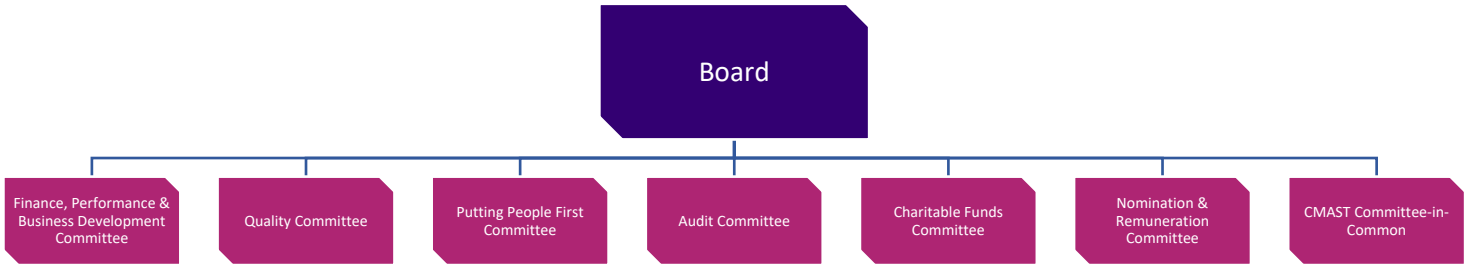
Liverpool Women's NHS Foundation Trust

Trust Board

11 May 2023, 09.30am

Boardroom, LWH & Virtual, via Teams



Liverpool Women's
NHS Foundation Trust

Trust Board

Location	Boardroom, LWH & Virtual via Teams
Date	11 May 2023
Time	09.30am

Item no. 23/24/	Title of item	Objectives/desired outcome	Process	Item presenter	Time
		PRELIMINARY BUSINESS			
019	Introduction, Apologies & Declaration of Interest	Receive apologies & declarations of interest	Verbal	Chair	0930 (5 mins)
020	Meeting Guidance Notes	To receive the meeting attendees' guidance notes	Written	Chair	
021	Minutes of the previous meeting held on 6 April 2023	Confirm as an accurate record the minutes of the previous meeting	Written	Chair	
022	Action Log and matters arising	Provide an update in respect of on-going and outstanding items to ensure progress	Written	Chair	
023	Patient / Staff Story	To receive a patient story	Presentation	Chief Nurse	0935 (20 mins)
024	Chair's announcements	Announce items of significance not found elsewhere on the agenda	Verbal	Chair	0955 (5 mins)
025	Chief Executive Report	Report key developments and announce items of significance not found elsewhere on the agenda	Written	Chief Executive	1000 (5 mins)
		MATERNITY			
026	Family Health Update – Maternity and Neonatal Three-Year Plan	For assurance	Written	Chief Operating Officer	1005 (15 mins)
		QUALITY & OPERATIONAL PERFORMANCE			
027a	Chair's Report from the Quality Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	1020 (25 mins)
027b	Quality & Operational Performance Report	For assurance – To note the latest performance measures	Written	Chief Operating Officer	
027c	Integrated Governance Assurance Report Quarter 3, 2022/23	For information	Written	Chief Nurse	
		BREAK – 10 mins			

Board Thank You – 5 mins					
FINANCE & FINANCIAL PERFORMANCE					
028a	Chair's Report from the Finance, Performance and Business Development Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	1100 (45 mins)
028b	Finance Performance Review Month 12 2022/23	For assurance - To note the current status of the Trust's financial position	Written	Chief Finance Officer	
028c	Financial Plan Overview 2023/24	To note	Written	Chief Finance Officer	
PEOPLE					
029a	Workforce Performance Report	For assurance – To note the latest performance measures	Written	Deputy Director of Workforce	1145 (10 mins)
BOARD GOVERNANCE					
030a	Corporate Objectives: Objective Setting 2023/24	For approval	Written	Chief Executive	1155 (20 mins)
030b	Covid-19 Inquiry Update	For assurance	Written	Trust Secretary	
030c	Board Assurance Framework	For assurance	Written	Trust Secretary	
CONSENT AGENDA (all items 'to note' unless stated otherwise) *All these items have been read by Board members and the minutes will reflect recommendations unless an item has been requested to come off the consent agenda for debate; in this instance, any such items will be made clear at the start of the meeting.*					
031	Emergency Planning Resilience and Response Annual Board Report	For noting	Written	Chief Operating Officer	Consent
032	Revised Risk Management Strategy for 2023/24	For approval	Written	Chief Nurse	
033	Proposed Risk Appetite Statement 2023/24	For approval	Written	Chief Nurse	
034	Review of non-executive director champion roles	For assurance	Written	Trust Secretary	
CONCLUDING BUSINESS					
035	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair	1215 (5 mins)
036	Chair's Log	Identify any Chair's Logs	Verbal	Chair	
037	Any other business & Review of meeting	Consider any urgent items of other business	Verbal	Chair	
038	Jargon Buster	For reference	Written	Chair	

Date of Next Meeting: 13 July 2023

1220 - 1230	*Questions raised by members of the public*	To respond to members of the public on matters of clarification and understanding.	Verbal	Chair

Liverpool Women's
NHS Foundation Trust

Meeting attendees' guidance

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

Before the meeting

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

General considerations:

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

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

Virtual / Hybrid Meetings via Microsoft Teams and other digital platforms

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

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

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

At the meeting

General Considerations:

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

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

Virtual / Hybrid Meetings via Microsoft Teams and other digital platforms

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

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

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

Attendance

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

After the meeting

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

Standards & Obligations

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

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

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

Page 129 Handbook to the NHS Constitution 26th March 2013

Liverpool Women's
NHS Foundation Trust

Board of Directors

Minutes of the meeting of the Board of Directors held in the Boardroom and Virtually via Teams at 09.30am on 6 April 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
Gloria Hyatt MBE	Non-Executive Director
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
Rachel London	Deputy Director of Workforce (in attendance for Chief People Officer)
Nashaba Ellahi	Deputy Director of Nursing & Midwifery (in attendance for Chief Nurse)
Joe Downie	Deputy Chief Operating Officer
Heledd Jones	Head of Midwifery (to item 009a)
Dr Rachael Gregoire	Scientific Director/HFEA Person Responsible (item 005 only)
Annie Gorski	Public Governor
Felicity Dowling	Member of the Public
Teresa Williamson	Member of the Public
Mary Whitby	Member of the Public
Denise Richardson	Member of the Public
Mark Grimshaw	Trust Secretary (minutes)

APOLOGIES:

Michelle Turner	Chief People Officer / Deputy Chief Executive
Dianne Brown	Chief Nurse

Core members	**Mar 22**	**Apr**	**May**	**Jun**	**Jul**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Apr 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	✓	✓	✓
Eva Horgan – Chief Finance Officer	✓	✓	✓	✓	✓	✓		✓	✓	Non-member		
Marie Forshaw – Chief Nurse & Midwife	✓	✓	A	✓	✓	Non-member						
Dianne Brown – Chief Nurse	Non-member					✓		✓	✓	✓	✓	A
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	NM	✓	A	✓	✓	✓		A	✓	✓	✓	✓
Jenny Hannon - Chief Finance Officer / Executive Director of Strategy & Partnerships	Non-member									✓	✓	✓
Matt Connor – Chief Information Officer (non-voting)	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓

23/24/	
001	**Introduction, Apologies & Declaration of Interest** The Chair welcomed everyone to the meeting. No declarations of interest were made, and apologies were noted as above.
002	**Meeting guidance notes** The Board received the meeting attendees' guidance notes.
003	**Minutes of the previous meetings held on 2 February 2023** Subject to the following amendment, the minutes of the Board of Directors meeting held on 2 February 2023 were agreed as a true and accurate record: • Amendment to the attendance record of Eva Horgan, Chief Finance Officer to reflect her departure from the organisation in December 2022.
004	**Action Log and matters arising** The Action Log was noted.
005	**Patient / Staff Story – Hewitt Fertility Centre** The Scientific Director/HFEA Person Responsible noted that the Hewitt Fertility Centre (HFC) had undergone a period of review and transformation over the previous 18 months, supported by Dianne Brown. Key transformation wins and challenges regarding finance and planning, digital, and clinical were outlined. It was noted that the HFC was regulated by the Human Fertilisation and Embryology Authority (HFEA) and that inspections of the services were undertaken. An unannounced inspection was expected with

	pre-inspection information submitted and interviews scheduled. Outstanding concerns and risks were outlined and assurance provided that the service was aware of the areas of challenge and was responding appropriately. It was highlighted that the HFC had performed well in relation to the UKAS assessments for Diagnostic Andrology Services and attention was drawn to the number of staff involved in award winning research. The Scientific Director/HFEA Person Responsible continued to describe the positive patient impacts that the HFC provided with examples given from recent patients and their families. Non-Executive Director, Louise Martin, queried whether the HFC was maximising its commercial income, citing egg freezing has a particular opportunity. It was confirmed that the HFC did provide this service and it was acknowledged that, with the appropriate ethical considerations, more could be done to promote it. The Chair remarked that he had recently visited the Knutsford site and there had been feedback that increasing flexibility for private pathways could be improved. The Medical Director stated that significant work had been undertaken to develop the respective patient pathways and there was now the potential to unlock additional private income. Non-Executive Director, Louise Kenny, noted that colleagues from University College Cork (National University of Ireland) had recently visited the HFC, recognising it as a site of best practice. Feedback received had been positive and it was hoped that the relationship could continue and develop. The Board noted the patient / staff story and thanks the Scientific Director/HFEA Person Responsible for her commendable leadership. *Rachael Gregoire left the meeting.*
006	Chair's announcements The Chair highlighted the following: • Attendance at a recent long service award ceremony. Sixteen recipients received their awards on the day but there were 41 individuals with 25+ years' service in the NHS that were acknowledged. • Congratulations were extended to Jennifer Deeney who had been awarded the 2023 March of Dimes Excellence in NICU Leadership Award winner. Given in partnership with Synova Associates LLC, this was an international award that honoured NICU leaders who demonstrated four essential attributes: effectively supported their team, advanced the care of patients and the operation of the unit, had strategic vision and had excellent communication skills. This was the first time the award had been given to a non-US resident. • Attendance at an NHS Provider conference in London. The national financial position had been the key theme. • Thanks to all staff for their hard work during the recent CQC inspection process. The Board noted the Chair's update.
007	Chief Executive's report The Chief Executive presented the report which detailed local, regional and national developments. The following key points were highlighted: • New permanent CT Scanner now fully operational at the Crown Street site • Mark Bakewell, current ICB Deputy Director of Finance, had been appointed as Place Director for Liverpool on an interim six-month basis • That there had been two uses of the Trust Seal during 2022/23 o The Board also provided their approval for the use of the Seal to execute a lease for part of the St Chad's Community Centre in Knowsley.

	Non-Executive Director, Jackie Bird, highlighted the North West Black, Asian and Minority Ethnic Assembly Statement which called on people in positions in power and privilege to step up in order to make sure that the NHS in the region dealt with the structural and institutional barriers that resulted in ethnic inequalities in access, experiences, and outcome. It was agreed that the Board should continue to take account of the issues raised in the statement. The Board of Directors: • noted the Chief Executive update. • Noted the use of the Trust Seal during 2022/23 • Approved the use of the Trust Seal to execute a lease for part of the St Chad's Community Centre in Knowsley.
008a	Maternity Improvement Update The Deputy Chief Operating Officer provided an overview of the progress being made against the key workstreams that fed into the overall Maternity Transformation Programme. In relation to the Maternity Assessment Unit (MAU) workstream, improvements made to date were outlined and it was expected that 100% compliance for triage within 30 minutes would be achieved by the end of May 2023 (98.23 % achieved between 1 February 2023 and 20 March 2023). The Trust continued to aspire to consistently achieve a 15-minute triage wait time within six months and it was confirmed that the staffing model to facilitate this would run 'in shadow' ahead of full implementation. The Chair sought assurance on the long-term sustainability of the proposed staffing model. The Deputy Chief Operating Officer confirmed that the staffing model had been revised and this was being monitored at daily bed meetings. The ability to flex staff into different maternity areas to respond to demand had been factored into the model. The addition of Advanced Care Practitioners into the workforce would also provide increased support. It was reported that the Family Health Division was working with the Business Intelligence teams to enhance the data available to understand how to drive improvements most effectively in relation to time to medical review for women presenting at MAU. The Medical Director confirmed the importance of the Trust understanding how effective processes were for escalating cases rated as an 'amber' or 'red' risk to be seen by an obstetrician. Sample audits were planned on a bi-monthly basis to gain patient feedback and track whether improvements were being made. Non-Executive Director, Louise Martin, noted a concern regarding abandoned telephone calls to MAU triage and requested that the six month and 12-month objectives be strengthened for this area by being more specific on the intended outcomes. It was queried if a system approach to MAU telephone triage was being explored. The Deputy Director of Nursing & Midwifery confirmed that this was being discussed at system level meetings. The Deputy Chief Operating Officer continued to provide an update on the MAT BASE improvement programme and the progress being made against the Ockenden recommendations. It was noted that patient flow through maternity was showing signs of improvement with discharges taking place throughout the day rather than being grouped at peak times. The Chair noted that he was encouraged that the Family Health Division was seeking holistic improvements to the whole maternity pathway and ensuring that patient flow was a priority. It was asserted that the challenges in maternity services could not be seen in isolation but rather as interconnected and co-dependent. The Board received the update.
008b	Perinatal Quality Surveillance & Safety The Board received the perinatal quality dashboard and framework. The Deputy Director of Nursing & Midwifery explained that the data provided within the report was monitored monthly and featured

	on the Family Health Divisional Board meeting agenda. This included reviewing and monitoring of compliance against all Maternity KPIs that were included within the Maternity Power BI dashboard. In addition to the above, it was reported that internal assurance process data was submitted externally to the Northwest Coast Regional Dashboard monthly. Any areas of concern which were highlighted as outliers were returned to Maternity Senior Leadership Team for further analysis and review by Clinical Director to identify areas for improvement and to share learning. The Chair remarked that the level of detail provided within the dashboard required a review to ensure that it was appropriate for the Board. Attention was drawn to the Caesarean Section rate and queried whether the current measure was germane. It was agreed that this would be reviewed with an outcome reported to the Quality Committee. Chair's Log: For the Quality Committee to receive the outcome of a review into the most appropriate method of measuring Caesarean Section (emergency and total) rates. The Chief Information Officer noted that the current PDR rate (50%) for maternity required significant improvement and requested additional assurance in future reports on the actions being taken. The Board noted that Safety Champion walkarounds continued to take place within clinical areas. Key issues identified, included: • Challenges with transferring acutely unwell patients to other hospital sites • Noted improvements to MAU and triage times – staff had stated they felt the environment felt safer. The Board received the report. *Heledd Jones left the meeting*
009a	Chair's Reports from the Quality Committee The Board considered the Chair's Reports from the Quality Committee meetings held on 20 February 2023 and 27 March 2023. Non-Executive Director, Sarah Walker, Chair of the Committee, highlighted the following issues: • The Committee would continue to monitor MAU triage performance and the sustainability of mitigating actions • The Committee had agreed with an interim suspension of the Maternity Continuity of Carer model and had been updated regarding a re-evaluation of the future approach • The quality impact of long waiting times had been explored • The Committee had requested that a refreshed Clinical & Quality Strategy be received at a future meeting • A verbal update relating to a recent maternal death was received. This involved a patient admitted to the Crown Street site and then transferred to the Royal Liverpool site. This would be reviewed through the Trust's incident management processes and a look back exercise on previous hospital transfers and their impact had been requested. The Board of Directors received and noted the Chair's Reports from the Quality Committee meetings held on 20 February 2023 and 27 March 2024.
009b	Quality & Operational Performance Report The Board considered the Quality and Operational Performance Report. The Chair stated that the Cancer 62-day performance was unacceptable and sought clarification on the underlying reasons and the improvement actions being put into place. The Deputy Chief Operating Officer acknowledged that the performance required significant improvement and noted

	that progress had been made during March 2023 to increase the compliance rate. It was explained that delays to histology were a contributing factor and action was being taken to improve the performance management of the Service Level Agreement in place for providing this diagnostic support. The Trust had also approached the Cancer Alliance to review existing processes and identify opportunities for improvement. Non-Executive Director, Louise Kenny, reported that the Quality Committee had discussed the 62-day performance and had requested additional detail on the cancer types so that the drivers behind the delays could be better understood. Chair's Log: For the Quality Committee to monitor Cancer 62-day performance and to seek assurance on the effectiveness of improvement actions. In relation to the 78-week wait target, the Trust had ended the fiscal year with 20 patients that continued to wait for an appointment – this was against a target of zero. All but one of the patients had been given a date during April 2023 (the exception being due to Covid-19). Work was now focused on reducing the number of patients waiting 65 weeks and 52 weeks respectively. Non-Executive Director, Jackie Bird, drew attention to the safe staffing section and noted that occupancy at the Gynaecology Emergency Department (GED) was low. It was queried whether staffing numbers were reviewed during the day. The Deputy Director of Nursing & Midwifery confirmed that staffing levels for GED were reviewed at the daily bed meetings. Non-Executive Director, Louise Martin, noted that the Serious Incident target for the year had been significantly breached and queried the reasons for this. The Deputy Director of Nursing & Midwifery explained that the threshold for declaring a serious incident had been amended during the year to include incidents with the isolated site as a contributory factor. This had increased the number of declared incidents. For 2023/24, further thought would be required on setting updated targets. Chair's Log: For the Quality Committee to undertake a deep dive into the main themes for Serious Incidents and for this to also consider the impact of health inequalities. The Deputy Chief Operating Officer highlighted that improvements were being seen in diagnostic performance and that there were potential opportunities to provide mutual aide for the system. The Board of Directors: • Received and noted the Quality & Operational Performance Report.
009c	Bi-annual staffing paper update, July 2022-December 2022 (Q2 & Q3) The Board received the report which set out the Trust position in the context of the National Nursing, Midwifery and AHP workforce challenges. The report was previously presented at Putting People First Committee (PPF) on 20 March 2023. The PPF Committee were assured with the triangulation of information presented that provided a Trust wide overview. The Committee commented on the available detail at a divisional level, noted in several appendices, which were discussed, supported, and demonstrated divisional actions being taken to address and improve safe staffing. Non-Executive Director, Jackie Bird, commended the quality of the report and suggested that further improvements could be made via the inclusion of: • Professional judgement of ward managers • Information on bank usage requests and numbers achieved • Information on overstaffed shifts and the optimum numbers required The Deputy Director of Workforce reported that system discussions relating to agency usage remained on-going. The Board of Directors:

	• Noted the contents of the paper and; • Took assurance from the actions undertaken to effectively manage and provide safe staffing within Nursing, Midwifery and AHP to support the delivery of safe care.
009d	Learning from Deaths Quarter 3, 2022/23 The Board received the report which presented the mortality data for quarter three and the learning from deaths information for quarter two. In Quarter three there were the following deaths: • Adult deaths – 0 • Stillbirths 8 • Neonatal deaths 16 (including 8 in utero transfers and 1 post-natal transfer) The stillbirth rate remained lower this year than last year but there was an increase in this quarter to 4.3/1000 live births. Due to small numbers, full year data should be reviewed to determine any trends. Benchmarking data was presented for Q3 which showed that LWH stillbirth rate was below the average for similar sized maternity services. There was an increase in Neonatal mortality. This resulted from 10 babies whose deaths resulted from congenital anomalies. International network benchmarking data was presented for 2021 neonatal mortality. This risk adjusted mortality for 2021 was the lowest it had been since this benchmarking commenced. The Board of Directors: • took assurance that there was an adequate process against the requirements laid out by the National Quality Board and that there were effective processes in place to assure the Board regarding governance arrangements in place to drive quality and learning from the deaths of adults in receipt of care at the Trust. • 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. • the care issues identified in the antenatal management from referring trusts. • Agreed that a review of antenatal care findings from the previous PMRT reviews be undertaken and if any common themes identified that this be presented to the local maternity and neonatal system
009e	Guardian for Safe Working Hours Quarterly Report – Q3 2022/23 The Board received the report from the Guardian of Safe Working Hours which covered aggregated exception reports, fines levied, data on rota gaps, locum usage, other relevant data, and qualitative narrative on good practice or persistent concern for the period of 1 October – 31 December 2022. Non-Executive Director, Zia Chaudhry, queried the level of agency staff usage to mange rotas. The Medical Director explained that agency staff usage was minimal but existing staff were filling rota gaps by working additional hours. This was contributing to a risk of burnout and reducing the opportunity for junior doctors to access training and education. Chair's Log: For the Putting People First Committee to explore the impact of junior doctor's working additional hours to cover rota gaps, particularly on training opportunities.

	The Board received the report and the assurances that the hours and templates were safe and compliant in each service and in line with the junior doctor contract.
010a	Chair's Report from the Putting People First Committee The Board considered the Chair's Report from the Putting People First Committee meeting held on 20 March 2023. Non-Executive Director, Gloria Hyatt, chaired the meeting and highlighted the following issues: • The Committee received a further update on compliance rates across the divisions for mandatory training with a focus on those that had not previously completed training or out of date by significant periods. Improvements had been demonstrated in areas although maternity and medical staffing remained a risk. • The Committee noted a significant risk in relation to the Post Graduate Doctor (PGD) workforce due to the increasing frequency of rotation of PGDs and the GP trainees causing increased difficulty with the complexity of the patients at LWH; an increasing number of staff working less than full time; and a significant number of gaps on the on-call rotas which were a challenge to manage. • The Committee received the proposed Equality Objectives for 2023 – 27 for workforce and patients. A discussion in relation to the narrative and measurability of the objectives led to the Committee pausing approval to allow suggested amendments to be made and to be submitted to the Trust Board in April 2023 for approval. The Board of Directors: • Received and noted the Chair's Report from the Putting People First Committee meeting held on 20 March 2023.
010b	Workforce Performance Report The Board received the Workforce Performance Report. The Chief People Officer noted that the following key issues: • Sickness rates continued a downward trend • Mandatory training compliance demonstrated signs of improvement The Chair asked if the Putting People First Committee was receiving and scrutinising trajectories for improvement. The Deputy Director of Workforce stated that trajectories existed but due to several variables they could often be unreliable. It was noted that there was a process for reviewing mandatory training to ensure that the areas remained appropriate. The Board of Directors noted the Workforce Report.
010c	Staff Survey 2022 – Key Themes and Headlines The Board received an overview of the key themes of the 2022 NHS Staff Survey. The Trust saw an encouraging trend of improvement across all themes, against a backdrop of national deterioration. It was also positive to note that staff felt that there had been improvements in team working and support from their line manager. The Trust had been highlighted nationally as the joint most highly improved Trust in England for the Staff Engagement score. Key areas identified for improvement were as follows: • As in previous years staff continued to say that their PDR did not help them do their job, only 20.9% of staff found it helpful. • Flexible working - although there had been an improvement in people getting a work life balance and feeling able to talk to their immediate manager about flexible working, only 50% of staff are satisfied with the opportunities for flexible working (the same as 2021). • There had been an increase in staff reporting experiencing discrimination on the basis of ethnic background, gender and religion (though a decrease for disability and sexual orientation).

	The Board acknowledged that whilst there remained a significant amount of work to make further improvements, it was important to note that there was evidence that good progress had been made across several areas. The Board noted the contents of the paper and the performance of the Trust in staff survey and agreed with the next steps outlined to make further improvements.
010d	EDI Reports for Publication The Deputy Director of Workforce explained that as a public sector body, the Trust was governed by the Equality Act 2010 and the Public Sector Equality Duty (PSED) in relation to its equality duties. As part of the PSED the Trust was required to publish reports for EDS 2022, Equality, Diversity & Inclusion (EDI) Annual Report and Equality Objectives. The Trust was also required to publish Gender Pay Gap report on the website, to meet the Government requirements for Gender Pay Gap reporting. The Board received an outline of the Trust's achievements in 2022/23 in relation to EDI and the plans for 2023/24. In addition, the required reports had been included as appendices for approval for publication on the Trust website. It was noted that these had been reviewed by the Putting People First Committee and requested amendments had been made when submitting to the Board. Non-Executive Director, Gloria Hyatt, suggested that the Trust could do more to ensure that the EDI agenda was mainstreamed throughout the organisation and embedded in non-EDI strategies and plans. It was agreed to explore this further in a future Putting People First Committee workshop. Non-Executive Director, Louise Martin, stated that the EDI agenda was not only about staff but also the Trust's patients. Referring to the learning from deaths report, Louise Martin remarked that too often deprivation was a causal factor for still birth and neonatal mortality and that the Trust had a responsibility to actively engage with this issue. The Board of Directors approved the following reports and agreed to their publication on the Trust website: • EDS 2022 • EDI Annual Report 2022/23 • Equality Objectives • Gender Pay Gap
	Board Thank you *Thank you's were presented to the following:* *1) Amber Houghton, Midwife - nominated for Mariposa Award as bereavement care professional of the year.* *2) Emma Rush, Emma Garnett, Paula Perez and Nicole Ferrier - all secured places in national cohort of 20 for FNF Early Career Nurse Midwife Leadership programme* *3) Rachel Gregoire – nominated for providing exceptional leadership for the Hewitt Fertility Centre* *4) Jen Deeney – awarded the 2023 March of Dimes Excellence in NICU Leadership Award winner.*
011a	Chair's Reports from Finance, Performance and Business Development Committee The Board considered the Chair's Reports from the Finance, Performance & Business Development Committee meetings held on 20 February 2023 and 27 March 2023. Non-Executive Director, Louise Martin, Chair of the Committee, highlighted the following issues: • The Committee continued to closely monitor the financial position and recovery actions • The Committee was focused on seeking assurances on operational performance, particularly the progress being made to reduce waiting times for patients.

	• The Committee had a challenging debate in relation to the CDC business case for 2023/24. Due to varying risks in relation to activity, revenue, and capital the Committee agreed that it was not in a position to make a recommendation to the Trust Board and was not fully committed to recommending a bid for continued funding 2023/24. Requests for additional detail and scenarios were requested to continue the discussion. • Positive assurances had been received regarding the progress being made to implement the EPR. The Board of Directors: • Received and noted the Chair's Reports from the FPBD Committee meetings held on 20 February 2023 and 27 March 2023.
011b	Chair's Reports from the Audit Committee The Board considered the Chair's Report from the Audit Committee meetings held on 9 February 2023 and 23 March 2023. Committee Chair and Non-Executive Director, Tracy Ellery, highlighted the following key issues: • The Committee received the external audit plan from Grant Thornton. Noted that materiality had been reduced to 1.8% as it was first year auditing the Trust's accounts (to provide a greater level of detail). Significant risks identified for the audit had been identified. Assurance was provided that there had been an effective handover with the previous external auditor – KPMG, and that there had been positive engagement with the finance team. • Two out of the five internal audit reports were marked as 'limited assurance' – o Ockenden Review o Intra NHS SLAs and Contracts Review • The Committee received an outline of performance to date on the Better Payment Practice Code (currently below 80% against 95% target) and the actions to improve performance in 2023/24. • The Committee approved the 2023/24 internal audit, anti-fraud and clinical audit plans. The Board of Directors: • Received and noted the Chair's Report from the Audit Committee meeting held on 23 March 2023.
011c	Chair's Report from the Charitable Funds Committee The Board considered the Chair's Report from the Charitable Funds Committee meeting held on 6 February 2023. Committee Chair and Non-Executive Director, Tracy Ellery, noted that the Committee awaited the draft Fundraising Strategy which was expected to be received at the next scheduled meeting. It was noted that Non-Executive Director Zia Chaudhry would be taking over the Chair of the Committee from the next scheduled meeting. The Board of Directors: • Received and noted the Chair's Report from the Charitable Funds Committee meeting held on 9 February 2023.
011d	Finance Performance Review Month 11 2022/23 The Chief Finance Officer presented the Month 11 2021/22 finance performance report which detailed the Trust's financial position as of 28 February 2023. At Month 11, the Trust was reporting a £3,898k deficit year to date (YTD) which was £4,469k off plan and was supported by £12,528k of non-recurrent items. The forecast out turn (FOT) was a £1,655k deficit, £2,181k worse than plan, after inclusion of £5,053k of recovery actions. The cash balance at 28 February 2023 was £10,793k, including ICS cash support of £6m which had been repaid in March 2023. Revenue support funding of £4.5m had been received to replace this.

	The Chief Finance Officer asserted that the Trust was experiencing the manifestation of the structural deficit which had been predicted and reported over several years. It was now expected that the 2022/23 financial plan would not be delivered to the identified target. A significant amount of effort was being applied to recovery actions which were being tracked closely by the Financial Recovery Board and the Finance, Performance and Business Development Committee. The Chief Finance Officer noted that the Trust had an outstanding debt with Liverpool University Hospitals NHS Foundation Trust (LUHFT) (£3.79m) which had been provided for in the 2021/22 and 2022/23 budgets. An invoice for £777k had been received and the Board was asked to approve the payment. The Chair requested an update on 2023/24 financial and operational planning. The Chief Finance Officer reported that a draft plan had been submitted in line with the timetable established by the ICB and NHS England. It was expected that a final plan would be submitted at the beginning of May 2023. Discussions continued with commissioners, but it was likely that the Trust would be submitting a deficit position. It was asserted that wider system support would be required to find solutions for the structural deficit that underpinned the Trust's financial challenges. Assurances were provided that quality impact and equality impact assessments would be undertaken ahead of decisions on savings. A process had also started to review the effectiveness of previous investments made by the Trust and whether resources could be diverted into other areas. The Board of Directors: • Noted and received the Month 11 2022/23 Finance Performance Review • Approved the payment of the £777k invoice to LUHFT as part of the overall debt owed by the Trust.
012a	Corporate Objectives 2022/23: Final Outturn Review The Board received the final outturn review against the 2022/23 Corporate Objectives, noting that the detail had been considered at the aligned Committees. The Board of Directors: • Received the report, and; • Noted the performance / progress to date against the 2022/23Corporate Objectives.
012b	Board Assurance Framework The Board of Directors received the Board Assurance Framework. The Trust Secretary explained that the BAF risks had been discussed at the aligned Committees during March 2023. The following key updates were noted: • The Putting People First Committee had recommended that the score for BAF risk 1.2 remain at '20' - (consequence 5, likelihood 4). • The Finance, Performance & Business Development Committee had recommended that the score for BAF risk 4.3 increase from 'a6' to '20' - (consequence 4, likelihood 5). The Trust Secretary reported that ahead of the next Board meeting, a significant review of the BAF was scheduled to take place – it was likely that this would result in a reduction of the number of BAF risks to help provide greater clarity on the key strategic risks facing the Trust. Suggested risk areas were as follows: • Clinical sustainability • Financial sustainability • Workforce • Patient Experience • Being an effective partner • Digital

	The Board reviewed and received the BAF Risks agreeing their contents and actions. *The following item was received under the 'Consent Agenda'*
013	**Trust Board Terms of Reference** The Board of Directors approved the Board Terms of Reference. *The following item was removed from the 'Consent Agenda'*
014	**Board Committee Annual Reports, 2023/24 cycles of business and Terms of Reference** The Board of Directors reviewed the following documents: • Committee Annual Reports for the Quality, Finance, Performance & Business Development, and Putting People First Committees • Committee Business Cycles for 2023/24 for the Quality, Finance, Performance & Business Development, Putting People First, and Audit Committees • Committee Terms of Reference for the Quality, Finance, Performance & Business Development, Putting People First, and Audit Committees The Chair noted that there were some inconsistencies between the quoracy requirements for the respective Board Committees. It was requested that these be reviewed ahead of the Board providing its approval for the Terms of Reference. The Board of Directors resolved to: • approve the following documents: o Committee Annual Reports for the Quality, Finance, Performance & Business Development, and Putting People First Committees o Committee Business Cycles for 2023/24 for the Quality, Finance, Performance & Business Development, Putting People First, and Audit Committees o Audit Committee Terms of Reference • Review the quoracy requirements within the Committee Terms of Reference for the Quality, Finance, Performance & Business Development, and Putting People First Committees to ensure consistency where appropriate ahead of providing approval.
015	**Review of risk impacts of items discussed** The Chair identified the following risk items and positive assurances: Risks: • The impact of industrial action on workforce pressures and performance recovery • The Trust's financial position and long-term sustainability Positive assurances • Hewitt Fertility Centre improvements
016	**Chair's Log** The following Chair's Logs were noted: • For the Quality Committee to receive the outcome of a review into the most appropriate method of measuring Caesarean Section (emergency and total) rates. • For the Quality Committee to monitor Cancer 62-day performance and to seek assurance on the effectiveness of improvement actions. • For the Quality Committee to undertake a deep dive into the main themes for Serious Incidents and for this to also consider the impact of health inequalities.
017	**Any other business & Review of meeting** None noted.

	Review of meeting No comments noted.
018	Jargon Buster Noted.

Liverpool Women's
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Action Log

Trust Board - Public
11 May 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~~ June 23	On track	MVP to be invited to June workshop to coincide with wider discussion on 'how the Trust listens (to patients)'

Chair's Log

Received / Delegated	Meeting Date	Issue and Lead Officer	Receiving / Delegating Body	Action Deadline	RAG Open/Closed	Comments / Update
Delegated	02.02.2023	To undertake a review of the ward management structure to ensure that it enables effective management relationships. Executive Lead: Chief People Officer	PPF	May 2023	Open	
Delegated	06.04.2023	To undertake a deep dive into the main themes for Serious Incidents and for this to also consider the impact of health inequalities. Executive Lead: Medical Director	Quality Committee	May 2023	Open	
Delegated	06.04.2023	To monitor Cancer 62-day performance and to seek assurance on the effectiveness of improvement actions. Executive Lead: Chief Operating Officer	Quality Committee	May 2023	Open	

Delegated	06.04.2023	To receive the outcome of a review into the most appropriate method of measuring Caesarean Section (emergency and total) rates. Executive Lead: Medical Director	Quality Committee	May 2023	Open	

Liverpool Women's
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CEO Report

Trust Board
May 2023

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*

HOLD

Section A - *Internal*

Flagship Liverpool birth cohort study aiming to improve health outcomes opens for recruitment

A major birth cohort study tracing the lives of 10,000 Liverpool families to enable researchers, clinicians, and policymakers to understand more about complex health issues opened on Tuesday 25th April.

Children Growing Up in Liverpool (C-GULL) is the first large-scale birth cohort study in the Liverpool City Region and will track 10,000 firstborn babies and their families from early pregnancy through childhood and beyond.

Researchers will collect information on their biological, physical, and mental health, as well as the home environment and more. This innovative study will use the latest data collection methods to give a comprehensive picture of the early life origins of health and wellbeing. This information will be used to inform policies and practices that promote the health and well-being of families in Liverpool and beyond.

C-GULL is a partnership between the University of Liverpool, the Wellcome Trust, Liverpool Women's Hospital NHS Foundation Trust, the Liverpool City Region Combined Authority, and Liverpool City Council. The study is delivered in collaboration with the NIHR Clinical Research Network North West Coast.

We're thrilled to be a part of this important study that will benefit families in our community and beyond. C-GULL will provide valuable insights into the early life origins of health and wellbeing and help us create a better future for our children."

Professor Louise Kenny, Lead Investigator (and LWH Non-Executive Director), said: "C-GULL is an exciting opportunity to make a real impact on the health of future generations. By tracking families from pregnancy through childhood, we can gain a deeper understanding of the complex factors that shape health outcomes."

C-GULL will be nested within a population-wide, civic data linkage platform. The study will collect extensive biological, biometric, socio-demographic, and psychosocial information at two-time points antenatally (12-16 weeks gestational age and 32-36 weeks gestational age), at birth, and when the child is aged three, 12, and 24 months.

Women are eligible to take part in the study if this is their first ongoing pregnancy, their pregnancy is in the first 12-16 weeks, they are aged 16 years and older and they have booked for their maternity care to be provided by Liverpool Women's Hospital.

Parents who participate in C-GULL will receive additional health checks and support for themselves and their children during pregnancy and childhood.

More information on C-GULL can be found here: https://www.liverpool.ac.uk/children-growing-up-in-liverpool/

Participants and prospective participants can find more information here: www.cgullstudy.com

Section A – *Internal*

The Women's View' April / May 2023

Bringing you the latest news, updates and all things LWH

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

Inside this special edition

- Dedicated to Excellence - our annual staff awards

digiCare 100days to Launch

The beginning of April 2023 marked the 100 days to launch of the Trust's Electronic Patient Record system (digiCare)

Please see a link to a short message below. This message is from Gary Price, Chief Operating Officer and Matt Connor, Chief Information Officer.

You can watch the video by clicking on or typing the following link into your browser either on your work or personal device:

https://tinyurl.com/ExecUpdatedigiCare100days

Section B - *Local*

NHS Cheshire and Merseyside Blog

As we enter the new financial year, we can now report that - by a hair's breadth - Cheshire and Merseyside narrowly missed the much-heralded national 78-week wait elective recovery target.

While I don't make a habit of praising colleagues over missed targets, I know the incredible amount of time, effort and innovation that has gone into getting us to this point.

NHS Cheshire and Merseyside will be reporting one of the smallest breaches to target of any Integrated Care Board - a phenomenal achievement.

I also know that the impact of recent NHS industrial action combined with an out-of-area independent provider unexpectedly returning a number of patients to Cheshire and Merseyside effectively prevented us from succeeding.

While our health and care system continues to operate just below the highest level of operational pressure, our response to ongoing system pressures will be further tested in the coming weeks - with the long Easter Bank Holiday weekend set to be immediately followed by a 96-hour period of industrial action by junior doctors.

Junior doctors are absolutely vital to the NHS. You will see them working in almost every part of a busy hospital, including A&E where they might diagnose you or put you under anaesthetic, write prescriptions, support the process of admission and discharge, maintain the flow of patients through the hospital and ensure beds are available for those who need them the most.

While the breadth and depth of what they do across the NHS means their absence will create further challenges, we continue to respect the right of NHS staff to take action.

Part of the solution to the current pressures continues to be encouraging greater use of virtual wards - which give more people the opportunity to receive the care they need from the comfort of their own home.

Virtual ward capacity across Cheshire and Merseyside is on the up - now standing at 227 'beds' available for patients with frailty, heart failure and / or acute respiratory illness.

They're operated either as a 'hospital at home' face-to-face service or a digitally-enabled remote monitoring service.

Finally, I'd like to note that - on April 1st 2023 - NHS Cheshire and Merseyside inherited significant additional devolved responsibilities from NHS England, including NHS Dentistry.

The COVID-19 pandemic, which had a disproportionate impact on the North West, disrupted routine dental care with NHS dentists having to focus on providing care for those with an urgent dental need.

We're under no illusions about the scale of the challenge - particularly with regard to access - but detailed due diligence has put us in a good position to take on these additional responsibilities and we're delighted to welcome members of the team from NHS England to support us with this endeavour.

Graham Urwin - Chief Executive

Full April 2023 update available here

Section B - *Local*

NHS Cheshire and Merseyside Integrated Care Board meeting

The NHS Cheshire and Merseyside Integrated Care Board met at the Lewis's Building, between 9am-11.40am on Thursday, 27 April.

https://www.cheshireandmerseyside.nhs.uk/media/athlhzoy/icb-public-pack-april-2023v1.pdf

MIAA 'Talking Fraud' Newsletter Spring 2023

The latest MIAA newsletter 'Talking Fraud' has been published.

This edition will cover:

- LUHFT & MIAA launch 'gamechanger' tech to clamp down on fraud
- How can I protect myself online?
- Fraud reclassified as national security threat
- And much more…
- Follow the link to find out more.

Section C - *National*

Delivery and continuous improvement review

This review considered how the NHS, working in partnership, can both deliver effectively on its current priorities and continuously improve quality and productivity in the short, medium and long term. Its findings and recommendations were consolidated into three actions:

- establish a national improvement board to agree a small number of shared national priorities on which NHS England, with providers and systems, will focus our improvement-led delivery work
- launch a single, shared 'NHS improvement approach' – NHS Impact 'improving patient care together' is the term we are using for this
- co-design and establish a Leadership for Improvement programme.

NHS England will work in partnership across systems to support organisations to embed a quality improvement method aligned with NHS Impact, which will inform ways of working across services at every level: primary care networks, local care networks, provider collaboratives, providers, integrated care boards and NHS England.

This website brings together improvement resources to support your organisation, including good practice pathways and guidance documents as well as cross-cutting workstreams such as GIRFT, intensive support and the national clinical audit.

Disparities in maternal deaths are unacceptable

Responding to the women and equalities committee's report on black maternal health, NHS Providers chief executive Sir Julian Hartley said:

"Trust leaders will be deeply concerned that black women are almost four times more likely to die from childbirth than white women.

"Disparities in maternal deaths are unacceptable, especially when NHS births are among the safest in the world. The NHS can, and must, do better.

"Trust leaders are committed to addressing inequalities in maternal care and providing high-quality personalised care to all mothers.

"As this report shows, much more progress is needed to improve care and outcomes for black mothers as well as efforts to tackle staff shortages in maternity services.

"The government's Maternity Disparities Taskforce, due to meet today, is a chance for renewed commitment to ensuring trusts and their staff have the investment they need to make much quicker progress on addressing maternal inequalities."

Section C – *National*

Patricia Hewitt's review into Integrated Care Systems published

Patricia Hewitt's independent review into Integrated Care Systems (ICS) was published at the beginning of April 2023.

The Secretary of State for Health and Social Care, Steve Barclay, commissioned Hewitt to chair the review in November 2022, asking her to explore how the oversight and governance of ICSs can best equip them for success.

The review identifies six key principles to enable ICS success, including:

- Collaboration within and between systems and national bodies;
- A limited number of shared priorities;
- Allowing local leaders the space and time to lead;
- The right support;
- Balancing freedom with accountability;
- Enabling access to timely, transparent and high-quality data.

The Hewitt Review drew upon the expertise and insight from across NHS, local government, social care and voluntary sectors, with patient representative organisations, academic experts and independent think tanks also adding their input to the call for evidence, which received more than 400 responses.

Commenting on the report, Hewitt said: "It was an enormous privilege to undertake this review, published today. Integrated Care Systems represent the best opportunity in a generation for the urgently needed transformation that we need in our health and care system. Everyone wants them to succeed.

"To fulfil their potential, however, we need not only to back our new structures, but also to change our culture. Everyone needs to change, and everyone needs to play their part. My recommendations are intended to help the health and care system make those changes – and I hope that ministers, NHS England and others will feel able to take them forward."

NHS Providers' Chief Executive, Sir Julian Hartley, praised the review's focus on prevention and health improvement in addition to the effects of inequality, racism and discrimination. He also positively noted the review's recommendations for multi-year funding and increasing the public health grant allocation, amongst other things.

Hartley also expressed some concerns however, particularly on the possibility of the some of the recommendations adding more complexity and bureaucracy as well as worries that trusts and Integrated Care Boards (ICB) won't be able to work as equal partners whilst ICBs have day-to-day oversight of providers.

Read the full review here.

Section C – *National*

Maternity Investigation Programme: Transition Update

Statement made on 30 March 2023 By Maria Caulfield MP – Parliamentary Under Secretary of State (Minister for Mental Health and Women's Health Strategy)

This statement updates Members on the transition of the Healthcare Safety Investigation Branch's (HSIB's) Maternity Investigation Programmes.

On 26 January 2022, by way of a Written Ministerial Statement, the Department of Health and Social Care announced that a separate Special Health Authority would be established to continue the independent Maternity Investigation Programme, which is currently overseen by the Healthcare Safety Investigation Branch.

The Department is committed to ensuring the continuation of independent, standardised maternity investigations that provide learning to the system and contribute to the Government's ambition to halve the 2010 rates of stillbirths, neonatal and maternal deaths and brain injuries in babies occurring during or soon after birth by 2025.

Following careful consideration, the Department has determined that the most appropriate and streamlined mechanism for delivering the valued and independent maternity investigations is for the function to be hosted within the Care Quality Commission. The purposes of the maternity investigation programme remain as set out last January: to provide independent, standardised and family focused investigations of maternity cases for families; to provide learning to the health system via reports at local, regional and national level; analyse data to identify key trends and provide system wide learning; be a system expert in standards for maternity investigations; and collaborate with system partners to escalate safety concerns.

We will now work with the CQC and the HSIB to complete the transition of the Maternity Investigation Programme to the CQC by October 2023.

As announced in the Written Ministerial Statement of 9 February 2023, the establishment of the new HSSIB will take place in October 2023, to enable all the necessary work to be completed to ensure a smooth transition of these investigation programmes.

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*23/23/026*		Date: 11/05/2023	
Report Title	Family Health Update – Maternity and Neonatal Three-Year Plan			
Prepared by	*Vicky Clarke, Divisional General Manger, Family Health*			
Presented by	*Vicky Clarke, Divisional General Manger, Family Health*			
Key Issues / Messages	The Board is asked to receive the report and note the reconfiguration of the Maternity Transformation programme to align its current priorities and key objectives to the themes recommended as part of the Three-Year Plan. 1. Listening to women and families with compassion 2. Supporting the workforce 3. Developing and sustaining a culture of safety 4. Meeting and improving standards and structures.			
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 ***• receive the report and note the reconfiguration of the Maternity Transformation programme to align its current priorities and key objectives to the themes recommended as part of the Three-Year Plan.*** ***• Note the current gap analysis and that work will continue to complete the action plan with progress reported via the Quality Committee.***			
Supporting Executive:	***Gary Price, Chief Operating Officer***			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☐

Strategic Objective(s)

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

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

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

REPORT DEVELOPMENT:

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

EXECUTIVE SUMMARY

NHS England published a three year delivery plan for maternity and neonatal services on 30th March 2023 following several national plans and reports, including the reports by Donna Ockenden and Dr Bill Kirkup.

This three-year plan brings together the key objectives maternity and neonatal services, and systems that support them, are asked to deliver against over the next three years.

NHS England developed the new delivery plan in consultation with service users, healthcare staff, trust leaders and other stakeholders, as well as with the Independent Working Group on maternity chaired by the Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists (RCOG). This consultation has supported NHS England to triage and review the actions remaining from the Ockenden and Kirkup reports as well as existing NHS England plans for maternity.

The report sets out the twelve priority objectives for NHS Trusts and systems for the next three years, across four themes:

5. Listening to women and families with compassion
6. Supporting the workforce
7. Developing and sustaining a culture of safety
8. Meeting and improving standards and structures.

The Trust has a Maternity Transformation programme which it is proposing is restructured to align its current priorities and key objectives to the themes recommended as part of the Three-Year Plan.

The Board is asked to

- receive the report and note the reconfiguration of the Maternity Transformation programme to align its current priorities and key objectives to the themes recommended as part of the Three-Year Plan.
- Note the current gap analysis and that work will continue to complete the action plan with progress reported via the Quality Committee.

NHS England's three-year delivery plan for maternity and neonatal services

Background

NHS England published a three year delivery plan for maternity and neonatal services on 30th March 2023 (Appendix One). Following several national plans and reports, including the reports by Donna Ockenden and Dr Bill Kirkup.

This three-year plan brings together the key objectives maternity and neonatal services, and systems that support them, are asked to deliver against over the next three years.

NHS England developed the new delivery plan in consultation with service users, healthcare staff, trust leaders and other stakeholders, as well as with the Independent Working Group on maternity chaired by the Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists (RCOG). This consultation has supported NHS England to triage and review the actions remaining from the Ockenden and Kirkup reports as well as existing NHS England plans for maternity.

The report sets out the twelve priority objectives for trusts and systems for the next three years, across four themes:

- ✓ **Listening to women and families with compassion**
- ✓ **Supporting the workforce**
- ✓ **Developing and sustaining a culture of safety**
- ✓ **Meeting and improving standards and structures.**

In response to the recent publication, the Trust has carried out a comprehensive preliminary gap analysis assessment of its current maternity transformation programme objectives and aligned these to the recommendations of the Three-Year plan. This will be an iterative process and will be further refined. It is proposed that this will continue to be managed through Family Health Transformation Governance and Assurance route, which has an established clinical multi-disciplinary and corporate working group, with Terms of Reference in place. This is led by Chief Nurse and Director of Midwifery and Board oversight is provided via Quality Committee, subcommittee of the Trust Board.

https://www.england.nhs.uk/publication/three-year-delivery-plan-for-maternity-and-neonatal-services/

Theme 1: Listening to and working with women and families with compassion

The plan identifies listening and responding to women and families as an essential component of safe and high-quality care: the importance of listening emerged strongly from both the Ockenden and Kirkup reports.

Theme 1 - Objective 1: 'Care that is personalised'
All women to receive compassionate personalised care based on an ongoing dialogue between women and families and their clinicians. NHS England and ICBs also have actions under this objective, with NHS England in particular committing to actions including:

- Producing standardised information to support the delivery of personalised care and aid decision-making
- Extending the national support offer for services who have not achieved UNICEF BFI accreditation or equivalent
- Creating a new patient-reported experience measure for maternity services by 2025.

Trusts are asked to:

- Provide maternity and neonatal staff with time, training, tools, and information to deliver personalised care
- Undertake regular audits of personalised care, including seeking feedback from women and parents, and acting on the findings
- Consider how to achieve midwifery continuity of carer in line with safe staffing principles
- Achieve the UNICEF UK Baby Friendly Initiative (BFI) standards on infant feeding, or equivalent, by 2027.

Theme 1 - Objective 2: 'Improve equity for mothers and babies
NHS England will in turn provide support for the implementation of Local Maternity and Neonatal System equity plans and pilot and evaluate new service models designed to reduce inequalities.
Trusts are asked to:

- Pay particular attention to health inequalities in providing services, for example facilitating informed decision-making in areas of inequalities and ensuring access to interpreter services.

Theme 1 - Objective 3: 'Work with service users to improve care'
The three-year plan acknowledges that co-production is beneficial at all levels of the NHS and is particularly important for those most at risk of experiencing health inequalities (NICE, 2018). Involving service user representatives helps identify what needs to improve and how to do it.

The plan recommends that this is done through maternity and neonatal voices partnerships (MNVPs) and by working with other organisations representing service users. MNVPs need to listen to and reflect the views of local communities including bereaved families and all groups.

Measuring impact: NHS England will monitor progress using:

- Indicators from CQC's maternity survey to monitor progress
- Indicators from Perinatal mental health services
- Proportion of services achieving UNICEF BFI accreditation.

Theme 2 - Objective 4: Growing, 'Retaining and Supporting our Workforce'
NHS England acknowledges that the ambitions of the three-year plan "can only be delivered by skilled teams with sufficient capacity and capability" and that currently services do not have the staff they need.

Objective four is to grow the workforce, and asks trusts to:

- Undertake regular local workforce planning, and to meet staffing establishment levels set by Birthrate Plus by 2027/28
- Develop and implement local plans to fill vacancies, including specific support for newly qualified staff and returners
- Provide additional administrative support.

Theme 2 Objective 5: 'Value and retain the workforce'
NHS England has committed to

- Providing funding for a retention midwife in every maternity unit during 2023/24, with ICBs providing this thereafter
- Providing funding to establish neonatal nurse quality and governance roles in trusts
- Strengthening neonatal clinical leadership at the national level.

Trusts are asked to take the following actions:

- Develop a retention improvement action plan to address local retention issues
- Reduce workforce inequalities and create an anti-racist workplace by acting on principles set out in combatting racial discrimination resources
- Identifying and addressing issues highlighted in student and trainee feedback surveys
- Offering newly registered midwives a preceptorship programme and providing mentors for newly appointed band 7 and 8 midwives

- Carry out succession planning and ensuring that the leadership pipeline represents the ethnic background of the workforce.

Theme 2 Objective 6: 'Invest in skills'
All staff are deployed to roles where they can develop and are empowered to deliver high quality care. Specialist roles within each profession, for example the labour ward coordinator, have a job description, orientation package, appropriate training, and ongoing development.

NHS England's proposed actions include:
- Refreshing the curriculum for maternity support workers and supporting the implementation of the maternity support worker (MSW) competency, education, and career development framework
- Developing leadership role descriptors for obstetricians by summer 2023
- Establishing a national training route for obstetric physicians.

Trusts are asked to:
- Undertake an annual training needs analysis and make training available in line with the core competency framework
- Ensure obstetricians and neonatal medical staff have appropriate clinical supervision in line with RCOG and British Association of Perinatal Medicine (BAPM) guidance
- Ensure locum medical staff covering middle grade obstetric rotas for two weeks or less possess an RCOG certificate of eligibility.
- Progress against these objectives will be measured by national surveys including the NHS Staff Survey and the GMC training survey, along with workforce data.

Theme 3 Objective 7: 'Developing and sustaining a culture of safety, learning and support'
This theme focuses on cultural issues identified in the Kirkup report including teamworking, professionalism, compassion, listening, and learning. It sets out objectives related to developing a safety culture, learning, and improving, and support and oversight with an ambition that all staff working in maternity and neonatal services:
- Are supported to work with professionalism, kindness, compassion, and respect
- Are psychologically safe to voice their thoughts and are open to constructive challenge
- Receive constructive appraisals and support with their development
- Work, learn and train together as a multi-disciplinary team.

Trusts are asked to
- Ensure maternity and neonatal leads have the time, training and development and lines of accountability to focus on developing a safety culture
- Support senior leaders to engage in national leadership programmes offered by NHS England by April 2024
- At board level, reviewing an implementation plan to improve and sustain culture, aligned with freedom to speak up (FTSU)
- Ensure staff are supported by clear and structured routes for the escalation of clinical concerns
- Ensure staff have access to FTSU training modules and a Guardian who can support them to speak up.

Theme 3 Objective 8: 'Learning and improving'
This sets an ambition that services will respond effectively when safety incidents occur.

Trusts are required to:
- Establish and maintain effective and compassionate processes to respond to families who experience harm or raise concerns, in line with the principles of duty of candour and including a single point of contact
- Respond effectively and openly to patient safety incidents using the patient safety incident response framework (PSIRF)
- Acting on outcomes data, staff feedback, clinical audits, and other sources of information to

learn from where things do not go well, as well as understanding 'what good looks like'
- Giving adequate time and formal structures to review and share learning and implement resulting action.
- Consider culture, ethnicity and language factors when responding to incidents.

Theme 4 Objective 9: 'Support and Oversight'
NHS England acknowledges that it is difficult to measure cultural improvement, and therefore will focus on the feedback of frontline staff as recorded by the NHS Staff Survey and other national surveys.

Trusts are asked to:
- Regularly review the quality of maternity and neonatal services, supported by the perinatal quality surveillance model and national maternity dashboard at a minimum
- Appointing an executive and non-executive maternity and neonatal board safety champion
- Involving the maternity and neonatal voice partnership in developing the trust's complaints process
- Listen to and act on feedback from staff at board level, in line with FTSU guidance.

Theme 4 Objective 10: 'Standards to ensure best practice'
This theme acknowledges the need for consistent implementation of nationally defined best practice with due regard to the needs of local populations to reduce variation and inequalities. This requires the development of clear standards and structures to support the delivery of the plan, including
- clinical best practice
- the provision of high-quality data
- effective digital tools.
- developing new best practice.

NHS England commits to:
- Supporting the integration of MEWS, NEWTT-2, and other tools with existing digital maternity information systems by autumn 2024
- Providing support to capital projects to increase and align neonatal cot capacity in 2023/24 and 2024/25
- Conducting a national maternity and neonatal infrastructure compliance survey to determine the level of investment needed for the maternity and neonatal estate.

Trusts are asked to:
- Implement version 3 of the Saving Babies' Lives Care Bundle by March 2024
- adopt the national MEWS and NEWTT-2 tools by March 2025, which will be updated by NHS England
- Regularly review and act on key local outcomes including stillbirth, neonatal mortality and brain injury, and maternal morbidity and mortality
- Ensure staff are enabled to deliver care in line with evidence-based guidelines including NICE
- Complete the national maternity self-assessment tool and use the findings to inform improvement plans.

Theme 4 Objective 11: 'Data to inform learning'
NHS England commits to several actions including convening a taskforce to progress the Kirkup report recommendation for a maternity and neonatal early warning system, to report by autumn 2023.

Trusts are asked to:
- review available data to identify and address areas of concern in maternity services, including inequalities
- ensure high-quality submissions to the maternity services data set and report incidents as appropriate to NHS Resolution, Healthcare Safety Investigation Branch (HSIB) and the national perinatal epidemiology unit.

Theme 4 Objective 12: 'Make better use of digital technology in maternity and neonatal services'
This relates to using digital technology in maternity and neonatal services. NHS England sets out several supporting actions including:

- Setting out the specification for a complaint EPR, including maternity, by March 2024
- Publishing a refreshed digital maternity record standard and maternity services data set standard by March 2024
- Incorporating pregnancy-related data and features into the NHS App.

Trusts are asked to:

- Develop and begin implementation of a digital maternity strategy and roadmap in line with NHS England's 'What good looks like framework' framework
- Where not being managed by the ICB, procure an EPR which complies with national specifications, including the digital maternity record standard and maternity services data set
- Include standardised collection and extraction of neonatal national audit programme data and the neonatal critical care minimum data set in neonatal module specifications.

In addition, the following will support the implementation of the 3-year plan ambitions:

- An ICB-wide dashboard to support benchmarking and improvement. The national maternity dashboard contains LMNS benchmarking on metrics where possible.
- The Maternity Incentive Scheme

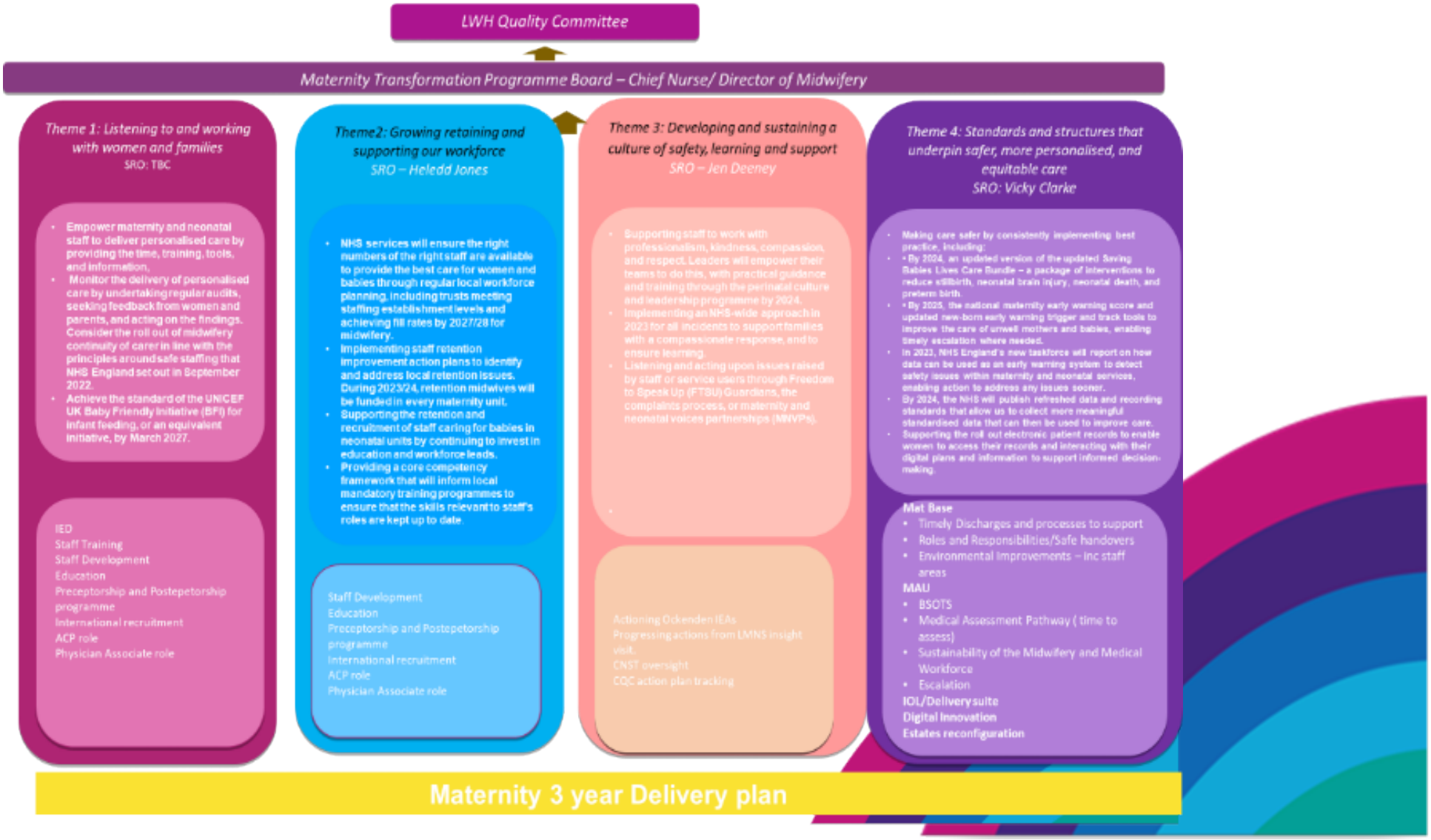
Care Quality Commission Role
The CQC key lines of enquiry for inspections will consider whether care is in accordance with best available evidence, such as NICE guidance. All the themes will also be considered by CQC as part of their inspection criteria.

Success measures for this theme include existing key outcome measures for safety: maternal mortality, stillbirths, neonatal mortality, brain injury during or soon after births, and preterm births – monitored nationally by ethnicity and deprivation. Latest data for Quarter 3 shows that Cheshire and Merseyside are doing better than the national average for these outcomes. NHS England will also use other metrics including the local implementation of version 3 of the Saving Babies' Lives Care Bundle and periodic digital maturity assessments of trusts.

Trust Progress to date

The Family Health Division has subsequently restructured its Maternity and Neonatal Transformation plan and priorities to align to the four emerging themes that are reflected in the Three-Year Plan. A review of the current workstreams has been carried out, and the ongoing discreet programmes of work have been dovetailed into this new overarching structure. The restructured programme is detailed below. SRO's (Senior Responsible Owner) have been identified to lead on each of the specific workstreams and working groups are currently being determined.

Maternity Transformation Programme Structure



Trust Actions / Next Steps

Workplans and areas of focus are currently being designed, along with a parallel prioritisation exercise undertaking. Detailed Project Initiation Documents will be produced for each of the four themes which will provide detail of KPI's, baseline metrics and how the Family Health Division proposes it measures success. The Family Health Division has commenced staff engagement sessions to share with staff the recommendations of the three-year plan and have established a divisional ethos of ***"clinically led, operationally supported"*** to empower staff to own, deliver and direct the changes within their respective areas. The intention is to devise a three-year overarching plan, which will feature interdependent projects and sequencing of initiatives, to ensure this is managed in an organised and systematic way, ensuring that progress and delivery can be appropriately evidenced and sustained.

The local plans will be underpinned and aligned to the national and regional priorities which are detailed below:

It is the responsibility of ICBs to:

- ✓ Have a digital strategy and, where possible, procure on a system-wide basis to improve standardisation and interoperability.
- ✓ Support women to set out their personalised care and support plan through digital means, monitoring uptake and feedback from users.
- ✓ Support regional digital maternity leadership networks.

NHS England will:

- ✓ Set out the specification for a compliant EPR, including setting out the requirements for maternity by March 2024.
- ✓ Publish a refreshed digital maternity record standard and maternity services data set standard by March 2024.
- ✓ Grow the digital leaders' national community, providing resources, training, and development opportunities to support local digital leadership.
- ✓ Incorporate pregnancy-related data and features into the NHS App to enhance the facility for women to view their patient records via the NHS app.
- ✓ Develop facets of a digital personal child health record with service user-facing tools to support neonatal and early years health by March 2025.

Recommendation

The Board is asked to

- receive the report and note the reconfiguration of the Maternity Transformation programme to align its current priorities and key objectives to the themes recommended as part of the Three-Year Plan.
- Note the current gap analysis and that work will continue to complete the action plan with progress reported via the Quality Committee.

Trust Responsibilities	Current Status	Link with other Maternity Improvement process / action plan	Further action required	By When	Led by
Theme 1 Listening to women and families with compassion					
Theme 1 - Objective 1: 'Care that is personalised'					
Provide maternity and neonatal staff with time, training, tools, and information to deliver personalised care		Ockenden report Maternity Self-Assessment Toolkit Mandatory training Trust Policy		Sept 23	FHD
Undertake regular audits of personalised care, including seeking feedback from women and parents, and acting on the findings		MVP feedback from several community groups. CoC outcomes		Sept 23	FHD
Consider how to achieve midwifery continuity of carer in line with safe staffing principles		4 CoC groups implemented in 2021. CoC teams suspended for 6 months from 8.5.23 to release additional midwifery staffing to inpatient areas until newly qualified midwives commence in post in Sep-Oct 2023		October 23	FHD
Achieve the UNICEF UK Baby Friendly Initiative (BFI) standards on infant feeding, or equivalent, by 2027.		Audits and staff education ongoing to prepare for UNICEF BFI re-accreditation assessment.		TBC	FHD
Theme 1 - Objective 2: 'Improve equity for mothers and babies					
Pay particular attention to health inequalities in providing services, for example facilitating informed decision-making in areas of inequalities and ensuring access to interpreter services.		Trust equality plan Interpreter on wheels available in clinical areas		Completed	FHD
Theme 1 - Objective 3: 'Work with service users to improve care'					
The three-year plan acknowledges that co-		Ockenden report – essential		Ongoing	FHD

Trust Responsibilities	Current Status	Link with other Maternity Improvement process / action plan	Further action required	By When	Led by
production is beneficial at all levels of the NHS and is particularly important for those most at risk of experiencing health inequalities (NICE, 2018). Involving service user representatives helps identify what needs to improve and how to do it. The plan recommends that this is done through maternity and neonatal voices partnerships (MNVPs) and by working with other organisations representing service users		action tracker Weekly meetings between MVP chair and Trust staff			
Theme 2 - Supporting the workforce					
June 23					
Undertake regular local workforce planning, and to meet staffing establishment levels set by Birthrate Plus by 2027/28		BR+ Audit completed in 2021, report received Jan 2022. Midwifery budget in line with BR+ Audit recommendations. BR+ audit refresh currently in progress, trajectory for receipt of report June 2023.		June 23 On Track	Heledd Jones
Develop and implement local plans to fill vacancies, including specific support for newly qualified staff and returners		Family Health Division Workforce plan. Preceptorship Programme Ockenden		**Completed**	Rachel Reeves
Provide additional administrative support		Significant operational infrastructure investment in 2022 resulting in a strengthen admin model to include Divisional General Manager Deputy Divisional Manager Operational Support		**Completed**	Gary Price

Trust Responsibilities	Current Status	Link with other Maternity Improvement process / action plan	Further action required	By When	Led by
		Manager			
Theme 2 Objective 5: 'Value and retain the workforce'					
Develop a retention improvement action plan to address local retention issues		Ockenden Post-ceptorship included in workforce plan		**Completed**	Heledd Jones
Reduce workforce inequalities and create an anti-racist workplace by acting on principles set out in combatting racial discrimination resources	TBC	Trust equality plan		**Completed**	Rachel Cowley
Identifying and addressing issues highlighted in student and trainee feedback surveys	TBC				
Offering newly registered midwives a preceptorship programme and providing mentors for newly appointed band 7 and 8 midwives		Ockenden Preceptorship programme implemented in 2021. Mentorship available for all newly recruited band 7 and band 8 posts. Opt in process		**Completed**	Alison Murray
Carry out succession planning and ensuring that the leadership pipeline represents the ethnic background of the workforce.		Trust workforce and equality plan			HRBP
Theme 2 Objective 6: 'Invest in skills'					
Undertake an annual training needs analysis and make training available in line with the core competency framework		TNA in the process of being refreshed- trajectory for completion 31.5.23	31.05.2023	**On track**	
Ensure obstetricians and neonatal medical staff have appropriate clinical supervision in line with RCOG and British Association of Perinatal Medicine (BAPM) guidance	TBC	Ockenden			
Ensure locum medical staff covering middle grade obstetric rotas for two weeks or less possess an RCOG certificate of eligibility.	TBC				
Progress against these objectives will be measured by national surveys including the NHS Staff Survey and the GMC training survey, along		Staff survey results 2022		**On Track**	HRBP

Trust Responsibilities	Current Status	Link with other Maternity Improvement process / action plan	Further action required	By When	Led by
with workforce data.					
Theme 3 - Developing and sustaining a culture of safety					
Theme 3 Objective 7: 'Developing and sustaining a culture of safety, learning and support'					
Ensure maternity and neonatal leads have the time, training and development and lines of accountability to focus on developing a safety culture		Ockenden Maternity Self Assessment Tool-kit		On Track	Jen Deeney Heledd Jones
Support senior leaders to engage in national leadership programmes offered by NHS England by April 2024		Ockenden essential action. LWH not included to date	TBC		Heledd Jones
At board level, reviewing an implementation plan to improve and sustain culture, aligned with freedom to speak up (FTSU)	TBC				
Ensure staff are supported by clear and structured routes for the escalation of clinical concerns		Trust Freedom to Speak Up Policy	Freedom to Speak up Ongoing staff promotion Wellbeing coaches with Maternity	**Completed**	Kevin Robinson
Ensure staff have access to FTSU training modules and a Guardian who can support them to speak up	TBC				
Theme 3 Objective 8: 'Learning and improving'					
Establish and maintain effective and compassionate processes to respond to families who experience harm or raise concerns, in line with the principles of duty of candour and including a single point of contact		Trust Serious Incident Policy Ockenden report- essential action PMRT process HSIB		**Completed**	Heledd Jones
Respond effectively and openly to patient safety incidents using the patient safety incident response framework (PSIRF)	TBC				
Acting on outcomes data, staff feedback, clinical audits, and other sources of information to learn		Ockenden Trust Quality Improvement	Quality Improvement strategy refresh	Ongoing	Dianne Brown / Heledd Jones

Trust Responsibilities	Current Status	Link with other Maternity Improvement process / action plan	Further action required	By When	Led by
from where things do not go well, as well as understanding 'what good looks like'		strategy			
Giving adequate time and formal structures to review and share learning and implement resulting action.		Trust Governance committee structures. Family Health Division Governance structure/framework	External review of Governance structures within Divisions currently underway	August 23	Mark Grimshaw
Consider culture, ethnicity and language factors when responding to incidents.		Ockenden Perinatal Mortality Review Tool (PMRT)	Essential parent app C&M initiative	September 23	Vicky Clarke
Theme 4 - Meeting and improving standards and structures					
Theme 4 Objective 9: 'Support and Oversight'					
Regularly review the quality of maternity and neonatal services, supported by the perinatal quality surveillance model and national maternity dashboard at a minimum		Perinatal Quality Mortality Paper presented to Quality Committee and to Trust Board in April 2023. GREEN FOR MATERNITY, need a neonatal update		On Track	Jen Deeney/Heledd Jones
Appointing an executive and non-executive maternity and neonatal board safety champion		NED Safety Champion- L Kenney Exec Safety Champion D Brown. Monthly walkabout and monthly safety champion meetings		**Completed**	Louise Kenny
Involving the maternity and neonatal voice partnership in developing the trust's complaints process		Discussed at MVP meetings. Currently MVP Chair does not have the capacity to be involved. In the proves of appointing a Deputy MVP Chair who could be involved in this requirement.	Proceed with Deputy MVP appointment		Yana Richens
Listen to and act on feedback from staff at board level, in line with FTSU guidance	TBC				

Trust Responsibilities	Current Status	Link with other Maternity Improvement process / action plan	Further action required	By When	Led by
Theme 4 Objective 10: 'Standards to ensure best practice'					
Implement version 3 of the Saving Babies' Lives Care Bundle by March 2024	SBL V3 not available yet	SBL V2 fully implemented. SBL 3 not available yet	Release of SBL3	TBC	Heledd Jones
adopt the national MEWS and NEWTT-2 tools by March 2025, which will be updated by NHS England	Not available yet	Neither developed Nationally yet		TBC	Alison Murray
Regularly review and act on key local outcomes including stillbirth, neonatal mortality and brain injury, and maternal morbidity and mortality		Discussed monthly as KPI performance. Improvement plans in place where required		Ongoing	Alice Bird
Ensure staff are enabled to deliver care in line with evidence-based guidelines including NICE		All policies developed in line with NICE guidance. NICE guidance and Quality Statements tabled at Maternity Governance monthly meetings.		Ongoing	Lorraine Corfield
Complete the national maternity self-assessment tool and use the findings to inform improvement plans.		Initially completed in 2021. Current review in progress, 50% completed- trajectory to complete review- end of June 2023.		Ongoing	Heledd Jones
Theme 4 Objective 11: 'Data to inform learning'					
review available data to identify and address areas of concern in maternity services, including inequalities		Ockenden Non-English speaking community midwifery team and enhanced community midwifery models of care in place		On Track	Sally Haymes
ensure high-quality submissions to the maternity services data set and report incidents as appropriate to NHS Resolution, Healthcare Safety Investigation Branch (HSIB) and the national perinatal epidemiology unit.		Full compliance with HSIB (this is a CNST MIS requirement- MIAA completed an audit in 2022, which demonstrated full			

Trust Responsibilities	Current Status	Link with other Maternity Improvement process / action plan	Further action required	By When	Led by
		compliance.			
Theme 4 Objective 12: 'Make better use of digital technology in maternity and neonatal services'					
Develop and begin implementation of a digital maternity strategy and roadmap in line with NHS England's 'What good looks like framework' framework		Ockenden LWH Digital Maternity Strategy in place		On Track	Matt Connor
Where not being managed by the ICB, procure an EPR which complies with national specifications, including the digital maternity record standard and maternity services data set		K2 EPR implemented in maternity services		On Track	Matt Connor
Include standardised collection and extraction of neonatal national audit programme data and the neonatal critical care minimum data set in neonatal module specifications.	TBC			On Track	Jen Deeney

Quality Committee Chair's Highlight Report to Trust Board
25 April 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 noted the following matters from the Quality Performance report:
  ○ continued poor performance against the cancer targets. The Committee noted work by the cancer team, and in partnership with the Cancer Alliance and Cheshire and Merseyside ICB. The Committee upheld significant concerns as the matter had been raised at successive meetings and commissioned a deep-dive of the cancer pathway.
  ○ Venous thromboembolism (VTE): improved performance due to data cleansing. Clarification on responsibility lines had been made, and training and mandatory data entry fields would further improve performance.
  ○ GED A&E: received a detailed presentational update of action taken to address the poor performance and quality of care. Based on findings of the review, it was noted that patient acuity predominantly aligns to Same Day Emergency Care criteria (SDEC) and not accident and emergency. The Committee agreed with the recommended approach to review the operational model.
	• The Committee received the Sub-Committee Chair Reports and noted the Safety and Effectiveness Sub-Committee plan to review the current reporting governance structure due to the volume of reporting groups to ensure escalation of matters to the most appropriate forum.
	• The Committee noted continued progress with Maternity Transformation programme initiatives, receiving a detailed update against each workstream. The Committee noted a planned review of the use of estate within the maternity department to respond to various issues, one of which being induction of labour.
	• The Committee noted the planned actions taken and in place to introduce the Patient Safety Incident Response Framework (PSIRF) replacing the Serious Incident Framework (SIF). The Trust is required to transition to the PSIRF model in September 2023.
	• The Committee received a detailed review of compliance against clinical mandatory training, further to the audit reports submitted to the Putting People First Committee. The Committee queried the mandatory element of the current training modules and whether this should be reviewed and also considered other methods to encourage compliance. The Committee noted the ongoing work to support recovery.
	• Noted work to be undertaken to develop the Quality Strategy.
	• The Committee discussed the ambition and achievability of the proposed Corporate Objectives 2023/24. The Committee agreed that they should maintain the long-term ambition of the objectives but should reflect the achievability against financial constraints within the narrative.

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 took positive assurance from a presentational update on the Outpatient Transformation Programme, noting a number of initiatives that had bettered patient quality of care and experience. The Committee noted the introduction of Patient Initiated Follow-Up (PIFU) for appropriate patients to improve patient choice and capacity. (ALL)	• The Committee recommended the Corporate Objectives 2023/24 aligned to the Quality Committee to the Trust Board. • The Committee approved the Clinical Audit Forward Plan for 2023-24. • The Committee received the revised Risk Management Strategy for 2023/24 and recommended approval to the Trust Board.

• The Committee received the quality and regulatory overview of key issues to note and emerging concerns. The Trust is yet to receive the draft report from the CQC in respect of the inspection of Maternity and Gynaecology Core Services and Well-Led. (ALL) • The Committee received the Integrated Governance Assurance Report Quarter 3, 2022/23 for assurance. The narrative and format of the report had been further modified to provide the required assurances to the Committee. The Committee noted that a workshop session had been held between the Governance Team and Legal Team to consider the claims data and how best to share actions and embed learning. (ALL) • Noted the Maternity Safety Champion update and actions taken during January to March 2023. A review of the role of Board Safety Champions and future reporting mechanisms would be undertaken. • The Committee took assurance from the review against the Seven Day Hospital Services (7DS) Clinical Standards. It was noted that there was no statistically significant variation in the length of stay nor number of discharges at the weekend, and that there was adequate medical staffing strategies in place to increase consultant presence out of hours. (ALL)	• The Committee recommended approval of the risk appetite statement and tolerance levels for 2023/24 aligned to the Committee's strategic aims to the Trust Board.

Summary of BAF Review Discussion (Board Committee level only)

- The Committee reviewed the quality related BAF risks. Noted no new risks, strategic threats and no risks closed on the BAF for Quality Committee.
- The Committee considered the close down position of the BAF risk scores for 2023/24 and recommended the Quarter 4 scores to the Board of Directors
- Noted circulation of the BAF for 2023/24 to Committee members for comments.

Comments on Effectiveness of the Meeting / Application of QI Methodology

- Appropriate discussion dedicated to identified reports
- Informative presentations to present data

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
06.	Review of BAF risks: Quality related risks	Assurance	14.	Seven Day Working Board Assurance – 6 monthly	Assurance
07.	Sub-Committee Chair Reports	Assurance	15.	Clinical Mandatory Training	Assurance
08.	Quality and Regulatory Update	Assurance	16.	Quality Strategy Development	Information
09.	Quality Performance Report Month 12, 2022/23	Assurance	17.	Corporate Objectives: objective setting for 2023/24	Approval
10.	Maternity Assessment Unit (MAU) Update	Information	18.	Clinical Audit work plan	Approval

11.	Integrated Governance Assurance Report Quarter 3, 2022/23	Assurance	**19.**	Risk Management Strategy	Information
12.	Patient Safety Incident Response Framework – Transition	Information	**20.**	Risk Appetite Statement – Quality Committee	Approval
13.	Safety Champion Update (quarterly)	Information			

3. 2023/24 Attendance Matrix

Core members	April	May	Jun	Jul	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Sarah Walker, (Chair) Non-Executive Director	**A**										
Louise Kenny, Non-Executive Director	✓										
Gloria Hyatt, Non-Executive Director	✓										
Jackie Bird, Non-Executive Director	✓										
Dianne Brown, Chief Nurse	✓										
Lynn Greenhalgh, Medical Director	✓										
Gary Price, Chief Operating Officer	✓										
Jenny Hannon, Chief Finance Officer	✓										
Michelle Turner, Chief People Officer	✓										
Nashaba Ellahi, Deputy Director of Nursing & Midwifery	**A**										
Philip Bartley, Associate Director of Quality & Governance	**A**										
Yana Richens, Director of Midwifery	**A**										
Heledd Jones, Head of Midwifery	**A**										

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	**23/24/027b**		**Date: 11/05/2023**	
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 11 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)	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	April 23	COO	Detailed in Chair's Report
Quality Committee	April 23	COO	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: (none)
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.
(none)	**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.
(none)				**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

Appendix 3

Liverpool Women's
NHS Foundation Trust

Trust Board

Performance Report

May 2023

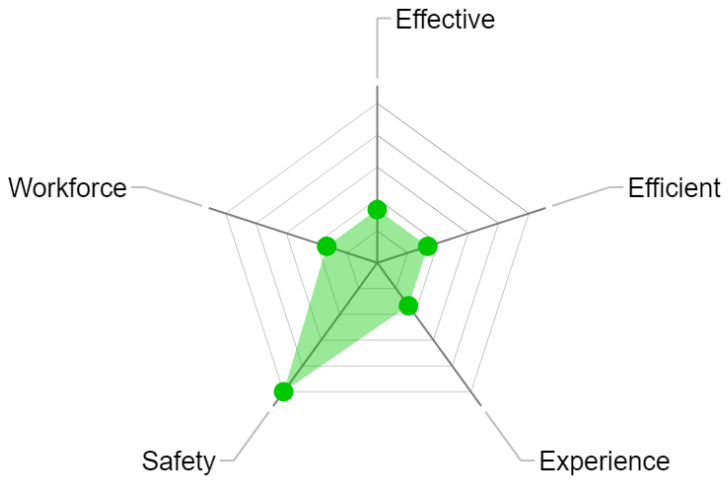
Section 1: Assurance Radar Charts by Trust Values

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'.

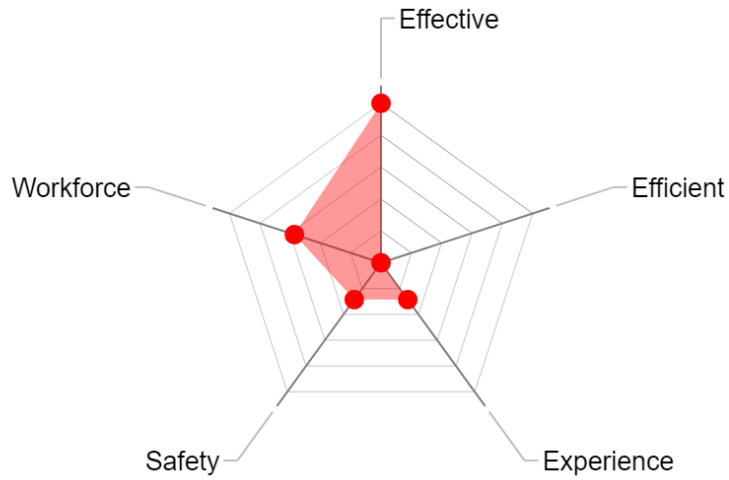
KPIs Passing Target for Six Months	7
KPIs Failing Target	15
KPIs Hit and Miss	10
KPIs No Target	2

KPIs Improving Variation	5
KPIs Concerning Variation	6
KPIs Common Cause Variation	23

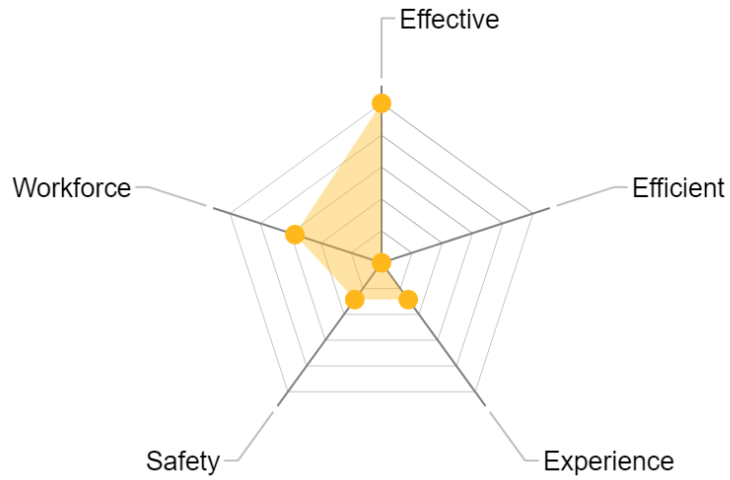
Consistently Passing



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

Good - Celebrate & Understand

KPI	Target < or >	Target	P	A	V
Cancer: 2 Week Wait	>=	>= 93%	91.70%	?	H
Complaints: Number Received	<=	<= 15	7	P	
Financial Sustainability Risk Rating: Overall Score	<=	3	3	P	
Infection Control: Clostridium Difficile	<=	0	0	P	
Infection Control: MRSA	<=	0	0	P	
MAU - Face to face Maternity Triage within 30 Mins	>=	>= 95%	99.16%	?	H
NHSE / NHSI Safety Alerts Outstanding	<=	0	0	P	
Turnover Rate	<=	<= 13%	10.00%	P	
Venous Thromboembolism (VTE)	>=	>= 95%	95.50%	?	H

Average - Investigate & Understand

KPI	Target < or >	Target	P	A	V
Cancer: 62 Day Screening Referrals (Percentage)	>=	>=90%	0.00%	?	
Diagnostic Tests: 6 Week Wait	>=	>= 99%	91.83%	?	
Friends & Family Test: In-patient/Daycase % positive	>=	95%	88.57%	?	
Never Events	<=	0	0	?	
Proportion of patient activity with an ethnicity code	>=	>=96%	95.63%	?	
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
18 Week RTT: Incomplete Pathway > 78 Weeks	<=	0	19		
A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge	>=	>= 95%	82.48%		
All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (After Re-allocation)	>=	>=85%	16.00%		
Cancer: 28 Day Faster Diagnosis	>=	>= 75%	53.48%		
Cancer: 31 Days from Diagnosis to 1st Definitive Treatment	>=	>=96%	65.22%		
Clinical Mandatory Training Compliance	>=	>= 95%	81.52%		
Friends & Family Test: A&E % positive	>=	95%	75.00%		
Friends & Family Test: Maternity % positive	>=	95%	85.95%		
Mandatory Training Compliance	>=	>= 95%	92.11%		
Prevention of Ill Health: Flu Vaccine Front Line Clinical Staff	>=	>= 80%	41.54%		
Sickness Absence Rate	<=	<= 4.5%	6.84%		
Neonatal Deaths per 1000 live Births	<=		8.1		
Overall size of Elective Waiting List	<=		17958		

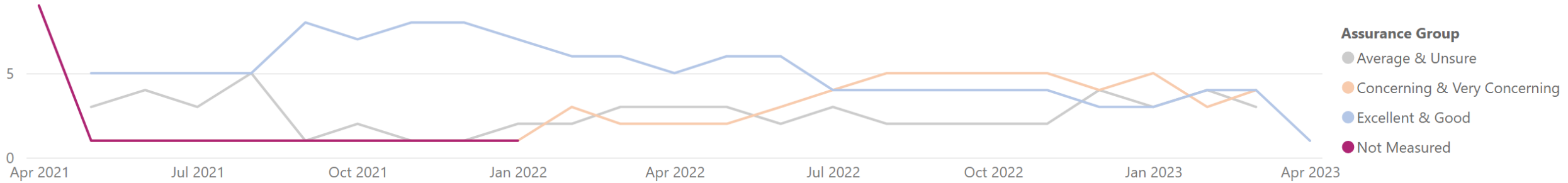
Very Concerning - Investigate & Take Action

KPI	Target < or >	Target	P	A	V
18 Week RTT: Incomplete Pathway > 52 Weeks	<=	0	1856		
Cancer: 104 Day Breaches	<=	0	8.5		
Serious Untoward Incindents: New (Rolling per year)	<=	24 /year	44		
Serious Untoward Incindents: Open	<=	<5	21		

Investigate & Understand

KPI	Target < or >	Target	P	A	V

Section 3: To deliver **Safe** Services

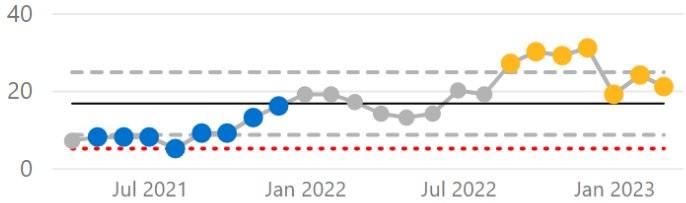


KPI	Assurance Category	Date	Target	Target < or >	Performance	Assurance	Variation	Trend
Infection Control: Clostridium Difficile	Good	March 2023	0	<=	0			
Infection Control: MRSA	Good	March 2023	0	<=	0			
MAU - Face to face Maternity Triage within 30 Mins	Good	March 2023	>= 95%	>=	99.16%			
NHSE / NHSI Safety Alerts Outstanding	Good	March 2023	0	<=	0			
Venous Thromboembolism (VTE)	Good	April 2023	>= 95%	>=	95.50%			
Never Events	Average	March 2023	0	<=	0			
Serious Untoward Incidents: Number of SUI's reported to CCG within agreed timescales	Average	March 2023	100%	>=	100.00%			
Serious Untoward Incidents: Number of SUI's with actions outstanding	Average	March 2023	0	<=	0			
Neonatal Deaths per 1000 live Births	Concerning	March 2023		<=	8.1			
Serious Untoward Incindents: New (Rolling per year)	Very Concerning	March 2023	24 /year	<=	44			
Serious Untoward Incindents: Open	Very Concerning	March 2023	<5	<=	21			

To deliver **Safe** Services - Exceptions

Serious Untoward Incindents: Open - Chief Nurse

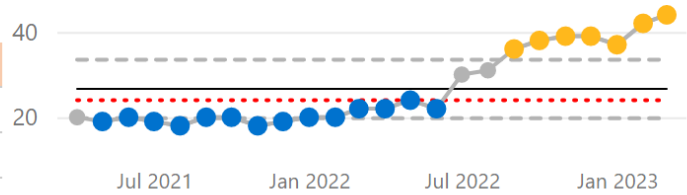
Assurance Category	Very Concerning
Date	March 2023
Target	<5
Target < or >	<=
Performance	21
Assurance	
Variation	



There are 21 open SUI accross the trust
2 - CSS
2- Neonates
4 - Maternity
13 - Gynaecology
Within Gynaecology a number of investigations are in relation to future generations, there have been 6 extension requests made to the ICB.
The Corportate Team continue to support the Divisions. There are plans in place to submit cases as a priority and to ensure all infoirmation is uploaded to Ulysess in a timely manor to improve reporting and retreivability.

Serious Untoward Incindents: New - Chief Nurse

Assurance Category	Very Concerning
Date	March 2023
Target	24 /year
Target < or >	<=
Performance	44
Assurance	
Variation	

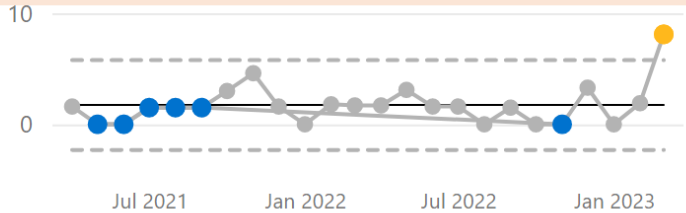


The number of Sis related to Future Generations has shown a significant increase. Particularly within Gynaecology, there have been a number of Critical Care Transfers and Lack of Joint Operating capacity with LUHFT for oncology patients post chemotherapy which relate to the single site risk.

These ongoing concerns form part of the work currently being undertaken as part of the LWH / LUHFT joint Partnership Board

Neonatal Deaths per 1000 live Births - Medical Director

Assurance Category	Concerning
Date	March 2023
Target	
Target < or >	<=
Performance	8.1
Assurance	
Variation	



All neonatal deaths proceed through the PMRT review process to determine whether or not there were any modificable factors and to grade both neonatal and antenatal care. These reviews occur 6-8 weeks following deaths and so have not yet happened for the babies within this month.

The babies who died were from the highest risk groups and there were none that would be classified as unexpected. Full thematic review will be available in due course.

Assurance Category	
Date	
Target	
Target < or >	
Performance	
Assurance	
Variation	

To deliver Safe services - Safer Staffing

March 2023					
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	88.71%	90.32%	145.16%	101.61%	*/**Staffing fill rates for days shift in March are reflective of RN vacancy, sickness and the bed occupancy on the inpatient ward. HDU bed occupancy allowed for movement of RN from HDU to support the ward on day shifts, all shifts are sent out to NHSP bank to cover shortfalls, over fill rates continue on nights to allow for senior nurse cover to rotate between the inpatient ward and GED
Induction & Delivery Suites	86.10%	82.80%	90.07%	91.94%	*Safe staffing required the Maternity bleep holder to redeploy RM to maintain clinical safety and prioritise 1:1 care in labour, and an escalation of CoC Midwives as per policy. Vacant shifts are requested to be filled with bank and agency up to planned staffing numbers.
Maternity & Jeffcoate	89.11%	109.68%	90.32%	102.42%	*/**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. All vacant shifts requested to be filled with bank. Additional care staff in place through temporary staffing arrangements to mitigate where fill rate of registered midwives was reduced to support ward.
MLU	86.29%	61.29%	78.23%	67.74%	*/**There were no episodes of Closure during the month, occupancy was reduced which allowed the safe delivery of Intrapartum and early postnatal care. Within Intrapartum Care clinician is Registered Midwife with Care staff supporting the running of the ward as opposed to providing direct clinical care. Vacant shifts are requested to be filled with bank.
Neonates (ExTC)	100.34%	95.16%	101.02%	87.10%	*/**Fill rates are reflective of the acuity and occupancy of the NICU (Neonatal Intensive Care Unit). Safe staffing maintained and CHPPD (Care Hours Per Patient Day) are as would be expected.
Transitional Care	35.48%	90.32%	51.61%	58.06%	*/**Fill rates are reflective of the occupancy of the TC (Transitional Care). Safe staffing maintained and CHPPD (Care Hours Per Patient Day) are as would be expected.

To deliver Safe services - Safer Staffing

Gynaecology: March Fill Rate

Fill rate – March staffing fill rate is reflective of the current RN vacancy position and the increase this month of short-term sickness, alongside maternity leave. Safe staffing has been maintained due to the ability to flexibly rotate RN across the division and also due to the low bed occupancy of 45.61% in the inpatient area, the fill rate 145.16% RN on nights is the reflection of senior RN cover rotating between GED and inpatient area which is under review

Attendance/ Absence – March sickness rate is reported as 9.39% of which 92.33% was attributed short term sickness, which is managed through the sickness and absence policy. Currently 0.61 WTE RN are on maternity leave

Vacancies – 0.91% RN vacancy

Red Flags – There were no Red flag incidents reported for the month of March

Bed Occupancy – For March Inpatient Bed Occupancy was recorded as 45.61%

CHPPD – For the month of March the CHPPD overall was reported to be 9.1. The split between Registered and Unregistered care staff is 5.3hr for Registered Nurse staff and 3.9hr for Health Care Assistant. When triangulating against other metrics in line with National Quality Board safe care has been maintained.

Neonates: March Fill Rate

Fill-rate –March has seen activity remain consistent in relation to acuity and occupancy. Staffing has been less challenging this month with a slight increase in sickness. Safe staffing and fill rates are reflective of acuity and occupancy. There has been use of Bank staff and substantive staff continue to provide flexibility by swapping and changing shifts with non-cot side staff working clinically. NWNODN and specialist commissioners have recognised the increase acuity and activity.

Attendance/Absence – March sickness ran at 5.46%, this was up from February by 0.67%. Short term sickness sits at 46.75% with long term sickness making up 53.25%, this remains unchanged from last month. Covid sickness make up less than 0.1% of sickness. Maternity leave has reduced again this month to 10 WTE and turnover sits at 7.55%, well below the Trust threshold.

Vacancies – Vacancy rate remains low. Substantive Matron has been recruited. ANNP posts advertised, only 1 wte from 3 wte posts recruited, posts are out to advert again. Working to secure funding from Neonatal Critical Care Review to support a governance lead post.

Red Flags – No red Flags

Bed Occupancy – Unit occupancy has run at 80.4% remaining the same as last month. However, acuity remains high. IC continues to run above the 80% standard at 98.1% up on last month by 12.4%. HD activity has remained unchanged at 86%. There was an increase in LD activity 6.1% to 73.6%. While TC activity has come down by 7.3% on last month to 66.3%.

CHPPD – Within the critical care areas the care is as would be expected, showing higher hours of registered nurse care and lower non- registered care. This split of 12.5 hrs of registered nurses and 1.2 is what is expected considering that most of these babies need cares are met by a nurse qualified in speciality. This will differ in TC because the numbers are reflective of the way in which non- registered staff provide care in TC supported by registered staff and parents, hence why we see 5.1 hrs by non-registered nurse and less by registered nurses of 3.0 hrs. Care in TC is reflective of the way staff support the family.

To deliver Safe services - Safer Staffing

Maternity: March Fill Rate

Fill-rate – Following a requirement to increase the midwifery staffing numbers in the Maternity assessment unit, agency use has occurred intermittently to fill additional shifts. Throughout the reporting period MLU was able to remain open supporting flow through all clinical areas. There has been a requirement to escalate CoC On call midwives as per internal escalation policy when reporting Midwifery red flags. Additional care staff were arranged to support clinical care delivery for postnatal women on Maternity Ward where RM shifts were unable to be filled. Maternity continued to undertake a minimum 4-hourly activity /acuity review, which allows senior midwifery staff to maintain safety by rotating staff to the areas of highest clinical need using risk based responsive decision making

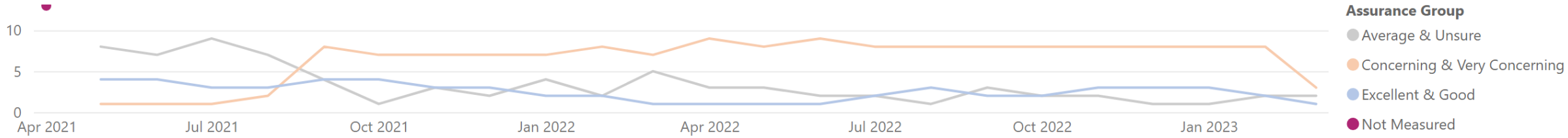
Attendance/Absence – Maternity continues to report levels of sickness above the trust threshold of 4.5% which is calculated in the headroom, within its midwifery and support staff group. Maternity sickness is reported at 11.59% in month, an increase of 3.04% from February. STS was increased to 31% with the top reasons for short term absence being cough/cold or gastrointestinal issues. It was noted that there was a decrease in LTS across all staff. Ward managers/matrons have individual sickness reviews and are planning return to work programmes with all LT employees to facilitate appropriate returns. Maternity leave equates to 12.52wte all of whom are within the Registered Midwives staffing group.

Vacancies – Vacancies at the end of Month 12 equated to 21.02 wte against current funded establishment, with 7.13wte Band 6 midwives currently undergoing recruitment processes. Following a successful open and recruitment day Maternity have made offers for 47.4wte NQM to commence in Autumn with executive agreement. Previous years data has been analysed in order to have a proactive position and realise requirements based on predicted turnover, maternity leave and acknowledging a proportion that have been made offers that then may withdraw from applications due to a variety of reasons. Extensive onboarding activities have already commenced for this cohort in collaboration with Preceptorship team supported by HRBP.

Red Flags - 16 Midwifery Red Flags are recorded in the Ulysses system in March, which included 2 instances of 1:1 care not being provided for a short period of time during labour until staff could be redeployed. All cases reviewed by the Intrapartum Matron and presented at Maternity Risk meeting, 5 triage breaches of >30mins due to influx of attendances and 6 delays of >4hrs for ongoing IOL (local red flag). 3 other red flags were reported.

CHPPD - Since April 2021, CHPPD in Maternity has included the number of babies in the total number of patients per inpatient ward at the 23.59hrs data capture. For Intrapartum Areas, Delivery and MLU care during established labour is required to be 1:1 with a registered midwife, with support staff utilised to assist with the functioning of the ward or help in the postnatal period once the birth care episode is completed prior to transfer to Maternity Ward. This was reported at 18.7 in February and 16.1 March for Delivery Suite, reflecting increased Intrapartum episodes within the month. As CHPPD calculation combines hours provided by registered and care staff it is not the most sensitive indicator for Intrapartum Care. 1:1 Care was achieved for 99.4% with red flags highlighted as above. The Maternity Ward is mixed antenatal and postnatal ward and therefore the fluctuation of case mix split will be significant due to babies being inclusive in the total, with a high proportion of postnatal to antenatal care, therefore reducing CHPPD. It is reported at 3.3 for February and 3.4 for March of which 2.1 is provided by registered staff and 1.3 is contributed by support staff. CHPPD has been reported at a steady rate since 2021 and prior to including babies in the patient population (pre-April 2021), CHPPD for Q4 20/21 was 5.7, and nationally all units have noted the decrease. The data capture for CHPPD is generated form a manual input and does not capture the movements that are made for each shift or 4hrly to match acuity. A proposal to capture the data from e-roster now that NHSP is integrated fully, with a task and finish group convened across divisions to enable, which will give more robust data recording. Presently, Maternity are working with BirthRate Plus to implement the new Ward Based Acuity Tool, an evidence based safe staffing tool designed for Maternity inpatient wards, with anticipated launch summer 2023.

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

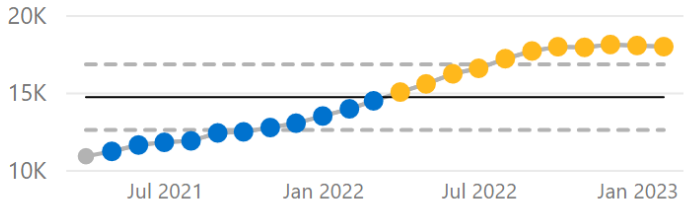


KPI	Assurance Category	Date	Target	Target < or >	Performance	Assurance	Variation	Trend
18 Week RTT: Incomplete Pathway > 104 Weeks	Excellent	March 2023	0	<=	0			
Cancer: 2 Week Wait	Good	February 2023	>= 93%	>=	91.70%			
Cancer: 62 Day Screening Referrals (Percentage)	Average	November 2022	>=90%	>=	0.00%			
Diagnostic Tests: 6 Week Wait	Average	March 2023	>= 99%	>=	91.83%			
Proportion of patient activity with an ethnicity code	Average	March 2023	>=96%	>=	95.63%			
18 Week RTT: Incomplete Pathway > 78 Weeks	Concerning	March 2023	0	<=	19			
A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge	Concerning	March 2023	>= 95%	>=	82.48%			
All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (After Re-allocation)	Concerning	February 2023	>=85%	>=	16.00%			
Cancer: 28 Day Faster Diagnosis	Concerning	February 2023	>= 75%	>=	53.48%			
Cancer: 31 Days from Diagnosis to 1st Definitive Treatment	Concerning	February 2023	>=96%	>=	65.22%			
Overall size of Elective Waiting List	Concerning	February 2023		<=	17958			
18 Week RTT: Incomplete Pathway > 52 Weeks	Very Concerning	March 2023	0	<=	1856			
Cancer: 104 Day Breaches	Very Concerning	February 2023	0	<=	8.5			

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

Overall size of Elective Waiting List - Chief Operating Officer

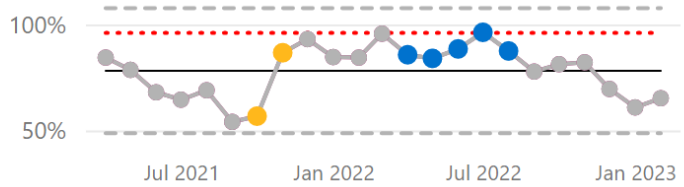
Assurance Category	Concerning
Date	February 2023
Target	
Target < or >	<=
Performance	17958
Assurance	
Variation	H



Impact of insourcing provider commencing end of January has steadied the position of total elective waiting list in February. It is anticipated that this will reduce slightly in March 2023 as additional capacity continues.

Cancer: 31 Days from Diagnosis to 1st Definitive Treatment - Chief Operating Officer

Assurance Category	Concerning
Date	February 2023
Target	>=96%
Target < or >	>=
Performance	65.22%
Assurance	F
Variation	

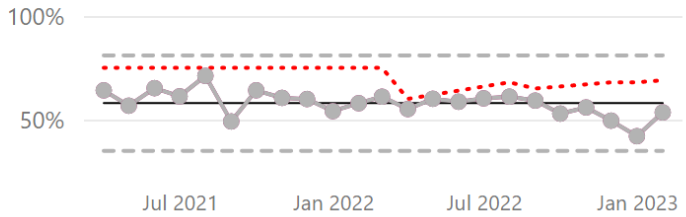


All patients waiting over 31 days are due to patients not being fit for surgery. Meeting held with Cancer Alliance Programme Director to review policy re: medical suspension however limited in its use. Request made to review MDT process

Surgical capacity available when required however majority of patients not able to be removed or suspended from pathway due to existing co-morbidities.

Cancer: 28 Day Faster Diagnosis - Chief Operating Officer

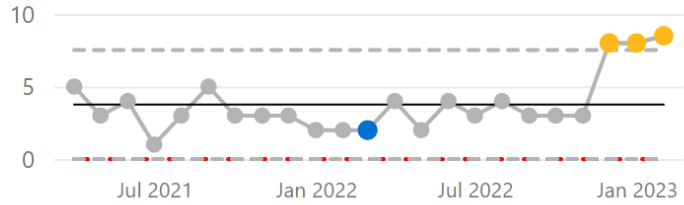
Assurance Category	Concerning
Date	February 2023
Target	>= 75%
Target < or >	>=
Performance	53.48%
Assurance	F
Variation	



10% improvement verses January position. Hysteroscopy demand and available capacity remains a key challenge. Further additional hysteroscopy sessions implemented which will support the cancer position however this will take2-3 months to impact on the position. Pipelle Biopsy pathway reviewed to reduce demand. Training and education underway. Escalation to Cancer Alliance re: challenges. Trust working with NHSE re: Estate. The risk of ambulatory capacity remains on the corporate risk register.

Cancer: 104 Day Breaches - Chief Operating Officer

Assurance Category	Very Concerning
Date	February 2023
Target	0
Target < or >	<=
Performance	8.5
Assurance	F
Variation	H



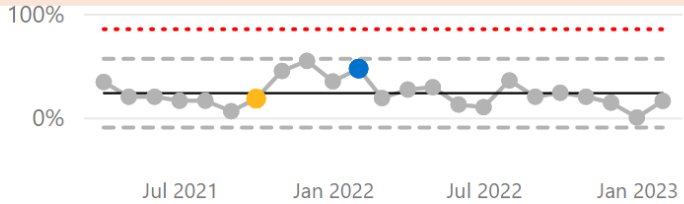
Cause - There are a number of patients waiting over 104 days with many still awaiting a decision to treat. External and internal diagnostics pressures are contributing to the position plus patients are also requiring a more detailed pre op assessment due to co-morbidities.

Action - Extra activity has been sourced at weekends to help reduce the internal ambulatory delays. Cancer team are tracking and escalating as required via the weekly cancer PTL meeting

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

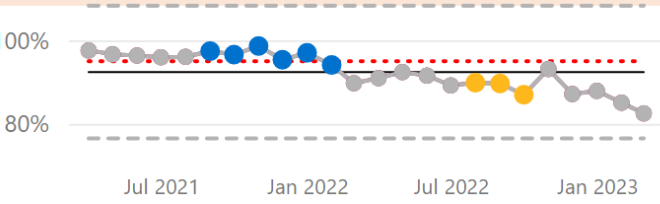
Assurance Category	Concerning
Date	February 2023
Target	>=85%
Target < or >	>=
Performance	16.00%
Assurance	F
Variation	



A number of factors including diagnostic delays, late referrals, complexity of patients and hysteroscopy capacity impacted this performance. Further detail and explanation was taken through March quality committee with a plan for mitigation and improvement. Weekly Executive oversite of this position now takes place until improvement is sustained.
Position will remain very challenging for the next 3 months whilst improvement plans take effect.

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

Assurance Category	Concerning
Date	March 2023
Target	>= 95%
Target < or >	>=
Performance	82.48%
Assurance	F
Variation	

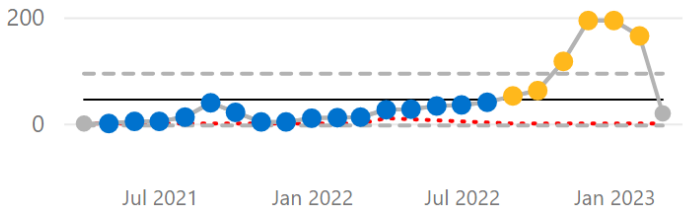


Performance continues to remain consistent between 80-90%. Long term sickness is proving challenging and the number of attendnaces has increased by 12% during the last 2 months.

Junior doctor staffing a key challenge after 5 p.m. This has been escalated to the deputy medical director, medical staffing lead and clinical directors. Additional medical staffing requested through the annual planning process. Medical worforce committee reviewing requirements

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

Assurance Category	Concerning
Date	March 2023
Target	0
Target < or >	<=
Performance	19
Assurance	F
Variation	

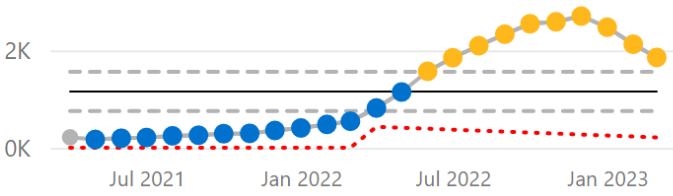


Significant improvement made in March to the 78+ week position with the Trust final position at less than 20. Those remaining above 78 weeks will be managed through Q1 and are as a result of patient choice or are for clinical reasons.

Weekly monitoring with NHSE takes place and will continue into 23/24 with focus turning to 65+ weeks. Weekly monitoring systems in place with additional capacity ongoing into April to support reduction in long waits

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

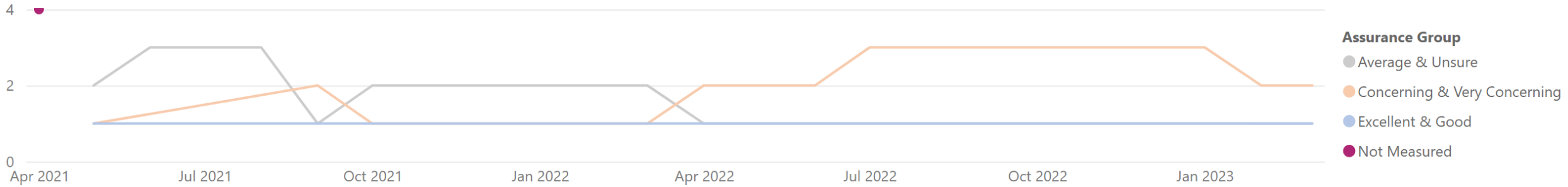
Assurance Category	Very Concerning
Date	March 2023
Target	0
Target < or >	<=
Performance	1856
Assurance	F
Variation	H



52+ weeks position is improving steadily. Additional capacity and oversight of the waiting list is ensuring any patient waiting beyond 52+ weeks is prioritised. Insourced capacity is demonstrating high discharge rate after 1st appointment. Capacity will need to be sustained through 23/24 to continue with reduction.

Weekly monitoring of PTL continues internally and externally with NHSE

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

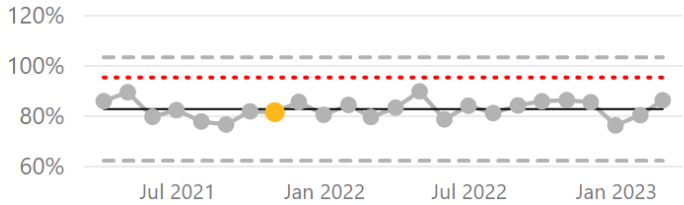


KPI	Assurance Category	Date	Target	Target < or >	Performance	Assurance	Variation	Trend
Complaints: Number Received	Good	March 2023	<= 15	<=	7	P		
Friends & Family Test: In-patient/Daycase % positive	Average	March 2023	95%	>=	88.57%	?		
Friends & Family Test: A&E % positive	Concerning	March 2023	95%	>=	75.00%	F		
Friends & Family Test: Maternity % positive	Concerning	March 2023	95%	>=	85.95%	F		

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

Friends & Family Test: Maternity % positive - Chief Nurse

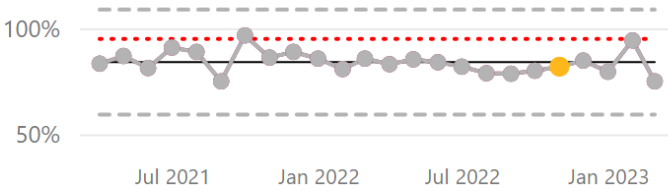
Assurance Category	Concerning
Date	March 2023
Target	95%
Target < or >	>=
Performance	85.95%
Assurance	
Variation	



Increase in % positive scores within month, but remains below trust target. Comments relate to delays of ongoing IOL. IOL Coordinator role approved and out to advert . Key work streams for this role will be to manage expectations and lead on the ongoing QI work re capacity and flow through IOL Improvement group

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

Assurance Category	Concerning
Date	March 2023
Target	95%
Target < or >	>=
Performance	75.00%
Assurance	
Variation	



The division have undertaken a review of Freinds and Family responses findings are that feedback for GED and EPAU are being reported through OPD. The division have raised with the PEX team who are investigating further.
The department manager has proactivly placed communication in the department to encourage feedback from patient, QR code displayed, FFT posters in the area, printed slips given to patients.
Displeased comments are shared to the clinical teams and on you said we did boards

Assurance Category	
Date	
Target	
Target < or >	
Performance	
Assurance	
Variation	

Assurance Category	
Date	
Target	
Target < or >	
Performance	
Assurance	
Variation	

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					
Mandatory Training Compliance	Workforce	5	Y		Y	Y				
MAU - Arrival to Triage within 30 Mins	Safety	5	Y	Y	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				

Maternity Division Board Report

Perinatal Quality Surveillance Highlight Report

April 2023 (March 2023 Data).

Introduction

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

implementing-a-revised-perinatal-quality-surveillance-model.pdf (england.nhs.uk)

This model proactively seeks to identify trusts that require support before serious issues arise. Implementation of a new quality surveillance model seeks to provide for consistent and methodical oversight of all services, specifically including maternity services. The model has also been developed to gather ongoing learning and insight, to inform improvements in the delivery of perinatal services. Provider Trusts and their Boards, supported by the senior maternity and neonatal triumvirate and the board-level perinatal safety champion at its centre, ultimately remain responsible for the quality of the services provided and for ongoing improvement to these. As the commissioners of maternity care, ICBs also have a statutory role to improve quality, safety and outcomes for their patients. The quality model supports trusts and ICBs to discharge their duties, while providing a safety net for any emerging concerns, trends or issues that are not quickly identified and addressed.

Purpose of the Report

As part of the guidance, the development of a locally agreed dashboard was mandated to include, as a minimum. This dashboard enables the drawing out of locally collected intelligence to monitor maternity and neonatal safety at board meetings. This dashboard should form part of the discussion held at Board Level with respect to maternity and neonatal safety issues, as set out within the national guidance. This report will also provide an overview of key quality & safety workstreams and performance and will cover the current position on clinical outcomes for women and babies against the national safety agenda. This report will firstly be sighted within the Family Health Division within further scrutiny at the Quality Committee, with further discussion at every Trust Board with the Executive and Non-executive Safety Champions.

Maternity Key Highlights – March/April 2023 Updates.

Succeses

- A total of 1580 women attended the LWH MAU (Maternity Assessment Unit) between 24th March and 27th April. 1556 women were seen within 30 minutes, which equates to 98.48% of women seen within 30-minute triage time. The average triage time overall for the month was 11 minutes 45 seconds with 1187 women, which equates to 75.13% of woman receiving triage within 15 minutes.
- Improvements in expediting and ensuring timely discharge, through piloting a twilight NIPE midwife and earlier deliveries of TTO's
- BBAS ward accreditation –Mat Base awarded Bronze
- Regular medication rounds to ensure timely administration of analgesia
- Infection Prevention & Control environment audit- 5 Stars 100%
- Implementation of weekly governance meetings on Mat Base (every Thursday afternoon)

Key Messages

- Increased use of technology to manage performance / Realtime reporting of sit reps and breaches
- Increased staffing for MAU 24/7 and ongoing recruitment
- Recruitment to senior roles within Family Health Division including; Lead governance managers and Transformation Programme Manager, Various Specialist Midwives roles including Diabetes, Consultant Midwife and FMU Lead Midwife
- Ongoing SLT review of Maternity Base staffing and innovation in use of roles to support (RN/Ward based Pharmacy Techs)
- Review of workstreams included within the Transformation Programme
- Scoping of how to reconfigure Estate and clinical processes to support improved flow
- Ockenden - implementation of MIAA recommendations, structured approach adopted for National Maternity Self Assessment evidence gathering and scrutiny
- Co-production of patient information with MVP and our patients as our partners to promote engagement/inclusion community wide/diverse views
- Ongoing Human Factors training

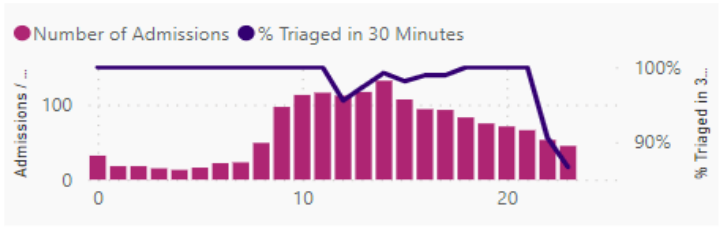
Emerging Issues

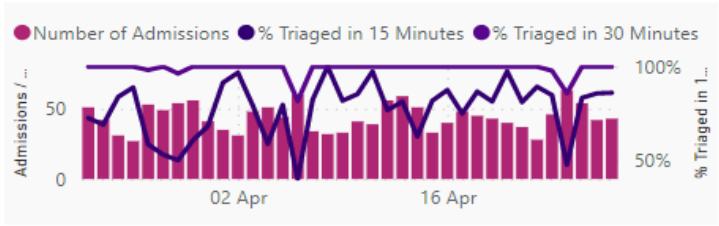
- CQC – Draft Report, Factual Accuracy Repsonce and review of MIS Complaince.
- Limited capacity of MVP to support improvement work
- Continuity of Care- COC suspended for a period of 6 months from 8th May 2023.
- Refreshed BirthRate Plus commisioned to review Midwifery Staffing - reported expected June 2023.
- Continued data relating to delays in ongoing IOL (midwiery Red flag). progam in place depedant upon capital approvement to redfined estate and provision of IOL capacity.

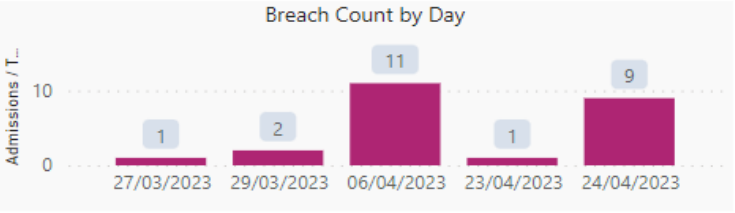
Liverpool Women's Maternity Assessment Unit

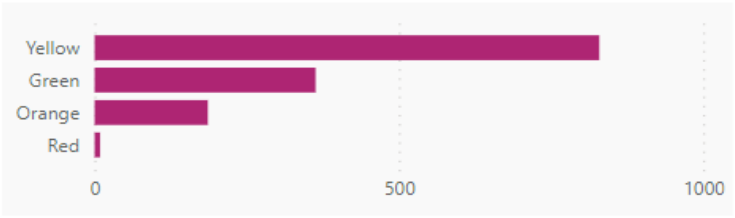
Number of Admissions	1580
Patients Triaged Within 15 Minutes	1187
Patients Triaged Within 30 Minutes	1556
Patients Triaged Within 40 Minutes	1564
Patients Triaged Within 50 Minutes	1572
Patients Triaged Within 60 Minutes	1574
Patients Triaged Within 90 Minutes	1580
Patients Triaged Within 120 Minutes	1580
% Triaged in 15 Minutes	75.13%
% Triaged in 30 Minutes	98.48%
% Triaged in 40 Minutes	98.99%
% Triaged in 50 Minutes	99.49%
% Triaged in 60 Minutes	99.62%
% Triaged in 90 Minutes	100.00%
% Triaged in 120 Minutes	100.00%

Admission Date
23/03/2023 27/04/2023



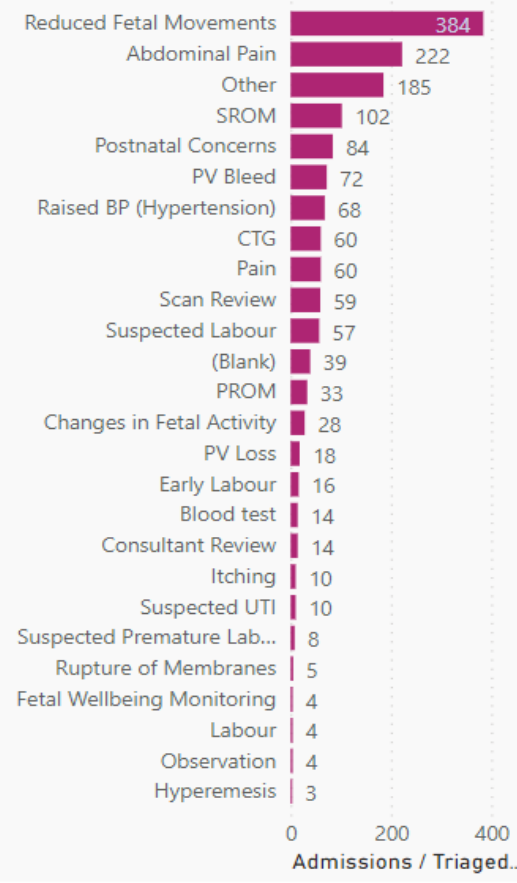






1580
Number of Admissions

98.48%
% Triaged in 30 Minutes



Maternity Clinical Dashboard.

Section 2: Integrated Performance Metrics

Excellent - Celebrate & Learn

KPI	Target	P	A	V
Antenatal Infectious Disease Screening - HIV, Hep B, Syphilis Coverage	>=90%	100.00 %		
Antenatal Sickle Cell and Thalassaemia Screening - Coverage	>=99%	99.65%		
Never Events - Maternity	0	0		
Rostered Cons on DS (Hrs per Wk)	>60	106.5		
Smoking - Interventions to maternity patients at 12 weeks	>= 95%	100.00 %		
Smoking - Offer of referral to Smoking Cessation Services	>= 95%	100.00 %		
Turnover - Maternity	<= 13%	9.05%		
Venous Thromboembolism (VTE) - Maternity	>= 95%	98.10%		
Emergency Caesarean Section Births Undertaken Post Failed Instrumental Delivery		0.33%		
Forceps Births	<=	7.15%		
New Hospital Acquired Pressure Ulcers Cat 2 - Maternity	<=	0		
Postpartum hysterectomy	TBA	0		

Good - Celebrate & Understand

KPI	Target	P	A	V
3rd and 4th Degree Tears	3.5% NMPA baseline (3.2-4.1 95%confidence interval)	2.23%		
3rd and 4th Degree Tears - Instrumental Births	<=7.8%	5.41%		
3rd and 4th Degree Tears - Vaginal Births	<=3.6%	1.12%		
Antenatal Sickle Cell and Thalassaemia Screening - FOQ Completion (ST3)	>=95%	96.10%		
Breastfeeding Initiation	>= 55%	63.03%		
Complaints: Number of Action plans received - Maternity	100%	100.00 %		
Complaints: Number Received - Maternity	<= 15	4		
Data Quality Maturity Index – APC	>= 99	99.9		
Data Quality Maturity Index – MSDS	>= 99	99.9		
Data Quality Maturity Index – OP	>= 99	99.6		

Good - Celebrate & Understand

KPI	Target	P	A	V
Discharge Summaries to be sent from Ward Areas to General Practice within 24 hours. - Maternity	>= 95%	97.20%		
Fetal Anomaly Scan - Undertaken between 18 and 20 Weeks	>= 95%	99.65%		
Induction Attendance Rate (Corporate) - Maternity	> = 90%	96.32%		
Infection Control: Clostridium Difficile	0	0		
MAU - Face to face Maternity Triage within 30 Mins	>= 95%	99.16%		
Newborn Hearing Screening: Timely Assessment (NH2) - Reporting 1 Qtr Behind	> = 90%	94.12%		
NHSE / NHSI Safety Alerts Outstanding	0	0		
Outpatients: DNA Rates: Follow-up - Maternity	<= 10%	11.05%		
Peer Support - Pregnant women informed of service	>= 95%	100.00 %		
Pregnant women with a BMI >= 35 at booking offered advice	>= 90%	98.51%		
Pressure Ulcers: Demonstrate a reduction (Hospital Aquired)	0	0		
Professional Registration Lapses - Maternity	0	0		
Sepsis: Deaths	0	0		
Serious Untoward Incindents: Open - Maternity	<5	2		
Super Numerary DS Shift Leader	100%	100.00 %		
Total number of women attended by anaesthetist after request for an epidural within 60 minutes	>=90%	90.00%		
Women whom have seen a midwife by 12 weeks (+ 6 days)	>= 92%	93.41%		

Average - Investigate & Understand

KPI	Target	P	A	V
Antenatal Sickle Cell and Thalassaemia Screening - Timliness (ST2)	>=50%	45.40%		
Blood Transfusions		1.98%		
Brachial Plexus Injury (Erbs Palsy)	TBA	0.00%		
Caesarean Section - Delayed	0	17.24%		
Caesarean Section - Elective Rate		18.40%		
Caesarean Section - Emergency Rate		23.58%		
Caesarean Section - Total Section Rate		41.78%		
Caesarean Section Category 2 - Delayed	0	37.18%		
Coroner Reg 28 Made to Trust		0		
Data Warehouse Availability - % of days the data warehouse has updated overnight	>= 96%	78.26%		
Fetal Anomaly Scan - Number rescanned by 23 Weeks	>= 98%	99.00%		
Friends & Family Test: Maternity % positive - Q1 Antenatal	95%	87.50%		
Friends & Family Test: Maternity % positive - Q4 Postnatal Community	95%	96.00%		
Haemorrhages > 1,500 ml	2.7% (2.1-3.5)	2.63%		
Hepatitis B Coverage (ID3) (Reporting 1 Qtr Behind)	>= 90%	99.27%		
HSIB Actions Returned		2		
Hypoxic Encephalopathy (Grade 2,3)	TBA	1		
Inborn term babies admitted to NICU	<= 5%	2.52%		
Induction Attendance Rate (Local) - Maternity	> = 90%	86.52%		
Instrumental Births	<=	12.03%		
Magnesium Sulphate	>= 85%	72.73%		
Maternity Services: Percentage of Black, Asian or Mixed women at 29 weeks on a CoC pathway	>=	29.31%		
Maternity Services: Percentage of women at 29 weeks on a CoC pathway	>=	15.77%		
Maternity Services: Percentage of women in bottom decile of deprivation at 29 weeks on a CoC pathway	>=	14.24%		
Midwifery Sickness Percentage		8.91%		
Midwifery Vacancy Percentage		17.00%		
MRI / CT Filed Reports - Maternity		50.00%		

Average - Investigate & Understand

KPI	Target	P	A	V
New Hospital Acquired Pressure Ulcers Cat 3 - Maternity	<=	0		
New Hospital Acquired Pressure Ulcers Cat 4 - Maternity	<=	0		
Number of Adjusted stillbirths per 1,000 total births		0		
Number of Maternity Incidents over 30 Days		26		
Number of PALS/PALS+		46		
Number of stillbirths > 37 weeks per 1,000 total births		0		
Number of stillbirths per 1,000 total births		1.63		
Outpatient Activity delievered Remotely - Maternity		13.46%		
Outpatients: DNA Rates: New - Maternity	< 8%	8.45%		
Outpatients: First Appointment Cancelled by Hospital - Maternity	<= 10%	9.07%		
Outpatients: Subsequent Appointment Cancelled by Hospital - Maternity	<= 10%	14.05%		
Patients with PPH >1500ml who had a blood transfusion		31.25%		
Peer Support - Breastfeeding women contacted by team during stay	>= 90%	91.84%		
Provision of Epidural in Labour		16.78%		
Reduction in number of incidences of Cord pH < 7	<= (4.3/ n births)*1000	0.50%		
Returns To Theatre (exc EVACS) - Maternity	<= 0.7%	0.00%		
Serious Untoward Incidents: Number of SUI's reported to CCG within agreed timescales - Maternity	100%	100.00 %		
Serious Untoward Incidents: Number of SUI's with actions outstanding - Maternity	0	0		
Skin to Skin Contact of 1 hour minimum	>= 80%	83.09%		
Total number of women attended by anaesthetist after request for an epidural within 30 minutes	>=80%	79.00%		
Ventouse Births	<=	4.55%		
Women whom have seen a midwife by 9 weeks (+ 6 days)		54.32%		

Concerning - Investigate

KPI	Target	P	A	V
Clinical Mandatory Training Compliance - Maternity	>= 95%	68.85%		
Complaints: Response Rates - Maternity	100%	33.33%		
Data Quality Maturity Index – Overall Score	>= 99	92.5		
Flu Vaccinations offered to Pregnant Women	>= 90%	35.14%		
Friends & Family Test: Maternity % positive	95%	85.95%		
Friends & Family Test: Maternity % positive - Q2 Birth	95%	81.63%		
Friends & Family Test: Maternity % positive - Q3 Postnantal Ward	95%	83.87%		
LMS:Percentage women receiving personalised care plan	>= 100%	95.38%		
Local Mandatory Training Compliance - Maternity	>= 95%	68.16%		
LocSSIPs Complete in Theatre - Maternity	>= 100%	87.50%		
Mandatory Training Compliance - Maternity	>= 95%	82.84%		
Newborn & Infant Physical Examination: Coverage (NP1)	>=95%	94.81%		
Newborn Blood Sampling - Avoidable repeat tests	<=2%	4.28%		
Newborn Hearing Screening: Coverage (NH1) - Reporting 1 Qtr Behind	>= 98%	97.31%		
Referral time to fetal medicine centre	>= 95%	81.25%		
Sickness - Maternity	<= 4.5%	9.25%		
Women whom received 1 to 1 Care when in established labour (>= 4cm dilation)	>= 100%	99.40%		

Very Concerning - Investigate & Take Action

KPI	Target	P	A	V
PDR Rate - Maternity	>= 90%	46.60%		

Investigate & Understand

KPI	Target	P	A	V

Section 3: Medical KPIs

Blue: Passing Target > 6 months; Grey: Hit & Miss Target last 6 months; Orange: Failing Target Last 6 Months
Grey Circle: Common Cause Variation; Green Arrow: Positive Variation; Red Arrow: Concerning Variation; Amber Arrow: Special Cause Variation

KPI	October 2021	November 2021	December 2021	January 2022	February 2022	March 2022	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022	October 2022	November 2022	December 2022	January 2023	February 2023	March 2023
3rd and 4th Degree Tears																		
Performance	4.09%	3.17% ↑	3.54% ↑	2.43%	2.61%	2.92%	2.43%	1.55%	1.20%	2.16%	2.09%	1.02% ↓	2.70%	2.85%	1.10%	2.54%	2.90%	2.23%
Numerator	17	13	13	10	9	11	9	6	4	8	8	4	10	10	4	9	9	8
Denominator	416	410	367	412	345	377	371	388	332	370	383	392	370	351	362	355	310	358
3rd and 4th Degree Tears - Instrumental Births																		
Performance	6.06%	5.56%	5.49%	7.14% ↑	8.57% ↑	7.69% ↑	6.17% ↑	3.95%	1.41%	3.53%	1.23%	2.78%	4.44% ↓	6.25%	3.66%	3.23%	7.58%	5.41%
Numerator	6	4	5	6	6	6	5	3	1	3	1	2	4	4	3	2	5	4
Denominator	99	72	91	84	70	78	81	76	71	85	81	72	90	64	82	62	66	74
3rd and 4th Degree Tears - Vaginal Births																		
Performance	2.64%	2.20% ↑	2.18% ↑	0.97%	0.87%	1.33%	1.08%	0.77%	0.90% ↓	1.35% ↓	1.83%	0.51%	1.62%	1.71%	0.28%	1.97%	1.29%	1.12%
Numerator	11	9	8	4	3	5	4	3	3	5	7	2	6	6	1	7	4	4
Denominator	416	410	367	412	345	377	371	388	332	370	383	392	370	351	362	355	310	358
Brachial Plexus Injury (Erbs Palsy)																		
Performance	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Numerator	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Denominator	652	660	620	653	555	588	597	648	607	633	660	658	648	593	614	625	516	614
Caesarean Section - Delayed																		
Performance	20.00%	37.50%	14.29%	17.65%	24.00%	27.27%	28.57%	25.81%	31.71%	34.48%	24.14%	10.53%	23.53%	4.76%	18.18%	22.58%	40.91%	17.24%
Numerator	2	6	3	3	6	6	6	8	13	10	7	2	8	1	4	7	9	5
Denominator	10	16	21	17	25	22	21	31	41	29	29	19	34	21	22	31	22	29
Caesarean Section - Elective Rate																		
Performance	17.38%	18.77%	17.17%	14.29%	17.71%	16.19%	16.83%	15.03%	17.87%	17.19%	18.40%	16.94%	16.77%	18.43%	17.10%	19.30%	16.73%	18.40%
Numerator	114	125	107	94	99	96	101	98	109	110	122	112	109	110	106	121	87	113
Denominator	656	666	623	658	559	593	600	652	610	640	663	661	650	597	620	627	520	614
Caesarean Section - Emergency Rate																		
Performance	19.21%	19.52%	23.27%	22.49%	20.75%	20.24%	20.83%	25.15%	28.03%	24.84%	23.68%	23.15%	26.00%	22.61%	24.35%	24.40%	23.85%	23.58%
Numerator	126	130	145	148	116	120	125	164	171	159	157	153	169	135	151	153	124	145
Denominator	656	666	623	658	559	593	600	652	610	640	663	661	650	597	620	627	520	615
Caesarean Section - Total Section Rate																		
Performance	35.83%	37.84%	39.64%	35.93%	37.39%	36.16%	36.84%	39.38%	44.98%	41.47%	41.47%	39.38%	41.92%	40.27%	40.20%	42.67%	39.33%	41.78%
Numerator	234	249	241	231	206	213	217	252	273	260	270	254	267	236	244	262	201	254
Denominator	653	658	608	643	551	589	589	640	607	627	651	645	637	586	607	614	511	608
Caesarean Section Category 2 - Delayed																		
Performance	50.00%	55.42%	55.81%	54.26%	56.67%	47.14%	58.02%	63.33%	59.78%	52.94%	46.32%	53.61%	57.30%	51.47%	56.99%	57.50%	53.52%	37.18%
Numerator	41	46	48	51	34	33	47	57	55	45	44	52	51	35	53	46	38	29
Denominator	82	83	86	94	60	70	81	90	92	85	95	97	89	68	93	80	71	78

Medical KPIs

Blue: Passing Target > 6 months; Grey: Hit & Miss Target last 6 months; Orange: Failing Target Last 6 Months
Grey Circle: Common Cause Variation; Green Arrow: Positive Variation; Red Arrow: Concerning Variation; Amber Arrow: Special Cause Variation

KPI	October 2021	November 2021	December 2021	January 2022	February 2022	March 2022	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022	October 2022	November 2022	December 2022	January 2023	February 2023	March 2023
Coroner Reg 28 Made to Trust																		
Performance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Numerator																		
Denominator																		
Emergency Caesarean Section Births Undertaken Post Failed Instrumental Delivery																		
Performance	1.07% ↓	0.90% ↓	0.96% ↓	1.37%	0.89%	1.85%	1.33%	0.46%	0.66%	0.94%	1.36%	0.76%	0.92%	0.34%	0.97%	0.48%	0.77% ↓	0.33% ↓
Numerator	7	6	6	9	5	11	8	3	4	6	9	5	6	2	6	3	4	2
Denominator	656	666	623	658	559	593	600	652	610	640	663	661	650	597	620	627	520	615
Forceps Births																		
Performance	8.69% ↑	6.61%	7.54%	8.36%	8.59%	6.24%	7.50%	6.90%	5.74%	9.38%	6.49%	7.26%	7.38%	5.86%	7.42%	6.06% ↓	7.50% ↓	7.15% ↓
Numerator	57	44	47	55	48	37	45	45	35	60	43	48	48	35	46	38	39	44
Denominator	656	666	623	658	559	593	600	652	610	640	663	661	650	597	620	627	520	615
Haemorrhages > 1,500 ml																		
Performance	3.37%	4.26%	2.96%	4.20%	4.54%	3.74%	4.58%	3.59%	3.62%	4.47%	5.07%	2.95%	2.67%	3.24%	2.97%	3.91%	3.52%	2.63%
Numerator	22	28	18	27	25	22	27	23	22	28	33	19	17	19	18	24	18	16
Denominator	653	658	608	643	551	589	589	640	607	627	651	645	637	586	607	614	511	608
HSIB Actions Returned																		
Performance	1	1	0	1	0	0	1	1	0	1	0	3 ↑	0	0	0	0	2	
Numerator																		
Denominator																		
Hypoxic Encephalopathy (Grade 2,3)																		
Performance	3	0	2	1	1	1	1	1	2	0	1	1	0	0	1 ↓	4	1	1
Numerator																		
Denominator																		
Inborn term babies admitted to NICU																		
Performance	5.02%	7.53%	5.28%	5.40% ↑	4.54%	5.51%	3.87%	7.47%	4.84%	5.66%	6.27%	4.25%	5.76%	4.77%	4.43%	4.47%	4.93%	2.52%
Numerator	30	46	29	32	23	30	21	44	26	32	38	25	34	25	25	25	23	14
Denominator	598	611	549	593	507	544	543	589	537	565	606	588	590	524	564	559	467	556
Instrumental Births																		
Performance	15.09%	10.81%	14.61%	12.77%	12.52%	13.15%	13.67%	11.66%	11.64%	13.44%	12.22%	11.78%	13.85%	10.72%	13.23%	9.89%	12.69%	12.03%
Numerator	99	72	91	84	70	78	82	76	71	86	81	72	90	64	82	62	66	74
Denominator	656	666	623	658	559	593	600	652	610	640	663	611	650	597	620	627	520	615
Magnesium Sulphate																		
Performance	100.00%	85.71%	100.00%	66.67%	100.00%	100.00%	66.67%	100.00%	100.00%	90.91%	90.00%	100.00%	85.71%	75.00%	66.67%	66.67%	100.00%	72.73%
Numerator	10	6	5	2	5	7	10	9	4	10	9	10	6	6	6	2	7	8
Denominator	10	7	5	3	5	7	15	9	4	11	10	10	7	8	9	3	7	11
MRI / CT Filed Reports - Maternity																		
Performance	0.00%	0.00%	100.00%	0.00%		50.00%			80.00%				50.00%	0.00%	50.00%		50.00%	
Numerator	0	0	2	0		1			4				1	0	1		1	
Denominator	1	1	2	1		2			5				2	1	2		2	

Medical KPIs

Blue: Passing Target > 6 months; Grey: Hit & Miss Target last 6 months; Orange: Failing Target Last 6 Months
Grey Circle: Common Cause Variation; Green Arrow: Positive Variation; Red Arrow: Concerning Variation; Amber Arrow: Special Cause Variation

KPI	October 2021	November 2021	December 2021	January 2022	February 2022	March 2022	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022	October 2022	November 2022	December 2022	January 2023	February 2023	March 2023
Number of Adjusted stillbirths per 1,000 total births																		
Performance	4.57	7.51	3.21	6.07	0	6.75	1.7	6.13	3.28	6.25	4.74	0	1.54	3.35	8.06	1.59	5.77	0
Numerator																		
Denominator																		
Number of stillbirths > 37 weeks per 1,000 total births																		
Performance	1.52	1.5	0	0	0	0	1.67	0	1.64	0	0	0	0	0	4.84 ↑	0	3.85	0
Numerator																		
Denominator																		
Number of stillbirths per 1,000 total births																		
Performance	6.1	9.01	4.82	9.1	7.16	10.12	5	6.13	4.92	10.94	4.52	4.54	3.08	6.7	9.68	3.19	7.69	1.63
Numerator																		
Denominator																		
Outpatient Activity delievered Remotely - Maternity																		
Performance	13.20%	14.52%	12.73%	15.45%	12.73%	14.22%	13.91%	13.46%	11.93%	11.02%	13.18%	13.52%	12.83%	14.46%	13.84%	14.62%	12.84%	13.46%
Numerator	438	533	420	537	407	546	479	542	432	390	525	522	503	591	471	580	463	537
Denominator	3,318	3,670	3,300	3,476	3,198	3,840	3,443	4,026	3,622	3,539	3,982	3,861	3,922	4,086	3,403	3,967	3,607	3,989
Patients with PPH >1500ml who had a blood transfusion																		
Performance	27.27%		11.11%	3.70%	23.33%	17.39%	3.70%	8.70%	9.52%	25.93%	10.00%	30.00%	12.50%	5.26%	11.76%	37.50%	5.56%	31.25%
Numerator	6		2	1	7	4	1	2	2	7	3	6	2	1	2	9	1	5
Denominator	22		18	27	30	23	27	23	21	27	30	20	16	19	17	24	18	16
Postpartum hysterectomy																		
Performance	1	0	2 ↑	0	0	0	1	0	1	0	0	1	0	0	0	0	0	0 ↓
Numerator																		
Denominator																		
Reduction in number of incidences of Cord pH < 7																		
Performance	0.63%	0.93%	1.34%	0.79%	0.93%	0.52%	1.03%	0.32%	1.01%	0.65%	0.31%	0.47%	0.79%	0.69%	1.00%	0.82%	0.40%	0.50%
Numerator	4	6	8	5	5	3	6	2	6	4	2	3	5	4	6	5	2	3
Denominator	639	647	599	632	538	581	580	631	592	612	643	638	630	576	600	608	503	600
Returns To Theatre (exc EVACS) - Maternity																		
Performance	0.66%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00% ↓	0.00% ↓	0.31%	0.00%	0.31%	0.00%	0.00%	0.71%	0.68% ↑	0.00% ↑	0.00%	0.00%
Numerator	2	0	0	0	0	0	0	0	1	0	1	0	0	2	2	0	0	0
Denominator	302	302	300	287	259	280	263	317	319	320	319	311	340	283	294	307	242	308
Ventouse Births																		
Performance	5.79%	3.90%	5.94%	3.95%	3.94%	6.41%	5.50%	4.45%	5.74%	3.75%	5.43%	3.03%	4.77%	4.02%	5.65%	3.67%	5.19%	4.55%
Numerator	38	26	37	26	22	38	33	29	35	24	36	20	31	24	35	23	27	28
Denominator	656	666	623	658	559	593	600	652	610	640	663	661	650	597	620	627	520	615

Section 4: Patient Experience KPIs

Blue: Passing Target > 6 months; Grey: Hit & Miss Target last 6 months; Orange: Failing Target Last 6 Months
Grey Circle: Common Cause Variation; Green Arrow: Positive Variation; Red Arrow: Concerning Variation; Amber Arrow: Special Cause Variation

KPI	October 2021	November 2021	December 2021	January 2022	February 2022	March 2022	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022	October 2022	November 2022	December 2022	January 2023	February 2023	March 2023
Complaints: Number of Action plans received - Maternity																		
Performance	100.00%	100.00%		100.00%	100.00%	100.00%	100.00%		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Numerator	4	1		2	1	3	1		3	3	1	3	5	4	2	1	1	3
Denominator	4	1		2	1	3	1		3	3	1	3	5	4	2	1	1	3
Complaints: Number Received - Maternity																		
Performance	4	3	2	0	1	1	3	2	5	4	5 ↑	3	1	2	2	2	2	4
Numerator																		
Denominator																		
Complaints: Response Rates - Maternity																		
Performance	20.00%	0.00%		50.00%	0.00%	33.33%	0.00%		33.33%	33.33%	0.00% ↓	33.33% ↓	33.33% ↓	50.00%	50.00%	0.00%	0.00%	33.33%
Numerator	1	0		1	0	1	0		1	1	0	1	2	2	1	0	0	1
Denominator	5	1		2	1	3	1		3	3	1	3	6	4	2	1	1	3
Friends & Family Test: Maternity % positive																		
Performance	81.52%	81.20% ↓	85.27%	80.14%	84.09%	79.28%	83.00%	89.47%	78.33%	83.76%	80.83%	83.87%	85.53%	85.98%	85.16%	75.95%	80.00%	85.95%
Numerator	150	108	110	117	111	88	83	85	94	98	97	26	136	92	109	120	28	104
Denominator	184	133	129	146	132	111	100	95	120	117	120	31	159	107	128	158	35	121
Friends & Family Test: Maternity % positive - Q1 Antenatal																		
Performance	80.95%	88.24% ↓	86.67% ↓	94.12%	92.31%	100.00%	90.91%	100.00%	100.00% ↑	93.75% ↑	90.91% ↑	100.00% ↑	84.21%	88.89%	90.00%	100.00%	100.00%	87.50%
Numerator	17	15	13	16	12	11	10	11	17	15	10	2	16	8	9	8	3	14
Denominator	21	17	15	17	13	11	11	11	17	16	11	2	19	9	10	8	3	16
Friends & Family Test: Maternity % positive - Q2 Birth																		
Performance	80.33%	88.89%	83.72%	79.63%	87.04%	80.00%	93.55%	89.47%	71.43%	85.71%	79.59%	90.00%	86.67%	87.80%	86.84%	88.71%	77.78%	81.63%
Numerator	49	40	36	43	47	28	29	34	25	42	39	9	52	36	33	55	7	40
Denominator	61	45	43	54	54	35	31	38	35	49	49	10	60	41	38	62	9	49
Friends & Family Test: Maternity % positive - Q3 Postnantal Ward																		
Performance	74.14%	74.47%	88.24%	72.50%	81.40%	74.36%	83.87%	88.46%	79.49%	78.95%	75.00%	88.89%	84.31%	80.49%	81.13%	85.45%	80.00%	83.87%
Numerator	43	35	45	29	35	29	26	23	31	30	27	8	43	33	43	47	12	26
Denominator	58	47	51	40	43	39	31	26	39	38	36	9	51	41	53	55	15	31
Friends & Family Test: Maternity % positive - Q4 Postnatal Community																		
Performance	93.18%	75.00%	80.00%	82.86%	77.27%	76.92% ↑	78.26% ↑	85.00% ↑	72.41% ↑	78.57% ↑	87.50% ↑	70.00% ↑	86.21% ↑	93.75% ↑	88.89% ↑	30.30%	75.00%	96.00%
Numerator	41	18	16	29	17	20	18	17	21	11	21	7	25	15	24	10	6	24
Denominator	44	24	20	35	22	26	23	20	29	14	24	10	29	16	27	33	8	25
Number of PALS/PALS+																		
Performance	52	44 ↑	32	44	42	31	27	26	40		45	44	36	48	21	46		
Numerator																		
Denominator																		

Section 5: Midwifery KPIs

Blue: Passing Target > 6 months; Grey: Hit & Miss Target last 6 months; Orange: Failing Target Last 6 Months
Grey Circle: Common Cause Variation; Green Arrow: Positive Variation; Red Arrow: Concerning Variation; Amber Arrow: Special Cause Variation

KPI	October 2021	November 2021	December 2021	January 2022	February 2022	March 2022	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022	October 2022	November 2022	December 2022	January 2023	February 2023	March 2023
Antenatal Infectious Disease Screening - HIV, Hep B, Syphilis Coverage																		
Performance	99.72%	100.00%	100.00%	100.00%	99.86%	99.63%	100.00%	100.00%	100.00%	100.00%	99.86%	99.72% ↑	100.00% ↑	100.00% ↑	100.00% ↑			
Numerator	716	723	604	698	719	806	585	714	691	658	727	717	640	707	575			
Denominator	718	723	604	698	720	809	585	714	691	658	728	719	640	707	575			
Antenatal Sickle Cell and Thalassaemia Screening - Coverage																		
Performance	99.86%	99.86%	99.03%	100.00%	100.00%	99.75%	100.00%	99.86%	99.71% ↑	100.00% ↑	99.59% ↑	99.58% ↑	99.84% ↑	99.86% ↑	99.65% ↑			
Numerator	719	725	614	699	724	808	583	715	689	656	721	713	635	712	572			
Denominator	720	726	620	699	724	810	583	716	691	656	724	716	636	713	574			
Antenatal Sickle Cell and Thalassaemia Screening - FOQ Completion (ST3)																		
Performance	92.82%	82.50%	90.63%	93.43%	94.53%	93.10%	89.48%	74.70%	99.71%	96.47%	92.69%	94.86%	96.13%	94.59% ↑	97.84% ↑	96.10% ↑		
Numerator	685	627	600	654	709	756	553	552	686	656	659	701	721	559	589	690		
Denominator	738	760	662	700	750	812	618	739	688	680	711	739	750	591	602	718		
Antenatal Sickle Cell and Thalassaemia Screening - Timliness (ST2)																		
Performance	39.30% ↓	45.92% ↓	48.04%	44.00%	40.53%	52.34%	42.39%	50.20%	53.20%	55.29%	52.04%	59.27%	56.86% ↑	55.16% ↑	62.13% ↑	45.40%		
Numerator	290	349	318	308	304	425	262	371	366	376	370	438	427	326	374	326		
Denominator	738	760	662	700	750	812	618	739	688	680	711	739	751	591	602	718		
Breastfeeding Initiation																		
Performance	64.34%	63.03%	60.79%	58.64%	61.90%	62.92%	64.12%	63.95%	61.70%	62.73%	61.27%	62.60%	62.22%	61.76%	62.97%	59.80%	63.03%	63.03%
Numerator	406	399	355	363	325	358	370	392	356	377	386	390	387	344	369	360	312	370
Denominator	631	633	584	619	525	569	577	613	577	601	630	623	622	557	586	602	495	587
Flu Vaccinations offered to Pregnant Women																		
Performance	82.46%	81.23%	80.93%	78.80%	73.17%	40.14%	22.42% ↓	29.86%	36.59%	38.17%	41.19% ↓	68.19%	80.36% ↑	81.34% ↑	77.43%	79.72%	73.73% ↑	35.14%
Numerator	611	610	522	580	551	336	141	221	266	263	318	506	532	593	446	617	508	260
Denominator	741	751	645	736	753	837	629	740	727	689	772	742	662	729	576	774	689	740
Hepatitis B Coverage (ID3) (Reporting 1 Qtr Behind)																		
Performance			99.27%															
Numerator			2,036															
Denominator			2,051															
LMS:Percentage women receiving personalised care plan																		
Performance	96.80%	98.81%	96.17%	96.64%	94.78%	92.57%	93.56%	95.48%	96.35%	94.30%	95.65%	96.93%	95.96%	96.07%	96.03%	96.74%	97.20% ↑	95.38%
Numerator	726	745	627	718	726	785	596	719	712	662	747	725	642	709	557	742	659	702
Denominator	750	754	652	743	766	848	637	753	739	702	781	748	669	738	580	767	678	736

Midwifery KPIs

Blue: Passing Target > 6 months; Grey: Hit & Miss Target last 6 months; Orange: Failing Target Last 6 Months
Grey Circle: Common Cause Variation; Green Arrow: Positive Variation; Red Arrow: Concerning Variation; Amber Arrow: Special Cause Variation

KPI	October 2021	November 2021	December 2021	January 2022	February 2022	March 2022	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022	October 2022	November 2022	December 2022	January 2023	February 2023	March 2023
Maternity Services: Percentage of Black, Asian or Mixed women at 29 weeks on a CoC pathway																		
Performance	39.60%	41.58%	37.89%	37.23%	59.46%	37.72%	41.90%	51.85%	48.11%	36.00%	41.94%	40.86%	39.81%	43.75%	42.86%	47.93%	56.16%	29.31%
Numerator	40	42	36	35	44	43	44	56	51	36	39	38	41	42	42	58	41	34
Denominator	101	101	95	94	74	114	105	108	106	100	93	93	103	96	98	121	73	116
Maternity Services: Percentage of women at 29 weeks on a CoC pathway																		
Performance	17.85%	20.52%	20.52%	18.72%	25.22%	16.85%	18.51%	21.68%	20.21%	16.01%	18.77%	18.92%	19.36%	16.94%	19.45%	20.07%	22.79%	15.77%
Numerator	113	134	126	114	143	107	114	142	134	106	119	109	121	103	114	122	129	91
Denominator	633	653	614	609	567	635	616	655	663	662	634	576	625	608	586	608	566	577
Maternity Services: Percentage of women in bottom decile of deprivation at 29 weeks on a CoC pathway																		
Performance	22.26%	24.78%	23.62%	21.68%	28.90%	23.33%	22.07%	25.87%	26.57%	19.10%	21.81%	24.13%	20.00%	19.74%	23.89%	20.58%	25.32%	14.24%
Numerator	69	84	77	67	89	70	66	89	93	64	70	69	67	60	75	64	78	41
Denominator	310	339	326	309	308	300	299	344	350	335	321	286	335	304	314	311	308	288
MAU - Face to face Maternity Triage within 30 Mins																		
Performance				76.10%	79.80%	68.74%	65.27%	63.78%	59.49%	61.17%	53.82%	55.59% ↓	60.38% ↓	63.01% ↓	56.94% ↓	59.52% ↓	97.68% ↑	99.16% ↑
Numerator				780	964	1,082	902	937	846	819	781	776	820	799	771	825	1,262	1,411
Denominator				1,025	1,208	1,574	1,382	1,469	1,422	1,339	1,451	1,396	1,358	1,268	1,354	1,386	1,292	1,423
Newborn & Infant Physical Examination: Coverage (NP1)																		
Performance	94.30%	94.38%	92.41%	95.09%	93.57%	95.79%	95.42%	92.11%	92.51%	92.94%	93.82%	94.83%	93.21%	94.85%	94.63%	94.81%		
Numerator	612	621	572	620	524	569	562	595	568	592	622	624	604	553	582	603		
Denominator	649	658	619	652	560	594	589	646	614	637	663	658	648	583	615	636		
Newborn Blood Sampling - Avoidable repeat tests																		
Performance	3.10%	3.98%	3.19%	3.00%	4.64%	3.28%	5.05%	2.62%	3.07%	3.05%	3.44%	2.81%	2.25% ↓	2.06% ↓	4.55%	4.28%		
Numerator	22	28	22	21	28	20	34	17	20	22	24	20	15	13	29	28		
Denominator	710	703	689	700	604	609	673	648	651	721	698	711	667	632	637	654		
Newborn Hearing Screening: Coverage (NH1) - Reporting 1 Qtr Behind																		
Performance			96.40%			94.58%			95.57%			96.48%			97.31%			
Numerator			1,822			1,571			1,595			1,728			1,591			
Denominator			1,890			1,661			1,669			1,791			1,635			
Newborn Hearing Screening: Timely Assessment (NH2) - Reporting 1 Qtr Behind																		
Performance			90.91%			90.57%			95.59%			96.43%			94.12%			
Numerator			80			48			65			54			64			
Denominator			88			53			68			56			68			

Midwifery KPIs

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Grey Circle: Common Cause Variation; Green Arrow: Positive Variation; Red Arrow: Concerning Variation; Amber Arrow: Special Cause Variation

KPI	October 2021	November 2021	December 2021	January 2022	February 2022	March 2022	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022	October 2022	November 2022	December 2022	January 2023	February 2023	March 2023
Peer Support - Breastfeeding women contacted by team during stay																		
Performance	91.06%	90.00%	83.70%	93.62%	94.53%	92.58%	92.95%	95.41%	92.38% ↑	93.57% ↑	94.17% ↑	90.24%	91.63%	88.37%	84.98%	91.26%	81.22%	91.84%
Numerator	214	216	190	220	190	212	211	208	206	233	226	222	219	190	198	188	160	225
Denominator	235	240	227	235	201	229	227	218	223	249	240	246	239	215	233	206	197	245
Peer Support - Pregnant women informed of service																		
Performance	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Numerator	396	400	388	414	374	374	368	385	377	407	414	389	391	359	363	367	412	402
Denominator	396	400	388	414	374	374	368	385	377	407	414	389	391	359	363	367	412	402
Pregnant women with a BMI >= 35 at booking offered advice																		
Performance	98.65%	93.24%	92.42%	93.51%	87.95%	93.18%	96.61%	93.15%	98.86%	96.39%	93.83%	98.68%	94.87%	98.61%	100.00%	95.00%	94.94%	98.51%
Numerator	73	69	61	72	73	82	57	68	87	80	76	75	74	71	56	76	75	66
Denominator	74	74	66	77	83	88	59	73	88	83	81	76	78	72	56	80	79	67
Pressure Ulcers: Demonstrate a reduction (Hospital Aquired)																		
Performance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Numerator																		
Denominator																		
Referral time to fetal medicine centre																		
Performance	53.33%	58.06%	66.67%	86.36%	50.00%	54.55%	56.25%	86.96%	76.19%	52.38%	69.23%	94.12%	56.25%	66.67%	84.62%	75.00%	92.31%	81.25%
Numerator	8	18	10	19	10	6	9	20	16	11	9	16	9	14	11	12	12	13
Denominator	15	31	15	22	20	11	16	23	21	21	13	17	16	21	13	16	13	16

Midwifery KPIs

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Grey Circle: Common Cause Variation; Green Arrow: Positive Variation; Red Arrow: Concerning Variation; Amber Arrow: Special Cause Variation

KPI	October 2021	November 2021	December 2021	January 2022	February 2022	March 2022	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022	October 2022	November 2022	December 2022	January 2023	February 2023	March 2023
Number of Maternity Incidents over 30 Days																		
Performance	376	97	119	121	120	234	221	273	204	256	498 ↑	348	308			14	26	
Numerator																		
Denominator																		
Skin to Skin Contact of 1 hour minimum																		
Performance	83.78% ↑	79.09%	83.22%	82.40%	80.09%	96.56%	86.26%	78.47%	77.42%	75.21%	77.52%	80.88%	78.85% ↓	79.01% ↓	79.21% ↓	77.34% ↓	83.42%	83.09%
Numerator	439	416	382	426	346	393	408	390	360	364	407	406	410	350	381	372	332	393
Denominator	524	526	459	517	432	407	473	497	465	484	525	502	520	443	481	481	398	473
Smoking - Interventions to maternity patients at 12 weeks																		
Performance	94.06% ↓	98.95%	98.73%	98.82%	98.73%	98.80%	97.44%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00% ↑	100.00% ↑	98.33% ↑	98.90% ↑	100.00% ↑	100.00% ↑
Numerator	95	94	78	84	78	82	76	110	86	82	91	99	67	90	59	90	67	100
Denominator	101	95	79	85	79	83	78	110	86	82	91	99	67	90	60	91	67	100
Smoking - Offer of referral to Smoking Cessation Services																		
Performance	94.06% ↓	97.89%	97.47%	98.82%	97.47%	98.80%	97.44% ↑	99.09% ↑	100.00% ↑	100.00% ↑	100.00% ↑	100.00% ↑	100.00% ↑	100.00% ↑	98.33% ↑	98.90% ↑	100.00% ↑	100.00% ↑
Numerator	95	93	77	84	77	82	76	109	86	82	91	99	67	90	59	90	67	100
Denominator	101	95	79	85	79	83	78	110	86	82	91	99	67	90	60	91	67	100
Venous Thromboembolism (VTE) - Maternity																		
Performance	95.48% ↓	96.70%	95.44%	95.58%	93.21%	95.51%	92.86%	97.69%	98.21%	97.58%	96.36%	98.14%	97.88% ↑	98.62% ↑	98.05% ↑	98.85% ↑	96.88% ↑	98.10% ↑
Numerator	676	674	649	671	577	638	637	678	660	685	689	686	693	642	652	687	589	671
Denominator	708	697	680	702	619	668	686	694	672	702	715	699	708	651	665	695	608	684
Women whom have seen a midwife by 12 weeks (+ 6 days)																		
Performance	95.10%	96.55%	96.20%	92.98%	91.13%	94.17%	93.37%	94.76%	94.08%	93.93%	95.28%	96.24%	97.73%	95.70%	96.79%	93.49%	94.94%	93.41%
Numerator	602	616	532	583	596	694	493	597	588	557	626	614	560	601	483	618	563	595
Denominator	633	638	553	627	654	737	528	630	625	593	657	638	573	628	499	661	593	637
Women whom have seen a midwife by 9 weeks (+ 6 days)																		
Performance	60.54%	61.47%	60.00%	52.65%	51.79%	59.26%	49.28%	54.59%	55.91%	59.71%	60.34%	62.94%	63.75% ↑	60.08%	65.45% ↑	46.77%	56.17%	54.32%
Numerator	448	461	387	387	391	496	310	404	407	412	467	467	422	438	377	362	387	402
Denominator	740	750	645	735	755	837	629	740	728	690	774	742	662	729	576	774	689	740
Women whom received 1 to 1 Care when in established labour (>= 4cm dilation)																		
Performance	99.61%	99.37% ↑	98.14%	98.33%	98.98%	96.56%	98.97%	99.22%	99.14%	98.99%	98.31%	99.60%	98.41%	99.33%	99.30%	99.82%	99.77%	99.40%
Numerator	505	475	422	529	387	393	480	509	344	490	640	503	494	445	570	561	428	496
Denominator	507	478	430	538	391	407	485	513	347	495	651	505	502	448	574	562	429	499

Section 6: Workforce KPIs

Blue: Passing Target > 6 months; Grey: Hit & Miss Target last 6 months; Orange: Failing Target Last 6 Months
Grey Circle: Common Cause Variation; Green Arrow: Positive Variation; Red Arrow: Concerning Variation; Amber Arrow: Special Cause Variation

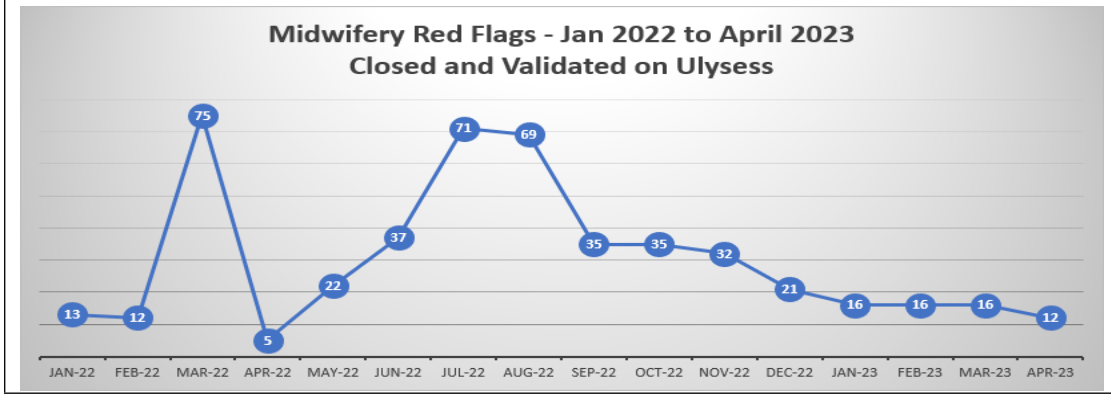
KPI	October 2021	November 2021	December 2021	January 2022	February 2022	March 2022	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022	October 2022	November 2022	December 2022	January 2023	February 2023	March 2023
Clinical Mandatory Training Compliance - Maternity	73.08%	71.61%	70.42%	56.41%	68.39%	68.09%	64.11%	62.91%	63.53%	62.27%	63.02%	61.91%	63.93%	64.94%	63.57%	64.81%	66.56%	68.85%
Induction Attendance Rate (Corporate) - Maternity	95.00%	96.00%	95.00%	94.00%	93.00%	93.00%	92.00%	94.00%	93.00%	94.40%	94.82%	94.82%	95.30%	94.92%	94.38%	95.89%	95.74%	96.32%
Induction Attendance Rate (Local) - Maternity	98.00%	98.00%	96.00%	92.00%	96.00%	96.00%	94.00%	94.00%	92.00%	91.67%	92.64%	92.64%	93.09%	92.37%	90.73%	84.83%	83.21%	86.52%
Local Mandatory Training Compliance - Maternity	59.00%	58.00%	56.00%	56.41%	55.38%	58.60%	57.16%	54.56%	59.70%	64.22%	64.38%	65.53%	66.58%	71.35%	71.45%	66.88%	66.08%	68.16%
Mandatory Training Compliance - Maternity	71.00%	72.00%	70.37%	72.83%	73.75%	73.56%	72.93%	74.45%	77.69%	76.82%	78.88%	78.04%	78.73%	80.05%	74.61%	81.26%	83.91%	82.84%
Midwifery Sickness Percentage	13.31%	12.63%	15.26%	16.37%	11.45%	9.64%	9.69%	9.65%	9.68%	11.00%	10.53%	9.58%	9.92%	10.60%	12.41%	11.59%	8.91%	
Midwifery Vacancy Percentage	5.32%	8.72%	7.84%	2.46%	2.00%	4.10%	13.20%	13.20%	17.00%									
Professional Registration Lapses - Maternity	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Rostered Cons on DS (Hrs per Wk)	91	91	91	91	91	91	106.5	106.5	106.5	106.5	106.5	106.5	106.5	106.5	106.5	106.5	106.5	
Sickness - Maternity	13.31%	12.63%	15.26%	16.37%	11.45%	11.95%	9.69%	9.65%	9.68%	11.25%	10.53%	9.58%	9.92%	10.60%	12.41%	11.59%	8.91%	9.25%
Super Numerary DS Shift Leader	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	
Turnover - Maternity	13.00%	12.00%	13.00%	13.00%	13.00%	14.00%	13.00%	14.00%	12.00%	11.80%	11.38%	11.12%	10.30%	10.19%	9.45%	8.82%	9.53%	9.05%

Dashboard Responses – March 2023.

Very Concerning – Investigate & Take Action.		
Metric	**Position**	**Response from FHD Senior Leadership Team**
PDR Rate – Maternity	46.60% (Target ≥ 95%)	• All MW Line Managers has been tasked with providing a date for PDR completion by March 23 – Ongoing. • HRBP and HOM have meetings scheduled with all MW Leaders to compile a plan for all staff to achieve compliance. This will then be monitored monthly and will feature as a standard agenda item on Family Health Divisional Board • Trajectory that all staff will require PDR by 31.05.2023 to be lead by clinical matrons with priority.

Midwifery Red Flags – March 2023.

Midwifery Red Flag	Number Reported on Ulysses
Delayed or Time Critical Activity	**1**
Missed or Delayed Care	**1**
Missed medication during admission	**0**
Delay of 30 Mins in providing pain relief	**1**
Delay >30mins between presentation & triage.	**5**
Full clinical examination not carried out when presenting in Labour	**0**
Delay >2hrs between admission and beginning of IOL process	**0**
Delayed recognition of and action on abnormal vital signs	**0**
Any occasion of inability to provide continuous 1:1 care in labour	**2**
Delay >4hrs of ongoing IOL	**6**
	TOTAL
	16



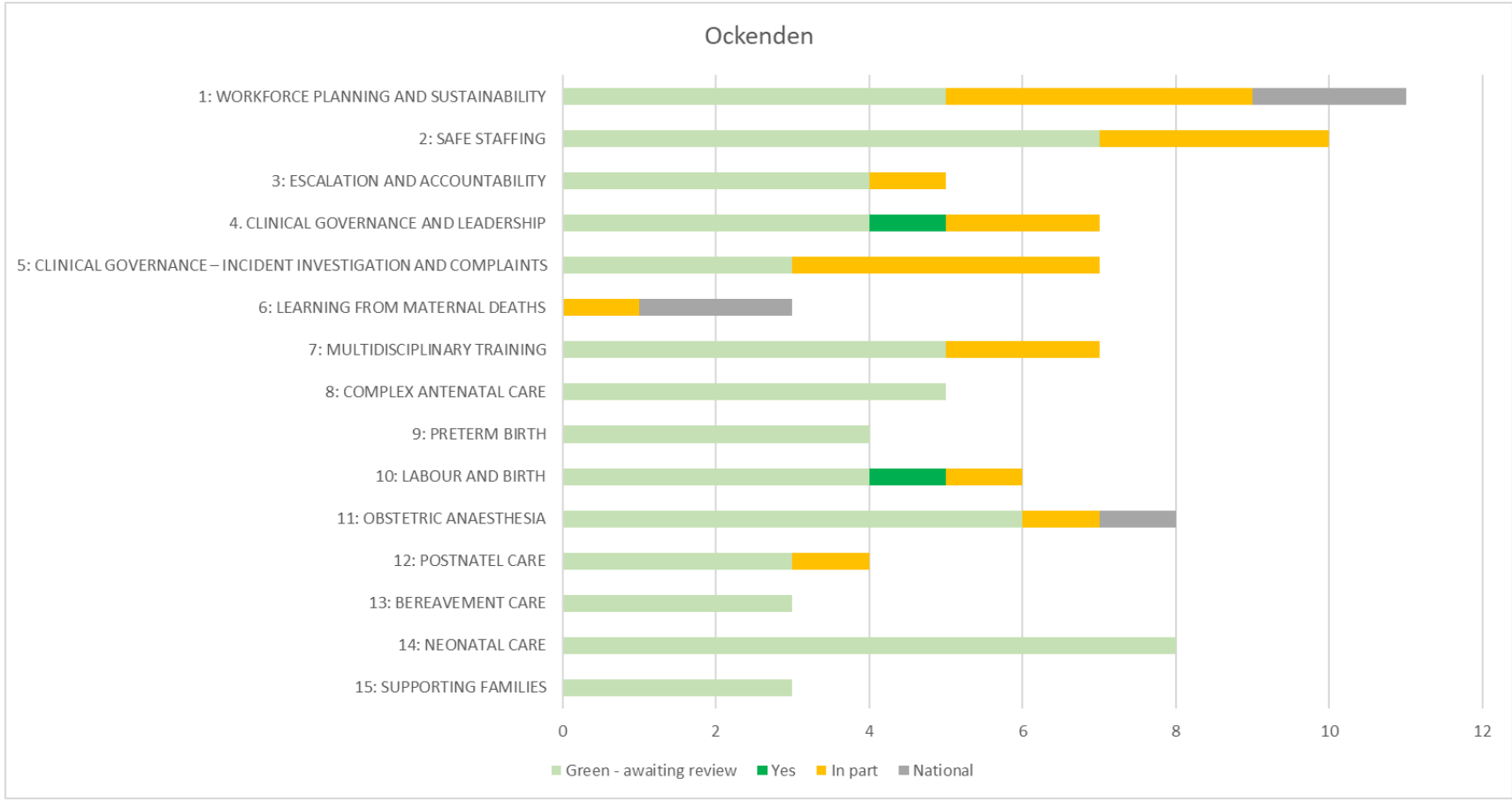
Actions Taken.

All staff are encouraged to recognise and report midwifery red flags using the Ulysses System and the maternity managers strive to close incidents in a timely fashion. Midwifery Red flags are monitored two hourly by the Midwifery 104 Bleep holder, with Data and governance oversight maintained through the Divisional Maternity Governance and Risk Committee. The Head of Midwifery provides a detailed narrative of midwifery red flags within the Bi-annual Midwifery Safe Staffing Paper. A SOP developed for the management and governance of Midwifery Red Flags and was ratified in division MRC in April 2023. In February and system update to Ulysses was executed enabling smarter reporting of MRF events as a cause group.

- Insufficient Midwifery Staffing on Divisional Risk Register, extreme ris 1705, HOM Lead.
- Weekly and Daily Roster Oversight Management by HOM, Matrons ar Managers.
- E-Roster Challenge sessions.
- Proactive management of staff sickness and improvements to RTW interviews
- Use of Escalation and Divert Policy where required, including use of non-clinical registrants and Cont of Care MW.
- NHSP and Agency use – with incentivized scheme developed and agre Senior Leadership Team.
- Medical Review, DOC/apologies and Escalation of delay to Senior Obs and 104 Bleep Holder.
- Ongoing recruitment and retention programme.
- Compliance to Birth Rate Plus Report and over recruitment to vacancy (Jan 2022)

Maternity Safety Breakdown – March 2023.

HSIB Referral Details:	March 2023 - Therapeutically Cooled Baby - IA not in line with Trust guidance. Decision to transfer into hospital made after 2 raised FH noted, this is outside of Trust guidance. There should have been fetal heart rate auscultation after each contraction when a fetal tachycardia is noted, for 3 consecutive contractions. It is likely that the decision to transfer would have been made at the same time as in this case. Ambulance arrived within 10 mins of call. No delay in review in medical review or decision to deliver – category 2 delivery - Decision to deliver 67 mins. Sepsis assessment completed on admission – High risk: abx given in theatre within 60 mins. Sepsis 6 data sheet commenced but incomplete. No hourly review of maternal temperature whilst in homebirth birthing pool. Reportable to HSIB, Trust concern with fetal monitoring at the homebirth. Should case be rejected by HSIB would escalate as SUI. HSIB Quarterly Review Meeting planned for May 5th 2023. Feed back from quarterly review to be included in June perinatal safety dashboard paper.
STEISS and SUI Events	March 2023 – Transfer to ITU at RLUH. 72-hour report notes delays in transfer to Delivery Suite with delay in administration of antibiotics. Delay in removal of cervical cerclage. No plan of frequency of bloods to identify deterioration in Sepsis, potential for earlier intervention and transfer to ITU. Full serious incident investigation underway. The Maternity Governance Team have reviewed the status of SUI Actions for 2022. In 2022, a total of 13 Serious Incident Investigations were undertaken. Across the SUIs a total of 145 actions were developed. Of this, 10 actions are current overdue, however these actions are sighted and are proactively being managed with the action owners. There are currently 31 ongoing actions and 84 have been completed. Further updates will be provided to the Trust Board and are monitored at family Health Divisional Board and Maternity Risk Meeting.
Perinatal Stillbirth Mortality.	Number of Stillbirth (Exc Terminations of Pregnancy) in March 2023**: 0** All perinatal deaths in January & February 2023 have been reported to MBRRACE and will be subject to a full MDT review with an exterr member. Details and actions plan of every death are detailed in the Regional Quarterly Mortality Report presented by the Deputy Medical Director at Quality Committee and Trust Board.
Ockenden Update	Several actions relate to SI's, PSIRF is due to be implemented into the Trust in September this will result in the SI threshold being removed. The Corporate Governance Team are managing this piece of work and will update the committee accordingly. One of the MIAA Audit recommendations is that all the essential actions rated as Green be reviewed as part of a check and challenge at the Workstream meeting -this will include 65 green actions. This will take until the end of September 2023 to complete. Compliance with Human Factors Level 2 training remains low.



FHD Risk Register.

Maternity currently holds 41 Risks within the Trust Risk register:
Risk Register management and review is a standing agenda item at the Maternity Risk Meeting, where risks and new risks are considered and discussed, and issues highlighted for escalation to FHDB and divisional quadrumvirate.
Closed and completed risks are agreed and overdue reviews of risk highlighted.
For March 23 the maternity division offer the following brief update:

- New Risk 2682 in relation to emergency evacuation of patients from birth suites on MLU has been added and scored as extreme following HoM/Div Manager walk around of MLU estate.

Risk Rating	Total	Previous Month
Extreme	2	1
High	29	26
Moderate	6	5
Low	4	3

	- New Risk 2679 in relation to increased incidents of slips, trips, falls, verbal abuse to staff, breaches to privacy and dignity and - health and safety regulations as a consequence of the introduction 24/7 patient visiting on Mat Base. - There are 5 overdue risk status requiring review- all risk owners have been notified and have been asked to provide assurance of risk review immediately. - All maternity risk owners have been updated to reflect change in management personnel within the division. - Maternity Division are proactively working through outstanding risk register actions and seeking evidential assurance of those actions completed. - Maternity Managers and Matrons are in the process of being provided with up-to-date risk register management training with Governance Manager.
Maternity Incentive Scheme	**Progress against the Year 4 Maternity Incentive Scheme (CNST):** Full compliance with Year 4 CNST was declared at January 2023 Trust Board meeting with the sign of template submitted to NHSR. The Division await the release of the Year 5 scheme guidance and will action upon receipt.
Women's. Feedback and MVP.	The Family Health Division has regular interaction with its MVP Chair and regular service user feedback sessions are carried out to help inform future service developments. The most recent service user engagement event took place on 30th April 2023 when a '15 Steps' project was completed on the Maternity Base. Formal feedback is awaited and will be actioned upon receipt.
Maternity Self-Assessment Tool.	This Safety Self-assessment tool has been designed for NHS maternity services and private maternity providers to allow them to self-assess whether their operational service delivery meets national standards, guidance, and regulatory requirements. Organisations can use the tool to inform the trust's maternity quality improvement and safety plan and so keep the trust board and commissioners aware of their current position. The tool has been developed in response to national review findings, and recommendations for good safety principles within maternity This version of the tool has been further influenced by the findings of the Ockenden review, 7 features of safety culture and the emerging themes from services on the safety support programme and the areas CQC found to be outstanding in other maternity services across England. The Division continue to use an appreciative enquiry framework to complete this self-assessment tool. The Senior Leadership Team reviews the current position and evidence repository. Weekly meetings are being held to review the evidence for each of the 194 questions/actions. To date 90 have been reviewed and 93 are yet to be reviewed, a tracking spreadsheet is being maintained to capture the rationale for

<table>
<tr><td></td><td>ratings and record sign off.

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<tr><td></td><td>Red</td><td>Amber</td><td>Green</td><td>TBC</td></tr>
<tr><td>2023 Review</td><td>3</td><td>30</td><td>57</td><td>93</td></tr>
</table>
</td></tr>
<tr><td>Family Health Safety Champions</td><td>Safety Champion walkarounds continue to take place within clinical areas. Walkaround in April 2023 by LG, RMc, FP an AW

- Safety Champions have visited maternity base and noted the ongoing ward-based improvements being made with regards to Safety huddles and handovers.
- Safety Champions have been sighted on the developments and improvements implemented within MAU both pre and post CQC visit and are pleased to see the improvements made within the unit, specifically the demonstrable improvement and comp women triaged < 30 minutes
- Discussions were carried out with staff who reported that the MAU felt much safer since the CQC visit and that the increased sta model on the unit has resulted in a much safer environment.
- MSC continue to review quarterly reports regarding perinatal deaths to ensure full compliance with all national requirements and will continue to provide exception reporting in collaboration with CD for Family Health
- Continued involvement and monitoring in ATAIN
- This perinatal quality dashboard/safety report (sent to every Trust Board) will continue to cover all aspects of safety champion walkabouts, highlighting issues for senior level oversight, areas of compliance for safety champions against the standards within the Maternity Incentive Scheme and updates pertaining to maternity safety.</td></tr>
</table>

Conclusion

The Family Health Division requests that Quality Committee receive this paper and seek assurance that perinatal quality safety is a key Divisional priority, and this report provides sufficient evidence of our ongoing compliance and progress with the implementation of a perinatal quality dashboard and framework.

The data provided within this report is monitored monthly and features on the Family Health Divisional Board meeting agenda and includes review and monitoring of compliance against all Maternity KPIs that are included within the Maternity Power BI dashboard.

In addition to the above internal assurance process data is submitted externally to the Northwest Coast Regional Dashboard monthly. Any areas of concern which are highlighted as outliers are returned to Maternity Senior Leadership Team for further analysis and review by Clinical Director to identify areas for improvement and to share learning.

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	**23/24/027c**		**Date: 11/05/2023**	
Report Title	**Integrated Governance Assurance Report Quarter 3, 2022/23**			
Prepared by	***Allan Hawksey Head of Risk and Safety***			
Presented by	***Phil Bartley, Associate Director of Governance and Quality***			
Key Issues / Messages	This report provides information of oversight and assurance monitoring of Integrated Governance and highlights key risks to the Trust.			
Action required	Approve ☐	Receive ☐	Note ☒	Take Assurance ☒
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable):			
	For Decisions - in line with Risk Appetite Statement – Y *If no – please outline the reasons for deviation.*			
	The Board is requested to note the contents of the paper and take assurance that there are sufficient governance processes in place consisting of divisional and corporate oversight to mitigate and manage risk.			
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	Comment:

service users 5.2 Failure to fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership	
Link to the Corporate Risk Register (CRR) – CR Number: N/A	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Quality Committee	Apr 23	CN	The Committee received the Integrated Governance Assurance Report Quarter 3, 2022/23 for assurance. The narrative and format of the report had been further modified to provide the required assurances to the Committee. The Committee noted that a workshop session had been held between the Governance Team and Legal Team to consider the claims data and how best to share actions and embed learning.

EXECUTIVE SUMMARY

The following Integrated Governance Assurance report covers Quarter 3 of 2022/23. The report is part of the regular reporting schedule of the Trust to ensure that there is oversight and assurance monitoring of Integrated Governance across the Trust.

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

Main points reflected within the main body of the report from the Corporate Team are:

- Incident reporting within the Ulysses system continues to increase across all Divisions reflecting staff awareness of what constitutes an incident supported by ongoing training within the system from the Corporate Team. **There have been no Serious Incidents declared as a result of potential / perceived incident under reporting.**
- A key area of risk for Q3 was within the investigations cause group relating to Inadequately Labelled Sample (381) and Haemolysed Sample (55) with (110) within the Community and (99) on Delivery Suite. **There is a steering group chaired by the Deputy Director of Nursing with all Divisions represented (including the Trust External Pathology Consultant) which has oversight of all blood sampling issues and has an ongoing workstream of directed education for clinicians to address ongoing areas such areas for improvement.**
- The members of the Medicines Safety Group (MSG) continue to encourage the reporting of medication incidents across the hospital so the Trust can learn from these incidents and prevent patient harm. **The members of the Group, led by the Deputy Chief Pharmacist continue to meet weekly to review all closed and reported incidents over the previous 7 days for themes, patterns and trends. Closed assurance is reviewed and challenged where required. The Deputy Chief Pharmacist and Head of Risk and Safety continue regular engagement sessions with colleagues across Divisions with the Medicines**

Safety Bus to promote incident reporting, challenge embedded learning from incidents and discuss developing themes, patterns and trends with Divisional actions required to prevent escalation and potential for patient harm

- Successful recruitment of permanent Fire Safety Advisor in a joint post with Alder Hey. **The Fire Safety Officer has already agreed a clear work plan with the Chief Operating Officer to address areas requiring improvement, ensuring site safety and increased compliance with the fire regulations.**
- 100% of the 18 CAS Alerts received in this quarter were acknowledged and responded to within their deadline targets. **No alerts breached the expected external deadline dates during this period ensuring that Alerts have been appropriately actioned by the right people, at the right time with a robust action plan in place where required on the Ulysses system.**
- During Quarter 3, The Trust assessed 751 friends and family responses that recorded they had a disability in response to the question "*Do you feel your views were considered within the decision-making process / care plan?*" This is to assure the Trust that patients with disabilities continue to be included in decisions about themselves. Out of the 751 responses, only 5.9 % (44) felt they were not involved in the decision-making process during this time. **The patient experience team are continuing to focus on the feedback from those 44 patients to learn and improve patient involvement with a target of 100% positive feedback.**
- Regarding clinical audit, a recent audit highlighted that all women were screened for anaemia by a full blood count at the first appointment, while the national average sits at 97-98% for other Trust's. Liverpool Women's Hospital also performed significantly better than the national average in prescribing oral iron for all women diagnosed with anaemia at 28 weeks (71%) and postnatally (75%). **This demonstrates some of the high-quality care that patients expect and that the Trust has delivered exceeding national average statistics.**
- A new Quality, Innovation & Compliance Manager was appointed in Q3. **They have had an immediate impact working with the Divisions to educate and simplify the process which has seen positive Divisional engagement and an increase in number (7 during Q3) and standard of Quality Improvement projects across all Divisions.**
- There were 8 serious incidents declared to the Integrated Care Board (ICB) during Q3 (a reduction of 11 from Q2) All of these cases have had Executive oversight and sign off. **Some cases related to the Isolated Site Risk (critical care transfer), isolated incidents not part of a theme, pattern or trend, had full duty of candour completed and an investigating officer appointed by the Divisions immediately to ensure investigations were expedited as quickly and comprehensively as possible to ensure any learning identified could be implemented in real time.**
- There were no externally reportable action plans overdue following feedback highlighted from the ICB as of 04 January following closure. **Work remains ongoing Divisionally to ensure that all action plans are captured and monitored internally within the Ulysses System. Progress is being supported and monitored by the Corporate Governance Team on a weekly basis. Compliance continues to progress positively.**

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

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

MAIN REPORT

INTRODUCTION

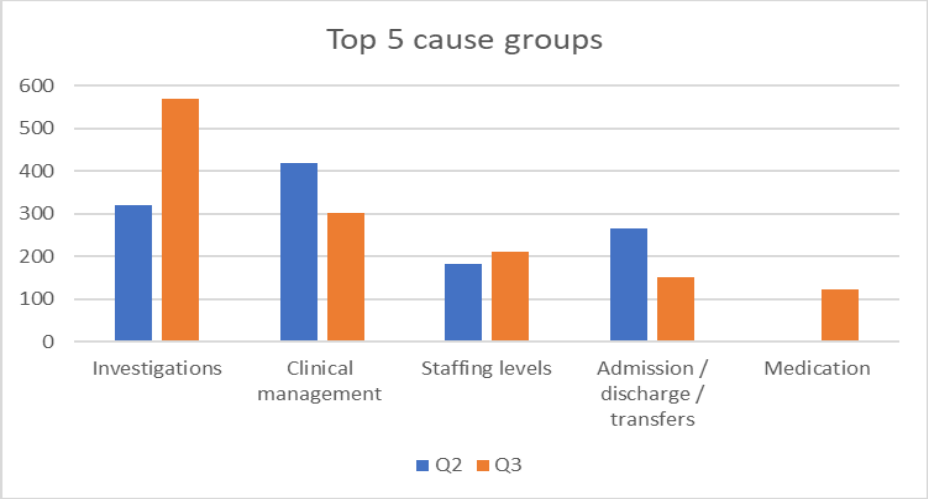
This integrated governance report is a quarterly integrated review of quality governance and the standard of care at Liverpool Women's Hospital. The intention of the report is to complement the monthly quality governance dashboards and performance reports by providing a longer term, thematic analysis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

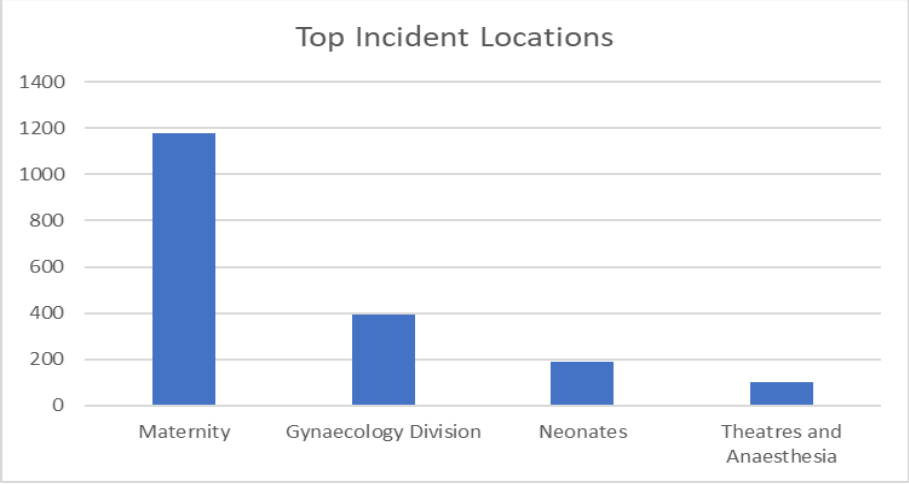
KEY THEMES AND AREAS OF RISK ACROSS THE TRUST

1. Incidents

HEADLINE - A key area of risk for Q3 was within the investigations cause group relating to Inadequately Labelled Sample (381) and Haemolysed Sample (55) with (110) within the Community and (99) on Delivery Suite

- 2023 reported in total
- Increase of 38 incidents compared to 1985 incidents in Quarter 2 22/23





Total number of incidents reported across Q2 for 2022/23 compared across 2021/22.

2021-22	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Total	557	636	498	510	468	835	597	718	577	686	657	657	**7396**
Quarterly	1691(>279)			1813 (>122)			1892 (>79)			2000 (>108)			(>2626)
2022-23	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**total**
Total	641	693	500	700	658	627	849	665	509				
Quarterly	1834 (<166)			1985 (>151)			2023 (>38)						

Patient Safety Incidents

1918 total PSI for Q3 (Trust wide)

Family health (1367)	Gynae (Inc HFC) (395)	CSS (191)
Investigations (461)	Investigations (84)	Investigations (24)
Clinical Management (233)	Communication (48)	Communication (22)
Staffing Levels (175)	Clinical Management (47)	Clinical Management (21)
Admission / Discharge / Transfer (113)	Appointments (43)	Medication (17)
Medication (84)	Admission / discharge / transfer (28)	Equipment (16)

Analysis of the key themes

- Investigations – inadequately labelled blood sample (381) and Haemolysed Sample (55)
- Clinical Management – Delay of over 4 hours during ongoing induction of labour (69) and failure to follow clinical guidelines (37)
- Communication – Failure within the team (47)
- Admission / discharge / transfer – Unplanned admission (30) and Term baby admitted to Neonatal Unit (28)
- Medication – Administration (51) and prescribing (31)

Improvements and actions

Trust Wide – A key area of risk for Q3 was within the investigations cause group relating to blood sampling errors (as per Q2 22/23). There remained a significant level of rejected samples from the laboratory.

There is a steering group chaired by the Deputy Director of Nursing with all Divisions represented (including the Trust External Pathology Consultant) which has oversight of all blood sampling issues and has an ongoing workstream of directed education for clinicians to address ongoing areas such areas for improvement.

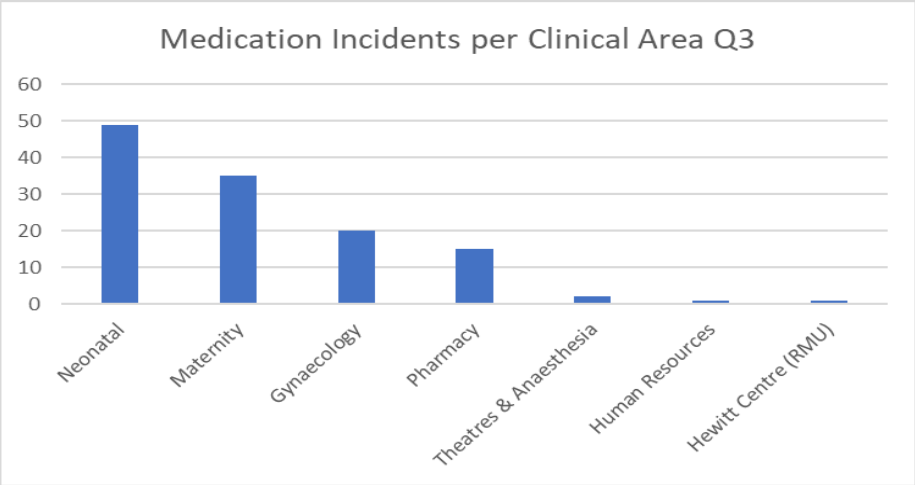
2. Medicines Safety

HEADLINE - A risk was added to the MMG risk register in Q2 relating to the failure to reduce the risk, diagnose and treat venous thromboembolism (VTE) in patients who are in hospital because of a lack of awareness of VTE guidance, education, and leadership across the Trust. This remains ongoing within Q3

Ulysses Data

Total number of medication incidents reported per quarter for past 12 months

Q1 22/23	**Q2 22/23**	**Q3 22/23**	**Q4 22/23**
110	99	123	To be reported
Q1 21/22	**Q2 21/22**	**Q3 21/22**	**Q4 21/22**
114	80	80	76



Improvements and actions:

The members of the Group, led by the Deputy Chief Pharmacist continue to meet weekly to review all closed and reported incidents over the previous 7 days for themes, patterns and trends. Closed assurance is reviewed and challenged where required. The Deputy Chief Pharmacist and Head of Risk and Safety continue regular engagement sessions with colleagues across Divisions with the Medicines Safety Bus to promote incident reporting, challenge embedded learning from incidents and discuss developing themes, patterns and trends with Divisional actions required to prevent escalation and potential for patient harm

3. Health & Safety

HEADLINE – Successful recruitment of permanent Fire Safety Advisor in a joint post with Alder Hey

In the last quarter, there were 23 non-clinical health and safety related incidents reported, an increase of seven from the previous quarter. The majority of incidents were reported by the Family Health Division, with Gynaecology & Fertility Division, Neonatal Services, Clinical Support Services, and Corporate function reporting four, four, three, and two incidents, respectively. All incidents were appropriately managed, and all processes were followed. A breakdown of all non-clinical health and safety incidents, reported in quarter 3, are detailed in the table below:

	FAMILY HEALTH	GYNAECOLOGY & RMU	CLINICAL SUPPORT SERVICES	NEONATES	CORPORATE FUNCTION	TOTAL
STAFF INCIDENTS						
PERSONAL INJURY/ILL HEALTH	1	1				2
ENVIRONMENT	4	1		4		9
NEEDLESTICK INCIDENTS	2	2	1			5
SLIPS, TRIPS & FALLS (non-clinical) including faints/collapse	2		1		1	4
INJURY	1		1			2
TOTAL	10	4	3	4	1	22
PATIENT & VISITOR RELATED INCIDENTS						
SLIPS/TRIPS/FALLS		1				1
TOTAL		1				1

Improvements and actions:

The Fire Safety Officer has already agreed a clear work plan with the Chief Operating Officer to address areas requiring improvement, ensuring site safety and increased compliance with the fire regulations.

Work remains ongoing within the team to increasingly raise the profile of the Health and Safety Team making Health and Safety everyone's business. The Health and Safety Group meeting chaired by the Head of Risk and Safety is now regularly well attended by all Divisions and there is work due to commence to develop a network of Health and Safety Champions across the Divisions to ensure proactive recognition and reporting of potential health and safety incidents in a timely manner and reported on to the Ulysses system.

4. Complaints, PAL's & PALS +

HEADLINE Complaints in Q3 22/23 saw a decrease of 6 complaints compared to the previous quarter

Gynaecology Services division, which incorporates Gynaecology and the Hewitt Fertility Centre services, accounted for 70% of the received volume. The Trust are continuing to see a sustained increase in the number of complaints received for relating to the Hewitt Fertility Centre when comparing previous levels. The majority of these are received from fee paying patients where they are requesting part or full reimbursement of the costs incurred due to their dissatisfaction with the services provided. Discussions are continuing with the Gynaecology Divisional team and Patient Experience team to try and understand the reasons for the increase and how they can be managed.

The number of PALS + cases dealt with this quarter is consistent, with Family Health Division, covering Maternity and Neonatal services, conducting the majority of these. Work continues to fully utilise the PALS + process provisions to achieve early resolution of concerns and provide more timely outcomes for people raising concerns. The trends show that this has a positive impact on reducing the number of complaints needing to be raised.

587 PALS cases were received in this quarter which is a small decrease of 4 cases overall. Initial end of quarter review has highlighted a few areas which have been repeatedly raised in this quarter:

- Patients continuing to contact PALS trying to gain information about appointments and associated delays due to capacity.
- Communications queries were recorded as the main category in 46% of the total cases for the quarter with appointments accounting for 26% of the cases recorded. Communications and appointments have remained static since last quarter with no change in the percentage in either category.
- The most cases received by a division was 327 PALS cases which were received this quarter by Gynaecology. With the busiest month being noted as October 22. Again, Appointment issues are noted as a driver for this increase which coincided with some national media coverage of the long delays being experienced and stories of patients "missed".
- Appointment provision is continuing to be a point of dissatisfaction from patients who feel they are experiencing extended waits and the severity of their own condition is not being considered in this decision.
- Patients are continuing to contact the patient experience team due to being unable to contact the correct admin or clinical area or having left messages, no return calls were made, or experiencing long waits when contacting GED and MAU.

Improvements and actions:

As telephony software (Netcall) allows for greater reporting capabilities which allows greater scrutiny and reporting of any issues. 2 workstreams are still underway reviewing the clinical call performance in both the Maternity Assessment Unit (MAU) and the Gynaecology Emergency Department (GED). Patient Experience Team have requested to be involved in both groups. There is Patient Experience representation on the workstream looking at the MAU improvements and this is already underway. The currently has been no update relating to the GED workstream or commencement date.

Appointments and difficulties in contacting the trust about these continue to be prevalent themes in the PALS cases received by the Trust. Patients are all aware nationally of the waiting lists across the NHS and that fear of not getting their own appointment is leading to an increase in more forceful queries being raised to try and expedite their own case. Plans to address these appointment backlogs are in place and reported via different forums in the Trust.

Face to face availability for the PALS service continues to be provided and utilised by our patients. Since recommencement of this face-to-face provision, there has been couple of security issues relating to patients attending the PALS office in Q2. These were notified as security issues and appropriate reviews undertaken and no further issues have been noted in Q3.

5. Clinical Effectiveness and Audit

HEADLINE – The Trust received 5 Clinical Audit Reports including Action Plans in Quarter 3.

1. Key successes from Clinical Audits completed Quarter 3

- Liverpool Women's Hospital has achieved impressive results across various aspects of its maternity and gynaecology services, according to recent audits. The hospital screened 100% of women for anaemia using a full blood count and exceeded national averages in prescribing oral iron for anaemic patients.

- The maternity department achieved above 95% compliance in measuring carbon monoxide levels in pregnant women at booking and demonstrated excellent midwifery-client communication regarding fetal movements.

- The hospital achieved full accreditation from the British Society for Gynaecological Endoscopy within a year of establishing its endometriosis service. Imaging was offered to 97% of patients prior to surgery, and all cases of stage 1 and 2 endometrioses were treated at first laparoscopy.

- The hospital also demonstrated high levels of patient satisfaction among patients with learning disabilities, autism, and dementia.

2. Key themes to be actioned as a result of Clinical Audit reports received in Quarter 3 which are monitored via the Clinical Audit & Effectiveness Team and Quality Improvement Group (QIG).

- 77% of babies born at gestations between 23 weeks + 6 days and 33 weeks + 6 days and their mothers received corticosteroids within 7 days of birth - This fall below the maternity incentive scheme standard of 80%.

- With regards diagnosis and management of anaemia during pregnancy, screening was identified as a key theme. 41% of women requiring a full blood count postnatally did not receive one, and 92% of pregnant women were screened for anaemia at 28 weeks gestation (falling below the national average of 98%). Only 20% of women with macrocytic anaemia at 28 weeks gestation had appropriate follow up screening (B12 and folate). Of the women diagnosed with anaemia, not all were treated appropriately as 71% at 28 weeks and 75% post-partum were started on oral iron. However, this was above the national average of 30% at 28 weeks and 74% at post-partum. It was highlighted that the management of postnatal anaemia was not addressed in the LWH local guideline.

- In the LWH endometriosis service, it was found that the referral criteria were not optimised (10% of patients did not need to be reviewed in the endometriosis centre). Furthermore, several patients had been waiting longer than 18 weeks. It was also noted that the Trust should expect more referrals in future, due to the newly achieved accreditation status. The high demand for the service currently outweighs the clinical and administrative resources available, so without extra staffing this could further increase wait times.

- Fetal growth scans after 23 weeks of gestation showed multiple areas of less than 100% compliance. Compliance in saving images of head circumference (74%), abdominal circumference (94%) and femur length (86%) did not meet target of 100%. There were issues identified with 'rounding up' measurements for head circumference (13%), abdominal circumference (6%), and femur length (7%). Compliance saving images of the stomach/diaphragm (81%), kidneys (84%) and bladder (86%) did not meet the target of 100%. There were also issues with saving images of the deepest vertical pool (DVP) (97% compliance) and he placenta (77% compliance).

- Regarding the care of patients with learning disabilities, autism, and dementia only 70% of staff had the required awareness and specialist training as part of their mandatory safeguarding training. This falls below the expected standard of 100% and has dropped significantly since the previous audit (94%).

Improvements and actions:

Where audits have determined that the level of expected standards have not been met, there are significant Divisional action plans formulated to address issues highlighted. All audits are reviewed by the Quality

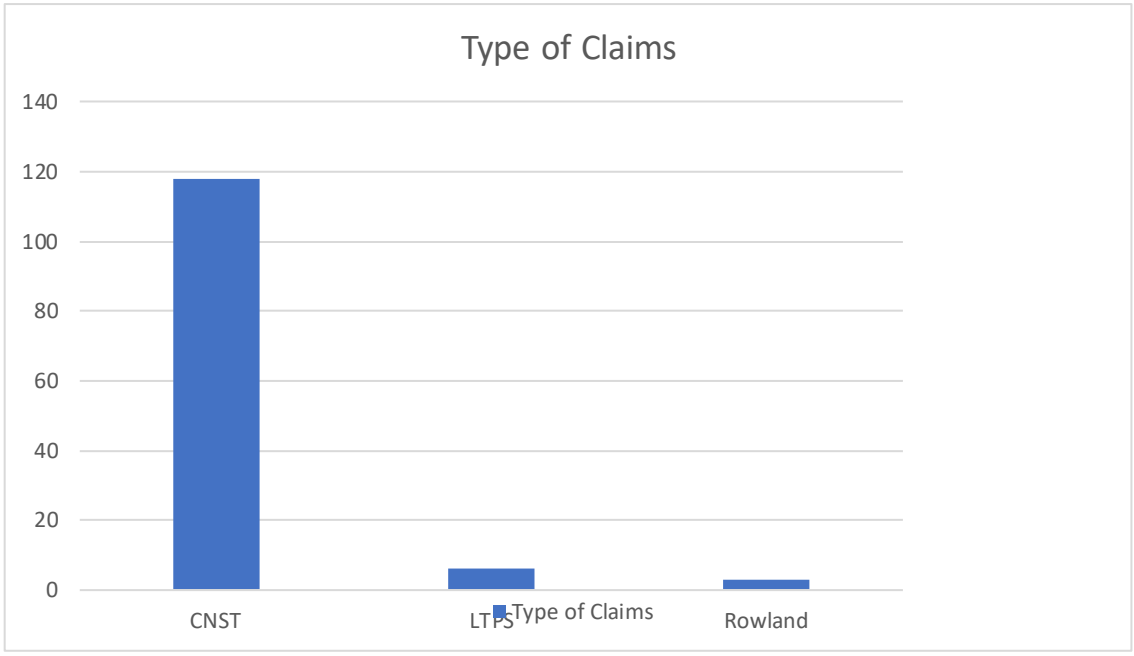
Improvement Group (QIG) and actions either approved or amended and updated where required. These are divisionally led and monitored by the Clinical Audit and Effectiveness (CAE) Department. The outcome of such action plans is subsequently reported back in to QIG where a further audit may be required. There is considerable oversight of all audits by QIG and the CAE Department.

6. Legal Services

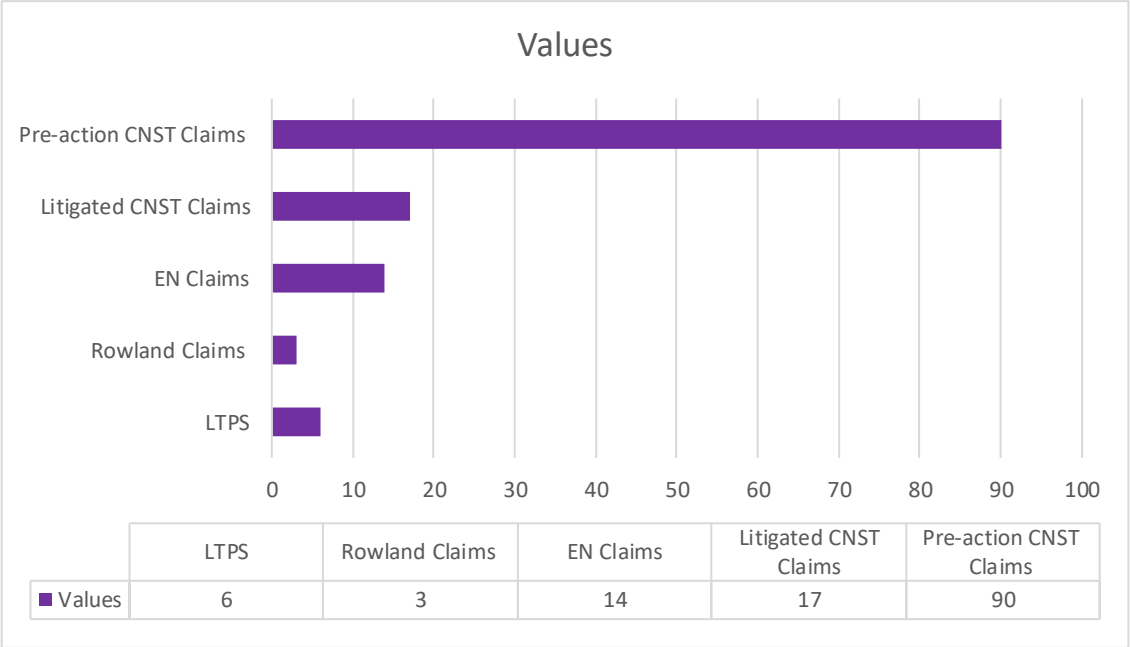
HEADLINE – To date in this financial year, the Trust has agreed settlements totalling £925,586. The previous financial year's settlements totalled £42,551,491.36. Damages settlements in 2019/20 totalled £16,901,232.

The Claims data has been generated using data extracted from the legal team's local database, supplemented by the NHS Resolution (NHSR) claims management system.

1. **Currently there are 126 Active "open" claims (121 Clinical claims - 6 non-clinical – 3 Rowlands cases) – as per Q2**



2. **The current procedural position of these claims are as follows.**



Improvements and actions:

The 2022 Trust scorecards have been released and a deepdive review of these claims alongside the GIRFT claism data are being analysed for the purpose of producing a report to inbed into the Trust lesson learning processes.

There has been an increased presence from legal within Divisional meetings in order to share actions from claims raised so that they can be implemented at the earliest opportunities and there will be increased debrief sessions following the settlement of claims to ensure that learning has been implemented and there is evidence of embedding such learning in usual practice and culture throughout all of the divisions.

7. Patient Experience

HEADLINE – Divisional FFT "you said, we did" reports are now a standing item on the Patient Involvement and Experience Subcommittee. This enables greater visibility and promotion of the improvements being implemented from the FFT and allows this learning to be shared across the various divisions who attend this meeting.

Friends and Family Test (FFT) – overview

FFT reports are scheduled and sent to all divisions on a weekly basis highlighting the comments that need reviewing and addressing, both positive and negative. Divisions have been encouraged to consult with the patient experience team if there are any specific reports that they need creating to assist with this review. F&F review is included in the Divisional reports required to be presented. KPI has been introduced to monitor the response initially to the displeased responses provided.

FFT results for Q3 22/23

Number of responses received

Total	Maternity	Gynaecology	Genetics	Reproductive Medicine (RMU)
3258	407	2423	85	188

Overall experience score (satisfaction report) – this score is based on the responses to the question "Please rate your overall experience (Poor=1 to Good=10)"

Trust score %	Maternity %	Gynaecology %	Genetics %	Reproductive Medicine (RMU) %
90.32 ↑	83.58 ↑	91.27 ↑	89.02 ↑	88.98 ↓

Recommendation score - this score is based on the responses to the question "*Thinking about the service we provided, overall, how was your experience of our service*?"

Trust score %	Maternity %	Gynaecology %	Genetics %	Reproductive Medicine (RMU) %
92.60 ↑	87.78 ↑	93.33 ↑	91.08 ↑	91.38 ↓

Improvements and actions:

Divisional FFT "you said, we did" reports are now a standing item on the Patient Involvement and Experience Subcommittee (PIESC). This enables greater visibility and promotion of the improvements being implemented from the FFT and allows this learning to be shared across the various divisions who attend this meeting.

These are also displayed in the patient and public areas of the relevant area. This is to promote the work done and also encourage more responses and patients see their feedback making a difference.

Below are some examples shared at the PIESC covering Q3 22/23.

You said – Long Wait to be seen

We did – The outpatient Department has implemented the use of a refreshment trolley for oncology patients who may be experiencing longer than expected waits for clinic and have strengthened communication with patients awaiting all clinics by verbalising delays over 30 minutes instead of only utilising the message board.

You said – Access to Scan

We did – Currently the Gynaecology Emergency Department is able to offer patients a scan with in a 72-hour period, improving access to scanning is a feature of the department service review inclusive of the Early pregnancy unit.

You Said - Pain relief and care after C Section not good

We did - Maternity Ward Management team have an improvement plan with a focus on Medication processes to ensure timely administration for all patients. With input of Manager, Matron, Consultant Lead and Pharmacist. This includes estates work to relocate the pharmacy room, return to four hourly medicine rounds ensuring regular access to analgesia, a role for pharmacy technicians to support this, and a pilot to undertake self-administration. This work will be evaluated in conjunction with our MVP

You said - Call bell not being answered timely for support on the Maternity Ward.

We did – Introduction of 24/7 Housekeeper and increase in the MSW establishment will allow staff to respond promptly to the needs of the patient when requested. Call bell answer times are monitored as part of the matron and midwifery managers intentional rounding and ongoing audits

8. Quality Improvement

/

Headline - A new Quality Improvement, Innovation & Compliance Manager was appointed in Q3

Key areas of activity from Q3 2022/23

- Recruitment was successful in appointing a new QI, Innovation & Compliance Manager
- The Quality & Safety Facilitator was appointed in September and are actively supporting the delivery of the QI agenda
- The refresh of the Trust wide approach to Quality Improvement has been implemented with the support Quality Improvement Group Members and Senior Managers trust wide.
- The learning, outcomes and new processes following our work with MIAA has been shared Quality Improvement Group Members and Senior Managers Trust wide.
- 7 additional QI projects registered at the end of Q3, with a continued upward trend
- Completion of a trust wide QI TNA, supported by L&D to inform QI learning and development priorities.

Plans for Q4 and beyond – a re-focus and a shared vision

The Team wants to change Trust culture and work towards a shared culture and vision of continuous improvement. They have appointed a senior manager to lead QI with them expected to start in post in early 2023.

Priorities to make this happen are as follows.

- QI Summit -launch event in January 2023
- Clearly defined and agreed improvement priorities within divisional and corporate teams
- Proactive performance management approach

- Agreeing objectives and ensuring appropriate governance and oversight locally within divisions.
- Creating robust reporting structures, through Quality Improvement Group (QIG) through to Quality Committee
- Fuelling staff motivation through the communication of success stories, positive feedback, and actions
- Being data driven, being clear about post benefit analysis
- Enhance the QI tools, training offer and processes currently in place
- Creation of digital platforms to support our QI work
- Learning from other organisations, locally & nationally

Improvements and actions:

The new post holder has had an immediate impact working with the Divisions to educate and simplify the process which has seen positive Divisional engagement and an increase in number (7 during Q3) and standard of Quality Improvement projects across all Divisions.

9. Serious Incidents and identified learning

HEADLINE **– There were 8 serious incidents declared to the Integrated Care Board (ICB) during Q3 (a reduction of 11 from Q2) – 3 in October 2 in November and 3 in December 2022. All of these cases had had Executive oversight and sign off**

Serious Incidents declared and final reports submitted to the ICB

Some cases related to the Isolated Site Risk (critical care transfer), isolated incidents not part of a theme, pattern, or trend, had full duty of candour completed and an investigating officer appointed by the Divisions immediately to ensure investigations were expedited as quickly and comprehensively as possible to ensure any learning identified could be implemented in real time.

There were no particular themes, patterns or trends identified within quarter 3 in addition to future Generations concerns other than the below.

There was a Never Event in Gynaecology Theatres which highlighted that the Trust LocSSIPS policy was not as embedded as previously indicated. This particularly involved new colleagues to the Trust and relevant patient safety critical policies not forming part of the local induction process. This was immediately highlighted within Clinical Support Services and incorporated into the local induction process. It also highlighted the potential for further education for established colleagues across the Divisions regarding LocSSIPS and its' underpinning of patient safety, particularly with the release of NatSSIPS2 in January 2023. The Head of Risk and safety has asked the Divisions to work collectively to determine a training package which will be taken to the Education Governance Meeting for approval as Mandatory (Safety) Training.

Overdue actions from previous submitted SI's / Serious Incidents

There was one overdue serious incident submission due with the ICB that had not had an appropriate extension request during Q3. An extension was subsequently approved by the ICB in January 2023.

There were no Serious Incidents Submitted in October 2022.

There were 3 Serious Incidents Submitted in November 2022. There remained 24 overdue action plans.

There was 1 Serious Incidents Submitted in December 2022.

Whilst the Trust ongoing action plans are not currently externally reportable, the Ulysses System is now being used more effectively to manage divisional action Plans. All action plans are updated on to the system following SI submission to the ICB and are monitored Divisionally and Corporately for compliance and reported to the Safety and Effectiveness Sub Committee monthly.

Dissemination of learning from serious incidents

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

- Learning and engagement teams events held online Trust wide for all services to present and discuss learning
- The weekly safety check in for all services to present and discuss learning
- Governance Boards within the divisions to share learning
- Trust wide shared learning portal to upload all divisional learning such as 7-minute briefings accessible to all staff
- The Safety and Effectiveness Sub Committee serious incident report
- Staff communications via secure social media
- SBARS
- The Divisional Governance Teams have been requested to provide evidence of embedded learning from October 2022 – this will be reported via the Safety and Effectiveness Sub – Committee and via this report into Quality Committee. Due to the number of overdue actions that remain, it is difficult for any Division to be able to demonstrate evidence of embedded learning and improved patient safety outcomes.

Improvements and actions:

Learning from all incidents is key to being able to demonstrate that the Trust is a Learning Organization. The Corporate Team continues to work in detail with the divisions to recognise how learning from incidents is captured and evidenced, how it is disseminated to new and existing colleagues, that is becomes embedded as part of practice and culture and that there is tangible evidence that learning has been addressed immediately, embedded after 6, 12 months and beyond and that learning continually evolves from current intelligence and is used to mitigate recurrences as much as practicable.

10. Divisional Triangulation and Integrated Governance Reports Q3

The following reports have been submitted to the Safety and Effectiveness Sub Committee by the Divisions covering Q3

Key points requested from Divisions are:

- Key areas of risk affecting patient safety and quality of services
- Divisional plans to manage and mitigate those risks
- Evidence of embedded learning Divisionally and cross Divisionally
- Audit of embedded learning within 6 months of learning being identified (As per Ockenden within Maternity but that expectation is across all Divisions) and how assurance is gained, 6 months, 12 months

and beyond that learning is embedded, practice and culture has changed and there is clear tangible evidence of improved patient safety outcomes

Family Health

- The neonatal team work closely with maternity services around PMRT which ensure that there is a clear line of sight on neonatal mortality (Risk 2430) throughout the division, working together to see how we can improve care delivery, outcomes, and family experience.
- The neonatal digital team work closely with the maternity digital team with regards to K2 (risk 2419) to ensure that all mother and baby information is accessible to the right person at the right time in the right location. This is not completely resolved but is significantly improved with joint working.
- The LNP Integrated Governance report is shared with Family Health Divisional Board.

Horizon Scanning – Area of Risk:

- Lack of Governance manager
- Increasing Strike action
- High sickness levels
- Mortality
- Police Investigation
- Non-colocation – staffing issues with consultant surgeons
- Stock reliability and quality

Clinical Support Services

Clinical Support Services are undertaking quarterly Divisional Integrated Governance Reports which are reported via Safety and Effectiveness Sub Committee monthly identifying divisional priorities in relation to patient safety and experience.

- Blood Sample Errors - CSS have completed their blood sampling errors action plan devised within the Division and are supporting the other Divisions to manage this risk. CSS is working across divisions to share learning and improve processes trust wide, as mentioned earlier in report.
- In 22-23 Theatres had a significant investment in their workforce establishment, which has led to a large increase in new staff members with limited experience. The Division expects there to be higher levels of errors within Theatres whilst new staff become fully competent and trained in LWH Theatre processes and standards.
- Imaging continues to progress against their workforce recovery plan but have had high levels of turnover throughout the quarter. During the quarter Imaging have managed to recruit an additional 3 sonographers who have been undergoing their supernumerary period. Now that the workforce has stabilised the Division expects incidents to gradually decrease and performance compliance to increase. In regard to CSS PALS query's during this quarter, the main theme was to do with appointment delay and availability, the Imaging services manager and CSS Divisional management are collaborating on an administrative review of our booking and scheduling processes to ensure that patients have timely notice of their appointments. We have implemented closer patient tracking list (PTL) management, over all of our Imaging referrals to make sure that patients are seen in a timely manner and according to longest wait.

- Pharmacy have had a significantly high turnover of staff during this quarter with a 37% average of turnover. As with Theatres, the Division therefore expects there to be a higher number of errors, as evidenced in our incident themes above whilst new staff become fully trained and competent in pharmacy systems and processes.
- In the Genetics Administration team, we have had a reduction of 1.2 whole time equivalents - this has placed additional pressures on the current staff, which has ultimately led to a higher rate of administrative errors within the Department. As previously mentioned, there has been a number of actions implemented to help improve staff morale and to minimise human error. In regard to Genetics PAL's queries received we are conducting a review of our booking and scheduling processes for Genetics due to a significant amount of first appointment cancellations by the hospital.

There remains work ongoing within the Gynaecology and Maternity service areas to be able to demonstrate key triangulation of risks within the Division. This will be reflected in the Q4 update report. The Corporate Team are providing ongoing support to the divisional governance functions.

CONCLUSION

This report seeks to provide assurance as to the Governance Systems in place in LWH and that staff are being open by reporting incidents, clinical and non-clinical, to ensure patients and staff safety is maintained. The Ulysses data clearly demonstrates a continuous positive reporting culture across all Clinical Divisions and Corporate Services

There remains work across all Divisions via their integrated governance reports to be able to demonstrate:

- Key areas of risk affecting patient safety and quality of services
- Divisional plans to manage and mitigate those risks
- Evidence of embedded learning Divisionally and cross Divisionally
- Audit of embedded learning within 6 months of learning being identified (As per Ockenden within Maternity but that expectation is across all Divisions) and how assurance is gained, 6 months, 12 months and beyond that learning is embedded, practice and culture has changed and there is clear tangible evidence of improved patient safety outcomes

It can be demonstrated particularly with Clinical Support Services and the Neonatal Directorate reports that the services have oversight of some of their key areas of risk, plans to manage and mitigate but evidence of embedded learning requires strengthening.

With respect to Gynaecology and Maternity services, where the majority of Trust SUIs occur, SUIs and associated action plans are being progressed but there remains some limited, but improved, evidence of embedded learning an improved patient safety outcomes as a result.

It is expected and directed from the Corporate Team that Q4 IGR reports identify the Divisional key areas of risk, have robust plans in place and that evidence of learning is shared with plans to embed and / or provide assurance as to the audit process that learning has been embedded sustained where improved patient safety and quality outcomes can be demonstrated back up with quality data.

It is requested that the members of the Committee review the contents of the paper and take assurance that there are adequate governance processes in place with ongoing support from the Corporate Team and that there is positive progress in managing risk across the Divisions with Senior Management having oversight of such risks.

Finance, Performance & Business Development Chair's Highlight Report to Trust Board
26 April 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 noted the following matters from the operational performance report:
  ○ significant poor performance against 62-day cancer target. Work with the oncology team, Cheshire and Merseyside ICS, and the Cancer Alliance to improve the position were noted. It was noted that the Quality Committee had escalated these concerns and commissioned a deep dive into cancer performance from the clinical and operational teams.
  ○ Review into GED A&E metrics has identified areas of improvement. The department had committed to review the service to identify an appropriate model and pathways for patients currently using this service.
  ○ Work to develop the patient-initiated follow-up (PIFU) pathway for appropriate services to release capacity.
• The Committee was informed that the Month 12 YTD financial position remained off track against plan and was supported by non-recurrent items. As anticipated the Trust did not meet the 2022/23 financial plan and the month 12 position was subject to ICB final system review and audit. The Committee noted the significant effort by all teams to achieve the year-end position.
• The Committee noted that there remains a risk to the sustainability of the Trust in both the long and short term as the Trust anticipates a deficit plan and the trust will require cash support to maintain liquidity through 2023/24. Long term financial sustainability solutions are being developed with system partners.
• The Committee received a position update on the Crown Street Community Diagnostic Centre (CDC) and associated financial risks. The Trust had submitted a plan for 2023/24 to the Regional and National CDC teams that was based on the 2021/22 approved CDC business case and updated to reflect any changes in national guidance for CDC's including the use of the national utilisation rates to set activity targets. The national team had approved the activity plan submitted.
	• Received a detailed presentational update on financial planning for 2023/24. Following further review by the Trust, and discussion with NHSE NW and C&M ICB, the deficit position had been improved. The financial plan was scheduled to be submitted to the ICB on 28 April 2023 and to NHSE on 04 May 2023. The Committee suggested that discussions regarding the Trust's financial settlements should continue and recommended that the Board should only provide its approval for submission once strong assurances could be provided that there would no further opportunities to improve the position.
	• The Committee received the draft Finance and Procurement Strategy and noted the ambitions, objectives, and commercial development principles presented. The Committee accepted the content of the strategy noting its alignment with the corporate objectives. The Finance Team would continue to develop and provide a final draft for approval.
	• The Committee received an update on the third-party service provider (meaning non-commercial service arrangements with other trusts and universities etc) assurance, and controls. MIAA had reported limited assurance on intra SLA contracts in February 2023. The Committee noted the significant work undertaken to improve grip and control of the SLA process and the remaining risks and assurance gaps. The Committee was supportive of the recommended actions to close the remaining gaps in a timely manner.
	• The Committee discussed the ambition and achievability of the proposed Corporate Objectives 2023/24. The Committee agreed that they should maintain the long-term ambition of the objectives but reflected that they might not all be achievable within 12 months.

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 took positive assurance from the progress within the programme activities underway for digiCare EPR Programme, the digiCare Digital Maternity (K2) programme, and GDE programme. In relation to the digiCare EPR programme, current focus was on delivery of training, delivered in the new digiCare Hub, a central place for the programme team, digital clinical leaders, and training. Training	• The Committee recommended the Corporate Objectives 2023/24 aligned to the FPBD Committee subject to minor amendments in relation to financial sustainability, to the Board of Directors.

compliance grip and control would be a priority, with daily reports provided to divisional leaders and executives. (ALL) • The Committee received the Emergency Planning Resilience and Response Annual Board Report and was assured that the Trust remained focused on continuing to meet its duties and aims to maintain a substantial level of compliance to the NHSE EPRR Core Standards for 2023. (ALL) • The Committee received an update on the Crown Street Enhancements (CSE) Programme noting positive developments against proposed projects to utilise estate capacity at the Crown Street site. (ALL)	

Summary of BAF Review Discussion (Board Committee level only)

- The Committee reviewed the FPBD related BAF risks. Noted no new risks, strategic threats and no risks closed on the BAF for FPBD Committee.
- The Committee considered the close down position of the BAF risk scores for 2023/24 and recommended the Quarter 4 scores to the Board of Directors
- Noted circulation of the BAF for 2023/24 to Committee members for comments.

Comments on Effectiveness of the Meeting / Application of QI Methodology

- All matters on the meeting agenda discussed fully; with active participation by and constructive challenge from all attendees in relation to the proposed actions and recommendations in each of the papers presented to the committee.

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
06.	Review of BAF risks: FPBD related risks	Assurance	13.	Finance and Procurement Strategy	Information
07.	Operational Performance Report Month 12 2022/23	Assurance	14.	Third Party Provider Assurance Update & SLA process review	Assurance
08.	Finance Performance Report Month 12, 2022/23, including recovery plan	Information	15.	Corporate Objective Setting 2023/24	Approval
09.	Planning 2023/24 Update	Information	16.	Crown Street Enhancements Programme Update	Information
10.	Digital Services Update	Assurance	17.	Future Generations Update	Information
11.	Community Diagnostic Centre 2023/24 Case	Information	18.	Sub-Committee Chairs Reports	Assurance
12.	EPRR Annual Board Report	Assurance			

3. 2023 / 24 Attendance Matrix

Core members	Apr	May	Jun	Jul	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Louise Martin, Non-Executive Director (Chair)	✓										
Tracy Ellery, Non-Executive Director	✓										
Sarah Walker, Non-Executive Director	A										
Jenny Hannon, Chief Finance Officer	✓										

Kathryn Thomson, Chief Executive	✓										
Gary Price, Chief Operations Officer	✓										
Dianne Brown, Chief Nurse	✓										
Matt Connor, Chief Information Officer	✓										
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)	**23/24/028b**		**Date: 11/05/2023**	
Report Title	**Finance Performance Review Month 12 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 12 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 12 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	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	26/04/23	CFO	Noted

EXECUTIVE SUMMARY

During 2022/23, Liverpool Women's Hospital faced significant challenges in delivering its financial plan, primarily due to workforce pressures, the need to address clinical risks caused by the Trust's isolated site as well investment required following the Ockenden reports.

At Month 12 the Trust is reporting a £2,721k deficit against a surplus plan of £528k, resulting in an adverse variance of £3,249k. The Trust successfully delivered the revised forecast outturn position agreed at Month 9 (before the additional items agreed as part of the Cheshire and Merseyside plan), despite ongoing pressures and the impact of industrial action. The Trust implemented a robust financial recovery plan in-year, successfully delivering £4,881k of recovery actions.

Delivery of the financial position is also supported by £12,253k of non-recurrent items. This supported management of the Trust's underlying deficit position in-year, however, will not be available in future years.

The cash balance was £9,790k at 31 March 2023. This included Public Dividend Capital (PDC) received from NHSE, which was necessary due to the overall deficit position.

	Plan	Actual	Variance	RAG	R	A	G
Surplus/(Deficit) YTD	£0.5m	-£2.7m	-£3.2m	↓	*>10% off plan*	*Plan*	*Plan or better*
I&E Forecast	£0.5m	-£2.7m	-£3.2m	↓	*>10% off plan*	*Plan*	*Plan or better*
NHS I/E Rating	3	3	0	↔	*4*	*3*	*2+*
Cash	£5.9m	£9.8m	£3.9m	↑	*<£1m*	*£1m-£4.5m*	*£4.5m+*
Total CIP Achievement YTD	£5.6m	£5.7m	£0.1m	↑	*>10% off plan*	*Plan*	*Plan or better*
Recurrent CIP Achievement YTD	£2.9m	£1.8m	-£1.1m	↔	*>10% off plan*	*Plan*	*Plan or better*
Elective Recovery Fund (net)	-£2.2m	-£1.2m	£0.9m	↔	*>10% off plan*	*Plan*	*Plan or better*
Non-Recurrent Items YTD	£6.0m	£12.3m	£6.3m	↔	*>£0*		*<£0*
Capital Spend YTD	£8.8m	£11.1m	£2.2m				

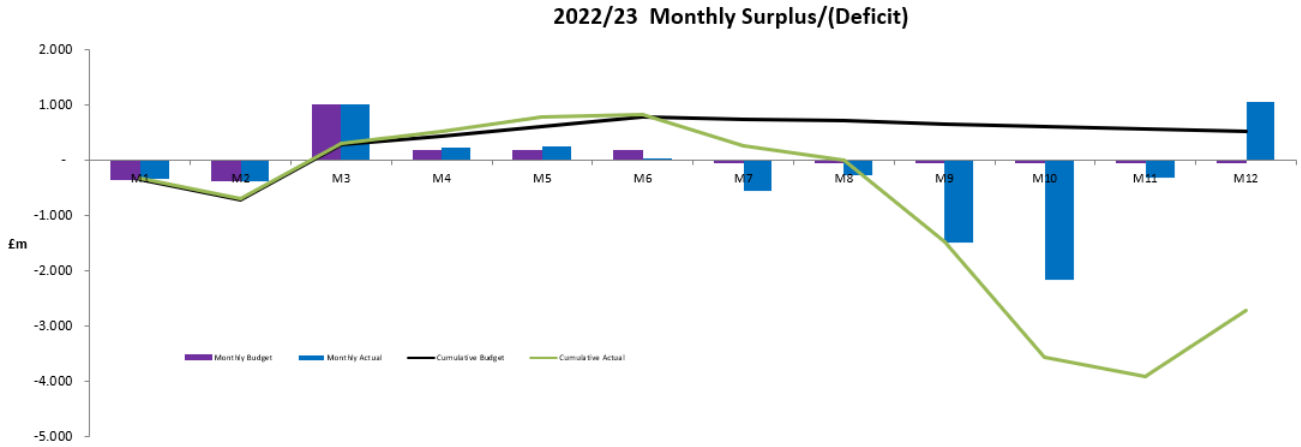
MAIN REPORT

1. Summary Financial Position

At Month 12 the Trust is reporting a £2,721k deficit which is £3,247k off plan. The Month 12 position is in line with this revised forecast position (before £1,068k additional movement agreed at Month 12).

£4,881k of recovery actions were successfully delivered in-year, following implementation of a robust financial recovery plan in Q3 of 2022/23. The 2022/23 position is also supported by £12,253k of non-recurrent items (in part covering the gap caused by the Trust's underlying deficit, for the 2022/23 financial year only).

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



Month 12 shows a surplus in month as funding for Neonatal activity, the Community Diagnostic Centre (CDC) and capital charges relating to earlier periods was received (this income remained unconfirmed prior to Month 12 and therefore could not be recognised at an earlier stage). Both income, £3.1m, and pay expenditure, £3.5m, were increased in Month 12 to reflect the estimated impacts of the 2022/23 unbudgeted pay award.

2. Divisional Summary Overview

In line with the previous forecast, the Trust has reported off plan. Work is continuing to improve the run-rate of individual Divisions and service lines, with robust cost control measures in place, efficiency and transformation programmes underway, and cost improvement schemes implemented, as part of the Trust's approach to delivering long-term financial sustainability.

Family Health: In response to the first Ockenden report and revised Birth-rate plus review, Maternity budgets were increased to reflect additional staffing requirements. In addition to this, the Division is overspent by £2,321k on pay. The division had successfully minimised agency usage, but usage did increase to the end of March. Non-pay expenditure is £773k overspent. Both pay and non-pay variances are partially offset by increased income, reducing the overall variance.

Gynaecology: The Division's contribution is £2,808k below plan, with a £1,929k variance on pay and pay and a £872k variance on non-pay. The Division has been working to increase capacity and maximise activity, to support elective recovery throughout the year.

Clinical Support Services: Excluding CDC (see below), the Division's contribution is £1,369k below plan. Pay costs are below budget by £215k with a significant underspend on medical, driven by recruitment challenges for anaesthetic medical staff. The non-pay overspend is £1,585k.

Agency: Agency spend across the Trust was £2,282k.

Energy costs: Gas and electricity prices have been fixed to March 2023, mitigating the risk of a volatile market. The total budget for electric and gas is £1,927k, and the outturn at Month 12 with the secured gas prices and estimated usage is £2,500k (an adverse variance of £573k).

3. Community Diagnostic Centre (CDC)

During 2022/23, the Trust successfully established a range of new diagnostic services as part of the CDC, delivering increased capacity for the Cheshire and Merseyside system as well as reducing clinical risks faced by Liverpool Women's patients as a result of the isolated site. Establishing new services, alongside construction required, is complex and some delays were experienced meaning activity forecasts were not delivered in full, resulting in some clawback of income.

4. Elective Recovery Fund (ERF)

The Trust is now behind plan by £943k on the in-year ERF, however it has been confirmed that there will be no ERF clawback for 2022/23.

5. Cost Improvement Programme (CIP)

The Trust had a stretching efficiency programme for 2022/23. This is comprised of a core CIP programme at the agreed maximum of 3% of turnover (£4.2m), plus non-recurrent efficiencies of £1.4m (vacancy factor) bringing the total to £5.6m. In Month 12, CIP exceeded plan, resulting in an outturn position of £5,674k (a favourable variance against plan). All CIP schemes were accompanied by Quality and Equality Impact Assessments.

Full detail can be seen in the appendix.

6. COVID-19

The Trust's annual COVID-related spend is £183k, £131k less than budget.

7. Cash and Borrowings

The cash balance was £9,790k at 31 March 2023. The balance includes £4,500k PDC cash support from NHS England.

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 expenditure for 2022/23 was £11,059k against an allocation of £8,820k and further additional PDC allocated of £2,200k (frontline digitisation £1.9m and imaging network funding). The final 2022/23 position was a small overspend of £39k.

9. Balance Sheet

The Month 12 balance sheet is reported before the impacts of revaluation are accounted for.

Deferred income has reduced significantly on Month 11 due to the repayment of £6m to the ICS and debtors have increased, driven by £3m of income anticipated to fund the 2022/23 pay deal.

10. Recovery

The original 2022/23 recovery plan identified gross savings of £5.3m against the forecast at Month 6. These estimated savings have varied as further work was undertaken to review and deliver them. As at Month 12, the Trust has achieved a total of £4.9m savings from the plan.

The Finance Recovery Board continues to focus on operational planning for 2023/24 and medium-term financial sustainability. Additional grip and control measures have been put in place.

11. Board Assurance Framework (BAF) Risk

As anticipated the Trust did not meet the 2022/23 financial plan, however, did successfully deliver the revised forecast, despite additional pressure in Q4 (this position remains subject to audit).

The BAF contains two risks 4.1 (Failure to ensure services are financially stable in the long term) and 4.3 (Failure to deliver the agreed 22/23 Financial plan). These are scored at 20 and 20 respectively. The 2022/23 risk has materialised and can now be re articulated for 2023/24. There remains a risk to the sustainability of the Trust in both the long- and short-term and the Trust will require cash support to maintain liquidity through this year. The Trust is working with system partners to develop a 3-year financial recovery plan and map out a path towards long-term financial sustainability.

12. Conclusion & Recommendation

The Board is asked to receive the Month 12 position.

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

FINANCE REPORT: M12

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: M12
YEAR ENDING 31 MARCH 2023

USE OF RESOURCES RISK RATING	YEAR TO DATE Actual
CAPITAL SERVICING CAPACITY (CSC)	
(a) EBITDA + Interest Receivable	5,728
(b) PDC + Interest Payable + Loans Repaid	3,206
CSC Ratio = (a) / (b)	**1.79**
NHSI CSC SCORE	**2**
Ratio Score 1 = > 2.5 2 = 1.75 - 2.5 3 = 1.25 - 1.75 4 = < 1.25	
LIQUIDITY	
(a) Cash for Liquidity Purposes	(15,571)
(b) Expenditure	146,391
(c) Daily Expenditure	401
Liquidity Ratio = (a) / (c)	**(38.8)**
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)	2,701
Total Income	(151,862)
I&E Margin	**-1.8%**
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)	-1.80%
I&E Margin (Plan)	0.40%
I&E Variance Margin	**-2.20%**
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	834
YTD Agency Expenditure	2,282
	174%
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: M12
YEAR ENDING 31 MARCH 2023

INCOME & EXPENDITURE	Month 12			YTD			YEAR		
£'000	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Forecast	Variance
Income									
Clinical Income	(11,434)	(17,059)	5,625	(137,008)	(144,184)	7,176	(137,008)	(144,184)	7,176
Non-Clinical Income	(623)	(735)	112	(7,404)	(7,677)	273	(7,404)	(7,677)	273
Total Income	**(12,057)**	**(17,793)**	**5,737**	**(144,413)**	**(151,862)**	**7,449**	**(144,413)**	**(151,862)**	**7,449**
Expenditure									
Pay Costs	7,056	12,194	(5,139)	81,856	93,027	(11,170)	81,856	93,027	(11,170)
Non-Pay Costs	2,681	2,161	520	33,641	33,722	(81)	33,641	33,722	(81)
CNST	1,637	1,672	(35)	19,640	19,643	(2)	19,640	19,643	(2)
Total Expenditure	**11,373**	**16,027**	**(4,654)**	**135,137**	**146,391**	**(11,253)**	**135,137**	**146,391**	**(11,253)**
EBITDA	**(684)**	**(1,767)**	**1,083**	**(9,275)**	**(5,471)**	**(3,804)**	**(9,275)**	**(5,471)**	**(3,804)**
Technical Items									
Depreciation	521	509	12	6,254	5,924	331	6,254	5,924	331
Interest Payable	2	(4)	7	29	21	8	29	21	8
Interest Receivable	(1)	(53)	52	(12)	(257)	245	(12)	(257)	245
PDC Dividend	207	264	(57)	2,478	2,573	(95)	2,478	2,573	(95)
Profit/Loss on Disposal or Transfer Absorption	0	(11)	11	0	(69)	69	0	(69)	69
Total Technical Items	**729**	**704**	**25**	**8,749**	**8,192**	**557**	**8,749**	**8,192**	**557**
(Surplus) / Deficit	**46**	**(1,062)**	**1,108**	**(526)**	**2,721**	**(3,247)**	**(526)**	**2,721**	**(3,247)**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 3
EXPENDITURE: M12
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	283	152	5,133	5,307	(174)	5,133	5,307	(174)
Medical	2,019	2,133	(115)	22,205	24,149	(1,944)	22,205	24,149	(1,944)
Nursing & Midwifery	3,076	3,409	(333)	36,840	37,767	(927)	36,840	37,767	(927)
Healthcare Assistants	509	627	(118)	6,099	6,482	(383)	6,099	6,482	(383)
Other Clinical	287	4,925	(4,638)	2,953	7,969	(5,016)	2,953	7,969	(5,016)
Admin Support	731	745	(14)	8,626	9,071	(445)	8,626	9,071	(445)
Agency & Locum	0	73	(73)	0	2,282	(2,282)	0	2,282	(2,282)
Total Pay Costs	**7,056**	**12,194**	**(5,139)**	**81,856**	**93,027**	**(11,170)**	**81,856**	**93,027**	**(11,170)**
Non Pay Costs									
Clinical Suppplies	757	1,116	(359)	8,404	10,192	(1,788)	8,404	10,192	(1,788)
Non-Clinical Supplies	81	(1,340)	1,421	3,174	129	3,044	3,174	129	3,044
CNST	1,637	1,672	(35)	19,640	19,643	(2)	19,640	19,643	(2)
Premises & IT Costs	1,000	502	499	12,069	10,016	2,053	12,069	10,016	2,053
Service Contracts	842	1,884	(1,041)	9,994	13,385	(3,391)	9,994	13,385	(3,391)
Total Non-Pay Costs	**4,317**	**3,833**	**485**	**53,281**	**53,364**	**(83)**	**53,281**	**53,364**	**(83)**
Total Expenditure	**11,373**	**16,027**	**(4,654)**	**135,137**	**146,391**	**(11,253)**	**135,137**	**146,391**	**(11,253)**

Note that the values above exclude hosted services and Technical Items.

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 4
COVID EXPENDITURE: M12
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	38	1	36	38	1	36
Medical	0	0	0	0	(0)	0	0	(0)	0
Nursing & Midwifery	12	0	12	145	1	144	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	1	(1)	0	78	(78)	0	78	(78)
Agency & Locum	0	0	0	0	0	0	0	0	0
Total Pay Costs	**15**	**1**	**14**	**183**	**95**	**87**	**183**	**95**	**87**
Non Pay Costs									
Clinical Suppplies	0	8	(8)	0	60	(60)	0	60	(60)
Non-Clinical Supplies	11	0	11	132	12	120	132	12	120
CNST	0	0	0	0	0	0	0	0	0
Premises & IT Costs	0	- 39	39	0	40	(40)	0	40	(40)
Service Contracts	0	(25)	25	0	(24)	24	0	(24)	24
Total Non-Pay Costs	**11**	**(56)**	**67**	**132**	**88**	**44**	**132**	**88**	**44**
Total Expenditure	**26**	**(54)**	**81**	**315**	**183**	**131**	**315**	**183**	**131**

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

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 5
BUDGET ANALYSIS: M12
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	(4,541)	(4,933)	393	(50,260)	(51,725)	1,465	(50,260)	(51,725)	1,465
Expenditure	2,237	2,742	(505)	26,826	28,818	(1,993)	26,826	28,818	(1,993)
Total Maternity	**(2,304)**	**(2,191)**	**(113)**	**(23,435)**	**(22,907)**	**(528)**	**(23,435)**	**(22,907)**	**(528)**
Neonatal									
Income	(1,911)	(2,497)	587	(21,351)	(23,103)	1,752	(21,351)	(23,103)	1,752
Expenditure	1,313	1,563	(250)	15,760	16,862	(1,102)	15,760	16,862	(1,102)
Total Neonatal	**(597)**	**(934)**	**336**	**(5,591)**	**(6,241)**	**650**	**(5,591)**	**(6,241)**	**650**
Division of Family Health - Total	**(2,901)**	**(3,125)**	**224**	**(29,026)**	**(29,147)**	**122**	**(29,026)**	**(29,147)**	**122**
Gynaecology									
Income	(2,207)	(2,400)	192	(24,425)	(24,267)	(159)	(24,425)	(24,267)	(159)
Expenditure	1,497	1,789	(293)	15,926	17,840	(1,914)	15,926	17,840	(1,914)
Total Gynaecology	**(710)**	**(610)**	**(100)**	**(8,499)**	**(6,427)**	**(2,072)**	**(8,499)**	**(6,427)**	**(2,072)**
Hewitt Centre									
Income	(967)	(1,020)	53	(9,228)	(9,379)	151	(9,228)	(9,379)	151
Expenditure	732	793	(62)	8,779	9,665	(887)	8,779	9,666	(887)
Total Hewitt Centre	**(235)**	**(227)**	**(8)**	**(449)**	**286**	**(735)**	**(449)**	**286**	**(736)**
Division of Gynaecology - Total	**(946)**	**(837)**	**(109)**	**(8,949)**	**(6,141)**	**(2,808)**	**(8,949)**	**(6,140)**	**(2,808)**
Theatres									
Income	0	0	0	0	0	0	0	0	0
Expenditure	1,019	1,465	(446)	11,790	12,178	(388)	11,790	12,178	(388)
Total Theatres	**1,019**	**1,465**	**(446)**	**11,790**	**12,178**	**(388)**	**11,790**	**12,178**	**(388)**
Genetics									
Income	(13)	(16)	4	(152)	(141)	(11)	(152)	(141)	(11)
Expenditure	174	131	42	2,026	1,773	253	2,026	1,773	253
Total Genetics	**161**	**115**	**46**	**1,874**	**1,632**	**242**	**1,874**	**1,632**	**242**
Other Clinical Support									
Income	(763)	(1,156)	393	(8,793)	(7,505)	(1,288)	(8,793)	(7,505)	(1,288)
Expenditure	881	1,077	(196)	10,564	10,776	(212)	10,564	10,776	(212)
Total Clinical Support	**118**	**(78)**	**196**	**1,771**	**3,271**	**(1,500)**	**1,771**	**3,271**	**(1,500)**
Division of Clinical Support - Total	**1,298**	**1,502**	**(204)**	**15,434**	**17,081**	**(1,647)**	**15,434**	**17,081**	**(1,647)**
Corporate & Trust Technical Items									
Income	(1,770)	(6,889)	5,119	(31,577)	(39,901)	8,325	(31,577)	(39,901)	8,325
Expenditure	4,364	8,287	(3,923)	53,591	60,829	(7,239)	53,591	60,829	(7,238)
Total Corporate	**2,594**	**1,398**	**1,197**	**22,014**	**20,928**	**1,086**	**22,014**	**20,928**	**1,086**
(Surplus) / Deficit	**46**	**(1,062)**	**1,108**	**(526)**	**2,721**	**(3,247)**	**(526)**	**2,721**	**(3,247)**
Of which is hosted;									
Income	(115)	(1,118)	1,003	(1,374)	(4,159)	2,785	(1,374)	(4,159)	2,785
Expenditure	115	1,118	(1,003)	1,374	4,159	(2,785)	1,374	4,159	(2,785)
Total Corporate	**0**	**(0)**	**0**	**0**	**(0)**	**0**	**0**	**0**	**(0)**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 6
CIP: M12
YEAR ENDING 31 MARCH 2023

Scheme	Target	Actual	Variance	Target	Actual	Variance	Target	FOT	Variance
Procurement ar	155	295	140	1,835	1,928	93	1,835	1,928	93
Estates utilisati	34	12	-22	412	148	-264	412	148	-264
Staffing and ski	173	724	550	2,078	2,286	208	2,078	2,286	208
Medicines Man	3	0	-3	30	0	-30	30	0	-30
Service Develop	0	0	0	0	0	0	0	0	0
Theatre Efficien	23	0	-23	369	0	-369	369	0	-369
Technology Driv	9	3	-6	106	35	-71	106	35	-71
Income	68	265	197	773	1,276	503	773	1,276	503
Other Savings P	0	0	0	0	0	0	0	0	0
Total	**465**	**1,299**	**834**	**5,603**	**5,674**	**71**	**5,603**	**5,674**	**71**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 7
BALANCE SHEET: M12 SUBJECT TO REVALUATION ADJUSTMENT AND AUDIT
YEAR ENDING 31 MARCH 2023

BALANCE SHEET £'000	YEAR TO DATE Opening	M12 Actual	Movement
Non Current Assets	101,380	106,477	5,097
Current Assets			
Cash	11,192	9,790	(1,402)
Debtors	5,929	10,053	4,124
Inventories	523	839	316
Total Current Assets	**17,644**	**20,682**	**3,038**
Liabilities			
Creditors due < 1 year - Capital Payables	(4,849)	(2,003)	2,846
Creditors due < 1 year - Trade Payables	(18,362)	(25,149)	(6,787)
Creditors due < 1 year - Deferred Income	(4,157)	(6,596)	(2,439)
Creditors due > 1 year - Deferred Income	(1,561)	(1,530)	31
Loans	(1,525)	(913)	612
Loans - IFRS16 leases	(49)	(30)	19
Provisions	(3,889)	(628)	3,261
Total Liabilities	**(34,392)**	**(36,849)**	**(2,457)**
TOTAL ASSETS EMPLOYED	**84,632**	**90,310**	**5,678**
Taxpayers Equity			
PDC	70,713	79,115	8,402
Revaluation Reserve	12,749	12,749	0
Retained Earnings	1,170	(1,554)	(2,724)
TOTAL TAXPAYERS EQUITY	**84,632**	**90,310**	**5,678**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
CASHFLOW STATEMENT: M12 SUBJECT TO AUDIT
YEAR ENDING 31 MARCH 2023

CASHFLOW STATEMENT £'000	Actual
Cash flows from operating activities	662
Depreciation and amortisation	5,950
Impairments and reversals	0
Income recognised in respect of capital donations (cash and non-cash)	0
Movement in working capital	(954)
Net cash generated from / (used in) operations	**5,658**
Interest received	263
Purchase of property, plant and equipment and intangible assets	(13,825)
Proceeds from sales of property, plant and equipment and intangible assets	58
Net cash generated from/(used in) investing activities	**(13,504)**
PDC Capital Programme Funding - received	3,902
PDC Distress Revenue Funding - received	4,500
Loans from Department of Health - repaid	(612)
Interest paid	(25)
PDC dividend (paid)/refunded	(1,321)
Net cash generated from/(used in) financing activities	**6,444**
Increase/(decrease) in cash and cash equivalents	**(1,402)**
Cash and cash equivalents at start of period	11,192
Cash and cash equivalents at end of period	**9,790**

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	(4,587)	913
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**	**(33,771)**	**913**

NHS
Liverpool Women's
NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST **9**
CAPITAL EXPENDITURE: M12
YEAR ENDING 31 MARCH 2023

		Capital Allocation before PDC £000	Outturn M12 £000	Variance to Capital Allocation before PDC £000
Estates	Estates - Delivery Suite	52	0	52
	Estates - Compliance	100	71	29
	Estates - H&S	375	398	(23)
	Estates - Backlog	350	73	277
	Estates work - Donated	0	21	(21)
	Estates - other	0	61	(61)
	Estates Total	**877**	**624**	**253**
Capital Projects	Crown Street Enhancements - GF Works	1,007	359	648
	CDC Digital and Digital Diagnostic Services	100	279	(179)
	Crown Street Enhancements - CDC - Medical Equipment	3,420	4,605	(1,185)
	Capital Projects Total	**4,527**	**5,243**	**(716)**
IM&T	IM&T - Hardware Replacement	95	135	(40)
	IM&T - Infrastructure Investment	979	366	613
	Meditech Expanse (EPR)	564	1,900	(1,336)
	Other PDC Projects (Digital Imaging, Cyber & Digital Diagnostics)	0	280	(280)
	VAT/prior year adjustments	(433)	(20)	(413)
	IM&T Total	**1,205**	**2,661**	**(1,456)**
Medical Equipment	Medical Equipment - Neonates	55	2	53
	Medical Equipment - Maternity	155	127	28
	Medical Equipment - Genetics	0	55	(55)
	Medical Equipment - HFC	726	1,041	(315)
	Medical Equipment - Theatres	600	592	8
	Medical Equipment - Pharmacy	30	29	1
	Medical Equipment - Imaging	645	654	(9)
	Medical Equipment Total	**2,211**	**2,500**	**(289)**
Other	IFRS 16 Impact	0	31	(31)
	Total Other	**0**	**31**	**(31)**
		8,820	**11,059**	**(2,239)**

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: Actual FOT exceed plan due to additional PDC projects (front line digitisation £1.9m, cyber and imaging)

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*23/24/028c*		**Date: 11/05/2023**	
Report Title	**Financial Plan Overview 2023/24**			
Prepared by	*Jennifer Huyton, Deputy Director of Finance and Strategy*			
Presented by	*Jenny Hannon, Chief Finance Officer / Executive Director of Strategy and Partnerships*			
Key Issues / Messages	*The Trust has a planned financial deficit of £15.5m in 2023/24, with an underlying structural deficit of approximately £30m.*			
Action required	**Approve ☐**	**Receive ☐**	**Note ☒**	**Take Assurance ☐**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable): N/A			
	For Decisions - in line with Risk Appetite Statement – Y *If no – please outline the reasons for deviation.*			
	The Trust Board is asked to note the financial deficit plan of £15.5m for 2023/24, as well as the risks articulated in this paper.			
Supporting Executive:	*Jenny Hannon, Chief Finance Officer/Executive Director of Strategy and 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* 1.2 Failure to recruit and retain key clinical staff 2.2 Failure to develop our model of care to keep pace with developments and respond to a changing environment 2.3 Failure to implement all feasible mitigations to ensure services delivered from the Crown Street site are as safe as possible, developing our facilities for the benefit of our patients as well as those across the system 3.1 Failure to deliver an excellent patient and family experience to all our service users 4.1 Failure to ensure our services are financially sustainable in the long term	Comment:
Link to the Corporate Risk Register (CRR) – CR Number: N/A	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Private Board	**4 May 23**	**CFO**	**The Board approved the submission of the plan ahead of the ICB deadline.**

EXECUTIVE SUMMARY

The Trust has carried an underlying, structural financial deficit for a number of years which presents ongoing financial sustainability challenges (first formally declared in 2014/15). The key drivers of this deficit are the costs of delivering maternity services, investments in recent years to reduce clinical risk as a result of the Trust's isolated site (in the absence of capital funding availability to provide a long-term solution) and limited opportunities for economies of scale due to the Trust's small size.

In recent years the deficit has been supported by non-recurrent sources of income and non-recurrent cost savings which are now reduced or no longer available to the Trust.

The proposed financial plan for 2023/34 is a revenue deficit position of £15.5m, after a recurrent Cost Improvement Programme (CIP) of £8.3m, accompanied by a capital budget of £5.2m. This includes non-recurrent system 'top-up' funding of £9.3m.

MAIN REPORT

1. Introduction

The Trust ended the 2022/23 financial year at a deficit of £2.7m, a variance of £3.3m from plan. This position was supported by £12.3m of non-recurrent items, in addition to £14.6m of system 'top up' income (as well as other sources of non-recurrent income). The Trust required cash support in year.

2023/24 is expected to be a challenging year financially and the financial planning process for 2023/24 has again involved providers working together across Cheshire and Merseyside to deliver plans within the allocation of funds available.

A revised financial framework, the NHS Payment Scheme (NHSPS), was introduced by the Health and Care Act 2022 to support the move to system working. From April 2023, the Trust's primary contracts will use the Aligned Payment and Incentive (API) approach; a form of blended payment with a fixed element to fund an agreed level of activity, and a variable element which will cover all elective activity on an activity-based payment basis.

The financial plan for 2023/24 is a deficit position of £15.5m, and was submitted to NHS England on 4 May 2023, following robust discussion and subsequent agreement from the Trust Board at an extraordinary meeting held on that date.

2. Liverpool Women's Structural Deficit

The Trust has an underlying, structural deficit of approximately £30m. The Trust first formally declared that it was clinically and financially unsustainable in 2014/15 and has reported its structural deficit through subsequent planning rounds, including reporting a c£25m underlying deficit as part of the 2022/23 planning round. The Trust has a good track record of delivering both planned savings targets and its overall financial plan, however it has received increasing levels of non-recurrent system 'top-up' income to balance its position, as demonstrated in the table below:

Year	Planned (Surplus)/ Deficit	Outturn (Surplus)/ Deficit	Variance (Favourable) /Adverse	CIP Delivered	NR Top-ups *	CNST **	Investments in Clinical Safety
2015/16	8,015	7,205	(810)	5,400	0	10,277	100
2016/17	7,000	5,729	(1,271)	2,000	3,477	14,251	500
2017/18	3,998	3,352	(646)	3,735	3,531	15,676	1,178
2018/19	1,605	488	(1,117)	3,656	4,161	15,231	512
2019/20	0	(272)	(272)	3,556	4,769	13,971	1,673
2020/21	4,591	3,992	(599)	2,048	9,452	16,756	926
2021/22	17	(34)	(51)	2,332	19,370	20,498	1,831
2022/23	(526)	1,655	2,181	5,844	14,620	23,181	4,967

*Non-Recurrent Top-ups exclude Elective Recovery Fund income
**Clinical Negligence Scheme for Trusts (CNST) excludes achievement of maternity incentive scheme

The Trust's underlying deficit has three primary drivers:

- Maternity tariff is insufficient to cover costs to deliver services, exacerbated by high CNST premiums and investments required in maternity safety
- The Trust's isolated site has necessitated investment to improve clinical safety and reduce risk

- Liverpool Women's Hospital is a relatively small Trust (c. £140m) with limited opportunity for economies of scale.

These factors cannot be addressed by the Trust alone and require long-term solutions at a national and system level, such as those set out in the Liverpool Clinical Services Review commissioned by the Cheshire and Merseyside Integrated Care Board.

3. 23/24 Planning Process

The Trust has maintained a robust planning and budget setting process which involves a number of levels of scrutiny and challenge and is aligned to national planning requirements and assumptions.

Budget setting is undertaken as part of an overall planning process incorporating detailed budgets, capital, activity planning, workforce planning, and other aspects in an integrated way, with the starting point being delivery of the Trust strategy. Recognising the challenging financial landscape, the Trust has had to review what is deliverable in 23/24 within the available resources to meet safety, access, and sustainability requirements.

Detailed budgets will be presented to the Finance, Performance and Business Development Committee (FPBD) in May, and subsequently presented to the Trust Board in June 2023.

4. Summary Position

The financial plan for the Trust in 2023/24 is summarised in the table below:

Summary Position		Total £000s
Income		
Income from activities	-	134,711
Other operating income	-	7,455
	-	**142,166**
Employee Expenses		
Permanent		81,789
Agency		2,272
Bank		4,066
Locum		68
Other		290
		88,485
Operating expenses (excluding employee expenses)		66,641
Non operating expenditure		2,466
		69,107
Other adjustments to get to adjusted financial performance		23
Total		**23**
(SURPLUS)/DEFICIT		**15,450**

The plan includes £4.9m of matched income and expenditure for the Community Diagnostic Centre but excludes funding for hosted services (the Local Maternity and Neonatal System).

5. Cost Improvement Programme

The planned cost improvement programme stands at £8.3m, which represents 5.3% of operating expenditure. This is a highly challenging target. The CIP target is broken down into categories in the table below:

CIP Breakdown by Category	Plan £000s	Revised £000s
Income	2,888	2,288
Pay	2,665	3,083
Non Pay	2,387	2,965
Total	**7,940**	**8,336**

At the time of producing this report, the Trust has successfully identified £5.3m of recurrent schemes or opportunities for cost improvement have been identified, with a further £3.0m to identify.

6. Capital Programme

A capital plan has been developed, with a total value of £5.2m, and £5.0m Capital Delegated Expenditure Limit (CDEL) allocated by the system. Capital requests developed by Divisions in line with their 5-year plans initially exceeded this value, however proposals have been subjected to multiple stages of internal cross-divisional and senior challenge and have been prioritised. As with revenue budgets, the detailed capital plan will be presented to the FPBD Committee in May and subsequently to Trust Board.

23/24 Capital Plan	Plan £000s
CDEL	5,035
Other	119
Total	**5,154**

7. Cash Management

Due to the planned deficit position, the Trust will require additional cash support in-year. It should be noted that the Trust also required cash support in 2015/16, 2016/17 and 2017/18 as well in the prior year (2022/23).

The Trust is working with system partners to identify shared solutions to cash management. Public Dividend Capital is available as an alternative, however there is a cost implication of approximately £250k if this source is utilised.

8. Financial Management and Cost Control

The Trust has a strong track record of financial management and control. Highly stringent financial management and cost control is in place to deliver the financial plan in 2023/24 with additional measures introduced to ensure that resources are used in the most effective and efficient way and represent value for money. Additional reporting and oversight will take place through the Board Committee structures.

9. Risks for 2023/24

The overall deficit position for 2023/24, and the larger underlying recurrent deficit represent a risk for the Trust in terms of short-term cash management and longer term financial and clinical sustainability. In addition to the over-arching issue of financial sustainability there are other risks, including:

- Ongoing balance between quality and available resources, and the requirement to deliver on finance, safety, *and* activity/access targets.

- Deficit plan and limitations on Trust investment will need to be balanced against the need to invest to reduce clinical risk.
- API funding mechanism – there is risk to income if activity targets are not met.
- Challenging cost improvement programme with plans still to be identified
- Risk of further inflation/ pressure above assumed levels in plan.
- Workforce availability is a national challenge and presents risk to both delivery of activity and cost control.

10.Addressing the Drivers of the Deficit and Long-Term Sustainability

The Trust first declared financial sustainability issues in 2014/15, and developed a long-term business plan at the time to address these. A number of issues have prevented delivery of this plan, including lack of capital for co-location with adult acute services, subsequent investment on site at Crown Street (necessary to maintain safety until a long-term solution can be implemented), and the clinical and operational requirements during the COVID period which decelerated the implementation of wider change programs. The Trust is unable to address the scale of the issues alone without continuing support and close working with the ICB and other regional and national partners.

The Trust is currently refining plans which set out a more sustainable long term financial position, with a view to producing a recovery plan agreed with system partners by September 2023.

The Trust recognises the importance of long term financial stability and the ongoing robustness of plans to achieve this. BAF risk 4.1 reflects the strategic risk in relation to this.

11.Conclusion and Recommendation

The financial plan for 2023/24 is a deficit position of £15.5m, and was submitted to NHS England on 4 May 2023, following agreement from the Trust Board at an extraordinary meeting held on that date.

The 2023/24 plan will be highly challenging to deliver and risks to delivery are noted. The Trust will continue with the implementation of stringent cost control measures required to meet the plan; however, all financial decisions will be accompanied by carefully considered Quality and Equality Impact Assessments, and the Trust will maintain its core focus on safety and quality of services. The Trust will continue to work closely with system partners to address and identify long-term solutions for both clinical and financial sustainability and will work to produce a 3-year financial recovery plan by September 2023.

The Trust Board is asked to note the in-year financial deficit plan of £15.5m for 2023/24, as well as the risks articulated in this paper. Detailed capital and revenue budgets will be presented for approval at the next meeting in June 2023.

Liverpool Women's
NHS Foundation Trust

Trust Board

Workforce Performance Report
April 2023

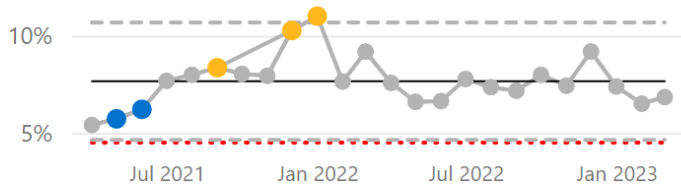
Section 6: To develop a well led, capable, motivated and entrepreneurial **Workforce**

KPI	Assurance Category	Date	Target	Target < or >	Performance	Assurance	Variation	Trend
Turnover Rate	Good	March 2023	<= 13%	<=	10.00%	P		
Clinical Mandatory Training Compliance	Concerning	March 2023	>= 95%	>=	81.52%	F		
Mandatory Training Compliance	Concerning	March 2023	>= 95%	>=	92.11%	F	H	
Prevention of Ill Health: Flu Vaccine Front Line Clinical Staff	Concerning	January 2023	>= 80%	>=	41.54%	F		
Sickness Absence Rate	Concerning	March 2023	<= 4.5%	<=	6.84%	F		

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

Sickness - Chief People Officer

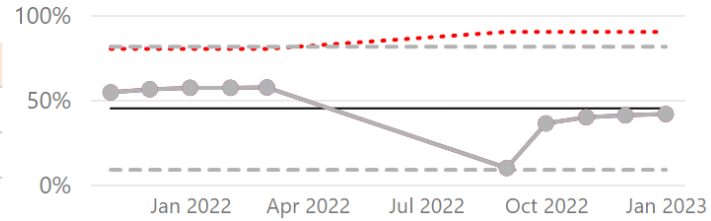
Assurance Category	Concerning
Date	March 2023
Target	<= 4.5%
Target < or >	<=
Performance	6.84%
Assurance	F
Variation	



Sickness increased by 0.34% in March, going up to 6.84%. The increase was seen across the divisions, with the exception of Gynaecology, where there was a fall of 0.27%. There is still a focus on ensuring return to work meetings are conducted in a timely manner, and that all staff have an annual Wellbeing Conversation. HR are working closely with local managers to ensure that both short and long term sickness are being managed appropriately.

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

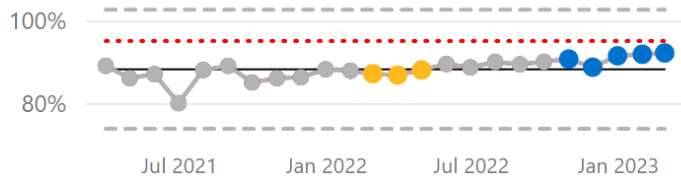
Assurance Category	Concerning
Date	January 2023
Target	>= 80%
Target < or >	>=
Performance	41.54%
Assurance	F
Variation	



Flu vaccine walkabout clinics continue across the Trust. National uptake for flu vaccine = 54%. LWH uptake for flu vaccine = 47%. Flu vaccine stock expires at end of June 23.

Mandatory Training Compliance - Chief People Officer

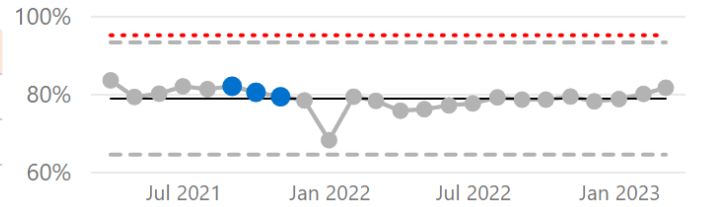
Assurance Category	Concerning
Date	March 2023
Target	>= 95%
Target < or >	>=
Performance	92.11%
Assurance	F
Variation	H



Compliance increased by 0.32% up to 92.11%. All the main divisions are now above the target figure of 95% except for Family Health, who are at 87.93%. Again, Matrons are reviewing compliance and will be given direct / time-specific action plans to ensure compliance improves. Those individuals who have competencies that expired over 12 months ago, or have never been completed are now being prioritised re) both individual compliance and assurance for patient safety.

Clinical Mandatory Training Compliance - Chief People Officer

Assurance Category	Concerning
Date	March 2023
Target	>= 95%
Target < or >	>=
Performance	81.52%
Assurance	F
Variation	



Compliance increased by 1.58%, giving a Trust-wide figure of 81.51%. HRBPs continue to work closely with local managers, with weekly assurance meetings to review compliance and agreed actions. As with core mandatory training, those individuals who have competencies that expired over 12 months ago, or have never been completed are now being prioritised re) both individual compliance and assurance for patient safety.

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*2023/24/030a*		Date: 11/05/2023	
Report Title	Corporate Objectives: Objective Setting 2023/24			
Prepared by	***Mark Grimshaw, Trust Secretary***			
Presented by	Executives			
Key Issues / Messages	***The report proposes the corporate objectives for 2023/24 following consultation with the respective Committees.***			
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 agree the draft 2023/24 corporate objectives			
Supporting Executive:	Executive Team			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

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

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

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

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Aligned Committees during March and April 2023. There was an ask to ensure that the objectives achieved a balance between being pragmatic / achievable within the year and sufficiently ambitious.			

EXECUTIVE SUMMARY

The Board received the final outturn position on the 2022/23 Corporate Objectives on 6 April 2023. Further detail on whether objectives are continuing (or otherwise) into 2023/24 is provided in Appendix 1 to this report.

For the last couple of years, the Trust has adopted a practice of aligning Corporate Objectives with a relevant Board Committee to provide an enhanced level of oversight. It is proposed that this practice continues and that the frequency of corporate objective reviews remains as follows (as was undertaken during 2022/23):

- First review – 6 months
- Final outturn – 12 months

Recommendation

The Board is asked to agree to the draft 2023/24 corporate objectives

MAIN REPORT

Liverpool Women's
NHS Foundation Trust

Corporate Objectives

2023 – 2024

Our Vision

To be the recognised leader in healthcare for women, babies and their families

Our shared vision at Liverpool Women's is simple and has withstood the test of time. It is underpinned by a shared set of values based around the needs of our people. We encourage these behaviours in all our staff, partners and volunteers to make sure our values are delivered in the same way, every day, to every person we care for.

Our Values	Care	Ambition	Respect	Engage	Learn

We have a set of five strategic aims which are central to all of our strategies and plans, and through working with patients, staff, governors and our partners we have developed a series of ambitions to push those aims one step further, helping us create the mind-set we need to achieve our vision and be outstanding in everything we do:

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

Our partnerships with other providers and organisations across the city are central to delivering our aims; we know we need to work together to make this happen.

To develop a Well Led, capable, motivated, and entrepreneurial Workforce				
Strategic Aim	**Proposed Corporate Objective**	**Executive Lead**	**Relevant Strategy**	**Board Committee**
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)	Moving closer to our aim of 25% of leaders (Band 7 or above) being from a racially minoritized background, by increasing to 13% in 2023/24	CPO	Putting People First Strategy	PPF
	Increasing the number of employees from a racially marginalised background by 5%, moving to 13% in 2023/24	CPO	Putting People First Strategy	PPF
	Ensure all new leaders (B7 and above) undertake active anti-racist training within their induction programme and ensure all existing B7 and above leaders undertake that training within the next 12 months	CPO	Putting People First Strategy	PPF
Recruit and retain key clinical staff	Demonstrate continued improvement from the 2022 NHS Staff survey in relation to staff engagement measures.	CPO	Putting People First Strategy	PPF
	Work towards establishing 24/7 consultant obstetric workforce by March 2024 and 8pm-12pm (twilights) for anaesthetic workforce by March 2025.	MD	Medical Workforce Strategy	PPF

To deliver Safe services				
Strategic Aim	**Proposed Corporate Objective**	**Executive Lead**	**Relevant Strategy**	**Board Committee**
Progress our plans to build a new hospital co-	Support and be a major contributor to the NHS Cheshire & Merseyside ICB Women's Services Committee	CFO	Future Generations Strategy	FPBD

located with an adult acute site Develop our model of care to keep pace with developments and respond to a changing environment	Embed and maximise the integrated digiCare EPR system and technologies ensuring systems are optimised for care delivery, secure, data accurate and that staff and patients are digitally supported to maximise digital benefits.	CIO	Digital Generations Strategy	FPBD
	Deliver on key national waiting time targets included within the national 2023/24 NHS planning guidance and demonstrate progress towards the three-year delivery plan for maternity and neonatal services, published by NHSE in March 2023.	COO	Our Strategy	FPBD
	Benchmark Trust's carbon footprint in Q1 and use this to set carbon footprint reduction targets through the implementation of sustainable practices across all areas of our operations.	COO	Green Plan	FPBD
	To lead on the development of a refreshed Quality Strategy with associated delivery plan and supported by a suite of monitoring metrics and dashboard. Including a focus on patient experience, safety, health inequalities and clinical outcomes	Chief Nurse	Clinical & Quality Strategy	QC

To deliver the best possible Experience for patients and staff				
Strategic Aim	**Corporate Objective**	**Executive Lead**	**Relevant Strategy**	**Board Committee**
Deliver an excellent patient and family experience to all our service users	Actively seek and use the diverse views of, patients, their families, and our communities to design and deliver services that best meet their needs. To ensure that services are utilising the findings of this intelligence to identify areas for service improvement and that we can	Chief Nurse	Clinical & Quality Strategy	QC

	demonstrate communication of the actions we have taken because of the feedback received.			

To be ambitious and Efficient and make best use of available resources				
Strategic Aim	**Proposed Corporate Objective**	**Executive Lead**	**Relevant Strategy**	**Board Committee**
Ensure our services are financially sustainable in the long term	Ensure efficient and effective use of all available resources, meeting agreed financial targets and working across the Cheshire and Mersey system for optimum outcomes for the region.	CFO	Our Strategy	FPBD
	Ensure the Trust has an updated, long-term financial plan in place during 2023/24 with clear views and actions in place in relation to long-term sustainability and with alignment to the Liverpool Clinical Services Review.	CFO	Our Strategy	FPBD
	Develop the Trust's commercial strategy during 2023/24 and pursue appropriate opportunities to maximise Trust income and expertise for the benefit of our patients	CFO	Our Strategy	FPBD

To participate in high quality research in order to deliver the most Effective outcomes				
Strategic Aim	**Proposed Corporate Objective**	**Executive Lead**	**Relevant Strategy**	**Board Committee**

Expand our existing partnerships, building on learning and partnership working throughout the COVID-19 pandemic, playing a key role in establishing any ICP or ICS	Maintain and develop key partnerships, ensuring robust governance structures are in place and effective reporting through the Trust's assurance framework.	CFO	Our Strategy	FPBD
	Support the ICS for C&M and work with the system to improve outcomes for Women's Health including Maternal and Neonatal care.	CFO	Our Strategy	FPBD
Progress our research strategy and foster innovation within the Trust	Increase nursing & midwifery participation in research as per the Trust's R&D Strategy	MD	Research & Innovation Strategy	QC
	Work towards achieving University Hospital Accreditation by March 2025	MD	Research & Innovation Strategy	QC
Fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership	The ambition is to fully implement and embed the Trust's accreditation programme by ensuring all wards and departments have, as a minimum, had a baseline assessment undertaken by September 2023	Chief Nurse	Clinical & Quality Strategy	QC
	Ensure delivery across all Maternity Transformation Programme workstreams, with good communication and engagement of the plan and work completed.	Chief Nurse	Clinical & Quality Strategy	QC

Liverpool Women's NHS Foundation Trust

To develop a Well Led, capable, motivated, and entrepreneurial Workforce						
Strategic Aim	**Proposed Corporate Objective**	**Executive Lead**	**Relevant Strategy**	**Board Committee**	**12 month update**	**Update for 2023/24**
Be recognised as the most inclusive organisation in the NHS with Zero discrimination for staff and patients (zero complaints from patients, zero investigations)	To progress year on year towards the organisational goal of 25% of our leadership workforce (Band 7 and above) being from an ethnically diverse background. This will require the Trust recruiting to 10 leadership roles each year between 2022-2025 (moving from 23 to 33 in 2022/23).	CPO	Putting People First Strategy	PPF	The original corporate objective has been modified to increase by 10 leadership roles each year until 25% of our leadership workforce is made up of colleagues from a racially minoritised background Between April 2022 and January 2023, staff in these roles increased from 25 to 31. Whilst not achieving the target of 10, this remains good progress towards it therefore this objective has been rated on track.	This objective has been retained for 2023/24 with updates made to the proposed measures / targets
	To work in partnership with health, education, local authority and community partners to increase the number of employees from an ethnic minority background by 5% year on year to ensure we achieve Riverside representation by 2025, moving from 11% to 16% in 2022/23.	CPO	Putting People First Strategy	PPF	Riverside ethnicity as detailed in a CCG report 2018 states 23.4% of the population are not white British/Irish, the fourth highest level in the city and 4.4% are 'other ethnic group (including Arab)' ethnicity. Currently **9%** of the LWH workforce is from a racially minoritised background, therefore further working in partnership with health, education, local authority and community partners is needed to increase the number of employees from a racially minoritised background by 5% year on year to ensure we achieve Riverside representation by 2025. This represents a significant challenge, therefore this objective has been rated as 'at risk'.	This objective has been retained for 2023/24 with updates made to the proposed measures / targets
Recruit and retain key clinical staff	Demonstrate improvement from the 2021 NHS Staff survey in relation to staff engagement measures.	CPO	Putting People First Strategy	PPF	The 2022 Staff Survey showed some positive improvements. The Staff Engagement Score improved from 6.9 to 7.1 which is classed as a statistically significant increase. Structures put in place over the last 12-18 months to improve staff engagement including *Big Conversations, Let's Talk Surveys, Great Place to Work Group and Divisional Key Messages* are becoming embedded, and Staff Engagement is a key objective in all Divisional People Plans (local workforce strategies).	This objective has been retained for 2023/24 with updates made to the date
	24/7 consultant obstetric workforce and 8am-12pm (twilights) for anaesthetic workforce by 2023	MD	Medical Workforce Strategy	PPF	24/7 resident neonatal consultant cover was achieved in January 2021 24/7 resident gynaecological consultant cover is not deemed necessary. Twilight obstetric cover achieved since July 2022. 4 more obstetric consultants required to move to 24/7 resident consultant cover. Once the correct number of staff are in place then there needs to be negotiation about the move and renumeration to 24/7 resident cover. This could be achieved by the end of 2023 however it has significant financial implications and may need to be phased differently. Anaesthetic Twilight consultant cover leading to 24/7 resident consultant cover. Twilight consultant cover will need approximately 7 WTE consultants. It is suggested that these are phased over the	This objective has been retained for 2023/24 with updates made to the proposed measures / targets

					next couple of years and then the move to 24/7 resident cover considered once this is achieved. This will have a significant financial implication.	

To deliver Safe services						
Strategic Aim	**Proposed Corporate Objective**	**Executive Lead**	**Relevant Strategy**	**Board Committee**	**12 month update**	**Update for 2023/24**
Progress our plans to build a new hospital co-located with an adult acute site	Complete refresh of business case for a new Liverpool Women's Hospital to reflect evolving models of care and system developments.	CFO	Future Generations Strategy	FPBD	The LCSR took place between September and December 2022. The review recommended that the Future Generations Programme be re-set as a system priority, led by a new sub-committee of the ICB Board, in line with best practice for service reconfiguration. Accordingly, the Trust's FG Programme paused for further work in December 2022, and the Trust is now supporting the work of the Women's Services Sub-Committee. This sub-committee is now responsible for developing service change proposal; however, the Trust will continue to contribute to this work.	Replaced with objective more aligned to the LCSR and the ICB sub-committee.
Implement all feasible mitigations to ensure services delivered from the Crown Street site are as safe as possible, developing our facilities for the benefit of our patients as well as those across the system	Deliver the Crown Street enhancement work program (including CT and blood bank services) to time and to budget working with system partners to ensure optimal patient benefit across the wider Cheshire and Mersey system.	CFO	Estates Strategy	FPBD	Bid for emergency capital funding was submitted by the Trust in early 2021 and re-submitted in July following a request from NHSI/E. Funding was approved in December 2021. Construction work for the permanent CT and MRI facilities substantially completed in December 2022. CT facilities became operational on 6 February 2023, with MRI due to commence w/c/ 20 March 2023. LWH inpatient pathways are now in place for CT imaging. The project to deliver 24/7 transfusion is expected to go live in 2023/24.	As this objective was noted as complete for 2022/23, it has been closed for 2023/24
Develop our model of care to keep pace with developments and respond to a changing environment	Deliver the launch of Trust's EPR programme in line with established timescales.	CIO	Digital Generations Strategy	FPBD	Work is underway to deliver a launch date in July 2023. This has been monitored monthly by the FPBD Committee.	Replaced with more specific objective about delivering and embedding the EPR programme.
	Recover and restore services for our patients and those across Cheshire and Merseyside in line with the National Operational plan requirements for 2022/23.	COO	Our Strategy	FPBD	In 2022/23 the Trust has progressed with recovery from the Covid Pandemic by ensuring capacity is available to treat those patients waiting the longest and also the most urgent. The Trust has commenced three main programmes of work to improve outcomes and efficiency for our patients in the 2nd half of 2022/23. These being the Theatre Improvement Programme, Maternity Triage and Flow, and Outpatient Utilization	This objective has been retained for 2023/24 with updates made to the date

					In line with the national requirements no patients were waiting over 104 weeks by June 2022 and significant progress has been made in reducing the number of patients waiting 78 weeks by the end of March 2023. General diagnostic performance has improved significantly in line with national requirements General capacity has been challenged as suspected cancer referrals have consistently been high compared to previous years. The Trust has maintained good performance against the 2 week referral and 31 day treatment target, however the 62 day target has been a challenge that continues to be addressed through the partnership of the Cheshire and Mersey Cancer Alliance. Urgent Care 4 hour performance remains well above the national average, however the Trust is committed to continue to improve this further through local redesign.	

To deliver the best possible Experience for patients and staff						
Strategic Aim	**Corporate Objective**	**Executive Lead**	**Relevant Strategy**	**Board Committee**	**12 month update**	
Deliver an excellent patient and family experience to all our service users	Actively seek and use the diverse views of, patients, their families, and our communities to design and deliver services that best meet their needs. To ensure that services are utilising the findings of this intelligence to identify areas for service improvement and that we can demonstrate communication of the actions we have taken because of the feedback received.	DON	Clinical & Quality Strategy	QC	The following work has progressed since previous reporting: • Merseyside Society for the Deaf – work ongoing with digital agenda within the Trust to improve accessibility. This includes working on the Outpatient transformation and text messaging. • Ongoing 'Come talk to us' events – held at both sites, generating lots of feedback and captured onto the Ulysses system as PALS. • Maternity Improvement Task and Finish Group – improvements noted from the National Patient Survey, with on-going improvements captured within maternity patient experience action plans • Inpatient and Cancer National surveys, actions plans, and improvements made. • Maternity Voices Panel – working with the chair to act on feedback. Process has been set up to ensure feedback is distributed to the correct area of the Trust, actioned and then MVP can implement 'You said we did'. • Catering group – introduced new menus, crockery and cutlery following feedback from patients. Awaiting new breakfast and beverage trolleys. • Genomics waiting area and counselling rooms have been updated following feedback from patients, more improvements planned to include refreshment stations • Engagement events both internally and externally. • Secret Shopper introduced and currently looking at the environment, food tasting and adaptive cutlery.	Retained with simplified language.

					• Non-English Speaking Team (NEST) is established and working well. • Local surveys undertaken listening to the views of all patients. • Friends and Family comments acted on to produce 'you said we did' that are displayed Trust wide. • Stakeholder list developed and scheduled events. • Gynaecology Oncology Support Group – empowering ladies with cancer to have informed decision making. • Honeysuckle Bereavement support group – monthly meetings with bereaved patients/partners. • Trust compliance with Reasonable Adjustments Guidelines is monitored on a quarterly basis via the Integrated Safeguarding Quality Assurance Report. • For Q3 2022/23 data shows that all patients with additional needs, who were admitted for either a gynaecology procedure or antenatal care were assessed for reasonable adjustments, with 49% were requiring adjustments to their care pathway. This is a reduction when compared to Q2 2022/23 however no conclusions can be reached at this time due to a lack of comparative data and the nature of reasonable adjustments being individual to the needs of the person. • Of these, two patients required the support of the safeguarding team to co-ordinate significant adaptations to the admissions pathway The 2022 Learning Disability Improvement Standards (LD-IS) for NHS Trusts 2018 & Dementia-Friendly Hospital Charter (DFHC) 2018 Audit in 2022 found: • All patients included in the audit were appropriately identified, their individual needs recognised, and reasonable adjustments were applied, where necessary. • Reviewing the adjustments completed, 71% required unrestricted access to a relative or carer and in all cases the relative or carer fed back they were actively involved in all aspects of care planning. When asked to score how they were made to feel, 96% scored between nine and ten, with 10 being the best, which is above the Trust FFT overall score of 90%.	
	To implement a formal governance and reporting structure for the implementation of the Ockenden Final Report recommendations. This will monitor and track progress allowing for robust assurance to be provided to the Quality Committee and Board ensuring that the organisation is fully sighted on its position.	DONM	Clinical & Quality Strategy	QC	Maternity Transformation Board in place with meetings held monthly receiving progress reports from 4 workstreams. Workstream 1- Ockenden, aims to achieve compliance with the 92 Essential Actions from Ockenden 2 Report. Of the 92 Essential Actions 5 actions relate to National workstreams. Of the remaining 87 EA position in LWH: • 23 Ambers (26%) • 64 Green (74%) The recent MIAA report raised the level of scrutiny and challenge in place along with evidence of the Green rated IEA's. The	Not carried forward as a corporate objective into 2023/24 as this will continue to be monitored via the Maternity Transformation Board and the Quality Committee.

					Ockenden workstream have completed the review of the Ambers and from April 2023 will be reviewing the Green rated actions. There is also an established process for updates & progress to be fed into the Trust Safety & Effectiveness Sub-Committee and then onto Quality Committee.	

To be ambitious and Efficient and make best use of available resources						
Strategic Aim	**Proposed Corporate Objective**	**Executive Lead**	**Relevant Strategy**	**Board Committee**	**12 month update**	
Ensure our services are financially sustainable in the long term	Ensure efficient and effective use of all available resources, meeting agreed financial targets and working across the Cheshire and Mersey system for optimum outcomes for the region.	CFO	Finance & Sustainability 2021-2025	FPBD	The Trust is facing financial challenge in 2022/23 and has implemented a Recovery Programme in order to address this. Despite this, the Trust has reported off plan since M10 and is now forecasting a £2.2m adverse variance o plan for 2022/23. Close working with the ICB and provider partners is in place.	Carried forward into 2023/24
	Ensure the Trust has an updated, long term financial plan in place during 2022/23 to reflect recent and proposed regime changes, with clear views and actions in place in relation to long term sustainability.	CFO	Finance & Sustainability 2021-2025	FPBD	A long-term financial model has been produced but there remains uncertainty in the medium term in relation to inflation and other key assumptions. Plans for 2023/23 currently indicate a significant deficit, with an underlying structural deficit of c. £30m. The Trust has a clear understanding of the drivers of this deficit. To achieve long-term financial sustainability, the Trust will require external support and is working closely with ICS partners to address long term financial sustainability.	This objective has been retained for 2023/24 with updates made to the date
	Develop the Trust's commercial strategy during 2022/23 and pursue appropriate opportunities to maximise Trust income for the benefit of our patients	CFO	Finance & Sustainability 2021-2025	FPBD	The Trust's approach to commercial and international development is included in the Trust's draft finance, procurement, and sustainability strategy – including a risk appetite statement. The strategy will be recommended for approval in Q1 2023/24.	This objective has been retained for 2023/24 with updates made to the date

To participate in high quality research in order to deliver the most Effective outcomes						
Strategic Aim	**Proposed Corporate Objective**	**Executive Lead**	**Relevant Strategy**	**Board Committee**	**12 month update**	
Expand our existing partnerships, building on learning and partnership working throughout the COVID-19 pandemic,	Maintain and develop key partnerships, ensuring robust governance structures are in place and effective reporting through the Trust's assurance framework.	MD	Our Strategy	FPBD	The Trust has several highly successful partnerships in place with a range of clinical networks, and with local Trusts, including with LUHFT & LHCH for CDC, Alder Hey for the Liverpool Neonatal Partnership, and Mersey Care for the provision of specific services and future development of estate. The Trust is also working closely with Place and the ICB regarding it's long-term strategy.	This objective has been retained for 2023/24

playing a key role in establishing any ICP or ICS					Progress in developing partnerships and associated governance is now reported on a quarterly basis to the Executive Team, and an Executive Lead has been identified. The Trust's approach to partnership working needs to remain dynamic at present, to enable a flexible response to a changing environment. The LNP went through a quality assurance process whereby the Partnership self-assessed itself against a predefined set of criteria based on the Well Led CQC domain. This was then presented to NEDs from both Boards. An overarching Partnership Board with Alder Hey is forming to encompass the Liverpool Neonatal Partnership, Starting Well research programme, newly developing services and current services. The Partnership Board will also look at strategic programmes that have a shared strategic aim.	
	Support the developing ICS for C&M and working with the system to improve outcomes for Women's Health including Maternal and Neonatal care.	CEO	Our Strategy	FPBD	Executives from LWH have engaged with the new Executive team of the ICB and at Place regarding the Case for Change for the Future Generations strategy. This case for change has been discussed at ICB Board meetings and is now a programme of the ICB (with a new sub-committee in place). COO and MD chair a C&M Gold Command for maternity services on a weekly basis Through the LMS LWH has two clinical leads embedded within leadership structure for maternity and gynaecology Executives have engaged with their respective forums hosted via the ICB ie C&M MDs meeting and other execs have theirs as well CMAST programmes of work are also supported by Executives where appropriate including developmental days e.g CEO chairing (SRO) the workforce group. CMAST MDs and DoS recently agreed to prioritise gynae services at a joint workshop held in March 2023. The Trust is hosting a joint workshop with colleagues from primary care and public health in Liverpool to expand on the Trust's model of care work and to consider the impact on prevention, health inequalities and the role of primary care in women's services.	This objective has been retained for 2023/24
Progress our research strategy and foster innovation within the Trust	Provide clear evidence of senior nursing & midwifery research leadership, as per the Trust R&D strategy by March 2023	MD	Research & Innovation Strategy	QC	Good progress has been made towards delivery of this objective, with good support and engagement seen across the Trust. Specific examples include: -Three professors of midwifery attend the RD&I Committee (for UCLAN, Liverpool John Moors, LTSM), which has driven greater	This objective has been retained for 2023/24

					collaboration and willingness to progress nursing and midwifery-led research. -A joint research midwifery post has been developed with LSTN and commenced Jan 2022. -Trial ongoing re speculum for 3rd/4th degree tears - created opportunity for midwife PhD. -Meetings ha taken place with PEFs in Trust to make research placements available for nurses and midwives, to be implemented in 2022. A Nursing Midwifery and AHP Talent pipeline has been developed and a business case accepted to fund the pipeline. Research development opportunities will be offered in early 2023 for nurses midwives and AHPs. The Trust now has a Nursing Midwifery and AHP Talent Pipeline to encourage staff to into Research. The Trust now has two employees who were awarded status as NIHR Senior Research Leaders.	
	Complete refresh of R&D strategy and progress year 1 objectives	MD	Research & Innovation Strategy	QC	Work to refresh the Trust's Research, Development and Innovation strategy has been underway for the past year. Recent consultation work regarding the strategy has been undertaken with a range of stakeholder groups, including the Trust's Council of Governors and representatives from all local universities. The R&D strategy was relaunched 27th March 2023	Not carried forward as the strategy has been updated.
Fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership	Ensure all wards and key areas have ward accreditation completed (twice a year)	DONM	Clinical & Quality Strategy	QC	The BBAS framework provides wards and departments with an evidence based, coordinated set of standards which are tailored to each individual ward/area against which the quality and safety of care can be measured. The framework is supported by the Nursing Audits and KPI assurance framework. The standards are based on the Trusts Five Key Strategic Aims and Ambitions to support the Trust Vision to be outstanding in everything that we do, as well as the CQC`s assessment framework. To date a total of 9 areas have received a Baseline Assessment and one area has been reaccredited. A further 13 areas are scheduled for Baseline assessments and 5 areas are scheduled for reaccreditation. Recognition and sharing of best practice across the organisation is in progress for those areas who have achieved Gold status. A proposal for a Quality and Safety walkaround schedule which will provide additional assurance of standards is also under review.	Updated with some more specifics regarding outcomes.

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*23/24/030b*		Date: 11/05/2023	
Report Title	Covid-19 Inquiry Update			
Prepared by	***Mark Grimshaw, Trust Secretary***			
Presented by	***Mark Grimshaw, Trust Secretary***			
Key Issues / Messages	The report provides an update on the Covid-19 Inquiry, the Trust's actions to date and potential next steps.			
Action required	Approve ☐	Receive ☐	Note ☒	Take Assurance ☐
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable): N/A			
	For Decisions - in line with Risk Appetite Statement – Y *If no – please outline the reasons for deviation.*			
	The Board is asked to note the report.			
Supporting Executive:	***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
N/A			

EXECUTIVE SUMMARY

This report outlines the response of the Trust to the UK Covid-19 Inquiry launched on July 21, 2022. The Inquiry aims to investigate the UK's preparedness and response to the pandemic and to identify lessons learned for the future. The report details the Trust's initial response to the Inquiry, which involved setting up an Inquiry Working Group.

The third module of the Inquiry, which focuses on the impact of Covid-19 on healthcare systems and patients, is outlined together with the outcomes of the preliminary hearing that took place on February 28, 2023. The report highlights some of the issues and themes emerging from the Inquiry, such as the authority and capacity of healthcare leaders, the impact on patients of cancelling routine care, and the effects of vaccination programs on healthcare provision. The report concludes by highlighting key steps for effective Rule 9 responses, including having a clear understanding of the key themes and issues and ensuring that all relevant stakeholders within the Trust are informed.

The Board is asked to note the report.

MAIN REPORT

INTRODUCTION

The government set up the UK Covid-19 Inquiry (the Inquiry) to examine the UK's preparedness and response to the pandemic, and to learn lessons for the future. Its chair is Baroness Heather Hallett DBE.

The inquiry was officially launched by Baroness Hallett on 21 July 2022. During the launch, she set out her approach to the inquiry as well as the timetable.

The chair is taking a modular approach to the Inquiry and date, she has announced three modules with teams set up across the UK to investigate and report on each module. These will be followed by public hearings chaired by Baroness Hallett. Further modules will be announced in due course.

This report outlines Trust's response to the Inquiry to date, the issues and themes emerging from the Inquiry (with a focus on Module 3), and the next steps/actions.

INITIAL RESPONSE TO THE INQUIRY

Once the Inquiry was announced the Trust appointed an Inquiry Lead (Trust Secretary) and several meetings were held over six months with key individuals from HR, Procurement, Corporate Nursing, Infection, Prevention & Control, Finance, and Communications to scope the Trust's approach to the Inquiry.

Key actions involved the following:

- Setup a dedicated site for the Inquiry Working Group to host documents
    - This was in recognition that the Inquiry may last several years, and that ownership of key documents should not rest with one individual
    - A dedicated email account has also been established for the same reason
- Develop a COVID-19 Staff List
    - This is to identify key individuals and decision-makers involved in the Trust's Covid-19 response – forwarding details are being sought from those who leave the organisation.
- Issue a Document Preservation Notice (DPN)
    - This is to prevent relevant files/information from being deleted.
- Ensure the Decision Log from Covid-19 Oversight & Scrutiny Committee is up-to-date with supporting evidence in place.
    - This is the most important record of the Trust's decision-making during the pandemic. Work continues to ensure that the relevant documentation is available for each decision and that this is easily searchable and accessible.

MODULE THREE

The third module investigation was launched on 8 November 2022 and it will examine the impact on the health sector including the impact of Covid-19 and of the governmental and societal responses to it, on healthcare systems and patients, hospital and other healthcare workers and staff. The provisional scope for module three has been published and the preliminary hearing took place on 28 February 2023. Among other issues, it will investigate healthcare systems and governance, hospitals, primary care, the

impact on NHS backlogs and non-Covid treatments, the effects on healthcare provision of vaccination programs, and long COVID diagnosis and support.

Pre rule 9[1] questionnaire

Many trusts voluntarily responded to an Inquiry questionnaire sent to over 500 NHS and non-NHS organisations late last year (including this Trust). Responses have helped the Inquiry identify themes and issues, and other matters that will be considered for inclusion in the Rule 9 requests. The survey has also assisted the Inquiry in identifying who should receive Rule 9 requests. Among the issues highlighted in the responses were:

- The authority and capacity of healthcare leaders to make decisions and deal with crisis management.
- The consequences for patients of cancelling or pausing routine and non-urgent care.
- Cooperation between trusts and coordination across local organisations, including the accelerated implementation of integrated care systems.
- Measures used to manage the healthcare system capacity, including coordination with the private sector.
- Staffing, mental health, and well-being of healthcare staff and patients.
- Adoption of new ways of working in the healthcare system such as the shift to technological delivery and online working.
- Impact within healthcare systems of access to and the suitability of PPE and the infection prevention and control measures put in place to manage patient and staff safety.

Organisations could apply to be a 'core participant (CP)' in the evidence-gathering process and

36 CPs have been approved for this module, and 31 made oral submissions suggesting changes to the scope. Represented were bereaved families, a disability charities consortium, and clinically vulnerable families. NHS England is the only organisation that is a CP and represents the health service in England in this module. It is worth noting that thirteen CPs are pregnancy, parenting, and baby charities and organisations.

NEXT STEPS

The Trust has yet to receive a Rule 9 request but as one of the most significant providers of maternity services in the country, considering the potential influence of pregnancy, parenting, and baby charities and organisations, there is potential for a request to be forthcoming. One particular area of interest will likely be the Trust's response to visiting arrangements and the access provided to birthing partners whilst maintaining infection prevention and control measures (and adhering to regional and national guidance). As noted, the Trust has a well-documented decision log for Covid-19-driven policy and standard operating procedure changes and amendments and there will be a focus on ensuring that clear and accurate timelines can be established.

There is a possibility that members of staff will be invited to provide evidence at Module Three public hearings. In this occurrence, it will be important to ensure that staff are fully supported. There will be an

[1] Rule 9 of the Inquiry Rules 2006 entitles the Inquiry to send a written request for evidence which will usually direct the recipient to the issues that need to be covered

opportunity to learn lessons from local trusts that were involved in the Infected Blood Inquiry. Key elements to effective Rule 9 responses include:

- Having a clear understanding of the key themes and issues that the Inquiry is focusing on so that responses are tailored accordingly.
- Ensuring that all relevant stakeholders within the Trust are informed about the request and the response so that it provides a full account
- Being realistic about what the Trust can reasonably provide, and to communicate clearly with the Inquiry about any limitations or constraints that may impact the Trust's ability to respond fully.
- Recognising the opportunity to ensure that key lessons are learned and sharing the Trust's insights

The Inquiry has also launched a listening exercise called "Every Story Matters". This exercise will be important because the Inquiry's generic and organisational approach means that it is not set up to fully elicit personal stories and experiences. The listening exercise will allow individuals to share their personal experiences and provide information about what happened, how it affected them and those around them, and what can be learned. The opportunity to participate in the listening exercise will be communicated to staff at an appropriate time.

RECOMMENDATION

The Board is asked to note the report.

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	***23/24/030c***		**Date: 11/05/2023**	
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 on their contents and actions.*** • ***Agree the suggested Q4 scores***			
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 and Quality Committees since the previous version was presented to Board in April 2023.			

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 April 2023 meetings. The Committees were asked to take a view on the Quarter 4 BAF scores and recommend them to the Board.

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 change to BAF score for Quarter 4 – (likelihood 3 x consequence 4). Whilst progress has been made in the year, further work is required to achieve the target risk score. This would mean that the target score is not achieved. In the updated 2023/24 BAF it is proposed that the key assurances and controls for this area be transposed into the 'sustainable workforce' risk.
- No proposed changes to the BAF title
- No changes to the strategic threats

1.2 Failure to recruit & maintain a highly skilled & engaged workforce

- No proposed change to BAF score for Quarter 4 – (likelihood 4 x consequence 5). This risk has been significantly discussed in recent months owing to the ongoing challenges with industrial action. As noted in previous iterations, this was not deemed sufficient to escalate the score but there has been no scope to reduce the score also. This would mean that the target score is not achieved. In the updated 2023/24 BAF it is proposed that the key assurances and controls for this area be transposed into the 'sustainable workforce' risk.
- No proposed changes to the BAF title
- No changes to the strategic threats

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

- No proposed change to BAF score for Quarter 4 – (likelihood 3 x consequence 4). This risk has been significantly updated in the last quarter following the Liverpool Clinical Services Review. The outcome from this remains in development and therefore it is proposed that it is too early to consider changing the risk score. This would mean that the target score is not achieved. In the updated 2023/24 BAF it is proposed that the key assurances and controls for this area be transposed into the 'effective partnerships' risk as the future of this issue will be taken forward as an ICB sub-committee.
- No proposed changes to the BAF title
- No changes to the strategic threats

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

- No proposed change to BAF score for Quarter 4 – (likelihood 4 x consequence 4). This risk is scored at the level it is predominantly due to the on-going risk of managing multiple clinical systems. This remains the case into Q4. This would mean that the target score is not achieved. Looking ahead to 2023/24, it is suggested that this element of the risk be carried over to the 'digital' risk and not included in the clinical sustainability risk.
- No proposed changes to the BAF title
- No changes to the strategic threats

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

- No proposed change to BAF score for Quarter 4 – (likelihood 4 x consequence 5). Despite the improvements made to the site over the quarter (CT scanner & MRI), this risk cannot be fully mitigated, and other significant risks remain. This would mean that the target score is not achieved. In the updated 2023/24 BAF it is proposed that the issues will carry forward into the 'clinical sustainability' risk
- No proposed changes to the BAF title
- No changes to the strategic threats

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

- Proposed change to BAF score for Quarter 4 – (likelihood 4 x consequence 4). Actions have been closed providing greater level of control meaning that the impact of a potential cyber-attack would be lessened. This means that the target score has broadly been achieved. Looking ahead to 2023/24, it is suggested that this element of the risk be carried over to the 'digital' risk.
- No proposed changes to the BAF title
- No changes to the strategic threats

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

- No proposed change to BAF score for Quarter 4 – (likelihood 3 x consequence 4). This would mean that the target score is achieved. In the updated 2023/24 BAF it is proposed that the issues will carry forward into the 'patient experience' risk and will be an area of significant focus

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

- No proposed change to BAF score for Quarter 4 – (likelihood 5 x consequence 4). This risk is scored at the level it is predominantly due to the on-going structural deficit facing the Trust. This remains the case into Q4. This would mean that the target score is not achieved. Looking ahead to 2023/24, it is suggested that this element of the risk be carried over to the financial sustainability risk.
- No proposed changes to the BAF title
- No changes to the strategic threats

4.2: Failure to expand our existing partnerships, building on learning and partnership working throughout the COVID-19 pandemic, playing a key role in establishing any ICP or ICS

- No proposed change to BAF score for Quarter 4 – (likelihood 2 x consequence 4). This means that the target score has been achieved. Looking ahead to 2023/24, it is suggested that this element of the risk be carried over to the 'partnerships' risk.
- No proposed changes to the BAF title
- No changes to the strategic threats

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

- No proposed change to BAF score for Quarter 4 – (likelihood 5 x consequence 4). This risk is scored at the level it is predominantly due to the Trust not achieving its financial plan. This has been confirmed during Q4. This would mean that the target score is not achieved. Looking ahead to 2023/24, it is suggested that this element of the risk be carried over to the financial sustainability risk.
- No proposed changes to the BAF title
- No changes to the strategic threats

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

- No proposed change to BAF score for Quarter 4 – (likelihood 2 x consequence 4). Despite the updated strategy being agreed, uncertainty remains regarding the funding of midwifery and nursing talent pipeline. This would mean that the target score is not achieved. In the updated 2023/24 BAF it is proposed that the issues will carry forward into the 'clinical sustainability' 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

- No proposed change to BAF score for Quarter 4 – (likelihood 3 x consequence 4). This would mean that the target score is not achieved. In the updated 2023/24 BAF it is proposed that the issues will carry forward as part of the Corporate Risk Register. The impact of the expected CQC report will also need to be factored into this.

New Risks or Strategic Threats

No new risks or strategic threats.

Closed Risks or Strategic Threats

No closed risks or strategic threats.

A draft updated BAF for 2023/24 has been produced and this has been circulated separately for Board members for their review and consideration. This includes a reduced number of BAF risks to help provide greater clarity on the key strategic risks facing the Trust. The risk areas covered are as follows:

- Clinical sustainability (to be aligned to the Quality Committee)
- Financial sustainability (to be aligned to FPBD)
- Workforce (to be aligned to the PPF Committee)
- Patient Experience (to be aligned to the Quality Committee)
- Being an effective partner (to be aligned to FPBD)
- Digital (to be aligned to FPBD)

Recommendation

The Board requested to

- review the BAF risks and agree on their contents and actions.
- Agree the suggested Q4 scores

NHS
Liverpool Women's
NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK 2022/2023

Trust Board – May 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	2022/23 Target
SA1 Workforce	1.1 Failure to be recognised as one of the most inclusive organisations in the NHS with Zero discrimination for staff and patients (zero complaints from patients, zero investigations)	PPF	CPO	12 (I3 x c4)	12 (I3 x c4)	12 (I3 x c4)	12 (I3 x c4)	⟷	8 (I2 x c4)
	1.2 Failure to recruit & maintain a highly skilled & engaged workforce	PPF	CPO	20 (I5 x c4)	20 (I5 x c4)	20 (I4 x c5)	20 (I4 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)	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)	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)	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)	16 (I4 x c4)	↓	15 (I3 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)	⟷	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	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)	⟷	8 (I2 x c4)
	4.3 Failure to deliver the agreed 2022/23 financial plan	FPBD	CFO			20 (I5 x c4)	20 (I5 x c4)	⟷	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)	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)	12 (I3 x c4)	⟷	8 (I2 x c4)

BAF HEAT MAP

Consequence	Likelihood				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic			2.1	2.3 1.2	
4 Major		4.2 5.1	1.1 3.1 5.2	2.4 2.2	4.3 4.1
3 Moderate					
2 Minor					
1 Negligible					

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

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

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)	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)	20 (5 x 4)	20 (5 x 4)	⟷	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). This has been assessed as remaining 'likely' rather than' almost certain' – hence the risk rating has remained static.

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.	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	16 (4 x 4)

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 3 Q movement	2022/23 Target
15 (3 x 5)	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. The Liverpool Clinical Services Review has resulted in the acceptance of the isolated site risks as a system priority with plans in place to manage through a newly established sub-committee of the ICB. There remains however no clear route to capital funding and there is not yet clarity regarding programme pace.

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	Future Generations Strategy has been included within refreshed overall corporate strategy and is a key supporting strategy within Trust strategic framework. *The Trust's public facing Future Generations documents will now be refreshed to reflect ICB leadership of the programme going forwards.*	Further communication required of strategy and Future Generations position within strategy with local community, patients and public, to be led by the ICB. Further work required to engage women and their families in option appraisal process and model of care development, to be led by the ICB. Extent of direct engagement with patients and the public by the Trust to be determined. 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. Public consultation required – this must be led by commissioners. Lobby local politicians and MPs for support.	
	Continuing dialogue with regulators	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 *The majority of dialogue with regulators will be led by the ICB in future. Chair and CEO will maintain ongoing dialogue with relevant key stakeholders at both national and regional level, as appropriate.* Trust Communications Team has established good links with respective teams at Place and the ICB and will support any future communication and engagement activities regarding the programme.		
	Continuing partnership with Liverpool University Hospitals	Partnership with Liverpool University Hospitals in place and strengthening. Shared dashboard and risk register under development. Shared review of relevant SIs.		
	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. LCSR commissioned and completed January 2023. Recommendations accepted. Programme re-set as system priority. *Active engagement with commissioners ongoing via newly established sub-committee of ICB.*		

	Future Generations Programme re-set as a system priority	The LCSR concluded in January 2023 and recommended that the programme is taken forward as a system priority, led by a specific sub-committee of the ICB, with two joint SROs, supported by a programme team. Sub-committee will involve commissioners, LWH, Alder Hey, Clatterbridge and Liverpool University Hospitals in refreshing the case for change and in engaging with other key partners.			

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
2.1 / 8	Maintain relationships with key ICS personnel	Medical Director	September 2022 - Ongoing	Board	
2.1/20	Refresh Future Generations Case for Change public facing documents	Associate Director of Strategy, Head of Communications	May 2023	Board	
2.1/21	Site visit at LWH with Graham Urwin, Raj Jain, David Sloman and Andrew Morris.	Medical Director	March 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	Future Generations Strategy has been included within refreshed overall corporate strategy and is a key supporting strategy within Trust strategic framework. *The Trust's public facing Future Generations documents will now be refreshed to reflect ICB leadership of the programme going forwards.*	Further communication required of strategy and Future Generations position within strategy with local community, patients and public, to be led by the ICB. Further work required to engage women and their families in option appraisal process and model of care development, to be led by the ICB. Extent of direct engagement with patients and the public by the Trust to be determined. 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. Public consultation required – this must be led by commissioners. Lobby local politicians and MPs for support.	
	Discussion of the case for change with MPs and local politicians	The Trust has held a series of briefing meetings with local MPs to explain the case for change and ask for their support. Ongoing dialogue and engagement as appropriate.		
	Comms and Engagement Activities	The Trust is working closely with ICB to plan pre-consultation engagement, and draft consultation timeline. Outcomes of previous engagement exercises has been reviewed - currently updating publicly available information. *The ICB is responsible for formal public engagement, the Trust. Trust Communications Team has established good links with respective teams at Place and the ICB and will actively participate in any future communication and engagement activities regarding the programme.*		

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
2.1 / 7	Lobby systems and MPs for active support	Head of Communications and Marketing	September 2022 - Ongoing	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 Update received February 2023 – no decision regarding the 8 hospitals has been made.	No clear route to sufficient capital funding for a new build – access to capital is a pre-requisite for public consultation Lack of system support outside of Cheshire and Mersey to secure the capital case WHH scheme prioritised in C&M LWH scheme 6th priority across North West Funding option not yet agreed No progress in receipt of funding and delivery of new hospital schemes already approved under New Hospitals Programme	

	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		

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 control over programme pace and direction	Active participation in ICB sub-committee	Sub-committee of the ICB has been established with joint SROs. Trust has made suggestions regarding appropriate clinical SRO. Trust will actively engage with programme once established.	Formation of ICB sub-committee creating delays and repetition in programme. Ability to hold other participating organisations to account regarding timescales. Clarity needed regarding route of assurance for LWH Board regarding programme progress. ICB programme resource not yet clear.	
	Continued management and monitoring of isolated site risks	On going monitoring and management of risks caused by isolated site. Regular reports to the Board.		
	Information sharing	The Trust will share with the ICB all information and intelligence produced to date as part of the Future Generations Programme, as requested, including the continued monitoring of the isolated site risks. The Trust will support the ICB by carrying out analysis and information gathering where requested.		
	Continuing partnership with Liverpool University Hospitals	Partnership with Liverpool University Hospitals in place and strengthening. Shared estates modelling work underway.		

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
2.1/3	Refreshed estates modelling and schedule of accommodation for new build, reviewed as part of planned estates workshop with LUHFT and Carnall Farrar.	Associate Director of Strategy Director of Estates and Facilities, LUHFT	March 2023	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)	16 (4 x 4)	⟷	12 (3x4)

Rationale for current risk score:

The lack of an EPR (and as a corollary, having in place a disparate number of systems), remains a significant risk to the organisation because information is spread across disparate systems leading to information being incomplete, hard to find in a timely manner and a potential for inaccuracies due to manual transfer of information. However, there is evidence of pro-active mitigating controls and progress being made in the procurement and subsequent implementation of an integrated Meditech EPR system. The Trust can demonstrate evidence of being open and responsive to change in service development and delivery, but further work can be done to strengthen the approach to horizon scanning and longer term, strategic planning at a Divisional level.

Strategic Threat *(what might cause this to happen)*	Controls *(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Source of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Controls/Assurance *(Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level or Insufficient evidence as to effectiveness of the controls or negative assurance)*	Overall Assurance Rating
The Trust's current clinical records system (paper and Electronic) are sub-optimal.	Approved Digital Generations Strategy	Quarterly risk assessments completed FPBD Committee overview and scrutiny Digital Hospital Committee oversight Approved EPR Business case which define clear direction and preferred solution. EPR programme board chaired by MD Independent lessons learnt Positive review MIAA Critical Application Audit (rolling programme across trust systems) Reporting into Audit Committee and Digital Hospital Group	Multiple Clinical Systems issues remain **(Action 2.2 / 2)** Ability of clinical staff to engage with the system development due to time and financial impact **(Actions 2.2 / 1, 2.2 / 3, 2.2 / 4)** ICS wide Shared Care Record programme not fully implemented/ active programme of work**)**	
	Approved Meditech Expanse Business Case			
	Maintenance of present system			
	Development of individual / service solutions e.g. PENs (Gynaecology) and Staff training			
	Incident reporting			
	Tactical solutions including the implementation of K2 Athena system			
	Exchange/LHCRE enables for patent information sharing			
	Virtual Desktop technology to aid staff working flexibly.			
	Additional network resilience for LUHFT supplied systems (K2/PENS/CRIS) to reduce risk of unplanned systems downtime			
	PACS upgrade removes a separate login for that system, reducing multiple systems issues.			
	Task and Finish group established to ensure that clinical investigation undertaken at external trusts have been actioned accordingly.	Safety and Effectiveness Sub-Committee		
	Appropriate task and finish groups established as required by Safety and Effectiveness sub-committee	Safety and Effectiveness Sub-Committee		
	Digital clinical leadership business case developed	Digital Hospital Sub-Committee		
	Optimisations to K2 system and refinements implemented	Digital Hospital Sub-Committee		
	Ongoing review of systems and mitigations quarterly	FPBD & QC		

Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
2.2 / 1	Develop staff communication plan for new system	CIO	December 2022	Digital Hospital Committee oversight	The comms plan is completed and signed off at EPR Programme Board. It is a living document that will evolve during the course of the programme.
2.2 / 3	Issue appropriate communication to all staff in relation to digital development by multiple means and forms	CIO	January 2023	Digital Hospital Committee oversight	This is largely being achieved through the CAGE, and Ops engagement, aswell as business process mapping workshops. What we still lack is dedicated comms officer to issue regular comms and the adoption of change agents. We expect both to be completed by end of Jan, following funding.

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

					evidence as to effectiveness of the controls or negative assurance)	
Clinical service strategies that do not sufficiently anticipate evolving healthcare needs of the local population and/or reduce health inequalities	Operational 'Plans on a page' for Divisions – incorporates horizon scanning section Operational planning process Availability of data on service trends and demographics Workforce plans		Divisional Board meetings Operational plans and budgets Divisional Boards Divisional Boards		To improve horizon scanning processes to constantly review and update plans on a page **(Action 2.2 / 7)** To understand commissioning priorities emerging from developing ICS **(Action 2.2 / 7)** To ensure that Divisions are fully utilising data to understand changing service demands **(Action 2.2 / 8)** To ensure that workforce plans are informed by trends and data led intelligence. **(Action 2.2 / 9)**	
	Gap Reference	Required Action	Lead	Implement By	Monitoring	Status
	2.2 / 8	To ensure that Divisions are fully utilising data to understand changing service demands	Deputy COO	~~September 2022~~ 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)	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)	16 (4x4)	↓	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. For Q4, it is proposed that the risk level be reduced to the target score of 15 due to the strengthening of 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
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 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.
2.4 / 3	Purchase and implement software for USB port control	CIO	March 2023	DHSC	Procured and solution is installed.
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)	⟷	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~~ May 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	20 (5 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

Review 14/2/23:

Updated delivery date for action 4.1/1 to allow for outputs of 23/24 operational planning

Proposal to increase BAF risk 4.3 from 16 (4x4) to 20 (5x4) 'almost certain' given financial position at month 10 and overall assurance rating noted as 'red'.

updates to narrative (tracked changes)

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: February 23

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)	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) indicating long term sustainability issues Monitor site visit November 2015 Strategic Outline Case September 2017 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 re-refreshed by July 2023. **(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) Process of review now owned by ICB as part of Liverpool Clinical Services Review National CDEL Issue Lack of capital nationally Ongoing costs of maintaining safety on site while long term solution is enacted Additional work being undertaken to quantify financial benefits of co-location as part of latest review. **(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 and 2023/24. 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. Ongoing Engagement through strategic development	ICB rather than Trust leading on development of proposals from January 2023	
	Reduction in CNST Premium by 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 s despite achievement of years two and three of CNST Maternity Incentive Scheme.	
	Reduction in back officecorporate overheads costs and review of productivity	Oversight on costs at FPBD and Board Focus on benchmarking and efficiencies, including joint working where possible. ICS workstream in place	Requirement for resource in relation to recovery. Economies of scale Pace of change of system wide solutions	

	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) Reduction in 22/23 income . **(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 including updated co-location benefits and corporate assumptions.	CFO	July 2023	FPBD Committee / Board	Delayed due to delays in national timetable for planning 2022/23. – revised timescale required following operational planning completion
	4.1 /5	Work towards strategic outline case production and approval	CFO	January 2023	Board	Proposed deferral to link with LTFM completionSubject to outcome of Women's services as part of ICS Liverpool Clinical Services
	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 for financially viable delivery of services on behalf of C&M.	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)	⟷	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	20 (5 x 4)	20 (5 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. Despite recovery efforts at Month 10 it is forecast that the Trust will be unable to deliver the 22/23 agreed plan, reporting an adverse variance for the full year.

The likelihood of this risk has been increased to 'almost certain' from 'likely' as the Trust approaches the year end. 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. Sign off of budgets by budget holders and managers, and holding to account against those budgets Divisional performance reviews Working within ICS/system to ensure issues understood and Trust secures required amount of available funding.	FPBD Committee 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, 2021/22 and 2022.13. 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.	
	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. Additional controls put in place		
	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	Deputy Chief Finance Officer	March 2023	FPBD Committee	

		Ongoing. QIAs in place before schemes are put in place.					
	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 Application for National revenue cash support submitted February 2023	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)	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)	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.	

Trust Board

COVER SHEET

Agenda Item (Ref)	***23/24/031***		**Date: 11/05/2023**	
Report Title	**Emergency Planning Resilience and Response Annual Board Report**			
Prepared by	***Lorraine Thomas, Emergency Planning & Business Continuity Manager***			
Presented by	***Gary Price, Chief Operating Officer***			
Key Issues / Messages	***This Emergency Preparedness, Resilience and Response (EPRR) Annual Report provides a summary of EPRR approach and activities for 2022/23.***			
Action required	**Approve ☐**	**Receive ☐**	**Note ☒**	**Take Assurance ☐**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	***To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it***	***For the intelligence of the Board / Committee without in-depth discussion required***	***To assure the Board / Committee that effective systems of control are in place***
	Funding Source (If applicable):			
	For Decisions - in line with Risk Appetite Statement – Y ***If no – please outline the reasons for deviation.***			
	The Board is asked to note the report.			
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* 5.2 Failure to fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership	Comment:
Link to the Corporate Risk Register (CRR) – CR Number:	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
FPBD	**Apr 23**	**COO**	**Recommended to the Board**

EXECUTIVE SUMMARY

This Emergency Preparedness, Resilience and Response (EPRR) Annual Report provides a summary of EPRR approach and activities for 2022/23. The EPRR Strategy implemented by the EPRR Committee aims to support the Trust to meet its duties under the Civil Contingencies Act 2004. These duties are supported by the requirement for compliance with the NHSE EPRR Core Standards. The NHSE Core Standards assurance process was completed in October 2022 with Trust compliance reported to the Board (November 2022). The assurance process outcomes are summarised within this report.

EPRR work-streams going forward will remain focused on completing actions identified within the Core Standards action plan, planning for and responding to arising situations and maintaining and improving compliance to the NHSE EPRR Core Standards for 2023.

MAIN REPORT

Introduction

As a category 1 responder under the civil contingencies Act 2004 the Trust is required to prepare for emergency and business continuity incidents and ensure that it has the capacity and capability to respond effectively to emergency situations including major incidents. Whilst managing emergency situations the Trust must as far as is reasonably practicable maintain business continuity, prioritising critical service delivery when necessary.

The Trust aims to meet its duties within a framework that is safe, effective, caring, responsive and well-led. The Trust EPRR agenda is led by the EPRR Accountable Emergency Officer (Chief Operating Officer) supported by the Emergency Planning, Resilience & Response Manager. In order to meet its legal duties the Trust holds a portfolio of emergency and business continuity plans which have been developed in consultation with divisional teams and relevant corporate leads.

The Trust is required to work in cooperation with other Category 1 Responders including other NHS Trusts and the emergency services, in relation to emergency planning processes and incident response. The Trust is represented at the Merseyside Local Health Resilience Partnership at both strategic and operational level. The partnership led by the Integrated Care Board and Director of Public Health with NHSE in attendance aims to coordinate and direct cooperative working including in relation to risk management and shared learning from exercises and incident response.

EPRR work streams continue to focus on compliance to the NHSE/I EPRR Core Standards in order to support preparedness for emergency incidents and ensure compliance in external assurance and audit processes. EPRR objectives for 2022/23 were detailed as below in the Annual Board Report for 2022 and this report discusses the meeting of these objectives.

- Discussion of EPRR priorities via the EPRR Sub-Committee;

- Review and prioritisation of EPRR Risks;
- Review of Trust emergency plans and arrangements based on lessons learned / shared learning;
- Business continuity planning including for scheduled service disruption as required;
- Provision of EPRR training including delivery of an exercise based on major incident response;
- Delivery of an exercise based on business continuity response to an information technology scenario;
- Delivery of a hospital evacuation exercise;
- Continued working in cooperation with other healthcare responders;
- Implementation of actions to support effective incident response.

Risk Review

EPRR risks are regularly reviewed and updated including consultation at the EPRR Sub-Committee with reporting to Corporate Risk Committee. Specific risks and actions in relation to the major incident response (November 2021) continued to be reviewed and monitored by the EPRR Sub-Committee and the Environment Safety Sub-Committee. This work stream was stepped down as a standing agenda item on the EPRR Sub-Committee by the Chief Operating Officer (October 2022).

Trust Emergency & Business Continuity Plans

The Trust holds a portfolio of emergency plans which are subject to a process of review as directed by Trust governance procedures and as required by changing national, regional and local structures, priorities or lessons learned. All emergency plans are subject to consultation and approval via the EPRR Sub-Committee. The following plans were reviewed and approved in 2022/23. All emergency plans remain current.

- EPRR Strategy;
- Major Incident Plan (specific updates);
- CBRN plan;
- Lockdown Plan;
- Pandemic Influenza Plan

Departmental Business Continuity Plans Review

The annual review of business continuity plans took place January – March 2022 with all BCPs updated. The review for 2023 will take place April – June 2023 as agreed at EPRR Sub-Committee. Outstanding actions identified by departments will be incorporated into an action plan and monitored via the EPRR Sub-Committee. A review of updated business continuity plans for key providers is currently in progress.

Incident Coordination Centre Activations

The Trust Incident Coordination Centre was activated to manage and monitor episodes of industrial action from December 2022 - April 2023, with command and control arrangements in place. A major / critical incident was not declared during these activations.

Business Continuity Planning

The Trust developed specific business continuity plans to support planned infra-structure works. This provided the opportunity to implement contingencies, test business continuity plans and rehearse strategic, tactical and operational incident response roles including internal alerting procedures, external notification arrangements and staff communications.

Business Continuity Plans were implemented to support the following scheduled infrastructure upgrades:

- Meditech Migration 4th - 5th May 2022
- Electrical Infrastructure works 21st August 2022
- Meditech Patch Application 5th - 6th October 2022

Trust EPRR leads worked in collaboration with estates, digital and operational leads to develop business continuity plans to support the above. Staff communications were circulated and external notification of the plans and arrangements were provided to NHSE North West, Liverpool Clinical Commissioning Group, Integrated Care Board (from July 2022), North West Ambulance Service, and where applicable Merseyside Fire & Rescue Service. Lessons learned were identified and shared at the EPRR Sub-Committee for incorporation within subsequent planning procedures.

External Audit and Assurance

An EPRR Assurance Board Report was submitted (November 2022) based on the outcomes of the NHSE EPRR Core Standards self -assessment review for 2022. The assessment process, outcomes and actions are fully detailed within the report, however in summary 56 EPRR Core Standards were applicable to NHS Specialist Trusts with an additional 13 deep dive criteria. Assessment of the deep dive criteria is not included within the overall compliance rating. The NHSE quality assurance process included peer review sessions led by the Integrated Care Board and submission of evidence against randomly selected standards.

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 to the above the Trust fully met 8 of the 13 deep dive criteria with a rating of ‘Green’ and 4 criteria were partially met with a rating of ‘Amber’. The remaining criterion was rated as non-compliant / ‘Red.’

The Trust submitted an overall compliance rating of ‘86% / Partially Compliant’ to the Integrated Care Board. An integral part of the EPRR annual assurance process is the development of an action plan to ensure achievement of compliance against outstanding core standards. An action plan was submitted to the Integrated Care Board with actions monitored via the EPRR Sub-Committee.
Further information on the EPRR assurance process, including the action plan is detailed within The EPRR Core Standards Board Report (November 2022).

Training

- Regional Cyber-Incident Management tabletop exercise attended by Digital and EPRR Leads April 2022.
- Exercise Downtime (IT systems outage) scheduled July 2022 was cancelled by the Emergency Accountable Officer in order to prioritise delivery of major incident training.
- Exercise Downtime has been scheduled for June 2023 in order to support rehearsal of Trust incident response and digital audit requirements. The exercise will be attended by command and control, digital, operational, clinical and EPRR roles. An action plan will be developed and monitored via the EPRR Sub-Committee and the relevant digital forum.
- An exercise was delivered in May 2022 by an external provider supported by the Trust Security Lead, to test the Trust response to a range of emergency scenarios.
- An exercise was delivered in October 2022 to test hospital evacuation procedures. The exercise served as preparation towards a further evacuation table-top exercise to be delivered in 2023 in conjunction with external partners.
- Trust Lockdown Plan was tested in conjunction with Security and EPRR lead October 2022.
- Programme of EPRR training for Strategic and Tactical Commanders joining the on-call rota has continued throughout 2022-23, providing training / refresher training on aspects of EPRR including legal duties, accountability, command and control structures and responsibilities, escalation and communication procedures, emergency plans and resources.
- NHSE Principles of Health Command mandatory training for strategic and tactical command roles is attended by directors and managers participating in the on-call rota. Training attendance is monitored via the EPRR Manager / EPRR Sub-Committee.
- Fire Warden training delivered by Fire Safety Leads continues to be reported to the EPRR Sub-Committee.

Conclusion / Recommendation

The EPRR activities and achievements discussed within this report demonstrate that the Trust remains focused on continuing to meet its duties under the CCA 2004 and aims to maintain a substantial level of compliance to the NHSE EPRR Core Standards for 2023.

Specific objectives for 2023/24 include:

- Introduce and embed in-house EPRR services in order to increase service provision;
- Review EPRR Risks via EPRR sub-Committee;
- Review of Trust emergency plans and arrangements based on lessons learned / shared learning;
- Annual review of business continuity plans including business continuity arrangements of key providers;
- Business continuity planning for specific circumstances, including scheduled service disruption as required;
- Provision of EPRR training including delivery of a tabletop and live exercises to rehearse incident response;
- Delivery of a business continuity exercise based on an information technology scenario;
- Delivery of a hospital evacuation exercise supported by delivery of increased fire simulation tests at ward level;
- Ensure compliance to Martyn's Law when in place (in conjunction with Trust Security Lead);
- Continued working in cooperation with other healthcare responders;

- Implementation of actions and completion of action plans to support effective incident response.

The Board is asked to note the report.

Trust Board

COVER SHEET

Agenda Item (Ref)	*23/24/032*		Date: 11/05/2023	
Report Title	**Revised Risk Management Strategy for 2023/24**			
Prepared by	*Allan Hawksey, Head of Risk and Safety* *Phil Bartley, Associate Director of Governance and Quality*			
Presented by	*Phil Bartley, Associate Director of Governance and Quality*			
Key Issues / Messages	The Board is asked to approve the proposed Risk Management Strategy for 2023/24.			
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 approve the proposed Risk Management Strategy for 2023/24.			
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:	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Corporate Risk Sub Committee	March 23	Deputy Chief Executive and Chief People Officer	Proposed updates approved to the Stategy
Quality Committee	March 23	Chief Nurse	Committee will be asked for comments ahead of Board approval

Quality Committee	Apr 23	Chief Nurse	Recommended for approval to the Board

EXECUTIVE SUMMARY

Risk management should be embedded in all of the organisation's practices and processes in a way that it is relevant, effective and efficient. The risk management process should be part of, and not separate from, those organisational processes.

In particular, risk management should be embedded into policy development, business and strategic planning and review, and the change management processes. Risk is an inherent part of the delivery of healthcare.

The risk management strategy outlines the Trust's current approach to risk management throughout the organisation.

Achievement of objectives is subject to uncertainty, which gives rise to threats and opportunities. Uncertainty of outcome is how risk is defined. Risk management includes identifying and assessing risks and responding to them. Risk is defined as the uncertainty in achieving an objective.

To support and enable this process to occur the Trust has a defined Risk Management Strategy in place which is led by the Associate Director of Governance and Quality and supported through the management structure of the organisation.

This Risk Management Strategy was presented to Audit Committee in March 2023 and Quality Committee in April 2023. Following feedback received, there have been performance milestones added to Section 8 of the Strategy measure the effectiveness of the Strategy over the following 3-year period, between 2023 – 2026 which will be reviewed annually, and key achievements reported back to Quality Committee. Furthermore, there have been additions in relation to proactive and reactive risk processes (sections 4 and 5) and more descriptive roles in relation to the accountability of divisional and service managers.

MAIN REPORT

The following report provides a review of the current Risk Management Strategy (last reviewed in 2022) and provides an updated proposed Risk Management Strategy for 2023/24, which identifies changes which are required to maintain it as a live document.

The Risk Management Strategy has previously been developed with consideration and adoption of available guidance and consultation with the Trust Executives.

Proposed Risk Management Strategy for 2023 - 2026 – it is proposed that this Strategy will cover a 3 year period with performance measured annually

The Risk Management Strategy (version 15 agreed for 2022 onwards) underwent a number of amendments and additions to reflect developments in the Trust's approach to assessment, management and mitigation of risk as follows:

- Reviewed statement of intent from the Chief Executive (subject to finalisation by the Chief Executive)
- Update wording regarding the underpinning of the BAF by Key Strategic Threats
- Risk team profile (and key contacts) including divisional governance management structure

- Delegation of responsibility throughout the Organisation and appropriate oversight of risk (update to section 2.5 and appendix B and C additions)

Two internal audits have recently been carried out to review the Trust's risk management processes by MIAA and these have demonstrated strong levels of assurance. Therefore, there is no requirement to undertake a significant review of the Trust's risk management strategy and processes.

However, the Trust continues to strive to adopt a culture of continuous improvement and following informal feedback from recent CQC well-led interviews, an opportunity has been taken to reflect on how the Trust's corporate risk register is utilised at a Board and Board Committee level. To provide enhanced visibility of these risks, an update to the strategy suggests that the risks on the corporate register are presented quarterly to both the Board and its Committees alongside the BAF (highlighted in section 2.6). This will not be the register in its entirety but rather a list of the risks and a demonstration of how they impact the Trust's strategic goals.

Recommendation

The Board is asked to approve the proposed Risk Management Strategy for 2023/24.

Risk Management Strategy

Liverpool Women's NHS Foundation Trust

Version 16.0
April 2023

Contents (to be re numbered once main body is finalised)

1 Foreword: Trust Risk Statement (statement to be reviewed and agreed by the Chief Executive) – minor amendments to wording

We are committed to delivering the highest quality services, which are safe and promote the wellbeing of service users, their relatives and carers, staff and stakeholders. We will ensure consistent risk management systems and processes are in place for continuous quality improvement and safer patient care. Managing risk is a key organisational responsibility and as such is seen as an integral part of the Trust's strong governance arrangements. The Trust is committed to implementing the principles of good governance, defined as:

The system by which the organisation is directed and controlled to achieve its objectives and meet the necessary standards of accountability, probity, and openness.

The Trust recognises that the principles of governance must be supported by an effective risk management system that is designed to deliver improvements in patient safety and care as well as the safety of its staff, patients and visitors. This strategy describes a consistent and integrated approach to the management of all risk across the Trust.

The principles of risk management apply to all staff and all areas of the Trust regardless of the type of risk. The Trust Board will ensure that risk management, quality and safety receive priority and the necessary resources within budgets, to achieve the Trust's strategic objectives. The Board recognises that the provision of healthcare and the activities associated with the treatment and care of patients, employment of staff, maintenance of premises and managing finances by their nature incur risks.

The Trust is committed to having a risk management culture that underpins and supports the business of the Trust. The Trust intends to demonstrate an ongoing commitment to improving the management of risk throughout the organisation. Where this is done well, this ensures the safety of our patients, visitors, and staff, and that as an organisation the board and management is not surprised by risks that could, and should, have been foreseen.

Strategic and business risks are not necessarily to be avoided, but, where relevant, can be embraced and explored in order to grow business and services, and take opportunities in relation to the risk. Considered risk taking is encouraged, together with experimentation and innovation within authorised limits. The priority is to reduce those risks that impact on patient safety, and reduce the Trust's financial, operational and reputational risks.

Kathryn Thomson
Chief Executive

2 Introduction

Risk management should be embedded in all the organisation's practices and processes in a way that it is relevant, effective and efficient. The risk management process should be part of, and not separate from, those organisational processes. In particular, risk management should be embedded into policy development, business and strategic planning and review, and the change management processes. Risk is an inherent part of the delivery of healthcare. The risk management strategy outlines the Trust's approach to risk management throughout the organisation.

Achievement of objectives is subject to uncertainty, which gives rise to threats and opportunities. Uncertainty of outcome is how risk is defined. Risk management includes identifying and assessing risks and responding to them. Risk is defined as the uncertainty in achieving an objective.

This board approved strategy for managing risk identifies accountability arrangements, resources available, and provides guidance on what may be regarded as acceptable risk within the organisation.

This strategy applies to all Trust staff, contractors and other third parties working in all areas of the Trust. Risk management is the responsibility of all staff and managers at all levels are expected to take an active lead to ensure that risk management is a fundamental part of their operational area.

The strategy is supported by a comprehensive 'risk assessment and process toolkit' and a programme of mandatory training, underpinning the fundamentals of the patient safety agenda 2019 and NHS England / Improvement and Care Quality Commission ambitions

2.1 Individual and Delegated Responsibilities

Risk management is the responsibility of all staff. Ultimately all who work at the Trust have a responsibility for the delivery of high quality, safe care, although this may manifest itself in various day to day to activities conducted by members of staff. The following sections define the organisational expectations of roles or groups:

Chief Executive
The Chief Executive is the responsible officer for Liverpool Women's NHS Foundation Trust and is accountable for ensuring that the Trust can discharge its legal duty for all aspects of risk. As the 'accountable officer', the Chief Executive has overall responsibility for maintaining a sound system of internal control, as described in the annual governance statement. Operationally, the Chief Executive has designated responsibility for implementation of this strategy as outlined below.

Chief Finance Officer
The Chief Finance Officer has responsibility for financial governance and associated financial risk.

Chief Nurse
The Chief Nurse has joint authority for clinical governance and absolute delegated authority for quality improvement, risk management, and complaints, and is executive lead for safeguarding and infection control.

Chief Operating Officer
The Chief Operating Officer is executive lead for health and safety and emergency planning,

Associate Director of Governance and Quality
The Associate Director of Governance and Quality, working closely with the Chief Nurse and supported by key staff, will be responsible for systems and processes for risk management and for reporting risk performance to board sub-committees.

Trust Secretary
The Trust Secretary is responsible for maintaining the Board Assurance Framework.

Medical Director
The Medical Director has joint responsibility for clinical governance, and responsibility for audit and clinical effectiveness.

Executive Directors
Executive Directors have responsibility for the management of strategic and operational risks within individual portfolios. These responsibilities include the maintenance of the corporate risk register and the promotion of risk management to staff within their directorates.

Executive Directors have responsibility for monitoring their own systems to ensure they are robust, for accountability, critical challenge, and oversight of risk.

Divisional Managers

Divisional Managers are the accountable officer for their division and take the lead on risk management within the division as the triumvirate, setting the example through visible leadership of their staff. They do this by:

- Taking personal responsibility for managing risk.
- Sending a message to staff that they can be confident that escalated risks will be acted upon.
- Ensuring risks are reviewed regularly, updated and acted upon appropriately.
- Identifying and managing risks that cut across delivery areas.
- Discussing risks on a regular basis with staff and up the line to help improve knowledge about the risk faced; increasing the visibility of risk management and moving towards an action focussed approach.
- Communicating downwards what top risks are and doing so in plain language.
- Escalating risks from the front line.
- Linking risk to discussions on finance and stopping or slowing down non-priority areas or projects to reduce risk as well as stay within budget, demonstrating a real appetite for setting priorities.
- Ensuring staff are suitably trained in risk management.
- Monitoring mitigating actions and ensuring risk and action owners are clear about their roles and what they need to achieve.
- Ensuring that people feel supported when identifying and escalating risks, and fostering a fair and just culture, which encourages them to take responsibility in helping to manage them.
- Ensuring that risk management is included in appraisals and development plans where appropriate.

Clinical Directors, Heads of Nursing/ AHP and Head of Midwifery
Clinical Directors, Heads of Nursing/ AHP and Head of Midwifery play and active role in supporting the Divisional Manager within the division as the triumvirate and set the example through visible leadership of their staff. They do this by working in partnership with the Divisional Manager as detailed in their responsibilities that are outlined above.

Heads of Corporate Services
Heads of Corporate Services will undertake the same roles and responsibilities as those outlined above for the divisional triumvirate.

Patient Safety Specialists
Patient Safety Specialists are new roles identified within the Patient Safety Strategy, of which the Trust has 3 nominated specialists. They are the patient safety experts within the Organisation to provide leadership, visibility and expert support to patient safety work. They are expected to:

- Support the development of a patient safety culture and safety systems.

- Engage directly with the executive team.
- Lead, oversee or support patient safety improvement and ensure that systems thinking, human factors understanding and just culture principles are embedded in all patient safety processes.
- Promote patient safety thinking beyond things going wrong to why things routinely go right healthcare and the systems approach to patient safety.
- Implement the rollout out of the new Patient Safety Incident Response Framework expected from Autumn 2022.

Senior Managers (Corporate, Ward & Departmental Managers)

Senior Managers are expected to be aware of and adhere to risk management best practice to:

- Identify risks to the safety, effectiveness and quality of services, finance, delivery of objectives and reputation- drawing on the knowledge of front-line colleagues.
- Identify risk owners with the seniority to influence and be accountable should the risk materialise.
- Assess the rating of individual risks looking at the likelihood that they will happen, and the consequence if they do.
- Identify the actions needed to reduce the risk and assign action owners.
- Record risks on the risk register.
- Check frequently on action progress, especially for high severity risks.
- Apply healthy critical challenge, without blaming others for identifying and highlighting risks, or consider that they are being unduly negative in doing so.
- Implement a process to escalate the most severe risks and use it.

Head of Risk and Safety

The Head of Risk and Safety will be responsible for ensuring that the systems and processes for risk management are monitored and maintained for their effectiveness. They:

- Will lead on effective operational risk management across the Trust as the Governance Lead reporting to the Associate Director of Governance and Quality
- Have oversight of all risk within the Trust
- Triangulates all trust risks through quarterly Integrated Governance Reports to Quality Committee
- Ensure risk is being managed proactively and effectively, ensuring escalation or de-escalation where required.
- Ensure the Ulysses Risk Management system is being fully utilised effectively
- Ensure risk and risk actions are regularly reviewed within required timescales
- Report to the Corporate Risk Sub Committee regarding new risks, closed risk assurance and the effectiveness of risk management across the Trust bi-monthly.
- Plan and undertake provisional underpinning work for the new Patient Safety Incident Response Framework and identify key performance indicators, once operational, for the forthcoming 12-month period.

All Staff

All staff are encouraged to use risk management processes as a mechanism to highlight areas they believe need to be improved. Where staff feel that raising issues may compromise them or may not be effective, they should be aware and encouraged to follow guidance on whistle blowing and raising concerns.

Staff side representatives also have a role in risk management including providing support and guidance to staff undertaking risk assessments where appropriate and providing advice in the event of a dispute to the validity of a risk assessment.

Delegated Responsibilities

Risk Area	Officer Responsible for co-ordination and advice	Responsible for Identification of risks	Responsible for analysis	Responsible for control (where there is a delegated Sub - Committee)
Incident Reporting & Analysis, Risk Registers.	Head of Risk and Safety and divisional Governance Managers	Individual Services Divisional Governance Managers Risk & Patient Safety Manager	All departments Divisional Governance Managers Risk and Patient Safety Manager	Corporate Risk Sub Committee Safety and Effectiveness Sub Committee
Board Assurance Framework (BAF)	Trust Secretary	Trust Board Trust Secretary	Trust Executive	Corporate Risk Sub Committee
Clinical and Non-Clinical Claims	Legal Services	Legal Services	Legal Services	Safety and Effectiveness Sub Committee
Complaints	Deputy Head of Patient Experience	Individual Services Divisional Governance Managers Complaints Officers	All departments Divisional Governance Managers Patient Experience Team	Patient Involvement and Experience Sub Committee
Serious Incident Investigations	Head of Risk and Safety and Divisional Governance Managers	Individual Services Divisional Governance Managers	All departments Divisional Governance Managers Risk and Patient Safety Manager	Safety and Effectiveness Sub - Committee
Building, land, plant, non-medical equipment – all estates	Deputy Director of Estates and Facilities	Individual services. Patient Facilities Manager Deputy Director of Estates and Facilities	Patient Facilities Manager Deputy Director of Estates and Facilities	Performance and Assurance Group
Catering and Food Hygiene	Deputy Director of Estates and Facilities	Individual services. Patient Facilities Manager Deputy Director of Estates and Facilities	Patient Facilities Manager Deputy Director of Estates and Facilities	Performance and Assurance Group
Emergency Preparedness, Resilience and Response EPRR	EPRR Lead Chief Operating Officer	Individual services EPRR Lead Chief Operating Officer	EPRR Lead Chief Operating Officer	Emergency Preparedness, Resilience and Response Committee
Fire Safety	Fire Safety	Individual	Fire Safety	Health and Safety

	Officer	Services Fire Safety Officer Chief Operating Officer	Officer Chief Operating Officer	Group
Health and Safety	Health and Safety Manager	Individual Services Health and Safety Manager	Health and Safety Manager Chief Operating Officer	Health and Safety Group
Human Resources	Deputy Director of HR	Deputy Director of HR	Deputy Director of HR	Putting People first Committee
Infection Prevention and Control	Director of Infection Prevention and Control	Infection Prevention and Control Team	Infection Prevention and Control Team	Infection Prevention and Control Committee
Digital Services / Information Governance	Head of Information Governance	Head of Information Governance	Head of Information Governance	Information Governance Committee
Medical Devices	Head of Risk and Safety and Medical Director	Risk and Patient Safety Manager	Risk and Patient Safety Manager	Safety and Effectiveness Sub Committee
Medicines Management	Deputy Chief Pharmacist	Deputy Chief Pharmacist	Deputy Chief Pharmacist	Medicines Management Group
Security	Local Security Management Specialist	Local Security Management Specialist	Local Security Management Specialist	Health and Safety Group
Audit and counter Fraud	Deputy Director of Finance	Deputy Director of Finance	Deputy Director of Finance	Audit Committee

2.2 The Core Elements of the Strategy

Risk Management Process

The Trust's risk management process ensures that risks are identified, assessed, controlled, and when necessary, escalated. These main stages are carried out through:

- Clarifying objectives
- Identifying risks to the objectives
- Defining and recording risks
- Completion of risk registers and identifying actions
- Escalation and de-escalation of risks

The identification of risk is the essential element of any risk management strategy or process. There needs to be a fully identified and supported approach to this element of risk management which includes formal risk assessment generated for incidents, claims, complaints etc. the identification of any new risks as part of normal business of meetings from papers or concerns raised is beneficial. The use of horizon scanning which is in built into the agendas of a number of committees, sub-committees and groups within the Trust provides a solid foundation in supporting robust discussions within the meeting and the identification of new risk on the horizon. This key element needs to be developed and embedded further within the divisional boards and sub groups to ensure there is a Trust wide approach to identifying risks on the horizon.

Governance Structure to Support Risk Management

There are different operational levels ensuring the governance of risk in the Trust:

- Board of Directors
- Executive Management Team

Divisional Governance Management is supported by divisional governance managers, who work as part of the senior management team within each division.

Risk management by the Board is underpinned by a number of interlocking systems of control. The Board reviews risk principally through the following three related mechanisms:

1. **The Board Assurance Framework (BAF)** sets out the strategic objectives, identifies key strategic threats in relation to each strategic objective along with the controls in place and assurances available on their operation. The BAF is cross-referenced with and contains all risks within the Corporate Risk Register. The BAF can be used to drive the board agenda.

2. **The Corporate Risk Register (CRR)** is the corporate high level operational risk register used as a tool for managing risks and monitoring actions and plans against them. Used correctly it demonstrates that an effective risk management approach is in operation within the Trust.
3. **Divisional and Local risk registers** are for recording and managing risks to the routine daily activities of each service. Local risks are discussed at team meetings, risks that cannot be managed at the local level may be escalated to the CRR

Additionally, the annual governance statement is signed by the Chief Executive. It sets out the organisational approach to internal control. This is produced at the year-end (following regular reviews of the internal control environment during the year) and scrutinised as part of the annual accounts process and brought to the board with the accounts.

2.3 Aim

The aim of this strategy is to set out the Trust's vision for managing risk. Through the management of risk, the Trust seeks to minimise, though not necessarily eliminate, threats and maximise opportunities.

i. The key objectives of risk management at the Trust are to:
   - Reduce the level of exposure to harm for patients, colleagues, or visitors by proactively identifying and managing personal risk to a level as low as reasonably practicable.
   - Promote success and protect everything of value to the Trust, such as high standards of patient care, safe working environment, the Trust's safety record, reputation, community relations, equipment or sources of income.
   - Continuously improve performance by proactively adapting to mitigate risk as much as possible and remaining resilient to changing circumstances or events.

ii. The Trust will establish an effective risk management system which ensures that:
   - All risks are identified that have a potential adverse effect on quality of care, safety and wellbeing of people, and on the business, performance and reputation of the Trust
   - Priorities are determined, continuously reviewed and managed through objectives that are owned and understood by all staff.
   - Risks to the achievement of objectives are anticipated and proactively identified.
   - Controls are put in place, effective in their design and application to mitigate the risk and

understood by those expected to use them.
- The operation of controls is monitored by management.
- Gaps in control are rectified by management in the most appropriate manner determined.
- Management is held to account for the effective operation of controls.
- Risks that exceed timescales for completion are proactively reviewed and escalated to the appropriate management for action.
- Assurances are reviewed and acted on.
- Staff continuously learn and adapt to improve safety, quality, and performance.
- Risk management systems and processes are embedded locally across operational divisions and in corporate services including business planning, service development, financial planning, project and programme management and education.

2.4 Risk Appetite and Statement

Risk Appetite

The resources available for managing risk are finite and so the aim is to achieve an optimum response to risk, prioritised in accordance with an evaluation of the risks. Risk is unavoidable, and every organisation needs to take action to manage risk in a way that it can justify to a level which is tolerable. The amount of risk that is judged to be tolerable and justifiable is the "risk appetite". (Appendix D provides a guidance template on setting the Trust risk appetite).

Risk appetite is therefore 'the amount of risk that an organisation is prepared to accept, tolerate, or be exposed to at any point in time.' *(Definition from HMT Orange Book, 2005).* It can be influenced by personal experience, political factors and external events.

Risks need to be considered in terms of both opportunities and threats and are not usually confined to money - they will invariably also impact on the capability of our organisation, its performance, and its reputation.

We need to know about risk appetite because: If we don't know what our organisation's collective appetite for risk is and the reasons for it, then this may lead to erratic or inopportune risk-taking exposing the organisation to a risk it cannot tolerate; or an overly cautious approach which may stifle growth and development. If our leaders do not know the levels of risk that are legitimate for them to take, or do not take important opportunities when they arise, then service improvements may be compromised, and patient outcomes affected.

The Trust will periodically review its appetite for and attitude to risk, updating these where appropriate. This includes the setting of risk tolerances at the different levels of the organisation, thresholds for escalation and authority to act, and evaluating the organisational capacity to handle risk. The periodic review and arising actions will be informed by an assessment of risk maturity, which in turn enables the board to determine the organisational capacity to control risk. The review will consider:

- Risk leadership.
- People.
- Risk policy and strategy.
- Partnerships.
- Risk management process.
- Risk handling.
- Outcomes.

Risk Appetite Statement

The risk appetite of the Trust is the decision on the appropriate exposure to risk it will accept to deliver its strategy over a given time frame. In practice, an organisation's risk appetite should address several dimensions:

- The nature of the risks to be assumed.
- The amount of risk to be taken on.
- The desired balance of risk versus reward.

On an annual basis the Trust will publish its reviewed and current risk appetite statement as a separate document. The statement will define the board's appetite for each risk identified to the achievement of strategic objectives for the financial year in question.

Risks throughout the organisation should be managed within the Trust's risk appetite, or where this is exceeded, action taken to reduce the risk.

The Trust's risk appetite statement will be communicated to relevant staff involved in the management of risk and published publicly.

2.5 Responsibility and Accountability

Liverpool Women's Hospital will ensure that there is accountability, authority, and appropriate competence for managing risk, including implementing the risk management process and ensuring the adequacy, effectiveness and efficiency of any controls. This will be facilitated by:

- Identifying risk owners that have the accountability and authority to manage risks.
- Identifying who is accountable for the development, implementation, and maintenance of the framework for managing risk.
- Identifying other responsibilities of people at all levels in the organisation for the risk management process.
- Establishing performance measurement and external/internal reporting and escalation processes; and
- Ensuring appropriate levels of recognition.

To enable all staff to fulfil their respective roles and responsibilities the Trust Governance Team will provide support, guidance, and training in risk management.

2.6 Committee Duties and Responsibilities

The Board sub-committees are responsible for assuring that the risks are being managed appropriately by considering the gaps, mitigation and Trust tolerance levels, and for assuring the Board where appropriate or raising any concerns to other relevant sub-committee, additionally each board sub-committee should review the board assurance framework at each of its respective meetings and the corporate risk on a quarterly basis.

Board of Directors

The Board is responsible for ensuring that the Trust has effective systems for identifying and managing all risks whether clinical, financial, or organisational. The risk management structure helps deliver the responsibility for implementing risk management systems throughout the Trust.

The responsibility for monitoring the management of risk across the organisation has been delegated by the board to the following inter-relating committees:

- Audit Committee
- Finance, Performance and Business Development Committee
- Quality Committee
- Putting People First Committee

The Board reviews the board assurance framework at each of its respective meetings and the corporate risk on a quarterly basis.

Specific responsibilities for the management of risk and assurance on its effectiveness are delegated as follows:

Audit Committee

The Audit Committee is responsible for providing assurance to the Trust board on the process for the Trust's system of internal control by means of independent and objective review of corporate governance and risk management arrangements, including compliance with laws, guidance, and regulations governing the NHS. In addition, it has the following responsibilities relating to risk:

> *To maintain an oversight of the Trust's general risk management structures, processes and responsibilities, including the production and issue of any risk and control related disclosure statements.*

Finance, Performance and Business Development Committee

This Committee is responsible for providing information and making recommendations to the Trust board on financial and operational performance issues, and for providing assurance that these are being managed safely. The committee will consider any relevant risks within the Board Assurance Framework and Trust corporate risk register as they relate to the remit of the committee, as part of the reporting requirements, and to report any areas of significant concern to the Corporate Risk Committee or the board as appropriate.

Quality Committee

The Committee is responsible for providing the Trust board with assurance on all aspects of quality of clinical care; governance systems including risks for clinical, information and research and development issues; and regulatory standards of quality and safety. The committee will consider any relevant risks within the Board Assurance Framework and corporate risk register as they relate to the remit of the committee, as part of the reporting requirements, and to report any areas of significant concern to the Corporate Risk Committee or the board as appropriate.

The Committee is provided with a quarterly integrated governance report which demonstrates how the systematic triangulation and analysis of aggregated data can be used to minimise the risk of a recurrence and underpin the trust's commitment to improving safety by learning and sharing lessons. Root cause analysis can be used on aggregated incidents, complaints, PALS information and claims to analyse the trends and identify changes in practice.

Putting People First Committee

The Committee is responsible for providing the Trust board with assurance on all aspects of governance systems and risks related to the workforce, and regulatory standards for human resources. The committee will consider any relevant risks within the Board Assurance Framework and corporate risk register as they relate to the remit of the committee, as part of the reporting requirements, and to report any areas of significant concern to the Corporate Risk Committee or the board as appropriate.

Trust Executive Team

The Trust executive team is responsible for the operational management and monitoring of risk, through the corporate risk register and Board Assurance Framework, and for agreeing resourced treatment plans and ensuring delivery.

2.7 Clinical Services and Corporate Risk Management Arrangements

All service areas will put the necessary arrangements in place within their areas for good governance, safety,

quality, and risk management.

Clinical services have the responsibility, through Divisional Managers as the accountable person, for the risks to their services and for the putting in place of appropriate arrangements for the identification and management of risks. Services will develop, populate and review their risks, drawing on risk processes to ensure risk registers are kept up to date through regular review.

In doing this, due account will be taken of the Trust's strategic and corporate objectives, particularly in terms of meeting regulatory standards and guidance, national performance standards and targets and relevant legislation, and of the issues and risks relevant to specific areas within the particular services

Operational Board meetings will review risk registers and contribute to the development of the risk registers and ensure that they are in place and operating within the defined tolerances and escalation processes.

Corporate Risk Sub Committee

The Sub Committee consists of a quorate of new members and functions to ensure effective oversight and scrutiny of the entire business of the Trust, the relationship between the Corporate Risk Sub Committee, and the other Board Sub- Committees, is based on inclusiveness, clarity of purpose and constructive challenge. The Corporate Risk Sub Committee will oversee the management of all corporate risks, reviewing closed assurance and new risk reports and will provide the Audit Committee with assurance on the effective operation of internal controls. The Trust's divisions (Corporate, Family Health, Clinical Support Services and Gynaecology) report to the Committee bi-annually.

3 Process for Managing Risk

Stage 1 – Clarifying Objectives

Whether a new risk has been identified or staff need to know what to do next; clarifying objectives is a critical stage of the risk management process. To understand whether something constitutes a risk it must first be understood what the objectives/outcomes are to be achieved.

Strategic or corporate objectives; to identify and clarify which Trust strategic or corporate objective is relevant to the division, directorate, or service. Look at the Trust business plan and the latest local business plan. If this step is missed or omitted, then the risk register will be neither relevant nor effective.

Local objectives should also be considered. By clarifying the objectives, it can be identified whether there is a risk to manage.

Stage 2 – Identifying Risks to Objectives

Once the objectives have been identified then risks can start to be identified. Consider the following questions:

- Do you know what all of the risks to the delivery of your objectives or work are, especially those that impact on delivering high quality, safe services?
- What could happen, and what could go wrong?
- How and why could this happen?
- What is depended upon for continued success?
- Is there anyone else who might provide a different perspective on your risks?
- Is it an operational risk or a risk to a strategic objective?

If possible, gather those staff together who are able to assist with the identification of risk for the area. Guidance on how to do this is available from the Governance Team (Section 6).

Stage 3 – Defining and Recording Risks

Once the risk has been identified then:

- Undertake a comprehensive risk assessment
    - Describe the risk, so that others understand what the risk is in relation to the description of condition, cause and consequence, being clear for each one.
    - Complete an initial risk assessment score so that the risk is appropriately escalated to management where required
    - Assign an owner to the risk who will oversee the risk management and review the initial score
    - List the key controls (actions) being taken to reduce the likelihood of the risk happening or reduce the impact.
    - If it is a severe risk (use risk matrix Appendix A) then consider what the contingency action plan is, i.e., what will you do should the risk happen.
    - Rate the likelihood of the risk materialising.
    - Rate the consequence of the risk happening.

All of these things should be recorded which will allow the risk to be recorded on and appropriate risk register(s) following risk assessment, if the risk assessment process has not enabled the risk to be eliminated or managed. The following sections describe in detail how to complete the risk register.

Stage 4 – Risk Register(s)

All service areas are to maintain a local risk register. This register contains operational and strategic risks that are routinely managed within the service, and for which the service has the required resources, controls and mitigation within the parameters of risk set by the risk appetite.

The Corporate Risk Register is a collection of risks that directly impact on to the delivery of the corporate aims. This register is populated by a variety of sources, i.e., risks that cannot be controlled or mitigated in the service area, external audit reports, and principal risks from the board assurance framework.

Traditionally, completing a risk register can be daunting but the aim is to have a simplified process to allow the monitoring of actions and aid decision-making, electronically.

Headings in the register(s) that need to be completed are:

1. The risk identification (ID) is the unique identifier to distinguish the risk from the other risks in your register. The ID will not change throughout the life of the risk.

The risk owner is the individual who is accountable and has overall responsibility for a risk; it may or may not be the same person as the action owner. High severity corporate risks, for example, will be owned by one Executive Director, but there may be many action owners. The risk owner must know, or be informed that they are the owner, and accept this.

2. Source of, how or where the risk was identified. This could include:
    - Business planning.
    - Clinical audit.
    - Complaints/PALS.
    - External audit.
    - External review.
    - Incident.
    - Internal audit.
    - Legislation.
    - Litigation.
    - National risks such as financial fraud

- NICE guidance.
- Regulatory standard.
- Risk Assessment.

3. Risk description as the name suggests, allows the risk to be described. It is important that risks are clearly articulated. If not, then it is difficult to put effective controls, or actions, in place to reduce the risk materialising and contingency plans. Using the following subheadings will help to clearly describe risk:
   - Condition
   - Cause
   - Consequence

For example:
Condition: Inability to release clinical staff for mandatory training due to staffing levels.
Cause: Results in staff not receiving compulsory training in resuscitation or blood safety.
Consequence: Leading to an increased safety risk to patients.

Getting this right is important as the key controls relate directly to the description of the risk. Key controls are the measures put in place as preventative measures to lessen or reduce the likelihood or consequence of the risk happening and/or the severity if it does. You must ensure that each control (or action where a gap in control has been identified) has an owner and target completion date.

These must describe the practical steps that need to be taken to manage and control the risk. Without this stage, risk management is no more than a paper based or bureaucratic process.

Not all risks can be dealt with in the same way. The 5T's provide an easy list of options available to anyone considering how to manage risk:

- **Tolerate** – the likelihood and consequence of a particular risk happening is accepted.
- **Treat** – work carried out to reduce the likelihood or consequence of the risk (this is the most common action).
- **Transfer** – shifting the responsibility or burden for loss to another party, e.g. the risk is insured against or subcontracted to another party.
- **Terminate** – an informed decision not to become involved in a risk situation, e.g. terminate the activity.
- **Take the opportunity** – actively taking advantage, regarding the uncertainty as an opportunity to benefit.

In most cases the chosen option will be to treat the risk. When considering the action to take remember to consider the cost associated with managing the risk, as this may have a bearing on the decision. The key questions in this instance are:

- Action taken to manage risk may have an associated cost. Make sure the cost is proportionate to the risk it is controlling.
- When agreeing responses or actions to control risk, remember to consider whether the actions themselves introduce new risks or affect other people in ways which they need to be informed about.

Stage 5 – Escalation and De-escalation of Risks

The consequence of some risks, or the action needed to mitigate them, can be such that it is necessary to escalate the risk to a higher management level, for example from a service risk to Division and up to the corporate risk register reviewed by the Corporate Risk Committee, Board Sub-Committee, and finally the Board.

Risk will be escalated or de-escalated within the defined tolerances and authority to act for each level.

For example: a service risk scoring high or extreme should only be escalated to the corporate risk register if it is **not** manageable within the service. If the risk **is** manageable within the service, then it remains on the service risk register. In a case whereby the risk is to be escalated to the corporate risk register, options for controls or mitigation must be offered. The risk owner should discuss and seek approval from their manager before risk escalation to the next level. Once an escalated risk has reached the Corporate Risk Register, the Corporate Risk Committee will consider the risk control options advised and make recommendations for action, the risk will then be de- escalated and returned to the risk owner for implementation. Where a risk is de-escalated this must be communicated to the management level below, and the risk monitored at the appropriate management level and risk forum.

It is important that risks are reviewed regularly to ensure appropriate action, including closing risks or action plans where necessary.

Stage 6 - Closure of Risk

Risk registers need to be current and up to date. It is therefore essential that risks are continually monitored and fully reviewed at least annually. They should be closed under the following circumstances:

- The Risk has materialised.
- The Risk has reached its target score and has remained stable for an acceptable period (following Senior Members authorisation)

All closed risks will be archived and not deleted

3.1 Risk Profile

A summary risk profile is a simple visual mechanism that can be used in reporting to increase the visibility of risks; it is a graphical representation of information normally found on an existing risk register. A risk profile shows all key risks as one picture, so that managers can gain an overall impression of the total exposure to risk.

3.2 Horizon Scanning

Horizon scanning is about identifying, evaluating, and managing changes in the risk environment, preferably before they manifest as a risk or become a threat to the business. Additionally, horizon scanning can identify positive areas for the Trust to develop its business and services, taking opportunities where these arise. The Trust will work collaboratively with partner organisations and statutory bodies to horizon scan and be attentive and responsive to change.

By implementing formal mechanisms to horizon scanning the Trust will be better able to respond to changes or emerging issues in a planned structured and co-ordinated way. Issues identified through horizon scanning should link into and inform the business planning process. As an approach it should consider ongoing risks to services.

The outputs from horizon scanning should be reviewed and used in the development of the Trust's strategic priorities, policy objectives and development. The scope of horizon scanning covers, but is not limited to:

- Legislation.
- Government white papers.
- Government consultations.
- Socio-economic trends.
- Trends in public attitude towards health.
- International developments.
- NHS England publications.
- Local demographics.
- Seeking stakeholders' views.

- Risk assessments.

All staff have the responsibility to bring to the attention of their managers potential issues identified in their areas which may impact on the Trust delivering on its objectives.

Board members have the responsibility to horizon scan and formerly communicate matters in the appropriate forum relating to their areas of accountability.

4 Proactive Risk Processes

Training

Knowledge of how to manage risk is essential to the successful embedding and maintenance of effective risk management.

Training required to fulfil this strategy will be provided in accordance with the Trust's training needs analysis.

All new staff undertake risk management training as part of their Corporate Induction. Training is mandated for all other staff on an annual basis. Compliance of this mandated training will be monitored by the Head of Risk and Safety monthly. Where compliance falls below 90% at any one time, the Head of Risk and safety will escalate to Divisional / Senior Managers to address compliance issues and will report into Corporate risk Sub – Committee if compliance issues remain.

Management and monitoring of training will be in accordance with the Trust's statutory and mandatory training policy.

Specific training will be provided for the board, in respect of high-level awareness of risk management. Risk awareness sessions are included as part of the board's development programme.

Strategies, policies and procedures

There are a range of policies that support the management of risk in the Trust. These are available on the Trust's intranet site. Policies that link closely to the risk management strategy are detailed under Associated Documents at section 1.0 of this risk management strategy & policy.

Resilience Management

The Trust has in place a comprehensive Major Incident Plan, as well as a range of plans and other associated documents that are designed to ensure the resilience of the Trust in a range of scenarios that would limit the operating capacity of the organisation. These plans are tested in line with the requirements of the Civil Contingencies Act and learning from these tests is communicated back into relevant groups to ensure the processes are refined.

Implementation of clinical guidance

The Trust has mechanisms in place to implement the latest guidance and recommendations – these processes are covered by the Management of National Clinical Guidelines policy.

Standards and Accreditation

The Trust ensures that it meets (and aims to exceed) a range of standards and accreditations. Many of these are covered by the Management of external agency visits, inspections and accreditations policy.

Audit Activity (clinical, internal and external)

There is extensive audit activity within the Trust covering a range of issues. Findings from these reviews are fed back to appropriate members of staff, and reports made to the clinical and research effectiveness committee and the Board of Director's assurance committees

5 Reactive Risk Processes

Learning and potential risks are identified from adverse events or complaints and concerns reported by patients and / or their carers to the Trust. The following can be considered as reactive Risk Processes;

.

Incidents

The Trust has a system for reporting adverse incidents, including serious incidents, set out in the Incident Reporting and Investigation Policy. All notified incidents are graded using a simple risk assessment matrix, consistent with that used for risk assessment.

Complaints

The Trust has a well-established complaints process, set out within the Complaints Policy which ensures that all concerns are responded to within the approved timescales. All serious complaints are the subject of a full root cause analysis. Information and action plans arising from complaints are used to develop or change the service delivery.

Claims & litigation

The Quality and Standards team works closely with the divisions to enable the early identification of potential legal claims against the Trust as set out in the Claims Policy.

Inquests

The Quality and Standards teamwork with Trust clinicians and HM Coroner to ensure the best outcomes for families and the Trust from the inquest process, as set out in the Inquest Policy. Any concerns or recommendations raised by the coroner are communicated appropriately to ensure that remedial action is taken.

Debriefing/Post Event Analysis

Potential risks and learning are identified following all reactive risk management activities as an integral part of these processes. Appropriate management action put in place to reduce or eliminate the possibility of a similar occurrence.

Root cause analysis

Training has been provided by the Trust and will be revised as part of the Patient Safety Incident Response Framework (PSIRF) implantation programme in 23/24.

6 Evidence Base

- Home Office Risk Management Policy and Guidance, Home Office (2011).
- A Risk Matrix for Risk Managers, National Patient Safety Agency (2008).
- NHS Audit Committee Handbook, Department of Health (2011).
- UK Corporate Governance Code, Financial Reporting Council (2010).

- ‘Taking it on Trust: A Review of How Boards of NHS Trusts and Foundation Trusts Get Their Assurance’, Audit Commission (2009).
- The Orange Book (Management of Risk – Principles and Concepts), HM Treasury (2004).
- Risk Management Assessment Framework, HM Treasury (2009).
- Understanding and Articulating Risk Appetite, KPMG (2008).
- Risk Appetite Frameworks- how to spot the genuine article, Deloitte (2013).
- Defining Risk Appetite and Managing Risk by Clinical Commissioning Groups and NHS Trusts, Good Governance Institute (2012).
- Good Practice Guide: Managing Risks in Government, National Audit Office (2011).
- Risk Management – principles and guidelines ISO 31000 (2009).
- Patient Safety Strategy (2020)

7 Risk Management Approach

Fair Blame

The Trust operates a ‘fair blame’ culture. An open & honest approach to reporting incidents and concerns is encouraged The Trust promotes a ‘fair blame’ culture. An open and honest approach to reporting in accordance with the principles of ‘An Organisation with a Memory’ and in accordance with the Incident reporting and investigation policy. It is recognised that whilst it is easy to promote a culture of learning and closing the loop with regard to risk management, the effect on staff directly involved in an incident or enquiry should not be underestimated, and support is provided in line with the. Supporting Staff involved in a complaint, claim or incident policy. Exceptional cases will arise where there is clear evidence of wilful or gross neglect contravening the Trust’s policies and procedures and/or Professional Codes of

Conduct, or where there is repeated evidence of poor performance despite intervention/support. These will be dealt with on an individual basis in accordance with Human Resources policies.

Duty of Candour

'Duty of candour' supports a culture of openness, honesty, and transparency and includes apologising and explaining what happened. Being open with patients often defuses the situation and allows open communication and learning to avoid recurrence. Patients and/or carers should receive an apology as soon as possible, within 10working days, after a patient safety incident has occurred. Staff should feel able to apologise on the spot; saying sorry is not an admission of liability and it is the right thing to do. This culture is promoted throughout the Trust in line with the Duty of Candour Policy

Reporting Concerns

All employees must ensure they are familiar with the Raising Concerns at Work Policy for raising concerns of matters relating to fitness to practice for reasons of conduct, health or competence.

8 Monitoring, Compliance and Audit

The Trust risk team, led by the Associate Director of Governance and Quality oversee all risks recorded on the Ulysses risk management system. The team review all new, closed, and outstanding risks and quality assures every risk assessment whether ongoing or completed. The team re-open closed risks, if necessary, where it is deemed appropriate action has not been taken and audit risks exceeding timescales, escalating to the appropriate management level where necessary,

We have performed well in audits undertaken by our internal auditor Mersey Internal Audit Agency (MIAA). In 2022/23, we received substantial assurance for an audit in relation to Risk Management.

To enhance what we have already achieved, by the end of 2023 – 2024 the Trust will have:

- Reviewed and consulted with staff about the effectiveness of communication systems to ensure that both reactive and proactive messages about safety reach all areas of the Trust
- Reviewed and enhanced practice to ensure that all risks are underpinned by a risk assessment that has been approved at departmental level
- Undertaken an audit of risk assessments and risks on the Trust's risk register for each area and department, providing feedback to the relevant areas ensuring any improvements are made accordingly.
- Reviewed the feedback from training in human factors and agreed the approach needed for the future
- Reviewed the outcomes of Executive quality and safety walk rounds, including seeking feedback from staff
- Started to embed our Patient Safety Incident Response Framework (PSIRF), evaluating, and enhancing the current system for reviewing and learning from Serious Incidents, repeat causality and effective action planning to learn from investigations
- Introduced an automated process for the approval of documents such as policies and procedures
- Ensured Divisional board agendas have a case study / patient story each quarter
- Mature systems of communication of safety and risk issues, both reactive and proactive, across the organisation
- Developed a system for proactive sharing of risk with partner organisations across the patient's pathway
- Human factors methodology firmly embedded in Trust systems and processes
- Undertaken a survey about the safety culture within the trust to identify and commenced any targeted improvement initiatives based on the findings of the survey.

Key measurables for 2024 – 2025 will be set following the annual review of the above any reported into Quality Committee in April 2024

The Trust Risk Team, which includes the divisional governance managers, are always for available for operational advice / support when required and are contactable as follows:

Name	Role	Extension
Phil Bartley	Associate Director of Governance and Quality	1383
Allan Hawksey	Heads of Risk and Safety	4437
Hayley Roberts	Quality, Safety and Governance Facilitator	4292
VACANT	Governance support officer	4292
Jenny Lamble	Governance support officer	4489
Paula Best	Divisional Governance Manager (maternity)	4433

Natalie Scott	Divisional Governance Manager (Gynaecology / Hewitt Centre)	1048
Virginia Wallace	Divisional Governance Manager (Neonatal)	1015
Ashleigh Gibbons	Divisional Governance Manager (Clinical Support Services)	4421

9 Dissemination, Implementation and Access to the Document

This strategy is available on the Trust intranet and has been widely circulated to executive colleagues, service managers and matrons and members of the Quality Committee, its sub committees. Any feedback from these committees will be considered to inform future versions of this strategy. All staff will be notified via the communications team of the strategy and other amendments. This Policy will be discussed at Quality Committee in April 2023 for consideration of submission to Trust Board in May 2023 for approval.

10 Key Performance Indicators

Describe Key Performance Indicators (KPIs)	Target	How will the KPI be Monitored?	Which Committee will Monitor this KPI?	Frequency of Review	Lead
All verified BAF strategic threats are reported to the Board of Directors at each formal meeting of the Board.	100%	The following mechanisms will be used to monitor compliance with the requirements of this document: • Evidence of reporting verified significant risk exposures to the Board of Directors at each formal meeting. • Evidence of review of significant risk exposure by the Corporate Risk Sub Committee at each formal meeting. • Periodic internal audit of any or all aspects of the Risk Management process as determined by the Audit Committee (risk identification, assessment, control, monitoring and reviews).	Corporate Risk Sub Committee & Trust Board (when meetings are scheduled)	Bi-Monthly	Trust Secretary
All significant risks are reported to and reviewed as a standing agenda item at each formal meeting of the Corporate Risk Sub-Committee.	100%		Corporate Risk Sub Committee	Bi-Monthly	Associate Director of Governance and Quality (Exec Lead: Chief Nurse)
The risk profiles (for extreme risks not on the corporate risk register) for all divisions are reviewed by the Corporate Risk Sub Committee at a frequency determined by the Corporate Risk Committee as part of a rolling programme of reviews.	100%		Corporate Risk Sub Committee	Bi-Monthly	Associate Director of Governance and Quality (Exec Lead: Chief Nurse)
Local risk registers are in place, maintained and available for inspection.	100%		Corporate Risk Sub Committee	Bi-Monthly	Associate Director of Governance and Quality (Exec Lead: Chief Nurse)
Local risk registers show details of control, assurances, location, owner, action plan (where necessary) and all risks and risk actions are within review date, and none are overdue for review.	100%		Corporate Risk Sub Committee	Bi-Monthly	Associate Director of Governance and Quality (Exec Lead: Chief Nurse)

Annual review and approval of the Trust's Risk Appetite	100%		Quality Committee	Annual Report	Associate Director of Governance and Quality (Exec Lead: Chief Nurse)
Risk management training mandatory for all staff at corporate induction	100%		Quality Committee	Annual Report	Associate Director of Governance and Quality (Exec Lead: Chief Nurse)
Risk management training mandatory for all staff as part of their mandatory training	100%		Quality Committee	Annual Report	Associate Director of Governance and Quality (Exec Lead: Chief Nurse)
Staff compliance with the risk management standard operating procedure (SOP)	100%		Quality Committee	Annual Report	Associate Director of Governance and Quality (Exec Lead: Chief Nurse)

11 Appendices

Appendix A - Risk Descriptors and Grading

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 a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff 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

Risk scoring = consequence x likelihood (C x L)

	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

For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

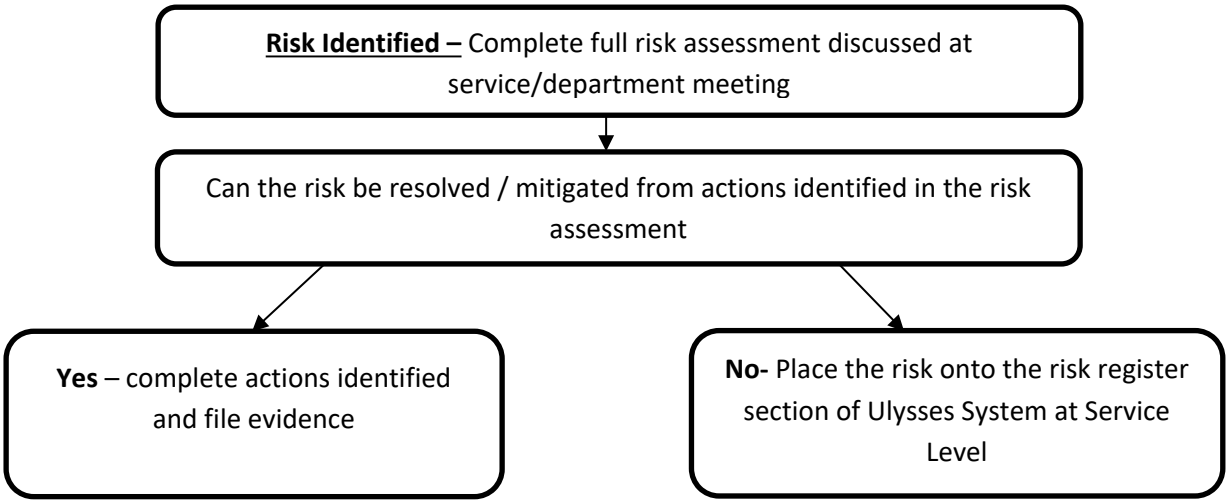
1 - 3	Low risk
4 - 6	Moderate risk
8 - 12	High risk
15 - 25	Extreme risk

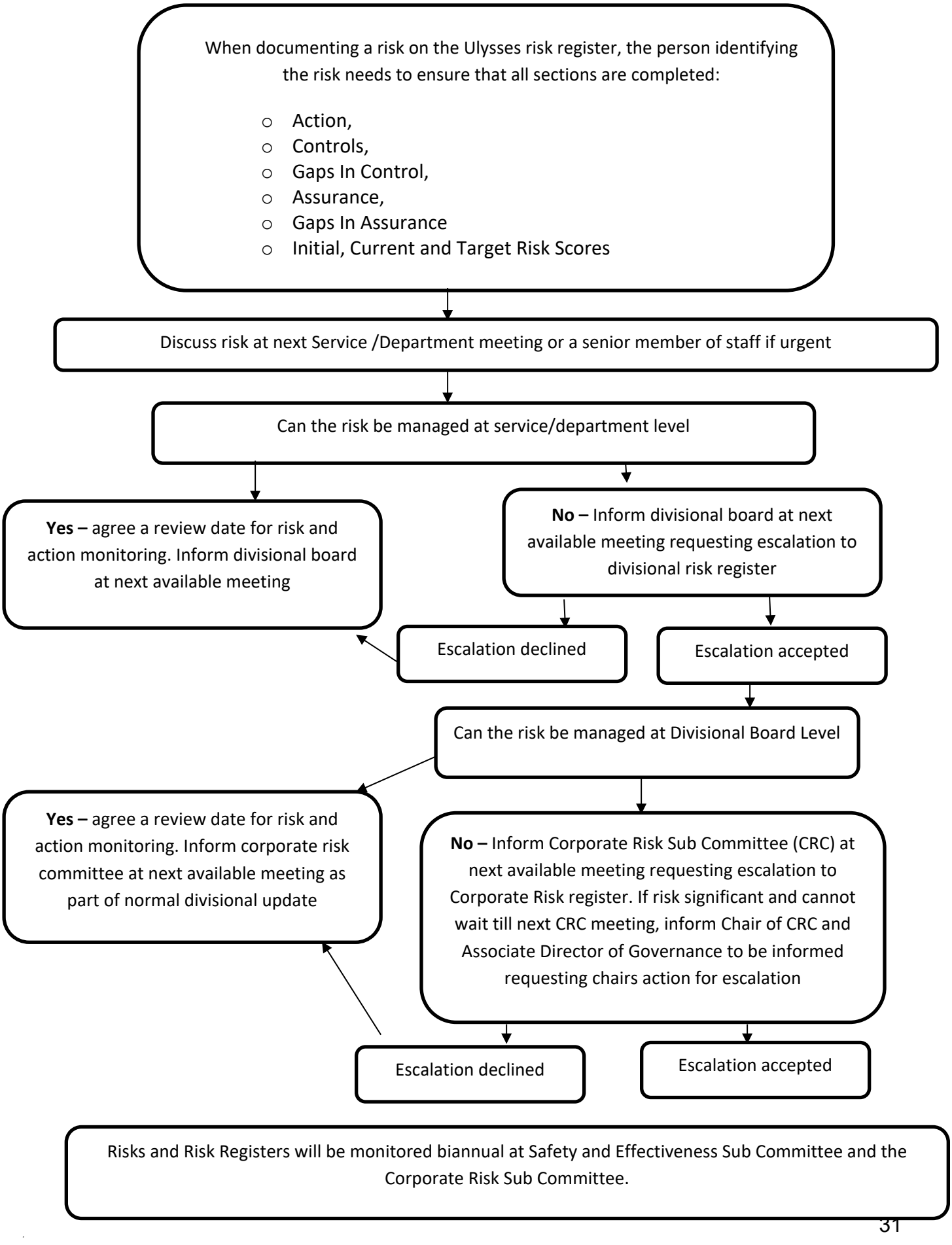
The risk matrix above can be used to provide an initial breakdown of the hazards into 4 Categories as follows:

Low Risk	Acceptable risk requiring no immediate action Review annually Place on the appropriate section of the Risk Register
Moderate Risk	Action planned within one month to reduce risk Commenced within 3 months Place on the appropriate section of the Risk Register
High Risk	Actions planned immediately Review Monthly Place on the appropriate section of the Risk Register
Extreme Risk	Immediate Actions required Reviewed weekly by ET Placed on the Corporate Risk Register

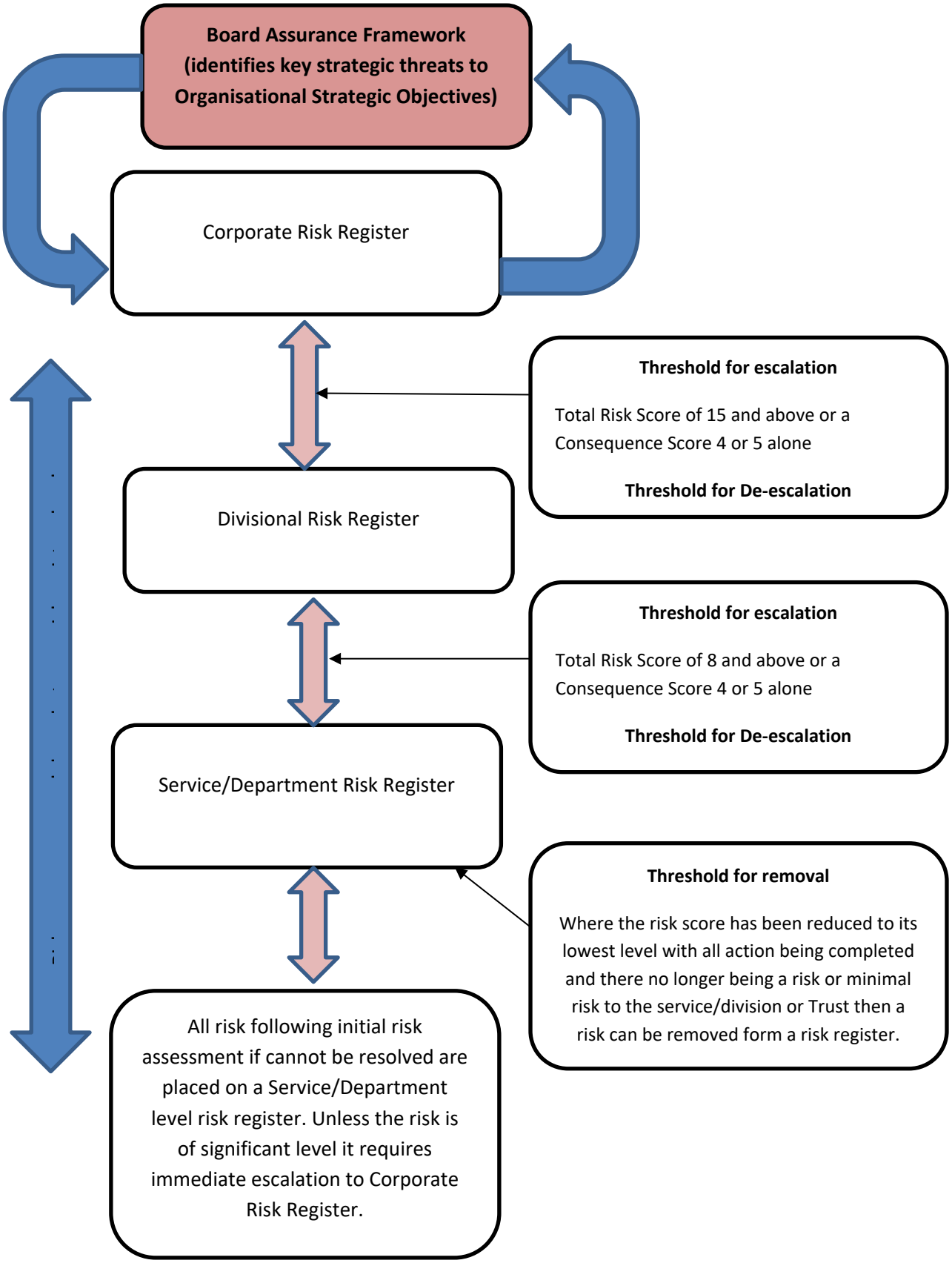
Appendix B – Risk Procedural Steps to Assessment

The following flow chart provides a visual representation of the process of managing risk registers




When documenting a risk on the Ulysses risk register, the person identifying the risk needs to ensure that all sections are completed:
Action,
Controls,
Gaps In Control,
Assurance,
Gaps In Assurance
Initial, Current and Target Risk Scores
Discuss risk at next Service /Department meeting or a senior member of staff if urgent
Can the risk be managed at service/department level
Yes – agree a review date for risk and action monitoring. Inform divisional board at next available meeting
No – Inform divisional board at next available meeting requesting escalation to divisional risk register
Escalation declined
Escalation accepted
Can the risk be managed at Divisional Board Level
Yes – agree a review date for risk and action monitoring. Inform corporate risk committee at next available meeting as part of normal divisional update
No – Inform Corporate Risk Sub Committee (CRC) at next available meeting requesting escalation to Corporate Risk register. If risk significant and cannot wait till next CRC meeting, inform Chair of CRC and Associate Director of Governance to be informed requesting chairs action for escalation
Escalation declined
Escalation accepted
Risks and Risk Registers will be monitored biannual at Safety and Effectiveness Sub Committee and the Corporate Risk Sub Committee.

Appendix C – Risk Procedural Steps to Escalation / De-escalation / Oversight



Appendix D - Initial Equality Impact Assessment

Name of policy/ business or strategic plans/CIP programme:	**Risk Management Strategy v 15**	
Does the proposal, service or document affect one group more or less favourable than another on the basis of:	**No**	**Justification/evidence and data source**
Age	No	No discrimination / inequality identified, the document sets out the Trust's approach and framework for Risk Management, ensuring this is systematic and objective and applied without prejudice or favour.
Disability: including learning disability, physical, sensory or mental impairment.	No	
Gender reassignment	No	
Marriage or civil partnership	No	
Pregnancy or maternity	No	
Race	No	
Religion or belief	No	
Sex	No	
Sexual orientation	No	
Human Rights – are there any issues which might affect a person's human rights?	**No**	**Justification/evidence and data source**
Right to life	No	No impact on human rights, the document sets out the Trust's approach and framework for Risk Management, ensuring this is systematic and objective and applied without prejudice or favour. The aim being to reduce risks to the organisation, its services and the safety and well-being of patients, visitors, staff and the wider public.
Right to freedom from degrading or humiliating treatment	No	
Right to privacy or family life	No	
Any other of the human rights?	No	

Assessment carried out by:

Date:

Signature and Job Title:

Appendix E – Glossary

Action	A response to control or mitigate risk.
Action Plan	A collection of actions that are specific, measurable, achievable, realistic and targeted.
Assessment	A review of evidence leading to the formulation of an opinion.
Assurance	Confidence based on sufficient evidence, that internal controls are in place, operating effectively and objectives are being achieved (Building the Assurance Framework: A Practical Guide for NHS Boards (2003), Department of Health. Taking it on Trust, Audit Commission (2009), Care Quality Commission, Judgement Framework, (2009).
Board Assurance Framework (BAF)	A matrix setting out the organisation's strategic objectives, the risks to achieving them, the controls in place to manage them and the assurance that is available.
Clinical Audit	'A quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria the implementation of change' (Principles of Best Practice in Clinical Audit (2002), National Institute of Clinical Excellence).
Compliance	Acting in accordance with requirements.
Contingency plan	The action(s) to be taken if the risk occurs.
Consequence	The result of a threat or an opportunity.
Corporate Governance	The system by which boards of directors direct and control organisations in order to achieve their objectives.
Control	Action taken to reduce likelihood and or consequence of a risk.
Cumulative Risk	The risk involved in several related activities that may have low impact or be unlikely to happen individually, but which taken together may have significant impact and or be more likely to happen; for example, the cumulative impact of cost improvement programmes.
Escalation	Referring an issue to the next appropriate management level for resolution, action, or attention.
External Audit	An organisation appointed to fulfil the statutory functions in relation to providing an opinion on the annual accounts of the Trust.
Gap in Assurance	Failure to gain sufficient evidence that policies, procedures, practices or organisational structures on which reliance is placed are operating effectively.
Gap in Control	Failure to put in place sufficient effective policies, procedures, practices or organisational structures to manage risk and achieve objectives.
Hazard	A potential source of damage or harm.
Internal Audit	The team responsible for evaluating and forming an opinion of the robustness of the system of internal control.
Internal Control	A scheme of checks used to ensure that systems and processes operate as intended and in doing so mitigate risks to the organisation.
Inherent/ Initial Risk	The level of risk involved in an activity before controls are applied.

Integrated Risk Management	A process through which organisations identify, assess, analyse and manage all risk and incidents for every level of the organisation and aggregate the results at a corporate level e.g., patient safety, health and safety, complaints, litigation and other risks.
Key Risk / Key Control	Risks and controls relating to strategic objectives.
Likelihood	The probability of something happening.
Mitigation / treatment of risk	Actions taken to reduce the risk or the negative consequences of the risk.
Negative Assurance	Evidence that shows risks are not being managed and/or controlled effectively e.g., poor external reviews or serious untoward incidents.
Reasonable	Based on sound judgement.
Reassurance	The process of telling others that risks are controlled without providing reliable evidence in support of this assertion.
Residual / Current Risk	The risk that is still present after controls, actions or contingency plans have been put in place.
Risk	The uncertainty of outcome of activity, described as the combination of likelihood and consequence, including perceived importance.
Risk Appetite	The level of risk that the organisation is prepared to accept, tolerate and be exposed to at any point in time.
Risk Capacity	The maximum level of risk to which the organisation should be exposed, having regard to the financial and other resources available.
Risk Management	The processes involved in identifying, assessing and judging risks, assigning ownership, taking actions to mitigate and anticipate them, and monitoring and reviewing progress.
Risk Matrix	A grid that cross references consequences against likelihood to assist in assessing risk.
Risk Maturity	The quality of the risk management framework.
Risk Owner	The person/group responsible for the management and control of all aspects of individual risks. This is not necessarily the same as the action owner, as actions may be delegated.
Risk Profile	The overall exposure of the organisation or part of the organisational to risk.
Risk Rating	The total risk score worked out by multiplying the consequences and likelihood scores on the risk matrix.
Risk Register	The tool for recording identified risks and monitoring actions and plans against them.
Risk Tolerance	The boundaries of risk-taking that the organisation is not prepared to go beyond.
Strategy	In the NHS a document that sets out the corporate approach and policy to a particular area or work activity. This is sometimes described as a policy, particularly outside the NHS.
Sufficient	Whatever is adequate

Appendix F – Risk appetite

Liverpool Women's NHS Foundation Trust

Risk Appetite for NHS Organisations
A matrix to support better risk sensitivity in decision taking

Good Governance Institute

Developed in partnership with the board of Southwark Pathfinder CCG and Southwark BSU – January 2012

Risk levels ▶ / Key elements ▼	0 **Avoid** Avoidance of risk and uncertainty is a Key Organisational objective	1 **Minimal** (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	2 **Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	3 **Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	4 **Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	5 **Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
Financial/VFM	Avoidance of financial loss is a key objective. We are only willing to accept the low cost option as VfM is the primary concern.	Only prepared to accept the possibility of very limited financial loss if essential. VfM is the primary concern.	Prepared to accept possibility of some limited financial loss. VfM still the primary concern but willing to consider other benefits or constraints. Resources generally restricted to existing commitments.	Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities.	Investing for the best possible return and accept the possibility of financial loss (with controls may in place). Resources allocated without firm guarantee of return – 'investment capital' type approach.	Consistently focussed on the best possible return for stakeholders. Resources allocated in 'social capital' with confidence that process is a return in itself.
Compliance/ regulatory	Play safe, avoid anything which could be challenged, even unsuccessfully.	Want to be very sure we would win any challenge. Similar situations elsewhere have not breached compliances.	Limited tolerance for sticking our neck out. Want to be reasonably sure we would win any challenge.	Challenge would be problematic but we are likely to win it and the gain will outweigh the adverse consequences.	Chances of losing any challenge are real and consequences would be significant. A win would be a great coup.	Consistently pushing back on regulatory burden. Front foot approach informs better regulation.
Innovation/ Quality/Outcomes	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems/ technology developments.	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations.	Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems / technology developments limited to improvements to protection of current operations.	Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.	Innovation the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice.
Reputation	No tolerance for any decisions that could lead to scrutiny of, or indeed attention to, the organisation. External interest in the organisation viewed with concern.	Tolerance for risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior management distance themselves from chance of exposure to attention.	Tolerance for risk taking limited to those events where there is little chance of any significant repercussion for the organisation should there be a failure. Mitigations in place for any undue interest.	Appetite to take decisions with potential to expose the organisation to additional scrutiny/interest. Prospective management of organisation's reputation.	Willingness to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation.	Track record and investment in communications has built confidence by public, press and politicians that organisation will take the difficult decisions for the right reasons with benefits outweighing the risks.
APPETITE	**NONE**	**LOW**	**MODERATE**	**HIGH**	**SIGNIFICANT**	

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Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	23/24/033		Date: 11/05/2023	
Report Title	**Proposed Risk Appetite Statement for 2023-24**			
Prepared by	*Allan Hawksey – Head of Risk and Safety* *Phil Bartley – Associate Director of Governance and Quality*			
Presented by	*Phil Bartley – Associate Director of Governance and Quality*			
Key Issues / Messages	The Board is asked to agree the appetite and risk tolerance levels for 2023-24 against the key strategic aims			
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 agree the appetite and risk tolerance levels for 2023-24 against the key strategic aims			
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* 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
FPBD, QC & PPF Committees	March – Apr 23	Assoc. Director of Quality & Governance	

EXECUTIVE SUMMARY

The Trust's Risk Management Strategy determines that on an annual basis the Trust will publish its' risk appetite statement as a separate document. This paper asks the Quality Committee to discuss and agree the risk appetite statement setting out the Liverpool Women's NHS Foundation Trust's tolerance levels for risk in relation to the key strategic aims for which this Committee is responsible. The statement will define the Trust's appetite for risk to the achievement of strategic aims for the current financial year.

The Board is asked to note that the relevant risk appetite statements for Putting People First Committee, Quality Committee and FPDB have been discussed and agreed at their respective committee meetings in March 2023 – April 2023.

The Board is asked to agree the appetite and risk tolerance levels for 2023-24 against the key strategic aims

MAIN REPORT

1. Introduction and summary

What is Risk Appetite?

Risk appetite can be defined as the amount of risk that an organisation is willing to take on in pursuit of value. It is the total impact of risk an organisation is prepared to accept in the pursuit of its strategic aims. Risk appetite therefore goes to the heart of how an organisation does business and how it wishes to be perceived by key stakeholders including employees, regulators, rating agencies and the public.

The amount of risk an organisation is willing to accept can vary from one organisation to another depending upon circumstances unique to each. Factors such as the external environment, people, business systems and policies will all influence an organisation's risk appetite.

What is the Process?

The Liverpool Women's Risk Management Strategy describes the process as follows:

"The risk appetite of the Trust is the decision on the appropriate exposure to risk it will accept in order to deliver its strategy over a given time frame". In practice, the Trust's risk appetite should address several dimensions:

- The nature of the risks to be assumed.
- The amount of risk to be taken on.
- The desired balance of risk versus reward.

Risks throughout the organisation should be managed within the Trust's risk appetite, or where this is exceeded, action taken to reduce the risk. The Trust's risk appetite statement will be communicated to relevant staff involved in the management of risk

Key Risks to the Trust

We recognise we can strengthen the use of and application of risk appetite ensuring that the Trust adoption of risk appetite tolerances is central to our risk management decision making. Risk appetite should be a factor at each decision-making body, both corporately and within divisions also considering system priorities. Risk appetite should be brought out more strongly in report templates to help inform discussions. Furthermore, the application of the risk appetite needs to be documented in discussions and when considering decisions and in Quality Impact Assessments (QIA) and Equality Impact Assessments (EIA).

Our current BAF target scores and risk appetite do not align, i.e., where we have low risk appetite, our target BAF score is relatively high. This is less about acceptance and more about being pragmatic about setting realistic targets, but it could be mentioned as a discrepancy. The BAF is constantly under review and further consideration will be given the risk appetite levels in 23/24 to ensure closer alignment between the two.

Assurance & Oversight

Training modules for various aspects in relation to Governance will be rolled out from July 2023, Risk Appetite will be included within these modules. There will also be a review and revision of the Risk Assessment Document to ensure this aligns with and factors in with the relevant in risk appetite statements that should be considered.

Upon conclusion of the training and review of current documents, monitoring and oversight will be provided by the Corporate Governance Team and the relevant committees to ensure Risk Appetite has been considered in decision making.

Areas of good/outstanding practice

There have been key discussions when risk appetite has been utilised to inform decision-making e.g., decision to invest in insourcing (£160k) despite this increasing pressure on the finances. This was justified as it would improve patient safety and experience.

The meeting considered to risk appetite statement was which was to be ambitious and efficient and make the best use of available resources. The Moderate risk appetite statement was considered in respect to meeting our statutory financial duties of maintaining expenditure within the allocated resource limits and adherence to departmental and internal expenditure and financial controls. This includes the demonstration of value for money in our spending decisions, while ensuring quality and safety is maintained.

Risk Appetite Levels

The following risk appetite levels, developed by the Good Governance Institute form the background to discussion in relation to appetite. Using this model as guidance the Board of Directors should agree an appetite statement that aligns to our strategic aims. The statement should then be considered when assessing risk target and tolerances in the Board Assurance Framework

Appetite Level	Description:
None	**Avoid** : The avoidance of risk and uncertainty is a Key Organisational objective
Low	**Minimal** : The preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential.
Moderate	**Cautious** : The preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.
High	**Open**: Being willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and value for money).
Significant	**Seek**: Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk). Also described as **Mature**: Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust.

2. Issues for consideration

It is proposed that the Risk Appetite Statement for 2023-24 remains unchanged from 2022-2023 and therefore is as follows.

To deliver the best possible experience for patients and staff

Our risk appetite for experience is **low**.

Liverpool Women's NHS Foundation Trust has a low-risk appetite for actions and decisions that, whilst taken in the interests of ensuring quality and sustainability of the Trust and its patients, may affect the experience of our patients, the reputation of the Trust or the reputation of the wider NHS. Such actions and decisions would be subject to a rigorous risk assessment and be signed off by the Senior Management Team.

To deliver safe services

Our proposed risk appetite is **low**.

Our fundamental strategic aim describes our commitment to patient and staff safety. When and wherever possible we will apply strict safety protocols for all clinical and non-clinical activity. We will not compromise the safety of our patients, we will report, record, and investigate our incidents and we will ensure that we continue to learn lessons to improve the safety and quality of our services.

To participate in high quality research and to deliver the most effective outcomes

Our proposed risk appetite is **high**.

A level of service redesign to improve patient outcomes that requires innovation, creativity, and clinical research are considered by Liverpool Women's NHS Foundation Trust to be an essential part of the risk profile of the Trust.

To deliver the best possible experience for patients and staff

Our proposed risk appetite is **low**.

Liverpool Women's NHS Foundation Trust has a low-risk appetite for actions and decisions that, whilst taken in the interests of ensuring quality and sustainability of the Trust and its patients, may affect the experience of our patients, the reputation of the Trust or the reputation of the wider NHS. Such actions and decisions would be subject to a rigorous risk assessment and be signed off by the Senior Management Team.

To be ambitious and efficient and make the best use of available resources

Our proposed risk appetite is **Moderate**

This is in respect to meeting our statutory financial duties of maintaining expenditure within the allocated resource limits and adherence to departmental and internal expenditure and financial controls. This includes the demonstration of value for money in our spending decisions, while ensuring quality and safety is maintained.

3. Conclusion & Recommendation

Agreeing a Risk Appetite statement is a requirement of the Board of Directors under the Trust Risk Management Strategy. In order to treat, terminate, transfer, or tolerate risks staff undertaking risk assessments and making decisions will need to understand what level of risk is acceptable to the Trust.

The Board is asked to agree the appetite and risk tolerance levels for 2023-24 against the key strategic aims.

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	***23/24/034***		**Date: 11/05/2023**	
Report Title	**Review of non-executive director champion roles**			
Prepared by	***Mark Grimshaw, Trust Secretary***			
Presented by	***Mark Grimshaw, Trust Secretary***			
Key Issues / Messages	***The report outlines proposals for the Trust's response to NHS England's guidance document – 'Enhancing Board Oversight – a new approach to non-executive champion roles'***			
Action required	**Approve ☐**	**Receive ☐**	**Note ☒**	**Take Assurance ☐**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	***To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it***	***For the intelligence of the Board / Committee without in-depth discussion required***	***To assure the Board / Committee that effective systems of control are in place***
	Funding Source (If applicable): N/A			
	For Decisions - in line with Risk Appetite Statement – Y/N ***If no – please outline the reasons for deviation.***			
	To agree the proposed changes to the Trust's NED Champion roles.			
Supporting Executive:	***Name and Job Title***			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

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

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

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

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Board Development	**Feb 22**	**Trust Secretary**	**Recommendations reviewed and reflected in report**

EXECUTIVE SUMMARY

Over the last few years within the NHS, there had been an increasing focus on the designation of Board Champions and nominated leads designed to engender board-level commitment and focus around key areas of service development or delivery.

In response to this issue, NHS England worked with stakeholders to review the issues the roles were originally established to address and consequently recommended that a smaller number of roles be retained with trust discretion provided for in other areas.

In April 2022, the Board agreed that the following NED champion roles be retained:

- Freedom to Speak up
- Safeguarding
- Board Maternity Safety Champion
- Wellbeing

The following roles were agreed to be removed with assurances being reported via relevant Committees:

- Termination of Pregnancy
- Mortality
- End of Life Care

This report provides an update on the discharging of the NED champion roles with amendments proposed where relevant.

Recommendation

The Board of Directors is asked to:

- Note the progress made to date in discharging the NED Champion roles
- agree on the proposed changes to the Trust's NED Champion roles.

MAIN REPORT

Introduction

Over the last few years within the NHS, there had been an increasing focus on the designation of Board Champions and nominated leads designed to engender board-level commitment and focus around key areas of service development or delivery.

The number of NED champion roles started to make it difficult for trusts to discharge them all effectively, particularly with a limited number of NEDs, and many did not have a role description, making it difficult to measure their impact on delivering change. Some roles had also been in place for over a decade without review.

In response to this issue, NHS England worked with stakeholders to review the issues the roles were originally established to address and consequently recommended that a smaller number of roles be retained with trust discretion provided for in other areas.

NHS England Guidance
https://www.england.nhs.uk/wp-content/uploads/2021/12/B0994_Enhancing-board-oversight-a-new-approach-to-non-executive-director-champion-roles_December-2021.pdf

Current Trust Position

The Trust has the following 'Board Champion', or 'Non-Executive Lead' roles assigned –

NED Champion Role	Assigned to:
Whistleblowing (FTSU)	Zia Chaudhry
Safeguarding	Gloria Hyatt
Board Maternity Safety Champion	Prof. Louise Kenny
Wellbeing	Sarah Walker

Update on NED Champion roles:

Whistleblowing (Freedom to Speak Up) – Zia Chaudhry
See Appendix 1 for role description

Freedom to Speak Up is closely aligned with Zia's values and interest and as NED Champion and liaising with the two Freedom to Speak Up Guardians plays to his strengths. The champion role is aimed at ensuring that speaking up on issues and concerns receives the deserved attention. The objective for the year was to build an understanding of the processes,

the national framework and build a relationship with the Guardians. This has been achieved, going forward the value to the Guardians of knowing there is a Board champion they can speak to themselves and the value to the Board of knowing the subject has some additional oversight. Regular catch ups are planned to continue to build the Guardian relationship.

Board Maternity Safety Champion – Prof. Louise Kenny (Deputy Board Maternity Safety Champion – Jackie Bird)
See Appendix 2 for role description

The Board Non-Executive Director Maternity Safety Champion, a role created in the last few years, has had its importance highlighted with the national attention on maternity services and several report and inquiry recommendations. Louise brings a clear professional advantage as an obstetrician but to a National role specification that requires additional clarity. We continue to work with the Executive Board Maternity Safety Champions to better define the role and set the organisations expectations, as the ED and NED boundaries can sometimes blur. The aim during 2023/24 is to make the role more realistic for a non-obstetric NED. To progress this succession and to ease Louise's availability clashes, we have appointed a deputy NED Maternity Safety Champion.

Wellbeing – Sarah Walker
See Appendix 3 for role description

In the role of NED wellbeing champion Sarah has engaged with leads and Executive Directors in this area and has made her contacts available to the organization. Follow up walkabout visits are planned and the need to formalize the outputs from activity is recognized.

Safeguarding – Gloria Hyatt
See Appendix 4 for role description

Gloria has a strong professional understanding of safeguarding and brings this to her role as Board champion. Contact with the safeguarding team have happened through the year but there is scope to increase frequency during 2023/24. Planning with the Chief Nurse and others will get the best from the relationship. Attending formal safeguarding meetings is less important and better to avoid straying into executive territory. A more informal approach is taken, getting to know the team, building a relationship so they knew they are listened to, and the Board has another route to gain insight into their work.

Other roles

The NHSE Guidance recommends that all other roles (beyond those with specific guidance) should be embedded in governance arrangements and aligned to committee structures where possible. The table below provides a list of these roles and identifies the current reporting arrangements.

Issue / Role	Current reporting	Proposed amendment to reporting (if necessary) – actions in **bold**
Termination of pregnancy	Guidance changes have been reported to the Quality Committee	No proposed amendments to reporting arrangements.
Doctor disciplinary	NED are requested to participate on a case by case basis – no one allocated NED.	No proposed amendments to reporting arrangements.
Hip fractures, falls and dementia	Trust performance in this area is overseen by the Safety and Effectiveness Sub-Committee with data also reported through to the Quality Committee.	No proposed amendments to reporting arrangements.
Palliative and end of life care	This is currently reported via the Bereavement Group, through the Patient Involvement and Experience Sub-Committee with any escalations to the Quality Committee.	A Quality Committee (NED) member attends meetings of the Bereavement Group (at least two per annum).
Resuscitation	The Trust has a designated Resus Group that reports to the Safety and Effectiveness Sub-Committee with matters escalated to the Quality Committee.	No proposed amendments to reporting arrangements.
Learning from deaths	Quarterly reports provided to the Quality Committee and the Board.	No proposed amendments to reporting arrangements.
Health and safety	There is a Trust Health & Safety Group that reports to the Corporate Risk Committee with matters escalated to the Quality Committee. An annual presentation on the Trust's Health and Safety arrangements is provided to the Board at a Development Session.	No proposed amendments to reporting arrangements.
Safety and risk	There is a Trust Health & Safety Group that reports to the Corporate Risk Committee with matters escalated to the Quality Committee.	No proposed amendments to reporting arrangements.
Lead for children and young people	Since the CQC inspection, there has been a 16-18 task and finish group in place. Assurances have reported to the Quality Committee.	Specific updates (including a staff story) have been presented to the Quality Committee on this area.
Counter fraud	Audit Committee receives quarterly updates and an annual report on Counter Fraud. There is a Counter Fraud Champion	No proposed amendments to reporting arrangements.

Emergency preparedness	EPRR arrangements report to the FPBD Committee with an annual statement made to the Board.	No proposed amendments to reporting arrangements
Procurement	Tender waiver reports received on a quarterly basis at Audit Committee. FPBD Committee scrutinise any major procurement decisions with approval sought by the Board in line with SFIs and the SORD.	No proposed amendments to reporting arrangements
Cyber security	There is a Digital Hospital Sub-Committee that reports directly to the FPBD Committee – matters include cyber security. There is a BAF risk on cyber security reviewed at the FPBD Committee and the Board.	No proposed amendments to reporting arrangements.
Security management – violence and aggression	Currently reported through the PPF Committee.	No proposed amendments to reporting arrangements

Recommendation

The Board of Directors is asked to:

- Note the progress made to date in discharging the NED Champion roles

Liverpool Women's
NHS Foundation Trust

Appendix 1

Non-Executive Director Board-level Freedom to Speak Up Champion

Post Holder: Zia Chaudhry

Date Appointed: 1 June 2022

Job Purpose:

The Robert Francis Freedom to Speak Up Report (2015) sought to develop a more supportive and transparent environment where staff are encouraged to speak up about patient care and safety issues. In line with the review, it is recommended that all NHS trusts should have this functional FTSU guardian role so that staff have a clear pathway and an independent and impartial point of contact to raise their concerns in the organisation.

The role of the NED champion is separate from that of the guardian. The NED champion should support the guardian by acting as an independent voice and board level champion for those who raise concerns. The NED should work closely with the FTSU guardian and, like them, could act as a conduit through which information is shared between staff and the board (p.146, Francis FTSU report).

All NEDs should be expected to provide challenge alongside the FTSU guardian to the executive team on areas specific to raising concerns and the culture in the organisation. When an issue is raised that is not being addressed, they should ask why.

The non-executive champion is responsible for:

- role-modelling high standards of conduct around FTSU
- ensuring they are aware of the latest guidance from National Guardian's Office
- challenging the chief executive, executive lead for FTSU and the board to reflect on whether they could do more to create a healthy and effective speaking up culture
- acting as an alternative source of advice and support for the FTSU Guardian
- overseeing speaking up matters regarding board members – see below.

It can be challenging to maintain confidentiality and objectivity when investigating issues raised about board members. This is why the role of the designated non-executive lead is critical. Therefore, in exceptional circumstances, it is expected that the non-executive lead will take the lead in determining whether:

- sufficient attempts have been made to resolve a speaking up concern involving a board member(s) and

Appendix 1

- if so, whether an appropriate fair and impartial investigation can be conducted, is proportionate, and what the terms of reference should be for escalating matters to regulators, as appropriate.

Depending on the circumstances, it may be appropriate for the non-executive lead to oversee the investigation and take on the responsibility of updating the worker. Wherever the non-executive lead does take the lead, they inform the FTSU Guardian, confidentially, of the case; keep them informed of progress; and seek their advice around process and record-keeping.

The non-executive lead informs NHS Improvement and CQC that they are overseeing an investigation into a board member (depending on the circumstances it may be required to provide the name of the board member under investigation). NHS Improvement and CQC can then provide the non-executive with support and advice.

Enablers to achieving these aims:

The non-executive lead can seek assurance from the following sources (not exhaustive):

- Speaking up concerns: numbers and themes
- Incident reporting: numbers, quality of reports, levels of feedback
- Grievances: numbers and themes
- FTSU Guardian user feedback
- Reports from boards doing walk-abouts
- Gap analysis against case reviews produced by the National Guardian
- National staff experience surveys
- FTSU Guardian board report
- Internal audit reports
- Employment tribunal judgements
- National Guardian Office case reviews
- External culture reviews
- CQC inspection reports
- Regular catch ups with Guardians to discuss themes

When necessary, the Trust will enable a non-executive lead to commission an external investigation (which might need an executive director to sign-off the costs) without compromising the confidentiality of the individual worker or revealing allegations before it is appropriate to do so.

Appendix 1

Key reference documents:

https://webarchive.nationalarchives.gov.uk/20150218150953/https:/freedomtospeakup.org.uk/wp-content/uploads/2014/07/F2SU_web.pdf

https://www.england.nhs.uk/wp-content/uploads/2021/05/ftsu-supplementary-information.pdf

Liverpool Women's
NHS Foundation Trust

Appendix 2

Non-Executive Director Board-level Maternity Safety Champion

Post Holder: Prof. Louise Kenny (Deputy – Jackie Bird)

Date Appointed: February 2021

Job Purpose:

In line with recommendations from the Ockenden Review, the Board-level safety champion role (currently held by the Chief Nurse & Midwife) should be supported by a Non-Executive Director. The two should work together to ensure a seamless leadership function.

The role of the Board-level safety champion is to act as a conduit between staff, frontline safety champions (obstetric, midwifery and neonatal), service users, LMS leads, the Regional Chief Midwife and Lead Obstetrician and the Trust Board to understand, communicate and champion learning, challenges and successes.

The Non-Executive Board-level maternity safety champion will act as a support to the Board-level safety champion by:

- bringing a degree of independent, supportive challenge to the oversight of maternity services
- ensuring that they are resourced to carry out their role
- challenging the Board to reflect on the quality and safety of its maternity services
- ensuring that the views and experiences of patients and staff are heard

Together the non-Executive Board-level maternity safety champion and the Board-level safety champion should:

- adopt a curious approach to understanding quality and safety of services
- jointly, with frontline safety champions, draw on a range of intelligence sources to review outcomes, including staff and user feedback to fully understand the services they champion
- Ensure the Board receives regular updates on issues requiring board-level action such as stillbirth rates, progress with implementing the Saving Babies' Lives care

Appendix 2

bundle; learning identified from cases meeting the Each Baby Counts criteria and Serious Incident investigations. Ensure that appropriate actions to address the findings are implemented and monitored at Board level to ensure the required improvements are made

- update the Trust Board on a monthly basis, on issues requiring Board-level action.

Enablers to achieving these aims:

- Attending Maternity Safety Champion meetings
- Supporting the Executive Board-level safety champion in reporting outcomes from the Safety Champion meetings to the Quality Committee
- Identifying maternity safety items requiring Board-level action at each Board meeting (verbally through the Quality Committee Chair's Report)
- Drawing attention to maternity related key performance indicators requiring attention during the Quality and Operational Performance item at Board
- Being briefed on outcomes from any locally undertaken culture surveys

Key reference documents:

- https://www.england.nhs.uk/wp-content/uploads/2020/12/annex-role-of-the-non-exec-board-safety-champion.pdf
- https://www.england.nhs.uk/wp-content/uploads/2020/08/Maternity_safety_champions_13feb.pdf

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Appendix 3

Non-Executive Director Board-level Wellbeing Guardian

Post Holder: Sarah Walker

Date Appointed: 1 June 2022

Job Purpose:

This role originated as an overarching recommendation from the Health Education England 'Pearson Report' (NHS Staff and Learners' Mental Wellbeing Commission 2019) and was adopted in policy through the 'We are the NHS People Plan for 2020-21 – action for us all'.

The NED should challenge the trust to adopt a compassionate approach that prioritises the health and wellbeing of its staff and considers this in every decision.

The role should help embed a more preventative approach, which tackles inequalities. As this becomes routine practice for the board, the requirement for the wellbeing guardian to fulfil this role is expected to reduce over time.

From an organisational perspective, the Wellbeing Guardian needs to:

- Challenge the organisation to include employee wellbeing in everything they do and actively create a 'culture of wellbeing', to care for people who care for others.
- Act as a 'critical friend' to question the impact of decisions on employee wellbeing – just as financial, performance or care quality impact are questioned.
- Ensure the Board holds senior leaders to account for the way employees are managed, empowered, and supported with their wellbeing.
- Seek data to show what's happening on the ground, evidencing the wellbeing needs of the diverse workforce (inputs) and that wellbeing strategy / policies / initiatives are working and impactful (outputs).
- Champion equality, diversity and inclusion, ensuring that the organisation considers the needs of the diverse groups within its workforce and adapts holistic approaches to wellbeing, appreciating peoples changing needs over time.
- Continually and strategically 'sense-check' the wellbeing agenda for the organisation and prompt improvement / developmental action if needed.
- Demonstrate that the Board (or equivalent senior leadership team) takes their personal wellbeing responsibilities seriously.

From a personal perspective, the Wellbeing Guardian needs to:

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- Strategically influence and shape the wellbeing agenda, speaking to the hearts and minds of the organisation's diverse workforce.
- Hold the values reflected in the role description, role modelling the values of fairness, compassion and inclusivity.
- Actively promote opportunities for the most vulnerable in the workforce to contribute and address wellbeing inequalities and the needs of diverse groups and individuals.
- Although Wellbeing Guardians must be competent and confident in their ability to challenge the executive team on behalf of the board Wellbeing Guardians are not accountable for the entire people agenda. They do not need to be an expert in wellbeing, but they do need to be adept at understanding the breadth of wellbeing in the context of their organisation and holding the organisation to account where improvements are identified.

With this in mind, a Wellbeing Guardian does not need to:

- Be a wellbeing expert.
- Take on executive/management responsibilities for ensuring wellbeing policies are operationally actioned and delivered.
- Get involved in 'the doing', operational management, or individual staff cases.
- Personally collect, analyse or present data on wellbeing.

Enablers to achieving these aims:

The role should be that of assurance and be empowered to act strategically. Therefore, the Trust will enable the Guardian by aligning functions such as HR / OD / Occupational Health and Wellbeing to operationally support them.

Key sources of information include:

- Putting People First Committee meeting papers
- Staff Survey
- Local staff surveys
- Understanding existing wellbeing interventions
- Regular discussions with Trust wellbeing leads

Key reference documents:

https://www.hee.nhs.uk/sites/default/files/documents/NHS%20(HEE)%20-%20Mental%20Wellbeing%20Commission%20Report.pdf

Appendix 3

https://www.england.nhs.uk/publication/we-are-the-nhs-people-plan-for-2020-21-action-for-us-all/

https://people.nhs.uk/executivesuite/support-in-difficult-times/wellbeing-guardians/

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Appendix 4

Non-Executive Director Board-level Safeguarding Champion

Post Holder: Gloria Hyatt

Date Appointed: 1 June 2022

Job Purpose:

Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff suggests that Boards should consider the appointment of a NED to ensure the organisation discharges its safeguarding responsibilities appropriately and to act as a champion for children and young people. The Trust also extends this remit to scrutinise the Trust's performance for adult safeguarding also.

Enablers to achieving these aims:

- Quarterly meetings to be held with the Trust's Safeguarding Leads to seek assurance on priority areas and actions being undertaken
- Attend at least two meetings of the Hospital Safeguarding Sub-Committee

Key reference documents:

https://www.rcn.org.uk/professional-development/publications/pub-007366

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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