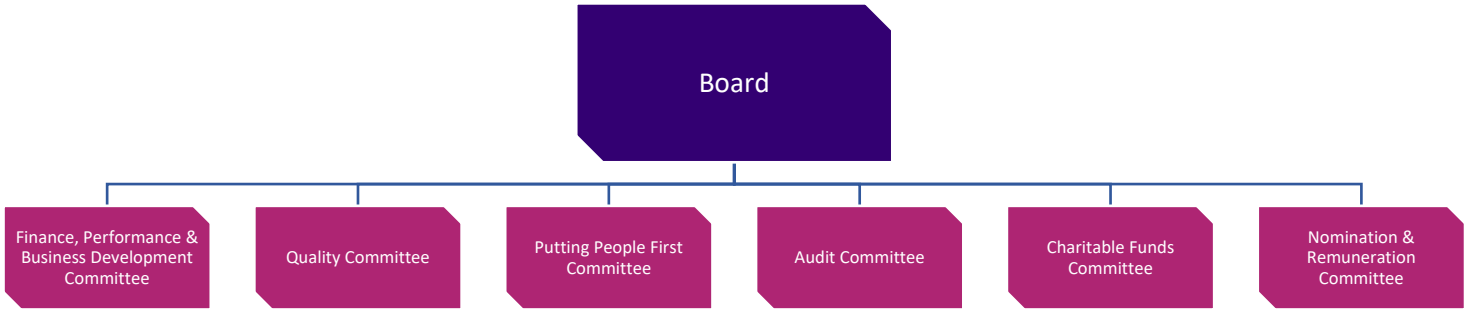
Liverpool Women's
NHS Foundation Trust

Trust Board

2 February 2023, 09.30am
Boardroom, LWH & Virtual, via Teams



NHS
Liverpool Women's
NHS Foundation Trust

Trust Board

Location	Boardroom, LWH and Virtual (via Teams)
Date	2 February 2023
Time	9.30am

AGENDA					
Item no. 22/23/	Title of item	Objectives/desired outcome	Process	Item presenter	Time
PRELIMINARY BUSINESS					
193	Introduction, Apologies & Declaration of Interest	Receive apologies & declarations of interest	Verbal	Chair	09.30 (5 mins)
194	Meeting Guidance Notes	To receive the meeting attendees' guidance notes	Written	Chair	
195	Minutes of the previous meeting held on 12 January 2023	Confirm as an accurate record the minutes of the previous meeting(s)	Written	Chair	
196	Action Log and matters arising	Provide an update in respect of on-going and outstanding items to ensure progress	Written	Chair	
197	Service Outline – C-GULL Research	To receive service outline	Presentation	Medical Director	0935 (15 mins)
198	Patient Story	To receive a patient story	Verbal	Chief Nurse	09.50 (20 mins)
199	Chair's announcements	Announce items of significance not found elsewhere on the agenda	Verbal	Chair	10.10 (5 mins)
200	Chief Executive Report	Report key developments and announce items of significance not found elsewhere on the agenda	Written	Chief Executive	10.15 (10 mins)
MATERNITY					
201a	Director of Midwifery Update	To receive	Presentation	Chief Nurse	10.25 (15 mins)
201b	Maternity Staffing report 1st July- 31st December 2022	To receive	Written	Chief Nurse	10.40 (10 mins)
QUALITY & OPERATIONAL PERFORMANCE					
202a	Chair's Reports from the Quality Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	10.50 (30 mins)
202b	Quality & Operational Performance Report	For assurance – To note the latest performance measures	Written	Chief Operating Officer	

202c	Mortality and Learning from Deaths Report Quarter 2, 22/23	For assurance	Written	Medical Director	
BREAK 11.20 – 11.25					
Board Thank You 11.25 – 11.30					
PEOPLE					
203a	Chair's Report from the Putting People First Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	11.30 (20 mins)
203b	Workforce Performance Report	For assurance – To note the latest performance measures	Written	Chief People Officer	
203c	Race Equity Declaration of Intent	To approve	Written	Chief People Officer	
FINANCE & FINANCIAL PERFORMANCE					
204a	Chair's Reports from the Finance, Performance and Business Development Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	11.50 (20mins)
204b	Finance Performance Review Month 9 2022/23	For assurance - To note the status of the Trust's financial position	Written	Chief Finance Officer	
BOARD GOVERNANCE					
205	Board Assurance Framework	For assurance	Written	Trust Secretary	12.10 (5 mins)
STRATEGY					
206	Liverpool Clinical Services Review	To receive	Written	Chief Finance Officer	12.15 (20 mins)
CONSENT AGENDA (all items 'to note' unless stated otherwise) *All these items have been read by Board members and the minutes will reflect recommendations, unless an item has been requested to come off the consent agenda for debate; in this instance, any such items will be made clear at the start of the meeting.*					
207	Emergency Preparedness, Resilience & Response Compliance	For assurance	Written	Chief Operating Officer	Consent
CONCLUDING BUSINESS					
208	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair	12.35 (5 mins)
209	Chair's Log	Identify any Chair's Logs	Verbal	Chair	
210	Any other business & Review of meeting	Consider any urgent items of other business	Verbal	Chair	
211	Jargon Buster	For reference	Written	Chair	
Finish Time: 12.40					

Date of Next Meeting: 6 April 2023

12.40 – 12.50	*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 12 January 2023

PRESENT

Robert Clarke	Chair
Kathryn Thomson	Chief Executive
Jenny Hannon	Chief Finance Officer / Executive Director of Strategy & Partnerships
Louise Martin	Non-Executive Director
Zia Chaudhry MBE	Non-Executive Director
Dr Lynn Greenhalgh	Medical Director
Dianne Brown	Chief Nurse
Michelle Turner	Chief People Officer / Deputy Chief Executive
Tracy Ellery	Non-Executive Director / Vice-Chair
Sarah Walker	Non-Executive Director
Jackie Bird MBE	Non-Executive Director
Prof. Louise Kenny CBE	Non-Executive Director / SID
Gary Price	Chief Operating Officer

IN ATTENDANCE

Matt Connor	Chief Information Officer
Vicky Clarke	Family Health Divisional Manager
Heledd Jones	Head of Midwifery
Yana Richens	Director of Midwifery
Angela Winstanley	Quality & Safety Midwife
Dr Alice Bird	Clinical Director, Family Health
Jen Deeney	Head of Neonatal Nursing
Catherine McClennan	Programme Director, LMNS
Annie Gorski	Public Governor
Mark Grimshaw	Trust Secretary (minutes)

APOLOGIES:

Gloria Hyatt MBE	Non-Executive Director

Core members	**Jan 22**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan 23**
Robert Clarke - Chair	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓
Kathryn Thomson - Chief Executive	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓
Dr Susan Milner - Non-Executive Director / SID	✓	✓	✓	✓	✓	Non-member						
Tracy Ellery - Non-Executive Director / Vice-Chair	✓	✓	✓	✓	✓	✓	✓	A		✓	✓	✓
Louise Martin - Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓
Tony Okotie - Non-Executive Director	✓	✓	✓	✓	✓	A	Non-member					

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

22/23/	
172	**Introduction, Apologies & Declaration of Interest** The Chair welcomed everyone to the meeting. Apologies were noted as above. The Chief Executive noted a declaration of interest in respect that she was the Senior Responsible Officer for the Local Maternity & Neonatal System (LMNS) – a body which had responsibility for assuring the compliance sign off for the Maternity Incentive Scheme on behalf of the Cheshire & Merseyside Integrated Care Board (ICB). The Chief Executive confirmed that she had not been involved in developing the position presented to the Board under item 22/23/177.
173	**Meeting guidance notes** The Board received the meeting attendees' guidance notes.
174	**Minutes of the previous meeting held on 1 December 2022** The minutes of the Board of Directors meeting held on 1 December 2022 were agreed as a true and accurate record.
175	**Action Log and matters arising** Updates against actions log were noted.
176	**Chair & CEO announcements** None noted.
177	**Maternity Incentive Scheme (CNST) Year 4 – Sign off** The Board received the final compliance position for the 10 Safety Actions and their associated standards, of the CNST Maternity Incentive Scheme Year 4, ahead of the submission date of 2 February 2023. The Chief Operating Officer noted that regular updates had been provided to both the Quality Committee and the Board throughout the Year 4 reporting period with the most recent Quality Committee receiving a detailed presentation on compliance in December 2022.

The Board welcomed the LMNS Programme Director who was attending the meeting as part of the assurance process for sign off. A meeting had been held with LMNS and ICB colleagues in December 2022 to provide assurance of the Trust's processes and to provide evidence of compliance against each of the ten safety standards. The Chief Operating Officer added that the Trust's internal auditor (MIAA) had also been able to provide assurance that the Trust had met requirements for two safety standards (1 & 10) and on the overall governance process.

The Family Health Divisional representatives outlined the evidence of full compliance against the ten safety standards. The Board made the following comments:

- Safety Action 2 – the Chair asked how the digital agenda for maternity was developing. It was confirmed that the Digital Midwives were becoming increasingly embedded in the service and that digital was the 'golden thread' through all transformation programmes. It was noted that a job description was in development for a Chief Midwifery Information Officer.
- Safety Action 4 – Non-Executive Director, Louise Martin, queried if the Trust's anaesthetists had met the safety requirements. It was confirmed that this was the case and there was confidence that this level could be maintained, with work progressing to develop a more sustainable model. The Chief Executive sought an update on work to ensure that a 24/7 consultant presence was in place. It was noted that a trajectory of recruitment would be included in the 2023/24 operational planning process.
- Safety Action 5 – The Chair acknowledged the importance of midwifery recruitment but sought further assurance on the work to retain the current workforce. The Head of Midwifery reported that the midwifery turnover rate had reduced since July 2022 (13% to 10%) and that there had been recent examples of previous leavers returning to the Trust. The Chief Executive added that midwifery recruitment and retention had been included as one of three priorities in the Cheshire & Merseyside Acute and Specialist Trust (CMAST) Provider Collaborative workforce programme. This would help to support joint work regarding strategies for recruitment and retention.
- Safety Action 6 – The Chief Nurse noted that the Trust was exploring a joint approach with partners to support smoking cessation. The Chair remarked that the rise of induction of labour and caesarean section rates was linked to a closer monitoring of risk factors and queried if this was a trend that was likely to continue. Representatives from the Family Health Division stated that this would be the case and that it would be important to continue to track data and ensure that there was adequate estate solutions and staffing capacity to respond effectively to growing demand.
- Safety Action 7 – It was noted that the Maternity Voices Partnership (MVP) Chair had been invited to the March 2023 Board workshop to discuss approaches to engagement. The Trust had taken a decision to fund a Deputy MVP Chair to increase capacity in this area.
- Safety Action 8 – The Board acknowledged that ensuring the appropriate training had been undertaken had been a significant challenge during the CNST Year 4 process. It was asked how the position of compliance could be maintained. The Head of Midwifery stated that this would continue to be a challenge but key to maintaining a consistent level would be to ensure effective forward planning with staffing rosters. The Chief Executive asked the LMNS Programme Director if there was good practice in other organisations that the Trust could learn lessons from. It was acknowledged that sharing training records across organisations would be a factor that significantly support compliance in this area, albeit acknowledging the importance of on-site teams training together.

The Chair asked what lessons had been learned from the CNST Year 4 process. The Director of Midwifery stated that had been a significant risk throughout the year on ensuring that Multi-Professional Education and Training (MPET) compliance was achieved and that further mitigations would be required for Year 5. It was noted that Birthrate+ was increasingly becoming unfit for purpose as a maternity staffing tool and that there would be a requirement to think wider about how best to meet staffing requirements. The Trust was also committed to go beyond the compliance

	requirements in Safety Action 5 to contribute meaningfully to improve population health. The Chief Nurse added that the CNST process required several audits to be undertaken and that further improvements would include ensuring the outcomes from these were converted into meaningful interventions. Non-Executive Director, Louise Martin, referenced a recent CQC report that discussed a deterioration in the numbers of women who felt that they had been adequately listened to during their maternity experience. It was suggested that there was a need for the Trust to quantify measures for this aspect and ensure that there was a focus on improvement during CNST Year 5 and beyond. Non-Executive Director, Sarah Walker, acknowledged the potential tension between meeting compliance targets and actively improving the quality of care. It was stated that the Trust would need to remain cognisant of this and that utilising quality improvement methods would support in this aim. The Board acknowledged the hard work of the Family Health team in delivering a position of compliance for CNST Year 4. The Board resolved to: • Receive assurance that to date all CNST Year 4 requirements had been met and that evidence was available to demonstrate compliance • Instruct the CEO to sign the Board Declaration Form ahead of the 2 February 2023 deadline.
	Board Thank you's The following Board thank you's were noted: 1. The Medical Director presented a thank you to Prof. Asma Khalil for her work in progressing the fetal medicine agenda at the Trust. The Board also extended their congratulations to Prof. Khalil who had recently been appointed as Vice-President of the Royal College of Obstetricians and Gynaecologists (RCOG). 2. The Chief Nurse presented a thank you to Nic Leicester and Hannah Triggs from the Neonatal team. They held a hugely successful Sibling Santa's Grotto event on the neonatal unit which had created experiences and memories for families.
178	Review of risk impacts of items discussed No new risk items identified.
179	Chair's Log No Chair's Logs noted.
180	Any other business & Review of meeting None noted. Review of meeting No comments noted.
181	Jargon Buster Noted.

Liverpool Women's
NHS Foundation Trust

Action Log

Trust Board - Public
2 February 2023

Key	Complete	On track	Risks identified but on track	Off Track

Meeting Date	Ref	Agenda Item	Action Point	Owner	Action Deadline	RAG Open/Closed	Comments / Update
1 December 2022	22/23/163b	Maternity Incentive Scheme (CNST) Year 4 – Scheme Update	For the MVP Chair to be invited to undertake a development session with the Board regarding patient involvement and engagement.	Trust Secretary	Mar 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	Feb 23	Complete	See item 22/23/201b
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	Feb 23	Complete	See item 22/23/201b
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	March 23	On track	
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	Complete	See item 22/23/197

Liverpool Women's
NHS Foundation Trust

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	Closed	Update provided to January 2023 PPF Committee
Delegated	03.11.2022	To understand the drivers behind the increase in neonatal activity during 2022/23. Executive Lead: Chief Operations Officer	Quality	January 2023	Closed	Report received at January 2023 Quality Committee (22/23/158)
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	Closed	Report received at January 2023 Quality Committee (22/23/162)
Delegated	07.07.2022	To receive a profile of agency usage against agreed establishment levels. Lead Officer: CFO	FPBD	January 2023	Closed	Report received at January 2023 FPBD Committee (22/23/169)

Liverpool Women's
NHS Foundation Trust

CEO Report

Trust Board
February 2022

Executive Summary:

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

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

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

Section A - *Internal*

Care Quality Commission

Inspectors from the Care Quality Commission (CQC) were on site on Tuesday 24th January 2023 and Wednesday 25th January 2023 to carry out an announced focused inspection of our maternity services. An unannounced inspection of our Gynaecology and Bedford Service was also held over the same two days and included theatres. The Trust will also be subject to a CQC Well-Led inspection on 21st, 22nd and 23rd February 2023.

Chief Constable's Commendation Ceremony

I was delighted to be asked by the Chief Constable of Merseyside police to deliver a speech at the Chief Constable's Commendation Ceremony in January. There were 114 recipients of awards, all were truly inspiring from many ranks of the police, police staff, members of the public and members of RNLI. It was a particular pleasure to see 22 members of Merseyside Police receive a commendation for the contribution they made to the incident at our hospital in November 2021.

It was an honour to be able to speak about our experience of working with Merseyside Police and to say a personal thank you to Merseyside Police for the support they gave to us when we needed them most.

Change to Board of Directors – Jenny Hannon appointed to the role of Chief Finance Officer / Executive Director of Strategy & Partnerships

We are pleased to announce following a competitive interview process that Jenny Hannon has been appointed to the role of Chief Finance Officer / Executive Director of Strategy & Partnerships

Jenny will commenced her new role from 1st January 2023.

I would like to congratulate Jenny on her appointment. We are delighted to welcome Jenny back to Liverpool Women's in a permanent capacity.

Liverpool Women's Trust magazine December / January

Bringing you the latest news, updates and all things LWH

Read the latest issue here: 'The Women's View'

Section B - *Local*

NHS Cheshire and Merseyside Blog

It will not have escaped your attention that pressure on NHS services is currently headline news at both regional and national level. Cheshire and Merseyside is far from immune from this issue.Across Cheshire and Merseyside, NHS services are currently experiencing exceptionally high demand – including high numbers of people attending emergency departments (A&E) and GP practices, as well as high call volumes on both NHS 111 and 999. In addition to annual winter-related pressures, the local picture is also being complicated by high numbers of flu and COVID-19 hospital admissions and understandable concern about Strep A in children. Uncomfortably, both the quality of many local NHS services and the access to them is currently compromised and we acknowledge the extraordinary strain that frontline health and care staff are under.

Hospital bed occupancy across Cheshire and Merseyside has recently been consistently above 95%, with more than 400 beds occupied by COVID-positive patients. Around 1,000 people currently remain in hospital across Cheshire and Merseyside despite being medically fit for discharge – leading to assessment, treatment and ambulance handover and response delays. Intensive and focused work is underway with health and care partners, including those in local Government, to urgently address this challenge. In particular, we are acutely aware of the need to minimise ambulance handover delays as the patient at greatest risk is the patient the NHS has not got to yet.

Last month ambulance handover times across the North West were on average 20 minutes slower than in the equivalent period in 2021. Our priority, as always, is to ensure safe and high-quality care for people across Cheshire and Merseyside, but it is clear that significant further challenges lie ahead in the coming weeks and months. While the NHS continues to focus on recovering services and reducing waiting lists that built up as a result of the pandemic, this work is inevitably being impacted by the current pressures. It is sadly unavoidable that some routine appointments and planned operations are now having to be rescheduled as a result. As always, people should attend all of their appointments unless advised otherwise.

NHS Cheshire and Merseyside's leadership team and wider staff team will continue to do all we can to support frontline colleagues.

As a system, a number of measures are in place to help relieve the current pressures, including:

- Work with NHS Trusts to ensure all possible capacity across the healthcare system is utilised and to support the release of ambulance crews.
- National funding of c£19.2m is being utilised across Cheshire and Merseyside to support hospital discharge processes and ensure more care packages are available in the community. In recent weeks an average of 338 'escalation beds' have been open across Cheshire and Merseyside to help cope with demand.
- Significant investment continues to be made in virtual wards to support more people to be treated out of hospital. Investment is also being made in reablement services, while the national additional roles reimbursement scheme is helping to create capacity in primary care.

Irrespective of how busy local NHS services are, and any NHS industrial action, it is essential that people who need urgent medical care continue to come forward – especially in emergency and life-threatening cases, when someone is seriously ill or injured or their life is at risk.

Please make NHS 111 Online your first port of call if you need urgent health advice. Information aboutwhen to call 999 and when to go to A&E is available via the national NHS website.

Graham Urwin - Chief Executive

Full January 2023 update available here

Section B - *Local*

Cheshire & Merseyside Acute and Specialist Trust (CMAST) Board Briefing – January 2023

CMAST Leadership Board met on an informal basis in both December and January.

On 2nd December the group considered the current facts and planned responses to then proposed strike action in a discussion led by the ICB workforce team. Further business considered by the Board included:

- A review and proposed refresh of the ongoing work on pathology hubs being led by the Diagnostics Programme Board –we expect this refresh to result in an updated timetable for delivery that may, in time, require Trust decision making
- Outcomes and conclusions of the Clinical Pathways Programmes, to date, on orthopaedics. This included a number of collaborative and improvement initiatives that did not require significant service change. Clinically and operationally led collaborative recommendations for optimising current system capacity were commended by the Board
- A discussion on the impact and imperatives in urgent and emergency care arising from recent system pressures
- NHSE Provider Collaborative Innovator Scheme expressions of interest process

The Board next met on 6th January as a shorter meeting in recognition of the ongoing significant operational pressures. The discussion was used to provide space for sharing and reflection covering the following areas:

- Current system pressures, hospital discharges and the ICB role as a system coordinator and convenor
- Reflection from recent strike experiences and a look forward to proposed future industrial action
- Cheshire and Merseyside orientation on the anticipated approach to responding to NHSE Planning requirements

NHS Cheshire and Merseyside Integrated Care Board meeting

The NHS Cheshire and Merseyside Integrated Care Board met at the Floral Pavilion, Marine Promenade, New Brighton, Wirral CH45 2JS between 10:45am-1:45pm on Thursday, January 26th

https://www.cheshireandmerseyside.nhs.uk/posts/nhs-cheshire-and-merseyside-integrated-care-board-meeting-4/

Section C - *National*

Foundation trust capital resource limits

The Health and Care Act 2022 includes a new discretionary power allowing NHS England to impose a limit on the capital expenditure of a foundation trust. This statutory guidance explains the circumstances in which an order is likely to be made, and the method NHSE would use to determine the limit.

Making health services work for deprived populations

The North East is home to over two and a half million people; over a third of which live in the 20% most deprived areas of England.

Professor Bola Owolabi, Director National Healthcare Inequalities Improvement Programme recently visited the region to see first-hand how ICSs are working effectively in partnership to narrow healthcare inequalities and improve access, experience and outcomes for their local populations. This short film shares local initiatives together with a blog which showcases Core20PLUS5 projects in action

Threat to health from air pollution

The significant health threats posed by air pollution are highlighted in The Chief Medical Officer's annual report, which makes a series of recommendations to continue progress to improve air quality – including to halve the NHS's contribution to poor air quality within a decade, as set out in the Delivering a net zero NHS report.

Engaging with disabled staff

Over 20 per cent of staff state they have a disability in the anonymised NHS staff survey, yet Electronic Staff Record figures record 3.7 per cent. This means that there is a 16% gap in people declaring their disability. This NHS Employers blog explores the language used to describe disability and the positive impact of using language that fully represents how people identify themselves.

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	***22/23/201b***		**Date: 02/02/2023**	
Report Title	**Maternity Staffing report 1st July- 31st December 2022**			
Prepared by	Heledd Jones, Head of Midwifery			
Presented by	Dianne Brown, Chief Nurse			
Key Issues / Messages	The Maternity Staffing Oversight Report outlines the requirements of Maternity Incentive Scheme Safety Action 5 and details LWH current position. This forms the required evidential standard for submission to Trust Board			
Action required	**Approve ☐**	**Receive ☒**	**Note ☐**	**Take Assurance ☐**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	***To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it***	***For the intelligence of the Board / Committee without in-depth discussion required***	***To assure the Board / Committee that effective systems of control are in place***
	Funding Source (If applicable):			
	For Decisions - in line with Risk Appetite Statement – Y/N ***If no – please outline the reasons for deviation.***			
	It is recommended that the Board receive the information in this paper.			
Supporting Executive:	***Dianne Brown, Chief Nurse***			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

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

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

Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* 3.1 Failure to deliver an excellent patient and family experience to all our service users	Comment: This relates to Midwifery staffing vacancies
Link to the Corporate Risk Register (CRR) – CR Number: Insufficient midwifery staffing levels as recognised by Birth Rate Plus, next review 20/09/22. Current score 6.	**Risk Number: 1705**

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Trust Board	**02.02.2023**	**Dianne Brown**	

EXECUTIVE SUMMARY

The Maternity Staffing paper is provided to the Board of Directors and outlines the requirements of the Maternity Incentive Scheme (MIS) Year 4, Safety Action 5 (SA5). The report sets out the Liverpool Women's NHS Foundation Trust (LWH) position in the context of midwifery staffing. This report covers the six-month period from 1st July 2022 to 31st December 2022 as is required for MIS.

MIS Year 4, SA5 requires that Trusts demonstrate an effective system of midwifery workforce planning. The recognised evidence-based tool within Maternity Services is Birth Rate Plus (BR+).

A Birth Rate Plus audit was completed in 2021, with the final report received in the Trust in January 2022.

The report highlights the following areas for discussion and noting (January 2022-June 2022).

- Budgeted establishment equates to 354.92wte which is 5.33wte above the BR+ recommendations
- Budgeted posts are inclusive of 23% headroom.
- Vacancy rate is 35.07wte in December 2022. Gross unavailability rate (including mat leave and sickness absence) equates to 86.98wte.
- Total recruitment in progress is 18.84wte. Leaving a residual vacancy rate of 16.23wte.
- Sickness absence rate is 12.2% in December 2022 which is a reduced position from January 2022 where it was 16.7%. This demonstrates a slight improved rigor in management of sickness absence in line with policy
- Turnover is under Trust threshold (13%) at 9.45% in December 2022 which is a vast improvement since the first six months of 2022.
- Midwife: Birth ratio in December 2022 is 1:26, against a national recommendation of 1:28. The Trust position will improve as vacancies are filled and will fall below the national recommendation
- 263 red flags noted in six months. Majority of the red flags relate to delays in ongoing Induction of Labour, owing to capacity and demand and midwifery staffing levels. Maternity leadership team are aware of all incidents reported, with oversight and scrutiny. An induction of labour improvement group has been established and plans in place to increase capacity in the Maternity unit.
- Supernumerary shift co-ordinator on labour ward is maintained at 100% for past six months
- 1:1 care in labour achieved a compliance rate of 98.31-99.6% in the reporting period, against a standard of 100%.

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

1.0 Introduction

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

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

2.0 Birth Rate Plus

Birth Rate Plus (BR+) is a recognised tool for workforce planning and strategic decision-making. It is based upon an understanding of the total midwifery time required to care for women and on a minimum standard of providing one-to-one midwifery care throughout established labour. Whilst birth outcomes are not influenced by staff numbers alone, applying a recognised and well-used tool is crucial for determining the number of midwives and support staff required to ensure each woman receives one-to-one care in labour. Cheshire and Mersey Local Maternity Neonatal Systems (LMNS) commissioned the BR+ assessment for all maternity units within the LMNS as part of the Ockenden review.

It was noted at a Trust Board meeting held 1st December 2022 that BR+ was increasingly becoming unfit for purpose as a maternity staffing tool and that there would be a requirement to think wider about how best to meet staffing requirements. Family Health Division Senior Leadership team have commissioned a further BR+ review scheduled for February 2023.

Included in the assessment is the staffing required for antenatal, intrapartum, and postnatal inpatient and outpatient services, including community births. Birth Rate + calculates the clinical establishment based on agreed standards of care and includes the midwifery management and specialist roles required to manage maternity services. Adjustment of clinical staffing between midwives and maternity support workers (Band 3) is included. The recommendation is to provide total care to women and their babies on 24 hours, 7 days a week basis, inclusive of the local percentage for annual, sick & study leave allowance and for travel in community. 23% uplift has been calculated to enable this.

3.0 Maternity Staffing Establishments

Birth Rate Plus audit commenced in LWH in Summer 2021 and annual activity was based on 7488 births (April 2020-March 2021). The report published in January 2022 recommended a workforce establishment of 349.59wte inclusive of 90:10 skill mix (90% midwives and 10% maternity support worker).

LWH midwifery and MSW budgeted posts for financial year 2022/23 equates to 354.93wte which is 5.34wte above the BR+ audit recommendation. Budgeted posts are inclusive of 23% headroom for training, annual leave etc. Rationale for going above the BR+ recommendation relates to the increase in the number of births during calendar year 2021, being 7854 an increase of 366.

Table 1 highlights midwifery and maternity support worker (MSW- Band 3) funded establishment 2022-23 inclusive of a headroom factor of 23%, with additional support staff posts excluded from the BR+ ratio.

Table 1- funded establishment

Table 1 - 2022/23 Funded Establishment	BR+ Recommendation at 23%	2022/23 Budget	Variance to Budget
Total Clinical Staff	273.36	285.51	-12.15
Contribution from Specialist Midwives	8.31	5.00	3.31
Total Direct Care Giving Midwives	281.67	290.51	-8.84
Non-Direct Care Giving (Non-Clinical)	33.27	31.15	2.12
Total Registered Midwives	314.94	321.66	-6.72
MSW's Included in BR+ (CoC, Community & Mat Ward)	34.65	33.27	1.38
Total MSW's	34.65	33.27	1.38
Total Posts Included in BR+ Ratio	349.59	354.93	-5.34
Support Staff Excluded from BR+ Ratio		37.23	
Total Establishment	349.59	392.16	

Table 2 reflects actual WTE in post in December 2022 compared to the BR+ recommendation and is split between midwifery and maternity support worker (Band 3) staff.

Table 2 – comparison of staff in post and BR+ recommendations

Table 2 - 2022/23 Contracted Establishment at M9	BR+ Recommendation at 23%	2022/23 In Post at M9	Variance to Budget
Total Clinical Staff	273.36	241.06	32.30
Contribution from Specialist Midwives	8.31	3.40	4.91
Total Direct Care Giving Midwives	281.67	244.46	37.21
Non-Direct Care Giving (Non-Clinical)	33.27	44.47	-11.20
Total Registered Midwives	314.94	288.93	26.01
MSW's Included in BR+ (CoC, Community & Mat Ward)	34.65	25.59	9.06
Total MSW's	34.65	25.59	9.06
Total Posts Included in BR+ Ratio	349.59	314.52	35.07
Support Staff Excluded from BR+ Ratio		29.97	
Total Establishment	349.59	344.49	

Table 3 demonstrates a breakdown of Midwifery and MSW (Band 3) vacancies shown in WTE at month 9 (December) 2022/23.

Table 3 – gross unavailability breakdown

True vacancy rate	35.07
Maternity leave	14.04
Sickness absence	37.87
Gross unavailability rate	86.98

4.0 Recruitment

As highlighted below (Table 4) recruitment activity reflects a breakdown of midwifery and MSW (Band 3) shown in WTE reflects a position of those currently in the recruitment process, recruited staff pending start date and total recruitment in progress.

Table 4: Recruitment overview

Recruited midwifery staff in progress (to commence in post month 11 & 12)	9.84
Recruited support staff in progress (to commence in post month 11).	5.00
Internationally recruited staff (tentative start date in M10 and M12)	4.00
Total recruitment in progress	18.84

Maternity has seen in the past 2 years a change in the demographic of its midwifery and support worker age profiles, bringing an increase in retire and return requests; there have been 44 retirement requests since January 2020 of which 22 colleagues requested a flexible retire and return arrangement which has resulted in a reduction in overall contracted hours. The service also has ongoing maternity leave, projected at 10 WTE on a rolling basis. The workforce profile is reviewed weekly by the senior midwifery team at the Senior Midwifery Leadership Operational group meeting chaired by the Head of Midwifery, to review ongoing workforce pressures and the rolling recruitment plan. The recruitment pipeline will reduce the vacancy rate to 16.23wte. Approval to over recruit taking into consideration the 3.0 WTE monthly midwifery attrition rate, was granted by the Trust Executive Team in April 2022.

Workforce initiatives and developments implemented during the past six months include the following:

- Appointment of a Consultant Midwife focusing on Intrapartum care.
- Appointment of a full midwifery matron team.
- In conjunction with staff members, review of the ACPs role which determined where best to utilise the skills of the ACPs who will be completing their training in February 2023.
- Further strengthening the midwifery preceptorship programme with investment in an additional 2.0wte preceptorship lead midwives (12 months posts).
- Creation of Intrapartum co-ordinator development posts, establishing a talent pool pipeline.
- Flexible Working applications encouraged and considered by the Senior Midwifery Leadership team on a weekly basis.
- Rolling band 6 advert on NHS Jobs.
- Stay interviews to identify what support staff require, to remain in post.
- Engagement with International Recruitment; 2 midwives have commenced in post with another 4 to commence in post before the end of the current financial year.
- Exploring midwifery apprenticeships with Higher Education Institutions.

- Increased bank rates for all midwifery staff, LWH pay the highest rates in Cheshire and Mersey region as a standard rate.
- Birth Rate Plus app purchased and implemented in August 2022 to monitor acuity, staffing and red flags. This is a digital solution to the current paper process that allows the senior leadership team in Maternity services to view a live dashboard of key indicators of safety and staffing. This app is used in MLU and Delivery Suite (for intrapartum areas i.e., labour and birth).

5.0 Maternity Staffing (Planned versus Actual)

Maternity services have a process for daily review of planned versus actual staffing, this information is fed into the twice daily staffing huddles. In addition, staffing is reported Trust wide in the daily virtual huddle (Bronze command) which consists of senior managers and the manager on call. LWH procure the services of NHS Professionals to fill bank shifts and if required agency shifts, to support temporary staffing shortfalls. Use of agency midwifery staff has reduced substantially since month 7. Weekly meetings are held between NHS Professionals, Family Health Divisional Manager, and the Head of Midwifery to monitor bank fill rates and to ensure consistent and safe staffing levels.

One of the main service priorities is to maintain safe midwifery staffing levels. Maternity staffing and acuity are assessed on a 4hrly basis by the Maternity Bleep Holder and should staffing fall by the numbers of midwives to provide safe care, the Maternity Escalation Guideline (v3.3) is followed. This includes the redeployment of staff which is facilitated through adherence to the Maternity Escalation Guideline, to review maternity staffing and acuity on a 4 hourly basis. Midwives and MSW undertake a rotational training programme, allowing midwives to rotate between all clinical areas, ensuring a workforce that are skilled to work across all clinical areas of the maternity service. The Maternity Bleep holder consistently reviews staffing with the aim of redeploying non- direct care givers to address spikes in clinical activity to maintain a safe clinical staffing ratio.

6.0 Sickness absence

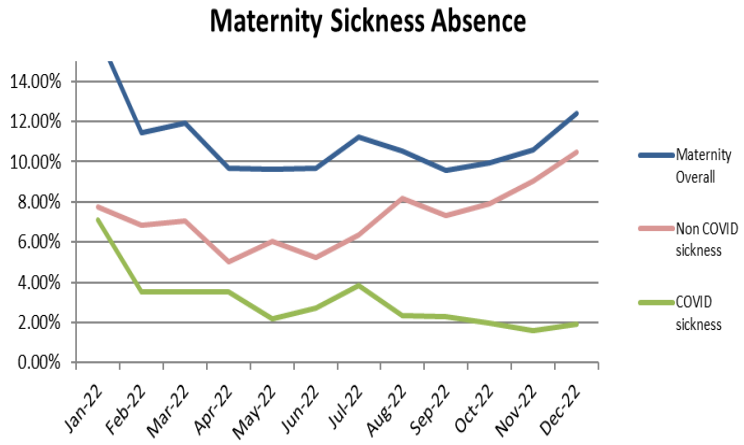
Sickness absence is a continuing challenge in the service with pressures from vacancies, colleagues reporting burn-out and ongoing impacts of Covid-19. The 12-month rolling sickness absence rate for the service stands at 10.69% which is a reduction to the previous year at 15.29%. The service has been above the Trust target of 4.50% for the last 12 months and beyond for example, the last time the service achieved the sickness target was in September 2018 at 4.25% but this was not sustained and has not been achieved since.

In December 2022, the split of absence weighted towards long term cases was 61.93%, this is a reduction to the weighting looking back to November 2021 at 76%. The service areas review sickness cases monthly, and any long-term cases are managed in accordance with the current Employee Attendance and Wellbeing policy. In terms of long-term sickness, returns are tracked within the service and the level of cases has been relatively stable since July 2022 moving between 30-34 cases. The number seen in long term cases is fluid with an average of eight returns in the service per month.

It is noted that the service continues to carry long covid absence and this equates to five cases – this is a reduction to previous reports as one individual has been welcomed back to work via a supported phased return plan. With respect to COVID sickness, all those reporting absence due to long COVID symptoms have been met with formally to discuss the upcoming changes with respect to moving to contractual sick pay from 1st September 2022 (https://www.nhsemployers.org/covid19). Alternate working, reduced return to works / phased plans / temporary non-clinical working are options that have been explored. Along with completing training on days where health permits.

The main reasons for absence are largely static across the service and wider division with cough/cold/flu (35%), anxiety/stress/depression (29%) and other musculoskeletal problems (6%) / gastrointestinal problems (5%) all the main reasons for sickness (interchangeably as the highest reported reason in month).

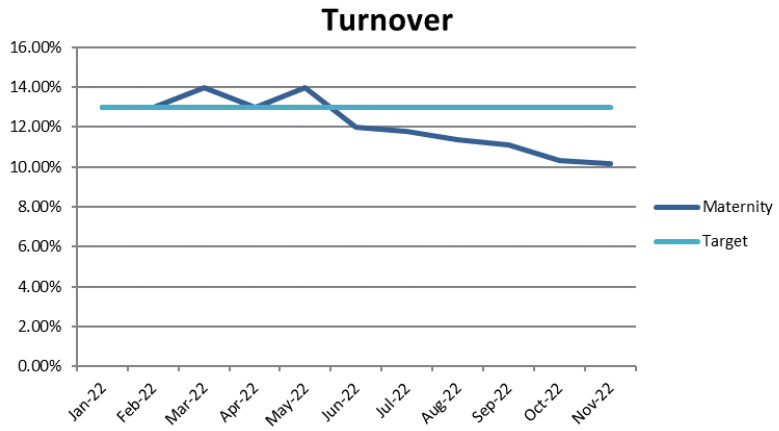
Table 5 – Sickness absence rates



Staff turnover within the first five months of 2022 either exceeded or matched the Trust threshold for turnover interchangeably between 12 / 13%. Since June 2022, turnover has steadily decreased to stand at 9.45%. The average number of leavers per month across the 12 months was 4.70wte, this will decrease in coming months given retention

is improving. The service continues to receive retire and return requests, along with general flexible working requests, these are considered on a weekly basis by the senior team within the service to ensure consistency and fairness in decision making. As previously, the Trust has welcomed back previous leavers in the last 12 months and welcomed B5 midwives seeking alternate employment and, in such cases, bespoke preceptor programmes have been developed / implemented.

Table 6 – Turnover



7.0 Midwife to Birth Ratio

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

At present the maternity service is reporting a ratio of 1:26 (December 22 position, Table 7) which meets the National recommendation of a 1:28 ratio.

Table 7 - midwife to birth ratio

Midwife to Birth					
July 22	**Aug 22**	**Sep 22**	**Oct 22**	**Nov 22**	**Dec 22**
1:30	**1:31**	**1:32**	**1:28**	**1:28**	**1:26**

8.0 Midwifery Red Flags

A midwifery red flag event is a warning sign and an early indicator that midwifery staffing ratios maybe incorrect at that given time. If a midwifery red flag event occurs, the midwife in charge of the service should be notified. The midwife in charge (Maternity Bleep Holder) should determine whether midwifery staffing is the cause and

take appropriate action, which may include redeployment of staffing to meet acuity or appropriate skill mix, as per Maternity Escalation Policy.

Table 8 highlights the number of midwifery red flags reported by month with Table 8.2 highlighting the reasons for reporting red flags. It is noted and recognised that the highest recorded red flags are related to delay in ongoing process of induction of labour >4 hours (150) and delay of 30 minutes or more between presentation and triage (73).

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

Table 8.1 & 8.2 – Red flag numbers by month and by themes

Midwifery Red Flags reported					
July 22	**Aug 22**	**Sep 22**	**Oct 22**	**Nov 22**	**Dec 22**
71	**69**	**35**	**35**	**32**	**21**

Midwifery Red Flag reported to Ulysess	Total Reported	Delayed or cancelled time-critical activity.	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication).	Delay of more than 30 minutes in providing pain relief.	Delay of 30 minutes or more between presentation and triage.	Full clinical examination not carried out when presenting in labour	Delay of 2 hours or more between induction and beginning of process	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	Other midwifery red flags may be agreed locally - LWH Delay >4hours during ongoing IOL.
Jul-22	71	0	0	0	2	27	1	1	1	3	36
Aug-22	69	1	0	0	1	41	0	3	0	2	21
Sep-22	35	0	0	1	0	3	0	2	0	4	25
Oct-22	35	3	0	0	0	1	0	3	0	12	16
Nov-22	32	0	2	1	1	0	0	1	0	0	27
Dec-22	31	0	0	0	0	1	0	5	0	0	25

Between July-December 2022, maternity identified 263 red flag incidents demonstrating a positive but inconsistent reporting culture. A Maternity Assessment Unit and Induction of Labour multi-professional working groups are in place to identify and implement actions to improve performance in delivery of care and to achieve full compliance in reporting red flags, utilising a Quality Improvement (QI) methodology.

9.0 Emerging service risks

On review of Liverpool Women's Hospital (LWH) data there has been an increase in unscheduled attendances to the Maternity Assessment Unit, and in line with Trust Policy pregnant women should be assessed within 30 minutes of attendance. Triage

telephone helpline should be available 24hs per day, 7 days per week to provide timely access, advice and support to pregnant women. Concerns were raised at Quality Committee regarding the current time to triage quality standard within the Maternity Assessment Unit. On review it is evident that there is a need to review systems processes and the current staffing model to deliver sustained improvements. Therefore the divisional team anticipate an increase in midwifery and medical staff are required to deliver a timely triage assessment to mitigate risks to pregnant women and their babies. Maternity Services Division Senior Leadership team are working through a revised workforce service model as part of 23/24 operational planning process. Given the emerging risks some immediate actions have been taken to increase staffing within the MAU whilst the wider review is ongoing.

10.0 Supernumerary Shift Coordinator on Labour Ward

Within LWH Delivery Suite, supernumerary shift leader compliance is consistently maintained at 100% as listed (Table 9). This role is pivotal in providing oversight into all birth activity within the Delivery Suite, MLU, Maternity Assessment Unit and Maternity Base Ward, and provides a helicopter view of all staffing/workforce requirements as well as birth activity. During night-time hours the Delivery Suite shift co-ordinator carries the maternity bleep (104) for maternity services. The Delivery Suite shift co-ordinator is rostered independently from the core midwifery staffing and this is evidenced in e-roster with a distinct marker against the shift coordinator indicating supernumerary status.

Table 9 – Supernumerary status

Supernumerary Shift Coordinator					
July 22	**Aug 22**	**Sep 22**	**Oct 22**	**Nov 22**	**Dec 22**
100%	**100%**	**100%**	**100%**	**100%**	**100%**

11.0 1:1 Care in Labour

NICE (2021) guidance supports one to one care in established labour, as one of the indicators of effective midwifery workforce planning. LWH has consistently across intrapartum areas of Midwifery Led Unit (MLU) and Delivery Suite (Obstetric led care), achieved a compliance rate between 98.1% and 99.6% in this reporting period.

Table 10 – 1:1 care in labour

1:1 Care in Established Labour					
July 22	**Aug 22**	**Sep 22**	**Oct 22**	**Nov 22**	**Dec 22**

98.99%	**98.31%**	**99.60%**	**98.41%**	**99.33%**	**99.30%**

MIS (Year 4), Safety Action 5 requires organisations to produce an action plan when compliance is less than 100%. As part of the review of the non-compliance to this required standard, each case where 1:1 care is not achieved has been reviewed to ensure no adverse clinical outcomes have occurred. On review of the 21 cases where 1:1 midwifery care was not provided in established labour; 6 women had a delayed transfer to Delivery Suite and 15 women delivered very soon after arrival at the Maternity Assessment Unit. There was no harm reported or documented to any of the 21 women and babies.

Actions planned over next 6 months:

- Review current maternity care pathways to explore models of care involving wider multi-professional teams.
- Progression with pace of the MAU, IOL and Maternity Base improvement groups utilising QI methodology.
- Further expansion of midwifery development roles to include, supernumerary shift co-ordinator role in the Maternity Assessment Unit, IOL co-ordinator role, Midwifery Led Unit Clinical Lead Midwife role and a Fetal Medicine Unit Clinical Lead Midwife role.
- To achieve compliance with NICE guidance introduction of a Diabetic Specialist Midwife role.
- Leadership development opportunities for band 6 midwives to become Deputy Ward managers on Maternity Base, with a focus on improving patient experience through timely administration of medication and seamless discharge processes, which will improve patient flow in the maternity unit.
- During times of increased acuity and reduced midwifery staffing numbers a contingency plan has been developed to support times of staff shortages in line with business continuity that releases supporting roles in the division onto the clinical floor.

Recommendation

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

Quality Committee Chair's Highlight Report to Trust Board
19 December 2022

Liverpool Women's NHS Foundation Trust

1. Highlight Report

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

• The Committee received a detailed position update in relation to blood sampling errors. The analysis of data identified that the majority of errors were related to specimen collection, specimen quality and labelling. An improvement plan was shared with the Committee which would support the aim to reduce pathology sample and collection errors to <1% of all samples, which would be in line with published figures and represent a 50% improvement. The Committee had been assured by the actions and improvements underway.	• The Committee received an update against the Maternity Incentive Scheme Year 4.
	  ○ The report outlined compliance against all ten safety actions and the associated standards, of which evidence was available to support.
	  ○ The report had been presented to the Local Maternity System who had raised questions against safety action 3, 4 and 6. A response was provided against each of these queries and available within the report and appendices provided.
	  ○ Mersey Internal Audit Agency (MIAA) had been asked to undertake an audit on the processes and review standards 1 and 10 specifically. The final recommendation report from MIAA would be presented to the Trust Board in January 2023.
	  ○ The Committee was assured by the position update and noted that it would be submitted to the Board for final oversight and sign-off in January 2023 ahead of submission to NHS Resolution.
	• The Committee considered lessons learnt from the Maternity Incentive Scheme Year 4 to support planning into Year 5.

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**
• Positive position against the ten safety actions of the Maternity Incentive Scheme Year 4. (ALL)	• None noted.
Summary of BAF Review Discussion (Board Committee level only)	
• None	
Comments on Effectiveness of the Meeting / Application of QI Methodology	
• Appropriate discussion dedicated to identified reports.	

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
146.	Maternity Incentive Scheme (CNST) Year 4 final paper	Assurance	**147.**	Pathology Sampling and Collection Errors 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	A			
Dianne Brown, Interim Chief Nurse	NM				✓	✓	✓	✓			

Quality Committee Chair's Highlight Report to Trust Board
23 January 2023

Liverpool Women's NHS Foundation Trust

1. Highlight Report

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

• The Sub-Committee Chair reports highlighted the role of divisional governance. A programme of work was being undertaken with the divisions and would be reported back to the Committee upon completion.
• The Maternity Transformation Board highlighted a risk in relation to the Trust response to the Ockenden recommendations. An independent audit undertaken by MIAA had recommended a review of all green IEAs assessed prior to the MTB establishment. The Family Health Division was currently considering proposals to mitigate against this risk.
• The Committee noted the following matters from the Quality Performance Report:
  ○ an increase of appointments cancelled by hospital (TCI's) as a result of industrial action. The trend would continue throughout the period of industrial action. A Strike Group had been instigated to manage service delivery. The Committee noted the increasing pressures to manage the service through a period of industrial action alongside the challenge of activity and recovery targets.
  ○ Gynaecology and elective recovery remained significantly challenging. The Committee requested the inclusion of trajectory and timelines to better inform them of the position.
  ○ the increase in Serious Incidents (SI) was noted in part due to the lookback exercise undertaken by the Future Generations (FG) team and reclassification of FG incidents to SIs.
• Particular attention was drawn to poor performance in relation to the MAU face to face triage within 30 minutes metric. It was noted that a revised process model would be needed to significantly improve the service. The introduction of hot weeks and senior clinician ward rounds would support improvements in the short-term. It was agreed to provide a detailed update within the Board Performance Report in February 2023 and bring a further report to the next scheduled Quality Committee.
• The Committee received the Medicines Management quarterly report. The Committee raised concern in relation to implementation of PGD's, procurement of drugs, and the low attendance at the Medicines Management Group. The Committee noted the improvements achieved to date in response to the CQC warning notices and that increased monitoring and oversight was successfully identifying further weaknesses.
	• The Committee received the Quality and Regulatory Update noting key issues and emerging concerns. It was noted since circulation of the report that the CQC had notified the Trust of their intention to inspect Maternity Services on 24 & 25 January 2023 as part of the national maternity inspection programme.
	• The Committee noted the findings of the HSIB lookback report into HSIB reported cases during 2021/22. The most significant findings and recommendations related to care during induction of labour; care in labour; and CTG monitoring. These reflected themes that HSIB had already identified nationally and regionally, as well as at the Trust, in the areas of clinical assessment, fetal monitoring, clinical oversight and escalation. The Committee discussed the known difficulties in relation to CTG monitoring that required national discourse.
	• Received the findings of a review of serious untoward incidents (SUIs) originating in Gynaecology and Clinical Support Service divisions to consider potential impact due to the isolation of the Trust site. A total of 25 SUIs were identified. Of these, 10 were identified as having had an impact of the isolation of services at LWH. The Future Generations Steering Group would continue to take forward the work programme.

Positive Assurances to Provide Identify in brackets should the assurance provide evidence against the CQC Key Questions – SAFE | EFFECTIVE | CARING | RESPONSIVE | WELL LED	Decisions Made
• The Committee received the Quality and Regulatory Update noting key issues and emerging concerns • The Committee received a position update of the Trust response and adherence to national changes introduced in relation to abortion care. The Committee was assured that evidence was being collated and that delivery of abortion care was in line with the current legislative changes. Changes regarding the digitisation of HSA4 forms would need to be formalised following an external update to providers, as well as and assessment of compatibility with the current IT systems in use. • The Committee received a detailed review in relation to in-utero transfer rates at LWH compared to SMH. The work demonstrated positive partnership working with the Northwest ODN. The review had highlighted a number of births transferred to LWH from the wider area outside of Cheshire and Merseyside which should be considered when discussing services with specialist commissioners.	• The Committee approved the terms of reference for the Patient Involvement and Experience Sub-Committee, Trust Safeguarding Sub-Committee, and the Research and Development Sub-Committee.

Summary of BAF Review Discussion (Board Committee level only)

- The Committee reviewed the related BAF risks. No risks closed on the BAF for Quality Committee.
- Informed of recommended increase to the risk score of BAF risk 1.2 Workforce (PPF Committee owned BAF risk) based on the numerous expected industrial action and subsequent impact on services.
- Noted significant work to be undertaken in relation to patient experience and associated strategies which would strengthen BAF risk 3.1. Completion date aim March 2023.

Comments on Effectiveness of the Meeting / Application of QI Methodology

- Appropriate discussion dedicated to identified reports.
- Recommended greater focus on outcomes within reports

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
156.	Review of BAF risks: Quality related risks	Assurance	161.	Thematic analysis of the 2021/22 Healthcare Safety Investigation Branch (HSIB) case investigation reports	Information
157.	Sub-Committee Chair Reports	Assurance	162.	Review of the impact of the isolation of clinical services at LWH on Serious Untoward Incidents (SUIs)	Information
158.	Quality Performance Report Month 9, 2022/23	Assurance	163.	Review to investigate in-utero transfer rates at LWH compared to SMH	Information
159.	Quality and Regulatory Update	Assurance	164.	Medicines Management Assurance Report Quarter 3, 2022/23	Assurance
160.	Abortion care providers response to NWROC 0273: B2156 and requirement to submit Abortion Notifications	Assurance			

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	✓	✓	NM		
Michelle Turner, Chief People Officer	✓	✓	✓	✓	A	A	✓	✓	✓		
Nashaba Ellahi, Deputy Director of Nursing & Midwifery	✓	✓	✓	A	✓	A	✓	✓	A		
Philip Bartley, Associate Director of Quality & Governance	✓	✓	✓	A	✓	A	A	A	✓		
Dianne Brown, Chief Nurse	NM				✓	✓	✓	✓	✓		
Jenny Hannon, Chief Finance Officer	NM								✓		

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	**22/23/202b**		**Date: 02/02/2023**	
Report Title	**Quality & Operational Performance Report**			
Prepared by	***Gary Price, Chief Operating Officer, Dr Lynn Greenhalgh, Medical Director and Dianne Brown, 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 9 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	Jan 23	COO	Detailed in Chair's Report
Quality Committee	Jan 23	COO	Detailed in Chair's Report
Putting People First Committee	Jan 23	CPO	Detailed in Chair's Report

Performance Report Contents

Appendix 1: Assurance & Variation Icons Descriptions

	Variation/Performance Icons		
Icon	*Technical Description*	*What does this mean?*	*What should we do?*
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or system itself.	**Consider if the level/range of variation is acceptable**. If the process limits are far apart you may want to change something to reduce the variation in performance.
	Special cause variation of an CONCERNING nature where the measure is significantly HIGHER.	**Something's going on!** Your aim is to have low numbers but you have some high numbers – something one-off, or a continued trend or shift of high numbers.	**Investigate** to find out what is happening/ happened. Is it a one off event that you can explain? Or do you need to change something?
	Special cause variation of an CONCERNING nature where the measure is significantly LOWER.	**Something's going on!** Your aim is to have high numbers but you have some low numbers - something one-off, or a continued trend or shift of low numbers.	
	Special cause variation of an IMPROVING nature where the measure is significantly HIGHER.	**Something good is happening!** Your aim is high numbers and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	Find out what is happening/ happened. **Celebrate** the improvement or success. Is there **learning** that can be shared to other areas?
	Special cause variation of an IMPROVING nature where the measure is significantly LOWER.	**Something good is happening!** Your aim is low numbers and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	
	Special cause variation of an increasing nature where UP is not necessarily improving nor concerning.	**Something's going on!** This system or process is currently showing an unexpected level of variation – something one-off, or a continued trend or shift of high numbers.	**Investigate** to find out what is happening/ happened. Is it a one off event that you can explain? Do you need to change something? Or can you celebrate a success or improvement?
	Special cause variation of an increasing nature where DOWN is not necessarily improving nor concerning.	Something's going on! This system or process is currently showing an unexpected level of variation – something one-off, or a continued trend or shift of low numbers.	

	Assurance Icons		
Icon	*Technical Description*	*What does this mean?*	*What should we do?*
	This process will not consistently HIT OR MISS the target as the target lies between the process limits.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **within** those limits then we know that the target may or may not be achieved. The closer the target line lies to the mean line the more likely it is that the target will be achieved or missed at random.	Consider whether this is acceptable and if not, you will need to change something in the system or process.
	This process is not capable and will consistently FAIL to meet the target.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the wrong direction** then you know that the target cannot be achieved.	**You need to change something in the system or process if you want to meet the target.** The natural variation in the data is telling you that you will not meet the target unless something changes.
	This process is capable and will consistently PASS the target if nothing changes.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the right direction** then you know that the target can consistently be achieved.	**Celebrate the achievement**. Understand whether this is by design (!) and consider whether the target is still appropriate; should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

Appendix 2: Assurance Category Descriptions

Variation/Performance	Assurance: P	Assurance: ?	Assurance: F	Assurance: (blank)
H	**Excellent** — Celebrate and Learn • This metric is improving. • Your aim is high numbers and you have some. • You are consistently achieving the target because the current range of performance is above the target.	**Good** — Celebrate and Understand • This metric is improving. • Your aim is high numbers and you have some. • Your target lies within the process limits so we know that the target may or may not be achieved.	**Concerning** — Celebrate but Take Action • This metric is improving. • Your aim is high numbers and you have some. • HOWEVER your target lies above the current process limits so we know that the target will not be achieved without change.	**Excellent** — Celebrate • This metric is improving. • Your aim is high numbers and you have some. • There is currently no target set for this metric.
L	**Excellent** — Celebrate and Learn • This metric is improving. • Your aim is low numbers and you have some. • You are consistently achieving the target because the current range of performance is below the target.	**Good** — Celebrate and Understand • This metric is improving. • Your aim is low numbers and you have some. • Your target lies within the process limits so we know that the target may or may not be achieved.	**Concerning** — Celebrate but Take Action • This metric is improving. • Your aim is low numbers and you have some. • HOWEVER your target lies below the current process limits so we know that the target will not be achieved without change.	**Excellent** — Celebrate • This metric is improving. • Your aim is low numbers and you have some. • There is currently no target set for this metric.
(common cause)	**Good** — Celebrate and Understand • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • HOWEVER you are consistently achieving the target because the current range of performance exceeds the target.	**Average** — Investigate and Understand • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • Your target lies within the process limits so we know that the target may or may not be achieved.	**Concerning** — Investigate and Take Action • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • HOWEVER your target lies outside the current process limits and the target will not be achieved without change.	**Average** — Understand • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • There is currently no target set for this metric.
H	**Concerning** — Investigate and Understand • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • HOWEVER you are consistently achieving the target because the current range of performance is below the target.	**Concerning** — Investigate and Take Action • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • Your target lies within the process limits so we know that the target may or may not be missed.	**Very Concerning** — Investigate and Take Action • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • Your target lies below the current process limits so we know that the target will not be achieved without change	**Concerning** — Investigate • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • There is currently no target set for this metric.
L	**Concerning** — Investigate and Understand • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • HOWEVER you are consistently achieving the target because the current range of performance is above the target.	**Concerning** — Investigate and Take Action • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • Your target lies within the process limits so we know that the target may or may not be missed.	**Very Concerning** — Investigate and Take Action • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • Your target lies above the current process limits so we know that the target will not be achieved without change	**Concerning** — Investigate • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • There is currently no target set for this metric.
↗				**Unsure** — Investigate and Understand • This metric is showing a statistically significant variation. • There has been a one off event above the upper process limits; a continued upward trend or shift above the mean. • There is no target set for this metric.
↘				**Unsure** — Investigate and Understand • This metric is showing a statistically significant variation. • There has been a one off event below the lower process limits; a continued downward trend or shift below the mean. • There is no target set for this metric.
(blank)				**Unknown** — Watch and Learn • There is insufficient data to create a SPC chart. • At the moment we cannot determine either special or common cause. • There is currently no target set for this metric

Liverpool Women's
NHS Foundation Trust

Trust Board

Performance Report

January 2023

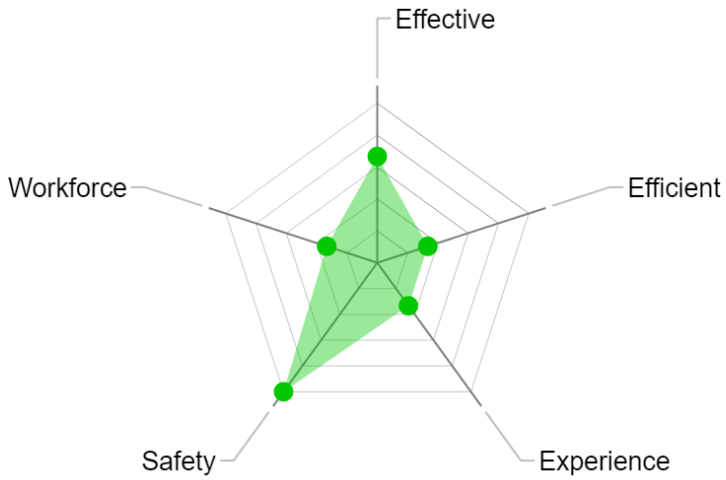
Section 1: Assurance Radar Charts by Trust Values

The indicators included in this report, have been stratified based on the level of assurance to be derived and using the NHSEI categorisation within 'Making Data Count'.

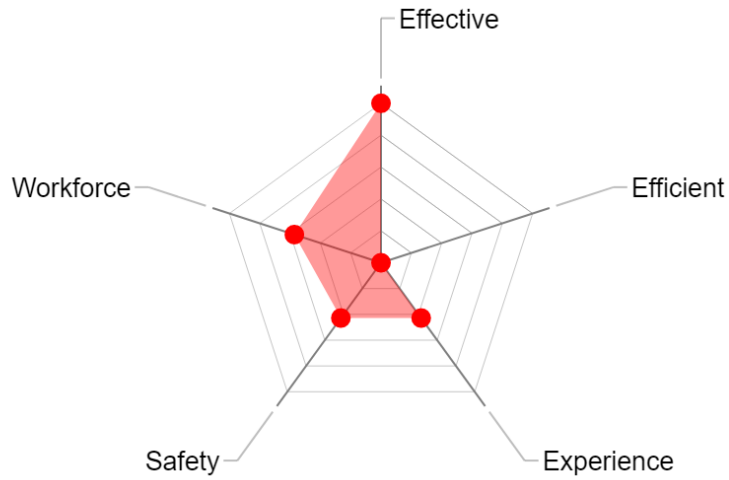
KPIs Passing Target for Six Months	8
KPIs Failing Target	17
KPIs Hit and Miss	6
KPIs No Target	3

KPIs Improving Variation	5
KPIs Concerning Variation	10
KPIs Common Cause Variation	19

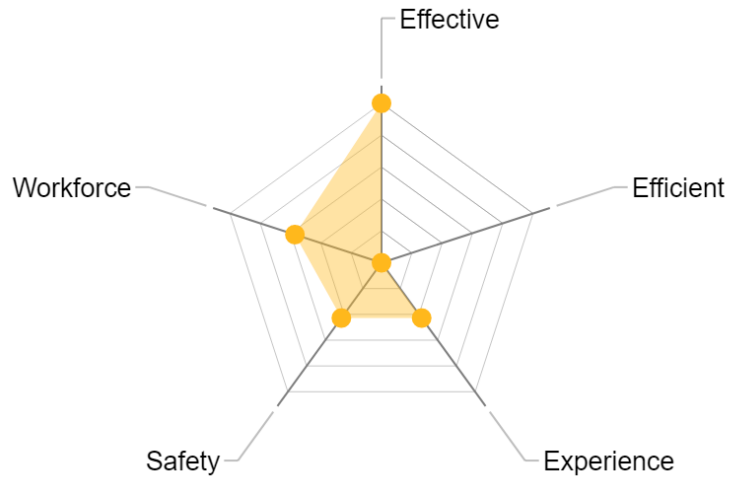
Consistently Passing



Consistently Failing



Hit and Miss



Section 2: Integrated Performance Metrics

Indicators are grouped here into assurance levels and variance. See Appendix 1 & 2 to understand how categories have been derived

Excellent - Celebrate & Learn

KPI	Target < or >	Target	P	A	V
18 Week RTT: Incomplete Pathway > 104 Weeks	<=	0	0	P	L
Infection Control: MRSA	<=	0	0	P	L
Proportion of patient activity with an ethnicity code	>=	>=96%	97.51%	P	H

Good - Celebrate & Understand

KPI	Target < or >	Target	P	A	V
Cancer: 2 Week Wait	>=	>= 93%	94.72%	?	H
Financial Sustainability Risk Rating: Overall Score	<=	3	3	P	
Infection Control: Clostridium Difficile	<=	0	0	P	
NHSE / NHSI Safety Alerts Outstanding	<=	0	0	P	

Average - Investigate & Understand

KPI	Target < or >	Target	P	A	V
Neonatal Deaths per 1000 live Births	N/A		0		
Cancer: 31 Days from Diagnosis to 1st Definitive Treatment	>=	>=96%	82.14%	?	
Cancer: 62 Day Screening Referrals (Percentage)	>=	>=90%	0.00%	?	
Never Events	<=	0	0	?	
Serious Untoward Incidents: Number of SUI's reported to CCG within agreed timescales	>=	100%	100.00 %	?	
Serious Untoward Incidents: Number of SUI's with actions outstanding	<=	0	0	?	

Integrated Performance Metrics

Indicators are grouped here into assurance levels and variance. See Appendix 1 & 2 to understand how categories have been derived

Concerning - Investigate

KPI	Target < or >	Target	P	A	V
All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (After Re-allocation)	>=	>=85%	20.00%		
Cancer: 104 Day Breaches	<=	0	3		
Cancer: 28 Day Faster Diagnosis	>=	>= 75%	55.87%		
Diagnostic Tests: 6 Week Wait	>=	>= 99%	83.90%		
Friends & Family Test: A&E % positive	>=	95%	84.78%		
Friends & Family Test: In-patient/Daycase % positive	>=	95%	92.17%		
Friends & Family Test: Maternity % positive	>=	95%	85.16%		
Mandatory Training Compliance	>=	>= 95%	88.67%		
Prevention of Ill Health: Flu Vaccine Front Line Clinical Staff	>=	>= 80%	45.29%		
Sickness Absence Rate	<=	<= 4.5%	9.18%		
Venous Thromboembolism (VTE)	>=	>= 95%	91.75%		
Complaints: Number Received	<=	<= 15	6		
Turnover Rate	<=	<= 13%	11.40%		

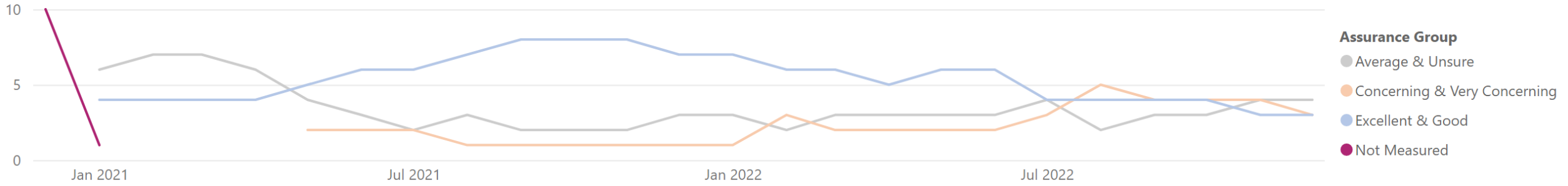
Very Concerning - Investigate & Take Action

KPI	Target < or >	Target	P	A	V
18 Week RTT: Incomplete Pathway > 52 Weeks	<=	0	2706		
18 Week RTT: Incomplete Pathway > 78 Weeks	<=	0	194		
A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge	>=	>= 95%	87.14%		
Clinical Mandatory Training Compliance	>=	>= 95%	78.02%		
Serious Untoward Incindents: New (Rolling per year)	<=	24 /year	39		
Serious Untoward Incindents: Open	<=	<5	31		

Investigate & Understand

KPI	Target < or >	Target	P	A	V
Intensive Care Transfers Out (Rolling 12 Months)	N/A		3		
Overall size of Elective Waiting List	N/A		18096		

Section 3: To deliver **Safe** Services

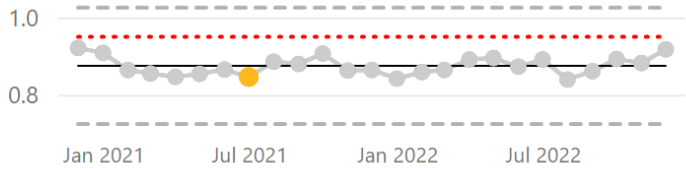


KPI	Assurance Category	Date	Target	Target < or >	Performance	Assurance	Variation	Trend
Infection Control: MRSA	Excellent	December 2022	0	<=	0			
Infection Control: Clostridium Difficile	Good	December 2022	0	<=	0			
NHSE / NHSI Safety Alerts Outstanding	Good	December 2022	0	<=	0			
Neonatal Deaths per 1000 live Births	Average	November 2022		N/A	0			
Never Events	Average	December 2022	0	<=	0			
Serious Untoward Incidents: Number of SUI's reported to CCG within agreed timescales	Average	December 2022	100%	>=	100.00%			
Serious Untoward Incidents: Number of SUI's with actions outstanding	Average	December 2022	0	<=	0			
Venous Thromboembolism (VTE)	Concerning	December 2022	>= 95%	>=	91.75%			
Serious Untoward Incindents: New (Rolling per year)	Very Concerning	December 2022	24 /year	<=	39			
Serious Untoward Incindents: Open	Very Concerning	December 2022	<5	<=	31			
Intensive Care Transfers Out (Rolling 12 Months)	Unsure	December 2022		N/A	3			

To deliver **Safe** Services - Exceptions

Venous Thromboembolism (VTE) - Medical Director

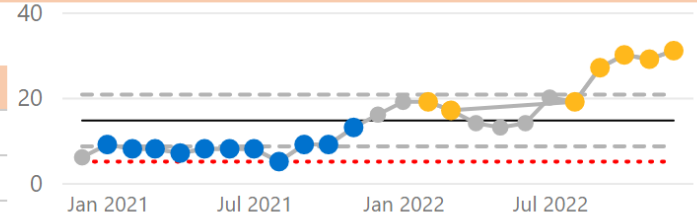
Assurance Category	Concerning
Date	December 2022
Target	>= 95%
Target < or >	>=
Performance	91.75%
Assurance	F
Variation	



The divisional actions taken is starting to demonstrate gradual improvement in VTE performance, however, it is acknowledged that this remains under threshold. A VTE lead is now established in role and prioritising VTE assessments move across to PENS to aid completion.

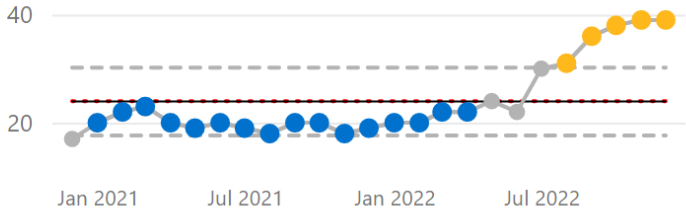
Serious Untoward Incidents: Open - Chief Nurse

Assurance Category	Very Concerning
Date	December 2022
Target	<5
Target < or >	<=
Performance	31
Assurance	F
Variation	H



Serious Untoward Incidents: New - Chief Nurse

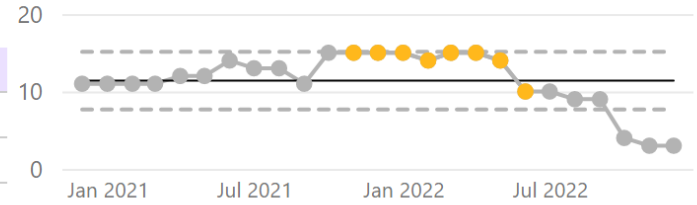
Assurance Category	Very Concerning
Date	December 2022
Target	24 /year
Target < or >	<=
Performance	39
Assurance	F
Variation	H



An increase in the number of rolling Serious Incidents is noted. Weekly meetings are held with divisions and governance managers to support timely completion and are escalated monthly at Safety and Effectiveness sub-committee meeting.

Intensive Care Transfers Out (Rolling 12 Month) - Medical Director

Assurance Category	Unsure
Date	December 2022
Target	
Target < or >	N/A
Performance	3
Assurance	
Variation	↘



Maternity Assessment Unit - Arrival to Triage within 30 minutes - Update

- In the January 2023 Quality Committee, attention was drawn to the MAU – Arrival to Triage within 30 minutes metric which was showing a deteriorating trend.
- Compliance has been reducing owing to staffing unavailability (combination of midwifery vacancies and sickness)
- Through the Maternity Transformation Board, rapid improvement measures have been put into place and significant improvement in this metric has been achieved towards the end of January 2023.
- A multi-professional group will oversee the sustainability of this improvement, led by the Chief Nurse.
- This metric will continue to be closely monitored by the Quality Committee and it will also bene included in the metrics reported to the Board for enhanced oversight of performance.

To deliver Safe services - Safer Staffing

November 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	87.50%	83.33%	128.33%	103.33%	*/**Staffing fill rates are reflective of the bed occupancy on HDU and inpatient ward allowing for redeployment of 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	84.87%	83.33%	82.31%	100.00%	*Safe staffing required the Maternity bleep holder to redeploy RM to maintain clinical safety and prioritise 1:1 care in labour, and on occasions redeployment of staff from the Maternity Base, an escalation of CoC Midwives as per policy. Vacant shifts are requested to be filled with bank.
Maternity & Jeffcoate	97.08%	87.50%	84.29%	82.50%	*/**All vacant shifts requested to be filled with bank. The Maternity bleep holder redeployed staff to maintain clinical safety to areas of high acuity and to ensure appropriate discharge flow to release capacity and ensure safe care maintained across maternity services.
MLU	87.50%	90.00%	75.83%	80.00%	*/**Due to internal escalation, there were 4 episodes of closure of MLU (each for less than 24hrs) in month with the staffing fill rate 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)	101.93%	91.67%	103.16%	81.67%	*Occupancy and acuity on the neonatal unit remains high, staffing reflects this to ensure safety is maintained.
Transitional Care	23.33%	116.67%	63.33%	76.67%	**Staffing reflects occupancy within TC to ensure safe standards are met.

To deliver Safe services - Safer Staffing

Gynaecology: November Fill Rate

Fill rate – November staffing fill rate is reflective of the current RN vacancy position alongside short-term sickness, further challenged with maternity leave,. Safe staffing has been maintained throughout by flexibly rotating RNs across the division and due to the low-bed occupancy in HDU (40.35%) this has enabled the HDU team to support the ward inpatients. The fill rate of 128.33% RN on nights reflects senior RN cover rotating between GED and inpatient area. The allocate rostering system now allows managers to make staff moves from other departments, however, there are further minor adjustments to be made so staff are not missed from the staffing fill rate, these will be resolved in the following month.

Attendance/ Absence – November sickness is reported as 6.67% reflecting 100% Short-term sickness and managed as per policy. Maternity leave is 1.61WTE

Vacancies -Recruited 2 RN in November reducing RN vacancy to 0.71WTE (RN awaiting start dates)

Red Flags – There are no Red Flags reported for November

Bed Occupancy – bed occupancy for the inpatient ward for November is 43.33%

CHPPD – 7.1

Neonates: November Fill Rate

Fill-rate – Occupancy and acuity throughout November has remained high, increasing further on previous months. Intensive care occupancy increased to 111.9 % from 103.5 % in October. This level is 1.9% higher than the maximum ITU occupancy of 2021. High dependency occupancy reduced to 48.1 % and low dependency occupancy remained high at over 100%. TC staffing remained safe throughout the month of November with care extended to babies on small baby pathway, ward antibiotics and babies on risk of hypoglycaemia pathway. Safe staffing has been maintained throughout the month and fill rates of just over 100% trained staff on day and night shifts are reflective of occupancy and acuity. The level of NHSP bank nurse usage in November is reflected in the increased ITU activity. The escalation policy has not been used this month..

Attendance/Absence - Sickness is running at 7.79% slightly up on previous months. Of this 50.45% is long-term and 49.55% short-term sickness. Covid sickness is reduced from last month from 1.36 % to 0.91% with short-term sickness predominantly related to cough, colds and flu and Gastrointestinal problems. Maternity leave reduced slightly to 11.89 wte. Turnover remains well below the Trust threshold at just over 9%.

Vacancies - There has been successful recruitment of 5 Band 3 Clinical Support Workers for low dependency. The band 5 neonatal nurses recruited for transitional care have completed recruitment checks and are due to commence in December. 3 WTE ANNP posts are out to advert currently. An interim Matron has been appointed to start on 5th December, 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 90.8 %, down 4 % on previous month. Intensive care activity increased further to 30.5% this month, High dependency activity dropped from 66.7% to 48.1% and low dependency remains very busy with a very slight reduction from 106.1%. to 103.7 %. The November position reflects higher acuity and activity than expected. Safe staffing has been maintained throughout.

To deliver Safe services - Safer Staffing

Maternity: November Fill Rate

Fill rate - Maternity continues to report levels of sickness above the trust threshold of 4.5% which is calculated in the headroom, within its midwifery and support staff group. Following the commencement of a cohort of 38 Newly Qualified Midwives (NQM) completing orientation to the clinical areas, agency usage was ceased, with vacant shifts released to bank continuing due to sickness rates and to cover remaining vacancy gaps. Maternity has been required to close MLU during this reporting period on 4 occasions, each less than 24hrs, to allow a consolidation of midwifery staffing to one clinical area to support both acuity and ensure appropriate skill mix was ensured. 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 when reporting Midwifery red flags.

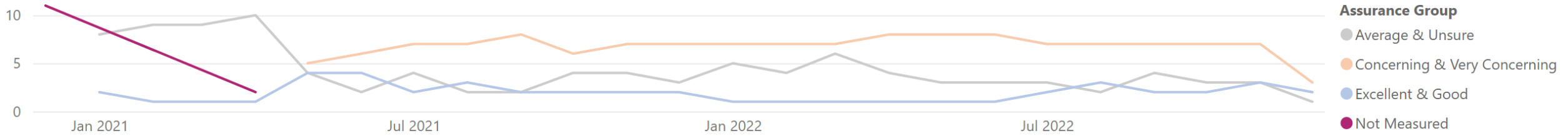
Attendance/ Absence – Maternity sickness is reported at 10.60% combined staff groups, with specific clinical staff sickness reflecting 9.12% for RMs and 15.57% for HCAs. This is an increase from the previous month at 9.92% combined staff groups but is a reduction from the same period in 2021. Maternity has a higher rate of LT sickness than ST sickness (34%STS versus 66%LTS), with the top reasons for short-term absence being cough/cold or gastrointestinal problems. Ward managers/matrons have individual sickness reviews, and maternity are planning return to work programmes with all LT employees to facilitate appropriate returns to work. A comprehensive sickness review programme overseen by the HRBP, and Deputy HOM continues monthly, and this oversight has supported the resolution of, and overall reduction in active LTS and resolution of cases. Maternity leave equates to 12.52wte across all staff groups.

Vacancies – Maternity International Recruitment as part of the collaborative NW bid welcomed the first midwife to commence employment in November at the Trust, with a further 7 midwives expected to commence employment before the end of the financial year. Additionally, 16.83wte Midwives consisting of NQM and experienced Band 6 Midwives are currently undergoing employment checks to be commenced in post by February, which will reduce the gross vacancy at M8 from 10% (28.76wte) significantly. Maternity continues with active and ongoing recruitment campaigns following previous Trust Board approval.

Red Flags –Ongoing work with the IOL workstream has now developed, with a dashboard for visibility of delays across the Trust. The dashboard highlights the most frequent red flag reported being one which reflects a locally added delay of > 4hrs for ongoing IOL. This is not a national NICE red flag, however one which has been locally agreed through sub-Board Committee (Putting People First Committee) following a recent deep dive, production of an action plan including a full review of current process to enable consistency in wording on the Ulysses reporting system of NICE Red Flags to ensure accurate reporting.

Bed Occupancy – Maternity continues to experience high levels of clinical activity and referrals from other units as a tertiary provider including in utero transfers for extreme preterm babies and those requiring specialist care at birth. During the month Maternity was required to deflect all activity for a period of 17 hours due to acuity and occupancy.

Section 4: To deliver the most **Effective** Outcomes

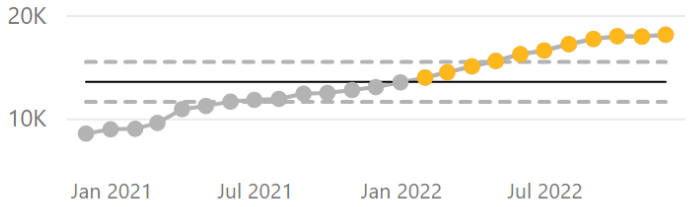


KPI	Assurance Category	Date	Target	Target < or >	Performance	Assurance	Variation	Trend
18 Week RTT: Incomplete Pathway > 104 Weeks	Excellent	December 2022	0	<=	0	P	L	
Proportion of patient activity with an ethnicity code	Excellent	December 2022	>=96%	>=	97.51%	P	H	
Cancer: 2 Week Wait	Good	November 2022	>= 93%	>=	94.72%	?	H	
Cancer: 31 Days from Diagnosis to 1st Definitive Treatment	Average	November 2022	>=96%	>=	82.14%	?		
Cancer: 62 Day Screening Referrals (Percentage)	Average	November 2022	>=90%	>=	0.00%	?		
All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (After Re-allocation)	Concerning	November 2022	>=85%	>=	20.00%	F		
Cancer: 104 Day Breaches	Concerning	November 2022	0	<=	3	F		
Cancer: 28 Day Faster Diagnosis	Concerning	November 2022	>= 75%	>=	55.87%	F		
Diagnostic Tests: 6 Week Wait	Concerning	November 2022	>= 99%	>=	83.90%	F		
18 Week RTT: Incomplete Pathway > 52 Weeks	Very Concerning	December 2022	0	<=	2706	F	H	
18 Week RTT: Incomplete Pathway > 78 Weeks	Very Concerning	December 2022	0	<=	194	F	H	
A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge	Very Concerning	December 2022	>= 95%	>=	87.14%	F	L	
Overall size of Elective Waiting List	Unsure	December 2022		N/A	18096		↗	

To deliver the most **Effective** Outcomes - Exceptions

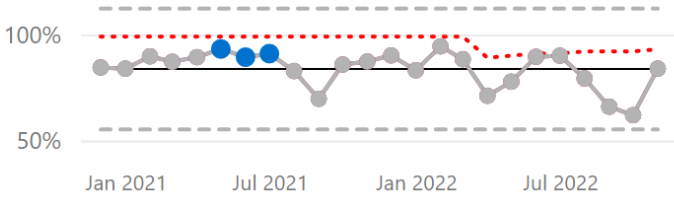
Overall size of Elective Waiting List - Chief Operating Officer

Assurance Category	Unsure
Date	December 2022
Target	
Target < or >	N/A
Performance	18096
Assurance	
Variation	



Diagnostic Tests: 6 Week Wait - Chief Operating Officer

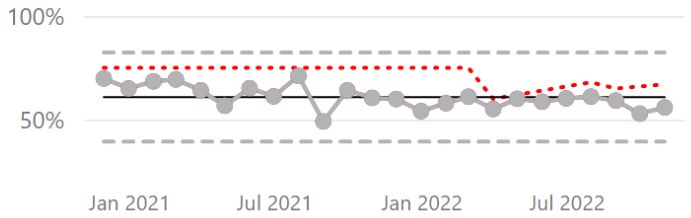
Assurance Category	Concerning
Date	November 2022
Target	>= 99%
Target < or >	>=
Performance	83.90%
Assurance	
Variation	



KPI204 - performance has risen dramatically in the last month due to a number of factors. Divisional management and the Imaging team have begun close PTL management of diagnostic waiters and have implemented protected daily capacity for non-obstetric ultrasound lists to reduce the variation in performance. CSS has worked with Gynae colleagues to ensure they are following the same PTL processes for their respective DM01 tests. Further capacity in imaging is required to improve and maintain.

Cancer: 28 Day Faster Diagnosis - Chief Operating Officer

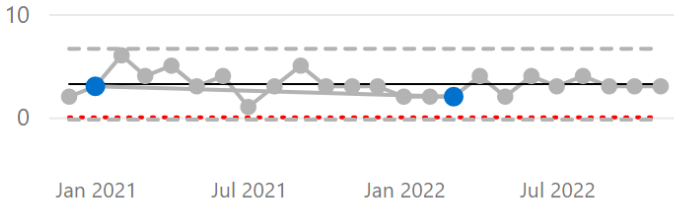
Assurance Category	Concerning
Date	November 2022
Target	>= 75%
Target < or >	>=
Performance	55.87%
Assurance	
Variation	



Insufficent ambulatory capacity. Risk now sits corporately. Additional capital monies required to expand the department. Business case being developed by the division plus a bid submitted to the cancer alliance for additional capital monies. No response from the cancer alliance as yet.

Cancer: 104 Day Breaches - Chief Operating Officer

Assurance Category	Concerning
Date	November 2022
Target	0
Target < or >	<=
Performance	3
Assurance	
Variation	

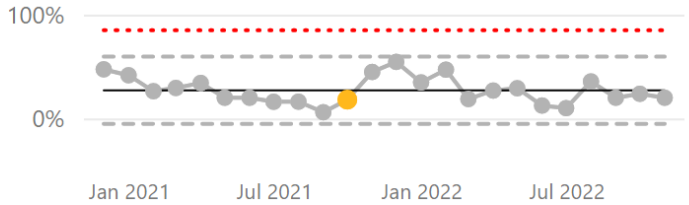


There are a number of patients waiting over 104 days with many still awaiting a decision to treat. External and internal diagnostics pressures are contributing to the position plus patients are also requiring a more detailed pre op assessment due to co-morbidities. Extra activity has been sourced at weekends to help reduce the internal ambulatory delays. Cancer team are tracking and escalating as required

To deliver the most **Effective** Outcomes - Exceptions

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

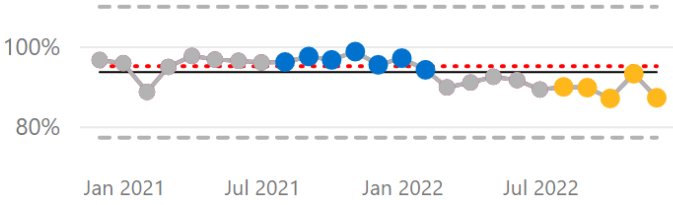
Assurance Category	Concerning
Date	November 2022
Target	>=85%
Target < or >	>=
Performance	20.00%
Assurance	F
Variation	



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. Issues regarding ambulatory capacity have been highlighted within other KPIs

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

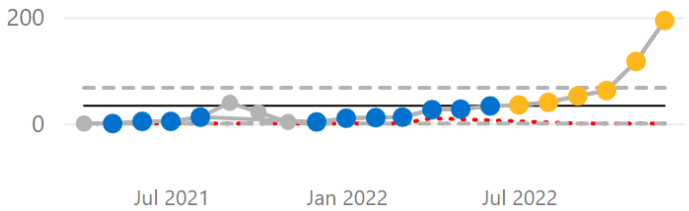
Assurance Category	Very Concerning
Date	December 2022
Target	>= 95%
Target < or >	>=
Performance	87.14%
Assurance	F
Variation	L



Performance continues to remain consistent between 85-90%. Long term sickness is proving challenging and the number of attendnaces has increased by 12%. Service review submitted to execs for discussion.

18 Week RTT: Incomplete Pathway > 78 Weeks - Chief Operating Officer

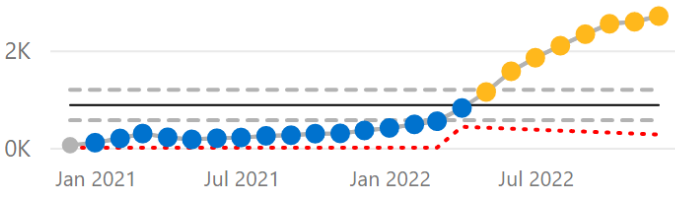
Assurance Category	Very Concerning
Date	December 2022
Target	0
Target < or >	<=
Performance	194
Assurance	F
Variation	H



Weekly report and meeting oversight of 78+ week waiters. 7+ week report outlines numbers of patients at pathway point, when next appointment is etc. Oversight from Deputy COO and reported through fortnightly Access Board. additional outpatient activity through Q4. Validation of patients continues with removal of patients from waiting list where appointments no longer required. A number of complex patients requiring joint surgery escalated to colleagues at LUFT to support

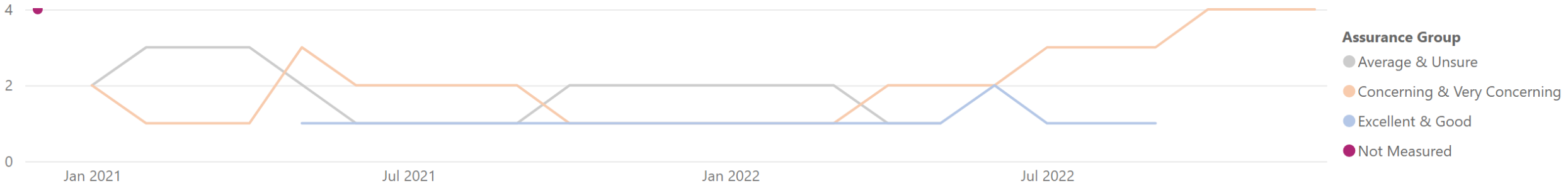
18 Week RTT: Incomplete Pathway > 52 Weeks - Chief Operating Officer

Assurance Category	Very Concerning
Date	December 2022
Target	0
Target < or >	<=
Performance	2706
Assurance	F
Variation	H



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 have submitted a paper on Elective Recovery to 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.

Section 5: To deliver the best possible **Experience** for patients and staff

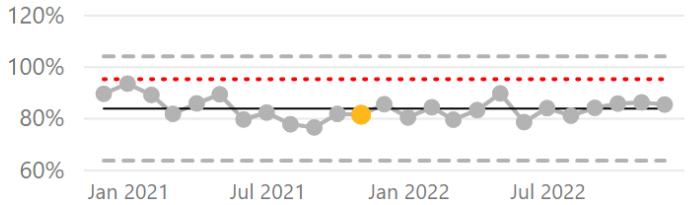


KPI	Assurance Category	Date	Target	Target < or >	Performance	Assurance	Variation	Trend
Complaints: Number Received	Concerning	December 2022	<= 15	<=	6			
Friends & Family Test: A&E % positive	Concerning	December 2022	95%	>=	84.78%			
Friends & Family Test: In-patient/Daycase % positive	Concerning	December 2022	95%	>=	92.17%			
Friends & Family Test: Maternity % positive	Concerning	December 2022	95%	>=	85.16%			

To deliver the best possible **Experience** for patients and staff - Exceptions

Friends & Family Test: Maternity % positive - Chief Nurse

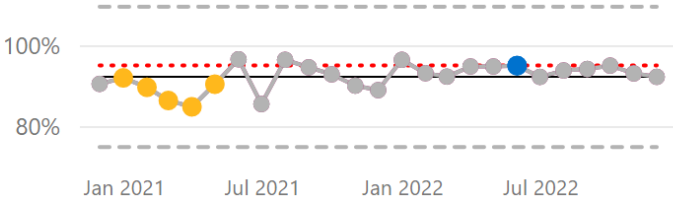
Assurance Category	Concerning
Date	December 2022
Target	95%
Target < or >	>=
Performance	85.16%
Assurance	F
Variation	



Responses remain low. Trust volunteers to be considered for the Maternity ward with the aim of speaking to patients to encourage them to provide feedback on the care they received during pregnancy and birth, if permissible within guidance.

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

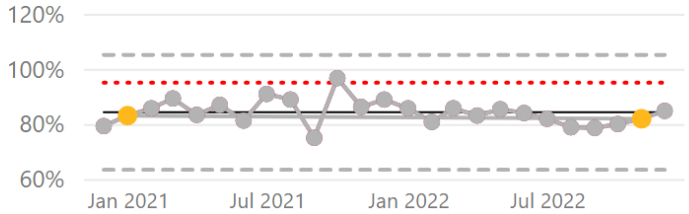
Assurance Category	Concerning
Date	December 2022
Target	95%
Target < or >	>=
Performance	92.17%
Assurance	F
Variation	



4 displeased comments, 2 of which relate to cancellation of operation, one without supporting narrative, other relates to staff attitude. It is evident there is improvement in pain management as no concerns escalated to ward manager / matron

Friends & Family Test: A&E % positive - Chief Nurse

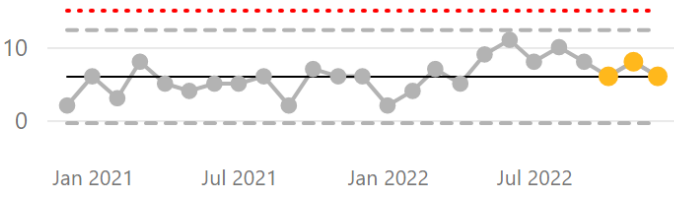
Assurance Category	Concerning
Date	December 2022
Target	95%
Target < or >	>=
Performance	84.78%
Assurance	F
Variation	



The comments received relate to staff attitude. These have since been addressed with the staff member who has been informally counselled .Patients are now encouraged to speak with the nurse in charge of the department on the day so any concerns/issues can be addressed at the time the incident occurred. Notices have been placed in the waiting room.

Complaints: Number Received - Chief Nurse

Assurance Category	Concerning
Date	December 2022
Target	<= 15
Target < or >	<=
Performance	6
Assurance	P
Variation	H



Complaint numbers continue to be raised on last year as pressures and strains across the Trust continue to be reflected in patient feedback. One continued noticeable increase is the rise in Complaints relating to the Hewitt Centre. This is due to a shift in process this year where complaints and concerns are raised when refunds or free cycles are requested are, in the absence of another avenue, referred to the complaints process to ensure a consistent approach to these requests and decisions.

December 2022 – Maternity Facts

Liverpool Women's NHS Foundation Trust

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

621 Babies Born

246 Inductions of labour

14 Home Births

Girls 293

328 Boys

1354 Visits to Maternity Assessment Unit

2 Breech Births

Spontaneous Vaginal Births 282

12 Sets of Twins

Sets of Triplets 1

30 Women recruited to research studies

106 Elective C - Sections

152 Emergency C - Sections

Have you had a December 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 82

Women Booked For Care 571

20 Pool Births

Heaviest Baby 11lb 6oz
Lightest Baby 1lb 5oz

Christmas Day 25th December: 11 Births.

Our busiest day 20th December : 32 Births.

KPI Lineage & Data Quality Overview

Metric Description	WE SEE	DQ Kite Mark	Board	FPBD	Quality	PPF	Family Health Division	CSS Division	Gynaecology Division	Maternity Clinical
18 Week RTT: Incomplete Pathway > 104 Weeks	Effective	5	Y	Y	Y				Y	
18 Week RTT: Incomplete Pathway > 52 Weeks	Effective	5	Y	Y	Y					
18 Week RTT: Incomplete Pathway > 78 Weeks	Effective	5	Y	Y	Y				Y	
A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge	Effective	5	Y	Y	Y				Y	
All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (After Re-allocation)	Effective	5	Y	Y	Y				Y	
Cancer: 104 Day Breaches	Effective	5	Y	Y	Y				Y	
Cancer: 2 Week Wait	Effective	5	Y	Y	Y				Y	
Cancer: 28 Day Faster Diagnosis	Effective	5	Y	Y	Y			Y	Y	
Cancer: 31 Days from Diagnosis to 1st Definitive Treatment	Effective	5	Y	Y	Y				Y	
Cancer: 62 Day Screening Referrals (Percentage)	Effective	5	Y	Y	Y				Y	
Clinical Mandatory Training Compliance	Workforce	5	Y		Y	Y				
Complaints: Number Received	Experience	5	Y		Y					
Diagnostic Tests: 6 Week Wait	Effective	5	Y	Y	Y			Y	Y	
Financial Sustainability Risk Rating: Overall Score	Efficient	5	Y	Y						
Friends & Family Test: A&E % positive	Experience	5	Y		Y				Y	
Friends & Family Test: In-patient/Daycase % positive	Experience	5	Y		Y				Y	
Friends & Family Test: Maternity % positive	Experience	5	Y		Y		Y			Y
Infection Control: Clostridium Difficile	Safety	5	Y		Y					
Infection Control: MRSA	Safety	5	Y		Y					
Intensive Care Transfers Out (Rolling 12 Month)	Safety	5	Y		Y					
Mandatory Training Compliance	Workforce	5	Y		Y	Y				
Neonatal Deaths per 1000 live Births	Safety	5	Y				Y			
Never Events	Safety	5	Y		Y					
NHSE / NHSI Safety Alerts Outstanding	Safety	5	Y		Y		Y			Y
Overall size of Elective Waiting List	Effective	5	Y					Y	Y	
Proportion of patient activity with an ethnicity code	Effective	5	Y	Y					Y	
Serious Untoward Incidents: Number of SUI's reported to CCG within agreed timescale	Safety	5	Y		Y					
Serious Untoward Incidents: Number of SUI's with actions outstanding	Safety	5	Y		Y				Y	
Serious Untoward Incindents: New	Safety	5	Y		Y				Y	
Serious Untoward Incindents: Open	Safety	5	Y		Y					
Sickness	Workforce	5	Y		Y	Y				
Turnover	Workforce	5	Y			Y				
Venous Thromboembolism (VTE)	Safety	5	Y		Y					
Prevention of Ill Health: Flu Vaccine Front Line Clinical Staff	Workforce		Y	Y	Y	Y				

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*22/23/202c*	Date: 02/02/2023		
Report Title	Mortality and Learning from Deaths Report Quarter 2, 22/23			
Prepared by	Lidia Kwasnicka, Gynaecologist; Ai-Wei Tang, Consultant Obstetrician; Rebecca Kettle, Consultant Neonatologist Chris Dewhurst, Deputy Medical Director			
Presented by	Lynn Greenhalgh, Medical Director			
Key Issues / Messages	The Board is asked to review the contents of the paper and take assurance that there is adequate processes and progress against the requirements laid out by the National Quality Board.			
Action required	Approve ☐	Receive ☐	Note ☒	Take Assurance ☒
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable): N/A			
	For Decisions - in line with Risk Appetite Statement – Y *If no – please outline the reasons for deviation.*			
Supporting Executive:	Lynn Greenhalgh Medical Director			

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

Link to the Board Assurance Framework (BAF) / Corporate Risk Register (CRR)	
Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks*	Comment: N/A
Link to the Corporate Risk Register (CRR) – CR Number:	Comment: No

EXECUTIVE SUMMARY

This "Mortality and Learning from Deaths" paper presents the mortality data for quarter 2, 2022/23 with the learning from the reviews of deaths from quarter 1 2022/23. The 'learning' can take some time after the death occurs due to the formal processes and MDT review process that occur. This results in the learning being presented a quarter behind the data.

The paper also provides the compliance data for the Maternity Incentive Scheme year 4, safety action 1:

> *Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?*

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

In quarter 1 there were the following deaths:

Adult deaths	**1 (un-expected)**
Direct Maternal Deaths	**0**
Stillbirths	**7 (excluding terminations of pregnancy) (rate 3.6/1000 total births)**
Neonatal deaths	**15 inborn (rate 7.2/1000 inborn births) + 2 deaths from postnatal transfers**

The stillbirth rate remains lower in this and the previous quarter, than for 21-22. This is reassuring although caution of interpretation due to small numbers is warranted.

There was an increase in Neonatal mortality. This resulted from 9 babies whose deaths resulted from congenital anomalies. Network benchmarking data is presented for neonatal mortality is presented.

The MBRRACE report for extended perinatal mortality in 2020 was published in October 2022. These data demonstrate that LWH is a negative outlier for stillbirth, perinatal and extended perinatal deaths. This year has previously been identified as having a particularly high neonatal mortality rate. Assurance on clinical care was provide by the NWODN review of neonatal mortality that has been presented to the committee and board previously.

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

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

- number of deaths in our care
- number of deaths subject to case record review
- number of deaths investigated under the Serious Incident framework
- number of deaths that were reviewed/investigated and as a result considered due to problems in care
- themes and issues identified from review and investigation
- actions taken in response, actions planned and an assessment of the impact of actions taken.
- Compliance with SA1 for the MIS of CNST.

MAIN REPORT

This is the quarter 2 2022/23 mortality report for adults, stillbirths and neonates. The report is part of the regular reporting schedule of the Trust to ensure that there is oversight and assurance monitoring of the mortality rates related to the clinical activity of the Trust. This is in accordance with recommendations by the National Quality Board "National Guidance on Learning from Deaths" and the Care Quality Commission. It outlines the work taking place operationally and being overseen by the Safety and Effectiveness Sub - Committee and Quality Committee. The paper also provides the evidence required for the Maternity Incentive Scheme (MIS) which was recommenced on May 6th 2022.

The data presented in this report relates to quarter 2 2022-23. The learning relates to deaths in Q1 2022-23. This is due to the multidisciplinary review of deaths not occurring in the quarter when the death occurred.

Additional data/information relating to mortality is presented in the embedded word document.

1 Adult Mortality

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

1.1 Obstetric Mortality Data Q2 2022/23

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

1.2 Learning from Obstetric Mortality Data

In Q3 2022/23, there was one death of a woman who died approximately 8 weeks after delivery. This case is subject to a Coronial investigation and, as per the requirements of the Ockenden review, a multiagency review has been completed with the Coroner's inquest due to take place in late November 2022. The LWH internal SI review was published in September 2022 and with root causes being

- Inappropriate discharge from hospital with failure in planning for on-going care
- Failure to provide clear communication between all services that provided care to the woman

Lessons learnt for LWH

- Antenatal screening questions do not identify post or present eating disorders
- There is no failsafe in place for the notification of pregnancy to the Health Visitor services
- The current system in place does not support accurate information sharing following admission/discharge of patients
- The community midwives do not always have close contact with the GPs which prevents sharing of information for vulnerable patients
- Medical input is required into completion of discharge summaries to ensure that there are clear actions for the GP to follow.
- The current system used to prescribe and administer medication does not support staff in the identification of missed doses

An action plan was initiated following the review to address the lessons learnt.

1.3 Gynaecology Mortality data Q2 2022/23

There was 1 death within Gynaecology Oncology in Q2 2022/23. This death was reviewed at a 72 hour review meeting and is progressing as a formal review. The initial outcome was that it is unlikely different management would have resulted in a different outcome but the findings from the formal review will be presented in Q3s learning from death paper.

1.4 Learning from Gynaecology Mortality Q1 2022/23

There were 2 expected deaths in Q1 22/23. Both were end of life palliative care cases that were reviewed using the mortality audit report tool. No issues with care were identified during the review.

2 Stillbirths

2.1 Stillbirth data

There were 7 stillbirths, excluding terminations of pregnancy (TOP) in Q2 2022/2023. This has resulted in an adjusted stillbirth rate of 3.6/1000 live births for Q2.

STILLBIRTHS	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May -22	June-22	July-22	Aug-22	Sept-22	Oct-22	Q2 cases	TOTAL 2022/23 (until Nov)
Total Stillbirths	6	3	7	4	6	3	4	3	7	3	2	3	12	25
Stillbirths (excluding TOP)	**5**	**2**	**4**	**0**	**5**	1	4	2	**3**	**3**	**1**	1	**7**	**15**
Births	665	622	659	561	595	601	654	613	645	659	656	636	1960	4462
Overall Rate /1000	9.0	4.8	10.6	7.1	10.1	3.3	6.1	4.9	10.9	4.6	3.0	4.7	6.1	5.6
Rate (excluding TOP)/1000	**7.5**	**3.2**	**6.0**	**0**	**8.4**	1.7	6.1	3.3	**4.7**	**4.6**	**1.5**	1.6	**3.6**	**3.4**
Pregnancy loss 22-24 weeks	0	0	1	0	1	0	0	0	0	0	1	1		

Table 1 Stillbirth rates > 24 weeks for 2021-22

Quarter	Rate 2019/20	Rate 2020/21	Rate 2021/22	Rate 2022/23
Q1	4.0	5.5	4.0	3.7
Q2	4.1	2.5	5.3	3.6
Q3	1.5	2.7	5.1	
Q4	1.7	3.2	5.0	
ANNUAL	2.9	3.4	4.9	

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

The stillbirth rate for the first two quarters 2022-23 is lower than seen on 2021-22. This is reassuring but assurance will only be provided with full year data due to the small numbers involved. There was one pregnancy loss (excluding TOP) born between 22 – 24 weeks gestational age.

2.1 Learning from Stillbirth reviews Q1 2022-23

All eligible cases underwent a full multidisciplinary team PMRT review with external clinician presence. Care from across the antenatal and intrapartum period was subject to clinical and managerial scrutiny. All bereaved parents were invited to be involved in the review process by submitting comments and questions via the Honeysuckle Team for discussion at the MDT Review

The reviews of Q1 cases (N=7) identified 3 (42.9%) had no antenatal care issues identified, and 4 (57.1%) had care issues identified which would not have changed the outcome of the pregnancy in accordance with the MBBRACE Grading system. In the review of postnatal care provided, 6 (85.7%) of cases had care issues identified, detailed in the narrative of the report.

Grade	Care in antenatal period	Percentage (%)	Care provided after Stillbirth	Percentage (%)
A	3	42.9	1	14.3
B	4	57.1	6	85.7
C	0	0	0	0
D	0	0	0	0

Table 3 PMRT review panel grading of care provided in cases of Stillbirth (N=7)

Learning from Q1 in the provision of antenatal care includes:

- Improving the electronic patient record to improve access to intrapartum plans of care
- Incorporating method for joint counselling into the Maternity base improvement plan.
- Review of demand and capacity in the multipregnancy clinic
- Cross divisional working with CSS to improve the follow up scans for patients who do not attend scanning appointments

In the care provided after delivery,:

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

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

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

There is ongoing progress with the following:

- Implementation of the CoC model to improve process in arranging for FU for CMW reviews, while working towards developing a defined role for a midwife in the community hub to review investigation results
- Ongoing recruitment of more fetal medicine consultants
- Business case to increase provision of bereavement care and support out of hours

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

3. Neonatal Mortality

3.1 Neonatal mortality Data

Neonatal deaths can be reported in several ways. The population can include in-born babies only, LWH booked pregnancies or all babies cared for in LWH (including babies transferred to LWH from other care providers). Deaths may be those within 28 days, those occurring prior to discharge from the NICU and those who die following transfer to another hospital. The data may include or exclude babies with congenital anomalies. The table below presents the total mortality at LWH, and mortality for those babies born at LWH in a rolling 12 month period.

	Oct-21	*Nov-21*	*Dec-21*	*Jan-22*	*Feb-22*	*Mar-22*	*Apr-22*	*May-22*	*Jun-22*	*Jul-22*	*Aug-22*	*Sep-22*	*Total*
Total Neonatal Mortality	8	5	3	2	3	3	*3*	*7*	*3*	8	4	5	54
INBORN Neonatal Mortality	**4**	**4**	**3**	**2**	**3**	**3**	***2***	***4***	***3***	**6**	**4**	**5**	**43**
Deliveries	655	665	622	659	561	595	*602*	*654*	*613*	632	658	652	7568
INBORN Neonatal Mortality Rate/1000 deliveries	**6.1**	**6.0**	**4.8**	**3.0**	**5.3**	**5.0**	***3.3***	***6.1***	***4.9***	**9.5**	**6.1**	**7.7**	**5.7**

Table 4: NICU Mortality.

Quarter	NMR all babies	NMR *in born*
Q3 (21_22)	8.2	5.7
Q4 (21_22)	4.4	4.4
Q1 (22_23)	7.0	4.8
Q2 (22_23)	7.2	6.2

Table 5: Neonatal Mortality Rate per quarter

In this quarter there were 6 babies born to mothers who originally booked there care at LWH. There were 9 in-utero transfers and 2 post-natal transfers. Of note there were 9 congenital anomalies which resulted in neonatal deaths (7 at term), this is a higher than usual number.

3.3. Learning from neonatal mortality reviews for Q4

There were 12 deaths subject to a PMRT review. There were no cases identified with care issues which were likely to have made a difference to the outcome. 3/12 cases identified care issues in other organisations which may have affected the outcome. There was one case of poor communication following the death of a baby whereby the community and health visitor teams sent a congratulations on your birth letter. The post-bereavement communication pathway is being reviewed and revised. which were related 3/10 cases were identified with issues which may have made a difference to the outcome.

Other Learning included the following:

- Unplanned extubation continue but the QI project has now commenced to aim to reduce this.
- Skin injuries in extremely preterm infants with plan to revise the extreme preterm pathway to include changing stas probe regularly and not to use ECG leads.
- Consultant team reminded of importance of documenting parental discussions

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

4. MBRRACE 2020 report

The MBRRACE 2020 report was published in October 2022. These data showed that LWH is a negative outier for thew following;

- Stillbirth (>24 weeks excluding ToP)
- Neonatal Death (deaths a (>24 weeks died within first 28 days of life)
- Extended Perinatal death (stillbirth + neonatal death)

The charts below demonstrate our stabilised and adjusted mortality data which provides a more reliable estimate of the underlying mortality rate, accounting for mother's age, socio-economic deprivation, baby's sex and ethnicity, multiplicity, and (for neonatal deaths only) gestational age at birth.

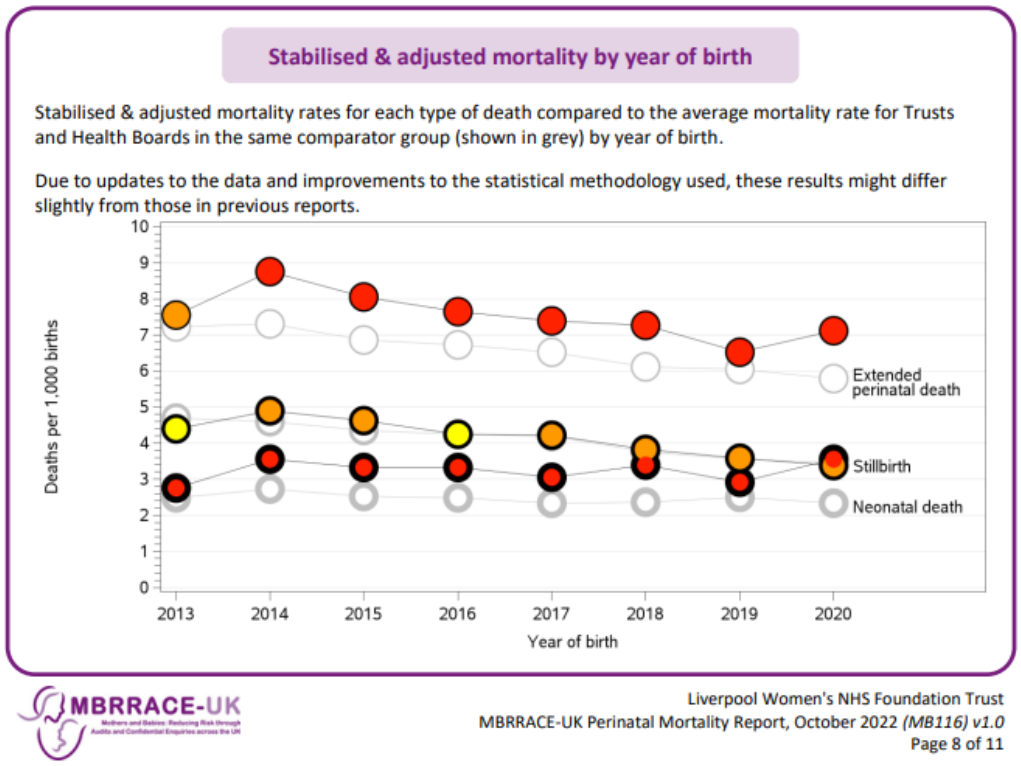


Fig 1.Stabilised and Adjusted mortality rate by year of birth

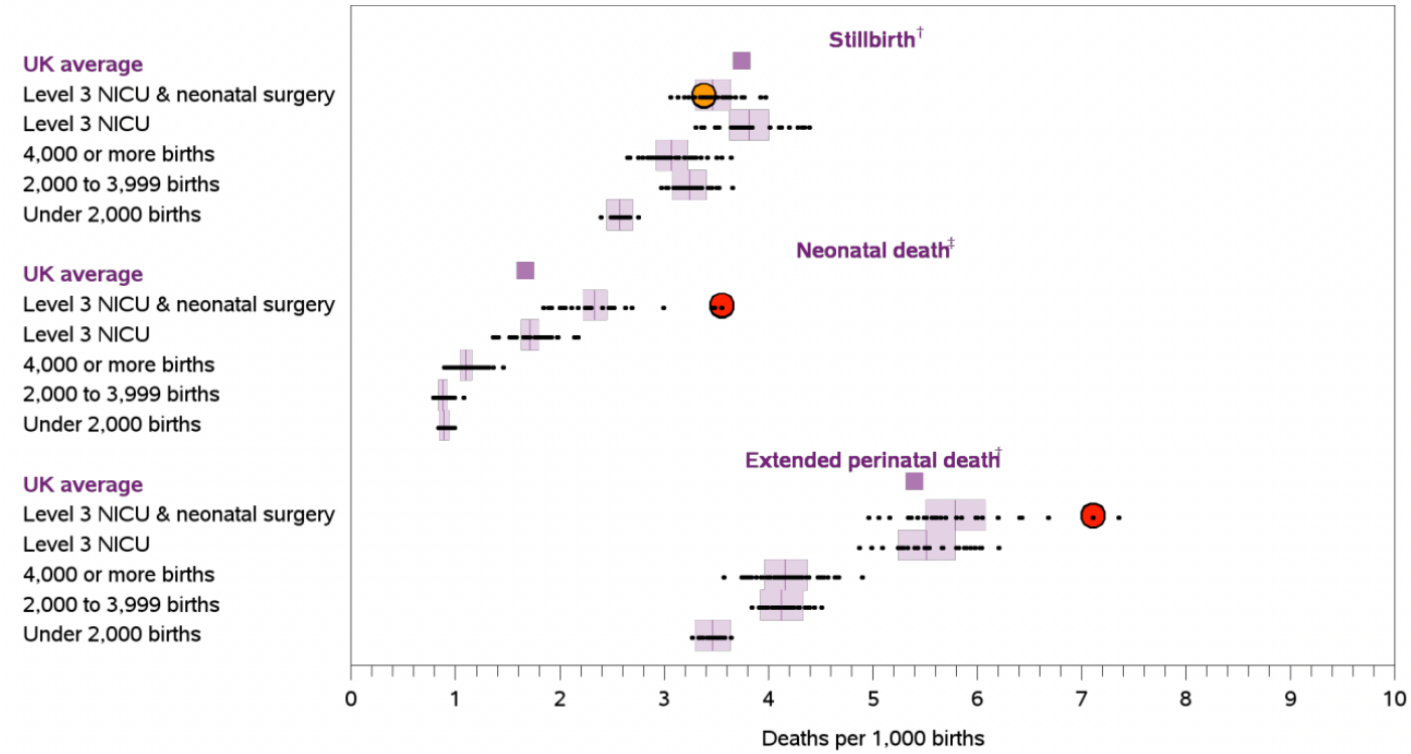


Fig 2. Stabilised and Adjusted Mortality rate Benchmarked against other level 3 NICU with a neonatal surgical provision.

2020 was acknowledged as year with high neonatal mortality. The NWODN network review was partly initiated by these data. This review did not identify a single or specific causal factors. The review did identify that there is a different flow of neonates into LWH, with nearly 4x as many in-utero transfers than other large level 3 NICUs.

Of note the MBRRACE report highlights that neonatal mortality rates increase with deprivation across all ethnic groups. In 2020 c49% of women booking their pregnancies at LWH were in the most deprived decile (10%) in the UK. The MBRACE report does adjust for deprivation,

but only at the quintile level (ie 20%). In other words, in the adjustment our population will look similar to other populations, when in fact it is more deprived.

We are working with Liverpool University, Alder hey Childrens Hospital and the NWODN to undertake a 3-year research collaboration studying geographical inequalities in neonatal mortality. Using local, regional and national datasets, the project is designed to investigate risk factors for neonatal mortality including maternal and pregnancy-related factors and socioeconomic characteristics. It is hoped that this work will allow us to better understand variations in neonatal mortality that have been observed across the North-West region.

5. Revised Year 4 Maternity Incentive Scheme requirements

The MIS was paused in Q3. However the adherence to the safety actions continued. The MIS year 4 recommenced from May 6th 2022 and adherence to safety action 1 is presented below.

This quarterly report (and previous quarterly reports) will continue to be discussed with the maternity, neonatal and Board level safety champions. Dissemination of learning will continue through associated clinical meetings and feedback to staff.

Standard	Denominator	Stillbirth	MTOP	Neonatal deaths	Loss<22	Born alive and still alive as part of a multiple pregnancy with a loss	% compliance	RAG
Ai) All Babies Reported within 7 days	47	14	8	22	1 (21+week triplet)	2	47 (100%)	
A ii) 100% Surveillance questions completed within 2 months	19	13 met (1 not eligible as surveillance assigned to another Trust)	N/A	6 met (3 not eligible as post neonatal deaths, 3 not eligible as gestation at birth <22 weeks, 10 not eligible as assigned to another Trust)	N/A	N/A	19 (100%)	

PMRT reviews undertaken	13	10	N/A	2; 1 not yet (deadline 12/11/22- but awaiting coroners pm);	N/A	N/A	12 (92.3%)	
Bi) At least 50% of all deaths of babies (suitable for review using PMRT) will have been completed to the point that at least a draft report has been generated by the tool within 4 months of each death	13	10 (3 not applicable as the report will be due post qualifying date; of these three it is anticipated that all will be reviewed at this standard after the submission date)	N/A	2 met; 1 not yet met (deadline 12/11/22- but awaiting coroners pm); 3 not eligible as gestation at birth <22 weeks; 3 not applicable as the report will be due post qualifying date	N/A	N/A	12 (92.3%)	
Bii) At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from 6 May 2022 will have been reviewed using the PMRT, by a multidisciplinary review team. Each of these reviews will have been completed to the point that at least a PMRT draft report has been generated by the tool	10	8 (3 have met even though the deadline was outside the qualifying date); 5 not applicable as the report will be due post qualifying date but it is anticipated that all 5 will be completed within this standard following the submission date;	N/A	2 met, (1 was met even though the deadline is post qualifying date); 3 not eligible as gestation at birth <22 weeks; 4 not applicable as the report will be due post qualifying date.	N/A	N/A	10 (100%)	

within four months of each death and the report published within six months of each death.								
For at least 95% of all deaths of babies who died in your Trust from 6 May 2022, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any questions and/or concerns they have about their care and that of their baby have been sought.	17	13 met (1 not eligible as surveillance assigned to another Trust)	N/A	4 met (including the case awaiting coroners pm); 3 not applicable as not suitable for review; 2 not yet met, data will be updated when review undertaken all not at the 4 month deadline before the data submission date	N/A	N/A	17 (100%)	

4. Recommendations

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

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

Putting People First (PPF) Committee Chair's Highlight Report to Trust Board
16 January 2023

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Industrial action on 15 and 20 December 2022 by the RCN passed without incident and was preceded by positive partnership working to agree services exempted from strike action which included maternity and neonatal services. Whilst a range of outpatient and inpatient procedures within gynaecology were rescheduled, impact on patients was minimised as far as possible. Risks of potential further industrial action was noted. • The Committee took partial assurance from the Workforce Performance Report due to performance in relation to a significant number of metrics, notably PDR compliance, sickness absence rates, mandatory training compliance and turnover and vacancy rates. The Committee acknowledged improved content and narrative provided within the new report template which provided assurance that the Committee was sighted on the correct metrics. • Although some areas of improvement had been demonstrated since the mandatory audits undertaken in October and November 2022 , Mandatory Training compliance continued to be a significant risk and limited assurance was taken from the report. The Committee noted the recommendation to receive an update from Divisional representatives including trajectories, plans to improve the position, and escalation steps if required. • The Committee received the GMC Survey Feedback Report 2022. The Trust had maintained its position and had not been identified as an outlier however the Committee felt that the Trust should be performing better as a specialist trust and to reflect the significant investments made on the consultant workforce.	• The Committee received a presentational update alongside the Audit and Sickness Report presenting the current position within the Trust following the implementation of the Employee Attendance and Wellbeing policy in March 2022. The Committee noted comments from staff users across the divisions who had been applying the policy. The Committee considered the recommendations and approved *'Option 2 – continue with the principles of the well-being policy, however, offer more structure to managers in the form of 'well-being' notices as per the proposed policy from the regional policy drafted. The notices would be issued in replace of short-term stages so enables clear management intervention and a clear route to a formal final stage review, should this be appropriate / required'*. It was agreed that detailed assurance would be provided to the Board through the Workforce Performance Report. • The Committee received initial data from the 2022 Staff Survey noting that the information could only be shared within the organisation and is subject to minor changes once the data from our chosen survey provider is aggregated with all NHS Trusts at a National Level. Detailed data had been shared with Divisions who have a 'heatmap' outlining their performance compared to the Trust overall. This data would support Divisions when setting their priorities for budget setting and workforce planning in the next few weeks. Themes from the staff survey would also be taken into account for the HR team operational priorities and the development of the new People Strategy.
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 CSS workforce working in the Physiotherapy department. She described a rapid recruitment process and a positive welcome to the team and offer of leadership training promptly upon appointment. She informed the Committee that she had been seconded up to a leadership role which had been a beneficial and positive experience. It was noted that a split role of management and clinician would be a preferred full-time option as opposed to a full-time management position. (WELL LED) • The Committee took assurance from the CSS workforce assurance report which demonstrated a grip on workforce challenges and proactive action to stabilise the workforce. It was noted that services provided within the CDC should further improve staff retention. The significance of effective partnership working for the CSS division was noted. • Noted the Medical Appraisal and Revalidation report covering Quarter 2, 2022/23. (ALL)	• The Committee considered and approved the policies presented. • The Committee approved Option 2 of the Audit and Sickness Report to be taken forward. • Approved the terms of reference of the Education Governance Sub-Committee and the Retention and Supply Task and Finish Group.
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.	

- Noted the removal of the Covid-19 strategic threat under BAF risk 1.1 as the issues under this remain as business as usual and are included under other BAF items, as agreed by the December 2022 Board.

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
92.	Board Assurance Framework (BAF): Workforce related risks	Assurance		98.	Staff Survey 2022: Initial update based on raw data	Information	
93.	Staff Story	Information		99.	Audit and Sickness Report January 2023	Assurance	
94.	Workforce Assurance Report: Clinical Support Services	Assurance		100.	GMC Survey Feedback Report 2022	Information	
95.	Chief People Officer Report	Information		101.	Medical Appraisal & Revalidation Quarterly Report Quarter 2, 2022/23	Information	
96.	Workforce KPI Dashboard Report	Assurance		102.	Policies for Approval & Policy Audit Update	Approval	
97.	Mandatory Training Audit Progress Report	Assurance		103.	Sub Committee Chair Reports & Terms of Reference	Assurance / Approval	

3. 2022 / 23 Attendance Matrix

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

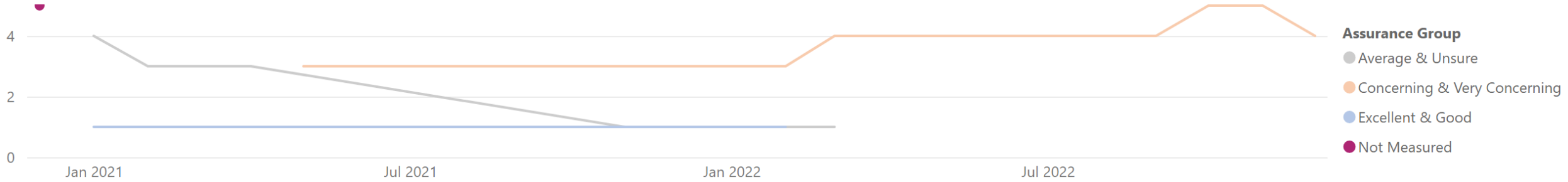
Present (✓) Apologies (A) Representative (R) Nonattendance (NA) Non-Member (NM) *Non-quorate meetings highlighted in greyscale*

Liverpool Women's
NHS Foundation Trust

Trust Board

Workforce Performance Report
January 2023

Section 6: To develop a well led, capable, motivated and entrepreneurial **Workforce**

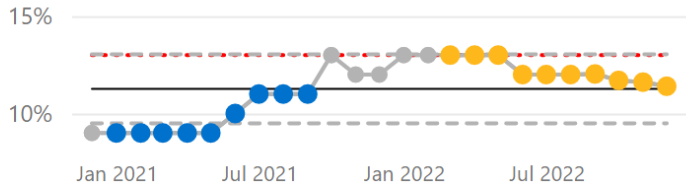


KPI	Assurance Category	Date	Target	Target < or >	Performance	Assurance	Variation	Trend
Mandatory Training Compliance	Concerning	December 2022	>= 95%	>=	88.67%	F	H	
Prevention of Ill Health: Flu Vaccine Front Line Clinical Staff	Concerning	November 2022	>= 80%	>=	45.29%	F		
Sickness Absence Rate	Concerning	December 2022	<= 4.5%	<=	9.18%	F		
Turnover Rate	Concerning	December 2022	<= 13%	<=	11.40%	P	H	
Clinical Mandatory Training Compliance	Very Concerning	December 2022	>= 95%	>=	78.02%	F	L	

To develop a well led, capable, motivated and entrepreneurial **Workforce** - Exceptions

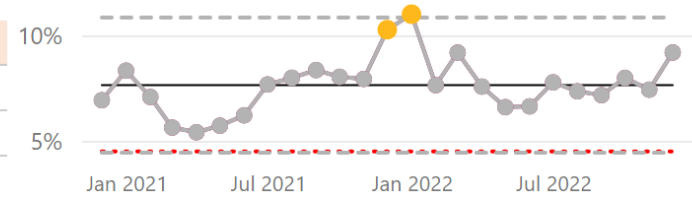
Turnover - Chief People Officer

Assurance Category	Concerning
Date	December 2022
Target	<= 13%
Target < or >	<=
Performance	11.40%
Assurance	P
Variation	H



Sickness - Chief People Officer

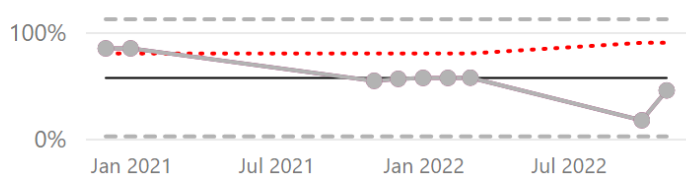
Assurance Category	Concerning
Date	December 2022
Target	<= 4.5%
Target < or >	<=
Performance	9.18%
Assurance	F
Variation	



Sickness absence increased across all divisions, with a resultant increase of 1.76% for the Trust as a whole, taking the single month figure up to 9.1%. The figure for sickness specifically linked to covid went up to 1.44%. HR continue to support local managers in robustly managing sickness absence, and the Trust's current Employee Attendance and Wellbeing Policy is due to be reviewed by the PPF committee in January 2023, with a full analysis of sickness data to be presented by the HRBP team.

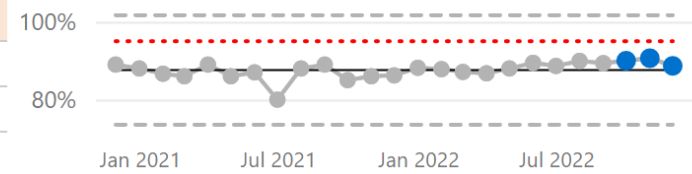
Prevention of Ill Health: Flu Vaccine Front Line Clinical Staff - Chief People Officer

Assurance Category	Concerning
Date	November 2022
Target	>= 80%
Target < or >	>=
Performance	45.29%
Assurance	F
Variation	



Mandatory Training Compliance - Chief People Officer

Assurance Category	Concerning
Date	December 2022
Target	>= 95%
Target < or >	>=
Performance	88.67%
Assurance	F
Variation	H



Overall compliance fell by 1.97%, mainly as a result of a fall of 5.16% in Family Health. Other divisions saw a modest increase or only a slight decrease. Following the mandatory training audit there is a focus on ensuring that staff who have never completed training, or are more than 12 months out of date, complete the required training. A system to generate automatic e-mails, telling staff when any of their training gets to within three months of its expiry date, has now been implemented.

Addressing Sickness Levels within Maternity Services at LWH

Summary

Sickness absence is currently one of the organisation's most pressing workforce challenges. In February 2022 a revised Employee Attendance and Wellbeing Policy was introduced which was intended to further our goal of becoming a Fair and Just organisation. The significant change to the policy was the removal of formal sanctions issued when short term sickness triggers were breached. Since this point, we have closely monitored the impact of the policy and PPF Committee in January 2023 received detailed analysis of sickness trends and management (available to the Board in the supporting documents on Admin Control).

The organisation listened to feedback from managers, staff, our Freedom to Speak Up Guardian and trade union colleagues and the PPF Committee and concluded that whilst there were some modifications which were required to the policy and process, no changes to the policy should be made for a 6-month period until there is evidence that managers are carrying out their duties within the policy, namely return to work discussions and wellbeing conversations.

Overview of Sickness Absence Trends at LWH

Sickness absence has been a persistent challenge at LWH for a number of years. Underlying sickness absence rates which were already above the average for the North West were further increased during Covid-19 and have not reverted back to 2018/19 levels. It is self-evident that unavailability of staff presents a serious risk to service delivery, quality of care and financial sustainability and has been a consistent area of focus for the organisation.

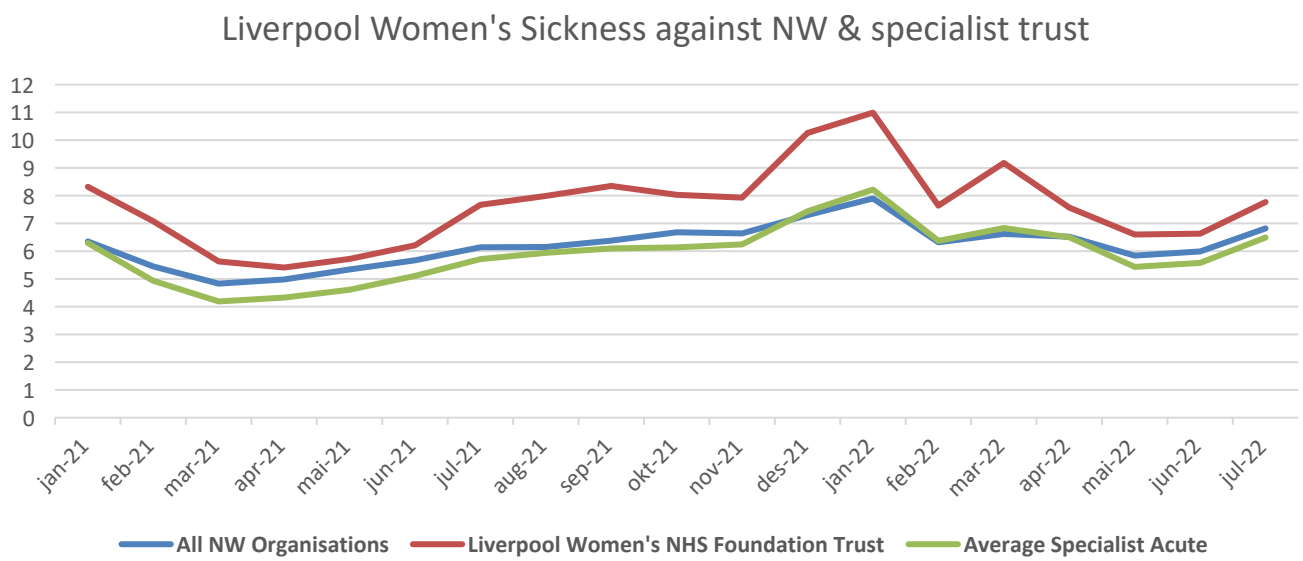
The graph below shows a comparison of the Trust with other acute specialist Trusts in the Cheshire and Merseyside region for the period January 2021 – July 2022. From the data, it can be seen that absence levels are higher at LWH but overall patterns of absence across the year follow a similar trend. During Covid, LWH consistently reported amongst the NW organisations with the highest rates of Covid related absence. As a closely located comparator, Liverpool University Hospitals NHS Foundation Trust averaged at 7% for the same period.

Figure 1- LWH absence benchmarked against NW Trusts

Average annual absence %	2018	2019	2020	2021	2022 (Jan - Jun)
LWH	4.6	5.5	6.3	7.4	8.3
All NW Organisations	4.9	5.1	5.9	6	7.03
NW Specialist Acute	4.45	4.90	5.00	5.50	6.40

To develop a well led, capable, motivated and entrepreneurial **Workforce** - Exceptions

Addressing Sickness Levels within Maternity Services at LWH



Whilst there are a number of areas in the Trust with high rates of absence, sickness within maternity has historically tracked higher than other clinical areas, and as our largest staff group, has a particularly significant impact. We benchmarked our absence over a 5-year period for MSWs and Midwives against a comparator Trust, Birmingham Women's and Children's. Whilst absence rates were broadly comparable in 18/19, since this time LWH has had a higher rate of absence.

Figure 2- LWH Absence rates for Maternity Services

Financial Years	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18 - 19 Sickness	5.45%	5.40%	5.49%	5.06%	5.05%	4.25%	3.55%	5.13%	6.38%	6.84%	7.92%	6.92%
19 - 20 Sickness	7.23%	5.75%	4.93%	5.53%	6.18%	6.20%	7.76%	8.28%	8.24%	6.75%	6.95%	9.53%
20 - 21 Sickness	9.22%	6.95%	7.18%	7.52%	6.38%	8.19%	10.55%	9.86%	10.63%	11.83%	11.30%	9.64%
21 - 22 Sickness	8.56%	9.26%	10.13%	12.28%	12.17%	14.11%	13.31%	12.63%	15.26%	16.37%	11.45%	11.95%
22 - 23 Sickness	9.69%	9.65%	9.68%	11.25%	10.53%	9.58%	9.92%					

Addressing Sickness Levels within Maternity Services at LWH

Figure 3- BWC Absence rates for Maternity Services

Financial Years	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18 - 19 Sickness	5.33%	3.62%	4.79%	5.08%	5.43%	6.13%	7.22%	7.67%	7.36%	8.02%	6.76%	6.48%
19 - 20 Sickness	6.84%	6.20%	5.98%	6.63%	5.54%	4.83%	5.20%	4.54%	6.82%	6.36%	5.97%	7.49%
20 - 21 Sickness	6.36%	5.97%	7.49%	6.69%	5.06%	5.06%	6.59%	6.61%	7.41%	7.54%	5.71%	5.15%
21 - 22 Sickness	4.84%	6.04%	6.61%	7.75%	8.77%	8.09%	8.55%	6.76%	9.12%	10.72%	6.45%	9.50%
22 - 23 Sickness	9.10%	6.21%	7.22%	8.49%	7.10%	8.08%	7.68%	5.98%	5.97%			

When making the decision to amend the policy, we analysed research undertaken by NHSI/E in April 2021 which looked at Trusts with the highest and lowest rates of sickness absence. The research found a link between lower absence rates and provision of occupational health, wellbeing and HR support as well as lower use of agency, lower vacancy rates and fewer number of staff absent due to stress/anxiety and depression. It also found a positive correlation between positive staff survey results and lower absence levels. In terms of policy, there was a link between policies which were simpler and where staff moved through stages more quickly, and lower absence rates.

As a Trust we have a stated commitment to improving our culture and increasing our levels of staff engagement, with staff feeling they are treated fairly us as their employer. The previous Sickness Policy was not felt to be effective. Since 2018, no member of staff had been dismissed as a result of the short-term sickness policy. (3 people have been dismissed in the last 5 years). Feedback from both staff and managers was that the policy punitive and was time consuming for managers in terms of meetings and administration. In 2021 a number of managers trialled a national training programme on managing wellbeing and attendance from a more holistic perspective and this was well evaluated. A further rationale was the desire for managers to implement effectively the (nationally mandated) annual Wellbeing conversations and change the focus on having quality conversations between line manager and member of staff. It was for these reasons that a decision was taken in February 2022 to trial a new policy which did not contain sickness stages for a period of 12 months.

To develop a well led, capable, motivated and entrepreneurial **Workforce** - Exceptions

Addressing Sickness Levels within Maternity Services at LWH

Evaluation

It was clear that there had been an increase in sickness since the policy had been in place including an increase in some areas (specifically maternity) of short term absence.
On average 1% to 1.5% of sickness absence was covid related.

Whilst the initial impression was that the policy may be exacerbating short term sickness by the removal of sanctions, what was clear from analysis was:

- Managers were not carrying out return to work interviews or wellbeing conversations in the majority of areas
- Managers were in the main, not meeting with staff to discuss when their sickness presented a concerning pattern (as permitted in the policy.)

	Total no of staff >4 episodes of absence in last 12 months	Total number of episodes	Total number of recorded RTW interviews	Total FTE days lost	Number of formal meetings convened
MATERNITY	60	307	20	2816	11
NEONATAL	19	90	28	1202	4
THEATRES	25	122	52	883	6
GYNAE	43	219	79	2420	7

Addressing Sickness Levels within Maternity Services at LWH

Proposed Changes to Policy and Process

A more fundamental change to be considered is the re-configuration of team structures within nursing and midwifery to ensure that managers/ team leaders have an optimum number of people to manage (in some areas there are more than 100 staff line manged by one individual).

In some areas, it is recommended that ward managers work to a job planned timetable where appropriate focus on staff management and engagement is stipulated.
Other changes to be led by the HR team include:

- Changes to the policy to emphasise importance of meetings and potential recourse to another formal policy should absence not improve
- Additional HR support for managers to advise when formal meetings need to take place.
- Return to Work Form to be readily available on desktop for easy access to managers
- HR Advisors to adopt consistent approach of meetings / drop ins / reporting to managers using best practice from all areas
- Lunch and Learn training sessions for managers for next 3 months to be sickness focused
- Additional training on wellbeing conversations to be rolled out
- The 2 (externally funded) dedicated Wellbeing Coaches in maternity to undertake all wellbeing conversations by April 23 and undertake manger wellbeing coaching.
- Enhance manager knowledge of reasonable adjustments – training via the HR team and promotion from the ASPIRE disability staff network.
- Full roll out of Staff Support Service.

Conclusion

The sickness rate will be tracked closely over the next 6 months with focused attention from PPF Committee and the Executive Team to ensure that all necessary actions are undertaken, and support is given to managers. At this point a further formal review of the impact of the policy will be undertaken with the potential for further changes to be made.

Trust Board

COVER SHEET

Agenda Item (Ref)	*22/23/203c*		**Date: 02/02/2023**	
Report Title	Race Equity Declaration of Intent			
Prepared by	***Michelle Turner, Chief People Officer***			
Presented by	*Michelle Turner Chief People Officer*			
Key Issues / Messages	To consider the Race Equity Declaration of Intent			
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: • ***Consider and endorse the Statement of Intent*** • ***Agree to its publication on the Trust website and social media*** • ***Require the Putting People First committee to have oversight of the development of the programme of work required to deliver the commitment to Race Equity and to provide assurance to the Board of progress or deviation from plan*** • ***Note the opportunity to align intent and actions through the review and refresh of the People, Quality and Patient Experience Strategies.***			
Supporting Executive:	***Michelle Turner, Chief People Officer***			

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

Strategy ☒ Policy ☐ Service Change ☐ Not Applicable ☐

Strategic Objective(s)

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

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

Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* 1.1 Failure to be recognised as one of the most inclusive organisation in the NHS with Zero discrimination for staff and patients (zero complaints from patients, zero investigations)	Comment:
Link to the Corporate Risk Register (CRR) – CR Number:	Comment:

REPORT DEVELOPMENT:

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

EXECUTIVE SUMMARY

The Trust has a strategic objective to drive towards becoming one of the most inclusive organizations in the NHS. The Board has previously agreed that the initial priority area of focus will be Racial Equity.

The attached paper sets out the Trust's Declaration of Intent regarding Racial Equity, namely, to foster an environment where colleagues, patients, their friends, and families, from all backgrounds, can thrive - free from discrimination, inequity, unfairness, and prejudice. To enable this, we will strive to remove bias – unconscious or otherwise – from our policies and processes and root out bullying, harassment, and other unacceptable behaviours.

Being actively anti-racist at LWH means opposing racism through positive actions that purposefully identify, discuss then challenge racism and the impact it has on our organisation, our systems, and our people.

There is no room for neutrality. LWH is committed to an equitable approach where our people are enriched by their differences ensuring fairness. We can and must do better.

LWH being antiracist is fundamental to ensuring we have the best, talented and diverse people to maintain our longstanding reputation for providing the safest care and outstanding experiences

The document sets out a series of commitments to support racial equity within our organization and all our areas of influence and responsibility. The Trust will proactively engage with and listen to racially minoritized staff, patients, their families, and our communities to understand their experience and explore with them our plans; to understand if the right issues are being tackled in the right way, and whether our goals and targets are the right ones to drive the improvement required.

The Putting People First Committee will have oversight, through the auspices of the Equality Diversity & inclusion Committee, of the development and progress of the underpinning workplans to deliver the ambition stated above and will provide assurance to the Board accordingly.

This year will see work commence on the refresh of the Trust's People Strategy, the Quality Strategy, and the Patient Experience Strategy. This will allow for alignment and consistent focus on race equity through these key organisational Strategies.

The Board is asked to:

- Consider and endorse the Statement of Intent
- Agree to its publication on the Trust website and social media
- Require the Putting People First committee to have oversight of the development of the programme of work required to deliver the commitment to Race Equity and to provide assurance to the Board of progress or deviation from plan
- Note the opportunity to align intent and actions through the review and refresh of the People, Quality and Patient Experience Strategies.

Race Equity
Declaration of Intent
(Draft)

January 2023

Liverpool Women's
NHS Foundation Trust

Anti-Racism Commitment

Liverpool Women's has a strategic objective to drive towards becoming one of the most inclusive organisations in the NHS. The Board has previously agreed that the initial area of focus within our wider inclusion agenda is racial equity.

At a time where statements are no longer enough, here at Liverpool Women's we want to proactively confront all forms of systemic racism as part of an ongoing commitment to being an anti-racist organisation.

Fundamental to this commitment is to foster an environment where colleagues, patients, their friends and families, from all backgrounds, can thrive - free from discrimination, inequity, unfairness and prejudice. To enable this, we will strive to remove bias – unconscious or otherwise – from our policies and processes and root out bullying, harassment and other unacceptable behaviours.

Being actively anti-racist at LWH means opposing racism through positive actions that purposefully identify, discuss, then challenge racism and the impact it has on our organisation, our systems and our people.

There is no room for neutrality. LWH is committed to an equitable approach where our people are enriched by their differences ensuring fairness. We can and must do better.

LWH being antiracist is fundamental to ensuring we have the best, talented and diverse people to maintain our longstanding reputation for providing the safest care and outstanding experiences

Context

The events which occurred following the death of George Floyd in USA, and the inequalities revealed by the COVID-19 Pandemic, shone a light on racism and the treatment of racially minoritised (**more accurately described as global majority)** communities across the globe.

This context, and the global focus on racial injustice and inequalities mean we must act now to address racial inequity and work together to create an anti-racist culture through the elimination of bias, discrimination and injustice across systems and institutions.

Racism is a structural problem which exists in nearly all major institutions and organisations. Liverpool Women's recognises institutional and systemic racism as a legitimate issue, one that has no quick fix, but can no longer go unaddressed.

The population of Liverpool is increasingly diverse and multicultural, yet

institutional racism is affecting the outcomes for racially minoritized residents. Among other indicators, racially minoritised residents face higher employment gaps, are more likely to be economically inactive, are paid less on average than white residents, are more likely to live in poverty and are less likely to own their own home.

We also know that people from racially minoritised backgrounds experience inequalities in health outcomes as well as inequalities in access to and experience of health services when compared to white groups.

Here at Liverpool Women's we fail to be truly representative of the population we serve, especially at a senior level in our organisation.

As a healthcare provider, we have a duty to:-

- ensure equity of access to healthcare and to healthcare careers;
- to use our influence and connections to role model exemplary practice;
- to innovate to address inequity;
- to challenge and influence through our relationships and partnerships to drive improvement at a system level.

Put simply; we must do the right thing for our racially minoritised employees patients and communities.

Our role as an employer

Liverpool Women's is a major employer with over 1600 employees. Despite this, less than 8.6% of the workforce are from the black and Asian global majority. Additionally, there is no representation at executive director level and only 9 % representation at a senior management level (band 7 and above). We are committed to creating a more diverse workplace to meet the needs of our diverse patient cohort and community.

Ambition

We will:

- Develop a diverse, representative workforce that promotes opportunity for underrepresented employees
- Increase the number of racially minoritised staff in senior positions
- Embed anti-racism as an integral part of the ethos and culture of the organization
- Proactively confront racism in our workplace and spheres of influence.

Actions

We will:

- Review and refresh our formal targets for increasing workforce diversity with a particular for focus on employees in leadership and senior positions
- Review and refresh our recruitment policy and practice to identify improvements based on emerging best diversity practice
- Implement well-managed use of positive action to address under representation in the organisation where appropriate
- Develop internal talent management strategies that give specific attention to developing internal staff from racially minoritised groups
- Develop and deliver meaningful and compulsory Equality & Diversity training for all employees, prioritizing those in leadership roles
- Complete a diversity monitoring data audit and address gaps utilizing Workforce Race Equality (WRES) data and patient experience data
- Publish a workforce monitoring report annually and our Race Equality Pay Gap to aid transparency and monitor progress
- Invest in resources to oversee this work, making links between, and providing support for, different parts of the organisation and external stakeholders.

Achievements

By 2025 there will be:

- An annual increase in the percentage of racially minoritised employees
- Significant progress towards our goal of a minimum of 25% of racially minoritised employees in the workforce
- An increase to a minimum of 25% of senior positions held by individuals from the global majority
- 100% completion by all staff of Equality & Diversity training in accordance with the Trust's Mandatory Training policy
- Well understood approach to racial equity across the organisation
- Clear accountability for diversity though the performance management framework

Our role as a healthcare provider

Liverpool Women's NHS Foundation Trust is committed to focusing on areas in healthcare that highlight health inequalities in access, experience or outcomes in racially minoritized groups. We will work towards reshaping policy and practice to support fair healthcare for all, from maternal health through to end-of-life care.

We will be working with the most vulnerable in the community who often experience the cumulative impact of race inequity. Our work will identify and tackle global majority health inequity and recognise the complex social determinants of health as well as the resulting effect on individual personal choices.

As a provider of healthcare, we will establish and maintain ongoing meaningful community and patient partnerships using a multi-pronged and multiple interventional level approach. Partnerships will be long-term, with inclusion and engagement across the age range to ensure cultural suitability in the planning and development of services to target community needs appropriately and effectively.

Ambition
To collectively make a significant difference to the healthcare of individuals and communities.

We will:

- Include and engage at a Community level
- Include and engage communities and patients at a Policy level
- Be a catalyst for change

Actions
We will:

- Establish ongoing meaningful community and patient partnerships
- Deliver workshops focused on patient-provider relationships
- Use the strengths of lived experiences in decision making
- Seek views of racism experienced when receiving Healthcare
- Bring in the right culturally appropriate support and expertise
- Increase participation and partnership in decision making through shared leadership in policymaking.

Our role as a partner

Institutional racism is bigger than any individual organisation. We are committed to working in partnership to extend our influence beyond the boundaries of our organization, to influence others and to actively work to challenge racism within our sphere of influence.

Ambition

We will

- Listen to and amplify the voice of racially minoritised communities
- Ṡhare our experience and learning to support partners in the city to make positive change

Actions

We will:

- Engage with our workforce and our communities to have honest· conversations about racism and barriers to healthcare and work in our organisation
- Through our outreach employment programmes we will proactively engage with young racially minoritized people in our community to support, develop and empower them to enact change
- Openly share our challenges and successes with others to inform their actions in tackling race equality; and be curious about other's actions
- Work closely with our local communities to develop trust and co-design solutions to the barriers to employment and healthcare
- Visibly support local and national campaigns for racial justice
- Be an active leader and play our part in educating and supporting healthcare providers to tạ́kle racism
- Encourage positive narratives, challenge negative media, images and communications, and celebrate and promote positive achievements

Achievements

By 2025 there will be:

- An improvement in the recognition and understanding of the day-to-.day experience of racism that makes life for racially minoritised people different from that of White people

Finance, Performance & Business Development Chair's Highlight Report to Trust Board
19 December 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 8 YTD position was off track against plan, this was being supported by non-recurrent items. Work continued with recovery actions to reduce the deficit position.
• The Committee noted a significant risk to funding for the Community Diagnostic Centre (CDC). The Trust awaits an outcome from the regional and national team but have been clear on the funding level required to continue delivering the CDC.
• The Committee received a progress update against the Recovery Plan for 2022/23. The Committee noted the reliance on two significant items, which, if they materialise, would mean the Trust would be more likely to achieve its plan. The outcome of both of these items should be known for Month 9 reporting.
• The following performance metrics were highlighted to the Committee's attention:
  ○ Diagnostic testing declining performance although actions underway to improve performance
  ○ Continued long-waiter lists, noting that unfortunately the extra capacity provided had been offset by consultant sickness absence
  ○ Cancer 62-day wait performance remained concerning. The Cheshire & Merseyside Cancer Alliance had been requested to review the 62-day position within the region.
  ○ Addition of Urgent Care metrics in a new format provided additional details to the Committee.
	• Noted that the Executive Committee were considering the option to outsource activity to improve the 52-week wait position and improve patient access to care. The action was within the approval limits of the Executive team to take forward if deemed appropriate.
	• The Committee received an update on operational planning for 2023/24 including progress to date and a clear internal planning timetable. Currently no national or regional guidance had been circulated although a draft high-level timetable had been produced. The Trust operational plans and budgets would be presented to the Committee in February 2023, and subsequently submitted to the Trust Board in March 2023 for Board sign-off.
	• The Committee received an Electronic Patient Records (EPR) Programme update in relation to delivery of the EPR programme and a recommended EPR Go-live date of the weekend of 07 July 2023. The Committee acknowledged the significant size of the project and the substantial dependencies on funding and training. The clear and consistent messaging that successful roll-out of EPR was reliant on all teams and responsibility fell across the executive portfolio was noted.
	• Received and supported the contract award recommendation for the provision of a networked Picture Archiving Communication Software Solution (PACS). The Committee noted that the PACS solution was part of a wider system initiative and that a collaborative procurement exercise had been undertaken, facilitated by the Cheshire and Merseyside Imaging Network (CAMRIN), which had been a robust process, carried out in accordance with both Trust SFI's and European Procurement Legislation.

Positive Assurances to Provide Identify in brackets should the assurance provide evidence against the CQC Key Questions – SAFE | EFFECTIVE | CARING | RESPONSIVE | WELL LED	**Decisions Made**
• The Committee received a revised template demonstrating the operational performance measures (ALL) • The Committee received the Cost Improvement Programme 2022/23 mid-year post implementation review, undertaken in line with the Well-Led Review recommendations and part of ensuring good governance, and ensuring that lessons would be learned from both successful and unsuccessful schemes. The Committee had been assured by the mid-year review undertaken. The outcomes for all 2022/23 schemes would be reported to the Committee in full as part of the full-year post implementation review exercise. (ALL) • The Committee received the Emergency Preparedness, Resilience & Response (EPRR) Core Standards Annual Assurance Board Report. The Trust had submitted an overall compliance rating of '86% / Partially Compliant', a reduction in rating since the 2021 submission of 89%. The reduction in compliance rate was due to factors including revision of the EPRR Core Standards and learning from the major incident (November 2021). The Committee noted the	• The Committee approved the recommended EPR Go-Live date of 07 July 2023. • The Committee supported the recommendation to award the PACS contract to the identified preferred provider and would recommend Trust Board approval.

EPRR Action Plan, to support achievement of compliance against outstanding core standards which would be monitored by the EPRR Sub-Committee with oversight by the FPBD Committee. The Committee took assurance that effective systems of control were in place in relation to achieving compliance to the NHSE EPRR Core Standards. (ALL) • The Committee noted that the Crown Street Enhancements Programme was progressing in line with revised timescales. (WELL LED) • Received and noted the Market Intelligence report. (WELL LED)	

Summary of BAF Review Discussion (Board Committee level only)

- The Committee reviewed the related BAF risks. No risks closed on the BAF for FPBD Committee.
- Noted the introduction of new BAF risk 4.3 Failure to deliver the agreed 2022/23 financial plan and approved the narrative and risk score.
- Noted strengthened narrative had been applied to BAF risk 2.2: Failure to develop our model of care to keep pace with developments and respond to a changing environment.

Comments on Effectiveness of the Meeting / Application of QI Methodology

- Sufficient time provided to discuss matters thoroughly and active participation
- Robust challenge

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
148.	Review of BAF risks: FPBD related risks	Assurance	154.	Emergency Preparedness, Resilience & Response Core Standards Annual Assurance Board Report	Assurance
149.	Finance Performance Report Month 8 2022/23	Information	155.	Electronic Patient Records (EPR) Programme Go-Live Paper	Approval
150.	Recovery Plan update – Month 8	Information	156.	Contract Award Recommendation for the provision of a networked Picture Archiving Communication Software Solution (PACS)	Approval
151.	Operational Performance Report Month 8 2022/23	Assurance	157.	Community Diagnostic Centre Update	Information
152.	Operational Planning 2023/24 Update	Information	158.	Crown Street Enhancements Programme Update	Information
153.	Cost Improvement Programme 2022/23: Mid-Year Post Implementation Review	Assurance	159.	LWH Market Share Intelligence Report	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*

Finance, Performance & Business Development Chair's Highlight Report to Trust Board
23 January 2023

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 9 YTD position was off track against plan. This is being supported by non-recurrent items. Work continues with recovery actions to reduce the deficit position.
• The Committee received a progress update against the Recovery Plan 2022/23. The Committee was informed of progress, noting that action to date had not yet been sufficient to recover the planned 2022/23 position.
• The following performance metrics were highlighted to the Committee's attention:
  ○ Cancellations related to industrial action had impacted upon operational performance and would continue to be a challenge throughout the period of industrial action
  ○ Estate water-safety PPMs had declined due to staffing challenges and would need to be improved
  ○ Uncertain likelihood of Trust and regional achievement against the national target to eliminate 78+ week waiters by the end of March 2023 due to significant pressures across the region. Recent outsourcing of patients has assisted the waiting list position and released consultant capacity; however the positive impact has been offset by the recent industrial action taken.
• The Committee received the annual update against third-party service provider controls. The report identified risks in relation to third party SLA controls and recommended actions to improve assurance in a timely manner. The Committee agreed the recommended actions and requested a progress update in 3 months.
• Risks in relation to funding for the Community Diagnostic Centre (CDC) for 2022/23 remain. The Trust had been asked to undertake a re-profiling exercise, based on activity and services delivered during H1. The Trust awaits an outcome from the regional and national team in relation to funding for 2022/23. The Committee noted that the 2023/24 Revenue Funding Policy for Community Diagnostic Centres has been published, however a final version has not yet been confirmed. The Committee highlighted significant concerns in relation to the financial viability of the CDC and risks that the CDC Programme posed upon the Trust.
	• It has been agreed that the Finance Recovery Board should continue to meet, with a renewed focus on the 2023/24 position away from its' initial purpose of focusing on 2022/23 recovery.
	• The Committee received a planning update for 2023/24 identifying the position and risks in relation to financial and operational planning moving into 2023/24. A draft Cheshire and Merseyside timeline has been released. The Committee noted the draft plan submission date to the ICS is required by 23 February 2023.
	• The Committee noted that the Integrated Care Partnership (ICP) had recently published its' strategy, and that the Trust will be required to undertake a detailed review of alignment between the ICP strategy and the Trust's own strategy and plans. It was also noted that the Trust had worked in partnership with Integrated Care Board (ICB) and Cheshire and Merseyside Acute and Specialist Provider Collaborative colleagues to successfully advocate for the prioritisation of women's health within the system and support effective development and delivery of system strategies and plans.
	• The Committee commissioned a comprehensive review of the internal SLA process in response to the findings of the Third-Party Service Provider Controls report received.
	• The Committee received a progress update in relation to delivering the Future Generations (FG) Programme. The Liverpool Clinical Services Review (LCSR) had been concluded in December 2022 and was due to present to the ICB on 26 January 2023. Once the ICB had considered the LCSR, the Trust will determine next steps for the Future Generations Programme. Until this time, most workstreams are paused, however the Trust is continuing work within the model of care and estates workstreams as appropriate.

Positive Assurances to Provide Identify in brackets should the assurance provide evidence against the CQC Key Questions – SAFE | EFFECTIVE | CARING | RESPONSIVE | WELL LED	**Decisions Made**
• The Committee received a positive presentational update in relation to the Theatre Utilisation quality improvement programme. The Committee commended the approach undertaken by the leadership team within the CSS Division to improve the Theatre Service, as demonstrated by the presentation and corroborated by consultant colleagues. (ALL) • The Committee received a progress update against delivery of the EPR programme noting demonstrable progress at pace. The Committee noted that the e-prescribing module fixes had been delivered and tested with positive results. The Programme had been successful with a	• The Committee requested that the risks in relation to SLA agreements as identified by the Third-Party Service Provider Control review be escalated onto the Trust risk register. • To remove the Neonatal Capital Programme Build Benefits Realisation Report from the Committee workplan as work concluded.

bid for funding to support implementation of the system including training and organisational change. (SAFE/EFFECTIVE/WELL LED) • Received the Neonatal Capital Programme Build benefits realisation report noting that the Neonatal Redevelopment Programme had successfully delivered against its' objectives and delivered material benefits for staff, babies and families. The Committee agreed that the formal benefits realisation reporting in relation to the neonatal redevelopment has concluded. • The Committee noted that the Crown Street Enhancements Programme was progressing in line with revised timescales. (WELL LED)	

Summary of BAF Review Discussion (Board Committee level only)

- The Committee reviewed the related BAF risks. No risks closed on the BAF for FPBD Committee.
- Noted a significant review of BAF risks 2.1 and 4.1 and 4.3 would be undertaken ahead of the next formal meeting.
- Informed of recommended increase to the risk score of BAF risk 1.2 Workforce (PPF Committee owned BAF risk) based on the numerous expected industrial action and subsequent impact on services.

Comments on Effectiveness of the Meeting / Application of QI Methodology

- All matters on the meeting agenda discussed thoroughly
- Effective and proactive participation from committee members and invited representatives
- The requirement for ensuring sufficient time is allocated to agenda items at future meetings was noted

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
168.	Review of BAF risks: FPBD related risks	Assurance	175.	Review of Strategic Progress	Information
169.	Finance Performance Report Month 9 2022/23	Information	176.	Assurance Third Party Service Provider Controls	Information
170.	Recovery Plan update – Month 9	Information	177.	Community Diagnostic Centre Update	Information
171.	Operational Performance Report Month 9 2022/23	Assurance	178.	Crown Street Enhancements Programme Update	Information
172.	Planning 2023/24 Update	Information	179.	Future Generations Programme Update	Information
173.	Theatre Utilisation Update	Information	180.	Neonatal Capital Programme Build benefits realisation	Information
174.	Digital Services Update	Assurance	181.	Sub-Committee Chair Reports	Assurance

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	✓	✓	✓	✓	✓	✓	✓	✓	NM		
Jenny Hannon, Chief Finance Officer	NM								✓		
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)	**22/23/204b**		**Date: 02/02/2023**	
Report Title	**Finance Performance Review Month 9 2022/23**			
Prepared by	***Linda Haigh, Interim Deputy Chief Finance Officer***			
Presented by	***Jenny Hannon, Chief Finance Officer***			
Key Issues / Messages	***To receive the Month 9 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 9 Financial Position.			
Supporting Executive:	***Jenny Hannon, 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 4.3: Failure to deliver the agreed 2022/23 financial plan	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	23/01/2023	Jenny Hannon, Chief Finance Officer	The Committee received the report.

EXECUTIVE SUMMARY

At Month 9 the Trust is reporting a £1,481k deficit year to date (YTD) which is £2,143k off plan and is supported by £12,818k of non-recurrent items. The forecast out turn (FOT) is £1,385k deficit, £1,911k worse than plan, after inclusion of £4,801k of recovery actions. This position and the expected non-achievement of plan has been shared with the Integrated Care System (ICS).

The cash balance at 31 December 2022 was £8,293k. Preparations are being made to apply for Provider Revenue Support funding in February 2023 to enable the Trust to continue to meet its liabilities as they fall due.

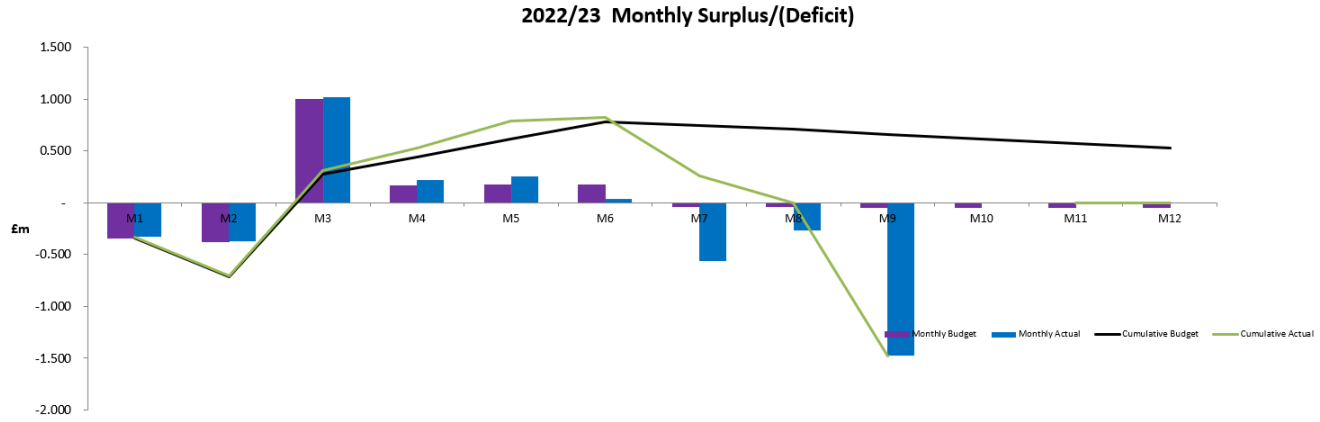
	Plan	Actual	Variance	RAG	R	A	G
Surplus/(Deficit) YTD	£0.7m	-£1.5m	-£2.1m	↑	*>10% off plan*	*Plan*	*Plan or better*
I&E Forecast	£0.5m	-£1.4m	-£1.9m	↓	*>10% off plan*	*Plan*	*Plan or better*
NHS I/E Rating	3	3	0	↔	*4*	*3*	*2+*
Cash	£5.9m	£8.3m	£2.4m	↑	*<£1m*	*£1m-£4.5m*	*£4.5m+*
Total CIP Achievement YTD	£4.2m	£3.9m	-£0.3m	↓	*>10% off plan*	*Plan*	*Plan or better*
Recurrent CIP Achievement YTD	£2.2m	£1.3m	-£0.8m	↓	*>10% off plan*	*Plan*	*Plan or better*
Elective Recovery Fund (net)	-£1.6m	-£0.8m	£0.8m	↑	*>10% off plan*	*Plan*	*Plan or better*
Non-Recurrent Items YTD	£6.0m	£12.8m	£6.8m	↑	*>£0*		*<£0*
Capital Spend YTD	£8.6m	£5.1m	-£3.5m				

MAIN REPORT

1. Summary Financial Position

At Month 9 the Trust is reporting a £1,481k deficit year to date (YTD) which is £2,143k off plan and is supported by £12,818k of non-recurrent items. The forecast out turn (FOT) is £1,385k deficit, £1,911k worse than plan, after inclusion of £4,801k of recovery actions. The Trust has reported this position to the ICS. The ICS are working with providers with a view to making and final changes to forecasts before month 10.

The graph below shows the in-month position against the plan.



2. Divisional Summary Overview

Divisions have developed recovery plans to improve run rates which are reflected in the YTD and outturn positions. Financial grip and control, management of pressures and delivery of the maximum (safe) recovery remain key to minimising the impact of ongoing and emerging expenditure requirements. Work is continuing across the Trust in relation to this and the long term sustainability position given the recognised financial challenges faced by the Trust.

Family Health: In response to the first Ockenden report and revised Birth-rate plus review, maternity budgets were increased to reflect the additional staffing requirements however in addition to this, the division is overspent by £1,316k on pay YTD. The division has minimised agency usage in the latter half of the year through the introduction of more robust processes. Non pay expenditure is also overspent YTD. Increased income is reducing the YTD variance. The FOT includes £1m from specialised commissioning for additional neonatal activity.

Gynaecology: The division's contribution is £2,320k below plan YTD, with variance on pay (£1,437k YTD) and non-pay expenditure (£706k YTD).

The division has been working to maximise activity and reduce backlogs but is underachieving against the Elective Recovery Funding ERF to date.

Clinical Support Services: The division's contribution is £491k below plan year to date. Pay costs are below budget by £787k with a significant underspend on medical, driven by anaesthetic vacancies. The non-pay overspend is £365k YTD.

Total agency spend is reported as £2.1m year to date with a full year forecast of £2.4m to the end of the financial year.

3. Community Diagnostic Centre

Risks to the funding for the Community Diagnostic Centre (CDC) have previously been reported. In Month 9 the income FOT for CDC was reduced to £2,841k, a net movement of £983k from Month 8 (a reduction to £2,060k expected under the price per unit income method less additional £781k expected for modalities incl. MRI). The Trust continues to work with the with the national and regional teams in relation to this.

4. Elective Recovery Fund (ERF)

Under the local ERF calculation for Month 9 (a regional/national calculation not having been shared), the Trust is now behind plan by £800k on the in-year ERF. This is not reflected in the position in line with regional advice and consistent with other providers.

5. CIP

The Trust has a stretching efficiency programme for 2022/23. This is comprised of a core Cost Improvement Programme (CIP) at the agreed maximum of 3% of turnover (£4.2m) plus non-recurrent efficiencies of £1.4m (vacancy factor) bringing the total to £5.6m. In Month 9 the CDC has a revised income forecast and will no longer contribute to overheads so previously reported CIP of £627k has been reduced to nil. Several increases in CIP FOT have offset this. The overall result is that CIP is slightly (£297k) behind plan (£4,208k) YTD and slightly (£144k) behind FOT plan £5,603k.

Following a reclassification of two projects (diagnostics and corporate services) the Trust is reporting FOT £1,042k behind the target for recurrent CIP (£2,784k). The Trust will need to generate more recurrent CIP to improve sustainability for 2023/24 and beyond.

The Trust's Financial Recovery Board have requested further review of the CIP plans and formal reviews of past investment cases. No scheme will be implemented without consideration of Quality and Equality Impacts (QIA and EIA)

6. COVID-19

The Trust's covid related spend YTD at Month 9 is £219k, slightly under budget, and FOT is under budget.

7. Cash and Borrowings

The cash balance at the end of Month 9 is £8,293k, an increase from £3,359k at Month 8. This balance reflects the benefits of advanced income payments and high creditor balances with some Cheshire and Mersey providers.

The Trust plans to apply for Provider Revenue Support in February 23 for receipt in March 23 to support the underlying deficit position.

8. Capital Expenditure

The capital programme for 2022/23 was oversubscribed and only critical investments were funded. The capital budget was agreed at £8,820k. Capital spend to Month 9 is £5,073k, which represents an underspend however FOT is forecast to exceed the original plan with spend on £2,184k of additional PDC projects (Frontline Digitisation £1.9m and Cheshire and Merseyside Radiology Imaging Network (CAMRIN).

9. Balance Sheet

From Month 8 there has been an increase of £1m in trade payables, which the Trust will work to reduce, and a £6m increase in deferred income due to cash received which is repayable.

Accounts Receivable debt at Month 9 is £2,100k vs £1,961k at Month 8 and £1,530k at March 2022 as additional income is invoiced as part of recovery plan actions. A strong focus remains on debt collection.

Performance against the Better Payment Practice Code is at 82% cumulatively by value and 77% by volume of transactions. A regular meeting to review and resolve aged creditors has been established.

10. Cheshire and Merseyside Position

At Month 9 the aggregated ICS financial position is a deficit of £71.9m against a planned deficit of £34.9m which is a year to date adverse variance of £36.9m. It is anticipated that the overall system plan of £30m deficit can still be achieved[1]

11. Forecast and Risks

A detailed re-forecast has been completed at Month 9 in light of expected recovery action plan delivery and the crystallisation of emerging risks as the year end approaches.

After assuming cumulative recovery actions of £4,801k in Month 9 FOT there remains a FOT variance to plan of £1,911k.

12. BAF Risk

It was noted at Board in December 2022 that a separate risk in relation to the in-year financial position be separated from the overall financial risk as articulated in 4.1 (Failure to ensure services are financially stable in the long term)

To this end BAF risk 4.3 has been added to the register (Failure to deliver the agreed 22/23 Financial plan).

These are scored at 20 and 16 respectively and kept under regular review.

13. Conclusion & Recommendation

The Board is asked to receive the Month 9 position noting the significant challenges to delivery and the impact on ongoing sustainability and cash.

[1] Cheshire and Merseyside System Finance Report – Month 9

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

FINANCE REPORT: M9

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: M09
YEAR ENDING 31 MARCH 2023

USE OF RESOURCES RISK RATING	YEAR TO DATE Actual
CAPITAL SERVICING CAPACITY (CSC)	
(a) EBITDA + Interest Receivable	4,742
(b) PDC + Interest Payable + Loans Repaid	2,095
CSC Ratio = (a) / (b)	**2.26**
NHSI CSC SCORE	**2**
Ratio Score 1 = > 2.5 2 = 1.75 - 2.5 3 = 1.25 - 1.75 4 = < 1.25	
LIQUIDITY	
(a) Cash for Liquidity Purposes	(17,203)
(b) Expenditure	105,591
(c) Daily Expenditure	690
Liquidity Ratio = (a) / (c)	**(24.9)**
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)	1,461
Total Income	(110,226)
I&E Margin	**-1.3%**
NHSI I&E MARGIN SCORE	**4**
Ratio Score 1 = > 1% 2 = 1 - 0% 3 = 0 - (-1%) 4 < (-1%)	
I&E MARGIN VARIANCE FROM PLAN	
I&E Margin (Actual)	-1.30%
I&E Margin (Plan)	0.60%
I&E Variance Margin	**-1.90%**
NHSI I&E MARGIN VARIANCE SCORE	**3**
Ratio Score 1 = > 0% 2 = (1) - 0% 3 = (2) - (1)% 4 = < (2)%	
Note: NHSI assume the score of the I&E Margin variance from Plan is a 1 for the whole year	
AGENCY SPEND	
YTD Providers Cap	560
YTD Agency Expenditure	2,126
	256%
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
INCOME & EXPENDITURE: M9
YEAR ENDING 31 MARCH 2023

INCOME & EXPENDITURE	Month 8			YTD			YEAR		
£'000	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Forecast	Variance
Income									
Clinical Income	(11,434)	(11,314)	(119)	(102,708)	(104,600)	1,892	(137,008)	(140,608)	3,599
Non-Clinical Income	(623)	(586)	(37)	(5,535)	(5,627)	92	(7,404)	(7,439)	35
Total Income	**(12,057)**	**(11,900)**	**(156)**	**(108,243)**	**(110,226)**	**1,983**	**(144,413)**	**(148,047)**	**3,634**
Expenditure									
Pay Costs	6,921	7,575	(655)	60,959	67,297	(6,338)	81,856	90,192	(8,336)
Non-Pay Costs	2,819	3,572	(753)	25,329	23,564	1,765	33,641	31,558	2,083
CNST	1,637	1,637	(0)	14,730	14,730	(0)	19,640	19,641	(1)
Total Expenditure	**11,376**	**12,784**	**(1,408)**	**101,018**	**105,591**	**(4,572)**	**135,137**	**141,391**	**(6,253)**
EBITDA	**(680)**	**884**	**(1,564)**	**(7,224)**	**(4,635)**	**(2,589)**	**(9,275)**	**(6,656)**	**(2,619)**
Technical Items									
Depreciation	521	497	24	4,691	4,433	257	6,254	5,927	327
Interest Payable	2	2	0	22	21	1	29	27	2
Interest Receivable	(1)	(37)	36	(9)	(106)	97	(12)	(121)	109
PDC Dividend	207	131	76	1,859	1,768	91	2,478	2,308	170
Profit/Loss on Disposal or Transfer Absorption	0	0	0	0	0	0	0	(100)	100
Total Technical Items	**729**	**592**	**137**	**6,562**	**6,116**	**446**	**8,749**	**8,041**	**708**
(Surplus) / Deficit	**49**	**1,476**	**(1,428)**	**(662)**	**1,481**	**(2,143)**	**(526)**	**1,385**	**(1,911)**

NHS
Liverpool Women's
NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST **2a**
INCOME & EXPENDITURE HOSTED SERVICES: M9
YEAR ENDING 31 MARCH 2023

INCOME & EXPENDITURE £'000	Month 8			YTD			YEAR		
	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Forecast	Variance
Income									
Clinical Income	(115)	(214)	100	(1,031)	(2,946)	1,915	(1,374)	(4,023)	2,649
Non-Clinical Income	0	4	(4)	0	20	(20)	0	20	(20)
Total Income	**(115)**	**(210)**	**96**	**(1,031)**	**(2,926)**	**1,895**	**(1,374)**	**(4,003)**	**2,629**
Expenditure									
Pay Costs	0	222	(222)	0	966	(966)	0	1,661	(1,661)
Non-Pay Costs	115	(12)	127	1,031	1,959	(929)	1,374	2,342	(968)
Total Expenditure	**115**	**210**	**(95)**	**1,031**	**2,926**	**(1,895)**	**1,374**	**4,003**	**(2,629)**
(Surplus) / Deficit	**0**	**(0)**	**0**	**0**	**(0)**	**0**	**0**	**(0)**	**0**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 3
ELECTIVE RECOVERY FUND ESTIMATE: M9
YEAR ENDING 31 MARCH 2023

	19/20 Baseline (104%)		22/23		22/23 v 19/20 Baseline		ERF Variance £000	ERF Plan £000	ERF Achieved £000
	Activity	Costed Activity £000	Activity	Costed Activity £000	Activity Variance	Costed Activity Variance			
Month 1		1,634		1,730		95	**44**	165	209
Month 2		1,813		2,053		240	**40**	182	222
Month 3		1,761		1,618		-143	**-144**	174	30
Month 4		1,831		1,621		-210	**-153**	182	29
Month 5		1,920		1,682		-238	**-179**	191	12
Month 6		2,016		1,736		-279	**-231**	191	-40
Month 7		1,787		**1,806**		20	6	183	189
Month 8		1,934		**1,891**		-43	-12	191	179
Month 9		1,648		**1,419**		-230	-172	**173**	1
Total Income		**14,695**		**14,137**		**-559**	**-800**	**1,634**	**832**
System Payment to achieve 104%							**1,634**	0	1,076
Adjustment back to plan							**800**	0	681
PY ERF Improvement							**365**	0	**365**
Total Variance							**1,999**	**1,634**	**365**

* 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.

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 4
EXPENDITURE: M9
YEAR ENDING 31 MARCH 2023

EXPENDITURE £'000	MONTH Budget	MONTH Actual	MONTH Variance	YEAR TO DATE Budget	YEAR TO DATE Actual	YEAR TO DATE Variance	YEAR Budget	YEAR Actual	YEAR Variance
Pay Costs									
Board, Execs & Senior Managers	435	464	(30)	3,829	4,046	(216)	5,133	5,449	(316)
Medical	1,884	2,070	(187)	16,420	17,935	(1,516)	22,205	24,214	(2,008)
Nursing & Midwifery	3,076	3,150	(74)	27,613	27,635	(22)	36,840	37,151	(311)
Healthcare Assistants	509	508	1	4,572	4,599	(27)	6,099	6,154	(55)
Other Clinical	287	515	(227)	2,091	4,218	(2,127)	2,953	5,692	(2,739)
Admin Support	731	738	(7)	6,434	6,737	(304)	8,626	9,099	(473)
Agency & Locum	0	131	(131)	0	2,126	(2,126)	0	2,432	(2,432)
Total Pay Costs	**6,921**	**7,575**	**(655)**	**60,959**	**67,297**	**(6,338)**	**81,856**	**90,192**	**(8,336)**
Non Pay Costs									
Clinical Suppplies	689	1,035	(346)	6,269	7,472	(1,203)	8,404	9,674	(1,270)
Non-Clinical Supplies	284	43	241	2,525	(692)	3,217	3,174	(1,368)	4,542
CNST	1,637	1,637	(0)	14,730	14,730	(0)	19,640	19,641	(1)
Premises & IT Costs	1,004	1,172	(168)	9,068	7,394	1,674	12,069	10,134	1,935
Service Contracts	842	1,323	(480)	7,466	9,390	(1,923)	9,994	13,118	(3,124)
Total Non-Pay Costs	**4,456**	**5,209**	**(753)**	**40,059**	**38,294**	**1,765**	**53,281**	**51,199**	**2,082**
Total Expenditure	**11,376**	**12,784**	**(1,408)**	**101,018**	**105,591**	**(4,572)**	**135,137**	**141,391**	**(6,253)**

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

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 5
COVID EXPENDITURE: M9
YEAR ENDING 31 MARCH 2023

EXPENDITURE £'000	MONTH Budget	MONTH Actual	MONTH Variance	YEAR TO DATE Budget	YEAR TO DATE Actual	YEAR TO DATE Variance	YEAR Budget	YEAR Actual	YEAR Variance
Pay Costs									
Board, Execs & Senior Managers	3	0	3	28	1	27	38	1	36
Medical	0	0	0	0	(0)	0	0	(0)	0
Nursing & Midwifery	12	0	12	109	1	108	145	1	144
Healthcare Assistants	0	(0)	0	0	15	(15)	0	15	(15)
Other Clinical	0	(0)	0	0	(0)	0	0	(0)	0
Admin Support	0	4	(4)	0	70	(70)	0	82	(82)
Agency & Locum	0	0	0	0	0	0	0	0	0
Total Pay Costs	**15**	**4**	**12**	**137**	**87**	**50**	**183**	**99**	**84**
Non Pay Costs									
Clinical Suppplies	0	17	(17)	0	43	(43)	0	58	(58)
Non-Clinical Supplies	11	2	9	99	2	97	132	2	130
CNST	0	0	0	0	0	0	0	0	0
Premises & IT Costs	0	3	(3)	0	88	(88)	0	97	(97)
Service Contracts	0	0	0	0	0	0	0	0	0
Total Non-Pay Costs	**11**	**22**	**(11)**	**99**	**133**	**(34)**	**132**	**157**	**(25)**
Total Expenditure	**26**	**25**	**1**	**236**	**219**	**16**	**315**	**255**	**59**

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

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
BUDGET ANALYSIS: M9
YEAR ENDING 31 MARCH 2023

INCOME & EXPENDITURE £'000	MONTH Budget	MONTH Actual	MONTH Variance	YEAR TO DATE Budget	YEAR TO DATE Actual	YEAR TO DATE Variance	YEAR - Internal Budget	YEAR - Internal Actual	YEAR - Internal Variance
Maternity									
Income	(3,964)	(4,140)	176	(37,215)	(38,304)	1,089	(50,260)	(51,448)	1,188
Expenditure	2,237	2,355	(118)	20,115	21,319	(1,204)	26,826	28,409	(1,583)
Total Maternity	**(1,727)**	**(1,785)**	**58**	**(17,100)**	**(16,985)**	**(115)**	**(23,435)**	**(23,039)**	**(395)**
Neonatal									
Income	(1,696)	(1,775)	80	(15,834)	(16,358)	524	(21,351)	(23,233)	1,882
Expenditure	1,313	1,413	(100)	11,820	12,481	(661)	15,760	16,566	(806)
Total Neonatal	**(382)**	**(362)**	**(20)**	**(4,014)**	**(3,877)**	**(137)**	**(5,591)**	**(6,667)**	**1,076**
Division of Family Health - Total	**(2,109)**	**(2,147)**	**38**	**(21,114)**	**(20,862)**	**(252)**	**(29,026)**	**(29,706)**	**681**
Gynaecology									
Income	(1,929)	(1,916)	(14)	(18,082)	(17,888)	(194)	(24,425)	(24,153)	(272)
Expenditure	1,293	1,500	(206)	11,843	13,045	(1,202)	15,926	17,505	(1,579)
Total Gynaecology	**(636)**	**(416)**	**(220)**	**(6,239)**	**(4,843)**	**(1,396)**	**(8,499)**	**(6,648)**	**(1,851)**
Hewitt Centre									
Income	(734)	(642)	(92)	(6,742)	(6,759)	17	(9,228)	(9,304)	76
Expenditure	732	868	(137)	6,584	7,525	(941)	8,779	9,883	(1,105)
Total Hewitt Centre	**(2)**	**226**	**(228)**	**(158)**	**766**	**(924)**	**(449)**	**579**	**(1,029)**
Division of Gynaecology - Total	**(638)**	**(189)**	**(448)**	**(6,397)**	**(4,077)**	**(2,320)**	**(8,949)**	**(6,069)**	**(2,880)**
Theatres									
Income	0	0	0	0	0	0	0	0	0
Expenditure	1,019	1,071	(52)	8,733	8,710	23	11,790	11,722	67
Total Theatres	**1,019**	**1,071**	**(52)**	**8,733**	**8,710**	**23**	**11,790**	**11,722**	**67**
Genetics									
Income	(13)	(20)	8	(114)	(110)	(4)	(152)	(154)	2
Expenditure	174	139	35	1,505	1,295	210	2,026	1,842	184
Total Genetics	**161**	**118**	**43**	**1,391**	**1,185**	**206**	**1,874**	**1,688**	**186**
Other Clinical Support									
Income	(716)	(720)	4	(6,548)	(5,638)	(909)	(8,793)	(7,177)	(1,616)
Expenditure	881	1,138	(257)	7,921	7,731	190	10,564	10,958	(394)
Total Clinical Support	**165**	**417**	**(252)**	**1,373**	**2,093**	**(719)**	**1,771**	**3,780**	**(2,009)**
Division of Clinical Support - Total	**1,345**	**1,607**	**(262)**	**11,497**	**11,988**	**(491)**	**15,434**	**17,191**	**(1,756)**
Corporate & Trust Technical Items									
Income	(3,120)	(2,897)	(222)	(24,739)	(28,095)	3,356	(31,577)	(36,580)	5,003
Expenditure	4,571	5,103	(533)	40,091	42,526	(2,435)	53,591	56,549	(2,958)
Total Corporate	**1,451**	**2,206**	**(755)**	**15,352**	**14,431**	**921**	**22,014**	**19,969**	**2,045**
(Surplus) / Deficit	**49**	**1,476**	**(1,427)**	**(662)**	**1,480**	**(2,143)**	**(526)**	**1,386**	**(1,911)**
Of which is hosted;									
Income	(115)	(210)	96	(1,031)	(2,926)	1,895	(1,374)	(4,003)	2,629
Expenditure	115	210	(95)	1,031	2,926	(1,895)	1,374	4,003	(2,629)
Total Corporate	**0**	**(0)**	**0**	**0**	**(0)**	**0**	**0**	**(0)**	**0**

NHS
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LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 7
CIP: M9
YEAR ENDING 31 MARCH 2023

Scheme	Target	Actual	Variance	Target	Actual	FOT	Variance
Procurement and Non P	153	37	-116	1,373	1,381	1,706	-129
Estates utilisation	34	12	-22	309	111	163	-249
Staffing and skill mix	173	149	-25	1,558	1,285	2,181	103
Medicines Management	3	0	-3	23	0	0	-30
Theatre Efficiency	37	0	-37	296	0	0	-369
Technology Driven Effici	9	3	-6	80	25	44	-62
Income	68	87	20	570	1,109	1,365	591
Total	**477**	**289**	**-188**	**4,208**	**3,912**	**5,459**	**-144**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 8
BALANCE SHEET: M09
YEAR ENDING 31 MARCH 2023

BALANCE SHEET £'000	YEAR TO DATE Opening	M9 Actual	Movement
Non Current Assets	101,380	101,910	530
Current Assets			
Cash	11,192	8,293	(2,899)
Debtors	5,929	10,912	4,983
Inventories	523	812	289
Total Current Assets	**17,644**	**20,017**	**2,373**
Liabilities			
Creditors due < 1 year - Capital Payables	(4,849)	(1,608)	3,241
Creditors due < 1 year - Trade Payables	(18,362)	(19,614)	(1,252)
Creditors due < 1 year - Deferred Income	(4,157)	(13,520)	(9,363)
Creditors due > 1 year - Deferred Income	(1,561)	(1,537)	24
Loans	(1,525)	(1,187)	338
Loans - IFRS16 leases	(49)	(32)	17
Provisions	(3,889)	(1,205)	2,684
Total Liabilities	**(34,392)**	**(38,703)**	**(4,311)**
TOTAL ASSETS EMPLOYED	**84,632**	**83,224**	**(1,408)**
Taxpayers Equity			
PDC	70,713	70,786	73
Revaluation Reserve	12,749	12,749	0
Retained Earnings	1,170	(311)	(1,481)
TOTAL TAXPAYERS EQUITY	**84,632**	**83,224**	**(1,408)**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 9
CASHFLOW STATEMENT: M09
YEAR ENDING 31 MARCH 2023

CASHFLOW STATEMENT £'000	Actual
Cash flows from operating activities	201
Depreciation and amortisation	4,433
Impairments and reversals	0
Income recognised in respect of capital donations (cash and non-cash)	0
Movement in working capital	2,589
Net cash generated from / (used in) operations	**7,223**
Interest received	106
Purchase of property, plant and equipment and intangible assets	(8,653)
Proceeds from sales of property, plant and equipment and intangible assets	0
Net cash generated from/(used in) investing activities	**(8,547)**
PDC Capital Programme Funding - received	73
Loans from Department of Health - repaid	(306)
Interest paid	(21)
PDC dividend (paid)/refunded	(1,321)
Net cash generated from/(used in) financing activities	**(1,575)**
Increase/(decrease) in cash and cash equivalents	**(2,899)**
Cash and cash equivalents at start of period	11,192
Cash and cash equivalents at end of period	**8,293**

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**

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LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 10
CAPITAL EXPENDITURE: M08
YEAR ENDING 31 MARCH 2023

CAPITAL EXPENDITURE £'000	Year to Date			FOT		
	Plan	Actual	Variance	Plan	Actual	Variance
Estates	743	341	402	800	861	(61)
Capital Projects	4,523	3,135	1,388	4,527	4,524	3
IM&T	482	646	(164)	718	948	(230)
Medical Equipment	2,477	646	1,831	2,211	2,096	115
Other	379	305	74	564	2,586	(2,022)
	8,604	5,073	3,531	8,820	11,015	(2,195)
Grand Total	8,604	5,073	3,531	8,820	11,015	(2,195)

Note 1: The Capital Expenditure is shown on an "Accruals" basis based on the date of receipt of the capital item by the Trust. This figure differs to the capital expenditure figure shown in the cashflow statement which is on a "Cash" basis.

Note 2 : Variances in the Board Pack are the true FOT for the year, however the variances reported in the NHSI M5 return are all zero as FOT has been reported as plan for each line.

Note 3: Actual FOT exceed plan due to additional PDC projects (front line digitisation £1.9m and CAMRIN)

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*22/23/205*		**Date: 02/02/2023**	
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 December 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 January 2023 meetings.

MAIN REPORT

Introduction

The following report provides an update to Board members on the latest review of the BAF items.

The report is intended to allow the members of the Board to review any proposed changes or additions and agree them moving forward. The report is also an opportunity for the Board to make informed judgements as to the level of assurance that they can take and to identify any further action required to improve the management of the identified risks.

Process for reviewing BAF areas during the meeting

As the Board works through the agenda, members are requested to consider the BAF areas contained in Appendix 1 and the associated interdependent 15 and above risks / CRR risks. Keeping these risks in mind should support consideration of whether any assurances provided through the reports received could contribute to mitigation (or escalation) of the BAF risks. These can be noted when the BAF itself is discussed.

In addition, members should consider whether because of the review of assurances and/or identification of risks, whether there is a need to commission additional assurance to be reported to future Board and / or Committee meetings. In particular, the Board needs to ask itself whether it is attaining adequate assurance against its highest scoring risks i.e., are these areas of risk driving the Board and Committee agendas. Any information that has been discussed in the meeting that needs to be shared with other corporate governance meetings should be included in the Chair's Log.

Changes to BAF

The table below 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 changes
1.2 Failure to recruit & maintain a highly skilled & engaged workforce

- No proposed changes were discussed at the January 2023 PPF Committee
- The Trust has been managing the impact of industrial action throughout 2022 whilst maintaining a BAF score of 20. Moving into 2023, it is likely that industrial action begins to be co-ordinated across the various unions and sectors. This will pose a severe and acute challenge to the Trust on those days, potentially to the extent which disrupts business to a 'catastrophic' extent (as defined by the risk descriptors in the Risk Management Strategy). Whilst this remains a possibility, it is proposed that the Trust should rate this risk as a '25' – the most highly rated risk on the BAF.

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

- No significant changes to note
- The LCSR makes several recommendations which will have a material impact on governance and activities surrounding the Future Generations Programme. The ICB will received the LCSR report at their board meeting, held in public on 26 January 2023. Once the outcome of that discussion is fully understood, the Trust will undertake a full review of BAF Risk 2.1, and will update the controls, sources of assurance, gaps in assurance and actions to reflect the implications of the report.

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

- No significant changes to note

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

- No significant changes to note

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

- No significant changes to note

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

- No significant changes to note

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

- No significant changes to note

4.2: Failure to expand our existing partnerships, building on learning and partnership working throughout the COVID-19 pandemic, playing a key role in establishing any ICP or ICS
• No significant changes to note
4.3: Failure to deliver the agreed 2022/23 financial plan
• New BAF risk. Agreed to separate from BAF risk 4.1 at December 2022 Board to reflect the risk to the FOT 22/23 and to provide greater visibility and clarity on the respective controls and assurances.
5.1: Failure to progress our research strategy and foster innovation within the Trust
• No significant changes to note
5.2: Failure to fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership
• No significant changes to note

New Risks or Strategic Threats

No new risks or strategic threats identified.

Closed Risks or Strategic Threats

No closed risks or strategic threats since previous iteration.

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.

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BOARD ASSURANCE FRAMEWORK 2022/2023

Trust Board – February 2023

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)	25 (I5 x c5)			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)
	4.3 Failure to deliver the agreed 2022/23 financial plan	FPBD	CFO			16 (I4 x c4)		N/A	16 (I4 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
1.2
4.2
5.1
1.1
3.1
5.2
2.2
4.3
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	25 (5 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~~ February 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 / 9	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 / 10	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	See Board agenda – February 2023	
	1.1 / 11	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 / 5	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 / 6	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 / 7	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: January 23

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)	25 (5 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.

The Trust has been managing the impact of industrial action throughout 2022 whilst maintaining a BAF score of 20. Moving into 2023, it is likely that industrial action begins to be co-ordinated across the various unions and sectors. This will pose a severe and acute challenge to the Trust on those days, potentially to the extent which disrupts business to a 'catastrophic' extent (as defined by the risk descriptors in the Risk Management Strategy). Whilst this remains a possibility, the Trust will be rating this risk as a '25' – the most highly rated risk on the BAF.

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 evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
The Covid-19 pandemic & associated elective recovery has the ongoing potential to 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 administrative and clinical staff resulting in a lack of capability to deliver safe care, effective outcomes and organisational objectives.~~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		
	Industrial action working group			

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	Deputy Director of Workforce	November 2022	PPF Committee	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 – *evidence required to move this into controls.*
1.2 / 4	To provide evidence that robust workforce plans are being reviewed regularly at Divisional Board	Deputy Director of Workforce	~~September 2022~~ April 23	PPF Committee	Workforce planning is a regular item at each Divisional Board – the evidence of this is reported through to DPRs. More evidence required that this 'robust' and can demonstrate maturity. Will be assessed as part of Divisional Governance maturity assessment – propose that

						deadline is amended accordingly.	
	1.2 / 5	Respond to Ockenden recommendations relating staffing	Deputy Director of Workforce	September 2022	PPF Committee	See Maternity Staffing report on February 23 Board agenda for more detail. Funding to fulfil Ockenden staffing requirements not yet fully secured – negotiations continue as part of budget setting.	
	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 LCSR 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 ICB 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 ICB 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 (LCSR) 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 LCSR)	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 LCSR)	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 LCSR)	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	Work to refresh the Strategic Outline Case was undertaken by the Trust's FG Project Team informed by the FGCAG. Much of the information produced will be relevant and can be used to complete a PCBC and inform public consultation. Following the Liverpool Clinical Services Review (LCSR), if recommendations are accepted, production of all business cases and responsibility will sit with the proposed sub-committee of the ICB. Liverpool Women's Hospital will be a member of this sub-committee. Stage 1 Assurance meeting has been held with NHS England and commissioners to carry out strategic sense check and agree governance and process. Should the LCSR recommendations be accepted, it is likely that the Stage 1 Assurance process will be repeated with a revised case for change, written by the ICB sub-committee from a system perspective.	Public consultation required – this must be led by commissioners	
	Discussion of case for change with patients, public and local community	The refreshed case for change will need to be shared with public, patients and the local community. The Trust's case for change and counterfactual case have already been validated by partners and independent clinical senate. It is likely that the ICB will lead work to engage with patients and the public, however Trust clinical staff will need to be central to discussions. The Trust has held a series of briefing meetings with local MPs to explain the case for change and ask for their support.	Lobby systems and MPs for active support Case for change and counterfactual case not yet shared with public. The Trust will need to decide whether to share its case for change (including the counterfactual case) with the public, once the ICB has taken a decision regarding the recommendations of the LCSR. Engagement with local community required regarding case for change	
	Comms and Engagement Activities	The Trust is working closely with ICB to plan pre-consultation engagement, and draft consultation timeline.	Further work required to engage women and their families in option appraisal process and model of care development	

		Currently reviewing outcomes of previous engagement exercises and updating publicly available information.		Communication with patients and the public regarding the outputs of the LCSR 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	TBC	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 LCSR	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 evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Clinical service strategies that do not sufficiently anticipate evolving healthcare needs of the local population and/or reduce health inequalities	Operational 'Plans on a page' for Divisions – incorporates horizon scanning section 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~~ April 2023	Executive Team	5 year transformational plans include section on horizon scanning to support future planning – further evidence required that data is being utilised as effectively as possible to support this. Updated performance reports will support this. Suggest that deadline is amended to reflect the need to assess the maturity of this process.
2.2 / 9	To ensure that workforce plans are informed by trends and data led intelligence.	Deputy COO	~~September 2022~~ April 23	Executive Team	See action 1.2 / 4

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 (LCSR) 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	
2.3 / 12	Complete construction of CT imaging suite	Associate Director of Strategy	December 2022	Crown Street Enhancements Programme Board, FPBD	
2.3 / 13	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	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~~ March 23	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. Suggested to amend deadline as new MVP Chair only in post from late 2022.	
	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.	
	3.1 / 11	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		
	3.1 /12	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		
	3.1 / 13	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.	
	3.1 / 14	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 evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
Lack of clinical capacity and resources i.e. workforce, estate etc. to treat patients in a timely manner resulting in delays in treatment and deterioration in Trust Performance standards	Fortnightly Access Board meetings with Divisional Operational Teams and Information present monitoring key performance	FPBD and Board meetings	Gaps in effective delivery of Access Policy including training of staff associated with RTT pathway management Gaps in Standard Operating Procedures for management of patient pathways Timescales for delivery of key elective recovery programme actions 3.1/10 – Work to reconfigure the MLU estate to maximise efficiencies for IoL.	
	Daily monitoring of performance through Power BI dashboards – daily and weekly updates on key performance metrics	Integrated Performance Report		
	Weekly Patient Tracking List (PTL) meetings with Divisional Operational teams and Patient Access	Access Board		
	Elective Recovery Programme in place with workstreams to improve performance and reduce waits	FPBD Executive Team reporting		
	External validation programme of work reviewing all admitted and non-admitted pathways to ensure RTT guidance being applied correctly	Access Board		
	Review of Medical & Nursing job plans to ensure capacity in place to treat patients in a timely manner	Updates via Divisional Performance Reviews and Hospital Management Meetings		
	Cancer Committee – meets bi-monthly to review Cancer performance and track actions to improve performance	FPBD		
	Theatre Utilisation Group	Updates via Divisional Performance Reviews and Hospital Management Meetings		
	Text reminder service to reduce DNA's and ensure patients still require appointments – facility in place if they wish to change or cancel appointments	Monitoring through Access Board		
	Patient Initiated Follow-Ups – to minimise numbers of patients who no longer require follow up to release capacity	Monitoring through Access Board		
	Locum Consultant in place for Gynaecology to increase clinical capacity	Updates via Divisional Performance Reviews and Hospital Management Meetings		
	Sub-specialisation of Gynaecology and sub-specialty recovery plans in place to monitor actions/risks at a sub specialty level and establish performance trajectories to deliver improvements	Updates via Divisional Performance Reviews and Hospital Management Meetings/Access Board		
	Controls in place to monitor length of stay for women in induction of labour - Daily safety huddles - IoL metrics included on Executive and SLT live dashboards - C&M weekly maternity escalation cell	Bi-annual workforce report		

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

Strategic Objective	SA4: To be ambitious and EFFICIENT and make the best use of available resources
Committee:	Finance, Performance and Business Development Committee
Risk Appetite:	Moderate

Principal risks (BAF)	Risk Score
4.1 Failure to ensure our services are financially sustainable in the long term	20 (5 x 4)
4.2 Failure to expand our existing partnerships, building on learning and partnership working throughout the COVID-19 pandemic, playing a key role in establishing any ICP or ICS	8 (2 x 4)
4.3 Failure to deliver the agreed 2022/23 financial plan	16 (4 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 can 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: December 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 are deemed above target funding and so has had a convergence factor in addition to the efficiency requirement applied.

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 (ICB, 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	Ongoing engagement through governance forums.	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		

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 (now ICB)	COO	~~August 2022~~ November 2022	Board	Draft SLA developed – requires consultation and finalisation with the LMNS – now linked to wider work around SLAs (see FPBD Agenda – Jan 23)

BAF Risk 4.3: Failure to deliver the agreed 2022/23 financial plan

Lead Director: CFO
Op Lead: Deputy CFO

Review Date: December 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
N/A	N/A	16 (4 x 4)		N/A	16 (4 x 4)

Rationale for current risk score:

Like many NHS organisations, LWH is facing a 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) and remained steady at Month 8. There are also a number of risks not accounted for in the FOT, particularly in relation to funding for the Community Diagnostic Centre and improvements assumed in run rate.

The likelihood of this risk has been assessed as being 'likely' rather than 'almost certain' as 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 (see BAF Risk 4.1).

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 in the 2022/23 financial year	Trustwide and divisional recovery plan in place.	Recovery plan with agreed actions in place; monitored through Financial Recovery Board, Executive Team and Finance, Performance and Business Development Committee and reported to Board.	Adherence to plan. A number of items need external input and agreement, e.g. additional income requests.	
	Monthly reporting and monitoring of position including taking corrective action where required.	FPBD Committee receives monthly reports, chair's reports from the Financial Recovery Board and specific recovery centred reports. Internal Audit- high assurance for all finance related internal audit reports in 2020/21 and 2021/22. External Audit – no amends to accounts and largely low rated recommendations in ISA260. 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. This is still the case in 2022/23 as block values are still based on this assessment. Reliance on Cheshire & Merseyside position and NHS Improvement/England national team to support proposed baseline adjustment for Elective Recovery Funding. 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 (action 4.3/3) 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) (action 4.3/4) Productivity and Efficiency: There is a Productive Operating Theatre workstream underway, this will form part of CIP going forward. (action 4.3/5) 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 (action 4.3/6). To prepare and plan for the impact on the 2023/ 24 planning process (4.3/7) 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. To work with the regional team to mitigate risk to CDC funding.	
	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.			
	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.	Agency use monitored weekly at Executive Team meetings and via regular meetings with the Divisions		
	Deferral of Investment: A number of planned investments have been paused and will be reviewed as part of operational planning 2023/24.	Quality impact assessments have been undertaken to prevent deleterious effects of deferrals.		
	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.	Outputs reported via FRB and FPBD.		
	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.	Outputs reported via FRB and FPBD.		
	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.	Outputs reported via FRB and FPBD.		

	Gap Reference	Required Action	Lead	Implement By	Monitoring	Status	
	4.3/1	Production of and management of recovery plan	Chief Finance Officer	February 2023	FPBD Committee		
	4.3/2	Ensure full CIP programme in place with relevant QIAs etc Ongoing. QIAs in place before schemes are put in place.	Deputy Chief Finance Officer	March 2023	FPBD Committee		
	4.3/3	To undertake discussions with commissioners regarding the significant increase in neonatal activity	Chief Finance Officer	January 2023	FPBD Committee		
	4.3/4	To undertake review to ensure any obsolete assets are impaired, asset lives are reviewed, and all capital expenditure is captured.	Chief Finance Officer	February 2023	FPBD Committee		
	4.3/5	Productive Operating Theatre workstream to conclude	Deputy COO	February 2023	FPBD Committee		
	4.3/6	Review of potential service changes (subject to QIA)	Deputy COO	March 2023	FPBD Committee		
	4.3/7	To prepare and plan for the impact of exiting 22/23 with an underlying deficit on the 2023/24 planning process	Chief Finance Officer	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 have sufficient cash resources in the 2022/23 financial year	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).	Updates provided to the FPBD Committee and the Board	Exploring and securing a longer-term solution to long term sustainability. To maintain potential option of PDC revenue support. To continue discussions with ICB regarding provided or facilitated cash support.	

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
4.3/8	Subject to QIA to also explore the potential to defer capital expenditure in some areas.	Deputy Director of Finance	February 2023	FPBD Committee	

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 the New Year

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
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 / 13	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.	

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	**22/23/**		**Date: 02/02/2023**	
Report Title	**Liverpool Clinical Services Review**			
Prepared by	***Jennifer Huyton, Associate Director of Strategy***			
Presented by	***Jenny Hannon, Chief Finance Officer/Executive Director of Strategy & Partnerships***			
Key Issues / Messages	**The Liverpool Clinical Services Review recommends greater collaboration between acute and specialist trusts in Liverpool. It also recommends that the Future Generations Programme is reset as a system priority, managed through a newly established subcommittee of the Integrated Care Board.**			
Action required	**Approve ☐**	**Receive ☒**	**Note ☐**	**Take Assurance ☐**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	***To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it***	***For the intelligence of the Board / Committee without in-depth discussion required***	***To assure the Board / Committee that effective systems of control are in place***
	Funding Source (If applicable):			
	For Decisions - in line with Risk Appetite Statement – Y/N ***If no – please outline the reasons for deviation.***			
	The Trust Board is asked to • ***receive the report*** • ***note the recommendations within the Liverpool Clinical Services Review*** • ***commit to ongoing support for and active participation in the new system-owned programme, previously known as Future Generations.***			
Supporting Executive:	***Jenny Hannon, Chief Finance Officer/Executive Director of Strategy & Partnerships***			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

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

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

Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* 2.1 Failure to progress our plans to build a new hospital co-located with an adult acute site 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	Comment:
Link to the Corporate Risk Register (CRR) – CR Number:	Comment:

REPORT DEVELOPMENT: N/A

EXECUTIVE SUMMARY

An independent consultancy firm, Carnall Farrar, was commissioned by the Cheshire and Merseyside Integrated Care Board (ICB) at the request of NHS England, to undertake the Liverpool Clinical Services Review, an independent review of the acute care model in Liverpool. The review aimed to identify opportunities to improve clinical hospital-based services in terms of clinical quality, efficiency, and effectiveness.

Liverpool Women's Hospital strongly engaged with and fully supported the review process. The review identified 12 opportunities and prioritised three of those opportunities. Solving clinical sustainability challenges affecting women's health in Liverpool was one of those three priorities.

The Liverpool Clinical Services Review concluded in December 2022 and made a series of recommendations primarily concerning the programme and governance arrangements required to deliver the opportunities identified. The report recommends that the Trust's Future Generations Programme, first established in 2014/15, is reset as a system priority. This recommendation is in keeping with the Trust's work within the Programme over several years to demonstrate the system impacts of those risks which arise as a result of the Trust's location, isolated from adult acute services.

The ICB reviewed the recommendations at their Board meeting on 26 January 2023. The ICB Board noted the report and all the recommendations within the report were agreed; however, with regards those recommendations to be overseen by the CMAST Committees in Common the Board removed from the recommendations the sentence 'the starting point for realising the opportunities identified in this review should be the 6 organisations within Liverpool' – and amended this to say that 'CMAST will be required to agree a priority programme'. The implementation plan and associated timescales were also agreed.

The purpose of this paper is to provide the Trust Board with an update regarding the outcomes of the review and the associated recommendations agreed by the ICB.

MAIN REPORT

1. Introduction and Background

Cheshire and Merseyside Integrated Care System (C&M ICS) were asked by NHS England to commission an independent review of the acute care model in Liverpool, with a view to identifying opportunities for greater collaboration between acute and specialised trusts that will improve clinical hospital-based services in terms of clinical quality, efficiency, and effectiveness. An independent consultancy firm, Carnall Farrar, commenced this work in August 2022. Day to day oversight of the work was provided by the One Liverpool Partnership Board. Liverpool Women's Hospital NHS Trust staff engaged fully and transparently with the team from Carnall Farrar throughout the review process.

The final report (Appendix 1) was received by the Cheshire and Merseyside Integrated Care Board (C&M ICB) at its meeting held in public on 26 January 2023, alongside a series of recommendations, an implementation plan and associated timescales (detailed below). The recommendations will impact next steps for the Trust's Future Generations Programme as well as ongoing partnership work to reduce the risks arising from the Trust's isolated site. The ICB noted the report at their Board meeting on 26 January 2023 agreed with the recommendations.

The purpose of this paper is to provide the Trust Board with an update regarding the outcomes of the review and the associated recommendations approved by the ICB.

2. Review Scope and Methodology

The organisations primarily in scope of the review were the six specialist and acute providers that are part of the Liverpool Place:

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

Agreed deliverables for the work were as follows:

- To make a clear and compelling case for greater collaboration.
- Identify priorities for collaboration and the reasons why.
- Develop a blueprint for the collaborative opportunities to be implemented.
- To articulate the conditions for success, setting out the supporting arrangements to be put in place.
- To produce an implementation roadmap to deliver the blueprint.

The review commenced with engagement with approximately 300 people through a series of individual interviews, group discussions with each of the acute and specialist provider executive teams and hospital management groups, a GP engagement session, and survey responses from over 150 senior staff from across Liverpool. Liverpool Women's Hospital staff were well represented within the survey following good engagement and a high number of responses submitted.

Data analysis was then carried out to sense check and evidence the hypotheses and views expressed during engagement.

The outputs of the discovery work were tested and refined through a series of workshops, with 12 opportunities identified. Those opportunities are:

1. Improving physical and mental health by strengthening ways of working with PCNs and neighbourhood teams and providing more anticipatory care, especially for people with long term conditions and complex lives.
2. Creating socially inclusive training and employment opportunities for the Liverpool City Region, leveraging anchor institution status to address local deprivation.
3. Improving outcomes and access to emergency care, making optimal use of existing co-adjacencies at Aintree, Broadgreen, Royal Liverpool, and Springfield Park (Alder Hey) sites.
4. Levelling-up performance on cancer and cardiovascular disease to address health inequalities.
5. Providing timely access to high-quality elective care by making efficient use of existing estates and assets.
6. Solving clinical sustainability challenges affecting women's health in Liverpool.
7. Combining expertise in clinical support services to provide consistent services across the city.
8. Developing world-leading services in Liverpool by realising the collaborative potential in innovation, research and clinical trials.
9. Attracting and retaining talent across Liverpool, providing a more joined-up offer for staff.
10. Achieving economies of scale in corporate services.
11. Building on and integrating digital investments to unlock innovative approaches to delivering care and achieving commitments to environmental sustainability.
12. Making best use of resources to secure financial sustainability for all organisations in Liverpool.

Liverpool Women's Hospital has been strongly engaged with review process, robustly advocating for women's services in Liverpool and Cheshire and Merseyside. The work carried out as part of the Future Generations Programme enabled the Trust to share a broad range of evidence, data, and information.

3. Report Recommendations

The report recommendations (which can be viewed in full in Appendix 1) primarily concern governance and programme arrangements required to deliver the 12 opportunities. The consensus of the One Liverpool Partnership Board is that of the twelve opportunities, there are three critical priorities to take forward immediately to address the challenges with greatest risk and opportunity within the Liverpool system. These are:

- Solving the clinical sustainability challenges affecting women's health in Liverpool.
- Improving outcomes and access to emergency care, making optimal use of existing co-adjacencies at the Aintree, Broadgreen and Royal Liverpool Hospital sites.
- Significant opportunities to achieve economies of scale in corporate services.

It is recommended that a detailed programme of work should be produced, building on existing programmes where appropriate and creating new mechanisms where required to ensure delivery; for example, Joint Committees between specific providers based on shared sites.

The recommendations concerning the clinical sustainability challenges affecting women's health in Liverpool are as follows:

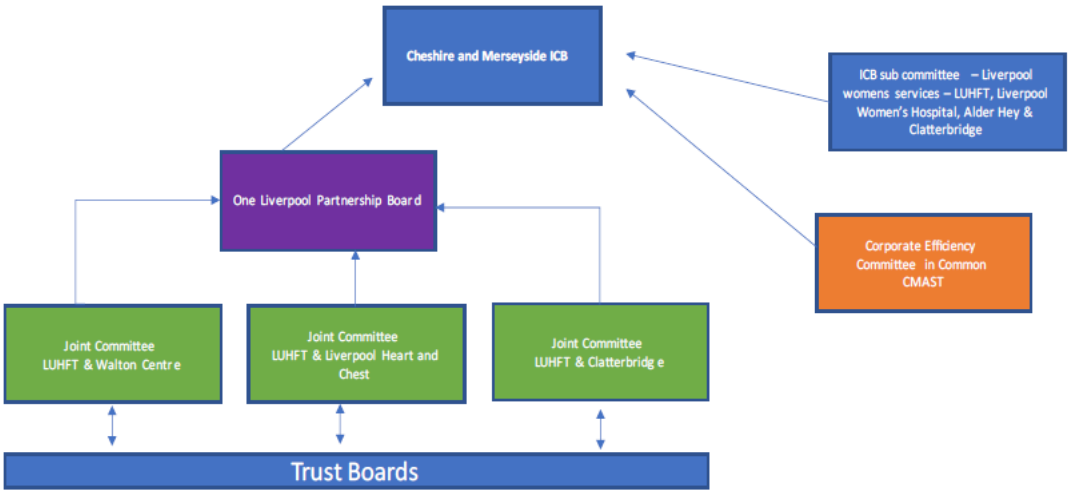
The current programme of work, the Future Generations Programme, led by Liverpool Women's Hospital NHS FT should be reset as a system priority. The opportunity to solve clinical sustainability challenges for women's health should be taken forward as an ICB-led service change programme, in line with best practice requirements for service reconfiguration. To support this, we recommend:

1. *A sub-committee of the ICB to be established to oversee the programme of work, including at minimum representation from Liverpool Women's Hospital NHS FT, Liverpool University Hospitals FT, Clatterbridge Cancer Centre NHS FT and Alder Hey Children's NHS FT. These organisations will need to identify dedicated*

clinical and managerial leadership to engage deeply in the programme with partners, with external stakeholders, with patients and the public and within their own organisations with staff.

2. *A director of the ICB be identified as the joint-SRO of the programme and chair the sub-committee leading the work.*
3. *A clinical joint-SRO to be identified who can work on the programme three days per week and chair the clinical working group. This individual should be experienced in service change with experience in a relevant clinical area, and independent of any of the organisations in Cheshire and Merseyside.*
4. *The finance director of the ICB to chair the finance, analytics and estates working group which will develop and review the economic and financial modelling, including capital requirements.*
5. *A dedicated team to be identified to support the programme, with the expertise needed to meet the different requirements of the programme such as clinical evidence and research, communications and engagement, finance, analysis and estates and capital development. This team should be hosted by the ICB reporting to the lead ICB director.*
6. *A reset work programme be created and agreed by January.*
7. *An operating model between the Liverpool University Hospitals NHS FT and Liverpool Women's Hospital NHS FT should be developed to optimise partnership working and short-term mitigation of risks, led by the existing Partnership Board.*

The governance arrangements resulting from the review are represented in the figure below:



Monthly reporting from the new Joint Committees into the One Liverpool Partnership Board will provide assurance on delivery of the recommendations. The One Liverpool Partnership Board will, in turn, report quarterly to the ICB. The ICB subcommittee for women's services will report monthly into the ICB.

The ICB reviewed the recommendations at their Board meeting on 26 January 2023. The report was noted and all the recommendations within the report were agreed; however, with regards those recommendations to be overseen by the CMAST Committees in Common the Board removed from the recommendations the sentence 'the starting point for realising the opportunities identified in this review should be the 6 organisations within Liverpool' – and amended this to say that 'CMAST will be required to agree a priority programme'. The implementation plan and associated timescales were also agreed.

Next Steps and Implications for Liverpool Women's Hospital

While all recommendations have some relevance for Liverpool Women's Hospital and the landscape in which it delivers care to women, babies, and families, the recommendations regarding the clinical sustainability challenges affecting women's health in Liverpool will have the greatest impact.

The Trust first established its Future Generations Programme in 2014/15, to address the clinical risks and issues which arise as a result of its isolated location. The findings of the independent Liverpool Clinical Services Review are in keeping with those of the Future Generations Programme. Since the Programme was first established, the Trust has been working determinedly in partnership with organisations from across the system (both providers and commissioners) to identify a solution and mitigate risks as far as possible. As part of this work, the Trust and partners have worked together to demonstrate that the risk does not simply relate to Liverpool Women's Hospital, rather it impacts the whole of the Cheshire and Merseyside system, and beyond, and that any solution must also be system-owned. This position has now been validated by the independent Liverpool Clinical Services Review.

Next steps from the ICB's implementation plan for women's health are summarised below:

Action	Lead	Deadline
1. Women's Health		
Establish a sub-committee of the ICB to oversee the programme to develop service change proposals for the future configuration of services: • Agree terms of reference and membership • Agree that Raj Jain chairs the sub committee	SRO, supported by ICB Governance lead	31/01/23
Agree that Christine Douglas is the Executive SRO for the programme	ICB CEO	31/01/23
Appoint an independent Clinical SRO	ICB Medical Director	28/02/23
Review existing governance in place – align or stand down if appropriate	SRO	31/01/23
Establish working groups for finance/estates/capital, engagement, clinical research/evidence.	SRO	24/02/23
Identify resources with the right skill mix and experience to support the programme, hosted by the ICB	SRO	24/02/23
Develop an operating model between the Liverpool University Hospitals NHS FT and Liverpool Women's Hospital NHS FT to optimise partnership working	LUHFT & LWH	31/03/23
Define the work programme and timescales for delivery	SRO	28/02/23
Establish monthly reporting to the ICB, aligned to the ICB Board cycle	SRO	28/02/23

4. Conclusion and Recommendations

The Liverpool Clinical Services Review was completed in December 2022. A final report has been published which identified 12 opportunities for collaboration, of which three were prioritised. One of the priorities was solving the clinical sustainability challenges affecting women's health in Liverpool. Alongside recommendations regarding the programme and governance arrangements required to deliver all opportunities identified, the report recommends that the Trust's Future Generations Programme, first established in 2014/15, is reset as a system priority. The ICB reviewed the recommendations at their Board meeting on 26 January 2023. The ICB Board noted the report and all the recommendations within the report were agreed.

The Trust Board is asked to

- receive the report
- note the recommendations within the Liverpool Clinical Services Review
- commit to ongoing support for and active participation in the new system-owned programme, previously known as Future Generations

Cheshire and Merseyside

Liverpool Clinical Services Review

An independent review of acute and specialist provider collaboration in Liverpool

Final version
18 January 2023

Contents

Purpose of the document

This document outlines the outputs of the Liverpool Clinical Services Review, commissioned by the Cheshire and Merseyside Integrated Care Board (ICB), and delivered by CF. The Cheshire and Merseyside Integrated Care System (ICS) was asked by NHS England (NHSE) to commission an independent review of the acute care model with a view to identifying opportunities that will improve hospital-based clinical services in terms of their quality, efficiency, and effectiveness.

The focus of the review and consequently this document is primarily on the six acute and specialist trusts: Alder Hey Children's NHS Foundation Trust; Clatterbridge Cancer Centre NHS Foundation Trust; Liverpool Women's Hospital NHS Foundation Trust; Liverpool Heart and Chest Hospital NHS Foundation Trust; Liverpool University Hospitals NHS Foundation Trust; and The Walton Centre NHS Foundation Trust. The Trusts operate as part of the Liverpool place-based partnership, led by the One Liverpool Partnership Board. Other partners core to One Liverpool include general practice, Mersey Care NHS Foundation Trust, and Liverpool City Council.

The review took was conducted over a 16-week period from August to December 2022, broadly following an Appreciative Inquiry (Ai) approach before deep-diving into priority areas. The outputs of this engagement are summarised in this document, which covers the case for greater acute and specialist provider collaboration, the priorities for action, the conditions needed for success, and the recommendations of the review.

Executive summary

CF was commissioned in August 2022 by the Cheshire and Merseyside Integrated Care Board (ICB), with day-to-day oversight from the One Liverpool Partnership Board, to undertake an independent review that identified and detailed how to realise collaborative opportunities for the acute and specialist trusts to optimise the acute care model for Liverpool.

The new Health and Care Act 2022 includes a set of legislative changes to enable health and care to work more closely together. Provider collaboratives are a key component of delivering system working, being one way in which providers work together to plan, deliver, and transform services. National guidance has mandated that all trusts providing acute and mental health services are expected to be part of one or more provider collaboratives.

Like ICSs all over the country, NHS Cheshire and Merseyside became a statutory organisation on 1 July 2022 and is now responsible for the health and care of over two and half million people across nine places. Liverpool is a place-based partnership in the Cheshire and Merseyside ICS, and major city in England. A significant proportion of the people of Liverpool live in deprivation, with 58.4% of households classified as being deprived to some degree, and/or with poor health and wellbeing. This contributes to the people of Liverpool living on average two and a half years less than people in the rest of England. Progress on closing this gap has stagnated in recent years and the gap between the most affluent and most deprived groups has widened. Much of the morbidity and early mortality is avoidable. Despite significant improvement over the last 20 years, the rate of avoidable mortality in Liverpool has remained consistently 50% above the national rate.

Organisations in Liverpool have collectively developed a 5-year strategy, One Liverpool, which runs from 2019 to 2024. Its aim is to deliver better population health and wellbeing in Liverpool, and it represents a whole system approach to delivering change that engaged Liverpool City Council, the local NHS and other key public and voluntary sector partners in its development. The One Liverpool strategy is part of the Liverpool City Plan and focuses on the positive and transformative actions that the health and care system will take together and with the people of Liverpool to improve population health and reduce health inequalities. In this context, the independent review was commissioned to complement this strategy and accelerate provider collaboration in recognition of the opportunity to optimise the acute care model and deliver financial sustainable services.

The review engaged over 300 people through individual interviews, group discussions with each of the acute and specialist provider executive and hospital management teams, a GP engagement session with PCN clinical leads, and over 150 senior staff from across Liverpool who contributed via a staff survey.

Through this engagement, twelve opportunities emerged that, together, form the strategic agenda for collaboration between the acute and specialist providers. These opportunities are additive to pre-existing priorities and will in some cases require wider partnerships to deliver on them. They outline a holistic and systematic requirement for collaboration between the acute and specialist providers themselves, and collectively with Mersey Care, PCNs, and the local authority, but also the academic institutions in Liverpool and other stakeholders. The twelve collaboration opportunities are:

1. **Improving physical and mental health by strengthening ways of working with PCNs and neighbourhood teams and providing more anticipatory care, especially for people with long term conditions and complex lives** – Liverpool has a higher burden of long-term conditions, in particular cardiovascular disease, and chronic obstructive pulmonary disease, and multimorbidity than the

national average. The current consequence of this is an increased use of hospital-based services, which reactively manage deterioration and acute exacerbation. There is a significant improvement opportunity by proactive, anticipatory management of conditions to improve health, avoid acute exacerbations and the need for hospital-based services.

2. **Creating socially inclusive training and employment opportunities for the Liverpool City Region, leveraging anchor institution status to address local deprivation** – People living in Liverpool are more disengaged from the labour market with long-term unemployment rates twice that of the rest of England. Once employed, however people living in Liverpool have better weekly earnings than in other areas. With NHS organisations being one of the major employers, their role within this opportunity is evident in providing wider economic benefits in terms of job offerings. Colleagues clearly described the opportunity to collaborate on shared apprenticeship and school leaver programmes for the local community. There is an imperative opportunity to support local people to gain and remain in employment, taking collective action to address local deprivation.
3. **Improving outcomes and access to emergency care, making optimal use of existing co-adjacencies at Aintree, Broadgreen, and Royal Liverpool sites** – There are challenges with both timely access and poor outcomes in the urgent and emergency care pathways. Emergency inpatient services across Liverpool are more commonly provided from only one of the city's five acute sites compared to other areas which means that when people need specialist care, they frequently require transfer to another site and their care becomes fragmented. For some specialties and conditions, this results in long lengths of stay in the emergency department and inpatient lengths of stay that are double the national average. This is associated with increased mortality and poorer outcomes for patients. There can even be significant delays in care when this is delivered between different providers occupying the same hospital site. There is an opportunity to embrace collaboration, and in doing so share best practice, drive up collective quality and performance standards and standardise pathways to ensure optimum emergency care delivery across the city.
4. **Levelling-up performance on cancer and cardiovascular disease to address health inequalities** – Cancer is the city's largest cause of premature deaths. There has been a large increase in referrals and consequently the number of people on the cancer patient tracking list from the pre-pandemic baseline. Additionally, the review found stark inequalities in cancer diagnosis. Patients diagnosed with cancer in the Emergency Department last year were between 2 and 6 times more likely to be an ethnic minority than white, and we know these late-stage diagnoses are likely to have a significant impact on survival rates. Similarly for cardiovascular disease, which is largely preventable through a healthy lifestyle and the early detection and control of risk conditions, there are significant gaps in diagnosis and treatment across Liverpool. There is an opportunity to address late diagnosis of cancer and cardiovascular disease, and inequalities in access which requires a place-based approach involving primary care and local government, working at PCN level to implement culturally sensitive targeted interventions, taking account of local needs.
5. **Providing timely access to high-quality elective care by making efficient use of existing estates and assets** – Elective waiting lists have grown across Liverpool by a third every year since 2019 and this has been further exacerbated by the impact of the pandemic. While all trusts in Liverpool have seen an increase in the number of people waiting for treatment, Liverpool University Hospitals NHS Foundation Trust has faced very challenging circumstances with both a significant elective 18 week and 104+ week backlog across multiple specialities. All organisations in the city have theatre capacity that could be used more effectively as a shared asset to provide timely access to high quality elective care.
6. **Solving clinical sustainability challenges affecting women's health in Liverpool** – Overwhelmingly, the most important challenge stakeholders identified as needing to be addressed was the clinical sustainability of services for women and the clinical risk in the current model of care. Specifically, seven

of twelve co-dependencies for maternal medicine centres and therefore for consultant-led obstetric services are not currently met at the Crown Street site. This results in fragmentation of services for women and babies, with some requiring ambulance transfer to other providers to receive the care they need. This, given the clinical circumstances necessitating the transfer, carries an inherent risk, and also result in mothers and babies being separated. There is an imperative opportunity and shared will amongst the acute and specialist providers to respond to the current case for change, developing a future care model to ensure the best possible care for women and babies across Liverpool.

7. **Combining expertise in clinical support services to provide consistent services across the city** – Stakeholders have spoken enthusiastically about the collaboration that already takes place for delivering clinical support services, both within the city, such as Liverpool Clinical Laboratories; and as part of the ICS, such as Cheshire and Merseyside Radiology Imaging Network (CAMRIN). There was widespread recognition that there was opportunity for further collaboration to combine expertise in clinical support services in order to address workforce challenges and make efficient use of resources. Examples of this include diagnostic imaging and the ability to address the workforce challenges, pharmacy and the sustainability of its workforce, and further consolidation of pathology services including resetting existing partnerships to maxmise value.
8. **Developing world-leading services in Liverpool by realising the collaborative potential in innovation, research, and clinical trials** – Over the years, the research and education infrastructure of Liverpool has had healthy investment, with significant resources available across the city region. Stakeholders almost universally reflected that there were opportunities to leverage this infrastructure to develop world-leading services for the city – primarily by delivering data-enabled clinical trials and establishing a hub to act as a single point of planning and operations for delivering clinical trials.
9. **Attracting and retaining talent across Liverpool, providing a more joined-up offer for staff** – Health and social care is the largest employer in the Liverpool City Region, employing 117,000 people. Across the six organisations, around 25,000 people were employed in 2021/22, many of whom live in Liverpool, and £1.29bn was spent on workforce costs in 2021/22. According to senior staff, the biggest challenge to ongoing service delivery is recruitment and retention of staff. Colleagues also consistently described how competition between Trusts magnifies this challenge and the benefits that collaborative working could have in addressing these issues. Opportunities included an integrated training and development offer, implementing staff passports, standardising policies, collective workforce planning, and joint recruitment, working together to create a strong employer brand to improve recruitment and retention rates and reduce recruitment costs.
10. **Achieving economies of scale in corporate services** – Across all organisations in Liverpool, £132.4 million is spent on corporate services (2021/22) and the majority of trusts spent more on corporate services per £100 million income than other Trusts. Collaborative working between the trusts would encourage a uniform approach to services and to the delivery of corporate services, freeing up resources by doing a greater number of tasks once between the organisations. As well as reducing cost and duplication, maximising this opportunity allows expertise across the city to be shared and leveraged for the benefit of all. This opportunity could be rapidly realised in transactional areas where services are process and system based including HR services such as recruitment checks, finance administration and IT support.
11. **Building on and integrating digital investments to unlock innovative approaches to delivering care and achieving commitments to environmental sustainability** – There has been significant investment in digital systems across the city with some organisations achieving international recognition for their efforts, but there is more work to do in order to bring all organisations up to the same standard. More than ten EPR and PAS systems are in use across organisations in Liverpool and despite some organisations using the same software company, the systems do not deploy functionality that allows

for interoperability. There is an opportunity to increase the overall level of interoperability between information and data systems to support the more effective delivery of care across organisational boundaries.

12. **Making best use of resources to secure financial sustainability for all organisations in Liverpool** – Currently, NHS organisations in Liverpool are in financial deficit with an aggregated reported deficit position of £12.3 million at YTD (August 2022/23), which is expected to deteriorate further over the rest of the financial year. The Cheshire and Merseyside ICS is set to see its allocation reduced by circa £350 million over the coming years and this sets the context for needing to stabilise the current position and prepare for the future challenge ahead. Throughout the review, colleagues have reflected on the financial pressures and sustainability challenges faced in Liverpool and how opportunities to collaborate could seek to address these challenges. Each of the opportunities outlined in the case for collaboration have either a direct or indirect financial benefit that organisations can realise.

Several of these opportunities are already being taken forward as part of implementing the One Liverpool strategy via the programme of work led by Liverpool Health Partners, and through ICS-wide programmes led by Cheshire and Merseyside Acute and Specialist Trusts (CMAST) and the Cancer Alliance. In these areas, the ongoing work can be supplemented by the findings and opportunities identified in this review.

The One Liverpool Partnership Board agreed that the review should move on to address the most critical issues facing the system, which are longstanding clinical risks for women's health, current financial sustainability, and operational pressures for emergency care. Two priorities were aligned upon as a core focus for collaboration: 1) Solving clinical sustainability challenges affecting women's health in Liverpool and 2) Improving outcomes and access to emergency care, making optimal use of existing co-adjacencies at Aintree, Broadgreen, and Royal Liverpool sites.

In pursuing these opportunities, we recommend that:

1. The twelve opportunities in the case for collaboration should be adopted by the six acute and specialist providers in Liverpool as their strategic agenda for working together. For five of the opportunities, wider partnerships are required, which should be forged to ensure progress, specifically:
    a. Improving physical and mental health by providing more anticipatory care (opportunity 1) requires working through the One Liverpool Partnership with General Practice, Liverpool City Council and Mersey Care FT,
    b. Levelling-up performance on cancer to address health inequalities (opportunity 4) requires working through a place-based partnership endorsed by the Cheshire and Merseyside Cancer Alliance,
    c. Work with all existing partners of the Liverpool Health Partners to pursue the research and innovation agenda (opportunity 8) and additionally include Liverpool City Council and Applied Research Collaboration North West Coast. This effort could be expanded to include interested providers across Cheshire and Merseyside ICB,
    d. The longer-term digital agenda (opportunity 11), which requires working through the Cheshire and Merseyside ICB as part of the Digital Programme,
    e. To solve clinical sustainability challenges affecting women's health (opportunity 6), work with the Cheshire and Merseyside ICB (see recommendation 4).

2. For the further five opportunities there is a synergy with the agenda of the Cheshire and Merseyside Acute and Specialist Trust Provider Collaborative and consequently the work should be undertaken in

the view of the Collaborative and in line with its governance. The starting point for realising the opportunities identified in this review should be the six organisations in Liverpool. Only once tangible progress is made within this scope should it be broadened to a wider geography. This includes:

a. Address elective care waits and backlog (opportunity 5) through the Elective Recovery and Transformation Programme,
b. Combine expertise in clinical support services (opportunity 7), in part through the Diagnostics Programme,
c. Attracting and retaining talent across Liverpool, providing a more joined-up offer for staff (opportunity 9) through the Workforce Programme,
d. Realise economies of scale in corporate services (opportunity 10) through the Efficiency at Scale workstream of the Finance, Efficiency & Value Programme, and
e. Making best use of resources to secure financial sustainability for all organisations in Liverpool (opportunity 12) through the Finance, Efficiency & Value Programme.

3. A rolling programme should be established, building on relevant pre-existing programmes, to take forward the opportunities for implementation. Overall, it will take a number of years to realise the potential benefits from this effort. The work should start by leveraging efforts already underway. Pre-existing programmes should incorporate the findings of the review into their ongoing work by undertaking a stocktake of existing workstreams, specifically:
   a. Levelling-up performance on cancer and cardiovascular disease to address health inequalities (opportunity 4) requires working through a place-based partnership endorsed by the Cheshire and Merseyside Cancer Alliance and the Liverpool Cardiology Partnership respectively,
   b. Provide anticipatory care to improve physical and mental health (opportunity 1) through the Complex Lives and Long Term Conditions Segments, of the One Liverpool Programme.

4. The current programme of work, the Future Generations Programme, led by Liverpool Women's Hospital NHS FT should be reset as a system priority. The opportunity to solve clinical sustainability challenges for women's health should be taken forward as an ICB-led service change programme, in line with best practice requirements for service reconfiguration. To support this, we recommend:
   a. A sub-committee of the ICB to be established to oversee the programme of work, including at minimum representation from Liverpool Women's Hospital NHS FT, Liverpool University Hospitals NHS FT, Clatterbridge Cancer Centre NHS FT and Alder Hey Children's NHS FT. These organisations will need to identify dedicated clinical and managerial leadership to engage deeply in the programme with partners, with external stakeholders, with patients and the public and within their own organisations with staff.
   b. A director of the ICB be identified as the joint-SRO of the programme and lead the work.
   c. A non-executive director of the ICB to be identified to chair the sub-committee.
   d. A clinical joint-SRO to be identified who can work on the programme for a dedicated period every week and chair the clinical working group. This individual should be experienced in service change with experience in a relevant clinical area, and independent of any of the organisations in Cheshire and Merseyside.
   e. The finance director of the ICB to chair the finance, analytics and estates working group which will develop and review the economic and financial modelling, including capital requirements.
   f. A dedicated team to be identified to support the programme, with the expertise needed to meet the different requirements of the programme such as clinical evidence and research, communications and engagement, finance, analysis and estates and capital development. This team should be hosted by the ICB reporting to the lead ICB director.

g. A reset work programme be created and agreed by January.
h. An operating model between the Liverpool University Hospitals NHS FT and Liverpool Women's Hospital NHS FT should be developed to optimise partnership working and short-term mitigation of risks, led by the existing Partnership Board.

5. Improving outcomes and access to emergency care, making optimal use of existing co-adjacencies should also be immediately prioritised for delivery. A programme of work should be established which implements the three new pathway elements proposed by this review: 1. fast-tracking, 2. passporting, and 3. in-reach. The overall aim of this work should be to ensure each hospital site in Liverpool delivers optimal care and efficiency, uninhibited by organisational boundaries. This should include creating integrated clinical teams on each site with joint ways of working. In taking this forward, we recommend:
   a. Clinicians should be at the forefront of the development of this approach and leads should be identified from each organisation and each site, to oversee the work and facilitate broad engagement with staff.
   b. There should be early engagement with General Practice, Mersey Care FT, and the North West Ambulance Service NHS Trust to incorporate pre- and post-hospital elements of the pathway.
   c. An operating model for each site should be developed, ensuring highest quality clinical pathways, clear accountability, and optimised site-based working. This should be underpinned by demand and capacity analysis.
   d. Building on the financial analysis undertaken as part of this review, a target financial model should be developed and agreed linked to 5c. This should reset financial flows and ensure overall efficiencies are realised including in respect to reduced length of stay and reduced interhospital ambulance transfers.
   e. Three joint committees should be established with delegated authority from the relevant trusts for site-based operations. These arrangements should oversee the design and delivery of the new operating models as well as business-as-usual operations, which will likely give rise to further improvement opportunities. The three committees should include at least one non-executive director and executive director from each organisation as well as a site-based leadership team. The committees should comprise of:
      i. Liverpool University Hospitals FT and Liverpool Heart and Chest Hospital FT for the Broadgreen site
      ii. Liverpool University Hospitals FT and The Walton Centre FT for the Aintree site
      iii. Liverpool University Hospitals FT and Clatterbridge Cancer Centre NHS FT for the Royal Liverpool site
   f. To progress the work, a dedicated team supporting all three joint committees should be established that provides capacity to systematically work through the operating model on each site, undertaking design work and modelling for the pathway and service transformation. This team should be led by a dedicated senior individual working across organisational boundaries on behalf of all organisations.

6. To provide overall Liverpool system oversight and review of performance on delivering high quality emergency care with aligned incentives and funding, two committees-in-common should be established involving relevant executives and non-executives from Alder Hey Children's NHS FT, Clatterbridge Cancer Centre NHS FT, Liverpool Heart and Chest Hospital NHS FT, Liverpool University Hospitals NHS FT, Liverpool Women's Hospital NHS FT, The Walton Centre NHS FT, Mersey Care FT, and General Practice Liverpool. These committees-in-common should meet quarterly and cover:

a. Quality – reviewing the effectiveness and quality of emergency care using shared data and analysis and determining further improvements required, and
b. Finance – reviewing overall financial effectiveness and establish effective incentive and risk sharing mechanisms.

7. To progress at pace Boards of relevant organisations should receive proposed terms of reference, including delegations, accountability, and escalation arrangements, for the governance groups set out in the recommendations 4, 5 and 6 in their January meetings. A proposal for how the programme(s) of work is resourced should also be included to ensure the appropriate team and leadership needed to deliver.

8. A communications and engagement plan should also be developed and agreed by all organisations. The aim should be to communicate the findings of the review and its recommendations and engage staff, patients, and the public on the next steps. Engagement on the future programme of work as well as open communications in respect to progressing the recommendations should be embedded into how this is taken forward.

Introduction and context

Like ICSs all over the country, NHS Cheshire and Merseyside became a statutory organisation on 1 July 2022 and is now responsible for the health and care of over two and half million people across nine places. Places are coterminous with local authority boundaries in Cheshire East, Cheshire West, Halton, Knowsley, Liverpool, Sefton, St Helens, Warrington, and Wirral. The ICS includes 18 NHS trusts, 355 GP practices in 50 PCNs and 590 community pharmacies that provide services for people in Cheshire and Merseyside, and in some cases beyond.

The geography has areas of substantial wealth and others of substantial deprivation. 33% of the population live in the most deprived 20% of neighbourhoods in England. The Index of Multiple Deprivation shows that Knowsley is the second most deprived borough in England and Liverpool the third. Knowsley also has the highest proportion in England of its population living in income deprived households (tied with Middlesborough), equating to one in four of all households. Even within the wealthier areas in the region, there is substantial deprivation and associated poor health – while 31% of neighbourhoods in Cheshire West and Chester are in the top two income deciles, 16% of neighbourhoods are in the lowest income deciles.

The vision for the ICS is for "everyone in Cheshire and Merseyside to have a great start in life and get the support they need to stay healthy and live longer". Its mission is to do this by working together, as equal partners, to support seamless, person-centred care and tackle health inequalities by improving the lives of the poorest fastest. In support of this vision and mission, the ICS has four strategic objectives, which are to:

- Improve population health and healthcare
- Tackle unequal outcomes and access
- Enhancing productivity and value for money
- Support broader social and economic development

Within Cheshire and Merseyside, place-based partnerships – led by Place Directors – have freedom to design and deliver services according to local need. This includes understanding and working with communities, joining up and co-ordinating services around the needs of people, addressing social and economic factors that influence health and wellbeing, and supporting quality and sustainability of local services.

Liverpool and its population

Liverpool is a major city in England and one of the Core Cities, along with Belfast, Birmingham, Bristol, Cardiff, Glasgow, Leeds, Manchester, Newcastle, Nottingham, and Sheffield. It is the 8th largest city by population size and is home to 565,000 people, including 119,000 children and young people, 332,000 working age adults, and 50,000 people over the age of 70. Liverpool has relatively less ethnically diverse communities compared to the other Core Cities, with 86% of population identifying as White British.

This population of Liverpool is expected to grow by 10% to 2043, which is 2% greater than the growth expected nationally. The group expected to see the largest growth, by 60%, is the 80+ group, which is slightly lower than the 70% growth seen nationally for this age group.

Liverpool has the greatest extent of deprivation in England as measured by the Index of Multiple Deprivation (IMD), with two in three people living in deprivation, and eight in every hundred people living in the most deprived one percent of the country. With respect to income, Liverpool is the 4th most deprived local authority, and the 5th most deprived with respect to employment and living environment.

The pertinence of this is characterised by the growing body of evidence showing that population health is determined to a great extent by social, environmental, economic, political, and cultural factors (the social determinants of health as set out in Figure 1). As a result, health follows a social gradient; a higher social position, whether measured by education, income, or occupational status, is associated with better health and longevity. The accumulation of positive and negative effects of social, economic, and environmental conditions on health and wellbeing throughout life contributes to inequalities in health.[1]

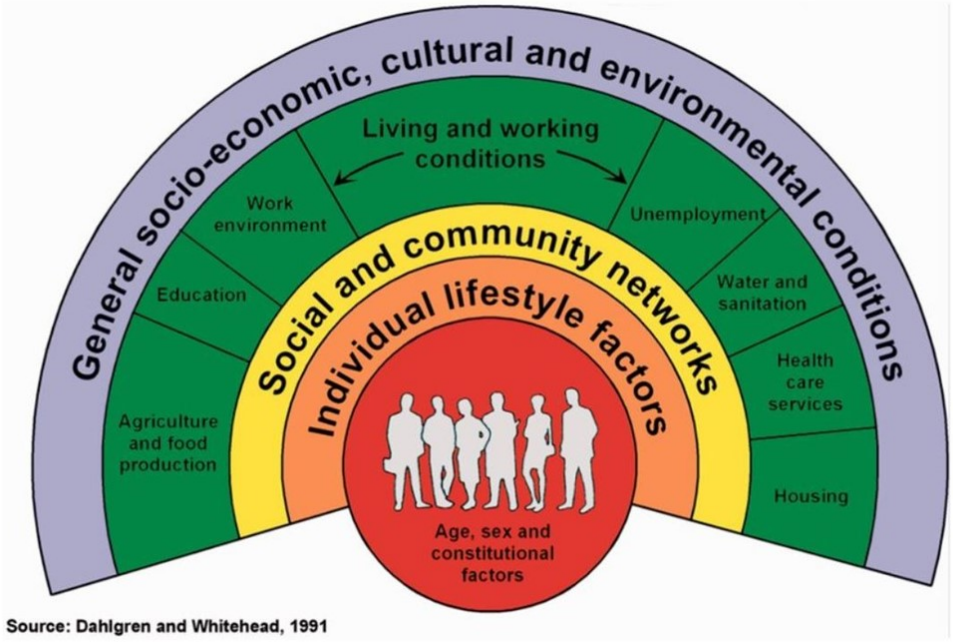


Figure 1: Dahlgren-Whitehead rainbow model of social determinants of health

In that context, the negative impact of deprivation affects people in Liverpool even before they are born. Babies are born to mothers in poorer health, who are twice as likely to smoke during early pregnancy and less likely to take folic acid supplements. Services in Liverpool have responded to this heightened risk by providing earlier access to maternity to more mothers than other places in England. The number of mothers who are smoking falls from 21.5% in early pregnancy to 11.3% at the time of delivery (compared to 17.1% and 12.4% respectively for the rest of England). However, this does not fully mitigate the impact of a poorer start in life for children. Babies are more likely to be low birth weight (7.3% compared to 6.9% nationally) and more likely to die as neonates (3.0 deaths per 1,000 live births compared to 2.8 nationally). This continues to affect children and young people in Liverpool throughout their life course. They are more likely to be overweight or obese at reception (26.8% compared to 23.0% nationally) with the gap increasing further by year 6 (41.2% compared to 35.2% nationally). They are more likely to live in dysfunctional families and have lower educational attainment than elsewhere in the country with only 44% of pupils achieving >Grade 5 in English and Maths at GCSE compared to 51.9% nationally.

As adults, lifestyle factors that contribute to improved health and wellbeing such as physical activity rates and healthy eating are all lower in Liverpool compared to the rest of the country. For example, 27% of

[1] Public Health England and the UCL Institute of Health Equity; Psychosocial pathways and health outcomes: Informing action on health inequalities (2017); (accessed on 20/09/2022) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/647709/Psychosocial_pathways_and_health_equity.pdf

adults are physically inactive compared to 22% in England. The environment people live in is also particularly challenging. In Liverpool, there are greater levels of air pollution, and households are more likely to suffer fuel poverty and live in overcrowded conditions. Children and adults also live in a city with the highest rates of violent crime in England; three times as many hospital admissions are due to violence than the England average.

More people also engage in health-harming behaviours. Adults are more likely to smoke and drink over 14 units of alcohol per week. Consequently, Liverpool has one of the highest rates of alcohol related hospital admissions in England with higher proportion of dependent drinkers not in treatment than the rest of England. People are also more likely to misuse and abuse drugs with two and half times as many deaths from drug misuse in Liverpool compared to the national average.

All these factors together, contribute to men and women in Liverpool living on average two and a half years fewer than the people in the rest of England, with the progress to close the gap stagnating in recent years. This gap is wider still between the most affluent and most deprived people living in Liverpool with men and women in Everton spending 18 and 17 fewer years of their lives respectively in good health compared to men and women living in Church.

Much of this morbidity and mortality is avoidable and despite significant improvement over the last 20 years, the rate of avoidable mortality in Liverpool has remained consistently 50% above the national rate. This represents an additional 740 people dying every year in Liverpool with the leading causes of these deaths being cancer, cardiovascular disease, and respiratory disease.

The cost-of-living crisis is also expected to have a negative impact on physical and mental health, with more than half of British people[2] already reporting a negative health effect from increased food, heating, and transport costs. In the short term, there will be an increased demand for health and care services and in recognition of this, the Combined Authority has earmarked £5 million to provide voluntary and community sector support[3]. In the longer term, the situation will likely exacerbate the existing health inequalities, making them starker still.

This context provides an opportunity for organisations in Liverpool to work together to improve outcomes, health and wellbeing for people living and working in Liverpool.

Collectively the six acute and specialist organisations in Liverpool provide local acute hospital services to the people of Liverpool and the surrounding areas including Sefton and Knowsley. Liverpool based providers also support service provision at neighbouring District General Hospitals such as Southport and Ormskirk Hospital NHS Trust. All organisations in Liverpool also provide specialist tertiary services for the wider Cheshire & Merseyside ICS, the North West of England, Isle of Man and North Wales, and train future staff for a significantly wider footprint. Several organisations, namely Alder Hey Children's NHS FT, Liverpool Heart and Chest Hospital NHS FT, the Hewitt Fertility Centre and fetal medicine services at the

[2] BMJ; Rising cost of living is damaging people's health, says royal college, 2022. https://www.bmj.com/content/377/bmj.o1231?ijkey=8666283869e9198ad1ceb17bf009f6ab08e86913&keytype2=tf_ipsecsha

[3] Liverpool City Combined Authority, 2022. https://www.liverpoolcityregion-ca.gov.uk/4-7m-cost-of-living-support-prioritised-as-liverpool-city-regions-44m-shared-prosperity-fund-plans-revealed/

Liverpool Women's Hospital NHS FT, and The Walton Centre NHS FT, have a national and international reputation that attracts quaternary referrals.

In this context, organisations in Liverpool have collectively developed a 5-year strategy, One Liverpool, which runs from 2019 to 2024. Its aim is to deliver better population health and wellbeing in Liverpool, and it represents a whole system approach to delivering change that engaged Liverpool City Council, the local NHS and other key public and voluntary sector partners in its development. The One Liverpool Strategy is part of the Liverpool City Plan and focuses on the positive and transformative actions that the health and care system will take together and with the people of Liverpool to improve population health and reduce health inequalities. In support of that, it has four objectives: 1. Targeted action on inequalities, at scale and with pace; 2. Empowerment and support for wellbeing; 3. Radical upgrade in prevention and early intervention; and 4. Integrated and sustainable health and care services. The strategy commits to being all age, all ethnicity, physical and mental health, aimed at empowering residents, improving equity and outcome focused.

Provider collaboration as a strategic enabler

The new Health and Care Act 2022 has a set of legislative changes to enable health and care to work more closely together. The intention is that there is a duty to collaborate, promoting joint working across healthcare, public health, and social care. The duty will apply to both NHS organisations and local authorities with a focus on reducing competition, removing the legislation that hinders collaboration and joint decision-making. Provider collaboratives are a key component of delivering system working, being one way in which providers work together to plan, deliver, and transform services. National guidance has mandated that all trusts providing acute and mental health services are expected to be part of one or more provider collaboratives by April 2022.

By working effectively at scale, providers can properly address unwarranted variation and inequality in access, experience, and outcomes across wider populations, improve resilience in smaller trusts, and ensure that specialisation and consolidation occur where this will provide better outcomes and value. Meeting these challenges is essential to delivering recovery from the pandemic and can only be achieved by providers working together with a shared purpose. The experiences of existing provider collaboration and the successful ways that providers have worked together to respond to the pandemic have demonstrated the specific types of benefits of scale that can be delivered including[4]:

- Reductions in unwarranted variation in outcomes and access to services,
- Reductions in health inequalities,
- Greater resilience across systems, including mutual aid, better management of system-wide capacity and alleviation of immediate workforce pressures,
- Better recruitment, retention, development of staff and leadership talent, enabling providers to collectively support national and local people plans,
- Consolidation of low-volume or specialised services, and
- Efficiencies and economies of scale.

In identifying, promoting, and championing the benefits of collaboration, NHS England have encouraged providers to build on local successes through provider collaborative structures and now, also require

[4] https://www.england.nhs.uk/wp-content/uploads/2021/06/B0754-working-together-at-scale-guidance-on-provider-collaboratives.pdf

all providers to be part of a collaborative. This policy imperative is seen as a mechanism to ensure providers support the delivery of the triple aim through:

- Aligning priorities,
- Supporting establishment of the Integrated Care System (ICS) with the capacity to support population-based decision-making, and
- Directing resources to improve service provision.

In Cheshire and Merseyside, there are two provider collaboratives: Cheshire and Merseyside Acute and Specialist Trust (CMAST) and Mental Health, Community and Learning Disability Collaborative (MHLDSC). The acute and specialist providers are part of CMAST, which in addition to the triple aim priorities, has identified a number of complementary functions that the collaborative can and should perform:

- Prioritising key programmes for delivery on behalf of the system, and
- Creating an environment of innovation, challenge, and support in order to deliver improved performance and quality of service provision.

Following the success of a number of CMAST initiatives and the establishment of the NHS Cheshire and Merseyside ICB, CMAST's ways of working have been formalised through a Joint Working Agreement, which has passed through each of the Trust Boards. The acute and specialist trusts have identified that a preferred model for their closer collaboration and joint working is to establish a governance structure that, so far as possible within the legislation, enables "group" and common decision-making structures. Each organisation has agreed to establish a committee that has functions delegated to it from its respective Trust which shall work in common with the other CMAST Committees in Common, but which will each take its decisions independently on behalf of its own Board. The CMAST Committees in Common will act collectively through the CMAST Leadership Board.

Through this Joint Working agreement, CMAST will pursue several immediate and short-term programmes of work to ensure the coordination of an effective provider response to current system and NHS priorities including ongoing pandemic response, NHS service restoration and elective recovery, support, and mutual aid, sharing best practice, increasing standardisation, and reducing variation.

The health and care landscape of Liverpool, particularly the acute sector, is unusual with six separate acute NHS organisations serving the local population. The complexity of the landscape is exacerbated by the range of specialist hospitals and services, and the varied financial positions and spectrum of care quality ratings across providers. Consequently, there is greater provider and system fragmentation within the Liverpool boundary. In the context of national policy on provider collaboration, there is a greater opportunity for working together differently and hence the review has focused on opportunities where the benefits to staff, patients and the wider healthcare system can be realised.

Stakeholders spoke extensively about the foundations for closer collaboration that have been set in Liverpool, particularly as a result of managing the Covid-19 pandemic response. During that time, a sense of shared purpose helped to accelerate collaboration and draw on the collective strengths of all partner organisations. A range of clinical examples of previous and current collaboration were cited including the work of the Liverpool Neonatal Partnership, mutual aid during the pandemic between organisations such as the use of paediatric ITU capacity at Alder Hey Children's NHS FT for adults, and stroke services between Liverpool University Hospitals NHS FT and The Walton Centre NHS FT. Additionally there were some limited examples of risk sharing between organisations, specifically for spinal services between Liverpool University Hospitals NHS FT and The Walton Centre NHS FT, and haemo-oncology services between Liverpool University Hospitals NHS FT and The Clatterbridge Cancer Centre NHS FT. Beyond clinical collaboration,

colleagues described opportunities that had been realised in the establishment of CIPHA as a population health management platform across Cheshire and Merseyside, and sharing of new internationally recruited nurses between Liverpool Heart and Chest Hospital NHS FT, The Walton Centre NHS FT, and Liverpool University Hospitals NHS FT.

The engagement that has taken place to date has clearly highlighted an enthusiasm for collaboration, and to build on the existing strengths within the organisations and the ongoing mutual aid arrangements that exists between organisations.

Purpose and scope of the review

CF was commissioned in August 2022 by the Cheshire and Merseyside Integrated Care Board (ICB), NHS Cheshire and Merseyside, with day-to-day oversight from the One Liverpool Partnership Board, to undertake an independent review of the acute care model with a view to identifying opportunities that will improve clinical hospital-based services in terms of clinical quality, efficiency, and effectiveness. The original terms of reference for the review can be found in Annex 1.

The organisations primarily in scope of the review were the six NHS Trusts that are part of the Liverpool Place: Alder Hey Children's NHS FT, Clatterbridge Cancer Centre NHS FT, Liverpool Heart and Chest Hospital NHS FT, Liverpool University Hospitals NHS FT, Liverpool Women's Hospital NHS FT, and The Walton Centre NHS FT.

Other partners core to One Liverpool include general practice, Mersey Care FT, and Liverpool City Council. The North West Ambulance Service (NWAS), the University of Liverpool and Liverpool John Moores University are also key partners to the six acute and specialist providers.

At the outset of the work, colleagues requested a reset of the scope of work. In particular, colleagues felt that the starting point for the review needed to articulate the significant collaborative efforts that were already underway. The revised objectives of the review were to identify and detail how to realise opportunities that optimise the acute care model for Liverpool including co-designing seamless pathways of care for those using services, which provide high quality and safe care, improving equity and integration in terms of access and outcomes, making best use of resources to create long term financial and clinical sustainability and maximising the wider potential of Liverpool City Region.

This revised scope was then socialised through a set of meetings and agreed by One Liverpool Partnership Board on 2 August.

The deliverables agreed were:

- A case for collaboration that sets out the context for, and drivers of, deeper collaboration, the priorities that have been chosen for collaboration and reasons why,
- A blueprint for collaborative opportunities that sets out detail on how to realise the collaboration opportunities chosen and identified areas of challenge and requirements to overcome,
- An articulation of the conditions for success which describe the supporting arrangements that will need to be in place to achieve the domains of collaboration outlined in the case for collaboration, and
- An implementation roadmap which sets out the steps needed to deliver the blueprint and support conditions for success.

Approach to the review

The approach to the review was one of Appreciative Inquiry (Ai), which is an established method to facilitate change that seeks to build on what is already working well. Collaboration opportunities were identified through exploring where strengths can be harnessed, where challenges are shared and where individual challenges need to be addressed collaboratively.

The review was conducted in full recognition of the NHS Long Term Plan, the One Liverpool Strategy, and the strategies of the six organisations. In support of that, over 50 documents were reviewed and considered as part of the review.

The terms of reference highlighted the need to engage with a range of stakeholders, including those beyond the primary scope of the review. The discovery phase of the work engaged almost 300 people with 70 individual interviews, group discussions with each of the acute and specialist provider executive teams and hospital management groups that engaged over 50 people, a GP engagement session with eight PCN clinical leads, and over 150 senior staff from across Liverpool contributing via a staff survey.

The engagement was supplemented by extensive data analysis to sense check and evidence the hypotheses and views expressed in the interviews, discussions, and survey outputs.

The outputs of the discovery work were reflected back, tested, and refined in a series of joint sessions – a small group discussion, a system-wide workshop and as part of a One Liverpool Partnership Board discussion in September 2022. The opportunities that have been identified vary in their detail, reflecting the constraints of the process.

The full interview list can be found at Annex 2 and covers both those people engaged through one-to-one and group discussions. The survey was anonymous. Participants in the workshops and boards meetings, which engaged in the overall findings reflected in this report are also listed in Annex 3.

Representatives from each organisation agreed the next phase of the work should move on to address the most critical issues facing the system, which are the longstanding clinical risks for women's health, current financial sustainability, and operational pressures for emergency care. They also wanted to push recommendations to a tangible level of detail on a subset of opportunities, as opposed to a broad-brush approach on many. Consequently, a gateway review including prioritisation took place as part of a One Liverpool Partnership Board discussion.

For the prioritised opportunities, a series of task and finish groups, involving clinical colleagues from all organisations, was held to work through the detail of the opportunity, with a system workshop to check and challenge the outputs. Participants in each task and finish group are listed in Annex 4 and for the workshop in Annex 3.

The roadmap for pursuing the opportunities was explored in a smaller roundtable discussion and confirmed at the One Liverpool Partnership Board discussion in November 2022. Participants of both meetings are listed in Annex 3.

The rest of this document sets out the case for greater acute and specialist provider collaboration, the priorities for action, and the conditions needed for success, and includes the recommendations of the review.

The case for greater acute and specialist provider collaboration

Twelve collaboration opportunities have emerged through the engagement and collectively these make up the strategic agenda for collaboration between the acute and specialist providers. These opportunities are additive to pre-existing priorities and will in some cases require wider partnerships to deliver on them. They outline a holistic and systematic requirement for collaboration between the acute providers themselves, and collectively with Mersey Care, PCNs, and the local authority, in particular, but also the academic institutions in Liverpool and other stakeholders.

Improving physical and mental health by providing more anticipatory care, especially for people with long term conditions and complex lives, through strengthened relationships with primary care

Liverpool has a higher burden of long-term conditions and multimorbidity than the national average. The consequence of this is an increased use of hospital-based services, which reactively manage deterioration and acute exacerbation as opposed to the proactive anticipatory management that could avoid use of hospital-based services. Liverpool also has one of the highest rates of unplanned admissions for chronic ambulatory sensitive conditions, with an additional 365 people a year admitted to hospital compared to the rest of the country. Much of this activity is from relatively small groups of the population - people with Complex Lives and long-term conditions.

Around 45% of the population have one or more long-term condition (LTC). People with LTCs account for 60% of all A&E attendances, 85% of all hospital admissions, 92% of mental health contacts and 91% of all community contacts. The long-term conditions that affect people living in Liverpool at a higher rate to the rest of England are chronic obstructive pulmonary disease (COPD), coronary heart disease (CHD), obesity, and depression. In Liverpool, there are 80,000 people with high blood pressure, 17,800 people with coronary heart disease and 17,400 with chronic obstructive pulmonary disease. The prevalence of these conditions is similar to the national average although many of these conditions will be co-existing, increasing the burden of disease. Throughout the engagement colleagues reflected on the younger presentation and extent of multi-morbidity in Liverpool.

In Liverpool people with complex lives represent 1% of the population but account for over £43 million spent every year on health and care services, or around 5% of the total locally commissioned expenditure on acute and community and services. They are people who have either:

- One or more physical condition, and one or more mental health condition, and one or more of either homelessness, substance and/or alcohol abuse, history of offending, high intensity use of A&E, history of being looked after, or domestic abuse,
- Or regardless of physical or mental health, three or more from - homelessness, substance and/or alcohol abuse, history of offending, high intensity use of A&E, history of being looked after, or domestic abuse.

People with Complex Lives are twice as likely to use acute hospital services than others and more than ten times as likely to use mental health services. As well as being more likely to access services, the average use of services is also significantly higher for those with Complex Lives, with 2.5 emergency department attendances per year compared to 0.3 for the rest of Liverpool, and 8 mental health contacts per year compared to 0.4.

Colleagues spoke passionately about the significant opportunities for collaboration to provide holistic, preventative, and anticipatory care for people in Liverpool and expressed a strong desire to work in

partnership with primary care to deliver this care. Many of the foundational elements needed, such as an integrated dataset, are already in place in Liverpool through CIPHA and so collaborative effort on population health management could have significant impact. Work to set up multi-disciplinary neighbourhood teams and provide integrated care must begin now for benefits to be realised in the future.

In pursuit of this opportunity, the acute and specialist providers in Liverpool should continue work collaboratively with system partners to support the development of effective place-based partnerships as part of the One Liverpool programme of work to deliver holistic, anticipatory care through multi-disciplinary neighbourhood teams that take targeted action at PCN-level. The CORE20plus5 approach should also be embedded into the One Liverpool strategy and delivery methodology to ensure that prevention and addressing health inequalities are core to the programme of work.

For long term conditions, an anticipatory model of care should be developed and implemented that encompasses case finding, care planning, structured education and self-management, and access to specialist opinion involving a health and social care multi-disciplinary team at a PCN level. For people with complex lives, the anticipatory model should be supplemented by care planning and navigation / co-ordination, rapid response, reablement and a healthy living environment. The One Liverpool Programme already has programmes of work related to both segments and these opportunities should be taken forward by the relevant Segment delivery groups.

Making place-based partnerships a priority ensures that the needs of local populations, at place and neighbourhood level, are being recognised by leveraging collective expertise, insight, and relationships. The objectives of a place-based partnership centre on improving the quality, co-ordination and accessibility of health and care services and this needs to be a focus in order fully to respond to the case for collaboration.

Creating socially inclusive training and employment opportunities for the Liverpool City Region, leveraging anchor institution status to address local deprivation

The position of NHS organisations as major employers and anchor institutions in the Liverpool City Region emphasises the role of a hospital beyond the direct patient care benefits that they deliver. Having a hospital within the community generates wider economic benefits as a result of the jobs it offers. It is also a focal point which can help partnerships between healthcare organisations and communities responding to the wider social determinants of health.

People living in Liverpool are more disengaged from the labour market with long-term unemployment rates twice that of the rest of England (3.9 people per 1,000 working age people in Liverpool vs. 1.9 in England). One in ten people receive Employment and Support Allowances compared to one in twenty in the rest of the country. This is even starker for those with long term health or mental health conditions with more relatively disengagement in the labour market than in the rest of the country.

One consequence of this lack of employment is that Liverpool has the greatest extent of deprivation in the country: two thirds of people in Liverpool are in the most deprived 30% of people nationally, and 8% are in the most deprived 1%. Income deprivation affects four in ten children in Liverpool, the fourth highest rate in the country after Middlesbrough, Knowsley, and Hartlepool. The lack of money (or low income) has been shown to have the strongest impact on children's cognitive, social-behavioural, educational attainment and

health outcomes, independent of other factors[5]. The consequence is increased risk of social and economic disadvantage in early adulthood, which includes lower earnings, higher risk of unemployment or spending time in prison (men) and becoming a lone parent (women)[6,7].Once employed, however people living in Liverpool have better weekly earnings (£480) than in other Core Cities (£465).

There is an imperative to support local people to gain and remain in employment, taking collective action to address local deprivation. Specifically, stakeholders described energy around creating socially inclusive training and employment opportunities through apprenticeship and preceptorship programmes for the Liverpool City Region. While many organisations offer a small number of such programmes already, the collective efforts of the acute and specialist providers in Liverpool could scale and significantly extend the reach of the ongoing work. Many other systems are already working collaboratively on socially inclusive employment to address local workforce challenges, by pooling and making use of unused apprenticeship levies and jointly procure training programmes for apprentices that could be replicated in Liverpool.

Improving outcomes and access to emergency care, making optimal use of existing co-adjacencies at Aintree, Broadgreen, and Royal Liverpool sites

Urgent and emergency pathways in Liverpool are one of the greatest points of pressure for the city, frequently cited by stakeholders as the most significant issue after the sustainability of women's health services in Liverpool. There are challenges with both timely access and poor outcomes, and performance has worsened since the onset of the covid pandemic. In most places access is falling short of national standards, especially with respect to emergency department waits.

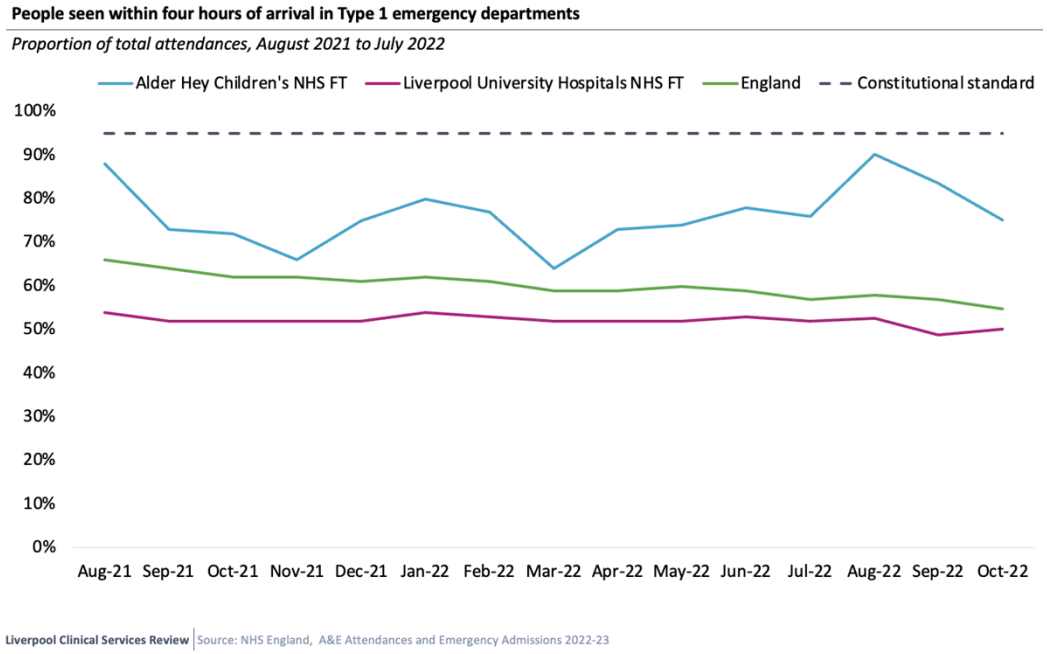


Figure 2: Four hour performance by organisation

[5] Cooper K and Stewart K. Does money affect children's outcomes? An update. London: Centre for Analysis of Social Exclusion; 2017. http://sticerd.lse.ac.uk/dps/case/cp/casepaper203.pdf (accessed 24/10/2022)

[6] Gregg P, Harkness S and Machin S. Child poverty and its consequences. York: Joseph Rowntree Foundation; 1999. www.jrf.org.uk/report/child-poverty-and-its-consequences (accessed 24/10/2022)

[7] Gregg P, MacMillan L and Vittori C. Nonlinear estimation of lifetime intergenerational economic mobility and the role of education. Department of Quantitative Social Science working paper no. 15-03. London: Institute of Education; 2015. http://repec.ioe.ac.uk/REPEc/pdf/qsswp1503.pdf (accessed 24/10/2022)

Liverpool University Hospitals NHS FT sees 52% of people within four hours of arrival at an emergency department. This is 43% below the constitutional standard, and 9% below the national average as set out in Figure 2.

Emergency inpatient services across Liverpool are more commonly provided from only one of the city's five acute sites compared to other areas, with some notable exceptions, which are non-interventional cardiology, respiratory and haematology services. This means that when people need specialist care, they frequently require transfer to another site and their care may become fragmented in some places. For some specialties and conditions, this results in long lengths of stay in the emergency department (Figure 3) and inpatient lengths of stay that are double the national average. This is associated with increased mortality and poorer outcomes for patients.

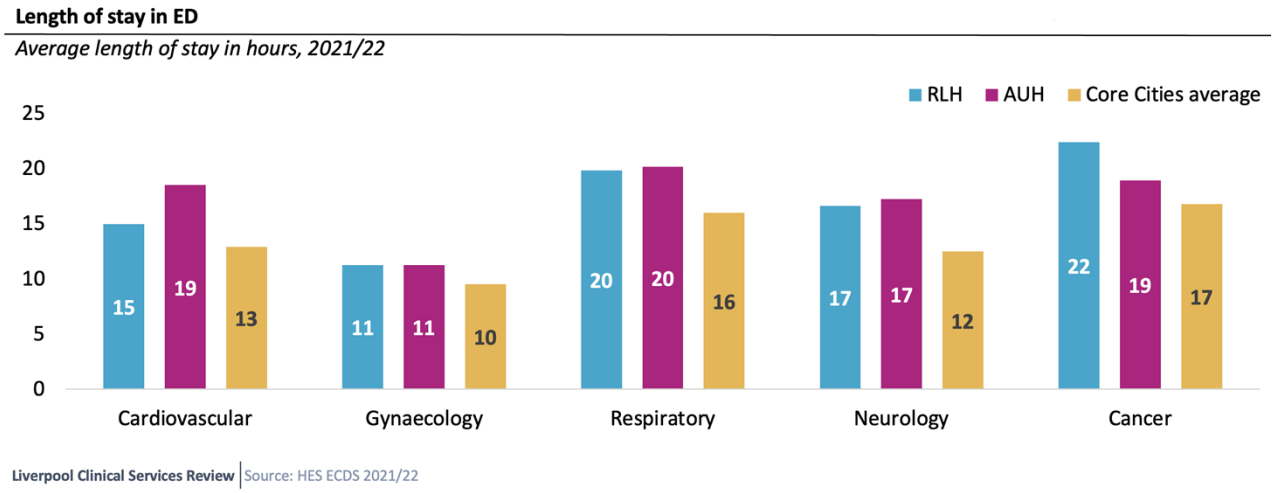


Figure 3: average length of stay in the emergency department by speciality

A specific example of this is care for non-ST elevation myocardial infarctions (NSTEMI). Liverpool has the fifth highest rate of death attributed to heart disease in England, whilst NHS Cheshire and Merseyside ICB is ranked 40 of 42 for access to invasive investigation for NSTEMI within 72 hours of hospital admission. When we consider length of stay for those with a NSTEMI, patients admitted to Aintree University Hospital or Royal Liverpool Hospital who are subsequently transferred to Liverpool Heart and Chest Hospital NHS FT have on average a combined length of stay that is double the length of stay of those who are admitted directly.

NSTEMI is an example of fragmented care and through the engagement it was clear that there were several other groups of people that were not having their emergency needs met through the existing pathways including women, people with head injuries and people with mental health needs.

Opportunities exist across a spectrum of collaboration. This includes sharing best practice, data and information, standardising quality, and performance standards, creating rotational posts and shared roles between organisations, standardising pathways, and ensuring robust protocols and procedures are in place, networking services and consolidating services. Stakeholders agreed it was important to consider this opportunity in more detail to understand where greater collaboration could have the most impact.

Levelling-up performance on cancer and cardiovascular disease to address health inequalities

Cancer is the city's largest cause of premature deaths with 605 deaths under the age of 75 in 2020, representing around a third of all premature deaths in Liverpool.

The impact of the pandemic on cancer care has been significant. The number of people referred for a cancer assessment has grown by 134% over the last 2 years and the number of people on the cancer waiting list has increased by 220% as shown in Figure 4. The 62-day backlog has increased by 241% compared to the pre-Covid baseline, with progress to work off the backlog worsening in recent months with progress to clear the 104-day cancer backlog also having stagnated recently.

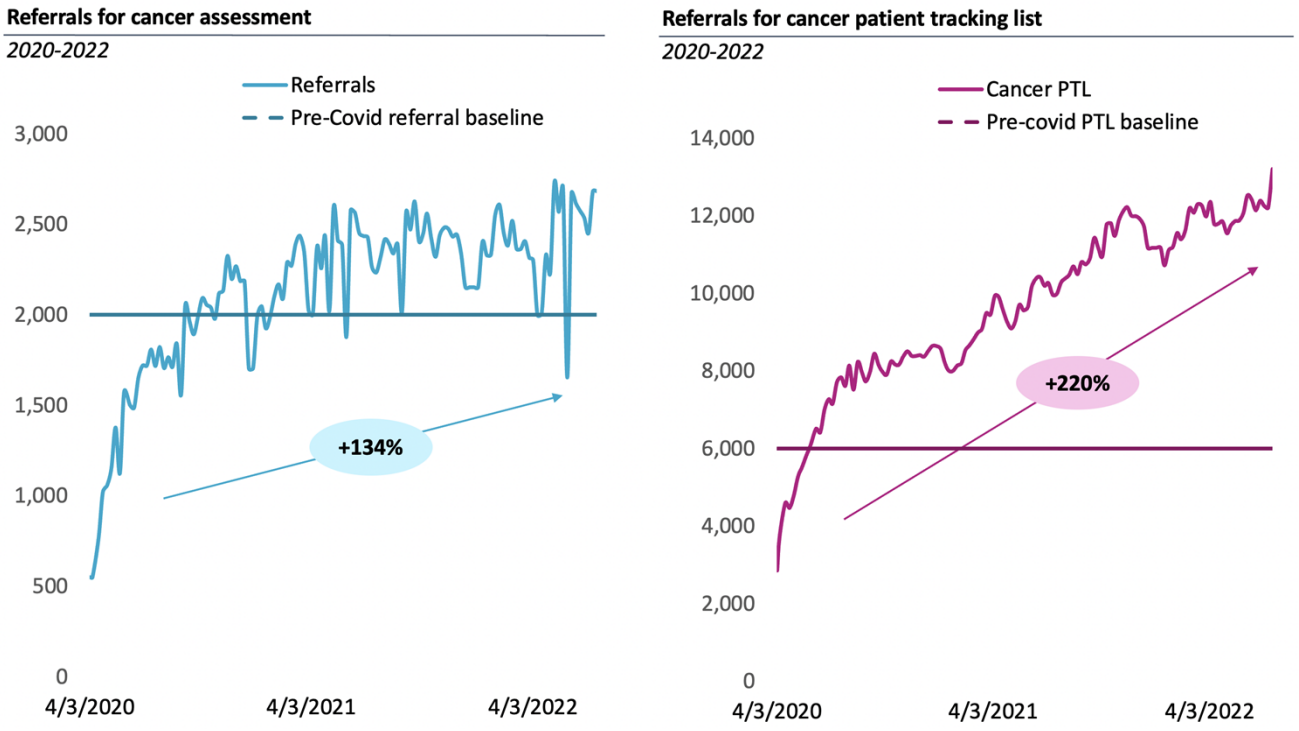


Figure 4: cancer assessment and patient tracking list referrals for Cheshire and Merseyside

This is a significant increase from the pre-pandemic baseline and collaboration between organisations needs to ensure that capacity is directed effectively between planned care backlog clearing efforts. The Cheshire and Merseyside Cancer Alliance is responsible for taking forward cancer recovery efforts including reducing waiting times for diagnosis and treatment, improving awareness of the symptoms of cancer, providing personalised care, and focusing on prevention to stop cancer from developing in the first place.

Every week, three people are diagnosed with cancer in the Emergency Department at the Royal Liverpool Hospital, and this cohort of patients also exposes some clear inequalities - patients diagnosed with cancer in the Emergency Department last year were between 2 and 6 times more likely to be from an ethnic minority than white. We know that cancers diagnosed in ED are likely to be in later stages of disease progression and there is likely to be an impact on survival rates as a consequence. Action to address late diagnosis of cancer and inequalities in access requires a place-based approach involving primary care and local government, working at PCN level to implement culturally sensitive targeted interventions, taking account of local needs. This approach should be endorsed by the Cancer Alliance and could be rolled out to other places in the Cheshire and Merseyside ICS.

Similarly, there are opportunities in cardiovascular disease, which is the second biggest cause of premature mortality in Liverpool, with around 400 deaths a year of people aged 75 and under from all cardiovascular causes. Liverpool has the fifth highest rate of death attributed to heart disease in England and the ninth highest from acute myocardial infarction for men. Cardiovascular disease is considered to be largely

preventable through a healthy lifestyle and the early detection and control of risk conditions; atrial fibrillation (AF), high blood pressure (hypertension, BP) and high cholesterol (the 'ABC' of CVD prevention). While significant progress has been made in diagnosis atrial fibrillation, gaps in hypertension and high cholesterol diagnosis and early treatment exist with only 58.5% of the expected people with high blood pressure diagnosed and of those diagnosed only 57% being treated in accordance with NICE guidelines. Cardiovascular disease and its early diagnosis are associated with deeply embedded inequalities in Liverpool and is the most significant contributor to the gap in life expectancy between the most and least deprived in Liverpool, accounting for 21% of the difference in 2021.

As with cancer care, action to address late diagnosis of cardiovascular disease and inequalities in access requires a place-based approach involving primary care and local government, working at PCN level to implement culturally sensitive targeted interventions, taking account of local needs. This approach should be endorsed by the Liverpool Cardiology Partnership and could be rolled out to other places in the Cheshire and Merseyside ICS.

Providing timely access to high-quality elective care by making efficient use of existing estates and assets

Elective waiting lists have grown across Liverpool by a third every year since 2019 as shown in Figure 5. This rate is expected to increase even further as the post-COVID recovery or 'bounceback' in referrals continues to be seen. While all trusts in Liverpool have seen an increase in the number of people waiting for treatment, Liverpool University Hospitals NHS FT has faced very challenging circumstances with both a significant elective 18 week and 104+ week backlog across multiple specialities. As of July 2022, 49% of patients were seen within 18 weeks with 9,869 waiting more than 52 weeks for treatment at Liverpool University Hospitals NHS FT, and 62 people waiting more than 104+ weeks as of June 2022. Waits of this nature mean that patients are living with painful conditions for longer, and recent research[8] has shown that those who wait more than 6 months for elective surgery will have a 50% increased chance of worse outcomes – a far shorter period than the 52 weeks many patients have waited already.

[8] Cisternas, Alvaro F.a; Ramachandran, Roshnia,*; Yaksh, Tony L.b; Nahama, Alexisa Unintended consequences of COVID-19 safety measures on patients with chronic knee pain forced to defer joint replacement surgery, PAIN Reports: November/December 2020

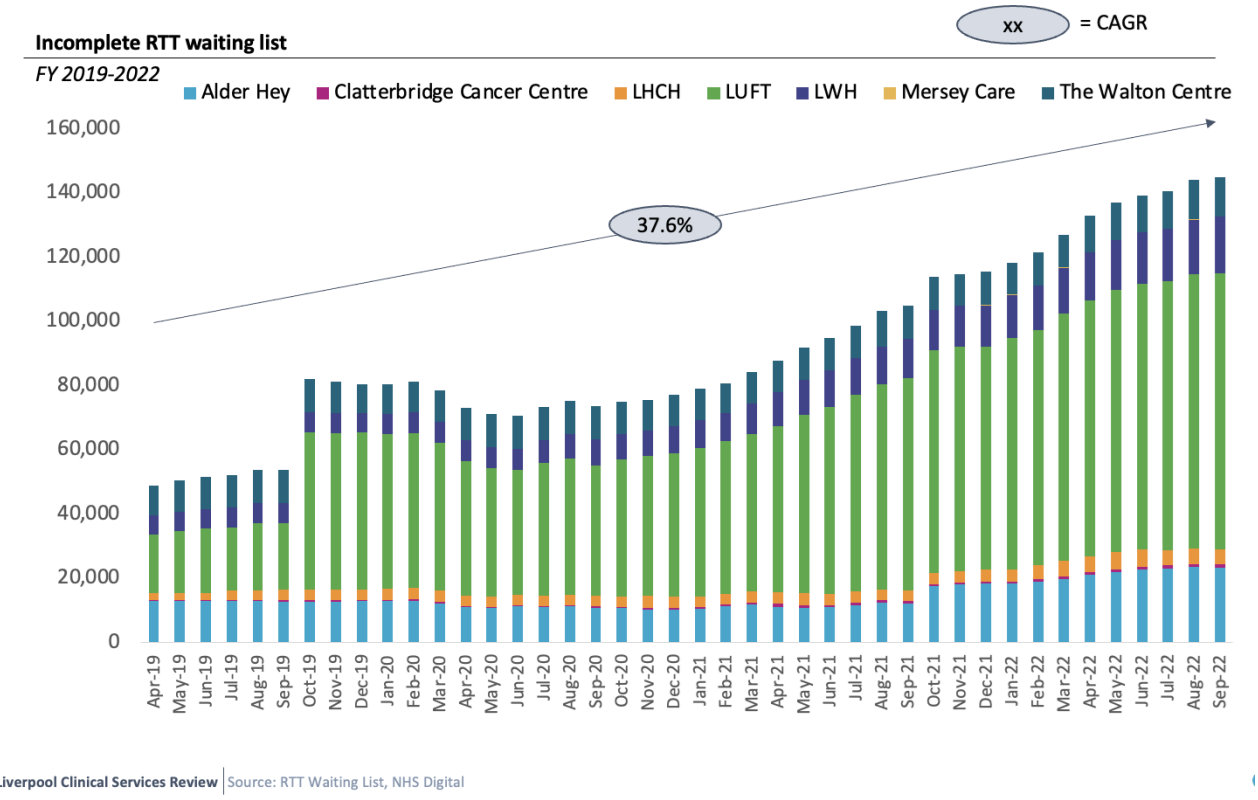


Figure 5: incomplete referral to treatment waiting list

Working through the elective backlog will be long-term challenge, given the continued 'bounceback' and the size of the current waiting list. The service changes set out by Liverpool University Hospitals NHS FT following its formation seek to create a split between elective and emergency activity, concentrating the former at Broadgreen. Implementation of this new configuration will not be immediate and, beyond this there is also an opportunity in the short to medium term to think about how to make efficient use of existing estates and assets across the city.

Following the pandemic, the Cheshire and Merseyside Acute and Specialist Trust Provider Collaborative (CMAST) mobilised a programme of work focusing on elective recovery efforts. The programme seeks to recover activity levels to pre-Covid levels and exceed them, reduce the waiting list and treatment backlogs, and transform pathways to deliver resilient pathways in the longer term.

Within Liverpool, all organisations in the city have physical theatre capacity that could be used between organisations more effectively to provide timely access to high quality elective care. An example of this in practice during the pandemic was the provision of ophthalmic surgery at the Crown Street site. Collaboration at the Liverpool footprint should be pursued alongside CMAST efforts on the basis that the any negative impact to access to care is minimal between these providers, and currently represents an underutilisation of system capacity.

Providing an increase to the level of elective capacity, where patients have a far lower risk of their procedure being cancelled or postponed due to emergency pressures, provides greater resilience in the system. This benefit is conferred when it is needed most, during periods of particularly high demand, such as winter, when elective performance typically suffers. In addition to the patient benefit, the ability to provide protected elective services offers more effective and attractive training opportunities and a potential opportunity to consider repatriation of activity from outside of Liverpool. There are also central

incentives for ICSs to recover elective activity to above pre-pandemic levels and collaborative efforts within and even beyond acute and specialist providers in Liverpool would support collectively achieving the funding available through the Elective Recovery Fund.

Solving clinical sustainability challenges affecting women's health in Liverpool

Overwhelmingly, the most important challenge stakeholders identified as needing to be addressed was clinical sustainability of services for women in Liverpool and the associated clinical risk. The Liverpool Women's Hospital NHS FT is a maternal medicine centre, has a world-leading reproductive medicine unit, and provides tertiary services across its full portfolio of specialities. The Liverpool Women's Hospital NHS FT main hospital site at Crown Street is isolated from other adult services in Liverpool meaning it is less able to manage acutely ill or rapidly deteriorating patients, women with complex surgical needs and significant medical co-morbidities. There is a lack of specialist expertise on site to render assistance, intensive care facilities and critical care outreach services, 24-hour laboratory services to support diagnosis, monitoring and intervention, therapies and recovery support, a blood transfusion laboratory suitable for the management of major haemorrhage, and imaging facilities to support timely diagnosis. Specifically, seven of twelve co-dependencies for maternal medicine centres (and therefore for consultant-led obstetric services) are not currently met at the Crown Street site. Additionally of the 1,132 standards for service delivery, currently 118 are not met by the Liverpool Women's Hospital NHS FT, and 75 of these are not met as a consequence of being on an isolated site.

Services should be co-located in the same hospital
Adult critical care
General and obstetric anaesthetics
Neonatology: L3
Emergency general surgery
Acute medicine
Acute stroke
General cardiology
Interventional radiology
X-ray
Obstetric ultrasound
Urgent access to CT scan
Emergency haematology and biochemistry

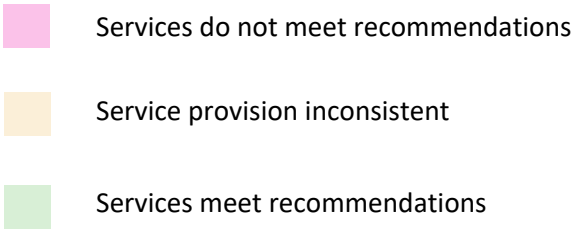


Figure 6: co-dependencies met for maternal medicine centre and consultant-led obstetric unit

Similarly, other adult acute sites in Liverpool do not have co-located women's services and are therefore less able to meet women's medical needs, including women who are pregnant, when they present at the emergency department or who are inpatients at other sites.

A number of groups are particularly impacted by the configuration of services across sites:

- Women with complex conditions who need specialist care while pregnant as their birth is classed as 'high-risk'
- Pregnant women needing intensive care while giving birth
- Babies requiring complex surgery after birth followed by specialist neonatal care

- Women needing intensive care while undergoing surgery for a gynaecological issue
- Women with complex conditions who need acute medical or surgical input
- Women admitted to LWH with acute medical or surgical problems needing general or specialist opinion
- Women with complex gynaecological issues requiring surgery and those with gynaecological cancers requiring surgery

The consequence of this is that women and babies are transferred by ambulance between sites to receive the care they need. LWH has the one of highest rate of transfers in the country for mothers and their babies with 11 transfers for every 1,000 discharges.

LWH is the only specialist obstetric and gynaecology service provider in the country in such an isolated position. This has created a significant gender inequality in access to services and suboptimal quality of care for women and their families, as well as increased risks for clinical and care staff to manage, both at the Crown Street site and other acute sites across Liverpool. The current risks have a multitude of impacts including difficulties in recruitment and retention, particularly for gynaecologists and anaesthetists, and an inability to meet national care standards. They are also driving increased clinical negligence costs for LWH with maternity CNST costs per £100m the highest in the country by a significant margin, over and above what those costs that are driven by the case mix and highly specialised service provision at the Liverpool Women's Hospital NHS FT.

While many risks have been mitigated or worked around, stakeholders spoke extensively about their concerns for the safety of women and babies whose condition deteriorates while within the hospital and the subsequent risk of being transferred across the city.

Combining expertise in clinical support services to provide consistent services across the city

Stakeholders have spoken enthusiastically about the collaboration that already takes place for delivering clinical support services, both within the city, such as Liverpool Clinical Laboratories, and as part of the ICS, such as Cheshire and Merseyside Radiology Imaging Network (CAMRIN). There was widespread recognition that there was still scope for further collaboration to combine expertise in clinical support services. The imaging and pathology networks sit within the overarching CMAST Diagnostic Programme, which brings together all diagnostic networks, including endoscopy, Community Diagnostic Centres, physiological testing, primary care diagnostics and digital in diagnostics. This dedicated programme of work is focused on diagnostics with focus on driving forward and facilitating collaboration, improving productivity, reducing waiting and reporting times, and ensuring only clinically appropriate tests are carried out.

Diagnostic imaging
Diagnostic tests, both imaging and reporting, have seen increased waiting times in 2022 compared to 2021 for six week waits, which reached a peak of 45% of the waiting list, and 13 week waits, which reached a peak of 25% of the waiting list.

Trusts within Cheshire and Merseyside have been working collaboratively since they joined together to procure their Radiology Information System (RIS) and Picture Archiving Communication Software (PACS) in 2012. This approach was ground-breaking and the first of its type in England and it is now seen as the gold standard for imaging networks. Since 2016, 12 Trusts across the ICS have come together to work on a large-scale change programme to improve services for patients and staff. Opportunities continue to exist to unify

systems as well push innovative practice further in this space including implementing the use of AI at scale in radiology.

One of the biggest challenges facing the service is the scale of the workforce challenge and while work is ongoing at the ICS level, stakeholders identified opportunities for further collaboration, specific to the acute and specialist Trusts in Liverpool. Joint radiology training posts and appointments between the organisations in Liverpool were thought to be valuable to support recruitment and retention of staff.

As with elective backlogs, collaboration to address 6- and 13-week backlogs for diagnostic imaging services at the Liverpool footprint should be pursued alongside CMAST efforts on the basis that the any negative impact to access to care is minimal between these providers, and currently represents an underutilisation of system capacity. These opportunities should be taken forward specifically by the Imaging workstream and the Imaging Network Management Group which forms part of the CMAST Diagnostic Programme.

Pathology

There is significant work underway to develop the Cheshire and Merseyside Pathology Network and consolidate pathology services across the footprint. The direction of travel has been consolidation of pathology services to concentrate expertise and deliver targeted investment to strengthen a regional pathology network. Following the formation of Liverpool University Hospitals NHS FT, Liverpool Clinical Laboratories (LCL) developed as a successful partnership between three organisations: Liverpool Heart and Chest Hospital NHS FT, Liverpool University Hospitals NHS FT, and Liverpool Women's Hospital NHS FT. LCL employs over 500 staff and processes the sixth highest volume of laboratory tests in England.

Stakeholders expressed that there was an opportunity for other organisations to take part in LCL and support its ambition to become a centre of excellence for clinical diagnostic and investigation services. To realise this opportunity, ways of working between existing organisations in the collaboration as well as any new partners need to be reset and worked through.

This opportunity should be taken forward specifically by the Pathology workstream and the Pathology Network Management Group of the CMAST Diagnostic Programme.

Pharmacy

Currently acute and specialist organisations in Liverpool collectively spend £11.4 million on pharmacy services for the city. Some organisations provide their services separately to one another, including having duplicated services on the same site. Colleagues described the pharmacy workforce as being particularly fragile due to increasing workloads and a lack of funding and opportunity for training opportunities for pharmacists.

The Transfers of Care Around Medicines initiative between Cheshire and Merseyside trusts and community pharmacies has saved £11 million over three years and an estimated 6,008 bed days[9] through medication reviews after discharge in the community. This collaboration is believed to be the fastest and widest roll-out of any such initiative in England, demonstrating the scope for further collaboration in this space.

[9] https://www.pharmacynetworknews.com/health-nhs/cheshire-and-merseyside-pharmacies-help-save-nhs-11-million

For future collaboration, stakeholders identified opportunities similar to those for radiology, with joint appointments as an opportunity to address the sustainability and resilience of the pharmacy workforce. This would enable better training opportunities for pharmacy staff with a broader range of experience and specialisms, which would in turn support recruitment and retention.

Colleagues also thought there would be benefit in pursuing a partnership model similar to the LCL to provide a single pharmacy function across Liverpool, recognising that collaboration on pharmacy services for the Aintree and Broadgreen sites already exists. Leveraging the scale of this service would enable pharmacists to spend more time on clinical services, and less time on infrastructure or back-office services[10]. This in-turn would allow pharmacist to drive medicines optimisation on wards in hospitals, thereby securing better outcomes for patients and better value for money.

Developing world-leading services in Liverpool by realising the collaborative potential in innovation, research, and clinical trials

Over the years, the research and education infrastructure of Liverpool has had healthy investment, with significant resources available across the city region. Stakeholders almost universally reflected that there were opportunities to leverage this infrastructure. There are two NIHR funded Clinical Research Facilities (CRF) in the city, one at the Royal Liverpool Hospital and the other at Alder Hey Hospital. These are two of 28 research facilities across the UK funded by the NIHR, and Alder Hey's CRF is one of two exclusively for paediatric patients in the country. Funding for these facilities has been granted until 2027. Organisations in Liverpool are estimated to have a combined income of c.£104 million annual for research and development in 2021/22, of which £31.6 million is Trust based and £73 million is allocated to academic institutions.

The acute and specialist trusts in Liverpool work in partnership to deliver the Liverpool CRF with 26 beds at the Liverpool University Hospitals NHS FT, units at the Clatterbridge Cancer Centre NHS FT, and at the Liverpool Heart and Chest Hospital NHS FT. The CRF at the Royal Hospital sites has more than doubled in size from 12 beds to 26 beds as part of the move to the new hospital. The CRF was instrumental in responding to the COVID-19 pandemic, working in partnership with academics at the University of Liverpool and Liverpool School of Tropical Medicine to test and develop vaccines and medicines to combat the virus.

As well as the CRF, organisations in Liverpool are involved in wider research collaboration. Examples include:

- Liverpool has an Experimental Cancer Medicine Centre (ECMC), which is a collaboration between the University of Liverpool (Liverpool Clinical Trials Centre and Good Clinical Practice Laboratory Facility) and The Clatterbridge Cancer Centre NHS FT
- The Clatterbridge Cancer Centre NHS FT is also part of a Biomedical Research Centre (BRC) with The Royal Marsden NHS FT, The Institute of Cancer Research (ICR), and City, University of London, which is the only BRC specifically focused on cancer

[10] Department of Health and Social Care, 2015. Operational productivity and performance in English NHS acute hospitals: Unwarranted variations. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf

- The Liverpool Centre for Cardiovascular Science (LCCS) has also been formed as a strategic research platform between University of Liverpool, Liverpool Heart and Chest Hospital Trust, Liverpool John Moores University and Liverpool Health Partners
- The Liverpool Neuroscience Biobank at The Walton Centre (LNBW) was established to promote multidisciplinary basic and translational neuro-oncology and neurology research working in Liverpool and within the Brain Tumour North West Collaboration.

Despite the investment in clinical research, clinical trial participation per 100,000 of the population in Liverpool is lower than Core City peers. Clinical research brings significant benefits to the patient population and studies have shown that Trusts with the best emergency mortality outcomes were those that were most active in clinical research[11]. A systematic review by the Health Services and Delivery Research programme, suggested that engagement with clinical research by individuals and healthcare organisations increased the likelihood of a positive healthcare performance.

The NIHR-INCLUDE commission, which sought to address the lack of representation in health and care research, identified the socio-economically disadvantaged, unemployed, and those on low income as under-represented groups in research[12,13]. Liverpool presents an opportunity to enhance research for such under-represented groups. People living in the city have some of the most challenging social issues in the UK, which means there also is a chance for research to make an impact on health where it is needed most.

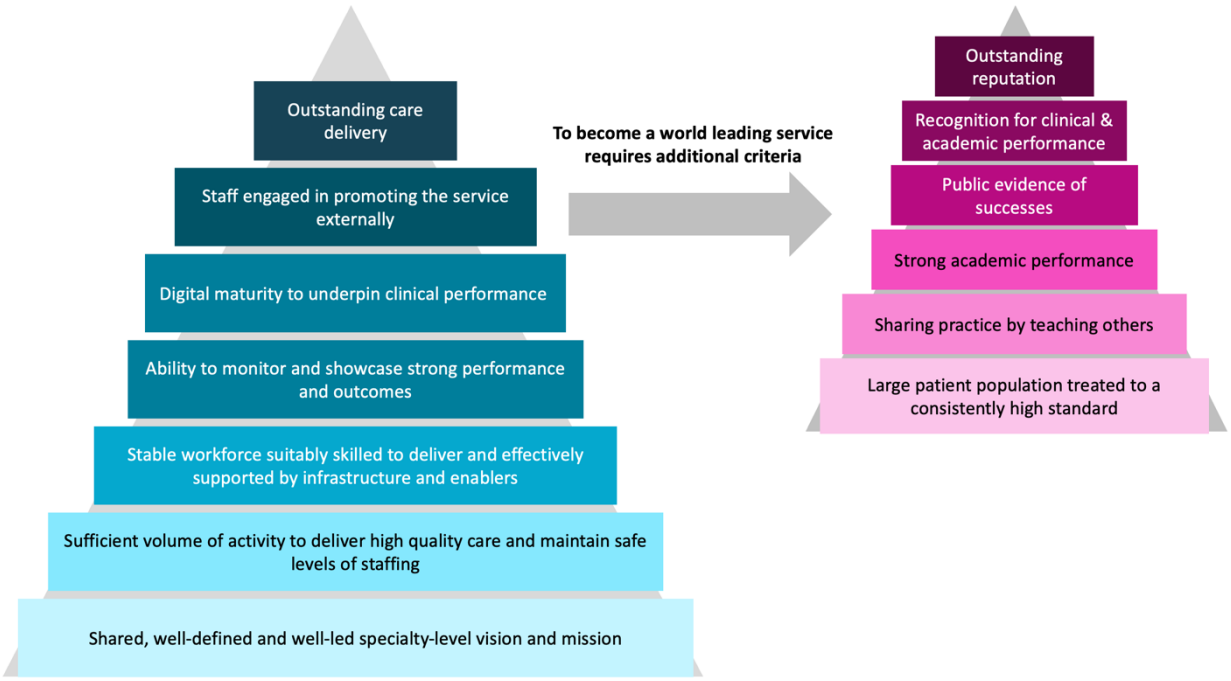


Figure 7: world-leading services framework

[11] Research Activity and the Association with Mortality, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4342017/

[12] NIHR (2020) Improving inclusion of under-served groups in clinical research: Guidance from the NIHR-INCLUDE project. UK: NIHR. Available at: www.nihr.ac.uk/documents/improving-inclusion-of-under-served-groups-in-clinical-research-guidance-from-include-project/25435 (date accessed: 21/10/2022)

[13] NIHR (2020) Ensuring that COVID-19 Research is Inclusive: Guidance from the NIHR CRN NIHR-INCLUDE project. UK: NIHR. Available at: www.nihr.ac.uk/documents/ensuring-that-covid-19-research-is-inclusive-guidance-from-the-nihr-crn-include-project/25441 (date accessed: 21/10/2022)

In addition, being able to harness the research and innovation potential across the Trusts is vital in fulfilling the criteria to becoming world leading services. The 'Outstanding' reputation that many of the acute and specialist Trusts have for service delivery from the CQC can be built upon to deliver world-leading services. A strong academic strategy will support delivery of the world leading services by attracting research funding and investment, talent, and driving quality as set out in Figure 7.

The research and innovation agenda for the city should be pursued through a refreshed scope of the Liverpool Health Partners (LHP), working with all existing partners and additionally include Liverpool City Council and Applied Research Collaboration North West Coast. The refreshed scope of the LHP should consider:

- Delivering data-enabled clinical trials from end-to-end by using routine data rapidly to identify potential trial recruitment pools, recruiting participants through a single point of entry, and tracking them through a trial using data collected from routine sources and telemedicine
- Establishing a hub to act as a single point of planning and operations for organisations interested in running a clinical trial in Liverpool, supported by spokes that support recruiting participants and facilitating ongoing monitoring

Attracting and retaining talent across Liverpool, providing a more joined-up offer for staff

Health and social care is the largest employer in the Liverpool City Region, employing 117,000 people. Across the six organisations, around 25,000 people were employed and £1.29bn was spent on workforce costs in 2021/22. As a result, the workforce agenda between the acute and specialist trusts is significant and has far reaching consequences into the community.

According to senior staff, the biggest challenge to ongoing service delivery is recruitment and retention of staff (Figure 8). This reflection is supported by data and is seen to manifest in several ways:

- The turnover rate for medical staff is relatively high, ranging between 20% to 35% across the Trusts, with four of the six organisations having a rate above the national median of 30%.
- Staff motivation shows room for improvement with staff reporting on or below average motivation scores in five out of six organisations.
- Satisfaction with training programmes is also variable across Liverpool with overall satisfaction lower than the national average at four out of six organisations.
- Use of bank and agency staff is high, and competition for capacity in the same staff groups leads to often escalating rates paid out to staff and subsequently disproportionate spend on agency and bank rates.

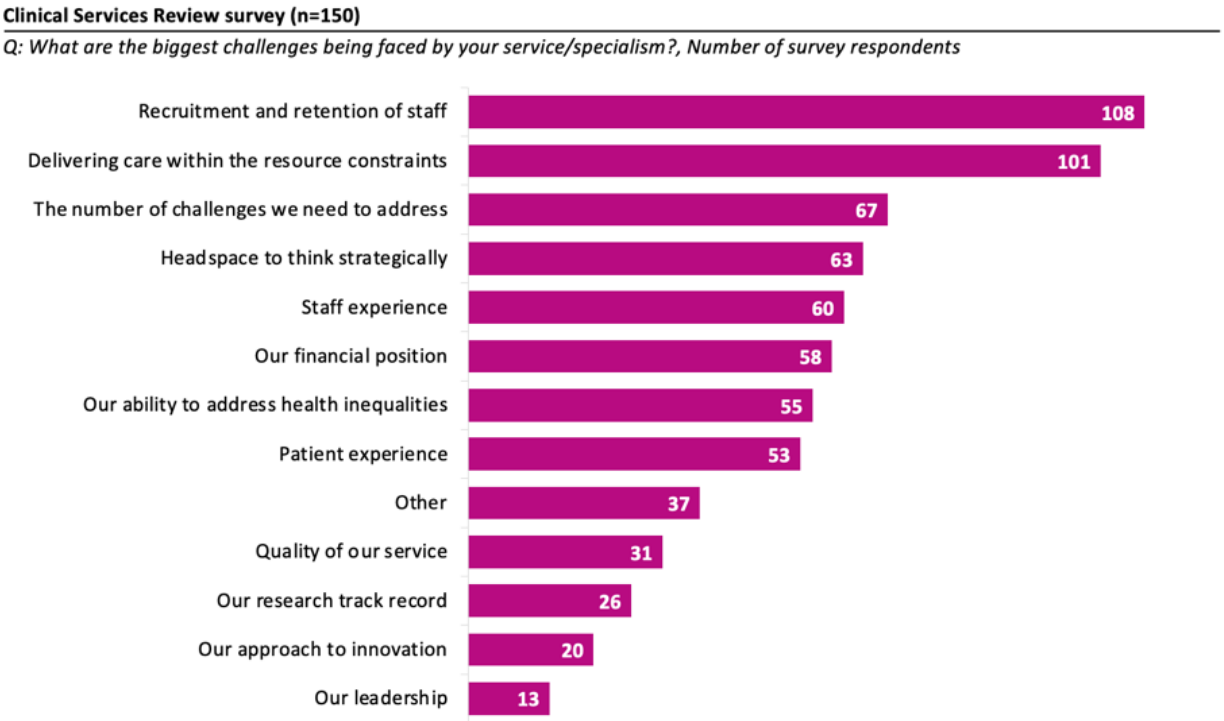


Figure 8: Liverpool Clinical Services Review survey - biggest challenges faced by your service responses

Colleagues also consistently described how competition between Trusts magnifies this challenge in particular in relation to staff groups that are common to all organisations, such as theatre staff.

To address these issues, stakeholders described a host of different opportunities in this space to work collaboratively to attract and retain talent at all levels. These included an integrated training and development offer, implementing staff passports, standardising policies, collective workforce planning, and joint recruitment. Working together to create a strong employer brand could improve recruitment and retention rates, reduce recruitment costs, and increase pride amongst staff.

A consistent theme in the opportunities described was the opportunity to integrate training, education, and development for staff. The collective scale and the diversity of work within the organisations allow for a greater range of programmes, and more varied training opportunities to be offered to all staff. Colleagues also described how each organisation had its own leadership development training and that a joint programme in this space could support colleagues to lead for collaboration. Colleagues also felt that implementing staff passporting mechanisms would not only improve often lengthy mandatory and staff training requirements, allowing faster recruitment, but would enable the movement of staff seamlessly between sites and support filling gaps in staffing at other organisations.

Working together could allow all organisations to set a single set of policies and prices for temporary staffing, allowing for a more consistent level of spend between them particularly given financial constraints. Work to set up a collaborative bank also has the potential to release significant savings, as well as bring greater flexibility of working for staff.

Through CMAST, there is an existing Workforce Programme focused on addressing system workforce pressures and leading on workforce development that should support the implementation of this

opportunity. In the longer term, recognising the inherent challenge for the health and social care workforce as a whole, organisations in Liverpool should work together to standardise workforce models and proactively identify roles that will be particularly difficult to recruit for. This should be done in conjunction with the implementation of new proactive models of care that provide preventative and anticipatory care.

Achieving economies of scale in corporate services

Another area where stakeholders were able to clearly articulate the potential for closer working was corporate services and leveraging the expertise across organisations and economies of scale in doing so. Across all organisations in Liverpool, £132.4 million is spent on corporate services (2021/22) and the majority of trusts spent more on corporate services per £100 million income than trusts in the Core Cities as shown in Figure 9. In 2020/21[14], all organisations in Liverpool spent more on finance and HR corporate functions for every £100 million of income earned than the national lower quartile.

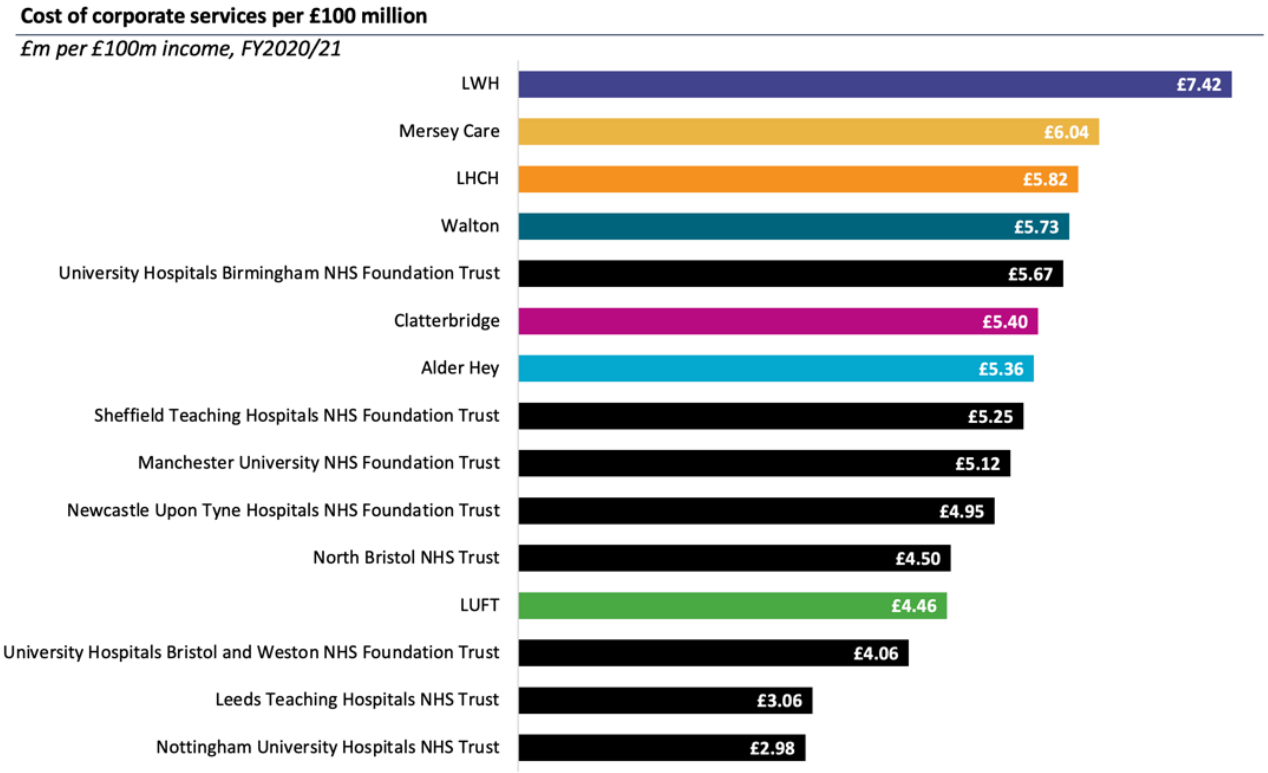


Figure 9: cost of corporate service per £100 million income by organisation

Post-covid there is more collaboration than ever, with a joint procurement function having been set up between The Walton Centre NHS FT, Clatterbridge Cancer Centre NHS FT, Alder Hey Children's NHS FT and Liverpool Heart and Chest Hospital NHS FT. There are also opportunities to build on, including the joint digital service that has been established between Alder Hey Children's NHS FT and Liverpool Heart and Chest Hospital NHS FT. Scaling these collaborative efforts further and applying them to other corporate services including HR, Finance, Estates and Facilities and IM&T has been recognised as a point of focus in addressing the financial challenges faced by the system. Specifically, collaborative working between the trusts would encourage a uniform approach to the delivery of corporate services, freeing up resource by

[14] Note: these figures pre-date the collaboration on procurement and the Clatterbridge Cancer Centre currently hosts the Cheshire and Merseyside Cancer Alliance along with other ICS function which inflates their position.

doing a greater number of tasks once between the organisations. As well as reducing cost and duplication, maximising this opportunity allows expertise across the city to be shared and leveraged for the benefit of all.

The case for collaborating on transactional services that could be more efficiently done once for all organisations is made clearly through payroll, in recognition of the work already undertaken on behalf of the system by St Helens and Knowsley Teaching Hospitals NHS Trust. This could be expanded to other areas where services are process and system based including HR services such as recruitment checks, finance administration and IT support, and should be addressed at pace.

With respect to facilities such as catering, colleagues also felt there would be significant benefit, both operational and financial, in joint procurement of services to leverage the scale of multiple organisations in the negotiation of contracts. Taking this further still, stakeholders saw an additional opportunity to support local economic growth by jointly procuring these services with local organisations, or potentially even bringing the services in-house with a host organisation to lead this.

In working these opportunities through, the different models for collaboration and consolidation of corporate services should be considered from retaining in-house functions and hosting to fully outsourcing services to external providers.

An existing programme of work pursuing this opportunity is being led by the Cheshire and Merseyside Acute and Specialist Provider Collaborative, through the Efficiency at Scale workstream of the Finance, Efficiency & Value Programme. The specific opportunities outlined in this opportunity should also be considered as part of realising the opportunity to deliver the emergency pathway (opportunity 3).

Building on and integrating digital investments to unlock innovative approaches to delivering care and achieving commitments to environmental sustainability

The Long-Term Plan is explicit about the need for digitally enabled care to become mainstream, and stakeholders across Liverpool are enthusiastic about the potential benefits of drawing on a greater range of digital solutions to support patient care.

There has been significant investment in digital systems across the city with some organisations achieving international recognition for their efforts, but there is more work to do in order to bring all organisations up to the same standard. More than ten EPR and PAS systems are in use across organisations in Liverpool which limits interoperability, and even where organisations are using the same software company, functions to support interoperability have not been deployed or are not made use of. Currently only Alder Hey Children's NHS FT and the Clatterbridge Cancer Centre NHS FT have invested in HL7 Fast Healthcare Interoperability Resource application programming interfaces.

While there is longstanding agreement that a place-based or system-based approach should be taken for EPR procurement in line the with national process that has been set up, re-procurement of services is still a way into the future for some organisations. Stakeholders spoke extensively about the opportunity to ensure that current procurement efforts are aligned to collective future ambitions and are future proofed for interoperability.

Alongside EPR systems, colleagues also describing the host of other software used such as Sunquest ICE for pathology services that are currently not deployed across all organisations. A specific example cited was at the Broadgreen site where pathology information such as blood test results are not visible between Liverpool University Hospitals NHS FT and Liverpool Heart and Chest Hospital NHS FT.

Digital solutions can also be put in place to support more anticipatory care closer to the home. Mersey Care NHS FT hosts the largest telehealth service in Europe and the service currently supports around 2,000 patients a day with long-term conditions such as COPD, diabetes, and heart failure across its catchment, with significant success in terms of outcomes for patients and reducing hospital visits. The benefits of using the service were particularly apparent for many stakeholders during the pandemic. However, colleagues also described these services as being underutilised in Liverpool and saw opportunity for clinical teams to work together to make better use of existing services and to expand their scope to meet the needs of local people.

A longer-term commitment for the city has been to implement a shared care record. The Share2Care record has been developed as Cheshire and Merseyside's Local Health and Care Record, providing a repository for key documentation through E-xchange. However as of December 2020, some organisations in Liverpool do not publish or view data using this platform including the Liverpool Women's Hospital NHS FT, some sites of the Liverpool University Hospitals NHS FT, Mersey Care NHS FT, and primary care. This should be resolved and pursued at a system level, docking into the ICB Digital Programme to ensure that there is consistency across the ICS.

Making best use of resources to secure financial sustainability for all organisations in Liverpool

Currently, NHS organisations in Liverpool are in financial deficit with an aggregated reported deficit position of £12.3 million at YTD (August 2022/23), which is expected to deteriorate further over the rest of the financial year.

The Cheshire & Merseyside ICS allocation per head to NHS organisations remains higher than all other core cities with the overall allocation due to decrease by c.£300 million over the coming years. Alongside this the new Specialised Commissioning allocation will mean that Cheshire and Merseyside will be allocated £50 million less income from specialised commissioning. Local government in Liverpool and across Cheshire and Merseyside has also seen one of the largest decreases in real terms spending power since 2010 with a decrease of £700 per head of the population.

This sets the context for needing to stabilise the current position before it deteriorates further and start to prepare for the future challenge ahead. Throughout the review, colleagues have reflected on the financial pressures and sustainability challenges faced in Liverpool and how opportunities to collaborate could seek to address these challenges. Each of the opportunities outlined have either a direct or indirect financial benefit that organisations can realise:

i. Colleagues spoke extensively about reducing cost through supporting more proactive anticipatory models of care, and reducing the number of high-cost interventions required in hospital
ii. Reducing duplication of effort and excess lengths of stays associated with fragmentation of emergency pathways
iii. All trusts have an opportunity to increase theatre utilisation and elective productivity, which would allow for more treatment to be delivered at a lower cost

iv. Increasing the elective throughput will help to prevent conditions from worsening and requiring more expensive care in the long-term
v. Increasing elective throughput will also help to keep profitable procedures within the NHS, rather than allowing them to go to the private sector
vi. Improving cancer and cardiovascular care to promote earlier diagnostics, will allow for earlier interventions, which are generally less expensive
vii. Reducing the number of transfers needs for women and babies across Liverpool to access services by resolving co-dependencies
viii. Reducing the level of spend on bank and agency staff by supporting staff recruitment, retention and health and wellbeing
ix. Improving the research offer will allow for greater income to be received from clinical trials and attract investment from life science companies. It will also contribute to improving the reputation of the organisations, which can also attract further investment for the city
x. Improving digital investment in care models will support more proactive and less expensive models of care
xi. Doing a host of corporate activities once between organisations will free up resource to be directed and invested elsewhere

In responding to the case for collaboration, we recommend:

The twelve opportunities in the case for collaboration should be adopted by the six acute and specialist providers in Liverpool as their strategic agenda for working together. For four of the opportunities, wider partnerships are required, which should be forged to ensure progress, specifically:

a. Improving physical and mental health by providing more anticipatory care (opportunity 1) requires working through the One Liverpool Partnership with General Practice, Liverpool City Council and Mersey Care NHS FT,
b. Levelling-up performance on cancer and cardiovascular disease to address health inequalities (opportunity 4) requires working through a place-based partnership endorsed by the Cheshire and Merseyside Cancer Alliance and the Liverpool Cardiology Partnership respectively,
c. Work with all existing partners of the Liverpool Health Partners to pursue the research and innovation agenda (opportunity 8) and additionally include Liverpool City Council and Applied Research Collaboration North West Coast. This effort could be expanded to include interested providers across Cheshire and Merseyside ICB,
d. The longer-term digital agenda (opportunity 11), which requires working through the Cheshire and Merseyside ICB as part of the Digital Programme,
e. To solve clinical sustainability challenges affecting women's health (opportunity 6), work with the Cheshire and Merseyside ICB (see recommendation 4).

For the further five opportunities there is a synergy with the agenda of the Cheshire and Merseyside Acute and Specialist Trust Provider Collaborative and consequently the work should be undertaken in the view of the Collaborative and in line with its governance. The starting point for realising the opportunities identified in this review should be the six organisations in Liverpool. Only once tangible progress is made within this scope should it be broadened to a wider geography. This includes:

a. Address elective care waits and backlog (opportunity 5) through the Elective Recovery and Transformation Programme,
b. Combine expertise in clinical support services (opportunity 7), in part through the Diagnostics Programme,
c. Attracting and retaining talent across Liverpool, providing a more joined-up offer for staff (opportunity 9) through the Workforce Programme,
d. Realise economies of scale in corporate services (opportunity 10) through the Efficiency at Scale workstream of the Finance, Efficiency & Value Programme, and
e. Making best use of resources to secure financial sustainability for all organisations in Liverpool (opportunity 12) through the Finance, Efficiency & Value Programme.

Priorities for action

Several opportunities are already being taken forward by programmes of work as part of implementing One Liverpool, the Liverpool Health Partners, and as ICS-wide programmes of work through CMAST and the Cancer Alliance. In these areas there is ongoing work, which can be supplemented by the findings and opportunities identified in this review.

To take the prioritised programmes of work forward, we recommend:

A rolling programme should be established, building on relevant pre-existing programmes, to take forward the opportunities for implementation. Overall, it will take a number of years to realise the potential benefits from this effort. The work should start by leveraging efforts already underway. Pre-existing programmes should incorporate the findings of the review into their ongoing work by undertaking a stocktake of existing workstreams, specifically:

a. Address inequalities in cancer diagnosis (opportunity 4) through the Early Detection workstream and Health Inequalities and Patient Engagement Programme, of the Cheshire and Merseyside Cancer Alliance, and
b. Provide anticipatory care to improve physical and mental health (opportunity 1) through the Complex Lives and Long Term Conditions Segments, of the One Liverpool Programme.

As transformational change becomes business as usual, priorities should be reassessed and agreed.

Colleagues agreed that the review should move on to address the most critical issues facing the system, which are longstanding clinical risks for women's health, current financial sustainability, and operational pressures for emergency care. Two priorities were aligned upon as a core focus for collaboration in the coming period:

1. Solving clinical sustainability challenges affecting women's health in Liverpool
2. Improving outcomes and access to emergency care, making optimal use of existing co-adjacencies at Aintree, Broadgreen, and Royal Liverpool sites

The collective financial challenge faced by Liverpool was considered to be underpinning and should be threaded through all collaboration opportunities. This was explicitly considered as part of realising the two opportunities prioritised and the opportunity benefit is articulated throughout this document.

Solving clinical sustainability challenges affecting women's health in Liverpool

In exploring this opportunity, it was recognised that extensive work has been ongoing for a number of years to set out the case for change and develop a set of recommendations for service change, including work to prepare for a public consultation. Between 2015 and 2017, an extensive programme of work was undertaken, led by the Liverpool Clinical Commissioning Group, supported by the Liverpool Women's Hospital NHS FT, and involving significant engagement from system partners on a pre-consultation business case to explore options for the future of health services for women and babies in the city.

The challenges prompting this work remain and have been reviewed by external independent bodies including the Northern England Clinical Senate. These independent views have universally recognised that services would become unsustainable and potentially unacceptable within the next 5 years, and consequently there is a system imperative to resolve this issue.

The current work, led by the Liverpool Women's Hospital NHS FT and supported by system-wide stakeholders and the Liverpool Place colleagues, as part of the Future Generations programme, has been focused on formalising existing joint working arrangements with Liverpool University Hospitals NHS FT and implementing further mitigating actions through a Partnership Board. These actions have included redevelopment of the existing neonatal unit, investment to increase 24/7 consultant cover and planning for a 24/7 on-site transfusion laboratory at Crown Street by April 2023.

The future programme of work to realise the women's health opportunity will need to follow the latest national guidance on service change and should be pursued as an ICB-led service change programme. In parallel to this, recognising the timescale of any service change programme, the ongoing work to continue to mitigate and address risks must be continued and strengthen through the existing Partnership Board arrangements. To deliver this, an operating model between the Liverpool University Hospitals NHS FT and Liverpool Women's Hospital NHS FT should be developed to optimise partnership working and short-term mitigation of risks. In so doing, there should be a recognition of the costs associated with these measures, driven by the unique nature of the service model, and financial support for this should be worked through with the ICB.

The service change work should begin by reconfirming and strengthening the current case for change. In responding to the challenges set out by the case for change, opportunities and best practice care models should be developed that set out how care could be delivered in the future. To deliver the future care model, service change will likely be required, by which we mean what services can be accessed and where. In following this process, extensive clinical engagement will be needed, as well as engagement from finance, estates, and information colleagues. Any potential service change implications would require the ICB to undertake an options appraisal process.

Service change and the requirement to consult is complex with no clear definitions in law. 'Substantial' changes to NHS service provision (how, where or when) mandate consultation with relevant Local Authorities who then determine the need for public consultation or not. Early engagement is key.

If an options appraisal process is recommended to consider the proposed service changes, it would need to follow best practice and requirements on service reconfiguration. As part of this process any interdependencies with other services will be considered as well as the potential impact of proposed service changes on population groups with protected characteristics. The outputs of the options appraisal process would be described in a pre-consultation business case (PCBC) which would set out the benefits and limitations of the options compared to the status quo. We would recommend that the Strategic Outline Case, which will describe the high-level business case for the changes and estimated capital and revenue requirements, is also drafted alongside the PCBC.

The ICB may then need formally to consult the public on any proposed service changes. Any decision to consult would require formal approval of the ICB Board, who would consider in public the PCBC. Before consultation on each preferred option, the financial proposal should be assessed for capital and revenue impact and only implementable and sustainable options (in service, economic and financial terms) should be offered for public consultation. Capital funding requirements of > £15 million mandate confirmation of affordability before consultation is launched.

Public consultation allows the public to comment on the options proposed and in support of this, a consultation document is produced. Input from the public information can be captured through holding events or through asking for responses online, for instance via a survey. Concurrently, an Outline Business Case (OBC) should be drafted to set out the preliminary information on the proposed options. Feedback from the public consultation, alongside internal views on the preliminary outline business case should be used to refine the options proposals and provide basis for any extra analysis to be performed. These alterations should be incorporated into A Decision-Making Business Case (DMBC) to refine and detail the preferred option and include detailed financial and implementation planning. To complete the process, a Full Business Case (FBC) should be produced to explain in detail the planned solution and how it matches service requirements and constraints, through the latest evidence and analysis. It should also show that the most economically advantageous offer is being proposed and is affordable.

There are a number of benefits that could be realised from service change and are important for people, staff, and the wider healthcare system. Optimal clinical co-location of services would result in improved patient safety, outcomes, and experience, through enhanced provision of clinical necessary services. It would support staff satisfaction, recruitment, and retention, ensuring that the organisation is an attractive and fulfilling place to work and that there are opportunities to upskill staff in multi-disciplinary teams (MDTs) though managing complex cases, providing access to an experienced workforce and development opportunities through close working with other specialities. Furthermore, co-location would expand the development of world-leading services for women and babies in Liverpool building on the existing research portfolio and strengthening the resilience of the workforce.

As well as resolving critical clinical and workforce issues through service change, there are several quantifiable opportunity benefits that may be possible to realise should there be a change in how services are provided. These include:

- Reducing maternity clinical negligence costs (CNST) at Liverpool Women's Hospital NHS FT which are significantly higher than peers at £2.3 million per 1,000 births. With the assumption that service provision would be enhanced and reduce risk, clinical negligence costs could reduce over a period time with the recurrent benefit equivalent to between £4.9 million to reach the peer median and £6.1 million to reach the upper quartile.
- Reducing soft facilities management costs at Crown Street depending on the resulting service provision there. Based on the assumption that 24/7 care may no longer be provided at the site, there would be an opportunity benefit of around £1.6 million
- Reducing the number of interhospital transfers needed between Liverpool University Hospitals NHS FT and Liverpool Women's Hospital NHS FT for women who need critical or specialist care, would have an opportunity benefit equivalent to £155,000 (through 229 transfers in 2019/20) which would not be cash-releasing
- Reducing the length of stay for people staying in hospital who subsequently need transfer has opportunity benefit based on 2019/20 activity equivalent to £65,825, although due to the occupancy rates at Liverpool University Hospitals NHS FT, we would not expect that this benefit would be cash-releasing.

Further benefits could also be realised by a change to service model as the current model of care has required significant investment to be made in workforce for example for additional rotas and capital for additional diagnostic capacity such as a CT scanner. Some of these investments could be unwound and efficiencies gained if the service model were to change in the long-term. In the short-term this investment

needs to continue to continue delivery of safe and effective services, and ongoing financial support should be worked through with the ICB.

To take forward this priority opportunity, we recommend that:
The current programme of work, the Future Generations Programme, led by Liverpool Women's Hospital NHS FT should be reset as a system priority. The opportunity to solve clinical sustainability challenges for women's health should be taken forward as an ICB-led service change programme, in line with best practice requirements for service reconfiguration. To support this, we recommend:

a. A sub-committee of the ICB to be established to oversee the programme of work, including at minimum representation from Liverpool Women's Hospital NHS FT, Liverpool University Hospitals FT, Clatterbridge Cancer Centre NHS FT and Alder Hey Children's NHS FT. These organisations will need to identify dedicated clinical and managerial leadership to engage deeply in the programme with partners, with external stakeholders, with patients and the public and within their own organisations with staff.
b. A director of the ICB be identified as the joint-SRO of the programme and lead the work.
c. A non-executive of the ICB to be identified to chair the sub-committee.
d. A clinical joint-SRO to be identified who can work on the programme for a dedicated period every week and chair the clinical working group. This individual should be experienced in service change with experience in a relevant clinical area, and independent of any of the organisations in Cheshire and Merseyside.
e. The finance director of the ICB to chair the finance, analytics and estates working group which will develop and review the economic and financial modelling, including capital requirements.
f. A dedicated team to be identified to support the programme, with the expertise needed to meet the different requirements of the programme such as clinical evidence and research, communications and engagement, finance, analysis and estates and capital development. This team should be hosted by the ICB reporting to the lead ICB director.
g. A reset work programme be created and agreed by January.
h. An operating model between the Liverpool University Hospitals NHS FT and Liverpool Women's Hospital NHS FT should be developed to optimise partnership working and short-term mitigation of risks, led by the existing Partnership Board.

Improving outcomes and access to emergency care, making optimal use of existing co-adjacencies at Aintree, Broadgreen, and Royal Liverpool sites

For emergency pathways, each hospital site in Liverpool should deliver optimal care and efficiency, uninhibited by organisational boundaries. The task and finish process for this opportunity recognised that for urgent and emergency care, there are a number of co-dependencies for services that are not met by current service delivery in Liverpool.

The core emergency department offer at the Royal Liverpool and Aintree sites does not benefit from on-site access to gynaecology and interventional cardiology services, necessitating interhospital transfer for some patients. More critically, the Major Trauma Centre at the Aintree site does not have on-site access to gynaecology, neonatology, obstetrics, thoracic or cardiac surgery. Although it also does not have access to acute paediatric services, this is mitigated by Alder Hey Children's Hospital NHS FT being the Major Trauma Centre for children and young people aged under 16 and providing access to specialist paediatric services on site, meeting all co-dependency requirements. For children aged between 16 and 18, colleagues

discussed the option of considering them as part of the scope of this opportunity, however this group represented small volumes and therefore effort was prioritised to addressing other groups first.

Two groups of users emerged: those for whom critical co-dependent services are not available on the site they are receiving care, and those for whom collective expertise and existing co-adjacencies could be further leveraged. For each, colleagues described an ambition for emergency pathways that enable people seeking urgent and emergency care to avoid unnecessary transfers between sites and organisations, minimising delays and providing timely access. This would also reduce repetition for people accessing services and duplication of effort for staff, by providing the right information at the right time for people, their carers and staff and making use of digital innovation and technology as far as possible. Colleagues aspired to deliver a pathway that facilitates joint ways of working within and between organisations and allows for proactive planning for onward care, thinking holistically about the person at every stage including presentation.

Guided by this ambition existing pathways for groups where needs are currently sub-optimally met were mapped and redesigned across eight pathways. Common themes between the redesigned pathways were identified and articulated into three additional pathway elements for how care should be delivered in the future. They are fast-tracking, passporting, and in-reach. Each element has specific benefits which are set out below.

Fast-tracking
When people with an emergency need require care, they either present directly or are conveyed by ambulance to either the Royal Liverpool or Aintree emergency departments, where they are assessed and often admitted to receive initial care before clinical teams determine they require specialist treatment and care at a different site. This results in long wait times both in the emergency department and as an inpatient awaiting transfer.

Fast-tracking allows for people to be directly conveyed or rapidly directed to the best place of care for their primary condition either through a rapid transfer protocol or access to specialist opinion using a digital platform to determine whether direct conveyance to hospital is appropriate. Fast tracking protocols already exist for a number of pathways, for example major trauma and stroke protocols directly to Aintree site, and STEMI direct conveyance to Liverpool Heart and Chest Hospital NHS FT.

Implementing fast-tracking will ensure that people receive streamlined and appropriate specialist care in a timely fashion, meeting their needs more effectively and reducing the need for transfers when they are critically unwell. Direct conveyance to the most appropriate setting will improve morbidity and potentially mortality.

Colleagues agreed that this opportunity should be initially implemented for cardiology services including acute coronary syndromes and arrythmias, and for neurology services specifically moderate head injuries.

This pathway change will reduce emergency department attendances to Liverpool University Hospitals NHS FT. If this model was in place in 2021/22, 577 cardiology, 118 cardiac and thoracic surgery, and 348 neurology attendances could have been avoided, equivalent to a potential saving of £175,000. As a consequence, spells at Liverpool University Hospitals NHS FT would also be avoided as patients attend the specialist centre directly. If this model was implemented in 2021/22, 411 cardiology spells, 110 cardiac and

thoracic surgery spells and 211 neurology spells would have been avoided with an opportunity benefit of £1.77 million.

There will also be a reduction in the number of interhospital transfers needed between Liverpool University Hospitals NHS FT and specialist trusts. For 2021/22, the numbers of transfer avoided would have been 577 cardiology and 118 cardiac and thoracic surgery transfers between Liverpool University Hospitals NHS FT and Liverpool Heart and Chest Hospital NHS FT and 91 neurology transfers between Liverpool University Hospitals NHS FT and The Walton Centre NHS FT. The potential opportunity benefit is £204,000.

Passporting

Some groups of people with an emergency need have access to a specialist advice service which can sign-post them to the correct service. For example, people with cancer have access to an oncology helpline. In some instances, people can be directly admitted to the Clatterbridge Cancer Centre Clinical Decisions Unit for assessment and treatment of their condition, however existing conveyancing protocols mean those attending by ambulance can currently only be taken to emergency departments at the Royal Liverpool or Aintree sites.

Passporting allows people with a known condition to bypass A&E and reach the most appropriate place for their primary need. In practice, this means having an agreed written care plan that can be easily located and accessed by any health care professional (for example by keeping it in the fridge) and implemented should an emergency need related to the known condition arise. This passport gives them 'priority' or direct access into the service they require. Passporting could result in a variety of alternative outcomes:

- People and their families or carers would have clear signposting should an emergency need arise
- Paramedics can directly convey to the appropriate service, notifying the relevant on-call team ahead of time
- Paramedics can access specialist advice from the relevant on-call team if there is uncertainty about the best conveyance destination
- Where direct access to services would not be appropriate, the passporting mechanism could alert the relevant team that the person is being taken to A&E so that relevant information can be shared, and ongoing specialist support provided

Implementing passporting will improve experience of care, safety, and outcomes by providing appropriate specialist care for people in the right place by specialist multidisciplinary teams who can comprehensively meet their needs. These teams will be guided by an individualised care plan and will only carry out relevant tests and diagnostics.

Colleagues agreed that the first areas to implement passporting would be for people with cancer and for people readmitted within 14 days of a stay in hospital. This pathway change has the potential to reduce emergency department attendances to Liverpool University Hospitals NHS FT. If this model was in place in 2021/22, 143 cancer attendances could have been avoided and 134 spells for cancer, equivalent to an opportunity benefit of £529,000. This would have been accompanied by a reduction in the number of interhospital transfers needed between Liverpool University Hospitals NHS FT and Clatterbridge Cancer Centre NHS FT and reduced length of stay. In 2021/22, the numbers of transfers avoided could have been up to 48, resulting in an additional opportunity benefit of £12,000, with the reduction in beds equivalent to 1.7 beds across the year and an opportunity benefit of £193,000.

In-reach

When someone with an acute need also has co-morbidities, they often require expert advice to optimise the management of their co-morbidities along with their acute presentation. Consultants can currently make consultant-to-consultant referrals for advice, however there are often delays in providing this and at times it will not come until post-discharge. Advice can be sought from colleagues informally but there is no established mechanism for this.

In-reach provides multi-disciplinary team input for people with a known condition who attend the hospital and need specialist advice for their known condition (which is not their primary need). In-reach means specialist advice can be easily and quickly obtained by other teams. This can happen through a variety of means which can reach any site if needed:

- through an "advice and guidance" service: a digitally enabled service manned by a dedicated specialist in which requests can be logged and responded to within a defined time period, via telephone or message depending on what is most appropriate.
- virtual consultation: based on the advice and guidance service, virtual consultations can be set up if recommended. This mechanism should leverage existing digital capabilities and models used for virtual appointments but in an acute inpatient setting.
- in person consultation: based on contact through the advice and guidance service, the dedicated specialist can easily move between sites to provide in person consultations where necessary.

In-reach improves the experience and care that people receive by ensuring this is holistic and that co-morbidities are proactively managed in the context of an unrelated acute presentation. This can contribute to a reduced length of stay as there is timelier access to specialist opinion and people, their carers and staff will have greater confidence in management and treatment plans. In-reach also creates an environment for further learning opportunities and cross-fertilisation of expertise and knowledge across professions and specialities. Models for in-reach already exist for some specialist services across the city for example cancer services.

This pathway change has the potential to reduce overall length of stay as people with multiple co-morbidities in Liverpool have a significantly higher length of stay than the national average. Those with fewer co-morbidities had a similar length of stay to the national average indicating where people have multiple co-morbidities, there would be a benefit from in-reach. If the in-reach model had been in place in 2021/22, 4,603 bed days or 12.6 beds could potentially have been saved, which is equivalent to an opportunity benefit of £1.3 million.

Colleagues agreed that in-reach should be implemented for all people with comorbidities across all sites beginning with those with diabetes to test the concept, and then rapidly rolled out for other conditions. This pathway should be implemented in all areas where sufficient demand exists across organisations to realise a cumulative benefit of the service.

To deliver these, an operating model for each site should be developed to include implementing processes to create joint teams across sites, ensuring clear clinical pathways and accountability, and optimising site-based working. This includes:

- Ring-fencing capacity for additional fast-tracking and passporting services,
- Sharing physical capacity, for example ITU beds, to enable elective activity to continue without being displaced by emergency pressures,
- Sharing diagnostic capacity such as x-ray machines and scanners to provide timely access,

- Making best use of staff experience and expertise, for example creating joint appointments to provide specialist input across sites, and
- Consolidating teams that could be shared, for example through having a single medical emergency team for each site and a shared discharge support team
- Clinical support services sharing physical capacity and workforce, for example a shared pharmacy service for the site with a single overnight rota for pharmacy.

Colleagues identified several priority pathways where these three pathway elements could be applied, with a view to maximising the impact of the opportunity:

- All sites should implement passporting for people with cancer and people readmitted within 14 days of a stay in hospital and in-reach for people with comorbidities, for this purpose defined as people with an HRG complication or comorbidities score (CC) of 10 and above.
- At Broadgreen site, focus should initially be on rapid implementation of fast-tracking for cardiology services including acute coronary syndromes and arrythmias; strengthening the STEMI pathway as well as setting up a pathway for direct conveyance of NSTEMI and pacing.
- At the Aintree site, colleagues should initially focus on fast tracking for moderate head injuries, as well as reviewing the effectiveness of the stroke pathway which has recently been implemented.
- At the Royal site, effort should be directed at developing passporting for people with cancer who could be seen directly at the CCC.

Implementing joint clinical working will also bring synergies in operations on each site and there are examples of inefficient use of resources that represent opportunities for non-clinical integration. As organisations collaborate to implement new clinical pathways, they should also embrace this broader agenda. These include:

- Digital: resolving interoperability of systems to ensure information can be shared and diagnostics such as pathology and radiology do not need to be duplicated,
- Corporate services: in support of joint operations on sites, shared HR, finance, strategy, and estates functions that work across organisations on sites, and
- Facilities management: where there is duplication of services on sites for both hard and soft facilities management services, for example catering, portering and security services.

The site-based operating models will have financial benefits over and above those set out for the clinical pathways in particular where services can be consolidated across sites to provide shared teams. The opportunities relevant to each site need to be systematically and holistically worked through to determine the full scale and scope of the site-based model.

We recommend that:

Improving outcomes and access to emergency care, making optimal use of existing co-adjacencies should also be immediately prioritised for delivery. A programme of work should be established which implements the three new pathway elements proposed by this review: 1. fast-tracking, 2. passporting, and 3. in-reach. The overall aim of this work should be to ensure each hospital site in Liverpool delivers optimal care and efficiency, uninhibited by organisational boundaries. This should include creating integrated clinical teams on each site with joint ways of working. In taking this forward, we recommend:

a. Clinicians should be at the forefront of the development of this approach and leads should be identified from each organisation and each site, to oversee the work and facilitate broad engagement with staff.
b. There should be early engagement with General Practice, Mersey Care FT, and the North West Ambulance Service NHS Trust to incorporate pre- and post-hospital elements of the pathway.
c. An operating model for each site should be developed, ensuring highest quality clinical pathways, clear accountability, and optimised site-based working. This should be underpinned by demand and capacity analysis.
d. Building on the financial analysis undertaken as part of this review, a target financial model should be developed and agreed linked to 5c. This should reset financial flows and ensure overall efficiencies are realised including in respect to reduced length of stay and reduced interhospital ambulance transfers.
e. Three joint committees should be established with delegated authority from the relevant trusts for site-based operations. These arrangements should oversee the design and delivery of the new operating models as well as business-as-usual operations, which will likely give rise to further improvement opportunities. The three committees should include at least one non-executive director and executive director from each organisation as well as a site-based leadership team. The committees should comprise of:
    i. Liverpool University Hospitals FT and Liverpool Heart and Chest Hospital FT for the Broadgreen site
    ii. Liverpool University Hospitals FT and The Walton Centre FT for the Aintree site
    iii. Liverpool University Hospitals FT and Clatterbridge Cancer Centre NHS FT for the Royal Liverpool site
f. To progress the work, a dedicated team supporting all three joint committees should be established that provides capacity to systematically work through the operating model on each site, undertaking design work and modelling for the pathway and service transformation. This team should be led by a dedicated senior individual working across organisational boundaries on behalf of all organisations.

This opportunity and the resulting recommendations form one part of the urgent and emergency care pathway and should be seen as additive to the other system initiatives such as efforts to reduce attendances and redirect demand to primary and community settings. Colleagues reflected on the urgent emergency pressures currently faced by the system and felt there were two particular areas of focus: community urgent and emergency care, and flow and discharge pathways. Prior to the pandemic, the North Mersey review of urgent care provision concluded there was a need for an integrated UTC model to be developed to support delivery of same day and urgent care needs of local people and connect seamlessly with other parts of the emergency pathway. There is a need to reset and reinvigorate this work in order to address urgent and emergency demand that continues to put pressure on organisations. At the

other end of the emergency pathway, colleagues also felt that there was a need to work together on improving flow and discharge along with community and social care to reduce the number of people in hospital who did not need have the criteria to reside. During the review period, colleagues also reflected on the need for a review of community and mental health services and capacity, reflecting on the long waits in the emergency department and in hospital for in-reach and onward care.

All organisations involved in the urgent and emergency pathway need a forum in which they can review system effectiveness with a shared data view and to make decisions about improving quality and safety of the emergency pathway as well as optimising the use of overall resources. Committees in Common create a mechanism for doing this by allowing two or more organisations to meet in the same place at the same time to discuss the same topics yet remain distinct and take their own decisions. The benefit of this arrangement is that it allows each organisation to retain control but is supportive of collaboration. It also reduces administrative burden and is an efficient decision-making process.

We recommend that:
To provide overall Liverpool system oversight and review of performance on delivering high quality emergency care with aligned incentives and funding, two committees-in-common should be established involving relevant executives and non-executives from Alder Hey Children's NHS FT, Clatterbridge Cancer Centre NHS FT, Liverpool Heart and Chest Hospital FT, Liverpool University Hospitals FT, Liverpool Women's Hospital NHS FT, The Walton Centre FT, Mersey Care FT, and General Practice Liverpool. These committees-in-common should meet quarterly and cover:

a. Quality – reviewing the effectiveness and quality of emergency care using shared data and analysis and determining further improvements required;
b. Finance – reviewing overall financial effectiveness and establish effective incentive and risk sharing mechanisms.

Conclusion and next steps

In conclusion, this report sets the direction and short-term priorities for further collaboration between the acute and specialist trusts in Liverpool. In describing these benefits, stakeholders also caveated these opportunities by highlighting several conditions that would need to be in place for them to be realised. The case for collaboration provides a basis for long term strategic efforts between acute and specialist providers in Liverpool and creates the shared vision and goal needed for collaboration.

Several elements were thought to be foundational including developing governance for collaborative decisions, sharing information, and having an interoperable digital environment, having an underpinning financial framework, and communicating and engaging clearly.

Developing the governance arrangements to support collaborative decisions making will be required for enduring collaboration. This will include outlining clear ways of working, which align the decision-making structures of organisations. Both the proposed joint committees and committees in common work in support of this condition. In aligning the operating models in the collaboration, the relationship between the collaboration and the wider provider collaboratives within the ICS need to be clarified.

Sharing of information and performance data was considered to be an important enabling factor in decision making and in providing clarity to issues that require collaboration. To ensure the smooth movement of

patients between sites and organisations, shared clinical information and a digital environment for staff, which supports movement between organisations.

Colleagues also described the uncertainty around how the financial flows will settle with the ICS, and how risk is managed within that can get in the way of clinical decision making that would support collaboration. In order to address this, creating effective incentives and risk sharing mechanisms for finance were thought to be important.

Critically, in recognition of the considerable scope of these opportunities, colleagues described needing strong clinical and non-clinical leadership to take forward the work, reflecting the significant mindset shifts that are needed. Stable leadership provides staff with clear direction and draws professionals together around a shared vision for the future, which is central to co-ordinating transformation across several sites and functions. Leadership oversight should be proportionate to the scope of the initiative that is being delivered.

Protecting time and creating dedicated capacity for collaboration will create the headroom needed to transform services and the way that organisations and people work together, ensuring that operationally pressures do not hinder progress. To make best use of this capacity, it was agreed that prioritising efforts and phasing delivery of the work was needed to make the biggest impact, rather than trying to collaborate on many things simultaneously. For some of the more significant opportunities that have been outlined, this will require a substantial commitment.

Overwhelming colleagues talked about the need for trusted relationships between partners as the basis for collaboration. Relationships have been improving over time; COVID helped to accelerate progress However, colleagues also highlighted that they would need to continue building trusted relationships, putting collaboration ahead of organisational sovereignty.

The collaborative opportunities that have been identified are considerable in scale and scope. Stakeholders have often been able to describe with enthusiasm the potential benefits of deeper collaboration.
There has been significant energy to engage in the process so far with a collective willingness and motivation to act on the findings of the review. To build on this momentum, action to implement the recommendations of the review needs to be taken swiftly and without delay, and should be resourced commensurate to their scope.

We recommend that:
To progress at pace Boards of relevant organisations should receive proposed terms of reference, including delegations, accountability, and escalation arrangements, for the governance groups set out in the recommendations 4, 5 and 6 in their January meetings. A proposal for how the programme(s) of work is resourced should also be included to ensure the appropriate team and leadership needed to deliver.

A communications and engagement plan should also be developed and agreed by all organisations. The aim should be to communicate the findings of the review and its recommendations and engage staff, patients, and the public on the next steps. Engagement on the future programme of work as well as open communications in respect to progressing the recommendations should be embedded into how this is taken forward.

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*22/23/207*		Date: 02/02/2023	
Report Title	Emergency Preparedness, Resilience & Response Core Standards Annual Assurance Board Report			
Prepared by	Lorraine Thomas, EPRR Manager			
Presented by	Gary Price, Chief Operating Officer / Accountable Emergency Officer			
Key Issues / Messages	This report provides a summary of the NHSE EPRR Core Standards assurance process and Trust compliance outcomes.			
Action required	Approve ☐	Receive ☐	Note ☐	Take Assurance ☒
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable):			
	For Decisions - in line with Risk Appetite Statement – No *If no – please outline the reasons for deviation.*			
	The Board is requested to take assurance that effective systems of control are in place in relation to achieving compliance to the NHSE EPRR Core Standards.			
Supporting Executive:	Gary Price Chief Operating Officer / Accountable Emergency Officer			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

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

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

Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks*2.2 Failure to develop our model of care to keep pace with developments and respond to a changing environment	Comment:
Link to the Corporate Risk Register (CRR) – CR Number:	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
EPRR Sub-committee	12/12/22	Gary Price	For submission to FPBD

FPBD	Dec 22	Gary Price	Recommended for approval to the Board

EXECUTIVE SUMMARY

1. Define the issue

NHS Trusts are required to complete an annual assurance process against the NHSE Emergency Preparedness, Resilience & Response (EPRR) Core Standards. The process is managed and monitored by NHSE and involves NHS Trusts completing a self-assessment of compliance against the core standards. The process is supported by Peer Review meetings and confirm and challenge procedures.

2. Key Findings

The Trust submitted an overall compliance rating of '86% / Partially Compliant'. This submission will be subject to a confirm and challenge process with outcomes confirmed by NHSE.

This outcome demonstrates a reduced level of compliance compared with the submission for October 2021. In October 2021 the Trust was rated as 89% / 'Substantially Compliant'. This reduction in compliance rate is due to factors including revision of the EPRR Core Standards and learning from the major incident (November 2021) with further information discussed below.

3. Solutions / Actions

An integral part of the EPRR annual assurance process is the development of an action plan to support achievement of compliance against outstanding core standards. Actions have been identified and submitted to NHSE and have been formulated into an action plan (Appendix 1). Progress on completing the action plan will be monitored by the EPRR Sub-committee with oversight by the Finance, Performance and Business Development Committee.

4. Recommendations

The Board is requested to take assurance that effective systems of control are in place in relation to achieving compliance to the NHSE EPRR Core Standards.

MAIN REPORT

INTRODUCTION

- This report provides a summary of the Trust's assessment and compliance rating against the NHSE EPRR Core Standards based on a self-assessment conducted in October 2022.

- As a Category 1 Responder under the Civil Contingencies Act (CCA) 2004, the Trust is required to prepare for emergency and business continuity incidents and ensure that it has the capability to respond to emergencies in a way that preserves life and operates within a framework that is safe, effective, caring, responsive and well-led. Whilst managing emergency situations, the Trust must,

as far as is reasonably practicable maintain business continuity, prioritising safety and critical service delivery. The EPRR Core Standards are designed to support NHS Trusts in meeting the above duties.

- The EPRR service is led by the Chief Operating Officer (designated Accountable Emergency Officer) with the support of the EPRR Manager. The EPRR governance structure is defined within the EPRR Strategy.

- The EPRR national annual assurance process is based on self-assessment against the NHSE EPRR Core Standards audit tool. Specialist Trusts were required to self-assess against 56 core standards and an additional 13 'deep dive' criteria. The deep dive criteria for 2022 related to evacuation and shelter procedures. The outcomes for the deep dive criteria are not included within the overall compliance rating.

- The Trust submitted a compliance rating of '86% / Partially Compliant' in October 2022. An action plan has been developed and submitted (Appendix 1), to support achievement of outstanding standards. The Core Standards action plan will be monitored by the EPRR Sub-committee with oversight via the Finance, Performance and Business Development Committee.

ANALYSIS

- The NHSE EPRR Core Standards were revised for 2022 including those standards relating to training.

- The Local Health Resilience Partnership (LHRP) held Peer Review sessions (chaired by NHSE) for NHS Trusts across Cheshire & Merseyside. The peer review sessions provided opportunity to discuss interpretation of individual standards, the required level and types of evidence and to share good practice. The process was designed to support consistency and standardisation of organisations' self-assessment processes and submissions.

- NHS Trusts were required to submit evidence against two randomly selected standards.

- EPRR Core Standards submissions will additionally be subject to the NHSE confirm and challenge process as detailed within the NHSE EPRR annual assurance guidance.

- Trust responses were based on activities monitored by the EPRR Sub-committee. Standard agenda items including development and revision of emergency and business continuity plans and arrangements, delivery of training and monitoring of EPRR action plans including the major incident action plan and review of the EPRR risks, directly support the EPRR annual assurance requirements.

- An overall compliance rating of '86% / Partially Compliant' was submitted to NHSE. The Trust fully met 48 of the 56 EPRR core standards with a rating of 'Green'. The remaining 8 standards were partially met with a rating of amber. In addition the Trust fully met 8 of the 13 deep dive criteria with a rating of Green, 4 criteria were partially met with a rating of amber. The remaining criterion was rated as non-compliant / 'Red' (as detailed above, deep dive criteria are not included in the overall rating). Further information on the partially met and non-compliant criteria is detailed within the action plan (Appendix 1).

Action Plan

- In relation to Trust compliance levels and specific actions, the Committee is requested to note the following points:

    - NHSE is currently delivering new Principles of Health Command mandatory training for all strategic and tactical health commanders. Dates for tactical command initially extended to the end of November. Further dates have now been released with sessions to be held at regular intervals on a continuing basis.

    - NHSE has established a Commander Portfolio Oversight Board to support development of a standardised Commander Personal Portfolio. The Trust is represented at the meetings by the EPRR Manager. The Trust will be implementing Commander Personal Portfolios based on the national template.

    - Due to factors including the above and the updating of emergency plans throughout 2022, the Trust will deliver revised EPRR training to all Strategic, Tactical and Operational commanders throughout 2023. EPRR training will continue to be available on an individual basis for directors and managers joining the on-call rota.

    - NHSE required NHS Acute Trusts to deliver a hospital evacuation table top exercise with multi-agency attendance in 2022, with subsequent hospital evacuation exercises to be delivered by NHS Specialist Trusts. This workstream is therefore within the Trust EPRR work plan for 2023.

    - It was confirmed at Peer Review that local NHS Trusts do not have an interoperable patient tracking process. It was therefore agreed that this action will be facilitated by the Local Health Resilience Partnership (attended by NHS provider organisations at strategic level). This action has therefore been attributed to the LHRP / Trust EPRR Strategic Leads and allocated an interim completion date for confirmation by the LHRP Chair.

CONCLUSION & RECOMMENDATION

- The EPRR action plan will be managed by the EPRR Manager in conjunction with the EPRR Sub-committee (Chaired by Accountable Emergency Officer) with oversight by the Finance, Performance and Business Development Committee and Corporate Risk Committee and other committees as appropriate.

- EPRR activities for 2023 will focus on meeting the outstanding standards and deep dive criteria in order to achieve an increased level of compliance to the NHSE EPRR Core Standards and other relevant audits and assurances. Specific actions will be directed towards training delivery, evacuation and shelter arrangements and actions to support evolving risks.

The Board is requested to take assurance that effective systems of control are in place in relation to achieving compliance to the NHSE EPRR Core Standards.

EPRR Core Standards Action Plan 2022-23

October 2022

EPRR Core Standards							
No	**Standard**	**Compliance**	**Status**	**Action**	**Progress**	**Responsibility**	**Target Date**
15	**Duty to Maintain Plans Mass Casualty**		Trust has a Major Incident Plan in place. Approved in consultation with the EPRR Sub-committee and available via Trust intranet/ on-call shared drive/ICCs. The Trust has capability to support incident response in terms of provision of Obstetric / Maternity support for Major Trauma Centre and provision of mutual aid for local acute Trusts. Trust has an approved procedure for managing and recording care of patients of unknown identity.	Trust to develop plans for management of an emergency incident involving multiple casualties on site.		EPRR Manager / Designated clinical lead	June 2023

16	**Duty to Maintain Plans** **Evacuation & Shelter**		The Trust has an Evacuation Strategy in place approved in consultation with EPRR Sub-committee and Associate Director of Health & Safety (Fire Safety Lead). EPRR event to test evacuation / command and control scheduled 31.10.22.	Trust plan to deliver further fire evacuation simulations and EPRR evacuation workshops in 2023 in preparation for delivering Trust wide Evacuation Exercise.		EPRR Manager Fire Safety Advisor	June 2023
21	**Command & Control Trained on-call staff**		Strategic / Tactical Managers attend internal EPRR for on-call training Attendance at NHS Principles of Health Command Training for Strategic and Tactical Managers monitored. Further staff scheduled to attend November 22.	All Strategic & Tactical Managers to attend NHSE PHC mandatory training.		EPRR Manager	February 2023
24	**Training & Exercising Responder Training**		Training records maintained of staff attending EPRR on-call training. Attendance at Principles of Health Command Training monitored. Personal training records previously in place for Strategic / Tactical Managers. This process to be reviewed and embedded.	Personal training records to be developed / embedded.		EPRR Manager	April 2023

33	**Warning & Informing**		Trust Communications action card, recently revised by Head of Communications. Communications Team version includes relevant contacts and passwords. Communications Lead / Trust Strategic Command aware of requirement to align to NHSE/ Police messages when relevant.	Communications currently reviewing out of hours service.		Head of Communications	March 2023
36	**Warning & Informing** **Media Strategy**		Communications Action Card in place. Head of Communications links with EPRR leads and procedures. Communications Team have experience of warning and informing the public in event of major incident and in support of business continuity plans e.g. scheduled telecommunications upgrades.	Communications Team to arrange/deliver training for media spokespeople.		Head of Communications	May 2023
53	**Business Continuity Commissioned Providers & Suppliers**		Trust increased procurement resilience in preparation for EU Exit / Covid 19 response. Trust holds BCPs of key suppliers and contractors.	Revised versions of BCPs for key contractors and suppliers to be requested and reviewed for 2023.		EPRR Manager / Identified BCP Leads	March 2023

67	**CBRN** **Staff Training Decontamination**		Training provided to Senior Managers on-call and Site Manager. EPRR folder including CBRN action cards for reception, security and switchboard staff held at Main Reception, Switchboard and Security.	CBRN incident response to be tested to ensure those who come into contact are aware of requirement to isolate patient.		EPRR Manager	March 2023

EPRR Core Standards Deep Dive – Evacuation & Shelter							
No	**Standard**	**Compliance**	**Status**	**Action**	**Progress**	**Responsibility**	**Target Date**
DD3	**Evacuation & Shelter** **Incremental Planning**		Hospital Evacuation Strategy approved via EPRR Sub-committee, includes evacuation stages, procedures and routes.	Evacuation Strategy to include full site / off site evacuation.		EPRR Manager	May 2023
DD6	**Evacuation & Shelter**		Evacuation Strategy in place.	Evacuation Strategy including equipment & training to include off-site transportation of patients		EPRR Manager/ Fire Safety Advisor	May 2023
DD7	**Evacuation & Shelter**		Trust does not have an interoperable patient tracking system. Agreed via Peer Review process this work stream to be explored via the LHRP / participating Trusts.	Potential system solutions to be explored via LHRP		LHRP / EPRR Strategic Leads	June 2023
DD12	**Evacuation & Shelter**		Evacuation plan references vulnerabilities.	Equality / Health Inequalities Impact Assessment to be completed to identify potential impact of evacuation /shelter arrangements.		EPRR Manager	January 2023

DD13	**Evacuation & Shelter** **Exercising**		Evacuation workshop held for Neonatal Unit (March 2022). Evacuation table top exercise scheduled 31.10.22.	Fire evacuation simulations and EPRR evacuation workshops to be delivered in preparation for delivering Trust wide Evacuation Exercise		Fire Safety Advisor / EPRR Manager	June 2023

NHS
Liverpool Women's
NHS Foundation Trust

Jargon Buster

We know that the language used in healthcare can sometimes be quite confusing, especially when acronyms are concerned. To make life a little easier, we will try to ensure that we spell out acronyms in full at first mention and then put the abbreviation in brackets, for example, Strategic Clinical Network (SCN) in our reports and minutes.

We've also put together a list of acronyms that you might see throughout our documentation. If you spot a gap, please email our Trust Secretary on mark.grimshaw@lwh.nhs.uk.

The following webpage might also be useful - https://www.england.nhs.uk/participation/nhs/

A		
A&E	Accident & Emergency	hospital department specialising in the acute care of patients who arrive without a prior appointment with urgent or emergency trauma
AC	Audit Committee	a committee of the board – helps the board assure itself on issues of finance, governance and probity
AGM	Annual General Meeting	a meeting to present and agree the trust annual report and accounts
AGS	Annual Governance Statement	a document which identifies the internal controls in place and their effectiveness in delivering effective governance
AHP	Allied Health Professionals	health care professions distinct from dentistry, optometry, nursing, medicine and pharmacy e.g. physiotherapists, radiographers, speech therapists and podiatrists
AHSC	Academic Health Science Centre	a partnership between a healthcare provider and one or more universities
AHSN	Academic Health Science Network	locally owned and run partnership organisations to lead and support innovation and improvement in healthcare
ALOS	Average Length of Stay	the average amount of time patients stay in hospital
AMM	Annual Members Meeting	a meeting that is held every year to give members the opportunity to hear about what the trust has done in the past year; could be part of the AGM
AO	Accountable Officer	senior person responsible and accountable for funds entrusted to their trust; for NHS provider organisations this person will be the chief executive
ALB(s)	Arms Length Bodies	an organisation that delivers a public service but is not a ministerial government department; these include HEE, HSCIC, HRA, HTA, NHSE, NICE, Monitor, NHSBSA, NHSBT, NHSI, NHSLA, MHPRA, CQC, PHE (See individual entries)
	Agenda for Change	the NHS-wide grading and pay system for NHS staff, with the exception of medical and dental staff and some senior managers; each relevant job role in the NHS is matched to a band on the Agenda for Change pay scale

B		
BAF	Board Assurance Framework	the key document used to record and report an organisation's key strategic objectives, risks, controls and assurances to the board
BCF	Better Care Fund	this fund creates a local single pooled budget to incentivise the NHS and local government to work more closely together in local areas
BMA	British Medical Association	trade union and professional body for doctors
BAME	Black Asian Minority Ethnic	terminology normally used in the UK to describe people of non-white descent
BoD	Board of Directors	executive directors and non-executive directors who have collective responsibility for leading and directing the trust
	Benchmarking	method of gauging performance by comparison with other organisations

C		
CAMHS	Child and Adolescent Mental Health Services	specialise in providing help and treatment for children and young people with emotional, behavioural and mental health difficulties
CapEx	Capital Expenditure	an amount spent to acquire or improve a long-term asset such as equipment or buildings. Typically, capital is raised via a loan, but it can come from reserves and is paid back/written off over a number of years from revenue income. This is a contrast with revenue spend which is always from in-year income
CBA	Cost Benefit Analysis	a process for calculating and comparing the costs and benefits of a project
CBT	Cognitive Behavioural Therapy	a form of psychological therapy used mostly in depression but increasingly shown to be a useful part of the treatment for schizophrenia
CCG	Clinical Commissioning Group	groups of GPs, clinicians and managers who are responsible for commissioning local health services in England (all GP practices must belong to a CCG)
CDiff	Clostridium difficile	a bacterial infection that most commonly affects people staying in hospital
CE / CEO	Chief Executive Officer	leads the day-to-day management of a foundation trust, is a board member and the accountable officer for the trust.
CF	Cash Flow	the money moving in and out of an organisation
CFR	Community First Responders	a volunteer who is trained by the ambulance service to attend emergency calls in the area where they live or work
CHC	Continuing Healthcare	Whereby those with long-term or complex healthcare needs qualify for social care arranged for and funded by the NHS
CIP	Cost Improvement Plan	an internal business planning tool outlining the Trust's efficiency strategy
CMHT	Community Mental Health Team	A team of mental health professionals such as psychiatrists,

		psychologists, social workers, community psychiatric nurses and occupational therapists, who work together to help people manage and recover from mental illness.
CoG	Council of Governors	the governing body that holds the non-executive directors on the board to account for the performance of the board in managing the trust, and represents the interests of members and of the public
COO	Chief Operating Officer	a senior manager who is responsible for managing a trust's day-to-day operations and reports to the CEO
CPD	Continuing Professional Development	continued learning to help professionals maintain their skills, knowledge and professional registration
CPN	Community Psychiatric Nurse	a registered nurse with specialist training in mental health working outside a hospital in the community
CQC	Care Quality Commission	The independent regulator of all health and social care services in England
CQUIN	Commissioning for Quality and Innovation	a sum of money that is given to providers by commissioners on the achievement of locally and nationally agreed quality and improvement goals
CSR	Corporate Social Responsibility	A business practice which incorporates sustainable goals, usually positive impacts on environmental, economic and social factors, into a business model
CT	Computed Tomography	A medical imaging technique
CFO	Chief Finance Officer	the executive director leading on finance issues in the trust
CNST	Clinical Negligence Scheme for Trusts	The Clinical Negligence Scheme for Trusts (CNST) handles all clinical negligence claims against member NHS bodies where the incident in question took place on or after 1 April 1995 (or when the body joined the scheme, if that is later). Although membership of the scheme is voluntary, all NHS Trusts (including Foundation Trusts) in England currently belong to the scheme.
	Caldicott Guardian	A board level executive director responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing. Each NHS organisation is required to have a Caldicott Guardian

D		
DBS	Disclosure and barring service	conducts criminal record and background checks for employers
DBT	Dialectical behavioural therapy	A type of psycho-therapy, or talk therapy, which has been developed from CBT to help those experiencing borderline personality disorder
DGH	District General Hospital	major secondary care facility which provides an array of treatment, diagnostic and therapeutic services, including A&E
DHSC	Department of Health and Social Care	the ministerial department which leads, shapes and funds health and care in England
DN	Director of Nursing	The executive director who has professional responsibility for services provided by nursing personnel in a trust

DNA	Did Not Attend	a patient who missed an appointment
DNAR	Do Not Attempt Resuscitation	A form issued and signed by a doctor, which tells a medical team not to attempt CPR
DPA	Data Protection Act	the law controlling how personal data is collected and used
DPH	Director of Public Health	a senior leadership role responsible for the oversight and care of matters relating to public health
DTOCs	Delayed Transfers of Care	this refers to patients who are medically fit but waiting for care arrangements to be put in place so therefore cannot be discharged
	Duty of Candour	a legal duty on hospital, community, ambulance and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm

E		
E&D	Equality and Diversity	The current term used for 'equal opportunities' whereby members of the workforce should not be discriminated against because of their characteristics. This is promoted by valuing diverse characteristics in a workplace.
ED(s)	Executive Directors *or* Emergency Department	senior management employees who sit on the trust board *or* alternative name for Accident & Emergency department
EHR	Electronic Health Record	health information about a patient collected in digital format which can theoretically be shared across different healthcare settings
EOLC	End of Life Care	support for patients reaching the end of their life
EPR	Electronic Patient Record	a collation of patient data stored using computer software
ESR	Electronic staff record	A collation of personal data about staff stored using computer software

F		
FFT	Friends and Family Test	a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care
FOI	Freedom of Information	the right to ask any public sector organisation for the recorded information they have on any subject
FT	Foundation Trust	a public benefit corporation, which is a legal body established to deliver healthcare to patients / service users and has earned a degree of operational and financial independence
FTE	Full Time Equivalent	a measurement of an employees workload against that of someone employed full time e.g. 0.5 FTE would be someone who worked half the full time hours
FTSU	Freedom to speak up	An initiative developed by NHS Improvement to

		encourage NHS workers to speak up about any issues to patient care, quality or safety
	Francis Report	the final report, published in 2013, of the public inquiry into care provided by Mid Staffordshire NHS FT chaired by Sir Robert Francis QC

G

GMC	General Medical Council	the independent regulator for doctors in the UK
GDP	Gross Domestic Product	the value of a country's overall output of goods and services
GDPR	General Data Protection Regulations	The legal framework which sets the guidelines for collecting and processing personal information from individuals living in the European Union

H

HCAI	Healthcare Associated Infection	these are infections that are acquired in hospitals or as a result of healthcare interventions; MRSA and Clostridium difficile can be classed as HCAIs if caught whilst in a healthcare setting
HCA	Health Care Assistant	staff working within a hospital or community setting under the guidance of a qualified healthcare professional
HDU	High Dependency Unit	an area in a hospital, usually located close to the ICU, where patients can be cared for more extensively than on a normal ward, but not to the point of intensive care, e.g. patients who have had major surgery
HEE	Health Education England	the body responsible for the education, training and personal development of NHS staff
HR	Human Resources	the department which focusses on the workforce of an organisation including pay, recruitment and conduct
HRA	Health Research Authority	protects and promotes the interests of patients and the public in health research
HSCA 2012	Health & Social Care Act 2012	an Act of Parliament providing the most extensive reorganisation of the NHS since it was established, including extending the roles and responsibilities of governors
HSCIC	Health and Social Care Information Centre	the national provider of information, data and IT systems for commissioners, analysts and clinicians in health and social care
HTA	Human Tissue Authority	regulates the removal, storage, use and disposal of human bodies, organs and tissue for a number of scheduled purposes such as research, transplantation, and education and training
HWB / HWBB	Health& Wellbeing Board	a local forum to bring together partners from across the NHS, local government, the third sector and the independent sector, led by local authorities
	Health Watch	A body created under the Health and Social Care Act 2012

		which aims to understand the needs and experiences of NHS service users and speak on their behalf.

I		
IAPT	Improved Access to Psychological Therapies	an NHS programme rolling out services across England offering interventions approved by the National Institute of Health and Care Excellence for treating people with depression and anxiety disorders
IG	Information Governance	ensures necessary safeguards for, and appropriate use of, patient and personal information. Key areas are information policy for health and social care, IG standards for systems and development of guidance for NHS and partner organisations
ICP	Integrated Care Pathway	a multidisciplinary outline of care, placed in an appropriate timeframe, to help a patient with a specific condition or set of symptoms move progressively through diagnosis and treatment to positive outcomes
ICS	Integrated Care system	Groups of NHS providers, commissioners and local authorities working together to improve health and care in the local area
ICT	Information Communications Technology	an umbrella term that includes any communication device or application, encompassing: radio, television, cellular phones, computer and network hardware and software, satellite systems, as well as the various services and applications associated with them
ICU *or* ITU	Intensive Care Unit Intensive therapy unit	specialist unit for patients with severe and life threatening illnesses
IP	Inpatient	a patient who is hospitalised for more than 24 hours
IT	Information Technology	systems (especially computers and telecommunications) for storing, retrieving, and sending information
IV	Intravenous	treatment which is administered by injection into a vein

K		
KLOE(s)	Key Line of Enquiries	detailed questions asked by CQC inspectors which help to answer the five key questions to assess services: are they safe, effective, caring, responsive and well-led?
KPIs	Key Performance Indicators	indicators that help an organisation define and measure progress towards a goal
	King's Fund	independent charity working to improve health and health care in England

L		
LD	Learning Disability	a disability which affects the way a person understands information and how they communicate
LGA	Local Government Association	the national voice of local government in England and Wales. It seeks to promote better local government and maintains communication between officers in different local authorities to develop best practice
LOS	Length of Stay	a term commonly used to measure the duration of a single episode of hospitalisation

M		
M&A	Mergers & Acquisitions	mergers bring together two or more bodies to form a new legal entity and disband the merging bodies. acquisitions are take-overs of one body by another
MD	Medical Director	a member of the board who has a clinical background and has professional responsibilities for doctors and dentists in the trust
MHPRA	Medicines and Healthcare Products Regulatory Agency	an executive agency of DHSC which is responsible for ensuring that medicines and medical devices work and are acceptably safe
MIU	Minor Injuries Unit	A unit which treats injuries or health conditions which are less serious and do not require the A&E service
MoU	Memorandum of Understanding	describes an agreement between two or more parties
MRI	Magnetic Resonance Imaging	a medical imaging technique
MRSA	Methicillin-Resistant Staphylococcus Aureus	a bacterium responsible for several difficult-to-treat infections in humans
MSA	Mixed Sex Accommodation	wards with beds for both male and female patients

N

NAO	National Audit Office	an independent Parliamentary body in the United Kingdom which is responsible for auditing central government departments, government agencies and non-departmental public bodies. The NAO also carries out Value for Money audits into the administration of public policy
NED	Non Executive Director	directors who are appointed, but not employed by the trust; they have no executive responsibilities and are responsible for vetting strategy, providing challenge in the boardroom and holding the executive directors to account
NHSBSA	NHS Business Services Authority	a Special Health Authority of DHSC which provides a range of services to NHS organisations including: NHS Prescription Services, NHS Pensions, Help With Health Costs, Student Services, NHS Dental Services, European Health Insurance Card, Supplier Management (including NHS Supply Chain) and NHS Protect
NHSBT	NHS Blood and Transplant	a Special Health Authority of DHSC responsible for providing a reliable, efficient supply of blood, organs and associated services to the NHS
NHSE	NHS England	an executive non-departmental public body with a mandate from the Secretary of State to improve health outcomes for people within England
NHSI	NHS Improvement	The Independent regulator of NHS Foundation Trusts
NHSLA	NHS Leadership Academy	national body supporting leadership development in health and NHS funded services
NHSP	NHS Professionals	provides bank (locum) healthcare staff to NHS organisations
NHSX		A unit designed to drive the transformation of digital technology in the NHS
NICE	National Institute for Health and Care Excellence	provides national evidence-based guidance and advice to improve health and social care
NIHR	National Institution for Health Research	The largest funder of health and social care research in the UK, primarily funded by the Department of Health and Social Care
NMC	Nursing and Midwifery Council	nursing and midwifery regulator for England, Wales, Scotland and Northern Ireland
	Never Event	serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. NHS England defines the list of never events every year

	NHS Digital	The information and technology partner to the NHS which aims to introduce new technology into services
	NHS Providers	NHS Providers is the membership organisation for NHS public provider trusts. We represent every variety of trust, from large acute and specialist hospitals through to community, ambulance and mental health trusts.
	Nolan Principles	key principles of how individuals and organisations in the public sector should conduct themselves comprising of: selflessness, integrity, objectivity, accountability, openness, honesty, leadership. Set by the Committee for Standards in Public Life, an independent advisory non-departmental public body set up to advise the prime minister on ethical standards
	NHS Resolution	not-for-profit part of the NHS which manages negligence and other claims against the NHS in England on behalf of their member organisations. Also, an insurer for NHS bodies
	Nuffield Trust	independent source of evidence-based research and policy analysis for improving health care in the UK, also a charity

O

OD	Organisational Development *or* Outpatients Department	a systematic approach to improving organisational effectiveness *or* a hospital department where healthcare professionals see outpatients (patients which do not occupy a bed)
OOH	Out of Hours	services which operate outside of normal working hours
OP	Outpatients	a patient who is not hospitalized for 24 hours or more but who visits a hospital, clinic, or associated facility for diagnosis or treatment
OPMH	Older People's Mental Health	mental health services for people over 65 years of age
OSCs	Overview and Scrutiny Committees	established in local authorities by the Local Government Act 2000 to review and scrutinise the performance of public services including health services
OT	Occupational Therapy	assessment and treatment of physical and psychiatric conditions using specific activity to prevent disability and promote independent function in all aspects of daily life

P		
PALS	Patient Advice & Liaison Service	offers confidential advice, support and information on health-related matters to patients, their families, and their carers within trusts
PAS	Patient Administration System	the automation of administrative paperwork in healthcare organisations, particularly hospitals. It records the patient's demographics (e.g. name, home address, date of birth) and details all patient contact with the hospital, both outpatient and inpatient
PbR	Payment by Results or 'tariff'	a way of paying for health services that gives a unit price to a procedure
PCN	Primary care network	A key part of the NHS long term plan, whereby general practices are brought together to work at scale
PDSA	Plan, do, study, act	A model of improvement which develops, tests and implements changes based on the scientific method
PFI	Private Finance Initiative	a scheme where private finance is sought to supply public sector services over a period of up to 60 years
PHE	Public Health England	a body with the mission to protect and improve the nation's health and wellbeing and reduce health inequalities
PHSO	Parliamentary and Health Service Ombudsman	an organisation which investigates complaints that individuals have been treated unfairly or have received poor service from government departments and other public organisations and the NHS in England
PICU	Psychiatric Intensive Care Unit *or* Paediatric Intensive Care Unit	a type of psychiatric in-patient ward with higher staff to patient ratios than on 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