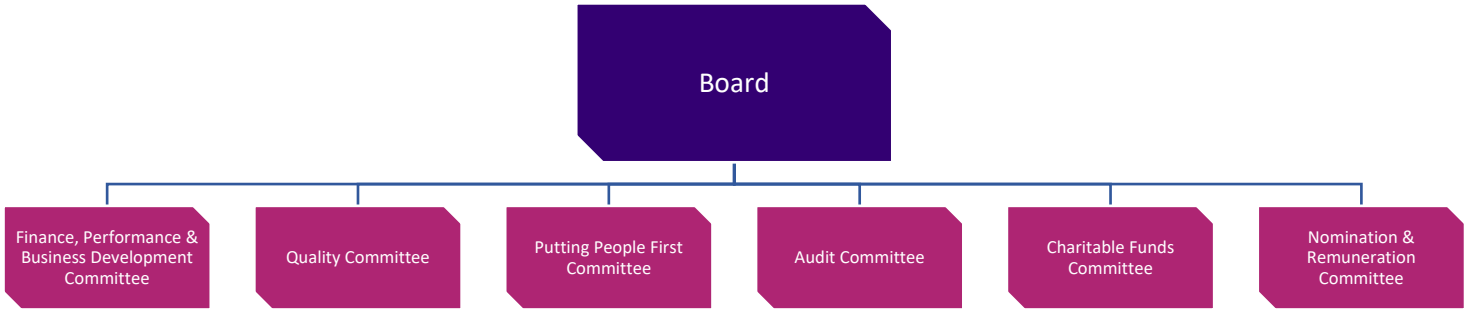
Liverpool Women's NHS Foundation Trust

Trust Board

3 November 2022, 09.30am
Boardroom, LWH & Virtual, via Teams



Liverpool Women's NHS Foundation Trust

Trust Board

Location	Boardroom and Virtual (via Teams)
Date	3 November 2022
Time	9.30am

AGENDA					
Item no. 22/23/	Title of item	Objectives/desired outcome	Process	Item presenter	Time
PRELIMINARY BUSINESS					
127	Introduction, Apologies & Declaration of Interest	Receive apologies & declarations of interest	Verbal	Chair	09.30 (5 mins)
128	Meeting Guidance Notes	To receive the meeting attendees' guidance notes	Written	Chair	
129	Minutes of the previous meeting held on 1 September 2022	Confirm as an accurate record the minutes of the previous meeting(s)	Written	Chair	
130	Action Log and matters arising	Provide an update in respect of on-going and outstanding items to ensure progress	Written	Chair	
131	Service Outline – CSS Division	To receive service outline	Presentation	Chief Operating Officer	0935 (15 mins)
132	Patient Story	To receive a patient story	Verbal	Interim Chief Nurse	09.50 (25 mins)
133	Chair's announcements	Announce items of significance not found elsewhere on the agenda	Verbal	Chair	10.15 (5 mins)
134	Chief Executive Report	Report key developments and announce items of significance not found elsewhere on the agenda	Written	Chief Executive	10.20 (5 mins)
MATERNITY					
135	Maternity Incentive Scheme (CNST) Year 4 – Scheme Update	To receive	Written	Chief Operating Officer	10.25 (5 mins)
QUALITY & OPERATIONAL PERFORMANCE					
136a	Chair's Report from the Quality Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	10.30 (40 mins)
136b	Quality & Operational Performance Report	For assurance – To note the latest performance measures	Written	Chief Operating Officer	

136c	Mortality and Learning from Deaths Report Quarter 1, 22/23	For assurance	Written	Medical Director	
136d	Seven Day Services	For approval	Written	Medical Director	
136e	Bi-annual staffing paper update, January 2022-June 2022 (Q4 21/22 & Q1 22/23)	For assurance	Written	Interim Chief Nurse	
BREAK					
Board Thank You					
PEOPLE					
137a	Chair's Report from the Putting People First Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	11.25 (5 mins)
137b	Workforce Performance Report	For assurance – To note the latest performance measures	Written	Chief People Officer	11.30 (10 mins)
FINANCE & FINANCIAL PERFORMANCE					
138a	Chair's Report from the Finance, Performance and Business Development Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	11.40 (60mins)
138b	Chair's Report from the Audit Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	
138c	Chair's Report from the Charitable Funds Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	
138d	Finance Performance Review Month 6 2022/23	For assurance - To note the current status of the Trust's financial position	Written	Chief Finance Officer	
138e	Our Strategy – Review of Delivery	To note and approve	Written	Chief Finance Officer	
BOARD GOVERNANCE					
139	Board Assurance Framework	For assurance	Written	Trust Secretary	12.40 (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.*					
140	Medical Appraisal and Revalidation Annual Report 2021/22	For assurance	Written	Medical Director	Consent
CONCLUDING BUSINESS					
141	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair	12.45 (5 mins)
142	Chair's Log	Identify any Chair's Logs	Verbal	Chair	

143	Any other business & Review of meeting	Consider any urgent items of other business	Verbal	Chair	
144	Jargon Buster	For reference	Written	Chair	
Finish Time: 12.50					

Date of Next Meeting: 1 December 2022

12.50 – 13.00	*Questions raised by members of the public*	To respond to members of the public on matters of clarification and understanding.	Verbal	Chair

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

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

Liverpool Women's NHS Foundation Trust

Meeting attendees' guidance

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

Before the meeting

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

General considerations:

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

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

Virtual / Hybrid Meetings via Microsoft Teams and other digital platforms

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

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

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

At the meeting

General Considerations:

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

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

Virtual / Hybrid Meetings via Microsoft Teams and other digital platforms

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

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

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

Attendance

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

After the meeting

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

Standards & Obligations

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

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

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

Page 129 Handbook to the NHS Constitution 26th March 2013

Liverpool Women's NHS Foundation Trust

Board of Directors

Minutes of the meeting of the Board of Directors held in the Boardroom and Virtually via Teams at 10.00am on 1 September 2022

PRESENT

Robert Clarke	Chair
Kathryn Thomson	Chief Executive
Eva Horgan	Chief Finance Officer
Gary Price	Chief Operating Officer
Louise Martin	Non-Executive Director
Zia Chaudhry MBE	Non-Executive Director
Jackie Bird MBE	Non-Executive Director
Dr Lynn Greenhalgh	Medical Director
Dianne Brown	Interim Chief Nurse
Michelle Turner	Chief People Officer / Deputy Chief Executive
Prof. Louise Kenny CBE	Non-Executive Director / SID

IN ATTENDANCE

Matt Connor	Chief Information Officer
Mary Passant	Programme Manager, Liverpool Neonatal Partnership (item 092 only)
Alison Bedford-Russell	Consultant Neonatologist (items 092 and 097c only)
Joanne Minford	Surgical lead, Liverpool Neonatal Partnership (item 092 only)
Gillian Walker	Patient Experience Matron (item 093 only)
Dawn Valentine-Gray	Macmillan Nurse (item 093 only)
Rebecca Kettle	Consultant Neonatologist (item 097c only)
Mandy McDonough	Assoc. Director of Nursing & Midwifery, Safeguarding (item 097f only)
Carl Griffiths	Named Nurse for Safeguarding Adults (item 097f only)
Karl Robinson	Freedom to Speak Up Guardian (item 097g only)
Mark Grimshaw	Trust Secretary (minutes)

APOLOGIES:

Sarah Walker	Non-Executive Director
Gloria Hyatt MBE	Non-Executive Director
Tracy Ellery	Non-Executive Director / Vice-Chair

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

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

22/23/	
088	**Introduction, Apologies & Declaration of Interest** The Chair welcomed everyone to the meeting. Apologies were noted as above and there were no declarations of interest. No items proposed to be removed from the consent agenda.
089	**Meeting guidance notes** The Board received the meeting attendees' guidance notes.
090	**Minutes of the previous meetings held on 7 July 2022** Subject to the following amendments, the minutes of the Board of Directors meeting held on 7 July 2022 were agreed as a true and accurate record. • Dr Susan Milner and Tony Okotie to be deleted from the 'Present' section of the attendance register.
091	**Action Log and matters arising** Updates against the following actions were noted as follows: 22/23/043 – Still-birth rates – The Medical Director noted that a detailed report was scheduled for the September 2022 Quality Committee and the appropriate onward reporting to the Board would be agreed at that point. 22/23/009a – The Interim Chief Nurse reported that the potential impact on the patient experience following closures of the Midwifery Led Unit (MLU) had been discussed by the Patient Involvement and Experience Sub-Committee. Whilst closing the MLU did have a negative impact on patient experience, decisions were always taken with patient safety and foremost concern. Wherever possible, use of the birthing pools was continued. The Chief People Officer queried how patient expectations were managed. The Interim Chief Nurse undertook to provide an update to the next scheduled Board meeting.

	The Chief Operating Officer noted that the frequency of MLU closures had lessened with improved staffing availability. Chair's Log – mandatory training benchmarking – the Chief People Officer noted the challenge of accessing comparable benchmarking information as trusts measured mandatory training compliance in different ways. Work was continuing to enhance the workforce report which would include benchmarking information where available and appropriate. *Mary Passant, Alison Bedford-Russell and Joanne Minford joined the meeting.*
092	Service Outline – Liverpool Neonatal Partnership The Board received an update on the Liverpool Neonatal Partnership. It was remarked that the relationship between both organisations continued to develop and strengthen, and this had led to several areas of progress in terms of the clinical service and the strategic direction. Challenges experienced by the Partnership were outlined and these included issues relating to multiple systems, capacity management and the on-going recruitment and training requirements for the new unit, the build for which was delayed. Assurance was provided that mitigating actions were in place and that there would be a significant focus on nurse recruitment and training, with a second round of recruitment planned in early 2023. The Board noted the positive development relating to achieving specialised commissioning funding for nurse recruitment. The Chief Information Officer queried if support could be provided to help mitigate the identified challenges relating to multiple clinical systems. It was noted that there had been information governance issues when attempting to share patient information. The Chair remarked that timely access to data was vital to achieve the 'one service, two sites' vision. The Chief Information Officer undertook to work with the Partnership to support information sharing. The service outline was noted. *Mary Passant, Alison Bedford-Russell and Joanne Minford left the meeting.* *Gillian Walker and Dawn Valentine-Gray joined the meeting.*
093	Patient Story The patient relayed their experience of receiving oncology services at the Trust. It was noted that following a colposcopy, they had received a cervical cancer diagnosis despite having no symptoms. Scans and tests had been undertaken at Arrowe Park hospital and these identified that specialist care at the Trust was required. Early outpatient experiences were positive and practice from the consultant during surgery had been exemplary, particularly in relation to ensuring all in attendance had 'checked in' and were aware of their roles. Following what had been a significant operation, there had been initially good care provided on the ward. However, this deteriorated and became markedly more 'task orientated' and less care focussed. Providing timely pain relief did not appear to be a priority and there had been a lack of empathy from some staff. A significant amount of noise on the ward and poor presentation and quality of food had also impacted negatively on their experience. Overall, it was suggested that some small changes to how care was provided would have made a big difference to the patient's experience. The Chief Executive apologised to the patient for the poor aspects of the care they had received. The Interim Chief Nurse agreed that some unacceptable practice had been described and stated that it would be important to understand the reasons behind the divergence from what was expected of Trust staff in both their performance and attitude. The Chair suggested that it would be important for local managers to reiterate expectations of the roles and to ensure that they were being patient centred.

	Non-Executive Director, Louise Martin, remarked that during a recent 'Big Conversation' visit, staff had described that, on occasion, they felt limited in the amount of time they could provide to more patient focussed activities. It was stated that it would therefore also be important to listen to the staff perspective to determine if there were systemic issues leading to instances where patient experience fell below the required standard. There was agreement that there was an opportunity to improve the food offer provided to patients. The Chief People Officer stated that work would be undertaken to close the feedback loop from the 'Big Conversation' and that direct feedback would be provided to staff regarding the patient experience described. On behalf of the Board, the Chair thanked the patient for their time and bravery for sharing their story and stated that it was vital for the Board to hear first-hand experiences from patients. *Gillian Walker and Dawn Valentine-Gray left the meeting.*
094	Chair's announcements The Chair reported that the underpinning governance processes for the Cheshire and Merseyside Acute and Specialist Trusts (CMAST) Provider Collaborative continued to develop, and a Joint Working Agreement and Committee in Common model would be tabled to the Board for approval in October 2022. The Trust's Annual Member's Meeting was scheduled for the 22 September 2022. This would be a 'hybrid' meeting, meeting both in person at the Trust and on-line to maximise accessibility for members, the public and staff. Since the previous Board meeting, two Nomination and Remuneration Committees had been held. The meeting in July covered the Executive and Chief Executive appraisals and a meeting had been held ahead of the Board (1 September) in which the recruitment process for the Chief Nurse & Midwife had been agreed. The Committee also approved a new Fit and Proper Person policy. The Board noted the Chair's update.
095	Chief Executive's report The Chief Executive presented the report which detailed local, regional, and national developments. It was reported that the independent review commissioned by NHS England to explore the configuration of clinical services in Liverpool had commenced. The Trust was participating in the review and to date there had been strong engagement from the Trust's clinicians. It was noted that the Board would be kept appraised as the review developed. The Board of Directors noted the Chief Executive update.
096a	Maternity Incentive Scheme (CNST) Year 4 – Scheme Update The Chief Operating Officer 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. The 'pause' in reporting, in place since early 2022, had now been lifted, with updated reporting deadlines provided. It was noted that specific information was required to be noted by the Board. This related to the following: • Safety Action 5 – Midwifery Staffing Update (Appendix C) • Safety Action 3 – ATAIN and TC Audit for Q1 22-23 (Appendix B) • Safety Action 9 - Perinatal Surveillance Dashboard Update (Appendix A) The Chief Operating Officer highlighted the following areas of potential risk to compliance:

	• There was a challenge of ensuring that 90% of each maternity staff group attended multi-professional education and training (MPET). A particular issue relating to junior doctor rotation patterns was noted with junior anaesthetists a main concern. A mitigation plan was in place, and this was being regularly monitored. • The MVP Chair, previously vacant, had been filled from 1 September 2022. The Chair queried the level of confidence of achieving compliance against the ten safety actions. The Chief Operating Officer stated that there was a high degree of confidence of delivery. It was agreed however, that further assurance on Safety Action 8 regarding MPET training should be received by the Quality Committee. Chair's Log: For the Quality Committee to receive additional assurance on progress to achieve compliance against MIS Safety Action 8 (MPET Training) Attention was drawn to the Midwifery Staffing report (Appendix C). It was noted that: • Budgeted establishment equated to 354.92wte which was 5.33wte above the BR+ recommendations • Budgeted posts were inclusive of 23% headroom, which was an increase from the previous 21.4% in maternity and a reflection of the additional specialist training requirements of midwives It was highlighted however, that a vacancy shortfall of 30 midwives would persist beyond the October 2022 intake. Plans for additional recruitment were in place and it was stated that the Trust was also taking proactive action to ensure existing midwives were retained. Non-Executive Director, Jackie Bird, noted that 164 red flags had been reported in the Midwifery Staffing report and queried if this was a concern. The Interim Chief Nurse stated that the majority of the red flags related to patient flow issues rather than direct maternity care, but it was acknowledged that it was important to learn from them. Chair's Log: For the Quality Committee to receive an overview of themes and lessons learned from maternity red flags. The Board of Directors: • Received the current position in relation to CNST Year 4 • Noted the specific updates in relation to: o Perinatal Surveillance Dashboard Update o ATAIN and TC Audit for Q1 22-23 o Maternity Staffing
096b	Digital.Maternity The Chief Information Officer presented the digital maternity strategy. The aim of the strategy (over a three-year period) was to ensure that Liverpool Women's Hospital had the best maternity digital capabilities to provide safe and effective care and maximise collaboration with our women and partners. It was noted that the strategy had been coproduced with maternity staff. Non-Executive Director, Jackie Bird, queried the plans in place to ensure that patients were actively engaged with the aims of the strategy. The Chief Information Officer acknowledged the importance of this and stated that the Trust's wider programme of digital inclusion would support this aim. Non-Executive Director, Zia Chaudhry, remarked that the importance of partnership working was referenced throughout the document and queried where this would be co-ordinated from. It was explained that the Local Maternity and Neonatal System would have a key role in this aspect and in ensuring that improvements were made to how information was shared.

	The Board of Directors reviewed and approved the strategy taking assurance that it had been developed collaboratively across the Trust and represented the strategic direction for digital requirements within Maternity.
097a	Chair's Report from the Quality Committee The Board considered the Chair's Report from the Quality Committee meeting held on 25 July 2022. The CQC Insight Tool intelligence indicated that the overall performance for the Trust was declining. The Committee expressed concern in relation to this position ahead of future independent inspections. It was noted that the soon to be launched Ward Accreditation process would strengthen the evidence available to the Trust regarding levels of compliance. The Board of Directors received and noted the Chair's Report from the Quality Committee meeting held on 25 July 2022.
097b	Quality & Operational Performance Report The Board considered the Quality and Operational Performance Report. The Chief Operating Officer noted that performance against access standards had moved in a positive direction. Removing the number of 104 week waits by July 2022 had been achieved, the aim to reduce 78 week waits by March 2023 was on trajectory and the number of 52-week waits had plateaued. Work was underway to allocate resources to ensure that the longest waiters were seen. Whilst, cancer performance had also seen improvements, the 62-day metric remained challenged. The Trust was liaising with the 'Getting it Right First Time' (GIRFT) team to open Theatre 5. Achieving adequate staffing remained a challenge and the level of resources required were being reviewed. Non-Executive Director, Louise Martin, stated that enhanced narrative against this metric would be required in future reports. The Chair acknowledged the promising signs of improvement. However, it was stated that there remained areas of performance that had been below the expected level for a significant period. The Chief Operating Officer confirmed that the Trust was attempting to achieve beyond the national targets. However, there had been a 136% increase on referrals since the 2019/20 baseline which was creating challenges in the Trust's ability to improve access to services. The Chair also highlighted that there had been an on-going deterioration to the patient experience metrics and stated that there was a need to start to show improvement in this area. The Interim Chief Nurse stated that several areas of patient experience intelligence were being explored at the Patient Involvement and Experience Sub-Committee. It was acknowledged that the presentation of complaints data to the Board required improvement to ensure that it was meaningful and added value to discussions. The Board of Directors: • Received and noted the Quality & Operational Performance Report. *Alison Bedford-Russell and Rebecca Kettle joined the meeting*
097c	Neonatal Mortality Review Update The Medical Director reported that following identification of the Trust as an outlier for pre-term mortality in the period 2015-2018 (specifically for babies born <27 weeks gestation), an independent review had been commissioned by the Trust to be undertaken by Birmingham Women's Hospital. The Birmingham review identified differences in clinical practice but did not identify a reason for the increased mortality rates. Following the review, it was evident the preterm mortality rates remained high at the Trust in 2019 / 2020, both on regional and national benchmarking. Therefore, a further review was commissioned within the NWODN, at the request of LWH, to benchmark against St Mary's Hospital (SMH), the other surgical NICU in the region, which benchmarks favourably nationally.

	This had been a detailed review which had produced several key findings and recommendations. In summary, no one causative factor had been identified but rather a number of areas of improvement had been flagged. It was reported that an action plan had been developed and this would be overseen by the Family Health Divisional Board. Non-Executive Director, Prof. Louise Kenny, stated that the Trust's mortality rate for babies born less than 27 weeks gestation was concerning. It was noted that it was likely that maternity and children's services would not be co-located for a significant period, and it was therefore queried what mitigations were planned to reduce the need for cross-site transfers – an issue that appeared to be a causative factor in the higher-than-expected mortality rate. It was confirmed that the new neo-natal unit and Alder Hey Hospital would mitigate the need for multiple transfers. It was agreed that additional mitigations should be explored ahead of the completion of the Alder Hey unit and for this to be captured in the review action plan. Action: To include the need to explore potential improvements to the model of care for babies transferred between the Crown St and Alder Hey sites in the neonatal review action plan. It was highlighted that the review had found that there was a notably greater number of in utero transfers in LWH compared to SMH, but further analysis of this was beyond the scope of the review. It was agreed that this issue would benefit from further exploration and understanding. Chair's Log: For the Quality Committee to explore the reasons behind a notably greater number of in utero transfers in LWH compared to SMH (noted from Neonatal External Review). The Board of Directors: • received the report • noted that further research would be required to understand the impact of deprivation levels on mortality rates and that this was progressing in partnership with the University of Liverpool. *Alison Bedford-Russell and Rebecca Kettle left the meeting.*
097d	Quality Improvement Update The Interim Chief Nurse provided an overview of the Trust's progress to date with embedding a Quality Improvement (QI) culture within the organisation and an outline of next steps. In October 2021, the Trust engaged MIAA to provide designated expert support to improve QI provision. To achieve the deliverables MIAA sectioned the activity of work into three parts. • Information gathering and understanding existing processes, resources, and culture. • Engaging with staff to co-design. • Increasing QI knowledge and training. The approach to the training was high level and focussed on raising awareness of QI and the model of improvement adopted by the Trust. Several example QI projects were highlighted. Next steps involved building on the work completed to date and to consider how to spread adoption most effectively at every level. Priorities to make this happen included: • QI Summit launch event in Autumn 2022 • Completion of Trust wide QI Training Needs Assessment (TNA), supported by L & D will inform future training needs • Clearly defined and agreed improvement priorities within divisional and corporate teams agreed at operational planning stage, driven by thematic learning. • Each ward manager, matron and operational manager having one QI Project to lead on and deliver • Being data driven and ensuring a proactive performance management approach

	• Sharing learning and embedding change Overall, the aim was to move from a QI project approach to embedding a culture of continuous improvement throughout the Trust. The Board of Directors noted the contents of the presentation.
097e	Women's Health Strategy for England The Interim Chief Nurse outlined the background and context to the recently published Women's Health Strategy. The ambition of the Strategy was to, within the next ten years, boost health outcomes for all women and girls, and radically improve the way in which the health and care system engaged with and listens to all women and girls, ensuring that care was wrapped around the needs of individual women and girls, rather than based on specific issues or conditions. The Strategy took a 'life-course' approach: focusing on understanding the changing health and care needs of women and girls across their lives. Professor Dame Lesley Regan (Women's Health Ambassador) had visited the Trust in early August 2022. The Trust was able to showcase how it provided a life course approach to care and how it was leading work with system partners. The Interim Chief Nurse continued to outline the next steps the Trust was taking to meet the aims of the Strategy. This would include reviewing the strategic priorities to ensure the ambitions set out in the Women's Health Strategy were fully embedded. A granular review was planned that would map out existing work and its alignment to the strategy, as well as ensuring that plans were in place at a Divisional and Trust-wide level to deliver the specific plans set out in the strategy. The Trust also be working with partners to ensure the ambition set out in the strategy was realised across Cheshire and Merseyside. The Chief People Officer noted the opportunity to link this agenda to the Trust's aim to improve the experience of racially minoritized women. It was queried if the Trust was planning a conference to take this issue forward. The Interim Chief Nurse confirmed this to be the case. The Chair stated that there was a need for the Board to consider in further detail how the aims of the Strategy would be addressed at the Trust. Action: To ensure alignment of the WHS with the Trust's strategic aims and objectives in the upcoming review of the Trust's Strategy in November 2022. The Board of Directors noted the contents of the presentation. *Carl Griffiths and Mandy McDonough joined the meeting*
097f	Safeguarding Annual Report The Board received an overview of Safeguarding activity within the Trust for the period 1st April 2021 to the 31 March 2022. Progress against the 2020/21 priorities was outlined and the key priorities for the coming 12 months were reported. These were central to supporting core safeguarding activities and demonstrated the organisations compliance with Section 11 of the Children Act (2004) and the Care Act (2014). The Trust had approached the NHS England Head of Safeguarding to peer review the Trust's Safeguarding process to provide external validation or practice. It was noted that there had been a challenge during the reporting period relating to achieving compliance for training requirements. Non-Executive Director, Louise Martin, queried if a timescale for achieving compliance had been established. The Interim Chief Nurse reported that the Heads of Nursing and Midwifery had been asked to report to the Executive Team in August 2022 to provide assurance on their plans to achieve compliance. Progress was being monitored on a fortnightly basis.

	The Chief Executive noted the achievements of the Safeguarding Team and highlighted the challenges they faced with often complex, time consuming and high risks cases. It was asserted that the team provided a high level of assurance to the organisation. A reminder of the relevant safeguarding legislation and the Board responsibilities for safeguarding arrangements was provided. The assurance mechanisms for safeguarding compliance and oversight were outlined. Action: To receive a safeguarding case study and actions taken by the Trust at a future Board development session The Board of Directors received and approved the Safeguarding Annual Report 2021/22. *Carl Griffiths and Mandy McDonough left the meeting* *Kevin Robinson joined the meeting*
097g	Whistleblowing / Freedom to Speak up Annual Report 2021/22 The Board received the annual report completed by the two Freedom to Speak Up Guardians which aimed to provide assurance regarding Whistleblowing. It included details of those issues that had been formally raised with the Trust and how they have been dealt with. The Freedom to Speak Up Guardian reported that there had been 44 contacts during 2020/21, a decrease of 39% from the previous year. However, it was noted that 2020/21 had been an outlier and the contacts for 2021/22 represented a regression toward the mean. The two main themes for contacts during 2021/22 related to issues regarding how managers had dealt with concerns raised and how change was managed and implemented across the organisation. At the beginning of Q3 the second Guardian role was successfully filled. Dr Srinivasarao Babarao (Shri) was a Consultant Neonatologist and as a medical staff member this opens an additional avenue for any medical colleges who prefer to discuss their concerns with a peer. Shri had forged strong links with the junior Doctors by taking over the main delivery of their induction sessions and was providing a voice for the Guardians and speaking up at medical/clinical meetings. It was noted that new Freedom to Speak Up training had been released during the year for healthcare staff and that the Trust Freedom to Speak to Speak Up Strategy was launched in September 2021. Progress against this was monitored at the Putting People First Committee. The Chair queried how the Trust tested awareness of the Guardian function. The Freedom to Speak Up Guardian noted that a 'temperature check' survey was utilised bi-annually. It was also noted that there had been issues raised from a wide range of staff and departments which provided assurance regarding widespread understanding. The Chief Information Officer asked how learning from incidents raised was followed up. The Freedom to Speak Up Guardian explained that contact was retained with individuals who had raised a concern. Additionally, overall trends were identified and reported into the Trust's governance framework. The Chief People Officer stated that further work could be undertaken to ensure that Divisional teams were acting on the themes identified and ensuring that responses became business as usual practice. The Chief People Officer added that the Trust had seen a reduction in anonymous concerns raised which was a positive indicator of a healthy reporting culture. The Board of Directors noted the contents of the reports and the assurances provided. *Kevin Robinson left the meeting*

	Board Thank you The Chief Executive noted thanks to Alison Ewing who was retiring as the Trust's Chief Pharmacist. This was a role shared across a number of Liverpool trusts and Alison had provided exceptional leadership, challenge and expertise in a highly complex area. The Chief Operating Officer introduced Marian Fleming. Marian had dedicated nearly 50 years to the NHS and at 68 she was still working in LWH theatre in obstetric scrub. The Board thanked Marian for her continuing service and stated that she was an inspiration to all working in the NHS.
098a	**Chair's Report from the Putting People First Committee** The Board considered the Chair's Report from the Putting People First Committee meeting held on 18 July 2022. The Board of Directors: • Received and noted the Chair's Report from the Putting People First Committee meeting held on 18 July 2022.
098b	**Workforce Performance Report** The Board received the Workforce Performance Report. The Chief People Officer reported that there had been an increase in Covid-19 related absence during the reporting period. This had the largest impact on the midwifery workforce which was suggestive of other underlying reasons for absence. There had been a decrease in absence due to stress and anxiety and this was being further supported by the availability of an on-site psychologist. There continued to be challenges to achieve mandatory training compliance and this was linked to staffing availability. A range of incentives was being explored to improve the completion rate. The Interim Chief Nurse noted that the Heads of Nursing and Midwifery had been tasked with supporting the effort to increase compliance. It was highlighted that staff turnover was broadly stable and the following actions were being taken to further strengthen the Trust's position: • A more robust exist interview process • 'Stay' interviews in place • Increasing flexibility of available working patterns The Chair noted that it was positive to receive assurance that the importance of staff retention was not being overlooked. The Chief People Officer added that retention efforts had not only been focused on long-term staff but also on those who were newly qualified. Lessons were being learned from the successful midwifery preceptorship model. It was agreed that an evaluation of the Trust's midwifery preceptorship programme would be undertaken after being in place for 12 months. **Action: To undertake an evaluation of the Trust's midwifery preceptorship scheme** The Chief Information Officer queried if there was evidence that the Trust's changed approach to managing sickness absence had been effective. The Chief People Officer confirmed that there had not been a significant increase in recorded sickness following the policy change. There remained an issue on ensuring that high quality discussions between the manager and member of staff were taking place. Where there was evidence that such discussions had occurred, there were positive responses. The Board of Directors: • Noted the Workforce Report.
098c	**WRES and WDES Report 2022** The Chief People Officer presented the report that outlined the Trust's current position in relation to the ED&I strategic ambitions outlined within the Trust Strategy. Also presented was the annual data

	pertaining to the Workforce Race Equality Standard (WRES) and the Workforce Disability Standard (WDES). National metrics reported for WRES and WDES where the Trust had seen a decrease in position from previous year included: • Likelihood of racially minoritized applicants being appointed from interview. • Likelihood of racially minoritized staff entering formal disciplinary process. • Likelihood of disabled candidate being appointed from interview. • Likelihood of entering formal capability process. • Number of staff experiencing harassment, bullying or abuse from staff. Overall, the Trust performed better than average when considering the available data. However, the Trust had a stated aim to be one of the most inclusive NHS organisations and therefore several actions were outlined that would further strengthen the ED&I position. This included the development of an ED&I Strategy that would involve the development of a dashboard that would align quality outcomes with ED&I measures. The Chief Executive would also start to Chair the ED&I Sub-Committee from January 2023 which would provide direct oversight of the Trust's progress in this area. Non-Executive Director, Zia Chaudhry, queried if the use of positive action had been considered when attracting staff to work at the Trust. The Chief People Officer confirmed that this was an action that was being considered. It was acknowledged that with both staff and patients, the Trust had tended to connect with organisations that already had a strong voice. The challenge would be to understand the areas that required focus and to ensure appropriate connections were made. The Board of Directors: • Noted the contents of the report and the assurances that appropriate actions were being taken to support the ongoing work on the ED&I agenda. • Approved the publication of the report onto the Trust website.
099a	Chair's Report from the Finance, Performance and Business Development Committee The Board considered the Chair's Reports from the Finance, Performance and Business Development Committee meeting held on 25 July 2022. The Committee Chair, Louise Martin, stated that the Trust was facing significant challenges both in terms of the financial position and the operational performance requirements. The Committee was making a focused effort to ensure that issues were considered holistically with implications viewed from different perspectives. It was noted that a refresh of the Community Diagnostic Centre business case was planned, which would take account of the changes to the project plan and funding mechanism which had taken place since the original submission of the case. The updated case would be brought to the Committee for review and Board for approval. The Board of Directors: • Received and noted the Chair's Report from the Finance, Performance and Business Development Committee meeting held on 25 July 2022.
099b	Chair's Report from the Audit Committee The Board considered the Chair's Report from the Audit Committee meeting held on 21 July 2022. The Committee Chair, Tracy Ellery, highlighted a higher-than-expected number of tender waivers. It was explained that the Trust did have low thresholds for tender requirements and that, on occasion, the Trust received PDC capital later in the year which impacted the ability to plan effectively. It was acknowledged however, that there were opportunities to improve the aspects within the Trust's control.

	The Committee had also noted a concern regarding the on-going need to defer action deadlines, particularly where there was a single point of ownership / failure. It was asserted that a reliance on single individuals to close out actions demonstrated a weakness in internal control. It was noted that the Trust had made significant recent investments to strengthen operational management capacity and it was expected that this would reduce the risk of single points of failure. There was also agreement that recommendations should be assigned to job roles and not named individuals. The Board of Directors: • Received and noted the Chair's Report from the Audit Committee meetings held on 21 July 2022.
099c	Finance Performance Review Month 4 2022/23 The Chief Finance Officer presented the Month 4 2022/23 finance performance report which detailed the Trust's financial position as of 31 July 2022. It was noted that at Month 4, the Trust was reporting a £0.497m surplus. This was £53k ahead of plan but was supported by £4m of non-recurrent items. The forecast outturn for the year remained consistent with the plan, at £0.526m surplus, although there were risks to this being delivered. Work was underway with the Divisions to develop financial recovery plans and agency usage was a particular concern. Other risks to the financial position included a lower-than-expected activity level for the Community Diagnostic Centre and being behind plan with regards to the Elective Recovery Fund. Progress had been made against the Trust's Cost Improvement Programme (CIP) projects and the position was ahead of plan (£1,253k delivered against a £1,251 target). Non-Executive Director, Jackie Bird, queried how the Trust was managing the balance between maintaining and improving quality and ensuring delivery within the available financial envelope. The Chief Finance Officer acknowledged that the Trust may need to consider and take difficult decisions as the year progressed. Ultimately this would be following a process of prioritisation in which investments would be made if there was clear evidence that safety and quality for patients would be compromised. A discussion was held regarding productivity and the level of investment made since 2019/20 versus the level of output being achieved. Chair's Log: FPBD Committee to undertake a review of the impact of service investments since 2019/20 in relation to productivity gains. The Chair remarked that it would be important that the Trust had a clear understanding of the items that were driving an overspend and what actions could be taken in response that were within the control of the Board. The Chief Finance Officer confirmed that assurances on this work would report to future FPBD Committees and the Board. The Board of Directors: • Noted and received the Month 4 2022/23 Finance Performance Review
100a	Board Assurance Framework The Board of Directors received the Board Assurance Framework. The Trust Secretary explained that the BAF risks had been discussed at the aligned Committees during July 2022. The report outlined proposed scores for Quarter 2 2022/23 for each respective BAF risk. There had also been several housekeeping amendments and updates made to actions. There was one new strategic threat proposed for BAF risk 3.1 – Lack of clinical capacity and resources i.e. Workforce, estate etc. to treat patients in a timely manner resulting in delays in treatment and

	deterioration in Trust Performance standards. This had been added following a recommendation from both the Quality Committee and FPBD Committee. There was a suggestion that a risk relating to Induction of Labour should be added to BAF risk 3.1. **Action: To include a reference to the on-going work to strengthen the Trust's approach to the Induction of Labour pathway under Risk 3.1** The Board of Directors: • Reviewed the BAF Risks • Agreed the suggested Q2 scores
100b	**Well-Led Action Plan** The Trust Secretary provided an update on several recently published documents that would have a significant impact on the Trust's governance arrangements. It was noted that it was also good practice for the Board to undertake an annual review against the NHSI Well-Led Framework (last external review reported in July 2021). It had been considered germane to review these issues in the round and produce a composite action plan to help the Trust improve its well-led practice and to also prepare to operate in the updated regulatory landscape. The Board of Directors received the well-led action plan. *The following items were considered as part of the consent agenda*
101	**Research, Development & Innovation Annual Report 2021/2022** The Board of Directors noted the content of the annual report.
102	**Corporate Governance Manual – 2022 Update** Subject to the governance framework diagram being updated, the Board of Directors approved the amendments made to the Corporate Governance Manual from July 2021 to date.
103	**Review of risk impacts of items discussed** The Chair identified the following risk items: Risks: • Ensuring that lessons were learned from the patient story • Interoperability challenges (multiple clinical systems) • Mandatory training non-compliance • On-going challenges with waiting times • The need to ensure improvements to the Trust's QI approach • The Trust's financial position and long-term sustainability Positive Assurances • Evidence of effective partnership development
104	**Chair's Log** The following Chair's Logs were noted: • For the Quality Committee to receive additional assurance on progress to achieve compliance against MIS Safety Action 8 (MPET Training) • For the Quality Committee to receive an overview of themes and lessons learned from maternity red flags. • For the Quality Committee to explore the reasons behind a notably greater number of in utero transfers in LWH compared to SMH (noted from Neonatal External Review).

	• FPBD Committee to undertake a review of the impact of service investments since 2019/20 in relation to productivity gains.
105	Any other business & Review of meeting The Chief Finance Officer noted that the Trust had been informed that the External Auditor could not commit to fulfilling the three-year extension agreed by the Council of Governors in November 2021 due to resourcing challenges. Assurance had been provided that the 2022/23 audit could be completed but this would be later in the year. The Council of Governors had been fully briefed, and an Audit Panel had been formed to review the available options and agree a way forward. Review of meeting No comments noted.
106	Jargon Buster Noted.

Liverpool Women's
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Action Log

Trust Board - Public
3 November 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
1 September 2022	22/23/100a	Board Assurance Framework	To include a reference to the on-going work to strengthen the Trust's approach to the Induction of Labour pathway under Risk 3.1	Trust Secretary	Nov 22	Complete	See item 22/23/140
1 September 2022	22/23/098b	Workforce Performance Report	To undertake an evaluation of the Trust's midwifery preceptorship scheme	Interim Chief Nurse	Dec 22	On track	
1 September 2022	22/23/097e	Women's Health Strategy for England	To ensure alignment of the WHS with the Trust's strategic aims and objectives in the upcoming review of the Trust's Strategy in November 2022.	Chief Finance Officer	Nov 22	On track	Reference made in item 139e. Further consideration required at CoG session on 17 November 2022.
1 September 2022	22/23/097c	Neonatal Mortality Review Update	To include the need to explore potential improvements to the model of care for babies transferred between the Crown St and Alder Hey sites in the neonatal review action plan.	Medical Director	Dec 22	On track	
1 September 2022	22/23/097f	Safeguarding Annual Report	To receive a safeguarding case study and actions taken by the Trust at a future Board development session	Interim Chief Nurse	Jan 23	On track	
7 July 2022	22/23/078c	Standalone Site - Update on Quality and Safety Risks	To receive review of all serious incidents to date over the last five years identifying incidents where the current configuration	Medical Director	Dec 22	On track	Scheduled to be received at the November 2022 Quality Committee with onward reporting to the Board.

			of services was either a root cause or a contributory factor				
7 July 2022	22/23/076	Chief Executive's report	To provide an overview of the C-GULL study to a future Board meeting	Medical Director	~~Nov 22~~ Feb 2023	On track	To be reported under the 'Service Line' item at a future Board meeting.
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	Completed	Report received at September 2022 Quality Committee – see Chair's Report in item 22/23/136a
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	Completed	See item 22/23/137e
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	Completed	Update provided to the September 2022 meeting. Additional ask made to check whether patients were made aware of possible MLU closures. Confirmed by Head of Midwifery that Community midwives and homebirth team inform women about capacity and staffing issues and how it can impact on the birth plan and place of birth.
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	Completed	Received at September's Board - item 093d

Liverpool Women's
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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	01.09.2022	To undertake a review of the impact of service investments since 2019/20 in relation to productivity gains. Lead Officer: Chief Finance Officer	FPBD	November 2022	On track	
Delegated	01.09.2022	To explore the reasons behind a notably greater number of in utero transfers in LWH compared to SMH (noted from Neonatal External Review). Executive Lead: Medical Director	Quality	January 2023	On track	
Delegated	01.09.2022	To explore themes and lessons learned from maternity red flags. Executive Lead: Interim Chief Nurse	Quality	November 2022	On track	
Delegated	01.09.2022	To receive additional assurance on progress to achieve compliance against MIS Safety Action 8 (MPET Training) Executive Lead: Chief Operating Officer	Quality	October 2022	Completed	Assurance provided to the Committee on MPET training compliance
Delegated	07.07.2022	To receive a profile of agency usage against agreed establishment levels. Lead Officer: CFO	FPBD	November 2022	On track	
Delegated	07.07.2022	To explore the junior doctor experience in more detail, receiving a staff story to support this aim. Lead Officer: CPO	PPF	Nov 2022	On track	

Delegated	07.07.2022	To receive additional information regarding the Trust's approach to the 'Civility Saves Lives' agenda Lead Officer: CPO	PPF	Sept 2022	Completed	Update provided to October 2022 PPF meeting
Delegated	05.05.2022	To receive benchmarking information on mandatory training compliance. Lead Officer: CPO	PPF	~~July 2022~~ December 2022	Risks identified	Challenges noted regarding the comparability of data at PPF. To be reviewed as part of the on-going development of the performance report.
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	November 2022	On track	
Delegated	03.02.22	To review the development of a business case for an expanded endometriosis service. Lead Officer: CFO	FPBD	October 2022	Complete	To be discussed through the Divisional Operational Planning process and outcome to be reported via the six monthly review of these. Update 26.09.22: The Chief Operating Officer reported that development of this business case would be taken through the standard governance process. It was agreed to close the action.

Liverpool Women's
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CEO Report

Trust Board
November 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.

Section A - *Internal*

Cheshire and Merseyside Acute and Specialist Trusts (CMAST) Provider Collaborative - Governance

Cheshire and Merseyside (C&M) acute and specialist providers have come together to collaborate on matters that can be best progressed and responded to, at scale, and through shared focus or action.

Working together achieved real and tangible benefits during the pandemic, with much of CMAST's foundations emerging from these activities but also building upon, wider and existing, local collaborative strengths such as the Cancer Alliance. This resulted in leaders advocating that CMAST's ways of working be embedded through a Joint Working Agreement.

At a meeting in early October 2022, the Board of Directors:

- Endorsed and approve the CMAST Joint Working Agreement and Committee in Common as proposed
- Agreed to adopt and sponsor the approaches to collaborative working and decision making, as described, recognising the anticipated evolution and development of these proposals under the direction of C&M Trust leadership

Visit by Chief Midwifery Officer of England, Professor Jacqueline Dunkley-Bent.

Prof Jacqueline Dunkley-Bent visited the Trust on Tuesday, 11th October and officially opened the first Bereavement Room on Delivery Suite, launching our Bereavement Suite Appeal. The appeal aims to raise £100k to transform a number of rooms across Maternity and Gynaecology. Providing much needed home from home comforts for our families who have sadly lost a baby. You can watch a short video on the appeal here.

During her visit Jacqueline awarded bereavement Midwives, Maria Kelleher and Pauline McBurnie and Bereavement Support Worker, Sarah Martin with a special Chief Midwife Award for their endless work and compassionate care given to our families at their most difficult time.

Section A - *Internal*

Baby Loss Awareness Week

Baby Loss awareness week took place between 9th – 15th October. Each year the Honeysuckle Team work extremely hard to break down barriers, address stigmas and raise awareness throughout out the week.

This year the team had a full schedule of activities planned which included:

- **Information Stand Main Reception.** The Team were on hand in Main Reception chatting with staff and patients about the bereavement care at LWH and the support available.
- **Annual Service of Remembrance.** The service was held on Tuesday, 11th October at St George's Hall. The team were joined by hundreds of families who came together to remember their precious little ones. Liverpool Men's Choir sang beautifully and families were able to sit together and make crafts.

Throughout the service the team highlighted their ongoing support and monthly support group, open to anyone affected by miscarriage, ectopic or molar pregnancy, termination of pregnancy for fetal anomaly, stillbirth and early neonatal death.

Group sessions take place in a calm, welcoming environment with refreshments, crafts and a listening ear for anyone. Watch a short video about the support group here.

Upcoming support group sessions:

- *Friday 18th November 2022, 10.00am – 12.00pm, Deysbrook Village Centre, Deysbrook Way, West Derby, Liverpool, L12 4XF*
- *Thursday 8th December 2022, 6.00pm – 8.00pm, Blair Bell Centre, Liverpool Women's NHS Foundation Trust, Crown Street, Liverpool, L8 7SS*

Please contact The Honeysuckle Team to book a place 0151 702 4151 / honeysuckle@lwh.nhs.uk

Section A - *Internal*

Visit from Baroness Glenys Thornton – Shadow Women and Equalities Minister

Baroness Thornton visited the Trust towards the end of September 2022 and in feedback to Yana Richens, the Trust's Director of Midwifery, she particularly remarked on the Neonatal Unit. Baroness Thornton noted that was "moving to see how much thought is given to not only supporting and caring for these tiny vulnerable babies, but also their families. A great deal of thought and attention has been paid to the design, staffing and ambiance". Praise was given to the Head of Nursing (Neonatal) and her team for their leadership.

HEE Placement Provider Self-Assessment (SA) 2022

The SA is a process by which organisations carry out their own quality evaluation against a set of standards. It is based on the philosophy of continuous quality improvement, the identification of quality improvement potential, the development of action plans, implementation, and subsequent evaluation.

The SA is divided into three main sections:

• Section 1: Organisation details and Board level sign off

• Section 2: Education Contract KPIs

• Section 3: HEE Quality Framework Standards

The Trust submission is on-line only and this was signed off by the Medical Director ahead of the 16 October 2022 deadline.

Congratulations to our Employee & Team of the Month colleagues for September

Team of the Month goes to **HFC Secretaries –** This team work very hard and go above and beyond in their area of work. Not only care about the patients by being helpful, conscientious and have great empathy along patients journey, often being faced with challenging situations. They also care about each other and how they are feeling which is especially relevant in the present climate.

& Employee of the month goes to **Christina Wallace,** Health Care Assistant, Fetal Medicine Unit (FMU) who demonstrates empathy with the patients, families and staff on a daily basis and not only provides care and support to the patients but also looks out for the staff.

Well done to you all.

Section A - *Internal*

Black History Month October 2022

Black History Month (BHM) came to a close at the end of October and has been an opportunity for everyone across the Trust to **celebrate** the contributions of our black colleagues, to **educate** one another on the inequalities experienced by people from BAME backgrounds and to **inspire** one another to maintain and further develop an inclusive and diverse culture which is supportive and welcoming for all. The theme for this month is **'Time for Change: Action not Words'**.

We have a couple of videos for you to watch from our colleagues and these can be viewed below…

Dr Kiran by Jilani, Consultant Obstetrician and Vice Chair of the REACH Network (previously known as the BAME Network) has recorded a video here Dr Kiran Jilani - Black History Month 2022.

Dr Kiran Jilani talks about…

- Research into cultural differences and race discrimination in the NHS
- Liverpool Women's Hospital findings for a survey conducted by Dr Kiran Jilani about the experiences of ethnic minority staff
- Dr Kiran Jilani's personal experiences of racism

You can also watch a video from **Dr Andrew Weeks, Consultant Obstetrician** here Dr Andrew Weeks highlights the importance of Black History Month and talks about race, poverty, disproportionate mortality rates and the importance of cultural education.

Celebrating Diwali – 24 October 2022

Diwali is an Indian festival, celebrated by many all over the world, symbolising the spiritual 'victory of light over darkness, good over evil, and knowledge over ignorance'. The festival is celebrated over five days, often with long parties into the night and streets being lit up by diyas—cup-shaped, clay oil lamps—lanterns and candles.

Diwali is also referred to as the 'Festival of Lights' with each day recognising different religious significance. Below you will find a list of all five days of Diwali, with their names, religious importance and how many choose to celebrate.

Click the link for more details on the five days of Diwali: Happy Diwali

I hope all of those who celebrated Diwali had a safe and happy time.

The Women's View – Issue 13 October / November 2022

The latest edition of 'The Women's View' is now available for download

https://tinyurl.com/TWV13OctNov22

Section B - *Local*

First patients welcomed at new Royal Liverpool University Hospital

The new Royal Liverpool University Hospital welcomed its first patients on Tuesday 4 October 2022 as outpatient services began operating from the new building.

James Sumner, Chief Executive at Liverpool University Hospitals NHS Foundation Trust, said: “Today (4 October) is a real milestone for the new Royal as we welcome our first outpatients to Liverpool’s new state-of-the-art hospital.

“The new Royal is for the people of Liverpool and the city region and we are so proud that we can start to give our patients, staff and local communities the long-awaited hospital they deserve.”

The hospital undertook a phased 24-day move from the current Royal, which started on Wednesday 28 September. The A&E Department (the last area to move) opened at 12.00am on Thursday 20 October.

New Chief People Officer for Liverpool University Hospitals NHS Foundation Trust

Liverpool University Hospitals NHS Foundation Trust (LUHFT) has announced the appointment of Heather Barnett as its new Chief People Officer.

Heather will be joining LUHFT from Mid Cheshire Hospitals NHS Foundation Trust, where she has been Executive Director of People and Interim Deputy Chief Executive.

Heather has previously worked at Clatterbridge Cancer Centre NHS Foundation Trust as the Director of Workforce and Organisational Development and brings a wealth of expertise in successful change management, organisational development and executive coaching. Heather will start her new role at the Trust in January.

Section B - *Local*

Liverpool Health Partners (LHP) is announcing a new strategic era for the city's academic health science system.
In a bold move, designed to refresh and invigorate the city's research system, LHP is undergoing a relaunch to meet the needs of an ecosystem with the health of its population at its heart.

Having delivered all goals set within their previous strategic period, the Partners are now moving into a new era of collaboration.
The responsibility for strategic decision making will transfer to Partner organisations with effect from 1st October 2022. The Partnership taking forward this new vision will build upon the solid foundations set by LHP during the strategic period 2019-2022.

LHP SPARK (the Single Point of Access to Research and Knowledge) remains at the heart of the Liverpool research community, facilitating and delivering solutions for investigators and research teams. Its services are uninterrupted, including support for study set up, grants and sponsorship.

SPARK will be hosted by the NIHR Clinical Research Network North-West Coast (CRN NWC), NIHR Research Design Service North-West (RDS), NIHR Applied Research Collaboration North-West Coast (ARC), Liverpool Clinical Trials Centre (LCTC) and Innovation Agency North-West Coast (IA).

Three LHP programmes will continue their work towards transforming the health of the local population: Starting Well, Cardiovascular and Neuroscience and Mental Health. They will each be hosted by Partner organisations.

Dawn Lawson, Chief Executive, said: "We are extremely proud of the achievements of Liverpool Health Partners and the fulfilment of our Strategic Plan 2019-22. I would like to thank colleagues for their hard work and relentless commitment to collaboration.

"Significant grant income, reduced study set up times, hundreds of academic papers published, two new Clinical Research Facilities and increased research capacity are just some of the highlights of three years of hard work, dedication, and innovation by the Partnership.

"Another significant achievement was the temporary command and collaboration structure established at the start of the COVID-19 pandemic to deliver a rapid research response for the people of Liverpool and contribute to the worldwide effort in defeating the disease. This rapid response was established as the STrategic One Liverpool Partnership for COVID (Liverpool STOP COVID).

"These achievements will work as a brilliant springboard for the newly refreshed organisation to drive forward the vision and mission we set out in 2019 and to continue to make significant strides in improving the health and wellbeing of the local population."

The 2019-2022 Strategy set bold and ambitious targets to take the Partnership forward with seven strategic goals:

1 Make Cheshire and Merseyside a more attractive place to do research.
2 Improve capacity and capability.
3 Improve opportunities for partners to contribute to LHP.
4 Improve the recognition and profile of LHP.
5 Ensure continual improvement of LHP.
6 Develop and support the innovation pipeline.
7 Focus research on the region's health needs.

Section B - *Local*

NHS Cheshire and Merseyside Integrated Care Board meetings

Thursday, September 29th. The meeting papers are available here.

Thursday, October 27th. The meeting papers are available here.

Major plan for local stroke services gets go-ahead

A comprehensive stroke centre for North Mersey is to be created at Aintree University Hospital, dedicated to caring for people in the critical 72-hour period after a stroke occurs.

The new centre will bring together the hyper-acute stroke care currently based at the Royal Liverpool University Hospital, Aintree University Hospital, and Southport Hospital.

Providing this service from a single unit is designed to improve access to the specialist staff, tests, equipment and procedures that are crucial for diagnosing and treating people as quickly and effectively as possible following a stroke.

Locating the comprehensive stroke centre at Aintree Hospital means it will be on the same site as The Walton Centre, the specialist neurosciences hospital, which provides a stroke treatment called thrombectomy, available 24 hours a day, seven days a week. It's hoped that creating the comprehensive stroke centre will significantly increase the number of local patients able to receive thrombectomy within the required time window.

The proposal does not involve any reduction in NHS funding for stroke care locally – in fact, it will see extra investment made in services to enable the change.

The comprehensive stroke centre proposals were developed by clinicians from Liverpool University Hospitals NHS Foundation Trust, Southport & Ormskirk Hospital NHS Trust and The Walton Centre NHS Foundation Trust.

Section C - *National*

NHS England's New Operating Model

The document sets out how NHS England (NHSE), integrated care boards (ICBs), and providers will work together in the new statutory framework created by the Health and Care Act 2022.

This framework (previously referred to as an 'operating model') has four core foundations, which define NHSE's:

- Purpose
- Areas of value
- Leadership behaviours and accountabilities
- Medium-term priorities and long-term aims

CQC report on the state of health care and adult social care in England 2021/22

On 21 October the Care Quality Commission (CQC) published its latest State of Care report. The report looks at the trends, shares examples of good and outstanding care, and highlights where care needs to improve. The report also highlights concerns about specific service areas, in particular maternity services and those that care for people with a learning disability and autistic people – areas where inspections continue to find issues with culture, leadership, and a lack of genuine engagement with people who use services.

A closed culture is a poor culture in a health or care service that increases the risk of harm. This includes abuse and human rights breaches. The development of closed cultures can be deliberate or unintentional – either way it can cause unacceptable harm to a person and their loved ones.

In addition to its focus on safeguarding vulnerable patients and making reasonable adjustments accordingly, the Trust is very sighted on ensuring leadership behaviours that promote speaking up by staff, and active listening and engagement with patients and their families/carers. Work is currently underway to further develop the mechanisms of engagement with patients, service users, their families and carers, with a particular focus on vulnerable or marginalised groups.

The Trust has a range of methods for staff to speak up and raise their concerns; speaking up is promoted as a positive action, and team culture and leadership behaviours are regularly tested through a range of measures including the Annual Staff Survey, Quarterly pulse surveys, the Big Conversation and by triangulating a range of metrics including measures such as turnover, patient feedback, incidents.

This briefing summarises the findings of the report and includes NHS Providers' press statement on the report.

https://nhsproviders.org/media/694350/2022-10-nhs-providers-on-the-day-briefing-on-cqc-state-of-care-report-3.pdf

Section C - *National*

Research uncovers health inequalities

Research commissioned by CQC has highlighted how some groups of people consistently report poorer experiences of care and support than others.

The 4,000 Voices Survey, conducted by Ipsos, looked at the experiences of older people using health and social care services in the last 6 months.

Overall, people aged 65 and over were positive towards the care and support they have received, with more than three-quarters describing their care and support as good, including around half saying it has been very good.

But experiences were less positive in more deprived areas, with 76% in the most deprived areas saying their care and support has been good, compared with 80% in the least deprived areas.

The survey also found that those living in the most deprived areas were more likely to say they had a long-term condition, disability or illness, compared with those living in less deprived areas.

We also found that disabled people were less likely than non-disabled people to describe the care and support they received as good.

Also, disabled people, those with a long-term health condition and people living in more deprived areas were less satisfied with their access to services.

The findings from the survey were used as evidence in this year's State of Care report.

- **Report: 4,000 voices**
- **Ipsos: Most older people in England are positive about the care and support received for their health and wellbeing in the last six months, but there are risks to health inequalities**

Summary of statutory board meetings: CQC, September 2022

September’s summary includes updates on Care Quality Commission’s operations, a quarterly update from Healthwatch England and the CQC’s first public annual complaints report.

https://nhsproviders.org/media/694202/cqc-board-meeting-summary-2109.pdf

Section C - *National*

NHS England consultations on changes to provider licence and on revised NHS enforcement guidance, and published governance documents

On 27 October, NHS England (NHSE) published three sets of documents:

- A consultation on changes to the NHS provider licence. The consultation opens on 28 October, and will run for six weeks, closing on 9 December 2022.
- A new code of governance for trusts, addendum to your statutory duties, and guidance on good governance and collaboration.
- A separate consultation on changes to the NHS enforcement guidance, setting out how NHSE intends to deal with breaches of the provider licence. This consultation also closes on 9 December.

The need to change the licence has arisen from changes to the statutory and operating environment, including a shift of emphasis from economic regulation and competition to system working and collaboration. The proposed changes will bring the licence up to date, reflecting the new legislation and supporting providers to work effectively as part of integrated care systems (ICSs).

The three guidance documents underpinning the provider licence were consulted on earlier this year and are published today alongside NHSE's response to that consultation.

The revised enforcement guidance describes NHS England's intended approach to using its enforcement powers in relation to integrated care boards (ICBs), NHS foundation trusts and trusts, licensed independent providers of NHS services, and licensed NHS controlled providers. It explains the regulatory and statutory processes in the event of enforcement action and subsequent rights of appeal.

Section C - *National*

Report following the Independent Investigation into East Kent Maternity and Neonatal Services

Mid-October 2022 saw the publication Reading the Signals; Maternity and Neonatal Services in East Kent – the Report of the Independent Investigation.
The report sets out the devastating consequences of failings and the unimaginable loss and harm suffered by families and it reconfirms the requirement for Boards to remain focused on delivering personalised and safe maternity and neonatal care.

NHS England have stated that trusts must ensure that the experience of women, babies and families who use services are listened to, understood and responded to with respect, compassion and kindness. The experiences bravely shared by families with the investigation team must be a catalyst for change. It has been requested that every board member must examine the culture within their organisation and how they listen and respond to staff.

The report outlines four areas for action:

- To get better at identifying poorly performing units
- Giving care with compassion and kindness
- Teamworking with a common purpose
- Responding to challenge with honesty.

NHS England has asked every Trust and ICB to review the findings of this report at the next public board meeting, and for boards to be clear about the action they will take, and how effective assurance mechanisms are at ‘reading the signals’.

The Trust will now take time to review the findings of the report and have asked the division of family health to provide a response to the report in the Quality Committee in November 2022. A report will then be produced at the December 2022 Board to provide the requested assurances.

NHS
Liverpool Women's
NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	22/23/135	Date 03/11/2022
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. Detailed Trust Board Minutes must be made available specifically in response to the Perinatal Dashboard paper and the Saving Babies Lives update.	

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 Trust Board is asked to:

- ***Receive the current position in relation to CNST Year 4***
  - ***Receive the Paper for Perinatal Quality Surveillance Dashboard (September Data)***

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 November 2022 Trust Board meeting and these include:

- Receive the Paper for Perinatal Quality Surveillance Dashboard (September Data)
- Receive the SBLCBV2 Regional Chief Midwife Survey

Previous discussions at the Board have requested further detailed analysis of any risks identified that may pose a risk to achieving full compliance. Recently these discussions have 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.

In October 2022, a further revision of the Maternity Incentive Scheme was published and along with some safety action updates, a new Trust Board sign off date was announced. Areas highlighted in BLUE denote any updates or extra requirements announced in the October 2022 MIS publication.

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.

October 2022

On 11th October 2022, NHS Resolution, in response to the recognition of ongoing pressure within the national maternity system, published a further updated to the scheme guidance (Appendix 1). A new revised Board Declaration date was issued and sign off of the scheme now stands at **February 2nd 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 October 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 position and progress with maternity safety actions by the Head of Midwifery, Director of Midwifery and Clinical Director for Maternity Services (May and October 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 **2nd February 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 compliance submission 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 consists 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 allows oversight by the FHD Division Management Team and CNST Oversight Group.

- Every action has been nominated a lead, with associated actions being given to action owners. Action Leads and owners who are responsible for ensuring their progress, challenges and completions are presented and overseen by the FHD CNST Oversight Group. This meeting, now twice monthly, is chaired by the Chief Operating Officer 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 October 2022 scheme update – October 2022.

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 – Consultant Obstetrician Rebecca Kettle – Consultant Neonatologist Sarah Howard – Quality & Safety Matron	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 – 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 - 96.67% Compliance. *Note – One case (82439) did not meet the two month timeframe required in this standard, due to shared responsibility with another Trust. The Scheme guidance (page 14) accounts for this and must be noted on the Board Declaration form. The external validation process by MBRRACE will account for this and apply adjustments to 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 - On track for completion. - 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 ***Thematic Review of Stillbirths 21/22 -Submitted to QC 26th Sept 2022*** **Q1** 22/23 Learning from Deaths Report - Submitted to QC 26th Sept 22 - Submitted to Board TBC	
SA.2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	New requirement for a digital maternity to align with Trust Digital strategy -the Maternity Digital Strategy has been developed and was presented and approved at Trust Board in September 2022 by the CIO. MSDS data for July 2022 data has been 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	

	Leads: Head and Deputy of Information Richard Strover & Hayley McCabe	data. Confirmed with LMNS on 14.10.2022 that Digital Strategy has been received.	
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– Consultant Neonatologist Sarah Brownrigg – ANNP Paula Nelson – ANNP Sarah Howard – Quality & Safety Matron	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 and Q1 22-23 have been submitted to the FHD Safety Champions. Q2 report development underway and will be submitted to safety champions meeting and FHDB and QC in November 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 was submitted to Trust Board in July 2022 and outlined the ongoing obstetric workforce review and associated action plan. 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 reflect requirements within scheme guidance.	

SA.5	Can demonstrate an effective system of midwifery workforce planning to the required standard? Leads: Heledd Jones – Head of Midwifery Alison Murray – Deputy 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. • 100% Supernumerary Labour Ward Co-ordinator • Provision of 1:1 Care in Labour A further detailed midwifery staffing analysis was tabled at Trust Board in September 2022, with detailed Trust Board Minutes being to be made available to the MIS scheme leads and Head Of Midwifery, 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.	
SA.6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives Care Bundle Version 2? Leads: Clinical Director Alice Bird – Obstetrics Angela Winstanley – Quality & Safety Matron	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 Survey 6 submitted to Trust Board in June 2022. - SBLCBV2 Survey 7 in the Appendix to this Update - October 2022 A brief synopsis of the audit results of each safety element as follows Full audit to be tabled at Quality Improvement Group – October 2022 **Element 1 Smoking in Pregnancy – COMPLIANT.** • CO Screening compliances of >95% at Booking and >80% at 36 Weeks, over a four-month period. Action plan formulated to address compliance rates at 36 weeks. • Proportion of women with CO >4ppm (*audit sample requirement was 20 cases, LWH sample 47)* – 57.5% accepted referral, 38.3% declined referral. **Element 2 FGR Screening & Management - COMPLIANT** • 100% of cases identified as high risk and 100% of cases identified as moderate risk of FGR compliant with the relevant risk assessment at 20wks. • 85.7% of sample compliant with the complete high-risk pathway. 90% compliance with complete moderate risk pathway. **Element 3 Managing Reduced Fetal Movements – COMPLIANT** 100% Compliance of women receiving information on RFM. 100% Compliance of women attending with RFM having a computerised CTG **Element 4 MDT Training & Fetal Surveillance Training – COMPLAINCE ON TRACK.** • This element centres on MDT training and Fetal Surveillance Training (Full update on compliance and trajectory as per Safety Action 8) **Element 5 Preterm Labour Prediction, Prevention and Management – COMPLIANT** *(No compliance targets in this element, only requirement is action plan developed for those < 80%. Audit sample required 20 cases presenting with threatened preterm birth, LWH Sample 48)* • 77% of cases of threatened preterm labour (TPTL) had complete course of corticosteroids within 7 days of birth. • 8.3% gave birth >7 days after completion of corticosteroids (should be as low as possible and reported as the proportion) • 87% of cases of women in threatened preterm labour received magnesium sulphate • 100% of women give birth in a setting appropriate to gestation (Level 3-4 NICU at LWH supports births of all gestations) Saving Babies Lives Audit Number 2022-019 will be submitted to QIG in Oc	

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? Lead: Heledd Jones Head of Midwifery .	A new MVP Chair has been successfully recruited and started in her role in September 2022. HOM has plan with the FHDB that is being aligned to ensure that all MIS requirements are achieved. Agreement by Executive Committee to fund a Deputy Chair in order to strengthen MVP representation. Invites extended to newly appointed MVP Chair to attend Maternity Risk & Governance Meeting and Divisional Safety Champion meeting. MVP Chair is a member of the Maternity Service Improvement Action Plan Task and Finish Group, latest meeting held October 13th 2022 of which MVP Chair attended. MVP Chair meeting weekly with HOM for feedback from service users, to identify improvements with potential for rapid resolution, safety concerns identified by service users escalated to MVP etc. Updated ToR requested from MVP. Plans for MVP Meeting in December 2022.	
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 original submission date of 5th December 2022 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. A full and detailed analysis of current training compliance rates and trajectories can be found in the Perinatal Dashboard Paper in the appendix to this paper.	
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. Trust Boards must have reviewed current staffing in the context of the letters to systems on 1st April 2022 and 21st September regarding roll out of Midwifery COC. 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. 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. Letter received in September 2022 by SLT and position statement released to all staff that reflects that the Mat Service will continue with the ongoing pause in the toll out of COC. The LMNS have also acknowledged the current CoC status at a touchpoint meeting on 14th October 2022. 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 eligible HSIB cases have been reported to HSIB. This has been audited and cross checked against available Badger Net data with regards to inborn cooled babies and early neonatal deaths. • All families, referred to HSIB, have had information on HSIB and Early Notification/NHSR Scheme in the form of a letter and DOC documented discussion. • All Duty of Candour duties have been 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. • MIAA are intending an audit of this standard for further assurance of compliance.	

Conclusion

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

The Trust Board should take reassurance and assurance that out current position, with regards to all the safety elements and actions can be supported by evidence, which will be scrutinised prior to final board submission.

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 Multi-Disciplinary Team training requirements outlined in the perinatal quality surveillance dashboard.

Appendix

1. Regional Chief Midwifery SBL Survey October 2022 (Survey 7).

2. Perinatal Dashboard paper

Access to SBLCB v2 Survey

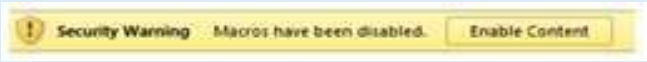
In order to reduce the burden that this survey has on the submitter's time, we have pre-populated this survey with your provider's responses from the last survey.

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
Collect: week commencing 16th May

Survey 7 Collection Round: October 2022
Circulate: week commencing 3rd October
Collect: week commencing 7th November

TRUE

Update Report

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: <u>April 2021</u>** Circulate: 30th April Collect: 28th May **Survey 6 Collection Round: <u>April 2022</u>** Circulate: week commencing 18th April Collect: week commencing 16th May Survey 7 Collection Round: October 2022 Circulate: week commencing 3rd October Collect: week commencing 7th November

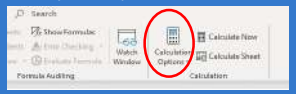
The purpose of this survey is to gather information on how much of current standard practice aligns with the interventions that make up the Saving Babies' Lives Care Bundle v2. Each intervention is made up of improvement activities. Improvement activities are the actions that make up the elements of 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	7th
Survey Date	Oct-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.*	No
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 Applicable

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	Qulaity & Safety Matron
Hospital Name	
Trust Name	Click to Select
Trust Code	Automatic
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									
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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)

NHS
Liverpool Women's
NHS Foundation Trust

Maternity Perinatal Quality Surveillance Model: October 2022 (September 2022 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 32 red flags reported in September within Maternity. A further increase from previous months reporting. - 23 incidents - delay in ongoing process of induction >4 hours - 2 Incidents - delay >30 mins between presentation and triage 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. The Head of Midwifery provides a detailed narrative of midwifery red flags within the Bi-annual Midwifery Safe Staffing Paper, sighted for Trust Board September 2022. In September, the Division closed 72 incidents reported as midwifery red flags, this included a large number of incidents within the web holding file relating to delays in triage, ongoing IOL delays and 1:1 support in labour provision.
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 and Cont of Care MW. - 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 and over recruitment to vacancy (Jan 2022) - 46 WTE Midwives anticipated to commence in post in October 2022. In September live reporting will be enacted with the introduction of the Birth rate Plus Acuity App – where red flags are reported instantly and captured in conjunction with the acuity of the areas at that point. 1:1 Care in Labour remains above >98% and all individual cases reviewed to ensure no adverse outcomes

	and presented at the Maternity Risk Committee. The most common red flag reported (a locally developed red flag) in Maternity services are a delay in Induction of Labour until it is safe to proceed to do so to ensure 1:1 care labour provision is preserved.
MVP Feedback.	Invites have been sent for Ms Irvine-Naderali to join the divisional maternity risk and clinical meetings. MVP Chair meeting weekly with HOM for feedback from service users, to identify improvements with potential for rapid resolution, safety concerns identified by service users escalated to MVP etc. Updated ToR requested from MVP . The Maternity Improvement Task & Finish Group continues to have attendance from the MVP Chair and part of this improvement group work will be a revisit of the '15 Steps' initiative.
HSIB Referral Details:	The Family Health Division had TWO cases eligible for reporting to HSIB in September 2022. All Duty of Candour was completed. Case 1 – G1 P0 40+1 weeks gestation. IOL for RFM, Failed forceps, emergency C/S. Baby boy 3770gms, 87th centile born with low Apgars and required resuscitation. Baby was unexpected admitted to the Neonatal Unit and was therapeutically cooled as cord Ph – Arterial 6.86 Bex -21.4 / Venous 6.91 Bex -20.5 / Lactate 13.83: Early learning – Loss of situational awareness in theatre, decision to delivery time outside of guidance. Case 2 – P. 39+4. Low risk. Attended with Pre Labour SROM – home expectant management. Reattended in labour – 7cm dilated. Forceps birth with suspicious CTG. Low apgars, low cord gases. Early Learning - Quantifying antepartum blood loss to determine appropriate plan of care. CTG interpretation and fresh eyes do not agree this should be escalated. CTG concerns are identified escalation is prompt and oxytocin infusion reviewed. CTG monitoring should be maintained during fetal blood sampling. Escalation and involvement of the Consultant Obstetrician on call. Contemporaneous record keeping surrounding discussions and decision for delivery The SOP for the HSIB reporting and management process was ratified at the Maternity Risk Meeting and the Family Health Divisional Board and can be found at the following link. Updates have included how cross divisional learning will be continued and that the Trust Quality Committee will received updates on a quarterly basis.
Maternity Serious Safety Incidents	The Family Health Division reported one incident to STEISS/CCG in September: Undiagnosed placenta accreta detected during a Category 3 caesarean section. Patient estimated blood loss 4670ml, required assistance of on call gynecology oncologists and caesarean hysterectomy. Early Learning: Missed opportunities to develop a plan for delivery, inappropriate adherence to guidance resulting in unplanned procedure. Missed opportunity to counsel women and family given the language barrier. Had placenta not been removed potential for dissection of focal accreta
Perinatal Mortality.	Number of Neonatal Perinatal Deaths in September 2022**: 0** Number of Stillbirth (Exc TOP) Perinatal Deaths in September 2022**: 1** All perinatal deaths in September 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 Regional Quarterly Mortality Report presented by the Deputy Medical Director at Quality Committee and Trust Board.
FHD Risk Register.	Maternity currently holds 36 Risks within the Trust Risk register: Risk Register management and review is a standing agenda item at the Maternity Risk Meeting, where risks and new risks are considered and discussed, and issues highlighted for escalation to

Risk Rating	Total
Extreme	7
High	24
Moderate	4

	FHDB and divisional quadrumvirate. Closed and completed risks are agreed and overdue reviews of risk highlighted. For September the maternity division offer the following brief update: - There are 11 overdue risk status requiring review – escalated to Senior Leadership Team. - All Maternity Risk descriptions have been updated to reflect condition, cause, and consequence descriptors - All maternity risk owners have been updated to reflect change in management personnel within the division. - Maternity Division are proactively working through outstanding risk register actions and seeking evidential assurance of those actions completed. - Maternity Managers and Matrons are in the process of being provided with up-to-date risk register management training with Governance Manager.
Maternity Incentive Scheme Progress Year 4.	**Progress against the Year 4 Maternity Incentive Scheme (CNST):** 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. MSDS – No reported problems. Digital Strategy Completed – linking to trust wide digital strategy and shared and discussed at Trust Board in September 2022. This has also been shared with the LMNS. 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. Quarterly ATAIN and TC Reviews continue, sighted by FHDB and Safety Champions. Clinical Workforce – Action complete with all evidence collated for assurance of completion. Midwifery Workforce – Detailed staffing paper against Birth Rate Plus Report of 2021 has been sighted at Trust Board, further staffing paper at Trust Board in September 2022. SBLCBv2 – All workstreams currently on track for completion. CO Screening requirements met. Full SBLCBV2 Audits completed, Clinical Director and Q&S Matron are working on action plans and will be shared at QIG Committee in October 2022. Full FGR audit underway, due for completion in December 2022 for submission to QIG. MVP – MVP Chair in place. Invited to attend Maternity Risk Meeting. Updated ToR requested. 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 in MPMET Training Compliance section. Safety Champions – Safety Issues continue to be escalated. BLSC sighted on Perinatal Clinical dashboard and submitted monthly. HSIB and NHSR Notifications – No issues identified. All HSIB and D.O.C duties completed to date. ***A detailed paper is sighted at both Quality Committee and Trust Board where compliance with the MIS scheme is discussed and noted.***
Family Health Safety Champions.	Q2 2022-2023 Further Safety Champion activity is tabled to be sighted at Quality Committee on 24.10.2022. Safety Champion walkarounds and meetings are diarised and planned for the remainder of 2022. The FHD Safety Champions have responded to a request from the NWC Safety Champions continue with unit walkarounds, in collaboration with the Board Levels Safety Champions and the Q2 Safety Champions report will be presented at Quality Committee in October 2022. Staffing issues remains the biggest concerns for our frontline staff. A full detailed report of safety champion activity can be found in the Q2 Report.

Quality Improvement/ MatNeoSIP Update	The Maternity Division are working on the introduction of the RCOG Escalation Toolkit Campaign and currently are focusing on the Teach or Treat Element, in collaboration with the Mat Neo SIP Programme. The overall aims of the campaign to improve clinical escalation are: • To reduce delays in escalation by improving the response escalation and action taken • To standardise the use of safety critical language • To reduce feelings of hierarchy, creating a supportive environment which empowers staff of all levels to speak up when they identify deterioration or a potential mistake • To promote a culture of respect, kindness and civility amongst staff members, normalising positive feedback and saying thank you to each other • To improve the ways in which we listen to women. *What does Teach or Treat aim to do?* Promote respectful conversations between staff members so that junior members of the team are not afraid to be unsure, be wrong, or escalate concerns. Promote shared understanding of a clinical situations from different clinicians' perspectives Put the woman at the heart of the decision making and information giving. Identify when escalation has taken place. Promote a flattened hierarchy, a culture of learning and of mutual respect. Empower all members of the team to respectfully challenge if they think another member may be making a mistake. *When is Teach or Treat used?* When implemented in units around the country, it was most widely used when interpreting CTGs. However, it can be used in any clinical situation. On ward rounds When performing "fresh eyes" if there is disagreement between the two clinicians. When escalating clinical concerns. In CTG / intrapartum care teaching Optimization of Preterm Infant. There is a collaboration opportunity at the e-networking event Share learning and drive improvement across the Northwest Coast for both our active workstreams 'Optimisation of the pre-term infant' and 'Early recognition of deterioration in mother and baby'. All MatNeo SIP clinicians within the Division will be encouraged to attend. This will support the team in their already well recognised achievements with the NWC MatNeoSIP QI projects such as reducing the incidence of cerebral palsy by offering magnesium sulphate to all eligible women in England during preterm labour (currents rates of MgS04 administration are at >80% in women with threatened preterm birth) and optimum antenatal corticosteroid administration.

Maternity MPMET Training Compliance – October 2022

(Red Figures denote trajectory based on booking so far)

CNST SA8	Staff Group	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	
SA 8b. MPMET	Midwives	13%	19%	22%	38%	61%	76%	78%	78%	80%	83%	92%	
	Maternity HCA	10%	19%	21%	30%	49%	69%	75%	75%	71%	72%	94%	
	Cons Obstetrician	6%	10%	46%	62%	71%	71%	71%	71%	84%	85%	92%	
	Trainee Obstetrician	9%	20%	51%	64%	91%	97%	97%	97%	29%	65%	91%	New rotation in August
	Cons Anaesthetist	6%	13%	26%	26%	26%	37%	37%	37%	50%	81%	100%	
	Trainee Anaesthetist	11%	44%	44%	11%	33%	55%	55%	55%				New rotation in September
SA 8c. Fetal Surveillance	Midwives	2%	7%	19%	28%	53%	72%	78%	78%	85%	88%	95%	
	Cons Obstetrician	2%	10%	20%	35%	60%	63%	74%	74%	74%	84%		
	Trainee Obstetrician	0%	13%	39%	63%	67%	80%	83%	83%	24%	73%	96%	New rotation in August
SA 8d. NLS	Midwives	13%	19%	22%	39%	62%	76%	78%	78%	80%	83%	92%	Delivered on MPMET day
	Cons Neonatologist	94%	94%	94%	94%	100%	100%	100%	100%	100%	100%	100%	
	Trainee Neonatologist	95%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	New rotation March & September
	ANNPs	62%	85%	88%	88%	88%	86%	93%	93%	96%	96%		
	Neonatal Nurses	80%	84%	89%	89%	89%	89%	96%	99%	99%	96%		

Owing to the high quality content of the MPMET sessions at Liverpool Women's NHS Foundation Trust, the Maternity Education Team have been approached by other Trusts both from within the Cheshire & Merseyside region, Wigan, Wrightington and Leigh NHS Trust and from the Isle of Mann to attend and observe. We will be welcoming these Trusts to our sessions in the coming months and will be keen to hear feedback from them.

Family Health Division Training Narrative – October 2022

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 learn from incidents and concerns to continuously improve the care we are providing to women, families and babies. The LWH 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 and ratified 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. ** 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%.

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. In order to achieve full compliance of newly rotated anaesthetic colleagues, extra sessions of MPMET training day have been developed. Twelve (of 14) anaesthetists have been booked onto these sessions and will enable the Division to declare full compliance.

Perinatal Dashboard

The infographic below is designed to align with the requirements as set out in the [implementing-a-revised-perinatal-quality-surveillance-model.pdf (england.nhs.uk)](#) and highlights some of the key KPIs monitored throughout the family health division. The Division now have a newly developed maternity dashboard (can be accessed clicking on the link below). The Family Health Division along with the Clinical Director and Head of Midwifery

[Maternity Clinical Dashboard New - Power BI](#)

	Metric	Standard/ National Standard	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Perinatal	1:1 Care in Labour	100% CNST 95% CCG	99.20%	98.60%	99.60%	99.40%	98.10%	98.30%	98.90%	96.50%	98.97%	99.20%	99.10%	98.59%	98.19%	98.24%
	Stillbirth Number >24 weeks (Adjusted)	Actual Number	3	1	2	5	2	5	0	5	1	4	2	3	3	1
	Stillbirth Adjusted % per 1,000 Birth		2.94%	1.47%	4.57%	7.51%	3.21%	6.07%	0%	6.75%	1.70%	6.13%	3.28%	4.70%	4.73%	1.53%
	Apgar <7 @ 5 Minutes (>37wks)	<1.6%	1.30%	0.80%	0.50%	1.15%	1.28%	0.51%	0.59%	1.15%	0.37%	1.19%	0.74%	1.06%	0.62%	0.34%
	Term Admission to NICU	<6%	4.91%	5.10%	4.52%	7.69%	5.46%	5.90%	5.70%	6.70%	2.95%	7.30%	4.24%	5.48%	5.45%	4.10%
	Women in reciept of CoC	100%	16.67%	19.91%	17.85%	20.52%	20.52%	18.7%	25.20%	16.90%	18.50%	21.68%	20.21%	16.01%	18.15%	17.22%
	BAME in recipet of CoC	100%	39.81%	47.96%	39.60%	41.58%	37.89%	37.20%	59.46%	37.70%	41.90%	51.85%	48.11%	36.00%	37.24%	27.86%
	Social Depravation of CoC	No standard	24.21%	26.40%	22.26%	24.78%	23.62%	21.70%	28.90%	23.30%	22.10%	25.87%	26.57%	19.10%	17.00%	13.98%
	Provision of Epidural in Labour	No standard	19.4%	20.3%	22.82%	17.78%	16.78%	18.97%	18.70%	19.20%	19.35%	19.10%	18.30%	20.85%	14.72%	17.05%
	Obstetric Haemorrhage recieveing blood transfusion	<2.7%	1%	1.63%	1.39%	0.31	0.66%	0.47%	1.81%	1.18%	0.85%	1.25%	1.15%	1.74%	1.08%	1.20%
	Coroner Reg 28 Made to Trust	Actual Number	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Workforce	HSIB Reports Returned	Actual Number	0	1	1	1	0	1	0	0	1	1	2	4	0	1
	Supernamary Shift Leader	100% CNST	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Midwifery Sickness	% of Workforce	12.17%	14.11%	13.31%	12.63%	15.26%	16.37%	11.45%	9.64%	9.69%	9.65%	9.68%	11%	10.53%	9.58%
	Midwife to Birth Ratio (in Post)	>1.30	31	32	30	29	30	30	30	30	28	31	29	30	31	31
	Midwifery Vacancy	% of Workforce	4.40%	3.30%	5.32%	8.72%	7.84%	2.46%	2.00%	4.10%	13.2%*	13.20%	17%	53.1 WTE	58.33 WTE 21%	No data available
Feedback	Rostered Cons Hrs on DS	Actual Number	91	91	91	91	91	91	91	91	106.5**	106.5	106.5	106.5	106.5	106.5
	Number of Formal Complaints	Actual Number	1	2	3	2	2	2	0	2	3	2	5	4	5	3
	Number of Maternity Incidents over 30 days	Actual Number	89	161	376	97	119	121	120	234	221	273	204	256	498	348
	Number of PALS/PALS +	Actual Number	67	46	52	44	32	44	42	31	27	26	40	44	47	44

Northwest Coast Regional Dashboard – Outlier Queries and Responses

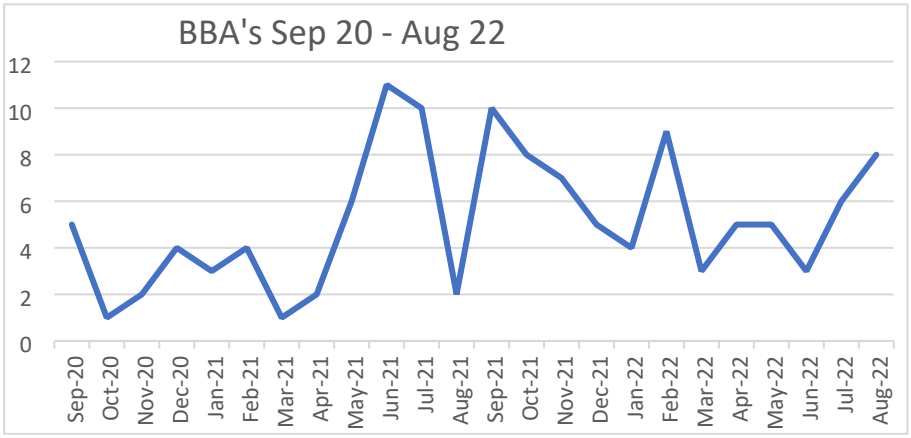
Born Before Arrival (BBA): Births at Home without midwifery attendance.

There was one request made by the Northwest Coast dashboard team for responses to outlier queries in September 2022. This pertained to the increase of 'BBA' births (Born at home without midwifery attendance) and a notable increase in the metric. September 2020 to August 2021 a reported 51 births occurred at home as a BBA, in comparison to September 2021- August 2022 where there was 73 BBA births. Response provided to LMNS as follows:

Birth Before Arrival

Comparing the years September 2020 to August 2021 and September 2021 to August 2022 there have been 43% more BBA's rising from 51 to 73. The peak months are June and September 2021, then the trend is a downwards one. Comparing overall figures March – Aug 2021 to the same period in 2022 there has been no increase.

Row Labels	Sum of count
Car Park	1
Homebirth	3
MAU / HOME	2
No documentation	9
Out patient Propess IOL	1
Rapid Delivery	11
SG	4
Grand Total	**31**



- On analysis of the most recent 6 months data to September 2022, there have been 31 BBAs.
- On review of the notes of each BBA the above table highlights potential themes. 9 BBAs did not have any documentation to explain the reason for the BBA.
- Eighteen births were recorded as rapid deliveries, 3 of which had previously had an admission to MAU and were discharged home as either early labour or SROM with documentation to return if labour begins or intensifies.
- Four births were women that had significant safeguarding input.
- Three births were booked under the homebirth team, 2 of which the midwife arrived after baby was born, and one was born 40 minutes after calling the midwife who was already at another birth.
- All but one birth was a parous woman. There was no documentation from notes that any of the women had been triaged by MAU or had called and not been able to get through.

Actions have been taken to address issues as highlighted in the analysis include, LOTW to remind staff on accurate documentation of potential reasons for BBA upon admission to LWH. The HOM and Divisional Managers and Matrons will continue to monitor this metric to identify any further learning available.

Conclusion

The Family Health Division asks the Trust 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 Director and senior leadership team for Maternity at the FHDB, and outlier comments supplied to the LMNS from the Clinical Director for Obstetrics or Head of Midwifery.

Quality Committee Chair's Highlight Report to Trust Board
26 September 2022

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Noted that the Trust would be involved in a pan-trust review of caesarean section rates as theatre capacity could not accommodate the increasing rates of caesarean sections on a long-term basis. • The Committee noted the worsening position against the face-to-face maternity triage within 30 minutes metric. A Quality Improvement project was underway and ongoing work with the BSOTS model was progressing. It was noted that the Maternity Transformation Board had been tasked to monitor and improve performance against this metric. The Maternity Transformation Board would escalate the matter to the Committee if required. • The Committee received an update against the Blood Sampling errors and noted continued sampling errors and the associated impact on care, poor patient experience and costs. The Committee requested a further update to include a detailed action plan clarifying trajectories, accountabilities and investment requirements to understand better how this matter would be taken forward and resolved. • The Committee considered the maturity of divisional governance to undertake a wide range of projects identified by several reports discussed at the meeting. The Committee was asked to note that a development plan with the senior divisional meetings to drive forward good governance had been planned.	• The Committee noted that the Performance report would be strengthened with additional focus on Quality metrics to be included in future performance reports, for example, Ward accreditation, MUST, VTE, and SI dashboard data. • The Committee noted a request to the Divisions to provide divisional integrated governance and learning reports. These would be used to better inform the Integrated Governance Report and Serious Incident Reports submitted to the Quality Committee. • The Committee received a verbal update in relation to a serious incident raised within Imaging. Duty of candour principles had been implemented and support provided to the family. Support had also been provided to the sonographer and the team involved. A written report would be provided to the Committee when finalised. • The Committee noted continued progress against the isolated site risks programme of work.
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 received a Stillbirth Thematic review which summarised the themes associated with stillbirths, it identified learning and recommendations, many of which had also been recommended by the Ockenden review findings and implementation was underway.(RESPONSIVE/SAFE) • The Learning from Deaths quarterly report provided positive assurance. It was noted that the Trust remained compliant with Safety Action 1 of the Maternity Incentive Scheme requirements. The Committee noted a positive early indication that the neonatal mortality rate was on a downward trend and within range of comparator trusts. (ALL) • The Committee had been assured by the collaborative work with divisions to focus on reviewing overdue Serious Incident actions and associated evidence relating to both historical and recent submissions. The divisional governance managers were	

reviewing any overdue action plans and collating evidence for submission to the ICB. (ALL) • The Committee received the quarterly Medicines Management assurance report for Quarter 1, 2022/23. (SAFE) • The Committee received the Clinical Audit Annual Report noting an increase of completed clinical audits carried out in-year. (EFFECTIVE/SAFE/WELL LED)	

Summary of BAF Review Discussion (Board Committee level only)

- The Committee reviewed the Quality related BAF risks. It was noted that one new strategic threat had been agreed by Trust Board for BAF risk 3.1 Lack of clinical capacity and resources, which would be overseen by the Quality Committee.
- The Committee considered actions being taken within BAF risk 3.1 and BAF risk 5.2 in further detail. In response to ref 2418 - lack of support and appropriate care for patients presenting with mental health conditions, the Committee referred a Chair action to the Patient Involvement & Experience Sub-Committee to review access to mental health provision for patients presenting with mental health conditions across the Trust.
- No risks closed on the BAF for Quality Committee.
-

Comments on Effectiveness of the Meeting / Application of QI Methodology

- Highlighted attention to reports to be considered at the start of the meeting was useful to focus time and discussion.
- Appropriate discussion dedicated to identified reports.

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
89.	Board Assurance Framework	Assurance	**95.**	Serious Incidents & Learning Report	Assurance
90.	Sub-committee Chair Reports	Assurance	**96.**	Imaging Incident Update	Information
91.	Quality Performance Report Month 5, 2022/23	Assurance	**97.**	Isolated Site Risks (FG) Update	Information
92.	Stillbirth Thematic Review	Assurance	**98.**	Medicines Management Assurance Report Quarter 1, 2022/23	Assurance
93.	Blood Sampling Update	Information	**99.**	Clinical Audit Annual Report	Assurance
94.	Mortality and Perinatal Report (Learning from Deaths) Quarter 1	Assurance			

3. 2022 / 23 Attendance Matrix

Core members	April	May	Jun	Jul	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Tony Okotie	✓	✓	✓	**NM**							
Susan Milner	✓	**A**	**NM**								
Louise Kenny	**A**	✓	✓	A	✓						

Sarah Walker, Chair	**NM**	✓	✓	A	✓						
Gloria Hyatt	**NM**	✓	✓	✓	✓						
Jackie Bird	**NM**	✓	✓	✓	✓						
Marie Forshaw	✓	✓	✓	✓	NM						
Gary Price	✓	✓	✓	✓	✓						
Lynn Greenhalgh	✓	✓	✓	✓	✓						
Eva Horgan	✓	✓	✓	✓	✓						
Michelle Turner	✓	✓	✓	✓	A						
Nashaba Ellahi	✓	✓	✓	A	✓						
Philip Bartley	✓	✓	✓	A	✓						
Dianne Brown	Non-member				✓						

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

Liverpool Women's NHS Foundation Trust

1. Highlight Report

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

• Noted limited progress against EDS 2022 in relation to patient experience (highlighted by the S&E sub-committee chairs report). Noted that the ED&I Committee would be monitoring progress. The respective Divisional Boards had also been tasked with their increasing ownership regarding delivery against the standards.
• Increasing number of out-of-date policies highlighted by the Corporate Risk sub-committee. It was noted that divisions had been considering different ways to review and monitor policies they are responsible for. The Interim Chief Nurse had instigated a weekly performance report to track progress.
• The quality performance report highlighted the following risks:
  ○ Challenges to the 62-wait target and negative movement within the 52-wait target
  ○ Amber blood stock alert and potential impact on elective activity
  ○ Deteriorating performance against the triage on Maternity Assessment Unit within 30 minutes. It was agreed that the Committee should receive a detailed update within the next report.
  ○ Worsening performance against the complaints response rates. Noted a review of the complaints process with divisions underway and a requirement for any future extension requests to be approved by the Interim Chief Nurse.
• The Committee noted partial assurance from the Medicines Management Quarterly Update. The Committee raised concern in relation to several incidents regarding control drug management. The Committee recommended a Chair action to the Medicine Management Group to review the process and provide assurances to the Committee via its Chairs Report.
	• Chair action to the S&E Sub-Committee to consider how better to utilise patient feedback from social media channels.
	• New template of performance reporting using SPC Charts to be brought to Committee. It was requested that a briefing session on the new template would be useful for Board members.
	• Noted progress in relation to the work for LocSSIPs, including a revised policy, guidelines and a move towards becoming wholly digitised. It was noted that in the interim ahead of Meditech Expanse being launched, Power Bi was being utilised to validate observational data.
	• The Committee received an update against the Trusts Be Brilliant Ward Accreditation Scheme (BBAS) developed to bring together key measures of clinical care, operational performance, governance etc into one overarching framework to enable a comprehensive assessment of quality, safety and, care at ward, department or team level. The scheme would continue to be developed throughout implementation.

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**
• Identified an increase of SI reporting within the quality performance report as a positive improvement. (SAFE / WELL LED) • The Committee received and had been assured by the Hewitt HFEA Inspection report findings and action plan. The Committee noted three major areas of non-compliance listed, two of which had actions in place to address. The remainder remained open in relation to CE marked medical devices to be used when possible. The recommendation had been challenged based on internal VOC tests undertaken	• The Seven-day services report to be submitted to the Trust Board as mandated. • Approved the Adult Mortality Strategy.

on pots that demonstrated cell death and therefore not suitable for purposes of fertility testing. This had been reported to the MHRA and HFEA. Independent testing by the University of Liverpool was offered to support the case. The Committee was assured by evidence of achieving above the national target for embryo formation which demonstrated no negative impact from using the non-marked CE pots. (WELL LED)

- The Committee noted the ongoing management of the Imaging Serious Incidents declared in July 2022. A formal investigation led by external assessors had commenced in September 2022 and was due to be completed in November 2022. In lieu of the formal investigation report and recommendations the division had created a robust action plan to address issues swiftly. (ALL)
- A detailed thematic review of maternity SI's was considered. The main themes mirrored the themes identified by national reviews. The Committee was satisfied by the rigour applied. (ALL)
- The Committee received an update of compliance against the standards for the Maternity Incentive Scheme Year 4, notably Perinatal Quality Surveillance Dashboard (September 2022 data). The Trust aimed to sign off the majority of the standards at the December Trust Board meeting. (ALL)
- Received an overview of the role of the Maternity & Neonatal Safety Champions at both specialty and Board level. (ALL)
- Noted the 7-day service update and took assurance that there was adequate process in place to progress against the requirements laid out by the National Quality Board. It was recommended that the FPBD Committee should have sight of 24/7 cover to consider the financial impact. (WELL LED)
- Noted the Post implementation review against the Cost Improvement Programme 2021/22 and positive impact on quality of care and patient experience. (ALL)

Summary of BAF Review Discussion (Board Committee level only)

- The Committee reviewed the Quality related BAF risks. No risks closed on the BAF for Quality Committee.
- Committee requested detailed update against BAF risk 2.3 in relation to 24/7 anaesthetic cover at the next meeting.

Comments on Effectiveness of the Meeting / Application of QI Methodology

- Appropriate discussion dedicated to identified reports.
- Divisional presence at the meeting had been beneficial to present reports and receive direct feedback.

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
108.	Board Assurance Framework	Assurance	**115.**	Family Health Divisional Safety Champions – Q2 22-23 Report	Information
109.	Sub-committee Chair Reports	Assurance	**116.**	Medicines Management Assurance Report Quarter 2	Assurance
110.	Quality Performance Report Month 6, 2022/23	Assurance	**117.**	LocSSIPs Quarterly Assurance Report Quarter 2	Assurance
111.	Hewitt HFEA Inspection Report	Assurance	**118.**	Seven Day Services Working Board Assurance Bi-annual Update	Assurance
112.	Imaging Serious Untoward Incident Update	Information	**119.**	Be Brilliant Accreditation Scheme Update	Assurance
113.	Retrospective thematic review of maternity serious incidents	Information	**120.**	Adult Mortality Strategy	Approval
114.	Maternity Incentive Scheme (CNST) Year 4 – Scheme Update	Information	**121.**	CIP 21/22 Post Implementation Review	Assurance

3. 2022 / 23 Attendance Matrix

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

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	**22/23/136b**		**Date: 03/11/2022**	
Report Title	**Quality & Operational Performance Report**			
Prepared by	***Gary Price, Chief Operating Officer, Dr Lynn Greenhalgh, Medical Director and Dianne Brown, Interim Chief Nurse***			
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 6 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	October 22	COO	Detailed in Chair's Report
Quality Committee	October 22	COO	Detailed in Chair's 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.

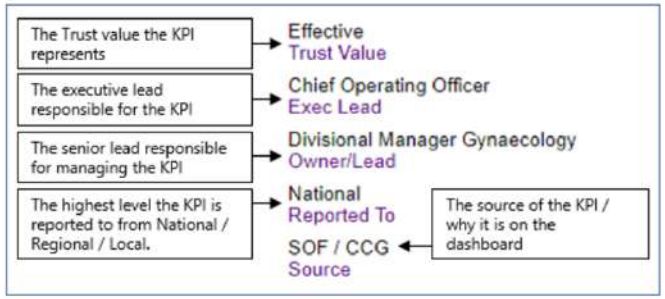
Cover Sheets - these provide an overview of performance with over arching narrative for each of the WE SEE values. In addition a selection of KPIs will be selected for a more in depth review. These are selected based on whether the KPI meets one or more of the following criteria:
•Outside of a control 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

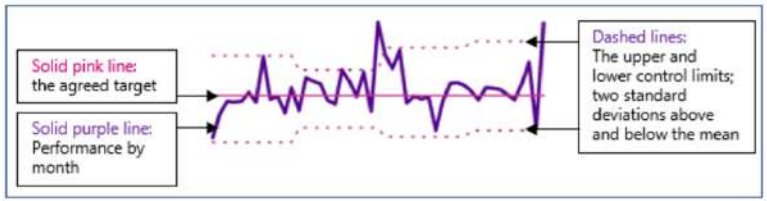
Data Sheets - these provide detailed information for each specific KPI measured. This includes data values for the previous 13 months, a sparkline included performance dating back to April 2018 where available. The sparkline graph includes the performance, target and control limits for the specific KPI. 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.

NHS
Liverpool Women's
NHS Foundation Trust

Trust Board

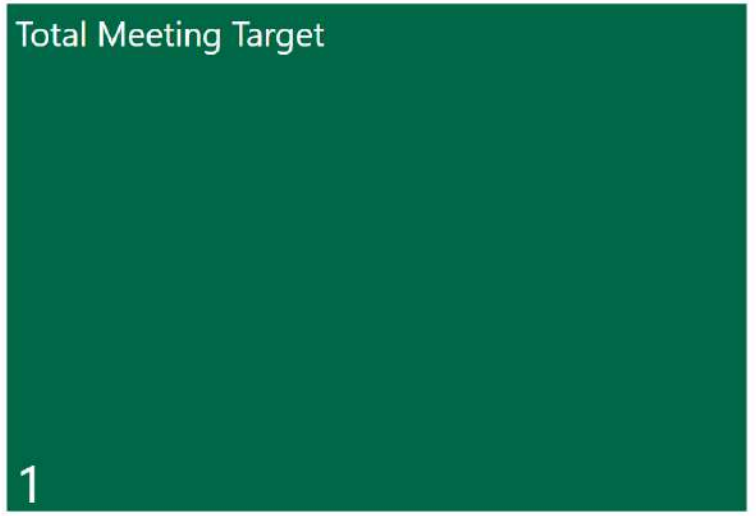
Performance Report

October 2022

WE SEE Summary

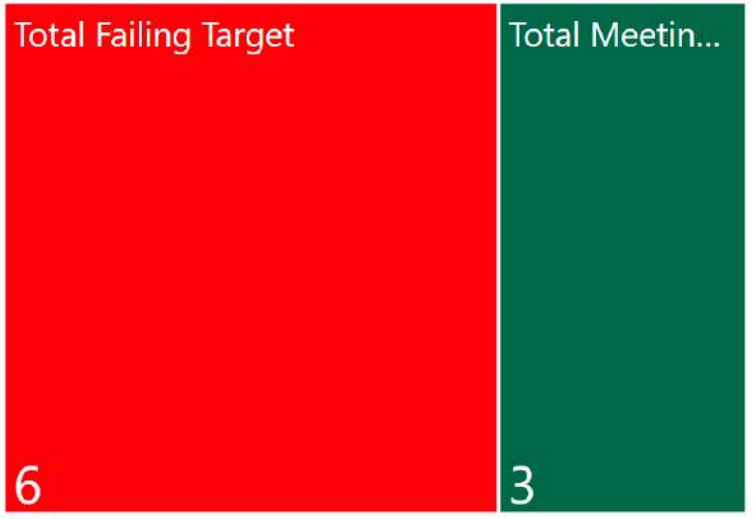
Workforce

Efficient



Safety

Effective



Experience

September – Maternity Facts

NHS Liverpool Women's NHS Foundation Trust

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

663 Babies Born

1 Set of Triplets

15 Home Births

Girls 315

348 Boys

1396 Visits to Maternity Assessment Unit

3 Breech Births

Spontaneous Vaginal Births 326

13 Sets of Twins

32 Women recruited to research studies

112 Elective C - Sections

153 Emergency C - Sections

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

Births on MLU 43

Instrumental Births 72

Women Booked For Care 769

20 Pool Births

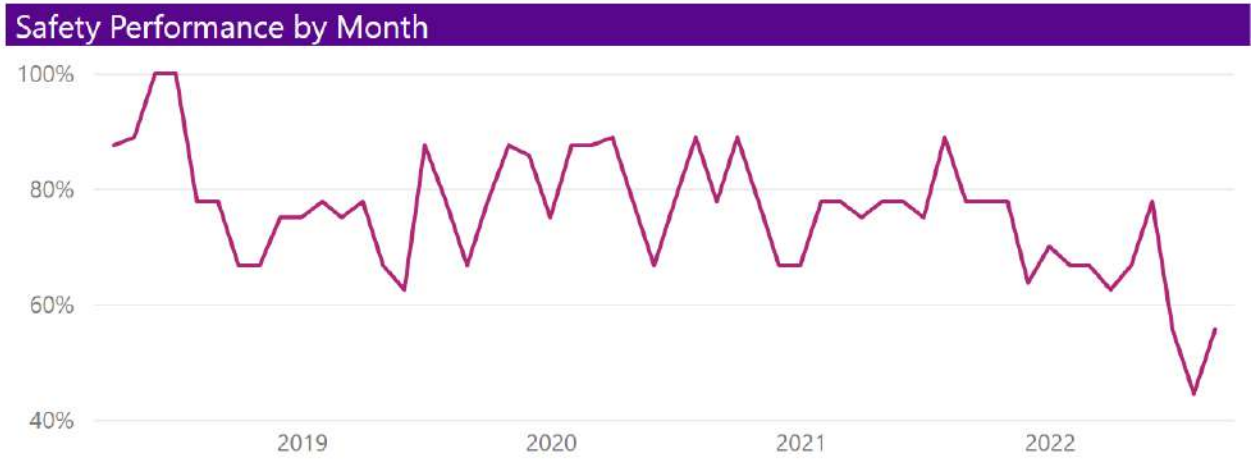
Heaviest Baby 11lb 1oz
Lightest Baby 1lb 6oz

Autumn Equinox 22nd September: 25 Births.

Our busiest day: 2nd September: 35 Births.

To deliver **Safe** services

Total Meeting Target	Total Failing Target
5	5



Positive Developments

SUIs rolling per year - This will continue to increase in line with positive reporting culture in the Trust to identify all Future Generations Serious Incidents.

Areas of Challenge

SUIs rolling per year – This has increased since previous reporting period in part due to an increase in reporting of cases related to our single site location

KPI	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Venous Thromboembolism (VTE)	87.96 %	90.64%	86.25 %	86.39 %	84.16 %	85.86 %	86.38%	89.11%	89.5%	87.26%	89.11%	83.92%	86.1%
Serious Untoward Incindents: New (Rolling per year)	20	20	18	19	20	20	22	22	24	22	30	31	36

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

To deliver Safe Services – Serious Incidents

Overview

There were 8 SIs in July 2022 and 2 in August 2022 making a total of 13 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	1	8	2								13

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

July 2022 Serious Incidents

Service	StEIS Ref.	Reported in Line with Policy	Summary
CSS – Gynae Theatres	2022-16017	Yes	Following surgery, an instrument (Malzoni Bipolar) was sent for cleaning and sterilisation. As part of standard protocol, the instrument is inspected by a member of the HSSU team before being sent for serialisation. It is at this time that the HSSU HCA has noticed that the instrument is damaged and missing a small piece from the tip approximately 1mm x 1.5 mm in diameter. The HCA had checked the bag that the instrument had been transported in for the missing piece but was unable to locate it. **Immediate Action Taken:** CSS Governance Manager to investigate and seek advice on the lifespan of a Malzoni bipolar, does age of the instrument play a factor in the possible deterioration through the sterilisation process over time. – The lead that connects to the Malzoni Bipolar has a lifespan of 50 uses, however the plastic sheath that slips over the piece of equipment does not. Report to be shared on Theatres Governance Boards for improved awareness and Learning. **Immediate Lesson Learnt:** Incident was presented in the daily safety and governance huddle (w/c 02/05/22) for two weeks, scrub practitioners asked to be vigilant when assembling and disassembling equipment. All theatres staff reminded of the importance of performing robust checks of all instrument pre and post-surgery. All instrumentation that are used are checked before and after the procedure to check that they are intact as part of the theatre time out and sign out. Staff are confirming that there are no equipment issues. If equipment issues are identified, inform the theatre team leader/coordinator, the piece of equipment will be quarantined, and a non-compliance form will be completed. Broken instrument has been used in training and awareness sessions, to ensure all staff aware of when performing checks before and after a procedure. This has taken place for two weeks (w/c 02/05/22) The instrument will then be sent for repair/ replacement.
Gynae	2022-14940	Yes	Patient attended as planned for a scan 3 weeks post surgical TOP. Scan was arranged at discharge as consultant felt there was less POC obtained than would be expected for the gestation . When patient was scanned it was determined she had a live intrauterine pregnancy greater than 12 weeks. **Immediate Action Taken:** 72-hour review for consideration as escalation to Serious Incident Duty of candour completed **Immediate Lesson Learnt:** To be determined following further investigation
CSS Imaging	2022 – 14853 Linked to 2022-13967	Yes	Baby transferred to LWH for paediatric review. Abnormality noted at birth of baby's left upper limb, no other abnormality noted at birth. Patient scanned five times within the imaging department, initial dating scan, 20-week anomaly scan and three growth scans. Potential missed opportunity for detection identified. Lack of regular peer auditing. **Immediate Action Taken:** Escalated as a serious incident. following Executive approval Linked to SI 2022- 13967 External partners notified External investigator appointed **Immediate Lesson Learnt:** To be determined following further investigation

To deliver Safe Services – Serious Incidents

July 2022 Serious Incidents

Service	StEIS Ref.	Reported in Line with Policy	Summary
Maternity	2022 – 14545 and 2022 - 14224	-	On Sunday 26.06.2022 and Wednesday 29.06.2022, Maternity Services at Liverpool Women's Hospital NHS Foundation Trust went into Divert following formal escalation. **Immediate Action Taken:** 72-hour escalation complete **Immediate Lesson Learnt:** No immediate lessons identified
Maternity	2022-15118	Yes	Patient had known cardiac condition, mitral valve replacement in 2009 and was under RLUH and LHCH. Booked under the Enhanced Midwifery Team and seen appropriately. Admitted to LWH with threatened pre-term labour on 25/06/22 and had Cat 2 caesarean section the following day, 26/06/22. Day 5 postnatal, condition deteriorated complaining of increasing pain. Discussion with HDU at RLUH, plan for CT scan. Transferred to RLUH. **Immediate Action Taken:** 72-hour report Escalated to SI investigation **Immediate Lesson Learnt:** No immediate lessons identified
Maternity	2022-15128	Yes	34weeks 0 days gestation. Delay from time of admission (19:53 hours) to initial review within Maternity Assessment Unit (21:40) of 107 minutes. When seen abnormal fetal heart rate pattern on electronic fetal monitoring system, requiring immediate delivery. Arrangements made for category 1 caesarean section. Baby required respiratory resuscitation and transferred to Neonatal Unit. No neurological issues during admission. **Immediate Action Taken:** 72-hour report Escalated to SI investigation Staffing levels monitored daily with Executive oversight. Where staffing levels fall below recommended safe staffing bank and agency deployed for the shortfall. **Immediate Lesson Learnt:** No immediate lessons identified
Maternity	2022-18827	Yes	Divert of maternity services Time of commencement of Divert: 30.07.2022 at 12.55.pm Time of Stand down of Divert: 30.07.2022 at 17.15pm. Total period of 4 hours and 20 minutes. **Immediate Action Taken:** Discussed with MOC, Consultant Obstetrician, DS shift leader, 104 Bleep holder and Intrapartum Matron - decision made to divert for a minimum period of 4 hours and then review again. MOC, Executive on call, 104 bleep holder and Intrapartum Matron contacted the following units for support. **Immediate Lesson Learnt:** Prompt escalation by the 104 Bleep holder to the MDT resulted in the safe redeployment of staff and recourses to maintain a safe service for women and their babies.

To deliver Safe Services – Serious Incidents

July 2022 Serious Incidents

Service	StEIS Ref.	Reported in Line with Policy	Summary
Maternity	2022 – 14545 and 2022 - 14224	-	Elective reintubation on the neonatal unit on 12/07/22 with unexpected clinical deterioration leading to full resuscitation and death. Preterm baby receiving respiratory support via a ventilator. Decision made on ward round to change the breathing tube due to a leak around the tube. During insertion of final tube baby did not recover, resuscitated but unfortunately passed away. **Immediate Action Taken:** Discussion with parents 72-hour review initiated MDT debrief Externally reportable to HM Coroner **Immediate Lesson Learnt:** None immediately identified pending investigation

Detail for August 2022 incidents to follow in December 2022 (post November 2022 Quality Committee)

To deliver Safe Services – Serious Incidents

HSIB Cases Reported and NHSR Early Notification Scheme

During July 2022 there was 1 case which met the HSIB criteria and have been reported to HSIB.

	Jan	Feb	Mar	April	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Total
2019	0	3	1	0	3	1	2	0	0	0	1	2	13
2020	1	3 (1 rejected)	1 (rejected)	0	0	0	4 (3 rejected)	0	0	2	3 (2 rejected)	0	14
2021	1	1	2	0	2	0	1	0	3	1	3	1	7
2022	2	1	3	2	0	2	1	0					11 to date

Duty of Candour
There were 8 serious incidents reported in July 2022 and 2 in August 2022. Duty Of Candour was 100% compliant where DoC was applicable.

Overdue Actions for reported Sis
There are currently no overdue serious incident submissions due with the ICB that have not had extension requests.
There are currently 28 action plans under review following feedback highlighted from the ICB. These relate to overdue actions and associated evidence relating to historical and recent submissions. The divisional governance managers are currently reviewing their overdue action plans and are collating evidence for submission to the ICB. Progress is being supported and monitored by the Corporate Governance Team on a weekly basis.

Dissemination of learning from serious incidents

The Trust communicates learning from serious incidents via a number of ways such as the following:

•Learning and engagement teams events held online Trust wide for all services to present and discuss learning
•The weekly safety check in for all services to present and discuss learning
•Governance Boards within the divisions to share learning
•Trust wide shared learning portal to upload all divisional learning such as 7-minute briefings accessible to all staff
•The Safety and Effectiveness Sub Committee serious incident report
•Staff communications via secure social media
•SBARS
•The Divisional Governance Teams have been requested to provide evidence of embedded learning from October 2022 – this will be reported via the Safety and Effectiveness Sub – Committee and via this report into Quality Committee

To deliver Safe services - Safer Staffing

July 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	72.50%	86.67%	116.67%	100.00%	* Staffing fill rates are reflective of the bed occupancy on HDU and inpatient ward allowing for redeployment of RN to support the ward and Ward Manager working clinically covering last minute sickness, all shifts out to NHSP bank to cover vacancies * overfill rates on nights are to allow for senior nurse cover to rotate between ward and GED
Induction & Delivery Suites	79.23%	80.00%	83.85%	105.00%	*Safe 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, an escalation of CoC Midwives as per policy. Vacant shifts are requested to be filled with bank and agency as required.
Maternity & Jeffcoate	67.14%	78.57%	73.81%	85.05%	*/**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 and ensure safe care maintained across maternity services.
MLU	58.33%	60.00%	70.83%	63.33%	*/**Due to internal escalation, there were 10 episodes of closure of MLU in month- and the staffing fill rate is reflective of the deployment of staff on these occasions to Delivery Suite to consolidate activity through one area for both RM and Care Staff.
Neonates (ExTC)	102.11%	76.67%	98.60%	93.33%	Fill rates are reflective of occupancy and acuity, safe staffing has been maintained throughout the month.
Transitional Care	36.67%	116.67%	83.33%	63.33%	Fill rates are reflective of occupancy and safe staffing was maintained throughout the month.

To deliver Safe services - Safer Staffing

Gynaecology: September Fill Rate

Fill rate - September staffing fill rate is reflective of the current RN vacancy position alongside short and long-term sickness. This is, further challenged with maternity leave, however, safe staffing has been maintained by the ability to flexibly rotate RN across the division. Due to the low bed occupancy of 33.61% in HDU the team have supported ward inpatient care. The fill rate of 111.29% RN on nights is the reflection of senior RN cover rotating between GED and inpatient areas. The allocate rostering system has improved to support managers to make staff moves from other departments, with some further improvements expected the following month

Attendance/ Absence - September sickness is 13.29% with 25.65% reflective of short-term sickness and 74.35% long-term sickness. Return to works are managed as per policy accordingly. Maternity leave equates 1.61WTE

Vacancies – 2.84% WTE RN vacancies, 1 WTE HCA vacancies with all vacancies out to recruitment

Red Flags – No red flags reported

Bed Occupancy – bed occupancy for the inpatient ward was 64.59%

CHPPD – 4.1

Neonates: September Fill Rate

Fill-rate – Occupancy and acuity throughout September has remained high, however slightly lower than previous months. Intensive care and High dependency occupancy are 77.8% and 88.9% respectively, safe staffing has been maintained and fill rates are reflective of occupancy and acuity. The increase activity has seen an increase in bank nurse usage. The escalation policy has not been used this month.

Attendance/Absence - Sickness is running at 6.49% with little change from the previous months. Of this 70% is long term and 30% short term. Less than 1% is covid sickness. Maternity leave stands at 14.82 wte. Turnover remains well below the national average at just under 8%.

Vacancies - There has been successful recruitment campaigns at band 6, 5 and 4. There are currently only 4 wte band 5 vacancies and 4 band 6 vacancies with band 6 vacancies due to secondments and not currently being backfilled. Neonatal services have appointed 4 trainee ANNP's to start in January 2023. Band 3 vacancies are out to advert. Successful recruitment across the Liverpool Neonatal Partnership has been undertaken.

Red Flags – No red flags reported

Bed Occupancy – Activity remains high within the NICU with overall occupancy at 89.2%. Intensive care activity is down just under 9% on last months, High dependency has risen slightly up from 85.5% to 88.9% and Low dependency has dropped from 115.2% to 96.3%. However, this reflects higher activity than expected. Safe staffing has been maintained throughout.

To deliver Safe services - Safer Staffing

Maternity: September Fill Rate

Fill-rate – Bank and agency usage continues due to sickness rates and to cover vacancy gaps. Maternity has been required to close MLU during this reporting period on 10 occasions, to allow a consolidation of midwifery staffing to one clinical area. Clinical activity and staff rostered to MLU have been reallocated across the first floor of Maternity Services, to maintain safe midwifery care. Maternity undertakes a 4-hourly activity /acuity review, which allows senior midwifery staff to maintain safety by rotating staff to the areas of highest clinical need. Midwifery managers and specialist midwives have been rostered into clinical rota gaps to support safe staffing, with a requirement to escalate CoC On call midwives as per internal escalation policy.

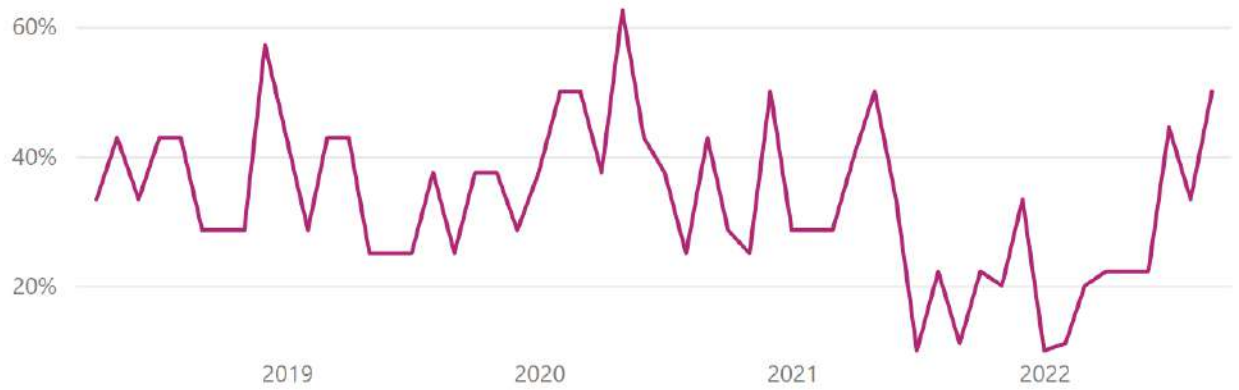
Attendance/ Absence – Maternity sickness is reported at 9.58% which is a combination of clinical, non-clinical and administration staff. This is a decrease from the previous month at 10.53% and is a reduction from the same period in 2021, continuing with a downward trajectory. Maternity has a higher rate of long-term than short-term sickness (34%STS versus 66%LTS), with the top reasons for short-term absence being cough/cold or gastrointestinal problems. 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 Deputy HOM continues on a bi-weekly basis and this oversight has supported the resolution of, and overall reduction in active LTS and resolution of cases. Maternity leave equates to 12.83wte across all staff groups.

Vacancies – Following a significant recruitment drive and the early receipt of NMC Pin for 6 newly registered midwives, we were able to commence employment earlier than planned in October for their orientation period. We also welcomed 3.00wte Band 6 Midwives. 38 NQM equating to 35.73wte are scheduled to commence in the Autumn cohort, with additional 8 NQM equating to 7.64wte recruited for January start date. Additionally, 2.00wte Band 6 Midwives are currently undergoing recruitment checks, with a rolling advert maintained. Following our IR as part of the collaborative NW bid, we are expecting the first of our Internationally educated midwives to arrive in the Trust before December 2022.

Red Flags – Following the implementation of the Birth Rate Plus Intrapartum App- this now allows live reporting and further triangulation of incident reports with immediate narrative as actions and escalation from the intrapartum coordinators. Ongoing work with the IOL workstream has developed a dashboard for visibility of delays across the Trust, with the most frequent red flag reported being a locally added delay > 4hrs for ongoing IOL.

Bed Occupancy – Maternity continues to experience high levels of clinical activity and referrals from other units as a tertiary provider including in utero transfers for extreme preterm infants from the NW Coast and subsequently impacting on the high occupancy of the Neonatal Unit in month. Intermittent closure of the MLU due to staffing concerns and acuity has reduced the overall Intrapartum capacity and our low-risk offer, however the homebirth service has been maintained to facilitate a low risk choice for women.

To deliver the most **E**ffective outcomes



Positive Developments

- Sustained and improving cancer position across 2WW, 31 DTT (improved to 89%) and 62 day position (35% in August)
- Continue to have Zero 104+ week waits and 78+ week patients being managed proactively

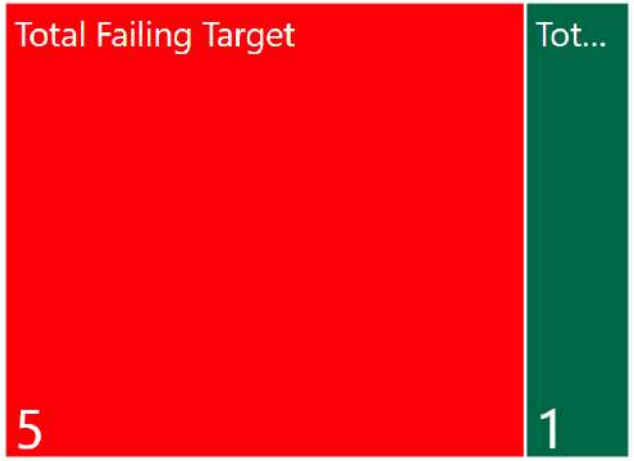
Areas of Challenge

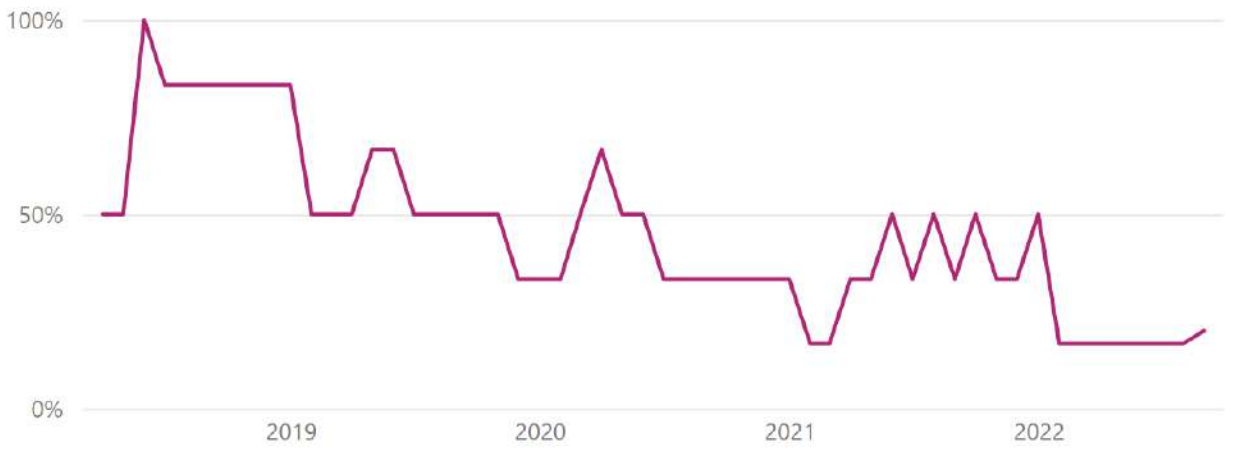
- 52+ weeks remains a challenge. Elective Recovery plan in place with a number of actions ongoing to increase capacity. Weekly and fortnightly meetings targeted at long waits and actions being taken to mitigate
- Ambulatory capacity – increasing demand and restrictions with capacity impacting ability to treat ambulatory patients. Bid submitted to Cancer Alliance for additional capital to support – business case in development which will also feature in planning discussions for 23/24.
- Consultant sickness – increasing numbers of consultants on long term sick or absence impacting capacity. Ongoing into September and October

KPI	September 2021	October 2021	November 2021	December 2021	January 2022	February 2022	March 2022	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022
18 Week RTT: Incomplete Pathway > 104 Weeks	3	1	0	0	1	1	0	0	0	0	0	0	0
18 Week RTT: Incomplete Pathway > 52 Weeks	256	288	294	354	406	479	544	816	1145	1571	1850	2097	2334
18 Week RTT: Incomplete Pathway > 78 Weeks	39	21	3	3	11	12	12	26	29	33	35	40	52
All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (After Re-allocation)	6.06%	18.18%	44.83%	54.55%	34.78%	47.06%	18.75%	26.92%	29.17%	12.5%	10%	35.71%	
Cancer: 104 Day Breaches	5	3	3	3	2	2	2	4	2	4	3	4	
Cancer: 2 Week Wait	96.06%	95.33%	97.04%	95.31%	76.65%	81.91%	67.87%	11.9%	52.71%	88.47%	93.29%	95.74%	
Cancer: 28 Day Faster Diagnosis	49.12%	64.14%	60.5%	59.93%	54.1%	57.91%	61.07%	55.1%	60.06%	58.63%	60.26%	61.1%	
Cancer: 31 Days from Diagnosis to 1st Definitive Treatment	54.05%	56.76%	86.67%	93.1%	84.62%	84.380%	95.65%	85.71%	84%	88.46%	96.3%	87.5%	
Overall size of Elective Waiting List	12389	12458	12736	13017	13481	13945	14461	15027	15553	16206	16559	17181	17677

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

Division and Department are reviewing the Friends and Family displeased comments and triangulating information to support improvements. Current themes indicate the relationship to wait times for scan is a repeated displeased response. Division are reviewing the service within GED for early pregnancy scans.

Areas of Challenge

FFT % positive in A&E – this remains below threshold since November 2021, with little improvement .

KPI	September 2021	October 2021	November 2021	December 2021	January 2022	February 2022	March 2022	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022
A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge	97.43% ↑	96.58% ↓	98.64% ↑	95.36% ↓	97.02% ↑	94.11% ↓	89.73% ↓	90.94% ↑	92.38% ↑	91.55% ↓	89.2% ↓	89.85% ↑	89.66% ↓
Diagnostic Tests: 6 Week Wait	69.65% ↓	85.81% ↑	87.25% ↑	90.13% ↑	83.08% ↓	94.39% ↑	88.32% ↓	71.08% ↓	77.74% ↑	89.47% ↑	90% ↑	79.29% ↓	
Friends & Family Test: A&E % positive	75% ↓	96.67% ↑	86.21% ↓	88.89% ↑	85.71% ↓	80.77% ↓	85.71% ↑	83.08% ↓	85.37% ↑	84% ↓	81.91% ↓	78.82% ↓	78.57% ↓

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

Neonatal Deaths per 1000 live Births

Target: **(Blank)**

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

DQKM

Safety
Trust Value

Medical Director
Exec Lead

Clinical Director Family Health
Owner/Lead

Local
Reported To

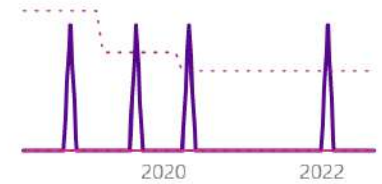
Trust
Source

Never Events

Target: **0**

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

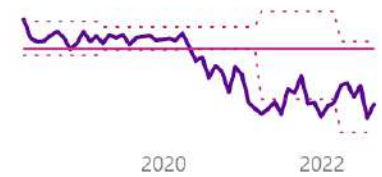
Target: **>= 95%**

Attribute	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
% Performance	↓ 87.96%	↑ 90.64%	↓ 86.25%	↑ 86.39%	↓ 84.16%	↑ 85.86%	↑ 86.38%	↑ 89.11%	↑ 89.5%	↓ 87.26%	↑ 89.11%	↓ 83.92%	↑ 86.1%
Denominator	↓ 1138	↑ 1111	↓ 1098	↑ 1029	↓ 1111	↑ 1011	↑ 1109	↑ 1047	↑ 1114	↓ 1052	↑ 1111	↓ 1157	↑ 1122
Numerator	↓ 1001	↑ 1007	↓ 947	↑ 889	↓ 935	↑ 868	↑ 958	↑ 933	↑ 997	↓ 918	↑ 990	↓ 971	↑ 966

DQKM

May 2022

The divisional actions taken is starting to demonstrate an improvement in VTE performance, however it is acknowledged this remains under threshold. The division anticipate this 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

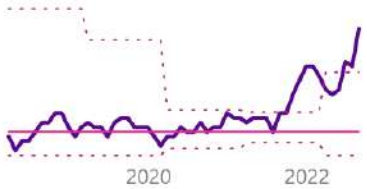
National
Reported To

SOF / CCG
Source

Serious Untoward Incidents: Open

Target: **<5**

Attribute	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Performance Value	9	9	13	16	19	19	17	14	13	14	20	19	27



Safety
Trust Value

Director of Nursing & Midwifery
Exec Lead

Head of Governance
Owner/Lead

TBC
Reported To

TBC
Source

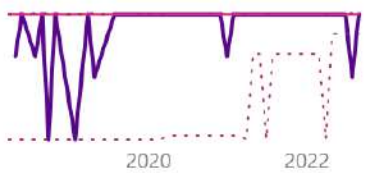
DQKM

July 2022 There had been a spike in SI's reported in July 2022. The reduced number of Investigating officers (IOs) has impacted the ability for timely investigation. This has since been rectified as further IO's trained. Weekly cross-divisional governance meetings provide oversight and monitoring. Following the increase seen, 1 SI de-escalated, 2 are finalised. No SI's are overdue.

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

Target: **1**

Attribute	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
% Performance	100%	100%	100%	100%	100%	100%	100%		100%	100%	100%	50%	100%
Denominator	4	1	4	3	4	2	3	0	2	1	8	2	9
Numerator	4	1	4	3	4	2	3	0	2	1	8	1	9



Safety
Trust Value

Director of Nursing & Midwifery
Exec Lead

Head of Governance
Owner/Lead

TBC
Reported To

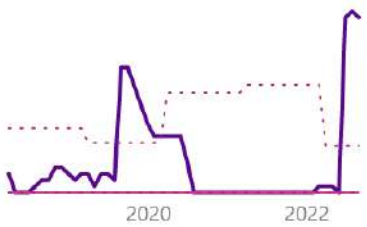
TBC
Source

DQKM

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

Target: **0**

Attribute	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Performance Value	0	0	0	0	0	0	1	1	1	0	28	29	28



Safety
Trust Value

Director of Nursing & Midwifery
Exec Lead

Head of Governance
Owner/Lead

TBC
Reported To

TBC
Source

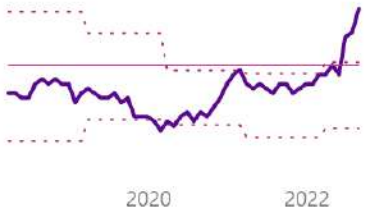
DQKM

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

Serious Untoward Incidents: New (Rolling per year)

Target: **24 /year**

Attribute	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Performance Value	20	20	18	19	20	20	22	22	24	22	30	31	36



Safety
Trust Value

Director of Nursing & Midwifery
Exec Lead

Head of Governance
Owner/Lead

TBC
Reported To

TBC
Source

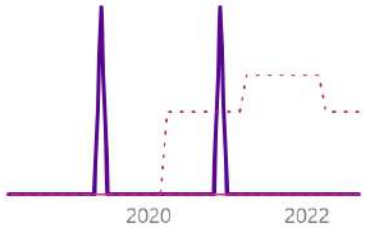
DQKM

Infection Control: MRSA

Target: **0**

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

Infection Control Lead
Owner/Lead

National
Reported To

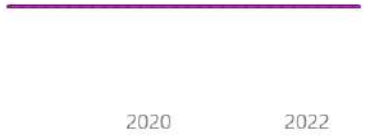
SOF / CCG
Source

Infection Control: Clostridium Difficile

Target: **1**

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

Infection Control Lead
Owner/Lead

National
Reported To

SOF / CCG
Source

Flu Vaccine Uptake Trustwide

Target: **>=100%**

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

DQKM

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

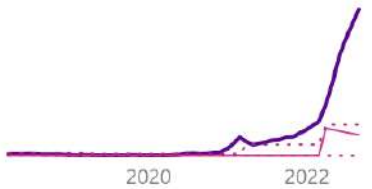
Target: **0**

Attribute	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Performance Value	↑ 256	↑ 288	↑ 294	↑ 354	↑ 406	↑ 479	↑ 544	↑ 816	↑ 1145	↑ 1571	↑ 1850	↑ 2097	↑ 2334
Target Value	↑ 0	↑ 0	↑ 0	↑ 0	↑ 0	↑ 0	↑ 0	↑ 430	↑ 410	↑ 390	↑ 370	↑ 350	↑ 330

DQKM

September 2022

The Trust has seen significant pressure on the number of 52 week patients. The numbers continue to increase due to; Consultant long term absence, increase in referrals due to late presentation due to COVID pandemic as well as a shortfall in general gynaecology capacity. The Gynaecology Division are developing a paper on Elective Recovery for FPBD in October which will outline short & long term requirements to reduce the number of long waits. This will take at least 18 months to reduce back to 0. System requires no patient to be seen longer than 78 weeks by March 2023. The Trust is managing these through weekly meetings to track individual patients and summary of actions being taken is being presented through Access Recovery Board.



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

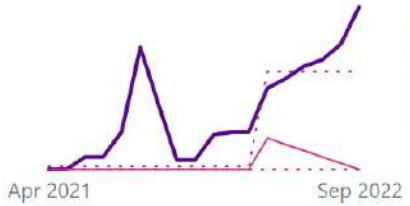
Target: **0**

Attribute	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Performance Value	↑ 39	↓ 21	↓ 3	→ 3	↑ 11	↑ 12	→ 12	↑ 26	↑ 29	↑ 33	↑ 35	↑ 40	↑ 52
Target Value	↑ 0	↓ 0	↓ 0	→ 0	↑ 0	↑ 0	→ 0	↑ 10	↑ 8	↑ 6	↑ 4	↑ 2	↑ 0

DQKM

August 2022

The Trust has instigated weekly 78+ week meetings to individually track patients over 78 weeks to ensure all have plans in place and to expedite activity where appropriate. Summary of position will be provided to the Deputy COO and this will be monitored through Access Recovery board



Effective
Trust Value

Chief Operating Officer
Exec Lead

Deputy Chief Operating Officer
Owner/Lead

National
Reported To

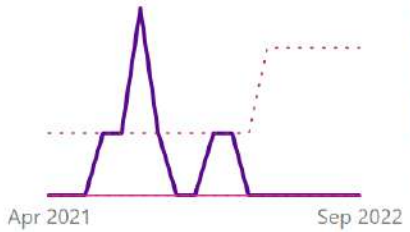
SOF / CCG
Source

18 Week RTT: Incomplete Pathway > 104 Weeks

Target: **0**

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

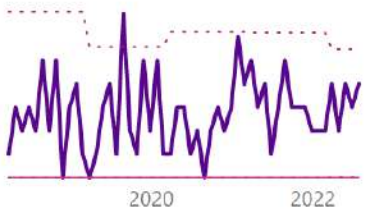
SOF / CCG
Source

Cancer: 104 Day Breaches

Target: **0**

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

DQKM



Effective
Trust Value

Chief Operating Officer
Exec Lead

Divisional Manager Gynaecology
Owner/Lead

National
Reported To

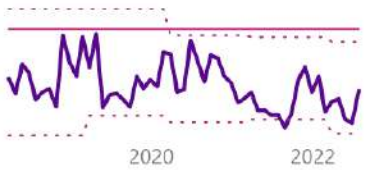
External
Source

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

Target: >=85%

Attribute	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22
% Performance	16.22%	6.06%	18.18%	44.83%	54.55%	34.78%	47.06%	18.75%	26.92%	29.17%	12.5%	10%	35.71%
Denominator	18.5	16.5	16.5	14.5	11	11.5	8.5	16	13	12	12	10	14
Numerator	3	1	3	6.5	6	4	4	3	3.5	3.5	1.5	1	5

DQKM



Effective
Trust Value

Chief Operating Officer
Exec Lead

Divisional Manager Gynaecology
Owner/Lead

National
Reported To

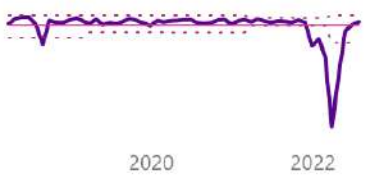
CCG
Source

Cancer: 2 Week Wait

Target: >= 75%

Attribute	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22
% Performance	96.42%	96.06%	95.33%	97.04%	95.31%	76.65%	81.91%	67.87%	11.9%	52.71%	88.47%	93.29%	95.74%
Denominator	279	279	300	338	277	257	293	305	294	425	295	313	376
Numerator	269	268	286	328	264	197	240	207	35	224	261	292	360

DQKM



Effective
Trust Value

Chief Operating Officer
Exec Lead

Divisional Manager Gynaecology
Owner/Lead

National
Reported To

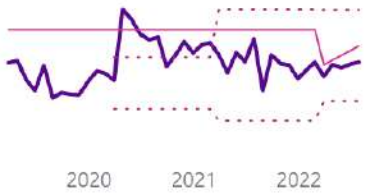
CCG
Source

Cancer: 28 Day Faster Diagnosis

Target: >= 75%

Attribute	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22
% Performance	71.12%	49.12%	64.14%	60.5%	59.93%	54.1%	57.91%	61.07%	55.1%	60.06%	58.63%	60.26%	61.1%
Denominator	232	397	290	362	287	305	297	298	314	328	307	307	347
Numerator	165	195	186	219	172	165	172	182	173	197	180	185	212
Target %	75%	75%	75%	75%	75%	75%	75%	75%	60%	62%	64%	66%	68%

DQKM



Effective
Trust Value

Chief Operating Officer
Exec Lead

Divisional Manager Gynaecology
Owner/Lead

National
Reported To

SOF / CCG
Source

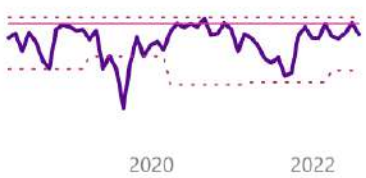
Cancer: 31 Days from Diagnosis to 1st Definitive Treatment

Target: >=96%

Attribute	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22
% Performance	68.97%	54.05%	56.76%	86.67%	93.1%	84.62%	84.380%	95.65%	85.71%	84%	88.46%	96.3%	87.5%
Denominator	29	37	37	30	29	26	32	23	21	25	26	27	32
Numerator	20	20	21	26	27	22	27	22	18	21	23	26	28

DQKM

August 2022 .



Effective
Trust Value

Chief Operating Officer
Exec Lead

Divisional Manager Gynaecology
Owner/Lead

National
Reported To

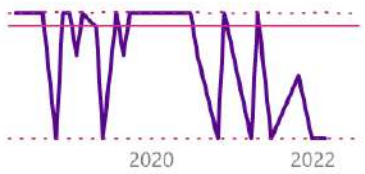
CCG
Source

Cancer: 62 Day Screening Referrals (Percentage)

Target: >=90%

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

DQKM



Effective
Trust Value

Chief Operating Officer
Exec Lead

Divisional Manager Gynaecology
Owner/Lead

National
Reported To

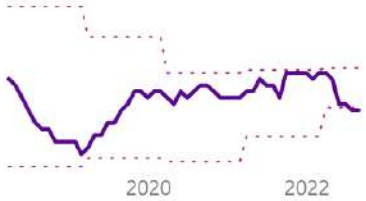
CCG
Source

Intensive Care Transfers Out (Rolling 12 Months)

Target: (Blank)

Attribute	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Performance Value	↓ 11	↑ 15	→ 15	→ 15	→ 15	↓ 14	↑ 15	→ 15	↓ 14	↓ 10	→ 10	↓ 9	→ 9

DQKM



Effective
Trust Value

Medical Director
Exec Lead

Deputy Medical Director
Owner/Lead

Local
Reported To

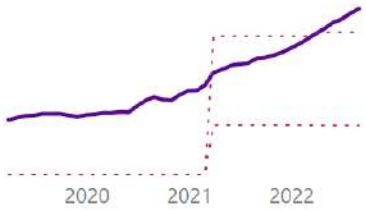
Trust
Source

Overall size of Elective Waiting List

Target: (Blank)

Attribute	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Performance Value	↑ 12389	↑ 12458	↑ 12736	↑ 13017	↑ 13481	↑ 13945	↑ 14461	↑ 15027	↑ 15553	↑ 16206	↑ 16559	↑ 17181	↑ 17677

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

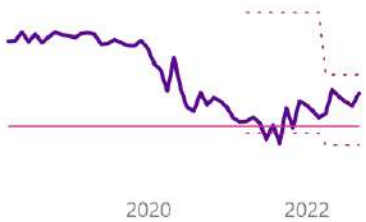
Target: >=96%

Attribute	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
% Performance	↓ 95.45%	↑ 96.58%	↓ 95.94%	↑ 96.8%	↓ 96.68%	↓ 96.49%	↓ 96.27%	↑ 96.41%	↑ 97.16%	↓ 96.94%	↓ 96.79%	↓ 96.65%	↑ 97.04%
Denominator	↓ 15339	↑ 14525	↓ 15273	↑ 13116	↓ 14184	↓ 13606	↓ 15244	↑ 13938	↑ 15695	↓ 14553	↓ 14374	↓ 15739	↑ 15300
Numerator	↓ 14641	↑ 14028	↓ 14653	↑ 12696	↓ 13713	↓ 13128	↓ 14675	↑ 13438	↑ 15250	↓ 14108	↓ 13912	↓ 15212	↑ 14847

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

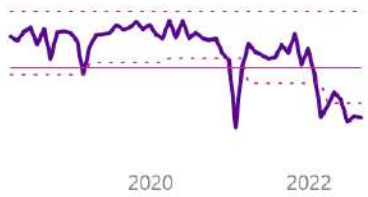
National
Reported To

SOF
Source

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

Target: >= 95%

Attribute	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
% Performance	97.43%	96.58%	98.64%	95.36%	97.02%	94.11%	89.73%	90.94%	92.38%	91.55%	89.2%	89.85%	89.66%
Denominator	971	1052	883	969	1039	1086	1139	1038	1129	1112	1194	1182	1209
Numerator	946	1016	871	924	1008	1022	1022	944	1043	1018	1065	1062	1084



Experience
Trust Value

Chief Operating Officer
Exec Lead

Divisional Manager Gynaecology
Owner/Lead

National
Reported To

CCG
Source

DQKM

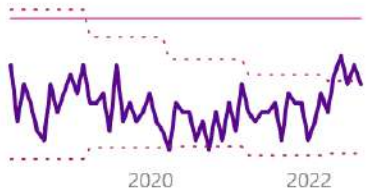
September 2022

A&E performance has reduced however following further investigation several of the patients waiting longer than 4 hours are pregnancy related and therefore should be excluded. The division are working with corporate teams to understand how pregnancy patients can be removed moving forward.

Complaints: Number Received

Target: <= 15

Attribute	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Performance Value	2	7	6	6	2	4	7	5	9	11	8	10	8



Experience
Trust Value

Director of Nursing & Midwifery
Exec Lead

Head of Audit, Effectiveness an...
Owner/Lead

Local
Reported To

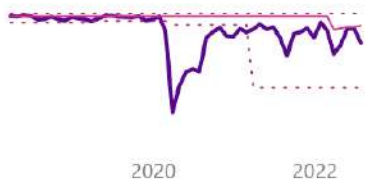
Trust
Source

DQKM

Diagnostic Tests: 6 Week Wait

Target: >= 99%

Attribute	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22
% Performance	82.73%	69.65%	85.81%	87.25%	90.13%	83.08%	94.39%	88.32%	71.08%	77.74%	89.47%	90%	79.29%
Denominator	695	794	747	737	628	733	713	796	816	867	731	780	845
Numerator	575	553	641	643	566	609	673	703	580	674	654	702	670
Target %	99%	99%	99%	99%	99%	99%	99%	99%	89%	90%	91%	91%	92%



Experience
Trust Value

Chief Operating Officer
Exec Lead

Divisional Manager Clinical Sup...
Owner/Lead

National
Reported To

CCG
Source

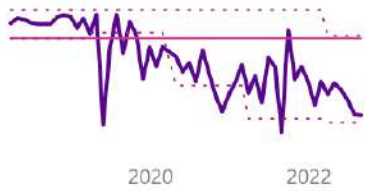
DQKM

Overall performance for DM01 in July was 90.00% with 702/780 diagnostic tests completed within 6 weeks. This represents a 5% increase on June's position. Positive performance was seen in DEXA, which saw all patients within the 6-week target. Non-obstetric ultrasound performed well at 95% and Cystometry continues to hamper the DM01 performance with 58% tests (n= 63/111) completed within target. Gynaecology divisional management have been tasked with creating a mitigating action plan for cystometry, which is scheduled to be presented at the next Access Recovery Board (29/08/22).

Friends & Family Test: A&E % positive

Target: **95%**

Attribute	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
% Performance	75%	96.67%	86.21%	88.89%	85.71%	80.77%	85.71%	83.08%	85.37%	84%	81.91%	78.82%	78.57%
Denominator	36	30	29	36	35	26	28	65	82	75	94	85	14
Numerator	27	29	25	32	30	21	24	54	70	63	77	67	11



Experience
Trust Value

Director of Nursing & Midwifery
Exec Lead

Head of Nursing Gynaecology
Owner/Lead

National
Reported To

External
Source

DQKM

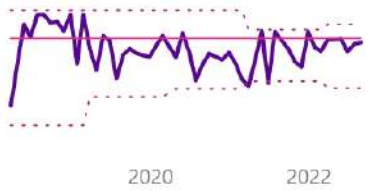
September 2022

Positive response rate for A&E in September showed a slight decrease compared to August, the department continue to promote FFT responses
The division are reviewing and triangulating the displeased comments in order to respond to feedback
which are shared on "you said we did " board

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

Target: **0.95**

Attribute	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
% Performance	94.53%	92.79%	90%	88.89%	96.4%	93.07%	92.23%	94.74%	94.74%	94.95%	92.16%	93.75%	94.12%
Denominator	128	111	130	108	111	101	103	114	95	99	102	96	17
Numerator	121	103	117	96	107	94	95	108	90	94	94	90	16



Experience
Trust Value

Director of Nursing & Midwifery
Exec Lead

Head of Nursing Gynaecology
Owner/Lead

National
Reported To

External
Source

DQKM

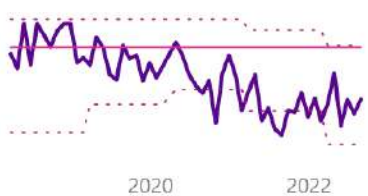
August 2022

93.75% positive response received, we continue to monitor responses and 96 patients eligible to feedback positively 90 received

Friends & Family Test: Maternity % positive

Target: **95%**

Attribute	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
% Performance	76.28%	81.52%	81.2%	85.27%	80.14%	84.09%	79.28%	83%	89.47%	78.33%	83.76%	80.83%	83.87%
Denominator	156	184	133	129	146	132	111	100	95	120	117	120	31
Numerator	119	150	108	110	117	111	88	83	85	94	98	97	26



Experience
Trust Value

Director of Nursing & Midwifery
Exec Lead

Head of Midwifery
Owner/Lead

National
Reported To

External
Source

DQKM

August 2022

97 out of 120 patients who responded were pleased with their care in maternity services in LWH. Currently in the process of trying to increase number of response received. I Pads are being ordered for the maternity ward, to allow women to provide direct feedback prior to being discharged from the ward.

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	September 2022	>= 95%	No	LCL Breached
Director of Nursing & Midwifery	Friends & Family Test: In-patient/Daycase % positive	September 2022	0.95	No	LCL Breached
Director of Nursing & Midwifery	Friends & Family Test: Maternity % positive	September 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				Y		
Financial Sustainability Risk Rating: Overall Score	Efficient	Y	Y							
Flu Vaccine Uptake Trustwide	Safety	Y	R	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						
Serious Untoward Incidents: Number of SUI's with actions outstanding	Safety	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)	*22/23/136c*		Date: 03/11/2022	
Report Title	Mortality and Learning from Deaths Report Quarter 1, 22/23			
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 Committee members are asked to review the contents of the paper and take assurance that there is adequate processes and progress against the requirements laid out by the National Quality Board			
Action required	Approve ☐	Receive ☐	Note ☒	Take Assurance ☒
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable): N/A			
	For Decisions - in line with Risk Appetite Statement – Y *If no – please outline the reasons for deviation.*			
	It is 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.* *• Compliance with SA1 for the MIS of CNST.*			
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

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Quality Committee	24/10/2022	Medical Director	The Committee was assured by the report.

EXECUTIVE SUMMARY

This "Mortality and Learning from Deaths" paper presents the mortality data for quarter 1, 2022/23 with the learning from the reviews of deaths from quarter 4 2021/22. The 'learning' can take some time after the death occurs due to the formal processes and MDT review process that occur. This results in the learning being presented a quarter behind the data.

The paper also provides the board with compliance data for the Maternity Incentive Scheme year 4, safety action 1: *Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?*

The MIS recommenced on May 6th 2022. This paper provides assurance to the board that we are compliant with SA1 in the current reporting period.

In quarter 1 there were the following deaths:

Adult deaths	**2 (both expected)**
Direct Maternal Deaths	**0**
Stillbirths	**7 (excluding terminations of pregnancy) (rate 3.7/1000 total births)**
Neonatal deaths	**9 inborn (rate 4.8/1000 inborn births) + 4 deaths from postnatal transfers**

The stillbirth rate is lower in this quarter than the previous 4 quarters, although caution of interpretation due to small numbers is warranted. An annual review of stillbirths for 2021/22 was completed and presented to the quality committee, and is embedded in this document for information.

The neonatal mortality rate is presented. Benchmarking with the Vermont Oxford Network for babies >1500g is presented showing that the mortality for 2021 was well within the network interquartile range for the first time in several years.

Learning from PMRT reviews is presented with more detailed information relating to the reviews in the paper.

Recommendation: 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.
- Compliance with SA1 for the MIS of CNST.

MAIN REPORT

This is the quarter 1 2022/23 mortality report for adults, stillbirths and neonates. The report is part of the regular reporting schedule of the Trust to ensure that there is oversight and assurance monitoring of the mortality rates related to the clinical activity of the Trust. This is in accordance with recommendations by the National Quality Board "National Guidance on Learning from Deaths" 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) which was recommenced on May 6th 2022.

The data presented in this report relates to quarter 1 2022-23. The learning relates to deaths in Q4 2021-22. This is due to the multidisciplinary review of deaths not occurring in the quarter when the death occurred.

Additional data/information 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 number of deaths in our care 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 Q1 2022/23

There were no direct maternal deaths (deaths within 42 days of delivery) in quarter 1.

1.2 Learning from Obstetric Mortality Data

In Q3 2022/23, 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. This review is on-going. The outcome and learning from the review and investigation will be included in this report when available.

1.3 Gynaecology Mortality data Q1 2022/23

There were 2 deaths within Gynaecology Oncology in Q1 2022/23. Both were expected deaths due to gynaecological malignant conditions.

1.4 Learning from Gynaecology Mortality Q4 2021/22

There were no deaths subject to investigation in Q4 2021/22.

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 3.7/1000 live births for Q1.

STILLBIRTHS	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	TOTAL 2022/23
Total Stillbirths	7	4	2	4	6	3	7	4	6	3	4	3	10
Stillbirths (excluding TOP)	**7**	**3**	**1**	**3** (2 preg)	**5**	**2**	**4**	**0**	**5**	**1**	**4**	**2**	**7**
Births	692	695	684	655	665	622	659	561	595	602	654	613	1869
Overall Rate /1000 births	10.1	5.8	2.9	6.1	9.0	4.8	10.6	7.1	10.1	5.0	6.1	4.9	5.4
Rate (excluding TOP)/1000	**10.1**	**4.3**	**1.5**	**4.6**	**7.5**	**3.2**	**6.0**	**0**	**8.4**	**1.7**	**6.1**	**3.3**	**3.7**

Table 1 Stillbirth rates for 2021-22

Table 2: Annual Stillbirth rate/1000 births (excluding terminations)

Quarter	Rate 2019/20	Rate 2020/21	Rate 2021/22	Rate 2022/23
Q1	4.0	5.5	4.0	3.7
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**	

The annual stillbirth rate for 2021-22 was higher than in previous years. (see fig 2 above). The Maternity team have conducted a thematic review data and will present this to QC in September 2022.

In Q1 2022/23 the still birth rate of 3.7 stillbirths/1000 live births is lower than all the previous 4 quartiles however the numbers are small and caution in interpretation is warranted.

The ONS data for 2021 stillbirths in England and Wales was confirmed in August 2022. The stillbirth rate increased to 4.1 per 1,000 total births, an increase from 3.8 in 2020. This is higher than the pre-coronavirus rate (3.9 stillbirths per 1,000 total births) in 2019. It is thought likely that the increase in stillbirths in 2021 is related 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.

2.1 Learning from Stillbirth reviews Q4

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 Q4 2021/22 have been subject to a full multidisciplinary review panel meeting utilising the PMRT tool with external clinician presence. All ll 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 reviews of Q4 cases (N=11) has evaluated that 4/11 (36.4%) had appropriate antenatal care and 6/11 (54.5%) identified care issues which would not have changed the outcome of the pregnancy.

One case was investigated as a Steis reported Serious Incident (Grade D care). This case identified there was a missed opportunity for earlier delivery. The importance of re-evaluation of a situation when new findings are identified and the education of staff on computerised CTG interpretation with STV has been implemented.

Grade	Care in antenatal period	Percentage (%)	Care provided after Stillbirth	Percentage (%)
A	4	36.4	7	63.6
B	6	54.5	4	36.4
C	0	0	0	0
D	1	9.1	0	0

Table 3 PMRT review panel grading of care provided in cases of Stillbirth (N=11, including 2x 22-24 weeks pregnancy losses)

Learning from Q4 in the provision of antenatal care includes:

- Consideration of developing a defined role for a MW within the community hub to include review of investigation results and triage calls
- Review feasibility to have 'interpreter services on wheels' permanently in all areas to facilitate increased utility of interpreters
- The need for increased fetal medicine consultants
- Educational package for staff on utility of computerised CTG and interpretation with STV

In the care provided after delivery, there remains:

- a need to educate on the importance of arranging for stillbirth investigations, thus the plan to develop a pictorial graph with all the SB investigations required, with the appropriate blood sampling bottles, to facilitate and remind all on the need to arrange for investigations.
- the work in progress to increase availability of Honeysuckle team members to provide support out of hours

Actions that are completed from areas of learning from previous quartiles include:

- Integration of K2 with electronic GROW package to have an electronic system for fetal growth surveillance

There is ongoing progress with the following:

- Implementation of the CoC model to improve process in arranging for FU for CMW reviews, while working towards developing a defined role for a midwife in the community hub to review investigation results
- Ongoing recruitment of more fetal medicine consultants

- Business case to increase provision of bereavement care and support out of hours

The attached appendices provide information on progress with on-going actions from related to prior stillbirths.

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. The table below presents the total mortality at LWH, and mortality for those babies born at LWH in a rolling 12 month period.

	Jul-21	*Aug-21*	*Sep-21*	*Oct-21*	*Nov-21*	*Dec-21*	*Jan-22*	*Feb-22*	*Mar-22*	*Apr-22*	*May-22*	*Jun-22*	*Total*
Total Neonatal Mortality	5	3	3	8	5	3	2	3	3	*3*	*7*	*3*	48
INBORN Neonatal Mortality	**3**	**2**	**2**	**4**	**4**	**3**	**2**	**3**	**3**	***2***	***4***	***3***	**35**
Deliveries	692	695	684	655	665	622	659	561	595	*602*	*654*	*613*	7697
INBORN Neonatal Mortality Rate/1000 deliveries	**4.3**	**2.9**	**2.9**	**6.1**	**6.0**	**4.8**	**3.0**	**5.3**	**5.0**	***3.3***	***6.1***	***4.9***	**4.5**

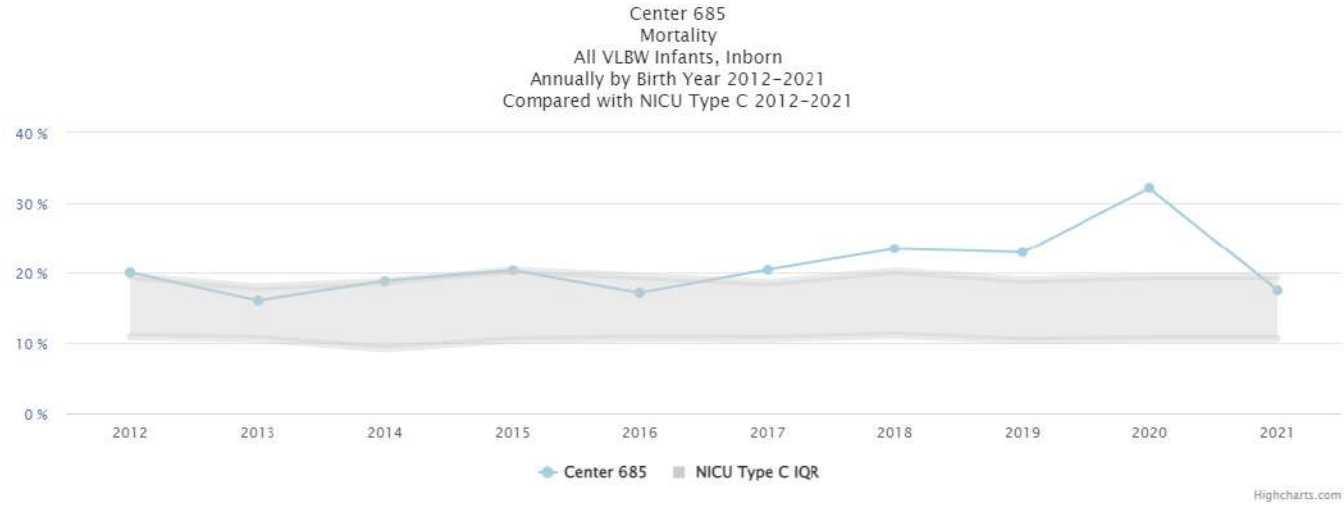
Table 4: NICU Mortality.

Quarter	NMR all babies	NMR *in born*
Q2 (21_22)	5.3	3.3
Q3 (21_22)	8.2	5.7
Q4 (21_22)	4.4	4.4
Q1 (22_23)	7.0	4.8

Table 5: Neonatal Mortality Rate per quarter

Benchmarked mortality for all babies <1500g in the Vermont Oxford Network

The chart below shows the mortality for VLBW babies born in LWH between 2017 and 2021. The grey bar indicates the interquartile range for similar centres in the Vermont Oxford Netowrk (international). These data do not risk adjust for case mix, but are comparing similar units with a surgical and cardiac service. For the first time since 2016, the mortality rate is within the network interquartile range. Benchamrked data with UK centres is not yet available and will be shared when produced.



Mortality for all Very Low Birth Weight babies in the VON network. LWH data is the blue line with surgical/cardiac NICU interquartile range being the shaded grey area.

3.3. Learning from neonatal mortality reviews for Q4

There were 10 deaths subject to a PMRT review. There were no cases identified with care issues which were likely to have made a difference to the outcome. 3/10 cases were identified with issues which may have made a difference to the outcome.

Learning included the following:

- To include “high risk” antenatal cases in the twice daily MDT maternity/neonatal huddle
- Lesson of the week about hypocarbia identification and management
- Development of a themed week to promote thermoregulation

The attached appendices provide information on progress with on-going actions from related to prior deaths.

3.3. External Review of Preterm mortality by the NWODN

An external review by the North-West Neonatal ODN of LWH mortality for extremely preterm infants has been published and presented to LWH. 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 has been presented to QC with an action plan developed by the division.

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 adherence to safety action 1 is presented below.

This quarterly report (and previous 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.

Standard	Number Eligible	Number Achieved and % age compliance	Status – Green/red
All perinatal deaths eligible to be notified to MBRRACEUK from 6 May 2022 onwards must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within one month of the death.	13 cases notified (1 < 22 weeks so review with Perinatal Mortality Review Tool was not required)	13 – 100%	Green
A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 6 May 2022 will have been started within two months of each death.	12	12 – 100%	Green
At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, from 6 May 2022, will have been reviewed using the PMRT, by a multidisciplinary review team.	8 reviewed 4 pending and anticipated within the reporting period	8 – 66%	Green
Each of these reviews will have been completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death	5 draft reports completed 4 drafts pending for completion within the reporting period due by 17th October on track *3 cases have the four-month deadline fall after the reporting period ends on 5th Dec	Currently 5 – 45% Anticipated 9 – 100%	Green
and the report published within six months of each death.	5 reports published **7 cases have the six-month deadline fall after the reporting period ends on 5th Dec	5 – 100%	Green
For at least 95% of all deaths of babies who died in your Trust from 6 May 2022, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any questions and/or concerns they have about their care and that of their baby have been sought	12	12 – 100%	Green

4. Recommendations

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

- number of deaths in our care
- number of deaths subject to case record review
- number of deaths investigated under the Serious Incident framework
- number of deaths that were reviewed/investigated and as a result considered due to problems in care
- themes and issues identified from review and investigation
- actions taken in response, actions planned and an assessment of the impact of actions taken.
- Compliance with MIS year 4.

Reports provided for further information to the Board (uploaded to Admin Control file):

- Cheshire and Mersey Maternity Provider Standardised Quarterly Perinatal Board Report
- Thematic review of Stillbirths in 2021/22

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*22/23/136d*		Date: 03/11/2022	
Report Title	Seven Day Services			
Prepared by	Chris Dewhurst, Deputy Medical Director and Joe Downie Deputy Chief Operating Officer			
Presented by	Lynn Greenhalgh, Medical Director			
Key Issues / Messages	*Trust Boards should assess at least once a year whether their acute services are meeting the four priority 7DS clinical standards to demonstrate their performance against the four priority 7DS clinical standards to their commissioners and to their regulators. This report outlines the Trust's 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 – Y *If no – please outline the reasons for deviation.*			
	The trust board are recommended to review the contents of this paper and be assured that: *i. the variance in length of stay and discharge is elucidated in these data.* *ii. There has been a deep dive which has identified that the length of stay following admission at the weekend, although longer than average, is not clinically significant. The reduced number of discharges on Sunday in Gynaecology reflects the reduced number of admissions at the weekend.* *iii. There are medical staffing strategies in place to increase consultant presence out of hours.* *It is recommended that the board are provided with assurance by the Quality Committee reviewing the divisional 7-day service action plans. It is advised that risk 2323 is revised in light of this report.*			
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)	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
Link to the Corporate Risk Register (CRR) – CR Number: 2323	The Trust is currently non-compliant with standards 2,5,6 of the seven day service standards

	Cause: There is insufficient number of consultants to run consultant of the week rota, the Trust is non co-located which is affecting seven day access to diagnostic services and 24hr access to consultant delivered interventions Consequence: Non-compliance with requirements, impact on reputation, impact on patient safety, lack of equity of service presence across locality. Extreme Risk. Scored at 15.

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Quality Committee	24/10/2022	Deputy Medical Director	The Committee received partial assurance. Assurance was received that there is no difference in length of stay or discharges at the weekend. The committee were not assured that there is appropriate job planned consultant time for emergency care at the weekend, though they acknowledged this is being reviewed as part of the 5-year medical staffing strategies. Review of the care and scope of work provided by Gynaecology Emergency Department is recommended. An update on progress in the anaesthetic consultant workforce has been requested. This paper has been requested to go to the Finance, Performance and Business Development Committee meeting to triangulate potential financial impact of workforce expansion. The lack of access to onsite diagnostic test and consultant led interventions is driven by the lack of co-located services which is addressed in the Future Generations strategy.

EXECUTIVE SUMMARY

The Seven Day Hospital Services (7DS) Clinical Standards were developed to support providers of acute services to deliver high quality care and improve outcomes on a seven-day basis for patients admitted to hospital in an emergency. The importance of ensuring that patients receive the same level of high-quality care every day is reflected in the inclusion of these standards in the NHS Standard Contract. Delivery of the 7DS clinical standards should also support better patient flow through acute hospitals.

Ten 7DS clinical standards were originally developed by the NHS Services, in 2013 with four priority standards selected

1. to ensure that patients have access to consultant-directed assessment (Clinical Standard 2),
2. diagnostics (Clinical Standard 5),
3. interventions (Clinical Standard 6) and
4. ongoing review (Clinical Standard 8) every day of the week.

Trust Boards should assess at least once a year whether their acute services are meeting the four priority 7DS clinical standards to demonstrate their performance against the four priority 7DS clinical standards to their commissioners and to their regulators.

The findings of the 7-day service review demonstrate that there the length of stay for some emergency patients at the weekend is (statistically) longer than average but the time difference is small and not clinically significant. There are fewer discharges of gynaecology emergency patients at the weekend but this reflects the reduced emergency admissions at the weekend.

Diagnostic tests and consultant led interventions are not available on-site but are provided within the local networks. It is recognised that several of these requirements will not be on-site until LWH is co-located with another adult acute provider.

Consultant Job plans do not provide for a 7-day service across all specialities but the Divisional medical workforce strategies will be reviewed by the divisions to specifically address this issue.

It is recommended that the Board are assured that this paper highlights the variance from the 7-day service standards. It is advised that risk 2323 is reviewed in light of this paper.

MAIN REPORT

1. Background

A substantial body of evidence exists which indicates significant variation in outcomes for patients admitted to hospitals in an emergency, at the weekend across the NHS in England. This variation is seen in mortality rates, patient experience, length of hospital stay and re-admission rates. Additionally medical, nursing, other health professional and managerial staffing levels, as well as trainee doctors' perceptions of supervision by consultants, also vary by day of the week.

To tackle this, in 2013 the NHS Services, Seven Days a Week Forum developed 10 clinical standards to end variations in outcomes at the weekend. The 10 standards are below.

1. Patients, and where appropriate families and carers, must be actively involved in shared decision making and supported by clear information from health and social care professionals to make fully informed choices about investigations, treatment and on-going care that reflect what is important to them. This should happen consistently, seven days a week.

2. All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.

3. All emergency inpatients must be assessed for complex or on-going needs within 14 hours by a multi-professional team, overseen by a competent decision-maker, unless deemed unnecessary by the responsible consultant. An integrated management plan with estimated discharge date and physiological and functional criteria for discharge must be in place along with completed medicines reconciliation within 24 hours.

4. Handovers must be led by a competent senior decision maker and take place at a designated time and place, with multi-professional participation from the relevant in-coming and out-going shifts. Handover processes, including communication and documentation, must be reflected in hospital policy and standardised across seven days of the week.

5. Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week:

6. Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.

7. Liaison mental health services should be available to respond to referrals and provide urgent and emergency mental health care in acute hospitals with 24/7 Emergency Departments 24 hours a day, 7 days a week.

8. All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.

9. Support services, both in the hospital and in primary, community and mental health settings must be available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken.

10. All those involved in the delivery of acute care must participate in the review of patient outcomes to drive care quality improvement. The duties, working hours and supervision of trainees in all healthcare professions must be consistent with the delivery of high-quality, safe patient care, seven days a week.

Trust Boards should demonstrate their performance against. four priority standards;

1. to ensure that patients have access to consultant-directed assessment (Clinical Standard 2),
2. diagnostics (Clinical Standard 5),
3. interventions (Clinical Standard 6) and
4. ongoing review (Clinical Standard 8).

2. Assurance Framework

In February 2022 a revised Board Assurance framework was developed which reduced the internal data collection. This framework is available here; https://www.england.nhs.uk/wp-content/uploads/2022/02/B1231-board-assurance-framework-for-seven-day-hospital-services-08-feb-2022.pdf

The assurance framework consist of the following 9 key lines of enquiry.

1. **The daily hospital sitrep shows significant variation in LOS associated with the day of the week patients are admitted. NO**

   Length of Stay (LoS) and Discharge data for 21/22 is demonstrated in the charts table. Each chart represents a clinical speciality and presents the data for each day along with the standard deviation for the 7-day period. The data relates to emergency admissions for gynaecology, but to all admissions for maternity (due to the classification of admission for pregnant women). The neonatal data relates to babies admitted to the neonatal unit.

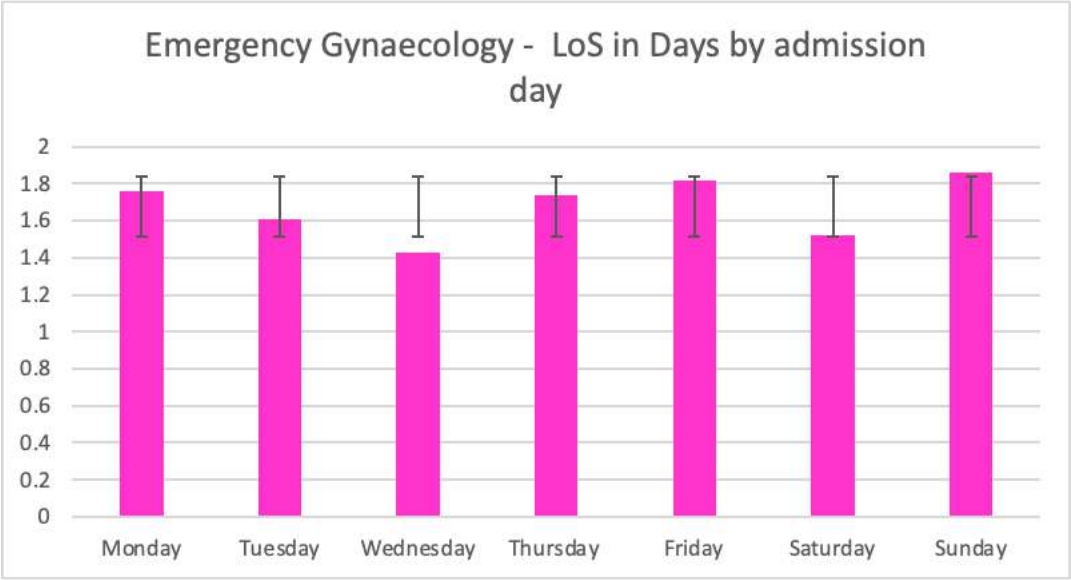


Chart 1. Length of stay (LoS) following an emergency Gynaecology admission on Sunday is longer than average, but only by < 1 hour.

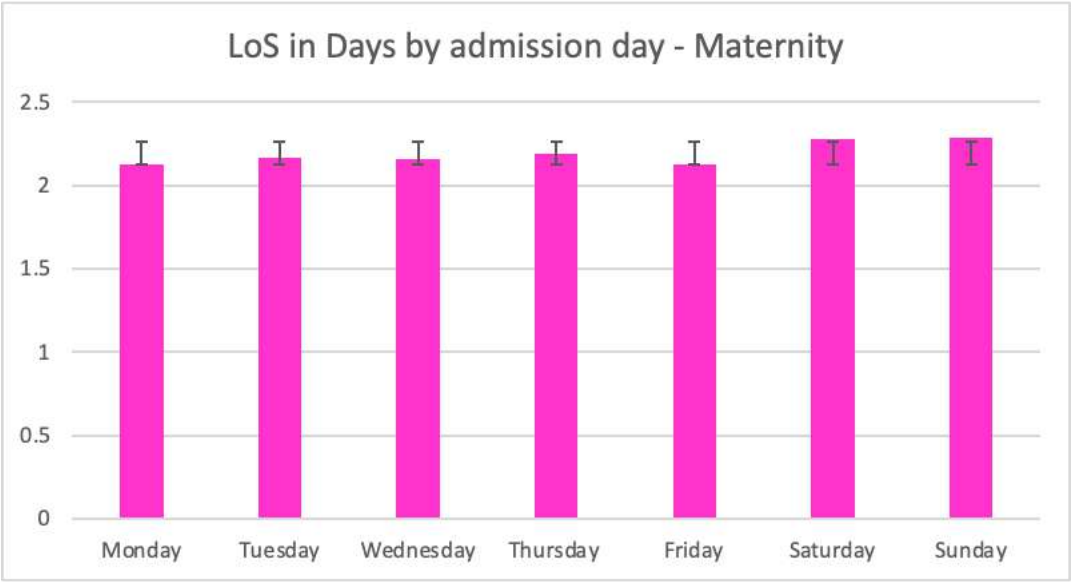


Chart 3. Length of stay following an Obstetric admission at the weekend is longer than average, but the difference is small (2.3 vs 2.2 days). An obstetric admission at the Weekend stays c 3 hours longer than the average length of stay following admission Mon-Friday.

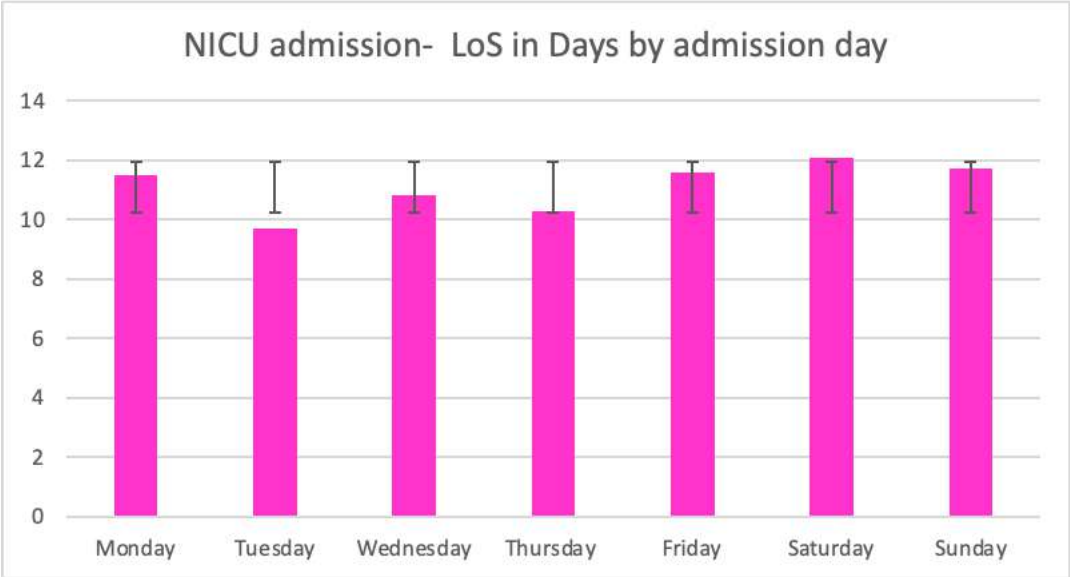
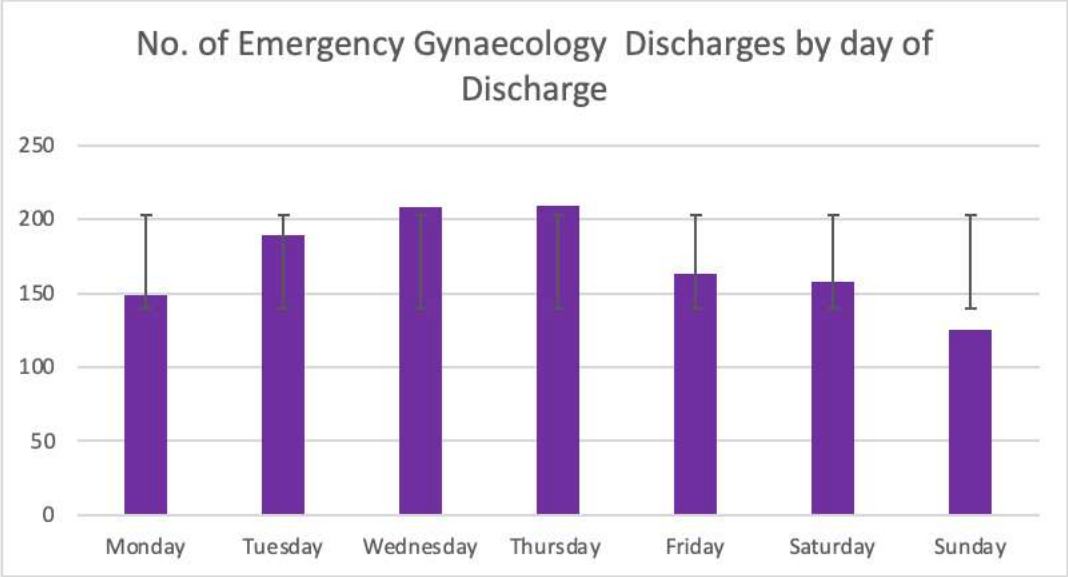


Chart 4. Length of stay following a Neonatal admission on a Saturday is longer than average, being 12.1 days compared to an average of 10.8 days Monday to Friday. The length of stay is generally determined by the gestation at birth.

The reasons for the observed differences in Length of Stay cannot be elucidated from these data. Whilst the length of stay for some admissions at the weekend is longer than average, the difference is small in real terms for adult patients (< 1 hour for gynaecology, 2.3 vs 2.2 days for maternity) and deemed not to be clinically significant. The length of stay for neonatal patients is mostly determined by the gestation at birth or clinical diagnosis, rather than the care provided. For these reasons, it is recommended that the board are assured that there is no significant variation in LOS associated with the day of the week patients are admitted.

2. **The daily hospital sitrep shows significant variation in the number of discharges by day of the week. NO**

The following charts represent the number of discharges over a 12-month period (21-22) grouped by day of the week.



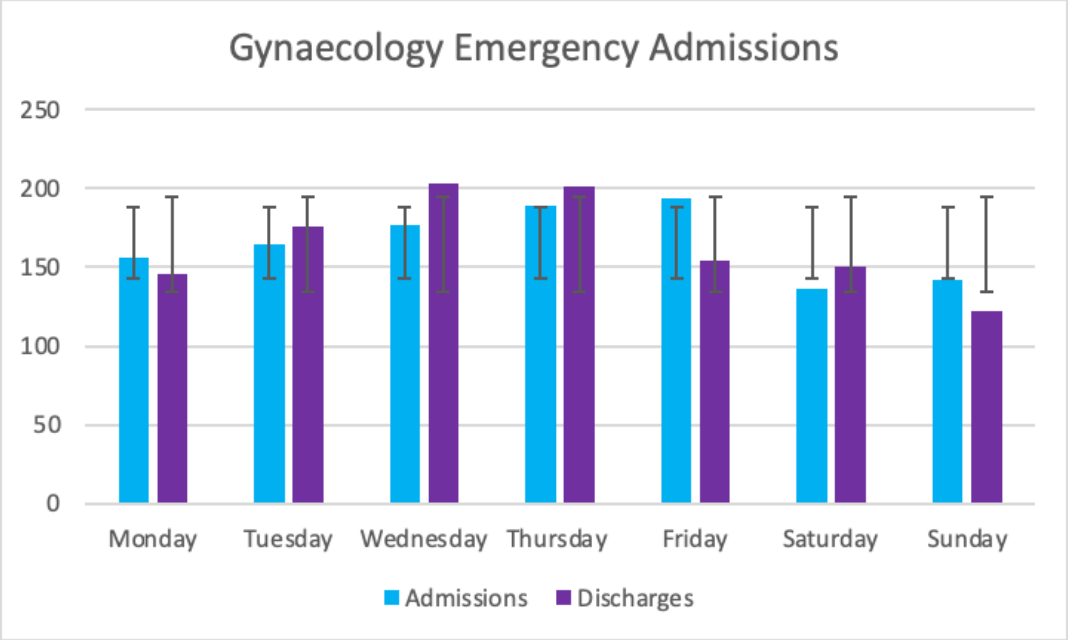


Chart 5 (top) There are fewer discharges for emergency admissions on Sunday compared to the rest of the week.

Chart 6 (bottom) This chart demonstrates that there is also variation in the number of emergency gynaecology admissions, with fewer patients admitted at the weekend. When triangulated with the average LoS, the reduced number of discharges on Sunday likely reflect the reduced admissions on Saturday.

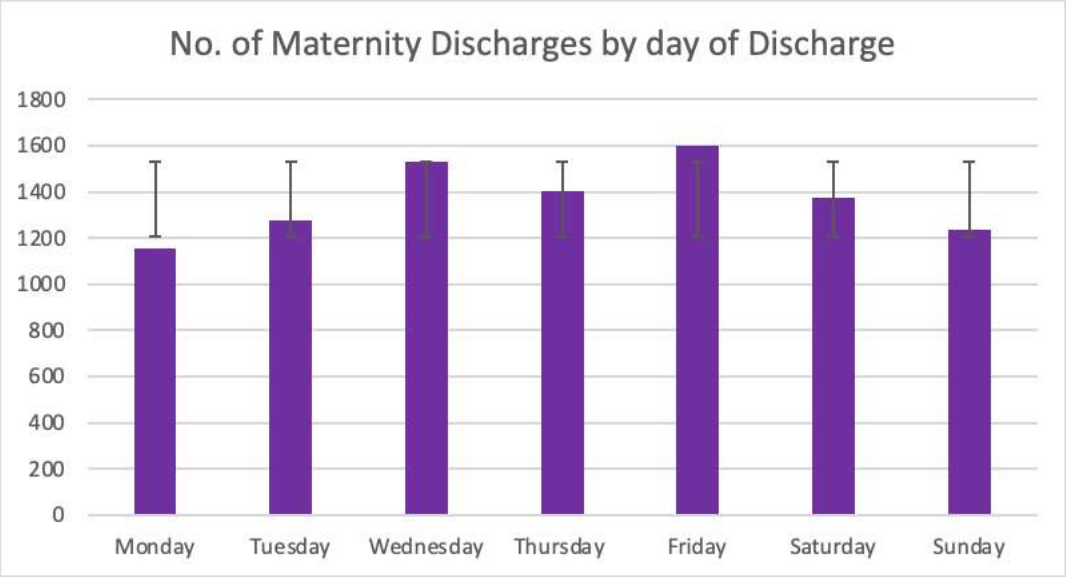


Chart 6. There is no difference between the number of maternity patients discharged at the weekend and the rest of the week. These data include all maternity admissions due to the coding not being separated into elective and emergency admissions. There are fewer women discharged on Monday which likely reflects the reduced elective admissions at the weekend.

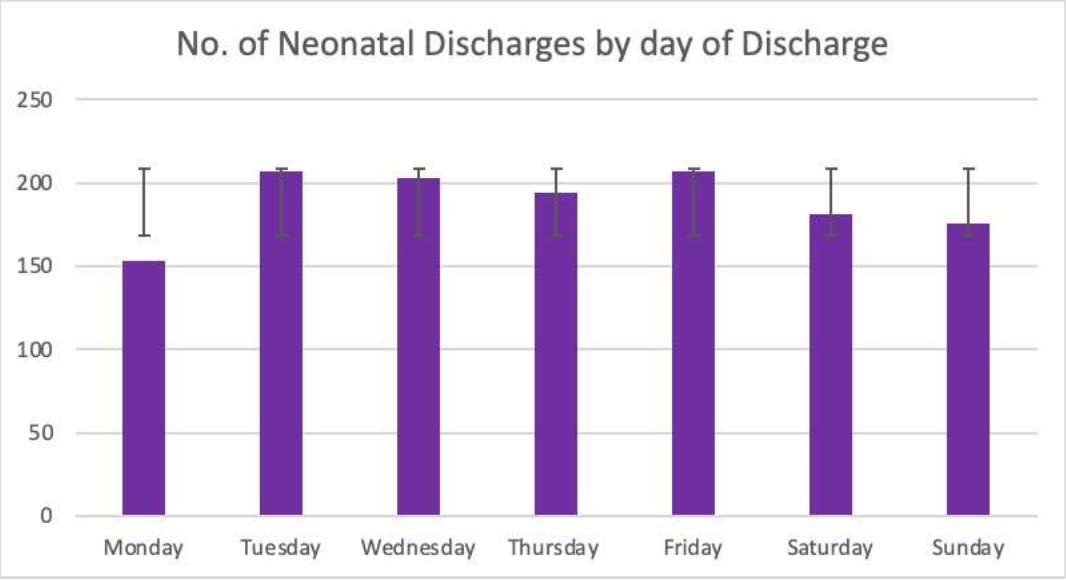


Chart 8. These data relate to babies discharged from the neonatal unit. There is no difference in the number discharged at the weekend, with fewer babies discharged on Monday.

It is recommended that the board are assured that there is no significant variation in discharges by day of the week patients. The observed difference in gynaecology can be explained by the reduced number of admissions at the weekend.

3. **Job plans for consultants in all acute specialties provide scheduled on-site consultant cover every day that reflects the likely demand for that specialty. No**

Obstetrics No
Job plans include a resident consultant for 15.5 hours 7-days/week for delivery suite. The medical assessment unit and ward have consultant cover for 5 days/week. The resident consultant covers these areas at the weekend. The Gap in weekend consultant cover is having a second consultant to cover the ward round and medical assessment unit at the weekend.

Neonatology Yes
The neonatal unit has 24/7 consultant cover with two consultants covering the ITU and HDU areas 7 days/week.

Gynaecology No
At the weekend the on-call gynaecology consultant conducts a ward round and is available to manage emergencies. This is covered within the PA allocation for being "on-call" but not as a separate activity. The Gynaecology emergency department is routinely staffed with a consultant Monday to Friday but not at the weekend.

Anaesthetics No
There is a resident Anaesthetist present 0800 to 22:00 Mon-Thursday, and till 18:00 on Fridays. There is an on-call Anaesthetic presence at the weekend.

The Ockenden review identified that multidisciplinary working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward. The final report confirmed that this MDT included participation by anaesthetists, though didn't specify if this should be a consultant. This Ockenden requirement is currently fulfilled by a consultant anaesthetist Mon- Thursday and a post graduate doctor Friday to Sunday.

4. **24/7 access to emergency diagnostic tests**

Emergency diagnostic test	Available on site at weekends	Available via network at weekends	Not available
USS		**X**	
CT		**X**	
MRI		**X**	
Endoscopy		**X**	
Echocardiography		**X**	
Microbiology		**X**	

5. **24/7 access to emergency consultant-led interventions**

Emergency diagnostic test	Available on site at weekends	Available via network at weekends	Not available
Intensive care		**X**	
Interventional radiography		**X**	
Interventional endoscopy		**X**	
Surgery*	**X**	**X**	
Renal Replacement therapy		**X**	
Stroke thrombectomy		**X**	
PCI for MI		**X**	
Cardiac pacing		**X**	

***** Gynaecological surgery and caesarean section are available on site. All other surgery is provided by other acute providers

6. **If the answers to questions 1,2 or 3 above are 'No' please provide evidence here from suitable deep dive audits on relevant specialties to demonstrate the level of compliance with Standard 2 and Standard 8.**
   See above.

7. **The Executive Medical Director has approved derogation regarding Standard 8 for the following specialties. List the specialties and the details of the derogation here. Note such derogations should be reviewed at least annually and examined in relation to any relevant patient safety issues.**
   If there are insufficient consultants in a specialty to meet Standard 8, the Executive Medical Director may grant a derogation to allow the inclusion of Specialty Doctors and doctors in higher specialist training at ST4 and above to provide some of the daily ward rounds. The MD at LWH does not approve any derogation for HDU patients due to the isolated nature of our site.

8. **Narrative section to include any other aspects of 7-day services to draw to the Board's attention**
   The main hospital site at Crown Street, Toxteth, is isolated from other adult services and consequently, is less able to manage acutely ill or rapidly deteriorating patients, women with complex surgical needs and women with significant additional medical conditions. Therefore, women continue to be transferred to and from other Trusts for the care they need, often when they are at their most clinically vulnerable.

   LWH is the only specialist obstetric and gynaecology service provider in the country in this isolated position. This creates inequalities in access and reduced quality of care for

women and their families. It also increases the risks that staff have to manage at the Crown Street site and other acute sites across Liverpool.

In summary, there is a current lack of:

- A wide range of specialist clinicians on site to provide assistance when needed
- Intensive care facilities and critical care services
- 24-hour laboratory services
- Therapies and recovery support
- A blood transfusion laboratory
- Imaging facilities to support timely diagnosis.

In 2020 we completed a £15m refurbishment to improve and upgrade our existing Neonatal Unit and we have recently commenced a £6.5m Crown Street Enhancements Programme to further address some of the clinical challenges we face on the current Liverpool Women's site. This will see a number of additional services added to the Crown Street site including; CT Imaging and Colposcopy Suites, and we also have potential plans to develop a Blood Bank on site.

However, only co-location with an adult acute site will provide on-site access to specialist services including intensive care, consultant led interventions and diagnostics.

9. Action plan section to describe the key actions being undertaken to address issues identified in sections 1-8

1. Consultant Job plans are reviewed on an annual basis. The divisional Leadership teams have developed 5-year strategies and aligned medical staffing strategies. These should be reviewed to ensure they meet the requirements of 7-day services.
2. The development of the Community Diagnostic centre on the Liverpool Women's Hospital site will provide access to MRI, CT, USS and echocardiography. SOPs will be developed to ensure this access is available at the weekend for LWH in-patients. Assurance will be provided by the CDC oversight team regarding this.
3. The Future generations strategy remains the key priority for the Trust. The information presented in this paper highlight the deficiencies in access to urgent diagnostic tests and consultant led interventions that are not available on site. The Trust will continue to pursue the aim to relocate to an adult acute site within the city.

3. Recommendation

The trust board are recommended to review the contents of this paper and be assured that:

i. the variance in length of stay and discharge is elucidated in these data.
ii. There has been a deep dive which has identified that the length of stay following admission at the weekend, although longer than average, is not clinically significant.

The reduced number of discharges on Sunday in Gynaecology reflects the reduced number of admissions at the weekend.

iii. There are medical staffing strategies in place to increase consultant presence out of hours.

It is recommended that the board are provided with assurance by the Quality Committee reviewing the divisional 7-day service action plans. It is advised that risk 2323 is revised in light of this report.

Trust Board

COVER SHEET

Agenda Item (Ref)	***22/23/136e***		**03/11/2022**	
Report Title	Bi-annual staffing paper update, January 2022-June 2022 (Q4 21/22 & Q1 22/23)			
Prepared by	***Nashaba Ellahi, Deputy Director of Nursing and Midwifery***			
Presented by	***Nashaba Ellahi, Deputy Director of Nursing and Midwifery***			
Key Issues / Messages	***The Board is asked to note the contents of the paper and take assurance of the actions undertaken to effectively manage and provide safe staffing within Nursing, Midwifery and AHP to support the delivery of safe care.***			
Action required	Approve ☒	Receive ☐	Note ☐	Take Assurance ☒
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable): NA			
	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 paper and take assurance of the actions undertaken to effectively manage and provide safe staffing within Nursing, Midwifery and AHP to support the delivery of safe care.			
Supporting Executive:	Dianne Brown, Interim Chief Nurse			

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: Risk score of 20; target 16
Link to the Corporate Risk Register (CRR) – CR Number: The below are service level risks, however for context are highlighted. **FH (Maternity)** Risk number: 1705 – midwifery staffing "insufficient midwifery staffing levels as recognised by birth rate plus. Risk score of 20; target 6 **Gynaecology** Risk number: 2256 – Risk to staff the Telephone Triage Line (GED). Risk score of 12; target 3 Risk number: 2395 - OPD ambulatory staffing Risk score of 15; target 12 **CSS** Risk number: 2549 – Staff shortages in the Imaging Dept. Risk score of 20; target 12 Risk number: 2579 – Staffing for CDC. Risk score of 15; target 5 Risk number: 2519 – Risk to staffing the X-Ray on call rota. Risk score of 15; target 10 Risk number: 2546 – Reduction of staff in genetic counselling. Risk score of 12; target 4	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
PPF Committee	Oct 22	Interim CN	Assurances recommended to the Board

EXECUTIVE SUMMARY

The bi-annual Nursing, Midwifery and Allied Health Professional (AHP) staffing report is provided to the Board of Directors after being presented to the Putting People First (PPF) Committee on 03 October 2022. This report covers the period from January 2022 to June 2022 (Quarter 4; 21/22 and Quarter 1; 22/23). The report provides assurance that there are robust systems and processes in place throughout the year to monitor and manage Nursing, Midwifery and AHP staffing requirements. The PPF Committee were assured with the triangulation of information presented and noted the divisional level detail in several appendices (since removed), which were discussed, supported, and demonstrated divisional oversight and actions being taken to address and improve safe staffing.

The report presented highlights the following areas for discussion and noting during the reporting period (January 2022-June 2022):

- Vacancy rate (June 2022) is 13.32%, with Maternity reflecting the greatest vacancies, however overall vacancy rate has increased due to several business cases being approved that demonstrated the need to increase staffing
- Maternity leave fluctuates between 36.0-38.0wte on maternity leave per month, with June 2022 recorded the lowest in the reported period at 32.48wte
- Sickness has been above target of 4.5% with June 2022 reflecting 8.17%, (5.76% non-covid related sickness)
- Long-term (LT) sickness rates have been the lowest within NMC/HCA staff groups over the past 12 months. June 2022 highlights LT sickness as 59% (NMC/HCA) and 50% (AHP) of the total sickness.
- Turnover has remained under or at Trust threshold (13%) in NMC/HCA for past 12 months, however, turnover is high in small teams as reflected in AHP workforce
- Age profile remains static except with a marginal reduction of staff who can retire now or in next five years seen
- June 2022 reflects Staff Training and Personal Development Review thresholds were not met, except for Mandatory Training (MT) for AHPs. AHPs have shown the most improvement over the six-month period, but remain below threshold, divisions overall have marginally improved across most indicators.
- Clinical Incidents (281) related to staffing or staff sickness were noted highest in Maternity Services with 216. Red Flag events (174) were all reported from Maternity services. There were 12 Serious Incidents with most occurring in Maternity.
- Patient experience – 33 comments (from 4730) comments received in Friends and Family Test (FFT) mentioned staffing numbers or staffing shortages in the patients' experience. 106 comments (from 3084) relating to the Trust question "please tell us anything we could have done better" also related to staffing numbers or staff shortages
- Complaints – 36 formal complaints received with 2 relating to staffing levels, none were upheld. No PALS+ recorded in relation to staffing as main concern. 2 PALS cases (from 899) noted staff shortages in concerns raised. 49 Compliments were received
- Staff experience – 32 reported violence and aggression incidents, with 16 incidents relating to non-physical violence or aggression towards staff. Several interventions in place to support staff and managers.
- Recruitment and Retention – ongoing recruitment across the Trust continues with successful early recruitment of Midwives that will commence in October 2022. LWH continues to participate in International Recruitment with Midwifery (7) and Theatres (10), with predicted start days of January 2023 for midwives, yet unknown for Theatre staff. Successful NHSI funding to support retention with retention team in place supporting Care Certificate, interviews, and onboarding.

All Divisions receive data as reflected above that is owned and reviewed at Divisional Board.

MAIN REPORT

1. Introduction

To provide the Board of Directors with assurance that a six-monthly establishment review pre-budget setting (2022/2023) has been undertaken by divisions in relation to the Nursing, Midwifery and Allied Health Professional (AHP) workforce requirements. To report against the workforce requirements identified in 2022/2023 to achieve safe staffing across services within the Trust.

2. Background

NHS organisations have a responsibility to undertake an annual comprehensive Nursing and Midwifery skill mix review to ensure that there are safe care staffing levels to provide assurance to the Board and stakeholders that the organisation is safe to provide high quality care.

The annual Nursing and Midwifery staffing establishment review considers relevant guidance and resources available to support NHS providers to deliver the right staff, with the right skills, in the right place at the right time (National Quality Board (NQB), 2016) through effective staffing (NICE, 2014; NICE, 2015; NHSI, 2018).

The annual comprehensive Nursing and Midwifery workforce planning skill mix review was underway in Quarter 1 ahead of budget setting to effectively inform any changes before staffing establishments are reviewed and signed off by the Chief Nurse and Midwife and Board of Directors.

The bi-annual Nursing and Midwifery staffing report details the Trusts position against the requirements of NICE guidance for adult wards (2014); NICE Guidance for maternity settings (2015), NQB Safer Staffing Guidance (2016) and NHSI, Developing Workforce Safeguards (2018).

The Board of Directors receives twice-yearly staffing review papers; one which confirms a complete Nursing and Midwifery establishment review was undertaken via Divisional overviews as presented at PPF Committee on 03 October 2022 and a further comprehensive staffing report to ensure workforce plans are still appropriate across the clinical workforce, allowing for seasonal variance to be captured and reviewed appropriately.

Additionally, separate twice-yearly Midwifery staffing oversight reports are presented to Board of Directors that update on staffing/safety issues, as a requirement for the Maternity Incentive Scheme, Year Four, Safety Action 5. Neonatal services report staffing to Board of Directors yearly in line with Clinical Negligence Scheme for Trusts (CNST) requirements.

Each month the Board of Directors receive an overview of the Nursing and Midwifery staffing including fill rates, attendance/absence, vacancies, red flags, and bed occupancy. The information is presented within the Integrated Performance Report.

Developing Workforce Safeguards (NHSI, 2018) additionally recommends:

- Adoption of the principles of safe staffing utilising a 'triangulated' approach to staffing, utilising evidence-based tools, and data, where available, professional judgement and outcomes (e.g., nurse sensitive indicators, complaints, incidents)

- implementation of care hours per patient day (CHPPD) as a metric as recommended by Lord Carter's review of NHS productivity, however with the caution that it should not be used in isolation

Safe, Effective, Caring, Responsive and Well Led Care		
Measure and Improve -patient outcomes, people productivity and financial sustainability- -report investigate and act on incidents (including red flags) - -patient, carer and staff feedback-		
-implement Care Hours per Patient Day (CHPPD) - develop local quality dashboard for safe sustainable staffing		
Expectation 1	**Expectation 2**	**Expectation 3**
Right Staff 1.1 evidence based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	**Right Skills** 2.1 mandatory training, development and education 2.2 working as a multi-professional team 2.3 recruitment and retention	**Right Place and Time** 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

Table 1: National Quality Board (2016)

3. Workforce planning - Setting evidenced based establishments

Evidence based workforce planning is supported using available tools such as Safer Nursing Care Tool (SNCT, 2014) developed to assist NHS hospitals measure patient acuity and dependency on adult inpatient areas and Emergency Departments to inform decision making on staffing and workforce as part of a triangulated approach. SNCT is not suitable for day-case patients.

The licence for SNCT was acquired by the Trust in July 2021 to use within Gynaecology in-patient ward ahead of the annual workforce planning review. Following training, Liverpool Women's Hospital participated in beta-testing of the Safer Nursing Care Tool within Gynaecology supported by NHSI. Results have been submitted to NHSI and expected to be conveyed back to act on in Quarter 2.

National guidance (Intensive Care Society, 2019) supports staffing recommendations in Level 2 care facilities (High Dependency Units) as a registered nurse/patient ratio of a minimum of 1:2 to deliver direct care.

Maternity Services are assessed using Birthrate Plus®. The Birthrate Plus® methodology is based on an assessment of clinical risk and the needs of women and their babies during labour, delivery, and the immediate post-delivery period. Birthrate Plus® utilises the accepted standards of one midwife to one woman to determine the total midwife hours and therefore the staffing required to deliver midwifery care to women across the whole maternity pathway using NICE guidance (2015) and acknowledged best practice (RCM, 2018)

British Association of Perinatal Medicine (BAPM) standards have been utilised to provide the benchmark for staffing within the Neonatal Unit.

Theatre staffing is based on the Association for Perioperative Practice (AfPP) guidance. This methodology adopted supports efficient management of elective and scheduled operating sessions by effective use of resources and clinical efficiency in operating departments.

3.1 Care Hours Per Patient Per Day (CHPPD) and Actual versus Planned Care

From April 2016, following the Carter Review all Trusts were required to publish staffing fill rates of RN/RM and Care Staff by hours and percentages (Actual versus Planned) and CHPPD via the Strategic Data Collection Service (SDCS), run by NHS Digital. A summary of the submission is uploaded onto the Trust website each month. Appendix 1 highlights data submitted from January 2022-June 2022.

CHPPD relates only to hospital wards where patients stay overnight and is calculated by taking all the shift hours worked over the 24-hour period by Registered nurses/ midwives and nursing assistants and dividing this by the number of patients occupying a bed at midnight. The data is aggregated each day over the month. In maternity mothers and babies are included in the census.

It is important to note that the use of CHPPD will only capture the care hours provided to each bed and does not capture all the activity on the ward such as the turnover of patients through that bed within the 24-hour period or recognise the acuity of the patient receiving the care.

By itself, CHPPD does not reflect the total amount of care provided on a ward nor does it directly show whether care is safe, effective, or responsive. It should therefore be reviewed alongside patient acuity and dependency data as CHPPD is not a metric to either determine registered nurse/ midwife requirements nor provide assurance for safe staffing.

CHPPD data does not routinely capture; part shifts worked by staff, supervisory ward managers and the flexible use of staff across a service pathway, such as a staff member moving to another ward for a shift/part of shift. These staffing strategies, along with factors such as, the acuity/dependency of the patients on the ward, and if there are any empty beds, allow the Matrons to risk assess staffing provision on a shift-by-shift basis to maintain safe staffing levels.

4. Operational oversight of staffing and acuity-based care

A series of actions implemented in the Trust are undertaken on a monthly, weekly, and daily basis to manage safe and effective staffing and optimise care for women and babies across services and divisions. This is captured as:

- Monthly rosters sign off meetings undertaken by Heads of Nursing, Midwifery and AHP (NMAHPS) across all divisions, where roster effectiveness is challenged against roster compliance KPIs. Final roster approvals are signed off by Heads of NMAHPs.
- Weekly forward view of staffing overseen by Heads of NMAHP and Matrons.
- Maternity and Neonatal services provide information for staffing on a weekly basis to NHS Gold command.
- Staffing reported to Bronze (staffing meetings) twice daily (Mon-Fri) and recorded on Power BI (RAG rated). Any identification of risk is addressed and where not resolved escalated to Silver (daily huddle) for resolution. First on call manages staffing at weekends and bank holidays.
- RAG rated staffing matrix in place for Neonatal and Maternity. Acuity and activity review is undertaken at 10am/10pm and 12am/12pm each day with MDT jointly in NNU and Maternity; focusing on staffing, activity,

dependency, and ability to take women and babies recorded.

- Maternity operational oversight (104 bleep holder) completes 4 hourly oversight reviews of acuity, dependency and staffing to determine appropriate midwifery care across all areas. Helicopter role oversees and supports staff moves, staff breaks and care ratios
- Neonatal services adhere to national reporting to Cot Bureau three times daily
- Silver (daily huddle) informed of staffing position forecasted as they arise, into the following shift and ahead of a weekend.

4.1 Temporary Staffing

Since 22nd November 2021, NHS Professionals (NHSP) service commenced in the Trust. Operational oversight on a weekly basis continues and allows early resolution to issues arising. Early commencement of actions to reduce agency expenditure are in place, however with gross unavailability (includes sickness, maternity leave as well as 'true' vacancies) an increased use of agency has been seen. With a need to block book staffing to mitigate and support safe staffing where possible, the resultant rise in spend has been seen mostly in Maternity services.

The ongoing focus on recruitment and retention further aims to reduce the reliance on agency usage alongside the following actions:

- Automatic onboarding to NHSP of new starters with 'opt out' option to reduce need to register separately
- NHSP attendance at twice daily staffing meetings to support priority shift allocation
- NHSP team proactively manage agencies and cancellations
- Review and agree competitive incentives through NHSP Operational Group to support increase in fill rate
- NHSP Recruitment Team who will support with Bank Only recruitment
- Maternity roster management/forward view meeting to support decision making on shifts escalating to agency

In Quarter 4 (2021/2022) and Quarter 1 (2022/2023) NHSP had a specific focus on Bank recruitment. The following is a summary of activity during this period:

- Rolling adverts out for midwives and nurses advertised across multiple platforms including NHS jobs and indeed.
- Attendance at Liverpool John Moores University jobs fair to attract students and promote NHSP/LWH (a lot of interest in LWH from students)
- Facebook® and LinkedIn® campaign to promote LWH locally, however only four enquiries received that as yet have not resulted in those individuals working in the Trust
- Bank engagement team scoped out Northwest bank to identify staff to add LWH to their profile

All new starters broken down by role and recruitment type from Jan 2022-June 2022 are noted in Table 2. The figures reflect those staff who were newly added onto the bank during the reporting period and those staff who completed TUPE process in January 2022 onwards as prior to this those staff would not have been registered on the NHSP system.

Roles	Bank	Multi-post Holder (MPH)	Total
HCAs Band 2&3	30	19	49
Midwives	4	29	33
Nurses	6	7	13
Theatres	4	13	17
Total	44	68	112

Table 2 – Number of individuals added new to NHSP Bank between Jan 2022-June 2022

The performance of bank and agency demand and fill rate by directorate/division is reflected in Appendix 2.

The Trust has invested in the interface from Allocate Software as this enables unfilled shifts to be sent directly from HealthRoster to NHSP and then once filled they will interface to HealthRoster. In the reporting period, two rollout sites piloted (Delivery Suite, Gynaecology Ward). The pilot was successful with go-live in roster period commencing 6th June 2022. The remainder roster is planned for over late summer 2022 in remainder in-patient areas, with GOPD and CSS planned for winter 2022.

5. Trustwide Nursing, Midwifery and AHP Workforce Measures (January 2022-June 2022 data; Q4 & Q1 position))

5.1 Vacancy position

The data highlights the vacancy position in June 2022 (Table 3) for Nursing, Midwifery and AHP of 136.65wte. This demonstrates a vacancy rate of 13.32%. Reassuringly, the higher vacancy position relates to new posts being added over the previous six months in key areas. The new posts follow reviews such as those within the Imaging Department and Theatres, where future proofing services required additional staffing resource to meet demands. These posts are being supported with business cases. Maternity vacancy rate reflects Board of Directors approval to Birthrate Plus review and refresh where additional investment into staffing has been supported. Over 50.0wte posts have been recruited to and commence in post in October 2022. Maternity is also recruiting 8.0wte internationally with tentative start dates in January 2023.

All divisions are actively recruiting to their vacancy positions.

The vacancy position of 136.65 wte is largest in Family Health Division combined (Maternity, 70.53wte and Neonatal, 17.43wte), followed by CSS Division (33.2wte) and Gynaecology Division (15.49wte).

Sum of Wte Budget	Sum of Wte Contracted	Sum of Wte Actual	Sum of WTE Vacancies
1025.74	**889.09**	**848.87**	**136.65**

Table 3: June 2022 Trustwide vacancy position

5.2 Maternity Leave

Table 4 highlights the rolling and relatively static position of staff on maternity leave across each staff group and Trustwide. The group of staff with the largest maternity leave are those who are registered midwifes or nurses.

Maternity Leave	January 2022			February 2022			March 2022			April 2022			May 2022			June 2022		
	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP
Total by WTE	4.41	31.53	1.00	4.41	32.92	1.00	4.41	31.76	1.00	3.61	32.41	1.00	3.61	31.72	1.00	0.00	31.48	1.00

Table 4: Maternity leave

5.3 Sickness absence

The sickness absence over the reported six-month period (Table 5) has remained high and above the Trust threshold of 4.50%, with the largest combined peak across all staff groups in January 2022 at 13.97%. The lowest combined overall sickness rate was seen in May 2022 in the last six months.

Covid-19 related sickness saw a peak in January 2022 (Table 5), with a further peak in April 2022. Examining more closely when the peaks in staff covid related sickness was seen is consistent to when spikes in community and hospital cases UK wide were seen. Infection, Prevention and Control (IPC) overview at the time of increased staff sickness noted no lapses in IPC practises in work by staff.

The overall percentage of sickness across the 3 staff groups in June 2022 is 8.17% and further breakdown of this illustrates the following:

- 5.76% was all non-covid related sickness
- 2.41% was covid-19 related sickness
- 0% was covid -19 special leave (this is not calculated in the sickness recorded)

	Jan-22			Feb-22			Mar-22			Apr-22			May-22			Jun-22		
	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP
Sickness	14.73%	13.91%	10.28%	9.57%	9.51%	9.10%	10.93%	10.96%	10.75%	10.98%	9.73%	8.70%	10.44%	7.11%	10.94%	10.97%	7.12%	9.88%
Overall Absence of All 3 Staff Group		13.97%			9.51%			10.94%			9.99%			8.09%			8.17%	
COVID Sickness	6.46%	6.02%	3.67%	2.95%	2.85%	2.34%	3.38%	2.85%	1.24%	3.70%	2.94%	3.00%	1.70%	1.85%	3.84%	1.77%	2.51%	4.42%
Overall Absence of All 3 Staff Group		6.04%			2.86%			2.91%			3.13%			1.90%			2.41%	
Sickness WITHOUT COVID Sickness	8.27%	7.89%	6.61%	6.62%	6.66%	6.76%	7.55%	8.11%	9.51%	7.28%	6.79%	5.70%	8.75%	5.27%	7.09%	9.20%	4.61%	5.46%
Overall Absence of All 3 Staff Group		7.93%			6.65%			8.03%			6.86%			6.19%			5.76%	
COVID Special Leave	0.43%	0.71%	0.00%	0.11%	0.24%	0.00%	0.17%	0.33%	0.48%	0.00%	0.04%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Overall Absence of All 3 Staff Group		0.62%			0.20%			0.30%			0.03%			0.00%			0.00%	
Trust Target 4.50%																		

Table 5: All sickness absence

5.4 Long-term and short-term sickness

Sickness over the six-month period reflects that long-term sickness continues to remain the greatest challenge across NMC/HCA staff groups, similar to previous six months data (Q2 & Q3, 2021). June 2022 (Table 6) shows the lowest long-term sickness rate since January 2022 in the reporting period and accounts for 59% (NMC/HCA) and 50% (AHP) of the total sickness.

The long-term sickness rates have been the lowest within NMC/HCA staff groups over the past 12 months.

	Jan-22		Feb-22		Mar-22		Apr-22		May-22		Jun-22	
	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term
NMC Staff Group Trust Total	39%	61%	28%	72%	36%	64%	38%	62%	36%	64%	41%	59%
HCA Staff Group Trust Total	35%	65%	35%	65%	38%	62%	40%	60%	39%	61%	41%	59%
AHP Staff Group Trust Total	50%	50%	31%	69%	21%	79%	15%	85%	26%	74%	50%	50%

Table 6: Long-term and short-term sickness proportions

5.5 Turnover

The Trust turnover threshold is 13%. The position has fluctuated over the last six months (Table 7) with the AHP workforce reflecting higher turnover than threshold. This is due to AHPs being a relatively small cohort of staff in small teams which artificially raises the percentage of turnover when the numbers of leavers may be only 1-2 staff. NMC and HCA staff groups have remained at or under threshold for the past 12 months.

	Jan-22			Feb-22			Mar-22			Apr-22			May-22			Jun-22		
	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP
Staff Group Trust Total	11%	13%	24%	11%	13%	14%	11%	13%	17%	12%	12%	15%	12%	13%	21%	10%	12%	25%
Trust Target 13%																		

Table 7: Turnover

5.6 Age profile

The age profile in the staff groups overall have marginally shifted over most of the age bands, with recruitment of midwives in October 2021 seeing a previous increase in age band 21-25, and now see this is a static position reflecting retention of those midwives ahead of further batch recruitment of newly qualified midwives. Table 8 reflects the position overall across all NMAHP staff groups. There remains a risk in Nursing and Midwifery to those who may retire now or in the next five years, however the numbers have positively, yet marginally reduced further, since previous reporting.

Headcount	Jan-22			Feb-22			Mar-22			Apr-22			May-22			Jun-22		
	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP
<=20 Years	3	0	0	5	0	0	5	0	0	4	0	0	3	0	0	3	0	0
21-25	17	61	1	18	61	1	19	60	1	20	59	1	23	60	1	25	59	1
26-30	30	87	4	29	87	5	29	82	6	30	77	6	31	79	6	31	82	5
31-35	31	110	8	30	113	12	29	115	12	26	117	13	25	117	13	24	120	13
36-40	30	91	7	30	91	7	30	88	7	33	91	6	33	92	5	32	92	4
41-45	19	91	5	20	90	5	21	95	6	21	95	8	22	95	8	23	98	7
46-50	35	68	3	36	70	3	35	66	2	34	69	2	30	68	2	30	71	3
51-55	29	83	6	29	81	5	30	86	5	28	83	5	32	81	5	32	81	5
56-60	30	85	6	29	87	6	29	84	5	26	83	6	26	83	5	28	84	5
61-65	23	35	1	24	35	1	25	35	1	28	35	1	28	36	1	27	39	1
66-70	4	4	0	4	3	0	4	3	0	4	2	0	4	2	0	4	2	0
>=71 Years	1	1	0	1	1	0	1	1	0	0	1	0	0	1	0	0	1	0
Total	252	716	41	255	719	45	257	715	45	254	712	48	257	714	46	259	729	44
Total of all 3 Staff Groups	1009			1019			1017			1014			1017			1032		

Table 8: NMAHP age profile data

6. Trustwide Nursing, Midwifery and AHP Training and Personal Development Review (January 2022-June 2022)

Across all staff groups it can be seen (Table 9) that the achievement and performance of training (MT, CMT, LMT) and Personal Development Reviews (PDRs) has been a fluctuating position across the six-months. Trust thresholds for indicators are as follows:

- Core Mandatory Training (CMT) – 95%
- Local Mandatory Training (LMT) – 95%
- Mandatory Training (MT) – 95%
- PDR – 90%

AHP staff group have shown the most improvement across all indicators, albeit are only above threshold in Mandatory Training in June 2022. All other indicators in June 2022 across all staff groups remain below threshold with some improvements since January 2022. All Divisions continue to work to improve this position with oversight within Divisions. Due to the challenges faced in Maternity they have more focussed improvement plans in place. They included a training data validation and cleansing exercise with workforce Information and headroom recalculation and uplift (23%) in April 2022. A risk-based approach to prioritising training which is clinically focussed has been undertaken with trajectories set and projected to achieve by January 2023. Additionally Maternity have a 12-month training plan for Multi-Professional Education and Training (MPET). All divisions have completed a training data validation exercise with similar challenges as Maternity and are therefore looking to adopt a comparable approach.

	Jan-22				Feb-22				Mar-22				Apr-22				May-22				Jun-22			
	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR
NMC Staff Group Trust Total	77.89%	65.30%	83.98%	77.90%	77.72%	65.63%	82.21%	74.59%	77.83%	67.96%	82.51%	62.67%	76.10%	69.28%	84.48%	77.03%	75.74%	66.19%	84.62%	76.41%	76.34%	68.53%	87.23%	81.37%
HCA Staff Group Trust Total	78.13%	68.93%	89.27%	77.66%	77.94%	70.36%	88.63%	69.23%	77.49%	70.17%	88.40%	56.07%	75.88%	68.51%	91.16%	65.40%	78.07%	62.78%	92.24%	71.56%	80.58%	70.88%	94.97%	80.93%
AHP Staff Group Trust Total	81.19%	100.00%	90.17%	82.35%	79.25%	77.27%	91.63%	73.68%	87.68%	86.96%	90.31%	66.67%	89.08%	92.91%	91.60%	82.86%	91.62%	93.08%	95.86%	70.27%	89.25%	90.91%	96.84%	83.78%

Table 9: Training and PDR data

7.0 Measurement of Quality of Care

7.1 Clinical Incident Reporting

The Trust has a local incident reporting system (Ulysses) that staff access to report any patient safety incident that is unintended or unexpected which could have (near miss) or did lead to harm, allowing the organisation to investigate, learn and take action to prevent re-occurrence. Incidents related to staffing levels are an example of incidents reported.

The number of Trustwide clinical incidents reported within the last six months (Jan 2022-June 2022) can be seen in Table 10. The data further highlights the incidents related to staffing levels and/or staff sickness affecting staffing levels and is drawn from the overall incidents reported within the timeframe.

Of the total clinical incidents related to staffing Family Health Division had the largest volume of 217; (Maternity, 216 Neonatal, 1), Clinical Support Services (CSS) Division reported 29 and Gynaecology Division reported 37.

Since previous reporting period (July 2021-Decemer 2021) all but one area (Neonatal) saw a rise in the number of clinical incidents relating to staffing, with Maternity seeing the greatest rise (25), then CSS division (9) and Gynaecology division (8). When triangulated with gross unavailability of staff in Maternity in particular, the increased reporting reflects the multi-factorial position.

Reporting Period January 2022- June 2022
Total incidents reported = 3834
Total clinical incidents reported = 3363
Total staffing levels/staff sickness incidents reported related to clinical incidents = 284 (1 incident relates to Corporate Services/H&S)

Table 10**:** Trustwide overview of incidents

7.2 Red flag events

NICE guidance (2014, 2015) recommends that the trust have a mechanism to capture “red flag” events (Appendix 3). The trust has incorporated the reporting of red flag events into the Trust incident reporting system. Incidents can be triangulated against acuity and dependency and planned versus actual staffing levels for the day. Triangulation of data assists with informed decision making related to staffing.

There were 174 red flags reported between January 2022 – June 2022 with the majority reported in Maternity services. The breakdown of red flags is as follows: Maternity services, 174; Neonatal Unit, 0; CSS, 0 and Gynaecology, 0.

On closer analysis of closed red flags in Maternity between January 2022 – June 2022, the 3 highest closed red flags following appropriate review are related to the delay in ongoing process of induction of labour >4 hours (62), delay >2 hours between admission and induction of labour (31) and staffing problems – levels and skill mix (21).

To ensure patient safety, all women waiting for a bed on delivery suite or for an available midwife to provide 1:1 care in labour receive care as per Induction of Labour Guidelines (v9.1). This means that women are cared for in an induction of labour bay with care overseen by a midwife. Women waiting for transfer to delivery suite for ongoing induction of labour are subject to a twice daily multi-disciplinary review to prioritise case-based need. The Maternity bleep holder and the Multi-Disciplinary Team review inductions of labour who are scheduled to come in the following day to identify and pre-empt any areas of challenge. All red flags are reviewed in Maternity Clinical Risk meeting.

Divisional oversight of Red Flags is reported into the Trust Integrated Performance Report each month.

7.3 Serious Incidents

As highlighted by the Serious Incident Framework (NHSE, 2015) serious incidents in health care are events where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant that they warrant attention to ensure these incidents are identified correctly, investigated thoroughly and trigger actions that will prevent them from happening again.

There was a total of twelve serious incidents (SIs) in the Trust between January 2022-June 2022. Of the twelve, nine occurred in Maternity (5 Escalation issues, 1 Divert, 1 Surgical issue, 1 retained swab (Never Event), 1 community maternal death). In addition to this, there was one jointly owned serious incident between Maternity and Neonatal relating to Clinical Management Guidelines not being followed. Neonates has one SI which related to an Invasive Procedure. Gynaecology Division also had one serious incident that related to surgical issues related to a complex case. CSS division reported none during the reporting period.

None of the incidents highlighted staff shortages as a root cause of incident, however one of the SIs relating to escalation issues, identified failure to identify or escalate concerns at different stages in care and involved different grades of staff.

7.4 Patient Experience - Friends and Family Test (FFT)

The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. Guidance sets out the requirement of FFT under the NHS Standard Contract for organisations (NHSE/I, 2019).

A total of **4730** "Overall Experience" comments were received during the period January 2022 - June 2022.

Of these **244** (5.1%) comments were received by patients noting themselves as "displeased". Of these displeased comments **33** (13.5%) mentioned staffing numbers/shortages in their description of their experience. These mainly related to Maternity services but did cover other areas as well. The common theme of these were the lack of support on the ward which the patients attributed to being understaffed.

Following changes in National FFT requirements commencing (2020) the Trust introduced an additional question and started to ask patients "please tell us anything we could have done better". In the period from January 2022 - June

2022, **3084** comments were left in this section covering both Pleased and Displeased results. Of these **106** (3.4%) identified staffing numbers/shortages as something that needed to be improved, compared to the previous six months where 80 comments were left from 2235. The majority of these related to Maternity services, mainly attributed to Maternity Base with common themes such as: waiting for pain relief/call bells; delayed discharge; patients being concerned about the wellbeing of staff due to workload. Gynaecology themes were noted as: delayed discharge; waiting times in GED.

7.5 Complaints, Concerns and Compliments

There were **36** formal complaints received in the Trust during January 2022– June 2022 which was an increase of eight from previous six months (28). These contained 215 individual categories of concerns that required investigation within these 36 complaints. An average of 6 categories of concerns raised per complaint. Response rates for these complaints answered in timeframe agreed with the complainants stands at 52% compliance for this reporting period. There were 2 complaint categories where staffing levels were raised specifically and following investigation these were found to be "not upheld".

There were **15** PALS+ recorded during the reporting timeframe with **none** of these cases noting staffing as the main issue raised. There were **899** PALS cases noted within January 2022 – June 2022 which is a reduction from the previous reporting period (1263). There were **2** PALS case noted where shortages of staff were noted as the issue raised. These are reported into relevant divisions who review and respond.

There was a total of **49** compliments Trustwide received (via PALS) within the timeframe which broadly covered general satisfaction of the service provided, which includes staff groups and individuals. Of the **49** compliments the clinical divisions breakdown is: Gynaecology, 25; Maternity, 14; and CSS, 4. The remainder were in more than one area or in corporate services. All compliments, where possible when individuals are identified, are shared with the individual and their manager/leaders.

7.6 Staff Experience

Recognising that there can be challenges working in busy clinical roles at LWH, several interventions are in place to support staff and managers. We recognise safe staffing is the single most important determinant of employee morale, closely followed by supportive line management. LWH has implemented several strands of work to support the working lives of staff. The following is an appraisal of action being taken:

Health and Wellbeing - Nursing, Midwifery and AHP staff in all areas of the Trust had access to 18 sessions with Inspire Talkz, ex-rugby players who have experienced mental health issues and deliver group and 1-1 training sessions on keeping mentally well in the workplace and improving resilience. Going forward, 2.0wte Wellbeing Coaches will commence in the Trust in the summer to provide ongoing support to individuals and Teams. A Clinical Psychologist dedicated to supporting staff is also commencing in August 22.

Leadership and Management Programme - Engaging, motivating, and empowering staff have been topics covered on the two programmes run in the reporting period.

Flexible Working - Representatives from Nursing and Midwifery have been engaged in a task and finish group looking at how we can give staff more autonomy and ownership over their working pattern. Following a survey to all staff, a trial of shorter shifts and other flexible working measures are being implemented in pilot areas over the next six months.

Breaks Audits - Breaks continue to be closely monitored, with a programme of ongoing audits and feedback on progress at Professional Forum. Recent feedback has reflected staff are taking breaks for majority of the time they are on duty.

The Trust continues to facilitate *Trust forums* designed to support staff or enable them to share their views. Commitment of attendance from NMAHP'S is seen for the *Great Place to Work Group* and *Schwartz Rounds.* A focus on improved internal communication has taken place with the launch of '*3 key messages'*, a mix of Trust, divisional and local communications which is disseminated to staff through huddle and handover. Staff Survey action plans focus on 3 key areas of improvement and are tracked through Divisional Boards. Managers have had Quality Improvement Training to give them the tools they need to embed sustainable change.

7.7 Staff reported incidents (Violence and Aggression)

During January 2022 – June 2022 the number of reported incidents related to verbal or physical acts of violence or aggression against staff is recorded as **32**. This is twelve more than the previous reporting period, which may reflect an actual increase in incidents or improved reporting culture. Of the 32 incidents 16 of these incidents were relating to non-physical violence or aggression towards staff. One incident related to covid rules, one incident reflects a staff-on-staff incident with the remainder 14 incidents of varied causes with no patterns or trends. None of the reported incidents were physical incidents and none involved the Police.

Historically most violence and aggression incidents have been reported from maternity services, however, the current reporting period has seen a shift with an increase of incidents in gynaecology services (7). The remainder incidents from the 16 related to non-physical violence and aggression towards staff from patients or visitors are Corporate (6), Maternity (2) and Imaging (1). Matron in Gynaecology is aware of increased incidents and has requested zero tolerance posters for display, risk assessments and nurse alarm call bells.

There is continued emphasis on hearing staff views to make improvements on the experience of health and wellbeing and reporting of violence at work.

8.0 Attraction, Recruitment and Retention

LWH continues to engage and support plans within the North-West Maternity Region on International Recruitment (IR) as part of a collaborative bid hosted by Wrightington, Wigan and Leigh NHS FT. We are expecting 7 international recruits in Midwifery to commence in the Trust following successful completion of OSCE and entry onto the NMC register in January 2023. On arrival to LWH they will have a full onboarding programme. IR is in progress in Theatres with plans to have 10 WTE. Dates of when they will arrive are yet to be confirmed.

Ongoing recruitment of newly qualified nurses and midwives continues as students qualify and in line with vacancy position across all divisions. In Maternity recruitment of newly qualified midwives has been undertaken in the reporting period with approximately 52 newly qualified midwives commencing in October 2022. In addition to the recruitment of newly qualified staff, rolling adverts for posts across all divisions continues to attract experienced nurses, midwives and AHPs until they reduce or resolve their vacancy position.

LWH was successful in bidding for two sources of NHSI funding to be used to support Midwifery and Health Care Support Workers (HCSW) retention and ongoing support for 6-12months. The retention team is now in place and have been supporting the first cohort of HCSW staff through the Care Certificate. Anticipated completion date for Care Certificate for remainder staff is March 2023. A scoping exercise with HCSWs has been undertaken to gauge training

needs and pastoral support to identify areas of development. The retention team have developed generic interview questions for use in the Trust and supported HCSW interviews.

The Retention Lead Midwife has undertaken a series of actions since appointment. They have worked collegiately with learning and development to support a smoother onboarding process, commenced 'stay' interviews with midwives, been an active member of the Flexible Working Group to develop flexible working within Maternity and provided support following safety incident. In addition, they are undertaking a project to establish how support is offered to staff who are on long-term sick leave, with a view to accomplishing a smoother return to work for affected staff.

9.0 Actions and recommendations:

The following actions are proposed during next six months (July 2022 - December 2022):

- Purchase and implementation of Birthrate Plus acuity app in intrapartum areas (i.e., labour and birth) maternity to support oversight of a live dashboard of key indicators of safety and staffing
- Gynaecology establishment review of in-patient ward after SNCT analysis and staffing recommendations received
- Planned audit of all Mandatory Training across Trust co-ordinated by Head of Learning & Organisational Development
- Succession planning across all divisions in line with business planning cycle
- Several actions related to ongoing work with NHSP such as:
    - Rolling adverts with focus on full bank recruitment and increase substantive staff registration
    - Testimonials from NHSP/LWH bank staff to share on Facebook®/ LinkedIn® / NHSP and Trust websites
    - Attendance at future jobs fairs in region. Attend any relevant LWH recruitment events.
    - Survey to share among both substantive staff as well as externally on LinkedIn® to understand what would motivate staff to work at LWH
    - Payrates review- compare local trusts payrate versus fill rate to understand if pay is a factor
- Joint working with Head of OD&L and Deputy Director of Nursing and Midwifery to develop Chief Nurse sponsorship and enrichment opportunities

10.0 Conclusions

The Board of Directors are asked to recognise that managing Nursing, Midwifery and AHP staffing is not without risk (as noted on the CRR), however this is effectively managed by utilising a triangulated approach and through a series of actions, escalations, and mitigations to support the delivery of safe patient care.

The Board of Directors are requested to agree and support the actions and recommendations highlighted in Section 9.0 of the report that have been agreed and supported by the Putting People First Committee.

Furthermore, the Board of Directors are requested to take assurance that divisional oversight and actions to address areas of challenge is in place as reported at PPF Committee. Specifically noting that Maternity services report staffing twice yearly directly to the Board of Directors to fulfil requirements as outlined by The Maternity Incentive Scheme (MIS) Year 4, Safety Action 5. Neonatal services provide Board of Directors with a yearly Clinical Negligence Scheme for Trusts (CNST) compliance report.

Appendix 1 – CHPPD and Actual versus Planned Fill Rates

The NHS Digital Return via Strategic Data Collection Service (SDCS) - Safe Staffing Fill Rate each month are noted as per below from January 2022 – June 2022. The data is presented monthly to Board of Directors via the Integrated Performance Report, supported by a detailed narrative and triangulation of information from the Heads of Nursing and Midwifery.

January 2022

WARD	Fill Rate Day% RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff
Gynae Ward	88.7%	65.6%	129.0%	91.9%
Induction & Delivery Suites	95.3%	95.2%	102.5%	75.3%
Maternity & Jeffcoate	77.4%	83.3%	81.1%	97.3%
MLU	64.5%	25.8%	71.8%	45.2%
Neonates (ExTC)	95.6%	106.5%	94.9%	114.5%
Transitional Care	74.2%	103.2%	112.9%	38.7%

February 2022

WARD	Fill Rate Day% RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff
Gynae Ward	93.8%	70.2%	137.5%	100.0%
Induction & Delivery Suites	88.5%	75.0%	93.1%	94.6%
Maternity & Jeffcoate	78.6%	83.7%	73.5%	83.0%
MLU	74.1%	42.9%	82.1%	78.6%
Neonates (ExTC)	89.5%	89.3%	86.8%	98.2%
Transitional Care	53.6%	114.3%	100.0%	60.7%

March 2022

WARD	Fill Rate Day% RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff
Gynae Ward	90.0%	75.0%	137.0%	100.0%
Induction & Delivery Suites	91.0%	91.0%	95.0%	90.0%
Maternity & Jeffcoate	72.0%	80.0%	75.0%	89.0%
MLU	51.0%	35.0%	64.0%	48.0%
Neonates (ExTC)	87.0%	82.0%	88.0%	76.0%
Transitional Care	52.0%	97.0%	84.0%	65.0%

April 2022

WARD	Fill Rate Day% RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff
Gynae Ward	87.0%	77.0%	130%	95%
Induction & Delivery Suites	95.0%	77.0%	87%	100%
Maternity & Jeffcoate	81.0%	101.0%	70%	94%
MLU	58.0%	63.0%	75%	57%
Neonates (ExTC)	100.0%	75.0%	101%	55%
Transitional Care	43.0%	97.0%	127%	37%

May 2022

WARD	Fill Rate Day% RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff
Gynae Ward	85.5%	68.8%	129.0%	98.4%
Induction & Delivery Suites	82.5%	76.3%	95.3%	100.0%
Maternity Base & Jeffcoate	74.2%	97.4%	74.2%	99.1%
MLU	67.7%	54.8%	86.3%	51.6%
Neonates (ExTC)	103.7%	82.3%	103.4%	87.1%
Transitional Care	32.3%	109.7%	103.2%	51.6%

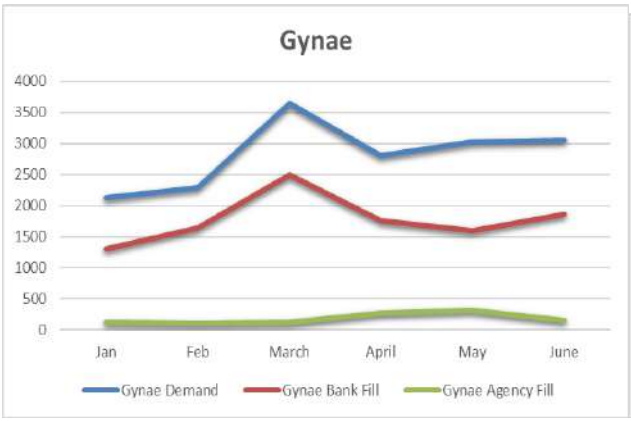
June 2022

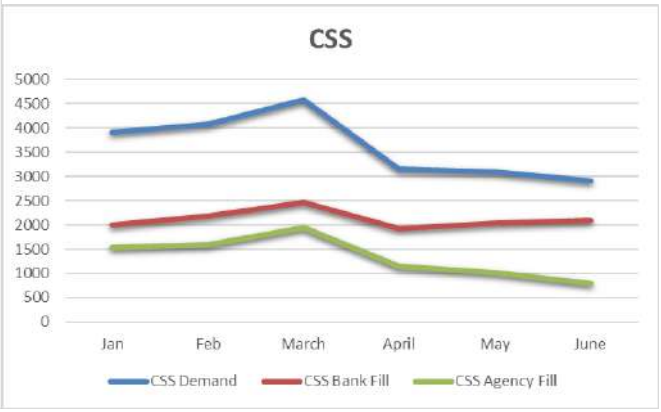
WARD	Fill Rate Day% RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff
Gynae Ward	80.8%	81.1%	115.0%	96.7%
Induction & Delivery Suites	83.1%	84.4%	96.8%	91.7%
Maternity Base & Jeffcoate	66.2%	79.5%	75.7%	88.9%
MLU	67.5%	36.7%	75.8%	60.0%
Neonates (ExTC)	104.7%	91.7%	104.6%	95.0%
Transitional Care	50.0%	130.0%	113.3%	66.7%

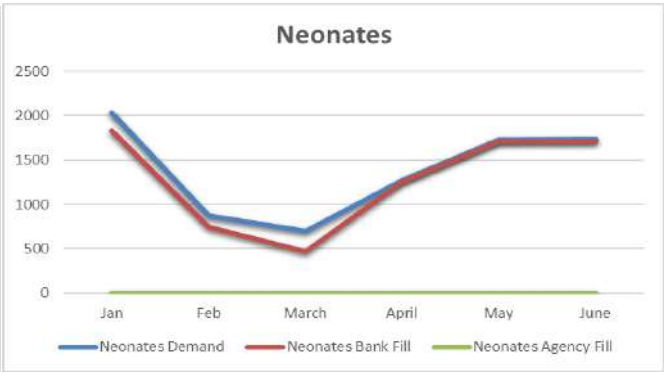
CHPPD

CHPPD	Jan 22	Feb 22	March 22	April 22	May 22	June 22
Trust wide	8.7	8.8	8.8	8.8	8.4	8.3

Appendix 2: NHSP January 2022- June 2022 Bank and Agency demand and fill rates by Directorate/Division







Appendix 3: NICE Guidance on Red Flag Events

Midwifery Red Flag Events (NICE NG54-Safe midwifery staffing for maternity settings, 2015)

A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing. If a midwifery red flag event occurs, the midwife in charge of the service should be notified. The midwife in charge should determine whether midwifery staffing is the cause, and the action that is needed.

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

Other midwifery red flags may be agreed locally.

Nursing Red Flag Events (Nice SG1 – Safe staffing for nursing in adult inpatient wards in acute hospitals, 2014)

A nursing red flag event is a warning sign that something may be wrong with nurse staffing. If a red flag event occurs, the nurse in charge of the service should be notified. The nurse in charge should determine whether nurse staffing is the cause, and the action that is needed.

- Unplanned omission in providing patient medications.
- Delay of more than 30 minutes in providing pain relief.
- Patient vital signs not assessed or recorded as outlined in the care plan.
- Delay or omission of regular checks on patients to ensure that their fundamental care needs are met as outlined in the care plan. Carrying out these checks is often referred to as 'intentional rounding' and covers aspects of care such as:
    - Pain: asking patients to describe their level of pain level using the local pain assessment tool.
    - Personal needs: such as scheduling patient visits to the toilet or bathroom to avoid risk of falls and providing hydration.
    - Placement: making sure that the items a patient needs are within easy reach.

    - Positioning: making sure that the patient is comfortable, and the risk of pressure ulcers is assessed and minimised.

- A shortfall of more than 8 hours or 25% (whichever is reached first) of registered nurse time available compared with the actual requirement for the shift. For example, if a shift requires 40 hours of registered nurse time, a red flag event would occur if less than 32 hours of registered nurse time is available for that shift. If a shift requires 15 hours of registered nurse time, a red flag event would occur if 11 hours or less of registered nurse time is available for that shift (which is the loss of more than 25% of the required registered nurse time).
- Less than 2 registered nurses present on a ward during any shift.

Other nursing red flag events may be agreed locally.

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

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Received a detailed review into Maternity mandatory training compliance which had considered the impact of sickness and staff retention on headroom and triangulation with incidents raised. It was noted that a short-term improvement in local/specific training had been demonstrated however this had impacted other training requirements as seen in the downward trends in PDR and core mandatory training. The Learning and OD Team and HR would continue work to support local services and address individual non-compliance and ensure the validation process is successfully completed. The Committee noted the actions being taken to reduce the risk. • Potential risk of industrial action. The Royal College of Nursing (RCN) intends to hold an industrial action ballot, with the opening day of the ballot on 06 October 2022. It is likely that other trade unions will also hold ballots but the dates of these have not yet been declared. Contingency planning within divisions was underway. The BMA Junior Doctors Pay Restoration campaign are meeting in the next week to confirm their intentions.	• Wagestream went live on 01 September 2022, as part of the aim to give staff financial flexibility and reduce reliance on high-cost short term loans. Wagestream is a charity-backed organisation used by over 650,000 people worldwide. Currently around 7% of staff are accessing the service in line with expectations, ultimately the aim is that 20% of staff access the service. • It was noted that the roll out of the Fair and Just Culture programme had been delayed due to the resignation of the project lead and the impact of covid-19 on the wider workforce however the team had progressed to phase 3 of the programme – implementation, and had begun to train leaders in the Fair and Just Culture approach. To date, 200+ leaders and managers had been asked to complete the training; from which 39% had passed, 41% remain in progress, and 20% who had not yet started. It was confirmed that the LWH approach to Fair and Just Culture was in line with the campaign 'Civility Saves Lives' which highlights the link between uncivil behaviours and poorer outcomes for both patients and staff. The Fair and Just Culture programme was also aligned with our 'Values to Behaviours' framework and human factors training. • NHS Staff Survey 2022 was due to be released via an electronic response as opposed to paper questionnaires. • Received the outsourced contract services review detailing value for money and positive support from contractors over the past twelve months. A number of issues in terms of KPI compliance and communication had been highlighted and actions in place to address those issues to improve services.
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**
• Received a positive staff story from a member of staff who had joined as midwife and was now a matron. The importance to provide leadership training to support successful promotions for clinical staff into management roles was noted. (WELL LED) • The Committee noted that MIAA conduct a bi-annual audit of recruitment. In addition, an internal recruitment audit had been undertaken and identified evidence of qualifications should be sought and not a reliance on membership to clinical or professional bodies as an alternative. (WELL LED) • Received a detailed update on bi-annual safer staffing review. The Committee was assured by the continued monitoring and actions to ensure safe staffing had taken place. (ALL) • The Committee noted the Medical revalidation and Pharmacy revalidation Annual Reports. It was noted that significant improvement had been made in managing doctors who do not seek approval for late/incomplete appraisals. Positive assurance was taken from the processes in place to appropriately manage the process. (SAFE / WELL LED)	• The Committee approved the statement of compliance Annex D, confirming that the organisation, as a designated body, follows revalidation regulations. • The Committee ratified several HR policies.

• Received a Staff Engagement Update noting the workstreams underway to engage with the workforce including: Great Place to Work Group; Let's Talk Survey; Annual National Staff Survey; Big Conversation; and 3 Key Messages. (WELL LED)	

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.
- Considered BAF risk 1.2 Failure to recruit & maintain a highly skilled & engaged workforce and a concern raised by the Finance Committee in relation to high agency usage particularly within maternity services. The Committee agreed to request assurances in relation to the processes in place to achieve the agency workforce targets.

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
49.	Board Assurance Framework (BAF): Workforce related risks	Assurance		56.	Pharmacy Revalidation Annual Report	Information	
50.	Staff Story	Information		57.	Fair and Just Culture Update	Information	
51.	Chief People Officer Report	Information		58.	Staff Engagement Update and NHS Staff Survey Annual Results & Action Plan	Information	
52.	Workforce KPI Dashboard Report	Assurance		59.	Outsourced Services Contract Review	Assurance	
53.	Maternity Mandatory Training	Information		60.	Recruitment Audit	Assurance	
54.	Bi-Annual Safer Staffing Review	Assurance		61.	Policies for Approval	Approval	
55.	Medical Appraisal and Revalidation Annual Report 2021/22 & Quarter 1, 2022/23 report	Assurance		62.	Sub Committee Chair Reports	Assurance	

3. 2022 / 23 Attendance Matrix

Core members	May	Jun	Oct	Jan	Mar
Susan Milner	✓	NM			
Gloria Hyatt	✓	✓	✓		
Louise Martin	✓	✓	✓		
Zia Chaudhry	✓	✓	✓		
Michelle Turner	✓	✓	✓		
Marie Forshaw	✓	✓	NM		
Dianne Brown	NM		✓		
Gary Price	✓	✓	✓		
Claire Deegan	A	✓	NM		
Linda Haigh	NM		✓		

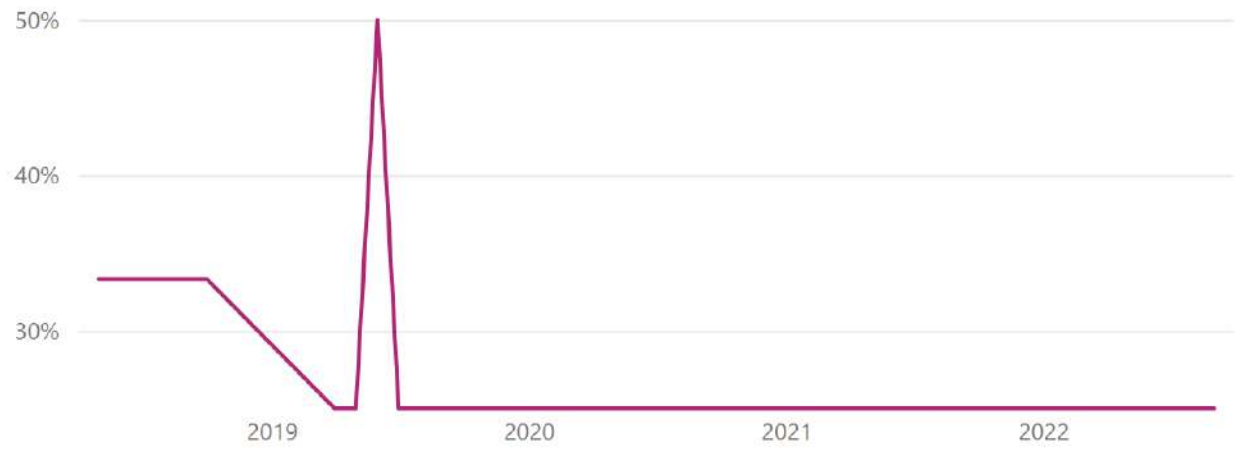
Liz Collins	✓	✓	✓		
Dyan Dickins	✓	✓	A		
Present (✓) Apologies (A) Representative (R) Nonattendance (NA) Non-Member (NM) *Non-quorate meetings highlighted in greyscale*					

Liverpool Women's
NHS Foundation Trust

Trust Board

Workforce Performance Report
November 2022

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



Positive Developments

Current in depth mandatory training audit taking place as part of ongoing programme of improvements to recording and reporting processes. Enhanced governance framework working effectively to ensure that there is appropriate approval through Education Governance that mandatory training competencies are being applied appropriately. Roll out of new email reminder system imminent and new starters now have the ability to carry out their online training before they start in post at LWH

Areas of Challenge

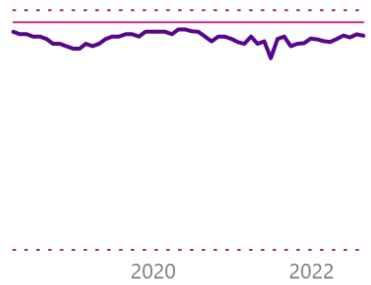
The vacancies and sickness absence in maternity will continue to negatively impact compliance until November but the Division has a clear trajectory for improvement. Impact of the revised Attendance Policy is being closely monitored by PPF committee

KPI	September 2021	October 2021	November 2021	December 2021	January 2022	February 2022	March 2022	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022
Clinical Mandatory Training Compliance	81.91%	80.35%	79.21%	78.26%	68.06%	79.22%	78.15%	75.62%	76%	76.99%	77.49%	79.05%	78.47%
Mandatory Training Compliance	89%	85%	86%	86.23%	88.17%	87.82%	87.11%	86.76%	88.01%	89.44%	88.64%	89.94%	89.37%
Sickness Absence Rate	8.35%	8.03%	7.93%	10.26%	10.99%	7.64%	9.18%	7.57%	6.6%	6.63%	7.77%	7.35%	7.16%
Turnover Rate	11%	13%	12%	12%	13%	13%	13%	13%	13%	12%	12%	12%	12.03%

Mandatory Training Compliance

>= 95%

KPI095T



Workforce
Trust Value

Chief People Officer
Exec Lead

Deputy Director of Workforce
Owner/Lead

Local
Reported To

Trust
Source

Attribute	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
% Performance	89%	85%	86%	86.23%	88.17%	87.82%	87.11%	86.76%	88.01%	89.44%	88.64%	89.94%	89.37%
Numerator	0.89	0.85	0.86	0.86	0.88	0.88	0.87	0.87	0.88	0.89	0.89	0.9	0.89

DQKM

The overall Trust mandatory training compliance fell by 0.57%, from 89.94% in month five, to 89.37% in month six. This is now 5.63% under the Trust's target rate of 95% and rated as amber. Across the largest clinical areas, compliance fell by 1.82% in Gynaecology, and by 0.84% in Maternity, but increased by 0.74% in Neonates. At divisional level, compliance fell by 1.59% in the Gynae Division, by 0.18% in Family Health, and by 1.64% in Clinical Support Services, but increased by 0.56% in the Corporate Division.

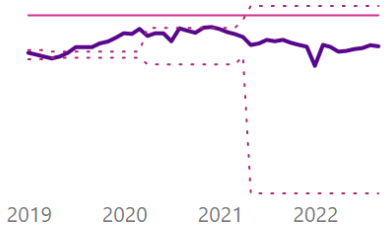
The HR and L&D teams continue to provide support, information, and training to managers across the Trust. Trajectories to underpin a sustained increase in compliance have been developed and are monitored by the Divisional Management Teams. Auto-enrolment has now been rolled out to ensure more accurate reporting and to make it easier for staff to access e-learning modules. There have been a number of technical issues with some new mandatory training courses, but compliance with these will not be included in any reported figures until three months after the problems have been addressed (to allow staff time to complete these courses). The Head of Learning & Development is currently undertaking an audit of all mandatory training.

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. 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



Workforce
Trust Value

Chief People Officer
Exec Lead

Deputy Director of Workforce
Owner/Lead

Local
Reported To

Trust
Source

Attribute	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
% Performance	81.91%	80.35%	79.21%	78.26%	68.06%	79.22%	78.15%	75.62%	76%	76.99%	77.49%	79.05%	78.47%

DQKM

September 2022

The overall Trust clinical mandatory training compliance fell by 0.58% from 79.05% in month five, to 78.47% in month six. This is now 16.53% under the Trust's target rate of 95% and rated as red. Across all the largest clinical areas, compliance increased by 0.14% in Gynaecology, and by 0.76% in Neonates, but fell by 1.11% in Maternity. At divisional level, compliance increased by 1.44% in the Corporate Division, but fell by 0.34% in the Gynaecology Division, by 0.52% in Family Health, and by 0.73% Clinical Support Services.

The HR and L&D teams continue to provide support, information, and training to managers across the Trust. Trajectories to underpin a sustained increase in compliance have been developed and are monitored by the Divisional Management Teams. Auto-enrolment has now been rolled out to ensure more accurate reporting and to make it easier for staff to access e-learning modules.

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. 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	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
% Performance	8.35%	8.03%	7.93%	10.26%	10.99%	7.64%	9.18%	7.57%	6.6%	6.63%	7.77%	7.35%	7.16%

Workforce
Trust Value

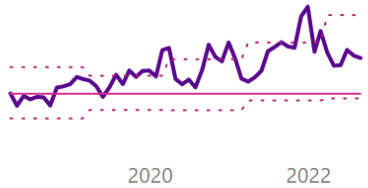
Chief People Officer
Exec Lead

Deputy Director of Workforce
Owner/Lead

National TBC
Reported To

SOF / CCG / Trust
Source

DQKM



September 2022

The single month sickness absence figure fell slightly by 0.19%, from 7.35% in month five, to 7.16 in month six. This is therefore now 2.66% above the Trust's target figure of 4.50% and is rated as red.

In the largest clinical areas, sickness fell by 0.71% in Gynaecology, and by 0.95% in Maternity, but increased by 0.27% in Neonates. At divisional level, sickness fell by 0.85% in the Gynae Division, and by 0.50% in Family Health, but increased by 1.15% in Clinical Support Services, and by 0.08% in the Corporate Division.

The split between short and long term sickness was fairly consistent across the Trust, with overall, short term sickness counting for around a third of the total figure, and long term sickness two thirds.

In terms of diagnosis, the top three most common again remained unchanged, with cold/cough/flu the most prevalent diagnoses, followed by anxiety/stress/depression, and then gastrointestinal problems. The figure for sickness specifically resulting from covid 19 fell from 1.33% in month five, to 1.14% in month six.

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 remain in place specifically to address the situation with regards to covid 19. 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. This year's flu vaccination campaign began at the end of September, running alongside the programme to deliver the second covid booster. Staff have been offered the opportunity to have both vaccinations in one visit, or have them separately if they so wish. The new trauma and PTSD support service will be launched at the end of this month, and the new role of Health & Wellbeing Coach has been introduced to support staff to be more proactive about their health and wellbeing, with one coach already in post and a second has now been recruited.

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. Nevertheless, every endeavour continues to be made to bring the figure within Trust target through effective collaboration between managers, Human Resources and Occupational Health.

Turnover Rate

Target: <= 13%

Attribute	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
% Performance	11%	13%	12%	12%	13%	13%	13%	13%	13%	12%	12%	12%	12.03%
Numerator	0.11	0.13	0.12	0.12	0.13	0.13	0.13	0.13	0.13	0.12	0.12	0.12	0.12

Workforce
Trust Value

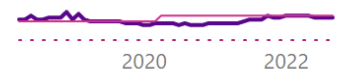
Chief People Officer
Exec Lead

Deputy Director of Workforce
Owner/Lead

National TBC
Reported To

SOF
Source

DQKM



August 2022

Turnover has stabilised at 12%. Putting aside departments with low workforce numbers, where turnover percentages can appear disproportionately high, there remain three areas where turnover is significantly above target, Finance (24.12%), Gynaecology (15.83%) and Integrated Admin (14.94%)

Support and oversight is being applied to these areas, with feedback and actions from the Big Conversation being communicated to staff to give assurances their concerns are listened to . Work is being undertaken in Gynaecology to develop improved career pathways for Healthcare Assistants, supported by the HCA Development Lead Nurse and upskilling, rotational posts and new roles such as the Nurse Associate are in Development. At a Trust level, exit interviews are being booked into diaries by the HR team in an attempt to improve uptake.

Finance, Performance & Business Development Chair's Highlight Report to Trust Board
26 September 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 detailed update against the Electronic Patient Record (EPR) programme. It was noted that an independent review had been commissioned to assess the readiness of the EPR solution against a proposed November 2022 go-live date. The outcome of the assessment concurred with the view of the EPR Programme Board; in that a November 2022 go-live date would not be feasible. A total of 27 recommendations had been proposed from which the EPR Programme Board would pull together a robust plan and share with the Committee.
• The following key matters from M5 financial performance report noted:
  ○ At Month 5, the Trust was reporting a £755k surplus. The forecast outturn for the year remained consistent with the plan, at £526k surplus for the year.
  ○ Elective recovery fund (ERF) income: system-wide data on ERF performance had not yet been released. Currently the Trust was not meeting ERF activity targets (to the value of £208k). It was noted that overall performance depended upon the Cheshire and Merseyside system achieving the target.
  ○ Fuel costs remains a significant risk. The Trust was exploring benefits of fixing prices over winter.
  ○ Capital spend was behind trajectory with £2,947k spent to Month 5 (£2,523k behind plan). Project leads had been asked to place orders by the end of October 2022 and that funds not committed by then would be reallocated to other projects to enable funds to be used in year.
  ○ Agency spend across the Trust remained above plan driven principally by staffing needs recognised in the 2022/23 plan. It was noted that the agency cap would return from September 2022, however the Trust target had not yet been confirmed by the ICS.
  ○ Potentially a material risk on Community Diagnostic Centre (CDC) funding
• Trajectory and plan in place to reduce and clear the 78+ week waits by April 2023. Additional capacity required to reduce and clear the 52+ week waits by March 2025. A proposal to consider the additional investment required would be submitted to FPBD.
• The Committee was advised that a number of CDCs across the country, including LWH had struggled to deliver levels of activity as planned. An opportunity had been offered by the regional team to potentially revise plans which would lower the activity
	• The Trust was working with NHS England to develop a Gynaecology Hub for Elective Recovery, utilising Theatre space at the Trust for patients across the region.
	• The Committee received an update against the Major Incident declared on 14 November 2021. The Committee noted actions in relation to security management in response to the findings. Recommendations in relation to the enhancement of the security current contract would have a financial impact.
	• Noted continued progress developing the Trust 'Our Strategy', development and alignment of the Integrated Care Board (ICB) Strategy and Trust plans to embed delivery of the strategy into operational planning.
	• Noted a delay in works to the CT and MRI due to inconsistencies in the Siemens information and availability to complete turnkey works. Revised timescales noted as follows: CT works planned to complete on 23 December 2022, and a clinical go-live in January 2023; MRI works will complete at the end of February 2023, enabling clinical go-live in March 2023.

plan and reduce expenditure. A refresh of the CDC Business Case was planned which would take account the changes to the project plan and funding mechanism which had taken place since the original submission. The updated case would be presented to the Committee for approval.	
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**
• An external validation of PTLs had been undertaken during September 2022 which had concluded good patient management. (EFFECTIVE/CARING) • Noted the establishment of a Theatres Improvement Group to improve efficiency & productivity, utilising Theatres Checklist sent by NHSE and a Gynaecology Transformation Group to take forward key workstreams within Outpatients, Ambulatory, Women's Health services and Acute Pathways (Non-Elective/Emergency). (ALL) • Received a detailed report on the analysis of agency spend which included risks and mitigation planned for agency spend. (RESPONSIVE/SAFE) • Noted the National Cost Collection Index (NCCI) exercise had been undertaken and submitted for 2021/22. The results from the NCCI exercise for 2020/21 had been published and the Trust had achieved a score of 103, a small increase from 102 the previous year. The Trust had been satisfied with the position in light of significant cost base increases throughout 2020/21. (WELL LED) • Received positive assurance from the post implementation review of the CIP 2021/22. It was agreed that the report should be shared with the Quality Committee as evidence of positive impact on patient experience as a result of CIP initiatives. (ALL) • Noted developments against the Trust Green Plan and that the C&M ICB had reviewed and approved the plan noting sufficient alignment with the Sustainable Development Assessment Tool. (RESPONSIVE) • The Committee received positive assurances from the bi-annual review against the Digital Generations Strategy and the Digital Services update. (EFFECTIVE) • Noted continued progress in delivering Future Generations Programme and working closely with ICB and Place colleagues. (ALL)	• Committee recommended introducing a Non-Executive Director (NED) to join the EPR Programme Board going forward for additional scrutiny. • Approved the Digital Hospital Sub-Committee Terms of Reference. • Noted that a post implementation review exercise of Our Strategy had been completed and would be reported to the Trust Board as part of a workshop session in October 2022.
Summary of BAF Review Discussion **(Board Committee level only)**	
• The Committee reviewed the Finance related BAF risks. It was noted that one new strategic threat had been agreed by Trust Board for BAF risk 3.1. Potential areas for further assurance and improve gaps in control for the following BAF risks 2.1, 2.2, 4.1 and 4.2 had been highlighted. No changes to risks scores were recommended. No risks closed on the BAF for FPBD Committee.	
Comments on Effectiveness of the Meeting / Application of QI Methodology	
• Sufficient time provided to discuss matters thoroughly • Quality of reports received commendable as directed detailed discussion on content as opposed to clarification.	

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
82.	Review of BAF risks: FPBD related risks	Assurance	**90.**	Major Incident Update	Information
83.	EPR External NHS Digital Review	Assurance	**91.**	Review of Strategic Progress	Information
84.	Finance Performance Report Month 5 2022/23	Assurance	**92.**	Crown Street Enhancements Programme Update	Information
85.	Operational Performance Report Month 5 2022/23	Assurance	**93.**	Future Generations Programme Update	Information
86.	Agency Spend Analysis- Month 5 2022/23	Information	**94.**	Community Diagnostic Centre Update	Information
87.	National Cost Collection Index	Information	**95.**	Sub-Committee Chairs Reports	Assurance
88.	Cost Improvement Programme 2021/22: Full Year Post Implementation Review		**96.**	Digital Services Update	Information
89.	Delivery a Net Zero NHS and Trust Green Plans	Information	**97.**	Digital Generations Strategy 2020-2024 Bi-annual review	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	✓	✓	✓	A	✓						
Eva Horgan	✓	✓	✓	✓	✓						
Kathryn Thomson	✓	✓	A	✓	✓						
Gary Price	✓	✓	✓	✓	✓						
Marie Forshaw	✓	✓	✓	✓	NM						
Dianne Brown				NM	✓						

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

Finance, Performance & Business Development Chair's Highlight Report to Trust Board
24 October 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 was informed that whilst the Month 6 YTD position remained on track against plan, this was being supported by non-recurrent items (£7.8m). If the Trust was to achieve its full year plan, significant improvements in the monthly run rate are needed. There is limited opportunity to generate other non-recurrent mitigations to support the position to March 2023. The Committee requested additional clarity on both items of expenditure outside and within the Trust's control. It was agreed that the Committee would require sight of a credible financial recovery plan to outline the actions available to recover the financial position. There was acknowledgement that actions within such a plan would require pace and should not wait until the next scheduled Committee meeting for approval/progressing. • It was noted that the Trust's performance against the 52-week wait metric had deteriorated. The availability of clinical staff had been a contributory factor, and this was delaying patients receiving their first outpatient appointment. Costed options for increasing capacity were presented to the Committee, with it highlighted that 40% of patients were discharged following an initial appointment. It was agreed that the proposals should be considered in the context of operational/financial recovery planning, system discussions and planning for 2023/24. • It was reported that whilst the mobile CT service is working well with over 4,000 patients having received their diagnostics onsite, the service was operating below capacity. It was reported that this was being escalated to the system, particularly in the context of waiting list challenges. Work to progress permanent staffing solutions for the Community Diagnostic Centre was underway with recruitment for imaging beginning in January 2023.	• The Committee requested to receive a copy of the financial recovery plan at the November 2022 meeting. • The Committee received an update on the Marketing Strategy. There was a request for additional clarity on the senior ownership of the Trust's public and patient engagement programmes. • It was noted in the Future Generations Update that the finalisation of the Clinical Case for Change for Board consideration would be aligned with the outputs from the Liverpool Clinical Service Review.
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**
• A six-month update on the 2022/23 Operational Plan was received. It was noted that all posts within the operational structure had been recruited to and this was having a positive impact on delivery. A level of contingency had been factored into the second half of the year as unplanned challenges were possible e.g., amber blood alert, potential industrial action, Covid-19/Flu waves. • Whilst it was recognised that the Trust had significant financial challenges – both acute and in its longer-term sustainability, positive progress had been made in the approach to the 2023/24 planning process. There had been strong engagement from a wide range of teams and individuals. • An update relating to the EPR Programme was received. Progress had been made on the business change workshops and this was being supported by strengthened divisional leadership. The possibility of receiving additional capital funding was highlighted and it was noted that this could potentially have a positive impact on the Trust I&E position.	• No decisions made.

Summary of BAF Review Discussion (Board Committee level only)
• The Committee reviewed the related BAF risks. No changes to risks scores were recommended. No risks closed on the BAF for FPBD Committee. • There was a discussion as to whether the risk to the delivery of the 2022/23 financial plan was visible as possible (currently listed as a 'strategic threat' under BAF risk 4.1). Agreed that this would be given due consideration with a recommendation made to the next Committee.
Comments on Effectiveness of the Meeting / Application of QI Methodology
• Sufficient time provided to discuss matters thoroughly

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
106.	Review of BAF risks: FPBD related risks	Assurance	**113.**	Marketing Strategy Update	Information
107.	Finance Performance Report Month 6 2022/23	Assurance	**114.**	Future Generations Programme Update	Information
108.	Operational Performance Report Month 6 2022/23	Assurance	**115.**	Community Diagnostic Centre Update	Information
109.	Elective Recovery Investment	Approval	**116.**	Crown Street Enhancements Programme Update	Information
110.	2022/23 Operational Plan 6-month update	Information	**117.**	HFMA Sustainability	Assurance
111.	Planning Update	Information	**118.**	Sub-Committee Chairs Reports	Information
112.	Digital Services Update including Information Governance Update	Assurance			

3. 2022 / 23 Attendance Matrix

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

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

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

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• It was noted that whilst all the 2019/20 MIAA/Internal audit recommendations had been closed, there remained several outstanding actions from 2020/21, some of which had been subject to deadlines being deferred on repeat occasions. The Committee requested that the Executive Team ensure that progress was being made against the recommendations ahead of the next scheduled Audit Committee. The point was reiterated that actions should be assigned to job roles rather than named individuals.	• The Committee Chair provided an update regarding the on-going external audit procurement process. It was noted that events were on track to present an option for decision at the Council of Governors meeting scheduled for the 17 November 2022. • Considering a potential change in external auditor for 2022/23, the Committee requested an additional report at the next scheduled meeting to outline the process in place to ensure that the ISA260 recommendations would be closed out. • The Committee requested that actions to reduce tender waivers should be included within the developing Procurement Strategy.
Positive Assurances to Provide	**Decisions Made**

• Three internal audit reports were received:
  ○ Health and Safety (Substantial assurance)
  ▪ The Committee noted an issue relating to ensuring that there was the required attendance at H&S related governance meetings. It was noted that the form and function of these meetings was being reviewed and that this would include considerations of attendance.
  ○ Financial Reporting & Integrity (High assurance)
  ○ Consultant Job Planning (Moderate assurance)
  ▪ It was stated that the audit had been undertaken whilst a new system (allocate) had recently been implemented. It was expected that the issues raised would resolve with pace.
• The internal audit programme for 2022/23 was noted as being on track.
• The Committee was informed of continued awareness raising activity relating to anti-fraud.
• Noted that there had been a tender waiver submitted and subsequently rejected which was an indication of robust controls and processes. Awareness work by the procurement team continued and there was a general trend of reducing waiver volume.
• Assurance was received that the Trust had been able to evidence robust processes when completing the HFMA Sustainability Checklist.
• In receiving the 2021/22 Clinical Audit Annual Report and the 2022/23 mid-year report, the Committee received assurance that the process for identifying and completing audits had strengthened, particularly in relation to setting more deliverable programmes of work and ensuring prioritisation of resources.
• A mid-year review of the Trust's Assurance Framework was received. Noted as being good practice ahead of developing the Annual Governance Statement at Year-End.
	• The Committee agreed to review the date of the next scheduled meeting, with a view of moving the date back from mid-January to the beginning of February. This would enable a potentially new external auditor to embed ahead of reporting to the Committee.

• The Committee received outputs from the conflicts of interest checks process. There had been one reportable breach during the reporting period and the Committee received assurance on how this had been managed. • Assurance was received that the Trust had strengthened its controls relating to external inspections and accreditations. • The Committee reviewed the effectiveness of its internal audit function utilising a series of questions and checkpoints developed by the finance team. No issues of concern raised.	

Comments on Effectiveness of the Meeting / Application of QI Methodology

- No issues raised.

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
041	Follow up of Internal Audit and External Audit Recommendations	To receive and review an update of actions taken.	047	Conflicts of Interest Controls	For assurance
042	MIAA Internal Audit Reports a) Internal Audit Progress Report b) Anti-Fraud Progress Report 2021/22 c) Insight Update	To note the contents and any recommendations from the report.	048	Clinical Audit Annual report 2021-22 & Interim Progress report 2022-23	To receive update
043	External Auditor Update	To receive update	049	Management of External Visits, Inspections & Accreditations	To receive update
044	Waivers Q2 Financial Year 2022/23	To note	050	Chairs reports of the Board Committees	Review of Chair's Reports for overarching assurance.
045	HFMA Sustainability Checklist		051	Board Assurance Framework (BAF)	To receive assurance
046	Assurance processes, governance, risk management and internal control	For assurance	052	Review of Internal Audit	To discuss

3. 2022 / 23 Attendance Matrix

Core members	June	July	October	January	March
Tracy Ellery	✓	✓	✓		
Zia Chaudhry	✓	✓	✓		
Jackie Bird	✓	✓	✓		

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

Charitable Funds Committee Chair's Highlight Report to Trust Board
17 October 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 charity's net movement in funds for the first quarter was a £46k decrease, taking the Trust's fund balances to £516k. The investment fund shows an unrealised revaluation loss of £91k in the first quarter with the total investment fund being valued at £819k. • The Committee raised concern that the project bid to refurbish the junior doctors mess, submitted two years ago from NHS Charities Together remained unspent and requested assurance from the Executive Team that this would be completed. It was noted that this project was at risk of losing its fund as any unspent funds need to be returned by March 2023. • Identified a recurring theme in relation to not spending committed funds and requested a list of committed but not drawn down applications to be presented at the next meeting.	• It was agreed to review the newly identified charity related fundraising risks and triangulate with existing corporate risks. • The Committee reviewed the Charity Annual report and Accounts and provided comments. A revised report would be circulated to the Committee for comment ahead of formal approval by the Board of Trustees in December 2022. The final annual report and accounts should be filed with the Charity Commission in advance of the 31 January 2023. • Committee received a presentation update against development of the Fundraising Strategy for 2022/25. It was noted that further discussion with the Board of Trustees would take place in November 2022 to agree the planning and direction of the strategy. • Roundabout replanting, supported by fundraising from Merseyside Fire and Rescue and designed by pupils from Archbishop Blanch School pupils. An unveiling ceremony would be held on 03 November 2022.
Positive Assurances to Provide	**Decisions Made**
• The Committee received the charity related fundraising risks which had been added to the Corporate Risk Register. As a new set of corporate risks the established Trust process would be adopted and the risks would be reviewed and updated on a regular basis by the Fundraising Team. • The Committee noted the positive movement of the interdebtedness position between the charity and the Trust was at £50k at the end of quarter 1, 2022/23 and noted the positive action to repay on a monthly basis. • Received a presentational update of investment performance. • Committee received an annual benchmarking review of the Financial Service Support Costs provided by the Trust to the Charity and had been assured that the amount recharged was reasonable. • Received the Fundraising Update noting positive progress against fundraising appeals. £123k total funds received during June-August 2022. The first Challenge Event had been entered and positively signed up to.	• Committee approved the request to divest from oil and gas holdings in line with the agreement on ethical investment. • The Committee approved a funding application expenditure for a fellow (30k) to undertake research related actions in relation to the Mona Lisa Laser. • Received a report on staffing of the fundraising team and approved the recruitment request to appoint to the vacant Fundraising Assistant position, approved a temporary increase of the Fundraising Manager working hours to cover the Assistant duties during the interim; and approved a recruitment and retention premium for the Head of Fundraising.

Comments on Effectiveness of the Meeting / Application of QI Methodology
• Commented on the quality of reports received allowing positive discussion.

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
18.	Review of Charitable Funds related risks	Information	**23.**	Authorisation of funding applications expenditure	Approval
19.	Quarterly Financial Position Report 2022/23	Information	**24.**	CF Applications Impact Annual review	Information
20.	Investment Position Update	Approval	**25.**	Fundraising Strategy 2022-2025	Information
21.	Charity Annual Report and Accounts 2021/22	Approval	**26.**	Fundraising Update	Information
22.	Financial Services Support Costs: Annual Benchmarking Review	Information			

3. 2022 / 23 Attendance Matrix

Core members	June 2022	Sept 2022	Feb 2023
Tracy Ellery (Chair)	✓	✓	
Louise Martin	✓	✓	
Jackie Bird	✓	✓	
Eva Horgan	✓	✓	
Michelle Turner	A	A	
Marie Forshaw	✓	NM	
Chris Gough	✓	A	
Kate Davis	✓	✓	
Dianne Brown	NM	A	

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	**22/23/138d**		**Date: 03/11/2022**	
Report Title	**Finance Performance Review Month 6 2022/23**			
Prepared by	***Linda Haigh, Interim Deputy Chief Finance Officer***			
Presented by	***Eva Horgan, Chief Finance Officer***			
Key Issues / Messages	***To receive the Month 6 financial position.***			
Action required	**Approve ☐**	**Receive ☒**	**Note ☐**	**Take Assurance ☐**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	***To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it***	***For the intelligence of the Board / Committee without in-depth discussion required***	***To assure the Board / Committee that effective systems of control are in place***
	Funding Source (If applicable): N/A			
	For Decisions - in line with Risk Appetite Statement – If no – please outline the reasons for deviation.			
	The Board is asked to receive the Month 6 Financial Position.			
Supporting Executive:	***Eva Horgan, Chief Finance Officer***			

Equality Impact Assessment *(if there is an impact on E,D & I, an Equality Impact Assessment **MUST** accompany the report)*							
Strategy ☐	Policy ☐	Service Change ☐	Not Applicable ☒				
Strategic Objective(s)							
To develop a well led, capable, motivated and entrepreneurial ***workforce***	☒	To participate in high quality research and to deliver the most ***effective*** Outcomes	☒				
To be ambitious and ***efficient*** and make the best use of available resource	☒	To deliver the best possible ***experience*** for patients and staff	☒				
To deliver ***safe*** services	☒						
Link to the Board Assurance Framework (BAF) / Corporate Risk Register (CRR)							
Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* 4.1 Failure to ensure our services are financially sustainable in the long term		Comment:					
Link to the Corporate Risk Register (CRR) – CR Number: N/A		Comment:					

REPORT DEVELOPMENT:

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

EXECUTIVE SUMMARY

At Month 6, the Trust is reporting a £822k surplus YTD. This is on plan but is supported by £7.8m of non-recurrent items. If the Trust is to achieve its plan improvements in run rate are needed, and a Recovery Plan is underway to support this. There is limited opportunity to generate other non-recurrent mitigations to support the position to March. At month 6, the forecast outturn was reported to NHSE consistent with the plan, at £526k surplus. Risks of achieving this totalling £8.3m were also reported to NHSE. The ICB must be informed of any trusts going off plan by Working Day 4. There was a detailed discussion regarding the position and reporting at the Finance, Performance and Business Development Committee and it was decided that further efforts on Financial Recovery should be made to manage the position before reporting off plan.

Since reporting to NHSE in M6, the divisions re-examined their forecasts. The forecast deficit reported for M6 to FPBD was £3.4m deficit (a £4m adverse variance). The Committee supported the approach of agreement and delivery of a Recovery Plan, which is in train at both a divisional and a Trustwide level, to manage this. This will include all possible options for actions to return to plan. Both the Trustwide plan and progress against it will be reported to the Committee in November. This is also being closely overseen by the Executive Team.

Elective recovery fund (ERF) income for 2022/23 is accrued to plan as instructed by the region. The Trust is not meeting ERF activity targets (to the value of £681k adverse variance on a £1,076k YTD in year plan). Funding depends on the Cheshire and Merseyside system achieving the target which is unlikely. It has been indicated that ERF will not be recovered for Q1 or Q2, but a risk remains about the remaining quarters.

The cost improvement programme (CIP) is reported as exceeding plan of £2.8m at £3.5m for Month 6, although this includes £2.1m of non-recurrent CIP. The positive variance relates to non-recurrent CIP. There is a risk on recurrent CIP which was reported to NHSE as c£1m.

Capital spend is behind trajectory with £2.9m spent to Month 6 (£4.5m behind plan). Project leads have been asked to place orders by the end of October 2022 and funds not committed by then will be reallocated to other projects to enable funds to be used in year.

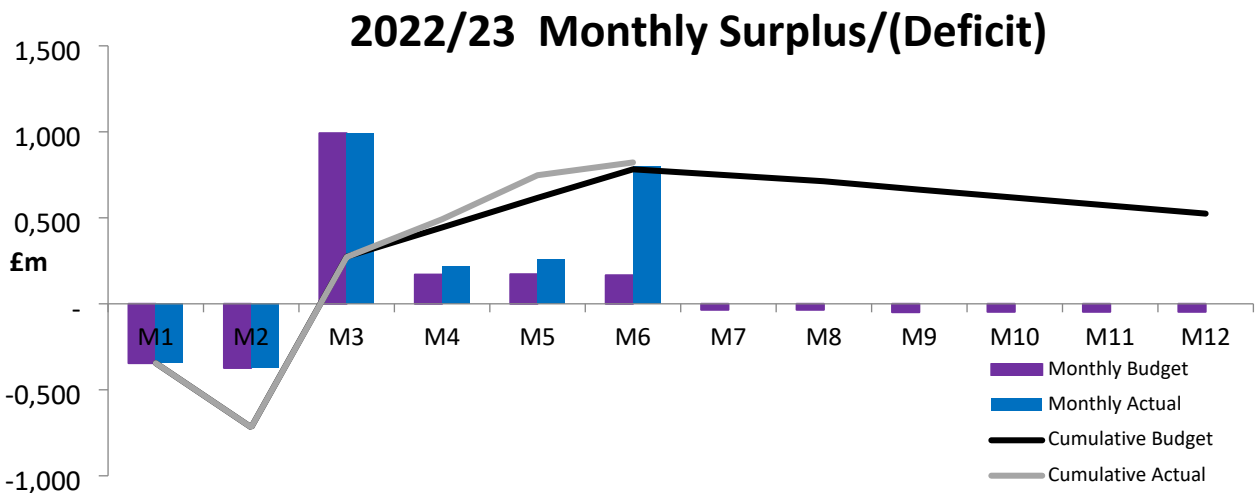
The cash balance was £3.3m at 30 September vs a forecast (per M5) of £3.5m, below minimum levels set out in the Treasury Management policy (current policy states 15 days expenditure or c £5.9m minimum cash level). The cash reduced to £2.6m prior to block funding being received. Short term cash support has been agreed via the ICB.

	Plan	Actual	Variance	RAG	R	A	G
Surplus/(Deficit) YTD	£0.8m	£0.8m	£0.0m	↔	*>10% off plan*	*Plan*	*Plan or better*
I&E Forecast (before Recovery actions)	£0.5m	-£3.4m	-£4.0m	↓	*>10% off plan*	*Plan*	*Plan or better*
NHS I/E Rating	3	3	0	↔	*4*	*3*	*2+*
Cash	£5.9m	£3.3m	-£2.6m	↓	*<£1m*	*£1m-£5.8m*	*£5.9m+*
Total CIP Achievement	£2.8m	£3.5m	£0.7m	↑	*>10% off plan*	*Plan*	*Plan or better*
Recurrent CIP Achievement	£2.0m	£1.4m	-£0.6m	↔	*>10% off plan*	*Plan*	*Plan or better*
Elective Recovery Fund (net)	£1.1m	£1.4m	£0.4m	↔	*>10% off plan*	*Plan*	*Plan or better*
Non-Recurrent Items YTD	£3.1m	£7.8m	£4.7m	↓	*>£0*		*<£0*
Capital Spend YTD	£6.5m	£2.9m	-£3.7m				

MAIN REPORT

1. Summary Financial Position

At Month 6 the Trust is reporting a £822k surplus YTD which is on plan. A forecast outturn was reported to NHSE of a £526k surplus for the year. Since reporting, the divisions have been asked to re-examine their forecasts. The forecast deficit for the year without further mitigation would be £3.4m. The graph below shows the in-month position against the revised plan.



2. Divisional Summary Overview

Divisions are now all significantly off plan and have developed Recovery Plans which they are working to in order to improve run rate. The pay award was actioned in Month 6.

Family Health: The Division is overspent by £1.2m on pay YTD, primarily driven by use of bank and agency Midwives. There is a significant overspend in Neonatal driven by increased activity and acuity in the service. There is also pressure on the Fetal Medicine Unit due to significantly increased demand.

Gynaecology: The division's expenditure is £1.6m YTD above plan, £1.2m on pay, driven primarily by medical and bank nursing costs. There is an overspend in non-pay expenditure (£286k YTD), primarily due to drugs costs. The division has been working to maximise activity (see ERF), but is underachieving to date.

Clinical Support Services: The division's expenditure is £502k above plan year to date, primarily driven by non-pay which is overspent by £375k YTD, with £284k of this for services from other NHS Foundations trusts.

Agency: Agency spend across the Trust is £1.7m YTD, £1.3m above plan. Until the 2022/23 target is confirmed performance is measured against the 2019/20 cap of £1.8m which has been breached YTD. Under the Recovery Plan all agency requests will be authorised by at least a deputy Divisional Manager. A clear trajectory for ceasing agency usage is also being agreed.

Energy costs: Gas prices to March 2022 have been fixed. Risk remains in electric prices. A forecast of £0.2m adverse variance is in place (budgets having been increased significantly in 2022/23).

3. Community Diagnostic Centre

There is a risk to the funding for the CDC. The budget is set on the original business case amount of £4.4m. The FOT for income reflects the final allocation of £4.6m. The guidance changed mid-September and funding may move to a cost per test basis in Quarters 3 and 4 based on levels of activity delivered in Quarters 1 and 2. On this basis, the revised activity forecast equates £2.3m. The expenditure committed by LWH is £3.8m. The Trust await an outcome from the regional and national team but have been about commitments made and funding required. Any funding reductions would result in further detrimental impact to the FOT position.

4. Elective Recovery Fund

Under the local ERF calculation for Month 6 (a regional/national calculation not having been shared), the Trust is now behind plan by £681k on in-year ERF. This is not reflected in the position in line with regional advice.

Providers are required to increase elective activity levels to 104% of 2019/20 levels as a minimum in 2022/23, with the exception of outpatient follow ups which are capped at 85% of 2019/20 activity. Additional funding is managed within the ICS not given to local providers directly. There remains uncertainty both about the overall level of ERF and how this will be distributed to providers. Currently Cheshire & Merseyside ICS is significantly behind target on ERF. Any possible reduction in ERF funding would deteriorate the FOT.

The Trust received additional ERF funding relating to 2021/22 in Month 1 £373k. This included an uplift for quarter 4 following confirmation of the 2019/20 baseline adjustment.

5. CIP

5a. CIP Performance 2022/23

The Trust has a stretching efficiency programme for 2022/23. This is comprised of a core CIP programme at the agreed maximum of 3% of turnover (£4.2m) plus non-recurrent efficiencies of £1.4m (vacancy factor) bringing the total to £5.6m. The Trust is achieving its total CIP target YTD and is forecast to achieve for the full year, albeit with more non recurrent measures than initially planned. Further detail is in the appendix.

Work is underway on a Financial Recovery Plan to review discretionary spend and identify mitigating CIP both for CIP that is not delivering and also to other overspends. No scheme will be implemented without a full QIA or EIA.

6. COVID-19

The Trust's covid related spend at Month 6 is £186k vs £157k budget. The forecast outturn spend is below plan. Covid rates into the winter and guidance will be monitored. The Trust will need to control costs and adjust forecasts accordingly.

7. Cash and Borrowings

The cash balance at the end of Month 6 is £3.3m, a decrease of £3.3m from Month 5. This balance is below minimum levels set out in the Treasury Management policy (15 days expenditure or c£5.9m minimum cash level). Cash levels are under close scrutiny and the Trust has secured short term support via the ICB.

8. Capital Expenditure

The capital programme for 2022/23 was oversubscribed and only critical investments were funded. The capital budget was agreed at £8.8m. Capital spend to Month 6 is £4.5m underspent but forecast to plan. Several capital purchases are being quoted at higher than plan estimates. Divisions are being asked to prioritise which pressures to fund and which projects to de-prioritise to remain within their funded total by division. Leads have been asked to place orders October so reallocate any remaining funding can be reallocated.

9. Balance Sheet

Accounts Receivable debt had increased at Month 6 £2.6m against £1.5 at March 2022, primarily relating to one education invoice due.

Performance against the Better Payment Practice Code reduced slightly to 83% by value. Performance by volume of transactions reduced slightly to 76%. Work is underway to improve this (subject to available cash).

10. Financial Recovery and Forecast

The forecast for the full year stands at a £4m shortfall without further corrective action. Divisions have all prepared and are working to individual Recovery Plans. There is also a trustwide plan which will be presented, along with updates against actions, to FPBD in November. This is being managed by the Financial Recovery Board and Executive Team. The situation has been clearly explained to the ICB who are supporting with short term cash support.

FPBD has also reviewed the Trust's underlying position and deficit and work has started on planning for 2023/24 and beyond.

11. BAF Risk

The financial position has worsened, and cash has reduced in month. If spend continues at a higher rate than income, cash levels could reduce further. The BAF risk is being reviewed and may be adjusted for Month 7 reporting.

12. Virements

A number of virements have been undertaken, approved in line with SFIs, and are listed in appendix

13. Conclusion & Recommendation

The Board is asked to receive the Month 6 position and to note the risk to achieving the financial plan. The Board is asked to note the work being undertaken on Financial Recovery.

Liverpool Women's NHS Foundation Trust

Appendix A Virements since Budget Approved by Board June 2022.

VIREMENTS 2022 -23																
Description	Directorate	Final Line	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	Comment
2022-23 AMBULATORY Virement	GYNAECOLOGY	NON PAY EXPENDITURE	-	-	-	-	-	82,492	-5,695	-5,695	-5,695	-5,695	-5,695	62,645	116,662	ERF - Aligning Budget to spend profile
		PAY EXPENDITURE	-	-	-	-	-	-126,395	-20,874	-20,874	-20,874	-20,874	-20,874	114,103	-116,662	ERF - Aligning Budget to spend profile
2022-23 AMBULATORY Virement Total			-	-	-	-	-	-43,903	-26,569	-26,569	-26,569	-26,569	-26,569	176,748	-	
2022-23 CDC Virement	RISK MANAGEMENT	NON PAY EXPENDITURE	73,333	73,333	73,333	73,333	73,333	73,333	73,333	73,333	73,333	73,333	73,333	73,334	880,000	CDC - Realigning Pay and Non Pay budgets
	TRANSFORMATION	NON PAY EXPENDITURE	189,250	189,250	189,250	189,250	189,250	189,250	189,250	189,250	189,250	189,250	189,250	189,250	2,271,000	CDC - Realigning Pay and Non Pay budgets
		PAY EXPENDITURE	-262,583	-262,583	-262,583	-262,583	-262,583	-262,583	-262,583	-262,583	-262,583	-262,583	-262,583	-262,583	-3,151,000	CDC - Realigning Pay and Non Pay budgets
2022-23 CDC Virement Total			-	-	-	-	-	-	-	-	-	-	-	-	-	
2022-23 Income ERF Upload	CENTRAL INCOME	INCOME	565,584	41,500	303,541	41,500	-220,541	-220,541	41,500	-220,541	303,541	-211,848	50,193	-473,890	0	ERF - Moving ERF from Central Cost Centre to Gynaecology
	RISK MANAGEMENT	INCOME	-528,051	-38,613	-283,332	-38,613	206,106	206,106	-38,613	206,106	-283,332	197,413	-47,307	442,132	-0	ERF - Moving ERF from Central Cost Centre to Gynaecology
	TRANSFORMATION	INCOME	-37,533	-2,887	-20,210	-2,887	14,435	14,435	-2,887	14,435	-20,210	14,435	-2,887	31,758	-	ERF - Moving ERF from Central Cost Centre to Gynaecology
2022-23 Income ERF Upload Total			-	-	-	-	-	-	-	-	-	-	-	-	-	
2022-23 Income Profiling Upload	RISK MANAGEMENT	INCOME	21,465	19,902	43,131	-35,541	-36,323	-35,323	-28,374	-28,156	-26,591	-24,823	-25,040	155,678	8	Adjusting Budget profile to Match Plan submission Profile
2022-23 Income Profiling Upload Total			21,465	19,902	43,131	-35,541	-36,323	-35,323	-28,374	-28,156	-26,591	-24,823	-25,040	155,678	8	
2022-23 Pay Budget Adjustment	CENTRAL INCOME	INCOME	-	-	-	-	-	-1,033,682	-172,280	-172,280	-172,280	-172,280	-172,280	-172,280	-2,067,362	M6 - Pay Uplift
		PAY EXPENDITURE	-	-	-	-	-	-	-	-	-	-	-	-	-	M6 - Pay Uplift
	CONTRACT MANAGEMENT	PAY EXPENDITURE	-	-	-	-	-	0	0	0	0	0	0	0	0	M6 - Pay Uplift
	COVID	PAY EXPENDITURE	-	-	-	-	-	1,541	257	257	257	257	257	257	3,082	M6 - Pay Uplift
	CSS Management	PAY EXPENDITURE	-	-	-	-	-	70	12	12	12	12	12	12	139	M6 - Pay Uplift
	ESTATES	NON PAY EXPENDITURE	-	-	-	-	-	60,848	10,141	10,141	10,141	10,141	10,141	10,141	121,695	M6 - Pay Uplift
		PAY EXPENDITURE	-	-	-	-	-	12,695	2,076	2,076	2,076	2,076	2,076	2,076	25,153	M6 - Pay Uplift
	FINANCE	PAY EXPENDITURE	-	-	-	-	-	5,000	833	833	833	833	833	833	10,000	M6 - Pay Uplift
	GENETICS SERVICES	PAY EXPENDITURE	-	-	-	-	-	5,734	956	956	956	956	956	956	11,469	M6 - Pay Uplift
	GOVERNANCE	PAY EXPENDITURE	-	-	-	-	-	5,053	875	875	875	875	875	875	10,302	M6 - Pay Uplift
	GYNAECOLOGY	PAY EXPENDITURE	-	-	-	-	-	84,500	13,901	13,901	13,901	13,901	13,901	13,901	167,908	M6 - Pay Uplift
	HEWITT FERILITY CENTRE	PAY EXPENDITURE	-	-	-	-	-	35,174	5,862	5,862	5,862	5,862	5,862	5,862	70,348	M6 - Pay Uplift
	HR & MARKETING	PAY EXPENDITURE	-	-	-	-	-	3,325	487	487	487	487	487	487	6,244	M6 - Pay Uplift
	IM&T	PAY EXPENDITURE	-	-	-	-	-	10,414	2,138	2,138	2,138	2,138	2,138	2,138	23,244	M6 - Pay Uplift
	IMAGING	PAY EXPENDITURE	-	-	-	-	-	7,736	1,289	1,289	1,289	1,289	1,289	1,289	15,472	M6 - Pay Uplift
	INTEGRATED ADMINISTRAT	PAY EXPENDITURE	-	-	-	-	-	1,978	330	330	330	330	330	330	3,956	M6 - Pay Uplift
	LEARNING AND DEVELOPMI	PAY EXPENDITURE	-	-	-	-	-	8,827	1,471	1,471	1,471	1,471	1,471	1,471	17,655	M6 - Pay Uplift
	MATERNITY	PAY EXPENDITURE	-	-	-	-	-	127,012	21,134	21,134	21,134	21,134	21,134	21,135	253,817	M6 - Pay Uplift
	NEONATAL	PAY EXPENDITURE	-	-	-	-	-	64,440	10,740	10,740	10,740	10,740	10,740	10,740	128,880	M6 - Pay Uplift
	OPERATIONAL MANAGEME	PAY EXPENDITURE	-	-	-	-	-	88	15	15	15	15	15	15	176	M6 - Pay Uplift
	PATIENT RECORDS	PAY EXPENDITURE	-	-	-	-	-	10,890	1,815	1,815	1,815	1,815	1,815	1,815	21,781	M6 - Pay Uplift
	PHARMACY	PAY EXPENDITURE	-	-	-	-	-	6,489	1,111	1,111	1,111	1,111	1,111	1,111	13,154	M6 - Pay Uplift
	PHYSIOTHERAPY	PAY EXPENDITURE	-	-	-	-	-	640	107	107	107	107	107	107	1,279	M6 - Pay Uplift
	RESEARCH AND DEVELOPMI	PAY EXPENDITURE	-	-	-	-	-	5,961	1,076	1,076	1,076	1,076	1,076	1,076	12,417	M6 - Pay Uplift
	RISK MANAGEMENT	NON PAY EXPENDITURE	-	-	-	-	-	499,420	80,594	80,594	80,594	80,594	80,594	80,594	982,986	M6 - Pay Uplift
		PAY EXPENDITURE	-	-	-	-	-	-	-	-	-	-	-	-	-	M6 - Pay Uplift
	THEATRES	PAY EXPENDITURE	-	-	-	-	-	42,209	9,453	9,453	9,453	9,453	9,453	9,453	98,928	M6 - Pay Uplift
	TRANSFORMATION	PAY EXPENDITURE	-	-	-	-	-	9,912	1,652	1,652	1,652	1,652	1,652	1,652	19,825	M6 - Pay Uplift
	TRUST OFFICES	PAY EXPENDITURE	-	-	-	-	-	24,041	4,007	4,007	4,007	4,007	4,007	4,007	48,082	M6 - Pay Uplift
2022-23 Pay Budget Adjustment Total			-	-	-	-	-	1	0	0	0	0	0	0	0	
22-23 Budget ERF Adjustment	CENTRAL INCOME	NON PAY EXPENDITURE	-	-	-	-22,780	-5,695	-5,695	-5,695	-5,695	-5,695	-5,695	-5,695	-5,695	-68,340	ERF - Moving ERF from Central Cost Centre to Gynaecology
		PAY EXPENDITURE	-	-	-	-131,496	-32,874	-32,874	-32,874	-32,874	-32,874	-32,874	-32,874	-32,874	-394,488	ERF - Moving ERF from Central Cost Centre to Gynaecology
	GYNAECOLOGY	NON PAY EXPENDITURE	-	-	-	22,780	5,695	5,695	5,695	5,695	5,695	5,695	5,695	5,695	68,340	ERF - Moving ERF from Central Cost Centre to Gynaecology
		PAY EXPENDITURE	-	-	-	131,496	32,874	32,874	32,874	32,874	32,874	32,874	32,874	32,874	394,488	
22-23 Budget ERF Adjustment Total			-	-	-	-	-	-	-	-	-	-	-	-	-	
22-23 Budget Risk Management Virement	CENTRAL INCOME	NON PAY EXPENDITURE	-	-	-	-	-	-	-	-	-	-	-	-	-	Budget Phasing Correction
	GYNAECOLOGY	NON PAY EXPENDITURE	-	-	-	-	-	-	-	-	-	-	-	-	-	Budget Phasing Correction
	RISK MANAGEMENT	NON PAY EXPENDITURE	-	-	-	-	-6,050	-1,190	1,210	1,210	1,210	1,210	1,210	1,190	-	Budget Phasing Correction
22-23 Budget Risk Management Virement Total			-	-	-	-	-6,050	-1,190	1,210	1,210	1,210	1,210	1,210	1,190	-	
22-23 Budget Virement	NEONATAL	INCOME	-	-	-	-	-51,268	-10,254	-10,254	-10,254	-10,254	-10,254	-10,254	-10,252	-123,044	Neonatal Budget Adjustment
		PAY EXPENDITURE	-	-	-	-	35,307	7,061	7,061	7,061	7,061	7,061	7,061	7,067	84,740	Neonatal Budget Adjustment
	RISK MANAGEMENT	INCOME	-	-	-	-	15,961	3,193	3,193	3,193	3,193	3,193	3,193	3,185	38,304	Neonatal Budget Adjustment
22-23 Budget Virement Total			-	-	-	-	-	-	-	-	-	-	-	-	-	
Grand Total			21,465	19,902	43,131	-35,541	-42,373	-80,415	-53,733	-53,515	-51,950	-50,182	-50,399	333,616	8	

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

FINANCE REPORT: M6

YEAR ENDING 31 MARCH 2023

Liverpool Women's NHS Foundation Trust

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Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 1
NHS IMPROVEMENT RATIOS: M06
YEAR ENDING 31 MARCH 2023

USE OF RESOURCES RISK RATING	YEAR TO DATE Actual
CAPITAL SERVICING CAPACITY (CSC)	
(a) EBITDA + Interest Receivable	5,117
(b) PDC + Interest Payable + Loans Repaid	1,245
CSC Ratio = (a) / (b)	**4.11**
NHSI CSC SCORE	**1**
Ratio Score 1 = > 2.5 2 = 1.75 - 2.5 3 = 1.25 - 1.75 4 = < 1.25	
LIQUIDITY	
(a) Cash for Liquidity Purposes	(13,571)
(b) Expenditure	68,349
(c) Daily Expenditure	447
Liquidity Ratio = (a) / (c)	**(30.4)**
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)	(837)
Total Income	(73,413)
I&E Margin	**1.1%**
NHSI I&E MARGIN SCORE	**1**
Ratio Score 1 = > 1% 2 = 1 - 0% 3 = 0 - (-1%) 4 < (-1%)	
I&E MARGIN VARIANCE FROM PLAN	
I&E Margin (Actual)	1.10%
I&E Margin (Plan)	1.10%
I&E Variance Margin	**0.00%**
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	745
YTD Agency Expenditure	1,248
	68%
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 2
INCOME & EXPENDITURE: M6
YEAR ENDING 31 MARCH 2023

INCOME & EXPENDITURE	Month 6			YTD			YEAR		
£'000	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Forecast	Variance
Income									
Clinical Income	(12,295)	(12,244)	(51)	(68,407)	(69,726)	1,319	(137,008)	(137,329)	321
Non-Clinical Income	(623)	(684)	61	(3,666)	(3,688)	22	(7,404)	(7,183)	(222)
Total Income	**(12,918)**	**(12,929)**	**11**	**(72,073)**	**(73,413)**	**1,340**	**(144,413)**	**(144,512)**	**99**
Expenditure									
Pay Costs	7,012	9,153	(2,141)	40,228	44,713	(4,485)	81,858	87,673	(5,815)
Non-Pay Costs	3,329	1,356	1,973	16,827	13,816	3,012	33,639	32,153	1,485
CNST	1,637	1,637	(0)	9,820	9,820	(0)	19,640	19,640	(0)
Total Expenditure	**11,978**	**12,146**	**(168)**	**66,876**	**68,349**	**(1,473)**	**135,137**	**139,467**	**(4,330)**
EBITDA	**(940)**	**(783)**	**(157)**	**(5,197)**	**(5,064)**	**(133)**	**(9,275)**	**(5,045)**	**(4,230)**
Technical Items									
Depreciation	521	508	13	3,127	3,049	78	6,254	6,098	156
Interest Payable	2	2	1	15	14	0	29	23	6
Interest Receivable	(1)	(10)	9	(6)	(53)	47	(12)	(115)	103
PDC Dividend	207	203	3	1,239	1,231	8	2,478	2,477	1
Profit/Loss on Disposal or Transfer Absorption	0	0	0	0	0	0	0	0	0
Total Technical Items	**729**	**702**	**27**	**4,375**	**4,242**	**133**	**8,749**	**8,484**	**265**
(Surplus) / Deficit	**(211)**	**(80)**	**(131)**	**(822)**	**(822)**	**0**	**(526)**	**3,439**	**(3,965)**

Note that the forecast above is before the actions being undertaken as part of the Recovery Plan. A forecast balanced to plan has been reported to the ICB and NHSE but the risks associated with this have been made clear. This will be further reviewed at Month 7.

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST **2a**
INCOME & EXPENDITURE HOSTED SERVICES: M6
YEAR ENDING 31 MARCH 2023

INCOME & EXPENDITURE £'000	Month 6 Budget	Month 6 Actual	Month 6 Variance	YTD Budget	YTD Actual	YTD Variance
Income						
Clinical Income	(115)	(341)	227	(687)	(1,686)	999
Non-Clinical Income	0	0	0	0	20	(20)
Total Income	**(115)**	**(341)**	**227**	**(687)**	**(1,666)**	**979**
Expenditure						
Pay Costs	0	105	(105)	0	559	(559)
Non-Pay Costs	115	237	(122)	687	1,107	(420)
Total Expenditure	**115**	**341**	**(227)**	**687**	**1,666**	**(979)**
(Surplus) / Deficit	**0**	**0**	**0**	**0**	**0**	**(0)**

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LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 3
ELECTIVE RECOVERY FUND ESTIMATE: M6
YEAR ENDING 31 MARCH 2023

	19/20 Baseline (104%)		22/23		22/23 v 19/20 Baseline		ERF Variance £000	ERF Plan £000	ERF Achieved £000
	Activity	Costed Activity £000	Activity	Costed Activity £000	Activity Variance	Costed Activity Variance			
Month 1		1,634		1,730		95	**44**	165	209
Month 2		1,813		2,053		240	**40**	182	222
Month 3		1,761		1,618		-143	**-144**	174	30
Month 4		1,831		1,621		-210	**-153**	182	29
Month 5		1,920		1,682		-238	**-179**	191	12
Month 6		2,016		1,629		-387	**-290**	182	-108
Total Income		**10,975**		**10,332**		**-643**	**-681**	**1,076**	**395**
System Payment to achieve 104%							**1,076**	0	1,076
Adjustment back to plan							**681**	0	681
PY ERF Improvement							**373**	0	373
Total Variance							**1,449**	**1,076**	**373**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 4
EXPENDITURE: M6
YEAR ENDING 31 MARCH 2023

EXPENDITURE £'000	MONTH Budget	MONTH Actual	MONTH Variance	YEAR TO DATE Budget	YEAR TO DATE Actual	YEAR TO DATE Variance	YEAR Budget	YEAR Actual	YEAR Variance
Pay Costs									
Board, Execs & Senior Managers	430	474	(44)	2,524	2,663	(139)	5,130	5,373	(243)
Medical	1,613	2,281	(668)	10,303	11,709	(1,406)	21,085	23,277	(2,192)
Nursing & Midwifery	2,987	3,721	(734)	16,896	18,440	(1,544)	33,857	36,084	(2,227)
Healthcare Assistants	580	689	(110)	2,881	3,104	(223)	5,890	6,040	(150)
Other Clinical	534	566	(32)	3,048	2,736	312	6,224	5,716	508
Admin Support	798	969	(170)	4,160	4,361	(201)	8,837	8,989	(151)
Agency & Locum	70	453	(383)	417	1,701	(1,283)	834	2,195	(1,361)
Total Pay Costs	**7,012**	**9,153**	**(2,141)**	**40,228**	**44,713**	**(4,485)**	**81,858**	**87,673**	**(5,815)**
Non Pay Costs									
Clinical Suppplies	670	966	(295)	4,203	4,874	(671)	8,413	9,456	(1,043)
Non-Clinical Supplies	832	(1,109)	1,941	1,628	(1,319)	2,947	3,163	267	2,896
CNST	1,637	1,637	(0)	9,820	9,820	(0)	19,640	19,640	(0)
Premises & IT Costs	1,004	597	407	6,057	4,950	1,108	12,069	10,540	1,529
Service Contracts	823	903	(80)	4,939	5,311	(372)	9,994	11,891	(1,897)
Total Non-Pay Costs	**4,966**	**2,993**	**1,973**	**26,648**	**23,636**	**3,012**	**53,279**	**51,794**	**1,485**
Total Expenditure	**11,978**	**12,146**	**(168)**	**66,876**	**68,349**	**(1,473)**	**135,137**	**139,467**	**(4,330)**

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LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 5
COVID EXPENDITURE: M6
YEAR ENDING 31 MARCH 2023

EXPENDITURE £'000	MONTH Budget	MONTH Actual	MONTH Variance	YEAR TO DATE Budget	YEAR TO DATE Actual	YEAR TO DATE Variance	YEAR Budget	YEAR Actual	YEAR Variance
Pay Costs									
Board, Execs & Senior Managers	3	12	(9)	19	14	5	38	14	24
Medical	0	0	0	0	(0)	0	0	(0)	0
Nursing & Midwifery	13	0	13	73	0	73	145	0	145
Healthcare Assistants	0	2	(2)	0	18	(18)	0	18	(18)
Other Clinical	0	0	0	0	(0)	0	0	(0)	0
Admin Support	0	8	(8)	0	58	(58)	0	88	(88)
Agency & Locum	0	0	0	0	0	0	0	0	0
Total Pay Costs	**17**	**22**	**(6)**	**91**	**89**	**2**	**183**	**119**	**64**
Non Pay Costs									
Clinical Suppplies	0	5	(5)	0	28	(28)	0	52	(52)
Non-Clinical Supplies	11	15	(4)	66	15	51	132	15	117
CNST	0	0	0	0	0	0	0	0	(0)
Premises & IT Costs	0	4	(4)	0	78	(78)	0	78	(78)
Service Contracts	0	(24)	24	0	(24)	24	0	(24)	24
Total Non-Pay Costs	**11**	**(1)**	**12**	**66**	**96**	**(30)**	**132**	**120**	**12**
Total Expenditure	**27**	**22**	**6**	**157**	**185**	**(28)**	**315**	**239**	**75**

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LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 6
BUDGET ANALYSIS: M6
YEAR ENDING 31 MARCH 2023

INCOME & EXPENDITURE £'000	MONTH Budget	MONTH Actual	MONTH Variance	YEAR TO DATE Budget	YEAR TO DATE Actual	YEAR TO DATE Variance
Maternity						
Income	(4,348)	(4,419)	70	(24,746)	(25,157)	411
Expenditure	2,339	2,899	(560)	13,374	14,308	(933)
Total Maternity	**(2,010)**	**(1,519)**	**(490)**	**(11,372)**	**(10,850)**	**(522)**
Neonatal						
Income	(1,839)	(1,907)	68	(10,532)	(10,560)	28
Expenditure	1,355	1,599	(244)	7,810	8,387	(577)
Total Neonatal	**(484)**	**(308)**	**(176)**	**(2,722)**	**(2,173)**	**(549)**
Division of Family Health - Total	**(2,493)**	**(1,827)**	**(666)**	**(14,093)**	**(13,023)**	**(1,071)**
Gynaecology						
Income	(2,113)	(2,076)	(37)	(12,016)	(11,940)	(76)
Expenditure	1,309	1,844	(535)	7,734	8,542	(808)
Total Gynaecology	**(805)**	**(232)**	**(572)**	**(4,282)**	**(3,398)**	**(884)**
Hewitt Centre						
Income	(768)	(795)	26	(4,489)	(4,414)	(74)
Expenditure	746	925	(179)	4,298	4,978	(680)
Total Hewitt Centre	**(23)**	**130**	**(153)**	**(190)**	**564**	**(754)**
Division of Gynaecology - Total	**(827)**	**(102)**	**(725)**	**(4,472)**	**(2,835)**	**(1,638)**
Theatres						
Income	0	0	0	0	0	0
Expenditure	959	1,148	(189)	5,544	5,731	(187)
Total Theatres	**959**	**1,148**	**(189)**	**5,544**	**5,731**	**(187)**
Genetics						
Income	(13)	(10)	(3)	(76)	(38)	(38)
Expenditure	164	167	(3)	958	784	174
Total Genetics	**152**	**158**	**(6)**	**882**	**746**	**136**
Other Clinical Support						
Income	(377)	(370)	(7)	(2,156)	(2,136)	(20)
Expenditure	569	707	(138)	3,323	3,754	(431)
Total Clinical Support	**192**	**337**	**(145)**	**1,167**	**1,618**	**(451)**
Division of Clinical Support - Total	**1,303**	**1,643**	**(340)**	**7,593**	**8,095**	**(502)**
Corporate & Trust Technical Items						
Income	(3,574)	(3,694)	120	(18,745)	(20,834)	2,088
Expenditure	5,380	3,900	1,480	28,896	27,774	1,122
Total Corporate	**1,806**	**206**	**1,600**	**10,150**	**6,940**	**3,210**
(Surplus) / Deficit	**(211)**	**(80)**	**(131)**	**(822)**	**(822)**	**(0)**
Of which is hosted;						
Income	(115)	(232)	117	(458)	(1,052)	594
Expenditure	115	231	(117)	458	1,052	(594)
Total Corporate	**0**	**(0)**	**0**	**0**	**0**	**(0)**

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LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 7
CIP: M6
YEAR ENDING 31 MARCH 2023

Scheme	Target	Actual	Variance	Target	Actual	Variance	Target	FOT	Variance
Procurement and Non Pay	181	1,018	837	914	1,738	824	1,835	2,788	953
Estates utilisation	34	12	-22	206	99	-107	412	362	-50
Staffing and skill mix	186	158	-29	1,039	946	-93	2,078	1,892	-186
Medicines Management	3	3	0	15	15	0	30	30	0
Service Developments	0	0	0	0	0	0	0	0	0
Theatre Efficiency	47	0	-47	200	0	-200	369	0	-369
Technology Driven Efficiencies	9	6	-3	53	22	-31	106	70	-36
Income	78	88	11	366	719	353	773	1,338	564
Other Savings Plans	0	0	0	0	0	0	0	0	0
Total	**538**	**1,285**	**746**	**2,793**	**3,540**	**747**	**5,603**	**6,479**	**876**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 8
BALANCE SHEET: M06
YEAR ENDING 31 MARCH 2023

BALANCE SHEET £'000	YEAR TO DATE Opening	M06 Actual	Movement
Non Current Assets	101,380	101,134	(246)
Current Assets			
Cash	11,192	3,251	(7,941)
Debtors	5,929	10,267	4,338
Inventories	523	701	178
Total Current Assets	**17,644**	**14,219**	**(3,425)**
Liabilities			
Creditors due < 1 year - Capital Payables	(4,849)	(1,837)	3,012
Creditors due < 1 year - Trade Payables	(18,362)	(17,678)	684
Creditors due < 1 year - Deferred Income	(4,157)	(5,784)	(1,627)
Creditors due > 1 year - Deferred Income	(1,561)	(1,545)	16
Loans	(1,525)	(1,219)	306
Loans - IFRS16 leases	(49)	(36)	13
Provisions	(3,889)	(1,676)	2,213
Total Liabilities	**(34,392)**	**(29,775)**	**4,617**
TOTAL ASSETS EMPLOYED	**84,632**	**85,578**	**946**
Taxpayers Equity			
PDC	70,713	70,713	0
Revaluation Reserve	12,749	12,749	0
Retained Earnings	1,170	2,116	946
TOTAL TAXPAYERS EQUITY	**84,632**	**85,578**	**946**

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LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
CASHFLOW STATEMENT: M06
YEAR ENDING 31 MARCH 2023

CASHFLOW STATEMENT £'000	Actual
Cash flows from operating activities	2,014
Depreciation and amortisation	3,049
Impairments and reversals	0
Income recognised in respect of capital donations (cash and non-cash)	0
Movement in working capital	(5,538)
Net cash generated from / (used in) operations	**(475)**
Interest received	49
Purchase of property, plant and equipment and intangible assets	(5,873)
Proceeds from sales of property, plant and equipment and intangible assets	0
Net cash generated from/(used in) investing activities	**(5,824)**
PDC Capital Programme Funding - received	0
PDC COVID-19 Capital Funding - received	0
Loans from Department of Health Capital - repaid	(306)
Loans from Department of Health Revenue - received	0
Loans from Department of Health Revenue - repaid	0
Interest paid	(15)
PDC dividend (paid)/refunded	(1,321)
Net cash generated from/(used in) financing activities	**(1,642)**
Increase/(decrease) in cash and cash equivalents	**(7,941)**
Cash and cash equivalents at start of period	11,192
Cash and cash equivalents at end of period	**3,251**

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 10
CAPITAL EXPENDITURE: M06
YEAR ENDING 31 MARCH 2023

CAPITAL EXPENDITURE	Year to Date			FOT		
£'000	Plan	Actual	Variance	Plan	Actual	Variance
Estates	583	29	554	800	800	0
Capital Projects	4,357	1,916	2,441	4,527	4,527	0
IM&T	623	696	(73)	1,282	1,282	0
Medical Equipment	1,787	220	1,567	2,211	2,211	0
	7,350	2,861	4,489	8,820	8,820	0
Grand Total	7,350	2,861	4,489	8,820	8,820	0

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*22/23/138e*		**Date: 03/11/2022**	
Report Title	**Our Strategy – Review of Delivery**			
Prepared by	*Jennifer Huyton, Associate Director of Strategy*			
Presented by	*Eva Horgan, Chief Finance Officer*			
Key Issues / Messages	*To inform the Board of delivery against the overarching Trust strategy to date.*			
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 Trust Board are asked to: • *Note the progress towards delivery of Our Strategy and its strategic objectives* • *Note the wider progress towards achievement of the Trust's ambitions* • *Approve the proposed changes to the strategic objectives.*			
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* 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) 1.2 Failure to recruit and retain key clinical staff 2.1 Failure to progress our plans to build a new hospital co-located with an adult acute site 2.2 Failure to develop our model of care to keep pace with developments and respond to a changing environment 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 3.1 Failure to deliver an excellent patient and family experience to all our service users 4.1 Failure to ensure our services are financially sustainable in the long term 4.2 Failure to expand our existing partnerships, building on learning and partnership working throughout the COVID-19 pandemic, playing a key role in establishing any ICP or ICS 5.1 Failure to progress our research strategy and foster innovation within the Trust 5.2 Failure to fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership	Comment:
Link to the Corporate Risk Register (CRR) – CR Number: N/A	Comment:

REPORT DEVELOPMENT:

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

EXECUTIVE SUMMARY

The Trust's overarching strategy, Our Strategy 2021-2025, was developed during 2020/21 and launched in April 2021. This report provides an update to the Trust Board in respect of progress made towards delivery of the objectives and achievement of the ambitions set out within the strategy. The report considers progress from both a quantitative and qualitative perspective.

Good progress has been made towards delivery of the Trust strategy since its launch. The majority of objectives are on track for delivery, and where objectives are rated as 'at risk', plans are in place to address issues. Delivery of the strategy has been well embedded into the Trust's day-to-day activities and future planning cycles. In addition to delivery of the strategic objectives, there has also been significant broader progress towards achieving the Trust's ambitions, as set out in Our Strategy.

MAIN REPORT

1. Introduction

This paper sets out progress made towards delivering the ambitions and objectives described in the Trust's overarching strategy, Our Strategy 2021-2025, since its launch in April 2021. The paper takes both a qualitative and quantitative approach to summarising delivery to date against the strategy; it details performance against specific objectives while also noting some of the many achievements that have been made in the last year which help move us closer towards achieving our ambitions and vision.

The outcomes from this review will be used to inform the Trust's operational plans for 2023/23.

2. Delivery and Monitoring

During the development process for Our Strategy, the Trust Board agreed that the Trust's existing 5 aims, were still relevant and appropriate for the organisation. The Board also agreed to enhance the aims by setting a far-reaching *ambition* aligned to each of them. These aims and ambitions were supported by 10 strategic objectives (with 31 underpinning SMART targets), against which quantitative delivery would be monitored.

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

The primary focus of Our Strategy centres on 3 of the Trust aims; People, Safety and Experience, however the remaining aims of Efficiency and Effectiveness still play a key role in the strategy.

The objectives are delivered in three primary ways:

- Specific programmes and workstreams designed to deliver objectives
- Supporting strategies and plans
- Divisional and departmental plans.

In 2021, Divisions first developed '5 Year Service Transformation Plans', which form a bridge between Our Strategy (and its supporting strategies), and annual operational plans, turning strategy into clear plans at a divisional level.

The specific supporting strategies, plans, programmes and workstreams through which each objective is delivered are detailed in Appendix 1. More broadly, the strategy is delivered through ensuring that everyone in the organisation understands our focus on people, safety, and experience, and by encouraging the values and behaviours necessary to achieve our vision. These values and behaviours have been promoted through the Trust's Be Kind campaign, and leadership development programmes.

As well as delivery of the specific strategic objectives, there are also innumerable projects and pieces of work ongoing throughout the organisation that contribute to achieving our aims, ambitions and our vision. We have been celebrating these achievements through the Trust's Be Brilliant campaign and at our recent Annual Members Meeting.

3. Proposed Changes to Objectives

Our Strategy was developed during a period of significant change in the wider health and care landscape, and during a global pandemic. Therefore, the Trust Board agreed to review objectives after the first year of implementation to ensure they remained suitable and appropriate, and to ensure the Trust was able to adapt to meet new requirements.

The following changes are proposed:

	Ambition	Objective	Executive Sponsor	Detail	Proposed Action
People	We will be an outstanding employer	Be recognised as the most inclusive organisation in the NHS with Zero discrimination for staff and patients (zero complaints from patients, zero investigations)	Chief People Officer	~~Treble number of staff from ethnic minority backgrounds in leadership roles (Band 7 and above) by 2022~~ Increase staff from ethinic minority backgrounds in leadership roles by 10 each year, until at least 25% of our leadership workforce are from ethnic minority backgrounds by 2022	AMEND MEASURE
Safety	Our services will be the safest in the country	Progress our plans to build a new hospital co-located with an adult acute site	Medical Director	Complete refresh of site options appraisal and business case for a new Liverpool Women's Hospital in ~~2021~~ 2022	AMEND DATE
		Develop our model of care to keep pace with developments and respond to a changing environment	Chief Operating Officer	Review Future Generations model of care for all services, taking account of all post-COVID learning and changes to care delivery models by ~~2021~~ 2022	AMEND DATE
				Consult and engage patients, staff and families during and subsequent to the development process - ~~2021~~ 2023	AMEND DATE
Experience	Every patient will have an outstanding experience	Deliver an excellent patient and family experience to all our service users	Chief Nurse and Midwife	~~Achieve Bliss baby charter accreditation by 2023~~ Achieve Family Integrated Care accredition by 2022	AMEND MEASURE
Efficiency	We will deliver maximum efficiency	Ensure our services are financially sustainable in the long term	Chief Finance Officer	Appraise options for future organisational form (up to and including merger) by 2022	DEFER
				Develop the Trust's commercial strategy during 2022	PAUSE
Effectiveness	Outcomes will be the best in class	Progress our research strategy and foster innovation within the Trust	Medical Director	~~Achieve university hospital status by March 2023~~ Increase the number of staff across the multidisciplinary clinical workforce who hold a substantive University contract by 50% by 2025	AMEND MEASURE
		Fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership	Chief Nurse and Midwife	Achieve a well-led 'good' rating by 2021	REMOVE

Rationale for proposed changes is included in Appendix 2.

4. Performance

Overall, the Trust is making good progress towards delivery of the strategy and is on target to meet the majority of its 10 objectives (and 31 supporting SMART targets):

Status	Objectives	Targets
Complete	0	5
On track	6	15
At risk	4	5
Behind target	0	2
Removed/Paused	0	4
Total	**10**	**31**

This section of this paper summarises quantitative delivery against objectives and SMART targets, as well as providing a flavour of some of the successes the Trust has delivered while working towards realising its ambitions. Further examples of successes delivered at a divisional level are included in Appendix 3. Detailed information regarding performance against each SMART target is provided in Appendix 4.

People

Ambition: We will be an outstanding employer

	Objective	Overall RAG	Exec Sponsor	SMART Target	Target RAG
People	Be recognised as the most inclusive organisation in the NHS with Zero discrimination for staff and patients (zero complaints from patients, zero investigations)		Chief People Officer	~~Treble number of staff from ethnic minority backgrounds in leadership roles (Band 7 and above) by 2022~~ Increase staff from ethnic minority backgrounds in leadership roles by 10 each year, until at least 25% of our leadership workforce are from ethnic minority backgrounds	METRIC AMENDED
				Ensure our workforce matches the ward of Riverside in terms of % of staff from ethnic minority backgrounds by 2025	
	Recruit and retain key clinical staff		Chief People Officer	Be in the top 10% of NHS organisations for staff engagement as evidenced by the Annual National NHS Staff Survey by 2024	
				Grow the consultant workforce to achieve 24/7 consultant cover by 2023	
				Provide an excellent education and clinical experience for all staff	

While these objectives are rated as 'at risk' overall, there are a range of factors which influence delivery (including those out with the Trust's control), and this rating reflects the significant workforce challenges experienced by the whole NHS over the last 2 years. Despite this, there is demonstrable progress towards delivery, with achievements often delivered in highly challenging circumstances.

Examples of additional progress made since the launch of the strategy towards achieving our ambition to be an outstanding employer:

- Completion of Talent Management Strategy.
- Refreshed PDR process which includes a greater focus on career conversations.
- Support package implemented for new leaders during their first 12 months in post.
- Increased Health and Well Being offer to staff.
- Comprehensive support offered to staff following major incident.
- Recruitment of full Gynaecology consultant workforce.
- Successful appointment to key clinical leadership roles.
- Support for clinical leadership roles.
- New service offered to staff to enable access to evidence based psychological therapies, support, and training and workshops around the potential impact of trauma.

- 100% of midwives under preceptorship remained with the Trust in 2022, following completion.
- Fair and Just Culture Programme work recommenced.

Safety

Ambition: Our services will be the safest in the country

	Objective	Overall RAG	Exec Sponsor	SMART Target	RAG
Safety	Progress our plans to build a new hospital co-located with an adult acute site		Medical Director	Complete refresh of site options appraisal and business case for a new Liverpool Women's Hospital in ~~2021~~ 2022	DATE AMENDED
				Contribute to the development and delivery of the Liverpool-wide estates plan during 2021	
	Develop our model of care to keep pace with developments and respond to a changing environment		Chief Operating Officer	Review Future Generations model of care for all services, taking account of all post-COVID learning and changes to care delivery models by ~~2021~~ 2022	DATE AMENDED
				Consult and engage patients, staff and families during and subsequent to the development process - ~~2021~~ 2023	DATE AMENDED
				Deliver the Quality and Clinical strategy in line with the timescales set out therein	
				Provide our hospital with the best digital capabilities and embed a digital first culture through delivering the Digital.Generations strategy by 2025	
	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		Chief Finance Officer	Secure investment to develop CT and blood bank services on site by 2021	
				Maximise the Gynaecology workforce to deliver timely, safe and effective care to our patients.	

All 3 safety objectives are rated as 'on track', with 2 (of 8) SMART targets complete, and the remaining 6 on track. The Future Generations Programme is progressing well and at pace, with detailed progress reported to the Quality and Finance, Performance and Business Development Committees. The Trust maintains a clear focus on safety at the Crown Street site, with actions to address clinical risks reported to the Quality Committee monthly and the Trust Board on a quarterly basis. A summary of clinical risks relating to the isolated site, actions implemented to address them and remaining residual risk, was recently shared with the Cheshire and Merseyside Integrated Care Board (C&M ICB).

Additional actions and achievements delivered under this objective include:

- Arrangements for mitigating risks in delivering planned and unplanned care reviewed.
- Partnership board with Liverpool University Hospitals established.
- The Crown Street Enhancements Programme is well established and due to complete in Feb 2022.
- Progress made towards establishing 24/7 transfusion laboratory onsite.
- Completion of new Fetal Medicine Unit and established new twin to twin laser service.
- Successful business case for Community Diagnostic Centre (CDC) funding. CDC services now partially established.
- Established Europe's first Neonatal Telemedicine Service with Alder Hey.
- Expansion of Telemedicine programme to obstetric service.
- Expansion of partnership working with multiple Trusts across Liverpool.
- Completion of the Trust's Quality Improvement Framework.
- Implementation of a highly successful Robotic Assisted Surgery service.

Experience

Ambition: Every patient will have an outstanding experience

	Objective	Overall RAG	Exec Sponsor	SMART Target	RAG
Experience	Deliver an excellent patient and family experience to all our service users		Chief Nurse and Midwife	~~Achieve Bliss baby charter accreditation by 2023~~ Achieve Family Integrated Care accredition by 2022	METRIC AMENDED
				Achieve the Unicef Baby Friendly Initiative by 2025	
				Achieve full delivery of the Patient Experience Framework by 2025	
				Pro-actively seek the views of diverse communities to inform the design of our services for the future, ensuring we champion the voices of our future service users	

This objective remains on track for delivery; the Trust has successfully achieved the Family Integrated Care accreditation and is on track to achieve the UNICEF Baby Friendly Initiative by 2025, with the next re-accreditation process due to take place in Q4 of 2022/23. The revised Women, Babies and Families Experience Framework has been completed and launched, with specific objectives in place to underpin delivery. Delivery is on track and regularly monitored by the Patient Involvement and Experience Committee. The Trust is building on a good track record of patient engagement (such as the Neomates group input into the design of the new Neonatal Unit), to establish a Trust-wide Patient and Public Engagement Group with the ability to inform service design and provide insight into transformational programmes.

Additional actions and achievements delivered under this objective include:

- We were among the best performing trusts in the country within the Gynaecology Inpatients Survey for 2021.
- New fetal medicine service is reducing need for families to travel long distances to receive care.
- The Trust's baby loss support worker, Sarah Martin, won the 'Exceptional Support Worker of the Year' at the National 'Our Health Heroes awards'.
- Continued Increase in breastfeeding rates, in particular within Continuity of Carer Teams.
- The Trust has completed and launched its 'Patients with Additional Needs' strategy.
- Recruitment of a new Patient Experience Matron, who is successfully building links with community groups and sharing learning from patient experiences with the Trust Board and throughout the organisation.
- Recruitment of new Culture Midwife.
- Completion of Women, Babies and Families Experience Strategy.

Efficiency

Ambition: We will deliver maximum efficiency

	Objective	Overall RAG	Exec Sponsor	SMART Target	RAG
Efficiency	Ensure our services are financially sustainable in the long term		Chief Finance Officer	Ensure efficient and effective use of all available resources	
				Ensure the Trust has an updated, balanced long term financial plan in place by 2021/22	
				Pursue appropriate opportunities to maximise Trust income for the benefit of our patients	
				Appraise options for future organisational form (up to and including merger) by 2022	DEFER OBJECTIVE
				Develop the Trust's commercial strategy during 2022	PAUSE OBJECTIVE

This objective is currently rated as having some risk to delivery, primarily because there remain significant challenges in setting agreeing a balanced long term financial plan. This is because the organisation's size does not deliver economies of scale, and clinical workarounds implemented to reduce the risks of the isolated site are often costly and not funded by commissioners. Despite this, good progress has been made, particularly towards ensuring that the Trust utilises all resources efficiently and effectively, and in successfully securing significant system.

Additional actions and achievements delivered under this objective include:

- Positive value for money opinion received from external auditors for the 2021/22 financial year.
- High assurance received in respect of all Finance internal audit reports for 2021/22.
- Robust processes are in place for the management of expenditure.
- The Trust has maintained a national cost collection index close to 100 for a sustained period.
- The Trust has a strong track record of CIP delivery.
- Surplus position delivered in 2021/22.
- Successful bids for Public Dividend Capital for a surgical robot, colposcopy suite, MRI and CDC equipment, as well as CDC revenue income of £2.4m in 2021/22 and £4.6m in 2022/23.
- The Trust has submitted a bid for capital funding to support development of a new ambulatory suite at Crown Street, which will deliver increased activity and improved cancer target performance for the region.

Effectiveness

Ambition: Our outcomes will be best in class

	Objective	Overall RAG	Exec Sponsor	SMART Target	RAG
Effectiveness	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		Chief Operating Officer	Develop a clear plan for all desirable partnerships during 2021, ensuring robust governance structures are in place	
	Progress our research strategy and foster innovation within the Trust		Medical Director	~~Achieve university hospital status by March 2023~~ Increase the number of staff across the multidisciplinary clinical workforce who hold a substantive university contract by 50% by 2025	OBJECTIVE AMENDED
				Provide clear evidence of senior nursing and midwifery research leadership by 2021	
				Demonstrate full recovery of the research, development and innovation activities during 2021 following the COVID-19 pandemic	
				Provide clear evidence of the Trust's research and development response to COVID-19 pertaining to the specific needs of the Liverpool population, during 2021	
				Refresh the research, development and innovation strategy, engaging with stakeholders throughout	
	Fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership		Chief Nurse and Midwife	Achieve a well-led 'good' rating by 2021	NOT FEASIBLE
				Achieve a well-led 'outstanding' rating by 2023	
				Achieve an overall rating of outstanding by 2025	

The Trust's objective to expand partnership working and play a key role within the emerging ICB is rated as 'on track'. The Trust has a wide range of successful partnerships in place and has made significant progress in this area since the launch of the strategy.

Work to refresh the Trust's Research, Development and Innovation strategy will compete in November 2022. Recent consultation work regarding the strategy has been undertaken, and the final version is due to be presented to the Research and Development Committee in November 2022, and the Trust has implemented a programme of review, self-assessment and preparation for CQC inspection to ensure that the well-led framework is fully embedded. A series of leadership development programmes has been implemented across different levels, to ensure the highest standards of leadership are delivered.

Additional actions and achievements delivered under these objectives include:

- Partnership working with C&M providers and the ICB to achieve balanced regional financial plan.
- Continued partnership working with Mersey Care, Liverpool University Hospitals, Liverpool Heart and Chest Hospital, Clatterbridge Cancer Centre and Alder Hey hospital to deliver a broad range of services and transformational programmes.
- Close partnership working with colleagues at place and within the ICB in respect of the Future Generations Programme.

- Successful partnership working with external suppliers to deliver new estate and services.
- Conducted 123 clinical research studies across speciality areas within the Trust; 148 publications have resulted from research involvement.
- The Duty of Candour audit found that there was 100% compliance related to Serious Incident Investigations.
- The Analgesia Efficacy for Major Gynaecological Procedures Re-audit demonstrated excellent compliance against pre-determined standards with 100% of patients having pain assessed in the recovery room with simple multimodal analgesia prescribed unless contraindicated.
- In response to a surge in COVID-19 research activity in Liverpool, the Trust continued to actively support the Liverpool School of Tropical Medicine with the delivery of the Astra Zeneca / Oxford, COMCOV II and COV009 vaccine trials.
- Leadership development programme for Band 7 and Band 8a staff implemented.
- Support and mentoring programme implemented for staff at band 8a and above joining the Trust.

5. Look forward 2023/24

There is an agreed action in the Trust's updated Well-Led action plan (agreed September 2022) to review the Trust's Strategy to ensure that it clearly articulates how organisational plans integrate with the ICB five-year joint plan and annual capital plan, and other shared plans for delivery of agreed improvements. It was noted that the strategy should adopt or be aligned with the (triple) aims of improving patient experience, improving population health, and improving value.

A review has been undertaken of the Trust's strategy and the current high-level strategy published by the Cheshire and Merseyside ICB. There is demonstrable evidence of close alignment of the values and aims but as the detail emerges, this will be closely tracked to ensure that this alignment continues. The following will also be taking into consideration as the Trust continues to develop and update its strategic direction:

National:

- Women's Health Strategy
    - There is existing demonstratable alignment between the Trust's aims and objectives and those that are included within this strategy
- Long Term Plan
- Operating Framework & Allocations
- Maternity enquiries / national reports

System:

- C&M Clinical Strategy
- C&M Maternity Strategy
- C&M Estates Strategy
- Joint Forward Plan

Place:

- One Liverpool
- Liverpool Clinical Services Review

Further work on future planning of the Trust's strategic direction will be undertaken with the Council of Governors later this month. This will include consideration to the direction of the ICB and the implications of the Women's Health Strategy.

6. Conclusion and Recommendation

Good progress has been made towards delivery of the Trust strategy since its launch in April 2021, despite significant challenges and pressures during this period, such as the continued impact of the COVID-19 pandemic, elective recovery, and national workforce challenges, which have impacted both the Trust and its partners.

The majority of objectives are on track for delivery, and where objectives are rated as 'at risk', plans are in place to address issues. Delivery of the strategy has been well embedded into the Trust's day-to-day activities and future planning cycles. In addition to delivery of the strategic objectives, there has also been significant broader progress towards achieving the Trust's ambitions, as set out in Our Strategy.

The Trust Board are asked to:

- Note the progress towards delivery of Our Strategy and its strategic objectives
- Note the wider progress towards achievement of the Trust's ambitions
- Approve the proposed changes to the strategic objectives.

Appendices

Appendix 1 – Strategic Objective Delivery Vehicles

Appendix 2 – Proposed Changes to Objectives

Appendix 3 – Divisional Strategy Delivery Examples

Appendix 4 – Detailed Performance Against All Objectives and SMART Targets

	Ambition	Objective	Executive Sponsor	Primary Delivery Vehicles
People	We will be an outstanding employer	Be recognised as the most inclusive organisation in the NHS with Zero discrimination for staff and patients (zero complaints from patients, zero investigations)	Chief People Officer	-Putting People First Strategy -Talent Management Strategy -Clinical and Quality Strategy -Women, Babies and Familes Experience Framework
		Recruit and retain key clinical staff	Chief People Officer	-Divisional Service Transformation Plans -Putting People First Strategy -Future Generations -Crown Street Enhancements -Community Diagnostic Centre Programme -Talent Management Strategy -Clinical and Quality Strategy
Safety	Our services will be the safest in the country	Progress our plans to build a new hospital co-located with an adult acute site	Medical Director	-Future Generations Programme
		Develop our model of care to keep pace with developments and respond to a changing environment	Chief Operating Officer	-Future Generations Programme -Digital Generations Strategy -LUHFT Partnership Board -Liverpool Neonatal Partnership -Community Diagnostic Centre Programme -Divisional Service Transformation Plans
		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	Chief Finance Officer	-Future Generations Programme -LUHFT Partnership Board -Liverpool Neonatal Partnership -Crown Street Enhancements Programme -Community Diagnostic Centre Programme -Divisional Service Transformation Plans
Experience	Every patient will have an outstanding experience	Deliver an excellent patient and family experience to all our service users	Chief Nurse and Midwife	-Women, Babies and Families Experience Framework -Clinical and Quality Strategy -Divisional 5 Year Service Transformation Plans -Patients with Additional Needs Strategy -Patient Involvement and Experience Committee
Efficiency	We will deliver maximum efficiency	Ensure our services are financially sustainable in the long term	Chief Finance Officer	-Future Generations Programme -Finance and Procurement Strategy -Financial Recovery Board -Divisional Service Transformation Plans

Effectiveness	Outcomes will be the best in class	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	Chief Operating Officer	-LUHFT Partnership Board -Liverpool Neonatal Partnership -FPBD Partnership Oversight -Community Diagnostic Centre Programme
		Progress our research strategy and foster innovation within the Trust	Medical Director	-R,D & I Strategy -Divisional 5 Year Service Transformation Plans
		Fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership	Chief Nurse and Midwife	-Putting People First Strategy -Leadership development programmes

	Ambition	Objective	Executive Sponsor	Detail	Proposed Action	Rationale
People	We will be an outstanding employer	Be recognised as the most inclusive organisation in the NHS with Zero discrimination for staff and patients (zero complaints from patients, zero investigations)	Chief People Officer	~~Treble number of staff from ethnic minority backgrounds in leadership roles (Band 7 and above) by 2022~~ Increase staff from ethinic minority backgrounds in leadership roles by 10 each year, until at least 25% of our leadership workforce are from ethnic minority backgrounds by 2022	AMEND MEASURE	Proposed change from a relative increase ('treble the number') to a percentage of the workforce, in relation to the local population. This was discussed and agreed by the Putting People First Committee and was felt to be more relevant and a better measure of performance, as well as representing a more ambitious target.
Safety	Our services will be the safest in the country	Progress our plans to build a new hospital co-located with an adult acute site	Medical Director	Complete refresh of site options appraisal and business case for a new Liverpool Women's Hospital in ~~2021~~ 2022	AMEND DATE	Dates of Future Generations Programme amended due to external factors.
		Develop our model of care to keep pace with developments and respond to a changing environment	Chief Operating Officer	Review Future Generations model of care for all services, taking account of all post-COVID learning and changes to care delivery models by ~~2021~~ 2022	AMEND DATE	Dates of Future Generations Programme amended due to external factors.
				Consult and engage patients, staff and families during and subsequent to the development process - ~~2021~~ 2023	AMEND DATE	Dates of Future Generations Programme amended due to external factors.
Experience	Every patient will have an outstanding experience	Deliver an excellent patient and family experience to all our service users	Chief Nurse and Midwife	~~Achieve Bliss baby charter accreditation by 2023~~ Achieve Family Integrated Care accredition by 2022	AMEND MEASURE	On further investigation, this accreditation was found to be costly (£15k per year) and as it was not recognised by either the Royal College of Paediatrics or the British Association of Perinatal Medicine, it was felt that the benefit afforded from accreditation did not represent value for money. Therefore, the Chief Nurse and Midwife agreed that the Trust should pursue the Family Integrated Care accreditation as an alternative.
Efficiency	We will deliver maximum efficiency	Ensure our services are financially sustainable in the long term	Chief Finance Officer	Appraise options for future organisational form (up to and including merger) by 2022	DEFER	This objective is not currently appropriate following the recent merger of Liverpool University Hospitals NHS Trust, the formation of Integrated Care Boards in July 2022 and the ongoing Liverpool Clinical Services Review. Any future discussion regarding organisational form will likely take place from a system perspective.
				Develop the Trust's commercial strategy during 2022	PAUSE	The Trust has a high number of competing priorities to manage at the present time (including the Future Generations Programme, Community Diagnostic Centre Programme, Crown Street Enhancements Programme, Elective Recovery and the implementation of Ockenden actions), and therefore expansion of commercial activities is not a primary focus. Reference to an approach to commercial activities will be included within the Finance and Procurement Strategy (currently under development), in order to provide guidance and to articulate the Trust's risk appetite and enable commercial activities to be pursued if appropriate.
Effectiveness	Outcomes will be the best in class	Progress our research strategy and foster innovation within the Trust	Medical Director	~~Achieve university hospital status by March 2023~~ Increase the number of staff across the multidisciplinary clinical workforce who hold a substantive University contract by 50% by 2025	AMEND MEASURE	Change proposed because the requirements to achieve university hospital status have now changed and do not reflect an organisation's size, making it essentially impossible for Liverpool Women's Hospital to achieve it. This revised measure remains ambitious and also reflects the Trust's determination to engage all staff groups in research.
		Fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership	Chief Nurse and Midwife	Achieve a well-led 'good' rating by 2021	REMOVE	This was not possible to achieve as no inspections were carried out in 2021. The Trust also has an objective to achieve an outstanding rating by 2023, which remains in place.

Family Health Divisional Update (September 2022)

NHS
Liverpool Women's
NHS Foundation Trust

The Last 6 Months…

- Significant investment in midwifery workforce, Appointed two additional Preceptorship midwives
- Appointed to DOM & HOM, Divisional Manager, Deputy Divisional Manager, Operational Support Manager, Divisional PA
- Talent pool for all grades to encourage all staff to develop
- Redesign of nursing leadership structure
- Proactive recruitment Nurses, ANNP and Consultants Neonatal
- Delivery of RCOG guidelines for consultant workforce
- Secured external investment for AHP role with Neonatal department Development of the AHP team inline with GIRFT
- Improved DNA rates for new and follow up maternity appointments
- Appointed into the role of Maternity Voices Partnership
- Enhanced collaboration between Imaging and FMU
- Launched the Maternal Medicine Centre (MMC)
- Clinically focussed, concise real time performance monitoring - GROW
- Estates remedial works commenced on Mat Base, Honeysuckle DS, HDU DS, Antenatal Reception
- 5 workstreams now live to improve Maternity Transformation at LWH

The Next 6 Months…

- Workforce: International recruitment, continued recruitment and further develop the recruitment and retention strategy for B6 midwives in the postceptorship programme, managing the culture in maternity services
- Governance & Quality: Clinical Audits, QI project per service, CQC self-assessment, Ockenden, CNST, Women and families' expectations regarding choice and personalisation of maternity care.
- Service Expansion: Phlebotomy services, FMU, specialist antenatal clinics, community services, preterm labour, MAU/BSOTS triage, Present estate restricts ambition for maternity services
- Key decisions: Diabetes service, FMU service development, COC, community and delivering services closer to home
- Contracts & Finances: SLA reviews, financial commissioning uncertainty until ICS is in place and post covid finances clarified
- Recovery: Theatre Utilisation review for elective and non-elective, capacity and demand across all services, the ongoing training requirements which are driven by trust and external regulatory bodies.
- Collaboration: Continue to support our colleagues in the Gynaecology and CSS Divisions wherever possible. Further to the national critical care review, it is envisaged that capacity within Cheshire and Mersey will be reallocated. uncertainty regarding timescales and what changes will be implemented

Gynaecology Divisional Update (September 2022)

NHS
Liverpool Women's
NHS Foundation Trust

The Last 6 Months…

- Recruitment of 2x Oncology Consultants and Advanced Nurse Practitioners
- Identification and approval of CIP schemes
- Key leadership posts recruited – OPD Matron, Deputy Divisional Manager, Quality Matron, IP Matron
- Closer working with colleagues at LUFT – Oncology and Endometriosis
- Building relationships with Family Health and CSS divisions
- Hewitt Transformational Work ongoing – dedicated management support
- Review of non-elective services and pathways – Possible relocation of services
- Provided mutual aid to the Countess of Chester with their cancer recovery programme
- New SMT established and embedded
- Use of digital technology – virtual OPD

The Next 6 Months…

- Workforce: Advanced Nurse Practitioners (divisionally), General Gynaecologists, Scanning capacity
- Governance & Quality: CQC self-assessments, HFEA standards, QI projects
- Service Expansion: Ambulatory services / General Gynaecology workforce requirements
- Key decisions: Elective Recovery Financial Costs, EPAU / MAU
- Contracts: Review and Implementation of SLA's. Finalise annual planning for 2023
- Recovery: Provide the Trust with a revised financial plan required to deliver elective recovery
- **Collaboration:** To support our divisional staff and to strengthen relationships cross divisionally

CSS Divisional Update (September 2022)

Liverpool Women's NHS Foundation Trust

The Last 6 Months…

- Significant investment in theatre staffing; 51 new recruits
- 5 new recruits for sonography, with 2 new bank staff
- Rotational Band 5 physiotherapist with Aintree Hospital
- New Imaging Services Manager, CSS Matron, PACS Manager, Deputy Divisional Manager, CDC Operational team (3 members), Assistant TP, Divisional PA
- Physiotherapy Clinical Lead appointed as Clinical Project Lead for Perinatal Pelvic Health Services
- SCITT course has been brought in-house
- Appointed into joint roles for the Cheshire and Merseyside Neonatal and Paediatric Genomic Medicine Unit
- Enhanced working relationships with LCL & AHCH labs
- Implemented mobile CT scanner and respiratory physiology tests for the CDC
- Enhanced collaboration between Imaging and FMU
- Hosted the Trust's first 'Medical Gases Group' meeting
- Supported Maternity with dedicated pharmacy support
- Theatre Utilisation Project commenced
- 5 workstreams now live to improve Pathology services at LWH

The Next 6 Months…

- Workforce: International recruitment, Medicines Safety Nurse/Midwife
- Governance & Quality: BBAC, Clinical Audits, QI project per service, CQC self-assessment
- Service Expansion: CDC onboarding, Cross Sectional Imaging, Genomics Service Specification, therapies assistant
- Key decisions: Dietetics service, Future of the CDC
- Contracts: Decontamination (tracking system and service provider), pathology services
- Recovery: Theatre Two / Elective Recovery Hub
- Collaboration: Continue to support our colleagues in the Gynaecology and Family Health Divisions wherever possible

	Ambition	Objective	Overall RAG	Executive Sponsor	Detail	RAG	Comments
People	We will be an outstanding employer	Be recognised as the most inclusive organisation in the NHS with Zero discrimination for staff and patients (zero complaints from patients, zero investigations)		Chief People Officer	~~Treble number of staff from ethnic minority backgrounds in leadership roles (Band 7 and above) by 2022~~ Increase staff from ethnic minority backgrounds in leadership roles by 10 each year, until at least 25% of our leadership workforce are from ethnic minority backgrounds	OBJECTIVE AMENDED	The original corporate objective has been modified to increase by 10 leadership roles each year until 25% of our leadership workforce being from a racially minoritised background is reached (to at least match the ward of Riverside, aligning wih tthe objective below). Agreed by the PPF Committee. Between April 2020 and April 2022, staff in post increased from 16 to 25. Whilst this is good progress, it does fall short of the aim, therefore this objective has been rated as 'at risk'.
					Ensure our workforce matches the ward of Riverside in terms of % of staff from ethnic minority backgrounds by 2025		Riverside ethnicity as detailed in a CCG report 2018 states 23.4% of the population are not white British/Irish, the fourth highest level in the city and 4.4% are 'other ethnic group (including Arab)' ethnicity. Currently 9.5% of the LWH workforce is from a racially minoritised background, therefore further working in partnership with health, education, local authority and community partners is needed to increase the number of employees from a racially minoritised background by 5% year on year to ensure we achieve Riverside representation by 2025. This represents a significant challenge, therefore this objective has been rated as 'at risk'.
		Recruit and retain key clinical staff		Chief People Officer	Be in the top 10% of NHS organisations for staff engagement as evidenced by the Annual National NHS Staff Survey by 2024		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 implement the 'Big Conversation' series of listening events, commencing in June 2022, to learn more from the staff about about working at Liverpool Women's and where improvements can be made. Good feedback was received from these events and they were repeated in September 2022. Staff survery results are influenced by a range of factors, including those outside of the Trust's control (e.g. national focus on maternity services, national worksforce shortages etc). The next staff survey is due shortly and it is hoped that the result will represent an improvement, however at present this objectuve has been rated as 'behind target'.
					Grow the consultant workforce to achieve 24/7 consultant cover by 2023		Good progress made towards delivery 24/7 consultant cover. Neonatal was compliant from April 2022 with Maternity to achieve twilight cover shortly. Improvements have been made in both recruitment and retention within the gynae consultant workforce (where 24/7 cover is not planned for or needed at the present time). The Division are continuing to consider the workforce model against the service demands. Progress has been made to extend anaesthetic consultant cover onsite for four days per week until 22:00 hrs with the ambition to achieve a fifth day and then weekends over time. Achieving 24/7 cover within anaesthetics remains the biggest challenge, however this objective has been rated as 'on track' due to the good progress made overall.
					Provide an excellent education and clinical experience for all staff		The Trust monitors the results from a range of surveys regarding its educational experience, including the GMC survey and NET survey. Feedback is reviewed and actions put in place to address any issues raised. Feedback has been recieved that the curriculum received by O&G trainess is good, but some concerns were raised re meeting surgical targets (due to impact of COVID). Changes in the curriculum for anaestheticvs trainees are a challenge for LWH, and it is difficult to attract senior trainees. Additional PAs for educational supervisors have been agreed (including within anaesthetics). The Trust receives good feedback from the university, as well as from midwifery and nursing practice educators, and provides an excellent post grad educational offer through the GP education scheme (e.g. menopause CPD offered by Dr Paula Briggs). An education strategy is to be drafted to to capture plans, for example regarding simulation training and headroom/time to train. Given the good feedback received and range of actions in place, this objective has been rated as 'on track'.
Safety	Our services will be the safest in the country	Progress our plans to build a new hospital co-located with an adult acute site		Medical Director	Complete refresh of site options appraisal and business case for a new Liverpool Women's Hospital in ~~2021~~ 2022	DATE AMENDED	The majority of the work to complete a Strategic Outline Case has been completed, with options appraisal carried out through the Future Generations Clinical Advisory Group. The Trust agreed in September 2022 to take the lead on development of the Pre-Consultation Business Case, working closely with colleagues at Place. At the time of writing, governance arrangements for the PCBC are to be agreed. The Trust is working closely with ICB colleagues to ensure they are engaged with the programme and production of the case. Refresh of the case is now scheduled for completion in 2022, to align with the New Hospitals Building Programme EOI process and the formation of ICBs. The work of the FG Programme is reported on a monthly basis in detail to both the Quality and FPBD Committees (who each oversee different parts of the programme).
					Contribute to the development and delivery of the Liverpool-wide estates plan during 2021		Complete. The Trust has successfully contributed to Liverpool and Cheshire and Merseyside Strategic Estates plans, through direct participation in estates strategy development workshops, it's role in the LUHFT Estates Strategy and the continued development of the future vision for Crown Street. While this objective as stated was completed during 2021, the C&M Estates Strategy and associated capital programme remains under development by the ICB, and therefore work in this area will continue throughout 2022 and beyond.
		Develop our model of care to keep pace with developments and respond to a changing environment		Chief Operating Officer	Review Future Generations model of care for all services, taking account of all post-COVID learning and changes to care delivery models by ~~2021~~ 2022	DATE AMENDED	Work to refresh the Future Generations model of care is well underway with initial outputs received used to inform estates modelling. This work will be an itterative process, completed in line with business case and FGCAG timescales. Workstream Terms of Reference and work plan are in place, aligned to the wider FG Programme. This workstream is clinically led.
					Consult and engage patients, staff and families during and subsequent to the development process - ~~2021~~ 2023	DATE AMENDED	Some public engagement has been undertaken, however recruitment to the planned FG Patient Reference Group has been challenging. Therefore there are now plans in place to utilise the newly formed Trust-wide Patient and Public Engagement Group for feedback and participation in the options appraisal exercise. This work will take place during Q3 of 2022/23, in line wiht the wider FG Programme timeframes.
					Deliver the Quality and Clinical strategy in line with the timescales set out therein		The work plan is regularly reviewed by the Quality Committee and provides assurance that evidence is being collated, delivery of the strategy remains within agreed timescales and that the plans have been reviewed, scrutinised, and signed off by the relevant clinical services. Divisions have 5 Year Service Transformation Plans in place to ensure that the Clinical Serrvice Priorities set out wihtin the Clinical and Quality Strategy are embedded into divisional programmes of work.
					Provide our hospital with the best digital capabilities and embed a digital first culture through delivering the Digital.Generations strategy by 2025		There is an effective Digital. Generations strategy in place which regularly reports to the FPBD Committee. Key progress has been achieved through working towards the Informatics Skills Development Network (ISDN) Excellence in Informatics Level 2 accreditation, improving the IT infrastructure including the data network refresh and the cloud backup project, and the successful digital bidding which has resulted in approximately 2 million of additional investment secured for improving digital maturity across the Trust. Service desk improvement has not progressed as quickly as desired but there is a robust plan in place to further develop this work. The Meditech Expanse project is progressing and has an intensive work plan is in place to provide assurance and ensure delivery within agreed timescales.
		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		Chief Finance Officer	Secure investment to develop CT and blood bank services on site by 2021		Complete. Bid for emergency capital funding was submitted by the Trust in early 2021, and re-submitted in July following a request from NHSI/E. Funding was approved in December 2021, and work to complete permenant CT facilities is now due to complete in December 2022.
					Maximise the Gynaecology workforce to deliver timely, safe and effective care to our patients.		The Division continue to review all workforce requirements, reviewing job plans, roles and responsibilities plus any other training needs. Recent recruitment includes two Consultant oncologists plus the addition of advanced nurse practitioners (ANPs). All Consultant job plans were reviewed last November and are due to be reviewed again in the near future. This will ensure capacity is maximised. Specialist nurse roles are being reviewed with the intention of increasing capacity to support the elective recovery programme.
Experience	Every patient will have an outstanding experience	Deliver an excellent patient and family experience to all our service users		Chief Nurse and Midwife	~~Achieve Bliss baby charter accreditation by 2023~~ Achieve Family Integrated Care accredition by 2022	OBJECTIVE AMENDED	The Division agreed with the Chief Nurse to not pursue formal Bliss accreditation as the value it would add to the service was not commensurate with the expense. Bliss Accreditation is not recognised by the Royal College or BAPM. It was agreed to work with the NWNODN to achieve Family Integrated Care (FiCare) accreditation instead as this was more comprehensive and more applicable to Neonatal services. Formal accreditation was received in May 2022.
					Achieve the Unicef Baby Friendly Initiative by 2025		BFI accreditation achieved in 2014 and re-accreditation in 2016. Re- assessment in October 2019 where 8 standards had not met the require 80%. A remote BFI assessment as planned on standards not met in April 2020, however BFI re-assessments were suspended due to the Covid pandemic. Presently working on preparing for BFI re-accreditation in Q4 2022/23.
					Achieve full delivery of the Patient Experience Framework by 2025		The Trust's Women, Babies and Families Experience Framework was developed (aligned to the national Patient Experience Framework) and published during 2021/22, with specific objectives in place. Delivery against the strategy is monitored through the Patient Involvement and Experience Committee on a regular basis. The newly recruited Patient Experience Matron is involved in planning a number of QI projects in relation to delivery of the strategy, and in reviewing and supporting completion of Equality impact Assessments for transformational programmes such as the Community Diagnostic Centre development. Work is underway to establish a Carer's Passport, 'You Said We Did' information has been displayed in clinical areas with a new related KPI in place. This objective is on track to deliver and has potential to deliver in full prior to the target date of 2025.

					Pro-actively seek the views of diverse communities to inform the design of our services for the future, ensuring we champion the voices of our future service users		Patient Experience Matron has been successful in building strong links with a range of community groups and relevant charities, and in ensuring better and wider representation of patient stories at Trust Board. The Trust is in the process of establishing a Public and Patient Engagement Group, to inform service design, provide feedback and inform programmes such as the Future Generations Programme.
Efficiency	We will deliver maximum efficiency	Ensure our services are financially sustainable in the long term		Chief Finance Officer	Ensure efficient and effective use of all available resources		Positive VfM opinion received from external auditors for 2021/22. High assurance received on all finance internal audit assurance reports for 21/22. Robust processes in place for management of expenditure eg annual budget setting process, Business Case Review Panel, and Financial Recovery Board. The Trust has manintained a national cost collection index close to 100 for a number of years demonstrating that it is relatively financially efficient despite structural issues due to size and location. Strong track record of CIP delivery. Progress monitored by FPBD and Audit Committees.
					Ensure the Trust has an updated, balanced long term financial plan in place by 2021/22		A long term financial model has been produced but there remains uncertainty in the medium term in relation to inflation and other key assumptions. In addition the new structures within the NHS mean that there is some uncertainty around planning assumptions. This is continually updated and worked on but not concluded.
					Pursue appropriate opportunities to maximise Trust income for the benefit of our patients		The Trust has been successful in securing significant system income both via the Integrated Care Board and other provider organisations; this has been in recognition of the financial challenges faced by Liverpool Women's and some of the structural issues which are beyond the Trust's control. Separately, the Trust has done extremely well at increasing private fertility income over the last few years. However there is still scope to increase private patient income in other areas and also explore other commercial income opportunities. Opportunities in respect of private physiotherapy income are currently being explored.
					Appraise options for future organisational form (up to and including merger) by 2022	DEFER OBJECTIVE	It is proposed that this objective is paused/deferred, as pursuit of this is not currently appropriate following the recent merger of Liverpool University Hospitals NHS Trust, the formation of Integrated Care Boards in July 2022 and the ongoing Liverpool Clinical Services Review. Any future discussion regarding organisational form will likely take place from a system perspective.
					Develop the Trust's commercial strategy during 2022	PAUSE OBJECTIVE	It is proposed that this objective is paused/deferred. The Trust has a high number of competing priorities to manage at the present time (including the Future Generations Programme, Community Diagnostic Centre Programme, Crown Street Enhancements Programme, Elective Recovery and the implementation of Ockenden actions), and therefore expansion of commercial activities is not a primary focus. Reference to an approach to commercial activities will be included within the Finance and Procurement Strategy (currently under development), in order to provide guidance and to articulate the Trust's risk appetite and enable commercial activities to be pursued if appropriate.
Effectiveness	Outcomes will be the best in class	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		Chief Operating Officer	Develop a clear plan for all desirable partnerships during 2021, ensuring robust governance structures are in place		The Trust has a number of highly successful partnerships in place with a range of clinical networks, and with local Trusts, including with LUHFT & LHCH for CDC, Alder Hey for the Liverpool Neonatal Partnership, and Mersey Care for the provision of specific services and future development of estate. The Trust is also working closerly with Place and the ICB regarding it's long term strategy. Progress in developing partnerships and associated governance is now reported on a quarterly basis to the FPBD Committee, and an Executive Lead has been identified. The Trust's approach to partnership working needs to remain dynamic at present, to enable a flexible response to a changing environment.
		Progress our research strategy and foster innovation within the Trust		Medical Director	~~Achieve university hospital status by March 2023~~ Increase the number of staff across the multidisciplinary clinical workforce who hold a substantive university contract by 50% by 2025	OBJECTIVE AMENDED	This objective as originally stated is now not feasible, due to the minimum number of staff required to have been granted professorship. This number is not adjusted for the size of an organisation, and has recently been increased to 20, making it virtually impossible for a Trust the size of LWH to meet. Therefore, the objective has been amended to an ambitious, but more realistic target, which will support the Trust to maintain and build on existing good links with local universities. At present, 6 staff hold a substantive university contract.
					Provide clear evidence of senior nursing and midwifery research leadership by 2021		Really good progress has been made towards delivery of this objective, with good support and engagement seen across the Trust. Specific examples include: -Three professors of midwifery attend the RD&I Committee (for UCLAN, Liverpool John Moors, LTSM), which has driven greater collaboration and willingness to progress nursing and midwifery-led research. -A joint research midwifery post has been developed wiht LSTN and commenced Jan 2022. -Trial ongoing re speculum for 3rd/4th degree tears - created opportunity for midwife PhD. -Meetings have taken place wiht PEFs in Trust to make research placements available for nurses and midwives, to be implemented in 2022. There are still further opportunities to fully embed and further expand this workstream, therefore this objective is rated as 'on track'.
					Demonstrate full recovery of the research, development and innovation activities during 2021 following the COVID-19 pandemic		All research activities were initally put on hold in April 2020. All projects were reviewed and risk assessments undertaken to determine whether some could continue safely and without adverse impact (for example studies involving retrospective data analysis). This was followed by a period of 'managed recovery' to re-start all research placed on hold. This process has been completed, and by 2021 all research activities had been re-started, with new projects initiated.
					Provide clear evidence of the Trust's research and development response to COVID-19 pertaining to the specific needs of the Liverpool population, during 2021		The Trust carried out a range of research and development activities in response to the COVID-19 pandemic, including: -Secondment of nurses to LUHFT to support research on COVID actue wards -Participation in, supply of factilities for and seconment of staff to the Astra Zenneca vaccine trial (led by the Liverpool School of Tropical Medicine) -Vaccine in pregnancy trial - research team worked in tandem with clinical service offering vaccines at LWH to provide extra reassurance for patients (provision of additional follow ups). The team was the second highest recruiter to the trial nationally. Research activities in repsonse to COVID were documented by the RD&I Committee (and onward Chair's reportsa to Quality Committee), the Executive Committee and Liverpool Health Partnership weekly meetings between April 2020 and summer 2021.
					Refresh the research, development and innovation strategy, engaging with stakeholders throughout		Work to refresh the Trust's Research, Development and Innovation strategy has been underway for the past year. Recent consultation work regarding the strategy has been undertaken wiht a range of stakeholder groups, including the Trust's Council of Governors and representatives from all locla universities. The final version of the strategy is due to be presented to the Research and Development Committee in November 2022, prior to approval by the Quality Committee or Trust Board as appropriate. The strategy covers a 5-year period, contains 5 themes with underpinning objectives, and once the strategy is agreed a clear plan will be in place for delivery of each.
		Fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership		Chief Nurse and Midwife	Achieve a well-led 'good' rating by 2021	NOT FEASIBLE	This objective was not possible to achieve as no inspections were carried out in 2021. The Trust also has an objective to achieve an outstanding rating by 2023, which remains in place.
					Achieve a well-led 'outstanding' rating by 2023		The Trust has made really good progress in embedding the well-led framework. There has been significant investment in leadership development, e.g. Reach for the Stars programme, B7/8a leadership development, leadership forum, and the launch of the Talent Management strategy. The Trust has also made good progress in respect of increased public engagement (see above) and implementation of QI methodology (new QI Framework completed and launched in 2022). There are clear governance processes in place for managing risks, issues and performance (e.g. risks related to isolated site reported quarterly to Trust Board, Divisional Performance Reviews & Financial Recovery Board in place). The Trust strategy was refreshed and launched in 2021, is supported by a cohesive framework of credible supporting strategies and plans, and includes a clear focus on ensuring sustainable delivery of services in the long term. This objective is currently rated as 'at risk', as we are aware there is further work to do to act on and address the feedback received in the most recent staff survey.
					Achieve an overall rating of outstanding by 2025		See above. Objective to be reviewed in more detail following the Trust's next CQC inspection.

Complete
On track
At risk
Behind target

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	***22/23/139***		**Date: 03/11/2022**	
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 in September 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 since the last Board meeting these were reviewed and discussed during the October 2022 meetings.

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 because 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 table below outlines the changes made since the previous iteration.

1.1 Failure to be recognised as one of the most inclusive organisations in the NHS with Zero discrimination for staff and patients (zero complaints from patients, zero investigations)
• No changes to the BAF
1.2 Failure to recruit & maintain a highly skilled & engaged workforce

- No proposed changes
- Considered BAF risk 1.2 Failure to recruit & maintain a highly skilled & engaged workforce and a concern raised by the Finance Committee in relation to high agency usage particularly within maternity services. The Committee agreed to request assurances in relation to the processes in place to achieve the agency workforce targets.

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

- No significant changes to note

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

- No significant changes to note

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

- No significant changes to note
- Good progress has been made this period in progressing development of the Trust's future model of care, as part of the Future Generations Programme of work. In September 2022, a second workshop was held with the Trust's clinical leaders to agree ideal location of care for granular elements of maternity, gynaecology and clinical support services. The session was successful with good engagement, detailed discussion and challenge between the specialties, and ideal location has been agreed for the majority of areas. Further work is required for a number of areas (including fertility services, day case surgery and pre-op assessment and laboratories); additional sessions will take place during November 2022 to complete this. The outputs of this workstream will inform both the vision for the future of the Crown Street site and the proposed new Liverpool Women's Hospital, and further refine the draft schedule of accommodation for the proposed new hospital

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

- No significant changes
- Cyber Security Strategy agreed by the Board and added into the controls

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

- New line of controls, assurances and gaps in control listed for Induction of Labour following a recommendation from the September 2022 Board.

BAF Risk 4.1: Failure to ensure our services are financially sustainable in the long term

- No significant changes
- Risk relating to external auditor added to cross-reference page
- There was a discussion at October's FPBD Committee as to whether the risk to the delivery of the 2022/23 financial plan was visible as possible (currently listed as a 'strategic threat' under BAF risk 4.1). Agreed that this would be given due consideration with a recommendation made to the next 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

- No proposed change to BAF score for Quarter 2 – (likelihood 2 x consequence 4). There remains a high degree of uncertainty around the partnership landscape and the FPBD Committee has responded by receiving strengthened assurance of the effectiveness of the Trust's partnership arrangements.
- No proposed amendments to the BAF title or supporting narrative
- Controls, Assurances and Gaps in control / assurance have been tidied and actions updated.

5.1: Failure to progress our research strategy and foster innovation within the Trust

- No proposed change to BAF score for Quarter 2– (likelihood 2 x consequence 4). Significant progress was made throughout 2021/22 and appointments joining the Trust should further strengthen this. It is expected that the score for this risk can be scored at '4' for the third quarter of 2022/23 and therefore it suggested to maintain a target score of '4' for 2022/23.
- Controls, Assurances and Gaps in control / assurance have been tidied and actions updated.

5.2: Failure to fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership

- No proposed change to BAF score for Quarter 2 – (likelihood 3 x consequence 4). There is evidence of improvement and strengthened controls heading into 2022/23 (ward accreditation programme, agreed QI Framework etc) that if implemented effectively should provide assurance to reduce the score to '8'. It is therefore suggested to maintain this as the target for 2022/23.
- No proposed amendments to the BAF title, strategic threat descriptor
- Controls, Assurances and Gaps in control / assurance have been tidied and actions updated.

New Risks or Strategic Threats

No new risks or strategic threats.

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.

BOARD ASSURANCE FRAMEWORK 2022/2023

Trust Board – November 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)	12 (I3 x c4)			⟷	8 (I2 x c4)
	1.2 Failure to recruit & maintain a highly skilled & engaged workforce	PPF	CPO	20 (I5 x c4)	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)	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)	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)	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)	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)			⟷	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	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)			⟷	8 (I2 x c4)
SA5 Effective	5.1 Failure to progress our research strategy and foster innovation within the Trust	Quality	MD	8 (I2 x c4)	8 (I2 x c4)			⟷	4 (I1 x c4)
	5.2 Failure to fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership	Quality	CNM	12 (I3 x c4)	12 (I3 x c4)			⟷	8 (I2 x c4)

BAF HEAT MAP


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

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

Principal risks (BAF)	Risk Score
1.1 Failure to be recognised as the most inclusive organisation in the NHS with Zero discrimination for staff and patients (zero complaints from patients, zero investigations)	12 (3 x 4)
1.2 Failure to recruit & maintain a highly skilled & engaged workforce	20 (4 x 5)

Risk and Controls Summary

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

2087 - No change in risk score since last review. Last reviewed 13/07/2022

2323 - No change in risk score since last review. Last reviewed 15/09/2022

1705 – No change in risk score since last review. Last reviewed 16/09/2022.

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

2549 – NEWLY ADDED. Last reviewed 17/10/2022

2467 – NEWLY ADDED. Last reviewed 11/10/2022

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
2549	Staff shortages in the Ultrasound Team within the Imaging Department due to Vacancies and 5 staff members leaving in May & June 22	20
2467	Inability to recruit specialised allied health professions in a timely manner for blood bank	
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

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: August 2022**

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)	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.

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)** Enhance availability and quality of training across all protected characteristics including disability and inter-sectionality (Action 1.1 / 5) Establishment and Declaration and Embedding of LWH as an Anti-Racist Organisation (Action 1.1 / 6) Development of ED&I Strategy (Action 1.1 / 7)	
	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	February 2023 (ongoing)	E&D Sub-Committee	Wellbeing Coach and Assistant Psychologist vacancies will be targeted via Universities with specific focus on racially minoritised communities. Review piece with Patient Experience to identify and prioritise communities within which to target entry level roles. HCA and admin roles- specific careers event in Toxteth (small numbers of roles).
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	September 2022	E&D Sub-Committee	New process and policy developed and tested with stakeholders. New paperwork highlights actions and risks to feed into ED&I 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	September 2022	E&D Sub-Committee	

	1.1 / 5	Enhance availability and quality of training across all protected characteristics including disability and inter-sectionality	Head of Culture, Inclusion, Wellbeing and Engagement	December 2022	E&D Sub-Committee	Enhanced training for senior leaders developed, additional baseline training in development, additional training around neurodiversity etc required.	
	1.1 / 6	Establishment and Declaration and Embedding of LWH as an Anti-Racist Organisation	Head of Culture, Inclusion, Wellbeing and Engagement	February 2022	E&D Sub-Committee	To be determined via the PPF Development Session in October 22.	
	1.1 / 7	Development of ED&I Strategy	Head of Culture, Inclusion, Wellbeing and Engagement	December 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: August 22

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)	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)** Mandatory Training Compliance is currently not at required levels **(Action 1.2/3)**	
	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)		
	Quarterly Trust wide listening events- Big Conversation	Reports and feedback from Big Conversation into the Board and Divisional Boards		
	Divisional oversight of Mandatory training	Trajectories monitored via Divisional Boards		
	Mandatory training quarterly validation	Assurance that MT competencies are assigned correctly via sign off from practice educators and Heads of Nursing		

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	November 2022	PPF Committee	Audit to PPF November
1.2 / 2	To receive assurance that Divisional Boards are effectively reviewing and updating workforce plans	Deputy Director of Workforce	September 2022	PPF Committee	
1.2 / 3	To receive assurance that mandatory training compliance is increasing	Deputy Director of Workforce	November 2022	PPF Committee	Audit to PPF November

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 &	Staff working from home where appropriate, use of virtual meetings and enhanced IT provision	PPF Committee	None noted.	

associated elective recovery has the ongoing potential to impact staff morale, wellbeing and retention	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	Feedback from staff side				
	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					
	Strategic Medical Workforce group established for short and medium term workforce planning	Chair's report into PPF				
	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 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 01/09/22

2085 - No change in risk score since last review. Last reviewed 19/07/2022

2086 - No change in risk score since last review. Last reviewed 13/07/2022

2316 - No change in risk score since last review. Last reviewed 16/09/22

2296 - No change in risk score since last review. Last reviewed 13/07/22

2321 – Reduced from 16 to 12. Last reviewed 15/09/2022

2469 – No change in risk score since last review. Last reviewed 15/07/2022

2470 – No change in risk score since last review. Last reviewed 14/09/2022

2468 – NEWLY ADDED. Last reviewed 11/10/2022

2572, 2599, 2598, 2604 – NEWLY ADDED. Last reviewed 22/09/2022

2627 – NEWLY ADDED. Last reviewed 03/10/2022

2385 – NEWLY ADDED. Last reviewed 16/09/2022

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
2468	The Trust is currently delivering a high number of complex programmes concurrently which have multiple interdependencies and tight deadlines. This includes CSE, CDH, K2, Meditech Expanse roll out.	16
2572, 2599, 2598, 2604	There is a lack of strategic leadership and robust procedures to ensure the safety of people and assets within the Crown Street and Knutsford sites due to the absence of a national security framework and as a result of a commissioned review of trust security	16 (15)
2627	CAMRIN Digital solutions being reviewed	16
2385	Risk of 95% of the Trust staff are not adequately trained in Information Governance, Confidentiality and Data Protection, which includes bank staff and volunteers	15
2579 (CRR)	Delay articulating the staffing model for CT and MRI provided by the CDC and impact on difficulties staffing the X-Ray on call rota	15
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	12
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: August 2022

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)	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 adult acute services, 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 all significant stakeholders for the case for change. There remains however no clear route to capital funding, and no clear direction from the C&M ICS regarding a way forward.

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, Lesley Regan CFO has met with national Director of Capital, Chris Jackson	Lack of system support outside of Cheshire and Mersey to secure the capital case Formation of ICB creating delays and repetition in programme H&CP submissions for capital bids not successful despite system agreement of clinical case No clear route to capital funding 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 New ICS in place from 1 July 2022 with new stakeholders to understand the case 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. Case for Change and Counterfactual Case presented to Shadow ICB in June 2022. Current LWH risk presented to ICB in August 2022. LWH MD is maintaining contact with ICB MD regarding level of clinical risk.		
	Future Generations Steering Group established	FG Steering Group established to provide strategic direction and oversight of the FG Programme. Terms of Reference approved by FPBD July 22. Multiple underpinning workstreams/subgroups also established, each led by Executive Directors.		
	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 Programme through Project Management Office, with oversight and strategic direction provided by the FG Steering Group	Associate Director of Strategy	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	Associate Director of Strategy	November 2022	Board	
2.1/3	Business case refresh – refreshed estates modelling and schedule of accommodation for new build	Associate Director of Strategy	December 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)	Associate Director of Strategy	March 2024	Board		
	2.2 / 7	Lobby systems and MPs for active support	Head of Communications and Marketing	September 2022 - Ongoing	Board		
	2.2 / 8	Build relationships with key ICS personnel	Medical Director	September 2022 - Ongoing	Board		
	2.2 / 10	Request re-prioritisation of C&M capital schemes	Chief Finance Officer	April 2022 - Ongoing	Board		
	2.2 / 12	Presentation of case for change and counterfactual case at HOSC	Medical Director, Associate Director of Strategy	January 2023	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 – Nov 2022	Board	
2.1 / 15	Agreement of responsibility for production of pre-consultation business case with commissioners	Chief Finance Officer	~~September 2022~~ December 2022	Board	
2.1 / 16	Public consultation regarding options to address case for change (external control of this action by commissioners)	Chief Finance Officer	May 2023	Board	
2.1 / 17	Present case for change and counterfactual case at public Board meeting	Medical Director	December 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 - ongoing	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 LWH scheme 6th priority across North West Funding option not yet agreed	
	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	Date unknown, outside of LWH control	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: August 22

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)	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		
	Ongoing review of systems and mitigations quarterly	FPBD & QC		

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 / 3	Issue appropriate communication to all staff in relation to digital development by multiple means and forms	CIO	November 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 local population and/or reduce health inequalities	Operational 'Plans on a page' for Divisions – incorporates horizon scanning section	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)** 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)**	
	Operational planning process	Operational plans and budgets		
	Availability of data on service trends and demographics	Divisional Boards		
	Workforce plans	Divisional Boards		

	Gap Reference	Required Action	Lead	Implement By	Monitoring	Status	
	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: August 2022

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)	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, and that following the implementation of the actions outlined below, the Trust does not believe that any further mitigation is possible. This view was recently confirmed by an independent review undertaken by the Northern England Clinical Senate, in February 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
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 revised 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 joint anaesthetic appointments with LUHFT	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		
	LWH appointed at C&M Maternal Medicine Centre	LWH working as part of NW Maternal Medicine Network		
	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 Mannitol -Phlebotomy -Pathology	Community Diagnostic Centre Oversight Group reviews progress on a fortnightly basis. Progress also reported to and monitored by regional CDC Programme Board. Mobile CT and respiratory testing operational.		
	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& ROTEM -Innovative use of bedside clotting analysis and fibrinogen concentrates -Early order of blood products (high wastage)	Quality Committee		

	-Out of hours transfusion lab provided off-site by LCL Outreach midwife post -AN & Gynae outpatient service at Aintree Hospital -Gynaecology Tier 2 rota providing cover for LWH and Liverpool Place -Expanded role of anaesthetists to cover HDU patients and provide pain service -Additional pain service provided by Walton Centre, with psychologist input -Uoskilling of HDU staff -Joint clinics -SLAs in place for clinical support services from LUHFT -Ambulance transfer of patients for urgent imaging or other diagnostics not currently provided on site -Planned pre-op diagnostics provided off-site by LUHFT -Appointment of resus officers, upgrading of resus trolleys and provision of automated defibrillator trolleys -Existing informal links with partner organisations -ANP roles -Transfer of patients for urgent imaging and critical care -Theatre slots at LUHFT with access to colorectal surgeons -Purchase of sentinel node biopsy and 3D laparoscopic kit -ACHD Partnership					
	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 / 3	Detailed agreements to form part of SLA with LUHFT, clearly explaining routes of access and expectations of both organisations.	Deputy Chief Finance Officer	December 2022	Partnership Board, TBDG	The sub groups for the partnership have not determined the content of the SLA schedules yet
	2.3 / 4	Project to establish 24/7 transfusion laboratory on site at Crown Street	Head of AHPs	March 2023	Crown Street Enhancements Programme Board, FPBD	Staffing continues to be an issue that requires resolution
	2.3 / 5	Implement remote issue of blood products to minimise delay in transfusion	Head of AHPs	October 2022	Crown Street Enhancements Programme Board, FPBD	Now on track
	2.3 / 6	Continue to recruit to secure 24/7 Anaesthetics cover	Clinical Directors	January 2023	TBDG	
		Complete construction of CT imaging suite	Associate Director of Strategy	December 2022	Crown Street Enhancements Programme Board, FPBD	
		Complete construction of MR imaging suite	Associate Director of Strategy	February 2023	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	September 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 -Phlebotomy	Deputy Chief Operating Officer	December 2022	CDC Oversight Group, FPBD	

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

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)	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 Security Strategy	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 / 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
2472	All twenty delivery suite beds (Hilrom) in use are not fit for purpose	20
2485	Limited access to MRI scan (currently 5-6 weeks wait) needed for cancer patient pre treatment (both surgical and radiotherapy treatment).	16
2606 (CRR)	failure to comply with national infection trajectory specifically in relation to E.coli bacteraemia	10
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
2488 (CRR)	Failure to meet clinical demand for red blood cells	9
2603 (CRR)	Current Intranet in poor condition and no longer fit for purpose	9

Risk and Controls Summary

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

2430 - No change in risk score since last review. Last reviewed 14/09/2022.

2418 - No change in risk score since last review. Last reviewed 16/08/2022.

1966 - No change in risk score since last review. Last reviewed 12/09/2022.

2088 - No change in risk score since last review. Last reviewed 14/09/2022

2472 – NEWLY ADDED. Last reviewed 13/07/2022

2485 – NEWLY ADDED. Last reviewed 10/11/2021

2606 – NEWLY ADDED. Last reviewed 26/08/2022

2488 – NEWLY ADDED. Last reviewed 12/10/2022

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: August 2022

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)			⟷	12 (3 x 4)

Rationale for current risk score:

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.

Following the operational pressures faced as a result of the COVID pandemic, a large number of patients had their treatment and appointments delayed as a result of changes to clinical capacity. This has led to an increasing number of patients waiting beyond 52 weeks to receive their treatment. Continued rises in referrals from Primary Care and an increasing backlog of patients to be seen has led to delays in care and deterioration of Trust performance in relation to national Referral to Treatment (RTT) standards

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		
	Patient experience Review reports produced by the Divisions and reported to PIESC	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	We have been waiting for a new chair to be appointed for the MVP since the last chair had stood down. The new chair starts in September so we plan to contact the MVP then to discuss the review of the complaints process.
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	PEX team still developing the process but will be completed by the deadline if the Microsoft side of the process is completed.
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	The PEX matron is currently reviewing how the Stories can be shared with the wider audience.

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.	
	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		

					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.	

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	October 2022	Patient Involvement & Experience Sub-Committee	We have been waiting for a new chair to be appointed for the MVP since the last chair had stood down. The new chair starts in September so we plan to contact the MVP.
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	There are slight improvements on the KPI but this is discussed at each PIESC to ensure that it is being reviewed and Power BI is being updated. We have found that the areas are doing the You said we did out in the areas but not updating the Power BI so not reflective in the KPI.

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
Lack of clinical capacity and resources i.e. workforce, estate etc. to treat patients in a timely manner resulting in delays in treatment and deterioration in Trust Performance standards	Fortnightly Access Board meetings with Divisional Operational Teams and Information present monitoring key performance	FPBD and Board meetings	Gaps in effective delivery of Access Policy including training of staff associated with RTT pathway management Gaps in Standard Operating Procedures for management of patient pathways Timescales for delivery of key elective recovery programme actions 3.1/10 – Work to reconfigure the MLU estate to maximise efficiencies for IoL.	
	Daily monitoring of performance through Power BI dashboards – daily and weekly updates on key performance metrics	Integrated Performance Report		
	Weekly Patient Tracking List (PTL) meetings with Divisional Operational teams and Patient Access	Access Board		
	Elective Recovery Programme in place with workstreams to improve performance and reduce waits	FPBD Executive Team reporting		
	External validation programme of work reviewing all admitted and non-admitted pathways to ensure RTT guidance being applied correctly	Access Board		
	Review of Medical & Nursing job plans to ensure capacity in place to treat patients in a timely manner	Updates via Divisional Performance Reviews and Hospital Management Meetings		
	Cancer Committee – meets bi-monthly to review Cancer performance and track actions to improve performance	FPBD		
	Theatre Utilisation Group	Updates via Divisional Performance Reviews and Hospital Management Meetings		
	Text reminder service to reduce DNA's and ensure patients still require appointments – facility in place if they wish to change or cancel appointments	Monitoring through Access Board		
	Patient Initiated Follow-Ups – to minimise numbers of patients who no longer require follow up to release capacity	Monitoring through Access Board		
	Locum Consultant in place for Gynaecology to increase clinical capacity	Updates via Divisional Performance Reviews and Hospital Management Meetings		
	Sub-specialisation of Gynaecology and sub-specialty recovery plans in place to monitor actions/risks at a sub specialty level and establish performance trajectories to deliver improvements	Updates via Divisional Performance Reviews and Hospital Management Meetings/Access Board		
	Controls in place to monitor length of stay for women in induction of labour - Daily safety huddles - IoL metrics included on Executive and SLT live dashboards - C&M weekly maternity escalation cell	Bi-annual workforce report		

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
3.1/8	Continue to provide updates to the Board regarding the Elective Recovery Plan through Divisional Performance Reviews and to FPBD on a monthly basis through the Integrated Performance Report	Deputy COO	On-going	Board	
3.1/ 9	Access Policy review and delivery of SOP's via Waiting List Management audit action plan	Patient Access Lead	December 2022	Access Board	
3.1/ 10	Work to reconfigure the MLU estate to maximise efficiencies for IoL.	FH Div Manager	January 2023	Exec DPR	

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
2621 (CRR)	The Trust's external auditors have informed LWH that they are unable to honour their commitment to undertake the 22/23 (and 23/24 and 24/25) external audits in line with national timelines. They are able to undertake the 22/23 audit but this would be late.	8

Risk and Controls Summary

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

2621 – NEWLY ADDED – Last reviewed 14/09/2022

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: August 22

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)	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	October 2022	FPBD Committee / Board	Propose deferral to October 2022 to allow completion of model. Delayed due to delays in national timetable for planning 2022/23.	
	4.1 /5	Work towards strategic outline case production and approval	CFO	January 2023	Board	Proposed deferral to link with LTFM completion	
	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	

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: August 22**

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)			⟷	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			
	Quarterly Partnership Report	FPBD Committee		

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~~ November 2022	Board	Draft SLA developed – requires consultation and finalisation with the LMNS

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
2582	Failure to meet the governance and risk management requirements of the Family Health Division	16
2456	Delay in review of clinical incidents, outside of the parameters expected by the Trust policy, leading to failure to act on safety concerns, missed learning opportunities and delay in escalation of SUIs	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.

2456 – NEWLY ADDED. Last reviewed 14/09/2022

2232 - No change in risk score since last review. Last reviewed 21/09/2022.

2295 - No change in risk score since last review. Last reviewed 15/09/2022

2329 - No change in risk score since last review. Last reviewed 17/10/2022

2582 – NEWLY ADDED – Last reviewed 26/09/2022

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: August 2022

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)	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.	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	Ongoing funding will be required to support the talent pipeline **(Action 5.1 / 1)**	
	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.	Implementation of the talent pipeline will be monitored via the RD&I sub committee		
	The Trust has now appointed a Director of Midwifery who has a strong research background. She will support and facilitate midwifery research.	RD&I sub-committee (also attended by three Professors of Midwifery from the respective local universities)		

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	This is now awaiting review at the next Business Case Approval Meeting.

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.	
	C-GULL programme of work commenced – staff recruited, building work underway, regulatory approval on track. Recruitment of first participant expected in late Autumn 2022.	R&D Sub-Committee Chair's Reports		

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	

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: August 22

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)	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	Programme developed and will be implemented imminently
5.2 / 2	Ensure all policies and procedures are within their review date	Assoc. Director of Quality & Governance	July 2022	Quality Committee	The position had improved but further work required ensure this becomes BAU. New controls – Trust wide QI project on-going re reducing duplication of policies. Additional working group set up outside Polices and procedures group to agree a consistent process for review trust wide.

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Ineffective understanding and learning following significant events and evidencing improved practice and clinical outcomes.	Regular dialogue with regulators Incident reporting and investigation policies and procedures. MDT involvement in safety HR policies in relation to issues relating to professional and personal responsibility Mandatory training in relation to safety and risk Serious Incident Feedback form Serious Incident panels Safety is included as part of executive walk rounds. Risk Management Strategy	CQPG Meetings Reporting of incidents and management of action plans through Safety & Effectiveness Sub-Committee Reflection of risks and Corporate Risk Register and Board Assurance Framework CQC Assessment Annual Quality Account Report Monthly meetings with the divisions and Assoc. Director of Quality & Governance and Dep. Chief Nurse & Midwife to review the risk profile, ensuring we move at pace being able to evidence the work we are doing, including any learning from incidents/events etc Discussions with staff on walk arounds conducted by the Director of Nursing & Midwifery and senior clinical staff.	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)**	

		Shared learning page now live on the intranet		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)**	
	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 30 staff in May and June 2022.				
	Divisions are to bring learning from SI's, incidents and complaints etc to Safety and Effectiveness from September. Also, Divisions required to bring a Divisional Integrated Governance Report to Safety & Effectiveness each month, to feed into the Quarterly IGR for QC. Focus on triangulation to inform divisional priorities and learning opportunities	Safety & Effectiveness Sub-Committee			
	Human Factors training in place	Mandatory training compliance figures			

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	Improvements have been made but remains on-going. Additional resource secured for project during September 2022
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 / 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	
5.2 / 8	Legal polices re claims and learning are being reviewed, revised and will be shared	Head of Governance & Quality	October 2022	Safety & Effectiveness Sub-Committee	

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance (*Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Ineffective and / or ill-defined quality improvement methodology will result in the Trust missing opportunities to improve the safety, effectiveness and experience of care.	Quality Improvement training materials available on Trust Intranet	Training levels reported to the Quality & Clinical Audit Group	Opportunities to engage individuals in QI training limited, particularly during pandemic Evidence of QI projects being undertaken but not 'formalised'	
	Quality Improvement projects tracked	Safety & Effectiveness Sub-Committee		
	Quality Account tracking key projects	Annual Quality Account		
	Quality Improvement Framework developed and agreed	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.		

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	Recruitment to a new QI role has commenced
5.2 / 9	Increase levels of QI training	Assoc. Director of Governance & Quality	July 2022	Quality Committee	QI summit to commence in October, refresh of QI with a shared vision to take our QI journey forward.
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	February 2023	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	February 2023	Quality Committee	

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*22/23/140*		Date: 03/11/2022	
Report Title	Medical Appraisal and Revalidation Annual Report 2021/22			
Prepared by	Lynn Greenhalgh, Responsible Officer & MD Lynn Johnson, Revalidation Support Manager			
Presented by	Dr Lynn Greenhalgh			
Key Issues / Messages	1. Medical appraisal and revalidation processes are robust despite ongoing waves of COVID 19. 2. Annex D for approval			
Action required	Approve ☒	Receive ☐	Note ☐	Take Assurance ☒
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable):			
	For Decisions - in line with Risk Appetite Statement – Y/N *If no – please outline the reasons for deviation.*			
	1. To receive the annual report and note that this will be shared with the higher Responsible Officer *2.* Take assurance that despite COVID 19 there were effective medical appraisal and revalidation processes in place *3.* To approve the statement of compliance Annex D confirming that the organisation, as a designated body, is in compliance with the regulations and to note that this needs CEO signature and Board approval.			
Supporting Executive:	Dr Lynn Greenhalgh Medical Director			

Equality Impact Assessment *(if there is an impact on E,D & I, an Equality Impact Assessment **MUST** accompany the report)*							
Strategy ☐	Policy ☒	Service Change ☐	Not Applicable ☐				
Strategic Objective(s)							
To develop a well led, capable, motivated and entrepreneurial ***workforce***	☒	To participate in high quality research and to deliver the most ***effective*** Outcomes	☐				
To be ambitious and ***efficient*** and make the best use of available resource	☐	To deliver the best possible ***experience*** for patients and staff	☒				
To deliver ***safe*** services	☒						
Link to the Board Assurance Framework (BAF) / Corporate Risk Register (CRR)							
Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* 1.2 Failure to recruit and retain key clinical staff			Comment:				
Link to the Corporate Risk Register (CRR) – CR Number:			Comment:				

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
PPF Committee	Oct 22	MD	Annex D recommended for approval by the Board

EXECUTIVE SUMMARY

Executive summary – 2021/22 Revalidation and Appraisal annual report

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

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

During this revalidation year April 2021 to March 2022, the team supporting revalidation for the Trust was:
Dr Lynn Greenhalgh, Responsible Officer (RO),
Dr Janine Elson, Appraisal Lead,
Lynn Johnson Revalidation Support Manager and
a team of 17 trained appraisers who each will undertake between 4-7 appraisals/year.

Liverpool Women's NHS Foundation Trust as a designated body had 88 doctors with a prescribed connection in the revalidation year April 2021 to March 2022. All doctors were engaged with the process and all doctors were accounted for in terms of their participation.

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

For the time period of this report doctors were expected to have an appraisal however the requirement to produce supporting evidence was reduced and it was expected that there would be a conversation regarding wellbeing.

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

The Trust Board usually receives these two papers for approval.

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

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

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

Revalidation recommendations:

37 doctors' revalidation date fell during this year. 26 received a positive recommendation.

11 recommendations were deferred due to the RO having insufficient evidence. 9 deferrals were due to the practitioner having insufficient evidence for the Responsible Officer to recommend revalidation 7 of these practitioners have subsequently been recommended for revalidation. 1 deferrals were because the practitioner was undergoing a disciplinary procedure and the other has GMC undertakings.

Governance and Quality Assurance:

The Responsible Officer has provided quarterly assurance paper to the Putting People First Committee and this annual report to NHS England to demonstrate compliance with the Framework of Quality assurance for Responsible Officers and Revalidation.

Appraisal update training

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

Internal quality assurance is performed by a peer review of a random sample of 10% of completed appraisals. For the year 2021/22 this was done using the NHSE SUPPORT tool which is designed for use with the MAG 2020 appraisal form. This provides not only feedback to individual appraisers but also a learning and discussion opportunity for the reviewing appraisers. All appraisers are expected to attend at least one peer review session a year.

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

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

Implementation of L2P – a new Appraisal and Revalidation management system

The contract on the previous Appraisal and Revalidation management system ended and after a procurement exercise L2P was chosen as the new system to manage the Appraisal and Revalidation process within the Trust. This system has been in place since February 2022 and feedback from the appraisees has been positive. The administration function of the system is superior to that of Equiniti and the system incorporates the delivery and management of the 360 degree feedback process. Progress with revalidation can also be monitored.

Recommendations:

To receive the annual report and note that this will be shared with the higher Responsible Officer

Take assurance that despite COVID 19 there were effective medical appraisal and revalidation processes in place

To approve the statement of compliance Annex D confirming that the organisation, as a designated body, is in compliance with the regulations and to note that this needs CEO signature and Board approval.

1. Purpose of the paper

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

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

2 Background

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

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

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

The RO oversees compliance by:

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

3 Governance Arrangements

The current Responsible Officer is Dr Lynn Greenhalgh. The Trust responsible Officer is appraised by an external appraiser nominated by NHS England. Her last appraisal was June 2022. She took over being RO in April 2021 after a period of 3 months acting as RO in an interim capacity.

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

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

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

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

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

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

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

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

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

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

4 Policy and Guidance

The 2017 Medical Appraisal and Revalidation policy has been updated in line with current national policy and is presented for ratification to this meeting. This is due to be updated in April 2023. (Appendix B).

5 Quality Assurance

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

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

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

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

The contract for the current Equiniti Revalidation Management System used by the Trust is expired in November 2021. After a procurement exercise with the Trust's Procurement Team a new system called L2P was procured, and the system implemented in February 2022. Data from the previous system was transferred and feedback from the revalidation team has been positive. The transition onto the new system was smooth.

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

6 Medical Appraisals

Appraisal and Revalidation Performance Data

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

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

	Number	Completed appraisals	Incomplete/missed appraisal Authorised	Incomplete/missed appraisal Not Authorised
Consultant	78	56	21	1 def
Staff Grade, Associate Specialist Speciality Doctor	3	2	1	
Temporary or Short-term Contract holders.	7	6	1	
Total	88	64	23	1

Reasons for the incomplete/missed appraisal authorised were:

There were 21 approved late appraisals, 1 deffered. Circumstances for late appraisals include maternity leave, family illness, covid-19, bereavements, and also the changeover of appraisal systems, Appraisers and Appraisees needed time to adjust to the new system. The majority of the late approved completed within 3 months of their original date but sought approval from the RO.

The overall rate of unauthorised missed/incomplete appraisal is approximately 1% which is the same as the previous year. This will be actively managed by the revalidation team.

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

7 Appraiser training

As part of the Revalidation process, every doctor will undergo a formal appraisal process each year facilitated by a trained appraiser. The Trust has 17 trained appraisers.

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

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

The new Revalidation and Appraisal management system L2P has in-built resources and training videos to help support appraisees and appraisers when navigating the system. Also enclosed is a comprehensive checklist for doctors and appraisers to ensure they are uploading relevant information/data throughout the system. L2P also offer in-house training via Teams or face-to-face.

8 Appraisee

Doctors upload documentation into a portfolio on RMS (Revalidation Management System) covering the GMC domains as outlined in Good Medical Practice. RMS requires the completion of pre-appraisal documentation by doctors regarding their own probity and health. Their PDP and Job plan are part of the portfolio. This portfolio is submitted to their appraiser prior to their appraisal meeting.

In each revalidation cycle, each doctor is obliged to gather patient and colleague feedback once. There is a system built into RMS to facilitate this, the feedback is discussed at appraisal, and feeds into the personal development plans.

For the vast majority of appraisals within the time period of this report the Trust used the Equiniti RMS (Revalidation Management System) as the system for doctors to upload their revalidation and appraisal evidence, however this will now be transferred to L2P. All documentation within the practitioners revalidation cycle has been transferred onto the new system as well as a complete record of all input into Equniti being held by the revalidation manager.

Appraisees that are new to the Trust as supported by the Revalidation Manager and the Appraisal Lead with training on the RMS and the expectations of the Trust with regards the supporting information necessary for appraisal submission.

9 Access, security and confidentiality

The Trust has an implemented framework of Information Governance to ensure all the information held on staff members are complaint with the Data protection and confidentiality, information security and information quality on an annual basis.

10 Issues for Board consideration

- The number of doctors with a prescribed connection and requiring appraisal has remained reasonably static at 101 doctors increased from 97 in 20/21.
- The team have worked hard to maintain the appraiser numbers as trained experienced appraisers have left the Trust. This is tracked by the Revalidation team.
- Appraiser time is accounted for within job plans with a currency of 0.25 PA. The Appraisal lead currency is 0.5 PA.
- The revalidation team has worked hard to support doctors as the appraisal system has restarted after the pause during the peak of the COVID-19 pandemic.
- The Revalidation Support Manager, Appraisal Lead and Appraisers have managed to support doctors through the appraisal system during the pandemic.

11 Conclusions

Medical Revalidation is in its second cycle. The Trust has seen a significant improvement in managing doctors who do not seek approval for late/incomplete appraisals. This is thanks to the efforts of the team and is reflected in the performance data.

12. Recommendations

To receive the annual report and note that this will be shared with the higher Responsible Officer

Take assurance that despite COVID 19 there were effective medical appraisal and revalidation processes in place

To approve the statement of compliance Annex D confirming that the organisation, as a designated body, is in compliance with the regulations and to note that this needs CEO signature and Board approval.

Appendix A – Annex D Statement of Compliance 2021/2022

2021-2022 Annual Submission to NHS England North West:

Appraisal and Revalidation and Medical Governance

Name of organisation:		
	Name	Contact information
Responsible Officer	Dr Lynn Greenhalgh	lynn.greenhalgh@lwh.nhs.uk
Medical Director	Dr Lynn Greenhalgh	lynn.greenhalgh@lwh.nhs.uk
Medical Appraisal Lead	Dr Janine Elson	janine.elson@lwh.nhs.uk
Appraisal & Revalidation Manager	Lynn Johnson	lynn.johnson@lwh.nhs.uk
Additional Useful Contacts		

Contents

Introduction:

The Annual Organisational Audit has been stood down again for the 2021/22 year. A refreshed approach is planned for 2022/23. It still remains a requirement for each Designated Body to provide assurance to their Board about the governance arrangements in place in relation to appraisal, revalidation and managing concerns. In addition, NHS England North West use information previously provided in the AOA to inform a plan for quality visits to Designated Bodies. These visits are now starting to be planned in again moving forwards.

Amendments have been made to Board Report template (Annex D) with the intention of making completion of the submission straightforward whilst retaining the goals of the previous report:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

This template for an Annual Submission to NHS England North West should be used as evidence for the Board (or equivalent management team) of compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) or appended to your own board report where a local template exists.

This completed document is required to be submitted to NHS England North West by the end of September 2022 and should be sent to england.nw.hlro@nhs.net

Annual Submission to NHS England North West

Section 1 – General:

The board / executive management team – [*delete as applicable*] of [*insert official name of DB*] can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

   2021/2022 update: Dr Lynn Greenhalgh, Medical Director, continues to be the Responsible Officer

   Action for next year: To consider the Deputy Medical Director to receive Responsible Officer Training so support the RO.

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

   Yes

   2021/2022 update including description of Appraisal & Revalidation support:

   After a successful procurement procedure, the Trust chose to move its appraisal and revalidation system from Equiniti to L2P. This has been implemented since the beginning of March 2022. The transfer to the new system has gone smoothly and the consultant body have switched easily to the new system.

   Action for next year: to continue to monitor the embedding of L2P

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

   2021/2022 update: The revalidation manager completes this task which is held in the appraisal and revalidation system.

   Action for next year: to continue to maintain accurate records

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

   List of relevant policies and date of last review: The Medical Appraisal and Revalidation Policy is due for review in April 2023. It was last reviewed in 2021 in accordance with recommendations from an external audit by MIAA.

   2021/2022 update:

   Action for next year: To update the Medical Appraisal and Revalidation Policy

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

2021/2022 update: External review of the organisation's appraisal and revalidation processes was completed in 2020-21 therefore the previous year. This year L2P will be embedded and then a further external assessment requested next year to ensure the new system is enabling good appraisal. Action for next year: To request a MIAA audit of Appraisal in the Trust after the new appraisal and revalidation system has embedded.

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

List of relevant policies and date of last review: 2021/2022 update: Short term doctors who are not under going ARCP are treated the same as those in long term posts as regards appraisal and revalidation. The same Governance structure will apply. They are added and managed through the L2P appraisal/revalidation management system. Where this is not possible due to time constraints their Education Supervisor is asked to perform an exit appraisal so that they have documentation to take forwards into their next placement and we have evidence of their work at LWH. Action for next year: To continue to monitor the short term doctor closely to continue compliance with the above

7. Where a Service Level Agreement for External Responsible Officer Services is in place

Describe arrangements for Responsible Officer to report to the Board: N/A Date of last RO report to the Board: N/A Action for next year: N/A

Section 2a – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the

doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes. For organisations that have adopted the Appraisal 2020 model, there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet used the Appraisal 2020 model may want to consider whether to adopt the model and how they will do so.

2021/2022 update: The Trust now uses L2P which is based on the Appraisal 2020 model. Prior to that practitioners had the option of using a MAG 2020 form or using the previous appraisal system Equiniti.
Action for next year: To work with L2P to ensure that it reflects up to date guidance regarding appraisals

8. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

2021/2022 update: N/A
Action for next year:

9. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

List of relevant policies and date of last review: Yes
2021/2022 update:
Action for next year: the Medical Appraisal and Revalidation Policy is due for renewal in April 2023.

10. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Number of available appraisers: 17
2021/2022 update: the appraisal and revalidation team will continue to maintain a steady number of appraisers.
Action for next year: To monitor the number of appraisers to ensure the levels are appropriate for the number of appraisees

11. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent).

2021/2022 update: There are regular appraiser update meetings. The appraisal lead has set up a series of peer review sessions where appraisers review the quality of each other's appraisal performance using the SUPPORT tool. In addition 1:1 sessions are given by the appraisal lead for any appraiser who is identified as needing additional training or support.

Action for next year: To continue to embed this process

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/

12. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

List of relevant policies and date of last review: 2021/2022 update: Yes, a quarterly Responsible Officer report is tabled at the Putting People First Committee. Action for next year: To continue with this reporting structure.

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Total number of doctors with a prescribed connection as at 31 March 2022	101
Total number of appraisals undertaken between 1 April 2021 and 31 March 2022	**94**
Total number of appraisals not undertaken between 1 April 2021 and 31 March 2022	**7** **3 of these complete now** **1 mat leave**
Total number of agreed exceptions	**7**

Section 3 – Revalidation Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Recommendations to the GMC:	
Total number of positive recommendations submitted between 1 April 2021 and 31 March 2022	**26**
Total number of recommendations for deferral submitted between 1 April 2021 and 31 March 2022	**11**

Total number of recommendations for non-engagement submitted between 1 April 2021 and 31 March 2022	**0**
Total number of recommendations submitted after due date between 1 April 2021 and 31 March 2022	**0**

2.

2021/2022 update: Action for next year:

3. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

List of relevant policies and date of last review: 2021/2022 update: All doctors are e mailed to inform them that they have been recommended for revalidation. If a doctor is going to be deferred communication happens prior to the deferral. The revalidation manager is made aware of the deferrals. Action for next year:

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors. This includes reporting and collation of, for example, complaints, safeguarding concerns and incidents to identify necessity for appropriate intervention at the earliest opportunity.

List of relevant policies and date of last review: 2021/2022 update: Yes. The Trust uses the Ulysses system for incident reporting and triangulates with complaints and serious incidents. Each practitioner is provided with a summary of complaints and serious incidents prior to their appraisal. Action for next year:

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

2021/2022 update: Any formal concerns about a practitioner are raised with the Responsible Officer/Medical Director or the Deputy Medical Director Action for next year:

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

List of relevant policies and date of last review: Maintaining High Professional Standards. 2021/2022 update: This policy which is based on the NHS policy 'Maintaining High Professional Standards in the NHS' has been updated this year and was ratified in September 2021. Action for next year:

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[2]

Outline arrangements and frequency for reporting to the Board: Quarterly 2021/2022 update: A quarterly Responsible Officer report is submitted to the Putting People First Committee and it contains the information as described above Action for next year:

[2] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[3]

2021/2022 update: MPIT form are used Action for next year:

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

2021/2022 update: The training for the adoption of 'Fair and Just Culture' methodology is underway Action for next year: to roll out the training further

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

List of relevant policies and date of last review: 2021/2022 update: yes Action for next year:

Section 6 – Summary of comments, and overall conclusion

[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Please use the Comments Box to detail any additional information that you wish to highlight (the following provides a guide to information that you may wish to include):

- **General review of actions since last Board report.** A new Appraisal and Revalidation Management system has been implemented since the last Board report (March 2022). The new system has been adopted easily.

  Quarterly Responsible Officer reports are now being presented to the Putting People First Committee.

- **Actions still outstanding** Continued **s**upport for practitioners using the L2P system as we progress through the appraisal cycle
- **Any reflections of impact of COVID 19 on delivering service to patients** Although the impact of the seriousness of the COVID pandemic has lessened over 2021-2022 the waves experienced during this time have had a large impact on staffing not only of medical consultants but also in the wider multi disciplinary team. This has resulted in increased sickness for medical staff and in turn has led to service disruption. Staff are tired. As thoughts move towards recovery great care needs to be taken to balance the need for increased performance against staff well being.
- **Current Issues** Peer reviews of appraisals is still relatively new and needs to be continued to be embedded in the coming year.
- **New Actions:** External Audit of Appraisals since the adoption of a new appraisal and revalidation management system to be requested in 22-23

Overall conclusion:

The Trust can take assurance that the processes for medical appraisal and revalidation are robust.

Section 7 – Statement of Compliance:

The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: _ _ _ _ _ _ _ _ _ _ _ _

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _

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
CNST	Clinical Negligence Scheme for Trusts	The Clinical Negligence Scheme for Trusts (CNST) handles all clinical negligence claims against member NHS bodies where the incident in question took place on or after 1 April 1995 (or when the body joined the scheme, if that is later). Although membership of the scheme is voluntary, all NHS Trusts (including Foundation Trusts) in England currently belong to the scheme.
	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	the value of a country's overall output of goods and 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 experiences of NHS service users and speak on their behalf.

I		
IAPT	Improved Access to Psychological Therapies	an NHS programme rolling out services across England 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 an 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