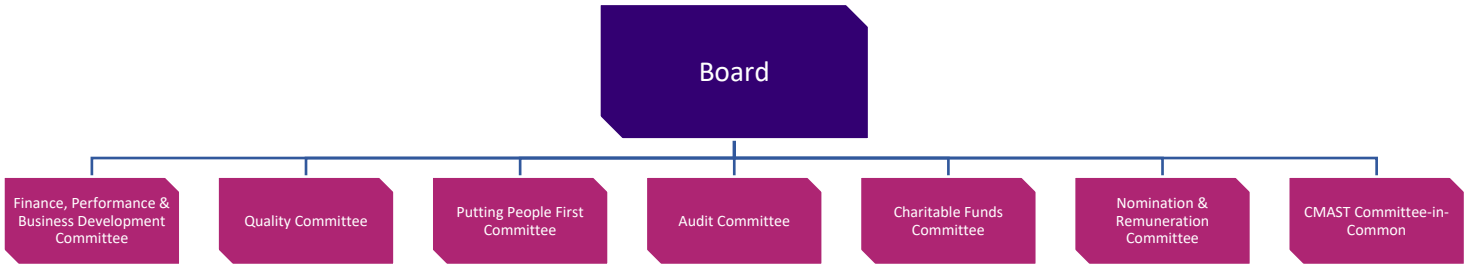
Liverpool Women's
NHS Foundation Trust

Trust Board

10 August 2023, 9.30am
Virtual, via Teams



Liverpool Women's
NHS Foundation Trust

Trust Board

Location	Virtual via Teams
Date	10 August 2023
Time	9.30pm

Item no. 23/24/	Title of item	Objectives/desired outcome	Process	Item presenter	Time
PRELIMINARY BUSINESS					
102	Introduction, Apologies & Declaration of Interest	Receive apologies & declarations of interest	Verbal	Chair	0930 (5 mins)
103	Meeting Guidance Notes	To receive the meeting attendees' guidance notes	Written	Chair	
104	Minutes of the previous meeting held on 13 July 2023	Confirm as an accurate record the minutes of the previous meeting	Written	Chair	
105	Action Log and matters arising	Provide an update in respect of on-going and outstanding items to ensure progress	Written	Chair	
106	Chair's & CEO announcements	Announce items of significance not found elsewhere on the agenda	Verbal	Chair	0935 (5 mins)
MATERNITY					
107	Perinatal Quality Surveillance & Safety Dashboard	For assurance	Written	Chief Nurse	0940 (5 mins)
QUALITY & OPERATIONAL PERFORMANCE					
108	Quality & Operational Performance Report	For assurance – To note the latest performance measures	Written	Chief Operating Officer	0945 (25 mins)
109	Patient Safety Incident Response Framework (PSIRF) Plan	For approval	Written	Chief Nurse	
PEOPLE					
110	Workforce Performance Report	For assurance – To note the latest performance measures	Written	Chief People Officer	1010 (5 mins)
FINANCE & FINANCIAL PERFORMANCE					
111	Finance Performance Review Month 3 2023/24	For assurance - To note the current status of the Trust's financial position	Written	Chief Finance Officer	1015 (15 mins)
CONSENT AGENDA (all items 'to note' unless stated otherwise) *All these items have been read by Board members and the minutes will reflect recommendations, unless an item has been requested to come off the consent agenda for debate; in this instance, any such items will be made clear at the start of the meeting.*					

112	Liverpool Trusts Joint Committee – Committee Assurance Report	To receive	Written	Chair	Consent
CONCLUDING BUSINESS					
113	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair	1030 (5 mins)
114	Chair's Log	Identify any Chair's Logs	Verbal	Chair	
115	Any other business & Review of meeting	Consider any urgent items of other business	Verbal	Chair	
116	Jargon Buster	For reference	Written	Chair	

Date of Next Meeting: 14 September 2023

1035 - 1045	*Questions raised by members of the public*	To respond to members of the public on matters of clarification and understanding.	Verbal	Chair

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NHS Foundation Trust

Meeting Guidance Notes

Meetings are an essential part of any NHS Foundation Trust's decision-making process. To ensure that these meetings are productive and efficient, it is crucial to follow proper etiquette and behaviours before, during, and after the meeting. Here are some guidance notes to keep in mind:

Before the Meeting:

- Review the agenda: Before attending the meeting, make sure to review the agenda to understand the purpose of the meeting, the topics that will be discussed, and what is expected of you.
- Come prepared: Bring any necessary documents or materials to the meeting, such as reports, data, or notes.
- Ensure your apologies are sent if you are unable to attend and *arrange for a suitable deputy to attend in your absence - members are expected to attend at least 75% of all meetings held each year.

  **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.*

- Be punctual: Arrive on time, or better yet, a few minutes early, to ensure that you are ready to start the meeting promptly.
- Check the technology: If the meeting is a hybrid one, meaning some participants are attending in person and others are attending remotely, make sure to check the technology beforehand. Ensure that the meeting room has adequate audio-visual equipment, such as microphones and cameras, to allow remote participants to participate fully.
- Communicate with remote participants: If you are attending the meeting remotely, make sure to communicate any special requirements or needs to the meeting organizer in advance. This will help them to accommodate you better during the meeting.
- Test the connection: Make sure to test your internet connection and any required software or applications beforehand to avoid technical issues during the meeting.

During the Meeting:

- Listen actively: Listen attentively to what others are saying and avoid interrupting or talking over others. This will help you to fully understand the issues being discussed and contribute to meaningful discussions.
- Be respectful: Respect others' opinions and perspectives, even if you disagree with them. Avoid using derogatory language and be courteous and professional at all times.
- Stay focused: Stay focused on the agenda and avoid going off-topic. This will help the meeting to stay on track and achieve its objectives.
- Pay attention to the camera: If you are attending the meeting remotely, make sure to look at the camera instead of the screen when speaking. This will help to create a more engaging experience for in-person participants.
- Mute when not speaking: If you are attending the meeting remotely, make sure to mute your microphone when not speaking to avoid background noise.
- Encourage participation: Encourage participation from both in-person and remote participants. Ask remote participants for their opinions and actively engage them in the discussion.

Standards and Obligations

These points outline key behaviours and processes to be followed during our meetings.

- Minutes should note when there is no consensus, including who agreed and disagreed.
- Members must be open and declare any conflicts of interest to the committee chair, who should be notified if any conflicts of interest are perceived. If concerns are not adequately addressed, members may consider whistleblowing or contacting the Senior Independent Director for high-level concerns.
- At the end of the meeting, a standing item should identify new risks to the organization and document them in the relevant risk register with appropriate scores. These steps ensure transparency, accountability, and effective risk management within the NHS Foundation Trust.

After the Meeting:

- Follow up: Follow up on any action items assigned to you during the meeting promptly.
- Share the recording: If the meeting was recorded, share the recording with all participants, both in-person and remote. This will allow everyone to review the discussion and follow-up on any action items.
- Provide feedback: If you have any feedback or suggestions on how the meeting could be improved, share them with the appropriate person.
- Evaluate the technology: Evaluate the technology used during the meeting and identify any areas for improvement. This will help to ensure that future hybrid meetings are even more effective.
- Thank participants: Thank the chairperson and other participants for their time and contributions.

In conclusion, following proper etiquette and behaviours before, during, and after the meeting, as well as specific considerations for hybrid meetings, will help to ensure that our meetings are productive, efficient, and respectful. Remember to come prepared, listen actively, stay focused, follow up promptly, and provide feedback.

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 1.30pm on 13 July 2023

PRESENT

Robert Clarke	Chair
Kathryn Thomson	Chief Executive
Jenny Hannon	Chief Finance Officer / Executive Director of Strategy & Partnerships / Deputy Chief Executive
Zia Chaudhry MBE	Non-Executive Director
Dr Lynn Greenhalgh	Medical Director
Dianne Brown	Chief Nurse
Michelle Turner	Chief People Officer
Sarah Walker	Non-Executive Director
Jackie Bird MBE	Non-Executive Director
Gary Price	Chief Operating Officer
Gloria Hyatt MBE	Non-Executive Director

IN ATTENDANCE

Matt Connor	Chief Information Officer
Jen Huyton	Deputy Chief Finance Officer
Gillian Walker	Patient Experience Matron (item 084 only)
Richard Diamond	Estates and Facilities Manager (item 084 only)
Issy Garnell	Supported Intern (item 084 only)
Anne Bridson	Learning and Development Facilitator (item 084 only)
Annie Gorski	Public Governor
Gilly Graham	Member of the Public
Denise Richardson	Member of the Public
Lesley Mahmood	Member of the Public
Teresa Williamson	Member of the Public
Mark Grimshaw	Trust Secretary (minutes)

APOLOGIES:

Prof. Louise Kenny CBE	Non-Executive Director / SID
Tracy Ellery	Non-Executive Director / Vice-Chair
Louise Martin	Non-Executive Director

Core members	**Jul 22**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Apr**	**May**	**Jun**	**Jul 23**
Robert Clarke - Chair	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓
Kathryn Thomson - Chief Executive	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓
Tracy Ellery - Non-Executive Director / Vice-Chair	✓	A		✓	✓	✓	✓	✓	A	✓	A
Louise Martin - Non-Executive Director	✓	✓		✓	✓	✓	✓	✓	✓	✓	A
Prof Louise Kenny - Non-Executive Director	A	✓		A	A	✓	✓	✓	✓	A	A

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

23/24/	
080	**Introduction, Apologies & Declaration of Interest** The Chair welcomed everyone to the meeting. Apologies were noted as above and no new declarations of interest were made.
081	**Meeting guidance notes** The Board received the meeting attendees' guidance notes.
082	**Minutes of the previous meeting held on 8 June 2023** The minutes of the Board of Directors meeting held on 8 June 2023 were agreed as a true and accurate record.
083	**Action Log and matters arising** Updates against action log were noted.
084	**Staff Story** The Learning and Development Facilitator introduced Issy Garnell who had been working at the Trust as part of the supported internship scheme over the previous ten months. Issy noted that she had been asked by the Trust to undertake a 'secret shopper' exercise to bring her lived experience to develop the Trust's approach to being a welcoming place to all staff, patients, and their families. A video was shown, recorded from Issy's point of view, to demonstrate some of the physical challenges when navigating the Trust's estate for a member of staff who was in a wheelchair and had other accessibility issues. The Chief Nurse noted that the Trust had received feedback from patients and the wider public regarding accessibility and Issy's video had highlighted these acutely. The Estates and Facilities Manager noted that a capital allocation for adjustments had been made and several 'quick wins' had either been completed or were underway. Site audits were also being completed that would feed into a five year 'road map' for longer term estate improvements from an accessibility perspective.

	The Chief People Officer remarked that the accessibility improvements being made to the Trust estate were long overdue and that it would be important for the Board to reflect on this. The Chair acknowledged the need for pace for the identified improvements and queried if timescales were known. The Estates and Facilities Manager noted that elements of the work would require a tendering process which would take several months to complete. However, it was stated that work that did not require significant capital to progress could be completed quickly, and this would be prioritised. The Chair requested that an update be provided in six months on the progress made to improve the accessibility of the Trust's estate. **Action: For the Board to receive an update in six months on the progress made to improve the accessibility of the Trust's estate.** The Chief Executive noted how much the Trust had learned from its supported interns and thanks were extended to Issy and her colleagues and to the Learning & Development Facilitator for successfully managing the programme. Richard Diamond, *Estates and Facilities Manager*, Issy Garnell, *Supported Intern*, Anne Bridson, *Learning and Development Facilitator* and Gillian Walker*, Patient Experience Matron,* left the meeting.

085	**Chair's announcements**
	The Chair provided the following updates:
	• The Board Nomination & Remuneration Committee had met a number of times since the previous meeting. Work undertaken included:
	  o Agreeing the process, job description and person specification for the recruitment of a new Chief Executive. It was expected that the job advert would go live on 17 July 2023 and close at the end of the month.
	  o Annual appraisal of the Executive Directors
	• System Working – A pan Liverpool Hospitals Joint Committee had been established to help to co-ordinate collaboration work. Further detail was available in item 91a.
	• The Trust's CQC Report had been published, further discussion would take place under item 88c. The Trust's well-led rating had remained static (requires improvement) from the 2020 inspection and there would be a need to reflect on this and identify areas for improvement. A development session was scheduled in September 2023 to facilitate this reflection and identification of key themes.
	• Dame Pauline Harris visited the Trust on 12 July 2023 to be presented with an Honorary degree from the University of Liverpool and officially open the Children Growing up in Liverpool (C-GULL) Birth Cohort Study research clinic.
	• The Chair had attended a Learners Event to celebrate the on-going achievement of staff in continuing their professional development.

086	**Chief Executive's report** The Chief Executive presented the report which detailed local, regional, and national developments. The Chief Executive noted that NHS Providers' Chief Executive Sir Julian Hartley visited Liverpool Women's Hospital NHS Foundation Trust on 16 June 2023. The visit provided an opportunity for Trust leaders to express concern around the ongoing financial and clinical sustainability of the Trust and the women's services it delivers. The National Guardian's Office had recently published analysis of the Freedom to Speak Up questions as outlined in the NHS Staff Survey 2022 Fear and Futility: what does the staff survey tell us about speaking up in the NHS? - National Guardian's Office. The Trust was in the top ten most improved in terms of the Freedom to Speak Up sub-score (called the Raising Concerns sub-score in NHS Staff Survey reports). The Trust received a letter from the National Guardian's office which formally

	recognised the progress made towards creating a truly open culture where raising concerns was actively encouraged. The National Guardian was scheduled to visit the Trust later this year to hear from the Guardians, leaders and staff about the Trust's approach and ongoing work with respect to raising concerns and creating a Fair & Just culture. The National Maternity Safety Support Programme Team would be visiting Liverpool Women's Hospital on 24th July – 27th July 2023. The team was formed of senior and experienced Obstetric & Midwifery Maternity Improvement Advisors (MIAs) and the National Maternity Quality Improvement Lead. It was led by the Deputy Chief Midwifery Officer for England and the National Speciality Lead for Obstetrics. This was not an inspection process but rather an approach to support continuous improvement. An update on the outcomes from the visit would be reported to the September 2023 Board. A front-line visit to the Trust for the purposes of Liverpool Safeguarding Children's Partnership Section 11 compliance was conducted on 17 March 2023. Visitors representing the LSCP Scrutiny, Audit, and Review Group (SARG), met with safeguarding leads for the organisation and conducted a panel discussion with frontline practitioners from the hospital. Visitors were assured of compliance on all standards and no areas were identified to improve practice against the standards. The Board of Directors noted the Chief Executive update.
087	Perinatal Quality Surveillance & Safety Dashboard The Chief Nurse presented the dashboard highlighting key performance issues, midwifery red flags, and Healthcare Safety Investigation (HSIB) referrals. It was noted that there were no incidents in May 2023, that required reporting to STEISS and investigation under the SUI criteria. It was noted that Maternity Assessment Unit triage times continued to show sustained improvement and there had been a reduction in maternity red flags. In terms of updates from Maternity Safety Champion meetings, the Chief Nurse noted that the approach was being refreshed to help the forum to be more targeted in its work. There had been a meeting held with staff on the Maternity Assessment Unit regarding the CQC report. Staff had broadly concurred with the findings and plans for improvement would be co-produced with a further drop-in session planned. The Consultant Safety Lead had undertaken a recent risk assessment and highlighted a challenge with theatre access for category two C-Sections. A deep dive had been requested with the support of the wider theatre teams (recognising interdependencies). The Chair noted the encouraging signs of improvement in relation to workforce metrics but highlighted an on-going challenge with blood sampling errors. The Chief Nurse stated that the number of errors was reducing and there was a better understanding of the causality. It was believed that the correct processes were in place to ensure continued improvement, and this would be accelerated once DigiCare and the electronic solutions it offered embedded with staff. The Board of Directors: • Noted the Perinatal Quality Surveillance & Safety Dashboard for June 2023.
088a	Chair's Reports from the Quality Committee The Board considered the Chair's Reports from the Quality Committee meetings held on 30 May and 26 June 2023. The Committee Chair, Sarah Walker, noted the following key points: • Performance continued to be challenged in relation to 62-day and faster diagnosis (two-week wait) cancer targets. The Committee requested a 'deep-dive' review into pathways to better understand potential barriers to improvement – to be received in July 2023

	• The Committee received a review into the most appropriate method of measuring caesarean section (emergency and total) rates as commissioned by the Trust Board. Further work was requested based on the discussion, and this would report back to the Committee in due course. • The Committee received its first staff experience story from the Children and Young Person's Specialist Nurse who commenced post in August 2022. The Committee noted the positive initiatives to ensure appropriate child centred care within health services provided by the Trust. The Chair noted a reference in the May 2023 report relating to constructive feedback that had been received from the Maternity Voices Partnership (MVP) who had conducted a 15 Steps toolkit visit. It was queried how the relationship with the MVP was developing. The Chief Nurse confirmed that the relationship had matured and was now in a place where genuine co-production for service change could be delivered. The Board of Directors received and noted the Chair's Reports from the Quality Committee meetings held on 30 May and 26 June 2023.
088b	Quality & Operational Performance Report The Board considered the Quality and Operational Performance Report. The Chief Operating Officer highlighted the following key points: • Gynaecology Elective recovery was on a positive trajectory, in line with the 2023/24 plan submitted to ICB. • 65 weeks wait performance (to eliminate patients waiting >65 weeks by March 24) and 52 weeks wait performance (to eliminate patients waiting >52 weeks by March 25) was surpassing the established trajectory. Comparison slides for Cheshire and Mersey Trusts had been included within the report. • The 6-week routine diagnostic target supporting elective recovery remained good. Mutual aid offers for other Trusts was under review. • Work was ongoing to sustain capacity through cheaper, more permanent solutions as demand shifted from outpatient to Theatre waits. This was being underpinned by Theatre and Outpatient Improvement Programmes. • The Trust narrowly missed achieving 106% elective work vs. 2019/20 for months 1 and 2 due to impact of industrial action. • Cancer metrics were improving. The 2-week target had been challenged by industrial action but recovered in M2. Performance against the 31-day decision to treat target was good. The main challenge related to the overall size of waiting list (30% increase in referrals) and the 28-day diagnostic delays which were affecting 62-day performance. These were multifactorial and were improving and overseen by the Cancer Improvement Group (Chair's Report provided in Appendix 1). The Trust was also meeting with NHSE and the Cheshire and Mersey Cancer Alliance at the end of June 2023 to review the plans. • Performance against urgent care targets was good with the 4 hr ED target and MAU triage time showing sustained good performance. The Trust was planning to reduce the MAU triage time target from 30 mins to 15 mins in July 2023. Non-Executive Director, Jackie Bird, referenced the 'deep dive' into cancer performance that was scheduled at the Quality Committee in July 2023 and asked if this would include an update on the unintended consequences/potential harm resulting from delays. The Chief Operating Officer confirmed that this update would be included in addition to a detailed breakdown for each cancer type. The Chair queried what interventions the Trust was making to improve cancer performance. The Chief Operating Officer reported that key interventions included increasing internal hysteroscopy capacity

	and to also ensure closer monitoring of the turnaround times with Liverpool Clinical Laboratories to reduce diagnostic delays. The Chair asked if the Trust had the appropriate key performance indicators (KPIs) in place to effectively monitor and track improvements. It was noted that the KPIs had been agreed with the Cancer Alliance and Trust clinicians. The Chair asked for detail regarding the expected timescales for improvements to the 62-day target. It was noted that performance would be back to the pre-pandemic level (75%) by October 2023. The Chief Nurse drew attention to strong performance in relation to infection, prevention, and control, and to VTE. It remained the view of the Trust that the increase in Serious Incidents was attributable to a change to the classification of incidents relating to the isolated site (made in January 2023). This would be kept under scrutiny over the coming months. The Board of Directors received and noted the Quality & Operational Performance Report.
088c	CQC Inspection Report – Trust Response The Trust had received the final report into the findings of the Care Quality Commission unannounced inspection in January 2023, and Well Led inspection of February 2023. The report highlighted the steps taken to date in response of the findings and provided assurances regarding oversight and completion of required actions including next steps. Particular attention was drawn to the immediate remedial action that had been taken in response to the Section 29A Warning Notice issued by the CQC in relation to the Maternity Assessment Unit (MAU) triage times and appropriate escalation to medical review. There had been reliable and sustained improvements within the MAU. Reference was made to the need for the Board to reflect on the wider themes identified within the report in order to drive the required improvements. These were in addition to the 'must-do' and 'should-do' actions that were being monitored closely throughout the organisation. This reflection would take place at a scheduled Board development session in September 2023. It was reported that the CQC would receive an update on the progress made by the Trust at a relationship meeting in August 2023. The Chair queried the process for the removal of the Warning Notice. The Chief Nurse stated that the CQC had been kept appraised of the progress made by the Trust but a date for re-inspection had not yet been agreed. Non-Executive Director, Jackie Bird, suggested that it would be important to communicate the improvements made to patients to assuage any concerns. The Board of Directors noted the report.
088d	Guardian of Safe Working Hours (Junior Doctors) Annual Report 2022/23 The Medical Director reminded the Board that under the 2016 Terms & Conditions for doctors and dentists in training, there was a requirement for the Guardian of Safe Working Hours (GoSWH) to submit a quarterly report and an annual report to the Trust Board. The Board was advised that: • Rota establishment continued to fluctuate throughout the year with processes in place to mitigate the use of high-cost agency locums by using internal bank, doctors in training and ANNPs • During this reporting period, 2022/23, the service continued to operate with a reduced number of post graduate doctors (PGD's) due to a combination of maternity leave and long-term sickness, as well as senior PGD's obtaining CCT. Overall, it was noted that there continued to be an increase in rota gaps, and this was starting to negatively impact the Trust's outcomes on the GMC survey. The Deputy Medical Director was undertaking a project to comprehensively review the PGD workforce, particularly identifying actions to reduce the amount of time PGD's were taken out of training. The Chief People Officer noted that

	whilst some solutions would require national and system intervention, there were actions the Trust could take to reduce pressure e.g. ensuring FY1 and FY2 doctors had a good experience to encourage them to take up available roles and be proactive with offers. The Chair asked how the Trust could move towards a more sustainable PGD staffing position. The Chief People Officer noted that there was a need to explore alternative roles to deliver care i.e., physician associates and advanced nurse/midwifery practitioners. It would also be important to understand rota requirements and plan effectively and proactively through strong clinical leadership at a divisional level. The Chief Finance Officer added the need to factor in robust workforce plans into the three-year financial recovery plan. The Board of Directors: • noted the assurances provided in the report. • noted the risk of PGD rota gaps.
089a	Chair's Report from the Putting People First Committee The Board considered the Chair's Report from the PPF Committee meeting held on 22 May 2023. Committee Chair, Gloria Hyatt, noted the following key issues: • A staff story had been received from a GP ST2 Trainee and they had noted that there had been issues experienced particularly by male GP trainees not from the UK into the placement programme at the Trust. It was suggested that a dedicated supervisor for cultural and pastoral support be provided, and the Committee considered the importance of culturally competent trainers and leaders. • The Committee received a positive position update against the Midwifery Preceptorship Programme, noting a retention rate for all cohorts at the Trust currently at 98%. The Chair queried if lessons had been learned from this example for other areas in the Trust. The Chief Nurse stated that the most significant lesson was that local leaders and managers made the largest impact on staff experience. This idea had been applied to theatres most recently and there were signs of cultural improvement in this area. The Board of Directors received and noted the Chair's Report from the PPF Committee meeting held on 22 May 2023.
089b	Workforce Performance Report The Chief People Officer noted that there were encouraging signs of improving trends across several workforce metrics which demonstrated that grip and control was increasing. Maternity sickness rates had shown improvement – c.6% compared to c.10% at the same time in the previous year. There were some emerging issues in gynaecology with regards to sickness and mandatory training rates and these were being closely monitored. The Trust was also working to ensure that flu and Covid-19 vaccine rates improved. The Board noted the workforce performance report.
089c	Review of Culture and Staff Engagement at LWH The Board received an overview of the key themes and associated actions from the Big Conversation undertaken in April 2023, as well as relevant data from the staff survey and local communication and involvement mechanisms, to provide the Board with a temperature check of levels of staff motivation and engagement. It was noted that staff culture updates would form part of the Workforce Performance Report going forward to support the Trust in meeting Code of Governance requirements. The Board of Directors noted the report.

	Board Thank you The following Board Thank You's were presented: 1) Caroline Batin- Robinson, Kay Ross, and the rest of the Neonatal Infant Feeding team who had implemented the Memory Milk Gift initiative at Liverpool Women's Hospital – presented by the Chief Nurse 2) Andrew Allan, Olivia Sandys and Laura McGarry for their work in supporting the Trust to achieve a positive UKAS accreditation result – presented by the Medical Director
090a	**Chair's Reports from the Finance, Performance and Business Development Committee** The Board considered the Chair's Reports from the FPBD Committee meetings held on 31 May and 28 June 2023. The Committee Chair, Non-Executive Director Louise Martin, noted that the performance challenges discussed at the Committee had been covered elsewhere on the Board agenda. The Committee continued to receive updates regarding the Trust's financial position, and it had been noted that whilst M1 and M2 had reported in line with the plan, this had been achieved through utilising non-recurrent items. The Committee had scrutinised the actions in place to address this and improve the monthly run-rate. The Committee received an options paper for the operations of the Crown Street Community Diagnostic Centre (CDC) in 2023/24 and further updated financial information was tabled at the meeting. A majority of the Committee supported the recommendation to proceed with an option to pursue a 5-day model, worked over weekends 8am – 8pm with a top-up enabling 7-day provision for 5 months (only). The Committee supported the overarching principles of collaborative system working but expressed its' disappointment at the current imbalance of risk sharing which required individual trusts to retain all risks associated with performance (activity, staffing and costs). The Trust Board had approved the recommended option at a private meeting. The Committee took assurance from the progress within the programme activities underway for DigiCare Electronic Patient Record (EPR) Programme noting readiness, cutover plans and key risks to project delivery. The Committee was assured by the governance and preparedness of the Digital Team to go-live with EPR in July 2023. The Board of Directors received and noted the Chair's Report from the FPBD Committee meeting held on 31 May and 28 June 2023.
090b	**Chair's Report from the Charitable Funds Committee** The Board considered the Chair's Report from the Charitable Funds Committee meeting held on 22 June 2023. The Committee Chair, Non-Executive Director Zia Chaudhry, noted that the Committee deferred a subsequent funding application for expenditure for equipment (Mona Lisa Laser) due to insufficient information provided. Additional detail in relation to the Mona Lisa Laser application was requested, particularly clarification of any ongoing revenue costs, and sight of the business case. The Committee had also received the draft Charitable Funds Strategy 2023-2027. The Committee provided feedback on the narrative to offer additional clarity ahead of submission to the Board of Trustees. The Committee recommended its effectiveness review, terms of reference and business cycle 2023/24 for approval. The Board of Directors:

	• noted the Chair's Report from the Charitable Funds Committee meeting held on 22 June 2023. • noted the 2022/23 Committee effectiveness review. • approved the updated Committee terms of reference and 2023/24 business cycle.
090c	Finance Performance Review Month 2 2023/24 The Chief Finance Officer presented the Month 2 2023/24 finance performance report which detailed the Trust's financial position as of 31 May 2023. At Month 2, the Trust was reporting a £3,078k deficit which represented a £2k favourable variance to plan. This position was supported by £1,667k of non-recurrent items. The forecast outturn was a £15,427k deficit, which was in line with the submitted plan. It was noted that the Trust had engaged additional support to support a rapid recovery. Some positive trends had been identified in agency spend – at Month 2 the Trust had a favourable variance of £239k against plan. Actual costs of £151k were predominantly driven by maternity (sickness and vacancy) and theatres (vacancy). Enhanced controls had been implemented regarding agency spend. The Cost Improvement Program (CIP) had fallen short of the YTD target by £293k, however at present the Trust was forecasting to deliver to plan. £2.9m of the £8.3m (5.3%) target currently remained unidentified with targeted work underway to address this. Non-Executive Director, Louise Martin, noted that the FPBD Committee had been seeking assurance on the development of the CIP. Further assurance would be sought over the next couple of meetings regarding the development of a longer-term three-year recovery plan. The Chief Finance Officer noted that that additional support would help to provide structure and ways of taking identified workstreams forward with greater pace. This would include the establishment of a Programme Management Office (PMO) (from existing internal resource). The Chair remarked that financial turnaround would need to be achieved in the latter half of the financial year and reasserted the need for pace in delivery. The cash balance was £4,750k at the end of Month 2. As the Trust had a deficit plan for 2023/24, it would require cash support throughout the year and the finance team was monitoring cash levels on a rolling 13-week basis. The Trust was liaising closely with the ICB and the national cash team to ensure cash levels were sufficient to meet operational needs. Non-Executive Director, Jackie Bird, asked if there was an awareness of the financial situation across the Trust and whether staff were engaged in the recovery efforts. The Chief People Officer stated that the Trust was committed to an approach to recovery that involved staff from across the organisation. It was noted that front-line staff often had a clear view on opportunities for efficiencies and improvements. The Board of Directors: • Noted and received the Month 12 2022/23 Finance Performance Review
091a	Partnerships Oversight – Quarterly Update The Board received an update on the Trust's partnerships with NHS bodies, noting that building effective partnerships was critical for NHS organisations operating in the emerging health and care landscape. Whilst the report focused on the Trust's provider partnerships, it also detailed the Trust's involvement within the Liverpool Place and wider system joint committees and workstreams. The report would be received by the Board quarterly going forward. The Chair stated that it would be helpful to see increased clinical accountability within the Trust's respective partnerships. The Medical Director noted that the recently developed joint risk register with Liverpool University Hospitals NHS FT (LUHFT) provided a good example of this.

	Attention was drawn to the Liverpool Trusts Joint Committee (LTJC) Terms of Reference which had been submitted for approval by the Board. The Trust Secretary noted that appendix 2 (delegation) had yet to be agreed and work was continuing to draft this element. The Board of Directors: • Noted the report. • Approved the terms of reference for the Liverpool Trusts Joint Committee.
091b	Annual Evaluation of Board of Directors and Board Development Plan The Board received a summary of the evaluation process and Board development work undertaken in 2022/23. The Trust Secretary noted that the 2023/24 Board development plan would take account of the recently published CQC report and present to the Board in September 2023. The Board of Directors: • Noted the Board evaluation for 2022/23 • Note progress made against the Board Development Plan for 2022/23
091c	Governance and Performance Framework 2023/24 The Trust Secretary introduced the updated Governance and Performance Framework 2023/24. It was noted that since its implementation in July 2021, the framework had driven positive changes, such as streamlined reporting structures, improved performance reports, and enhanced templates. However, the healthcare landscape had evolved, prompting necessary updates to the framework. Proposed changes included refining the Finance, Performance and Business Development Committee structure, simplifying the Performance Management Framework and meeting templates. Future work involved auditing Divisional Boards, developing best practice templates, and continuing training initiatives. The Board of Directors: • approved the updated Governance and Performance Framework • approved the adoption of the processes and templates included within the document.
091d	Board Assurance Framework The Board of Directors received the Board Assurance Framework. The Trust Secretary explained that the BAF had been significantly updated for 2023/24 to clarify the Trust's most significant strategic risks. This had resulted in predecessor BAF risks that were reported throughout 2022/23 being either replaced or merged into the new BAF risks for 2023/24. The new BAF risks had been scrutinised and discussed at the Board's committees and opening BAF scores and target scores had been proposed to the Board. The Board of Directors • reviewed the BAF risks and agreed on their contents and actions. • agreed on the suggested 2023/24 Q1 scores *The following items were considered as part of the consent agenda*
092	2023/24 Operational Plan Narrative Summary The Board received a summary of the 2023/24 Operational Plan Narrative which included the Divisional Plans on a Page. Progress against these will be monitored via committees throughout the year and formal updates would be given to Trust Board as in previous years.

	The Board of Directors received the report.
093	Director of Infection Prevention & Control – Annual Report 2022/23 The Board received the report on performance related to Infection Prevention & Control and exception reporting during 2022-23. The Trust's objective was met in respect of MRSA bacteraemia and Clostridioides difficile infection and the Trust exceeded the nationally set trajectory in respect of Gram-negative bacteraemia. The Board of Directors approved the report and agreed for its publication on the Trust website.
094	Health and Safety Annual Report 2022/23 The Board received an overview of compliance and governance assurance regarding the health and safety arrangements, activities, performance, and improvements for Liverpool Women's NHS Foundation Trust (LWH) for the financial year 2022/2023. The Board of Directors noted the report.
095	RD&I Annual Report 2022/23 The Board received the RD&I Annual Report 2022/23. The Board of Directors noted the report.
096	Integrated Governance Assurance Report Quarter 4 2022/23 The Board reviewed the contents of the paper and took assurance that there were adequate governance processes in place and that positive progress had been made in managing risk with Senior Management having oversight of such risks.
097	Mortality and Learning from Deaths Report Quarter 4, 22/23 The Board reviewed the contents of the paper and took assurance that there were adequate governance processes in place when learning from deaths. The Board of Directors noted: • number of deaths in our care • number of deaths subject to case record review • number of deaths investigated under the Serious Incident framework • number of deaths that were reviewed/investigated and as a result considered due to problems in care • themes and issues identified from review and investigation • actions taken in response, actions planned and an assessment of the impact of actions taken. • the care issues identified in the antenatal management from referring trusts and the recommendation 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
098	Review of risk impacts of items discussed The Chair identified the following risk items: • Performance against access targets • Medical staffing challenges, particularly PGD rota gaps • The Trust's 2023/24 financial position, longer-term sustainability challenges, and the potential impact on quality and safety.
099	Chair's Log

	None noted.
100	Any other business & Review of meeting The Chief Operating Officer noted that NHS Resolution had requested that the Trust review its compliance statement for the Maternity Incentive Scheme Year 4 considering the published CQC Report. A review had been undertaken by the Family Health Division and the Trust intended to continue to declare compliance against all ten safety standards. An assurance report would be presented to the July 2023 Quality Committee. Review of meeting No comments noted.
101	Jargon Buster Noted.

Liverpool Women's
NHS Foundation Trust

Action Log

Trust Board - Public
10 August 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
13 July 2023	23/23/084	Staff Story	For the Board to receive an update in six months on the progress made to improve the accessibility of the Trust's estate	COO	December 2023	On track	
8 June 2023	23/24/055	Quality & Operational Performance Report	To produce a simplified cancer dashboard to illustrate the breakdown of the various elements of cancer pathway and the Trust's performance against this.	COO	~~August 23~~ September 2023	On track	Breakdown to be reported to August 2023 FPBD Committee and then 14 September 2023 Board meeting following feedback.
11 May 2023	23/24/025	Chief Executive's report	For quarterly C-GULL recruitment numbers to be included within the Quality & Operational Performance Report	COO	August 23	Complete	Included within item 23/24/108

Chair's Log

Received / Delegated	Meeting Date	Issue and Lead Officer	Receiving / Delegating Body	Action Deadline	RAG Open/Closed	Comments / Update
Delegated	11.05.2023	For the Quality Committee to assess the impact of changes to the Continuity of Carer pathway after six months of implementation. Executive Lead: Chief Nurse	Quality Committee	September 2023	Open	

Delegated	11.05.2023	For the Patient Involvement & Experience Sub-Committee to receive an update from the Patient Experience Matron on the work to enhance patient information regarding baby scans and the development of a central offer for childcare/family support during and post scans. Executive Lead: Deputy Director of Nursing & Midwifery	PIESC	September 2023	Open	
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	~~July 2023~~ September 2023	Open	Requested to defer report to September 2023 to allow the relevant discussions and reviews to take place.
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	June 2023	Closed	Reported to the June 2023 QC Meeting

Trust Board

COVER SHEET

Agenda Item (Ref)	***23/24/107***		**Date: 10/08/2023**	
Report Title	**Perinatal Quality Surveillance & Safety Dashboard**			
Prepared by	**Governance and Senior Leadership Team, Family Health Division**			
Presented by	**Dianne Brown – Chief Nurse**			
Key Issues / Messages	The Implementation of a new perinatal quality surveillance model seeks to provide consistent and methodical oversight of maternity and neonatal services. The model has been developed to provide ongoing learning and insight, and to inform ongoing improvements in the delivery of perinatal services. A prerequisite of the model is to highlight trusts that require support before serious issues occur to enable proactive management and support.			
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.***			
	Trust Board is asked to receive the report which gives assurance that effective systems of control are in place to monitor quality and safety in Maternity and Neonatal Services at LWH.			
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* 2 – Inability to ensure the on-going sustainability of clinical services and maintain a high standard of care at the current Crown Street site.	Comment:
Link to the Corporate Risk Register (CRR) – CR Number: N/A	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome

EXECUTIVE SUMMARY

This report provides an overview of quality and safety performance in maternity and neonatal services at LWH to provide assurance to the Trust Board and to highlight areas of concern which require further scrutiny.

The requirement for Trust Boards to implement a locally agreed dashboard, is a required standard for the Maternity Incentive Scheme (MIS) (October 2021). The dashboard should be presented to the Trust Board by the Board Level Safety Champions, monthly. Evidential requirements as laid out within the MIS guidance require that discussions surrounding safety intelligence are taking place at Board level.

The Information Team have developed a comprehensive perinatal quality surveillance dashboard, which is presented monthly at the Maternity Risk Meeting, the Neonatal Operational Management Meeting and the Family Health Divisional Board meeting, following which it is cascaded by the maternity safety champions to staff via the following communication methods, e-mail, closed social media groups and clinical departmental meetings.

Perinatal Quality Surveillance Highlight Report July 2023 (June 2023 Data)

Introduction

In December 2020, following the publication of the Ockenden Report, Trusts were mandated to develop and implement a revised perinatal quality surveillance model. NHS England set out six requirements to strengthen and optimise board oversight for maternity and neonatal safety:

1. To appoint a non-executive director to work alongside the board-level perinatal safety champion to provide objective, external challenge, and enquiry.

2. That a monthly review of maternity and neonatal safety and quality is undertaken by the Trust board.

3. That all maternity Serious Incidents (SIs) are shared with Trust boards and the LMS, in addition to reporting as required to HSIB.

4. To use a locally agreed dashboard to monitor maternity and neonatal safety at board meetings.

5. Having reviewed the perinatal clinical quality surveillance model in full, in collaboration with the local maternity system (LMS) lead and regional chief midwife, formalise how trust-level intelligence will be shared to ensure early action and support for areas of concern or need.

6. To review existing guidance, refreshed how to guides and a new safety champion toolkit to enable a full understanding of the role of the safety champion, including strong governance processes and key relationships in support of full implementation of the quality surveillance model.

The Implementation of a new quality surveillance model seeks to provide consistent and methodical oversight of all services, specifically maternity services. The model has been developed to provide ongoing learning and insight, and to inform ongoing improvements in the delivery of perinatal services. A prerequisite of the model is to highlight trusts that require support before serious issues occur to enable proactive management and support.

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.

Family Health Clinical Dashboard (June 2023)

Areas of concern

Very Concerning – Investigate & Take Action.		
Metric	**Position**	**Narrative**
Antenatal Steroids	31.25% (no target) Last month 50%	Antenatal steroid administration has decreased from 50% in May 2023. There has been a shift in administration/hesitancy after publication of data to suggest low but long-term sequelae in babies when steroids have been given. Women and birthing people are being counselled regarding this and may explain the reduction. A deep dive will be done by the Maternity

		clinical teams to ascertain if this is a national or local issue, with feedback at the Maternity Clinical meeting in September 2023.
Flu Vaccinations Offered to Pregnant Women	38.61% (target >=90)	Flu vaccination season runs from September to February. Community midwives discuss flu vaccination with pregnant women at every antenatal contact. A meeting was held between representatives from LWH Maternity services and Liverpool Council Immunisation Public Health Team on Monday 31st July to plan for Autumn 2023 flu season. One of the actions from the meeting is to meet with NHS England immunization team in the next few weeks to come up with a plan for vaccination of pregnant women in 2023. LCC Public Health are arranging the meeting.
Concerning – Investigate and understand		
Friends and Family Test Positive Results (Maternity)	83.97% (Target 95%)	Midwifery Matrons meet on a weekly basis to discuss Friends and Family feedback. Improvements are put into place where any trends or themes are identified. One theme identified is delayed administration of pain relief and medication on the Maternity Ward. This is one area that is being addressed by the Mat Base Improvement Group, which is a pillar of the Maternity Transformation Board. One of the actions implemented is the allocation of an individual midwife per shift to administer medication on a 4hrly basis, to ensure that all women are given prescribed medication and pain relief on time and when required. Another theme is women asking for their partners to be able to stay with them on Mat Base overnight. A project allowing birthing partners to visit Mat Base over a 24hr period is in progress and is being evaluated by the Trust Patient Experience team. Progress updates are given at the weekly Maternity Voices Partnership meetings.
LMS Percentage Of Women Receiving Personalised Care Plan	95.89% (Target 100%)	K2 documentation is subject to a monthly audit to identify compliance with completing the data entry requirement for provision of personalised care. Feedback is given to community midwives after each audit, with a targeted plan for community midwives who have not completed the relevant documentation. Trajectory for achieving 100% compliance has been set for October 2023.
Newborn Blood Sampling – avoidable repeat tests	4.84% (Target <=2%)	The error rate is increasing. The following actions have been taken and are monitored on a weekly basis: • Improvement plan in the process of being drafted and will be completed by 31.8.23. • Staff with repeated error rates are required to attend refresher training in how to obtain a correct newborn blood spot. • Linking in with the Trust blood sampling improvement group to identify and implement other areas of best practice.
Newborn Hearing Screening	97.31% (Target >=98%)	Performance was not met as most babies did not attend, despite two appointments being sent as per policy (a hearing test is not mandated). Two parents declined the screening, three babies returned home to the Isle of Man. Whilst 9 babies missed the KPI date, they each did have their hearing screened inside the maximum screening age of three months.
Outpatient Appointments Subsequently Cancelled by Hospital (Maternity)	14.9% (Target <=9%)	Some outpatient appointments were cancelled due to the Junior Doctors Industrial Action which took place between the 14-17th June 2023. All cancelled appointments were re-scheduled following discussions with clinicians to ensure that all pregnant women received an appointment as per their risk status.

Outpatient Appointments Subsequently Cancelled by Hospital (Neonates)	32 (Target <=10%)	Improvements seen within this KPI since its peak in April. KPI will continue to be monitored and a review of processes will be undertaken now Digicare is live. The process review should be completed by October.
Outpatient DNA Follow Up (Neonates)	16.2% (Target <=10%)	The DNA rate had improved from 19% in the previous month to 11% with a total of 7 appointments that did not attend. A review of admin process for booking appointments has been commenced and is on track to be completed by October 2023. Text messages have been introduced to remind parents of their babies' outpatient appointment.
Referral Time to Fetal Medicine	94.12% (Target >=95%)	Improvements seen in referral time to FMU since appointment of the Midwifery Clinical Lead post, which is an interim post. Compliance should improve to meet the KPI by September 2023. A business case is in the process of being completed with the aim of securing funds to create a substantial Clinical Lead Midwifery role for FMU.
Women Who Have Seen A Midwife By 9 Weeks	53.27%	All electronic patient records of women who present to see a midwife after 9 weeks are reviewed by the Community Midwifery matron and team leaders to ascertain the reason for delay in presenting. Majority of women presented to their community midwife after 10 weeks gestation as it was their preference to wait until completion of the 1st trimester and the others presented late as they were unaware that they were pregnant. Monthly review of women presenting late to their community midwife will continue, to identify any areas of risk, i.e., women being unable to access services owing to language barriers etc.

Areas of Improvement

Sickness Absence

Sickness across the division has reduced in month to 6.21% and in maternity this translates to 6.49% which is a three-month downward trend, and it is the lowest rate seen since August 2020. The reported increase in sickness in the obstetric team has decreased to near nil (0.10%) and there is no sickness to report in the Neonates medical team. Sickness rates in the Neonatal service has seen marginal fluctuations with a slight increase seen in June 2023 to 5.66% (0.42% increase) however this remains the fourth lowest sickness rate seen in the last 12 months in the service.

Core Mandatory, Clinical Mandatory and Specialty Specific Training Compliance

Overall divisional training compliance is 84.12%. Areas of concern are Paediatric Basic Life Support (Neonates) reporting below 50% compliance and stands at 13% with 26 colleagues required to complete the training, also Resuscitation Training Level 3 at 54.55%. All staff who are out of date with resuscitation training have been asked to book training before the end of August 2023.

The second area of concern is Aseptic Non-Touch Technique which is at a compliance of 64.30%. Targeted intervention includes training staff to do cascade training, so that they can target colleagues on shifts who are out of date with ANTT. Trajectory in place to achieve KPI compliance by end of September 2023.

The divisional compliance rates are below -

90.80% in Core Mandatory (increase) this equates to 88.09% in Maternity (1.2% increase, 6% increase cumulatively across four consecutive months) and 95.98% in Neonates (0.4% increase, continued compliance maintained for six consecutive months).

89.01% in PDR (increase) which equates to 88% Maternity (21% increase and 37% cumulative increase across two months) and 90.48% in Neonates (8% increase and 14% cumulatively across two months)

81.91% in Clinical Mandatory (increase) with Maternity at 77.4% (a 4.16% increase) and Neonates at 90.5% (a 2.3% increase and a five-month positive trend).

81.06% in Specialty specific/local training (increase) this equates to 77.41% in Maternity (3% increase) and 89.92% in Neonates (a 1% increase).

Training remains a risk for the Division, and it is noted on the corporate risk register however, whilst not at compliance or sustained, it is acknowledged that improvements are being made and this will continue. Training compliance is discussed on a weekly basis as part of the Divisional oversight plan and will continue until the KPI is achieved.

Clinical training compliance

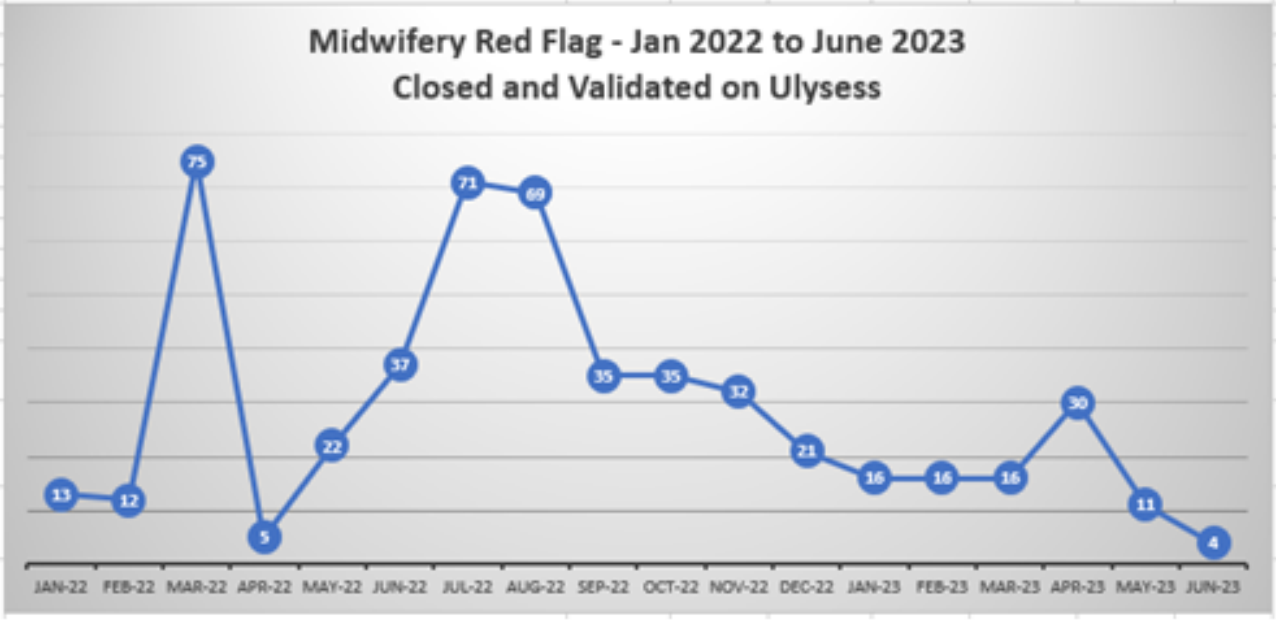
CNST MIS Year 5 Safety Action 8 requires evidence by February 2024 that at least 90% of each maternity unit staff group attendance an 'in-house' multi-professional maternity emergencies training session within the last year.

CNST SA8	Staff Group	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	
SA 8b. MPMET	Midwives	79%						NQM, B6, B7, B8.
	Maternity HCA	75%						
	Cons Obstetrician	53%						
	Trainee Obstetrician	x						New rotation in Aug
	Cons Anaesthetist	28%						
	Trainee Anaesthetist	x						New rotation in Aug and Nov
SA 8c. Fetal Surveillance	Midwives	77%						NQM, B6, B7, B8.
	Cons Obstetrician	62%						
	Trainee Obstetrician	x						New rotation in Aug
SA 8d. NLS	Midwives	81%						Delivered on MPMET day
	Cons Neonatologist	100%						
	Trainee Neonatologist	100%						New rotation Mar & Sept
	ANNPs	93%						
	Neonatal Nurses	83%						

- Figures above do not include LTS or Mat Leave- data to be cleansed at the end of reporting period.
- New medical trainees' rotation Aug (Obstetrics), Sept (Neonatal) November (Anaesthetics) New midwifery intake in October- training days built in as part of the orientation period. Additional dates planned to support intakes.

Midwifery Red Flags

Midwifery Red Flag Event - Validated	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	
1:1: Care in Labour Not Supported	5	2	2	2	1	0	
>30 min Delay in Presentation to Triage	6	2	5	12	1	2	
>2 hour delay in admission to IOL	5	2	0	0	0	0	
>4 hour delay in ongoing IOL (LWH MRF)	0	10	6	14	9	1	
Delay in time critical activity	0	0	1	0	0	0	
Delay in pain relief >30 mins	0	0	1	0	0	1	
Missed medication during hospital admission	0	0	0	0	0	0	
Delayed recognition of and action on abnormal vital s	0	0	0	0	0	0	
Full clinical examination - presenting in labour	0	0	0	0	0	0	
Missed or Delay Care (Suturing)	0	0	1	2	0	0	
Total	16	16	16	30	11	4	



There were 93 red flags reported between January 2023–June 2023 which is a reduction of 170 from July 2022-December 2022 where 263 red flags were reported. There were no reports of any harm caused to patients during this time, from the incidents reported as midwifery red flags. There remains a required element of clinical, manual validation, due to some reporting errors but a positive reduction has been demonstrated.

Family Health Safety Reporting

In June there were 424 incidents entered across Family Health Division. Top 5 causes are listed below:

1. Clinical management
2. Investigations

3. Admission/transfer/discharge
4. Staffing levels
5. Diagnosis

All incidents are reviewed and overseen as per Trust process, via daily departmental review, MDT review where required and the weekly Trust Safety meeting. Family Health Division report an average of 387 incidents per month. Tolerance level is currently set at 30 which equates to 10% of incidents reported. There is therefore an expectation that 90% (roughly 357) will be reviewed and closed within month. During the past month, FHD have closed 420 incidents. There were 73 incidents open in the web-holding files at the end of June, a reduction of 14 from the previous week. All had been opened and initially reviewed, subsequently waiting for either MDT or other further review.

Perinatal Mortality – Intrauterine Deaths >24weeks.

During June 2023, there were 2 still birth cases, one of which was twins, resulting in three reportable still births. Each of these were reviewed and a full MDT is scheduled in August, led by the designated Obstetric PMRT lead and supported by the risk midwife. These cases have been reported to MBRRACE, parental support continues to be provided by the Honeysuckle Team. Details and action plans of every death are detailed in the Regional Quarterly Mortality Report presented by the Deputy Medical Director at Quality Committee and Trust Board.

Healthcare Safety Investigation Referrals (HSIB)

There was one case reported to HSIB in June 2023. This relates to a shoulder dystocia. Additional information was requested from the Trust which has been submitted. HSIB are progressing with their investigation.

There have been five cases reported to HSIB during 2023. Three relate to Maternity services and one relating to Gynaecology services (maternal death). LWH have also been asked to contribute to an investigation relating to another Trust (the patient delivered at LWH but sadly died within the community outside of Liverpool).

Two of these are currently in the factual check stage and the other three are being investigated. All are on track.

Serious Incident Reporting

There was one clinical incident that met the SI criteria in June and was reported via StEIS. This was regarding a Transfusion Associated Circulatory Overload (TACO). This is currently being investigated and is on track for completion by the ICB's deadline.

Patients and their families are contacted at the beginning of each investigation and invited to submit any questions or concerns they wish to be included. These points are clearly identified within the investigation report and each patient or family are invited to a meeting upon completion of the investigation.

Following each investigation, the report is shared with the clinical team involved and staff are offered a debrief. Action plans form part of the overall report, and individual actions are monitored and updated with support from the Governance Team.

The Maternity Division communicates learning from serious incidents via the following methods:

- Immediate feedback to staff
- Sharing Lessons of the Week via Microsoft Teams
- Appreciation letters being sent to staff involved in incidents when good practice has been identified.
- Investigating Officer presenting the case at the Trust Safety Check in meeting.
- Cases shared at ward safety and governance meetings.

Maternity Incentive Scheme Year 5 (CNST): Scheme release: 31.05.2023

NHS Resolution have published Year 5 of the Maternity incentive Scheme. As in previous years there are ten key safety actions with several evidential requirements and standards. The scheme is Executively Led by the Chief Nurse and operationally managed through a designated workstream of the Maternity Transformation Board.

Ockenden Update

The Ockenden report, published in 2022, outlined 15 immediate and essential actions (IEAs) of which the Trust should demonstrate compliance against. In response to the findings of a MIAA Audit, the Division are undertaking a review, check and challenge of all 15 IEAs with monitoring and assurance provided to the Family Health Divisional Board. To date the team have reviewed all 15 IEAs and in the last month, 4 essential actions have been progressed from Amber to Green.

Immediate and Essential Action	Compliance with evidence to support	In Part	National Recommendation (Not for Trust Review)
Workforce Planning and Sustainability	5	3	3
Safe Staffing	8	2	0
Escalation & Accountability	5	0	0
Clinical Governance & Leadership	5	2	0
Clinical Governance Incident Investigating & Complaints	4	3	0
Learning from Maternal deaths	0	1	2
MDT Training	6	1	0
Complex Antenatal care	5	0	0
Preterm Birth	4	0	0
Labour & Birth	6	0	0
Obstetric Anaesthesia	7	0	1
Postnatal care	3	1	0
Bereavement Care	3	1	0
Neonatal Care	8	0	0
Supporting Families	3	0	0
	70	**14**	**6**

Maternity Self-Assessment Tool – Appreciative Enquiry Workstream.

The tool has been developed in response to national review findings, and recommendations for good safety principles within maternity services. 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 have used an appreciative enquiry framework to re-assess and complete this self-assessment tool in 2023 and evidence is stored in a repository. Majority recommendations have been implemented in the Trust.

The Red areas relate to:

- Development of a Quality Improvement Programme in the Trust, which the corporate Governance team are leading (equates for 2 recommendations).
- Administration post in the Governance team (previous post holder not replaced, however other workforce investment in the team).

- Audit of a Safety Huddle SOP. A Safety Huddle SOP is being drafted and will be subject to audit when completed.

Red	Amber	Green
4	64	114

Conclusion

The Family Health Division requests that the Trust Board 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 and Neonatal KPIs that are included within the Power BI dashboards.

Recommendation

Trust Board is asked to receive the report which gives assurance that effective systems of control are in place to monitor quality and safety in Perinatal Services at LWH.

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*23/24/108*		Date: 10/08/2023	
Report Title	Quality & Operational Performance Report			
Prepared by	**Quality & Operational Performance Report**			
Presented by	***Gary Price, Chief Operating Officer, Dr Lynn Greenhalgh, Medical Director and Dianne Brown, Chief Nurse***			
Key Issues / Messages	***Gary Price, Chief Operating Officer***			
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 – N *If no – please outline the reasons for deviation.*			
	The Board is asked to note the assurances within the Month 3 Quality and Operational Performance Report.			
Supporting Executive:	Dianne Brown, Chief Nurse & 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* N/A	Comment:
Link to the Corporate Risk Register (CRR) – CR Number: N/A	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Considered at the respective Board Committees during July 2023.			

EXECUTIVE SUMMARY

Performance Report Contents

Metrics Summary

Gynaecology Elective recovery continues to deliver a positive trajectory in line with the 2023/24 plan submitted to the ICB. Both the 65 weeks wait (to eliminate patients waiting over 65 weeks for treatment by March 24) and the 52 weeks wait (to eliminate patients waiting over 52 weeks for treatment by March 25) continue to achieve better than the trajectory, one of a handful of Trusts achieving this across Cheshire & Merseyside. The 6-week routine diagnostic target continues to improve with compliance of 95%+ in M3 which is compliant with the NHSE trajectory to achieve 95% by March 2025.

Cancer metrics continue to improve. The 2-week target continues to be challenged with industrial action however has improved further again for M3, the 31-day decision to treat target is good. Both the overall size of the waiting list (due to a 30% increase in referrals) and 28-day diagnostic delays are the main challenge which results in a poor 62-day performance. 28 Day FDS has improved in Month 2 however due to clearance in backlog, and priority to reduce the 62+ day waiting list, it is likely that 28 Day FDS compliance will be impacted in Month 3. However, there is continued reduction in the 62+ day PTL and the variation to trajectory is improving. The Trust met with NHSE Performance Senior team on 29th June to review Cancer performance and provide assurance on actions and trajectories. The slides are included as part of the performance pack

Urgent care targets continue to be good with the 4 hr ED target showing sustained improvement and performance in June just slightly under the 95% National AED 4-hour standard, significantly better than Cheshire & Merseyside compliance. The MAU triage time following suit with the Trust meeting its 95% target. The MAU triage time will move from 30 mins to 15 mins in July and this is demonstrating strong compliance

Quality Metrics

Several areas are reporting positive and an improving position.

In terms of safety, Infection and Preventions control measures of hospital acquired infections of measures of C Diff and MRSA remain at Zero. Active monitoring and oversight are led the by Infection control and prevention committee.

Several metrics noted with excellent performance relate to Falls risk assessment, new hospital acquired Category 3 pressure ulcers (none), no recorded never events and no Serious Incident actions remain outstanding.

Ongoing focus remains on complaints, with a reduction of complaints received noted and ongoing improvements with the completion of complaint responses demonstrating one complaint overdue compared to previous reported performance.

There was one episode where a woman revieing care on the delivery suite (99.78%) did not receive 1:1 care in labour. Exceptions are detailed within the report, a harm review completed with no issues identified.

Maternity ad Gynaecology have specific and intentional actions relating to improving patient and family experience to ensure improvements are realised across the Family and Friends test, actions highlighted within the summary report.

Recommendation

The Board is asked to note the assurances within the Month 3 Quality and Operational Performance Report.

Appendix 1: Assurance & Variation Icons Descriptions

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

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

Appendix 2: Assurance Category Descriptions

Variation/Performance	Assurance (P)	Assurance (?)	Assurance (F)	Assurance (blank)
H	**Excellent** — **Celebrate and Learn** • This metric is improving. • Your aim is high numbers and you have some. • You are consistently achieving the target because the current range of performance is above the target.	**Good** — **Celebrate and Understand** • This metric is improving. • Your aim is high numbers and you have some. • Your target lies within the process limits so we know that the target may or may not be achieved.	**Concerning** — **Celebrate but Take Action** • This metric is improving. • Your aim is high numbers and you have some. • HOWEVER your target lies above the current process limits so we know that the target will not be achieved without change.	**Excellent** — **Celebrate** • This metric is improving. • Your aim is high numbers and you have some. • There is currently no target set for this metric.
L	**Excellent** — **Celebrate and Learn** • This metric is improving. • Your aim is low numbers and you have some. • You are consistently achieving the target because the current range of performance is below the target.	**Good** — **Celebrate and Understand** • This metric is improving. • Your aim is low numbers and you have some. • Your target lies within the process limits so we know that the target may or may not be achieved.	**Concerning** — **Celebrate but Take Action** • This metric is improving. • Your aim is low numbers and you have some. • HOWEVER your target lies below the current process limits so we know that the target will not be achieved without change.	**Excellent** — **Celebrate** • This metric is improving. • Your aim is low numbers and you have some. • There is currently no target set for this metric.
~	**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.
○				**Unknown** — **Watch and Learn** • There is insufficient data to create a SPC chart. • At the moment we cannot determine either special or common cause. • There is currently no target set for this metric

Liverpool Women's
NHS Foundation Trust

Trust Board

Performance Report

July 2023

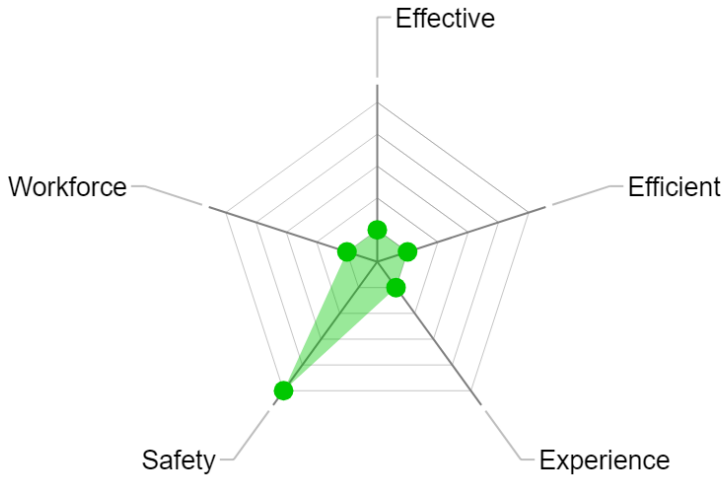
Section 1: Assurance Radar Charts by Trust Values

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'.

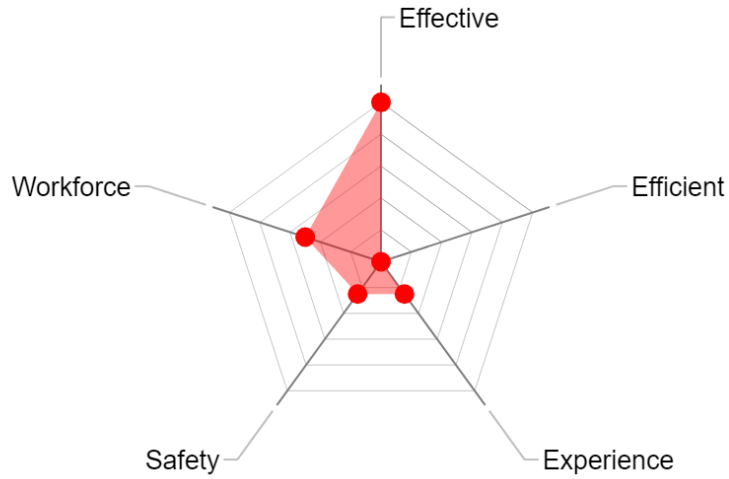
KPIs Passing Target for Six Months	9
KPIs Failing Target	16
KPIs Hit and Miss	8
KPIs No Target	2

KPIs Improving Variation	10
KPIs Concerning Variation	4
KPIs Common Cause Variation	21

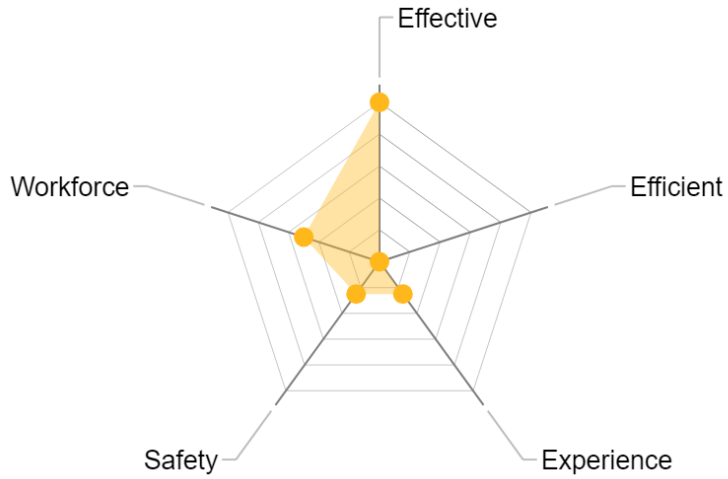
Consistently Passing



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
Never Events	<=	0	0	P	L
Serious Untoward Incidents: Number of SUI's with actions outstanding	<=	0	0	P	L
Turnover Rate	<=	<= 13%	9.54%	P	L

Good - Celebrate & Understand

KPI	Target < or >	Target	P	A	V
Complaints: Number Received	<=	<= 15	5	P	
Diagnostic Tests: 6 Week Wait	>=	>= 99%	96.07%	?	H
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%	99.57%	?	H
NHSE / NHSI Safety Alerts Outstanding	<=	0	0	P	
Venous Thromboembolism (VTE)	>=	>= 95%	92.61%	?	H

Average - Investigate & Understand

KPI	Target < or >	Target	P	A	V
Neonatal Deaths per 1000 live Births	<=		3.6		
18 Week RTT: Incomplete Pathway > 65 Weeks	<=	0	401	?	
Friends & Family Test: In-patient/Daycase % positive	>=	95%	87.72%	?	
Proportion of patient activity with an ethnicity code	>=	>=96%	94.05%	?	
Serious Untoward Incidents: Number of SUI's reported to CCG within agreed timescales	>=	100%	100.00 %	?	

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	18	F	
A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge	>=	>= 95%	94.85%	F	
All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (After Re-allocation)	>=	>=85%	15.63%	F	
Cancer: 104 Day Breaches	<=	0	6	F	
Cancer: 2 Week Wait	>=	>= 93%	79.72%	F	
Cancer: 31 Days from Diagnosis to 1st Definitive Treatment	>=	>=96%	72.73%	F	
Cancer: 62 Day Screening Referrals (Percentage) Rolling 12 Months	>=	>=90%	33.33%	F	
Clinical Mandatory Training Compliance	>=	>= 95%	85.87%	F	H
Friends & Family Test: A&E % positive	>=	95%	81.25%	F	
Friends & Family Test: Maternity % positive	>=	95%	83.97%	F	
Mandatory Training Compliance	>=	>= 95%	93.66%	F	H
Prevention of Ill Health: Flu Vaccine Front Line Clinical Staff	>=	>= 80%	41.54%	F	
Serious Untoward Incidents: Open	<=	<5	9	F	
Sickness Absence Rate	<=	<= 4.5%	5.77%	F	L
18 Week RTT: Incomplete Pathway > 52 Weeks	<=	0	1415	?	H
Overall size of Elective Waiting List	<=		16817		H

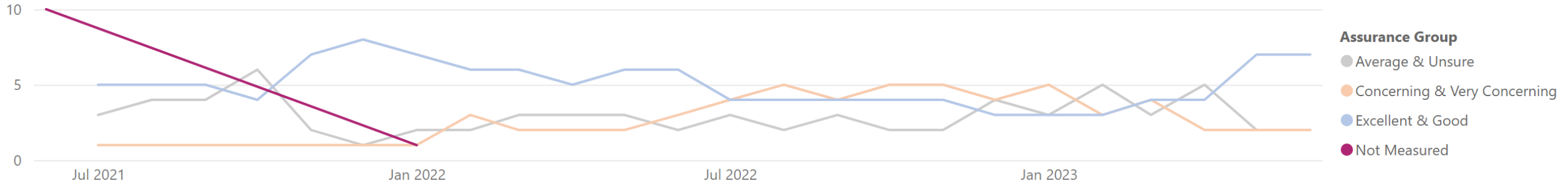
Very Concerning - Investigate & Take Action

KPI	Target < or >	Target	P	A	V
Cancer: 28 Day Faster Diagnosis	>=	>= 75%	51.13%	F	L
Serious Untoward Incidents: New (Rolling per year)	<=	24 /year	48	F	H

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
Never Events	Excellent	June 2023	0	<=	0			
Serious Untoward Incidents: Number of SUI's with actions outstanding	Excellent	June 2023	0	<=	0			
Infection Control: Clostridium Difficile	Good	June 2023	0	<=	0			
Infection Control: MRSA	Good	June 2023	0	<=	0			
MAU - Face to face Maternity Triage within 30 Mins	Good	June 2023	>= 95%	>=	99.57%			
NHSE / NHSI Safety Alerts Outstanding	Good	June 2023	0	<=	0			
Venous Thromboembolism (VTE)	Good	June 2023	>= 95%	>=	92.61%			
Neonatal Deaths per 1000 live Births	Average	June 2023		<=	3.6			
Serious Untoward Incidents: Number of SUI's reported to CCG within agreed timescales	Average	June 2023	100%	>=	100.00%			
Serious Untoward Incindents: Open	Concerning	June 2023	<5	<=	9			
Serious Untoward Incindents: New (Rolling per year)	Very Concerning	June 2023	24 /year	<=	48			

To deliver Safe services - Safer Staffing

June 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	85.8%	78.9%	133.3%	98.3%	*/**Day shift fill rates are reflective of the short and long-term sickness on the inpatient area. Due to the low bed occupancy in HDU staff have been able to rotate and support the inpatient ward on days maintaining safe staffing. *The night duty fill rate is indicative of 3 RN to facilitate senior nurse cover to rotate between the inpatient ward and GED.
Induction & Delivery Suites	79.8%	83.3%	82.9%	96.7%	*The template from RM in DS changed from 13 to 15 MW per shift due to the temporary pause of MCOC model of care and no longer having the availability of 4 on call midwives. Safe staffing required the Maternity bleep holder to redeploy RM to maintain clinical safety and prioritise 1:1 care in labour and ensure ringfenced staffing in MAU. Vacant shifts are requested to be filled with bank and agency up to planned staffing numbers
Maternity & Jeffcoate	77.1%	111.7%	82.4%	106.7%	*/**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 were fill rate of registered midwives was reduced to support ward.
MLU	87.5%	60.0%	92.5%	56.7%	*/**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. Low fill rate is attributed to LTS, of which recruitment of fixed term contracts has occurred- with the MSW currently in their orientation and training period.
Neonates (ExTC)	94.9%	115.0%	96.5%	105.0%	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	26.7%	110.0%	40.0%	93.3%	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: June Fill Rate

Fill rate – June staffing fill rate on days is reflective of the increase this month of short-term and long -term sickness, alongside maternity leave. Safe staffing has been maintained due to due to the low bed occupancy of 39.99% % in the inpatient area the ability to flexibly rotate staff from the HDU area due to the low bed occupancy in HDU which was recorded as 45%. The fill rate of 133.30% RN on nights remains above the 100% as this is reflective of senior RN cover rotating between GED and inpatient area, workforce is currently under review.

Attendance/ Absence – sickness and absence for the month of June was reported as 9.1%, an increase from the recorded 4.54% in the previous month. Short term sickness contributed to the increase and rising to 51.95% whilst long-term sickness was at 48.05%

Vacancies – 0 vacancies

Red Flags – There were 0 nursing red flags incidents submitted for the month of June.

Bed Occupancy – Bed occupancy for the Gynaecology inpatient ward for June was recorded as 39.99% slight increase from May which was 37.38%

CHPPD – For the month of June the CHPPD overall was reported to be 9.1. The split between Registered and unregistered care staff was 5.3 for Registered Nurse staff and 3.8hr for Health Care Assistant.

Neonates: June Fill Rate

Fill-rate – Occupancy has decrease in June however, IC activity has increased in the NICU, HD occupancy rate decreased to expected standard, safe staffing has been maintained and fill rates are reflective of acuity and occupancy. The increase in IC activity is reflected in the use of Bank. The escalation policy has had to be used this month; however, no transfers were undertaken.

Attendance/Absence – June sickness ran at 5.66%, this was slightly up on previous month. This is accounted for in a 0.3% increase in covid sickness. Short-term sickness continues to sit at 100% with no long-term sickness, all individuals are being managed in line with the HR Policy. Maternity is running at 10.21 FTE and Turnover sits at 8.3% well below the Trust threshold.

Vacancies – We are out to advert for Band 6 posts, ANNP posts, qualified and out to advert for Education and governance posts.

Red Flags – No red Flags

Bed Occupancy – Unit occupancy has run above 78.3%, this is just below the expected 80%. IC has run at 96.4%, HD 79.7%, LD 66.8 %, and TC 43.3%, activity. June has shown high occupancy and acuity in IC.

CHPPD – Within the critical care areas the care as would be expected, showing higher hours of registered nurse care and lower non- registered care. This split of 12.1 hrs of registered nurses and 1.5 is what is expected considering that most of these babies need care by a nurse qualified in speciality. This will differ in TC because the numbers are reflective of the way in which non- registered care leads TC supported by registered staff and parents, hence why we see 6.7 hrs by non-registered nurse and less by registered nurses 2.2 hrs, but appropriate for care delivery. Care in TC is more about supporting the family.

To deliver Safe services - Safer Staffing

Maternity: June Fill Rate

Fill-rate – Following the remodelling of the care delivery pathway for MCoC, the move from on call availability to a shift-based model for the Intrapartum element was established. During the temporary suspension, the Delivery Suite planned staffing has increased to 15 RM per shift from 13 MWs per shift. Where staffing requirements could not be met all vacant shifts were escalated to NHSP or on occasion premium rate agency. Additionally, there has been the requirement for deployment of specialist Midwives, ward managers and matrons for periods of time to ensure safety, particularly in peaks of high activity in MAU to maintain triage time within 30mins noting performance was achieved at 99.9%. Throughout the reporting period MLU was able to remain open supporting flow through all clinical areas. Additional care staff were provided to support clinical care delivery for postnatal women on Maternity Ward when RM shifts were unable to be filled utilising temporary staffing solutions. 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 included in the headroom, within its midwifery and support staff group. Maternity sickness is reported at 6.49% in month, a decrease of 1.3% from May continuing a downward trajectory. STS accounts for 32%, with the top reasons for short term absence being cough/cold or gastrointestinal issues. LTS is 68%. 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 11.68wte all of whom are within the Registered Midwives staffing group.

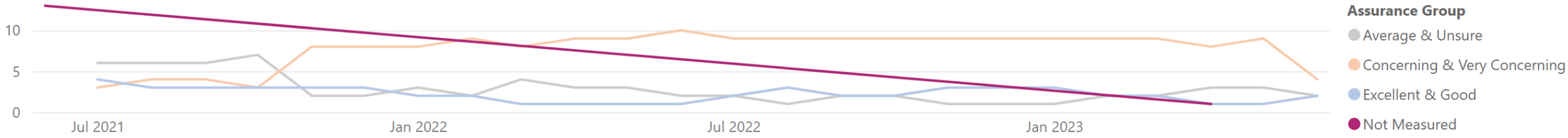
Vacancies – Several Midwives at Band 5 and 6 are currently undergoing recruitment processes and Maternity is expected to reach full establishment by M7 when all new starters are in post.

Red Flags – During June 4 Midwifery Red Flags were identified, which included 2 triage breaches of >30mins due to influx of attendances with all undergoing analysis to drive quality improvement as part of the MAU workstreams. There was 1 delay of >4hrs for ongoing IOL (local red flag), which affected patient experience, and 1 delay of >30mins in facilitating epidural which was the preferred choice of analgesia- although alternative pharmaceutical analgesia was provided. Apologies were offered to the women who rapidly progressed in labour.

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. CHPPD was reported at 17.7 in June for Delivery Suite for registered staff which is an increase from 16.4 in May. As CHPPD calculation combines hours provided by registered and care staff it is not the most sensitive indicator for Intrapartum Care. 1:1 Care provided by a Midwife to all women is a more accurate measure and this was achieved for 100 % of women in month.

The Maternity Ward is mixed antenatal and postnatal ward and therefore the fluctuation of case mix will be significant to CHPPD calculations, due to babies being inclusive in the total and classed also as patients. It is reported at 3.9 for June, which was consistent with 4.0 achieved in May. We await the national refresh of the BirthRate Plus Ward Based Accuity Tool with anticipated launch this autumn which will provide a real time evidence-based data to support staffing deployment decisions and provide assurance within this area following significant updating on a national level based upon the changing complexity of ward-based care in Maternity services.

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

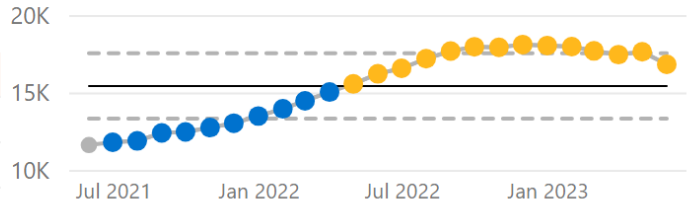


KPI	Assurance Category	Date	Target	Target < or >	Performance	Assurance	Variation	Trend
18 Week RTT: Incomplete Pathway > 104 Weeks	Excellent	June 2023	0	<=	0	P	L	
Diagnostic Tests: 6 Week Wait	Good	June 2023	>= 99%	>=	96.07%	?	H	
18 Week RTT: Incomplete Pathway > 65 Weeks	Average	June 2023	0	<=	401	?		
Proportion of patient activity with an ethnicity code	Average	June 2023	>=96%	>=	94.05%	?		
18 Week RTT: Incomplete Pathway > 52 Weeks	Concerning	June 2023	0	<=	1415	?	H	
18 Week RTT: Incomplete Pathway > 78 Weeks	Concerning	June 2023	0	<=	18	F		
A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge	Concerning	June 2023	>= 95%	>=	94.85%	F		
All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (After Re-allocation)	Concerning	May 2023	>=85%	>=	15.63%	F		
Cancer: 104 Day Breaches	Concerning	May 2023	0	<=	6	F		
Cancer: 2 Week Wait	Concerning	May 2023	>= 93%	>=	79.72%	F		
Cancer: 31 Days from Diagnosis to 1st Definitive Treatment	Concerning	May 2023	>=96%	>=	72.73%	F		
Cancer: 62 Day Screening Referrals (Percentage) Rolling 12 Months	Concerning	March 2023	>=90%	>=	33.33%	F		
Overall size of Elective Waiting List	Concerning	June 2023		<=	16817		H	
Cancer: 28 Day Faster Diagnosis	Very Concerning	May 2023	>= 75%	>=	51.13%	F	L	

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

Overall size of Elective Waiting List - Chief Operating Officer

Assurance Category	Concerning
Date	June 2023
Target	
Target < or >	<=
Performance	16817
Assurance	
Variation	H

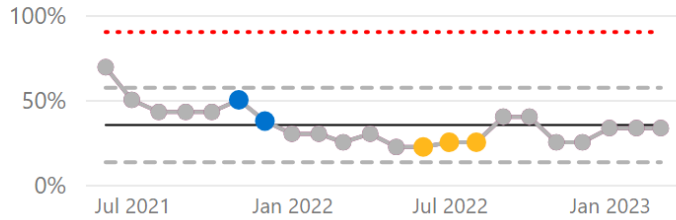


Performance has improved in June - now dmeonstrating clear trend that additional capacity within General Gynaecology is making significant improvements to the waiting list size. PTL continues to reduce and is now under 17000 patients consistently.

Continued industrial action as well as Digi Care go live in July could impact this position. Focussed attention through the Access sub-committee and transformation workstreams are monitoring performance and have actions in place to mitigate

Cancer: 62 Day Screening Referrals (Percentage) Rolling 12 Months - Chief Operating Officer

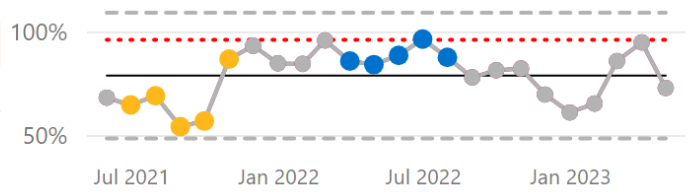
Assurance Category	Concerning
Date	March 2023
Target	>=90%
Target < or >	>=
Performance	33.33%
Assurance	F
Variation	



These are patients that are referred from cervical screening programme and are a very low number each month (2-3). They are managed alongside the 2-week cancer referral patients and should then be considered as part of that pathway.

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

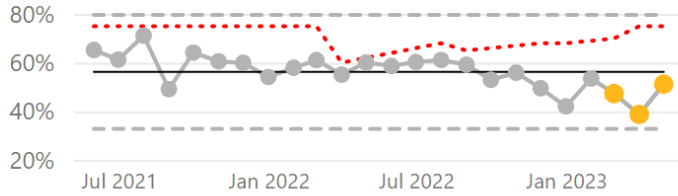
Assurance Category	Concerning
Date	May 2023
Target	>=96%
Target < or >	>=
Performance	72.73%
Assurance	F
Variation	



There has been significant improvement in performance through Q1 in this metric. This improvement is down to the actions taken as part of the Trusts Cancer Improvement Plan. This is a multi-agency plan which involves the Trust, Liverpool Place and the Cheshire and Mersey Cancer Alliance. The plan was shared with the Trusts Quality Committee in May 2023 who will continue to monitor its effect and the ability to sustain this increase in performance.

Cancer: 28 Day Faster Diagnosis - Chief Operating Officer

Assurance Category	Very Concerning
Date	May 2023
Target	>= 75%
Target < or >	>=
Performance	51.13%
Assurance	F
Variation	L

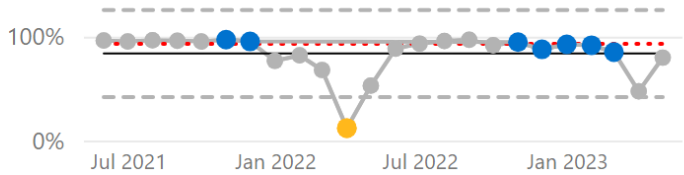


The Trust is off trajectory with this measure to achieve 75% by March 24.
The key drivers of this performance are a continued rise in referrals and therefore challenges and delays with diagnostic capacity, most notably Hysteroscopy and Pathology. These are noted as risks on the risk register and improvements are overseen by the Cancer Committee via the Cancer Improvement Plan that reports to Quality Committee.

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

Cancer: 2 Week Wait - Chief Operating Officer

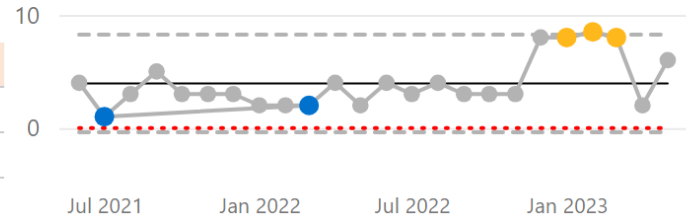
Assurance Category	Concerning
Date	May 2023
Target	>= 93%
Target < or >	>=
Performance	79.72%
Assurance	F
Variation	



Performance dipped during April 2023 due to activity lost for the IA and Easter period. Position now recovering with further improvement expected during June 2023.

Cancer: 104 Day Breaches - Chief Operating Officer

Assurance Category	Concerning
Date	May 2023
Target	0
Target < or >	<=
Performance	6
Assurance	F
Variation	

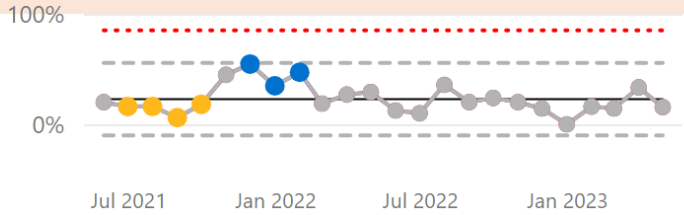


Trust continues to have a large number of patients over 62 days due to delays in Diagnostics and receiving Lab results. Cancer Improvement Plan and working group in place with identified workstreams and leads. Improvement Lead, funded by Cancer Alliance now appointed and will be in place from 24th July.

Trust has been placed in Tier 2 Performance monitoring with first meeting scheduled for 29th June. Harm reviews completed for all patients identifying key themes.

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

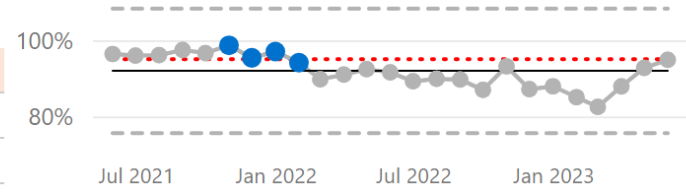
Assurance Category	Concerning
Date	May 2023
Target	>=85%
Target < or >	>=
Performance	15.63%
Assurance	F
Variation	



The Trust is off trajectory with this measure. The key drivers of this performance are a continued rise in referrals and therefore challenges and delays with diagnostic capacity, most notably Hysteroscopy and Pathology. These are noted as risks on the risk register and improvements are overseen by the Cancer Committee via the Cancer Improvement Plan that reports to Quality Committee. Several key actions have been put in place including working with Primary Care

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

Assurance Category	Concerning
Date	June 2023
Target	>= 95%
Target < or >	>=
Performance	94.85%
Assurance	F
Variation	

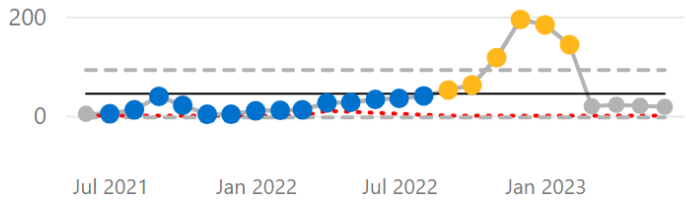


Significant improvement in performance. EPAU patients now being recorded correctly following discussion with the ICB

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

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

Assurance Category	Concerning
Date	June 2023
Target	0
Target < or >	<=
Performance	18
Assurance	
Variation	

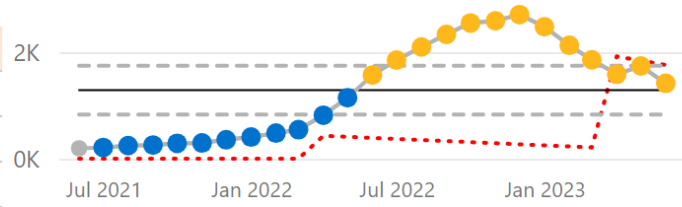


Number of 78+ weeks has remained stable for June. Outstanding patients waiting beyond 78+ weeks for clinical reasons or by patient choice. Trajectory demonstartes expecting to be 0 by end of July 2023 unless patient cancels or is cancelled for clinical reasons.

Currently monitored through weekly NHSE meetings. 65+ weeks reducing steadily, currently at 365 at end of June, ahead of trajectory of 719.

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

Assurance Category	Concerning
Date	June 2023
Target	0
Target < or >	<=
Performance	1415
Assurance	
Variation	



Improvement in June. Continued use of Insourcing company for clearance of long waiters making significant impact. Insourcing to cease end of July with alternative plan for locum/agency support to commence from August

Trust currently ahead of monthly trajectory with NHSE, monitored through weekly Elective Restoration & Recovery meetings - target for June is 1760. Digi Care go live may impact data and is noted as a risk t o potential increase in July

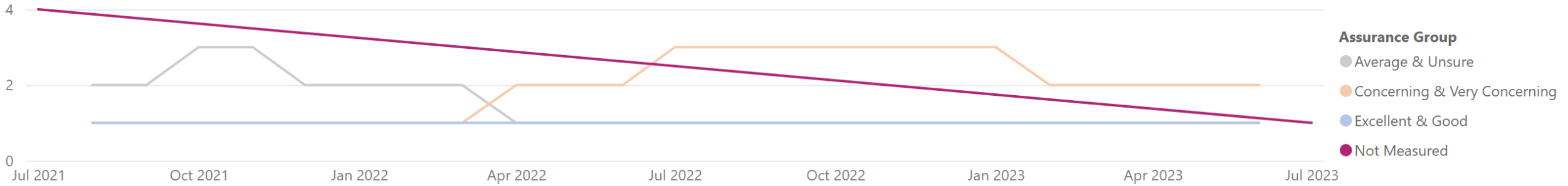
Assurance Category	
Date	
Target	
Target < or >	
Performance	
Assurance	
Variation	

Assurance Category	
Date	
Target	
Target < or >	
Performance	
Assurance	
Variation	

Industrial Impact Q1

	Theatre sessions cancelled	Outpatient clinics cancelled
April	16	18
June	20	69
July	14	7

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



KPI	Assurance Category	Date	Target	Target < or >	Performance	Assurance	Variation	Trend
C-Gull Recruitment	Not Measured	July 2023		<=	64			
Complaints: Number Received	Good	June 2023	<= 15	<=	5			
Friends & Family Test: In-patient/Daycase % positive	Average	June 2023	95%	>=	87.72%			
Friends & Family Test: A&E % positive	Concerning	June 2023	95%	>=	81.25%			
Friends & Family Test: Maternity % positive	Concerning	June 2023	95%	>=	83.97%			

CGULL study update as of 26.07.2023

- Open 3 months
- New lead midwife – Carly Williams
- Women recruited = 58
- Partners recruited = 15
- Breakdown of contact

Total Call data (Not including Partners)	Not Eligible	No Action taken pending Midwife review	Appointments Made	DNA or decline after appointment made	Declined on first contact call	Outreach requested	Follow up/Outstanding enquiry	Partners consented (Additional to main data set)
414	26	10	84	14	109	1	186	15

UNIVERSITY OF LIVERPOOL

Children Growing Up in Liverpool

Ongoing engagement work

- Marketing campaign for wider reach of target groups – billboard/bus posters/train stations/supermarket boards/community notice boards
- Incentives to offer recruits other than bag of merchandise
- LWH working on social media posts
- LWH have placed posters around all areas including corridors
- Manned tables set in main foyer and antenatal clinic with midwife approaching patients
- LWH staff monthly prize draw for retaining engagement
- LWH staff to be gifted thank you pizza 1 night shift a month or when milestone targets are met
- CGULL participants invited to prize draws monthly, events locally pregnancy yoga/afternoon tea – helps retainment
- Outreach centre engaged – pending confirmation on availability for room space

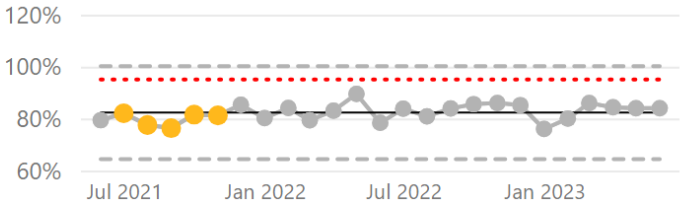
NHS Liverpool Women's NHS Foundation Trust

wellcome

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

Friends & Family Test: Maternity % positive - Chief Nurse

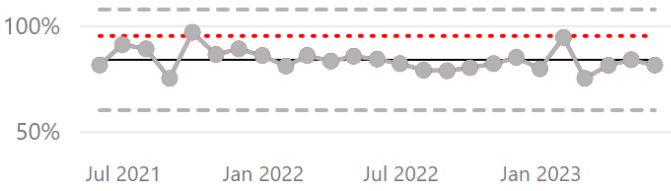
Assurance Category	Concerning
Date	June 2023
Target	95%
Target < or >	>=
Performance	83.97%
Assurance	
Variation	



Midwifery matrons meet on a weekly basis to discuss friends and family feedback and improvements put into place for any areas of themes and trends. One example is implementation of a midwife to adminster medication on Mat Base.

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

Assurance Category	Concerning
Date	June 2023
Target	95%
Target < or >	>=
Performance	81.25%
Assurance	
Variation	



A Slight reduction in postive responses month on month in the Emergency Department is noted , locally the nurse in Charge is accessible to deal with any concerns highlighted by patients on the day . Addressing the themes specifically highlighted in FFT displeased (wait to be seen and access to scans) the Division are planning to make changes to the EPAU service in an attenpt to increase patient satisfaction as well as patient flow hroughout the department .

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 > 65 Weeks	Effective	5	Y	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) Rolling 12 Months	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				

Liverpool Women's
NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*23/24/109*		Date: 10/08/2023	
Report Title	Patient Safety Incident Response Framework (PSIRF) – Our PSIRF Journey so far & Patient Safety Incident Response Plan (PSIRP) for approval			
Prepared by	Philip Bartley – Associate Director of Quality & Governance			
Presented by	Dianne Brown – Chief Nurse			
Key Issues / Messages	This report is to provide Trust Board with an update on the Trusts progress in the formal implementation of the PSIRF. Trust Board are asked to take assurance in relation to the work undertaken by the Trust so far in planning for the framework implementation. Furthermore, Trust Board are asked to approve our Patient Safety Incident Response Plan (PSIRP) and Policy. Following approval, this is due to be submitted to the integrated Care Board (ICB) prior to our PSIRF go live date of 1 September 2023.			
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.*			
	Trust Board are asked to take assurance in relation to the work undertaken by the Trust so far in planning for the framework implementation. ***Furthermore, Trust Board are asked to approve our Patient Safety Incident Response Plan (PSIRP) and Policy, providing a signed Board paper in support of this. Following approval, this is due to be submitted to the integrated Care Board (ICB) prior to our PSIRF go live date of 1 September 2023.***			
Supporting Executive:	Dianne Brown, Executive 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* N/A	Comment:
Link to the Corporate Risk Register (CRR) – CR Number:	Comment:

EXECUTIVE SUMMARY

The Patient Safety Incident Response Framework (PSIRF) was introduced for implementation by nationally appointed early adopters in 2020 as a result of the introduction National Patient Safety Strategy.

Following significant delays in publication of the final framework due to Covid, the final framework was published on 16 August 2022. Since this time, the Trust have undertaken several actions in preparation for the national roll out of the framework which will replace the Serious Incident Framework (SIF). This will have an emphasis on learning, involvement & improvement rather than as being part of a framework of accountability.

From 1 September 2023, the trust will start the transition phase by using PSIRF methodology with the Serious Incident Framework (SIF) ceasing to exist as per national guidance.

This report is to provide an update as to how the Trust has prepared for the implementation of PSIRF, what work has been completed and what will continue to progress during the implementation phase of the framework across the Trust. The paper also details the requirements for the Trust Board, so it is aware of its responsibilities in relation to patient safety incident management & improvement.

Furthermore, the Trust is required to submit its Patient Safety Incident Response Plan (PSIRP) and Policy to the Integrated Care Board (ICB) for approval prior to 1 September 2023. It is requested that a signed board paper accompanies the plan & policy approving our implementation plan. As such, Trust Board are asked to approve our Patient Safety Incident Response Plan (PSIRP) and Policy. Following approval, this is due to be submitted to the integrated Care Board (ICB) prior to our PSIRF go live date of 1 September 2023.

MAIN REPORT

What is PSIRF

The Patient Safety Incident Response Framework (PSIRF) replaces the Serious Incident Framework (SIF). The PSIRF has four key aims with regards to patient safety incidents: compassionate engagement and involvement of those affected; a system-based approach to learning; considered and proportionate responses; supportive oversight focused on strengthening response systems and improvement.

Under the PSIRF, we will no longer be talking about 'serious incident investigations' or 'root causes'. In their place will be a more flexible, system-focused approach, with improvement and engagement with patients/families/staff taking centre stage. This new system aims to channel resources where they will have most impact, rather than going through the motions of churning out incident investigation reports in every case.

The PSIRF applies to all services provided under the NHS standard contract (except for primary care currently), including NHS-funded services in the independent sector.

Organisations are required under the PSIRF to develop a patient safety incident response policy and a patient safety incident response plan (PSIRP), which must be based on a thorough understanding of the organisation's patient safety incident profile and improvement priorities. Both the policy and plan must be made publicly available on the organisation's website.

Whereas the Serious Incident Framework requires providers to consider whether or not the 'serious incident' threshold for investigation is met, the PSIRF does not prescribe what to investigate and there are no prescribed timelines for investigations, with these to be agreed on a case-by-case basis (although learning responses should usually be completed within 1- 3 months, with a long-stop of 6 months).

Progress to date

- Executive Lead for PSIRF

The Trust Executive Lead for implementation of PSIRF will be the Executive Chief Nurse.

- Patient Safety Specialists

There have been 3 specialists appointed to undertake this function in addition to their substantive posts - Associate Director of Governance and Quality, Deputy Chief Pharmacist and Head of Risk and Safety.

As a further result of Ockenden recommendations, a Consultant Obstetrician (Safety Lead) has been appointed as Maternity Lead within their current role and responsibility. There is no current published guidance on the clear expectations of this role.

- Patient Safety Training

The National levels 1 and 2 patient safety training packages are now live and have incorporated into all staff mandatory training requirements for 2022 / 2023 and 2023 / 2024. Levels 3 to 5 will follow (not yet live). This is now an essential competency on ESR.

- Human Factors Training

The Trust is currently rolling out Human Factors Training to approximately 1100 staff face to face band 7 and above and all maternity colleagues and has been approved by the LMNS. The training has been written by Jonathan Hurst (Consultant Neonatologist), Linda Watkins (Consultant Obstetrician and Director of Medical Education) and Allan Hawksey (Head of Risk & Safety).

- Investigative Training

There have been further investigative training courses provided by an external facilitator whereby 32 additional staff from various disciplines have been trained in investigation methodology throughout 2022.

- Patient Safety Incident Response Plan and Policy

This has been completed with the involvement of divisional colleagues. The Head of Risk and Safety had led a review of various data sources to review themes, patterns, and trends, repeat causality and the effectiveness of action plans.

- Ulysses incident management system

The Ulysses system is in the process of being updated to ensure we capture data in accordance with the requirements of PSIRF. Ulysses is now updated to ensure we are compliant with Learning from Patient Safety Events (LFPSE) which replaced the National Reporting and Learning System (NRLS). The Trust went live with this on 14 May which is ahead of the September 2023 deadline set by NHSE/I.

The team will also undertake further work in the interim to ensure that the Trust retain an archive of all available Serious Incidents on StEIS once it is switched off.

- Patient Safety Partners

The Head of Risk and Safety and Associate Director of Governance and Quality are currently reviewing the requirement for this role as an effective patient advocate but also an independent scrutineer of patient safety.

- Collaboration with other Trusts

The Head of Risk and Safety and Safety and Associate Director of Governance and Quality have attended external North West Events, also continuing to actively working with external Trusts within the Region to understand what they have implemented to-date and to identify any shared learning that may assist the Trust in the continued roll out of the Patient Safety Incident Response Framework as part of an ongoing learning collaborative. We draw particular reference to our extensive conversations with East Lancashire NHSFT, considering their learning as an early adopter as part of our approach.

- Commissionner / Provider meeting – ICB & Specialised Commissioning

The Associate Director of Governance and Quality has established monthly meeting with the ICB which is an opportunity to discuss all governance related issues including PSIRF implementation. These discussions have partly focused on how the ICB will monitor and support our improvement and learning journey, and how they will monitor our compliance with the new patient safety incident response standards. Further information is also required on how they will support the co-ordination of cross system learning responses. At this point it's not clear how the ICB will do this so a further update from them requested when we last met on 28 July 2023.

Furthermore, the trust have also liaised and met with Janine Dyson, Head of Quality at NHSE for Specialised Commissioning, Health & Justice Services to ensure our PSIRP meets their requirements.

- Internal Engagement and implementation

There continues to be range of internal stakeholder events including drop-in sessions, PSIRF Roadshows, training sessions, trust wide communication/update bulletins and education sessions. This has further engaged and involved colleagues across the trust, introducing new tools and guidance to support a smooth transition.

- Training

HSIB are due to release additional dates for investigative training. Once released, these will be allocated to our current pool of Investigation officers later in 2023 and early 2024 to support them with the transition to changes to our investigative process. In the meantime, engagement and support sessions as outlined above will cover this subject area.

121 colleagues Trust wide have been enrolled onto a free CPD accredited HSIB course in relation to a 'Systems Approach to learning from Patient Safety Incidents'. Colleagues are required to complete this course at their own pace before 30 September 2023. This covers complex systems, systems thinking and Human Factors, Investigation practices such as interviewing, capturing work-as-done, using a systems framework (SEIPS), synthesising data, and writing reports. This will also support colleagues to develop effective safety actions and recommendations and understand the requirements in relation to engaging and involving those affected by patient safety incidents

<u>Provider oversight roles and responsibilities – Trust Board</u>

The corporate governance team are in the process of arranging a training session with HISB in relation to Safety investigation for strategic decision makers and senior leaders in healthcare. This will support the Board in overseeing patient safety incident responses. It is anticipated this will take place in early November 2023. In the

meantime, the below sets out the responsibilities for the Trust Board which can be read alongside an appendix for this paper. This describes questions to guide provider board oversight of patient safety incident management and improvement.

The trust board (or those with delegated responsibility, including members of board quality sub-committees) is responsible and accountable for effective patient safety incident management in their organisation. This includes supporting and participating in cross system/multi-agency responses and/or independent patient safety incident investigations (PSIIs) where required.

The Chief Nurse is the PSIRF Executive Lead for the Trust. They must provide direct leadership, advice, and support in complex/high profile cases, and liaise with external bodies as required. They must also support the following responsibilities.

- Ensure the organisation meets national patient safety incident response standards

The PSIRF executive lead, supported by the rest of the board/leadership team, must oversee the development, review and approval of the organisation's policy and plan for patient safety incident response, ensuring they meet the expectations set out in the patient safety incident response standards where relevant.

- Ensure PSIRF is central to overarching safety governance arrangements The board or leadership team must have access to relevant information about their organisation's preparation for and response to patient safety incidents, including the impact of changes following incidents.

It is the PSIRF executive lead's responsibility to ensure:

- Oversight roles and responsibilities specification patient safety incident reporting and response data, learning response findings, safety actions, safety improvement plans, and progress are discussed at the board or leadership team's relevant sub-committee(s)
- Roles, training, processes, accountabilities, and responsibilities of staff are in place to support an effective organisational response to incidents.

Mechanisms for the ongoing monitoring and review of the patient safety incident response plan, delivery of safety actions and improvement must form part of the overarching quality governance arrangements and be supported by clear financial planning to ensure appropriate resources are allocated to PSIRF activities and safety improvement. The board or leadership team should monitor the balance of resources going into patient safety incident response versus improvement. Repeat responses should be avoided when sufficient learning is available to enable the development and implementation of a safety improvement plan.

Updates to the policy and plan should be made as required as part of regular oversight processes. An overall review of the patient safety incident response policy and plan should be undertaken at least every four years alongside a review of all safety actions.

- Quality assure learning response outputs

A final report should be produced for all individual PSIIs, and this reviewed and signed off as complete. Sign-off of provider-led PSIIs is the responsibility of the board/leadership team of the organisation(s) involved.

The PSIRF executive lead should be responsible for reviewing PSII reports in line with the patient safety incident response standards and signing it off as finalised. They may be supported in this by relevant colleagues as appropriate.

While a full report for submission to the board/leadership team may not be produced for learning response methods other than PSII, PSIRF executive leads should monitor the quality of all response methods. A sampling approach may be best for this.

Organisations must have processes to ensure that all safety actions implemented in response to learning or wider safety improvement plan(s) are monitored, to check they are delivering the required improvement. Progress on individual actions should be reviewed at appropriate intervals using relevant data, and an overall assessment of the delivery of all safety actions at least every four years as part of the requirements to specification review patient safety incident response plans

Patient Safety Incident Response Plan (PSIRP)

Providers are required to develop and submit a Patient Safety Incident Response Plan (PSIRP) to Cheshire and Merseyside Integrated Care Board (ICB) for agreement and sign off prior to 1 September 2023. A PSIRP is a requirement of each provider or group/network of providers delivering NHS-funded care. After 'Sign Off', an edited version of the PSIRP document will be published on the Trusts website.

Within the PSIRP, the trust must identify and list its top patient safety incident risks/priorities using a risk register type arrangement. To inform our PSIRP, the following types of data sources were considered; serious incident data for the previous three years, patient safety incident risks, patient safety incident reports; complaints and claims.

Our PSIRP is essentially a strategic plan to address the findings of the above data review. This can be found as an appendix alongside this paper and can read in conjunction with our associated Patient Safety Incident Response Policy. As required, the documents we have completed identifies our current patient safety related resources, together with which carefully prioritised and selected patient safety incident types are expected to the subject of Patient Safety Investigations (PSIIs) for the following year, to begin to impact systems improvement. It also identifies a plan for the meaningful and effective use of other incident responses as appropriate

There should be between 3 and 6 Patient Safety Incident Investigations completed (as deemed possible and appropriate), for each of the narrowly specified incident types prioritised. Once this set of narrowly specified investigations are all completed, a thematic /meta data analysis will then be conducted to identify common casual factors and interdependencies.

Appendix 1 – Patient Safety Incident Response Plan

Appendix 2- Patient Safety Incident Response Policy

Appendix 3 – ICB Checklist in relation to the requirements for sign off of our PSIRP – (RAG rated to confirm LWH status)

Appendix 4 – Slide Deck delivered to various Meetings/Committee's Trust Wide

Appendix 5 - Questions to guide provider board oversight of patient safety incident management and improvement

RECOMMENDATION

Trust Board are asked to take assurance in relation to the work undertaken by the Trust so far in planning for the framework implementation.

Furthermore, Trust Board are asked to approve our Patient Safety Incident Response Plan (PSIRP) and Policy, providing a signed Board paper in support of this. Following approval, this is due to be submitted to the integrated Care Board (ICB) prior to our PSIRF go live date of 1 September 2023.

NHS
Liverpool Women's
NHS Foundation Trust

Patient Safety Incident Response Plan (PSIRP).

Patient safety incident response plan

Effective date: 1st September 2023

Estimated refresh date: 1st March 2024

	NAME	TITLE	SIGNATURE	DATE
Author	Allan Hawksey	Head of Risk and Safety	*A.J.Hawksey*	02/08/2023
Reviewer				
Authoriser				

Foreword

The Patient Safety Incident Response Framework (PSIRF) is a much more measured and focussed approach to how The Trust respond to patient safety incidents. There will need to be a clear cultural and systems shift in thinking and how the Trust effectively respond to patient safety incidents, to reduce the risk of an incident happening again as much as possible. Within the Serious Incident Framework, there were set timescales to complete an investigation within 60 days and external organisations often approved the Trust investigative plan and strategy – PSIRF provides the Trust with more autonomy and flexibility in its' approach to patient safety incidents.

Effective initial implementation and ongoing effective development of PSIRF will be achieved through identifying key themes patterns and trends from Trust data, identifying opportunities for effective learning, ensuring those plans in plans in place are progressed immediately, over the medium and longer term. These will be reviewed and re-evaluated where tangible evidence is produced to provide effective assurance that the Trust can demonstrate effective learning, sustainable improvements in the quality and safety of services and improved patient safety outcomes, demonstrable though data.

Effective engagement is a key fundamental of PSIRF. Clear communication from the incident developing (near miss) or occurring cannot be underestimated, with patients, families, carers, or advocacy. Ongoing effective communication to determine the focus of any review or investigation is vital to ensure that the voice of the patient is at the heart of the Trust response throughout and post closure. Documentation of clear communication and engagement is vital.

The process of reviewing or investigating an incident, in accordance with the Trust Fair and Just Culture, and providing psychological safety to encourage openness and transparency throughout, can help colleagues reflect the decisions they made in caring for and treating a patient and facilitate closure.

The Trust acknowledges that PSIRF is a new approach to patient safety incidents but much of the requirements have been part of business as usual for some time. The implementation process will take time to progress and embed and will require regular review to ensure the Trust can demonstrate positive assurance in tangible improvements to the quality and safety of services with improved patient safety outcomes. Data quality and the flexibility of the Trust approach will need to be at the heart of the implementation process to ensure it is continuous evolution.

The Trust in its' entirety is ready to embrace PSIRF and the challenges ahead.

Contents

Introduction

This patient safety incident response plan sets out how Liverpool Women's NHS Foundation Trust (the Trust) intends to respond to patient safety incidents over a period of 24 months.

The plan will not be rigid and will be subject to ongoing review, which will be data driven. The patients' view will be at the heart of the Trust's approach with the focus on the quality and safety of services that the Trust offer and achieving the best possible outcomes for patients and colleagues.

The plan is underpinned by the existing Trust Managing Incidents and Serious Incidents Policy, which is currently under review and the new Trust patient safety incident response policy.

A glossary of terms used can be found at Appendix 1

Trust services (CQC Profile)

Liverpool Women's NHS Foundation Trust (the Trust) specialises in the health of women, babies and their families.

As one of only two such specialist trusts in the UK and the largest women's hospital in Europe the trust holds a unique position.

The main hospital, a modern landmark building, is located on Crown Street in Toxteth and it is here that the team deliver around 8,000 babies and perform some 10,000 Gynaecological procedures each year.

The maternity team cares for women and their babies from conception to birth supported by the neonatal team who provide around the clock care for premature and new born babies needing specialist care.

The trust's fertility team helps families to improve the chance of conceiving babies. In gynaecology, the trust undertakes care of women with the many varied conditions associated with the female reproductive system and is a centre for gynaecology oncology.

The genetics team supports families with the diagnosis and counselling of genetic conditions.

On average 20 babies and three premature babies are born and cared for daily, the trust is primarily known for maternity and neonatal services.

The trust also carries out 30 gynaecology operations and the reproductive medicine unit completes six cycles of IVF treatment every day.

The trust also specialises in clinical and laboratory genetics.

The trust offers choice and flexibility through the provision of both NHS and private care

Defining The Trust patient safety incident profile

Fair and Just Culture is at the heart of all of the Trust Governance processes. This promotes an open and transparent culture to identify and understand patient safety incidents and a desire to learn from and improve the quality and safety of services.

The Trust has a daily huddle to discuss all reported incidents across the Divisions, a weekly safety check in meeting to discuss quality and safety issues, Executive Led weekly Trust Harm meeting, a Quality Improvement Group with the focus on actions from learning, audit and effectiveness, and a monthly Safety and Effectiveness Sub Committee to review, discuss and have oversight of key safety issues. All these collectively, underpin the Trust quality strategy.

PSIRF sets the national requirements listed within the plan. The remainder of the plan is data driven, covering the last 3 years which has provided an insight into the key patient safety incident themes, patterns and trends, repeat causality and the greatest opportunities for learning to improve patient safety outcomes.

The Corporate Governance Team has engaged with internal and external key stakeholders, having reviewed Trust wide data from various sources to determine the Trust safety profile and identify the optimum methods of review to ensure maximum learning and effective plans to improve the quality and safety of services.

The team commenced planning for PSIRF in September 2022 and have consulted with East Lancashire NHS Trust as an early adaptor to assist with the planning process and to learn from them what went well, what didn't work well and what guidance they could provide. This was in addition to consultations with Birmingham Women's and Children's NHS Trust as the other specialist Trust to Liverpool Women's in the Country and all local Trusts who were commencing their PSIRF implementation journey.

The team have had a number of regular engagement meetings with the Integrated Care Board (ICB) both on a one-to-one basis whilst still the Clinical Commissioning Group (CCG) and regularly as part of a local collaborative with other Trusts since the implementation of the ICB.

Infernally, a number of presentations have been presented to Board colleagues to ensure that they were fully appraised and understood the impact and PSIRF and their associated responsibilities. Presentations have also been taken to the Trust Safety and Effectiveness Sub Committee, Quality Committee and Trust Safety Meeting to ensure that all colleagues had oversight on the progress of PSIRF implementation.

Divisional engagement meetings on a weekly basis have been undertaken with Divisional Governance Colleagues and have been presented on a scheduled basis to Divisional Boards and Senior Leadership Teams to determine and agree Divisional profiles and to ensure that they were too appraised and understood the impact and PSIRF and their associated responsibilities

The data sources used to define the trust profile are outlined below. In order to determine the focus and priorities for PSII, there have been a number of stakeholder engagement sessions to prioritise, agree and finalise the Trust priorities (subject to ongoing review).

The Trust utilise the Ulysses Incident Management System to manage incidents. The Corporate Governance Team collated data on all incidents from 01 April 2020 to 31 March 2023 to ensure the data was reflective of pre / during and post Covid incident reporting to minimise any potential impact from the pandemic on incident reporting.

In addition to incidents, a number of data sources were collated and reviewed to ensure that the Trust focus included but was not limited to those incidents reported on to the Ulysses System. These sources included:

- Serious Incident Investigations (last 5 years)
- Health inequalities data (associated with SI review)
- Formal Reviews
- HSIB investigations
- Complaints / PALS / PALS+
- Safeguarding reviews
- Mortality reviews
- Freedom to speak up concerns
- Trust staff survey annual results
- Legal claims (new / ongoing / settled)
- Inquests
- Quality improvement and Service evaluation projects
- Clinical audits – initial and reaudit

The Ulysses data for the reporting period contained 19920 incidents, of which, 18363 were deemed to be patient safety incidents. Of these, there were 18021 clinical incidents, that were as follows by Division / Directorate:

- Maternity Directorate – 9378
- Neonates Directorate – 1658
- Gynaecology Division – 5444
- Clinical Support Services Division - 1541

This data was considered during the divisional engagement sessions with incident categories (cause group) and subcategories (cause group 1) within the themes to determine the overall Trust profile. The Trust profile, in turn, is underpinned by Divisional priorities for Patient Safety Incident Investigations.

Investigations	3332
Clinical Management	2819
Admission / Discharge / Transfer	1361
Staffing Levels	1311
Communication	1300
52 Week RTT Breach	1282
Medication	1219

Diagnosis	746
Appointments	743
Patient Records / Identification	677
Equipment	662
Haemorrhage	438
Blood Transfusion	291
Injury	211
Infection	171
Cancellations - Theatres	149
Unexpected Death	114
Invasive Procedure Problem	110
IT Problems	108
Service Provision And/or Interruption	107
Failed Instrumental Delivery	102
Patient Safety / Experience	92
Covid-19	73
Resuscitation	70
Complaint	70
Unattended Birth	69
62 Day Cancer Breach	67
Safeguarding Children	65
Feeding Issue	61
Slips Trips And Falls	54
Environment	48
Safeguarding Adults	41
Standard/audit Deficit	37
104 Day Cancer Breach	34
Pressure Ulcer	31
Information Governance	27
Midwifery Red Flag	27
Interpretation Services	26
Security	23
Non-Physical Assault	20
Allergic Reaction	19
Transport Problem	18
Ambulance Related	15
Access To Gynaecology Emergency Theatre	15
Expected Death	15
Sharps	14
Surgical Count	10
Peripartum Morbidity	9
Medicines Fridges	8
Convulsions	8
Thromboembolism	8
Failed Regional Technique	6
Manual Handling	5

COSHH	5
Self-Harming Behaviour	4
Professional Registration Issue	3
Unexplained Organ Damage	3
Human Resources	3
Fire Incident	2
Nursing Red Flag	1
Collision/Contact	1
Physical Assault	1
Pulmonary Oedema	1
Splash	1
Grand Total	**18363**

The Trust profile, however, must retain flexibility in its approach to risk and learning, and therefore, where there is significant risk, opportunities for significant new learning and impacts on quality and safety of services, the Trust will retain capacity for additional PSII outside of the Trust profile where required.

Defining the Trust patient safety improvement profile

The Trust has developed strong governance processes across the Clinical divisions and the Corporate Governance Team and continues to review its' governance processes to ensure that they remain fit for purpose, ensure that patient safety is the focus and that there remains an ongoing process of effective learning, continuous improvement within a fair and just culture. The Trust will also continue to embrace national and regional guidance and support from NHS organisations, Regulators, Commissioners and Partner Agencies.

The Trust Quality Committee will retain oversight of quality improvement measures and safety improvement plans to ensure that they remain of the highest standard. Its' subcommittee, The Safety and Effectiveness Sub Committee will ensure that the clinical and corporate divisions provide robust assurance to learning and safety improvement plans, ensuring that the process of embedded learning from PSIRF continues. The quality Improvement Group will ensure that the clinical and corporate divisions provide robust assurance to quality improvement, in accordance with the Trust Quality Strategy.

The Trust will continue to ensure that quality and safety of services is paramount to the investigations that it undertakes in accordance with National and Local Priorities and that its' approach remains flexible to new risk and significant opportunities for learning.

Patient safety incident response plan: national requirements

Quality and Safety of services and effective learning will remain the focus for the Trust, improving patient safety outcomes and reducing repeat causality of incidents.

Never events and deaths, where there are perceived deficiencies in care, will clearly require a Patient Safety Incident Investigation to identify and maximise opportunities for learning. Other incident types will also require a Patient Safety Incident Investigation mandated nationally.

All investigations will be undertaken in accordance with the Trust fair and just culture.

In addition to a Patient Safety Incident Investigation, some incident types will require specific reporting and/or review processes to be followed. All types of incidents that have been nationally defined as requiring as specific response will be reviewed according to the suggested methods.

Incident	Process	Quality and Safety Improvement
Maternity and neonatal incidents meeting HSIB and Special Healthcare Authority referral criteria	Work with partners to ensure cases are referred to Healthcare Safety Investigation Branch (HSIB)	Respond to recommendations from external referred agency/organisation as to underpin the Trust Quality Strategy
Child death	Refer for Child Death Overview Panel (CDOP) and liaise with panel as locally led PSII may be required	
Death of a person who has lived with a Learning Disability or autism	Refer for Learning Disabilities Mortality Review (LeDeR) liaise with ICB (LeDeR Local Area Co-ordinator) as locally led PSII may be required	
Safeguarding incidents in which: Babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence. Adults over 18 years old are in	Refer to local authority safeguarding lead via LWHFT named safeguarding lead LWHFT will contribute to domestic independent inquiries, joint targeted area	

receipt of care and support needs from their local authority. The incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence.	inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and the local safeguarding adults boards	
Domestic homicide	Identified by the police usually in partnership with the local community safety partnership with whom the overall responsibility lies for establishing review of the case. Where the CSP considers that the criteria for a domestic homicide review are met and establishment of a DHR panel, LWHFT will contribute as required by the DHR panel.	
Incidents in screening programmes	Work with partners to ensure cases are referred to Public Health England (PHE)	
Patient Safety incidents meeting the Never Event criteria 2018 or its replacement	Patient Safety Incident Investigation	Local / Divisional / Trust wide recommendations and actions to underpin the Trust Quality Strategy
Deaths of patients detained under the MHA (1983) or where the MCA (2005) applies, where there is reason to think that the death may be linked to problems in care	Patient Safety Incident Investigation	Respond to recommendations from external referred agency/organisation as to underpin the Trust Quality Strategy
Patient safety incidents resulting in death where the death is thought more likely than not to be due to problems in care	Patient Safety Incident Investigation	Respond to recommendations from external referred agency/organisation as to underpin the Trust Quality Strategy

Trust patient safety incident response plan: Divisional focus

Trust requires 6 patient safety priorities as local focus based on the analysis of the data that has driven and underpinned this Patient Safety Incident Response Plan in addition to 2 Trust Priorities relating to being an isolated site and the host of the Regional Community Diagnostic Centre. All outcomes from Patient Safety Incident Investigations will be used to inform and underpin Patient Safety and Quality workstreams and associated Trust Policies and Strategies.

Incident	Process	Quality and Safety Improvement
Future Generations isolated site incidents including critical care transfers	Patient Safety Incident Investigation where agreed (detail provided in associated LWHFT policies)	Local / cross divisional / Trust wide / National recommendations and actions and these will underpin the Trust Quality Strategy
Community Diagnostic Centre associated incidents (to be queried on a case-by-case basis)	Patient Safety Incident Investigation where agreed (detail provided in associated LWHFT policies)	
1. Admission / discharge / transfer issues (Communication, appointments, delays in discharge, delays in admissions/transfers)	Patient Safety Incident Investigation where agreed (detail provided in associated LWHFT policies)	Local / cross divisional / Trust wide / National recommendations and actions and these will underpin the Trust Quality Strategy
2. Clinical management / Diagnosis (including deteoriating patients and escalation) / Treatment (including retained products) / delays to follow up / imaging incidents	Patient Safety Incident Investigation where agreed (detail provided in associated LWHFT policies)	Local / cross divisional / Trust wide / National recommendations and actions and these will underpin the Trust Quality Strategy
3. Skin injuries (grade2, 3 and 4 pressure ulcers / unexplained injuries)	Patient Safety Incident Investigation where agreed (detail provided in associated LWHFT policies)	Local / cross divisional / Trust wide / National recommendations and actions and these will underpin the Trust Quality Strategy
	Patient Safety Incident	Local / cross divisional /

4. Invasive procedure problems including injury following surgery	Investigation where agreed (detail provided in associated LWHFT policies)	Trust wide / National recommendations and actions and these will underpin the Trust Quality Strategy
5. Medication prescribing and administration	Patient Safety Incident Investigation where agreed (detail provided in associated LWHFT policies)	Local / cross divisional / Trust wide / National recommendations and actions and these will underpin the Trust Quality Strategy
6. Equipment failure	Patient Safety Incident Investigation where agreed (detail provided in associated LWHFT policies)	Local / cross divisional / Trust wide / National recommendations and actions and these will underpin the Trust Quality Strategy
Incident resulting in moderate or severe harm to patient	Statutory Duty of Candour and: Local review using appropriate toolkit Patient Safety Incident Investigation where agreed (detail provided in associated LWHFT policies)	New / ongoing improvement plan focussing on Quality and Safety Thematic review where required (data driven) Local / cross divisional / Trust wide / National recommendations and actions and these will underpin the Trust Quality Strategy
No/Low Harm Patient Safety Incident	Local and thematic review	New / ongoing improvement plan focussing on Quality and Safety Thematic review where required (data driven)

Glossary of terms

PSIRF - Patient Safety Incident Response Framework. This is a national framework applicable to all NHS commissioned outside of primary care. Building on evidence gathered and wider industry best-practice, the PSIRF is designed to enable a risk-based approach to responding to patient safety incidents, prioritising support for those affected, effectively analysing incidents, and sustainably reducing future risk.

PSIRP - Patient Safety Incident Response plan. The Trust Local plan sets out how we will carry out the PSIRF locally including our list of local priorities. These have been developed through a coproduction approach with the divisions and specialist risk leads supported by analysis of local data.

PSII - Patient Safety Incident Investigation. PSIIs are conducted to identify underlying system factors that contributed to an incident. These findings are then used to identify effective, sustainable improvements by combining learning across multiple patient safety incident investigations and other responses into a similar incident type. Recommendations and improvement plans are then designed to effectively and sustainably address those system factors and help deliver safer care for our patients.

AAR – After action review. A method of evaluation that is used when outcomes of an activity or event have been particularly successful or unsuccessful. It aims to capture learning from these to identify the opportunities to improve and increase to occasions where success occurs.

SJR - Structured judgement review Originally developed by the Royal College of Physicians. The Trust follows the Royal College of Psychiatrists model for best practice in mortality review. The SJR blends traditional, clinical judgement based review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, and to score care for each phase. This allows the Trust to identify deaths assessed as more likely than not due to problems in care. This allows the Trust to identify those deaths which may need to progress to PSII according to the given national priorities.

SWARM - Used within Healthcare in the UK and US, a SWARM approach allows for the rapid review of an incident – staff swarm to a discussion and where possible the location of an incident to allow for it to be explored on a systemic basis and to support those immediately involved.

Never Event - Patient safety incidents that are considered to be wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare provider

Patient Safety Incident Response Policy

Effective date: 01 September 2023

Estimated refresh date: 01 March 2023

	NAME	TITLE	SIGNATURE	DATE
Author	Allan Hawksey	Head of Risk and Safety	*A.J.Hawksey*	17/07/2023
Reviewer				
Authoriser				

Contents

Purpose

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out Liverpool Women's NHS Foundation Trust's approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

This policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF:

- compassionate engagement and involvement of those affected by patient safety incidents
- application of a range of system-based approaches to learning from patient safety incidents
- considered and proportionate responses to patient safety incidents and safety issues
- supportive oversight focused on strengthening response system functioning and improvement.

Scope

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across all patient facing services and departments delivering care.

Responses under this policy follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component. Responses do not take a ‘person-focused’ approach where the actions or inactions of people, or ‘human error’, are stated as the cause of an incident.

There is no remit to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement. Other processes, such as claims handling, human resources investigations into employment concerns, professional standards investigations, coronial inquests and criminal investigations, exist for that purpose. The principle aims of each of these responses differ from those of a patient safety response and are outside the scope of this policy.

Information from a patient safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response.

The Trust patient safety culture

Liverpool Women's NHS Foundation Trust promotes a fair and just culture approach in all work undertaken or planned to improve safety culture.

Psychological safety underpins openness and transparency to encourage incident reporting and raising concerns.

The Trust will always encourage and support incident reporting where an incident may have or is likely to occur which has caused, contributed to or may lead to harm of a patient, visitor or colleague.

Please refer to the Trust's current managing incidents policy is embedded for reference and will be updated further time for the PSIRF go live date of 1 September 2023.

http://imt012/Policies_Procedures_and_Guidelines/Guidance%20Documents/Managing%20Incidents%20%20Serious%20Incidents%20Policy.pdf

Patient safety partners

The Trust is currently in a process to recruit Patient Safety Partners in line with the NHSE guidance Framework for involving patients in patient safety .

Patient Safety Partners (PSP) will have a fundamental role in supporting PSIRF providing a perspective through a patient lens to support developments and innovations to drive continuous improvement in respect of quality and safety of services.

The PSP will be involved in the designing of safer healthcare at all levels in the organisation, to promote safety in the Trust and maximise opportunities for effective and embedded learning. They will use their experience as a patient, patient representative or member of the local community to provide support, guidance and challenge.

PSPs will be part of the Liverpool Women's Hospital Family and will work alongside all staff, volunteers and patients. They will attend quality and safety focussed meetings (face-to-face and online) and be intrinsically involved in patient safety and quality initiatives.

Full role descriptions will be provided for PSPs along with any training and support requirements identified so that they can fulfil their role to its' full potential and ensure the best patient safety outcomes for all patients.

Addressing health inequalities

Liverpool Women's NHS Foundation Trust (the Trust) specialises in the health of women, babies, and their families. As one of only two such specialist trusts in the UK and the largest women's hospital in Europe the trust holds a unique position.

The Trust has a key role to play in tackling health inequalities in partnership with local partner agencies and services. However, most of the fundamental factors driving inequalities in health are beyond the responsibility of the health care system alone and are driven by a number of socio-economic factors.

Through the implementation of PSIRF, the Trust will utilise data and learning to identify actual and potential health inequalities and make recommendations to the Trust Board and partner agencies in order to try and reduce the negative impacts on patients due to such inequalities.

Engagement with patients, families and wider following a patient safety investigation must also recognise the diverse needs of the communities that the Trust serve and ensure inclusivity for all.

Engaging and involving patients, families and staff following a patient safety incident

The PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families and staff). This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required.

Involving Patients, Families and Patient Representatives

The Trust is committed to involving patients and families following patient safety incidents, engaging them at the earliest opportunity and throughout in the ongoing investigation process, fulfil the duty of candour statutory and non-statutory requirements.

Patients, families and patient representatives often provide a unique, or different perspective to the circumstances around patient safety incidents and may have questions or needs to that of the organisation that will need to be incorporated into the investigation ensuring that the process is patient centred throughout.

This policy refreshes and prioritises the existing guidance relating to the duty of candour and 'being open and honest' and recognises the need to involve patients, families and patient representatives as soon as possible in all stages of any investigation, or improvement planning, unless they express a wish not to be involved.

Further guidance in relation to involving patients and families following a patient safety incident is available from NHSE at: https://www.england.nhs.uk/publication/patient-safety-incident-response-framework-and-supporting-guidance/#heading-2

Please also refer to the Trust Being Open and Duty of Candour Policy http://intranet/Policies_Procedures_and_Guidelines/Guidance%20Documents/Being%20Open%20and%20Duty%20of%20Candour%20Policy%20and%20Procedure.pdf

Involving Colleagues and Partner Agencies

Involvement of colleagues and partner agencies at the earliest opportunity and throughout an investigation is fundamental when responding to a patient safety incident ensuring that there is a process of openness and transparency throughout.

The Trust will, in accordance with the Fair and Just Culture, continue to promote, support and encourage incident reporting, including near misses and all levels of harm. The Trust can only deal with and respond to incidents that are reported onto the Ulysses System and identify actions required to manage and mitigate risk.

Staff and colleagues need to feel supported to speak out and openly report incidents and concerns. They also need to be supported when they are involved in incidents and the Trust has a clear policy for managers and colleagues to ensure that the right support is identified and available at the right time.
http://intranet/Policies_Procedures_and_Guidelines/Guidance%20Documents/Supporting%20Staff%20following%20a%20work%20related%20traumatic%20event%20or%20Serious%20Incident.pdf

Patient safety incident response planning

PSIRF supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm. Beyond nationally set requirements, organisations can explore patient safety incidents relevant to their context and the populations they serve rather than only those that meet a certain defined threshold.

Trust planning needs to account for and consider other sources of information such as complaints, risks, legal claims, mortality reviews and other forms of direct feedback from staff and patients. PSIRF guidance specifies the following standards that the Trust plans should reflect:

1. A thorough analysis of relevant organisational data
2. Collaborative stakeholder engagement
3. A clear rationale for the response to each identified patient safety incident type

They will be:

1. Updated as required and in accordance with emerging intelligence and improvement efforts
2. Published on the Trust external facing website

The Trust patient safety incident response plan (PSIRP) will reflect these standards and will be published alongside this overarching policy framework.

Resources and training to support patient safety incident response

PSIRF recognises that the Trust has limited resources and capacity to investigate and learn effectively from patient safety incidents. It is essential that Liverpool Women's Hospital ensure that it uses capacity and resources effectively to deliver the plan. The PSIRP provides more specific details in relation to this including the number of comprehensive investigations that may be required for single or small groups of incidents that do not fall into one of the broader improvement workstreams/priorities.

Currently the Corporate Governance Team / Wider Trust has the following working time equivalent posts to support and facilitate the PSIRF framework:

- 3 x Patient Safety Specialists and 1 Maternity Dedicated Patient Safety Specialist (additional role to substantive posts)
- 1 x Associate Director of Governance and Quality
- 1 x Head of Risk and Safety
- 1 x Head of Continuous Improvement
- 1 x Quality and Governance Facilitator
- 1 x Medical Device Safety Officer (additional role to substantive posts)
- 2 x Ulysses Governance Support Administrators

There is a pool of trained investigators who can undertake comprehensive investigations, however the majority have a substantive clinical or governance role, so must be allocated time within job plans to complete investigations

All staff are required to complete mandatory patient safety training levels 1 and 2 which covers the basic requirements of reporting, investigating, and learning from incidents.

Trust patient safety incident response plan

The Trust plan sets out how Liverpool Women's NHS Foundation Trust intends to respond to patient safety incidents for 2023 - 2025. The plan will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected, as well as the plan.

The plan is based on a thorough analysis of themes, patterns, and trends from:

- Serious Incident Investigations (last 5 years)
- Health inequalities data (associated with SI review)
- Formal Reviews
- HSIB investigations
- Complaints / PALS / PALS+
- Safeguarding reviews
- Mortality reviews
- Freedom to speak up concerns
- Trust staff survey annual results
- Legal claims (new / ongoing / settled)
- Inquests
- Quality improvement and Service evaluation projects
- Clinical audits – initial and reaudit

Reviewing the patient safety incident response policy and plan

The patient safety incident response plan is a ‘living document’ that will be appropriately amended and updated as we use it to respond to patient safety incidents. Initially the plan will be reviewed within 6 months; with ongoing improvement work the patient safety incident profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous period.

Updated plans will be published on the Trust website, replacing the previous version.

A rigorous planning exercise will be undertaken, as agreed with the integrated care board (ICB)) to ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include reviewing Trust response capacity, mapping services, a wide review of organisational data (for example, patient safety incident investigation (PSII) reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement

Responding to patient safety incidents

Patient safety incident reporting arrangements

Patient safety incident reporting will follow the Trust Managing Incidents and Serious Incidents Policy (currently under review) It is recognised that staff must continue to feel supported and able to report any incidents or concerns in relation to patient safety, whilst promoting a system of continuous improvement within the fair and just culture.

Responding to cross-system incidents/issues

The Corporate Governance and Divisional Governance teams will ensure any incidents that require external engagement are identified and shared through existing channels and networks, and that partnership colleagues are fully engaged in investigations and learning as and when required. This process will be reciprocated by the Trust.

Certain incidents will require external reporting to national bodies such as HSIB, HSE, RIDDOR and MHRA.

Patient safety incident response decision-making

The Trust has governance and assurance systems to ensure oversight of incidents at both Divisionally and Trust Wide. Corporate and Divisional Governance teams work managers to ensure the following arrangements are in place.

- Identification and escalation of any incidents that have, or may have caused significant harm (moderate, severe or death)
- Identification of themes, trends, or clusters of incidents within a specific service
- Identification of themes, trends or clusters of incidents relating to specific types of incidents
- Identification of any incidents relating to local risks and issues (eg – CQC concerns)
- Identification of any incidents requiring external reporting or scrutiny (eg – Never Events, Neonatal deaths, RIDDOR)
- Identification of any other incidents of concern, such as serious near-misses or significant failures in established safety procedures

This data will be reviewed regularly against the identified priorities in the PSIRP to determine whether any shift in focus is required, which will be agreed by the Quality and Committee if required.

The process for completion of a Patient Safety Incident Review, currently identified as a 72-hour rapid review, to determine further investigation or escalation required will remain. This will include a wider range of options for further investigation outlined in the PSIRF.

The principles of proportionality and a focus on incidents that provide the greatest opportunity for learning will be central to this decision making under the Trust's PSIRP. This may often mean no further investigation is required, especially where the incident falls within one of the improvement themes identified in the PSIRP and this will be considered on a case-by-case basis with justification where necessary.

Timeframes for learning responses

Learning responses must balance the need for timeliness and capture of information as close to the event as possible, with thoroughness and a sufficient level of investigation to identify the key contributory factors and associated learning for improvement.

The PSIRP provides more detail on the types of learning response most appropriate to the circumstances of the incident. Initial incident investigation – as soon as possible, within 5 working days of reporting

- Further learning response (eg: Patient Safety Incident Investigation's (PSII's), After Action Review (ARR), Swarm huddle – within 20 working days of reporting
- Comprehensive Investigation – 60 - 120 working days depending on complexity

A toolkit of learning response types is available from NHSE at https://www.england.nhs.uk/publication/patient-safety-learning-response-toolkit/

Safety action development and monitoring improvement

PSIRF moves away from the identification of 'recommendations' which may lead to determining a resolution at an early stage of the safety action development process.

"Learning response methods enable the collection of information to acquire knowledge. This is important, but it is only the beginning. A thorough human factors analysis of a patient safety incident does not always translate into better safety actions to reduce risk. You must move from identifying the learning to implementation of the lessons. Without an integrated process for designing, implementing, and monitoring safety actions, attempts to reduce risk and potential for harm will be limited."

Quality Improvement to support embedded learning and improvement following a patient safety investigation is key to improving patient safety outcomes. Close links have been and will continue to be developed and maintained with the Continuous Improvement Team. PSIRF provides an opportunity to strengthen this and for the QI and Patient Safety functions to work hand in hand.

Safety actions arising from a learning response should follow the SMART (Specific, Measurable, Achievable, Realistic, Time-bound) principles and thought must be given to monitoring and measures of success. Further guidance on this can be found in NHSE Guidance at https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-Safety-action-development-v1.1.pdf

Monitoring of completion and effectiveness of safety actions will be through organisational governance processes reporting within Divisions and their associated governance meetings, to Safety and Effectiveness Sub Committee and Quality Committee.

The Corporate Governance Team will maintain an overview across the organisation to identify themes, patterns and trends via the Integrated Governance Report supported by Divisions on a quarterly basis.

Safety improvement plans

The PSIRP details how the Trust will ensure patient safety incidents are investigated in a more holistic and inclusive way, to identify key learning and safety actions which will reduce risk, improve safety and quality of services and improved patient safety outcomes for all patients.

These themes are clearly detailed in the PSIRP.

The Trust will continually review its' governance processes in line with the PSIRF guidance so it is clear how the PSIRP improvement priorities will be overseen through the Trust Governance Processes to provide 'ward to board' assurance.

Oversight roles and responsibilities

"When working under PSIRF, NHS providers, integrated care boards (ICBs) and regulators should design their systems for oversight "in a way that allows organisations to demonstrate [improvement], rather than compliance with prescriptive, centrally mandated measures". To achieve this, organisations must look carefully not only at what they need to improve but also what they need to stop doing (eg panels to declare or review Serious Incident investigations).

Oversight of patient safety incident response has traditionally included activity to hold provider organisations to account for the quality of their patient safety incident investigation reports. Oversight under PSIRF focuses on engagement and empowerment rather than the more traditional command and control."

NHSE, PSIRF Guidance 'Oversight roles and responsibilities specification and Patient safety incident response standards'

Responsibility for oversight of the PSIRF for provider organisations sits with the Trust Board. The Executive Lead is the Chief Nurse who holds responsibility for effective monitoring and oversight of PSIRF.

The Trust is committed to working with the ICB and other national commissioning bodies as required. Oversight and assurance arrangements will be developed through joint planning and arrangements must incorporate the key principles detailed in the guidance namely

1. Compassionate engagement and involvement of those affected by patient safety incidents
2. Policy, planning and governance
3. Competence and capacity
4. Proportionate responses
5. Safety actions and improvement

Complaints and appeals

Complaints relating to this guidance, or its implementation can be raised informally with any of the the Trust Patient Safety Specialists, initially, who will aim to resolve any concerns as appropriate.

Formal complaints from patients or families can be lodged through the Trust's complaints procedure via PALS@lwh.nhs.uk 0151 702 4353 or in writing as follows:

PALS
Liverpool Women's NHS Foundation Trust
Crown Street
Liverpool
L8 7SS

Directly with the Chief Executive:

The Chief Executive,
Liverpool Women's NHS Foundation Trust,
Crown Street,
Liverpool,
L8 7SS

Cheshire and Merseyside Integrated Care Board
Patient Safety Incident Response Framework (PSIRF) sign off checklist for the Patient Safety Incident Response Plan (PSIRP).

March 2023

What do we expect?	Yes/No?
Signed Board Paper, approving your patient safety implementation plan	
Transition for Close Down of Serious Incident Plan	
Patient Safety Incident Response Plan	
Patient Safety Incident Response Policy	

Required in the above documents	Yes/No?
Incident prioritisation process	
Patient Safety Incident Investigations (PSIIs) – including how to evaluate & monitor outcomes following PSIIs, for progress against the PSRIF to be measured and safety risks effectively mitigated	
PSIRF national priorities	
Local priorities	
Responding to patient safety	
Engaging & involving of patient, families and carers following patient safety incidents	
Statutory Duty of Candour	
Patient Safety Partners	
Involvement & support from staff following incidents	
Resources, learning and improving to support patient safety incident response	
Patient Safety Culture	
Addressing health inequalities	
Patient safety incident investigations	
Patient safety incident response planning	
Patient safety incident reporting arrangements	
Patient safety incident response decision-making	
Responding to cross-system incident/issues	
Timeframes for learning responses	
Safety action development and monitoring improvement	
Safety improvement plans	
Mortality Issues	
Oversight roles and responsibilities	
Complaints & appeals	

Required evidence of	Yes/No?
Whistleblowing evidence	
Case notes reviews	
Staff survey results	
Claims	
Staff suspensions	
Risk assessments	

Organisation patient safety reports	
Identification of the interventions (or alternative review techniques) available and planned for incidents that fall outside the patient safety incident investigation plan but require action or new insight, e.g.: • 'being open' conversations • incident timelines (to inform Duty of Candour disclosure and being open conversations) • structured judgement review/case note review/clinical review (to identify whether issues of concern and to inform Duty of Candour disclosure and being open conversations) • after-action review (for rapid local team review) • audit (to measure/monitor compliance against policy/guidance/expectations)	

Series of Events	Yes/No
Creation of above documents and requirements	
Request sign off from Provider Board	
Once approved by Provider Board, request review from ICB panel	
ICB Panel to review, with at least one member from relevant Place to Provider	
Sign off from Director of Nursing and Care for Cheshire and Merseyside ICB, following sign off from ICB panel	
ICB to draft a letter to the Provider's Director of Nursing/Care for confirmation of PSIRF sign off	
PSIRP documents uploaded to the organisation's website	
Check-ins at the Providers discretion for progress with the implementation of PSIRF and closure of Serious Incidents	

APPENDIX 4

NHS
Liverpool Women's
NHS Foundation Trust

Patient Safety Incident Response Framework & LWH Implementation

May 2023

Phil Bartley – Associate Director of Quality & Governance
Allan Hawksey – Head of Risk & Safety
Mark Campbell – Head of Continuous Improvement

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1

Objectives

- What progress has been made to implement PSIRF at LWH
- What further work and support is required to operate PSIRF at LWH according to national standards

2

A New Approach to Responding to Patient Safety Incidents

- The PSIRF will replace the current Serious Incident Framework (2015)
- The framework represents a significant shift in the way the NHS responds to patient safety incidents and is a major step towards establishing a safety management system across the NHS
- The PSIRF supports the development and maintenance of an effective patient safety incident response system that integrates four key aims:

3

PSIRF Principles

NHS Liverpool Women's NHS Foundation Trust

Compassionate engagement and involvement of those affected by patient safety incidents:

- Expectations are clearly set for engaging, involving, and supporting those affected by patient safety incidents
- Aligned with ongoing research around improving patient and family involvement

Considered and proportionate responses to patient safety incidents:

Changes blunt rules to determine what to learn from and what not to learn from
Resource planning based on thorough understanding of patient safety incident profiles and ongoing improvement activity.
Supports organisations to be more proportionate, sensitive and considered in their approach

Application of a range of system-based approaches to learning from patient safety incidents:

- Promotes a range of methods for responding to and learning from patient safety incidents
- Moves away from RCA
- Timelines are more flexible and set in consultation with the patient and/or family
- Quality of response and resulting improvement work is the priority

Supportive oversight focused on strengthening response system functioning and improvement:

Regulators and ICSs will consider the strength and effectiveness of organisations' incident response processes
Makes leaders of organisations providing healthcare accountable for how their organisation responds and improves following patient safety incidents.

4

PSIRF Main Changes

- A move away from defining a list of serious incidents nationally
- A smaller list of categories of incidents which require reporting externally (StEIS) and full Patient Safety Incident Investigations (PSII) including:

✓ Never Events
✓ Patient deaths identified as being more likely than not due to problems in care following a case review
✓ Mental Health related homicides
✓ Maternal and neonatal deaths that meet the current 'Each Baby Count's criteria'
✓ Local Priorities

- A risk based approach which is more proactive and will form part of the Patient Safety Incident Response Plan (PSIRP)

5

PSIRF Main Changes

- Designed for safety and learning – rather than performance management and emphasises a fair response to patient safety incidents
- Timescales agreed with patients/families not set nationally/locally
- Promotes increased transparency and the need to support those affected by a patient safety incident:
- Terms of reference and inclusion of patient/families within the investigation process
- Support focused on patient/families and staff involved in incidents
- Promotes a system based approach to incident investigation
- Introduces new Patient Safety Incident Standards for Commissioners, Boards and Investigators
- Trust Board overview and approval of incidents rather than CCG's
- New methodologies for investigations (not root cause analysis)
- New national report templates

6

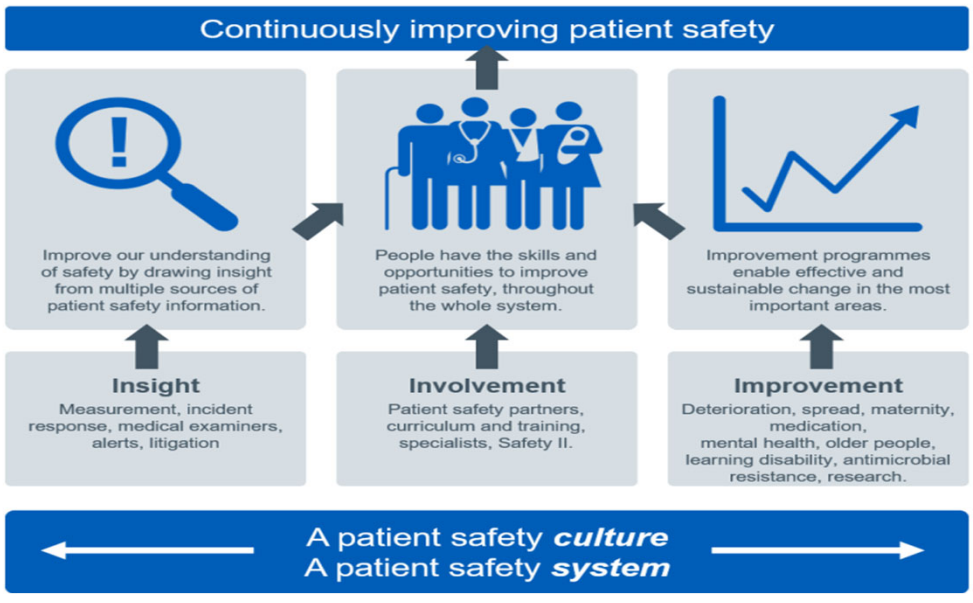
Patient Safety Incident Response Activity

- Patient Safety Incident Investigation (PSII) – in-depth review of a single or cluster of incidents to understand what happened and how
- Multidisciplinary Team Review – aims to through open discussion to agree the key contributory factors and system gaps that impact on safe patient care
- Swarm Huddle – initiated as soon as possible after an event and involves and MDT discussion. Staff 'swarm' to the site to gather information about what happened and why and decide what needs to be done to reduce reoccurrence
- After Action Review (ARR) – structured facilitated discussion of an event, based around 4 questions

1. What was expected to happen? 2. What actually happened?
3. What was the difference between the expected outcome and the event?
4. What is the learning?

7

Figure 1: Summary of the NHS Patient Safety Strategy



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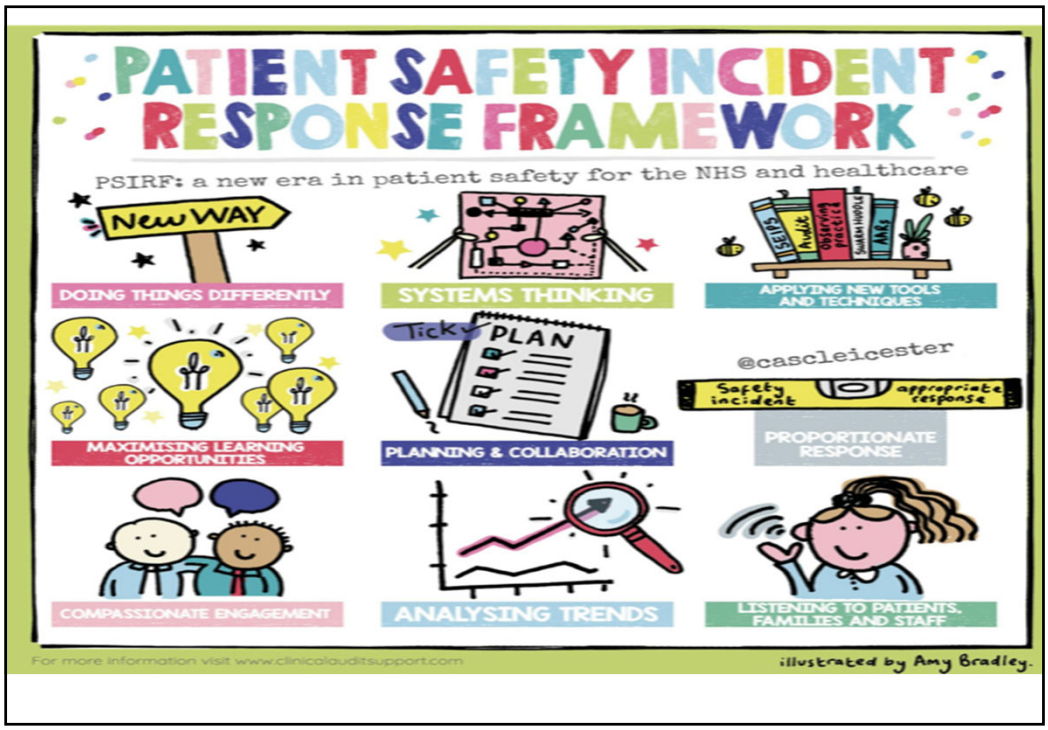
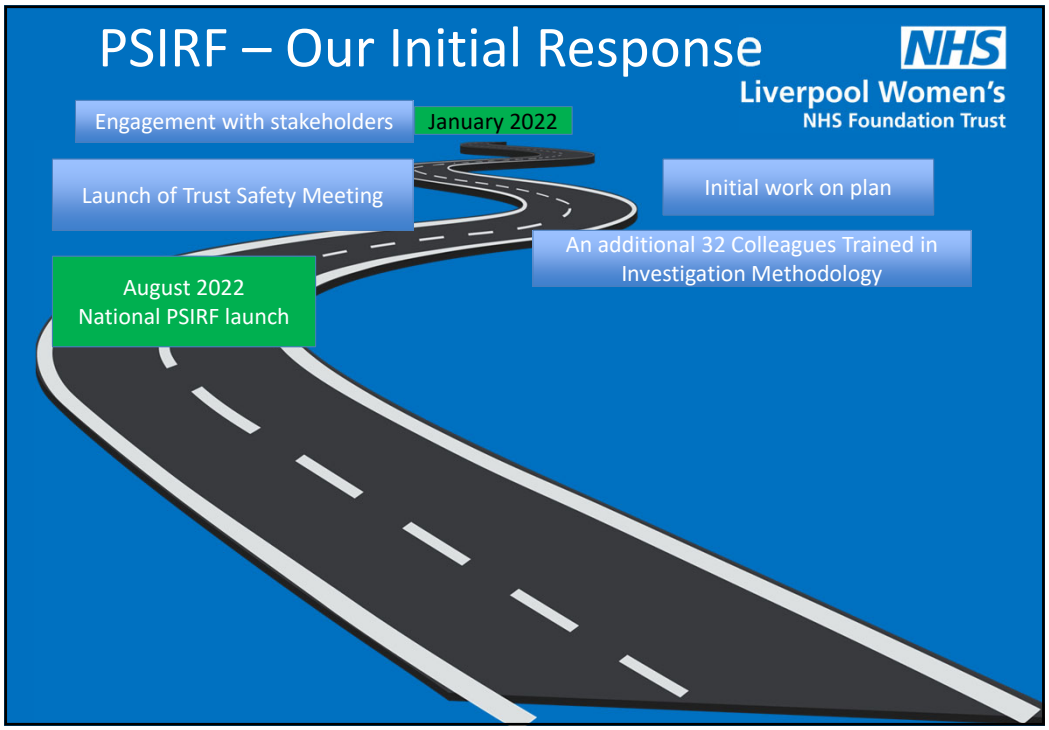

PATIENT SAFETY INCIDENT RESPONSE FRAMEWORK
PSIRF: a new era in patient safety for the NHS and healthcare
New WAY
DOING THINGS DIFFERENTLY
SYSTEMS THINKING
APPLYING NEW TOOLS AND TECHNIQUES
MAXIMISING LEARNING OPPORTUNITIES
Ticky PLAN
PLANNING & COLLABORATION
@cascleicester
Safety incident
appropriate response
PROPORTIONATE RESPONSE
COMPASSIONATE ENGAGEMENT
ANALYSING TRENDS
LISTENING TO PATIENTS, FAMILIES AND STAFF
For more information visit www.clinicalauditsupport.com
illustrated by Amy Bradley.

9


PSIRF Road Map
NHS
Liverpool Women's
NHS Foundation Trust
January 2022
August 2022
National PSIRF launch
ICB Sign off and
Implementation at LWH
31 August 2023

10


PSIRF – Our Initial Response
NHS
Liverpool Women's
NHS Foundation Trust
Engagement with stakeholders
January 2022
Launch of Trust Safety Meeting
Initial work on plan
An additional 32 Colleagues Trained in Investigation Methodology
August 2022
National PSIRF launch

11


What we have done so far
NHS
Liverpool Women's
NHS Foundation Trust
Initial work on plan
January 2022
Engagement with stakeholders
Launch of Trust Safety Meeting
An additional 32 Colleagues Trained in Investigation Methodology
August 2022
National PSIRF launch
Resource analysis
SUI analysis
April 2017 to
February 2023
Patient Safety Training levels 1 & 2 are now live
3 x Patient Safety Specialists & Safety Lead for Maternity
Executive Lead for PSIRF
Upgrade of Ulysses to support the launch of LFPSE replacing NRLS
Roll out of Human Factors Training – B7 & above
External Engagement incl attendance at NW events
Collation of Health Inequalities Data within SUI analysis

12

13

Collaborate, Collaborate, Collaborate

Internal

- Patient Experience
- Communications
- Workforce and OD
- Quality Improvement
- Divisional and Corporate Teams
- Divisional Governance Teams

External

- PSIRF early adopters
- National groups
- Patient Safety Learning
- AQUA/HSIB
- Coroner
- CQC
- LMNS

14

Training and Preparation Needs

- Preparation training for investigators to be delivered by the Risk & Patient Safety Team
- Preparation training for learning response/safety leads (systems-based approach and techniques to be used)
- Preparation training for those engaging with those involved in patient safety incidents to facilitate compassionate and meaningful involvement
- Free courses on HSIB
- Support from Aqua -
- Toolkit workshops
- Roadshows and Drop in's – enhanced visibility & presence from the corporat team within all areas of the trust.

15

Patient Safety Partners Progress at LWH

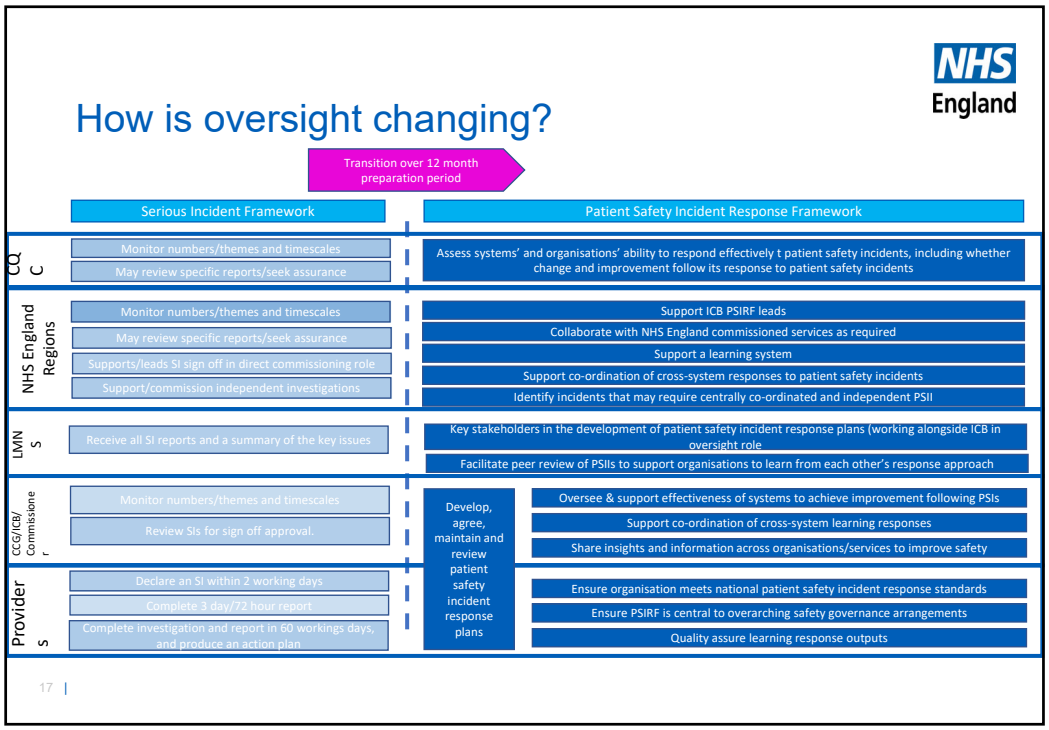
Collaboration with other organisations recruiting

Workshops with various groups who use patient voice representatives in their services,

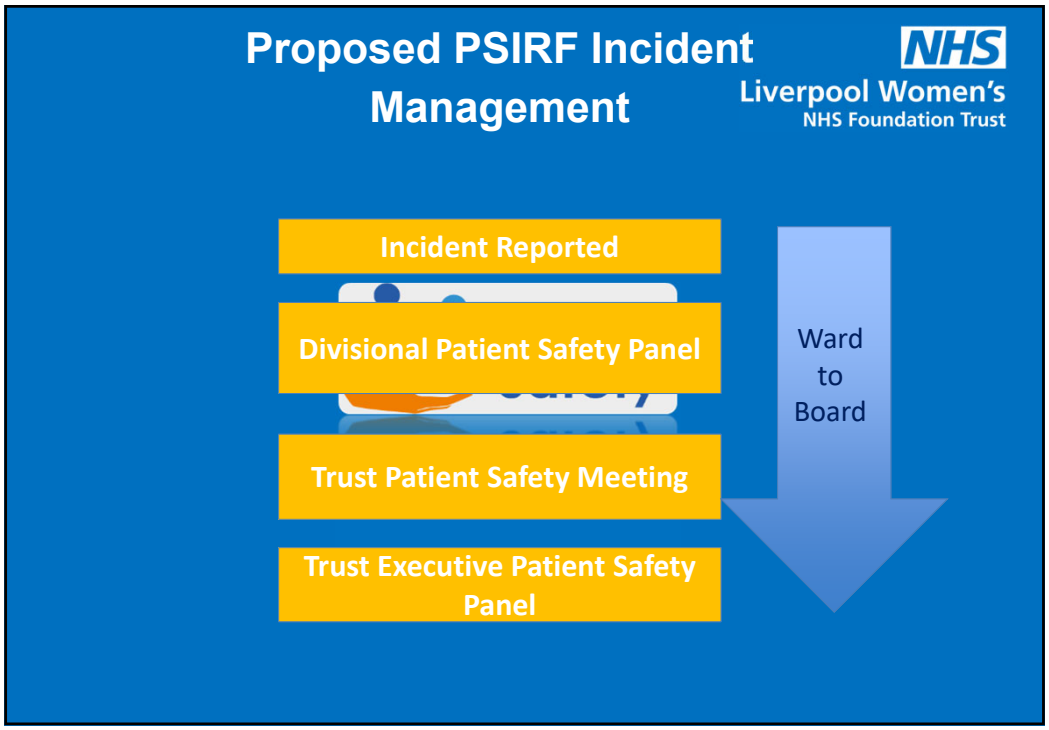
Link in with external partners to galvanise support and opportunities Development of LWH documentation to support the role in line with national requirements

Establishing links with people who have a lived experience of our services.

16


How is oversight changing?
NHS England
Transition over 12 month preparation period
Serious Incident Framework
Patient Safety Incident Response Framework
CQC
Monitor numbers/themes and timescales
May review specific reports/seek assurance
Assess systems' and organisations' ability to respond effectively t patient safety incidents, including whether change and improvement follow its response to patient safety incidents
NHS England Regions
Monitor numbers/themes and timescales
May review specific reports/seek assurance
Supports/leads SI sign off in direct commissioning role
Support/commission independent investigations
Support ICB PSIRF leads
Collaborate with NHS England commissioned services as required
Support a learning system
Support co-ordination of cross-system responses to patient safety incidents
Identify incidents that may require centrally co-ordinated and independent PSII
LMNS
Receive all SI reports and a summary of the key issues
Key stakeholders in the development of patient safety incident response plans (working alongside ICB in oversight role
Facilitate peer review of PSIIs to support organisations to learn from each other's response approach
CCG/ICB/ Commissioner
Monitor numbers/themes and timescales
Review SIs for sign off approval.
Develop, agree, maintain and review patient safety incident response plans
Oversee & support effectiveness of systems to achieve improvement following PSIs
Support co-ordination of cross-system learning responses
Share insights and information across organisations/services to improve safety
Providers
Declare an SI within 2 working days
Complete 3 day/72 hour report
Complete investigation and report in 60 workings days, and produce an action plan
Ensure organisation meets national patient safety incident response standards
Ensure PSIRF is central to overarching safety governance arrangements
Quality assure learning response outputs
17

17


Proposed PSIRF Incident Management
NHS
Liverpool Women's
NHS Foundation Trust
Incident Reported
Divisional Patient Safety Panel
Trust Patient Safety Meeting
Trust Executive Patient Safety Panel
Ward to Board

18

Patient Safety Incident Response Framework (PSIRF)

To Improve our approach to responding to patient safety incidents, we are in a period of preparation ahead of transitioning from the existing Serious Incident Framework to NHS England's new Patient Safety Incident Response Framework (PSIRF). This will launch on 1 September 2023.

Scan the QR code to find out:

- **What PSIRF is?**
- **What happens next?**
- **What does it mean for me?**

If you have any questions or would like to be involved, please contact Phil Bartley (Associate Director of Quality & Governance), Allan Hawksey (Head of Risk & Safety) & Mark Campbell (Head of Continuous Improvement)

19

Patient Safety Incident Response Framework & LWH Implementation –

Any Questions or suggested new ideas for our approach?

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20

Questions to guide provider board oversight of patient safety incident management and improvement	
Engagement and involvement of those affected by patient safety incidents	How do we ensure those affected by patient safety incidents are engaged and involved in any learning response? • Does engagement include prompt and effective communication between those affected by a patient safety incident and our organisation? • Does engagement and involvement occur respectfully and according to individual needs? • How do we know how well our processes are working? What are the current barriers? • Are patients or staff with protected characteristics represented more often than others in any of our incidents and responses? What are the organisational or cultural reasons behind this?
Policy, planning and governance	Does our patient safety incident response plan match the risks that feel tangible to us as an organisation? • Does emerging intelligence match our assumptions about the biggest risks in our plan? Can we demonstrate wide collaboration and stakeholder involvement in the development and maintenance of our plan? • Does our plan demonstrate a thorough analysis of data and provide a clear rationale for the selection of patient safety incidents for further learning? • Is our ICB assisting cross-organisation working and information sharing? • How do we choose our response to a patient safety incident? • How do we support those who bring 'bad news' or surprises about organisational safety?
Competence and capacity	Are we employing and continuously developing expertise in patient safety science for key roles? • Are our learning responses adequately resourced (including funding, time, equipment, and training)? • Are training and competence requirements met for learning response leads? • Do we have the competence within our teams to feel we can confidently have conversations with patients and families about patient safety incidents? • Does our ICB have its own continuous development plans in patient safety science

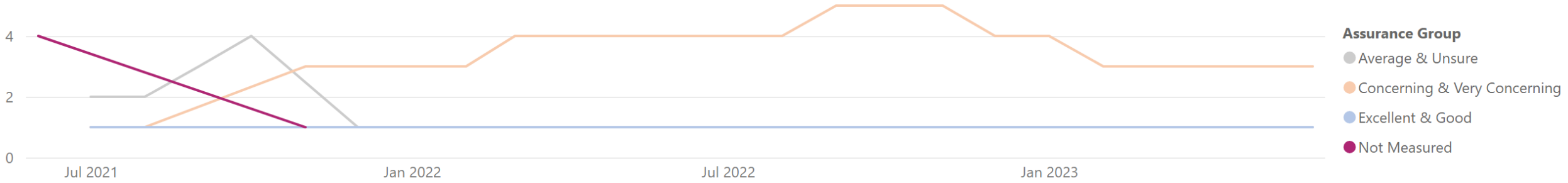
	training and competence to enable it to participate effectively? • Are our teams confident in having conversations with patients and families affected by an incident but where an individual learning response will not be completed in response?
Proportionate responses	• How are we triangulating insight from our responses to patient safety incidents? • Are we using recognised system-based methodologies for data collection and analysis? • Is external guidance/information used to inform patient safety responses and findings? • Do we have collaborative arrangements with our ICB to facilitate cross-system learning responses? This includes processes for recognising when support may be required and raising this with ICB colleagues Are learning responses completed in a timely manner in line with expectations of those affected
Safety actions and improvement	• How easy is it to make an improvement in our organisation? Is time, priority and expertise given to those who need it? • Do we have and use processes to share emergent intelligence and receive support from external partners (eg ICSs, regional and national NHS teams, royal colleges, professional associations, patient groups, charities etc) • How do we assess the sustainability of our safety actions and improvements?

Liverpool Women's
NHS Foundation Trust

Trust Board

Workforce Performance Report
July 2023

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

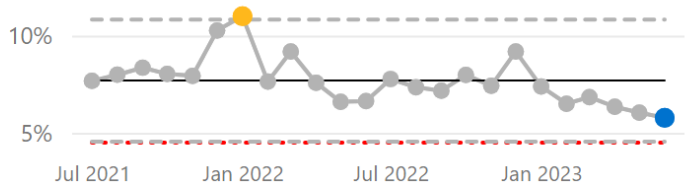


KPI	Assurance Category	Date	Target	Target < or >	Performance	Assurance	Variation	Trend
Turnover Rate	Excellent	June 2023	<= 13%	<=	9.54%	P	L	
Clinical Mandatory Training Compliance	Concerning	June 2023	>= 95%	>=	85.87%	F	H	
Mandatory Training Compliance	Concerning	June 2023	>= 95%	>=	93.66%	F	H	
Prevention of Ill Health: Flu Vaccine Front Line Clinical Staff	Concerning	January 2023	>= 80%	>=	41.54%	F		
Sickness Absence Rate	Concerning	June 2023	<= 4.5%	<=	5.77%	F	L	

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

Sickness - Chief People Officer

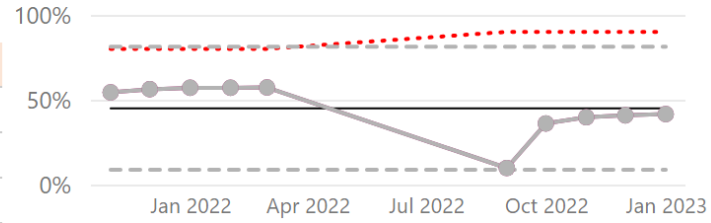
Assurance Category	Concerning
Date	June 2023
Target	<= 4.5%
Target < or >	<=
Performance	5.77%
Assurance	F
Variation	L



Sickness fell by 0.27% in Jun, going down to 5.77%. At a divisional level, it fell in the Family Health (0.73%), Clinical Support Services (0.66%) and Corporate divisions (0.09%) but increased in Gynaecology division by 1.02%. Sickness absence is reviewed on a weekly basis by divisional management teams with a particular scrutiny of return-to-work meetings which are seeing an increase in compliance. All divisions are now producing monthly infographics to visualise for staff the levels and impact

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

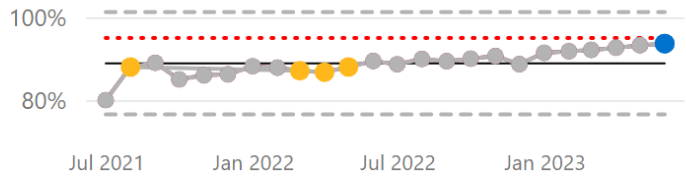
Assurance Category	Concerning
Date	January 2023
Target	>= 80%
Target < or >	>=
Performance	41.54%
Assurance	F
Variation	



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

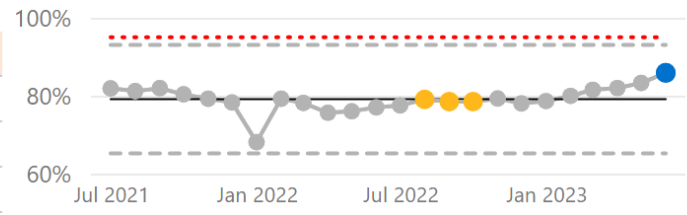
Assurance Category	Concerning
Date	June 2023
Target	>= 95%
Target < or >	>=
Performance	93.66%
Assurance	F
Variation	H



Compliance increased by 0.42% up to 93.66%, which is now just 1.34% below the Trust's target figure of 95%. All the main divisions are now above the target figure except for Family Health, who increased to 90.21% this month. Compliance continues to be reviewed on a weekly basis by divisional management teams, with a specific focus on those individuals who have competencies that expired over 12 months ago or have never been completed.

Clinical Mandatory Training Compliance - Chief People Officer

Assurance Category	Concerning
Date	June 2023
Target	>= 95%
Target < or >	>=
Performance	85.87%
Assurance	F
Variation	H



Compliance increased by 2.61%, giving a Trust-wide figure of 85.87%. While there were increases in Clinical Support Services, Family Health, Corporate and Gynae Divisions. Previous reports highlight Family Health as being of concern, showing in month 2 as 77.63%, in month 3 they have now increased to 93.87% which is just below Trust target. Compliance continues to be reviewed on a weekly basis by divisional management teams, with a specific focus on those individuals who have competencies that

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	**23/24/111**		**Date: 10/08/2023**	
Report Title	**Finance Performance Review Month 3 2023/24**			
Prepared by	***Jen Huyton, Deputy Chief Finance Officer / Deputy Director of Strategy***			
Presented by	***Jenny Hannon, Chief Finance Officer / Executive Director of Strategy and Partnerships***			
Key Issues / Messages	***To note the Month 3 financial position.***			
Action required	**Approve ☐**	**Receive ☐**	**Note ☒**	**Take Assurance ☐**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	***To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it***	***For the intelligence of the Board / Committee without in-depth discussion required***	***To assure the Board / Committee that effective systems of control are in place***
	Funding Source (If applicable): N/A			
	For Decisions - in line with Risk Appetite Statement – If no – please outline the reasons for deviation.			
	The Board is asked to note the Month 3 position and note the actions taken in respect of financial recovery.			
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* 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	26/07/23	Jenny Hannon, Chief Finance Officer	The Committee noted the report.

EXECUTIVE SUMMARY

The Trust has a challenging financial plan for 2023/24 of £15.5m deficit. At Month 3 the Trust is reporting a £4,634k deficit which represents a £1k favourable variance to plan. This position is supported by £2.1m of non-recurrent items and the acceleration of CIP. The forecast outturn is £15,427k deficit, which is in line with the submitted plan.

CIP has over-delivered against the YTD target by £139k. At the Trust is forecasting to deliver to plan. As at Month 3, £2.6m of the £8.3m (5.3%) target was unidentified, however the Trust is now focused on rapid financial recovery, including identification of new schemes.

The cash balance was £3.0m at the end of Month 3. The average cash balance throughout the month was £11m.

MAIN REPORT

1. Summary Financial Position

	Plan	Actual	Variance	RAG	*R*	*A*	*G*
Surplus/(Deficit) YTD	-£4.6m	-£4.6m	£0.0m	↔	*>10% off plan*	*Plan*	*Plan or better*
I&E Forecast	-£15.5m	-£15.5m	£0.0m	↔	*>10% off plan*	*Plan*	*Plan or better*
NHS I/E Rating	3	3	0	↔	*4*	*3*	*2+*
Cash	£6.0m	£3.0m	-£3.1m	↓	*<£1m*	*£1m-£4.5m*	*£4.5m+*
Total CIP Achievement YTD	£1.1m	£1.2m	£0.1m	↑	*>10% off plan*	*Plan*	*Plan or better*
Recurrent CIP Achievement YTD	£1.1m	£1.2m	£0.1m	↑	*>10% off plan*	*Plan*	*Plan or better*
Aligned Payment Incentive	106%	106%	0%	↑	*>10% off plan*	*Plan*	*Plan or better*
Non-Recurrent Items YTD	£0.3m	£2.0m	£1.7m	↑	*>£0*		*<£0*
Capital Spend YTD	£1.5m	£1.1m	-£0.3m	↓	*>10% off plan*	*Plan*	*Plan or better*

At Month 3 the Trust is reporting a £4,634k deficit, which represents a £1k favourable variance to plan year to date (YTD). This is supported by £2,588k of non-recurrent items. The forecast outturn is £15,450k deficit, which is in line with the submitted plan.

2. Financial Recovery

Underlying Position

As noted above, the YTD break even position is supported by £2,588k of non-recurrent items. The adjusted position in Month 3 (following removal of key non-recurrent items) is a deficit of £7,223k, which represents an adverse variance of £2,588k against plan.

The key drivers of the underlying year to date position are:

- CIP and requirement to reduce pay investment (£828k)
- Nursing, midwifery, and support staff pressures (£1,333k) across maternity, gynae, and theatres (some of which relates to costs of industrial action)
- Medical staffing (£207k); driven by Family Health (some of which relates to industrial action)
- Estates (c£256k); energy and soft FM costs
- Admin and clerical (c£172k); cost pressures in corporate areas

Whole Time Equivalents (WTE)

At Month 3 WTEs total 1,697, compared to 1,688 at M12 2022/23. There are favourable movements in admin and clerical and agency, offset by increases in nursing and support staff.

Cost Improvement Programme

The Trust has a cost improvement programme target of £8.3m. This equates to 5.3% of expenditure. £0.2m has been identified during the period against the unidentified target however £2.6m remains unidentified. At Month 3, there is a favourable variance of £139k against the £1,101k target.

Finance Recovery Actions

The Trust is taking action on financial recovery and has brought in support to facilitate delivery of infrastructure, documentation, and governance of the recovery programme, and enable the pace of change required to deliver the challenge. A Project Management Office (PMO) has been established from within existing resources, which will re-design recovery workstreams and identify which streams need to be prioritised or consolidated aligned to PMO capacity.

The Financial Grip and Control Working Group will implement revised financial approval limits across pay and non-pay, accompanied by a defined set of criteria and exemptions (for clinical safety only) for approval of spend.

The Quality Impact Assessment Assurance Committee will be responsible for signing off all Quality Impact Assessments for all transformational schemes, as well as ensuring the Trust does not lose focus on quality during the financial recovery process.

3. Divisional Summary Overview

Family Health
The Family Health Division has an adverse variance of £759k YTD. £672k of this relates to Maternity, with £87k relating to Neonatal. The maternity variance is driven by pay pressures in medical staffing and midwifery staffing (caused by sickness, vacancies, and maternity leave), as well as under-delivery of non-pay CIP. There has been an improvement in agency usage with zero spend reported in Month 3.

Gynaecology
The Gynaecology Division has an adverse variance to plan of £923k YTD, driven primarily by nursing and support staff pay pressures and Aligned Payment and Incentive (API) income underperformance (see below for further details). The pay pressures relate to sickness (rates have risen to 10.4% in month), additional activity, and some cost pressures.

Clinical Support Services
CSS are £686k adverse to plan YTD, driven by Imaging pay (£185k) in relation to staffing pressures and theatres pay (£281k), driven by nursing, ODP and support staff costs partially mitigated by a vacancy factor in medical staffing.

The Community Diagnostic Centre position is £27k adverse YTD, driven by income underperformance.

4. Aligned Payment and Incentive (API)

Overall, at Month 3, the Trust has delivered 106% of its adjusted 2019/20 baseline, compared to 99% in the same period last year. The average activity target for 2023/24 is 106%, however this assumes activity will phase up throughout the year. Despite this, there is some income underperformance compared to plan. This is driven by the impact of industrial action as well as changing case mix, a shift in activity type from day case to outpatient procedure.

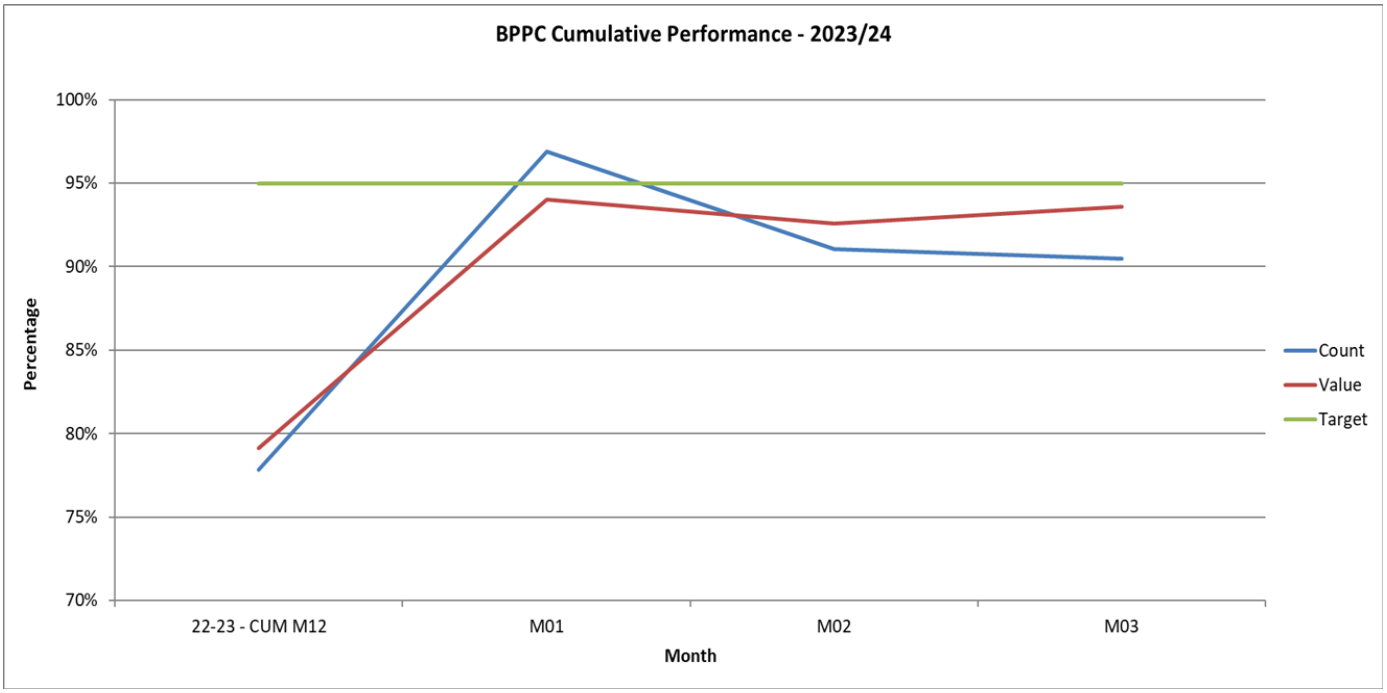
5. Cash and Borrowings

Total cash at the end of June was £3.0m. This was in line with the forecast and the balance increased to £11m on 3 July following receipt of income and cash from the Integrated Care Board (ICB). The average daily balance across June was c£11m.

As the Trust has a deficit plan for 2023/24, it will require cash support throughout the year and is closely monitoring cash levels on a rolling 13-week basis. The Trust is liaising closely with the ICB and the national cash team to ensure cash levels are sufficient to meet operational needs.

6. Better Payment Practice Code

The NHS has a target to pay at least 95% of all NHS and non-NHS trade payables within 30 calendar days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed. The below shows the cumulative performance percentages by both count and value for the current and previous financial year.



7. Balance Sheet

Other than movements in cash considered above, the other significant balance sheet movements relate to the reduction of trade payables in quarter 1, which included payment of the 2022/23 non-consolidated pay increases for

staff, and the settlement of historic creditor balances. There was an increase in deferred income, which arose principally from cash support from the ICB and receipt of Health Education England income.

8. Capital Expenditure

The Trust's overall capital programme for 2023/24 equates to £5.154m. The capital plan remains under regular review to ensure timeliness of spend and efficient pricing.

Year to date capital spend of £1,145k is £306k below plan. This includes significant IT spend to ensure the EPR project operates successfully following the initial go-live date in July. Estates works are ongoing, and medical equipment is being scoped and ordered, but remains slightly behind schedule.

9. Agency

At Month 3, the Trust has a favourable variance of £403k against plan. Actual costs of £182k are predominantly driven by theatres (vacancy), and maternity (sickness and vacancy), however no spend was incurred in maternity during the period.

10. BAF Risk

There are no proposed changes to the BAF score.

11. Conclusion & Recommendation

The Board is asked to note the Month 3 position and note the actions taken in respect of financial recovery.

Appendices

Appendix 1 – Board Finance Pack, M3

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

FINANCE REPORT: M3

YEAR ENDING 31 MARCH 2024

Liverpool Women's
NHS Foundation Trust

Contents

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST NHS IMPROVEMENT RATIOS: M3 YEAR ENDING 31 MARCH 2024	1

USE OF RESOURCES RISK RATING	YEAR TO DATE Actual
CAPITAL SERVICING CAPACITY (CSC)	
(a) EBITDA + Interest Receivable	(2,541)
(b) PDC + Interest Payable + Loans Repaid	666
CSC Ratio = (a) / (b)	**(3.82)**
NHSI CSC SCORE	**4**
Ratio Score 1 = > 2.5 2 = 1.75 - 2.5 3 = 1.25 - 1.75 4 = < 1.25	
LIQUIDITY	
(a) Cash for Liquidity Purposes	(18,878)
(b) Expenditure	37,837
(c) Daily Expenditure	104
Liquidity Ratio = (a) / (c)	**(182.1)**
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)	4,634
Total Income	(35,154)
I&E Margin	**-13.2%**
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)	-13.20%
I&E Margin (Plan)	-13.10%
I&E Variance Margin	**-0.10%**
NHSI I&E MARGIN VARIANCE SCORE	**2**
Ratio Score 1 = > 0% 2 = (1) - 0% 3 = (2) - (1)% 4 = < (2)%	
Note: NHSI assume the score of the I&E Margin variance from Plan is a 1 for the whole	
AGENCY SPEND	
YTD Providers Cap	585
YTD Agency Expenditure	182
	-69%
NHSI AGENCY SPEND SCORE	**1**
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.
The overall ratio is determined using weighted average of each score and then rounding down

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
INCOME & EXPENDITURE: M3
YEAR ENDING 31 MARCH 2024

INCOME & EXPENDITURE £'000	Month 3 Budget	 Actual	 Variance	YTD Budget	 Actual	 Variance	YEAR Budget	 Forecast	 Variance
Income									
Clinical Income	(11,172)	(11,277)	106	(33,516)	(33,272)	(244)	(134,750)	(136,364)	1,614
Non-Clinical Income	(596)	(702)	106	(1,789)	(1,882)	93	(7,416)	(7,142)	(274)
Total Income	**(11,768)**	**(11,979)**	**211**	**(35,305)**	**(35,154)**	**(151)**	**(142,166)**	**(143,506)**	**1,340**
Expenditure									
Pay Costs	7,555	8,123	(569)	22,632	24,255	(1,623)	88,336	93,823	(5,487)
Non-Pay Costs	3,214	2,974	240	9,644	8,193	1,452	38,631	35,456	3,175
CNST	1,800	1,787	14	5,401	5,389	12	21,603	21,589	14
Total Expenditure	**12,569**	**12,884**	**(315)**	**37,677**	**37,837**	**(159)**	**148,570**	**150,868**	**(2,298)**
EBITDA	**801**	**905**	**(103)**	**2,372**	**2,683**	**(311)**	**6,404**	**7,362**	**(958)**
Technical Items									
Depreciation	548	483	65	1,645	1,605	40	6,579	6,117	463
Interest Payable	2	2	0	6	5	1	21	21	0
Interest Receivable	(17)	(42)	25	(49)	(141)	92	(200)	(515)	315
PDC Dividend	220	220	(0)	661	661	0	2,645	2,644	1
Profit/Loss on Disposal or Transfer Absorption	0	(6)	6	0	(179)	179	0	(179)	179
Total Technical Items	**753**	**657**	**97**	**2,263**	**1,951**	**312**	**9,045**	**8,087**	**958**
(Surplus) / Deficit	**1,555**	**1,561**	**(7)**	**4,635**	**4,634**	**1**	**15,450**	**15,449**	**0**

NHS
Liverpool Women's
NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 2a
WTE: M3
YEAR ENDING 31 MARCH 2024

TYPE	DESCRIPTION	M12	M1	M2	M3	Movement M2-M3
SUBSTATIVE	REGISTERED NURSING, MIDWIFERY & HEALTH VISITING STA	631.94	648.33	649.61	645.49	(4.12)
	ALLIED HEALTH PROFESSIONALS	82.04	81.95	81.35	83.27	1.92
	OTHER REGISTERED SCIENTIFIC, THERAPEUTIC & TECHNICA	11.78	11.31	11.31	12.31	1.00
	REGISTERED HEALTH CARE SCIENTISTS	49.22	53.62	54.54	54.34	(0.20)
	HCA & SUPPORT TO CLINICAL STAFF	234.51	237.51	244.48	237.49	(6.99)
	MANAGERS & SENIOR MANAGERS	59.92	63.32	64.32	61.32	(3.00)
	ADMIN AND ESTATES STAFF	13.00	13.00	13.00	14.00	1.00
	OTHER INFRASTRUCTURE & SUPPORT STAFF	288.12	288.08	284.17	285.09	0.92
	MEDICAL AND DENTAL	185.09	190.90	191.67	193.80	2.13
	ANY OTHER STAFF	14.00	14.00	14.00	14.00	0.00
SUBSTATIVE TOTAL		**1,569.62**	**1,602.02**	**1,608.45**	**1,601.11**	**(7.34)**
BANK	REGISTERED NURSING, MIDWIFERY & HEALTH VISITING STA	47.33	37.81	43.37	45.40	2.03
	ALLIED HEALTH PROFESSIONALS	17.42	13.00	16.78	15.67	(1.11)
	OTHER REGISTERED SCIENTIFIC, THERAPEUTIC & TECHNICA	-	-	-	-	0.00
	REGISTERED HEALTH CARE SCIENTISTS	0.28	0.91	0.64	0.46	(0.18)
	HCA & SUPPORT TO CLINICAL STAFF	31.22	25.76	25.13	24.57	(0.56)
	MANAGERS & SENIOR MANAGERS	-	-	-	-	0.00
	ADMIN AND ESTATES STAFF	-	0.23	0.12	0.09	(0.03)
	OTHER INFRASTRUCTURE & SUPPORT STAFF	6.25	7.27	6.44	4.36	(2.08)
	MEDICAL AND DENTAL	2.00	2.80	2.80	2.00	(0.80)
	ANY OTHER STAFF	-	-	-	-	0.00
TOTAL BANK		**104.50**	**87.78**	**95.28**	**92.55**	**(2.73)**
AGENCY	REGISTERED NURSING, MIDWIFERY & HEALTH VISITING STA	8.23	10.49	2.03	0.08	(1.95)
	ALLIED HEALTH PROFESSIONALS	4.04	1.23	3.26	3.26	0.00
	OTHER REGISTERED SCIENTIFIC, THERAPEUTIC & TECHNICA	-	-	-	-	0.00
	REGISTERED HEALTH CARE SCIENTISTS	-	-	-	-	0.00
	HCA & SUPPORT TO CLINICAL STAFF	-	-	-	-	0.00
	MANAGERS & SENIOR MANAGERS	-	-	-	-	0.00
	ADMIN AND ESTATES STAFF	1.00	-	-	-	0.00
	OTHER INFRASTRUCTURE & SUPPORT STAFF	-	1.73	-	-	0.00
	MEDICAL AND DENTAL	0.10	-	-	-	0.00
	ANY OTHER STAFF	-	-	-	-	0.00
AGENCY TOTAL		**13.37**	**13.45**	**5.29**	**3.34**	**(1.95)**

TRUST TOTAL	**1,687.49**	**1,703.25**	**1,709.02**	**1,697.00**	**(12.02)**

NHS
Liverpool Women's
NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 3
EXPENDITURE: M3
YEAR ENDING 31 MARCH 2024

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	468	519	(51)	1,403	1,521	(118)	5,411	5,697	(286)
Medical	2,092	2,112	(20)	6,276	6,484	(207)	25,105	26,391	(1,287)
Nursing & Midwifery	3,105	3,601	(495)	9,284	10,390	(1,105)	37,631	40,929	(3,298)
Healthcare Assistants	547	655	(108)	1,641	1,869	(228)	6,565	7,375	(810)
Other Clinical	419	335	85	1,258	1,352	(94)	2,612	3,337	(725)
Admin Support	762	870	(108)	2,286	2,458	(172)	9,164	9,665	(501)
Agency & Locum	161	31	130	483	182	301	1,848	428	1,419
Total Pay Costs	**7,555**	**8,123**	**(569)**	**22,632**	**24,255**	**(1,623)**	**88,336**	**93,823**	**(5,487)**
Non Pay Costs									
Clinical Suppplies	834	1,154	(320)	2,504	2,873	(370)	10,031	10,771	(740)
Non-Clinical Supplies	755	101	653	2,290	1,028	1,261	8,876	6,143	2,732
CNST	1,800	1,787	14	5,401	5,389	12	21,603	21,589	14
Premises & IT Costs	876	1,268	(393)	2,627	2,477	150	10,467	10,768	(301)
Service Contracts	750	450	300	2,224	1,814	410	9,257	7,773	1,484
Total Non-Pay Costs	**5,015**	**4,761**	**254**	**15,045**	**13,582**	**1,463**	**60,235**	**57,045**	**3,190**
Total Expenditure	**12,569**	**12,884**	**(315)**	**37,677**	**37,837**	**(159)**	**148,570**	**150,868**	**(2,298)**

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

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
BUDGET ANALYSIS: M3
YEAR ENDING 31 MARCH 2024

INCOME & EXPENDITURE £'000	MONTH 3 Budget	MONTH 3 Actual	MONTH 3 Variance	YEAR TO DATE Budget	YEAR TO DATE Actual	YEAR TO DATE Variance	YEAR - Underlying Budget	YEAR - Underlying Actual	YEAR - Underlying Variance	YEAR - Recovery Budget	YEAR - Recovery Actual	YEAR - Recovery Variance
Maternity												
Income	(4,002)	(4,024)	22	(12,007)	(12,087)	80	(48,328)	(48,178)	(150)	(48,328)	(48,178)	(150)
Expenditure	2,437	2,666	(229)	7,312	8,064	(752)	29,216	31,501	(2,284)	29,216	31,501	(2,284)
Total Maternity	**(1,565)**	**(1,358)**	**(207)**	**(4,695)**	**(4,023)**	**(672)**	**(19,112)**	**(16,678)**	**(2,434)**	**(19,112)**	**(16,678)**	**(2,434)**
Neonatal												
Income	(1,839)	(1,861)	22	(5,517)	(5,514)	(3)	(22,067)	(22,190)	122	(22,067)	(22,190)	122
Expenditure	1,470	1,512	(42)	4,411	4,494	(84)	17,643	17,830	(187)	17,643	17,830	(187)
Total Neonatal	**(369)**	**(349)**	**(20)**	**(1,106)**	**(1,019)**	**(87)**	**(4,424)**	**(4,360)**	**(64)**	**(4,424)**	**(4,360)**	**(64)**
Division of Family Health - Total	**(1,934)**	**(1,707)**	**(227)**	**(5,801)**	**(5,043)**	**(759)**	**(23,535)**	**(21,037)**	**(2,498)**	**(23,535)**	**(21,037)**	**(2,498)**
Gynaecology												
Income	(2,180)	(2,086)	(93)	(6,539)	(6,350)	(189)	(26,208)	(25,483)	(725)	(26,208)	(25,483)	(725)
Expenditure	1,431	1,835	(403)	4,294	4,860	(565)	17,123	19,465	(2,342)	17,123	19,465	(2,342)
Total Gynaecology	**(748)**	**(252)**	**(496)**	**(2,245)**	**(1,490)**	**(755)**	**(9,085)**	**(6,019)**	**(3,066)**	**(9,085)**	**(6,019)**	**(3,066)**
Hewitt Centre												
Income	(843)	(763)	(80)	(2,529)	(2,499)	(30)	(10,365)	(9,920)	(445)	(10,365)	(9,920)	(445)
Expenditure	794	832	(38)	2,382	2,520	(138)	9,527	10,205	(679)	9,527	10,205	(679)
Total Hewitt Centre	**(49)**	**68**	**(117)**	**(147)**	**21**	**(168)**	**(838)**	**286**	**(1,124)**	**(838)**	**286**	**(1,124)**
Division of Gynaecology - Total	**(797)**	**(184)**	**(614)**	**(2,392)**	**(1,469)**	**(923)**	**(9,923)**	**(5,733)**	**(4,190)**	**(9,923)**	**(5,733)**	**(4,190)**
Theatres												
Income	0	0	0	0	0	0	0	0	0	0	0	0
Expenditure	1,059	1,292	(233)	3,177	3,521	(345)	12,285	14,079	(1,793)	12,285	14,079	(1,793)
Total Theatres	**1,059**	**1,292**	**(233)**	**3,177**	**3,521**	**(345)**	**12,285**	**14,079**	**(1,793)**	**12,285**	**14,079**	**(1,793)**
Genetics												
Income	(4)	(5)	1	(11)	(16)	6	(42)	(16)	(26)	(42)	(16)	(26)
Expenditure	161	165	(4)	482	481	1	1,928	1,937	(9)	1,928	1,937	(9)
Total Genetics	**157**	**160**	**(3)**	**471**	**465**	**7**	**1,886**	**1,921**	**(35)**	**1,886**	**1,921**	**(35)**
Other Clinical Support												
Income	(677)	(592)	(85)	(1,960)	(1,727)	(233)	(9,272)	(6,714)	(2,558)	(9,272)	(6,714)	(2,558)
Expenditure	968	1,073	(105)	2,879	2,994	(114)	12,231	11,876	355	12,231	11,876	355
Total Clinical Support	**291**	**481**	**(189)**	**919**	**1,267**	**(348)**	**2,959**	**5,161**	**(2,202)**	**2,959**	**5,161**	**(2,202)**
Division of Clinical Support - Total	**1,507**	**1,932**	**(425)**	**4,567**	**5,253**	**(686)**	**17,130**	**21,161**	**(4,031)**	**17,130**	**21,161**	**(4,031)**
Corporate & Trust Technical Items												
Income	(2,224)	(2,949)	726	(6,742)	(7,535)	793	(25,884)	(28,388)	2,504	(25,884)	(31,585)	5,701
Expenditure	5,002	4,469	533	15,004	13,428	1,575	57,663	61,505	(3,842)	57,663	52,644	5,019
Total Corporate	**2,779**	**1,520**	**1,259**	**8,261**	**5,893**	**2,369**	**31,778**	**33,116**	**(1,338)**	**31,778**	**21,058**	**10,720**
(Surplus) / Deficit	**1,555**	**1,561**	**(7)**	**4,635**	**4,634**	**1**	**15,450**	**27,507**	**(12,057)**	**15,450**	**15,449**	**1**
Of which is hosted;												
Income	0	(302)	302	0	(574)	574	0	(580)	580	0	(580)	580
Expenditure	0	302	(302)	0	574	(574)	0	580	(580)	0	580	(580)
Total Corporate	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(0)**	**0**	**0**	**(0)**	**0**

NHS
Liverpool Women's
NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 5
CIP: M3
YEAR ENDING 31 MARCH 2024

		MONTH			YTD			FOT		
TYPE	**Scheme**	**Target**	**Actual**	**Variance**	**Target**	**Actual**	**Variance**	**Target**	**Actual**	**Variance**
Income	Income Private Patient	9	12	3	28	12	(16)	470	470	0
Income	Income non-patient care	20	17	(3)	59	50	(9)	495	495	0
Income	Other income	83	1	(82)	250	4	(246)	1,057	1,057	0
Income	Unidentified - Income	0	0	0	0	0	0	267	267	0
Total Income		**112**	**30**	**(82)**	**336**	**66**	**(270)**	**2,289**	**2,289**	**0**
Pay	Service re-design	18	4	(14)	54	11	(43)	217	217	0
Pay	E-Rostering	2	0	(2)	6	0	(6)	25	25	0
Pay	Establishment reviews	0	182	182	0	182	182	65	65	0
Pay	Digital transformation	0	0	0	0	0	0	0	0	0
Pay	Corporate services transformation	(4)	0	4	(11)	0	11	(45)	(45)	0
Pay	Other Pay	2	0	(2)	5	0	(5)	200	200	0
Pay	Unidentified - Pay	0	0	0	0	0	0	2,234	2,234	0
Total Pay		**18**	**185**	**167**	**54**	**193**	**139**	**2,697**	**2,697**	**0**
Non-Pay	Service re-design	183	648	465	549	977	428	2,262	2,262	0
Non-Pay	Medicines optimisation	14	0	(14)	41	0	(41)	164	164	0
Non-Pay	Procurement - medical devices and consumables	14	0	(14)	41	0	(41)	175	175	0
Non-Pay	Digital transformation	10	0	(10)	30	0	(30)	122	122	0
Non-Pay	Pathology & imaging networks	0	0	(0)	1	0	(1)	5	5	0
Non-Pay	Procurement - non-clinical	4	0	(4)	13	0	(13)	51	51	0
Non-Pay	Fleet optimisation	0	0	0	0	0	0	20	20	0
Non-Pay	Other	11	1	(10)	34	4	(30)	452	452	0
Non-Pay	Unidentified - Non Pay	1	0	(1)	2	0	(2)	100	100	0
Total Non-Pay		**237**	**649**	**412**	**711**	**981**	**270**	**3,350**	**3,350**	**0**
Total		**367**	**864**	**497**	**1,101**	**1,239**	**139**	**8,336**	**8,336**	**0**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
BALANCE SHEET: M3
YEAR ENDING 31 MARCH 2024

BALANCE SHEET £'000	YEAR TO DATE Opening	M3 Actual	Movement
Non Current Assets	102,405	101,977	(428)
Current Assets			
Cash	9,790	2,955	(6,835)
Debtors	9,647	8,715	(932)
Inventories	839	867	28
Total Current Assets	**20,276**	**12,537**	**(7,739)**
Liabilities			
Creditors due < 1 year - Capital Payables	(2,002)	(1,656)	346
Creditors due < 1 year - Trade Payables	(26,820)	(15,261)	11,559
Creditors due < 1 year - Deferred Income	(4,492)	(12,909)	(8,417)
Creditors due > 1 year - Deferred Income	(1,530)	(1,522)	8
Loans	(918)	(913)	5
Loans - IFRS16 leases	(50)	(50)	0
Provisions	(628)	(596)	32
Total Liabilities	**(36,440)**	**(32,907)**	**3,533**
TOTAL ASSETS EMPLOYED	**86,241**	**81,607**	**(4,634)**
Taxpayers Equity			
PDC	79,115	79,115	0
Revaluation Reserve	8,679	8,679	0
Retained Earnings	(1,553)	(6,187)	(4,634)
TOTAL TAXPAYERS EQUITY	**86,241**	**81,607**	**(4,634)**

**the opening non-current asset value and revaluation reserve has been revised following changes to the accounts agreed with external audit in June*

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 7
CASHFLOW STATEMENT: M3
YEAR ENDING 31 MARCH 2024

CASHFLOW STATEMENT £'000	Actual
Cash flows from operating activities	(4,288)
Depreciation and amortisation	1,605
Impairments and reversals	0
Income recognised in respect of capital donations (cash and non-cash)	0
Movement in working capital	(2,924)
Net cash generated from / (used in) operations	**(5,607)**
Interest received	109
Purchase of property, plant and equipment and intangible assets	(1,516)
Proceeds from sales of property, plant and equipment and intangible assets	179
Net cash generated from/(used in) investing activities	**(1,228)**
PDC Capital Programme Funding - received	0
Loans from Department of Health - repaid	0
Interest paid	0
PDC dividend (paid)/refunded	0
Net cash generated from/(used in) financing activities	**0**
Increase/(decrease) in cash and cash equivalents	**(6,835)**
Cash and cash equivalents at start of period	9,790
Cash and cash equivalents at end of period	**2,955**

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**

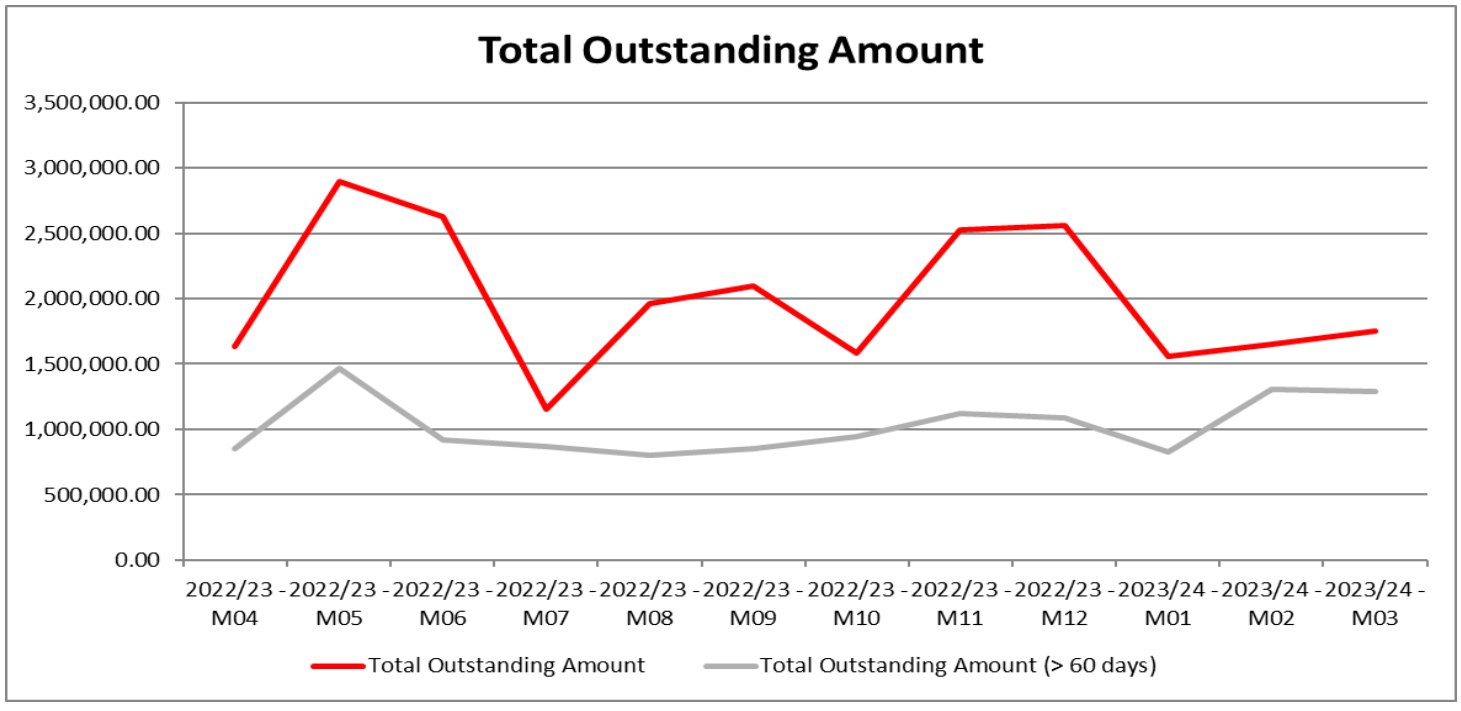
Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 8
CAPITAL EXPENDITURE: M3
YEAR ENDING 31 MARCH 2024

		YTD			YEAR		
Area	Capital Scheme	PLAN	ACTUAL	VARIANCE	PLAN	FOT	VARIANCE
Digital	EPR frontline digitisation	302	294	8	560	560	0
Digital	IT/digital investment - infrastructure	155	585	(430)	706	706	0
Digital	IT/digital investment - hardware	150	0	150	280	280	0
Digital	Community diagnostic equipment	153	0	153	153	153	0
Digital	Community diagnostic IT	100	0	100	100	100	0
Digital	PACS - image sharing - CAMRIN programme	0	0	0	49	49	0
Estates	Building works/refurbishment - Maternity	125	11	114	950	950	0
Estates	Building works/refurbishment - Neonatal	0	0	0	180	180	0
Estates	Building works/refurbishment - Gynaecology	62	0	62	300	300	0
Estates	Estates programme	130	53	77	560	560	0
Estates	Charity funded bereavement suite works	0	0	0	70	70	0
Medical Equipment	Medical equipment - Clinical Support - Fluoroscopy	0	0	0	262	262	0
Medical Equipment	Medical equipment - Clinical Support - Theatres	0	0	0	107	107	0
Medical Equipment	Medical equipment - All other clinical areas	274	189	85	738	738	0
Medical Equipment	Medical equipment - leased blood gas analysers	0	0	0	139	139	0
	Other	0	13	(13)	0	0	0
TOTAL CAPITAL		**1,451**	**1,145**	**306**	**5,154**	**5,154**	**0**

Note : 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 figures shown in the cashflow statement which are on a "Cash" basis.

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 9
AGED DEBTORS BALANCE: M3
YEAR ENDING 31 MARCH 2024

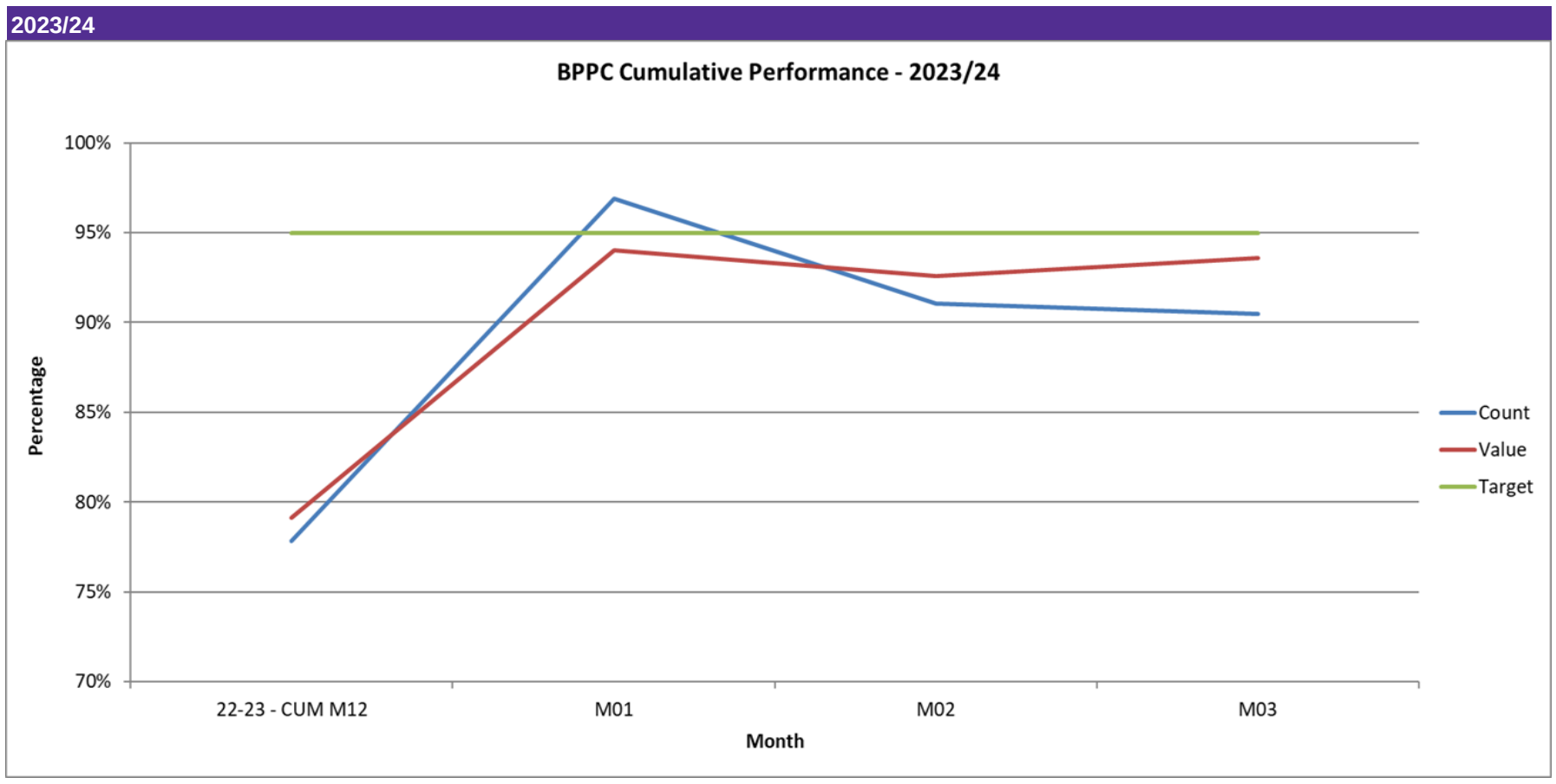


The underlying aged debtors is shown in the graph above. The level of debtor within the sales ledger has fallen significantly since the end of March, from £2.6m to £1.7m.

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 10
BETTER PAYMENT PRACTICE CODE (BPPC) - CUMULATIVE PERFORMANCE FOR M3
YEAR ENDING 31 MARCH 2024

The NHS has a target to pay at least 95% of all NHS and non-NHS trade payables within 30 calendar days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed. The below shows the cumulative performance percentages by both count and value for the current and previous financial year.

2023/24



	M01	M02	M03
Cumulative Performance - Count	97%	91%	90%
Cumulative Performance - Value (£)	94%	93%	94%

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 11
AGENCY USAGE: M3
YEAR ENDING 31 MARCH 2024

		MONTH			YTD			FOT		
Division	Directorate	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Family Health	Maternity	0	0	(0)	-	64	(64)	-	87	(87)
Gynaecology	Gynaecology	0	12	(12)	-	22	(22)	-	131	(131)
CSS	Theatres	0	15	(15)	-	49	(49)	-	166	(166)
CSS	CDC	12	(0)	12	36	15	21	61	15	46
CSS	Imaging	0	4	(4)	-	27	(27)	-	27	(27)
Corporate	All Corporate Directorates	149	(0)	149	447	5	442	1,787	3	1,784
Total Agency		**161**	**31**	**130**	**483**	**182**	**301**	**1,848**	**428**	**1,419**
Performance against plan		**194**	**31**	**163**	**585**	**182**	**403**	**2,333**	**428**	**1,905**

Liverpool Women's NHS Foundation Trust

Trust Board

KEY INFORMATION

Agenda Item (Ref)	***23/24/112***	**Date of meeting: 10/08/2023**		
Report Title	**Liverpool Trusts Joint Committee – Committee Report**			
Prepared by	***Mark Grimshaw, Trust Secretary***			
Presented by	***Robert Clarke, Chair***			
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***
Recommendation:	***The Board of Directors is asked to receive the report***			
Supporting Executive(s):	***Mark Grimshaw, Trust Secretary***			

Committee or meeting report considered at:	Date	Lead	Outcome
Liverpool Trusts Joint Committee	16 June 2023	David Flory, Chair Liverpool University Hospitals NHS Foundation Trust	Detail noted in the main body of the report

EXECUTIVE SUMMARY

Outline:

The Cheshire and Merseyside Integrated Care System (ICS) commissioned an independent review in response to NHS England's request in 2022. The review aimed to enhance collaboration between acute and specialised trusts for optimizing acute care in Liverpool and the wider region. The Liverpool Care Services Review was the result of this effort, approved by the Cheshire and Merseyside Integrated Care Board in January 2023. To implement the review's recommendations, a Liverpool Trusts Joint Committee (LTJC) was established. This report provides an overview from the Committee's meeting on 16 June 2023. The committee discussed updates from various sub-committees and initiatives focused on improving healthcare services and efficiency in Liverpool.

Recommendation:

The Board of Directors is asked to receive the report.

MAIN REPORT

Information: The Rationale & Evidence for the Recommendations

Introduction

The Cheshire and Merseyside Integrated Care System (ICS) were asked in 2022 by NHS England to commission an independent review to:

a) identify and provide recommendations to realise opportunities for greater collaboration between acute and specialised trusts to optimise the model of acute care in Liverpool and beyond; and

b) considered alignment and interdependencies with One Liverpool, the city's health and wellbeing strategy, and the wider Cheshire and Merseyside system.

This outcome of this work was the Liverpool Care Services Review which the Cheshire and Merseyside Integrated Care Board (ICB) received and approved at its Board meeting on 26 January 2023. A copy of this Review is available on the ICS's website, although separate papers for information would have been taken to each of the member NHS provider's Boards.

In order to ensure the delivery of six of the recommendations of the Review, a Liverpool Trusts Joint Committee (LTJC) has been set up, with terms of reference agreed by this Board in July 2023. The following report provides a summary of the business transacted by the Committee at its meeting held on 16 June 2023.

Trust Strategy & System Impact

Through receipt of this report, the Board maintains a view of how Liverpool Place and the Trust's within this footprint are working collaboratively to deliver against the outputs of the Liverpool Care Services Review

Main body

Matters for Escalation

There are no matters for escalation.

Key Discussions

The Committee received an update on the activities from the following sub committee as follows:

1. **The Walton Centre NHS Foundation Trust/Liverpool University Hospitals NHS Foundation Trust Joint Committee Update**
   - approval of the Terms of Reference
   - development of a Work Plan
   - focus on the existing collaborative work between the two trusts
   - Medical Directors leading on reviewing clinical pathways

- review of estates to identify benefits and reduce duplication
- review of procurement with specialist trusts to improve efficiencies.

2. **Liverpool Heart & Chest/Liverpool University Hospitals NHS Foundation Trust Joint Committee Update**
   - approval of the Terms of Reference
   - development of a Work Plan
   - an overview on the work of the established groups reporting into the Joint Committee, those being the Cardiology Partnership, an operational working group and a Joint Site Committee
   - an increase in mutual aid between the trusts on orthopaedic activity
   - the review of estates between the sites.

3. **Clatterbridge Cancer Centre NHS FT/Liverpool University Hospitals NHS FT Joint Committee Update**
   - approval of the Terms of Reference
   - development of a Work Plan
   - planned format of bi-monthly meetings, with scheduled deep-dives into specific workstreams planned.

4. **Liverpool Women's Health NHS FT/Liverpool University Hospitals NHS FT Partnership Group (Integrated Care Board sub-committee)**
   - Recruitment processes of specific roles to support the programme

- A verbal update on the development of a joint Risk Register between the Trusts which would be presented at a future meeting.

An update on the PLACE work updates was also presented detailing Alder Hey, Merseyside and Liverpool University Hospitals NHS FT.

Liverpool Electronic Patient Record Review Work
The Committee received an overview of progress on the Liverpool-wide review of Electronic Patient Records (EPR), which explored the following options:

- a consolidated EPR platform across all Liverpool Trusts
- integration of the existing EPR platforms across all Liverpool Trusts
- a 'do nothing' option to change existing EPR arrangements, whilst developing plans to collaborate more effectively.

An update would be presented at a future meeting.

Pathology Network Roadshows Update
Committee members received an overview of the Pathology Network Roadshows which detailed the Target Operating Model which had been developed in response to the change drivers identified. The Pathology Review was being undertaken at a Cheshire & Merseyside level, however, aligned with Recommendation 7 of the Liverpool Clinical Services Review which outlined the need to combine expertise in clinical support services to provide consistent services across Liverpool.

Decisions Made

The Terms of Reference were recommended for ratification by each Trust Board of Directors.

Information: Additional considerations

Equality, Diversity & Inclusion Implications

No specific E,D & I implications.

Quality, Financial or Workforce implications

No specific quality, financial or workforce implications

Link to the Board Assurance Framework and/or Corporate Risk Register

The Trust's involvement in this Committee provides a strong control for BAF Risk 6 – The right partnerships are not developed and maintained to support the success of the Cheshire & Merseyside ICB and the CMAST Provider Collaborative.

Recommendation

The Board of Directors is asked to receive the report.

SUPPORTING DOCUMENTS

No supporting documents.

Liverpool Women's
NHS Foundation Trust

Jargon Buster

We know that the language used in healthcare can sometimes be quite confusing, especially when acronyms are concerned. To make life a little easier, we will try to ensure that we spell out acronyms in full at first mention and then put the abbreviation in brackets, for example, Strategic Clinical Network (SCN) in our reports and minutes.

We've also put together a list of acronyms that you might see throughout our documentation. If you spot a gap, please email our Trust Secretary on mark.grimshaw@lwh.nhs.uk.

The following webpage might also be useful - https://www.england.nhs.uk/participation/nhs/

A		
A&E	Accident & Emergency	hospital department specialising in the acute care of patients who arrive without a prior appointment with urgent or emergency trauma
AC	Audit Committee	a committee of the board – helps the board assure itself on issues of finance, governance and probity
AGM	Annual General Meeting	a meeting to present and agree the trust annual report and accounts
AGS	Annual Governance Statement	a document which identifies the internal controls in place and their effectiveness in delivering effective governance
AHP	Allied Health Professionals	health care professions distinct from dentistry, optometry, nursing, medicine and pharmacy e.g. physiotherapists, radiographers, speech therapists and podiatrists
AHSC	Academic Health Science Centre	a partnership between a healthcare provider and one or more universities
AHSN	Academic Health Science Network	locally owned and run partnership organisations to lead and support innovation and improvement in healthcare
ALOS	Average Length of Stay	the average amount of time patients stay in hospital
AMM	Annual Members Meeting	a meeting that is held every year to give members the opportunity to hear about what the trust has done in the past year; could be part of the AGM
AO	Accountable Officer	senior person responsible and accountable for funds entrusted to their trust; for NHS provider organisations this person will be the chief executive
ALB(s)	Arms Length Bodies	an organisation that delivers a public service but is not a ministerial government department; these include HEE, HSCIC, HRA, HTA, NHSE, NICE, Monitor, NHSBSA, NHSBT, NHSI, NHSLA, MHPRA, CQC, PHE (See individual entries)
	Agenda for Change	the NHS-wide grading and pay system for NHS staff, with the exception of medical and dental staff and some senior managers; each relevant job role in the NHS is matched to a band on the Agenda for Change pay scale

B		
BAF	Board Assurance Framework	the key document used to record and report an organisation's key strategic objectives, risks, controls and assurances to the board
BCF	Better Care Fund	this fund creates a local single pooled budget to incentivise the NHS and local government to work more closely together in local areas
BMA	British Medical Association	trade union and professional body for doctors
BAME	Black Asian Minority Ethnic	terminology normally used in the UK to describe people of non-white descent
BoD	Board of Directors	executive directors and non-executive directors who have collective responsibility for leading and directing the trust
	Benchmarking	method of gauging performance by comparison with other organisations

C		
CAMHS	Child and Adolescent Mental Health Services	specialise in providing help and treatment for children and young people with emotional, behavioural and mental health difficulties
CapEx	Capital Expenditure	an amount spent to acquire or improve a long-term asset such as equipment or buildings. Typically, capital is raised via a loan, but it can come from reserves and is paid back/written off over a number of years from revenue income. This is a contrast with revenue spend which is always from in-year income
CBA	Cost Benefit Analysis	a process for calculating and comparing the costs and benefits of a project
CBT	Cognitive Behavioural Therapy	a form of psychological therapy used mostly in depression but increasingly shown to be a useful part of the treatment for schizophrenia
CCG	Clinical Commissioning Group	groups of GPs, clinicians and managers who are responsible for commissioning local health services in England (all GP practices must belong to a CCG)
CDiff	Clostridium difficile	a bacterial infection that most commonly affects people staying in hospital
CE / CEO	Chief Executive Officer	leads the day-to-day management of a foundation trust, is a board member and the accountable officer for the trust.
CF	Cash Flow	the money moving in and out of an organisation
CFR	Community First Responders	a volunteer who is trained by the ambulance service to attend emergency calls in the area where they live or work
CHC	Continuing Healthcare	Whereby those with long-term or complex healthcare needs qualify for social care arranged for and funded by the NHS
CIP	Cost Improvement Plan	an internal business planning tool outlining the Trust's efficiency strategy
CMHT	Community Mental Health Team	A team of mental health professionals such as psychiatrists,

		psychologists, social workers, community psychiatric nurses and occupational therapists, who work together to help people manage and recover from mental illness.
CoG	Council of Governors	the governing body that holds the non-executive directors on the board to account for the performance of the board in managing the trust, and represents the interests of members and of the public
COO	Chief Operating Officer	a senior manager who is responsible for managing a trust's day-to-day operations and reports to the CEO
CPD	Continuing Professional Development	continued learning to help professionals maintain their skills, knowledge and professional registration
CPN	Community Psychiatric Nurse	a registered nurse with specialist training in mental health working outside a hospital in the community
CQC	Care Quality Commission	The independent regulator of all health and social care services in England
CQUIN	Commissioning for Quality and Innovation	a sum of money that is given to providers by commissioners on the achievement of locally and nationally agreed quality and improvement goals
CSR	Corporate Social Responsibility	A business practice which incorporates sustainable goals, usually positive impacts on environmental, economic and social factors, into a business model
CT	Computed Tomography	A medical imaging technique
CFO	Chief Finance Officer	the executive director leading on finance issues in the trust
CNST	Clinical Negligence Scheme for Trusts	The Clinical Negligence Scheme for Trusts (CNST) handles all clinical negligence claims against member NHS bodies where the incident in question took place on or after 1 April 1995 (or when the body joined the scheme, if that is later). Although membership of the scheme is voluntary, all NHS Trusts (including Foundation Trusts) in England currently belong to the scheme.
	Caldicott Guardian	A board level executive director responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing. Each NHS organisation is required to have a Caldicott Guardian

D		
DBS	Disclosure and barring service	conducts criminal record and background checks for employers
DBT	Dialectical behavioural therapy	A type of psycho-therapy, or talk therapy, which has been developed from CBT to help those experiencing borderline personality disorder
DGH	District General Hospital	major secondary care facility which provides an array of treatment, diagnostic and therapeutic services, including A&E
DHSC	Department of Health and Social Care	the ministerial department which leads, shapes and funds health and care in England
DN	Director of Nursing	The executive director who has professional responsibility for services provided by nursing personnel in a trust

DNA	Did Not Attend	a patient who missed an appointment
DNAR	Do Not Attempt Resuscitation	A form issued and signed by a doctor, which tells a medical team not to attempt CPR
DPA	Data Protection Act	the law controlling how personal data is collected and used
DPH	Director of Public Health	a senior leadership role responsible for the oversight and care of matters relating to public health
DTOCs	Delayed Transfers of Care	this refers to patients who are medically fit but waiting for care arrangements to be put in place so therefore cannot be discharged
	Duty of Candour	a legal duty on hospital, community, ambulance and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm

E		
E&D	Equality and Diversity	The current term used for 'equal opportunities' whereby members of the workforce should not be discriminated against because of their characteristics. This is promoted by valuing diverse characteristics in a workplace.
ED(s)	Executive Directors *or* Emergency Department	senior management employees who sit on the trust board *or* alternative name for Accident & Emergency department
EHR	Electronic Health Record	health information about a patient collected in digital format which can theoretically be shared across different healthcare settings
EOLC	End of Life Care	support for patients reaching the end of their life
EPR	Electronic Patient Record	a collation of patient data stored using computer software
ESR	Electronic staff record	A collation of personal data about staff stored using computer software

F		
FFT	Friends and Family Test	a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care
FOI	Freedom of Information	the right to ask any public sector organisation for the recorded information they have on any subject
FT	Foundation Trust	a public benefit corporation, which is a legal body established to deliver healthcare to patients / service users and has earned a degree of operational and financial independence
FTE	Full Time Equivalent	a measurement of an employees workload against that of someone employed full time e.g. 0.5 FTE would be someone who worked half the full time hours
FTSU	Freedom to speak up	An initiative developed by NHS Improvement to

		encourage NHS workers to speak up about any issues to patient care, quality or safety
	Francis Report	the final report, published in 2013, of the public inquiry into care provided by Mid Staffordshire NHS FT chaired by Sir Robert Francis QC

G

GMC	General Medical Council	the independent regulator for doctors in the UK
GDP	Gross Domestic Product	the value of a country's overall output of goods and services
GDPR	General Data Protection Regulations	The legal framework which sets the guidelines for collecting and processing personal information from individuals living in the European Union

H

HCAI	Healthcare Associated Infection	these are infections that are acquired in hospitals or as a result of healthcare interventions; MRSA and Clostridium difficile can be classed as HCAIs if caught whilst in a healthcare setting
HCA	Health Care Assistant	staff working within a hospital or community setting under the guidance of a qualified healthcare professional
HDU	High Dependency Unit	an area in a hospital, usually located close to the ICU, where patients can be cared for more extensively than on a normal ward, but not to the point of intensive care, e.g. patients who have had major surgery
HEE	Health Education England	the body responsible for the education, training and personal development of NHS staff
HR	Human Resources	the department which focusses on the workforce of an organisation including pay, recruitment and conduct
HRA	Health Research Authority	protects and promotes the interests of patients and the public in health research
HSCA 2012	Health & Social Care Act 2012	an Act of Parliament providing the most extensive reorganisation of the NHS since it was established, including extending the roles and responsibilities of governors
HSCIC	Health and Social Care Information Centre	the national provider of information, data and IT systems for commissioners, analysts and clinicians in health and social care
HTA	Human Tissue Authority	regulates the removal, storage, use and disposal of human bodies, organs and tissue for a number of scheduled purposes such as research, transplantation, and education and training
HWB / HWBB	Health& Wellbeing Board	a local forum to bring together partners from across the NHS, local government, the third sector and the independent sector, led by local authorities
	Health Watch	A body created under the Health and Social Care Act 2012

		which aims to understand the needs and experiences of NHS service users and speak on their behalf.

I		
IAPT	Improved Access to Psychological Therapies	an NHS programme rolling out services across England offering interventions approved by the National Institute of Health and Care Excellence for treating people with depression and anxiety disorders
IG	Information Governance	ensures necessary safeguards for, and appropriate use of, patient and personal information. Key areas are information policy for health and social care, IG standards for systems and development of guidance for NHS and partner organisations
ICP	Integrated Care Pathway	a multidisciplinary outline of care, placed in an appropriate timeframe, to help a patient with a specific condition or set of symptoms move progressively through diagnosis and treatment to positive outcomes
ICS	Integrated Care system	Groups of NHS providers, commissioners and local authorities working together to improve health and care in the local area
ICT	Information Communications Technology	an umbrella term that includes any communication device or application, encompassing: radio, television, cellular phones, computer and network hardware and software, satellite systems, as well as the various services and applications associated with them
ICU *or* ITU	Intensive Care Unit Intensive therapy unit	specialist unit for patients with severe and life threatening illnesses
IP	Inpatient	a patient who is hospitalised for more than 24 hours
IT	Information Technology	systems (especially computers and telecommunications) for storing, retrieving, and sending information
IV	Intravenous	treatment which is administered by injection into a vein

K		
KLOE(s)	Key Line of Enquiries	detailed questions asked by CQC inspectors which help to answer the five key questions to assess services: are they safe, effective, caring, responsive and well-led?
KPIs	Key Performance Indicators	indicators that help an organisation define and measure progress towards a goal
	King's Fund	independent charity working to improve health and health care in England

L		
LD	Learning Disability	a disability which affects the way a person understands information and how they communicate
LGA	Local Government Association	the national voice of local government in England and Wales. It seeks to promote better local government and maintains communication between officers in different local authorities to develop best practice
LOS	Length of Stay	a term commonly used to measure the duration of a single episode of hospitalisation

M		
M&A	Mergers & Acquisitions	mergers bring together two or more bodies to form a new legal entity and disband the merging bodies. acquisitions are take-overs of one body by another
MD	Medical Director	a member of the board who has a clinical background and has professional responsibilities for doctors and dentists in the trust
MHPRA	Medicines and Healthcare Products Regulatory Agency	an executive agency of DHSC which is responsible for ensuring that medicines and medical devices work and are acceptably safe
MIU	Minor Injuries Unit	A unit which treats injuries or health conditions which are less serious and do not require the A&E service
MoU	Memorandum of Understanding	describes an agreement between two or more parties
MRI	Magnetic Resonance Imaging	a medical imaging technique
MRSA	Methicillin-Resistant Staphylococcus Aureus	a bacterium responsible for several difficult-to-treat infections in humans
MSA	Mixed Sex Accommodation	wards with beds for both male and female patients

N

NAO	National Audit Office	an independent Parliamentary body in the United Kingdom which is responsible for auditing central government departments, government agencies and non-departmental public bodies. The NAO also carries out Value for Money audits into the administration of public policy
NED	Non Executive Director	directors who are appointed, but not employed by the trust; they have no executive responsibilities and are responsible for vetting strategy, providing challenge in the boardroom and holding the executive directors to account
NHSBSA	NHS Business Services Authority	a Special Health Authority of DHSC which provides a range of services to NHS organisations including: NHS Prescription Services, NHS Pensions, Help With Health Costs, Student Services, NHS Dental Services, European Health Insurance Card, Supplier Management (including NHS Supply Chain) and NHS Protect
NHSBT	NHS Blood and Transplant	a Special Health Authority of DHSC responsible for providing a reliable, efficient supply of blood, organs and associated services to the NHS
NHSE	NHS England	an executive non-departmental public body with a mandate from the Secretary of State to improve health outcomes for people within England
NHSI	NHS Improvement	The Independent regulator of NHS Foundation Trusts
NHSLA	NHS Leadership Academy	national body supporting leadership development in health and NHS funded services
NHSP	NHS Professionals	provides bank (locum) healthcare staff to NHS organisations
NHSX		A unit designed to drive the transformation of digital technology in the NHS
NICE	National Institute for Health and Care Excellence	provides national evidence-based guidance and advice to improve health and social care
NIHR	National Institution for Health Research	The largest funder of health and social care research in the UK, primarily funded by the Department of Health and Social Care
NMC	Nursing and Midwifery Council	nursing and midwifery regulator for England, Wales, Scotland and Northern Ireland
	Never Event	serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. NHS England defines the list of never events every year

	NHS Digital	The information and technology partner to the NHS which aims to introduce new technology into services
	NHS Providers	NHS Providers is the membership organisation for NHS public provider trusts. We represent every variety of trust, from large acute and specialist hospitals through to community, ambulance and mental health trusts.
	Nolan Principles	key principles of how individuals and organisations in the public sector should conduct themselves comprising of: selflessness, integrity, objectivity, accountability, openness, honesty, leadership. Set by the Committee for Standards in Public Life, an independent advisory non-departmental public body set up to advise the prime minister on ethical standards
	NHS Resolution	not-for-profit part of the NHS which manages negligence and other claims against the NHS in England on behalf of their member organisations. Also, an insurer for NHS bodies
	Nuffield Trust	independent source of evidence-based research and policy analysis for improving health care in the UK, also a charity

O

OD	Organisational Development *or* Outpatients Department	a systematic approach to improving organisational effectiveness *or* a hospital department where healthcare professionals see outpatients (patients which do not occupy a bed)
OOH	Out of Hours	services which operate outside of normal working hours
OP	Outpatients	a patient who is not hospitalized for 24 hours or more but who visits a hospital, clinic, or associated facility for diagnosis or treatment
OPMH	Older People's Mental Health	mental health services for people over 65 years of age
OSCs	Overview and Scrutiny Committees	established in local authorities by the Local Government Act 2000 to review and scrutinise the performance of public services including health services
OT	Occupational Therapy	assessment and treatment of physical and psychiatric conditions using specific activity to prevent disability and promote independent function in all aspects of daily life

P		
PALS	Patient Advice & Liaison Service	offers confidential advice, support and information on health-related matters to patients, their families, and their carers within trusts
PAS	Patient Administration System	the automation of administrative paperwork in healthcare organisations, particularly hospitals. It records the patient's demographics (e.g. name, home address, date of birth) and details all patient contact with the hospital, both outpatient and inpatient
PbR	Payment by Results or 'tariff'	a way of paying for health services that gives a unit price to a procedure
PCN	Primary care network	A key part of the NHS long term plan, whereby general practices are brought together to work at scale
PDSA	Plan, do, study, act	A model of improvement which develops, tests and implements changes based on the scientific method
PFI	Private Finance Initiative	a scheme where private finance is sought to supply public sector services over a period of up to 60 years
PHE	Public Health England	a body with the mission to protect and improve the nation's health and wellbeing and reduce health inequalities
PHSO	Parliamentary and Health Service Ombudsman	an organisation which investigates complaints that individuals have been treated unfairly or have received poor service from government departments and other public organisations and the NHS in England
PICU	Psychiatric Intensive Care Unit *or* Paediatric Intensive Care Unit	a type of psychiatric in-patient ward with higher staff to patient ratios than on a normal acute admission ward *or* an inpatient unit specialising in the care of critically ill infants, children, and teenagers
PLACE	Patient-Led	Surveys inviting local people going into hospitals as
	Assessments of the Care Environment	part of a team to assess how the environment supports patient's privacy and dignity, food, cleanliness and general building maintenance
PPI	Patient and Public Involvement	mechanisms that ensure that members of the community --- whether they are service users, patients or those who live nearby – are at the centre of the delivery of health and social care services
PTS	Patient Transport Services	free transport to and from hospital for non-emergency patients who have a medical need

	Primary Care	the first point of contact with the NHS for most people and is delivered by a wide range of independent contractors, including GPs, dentists, pharmacists and optometrists, it also includes NHS walk-in centres and the NHS 111 telephone service

Q

QA	Quality assurance	monitoring and checking outputs to make sure they meet certain standards
QI	Quality improvement	A continuous improvement process focusing on processes and systems
QIA	Quality Impact Assessment	A process within NHS trusts which ensures the quality of service is systematically considered in decision- making on service changes
QUI	Qualities and Outcomes Framework	The system for performance management and payment of GP's in the NHS

R

R&D	Research & Development	work directed towards the innovation, introduction, and improvement of products and processes
RAG	Red, Amber, Green classifications	a system of performance measurement indicating whether something is on or better than target (green), below target but within an acceptable tolerance level (amber), or below target and below an acceptable tolerance level (red)
RGN	Registered General Nurse	a nurse who is fully qualified and is registered with the Nursing and Midwifery Council as fit to practise
RoI	Return on Investment	the benefit to the investor resulting from an investment of some resource. A high RoI means the investment gains compare favourably to investment cost. As a performance measure, RoI is used to evaluate the efficiency of an investment or to compare the efficiency of a number of different investments.
RTT	Referral to Treatment Time	the waiting time between a patient being referred by a GP and receiving treatment

S		
SALT	Speech and Language Therapist	assesses and treats speech, language and communication problems in people of all ages to help them better communicate
SFI	Standing Financial Instructions	Policy used for the regulation of the conduct of an NHS trust in relation to all financial matters
SHMI	Summary Hospital Level Mortality Indicator	reports mortality at trust level across the NHS in England using standard and transparent methodology
SID	Senior independent Director	a non-executive director who sits on the board and plays a key role in supporting the chair; the SID carries out the annual appraisal of the chair, and is available to governors as a source of advice and guidance in circumstances where it would not be appropriate to involve the chair
SIRO	Senior Information Risk Officer	a senior manager who will take overall ownership of the organisation's information risk policy
SITREP	Situation Report	a report compiled to describe the details surrounding a situation, event, or incident
SLA	Service Level Agreement	an agreement of services between service providers and users or commissioners
SoS	Secretary of State	the minister who is accountable to Parliament for delivery of health policy within England, and for the performance of the NHS
SRO	Senior Responsible officer	A leadership role which is accountable for the delivery and outcome of a specific project
STP	Sustainability and Transformation Partnership	Partnerships formed between local councils and NHS services to help plan and run services, and agree system-wide priorities
SUI	Series Untoward Incident / Serious Incident	A serious incident which resulted in one or more of the following: unexpected or avoidable death, a never event, a prevention of organisation's ability to continue to deliver healthcare services, abuse, or loss of confidence in a service
SWOT	Strengths, Weaknesses, Opportunities, Threats	a structured planning method used to evaluate the strengths, weaknesses, opportunities and threats involved in a project or in a business venture
	Secondary Care	NHS health service provided through hospitals and in the community

T		
TTO	To Take Out	medicines to be taken away by patients on discharge

	Tertiary Care	healthcare provided in specialist centres, usually on referral from primary or secondary care professionals

V

VTE	Venous Thromboembolism	a condition where a blood clot forms in a vein. This is most common in a leg vein, where it's known as deep vein thrombosis (DVT). A blood clot in the lungs is called pulmonary embolism (PE)
VfM	Value for Money	used to assess whether or not an organisation has obtained the maximum benefit from the goods and services it both acquires and provides, within the resources available to it

W

WLF	Well Led Framework	a set of indicators that seek to identify how well led an organisation is, also used as a framework for board governance reviews
WRES	Workforce Race Equality Standard	a metric to demonstrate progress against a number of indicators of workforce equality, including a specific indicator to address the low levels of black and minority ethnic (BME) board representation
WTE	Whole-time equivalent	See FTE

Y

YTD	Year to Date	a period, starting from the beginning of the current year, and continuing up to the present day. The year usually starts on 1st April for financial performance indicators