long-Term actions to be developed upon receipt of cause of death if required. SUI process to be undertaken to identify medium- and long-term actions **Immediate Lesson Learnt:** To be confirmed upon receipt of cause of death Communication with Primary Care following discharge did not include the full details of the admission and discharge medication. Improvements in communication required COVID: The changes in practice related to telephone apts, lack of visitors in hospital are likely to have impacted on the information provided to the medical team. Communication with Mersey Care was not undertaken during the pregnancy. Clinical staff were not made aware of the previous history.
Maternity and Neonates	2022-9742	Yes	Baby born on 19th April 2022 Antenatally found to have right sided unilateral hydronephrosis, right sided ureteric dilatation and bladder ureterocele In accordance with LWH neonatal guideline this baby should have been on prophylactic antibodies (Trimethoprim). The LWH guideline states: NEONATAL MEDICAL TEAM Will prescribe Trimethoprim 2mg/kg once daily for all babies with ureteric dilatation. These were not commenced by the postnatal SHO and baby was sent home Baby admitted to Alder Hey Children's Hospital on 28th April, day 11 of life for attendance for routine postnatal ultrasound as stipulated by our guideline and found to have pyelonephritis Admitted for 14 days antibiotics and needed a long line inserted into a vein Had to go to theatre for draining of pus from the bladder ureterocoele Has grown pseudomonas from urine culture which would not have been sensitive to Trimethoprim Baby is now on IV ciprofloxacin **Immediate Action Taken:** Which babies to be started on prophylactic antibiotics to be made clearer on guideline Support staff involved and feedback to them about this error Further investigations to be undertaken by the Fetal Medicine Unit **Immediate Lesson Learnt:** Which babies to be started on prophylactic antibiotics to be made clearer on guideline Policy for postnatal antibiotics for babies with ureteric dilatation must be followed

To deliver Safe Services – Serious Incidents

HSIB Cases Reported and NHSR Early Notification Scheme

During April 2022 there were 2 cases which met the HSIB criteria and has been reported to HSIB. No cases in May 2022.

	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
2022	2	1	3	2	0								8 to date

The main themes of the incidents reported is in relation to; cooled babies, there have been small numbers of neonatal death and Hypoxic Ischaemic Encephalopathy (HIE):

Duty of Candour
There were 2 serious incidents reported in May 2022 and Duty Of Candour was 100% compliant.

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

May 2022					
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	85.48%	68.82%	129.03%	98.39%	The fill rate for RN in April reflects the change in the establishment template. The overfill of RN on nights is due to a trial of Senior Nurse band 6 cover rostered onto night duty to support the junior staff and the Gynaecology Emergency Department. Safe staffing was maintained throughout May. HDU staff have supported the ward due to the low occupancy and demand for HDU beds. The staffing is monitored twice daily in staffing huddles and by divisional senior nursing team.
Induction & Delivery Suites	82.51%	76.34%	95.29%	100.00%	Staffing required the Maternity Bleep holder to redeploy RM to maintain clinical safety and prioritise 1:1 care in labour, which included the intermittent closure of MLU and on occasions redeployment of staff from the Mat Base. Vacant shifts are requested to be filled with bank and agency as required.
Maternity & Jeffcoate	74.19%	97.39%	74.19%	99.10%	All vacant shifts requested to be filled with bank and agency as required. The Maternity Bleep holder redeployed staff to maintain clinical safety to areas of high acuity and to ensure appropriate discharge flow to release capacity. Safe care maintained across maternity services.
MLU	67.74%	54.84%	86.29%	51.61%	Due to internal escalation, there were five episodes of closure of MLU- and the staffing fill rate is reflective of the deployment of staff to Delivery Suite to consolidate activity through one area for both RM and Care Staff. Safe care maintained.
Neonates (ExTC)	103.74%	82.26%	103.40%	87.10%	* and ** Fill rates are reflective of occupancy and acuity on the NICU during April. Safer staffing was always maintained.
Transitional Care	32.26%	109.68%	103.23%	51.61%	TC occupancy has continued to be low this month. Staff were redeployed to the unit where appropriate ensuring that safe staffing was always maintained on TC

To deliver Safe services - Safer Staffing

Gynaecology: May Fill Rate

Fill-rate –The fill rate for RN in April reflects the change in the establishment template. The overfill of RN on nights is due to a trial of Senior Nurse band 6 cover rostered onto night duty to support the junior staff and the Gynaecology Emergency Department. Safe staffing was maintained throughout May. HDU staff have supported the ward due to the low occupancy and demand for HDU beds. The staffing is monitored twice daily in staffing huddles and by divisional senior nursing team

Attendance/ Absence – sickness absence for the ward 6.10% (56.73% STS and 43.27% LTS) and 3.23 WTE on Maternity leave

Vacancies – 4 WTE RN, 1 WTE HCA, 1 WTE HCA on secondment, all out to recruitment

Red Flags – 0 recorded

Bed Occupancy – 66.25%

CHPPD – 7.6

Neonates: May Fill Rate

Fill-rate – Occupancy and acuity throughout May has significantly increased in the NICU and has seen the IC and HD occupancy rate increase to over 86%, safe staffing has been maintained and fill rates are reflective of acuity and occupancy. The increase in activity has seen an increase in the use of Bank staff. The escalation policy has been used this month; however, no transfers were undertaken.

Attendance/Absence – May sickness ran at 5.71%, this was down 1% on last month. Short-term sickness continues to sit at approximately 30% with long-term sickness making up 70%, all individuals are being managed in line with HR Policy. Covid sickness and covid special leave made up approximately 1.5% this is down 1.5% on last month. Maternity is running at 9.91 WTE and turnover sits at 8% well below the Trust target.

Vacancies - Out to advert for Band 5 posts, with lots of interest from our current students. No vacancies at band 6 and 7. We have asked HEE if they would support a further 2 ANNP trainee places.

Red Flags – No red Flags

Bed Occupancy – Unit occupancy has run above 85%, this is above the expected 80%. IC has run at 96%, HD 86.1%, LD 87.6 %, and TC is down 46.8%, activity is up in all areas on previous month. May has been a much busier month.

To deliver Safe services - Safer Staffing

Maternity: May Fill Rate

Fill-rate – Maternity continues to report levels of sickness above the trust target, within its midwifery and support staff groups, however this continues to be on a downward trajectory. Bank and agency usage continues due to sickness rates and to cover vacancy gaps. Due to both long term (LT) and short-term (ST) 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 have been rostered into clinical rota gaps to support safe staffing during this period while enacting Business Continuity Plans.

Attendance/Absence – Maternity sickness is reported at 9.65% which is a combination of clinical, non-clinical and administration staff. Maternity has seen a decrease in sickness rates with staff resuming back to duty from 9.65% in the previous month. Maternity sickness has a higher rate of LT sickness than ST sickness (32%STS versus 68%LTS). Ward managers/matrons have individual sickness reviews, and maternity are planning return to work programmes with all LT employees to facilitate appropriate returns to work. A comprehensive sickness review programme overseen by the HRBP and acting HOM continues on a weekly basis and this oversight has supported the resolution of, and overall reduction in active LTS.

Vacancies – Current vacancy rate of 47.85 WTE for midwifery staff; this is an increase following new staffing establishments and increased headroom after Birthrate Plus report agreed and supported by trust board. Maternity maintains an active recruitment plan with a rolling NHS jobs advert for the B6 post with 4.0 WTE due to join in the coming months; the service will also welcome new individuals to the HOM and DOM posts at the end of June/beginning of July. There has a commitment to over recruit for midwives and from this, conditional offers have been made to Band 5 midwives to commence as they receive PIN numbers in autumn - with extensive onboarding activities planned over the summer months. Maternity is currently implementing an International Recruitment programme as part of the Northwest Collaboration with 8 overseas trained midwives, however the lead trust for the collaborative have informed providers that there is an expected delay of the anticipated summer arrival date and therefore arrival has been projected for September.

Red flags – Maternity have a positive reporting culture for red flags, with monthly oversight reports at the Maternity Risk and Clinical Meeting. These are also reported by the 104 Maternity bleep holder 4hrly as part of the bleep recording.

Bed Occupancy – Maternity continues to experience high levels of clinical activity and referrals from other units as a tertiary provider including in utero transfers. Following the appointment of a Deputy Divisional Manager, Maternity Capacity and Demand work is now being undertaken. Intermittent closure of the MLU due to staffing concerns has reduced the overall Intrapartum capacity and our low-risk offer.

Neonatal Deaths per 1000 live Births

Target: **(Blank)**

Attribute	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Performance Value	↓ 0	→ 0	↑ 1.5	→ 1.5	→ 1.5	↑ 3	↑ 4.6	↓ 1.6	↓ 0	↑ 1.8	↓ 1.7	→ 1.7	↑ 3.1

DQKM

Safety
Trust Value

Medical Director
Exec Lead

Clinical Director Family Health
Owner/Lead

Local
Reported To

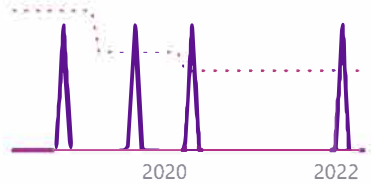
Trust
Source

Never Events

Target: **0**

Attribute	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Performance Value	→ 0	→ 0	→ 0	→ 0	→ 0	→ 0	→ 0	→ 0	→ 0	↑ 1	↓ 0	→ 0	→ 0

DQKM



Safety
Trust Value

Medical Director
Exec Lead

Head of Governance
Owner/Lead

National
Reported To

Trust
Source

NHSE / NHSI Safety Alerts Outstanding

Target: **0**

Attribute	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Performance Value	→ 0	→ 0	→ 0	→ 0	→ 0	→ 0	→ 0	→ 0	→ 0	→ 0	→ 0	→ 0	→ 0

DQKM

Safety
Trust Value

Director of Nursing & Midwifery
Exec Lead

Head of Governance
Owner/Lead

TBC
Reported To

TBC
Source

Venous Thromboembolism (VTE)

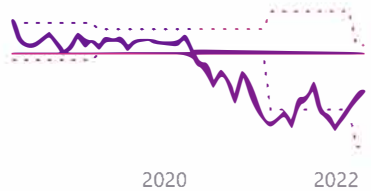
Target: **>= 95%**

Attribute	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
% Performance	↑ 85.39%	↑ 86.51%	↓ 84.58%	↑ 88.55%	↓ 87.96%	↑ 90.64%	↓ 86.25%	↑ 86.39%	↓ 84.16%	↑ 85.86%	↑ 86.38%	↑ 89.11%	↑ 89.5%
Denominator	↑ 1157	↑ 1156	↓ 1167	↑ 1127	↓ 1138	↑ 1111	↓ 1098	↑ 1029	↓ 1111	↑ 1011	↑ 1109	↑ 1047	↑ 1114
Numerator	↑ 988	↑ 1000	↓ 987	↑ 998	↓ 1001	↑ 1007	↓ 947	↑ 889	↓ 935	↑ 868	↑ 958	↑ 933	↑ 997

DQKM

May 2022

The divisional actions takenris starting to demonstrate an improvement in VTE performance however it is acknowledged this remains under threshold. The division anticipatethis will improve further by the end of Q2. A VTE Lead is now established in role and prioritising VTE assessments move across to PENS to aid completion.



Safety
Trust Value

Medical Director
Exec Lead

Deputy Medical Director
Owner/Lead

National
Reported To

SOF / CCG
Source

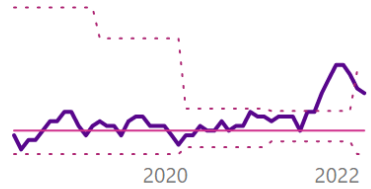
Serious Untoward Incidents: Open

Target: **<5**

Attribute	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Performance Value	8	8	8	5	9	9	13	16	19	19	17	14	13

DQKM

May 2022 — There is currently a number of SI's open for Maternity due to staffing pressures within the divisions governance department and SLT. Posts are in the process of being recruited to which will support the progression of these SI's going forwards.



Safety
Trust Value

Director of Nursing & Midwifery
Exec Lead

Head of Governance
Owner/Lead

TBC
Reported To

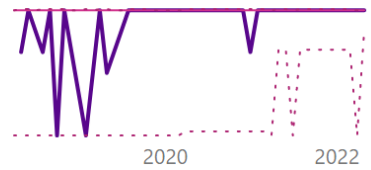
TBC
Source

Serious Untoward Incidents: Number of SUI's reported to CCG within agreed timescales

Target: **1**

Attribute	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
% Performance	100%	100%		100%	100%	100%	100%	100%	100%	100%	100%		100%
Denominator	4	1	0	1	4	1	4	3	4	2	3	0	2
Numerator	4	1	0	1	4	1	4	3	4	2	3	0	2

DQKM



Safety
Trust Value

Director of Nursing & Midwifery
Exec Lead

Head of Governance
Owner/Lead

TBC
Reported To

TBC
Source

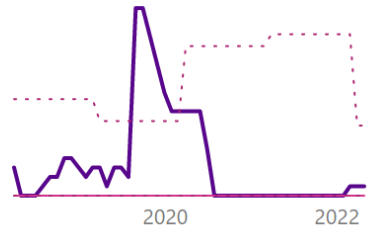
Serious Untoward Incidents: Number of SUI's with actions outstanding

Target: **0**

Attribute	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Performance Value	0	0	0	0	0	0	0	0	0	0	1	1	1

DQKM

May 2022 — This has now been submitted to the CCG on 10 June 2022 and is no longer overdue.



Safety
Trust Value

Director of Nursing & Midwifery
Exec Lead

Head of Governance
Owner/Lead

TBC
Reported To

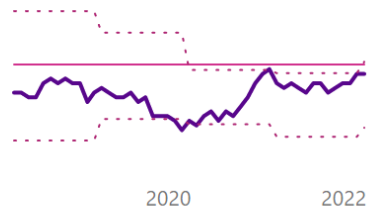
TBC
Source

Serious Untoward Incidents: New (Rolling per year)

Target: **24 /year**

Attribute	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
Performance Value	20	19	20	19	18	20	20	18	19	20	20	22	22

DQKM



Safety
Trust Value

Director of Nursing & Midwifery
Exec Lead

Head of Governance
Owner/Lead

TBC
Reported To

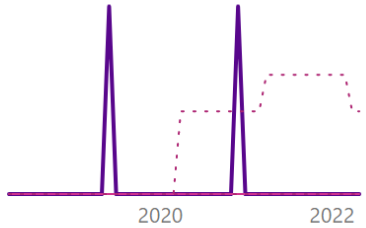
TBC
Source

Infection Control: MRSA

Attribute	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Performance Value	0	0	0	0	0	0	0	0	0	0	0	0	0

DQKM

Target: **0**



Safety
Trust Value

Director of Nursing & Midwifery
Exec Lead

Infection Control Lead
Owner/Lead

National
Reported To

SOF / CCG
Source

Infection Control: Clostridium Difficile

Attribute	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Performance Value	0	0	0	0	0	0	0	0	0	0	0	0	0

DQKM

Target: **1**

Safety
Trust Value

Director of Nursing & Midwifery
Exec Lead

Infection Control Lead
Owner/Lead

National
Reported To

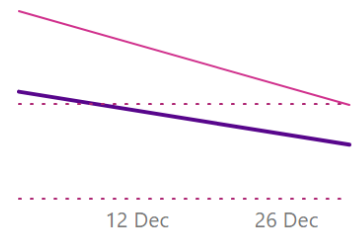
SOF / CCG
Source

Flu Vaccine Uptake Trustwide

Attribute	Dec-21	Jan-22
% Performance	57.06%	57.06%
Denominator	1933	1971
Numerator	1103	1135

DQKM

Target: **>=100%**



Safety
Trust Value

Chief People Officer
Exec Lead

Deputy Director of Workforce
Owner/Lead

National
Reported To

External
Source

18 Week RTT: Incomplete Pathway > 52 Weeks

Target: **0**

Attribute	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Performance Value	↓ 170	↑ 194	↑ 209	↑ 244	↑ 256	↑ 288	↑ 294	↑ 354	↑ 406	↑ 479	↑ 544	↑ 816	↑ 1145
Target Value	↓ 0	↑ 0	↑ 0	↑ 0	↑ 0	↑ 0	↑ 0	↑ 0	↑ 0	↑ 0	↑ 0	↑ 430	↑ 410

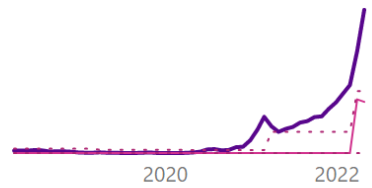
DQKM

April 2022

There continues to be significant delays for patients waiting for surgery. there are also increasing numbers of patients who are waiting over 52 weeks for their first out-patient appointment.

Patients are currently dated for surgery based on clinical priority. The position is monitored via Access Board and PTL and currently sits on the divisional risk register.

The Division continues to carefully monitor waiting times and clinic utilisation. WLIs are staffed as often as possible.



Effective
Trust Value

Chief Operating Officer
Exec Lead

Deputy Chief Operating Officer
Owner/Lead

National
Reported To

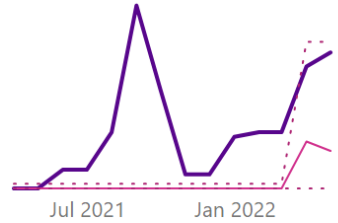
SOF / CCG
Source

18 Week RTT: Incomplete Pathway > 78 Weeks

Target: **0**

Attribute	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Performance Value	→ 0	↑ 4	→ 4	↑ 12	↑ 39	↓ 21	↓ 3	→ 3	↑ 11	↑ 12	→ 12	↑ 26	↑ 29
Target Value	→ 0	↑ 0	→ 0	↑ 0	↑ 0	↓ 0	↓ 0	→ 0	↑ 0	↑ 0	→ 0	↑ 10	↑ 8

DQKM



Effective
Trust Value

Chief Operating Officer
Exec Lead

Deputy Chief Operating Officer
Owner/Lead

National
Reported To

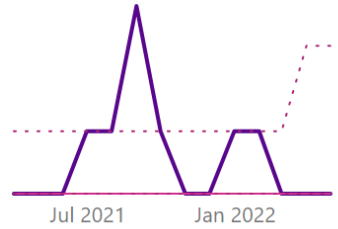
SOF / CCG
Source

18 Week RTT: Incomplete Pathway > 104 Weeks

Target: **0**

Attribute	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Performance Value	→ 0	→ 0	↑ 1	→ 1	↑ 3	↓ 1	↓ 0	→ 0	↑ 1	→ 1	↓ 0	→ 0	→ 0
Target Value	→ 0	→ 0	↑ 0	→ 0	↑ 0	↓ 0	↓ 0	→ 0	↑ 0	→ 0	↓ 0	→ 0	→ 0

DQKM



Effective
Trust Value

Chief Operating Officer
Exec Lead

Deputy Chief Operating Officer
Owner/Lead

National
Reported To

SOF / CCG
Source

Cancer: 104 Day Breaches

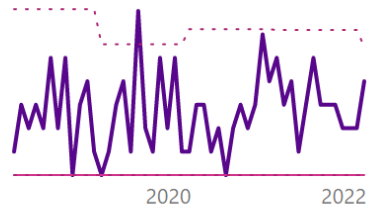
Target: **0**

Attribute	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
Performance Value	↑ 5	↓ 3	↑ 4	↓ 1	↑ 3	↑ 5	↓ 3	→ 3	→ 3	↓ 2	→ 2	→ 2	↑ 4

DQKM

April 2022

There were 4 x 104 day breaches in month.
The breach reasons for these were as follows : - patients had complex pre-operative pathways with delays due to being 'not fit to list'. they both needed a considerable amount of pre-op diagnostic testing.
One patient cancelled and DNA a number of appointments which caused considerable delays.



Effective
Trust Value

Chief Operating Officer
Exec Lead

Divisional Manager Gynaecology
Owner/Lead

National
Reported To

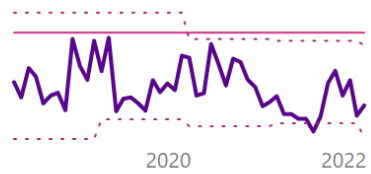
External
Source

All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (After Re-allocation)

Target: >=85%

Attribute	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
% Performance	34.21%	20%	20%	16.13%	16.22%	6.06%	18.18%	44.83%	54.55%	34.78%	47.06%	18.75%	26.92%
Denominator	19	10	10	15.5	18.5	16.5	16.5	14.5	11	11.5	8.5	16	13
Numerator	6.5	2	2	2.5	3	1	3	6.5	6	4	4	3	3.5

DQKM



Effective
Trust Value

Chief Operating Officer
Exec Lead

Divisional Manager Gynaecology
Owner/Lead

National
Reported To

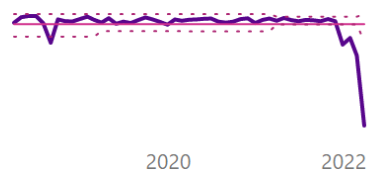
CCG
Source

Cancer: 2 Week Wait

Target: >= 75%

Attribute	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
% Performance	95.71%	97.92%	96.2%	95.32%	96.42%	96.06%	95.33%	97.04%	95.31%	76.65%	81.91%	67.87%	11.9%
Denominator	280	289	342	299	279	279	300	338	277	257	293	305	294
Numerator	268	283	329	285	269	268	286	328	264	197	240	207	35

DQKM



Effective
Trust Value

Chief Operating Officer
Exec Lead

Divisional Manager Gynaecology
Owner/Lead

National
Reported To

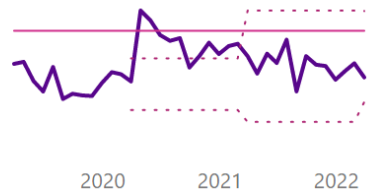
CCG
Source

Cancer: 28 Day Faster Diagnosis

Target: >= 75%

Attribute	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
% Performance	64.12%	56.72%	65.18%	61.24%	71.12%	49.12%	64.14%	60.5%	59.93%	54.1%	57.91%	61.07%	55.1%
Denominator	262	305	336	307	232	397	290	362	287	305	297	298	314
Numerator	168	173	219	188	165	195	186	219	172	165	172	182	173

DQKM



Effective
Trust Value

Chief Operating Officer
Exec Lead

Divisional Manager Gynaecology
Owner/Lead

National
Reported To

SOF / CCG
Source

Cancer: 31 Days from Diagnosis to 1st Definitive Treatment

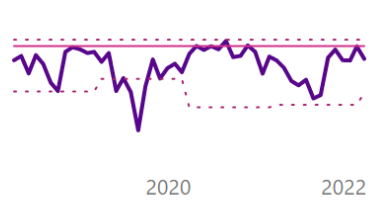
Target: >=96%

Attribute	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
% Performance	84.380%	78.57%	68%	64.52%	68.97%	54.05%	56.76%	86.67%	93.1%	84.62%	84.380%	95.65%	85.71%
Denominator	32	28	25	31	29	37	37	30	29	26	32	23	21
Numerator	27	22	17	20	20	20	21	26	27	22	27	22	18

DQKM

April 2022

The KPI position for April 2022 is currently 86% against target of 96%. There has been a slight reduction in the percentage against target. This KPI has been impacted by the delay in patients being seen as part of the 2 week wait pathway. Improvement is expected in May 2022



Effective
Trust Value

Chief Operating Officer
Exec Lead

Divisional Manager Gynaecology
Owner/Lead

National
Reported To

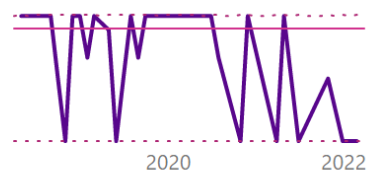
CCG
Source

Cancer: 62 Day Screening Referrals (Percentage)

Target: >=90%

Attribute	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
% Performance	0%	100%		0%				50%		0%		0%	
Denominator	1	0.5	0	0.5	0	0	0	2	0	1	0	1	0
Numerator	0	0.5	0	0	0	0	0	1	0	0	0	0	0

DQKM



Effective
Trust Value

Chief Operating Officer
Exec Lead

Divisional Manager Gynaecology
Owner/Lead

National
Reported To

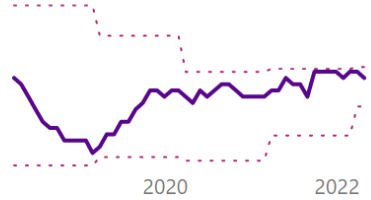
CCG
Source

Intensive Care Transfers Out (Rolling 12 Months)

Target: (Blank)

Attribute	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Performance Value	12	14	13	13	11	15	15	15	15	14	15	15	14

DQKM



Effective
Trust Value

Medical Director
Exec Lead

Deputy Medical Director
Owner/Lead

Local
Reported To

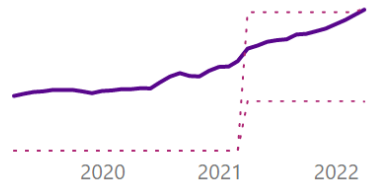
Trust
Source

Overall size of Elective Waiting List

Target: (Blank)

Attribute	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
Performance Value	10884	11198	11609	11782	11877	12389	12458	12736	13017	13481	13945	14461	15027

DQKM



Effective
Trust Value

Chief Operating Officer
Exec Lead

Divisional Manager Clinical Sup…
Owner/Lead

National
Reported To

SOF
Source

Proportion of patient activity with an ethnicity code

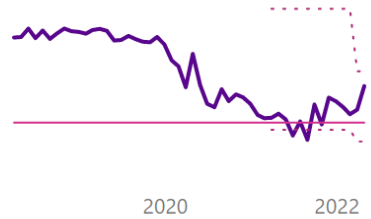
Target: >=96%

Attribute	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
% Performance	96.28%	96.1%	95.59%	96.03%	95.45%	96.58%	95.94%	96.8%	96.68%	96.49%	96.27%	96.41%	97.16%
Denominator	15151	16178	15200	14120	15339	14525	15273	13116	14184	13606	15244	13938	15695
Numerator	14588	15547	14529	13560	14641	14028	14653	12696	13713	13128	14675	13438	15250

DQKM

February 2022

Although the Trust continues to meet this target there is an ongoing focus to ensure a patients ethnicity is recorded. The main challenge relates to increases in first attendance virtual appointments and fewer contacts with administrative staff prior to the patient attending.



Effective
Trust Value

Chief Operating Officer
Exec Lead

Divisional Manager Gynaecology
Owner/Lead

National
Reported To

SOF
Source

A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge

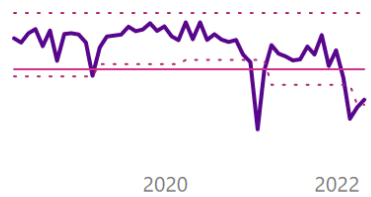
Target: >= 95%

Attribute	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
% Performance	96.67%	96.37%	95.95%	96.06%	97.43%	96.58%	98.64%	95.36%	97.02%	94.11%	89.73%	90.94%	91.75%
Denominator	1021	1073	1036	989	971	1052	883	969	1039	1086	1139	1038	1043
Numerator	987	1034	994	950	946	1016	871	924	1008	1022	1022	944	957

DQKM

May 2022 The gynaecology division has reached 92% against a target of 95% for this KPI in May 2022 which shows a continuing improvement towards the target of 95%.

GED performance has continued to be affected by sickness within the clinical team and junior doctor team which has impacted on the number of breaches.



Experience
Trust Value

Chief Operating Officer
Exec Lead

Divisional Manager Gynaecology
Owner/Lead

National
Reported To

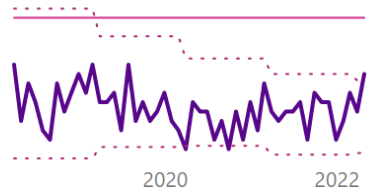
CCG
Source

Complaints: Number Received

Target: <= 15

Attribute	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Performance Value	4	5	5	6	2	7	6	6	2	4	7	5	9

DQKM



Experience
Trust Value

Director of Nursing & Midwifery
Exec Lead

Head of Audit, Effectiveness an…
Owner/Lead

Local
Reported To

Trust
Source

Diagnostic Tests: 6 Week Wait

Target: >= 99%

Attribute	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
% Performance	89.29%	93.16%	89.3%	90.95%	82.73%	69.65%	85.81%	87.25%	90.13%	83.08%	94.39%	88.32%	71.08%
Denominator	280	453	654	652	695	794	747	737	628	733	713	796	816
Numerator	250	422	584	593	575	553	641	643	566	609	673	703	580

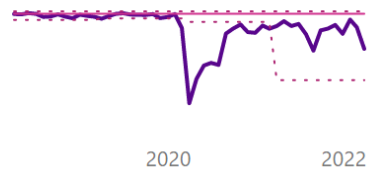
DQKM

Overall performance for each diagnostic area:
Diagnostic Waiting Times
Numerator 673, Denominator 713, Achievement 94.39%, Target 99.00%

Dexa: Numerator 35, Denominator 36, Achievement 97.22%
Non-Obstetric Ultrasound: Numerator 559, Denominator 573, Achievement 97.56%
Cystoscopy: Numerator 3, Denominator 5, Achievement 60.00%
Cystometry: Numerator 76, Denominator 99, Achievement 76.77%

KPI performance is at its highest since February 2020, demonstrating the impact of our Diagnostic recovery plan. Dexa and US scans have worked incredibly hard to maxmimise their performance with limited capacity. Cystometry capacity remains an issue, with a review with the Gynaecology division ongoing. Cystoscopy issues include patients not being fit for intervention, delays with pre-op investigation, and capacity issues.
Mitigating actions?: CSS Divisional Team continues to monitor and validate the PTL for Dexa, Gynae Imaging and Cystoscopy,
whilst the Gynaecology Divisional Team are monitoring and validating the PTL for Cystometry and RMU Imaging. To mitigate capacity issues, the department is looking to recruit 4.2 WTE sonographer vacancies. Similarly, the division is looking to recruit additional administrative capacity to monitor and support compliance.

When will target be achieved?: Q3
Why this timeframe?: National shortage of sonographers and radiographers. This is to allow for a gradual recruitment process.



Experience
Trust Value

Chief Operating Officer
Exec Lead

Divisional Manager Clinical Sup…
Owner/Lead

National
Reported To

CCG
Source

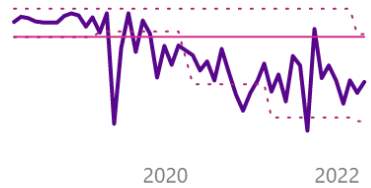
Friends & Family Test: A&E % positive

Target: **95%**

Attribute	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
% Performance	86.96%	81.25%	90.91%	88.89%	75%	96.67%	86.21%	88.89%	85.71%	80.77%	85.71%	83.08%	85.37%
Denominator	46	32	33	27	36	30	29	36	35	26	28	65	82
Numerator	40	26	30	24	27	29	25	32	30	21	24	54	70

DQKM

May 2022 positive responses have improved month of may 85.37% from 83% the department are requesting all patients to respond to the request for feedback



Experience
Trust Value

Director of Nursing & Midwifery
Exec Lead

Head of Nursing Gynaecology
Owner/Lead

National
Reported To

External
Source

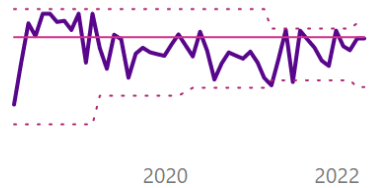
Friends & Family Test: In-patient/Daycase % positive

Target: **0.95**

Attribute	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
% Performance	90.35%	96.52%	85.45%	96.4%	94.53%	92.79%	90%	88.89%	96.4%	93.07%	92.23%	94.74%	94.74%
Denominator	114	115	110	111	128	111	130	108	111	101	103	114	95
Numerator	103	111	94	107	121	103	117	96	107	94	95	108	90

DQKM

May 2022 positive feedback for may 94.7% the division continue to strive to deliver outstanding patient care and experience all feedback is communicated to staff



Experience
Trust Value

Director of Nursing & Midwifery
Exec Lead

Head of Nursing Gynaecology
Owner/Lead

National
Reported To

External
Source

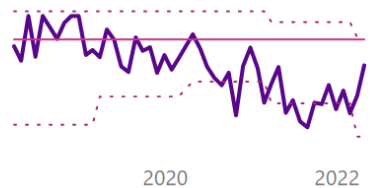
Friends & Family Test: Maternity % positive

Target: **95%**

Attribute	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
% Performance	89.12%	79.35%	82.03%	77.5%	76.28%	81.52%	81.2%	85.27%	80.14%	84.09%	79.28%	83%	89.47%
Denominator	147	155	128	160	156	184	133	129	146	132	111	100	95
Numerator	131	123	105	124	119	150	108	110	117	111	88	83	85

DQKM

May 2022 The service is still under some restrictions due to the COVID pandemic which are impacting on women experience, we are now allowing a second birth partner for delivery and on the postnatal ward. The Matrons and Managers are monitoring live patient feedback on power BI and can feedback live to displeased comments. Staffing has been a pressure but is improving and recruitment has taken place with an expected start date of October 22



Experience
Trust Value

Director of Nursing & Midwifery
Exec Lead

Head of Midwifery
Owner/Lead

National
Reported To

External
Source

Digital.Information Data Health Check

All Denominators outside of LCL have been reviewed and accepted as correct

Exec Lead	KPI	Current Month Reported	Target	KPI Meeting Target	Denominator Check
Chief People Officer	Clinical Mandatory Training Compliance	May 2022	>= 95%	No	LCL Breached

KPI Lineage

Metric Description	WE SEE	Board	FPBD	Quality	PPF	Family Health Division	CSS Division	Gynaecology Division	Maternity Clinical	Neonates Clinical (MDT)
18 Week RTT: Incomplete Pathway > 52 Weeks	Effective	Y	Y	Y						
A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge	Experience	Y	Y	Y				Y		
All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (After Re-allocation)	Effective	Y	Y	Y				Y		
Cancer: 104 Day Breaches	Effective	Y	Y	Y				Y		
Cancer: 2 Week Wait	Effective	Y	Y	Y				Y		
Cancer: 28 Day Faster Diagnosis	Effective	Y	Y	Y			Y	Y		
Cancer: 31 Days from Diagnosis to 1st Definitive Treatment	Effective	Y	Y	Y				Y		
Cancer: 62 Day Screening Referrals (Percentage)	Effective	Y	Y	Y				Y		
Clinical Mandatory Training Compliance	Workforce	Y		Y	Y					
Complaints: Number Received	Experience	Y		Y						
Diagnostic Tests: 6 Week Wait	Experience	Y	Y					Y		
Financial Sustainability Risk Rating: Overall Score	Efficient	Y	Y							
Flu Vaccine Uptake Trustwide	Safety	Y	Y	Y	Y					
Friends & Family Test: A&E % positive	Experience	Y		Y				Y		
Friends & Family Test: In-patient/Daycase % positive	Experience	Y		Y				Y		

KPI Lineage

Metric Description	WE SEE	Board	FPBD	Quality	PPF	Family Health Division	CSS Division	Gynaecology Division	Maternity Clinical	Neonates Clinical (MDT)
Friends & Family Test: Maternity % positive	Experience	Y		Y					Y	
Infection Control: Clostridium Difficile	Safety	Y		Y						
Infection Control: MRSA	Safety	Y		Y						
Intensive Care Transfers Out (Rolling 12 Month)	Effective	Y		Y						
Mandatory Training Compliance	Workforce	Y		Y	Y					
Neonatal Deaths per 1000 live Births	Safety	Y				Y				Y
Never Events	Safety	Y		Y						
NHSE / NHSI Safety Alerts Outstanding	Safety	Y		Y					Y	
Overall size of Elective Waiting List	Effective	Y					Y	Y		
Proportion of patient activity with an ethnicity code	Effective	Y	Y					Y		
Serious Untoward Incidents: Number of SUI's reported to CCG within agreed timescale	Safety	Y		Y			Y			
Serious Untoward Incidents: Number of SUI's with actions outstanding	Safety	Y		Y			Y	Y		
Serious Untoward Incindents: New	Safety	Y					Y	Y		
Serious Untoward Incindents: Open	Safety	Y		Y						
Sickness	Workforce	Y		Y	Y					
Turnover	Workforce	Y			Y					
Venous Thromboembolism (VTE)	Safety	Y		Y						

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	***22/23/077c***		**Date: 07/07/2022**	
Report Title	**Standalone Site - Update on Quality and Safety Risks**			
Prepared by	***Jennifer Huyton, Head of Strategy and Transformation***			
Presented by	***Lynn Greenhalgh, Medical Director***			
Key Issues / Messages	**To update the Trust Board on the actions taken to mitigate quality and safety risks on Crown Street as a standalone site and to note the residual level of risk remaining.**			
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 actions taken to mitigate quality and safety risks and to note the residual level of risk which remains. The Board are asked to note the proposed reporting of this going forward to ensure there is clear sight on remaining risks and their impacts.			
Supporting Executive:	**Lynn Greenhalgh, Medical Director** **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* 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	Comment:
Link to the Corporate Risk Register (CRR) – CR Number:	Comment:

REPORT DEVELOPMENT: N/A

EXECUTIVE SUMMARY

Despite investment in mitigations at the Crown Street site, there remain significant structural risks in place meaning that even after all planned mitigations are in place, provision of Liverpool Women's services from the current Crown Street site will remain as no longer clinically sustainable, as first formally declared in 2014.

A paper was presented to the Trust Board in March 2022 detailing the primary risks which arise as a result of the Trust's isolated position and current configuration of services across Liverpool. This paper provides an update on progress made towards reducing risks where possible, as well as the ongoing impact of those risks. Progress includes:

- Increased partnership working with Liverpool University Hospitals NHS FT (LUHFT) and Liverpool Heart and Chest Hospital NHS FT (LHCH)
- Establishment of new diagnostic imaging services on site
- Progress towards delivering further imaging services as well as physiological testing services on the Crown Street site.

The Board is asked to note the progress made, the risks that remain and key data in relation to the impacts of the standalone status of the Trust.

MAIN REPORT

1. Introduction and Context

In March 2022, a report was provided to the Trust Board which detailed a range of 'deficiencies' experienced by the Trust as a result of the configuration of services in Liverpool, i.e. provision of women's and neonatal services from a site isolated from adult acute services. The report highlighted the impact of, and risk related to each of these deficiencies, noted the current 'clinical workarounds' in place currently to reduce risk, future planned workarounds and residual risk that cannot be further mitigated while services remain at the Crown Street site.

The purpose of this paper is to provide the Board with an update regarding the ongoing impact of these clinical risks, as well as progress made in delivering planned mitigations.

2. Update on Risks, Mitigations in Place and Planned, and Residual Risk

A detailed table listing the primary identified risks, mitigations (actual and planned) and the subsequent residual risk was presented to the Trust Board in March 2022. Risks, status and progress made towards mitigation are detailed in the table below:

Risk	Status	Progress
Lack of ITU	This risk cannot be fully mitigated and remains high. Pressures within the regional ambulance service exacerbate this risk due to increased risk of delayed transfers.	LUHFT Partnership working groups in maternity, gynaecology and anaesthetics have been established with a view to formalising pathways for planned and unplanned care and underpinning by SLA. This will improve reliability of current arrangements but will not mitigate risk. A telemedicine pilot has been implemented to provide additional support for pregnant

		women on ITU at the Royal Liverpool Hospital.
Lack of Onsite 24/7 Transfusion Laboratory and Other Laboratory Diagnostics	This risk can be partially mitigated in an efficient way but cannot be fully mitigated. The risk is currently high and will remain significant after mitigations are implemented.	Delays have been experienced in the implementation of 'remote issue' technology for blood products, due to problems achieving integration between IT systems (managed by external suppliers). However, this issue has now been resolved and implementation is anticipated within the next 12 weeks. Once implemented, this will reduce the time it takes to receive blood products in the event of major haemorrhage, thus partially reducing the risk to patients. Work is continuing to implement a 24/7 transfusion laboratory on site, with reconfiguration of estate now anticipated by March 2023. This project has good engagement from partners Liverpool Clinical Laboratories but remains highly challenging to deliver due to national workforce shortages within laboratory staff groups.
Lack of access to diagnostics (imaging): • **CT** • **MR** • **IR**	Current risk remains high but will be largely (but not fully) mitigated once the CDC is fully operational. There will remain a significant risk in respect of workforce.	Construction work for permanent CT and MR facilities is progressing well with completion anticipated on 16 December 2022. The services are planned to 'go-live' from January 2023. The Trust is working through a range of partnership options for the operation of both imaging facilities. Workforce recruitment remains a significant risk with a national shortage of suitable radiographers. The Trust is progressing with an insourcing solution to address this in the short term. A mobile CT scanner has been installed on site as part of the Community Diagnostic Centre (CDC) Programme and has been operational since March 2022. Liverpool Women's outpatients are able to access the scanner and the additional capacity has positively impacted waiting times. Access for Liverpool Women's inpatients who are ambulant is anticipated shortly, with LUHFT clinicians recently agreeing to provide reporting for this group of patients.

Lack of access to diagnostics (pre-operative testing, peri-operative medicine, pre-hab)	This risk can be partially mitigated in an efficient way but cannot be fully mitigated. The current risk is significant but will be mitigated once the CDC is fully operational. There will be a significant remaining risk re workforce.	Good progress has been made towards implementation of respiratory testing facilities at the Crown Street site, in partnership with Liverpool Heart and Chest Hospital (LHCH). 'Go-live' is anticipated from August 2022. Implementation of cardiology services is also progressing through the CDC Programme and is anticipated later in the calendar year.
Lack of access to other adult acute specialties and lack of access to urgent/acute clinical support, including: • **Cardiac arrest team** • **Medical on-call** • **Surgical on-call**	This risk cannot be fully mitigated and remains high.	Increased access to theatre sessions at the Aintree site for complex gynaecology surgery has been secured through the LUHFT/LWH Partnership board. A Placenta Accreta team has been formed at LWH. A LWH Task and Finish group recommends that the diagnosis of placenta accreta cases for LWH patients will remain on site. Delivery of these patients should be a networked approach with the more complex cases being referred to St Mary's and the lower risk patients being delivered at LWH. Regionally the Placenta Accreta network is being established with a LWH consultant playing a leading role. The North West Maternal Medicine Network came into existence as of July 2022. LWH is a maternal medicine centre and hopes to go live with this imminently after the appointment of a MDT coordinator.
Lack of access to clinical support services: • **OT** • **Respiratory Physio** • **Dietetics** • **SALT** • **Pain service** • **Psychology**	This risk cannot be fully mitigated and remains significant.	The LUHFT Partnership Board will establish a working group to review arrangements for access to therapies and other caliceal support services., This has not yet taken place.
Lack of access to obstetric, gynaecological and maternity care for women on non-LWH sites	This risk cannot be fully mitigated and remains high.	The LUHFT/LWH Partnership board has been established with underpinning working groups responsible for reviewing and formalising arrangements for both planned and unplanned shared care between sites. The Complex Gynaecology and Maternity

		groups have been established and are now active with Terms of Reference agreed.

As previously reported to the Trust Board, the range of clinical workarounds and mitigations previously implemented and in progress towards delivery have required significant capital and revenue investment and as such impact the Trust's financial position. Some of the workarounds are inherently inefficient and carry the risk of difficulty in securing staff.

Once the Community Diagnostic Centre is fully open and the transfusion laboratory operational, it is judged that **all possible structural mitigations will have been put in place or are planned at Crown Street**. This view was corroborated by the Northern England Clinical Senate, following their independent review of the Trust's Counterfactual Case in March 2022.

3. SI Reporting

A review of all serious incidents to date over the last five years is underway, to identity incidents where the current configuration of services was either a root cause or a contributory factor. This review will be completed in July 2022 and the outcome will be reported to the Trust Board. It is known that there have been a number of recent incidents recorded which related to but were not solely due to the configuration of services. These incidents will be reported as part of the 5-year review.

Additional mandatory processes have now been implemented within the Trusts risk reporting system to ensure that for all future incidents, any issues relating to the current configuration of services are highlighted. This will begin to provide live data. Separately, the Trust has requested that commissioners record and investigate all transfers of adult patients to critical care as SIs. At the time of writing, the Trust is awaiting a formal response from commissioners on this matter.

4. Partnership Board and Impact on Other Sites

As reported previously to the Trust Board, a Partnership Board has been established with LUHFT, as recommended as part of the Single Issue Quality Surveillance Group action plan 2020. It has an agreed Terms of Reference, led by the Medical Directors of both organisations, with other executive level input. Working groups have been established at a specialty level which will feed into the Partnership Board. These will cover Complex Gynaecology, Maternity, Anaesthetics, Genomics and Digital. At the time of writing, the Maternity and Complex Gynaecology groups are now active.

The overall Partnership Board is progressing well. At the most recent meeting it was agreed that the two organisations would explore partnership working in relation to the Community Diagnostic Centre (in particular imaging services). LUHFT involvement with the Future Generations Programme was also discussed, covering the future use of the Crown Street site for NHS services, the impact of reconfiguration of LUHFT services on the programme and establishing an 'assumptions attesting forum' to assist in the development of LWH's future model of care.

The partnership has also been successful in securing theatre slots for complex gynaecology surgery at the Aintree site.

5. Independent Clinical Review of Acute and Specialist Services in Liverpool

Cheshire and Merseyside Integrated Care System (C&M ICS) is commissioning an independent review of acute and specialist care in Liverpool. The review was requested by NHS England/Improvement. Liverpool has a complex health and care system, with seven acute and specialist provider trusts, all of which provide good care but are challenged by service duplication, variation in quality and outcomes and experiences of care. Liverpool hospitals provide acute services to a large population from across Merseyside. Tertiary services extend to patients in Cheshire, Merseyside, Isle of Man, North Wales and nationally.

One Liverpool, the city's health and care strategy published in 2019, pledged that the system would come together for transformational change in Liverpool-based hospital services and infrastructure. Currently there are a number of service change programmes in progress to integrate acute and specialist services. However, this review will go further in recommending a long-term optimum care model for all acute and tertiary services delivered in Liverpool.

The review will also incorporate ways to maximise education, research, and innovation and to enhance the reputation of the Liverpool health and care system as a place for clinicians to live and work. Primary care, community, social care and voluntary sector partners will be key stakeholders in the review, recognising the interdependencies across all care settings, opportunities to deliver more care closer to home and the benefits of digital innovation.

The process to commission the independent review is currently underway.

The NHS organisations within scope of the review are:

- Alder Hey Children's NHS FT
- Clatterbridge Cancer Centre NHS FT
- Liverpool Women's NHS FT
- Liverpool Heart and Chest NHS FT
- Liverpool University Hospitals FT
- Mersey Care NHS FT
- The Walton Centre NHS FT

Stakeholders involved with the review include:

- General Practice, including the Local Medical Committee and the city's ten Primary Care Networks (PCNs)
- Liverpool City Council
- Cheshire & Merseyside Acute & Specialist Trusts provider collaborative and Cheshire and Merseyside out of hospital collaborative

A Terms of Reference for the review has been made available in the Supporting Document folder in Admin Control.

6. Key Statistics and Reporting

As part of the remit of the Partnership Board, the Business Intelligence and Clinical teams have worked together to produce a dashboard to enable both Trusts to readily access key data pertaining to the configuration of services, for example, the number of pregnant women at the Royal or Aintree, transfers and blood transfusion data. The dashboard will be further refined and developed over the coming months.

7. Clinical Case and Business Case

The Trust continues to work on the clinical case for change, including the counterfactual case, and have shared these with a number of key stakeholders. There is strong support for the clinical case confirmed from a broad range of stakeholders across the region.

8. Conclusions and Next Steps

The Board is asked to note the recent progress that has been made in relation to further reducing risk on the Liverpool Women's site. This includes the CDC and diagnostics including MRI and CT, 24/7 transfusion laboratory and effective partnership working with both commissioners and multiple provider organisations.

However even once all mitigations are implemented, there will still remain an unacceptable level of clinical risk due to the isolated nature of the Crown Street site. This has an ongoing impact on the demands on and workload of clinicians, both based at the Trust and at other locations, as well as quality, risk to outcomes and both patient and staff experience. In turn this presents a significant risk to the Trust's recruitment and retention.

The Board is asked to note the risks that remain and key data in relation to the impacts of the standalone status of the Trust.

Trust Board

COVER SHEET

Agenda Item (Ref)	*22/23/77d*		Date: 07/07/2022	
Report Title	**Integrated Governance Assurance Report Quarter 4**			
Prepared by	***Phil Bartley, Associate Director of Quality and Governance***			
Presented by	***Phil Bartley, Associate Director of Quality and Governance***			
Key Issues / Messages	This report provides information of oversight and assurance monitoring of Integrated Governance and highlights key risks to the Trust.			
Action required	Approve ☐	Receive ☐	Note ☒	Take Assurance ☒
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable):			
	For Decisions - in line with Risk Appetite Statement – Y *If no – please outline the reasons for deviation.*			
	It is requested that the members of the Board review the contents of the paper and take assurance that there are adequate governance processes in place and the positive progress in managing risk has been made with Senior Management having oversight of such risks.			
Supporting Executive:	***Marie Forshaw, Director of Nursing and Midwifery***			

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

Link to the Board Assurance Framework (BAF) / Corporate Risk Register (CRR)	
Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* 3.1 Failure to deliver an excellent patient and family experience to all our service users 5.2 Failure to fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership	Comment:
Link to the Corporate Risk Register (CRR) – CR Number:	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Quality Committee	June 22	Assoc. Director of Quality	The Committee noted that whilst they were assured by the demonstration of compliance activity, the report could be further strengthened through enhanced triangulation. It was noted that the Divisions were being asked to support this development and would feed into future reports.

EXECUTIVE SUMMARY

The following Integrated Governance Assurance report covers Quarter 4 of 2021/22. The report is part of the regular reporting schedule of the Trust to ensure that there is oversight and assurance monitoring of Integrated Governance across the Trust.

This report continues to be revised to ensure it captures the key risks and achievements for the Trust, clearly identifying areas for improvement documenting plans in place to address such issues.

The Board is asked to note that this report does not reflect the associated risks in relation to the Trust's Future Generations Strategy. Work is on-going between governance, patient experience, finance & transformation & strategy which may support further additions to this paper throughout 2022/23 and beyond in relation to this piece of work.

MAIN REPORT

1. INTRODUCTION

This integrated governance report is a quarterly integrated review of quality governance and the standard of care at Liverpool Women's Hospital. The intention of the report is to complement the monthly quality governance dashboards and performance reports by providing a longer term, thematic analysis of key issues and providing an opportunity for wider dissemination of learning.

2. ANALYSIS AND TRIANGULATION OF KEY RISKS ACROSS THE TRUST

The report has clearly identified themes (both positive and negative) within incidents and complaints and the triangulation of these across the divisions. These are outlined as follows.

2.1 Positive Findings

- The Trust has now established a Fit Mask Testing hub and system of recall for retesting
- The Patient Experience Matron (PEM) role continues to develop. They have been scoping out the new role of PEM and establishing the role within the Trust and forging positive relationships multiple external stakeholders.
- The PEM is working with the Patient Experience Team and operational teams more widely, monitoring themes and trends triangulating with incidents, claims, complaints etc. Any actions taken in response are recorded to support lesson learning ensuring improvements are made.

- In this financial year, the Trust has agreed settlements totalling £20,215,002. This is considerably reduced when you consider the previous financial year's settlements which totalled £81,221,851.91.
- 7 Clinical Audit projects have been selected for presentation at Health Care Conferences UK (HCCUK) 'Clinical Audit Leadership for Improvement Summit 2022'. A large volume of clinical audit abstracts were submitted nationally this year, with Liverpool Women's being in the top third of all of those received.
- Our Quality Improvement Framework has now been approved and shared Trust wide. Work is on-going to make this work a reality and showcasing improvements and outstanding pieces of work trust wide. Progress on this will reported in the Q1 IGR considering the cessation of our work with MIAA.

1.2 Triangulation of key risks for the Trust as outlined in this report

Division	Key risks noted for improvement	What are we doing to improve the position both short and long term	Committee/division/person responsible
Trust Wide	A key area of risk continued to be within the investigations cause group relating to blood sampling errors There was a significant level of rejected samples from the laboratory. Although the number of incidents in relation to this has reduced compared to the last quarter, there is still cause for concern in relation to this on-going issue.	Each area is have undertaken a significant piece of work in relation to this area which this committee is already sighted on. Reports continue to be provided to this committee and the Safety & Effectiveness Sub Committee as recent as June 22. Due to the continued risk, this piece of work is now under the oversight of the pathology steering group which the committee are sighted on.	All areas are responsible overseen by the Pathology Steering Group
Trust wide	A gap has been identified in managers, supervisors, team leaders' health and safety legal duties and responsibilities knowledge	A set of health and safety related questions for all staff grades are being created to ascertain interview candidates' knowledge of H&S law and duty, this will assist in identifying any additional health and safety training needs H&S Manager is to design suitable and sufficient training media for all new managers, supervisors, team leaders in additional to corporate induction health and safety training The Governance team are currently reviewing their approach	HR Interview Panels Health and Safety Manager Governance Chief Operating Officer

		to Health & Safety with new roles in the process of being created to support this agenda. Further progress will be reported in the Q1 IGR.	
Trust wide	A new requirement from CNST requires the Trust to review its scorecard at least twice in the MIS reporting period at either a Board or Directorate Level Meeting. The Trust is reviewing its approach to CNST and the use of the Trust Scorecard and will update its practice accordingly being able to evidence the triangulation of data in relation to incidents, claims and complaints.	The Associate Director of Quality & Governance is currently working with the Trusts legal team to ensure that a programme of training is delievered to its staff so they have the skills and knowlegde in realtion in the Scorecard to support them in relation to the triangulation of data for incidents, claims and complaints. This is expected to be delivered in Q2. This piece of work has been tabled for discussion at Safety & Effectivness Sub-Committee, a further update will be provided in the Q1 IGR report as to how this work is being managed trust wide in the absence of any formal training ensuring consistency across the divisions. Furhermore, work was also on-going between governance, the divisonal safety leads, legal, finance team and NHSR to establish a robust process between teams in relation to CNST more generally. This work will progress in Q1 with the CNST oversight meeting due to re-commence. Further progress will be reporting within future additions of this report.	Associate Director of Quality & Governance Deputy Director of Finance CNST leads Safety leads Legal
Trust Wide	Medication incident reporting continues to decrease across the Trust.	The medication incident reporting culture across the hospital needs to improve and the Medicines Safety Group (MSG) will develop their workplan around this key theme. The group has recognised the need for a Lead Medicines	Medicines Management Safety Group

		Safety Nurse/Midwife to work across the hospital and a business case will be developed for this key role.	
Trust wide	Telephony contact issues continue to be a trend throughout the complaints and PALS concerns raised. Contact issues are reported on both clinical and non-clinical lines, with issues contacting the clinical lines for advice and guidance the most significant risk. The Patient Experience Department have previously requested 4 weekly reports detailing the call performance statistics from the operational leads of the Divisions to monitor the scope of the issue. There reports are yet to be provided or any assurance the call performance is being monitored and actioned has not been provided.	This is to be reported on as a separate agenda item during this Quality Committee Meeting	Patient Experience Team and divisions trust wide.
Clinical Audit & Effectiveness	System for recording all Clinical Audit activity	Considering reverting back to previous system using predominantly Microsoft Excel (which worked well) from current Audit Module on Ulysses which has been trialled for over a year, due to the system not providing the required assurance. Consideration to be given as to how Meditech expanse can support this work going forwards.	Safety & Effectiveness Sub Committee Quality Improvement Group Associate Director of Governance and Quality Head of Audit & Patient Experience Deputy Head of Clinical Audit & Effectiveness
Trust wide	The drive for QI needs to be more evident within the Trust divisions, divisions require support to enable them to plan how best to achieve this and to use the Quality Function	Due to cessation of our work with MIAA, a full update will be provided in the Q1 IGR about plans to take our QI journey forward as part of a collaborative	Associate Director of Governance and Quality Interim Associate Director Dianne

	within the trust as a source for information, advice, and guidance to support the further development and implementation of their division level plans. Considering the themes within our incidents and complaints, opportunities for QI have been missed and greater collaboration is required to improve our approach to QI and to enable a better and safer patient experience.	trust approach.	Brown Al divisions & areas within the trust

The detailed underpinning information for the identification of these key themes and risks can be found in the following appendices (key headlines identified underneath for each area):

Appendix 1 – Incidents

Key Headline(s): A key area of risk for Q4 was within the investigations cause group relating to blood sampling errors. There continues to be a significant level of rejected samples from the laboratory.

Appendix 2 - Medicines Management & Incidents

Key headline(s): Medication incident reporting continues to decrease across the Trust.

Appendix 3 – Health and Safety

Key headline(s): The Trust has now established a Fit Mask Testing hub and system of recall for retesting

Appendix 4 - Complaints, PAL's & PALS +

Key headline(s): Telephony contact issues continue to be a trend throughout the complaints and PALS concerns raised. Contact issues are reported on both clinical and non-clinical lines, with issues contacting the clinical lines for advice and guidance the most significant risk. The Patient Experience Department have previously requested 4 weekly reports detailing the call performance statistics from the operational leads of the Divisions to monitor the scope of the issue. There reports are yet to be provided or any assurance the call performance is being monitored and actioned has not been provided.

Appendix 5 - Clinical Effectiveness and Audit

Key headline(s): The Patient Experience Matron (PEM) has been scoping out the new role of PEM and establishing the role within the Trust and linking with key stakeholders

Appendix 6 - Claims cases and Inquests

Key headline(s): In this financial year, the Trust has agreed settlements totalling £20,215,002. The previous financial year's settlements totalled £81,221,851.91.

Appendix 7 – Patient Experience

Key headline(s): The Patient Experience Matron (PEM) has been scoping out the new role of PEM and establishing the role within the Trust and linking with key stakeholders

Appendix 8 – Quality Improvement

Key headline(s): Our Quality Improvement Framework was approved at February Quality Committee

Appendices made available to Board members via the 'Supporting Documents' folder in Admin Control.

3. RECOMMENDATION

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

Trust Board

Cover Sheet

Agenda Item (Ref)	**22/23/077e**			**Date: 07/07/2022**
Report Title	**Guardian of Safe Working Hours (Junior Doctors) Q4 / Annual Report**			
Prepared by	***Kat Pavlidi, Guardian Safe Working Hours***			
Presented by	***Kat Pavlidi, Guardian Safe Working Hours***			
Key Issues / Messages	**GSWH Annual Board Report, 2021 - 2022**			
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/N ***If no – please outline the reasons for deviation.***			
	The Board is asked to read and note the assurances contained within 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)	Comment:
Link to the Corporate Risk Register (CRR) – CR Number:	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome

PPF	**16/5/22**	**MD**	**The Committee recommended the report to the Board**

EXECUTIVE SUMMARY

This report covers all of the above for the reporting period and relates to April 1st 2021 – March 31st 2022.

Under the 2016 T&Cs for doctors and dentists in training, there is a requirement for the Guardian of Safe Working Hours (GoSWH) to submit a quarterly report to a sub-board committee and an annual report to the Trust Board with the following information:

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

The Board is advised:

- Rota establishment continues to fluctuate throughout the year with 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 March 2022, with an exception during a two-week period over Christmas/New Year, there has not been a requirement to change working patterns due to the ongoing COVID situation
- Exception reports continue to be submitted; however, the Board should be advised that the old system of exception reporting (DRS), used until the 31st August 2021, is no longer available to view and therefore is no update on the number of reports submitted for the first two quarters of this year. The GoSWH and the HR lead, Rochelle Collins, are both looking to resolve this issue.

Introduction

The Trust received a full rotation for all doctors in training over 2021-2022. However, there is still a need to cover unexpected absences such as sickness and or isolation due to Covid symptoms, and therefore 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, as well as ANNPs.

As referenced in previous reports, the number of gaps requiring locum cover fluctuate throughout the year due the number of times the specialties rotate, maternity leave, long-term absences 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 shielding for pregnancy after 28 weeks as mandated by HEE.

Within this year, the number of shielding junior doctors due to medical or pregnancy reasons was 5 – one in Anaesthetics, and 4 in O&G.

During the Christmas/New Year period, there was a need to set up a back-up rota in O&G 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.

1. Work schedules

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. There have been steps taken to mitigate this for the oncoming August 2022 rotation.

2. Rota compliance

All junior doctor rotas are compliant with the 2016 T&Cs.

3. Staffing levels

The number of doctors available at the trust are at an overestablished rate by WTE, with the numbers within each service available in the table below. Despite this overestablishment, we are seeing increasing rota gaps, owing to sickness (both short and long-term), maternity leave, doctors taking time out of programme for training/other experience, and obtaining their CCT (completion of training).

Number of doctors in training (WTE):

Number of doctors in training (WTE):	Lead Employer					Locally employed				
Quarter	1	2	3	4	Average	1	2	3	4	Average
Anaesthetics	11.8	11.6	11.6	10.6	11.4	3	0	0	6	2.25
Neonates + ANNPs	17.6	17.6	17.6	18.2	17.75	Info on ANNPs not available				
O&G	43.8	49.2	50.2	49.4	48.15	3	3	2	1	2.25

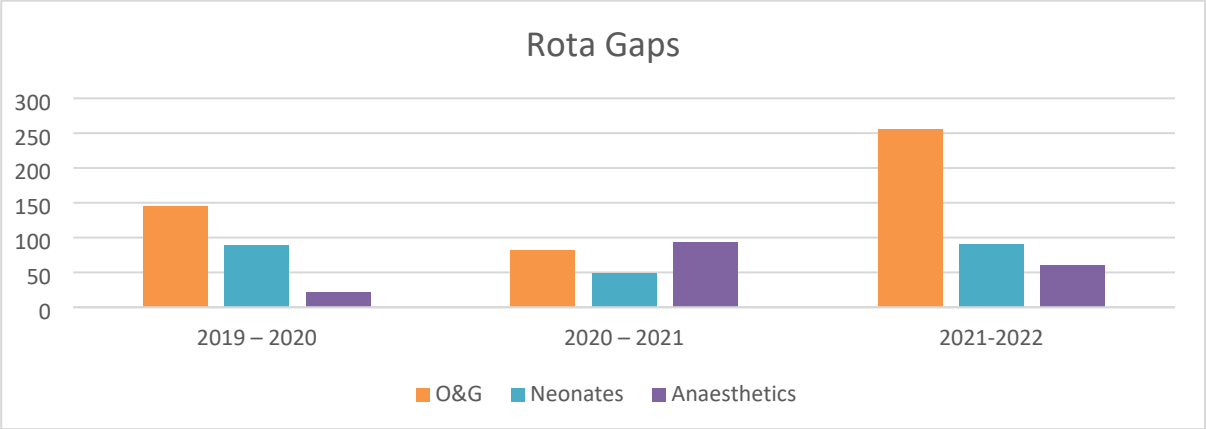
4. Rota gaps

Rota gaps total per quarter

Quarter	Anaesthetics	Neonates	O&G
Q1	10	10	54
Q2	3	17	53
Q3	6	30	59
Q4	42	33	90
Total	61	90	256

Total gaps per specialty over last 3 years

Service	2019-2020	2020-2021	2021-2022	% change
Anaesthetics	21	93	61	-34
Neonates	89	49	90	+84
O&G	145	82	256	+212



Agency locum cover and gaps unfilled

No agency locums were used within this last year, with the locums being taken from doctors in training in post at the time of the gap, and from the internal bank.

2 gaps within the O&G service went unfilled during the 4th quarter. 1 gap within the anaesthetic service went unfilled during the 2nd quarter.

Genetics

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

5. Exception reports and junior doctor forum

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

From the 1st September – 31st March 2022, exception reports were made on a new Allocate eRota system and are accurate and up to date.

There were 28 exception reports made, all from O&G trainees. Two were related to educational opportunities.

Period	Specialty	Grade	Reason	#exceptions	No: hours	Outcome
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
Q4	O&G	ST3	Hours and natural breaks	6	4	Payment for extra hour and TOIL
	O&G	ST1	Hours and natural breaks	1	1.5	TOIL

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

Outcomes have included both time off in lieu, as well as payment, as the latter being required more often due to low staffing levels during the day, where TOIL isn't able to be given.

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 in the exception reports received in 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.

Exception reporting is encouraged regularly by the GoSWH, but a trend is noted where doctors do not submit them. This is a national trend noted, with likely reasons being:

- A fear that doctors would be perceived as being inefficient
- Extra time ends up being useful due to training opportunities gained
- A feeling that nothing will get done about the problem
- A fear that doctors would be perceived as unprofessional
- Finishing or starting early on some days so extra time worked 'balances' out

The GoSWH has met with each batch of doctors within each specialty in the last 3 months to explain the process of exception reporting and encourage/increase the level of exception reports which will be monitored.

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

6. Fines

To date, the Guardian has not issued any fines in this annum.

7. Fatigue and Facilities Charter

Outlined within the 2016 Junior Doctors Contract, £30,000 was given to each trust by the BMA as part of their Fatigue and Facilities Charter, to enable improvements to rest facilities for Junior Doctors. This money has so far gone unused due to the lack of an appropriate space for the Mess.

Currently, the Junior Doctors Mess exists on the 2nd floor by the Genetics corridor and isn't utilised regularly.

The main reasons for this are due to the distance from the mess to clinical areas, as well as lack of some natural breaks available for doctors. In addition, the Neonatal and Anaesthetic service have their own break rooms in their departments, and those trainees use the Junior Doctors Mess less often for that reason.

A site for a new Mess has been found as of the beginning of 2022 and will be closer to all clinical areas, with the Junior Doctors being surveyed on what changes they wish to see for the Mess.

Other relevant data

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

Actions taken to resolve issues

1. Staffing

A multidisciplinary meeting has been set up to assess the rota cover within O&G in August 2022, to attempt to 'work smarter, not harder'. Attached to this report is one recommendation that will be discussed: a document outlining Tier 3 doctor staffing, and what steps can be taken to mitigate the risk of gaps in the incoming year.

2. Rota gaps

Doctors previously training at LWH have been asked to be part of the bank of locums, in addition to current trainees, with 2 doctors having covered several gaps especially in the last quarter.

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

3. Exception reporting

The GoSWH continues to work with Educational Supervisors on how to address exception reports, including specific timescales, in line with the T&Cs 2016. This will ensure all exceptions are responded to, resolved in good time, and escalated where necessary.

The Guardian is continuing to engage with junior doctors at their scheduled JD forum and continues to promote the use of the exception reporting system.

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.

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.

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

Finally, acknowledging that the number of rota gaps, although covered mostly in advance of the shift occurring, is increasing burnout rates. The Trust has appointed a Mental health and wellbeing champion, Professor Andrew Weeks, who has been available for staff to speak to, and regularly updates the Trust with supportive emails and advice, with the aim to relieve ongoing mental health problems.

The Committee is asked to understand that covering rota gaps as a locum are in addition to hours worked of compliant rotas. Therefore any extra sessions carried out are with prior agreement with the junior doctor, although this inevitably leads to an increase in the overall hours worked. The Committee are asked to understand that the GoSWH is concerned about this issue, as it could be deemed unsafe practice in the longterm with too many doctors working too many hours. There is a balance required, however, to cover gaps to ensure safe provision of care to patients. Frequent rota gaps being advertised is something that is being looked into to help mitigate this problem in the longterm.

Summary

The Board is advised:

- the number of gaps across O&G and Neonates has increased compared to 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 highcost agency locums wherever possible by using internal bank, doctors in training and ANNPs, however this is increasing levels of burnout amongst junior doctors.
- The complete 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 Committee that doctors in training are safely rostered and enabled to work hours that are safe and in compliance with their contract, but that the number of gaps is of very high risk, and is a concerning trend.

Recommendations:

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

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*22/23/077f*	Date: 07/07/2022		
Report Title	Learning from Deaths Quarter 4, 21/22			
Prepared by	Lidia Kwasnicka, Gynaecologist; Ai-Wei Tang, Consultant Obstetrician; Rebecca Kettle, Consultant Neonatologist and Chris Dewhurst, Deputy Medical Director.			
Presented by	Lynn Greenhalgh, Medical Director			
Key Issues / Messages	The Board is asked to review the contents of the paper and Take assurance that there is adequate processes and progress against the requirements laid out by the National Quality Board			
Action required	Approve ☐	Receive ☐	Note ☒	Take Assurance ☒
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable): N/A			
	For Decisions - in line with Risk Appetite Statement – Y *If no – please outline the reasons for deviation.*			
	The Board is asked to review the contents of the paper and Take assurance that there is adequate processes and progress against the requirements laid out by the National Quality Board			
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
Link to the Corporate Risk Register (CRR) – CR Number:	Comment: No

EXECUTIVE SUMMARY

This "Learning from Deaths" paper presents the mortality data for quarter 4, 2021/22 with the learning from the reviews of deaths from quarter 3 2021/22. The 'learning' can take some time after the death occurs due to the formal processes and MDT reviews that occur. This results in the learning being presented a quarter behind the data.

In quarter 4 there were the following deaths:

Adult deaths	**0**
Direct Maternal Deaths	**0**
Stillbirths	**9 (rate 5.0/1000 total births)**
Neonatal deaths	**8 inborn (rate 4.4/1000 inborn births) + 0 deaths from postnatal transfers**

The Annual data for 21/22 are below

Adult Deaths	**4**
Direct Maternal Deaths	**0**
Stillbirths (excluding TOP)	**4.9/1000 total births**
Stillbirths (incl. TOP)	**7.1/1000 total births**
Neonatal Deaths	**3.6/1000 deliveries (inborn)**

The stillbirth rate has increased at LWH since 2019/20. National ONS data demonstrates that the stillbirth rate has increased from 2020 to 2021 (3.9 to 4.2/1000 births) with the stillbirth rate now similar to the rate observed in 2018. A thematic review of stillbirths will be conducted in Q2 2022/23 when the learning from stillbirths in Q4 from 2021/22 will be available.

Neonatal deaths and stillbirths are now reported using a regional standardised template. These standardised templates are included in this report.

Lessons learnt from quarter 3 and actions taken are presented in this paper. Common themes from recent learning from deaths reviews include:

1. Importance of accurate growth plotting on fetal growth charts
2. Quality improvement programme to reduced unplanned neonatal extubation
3. Timely radiology provision out of hours for the neonatal unit.

The learning from deaths paper Q4 21/22 has been presented at May's Quality Committee. The Committee received positive assurance from the content of the report. The paper for the Trust board includes the same information but updated re the national ONS data for 2021 on stillbirths and final learning from the SI report relating to the adult gynaecology death reflecting non co-location with adult services.

Recommendation: It is it is requested that the members of the Trust 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 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.
- Specific recommendations
    - the monitoring and review of the stillbirth rate continues by the Family Health board, with a thematic review to be conducted with Q4 data and learning. Issues identified at the reviews and recommendations made will now be tracked through the Maternity Clinical Meeting
    - the monitoring and review of the neonatal mortality rate continues with an external review of mortality for extremely preterm infants to be available in Q2 2022-23.

MAIN REPORT

This is the quarter 4 2021/22 mortality report for adults, stillbirths and neonates. This report updates the Trust board regarding the systems and processes to review and learn from deaths of patients under our care. The report is part of the regular reporting schedule of the Trust to ensure that there is oversight and assurance monitoring of the mortality rates related to the clinical activity of the Trust. This is in accordance with recommendations by the National Quality Board and the Care Quality Commission. It outlines the work taking place operationally and being overseen by the Safety and Effectiveness Sub - Committee and Quality Committee. The paper also provides the evidence required for the Maternity Incentive Scheme (MIS), however this programme was paused during Q4 21/22, recommencing on May 6th 2022. Future reports will provide compliance against the evidential requirements for the MIS.

The data presented in this report relates to quarter 4 2021-22. The learning relates to deaths in Q3. This is due to the multidisciplinary review of deaths not occurring in the quarter when the death occurred. Additional data relating to mortality is presented in the embedded word document.

1 Adult Mortality

The data relating to adult mortality is pure data and is not standardised mortality data (such as SHMI) due to the low level of mortality numbers encountered and the complexity of the patients cared for by the Trust. The use of pure data and not standardised mortality rates has been previously agreed with the CCG as the Trusts approach to monitoring mortality rates.

1.1 Obstetric Mortality Data Q4

There were no direct maternal deaths (deaths within 42 days of delivery) in quarter 4.

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. In Q3, there was one death of a woman who died approximately 8 weeks after delivery. This case is subject to a Coronial investigation and, as per the requirements of the Ockenden review, a multiagency review has been initiated.

1.2 Gynaecology Mortality data Q4

There were no deaths within Gynaecology Oncology nor out of hospital deaths in Q3.

1.2.1 Learning from Gynaecology Mortality Q3

A Serious Incident investigation was conducted for a woman who died in Q2 2021/22. She had undergone debulking surgery for ovarian cancer and died 8 days later following a sudden deterioration due to an acute gastric dilatation and intra-abdominal haemorrhage. This is a rare complication of surgery but can also be related to other aetiologies. Learning from the review included;

- Ward round changed to 08:30 am rather than previously prescribed 10:30 to allow time for actioning and addressing clinical tasks, particularly in the unwell patients.
- Better communication with family should be addressed by senior team members at all levels, constant checking of understanding to resolve any unmet expectations.
- CT scans should be done in postoperative patients who had abdominal surgery, particularly those with delayed or unexpected recovery delays.
- Not being co-located with acute services contributed towards the decision making around requesting CT scans for patients on the LWH site.

2 Stillbirths

2.1 Stillbirth data

There were 9 stillbirths, excluding terminations of pregnancy (TOP) in Q4 2021/2022. This has resulted in an adjusted stillbirth rate of 5.1/1000.

STILLBIRTHS	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	TOTAL 2021/22
Total Stillbirths	3	6	4	7	4	2	4	6	3	7	4	6	56
Stillbirths (excluding TOP)	**3**	**3**	**2**	**7**	**3**	**1**	**3** (2 preg)	**5**	**2**	**4**	**0**	**5**	**38**
Births	639	672	696	692	695	684	655	665	622	659	561	595	7835
Overall Rate /1000 births	4.7	8.9	5.7	10.1	5.8	2.9	6.1	9.0	4.8	10.6	7.1	10.1	7.1
Rate (excluding TOP)/1000	**4.7**	**4.5**	**2.9**	**10.1**	**4.3**	**1.5**	**4.6**	**7.5**	**3.2**	**6.0**	**0**	**8.4**	**4.85**

Table 1 Stillbirth rates for 2021-22

The annual stillbirth rate for 2021-22 is higher than in previous years. (see fig 2 below). The NHS Long Term plan has set a target of reducing stillbirths by 50% by 2025. That would require England to reduce its stillbirth rate to 2.6 stillbirths per 1,000 births.

Provisional ONS data for 2021 demonstrates that the stillbirth rate rose to 4.2 stillbirths per 1,000 births from 3.9 stillbirths per 1,000 births in 2020, a 7.7% increase. The stillbirth rate is now similar to the rate observed in 2018. Women aged under 20 years had the largest percentage increase in stillbirth rates between 2020 and 2021, with the stillbirth rate rising from 4.4 stillbirths per 1,000 total births to 5.3 stillbirths per 1,000 births (a 20.5% increase).

Quarter	Rate 2019/2020	Rate 2020/2021	Rate 2021/2022
Q1	4.0	5.5	4.0
Q2	4.1	2.5	5.3
Q3	1.5	2.7	5.1
Q4	1.7	3.2	5.0
ANNUAL	2.9	3.4	4.9

Table 2: LWH Stillbirth rates by quarter in and year since 2019. NB The difference between 2020/21 and 2021/22 is not statistically significant, though it is statistically significantly increased when 2021/22 is compared with 2019/20

The provisional ONS data demonstrates that for the first time since 2014 stillbirth rates have shown a year-on-year increase. The rate for 2021 was the same as in 2017. It is thought likely that the increase in stillbirths in 2021 is related in some way to the COVID–19 pandemic. The nature of the link is not yet

clear, but may be due to the impact on maternity services of lockdowns and pressures on the NHS, or in some cases may be the direct effects of the COVID-19 virus on pregnant mothers or on the placenta

The 44% increase from 2.4 to 4.9 per 1000/births at LWH is greater than the 7.7% increase seen nationally. Caution must be observed when comparing these data as the small numbers at LWH will have a larger effect on the percentage increase. It may be however that the underlying cause for the national increase in stillbirths has had a greater impact on the local population given its degree of deprivation.

National data is available from the NHS trusts that submit data to the CHKS group for benchmarking. CHKS data for Jan – Dec 2021 are below. These data demonstrate compare trusts with >7000 births demonstrating that LWH stillbirth rates are within the expected range when compared with peers (range is from 3.1 to 5.6 stillbirths/1000 births).

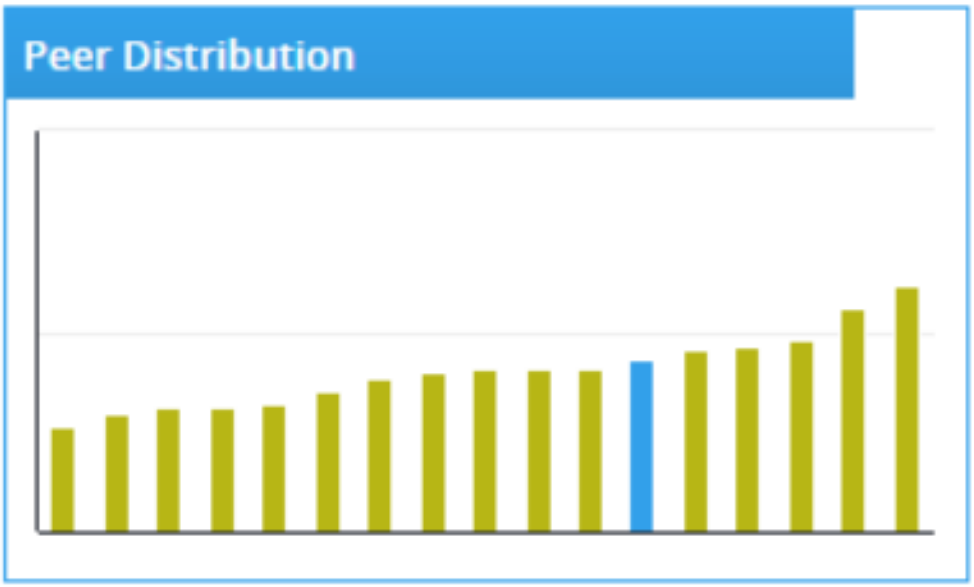


Chart 1 Stillbirths for Jan – Dec 21, LWH in blue. Comparators = maternity services with > 7000 deliveries who submit data to CHKS

2.1 Learning from Stillbirth reviews Q3

All eligible cases undergo a full PMRT review, with care from across the antenatal and intrapartum period being subject to clinical and managerial scrutiny. The care that the mother receives is subject to a grade which aligns with the MBRRACE-UK grading system Postnatal care is reviewed, typically with a focus on the bereavement care the family receive. Any complications of labour and within the postnatal period are subject to the same grading system

All stillbirths in Q3 (n=10) have been subject to a full multidisciplinary review panel meeting utilising the PMRT tool with external clinician presence.
In the antenatal period, the proportion of cases with no care issues identified has remained similar to those percentages reported in previous quarters.

Grade	Care in antenatal period	Percentage (%)	Care provided after Stillbirth	Percentage (%)
A	7	66.7	7	66.7
B	1	11.1	3	33.3
C	1	11.1	0	0
D	1	11.1	0	0

Table 3. Grading of care from review of stillbirths.

All bereaved parents were invited to be involved in the review process by submitting comments and questions via the Honeysuckle Team for discussion at the MDT Review.

The MDT reviews of Q3 cases (N=10) has evaluated the majority (66.7%) of stillbirth cases as having had appropriate antenatal care and were graded as 'A' in accordance with the MBRRACE grading system.

Learning from antenatal care:

- The need for appropriate charting on GROW chart, and the awareness to act on abnormal findings. This led to missed opportunities to refer for fetal growth surveillance which may have identified growth restriction. Individual feedback has taken place, and there is ongoing training for utility of the GAP/GROW programme and the audit on the rate of missed FGR.
- The importance of effective communication between various hospitals on confirming the chorionicity of twin pregnancies prior to any counselling or intervention. In view of this, the referral pathway into the FMU Multiple Pregnancy Clinic is being reviewed.

Learning from post-natal care:

- the importance to perform SB investigations in trying to identify a cause, and a LOTW has been shared to remind all clinicians regarding this
- The importance of clarifying uncertainties with senior medical staff prior to completing SB certificate.

Actions that are completed from areas of learning from Q2 include:

- A new SOP in place for the process of cross-covering FMU clinics and rescheduling of appointments if required in unexpected illness
- Individual feedback and LOTW shared on the importance of complete risk assessment when patients attend MAU

There is ongoing progress for the following:

- Implementation of the Continuity of Carer model to improve process in arranging for follow up for community midwifery reviews
- Integration of K2 with electronic GROW package to have an electronic system for fetal growth surveillance
- Review provision of bereavement care and support out of hours

In order to maintain a close monitoring of any identified themes, trends, rising data and issues resulting from stillbirth reviews, the stillbirth data and a summary of cases discussed at the PMRT MDT reviews will be an agenda item at the monthly Maternity Clinical Meeting.

A full review of the LWH stillbirth data and lessons learnt will be undertaken once the learning from Q4 21/22 is completed. A report will then be submitted to QC and Trust board in Autumn 2022/23.

3. Neonatal Mortality

3.1 Neonatal mortality Data

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, those occurring prior to discharge from the NICU and those who die following transfer to another hospital. The data may include or exclude babies with congenital anomalies. Table 4 provides the total number of deaths, and deaths of those born at LWH.

	Apr-21	*May-21*	*Jun-21*	*Jul-21*	*Aug-21*	*Sep-21*	*Oct-21*	*Nov-21*	*Dec-21*	*Jan-22*	*Feb-22*	*Mar-22*	*Total*
Discharges	100	97	106	93	119	113	129	129	114	126	96	108	1330
Total Neonatal Mortality	3	1	2	5	3	3	8	5	3	2	3	3	41
INBORN Neonatal Mortality	**2**	**0**	**0**	**3**	**2**	**2**	**4**	**4**	**3**	**2**	**3**	**3**	**28**
Deliveries	622	654	673	692	695	684	655	665	622	659	561	595	7777
INBORN Neonatal Mortality Rate/1000 deliveries	**3.2**	**0**	**0**	**4.3**	**2.9**	**2.9**	**6.1**	**6.0**	**4.8**	**3.0**	**5.3**	**5.0**	**3.6**

Table 4: NICU Mortality.

Quarter	NMR all babies	NMR *in born*
Q1	3.1	1.0
Q2	5.3	3.3
Q3	8.2	5.7
Q4	4.4	4.4
4 Q rolling average	5.3	3.6

Table 5 Neonatal mortality/quarter.

An ongoing external review by the North-West Neonatal ODN of LWH mortality for extremely preterm infants is continuing. This was initiated following benchmarking data relating to a higher mortality in infants of 24 weeks gestation age when compared with other level 3 neonatal units in the North-West and a spike in mortality rates in 2020. This report is now due to be available in Q2 2022.

3.3. Learning from neonatal mortality reviews for Q3

There were 15 deaths subject to a PMRT review. One baby died in alder Hey Children's Hospital. For this case the LWH care of the mother and child have been reviewed, but the care after death has not yet been reviewed jointly with AHCH.

All neonatal deaths on NICU were reviewed using the standardised national perinatal mortality review tool (PMRT) within 2 months of the death occurring (MIS requirement). All Q3 reviews have been completed (15/11). The grading of care for the PMRT is as follows;

- Grade A No issues with care identified from birth up to the point the baby died.
- Grade B Care issues identified which would have made no difference to the outcome for the baby.
- Grade C Care issues identified which may have made a difference to the outcome for the baby.
- Grade D Care issues identified which were likely to have made a difference to the outcome for the baby.
-

PMRT grading	Care provided to the mother up to the point that the baby was delivered	Care provided to the baby up to the point that the baby was confirmed as having died	Care provided to the mother following confirmation of the death of her baby
PMRT grade A	9	5	14
PMRT grade B	6 (*2 PN transfer*)	9	1
PMRT grade C	1	2	
PMRT grade D			
Total cases	16	16	15*

Table 6. PMRT review panel grading of care provided in cases of Neonatal Death Q3

Of 16 reviews 13 were found to have care issues which would not have affected the outcome. 3 cases identified care issues which may have made a difference to the outcome. One case related to not being co-located with adult ITU services, and another to not being co-located with paediatric services.
LWH Learning identified included the following (see attachment for further detail)

1. Need for radiology attendance out of hours in a timely manner. Plan for revised provision out of hours to ensure attendance within 30 minutes of request.
2. Two unplanned extubations have resulted in development of a QI initiative to reduce this risk

5. Revised Year 4 Maternity Incentive Scheme requirements

The MIS was paused in Q3. However the adherence to the safety actions continued. The MIS year 4 recommenced from May 6th 2022 and in future reports adherence to safety action 1 will be presented.
This quarterly report (and pervious quarterly reports) will continue to be discussed with the maternity, neonatal and Board level safety champions. Dissemination of learning will continue through associated clinical meetings and feedback to staff.

4. Recommendations

It is it is requested that the members of the Board review the contents of the paper and take assurance that there are adequate governance processes in place 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.
- Specific recommendations
    - the monitoring and review of the stillbirth rate continues by the Family Health board, with a thematic review to be conducted with Q4 data. Issues identified at the reviews and recommendations made will now be tracked through the Maternity Clinical Meeting
    - the monitoring and review of the neonatal mortality rate continues with an external review of mortality for extremely preterm infants to be available in Q2 2022-23

Appendix 1
Regional Standardised Reports

Q4 Stillbirth Report on Regional

Q4 Neonatal mortality report

Shared with the Board via the Supporting Documents folder in Admin Control

Putting People First (PPF) Committee Chair's Highlight Report to Trust Board
16 May 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 a trust wide deep dive into mandatory training compliance which detailed key findings and options to improve compliance. The Committee had been assured by the review undertaken and approved of the suggested recommendations. It was noted that the options should be selected by the divisions/departments as best fit for their teams. • Potential risks of continued rota issues and gaps on the medical workforce was noted within both the Director of Medical Education Annual Report and the Guardian for Safe Working Hours report. Currently the workforce is covering the rota gaps with additional shifts but there is a risk of fatigue amongst the O&G postgraduate doctors in training. A workforce paper has been produced to evidence the need for continuing over recruitment to maintain safe rotas for tier 3, safe working and ability to train. Approval has been given for this and posts should currently be out to advert. Alongside this a Junior Doctor Working Group had been set up with the Deputy Medical Director as Chair as a forum to manage junior doctor rotas. The Committee was partially assured by the Director of Medical Education Annual report as although the rota gap risk was currently being mitigated it was unlikely to be sustainable.	• The Committee noted that a business case is being prepared to secure funding for the Volunteers Service. • Noted the development and involvement of the Trust taking on the lead role for the midwifery workforce workstream on behalf of Cheshire and Merseyside Acute and Specialist Trusts (CMAST). • The Committee received the Age Profile and Stand-alone posts update noting that the number of stand-alone posts had reduced during the past three years as a focus on new ways of working and succession planning had been introduced. This work also supported mitigation against the risks of the age profile of the workforce. Ongoing focus on this issue would need to be maintained by divisions to ensure necessary steps to safeguard the workforce supply for the future. • Work to maintain momentum to relocate the junior doctors mess to a less isolated area nearer clinical activity continued. This must be completed by June 2022. • Due to the increase of in-person training the Postgraduate Team had successfully submitted a bid to receive funding for a portacabin to increase space for training. Work would be undertaken with estates to realise this. • The Committee received the update on supporting the Health and Wellbeing of staff, managers and leaders at the Trust as remitted by the Trust Board as a Chair action in January 2022. The Committee noted the initiatives that have been put into place during the past 12 months and queried the uptake of the offers available. A reluctance of managers to undertake the wellbeing conversations was also noted. The Heads of Services would be asked to reflect on the resistance to initiate wellbeing conversations.
Positive Assurances to Provide Identify in brackets should the assurance provide evidence against the CQC Key Questions – SAFE | EFFECTIVE | CARING | RESPONSIVE | WELL LED	**Decisions Made**
• The Committee listened to a staff story from a volunteer who had volunteered at the Trust for 2 years. She described the importance of the meet and greet role and the support and comfort provided to patients attending the Trust on their own particularly during the pandemic. The volunteer had been enthused by the opportunity to take part in the Theatres Patient Journey assessments. She informed the Committee that the valuable experiences from volunteering at the Trust had led her to finding out about the Nursing apprenticeship scheme and securing an apprenticeship role at a neighbouring trust. Consideration of opening apprenticeship applications to volunteers was recommended by the Committee, as was sharing this volunteer story wider to support volunteer recruitment. (CARING) • The Committee received positive assurance from the Volunteer Strategy Achievements Annual Report 2021/22. The positive introduction of the volunteer responder role was noted	• None

as enhancing patient experience, volunteers experience and saving staff time. (CARING/WELL LED/RESPONSIVE) • Committee received a detailed Workforce Assurance report from Gynaecology Division. The Committee noted focussed work undertaken by the division notably to improve staffing, leadership, and succession planning. The Committee was assured that actions in place to improve workforce challenges within the Fertility Unit would produce demonstrable improvements within 6-12 months. (WELL LED/SAFE) • Positive reduction of staff sickness rates noted. (SAFE/WELL LED) • The Committee noted the Leadership and Talent Management Strategic Framework and positive progress against the objectives of the PPF Strategy. Triangulation with the EDI programme would be useful to link related targets and ensure inclusivity. • The Committee noted the Medical Appraisal & Revalidation Report covering Quarter 4, 2021/22.	

Summary of BAF Review Discussion (Board Committee level only)

- The Committee reviewed the PPF aligned BAF risks. No changes to risks scores were recommended. No risks closed.

Comments on Effectiveness of the Meeting / Application of QI Methodology

- Timely
- Robust discussion

2. Summary Agenda

No.	Agenda Item	Purpose	Rating	No.	Agenda Item	Purpose	Rating
06.	Board Assurance Framework (BAF): Workforce related risks	Assurance		13.	Age Profile and Stand-alone posts: Risks and Mitigations	Information	
07.	Staff Story Volunteer Service	Information		14.	Leadership and Talent Management Strategic Framework - Update	Information	
08.	Volunteer Strategy Achievements Annual Report	Assurance		15.	Medical Appraisal & Revalidation Quarterly Report Quarter 4, 2021/22	Information	
09.	Gynaecology Service Workforce Assurance Report	Assurance		16.	Guardian of Safe Working Hours (Junior Doctors) Q4, 2021/22	Assurance	
10.	Chief People Officer Report	Information		17.	Director of Medical Education Annual Report	Assurance	
11.	Workforce KPI Dashboard Report	Assurance		18.	Supporting the Health and Wellbeing of our Staff, managers and leaders at LWH	Information	
12.	Mandatory Training Deep dive	Assurance		19.	Sub Committee Chair Reports	Assurance	

3. 2022 / 23 Attendance Matrix

Core members	May	Jun	Sep	Jan	Mar

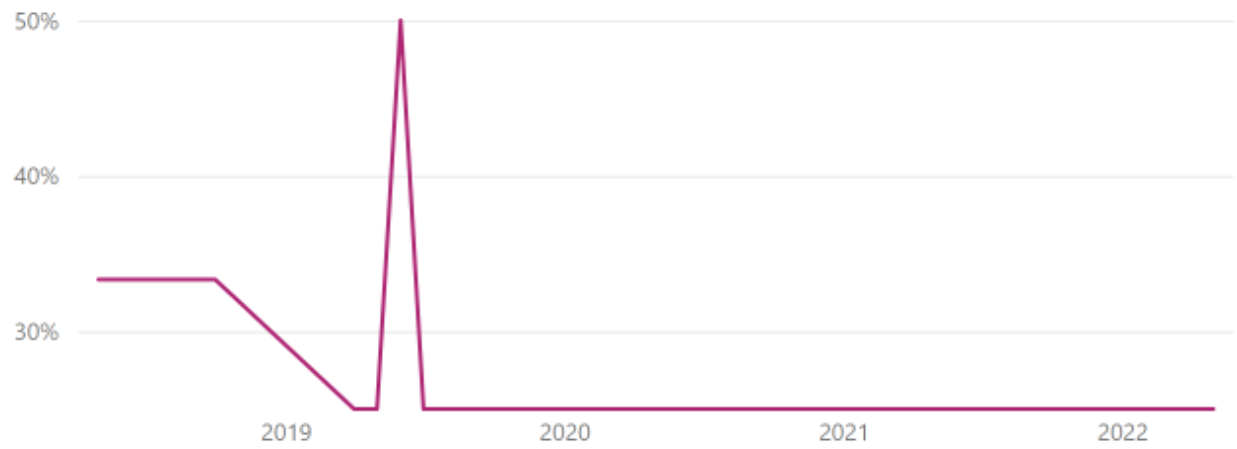
Susan Milner	✓				
Gloria Hyatt	✓				
Louise Martin	✓				
Zia Chaudhry	✓				
Michelle Turner	✓				
Marie Forshaw	✓				
Gary Price	✓				
Claire Deegan	A				
Liz Collins	✓				
Dyan Dickins	✓				
Present (✓) Apologies (A) Representative (R) Nonattendance (NA) Non-Member (NM) *Non-quorate meetings highlighted in greyscale*					

Liverpool Women's
NHS Foundation Trust

Trust Board

Workforce Performance Report
July 2022

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



Positive Developments

The new process for identifying KPIs to be highlighted for review has been implemented as part of the new performance report layout. This is based on criteria set out in the report cover page. In future months this process will be embedded to provide more focussed narrative for discussion.

Areas of Challenge

Detailed commentary for each of the workforce KPIs is available within the report .

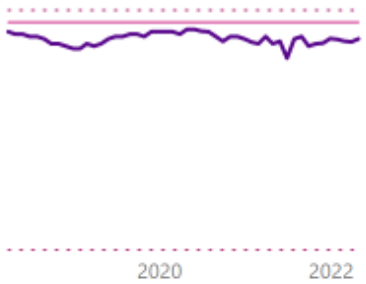
KPI	May 2021	June 2021	July 2021	August 2021	September 2021	October 2021	November 2021	December 2021	January 2022	February 2022	March 2022	April 2022	May 2022
Clinical Mandatory Training Compliance	79.16% ↓	80% ↑	81.88% ↑	81.17% ↓	81.91% ↑	80.35% ↓	79.21% ↓	78.26% ↓	68.06% ↓	79.22% ↑	78.15% ↓	75.62% ↓	76% ↑
Mandatory Training Compliance	86% ↓	87% ↑	80% ↓	88% ↑	89% ↑	85% ↓	86% ↑	86.23% ↑	88.17% ↑	87.82% ↓	87.11% ↓	86.76% ↓	88.01% ↑
Sickness Absence Rate	5.72% ↑	6.21% ↑	7.67% ↑	7.99% ↑	8.35% ↑	8.03% ↓	7.93% ↓	10.26% ↑	10.99% ↑	7.64% ↓	9.18% ↑	7.57% ↓	6.6% ↓
Turnover Rate	9% →	10% ↑	11% ↑	11% →	11% →	13% ↑	12% ↓	12% →	13% ↑	13% →	13% →	13% →	13% →

Mandatory Training Compliance

>= 95%

KPI095T

Attribute	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
% Performance	86%	87%	80%	88%	89%	85%	86%	86.23%	88.17%	87.82%	87.11%	86.76%	88.01%
Numerator	0.86	0.87	0.8	0.88	0.89	0.85	0.86	0.86	0.88	0.88	0.87	0.87	0.88



Workforce
Trust Value

Chief People Officer
Exec Lead

Deputy Director of Workforce
Owner/Lead

Local
Reported To

Trust
Source

DQKM

Narrative

The overall Trust mandatory training compliance increased by 1.25%, from 86.76% in month one to 88.01% in month two. This is now 6.99% under the Trust's target rate of 95% and rated as amber. In the largest clinical areas, compliance increased by 1.52% in Maternity, and by 0.26% in Neonates while Gynaecology remained static at 91.15%. At the divisional level, compliance increased by 0.68% in the Gynaecology Division, by 1.27% in Family Health, and by 1.67% in the Corporate Division, while Clinical Support services decreased by 0.78% but still over Trust target with 95.61%

The HR and L&D teams continue to provide support, information, and training to managers across the Trust. The Bi-annual training validation has been completed in month one and reflects in month two figures. Work is also underway looking at the onboarding process and the induction checklists for staff and managers. Local and divisional trajectories are being developed to support the improvement of compliance.

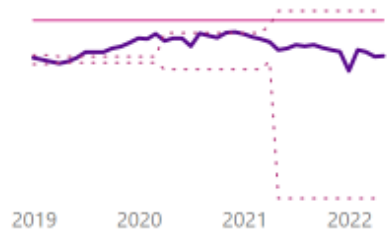
While every effort is being made to improve and maintain compliance rates, it is difficult to accurately predict when the target figure of 95% will be achieved, particularly in light of the continuing COVID 19 global pandemic and the pressures it has created both operationally and in terms of staffing. 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.

Clinical Mandatory Training Compliance

>= 95%

KPI378T

Attribute	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
% Performance	79.16%	80%	81.88%	81.17%	81.91%	80.35%	79.21%	78.26%	68.06%	79.22%	78.15%	75.62%	76%



Workforce
Trust Value

Chief People Officer
Exec Lead

Deputy Director of Workforce
Owner/Lead

Local
Reported To

Trust
Source

DQKM

May 2022

Narrative

The overall Trust clinical mandatory training compliance increased by 0.38% from 75.62% in month one, to 76% in month two. This is now 19% under the Trust's target rate of 95% and rated as red. In the largest clinical areas, compliance increased in Gynaecology by 0.70%, but fell by 1.20% in Maternity, and by 0.45% in Neonates. At the divisional level, compliance increased by 2.35% in the Gynaecology Division, by 3.12% in Clinical Support Services, and by 3.38% in the Corporate Division while Family Health fell by 0.86%.

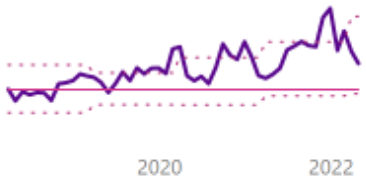
The HR and L&D teams continue to provide support, information, and training to managers across the Trust. The Bi-annual training validation has been completed in month one and reflects in month two figures. Work is also underway looking at the onboarding process and the induction checklists for staff and managers. Local and divisional trajectories are being developed to support the improvement of compliance.

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.

Sickness Absence Rate

Target: **<= 4.5%**

Attribute	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
% Performance	↑ 5.72%	↑ 6.21%	↑ 7.67%	↑ 7.99%	↑ 8.35%	↓ 8.03%	↓ 7.93%	↑ 10.26%	↑ 10.99%	↓ 7.64%	↑ 9.18%	↓ 7.57%	↓ 6.6%



Workforce
Trust Value

Chief People Officer
Exec Lead

Deputy Director of Workforce
Owner/Lead

National TBC
Reported To

SOF / CCG / Trust
Source

DQKM

May 2022

Narrative

The single month sickness absence figure fell 0.97%, from 7.57% in month one, to 6.60% in month two. This is now 2.10% above the Trust's target figure of 4.50% and is therefore rated as red. Sickness fell in all the largest clinical areas: by 3.66% in Gynaecology, by 0.04% in Maternity, and by 0.80% in Neonates. At divisional level, sickness fell in three of the four divisions: by 3.13% in Gynaecology, by 0.33% in Family Health, by 0.67% in the Corporate Division while there was a 1.47% increase in Clinical Support Services. Overall, the proportion of sickness that was short term increase slightly from accounting for 25% of the overall figure in month one, up to 33.86% in month two. 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 has reduced again falling from 2.67% in month one to 1.55% in month two.

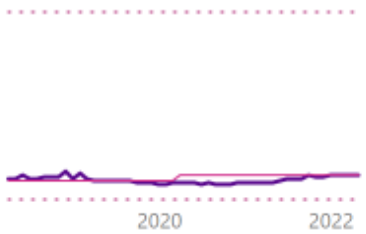
The HR Department are continuing to provide support for managers in managing sickness absence and in supporting staff. This includes providing a full range of information and data, training, and regular meetings with local and divisional managers. A range of measures are in place specifically to address the situation with regards to COVID 19. These are available to all staff and include risk assessments, testing and vaccination programmes. A lot of work has also been done in pulling together and communicating to staff a whole range of health & wellbeing advice and support, through both the Cheshire and Merseyside Resilience Hub, and local initiatives such as the Wellbeing Conversations. The new Attendance Management & Wellbeing Policy has now been launched, and compliance for recording return to work meetings is now regularly monitored and discussed with local managers. The toolkit for managers has also been revised and updated.

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.

Turnover Rate

Target: <= 13%

Attribute	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
% Performance	→ 9%	↑ 10%	↑ 11%	→ 11%	→ 11%	↑ 13%	↓ 12%	→ 12%	↑ 13%	→ 13%	→ 13%	→ 13%	→ 13%
Numerator	→ 0.09	↑ 1	↑ 0.11	→ 0.11	→ 0.11	↑ 0.13	↓ 0.12	→ 0.12	↑ 0.13	→ 0.13	→ 0.13	→ 0.13	→ 0.13



Workforce
Trust Value

Chief People Officer
Exec Lead

Deputy Director of Workforce
Owner/Lead

National TBC
Reported To

SOF
Source

DQKM

There has been an incremental rise in turnover the last 12 months to reach the current rolling rate of 13%.

Areas exceeding the target include Finance (19%), Gynaecology (19%) Imaging (34%) Integrated Admin (15%) Integrated Governance (16%) Maternity (14%) Operational Support Services (17%) Pharmacy (21%) and physiotherapy (24%)

A number of the departments with high turnover rates have active improvement plans in place and are receiving support from the OD/HR team to improve staff engagement. These include Imaging, Pharmacy and Integrated Admin. Turnover % are higher in departments such as Physiotherapy with a headcount of only 5.

Actions taken centrally to support retention and understand reasons for leaving include

May 2022

-Revised Exit Interview Process: In order to encourage more leavers to take up the offer of an exit interview, invites are automatically being sent to have an exit interview with a member of the HR Team
-Stay conversations: These have been piloted by the Retention Lead Midwife within maternity who is delivering training to N&M managers to undertake these conversations in their areas
-Career Conversations: These are now embedded as part of the PDR process and N&M staff from an ethnically diverse background are having additional focused career conversations
-Flexible working project: LWH participated in national 'Flex for the Future' programme. Work life balance is being analysed as a reason for leaving, trials of different rostering patterns are currently being explored in response to staff feedback from the flexible working survey and 1-1 conversations
-Big Conversation: Divisional and Trust wide actions to respond to staff feedback about why they wouldn't recommend Liverpool Women's as a place to work.

During the peak of covid, there was an increase in staff choosing to retire within N&M, this trend now appears to have ceased. National Drivers including the Annual and Lifetime Allowance restrictions within the NHS Pension Scheme pose a risk of staff choosing to retire early and this is affecting more staff, not only high earners. LWH continues to face high competition from other Trusts and the private sector for employees in administrative and entry level roles, and this has only increased since covid restrictions have been released. We have resumed our widening participation and careers promotion activities and the Lead Nurse for HCA Development is promoting our HCA roles at a Liverpool wide careers fair this month.

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*22/23/078c*		**Date: 07/07/2022**	
Report Title	**'Big Conversation' Feedback**			
Prepared by	*Rachel Cowley, Head of Culture and Staff Experience*			
Presented by	*Michelle Turner, Chief People Officer*			
Key Issues / Messages	*This paper provides the Board with an overview of the First 'Big Conversation' which took place at LWH over a 24 hour period on 15 June 2022.*			
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/N *If no – please outline the reasons for deviation.*			
	The Board is asked to note the contents of the report, be assured that staff engagement remains a key priority at Liverpool Women's and the new format for staff opinions and views to be heard though a 24 hour big conversation was positively received by all. This format will continue in future with the next planned event for September 2022, immediately prior to the next national staff survey.			
Supporting Executive:	*Name and Job Title*			

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	**Jun 22**	**CPO**	**Workshop session held**

EXECUTIVE SUMMARY

This paper provides the Board with an overview of the First ‘Big Conversation’ which took place at LWH over a 24 hour period on 15 June 2022.

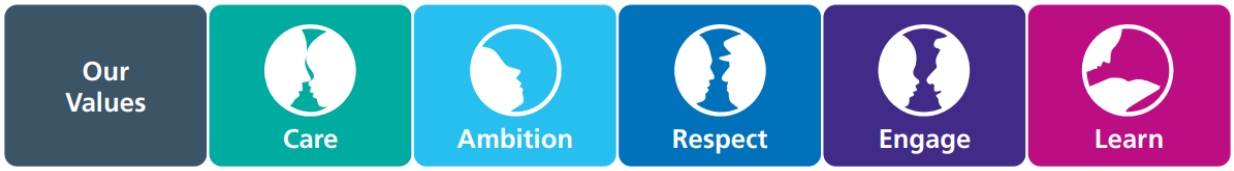
This paper details the background and reasons for a new approach to seeking staff feedback. It outlines the common themes identified from the intelligence gathered during the ‘Big Conversation; and the planned next steps.

Key to success is ensuring we have a positive mechanism for feeding back to all staff and ensuring updates are regularly communicated, which is also outlined within this paper as a recommendation for the Board consideration.

MAIN REPORT

1. Introduction

Liverpool Women's Trust has a set of shared values and behaviours which are encouraged in all staff, partners and volunteers to make sure the values are delivered in the same way, every day, to every person.



Liverpool Women's recognises that **Staff Engagement** is key to success in order to ensure excellent staff and patient experiences. Staff engagement can be measured through the national Staff Surveys, which has staff engagement as one of its 9 key themes as well as the local quarterly 'Let's Talk surveys',

Liverpool Women's has a strategic ambition outlined within the Trust Strategy 2021 – 2025 in relation to recruitment and retention of key clinical staff:

- ***Be in the top 10% of NHS organisations for staff engagement as evidenced by the Annual National NHS Staff Survey by 2024***

This is echoed in the Trust's Putting People First Strategy 2019 – 2024 where there is an ambition to:

- ***Create a workplace in which staff are healthy, resilient, engaged, motivated and show imitative and who are actively involved with the Trust…***

Liverpool Women's recognises that the 2021 national staff survey results did not demonstrate the progress on engagement that we hoped to achieve and there was a need to understand some of the qualitative intelligence behind the data. As a result, the Trust decided to host a 'Big Conversation 'to learn more from the staff about what is brilliant about working at Liverpool Women's and where improvements can be made.

The Big Conversation was hosted over a 24-hour period and was taken to each team/department focusing on two key questions:

- What is brilliant about your team / department?
- What would you like to see us change, to make things even better?

In addition to this for each clinical area there were specific questions asked tailored to their divisional staff survey results.

Intelligence gathered throughout the Big Conversation have identified some common themes for the Trust to consider and take action on. In addition to this divisional specifics will be identified and actions taken to make necessary improvements.

2. Background

For a number of years Liverpool Women's hosted quarterly Listening events, face to face in the Blair bell where staff were required to book a place in advance. During covid we adapted this to a virtual listening event, utilising MS teams.

A decision was taken for Liverpool Women's to host a **24 hour Big conversation** from 8am on 15 June until 8am, on 16 June 2022. This would require volunteers from Executive team, Non-Executive Directors, Senior Leaders and the Workforce team to visit different teams / departments throughout the 24 hour period, also to host specific staffing group listening events in the Blair Bell. In addition to this Kathy Thomson, CEO, had bookable meetings during this period for staff who wished to speak with her directly.

3. Common Themes Raised

The common themes raised during the 24 hour big conversation were:

- Lack of Kindness – managers & colleagues
- Silo working across departments and some feel undervalued by the organisation
- Processes – unwieldly, unclear, unresponsive & slow things down
- Staffing levels
- Equipment – shortages, hard to replace
- Environment – staff facilities, space, changing facilities
- Poor communication particularly in clinical areas
- Poor Flexibility in clinical areas
- Lack of awareness of career progression / development in clinical areas
- Recognition/appreciation/feeling valued
- Need forum for innovation and good ideas
- Safety in raising concerns

Some of the regular quotes and comments shared by staff are demonstrated below:

The intelligence gathered as part of the 24 hour Big Conversation has been separated into divisional and team comments, which has been shared with Divisional Boards and SLT's at the end of June. Managers will develop divisional You Said / We Did processes to check what has been heard with staff and ensure any actions/interventions are right before they are implemented. The You Said /

We Did documents will be updated and communicated to divisional staff on a monthly basis so staff are well informed about progress with plans.

4. Ongoing Engagement Actions

There are a number of ongoing staff engagement activities at Liverpool Women's, these are showcased below:

4.1 Great Place to Work Group

Liverpool Women's **Great Place to Work Group** was developed in May 2021 and whilst it was recognised by this group that not all staff currently feel the Trust is a Great Place to Work, the ambition of the group is to improve communication channels and staff engagement with the Leaders in the Trust, ensure the staff voice is listened to and the Trust learns from staff experience.

Following recent efforts there was good representation at the last Great Place to work Group meeting from all teams, including Clinical and Operational colleagues. Dates for the remainder of 2022 have been communicated and the group need to consider key topics / discuss new initiatives at each meeting that tie in with the themes from the Big Conversation.

4.2 Recognition / Celebration Boards

The Trust currently has '**how are we doing'** and '**reasons to be proud'** boards near the Costa Coffee shop on the ground floor. The 'how we are doing board has different information about the Trust and it's progress, this includes CQC rating, the Trusts response to covid, Infection, Prevention and Control Service statistics and other Trust messages.

Based on feedback from the Big Conversation it is clear that the Trust needs to clearly demonstrate how it is taking action following staff feedback using a 'y**ou said / we did'** approach., Appropriate, highly visible boards will be identified and located to do this at a Trust level. In addition to this it is recognised that Divisions need to ensure their monthly 'you said / we did' messages are visually displayed within the staff areas in their departments so that staff are aware of what is being worked on and progress updates can quickly be shared with the staff impacted. The '3 Key Messages' is another tool where managers can update staff at daily huddles about how their feedback has been acted upon.

The '**reasons to be proud'** board celebrates staff and team of the month winners. It is clear from the big conversation that divisions need to consider how they replicate this within their own staffing areas, as well as local recognition. There is potential for divisional winners to be showcased locally as part of the 3 key messages which are shared fortnightly.

Many departments have local recognition schemes such as **'Star of the Week'** which are working well. A summary of good practice will be shared Trust wide.

Staff most value recognition from their immediate line manager. **'Hometime Checklists'** have previously been implemented to good effect, to ensure staff are thanked at the end of a shift and other examples of good practice will be shared.

4.3 Three Key Messages

Three Key Messages has been rolled out from April 2022, a new message is shared in each area every fortnight. The 3 key messages include a Trust wide message, divisional message and a departmental / team message. Each department / team is encouraged to print and visually display the 3 key messages within their staff areas and to talk about these in their huddles / handover meetings. It is clear from the big conversation that this happens well in some areas however more work is still required for this to be successful in all areas.

4.4 Staff Surveys

Quarterly Let's Talk survey is survey developed as a regular method of taking a 'temperature check' of staff engagement, staff can complete online during the months of April, July and January. There is no Let's Talk in October as during this time the Trust participates in the National Staff Survey.

From July 2021 a National decision was taken for quarterly surveys in April, July and January to be compulsory for all Trust with a view to the standard engagement questions required to be reported on. These are the same engagement questions as those used in the National staff survey:

- I look forward to coming to work
- I am enthusiastic about my job
- Time passes quickly when I am working
- There are frequent opportunities for me to show initiative in my role
- I am able to make suggestions to improve the work of my team/department
- I am able to make improvements happen in my area of work
- Care of patients/service users is my organisations top priority
- I would recommend my organisation as a place to work
- If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation

Divisional Leaders receive reports for discussion at Divisional Board and as a temperature check against Divisional Plans and to cascade outcomes of the Let's Talk results their teams on issues raised and actions taken in response on at least a quarterly basis through the you said / we did approach.

Liverpool Women's **next Let 's Talk survey is in July 2022** and the engagement responses are tracked to evidence any changes or progress from the national staff survey responses in October 2021.

4.5 Improved Staff Environments

Upgrading of Staff Facilities has been considered and will be supported as outlined in the 'We Care' Health and Wellbeing offer for staff, this includes upgrades to our staff outdoor spaces with the introduction of beehives, wild flower garden and a zen garden, as well as an upgrade to the conservatory space and staff rooms that require refreshing.

In addition to this there are plans for an improved Junior Doctors Mess, with a proposal for a new location which would be more suitable and accessible following engagements with Junior Doctors.

Some of this work commenced in 2021 however there are actions to continue and complete in 2022.

4.6 Review of Healthcare Support Worker Roles

The Trust is part way through a **review of roles and responsibilities of all HCAs** in the organisation and will be taking on board feedback from the Big Conversation in relation to where the support worker role can be developed and extended to aid personal and career development and release other nurses and midwives to undertake other duties.

4.8 Investment in Retention and Development Roles

Through investment from NHSI/E, a bespoke team has been created to **improve retention, engagement and development within the Midwifery and HCA Workforce**. They are

- Staff Engagement and Retention Lead Midwife (Band 7)
- HCA Support and Development Lead (Band 6)
- HCA Peer Support Lead

The team has been in place for couple of months and key activities have included listening events with staff, implementation of 'stay interviews', a deep dive into sickness absence, review the training and development pathways of HCAs and support HCAs with practical input to complete the Care Certificate.

4.9 Increasing the profile of the People Agenda within management and divisional structures

Every manager has been instructed to ensure **objectives relating to the wellbeing and engagement** of their teams are included in management objectives. Divisional Boards have been tasked to ensure that sufficient time is devoted to the people agenda within these forums. Every clinical manager will be invited to a feedback conversation with a Director to explore their experiences and reinforce the expectations of them as people managers.

5. Next Steps following the Big Conversation – June 2022

It is key that Liverpool Women's does not lose momentum with the great intelligence gathered from the big conversation in June 2022 and builds trust with the staff to evidence that they will be kept informed and involved in decisions and initiatives that are planned to improve the staff experience within Liverpool Women's.

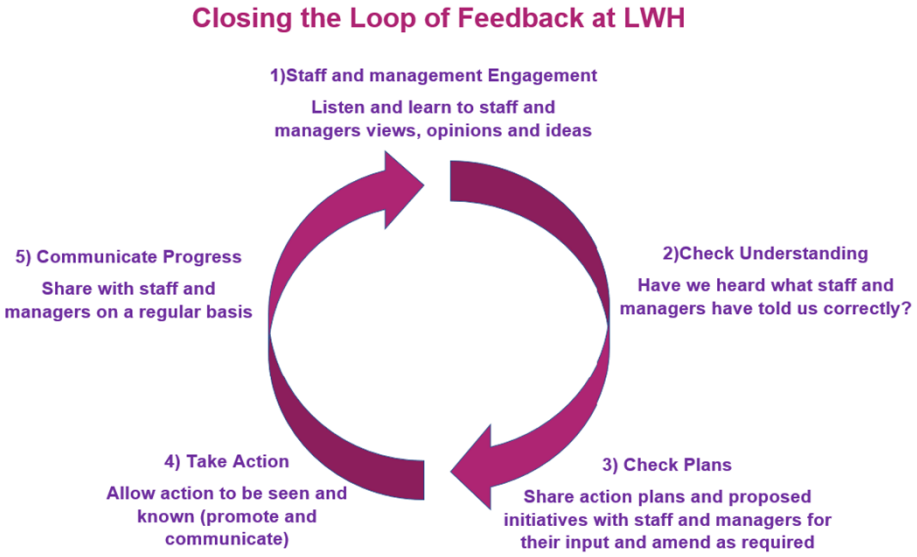
The planned feedback and communications include:

- Initial thank you for getting involved – In the Loop 21.06.22
- Communicating common themes to the Governors – 27.06.22
- Thank you, initial headline themes, timeline for local feedback Exec video - w/c 27.06.22
- Communicating the big themes & feedback timeline to the wider organisation – w/c 27.06.22
- Identifying & sharing the feedback for corporate or divisional level action – w/c 04.07.22
- Sharing the local findings with local teams & their managers – w/c 04.07.22 onwards
- Supporting local managers to develop interventions/response to that feedback - ongoing
- Ensuring ongoing feedback locally & organisational - ongoing
- Actively demonstrating you said/we did - over summer months
- Plan another Big Conversation immediately prior to the Staff Survey issue (early 09.22)

Recommendation

The Board is asked to note the contents of the report, be assured that staff engagement remains a key priority at Liverpool Women's and the new format for staff opinions and views to be heard through a 24 hour Big Conversation was positively received by all. This format will continue in future with the next planned event for September 2022, immediately prior to the next national staff survey. The September event will focus on progress since the last Big Conversation (You Said/We Did) as well as testing out current levels of engagement.

In addition the Board is note the approach to be adopted trust wide in terms of feedback to staff.



Finance, Performance & Business Development Chair's Highlight Report to Trust Board
23 May 2022

Liverpool Women's NHS Foundation Trust

1. Highlight Report

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

• The following key matters from M1 financial performance report noted:
  ○ Agency spend across the Trust £171k above plan;
  ○ Fuel costs remain an area of volatility and risk to the Trust, at £33k above plan;
  ○ Financial Recovery Board will continue to meet in 2022/23 and will undertake several pieces of work to understand the drivers for the underlying deficit, movement in expenditure and opportunities to improve the financial position.
• The Committee received a detailed presentation on recovery and restoration of access targets. Information in relation to overdue follow-ups was provided within the presentation, noting that 91% of overdue follow-ups are 6 months and less. Although significant challenges to address the patient backlogs, the Committee was assured that the Trust was appropriately focussed on the key risks and had actions in place to improve the position. The Committee commended the detail provided within the presentation and queried how this information could be better relayed within the performance reports for Board Committees.
• The Committee received an update on the Crown Street Enhancements (CSE) Programme noting that there had been a delay of one month to the completion of the Colposcopy Suite, due to issues in the supply chain. At present there is no change in forecast costs, however there is a risk of a modest increase in cost due to inflation in the sector.
	• The Committee received a comprehensive presentation detailing the Planning 2022/23 position. It was noted that the whole Cheshire & Merseyside Plan had not yet been agreed nationally, consequently meaning that the Trust did not have an agreed plan. The Trust had been notified of a further plan submission date of 20 June 2022. For those trusts with a planned deficit a further process of peer review was being put in place. The Trust Board would be asked to approve the final plan on 16 June 2022.
	• The Committee noted the EPR (Meditech Expanse) go-live date of the 05 November 2022. The go-live date would be carefully managed through the programme governance and a communications campaign.
	• The Committee acknowledged positive collaboration between K2, Perinatal Institute (PI), and the digital midwives to develop a fully integrated GROW chart. The digital midwives are making progress with testing ahead of wider staff demonstrations and training.

Positive Assurances to Provide Identify in brackets should the assurance provide evidence against the CQC Key Questions – SAFE | EFFECTIVE | CARING | RESPONSIVE | WELL LED	**Decisions Made**
• The Committee noted at Month 1, a £0.345m deficit against a £0.368m deficit plan. The Trust is currently forecasting to achieve the Board approved plan for the year. • The Committee took assurance from the analytical review of the financial statements 2021/22 against 2020/21. The report had been beneficial to demonstrate the impact of decisions taken throughout the year on the accounts. • The Committee noted that the Trust continues to make good progress in establishing community diagnostic centre services at the Crown Street site. CT scanning had stepped up to a 7-day service and respiratory testing services planned to go live from 06 June 2022.	

• The Committee noted the ambition of the Finance, Procurement and Digital Services teams towards Skills Development Network Accreditation. Each team is striving to provide excellent services to the Trust and will use the accreditation process to support continuous development. The Committee agreed to receive an annual update to review progress.	

Summary of BAF Review Discussion (Board Committee level only)

- The Committee reviewed the Finance related BAF risks. No changes to risk scores were recommended and no risks closed.

Comments on Effectiveness of the Meeting / Application of QI Methodology

- Sufficient time provided to discuss matters thoroughly
- Good contributions and challenge throughout the meeting.

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
27.	Board Assurance Framework Review	Assurance	32.	Digital Services Update	Assurance
28.	Finance Performance Report Month 1 2022/23	Assurance	33.	Community Diagnostic Centre Update	Information
29.	Annual Accounts and Analytical Review of Financial Statements 2021/22 (prior Audit)	Assurance	34.	Skills Development Network Accreditation	Information
30.	Operational Performance Report Month 1 2022/23	Assurance	35.	Sub-Committee Chairs Reports	Assurance
31.	Planning 2022/23 Update	Assurance	36.	Crown Street Enhancements Programme	Information

3. 2022 / 23 Attendance Matrix

Core members	Apr	May	Jun	Jul	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Louise Martin	✓	A									
Tracy Ellery	✓	✓									
Tony Okotie	✓	✓									
Sarah Walker	✓	✓									
Eva Horgan	✓	✓									
Kathryn Thomson	✓	✓									
Gary Price	✓	✓									
Marie Forshaw	✓	✓									

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

Finance, Performance & Business Development Chair's Highlight Report to Trust Board
27 June 2022

Liverpool Women's NHS Foundation Trust

1. Highlight Report

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

• The following key matters from M2 financial performance report noted:
  ○ Expectation was that the financial position for M3 would be reported against the revised plan (agreed at Board and system level)
  ○ There had been financial pressures in each of the Divisions for 2022/23 to date. The principal driver was agency costs. A 'deep dive' is scheduled with each Division to understand issues and to agree an improvement trajectory.
  ○ At M2 the CIP plan is behind schedule with £292k of CIP achieved against a £471k target
  ○ Capital spend to M2 is £828k underspent. This was due to the Trust awaiting revised plan submissions in June and outcome of bids for additional funding before committing to some asset replacement schemes.
  ○ The underlying financial position remained unsustainable with the Trust reliant on £1.6m of non-recurrent mitigation for the year-to-date
  ○ Whilst the Trust was performing well in relation to Elective recovery work, this was having an impact on staff capacity.
  ○ Financial Recovery Board will continue to meet in 2022/23 and will undertake several pieces of work to understand the drivers for the underlying deficit, movement in expenditure and opportunities to improve the financial position. The Committee noted the importance of understanding the underperformance on agency costs and CIP.
• The Committee noted that access target performance continued to be challenged and it was agreed that this would need to be kept under close monitoring. A discussion at Quality Committee was referenced in which it was recognised that improving this area would require a careful balance of performance management, workforce support and prioritisation to ensure patient harm was mitigated.
• The Committee noted a risk to the EPR implementation date relating to 'future state' workshops being deferred due to clinical teams being unable to attend due to other clinical priorities.
	• The Committee agreed that narrative explanations of performance exceptions could be strengthened to better explain the drivers of underperformance and the actions being taken in response.
	• The Committee requested that the financial performance on the Trust's Digital programme be disaggregated for major projects / work streams to enable enhanced oversight.
	• Noted that lessons would be learned from the recent Countess of Chester CQC report in relation to the implementation of the EPR system.

Positive Assurances to Provide Identify in brackets should the assurance provide evidence against the CQC Key Questions – SAFE | EFFECTIVE | CARING | RESPONSIVE | WELL LED	**Decisions Made**
• The Committee noted an improved cash position and a forecast position at 2022/23 year-end of c£3m.	• No decisions noted.

• The Trust has been able to agree a surplus plan of £562k for 2022/23 with the Cheshire & Merseyside system. This provided a positive basis for future planning and would also take the Trust away from the most stringent regulatory scrutiny under the System Oversight Framework. • Noted that there had been improvements in the Trust's performance in relation to the 4hr A&E target, 2 week waits (cancer) and diagnostic waits. • Noted that GROW 2.0 had been implemented into the K2 digital maternity system. This reduced a known risk and was the first time such an implementation had been successfully achieved. • The Committee was informed that progress was being made in relation to the Future Generations project and that a clinical model of care group had commenced. The outputs of this group would feed into an Estates group in due course. The Committee remarked that it would be important for clinicians to be encouraged to think innovatively when considering the future of maternity services in the city. • The Committee received its first quarterly Partnership Update. Assurance provided that the Trust was viewed as a 'good partner' by external stakeholders. It was agreed that partnerships would become increasingly fundamental to the operations of the Trust, and the effectiveness of the Trust's approach would be monitored by regulators. • Positive progress was being made on the transfusion element of the Crown St Enhancements programme.	

Summary of BAF Review Discussion
(Board Committee level only)

- The Committee reviewed the Finance related BAF risks. It was reported that a discussion was held at the Quality Committee regarding the Trust's position in relation to performance against key access targets. There was agreement that this was a key risk to the Trust achieving its strategic aims and it therefore needed to be reflected on the BAF. An action was taken to articulate this as a 'strategic threat' and bring back for approval to the next scheduled Committee meeting. A decision would be made in relation to which BAF risk was the most appropriate 'owner' of the strategic threat.

Comments on Effectiveness of the Meeting / Application of QI Methodology

- Sufficient time provided to discuss matters thoroughly
- Good contributions and challenge throughout the meeting.

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
45.	Review of BAF risks: FPBD related risks	Assurance	51.	Partnership Oversight (quarterly)	Information
46.	Finance Performance Report Month 2 2022/23	Assurance	52.	Crown Street Enhancements Programme	Information
47.	Planning 2022/23 Update	Information	53.	Community Diagnostic Centre Update	Information
48.	Operational Performance Report Month 2 2022/23	Assurance	54.	Procurement of CDC Insourcing (Short Term Insourcing Staffing Solution for CT & MRI)	Assurance

49.	Digital Services Update	Assurance	**55.**	Sub-Committee Chairs Reports	Assurance
50.	Future Generations Programme Update	Information			

3. 2022 / 23 Attendance Matrix

Core members	Apr	May	Jun	Jul	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Louise Martin	✓	A	✓								
Tracy Ellery	✓	✓	✓								
Tony Okotie	✓	✓	NM								
Sarah Walker	✓	✓	✓								
Eva Horgan	✓	✓	✓								
Kathryn Thomson	✓	✓	A								
Gary Price	✓	✓	✓								
Marie Forshaw	✓	✓	✓								

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

Charitable Funds Committee Chair's Highlight Report to Trust Board
20 June 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 noted the interdebtedness position between the charity and the Trust was £98k at year end 2021/22. A discussion relating to approaches that could be undertaken to retrieve the debt in a more timely manner was undertaken. • Highlighted the requirement for a scheme of delegation for the direction of non-cash goods donated to the Charity. As per its terms of reference the Committee is expected to "*scrutinise requests for use of charitable funds to ensure that any such use is in accordance with the aims and purposes of any charitable fund or donation and are clinically and ethically appropriate. Committee members will bear in mind due diligence to Charity Commission and Trust guidance regarding the ethical use of funds and acceptance of donations".*	• The Committee noted that the annual accounts would be submitted to the independent examiners. A review of timetabling the annual report to the Committee would be undertaken. • The draft charity annual report was reviewed. It was agreed to share the list of charity allocations to clarify charitable spending to the Committee. It was advised that further clarity on allocation of spending should be included within the annual report.
Positive Assurances to Provide	**Decisions Made**
• The Committee received the annual financial position report for 2021/22. The charity's net movement in funds for the year was £58k, increasing the Trust's fund balances to £562k at 31 March 2022. Income for the year was £11k lower than the revised plan at £279k. Charitable activities spend was £17k lower at £228k. • Received the Fundraising Update, noting positive progress against fundraising appeals, for example the Mona Lisa Laser appeal and the Bereavement Suite appeal.	• Considered the Fundraising Strategy / Forward Plan and recommended a Board Development Session be arranged to consider the future direction of the Charity as a Board of Trustees.
Comments on Effectiveness of the Meeting / Application of QI Methodology	
• Positive meeting. Good level of discussion and debate.	

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
06.	Annual Financial Position Report 2021/22	Information	**08.**	Fundraising Strategy 2022-2025	Information
07.	Draft Charity Annual Report 2021 22	Information	**09.**	Fundraising Update	Information

3. 2022 / 23 Attendance Matrix

Core members	June 2022	Sept 2022	Dec 2022	March 2023
Tracy Ellery (Chair)	✓			
Tony Okotie	✓			
Louise Martin	✓			
Jackie Bird	✓			
Eva Horgan*	✓			
Michelle Turner	A			
Marie Forshaw	✓			
Chris Gough	✓			
Kate Davis	✓			

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	**22/23/079c**		**Date: 07/07/2022**	
Report Title	**Finance Performance Review Month 2 2022/23**			
Prepared by	***Claire Deegan, Deputy Chief Finance Officer***			
Presented by	***Eva Horgan, Chief Finance Officer***			
Key Issues / Messages	***To note the Month 2 financial position.***			
Action required	**Approve ☐**	**Receive ☐**	**Note ☒**	**Take Assurance ☐**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	***To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it***	***For the intelligence of the Board / Committee without in-depth discussion required***	***To assure the Board / Committee that effective systems of control are in place***
	Funding Source (If applicable): N/A			
	For Decisions - in line with Risk Appetite Statement – If no – please outline the reasons for deviation.			
	The Board is asked to note the Month 2 Financial Position.			
Supporting Executive:	***Eva Horgan, Chief Finance Officer***			

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

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

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Finance, Performance and Business Development Committee	28/06/2022	Eva Horgan, Chief Finance Officer	The Committee noted the report.

EXECUTIVE SUMMARY

At Month 2, the Trust is reporting a £0.715m deficit against a £0.715m deficit plan. However, this is based on performance against the original plan finalised in April 2022. During Month 3 a revised plan has been approved by the Board and agreed at system level. This will be reflected in Month 3 reporting.

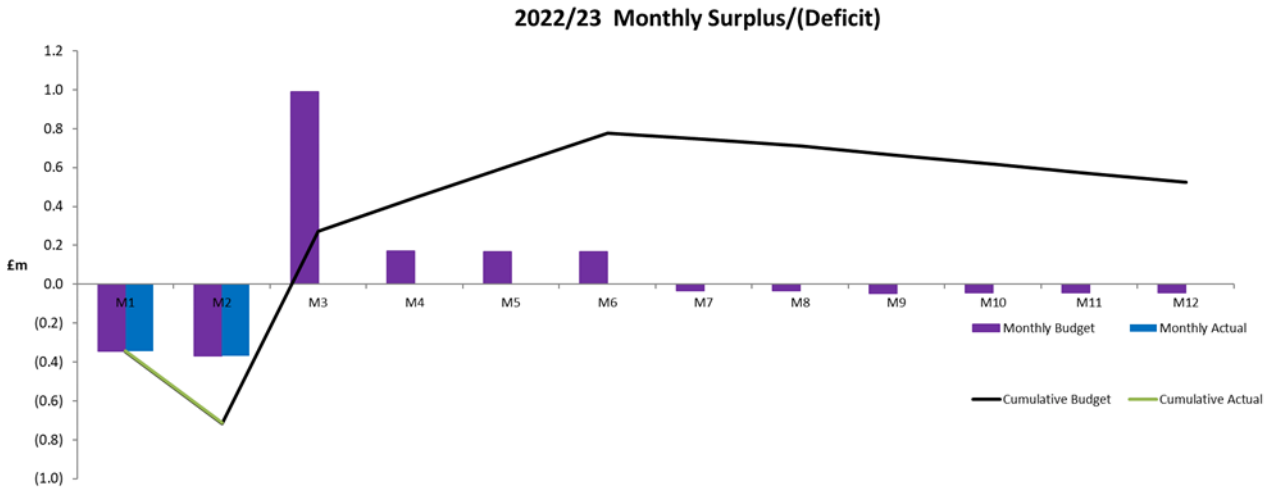
At M2 ERF income for 2022/23 has been accrued to plan as the detailed calculation methodology has not been shared by the national team so there is still some uncertainty as to how this will work. System-wide data on ERF performance has not yet been released.

	Plan (Revised)	Actual	Variance	RAG	*R*	*A*	*G*
Surplus/(Deficit) YTD	-£0.7m	-£0.7m	£0.0m	↔	*>10% off plan*	*Plan*	*Plan or better*
I&E Forecast	£0.5m	£0.5m	£0.0m	↔	*>10% off plan*	*Plan*	*Plan or better*
NHS I/E Rating	3	3	0	↔	*4*	*3*	*2+*
Cash	£6.0m	£6.0m	£0.0m	↔	*<£1m*	*£1m-£4.5m*	*£4.5m+*
Total CIP Achievement	£0.5m	£0.3m	-£0.2m	↓	*>10% off plan*	*Plan*	*Plan or better*
Recurrent CIP Achievement	£0.4m	£0.3m	-£0.2m	↓	*>10% off plan*	*Plan*	*Plan or better*
Elective Recovery Fund (net)	£0.4m	£0.7m	£0.3m	↔	*>10% off plan*	*Plan*	*Plan or better*
Non-Recurrent Items YTD	£0.6m	£1.6m	£1.0m	↓	*>£0*		*<£0*
Capital Spend YTD	£2.4m	£1.5m	-£0.9m				

MAIN REPORT

1. Summary Financial Position

At Month 2 the Trust is reporting a £0.715m deficit which was in line with the deficit plan of £0.715m which was submitted in April 2022. However, in June the Trust Board approved a revised plan of a £0.562m surplus; this will be reflected in Month 3 reporting.



2. Divisional Summary Overview

The plan for 2022/23 included significant funded pressures identified during 2021/22. Financial management and adherence to budgets will be key in 2022/23. All clinical divisions are producing detailed forecasts prior to Month 3 reporting.

Family Health: The Division is overspent by £105k on pay in month. Agency costs are £268k. These are offset by underspend on substantive pay. Recruitment of midwives continues with a significant cohort due to join in October. In the meantime the division is working to reduce agency and incentivise bank shifts. Non pay expenditure is also overspent.

Gynaecology: The division remains overspent by £303k in month, principally on medical pay in both Gynaecology and Hewitt Fertility Centre.

Clinical Support Services: The division is marginally ahead of plan in month. However, underspends on anaesthetic staffing are masking pressures in agency and nursing costs within theatres. The additional investment in theatres in 2022/23 has enabled significant recruitment to permanent positions.

Agency: Agency spend across the Trust is £369k above plan, driven principally by staffing needs recognised in the 2022/23 plan but not yet recruited to permanently.

Fuel costs: The position has improved slightly in M2 but remains an area of volatility and risk to the Trust.

3. Elective Recovery Fund

Providers are required to increase elective activity levels to 104% of 2019/20 levels as a minimum in 2022/23. Additional funding is managed within the ICS to support this initiative. LWH as a standalone organisation has exceeded this baseline but no additional income has been recognised at this stage pending confirmation of this by the regional and national teams.

4. CIP

At M2 the CIP plan is behind schedule with £292k of CIP achieved against a £471k target. This will be monitored in detail within Divisions and through the Finance Recovery Board. Of the CIP savings achieved to date, virtually all are recurrent.

5. COVID-19

The Trust's covid related spend at month 2 is £113k. These costs are expected to fall significantly as the infection control and security costs reduce. Work is also underway to reduce other premises costs including storage hire.

6. Cash and Borrowings

The cash balance at the end of M2 is £6m, a reduction of £3m from M1. This is still well within the Trust's planning limits and reflects the timing of capital payments carried forward as creditors at the end of 2021/22.

7. Capital Expenditure

The capital programme for 2022/23 is oversubscribed and the Trust can only accommodate investment identified as business critical. All clinically essential requests are being processed and this is not holding up the progression of ongoing projects or purchase of any essential equipment.

An additional £285k of system funding has now been made available to the Trust. Therefore the capital programme has increased to £8.820m. The Trust continues to look for other opportunities for additional capital funding, for example from the local radiology imaging network (CAMRIN) to manage capital pressures during the year.

A capital group is in place to monitor spend and change in prioritisation to ensure any changes in risk/clinical need during the year are accommodated.

8. Balance Sheet

Debtors are distorted at the end of month 2 due to invoice raised in advance to support the Trust's cash balance.

Performance against the Better Payment Practice Code for non-NHS suppliers has fallen in M2 to 87% by value. Performance by volume of transactions is lower at 75%. This is an area of focus nationally and will be subject to renewed focus within the finance and procurement teams to move it to the 95% target.

9. BAF Risk

There are no proposed changes to the BAF score.

10. Conclusion & Recommendation

The Board is asked to note the position.

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

FINANCE REPORT: M2

YEAR ENDING 31 MARCH 2023

NHS
Liverpool Women's
NHS Foundation Trust

Contents

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 1
NHS IMPROVEMENT RATIOS: M02
YEAR ENDING 31 MARCH 2023

USE OF RESOURCES RISK RATING	YEAR TO DATE Actual
CAPITAL SERVICING CAPACITY (CSC)	
(a) EBITDA + Interest Receivable	719
(b) PDC + Interest Payable + Loans Repaid	403
CSC Ratio = (a) / (b)	**1.78**
NHSI CSC SCORE	**2**
Ratio Score 1 = > 2.5 2 = 1.75 - 2.5 3 = 1.25 - 1.75 4 = < 1.25	
LIQUIDITY	
(a) Cash for Liquidity Purposes	(15,298)
(b) Expenditure	22,922
(c) Daily Expenditure	376
Liquidity Ratio = (a) / (c)	**(40.7)**
NHSI LIQUIDITY SCORE	**4**
Ratio Score 1 = > 0 2 = (7) - 0 3 = (14) - (7) 4 = < (14)	
I&E MARGIN	
Deficit (Adjusted for donations and asset disposals)	709
Total Income	(23,626)
I&E Margin	**-3.0%**
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)	-3.00%
I&E Margin (Plan)	-3.10%
I&E Variance Margin	**0.10%**
NHSI I&E MARGIN VARIANCE SCORE	**1**
Ratio Score 1 = > 0% 2 = (1) - 0% 3 = (2) - (1)% 4 = < (2)%	
Note: NHSI assume the score of the I&E Margin variance from Plan is a 1 for the whole year	
AGENCY SPEND	
YTD Providers Cap	298
YTD Agency Expenditure	509
	71%
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 2
INCOME & EXPENDITURE: M2
YEAR ENDING 31 MARCH 2023

INCOME & EXPENDITURE	Month 2			YTD		
£'000	Budget	Actual	Variance	Budget	Actual	Variance
Income						
Clinical Income	(10,880)	(11,174)	294	(21,761)	(22,460)	699
Non-Clinical Income	(599)	(635)	36	(1,198)	(1,166)	(32)
Total Income	**(11,479)**	**(11,809)**	**330**	**(22,959)**	**(23,626)**	**667**
Expenditure						
Pay Costs	6,634	7,113	(479)	13,266	14,199	(932)
Non-Pay Costs	2,686	2,583	103	5,350	5,150	199
CNST	1,787	1,787	(0)	3,573	3,573	(0)
Total Expenditure	**11,107**	**11,482**	**(375)**	**22,189**	**22,922**	**(733)**
EBITDA	**(373)**	**(327)**	**(46)**	**(769)**	**(704)**	**(66)**
Technical Items						
Depreciation	534	507	27	1,068	1,031	37
Interest Payable	2	3	(0)	5	5	(0)
Interest Receivable	(1)	(8)	7	(2)	(15)	13
PDC Dividend	207	198	9	413	398	15
Profit/Loss on Disposal or Transfer Absorption	0	0	0	0	0	0
Total Technical Items	**742**	**699**	**43**	**1,484**	**1,419**	**65**
(Surplus) / Deficit	**369**	**372**	**(3)**	**715**	**715**	**(1)**

NHS
Liverpool Women's
NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST **2a**
INCOME & EXPENDITURE HOSTED SERVICES: M2
YEAR ENDING 31 MARCH 2023

INCOME & EXPENDITURE £'000	Month 2 Budget	 Actual	 Variance	YTD Budget	 Actual	 Variance
Income						
Clinical Income	(115)	(303)	188	(229)	(421)	192
Non-Clinical Income	0	0	0	0	20	(20)
Total Income	**(115)**	**(303)**	**188**	**(229)**	**(401)**	**172**
Expenditure						
Pay Costs	0	99	(99)	0	200	(200)
Non-Pay Costs	115	203	(89)	229	201	28
Total Expenditure	**115**	**302**	**(188)**	**229**	**401**	**(172)**
(Surplus) / Deficit	**0**	**(0)**	**0**	**0**	**(0)**	**0**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 3
EXPENDITURE: M2
YEAR ENDING 31 MARCH 2023

EXPENDITURE £'000	MONTH 2 Budget	MONTH 2 Actual	MONTH 2 Variance	YEAR TO DATE Budget	YEAR TO DATE Actual	YEAR TO DATE Variance
Pay Costs						
Board, Execs & Senior Managers	405	419	(14)	814	836	(23)
Medical	1,745	1,815	(71)	3,490	3,722	(232)
Nursing & Midwifery	2,792	2,981	(189)	5,598	5,918	(320)
Healthcare Assistants	472	534	(62)	944	1,022	(77)
Other Clinical	477	430	47	955	854	100
Admin Support	673	667	6	1,328	1,339	(11)
Agency & Locum	70	267	(198)	139	508	(369)
Total Pay Costs	**6,634**	**7,113**	**(479)**	**13,266**	**14,199**	**(932)**
Non Pay Costs						
Clinical Suppplies	708	755	(47)	1,416	1,497	(81)
Non-Clinical Supplies	118	(121)	239	298	(150)	448
CNST	1,787	1,787	(0)	3,573	3,573	(0)
Premises & IT Costs	1,015	1,085	(70)	2,031	2,239	(209)
Service Contracts	846	863	(18)	1,606	1,565	41
Total Non-Pay Costs	**4,473**	**4,370**	**103**	**8,923**	**8,724**	**199**
Total Expenditure	**11,107**	**11,482**	**(375)**	**22,189**	**22,922**	**(733)**

Note that the values above exclude £69k in relation to hosted services.

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 4
COVID EXPENDITURE: M2
YEAR ENDING 31 MARCH 2023

EXPENDITURE	MONTH 2			YEAR TO DATE		
£'000	Budget	Actual	Variance	Budget	Actual	Variance
Pay Costs						
Board, Execs & Senior Managers	3	(12)	16	6	1	5
Medical	0	0	0	0	(0)	0
Nursing & Midwifery	12	(3)	15	24	0	24
Healthcare Assistants	0	11	(11)	0	15	(15)
Other Clinical	0	0	0	0	(0)	0
Admin Support	0	6	(6)	0	26	(26)
Agency & Locum	0	0	0	0	0	0
Total Pay Costs	**15**	**1**	**14**	**30**	**42**	**(12)**
Non Pay Costs						
Clinical Suppplies	0	6	(6)	0	12	(12)
Non-Clinical Supplies	11	(0)	11	22	12	10
CNST	0	0	0	0	0	0
Premises & IT Costs	0	40	(40)	0	72	(72)
Service Contracts	0	0	0	0	(24)	24
Total Non-Pay Costs	**11**	**45**	**(34)**	**22**	**72**	**(50)**
Total Expenditure	**26**	**47**	**(21)**	**52**	**113**	**(61)**

Note that the values above include £4k YTD related to Vaccination and LAMP Testing expenditure which should both be reimbursed.

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 5
BUDGET ANALYSIS: M2
YEAR ENDING 31 MARCH 2023

INCOME & EXPENDITURE £'000	MONTH 2 Budget	MONTH 2 Actual	MONTH 2 Variance	YEAR TO DATE Budget	YEAR TO DATE Actual	YEAR TO DATE Variance
Maternity						
Income	(4,156)	(4,110)	(46)	(7,928)	(7,906)	(23)
Expenditure	2,206	2,267	(61)	4,408	4,509	(101)
Total Maternity	**(1,950)**	**(1,843)**	**(107)**	**(3,521)**	**(3,397)**	**(124)**
Neonatal						
Income	(1,757)	(1,732)	(25)	(3,371)	(3,336)	(34)
Expenditure	1,284	1,359	(75)	2,568	2,654	(86)
Total Neonatal	**(473)**	**(373)**	**(100)**	**(803)**	**(683)**	**(120)**
Division of Family Health - Total	**(2,423)**	**(2,217)**	**(207)**	**(4,323)**	**(4,080)**	**(244)**
Gynaecology						
Income	(2,016)	(2,006)	(10)	(3,846)	(3,818)	(28)
Expenditure	1,181	1,230	(48)	2,362	2,479	(117)
Total Gynaecology	**(834)**	**(776)**	**(58)**	**(1,484)**	**(1,338)**	**(145)**
Hewitt Centre						
Income	(751)	(716)	(35)	(1,467)	(1,466)	(2)
Expenditure	711	847	(137)	1,421	1,607	(186)
Total Hewitt Centre	**(40)**	**131**	**(172)**	**(46)**	**142**	**(188)**
Division of Gynaecology - Total	**(875)**	**(645)**	**(230)**	**(1,530)**	**(1,197)**	**(333)**
Theatres						
Income	0	0	0	0	0	0
Expenditure	917	892	25	1,834	1,814	20
Total Theatres	**917**	**892**	**25**	**1,834**	**1,814**	**20**
Genetics						
Income	(13)	(8)	(5)	(25)	(10)	(16)
Expenditure	169	146	23	338	282	56
Total Genetics	**156**	**138**	**18**	**312**	**272**	**40**
Other Clinical Support						
Income	(361)	(353)	(9)	(693)	(682)	(11)
Expenditure	618	621	(4)	1,235	1,237	(2)
Total Clinical Support	**257**	**269**	**(12)**	**542**	**555**	**(13)**
Division of Clinical Support - Total	**1,330**	**1,298**	**31**	**2,688**	**2,641**	**47**
Corporate & Trust Technical Items						
Income	(2,540)	(3,187)	647	(5,857)	(6,810)	953
Expenditure	4,878	5,121	(244)	9,736	10,160	(424)
Total Corporate	**2,338**	**1,935**	**403**	**3,879**	**3,350**	**529**
(Surplus) / Deficit	**369**	**372**	**(2)**	**715**	**715**	**(0)**
Of which is hosted;						
Income	(115)	(303)	188	(229)	(401)	172
Expenditure	115	302	(188)	229	401	(172)
Total Corporate	**0**	**(0)**	**0**	**0**	**(0)**	**0**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 6
CIP: M2
YEAR ENDING 31 MARCH 2023

	Month 2			YTD			Full Year		
Scheme	**Target**	**Actual**	**Variance**	**Target**	**Actual**	**Variance**	**Target**	**FOT**	**Variance**
Procurement and Non Pay	102	73	(29)	205	147	(58)	1,295	1,295	0
Estates utilisation	34	29	(5)	68	58	(10)	412	412	0
Staffing and skill mix	41	27	(14)	82	54	(28)	578	578	0
Medicines Management	0	0	0	0	0	0	30	30	0
Service Developments	30	0	(30)	61	0	(61)	466	466	0
Theatre Efficiency	3	0	(3)	7	0	(7)	100	100	0
Technology Driven Efficiencies	8	0	(8)	16	0	(16)	206	206	0
Income	0	0	0	0	0	0	797	797	0
Other Savings Plans	17	17	0	33	33	0	316	316	0
Total	**235**	**146**	**(90)**	**471**	**292**	**(179)**	**4,200**	**4,200**	**0**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 7
BALANCE SHEET: M02
YEAR ENDING 31 MARCH 2023

BALANCE SHEET £'000	YEAR TO DATE Opening	M02 Actual	Movement
Non Current Assets	101,380	101,852	472
Current Assets			
Cash	11,192	6,017	(5,175)
Debtors	5,929	10,570	4,641
Inventories	523	553	30
Total Current Assets	**17,644**	**17,140**	**(504)**
Liabilities			
Creditors due < 1 year - Capital Payables	(4,849)	(2,787)	2,062
Creditors due < 1 year - Trade Payables	(18,362)	(17,376)	986
Creditors due < 1 year - Deferred Income	(4,157)	(8,311)	(4,154)
Creditors due > 1 year - Deferred Income	(1,561)	(1,556)	5
Loans	(1,525)	(1,525)	0
Loans - IFRS16 leases	(49)	(45)	4
Provisions	(3,889)	(3,475)	414
Total Liabilities	**(34,392)**	**(35,075)**	**(683)**
TOTAL ASSETS EMPLOYED	**84,632**	**83,917**	**(715)**
Taxpayers Equity			
PDC	70,713	70,713	0
Revaluation Reserve	12,749	12,749	0
Retained Earnings	1,170	455	(715)
TOTAL TAXPAYERS EQUITY	**84,632**	**83,917**	**(715)**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 8
CASHFLOW STATEMENT: M02
YEAR ENDING 31 MARCH 2023

CASHFLOW STATEMENT £'000	Actual
Cash flows from operating activities	(327)
Depreciation and amortisation	1,031
Impairments and reversals	0
Income recognised in respect of capital donations (cash and non-cash)	0
Movement in working capital	(2,304)
Net cash generated from / (used in) operations	**(1,600)**
Interest received	14
Purchase of property, plant and equipment and intangible assets	(3,589)
Proceeds from sales of property, plant and equipment and intangible assets	0
Net cash generated from/(used in) investing activities	**(3,575)**
PDC Capital Programme Funding - received	0
PDC COVID-19 Capital Funding - received	0
Loans from Department of Health Capital - repaid	0
Loans from Department of Health Revenue - received	0
Loans from Department of Health Revenue - repaid	0
Interest paid	0
PDC dividend (paid)/refunded	0
Net cash generated from/(used in) financing activities	**0**
Increase/(decrease) in cash and cash equivalents	**(5,175)**
Cash and cash equivalents at start of period	11,192
Cash and cash equivalents at end of period	**6,017**

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	(3,975)	1,525
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**	**(33,159)**	**1,525**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST **9**
CAPITAL EXPENDITURE: M2
YEAR ENDING 31 MARCH 2023

CAPITAL EXPENDITURE	Year to Date			FOT		
£'000	Plan	Actual	Variance	Plan	Actual	Variance
Estates	52	0	52	550	550	0
Capital Projects	788	1,286	(498)	4,527	4,527	0
Digital	258	193	65	1,161	1,161	0
Medical Equipment	1,255	46	1,209	2,297	2,297	0
	0	0	0	0	0	0
	0	0	0	0	0	0
Other	**0**	**0**	**0**	**0**	**0**	**0**
Grand Total	**2,353**	**1,525**	**828**	**8,535**	**8,535**	**0**

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

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*22/23/080*		**Date: 07/07/2022**	
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 5 May 2022.

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 May and June 2022.

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

The review process for this month's update has focused on ensuring that mitigating actions against identified gaps in assurance have been updated. These can be seen in the track changes on the BAF in Appendix 1. The review for September's Board will be more extensive and will propose Quarter 2 2022/23 scores.

New Risks or Strategic Threats

At the Quality Committee in June 2022, a discussion was held regarding the Trust's position in relation to performance against key access targets. There was agreement that this was a key risk to the Trust achieving its strategic aims and it therefore needed to be reflected on the BAF. An action was taken to articulate this as a 'strategic threat' and bring back for approval to the next scheduled Committee meeting. The outputs of this will be reported to the September 2022 Board.

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.

NHS
Liverpool Women's
NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK 2022/2023

Trust Board – July 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/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on many 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 2022/2023

SA	BAF Risk	Committee	Lead	May 2022	Q2	Q3	Q4	Q 2 Q movement	2022/23Target
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)				⟷	8 (I2 x c4)
	1.2 Failure to recruit and retain key clinical staff	PPF	CPO	20 (I5 x c4)				⟷	16 (I4 x c4)
SA2 Safe	2.1 Failure to progress our plans to build a new hospital co-located with an adult acute site	FPBD	CFO	15 (I3 x c5)				⟷	10 (I2 x c5)
	2.2 Failure to develop our model of care to keep pace with developments and respond to a changing environment	FPBD	COO	16 (I4 x c4)			▬	⟷	12 (I3 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)				⟷	15 (I3 x c5)
	2.4 Major and sustained failure of essential IT systems due to a cyber attack	FPBD	CIO	20 (I4 x c5)				↑	15 (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)
SA4 Efficient	4.1 Failure to ensure our services are financially sustainable in the long term	FPBD	CFO	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	MD	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)				⟷	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)				⟷	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 & maintain a highly skilled & engaged workforce	20 (4 x 5)

Ref	Corporate Risk Register / High Scoring (15+) Risks	Risk Score
2443	Inability to recruit specialised allied health professions in a timely manner	16
1705	Insufficient midwifery staffing levels as recognised by birth rate place plus.	20
2424	Unable to meet safe staffing levels in line with BAPM requirements	15
2087 **(CRR)**	Uncertainty about provision of a safe Maternity service able to give more effective interventions with 24/7 Consultant presence on Delivery suite and sufficient consultant cover for 10 elective caesarean lists per week and high-level MAU cover.	16
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
2491 (CRR)	Noncompliance with mandated level of fit mask testers qualification, accreditation, and competency	15

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 09/03/2022

2323 - No change in risk score since last review. Last reviewed 08/03/2022

1704 – No change in risk score since last review. Last reviewed 11/02/2022.

2491 – No change in risk score since last review. Last reviewed 08/03/2022

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: April 2022	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:

May 2022	Q2	Q3	Q4	Q 2 Q movement	2022/23 Target
12 (3 x 4)				⟷	8 (2 x 4)

Rationale for current risk score:

The Trust has several strong controls in place against this risk and can demonstrate effective performance in comparison with other NHS trusts. During 2021/22, for the first time, the Trust 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 during 2022/23.

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	To ensure that there are robust processes in place to target advertising, work shadowing opportunities, pre-application training and offering career advice **(Action 1.1 / 1)** To simplify the EIA process **(Action 1.1 / 2)** To further widen opportunities for the local community to join the LWH workforce **(Action 1.1 / 3)** To continue to develop more diverse recruitment and selection processes **(Action 1.1 / 4)**	
	Links with community leaders established to improve under-representation	PPF Strategy and action plan – monitored by PPF Committee		
	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 and WDES submissions		
	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		
	HR policies reviewed in line with fair and just culture	Policy review process reported to PPF		
	WDES and WRES action plan delivery in line with timescales presented from NHS England	WDES and WRES Action Plan submissions		
	Demographic tracking for training access	In place and monitored by Head of L&D OD		
	Establishment of staff inclusion Networks and work in collaboration with local Trusts to promote staff networks and LGBTQ Network to be launched in 2022.	Progress reported to PPF Committee		
	Reciprocal Mentorship Scheme developed	Feedback through Executive Team		
	Extension of e-learning package to design and deliver specific EDI training and education to all LWH staff	PPF Committee		
	Education and celebration of the key EDI events: Black History Month, Disability History Month, LGBT+ History Month and key faith observance days/festival	Staff Communications		
	Utilising widening participation programmes and alternative ways to advertise and promote our job opportunities to attract local population to work at LWH.	PPF Committee		
	Staff from diverse backgrounds having career conversations with manager	Review of appraisal process – PPF and feedback from staff inclusion networks		

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
1.1 / 1	Robust targeting of job adverts – engagement in health and careers fairs with local community groups for example Pakistani Centre, Al Ghazali Centre	Head of Culture, Inclusion, Wellbeing and Engagement	September 2022 (ongoing)	E&D Sub-Committee	
1.1 / 2	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 Due to absence within a key post this has not progressed however bank resource has now been secured and this piece of work will be completed by September 22	Head of Culture, Inclusion, Wellbeing and Engagement	~~July~~ September 2022	E&D Sub-Committee	
1.1 / 3	Establishment of mentoring scheme for 14/15 year olds in the L8 area to encourage them into the midwifery pathway	Head of Culture, Inclusion, Wellbeing and Engagement	September 2022	E&D Sub-Committee	
1.1 / 4	Exploration and implementation of more diverse recruitment and selection processes including diverse interview panels and alternative recruitment methods Diverse interview panels have commenced but are yet to be consistently applied to all senior roles. Employees with protected characteristics have been invited to take part in national training to participate in recruitment processes in other NHS Trusts.	Head of Culture, Inclusion, Wellbeing and Engagement	~~March~~ September 2022	E&D Sub-Committee	

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

Unable to effectively engage with our patient and staff groups to understand further the needs of individuals with protected characteristics and respond proactively to identified needs	Patient information leaflets are up to date and accessible for all protected groups. Patient leaflets are on the website that can translate this information into various languages/ fonts and read aloud versions.	Annual audit of patient leaflets to ensure accessibility and usability	Need to create template for patient story capture and response at Divisional level and process to ensure consistent approach is sustainable over time **(Action 1.1 / 4**). To provide assurance regarding Patient Information Leaflet audit to PIEG on an annual basis (**Action 1.1 / 5**) Local ownership of FFT results to enable improvements to be created and implemented at a local level **(Action 1.1 / 6)**	
	Utilisation of the Health Inequalities data within power BI to lead work between the Patient Experience Team and the Cultural Liaison Midwife to target areas of disparity.	Updates from these associated actions are presented and updated through the Patient Involvement and Experience Subcommittee.		
	Engagement with local groups lead by the Patient Experience Matron to listen to the concerns and required adjustments and improvements desired. These include the local Muslim mosque and Merseyside Deaf society	Updates from these interactions, and any associated actions are presented and updated through the Patient Involvement and Experience Subcommittee.		
	FFT Data now included EDI monitoring to allow experience reviews to be compared between groups with and without a protected characteristic	Data is presented at Patient Involvement and Experience Subcommittee.		
	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		
	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		

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
1.1 / 4	To create template for patient story capture and response at Divisional level and process to ensure consistent approach is sustainable over time	Head of Audit, Effectiveness and Patient Experience	July 2022	Patient Involvement & Experience Sub-Committee	
1.1 / 5	To provide assurance regarding Patient Information Leaflet audit to PIEG on an annual basis	Head of Audit, Effectiveness and Patient Experience	September 2022	Patient Involvement & Experience Sub-Committee	
1.1 / 6	Local ownership of FFT results to enable improvements to be created and implemented at a local level	Head of Audit, Effectiveness and Patient Experience	September 2022	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	Move to recovery of pre-covid activity levels whilst adhering to all covid restrictions and requirements Hybrid working where appropriate Eased rules for mask wearing in non-clinical spaces providing 1m distancing can be observed Adherence to national guidance in respect of isolation periods for covid positive staff Clear criteria as to elements of activity and types of patients the Trust can assist with Asymptomatic testing twice weekly for staff Staff 'booster' vaccination and flu plan for 22/23 in place Visiting restrictions Patient testing	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	Levels of Asymptomatic staff testing remain lower than desired	

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
1.1 / 7	Close working with Cheshire and Mersey procurement via Covid Supply Response (CSR)	Head of Procurement	On-going	EPPR	

BAF Risk 1.2: Failure to recruit & maintain a highly skilled & engaged workforce

Lead Director: CPO
Op Lead: Deputy Director of Workforce

Review Date: Apr 22

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:

May 2022	Q2	Q3	Q4	Q 2 Q movement	2022/23 Target
20 (4 x 5)				⟷	16 (4x4)

Rationale for current risk score:

The Trust has acute and chronic staffing challenges in several areas and a sickness absence rate which has been consistently above target. Staff engagement scores are below the average for peer organisations as measured by the Annual Staff Survey. Maternity staffing issues are acute and have been exacerbated by absence linked to the Covid pandemic and low morale. The Trust has seen an increase in turnover associated with staff opting to leave the service or take retirement. There are significant challenges associated with specialist obstetric anaesthesia recruitment and theatre staffing. Other impacting factors include insufficient numbers of doctors in training, national shortage of nurses & midwives, the clinical risk associated with an isolated site impacting on the recruitment & retention of senior specialist medical staff, the impact of pension tax changes, the ongoing pandemic challenges and the associated recovery of elective activity.

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 appraisals requires further improvement and monitoring **(Action 1.2 / 1)** Further evidence required that robust plans are being reviewed regularly at Divisional Board level **(Action 1.2 / 2)**	
	LWH 'People Promise' to launch in 2022 – bringing together key strands of people strategy including behavioural framework	PPF		
	Behavioural framework developed in partnership with staff in 2021	PFF Committee, In the Loop, Great Place to Work Group		
	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		
	Consultant revalidation process.	Outcomes reported to PPF and the Board		
	Reward and recognition processes linked to values.	Monthly KPI's for controls.		
	Pay progression linked to mandatory training compliance	Monthly KPI's for controls.		
	Targeted OD intervention for areas in need to support.	PPF Committee		
	New Leadership Programme and Talent Management framework in place.	Leadership & Talent Strategy		
	Programme of health and wellbeing initiatives including launch of LWH Staff Support Service, recruitment of LWH Psychologist and Wellbeing Coaches	Reported to PPF Committee		
	All new starters complete mandatory PDR training as part of corporate induction ensuring awareness of responsibilities.	Monthly KPI's for controls.		
	Workforce planning processes in place to deliver safe staffing.	Divisional Board and Divisional Performance Reviews		
	Shared decision making with JLNC and Partnership Forum.	Chair's Report to PPF Committee		
	Putting People First Strategy	Progress reported to PPF Committee		
	Guardian of Safe Working.	Report form Guardian of Safe Working		
	PDR training programme in place and PDR window for band 7 and above in N&M commenced in 2021	Monthly KPI's for controls.		
	Two Freedom to Speak Up Guardians (including representation from a diverse and clinical background)	Bi-annual Speak Up Guardian Reports.		
	Whistle Blowing Policy	Annual Report to PPF and Audit Committee		
	Regular Local Staff Surveys	Quarterly internal staff survey (In the Loop)		
	Regular Listening Events	Listening events increased to bi-monthly		

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
1.2 / 1	To review indicators showing direction of travel for the quality of appraisals	Deputy Director of Workforce	September 2022	PPF Committee	
1.2 / 2	To receive assurance that Divisional Boards are effectively reviewing and updating workforce plans	Deputy Director of Workforce	September 2022	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 & associated elective recovery has the ongoing potential to	Staff working from home where appropriate, use of virtual meetings and enhanced IT provision	PPF Committee Feedback from staff side	None noted.	
	Refreshed staff absence process and monitoring with increased flexibility			
	Regular staff communications Listening Event for staff completed to consider what further action the Trust could take to ensure staff are protected as much as possible. Specific sessions held for staff with protected characteristics.			
	Risk Assessments undertaken for shielding & vulnerable staff			

impact staff morale, wellbeing and retention	Gap Reference	Required Action	Lead	Implement By	Monitoring	Status	
	N/A						

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	Further utilisation of the rota management system. E-Rostering System not fully utilised **(Action 1.2 / 3)** Requirement for assurance that workforce plans are reviewing regularly at Divisional Board level **(Action 1.2 / 4)** Requirement to respond effectively to Ockenden recommendations regarding staffing **(Action 1.2 / 5)** Clinical risks associated with isolated site impact upon recruitment & retention of specialist medical staff **(Action 1.2 / 6)**	
	Regional Training Programme Directors manage the junior doctor rotation programme and highlight shortages to the Lead Employer.	Lead Employer notifies the Trust of Gaps in local rotations, giving the Trust autonomy to recruit at a local level into these gaps		
	Effective electronic rota management system for AFC staff implemented with doctors implemented by early 2022	PPF Committee		
	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		
	Guardian of Safe Working Hours appointed in 2016 under new Junior Doctor Contract.	Quarterly reporting by Guardian of Safe Working.		
	Acting down policy and process in place to cover junior doctor gaps	Quarterly reporting by Guardian of Safe Working.		
	National Revalidation process ensuring competent staff.	Revalidation report to PPF Committee		
	Shared decision making and review of risk with JLNC.	Chair's Report to PPF Committee		
	Succession Planning and Talent Programmes	PPF Committee		
	NHSE/I leadership programme to reduce sickness	PPF Committee		
	Shared appointments with other providers	PPF Committee		
	Secured operating time at the LUH	PPF Committee		
	Increased consultant recruitment with incentives Neonatal Partnership	PPF Committee		
	Maternity introduction of ACP Midwives	PPF Committee		
	Work underway to ensure that the number of staff without a Covid-19 vaccine is minimised	PPF Committee		
	Flexible working programme	PPF Committee		
	Bi-annual safe staffing reports	PPF Committee and Board		
	Birth rate Plus Report	Board		
	NHSP utilisation for bank staff			
	Preceptorship for nursing and midwifery staff			

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
1.2 / 3	E-rostering system for doctors - Allocate is implemented for O&G and work commenced for other specialties Roll out of the e-rostering system Allocate for Neonatal and Anaesthetics is ongoing. Project resource has been identified to progress and this work will be completed by Autumn 22	Deputy Director of Workforce	November~~June~~ 2022	PPF Committee	
1.2 / 4	To provide evidence that robust workforce plans are being reviewed regularly at Divisional Board	Deputy Director of Workforce	September 2022	PPF Committee	
1.2 / 5	Respond to Ockenden recommendations relating staffing	Deputy Director of Workforce	September 2022	PPF Committee	
1.2 / 6	To ensure that staffing issues are included and noted as a key risk in discussions regarding the single site risk.	CPO	On-going	Board	

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	20 (4 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 08/11/21

2085 - No change in risk score since last review. Last reviewed 15/09/2021

2086 - No change in risk score since last review. Last reviewed 07/12/21

2296 – Risk moved from 16 to 9 - Discussed as part of the 24/7 transfusion project - machine is still under contract extension

2321 - No change in risk score since last review. Last reviewed 09/03/2022

2469 – No change in risk score since last review. Last reviewed 13/01/2022

2470 – No change in risk score since last review. Last reviewed 09/03/2022

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.	9
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: CFO
Op Lead: Head of Transformation & Strategy

Review Date: Apr 22

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:

May 2022	Q2	Q3	Q4	Q 2 Q movement	2022/23 Target
15 (3 x 5)				⟷	10 (2 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 and key partners 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 Regional and national NHSE leaders have visited the Trust and been briefed about the case for change, including Amanda Doyle, Jackie Dunkley-Bent, Ruth May	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 Business case refresh is led by Trust rather than commissioners as with previous case Public consultation required Transfer of commissioning arrangements from CCGs to ICS Potential change in ICS Board in April 2022 Requirement for commissioners to agree process to manage non-compliance with service specifications and standards where no further provider action can be taken. Case for change and counterfactual case to be presented to HOSCs Lobby systems and MPs for active support External review/testing of counterfactual case - ongoing External review/testing of refreshed case for change, following completion of FGCAG work/business case refresh - ongoing	
	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		
	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)		
	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 The Trust is working closely with Liverpool CCG to plan pre-consultation engagement, engagement with HOSCs and draft consultation timeline. Meetings held with CIC, Spec Comm, Cancer Alliance Steering Group and Programme Board, Adult CCN and LMS and have received unambiguous support for the case for change from all stakeholder groups. Meeting held with specialised commissioners to discuss management of non-compliance with standards, where no further action can be taken by the Trust to mitigate non-compliance.		
	Future Generations project group established with the Trust	Reports to the FPBD		
	External validation of case for change	Output from Clinical Summit report (2019 and 2022)		

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 - ongoing	Board	
2.1/2	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	October 2022	Board	
2.1/3	Business case refresh – refreshed estates modelling and schedule of accommodation for new build	Head of Strategy and Transformation	October 2022	Board	
2.1/4	External validation of case for change and counterfactual case COMPLETE – REFERENCED IN SOURCES OF ASSURANCE	Medical Director	April 2022	Board	
2.1/5	Commence public consultation (external control of this action by commissioners and NHSE/I)	Head of Communications and Marketing	December 2022	Board	
2.1/6	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	
2.2 / 7	Lobby systems and MPs for active support	Head of Communications and Marketing	September 2022	Board	
2.2 / 8	Build relationships with key ICS personnel	Medical Director	September 2022	Board	

	2.2 / 9	Meetings with key partners to share case for change and counterfactual case and request explicit support COMPLETE – REFERENCED IN SOURCES OF ASSURANCE	Medical Director, Head of Strategy and Transformation	April 2022	Board		
	2.2 / 10	Request re-prioritisation of C&M capital schemes	Chief Finance Officer	April 2022	Board		
	2.2 / 11	Meeting with specialised commissioners to discuss management of non-compliance with standards, where no further action can be taken by the Trust to mitigate non-compliance. COMPLETE – REFERENCED IN SOURCES OF ASSURANCE	Medical Director, Chief Finance Officer	April 2022	Board		
	2.2 / 12	Presentation of case for change and counterfactual case at HOSC	Medical Director, Head of Strategy and Transformation	June/July 2022	Board		

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 the local community and receive buy-in to move project forward.	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	Further communication required of strategy and Future Generations position within strategy with local community, patients and public	
	Pre-consultation Business Case and public consultation	Trust refresh of Strategic Outline Case is underway, informed by work of the FG CAG. Much of this information can be used by commissioners to complete a PCBC ready to inform public consultation. Stage 1 Assurance meeting has been held with NHS England and commissioners to carry out strategic sense check and agree governance and process	Public consultation required – this must be led by commissioners No clear agreement at present regarding commissioners vs provider responsibility for completion of PCBC	
	Discussion of case for change with patients, public and local community	Refreshed case for change and counterfactual case will need to be shared with public, patients and the local community. Case for change and counterfactual case have already been validated by partners and independent clinical senate.	Lobby systems and MPs for active support Case for change and counterfactual case not yet shared with public Engagement with local community required regarding case for change and counterfactual case	
	Comms and Engagement Activities	The Trust is working closely with Liverpool CCG to plan pre-consultation engagement, and draft consultation timeline. Currently reviewing outcomes of previous engagement exercises and updating publicly available information.	Further work required to engage women and their families in option appraisal process and model of care development	

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
2.1 / 13	Promotion of Trust Strategy and FG Strategy as part of overall Strategy Comms and Engagement plans	Head of Communications and Marketing	April 2022 – Sept 2022	Board	
2.1 / 14	Stage 1 Assurance meeting to take place with NHSE COMPLETE – REFERENCED IN SOURCES OF ASSURANCE	Chief Finance Officer	April 2022	Board	
2.1 / 15	Agreement of responsibility for production of pre-consultation business case with commissioners	Chief Finance Officer	August 2022	Board	
2.1 / 16	Public consultation regarding options to address case for change (external control of this action by commissioners)	Chief Finance Officer	December 2022	Board	
2.1 / 17	Present case for change and counterfactual case at public Board meeting	Medical Director	June/July 2022	Board	
2.1 / 18	Comms and engagement campaign and public engagement activities to support consultation, options appraisal, model of care development	Head of Communications and Marketing	July 2022	Board	

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
Failure to secure capital funding to progress our plans to build a new hospital co-located with an adult acute site	Submission of Expression of Interest to New Hospital Building Programme	Expression of interest submitted September 2021 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 WHH scheme prioritised in C&M – request re-prioritisation Funding option not yet agreed	
	Engagement with Liverpool City Council re alternate source of funding	Previous application for funding submitted and agreed 2019 New ongoing engagement to refresh request and model funding options		
	Engagement with regional and national teams regarding capital funding options	Regular meetings between CFO and regional teams to discuss capital funding options Engagement with LUHFT CEO to discuss capital funding options		

2.1/ 19	Approval of EOI (external control of this by NHSE/I)	Chief Finance Officer	September 2022	Board	
2.2 / 20	Engagement with LCC to develop and potentially agree alternate capital funding source	Chief Finance Officer	April – July 2022	Board	

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:

May 2022	Q2	Q3	Q4	Q 2 Q movement	2022/23 Target
16 (4 x 4)				⟷	12 (3x4)

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 FPBD Committee overview and scrutiny Digital Hospital Committee oversight Approved EPR Business case which define clear direction and preferred solution. EPR programme board chaired by MD Independent lessons learnt Positive review MIAA Critical Application Audit (rolling programme across trust systems) Reporting into Audit Committee and Digital Hospital Group	Multiple Clinical Systems issues remain **(Action 2.2 / 2)** Ability of clinical staff to engage with the system development due to time and financial impact **(Actions 2.2 / 1, 2.2 / 3, 2.2 / 4)** Optimisations to K2 system and refinements which are required **(Action 2.2 / 5)** Not all Trust using LHCRE for patient information exchange **(Action 2.2 / 6)**	
	Approved Meditech Expanse Business Case			
	Maintenance of present system			
	Development of individual / service solutions e.g. PENs (Gynaecology) and Staff training			
	Incident reporting			
	Tactical solutions including the implementation of K2 Athena system			
	Exchange/LHCRE enables for patent information sharing			
	Virtual Desktop technology to aid staff working flexibly.			
	Additional network resilience for LUHFT supplied systems (K2/PENS/CRIS) to reduce risk of unplanned systems downtime			
	PACS upgrade removes a separate login for that system, reducing multiple systems issues.			
	Task and Finish group established to ensure that clinical investigation undertaken at external trusts have been actioned accordingly.	Safety and Effectiveness Sub-Committee		
	Appropriate task and finish groups established as required by Safety and Effectiveness sub-committee	Safety and Effectiveness Sub-Committee		
	Digital clinical leadership business case developed	Digital Hospital Sub-Committee		
	Optimisations to K2 system and refinements implemented	Digital Hospital Sub-Committee		

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
2.2 / 1	Develop staff communication plan for new system	CIO	December 2022	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	November 2022	Digital Hospital Committee oversight	
2.2 / 4	Develop a business case for appropriate digital training capabilities for the Trust CLOSE - funding not required. Utilise existing e-learning platform	CIO	April 2022	Digital Hospital Committee oversight	
2.2 / 5	Implement required system optimisations as identified by Maternity and other Trust stakeholders	CIO	April 2022	Digital Hospital Committee oversight	
2.2 / 6	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 Added to controls	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 **(Action 2.2 / 7)** To understand commissioning priorities emerging from developing ICS **(Action 2.2 / 7)**	
	Operational planning process	Operational plans and budgets		
	Availability of data on service trends and demographics	Divisional Boards		
	Workforce plans	Divisional Boards		

local population and/or reduce health inequalities					To ensure that Divisions are fully utilising data to understand changing service demands **(Action 2.2 / 8)** To ensure that workforce plans are informed by trends and data led intelligence. **(Action 2.2 / 9)**		
	Gap Reference	Required Action	Lead	Implement By	Monitoring	Status	
	2.2 / 7	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	July 2022	Executive Team		
	2.2 / 8	To ensure that Divisions are fully utilising data to understand changing service demands	Deputy COO	September 2022	Executive Team		
	2.2 / 9	To ensure that workforce plans are informed by trends and data led intelligence.	Deputy COO	September 2022	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: Apr 2022**	**Ulysses Ref: TBC**

Strategic Priority: SA2: To deliver SAFE services

Lead Committee: Quality Committee

Provider Licence Compliance link:

N/A

SCORE:

May 2022	Q2	Q3	Q4	Q 2 Q movement	2022/23 Target
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	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 2.3/2)** 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. **(Action 2.3/3)** Lack of 24/7 transfusion laboratory on site leads to delay in patients receiving transfusion. **(Action 2.3/4, 2.3/5)** 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 (Maternity) and January 2022 (Neonates). There remains an on-going challenge in relation to Anaesthetics recruitment. **(Action 2.3/6)** Financial and workforce constraints for delivery of additional facilities on site. **(Action 2.3 / 1)** Construction works not yet complete to accommodate new FMU, colposcopy suite, CT & MR Imaging suites – due to complete December 2022 **(Action 2.3/8)** 24/7 transfusion laboratory not yet established – aim for completion September 2022 **(Action 2.3/4)** Colposcopy decant not yet complete – aim for completion June 2022 **(Action 2.3/9)** Full CDC Services not yet implemented **(Action 2.3 / 10)** Signed SLA with LUHFT required **(Action 2.3 /3)**	
	£15m capital investment in neonatal estate to address infection risk	IPC Reports		
	Transfer arrangements well established for neonates	Transfers out monitored by Partnership		
	Transfer arrangements for adults	Transfers out monitored at HDU Group		
	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	Partnership activity to report through to FPBD and Board on a quarterly basis		
	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,		
	Investments in additional staffing inc. towards 24/7 cover - Maternity	Staff Staffing levels reports to board		
	Investments in additional staffing inc. towards 24/7 cover - Anaesthetics	Staff Staffing levels reports to board		
	Investments in additional staffing inc. towards 24/7 cover – Gynaecology, including additional investment in ANP roles within GED	Staff Staffing levels reports to board		
	Investments in additional staffing inc. towards 24/7 cover - Neonates	Staff Staffing levels reports to board		
	Enhanced resuscitation training provision - Paediatric	Training compliance rates reported to PPF Committee		
	Enhanced resuscitation training provision - Adult	Training compliance rates reported to PPF Committee		
	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		
	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.		
	Divisional Operational Plans completed	Divisional Boards		
	Use of telemedicine to facilitate consultations both at Crown Street and other sites	Divisional Boards		
	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		

	Progress being made in relation to building relationships with LUFT - Task and finish groups established, reporting into the Partnership Board with LUHFT setting out arrangements for partnership working across all four LWH and LUHFT sites	Partnership Board meetings and involvement in wider Estates Strategy Mapping of requirements from and interdependencies with LUHFT across all Trust specialties			
	Agreed funding for all mitigations on site are included in operational planning	FPBD (monthly oversight reports and detailed budget)			
	A telemedicine pilot has been implemented to provide additional support for pregnant women on ITU at the Royal Liverpool Hospital.	Single Site risk report – provided to July 2022 Board			
	SOP implemented for paediatric resus provision	Safety and Effectiveness Senate – received update in January 2022			

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
2.3 / 1	Agree funding for all mitigations on site are included in operational planning See controls	Deputy Chief Finance Officer	April 2022	FPBD Committee	
2.3 / 2	Provision of staffed and dedicated ambulance to facilitate transfer of adult patients to be explored.	Deputy Chief Operating Officer	TBC	Quality Committee	
2.3 / 3	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 / 4	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 / 5	Implement remote issue of blood products to minimise delay in transfusion delayed due to issues with external suppliers	Head of AHPs	October 2022	Crown Street Enhancements Programme Board, FPBD	
2.3 / 6	Continue to recruit to secure 24/7 Anaesthetics cover	Clinical Directors	January 2023	TBDG	
2.3 / 7	Clear SOP to be implemented for paediatric resus provision	Deputy Medical Director	January 2022	Quality Committee	
2.3 / 8	Complete construction of colposcopy, CT & MR imaging suites	Head of Strategy and Transformation	December 2022	Crown Street Enhancements Programme Board, FPBD	
2.3 / 9	Project to manage decant and new ways of working within colposcopy delayed due to delay in build programme	Deputy Divisional Manager for Gynaecology	August 2022	Crown Street Enhancements Programme Board, FPBD	
2.3 / 10	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 / 11	Project to expand use of telemedicine technology	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: April 2021

Ulysses Ref: TBC

Strategic Priority: SA2: To deliver SAFE services

Lead Committee: FPBD Committee

Provider Licence Compliance link:

SCORE:

May 2022	Q2	Q3	Q4	Q 2 Q movement	2022/23 Target
20 (4x5)				↑	15 (3x5)

Rationale for current risk score:

The Trust's Digital Services department places cyber security management at the core of operational activities, ensuring it maintains its Cyber Essentials 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 (5). Due to recent world events, the environment risk or likelihood for a cyber-attack has increased from possible (3) to likely (4) due to increased cyber threats from Russia. The NHS has reflected the increased threat through guidance issued to all NHS providers and arm's length bodies during March 2022.

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 Mobile device management – providing enhanced security for mobile devices	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 **(Action 2.4 / 1)** Lack of Network Access Controls within the physical network **(Action 2.4 / 2)** Effective USB port control **(Action 2.4/ 3)** Lack of visibility of medical devices **(Action 2.4 / 4)**	

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
2.4 / 1	Implement a Cyber Security strategy	CIO	August 2022	FPBD	
2.4 / 2	Procure and implement Network Access Control (NAC) solution	CIO	Dec 2022	DHSC	
2.4 / 3	Purchase and implement software for USB port control	CIO	September 2022	DHSC	
2.4 / 4	Improve grip, control and governance on medical devices	CIO	October 2022	Medical Devices / 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)

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

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 12/01/2022.

2088 - No change in risk score since last review. Last reviewed 09/03/2022

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: Apr 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:

May 2022	Q2	Q3	Q4	Q 2 Q movement	2022/23 Target
12 (3 x 4)				⟷	12 (3 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.

The Ockenden Final Report made several comments about the importance of trusts listening effectively to the patient voice and strengthening the Trust's approach to this will be a significant area of priority during 2022/23. Considering the importance of this and the fact that available controls / assurances remain limited in this area, the target score for 2022/23 has been set at '12' to reflect the current reality.

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	Women, babies and their families experience strategy 2021 - 2026	Patient Involvement & Experience Sub-Committee	External MVP involvement in reviewing complaints processes Lack of assurance patient stories are shared at local divisional level Evidence how the divisions are using this data to influence their service design and improvements	
	PALs and Complaints data	Patient Involvement & Experience Sub-Committee		
	Patient Stories to Board	Board Meeting		
	Friends and Family Test	Patient Involvement & Experience Sub-Committee		
	National Patient Survey	Patient Involvement & Experience Sub-Committee		
	Healthwatch feedback	Patient Involvement & Experience Sub-Committee		
	Social media feedback	Patient Involvement & Experience Sub-Committee		
	Membership feedback	Council of Governors		
	Patient Experience Matron in place to build relationships with local community leaders and mechanisms for hearing feedback on the Trust's services	Reports Patient Involvement and Experience Sub-Committee and attends CoG Comms and Engagement Group		
	Bespoke Patient Surveys	Patient Involvement & Experience Sub-Committee		

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
3.1 / 1	MVP to conduct a review of complaints process	Head of Audit, effectiveness, and Patient Experience	October 2022	Patient Involvement & Experience Sub-Committee	
3.1 / 2	Formal process implemented to track and monitor bespoke surveys requested.	Head of Audit, effectiveness, and Patient Experience	November 2022	Patient Involvement & Experience Sub-Committee	
3.1 / 3	Development and improvements to the Patient experience Review reports produced by the Divisions and reported to PIESC	Divisional Management Teams	September 2022	Patient Involvement & Experience Sub-Committee	
3.1 / 4	Development of a process to share the board presented patient stories to a wider audience such as divisional board and team meetings.	Patient Experience Matron. Head of Comms. Divisional Management Teams	December 2022	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
Failure to act on the feedback provided by patients, carers, and the local communities.	Failure to act on the feedback provided by patients, carers, and the local communities.	Women, babies and their families experience strategy 2021 - 2026	MVP review needed of complaints actions and themes for improvement presented at PIESC No formal external process in place to monitor completion of complaint/ PALS+ action plans. Poor performance against Trust KPI for displeased FFT responses Gaps in QI understanding/training that is being addressed by the recently approved QI framework in the 4-year workplan.	
	Family Liaison Service	Action plans for complaints and PALS+ cases		
	PALs and Complaints data	Action plans for National surveys		
	Friends and Family Test	Action Plans for Bespoke Surveys		
	National Patient Survey	KPI for Displeased comments responses in FFT		
	Healthwatch feedback	QI Framework		

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
3.1 / 5	MVP to become involved in the review of information presented at PIESC	Head of Audit, Effectiveness and Patient Experience	Aug 2022	Patient Involvement & Experience Sub-Committee	

	3.1 / 6	Creation of formal external process to monitor completion of complaint/ PALS+ action plans	Head of Audit, Effectiveness and Patient Experience	November 2022	Patient Involvement & Experience Sub-Committee		
	3.1 / 7	Improvement of compliance against Trust KPI relating to displeased comments in FFT	Divisional Management Teams	August 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: Apr 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:

SCORE:

May 2022	Q2	Q3	Q4	Q 2 Q movement	2022/23 Target
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 an isolated site, it is not financially sustainable. This position is worsening each year as the impact of prior capital investment, ongoing and increasing revenue investment in staying safe on site, and other pressures such as CNST premium costs and the costs of implementing Ockenden actions are added into the cost base. The financial regime is becoming more constrained into 2022/23 and beyond, as Cheshire and Merseyside is deemed above target funding and so has had a convergence factor in addition to the efficiency requirement applied.

The Trust has undertaken what it can to manage costs and has robust financial controls in place as externally evidenced to and validated by audit. A Financial Recovery Board is in place to manage the position and the emerging Integrated Care System and region have a clear understanding of the Trust's underlying deficit however due to the overall constraints on the financial position are not able to guarantee that a shortfall in funding will not be in place.

Additional funding may be available e.g. through Ockenden but is unlikely to be sufficient to meet the Trust's requirements. If deficits are in place year on year further cost will be added associated with revenue cash support.

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 July 2022. **(Action 4.1 / 1)**	
	Future Generations business case demonstrates the Trust is financially viable long term if the preferred option of co-location with an adult acute site is funded.	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. **(Action 4.1 / 5)**	
	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	Deficit plan likely in 2022/23. Significant financial challenge across C&M as a whole. Increasing costs (e.g. Ockenden) without income matching this. **(Action 4.1 / 4)**	
	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. Expression of Interest not ranked first in C&M. **(Action 4.1 / 5)**	
	Clinical Engagement and support for proposals	Northern Clinical Senate Report supporting preferred option both in 2017 and 2022.		
	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.	Potential resourcing issues to manage this. Actual premium costs still increasing significantly despite achievement of years two and three of CNST Maternity Incentive Scheme.	
	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.	
	Development of Community Diagnostic Centre.	Upfront capital and revenue funding provided. Letter of comfort from ICS. Funding agreed for 2022/23 and general commitment to ongoing	Significant revenue implications on an ongoing basis, not directly related to LWH patients. No definitive ongoing revenue funding source in place (although 2022/23 funding agreed). **(Action 4.1 / 8)**	
	Agreed financial plan for 2022/23 with NHSI/E and C&M	FPBD and Board (monthly reports)		

	Gap Reference	Required Action	Lead	Implement By	Monitoring	Status	
	4.1/1	Refresh LTFM	CFO	July 2022	FPBD Committee / Board		
	4.1/2	Agree financial plan for 2022/23 with NHSI/E and C&M See Controls	CFO	April 2022	Board		
	4.1/3	Agree required cash support for 2022/23 with NHSI/E and obtain revenue support Complete. Not required due to surplus plan but confirmation received from C&M that cash support would be available if it were required.	CFO	May 2022	FPBD Committee		
	4.1 /4	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 or as much funding as possible is made available Complete. Although direct Ockenden funding was not sufficient to cover budgetary pressures, overall System and other funding was enough to cover all essential cost pressures.	CFO	May 2022	FPBD Committee		
	4.1 /5	Work towards business case production and approval	CFO	July 2022	Board		
	4.1 /6	Work with commissioners and ICS on revised financial models including population-based approach and Aligned Incentive and Payment contracts	CFO	March 2023	FPBD Committee		
	4.1 / 7	Ensure financial position well understood by regional team and clearly articulated.	CFO	March 2023	FPBD Committee		
	4.1 / 8	Agree ongoing funding model for Community Diagnostic Centre	CFO	March 2023	FPBD Committee		

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Risk that the Trust will not deliver agreed plan or have sufficient cash resources in the 2022/23 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	
4.1/9	Ensure regular reporting in place and corrective action taken where needed	Deputy Director of Finance	April 2023	FPBD Committee		
4.1/10	Ensure full CIP programme in place with relevant QIAs etc Ongoing. QIAs in place before schemes are put in place.	Deputy Director of Finance	April 2022	FPBD Committee		
4.1/11	Agree sufficient cash resource Complete. Not required due to surplus plan but confirmation received from C&M that cash support would be available if it were required.	CFO	April 2022	FPBD Committee		
4.1/12	Mitigations to be worked up Complete. Mitigations in place or underway and allowed for in budgets 2022/23	CFO	May 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: Apr 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:

May 2022	Q2	Q3	Q4	Q 2 Q movement	2022/23 Target
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 of clinical services for different providers and/or ineffective governance may lead to ineffective use of resources (clinical, financial, people) amongst ICS partners	Quarterly Partnership Reporting to FPBD and Board in 2022/23	FPBD and Board meetings	Governance arrangements are developing **(Action 4.2 / 1)** Governance arrangements are developing for LMS **(Action 4.2 / 2)**	
	Robust engagement with ICS discussions and developments through CEO and Chair	CEO Report updates to the Board		
	Evidence of cash support for the Trust's 2021/22 breakeven position	Trust budget agreed by the Board		
	Chair of the Maternity Gold Command for Cheshire and Merseyside	Executive Team reporting		
	C&M Maternal Medicine Centre	Chairs reports feed into the Maternity Transformation meetings		
	Neonatal partnership in place with Alder Hey	Regular updates to the Board		
	Partnership Board in place with LUHFT and involvement in wider Estates Plan	Updates provided to the Quality Committee and Board		
	Positive and developing relationship with Merseycare NHS FT	Updates provided to the FPBD Committee		
	LMS Hosting Arrangement	Updates provided to the Board		
	Finance Directors Group	Updates provides to the Executive Team and through the governance structure when appropriate		
	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		
	LWH have provided assistance to LUFT by taking over LWH non obstetric Ultrasound scanning activity	Mutual aid reported through to the Quality Committee and Board		
	LWH identified as Gynaecology Oncology Hub for Cheshire and Mersey.			
	Theatre sessions provided at LWH for other Trusts such as Colorectal for LUFT			
	Provision of mutual aid to NWAST by supporting staff testing on LWH site for them			
	Provision of Mutual aid to NWAST for staff Covid-19 vaccinations			

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 (one year review meeting held in April 2022) – agreed to build on SLA previously in place with CCG	COO	August 2022	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 16/02/2022.

2295 - No change in risk score since last review. Last reviewed 13/01/2022

2329 - No change in risk score since last review. Last reviewed 04/03/2022

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: April 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:

May 2022	Q2	Q3	Q4	Q 2 Q movement	2022/23 Target
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 challenges in recruitment and retention of staff, damage to reputation or withdrawal of funding	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. Nursing, Midwifery and Allied Health Professional Talent pipeline developed to provide further support and development for non-medical workforce in relation to the research agenda. The Trust has now appointed a Director of Midwifery who has a strong research background. She will support and facilitate midwifery research.	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. Monitored via RD&I Subcommittee Implementation of the talent pipeline will be monitored via the RD&I sub committee RD&I sub-committee (also attended by three Professors of Midwifery from the respective local universities)	Ongoing funding will be required to support the talent pipeline **(Action 5.1 / 1)**	

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
5.1 / 1	To secure funding to support the talent pipeline	Medical Director	September 2022	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. Regular attendance at RD&I sub-committee by LHP theme leads	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 / 2	Continue progress towards university hospital status application	Medical Director	March 2023	Research and Development Sub-Committee	
5.1 / 3	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	July 2022	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: Apr 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	2022/23 Target
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 received a warning notice regarding medicine management. Good assurance is in place regarding the Trust's response to this (supported by MIAA audit) and the warning notice being withdrawn. Further work required to refine process and to ensure that the Trust always remains 'inspection ready'.

The Trust was subject to an external well-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 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.	CQC Framework to be implemented – to include well-led framework, and the on-going development of the CQC self-assessment process including a review of previous CQC action pans.	Quality Committee Executive Team oversight Divisional Board and performance review meetings Trust Board	Ward Accreditation and CQC Self-Assessment process yet to be implemented **(Action 5.2 / 1)** Number of policies and SOPs out of review date **(Action 5.2 / 2)**	
	Horizon scanning for changes in the CQC's regulatory approach	Quality Committee		
	Planned monthly engagement meetings with CQC	Quality Committee		

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
5.2 / 1	To implement updated Ward Accreditation programme	Deputy Director of Nursing & Midwifery	July 2022	Quality Committee	
5.2 / 2	Ensure all policies and procedures are within their review date	Assoc. Director of Quality & Governance	July 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	Lack of testing of action plans following audits to ensure they lead embedded change – will be supported by ward accreditation once in place **(Action 5.2 / 3)** Inconsistent completion and dissemination of actions and improvement plans – signs of improvement but with further work required. **(Action 5.2 / 4)** Lack of consistent between divisional governance meetings (noted in recent well-led report) **(Action 5.2 / 3)** Human Factors training compliance and availability **(Action 5.2 / 5)** Root Cause Analysis training compliance and availability **(Action 5.2 / 6)** Monitoring compliance with risk management training **(Action 5.2 / 7)**	
	Incident reporting and investigation policies and procedures.			
	MDT involvement in safety			
	HR policies in relation to issues relating to professional and personal responsibility			
	Mandatory training in relation to safety and risk			
	Serious Incident Feedback form			
	Serious Incident panels			
	Safety is included as part of executive walk rounds.			
	Risk Management Strategy			
	Link on desktop of computer with a link to lesson learnt section of web page			
	Use of the action planning module is to be embedded across all divisions	The Governance team to use weekly meetings for review actions and ensure shared. Governance team to ensure oversight and reporting of progress		
	Dip sampling of SI's and review of action previous plans that were submitted to CCG's to ensure changes in practice were embedded and successful.	Quality Committee		
	Route Cause Analysis training booked for 35 staff in May and June 2022.			

	Gap Reference	Required Action	Lead	Implement By	Monitoring	Status	
	5.2 / 3	To ensure that Divisional Governance meetings are consistent and seek evidence of actions / lessons being embedded	Deputy COO	July 2022	Safety & Effectiveness Sub-Committee		
	5.2 / 4	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	July 2022	Safety & Effectiveness Sub-Committee		
	5.2 / 5	Business case for the provision of Human Factors Training to be developed and submitted to education governance committee	Medical Ed Lead	July 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	July 2022	Safety & Effectiveness Sub-Committee		
	5.2 / 7	Governance team to monitor compliance levels with risk management training and highlight staff who are noncompliance to the Divisions and provide compliance update to Safety and Effectiveness Sub-committee.	Head of Risk	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 Quality Improvement projects tracked Quality Account tracking key projects Quality Improvement Framework developed and agreed	Training levels reported to the Quality & Clinical Audit Group Safety & Effectiveness Sub-Committee Annual Quality Account In January and February 2022, a Task and Finish Group commenced to design and a deliver a new a QI SOP and an improvement Process identifier. The process identifier distinguishes the differences between QI projects, daily improvements, service evaluations, research and audit which has previously caused some confusion for staff within LWH. These documents were subsequently approved by Quality Improvement Group (QIG) and Policies and Procedures Group, they have now been disseminated and published trust wide. Effectiveness leads have been asked to ensure teams within their areas are sighted and supported to understand them. In the absence of a corporate QI lead, support is being provided by the Associate Director of Quality & Governance with a QI collaborative on the horizon to drive this agenda forward even further. The Associate Director of Quality & Governance and Trust Risk & Patient Safety Manager have undertaken a data cleansing exercise. This was to ensure the data within Ulysses demonstrates the on-going pieces of work reflect the correct workstream each project should be aligned to with reference to the process improvement identifier. This will further support staff to understand the processes with new reports shared more widely on a weekly basis. This work will be monitored by QIG and Quality Committee moving forwards to ensure improvements are sustained and embedded.	Opportunities to engage individuals in QI training limited, particularly during pandemic Evidence of QI projects being undertaken but not 'formalised'	

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
5.2 / 8	Continuous review of the trusts approach to QI to enable the planning of priorities identifying improvements required	Assoc. Director of Governance & Quality	On-going	Quality Committee	
5.2 / 9	Increase levels of QI training	Assoc. Director of Governance & Quality	July 2022	Quality Committee	
5.2 / 10	Simplify process to encourage staff to record QI projects within formal framework See update to assurances	Assoc. Director of Governance & Quality	June 2022	Quality Committee	
5.2 / 11	Establish what changes can be made to Ulysses to align the system better with the flow of QI projects.	Assoc. Director of Governance & Quality	September 2022	Quality Committee	
5.2 / 12	To create a platform for completed QI projects to be showcased and shared trust wide.	Assoc. Director of Governance & Quality	September 2022	Quality Committee	

NHS
Liverpool Women's
NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*22/23/081*	Date: 07/07/2022
Report Title	Annual Report of the Director of Infection Prevention & Control & IPC BAF	
Prepared by	*Dr Tim Neal*	
Presented by	*Dr Tim Neal DIPC*	
Key Issues / Messages	*Trust Board review of the Annual Report and Work Plan is a requirement of the Health Care Act* *The Trust has met its National Targets in respect of mandatorily notifiable infections* *The Trust has managed a second year of the Covid-19 pandemic, reporting 1 nosocomial infection and no patient outbreaks*	

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 requested to
	• note the content of the annual report and approve:
	  ○ Publishing to the Trust website; and
	  ○ The work plan for 2022-23.
	• take assurance that the Trust is taking all actions reasonably practicable to ensure it is working to meet its responsibilities for Infection Prevention and Control in relation to Covid-19.			

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 x

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* Choose an item.	Comment:
Link to the Corporate Risk Register (CRR) – CR Number:	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Quality Committee	June 22	DIPC	The Committee requested that timescales be added to the remedial actions within the

			updated IPC BAF

EXECUTIVE SUMMARY

1. Define the issue

The Trust Annual Infection Prevention & Control Report (2021-22) is presented outlining the processes in place to reduce the risk of infection to patients, the Trust reporting structures, and the outcomes of surveillance of infection in the Organisation.

A work plan for the Infection Prevention & Control Team for 2022-23 is presented for approval.

2. Key Findings

The Trust reported zero *C.difficile* infections and zero MRSA bacteraemia, in compliance with national targets. The Trust report a 50% reduction in Gram-negative bacteraemia compared to the 2016-17 outturn.

Approximately 200 inpatients were managed with Covid-19 infection in the second year of the pandemic. 1 patient was categorised as nosocomial infection

Surgical site infections remain below the Trust target of 5% at 2-3%

NHSI IPC BAF Assurance Framework

On the 24 December 2021 NHSE/I provided all Trusts with version 1.8 of the Infection Prevention and Control Board Assurance Framework (IPC BAF) to review and map compliance with UK Health security agency (formerly Public Health England PHE) Covid-19 related IPC guidance. The BAF was provided to Trusts as a method of assessing compliance and providing assurance to Quality Committee. The updated BAF focusses on 10 compliance criteria with 102 key lines of enquiry (KLOE) in relation to compliance or non-compliance with national guidance (IPC code of practice). The BAF also supports identification of any gaps in assurance and mitigation for gaps.

The full BAF is detailed in Appendix 1. The yellow text boxes highlight new standards being reported against. The unhighlighted text boxes reflect existing standards where previous reporting and assurance has been provided. The red highlighted text boxes show areas where gaps are present, or a change is envisaged. For each of the new elements an assurance statement is provided and/or documented evidence (embedded or hyperlinked documents) which underpins the assurance statement.

The Trust position in April 2022 declared compliance with 95/102 KLOE leaving 7 that identified gaps where improvements needed to be made or changes would be required because of the live position during the Covid-19 pandemic. For each of the 7 gaps, details of actions being taken to demonstrate compliance are provided along with any existing mitigation in place to manage risk.

Key areas of action underway to improve position are:

- Review of the Trust Covid-19 environmental risk assessments by the Trust Health and Safety Manager and IPC Team. This has been undertaken with a

plan to include the hierarchy of controls and ventilation into relevant health and safety policy.

- Assessment of ventilation systems – Refreshed assessment undertaken in February 2022 with report anticipated. Any actions required will be taken based on findings.
- Monitoring of antimicrobial use – Deputy Chief Pharmacist's plan includes an audit commencing in summer 2022; results to be reported into Medicines Management Group.
- Visiting guidance has changed since the template was received in December 2021. At that time, we were fully compliant. Since then, the recent guidance has changed, and work on further compliance is underway.
- Signage – currently compliant, updated as guidance changes (live position).
- Visitors during AGPs – IPC seasonal respiratory infections winter/spring 2021-2022 guidance issued April 2022 advises that only those essential health care staff who are needed to undertake the procedure are present.
- Dress code policy – an amendment required to reflect new guidance on the laundering of uniforms and work wear.
- Inpatient compliance with mask use- adherence in LWH reflective of evolving guidance. IPC Team oversee monitoring of adherence across all areas on a weekly basis. Any patient non-adherence is reviewed to ensure rationale is captured in collaborative records.

3. Recommendations

The Board is requested to

- note the content of the annual report and approve:
  - Publishing to the Trust website; and
  - The work plan for 2022-23.
- take assurance that the Trust is taking all actions reasonably practicable to ensure it is working to meet its responsibilities for Infection Prevention and Control in relation to Covid-19.

Infection Prevention & Control Annual Report 2021 - 2022

Dr Tim Neal, Director of Infection Prevention & Control

Contents Page

TABLE OF ABBREVIATIONS

ANTT	Aseptic Non Touch Technique
BAF	Board Assurance Framework
CCG	Clinical Commissioning Group
CPE	Carbapenamase-Producing Enterobacteriales
CQC	Care Quality Commission
DIPC	Director of Infection Prevention and Control
HCA	Health Care Act
HCAI	Health Care Associated Infection
HII	High Impact Intervention
PHE	Public Health England
IPC	Infection Prevention & Control
IPCG	Infection Prevention and Control Group
IPCN	Infection Prevention and Control Nurse
IPCT	Infection Prevention & Control Team
IPS	Infection Prevention Society
LWFT	Liverpool Women's NHS Foundation Trust
MRSA & MSSA	Meticillin Resistant (Sensitive) Staphylococcus Aureus
NICERS	New Infection Control environmental reporting system
NLMS	National Learning Management System
NUMIS	Nursing & Midwifery Information System
OLM	Oracle Learning Management System
SI	Serious Incident
SEC	Safety and Effectiveness Committee
SWSG	Strategic Water Safety Group
SSI	Surgical Site Infection
TNA	Training Needs Analysis

1 Summary of Key Achievements and Main Findings

1.1 Key Achievements 2021-2022

The Trust was compliant with the prescribed C.*difficile* and *MRSA bacteraemia* targets

Table 1: Trust Attributable Infections

Organism	Target/Trajectory	April 2019 - March 2020	April 2020 - March 2021	April 2021 - March 2022
***Clostridioides difficile* infection (CDI)**	0	0	0	0
Meticillin resistant *Staphylococcus aureus* (MRSA) sepsis	0	1	1	0
Meticillin sensitive *Staphylococcus aureus* (MSSA) sepsis	Adult = 0 No target for NICU	5	1	1
***E.coli* sepsis**	50% reduction by March 2022(national not Trust target)	8	8	4
Klebsiella	50% reduction by March 2022(national not Trust target)	0	0	0
Pseudomonas	0	0	0	0

1.2 Main Findings

The Global Coronavirus pandemic has disrupted much of the normal working of the Trust in the reported year. The IPCT has been instrumental to devising pathways and safe systems to allow the Trust to provide services to its priority patients and mutual aid to other local organisations. In addition to the workload generated by Covid-19 the IPCT has continued to oversee education, guidelines as the Trust transitions to the Governments @Living with Covid Strategy'

1.2.1 Education

The IPCT has maintained current induction and mandatory training.

1.2.2 Guidelines

The two documents have been developed in the year
IPC for Seasonal Infections Winter 2021 – 2022
Management of Investigation of Cases and Outbreaks of COVID

1.2.3 Infection Prevention and Control Audits and Clinical Practice Audits

55 (100%) Infection Prevention and Control Audits and 542 (97%) clinical practice ward audits (including 5 moments for hand hygiene and Saving Lives High Impact Intervention audits) have been completed in accordance with the Trust plan. No community midwives' audit were completed.

1.2.4 MRSA

34 adult patients were identified in the Trust with MRSA, 31 were identified by pre-emptive screening. one neonate was identified with MRSA colonisation.

1.2.5 C. difficile

There have been no Trust acquired *C.difficile* infections in 2021-22 (Target = zero)

1.2.6 Bacteraemia

There were 3 MSSA bacteremia's in 2021-22, all in adult patients (1 Trust Attributable)

13 neonates had significant Gram-negative sepsis (5 congenital) and 7 neonates had significant Gram-positive infections (4 congenital).

There were 8 *E. coli* bacteraemias in 2021-22 (4 Trust attributable). A 50% reduction from previous years

There were 2 *Klebsiella pneumoniae* bacteraemias in 2021 – 22 (0 Trust Attributable)

There were no glycopeptide resistant enterococcal bacteremias in 2021-22

1.2.7 Surgical Site Infection Surveillance

The IPC team continue to review surgical site infections (SSI) for a two-month period twice yearly). SSI rates remain below the Trust threshold of 5%, at around 2 - 3%.

2 Infection Prevention & Control Team Members

During 2021-22 the Infection Prevention and Control team (IPCT) has been supported by a seconded Neonatal Nurse, a fixed term Gynaecology Nurse and an Interim Infection Prevention and Control Practitioner (until July 2021).

Miss K Boyd
Infection Prevention & Control Analyst (part time 0.80 WTE - 30 hours/week Infection Prevention and Control Analyst, 0.20 WTE - 7.5 hours/week Policy Officer for the Governance team)
Mrs D Fahy
Infection Prevention & Control Nurse - (0.60 WTE – 22.50 hours/week) Until May 2021, (Left the Trust).
Dr T J Neal
Consultant Microbiologist – Infection Prevention & Control Doctor and Director of Infection Prevention and Control (DIPC) (2 sessions / week worked on LWFT site)
Mrs Anne-Marie Roberts
Interim Infection Prevention and Control Practitioner (0.9 WTE– 34.5 hrs) – (changed to a permanent Infection Prevention and Control Practitioner (1 WTE – 37.5 hours) in July 2021)
Mrs Eleanor Walker
Seconded Link Neonatal Nurse (0.40 WTE – 15 hours)

Mrs Jenny McLaughlin
Fixed term Infection Nurse (0.80 WTE – 30 hours) – (changed to Permanent Infection Prevention and Control Nurse (0.80 WTE – 30 hours)
The IPCT is represented at the following Trust Committees:

Huddle	Daily
Covid-19 Oversight Meeting	Weekly
Covid-19 Command meetings	Weekly
Safety and Effectiveness Committee	Monthly
Infection Prevention & Control	Quarterly
Water Safety Group	Quarterly
Strategic Water Safety Group	Quarterly
Medicines Management	Monthly
PLACE	Ad-hoc
Building Planning	Ad-hoc
Health and Safety Committee	Quarterly
Nursing and Midwifery Forum	Monthly
Maternity Quality Meeting	Monthly
Education Governance Meeting	Quarterly
Cleaning National Standards	Ad Hoc

The Team is managed by the Deputy Director of Nursing and Midwifery.

There are no Trust costs associated with the Infection Prevention and Control doctor and DIPC.

3 Role of the Infection Prevention & Control Team

The following roles are undertaken by the IPC team: -

- Education
- Surveillance of hospital infection
    - Surgical Site data collection
    - National bacteraemia data reporting
    - PHE data reporting
- Investigation and control of outbreaks
- Development, implementation and monitoring of Infection Prevention and Control policies
- Audit
- Assessment of new items of equipment
- Assessment and input into service development and buildings / estate works
- Patient care/ incident reviews

Infection Prevention and Control advice is available from the Infection Prevention & Control team and 'on-call' via the DIPC or duty Microbiologist at Liverpool Foundation Trust

4 Infection Prevention and Control Group

The IPC Group meets quarterly and is chaired by the Chief Nurse. The group receives regular reports on Infection Prevention and Control activities from clinical and non-clinical divisions/departments.

Reports received include those from:

- Estates and Operational Services
- Health and Safety
- Occupational Health
- Decontamination
- Divisions/departments
- Link Group
- Water Safety group
- Infection Prevention and Control team members

The Terms of Reference of the IPCG are included as **Appendix A**

The IPCT report quarterly to IPCG and the DIPC reports quarterly to SEC which also receive minutes of the IPCG meetings. The Quality Committee receives minutes from SEC. The Trust Board also receives an annual presentation and report from the DIPC.

Trust IPC issues, processes and surveillance data are relayed to the public via Infection Prevention and Control posters, patient information leaflets, the Trust website (copy of this report) a notice board in the main reception which is updated on a monthly basis and departmental notice boards in ward areas.

Throughout the year many changes in practice have been initiated, facilitated, supported or mandated through the work of the IPCT and IPCG. Some of these are on a large scale, such as input of the IPCT into large capital projects undertaken by the Trust (see section 9.2) however many appear smaller and take place in the clinical areas as a consequence of audit, observations and recommendations. These interventions equally contribute to the provision of clean and safe care in the organisation. The IPCT examined its effectiveness throughout the year. The following detail some of the changes facilitated throughout the year.

- ANTT e-learning and training and assessment of ANTT in clinical practice commenced 26th April 2021
- IPC audits moved from NICERS to Microsoft Team and Power BI with the update of HII and addition of mattress audits. Audits then integrated into a new hospital audit programme of audits.
- National IPC training incorporated into LWFT Mandatory Training programme (Dec 2010
- National guidance regarding IPC and respiratory infections (including covid-19) incorporated into clinical practice.
- Inclusion of ‘donning and doffing of PPE’ and ‘Coronavirus -Every action counts hierarchy of controls’ videos as yearly mandatory training.

5 External Bodies

5.1 Health Care Act & Care Quality Commission

The Health Care Act (HCA) was published in October 2006 and revised in January 2008 and January 2011 as the Health and Social Care Act. This code of practice sets out the criteria by which managers of NHS organisations are to ensure that patients are cared for in a clean environment where the risk of HCAI is kept as low as possible.

The Health Care Act action plan is a standing item on the IPCG agenda which monitors progress. There is one outstanding standard of the HCA with which the Trust is not fully compliant. This relates to surveillance software however as this action has been outstanding for so many years the DIPC has decided not to pursue this further.

5.2 Liverpool Clinical Commissioning Group (CCG) Assurance Framework

Assurance data is reported monthly to the CCG and Quarterly at IPCG it incorporates performance data, exception reporting audit data and screening compliance.

5.3 Mandatory Surveillance

The Trust submits data on MRSA, MSSA, *E.coli, Clostridioides difficile, Klebsiella* and *Pseudomonas* infections by the 15th day of each month to the Public Health England via an online Health Care Associated Infection Data Capture System. HCAI data is also submitted each month for the Trust Quality Report and Corporate Information.

6 Education

6.1 Mandatory training and Induction:

Mandatory training in Infection Prevention and Control is a requirement for all Trust staff including clinical, non-clinical staff and contractors. The IPCT update the training package annually and ensure that it reflects best practice, national recommendations and issues identified as non-compliant in the previous year. All staff receives training in Infection Prevention and Control every three years via electronic learning and a Hand Hygiene Assessment. The electronic package is incorporated into the NLMS and linked to OLM.

Training continues to be provided by the IPCT for medical staff which includes consultants, trainees and ad-hoc mandatory training for corporate services. Three formal teaching sessions have been delivered by the DIPC throughout 2021-2022

The IPCT has provided 19 general training sessions in 2021-2022 (Including, the use of standard precautions, and Audit/NUMIS/ad hoc hand hygiene training)

Although the majority of mandatory training is delivered by the IPC team a number of Link Staff also provide training including hand hygiene within their areas.

6.2 Link Staff

The IPC link staff meetings are held twice yearly at the end of the Professional Development days. The programme is organised to reflect current initiatives, implementation of new guidance and reinforcement of any non-compliance relating to IPC. The number of attendees on each development day was 11 and 4, Link Staff meetings and Professional Development days are included in the TNA provision for Link Staff.

6.3 ANTT Training

Sixteen ANTT training sessions were provided in 2021-22 by the Infection prevention and control team. ANTT e- learning was purchased in Oct 2021; Each department has ANTT assessors who have been trained to assess ANTT in clinical practice. ANTT was added to the core clinical competencies and ANTT e-learning training and assessment in clinical practice commenced in April 2021. Results of ANTT training and assessment can now be viewed on Power BI. ANTT training and assessment was streamlined for all clinical staff to yearly training and assessment.

6.4 Donning and Doffing of Personal Protective Equipment (PPE) Training

In 2021-22 IPC staff completed 3 face to face donning and doffing training sessions. In June 2021 a 'donning and doffing video' and the 'Coronavirus- Every Action Counts – Hierarchy of control video' were added to yearly mandatory training for staff.

6.5 Guidelines/Policies

No new IPC policies have been required. The below Policies SOP have been reviewed in line with the Trust policy process.

- Novel IPC Guidance
- Management and investigation of cases and outbreaks of COVID SOP creation
- PPE quick reference SOP
- Reusable visor SOP
- Aseptic Non-Touch technique SOP
- Use and Disposal of Sharps SOP
- Seasonal and Pandemic Influenza SOP
- Management of Known Suspected or at Risk Creutzfeldt Jacob Disease SOP
- Prevention of Wound Infections SOP
- Personal Protective Equipment SOP
- Peripheral Cannula and Ongoing Care SOP
- Management of Norovirus SOP
- Management of Inpatients with Vial Infection rashes SOP
- Management of Hepatitis A and E SOP
- Management of Diarrhoea SOP
- Management of Blood Borne Viruses SOP
- Linen SOP
- Isolation and Barrier Nursing SOP
- Effective Hand Hygiene SOP
- Communal Refrigerator in healthcare Settings SOP
- Carbapenemase Producing Enterobacterales (CPE) SOP
- MRSA Policy
- Management of Diarrhoea caused by Clostridioides difficile Policy
- Isolation and Barrier Nursing SOP
- Management of Diarrhoea SOP
- Management of Pulmonary Tuberculosis SOP

7 Audits

7.1 ICNA Trust audit programme

The IPCT continue to use the updated IPS audit tools. The audit programme for the year is established and agreed by the IPCG. Clinical practice audits (PPE, and Hand Hygiene) are completed with a minimum frequency of twice yearly by ward/clinical staff. 5 moments for hand hygiene audits are completed by ward/clinical staff monthly.

The IPS Clinical Practice audits, Saving Lives audits and monthly '5 moment's' audits are entered onto the NICERS system allowing oversight of results and compliance by local managers. A total of 30 PPE audits (93%) and 44 Hand Hygiene audits (80%) have been carried out by ward department staff and have been reviewed by the IPCT. Clinical Practice audits scores range from 92-100%.

312 Saving Lives High Impact Intervention (HII) audits have been carried out by ward department staff and have been reviewed by IPCT. Saving Lives scores range from 80 – 100%.
A total of 156 (99%) 5 moments for Hand Hygiene audits have been carried out by ward department staff and have been reviewed by the IPCT. Hand Hygiene audit scores range from 99 - 100%.

The Infection Prevention and Control environmental audits are carried out a minimum of twice a year in each clinical area unannounced by the IPC team. A total of 55 Infection Prevention and Control audits in 21 clinical areas have been undertaken. Individual department scores, main themes of non-compliance and areas of improvement are recorded and available on Power BI.
2021-22 IPC audit scores range from 77 - 100%

Community midwives are expected to complete a combined self-assessment of environmental and clinical practice elements twice per year. The Community Team Leaders are responsible for entering the data. For the period April 2021-2022 no self-assessments were completed.

IPC Team have collaborated with the Head of Corporate Nursing to streamline IPC audits and the other audits which Include IPC aspects (accreditation, KPI, mattress audits) into a new Trust wide audit programme.

Mattress audits
Mattress audits are completed in all areas in the Trust. The audit examines cleanliness and mattress integrity.
58 mattress audits were completed by departments during 2021-22 (782 individual mattresses audited) with scores ranging from 80-100%. Results are available on Power BI and reported through the Divisional report to IPCG. Local areas have ownership for replacement and condemning of any mattress not fit for purpose. There is a system in place for the provision and storage of replacement mattresses across the Trust.

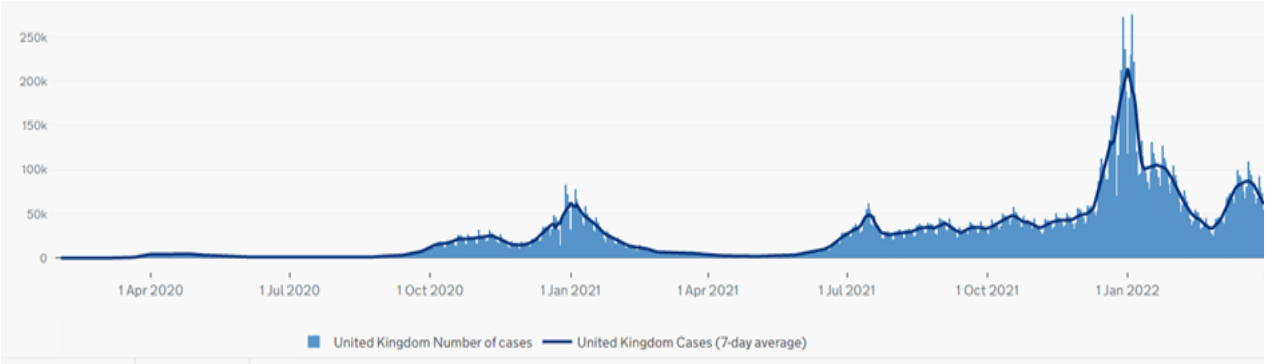
8 Covid-19 Pandemic

On 31 December 2019, the World Health Organization (WHO) was informed of a cluster of cases of pneumonia of unknown cause detected in Wuhan City, Hubei Province, China.

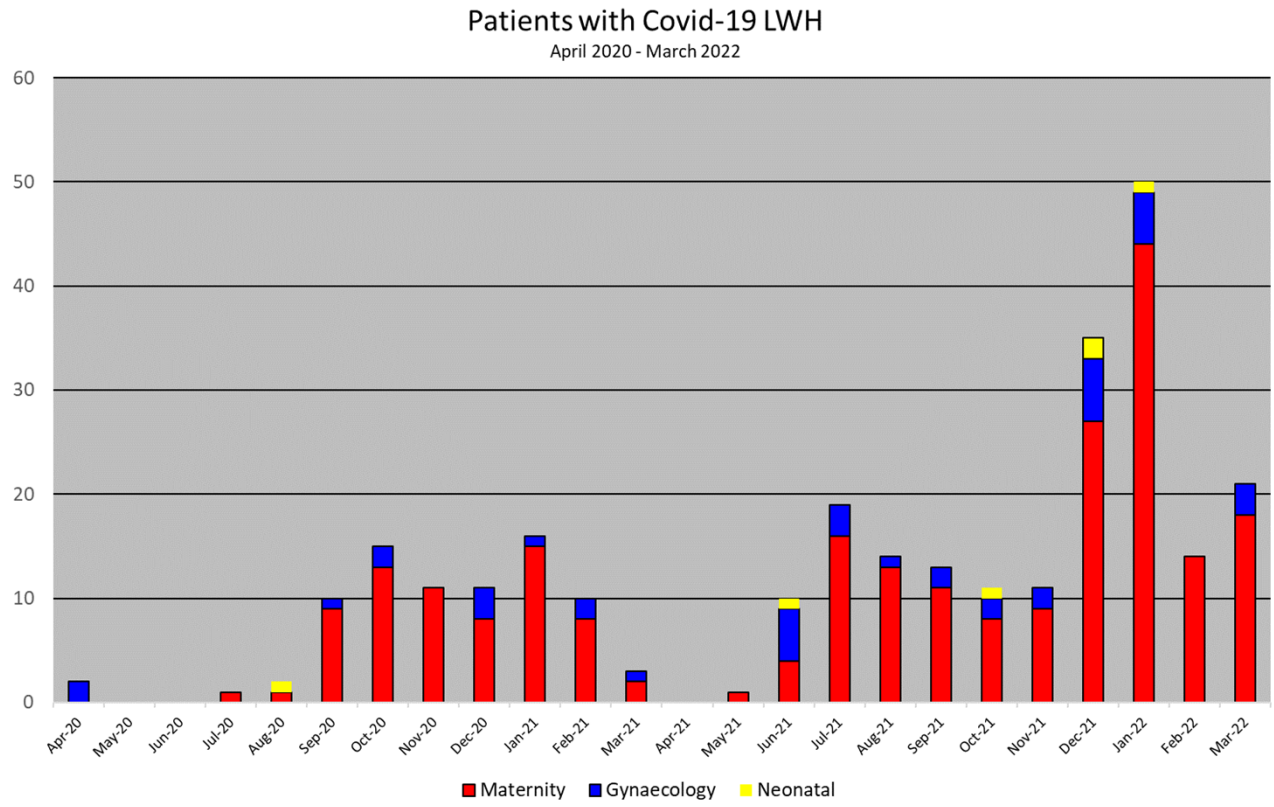
On 12 January 2020, it was announced that a novel coronavirus had been identified in samples obtained from cases. This virus is referred to as SARS-CoV-2, and the associated disease as COVID-19.

The World Health Organization declared the outbreak a Public Health Emergency of International Concern on 30 January 2020, and a pandemic on 11 March 2020.

The first case in the UK was confirmed on 31st January 2020 and between then and the end of March 2022 the UK recorded over 21 million cases and approximately 170,000 deaths.



LWH has managed 280 inpatients with Covid-19 infection since the commencement of the pandemic, 199 in 2021-22. The majority of patients have been maternity patients. There were a further 241 patients identified by screening prior to planned surgery or procedures.



Hospital Onset Covid-19 infection (HOCI) is categorised by the time from admission against national criteria which were introduced in the summer of 2020.

- Community-Onset (CO) - positive specimen date <=2 days after hospital admission or hospital attendance;
- Hospital-Onset Indeterminate Healthcare-Associated (HO.iHA) - positive specimen date 3-7 days after hospital admission;
- Hospital-Onset Probable Healthcare-Associated (HO.pHA) - positive specimen date 8-14 days after hospital admission;
- Hospital-Onset Definite Healthcare-Associated (HO.dHA) - positive specimen date 15 or more days after hospital admission.

There was one nosocomial (healthcare acquired) case of COVID-19 in 2021-22.

All other patients with COVID-19 cared for at LWH were community onset cases determined pre-admission or on admission. There have been no patient COVID-19 infection outbreaks.

Throughout the pandemic the Trust has implemented national guidance both on PPE (to ensure the safety of staff) and infection control to reduce the risk of transmission in the hospital. The IPC team worked closely with other stakeholders to devise pathways for the safe placement of patients.

In 2021-22 during the Covid-19 pandemic the following processes were put in place / continued: -

- Review of IPC Team and substantive posts agreed
- IPC overview at Oversight & scrutiny committee, Command & control and daily huddle on Microsoft Teams
- Covid -19 audits continued to measure and improve compliance
- Assurance provided against national Board Assurance Framework (BAF)
- Updates to local IPC Covid-19 guidance

8.1 COVID Audits

In 2021 – 2022 the IPC completed COVID audits throughout the Trust to review compliance in the following areas: -

- PPE
- Correct hand Hygiene
- PPE Signage
- Staff knowledge
- Correct Barrier Nursing
- Environmental Cleanliness
- Social Distancing

Overall compliance was 95% and any noncompliance was addressed at the time of audit with staff involved.

8.2 COVID staff outbreaks

The Trust reported 0 staff outbreaks of Covid-19 infection in 2021 -22

9 Infection Prevention and Control and the Environment

9.1 Water Safety

The Trust has a local Water Safety Group which meets quarterly to assure compliance with the Trust Water Safety Plan (planned preventative maintenance, flushing compliance, rectification of system defects and surveillance). In addition to reporting to the Trust IPC Group the WSG reports to a regional strategic WSG chaired by the DIPC and attended by the Independent Authorising Engineer (water).

The average weekly water flushing compliance for 2021-2022 was 93% (range 74-90%).

Water sampling (surveillance) is undertaken in accordance with the timetable outlined in the water safety plan. Positive results are managed in accordance with national guidance.

9.2 Building Projects & Design Developments

The team remain reliant on the Estates department and the Divisions alerting and involving the team in impending projects via the Infection Prevention and Control group meetings.

2021-22 projects requiring IPC Team involvement included:

- Major refurbishment FMU move to floor 2 completed November 2021
- Imaging / Colposcopy department – major refurbishment to move bone density room and colposcopy rooms and extend and incorporate CT scanner.
- Aintree Obstetric /Gynaecology Outpatient Department merge
- Changes made to facilitate social distancing trust wide in relation to COVID-19 pandemic

10 Surveillance of Infection

Hospital infection (or possible infection) is monitored in the majority of the hospital by 'Alert Organism Surveillance' this involves scrutiny of laboratory reports for organisms associated with a cross infection risk e.g., MRSA, *Clostridioides difficile* etc.

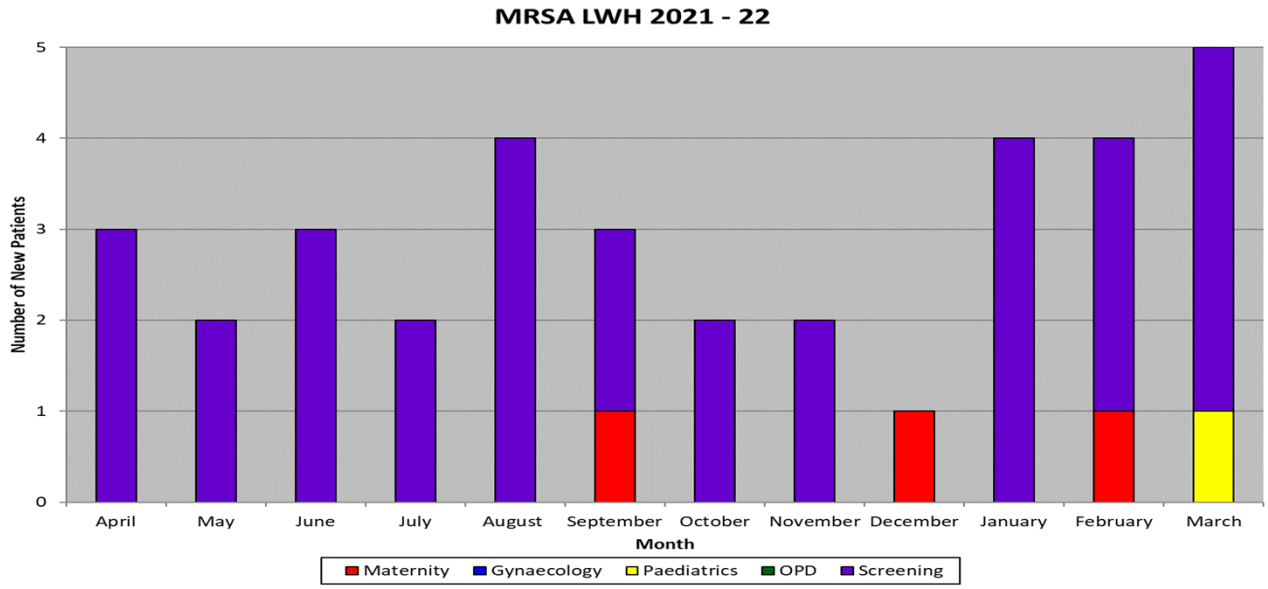
On the Neonatal Unit, which houses most of the long-stay patients, surveillance is undertaken by both ‘Alert Organism’ and by prospective routine weekly surveillance of designated samples. The IPCT examines results of these samples and action points are in place for the unit based on these results.

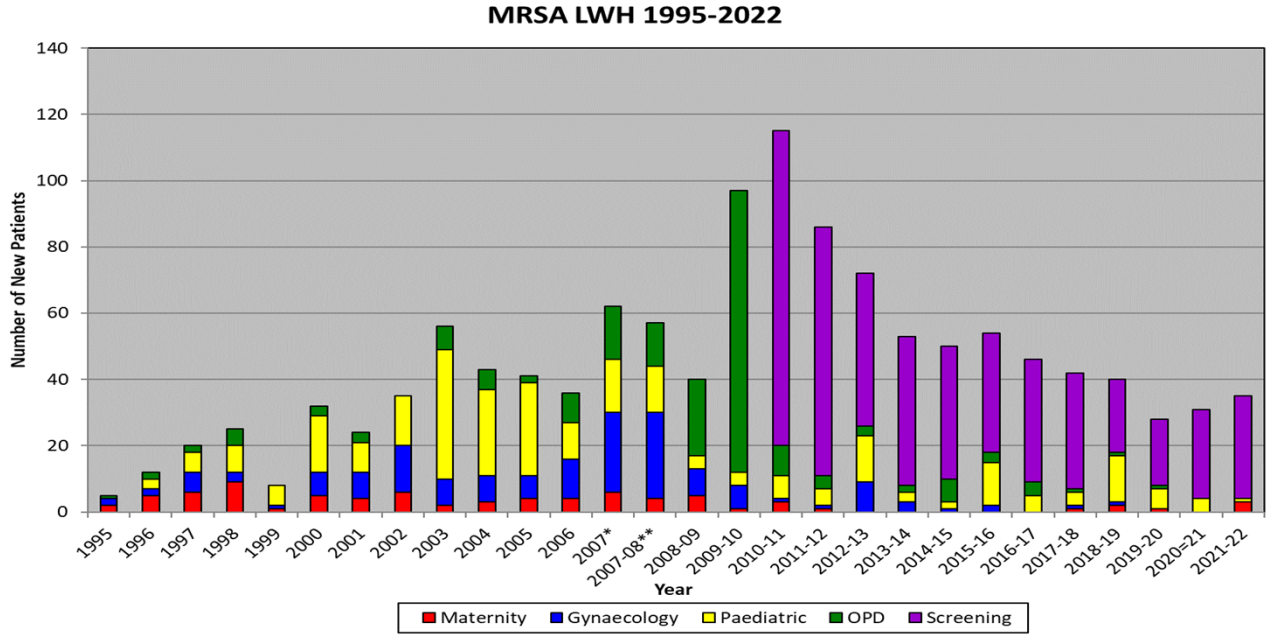
Surveillance of bacteraemias (blood stream infections) for both national mandatory and in house schemes is also undertaken. National mandatory reporting of blood stream infections includes *Klebsiella* and *Pseudomonas* in addition to *E.coli* and *S.aureus.*

10.1 Alert Organism Surveillance

10.1.1 MRSA

The total number of patients identified carrying Meticillin Resistant *Staphylococcus aureus* (MRSA) in the Trust during the year 2021-22 was 35. Thirty one of the 34 adult patients were identified by routine screening either on, or prior to, admission. Three maternity patients had MRSA in surgical wounds, these cases were not linked. The patient identified with MRSA on the neonatal unit was colonised on admission. The charts below show the number of new patients identified with MRSA and the annual totals for the period 1995 – 2022.





As outlined in previous Annual Reports the Government had established targets for screening such that all elective admissions and all eligible emergency admissions to hospital should be screened for carriage of MRSA.

In the period April 2021 to March 2022, 4267 adult patients were screened for MRSA carriage: 31 (0. 7%) were positive.

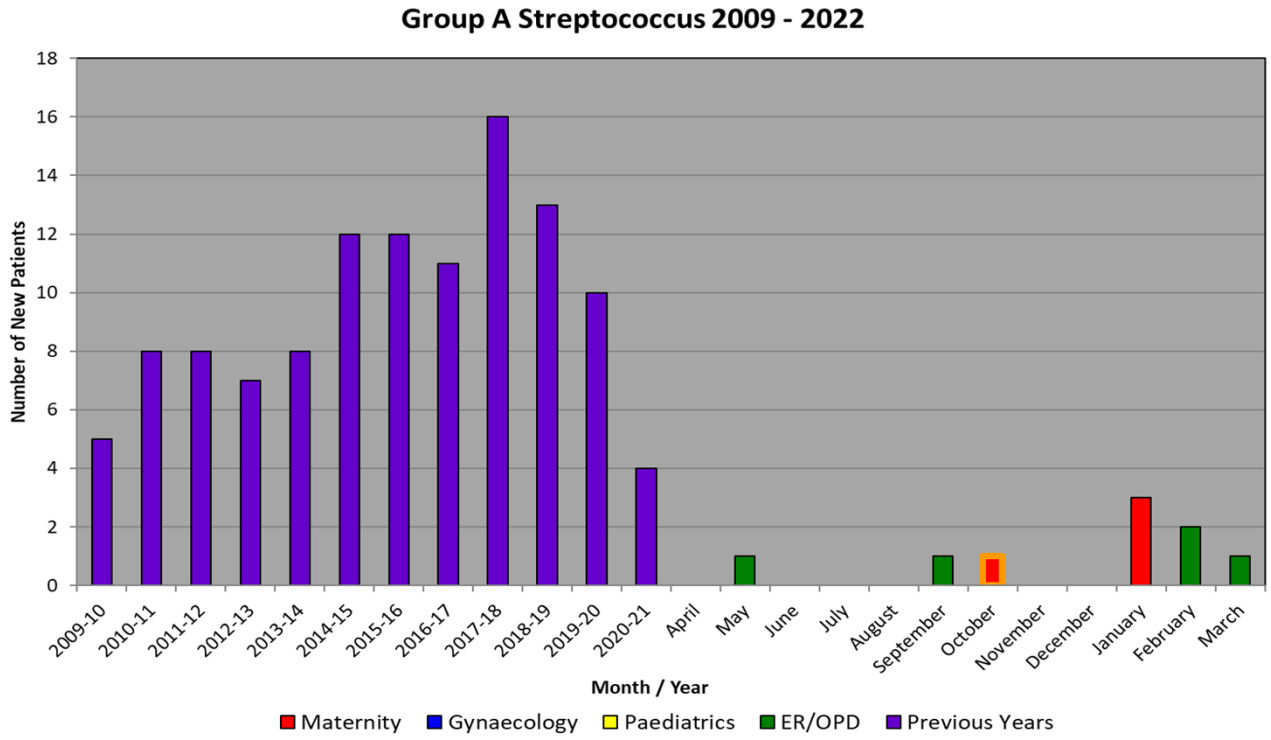
During the period of this report 1 neonate was identified with MRSA a decrease from 4 the previous year. There were no clusters or other epidemiological linking of adult or neonatal patients with MRSA.

10.1.2 Clostridioides difficile

Mandatory reporting of this disease commenced in January 2004 and includes all patients over 2 years old. Historically the number of cases at LWFT has been low. The prescribed trajectory for this disease for the Trust in 2021-22 was one.
During the period April 2021 – Mar 2022 there were no patients identified with *C.difficile* infection in the Trust. The last reported positive *C.difficile* patient in LWH was in 2017-18

10.1.3 Group A Streptococcus

In the period April 2021 to March 2022, 9 patients were identified with Group A Streptococcus as detailed below. This is an increase on the number reported in 2020-21 but is in line with annual numbers reported pre-pandemic. All patients with Group A Streptococcal infection are reviewed. One patient had Group A streptococcal puerperal sepsis (bacteraemia), review of this case identified good care and no preventable factors. Two patients presenting to the maternity service in January 2022 were infected with the same strain of Group A streptococcus this most likely represents cross infection although a specific transmission event was not identified.



10.1.4 Glycopeptide Resistant Enterococcus (GRE)

There were no GRE bacteraemia's reported.

10.1.5 Carbapenemase Producing Enterobacteriales

The screening for multidrug - resistant organisms was incorporated into National guidance and in 2014 LWH commenced screening patients in high-risk groups for Carbapenemase producing Enterobacteriales (CPE). In June 2016 the screening process was extended. All patients who have been an inpatient in any other hospital within the preceding 12 months require screening. Meditech facilitates the risk assessment.

Month	Screening Compliance
Apr 21 - June 21	81%
July 21 – Sept 21	90%
Oct 21 – Dec 21	92%
Jan 22 – Mar 22	85%

The main theme of non-compliance identified has been missed screens on patients who are direct transfers from another hospital having been an inpatient for more than 24 hours. This issue has been addressed with Ward Managers, IPCT Link staff and clinical staff in the relevant areas.

10.1.6 Routine Neonatal Surveillance

Nearly all infection on the Neonatal unit is, by definition, hospital acquired although a small proportion is maternally derived. Routine weekly colonization surveillance has continued this year on the Neonatal unit. Results are shown in Appendix B

As colonisation is a precursor to invasive infection the purpose of this form of surveillance is to give an early warning of the presence of resistant or aggressive organisms and to ensure current empirical antimicrobial therapy remains appropriate. Action points are embedded in the Neonatal unit and IPC policies linked to thresholds of colonisation numbers to limit spread of resistant or difficult to treat organisms.
As well as resistant or aggressive organisms focus has remained on both *Pseudomonas aeruginosa*. and *Staphylococcus aureus* as potential serious pathogens. The median number of babies colonized with *Pseudomonas* each week was 1, (an increase from last year), and with *S.aureus* was 3 (unchanged from last year).

10.2 Bacteraemia Surveillance

10.2.1 Neonatal Bacteraemia

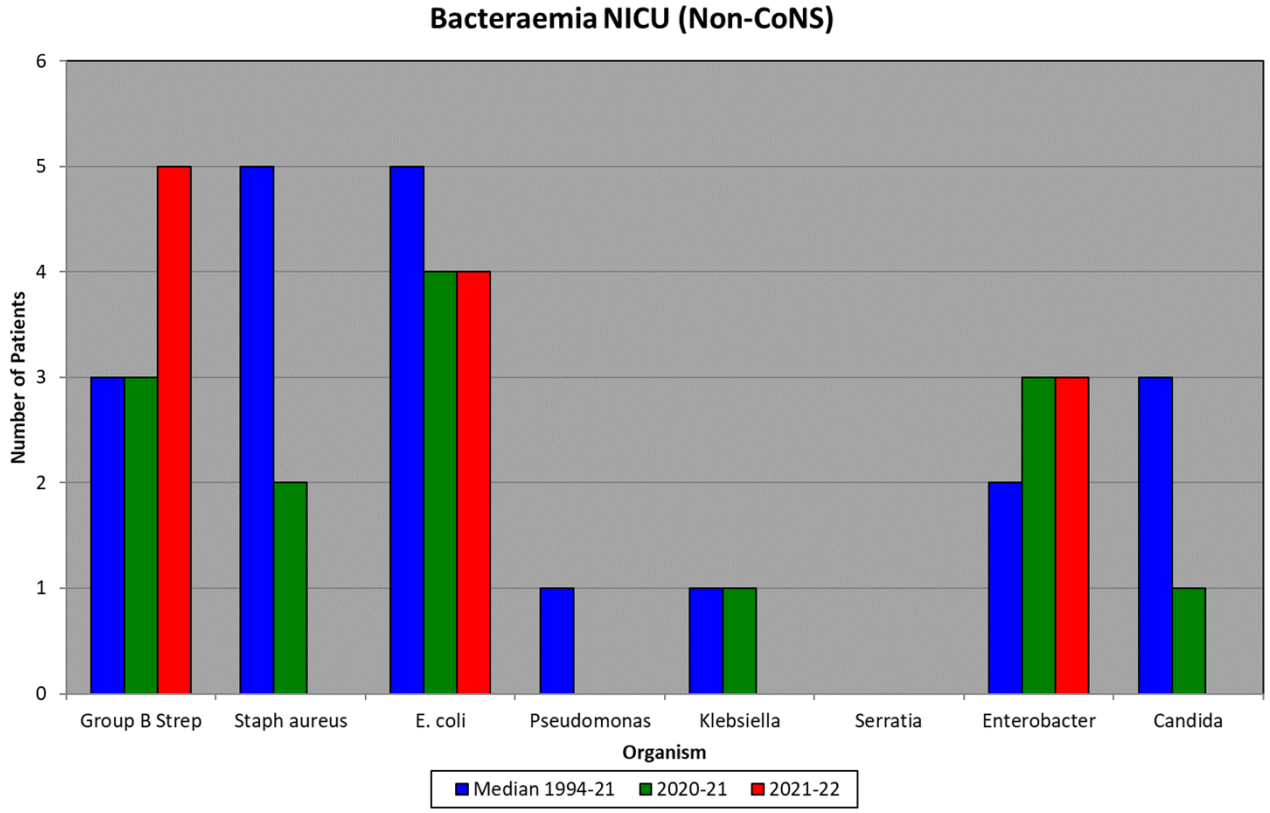
As always, the commonest organism responsible for Neonatal sepsis was the common skin organism, coagulase-negative staphylococcus (CoNS). In the period April 2022 – March 2022 13 babies (10 in 2020-21 and 9 in 2019-20) had infections with Gram-negative organisms, 5 of these infections (1 *E. coli*, 1 *Moraxella sp*, 1 *Chrysyomonas sp*, 1 *Pantoea sp*, and 1 *Citrobacter sp*) occurred in the first 5 days of life and were congenitally acquired. The remaining 8; (3 *E. coli,* 3 *Enterobacter* sp, 1 *Citrobacter sp* and 1 *Stenotrophomonas sp*) occurred after 5 days of life.

There were 7 episodes of infection with significant Gram-positive pathogens (5 in 2020-21 and 12 in 2019-20); 4 of these infections (2 Grp B Streptococcus, *1 S.pneumoniae* and 1 *L*.monocytogenes) were congenitally acquired and 3 (all group B Streptococcus) occurred after day 5.

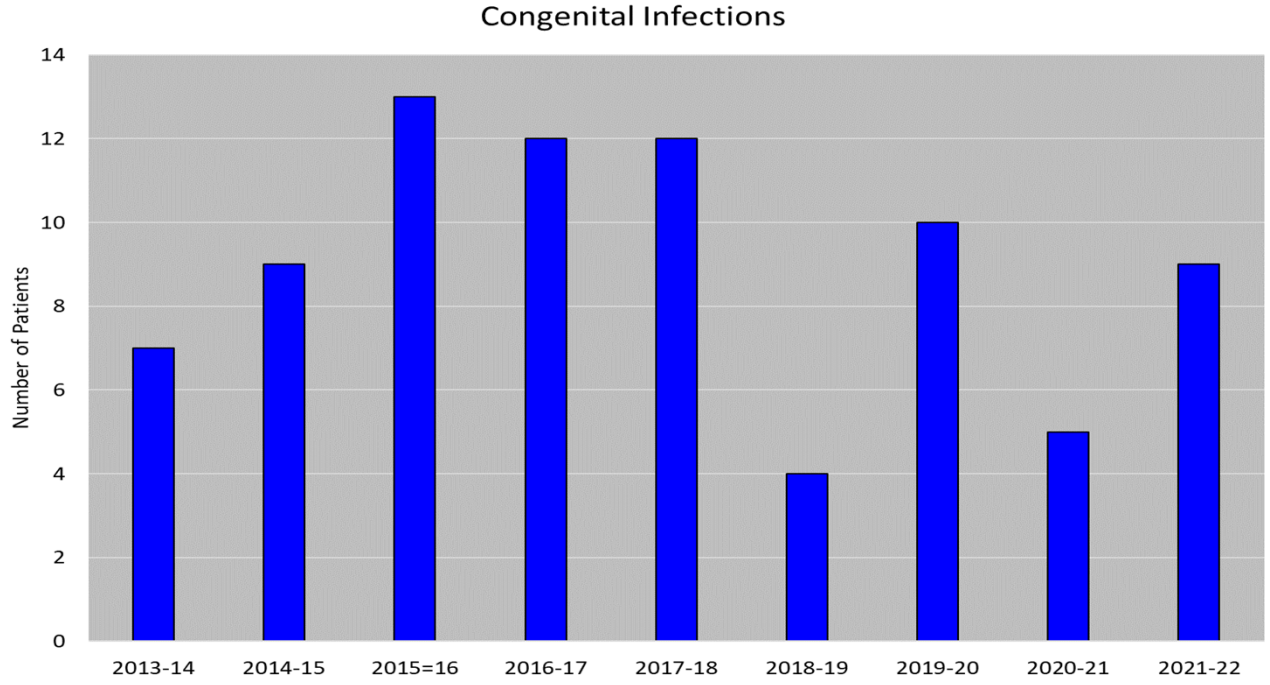
All Non-coagulase-negative Staphylococcal sepsis on the unit is subject to a review to determine the focus of infection, precipitating causes and the appropriateness of care.

The bar chart below describes the pattern of ‘definite-pathogen’ Neonatal bacteraemia in the current year in comparison to last year and the median value for each organism for preceding years. There is considerable variability in the figures from year to year (probably reflecting the complex of pathogen host relationship in this group). Of note there were no

S.aureus bacteraemias in neonates in the reporting year and no Pseudomonas sepsis has been reported since 2017-18.



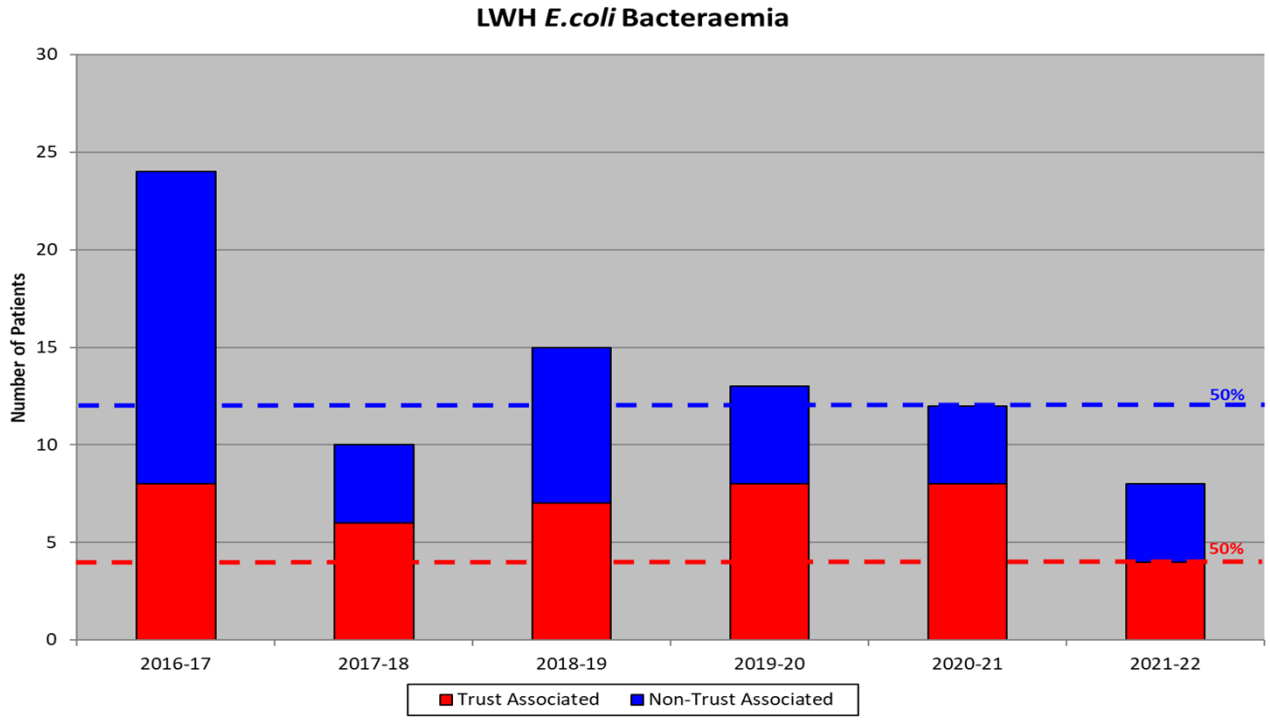
The IPCT have been monitoring the number of Neonatal infections classified as 'congenital' i.e., presenting in the first 5 days of life. 9 babies this year had congenital infection.



10.2.2 Adult Bacteraemia Surveillance

There have been no MRSA bacteraemias in adult patients in the period April 2021 to March 2022, however there were three MSSA bacteraemia.

There is a national ambition to reduce Gram-negative bacteraemia (particularly *E.* coli) by 50%. Although this is not a specific Trust target the IPCT have been working with regional groups facilitated by the CCG to reduce *E. coli* sepsis. In 2021-22 the Trust reported 8 *E. coli* bacteraemia's (4 Neonates (1 congenital) and 4 adults) compared to 12 in 2020-21 and 13 in 2019-20. Both the total number of *E. coli* bacteraemia's and those categorised as Trust associated (defined by time from admission) are reduced this year.



The IPCT expect clinical areas to undertake an RCA of all significant bacteraemias to establish any elements of sub-optimal care. A regular multidisciplinary meeting is held with members of the maternity and gynaecology divisions to review all infective pathology.

In addition to the mandatory surveillance the IPCT has been collecting clinical data on bacteraemic adults in the Trust; 28 patients were identified with positive blood cultures from 414 cultures submitted (6.8%). 10 (35% of positives, 2.4% of total) of these were contaminated with skin organisms. Details of the 18 significant bacteraemias are provided in Appendix C

10.3 Surgical Site Surveillance

Potential Surgical Site Infections are discussed at monthly review meetings where any themes are highlighted and fed back to Divisions through 'Lessons of the week' information.

Given the static nature of the wound infection rate over several years, and the favourable Trust position when benchmarked against other organisations in the national GIRFT survey, a decision was taken to reduce continuous prospective wound surveillance to twice yearly surveillance; (July - August and January – February).

SSI rates for Maternity and Gynaecology divisions remain between 2-3%, being lower than the 5% Trust target.

11 Health & Wellbeing

The Trust Health & Wellbeing Department report monthly to the IPCG including vaccination updates. Staff have historically been screened for TB, Hepatitis B and Rubella immunity. Guidance on Measles, Chicken pox, HIV and Hepatitis C have been incorporated for all 'new starters' and a catchup exercise is in place for staff already employed. The IPCG supports the Health & Wellbeing team in ensuring that workers in designated areas have appropriate vaccinations and immunity.

12 Infection Control Team Work Plan

12.1 Infection Control Team Work Plan 2021-2022

Work Plan	Completion Date	Comments
Covid-19 Planning		
• Advise and support management and care of patients with Covid-19	Ongoing	
• Work within Trust structures to support the Trust reset plan	Ongoing	
• Maintain and update the Board assurance framework related to Covid-19	Ongoing	Completed
Training		
• Continue all Trust mandatory & induction training	Ongoing	
• Continue to support link staff personal development	Ongoing	
• Link staff to be given allocated time and working alongside managers across the areas	Ongoing	
Audit		
• Continue to audit in line with the IPS Audit programme	Ongoing	
• Ensure Trust Covid audit is undertaken to provide assurance to Trust	Ongoing	
• Investigate the potential for having a new Audit system and link to Power BI	Nov 20	Completed
Reporting		
• Investigate the potential for having more robust way of pulling CPE data for percentages	Ongoing	Completed
Engage		
• More engagement with the Link Staff	Ongoing	Completed
• Back to basics with Infection Control processes and policies with staff	Ongoing	Completed
Surveillance		
• Continue 'Alert Organism' surveillance focused on resistant pathogens	Ongoing	
• Continue to monitor cases mandatorily reportable infections	Ongoing	
• Undertake a comprehensive review surgical site infections	Ongoing	
• Implement actions identified through RCA of bacteremia's and C.difficile infections	Ongoing	
• Work with the CCG and Trust Sepsis lead to deliver their target reduction in Gram-negative sepsis.	Ongoing	
• Send Business case to Head of Governance for ICNET surveillance system	Ongoing	Completed

Health Act & NICE • Review compliance and evidence • Review and ensure Trust maintains its compliance with current NICE guidance relating to infection, infection control, sepsis and antimicrobial stewardship.	Ongoing Ongoing	

Infection Control Teamwork Plan 2022-2023

Work Plan	Completion Date	Comments
Covid-19 Planning • Advise and support management and care of patients with Covid-19 • Work within Trust structures to support the Trust reset plan and 'Living with covid' guidance • Maintain and update the Board assurance framework related to Covid-19	 Ongoing Ongoing Ongoing	
Training • Continue all Trust mandatory & induction training • Review and continue to support IPC Link staff role and professional development • Link staff to be given allocated time and working alongside managers across the areas	 Ongoing Ongoing	
Audit • Continue to audit in line with the IPS Audit programme	 Ongoing	
Reporting • Continue to support the new Trust wide audit programme	 Ongoing	
Engage • Continue active engagement with Link staff, managers, and matrons • Encourage Link staff to accompany IPC Team on IPC environmental audits for professional development	 Ongoing Ongoing	
Surveillance • Continue 'Alert Organism' surveillance focused on resistant pathogens • Continue to monitor cases mandatorily reportable infections • Implement actions identified through RCA of bacteremia's and C.difficile infections • Work with the CCG and Trust Sepsis lead to deliver their target reduction in Gram-negative sepsis.	 Ongoing Ongoing Ongoing Ongoing	

Health Act & NICE • Review compliance and evidence • Review and ensure Trust maintains its compliance with current NICE guidance relating to infection, infection control, sepsis and antimicrobial stewardship.	Ongoing Ongoing	

13 Appendices

13.1 Appendix A – Terms of Reference - Infection Prevention and Control Group Terms

INFECTION PREVENTION AND CONTROL GROUP TERMS OF REFERENCE

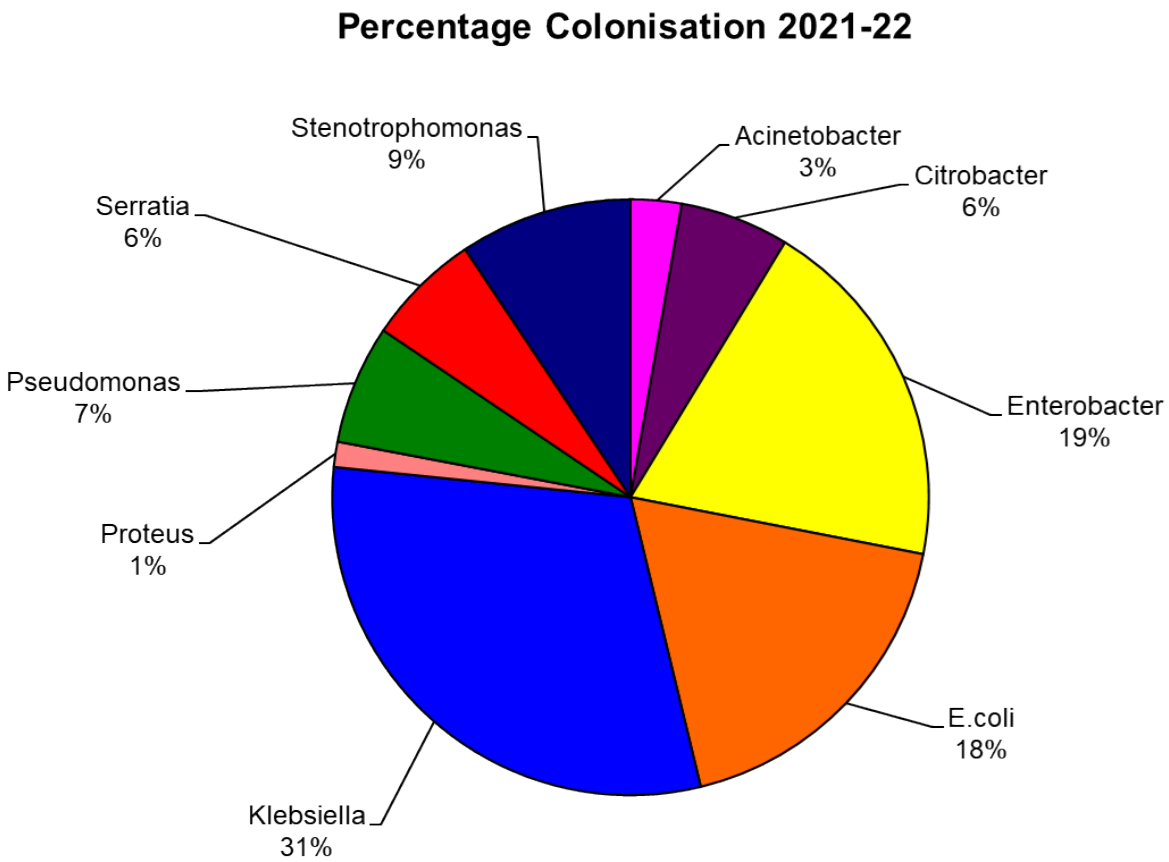
Constitution:	The Group is established by the [Effectiveness and Safety Committee and will be known as the Infection Prevention and Control group.
Duties:	The Group is responsible for: providing assurance to the Trust Board in relation to those systems and processes it monitors and ensure compliance with external agency's standards e.g.: CQC etc. 1. Agree and disseminate the systems and processes for effective Infection Prevention and Control. 2. Develop the strategic direction of Infection Prevention and Control, ensuring that the team is resourced sufficiently to achieve improvement in performance. 3. Review and approve the work of the Infection Prevention & Control team members in line with Trust objectives through the IPCG team work plan. 4. Review and endorse all policies relating to Infection Prevention & Control and evaluate their implementation. 5. Receive and review regular reports of infection incidents or outbreaks and ensure that reports are forwarded to appropriate external authorities. 6. Ensure that lessons identified from incidents, outbreaks, or reports from external organisations are actioned by relevant Divisions in the organisation. 7. Implement a regular reporting timetable including comprehensive Division reports and reports from support services at regular intervals. 8. Ensure that effective Infection Prevention and Control is being delivered in Divisions and monitor evidence of prevention and control practice. 9. Promote and facilitate the education of staff of all grades in hand hygiene Infection Prevention & Control and related topics Receive, discuss and endorse the annual Infection Prevention & Control report produced by the Infection Prevention & Control team

	prior to submission to the Safety and Effectiveness Committee and Trust Chief Executive.
Membership:	The Group membership will be appointed by the SEC and will consist of: • The Chair – Director of Nursing, Midwifery or Representative of CEO • Director of Infection Prevention and Control • Infection Prevention & Control practitioner • Trust Decontamination Lead • Representative of Public Health England • Estates or Patient Facilities Manager • Health and Safety Advisor • Occupational Health Nurse • Deputy Director of Nursing and Midwifery • Head of Nursing Gynaecology Division • Head of Midwifery Maternity • Head of Nursing Neonates • Head of Nursing Clinical Support Division • Antibiotic Pharmacist • Representative from Clinical Commissioning Group • Safety Lead from Family Health Division • Safety Lead from Gynaecology Division • Safety Lead from Clinical Support Division Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum The Effectiveness and Safety Committee will appoint a member of the Group as Chair of the Group and another member to be Vice Chair from the outset. The Vice Chair will automatically assume the authority of the Chair should the latter be absent.
Quorum:	A quorum shall be 6 members including: Chair (or approved Deputy) IPCN or DIPC Representative from each Division Representative from Facilities Department
Voting:	Each member will have one vote with the Chair having a second and casting vote, if required. Should a vote be necessary a decision will be determined by a simple majority.
Attendance:	**a. Members** Members will be required to attend a minimum of 75% of all meetings. **b. Officers** Other officers and staff of the Trust will be invited to attend the

	meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed. Representatives from partner organisations or other external bodies may be invited to attend as appropriate. Such representatives will not have voting rights.
Frequency:	Meetings shall be held [4] times per year. Additional meetings may be arranged from time to time, if required, to support the effective functioning of the Trust.
Authority:	The Group is authorised by the SEC to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Group.
Accountability and reporting arrangements:	The Group will be accountable to the SEC The minutes of Group will be formally recorded and submitted to the SEC. The Chair of the Group shall draw to the attention of the SEC any issues that require disclosure to it or require executive action. The Group will report to the SEC annually on its work and performance in the preceding year. Trust standing orders and standing financial instructions apply to the operation of the Group.
Reporting Committees/Groups	The sub-committees/groups listed below are required to submit the following information to the Infection Prevention and Control Group: a) Chairs Report [and/or] minutes of meetings; and b) an Annual Report setting out the progress they have made and future developments. The following sub committees/groups will report directly to the Committee: • Local Water Safety Group • Link Staff Meeting / Professional Development Day
Monitoring effectiveness:	The Group will undertake an annual review of its performance against its duties in order to evaluate its achievements.
Review:	These terms of reference will be reviewed at least annually by the SEC.
Reviewed by Infection prevention and Control Group:	30/04/2021
Review date:	30/04/2022
Document owner:	Marie Forshaw, Director of Nursing and Midwifery Email: marie.forshaw@lwh.nhs.uk Tel: 01517024010

13.2 Appendix B - Neonatal Colonisation Surveillance

Organism	2011/12	2012-13	2013/14	2014/15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22
Acinetobacter	1	3	3	6	3	3	3	3	3	3	3
Citrobacter	6	6	4	3	4	7	4	6	3	4	6
Enterobacter	21	21	17	14	17	22	19	18	23	20	19
E.coli	23	20	30	27	21	22	28	23	20	26	18
Klebsiella	38	32	34	39	41	35	31	34	39	33	31
Proteus	0	3	1	1	1	1	1	0	2	1	1
Pseudomonas	6	11	5	4	3	3	4	6	3	5	7
Serratia	2	2	2	1	3	2	5	3	2	3	6
Stenotrophomonas	3	2	4	4	7	5	5	7	5	5	9



13.3 Appendix C - Adult Bacteraemia Surveillance 2021-2022

28 Positive blood cultures

10 Coagulase-negative staphylococcus or other contaminant.

18 Pathogens

Directorate	Organism	Potentially Hospital Associated	Likely Source
Gynaecology	*Clostridioides* sordelli	N	Endometritis
	Group B Strep	N	RPOC
	E.coli	N	Kidney Infection
	E.coli	N	Genital Tract
Maternity	MSSA	Y	Cannula
	Group B Streptococcus	N	Chorioamnionitis
	E.coli	Y	Chorioamnionitis
	Group B Streptococcus	N	Chorioamnionitis
	MSSA	N	UTI
	Group B Streptococcus	Y	Chorioamnionitis
	Klebsiella Pneumonae	N	Urine
	E.coli	Y	Chorioamnionitis
	Group A Streptococcus	N	Sepsis
	Klebsiella Pneumonae	N	Urine
	Group B Streptococcus	N	Genital Tract
	Group B Streptococcus	N	Genital Tract
	Strep Aginosus	N	? Abscess
	Group B Streptococcus / MSSA	N	Genital Tract

Appendix 1

Appendix 1 Infection prevention and control board assurance framework

1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**

Systems and processes are in place to ensure that:
• a respiratory season/winter plan is in place:
  ○ that includes point of care testing (POCT) methods for seasonal respiratory viruses to support patient triage/placement and safe management according to local needs, prevalence, and care services
  ○ to enable appropriate segregation of cases depending on the pathogen.
  ○ plan for and manage increasing case numbers where they occur.
  ○ a multidisciplinary team approach is adopted with hospital leadership, estates & facilities, IPC Teams and clinical staff to assess and plan for creation of adequate isolation rooms/units as part of the Trusts winter plan.
	Winter Plan in place
	
	Seasonal Respiratory Infections Winter 2021 guidance in place IPC for seasonal Respiratory Infections Winter 2021
	
	POCT methods are used to support triage and placement of patients and is outlined in divisional guidance.		

• health and care settings continue to apply COVID-19 secure workplace requirements as far as practicable, and that any workplace risk(s) are mitigated for everyone.
• Organisational /employers risk assessments in the context of managing seasonal respiratory infectious agents are:
  ○ based on the measures as prioritised in the hierarchy of controls. including evaluation of the ventilation in the area, operational capacity, and prevalence of infection/new variants of concern in the local area.
  ○ applied in order and include elimination; substitution, engineering, administration and PPE/RPE.
  ○ communicated to staff.
• safe systems of working; including managing the risk associated with infectious agents through the completion of risk assessments have been approved through local governance procedures, for example Integrated Care Systems.
	Covid-19 Health and Safety Guidance and risk assessments are available on the LWH Intranet Health and Safety team facilitate review of the risk assessments and mitigate risks with IPC input.
	
	Covid Secure Risk assessments are completed for all areas and submitted to Health and Safety Team.
	
	National guidance is followed.
		Criteria for completing a local risk assessment was updated 2 Feb 2022
		
		Discussion with Governance team about updating the current HSE risk assessment form to include hierarchy of controls and ventilation
			Agreement made to integrate or use this risk assessment to be led by Health and Safety Team with IPC input.
			
			Acute Trust and outpatient
			C1578_ii_EAC-risk-assessment-tools-acu
			C1578_ii_EAC-risk-assessment-tools-acu

• if the organisation has adopted practices that differ from those recommended/stated in the national guidance a risk assessment has been completed and it has been approved through local governance procedures, for example Integrated Care Systems.	National guidance is followed.		
• risk assessments are carried out in all areas by a competent person with the skills, knowledge, and experience to be able to recognise the hazards associated with respiratory infectious agents.	Covid Secure Risk assessments / Health and safety risk assessment		
• if an unacceptable risk of transmission remains following the risk assessment, the extended use of Respiratory Protective Equipment (RPE) for patient care in specific situations should be considered.	Staff Hub - Risk assessments		
• ensure that patients are not transferred unnecessarily between care areas unless, there is a change in their infectious status, clinical need, or availability of services.	Obstetric Care for women during the COVID-19 pandemic Cohorting patients who are admitted to gynae ward		
• the Trust Chief Executive, the Medical Director or the Chief Nurse has oversight of daily sitrep.in relation to COVID-19, other seasonal respiratory infections, and hospital onset cases	There is oversight of the daily sitrep reports and these are available on Power BI for review		
• there are check and challenge opportunities by the executive/senior leadership teams of IPC practice in both clinical and non-clinical areas.	Executives and senior managers teams check and challenge practice on designated Thursday walk around LWH		
• resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors).	IPC Policy Covid-19 risk assessments undertaken by IPC Team reported on Power BI IPC Team environmental audits and IPC Link and ward based clinical IPC audits as per audit programme		
• the application of IPC practices within this guidance is monitored, e.g.:	Covid-19 risk assessments undertaken by IPC Team reported on Power BI		
○ hand hygiene. ○ PPE donning and doffing training. ○ cleaning and decontamination.	Effective Hand Hygiene IPC for seasonal Respiratory Infections Winter 2021 LWH PPE Update Enhanced Cleaning		

• the IPC Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board.	Review at Infection control committee		
• the Trust Board has oversight of ongoing outbreaks and action plans.	Review at Covid oversight, command meetings and ICC committee		
• the Trust is not reliant on a particular mask type and ensure that a range of predominantly UK Make FFP3 masks are available to users as required.	Procurement Team monitor mask purchase Issues with PPE supply and stock is discussed at oversight and command and control meetings Fit testing SOP and program for Fit testing agreed which includes this requirement.		

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of i infections			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that: • the Trust has a plan in place for the implementation of the National Standards of Healthcare Cleanliness and this plan is monitored at board level.	The Trust are working towards the implementation of the new national standards of healthcare cleanliness with oversight at board level.		
• the organisation has systems and processes in place to identify and communicate changes in the functionality of areas/rooms	Estate's manager has oversight of any planned changes, and this is reported through ICC committee / oversight or command and control meetings.		
• cleaning standards and frequencies are monitored in clinical and non-clinical areas with actions in place to resolve issues in maintaining a clean environment.	OCS Audim monitoring IPC Team monitoring through audit. Local clinical auditing		
• increased frequency of cleaning should be incorporated into the guidance.	Enhanced Cleaning SOP Cleaning Policy		
• if an alternative disinfectant is used, the local infection prevention and control team (IPCT) are consulted on this to ensure that this is effective against enveloped viruses. • manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/disinfectant solutions/products.	IPC and Health and safety teams have oversight of product use which is in line with national guidance and manufacturers guidance		
• a minimum of twice daily cleaning of: ○ patient isolation rooms. ○ cohort areas. ○ Donning & doffing areas ○ 'Frequently touched' surfaces eg, door/toilet handles, patient call bells, over bed tables and bed rails. ○ where there may be higher environmental contamination rates, including: ▪ toilets/commodes particularly if patients have diarrhoea.	Enhanced Cleaning SOP Cleaning Policy		

• A terminal/deep clean of inpatient rooms is carried out: ○ following resolutions of symptoms and removal of precautions. ○ when vacated following discharge or transfer (this includes removal and disposal/or laundering of all curtains and bed screens); ○ following an AGP **if room vacated** (clearance of infectious particles after an AGP is dependent on the ventilation and air change within the room). • reusable non-invasive care equipment is decontaminated: ○ between each use. ○ after blood and/or body fluid contamination ○ at regular predefined intervals as part of an equipment cleaning protocol ○ before inspection, servicing, or repair equipment. • Compliance with regular cleaning regimes is monitored including that of reusable patient care equipment. • As part of the Hierarchy of controls assessment: ventilation systems, particularly in, patient care areas (natural or mechanical) meet national recommendations for minimum air changes refer to country specific guidance. In patient Care Health Building Note 04-01: Adult in-patient facilities. • the assessment is carried out in conjunction with organisational estates teams and or specialist advice from ventilation group and or the organisations, authorised engineer. • a systematic review of ventilation and risk assessment is undertaken to support location of patient care areas for respiratory pathways • where possible air is diluted by natural ventilation by opening windows and doors where appropriate • where a clinical space has very low air changes and it is not possible to increase dilution effectively, alternative technologies are considered with Estates/ventilation group. • when considering screens/partitions in reception/ waiting areas, consult with estates/facilities teams, to ensure that air flow is not affected, and cleaning schedules are in place.	Enhanced Cleaning SOP Cleaning Policy imt012/Policies_Procedures_and_Guidelines/Guidance Documents/Isolation and Barrier Nursing.pdf Decontamination of medical Devices Policy OCS Audim monitoring IPC Team monitoring through audit. Local clinical auditing Yes Health and safety Policy Covid secure risk assessments Advice on LWH staff Hub Consultations have occurred with Estates and facilities regarding discussions about reception and	No UpToDate assessment available – discussed with Estates ad Facilities manager and mitigating actions to be implemented	Authorised engineer was appointed in February 2022 and has visited the site and will produce a report and action plan . All PPM's now scheduled and compliant except for ceiling grill extract fans awaiting scheduling

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and process are in place to ensure that: • arrangements for antimicrobial stewardship are maintained • previous antimicrobial history is considered • the use of antimicrobials is managed and monitored: ○ to reduce inappropriate prescribing. ○ to ensure patients with infections are treated promptly with correct antibiotic. • mandatory reporting requirements are adhered to, and boards continue to maintain oversight. • risk assessments and mitigations are in place to avoid unintended consequences from other pathogens.	Antimicrobial Formulary Prescribing of Medicines Policy Administration of Medicines Management of Sepsis in Obstetrics Sepsis care bundle Acutely Ill Patients Clinical Guideline IPC Policy http://lwintranet/Policies_Procedures_and_Guidelines/Guidance%20Documents/Clostridium%20difficile%20Policy.pdf Regular Power BI Reports on antimicrobial prescribing / stewardship Antimicrobial Drugs - Power BI High Cost & Non-formulary Drugs	Reports and audit results should go to Medicines Management Group and CGC (see appendix 2. Administration of Medicines	Discussion with Deputy chief Pharmacist who advises these haven't happened for a while, but they will be ensuring it starts formally in 2022/23

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that: • visits from patient's relatives and/or carers (formal/informal) should be encouraged and supported whilst maintaining the safety and wellbeing of patients, staff and visitors • national guidance on visiting patients in a care setting is implemented.	Visiting during the COVID-19 Visiting SOP in place in divisions	Change in guidance 8/3/22 Living with covid -`9 –	Divisions are currently reviewing all SOPs to allow re- introduction of general visiting after restrictions due to

• restrictive visiting may be considered appropriate during outbreaks within inpatient areas This is an organisational decision following a risk assessment. • there is clearly displayed, written information available to prompt patients' visitors and staff to comply with handwashing, wearing of facemask/f ace covering and physical distancing. • if visitors are attending a care area with infectious patients, they should be made aware of any infection risks and offered appropriate PPE. This would routinely be an FRSM.	Visiting on gynae and Bedford during COVID Visiting on the neonatal unit during COVID -19 Visiting within maternity Wards During COVID -19 Posters and signage around trust IPC posters on isolation rooms infection prevention and control policy Isolation and Barrier Nursing PPE available for use	visiting healthcare inpatient settings: principles.	Omicron variant to go to oversight by 15/3/22 Further Signage may be required and updated when other entrances opened to public and staff

• visitors with respiratory symptoms should not be permitted to enter a care area. However, if the visit is considered essential for compassionate (end of life) or other care reasons (eg, parent/child) a risk assessment may be undertaken, and mitigations put in place to support visiting wherever possible. • visitors are not present during AGPs on infectious patients unless they are considered essential following a risk assessment eg, carer/parent/guardian • Implementation of the Supporting excellence in infection prevention and control behaviors Implementation Toolkit has been adopted C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk)	imt012/Policies_Procedures_and_Guidelines/Guidance Documents/Patients and Visitors at Reception.pdf Yes, supporting IPC behaviours Implementation toolkit has been adopted and has supported LWH guidance and education. Every action counts video is part of yearly mandatory training.	Unable to find a SOP, guideline or Policy that says this. AGP only performed in certain areas likely to be theatre or NICU or crash call for resuscitation.	Further Signage may be required and updated when other entrances opened to general public and staff

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that: • signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival. • infection status of the patient is communicated to the receiving organization, department or transferring services, when a possible or confirmed seasonal respiratory infection needs to be transferred. • staff are aware of agreed template for screening questions to ask. • screening for COVID-19 is undertaken prior to attendance wherever possible to enable early recognition and to clinically assess patients prior to any patient attending a healthcare environment • front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19/ other respiratory infection symptoms and segregation of cases to minimise the risk of cross-infection as per national guidance. • triage is undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible. • there is evidence of compliance with routine patient testing protocols in line with trust approved hierarchies of control risk assessment and approved.	Signage and reception triage staff present Yes – SBAR handover and on PENS/ K2 Athena imt012/Policies_Procedures_and_Guidelines/Guidance Documents/Patients and Visitors at Reception.pdf IPC for seasonal Respiratory Infections Winter 2021 Yes this is within divisional SOP's and reported in Power BI Maternity COVID-19 Testing and Receiving of results Patient and Visitors at reception Management of suspected and confirmed COVID-19 patients' arrival and discharge Obstetric care for women during the COVID-19 Pandemic Review of GED Services in Response to COVID-19 Pandemic Temporary Imaging SOP for Ultrasound Obstetric patients due to Current Covid-19 Pandemic imt012/Policies_Procedures_and_Guidelines/Guidance Documents/Maternity Telephone Triage.pdf		Signage to be updated as above at all entrances and to include this

• patients with suspected or confirmed respiratory infection are provided with a surgical facemask (Type II or Type IIR) to be worn in multi-bedded bays and communal areas if this can be tolerated. • patients with respiratory symptoms are assessed in a segregated area, ideally a single room, and away from other patients pending their test result. • patients with excessive cough and sputum production are prioritised for placement in single rooms whilst awaiting testing. • patients at risk of severe outcomes of respiratory infection receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare eg, priority for single room isolation and risk for their families and carers accompanying them for treatments/procedures must be considered. • where treatment is not urgent consider delaying this until resolution of symptoms providing this does not impact negatively on patient outcomes. • face masks/coverings are worn by staff and patients in all health and care facilities. • where infectious respiratory patients are cared for physical distancing remains at 2 metres distance. • patients, visitors, and staff can maintain 1 metre or greater social & physical distancing in all patient care areas; ideally segregation should be with separate spaces, but there is potential to use screens, eg, to protect reception staff. • patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly. • isolation, testing and instigation of contact tracing is achieved for all patients with new-onset symptoms, until proven negative. • patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately.	Patient and Visitors at reception Cohorting of patients who are admitted to the gynae ward Obstetric patients with proven or suspected COVID IPC for seasonal Respiratory Infections Winter 2021 Yes as above Yes as above Yes as above Yes as above Management of investigation of cases and outbreaks of covid Yes as above Maternity Admission COVID-19 Management of suspected and confirmed COVID-19 patients arrival and discharge IPC for seasonal Respiratory Infections Winter 2021 Maternity Telephone Triage Urogynaecology Midwife referrals and consultations during COVID-19 pandemic		

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that:			

• appropriate infection prevention education is provided for staff, patients, and visitors. • training in IPC measures is provided to all staff, including: the correct use of PPE including an initial face fit test/and fit check each time when wearing a filtering face piece (FFP3) respirator and the correct technique for putting on and removing (donning/doffing) PPE safely. • all staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it; • adherence to national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk.	Yes, donning and doffing training completed, this training has now been made mandatory and all staff watch a video for training purposes. Every action counts video + signage around trust Covid -19 audits IPC audit program IPC seasonal respiratory infections		
• gloves are worn when exposure to blood and/or other body fluids, non-intact skin or mucous membranes is anticipated or in line with SICP's and TBP's.	LWH PPE Update		
• the use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance.	Yes, paper towels available in all bathrooms and toilets		
• staff maintaining physical and social distancing of 1 metre or greater wherever possible in the workplace	Staff Hub IPC seasonal respiratory infections		
• staff understand the requirements for uniform laundering where this is not provided for onsite.	Has been in Staff communications	Needs to be added into Dress code policy	
• all staff understand the symptoms of COVID-19 and take appropriate action if they or a member of their household display any of the symptoms (even if experiencing mild symptoms) in line with national guidance.	Staff Hub FAQ		
• to monitor compliance and reporting for asymptomatic staff testing	Staff testing spreadsheet		

• there is a rapid and continued response to ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals).	Yes this is highlighted in the command and control and Oversight meetings.		
• positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported.	Management of investigation of cases and outbreaks of covid		

7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure: • that clear advice is provided, and monitoring is carried out of inpatients compliance with wearing face masks (particularly when moving around the ward or healthcare facility) providing it can be tolerated and is not detrimental to their (physical or mental) care needs. • separation in space and/or time is maintained between patients with and without suspected respiratory infection by appointment or clinic scheduling to reduce waiting times in reception areas and avoid mixing of infectious and non-infectious patients. • patients who are known or suspected to be positive with a respiratory pathogen including COVID-19 where their treatment cannot be deferred, their care is provided from services able to operate in a way which minimise the risk of spread of the virus to other patients/individuals. • patients are appropriately placed ie, infectious patients in isolation or cohorts. • ongoing regular assessments of physical distancing and bed spacing, considering potential increases in staff to patient ratios and equipment needs (dependent on clinical care requirements). • standard infection control precautions (SIPC's) are used at point of care for patients who have been screened, triaged, and tested and have a negative result • the principles of SICPs and TBPs continued to be applied when caring for the deceased	Signage around the Trust Monitoring undertaken by IPC Team when undertaking covid -19 audits Patients who attend are currently triaged prior to attending – see divisional SOP's Yes – see divisional SOP's IPC seasonal respiratory infections See divisional SOP's Covid -19 risk assessments IPC seasonal respiratory infections	Monitoring of inpatients is not documented within LWH SOP's or guidance	To be added to divisional guidance
8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**

There are systems and processes in place to ensure: • testing is undertaken by competent and trained individuals. • patient testing for all respiratory viruses testing is undertaken promptly and in line with national guidance;	COVID testing team / Fit test training / Donning and Doffing training every action counts		
• staff testing protocols are in place	Staff testing Quick reference guide Staff testing spreadsheet / lateral flow / lamp testing – see guidance on staff hub		

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• there is regular monitoring and reporting of the testing turnaround times, with focus on the time taken from the patient to time result is available. • there is regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data). • screening for other potential infections takes place. • that all emergency patients are tested for COVID-19 and other respiratory infections as appropriate on admission. • that those inpatients who go on to develop symptoms of respiratory infection/COVID-19 after admission are retested at the point symptoms arise. • that all emergency admissions who test negative on admission are retested for COVID-19 on day 3 of admission, and again between 5-7 days post admission. • that sites with high nosocomial rates should consider testing COVID-19 negative patients daily. • that those being discharged to a care home are tested for COVID-19, 48 hours prior to discharge (unless they have tested positive within the previous 90 days), and result is communicated to receiving organisation prior to discharge. • those patients being discharged to a care facility within their 14-day isolation period are discharged to a designated care setting, where they should complete their remaining isolation as per national guidance	Yes – on Power BI Power bi for admission testing and 3 and 5 day swabs IPC seasonal respiratory infections Divisional SOP's Within divisional policy Management of investigation of cases and outbreaks of covid Not currently applicable, national guidance followed Within divisional guidance Within divisional guidance		

• there is an assessment of the need for a negative PCR and 3 days self-isolation before certain elective procedures on selected low risk patients who are fully vaccinated, asymptomatic, and not a contact of case suspected/confirmed case of COVID-19 within the last 10 days. Instead, these patients can take a lateral flow test (LFT) on the day of the procedure as per national guidance.	Swabbing of Elective Admissions including Day case Maternity COVID-19 Testing and Receiving of results		

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that • the application of IPC practices are monitored and that resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors).	COVID audits / environmental audits - Link staff support their areas. IPC Team provide face to face, telephone, and email support		
• staff are supported in adhering to all IPC policies, including those for other alert organisms.			
• safe spaces for staff break areas/changing facilities are provided.	Yes, covid secure facilities are provided		
• robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of an outbreak.	Yes – risk assessments completed and covid audits undertaken Management of investigation of cases and outbreaks of COVID		
• all clinical waste and linen/laundry related to confirmed or suspected COVID-19 cases is handled, stored, and managed in accordance with current national guidance.	Yes, as per national guidance and Linen SOP infection prevention and control policy		
• PPE stock is appropriately stored and accessible to staff who require it.	Yes, local, and central storage		

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that: • staff seek advice when required from their IPCT/occupational health department/GP or employer as per their local policy. • bank, agency, and locum staff follow the same deployment advice as permanent staff. • staff who are fully vaccinated against COVID-19 and are a close contact of a case of COVID-19 are enabled to return to work without the need to self-isolate (see Staff isolation: approach following updated government guidance) • staff understand and are adequately trained in safe systems of working, including donning, and doffing of PPE • a fit testing programme is in place for those who may need to wear respiratory protection. • where there has been a breach in infection control procedures staff are reviewed by occupational health. Who will:	Staff Hub – Questionnaires via HR / IPC Yes Details are on the Staff hub – Managers and HR Yes, donning, and doffing training completed, this training has now been made mandatory and all staff watch a video for training purposes. Every action counts video + signage around trust Yes, a Fit testing programme is in place Currently Managers / staff complete IPC covid questionnaire and advice		

○ lead on the implementation of systems to monitor for illness and absence.	given by IPC team / HR. Referral to Occupational Health by manager / HR.		

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○ facilitate access of staff to antiviral treatment where necessary and implement a vaccination programme for the healthcare workforce ○ lead on the implementation of systems to monitor staff illness, absence and vaccination against seasonal influenza and COVID-19 ○ encourage staff vaccine uptake. • staff who have had and recovered from or have received vaccination for a specific respiratory pathogen continue to follow the infection control precautions, including PPE, as outlined in national guidance. • a risk assessment is carried for health and social care staff including pregnant and specific ethnic minority groups who may be at high risk of complications from respiratory infections such as influenza and severe illness from COVID-19. ○ A discussion is had with employees who are in the at-risk groups, including those who are pregnant and specific ethnic minority groups; ○ that advice is available to all health and social care staff, including specific advice to those at risk from complications. ○ Bank, agency, and locum staff who fall into these categories should follow the same deployment advice as permanent staff. ○ A risk assessment is required for health and social care staff at high risk of complications, including pregnant staff.	Yes Yes Yes Yes, see LWH guidance Yes, Covid risk assessment is Completed by managers		

• vaccination and testing policies are in place as advised by occupational health/public health.	Yes Trust vaccination programme Staff testing quick reference guide		
• staff required to wear FFP3 reusable respirators undergo training that is compliant with HSE guidance, and a record of this training is maintained and held centrally/ESR records.	Fit tester training provided and recorded within health and safety / staff ESR		
• staff who carry out fit test training are trained and competent to do so.	Trained Fit testers are available		
• all staff required to wear an FFP3 respirator have been fit tested for the model being used and this should be repeated each time a different model is used.	Yes, Programme in place for ongoing Fit Testing		
• all staff required to wear an FFP3 respirator should be fit tested to use at least two different masks	Yes, as above		
• a record of the fit test and result is given to and kept by the trainee and centrally within the organisation.	Yes, on ESR		
• those who fail a fit test, there is a record given to and held by employee and centrally within the organisation of repeated testing on alternative respirators and hoods.	Yes, ESR and Health and Safety Team		

• that where fit testing fails, suitable alternative equipment is provided. Reusable respirators can be used by individuals if they comply with HSE recommendations and should be decontaminated and maintained according to the manufacturer's instructions. • members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm. • a documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health. • boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board. •consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between planned/elective care pathways and urgent/emergency care pathways as per national guidance.	Fit testing SOP Fit testing SOP Covid staff risk assessment / OH review Covid risk assessment / OH review Spreadsheet completed Move to ESR records Discussed at Oversight and command and control meetings		
• health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone. • staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing. • staff who test positive have adequate information and support to aid their recovery and return to work.	Yes, covid secure risk assessments Managers, HR, and Occupational Health Managers, HR, and Occupational Health Health and wellbeing staff Staff HUB		

Trust Board

COVER SHEET

Agenda Item (Ref)	*22/23/082*		**Date: 07/07/2022**	
Report Title	Annual Health & Safety Report 2021/22			
Prepared by	***Tracy Bryning, Health and Safety Manager***			
Presented by	***Phil Bartley, Associate Director of Quality & Governance***			
Key Issues / Messages	*The Annual Health & Safety report is presented for assurance.*			
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 report for assurance.			
Supporting Executive:	Gary Price, Chief Operating Officer			

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

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

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Health & Safety Group.	May 22	Assoc. Director of Quality	Accepted the following recommendations: • Support the continuous review of the Trust's Health and Safety Management System arrangements • Support the continuing development and promotion of a positive health and safety management system and culture

			• Encourage managers and staff to commit to attendance of health and safety related training • Promote health and safety duty and responsibilities across the Trust.
Quality Committee	June 22	Assoc. Director of Quality	The importance of taking a 'matrix management' approach to H&S across the Board's Committee was noted (in recognition that the issues cut across, estates, patient safety and workforce). The Committee recommended that the Report be noted by the Board.

EXECUTIVE SUMMARY

This report gives an overview of compliance and governance assurance regarding the health and safety arrangements, activities, performance and improvements for Liverpool Women's NHS Foundation Trust (LWH) for the financial year 2021/2022.

As in the previous reporting year, the Trust faced many challenges in light of the on-going covid-19 pandemic, constantly changing guidance and collaborations between the HSE, PHE, DHSC and TUC.

Actions have been taken to improve the Trust's fit mask testing resilience to align with the Department of Health and Social Care's (DHSC) mandated resilience principles for fit mask testing and provision. The challenge remains in releasing staff from clinical duties in order to complete testing, despite the Fit Mask Tester being placed in clinical areas. A significant number of staff have not yet come forward for retesting and a higher number again have not rebooked to be tested on a second or third mask, meaning that the organisation is not compliant with the DHSC resilience principles for fit mask testing.

Managers are responsible for the regular review, monitoring and updating of workplace risk assessments, including covid secure risk assessments. Due to many pressures on staff in the past year, there is a gap in managers completing annual workplace audits. This will be addressed by the introduction of the Ulysses Risk and Safety Management module by late autumn 2022. The module will act as a repository for all workplace risk assessments and will reflect compliance across the Trust.

The work plan in Section 10 details plans for future improvements and activities, demonstrating the Trust's commitment to effective health and safety management and continuing improvements in health and safety performance.

Whilst slower progress has been made in this reporting period, hindered by the impact of the covid 19 pandemic, in relation to the overall health and safety management system, there remains some scope for improvement, particularly in relation to risk assessment reviews, audit and communication.

Recommendation

The Board is asked to receive the assurances in the report

Liverpool Women's
NHS Foundation Trust

Health and Safety Annual Report 2021/2022

Including Annual Sharps Report

Tracy Bryning
Health and Safety Manager

28th April 2022

Report

Key Objectives and Current Situation

1.1 Risk Assessments & Audits

i. Mandatory annual health and safety workplace assessments were interrupted by the onset of the pandemic at the beginning of 2021, when historically Trust wide annual health and safety workplace audits would have been completed. These remain behind schedule. In addition, managers are expected to maintain comprehensive covid secure risk assessments of all areas, as directed by the Health and Safety Executive. An overarching organisational covid secure risk assessment has been completed and remains current.

ii. The Health and Safety Manager has created a rolling programme for workplace audits which will allow her to be able to undertake the workplace audit in association with the service/departmental manager; enabling some issues to be addressed on the spot, supporting the manager and enhancing their knowledge of health and safety by discussing any gaps found and why they have to be prioritised. This method will also enable the Health and Safety Manager to engage in all areas across the sites and departments.

iii. The deployment of the Ulysses Risk and Safety Management Module was delayed due to the covid-19 situation. This project has been made a priority action for 2022. The Health and Safety Manager is currently working with specialists from Ulysses to ready the system for staffs use.

The benefits of this module include:

- Ulysses is fully supported by both I.T. and the Governance Risk Team
- All staff are familiar with its functionality
- There are no limits to user licences
- Training is fully supported
- It is fully customisable and we would benefit from other users development of the module
- It can manage any of our risk assessments; staff will be able to use their existing log in details to complete annual departmental audits and actions, risk assessments, etc.
- The module links to relevant incidents, risk register entries or risk assessments and provides an overall compliance dashboard for each individual element e.g. fire, water, COSHH, DSE, injuries, sharps and so on
- Easy to interrogate from a reporting perspective and matches corporate reporting for incidents, risks, safeguarding, legal, alerts and complaints

1.2 Fit Mask Testing

i. **Overview**

In June 2021, the DHSC mandated resilience principles for fit mask testing requiring staff to be retested at two yearly intervals and to be successfully tested and have access to a minimum of two mask types. There has also been a mandated requirement to be able to report on fit testing activity across the organisation. The Health and Safety Manager was invited to represent the Trust at the DHSC's national stakeholder group.

To facilitate fit mask testing, the Trust has been able to access support provided by the DHSC and has benefited from having an accredited fit mask tester on site 37.5 hours per week since January 2022. The placement will end in September 2022. Prior to the introduction of the resilience principles, the Trust had 32 fit mask testers, however, the new principles stipulate that organisations could no longer utilise cascade trained testers. The practice of using cascade fit mask testers ceased in January 2022. By accessing DHSC funding, we were able to have 12 staff trained to grow the number of internal fit mask testers to 12 across the divisions giving resilience across the organisation for fit mask testing.

Table 1 ***shows current fit testing figures:***

Department or area	Total staff testing required	Total tests completed	Pass on 1 mask	Pass on 2 masks	Staff untested
Anaesthetics	33	0	0	0	33
Delivery Suite	95	3	3	0	92
GED	1	1	1	0	0
Gynae services	1	1	1	0	0
Gynae Unit	9	1	0	0	8
Gynae HDU	8	0	0	0	8
Imaging	1	0	0	0	1
IPC / NICU	1	1	1	0	0
Maternity	64	13	8	0	51
MAU	1	1	0	0	0
Medical Staffing and Trainees	76	14	13	0	62
NICU	220	83	41	0	147
Physio	3	0	0	0	3
Resus Team	1	0	0	0	1
Theatres	96	66	52	0	39
Transport	3	0	0	0	3
TOTAL	**613**	**184**	**120**	**0**	**448**

A significant number of staff have not yet come forward for retesting and a higher number again have not rebooked to be tested on a second or third mask meaning that the organisation is not compliant with the DHSC resilience principles for fit mask testing. Administrative actions are underway to improve recall and attendance for testing.

ii. **Fit Test Training**

In January 2022, twelve staff from across the divisions completed training as fit mask testers using the qualitative method of testing and four staff completed training as fit mask testers using the quantitative method of testing. Testers were provided with new fit mask testing kits to use and maintain within their own areas. Testers have been contacted for an update on their testing activities and issuing of certificates; this information will be incorporated in to the Governance monitoring process until mandated ESR reporting streams are established (due to go live with reporting May 2022).

iii. **Substantive Fit Mask Tester/Co-ordinator**

The Trust has fallen behind in its commitment to recruit a substantive Fit Mask Tester/Co-ordinator and ensure that they are accredited as a tester. There is no further update at present.

iv. **Recording of Mask Types for Individuals**

Much work has been completed to allow staffs assigned mask types to be recorded within the Skills section of E-Roster. There is a helpful reporting facility that will allow for a quick look up of, for example, how many staff are using a particular mask type as their first or second choice.

v. **Transparent Face Masks**

The Trust has yet to create suitable and sufficient pathways to bring the use of transparent face masks into use. There are a number of scenarios where these mask types are urgently needed:

- Positive non-verbal communication – reflecting understanding and sensitivity (a reassuring smile)
- To help with patient/staff communication – essential for those with hearing difficulties and who rely on lip reading
- To help staff with hearing difficulties to confidently and safely communicate with patients, carers and colleagues

There are now three transparent mask types available and approved by the DHSC, NHS England and NHSI/E, including an FFP3 type, for use in clinical settings.

Our procurement team has recently identified monies to allow us to begin to make purchases; however, we have no idea of numbers or pathways in which they will be deployed. The masks are not yet available via NHS Supplies and we are awaiting samples from the three recommended suppliers to trail within the organisation.

vi. **Other Issues**

- The designated Fit Mask Testing Hub remains inaccessible to the Governance and Fit Mask Testers. This has posed a risk of trips due to overload of fit mask testing supplies in the Risk Office, a higher than acceptable fire load, operational difficulties for the Associate Director of Quality and Governance, a reduced experience for

those being tested and an environment which does not meet the specifications for suitable and sufficient testing.

- Until recently, it was not known that there was a mandated requirement for the Portacount machine to be sent away for recalibration on an annual basis, date specific. The Trust's machine is currently with the manufacturer for recalibration, however, to ensure our legal health and safety duty is met there is a need to contact and retest any staff members who were tested on the Portacount machine from May 2020 to date.

vii. **Summary of Actions**

a. Divisions have been informed that they must facilitate fit testing with the designated Fit Tester as uptake has been lower than expected in some departments, leading to breaches in the requirement to retest staff at a two yearly interval, exposing people and the organisation to risks that could otherwise be managed through compliance.

b. Expedite the recruitment of a substantive Fit Mask Tester/Co-ordinator who has achieved accreditation, to be in post by the end of August 2022 in readiness to take over from the current seconded tester.

c. Governance and Infection Control Teams have commenced the creation of appropriate documentation and pathways to determine a way forward in introducing transparent fit masks into the organisation starting with the clinical patient pathway.

1.2 PPE

i. In response to the on-going covid 19 pandemic and the need for continuous provision of appropriate PPE (personal protective equipment) for all staff, the establishing central PPE store rooms continues to ensure safe levels of stock are maintained with a robust internal requisition and distribution process established.

ii. An Executive Oversight Meeting continues to be held regularly.

1.3 COSHH

i. **Alcumus Sypol COSHH Management Software**

Since October 2021 the organisation has maintained 100% compliance utilising the Alcumus Sypol COSHH management software, for completing COSHH risk assessments.

The Health and Safety Manager, who is Co-ordinator for the Alcumus Sypol System, is monitoring usage of the system and has established meaningful compliance reports for system users and managers.

1.4 DSE

i. Annual DSE (display screen equipment) risk assessments are required to be undertaken for all DSE users across the organisation and for those who are homeworking, on an annual basis or when there is a significant change in software, hardware or a person's individual circumstances, as is a requirement of the Display Screen Regulations 1992 (amended 2002).

ii. The requirement to undertake these individualised risk assessments are shortly to become a competency and will be monitored via ESR. This will enable the Trust to produce reliable evidence of compliance.

1.5 Stress Management

i. 2021/22 was a challenging working year for many staff across all disciplines due to the ongoing covid 19 pandemic and following a terrorist incident at the Liverpool Women's hospital site.

Employers have a legal duty to protect employees from stress at work by completing a risk assessment and acting on it. Stress risk assessments can be undertaken at the request of persons who are experiencing stress symptoms, by a manager who has identified signs of stress in a staff member or group of staff or following an Occupational Health review.

In addition to statutory stress risk assessments, which follow the HSE stress management standards; the Trust were mindful of staffs health and wellbeing and supported a number of initiatives to support staffs mental and physical wellbeing. Following the terrorist incident, immediate management support and a number of additional counselling support streams were put into place. There was an increased and visible presence of Executive staff on site who visited staff in all areas. The Trust has a proactive Health and Wellbeing Committee, Mental Health First Aiders, Staff Support network and disability network group. Mental Health First Aider's are accessible throughout the Trust and a staff counselling service is accessible twenty four hours a day.

2. Health and Safety Training

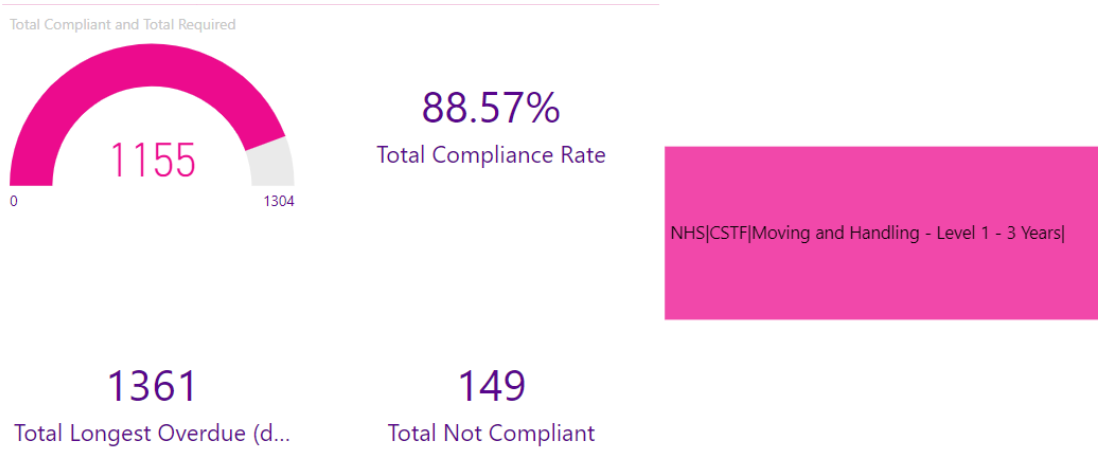
i. Manual Handling (People and Inanimate Objects)

The Manual Handling Operations Regulations (1992) sets out a hierarchy of measures to reduce the risks of manual handling in the workplace, so far as are reasonably practicable. These measures include access to specialist advice, access to suitable and sufficient training programs, provision of people and inanimate object handling equipment to reduce the risks and adequate risk assessments.

LWH has maintained a service level agreement (SLA) with Liverpool University Hospitals Foundation Trust (LUHFT) to provide update training for our manual handling cascade trainers and delivery of training for newly nominated manual handling cascade trainers. The SLA includes provision of ad hoc guidance and advice from LUHFTs Manual Handling Advisor.

An e-learning package for Moving and Handling Level 1 certificate is now accessible to all staff to support safe moving and handling practices.

Table 2 *shows current compliance with Moving and Handling Training*



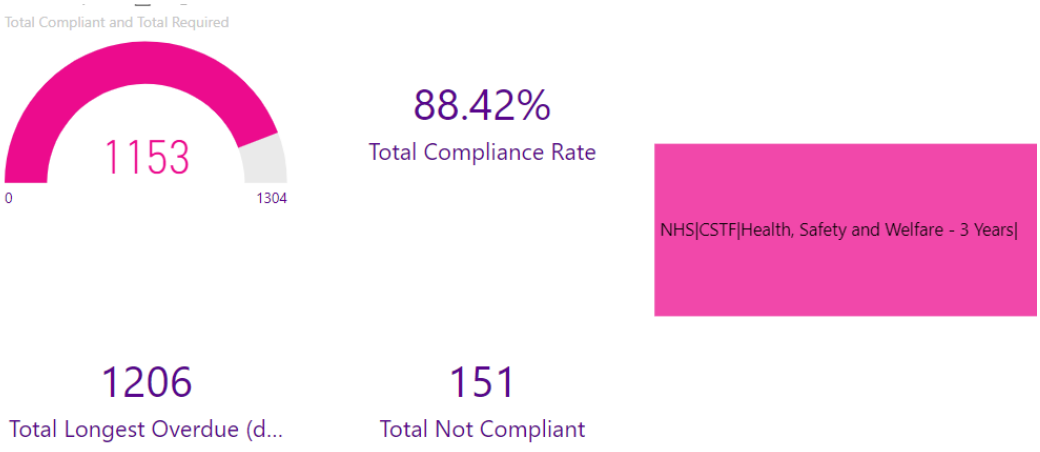
ii. First Aid

First Aid training continues to be provided externally via the Health and Safety Training Manager.

iii Health, Safety & Welfare Mandatory Training

Health and Safety legislation requires employers to provide adequate health and safety training and employers have a general duty to provide information, instruction and training and to provide a safe place of work, under Section 2 of the Health and Safety at Work Act (1974).

Table 3 *shows current compliance with Health and Safety Training*



Overall, across the organisation there have been operationally issues in releasing staff to complete mandatory training subjects. There have been notably improvements in the latter end of the reporting year; managers and governance staff are committed to improving compliance.

iv **Executive Health & Safety Training**

As part of the Health and Safety Regulations and the Care Quality Commission Well Led Domain, a training session has been designed for executives and executive directors which is offered on annual basis to ensure that the board members remain up to date with their legal responsibilities under the Health and Safety at Work Act.

v **Ligature Rescue and Ligature Rescue First Aid**

A cohort of matrons and managers attended ligature rescue and ligature rescue first aid training in July 2021. The Health and Safety Manager then offered sessions to further educate staff from areas considered high risk for ligature attempts. The training covered ligature situations, ligature types, ligature rescue, ligature first aid and governance such as preserving a ligature scene for forensic analysis, working with Police, supporting staff after a traumatic event, incident reporting and note taking.

Appropriate supporting documentation was produced including ligature risk management and risk assessment tools, standard operating procedure and guide to removing items from at risk patients that they may use as a ligature.

Two types of ligature cutters have been deployed to all adult resuscitation trolleys in a clear pouch with a step by step guide on their use and managing a ligature rescue. The cutters have been added to the MyKit check list for resuscitation trolleys.

Staff are given an overview of the ligature cutters as part of BLS training and a practical video is near to completion as a training media for all front facing staff.

vi **Training Needs Analysis 2022/23**

The Health and Safety Training Needs Analysis has been completed and submitted for 2022/23 and includes provision for the delivery of the following health and safety related training in addition to mandatory health and safety training requirements:

- DSE (Display Screen Equipment) Assessor Training
- COSHH (Control of Substances Hazardous to Health) Awareness Training
- Health and Safety Awareness Training for Managers, Supervisors, Team Leaders
- First Aider Training and Update Training
- Manual Handling Cascade Trainers Training – new and refresher training
- Medical Gases update training for Officers and Trainers
- Ligature Response and Ligature First Aid
- Ulysses Health and Safety Risk Management Module
- Fire Warden Training
- Ladder Safety Training

Failure of staff to attend a health and safety funded training place without contact or acceptable mitigation will result in a cross charge being made to the service area.

3. **Policies & Standard Operating Procedures (SOP's)**

   i. The current Slips, Trips and Falls SOP is to be converted back to a policy as per regulatory guidance. Direction has been given that two policies are required, one for the management of clinical related slips, trips and falls; the other for the management of non-clinical slips, trips and falls.

   ii. Health and safety related policies and SOP's are reviewed and updated in line with any significant changes in practice, law or Trust policy procedures.

4. **Ulysses Health and Safety Risk Management Module**

   A suitable solution for electronic risk management of health and safety documentation has been procured. The Ulysses Risk and Safety Module will act as a repository for all risk assessments and will reflect organisational compliance with its duty to complete risk assessments and act upon the. The Health and Safety Manager is working with Ulysses support to develop the module in readiness to share with all areas with the aim of launching the system in late autumn 2022.

   The benefits of this investment include:

   - Ulysses is fully supported by both I.T. and the Governance Risk Team
   - All staff are familiar with its functionality
   - There are no limits to user licences
   - Training is fully supported
   - It is fully customisable and we would benefit from other users development of the module
   - Staff will be able to use their existing log in details to complete annual departmental audits and actions, risk assessments, etc.
   - The module links to relevant incidents, risk register entries or risk assessments and provides an overall compliance dashboard for each individual element e.g. fire, water, DSE, injuries, sharps and so on
   - Easy to interrogate from a reporting perspective and matches corporate reporting for incidents, risks, safeguarding, legal, alerts and complaints

5. **Health & Safety Management System**

   Employers have a duty to consult with their employees, or their representatives, on health and safety matters. Communication is key to an effective health and safety system and industry best practice is to apply a reflective and collaborative learning stance to health and safety incident investigation. It is good practice for large organisations to establish and maintain a Health and Safety Committee, where the Committee should provide a link between staff doing the work and the people directing it.

   The Health and Safety Group, as it has been known since April 2021, continues to meet on a quarterly basis with the caveat to be able to call an extraordinary meeting.

Initiatives have begun to heighten the profile of health and safety across the Trust:

- Regular place on the Safety Check in meetings
- Creating a list of health and safety related questions for interview candidates of all levels and grades
- Regular articles in the staff weekly Digest
- Items shared through the Executive and In the Loop messaging
- Quarterly gap analysis
- A number of other initiatives are currently being explored

6. Reported Non Clinical Health and Safety Incidents

In the reporting period 2021/22 there were eighty six non-clinical health and safety related incidents reported, which sees an increase in reported incidents of eight incidents from the 2020/21 period. There is concern of an under reporting of non-clinical incidents in this reporting period, however, the Trust experienced a significantly decreased footfall of staff, patients and visitors through the continuing covid 19 pandemic.

Table 4 – *Non Clinical Health & Safety Incidents by Cause*

	SERVICE AREA					
	MATERNITY (FAMILY)	NICU	GYNAECOLOGY & HEWITT	CORPORATE FUNCTIONS	CLINICAL SUPPORT SERVICES	TOTAL
STAFF INCIDENTS						
COLLISION		1				1
COSHH (INCLUDING SPLASH)	3				3	6
ILL HEALTH	4				1	5
INJURY	5	1	4	2	3	15
MOVING & HANDLING	1		1	1		3
NEEDLESTICK INJURIES	7	11	6		5	29
SLIPS, TRIPS, FALLS	4		3	2	2	11
TOTAL STAFF INCIDENTS	24	13	14	5	14	70
ORGANISATIONAL INCIDENTS						
EQUIPMENT		1	2			3
ENVIRONMENT	1	1	3			5
TOTAL ORGANISATION	1	2	5			8
PATIENT/VISITOR INCIDENTS						
SLIPS, TRIPS, FALLS	3	1	2			6
INJURY		2				2
TOTAL PATIENT INCIDENTS	3	3	2			8
OVERALL TOTALS	28	18	21	5	14	86

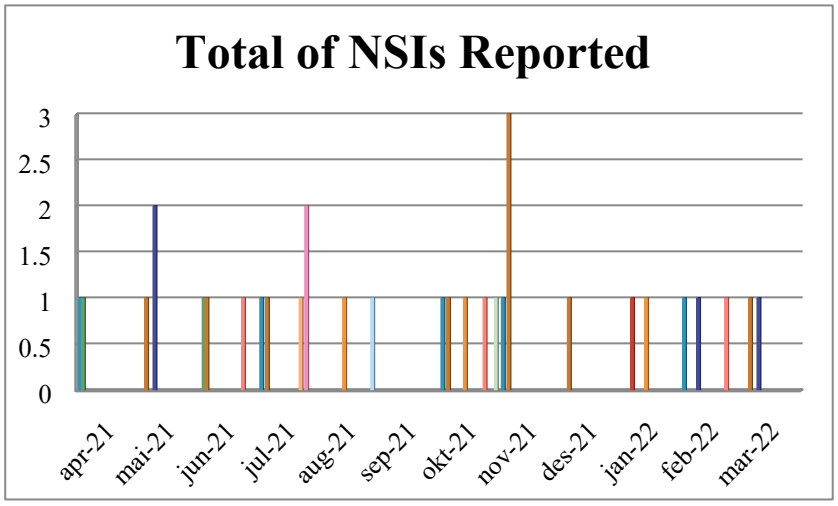
- The three primary causes of incidents are categorised as needlestick incidents, slips trips falls and injury. Further analysis of these cause groups are detailed in the following tables and narrative.

6.1 Needlestick Injuries

Inoculation incidents may be subdivided into two categories. Those resulting from percutaneous exposure which occurs as a result of a needlestick or a medical sharp contaminated with blood or bodily fluid; and those resulting from mucocutaneous exposure which occur when bodily fluids come in to contact with open wounds or mucous membranes such as the mouth and eyes. There are more than twenty pathogens that can be transmitted following a needlestick (NSI) or sharps injury. The most common are Hepatitis B, Hepatitis C and HIV and, therefore, are a significant occupational hazard to healthcare professionals.

The total number of needlestick injury incidents formally reported via the Ulysses reporting system in 2021/22 was twenty nine including two near miss events, equal to incidents reported in 2020/21. However, as in previous year's reports, there is conflicting data between staff presenting to Occupational Health following a needlestick injury with a discrepancy of one more staff member known to Occupational Health than is reflected in formal incident reports.

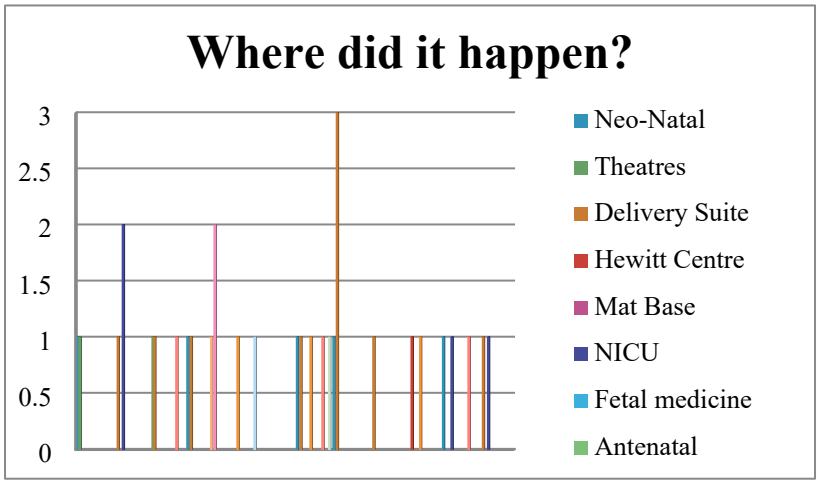
Table 5 – *Needlestick Incidents 2021/22*



From a Ulysses extract, fourteen of these incidents involved percutaneous exposure to hollow bore needles, two from a suture needle, one from scalpels/blades, six from a cfm (cerebral fluid monitoring) needle, one from a lancet and one from a broken capillary tube. There were two near miss incidents recorded due to poor disposal.

An annual summary of needlestick injuries includes cause, equipment failure and where preventative impovements can be made has been shared with all clinical Heads, Infection Control Team and the Medical Director.

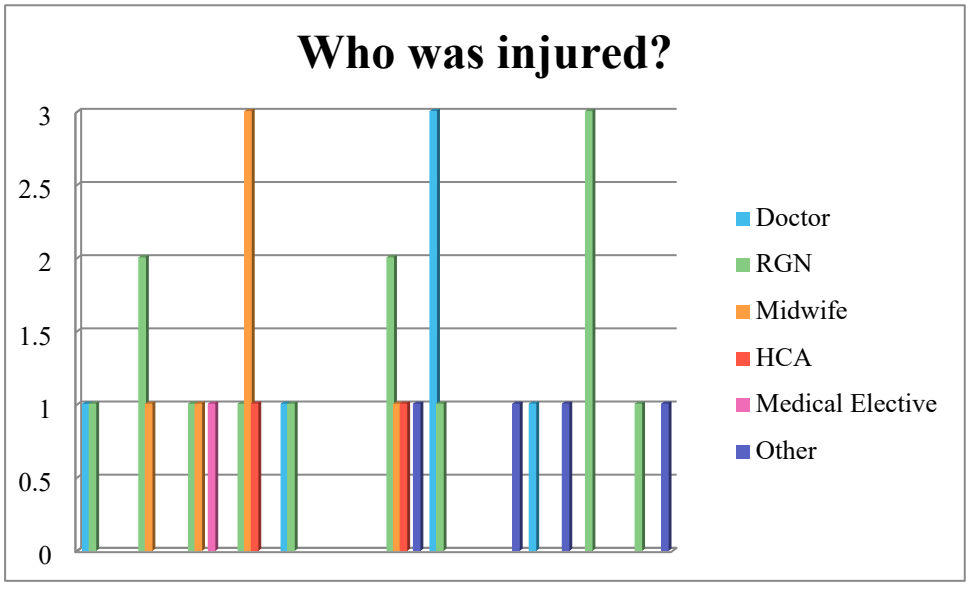
Table 6 – *Needlestick Incidents by Service 2021/22*



The Neonatal Unit reported the highest number of needlestick injuries at eleven incidents, six of which were attributed to CFM needles. Historically CFM needlestick injuries have been a significant cause of injury for our staff.

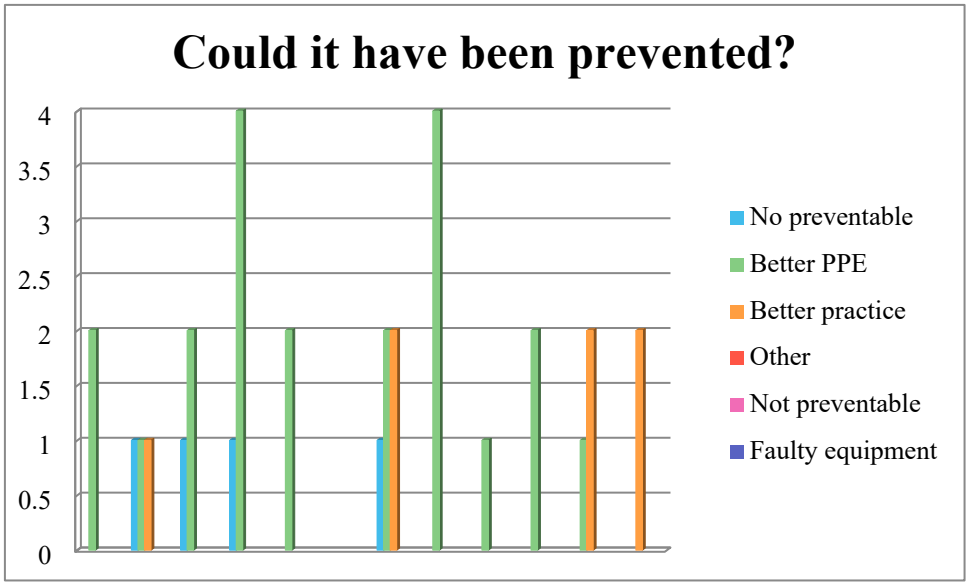
It was reported in April's Neonatal Health and Safety Incident report that the Neonatal Unit has resumed the use of CFM pads and, therefore, CFM needle injuries are expected to be negated.

Table 7 – *Staff Reporting a Needlestick Injury to Occupational Health in 2021/22*



The majority of needlstick injuries were sustained by nursing staff, thirteen in total. Six doctors and six midwives, two HCA's, on medical elective students reported injuries and there were four staff whose professions were not noted.

Table 8 – ***Could the injury have been prevented 2021/22***



Seven incidents were attributed to poor practice, twenty one incidents could have been avoided with better PPE and two were deemed to be not preventable.

There were no incidents of bodily fluids being splashed into staff's eyes.

All incidents were of a low risk nature and the Sharps Injury and BBV Policy was followed in each case with exception that in many incidences were staff delaying contact with Occupational Health or the Emergency Department due to staffing pressures and them not being released from duty. This is contrary to policy as staff must be released from duty and managers must manage the situation. PEP, a short-term antiretroviral treatment to reduce the likelihood of HIV infection, should be initiated as soon as possible after exposure, preferably within 24 hours and under 72 hours.

The use of the Sharpsmart disposal system still offers good value. Ongoing audits are carried out at factory level where the containers are opened, photographed and checked for non-compliant contents. The onsite audits look at usage and whether the documentation is correct and complete.

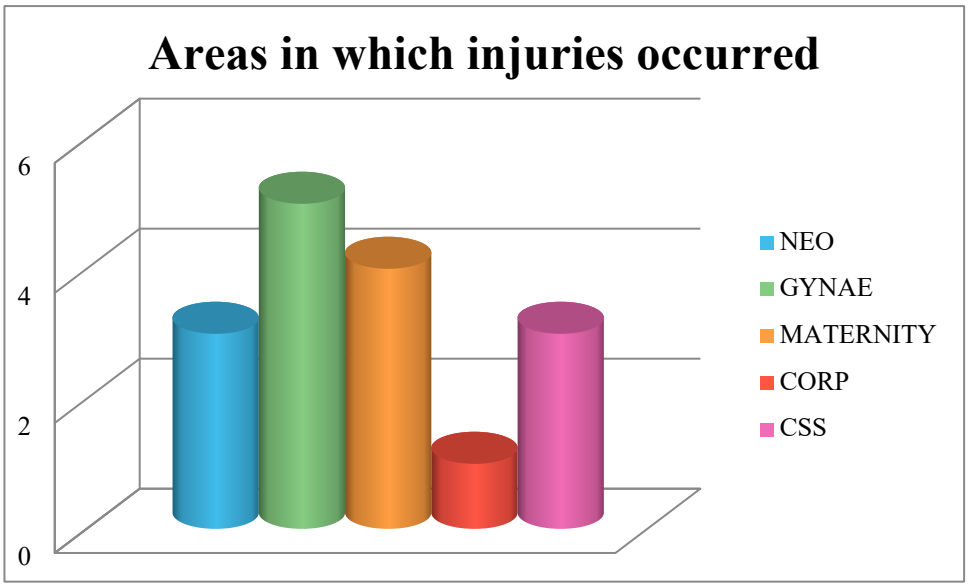
Ongoing training continues to be delivered by the auditor whenever any 'bad practices' are observed or evidenced.

No issues have been raised over any safety aspects of the system.

6.2 Personal Injury

Table 9 – *Injury Incidents by Division*

There were a total of sixteen personal injuries in this reporting period. Two of the three reported injuries which occurred in the Neonatal Unit involved visitors being scalded from a hot water, appropriate steps were taken, after care of the visitors' injuries, to isolate the source and request urgent maintenance.



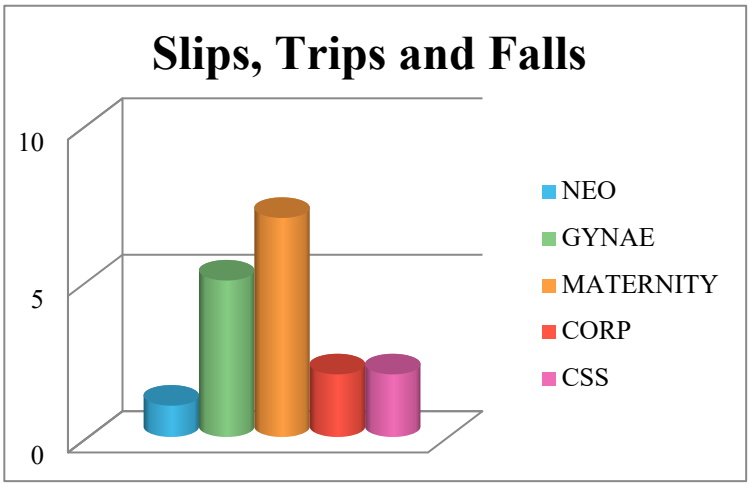
There were no further themes identified and all incidents of personal injury were dealt with appropriately, within protocols and first aid was applied, where necessary.

6.3 Slips, Trips & Falls

There were a total of seventeen slips, trips and falls incidents reported during 2021/22 a decrease of one incident from the previous reporting period 2020/21. The majority of slip, trips and falls incidents were reported by Maternity Services (seven).

There were several reports of staffing tripping on cables or poorly placed equipment. All staff have been reminded to be vigilant to slip, trip and falls hazards and the need to deal with these immediately. The importance of using wet floor warning signs has also been reiterated, including appropriate placement and removing the signs to a safe storage area once the hazard has been removed.

Table 10 – *Slips, Trips, Falls incidents by Division*



7 RIDDORS (Reporting of Injuries, Diseases and Dangerous Occurrences)

The Trust is required to submit RIDDOR reportable incidents to the HSE within prescribed timescales. Persistent late reporting exposes the Trust to potential prosecution for non-compliance with the regulations.

In this reporting year there were nine RIDDOR reports made to the HSE which was an increase of eight from the previous annual report.

Cause	Cause Group	Reportable Injury/Occurrence or Over 7 Day Absence
Fall from chair	Injury	Over 7 day absence – soft tissue injuries
Trip	Injury	Over 7 day absence – soft tissue injuries
Trip	Injury	Over 7 day absence – soft tissue injuries
Trip	Injury	Over 7 day absence – soft tissue injuries
Slip	Injury	Over 7 day absence – soft tissue injuries
Psych Trauma	Injury	Over 7 day absence
Psych Trauma	Injury	Over 7 day absence
Psych Trauma	Injury	Over 7 day absence
Collision	Injury	Fracture

Staff members received appropriate care and support in all incidents. Investigations were completed, where required and appropriate communications made with all staff to prevent similar occurrences in the future, such as guidance for preventing slips, trips and falls.

8. Legal Claims

The Health and Safety Manager provided investigation reports in response to one new employer liability claim in relation to a staff member tripping on a wet floor sign and suffering significant soft tissue injuries; and one public liability claim following a parent slipping in a shower in 2019, requiring stitches to his foot.

Two EPL claims remained on going from the previous reporting period.

9. Health & Safety Executive (HSE) Priority Objectives 2022/23

The prevention of death, injury and ill health to those at work and those affected by work activities:

- Lead and engage with others to improve workplace health and safety
- Provide an effective regulatory framework
- Secure effective management and control of risk Reduce the likelihood of low-frequency, high-impact catastrophic incidents

10. Health and Safety Work Plan for 2022/23

Health & Safety Work Plan 2022/23		
Actions	**Responsible Persons**	**Target Date**

Continue to work with the Governance Team & COO to establish a robust safety management system, as per HSG65	Health & Safety Manager	On-going
Continue to address gaps in the health and safety self-analysis and improving the health and safety profile	Health & Safety Manager	On-going
Further review, audit and develop health and safety policies and SOPs	Health & Safety Manager	On-going
Monitor health and safety incidents. Support divisional representatives to provide quarterly incident reports to the Health & Safety Group. Monitoring and act upon incident trends.	Health & Safety Manager	On-going
Provide an annual health and safety Report to the Health & Safety Group and Corporate Risk Sub Committee	Health & Safety Manager	On-going
Report RIDDORs to the HSE	Health & Safety Manager	On-going
To continue to modernise health & safety annual workplace audits and introduce electronic solutions through the roll out of the Ulysses Risk Management Module	Health & Safety Manager	August 2022
Continue to review and improve upon health and safety training provision	Health & Safety Manager	On-going
To keep the Trust up to date with changes in health and safety legislation and significant HSE projects or guidance	Health & Safety Manager	On-going
Introduction of Trust wide electronic stress risk assessment tools	Health & Safety Manager	March 2023

11. Recommendations

The Board is asked to note the assurances in the report.

Liverpool Women's
NHS Foundation Trust

Jargon Buster

We know that the language used in healthcare can sometimes be quite confusing, especially when acronyms are concerned. To make life a little easier, we will try to ensure that we spell out acronyms in full at first mention and then put the abbreviation in brackets, for example, Strategic Clinical Network (SCN) in our reports and minutes.

We've also put together a list of acronyms that you might see throughout our documentation. If you spot a gap, please email our Trust Secretary on mark.grimshaw@lwh.nhs.uk.

The following webpage might also be useful - https://www.england.nhs.uk/participation/nhs/

A		
A&E	Accident & Emergency	hospital department specialising in the acute care of patients who arrive without a prior appointment with urgent or emergency trauma
AC	Audit Committee	a committee of the board – helps the board assure itself on issues of finance, governance and probity
AGM	Annual General Meeting	a meeting to present and agree the trust annual report and accounts
AGS	Annual Governance Statement	a document which identifies the internal controls in place and their effectiveness in delivering effective governance
AHP	Allied Health Professionals	health care professions distinct from dentistry, optometry, nursing, medicine and pharmacy e.g. physiotherapists, radiographers, speech therapists and podiatrists
AHSC	Academic Health Science Centre	a partnership between a healthcare provider and one or more universities
AHSN	Academic Health Science Network	locally owned and run partnership organisations to lead and support innovation and improvement in healthcare
ALOS	Average Length of Stay	the average amount of time patients stay in hospital
AMM	Annual Members Meeting	a meeting that is held every year to give members the opportunity to hear about what the trust has done in the past year; could be part of the AGM
AO	Accountable Officer	senior person responsible and accountable for funds entrusted to their trust; for NHS provider organisations this person will be the chief executive
ALB(s)	Arms Length Bodies	an organisation that delivers a public service but is not a ministerial government department; these include HEE, HSCIC, HRA, HTA, NHSE, NICE, Monitor, NHSBSA, NHSBT, NHSI, NHSLA, MHPRA, CQC, PHE (See individual entries)
	Agenda for Change	the NHS-wide grading and pay system for NHS staff, with the exception of medical and dental staff and some senior managers; each relevant job role in the NHS is matched to a band on the Agenda for Change pay scale

B		
BAF	Board Assurance Framework	the key document used to record and report an organisation's key strategic objectives, risks, controls and assurances to the board
BCF	Better Care Fund	this fund creates a local single pooled budget to incentivise the NHS and local government to work more closely together in local areas
BMA	British Medical Association	trade union and professional body for doctors
BAME	Black Asian Minority Ethnic	terminology normally used in the UK to describe people of non-white descent
BoD	Board of Directors	executive directors and non-executive directors who have collective responsibility for leading and directing the trust
	Benchmarking	method of gauging performance by comparison with other organisations

C		
CAMHS	Child and Adolescent Mental Health Services	specialise in providing help and treatment for children and young people with emotional, behavioural and mental health difficulties
CapEx	Capital Expenditure	an amount spent to acquire or improve a long-term asset such as equipment or buildings. Typically, capital is raised via a loan, but it can come from reserves and is paid back/written off over a number of years from revenue income. This is a contrast with revenue spend which is always from in-year income
CBA	Cost Benefit Analysis	a process for calculating and comparing the costs and benefits of a project
CBT	Cognitive Behavioural Therapy	a form of psychological therapy used mostly in depression but increasingly shown to be a useful part of the treatment for schizophrenia
CCG	Clinical Commissioning Group	groups of GPs, clinicians and managers who are responsible for commissioning local health services in England (all GP practices must belong to a CCG)
CDiff	Clostridium difficile	a bacterial infection that most commonly affects people staying in hospital
CE / CEO	Chief Executive Officer	leads the day-to-day management of a foundation trust, is a board member and the accountable officer for the trust.
CF	Cash Flow	the money moving in and out of an organisation
CFR	Community First Responders	a volunteer who is trained by the ambulance service to attend emergency calls in the area where they live or work
CHC	Continuing Healthcare	Whereby those with long-term or complex healthcare needs qualify for social care arranged for and funded by the NHS
CIP	Cost Improvement Plan	an internal business planning tool outlining the Trust's efficiency strategy
CMHT	Community Mental Health Team	A team of mental health professionals such as psychiatrists,

		psychologists, social workers, community psychiatric nurses and occupational therapists, who work together to help people manage and recover from mental illness.
CoG	Council of Governors	the governing body that holds the non-executive directors on the board to account for the performance of the board in managing the trust, and represents the interests of members and of the public
COO	Chief Operating Officer	a senior manager who is responsible for managing a trust's day-to-day operations and reports to the CEO
CPD	Continuing Professional Development	continued learning to help professionals maintain their skills, knowledge and professional registration
CPN	Community Psychiatric Nurse	a registered nurse with specialist training in mental health working outside a hospital in the community
CQC	Care Quality Commission	The independent regulator of all health and social care services in England
CQUIN	Commissioning for Quality and Innovation	a sum of money that is given to providers by commissioners on the achievement of locally and nationally agreed quality and improvement goals
CSR	Corporate Social Responsibility	A business practice which incorporates sustainable goals, usually positive impacts on environmental, economic and social factors, into a business model
CT	Computed Tomography	A medical imaging technique
CFO	Chief Finance Officer	the executive director leading on finance issues in the trust
	Caldicott Guardian	A board level executive director responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing. Each NHS organisation is required to have a Caldicott Guardian

D		
DBS	Disclosure and barring service	conducts criminal record and background checks for employers
DBT	Dialectical behavioural therapy	A type of psycho-therapy, or talk therapy, which has been developed from CBT to help those experiencing borderline personality disorder
DGH	District General Hospital	major secondary care facility which provides an array of treatment, diagnostic and therapeutic services, including A&E
DHSC	Department of Health and Social Care	the ministerial department which leads, shapes and funds health and care in England
DN	Director of Nursing	The executive director who has professional responsibility for services provided by nursing personnel in a trust
DNA	Did Not Attend	a patient who missed an appointment
DNAR	Do Not Attempt Resuscitation	A form issued and signed by a doctor, which tells a medical team not to attempt CPR
DPA	Data Protection Act	the law controlling how personal data is collected and used
DPH	Director of Public Health	a senior leadership role responsible for the oversight and care of matters relating to public health
DTOCs	Delayed Transfers of Care	this refers to patients who are medically fit but waiting for care

		arrangements to be put in place so therefore cannot be discharged
	Duty of Candour	a legal duty on hospital, community, ambulance and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm

E		
E&D	Equality and Diversity	The current term used for 'equal opportunities' whereby members of the workforce should not be discriminated against because of their characteristics. This is promoted by valuing diverse characteristics in a workplace.
ED(s)	Executive Directors *or* Emergency Department	senior management employees who sit on the trust board *or* alternative name for Accident & Emergency department
EHR	Electronic Health Record	health information about a patient collected in digital format which can theoretically be shared across different healthcare settings
EOLC	End of Life Care	support for patients reaching the end of their life
EPR	Electronic Patient Record	a collation of patient data stored using computer software
ESR	Electronic staff record	A collation of personal data about staff stored using computer software

F		
FFT	Friends and Family Test	a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care
FOI	Freedom of Information	the right to ask any public sector organisation for the recorded information they have on any subject
FT	Foundation Trust	a public benefit corporation, which is a legal body established to deliver healthcare to patients / service users and has earned a degree of operational and financial independence
FTE	Full Time Equivalent	a measurement of an employees workload against that of someone employed full time e.g. 0.5 FTE would be someone who worked half the full time hours
FTSU	Freedom to speak up	An initiative developed by NHS Improvement to encourage NHS workers to speak up about any issues to patient care, quality or safety
	Francis Report	the final report, published in 2013, of the public inquiry into care provided by Mid Staffordshire NHS FT chaired by Sir Robert Francis QC

G		
GMC	General Medical Council	the independent regulator for doctors in the UK
GDP	Gross Domestic Product	thevalueofacountry'soveralloutputofgoodsand services
GDPR	General Data Protection Regulations	The legal framework which sets the guidelines for collecting and processing personal information from individuals living in the European Union

H		
HCAI	Healthcare Associated Infection	these are infections that are acquired in hospitals or as a result of healthcare interventions; MRSA and Clostridium difficile can be classed as HCAIs if caught whilst in a healthcare setting
HCA	Health Care Assistant	staff working within a hospital or community setting under the guidance of a qualified healthcare professional
HDU	High Dependency Unit	an area in a hospital, usually located close to the ICU, where patients can be cared for more extensively than on a normal ward, but not to the point of intensive care, e.g. patients who have had major surgery
HEE	Health Education England	the body responsible for the education, training and personal development of NHS staff
HR	Human Resources	the department which focusses on the workforce of an organisation including pay, recruitment and conduct
HRA	Health Research Authority	protects and promotes the interests of patients and the public in health research
HSCA 2012	Health & Social Care Act 2012	an Act of Parliament providing the most extensive reorganisation of the NHS since it was established, including extending the roles and responsibilities of governors
HSCIC	Health and Social Care Information Centre	the national provider of information, data and IT systems for commissioners, analysts and clinicians in health and social care
HTA	Human Tissue Authority	regulates the removal, storage, use and disposal of human bodies, organs and tissue for a number of scheduled purposes such as research, transplantation, and education and training
HWB / HWBB	Health& Wellbeing Board	a local forum to bring together partners from across the NHS, local government, the third sector and the independent sector, led by local authorities
	Health Watch	A body created under the Health and Social Care Act 2012 which aims to understand the needs and experiencesofNHSserviceusersandspeakontheir behalf.

I		
IAPT	Improved Access to Psychological	an NHS programme rolling out services across England

	Therapies	offering interventions approved by the National Institute of Health and Care Excellence for treating people with depression and anxiety disorders
IG	Information Governance	ensures necessary safeguards for, and appropriate use of, patient and personal information. Key areas are information policy for health and social care, IG standards for systems and development of guidance for NHS and partner organisations
ICP	Integrated Care Pathway	a multidisciplinary outline of care, placed in an appropriate timeframe, to help a patient with a specific condition or set of symptoms move progressively through diagnosis and treatment to positive outcomes
ICS	Integrated Care system	Groups of NHS providers, commissioners and local authorities working together to improve health and care in the local area
ICT	Information Communications Technology	an umbrella term that includes any communication device or application, encompassing: radio, television, cellular phones, computer and network hardware and software, satellite systems, as well as the various services and applications associated with them
ICU *or* ITU	Intensive Care Unit Intensive therapy unit	specialist unit for patients with severe and life threatening illnesses
IP	Inpatient	a patient who is hospitalised for more than 24 hours
IT	Information Technology	systems (especially computers and telecommunications) for storing, retrieving, and sending information
IV	Intravenous	treatment which is administered by injection into a vein

K		
KLOE(s)	Key Line of Enquiries	detailed questions asked by CQC inspectors which help to answer the five key questions to assess services: are they safe, effective, caring, responsive and well-led?
KPIs	Key Performance Indicators	indicators that help an organisation define and measure progress towards a goal
	King's Fund	independent charity working to improve health and health care in England

L		
LD	Learning Disability	a disability which affects the way a person understands information and how they communicate

LGA	Local Government Association	the national voice of local government in England and Wales. It seeks to promote better local government and maintains communication between officers in different local authorities to develop best practice
LOS	Length of Stay	a term commonly used to measure the duration of a single episode of hospitalisation

M

M&A	Mergers & Acquisitions	mergers bring together two or more bodies to form a new legal entity and disband the merging bodies. acquisitions are take-overs of one body by another
MD	Medical Director	a member of the board who has a clinical background and has professional responsibilities for doctors and dentists in the trust
MHPRA	Medicines and Healthcare Products Regulatory Agency	an executive agency of DHSC which is responsible for ensuring that medicines and medical devices work and are acceptably safe
MIU	Minor Injuries Unit	A unit which treats injuries or health conditions which are less serious and do not require the A&E service
MoU	Memorandum of Understanding	describes an agreement between two or more parties
MRI	Magnetic Resonance Imaging	a medical imaging technique
MRSA	Methicillin-Resistant Staphylococcus Aureus	a bacterium responsible for several difficult-to-treat infections in humans
MSA	Mixed Sex Accommodation	wards with beds for both male and female patients

N

NAO	National Audit Office	an independent Parliamentary body in the United Kingdom which is responsible for auditing central government departments, government agencies and non-departmental public bodies. The NAO also carries out Value for Money audits into the administration of public policy
NED	Non Executive Director	directors who are appointed, but not employed by the trust; they have no executive responsibilities and are responsible for vetting strategy, providing challenge in the boardroom and

		holding the executive directors to account
NHSBSA	NHS Business Services Authority	a Special Health Authority of DHSC which provides a range of services to NHS organisations including: NHS Prescription Services, NHS Pensions, Help With Health Costs, Student Services, NHS Dental Services, European Health Insurance Card, Supplier Management (including NHS Supply Chain) and NHS Protect
NHSBT	NHS Blood and Transplant	a Special Health Authority of DHSC responsible for providing a reliable, efficient supply of blood, organs and associated services to the NHS
NHSE	NHS England	an executive non-departmental public body with a mandate from the Secretary of State to improve health outcomes for people within England
NHSI	NHS Improvement	The Independent regulator of NHS Foundation Trusts
NHSLA	NHS Leadership Academy	national body supporting leadership development in health and NHS funded services
NHSP	NHS Professionals	provides bank (locum) healthcare staff to NHS organisations
NHSX		A unit designed to drive the transformation of digital technology in the NHS
NICE	National Institute for Health and Care Excellence	provides national evidence-based guidance and advice to improve health and social care
NIHR	National Institution for Health Research	The largest funder of health and social care research in the UK, primarily funded by the Department of Health and Social Care
NMC	Nursing and Midwifery Council	nursing and midwifery regulator for England, Wales, Scotland and Northern Ireland
	Never Event	serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. NHS England defines the list of never events every year
	NHS Digital	The information and technology partner to the NHS which aims to introduce new technology into services
	NHS Providers	NHS Providers is the membership organisation for NHS public provider trusts. We represent every variety of trust, from large acute and specialist hospitals through to community, ambulance and mental health trusts.

	Nolan Principles	key principles of how individuals and organisations in the public sector should conduct themselves comprising of: selflessness, integrity, objectivity, accountability, openness, honesty, leadership. Set by the Committee for Standards in Public Life, an independent advisory non-departmental public body set up to advise the prime minister on ethical standards
	NHS Resolution	not-for-profit part of the NHS which manages negligence and other claims against the NHS in England on behalf of their member organisations. Also, an insurer for NHS bodies
	Nuffield Trust	independent source of evidence-based research and policy analysis for improving health care in the UK, also a charity

O

OD	Organisational Development *or* Outpatients Department	a systematic approach to improving organisational effectiveness *or* a hospital department where healthcare professionals see outpatients (patients which do not occupy a bed)
OOH	Out of Hours	services which operate outside of normal working hours
OP	Outpatients	a patient who is not hospitalized for 24 hours or more but who visits a hospital, clinic, or associated facility for diagnosis or treatment
OPMH	Older People's Mental Health	mental health services for people over 65 years of age
OSCs	Overview and Scrutiny Committees	established in local authorities by the Local Government Act 2000 to review and scrutinise the performance of public services including health services
OT	Occupational Therapy	assessment and treatment of physical and psychiatric conditions using specific activity to prevent disability and promote independent function in all aspects of daily life

P

PALS	Patient Advice & Liaison Service	offers confidential advice, support and information on health-related matters to patients, their families, and their carers within trusts

PAS	Patient Administration System	the automation of administrative paperwork in healthcare organisations, particularly hospitals. It records the patient's demographics (e.g. name, home address, date of birth) and details all patient contact with the hospital, both outpatient and inpatient
PbR	Payment by Results or 'tariff'	a way of paying for health services that gives a unit price to a procedure
PCN	Primary care network	A key part of the NHS long term plan, whereby general practices are brought together to work at scale
PDSA	Plan, do, study, act	A model of improvement which develops, tests and implements changes based on the scientific method
PFI	Private Finance Initiative	a scheme where private finance is sought to supply public sector services over a period of up to 60 years
PHE	Public Health England	a body with the mission to protect and improve the nation's health and wellbeing and reduce health inequalities
PHSO	Parliamentary and Health Service Ombudsman	an organisation which investigates complaints that individuals have been treated unfairly or have received poor service from government departments and other public organisations and the NHS in England
PICU	Psychiatric Intensive Care Unit *or* Paediatric Intensive Care Unit	a type of psychiatric in-patient ward with higher staff to patient ratios than on a normal acute admission ward *or* an inpatient unit specialising in the care of critically ill infants, children, and teenagers
PLACE	Patient-Led	Surveys inviting local people going into hospitals as
	Assessments of the Care Environment	part of a team to assess how the environment supports patient's privacy and dignity, food, cleanliness and general building maintenance
PPI	Patient and Public Involvement	mechanisms that ensure that members of the community --- whether they are service users, patients or those who live nearby – are at the centre of the delivery of health and social care services
PTS	Patient Transport Services	free transport to and from hospital for non-emergency patients who have a medical need
	Primary Care	the first point of contact with the NHS for most people and is delivered by a wide range of independent contractors, including GPs, dentists, pharmacists and optometrists, it also includes NHS walk-in centres and the NHS 111 telephone service

Q		
QA	Quality assurance	monitoring and checking outputs to make sure they meet certain standards
QI	Quality improvement	A continuous improvement process focusing on processes and systems
QIA	Quality Impact Assessment	A process within NHS trusts which ensures the quality of service is systematically considered in decision- making on service changes
QUI	Qualities and Outcomes Framework	The system for performance management and payment of GP's in the NHS

R		
R&D	Research & Development	work directed towards the innovation, introduction, and improvement of products and processes
RAG	Red, Amber, Green classifications	a system of performance measurement indicating whether something is on or better than target (green), below target but within an acceptable tolerance level (amber), or below target and below an acceptable tolerance level (red)
RGN	Registered General Nurse	a nurse who is fully qualified and is registered with the Nursing and Midwifery Council as fit to practise
RoI	Return on Investment	the benefit to the investor resulting from an investment of some resource. A high RoI means the investment gains compare favourably to investment cost. As a performance measure, RoI is used to evaluate the efficiency of an investment or to compare the efficiency of a number of different investments.
RTT	Referral to Treatment Time	the waiting time between a patient being referred by a GP and receiving treatment

S		
SALT	Speech and Language Therapist	assesses and treats speech, language and communication problems in people of all ages to help them better communicate
SFI	Standing Financial Instructions	Policy used for the regulation of the conduct of an NHS trust in relation to all financial matters
SHMI	Summary Hospital Level Mortality Indicator	reports mortality at trust level across the NHS in England using standard and transparent methodology
SID	Senior independent Director	a non-executive director who sits on the board and plays a key role in supporting the chair; the SID carries out the annual appraisal of the chair, and is available to governors as a source of advice and guidance in circumstances where it would not be appropriate to involve the chair
SIRO	Senior Information Risk Officer	a senior manager who will take overall ownership of the organisation's information risk policy
SITREP	Situation Report	a report compiled to describe the details surrounding a situation, event, or incident
SLA	Service Level Agreement	an agreement of services between service providers and users or commissioners
SoS	Secretary of State	the minister who is accountable to Parliament for delivery of health policy within England, and for the performance of the NHS
SRO	Senior Responsible officer	A leadership role which is accountable for the delivery and outcome of a specific project
STP	Sustainability and Transformation Partnership	Partnerships formed between local councils and NHS services to help plan and run services, and agree system-wide priorities
SUI	Series Untoward Incident / Serious Incident	A serious incident which resulted in one or more of the following: unexpected or avoidable death, a never event, a prevention of organisation's ability to continue to deliver healthcare services, abuse, or loss of confidence in a service
SWOT	Strengths, Weaknesses, Opportunities, Threats	a structured planning method used to evaluate the strengths, weaknesses, opportunities and threats involved in a project or in a business venture
	Secondary Care	NHS health service provided through hospitals and in the community

T		
TTO	To Take Out	medicines to be taken away by patients on discharge

	Tertiary Care	healthcare provided in specialist centres, usually on referral from primary or secondary care professionals

V

VTE	Venous Thromboembolism	a condition where a blood clot forms in a vein. This is most common in a leg vein, where it's known as deep vein thrombosis (DVT). A blood clot in the lungs is called pulmonary embolism (PE)
VfM	Value for Money	used to assess whether or not an organisation has obtained the maximum benefit from the goods and services it both acquires and provides, within the resources available to it

W

WLF	Well Led Framework	a set of indicators that seek to identify how well led an organisation is, also used as a framework for board governance reviews
WRES	Workforce Race Equality Standard	a metric to demonstrate progress against a number of indicators of workforce equality, including a specific indicator to address the low levels of black and minority ethnic (BME) board representation
WTE	Whole-time equivalent	See FTE

Y

YTD	Year to Date	a period, starting from the beginning of the current year, and continuing up to the present day. The year usually starts on 1st April for financial performance indicators