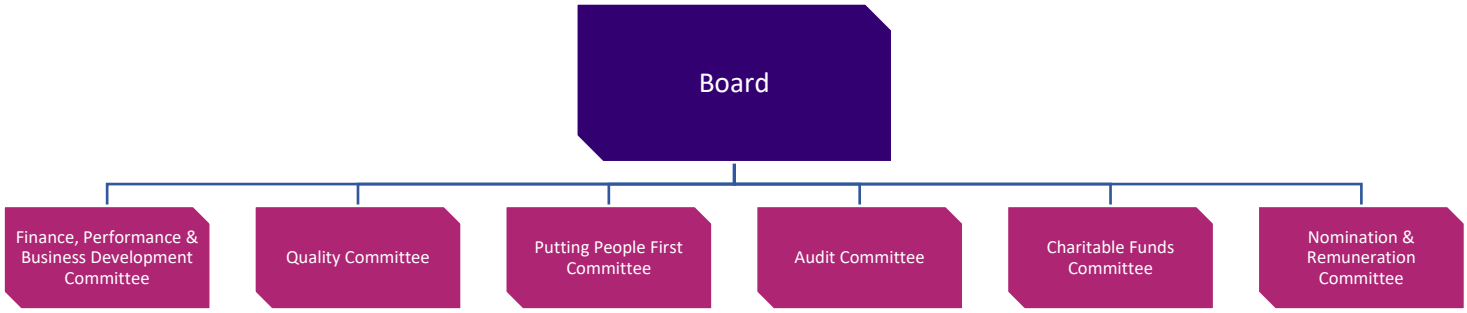
Liverpool Women's NHS Foundation Trust

Trust Board

1 December 2022, 09.30am
Boardroom, LWH & Virtual, via Teams



NHS
Liverpool Women's
NHS Foundation Trust

Trust Board

Location	Boardroom and Virtual (via Teams)
Date	1 December 2022
Time	9.30am

AGENDA					
Item no. 22/23/	Title of item	Objectives/desired outcome	Process	Item presenter	Time
PRELIMINARY BUSINESS					
155	Introduction, Apologies & Declaration of Interest	Receive apologies & declarations of interest	Verbal	Chair	09.30 (5 mins)
156	Meeting Guidance Notes	To receive the meeting attendees' guidance notes	Written	Chair	
157	Minutes of the previous meeting held on 3 November 2022	Confirm as an accurate record the minutes of the previous meeting(s)	Written	Chair	
158	Action Log and matters arising	Provide an update in respect of on-going and outstanding items to ensure progress	Written	Chair	
159	Service Outline – Family Health Division	To receive service outline	Presentation	Chief Operating Officer	0935 (15 mins)
160	Patient Story	To receive a patient story	Verbal	Chief Nurse & Midwife	09.50 (20 mins)
161	Chair's announcements	Announce items of significance not found elsewhere on the agenda	Verbal	Chair	10.10 (5 mins)
162	Chief Executive Report	Report key developments and announce items of significance not found elsewhere on the agenda	Written	Chief Executive	10.20 (10 mins)
MATERNITY					
163a	East Kent Report – LWH Response	To receive	Presentation	Chief Nurse & Midwife	10.30 (25 mins)
163b	Maternity Incentive Scheme (CNST) Year 4 – Scheme Update	To receive	Written	Chief Operating Officer	10.55 (5 mins)
QUALITY & OPERATIONAL PERFORMANCE					
164a	Chair's Report from the Quality Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	11.00 (30 mins)
164b	Quality & Operational Performance Report	For assurance – To note the latest performance measures	Written	Chief Operating Officer	

164c	Integrated Governance Report – Q2 2022/23	For assurance	Written	Chief Nurse & Midwife	
164d	Guardian for Safe Working Hours Quarterly Report – Q1 & Q2, 2022/23	For assurance	Written	Medical Director	
164e	Analysis of clinical incidents attributable to the isolation of LWH services from other specialist services	To note	Written	Medical Director	
BREAK					
Board Thank You					
PEOPLE					
165a	Chair's Report from the Putting People First Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	11.45 (15 mins)
165b	Workforce Performance Report	For assurance – To note the latest performance measures	Written	Chief People Officer	
FINANCE & FINANCIAL PERFORMANCE					
166a	Chair's Report from the Finance, Performance and Business Development Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	12.00 (30mins)
166b	Finance Performance Review Month 7 2022/23	For assurance - To note the current status of the Trust's financial position	Written	Chief Finance Officer	
166c	Recovery Plan	To receive	Written	Chief Finance Officer	
BOARD GOVERNANCE					
167a	Approval of Charitable Funds Annual Report & Accounts 2021/22	For approval	Written	Chief Finance Officer	12.30 (15 mins)
167b	Corporate Objectives 2022/23: Six Month Review	For assurance	Written	Chief Executive	
167c	Board Assurance Framework	For assurance	Written	Trust Secretary	
CONSENT AGENDA (all items 'to note' unless stated otherwise) *All these items have been read by Board members and the minutes will reflect recommendations, unless an item has been requested to come off the consent agenda for debate; in this instance, any such items will be made clear at the start of the meeting.*					
No items in the consent agenda					
CONCLUDING BUSINESS					
168	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair	12.45 (5 mins)
169	Chair's Log	Identify any Chair's Logs	Verbal	Chair	
170	Any other business & Review of meeting	Consider any urgent items of other business	Verbal	Chair	
171	Jargon Buster	For reference	Written	Chair	

Finish Time: 12.50					

Date of Next Meeting: 12 January 2023

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 09.30am on 3 November 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
Dr Lynn Greenhalgh	Medical Director
Dianne Brown	Interim Chief Nurse
Michelle Turner	Chief People Officer / Deputy Chief Executive
Gloria Hyatt MBE	Non-Executive Director
Tracy Ellery	Non-Executive Director / Vice-Chair

IN ATTENDANCE

Matt Connor	Chief Information Officer
Jenny Hannon	Assoc. Director – System Partnerships
Joe Downie	Deputy Chief Operating Officer
Chris Dewhurst	Deputy Medical Director
Megan Binns	Graduate Management Trainee
Ellen Gerrard	CSS Divisional Manager (until item 136d)
Devender Roberts	Clinical Lead C&M Women's Health Partnership (item 132 only)
Gillian Walker	Patient Experience Matron (item 132 only)
Vicky Clarke	Family Health Divisional Manager (item 135 only)
Alison Murray	Deputy Head of Midwifery (item 135 only)
Nashaba Ellahi	Deputy Director of Nursing and Midwifery (item 136e only)
Lesley Mahmood	Member of the public
Felicity Dowling	Member of the public
Teresa Williamson	Member of the public
Mark Grimshaw	Trust Secretary (minutes)

APOLOGIES:

Sarah Walker	Non-Executive Director
Jackie Bird MBE	Non-Executive Director
Prof. Louise Kenny CBE	Non-Executive Director / SID

Core members	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Sep**	**Oct**	**Nov 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	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
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	NM	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
Gloria Hyatt – Non-Executive Director	NM	✓	✓	✓	✓	✓	✓	✓	✓	A		✓
Sarah Walker – Non-Executive Director	NM	✓	✓	✓	✓	✓	A	✓	A	A		A
Jackie Bird – Non-Executive Director	NM					✓	A	✓	✓	✓		A

22/23/	
127	**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.
128	**Meeting guidance notes** The Board received the meeting attendees' guidance notes.
129	**Minutes of the previous meetings held on 1 September 2022** The minutes of the Board of Directors meeting held on 1 September 2022 were agreed as a true and accurate record.
130	**Action Log and matters arising** Updates against the following actions were noted as follows: 22/23/097e – Women's Health Strategy for England – It was agreed to close the action on the tracker as the Trust's strategic objectives would be reviewed to ensure alignment with the Women's Health Strategy.
131	**Service Outline – Clinical Support Services Divisional Update** The Chief Operating Officer reported that the representatives from the Trust's three Divisions would be attending Board over the next few meetings to present on their key developments and challenges. The aim of this was to help demonstrate that effective leadership and grip on significant risks was in place throughout the organisation.

	The CSS Divisional Manager provided an outline of the Division noting that it consisted of a broad spectrum of clinical departments. The following were identified as key work programmes for the Division: • Crown Street Community Diagnostic Centre • Theatre Utilisation Programme • Anaesthetic workforce challenges Non-Executive Director, Louise Martin, queried if the Division was experiencing workforce challenges with theatre support staff. The CSS Divisional Manager noted that there had been an improvement over the previous 12 months following a focus on recruitment. There was an on-going challenge with transitioning new staff through a preceptorship period and it was remarked that the work of the Practice education facilitators (PEFs) was fundamental to the success of the transition. It was confirmed that most new staff would exit the supervisory period in January / February 2023. The Chief Executive stated that investment into areas such as the PEF team will support the retention of staff thereby reducing agency staff usage and sickness rates. It was suggested that this was an example of strategic investment that should be considered in the round by the respective Board Committee Chairs and the Executive leads to support holistic and joined-up decision making. The Chair queried if the CSS Division was working to identify further efficiencies. The CSS Divisional Manager reported that programmes of work included agency spend reduction, stock management redesign and a review of drug spend. The service outline was noted. *Gillian Walker, Patient Experience Matron and Devender Roberts, Clinical Lead C&M Women's Health Partnership joined the meeting.*
132	Patient Story The patient and their partner informed the Board that their twin girls were born by emergency C/Section at 35 weeks and two days due to a cord prolapse of the first twin. Sadly, one of the twins passed away shortly after birth and the other twin required support from the neonatal unit. The patient was transferred to the Royal Liverpool Hospital which meant her partner was left alone with both twins at the Crown Street site. Due to Covid-19 restrictions that were in place at the time, the patient's partner was unable to be supported by a family member whilst inside the hospital. The Trust's Honeysuckle (Bereavement) team were providing support to the patient's partner, but this support and therefore access to their daughter, was only available during the week and not over the weekend. This resulted in the parents not being able to spend time over the weekend with their daughter – the child being moved to the funeral directors on the Friday. The patient and their partner identified that seven-day bereavement support would have improved their experience significantly. It was also noted that continued follow up support would have been appreciated as the impact of the trauma continued to be experienced. The Patient Experience Matron reported that the Trust had taken steps to increase senior oversight of the Honeysuckle Service with the Director of Midwifery now having responsibility. Under this new arrangement, work was being undertaken to provide a more flexible and centred approach to the service. Families had also been invited to co-produce and co-design changes to the service. The Honeysuckle Team were currently recruiting an additional registered person. This would support the seven day a week service that Honeysuckle families had requested. The Chief Executive apologised to the family regarding some of the decisions the Trust had taken during the Covid-19 pandemic. Whilst patient safety had been prioritised, with reflection and hindsight, decisions regarding family support and access could have been made differently in some

	instances. It was stated that the family's journey with the Trust should not end, and that they would always be welcome to come to the hospital to remember the time they had spent with their daughter. It was remarked that the story also outlined the challenges of the Trust being on an isolated site, as the patient had been separated from her partner and children during a very challenging time. On behalf of the Board, the Chair thanked the patient and her family for sharing their story and noted that there had been several areas of learning that would be taken forward. *Gillian Walker and Devender Roberts left the meeting.*
133	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 (CiC) model had been tabled to and approved by the Board in October 2022. Other issues noted included: • The Chair had attended an Annual Learners Event in September 2022 – this celebrated all individuals in the Trust who had completed a programme or qualification at all levels • Interviews had been held for the Chief Nurse and Midwife role – Dianne Brown had been successful in securing the substantive position. • Two Nomination & Remuneration Committee meetings had been held since the previous Board in September 2022 and these had considered recruitment arrangements for the Chief Finance Officer and Chief Nurse and Midwife roles. • A joint Non-Executive Director and Governor training session had been held on 21 September 2022 (facilitated by NHS Providers). This had outlined the roles and responsibilities of the two functions. A Council of Governors meeting was scheduled for the 17 November 2022 and the learning from this training would be shared. The Council would also be considering a recommendation for the appointment of the external auditor. The Board noted the Chair's update.
134	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 was underway and that Trust representatives were participating in the various underpinning workshops. The final report / outcomes were expected in January 2023. Prof Jacqueline Dunkley-Bent visited the Trust on Tuesday 11 October 2022 and officially opened the first Bereavement Room on Delivery Suite, launching the Bereavement Suite Appeal. 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. An Annual Service of Remembrance was held on Tuesday 11 October at St George's Hall. The bereavement team were joined by hundreds of families. 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. Mid-October 2022 saw the publication 'Reading the Signals; Maternity and Neonatal Services in East Kent – the Report of the Independent Investigation'. The report set out the devastating consequences of failings and the unimaginable loss and harm suffered by families and reconfirmed the requirement

	for Boards to remain focused on delivering personalised and safe maternity and neonatal care. The Trust was reviewing the findings, and this would report to the next scheduled Board meeting in December 2022. It was agreed that there was a need to reflect on the overarching themes and consider how these aligned with other maternity reports and the recent CQC state of care report. The Chair stated that it would be important to avoid a 'compliance mentality' to the Trust's response and ensure that the Board was well sighted on the key issues that would make the most significant impact for women and their families. It was asserted that there was an opportunity for the Trust to be a 'thought leader' and show leadership for the local system and nationally. The Board of Directors noted the Chief Executive update. *Vicky Clarke, Family Health Divisional Manager and Alison Murray, Deputy Head of Midwifery joined the meeting*
135	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. It was noted that specific information was required to be noted by the Board. This related to the following: • Safety Action 6 – Regional Chief Midwifery SBL Survey October 2022 (Appendix 1) • Safety Action 9 - Perinatal Surveillance Dashboard Update (Appendix 2) The Chief Operating Officer noted the continuing challenge of ensuring that 90% of each maternity staff group attended multi-professional education and training (MPET). A mitigation plan was in place, and this was being regularly monitored. The Deputy Director of Midwifery noted that there was confidence that the training would be delivered. The process would be improved for future years by aligning it with job planning. For the Year 5 MIS programme, it was expected that neonatal staff would also be required to undertake the training. Non-Executive Director, Louise Martin, drew attention to the perinatal dashboard and noted that there had been missed opportunities with an undiagnosed placenta accreta due to a language barrier. It was queried what steps the Trust was taking to address this. The Deputy Chief Midwife confirmed that the interpreter on wheels service had improved this aspect. Non-Executive Director, Zia Chaudhry, noted that language challenges were also referenced within the learning from deaths report (item 22/23/136c), and it was asked what the Trust was doing to expand access to the interpreter on wheels service. The medical Director noted that work was being undertaken to review serious incidents through a non-English speaking and social deprivation lens to identify the most effective actions to implement. The Chief Nurse & Midwife stated that language should be part of the ante-natal risk assessment with a contingency plan in place should a translator not be available. It was noted that the Integrated Care Board (ICB) and Maternity Voices Partnership (MVP) would be involved in the sign off process ahead of presenting to the Board in the New Year. 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 Regional Chief Midwifery SBL Survey October 2022 *Vicky Clarke and Alison Murray left the meeting*
136a	Chair's Reports from the Quality Committee The Board considered the Chair's Reports from the Quality Committee meetings held on 26 September and 24 October 2022.

	The Committee had noted the following issues: • Limited progress against Equality Delivery System (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. • Increasing number of out-of-date policies highlighted by the Corporate Risk subcommittee. • Partial assurance from the Medicines Management Quarterly Update. The Committee raised concerns 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. • 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. The Board of Directors received and noted the Chair's Reports from the Quality Committee meetings held on 26 September and 24 October 2022.
136b	Quality & Operational Performance Report The Board considered the Quality and Operational Performance Report. The Chief Operating Officer noted that there continued to be work undertaken to improve the formatting of the data and an update would be available in the New Year. The Chief Operating Officer noted that September 2022 had seen an increase in maternity activity. There had been a 40% C/Section rate which was increasing pressure on theatres and staffing. The Trust's neonatal services had also been overperforming in terms of delivery for the year to date. Performance against the 52 week wait target had plateaued and proposals were scheduled to be considered by the Finance, Performance and Business Development Committee regarding investing to increase capacity. A bid had also been submitted to the system to increase ambulatory capacity. An external company had undertaken a review of the Trust's waiting lists and had provided strong third line assurance on the data quality. There had been examples of good partnership working as colleagues from Liverpool University Hospitals were supporting three sessions a day for Trust oncology patient and a colorectal consultant was spending one day a week at Crown Street. The mobile MRI was also scheduled to receive patients during November 2022 which would support diagnostic waiting times. The Chair queried the process the Trust undertakes when it is overperforming on a block contract. The Chief Finance Officer noted that whilst there was no additional resource available, the Trust ensured that it had the requisite data to evidence the overperformance and this was escalated to the relevant commissioning body. Non-Executive Director, Tracy Ellery, and the Medical Director agreed that it would be useful for the Trust to understand the drivers behind the increase in neonatal activity. Chair's Log: Quality Committee to understand the drivers behind the increase in neonatal activity during 2022/23. The Chief Nurse & Midwife noted that there was an awareness of the need to improve performance on the patient experience metrics and stated that focused actions were in place. The Board of Directors: • Received and noted the Quality & Operational Performance Report.
136c	Mortality and Learning from Deaths Report Quarter 1, 22/23

	The Board received the report which presented the mortality data for quarter one and the learning from deaths information for quarter four (2021/22). In Quarter One there were the following deaths: • Adult deaths – 2 (both expected) • Direct Maternal Deaths – 0 • Stillbirths 7 (rate 3.7/1000) • Neonatal deaths 9 inborn (rate 4.8/1000 inborn births) + 4 deaths from postnatal transfers (It was noted that the stillbirth rate was lower in this quarter than the previous four quarters, although caution of interpretation due to small numbers was warranted. An annual review of stillbirths for 2021/22 was completed and presented to the Quality Committee and had been shared with the Board via the supporting documents. The neonatal mortality rate was presented. Benchmarking with the Vermont Oxford Network for babies >1500g was highlighted and this showed that the mortality for 2021 was within the network interquartile range for the first time in several years. The Board of Directors noted: • 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.
136d	Seven Day Services The Deputy Medical Director noted that Boards should assess at least once a year whether their acute services were meeting the seven-day service (7DS) clinical standards to demonstrate performance to commissioners and regulators. The Quality Committee had received the report in October 2022 and noted partial assurance. Assurance was received that there was no difference in length of stay or discharges at the weekend. The Committee was not assured that there was appropriate job planned consultant time for emergency care at the weekend, although it was acknowledged this was being reviewed as part of the 5-year medical staffing strategies. Review of the care and scope of work provided by Gynaecology Emergency Department had been recommended. An update on progress in the anaesthetic consultant workforce was also requested. The paper has been remitted to the Finance, Performance and Business Development Committee meeting to triangulate the potential financial impact of workforce expansion. The lack of access to onsite diagnostic test and consultant led interventions was driven by the lack of co-located services which was addressed in the Future Generations strategy. The Board of Directors noted the contents of the report and the assurances that: • the variance in length of stay and discharge was elucidated in the data. • there had been a deep dive which had identified that the length of stay following admission at the weekend, although longer than average, was not clinically significant. The reduced number of discharges on Sunday in Gynaecology reflected the reduced number of admissions at the weekend. • there were medical staffing strategies in place to increase consultant presence out of hours.

	Nashaba Ellahi, Deputy Director of Nursing and Midwifery joined the meeting
136e	**Bi-annual staffing paper update, January 2022-June 2022 (Q4 21/22 & Q1 22/23)** The Board received a detailed bi-annual safer staffing review covering the period January to June 2022. The Deputy Director of Nursing and Midwifery highlighted the following key points: • Vacancy rate (June 2022) was 13.32%, with Maternity reflecting the greatest vacancies, however overall vacancy rate had increased due to several business cases being approved that demonstrated the need to increase staffing • Sickness had been above target of 4.5% with June 2022 reflecting 8.17%, (5.76% non-covid related sickness) • Long-term sickness rates had been the lowest within NMC/HCA staff groups over the past 12 months. • Turnover had remained under or at Trust threshold (13%) in NMC/HCA for past 12 months, however, turnover was high in small teams as reflected in AHP workforce • Age profile remained static except with a marginal reduction of staff who could retire now or in next five years seen • 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) 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 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 continued with successful early recruitment of Midwives that commenced in October 2022. Non-Executive Director, Louise Martin, queried if work to reduce agency spend was being made more challenging by sickness rates and other factors e.g. maternity leave. The Deputy Director of Nursing & Midwifery confirmed that progress was being made to reduce agency usage and this was being supported by a rolling recruitment to 105% capacity policy for midwives. The Chief Executive noted that it would be useful to see a breakdown of the midwifery establishment against the investments made by the Trust over the previous three years. **Action: To provide a breakdown of the midwifery establishment against the investments made by the Trust over the previous three years.** It was stated that it would also be useful to understand the factors that meant that the Trust was not operating with the funded establishment for midwives e.g. sickness, maternity leave. The Chief People Officer noted that it was a recommendation from the Ockenden Report for trusts to be realistic about their sickness rate and ensure that headroom took consideration of this. **Action: To outline the factors (quantified) that result in the Trust not operating to its funded midwifery establishment.**

	Non-Executive Director, Zia Chaudhry, queried how the Trust built on interest from students and school leavers in a career at the Trust. It was acknowledged that whilst the Trust engaged with this demographic, improvements could be made in tracking how many pursue careers at the Trust after initial contact. Chair's Log: For the Putting People First Committee to explore how effectively the Trust retains contact with students and school leavers following career engagement events. The Chief Information Officer queried how the Trust managed violence and aggression incidents. It was noted that these were discussed in safety huddles and follow ups undertaken to ensure support was in place if required. The Board of Directors noted the report and the assurance of the actions undertaken to effectively manage and provide safe staffing within Nursing, Midwifery and AHP to support the delivery of safe care. *Nashaba Ellahi left the meeting*
	Board Thank you The Chief Executive noted thanks to Father Peter who was steeping down from the Trust's chaplaincy service. Father Peter had provided a fantastic service to the Trust and had been a great comfort and advocate for patients. The Chief Nurse & Midwife reported that a commendation had been received from a social worker who had worked with a Trust midwife – Laura McCarren. It was noted that Laura had been allocated to work with a mother who had complex mental health challenges. She was non-judgemental in her approach and had been thorough identifying and addressing risks appropriately. The social worker had stated that they believed that Laura's efforts had made a big difference in ensuring the safety and welfare of mother and baby.
137a	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 3 October 2022. The Committee had considered the potential risk of industrial action and noted the actions being undertaken to prepare the Trust. A detailed review into maternity mandatory training compliance had been received. 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 Board of Directors: • Received and noted the Chair's Report from the Putting People First Committee meeting held on 3 October 2022.
137b	Workforce Performance Report The Board received the Workforce Performance Report. The Chief People Officer remarked that several issues in the report had been discussed in other items on the agenda. It was asserted that this demonstrated that people and staffing were significant themes for the organisation. The Board of Directors:

	• Noted the Workforce Report.
138a	Chair's Reports 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 26 September and 24 October 2022. The Chair of the October 2022 meeting, Tracy Ellery, reported that the Committee had been informed that if the Trust was to achieve its full year plan, significant improvements in the monthly run rate were needed. 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. Discussions were also held regarding the preparation for the 2023/23 planning process. 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.
138b	Chair's Report from the Audit Committee The Board considered the Chair's Report from the Audit Committee meeting held on 20 October 2022. The Committee Chair, Tracy Ellery, 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. The current external auditor had not been present for the meeting but had attended a pre-meet with Committee members only. 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 Board of Directors: • Received and noted the Chair's Report from the Audit Committee meeting held on 20 October 2022.
138c	Chair's Report from the Charitable Funds Committee The Board considered the Chair's Report from the Charitable Funds Committee meeting held on 17 October 2022. The Committee Chair, Tracy Ellery, noted that the Committee had received a presentation update against development of the Fundraising Strategy for 2022/25. It was noted that further discussion with the Board (as Corporate Trustee) would take place in November 2022 to agree the planning and direction of the strategy. The Committee noted the positive movement of the inter-indebtedness 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 monthly. The Committee had approved the request to divest from direct investment in oil and gas holdings in line with ethical investment and green plan aims. The Committee raised a concern that the project bid to refurbish the junior doctors mess, submitted two years ago from NHS Charities Together remained unspent. The Chief Operating Officer confirmed that a task and finish group was in place to oversee this project and work was expected to commence in December 2022 when a portacabin would be in situ to help manage the transition.

	The Board of Directors: • Received and noted the Chair's Report from the Charitable Funds Committee meeting held on 17 October 2022.
138d	Finance Performance Review Month 6 2022/23 The Chief Finance Officer presented the Month 6 2022/23 finance performance report which detailed the Trust's financial position as of 30 September 2022. It was noted that at Month 6, the Trust was reporting a £0.822m surplus. This was on plan but was supported by £7.8m of non-recurrent items. If the Trust was to achieve its plan improvements in run rate were needed, and a Recovery Plan was underway to support this. The Chief Finance Officer noted that the ICB had been briefed on the key issues and risks. A protocol for going off plan was being developed by the ICB which the Trust would comply with. The Chief Finance Officer continued to outline the key risks to financial recovery. As activity had been lower than expected, and due to a change in fund the funding model, there was a risk to the funding of the Community Diagnostic Centre (CDC). The Trust was making the case that it should not be in financial detriment for hosting a service on behalf of the system. The Trust was also behind plan in relation to the Elective Recovery Fund. The cash balance at the end of Month 6 was £3.3m, a decrease of £3.3m from Month 5. This balance was below minimum levels set out in the Treasury Management policy (15 days expenditure or c£5.9m minimum cash level). Cash levels were under scrutiny and the Trust had secured short term support via the ICB. The Trust was achieving its total Cost Improvement Programme (CIP) target YTD and was forecast to achieve for the full year, albeit with more non-recurrent measures than initially planned. Any further CIPs would remain subject to a Quality Impact Assessment. The Chair remarked that it would be important for the Trust to demonstrate that it had taken all available actions to achieve as close to the plan as possible. Evidencing grip on the areas within the Trust's control was vital together with being able to highlight the impact (and quantum) of areas outside of the Trust's control. The Board of Directors: • Noted and received the Month 6 2022/23 Finance Performance Review • Agreed that the Trust's financial position would be an area under scrutiny over the next six months.
138e	Our Strategy – Review of Delivery The Board received an update in respect of progress made towards delivery of the objectives and achievement of the ambitions set out within the Trust's overarching strategy. It was asserted that good progress had been made towards delivery of the Trust strategy since its launch. The majority of objectives were on track for delivery, and where objectives were rated as 'at risk', plans were in place to address issues. The Chair challenged the proposal to pause the objective to 'develop the Trust's commercial strategy during 2022' noting that in a challenged financial landscape, exploring commercial opportunities would be important. It was acknowledged that the Trust was facing several competing priorities and the resource to develop a full strategy might not be available. It was agreed to review what would be possible in terms of identifying commercial opportunities for the Trust. Action: To review what would be possible in terms of identifying commercial opportunities for the Trust.

	The Chief Executive also noted that the criteria for achieving university hospital status might be changing which would re-open the possibility to the Trust. It was agreed that this strategic objective would be reinstated. The Board of Directors: • Noted the progress towards delivery of Our Strategy and its strategic objectives • Noted the wider progress towards achievement of the Trust's ambitions • Subject to the suggested amendments, approved the proposed changes to the strategic objectives.
139	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 October 2022. 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 (November 2022). The Board of Directors: • Reviewed the BAF Risks *The following items were considered as part of the consent agenda*
140	Medical Appraisal and Revalidation Annual Report 2021/22 The Board of Directors: • received the annual report and noted that this would be shared with the higher Responsible Officer • Took assurance that despite COVID 19 there were effective medical appraisal and revalidation processes in place • Approved the statement of compliance Annex D confirming that the organisation, as a designated body, was in compliance with the regulations and noted that this needed CEO signature and Board approval.
141	Review of risk impacts of items discussed The Chair identified the following risk items: • Ensuring that there is a comprehensive response to the issues raised in the East Kent report and that the Trust capitalises on the opportunity to be a 'thought leader' in its approach • Equality and access to services – ensuring that issues are embedded in risk assessments • On-going challenges with waiting times and trajectories • The Trust's financial position and long-term sustainability
142	Chair's Log The following Chair's Logs were noted: • Quality Committee to understand the drivers behind the increase in neonatal activity during 2022/23. • For the Putting People First Committee to explore how effectively the Trust retains contact with students and school leavers following career engagement events.
143	Any other business & Review of meeting

	None noted. Review of meeting The Chief Executive noted in many of the discussions held throughout the meeting, the dynamic tension between the occasionally competing financial, operational, quality and workforce challenges had been expressed. It was suggested that the respective Chairs and Executive Leads for the Quality, Finance, Performance & Business Development and Putting People First Committees should meet to discuss how best to ensure that this tension was being managed to ensure effective and risk-based decision-making.
144	Jargon Buster Noted.

Liverpool Women's
NHS Foundation Trust

Action Log

Trust Board - Public
01 December 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
3 November 2022	22/23/138e	Our Strategy – Review of Delivery	To review what would be possible in terms of identifying commercial opportunities for the Trust.	Chief Finance Officer	Jan 23	On track	
3 November 2022	22/23/136e	Bi-annual staffing paper update, January 2022-June 2022 (Q4 21/22 & Q1 22/23)	To outline the factors (quantified) that result in the Trust not operating to its funded midwifery establishment.	Chief Nurse & Midwife	Jan 23	On track	
3 November 2022	22/23/136e	Bi-annual staffing paper update, January 2022-June 2022 (Q4 21/22 & Q1 22/23)	To provide a breakdown of the midwifery establishment against the investments made by the Trust over the previous three years.	Chief Nurse & Midwife	Jan 23	On track	
1 September 2022	22/23/098b	Workforce Performance Report	To undertake an evaluation of the Trust's midwifery preceptorship scheme	Chief Nurse & Midwife	Dec 22	Complete	Reported to the November 2022 PPF Committee – see item 165a.
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 took place at CoG session on 17 November 2022. *Suggestion to close from the action plan but note the on-going need to continue to align the WHS aims with the Trust's objectives and strategy*

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	Complete	Included within the Neonatal Services Review action plan. Updates to which will report through to the Quality Committee.
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	Chief Nurse & Midwife	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 of services was either a root cause or a contributory factor	Medical Director	Dec 22	Complete	Received at the November 2022 Quality Committee with onward reporting to the Board.
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.

Chair's Log

Received / Delegated	Meeting Date	Issue and Lead Officer	Receiving / Delegating Body	Action Deadline	RAG Open/Closed	Comments / Update
Delegated	03.11.2022	To explore how effectively the Trust retains contact with students and school leavers following career engagement events. Executive Lead: Chief People Officer	PPF	January 2023	On track	
Delegated	03.11.2022	To understand the drivers behind the increase in neonatal activity during 2022/23.	Quality	January 2023	On track	

		Executive Lead: Chief Operations Officer				
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	Completed	FPBD received updated within Financial Recovery Plan Report item, 22/23/131 on 21.11.2022. Action closed.
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~~ PPF	November 2022	Completed	PPF received report on 14 November 2022. Action closed. Six-month update commissioned.
Delegated	07.07.2022	To receive a profile of agency usage against agreed establishment levels. Lead Officer: CFO	FPBD	January 2023	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	Completed	PPF received a staff story from a junior doctor on 14 November 2022.
Delegated	05.05.2022	To receive benchmarking information on mandatory training compliance. Lead Officer: CPO	PPF	~~July 2022~~ December 2022	Completed	PPF verbal update July 2022: confirmed that other trusts are reporting similar core mandatory training compliance to LWH but comparison trusts do not report on either their clinical or local/specialist mandatory training, hence we have high levels of transparency.

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	Completed	Quality Committee received update within appended report to action log, 22/23/128 on 21 November 2022. Action closed.

Liverpool Women's
NHS Foundation Trust

CEO Report

Trust Board
December 2022

Executive Summary:

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

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

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

Chief Executive Report

Section A - *Internal*

Liverpool Women's terrorist attack. One year on.

It's been a year since Liverpool Women's Hospital became a target for a terrorist attack in November 2021. Although a year has passed the events of that Sunday in November have left their mark on the Trust and things will never quite be the same.

As we approached the anniversary of the incident, it was timely to reflect on that day and how we worked together as staff, patients, visitors, NHS partners and the local community, to keep each other safe.

Over 8000 babies are born each year at Liverpool Women's – it holds a special place in the heart of the city we serve. The incident was extremely traumatic and upsetting for everyone in the city, not least our staff, our patients, their families and our local community. Whilst we can be grateful that the absolute worst did not happen, there is no escaping the fact that there was the intent to cause significant harm to NHS staff, pregnant women, newborn babies, their families and other people who were in our care. The scars on our buildings have diminished but some of the deeper scars of that terrible intent remain.

Imagine being the woman in labour when the bomb exploded right outside your window; or the midwife or other clinician having to carry on looking after people on that day despite your fear about what may happen next; imagine being a partner on your way to visit the hospital to see your newborn baby on your happiest of days; or being in main reception when the bomb went off and glass and smoke blew in.

Our services already felt different due to COVID-19 restrictions. We knew immediately the terror and anxiety parents, partners, patients and families would be feeling. Our staff ran towards danger not away from it. Their primary aim as always was to help and care for people, regardless of the risk to themselves and their commitment and dedication remained in the days and weeks following the incident as we continued to run a hospital within a live police cordon. Our staff were truly outstanding – our night shift staff were arriving hours early to ensure they could get on site and release the day shift. Our partners in the city immediately responded to our calls for help - we had on-site counsellors within a couple of hours of the incident from Mersey Care NHS Foundation Trust and other hospitals accepted some of our women during our brief closure to admissions.

We were faced with running a hospital from within a Police Cordon, under the control of Police and Counter Terrorism. We had to make quick decisions about what could be stood down, what could be transferred and when we would be able to resume normal service.

Some outpatient and inpatient activity was cancelled in the 24 hours following the incident, transferred to a neighbouring Trust or converted to telephone appointment. No elective admissions were cancelled 48 hours after the incident. 17 babies were born on site on that day.

As always, there was learning from the events of that day. Running a major incident from a site which is no longer under your control creates specific challenges. The Trust remained in Major Incident for 10 days, with the site remaining under the control of Police and NW Counterterrorism (NWCTU) specialist investigation teams during this time.

We quickly undertook a formal review of the entire incident, to identify what went well and what could have been better. This included debriefs with system partners, Police and counter terrorism colleagues. Lessons learnt have been supported by specialist security advice, considered crucial as the Trust is on a single isolated site without the infrastructure of a large acute Trust.

Liverpool is a city with a huge heart which it wears proudly on its sleeve. Liverpool Women's holds a special place in that heart. There was significant anger in the city when we were targeted. We were immediately sighted on the need to ensure that the attack did not trigger community tensions and a cohesive stance was taken by the Trust, the police and local community and religious leaders to demonstrate that we stood shoulder to shoulder and would not tolerate the incident being used to discriminate, blame or isolate anyone within our hospital or our community. If there is a positive to take from such an event, it is that the incident has connected the hospital even more to the community it serves.

Fortunately, events like these are rare and Liverpool Women's feels like a safe place again but everyone connected to the Trust will never forget the events of that day.

Chief Executive Report

Section A - *Internal*

Crown Street Enhancements Programme update

The Crown Street Enhancements Programme at Liverpool Women's was established to deliver a number of exciting projects designed to improve safety, as well as the experience of patients and staff at Liverpool Women's. There are a number of clinical risks and challenges that the Trust will be mitigating by enhancing our current site, as well as improving our compliance with clinical standards.

Improving our facilities will help to provide a better patient and staff experience whilst also providing an interim solution to tackle some of our clinical challenges.

The Trust's long-term preferred plan of re-locating and building a new Liverpool Women's Hospital adjoined to other adult acute services in the city remains the same. However, whilst Liverpool Women's remains at its current home it is important that its services and facilities continue to be developed to deliver the best and safest care possible as well as outstanding experiences.

- In late 2020, the Trust was successful in securing £6.5m of capital financing, to address some of the clinical challenges we face on the current Liverpool Women's site.
- In 2020, the Trust began piloting Robotic Assisted Surgery within its Gynaecology service.
- The Fetal Medicine Unit (FMU) was relocated from the ground floor to the 2nd floor to allow space for the new Community Diagnostic Centre to be built. FMU moved into their new unit in November 2021.
- The Trust is currently working to establish a 24/7 Transfusion laboratory at Crown Street, working in conjunction with Liverpool Clinical Laboratories (LCL).
- The New Colposcopy Unit at Liverpool Women's opened its doors to patients on 9th November 2022.
- The development of the Community Diagnostic Centre in partnership with Liverpool University Hospitals (LUHFT), Liverpool Heart and Chest (LHCH) and Clatterbridge Cancer Centre (CCC) began in March 2022
- LWH took delivery of a Mobile CT scanner in February 2022 and its first patient was seen on in March 2022. At the end of October 2022, the mobile CT Scanner had seen its 4500th patient scanned.
- Mobile MRI scanner is now on site and the first patients were seen 8th November 2022
- Permanent CT and MRI imaging are expected to be in place by early 2023.

The naming of the CDC has been confirmed as Crown Street Community Diagnostic Centre

The implementation of these services means that patients are benefiting from reduced waiting times and treatment closer to home along with…

- earlier diagnoses for patients through easier, faster, and more direct access to the full range of diagnostic tests needed to understand patients' symptoms.
- a reduction in hospital visits which will help to reduce the risk of COVID-19 transmission; and
- a contribution to the NHS' net zero ambitions by providing multiple tests at one visit, reducing the number of patient journeys and helping to cut carbon emissions and air pollution. Offering a number of different services to patients including CT scans

Section A - *Internal*

Change to Board of Directors - Dianne Brown appointed to role of Chief Nurse

We are pleased to announce following a competitive interview process that Dianne Brown (currently Interim Chief Nurse) has been appointed to the role of Chief Nurse, subject to the completion of all pre-employment checks.

Dianne will remain in her Interim post until formally commencing her new role in the next few weeks.

I would like to congratulate Dianne on her appointment and for her commitment to supporting the Trust in an interim capacity over recent months. We are delighted to welcome Dianne back to Liverpool Women's in a permanent capacity.

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

Team of the Month goes to **Housekeepers, Gynae & Maternity –** This team work together caring for their areas with great enthusiasm they respect, engage and support one another and share ideas of improvement.

& Employee of the month goes to **Steve Dobie,** Overseas Visitors Manager -

Steve is forward thinking in his field, with his expertise in Overseas Visitors guidance he ensures that we as a Trust are fully compliant and he puts LWH on the map for the work he does regionally and nationally

Well done to you all.

Section B - *Local*

NHS Cheshire and Merseyside Stakeholder Brief - November 2022

With the COP27 summit underway in Sharm-el-Sheikh and action on climate change very much in focus, work to deliver against Cheshire and Merseyside's Green Plan and meet our ambition of net zero continues apace.

There are many examples of practical measures that are being introduced to help lower our collective carbon footprint – from reducing printing across the system to rolling out new zero-emission electric vehicles.

Sustainable transformation requires leadership and engagement from board-level staff, however. That's why we've agreed to arrange bespoke Net Zero Leadership Training for Board members across Cheshire and Merseyside's health and care system.

All NHS Cheshire and Merseyside staff must also now complete dedicated 'Building a Net Zero NHS' training as part of their statutory and mandatory training. We believe we are amongst the first Integrated Care Boards in the country to make this commitment.

In other news, NHS Cheshire and Merseyside has recently signed two key pledges – the Armed Forces Covenant and Mencap's Treat Me Well pledge.

Signing the Armed Forces Covenant underlines our commitment to working with partners to ensure that no member of the Armed Forces community faces disadvantage in accessing services.

I'm pleased to share that our Chair Raj Jain and I have also both shown our commitment to improving health and care support for people with a learning disability by signing Mencap's Treat Me Well pledge. This issue was brought into sharp focus recently by the sobering BBC Panorama investigation 'Will the NHS care for me?' We simply must continue to tackle health inequality wherever we find it.

I'm delighted that Councillor Louise Gittins, the leader of Cheshire West and Chester Council, has agreed to Chair the new-look Cheshire and Merseyside Health and Care Partnership (our statutory Integrated Care Partnership) and I'm excited to see how cross-partner integration can support and enhance our collective work.

Finally, I'd like to congratulate everyone involved in the 24-day move to the new Royal Liverpool University Hospital site.

Relocating an entire hospital, its staff and patients safely and smoothly is testament to the exceptional planning, dedication and professionalism of NHS staff.

Graham Urwin - Chief Executive

Full November 2022 update available here

Section B - *Local*

First meeting of new-look Cheshire and Merseyside Health and Care Partnership

Cheshire and Merseyside Health and Care Partnership – the sub-region's new statutory Integrated Care Partnership – met for the first time at the Partnership for Learning conference centre in Halewood, Knowsley on November 8th 2022.

Consisting of representatives across the NHS, local authorities, voluntary sector, housing, police and fire and rescue, the Partnership Board provides a multi-agency forum to assess the health, public health and social care needs of people across Cheshire and Merseyside – and develop a combined strategy to address them.

Councillor Louise Gittins, the leader of Cheshire West and Chester Council, was unanimously confirmed as Chair, with Raj Jain – the Chair of NHS Cheshire and Merseyside – confirmed as vice-chair. A process to appoint a second vice-chair, to represent the voluntary sector, is already underway.

Cllr Gittins described her appointment as "an honour" and the inception of the multi-agency partnership as "a once in a lifetime opportunity to make a real difference across our communities". As a "Marmot community", she said the Partnership must come together to help tackle health inequalities across Cheshire and Merseyside.

At the end of the meeting partners outlined their collective commitment to work across traditional organisational boundaries and hold each other to account for delivery as well as to further develop their shared purpose – ensuring residents, service users and patients are at the centre of everything the Partnership does.

https://www.cheshireandmerseyside.nhs.uk/posts/first-meeting-of-new-look-cheshire-and-merseyside-health-and-care-partnership/

NHS Cheshire and Merseyside Integrated Care Board meeting

The next meeting of NHS Cheshire and Merseyside Integrated Care Board will take place at the Halliwell Jones Stadium in Warrington between 10am-1pm on Monday, November 28th.

https://www.cheshireandmerseyside.nhs.uk/posts/nhs-cheshire-and-merseyside-integrated-care-board-meeting-3/

Section C - *National*

Government Changes

On the 25 October, Rishi Sunak MP became Prime Minister following the resignation of Liz Truss MP as Prime Minister and leader of the Conservative party. He has since carried out a government reshuffle, reappointing Jeremy Hunt MP to the position of Chancellor of the Exchequer and appointing Steve Barclay MP as Secretary of State for Health and Social Care.

This briefing from NHS providers provides an overview of the changes and includes the following:

- A biography of the new Secretary of State for Health and Social Care, and his ministerial team
- A biography of the new Prime Minister
- Biographies of the new Chancellor and other ministers relevant to health and social care
- A list of Cabinet members and those attending Cabinet
- NHS Providers press statements

shorturl.at/ruyN6

NHS Providers' new chief executive

Julian Hartley, who is currently chief executive at The Leeds Teaching Hospitals NHS Trust, will take up his new role with NHS Providers, on 1 February 2023.

Section C - *National*

UK COVID-19 Public Inquiry

The NHS England Inquiry team met with the Public Inquiry during November to understand its approach to how those organisations who delivered care will be asked to or be able to participate.

As a first step in its Module 3 investigations, the Public Inquiry will be conducting a short survey of trusts and ICBs via a questionnaire. A letter from the Public Inquiry to your Chief Executive will be sent at the end of November with a short questionnaire and accompanying FAQs. NHS Trusts and ICBs will be asked to send the completed questionnaire to the Public Inquiry directly. The Public Inquiry will also be surveying other healthcare providers in due course.

The Trust Secretary is the Trust's designated Inquiry Lead and will bring a report back to the Board in the New Year outlining the Trust's approach to the Inquiry to date and the proposed future actions.

NHS
Liverpool Women's
NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	22/23/163b	Date 01/12/2022
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.	

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)***
  - ***Receive the ATAIN & Transitional Care Audit Q2 Report.***
  - ***Receive an extract from the NHSD Monthly CNST scorecard confirming all 6 Data Quality metrics were met for July's submission for Liverpool Women's***

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 Trust Board and these include:

- Receive the Paper for Perinatal Quality Surveillance Dashboard (October Data)
- ATAIN & Transitional Care Audit Q2 Report.
- Receive extract from the NHSD Monthly CNST scorecard confirming all 6 Data Quality metrics were met for July's submission for Liverpool Women's

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. *15.11.2022 - There are 33 cases eligible for reporting to MBRRACE for this standard. Of these cases 12 are exempt from this standard as the surveillance case is assigned to an external trust.* 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 - 100% Compliance. *15.11.2022 - There are 32 cases eligible for this standard, one case less than standard Ai. The 33rd case (84430) does not qualify as the standard deadline is after the qualifying date for CNST.* 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 – 80% - Fully published within six months - On track for completion – 100%. 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	
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 data.	

	Leads: Head and Deputy of Information Richard Strover & Hayley McCabe	Confirmed with LMNS on 14.10.2022 that Digital Strategy has been received. Confirmation that NHS Digital have noted that the Trust has passed the 6 criteria for the Maternity Safety Data **(see Appendix 3)**	
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. The combined ATAIN & Transitional Care Audit Q2 report can be found in the appendix to this update.	
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 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 Birth Rate+… and/if (MIS, 2022) -Trust Boards are not compliant with a funded establishment based on Birth Rate+, 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 submitted to Trust Board in November 2022 A brief synopsis of the audit results of each safety element as follows Full audit to be tabled at Quality Improvement Group – December 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 – COMPLIANT** • 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)	

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 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 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 which MVP Chair attended. MVP Chair meeting weekly with DoM, HoM and Matrons 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 received from MVP – sighted by Safety Champions, to be reviewed by FHDB. MVP Meeting scheduled 30th November 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 – Obstetric 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 specific details of the CoC plan were discussed in-depth. Letter received from NHSE in September 2022 by the Senior Leadership Team and position statement released to all staff that reflects that the Maternity Service will continue will continue with the four CoC teams which were previously rolled out, with a pause on any further trajectory. 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 in December 2022 and Trust Board in January 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 requested 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. Perinatal Dashboard
2. ATAIN & TC Audit Q2 Report – *included within the Supporting Documents in Admin Control*
3. Extract from the NHSD Monthly CNST scorecard

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Maternity Perinatal Quality Surveillance Model: November 2022 (October 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 34 red flags reported in September within Maternity. A decrease from previous months reporting. - 16 incidents - delay in ongoing process of induction >4 hours - 12 Breaches 1:1 Support in labour not provided - 3 Delay Tx in Antenatal Postnatal care. - 2 Incidents - delay >30 mins between presentation and triage - 1 Delay >30mins between admission 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. Safety & Effectiveness Senate will continue to maintain an overview of MRF events via PPF as the Trust is currently a regional outlier for reporting of MRF events. A review has been undertaken with Maternity Services which has provided context to how and when the local red flag relating to 'Delay in ongoing process of induction >4hours' was agreed. In Cheshire and Mersey, it has been confirmed by the LMNS that no other regional Maternity services have any additionally locally agreed red flags; all Maternity services report against the red flags as identified by NICE (2015). Maternity Services to present a more detailed paper to Safety and Effectiveness Committee, outlining the rationale for introducing the local red flag and rationale for continuing to report against the local red flag. Paper to include an update on the induction of labour QI project. Decision to retain the local red flag to be agreed through Safety and Effectiveness Committee. Red flag reporting to be included into Divisional Performance Review dashboards that can support provision of a detailed narrative against the number of red flags and themes and trends. Re-align the red flags in Ulysses to those in NICE (2015) guidance to ensure they are written as specified in guidance an alter Ulysses to reflect midwifery red flags as cause group and a drop drown selection of pre-populated red flags be then selected from to avoid mis-reporting red flags

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 incentivized 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.
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:	There were no eligible cases for reporting to HSIB in October 2022.
Maternity Serious Safety Incidents	The Family Health Division reported one incident to STEISS/CCG in October 2022: Primigravida, low risk pregnancy. Normal antenatal care. Spont labour. Instrumental birth in theatre, CTG concerns. Uneventful recovery, tx to ward, PPH. EBL >1100mls. Tx to HDU, obs stable, bloods taken Hb>100 – tx to ward 9hrs post PPH. Failed TWOC, Hb returned 64.0, deranged biochemistry. Unsuccessful TWOC. Transfusion and discharged on day 5. Returned to MAU on day 6 with 2nd PPH – unstable on admission – to Theatre for EUA - perineal hematoma repaired. Tx to HDU. Biochemistry results deramged, specialist in Birmingham Liver Unit. Clinical course then required tx to RLUH for CT USS – Delay in obtaining HDU bed at External trust. SUI declared on the basis of delays in some clinical treatment and HDU/ITU/Acute service not available on Crown Street Site.
Perinatal Mortality.	Number of Neonatal Perinatal Deaths in October 2022**: 3** - 39+2 Week RIP at Home with palliative care plan and congenital abnormality – Not reportable to HSIB – Full PMRT Review planned. - 37+0 Week RIP at Claire House with palliative care plan and congenital abnormality – Not reportable to HSIB – Full PMRT Review planned. - 22+0 Week RIP on day 13 of life – complications of extreme prematurity. Number of Stillbirth (Exc TOP) Perinatal Deaths in October 2022**: 1** - 25+4 Week Antenatal SB – Complications of Prelabour prolonged SROM- Full PMRT Review planned. All perinatal deaths in October 2022 have been reported to MBRRACE and will be subject to a full MDT review with an external panel member. Details and actions plan 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	23
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 3 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. Ward Managers and Matrons will be invited to attend Safety Champion meetings and participate in feedback.

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.

MIS Year 4: Maternity MPMET & Fetal Surveillance Training Compliance. November 2022

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	Dec 22	
SA 8b. MPMET	Midwives	13%	19%	22%	38%	61%	76%	78%	78%	80%	78%	95%		Figure appears to have gone down due to 37 New starters – all booked on to MPMET before end of Nov 2022
	Maternity HCA	10%	19%	21%	30%	49%	69%	75%	75%	71%	74%	97%		
	Cons Obstetrician	6%	10%	46%	62%	71%	71%	71%	71%	84%	85%	92%		
	Trainee Obstetrician	9%	20%	51%	64%	91%	97%	97%	97%	29%	53%	91%		New rotation in August
	Cons Anaesthetist	6%	13%	26%	26%	26%	37%	37%	37%	50%	69%	100%		
	Trainee Anaesthetist	11%	44%	44%	11%	33%	55%	55%	55%	12%	16%	93%		New rotation in November
SA 8c. Fetal Surveillance	Midwives	2%	7%	19%	28%	53%	72%	78%	78%	85%	88%	99%		This figure includes all NQM, B6, B7, B8.
	Cons Obstetrician	2%	10%	20%	35%	60%	63%	74%	74%	74%	84%	91%		This figure is based on bookings made for 24.11.22.
	Trainee Obstetrician	0%	13%	39%	63%	67%	80%	83%	83%	24%	73%	91%		
SA 8d. NLS	Midwives	13%	19%	22%	39%	62%	76%	78%	78%	80%	83%	95%		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%	100%	100%		
	Neonatal Nurses	80%	84%	89%	89%	89%	89%	96%	99%	99%	100%	100%		

Red data denotes trajectory based on bookings and confirmation of attendance.

Family Health Division Training Narrative – November 2022

Safety 8A Safety Action Requirement: A local training plan is in place to ensure that all six core modules of core competency framework, will be included in your unit training programme over 3 years, starting from the launch of MIS in August 2021 to 5th December 2022.

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

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 can 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.

Safety Action 8B Requirement: 90% of each relevant maternity unit staff group have attended an 'in house' one day, multi-professional day, that includes maternity emergencies, starting from the launch of MIS in August 2021 to 5th December 2022. MPMET.

Liverpool Women's Multi Professional Mandatory Emergency Training (MPMET) day incorporate all elements of the core competency framework, local cases are used within the training day and every session is multidisciplinary, with attendance from Senior and Junior Obstetricians, Senior and Junior Midwifery Staff, Anaesthetic presence, and Healthcare assistants. 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 are pleased to highlight that the education faculty are reporting a positive compliance against the 90% target in all relevant staff groups. As demonstrated in the table above, we can confirm that all required staff groups will have met the compliance target of 90% by the end of November 2022.

A MPMET study day is planned on 22nd November 2022 of which a further 2 trainee obstetricians, 3 consultant obstetricians and 23 midwives are scheduled and confirmed to attend. Assurance have been sought from the Clinical Director, Lead Anaesthetist, and the Head of Midwifery that all staff will be in attendance.

Safety Action 8C: Requirement: 90% of each relevant maternity unit staff group have attended an 'in house' one day, multi-professional day, that includes antenatal and intrapartum fetal monitoring, starting from the launch of MIS in August 2021 to 5th December 2022.

In December 2021, a fetal surveillance one day, training course was designed to meet the educational requirements of the Maternity Incentive Scheme and the relevant Ockenden IEAs and attendance commenced in January 2022. The fetal surveillance study day includes education and training, aligned to meet the requirements of the SBLCBV2, including human factors, risk assessment, learning from local incidents and complicated high risk antenatal cases, obstetric emergencies including management of fetal bradycardia. Intermittent Auscultation, Electronic fetal monitoring and risk assessment are included along with the RCOG/RCM Escalation toolkit.

We are pleased to highlight that the fetal surveillance and education teams are reporting a positive compliance against the 90% target. As demonstrated in the table above, we can confirm that all required staff groups will have met the compliance target of 90% by the end of November 2022.

A multi-disciplinary fetal surveillance study day is planned on 24th November 2022 of which a further 2 trainee obstetricians, 2 consultant obstetricians and 23 midwives are scheduled and confirmed to attend. Assurance have been sought from the Clinical Director and the Head of Midwifery that all staff will be in attendance.

Safety Action 8D: Can you evidence that 90% of the team required to be involved in immediate resuscitation of the newborn and management of the deteriorating new born infant have attended in-house neonatal life support training or NLS course starting from launch of the MIS year four in August 2021 to 5th December 2022.

We are pleased to confirm that all relevant staff groups have attended an in-house neonatal life support training (delivered on MPMET) study day for midwifery and obstetric staff to a compliance target of 95%. Clinicians from the Neonatal division are all compliant with training in neonatal resuscitation and have certificated attendance at the New-born Life Support course.

Maternity 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	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
Perinatal	1:1 Care in Labour	100% CNST 95% CCG	99.60%	99.40%	98.10%	98.30%	98.90%	96.50%	98.97%	99.20%	99.10%	98.59%	98.19%	98.24%	98.01%
	Stillbirth Number >24 weeks (Adjusted)	Actual Number	2	5	2	5	0	5	1	4	2	3	3	1	1
	Stillbirth Adjusted % per 1,000 Birth		4.57%	7.51%	3.21%	6.07%	0%	6.75%	1.70%	6.13%	4.92%	10.94%	4.52%	4.54%	3.08%
	Apgar <7 @ 5 Minutes (>37wks)	<1.6%	0.50%	1.15%	1.28%	0.51%	0.59%	1.15%	0.37%	1.19%	0.74%	1.06%	0.66%	1.19%	0.68%
	Term Admission to NICU	<6%	4.52%	7.69%	5.46%	5.90%	5.70%	6.70%	2.95%	7.30%	4.24%	5.66%	6.27%	4.25%	5.76%
	Women in reciept of CoC	100%	17.85%	20.52%	20.52%	18.7%	25.20%	16.90%	18.50%	21.68%	20.21%	16.01%	18.77%	18.92%	19.36%
	BAME in recipet of CoC	100%	39.60%	41.58%	37.89%	37.20%	59.46%	37.70%	41.90%	51.85%	48.11%	36.00%	41.94%	40.80%	39.81%
	Social Depravation of CoC	No standard	22.26%	24.78%	23.62%	21.70%	28.90%	23.30%	22.10%	25.87%	26.57%	19.10%	17.00%	13.98%	16.10%
	Provision of Epidural in Labour	No standard	22.82%	17.78%	16.78%	18.97%	18.70%	19.20%	19.35%	19.10%	18.30%	20.85%	14.72%	17.05%	17.74%
	Obstetric Haemorrhage recieveing blood transfusion	<2.7%	1.39%	0.31	0.66%	0.47%	1.81%	1.18%	0.85%	1.25%	1.15%	1.74%	1.08%	1.20%	0.47%
	Coroner Reg 28 Made to Trust	Actual Number	0	0	0	0	0	0	0	0	0	0	0	0	0
Workforce	HSIB Reports Returned	Actual Number	1	1	0	1	0	0	1	1	2	4	0	1	1
	Supernamary Shift Leader	100% CNST	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Midwifery Sickness	% of Workforce	13.31%	12.63%	15.26%	16.37%	11.45%	9.64%	9.69%	9.65%	9.68%	11%	10.53%	9.58%	9.92%
	Midwife to Birth Ratio (in Post)	>1.30	30	29	30	30	30	30	28	31	29	30	31	31	TBC
	Midwifery Vacancy	% of Workforce	5.32%	8.72%	7.84%	2.46%	2.00%	4.10%	13.2%*	13.20%	17%	53.1 WTE	58.33 WTE 21%	57.93% WTE 21%	TBC
Feedback	Rostered Cons Hrs on DS	Actual Number	91	91	91	91	91	91	106.5**	106.5	106.5	106.5	106.5	106.5	106.5
	Number of Formal Complaints	Actual Number	3	2	2	2	0	2	3	2	5	4	5	3	1
	Number of Maternity Incidents over 30 days	Actual Number	376	97	119	121	120	234	221	273	204	256	498	348	308
	Number of PALS/PALS +	Actual Number	52	44	32	44	42	31	27	26	40	44	47	44	39

Northwest Coast Regional Dashboard – Outlier Queries and Responses

There have been no requests for outlier responses in October 2022.

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.

Select Your Trust >>>>>>	REP

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

Reporting Period July 2022

Rate		Numerator	Denominator	Rate	Rate per Thousand	Result
CQIMApgar	CQIMApgar	5	530	0	0	Yes
	CQIMDQ14	620	690	89.9	0	Yes
	CQIMDQ15	605	605	100	0	Yes
	CQIMDQ16	545	605	90.1	0	Yes
	CQIMDQ24	530	545	97.2	0	Yes
CQIMBreastfeeding	CQIMBreastfeeding	395	580	68.1	0	Yes
	CQIMDQ08	580	635	91.3	0	Yes
	CQIMDQ09	600	690	87	0	Yes
CQIMPPH	CQIMPPH	25	620	0	40	Yes
	CQIMDQ10	620	690	89.9	0	Yes
	CQIMDQ11	230	620	37.1	0	Yes
	CQIMDQ12	25	620	4	0	Yes
CQIMPreterm	CQIMPreterm	50	600	0	85	Yes
	CQIMDQ09	600	690	87	0	Yes
	CQIMDQ22	605	605	100	0	Yes
	CQIMDQ23	545	605	90.1	0	Yes
CQIMSmokingBooking	CQIMSmokingBooking	85	670	12.7	0	Yes
	CQIMDQ03	725	690	105.1	0	Yes
	CQIMDQ04	680	725	93.8	0	Yes
	CQIMDQ05	85	680	12.5	0	Yes
CQIMSmokingDelivery	CQIMSmokingDelivery	125	620	20.2	0	Yes
	CQIMDQ06	620	620	100	0	Yes
CQIMTears	CQIMTears	10	330	0	24	Yes
	CQIMDQ14	620	690	89.9	0	Yes
	CQIMDQ15	605	605	100	0	Yes
	CQIMDQ16	545	605	90.1	0	Yes
	CQIMDQ18	355	605	58.7	0	Yes
	CQIMDQ20	10	330	3	0	Yes
CQIMVBAC	CQIMVBAC	5	40	12.5	0	Yes
	CQIMDQ14	620	690	89.9	0	Yes
	CQIMDQ15	605	605	100	0	Yes
	CQIMDQ16	545	605	90.1	0	Yes
	CQIMDQ18	355	605	58.7	0	Yes
	CQIMDQ26	605	605	100	0	Yes
	CQIMDQ27	725	725	100	0	Yes
	CQIMDQ28	345	725	47.6	0	Yes

Rate		Numerator	Denominator	Rate	Rate per Thousand	Result
BMIDQ	BMIDQ	590	605	97.5	0	Yes
CSFDQ	CSFDQ	725	725	100	0	Yes
PCSPDQ	PCSPDQ	710	725	97.9	0	Yes
EthnicityDQ	EthnicityDQ	695	725	95.9	0	Yes
MCOC	MCOC					Yes
	COC_DQ04	685	700	97.9	0	Yes
	COC_DQ05	110	110	100	0	Yes
	COCDQCareProfilID	24635	24900	98.9	0	Yes

Help with CQIM Measure			
Select Measure >>>>>>		BMIDQ	
Threshold	>=0.90	Associated Measure/Rate	BMIDQ
Percentage of women who reach 15 weeks gestation (105 days) in the month, with a valid BMI recorded			

Total CQIMs	11	
CQIMs Passed	11	Yes

Criteria Passed	6 / 6	These Figures are based on your latest good submission that you have made for July 2022

Quality Committee Chair's Highlight Report to Trust Board
21 November 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 due to receive a detailed action plan in relation to blood sampling errors but noted an extension request due to a vacant post within the CSS senior leadership team. There was agreement that this was not an acceptable cause of delay, and the division would be asked to respond in month.
• The Sub-Committee Chair reports highlighted a lack of representation at meetings due to vacancies and changes in leadership. The Chief Operations Officer agreed to review attendance.
• Noted a deterioration against the 52-week position confirming that the Trust had become an outlier within the region against this metric. The Committee was asked to consider the option to outsource activity which had been implemented by other trusts nationwide (LWH being one of three Trusts that had not outsourced in the C&M system). The Committee considered how to quality assure care of patients under such an arrangement. The case for investment would be taken to the FPBD Committee.
	• Noted the detailed work undertaken to review clinical incidents attributable to the isolation of LWH services from other specialist services. Received the draft LUHFT LWH Joint risk register. It was agreed that the Committee should receive a 6 monthly report on the LUHFT LWH Joint Risk register and the progress of the reduction of risks identified. The report identified additional work to consider the impact of the peri-natal mental health team for Trust patients.
	• Committee noted the action from Board and FPBD Committee for the Board Committee Chairs and Executive Leads to meet to agree how to triangulate information and matters of business that impact finance, workforce, and quality of care across the Committees.
	• A review of rate of follow-up care metric underway since identified as an outlier.
	• The Committee received a revised Integrated Governance Report which now included Serious Incident reporting, and monthly divisional integrated governance reports from Family Health and Gynaecology identifying divisional priorities in relation to patient safety and experience. The Committee commended the strengthened process with the divisions and advised further work on strengthening evidence on outcomes within the report.
	• The Committee received an update against the Maternity Incentive Scheme Year 4. The following was noted:
	  ○ receipt of the Perinatal Quality Surveillance Dashboard (October data)
	  ○ ATAIN & Transitional Care Audit Q2 Report
	The Committee noted that they would undertake a detailed review of compliance against the safety actions in December 2022 ahead of Trust Board sign off early 2023.

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 quality performance report highlighted the following positive improvements against nutrition, falls, and IPC metrics. (ALL) • The Committee took assurance from the Learning from Deaths report for Quarter 2, 2022/23. It was confirmed that quarterly cross divisional mortality meetings are held to review the cases and identify learning. It was also noted that Trust SIs are reviewed regionally through the LMNS. Dissemination of learning from the region would be clarified as this information would be beneficial to share. (ALL)	• None noted

• The Committee received an overview in respect of the progress that services have made against their priorities to ensure delivery of the Clinical and Quality Strategy for 2022/23. (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.

Comments on Effectiveness of the Meeting / Application of QI Methodology

- Appropriate discussion dedicated to identified reports.
- Articulate executive summaries provided within the reports.

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
130.	Board Assurance Framework	Assurance	134.	Integrated Governance Assurance Report, Quarter 2, 2022/23	Assurance
131.	Sub-committee Chair Reports	Assurance	135.	Mortality and Perinatal Report (Learning from Deaths) Quarter 2, 2022/23	Assurance
132.	Analysis of clinical incidents attributable to the Isolation of LWH services from other specialist services	Information	136.	Clinical Quality Strategy and Quality Update November 2022	Information
133.	Quality Performance Report Month 7, 2022/23	Assurance	137.	Maternity Incentive Scheme (CNST) Year 4 – Scheme Update	Information

3. 2022 / 23 Attendance Matrix

Core members	April	May	Jun	Jul	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Tony Okotie, Non-Executive Director	✓	✓	✓	**NM**							
Susan Milner, Non-Executive Director	✓	**A**	**NM**								
Louise Kenny, Non-Executive Director	**A**	✓	✓	A	✓	✓	✓				
Sarah Walker, Chair, Non-Executive Director	**NM**	✓	✓	A	✓	**A**	✓				
Gloria Hyatt, Non-Executive Director	**NM**	✓	✓	✓	✓	✓	✓				
Jackie Bird, Non-Executive Director	**NM**	✓	✓	✓	✓	✓	✓				
Marie Forshaw, Chief Nurse and Midwife	✓	✓	✓	✓	NM						
Gary Price, Chief Operating Officer	✓	✓	✓	✓	✓	✓	✓				
Lynn Greenhalgh, Medical Director	✓	✓	✓	✓	✓	A	✓				
Eva Horgan, Chief Finance Officer	✓	✓	✓	✓	✓	A	✓				
Michelle Turner, Chief People Officer	✓	✓	✓	✓	A	A	✓				

Nashaba Ellahi, Deputy Director of Nursing & Midwifery	✓	✓	✓	A	✓	A	✓				
Philip Bartley, Associate Director of Quality & Governance	✓	✓	✓	A	✓	A	A				
Dianne Brown, Interim Chief Nurse	NM				✓	✓	✓				

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	**22/23/164b**		**Date: 01/12/2022**	
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 7 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	Nov 22	COO	Detailed in Chair's Report
Quality Committee	Nov 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.

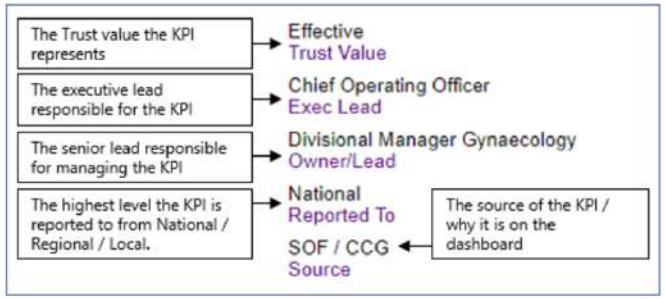
Cover Sheets - these provide an overview of performance with over arching narrative for each of the WE SEE values. In addition a selection of KPIs will be selected for a more in depth review. These are selected based on whether the KPI meets one or more of the following criteria:
•Outside of a control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

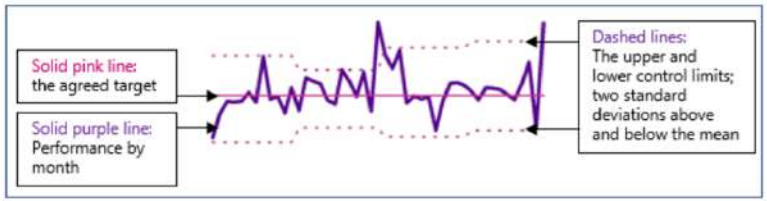
Data Sheets - these provide detailed information for each specific KPI measured. This includes data values for the previous 13 months, a sparkline included performance dating back to April 2018 where available. The sparkline graph includes the performance, target and control limits for the specific KPI.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

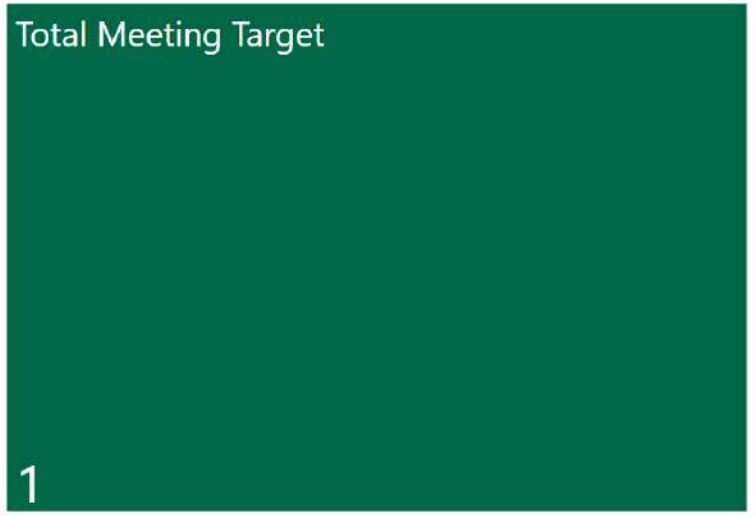
Performance Report

November 2022

WE SEE Summary

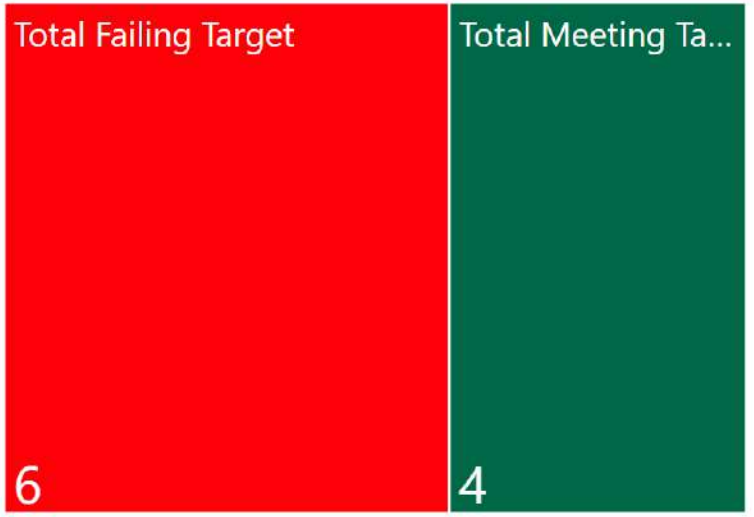
Workforce

Efficient

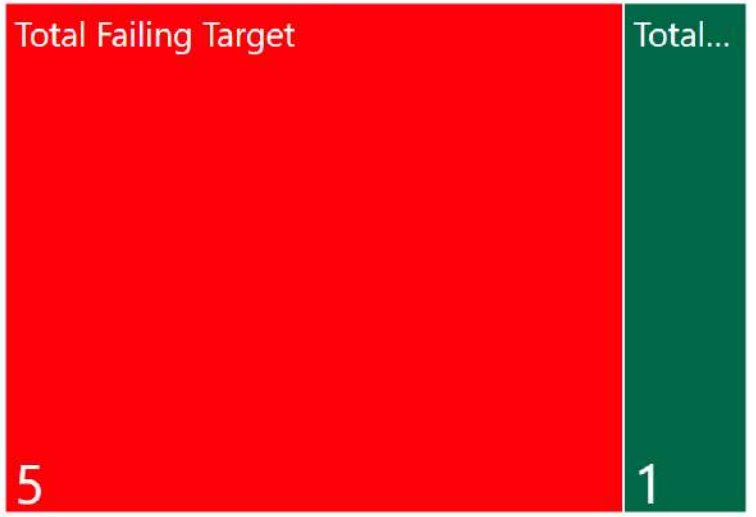


Safety

Effective



Experience



October 2022 – Maternity

NHS Liverpool Women's NHS Foundation Trust

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

650 Babies Born

248 Inductions of labour

8 Home Births

Girls 328

322 Boys

1358 Visits to Maternity Assessment Unit

4 Breech Births

Spontaneous Vaginal Births 276

13 Sets of Twins

24 Women recruited to research studies

109 Elective C - Sections

169 Emergency C - Sections

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

Births on MLU 53

Instrumental Births 90

Women Booked For Care 686

17 Pool Births

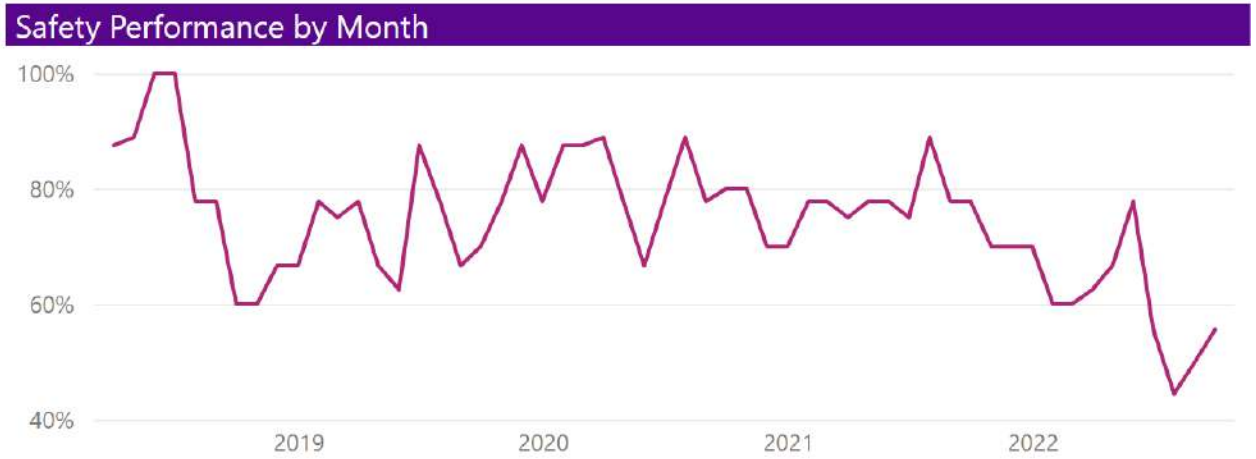
Heaviest Baby 10lb 15.5oz
Lightest Baby 1lb 3oz

Halloween 31st October: 19 Births.

Our busiest day: 3rd October: 30 Births.

To deliver **Safe** services

Total Meeting Target	Total Failing Target
5	5



Positive Developments

SUIs (new rolling) - The Trust has recognised Future Generations cases require identifying appropriately to support collating information to support case for change. There are currently 6 cases, 4 relate to Gynaecology/Oncology identifying a lack of joint operating capacity with LUHFT. 1 case relates to Gynaecology and a critical care emergency transfer to and back from LUHFT. A final case relates to Maternity and a women post-delivery and an emergency re-admission requiring transfer for treatment to LUHFT.

Falls and MUST – Ward Manager and Head of Nursing continue to validate data. Significant improvement noted across risk assessments completed. Ward manager discusses results at daily huddle and governance meetings to aid education and improvements.

Areas of Challenge

SUIs (new rolling) - An increase in the number of rolling Serious Incidents is noted with 38 in October. Weekly meetings are held with divisions and governance managers to support timely completion and issues escalated appropriately .

Nurses are escalating issues relating to VTE to junior doctors which is planned to increase compliance

There is a planned review of metrics to be included within this report to be discussed at Quality Committee on the 19.12.2022

KPI	October 2021	November 2021	December 2021	January 2022	February 2022	March 2022	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022	October 2022
Prevention of Ill Health: Flu Vaccine Front Line Clinical Staff		54.3% ↑	56.15% ↑	57.05 % ↑	57.05% →	57.22 % ↑						17.27% ↑	
Serious Untoward Incidents: New (Rolling per year)	20 →	18 ↓	19 ↑	20 ↑	20 →	22 ↑	22 →	24 ↑	22 ↓	30 ↑	31 ↑	36 ↑	38 ↑
Venous Thromboembolism (VTE)	90.64 % ↑	86.25% ↓	86.39% ↑	84.16 % ↓	85.86% ↑	86.38 % ↑	89.11% ↑	89.5% ↑	87.26% ↓	89.11% ↑	83.92% ↓	86.1% ↑	89.24% ↑

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

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	89.92%	93.55%	127.42%	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 short term 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	82.63%	88.17%	73.70%	103.23%	*/**Staffing is monitored by the Maternity bleep holder (104) on a 4 hourly basis on the induction suite and Delivery Suite. Midwifery staff are re-deployed from the Maternity ward or other clinical areas to provide 1:1 care provision for all women in established labour. During periods of increased acuity Continuity of Carer team midwives are escalated to work on Delivery Suite. Midwifery vacancy rate has reduced from 55wte in July 2022 to 15wte in October 2022. Vacant shifts owing to sickness and maternity leave are filled with bank staff wherever possible.
Maternity & Jeffcoate	77.19%	91.23%	74.88%	89.09%	*/**Maternity bleep holder (104) reviews staffing on a 4 hourly basis. Staff are redeployed to the area with the highest clinical acuity to always maintain patient safety and to ensure appropriate discharge flow to release capacity. Additional Maternity Support Workers have been recruited to work on the maternity ward to provide additional support whilst recruitment is ongoing to the current 15wte midwifery vacancies.
MLU	70.16%	70.97%	73.39%	67.74%	Due to internal escalation, there were 8 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)	104.24%	61.29%	104.07%	62.90%	*Occupancy and acuity on the neonatal unit remains high, staffing reflects this to ensure safety is maintained.
Transitional Care	38.71%	116.13%	74.19%	90.32%	**Staffing reflects occupancy within TC to ensure safe standards are met.

To deliver Safe services - Safer Staffing

Gynaecology: October Fill Rate

Fill rate – Registered Nurse day fill rate has been impacted by short term sickness absence; however, this has improved since the previous reporting month. Safe staffing levels have been maintained by inter -Divisional moves including usage of HDU registered Nurses available due to low bed occupancy on the HDU unit. Health roster meetings continue to support planned assignment counts and any shifts vacant due to short notice absence are sent to NHSP bank as they arise. The registered Nurse night overfill rate of 127.42% is the reflection of senior RN cover rotating between GED and inpatient areas.

Attendance/ Absence - Sickness and absence rate during October has improved and is recorded at 7.98%. Short term sickness accounts for 73.35% and long term 26.65%. The top causes across the division are recorded as Gastrointestinal and Cough/ Cold/Flu. Timely sickness management is monitored in keeping with sickness and absence policy and reported on monthly by Divisional Matrons and HR. Maternity leave equates to 1.61 WTE.

Vacancies Registered Nurse vacancy is 2.30 WTE and for Health care assistants' vacancy is Nil. All outstanding vacancies are being processed via Trac recruiting system.

Red Flags – No Nursing Red flags reported in October 2022

Bed Occupancy – The Gynaecology ward has a total of 24 inpatients beds, during October 2022 average bed occupancy was at 18 equating to a 75% bed occupancy average. The high Dependency unit has 2 designated Beds, during October 2022 bed occupancy on average was 0.90 equating to 45% occupied.

CHPPD – 7.5

Neonates: October Fill Rate

Fill-rate – Occupancy and acuity throughout October has remained high, increasing on previous months. Intensive care and High dependency occupancy are 103.5% and 66.7% 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 7.12% slightly up on previous months. Of this 51.46% is long term and 48.54% short term sickness. Covid sickness is up on last month at 1.63%. Maternity leave stands at 13.13 wte. Turnover remains well below the Trust threshold at just under 9%.

Vacancies - There has been successful recruitment campaigns at band 6, 5 and 4 and people are now taking up posts. Band 3 post have been advertised and interviews are in November. Posts to go out to advert are for 3 wte ANNP posts. An interim Matron has been appointed and a substantive post will go out in January 2023.

Red Flags – No red flags reported

Bed Occupancy – Activity remains high within the NICU with overall occupancy at 94.6%, up 5.5% on previous month. Intensive care activity is up at just under 26% this month, High dependency has dropped from 88.9% to 66.7%, and Low dependency has increased from 96.3%. To 106.1%. This reflects higher activity than expected. Safe staffing has been maintained throughout

To deliver Safe services - Safer Staffing

Maternity: October Fill Rate

Fill-rate – Bank and agency usage continues due to sickness rates and to cover vacancies. MLU during this reporting period on 8 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.

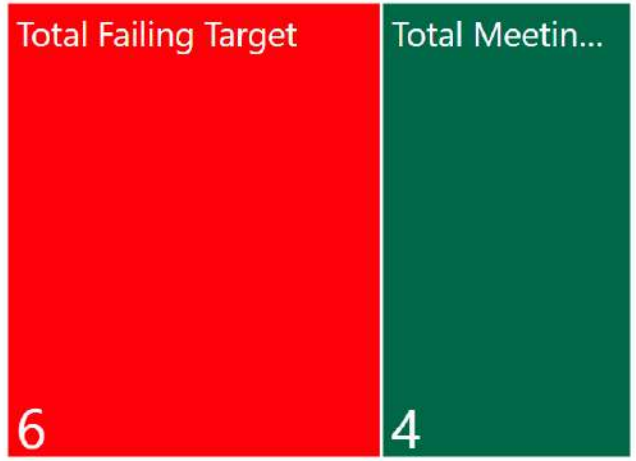
Attendance/ Absence – Maternity sickness is reported at 9.92% a 0.34% increase from September 22. General non-covid related sickness has increased standing at 7.93% and covid related sickness has decreased to 1.99%. Weighting towards long term sickness cases (40/60%) with regular meetings taking place to discuss LTS cases. Reasons for absence remain comparable to previous months with cough/cold, gastrointestinal issues and anxiety/stress being top reasons for absence in maternity services. Maternity leave equates to 12.83wte across all staff groups.

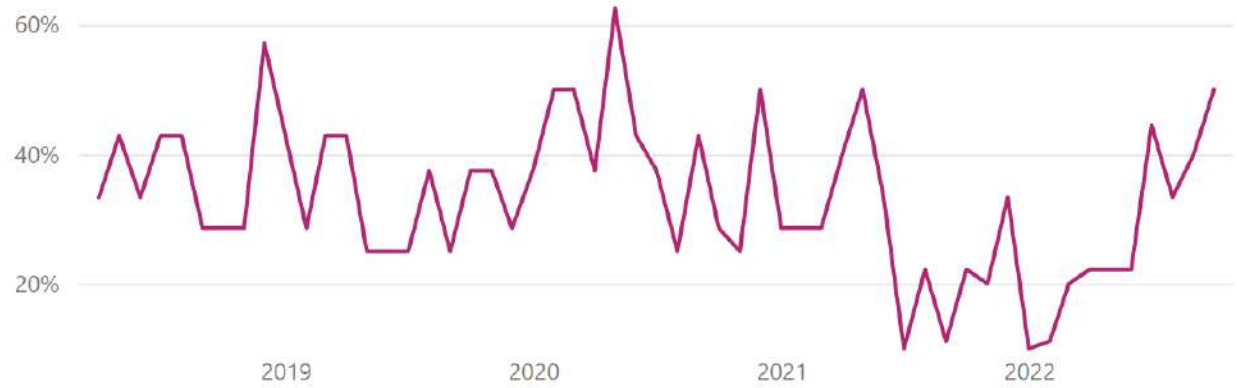
Vacancies- 38 (35.73wte) newly qualified midwives commenced employment in October 22 and all are included in the midwifery staffing numbers from 31.10.22. Actual midwifery vacancy rate has reduced to 24.18wte (7.51%) with recruitment plans in place for 2 international recruitment midwives to commence in post before the end of the current calendar year, 2x Band 6 recruited and 8 NQM to commence in January 2023. A rolling advert for experienced midwives is on NHS jobs.

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 – High bed occupancy on Mat Base and Delivery Suite owing to complexity of patients requiring inpatient care provision. Tertiary obstetric unit accepting high risk pregnancies and in-utero transfers from 22 weeks gestation of pregnancy from Northwest Coast and Isle of Man. Intermittent closure of the MLU due to staffing concerns and acuity reduces the overall Intrapartum capacity on Delivery Suite. Plan for November to keep the MLU open as much as possible and aiming to increase number of low-risk women giving birth on the Midwifery Led Unit.

To deliver the most **E**ffective outcomes





Positive Developments

The trust is working with the C&M Cancer Alliance and has submitted a bid for £1.5 million for increased ambulatory capacity. Should this be successful this will be a significant contributor into increasing clinical acidity in this service as appropriate space is a significant challenge with all existing ambulatory clinical capacity in use

The 2 week urgent cancer target remains green and the q2 31 day performance was the best post pandemic with sustained quarterly performance on the 80% range.
Positive position in relation to IPC metrics

Areas of Challenge

October saw an increase in the numbers of emergency gynaecology surgeries completed out of hours. This reasons for this are multifactorial and work in underway with the division to address this, however if it continues then this increased the case for increasing planned in hours elective capacity by developing the utilization of the 5th Gynaecology theatre, this will be subject to workforce and investment

The trust saw an increase in gynaecology consultant absence in September, October and through into November which as impacted on recovery. At points 4 consultants have been absent which has resulted in increased pressure. Whilst the service is able to mitigate some activity through non-core sessions this comes at a financial pressure.

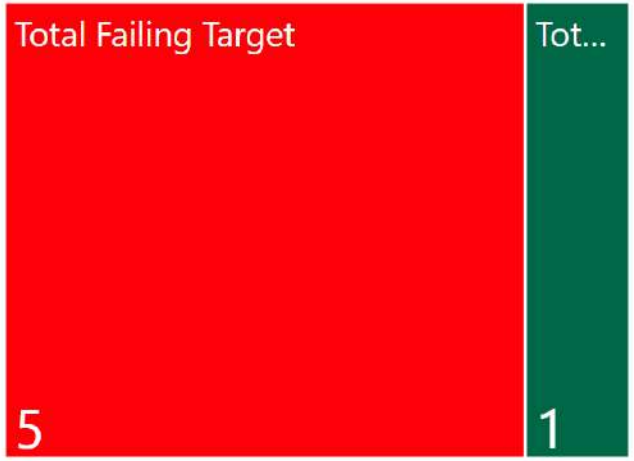
Continued review of capacity is ongoing. In October additional registrar clinics have been added to address the decline in the 52 week position
women are triaged to the most appropriate pathway early to avoid breeches

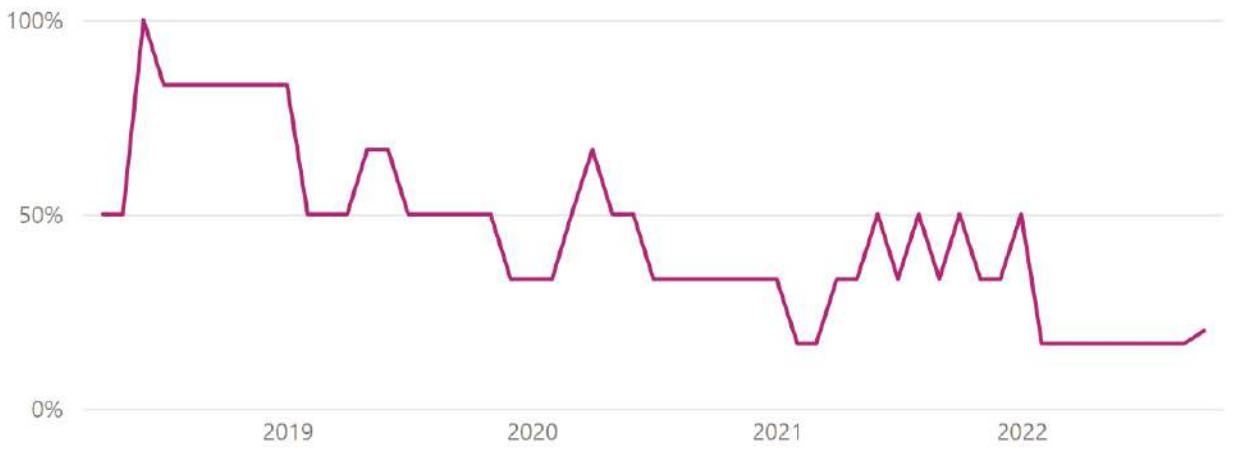
The Diagnostic 6 week wait performance has been a challenge in September and October largely related to non obstretic ultrasound capacity. This is being reviewed formally through a pan Trust imaging project which aims to improve system, processes and clinical pathways

KPI	October 2021	November 2021	December 2021	January 2022	February 2022	March 2022	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022	October 2022
18 Week RTT: Incomplete Pathway > 52 Weeks	288 ↑	294 ↑	354 ↑	406 ↑	479 ↑	544 ↑	816 ↑	1145 ↑	1571 ↑	1850 ↑	2097 ↑	2334 ↑	2548 ↑
18 Week RTT: Incomplete Pathway > 78 Weeks	21 ↓	3 ↓	3 →	11 ↑	12 ↑	12 →	26 ↑	29 ↑	33 ↑	35 ↑	40 ↑	52 ↑	62 ↑
All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (After Re-allocation)	18.18% ↑	44.83% ↑	54.55% ↑	34.78% ↓	47.06% ↑	18.75% ↓	26.92% ↑	29.17% ↑	12.5% ↓	10% ↓	35.71% ↑	20% ↓	
Cancer: 2 Week Wait	95.33% ↓	97.04% ↑	95.31% ↓	76.65% ↓	81.91% ↑	67.87% ↓	11.9% ↓	52.71% ↑	88.47% ↑	93.29% ↑	95.74% ↑	96.95% ↑	
Cancer: 28 Day Faster Diagnosis	64.14% ↑	60.5% ↓	59.93% ↓	54.1% ↓	57.91% ↑	61.07% ↑	55.1% ↓	60.06% ↑	58.63% ↓	60.26% ↑	61.1% ↑	59.18% ↓	
Cancer: 31 Days from Diagnosis to 1st Definitive Treatment	56.76% ↑	86.67% ↑	93.1% ↑	84.62% ↓	84.380% ↓	95.65% ↑	85.71% ↓	84% ↓	88.46% ↑	96.3% ↑	87.5% ↓	77.78% ↓	
Overall size of Elective Waiting List	12458 ↑	12736 ↑	13017 ↑	13481 ↑	13945 ↑	14461 ↑	15027 ↑	15553 ↑	16206 ↑	16559 ↑	17181 ↑	17677 ↑	17953 ↑

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

Review of FFT process underway, consideration to how these can be utilised by LWH to help embed improvement. Divisions are exploring digital solutions to improve FFT responses received by patients and promoting use of the 'You said, We did' posters to encourage and reflect learning from patient responses received.

Whilst the 4 week target remains high compared to other Trusts breeches continue to increase. Work is underway to develop the EPAU pathway through ED to ensure women are triaged to the most appropriate pathway early to avoid breeches

Areas of Challenge

FFT (inpatient/day case % positive) 94.96%, which although is marginally below threshold this reflects a position of low FFT responses received when viewing the numerator and denominator and therefore may not be statistically relevant as a satisfaction score.

The Diagnostic 6 week wait performance has been a challenge in September and October largely related to non obstetric ultrasound capacity. This is being reviewed formally through a pan Trust imaging project which aims to improve system, processes and clinical pathways

KPI	October 2021	November 2021	December 2021	January 2022	February 2022	March 2022	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022	October 2022
A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge	96.58% ↓	98.64% ↑	95.36% ↓	97.02% ↑	94.11% ↓	89.73% ↓	90.94% ↑	92.38% ↑	91.55% ↓	89.2% ↓	89.85% ↑	89.66% ↓	86.97% ↓
Diagnostic Tests: 6 Week Wait	85.81% ↑	87.25% ↑	90.13% ↑	83.08% ↓	94.39% ↑	88.32% ↓	71.08% ↓	77.74% ↑	89.47% ↑	90% ↑	79.29% ↓	65.93% ↓	
Friends & Family Test: In-patient/Daycase % positive	92.79% ↓	90% ↓	88.89% ↓	96.4% ↑	93.07% ↓	92.23% ↓	94.74% ↑	94.74% →	94.95% ↑	92.16% ↓	93.75% ↑	94.12% ↑	94.96% ↑

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

DQKM

Safety
Trust Value

Medical Director
Exec Lead

Clinical Director Family Health
Owner/Lead

Local
Reported To

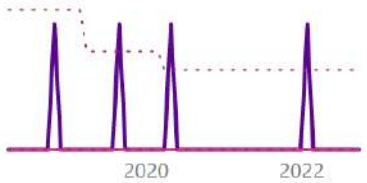
Trust
Source

Never Events

Target: **0**

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

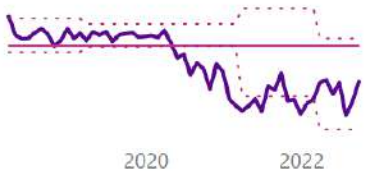
TBC
Source

Venous Thromboembolism (VTE)

Target: **>= 95%**

Attribute	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
% Performance	↑ 90.64%	↓ 86.25%	↑ 86.39%	↓ 84.16%	↑ 85.86%	↑ 86.38%	↑ 89.11%	↑ 89.5%	↓ 87.26%	↑ 89.11%	↓ 83.92%	↑ 86.1%	↑ 89.24%
Denominator	↑ 1111	↓ 1098	↑ 1029	↓ 1111	↑ 1011	↑ 1109	↑ 1047	↑ 1114	↓ 1052	↑ 1111	↓ 1157	↑ 1122	↑ 1106
Numerator	↑ 1007	↓ 947	↑ 889	↓ 935	↑ 868	↑ 958	↑ 933	↑ 997	↓ 918	↑ 990	↓ 971	↑ 966	↑ 987

DQKM



Safety
Trust Value

Medical Director
Exec Lead

Deputy Medical Director
Owner/Lead

National
Reported To

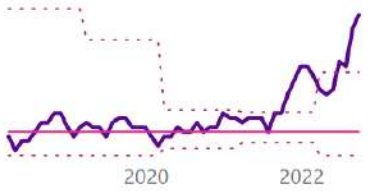
SOF / CCG
Source

Serious Untoward Incidents: Open

Target: **<5**

Attribute	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
Performance Value	→ 9	↑ 13	↑ 16	↑ 19	→ 19	↓ 17	↓ 14	↓ 13	↑ 14	↑ 20	↓ 19	↑ 27	↑ 30

DQKM



Safety
Trust Value

Director of Nursing & Midwifery
Exec Lead

Head of Governance
Owner/Lead

TBC
Reported To

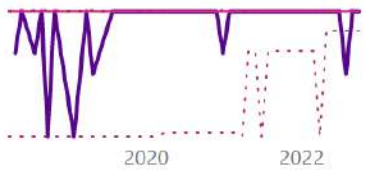
TBC
Source

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

Target: **1**

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

DQKM



Safety
Trust Value

Director of Nursing & Midwifery
Exec Lead

Head of Governance
Owner/Lead

TBC
Reported To

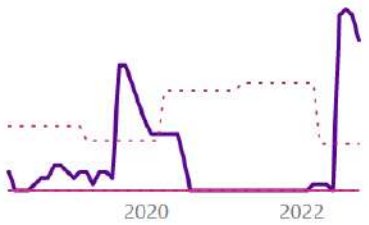
TBC
Source

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

Target: **0**

Attribute	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
Performance Value	→ 0	→ 0	→ 0	→ 0	→ 0	↑ 1	→ 1	→ 1	↓ 0	↑ 28	↑ 29	↓ 28	↓ 24

DQKM



Safety
Trust Value

Director of Nursing & Midwifery
Exec Lead

Head of Governance
Owner/Lead

TBC
Reported To

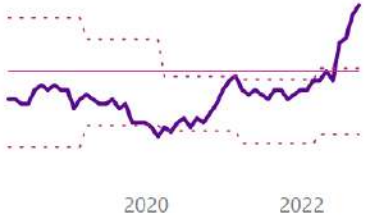
TBC
Source

Serious Untoward Incidents: New (Rolling per year)

Target: **24 /year**

Attribute	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
Performance Value	→ 20	↓ 18	↑ 19	↑ 20	→ 20	↑ 22	→ 22	↑ 24	↓ 22	↑ 30	↑ 31	↑ 36	↑ 38

DQKM



Safety
Trust Value

Director of Nursing & Midwifery
Exec Lead

Head of Governance
Owner/Lead

TBC
Reported To

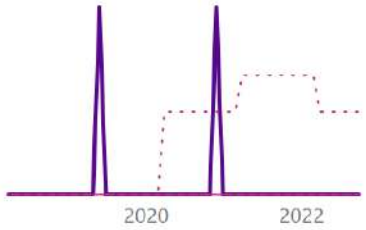
TBC
Source

Infection Control: MRSA

Target: **0**

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

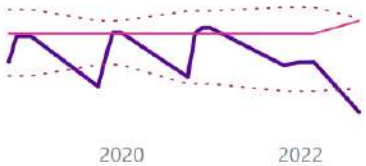
SOF / CCG
Source

Prevention of Ill Health: Flu Vaccine Front Line Clinical Staff

Target: **>= 80%**

Attribute	Nov-19	Dec-19	Jan-20	Oct-20	Nov-20	Dec-20	Jan-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Sep-22
% Performance	↑ 61.3%	↑ 80.98%	→ 80.98%	↑ 45.27%	↑ 80.45%	↑ 84.73%	→ 84.73%	↑ 54.3%	↑ 56.15%	↑ 57.05%	→ 57.05%	↑ 57.22%	↑ 17.27%
Denominator	↑ 1168	↑ 1083	→ 1083	↑ 1173	↑ 1166	↑ 1166	→ 1166	↑ 1140	↑ 1163	↑ 1185	→ 1185	↑ 1185	↑ 1222
Numerator	↑ 716	↑ 877	→ 877	↑ 531	↑ 938	↑ 988	→ 988	↑ 619	↑ 653	↑ 676	→ 676	↑ 678	↑ 211

DQKM



Safety
Trust Value

Chief People Officer
Exec Lead

Deputy Director of Workforce
Owner/Lead

(Blank)
Reported To

(Blank)
Source

18 Week RTT: Incomplete Pathway > 52 Weeks

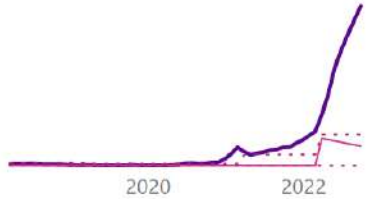
Target: **0**

Attribute	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
Performance Value	↑ 288	↑ 294	↑ 354	↑ 406	↑ 479	↑ 544	↑ 816	↑ 1145	↑ 1571	↑ 1850	↑ 2097	↑ 2334	↑ 2548
Target Value	↑ 0	↑ 0	↑ 0	↑ 0	↑ 0	↑ 0	↑ 430	↑ 410	↑ 390	↑ 370	↑ 350	↑ 330	↑ 310

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	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
Performance Value	↓ 21	↓ 3	→ 3	↑ 11	↑ 12	→ 12	↑ 26	↑ 29	↑ 33	↑ 35	↑ 40	↑ 52	↑ 62
Target Value	↓ 0	↓ 0	→ 0	↑ 0	↑ 0	→ 0	↑ 10	↑ 8	↑ 6	↑ 4	↑ 2	↑ 0	↑ 0

DQKM

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

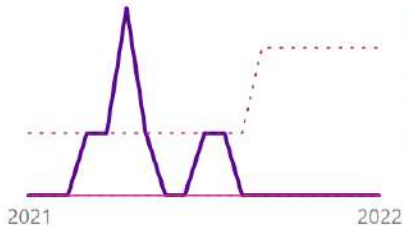
SOF / CCG
Source

18 Week RTT: Incomplete Pathway > 104 Weeks

Target: **0**

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

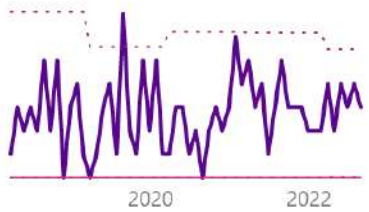
SOF / CCG
Source

Cancer: 104 Day Breaches

Target: **0**

Attribute	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	↑ 5	↓ 3	→ 3	→ 3	↓ 2	→ 2	→ 2	↑ 4	↓ 2	↑ 4	↓ 3	↑ 4	↓ 3

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)

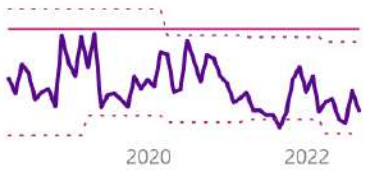
Target: >=85%

Attribute	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	6.06%	18.18%	44.83%	54.55%	34.78%	47.06%	18.75%	26.92%	29.17%	12.5%	10%	35.71%	20%
Denominator	16.5	16.5	14.5	11	11.5	8.5	16	13	12	12	10	14	10
Numerator	1	3	6.5	6	4	4	3	3.5	3.5	1.5	1	5	2

DQKM

September 2022

Several late referrals from external trusts with many patients already past day 62. Long standing issue and further discussions to take place with the cancer alliance to try and help resolve the issues.



Effective
Trust Value

Chief Operating Officer
Exec Lead

Divisional Manager Gynaecology
Owner/Lead

National
Reported To

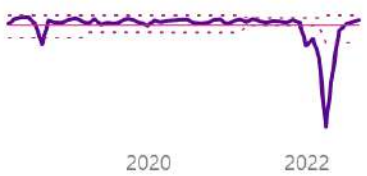
CCG
Source

Cancer: 2 Week Wait

Target: >= 75%

Attribute	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	96.06%	95.33%	97.04%	95.31%	76.65%	81.91%	67.87%	11.9%	52.71%	88.47%	93.29%	95.74%	96.95%
Denominator	279	300	338	277	257	293	305	294	425	295	313	376	328
Numerator	268	286	328	264	197	240	207	35	224	261	292	360	318

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	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	49.12%	64.14%	60.5%	59.93%	54.1%	57.91%	61.07%	55.1%	60.06%	58.63%	60.26%	61.1%	59.18%
Denominator	397	290	362	287	305	297	298	314	328	307	307	347	316
Numerator	195	186	219	172	165	172	182	173	197	180	185	212	187
Target %	75%	75%	75%	75%	75%	75%	75%	60%	62%	64%	66%	68%	65%

DQKM

September 2022

Currently just under target by 5% however performance will be challenged in the upcoming months due to estates capacity constraints. The division are exploring all possible options, but this is highly likely to remain an ongoing risk for several months.

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

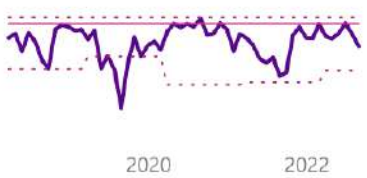
Target: >=96%

Attribute	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	54.05%	56.76%	86.67%	93.1%	84.62%	84.380%	95.65%	85.71%	84%	88.46%	96.3%	87.5%	77.78%
Denominator	37	37	30	29	26	32	23	21	25	26	27	32	27
Numerator	20	21	26	27	22	27	22	18	21	23	26	28	21

DQKM

September 2022

KPI target not met due to patient not being fit for surgery. Capacity available within the timeframe.



Effective
Trust Value

Chief Operating Officer
Exec Lead

Divisional Manager Gynaecology
Owner/Lead

National
Reported To

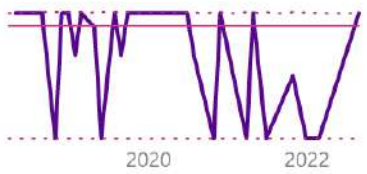
CCG
Source

Cancer: 62 Day Screening Referrals (Percentage)

Target: >=90%

Attribute	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			↑ 50%		→ 0%		→ 0%						
Denominator	0	0	↑ 2	0	→ 1	0	→ 1	0	0	0	0	0	↑ 1
Numerator	0	0	↑ 1	0	→ 0	0	→ 0	0	0	0	0	0	↑ 1

DQKM



Effective
Trust Value

Chief Operating Officer
Exec Lead

Divisional Manager Gynaecology
Owner/Lead

National
Reported To

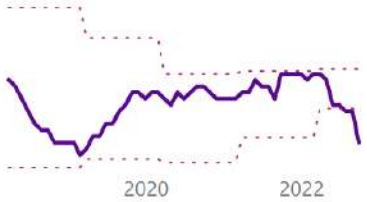
CCG
Source

Intensive Care Transfers Out (Rolling 12 Months)

Target: (Blank)

Attribute	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
Performance Value	↑ 15	→ 15	→ 15	→ 15	↓ 14	↑ 15	→ 15	↓ 14	↓ 10	→ 10	↓ 9	→ 9	↓ 4

DQKM



Effective
Trust Value

Medical Director
Exec Lead

Deputy Medical Director
Owner/Lead

Local
Reported To

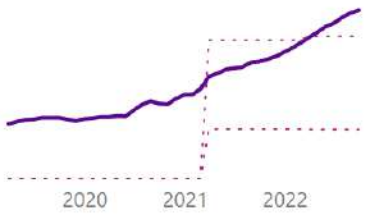
Trust
Source

Overall size of Elective Waiting List

Target: (Blank)

Attribute	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
Performance Value	↑ 12458	↑ 12736	↑ 13017	↑ 13481	↑ 13945	↑ 14461	↑ 15027	↑ 15553	↑ 16206	↑ 16559	↑ 17181	↑ 17677	↑ 17953

DQKM



Effective
Trust Value

Chief Operating Officer
Exec Lead

Divisional Manager Clinical Sup...
Owner/Lead

National
Reported To

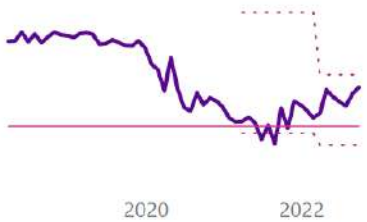
SOF
Source

Proportion of patient activity with an ethnicity code

Target: >=96%

Attribute	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
% Performance	↑ 96.58%	↓ 95.94%	↑ 96.8%	↓ 96.68%	↓ 96.49%	↓ 96.27%	↑ 96.41%	↑ 97.16%	↓ 96.94%	↓ 96.79%	↓ 96.65%	↑ 97.04%	↑ 97.24%
Denominator	↑ 14525	↓ 15273	↑ 13116	↓ 14184	↓ 13606	↓ 15244	↑ 13938	↑ 15695	↓ 14553	↓ 14374	↓ 15739	↑ 15300	↑ 15663
Numerator	↑ 14028	↓ 14653	↑ 12696	↓ 13713	↓ 13128	↓ 14675	↑ 13438	↑ 15250	↓ 14108	↓ 13912	↓ 15212	↑ 14847	↑ 15230

DQKM



Effective
Trust Value

Chief Operating Officer
Exec Lead

Divisional Manager Gynaecology
Owner/Lead

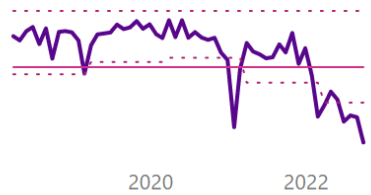
National
Reported To

SOF
Source

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

Target: >= 95%

Attribute	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
% Performance	96.58%	98.64%	95.36%	97.02%	94.11%	89.73%	90.94%	92.38%	91.55%	89.2%	89.85%	89.66%	86.97%
Denominator	1052	883	969	1039	1086	1139	1038	1129	1112	1194	1182	1209	1220
Numerator	1016	871	924	1008	1022	1022	944	1043	1018	1065	1062	1084	1061



Experience
Trust Value

Chief Operating Officer
Exec Lead

Divisional Manager Gynaecology
Owner/Lead

National
Reported To

CCG
Source

DQKM

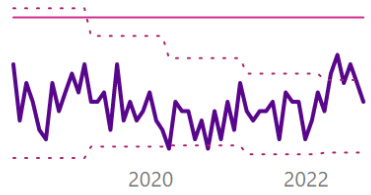
October 2022

Performance has fallen below 95% this month primarily due to staff sickness. The division have also identified that the pregnancy related attendances have also been included within the figures and should have been excluded as per national guidelines

Complaints: Number Received

Target: <= 15

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



Experience
Trust Value

Director of Nursing & Midwifery
Exec Lead

Head of Audit, Effectiveness an…
Owner/Lead

Local
Reported To

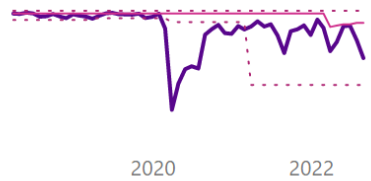
Trust
Source

DQKM

Diagnostic Tests: 6 Week Wait

Target: >= 99%

Attribute	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	69.65%	85.81%	87.25%	90.13%	83.08%	94.39%	88.32%	71.08%	77.74%	89.47%	90%	79.29%	65.93%
Denominator	794	747	737	628	733	713	796	816	867	731	780	845	769
Numerator	553	641	643	566	609	673	703	580	674	654	702	670	507
Target %	99%	99%	99%	99%	99%	99%	99%	89%	90%	91%	91%	92%	92%



Experience
Trust Value

Chief Operating Officer
Exec Lead

Divisional Manager Clinical Sup…
Owner/Lead

National
Reported To

CCG
Source

DQKM

Diagnostic Waiting Times Total: 507/769 or 65.93%; Dexa 21/22 or 95.45%; Non-Obstetric Ultrasound 442/675 or 65.48%; Cystoscopy 4/6 or 66.67%; Urodynamics - Pressures and Flow (Cystometry) 40/66 or 60.61%.

The 6-week DM01 performance is still being affected by August's sickness and annual leave as documented in the previous KPI narrative. Furthermore, in September we lost two locum sonographers, one due to behavioural issues and the other because of a lack of a professional registration. This inhibited the ability for sonography to recover the position quickly. Whilst we have had an additional two sonographers and a student start, we are still carrying 8.48 WTE vacancies.

Ultrasound conducted in the Hewitt Centre continues to impact the overall US position with only 39% (15/38) achievement in September.

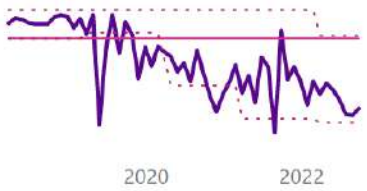
Performance is further affected by Cystocopy and Urodynamics which have made marginal improvements but continue to perform poorly relative to the other diagnostic tests.

Friends & Family Test: A&E % positive

Target: **95%**

Attribute	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
% Performance	96.67%	86.21%	88.89%	85.71%	80.77%	85.71%	83.08%	85.37%	84%	81.91%	78.82%	78.57%	80%
Denominator	30	29	36	35	26	28	65	82	75	94	85	14	110
Numerator	29	25	32	30	21	24	54	70	63	77	67	11	88

DQKM



Experience
Trust Value

Director of Nursing & Midwifery
Exec Lead

Head of Nursing Gynaecology
Owner/Lead

National
Reported To

External
Source

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

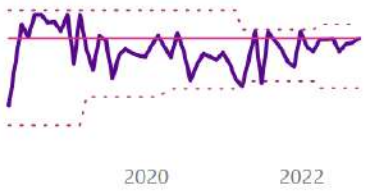
Target: **0.95**

Attribute	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
% Performance	92.79%	90%	88.89%	96.4%	93.07%	92.23%	94.74%	94.74%	94.95%	92.16%	93.75%	94.12%	94.96%
Denominator	111	130	108	111	101	103	114	95	99	102	96	17	119
Numerator	103	117	96	107	94	95	108	90	94	94	90	16	113

DQKM

October 2022

Improvement month on month noted in October's report currently 1% below target - The Departments have accepted additional volunteer support to facilitate the completion of FFT questionnaires as well as Manger and Matron walkarounds to ensure patients experiences remain positive, estimated date for achieving target Dec 2022



Experience
Trust Value

Director of Nursing & Midwifery
Exec Lead

Head of Nursing Gynaecology
Owner/Lead

National
Reported To

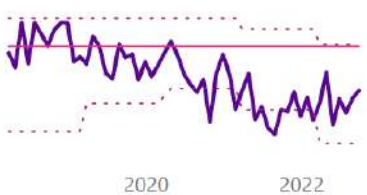
External
Source

Friends & Family Test: Maternity % positive

Target: **95%**

Attribute	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
% Performance	81.52%	81.2%	85.27%	80.14%	84.09%	79.28%	83%	89.47%	78.33%	83.76%	80.83%	83.87%	85.53%
Denominator	184	133	129	146	132	111	100	95	120	117	120	31	159
Numerator	150	108	110	117	111	88	83	85	94	98	97	26	136

DQKM



Experience
Trust Value

Director of Nursing & Midwifery
Exec Lead

Head of Midwifery
Owner/Lead

National
Reported To

External
Source

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							
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)	***22/23/164c***		**Date: 01/12/2022**	
Report Title	**Integrated Governance Assurance Report Quarter 2 22/23**			
Prepared by	***Allan Hawksey Head of Risk and Safety***			
Presented by	***Dianne Brown, Chief Nurse & Midwife***			
Key Issues / Messages	This report provides information of oversight and assurance monitoring of Integrated Governance and highlights key risks to the Trust.			
Action required	Approve ☐	Receive ☐	Note ☒	Take Assurance ☒
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable):			
	For Decisions - in line with Risk Appetite Statement – Y *If no – please outline the reasons for deviation.*			
	It is requested that the members of the Board review the contents of the paper and take assurance that there are adequate governance processes in place and the positive progress in managing risk has been made with Senior Management having oversight of such risks.			
Supporting Executive:	***Dianne Brown, Chief Nurse & Midwife***			

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

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

REPORT DEVELOPMENT:

EXECUTIVE SUMMARY

The following Integrated Governance Assurance report covers Quarter 2 of 2022/23. The report is part of the regular reporting schedule of the Trust to ensure that there is oversight and assurance monitoring of Integrated Governance across the Trust.

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

Main points reflected within the main body of the report are:

- Incident reporting within the Ulysses system continues to increase across all Divisions reflecting staff awareness of what constitutes an incident supported by ongoing training within the system from the Corporate Team.
- A key area of risk for Q2 was within the clinical management cause group relating to delay of over 4 hours during ongoing induction of labour (85) and delay > 30 minutes between presentation and triage (78)
- A further key area of risk for Q2 was within the investigations cause group relating to blood sampling errors (as per Q4 21/22 and Q1 22/23). There remained a significant level of rejected samples from the laboratory.
- The Trust celebrated World Patient Safety Day (WPSD) on 17th September by promoting patient safety practices across the hospital as this year's theme was "Medication Safety".
- The members of the Medicines Safety Group (MSG) continue to encourage the reporting of medication incidents across the hospital so we can learn from these incidents and prevent patient harm.
- Good administration and reporting systems have now been established for the management of face fit mask testing across all divisions, with 215 staff being compliant on 1 mask and 74 compliant on 2 masks. Staff who are not compliant with their fit testing have been individually written to, reminding them of their duty to maintain the fit of their mandatory two PPF3 masks by undertaking two-yearly testing or when a significant change in their face shape has occurred.
- 100% of the 11 CAS Alerts received in this quarter were acknowledged and responded to within their deadline targets. No alerts breached the expected external deadline dates during this period.

- There were two national patient safety alerts during this period, one of which was not relevant. The other was related to a supply distribution issue of a drug which is rarely used at LWH and was already being managed.
- 110 PALS cases were received in Aug 22 by Gynaecology. This is the highest number of PALS cases recorded in a single directorate in a month in 3 years. This was driven firstly by appointment queries which accounted for the most recorded category type that month. This was equal to the most amount of Appointment queries received in any month, and this was combined with the 5th highest number of communications we have recorded in the last 3 years. Combined this accounts for 70% of the PALS cases recorded for Gynaecology that month.
- Patients are continuing to contact the patient experience team due to being unable to contact the correct admin or clinical area or having left messages, no return calls were made, or experiencing long waits when contacting GED and MAU.
- Good compliance with National Institute for Health & Care Excellence (NICE) guidance with regards to assessment of chorionicity and amnionicity and growth scan appointment schedule was noted in relation to the management of multiple pregnancies. It was demonstrated that it is feasible within a twin clinic to implement cervical length screening and this intervention appears acceptable to women. A baseline for neonatal outcomes has been established. Overall, stable maternal and neonatal outcomes demonstrated in our cohort of twin pregnancies.
- Unplanned extubations continue to occur in the neonatal intensive care despite initial interventions. In some infants this results in a sustained significant increase in oxygen requirement. Most occur with some form of handling. Delays in transitioning/stopping antifungals in preterm infants. Uncertainty around the compliance with additional antifungal prophylaxis in prolonged courses of intravenous antibiotics in at-risk infants. Mild delays (not further described) in commencing prophylactic antifungals.
- So far in this financial year, the Trust has agreed settlements totalling £925,586. The previous financial year's settlements totalled £42,551,491.36. Damages settlements in 2019/20 totalled £16,901,232.
- The 2022 Trust scorecards have been released and a deepdive review of these claims alongside the GIRFT claims data are being analysed for the purpose of producing a report to inbed into the Trust lesson learning processes.
- In September an oncology patient took her story to Trust Board. One of the issues that the patient identified was around the food choices and presentation of food and provided photographs of some of the meals our patient had been severed. Our patients' comments were noted. It was feedback at Trust Board that currently there is a review of our patient menus and food provision for patients. This included patients who are not always at their bedside during mealtimes if their baby is on the Neonatal unit. Once confirmed there will be a launch of the new menus. The PEM has been working with the Trust senior Housekeeper and Ocs contractor in relation to sourcing new crockery, cutlery (including plate guards and requirements for patients with additional needs), trays, hand wipes.
- Patient Experience also assessed 603 responses from the Friends and Family Test that recorded they had a disability in response to the question "*Do you feel your views were considered within the decision-making process / care plan?*" This is to assure the Trust that patients with disabilities continue to be included in decisions about themselves. Out of the 603 responses, only 4.6 % felt they were not involved in the decision-making process during this time.
- A proposed refresh of our Trust wide approach to Quality Improvement was approved by Executive Colleagues in August.
- 9 new QI projects were registered at the end of Q2, an increase from Q1 with a continued upward trend expected for Q3 and Q4.

- There were 19 serious incidents declared to the Integrated Care Board (ICB) during Q2 with several relating to Future Generations standalone site issues. All of these cases have had Executive oversight and sign off.
- There were 28 action plans under review following feedback highlighted from the ICB as of 05 October. 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.
- Family Health and Gynaecology are undertaking monthly Divisional Integrated Governance Reports which are reported via Safety and Effectiveness Sub Committee monthly identifying divisional priorities in relation to patient safety and experience.
- These are reported via Safety and Effectiveness Sub Committee identifying key divisional priorities and the associated actions identified to manage patient safety and experience concerns. These reports continue to evolve, however, progress is positive.

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

The Quality Committee received the report in November 2022 and commended the strengthened process with the divisions and advised further work on strengthening evidence on outcomes within the report.

The Board are requested to note the contents of the paper and take assurance that there are sufficient governance processes in place consisting of divisional and corporate oversight to mitigate and manage risk.

MAIN REPORT

1. INTRODUCTION

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

2. ANALYSIS AND TRIANGULATION OF KEY RISKS ACROSS THE TRUST

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

2.1 Positive Findings

- Incident reporting within the Ulysses system continues to increase across all Divisions reflecting staff awareness of what constitutes an incident supported by ongoing training within the system from the Corporate Team.
- There has been a positive recruitment drive within maternity and significant investment with the appointment of 38 WTE midwives commencing September 2022.
- All individual imaging requirements with regards to posterior-anterior (PA) chest x-rays (CXR's) audited were found to have 100% compliance against the quality standards set and found to be of diagnostic quality with no need for any repeat imaging.
- The Patient Experience matron (PEM) supported two members of Merseyside Society for Deaf People (MSDP) and their British sign language interpreters to present at the Meditec Users Conference in September. They also led on a round table event in a breakout room. The experiences that were shared were extremely thought provoking and powerful. The CEO of Meditec met with the presenters expressing intention to scope out how the comments can be used in meditec technology and how improvements can be made. The CEO returns to England in December and is hoping to visit LWH and meet again with members of our local deaf community.
- A proposed refresh of the Trust wide approach to Quality Improvement was approved by Executive Directors in August**.**

2.2 Corporate triangulation of key risks for the Trust as outlined in this report

Division	Key risks noted for improvement	What are we doing to improve the position both short and long term	Committee/division /person responsible
Trust Wide (As reported in Q4 21/22, Q1 22/23 and remains ongoing)	A key area of risk continued to be within the investigations cause group relating to blood sampling errors. There was a significant level of rejected samples from the laboratory. Although the number of incidents in relation to this has reduced compared to the last	Each division has undertaken a significant piece of work in relation to this, which this committee is already sighted on. Reports continue to be provided to this committee and the Safety & Effectiveness Sub Committee. Due to the continued risk, this piece of	This is overseen by the Pathology Steering Group which has an Operation Group led by the Clinical Support Services

Risk remains	quarter, there is still cause for concern in relation to this on-going issue.	work is now under the oversight of the pathology steering group which the committee are sighted on.	Deputy Divisional Manager
Trust wide and focused within Maternity Newly escalated risk	Clinical management has significant increased since Q1 by 198 incidents with maternity identifying significant delays of over4 hours during ongoing induction of labour and delay > 30 minutes between presentation and triage.	There has been significant investment within maternity services to recruit 38 WTE new midwives commencing September 2022 to support identified staffing shortfalls and capacity to deliver expected care standards.	All Divisions Maternity
Trust wide Risk remains	Telephony contact issues continue to be a trend throughout the complaints and PALS concerns raised. Contact issues are reported on both clinical and non-clinical lines, with issues contacting the clinical lines for advice and guidance the most significant risk. The Patient Experience Department have previously requested 4 weekly reports detailing the call performance statistics from the operational leads of the Divisions to monitor the scope of the issue. Access to this data is currently being arranged.	2 workstreams are currently underway to review the clinical call performance in both the Maternity Assessment Unit (MAU) and the Gynaecology Emergency Department (GED). Patient Experience Team have requested to be involved in both groups and we have been assured by operational colleagues that this will be granted.	Patient Experience Governance Maternity Gynaecology
Trust wide	The drive for QI needs to be more evident within the Trust divisions, divisions require support to enable them to plan how best to achieve this and to use the Quality Function within the trust as a source for information, advice, and guidance to support the further development and implementation of their division level plans. Considering the themes within our incidents and complaints, opportunities for QI have been missed and greater collaboration	Q2 update A proposed refresh of the Trust wide approach to Quality Improvement was approved by Executive Colleagues in August. A new Quality Improvement Lead has been appointed and is due to commence in post in January 2023.	Associate Director of Governance and Quality Chief Nurse Dianne Brown All divisions & areas within the trust

	is required to improve our approach to QI and to enable a better and safer patient experience.		

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

Appendix 1 – Incidents

Key Headline(s): A key area of risk for Q2 was within the clinical management cause group relating to delay of over4 hours during ongoing induction of labour and delay > 30 minutes between presentation and triage.

Appendix 2 - Medicines Management & Incidents

Key headline(s): A new risk has been added to the MMG risk register relating to the failure to reduce the risk, diagnose and treat venous thromboembolism (VTE) in patients who are in hospital because of a lack of awareness of VTE guidance, education and leadership across the Trust.

Appendix 3 – Health and Safety

Key headline(s): The Health and Safety Team is expanding with plans in process to recruit a band 6 fire officer.

Appendix 4 - Complaints, PAL's & PALS +

Key headline(s): Appointments and difficulties in contacting the trust about these are also major themes in the PALS cases received by the Trust. Patients are all aware nationally of the waiting lists across the NHS and that fear of not getting their own appointment is leading to an increase in more forceful queries being raised to try and expedite their own case.

Appendix 5 - Clinical Effectiveness and Audit

Key headline(s): All individual imaging requirements with regards to posterior-anterior (PA) chest x-rays (CXR's) audited were found to have 100% compliance against the quality standards set and found to be of diagnostic quality with no need for any repeat imaging.

Appendix 6 - Claims cases and Inquests

Key headline(s): So far in this financial year, the Trust has agreed settlements totalling £925,586. The previous financial year's settlements totalled £42,551,491.36. Damages settlements in 2019/20 totalled £16,901,232.

Appendix 7 – Patient Experience

Key headline(s): Patient Experience matron (PEM) supported two members of Merseyside Society for Deaf People (MSDP) and their British sign language interpreters to present at the Meditec Users Conference in September. They also led on around table event in a breakout room. The experiences that were shared were extremely thought provoking and powerful. The CEO of Meditec met with the presenters and wants to scope out how their comments can be used in meditec technology and how improvements can be made. The CEO is back in England in December and is hoping to visit LWH and meet again with members of our local deaf community.

Appendix 8 – Quality Improvement

Key headline(s): A proposed refresh of our Trust wide approach to Quality Improvement was approved by Executive Colleagues in August**.**

Appendix 9 – Serious Incidents

Key headline(s): There were 19 serious incidents declared to the Integrated Care Board (ICB) during Q2 with several relating to Future Generations standalone site issues.

Appendix 10 – Divisional Triangulation and embedded learning

Key headline(s): Family Health and Gynaecology are undertaking monthly Divisional Integrated Governance Reports which are reported via Safety and Effectiveness Sub Committee monthly identifying divisional priorities in relation to patient safety and experience.

With the exception of Appendix 9 (included below to meet Ockenden requirements), the appendices are available to Board members via the supporting documents section of Admin Control.

The Board are requested to note the contents of the paper and take assurance that there are sufficient governance processes in place consisting of divisional and corporate oversight to mitigate and manage risk.

Serious Incidents and identified learning

New SI's reported to the ICB in September 2022

There were 9 Serious Incidents reported to the ICB

SI Ref	Ulysses Ref	Incident Recognition Date	Dept	StEIS Date	Within 48 hrs reporting KPI	Summary	Report Due to ICB	Investigation Lead	Duty of Candour
2022 – 20807 2022-20767 2022-20809 2022 – 20812	91828 91823 91827 91822	28/09/2022 for all 4 linked cases	Gynae Oncology	29/09/2022	Yes	Future generations cases. Patients have completed their cycles of treatment, however, have not been able to be operated on within the required timescales due to a lack of operating capacity with LUHFT. Additional lists required.	22/12/2022	Gynaecology	Completed verbally and followed up in writing for each patient

SI Ref	Ulysses Ref	Incident Recognition Date	Dept	StEIS Date	Within 48 hrs reporting KPI	Summary	Report Due to ICB	Investigation Lead	Duty of Candour

- **Immediate Action Taken:**

- Short term: weekly meetings with Ops team, and Dep Coo already in place.
- Acquisition of a 3-session weekly list at LUFT has now been confirmed awaiting start date (which may or may not be sufficient)
- Medium term goal; to be added to tracking list. Ops team to take over the co-ordination role of offsite surgery.
- Long term: Future generations to be co-located.

- **Immediate Lesson Learnt:**

- Need robust meetings with ops team to take a lead in obtaining extra lists on acute site.
- This has sat clinically since this complex surgery has been increasing over the last 3 1/2 yrs.

- **Rationale for serious incident investigation:**
- Incident demonstrating existing risk that is likely to result in significant future harm

SI Ref	Ulysses Ref	Incident Recognition Date	Dept	StEIS Date	Within 48 hrs reporting KPI	Summary	Report Due to ICB	Investigation Lead	Duty of Candour
2022 - 20757	92310	28/09/2022	Gynaecology Emergency Department	29/09/2022	Yes	Future generations case – critical care transfer. 21/08/2022 - Patient transferred from RLUH via ambulance post Miscarriage. Query abdominal sepsis bpv, patient unwell on arrival. After assessment by consultant and treatment a decision was made to transfer patient back to RLUH, via blue light ambulance.	22/12/2022	Gynaecology	Completed verbally and followed up in writing

SI Ref	Ulysses Ref	Incident Recognition Date	Dept	StEIS Date	Within 48 hrs reporting KPI	Summary	Report Due to ICB	Investigation Lead	Duty of Candour
• **Immediate Action Taken:** Escalation to Serious Incident Investigation • **Immediate Lesson Learnt:** No immediate lessons learned – subject to investigation • **Rationale for serious incident investigation:** • Incident demonstrating existing risk that is likely to result in significant future harm									

SI Ref	Ulysses Ref	Incident Recognition Date	Dept	StEIS Date	Within 48 hrs reporting KPI	Summary	Report Due to ICB	Investigation Lead	Duty of Candour
2022-20144	92726	20/09/2022	Gynaecology Colposcopy	20/09/2022	Yes	Patient attended colposcopy department for review as has VAIN - appointment had been delayed from June 2022. MRI performed in March 2022 which showed a 7cm suspect metastasis in pelvic node. Patient had no previous cancer diagnosis but had other complex co-morbidities including Crohn's disease. The scan report was not fed back to the requesting consultant and therefore was not actioned, resulting in a delay from March to September 2022. MRI was requested using a paper form.	13/12/2022	Gynaecology	Completed verbally and followed up in writing

SI Ref	Ulysses Ref	Incident Recognition Date	Dept	StEIS Date	Within 48 hrs reporting KPI	Summary	Report Due to ICB	Investigation Lead	Duty of Candour

- **Immediate Action Taken:**

- For escalation as a serious incident investigation
- Short – Communicate to all staff who request scans that this is now done via Meditech.
- Long term – Paper scan request forms removed as all requests are now to be made via Meditech

- **Immediate Lesson Learnt:**

- Trust has moved to electronic requesting since this incident happened.
- Communication sent from Clinical Director to reiterate the process for electronic requesting of scans/referrals.

- **Rationale for serious incident investigation:**

- Unexpected / potentially avoidable injury causing serious harm

SI Ref	Ulysses Ref	Incident Recognition Date	Dept	StEIS Date	Within 48 hrs reporting KPI	Summary	Report Due to ICB	Investigation Lead	Duty of Candour
2022 – 19915 2022 - 19917	92359 92463	14/09/2022	Maternity	15/09/2022	Yes	Divert of Maternity Services on 2 occasions: Thursday- 25/08/22 Time of commencement of Divert: 25/08/22 at 23.15 Time of Stand down of Divert: 26/08/22 at 03.215. Total period of 4 hours Saturday – 27/08/2022 Time of commencement of Divert: 27/08/22 at 12.30 Time of Stand down of Divert: 28/08/22 01.00 Total period of 12.5 hours	RCA not required. 72-hour report submitted.	Not applicable as no further investigation required.	Not a patient related Serious Incident so not applicable. Head of Midwifery to formally write to patients affected by the closure

SI Ref	Ulysses Ref	Incident Recognition Date	Dept	StEIS Date	Within 48 hrs reporting KPI	Summary	Report Due to ICB	Investigation Lead	Duty of Candour

- **Immediate Action Taken:**

- Head of Midwifery to contact all patients affected by closure with apology letter by 19/09/2022
- Monitoring of maternity staffing levels and acuity on a daily basis by matrons and maternity bleep holder.
- Continued use of Bank and Agency Staff to support staffing levels.
- Daily Consultant Obstetrician oversight with 104 Bleep holders and senior managers to ensure clinical safety
- Rolling advert for Band 6 midwives. Newly qualified midwives commencing in post-October 2022
- Ongoing Preceptorship programme and pastoral support to aid retention of the midwifery workforce by preceptorship team and PMAs.

- **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.
- **Rationale for serious incident investigation:**

- Incident threatening organisation's ability to continue to deliver an acceptable quality of healthcare services

SI Ref	Ulysses Ref	Incident Recognition Date	Dept	StEIS Date	Within 48 hrs reporting KPI	Summary	Report Due to ICB	Investigation Lead	Duty of Candour
2022-19395	92497	07/09/2022	Maternity	08/09/2022	Yes	Undiagnosed placenta accreta detected during a Category 3 caesarean section. Patient estimated blood loss 4670ml, required assistance of on call gynaecology oncologists and caesarean hysterectomy. 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	01/12/2022	Maternity	Completed verbally and followed up in writing

SI Ref	Ulysses Ref	Incident Recognition Date	Dept	StEIS Date	Within 48 hrs reporting KPI	Summary	Report Due to ICB	Investigation Lead	Duty of Candour

- **Immediate Action Taken:**

- Case to be reviewed at the placenta MDT with the histology
- Audit of the current pathway required
- Further discussions with gynecology required to provide rotated support for obstetrics
- In emergency rely on oncologist onsite that is not operating to attend

- **Immediate Lesson Learnt:**

- Pathway requires referral to FMU for previous CS and placenta praevia
- Review of clinical information at time of referral to FMU to identify additional risk factors

- **Rationale for serious incident investigation:**

- Unexpected / potentially avoidable injury causing serious harm

HSIB Cases Reported and NHSR Early Notification Scheme

	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	15
2022	2	1	3	2	0	2	1	0	0				11 to date

Duty of Candour

There were 19 serious incidents reported during Q3. Duty Of Candour was 100% compliant where DoC was applicable.

Overdue actions from previous submitted SI's / Serious Incidents

There are currently no overdue serious incident submissions due with the ICB that have not had extension requests.

There were 28 action plans under review following feedback highlighted from the ICB as of 05 October. 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

Liverpool Women's NHS Foundation Trust

Trust Board

Agenda Item	*22/23/164d*		*Date: 01/12/2022*	
Report Title	Guardian for Safe Working Hours Quarterly Report – Q1 & Q2 2022/23			
Prepared by	Rochelle Collins, Medical Workforce Manager			
Presented by	Lynn Greenhalgh, Medical Director			
Key Issues / Messages	To be assured that the hours and templates are safe and compliant in each service and in line with the junior doctor contract.			
Action required	Approve ☐	Receive ☐	Note ☐	Take Assurance ☒
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable):			
	For Decisions - in line with Risk Appetite Statement – Y *If no – please outline the reasons for deviation.*			
	The Board is asked to read and note this report from the Guardian of Safe Working Hours.			
Supporting Executive:	*Lynn Greenhalgh, Medical Director*			

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

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

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
PPF	Nov 22	MD	The Committee was assured by the update provided

EXECUTIVE SUMMARY

The Board is advised:

- rota establishment continues to fluctuate throughout the year with robust processes in place to mitigate the use of high-cost agency locums wherever possible by using internal bank, doctors in training and ANNPs
- The services continue to complete some work remotely, virtually and via telephone
- During this reporting period, Q1 & Q2 2022/23 the service operated with a reduced number of senior PGD's due to a combination of maternity leave and resignations due to PGD's completing their training.
- Redesign of the Tier 1 rota to provide additional weekend daytime cover working on the wards
- Introduction of a hot week for the Tier 1 and tier 2 doctors

Exception reports continued to be submitted; Two exception reports were submitted relating to lack of staff, two submitted on extra hours worked and one for educational opportunities. No work schedule reviews took place.

During this reporting period the service reviewed rotas due to service demands and the intake of a new rotation, Q2 month August.

The Board is asked to take assurance that the current rotas are compliant and PGD's are rostered in line with their contract.

The Board is asked to note the GOSW is currently away from the Trust therefore the GSWH may include further information from Q1 and Q2 in her next report should it not be include in this report.

REPORT

1. Introduction

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

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

This report covers all of the above for the reporting period 1st April – 30th September 2022 and relates to the final quarter of the year.

2. Guardian Report

2.1. Aggregated exception reports including outcomes

During this quarter, 5 exception reports were made, all from O&G PGDs.

Period	Specialty	Grade	Reason	#exceptions	No: hours	other	Outcome
Q1	O&G	ST1	Hours	2	4		Payment for extra hours
	O&G	F2	Support	1	0	Tier 1 doctor held 2 bleeps	In discussion*
	O&G	ST6	Educational	1	0	Unable to attend regional teaching	Noted and priority given for next teaching event
Q2	O&G	F1	Hours	1	1		Payment for extra hours
	O&G	ST1	Support	1	0	Tier 1 doctor held 2 bleeps	In discussion*

*Submitted late due to systems issues. The doctor held 2 bleeps due to 1 occasion of sickness on the nights shift and the second occasion due to miss communication between the agency and rota coordinator resulting in a booking not being confirmed, therefore no cover.

2.2. Details of fines levied

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

2.3. Data on rota gaps

As referenced in previous reports, the number of gaps requiring locum cover fluctuate throughout the year due the number of times the specialty rotates, maternity leave, long-term absence and completion of training (CCT). Therefore, as the year progresses, the services expect to work with increasing gaps. In Q4, Medical Workforce escalated a concern that the services may struggle to cover acute areas of work with senior (ST6+) PGD's due to a number of doctors completing their training and taking up consultant posts. The service agreed to advertise a number of Locally Employed Doctors commonly referred to as Clinical Fellow posts. The recruitment round was not as successful as the service had hoped and rather than being able to appoint senior doctors ST6+ equivalent the service was successful in recruiting tier 2 (St3 – ST5) equivalent and tier 1, Foundation year 3 posts to start in quarter 2 in line with the national rotation date.

It is essential for the Trust to continue to recruit fixed term research posts and locally employed doctors who are either out of programme or in between training as these doctors not only support the rotas but also gain excellent opportunities to research to enable them to apply for sub specialist posts in the future. In April and August, the O&G GP doctors, and in May and August the anaesthetic doctors all rotated; the Neonates doctors rotated in March and September.

As noted previously due to the staffing in rotations to fluctuate throughout the year there can be long term gaps such as maternity leave, vacant posts and long term sickness to short term gaps such as ad hoc sickness and phased returns after a period of prolonged absence. The majority of these gaps are mainly covered by locum shifts from the current cohort of doctors in training, trust employed doctors and ANNPs, however during this reporting period there has been a notable increase in the number of agency doctors used to cover gaps. This is thought to be due to the current doctors feeling burnt out.

Trainees requiring extra support (TRES)

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

During this quarter, there has been at least 3 TRES doctors within the O&G service. Two of these TRES doctors have long term medical issues which has led to them not being on the on-call rota, which affects the provision of out-of-hours working.

In the current rotation (august – august) there is one doctor on the tier 1 requiring additional support due to health issues, two doctors who have returned from maternity leave who require a number of weeks to work supernumerary. The Service anticipate the return of a senior doctor who due to injury requires a number of adjustments to work and a prolonged period of phased return. The college tutors and medical workforce continue to work alongside the Lead Employer to ensure the individual is well supported and able to return to work.

As noted in previous reports, it is a contractual requirement to share work schedules including template rotas and pay elements with PGDs eight weeks in advance of their placement. Unfortunately, two ST2 doctors did not progress to ST3 this was unexpected resulting in them working on the tier 2 rota (ST3-ST5) in the daytime and doubled up during out of hours. The doctors are doubled up out to hours to ensure there is no risk to patient safety and the doctors are not put into a position where they are asked nor expected to work above their own competencies.

2.4. Data on locum usage

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

Anaesthetics

Month	Number of unsociable shifts	Number of shift gaps	Dr's in training/bank/ trust Dr cover	Consultant cover	Unfilled
Apr 22	120	15	15	0	0
May 22	120	5	5	0	0
Jun 22	120	12	12	0	0
Jul 22	120	18	18	0	0
Aug 22	120	16	16	0	0
Sept 22	120	4	4	0	0

Of the 70 locum shifts in Q1 & Q2, all shifts were covered by the current junior doctor cohort undertaking additional shifts, bank doctors, and Trust doctors. During this reporting period, no shifts remained uncovered due to short term sickness.
The gaps were mainly a consequence of sickness and rota gaps.

Neonates

Month	Number of unsociable shifts	Number of shift gaps	Dr's in training Dr's/ANNPs cover	Consultant cover	Unfilled
Apr 22	168	11	11	0	0
May 22	168	2	2	0	0
Jun 22	168	7	7	0	0
Jul 22	168	15	14	1	0
Aug 22	168	22	22	0	0
Sept 22	168	8	8	0	0

Of the 65 locum shifts in Q1 & Q2, all shifts were covered by the current junior doctor cohort undertaking additional shifts, ANNPs, bank doctors, and Trust doctors and 1

consultant. During this reporting period, no shifts remained uncovered due to short term sickness.

Genetics

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

Obstetrics and Gynaecology

Month	Number of unsociable shifts	Number of shift gaps	Dr's in training/bank/trust Dr cover	Agency Locum cover	Consultant cover	Unfilled
Apr 22	252	48	46	1	0	0
May 22	252	44	38	2	0	1
Jun 22	252	47	37	5	3	2
Jul 22	252	100	64	14	0	12
Aug 22	252	77	60	10	3	4
Sept 22	252	39	25	12	0	2

Of the 355 locum shifts in Q1 & Q2, all shifts were covered by the current junior doctor cohort undertaking additional shifts, bank doctors, Trust doctors and consultants and agency doctors. There has been a significant increase in the number of gaps in the main due to rota gaps. The service will work alongside medical workforce to reduce the agency usage where possible.

During this reporting period, 23 shifts remained uncovered in GED. The department is usually covered by 1 x ST3+ doctor 1700-2100, 1 x F2 – ST2 doctor 1700 – 2100 and 1 x F2- ST2 doctor 1700 – 2200. The Trust makes every effort to cover gaps but given a high number of gaps are short term sickness this is not always possible; therefore, the decision is usually for GED to function with one less F2 – ST2 doctor.

3. Other relevant data

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

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

All services continue to cover locum shifts within the PGD and ANNP workforce, however, there has been a significant increase in the number of agency bookings in the main due to the cohort of PGD's in O&G reducing and doctors not wanted to work additional shifts due to burn out. This situation will continue to be monitored.

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

The O&G service redesigned the Tier 1 rota to enable additional weekend cover to both the maternity and gynaecology wards to support the discharging of patients.

After reviewing the Ockenden report, it was evident there was a lack of continuity of care from the OGD workforce with regards to maternity in patients. This resulted in a 'hot week' being established in the roster ensuring the same tier 1 and tier 2 (F2 – ST5) attends patients on the ward and MAU between Monday to Friday. The Tier 2 doctor supports the ward round consultant during the morning and covers MAU in the afternoon. The tier doctor supports the wards in the morning and supports the tier 2 doctor on MAU in the morning.

The O&G service plans to review rotas and rota slots in Q3 of this year to ensure the rotas and slots remain fitting to the skill set of the doctors.

There is also a Trust-wide medical workforce group in place to review the medical workforce and potential supporting roles such as physician assistants. The group has also requested for the O&G service to review the current rota templates to ensure the templates are fit for purpose.

5. Conclusion

The Board are advised:

- the number of gaps has increased compared to Q1 & Q2 of the previous reported year (2020-2021).
- should the rota establishment fluctuate throughout the year there are robust processes in place to mitigate the use of high-cost agency locums wherever possible by using internal bank, doctors in training and ANNPs
- As predicted, there were several gaps from Q1 of 2022-2023 (due to trainees obtaining CCT or leaving for Out of Programme training/experiences) and some fixed-term clinical fellow posts have been planned for to mitigate these gaps.
- The services will continue to monitor gaps and recruit where possible
- There has been an increase in the number of uncovered late shifts (17-00 – 2200hrs)
- There has been an increase in the number of consultants acting down to cover PGD gaps.

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

6. Recommendations

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

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*22/23/164e*		Date: 01/12/2022	
Report Title	Analysis of clinical incidents attributable to the Isolation of LWH services from other specialist services			
Prepared by	*Dr Bill Yoxall, Clinical Advisor to Future Generations*			
Presented by	*Dr Lynn Greenhalgh, Medical Director*			
Key Issues / Messages	Incidents relating to LWH being on an isolated site are now being collected and analysed to ensure that identified risks are being identified and risks can be mitigated as far as it practically possible. These incidents have been aligned to a draft LUHFT LWH Joint risk register.			
Action required	Approve ☐	Receive ☐	Note x	Take Assurance
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable):			
	For Decisions - in line with Risk Appetite Statement – Y/N *If no – please outline the reasons for deviation.*			
	The Board is asked to note the report.			
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 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 4.1 Failure to ensure our services are financially sustainable in the long term	Comment:

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

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Quality Committee	Nov 22	MD	Noted the detailed work undertaken to review clinical incidents attributable to the isolation of LWH services from other specialist services. Received the draft LUHFT LWH Joint risk register. It was agreed that the Committee should receive a 6 monthly report on the LUHFT LWH Joint Risk register and the progress of the reduction of risks identified. The report identified additional work to consider the impact of the peri-natal mental health team for Trust patients.

EXECUTIVE SUMMARY

1. Define the issue

It is well recognised that LWH NHSFT provides services for patients at a site (Crown Street) which is isolated from other specialist trusts. This isolation causes significant clinical risk for patients, which will increase over time with increasing complexity of health care. The Future Generations Project aims to reduce this clinical risk by informing service design.

Recent work has included collaborative working between LWH and LUHFT. A draft shared risk register is being developed as part of this collaboration. Please see the draft Risk Register in the supporting documents of Admin Control

A review has been performed of all clinical incidents reported from September 2021 to the end of September 2022 logged on Ulysses, the LWH clinical incident system in which the isolation of services at Crown Street was thought to have contributed.

From May 2022, a mandatory field on Ulysses has been introduced so when any incident is logged staff have to state whether or not the incident is due to LWH being an isolated site.

Incidents were mapped to the risks identified on the draft shared risk register. The purpose of this review was to describe how these risks are being experienced by the patients and staff at LWH.

2. Key Findings

41 relevant incidents were identified, although there is a significant and unknowable under-ascertainment of the true number. The findings, therefore, only provide a qualitative assessment of the situation.

The addition of a field in the Ulysses system for clinicians to highlight that an incident was potentially related to the isolated nature of the site part way through the report period appears to have increased the number of incidents identified.

Of the 41 incidents,

- 29 mapped to risks that have a current RAG rating of red
- 11 mapped to a risk with a current RAG rating of amber.
- 1 incident could not be mapped to an existing risk.

The commonest risk category was “Lack of access to other adult acute specialties at Crown Street”.

There are significant problems in patients having access to gynae-oncology operating lists at LUHFT because of unavailability of list spaces. This is preventing surgical intervention for occurring at the clinically appropriate time for many patients.

Several of the incidents (3) related to the lack of a facility to provide emergency psychiatric assessment on site for LWH patients. This serious gap in the portfolio of services provided at LWH and needs to be reflected appropriately on the Trusts Risk Register.

There is evidence that staff are trying to mitigate these risks by ad hoc ‘work arounds’ outside of current pathways.

There were no neonatal or safeguarding incidents reported in the data.

3. Solutions / Actions

More detailed retrospective information could be provided by reviewing other data sources: SUIs, Litigation claims, HSIB investigations, Safeguarding case reviews etc.

A system for the prospective collection of meaningful data is being developed as part of the Future Generations project.

An agreement has been reached with the Neonatal Department about which risks they should be reporting in relation to the isolation of their services.

Discussion with the Safeguarding Department should take place in order to understand any risks that occur there.

The facility to have on-site emergency psychiatric assessment needs to be developed.

4. Recommendations

It is recommended that incidents related to LWH being an isolated site are continued to be monitored, collated and mapped against the LUHFT LWH joint risk register once finalised and mitigations developed and monitored through the LUHFT LWH Partnership Board.

It is recommended that further evidence of the risks of LWH being an isolated site are identified by reviewing serious incidents. Maternity serious incidents were reviewed in the October 2022 Quality Committee but serious incidents from other clinical areas also need to be reviewed. Complaints, PALS and litigation claims should also be reviewed retrospectively and then prospectively to ensure that all risks are identified and actions put in place to mitigate risk as much as possible.

It was recommended and agreed that the Quality Committee receive a 6 monthly report on the LUHFT LWH Joint Risk register and the progress of the reduction of risk identified.

The Board is asked to note the report.

INTRODUCTION

Liverpool Women's Hospital first declared in 2014 that it was no longer clinically sustainable, due to the configuration of services in Liverpool and the resulting isolation of services provided by this Trust from the Crown Street site. With the increasing complexity of care that can be provided to gynaecology, maternity, and neonatal patients, alongside increasing medical and surgical complexity and acuity of patients themselves, this has led to an increasing burden of clinical risk to be managed by clinicians (both those from Liverpool Women's Hospital and from other sites across Liverpool).

The Trust established the Future Generations Programme to identify and deliver a long-term, sustainable solution to these issues, in collaboration with system partners. The Trust has also implemented a wide range of 'clinical workarounds' and additional actions to reduce clinical risk where possible, and has a number of programmes underway as part of the Crown Street Enhancements Programme to further reduce risk. Updates regarding the clinical risks and progress towards actions to reduce them are provided on a regular basis to the Quality Committee and the Trust Board.

However, despite this extensive work, there are a number of risks caused by the configuration of services that can never be mitigated on the Crown Street site, and a level of residual risk remains. Once the actions referenced above have been implemented, the Trust is of the view that there are no additional feasible actions which could be undertaken to further reduce the residual risk. This assessment was validated by an independent clinical senate (the Northern England Clinical Senate) in February 2022.

These remaining risks are currently being defined on a risk register shared between Liverpool Women's Hospital (LWH) and Liverpool University Hospitals NHSFT (LUHFT) (See Appendix 1). A review of all clinical incidents held in the clinical reporting system at LWH from September 2021 has been performed to illustrate how these risks are being experienced and to identify any other risks that have not been captured in this register. This paper describes this review and its outcomes.

ANALYSIS

There were 78 incidents captured in the Ulysses database report.

- 7 - duplicate reports.
- 20 - no evidence that the isolated site had played a part in the incident (appendix 2).
- 10 - incidents related to laboratory samples or services. These are summarised below (appendix 3) but not discussed further in this report.

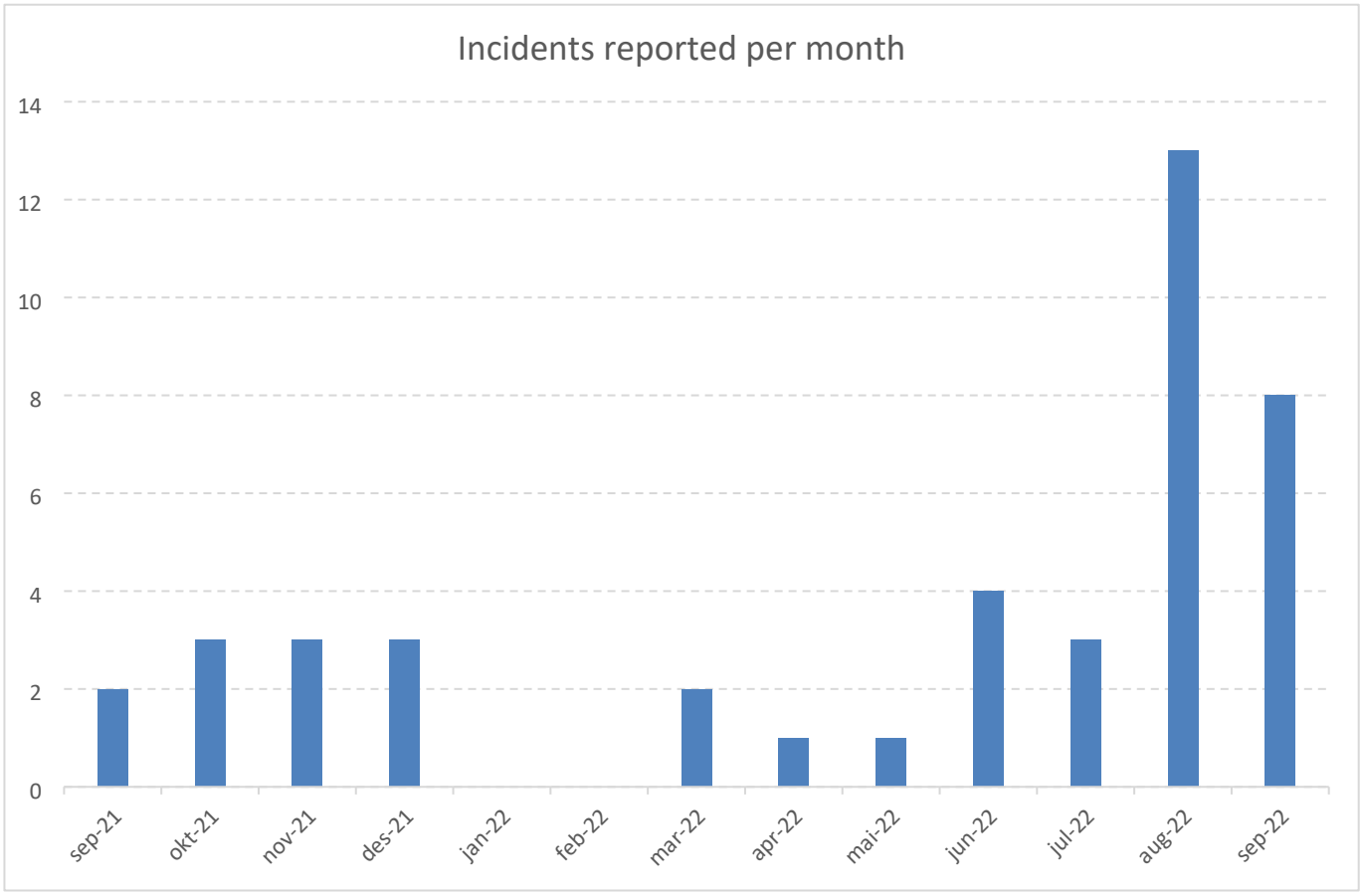
This report is based on the remaining 41 incidents.

It is likely that there has been an unquantifiable and significant under-ascertainment of these incidents.

There are several reasons for this:

- Not all incidents are reported
- Not all relevant incidents have been identified, this is illustrated by the apparent increase in the number of relevant incidents reported each month in the latter part of the data collection period, since the new 'flag' was put on to the incident reporting system (see chart below).

The strength of this report is, then, a qualitative description of the types of clinical incidents seen rather than a quantitative breakdown of the incidents.



Many of the incidents relate to a delay in patients receiving appropriate specialist care. Unfortunately, the duration of these delays is not captured in most of the incident reports. Most incidents record that there was a problem accessing appropriate care, but it is not always clear how or whether the situation was resolved.

The 41 incidents were mapped to the risks on the LUHFT LWH draft shared risk register. The result is shown in Table 1. Of the 41 incidents 29 mapped to risks that have a current RAG rating or red, 11 mapped to a risk with a current RAG rating or amber. 1 incident could not be mapped to an existing risk.

Detail of the incidents by theme is provided (Appendix 4)

Table 1. Mapping of all incidents to risks on the draft shared risk register.

Risk number	Risk description	Current RAG rating	Number of incidents
LWH/LUHFT/001	Cause: Lack of ITU at Crown Street Site		9
LWH/LUHFT/002	Cause: Lack of access to other adult acute specialties at Crown Street and lack of access to urgent/acute clinical support, including cardiac arrest team and medical and surgical on call		17
LWH/LUHFT/003	Cause: Lack of access to obstetric, gynaecological and midwifery care for women on LUHFT sites	Gynae	1
		Maternity	3
LWH/LUHFT/005	Cause: Lack of access to diagnostic imaging		8
LWH/LUHFT/007	Cause: Lack of access to clinical support services at Crown Street		2

Risk 001. Lack of ITU at Crown Street

9 women required transfer out from LWH to another hospital for ITU or HDU care.

5 were maternity patients.

4 were women who required ITU in the immediate post partum period.

1 was a patient who had been transferred back to LWH from another Trust whilst still requiring specialist care. There was inadequate discussion between the clinical departments and there was no capacity to provide the care that she needed on arrival, so she was sent back to the other hospital immediately.

4 patients were gynaecology patients.

2 were brought to the Emergency Dept and were acutely unwell requiring intensive care, which could not be provided safely or effectively in the department, so both were transferred out for ITU. 1 gynaecology patient required unanticipated post operative intensive care and was transferred out.

1 gynaecology patient had an operation deferred as she was predicted to require post operative High Dependency care and there was an inadequate number of trained staff on duty at LWH.

Action: The provision of a critical care unit at LWH is not possible and therefore this risk cannot be mitigated without co-location with an adult acute hospital.

Risk 002. Lack of access to other adult acute specialties at Crown Street

17 patients required input from other specialties.

5 patients were transferred for emergency surgical (5) or medical (1) care.

1 patient developed an ileus after a caesarean section and should have been transferred out for surgical care, but we were unable to do so due to unavailability of surgical beds.

1 patient developed a significant epistaxis at LWH. The ENT surgeon from another hospital attended LWH and dealt with the problem.

7 incidents involved patients who were unable to be listed for gynae-oncology surgery when clinically appropriate because of the lack of any space on the operating lists at LUHFT.

There were 3 incidents related to serious psychiatric illness and the lack of on site emergency psychiatric assessment.

1 patient presented to the Gynae ED with an acute psychosis and was transferred to LUHFT for assessment and ongoing care.

2 other gynaecology patients were expressing suicidal thoughts. No emergency mental health assessment could be provided. One patient left the hospital before an assessment could be made. The outcome of the other patient is not clearly recorded.

Action:

- **One 3 session operating day at the New Royal has been negotiated which will provide the capacity to operate on gynae-oncology patients who need operating on an acute adult site. A PTL for all joint procedures is being developed to track the capacity and demand for these services.**
- **Workstreams for shared care between LUHFT and Maternity and LUHFT and gynaecology have been established and their work feeds into the LUHFT LWH Partnership Board**
- **Transfers for emergency surgical and medical opinions will continue until LWH is co-located with adult acute services. It is hoped that with the permanent CT scanner and MRI scanner on site that this number will reduce. A workstream is underway to review the acutely unwell patient once the scanning services are established for LWH In-Patients to avoid unnecessary transfers.**

- **A review of services for psychiatrically unwell patients in LWH has started led by the Deputy Medical Director will feedback into Safety and Effectiveness Senate in 3 months.**

Risk 003. Lack of access to obstetric, gynaecological and midwifery care for women on LUHFT sites.

This risk is rated as amber for gynaecology.

1 patient presented at A+E in another hospital with a gynaecology emergency requiring surgical intervention, she was assessed on site by clinician from LWH, stabilised and transferred for LWH for definitive treatment.

This risk is rated red for maternity.

1 patient had an emergency caesarean section at another hospital due to severe maternal illness.

1 patient presented at A+E in another hospital with a complex wound infection requiring surgical intervention, she was assessed on site by clinician from LWH, stabilised and transferred for LWH for definitive treatment.

In another incident expressed breast milk from the mother of a preterm baby was discarded because she was an in-patient at another hospital and they did not have the facility to store the milk for her preterm baby.

Action:

- **LWH will assemble a flying squad for deliveries at other hospitals but there are implications of doing this on staffing at LWH as this takes a considerable number of staff.**
- **The second tier of gynaecology on call consultants will cover travelling to provide support at other hospitals for gynaecology emergencies**

Risk 005. Lack of access to diagnostic imaging

8 incidents related to difficulty accessing diagnostic imaging

1 of these was a maternity patient who required an abdominal ultrasound at LUHFT but could not access it due to ambulance unavailability.

3 patients required transfer for imaging and ongoing management for new clinical problems, 2 had developed post operative ileus and 1 had had a stroke.

3 patients needed urgent pre-operative CT scan for aggressive gynaecological cancers.

2 had the scan at LUHFT and returned to LWH for surgery.

In the other case the staff at LWH and LUHFT collaborated to perform the scan at the LWH mobile scanner.

1 non-ambulant outpatient was referred for a CT scan at LWH, where there is no patient hoist to perform the scan. The staff present lifted the patient in order to perform the scan.

Action: The permanent CT and MRI scanner will become operational in January 2023 and April 2023 respectively. The Deputy Medical Director and Deputy Chief Operating Officer are leading a piece of work to establish

- **The inpatient radiology pathway for LWH patients**
- **The acute medical and surgical pathway for LWH patients who have been scanned on site**

Risk 007. Lack of access to clinical support services at Crown Street

2 in-patients could not be fed orally because they required assessment of their unsafe swallow by SALT. This could not be provided on site.

Action: The Chief Nurse has requested a review of dietetic services at LWH.

Other issues

Staff mitigating risk by developing "Work arounds"

There are several examples of staff mitigating the risks they encounter by creating ad hoc solutions outside of agreed pathways. Examples are:

> There was no suitably trained and experienced ODP on duty to support the transfer so one patient for ITU, so of the LWH staff who was not on duty came in and supported the transfer.
>
> One in patient was unable to attend 2 appointments for abdominal ultrasound imaging at LUHFT because of ambulance unavailability, so she was taken to LUHFT by alternative transport.
>
> A patient who required urgent pre-operative CT scan was able to have this performed in the mobile scanner at LWH despite the absence of a pathway to support the scan or the reporting of the scan.
>
> 1 non-ambulant out patient who was referred for a CT scan at LWH. Non-ambulant patients should not be referred to LWH as there are no hoist facilities to allow them to be scanned. In this case, the staff present lifted the patient in order to perform the scan.

Neonatal Issues

There was only 1 Neonatal incident captured in the Ulysses system report. It is not clear whether this is because of the way that neonatal risks are reported or because of the way that data were extracted from the Ulysses database. Previous Future Generations work identified significant risks relating to the care provided to babies. Recommendations were made in order to mitigate these: improved staffing, the building of a new neonatal unit at Crown Street and the formation of the Liverpool Neonatal Partnership in collaboration with Alder Hey Children's Hospital. Once fully implemented, these developments will mitigate the neonatal risks, but will not fully resolve them, leaving a residual risk. Continued monitoring of the neonatal risks needs to be performed in order to ensure that the proposed developments are fully delivered, to measure whether they achieve the expected reduction in risk and to monitor the magnitude of the residual risk.

Action: Interhospital neonatal transfers between LWH and AHCH are already captured and reported on the LNP performance dashboard. An agreement has recently been reached with the neonatal department about which incidents will be reported in Ulysses relating to risks posed by the isolation of neonatal services from other paediatric specialist services.

Safeguarding Issues

There were no safeguarding incidents identified.

Safeguarding incidents are not logged through Ulysses and therefore not identified during this process.

Action: A joint performance report is being developed that will identify the quantity of safeguarding incidents in future and data regarding safeguarding incidents relevant to being on an isolated site will be incorporated in this report in the future.

ANALYSIS

Key findings

The risks identified on the shared risk register are being experienced by the patients in our care. It is not clear whether these are increasing in frequency or not because of incomplete acquisition of incidents.

The magnitude of the time delays identified in providing care cannot be measured or described from the data collected.

The eventual clinical outcome of some of the incidents reported is not recorded so reassurance cannot be provided about this.

Staff are mitigating some of the risks they encounter by ad hoc arrangements to 'work around' problems outside agreed pathways.

The commonest risk relates to lack of access to other specialist services for women cared for at LWH.

The greatest numbers related to lack of timely access to surgery at LUHFT for gynae-oncology patients. There were also several incidents relating to the non-availability of acute mental health assessment. This is not specifically referred to in the wording of the risk and this needs to be added to the register and actively managed. There were 1454 female suicides in England and Wales in 2021 (1). Suicide is the leading cause of death in women between the ages of 20 to 34 years in the UK, accounting for 16.7% of female deaths for this age group (2). The MBBRACE report published in November 2022 showed that in 2020, women were 3 times more likely to die by suicide during or up to six weeks after the end of pregnancy compared with 2017-219. The report also showed that maternal deaths from mental health related causes as a whole (suicide and substance abuse) account for nearly 40% of deaths occurring within a year after the end of a pregnancy with maternal suicide remaining the leading cause of direct deaths in this period. The failure to provide acute psychiatric assessment and care is a major deficit in the portfolio of services provided at LWH. The deputy medical director has already begun a review of mental health provision at LWH.

There may be other unrecognised risks and other data sources (SUI reports, legal claims, HSIB reports, safeguarding case reviews) could be helpful in identifying these.

This project did not identify and neonatal incidents, which is of concern given the ongoing clinical risks in that service. Ongoing monitoring of the previously identified risks in neonatology must be implemented to monitor the effectiveness of the mitigation put into place.

Solutions:

A project to collect high quality prospective data is being developed as part of the Future Generations project and a performance report will be produced from this.

Further information could be generated from existing data about retrospective performance utilising other data sources such as SUIs in gynaecology and Neonatal Departments (thematic analysis of maternity SUIs already complete), Thematic analysis of other incidents e.g. HSIB, legal claims, Safeguarding incidents.

Further development of Ulysses system could be implemented to permit the capture of information about the duration of the delays in providing appropriate care and to fully capture the final outcome of the problems encountered.

Access to emergency Mental Health Assessment must be added to the risk register and managed actively to ensure that this risk is resolved.

Monitoring of previously recognised neonatal risks is required in order to ensure that planned developments are implemented and deliver the risk reduction expected.

References

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2. Leading causes of death, UK: 2001 to 2018. Office for National Statistics. https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/articles/leadingcausesofdeathuk/2001to2018#toc
3. Saving Lives, Improving Mother's Care. Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018-20. MBRRACE-UK. November 2022. https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2022/MBRRACE-UK_Maternal_MAIN_Report_2022_v10.pdf

RECOMMENDATION

It is recommended that incidents related to LWH being an isolated site continue to be monitored, collated and mapped against the LUHFT LWH joint risk register once finalised and mitigations developed and monitored through the LUHFT LWH Partnership Board.

It is recommended that further evidence of the risks of LWH being an isolated site are identified by reviewing serious incidents. Maternity serious incidents were reviewed in the October 2022 Quality Committee but serious incidents from other clinical areas also need to be reviewed. Complaints, PALS and litigation claims should also be reviewed retrospectively and then prospectively to ensure that all risks are identified and actions put in place to mitigate risk as much as possible.

It was recommended and agreed that the LWH Quality Committee receives a 6 monthly report on the LUHFT LWH Joint Risk register and the progress of the reduction of risk identified.

The Board is asked to take assurance that the LUHFT LWH Partnership Board is tracking the risks of LWH being on an isolated site and is implementing strategies to mitigate these risks as much as possible.

Appendix 1. Incidents in the dataset which did not have any evidence that being on an isolated site had an impact on the incident.

- 11 neonatal incidents when an incorrectly labelled laboratory specimen had been sent so no analysis had been performed
- 2 neonatal incidents of the unit being on a 'red' status due to being at full capacity.
- 1 maternity episode of Group A sepsis that was well managed.
- 1 maternity incident due a missed antibiotic dose because of poor stock control on the ward.
- 1 maternity incident in which a hysterectomy was performed because of placenta accreta.
- 1 gynaecology episode with delay in providing O-ve blood intra-operatively due to internal issues relating to lack of clarity about changed procedures for storing O-ve
- 1 gynaecology incident which appears to relate to a transfusion reaction to an emergency O-ve transfusion in a woman with unusual antibodies .
- 1 gynaecology incident due to inadequate junior medical staffing.
- 1 gynaecology patient had her operation deferred because of failure to admit her the preceding day for medication and pre op bloods.

Appendix 2 Laboratory or laboratory sample incidents, not considered in any further detail in this report.

9 samples had gone astray during transfer from LWH to the off site laboratories (7 blood samples, 1 CSF sample, 1 Histology sample).

1 incident was also related to the blood fridge on the neonatal unit. This had malfunctioned and it was not clear whether it was the responsibility of LWH or AHCH to deal with this.

Appendix 3 – detailed breakdown of incidents by theme

<u>Inability to access theatre lists for gynae-oncological surgery</u>

7 of the 13 cases reported in August 2022 were women who were undergoing treatment for gynaecological cancers who had been listed for surgical treatment but could not access it as there was no room on the lists at LUHFT. 2 of these women were referred to Christie's for treatment. In one woman a decision was made to continue with chemotherapy and to remove her from the surgical list, although it is recorded that the patient still wanted to have surgery. The outcomes of the other cases are not recorded in the incident reports.

<u>Transfer from LWH for ITU or HDU care</u>

8 women were transferred out from LWH to another hospital for ITU or HDU care.

5 were maternity patients. 4 were women who required ITU in the immediate post partum period. These patients were exposed to the risks of exposing a patient who requires intensive care to ambulance transfer and to risks of delay in accessing appropriate care associated with the

pressures on emergency ambulance availability. These incidents also resulted in separation of the mother and baby at a critical time in the family's life.

The other maternity patient had been transferred back to LWH from another Trust whilst still requiring specialist care. There was inadequate discussion between the clinical departments and there was no capacity to provide the care that she needed on arrival, so she was sent back to the other hospital immediately. Her baby remained on the NICU at LWH throughout. This episode demonstrates clinical risk, emotional distress and the poor utilisation of health care resources.

3 patients were gynaecology patients.

2 were brought to the Emergency Dept and were acutely unwell requiring intensive care, which could not be provided safely or effectively in the department, so both were transferred out for ITU. These patients were exposed to the risks of delay in the recognition of the patients need for ITU and the provision of ITU and the exposure of a critically ill patient to an ambulance transfer.

The other gynaecology patient required unanticipated post operative intensive care. Due to staffing difficulties, there was no suitably trained and experienced ODP on duty to support the transfer so one of the LWH staff who was not on duty came in and supported the transfer. This is an example of the 'work arounds' that staff at LWH have to provide in order to mitigate the risks posed to their patients by the non co-location of services.

<u>Transfer from LWH for other specialist care</u>

6 patients were transferred for emergency surgical (5) or medical (1) care.

4 were maternity patients.

3 women had ileus post caesarean section and required transfer for CT and surgical management. The transfer resulted in separation of mother and baby.

The other maternity patient was ante partum with a pulmonary embolus. The community midwife continued to attend the hospital that the patient was transferred to in order to monitor the pregnancy.

2 were gynaecology patients.

One was in the gynaecology emergency department and a diagnosis of acute appendicitis was made. She remained at LWH for 18 hours before an ambulance transfer could be made, causing significant delay in her treatment.

The other gynaecology patient was referred in from another Trust A+E department with a suspected gynaecology emergency. No gynaecological problem was identified, so she was sent to a third hospital for surgical assessment. This is clearly poor quality care for this patient with delays in receiving appropriate care and a waste of health care resources.

A further maternity patient developed ileus after a caesarean section and should have been transferred out for surgical care, but we were unable to do so due to unavailability of surgical beds.

Difficulties accessing imaging

6 other patients were transferred to other hospitals for imaging.

1 of these was a maternity patient.

> Referred for in patient abdominal ultrasound. The procedure was cancelled twice because of difficulties with ambulance provision. Eventually the patient was transferred by other means and the scan was performed. This is another example of the LWH staff providing 'work arounds' to mitigate the clinical risks they are dealing with.

5 were gynaecology patients.

> One patient had developed post operative ileus and required transfer for imaging and surgical management.
>
> Oner was found to have had a stroke and was transferred for imaging and ongoing management.
>
> 3 patients needed urgent pre operative CT scan for aggressive gynaecological cancers.
>
> > 2 had to go to another hospital for CT scan, then returned to LWH for ongoing treatment. 1patinet, the staff at LWH and LUHFT collaborated to perform the scan at the LWH mobile scanner despite there being no agreed pathway to do this and report the scan. This is yet another example of staff developing 'work arounds' to mitigate clinical risk.

One further incident records a non-ambulant patient who was referred for a CT scan at LWH. Non-ambulant patients should not be referred to LWH as there are no hoist facilities to allow them to be scanned. In this case, the staff present lifted the patient in order to perform the scan. Another example of the staff 'working around' agreed pathways to mitigate clinical risk.

Difficulties in delivering specialist maternity, gynaecology or neonatal care to LWH patients whilst in other hospitals

1 patient had an emergency caesarean section at another hospital due to severe maternal illness. Her preterm baby was admitted to LWH in poor condition and the patient was admitted to ITU at the other hospital.

Two patients were transferred in to LWH for specialist treatment following admission to another Trust and assessment on site by a clinician from LWH. One had a complicated post operative wound infection requiring surgical intervention and one had a miscarriage requiring surgical intervention.

In 1 incident expressed breast milk from the mother of a preterm baby was discarded because she was an in-patient at another hospital and they did not have the facility to store the milk for her preterm baby. This was not only extremely distressing for the patient but also caused an avoidable clinical risk. Maternal breast milk provides a significant protection for preterm babies against necrotising enterocolitis, a leading cause of death in this group with high rates of long term morbidity and disability in survivors.

Difficulties in providing other specialist care to patients at LWH

Mental Health

There were 3 incidents related to serious psychiatric illness and the lack of on site emergency psychiatric assessment.

One gynaecology patient presented to the Gynae ED with an acute psychosis and was transferred to LUHFT for assessment and ongoing care. 2 other gynaecology patients were expressing suicidal thoughts. No emergency mental heath assessment could be provided. One patient left the hospital before an assessment could be made. The outcome of the other patient is not clearly recorded .

There were 1454 female suicides in England and Wales in 2021 (ONS ref). Suicide is the leading cause of death in women between the ages of 20 to 34 years in the UK, accounting for 16.7% of female deaths for this age group. The failure to provide acute psychiatric assessment and care is a major deficit in the portfolio of services provided at LWH.

Speech and Language Therapy

2 gynaecology in-patients required assessment of their swallow by SALT. This could not be provided on site, so it was no possible to allow these patients to feed orally. One lady was transferred as a in patient for assessment. The outcome of the other patient is not clear in the incident report .

ENT

1 patient developed a significant epistaxis at LWH. ON this occasion the ENT surgeon from another hospital attended LWH and dealt with the problem.

Miscellaneous

1 patient had her operation at LWH deferred because of unavailability of HDU nurses at the LWH site.

1 patient self discharged from LWH ED and went to A+E with a cannula still in place.

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

Liverpool Women's NHS Foundation Trust

1. Highlight Report

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

• Risk of industrial action - Planning for industrial action was ongoing both internally through Business Continuity Plans and across the Cheshire & Merseyside system. The Trust was working closely with union colleagues to manage the impact of potential strike action.
• The Committee took partial assurance from the positive reporting culture outlined within the Maternity Red Flag Deep Dive Review and recognised adoption of the recommendations would provide further and complete assurance. A 6-month update would be provided to monitor progress.
• The Committee took partial assurance from the Family Health workforce assurance report noting that full assurance could be taken upon completion of the proposed actions. Continued challenges in relation to sickness absence, core mandatory training and mandatory clinical training was noted.
• Issues in relation to a negative culture experienced by candidates on the Midwifery Preceptorship programme had been reported. Significant work had been undertaken to support the preceptees during that time. The Committee remitted an action to the Family Health Divisional Board to review the feedback from midwifery preceptees on culture within the division and related freedom to speak up feedback in order to provide a response.
• Received results of the PDR and Mandatory Training audits. The Committee noted the significant work undertaken to provide the detail and recommendations. Keys issues to highlight included:
  ○ increased headroom allocation within Family Health to specifically improve mandatory training and PDR compliance. The audit evidenced that the additional headroom was being used to cover sickness and vacancies and not to roster staff to protect time for learning.
  ○ several members of staff had never completed areas of mandatory training whilst working at the Trust.
	• A full review of car parking capacity arrangements was underway to address a shortage of capacity at Crown Street. It was confirmed that security and quality of the carparks was also being considered as part of the 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**
• Received a positive staff story from a member of the clinical workforce working as a Foundation 3 (F3). The benefit of F3 roles was as a constructive way to start training and get a sense of the job before committing to a specialism for the doctors was noted. The positive impact for the Trust to have committed trainees who want to learn and develop was also noted. (WELL LED) • The Committee was assured by the Workforce KPI Dashboard noting an improvement against all metrics except for sickness absence. (WELL LED) • Noted the changes undertaken to the Midwifery Preceptorship offer highlighting the key workforce metrics and staff experience as Newly Qualified Midwives at one year. (WELL LED)	• Chair action: to the Corporate Risk Subcommittee to review the narrative and scores of the midwifery staffing corporate risks to ensure reflective of current position since midwifery recruitment. • Chair action: to the Family Health Divisional Board to review feedback from midwifery preceptees on culture within the division and related freedom to speak up feedback and provide a response. • Approved the terms of reference of the Professional Forum of Nurses, Midwives & AHPs.

• The Committee noted a positive Self-Assessment Review of training at LWH submitted to HEENW confirming compliance against the 6 domains within the Quality Framework. (WELL LED) • Noted the Freedom to Speak Up Guardian Update covering the period Quarter 1 and Quarter 2 2022/23 which provided details of concerns raised and highlighted key themes identified. The Freedom to Speak Up Guardians were invited to several groups within the Trust to promote access. (WELL LED) • Noted the Medical Appraisal and Revalidation report covering Quarter 2, 2022/23. (ALL) • Assured by the Guardian of Safe Working Hours to ensure that doctors in training are safely rostered and enabled to work hours that are safe and in compliance with their contract. Additional actions to support the step-down process to cover the rota were also noted. (ALL)	

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 recommended a review of the subsidiary corporate risks 1705 and 2424 in light of recent recruitment to the midwifery workforce. The Committee agreed to remit the action to the Corporate Risk Subcommittee.

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
71.	Board Assurance Framework (BAF): Workforce related risks	Assurance		78.	Training Audits: PDR and Mandatory Training	Information	
72.	Staff Story	Information		79.	Self-Assessment review of training at LWH submitted to HEENW	Information	
73.	Chief People Officer Report	Information		80.	Freedom to Speak Up Guardian Update	Information	
74.	Maternity Red Flag Deep dive review	Assurance		81.	Medical Appraisal and Revalidation Quarterly Report, Quarter 2 2022/23	Information	
75.	Workforce Assurance Report: Family Health	Assurance		82.	Guardian of Safe Working Hours Quarterly Report, Quarters 1 & 2, 2022/23	Assurance	
76.	Midwifery Preceptorship evaluation	Information		83.	Sub Committee Chair Reports	Assurance	
77.	Workforce KPI Dashboard Report	Assurance					

3. 2022 / 23 Attendance Matrix

Core members	May	Jun	Oct	Nov	Jan	Mar
Susan Milner, Non-Executive Director	✓		NM			
Gloria Hyatt, Non-Executive Director	✓	✓	✓	✓		
Louise Martin, Non-Executive Director	✓	✓	✓	✓		

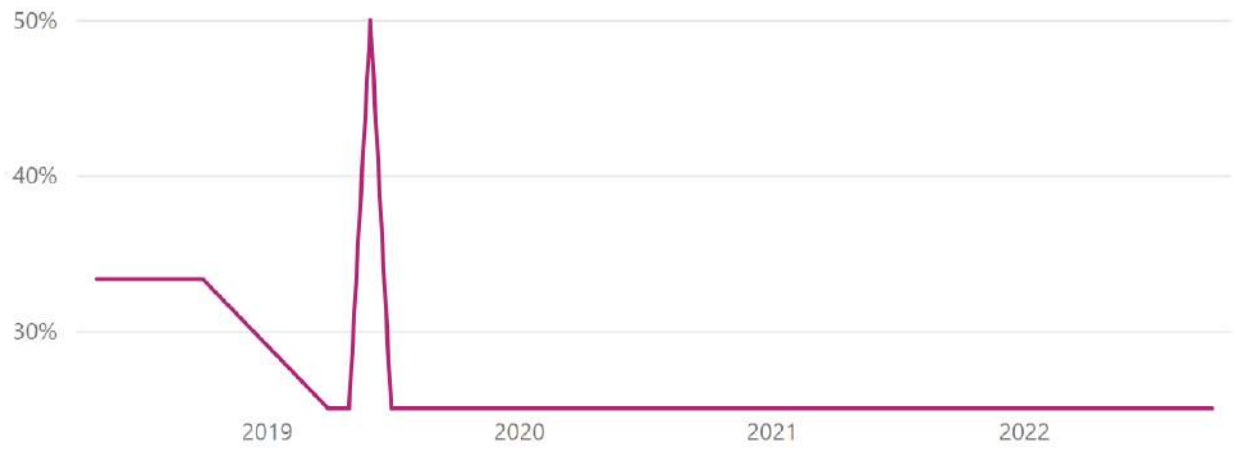
Zia Chaudhry, Non-Executive Director	✓	✓	✓	✓		
Michelle Turner, Chief People Officer	✓	✓	✓	✓		
Marie Forshaw, Chief Nurse & Midwife	✓	✓	NM			
Dianne Brown, Interim Chief Nurse	NM		✓	✓		
Gary Price, Chief Operations Officer	✓	✓	✓	✓		
Claire Deegan, Deputy Chief Finance Officer	A	✓	NM			
Linda Haigh, Interim Deputy Chief Finance Officer	NM		✓	✓		
Liz Collins, Staff Side Chair	✓	✓	✓	✓		
Dyan Dickins, MSC Chair	✓	✓	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
December 2022

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



Positive Developments

Improvements continue to be made to the user experience in ESR. Mandatory training email reminders are now being issued to all staff, advising them 3 months in advance of expired training. The ESR applicant landing page has also been launched, meaning new starters can carry out mandatory training and review useful information before they start at the Trust as part of a positive onboarding experience. Learning and Development/ HR are working with Practice Educators and Divisional colleagues to act on the results of the mandatory training and PDR audits, and make improvements to the way mandatory training is planned and delivered. A wellbeing coach has commenced in maternity, and is supporting the delivery of 'Wellbeing Conversations'. Following stakeholder feedback, the roll out of the new Staff Support Service, providing psychological support and wellbeing interventions, has commenced. Improvements to the Occupational Health space are being made to ensure this is a welcoming space for staff.

Areas of Challenge

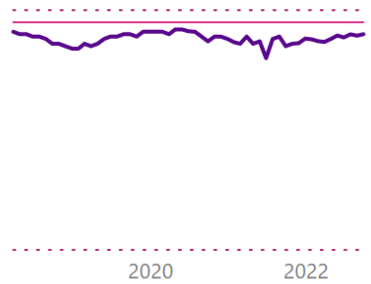
Sickness continues to be closely monitored, with audits of wellbeing conversations and return to work interviews currently ongoing. The requirements of additional mandatory training including essential learning are being considered as part of budget setting conversations.

KPI	October 2021	November 2021	December 2021	January 2022	February 2022	March 2022	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022	October 2022
Clinical Mandatory Training Compliance	80.35% ↓	79.21% ↓	78.26% ↓	68.06% ↓	79.22% ↑	78.15% ↓	75.62% ↓	76% ↑	76.99% ↑	77.49% ↑	79.05% ↑	78.47% ↓	78.47% →
Mandatory Training Compliance	85% ↓	86% ↑	86.23% ↑	88.17% ↑	87.82% ↓	87.11% ↓	86.76% ↓	88.01% ↑	89.44% ↑	88.64% ↓	89.94% ↑	89.37% ↓	90% ↑
Sickness Absence Rate	8.03% ↓	7.93% ↓	10.26% ↑	10.99% ↑	7.64% ↓	9.18% ↑	7.57% ↓	6.6% ↓	6.63% ↑	7.77% ↑	7.35% ↓	7.16% ↓	7.98% ↑
Turnover Rate	13% ↑	12% ↓	12% →	13% ↑	13% →	13% →	13% →	13% →	12% ↓	12% →	12% →	12.03% ↑	11.7% ↓

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	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
% Performance	↓ 85%	↑ 86%	↑ 86.23%	↑ 88.17%	↓ 87.82%	↓ 87.11%	↓ 86.76%	↑ 88.01%	↑ 89.44%	↓ 88.64%	↑ 89.94%	↓ 89.37%	↑ 90%
Numerator	↓ 0.85	↑ 0.86	↑ 0.86	↑ 0.88	↓ 0.88	↓ 0.87	↓ 0.87	↑ 0.88	↑ 0.89	↓ 0.89	↑ 0.9	↓ 0.89	↑ 0.9

DQKM

The overall Trust mandatory training compliance increased by 0.63%, from 89.37% in month six, to 90.00% in month seven. This is now 5.00% under the Trust's target rate of 95% and rated as amber. Compliance increased across the largest clinical areas: by 3.51% in Gynaecology, by 0.69% in Maternity, and by 0.74% in Neonates. At divisional level, compliance fell by 0.55% in the Corporate Division, but increased by 2.52% in the Gynae Division, by 0.63% in Family Health, and by 0.12% in Clinical Support Services.

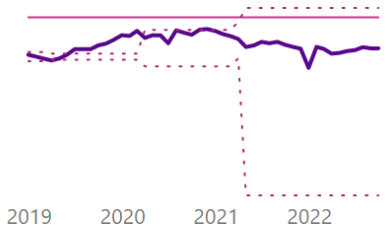
The HR and L&D teams continue to provide support, information, and training to managers across the Trust. Trajectories to underpin a sustained increase in compliance have been developed and are monitored by the Divisional Management Teams. Auto-enrolment has now been rolled out to ensure more accurate reporting and to make it easier for staff to access e-learning modules. 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	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
% Performance	↓ 80.35%	↓ 79.21%	↓ 78.26%	↓ 68.06%	↑ 79.22%	↓ 78.15%	↓ 75.62%	↑ 76%	↑ 76.99%	↑ 77.49%	↑ 79.05%	↓ 78.47%	→ 78.47%

DQKM

October 2022

The overall Trust clinical mandatory training compliance increased by 1.00% from 78.47% in month six, to 79.47% in month seven. This is now 15.53% under the Trust's target rate of 95% and rated as red. Across the largest clinical areas, compliance fell by 1.12% in Gynaecology, but increased by 2.02% in Maternity and by 2.38% in Neonates. At divisional level, compliance fell by 0.85% in Clinical Support Services, but increased by 0.02% in the Gynaecology Division, by 1.95% in Family Health, and by 2.35% 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.

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.

Finance, Performance & Business Development Chair's Highlight Report to Trust Board
21 November 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 the Month 7 YTD position was off track against plan, this was being supported by non-recurrent items. The risk of the forecast outturn moving away from plan was clearly noted and specific risks were quantified. The CFO and Deputy CFO had reported and discussed these risks with the ICB. A recovery plan is underway and evolving to mitigate the financial risks so the forecast out-turn can be achieved. The ICB has requested monthly meetings with the Chief Executive and CFO to monitor recovery and had requested sight of the recovery plan. • The cash balance was highlighted as a matter of concern as the balance is below minimum levels set out in the Treasury Management policy. Cash support has been assumed in January 2023 but has not yet been formally agreed. The Trust is strongly advocating for a solution within the system but if this is not possible, revenue PDC support would be required. • Noted a deteriorating trend against the 52-week position confirming that the Trust had become an outlier within the region against this metric. The Committee was asked to consider the option to outsource activity which had been implemented by other trusts nationwide (LWH being one of three trusts in the C&M system not outsourcing). The Committee advised that the Trust should be certain of its own productivity and pathways ahead of outsourcing care. It was agreed that a decision would need to be taken with views from each of the Board Committees as to whether the Trust should make this investment. • A presentational update on the Community Diagnostic Centre was provided which highlighted key challenges in relation to budget, funding pressures, and staffing solutions. It was recommended that the matter be escalated to CMAST to support delivery against waiting list activity. • The Committee was informed of a delay with the CT programme due to the build not yet meeting environmental conditions required to facilitate Siemens installation requirements for the permanent CT scanner. Implementation has been delayed from December 2022 until January 2023. A post implementation review would be undertaken to identify reasons for the late notification and not meeting planned timescales.	• The Committee received a detailed presentation on the planning for 2023/24 noting modelling of impact of different income scenarios and early discussions with commissioners, particularly Specialised Commissioning, where income does not cover activity or costs. • Agreed to articulate the impact and consequence if the Trust had not incurred additional expense during 2022/23, to support financial position documentation. • The Committee noted ongoing progress with the Future Generations long-term strategy. Focus had been on supporting the Liverpool Clinical Services Review and it was likely that the outcomes of this work would impact the direction of the Future Generations programme going forward. • Chair action remitted to Putting People First Committee to risk assess the agencies used for international recruitment and ensure meeting Modern Slavery Act 2015 requirements.
Positive Assurances to Provide Identify in brackets should the assurance provide evidence against the CQC Key Questions – SAFE | EFFECTIVE | CARING | RESPONSIVE | WELL LED	**Decisions Made**
• The Committee was assured by the Annual Business Case Post Implementation Reviews noting a good business case process in place. • Positive movement of agency spend within Maternity services noting a zero spend during the few weeks. • An update relating to the EPR Programme was received. The Trust had provisionally been allocated funding, subject to an approved NHS digital investment justification business case, towards the project. Progress continued with the business change workshops and build	• Approved the sharing of the Financial Recovery Plan with the ICB following suggested amendments. • Authorised the publication of the Trust's Modern Slavery Act 2015 Annual Statement on the Trust's website.

activities continue. The Committee received assurance that the revised go-live date was a realistic target and planning for the post-optimisation phase (Phase 2) was already underway. The Committee noted the newly introduced section on Digital Finance expenditure as a beneficial addition.

- Received a review against the Modern Slavery Act 2015 and the annual statement for approval. The Committee noted actions taken to strengthen the Trust's approach to Modern Slavery and proposed actions. It was confirmed that all employment agencies used to date had been risk assessed and approved and that new agencies to be onboarded for international recruitment would need to be verified.

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 as visible as possible (currently listed as a 'strategic threat' under BAF risk 4.1). Agreed that this should be escalated as a top-level risk. Narrative needed updating to include recovery planning work.
- Discussed BAF risk 2.2 Failure to develop our model of care to keep pace with developments and respond to a changing environment and requested strengthened narrative.

Comments on Effectiveness of the Meeting / Application of QI Methodology

- Sufficient time provided to discuss matters thoroughly and active participation in debates by all core members
- Balanced pragmatic debate considering the challenging position

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
128.	Review of BAF risks: FPBD related risks	Assurance	134.	Digital Services Update	Information
129.	Finance Performance Report Month 7 2022/23	Information	135.	Modern Slavery Act 2015 Annual review	Approval
130.	Operational Performance Report Month 7 2022/23	Assurance	136.	Future Generations Programme Update	Information
131.	Financial Recovery Plan 2022/23	Information	137.	Community Diagnostic Centre Update	Information
132.	Planning Update	Information	138.	Crown Street Enhancements Programme Update	Information
133.	Annual Business Case Post Implementation Reviews	Assurance	139.	Sub-Committee Chairs Reports	Information

3. 2022 / 23 Attendance Matrix

Core members	Apr	May	Jun	Jul	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Louise Martin, Non-Executive Director (Chair)	✓	A	✓	✓	✓	A	✓				
Tracy Ellery, Non-Executive Director	✓	✓	✓	✓	✓	✓	A				
Tony Okotie, Non-Executive Director	✓	✓	NM								
Sarah Walker, Non-Executive Director	✓	✓	✓	A	✓	A	✓				
Eva Horgan, Chief Finance Officer	✓	✓	✓	✓	✓	✓	✓				
Kathryn Thomson, Chief Executive	✓	✓	A	✓	✓	✓	✓				
Gary Price, Chief Operations Officer	✓	✓	✓	✓	✓	✓	✓				
Marie Forshaw, Chief Nurse & Midwife	✓	✓	✓	✓	NM						
Dianne Brown, Interim Chief Nurse				NM	✓	✓	✓				

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

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	**22/23/166b**		**Date: 01/12/2022**	
Report Title	**Finance Performance Review Month 7 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 7 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 7 Financial Position.			
Supporting Executive:	***Eva Horgan, Chief Finance Officer***			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

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

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

Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* 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
Finance, Performance and Business Development Committee	21/11/2022	Eva Horgan, Chief Finance Officer	The Committee received the report.

EXECUTIVE SUMMARY

At Month 7, the Trust is reporting a £257k surplus year to date (YTD). This is £487k off plan and is supported by £8.4m of non-recurrent items. The forecast out-turn (FOT) before further recovery actions is £2.4m deficit, £3m worse than plan, after inclusion of £1.9m of additional recovery actions. This improvement from the gap of £4.1m in the Month Six forecast is partly offset by a reinstatement of the annual leave accrual and some other amendments following Month Seven actuals. A recovery plan has been prepared and is starting to be delivered. A summary of this is in a separate paper (item 22/23/166c). Between Month 6 and Month 7 the CFO and Deputy CFO had a detailed discussion with the Integrated Care Board (ICB) where it was reiterated that the YTD position was likely to be off plan in Month 7, and that recovery actions would be required if the forecast out-turn was to be achieved. It was made clear and has been flagged in commentary throughout the year that achievement of the plan will take further action and improvement in run rate. The ICB has requested monthly meetings with the Chief Executive and CFO to monitor recovery. The net reported risk was in line with the gap remaining in the forecast, i.e. just under £3m.

Capital spend is behind trajectory with £3.3m spent to Month 7 (£4.2m behind plan) but most of the plan is now committed with orders placed.

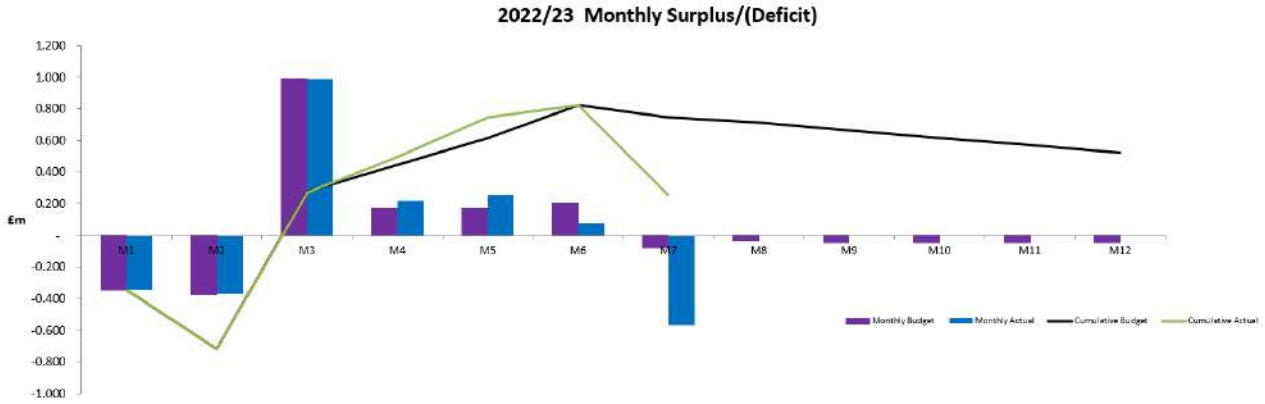
The cash balance was £5.3m at 31 October, below minimum levels set out in the Treasury Management policy (c£5.9m minimum cash level). The Trust will require cash support in the latter months of the year, discussions are ongoing with the ICB to support this.

	Plan	Actual	Variance	RAG	R	A	G
Surplus/(Deficit) YTD	£0.7m	£0.3m	-£0.5m	↓	*>10% off plan*	*Plan*	*Plan or better*
I&E Forecast	£0.5m	-£2.4m	-£3.0m	↓	*>10% off plan*	*Plan*	*Plan or better*
NHS I/E Rating	3	3	0	↔	*4*	*3*	*2+*
Cash	£5.9m	£5.5m	-£0.4m	↔	*<£1m*	*£1m-£4.5m*	*£4.5m+*
Total CIP Achievement YTD	£3.3m	£3.9m	£0.6m	↑	*>10% off plan*	*Plan*	*Plan or better*
Recurrent CIP Achievement YTD	£2.3m	£1.6m	-£0.7m	↔	*>10% off plan*	*Plan*	*Plan or better*
Elective Recovery Fund (net)	-£1.3m	-£0.6m	£0.7m	↓	*>10% off plan*	*Plan*	*Plan or better*
Non-Recurrent Items YTD	£0.0m	£8.4m	£8.4m	↑	*>£0*		*<£0*
Capital Spend YTD	£7.5m	£3.3m	-£4.2m				

MAIN REPORT

1. Summary Financial Position

At Month 7 the Trust is reporting a £257k surplus YTD which is £487k off plan. A forecast outturn was reported to NHSE of a £0.5m surplus for the year with net risks of £3m. The board report contains an FOT deficit of £2.4m, £3m off plan which assumes £1.9m of recovery actions savings to March 2023. Further recovery actions have been worked up and are contained in agenda item 22/23/131 in more detail. 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.

Family Health: The Division is overspent by £1.4m on pay YTD. The division is reducing agency spend through recruitment and retention programmes.

Gynaecology: The division's contribution is £1.5m adverse to plan YTD, £1.1m overspend on pay and £0.4m overspend on non- pay YTD. The pay variance includes higher costs of bank staff and additional payments to medical staff to reduce waiting lists. The division has been working to maximise activity (see ERF) but is underachieving to date. Clawback may occur for Q3&4 which is not reflected in the position.

Clinical Support Services: The division's contribution is £0.3m below plan year to date.

Agency: Agency spend across the Trust is £2m YTD, £1.5m above plan. The agency cap has been confirmed as equal to the LWH plan (£834k) which has been breached pro rata and in total YTD. Corrective action from all areas with high agency usage has been is underway including escalation of approval rights.

3. Community Diagnostic Centre

There is a risk to the funding for the Community Diagnostic Centre (CDC). The budget is set on the original business case, this is now likely to be lower than planned. There is also some risk in relation to a potential change in the financial framework. Discussions are underway with the regional team.

There is further risk in relation to a delay in completion of the CT Imaging Suite. The CT suite was due to be completed on 22 December, with go-live on 9 January. To enable this, CT equipment was due to be delivered to site and a 3-week commissioning period commenced on 22 November. However, construction partners were not able to meet environmental conditions necessary for delivery by 22 November, and as a result delivery and commissioning of the scanner has been delayed. Consequently training and go-live of clinical activity will also be delayed. This has the potential to result in an adverse revenue impact, should activity targets for CT not be met and the national CDC Programme choose to clawback income.

At the time of writing, the situation is live with mitigations actively sought by the Trust, contractors and the CT supplier. At the Trust's request, the contractor has expedited works on site and work is ongoing between all parties to try to ensure go live as soon as possible. The Trust's CDC Manager has successfully negotiated a delayed start (if required) with the Trust's CT workforce partner. The Trust has notified the Cheshire and Merseyside Regional CDC Programme of the delay and will continue to work with partners to minimise activity impact and therefore any risk to income. Additionally, it should be noted that the Trust's earlier decision to continue running the mobile CT scanner will also mitigate impact to any activity targets.

4. Elective Recovery Fund

Under the local ERF calculation for Month 7 (a regional/national calculation not having been shared), the Trust is now behind plan by £0.7m on in year ERF. This is not reflected in the position in line with regional advice. There remains a level of risk, as well as some potential opportunity if activity is increased.

5. CIP

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 a non-recurrent efficiencies of £1.4m (vacancy factor) bringing the total to £5.6m. As at month 7, the Trust is exceeding its total CIP target YTD and is forecast to exceed for the full year, albeit with more non recurrent measures than initially planned.

Work is ongoing through the divisions and Financial Recovery Board to identify additional mitigating CIP both for CIP that is not delivering and also to mitigate forecast overspends. No scheme will be implemented without consideration of Quality Impact Assessment or Equality Impact Assessment.

6. COVID-19

The Trust's covid related spend at Month 7 is £0.2m in line with budget.

7. Cash and Borrowings

The cash balance at the end of Month 7 was £5.5m, an increase from £3.3m at Month 6. This balance reflects the benefit of advanced payments and high creditor balances with some other C&M provider organisations.

This balance is below minimum levels set out in the Treasury Management policy (£5.9m minimum cash level). Cash levels are under close scrutiny. Support has been requested but not yet secured from the ICB.

The cashflow forecast assumes cash support via the ICB (which has not yet been agreed) in January 2023 and also assumes that part of the balance owed to local NHS organisations will be settled in March 2023. Discussions with the ICS regarding cash support have been escalated to the CFO. As at Month 6, there was over significant cash across C&M providers so the Trust is strongly advocating for a solution within the system. If this is not possible, revenue PDC support will be required, this will come at a cost.

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 7 is £4.2m underspent but spend is still forecast to plan, with most of the plan committed. Leads were asked to place orders by October so any remaining funding can be appropriately reallocated.

The Trust has submitted a case to support the Electronic Patient Record programme.

9. Balance Sheet

Accounts Receivable debt at Month 7 is £1.1m vs £2.6m at M6 and £1.5m at March 2022 as larger debts have been collected. A strong focus remains on debt collection.

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

10. Financial Recovery, Forecast and Risks

The forecast for the year, after £1.9m of recovery actions, is £2.9m off plan. Work is ongoing to close this gap. The forecast reported to NHSE remained on plan pending finalisation of the Recovery Plan. The level of net risk (after mitigations) was reported as £2.9m in line with the Trust's internal forecast.

The Forecast outturn by Division is as follows:

Division	Full Year Budget	FOT	Variance	Recovery Plan Assumed in the FOT
Family Health	(29,026)	(26,965)	(2,061)	674
Gynaecology	(8,949)	(6,447)	(2,501)	705
CSS	15,434	15,879	(445)	60
Corporate	22,015	19,966	2,048	430
Total LWH	(526)	2,433	(2,959)	1,869

11. BAF Risk

Due to the continued financial challenges in year, it was agreed at the Finance, Performance and Business Development Committee that a separate risk in relation to the in year financial position should be re-instated. This will be reflected in the BAF risk to FPBD in December.

12. Virements

A number of virements were actioned in M7, approved in line with the SFIs and are listed in the Appendix.

13. Conclusion & Recommendation

The Board is asked to receive the Month 7 position, noting the significant risks and challenges.

Liverpool Women's NHS Foundation Trust

Appendix A M7 Virements

Description	Directorate	Final Line	Subjective summary	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Sum of Year 1	Comment
2022-23 BCG Profiling	RISK MANAGEMENT	PAY EXPENDITURE	PAY BUDGET CODES	-	-	-	-	-	-	- 58,333	- 8,333	- 8,333	- 8,333	- 8,333	- 8,333	- 100,000	BCG Expenditure Budget
	NEONATAL	NON PAY EXPENDIT	ESTABLISHMENT EXPENSES	-	-	-	-	-	-	1,167	167	167	167	167	167	2,000	BCG Expenditure Budget
		PAY EXPENDITURE	ADMINISTRATIVE AND CLERICAL	-	-	-	-	-	-	16,700	2,386	2,386	2,386	2,386	2,386	28,628	BCG Expenditure Budget
			NURSING, MIDWIFERY AND HEALTH VISITING	-	-	-	-	-	-	40,467	5,781	5,781	5,781	5,781	5,781	69,372	BCG Expenditure Budget
2022-23 BCG Profiling Total				-	-	-	-	-	-	**0**	**0**	**0**	**0**	**0**	**0**	-	
2022-23 Contracts Managemen	RISK MANAGEMENT	NON PAY EXPENDIT	MISCELLANEOUS SERVICES	-	-	-	-	-	-	- 175,000	- 25,000	- 25,000	- 25,000	- 25,000	- 25,000	- 300,000	Contracts Management duplicated CIP
	GOVERNANCE	PAY EXPENDITURE	NURSING, MIDWIFERY AND HEALTH VISITING	-	-	-	-	-	-	-	-	-	-	-	-	-	Moving ADoNM budget to correct Subjective
	CONTRACT MANAGEI	NON PAY EXPENDIT	MISCELLANEOUS SERVICES	-	-	-	-	-	-	175,000	25,000	25,000	25,000	25,000	25,000	300,000	Contracts Management duplicated CIP
2022-23 Contracts Management Total				-	-	-	-	-	-	-	-	-	-	-	-	-	
2022-23 CSS Budget ADJ	GYNAECOLOGY	PAY EXPENDITURE	ADMINISTRATIVE AND CLERICAL	-	-	-	-	-	-	15,696	2,242	2,242	2,242	2,242	2,242	26,907	CSS 21/22 3% pay uplift correction
	THEATRES	PAY EXPENDITURE	HEALTHCARE ASSISTANTS AND OTHER SUPF	-	-	-	-	-	-	13,324	1,903	1,903	1,903	1,903	1,903	22,842	CSS 21/22 3% pay uplift correction
			HEALTHCARE SCIENTISTS	-	-	-	-	-	-	16,711	2,387	2,387	2,387	2,387	2,387	28,648	CSS 21/22 3% pay uplift correction
			MEDICAL AND DENTAL	-	-	-	-	-	-	67,140	9,591	9,591	9,591	9,591	9,591	115,097	CSS 21/22 3% pay uplift correction
			NURSING, MIDWIFERY AND HEALTH VISITING	-	-	-	-	-	-	34,555	4,937	4,937	4,937	4,937	4,937	59,238	CSS 21/22 3% pay uplift correction
	PHYSIOTHERAPY	PAY EXPENDITURE	ALLIED HEALTH PROFESSIONALS	-	-	-	-	-	-	4,023	575	575	575	575	575	6,897	CSS 21/22 3% pay uplift correction
	GENETICS SERVICES	PAY EXPENDITURE	ADMINISTRATIVE AND CLERICAL	-	-	-	-	-	-	1,073	153	153	153	153	153	1,839	CSS 21/22 3% pay uplift correction
			HEALTHCARE SCIENTISTS	-	-	-	-	-	-	114	16	16	16	16	16	196	CSS 21/22 3% pay uplift correction
			MEDICAL AND DENTAL	-	-	-	-	-	-	14,509	2,073	2,073	2,073	2,073	2,073	24,873	CSS 21/22 3% pay uplift correction
			NURSING, MIDWIFERY AND HEALTH VISITING	-	-	-	-	-	-	11,620	1,660	1,660	1,660	1,660	1,660	19,921	CSS 21/22 3% pay uplift correction
	IMAGING	PAY EXPENDITURE	ADMINISTRATIVE AND CLERICAL	-	-	-	-	-	-	872	125	125	125	125	125	1,495	CSS 21/22 3% pay uplift correction
			ALLIED HEALTH PROFESSIONALS	-	-	-	-	-	-	18,291	2,613	2,613	2,613	2,613	2,613	31,357	CSS 21/22 3% pay uplift correction
			EXECUTIVE BOARD AND SENIOR MANAGERS	-	-	-	-	-	-	1,786	255	255	255	255	255	3,062	CSS 21/22 3% pay uplift correction
			HEALTHCARE ASSISTANTS AND OTHER SUPF	-	-	-	-	-	-	1,209	173	173	173	173	173	2,072	CSS 21/22 3% pay uplift correction
			MEDICAL AND DENTAL	-	-	-	-	-	-	265	38	38	38	38	38	454	CSS 21/22 3% pay uplift correction
	PHARMACY	PAY EXPENDITURE	ADMINISTRATIVE AND CLERICAL	-	-	-	-	-	-	207	30	30	30	30	30	355	CSS 21/22 3% pay uplift correction
			HEALTHCARE SCIENTISTS	-	-	-	-	-	-	5,268	753	753	753	753	753	9,031	CSS 21/22 3% pay uplift correction
			SCIENTIFIC THERAPEUTIC AND TECHNICAL	-	-	-	-	-	-	6,801	972	972	972	972	972	11,659	CSS 21/22 3% pay uplift correction
	INTEGRATED ADMINIS	PAY EXPENDITURE	ADMINISTRATIVE AND CLERICAL	-	-	-	-	-	-	1,765	252	252	252	252	252	3,026	CSS 21/22 3% pay uplift correction
	RISK MANAGEMENT	PAY EXPENDITURE	PAY BUDGET CODES	-	-	-	-	-	-	- 215,231	- 30,747	- 30,747	- 30,747	- 30,747	- 30,747	- 368,967	CSS 21/22 3% pay uplift correction
2022-23 CSS Budget ADJ Total				-	-	-	-	-	-	- **0**	- **0**	- **0**	- **0**	- **0**	- **0**	- **0**	
2022-23 Gynae Budget ADJ	GYNAECOLOGY	PAY EXPENDITURE	ADMINISTRATIVE AND CLERICAL	-	-	-	-	-	-	9,868	1,410	1,410	1,410	1,410	1,410	16,917	Gynaecology 21/22 3% pay uplift correction
			HEALTHCARE ASSISTANTS AND OTHER SUPF	-	-	-	-	-	-	23,603	3,372	3,372	3,372	3,372	3,372	40,463	Gynaecology 21/22 3% pay uplift correction
			HEALTHCARE SCIENTISTS	-	-	-	-	-	-	795	114	114	114	114	114	1,362	Gynaecology 21/22 3% pay uplift correction
			MEDICAL AND DENTAL	-	-	-	-	-	-	96,805	13,829	13,829	13,829	13,829	13,829	165,952	Gynaecology 21/22 3% pay uplift correction
			NURSING, MIDWIFERY AND HEALTH VISITING	-	-	-	-	-	-	82,424	11,775	11,775	11,775	11,775	11,775	141,298	Gynaecology 21/22 3% pay uplift correction
	HEWITT FERILITY CENT	PAY EXPENDITURE	ADMINISTRATIVE AND CLERICAL	-	-	-	-	-	-	13,410	1,916	1,916	1,916	1,916	1,916	22,989	Gynaecology 21/22 3% pay uplift correction
			ALLIED HEALTH PROFESSIONALS	-	-	-	-	-	-	1,639	234	234	234	234	234	2,809	Gynaecology 21/22 3% pay uplift correction
			HEALTHCARE ASSISTANTS AND OTHER SUPF	-	-	-	-	-	-	5,323	761	761	761	761	761	9,126	Gynaecology 21/22 3% pay uplift correction
			HEALTHCARE SCIENTISTS	-	-	-	-	-	-	27,734	3,962	3,962	3,962	3,962	3,962	47,544	Gynaecology 21/22 3% pay uplift correction
			MEDICAL AND DENTAL	-	-	-	-	-	-	27,738	3,963	3,963	3,963	3,963	3,963	47,551	Gynaecology 21/22 3% pay uplift correction
			NURSING, MIDWIFERY AND HEALTH VISITING	-	-	-	-	-	-	25,698	3,671	3,671	3,671	3,671	3,671	44,054	Gynaecology 21/22 3% pay uplift correction
	RISK MANAGEMENT	PAY EXPENDITURE	PAY BUDGET CODES	-	-	-	-	-	-	- 315,037	- 45,005	- 45,005	- 45,005	- 45,005	- 45,005	- 540,064	Gynaecology 21/22 3% pay uplift correction
2022-23 Gynae Budget ADJ Total				-	-	-	-	-	-	- **0**	- **0**	- **0**	- **0**	- **0**	- **0**	- **0**	
2022-23 PDG pay uplift	GYNAECOLOGY	PAY EXPENDITURE	MEDICAL AND DENTAL	-	-	-	-	-	-	37,086	5,298	5,298	5,298	5,298	5,298	63,576	PGD 22/23 3% uplift
	THEATRES	PAY EXPENDITURE	MEDICAL AND DENTAL	-	-	-	-	-	-	21,727	3,104	3,104	3,104	3,104	3,104	37,246	PGD 22/23 3% uplift
	GENETICS SERVICES	PAY EXPENDITURE	MEDICAL AND DENTAL	-	-	-	-	-	-	3,374	482	482	482	482	482	5,784	PGD 22/23 3% uplift
	HEWITT FERILITY CENT	PAY EXPENDITURE	MEDICAL AND DENTAL	-	-	-	-	-	-	4,501	643	643	643	643	643	7,716	PGD 22/23 3% uplift
	RISK MANAGEMENT	NON PAY EXPENDIT	MISCELLANEOUS SERVICES	-	-	-	-	-	-	0	-	-	-	-	-	0	PGD 22/23 3% uplift
		PAY EXPENDITURE	PAY BUDGET CODES	-	-	-	-	-	-	- 124,768	- 17,824	- 17,824	- 17,824	- 17,824	- 17,824	- 213,889	PGD 22/23 3% uplift
	MATERNITY	PAY EXPENDITURE	MEDICAL AND DENTAL	-	-	-	-	-	-	34,111	4,873	4,873	4,873	4,873	4,873	58,477	PGD 22/23 3% uplift
	NEONATAL	PAY EXPENDITURE	MEDICAL AND DENTAL	-	-	-	-	-	-	22,845	3,264	3,264	3,264	3,264	3,264	39,163	PGD 22/23 3% uplift
	RESEARCH AND DEVE	PAY EXPENDITURE	MEDICAL AND DENTAL	-	-	-	-	-	-	1,125	161	161	161	161	161	1,928	PGD 22/23 3% uplift
2022-23 PDG pay uplift Total				-	-	-	-	-	-	- **0**	- **0**	- **0**	- **0**	- **0**	- **0**	- **0**	
2022-23 System Funding	RISK MANAGEMENT	PAY EXPENDITURE	MEDICAL AND DENTAL	-	-	-	-	-	-	583,331	83,333	83,333	83,333	83,333	83,333	999,996	Realinging Annual Leave & System agreed Plan to Pay reserves
			NURSING, MIDWIFERY AND HEALTH VISITING	-	-	-	-	-	-	906,620	129,517	129,517	129,517	129,517	129,517	1,554,205	Realinging Annual Leave & System agreed Plan to Pay reserves
			PAY BUDGET CODES	-	-	-	-	-	-	- 1,489,951	- 212,850	- 212,850	- 212,850	- 212,850	- 212,850	- 2,554,201	Realinging Annual Leave & System agreed Plan to Pay reserves
2022-23 System Funding Total				-	-	-	-	-	-	-	-	-	-	-	-	-	
2022-23 Vacancy factor	RISK MANAGEMENT	PAY EXPENDITURE	ADMINISTRATIVE AND CLERICAL	-	-	-	-	-	-	36,050	5,150	5,150	5,150	5,150	5,150	61,800	Aligning Vacancy Factor to Consultant Subjective
			AGENCY STAFF EXTERNAL	-	-	-	-	-	-	- 486,675	- 69,525	- 69,525	- 69,525	- 69,525	- 69,525	- 834,300	Aligning Vacancy Factor to Consultant Subjective
			HEALTHCARE ASSISTANTS AND OTHER SUPF	-	-	-	-	-	-	126,147	- 231	- 231	- 231	- 231	- 231	124,992	Aligning Vacancy Factor to Consultant Subjective
			MEDICAL AND DENTAL	-	-	-	-	-	-	- 313,978	- 26,602	- 26,602	- 26,602	- 26,602	- 26,602	- 446,988	Aligning Vacancy Factor to Consultant Subjective
			NURSING, MIDWIFERY AND HEALTH VISITING	-	-	-	-	-	-	638,456	91,208	91,208	91,208	91,208	91,208	1,094,496	Aligning Vacancy Factor to Consultant Subjective
2022-23 Vacancy factor Total				-	-	-	-	-	-	-	-	-	-	-	-	-	
22-23 Budget Upload	THEATRES	PAY EXPENDITURE	ADMINISTRATIVE AND CLERICAL	-	-	-	-	-	-	- 62,631	- 62,631	- 62,631	- 62,631	- 62,631	- 62,631	- 375,788	Moving Theatres approved business case budget to Correct subjectives from Admin subjective
			HEALTHCARE ASSISTANTS AND OTHER SUPF	-	-	-	-	-	-	1,530	1,530	1,530	1,530	1,530	1,530	9,178	Moving Theatres approved business case budget to Correct subjectives from Admin subjective
			HEALTHCARE SCIENTISTS	-	-	-	-	-	-	61,102	61,102	61,102	61,102	61,102	61,102	366,610	Moving Theatres approved business case budget to Correct subjectives from Admin subjective
22-23 Budget Upload Total				-	-	-	-	-	-	-	-	-	-	-	-	-	
22-23 Payaward Virement	CENTRAL INCOME	INCOME	INCOME FROM ACTIVITIES	-	-	-	-	-	-	-	-	-	-	-	-	-	Pay uplift income subjective correction from CCG to NHSE
22-23 Payaward Virement Total				-	-	-	-	-	-	-	-	-	-	-	-	-	
Grand Total				-	-	-	-	-	-	**0**	- **0**	- **0**	- **0**	- **0**	- **0**	-	

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

FINANCE REPORT: M7

YEAR ENDING 31 MARCH 2023

Liverpool Women's
NHS Foundation Trust

Contents

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 1
NHS IMPROVEMENT RATIOS: M7
YEAR ENDING 31 MARCH 2023

USE OF RESOURCES RISK RATING	YEAR TO DATE Actual
CAPITAL SERVICING CAPACITY (CSC)	
(a) EBITDA + Interest Receivable	5,081
(b) PDC + Interest Payable + Loans Repaid	1,422
CSC Ratio = (a) / (b)	**3.57**
NHSI CSC SCORE	**1**
Ratio Score 1 = > 2.5 2 = 1.75 - 2.5 3 = 1.25 - 1.75 4 = < 1.25	
LIQUIDITY	
(a) Cash for Liquidity Purposes	(14,538)
(b) Expenditure	80,941
(c) Daily Expenditure	529
Liquidity Ratio = (a) / (c)	**(27.5)**
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)	(274)
Total Income	(85,958)
I&E Margin	**0.3%**
NHSI I&E MARGIN SCORE	**2**
Ratio Score 1 = > 1% 2 = 1 - 0% 3 = 0 - (-1%) 4 < (-1%)	
I&E MARGIN VARIANCE FROM PLAN	
I&E Margin (Actual)	0.30%
I&E Margin (Plan)	0.90%
I&E Variance Margin	**-0.60%**
NHSI I&E MARGIN VARIANCE SCORE	**2**
Ratio Score 1 = > 0% 2 = (1) - 0% 3 = (2) - (1)% 4 = < (2)%	
Note: NHSI assume the score of the I&E Margin variance from Plan is a 1 for the whole year	
AGENCY SPEND	
YTD Providers Cap	490
YTD Agency Expenditure	1,990
	306%
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: M7
YEAR ENDING 31 MARCH 2023

INCOME & EXPENDITURE	Month 7			YTD			YEAR		
£'000	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Forecast	Variance
Income									
Clinical Income	(11,434)	(11,829)	395	(79,840)	(81,555)	1,714	(137,008)	(138,632)	1,623
Non-Clinical Income	(623)	(715)	92	(4,289)	(4,403)	114	(7,404)	(7,611)	207
Total Income	**(12,057)**	**(12,544)**	**487**	**(84,130)**	**(85,958)**	**1,828**	**(144,413)**	**(146,243)**	**1,830**
Expenditure									
Pay Costs	6,905	7,768	(864)	47,133	52,486	(5,353)	81,856	89,472	(7,616)
Non-Pay Costs	2,864	3,188	(324)	19,691	16,998	2,693	33,641	31,514	2,127
CNST	1,637	1,637	(0)	11,457	11,457	(0)	19,640	19,640	(0)
Total Expenditure	**11,405**	**12,593**	**(1,188)**	**78,281**	**80,941**	**(2,660)**	**135,137**	**140,627**	**(5,489)**
EBITDA	**(652)**	**49**	**(700)**	**(5,849)**	**(5,017)**	**(832)**	**(9,275)**	**(5,616)**	**(3,659)**
Technical Items									
Depreciation	521	353	168	3,648	3,402	246	6,254	5,856	398
Interest Payable	2	3	(0)	17	17	(0)	29	32	(3)
Interest Receivable	(1)	(12)	11	(7)	(65)	58	(12)	(143)	131
PDC Dividend	207	173	33	1,446	1,405	41	2,478	2,305	173
Profit/Loss on Disposal or Transfer Absorption	0	0	0	0	0	0	0	0	0
Total Technical Items	**729**	**517**	**212**	**5,104**	**4,759**	**345**	**8,749**	**8,049**	**700**
(Surplus) / Deficit	**78**	**566**	**(488)**	**(745)**	**(257)**	**(487)**	**(526)**	**2,433**	**(2,959)**

Please note that the forecast reported to the ICB and NHSE at Month 7 remained on plan, however net risk equating to £2,959k was also reported. The ICB are aware that the Trust will not achieve its plan without recovery actions.

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 2a
INCOME & EXPENDITURE HOSTED SERVICES: M7
YEAR ENDING 31 MARCH 2023

INCOME & EXPENDITURE £'000	Month 7 Budget	Month 7 Actual	Month 7 Variance	YTD Budget	YTD Actual	YTD Variance	YEAR Budget	YEAR Forecast	YEAR Variance
Income									
Clinical Income	(115)	(585)	471	(802)	(2,271)	1,470	(1,374)	(3,893)	2,519
Non-Clinical Income	0	0	0	0	16	(16)	0	12	(12)
Total Income	**(115)**	**(585)**	**471**	**(802)**	**(2,255)**	**1,454**	**(1,374)**	**(3,882)**	**2,508**
Expenditure									
Pay Costs	0	97	(97)	0	651	(651)	0	1,603	(1,603)
Non-Pay Costs	115	492	(377)	802	1,604	(802)	1,374	2,279	(905)
Total Expenditure	**115**	**589**	**(474)**	**802**	**2,255**	**(1,454)**	**1,374**	**3,882**	**(2,508)**
(Surplus) / Deficit	**0**	**4**	**(4)**	**0**	**0**	**0**	**0**	**0**	**(0)**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 3
ELECTIVE RECOVERY FUND ESTIMATE: M7
YEAR ENDING 31 MARCH 2023

	19/20 Baseline (104%)		22/23		22/23 v 19/20 Baseline		ERF Plan £000	ERF Achieved £000	ERF Variance £000
	Activity	Costed Activity £000	Activity	Costed Activity £000	Activity Variance	Costed Activity Variance			
Month 1		1,634		1,730		95	165	209	**44**
Month 2		1,813		2,053		240	182	222	**40**
Month 3		1,761		1,618		-143	174	30	**-144**
Month 4		1,831		1,621		-210	182	29	**-153**
Month 5		1,920		1,682		-238	191	12	**-179**
Month 6		2,016		1,736		-279	182	-49	**-231**
Month 7		1,787		1,746		-40	182	137	**-45**
Total Income		**12,761**		**12,186**		**-575**	**1,258**	**591**	**-667**
Adjustment back to plan							0	667	**667**
PY ERF Improvement							0	373	**373**
Total Variance							**1,258**	**1,631**	**372**

* ERF baseline is 104% of 2019/20 activity with the exception of Outpatient Follow Ups which are at 85% of 2019/20. This has been adjusted for pathway changes in Termination of Pregnancy.

NHS
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LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 4
EXPENDITURE: M7
YEAR ENDING 31 MARCH 2023

EXPENDITURE £'000	MONTH 7 Budget	MONTH 7 Actual	MONTH 7 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	436	448	(12)	2,960	3,111	(151)	5,133	5,357	(224)
Medical	2,365	2,054	311	12,668	13,763	(1,095)	22,205	23,404	(1,198)
Nursing & Midwifery	4,567	3,215	1,352	21,462	21,655	(193)	36,840	37,741	(901)
Healthcare Assistants	673	545	128	3,554	3,649	(95)	6,099	6,366	(267)
Other Clinical	(1,531)	438	(1,970)	1,517	3,174	(1,658)	2,953	5,013	(2,060)
Admin Support	813	778	35	4,972	5,143	(170)	8,626	9,049	(424)
Agency & Locum	(417)	289	(707)	0	1,990	(1,990)	0	2,541	(2,541)
Total Pay Costs	**6,905**	**7,768**	**(864)**	**47,133**	**52,486**	**(5,353)**	**81,856**	**89,472**	**(7,616)**
Non Pay Costs									
Clinical Suppplies	689	780	(92)	4,892	5,654	(763)	8,404	9,864	(1,459)
Non-Clinical Supplies	329	240	89	1,957	(1,084)	3,041	3,174	(1,371)	4,545
CNST	1,637	1,637	(0)	11,457	11,457	(0)	19,640	19,640	(0)
Premises & IT Costs	1,004	501	503	7,061	5,451	1,610	12,069	10,258	1,812
Service Contracts	842	1,666	(823)	5,781	6,977	(1,196)	9,994	12,764	(2,771)
Total Non-Pay Costs	**4,500**	**4,824**	**(324)**	**31,148**	**28,455**	**2,693**	**53,281**	**51,155**	**2,127**
Total Expenditure	**11,405**	**12,593**	**(1,188)**	**78,281**	**80,941**	**(2,660)**	**135,137**	**140,627**	**(5,489)**

NHS
Liverpool Women's
NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 5
COVID EXPENDITURE: M7
YEAR ENDING 31 MARCH 2023

EXPENDITURE £'000	MONTH 7 Budget	MONTH 7 Actual	MONTH 7 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)	15	22	1	20	38	1	36
Medical	0	0	0	0	(0)	0	0	(0)	0
Nursing & Midwifery	12	0	12	85	1	84	145	1	145
Healthcare Assistants	0	0	(0)	0	18	(18)	0	18	(18)
Other Clinical	0	0	0	0	(0)	0	0	(0)	0
Admin Support	0	3	(3)	0	62	(62)	0	87	(87)
Agency & Locum	0	0	0	0	0	0	0	0	0
Total Pay Costs	**15**	**(8)**	**23**	**107**	**81**	**25**	**183**	**106**	**76**
Non Pay Costs									
Clinical Suppplies	0	10	(10)	0	38	(38)	0	58	(58)
Non-Clinical Supplies	11	(14)	25	77	0	77	132	0	132
CNST	0	0	0	0	0	0	0	0	0
Premises & IT Costs	0	4	(4)	0	83	(83)	0	83	(83)
Service Contracts	0	24	(24)	0	0	0	0	0	0
Total Non-Pay Costs	**11**	**24**	**(13)**	**77**	**121**	**(44)**	**132**	**141**	**(9)**
Total Expenditure	**26**	**17**	**10**	**183**	**202**	**(18)**	**315**	**247**	**68**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 6
BUDGET ANALYSIS: M7
YEAR ENDING 31 MARCH 2023

INCOME & EXPENDITURE	MONTH 7			YEAR TO DATE			YEAR - Internal		
£'000	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Actual	Variance
Maternity									
Income	(4,156)	(4,407)	251	(28,902)	(29,564)	662	(50,260)	(50,557)	297
Expenditure	2,266	2,541	(275)	15,641	16,849	(1,208)	26,826	28,620	(1,794)
Total Maternity	**(1,890)**	**(1,866)**	**(24)**	**(13,262)**	**(12,715)**	**(546)**	**(23,435)**	**(21,937)**	**(1,497)**
Neonatal									
Income	(1,767)	(1,811)	44	(12,299)	(12,371)	72	(21,351)	(21,389)	38
Expenditure	1,383	1,392	(9)	9,193	9,779	(586)	15,760	16,362	(602)
Total Neonatal	**(384)**	**(419)**	**34**	**(3,106)**	**(2,591)**	**(514)**	**(5,591)**	**(5,028)**	**(563)**
Division of Family Health - Total	**(2,274)**	**(2,284)**	**10**	**(16,368)**	**(15,307)**	**(1,061)**	**(29,026)**	**(26,965)**	**(2,061)**
Gynaecology									
Income	(2,022)	(2,050)	28	(14,038)	(13,990)	(48)	(24,425)	(24,247)	(178)
Expenditure	1,522	1,552	(31)	9,256	10,094	(838)	15,926	17,001	(1,074)
Total Gynaecology	**(500)**	**(498)**	**(3)**	**(4,782)**	**(3,896)**	**(886)**	**(8,499)**	**(7,246)**	**(1,253)**
Hewitt Centre									
Income	(751)	(934)	183	(5,240)	(5,348)	108	(9,228)	(9,390)	162
Expenditure	822	863	(41)	5,121	5,841	(720)	8,779	10,189	(1,410)
Total Hewitt Centre	**71**	**(70)**	**142**	**(119)**	**493**	**(612)**	**(449)**	**799**	**(1,248)**
Division of Gynaecology - Total	**(429)**	**(568)**	**139**	**(4,901)**	**(3,403)**	**(1,498)**	**(8,949)**	**(6,447)**	**(2,501)**
Theatres									
Income	0	0	0	0	0	0	0	0	0
Expenditure	1,151	935	215	6,695	6,666	28	11,790	11,538	252
Total Theatres	**1,151**	**935**	**215**	**6,695**	**6,666**	**28**	**11,790**	**11,538**	**252**
Genetics									
Income	(13)	(11)	(2)	(89)	(49)	(40)	(152)	(91)	(61)
Expenditure	200	196	4	1,158	980	178	2,026	1,692	334
Total Genetics	**187**	**185**	**2**	**1,069**	**931**	**138**	**1,874**	**1,601**	**273**
Other Clinical Support									
Income	(731)	(759)	28	(5,087)	(4,148)	(938)	(8,793)	(8,186)	(607)
Expenditure	1,066	951	115	6,159	5,661	498	10,564	10,926	(362)
Total Clinical Support	**335**	**192**	**143**	**1,072**	**1,513**	**(440)**	**1,771**	**2,741**	**(970)**
Division of Clinical Support - Total	**1,673**	**1,313**	**360**	**8,836**	**9,110**	**(274)**	**15,434**	**15,879**	**(445)**
Corporate & Trust Technical Items									
Income	(2,731)	(3,162)	431	(19,277)	(22,743)	3,466	(31,577)	(36,264)	4,687
Expenditure	3,839	5,268	(1,428)	30,965	32,085	(1,120)	53,591	56,230	(2,640)
Total Corporate	**1,108**	**2,105**	**(997)**	**11,688**	**9,342**	**2,346**	**22,014**	**19,967**	**2,047**
(Surplus) / Deficit	**78**	**566**	**(488)**	**(745)**	**(257)**	**(487)**	**(526)**	**2,433**	**(2,959)**
Of which is hosted;									
Income	(115)	(589)	475	(802)	(2,255)	1,454	(1,374)	(3,882)	2,508
Expenditure	115	589	(474)	802	2,255	(1,454)	1,374	3,882	(2,508)
Total Corporate	**0**	**(0)**	**0**	**0**	**0**	**0**	**0**	**0**	**(0)**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 7
CIP: M7
YEAR ENDING 31 MARCH 2023

	Month 7			YTD M7			2022/23		
Scheme	**Target**	**Actual**	**Variance**	**Target**	**Actual**	**Variance**	**Target**	**FOT**	**Variance**
Procurement and Non Pay	153	118	-35	1,067	1,869	802	1,835	2,467	632
Estates utilisation	34	12	-22	241	112	-129	412	173	-239
Staffing and skill mix	173	158	-15	1,212	1,103	-108	2,078	1,892	-186
Medicines Management	3	0	-3	18	0	-18	30	0	-30
Service Developments	0	0	0	0	0	0	0	0	0
Theatre Efficiency	37	0	-37	237	0	-237	369	0	-369
Technology Driven Efficiencies	9	6	-3	62	28	-34	106	57	-49
Income	68	74	6	434	785	351	773	1,120	347
Other Savings Plans	0	0	0	0	0	0	0	0	0
Total	**477**	**367**	**-110**	**3,270**	**3,897**	**627**	**5,603**	**5,709**	**106**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 8
BALANCE SHEET: M7
YEAR ENDING 31 MARCH 2023

BALANCE SHEET £'000	YEAR TO DATE Opening	M07 Actual	Movement
Non Current Assets	101,380	101,207	(173)
Current Assets			
Cash	11,192	5,527	(5,665)
Debtors	5,929	9,760	3,831
Inventories	523	665	142
Total Current Assets	**17,644**	**15,952**	**(1,692)**
Liabilities			
Creditors due < 1 year - Capital Payables	(4,849)	(2,055)	2,794
Creditors due < 1 year - Trade Payables	(18,362)	(18,088)	274
Creditors due < 1 year - Deferred Income	(4,157)	(7,819)	(3,662)
Creditors due > 1 year - Deferred Income	(1,561)	(1,543)	18
Loans	(1,525)	(1,219)	306
Loans - IFRS16 leases	(49)	(34)	15
Provisions	(3,889)	(1,512)	2,377
Total Liabilities	**(34,392)**	**(32,270)**	**2,122**
TOTAL ASSETS EMPLOYED	**84,632**	**84,889**	**257**
Taxpayers Equity			
PDC	70,713	70,713	0
Revaluation Reserve	12,749	12,749	0
Retained Earnings	1,170	1,427	257
TOTAL TAXPAYERS EQUITY	**84,632**	**84,889**	**257**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 9
CASHFLOW STATEMENT: M7
YEAR ENDING 31 MARCH 2023

CASHFLOW STATEMENT £'000	Actual
Cash flows from operating activities	1,614
Depreciation and amortisation	3,402
Impairments and reversals	0
Income recognised in respect of capital donations (cash and non-cash)	0
Movement in working capital	(2,922)
Net cash generated from / (used in) operations	**2,094**
Interest received	60
Purchase of property, plant and equipment and intangible assets	(6,177)
Proceeds from sales of property, plant and equipment and intangible assets	0
Net cash generated from/(used in) investing activities	**(6,117)**
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	**(5,665)**
Cash and cash equivalents at start of period	11,192
Cash and cash equivalents at end of period	**5,527**

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	(4,281)	1,219
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**	**(33,465)**	**1,219**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 10
CAPITAL EXPENDITURE: M7
YEAR ENDING 31 MARCH 2023

CAPITAL EXPENDITURE £'000	Year to Date Plan	Actual	Variance	FOT Plan	Actual	Variance
Estates	608	74	534	800	800	0
Capital Projects	4,357	2,201	2,156	4,527	4,527	0
IM&T	631	740	(109)	1,282	1,282	0
Medical Equipment	1,867	262	1,605	2,211	2,211	0
Grand Total	7,463	3,277	4,186	8,820	8,820	0

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	**22/23/166c**		**Date: 01/12/2022**	
Report Title	**Recovery Plan**			
Prepared by	***Eva Horgan, Chief Finance Officer***			
Presented by	***Eva Horgan, Chief Finance Officer***			
Key Issues / Messages	***The Board is asked to take receive the report detailing the approach to Financial Recovery 2022/23.***			
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 report.			
Supporting Executive:	***Eva Horgan, Chief Finance Officer***			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

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

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

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

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Executive Committee	09/11/2022	Chief Finance Officer	The Committee reviewed and discussed the plan.
Finance, Performance and Business Development Committee	21/11/2022	Chief Finance Officer	The Committee received and discussed the plan and asked the Executive Team to further review.
Executive Committee	23/11/2022	Chief Finance Officer	The Committee reviewed and discussed the plan.

EXECUTIVE SUMMARY

As at Month 6, the Trust had a £4m gap identified to achieving the agreed plan of a £526k surplus for 2022/23. A Recovery Plan has been prepared. This has a total identified opportunity of £5.3m of which £1.9m was included in the Month 7 forecast. However many of these opportunities require further work up or decision including Quality Impact Assessment. The Trust also faces a number of risks which have not yet materialised and so are not included in the forecast out turn.

Significant work has gone into producing and implementing a recovery plan, which is summarised as at the time of writing in the table below. Although more actions have been identified than required, not all of these will be possible or pass the Quality Impact Assessment process.

Gross Estimated Saving £000	Non Recurrent	Recurrent	Total £000
Agency and Premium Pay	25	146	171
Balance Sheet and Non Recurrent	1,461		1,461
Capital	920		920
Defer Investment	60	180	240
Income	215	1,261	1,476
Non Pay, Procurement and Contracts	665	43	708
Productivity		147	147
Service		164	164
Total £000	**3,346**	**1,941**	**5,287**

Progress against this and development of further schemes will be managed by the Financial Recovery Board which will increase in frequency to fortnightly, and also via the Executive Team, FPBD and Board.

The Board is asked to receive and discuss the Recovery Plan.

MAIN REPORT

1. Introduction

Like many NHS organisations, LWH is facing significant financial challenge in 2022/23 and is at risk of not being able to deliver its financial plan. Whilst the Trust has been in deficit in the past, this has been agreed with regulators and planned for when it has happened. The 2022/23 plan is a small surplus position (£0.5m). As at Month 6 forecast out-turn (FOT) there was a £4m gap to achieving this to be bridged, even after assumptions on reducing run rate by further controls on agency and other spend. This reduced to £3m at Month 7 after £1.9m of recovery actions in the forecast (less £0.9m change following review of Month 7 actuals).

The Trust has put together a plan for recovering this financial position for the 2022/23 financial year; this is evolving and being added to over time. Further work will be undertaken for 2023/24 and beyond to try to move the organisation to a more sustainable financial footing where this is possible, noting the structural, underlying deficit that is in place.

This summary plan sets out the context, the reasons for the overspend, and what is being done to address it. It is supported by a number of detailed Recovery Plans at a Trustwide and Divisional level.

2. Context and Background

LWH has longstanding, structural financial challenges. This was formally called out in 2014 and has been clearly understood and communicated since then. The position is worsening each year as more clinical mitigations are put in place to stay as safe as possible on site.

There has also been a backdrop of increasingly prescriptive requirements in a number of areas, most notably maternity, without commensurate funding attached.

LWH was also significantly disadvantaged by the way the Covid baseline income values were set. Essentially these were based on expenditure in 2019/20 when the Trust's

expenditure in that year was artificially low due to the release of non-recurrent mitigations and phasing of the CNST Maternity Incentive, meaning that the values were c£12m lower than cost. This has been covered to varying degrees by non recurrent system funding.

For the past number of years the Trust has been reliant on non-recurrent measures but has been able to manage its position to meet or exceed plan as shown below.

	2019/20	2020/21	2021/22	2022/23 M6 FOT
Surplus/(Deficit) £000	272	-3,992	42	562

Table One: Surplus/Deficit 19/20 to 22/23 FOT

The 2022/23 underlying position is given in Appendix One. The Trust position has been supported by

- A range of contractual arrangements pre-pandemic. The Trust cannot cover costs through PbR income alone.
- Financial Recovery Fund/ Other Non-recurrent central income was provided up to 2019/20.
- In 2020/21-2022/23, "System" or "Top Up" income has been provided.
- Balance sheet releases e.g. provision releases.
- Non recurrent benefits such as VAT reviews.

3. Movement Since 2019/20 – Productivity and Run Rate

It should be noted that only around a third of the Trust's service provision relates to areas which include an element of planned care (i.e. Gynaecology, Fertility and Clinical Genetics). The majority (over 60%) of the work the Trust undertakes is in Maternity, Neonatal and Fetal Medicine.

Elective activity in totality has reduced since 2019/20, but there has been a significant increase in Neonatal activity. Deliveries have not increased in absolute terms but complexity has, with an increase of surgical and instrumental deliveries.

The Trust has also needed to make significant investments into staying safe on site, Ockenden and to manage other clinical pressures.

In Gynaecology acuity has increased significantly (with the average tariff on a like for like basis nearly 10% higher than in 2019/20). Consultant numbers in Gynaecology in 2019/20 were significantly depleted and individuals were undertaking significant additional activity in order to maintain safety at that time.

In addition, there have been some movements in referral patterns, for example an increase in two week urgent cancer referrals; this activity has to be prioritised.

A number of measures have been taken which have increased cost but not improved productivity e.g. to support recruitment and retention and payment for administrative time that was previously unremunerated.

However, there are also areas that have been identified for improvement, for example the Trust is undertaking work to look at The Productive Operating Theatre improvement programme. The Trust has put itself forward as an early adopter of the C&M improved theatre scheduling programme.

4. Plan 2022/23 and Variances

The position as at Month 6 was reported as on plan year to date (YTD) as outlined in the table below. However this was reliant on a level of non recurrent mitigation which may not be available in the second half of the year. The table shows the key variances against plan.

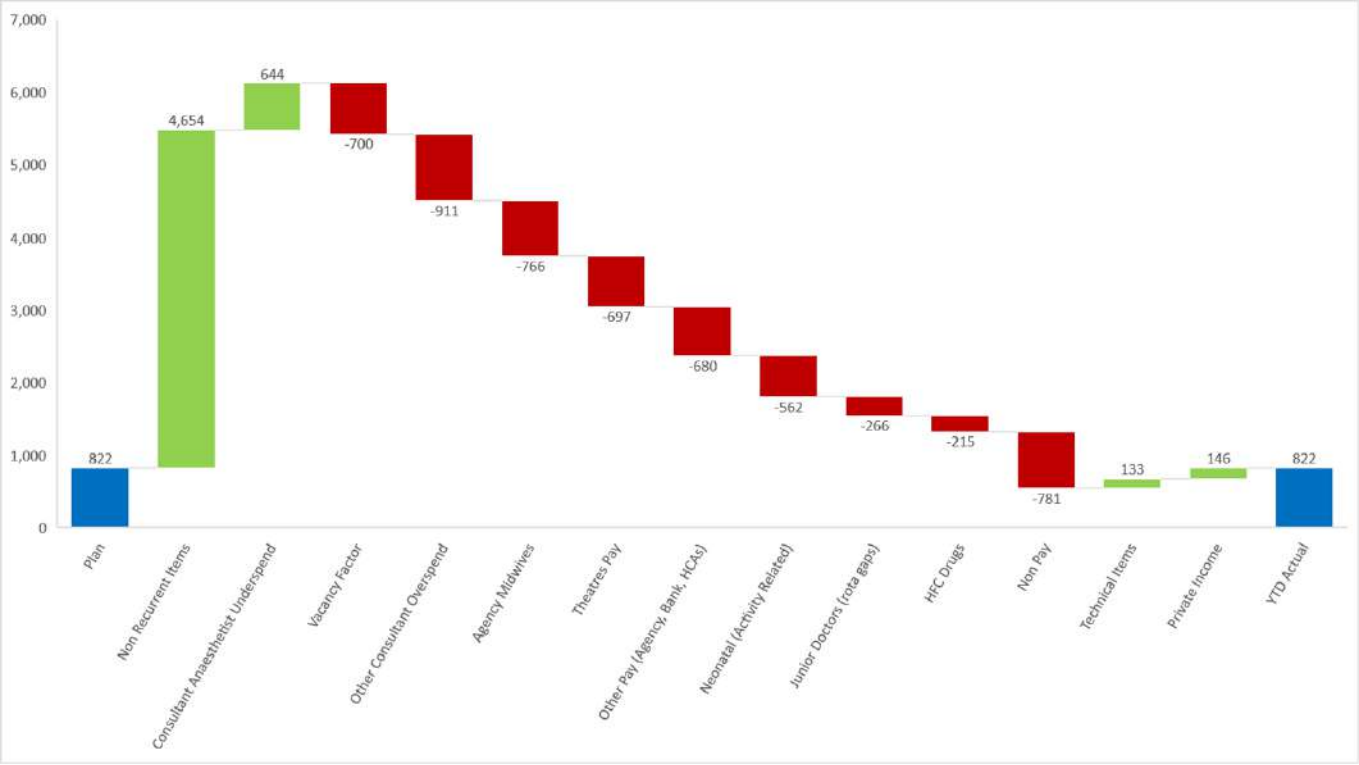


Chart Two: Key Variances YTD Month 6

There is a national shortage of midwives. Significant recruitment has occurred and from November there will be a substantial reduction in unplanned agency spend following recruitment and preceptorship.

In addition there has been a significant gap in the post graduate doctor trainee provision required. This has resulted in capacity being reduced from Consultant and Senior Team which affects planned work and therefore recovery. These gaps are likely to continue for the remainder of the year.

There are also significant pressures in the Neonatal service where activity has been significantly higher than the unit is funded for.

There are a number of drivers to these variances. Some of them are controllable (e.g. choosing a more expensive drug or piece of equipment, productivity (e.g. starting theatre sessions late) and some are outside of the Trust's control (e.g. post graduate doctor gaps,

national workforce shortages, excess inflation, activity/acuity driven overspends), and some may be a mixture or more nuanced (e.g. having to pay a premium rate due to lack of clinical staff availability). The Trust has assessed that the majority of its overspend relates to uncontrollable factors, for which mitigation must be found, but there was around a third of the overspend before mitigation which was deemed to be controllable, all of these expenditure lines have been reviewed and action taken to reduce spend where possible.

5. Risks and Opportunities to FOT

The forecast represents the Trust's assessment of the most likely position before mitigations/ recovery actions have been applied. There are a number of risks which have not yet materialised. There are two particular risks which could impact the Trust's ability to achieve its plans – namely the Elective Recovery Fund (ERF) and the Community Diagnostic Centre (CDC). Under the national rules for ERF, there would potentially be a clawback for under achievement. The payment mechanism for the CDC is under review.

The range of scenarios was presented to FPBD and, at this stage, remains wide. The best case is achievement of plan, likely currently stands at a £3m adverse variance, although this should improve as recovery actions are undertaken. The worst case, should all risks materialise, is a significantly worse deficit position.

6. Recovery Plan

A Recovery Plan has been produced. Estimated values are in place against some of the schemes but this is still being worked up. Key themes are:

- **Agency and Premium Pay**: There are a number of workstreams underway to reduce this spend. These include ensuring all approvals for usage are made by senior leaders, recruitment campaigns for permanent staff, a programme to support retention, management of sickness, removal of incentive payments and review of premium pay rates.
- **Neonatal Service:** Discussions are underway with commissioners about how this is to be managed, given the significant increase in activity and consequent staffing requirement above budget.
- **Deferral of Investment:** A number of planned investments have been paused and will be reviewed as part of operational planning 2023/24.
- **Capital:** A review is underway to ensure any obsolete assets are impaired, asset lives are reviewed, and all capital expenditure is captured. In addition, the capital plan for the remainder of the year is being reviewed line by line to see if there is anything that can be deferred to both reduce capital charges and also improve cash. This is subject to Quality Impact Assessment (QIA).
- **Productivity and Efficiency**: There is a Productive Operating Theatre workstream underway, this will form part of CIP going forward.
- **Service Change:** Any areas where service can be looked at, e.g. provision out of hours, is being looked at. This is subject to QIA.
- **Income:** A detailed look at all aspects of income has been undertaken and has already yielded some successes, e.g. updating arrangements and ensuring all billing is undertaken for service provided.
- **Non Pay, Procurement and Contracts:** Contracts have been looked at to ensure the Trust is not paying for any goods or services that are not required, and that prices charged are reasonable.

- **Balance Sheet and Non-Recurrent Items**: A full review of the balance sheet to ensure, for example, that accruals, provisions and deferred income has been appropriately released. In addition, a number of one off opportunities including sale of equipment have been identified.

The approach taken to Recovery at LWH is to have individual divisional Recovery Plans aggregated up to a trustwide plan, overlaid with trustwide and corporate potential savings. Work on this is ongoing and evolving so the summary below represents a snapshot. The table below shows the currently summarised identified opportunities with estimated in-years savings values (compared to the Month 6 FOT). However, note that a number of areas are being worked up and some of these numbers could increase (as well as potentially reduce). Whilst current gross identified recovery actions are above the gap in the forecast, not all of them are likely to be fully realised.

Gross Estimated Saving £000	Non Recurrent	Recurrent	Total £000
Agency and Premium Pay	25	146	171
Balance Sheet and Non Recurrent	1,461		1,461
Capital	920		920
Defer Investment	60	180	240
Income	215	1,261	1,476
Non Pay, Procurement and Contracts	665	43	708
Productivity		147	147
Service		164	164
Total £000	**3,346**	**1,941**	**5,287**

Table Three: Summary Recovery Plan, Month 6 FOT

There are a range of potential opportunities available. Most of these are non-recurrent in nature and some will cause additional pressure into 2023/24.

However there are also recurrent savings and areas that will have a full year effect into 2023/24.

Opportunities have been identified through a variety of means, e.g.:

- Review of NHSI Grip and Control Checklist (done previously through Financial Recovery Board)
- Use of the Trust's CIP identification methodology (e.g. increasing patient facing time, use of benchmarking such as model hospital, GIRFT etc).
- Detailed review of budgets and spend areas
- Discussion within divisions.

Work will continue as the situation evolves.

In addition the Trust is pursuing other avenues for both short and longer term efficiency opportunities. These include:

- Ensuring policies and processes are as robust as possible, through use of the HFMA Financial Sustainability Checklist and other means.

- Taking part in the "Liverpool Pound" work, with other Liverpool based NHS providers, to explore opportunities for collaboration or identification of opportunities, and sharing of best practice.
- Use of regional and nationally available tools such as the Productive series and Productivity analysis from NHS England colleagues.

Also note that a number of Executives are leading on different areas of recovery, this includes:

- Review of supernumerary time, retention of staff – Chief Nurse and Midwife
- Consultant WLIs and additional payments – Medical Director
- Productivity and Efficiency – Chief Operating Officer

It should also be noted that there are a number of opportunities or avenues being pursued which aren't quantified above. These include:

- Engagement with Specialised Commissioning- there is significant overperformance in Neonatal and FMU
- Review of availability of additional capital and revenue funds.

Also note that divisions and leadership teams are working on other supporting measures including:

- Retention schemes to keep staff in post and therefore reduce reliance on agency and bank.
- Further efforts on sickness rates.
- Ensuring there is clear grip and control in place at all levels in divisions, e.g. increasing seniority of staff signing off agency or bank usage or reducing approval limits.

The Trust is also using all available tools from the national and regional team (including analysis and bridges), benchmarking and joint working within Liverpool and C&M to ensure all opportunities are explored.

7. Risks to Delivery

The savings identified above are estimated, gross savings. Many of them require an active decision and Quality and Equality Impact Assessments. Values may differ or they may not be feasible to action once fully worked through. All potential recovery actions and savings have been rated as high, medium or low for both likelihood of delivery and also for the accuracy of the estimate. These will be kept under a watching brief with items expected to become clearer as schemes are worked up.

		Confidence in Delivery			
		Low	Medium	High	Total £000
Confidence in Value Estimate	Low	849	20	1,476	**2,345**
	Medium	38	698	70	**806**
	High	17	0	2,119	**2,136**
	Total	**904**	**718**	**3,665**	**5,287**

Table Four: Recovery Actions, Split by Confidence in Delivery and Estimated Value

As can be seen above, c£2m of identified actions are rated high in both confidence in delivery and value, including those items in the Month 7 Forecast position. This should improve over time.

There are a number of other risks and actions including the following:

- This process has been led by Operations and Finance so far. It's vital that clinical decision makers are engaged in the process.
- There needs to be buy in across the board including NEDs, executive team and senior leadership. This needs to be prioritised amongst many other clinical and operational priorities.
- There are a number of risks as well as opportunities to the position.
- There is limited time (four months) within the financial year to action change and recover what has previously been spent.
- Management time will need to be spent managing increased external scrutiny which will take time away from implementation.

8. Cash

Clearly running at an underlying deficit and a reliance on non-recurrent, and sometimes non-cash adjustments to manage the position is putting further pressure on cash. The Trust (as at month 6) had cash reserves of £3.2m and retained earnings of just over £2m. The trust posted a deficit of £4m in 2020/21 (due to issues with the baseline used to inform covid funding) which was not accompanied by any specific cash support. The Trust has negative net current assets and performance on payment of aged creditors is not good.

The situation has been discussed with colleagues at the Integrated Care Board who have provisionally agreed to provide short term cash support in the form of:

- Early payment of income due in year.
- Regular payment of monthly income at an earlier date (1st instead of 15th of the month).

These are clearly highly short term measures and are not answers to long term sustainability for the Trust.

Across Cheshire and Merseyside, there is significant of cash held across providers. LWH is free to request support from the national team in the form of PDC revenue support, this would come at a cost to LWH (and therefore the system) and would not reflect well on the system's ability to plan and manage across organisations, so discussions continue with the ICB to provide or facilitate support.

Clearly a more sustainable solution (preferably by improving the I&E position) is required. The Trust may also wish to consider, for the longer term, deliberately curbing capital expenditure – this would have a favourable impact on both I&E (reduced capital charges) and cash (if capital expenditure is below depreciation).

The Trust has already received support in the form of prepayment and has significant aged creditor balances within C&M.

9. Impact on Planning

Exiting the financial year with such a significant underlying deficit will clearly put significant pressure on 2023/24, which is likely to be a very challenging year financially both nationally and also in C&M due to the potential for additional convergence factors. There is also potentially a return to a more PbR based approach, and negotiating with the ICB who have a much larger footprint than the CCGs did may prove more challenging. Having only achieved 2022/23 through non recurrent means and at the level that will be required may set a difficult precedence for 2023/24 in terms of the Trust's true cost base.

10. Next Steps

Finance Business Partners and Divisional Managers will continue to work up plans and implement actions to reduce run rate. The Finance team will implement any non recurrent measures which can be taken. A number of actions have been reflected in the Month 7 forecast.

All divisions will take their individual recovery plans to their divisional boards for agreement.

This will be monitored through the Executive Committee, FPBD and Trust Board. The Financial Recovery Board (FRB) will be increased in frequency to fortnightly until the position improves to monitor progress at a granular level and share best practice between divisions. Further executive presence will be in place at the FRB.

With significant focus and action the Trust would be able to achieve its financial plan 2022/23, unless additional risks outside of the Trust's control impact – particularly the CDC or ERF- or if there is a significant unexpected issue with staffing or other costs. However this would require many non recurrent actions some of which would have a detrimental impact on future years (e.g. review of assets lives).

A number of other trusts have shared or committed to share their plans so these will be reviewed for other further opportunities. One trust has offered to peer review LWH's plan as well so that will be undertaken.

The Trust is in close contact also with the ICB who have requested significant analysis e.g. bridges and balance sheet analysis. This will be undertaken and any opportunities reviewed if they arise.

The Board is asked to discuss and review the approach and to support the Recovery Plan as set out above, noting that QIAs will be undertaken if required.

Appendix One: Underlying Position 2022/23

	£000
Plan 2022/23	**562**
System Top Up Income	(14,620)
Assume income at tariff not block	(5,005)
Net ERF Budget	(1,720)
Reverse Vacancy Factor	(1,400)
Full year effect 2022/23 cost pressures	(2,242)
Planned non recurrent items	(6,200)
Underlying Deficit	**(30,625)**

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*22/23/167a*		Date: 01/12/2022	
Report Title	Approval of Charitable Funds Annual Report & Accounts 2021/22			
Prepared by	David Dodgson, Financial Controller			
Presented by	Eva Horgan, Chief Finance Officer			
Key Issues / Messages	The Board as Corporate Trustee is asked to approve the 2021/22 Annual Report and Accounts of the Liverpool Women's Charity.			
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 as Corporate Trustee is asked to approve the 2021/22 Annual Report and Accounts of the Liverpool Women's Charity.			
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)					
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
Charitable Funds Committee	17/10/22	Eva Horgan, Chief Finance Officer	Charitable Funds Committee recommended that the Annual Report and Accounts is approved by Trust Board as Corporate Trustee.

EXECUTIVE SUMMARY

Liverpool Women's NHS Foundation Trust Charity Annual Report and Accounts for the 2021/22 financial year has been reviewed by the Charitable Funds Committee on the 17th October 2022.

The Charitable Funds Committee recommended their approval by the Trust Board in its role as Corporate Trustee of the charity.

In 2021/22, the Charity's incoming resources were £279k and total resources expended were £236k. The accounts have been subject to an Independent Examination.

The annual report sets out some of the highlights for the year, showcasing the work of the charity in supporting the Trust's services, staff and patients and families.

Following Board approval the Report and Accounts will be formally filed with the Charity Commission in good time for the 31st January 2023 deadline.

MAIN REPORT

1. Introduction

The Liverpool Women's NHS Foundation Trust Board is the Corporate Trustee of the Charity. The Board established a sub-committee, the Charitable Funds Committee, to oversee the management of the affairs of the Charitable Fund, on behalf of the Corporate Trustee.

The Corporate Trustee is kept informed on the work of the Charitable Funds Committee through briefings at Board meetings.

2. Accounts Overview

Liverpool Women's NHS Foundation Charitable Trust Annual Report and Accounts for the year ended 31st March 2022 are presented for review and approval.

Total Incoming resources for the 2021/22 financial year was £279k and total resources expended was £236k. There was also a realised and unrealised gain on investments of £15k, which means that the net movement in funds for 2021/22 was an increase of £58k (2020/21: £165k increase).

Key Features: Statement of Financial Activities (SOFA)

	2021/22 £'000	2020/21 £'000
Donations and legacies	226	328
Other trading activities (stall income)	33	5
Investment Income	20	19
Total Incoming Resources	**279**	**352**
Expenditure on Raising Funds	124	118
Charitable Activities	112	229
Total Resources Expended	**236**	**347**
Net Realised and unrealised (loss) / gains on investments	15	160
Net Movement in Funds	**58**	**165**

Key Features: Balance Sheet

	2021/22 £'000	2020/21 £'000
Investments	912	905
Total Fixed Assets	**912**	**905**
Debtors	3	4
Short term investments and deposits	7	4
Cash at bank and in hand	1	1
Total Current Assets	**11**	**9**
Creditors	(361)	(410)
Net Current Liabilities	**(350)**	**(401)**
Total Charity Funds	**562**	**504**

- There has been a slight increase in the Investments value compared to the prior year of £7k, which is largely due to the realised gain on investments which has been recognised in the SOFA.
- The creditor balance is lower than the prior year due to the charity repaying the Trust £175k in 2021/22. Of the £361k creditors figure only £96k of it relates to the interdebtedness with the Trust i.e. payments made on behalf of the charity by the Trust, the other £265k relates to accrued but not yet expensed commitments of the charity.
- At the 31st March, the charity was in a position of net current liabilities which meant that it could not have repaid the balance owed to the Trust of £96k without liquidating some investments.
- The net movement in funds in 2021/22 is an increase of £58k, with the closing fund balance £562k.

Key Features: Expenditure

	2021/22 £'000	2020/21 £'000
Staging fundraising events	13	10
Fundraising managers	102	100
Investment management costs	9	8
Total expenditure on raising funds	**124**	**118**
Patient welfare	66	14
Staff welfare	45	171
Equipment	1	22
Research	0	22

Total expenditure on charitable activities	**112**	**229**
Total Expenditure	**236**	**347**

Review of the Draft Annual Report & Accounts

The Annual Report and Accounts are provided for Trust Board review. The independent review by the external examiners has been completed. The Annual Report and Accounts has been reviewed by the Charitable Funds Committee on the 17th October 2022 and it recommended that they be approved by the Trust Board in its role as Corporate Trustee of the Charity.

Following the completion of the Independent Examiners work the Letter of Representation is also attached and should be signed on the same date as the approval of the Annual Report and Accounts by the Trust Board. Once the Independent Examiners are in receipt of the signed Letter of Representation they will issue the signature to be used at the bottom of their Independent Examiners Report.

The Annual Report and Accounts will then be filed with the Charities Commission in advance of the Charity Commission deadline of the 31st January 2023.

Recommendation

The Charitable Funds Committee recommends to the Trust Board that it reviews and formally approves the 2021/22 annual report and accounts in its role as the Corporate Trustee of the charity.

The Charitable Funds Annual Report and Accounts will then be filed with the Charities Commission before the deadline of the 31st January 2023.

NHS
Liverpool Women's
NHS Foundation Trust
Unit/Department name
Crown Street
Liverpool
L8 7SS

Tel: 0151 708 9988
Fax: 0151 702 4028
www.liverpoolwomens.nhs.uk

Liverpool Women's NHS Foundation Charitable Trust

To: Beever and Struthers

Dear Sirs

The following representations are made on the basis of enquiries of management and staff with relevant knowledge and experience such as we consider necessary in connection with your report on the charity's financial statements for the year ended 31 March 2022. These enquiries have included inspection of supporting documentation where appropriate. All representations are made to the best of our knowledge and belief.

GENERAL

1. We acknowledge that the work performed by you is substantially less in scope than an audit performed in accordance with International Standards on Auditing (UK and Ireland) and that you do not express an audit opinion.
2. We confirm that the charity was entitled to exemption under [section 144 of the Charities Act 2011 the requirement to have its financial statements for the financial year ended 31 March 2022 audited.
3. We have fulfilled our responsibilities as trustees as set out in the terms of your engagement letter dated dated 25 October 2021 under Charities Act 2011 for preparing financial statements in accordance with applicable law and United Kingdom Accounting Standards (UK Generally Accepted Accounting Practice), for being satisfied that they give a true and fair view.
4. All the transactions undertaken by the charity have been properly reflected and recorded in the accounting records.
5. All the accounting records and related financial information, including minutes of all management and trustee meetings and correspondence with The Charity Commission have been made available to you for the purpose of your work.

ASSETS AND LIABILITIES

6. The charity has satisfactory title to all assets and there are no liens or encumbrances on the charity's assets, except for those that are disclosed as applicable in the notes to the financial statements.
7. All actual liabilities, contingent liabilities and guarantees given to third parties have been recorded or disclosed as applicable.
8. We have no plans or intentions that may materially alter the carrying value and where relevant the fair value measurements or classification of assets and liabilities reflected in the financial statements.

LOANS AND ARRANGEMENTS

9. The charity has not granted any advances or credits to, or made guarantees on behalf of trustee other than those disclosed in the financial statements.

LEGAL CLAIMS

10. We have disclosed to you all claims in connection with litigation that have been, or are expected to be, received and such matters, as appropriate, have been properly accounted for and disclosed as applicable in the financial statements

LAWS AND REGULATIONS

11. We have disclosed to you all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing the financial statements

RELATED PARTIES

12. Related party relationships and transactions have been appropriately accounted for and disclosed as applicable in the financial statements. We have disclosed to you all relevant information concerning such relationships and transactions and are not aware of any other matters which require disclosure in order to comply with the requirements of charity law or accounting standards.

SUBSEQUENT EVENTS

13. All events subsequent to the date of the financial statements which require adjustment or disclosure have been properly accounted for and disclosed as applicable.

GOING CONCERN

Kathryn Thomson
Chief Executive

Robert Clarke
Chair

14. We believe that the charity's financial statements should be prepared on a going concern basis on the grounds that current and future sources of funding or support will be more than adequate for the charity's needs. We have considered a period of twelve months from the date of approval of the financial statements. We believe that no further disclosures relating to the charity's ability to continue as a going concern need to me made in the financial statements.

GRANTS AND DONATIONS

15. All grants, donations and other income, the receipt of which is subject to specific terms or conditions, have been notified to you. There have been no breaches of terms or conditions in the application of such income.

RESTRICTED GRANTS AND DONATIONS

16. Restricted grants and donations are as follows / listed overleaf:

Yours faithfully

.....

Signed on behalf of the board of trustees

Date:

Kathryn Thomson
Chief Executive

Robert Clarke
Chair

Liverpool Women's Hospital Charity

NHS
Liverpool Women's
NHS Foundation Trust

Trustee Annual Report and Financial Statements 2021–2022

For the year ended 31 March 2022

Registered Charity:
1048294

Liverpool Women's Hospital Charity

CONTENTS

Liverpool Women's Hospital Charity

CHAIR'S STATEMENT

Putting patients first is at the heart of everything we do. Our aim is to support the work of Liverpool Women's NHS Foundation Trust in providing the best possible healthcare for its patients, and to support research that will benefit patients here and elsewhere.

Alongside that main aim we also help to fund research and staff welfare initiatives as well as providing greater access to training and development opportunities.

Liverpool Women's NHS Foundation Trust is a specialist trust providing maternity, gynaecology, genetics and neonatology services in Liverpool and the North Mersey conurbation.

It is also the recognised specialist provider in Cheshire and Merseyside of high risk maternity care including fetal medicine, the highest level of neonatal care, complex surgery for gynaecological cancer, reproductive medicine and clinical genetics. It is the largest hospital in Europe to exclusively care for the health needs of women.

Our support for the Liverpool Women's NHS Foundation Trust helps the hospital to deliver best possible services and facilities to our patients, families and our dedicated staff, and as a charity we continue to support a wide range of charitable and health related activities during 2021–2022, focusing on four key areas:

- **Patient welfare and amenities** to help improve the experience of patients and their families, including the continued provision of on-site parental accommodation;
- Support for pioneering **research** into seeking new treatment for our patients;
- Investment in new **equipment** to enable the hospital to harness latest technologies; and
- **Staff education and welfare** to provide important support for our hospital's committed staff.

The Charity works hard to raise funds on behalf of the Trust to enhance overall patient experience by providing services and equipment above what is normally funded by the NHS. These enhancements make a big difference to the comfort and well-being of our patients.

Liverpool Women's Hospital Charity

WHO WE ARE

Putting patients first is at the heart of everything Putting patients first is at the heart of everything we do. Liverpool Women's Charity is registered with the Charity Commission for England and Wales – registration number 1048294.

The charity works hard to raise funds on behalf of the Trust to enhance overall patient experience by providing services and equipment above what is normally funded by the NHS. These enhancements make a big difference to the comfort and wellbeing of our patients.

Our charitable programmes fully support the entire range of patient services. The aim of the Liverpool Women's Charity is to support the care given to patients and their families. Alongside that main aim we also help to fund research and staff welfare initiatives as well as providing greater access to training and development opportunities.

HOW WE FUNDRAISE

We adhere to the Fundraising code of practice. All campaigns are managed by the Charity's staff and during the year LWH Charity did not receive any complaints about its fundraising approach and processes.

LWH Charity was not involved in any social investment over the past 12 months.

LWH CHARITY AND GRANT MAKING

LWH Charity was not involved in making any grants to external organisations over the last 12 months, but it did make grants to internal projects as per our aims and objectives.

PUBLIC BENEFIT

Liverpool Women's NHS Foundation Trust is the main beneficiary of the Charity and is a related party by virtue of being a corporate Trustee of the Charity. By working in partnership with the Trust, the charitable funds are used to the best affect for the benefit of the public served by the Trust.

When deciding upon the most beneficial way to use the charitable funds, the corporate trustee has to take into regard the main objectives, strategic plans of the Trust, whilst ensuring that the grants reflect the wishes of patients and staff.

Liverpool Women's Hospital Charity

TRUSTEE'S WELCOME

Welcome to our Annual Report for 2021–2022. The Trustees would like to thank all our supporters, volunteers and donors for their invaluable support throughout the year. Thank you to everyone who has given their time to raise funds and encouraged the wider community to support The Liverpool Women's Hospital Charity too.

The aim of the Liverpool Women's Charity is to support the care given to patients and their families across the entire range of patient services. Alongside that main aim we also help to fund research and staff welfare initiatives as well as providing greater access to training and development opportunities.

Against the backdrop of a challenging year, we are grateful for the tremendous support we have received from our donors, which has meant we have made a positive difference through our projects across the breadth of the Hospital's Charitable Funds initiatives.

None of this would have been possible without the commitment, dedication, and donations we have received not only from members of the public but also from both national and local companies and grant making trusts.

Some of the key highlights from this year have included:

- Continuing to support Honeysuckle families who have experienced a baby loss through monthly support groups, sibling books and memory making items.
- Planning the refurbishment of our Neonatal Family Flats where families with premature babies can stay, near to their babies in a comfortable environment.
- Introducing Family Integrated (Fi-Care) items to parents on the Neonatal unit to involve them in the care giving process.
- Achieving our first ever Pram Push event with over 150 participants supporting our Neonatal unit.
- Receiving the generous support for our staff from the local community in response to COVID-19 and the November incident outside the hospital.
- Supporting research into innovative laser therapy that treats side effects of early menopause in Cancer patients, provided by the Mona Lisa Laser.

A big thank you to everyone who has supported our hospital over the past year. We continue to have ambitious plans and so we look forward to your ongoing support for the work of The Liverpool Women's Charity.

Tracy Ellery
Chair of the Charitable Funds Committee

Liverpool Women's Hospital Charity

OUR IMPACT

The generous donations made to our Charity have enabled us to make and support many incredible impacts for staff, patients and families of the Liverpool Women's Hospital throughout 2021 and 2022.

We are proud to have made impacts across the following areas:

HONEYSUCKLE BEREAVEMENT SERVICES

Following charitable donations towards our Honeysuckle Fund, we have been able to continue important services for bereaved families who have experienced a baby loss through early miscarriage, stillbirth or neonatal death.

The charity continues to fund support sessions and important materials for memory making, such as photography equipment, items for footprints and lovelocks along with story books for siblings affected by the death of a baby. Cuddle cots are also funded by the charity to allow families to spend time with their babies on-site or at home before saying goodbye.

An annual remembrance service takes place in October each year to mark Baby Loss Awareness Week, allowing families to come together to remember their baby in a special way. In 2020 and 2021 this service was held virtually but funding has been secured to host a physical event in 2022 for 500 attendees. The charity also funds the maintenance and improvements of the hospital's Memorial Garden.

STAFF WELFARE

The Liverpool Women's Hospital has an incredible team of staff who work hard to provide the best care for women, babies and their families. We are proud to support our staff through training, welfare initiatives and enhancing their work environment. Through the support given by NHS Charities Together in 2021-2022, we were able to improve our staff experience through the introduction of several health and wellbeing initiatives such as Schwartz-Round support sessions and Mental Health First Aiders.

Work will commence shortly on the refurbishment of our staff conservatory and a zen garden for staff to use as a quiet space away from clinical areas. Funding has also been secured for the introduction of sleep pods for staff.

FETAL MEDICINE

This year, charitable funding enabled a refurbishment of the Fetal Medicine Unit, introducing comfortable furniture and artwork to enhance the patient experience.

The TAPS Support Foundation - Twin Anemia Polycythemia Sequence are also fundraising to bring a trial to improve outcomes for TAPS twins worldwide to Liverpool Women's Hospital.There is currently no best treatment for TAPS, and this news can leave families faced with uncertainty, and often fear about making the right choices for their pregnancies. This important clinical trial will hopefully bring answers to these families, paving the way for informed decision-making about treatments and outcomes.

Liverpool Women's Hospital Charity

NEONATAL UNIT

At Liverpool Women's Hospital we champion Family Integrated Care (Fi-Care). Fi-Care is a model that empowers parents/carers to be fully involved with all aspects of a baby's care throughout their journey on the Neonatal Unit, in partnership with the incredible Neonatal Team.

Because of the generous support given to our Neonatal Fund over the previous year, the Unit have been able to host Fi-Care Celebrations featuring support and educational sessions and activities for parents and staff, as well as coffee mornings, raffles and competitions for parents. Goody bags were also distributed to families here and at Alder Hey, with whom we have a Neonatal partnership.

We are delighted to have reached our target of £75,000 in 2021 to fully refurbish our family flats, located at walking-distance from the hospital site. The refurbished flats will provide a comfortable, home-from-home for our families, after a long day at their baby's cot-side.

We have also been able to fund Neonatal Transilluminator devices for neonates and babies, which when activated, illuminate a map of the veins through the surface of the skin, allowing clinicians to verify potency and avoid valves, providing a more effective vein puncture procedure with less discomfort for the baby.

GYNAECOLOGY

In 2021, Consultant, Dr. Paula Briggs identified the need to commence research trials to introduce an innovative piece of equipment that improves outcomes for women experiencing severe menopause symptoms and cancer patients. The MonaLisa Laser offers laser therapy to treat vaginal atrophy and is known to have positive results in a private setting. With the support of past patients and local community groups, the charity has almost reached a target of £50,000 to purchase a laser and we are working closely with the Trust's Research and Development Team to start the research required to introduce this laser treatment to the Trust.

Gynaecology clinicians expressed the need for items such as pyjamas, leggings and toiletries for women visiting the hospital in an emergency to give comfort to patients, leading to the introduction of our Care Bag Appeal. We were grateful to receive many donations of Care Bags throughout 2021 for Gynaecology patients. Support given to our Gynaecology Oncology department at the hospital also helped to fund specialist palliative care training for staff.

INFANT FEEDING

Owing to the generous support towards the Charity's Breast Pump Appeal, the hospital's Infant Feeding team were able to purchase 100 new hand-held breast pumps to distribute to new parents who would like support with breastfeeding their new-born baby once discharged from hospital.

Providing pumps to new parents helps to support them on their breastfeeding journey and takes away the worry of an additional expense.

Liverpool Women's Hospital Charity

FUNDRAISING ACTIVITIES

Throughout 2021 to 2022, we undertook a number of activities and events to fundraise, working with staff, businesses, members of the local community and other stakeholders. We are very proud to have had a successful year of fundraising, despite COVID-19 having restricted certain face-to-face and indoor activities. Here are some examples:

LITTLE WOOLLENS

The charity's Little Woollen's shop is based in the hospital, selling hand-made baby cardigans, blankets and hats. This volunteer-led project raised £24,000 for the Neonatal unit in 2021. The items sold are knitted by over 500 volunteers from across the county who make regular donations of knitting to raise important funds for the unit. Our online shop, introduced whilst Covid-19 restrictions remained in the hospital, also continues to be popular with customers from across the UK, selling knitted items and charity merchandise.

GO NEON FOR NEONATAL

Our annual Go Neon for Neonatal day in June continues to be popular with local schools, businesses, staff and patients, sporting their brightest clothes to raise money for our Neonatal Unit and raise awareness around pre-term birth.

CHARITY LOTTERY

2021 saw the introduction of our Charity Lottery and we are pleased to report that over 50 players have helped us raise approximately £1,200 in the past 12 months.

Liverpool Women's Hospital Charity

FUNDRAISING ACTIVITIES

WEDDING FAVOURS

The purchase of wedding favours to mark a couple's special day continues to be popular with past patients who want to show their support to the hospital.

PENNIES FROM HEAVEN

Staff at Liverpool Women's Hospital continue to support the charity by donating through the Pennies from Heaven Scheme.

PINK AND PURPLE PRAM PUSH

In September 2021 we held a Pink and Purple Pram Push in Croxteth Park to raise money for the Neonatal Unit. We were delighted with its popularity, with over 150 people and prams in attendance on the day walking the 5K route. Over £5,000 was raised collectively through the individuals who took part on the day, with sponsorship from MamaFit and Waterbabies.

BOLLYWOOD EVENT

In March 2022, inspirational fundraiser Abby Younis held a Bollywood Event at The Florrie to raise funds towards the MonaLisa Touch Laser. Abby Younis has dedicated her time to lead the fundraising for this project and the event raised an incredible £4,801.10.

Liverpool Women's Hospital Charity

PARTNERSHIPS

We have been very lucky to have worked in partnership with a number of businesses and organisations to facilitate projects to enhance the care given to patients and their families within the Liverpool Women's Hospital.
Cases of this have included:

JOHN LEWIS

We are grateful for the ongoing support of John Lewis Liverpool through their Give a Little Love initiative. John Lewis often donate items to the hospital's community midwifery team and are always on hand to support our Charity. We are delighted to continue to build on our relationship into 2022 when we welcome a John Lewis staff secondment to the charity at part of the company's Golden Jubilee scheme.

LFC AND JOIE

We were proud to partner with LFC and Joie in June 2021 when they donated beautiful baby gift packs for our new families, to mark the Football Club's birthday. LFC also continue to offer tickets to our staff and patients and donate items in support our of our fundraising.

PEOPLE'S FORD AND LOOKERS VAUXHALL

Two of our staff members were provided with temporary vehicles following the damage caused to their cars during the incident at Liverpool Women's Hospital on Sunday 14 November.

MAMAFIT

We were delighted to have MamaFit as the principal sponsor for our first ever Pink and Purple Pram Push in September. Rob from Mama Fit held a large scale warm up event with all participants before the 5K walk and continues to be involved in supporting the Charity.

OCS

The OCS Group team who work within the Liverpool Women's Hospital kindly chose to support our Charity and organised a sponsored cycle of 41 miles from our Hospital to Manchester. The group raised a remarkable £4,329.87 for the hospital's Honeysuckle Bereavement Team and have continued to support our charitable endeavours since.

Liverpool Women's Hospital Charity

IN-KIND SUPPORT

We want to say a big THANK YOU to the local and national businesses and organisations who have supported the hospital with over £40,000 worth of donations of in-kind gifts for our patients and staff, supporting our fundraising

- ASDA Bootle
- B&Q
- Belleva Hotel
- British Red Cross
- Castle Liverpool
- Costco
- Cuthbert's Bakehouse
- Dance Unlimited
- Everton Football Club
- Everton in the Community
- Fitwell
- Holistic Harmonies
- In Demand Radio
- Jockey's Club
- Liverpool Football Club
- Notcutts Garden Centre
- Nursem
- OCS
- Peri-Meno Queens
- Soroptimists Crosby
- Soroptimists Widnes
- Stork Cooperheat
- Susino Umbrellas
- Taskers
- The Chocolate Orange Man
- Timepiece Band
- Venture Photography
- Wild Thang

Thank you also to B&Q Foundation, Arnold Clarke Community Fund, Hospital Saturday Fund, Tesco Community Grants, Austin Smith Small Grants, Zara and NHS Charities Together for supporting our Charity projects in 2021-2022.

Liverpool Women's Hospital Charity

MEET OUR SUPPORTERS

We are grateful for the support of our current and past patients, their families and members of the local community and their fundraising efforts to help us fund the important patient-focused charity projects at Liverpool Women's Hospital.

The below supporters are just a small number of those who went above and beyond throughout 2021 and 2022:

MARK AND CARA ROBERTS

Mark and Cara Roberts raised an astounding £10,600 for the Neonatal Unit, with Mark completing 14 marathons over the course of 14 months to mark the 14 days that their daughter Darcey was cared for on the Unit.

"...Each and every single nurse, doctor, consultant, receptionist, cleaner helped us through what was the most difficult time of our lives... nothing was too much for anyone. No question was a silly one. Each baby was treated like their own. We'll be forever in their debt.No amount of money could repay what they did for us, but one night during our stay, Mark said if we ever were lucky enough to bring Darcey home, he would run a marathon for every night she was there."

WILLOW ELLIS

Willow's parents decided to take part in the 5k Pram Push to give something back to the Neonatal Unit after Willow was born almost two months early, after experiencing a failed placenta in January 2021. Willow's family raised £3,295 for the Unit and had a wonderful time at the Pram Push. Jess and Matthew said:

"We will forever be grateful for the outstanding care we received during our stay in hospital. We will never forget the constant care, kindness and uplifting spirit that all staff gave us daily and we were delighted to raise money to help take care of other babies and families in the same situations".

SARAH AND BRYN JONES

Sarah and Bryn Jones raised an incredible £6,493.75 in memory of their beautiful daughter Ela Megan Jones and had this to say:

"Ela was transferred to the Neonatal Unit in LWH at just one day old. She had the most fantastic care by all the team here, and she fought just as hard as every member of staff who looked after her. Unfortunately, she passed away at just one week old despite everyone's best efforts."

"...The level of care and support that Ela, and we as parents received was truly outstanding. It would mean the world to us as Ela's parents, to be able to give back a small token to the Hospital, to help support the unit that gave us such a precious week with our daughter, so they can continue their care for poorly babies and their families."

Liverpool Women's Hospital Charity

SPOTLIGHT ON STAFF

We are very fortunate to have the constant support of the dedicated staff members of the Liverpool Women's Hospital.

Year after year we see staff choosing to take on amazing challenges to raise money for their departments and projects. Some examples of this throughout 2021 and 2022 have included:

JENNIFER ROBINSON

Thank you to the amazing twins and multiples-specialist midwife Jen Robinson who ran 5k everyday throughout February 2022 in some of the worst weather that we had all year. Jen braved the cold to raise money to buy electrical breast pumps to be lent out to families to support breast feeding and breast milk-giving.

LEE JONES AND PAUL MALLANPHY

On the 3rd of October 2021 our colleagues Lee Jones and Paul Mallanaphy completed the London Marathon to raise money for the Neonatal Unit and the Hewitt Fertility Centre. Thank you, Lee and Paul, for taking on such a huge challenge and representing our Charity.

ELAINE NEARY

Thank In 2021, consultant Neonatologist Elaine Neary headed a crowdfunding campaign to raise money in memory of Fionn Neary-Connolly who sadly passed away at two weeks of life from congenital heart disease. The money raised has funded educational award grants for staff training in areas of cardiac and palliative care. Thank you to Elaine and her family and friends.

BECCI WEIR

Thank you to Neonatal nurse Becci Weir who held a Christmas Wreath Making Workshop in 2021 to share her craft making skills and raise money for the Neonatal Unit. Becci and Yvonne from Crafty Monkeys hosted a wonderful night and a festive time was had by all.

FUTURE PROJECTS

In closing this financial year, we have many exciting prospects for the year ahead following the success of our fundraising activities throughout 2021 and 2022. We have begun planning for the following projects, entering 2022 to 2023:

BEREAVEMENT SUITE APPEAL

The charity's main focus in 2022-2023 will be to fundraise for the renovation of several areas in the hospital for our bereaved families. Rooms on Delivery Suite and Gynaecology will be transformed from clinical spaces to welcoming, comfortable, homely rooms for those families who experience baby loss through early or late miscarriage and stillbirth.

We plan to hold the charity's first 'Strictly for Liverpool Women's Hospital' event in November 2022, along with launching a public fundraising appeal to help to reach the target of £100,000 to support the Trust to complete the work.

MONALISA TOUCH LASER RESEARCH TRIALS

Once the Mona Lisa Laser is purchased and on-site, research trials led by Dr. Paula Briggs will be able to commence. The charity has pledged to source support from charitable trusts to fund the research trials.

ENHANCING THE ENVIRONMENT FOR DIAGNOSTICS PATIENTS

Work is underway in the Trust to create a state-of-the-art imaging department which will house an MRI and CT scanner for diagnostic testing, ready for late 2022. The charity aims to fund cloud lighting to help create a more relaxed atmosphere for patients who may be anxious about undergoing the testing and the confined space.

CARE BOX APPEAL

The charity has expanded our Gynaecology-focused Care Bag Appeal to a wider Appeal which will reach each department with patients who are in need. We are appealing for donations of toiletries, pyjamas, underwear and other thoughtful gifts to create care boxes that can be distributed to those female patients who have very little.

STAFF WELLBEING SUPPORT

We will continue to support staff health and wellbeing initiatives through charitable funding and the distribution of gifts to our staff. We are dedicated to ensuring our hospital provides all staff with a comfortable workplace with places to rest and take breaks.

Overall, Liverpool Women's Hospital Charity pledges to actively fundraise for all projects to enhance the experience for the women, babies and families in our care, as well as our staff and will continue to promote the hospital's charity both on-site and in the local community throughout 2022–2023.

Liverpool Women's Hospital Charity

HOW CAN YOU HELP?

There are lots of ways you can support the work of Liverpool Women's Hospital Charity to help us enhance the services for the women, babies and families in our care. All donations are gratefully received and will directly benefit our patients and their families.

FUNDRAISING

We rely on the motivation and generosity of our incredible supporters to raise the vital funds needed to support the hospital services and are always inspired by the creativity and drive of individuals and groups who set themselves challenges to fundraise.

If you are keen to fundraise for us, please get in touch by emailing: *fundraising@lwh.nhs.uk* We will provide you with a fundraising pack, help promote your planned activities and support you throughout your fundraising journey.

BANK TRANSFERS AND STANDING ORDERS

Contact: *fundraising@lwh.nhs.uk* to make a donation or pay money you have raised by direct bank transfer. If you require bank details to make a monthly gift by standing order, please get in touch.

JUST GIVING

Both one-off donations can be made and regular gifts can be set up through our charity's
Just Giving page. Simply visit:
www.justgiving.com/liverpoolwomen

DONATIONS

Please mark cheques for 'Liverpool Women's Hospital Charity' along with your contact details and send to: Liverpool Women's Hospital Charity, Crown Street, Liverpool, L8 7SS.

LEAVE A LEGACY GIFT IN YOUR WILL

Legacy gifts are a crucial part of our income and allow us to offer even more support to the Liverpool Women's Hospital. if you decide to leave us a gift in your will you will be playing a part in impacting future generations of Liverpool for the better.

You can choose to donate as little as 1% of your estate. To leave us a gift in your will, give your solicitor our charity name and number:
The Liverpool Women's NHS Foundation Charitable Trust. Charity Number: 1048294.

JOIN OUR CHARITY LOTTERY

Visit: *unitylottery.co.uk/causes/liverpool-womens-hospital-charity* to sign up to our charity lottery for as little as £1 a week to be in with a chance of winning £25,000, whilst supporting the hospital.

BY PHONE

Please call (0151) 702 4194 and a member of our Fundraising Team will assist you in making a donation over the phone.

Liverpool Women's Hospital Charity

DONATE TO OUR LITTLE WOOLLENS SHOP OR CARE BAG APPEAL

Please hand any donations of knitted items for Little Woollens and care bag items for our patients to the main reception marked for *'Liverpool Women's Hospital Charity'* or visit the Fundraising Office opposite reception.

TEXT DONATIONS

If you would like to support the enhancement our general services, please text: *LIVERPOOLWOMENS* to 70085 to donate £5. Texts cost £5 plus one standard rate message.

FACEBOOK

You can now make a donation directly through our Facebook page 'Liverpool Women's Charity' by simply clicking the 'Donate' button located at the top of our page.

IN PERSON

The fundraising office is located opposite the main reception at Liverpool Women's and a member of the Fundraising Team is always available to accept donations and support your fundraising.

Liverpool Women's Hospital Charity

OUR ACHIEVEMENTS

What has been made possible.

£22,740
for the purchase of a Neonatal Simulator, including a baby manikin, a dummy probe, 3D tracking device and computer.

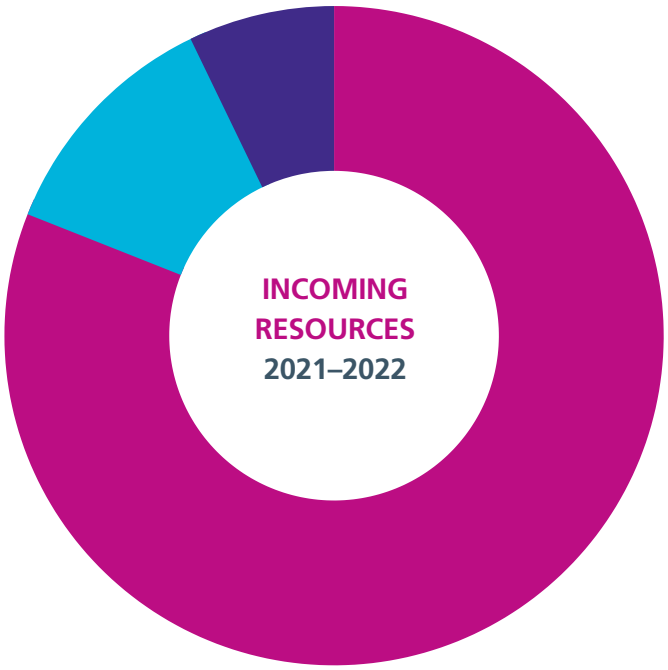
£5,156
for Bariatric chairs and lockers.

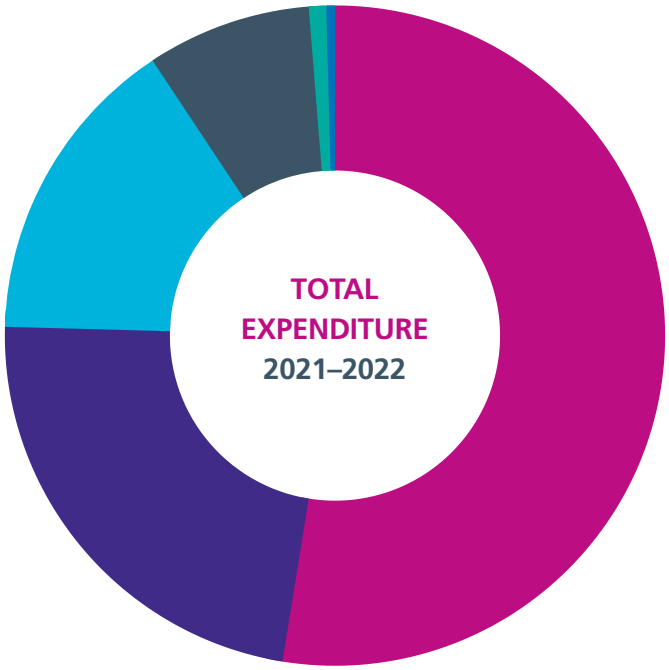
£14,780
for the ongoing running costs of providing parental accommodation for parents of babies on the Neonatal Unit.

£7,971
for artwork for the refurbishment of the Fetal Medicine Unit.

Liverpool Women's Hospital Charity

INCOME AND EXPENDITURE





Donations	81%	£226,000
Trading*	12%	£33,000
Investments	7%	£20,000

*Trading activities includes *Little Woollens* income of £25,000.

Raising funds	52%	£124,000
Patient welfare	23%	£54,000
Staff welfare	15%	£36,000
Support costs	8%	£19,000
Governance costs	1%	£2,000
Equipment	1%	£1,000

Donations and legacies income represents £226,000 and 81% of the total incoming resources enabling us to maintain our charitable activities for the hospital.

Total expenditure of £236,000 during the year included over £91,000 (39%) on charitable activities, which included Staff welfare £36,000, Patient welfare £54,000 and Equipment £1,000.

Liverpool Women's Hospital Charity

THANK YOU

On behalf of the patients, relatives and staff who have benefitted from improved services due to donations and fundraising, the Corporate Trustee would like to thank all patients and relatives and staff who have made charitable donations or have given your time.

The backing of all of our supporters is fundamental to the success of our charity, and I would like to take this opportunity to thank each and every one of you for your continued support over the last year.

Having read all about us, we invite you to consider supporting the work of our charity. If you would like to know more about how to make a donation please contact either Kate Davis or Nadia Alsafaar, our Charity Fundraisers by email at: fundraising@lwh.nhs.uk or by phone on: (0151) 702 4194

FOLLOW OUR SOCIAL MEDIA FOR NEWS AND UPDATES

Liverpool Women's Charity.

@LWHCharity

@LWHCharity

Tracy Ellery
Chair of the Charitable Funds Committee

Liverpool Women's Hospital Charity

STRUCTURE AND GOVERNANCE

The Corporate Trustee presents the Charitable Funds Annual Report together with the Financial Statements for the year ended 31 March 2022.

The Charity's Annual Report and Accounts for the year ended 31st March 2022 have been prepared by the Corporate Trustee in accordance with the accounting policies set out in note 1 to the accounts, the Charities Act 2011 and Accounting and Reporting by Charities: Statement of Recommended Practice applicable to Charities preparing their accounts in accordance with the Financial Reporting Standard 102.

The Charity's report and accounts include all the separately established funds for which Liverpool Women's NHS Foundation Trust is the sole beneficiary.

The Charitable Funds are registered as an umbrella charity, in accordance with the Charities Act 2011 using a model Declaration of Trust as approved by the Commission.

REFERENCE AND ADMINISTRATIVE DETAILS

The Liverpool Women's NHS Foundation Charitable Trust is an independent registered charity, which exists to raise, receive, manage and distribute donations for the benefit of the charitable purposes of the Liverpool Women's NHS Foundation Trust.

As a result of achieving Foundation Trust status in April 2005 the main umbrella charity changed its name from "Liverpool Women's Hospital Charitable Trust" to "The Liverpool Women's NHS Foundation Charitable Trust". This name change was approved by the Corporate Trustee on 2nd September 2005 and subsequently approved by the Charity Commission.

The Charity adopted a working name, "Liverpool Women's Charity", which was approved by the Charity Commission on 16th September 2009. The Charity has 11 individual subsidiary registered funds as at the 31st March 2022 (2021:11) and the notes to the accounts distinguish the types of fund held and disclose separately all material funds (note 17).

Charitable funds received by the Charity are accepted, held and administered as funds and property held on trust for charitable purposes relating to the health service. The funds are held in accordance with the National Health Service Act 1977 and the National Health Service and Community Care Act 1990 and these funds are held on trust by the Corporate Body.

The Liverpool Women's NHS Foundation Trust (the NHS Foundation Trust) is the Corporate Trustee of the Charitable Funds governed by the law applicable to Trusts, principally the Trustee Act 2000 and the Charities Act 2011.

Liverpool Women's Hospital Charity

TRUSTEE

The Corporate Trustee of the Charity is the Liverpool Women's NHS Foundation Trust and acts through the members of the Board of Directors. The members of the Board of Directors who served during the financial year and those in post as at the 1 December 2022 are set out on pages 29-31.

The Corporate Trustee devolved responsibility for the on-going management of funds to the Charitable Funds Committee, which administers the funds on behalf of the Corporate Trustee.

This Charitable Funds Committee was formed on the 8th February 2005. The names of those people who served as agents for the Corporate Trustee, as permitted under regulation 16 of the NHS Trusts (Membership and Procedures) Regulations 1990, are disclosed in the table on pages 29–31.

PRINCIPAL CHARITABLE FUND ADVISOR TO THE BOARD

The Director of Workforce and Marketing of the Liverpool Women's NHS Foundation Trust, under a scheme of delegated authority approved by the Corporate Trustee, has day to day responsibility for the management of the Charitable Funds.

The Charitable Funds Committee continues to develop the arrangements for delegation to nominated fund holders who manage the funds on an everyday basis.

STRUCTURE

The Charity's unrestricted fund was established using the model declaration of trust, and all funds held on trust as at the date of registration are part of this fund. Subsequent donations and gifts received by the Charity are added to the fund balance.

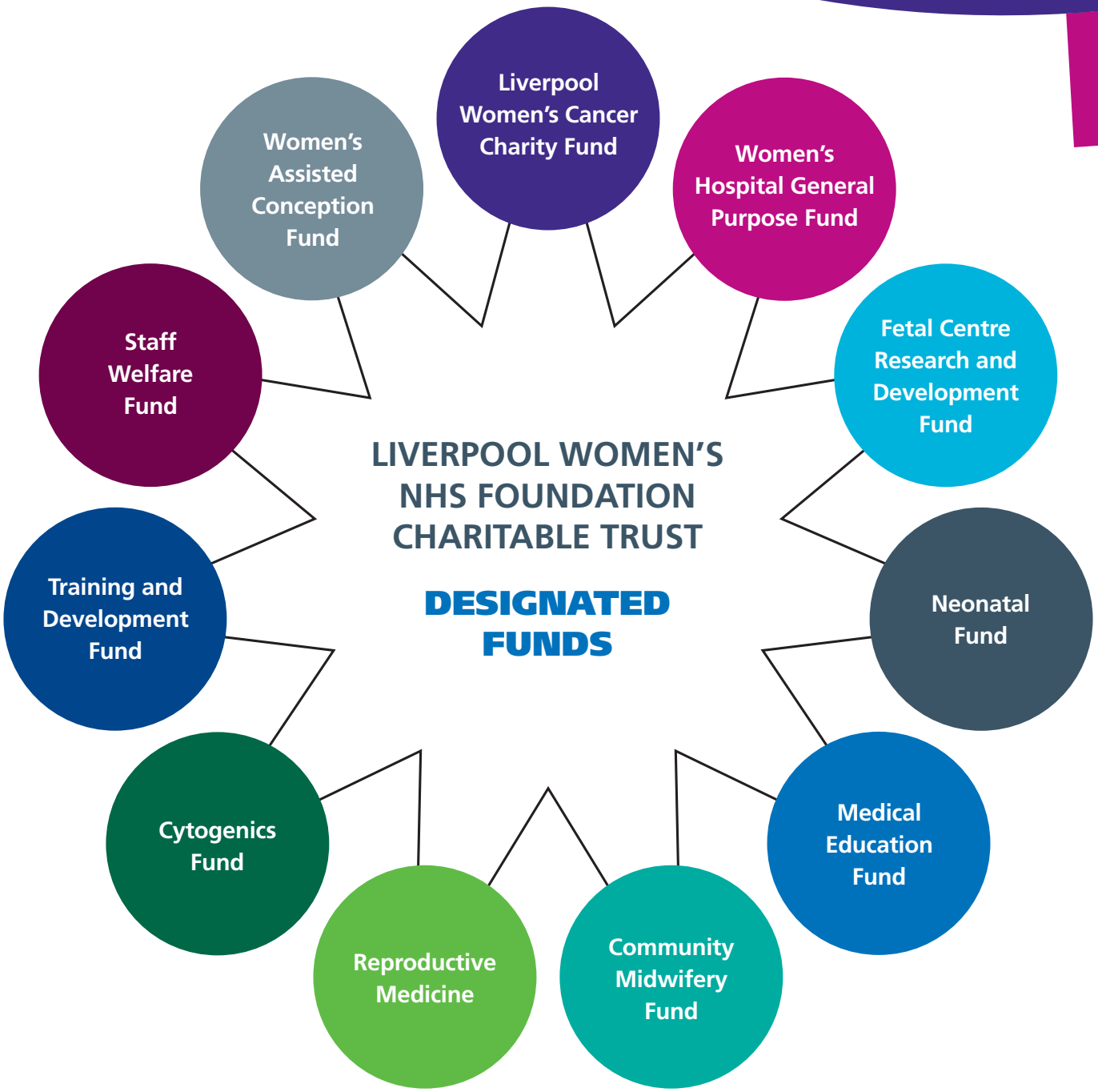
The fund covers a number of designations which have their own objectives and hold donations where a particular area or activity of the hospital was nominated by the donor at the time their donation was made. Whilst their nomination is not binding on the Corporate Trustee, the designated funds reflect these nominations.

The Corporate Trustee fulfils its legal duty by ensuring that funds are spent in accordance with the objectives of each fund and by the use of designated funds the Corporate Trustee respects the wishes of our generous donors.

Liverpool Women's Hospital Charity

DESIGNATED FUNDS

A list of designated funds held during 2021–2022.



Liverpool Women's Hospital Charity

RESERVES POLICY

Charitable reserves are identified as income which becomes available to the Charity and is to be spent at the Corporate Trustee's discretion in furtherance of any of the Charity's objects, but which is not yet spent, committed or designated. At 31 March 2022, the charity held £562,000 (2021: £504,000) in reserves of which £353,000 (2021: £364,000) were held in designated funds leaving £209,000 (2021: £140,000) in free reserves.

The closing charity balances are inclusive of all known and approved commitments, other than the salaried posts of the fundraising team whose costs are currently £102,000 per year. The fundraising costs are apportioned on an average fund basis across all charitable funds and therefore the closing £562,000 balance will cover 5.5 years of these costs. The trustee considers this to be a sufficient to meet fluctuations in donation and expenditure values.

The reserves policy has the objective of ensuring the Charity has sufficient funds available to honour commitments. The Corporate Trustee has a requirement to hold funds in order to support grants which will provide benefits for staff and funding for fixed term salaried posts such as the volunteer manager post.

The Corporate Trustee regularly reviews the level of reserves to ensure that commitments and spending plans are protected against falls in the Charity's income and investment values. The Corporate Trustee is mindful of the duty towards the Charity's current and future beneficiaries, and fulfils this responsibility by careful monitoring of expenditure and accessible money to guarantee day-to-day expenditure and ongoing commitments.

GRANT MAKING POLICY

All grants are made from the Charity's unrestricted funds – these funds comprise two elements:

The **General Purpose Fund** - this fund is constituted of gifts received by the Charity where no particular preference as to its expenditure has been expressed by donors.

Designated (Earmarked) Funds – these usually contain donations where a particular part of the hospital, activity or research was nominated by the donor at the time their donation was made. Whilst their nomination is not binding on the Corporate Trustee, the designated funds reflect these nominations.

The designated funds are overseen by fund holders who can make recommendations on how to spend the money within their designated area

Liverpool Women's Hospital Charity

GOVERNANCE

The Liverpool Women's NHS Foundation Trust is the sole Corporate Trustee of the Charity. The Corporate Trustee is managed through its Board of Directors (the Board) which consists of executive and non-executive directors. The Board established a committee, known as the Charitable Funds Committee, reporting to the Board. The role of the Committee is to oversee the management of the affairs of the Charitable Fund. This is a delegated duty carried out on behalf of the Corporate Trustee.

The role is to ensure that the Charity acts within the terms of its declaration of trust and appropriate legislation, and to provide information to the Audit Committee to enable it to provide assurance to the Board that the Charity is properly governed and well managed across its full range of activities.

The Corporate Trustee executive directors are subject to recruitment by a Remuneration and Nominations Committee whose membership comprises of the Chair, Chief Executive and non- executive directors of the Corporate Trustee. Non-executive directors of the Board are appointed by the Corporate Trustee's Council of Governors.

The Chair of the Charitable Funds Committee participates in the induction of new board directors and the Chief People Officer and Deputy Chief Executive ensures that board directors are informed of their responsibilities for charitable funds. The Corporate Trustee is kept informed of the discussions of the Charitable Funds Committee through briefings at its Board meetings.

In addition, the Board of the Corporate Trustee keeps the skill and development requirements of its individual directors under review and directors attend training events and meetings, hosted by a variety of external organisations, which provide the opportunity to enhance their skills and knowledge.

MANAGEMENT OF FUNDS

Each designated fund has a nominated fund holder(s) who, acting under delegated authority from the Charitable Funds Committee, and supported by detailed procedural instructions, is responsible for ensuring that expenditure is incurred in accordance with the charitable objectives of each fund.

Acting for the Corporate Trustee, the Charitable Funds Committee is responsible for the overall management of the Charitable Fund. The Committee is required to:

- Control, manage and monitor the use of the fund's resources including approval of all proposals for expenditure in excess of £40,000 for the General Purpose Fund and £30,000 for other designated funds.
- Provide support, guidance and encouragement for all its income raising activities, whilst managing and monitoring the receipt of all income.
- Ensure that 'best practice' is followed in the conduct of all its affairs and fulfilling all of its legal responsibilities.
- Ensure that the Investment Policy approved by the Board of Directors as Corporate Trustee is adhered to and that performance is continually reviewed whilst being aware of ethical considerations.
- Keep the Board of Directors fully informed on the activity, performance and risks of the Charity.

The accounting records and the day-to-day administration of the funds are dealt with by the Liverpool Women's NHS Foundation Trust's finance department. The Charitable Funds Committee meets on a quarterly basis and examines all expenditure approved by fund holders.

RISK MANAGEMENT

The Corporate Trustee has a duty to identify the risks to which the Charity is exposed, to keep these under review and establish systems to mitigate these risks.

The Charitable Funds Committee believes that the internal control systems in place are sufficiently embedded and that managers and staff are aware of their responsibility for internal control as part of their accountability for achieving objectives.

The Charitable Funds Committee has identified the major risks to the Charity's objects, commitments and future spending plans and the most significant risk is considered to be the potential losses arising from a fall in the value of investments.

The Charitable Funds Committee has considered this risk carefully and have established procedures to review the investment portfolio regularly, ensuring that the Charity's investments are spread over a wide and varied portfolio and are not concentrated in one particular investment or commercial sector.

The Charitable Funds Committee meets with Investment Managers, monitors performance and receives regular reports on the portfolio. The Corporate Trustee is mindful of the need to ensure spending plans and firm financial commitments are matched with income.

PARTNERSHIP WORKING AND NETWORKS

The role of the Charity in supporting Liverpool Women's NHS Foundation Trust continues to go from strength to strength and in order to meet our objectives effectively, we have continued to invest in our fundraising activities and our partnerships working with three independent charities.

The NHS Foundation Trust is closely associated with two independent charities that are based at the hospital:

- We are grateful for the generous work of the volunteers of the **League of Friends of the Liverpool Women's Hospital (charity registration number 512162)**, who raise funds each year for the Liverpool Women's NHS Foundation Trust. Fundraising activities range from small events, to more substantial fundraising through the shop and trolley service.

- Liverpool Women's NHS Foundation Trust has developed a partnership with a large maternity hospital in Kampala, Uganda with a view to sharing educational resources through exchange visits by medical, nursing and midwifery staff. **The Liverpool Mulago Partnership (charity registration number: 1135219**).

Liverpool Women's Hospital Charity

OBJECTIVES AND STRATEGY

The objectives of the umbrella charity require the Corporate Trustee to hold the fund upon trust and to apply the income and the capital for any charitable purpose or purposes relating to the National Health Service.

These wide objectives were agreed with the Charity Commission to give flexibility to allow the Corporate Trustee to use funds without being subject to any specific restriction. In practice, all expenditure has been, and will continue to be, related to services provided by the Liverpool Women's NHS Foundation Trust. Each designated fund has its own charitable objectives in support of the overarching objective of the umbrella charity.

We seek to use the charitable funds to improve the vital care and support we give to our patients and their families. This enables our staff to gain access to training and development activities, to conduct appropriate research and to augment staff welfare, focusing on areas not covered or fully supported by central NHS funds.

Making our vision happen involves all our partners, the Liverpool Women's Hospital League of Friends staff, patients, carers and the community.

PUBLIC BENEFIT

The Corporate Trustee has a duty to comply with Section 17 of the Charities Act 2011 to have due regard to the Charity Commission's general guidance on public benefit.

The Corporate Trustee can confirm that it has fulfilled the public benefit requirement and that this requirement is strongly embedded within the procedures for approving grants and spending plans.

The Charitable Funds Committee, on behalf of the Corporate Trustee, ensures that all grants and spending plans contain identifiable public benefits that are clear and meet the objects of the Charity funds. This is achieved by the Corporate Trustee keeping spending plans under review throughout the year.

A REVIEW OF OUR FINANCES AND PERFORMANCE

The net funds held, after taking account of current assets and liabilities, at 31st March 2022 were £562,000 (2021: £504,000). This represents an overall net increase of £58,000 (2021 increase: £165,000). This arises from an excess of income over expenditure of £43,000 (2021: £5,000) with net gains on investments of £15,000 (2021: £160,000).

The net gain on investments of £15,000 (2021: £160,000) are comprised of an unrealised loss of £52,000 (2021: unrealised gain of £141,000) and realised gains of £67,000 (2021 £19,000).

REVIEW OF INCOME

The Charity relies on donations, fundraising events and investment income as the main sources of income. Total incoming resources in the year were £279,000 (2021 £352,000).

Donations totalling £204,000 (2021: £323,000) were received from grateful patients, their families, friends and other supporters in acknowledgement of the high standard of care provided. Trading activities income of £33,000 (2021: £5,000) includes income from the knitting stall of £25,000 (2021: £1,000)

The Corporate Trustee recognises the importance of the care provided throughout the NHS Foundation Trust and appreciates the donations and kind words from donors.

Liverpool Women's Hospital Charity

LEGACY INCOME

There was £22,000 of legacy income during the year (2021: £5,000). Legacy income is only accrued when there is a reasonable certainty of receipt.

This is based on notifications provided by the representatives of the estates concerned. The Charity's officers liaise with solicitors to ensure that specific wishes are carried out.

REVIEW OF EXPENDITURE

From the total resources expended of £236,000 (2021: £347,000), charitable expenditure on direct charitable activity, was £91,000 (2021: £208,000) across a range of programmes.

FUND BALANCES

Fund balances at 31 March 2022 were £562,000 (2021: £504,000).

GIFT AID

Gift aid provides a great opportunity for donors to increase the value of their donation to our Charity. Provided the donor is a taxpayer, our Charity can claim from HM Revenue and Customs the basic rate tax paid on the gift. This increases donations by approximately 25%, so a gift of £10 is worth £12.50 to our charity.

INVESTMENTS

For investment purposes the Charity 'pools' its individual sub funds available, to maximise the returns on investments, whilst operating in accordance with the Board's agreed risk appetite. The funds are operated as a single investment fund under an official pooling scheme which was registered with the Charity Commission on 1 January 1999.

Investments are managed by Investec Wealth and Management on behalf of the Charity through an approved investment policy which includes an ethical restriction on investments in tobacco. The funds of the Charity are invested in a wide range of investments with the objective of maximising long term returns within a medium risk profile including UK equities and fixed interest securities, overseas equities held via collectives and cash.

The performance of the fund is reported by Investec Wealth and Management on a quarterly and annual basis against the benchmark set by the Corporate Trustee, the WM Unconstrained Universe, which is widely used by the charity sector.

The members of the Charitable Funds Committee meet annually with the Investment Manager to discuss performance and to review the investment strategy. The investment markets remain volatile and the Charity's investments continue to be actively managed

During the year the Charity's investment moved to a fund value of £912,000 as at 31 March 2022 from £905,000 at 31 March 2021. During the year, there were also disposals of investments at carrying value of £194k (2021: £295,000).

ADMINISTRATIVE DETAILS

NAME OF CHARITY

The Liverpool Women's NHS Foundation Charitable Trust. Registered charity number: 1048294.

PRINCIPAL OFFICE

Financial Accountant
Finance Department
Liverpool Women's NHS Foundation Trust
Crown Street L8 7SS
Tel: 0151 708 9988

FUNDRAISING

Fundraising Office
Email: fundraising@lwh.nhs.uk
Tel: 0151 702 4194

BANKERS

Barclays Bank PLC
48B - 50 Lord Street
Liverpool L2 1TD

INTERNAL AUDITORS

Merseyside Internal Audit Agency
Regatta Place
Brunswick Business Park
Summers Road
Liverpool L3 4BL

INDEPENDENT EXAMINERS

Beever and Struthers
St Georges House
215 - 219 Chester Road
Manchester M15 4JE

SOLICITORS

Hill Dickinson
No.1 St. Paul's Square
Liverpool L3 9SJ

INVESTMENT FUND MANAGERS

Investec Wealth and Managemen
2 Gresham Street
London EC2V 7QN

Liverpool Women's Hospital Charity

CORPORATE TRUSTEE BOARD OF DIRECTORS - NON-EXECUTIVE DIRECTORS

Name	Position held	Member of Charitable Funds Committee	1 April 2021 to 31 March 2022	As at 1 December 2022
Robert Clarke	Chair	No	In post	In post
Tony Okotie	Non-Executive Director Senior Independent Director until 30 April 2022	Yes	In post	Not in post (term ended 30 June 2022)
Jo Moore	Non-Executive Director Interim Chair of Charitable Funds Committee from 1 April 2021 to 8 September 2021	Yes	In post (until 8 September 2021)	Not in post
Susan Milner	Non-Executive Director	No	In post	Not in post (term ended 31 May 2022)
Tracy Ellery	Non-Executive Director Chair of Charitable Funds Committee from 9 September 2021	Yes	In post	In post
Louise Kenny	Non-Executive Director Senior Independent Director as of 1 May 2022	No	In post	In post

Liverpool Women's Hospital Charity

CORPORATE TRUSTEE BOARD OF DIRECTORS - NON-EXECUTIVE DIRECTORS

Name	Position held	Member of Charitable Funds Committee	1 April 2021 to 31 March 2022	As at 1 December 2022
Louise Martin	Non-Executive Director	Yes	In post (as of 1 April 2021)	In post
Zia Chaudhry	Non-Executive Director	No	In post (as of 1 December 2021)	In post
Gloria Hyatt	Non-Executive Director	No	In post (as of 1 December 2021)	In post
Sarah Walker	Non-Executive Director	No	In post (as of 1 December 2021)	In post
Jackie Bird	Non-Executive Director	Yes (as of May 2022)	Not in post	In post (as of 1 April 2022)

Liverpool Women's Hospital Charity

CORPORATE TRUSTEE BOARD OF DIRECTORS - EXECUTIVE DIRECTORS

Name	Position held	Member of Charitable Funds Committee	1 April 2021 to 31 March 2022	As at 1 December 2022
Kathryn Thomson	Chief Executive	No	In post	In post
Michelle Turner	Chief People Officer and Deputy Chief Executive	Yes	In post (Deputy Chief Executive as of 1 July 2021)	In post
Dr Lynn Greenhalgh	Medical Director	No	In post	In post
Marie Forshaw	Chief Nurse and Midwife	Yes	In post	In post (until 31 August 2022)
Gary Price	Chief Operating Officer	No	In post	In post
Eva Horgan	Chief Finance Officer	Yes	In post (as of 1 October 2021)	In post
Jenny Hannon	Chief Finance Officer	Yes	In post (until 30 September 2021)	Not in post
Matt Connor	Chief Information Officer	No	In post (as of 5 July 2021)	In post
Dianne Brown	Interim Chief Nurse	Yes (as of 1 September 2022)	Not in post	In post (as of 1 September 2022)

Liverpool Women's Hospital Charity

STATEMENT OF TRUSTEE'S RESPONSIBILITIES

The Corporate Trustee is responsible for preparing a Trustee's Annual Report and financial statements in accordance with applicable law and United Kingdom Accounting Standards (United Kingdom Generally Accepted Accounting Practice) including the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS102).

The law applicable to charities in England and Wales requires the Charity Trustee to prepare financial statements for each financial year which give a true and fair view of the state of affairs of the Charity and of its incoming resources and application of resources, of the Charity for that period.

In preparing the financial statements, the Trustee is required to:

A select suitable accounting policies and then apply them consistently;

B observe the methods and principles of the Charity SORP;

C make judgements and accounting estimates that are reasonable and prudent;

D state whether applicable United Kingdom accounting standards have been followed, subject to any material departures disclosed and explained in the financial statements; and

E prepare the financial statements on the going concern basis unless it is inappropriate to presume that the Charity will continue to operate.

The Corporate Trustee is responsible for keeping proper accounting records that disclose with reasonable accuracy at any time the financial position of the Charity and enable it to ensure that the financial statements comply with the Charities Act 2011, the applicable Charities (Accounts and Reports) Regulations, and the provisions of the Trust Deed.

It is also responsible for safeguarding the assets of the Charity and taking reasonable steps for the prevention and detection of fraud and other irregularities.

The Corporate Trustee is responsible for the maintenance and integrity of the Charity and financial information included on the Charity's website.

Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

Approved by the Corporate Trustee on the 1 December 2022 and signed on its behalf by:

Name: Tracey Ellery
Chair of the Charitable Funds Committee

INDEPENDENT EXAMINERS REPORT

I report on the accounts of the charity for the 12 months ended 31 March 2022 which are set out on pages 34 to 48.

RESPECTIVE RESPONSIBILITIES OF TRUSTEE'S AND EXAMINER

The charity's trustee is responsible for the preparation of the accounts. The charity's trustee considers that an audit is not required for this year under section 144(2) of the Charities Act 2011 (the 2011 Act) and that an independent examination is needed.

It is my responsibility to:

- examine the accounts under section 145 of the 2011 Act;
- follow the procedures laid down in the general Directions given by the Charity Commission under section 145(5)(b) of the 2011 Act; and state whether particular matters have come to my attention.

BASIS OF INDEPENDENT EXAMINER'S REPORT

My examination was carried out in accordance with the general Directions given by the Charity Commission. An examination includes a review of the accounting records kept by the charity and a comparison of the accounts presented with those records. It also includes consideration of any unusual items or disclosures in the accounts, and seeking explanations from you as trustee concerning any such matters. The procedures undertaken do not provide all the evidence that would be required in an audit and consequently no opinion is given as to whether the accounts present a "true and fair view" and the report is limited to those matters set out in the statement below.

INDEPENDENT EXAMINER'S STATEMENT

Since the charity's gross income exceeded £250,000 your examiner must be a member of a body listed in section 145 of the Act. I confirm that I am qualified to undertake the examination because I am member of the Institute of Chartered Certified Accountants which is one of the listed bodies.

In connection with my examination, no matter has come to my attention:

1. which gives me reasonable cause to believe that, in any material respect, the requirements:

- to keep accounting records in accordance with section 130 of the 2011 Act; and
- to prepare accounts which accord with the accounting records and comply with the accounting requirements of the 2011 Act have not been met; or

2. to which, in my opinion, attention should be drawn in order to enable a proper understanding of the accounts to be reached.

Andrew McLaren FCA
Independent Examiner:
Beever and Struthers St George's House,
215-219 Chester Road
Manchester M15 4JE

Liverpool Women's Hospital Charity

CHARITABLE FUNDS ACCOUNTS 2021–2022

Statement of Financial Activities for the year ended 31 March 2022

	Note	Unrestricted Funds 2022 £000	Restricted Funds 2022 £000	Total Funds 2022 £000	Total Funds 2021 £000
Incoming resources:	4				
Income and endowments from:					
Donations and legacies		226	0	**226**	328
Other trading activities		33	0	**33**	5
Investments	13	20	0	**20**	19
Other income		0	0	**0**	0
Total incoming resources		**279**	**0**	**279**	352
Resources expended:	7				
Expenditure on:					
Raising funds		124	0	**124**	118
Charitable activities		112	0	**112**	229
Total resources expended		**236**	**0**	**236**	347
Net expenditure before investment gains		**43**	**0**	**43**	5
Net (loss) / gain on investments - unrealised	12	(52)	0	**(52)**	141
Net gains on investments - realised		67	0	**67**	**19**
Net (expenditure)/income		**58**	**0**	**58**	165
Net movement in funds		**58**	**0**	**58**	165
Reconciliation of Funds:					
Fund balances brought forward 1st April		504	0	**504**	339
Fund balances carried forward 31 March		**562**	**0**	**562**	504

Liverpool Women's Hospital Charity

Balance Sheet as at 31 March 2022

	Note	Unrestricted Funds 2022 £000	Total Funds 2022 £000	Total Funds 2021 £000
Fixed assets:				
Investments	12	912	**912**	905
Total fixed assets		**912**	**912**	905
Current assets:				
Debtors	14	3	**3**	4
Cash at bank and in hand	15	8	**8**	5
Total current assets		**11**	**11**	9
Liabilities:				
Creditors and commitments falling due within one year	16	(136)	**(136)**	(350)
Creditors and commitments due greater than one year		(225)	**(225)**	(60)
Total current liabilities		**(361)**	**(361)**	(410)
Net current assets/(liabilities)		**(350)**	**(350)**	(401)
Total assets less current liabilities		**562**	**562**	504
The funds of the charity:				
Unrestricted funds	17	562	**562**	504
Total charity funds		**562**	**562**	504

The notes following the primary statements, numbered 1 to 21, form part of these accounts.

The financial statements contained within these accounts were approved by the Board of Directors on 1 December 2022 and signed on its behalf by:

Signed:

Tracey Ellery
Chair of the Charitable Funds Committee

Liverpool Women's Hospital Charity

Statement of Cash Flows for the year ended 31 March 2022

	Note	Total Funds 2022 £000	Total Funds 2021 £000
Cash flows from operating activities:			
Net cash provided by operating activities	18	**(25)**	(78)
Cash flows from investing activities:			
Dividends and interest from investments	4	**20**	19
Proceeds from sale of investments		**194**	314
Purchase of investments	12	**(174)**	(308)
Net cash provided by/(used in) investing activities		**40**	25
Change in cash and cash equivalents in the reporting period		**15**	(53)
Cash and cash equivalents at the beginning of the reporting period		**13**	66
Total cash and cash equivalents at the end of the reporting period	19	**28**	13

Notes to the accounts

1. Accounting Policies

1.1. Legal Status

The Liverpool Women's NHS Foundation Charitable Trust is an unincorporated charity registered with the charity commission. The address is Crown Street, Liverpool, L8 7SS.

1.2. Basis of preparation

The financial statements have been prepared under the historic cost convention, with the exception of investments which are included at fair value. The financial statements have been prepared in accordance with the Statement of Recommended Practice: Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS102) issued on July 2014, and the Financial Reporting Standard applicable in the United Kingdom and Republic of Ireland (FRS102) and the Charities Act 2011 and UK Generally Accepted Practice as it applies from 1 January 2019.

The trustee's consider that there are no material uncertainties about the Charity's ability to continue as a going concern. There are no material uncertainties affecting the current year's accounts. The Charity has recently reviewed its Investment policy thoroughly with its Investment advisors Investec Wealth and Management and will continue to monitor and react accordingly to the changes in the financial markets. There was a net increase in the closing fund balance in 2021/22 of £58k from £504k at the 1 April 2021 to £562k at the 31 March 2022.

The Charity constitutes a public benefit entity as defined by FRS102. The financial statements are prepared in sterling which is the functional currency of the entity.

Liverpool Women's Hospital Charity

1.3. Funds structure

Unrestricted funds comprise those funds which the Trustee is free to use for any purpose in furtherance of the charitable objects. Restricted funds comprise those funds where the donor has provided for the donation to be spent in furtherance of a specified charitable purpose.

The funds held are disclosed in note 17.

1.4. Incoming resources

All incoming resources are recognised once the Charity has entitlement to the resources, it is probable that the resources will be received and the monetary value of incoming resources can be measured with sufficient reliability.

Where there are terms or conditions attached to incoming resources, particularly grants, then these terms or conditions must be met before the income is recognised as the entitlement condition will not be satisfied until that point. Where terms or conditions have not been met or uncertainty exists as to whether they can be met then the relevant income is not recognised in the year but deferred and shown on the balance sheet as deferred income.

1.5. Incoming resources from legacies

Legacies are accounted for as incoming resources either upon receipt or where the receipt of the legacy is probable. Receipt is probable when:

- Confirmation has been received from the representatives of the estate that probate has been granted
- The executors have established that there are sufficient assets in the estate to pay the legacy, and
- All conditions attached to the legacy have been fulfilled or are within the charity's control

If there is uncertainty as to the amount of the legacy and it cannot be reliably estimated then the legacy is shown as a contingent asset until all of the conditions for income recognition are met.

1.6. Resources expended and irrecoverable VAT

All expenditure is accounted for on an accruals basis and has been classified under headings that aggregate all costs relating to each category of expense shown in the Statement of Financial Activities. Expenditure is recognised when the following criteria are met:

- There is a present legal or constructive obligation resulting from a past event
- It is more likely than not… that a transfer of benefits (usually a cash benefit) will be required in settlement
- The amount of the obligation can be measured or estimated reliably

Grants payable are payments made to the Liverpool Women's NHS Foundation Trust which is classed as a related party, in furtherance of the charitable objectives of the funds held on trust. In the case of an unconditional grant offer this is accrued once the recipient has been notified of the grant award. The notification gives the recipient a reasonable expectation that they will receive the one-year or multi-year grant. Grant awards that are subject to the recipient fulfilling performance conditions are only accrued when the recipient has been notified of the grant and any remaining unfulfilled condition attaching to that grant is outside of the control of the Charity.

Irrecoverable VAT is charged against the category of resources expended for which it was incurred.

1.7. Allocation of support costs

Support costs are those costs which do not relate directly to a single activity. These include some staff costs, costs of administration and independent examination costs. The analysis of support costs and the bases of apportionment applied are shown in note 7.

1.8. Fundraising costs

The costs of generating funds are those costs attributable to generating income for the charity, other than those costs incurred in undertaking charitable activities or the costs incurred in undertaking trading activities in furtherance of the charity's objectives. The costs of generating funds represent fundraising costs together with investment management fees. Fundraising costs include expenses for fundraising activities and a fee paid to related party, Liverpool Women's NHS Foundation Trust, which is used to cover the costs of the hospital's fundraising office salaries and overheads.

Liverpool Women's Hospital Charity

1.9. Charitable activities
Costs of charitable activities comprise all costs incurred in the pursuit of the charitable objects of the Charity. These costs comprise direct costs and an apportionment of overhead and support costs as shown in note 7.

1.10. Governance costs
Governance costs comprise all costs incurred in the governance of the charity. These costs include costs related to independent accounts examination.

1.11. Fixed asset investments
Investments are a form of basic financial instrument. Fixed asset investments are initially recognised at their transaction value and are subsequently measured at their fair (market value) as at the balance sheet date. The statement of Financial Activities includes the net gains and losses arising on revaluation and disposals throughout the year. Quoted stocks and shares are included in the Balance Sheet at the current market value quoted by the investment analyst.

The main form of financial risk faced by the charity is that of volatility in equity markets and investment markets due to wider economic conditions, the attitude of investors to investment risk and changes in settlement concerning equities and within particular sectors or sub sectors. Further information on the investments can be found in note 12.

1.12. Realised gains and losses
All gains and losses are taken to the Statement of Financial Activities as they arise. Realised gains and losses on investments are calculated as the difference between sales proceeds and opening market value (purchase date if later). Unrealised gains and losses are calculated as the difference between the market value at the year end and opening market value (or purchase date if later).

1.13. Pensions
The Charity is a grant making charity and has no employees.

1.14. Debtors
Debtors are amounts owed to the charity. They are measured at transaction price, less any impairment.

1.15. Cash and cash equivalents
Cash is represented by cash in hand and deposits with financial institutions repayable without penalty on notice of not more than 24 hours. Cash equivalents are highly liquid investments that mature in no more than three months from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

1.16. Creditors
Amounts owed to third parties due within one year are measured at the undiscounted amount of the cash or other consideration expected to be paid. All other creditors are measured at transaction price.

1.17. Financial instruments
A financial asset or a financial liability is recognised only when the entity becomes a party to the contractual provisions of the instrument.

Basic financial instruments are initially recognised at the transaction price, unless the arrangement constitutes a financing transaction, where it is recognised at the present value of the future payments discounted at a market rate of interest for a similar debt instrument.

Debt instruments are subsequently measured at amortised cost.

Other financial instruments are initially recognised at fair value, unless payment for an asset is deferred beyond normal business terms or financed at a rate of interest that is not a market rate, in which case the asset is measured at the present value of the future payments discounted at a market rate of interest for a similar debt instrument.

Other financial instruments are subsequently measured at fair value, with any changes recognised in the Statement of Financial Activities.

Financial assets that are measured at cost or amortised cost are reviewed for objective evidence of impairment at the end of each reporting date. If there is objective evidence of impairment, an impairment loss is recognised in the Statement of Financial Activities immediately.

Liverpool Women's Hospital Charity

Any reversals of impairment are recognised in the Statement of Financial Activities immediately, to the extent that the reversal does not result in a carrying amount of the financial asset that exceeds what the carrying amount would have been had the impairment not previously been recognised.

2. Related party transactions

The Corporate Trustee of the Liverpool Women's NHS Foundation Charitable Trust (the Charity) is the Liverpool Women's NHS Foundation Trust (the Trust). The Charity delivers its charitable objectives by making grants to the Trust. Grants made to the Trust in the year were £95,000 (2021: £242,000).

The amount owed to the Trust as at 31 March 2021 was £96,000 (2021: £159,000) (see note 16). During the year the Charity made a payment of £175,000 (2021 £390,000) to the Trust.

None of the members of the Trust Board, Charitable Funds Committee, senior Trust staff, or parties related to them were beneficiaries of the Charity, and none of these individuals have undertaken any material transactions within the Charity during the year.

The Charity employed no direct employees during the year to 31st March 2022 (2021: none). During the year the Trust recharged £102,000 fundraising salary costs (2021: £100,000) to the Charity.

3. Purposes of unrestricted and material designated funds

The purposes of unrestricted and material designated funds are:

Fund	Purpose
The Women's Hospital General Purpose Fund	Any charitable purpose(s) relating to the NHS wholly or mainly for the Liverpool Women's Hospital.
Liverpool Women's Cancer Charity	To further the advancement of scientific and medical education and research into topics related to cancer research.
Community Midwifery	Promoting the efficient performance of their duties by the midwives of the NHS Foundation Trust.
Reproductive Medicine Fund	To further the advancement of scientific and medical education and research into topics related to infertility, miscarriage and menopause.
Medical Education Fund	To further the advancement of scientific and medical education and research into topics related to the field of obstetrics and gynaecology.
Fetal Centre Research and Development	The investigation into causes of sickness in the unborn child and the prevention, treatment, cure and defeat of this sickness.
Neonatal Fund	The investigation into the causes of sickness in the newborn child and the prevention, treatment, cure and defeat of this sickness and to further the cause of premature newborn babies at the NHS Foundation Trust and to further the advancement of scientific and medical education and research into topics related to sickness in the newborn child.
Other Funds:	
Women's Hospital Staff Welfare Fund	For the relief of sickness by promoting the efficient performance of their duties by the staff of the Liverpool Women's Hospital.
Training and Development Fund	To further the advancement of scientific and medical education and research into topics relating to pregnancy and problems associated with giving birth and gynaecological problems.
Women's Assisted Conception Fund	To further the advancement of scientific and medical education into topics related to infertility in women.
Cytogenetics Fund	To further the advancement of scientific and medical education and research into topics related to cytogenetics.

Liverpool Women's Hospital Charity

4. Analysis of income

	2022 Unrestricted Funds £000	2022 Restricted Funds £000	2022 Total Funds £000	2021 Total Funds £000
Donations and legacies:				
Donations and gifts	**204**	0	**204**	323
Legacies	**22**	0	**22**	5
Total donations and legacies	**226**	**0**	**226**	328
Other trading activities:				
Stall income	**25**	0	**25**	1
Hire of birthing pools	**0**	0	**0**	4
Fundraising events	**8**	0	**8**	0
Total other trading activities	**33**	**0**	**33**	5
Income from investments:				
Dividend income	**20**	0	**20**	19
Total income from investments	**20**	**0**	**20**	19
Other income:	0	0	**0**	0
Total other income	**0**	**0**	**0**	0
Total Income	**279**	**0**	**279**	352

All income in the current and prior year was unrestricted.

5. Donated Goods

	2022 Unrestricted Funds £000	2022 Restricted Funds £000	2022 Total Funds £000	2021 Total Funds £000
Included within other trading activities:				
Sale of donated items	25	0	**25**	1
Total stall income included within other trading activities	**25**	**0**	**25**	**1**

Donated knitted items for resale are not recognised on receipt. Instead the value to the charity of the donated goods sold is recognised as income when sold. The proceeds of sale are categorised as "Income from other trading activities" in the Statement of Financial Activities and included within the stall income of £25,000.

Liverpool Women's Hospital Charity

6. Role of volunteers

The Charity is reliant on a team of volunteers who perform two main roles:

- Knitting – there are approximately 300 volunteer knitters who donate their time to knit baby items which are then sold on a weekly knitting stall in the main reception of the Liverpool Women's Hospital which is also run by volunteers. During the year the knitting stall raised £25,000 for the hospital's neonatal unit (2021: £1,000).
- Fundraisers – the Charity has many local volunteers who actively fundraise by hosting events such as garden parties, charity nights, participating in local and national events and being involved with bucket collections.

7. Allocation of support costs and overheads

All financial services costs provided by the Liverpool Women's NHS Foundation Trust have been treated as support costs and Independent examination fees have been treated as governance costs. Both support costs and governance costs have been apportioned across charitable activities expenditure proportionate to the expenditure level.

7.1 Support and Governance Costs

	2022 Unrestricted Funds £000	2022 Restricted Funds £000	2022 Total Funds £000	2021 Total Funds £000
Support Costs: Financial Services provided by Liverpool Women's NHS Foundation Trust	**19**	0	**19**	19
Governance Costs: Independent Examination Fees	**2**	0	**2**	2
Total	**21**	**0**	**21**	21

The Trustee does not receive any remuneration nor were any expenses paid to the Trustee in the year ending 31 March 2022 or the preceding financial year.

7.2 Apportionment of Support & Governance Costs across Charitable Activities

	2022 Patient welfare £000	2022 Staff welfare £000	2022 Equipment £000	2022 Research £000	2022 Total £000	2021 Total £000
Support Costs: Financial Services provided by Liverpool Women's NHS Foundation Trust	11	8	0	0	19	**19**
Governance Costs: Independent Examination Fees	1	1	0	0	2	**2**
Total	**12**	**9**	**0**	**0**	**21**	**21**

Liverpool Women's Hospital Charity

7.3 Analysis of expenditure

	2022 Unrestricted Funds £000	2022 Unrestricted Funds Support & Governance Costs £000	2022 Restricted Funds £000	2022 Total £000	2021 Total £000
Expenditure on raising funds:					
Staging fundraising events	**13**	**0**	**0**	**13**	10
Fundraising managers	**102**	**0**	**0**	**102**	100
Investment management costs	**9**	**0**	**0**	**9**	8
Total expenditure on raising funds	**124**	**0**	**0**	**124**	**118**
Expenditure on charitable activities:					
Patient welfare	**54**	**12**	**0**	**66**	14
Staff welfare	**36**	**9**	**0**	**45**	171
Equipment	**1**	**0**	**0**	**1**	22
Research	**0**	**0**	**0**	**0**	22
Total expenditure on charitable activities	**91**	**21**	**0**	**112**	**229**
Total Expenditure	**215**	**21**	**0**	**236**	**347**

Overhead and support costs including governance costs, volunteer costs, fundraising costs, finance and independent examination fees have been apportioned across charitable activities on the basis of the value of the fund.

8. Independent examination and audit fees

	2022 Unrestricted Funds £000	2022 Restricted Funds £000	2022 Total £000	2021 Total £000
Fees for examination of the accounts:				
Independent examiner's fees	**2**	**-**	**2**	2
Total fees	**2**	**0**	**2**	**2**

The Independent examination fee is shown in the above note excluding VAT in accordance with guidance, however, the VAT element is not recoverable making the overall Governance costs £2k as shown in note 7.1.

9. Analysis of staff costs

The Charity did not directly employ any staff during 2021/22 (2020/21: nil). The Charity instead received services from the Liverpool Women's NHS Foundation Trust, for example financial services for which a recharge is made by the Trust to the Charity.

10. Analysis of grants

The Charity does not make grants to individuals or third parties. All grants are made to the Liverpool Women's NHS Foundation Trust to provide for the care of our NHS patients in the furtherance of our charitable aims. The total cost of making grants, including support costs, is disclosed on the face of the Statement of Financial Activities.

The standing orders and standing financial instructions of the NHS Foundation Trust include the directions of the Trustee for the management of charitable funds and recognise that management processes may overlap with those of the NHS Foundation Trust.

The Trustee operates a scheme of delegation for the majority of charitable funds, under which fund holders manage the day to day disbursements on their projects in accordance with the standing orders and standing financial instructions of the NHS Foundation Trust.

Please refer to the Trustee's Annual report to the Account for additional information on the grant making activities performed during the year to 31 March 2022.

11. Transfers between funds

There were no transfers between funds during 2020/21 (2020/21: £nil).

12. Fixed asset investments

	2022 Total £000	2021 Total £000
Movement in fixed asset investment		
Market Value brought forward	897	743
Add: additions to investment at cost	174	308
Less: disposals at carrying value	(127)	(295)
Add: net (loss) / gain on revaluation - unrealised	(52)	141
Market Value as at 31 March	**892**	**897**
Cash held as part of investment portfolio	20	8
Total investment value as at 31 March	**912**	**905**
Historic Cost as at 31 March	708	649

Liverpool Women's Hospital Charity

Fixed asset investments by type

	2022 Total £000	2021 Total £000
Investments listed on a recognised Stock Exchange:		
UK Equities	**315**	343
European equities	**37**	35
North American equities	**201**	207
Japanese equities	**15**	16
Far East and Australasian equities	**26**	30
Emerging economies	**18**	21
International equities	**14**	13
Property	**50**	43
Alternative Assets	**70**	51
Other investments:		
UK fixed interest	**123**	121
Overseas Fixed Interest	**23**	17
Cash held as part of the investment portfolio	**20**	8
Total fixed asset investments	**912**	**905**

13. Total gross income from investments and cash on deposit

	2022 Total £000	2021 Total £000
Investments listed on a recognised Stock Exchange:		
UK Equities	**14**	15
European equities	**0**	0
Overseas and emerging equities	**3**	1
Other investments:		
UK fixed interest	**3**	2
UK Property	**0**	0
Alternative Assets	**0**	1
Total	**20**	**19**

14. Analysis of current assets

	2022 Total £000	2021 Total £000
Debtors under one year		
Investment income receivable	**3**	4
Total	**3**	4

15. Analysis of cash and deposits

	2022 Total £000	2021 Total £000
Short term investments and deposits	**7**	4
Cash at bank and in hand	**1**	1
Total	**8**	5

16. Analysis of liabilities and commitments

	2022 Total £000	2021 Total £000
Creditors and commitments under one year		
Amounts due to Liverpool Women's NHS Foundation Trust	**96**	156
Commitments	**38**	192
Other accruals	**2**	2
Total	**136**	350

	2022 Total £000	2021 Total £000
Creditors and commitments over one year		
Commitments	**225**	60
Total	**225**	60

Amounts owed to Liverpool Women's NHS Foundation Trust relates to grants paid out by the Trust on behalf of the Charity.

Movements in funding commitments during the period

	2022 Total £000	2021 Total £000
Balance at the start of the reporting period	252	352
Amounts added in current period	95	242
Amounts charged against commitments in the current period	(84)	(305)
Unused amounts reversed during the period	0	(37)
Balance at the end of the reporting period	**263**	**252**

Liverpool Women's Hospital Charity

17. Unrestricted funds

Analysis of unrestricted and material designated funds

	Funds brought forward at 1-Apr-21 £000	Incoming resources £000	Resources expended £000	Gain on investments £000	Funds carried forward at 31-Mar-22 £000
General Purpose	140	130	(75)	5	200
Liverpool Women's Cancer Charity	74	10	(21)	2	65
Community Midwifery	34	7	(11)	1	31
Reproductive Medicine Fund	2	3	5	0	10
Medical Education	51	2	(12)	1	42
Fetal Centre Research & Development Fund	50	7	(26)	1	32
Neonatal Fund	122	97	(68)	4	155
Other Funds	31	23	(28)	1	27
Total	**504**	**279**	**(236)**	**15**	**562**

Analysis of unrestricted and material designated funds

	Funds brought forward at 1-Apr-20 £000	Incoming resources £000	Resources expended £000	Gain on investments £000	Funds carried forward at 31-Mar-21 £000
General Purpose	104	42	(49)	43	140
Liverpool Women's Cancer Charity	62	6	(17)	23	74
Community Midwifery	25	6	(8)	11	34
Reproductive Medicine Fund	2	0	(1)	1	2
Medical Education	47	2	(14)	16	51
Fetal Centre Research & Development Fund	41	3	(10)	16	50
Neonatal Fund	33	139	(89)	39	122
Other Funds	25	154	(159)	11	31
Total	**339**	**352**	**(347)**	**160**	**504**

The purposes of the funds are given in note 3.

18. Reconciliation of net movement in funds to net cash flow from operating activities

	2022 Total £000	2021 Total £000
Net movement in funds	**43**	5
Adjustments for:		
Dividends and interest on investments	**(20)**	(19)
(Increase) / decrease in debtors	**1**	2
Increase / (decrease) in creditors	**(49)**	(66)
Total	**(25)**	(78)

19. Analysis of cash and cash equivalents

	2022 Total £000	2021 Total £000
Cash and deposits:		
Short term investments and deposits	7	4
Cash in hand	1	1
	8	5
Cash held as part of the investment portfolio	20	8
	28	13

20. Net Debt

2021/22:	At 1 April 2021 £000	Cashflows £000	At 31 March 2022 £000
Cash and deposits	13	**15**	**28**
Loans due within one year	(156)	**60**	**(96)**
Total	**(143)**	**75**	**(68)**

2020/21:	At 1 April 2019 £000	Cashflows £000	At 31 March 2020 £000
Cash and deposits	66	**(53)**	**13**
Loans due within one year	(122)	**(34)**	**(156)**
Total	**(56)**	**(87)**	**(143)**

Liverpool Women's Hospital Charity

21. Statement of Financial Activities for the year ended 31 March 2021

The below is the prior years' Statement of Financial Activities for the year ended 31 March 2021, which is shown for comparative purposes:

	Note	Unrestricted Funds 2021 £000	Restricted Funds 2021 £000	Total Funds 2021 £000	Total Funds 2020 £000
Incoming resources:	4				
Income and endowments from:					
Donations and legacies		328	0	**328**	202
Other trading activities		5	0	**5**	23
Investments	13	19	0	**19**	35
Other income		0	0	**0**	0
Total incoming resources		**352**	**0**	**352**	**260**
Resources expended:	7				
Expenditure on:					
Raising funds		118	0	**118**	79
Charitable activities		229	0	**229**	365
Total resources expended		**347**	**0**	**347**	**444**
Net expenditure before investment gains		**5**	**0**	**5**	(184)
Net (loss)/gain on investments – unrealised	12	141	0	**141**	(156)
Net gains on investments – realised		19	0	**19**	80
Net (expenditure)/ income		**165**	**0**	**165**	(260)
Net movement in funds		**165**	**0**	**165**	(260)
Reconciliation of Funds:					
Fund balances brought forward 1 April		339	0	**339**	599
Fund balances carried forward 31 March		**504**	**0**	**504**	339

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Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*2022/23/167b*		Date: 01/12/2022	
Report Title	Corporate Objectives 2022/23: Six Month Review			
Prepared by	***Mark Grimshaw, Trust Secretary***			
Presented by	Executives			
Key Issues / Messages	***The report provides a six-month position for the 2022/23 Corporate Objectives.***			
Action required	Approve ☐	Receive ☒	Note ☐	Take Assurance ☐
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable):			
	For Decisions - in line with Risk Appetite Statement – Y/N *If no – please outline the reasons for deviation.*			
	The Board is asked to note the performance / progress to date against the 2022/23 Corporate Objectives.			
Supporting Executive:	Executive Team			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

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

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

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

REPORT DEVELOPMENT:

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

EXECUTIVE SUMMARY

The Board of Directors reviewed the corporate objectives 2022/23 at its meeting on 5 May 2022 and formally approved them.

The cycle of periodic review usually involves the Board reviewing progress on the Corporate Objectives on a six-monthly basis and this report provides the position to date.

Recommendation

The Board is asked to note the performance / progress to date against the 2022/23 Corporate Objectives.

MAIN REPORT

NHS
Liverpool Women's
NHS Foundation Trust

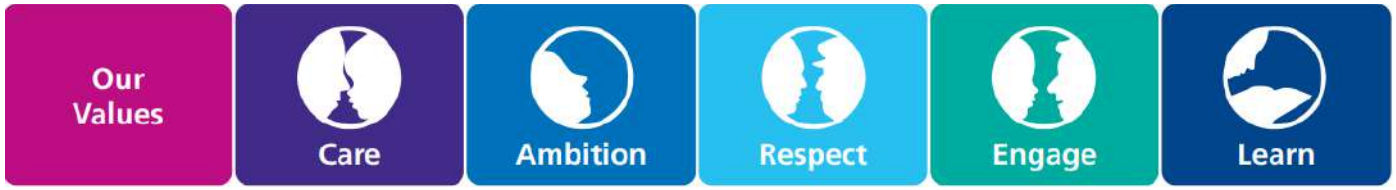
Corporate Objectives

2022 – 2023

Our Vision

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

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



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

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

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

Liverpool Women's NHS Foundation Trust

Key	Complete	On track	Risks identified but on track	Off Track

To develop a Well Led, capable, motivated, and entrepreneurial Workforce					
Strategic Aim	**Proposed Corporate Objective**	**Executive Lead**	**Relevant Strategy**	**Board Committee**	**6 month update**
Be recognised as the most inclusive organisation in the NHS with Zero discrimination for staff and patients (zero complaints from patients, zero investigations)	To progress year on year towards the organisational goal of 25% of our leadership workforce (Band 7 and above) being from an ethnically diverse background. This will require the Trust recruiting to 10 leadership roles each year between 2022-2025 (moving from 23 to 33 in 2022/23).	CPO	Putting People First Strategy	PPF	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'.
	To work in partnership with health, education, local authority and community partners to increase the number of employees from an ethnic minority background by 5% year on year to ensure we achieve Riverside representation by 2025, moving from 11% to 16% in 2022/23.	CPO	Putting People First Strategy	PPF	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	Demonstrate improvement from the 2021 NHS Staff survey in relation to staff engagement measures.	CPO	Putting People First Strategy	PPF	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 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 has recently closed and it is hoped that the result will represent an improvement, however at present this objective has been rated as 'behind target'.
	24/7 consultant obstetric workforce and 8am -10pm (twilights) for anaesthetic workforce by 2023	MD	Medical Workforce Strategy	PPF	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.

To deliver Safe services					
Strategic Aim	**Proposed Corporate Objective**	**Executive Lead**	**Relevant Strategy**	**Board Committee**	**6 month update**
Progress our plans to build a new hospital co-located with an adult acute site	Complete refresh of business case for a new Liverpool Women's Hospital to reflect evolving models of care and system developments.	CFO	Future Generations Strategy	FPBD	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 2023, to align with the conclusion of the Liverpool Clinical Services Review. 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).
Implement all feasible mitigations to ensure services delivered from the Crown Street site are as safe as possible, developing our facilities for the benefit of our patients as well as those across the system	Deliver the Crown Street enhancement work program (including CT and blood bank services) to time and to budget working with system partners to ensure optimal patient benefit across the wider Cheshire and Mersey system.	CFO	Estates Strategy	FPBD	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 permanent CT facilities is now due to complete in the New Year.
Develop our model of care to keep pace with developments and respond to a changing environment	Deliver the launch of Trust's EPR programme in line with established timescales.	CIO	Digital Generations Strategy	FPBD	The EPR programme continues to focus on the business change and configuration & build aspects of the implementation, with several workshops and demonstrations undertaken during the last reporting period. All remaining workshops have been scheduled with all but 1 to conclude before the festive period. Build activities continue, with high levels of development, however due to the success of the clinical engagement, a volume of additional clinical documents has been requested within Expanse resulting in additional scope of work. Integration activities continue to progress with the e-consent solution now fully interfaced into Expanse resulting in e-consent documents being available in the EPR. The training plan is being developed over the next reporting period with the Operational Leadership team.

	Recover and restore services for our patients and those across Cheshire and Merseyside in line with the National Operational plan requirements for 2022/23.	COO	Our Strategy	FPBD	In line with the national asks at the half year point the Trust has no 104 week waiting patients and is on trajectory to eliminate 78 week waiters by March 2023. The Trust has set itself a stretch target of eliminating 52 week waits 1 year early by March 2024 (vs national ask of March 2025) and this will need to be considered in the planning round. Despite a 30% increase in cancer referrals the 2 week target is being delivered, the 31 day target has seen sustained improvements and the 62 day target has started to see some improvement although there is still work to do. Diagnostic performance has been a challenge due to staffing however this is forecast to improve in Q3

To deliver the best possible Experience for patients and staff					
Strategic Aim	**Corporate Objective**	**Executive Lead**	**Relevant Strategy**	**Board Committee**	**6 month update**
Deliver an excellent patient and family experience to all our service users	Actively seek and use the diverse views of, patients, their families, and our communities to design and deliver services that best meet their needs. To ensure that services are utilising the findings of this intelligence to identify areas for	DONM	Clinical & Quality Strategy	QC	The following work has progressed since previous reporting: • Merseyside Society for the Deaf – work ongoing with digital agenda within the Trust to improve accessibility.

	service improvement and that we can demonstrate communication of the actions we have taken because of the feedback received.				• Brain Charity – volunteers have been introduced to support families on Neonates. This is yet to be evaluated o measure success • Merseyside Police –jointly working on Endometriosis and Menopause projects with learning to be shared/evaluated • Twice weekly 'Come talk to us' events – held at both sites, generating lots of feedback and captured onto the Ulysses system as PALS. • Maternity Improvement Task and Finish Group – improvements noted from the National Patient Survey, with on-going improvements captured within maternity patient experience action plans • Maternity Voices Panel – working with the chair to act on feedback • Catering group – introducing new menus following feedback from patients. • Genomics waiting area and counselling rooms have been updated following feedback from patients. • Trust compliance with Reasonable Adjustments Guidelines is monitored on a quarterly basis via the Integrated Safeguarding Quality Assurance Report. • Quarter 1 (22/23) data reflects 38% of those patients with additional needs were identified as requiring adjustments, of which 25% required the support of the safeguarding team to support care pathway. Quarter 2 (22/23) saw 58% of patients

					required adjustments, with only 10% of patients requiring additional support • Patient Story relating to Tokophobia heard at Trust Board demonstrating the positive impact Reasonable Adjustments have had in maternity care • Easy Read patient/carers feedback template has demonstrated how we have listened, engaged with resulting in overall positive experience whilst in hospital. The 2022 Learning Disability Improvement Standards (LD-IS) for NHS Trusts 2018 & Dementia-Friendly Hospital Charter (DFHC) 2018 Audit is in progress with findings expected in the next review.
	To implement a formal governance and reporting structure for the implementation of the Ockenden Final Report recommendations. This will monitor and track progress allowing for robust assurance to be provided to the Quality Committee and Board ensuring that the organisation is fully sighted on its position.	DONM	Clinical & Quality Strategy	QC	Maternity Transformation Board in place with meetings held monthly receiving progress reports from 5 workstreams. Workstream 1- Ockenden, aims to achieve compliance with the 92 Essential Actions from Ockenden 2 Report. Of the 92 Essential Actions 5 actions relate to National workstreams. Of the remaining 87 EA position in LWH: • 2 Reds (2.17%) • 27 Ambers (29.34%) • 58 Green (63%) MIAA drafting TOR to check evidence of Green EA in Q3 22/23 There is also an established process for updates & progress to be fed into the Trust Safety &

					Effectiveness Sub-Committee and then onto Quality Committee.

To be ambitious and Efficient and make best use of available resources					
Strategic Aim	**Proposed Corporate Objective**	**Executive Lead**	**Relevant Strategy**	**Board Committee**	**6 month update**
Ensure our services are financially sustainable in the long term	Ensure efficient and effective use of all available resources, meeting agreed financial targets and working across the Cheshire and Mersey system for optimum outcomes for the region.	CFO	Finance & Sustainability 2021-2025	FPBD	The Trust is facing financial challenge in 2022/23 and is undertaking a Recovery Programme in order to address this. Close working with the ICB is in place.
	Ensure the Trust has an updated, long term financial plan in place during 2022/23 to reflect recent and proposed regime changes, with clear views and actions in place in relation to long term sustainability.	CFO	Finance & Sustainability 2021-2025	FPBD	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.
	Develop the Trust's commercial strategy during 2022/23 and pursue appropriate opportunities to maximise Trust income for the benefit of our patients	CFO	Finance & Sustainability 2021-2025	FPBD	This has not yet started but will be undertaken in Quarter Four 2022/23.

To participate in high quality research in order to deliver the most Effective outcomes					
Strategic Aim	**Proposed Corporate Objective**	**Executive Lead**	**Relevant Strategy**	**Board Committee**	**6 month update**
Expand our existing partnerships, building on learning and partnership working throughout the COVID-19 pandemic, playing a key role in establishing any ICP or ICS	Maintain and develop key partnerships, ensuring robust governance structures are in place and effective reporting through the Trust's assurance framework.	MD	Our Strategy	FPBD	The Trust has several 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 closely 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 and Quality Committees, 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. The LNP went through a quality assurance process whereby the Partnership self-assessed itself against a predefined set of criteria based on

					the Well Led CQC domain. This was then presented to NEDs from both Boards
	Support the developing ICS for C&M and working with the system to improve outcomes for Women's Health including Maternal and Neonatal care.	CEO	Our Strategy	FPBD	Executives from LWH have engaged with the new Executive team of the ICB and at Place regarding the Case for Change for the Future Generations strategy. This case for change has been discussed at ICB Board meetings COO and MD chair a C&M Gold Command for maternity services on a weekly basis Through the LMS LWH has two clinical leads embedded within leadership structure for maternity and gynaecology Executives have engaged with their respective forums hosted via the ICB ie C&M MDs meeting and other execs have theirs as well CMAST programmes of work are also supported by Executives where appropriate including developmental days e.g CEO chairing (SRO) the workforce group
Progress our research strategy and foster innovation within the Trust	Provide clear evidence of senior nursing & midwifery research leadership, as per the Trust R&D strategy by March 2023	MD	Research & Innovation Strategy	QC	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 with LSTN and commenced Jan 2022. -Trial ongoing re speculum for 3rd/4th degree tears - created opportunity for midwife PhD. -Meetings have taken place with PEFs in Trust to make research placements available for nurses and midwives, to be implemented in 2022. A Nursing Midwifery and AHP Talent pipeline has been developed and a business case accepted to fund the pipeline. Research development opportunities will be offered in early 2023 for nurses midwives and AHPs. There are still further opportunities to fully embed and further expand this workstream, therefore this objective is rated as 'on track'.
	Complete refresh of R&D strategy and progress year 1 objectives	MD	Research & Innovation Strategy	QC	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 with a range of stakeholder groups, including the Trust's Council of Governors and representatives from all local 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	Ensure all wards and key areas have ward accreditation completed (twice a year)	DONM	Clinical & Quality Strategy	QC	The BBAS framework provides wards and departments with an evidence based, coordinated set of standards which are tailored to each individual ward/area against which the quality and safety of care can be measured. The standards are based on the Trusts Five Key Strategic Aims and Ambitions to support the Trust vision and to be outstanding in everything that we do, as well as the CQC `s assessment framework. To date a total of four out of eighteen departments have had a baseline assessment completed with a further five departments scheduled to be assessed by November end. This will ensure all inpatient areas have a baseline assessment by Q3 22/23. A further seven templates are in progress with managers to complete for Maternity outpatients/FMU/GED/Hewitt and Imaging departments. A SOP to support the BBAS implementation is in progress and a proposal for a Quality and Safety walkaround schedule which will provide additional assurance of standards.

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	***22/23/167c***		**Date: 01/12/2022**	
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 November 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 November 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

This report outlines proposed scores for Quarter 3 2022/23 for each respective BAF risk. There have also been several housekeeping amendments and updates made to actions. These have not been shown utilising track changes as the extent of the amendments, compromised the clarity of the document. For comparison purposes, the previous iteration of the BAF, has been shared with the Board in the supporting documents section of Admin Control.

A formatting change has been made to the pages that demonstrate the BAF linkages to the Corporate Risk Register risks and high scoring divisional risks. The joining arrows have been replaced with a cross referencing system to improve clarity.

The table below also 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 proposed change to BAF score for Quarter 3 – (likelihood 3 x consequence 4). Demonstrable progress has been made in this area and therefore it is proposed that the target for this risk in 2022/23 remains at '8'.
- Controls, Assurances and Gaps in control / assurance have been tidied and actions updated
- Suggested that the Covid-19 strategic threat be removed as the issues under this remain as business as usual and are included under other BAF items.

1.2 Failure to recruit & maintain a highly skilled & engaged workforce

- No proposed change to BAF score for Quarter 3 – (likelihood 4 x consequence 5). It is proposed that the target score set at '15' remains appropriate.
- Controls, Assurances and Gaps in control / assurance have been tidied and actions updated

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

- No proposed change to BAF score for Quarter 3 – (likelihood 3 x consequence 4). Demonstrable progress has been made in this area and therefore it is proposed that the target for this risk in 2022/23 remains at '8'.
- No proposed changes to the BAF title
- Narrative has been updated
- Controls, Assurances and Gaps in control / assurance have been tidied and actions updated
- No changes to the strategic threats

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

- No proposed change to BAF score for Quarter 3 – (likelihood 4 x consequence 4). It is likely that mitigations will be place for this risk during 2022/23 (new EPR system), effective Divisional Planning but it is unclear at the current time when the benefits for these will be realised. It is for this reason that the proposed target for 2022/23 is a '12'.
- No proposed changes to the BAF title, narrative or strategic threat descriptor
- Controls, Assurances and Gaps in control / assurance have been tidied and actions updated
- The November 2022 FPBD Committee requested that the narrative for this risk be reviewed and strengthened to ensure that it was reflective of the current challenges facing the Trust e.g. references to Covid-19 being of less relevance.

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 proposed change to BAF score for Quarter 3 – (likelihood 4 x consequence 5). There are several actions in train that should support the Trust in reducing this likelihood score down to 3 once they are completed and moved into the 'controls' column. The target for 2022/23 has therefore been set at 15 (3x5).
- No proposed amendments to the BAF title, strategic threat descriptor
- Controls, Assurances and Gaps in control / assurance have been tidied and actions updated.

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

- No proposed change to BAF score for Quarter 3 – (likelihood 4 x consequence 5).
- Controls, Assurances and Gaps in control / assurance have been tidied and actions updated.

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

- No proposed change to BAF score for Quarter 3 – (likelihood 3 x consequence 4).
- Controls, Assurances and Gaps in control / assurance have been tidied and actions updated.

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

- No proposed change to BAF score for Quarter 3 – (likelihood 5 x consequence 4). There remains a high degree of uncertainty around the financial landscape and whilst there are strong internal controls in place, the external environment means that it seems unlikely that a target lower than '16' can be set for 2022/23.
- No proposed amendments to the BAF title
- Controls, Assurances and Gaps in control / assurance have been tidied and actions updated.
- There was a recommendation at the November 2022 FPBD Committee to separate the financial sustainability threat from the 'in-year' threat to provide greater visibility to the latter. This will be undertaken for the December 2022 Committee and reported back to the Board. It was also agreed that the narrative for this new risk needed to include recovery planning work.

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 3 – (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 3 – (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 last 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 3 – (likelihood 3 x consequence 4). There is evidence of improvement and strengthened controls heading into 2022/23 (BBAS 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

BAF Risk 4.1 - There was a recommendation at the November 2022 FPBD Committee to separate the financial sustainability threat from the 'in-year' threat to provide greater visibility to the latter. This will be undertaken for the December 2022 Committee and reported back to the Board.

Closed Risks or Strategic Threats

BAF Risk 1.1 - Suggested that the Covid-19 strategic threat be removed as the issues under this remain as business as usual and are included under other BAF items.

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 – December 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)	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)	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)	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)	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)	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)	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)		⟷	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	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)		⟷	8 (I2 x c4)
SA5 Effective	5.1 Failure to progress our research strategy and foster innovation within the Trust	Quality	MD	8 (I2 x c4)	8 (I2 x c4)	8 (I2 x c4)		⟷	4 (I1 x c4)
	5.2 Failure to fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership	Quality	CNM	12 (I3 x c4)	12 (I3 x c4)	12 (I3 x c4)		⟷	8 (I2 x c4)

BAF HEAT MAP


Consequence
Likelihood
1
Rare
2 Unlikely
3
Possible
4
Likely
5
Almost certain
5 Catastrophic
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	BAF x REF	Corporate Risk Register / High Scoring (15+) Risks	Risk Score
2443	1.2	Inability to recruit specialised allied health professions in a timely manner	16
1705	1.2	Insufficient midwifery staffing levels as recognised by birth rate place plus.	20
2424	1.2	Unable to meet safe staffing levels in line with BAPM requirements	15
2549	1.2	Staff shortages in the Ultrasound Team within the Imaging Department due to Vacancies and 5 staff members leaving in May & June 22	20
2467	1.2	Inability to recruit specialised allied health professions in a timely manner for blood bank	
2087 **(CRR)**	1.2	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)**	1.2	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)**	1.2	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)	1.2	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: November 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)	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) Need to ensure that career conversations are being undertaken for all staff, particularly racially minoritized staff with a focus on their development and talent management	
	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		
	Updated EIA process and new policy	The EIA process is overseen by the ED&I sub-committee		

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). Advertisement of key roles via Inclusive Companies jobs page in place. Supported internships for BAME individuals from the local area to commence in January 2023.
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~~ January 2023	E&D Sub-Committee	See 1.1/1
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.	Head of Culture, Inclusion, Wellbeing and Engagement	January 2023	E&D Sub-Committee	Targeted recruitment days in partnership with local authority to take place from early 2023 onwards.

		Employees with protected characteristics have been invited to take part in national training to participate in recruitment processes in other NHS Trusts.(COMPLETED)					
	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	January 2023	E&D Sub-Committee	To be determined via a PPF Development Session.	
	1.1 / 7	Development of ED&I Strategy	Head of Culture, Inclusion, Wellbeing and Engagement	January 2023	E&D Sub-Committee	This will be included as a major strand of a revised PPF Strategy – to be developed in January 2023	

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)** **Work being undertaken to review the pathway for trans patients going through fertility prior to the commencement of hormone therapy.**	
	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		
	Role created in patient experience team to improve engagement with the local community groups	Outcomes and progress overseen by the PIESC and the ED&I sub-committee.		
	Regular Divisional reporting on protected characteristics for staff and their experience	Reported to the EDI sub-committee		

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
1.1 / 8	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	December 2022	Patient Involvement & Experience Sub-Committee	Patient Experience Matron is developing a process for the effective sharing of lessons from patient stories through to the Divisions
1.1 / 9	To provide assurance regarding Patient Information Leaflet audit to PIEG on an annual basis	Head of Audit, Effectiveness and Patient Experience	January 2023	Patient Involvement & Experience Sub-Committee	Audit currently being undertaken to review the accessibility of PILs in terms of language.
1.1 / 10	Local ownership of FFT results to enable improvements to be created and implemented at a local level	Head of Audit, Effectiveness and Patient Experience	January 2023	Patient Involvement & Experience Sub-Committee	The results are reporting through to Divisions but further work required before this can be moved to an embedded control

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

Lead Director: CPO
Op Lead: Deputy Director of Workforce

Review Date: November 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)	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 (Let's Talk)		
	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	February 2023	PPF Committee	Workforce plans for medical and non-medical staff to be presented as part of the annual planning process. Quarterly reporting of ED&I elements of ESR is being undertaken.
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*	Overall Assurance Rating

					evidence as to effectiveness of the controls or negative assurance)		
The Covid-19 pandemic & associated elective recovery has the ongoing potential to impact staff morale, wellbeing and retention	Staff working from home where appropriate, use of virtual meetings and enhanced IT provision 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		PPF Committee Feedback from staff side		None noted.		
	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

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	BAF x REF	Corporate Risk Register / High Level (15+) Risks	Risk Score
1961	2.2	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	2.2	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	2.3	There is a risk that during the Covid-19 pandemic, adult patients who suffer a cardiac arrest will receive suboptimal resuscitation	16
2386	2.4 & 2.2	Risk of personal and sensitive information being compromised or being misused	15
2316	2.3	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	2.2	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	2.2	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	2.3	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	2.2	CAMRIN Digital solutions being reviewed	16
2385	2.4	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)	2.2 & 2.3	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)**	2.3	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)**	2.3	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)**	2.3	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)**	2.2 & 2.3	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)**	2.3	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)**	2.3	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)**	2.3	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: November 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)	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 CEO has met with Regional Director, Richard Barker	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 sufficient capital funding for a new build – access to capital is a pre-requisite for public consultation 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 Outputs from the LSCR are likely to influence direction of the FG Programme and ICB engagement and support – report due New Year 2023	
	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) Business case refresh will be informed by outputs of Liverpool Clinical Services Review		
	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.		
	Independent Review and Testing of Case for Change, including Counterfactual Case	The Case for Change (including the counterfactual case) has been shared with and received support from the following stakeholder groups: • Commissioners (specialised commissioners and Place) • C&M Cancer Alliance • LMS • Adult Critical Care ODN • LMC		

		No stakeholders have expressed any disagreement with the case or counterfactual case. Counterfactual case has been reviewed by an independent clinical senate in 2022, who concurred with its conclusions. Original case for change reviewed by independent clinical senate in 2016.			
	External validation of case for change	Output from Clinical Summit report (2019 and 2022)			
	Liverpool Clinical Services Review (LSCR) commissioned	C&M ICB have commissioned the Liverpool Clinical Services Review, via the One Liverpool Partnership Board, to examine issues case by configuration of acute services in Liverpool. Outputs awaited in final report.			

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 (date TBC following output/ next steps of LSCR)	Board	
2.1/3	Business case refresh – refreshed estates modelling and schedule of accommodation for new build	Associate Director of Strategy	December 2022 (date TBC following output/ next steps of LSCR)	Board	
2.1/5	Commence public consultation (external control of this action by commissioners and NHSE/I)	Head of Communications and Marketing	May 2023 (date TBC following output/ next steps of LSCR)	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 commissioner's 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 Communication with patients and the public regarding the outputs of the LSCR will be required	

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	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 No clear route to sufficient capital funding for a new build – access to capital is a pre-requisite for public consultation No progress in receipt of funding and delivery of new hospital schemes already approved under New Hospitals Programme	
	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		
	Engagement with system partners through LSCR	Regular updates provided to the Executive Team – engagement of appropriate executives on working groups	Awaiting outputs from the report	

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
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: November 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)	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)** ICS wide Shared Care Record programme not fully implemented/ active programme of work**)**	
	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	The comms plan is completed and signed off at EPR Programme Board. It is a living document that will evolve during the course of the programme.
2.2 / 3	Issue appropriate communication to all staff in relation to digital development by multiple means and forms	CIO	January 2023	Digital Hospital Committee oversight	This is largely being achieved through the CAGE, and Ops engagement, aswell as business process mapping workshops. What we still lack is dedicated comms officer to issue regular comms and the adoption of change agents. We expect both to be completed by end of Jan, following funding.

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

					evidence as to effectiveness of the controls or negative assurance)		
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 Operational planning process Availability of data on service trends and demographics Workforce plans		Divisional Board meetings Operational plans and budgets Divisional Boards Divisional Boards		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)**		
	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: November 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)	20 (4x5)		⟷	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				
	Liverpool Clinical Services Review (LSCR) established	Engagement from appropriate Executives in designated working groups				

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	TBC (pending information from Liverpool Clinical Laboratories regarding training)	Crown Street Enhancements Programme Board, FPBD	Additional IT issues encountered
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	November 2022	Crown Street Enhancements Programme Board, FPBD	Complete
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: November 2022

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)	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 Medical Devices 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	March 2023	DHSC	Procured. Planning session with supplier scheduled 1st week of November. Implementation plan to follow with revised fully implemented date March 2023
2.4 / 3	Purchase and implement software for USB port control	CIO	March 2023	DHSC	Procured and solution is installed. Due to the invasive nature of the system, it is currently configured for monitoring mode. Assessment of the data collected to follow with port control policies to be implemented by March 2023
2.4 / 4	Improve grip, control and governance on medical devices	CIO	March 2023	Medical Devices / DHSC	Digital attendance at Medical Devices Committee. Asset inventory of medical devices under review. Funding for Digital solution to protect medical devices submitted to ICS in October.

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

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

Risk and Controls Summary

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

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

Ref	BAF X REF	Corporate Risk Register / High Level (15+) Risks	Risk Score
2418	3.1	Lack of support and appropriate care for patients presenting with mental health conditions	16
2430	3.1	Network outlier for pre-term mortality - rate is higher than the national average	16
2427	3.1	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	3.1	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	3.1	Failure to achieve 31 day and 62 day national cancer targets, and having monthly 104 day breaches	16
2472	3.1	All twenty delivery suite beds (Hilrom) in use are not fit for purpose	20
2485	3.1	Limited access to MRI scan (currently 5-6 weeks wait) needed for cancer patient pre treatment (both surgical and radiotherapy treatment).	16
2606 (CRR)	3.1	failure to comply with national infection trajectory specifically in relation to E.coli bacteraemia	10
1966 **(CRR)**	3.1	Risk of safety incidents occurring when undertaking invasive procedures	12
2088 **(CRR)**	3.1	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)	3.1	Failure to meet clinical demand for red blood cells	9
2603 (CRR)	3.1	Current Intranet in poor condition and no longer fit for purpose	9

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: November 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)		⟷	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 review the progress against the Women's, Babies and Families Experience Strategy. This is undertaken in June of each year and any concerns are escalated to the Quality Committee via the Chairs report.	External MVP involvement in reviewing complaints processes All information should be reviewed by the Divisional Board prior to coming to PIESC Evidence how the divisions are using this data to influence their service design and improvements Recent patient/women's stories to Trust Board have highlighted that the Heads of Service have not always been aware of the story that was being shared, at Trust Board, that reflected on the care provided within their division. This has resulted in a lack of opportunity for senior presence at the Trust Board meeting to answer any questions and identify actions that have been put into place in relation to the patient/women's experience within their Care Group, this also shows lack of assurance patient stories are shared at local divisional level No set policy/process for Experience based co design policy to listen to patient voices when service changes are needed. QI projects need to be developed from patient voices and experience based co-design.	
	PALs and Complaints data	Patient Involvement & Experience Sub-Committee review PALs and Complaint data quarterly via the Themes and Trend report, and any concerns raised are escalated to the Quality Committee via the Chairs report.		
	Patient Stories to Board	The Trust Board Meeting has a patient/women's story to Board most months throughout the year.		
	Friends and Family Test	Patient Involvement & Experience Sub-Committee review the Friends and Family themes and trends quarterly. Friends and Family also form part of the Trust Performance report that each Division must review. More recently a new KPI regarding displeased comments has been added. This has given each area the opportunity to review displeased comments and act on them. This also enables the areas to display the 'you said we did' data out in the areas.		
	National Patient Surveys	Patient Involvement & Experience Sub-Committee review the results of the National Maternity Survey, National Inpatient Survey and the National Cancer Survey Annually. All surveys are also reviewed by the Trust Quality Committee.		
	Healthwatch feedback	Patient Involvement & Experience Sub-Committee have both Healthwatch Sefton and Healthwatch Liverpool on the group as active participants.		
	Social media feedback	Patient Involvement & Experience Sub-Committee review as part of the quarterly themes and trends reports as working with the Communications team all social media comments are sent through to PEX to review and action.		
	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 on community engagement and relationships via the Patient Involvement and Experience Sub-Committee and attends CoG Comms and Engagement Group to share experiences		
	Bespoke Patient Surveys	Patient Involvement & Experience Sub-Committee review ad hoc		
	Patient experience review reports produced by the Divisions and reported to PIESC	Patient Involvement & Experience Sub-Committee listen to the Patient Experience Strategy updates from each Division via the Patient Experience review paper and any patient experience intelligence that they have.		
	BBAS – Ward Accreditation Scheme	Safety and Effectiveness Sub Committee review the BBAS quarterly and any issues are escalated to the Quality Committee via the chairs report. Patient Experience Matron forms part of the accreditation team		
	PLACE assessment	Patient Involvement & Experience Sub-Committee review the outcomes form the PLACE assessment, this is also on the Quality Committee		
	MVP	Patient Experience Matron attends the MVP meetings and MVP chair is part of the circulation list for PIESC		
	Care Opinion	Patient Involvement & Experience Sub-Committee review the Friends and Family themes and trends quarterly,		
	Patient Experience Walkabouts	Patient Involvement & Experience Sub-Committee review the Friends and Family themes and trends quarterly,		

	Matron Walkabouts	Matrons' operation group reviews the feedback gained and issues escalated on the chairs report to the Nursing and Professional forum				
	Non-Executive Director Quality Walkabouts	Quality Committee review the results from each walkabout ??				
	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	MVP chair linked in with the Deputy Head of Experience and the Patient Experience Matron. MVP chair also is now part of the Patient Involvement and Experience Distribution list and will attend meetings when available as works just 3 days per month.
	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	SOP developed and on the agenda for the Dec 22 Patient Involvement and Experience Sub Committee
	3.1 / 4	Development of a process to share the board presented patient stories to a wider audience such as divisional board and team meetings.	Patient Experience Matron. Head of Comms. Divisional Management Teams	December 2022	Patient Involvement & Experience Sub-Committee	The PEX matron and Deputy Chief Nurse have developed a SOP that will be used by each area with regards to Patient Stories.
		Divisional Boards to review Patient Experience Data prior to being reviewed by the Patient Involvement and Experience Sub Committee	Divisional Management Teams	Feb 23	Patient Involvement & Experience Sub-Committee	
		To develop a SOP for Experience based co design to listen to patient voices when service changes are needed.	Head of Audit, effectiveness, and Patient Experience	Feb 23	Patient Involvement & Experience Sub-Committee	
		QI projects need to be developed from patient voices and experience-based co-design.	Quality Manager	Feb 23	Quality Improvement Group	
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.	Managing Concerns and Complaints Policy		Complaints annual report is approved by Quality Committee and the Quarterly themes and trends report is discussed at Patient Involvement and Experience Sub Committee. The Integrated Governance report included Patient Experience data and is reviewed at Quality Committee.		MVP review needed of complaints actions and themes for improvement presented at PIESC No formal process in place to monitor the completion of complaint/ PALS+ action plans on the Ulysses system. Poor performance against Trust KPI for displeased FFT responses and you said we did in the areas and updating power bi No documented processes for all feedback received i.e., National Surveys, FFT PLACE assessments feedback	
	Annual Quality Schedule returns to the ICB (WELL-LED-01CARING-01)		The Quality schedule is reviewed by the ICB and this covers an annual submission for Well Led 01 and Caring 01. The reports are also discussed at the CQPG.			
	Women, babies and their families experience strategy 2021 - 2026		Patient Involvement & Experience Sub-Committee review the progress against the Women's, Babies and Families Experience Strategy. This is undertaken in June of each year and any concerns are escalated to the Quality Committee via the Chairs report.			
	KPI for displeased Friends and Family		Performance Reports are discussed at Quality Committee			
	KPI for Complaint responses		Performance Reports are discussed at Quality Committee			
	KPI for Complaint action plans		Performance Reports are discussed at Quality Committee			
	K041 national return		External to NHSE digital to monitor the complaints activity			
	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	MVP chair linked in with the Deputy Head of Experience and the Patient Experience Matron. MVP chair also is now part of the Patient Involvement and Experience Distribution list and will attend meetings when available as works just 3 days per month.
	3.1 / 7	Improvement of compliance against Trust KPI relating to displeased comments in FFT and to ensure that Power BI is updated so the 'You said we did data' can be extracted	Divisional Management Teams	Feb 2023	Patient Involvement & Experience Sub-Committee	This is being monitored by the Patient Involvement and Experience Sub Committee and there are improvements in some areas.
		To develop a SOP to document the process for when feedback is received and what needs to be completed in the Divisions.	Head of Audit, Effectiveness and Patient Experience	Feb 2023	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*	**Overall Assurance Rating**

			evidence as to effectiveness of the controls or negative assurance)		
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	BAF X REF	Corporate Risk Register / High Level (15+) Risks	Risk Score
2621 (CRR)	4.1	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: November 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)	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	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: November 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)		⟺	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)

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

Ref	BAF X REF	Corporate Risk Register / High Scoring (15+) Risks	Risk Score
2336	5.2	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	5.2	Failure to meet the governance and risk management requirements of the Family Health Division	16
2456	5.2	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)**	5.2	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)**	5.2	Inability to achieve and maintain regulatory compliance, performance and assurance.	8
2329 **(CRR)**	5.2	There is a risk to the Trust is not meeting it requirements for the safe and proper management of medicines	12

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: November 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)	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: November 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)	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 has been implemented – This includes a well-led framework, and the on-going development of the CQC self-assessment process including a review of previous CQC action pans. The Be Brilliant Accreditation Scheme (BBAS) launched in July 22.	Quality Committee Executive Team oversight Divisional Board and performance review meetings Trust Board	Number of policies and SOPs out of review date **(Action 5.2 / 2)** **The CQC self-assessment and BBAS programmes can duplicate each other. Findings from each may differ**	
	Horizon scanning for changes in the CQC's regulatory approach	Quality Committee		
	Engagement meetings with CQC and regular contact in between meetings with our CQC inspector.	Quality Committee		

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
5.2 / 1	Amalgamation of the BBAS programme and CQC self-assessment Inspection framework to provide the trust with one single assessment framework which falls in line with CQC's new regulatory approach.	Deputy Director of Nursing & Midwifery	April 2023	Quality Committee	Development on-going and expected to be rolled out in April 2023
5.2 / 2	Ensure all policies and procedures are within their review date	Assoc. Director of Quality & Governance	December 2022	Quality Committee	The position had improved but further work required to ensure this becomes BAU. Governance dashboards are in the process of being developed to enable divisions and senior leaders to identify risk and areas for development, this includes an update on policies and procedures. In the interim a weekly report is provided to the Chief Nurse, COO and divisional SLTs prior to expected roll-out of the new dashboards in December 22.

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	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	Monthly CQRM MeetingMonthly reporting of incidents and management of action plans through Safety & Effectiveness Sub-Committee and quarterly via Quality Committee Reflection of risks and Corporate Risk Register and Board Assurance Framework CQC Assessment	Lack of testing of action plans following audits to ensure they lead embedded change – will be supported by ward accreditation once embedded **(Action 5.2 / 3)**	

significant events and evidencing improved practice and clinical outcomes.	Mandatory training in relation to safety and risk Serious Incident Feedback form Weekly Patient Safety Meeting for Serious Incidents and unexplained harm/injuries Safety is included as part of executive walk rounds. Risk Management Strategy Link on desktop of computer with a link to lesson learnt section of web page Use of the action planning module is to be embedded across all divisions Monthly Divisional Integrated Governance Reports that focus on the embedded changes in practice and learning . Approx. 30 staff have been through Route Cause Analysis and Investigative Officer Training in May and June 2022. Human Factors training in place	Annual Quality Account Report Shared learning page now live on the intranet The Governance team to use weekly meetings for review actions and ensure shared. Governance team to ensure oversight and reporting of progress Safety & Effectiveness Sub-Committee on a monthly basis Mandatory training compliance figures	Inconsistent completion and dissemination of actions and improvement plans – signs of improvement but with further work required. **(Action 5.2 / 4)** Lack of consistency between divisional governance meetings (noted in recent well-led report) **(Action 5.2 / 3)** Human Factors training compliance and availability **(Action 5.2 / 5)** Monitoring compliance with risk management training **(Action 5.2 / 7)** **The Divisional Integrated Governance Reports are still in their infancy and will be further developed at pace in collaboration between local and corporate teams (Action 5.2 / 3)**			

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
5.2 / 3	To ensure that Divisional Governance meetings and reporting are consistent and seek evidence of actions / lessons being embedded	Deputy COO	January 2023	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 including the introduction of divisional dashboards feeding into power BI. 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.	Associate Director of Quality & Governance	January 2023	Safety & Effectiveness Sub-Committee	Corporate Governance are working closely with Ulysses and the information team on this piece of work.
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 & Safety	On-going	Safety & Effectiveness Sub-Committee	
5.2 / 8	Legal polices re claims and learning are being reviewed, revised and will be shared	Associate Director of Quality & Governance	January 2023	Safety & Effectiveness Sub-Committee	Revised policy to be presented to safety & effectiveness in Dec 22. Comments/suggestions are being sought from local teams at present.

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Ineffective and / or ill-defined quality improvement methodology will result in the Trust missing opportunities to improve the safety, effectiveness and experience of care.	Quality Improvement training materials available on Trust Intranet Quality Improvement projects tracked Quality Account tracking key projects Quality Improvement Framework, policies and procedures have been developed and agreed	Training levels reported to the Quality & Clinical Audit Group Bi-Monthly via Quality Improvement Group Annual Quality Account Quality Improvement Group bi-monhtly Quality Committee once per quarter The number of QI projects submitted for approval to commence have significantly increased in Q2.	Opportunities to engage individuals in QI training limited, particularly during pandemic (Action 5.2 / 9) Evidence of QI projects being undertaken but not always 'formalised'. This has however improved in Q2. (Action 5.2 / 12) Lack of QI training to support colleagues across the trust, to both those in post and new starters. (Action 5.2 / 9) QI lead post has been vacant since July 22. (Action 5.2 / 8)	

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 Manager role and a Quality Facilitator rolehas been completed. They are expected to start in post in January 23.
5.2 / 9	Increase levels of QI training	Assoc. Director of Governance & Quality	February 2023	Quality Improvement Group Quality Committee	Preliminary discussions have taken place with LD with a view to looking at the training offer trust wide including the trust induction.

						Each area within the trust has completed a QI TNA to give us a baseline of the QI knowledge & expertise available to us.	
	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	Completed	
	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	Quality & Safety summit to commence in January 2023, refresh of QI with a shared vision to take our QI journey forward. This has been communicated to QIG and Quality Committee and Trust Board. The new QI manager will also bring further ideas upon their appointment to make this a reality.	

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 a normal acute admission ward *or* an inpatient unit specialising in the care of critically ill infants, children, and teenagers
PLACE	Patient-Led	Surveys inviting local people going into hospitals as
	Assessments of the Care Environment	part of a team to assess how the environment supports patient's privacy and dignity, food, cleanliness and general building maintenance
PPI	Patient and Public Involvement	mechanisms that ensure that members of the community --- whether they are service users, patients or those who live nearby – are at the centre of the delivery of health and social care services
PTS	Patient Transport Services	free transport to and from hospital for non-emergency patients who have a medical need

	Primary Care	the first point of contact with the NHS for most people and is delivered by a wide range of independent contractors, including GPs, dentists, pharmacists and optometrists, it also includes NHS walk-in centres and the NHS 111 telephone service

Q

QA	Quality assurance	monitoring and checking outputs to make sure they meet certain standards
QI	Quality improvement	A continuous improvement process focusing on processes and systems
QIA	Quality Impact Assessment	A process within NHS trusts which ensures the quality of service is systematically considered in decision- making on service changes
QUI	Qualities and Outcomes Framework	The system for performance management and payment of GP's in the NHS

R

R&D	Research & Development	work directed towards the innovation, introduction, and improvement of products and processes
RAG	Red, Amber, Green classifications	a system of performance measurement indicating whether something is on or better than target (green), below target but within an acceptable tolerance level (amber), or below target and below an acceptable tolerance level (red)
RGN	Registered General Nurse	a nurse who is fully qualified and is registered with the Nursing and Midwifery Council as fit to practise
RoI	Return on Investment	the benefit to the investor resulting from an investment of some resource. A high RoI means the investment gains compare favourably to investment cost. As a performance measure, RoI is used to evaluate the efficiency of an investment or to compare the efficiency of a number of different investments.
RTT	Referral to Treatment Time	the waiting time between a patient being referred by a GP and receiving treatment

S		
SALT	Speech and Language Therapist	assesses and treats speech, language and communication problems in people of all ages to help them better communicate
SFI	Standing Financial Instructions	Policy used for the regulation of the conduct of an NHS trust in relation to all financial matters
SHMI	Summary Hospital Level Mortality Indicator	reports mortality at trust level across the NHS in England using standard and transparent methodology
SID	Senior independent Director	a non-executive director who sits on the board and plays a key role in supporting the chair; the SID carries out the annual appraisal of the chair, and is available to governors as a source of advice and guidance in circumstances where it would not be appropriate to involve the chair
SIRO	Senior Information Risk Officer	a senior manager who will take overall ownership of the organisation's information risk policy
SITREP	Situation Report	a report compiled to describe the details surrounding a situation, event, or incident
SLA	Service Level Agreement	an agreement of services between service providers and users or commissioners
SoS	Secretary of State	the minister who is accountable to Parliament for delivery of health policy within England, and for the performance of the NHS
SRO	Senior Responsible officer	A leadership role which is accountable for the delivery and outcome of a specific project
STP	Sustainability and Transformation Partnership	Partnerships formed between local councils and NHS services to help plan and run services, and agree system-wide priorities
SUI	Series Untoward Incident / Serious Incident	A serious incident which resulted in one or more of the following: unexpected or avoidable death, a never event, a prevention of organisation's ability to continue to deliver healthcare services, abuse, or loss of confidence in a service
SWOT	Strengths, Weaknesses, Opportunities, Threats	a structured planning method used to evaluate the strengths, weaknesses, opportunities and threats involved in a project or in a business venture
	Secondary Care	NHS health service provided through hospitals and in the community

T		
TTO	To Take Out	medicines to be taken away by patients on discharge

	Tertiary Care	healthcare provided in specialist centres, usually on referral from primary or secondary care professionals

V

VTE	Venous Thromboembolism	a condition where a blood clot forms in a vein. This is most common in a leg vein, where it's known as deep vein thrombosis (DVT). A blood clot in the lungs is called pulmonary embolism (PE)
VfM	Value for Money	used to assess whether or not an organisation has obtained the maximum benefit from the goods and services it both acquires and provides, within the resources available to it

W

WLF	Well Led Framework	a set of indicators that seek to identify how well led an organisation is, also used as a framework for board governance reviews
WRES	Workforce Race Equality Standard	a metric to demonstrate progress against a number of indicators of workforce equality, including a specific indicator to address the low levels of black and minority ethnic (BME) board representation
WTE	Whole-time equivalent	See FTE

Y

YTD	Year to Date	a period, starting from the beginning of the current year, and continuing up to the present day. The year usually starts on 1st April for financial performance indicators