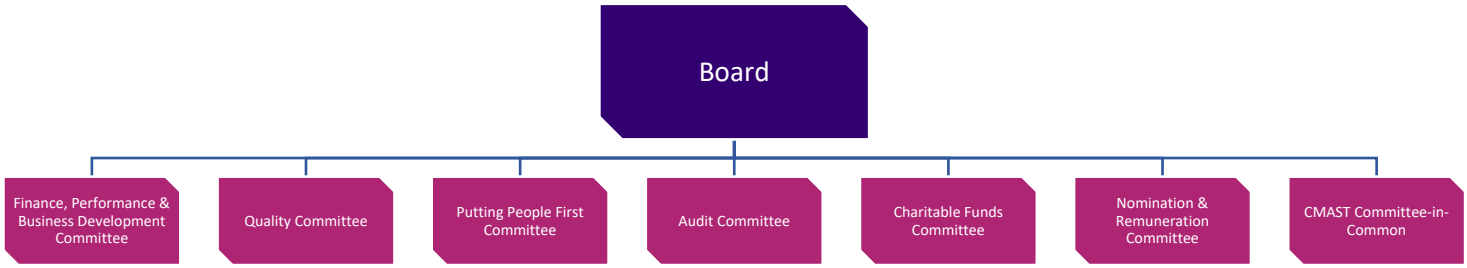
Liverpool Women's NHS Foundation Trust

Trust Board

12 October 2023, 10.30am
Boardroom, LWH & Virtual, via Teams



Liverpool Women's
NHS Foundation Trust

Trust Board

Location	Boardroom, LWH & Virtual via Teams
Date	12 October 2023
Time	10.30am

Item no. 23/24/	Title of item	Objectives/desired outcome	Process	Item presenter	Time
PRELIMINARY BUSINESS					
155	Introduction, Apologies & Declaration of Interest	Receive apologies & declarations of interest	Verbal	Chair	1030 (5 mins)
156	Meeting Guidance Notes	To receive the meeting attendees' guidance notes	Written	Chair	
157	Minutes of the previous meeting held on 14 September 2023	Confirm as an accurate record the minutes of the previous meeting	Written	Chair	
158	Action Log and matters arising	Provide an update in respect of on-going and outstanding items to ensure progress	Written	Chair	
159	Chair's & CEO announcements	Announce items of significance not found elsewhere on the agenda	Verbal	Chair	1035 (5 mins)
MATERNITY					
160	Preceptorship Update	For information	Presentation	Chief Nurse	1040 (20 mins)
161	Maternity Staffing report 1 January-30 June 2023	To receive	Written	Chief Nurse	1100 (15 mins)
162	Perinatal Quality Surveillance & Safety Dashboard	For assurance	Written	Chief Nurse	1115 (5 mins)
QUALITY & OPERATIONAL PERFORMANCE					
163	Quality & Operational Performance Report	To reeive the latest performance measures	Written	Chief Operating Officer	1120 (15 mins)
164	Learning from Deaths Quarter 1 2023/24	For assurance	Written	Medical Director	1135 (50 mins)
165	Annual Safeguarding Report	For assurance and approval	Written / Presentation	Chief Nurse	1225 (15 mins)
Board Thank you – 12.40pm					
Break – 12.45pm					
PEOPLE					
166	Workforce Performance Report	To receive the latest performance measures	Written	Chief People Officer	1250 (5 mins)
FINANCE & FINANCIAL PERFORMANCE					

167	Finance Performance Review Month 5 2023/24	To note the current status of the Trust's financial position	Written	Chief Finance Officer	**1255 (15 mins)**
BOARD GOVERNANCE					
168	Fit and Proper Person Test Requirements Update	To note and approve	Written	Trust Secretary	**1310 (5 mins)**
CONSENT AGENDA (all items 'to note' unless stated otherwise) *All these items have been read by Board members and the minutes will reflect recommendations, unless an item has been requested to come off the consent agenda for debate; in this instance, any such items will be made clear at the start of the meeting.*					
169	Emergency Preparedness, Resilience & Response Core Standards Annual Assurance Board Report	For assurance and approval	Written	Chief Operating Officer	Consent
170	Annual Self-Assessment for Placement Providers 2023 for Submission to NHSE	For assurance and approval	Written	Medical Director	
171	Medical Appraisal and Revalidation Annual Report 2022/23	For assurance and approval	Written	Medical Director	
CONCLUDING BUSINESS					
172	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair	**1315 (5 mins)**
173	Chair's Log	Identify any Chair's Logs	Verbal	Chair	
174	Any other business & Review of meeting	Consider any urgent items of other business	Verbal	Chair	
175	Jargon Buster	For reference	Written	Chair	

Date of Next Meeting: 9 November 2023

1320 - 1330	*Questions raised by members of the public*	To respond to members of the public on matters of clarification and understanding.	Verbal	Chair

Liverpool Women's
NHS Foundation Trust

Meeting 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 10.30am on 14 September 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
Gary Price	Chief Operating Officer
Gloria Hyatt MBE	Non-Executive Director
Prof. Louise Kenny CBE	Non-Executive Director / SID
Tracy Ellery	Non-Executive Director / Vice-Chair

IN ATTENDANCE

Matt Connor	Chief Information Officer
Gillian Walker	Patient Experience Matron (item 131 only)
Dr Paula Briggs	Consultant, Gynaecology (item 131 only)
Charlotte Bryant	North West Maternal Medicine Network, Manager (item 130 only)
Catherine Chmiel	North West Maternal Medicine Network, Lead Midwife (item 130 only)
Angela Winstanley	Quality and Safety Matron (until item 135a)
Yana Richens	Director of Midwifery
Heledd Jones	Head of Midwifery (until item 135a)
Kevin Robinson	Freedom to Speak up Guardian (item 135c only)
Rachel London	Deputy Director of Workforce (item 136a-c only)
Annie Gorski	Public Governor
Felicity Dowling	Member of the Public
Mark Grimshaw	Trust Secretary (minutes)

APOLOGIES:

Louise Martin	Non-Executive Director
Jackie Bird MBE	Non-Executive Director

Core members	**Nov 22**	**Dec**	**Jan**	**Feb**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sept 23**
Robert Clarke - Chair	⚑	⚑	⚑	⚑	⚑	⚑	⚑	⚑	⚑	⚑
Kathryn Thomson - Chief Executive	⚑	⚑	⚑	⚑	⚑	⚑	⚑	⚑	⚑	⚑
Tracy Ellery - Non-Executive Director / Vice-Chair	⚑	⚑	⚑	⚑	⚑	A	⚑	A	⚑	⚑
Louise Martin - Non-Executive Director	⚑	⚑	⚑	⚑	⚑	⚑	⚑	A	⚑	A

Prof Louise Kenny - Non-Executive Director	A	A	🏳	🏳	🏳	🏳	A	A	🏳	🏳
Eva Horgan – Chief Finance Officer	🏳	🏳	Non-member							
Dianne Brown – Chief Nurse	🏳	🏳	🏳	🏳	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	🏳	🏳	🏳	🏳
Sarah Walker – Non-Executive Director	A	🏳	🏳	🏳	🏳	🏳	🏳	🏳	A	🏳
Jackie Bird – Non-Executive Director	A	🏳	🏳	🏳	🏳	🏳	🏳	🏳	A	A
Jenny Hannon - Chief Finance Officer / Executive Director of Strategy & Partnerships	Non-member		🏳	🏳	🏳	🏳	A	🏳	🏳	🏳
Matt Connor – Chief Information Officer (non-voting)	🏳	🏳	🏳	🏳	🏳	🏳	🏳	🏳	🏳	🏳

23/24/	
126	**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.
127	**Meeting guidance notes** The Board received the meeting attendees' guidance notes.
128	**Minutes of the previous meeting held on 10 August 2023** The minutes of the Board of Directors meeting held on 10 August 2023 were agreed as a true and accurate record.
129	**Action Log and matters arising** Updates against action log were noted.
130	**Service Outline – Maternal Medicine Network** The North West Maternal Medicine Network (MMN), Manager and MMN Lead Midwife, reported that MMNs were a crucial part of NHS England's strategy to reduce mortality for pregnant individuals and neonatal morbidity and mortality. They ensured timely access to specialist care for those with acute and chronic medical issues during pregnancy. The Ockenden report emphasized the need for robust pathways to manage complex pregnancies, and the network approach had gained traction across various medical specialties, including fetal medicine. The North West region had 21 maternity providers, with three Maternal Medicine Centres at St Mary's Hospital, Royal Preston Hospital, and Liverpool Women's Hospital. These centres were supported by a Senior Leadership Team and Clinical Reference Groups. The MMN aimed to streamline referrals, develop guidelines, and promote collaboration among providers. It also supported education and training and was working on service evaluation and research projects. Long-term plans included clinical modelling, workforce development, and sustainability initiatives. Overall, it was

	asserted that MMNs would play a vital role in improving maternal and neonatal care in the North West region. The Medical Director noted that it was on the curriculum for trainee doctors that they would receive training on maternity medicine. It was queried if the MMN was involved in the provision of this training. The MMN Manager stated that this would be explored. It was also suggested that the MMN would benefit with developing links with the C-GULL research project. The Chief Executive stated that it would be important for the Board to maintain oversight of the progress being made by the MMN, particularly considering the levels of deprivation and the complexities within Liverpool. This would support ensuring that there were shared priorities across the MMN and that Multi-Disciplinary Team working was helping to improve maternal outcomes. Action: For the Board to receive an annual update on the Maternal Medicine Network. The Board thanked the North West Maternal Medicine Network (MMN), Manager and MMN Lead Midwife for their presentation.
131	Patient Story Dr Paula Briggs noted that there were positive developments in the area of menopause care and improving the patient journey. The Trust played a central role in supporting Women's Health Hubs and Primary Care in various ways, including training, mentorship, and governance initiatives. A patient's journey was shared as an example: after a hysterectomy and bilateral salpingo-oophorectomy (TAH/BSO) procedure in 2013 for prolapse, the patient was without HRT until they initiated it themselves two years later. Suboptimal symptom control led to desperation, sleep deprivation, and relationship issues. The importance of timely appointments in the menopause service was highlighted and it was noted that with the correct care, the patient saw a rapid return to normal function. The following key lessons were identified: • Staff members had emphasised the value of e-consultations and quarterly education sessions. • Collaboration with primary care was crucial. • An implant service was deemed important for patients unresponsive to initial treatments. Ongoing projects included a systematic review, clinical research, database development with Birmingham Women's Hospital, and a patient information leaflet in progress. The Chief Nurse asked what additional support the Board could provide to enhance the service. Dr Paula Briggs noted the importance of working with and collaborating with mental health services. It was agreed that work would progress to explore formalising relationships with Merseycare NHS Foundation Trust. Action: To explore the formalisation of collaboration and joint working with mental health care providers relating to the Trust's menopause service. The Board thanked Dr Paul Briggs for presenting the story.
132	Chair's announcements The Chair provided an update regarding meetings of the Nomination & Remuneration Committee that had been held in late August 2023 and earlier in the day. The recruitment of a Chief Executive had been a key matter of consideration at both meetings. At the meeting held in August 2023, the Committee had revisited its initial options appraisal, devised following the announcement to retire from the incumbent Chief Executive. When options were being developed, the Board engaged with

	partners across the NHS to gauge their support for the potential options, including the joint appointment concept. At that time, feedback had been provided that capacity to enable a joint appointment was not currently in place and therefore the Committee agreed to pursue a standalone Chief Executive appointment albeit with a clear intention to transition to closer working with a neighbouring Trust in due course. However, advice was subsequently received that the capacity to move towards a joint appointment was available prompting the Committee to reconsider its approach. It was recognised that a joint appointment would greatly support the intended strategic direction of the Trust. The ongoing recruitment process was stopped, as it no longer aligned with the revised direction. The Committee meeting held earlier in the day had begun to consider the appointment process and future working arrangements. Other matters considered included the 2022/23 Chief Executive appraisal and a review of the Committee Terms of Reference (no changes made). The Board noted the update.
133	Chief Executive's report The Chief Executive presented the report which detailed local, regional, and national developments. The Chief Executive stated that following the trial verdict of the Lucy Letby Investigation, the thoughts of the Trust were with the parents and families of the victims and everyone who had been affected. As detailed in news reports and information provided by Cheshire Police, there was an ongoing investigation relating to the full period of Lucy Letby's career, including training placements at Liverpool Women's Hospital, which took place between October – December 2012 and January – February 2015. The Trust had been liaising with Cheshire Police throughout this investigation and would continue to do so going forward. Any further details will be shared by Cheshire Police in due course. A Public Inquiry had been announced and a letter had been received from the Office of the Inquiry to request that the Trust take steps to ensure that key documentation be retained. Other matters noted included: • The Trust was delighted to announce Dame Lorna Muirhead as Patron of the Liverpool Women's NHS Foundation Trust's Charity • The Chief Executive had received a Chief Constable's commendation from Merseyside Police for the significant role she played in the aftermath of the terrorist incident at Liverpool Women's in November 2021. It was noted that it was positive to see the recognition for a number of police officers who supported the Trust through the incident. • The Trust had been awarded the NHS Pastoral Care Quality Award and received VCHA Veteran Aware Accreditation Approval • An updated brief had been made available by the NHS Cheshire & Merseyside Integrated Care Board regarding the work of the Women's Services Sub-Committee. This had been produced following the publication of Trust papers but future updates would be included going forward. • Recently produced Inpatient survey results showed that the Trust was performing better than most acute and specialist Trusts. • The Trust had recently received confirmation that it had demonstrated compliance with all ten safety standards for the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme ran by NHS Resolution (NHSr). This had been achieved following NHSr requesting additional evidence of compliance post the publication of the Trust's CQC Report. In confirming compliance, NHSr had been complimentary regarding the Trust's approach and governance processes. The Chief Operating Officer noted that only half of trusts in England delivering maternity services achieved all ten safety standards. The Board of Directors noted the Chief Executive update.

134a	Perinatal Quality Surveillance & Safety Dashboard The Chief Nurse presented the dashboard highlighting key performance issues, midwifery red flags, and Healthcare Safety Investigation (HSIB) referrals. A key area of focus related to delays to Induction of Labour (IoL). The Family Health Senior Leadership Team (SLT) recognised the issues with ongoing delays in IoL and a Task & Finish Group had been convened along with an Estate reconfiguration being developed and approved by Executive Team. This work was scheduled to commence on 18/9/23 to repurpose the current Maternity Led Unit (MLU) Estate to make this a multipurpose area, maximizing the use of the estate and creating an Induction of Labour lounge, which would help to reduce bottlenecks within the Delivery Suite estate (a contributing factor to IoL delays) There were no cases reported to HSIB in July 2023 and two incidents reported to STEIS for investigation under the Serious incident Framework. In terms of updates from Maternity Safety Champion meetings, there were no safety escalations to be made from Ward to Board in July 2023. Any identified concerns had been managed and resolved inter-divisionally. The Chief Executive highlighted that there had been a significant long-term trend of increased C-Sections and IoL. It was requested that this be explored and reported back to the Board. Action: To provide a briefing to the Board explaining the long-term increase in the C-Section and Induction of Labour rate. The Board of Directors: • Noted the Perinatal Quality Surveillance & Safety Dashboard for July 2023.
134b	Maternity Incentive Scheme (CNST) Year 5 2023 – Update Paper The Board received the report which outlined the scheme compliance requirements to achieve all ten safety actions and their associated standards for the Maternity Incentive Scheme Year 5. The Trust's current status against each of the ten standards was reported together with any identified key risks relating to the Trusts' ability to declare compliance. Attention was drawn to the following key risks: • Safety Action 6 – Whilst there were no concerns regarding compliance, additional check and challenge was required with the Local Maternity & Neonatal System utilising a new implementation tool. This would not be marked as 'green' until this had been undertaken. • Safety Action 8 - There were concerns identified with the ability to meet the compliance targets within the medical workforce (Obstetric and Anaesthetic) of attendance at MPMET and Fetal Surveillance Study Days due to ongoing industrial action. To mitigate this, several additional MPMET and Fetal Surveillance sessions had been planned, but Industrial Action presented ongoing uncertainty. This had been escalated to the Divisional Risk register. The Chief Finance Officer noted that there might be potential additional income as a result of the Trust achieving compliance with the Year 4 scheme. Opportunities would be explored as to whether an element of this income could be utilised to support Year 5 compliance. The Medical Director referred to the presentation received regarding the MMN, noting that they had highlighted updates to the Saving Babies Lives Care Bundle. It was asked if the Trust remained compliant following the update. The Director of Midwifery explained that this mainly related to diabetic services during pregnancy and noted that the Trust had recently appointed a lead midwife for diabetes. The Trust Board noted the following issues of compliance:

	• Safety Action 4 - the current position in relation to compliance of Consultant attendance against RCOG guidance in relation to clinical situations as per the 'Roles and Responsibilities of the Consultant providing acute care in Obstetrics and Gynaecology • Safety Action 8 - Receipt of the revision of the Maternity Training Needs Analysis • Safety Action 9 – That Board Level Safety Champions were meeting monthly and that any support of the Trust Board had been identified and implemented. The Board of Directors: • Receive the current position in relation to CNST Year 5 • Noted the key risks to compliance. • Approved the revision of the Maternity Training Needs Analysis and agreed submission to the LMNS and ICB. • Approved the ATAIN and TC Audit and Action Plan
135a	Chair's Report from the Quality Committee The Board considered the Chair's Report from the Quality Committee meetings held on 25 July 2023. The Committee Chair, Sarah Walker, noted the following key points: • The Committee received a review of critical care transfers of women from this Trust (LWH) to an external provider over a 5-year period. The Committee noted the difficulties to access data to provide the report and noted development of a reliable data collection system was a priority to allow ongoing monitoring. The review demonstrated a need for critical care in approximately one patient per month at LWH. There was no evidence that this number was reducing. The Committee noted the establishment of a working group to take action to mitigate the existing risks identified. The Committee recommended that the risks identified by this report be included within the BAF and Corporate Risk Register. • The Committee received an in-depth analysis of current cancer pathways, with an elevated focus by sub-specialty tumour site. A detailed presentation was delivered against each cancer pathway identifying capacity issues, delays in service, and areas of reliance on external partners. It was confirmed that a robust harm review process was in place. The Committee remained concerned about the performance against the cancer metrics, it noted the cancer recovery plan in place and requested a follow up report to the Committee including actions and timescales. The Board of Directors received and noted the Chair's Report from the Quality Committee meetings held on 25 July 2023.
135b	Quality & Operational Performance Report The Board considered the Quality and Operational Performance Report. The Chief Operating Officer highlighted the following key points: • Urgent Care targets continued to perform well. MAU triage within 30 minutes was consistently high and the Gynaecology Emergency Department (GED) 4 Hr target remained in a positive position with ongoing work to stabilise. This work consisted of a full pathway review of all aspects of the service. • Routine elective care performance continued in line with trajectories. Throughout the first 5 months of the year the Trust had lost over a month of activity due to industrial action and would have been further ahead if this was not the case. The number of longest waiters continued to reduce in line with annual plans. • Routine 6-week diagnostic performance continued to perform well. • Challenges with Cancer Performance were overseen by the Cancer Improvement Plan and through the regional Tier 2 Cancer improvement meetings. These were supported by the Cheshire and Mersey Cancer Alliance and Liverpool Clinical Laboratories. Rigorous actions to improve diagnostics performance and therefore the 62-day performance were in place, and

	these continued to report to the Quality Committee and FPBD Committee. The aim of these actions was to improve the cancer performance to the national trajectories in Q3. The Chair stated an on-going concern with cancer performance whilst noting the sustained improvement that was being achieved. It was noted that this was being extensively monitored by both the Quality and FPBD Committees. The Chair asked if the pathway review of GED was driven by safety or efficiency concerns. The Chief Nurse noted that safety was the primary driver as it was recognised that the complexity and acuity of presenting patients was increasing. The Board of Directors received and noted the Quality & Operational Performance Report.
135c	Whistleblowing / Freedom to Speak up Annual Report 2022/23 The Board received the Whistleblowing / Freedom to Speak up Annual Report 2022/23. The Chief People Officer noted the importance of staff, students and volunteers feeling empowered, enabled, and safe to speak up and raise concerns about any issue that may impact upon patient safety and care, and staff wellbeing. This had been starkly reinforced by the early learning from the events leading to the conviction of Lucy Letby, a neonatal nurse. The report set out NHS England's expectations of all Boards regarding Speaking Up in their organisation and the current arrangements in place at the Trust to provide and further develop a culture were speaking up was actively encouraged, enabled and viewed as a positive action. During the year, the Trust had introduced an additional Freedom to Speak Up Guardian who was a clinician and who often was available out-of-hours. The Guardians had regular meetings with the Chair and Chief Executive and also had access to a Non-Executive Director champion. The Freedom to Speak Up Guardian informed the Committee that the Freedom to Speak Up, Raising Concerns & Whistleblowing Policy had recently been updated to reflect the national guidance released by the National Guardian office during 2022/23. The Freedom to Speak Up Guardian informed the Committee that the Trust was in the top ten most improved in terms of the Freedom to Speak Up sub-score of the NHS Staff Survey 2022. This had been recognised by the National Guardian for the NHS, Dr Jayne Chidgey-Clark, who had requested to visit the Trust to observe Trust practises and procedures. Other positive indicators were noted: • The number of concerns increased during the year – demonstrating a positive reporting culture and confidence in the process. • No anonymous concerns had been raised. • Training compliance across the organisation was high. Non-Executive Director, Sarah Walker, acknowledged the positive indicators in the report and asked what the key learning points were and how did these translate to changes in practice. The Freedom to Speak Up Guardian explained that concerns were reported back to senior leaders and themes were escalated to the Putting People First Committee. A significant number of concerns were raised when staffing concerns in maternity were at their most acute. This supported the case for increased investment in this area. It was explained that many concerns related to staffing issues rather than direct patient safety issues. However, it was understood that poor staff relationships ultimately impact on patient care and therefore a listening approach is taken to each issue raised with the Guardians. Non-Executive Director, Zia Chaudhry, raised a concern that the current physical environment at the Trust was not conducive to staff feeling that they could raise a concern with privacy. Action: To explore how the Trust can facilitate a safe and private space for staff to raise concerns with the Freedom to Speak Up Guardians. The Board of Directors:

	• Reviewed the report and took assurance that there were robust processes in place to support the raising of concerns and to support the Guardians in their work • Noted the areas of focus for 2023/24 and the ongoing training and leadership activities. • Requested that the Putting People First Committee undertake a full review of the current speak up arrangements and the underpinning cultural programmes of work to support that; with a specific focus on the approaches and mechanisms in place to support those members of staff who may have cultural barriers to speaking up (Chair's Log) • Approved the 2022/23 annual report.
136a	Chair's Report from the Putting People First Committee The Board considered the Chair's Report from the PPF Committee meeting held on 17 July 2023. Committee Chair, Gloria Hyatt, noted a key concern raised by the Committee related to a worsening trend of sickness rates within Gynaecology. It was noted that monthly oversight meetings had been introduced. The Committee recommended increased focus within the Gynaecology division to improve the position. The Board of Directors received and noted the Chair's Report from the PPF Committee meeting held on 17 July 2023.
136b	Workforce Performance Report The Board considered the Workforce Performance Report. The Chief People Officer highlighted the following key points: • The turnover rate continued to show a decreasing trend. • Mandatory training compliance was improving. • The sickness rate continued a downward trend. There had been a particular improvement in maternity compared to the previous year's position. • The flu vaccine metric was showing historic data and would be updated for the next report. The Chair recognised the consistent and sustained improvements in relation to the Trust sickness rate. It was queried if the 4.5% target would be achieved. The Chief People Officer confirmed that whilst it was likely that several areas would achieve this target, some services tended to be more challenged (e.g., maternity) and this would be likely to continue. The Board noted the workforce performance report.
136c	WDES, WRES, Bank WRES, MWRES Report 2023 The Deputy Director of Workforce provided a comprehensive update on Equality, Diversity & Inclusion (EDI) work being undertaken at the Trust, with a focus on the Workforce Race Equality Scheme (WRES) and the Workforce Disability Equality Scheme (WDES). Key points included statutory reporting and action plans, the Equality Delivery System for NHS, Equality Objectives, and the NHS EDI Improvement Framework. The Trust had committed to addressing racism actively and building trust within its workforce and community. The Chief People Officer flagged that it might be possible that there is an increase in negative feedback and difficult conversations as trust develops. This would require the Board to 'hold its nerve' and remain committed to seeking honest conversations. Achievements in 2022/23 included improved inclusivity rankings, support for neurodiverse young people, pre-employment programs, and increased diversity in leadership roles. Efforts to enhance patient and community experiences were noted, such as secret shopper programs and improved interpreter services.

	For the 2023-2027 Equality Objectives, the focus was on recruitment, diversity, staff experience, equitable services, partnership with communities, and reducing health inequalities. The strategic aim was to be one of the most inclusive NHS organizations, with two specific measures for progress. The meeting also reviewed WRES and WDES headlines, including areas of concern like reduced likelihood of appointment from interviews and increased staff experiencing harassment. Areas of improvement included an increase in racially marginalized employees and disabled staff appointments. Monitoring progress against the 2023/24 workplan was emphasized, with clear metrics, reporting structures, and personal EDI objectives for executive directors. The Chief People Officer asserted that the commitment to addressing discrimination and improving inclusivity throughout the Trust was not an 'initiative' but rather something that should be mainstreamed across day-to-day business. The next six months were identified as a pivotal period for socialising the anti-racism approach. The Chair remarked that the Trust's approach to inclusivity had been remarked upon during the recent Chief Executive interview process and therefore expectations had been set outside of the organisation. The Director of Midwifery noted the importance of ensuring that the Trust could evidence that it was acting positively on the feedback that it was receiving from both staff and the local community. The Chief People Officer noted that there were some inconsistencies between the narrative and data shown in the report (the latter being accurate). These would be amended ahead of the WDES and WRES reports being published. The Board of Directors: • noted the contents of the report, and the assurances that appropriate actions were being taken. • Supported the ongoing work on the ED&I agenda. • Subject to the agreed amendments, approved the report for publication on the Trust website to fulfil the National requirements for WDES and WRES.
	Board Thank you The following Board Thank You's were presented: 1) Megan Johnson & Jeanette Jones – from the Access Team to thank them for all their hard work through DigiCare go live – Gary Price presented. 2) Richard Glyn Jones & Paul McGuire – EPR Team – for their hard work in delivering the DigiCare 'go-live' – Matt Connor presented.
137a	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 26 July and 30 August 2023. It was noted that at both meetings there had been significant focus on scrutinising the Trust's approach to financial recovery and the progress being made to recover the Trust's 2023/24 financial position. At the August 2023 meeting, the Committee noted limited assurance on the financial recovery programme, due to the early stage of delivery, whilst also noting the positive focus on implementing the appropriate processes, governance, and controls. The Board of Directors received and noted the Chair's Report from the FPBD Committee meeting held on 26 July and 30 August 2023.
137b	Chair's Report from the Audit Committee The Board considered the Chair's Report from the Audit Committee meeting held on 20 July 2023.

	The Committee Chair, Non-Executive Director Tracy Ellery, noted that the Committee received the External Auditor's Annual Report for the year ended 31 March 2023 which included the Value for Money (VfM) assessment that had not been available at the June 2023 Audit Committee meeting. The external auditor had recorded a significant weakness in arrangements related to deliverability of the financial plan to avoid further cash support. The external auditor did, however, acknowledge the Trust's view that the key drivers of this were outside of the Trust's control and that work continued with system partners to find sustainable solutions. It was also noted that internal grip and control processes had been implemented. An improvement recommendation had been raised by the external auditor that was accepted by Trust management. The external auditor had also considered whether the Trust's recent CQC report should be recorded as a significant weakness. After referral to an internal panel, the external auditor was satisfied that the Trust's response was such that this should not be adjudged to be a significant weakness. The Board of Directors: • noted the Chair's Report from the Audit Committee meeting held on 20 July 2023.
137c	Finance Performance Review Month 4 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 July 2023. At Month 4, the Trust was reporting a £6,443k deficit which represented a £530k adverse variance to plan. This position was supported by £2.6m of non-recurrent items. The forecast outturn was £15,450k deficit, in line with the submitted plan. The Trust was acting on financial recovery and had brought in support to facilitate delivery of enhanced infrastructure, documentation, and governance of the recovery programme, and enable the pace of change required to deliver the challenge. A Project Management Office (PMO) had been established from within existing resources and recovery workstreams had been initiated. A Quality Impact Assessment Assurance Committee had been established to review all Quality Impact Assessments for all transformational schemes and would focus on ensuring the Trust did not lose focus on quality during the financial recovery process. The Financial Grip and Control Working Group had implemented revised financial approval limits across pay and non-pay, accompanied by a defined set of criteria and exemptions (to ensure clinical safety) for approval of spend. Additionally, the Trust was producing a financial recovery plan, to be submitted to the Integrated Care Board (ICB) in September 2023, which would articulate the key steps required and support needed to achieve financial sustainability. Total cash at the end of Month 4 was £1.3m. This was due to the deficit position year to date and expected working capital movements. The balance increased to £11.3m on 1 August 2023 following receipt of income and cash from the ICB, and the average daily cash balance throughout Month 4 was over £9m. As the Trust had a deficit plan for 2023/24, cash support was required throughout the year. Cash levels were closely monitored 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. The following key issues were highlighted: • The YTD position was supported by £2.6m of non-recurrent items. The adjusted position in Month 4 (following removal of key non-recurrent items) was a deficit of £9.0m, which represented an adverse variance of £3.1m against plan. • The most significant driver of the underlying year to date position was staffing pressures. This included: o Nursing, midwifery, and support staff pressures (£1.6m) across maternity, gynaecology, and theatres (in part related to costs of industrial action)

	○ Medical staffing (£0.3m); driven by Family Health and Gynaecology (£200k of which related to industrial action) ○ Admin and clerical (£0.2m); cost pressures in corporate areas • The Trust had a cost improvement programme target of £8.3m. This equated to 5.3% of expenditure which would be challenging to deliver. At Month 4, there was an adverse variance of £129k against the £1,810k target. The Trust was focussed on identifying and implementing robust schemes that will deliver on an ongoing basis. • There had been a reduction in the pay run-rate in Month 4 and agency usage was favourable against the plan. Non-Executive Director, Sarah Walker, queried the volatility in the administrative support costs during the year. The Chief Finance Officer explained that there were unfunded costs in the budget, and these were being removed when an opportunity presented. Non-Executive Director, Tracy Ellery, stated the importance of minimising the level of deviation from the plan and asked what action was being taken to accelerate recovery action so that it would impact the 2023/24 position. The Chief Finance Officer stated that work was taking place to safely unwind areas of previous staffing investment and acknowledged that it would be important to be able to accurately forecast a year-end position by Month 6 to support the Trust's credibility. The Board of Directors: • Noted and received the Month 4 2023/24 Finance Performance Review
138a	Review of Strategic Progress The Chief Finance Officer explained that updates regarding strategic progress were previously reported to the Finance, Performance, and Business Development (FPBD) Committee. It had subsequently been agreed that in addition to the annual review of delivery of the overarching Trust strategy, bi-annual strategic progress reports would be presented directly to the Trust Board to ensure all Board members were sighted on strategy development and delivery. The Board received the key strategic developments and progress which had occurred to July 2023. The Board of Directors: • Noted the report.
138b	Board Assurance Framework The Board of Directors received the Board Assurance Framework. The Trust Secretary explained that the BAF had been reviewed and discussed at the aligned Committees during July 2023. There were no proposed changes to risk scores. Scores for Quarter 2 would be discussed at the September 2023 Committee meetings and reported through to the November 2023 Board meeting The Board of Directors • reviewed the BAF risks and agreed on their contents and actions. *The following items were considered as part of the consent agenda*
139	Corporate Governance Manual – 2023 Update The Board approved the proposed amendments to the Trust's Corporate Governance Manual.
140	Constitution Amendments The Board of Directors approved the suggested amendments to the Constitution and recommended that these be ratified at the Annual Member's Meeting.

141	Review of risk impacts of items discussed The Chair identified the following risk items: • Performance against access targets, particularly for cancer services • Delays to Induction of Labour • CNST Year 5 compliance, particularly in relation to MDT training • Need for continuing work around Freedom to Speak Up and ensuring an open and transparent culture. • The Trust's 2023/24 financial position, longer-term sustainability challenges, and the potential impact on quality and safety. • On-going challenges resulting from Industrial Action Positive assurances were noted around the recent Inpatient Survey results. It was also noted that the MMN presented a significant opportunity to improve maternity outcomes across the system.
142	Chair's Log • The Putting People First Committee to undertake a full review of the current speak up arrangements and the underpinning cultural programmes of work to support that; with a specific focus on the approaches and mechanisms in place to support those members of staff who may have cultural barriers to speaking up.
143	Any other business & Review of meeting None noted. Review of meeting No comments noted.
144	Jargon Buster Noted.

Liverpool Women's
NHS Foundation Trust

Action Log

Trust Board - Public
12 October 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
14 September 2023	23/24/135c	Whistleblowing / Freedom to Speak up Annual Report 2022/23	To explore how the Trust can facilitate a safe and private space for staff to raise concerns with the Freedom to Speak Up Guardians.	COO	November 2023	On track	
14 September 2023	23/24/134a	Perinatal Quality Surveillance & Safety Dashboard	To provide a briefing to the Board explaining the long-term increase in the C-Section and Induction of Labour rate.	MD	November 2023	On track	
14 September 2023	23/24/131	Patient Story	To explore the formalisation of collaboration and joint working with mental health care providers relating to the Trust's menopause service.	MD	December 2023	On track	
14 September 2023	23/24/130	Service Outline – Maternal Medicine Network	For the Board to receive an annual update on the Maternal Medicine Network	TS	October 2023	Closed	Added to Board work programme
13 July 2023	23/24/084	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	Closed	Update made to the Performance Report (item 163)

Liverpool Women's
NHS Foundation Trust

Chair's Log

Received / Delegated	Meeting Date	Issue and Lead Officer	Receiving / Delegating Body	Action Deadline	RAG Open/Closed	Comments / Update
Delegated	14.09.2023	To undertake a full review of the current speak up arrangements and the underpinning cultural programmes of work to support that; with a specific focus on the approaches and mechanisms in place to support those members of staff who may have cultural barriers to speaking up. Executive Lead: Chief People Officer	PPF	December 2023	Open	
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~~ November 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	Closed	Patient Experience Matron presented to the Sub-Committee on 8 August 2023
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	Closed	Report received in September 2023 PPF Committee

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	***23/24/161***		**Date: 12/10/2023**	
Report Title	**Maternity Staffing report 1st January-30th June 2023**			
Prepared by	Heledd Jones, Head of Midwifery			
Presented by	Dianne Brown, Chief Nurse			
Key Issues / Messages	The Maternity Staffing Oversight Report outlines the requirements of Maternity Incentive Scheme Safety Action 5 and details LWH current position. This forms the required evidential standard for submission to Trust Board			
Action required	**Approve ☐**	**Receive ☒**	**Note ☐**	**Take Assurance ☐**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	***To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it***	***For the intelligence of the Board / Committee without in-depth discussion required***	***To assure the Board / Committee that effective systems of control are in place***
	Funding Source (If applicable):			
	For Decisions - in line with Risk Appetite Statement – Y/N ***If no – please outline the reasons for deviation.***			
	It is recommended that the Board received the report paper.			
Supporting Executive:	***Dianne Brown, Chief Nurse***			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

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

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

Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* 3. Failure to deliver an excellent patient and family experience to all our service users	Comment: This relates to Midwifery staffing vacancies
Link to the Corporate Risk Register (CRR) – CR Number: Insufficient midwifery staffing levels as recognised by Birth Rate Plus, next review 4/10/2023. Current score 6.	**Risk Number: 1705**

REPORT DEVELOPMENT:

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

EXECUTIVE SUMMARY

The Maternity Staffing paper is provided to the Board of Directors and outlines the requirements of the Maternity Incentive Scheme (MIS) Year 5, Safety Action 5 (SA5). The report sets out the Liverpool Women's NHS Foundation Trust (LWH) position in the context of midwifery staffing. This report covers the six-month period from 1st January 2023 to 30th June 2023 as is required for MIS.

MIS Year 5, SA5 requires that Trusts demonstrate an effective system of midwifery workforce planning. The recognised evidence-based tool within Maternity Services is Birth Rate Plus (BR+).

A Birth Rate Plus refresh audit was completed in April 2023, with the final report received in the Trust in May 2023.

The report highlights the following areas for discussion and noting (January 2023-June 2023).

- LWH midwifery and MSW budgeted posts for financial year 2023/24 equates to 353.18wte which is 0.35wte below the BR+ audit recommendation.
- As the Trust is 0.35wte under the recommendation of BR+ with a funded establishment based on Birth Rate+ Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment and must be shared with the local commissioners.
- Plan is in place to reconfigure a non-BR+ post to convert to 0.35wte band 6 midwifery post to meet the requirements of BR+ by 31st October 2023.
- Budgeted posts are inclusive of 23% headroom for midwives and 21.4% uplift for maternity support workers.
- Vacancy rate is 15.10wte in June 2023. Gross unavailability rate (including mat leave) equates to 26.78wte.
- Total recruitment in progress is 43.44wte,
- Sickness absence rate is 6.49% in June 2023 which is a reduced position from the same period in 2022 at 16.7%. This demonstrates a demonstrable improvement in management of sickness absence in line with policy.
- Midwife: Birth ratio in June 2023 is 1:21 against a national recommendation of 1:28.
- There were 93 red flags reported between January 2023–June 2023 which is a reduction of 170 from previous reporting period (July 2022-December 2022) where 263 red flags were reported. Majority of the red flags relate to delays in ongoing Induction of Labour, owing to capacity and demand and midwifery staffing levels. An induction of labour improvement group is well established with capital plans in place to create a separate IOL area consisting of 5 rooms. This will help to improve patient flow on Delivery Suite to be able to expedite IOL patients to continue the process whilst also improve the patient experience.
- Supernumerary shift co-ordinator on Delivery Suite is maintained at 100% for the past six months.
- 1:1 care in labour achieved a compliance rate of 98.62% - 100% in the reporting period, against a standard of 100%.
- Significant improvement has been achieved in the performance of Triage assessment, following implementation of a revised midwifery staffing model in the Maternity Assessment Unit with 99.14% of women attending MAU being triaged within a period of 30 minutes from presenting to the department.

It is recommended that the Board accepts the information in this paper as assurance that there are robust systems and processes in place that fulfil the requirements of MIS Year 5, SA5.

1.0 Introduction

The Maternity Incentive Scheme (MIS) Year 5 Safety Action 5 requires that trusts demonstrate an effective system of midwifery workforce planning. Birth Rate Plus (BR+) is a recognised tool for workforce planning and strategic decision-making. It is based upon an understanding of the total midwifery time required to care for women and on a minimum standard of providing one-to-one midwifery care throughout established labour. Whilst birth outcomes are not influenced by staff numbers alone, applying a recognised and well-used tool is crucial for determining the number of midwives and support staff required to ensure each woman receives one-to-one care in labour. A Birth Rate Plus refresh audit was completed in Maternity Services at LWH in April 2023 and the report received in May 2023 (Appendix 1). Included in the assessment is the staffing required for antenatal, intrapartum, and postnatal inpatient and outpatient services, including community births. Birth Rate + calculates the clinical establishment based on agreed standards of care and includes the midwifery management and specialist roles required to manage maternity services. Adjustment of clinical staffing between midwives and maternity support workers (Band 3) is included. The recommendation is to provide total care to women and their babies over 24 hours, 7 days a week basis, inclusive of the local percentage for annual, sick & study leave allowance and for travel in community. 23% uplift has been calculated to enable this for midwives and 21.4% uplift for Maternity Support Workers.

2.0 Maternity Staffing Establishments

Birth Rate Plus refresh audit was completed in maternity at LWH in April 2023 based on FY22/23 annual activity and total births of 7386 (1st April 2022-31st March 2023). The report published in May 2023 recommended a workforce establishment of 353.53wte inclusive of 90:10 skill mix (90% midwives and 10% maternity support worker). LWH midwifery and MSW budgeted posts for financial year 2023/24 equates to 353.18wte which is 0.35wte below the BR+ audit recommendation. As the Trust is 0.35wte under the recommendation of BR+ with a funded establishment based on BR+, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment and must be shared with the local commissioners. Plan is in place to reconfigure a non-BR+ post to convert to 0.35wte band 6 midwifery post to meet the requirements of BR+ by 31st October 2023.

CNST Maternity Incentive Scheme Year 5, Safety Action 5 requires a clear breakdown of Birth Rate+ or equivalent calculations to demonstrate how the required establishment has been calculated. In line with midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of Birth Rate+ or equivalent calculations. Where Trusts are not compliant with a funded establishment based on Birth Rate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls. The plan to address the findings from the full audit or tabletop exercise of Birth Rate+ or equivalent undertaken, where deficits in staffing levels have been identified must be shared with the local commissioners.

Table 1 lists the Midwifery and MSW funded establishment 2023/24 compared to the Birth Rate Plus audit requirements (May 2023).

Maternity Tables - 2023/24

Table 1 - Funded Establishment	2023/24 BRP Reccomendation Wte	2023/24 LWH Funded Establishment Wte	2023/24 Variance Budget to BRP Wte
Clinical	287.87	287.37	- 0.50
Clinical - Support Staff	30.11	30.06	- 0.05
Total Direct Care Giving Midwives	317.98	317.43	- 0.55
Non-Direct Care	35.55	35.75	0.20
Total Budget to BRP Model	353.53	353.18	- 0.35
Clinical		8.17	
Clinical - Support Staff		54.98	
A&C		28.20	
Total Funded Roles outside of the BRP Mod	-	91.35	-
Total Establishment	353.53	444.53	- 0.35

Table 1- Funded establishment 2023/24

Care Hours Per Patient Per Day (CHPPD)

	DAY	DAY	NIGHT	NIGHT
	Average fill rate Midwives (%)	**Average fill rate Support staff (%)**	**Average fill rate Midwives (%)**	**Average fill rate Support staff (%)**
Induction of Labour and Delivery Suite	82.25%	86.9%	85.95%	94.2%
Maternity Base and Jeff Coate	88.95%	101.65%	84.2%	99.9%
Midwifery Led Unit (MLU)	85.05%	65.75%	83.2%	70.75%
Maternity Total fill rates	**85.41%**	**84.7%**	**84.45%**	**88.2%**

Table 2: Safe Staffing, Rota Fill Rates January- June 2023

Data in Table 2 is an average of the rota fill rates for the first 6 months of 2023. CHPPD relates only to hospital wards where patients stay overnight and is calculated by taking all the shift hours worked over the 24-hour period by Registered Midwives and Maternity Support Workers and dividing this by the number of patients occupying a bed at midnight. The data is

aggregated each day over the month. In maternity mothers and babies are included in the census.

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

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

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

3.0 Maternity Staffing (Planned versus Actual)

Maternity has a process for daily review of planned versus actual staffing, this information is fed into the twice daily staffing huddles. In addition, staffing is reported Trust wide in the daily virtual huddle (Bronze command) which consists of senior managers and the manager on call. LWH procure the services of NHS Professionals to fill bank shifts and if required agency shifts, to support temporary staffing shortfalls. Twice weekly meetings are held to monitor staffing fill rates and to allocate bank shifts to ensure consistent and safe staffing levels. Bank shifts have consistently been allocated to provide safe midwifery staffing cover owing to the vacancy rates.

One of the main service priorities is to maintain safe midwifery staffing levels. Maternity staffing and acuity are assessed on a 4hrly basis by the Maternity Bleep Holder and should staffing fall by the numbers of midwives to provide safe care, the Maternity Escalation Guideline (V3.4) is followed which includes the redeployment of staff. Midwives and MSW undertake a rotational training programme, allowing midwives to rotate between all clinical areas, ensuring a workforce that are skilled to work across all clinical areas of the maternity service. The Maternity Bleep holder consistently reviews staffing with the aim of redeploying non- direct care givers to address periods of high acuity in clinical activity to maintain a safe clinical staffing ratio.

4.0 Maternity Workforce Measures

Midwifery vacancies:

4.1: Reflected in Table 3 is the midwifery vacancy rate against the midwifery establishment and maternity leave rate in month 3 FY23/24

True vacancy rate	15.10wte
Maternity leave	11.68wte
Gross unavailability rate	26.78wte

Table 3: Vacancy rate

4.2 Recruitment

Table 4 lists the Midwifery recruitment pipeline together with tentative dates for commencing employment in maternity services at LWH.

Recruitment in progress	
Recruited staff Band 6 Commencing in post month 5	2.92wte
Recruited staff Band 5 (Newly Qualified Midwives) Commencing in post month 6-7	38.52wte
Recruitment pipeline-International Midwives Estimated start dates month 7-8	2.00wte
Total recruitment in progress	43.44wte

Table 4**:** Recruitment in progress

Maternity has 11.68wte (12 heads) ongoing maternity leave, projected at 10wte on a rolling basis. The workforce profile is reviewed monthly by the senior midwifery team with support from the HR Business Partner. Quarter 3 of the current financial year will reflect a full midwifery establishment. This will result in 28.34wte over establishment of the midwifery staffing budget and 22.99wte over the Birth Rate Plus audit requirement (May 2023). Approval to over recruit taking into consideration the 3.0wte monthly midwifery attrition rate and projected 10wte rolling basis of maternity leave was granted by the Trust Executive Team in Quarter 4 of the previous financial year.

The previously reported vacancy rate in maternity is proactively managed and stands at 4.3% with planned recruitment throughout 2023, this is a near 50% reduction to the vacancy rate reported in June 2022.

Along with a developed recruitment plan, the service continues to review different approaches and recent examples of this activity is a review of where adverts for roles are placed, engagement in regional conversations on Midwifery Apprenticeships continues, engagement in widening participation activity and establishment of an International Recruitment programme which commenced in December 2022.

4.3: Sickness absence

Whilst sickness absence is a continuing challenge in the service, there are improvements being seen in the overall sickness rate which stood at 6.49% in June 2023, which is the lowest rate in the service since August 2020.

The 12-month trend for the service is shared below in Table 5. The 12-month rolling sickness rate for the service stands at 7.79% - this is a 2.9% reduction. It has previously been noted that the service last achieved the Trust target of 4.5% in September 2018 (at 4.25%) and therefore, proactive management continues with further detail provided below.

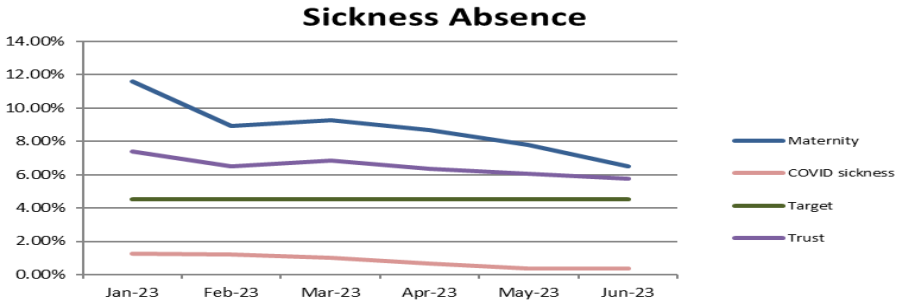


Table 5: Sickness absence

Maternity continues to see weighting towards Long Term Sickness (LTS) cases (24%/76%) which is a trend for the service and the same theme has been raised for the previous 12 months plus. We do know that LTS cases in maternity cases are not static, and movement is seen each month. Across the service, there were ten return-to works from LTS in May 2023 and seven in June 2023.

The trend of increased short-term sickness in Q3 of 2022 did not continue with proactive work taking place with respect to managing patterns of absence with data indicating that the duration 0- 2 days and 8-14 days is most prevalent in the service. Patterns of absence is identified / highlighted to the operational management team for further discussion where required, escalated actions such as a pause to NHSP shifts and / or an escalation absence review meeting with the Deputy Head of Midwifery has been instigated.

In terms of return-to-work conversations, the service is completing focussed activity to improve return to work compliance and ensuring meetings take place and are recorded in a timely manner after each occurence of absence. This is monitored on a weekly basis within the service at the operational leadership meeting chaired by the Head of Midwifery. The average time to complete return to work interviews is also under review with the service showing improved compliance at an average of 6 days which is within policy guidelines.

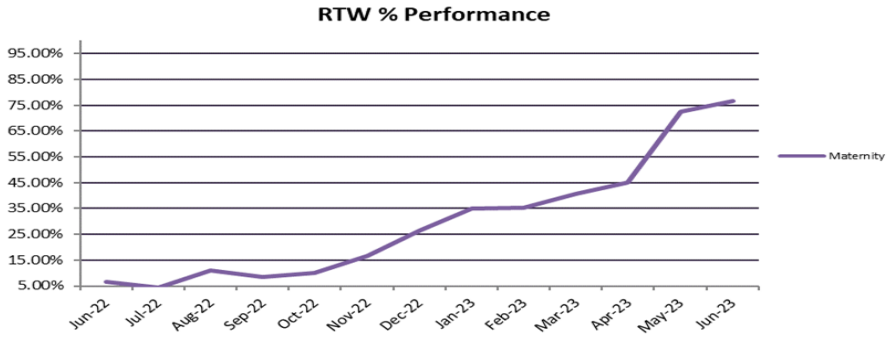


Table 6: Return to work interviews

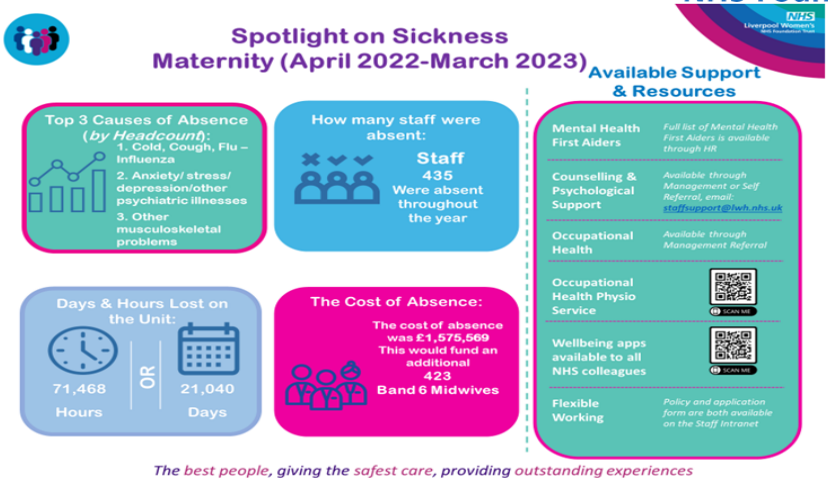
There has also been a focus on ensuring all staff have an annual Health and Wellbeing conversation. Health and Wellbeing conversations are supportive, coaching-style one to one conversations that focus on the wellbeing of our staff, they are also an integral part of the NHS wide People Plan as the overall aim is to create cultures where people feel heard, valued and in which diversity is respected.

Nationally, stress/anxiety is the highest reason for absence across the NHS accounting for 469,750wte days lost / 24.6% of all absence reported in February 2023. It is noted that this is also a high reason for absence in the service as detailed below. Therefore, the requirement for a Health & Wellbeing conversation remains a key priority.

The current compliance in the service is 27.78% and work continues. Engagement sessions are being promoted by the HWB team with specific focus to Maternity on Wednesday & Fridays.

The top reason for absence in the service is anxiety/stress, gastrointestinal issues, and other musculoskeletal problems – absence reasons as seen are comparable to both previous months and trends in absence data seen across the region from the previous 12 months. The challenges seen in the service are replicated across the Trust and region with the North-West continuing to be the region with the highest reported sickness absence across the NHS.

The service reviews sickness cases on a weekly basis and any long-term cases are managed in accordance with the current Employee Attendance and Wellbeing policy. The service engages in a service-wide attendance / LTS discussion as a management group each month so best practice can be shared along with looking at options such as redeployment as supportive measures. The recent updated infographic of spotlights on sickness have been received positively and are on display in each area to inform staff on the impacts of sickness.



At all absence meetings, be it long term or short term where patterns of concern have been identified, alternate working, reduced return to works / phased plans / temporary non-clinical working are options that are explored where it is deemed appropriate and engagement with staff-side is integral. Consideration is also given to training and requirement to become compliant should any modules have expired – to support a return to work, a request to do this prior to a return to working in a clinical area is preferred.

4.4: Turnover

Staff turnover within the first six months of 2023 was below the Trust threshold of 13% and amounts to an average of 3.33wte across the rolling 12-month period, this is an improved position to that previously reported.

The service continues to receive retire and return requests, along with general flexible working requests, these are considered on a weekly basis by the senior midwifery leadership team to ensure consistency and fairness in decision making.

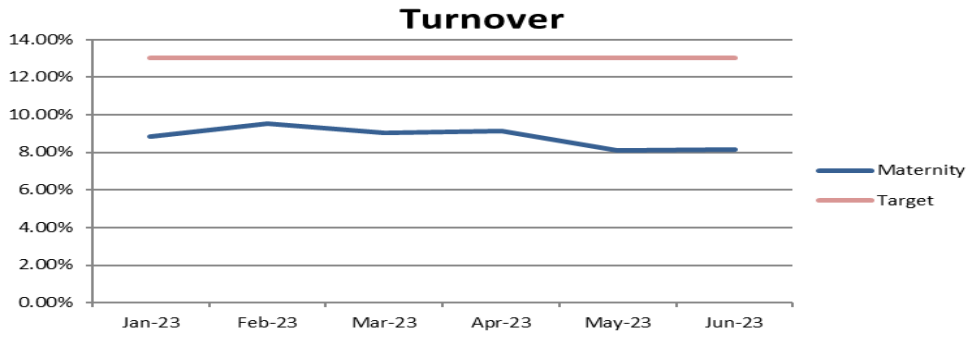


Table 7: Turnover

As previously, the service has welcomed back previous leavers in the last 12 months and welcomed B5 midwives seeking alternate employment and, in such cases, bespoke preceptor programmes have been developed / implemented – there are further established B5's due to join the Trust as included in the developed recruitment plan.

Overall, there are no concerns to raise with respect to turnover in the service and the matter of retention is linked to both the wider Maternity Transformation agenda and the recently published NHS Long Term Workforce Plan

4.5 Age Profile

Registrants: Majority registrants (midwives) employed in LWH Trust are in the 31-35 age group (12.28%), followed by 10.53% in the 26-30 age group. This reflects the work that is required to retain midwives at the Trust and the investment in the Preceptorship team, not only to provide clinical support but also pastoral care. Of notable significance is the reduction in the number of staff in the 60+ age group, however 9.43% of the midwifery workforce are in the 56-60 age group. Late career midwives require specific support in terms of sharing their years of experience whilst they wind down in preparation for retirement.

Support workers: An opposite is seen in the support worker age profile with the majority support workers employed in maternity services being in the 51-55 age group (3.73%) followed by the 36-40 age group (3.07%). The service is exploring opportunities for support workers to develop their careers along the midwifery apprenticeship routes.

Maternity	HCA	NMC
<20Years	0.00%	0.00%
21-25	1.54%	8.55%
26-30	1.10%	10.53%
31-35	1.10%	12.28%
36-40	3.07%	9.43%
41-45	1.75%	9.21%
46-50	2.19%	7.46%
51-55	3.73%	7.24%
56-60	2.41%	9.43%
61-65	3.07%	4.82%
65-70	0.22%	0.44%
>71years	0.22%	0.22%
	20.39%	**79.61%**

Table 8: Age Profile June 2023

5.0: Training and Personal Development reviews (PDR)

Maternity services have undertaken a key piece of work to improve the ongoing challenges faced with being unable to achieve training and PDR thresholds as noted in Table 9. The Division placed themselves in oversight, with weekly check and challenge by the Head of Midwifery at the Senior Midwifery Leadership Operational Group meetings. The series of actions identified and being progressed included a training data validation exercise completed in conjunction with workforce in April 2023. All training and PDR compliance data is reported monthly at Family Health Divisional Board. Notable improvement is evident since April 2023.
Table 9: Training and PDR

	22nd June 2023	30th June 2023
Mandatory	86.84%↓	87.86%↑
Clinical	76.18%↑	76.27%↑
Local	76.75%↑	76.94%↑
PDR	81.03%↑	86.97%↑

6.0 Quality of Care measurements:

6.1 Midwife to Birth Ratio

National recommendations suggest a 1:28 midwife to birth ratio, this ratio is monitored monthly through the maternity dashboard and published externally as part of our Strategic Clinical Network (SCN) dashboard. At present the maternity service is reporting a ratio of 1:21 (June 23 position, Table 10) which is reflective of midwifery turnover and current vacancy.

Midwife to Birth					
Jan 23	**Feb 23**	**March 23**	**April 23**	**May 23**	**June 23**
1:26	**1:18**	**1:25**	**1:21**	**1:21**	**1: 21**

Table 10: Midwife to birth ratio.

6.2 Supernumerary Shift Coordinator on Delivery Suite

Within LWH Labour Ward, supernumerary shift leader compliance is consistently maintained at 100% as listed (Table 11). This role is pivotal in providing oversight into all birth activity within the Labour Ward, Maternity Assessment Unit and Maternity Base Ward, and provides a helicopter view of all staffing/workforce requirements as well as birth activity. During night-time hours the Labour Ward shift co-ordinator carries the maternity bleep (104) for maternity services. The Labour Ward shift co-ordinator is rostered independently from the core midwifery staffing and this is evidenced in e-roster with a distinct marker against the shift coordinator indicating supernumerary status.

Supernumerary Shift Coordinator					
Jan 23	**Feb 23**	**March 23**	**April 23**	**May 23**	**June 23**
100%	**100%**	**100%**	**100%**	**100%**	**100%**

Table 11: Supernumerary status

6.3 1:1 Care in Labour

NICE (2021) guidance supports one to one care in established labour, as one of the indicators of effective midwifery workforce planning. LWH has consistently across intrapartum areas of Midwifery Led Unit (MLU) and Labour Ward (Consultant high risk care), achieved a compliance rate between 98.62% and 100% in this reporting period.

1:1 Care in Established Labour					
Jan 23	**Feb 23**	**March 23**	**April 23**	**May 23**	**June 23**
98.62%	**99.53%**	**99.19%**	**99.60%**	**99.78%**	**100%**

Table 12: 1:1 midwifery care in labour

MIS (Year 5), Safety Action 5 requires organisations to produce an action plan when compliance is less than 100%. As part of the review of the non-compliance to this required standard, each case where 1:1 care is not achieved has been reviewed to ensure no adverse clinical outcomes have occurred. The common themes identified for non-compliance include midwifery sickness, vacancies and the nature of maternity services which may include precipitate labour or presentation of a woman about to birth imminently.

This action plan held within maternity services (Appendix 2) is monitored at Maternity Risk and Clinical Meetings and reviewed as part of the assurance process to Family Health Divisional Board upwardly reporting to safety and effectiveness committee, as well as external reporting to the LMS.

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

6.4: Continuity of Carer (CoC)

Nationally Continuity of Carer remains within a “pause and reflect phase” as one of the considerations for individual Trusts from the Ockenden (2022) report. LWH implemented 4

CoC teams in 2021, providing care to women in areas of deprivation and to women of Black Asian Minority Ethnic origin, as per MBRRACE report (2021) recommendations.

A paper presented and approved at the Trust Quality Committee on the 27th March 2023 detailed a plan for the interim (6 month) suspension of the Midwifery Continuity of Carer (MCoC) model at Liverpool Women's NHS Foundation Trust. The paper included the rationale for the proposed model, which aims to release midwifery hours to support safe staffing levels within the inpatient areas, whilst also maintaining an element of enhanced support for the most vulnerable women who are currently allocated to the MCoC pathway. The paper provided detail on how the previous MCoC caseload would be safely transitioned to the revised model of care.

The staff within the CoC teams are commended for their dedication to the vision and aspirations of the model of care. This model has been embedded for two years at LWH and we are proud of the outcomes achieved.

Current midwifery staffing pressures, due to vacancies and sickness and more recently the uplift in the staffing of the Maternity Assessment Unit has impacted on overall numbers available for each shift in the inpatient areas. This has resulted in the continued escalation of the MCoC midwife team. It is recognised that this is unsustainable and the MCoC midwives' health and wellbeing needs to be considered.

The proposed model offers the least disruption to the women on the caseload. Most women will remain under the same named midwife, continuing to offer continuity in the antenatal and postnatal period. This proposal also offers midwives who have worked in the MCoC model, the ability to retain their skills in both the intrapartum area and community, thus addressing retention risks by suspending MCoC. Should MCoC be resumed, this model enables this to happen much easier than when MCoC was first implemented in 2021 and therefore provides the rational for the management team to recommend this proposal.

Midwifery Continuity of Carer teams were suspended across Maternity, from May 2023 for a period of six months, resulting in continued continuity of carer for women during the antenatal and postnatal periods but not during the intrapartum period.

6.5: Clinical Incidents and Midwifery Red Flags

A total of 2004 clinical incidents were reported on Ulysses during January-June 2023, this is an increase of 199 in comparison to the same period in 2022, indicating a positive reporting culture, which encourages improvement and learning. Top 5 causes are listed below:

1. Clinical management
2. Investigations
3. Admission/transfer/discharge
4. Staffing levels
5. Diagnosis

Of significance is the reduction in the number of staffing clinical incidents reported in the first 6 months of 2023 in comparison to the same period in 2022.

There were 93 red flags reported between January 2023–June 2023 which is a reduction of 170 from previous reporting period (July 2022-December 2022) where 263 red flags were reported. There remains a required element of clinical, manual validation, due to some reporting errors but a positive reduction has been demonstrated.

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	

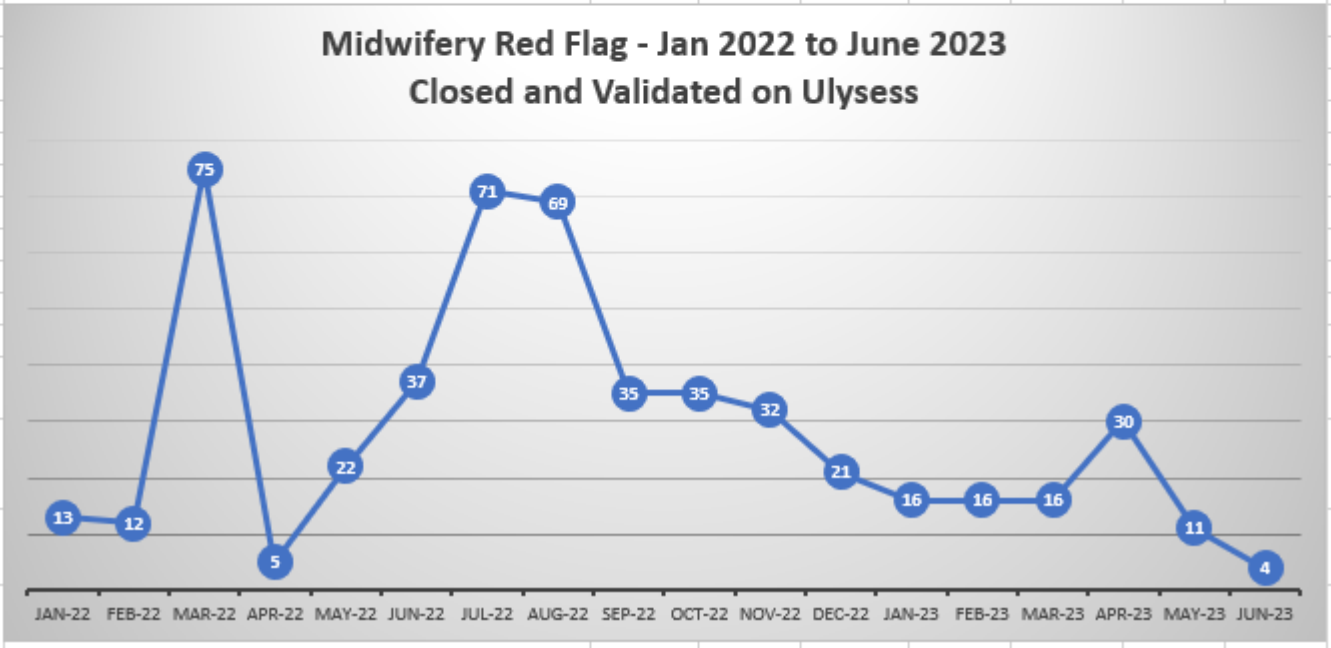


Table 13: Red flag themes

6.6: Serious Incidents (SI)

During January-June 2023, 5 Serious Incidents were reported in Maternity Services, of which 4 investigations have been completed and submitted to the ICB. 1 x SI investigation is in progress and on track to be completed before the end of September 2023. This case involves a patient suffering a Transfusion Associated Circulatory Overload (TACO) and initial investigations are unable to identify the rational for the transfusion also the transfusion process was not followed. The full review will identify any learning requirements.

The 4 SI investigations completed included x 2 ITU transfers and feed into the Future Generations Work. The other two investigations did not have any common themes, one related

to a missed dose of Anti-D, and the other an incorrect VTE assessment, involving a medication error, leading to a postnatal Pulmonary Embolus.

There are 56 outstanding actions relating to previous SI's, 18 of which are overdue. These are monitored by the maternity governance team with escalation and oversight at the monthly Maternity Risk Group.

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 Services are reviewing how they can strengthen the embedding of learning from incidents. This forms part of Ockenden essential actions 5.4 and 5.5 (Ockenden Report 2022).

The Family Health Division Senior Leadership Team recognise that timely review and completion of outstanding SI action plans needs improving. Greater oversight in Quarter 2 is planned involving oversight at Maternity Risk and Clinical meeting, reporting to Family Health Divisional Board. Simultaneously outstanding SI actions will be reported at the Trust Safety and Effectiveness meeting and to Trust Quality Committee via the Chairs report.

6.7: Birth Rate Plus Acuity App Implementation and Progress

The Birth Rate Plus Acuity App was implemented in Maternity Services in LWH in July 2022. The BR+ acuity App assesses real time staffing based on the clinical needs of women and babies for intrapartum areas. Using the BR+ classification system the App provides an assessment of women's needs during their episode of care in Labour Ward and Midwifery Led Unit, recorded in real time on a 4hourly basis. This enables service leaders to determine whether the Labour Ward and Midwifery Led Unit is adequately and safely staffed throughout the day and night.

Birth Rate plus consultancy are in the process of developing an App to assess women and babies needs during their episode of care on Maternity Base (Maternity Ward). Approval has been secured to implement the BR+ App on Maternity Base when available. Birth Rate Plus consultancy have not declared an intent to develop an App to assess real time staffing based on the clinical needs of pregnant women who present to Maternity Assessment Units (MAU).

6.8: Maternity Triage performance

Significant improvement has been achieved since the 28th January 2023 in the performance of Triage assessment, following implementation of a revised midwifery staffing model in the Maternity Assessment Unit. As illustrated in Table 14, 99.14% of women attending MAU are triaged within a period of 30 minutes from presenting to the department (28.1.2023-18.7.2023).

From the 31st May 2023 Triage assessment time was changed to 15minutes in line with the BSOTS model (Birmingham Symptom Specific Obstetric Triage System), which is consistent with all Maternity providers in Cheshire and Mersey region. A trajectory was set to achieve 75% Triage performance by the 31st July 2023, performance has superseded the trajectory with 83.39% compliance in 15minutes triage achieved by the 17th July. In addition to the above a midwife is allocated to telephone triage shifts, covering 24hs over 7 days per week, with 100% compliance since implementation of the revised model on the 28th January 2023.

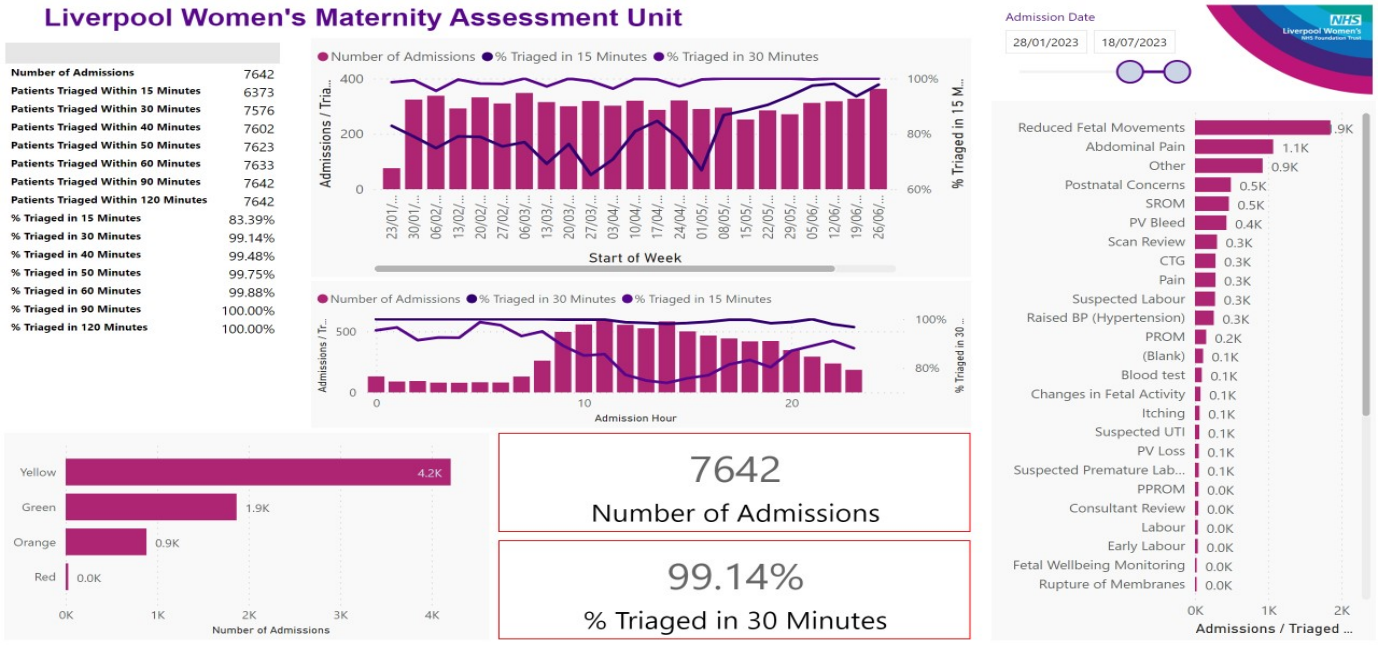


Table 14: MAU admissions and Triage assessment times

6.9: Staff Experience

During the six-month period January-June 2023, three members of staff have been subject to non-physical assaults/verbal assaults from patients and visitors. There were no reports of physical harm caused to staff.

Staff break audits are completed on a bi-annual basis, with positive results from the last audit, demonstrating that staff are increasingly being able to take their breaks, which is an improvement from the July-December 2022 audit results.

The Preceptorship Lead Midwives continue to positively contribute to supporting the retention of midwives via a robust programme of clinical induction and pastoral care for all new midwife recruits to Liverpool Women's Hospital. They are currently preparing for the next intake of midwives (43.44wte) who are expected to commence in post between August-October 2023. The Maternity Preceptorship Team have entered a submission for the NHS Pastoral Care Quality Award for their work supporting international midwives who have joined the Trust. Launched in March 2022, the NHS Pastoral Care Quality Award scheme is helping to standardise the quality and delivery of pastoral care for internationally educated nurses and midwives across England to ensure they receive high-quality pastoral support. It's also an opportunity for trusts to recognise their work in international recruitment and demonstrate their commitment to staff wellbeing both to potential and existing employees.

Actions included in Maternity Staffing paper July-December 2022 that were completed January-June 2023:

- Multi-professional review of maternity care pathways.
- Progression of the MAU, IOL and Maternity Base improvement groups utilising QI methodology (ongoing).
- Expansion of midwifery development roles to include, supernumerary shift co-ordinator role in the Maternity Assessment Unit, Midwifery Led Unit Clinical Lead Midwife role, Fetal Medicine Unit Clinical Lead Midwife role and Induction of Labour Co-ordinator (temporary post 9 months).
- To achieve compliance with NICE guidance introduction of a Diabetic Specialist Midwife role (post currently advertised).
- During times of increased acuity and reduced midwifery staffing numbers a contingency plan has been developed to support times of staff shortages in line with business continuity that releases supporting roles in the division onto the clinical floor.

In addition to the above developments a review of the midwifery leadership structure has been completed, resulting in the implementation of the below listed workforce roles and professional development opportunities, all of which have been delivered within the first 6 months of 2023.

- Appointment of a substantive Consultant Midwife role (internal appointment) with a focus on intrapartum care.
- 4 x Advanced Clinical Practitioners (midwives) successfully completed their training in May 2023 and are now supporting the medical staffing workforce in the MAU, ensuring that women receive treatment as per the BSOTS model.
- Recruitment to a full midwifery operational leadership team, including an interim Matron role providing pace and focus to secure improvements in the Maternity Assessment Unit (MAU).
- Revised Governance workforce structure and appointment of a Lead Governance Manager for the Family Health Division.
- Allocation of a non-clinical midwifery and support staff roster co-ordinator, which releases the clinical midwifery leadership team from administrative duties.
- Education programme for the Maternity Support Workers in line with the HEE Framework and care certificate programme.

- Allocation of a mentor for all new recruits at band 7 and above.

7.0: Actions identified for the next 6 months:

Focus and pace will continue over the next 6 months in line with Theme 2 of the Three-Year Delivery Plan for Maternity and Neonatal Services- Growing, retaining, and supporting our workforce. Some of the workforce development in the pipeline are:

- Recruitment of a Maternal Medicine Specialist midwife.
- Further investment and expansion of the ACP role.
- Alignment with University education providers to ensure that the future midwifery workforce is aligned with local population need.
- Tailoring interventions to midwifery career stages and local requirements, through professional development and shadowing opportunities, one example being secondment of a band 6 midwife to the Governance team on a 12-month basis.
- Implementation of Tobacco Dependency Advisor posts (Band 4) which will support women who smoke at the time of booking to quit smoking during pregnancy.
- Explore opportunities for support workers to do their midwifery training through apprenticeship programmes.
- All future midwifery leadership vacancies will be subject to positive recruitment from all ethnic groups.

8.0: Conclusion

It is recommended that the Trust Board receive and note the information provided in this paper and take assurance for how safe staffing is managed, recruited, and retained to keep women and babies safe within Maternity services.

Appendices

Appendix 1- Birth Rate Plus refresh audit report May 2023


Liverpool Women's Hospital NHSFT Birtl

Appendix 2- Action plan 1:1 midwifery care in labour


One%20to%20one%20care%20in%20la

birthrateplus® | Safe Staffing for Maternity Services

LIVERPOOL WOMEN'S HOSPITAL NHS FOUNDATION TRUST

MIDWIFERY WORKFORCE REPORT

May 2023

Discussion of Annual Data

1. This is a summary report of Liverpool Women's Hospital NHS Foundation Trust results presented to the Head of Midwifery on 19th May 2023.

2. 23% uplift for annual, sick and study leave has been included in the staffing calculations, as requested by the Head of Midwifery. 12.5% travel allowance is included.

3. As a review was carried out in 2021, the decision was made to undertake a modified version of the full assessment. The intrapartum casemix has the major impact on the midwifery establishment but as this was unlikely to have changed significantly, the same casemix was applied to the annual births for 2022/23.

4. Table 1 shows the casemix from July - September 2020 (Appendix 1 for description of casemix).

	% Cat I	% Cat II	% Cat III	% Cat IV	% Cat V
2020 DS % Casemix	2.2%	8.4%	19.6%	34.5%	35.3%
	30.2%			69.8%	
(Includes births on the Birth Centre)	*40.0%*			*60.0%*	

Table 1

5. Annual Activity is based on the FY 2022/23 and total births of 7386 as below:

	Annual Total
Delivery Suite Births	6466
Birth Centre	705
Home/BBAs	215
TOTAL BIRTHS	**7386**

Table 2

6. Table 3 shows the additional intrapartum activity in Delivery Suite.

	Annual Total
Medical Inductions of labour	2834
Antenatal cases	215
P/N readmissions	114
Non-viable pregnancies	64
Escorted transfers to other units	87

Table 3

7. Table 4 shows the activity in the Birth Centre.

	Annual Total
Births	705
Transfers to DS	719
Transfers to Mat Base 2	337
Triage cases	560

Table 4

8. Table 5 shows the annual activity on the Maternity Base 2.

	Annual Total
Antenatal admissions	675
Postnatal women	6834
P/N readmissions	114
NIPE	*Weekly hours*
Extra care babies	700

Table 5

9. Table 6 provides a summary of the community population receiving maternity care from Liverpool Women's Hospital NHSFT.

Imports AN & PN care Antenatal care only Postnatal care only	935 318 24
Community Exports (Out of Area women birthing in LWH)	1131
Home Births	215
Community Cases (AN &/or PN care)	7317
Total Postnatal women	7532
Attrition Cases	800
Total Bookings (less 24 postnatal imports)	8308

Table 6

10. The community annual total includes 1277 women who birth in neighbouring units and receive ante and/or postnatal care from Liverpool Hospital's community midwives (community imports). The birth episodes are provided by neighbouring units.

11. Exported cases of 1131 are those women who birth in Liverpool Women's Hospital namely 'out of area' cases and receive their community care from their home Trust (community exports).

12. Currently some women are booked and receive antenatal care in hospital clinics by community midwives rather than in the community setting, but for the workforce report, this activity is included in the community establishment rather than in the hospital staffing.

13. The Birthrate Plus staffing is based on the activity and methodology rather than on where women may be seen and/or which midwives provide the care.

14. The total clinical wte will contain the contribution from Band 3 MSWs in hospital and community postnatal services. Most maternity units work with a minimum of 90/10% skill mix split of the clinical total wte, although this is a local decision by the Senior Midwifery Team.

15. In addition to the midwifery staffing, there is a need to have support staff usually at Bands 2 and 3 working on delivery suite, maternity wards and in outpatient clinics. These roles are essential to the service but are not included in the midwifery ratio. To calculate the requirement for these support staff, professional judgement of the numbers per shift is used rather than a clinical dependency method.

Birthrate Plus® Baseline Staffing inclusive of 23% Uplift

A detailed summary is included on page 8.

Clinical WTE required	
Delivery Suite	91.75wte RMs
Midwifery Led Unit	16.06wte RMs
Maternity Assessment Unit	25.60wte RMs
Maternity Base 2	76.06wte *Includes B3 MSWs*
Outpatients Services Crown Street Day Unit	16.80wte RMs 4.92wte RMs
Aintree Obstetric Clinics and Day Unit	2.98wte RMs
Community Services:	84.3wte *Includes B3 MSWs*
Total Clinical WTE	**318.50wte RMs and PN MSWs**

Table 7

Clinical Specialist Midwives

16. The % of clinical time provided by specialist midwives included in the workforce calculations is a local decision although there is a commonly applied rationale within the methodology and generally accepted by Heads of Midwifery.

Non-Clinical Midwifery Roles

17. The total clinical establishment based on the current activity, as produced from Birthrate Plus® is 318.50wte and this excludes the non-clinical midwifery roles needed to provide maternity services, as summarised below.
    - Director of Midwifery, Heads of Midwifery, & Matrons/managers with additional hours for team leaders to participate in strategic planning & wider Trust business
    - Consultant Midwives
    - Mbrace midwife
    - HDU Education Lead/Education team
    - Fetal Surveillance midwife
    - Perinatal Mental Health
    - Breast feeding Co-ordinator
    - Antenatal & Newborn Screening Co-ordinator
    - PMA role
    - Bereavement midwife

    Applying 11% i.e.,35.03 wte to the Birthrate Plus clinical wte will provide additional staff as listed above.

    Note: To apply a % to the clinical total ensures there is no duplication of midwifery roles. The % can be set locally, although the RCM Staffing Guidance support 9 - 11% and Birthrate Plus is NICE endorsed hence being generally applied in maternity services.

Summary of Results

18. The calculated total workforce requirement for Liverpool Women's Hospital NHS Foundation Trust with 23% uplift to provide total clinical, specialist and management is 353.53wte. This can be compared with the current funded establishment.

19. The overall ratio for all births is 23.2 births to 1 wte midwife. If using this to calculate staffing for total births, a skill mix can be applied to the total establishment as some of the clinical staff will be maternity support worker in postnatal services.

birthrateplus® | Safe Staffing for Maternity Services

SUMMARY of DATA & REQUIRED WTE for

LIVERPOOL WOMEN'S HOSPITAL

Final version 19/05/2023

Annual Period 2022/23

23.0%

Total births in service **7386**

Casemix July to Sept 2020	Cat I	Cat II	Cat III	Cat IV	Cat V
DS %Casemix	2.2	8.4	19.6	34.5	35.3
Generic %Casemix	*9.1*	*12.0*	*18.9*	*29.7*	*30.3*

	Annual Nos.	Required WTE	
Delivery Suite			
Births	6466	81.16	**81.16**
Other DS Activity			
Antentatal cases	*215*	2.34	**10.58**
Inductions	*2834*	5.14	
Postnatal readmissions	*114*	1.98	
Escorted Transfers OUT	*87*	0.33	
Non-viables	*64*	0.79	
MAU	*0*	20.09	**20.09**
		5.51	**5.51**
Alongside Midwife Unit			
Births *(transfer home)*	*337*	5.13	**16.06**
Births *(transfer to ward)*	*368*	4.37	
Triage Cases	*790*	0.53	
Transfers to D/S	*719*	6.03	
Mat Base 2			
Antenatal Care			
Antenatal admissions	*675*	4.53	**4.53**
Postnatal Care			
Postnatal women	*6834*	63.62	**71.53**
Postnatal Re-admissions	*114*	0.61	
Extra Care Babies	*700*	4.66	
NIPEs		2.64	
OUTPATIENT SERVICES			
Antenatal Clinics			
LWH Specialist Midwife Clinics		4.60	**17.16**
LWH Consultant Clinics		1.23	
Fetal Maternal Medicine Clinics		5.46	
Maternal Medicine Service		5.51	
Aintree Obstetric Clinics		0.36	
Maternity Day Unit			
Crown Street ODU		4.92	**4.92**
Aintree Day Unit		2.62	**2.62**
COMMUNITY SERVICES			
Home Births	*215*	6.22	**84.32**
Community Cases (full AN & PN Care)	*6975*	70.03	
Community Cases (A/N care only)	*318*	1.79	
Community Cases (P/N Care ONLY)	*24*	0.11	
Community Bookings ONLY	*800*	1.07	
NIPEs		1.72	
Additional Safeguarding	*720*	3.40	
		318.50	

CLINICAL MIDWIFERY WTE REQUIRED **318.50**

Additional Specialist and Management wte **35.03**

Appendix 1

Method for Classifying Birthrate Plus® Categories by Scoring Clinical Factors in the Process and Outcome of Labour and Delivery

There are five [5] categories for mothers who have given birth during their time in the delivery suite [Categories I – V)

CATEGORY I **Score = 6**

This is the most normal and healthy outcome possible. A woman is defined as Category I [*lowest level of dependency*] if:
The woman's pregnancy is of 37 weeks' gestation or more, she is in labour for 8 hours or less; she achieves a normal delivery with an intact perineum; her baby has an Apgar score of 8+; and weighs more than 2.5kg; and she does not require or receive any further treatment and/or monitoring

CATEGORY II **Score = 7 – 9**

This is also a normal outcome, very similar to Category I, but usually with the perineal tear [score 2], or a length of labour of more than 8 hours [score 2]. IV Infusion [score 2] may also fall into this category if no other intervention. However, if more than one of these events happens, then the mother and baby outcome would be in Category III.

CATEGORY III **Score = 10 – 13**

Moderate risk/need such as Induction of Labour with syntocinon, instrumental deliveries will fall into this category, as may continuous fetal monitoring. Women having an instrumental delivery with an epidural, and/or syntocinon may become a Category IV.

CATEGORY IV **Score = 14 –18**

More complicated cases affecting mother and/or baby will be in this category, such as elective caesarean section; pre-term births; low Apgar and birth weight. Women having epidural for pain relief and a normal delivery will also be Category IV, as will those having a straightforward instrumental delivery.

CATEGORY V **Score = 19 *or more***

This score is reached when the mother and/or baby require a very high degree of support or intervention, such as, emergency section, associated medical problem such as diabetes, stillbirth, or multiple pregnancy, as well as unexpected intensive care needs post-delivery. Some women who require emergency anaesthetic for retained placenta or suture of third degree tear may be in this category.

Maternity Services
Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard? **All women in active labour receive 1-1 care from a Midwife.**

NICE guidance supports one to one care in established labour, as one of the indicators of effective midwifery workforce planning

The following action plan details how LWH Maternity services intend to achieve 100% compliance with 1-1 care in active labour with specific timescales for completion of the actions.

Monitoring of Reports to Maternity Risk Meeting.
Governance Committee for Oversight: Family Health Divisional Board.
Upwardly reporting to: Safety and Effectiveness Sub-group and onward to Trust Quality Committee and Trust Board.

Safety Action 5: CNST: All women in Active labour receive 1-1 care by a midwife.

Objective	Action	Lead	RAG	Timescale	Progress Update
To ensure there is a robust process in place to review midwifery staffing establishments to ensure the provision of 1-1 care in labour.	Review of Midwifery establishments including sickness and maternity leave and vacancy to ensure correct number of midwives in post and timely recruitment to vacant posts.	HOM Deputy HOM		Complete	Birth rate Plus refresh audit completed April 2023 and report received May 2023.
				Complete	Rolling recruitment plan in place for Band 5 and Band 6 Midwives when vacancies arise. 100% midwifery staffing anticipated by October 2023
				Continuing	In line with gaps in midwifery rotas we are reviewing our core midwifery care offer and ensuring that all available midwives are providing direct midwifery care, and all non-direct care midwives are readily available.

Objective	Action	Lead	RAG	Timescale	Progress Update
				Complete	Use of Bank (through NHSP) subject to weekly monitoring Non-clinical rota coordinator appointed
Maternity is required to reduce its sickness rate to align with the Trust target. To ensure all staff are appropriately managed in line with the Trust Sickness and Absence Policy.	All line managers are required to adhere to the Trust Attendance Policy	Head of Midwifery/ HR Business Partner		Complete	Sickness absence rate 7.52 % above Trust target of 4.5%. Regular sickness meetings held between line managers and employees including HR Business Partners.
	Ongoing management of sickness by Maternity Management team	Maternity Matrons		Ongoing	Monthly monitoring of return-to-work reports and HR meetings
		Deputy HOM HR Business partner		Ongoing	Monthly Matron Meeting with HRBP to assess sickness and RTWs
To ensure evidence of 1:1 care is provided through structured reporting mechanisms.	K2 Athena data report capture of non-compliance of 1:1 care	Head of Informatics.		Complete	Discussion held with RS – action agreed and daily report available. Monitored by Digital Midwife
	K2 Athena report of non-compliance of 1:1 care validation of report by	Intrapartum Matron DS Manager		Complete	Data validation cross referenced with MRF reports. Quarterly report

Objective	Action	Lead	RAG	Timescale	Progress Update
	Intrapartum Matron. Exception report to Maternity Clinical Risk meeting.	MLU Manager			Intrapartum Care Audit Q 4 2022-23.d
	Exception report identified themes surrounding delays in transfer from IOL suite. QI group implemented to improve patient flow across maternity and increase intrapartum bed capacity	Intrapartum Matron Delivery Suite obstetric lead		Ongoing	Recruitment agreed for IOL Coordinator B7 role 6-month fixed term/secondment Capital funding agreed for required estates upgrade
	Staff training to be completed after update of K2 Athena, to ensure all 1:1 care in labour statuses are reported accurately.	K2 Digital Lead Midwife		Completed	All staff trained
To ensure a structured process of reporting and reviewing Midwifery Red Flags within the Maternity Division.	Ensure Trust incident reporting system has ability to report all midwifery red flags.	Governance Team		Completed.	Revised Ulysses reporting aligns with NICE MRF including 1:1 care plus one locally agreed March 2023
	Ensure clinical staff are aware of the process of reporting Midwifery Red Flags, including lack of 1:1 care in active labour, on the Trust reporting system.	Quality & Safety Matron.		Completed.	Lesson of the week has been disseminated across Maternity Division. MRF guidance is displayed in all clinical areas
	Midwifery red flag report sighted at Maternity Clinical Risk Meeting.	Governance Manager for Maternity		Complete	Monthly MRF are reported at Mat Risk Clinical meeting
	Ensure 1:1 care in labour data is part of the updated divisional performance report which will be reviewed and clinically signed off at FHD Board.	Divisional Manager		Complete	1:1 data is a Trust KPI which are discussed at the monthly Divisional Performance Review meetings which are attended by the Trust Executives and also at Trust Quality Committee.

Objective	Action	Lead	RAG	Timescale	Progress Update
Band 7 shift leaders must complete BR plus acuity tool on every shift at appropriate time intervals	Ensure all B7 shift leaders have received training in BR plus acuity tool	Intrapartum Manager /Matron		Completed	Birthrate Plus regional reporting tool implemented. All shift leader reporting data as per standard required

Trust Board

COVER SHEET

Agenda Item (Ref)	***23/24/162***	**Date: 12/10/2023**
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 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*	Comment:

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

REPORT DEVELOPMENT:

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

EXECUTIVE SUMMARY

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 e-mail, closed social media groups and clinical departmental meetings.

MAIN REPORT

Perinatal Quality Surveillance Highlight Report September 2023 (August 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 (August 2023)

Areas of concern

Very Concerning – Investigate & Take Action.		
Metric	**Position**	**Narrative**
Flu vaccinations offered to pregnant women	41.95% (target >=90%)	The flu vaccine is available between September and February every year, and it is recommended that pregnant women get it as early as possible during the season. There is strong evidence that pregnant women have a much higher risk of serious illness because of flu, compared with the general population. The risks are higher during the last trimester of pregnancy. Vaccination against flu reduced the risk of complications caused by the virus. There is strong evidence that catching flu in pregnancy can affect the unborn baby. Babies born to women who have had flu are up to four times more likely to be born pre-term and to have a low birth weight. This may be because flu infection produces an inflammatory response in the body which can trigger pre-term labour. Flu in pregnancy can lead to stillbirth or death in the first week of life. All community midwives and MSW's have been given up to date flu vaccination information to give to pregnant who are on their caseloads. At every antenatal contact community midwife, MSW's and hospital midwives are required to ask pregnant women if they have received the flu vaccine and to document this in the electronic patient record. Community midwives and MSW's will advise pregnant women where they can go to be vaccinated. Drop-in vaccination clinics for pregnant women will be available in the Antenatal Clinic at Crown Street and at Aintree. Reception staff will ask pregnant women when they arrive for their ANC appointment if they are willing to have a flu vaccine whilst waiting to be seen in clinic. ACP's are being trained to vaccinate with the aim of offering the flu vaccine to pregnant women who attend the Maternity Assessment Unit.
LocSIPs compliance within Theatres – Maternity	35.30% (target >=100%)	LocSIPs should be completed in 100% of cases and this data is captured through input into Digicare and reflected in Power BI. There is current poor compliance with Category 1 CS deliveries and overall, it has not been possible to achieve 100%. On review of the other categories of delivery, with category 1 excluded there is still a lack of compliance. The introduction of Digicare has yet to show a sustained improvement, this may be reflective of data issues. It has been requested that a paper reflecting the challenges to achieving 100% and associated action plan is submitted to the LocSIPs committee. There has been a gradual improvement in intrapartum LocSIPs but this appears to now have plateaued. It is felt that without improvements in the training and updates to K2 there will be no further improvement. There are planned changes within K2 to support staff when completing documentation for vaginal deliveries and perineal repair. The swab counts must be completed at every delivery and the intrapartum team are improving the white boards in the rooms to support staff in completion of LocSIPs.

<table>
<tr>
<td></td>
<td></td>
<td>
<table>
<tr><td rowspan="2">Intrapartum LocSIPS (Excluding theatre cases)</td><td colspan="4">Month 2023</td></tr>
<tr><td>Sept</td><td>Aug</td><td>July</td><td>June</td></tr>
<tr><td>Forceps delivery</td><td>84%</td><td>79%</td><td>84%</td><td>77%</td></tr>
<tr><td>Ventouse delivery</td><td>70%</td><td>85%</td><td>65%</td><td>75%</td></tr>
<tr><td>Vaginal delivery</td><td>55%</td><td>48%</td><td>49%</td><td>53%</td></tr>
<tr><td>Perineal repair</td><td>57%</td><td>59%</td><td>62%</td><td>70%</td></tr>
</table>
Current actions ongoing in maternity LocSIPs
Theatre/intrapartum team to meet to discuss the compliance for theatre case LocSIPs. Areas or improvement to be identified and action plan.
Identify if there are certain theatre cases that are impacting on the LocSIPs for theatre. Further discussion required in relation to the Cat 1 board.
Understand the impact of Digicare on Maternity theatre LocSIPs.
FMU to review the draft LocSIPs data on Power Bi and ensure it achieves its objectives.
K2 updates planned for October 10th, 2023.
Actions completed
FMU to provide a quarterly report to the LocSIPs committee for procedures that are not captured via Power BI.
New white boards to be used in delivery rooms that are set out with area for swab count.
</td>
</tr>
<tr>
<td>Outpatients – Subsequent appointment cancelled by Hospital - Maternity</td>
<td>18.11% (target <=10%)</td>
<td>The deteriorating performance can be attributed to the ongoing outcome issues which has led to a high number of appointments having to be rearranged. Significant and demonstratable work has taken place Divisionally to resolve this issue and it is anticipated an improved performance will be seen against this metric from September 2023 onwards. The issue was further compounded by Digicare “Go Live” which had an unintended consequence of clinics being cancelled that had been opened in error during the migration period.</td>
</tr>
<tr>
<td colspan="3">Concerning – Investigate and understand</td>
</tr>
<tr>
<td>Antenatal steroids</td>
<td>61.1% (target >=60%)</td>
<td>NICE guidance recommends that antenatal corticosteroids treatment consisting of two injections of betamethasone given 24hs apart to improve the lung maturity in preterm deliveries if clinical indications are consistent with imminent delivery within 7 days. This metric changed in June 2022 to only include those babies whose mothers had received steroids within an optimal seven-day window prior to birth, in line with Saving Babies Lives and hence there appears to be a decline in performance but is in fact a different metric that needs separate metrics and targets. This is being discussed with the informatics team.</td>
</tr>
<tr>
<td>Delayed inductions of</td>
<td>1539.04</td>
<td>Current rates of IOL are approximately 1 in 10 pregnancies globally, and 1 in 4 in high income countries. Rates of IOL have risen steadily over the</td>
</tr>
</table>

labour (Avg time)		last 15 years, with UK induction rates rising from 20.4% in 2007-8 (REF) to 33% in 2022 (NHS Digital, 2022). Whilst this may be attributed to an increase in complex pregnancies over this period (National Maternity Review, 2015) there are also increasing rates of women opting to undergo elective IOL for non-medically indicated reasons, often termed "social inductions". Rates of IOL in LWH and in the Cheshire and Mersey region mirror the national increase which creates challenges for maternity services. IOL delays are reported through a daily SITREP to the LMNS, and monthly regional data is shared with staff and the executive team at the Trust Quality Committee. At LWH we are responding to the increase through workforce planning and re-configuration of estates in the maternity unit. The Senior Leadership team recognise the issues with ongoing delays in IOL and a Task and Finish group has been convened along with an Estate reconfiguration being developed and approved by Executive Team, and work started on the 23/9/23 to create 5 additional IOL beds. Incidents of delays to commencement and ongoing IOL are reported as midwifery red flags indicators within midwifery staffing reports and on review of the data there have been less delays in IOL during the first six months of 2023, in comparison to the same period during 2022. We have invested in our workforce and from the 8th October 2023, will have a midwifery workforce in line with the recommendations of Birth Rate plus audit (May 2023). In addition, we have invested in an IOL midwifery coordinator role who is integral to the developments and plans agreed at the Task and Finish group.
Maternity services – percentage of Black, Asian or Mixed women at 29 weeks on CoC Pathway	32.79%	The midwifery CoC teams have been very successful in achieving the evidence-based objectives set out in the Better Births Report and the Cochrane Systematic review. Four teams were implemented in LWH in the highest areas of Black, Asian, and Mixed ethnicity populations. Owing to midwifery staffing pressures, due to vacancies and sickness and following the uplift in the staffing of the Maternity Assessment Unit, this resulted in the continued escalation of the MCoC midwife team. It was recognised that this was unsustainable therefore a revised model of community midwifery care offering the least disruption to women on the caseload was proposed and accepted as a temporary solution by the Quality Committee in March 2023. The revised model of care was implemented in May 2023 for a period of six months. Most women remain under the same named midwife, continuing to offer continuity in the antenatal and postnatal period. Should MCoC be resumed, this model enables this to happen much easier than when MCoC was first implemented in 2021. The NES (Non-English Speaking) and Enhanced Community midwifery teams provide personalized antenatal and postnatal care to some Black, Asian or Mixed-race women who book for pregnancy care at LWH.
Midwife to Birth ratio	23	The midwife to birth ratio recommended by Safer Childbirth based on the expected national birth rate is, 28 births to one WTE midwife for hospital births and 35:1 for home births. Midwife to birth ratio at LWH in August 2023 was 1:23 which is excellent. A request has been submitted to the informatics team to move this KPI to the excellent section in place of the current concerning section.
Newborn Hearing screening	97.31% (target 98%)	The Newborn hearing screening test helps identify babies who have permanent hearing loss as early as possible. The newborn hearing test is

coverage (NH1) – reporting 1Qtr behind		highly recommended but it's not compulsory. The following actions have been implemented with the aim of reaching the KPI. A higher frequency of available clinics and times has been implemented offering a more family friendly approach, also side working in collaboration with community clinics. Text message reminder service has been introduced to the NHSP and all national letters have been added to the S4H. QR Code stickers are being added to the front of the Child Health red books, enabling parental responsibilities to review all screening programmes on the government website, through their phone. All screeners up to date with E learning NHSP Modules. One single answer phone message, regardless which phone number has a message left on it, this mitigates the possibility of the answer phone message not being listened to.

Areas of improvement

Sickness Absence

Neonates are reported under the sickness absence target at 3.70% which is the lowest reported rate since May 2020 and is a very positive improvement. This also correlates with ongoing improved training metrics.

The four-month positive trend in Maternity ceased in August following an increase in sickness absence to 7.94% (1.5% increase). This increase is attributed to short term absence in month with the service most prevalent occurrences (bar 28 days+) taking place between 0-1 and 1-2 days which equates to 18 and 14 occurrences respectively.

Core Mandatory, Clinical Mandatory and Specialty Specific Training Compliance

As of 7 September 2023, the Division was at 87.33% compliance overall. Paediatric Basic Life Support (Neonates) is at 26.67% - whilst staff are being supported to complete this training it is a marked increase from the 13% compliance as reported in July. Perinatal Mental Health (Maternity, 3 years) is at 45.5% and Fit Mask (2 Years) is at 45.45%. Aseptic Non-Touch Technique is at 73.67% and Collecting Bloods/Blood Components for transfusion is at 74.73%. All managers have access to this live data, via Power BI. Validation meetings are planned throughout October 2023.

Divisional compliance rates are listed below:

91.94% in Core Mandatory (increase) this equates to 89.24% in Maternity (0.89% increase) and 97.12% in Neonates (0.91% increase, continued compliance maintained for eight consecutive months)

90.99% in PDR (static) which equates to 88.30% Maternity (1.72% decrease) and 96.63% in Neonates (3.77% increase and 27% cumulatively across four months).

85.40% in Clinical Mandatory (increase) with Maternity at 82.69% (2.8% increase) and Neonates at 92.02% (1.45% increase).

85.15% in Specialty specific/local training (increase) this equates to 82.11% in Maternity (1.36% increase and 7% cumulatively across three months) and 91.98% In Neonates (1.91% increase).

Training remains a risk for the Division, and it is noted on the corporate risk register however, positive improvements are acknowledged. Increases can be seen across the modules detailed above apart from PDRs in Maternity. The decrease in PDR compliance in Maternity is predominantly owing to the commencement of new midwifery recruits, however this is monitored weekly at the Senior Midwifery Leadership group meeting. There is a weekly education newsletter which provides detailed updates on progress and this information has been received positively.

Mandatory, Clinical and Service Specific Training continues an upward trajectory for all components; however, the service acknowledges that this remains below compliance currently. In relation to the CNST elements, for each of the training day requirements all staff groups have a trajectory to be >90% attendance as defined by the scheme end date on the 30th November, however the ongoing uncertainty around industrial action remains a risk in terms of the release of faculty and candidates in attending the course. This has ongoing divisional oversight and scrutiny ensuring that we can react to any potential issues promptly.

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 Led by the Chief Nurse with monthly compliance/assurance meetings planned with all safety action leads. This is managed through the Maternity Transformation Board as a sub-group to workstream 3 and reported via the Maternity Transformation Board, Quality Committee and upwards to Trust Board.

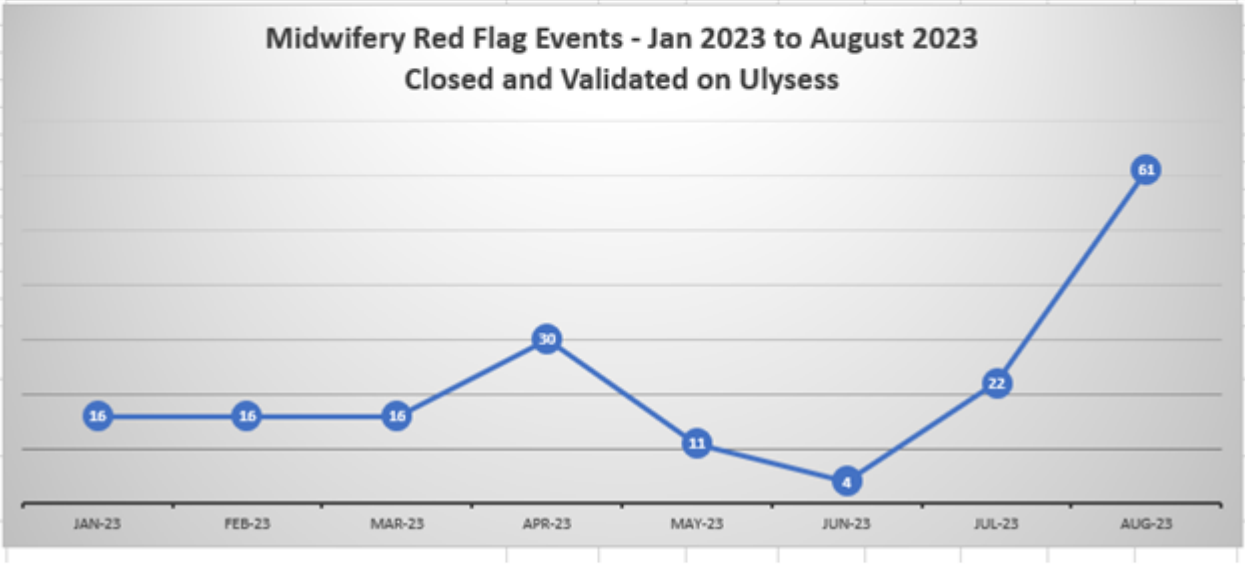
In relation to Maternity Incentive Scheme SA8 elements, for each of the requirements all staff groups have a trajectory to be >90% attendance as defined by the scheme end date on the 30th November. However, the ongoing uncertainty around industrial action remains a risk in terms of the release of faculty and candidates in attending the course. This has ongoing divisional oversight and scrutiny ensuring that we can react to any potential issues promptly.

CNST SA8	Staff Group	31 Jul 23	31 Aug 23	30 Sep 23	31 Oct 23	30 Nov 23	
SA 8b. MPMET	Midwives	79%	87%	89%			NQM, B6, B7, B8.
	Maternity HCA	75%	79%	77%			
	Cons Obstetrician	53%	59%	71%			
	Trainee Obstetrician	x	58%	61%			New rotation in Aug
	Cons Anaesthetists	28%	27%	47%			
	Trainee Anaesthetists	x	36%	40%			New rotation in Aug and Nov November
SA 8c. Fetal Surveillance	Midwives	77%	83%	87%			NQM, B6, B7, B8.
	Cons Obstetrician	62%	59%	71%			
	Trainee Obstetrician	x	29%	64%			New rotation in Aug
SA 8d. NLS	Midwives	81%	88%	89%			
	Cons Neonatologist	100%	100%	100%			
	Trainee Neonatologist	100%	100%	100%			New rotation Mar & Sept
	ANNPs	93%	93%	100%			
	Neonatal Nurses	95%	98%	96%			

Midwifery Red Flags

All staff are encouraged to report midwifery red flags using the Ulysses System and maternity managers strive to investigate incidents in a timely fashion. All reported incidents are reviewed and monitored on a four hourly basis. Staff are supported to report all incidents and are provided with feedback. The number of red flag incidents relating to delays in induction of labour has significantly increased in the past month and coincides with significant increases in acuity. All incidents will continue to be monitored and all trends and themes will be shared with staff.

Midwifery Red Flag Event - Validated	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
1:1: Care in Labour Not Supported	5	2	2	2	1	0	0	5
>30 min Delay in Presentation to Triage	6	2	5	12	1	2	1	5
>2 hour delay in admission to IOL	5	2	0	0	0	0	2	12
>4 hour delay in ongoing IOL (LWH MRF)	0	10	6	14	9	1	18	36
Delay in time critical activity	0	0	1	0	0	0	0	3
Delay in pain relief >30 mins	0	0	1	0	0	1	1	0
Missed medication during hospital admission	0	0	0	0	0	0	0	0
Delayed recognition of and action on abnormal vital s	0	0	0	0	0	0	0	0
Full clinical examination - presenting in labour	0	0	0	0	0	0	0	0
Missed or Delay Care (Suturing)	0	0	1	2	0	0	0	0
Total	16	16	16	30	11	4	22	61



Family Health Safety Reporting

Over the past six months, there was an average of 353 incidents reported per month. August had a higher-than-average number of incidents with 466 reported, 174 of which were investigations. All incidents are overseen as per Trust process with issues being escalated for MDT review at the weekly Trust Safety Meeting.

At the time of writing this report, the web holding file stands at 269. The target for the Division is 30. The number within the WHF can fluctuate and despite over 400 incidents being reviewed and closed during August, the target remains difficult to achieve. A review of the numbers of incidents reported per month and a proposal to increase the target was discussed and accepted at the Safety and Effectiveness meeting on 11 August 2023.

Perinatal Mortality – Intrauterine Deaths >24weeks.

During August 2023, there were 2 still birth cases. Both cases were reviewed, and a full MDT will be undertaken on 8 November at the Perinatal Mortality and Morbidity Meeting (PMRT). This is to allow time for the postmortem / placental histology results to be available. Both cases have been reported to MBRRACE and 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 August 2023. This was rejected by HSIB as the MRI was normal and it was deemed the baby did not have HIE. All current cases are on track for completion within the timeframes set out by HSIB.

Serious Incident Reporting

There was one clinical incident that met the SI criteria in August and was reported via StEIS. This was regarding an intrauterine death at 31 +4 weeks which is currently being investigated and is on track for completion by the ICB's deadline.

The Patient Safety Incident Response Framework (PSIRF) replaced the Serious Incident Framework within our Trust in September 2023. PSIRF supports organisations to respond to incidents in a way that maximises learning and improvement rather than basing responses on those incidents that appear to meet arbitrary and subjective definitions of harm. Organisations can explore patient safety incidents relevant to their context and the populations they serve rather than exploring only those that meet a certain nationally defined threshold.

This is very different to the SI Framework we have worked with in the past. Some of the existing tools and mechanisms used to consider whether a patient safety incident meets the SI criteria will no longer be required.

Ockenden Update

As previously reported, the Ockenden workstream forms part of the Maternity Transformation Board which reports onwards to the Trust Quality Committee. The monthly workstream meeting was chaired by the Head of Midwifery and has attendance from a multi-professional team. This workstream has now been stood down and will be incorporated into workstream 3 which is aligned with the overall Maternity Transformation Programme.

Regular updates are still required by LMNS and will be provided.

Immediate and Essential Action	Compliance with evidence to support	In Part	National Recommendation (Not for Trust Review)
Workforce Planning and Sustainability	3	0	0
Safe Staffing	8	0	0
Escalation & Accountability	3	1	0
Clinical Governance & Leadership	4	0	0

Clinical Governance Incident Investigating & Complaints	11	0	1
Learning from Maternal deaths	6	0	0
MDT Training	4	0	0
Complex Antenatal care	5	0	0
Preterm Birth	5	2	0
Labour & Birth	0	1	2
Obstetric Anaesthesia	4	3	0
Postnatal care	4	3	0
Bereavement Care	5	0	0
Neonatal Care	8	2	0
Supporting Families	5	3	2

There are 15 amber rated sections and will continue to review and update to ensure the narrative is a true reflection of the current position. The focus going forward will be around ensuring the appropriate evidence has been submitted and uploaded.

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 Maternity and Neonatal Services at LWH.

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*23/24/163*		Date: 12/10/2023	
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 receive the Month 4 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
N/A			

EXECUTIVE SUMMARY

Performance Report Contents

Metrics Summary

Section 1: LWGH Assurance Radar Charts by Trust Values

Section 2: Integrated Performance Metrics

Section 3: Safe Services

Section 4: Effective Outcomes

Section 5: Best Experience

KPI Lineage and Data Quality Overview

Appendix 1 – Assurance and Variation Icon Descriptions

Appendix 2 – Assurance Category Descriptions

Metrics Summary

As outlined in Trust Board sub-committees, Month 5 performance was noted to have been impacted by several factors including the Digi Care go live in July and continued Industrial Action for both Junior Doctors and Consultants. It was noted that industrial action will continue into M6 & M7 further impacting delivery of performance.

Gynaecology Elective recovery was noted to be continuing to deliver a positive trajectory in line with the 2023/24 plan submitted to the ICB. Risks were noted to delivery in future months due to potential continuation of Industrial Action

Updates were given regarding Cancer performance and continuing challenges. Committees were updated on NHSE Tier 2 discussions that the Trust will continue to be in Tier 2 performance monitoring for Q3. Assurance was noted of some of the improvements seen particularly regarding Hysteroscopy dating of patients and Histology Turnaround Times however more improvements are still required; particularly related to reducing the 62-day waiting list and 28 Day Faster Diagnosis Standard. The Chairs report from the Cancer Improvement Group was noted at committees. Committees were informed of the national changes to Cancer Waiting Time standards announced in August 2023 and reduction in number of metrics to be monitored. This will be reflected in future performance reports.

Performance related to Urgent Care metrics including AED 4-hour standard and the MAU 15- & 30-minute triage targets were noted to be good and demonstrating consistent improved performance in 23/24.

FPBD Committee were informed of national directives related to Elective Recovery and waiting times being launched in Q3. The committee was asked, on behalf of the Board, to review an NHSE Self-Assurance Checklist related to Outpatients. The checklist noted 1 area of non-compliance which will be reviewed operationally and a report outlining position and potential actions to be taken through committees in Q3. The committee agreed to sign off the checklist for submission to NHSE.

Updates were given to committees regarding Quality metrics. This including improvements made with MUST, Infection Control Indicators and Complaints responses. The launch of Digi Care was having some impacts in metrics however these were noted to be identified and being addressed as part of the existing post go live governance processes.

Areas of challenge were noted with FFT, VTE and Falls risk assessment compliance. Work is ongoing for improved oversight of KPI's through the Patient Care Services status board and updates on progress will be given through committees to demonstrate assurance on actions being taken. Committees requested further updates on metrics related to supporting patients to eat, drink and mobilise post-surgery as well as including further detail on Flu Vaccine uptake. Further information will be provided in future committee meetings.

Recommendation

The Board is asked to receive the Month 5 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.
(blank)				**Unknown** — **Watch and Learn** • There is insufficient data to create a SPC chart. • At the moment we cannot determine either special or common cause. • There is currently no target set for this metric

NHS
Liverpool Women's
NHS Foundation Trust

Trust Board

Performance Report

September 2023

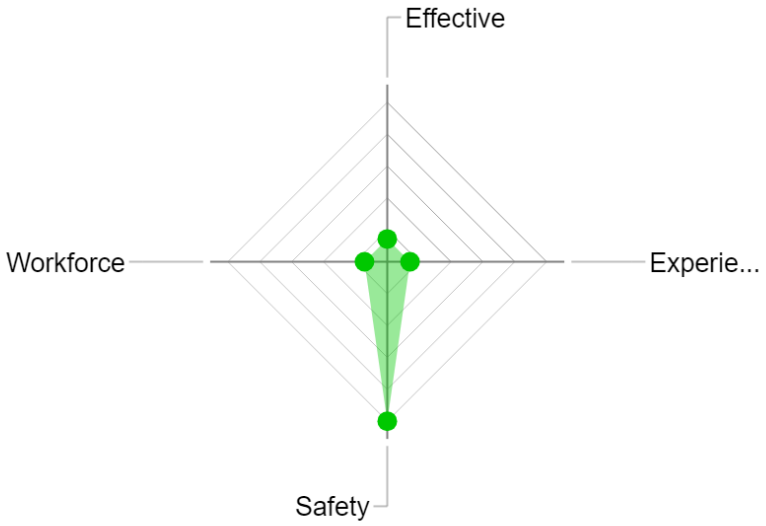
Section 1: Assurance Radar Charts by Trust Values

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'.

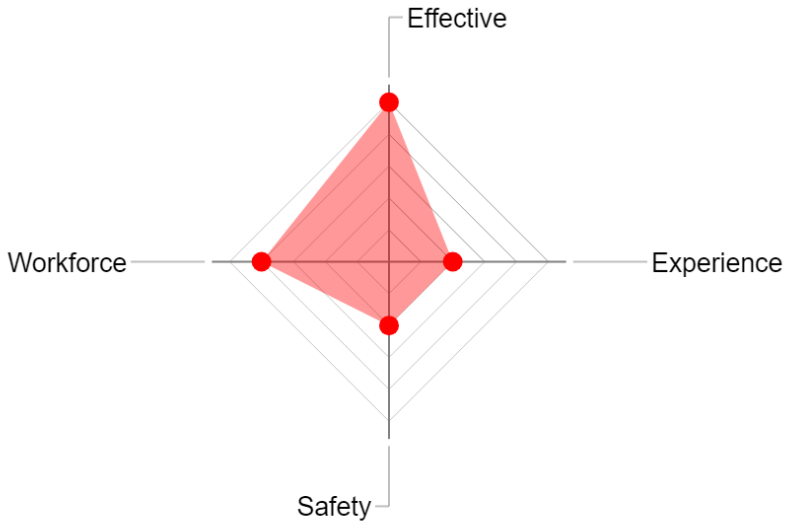
KPIs Passing Target for Six Months	10
KPIs Failing Target	13
KPIs Hit and Miss	9
KPIs No Target	5

KPIs Improving Variation	11
KPIs Concerning Variation	3
KPIs Common Cause Variation	22

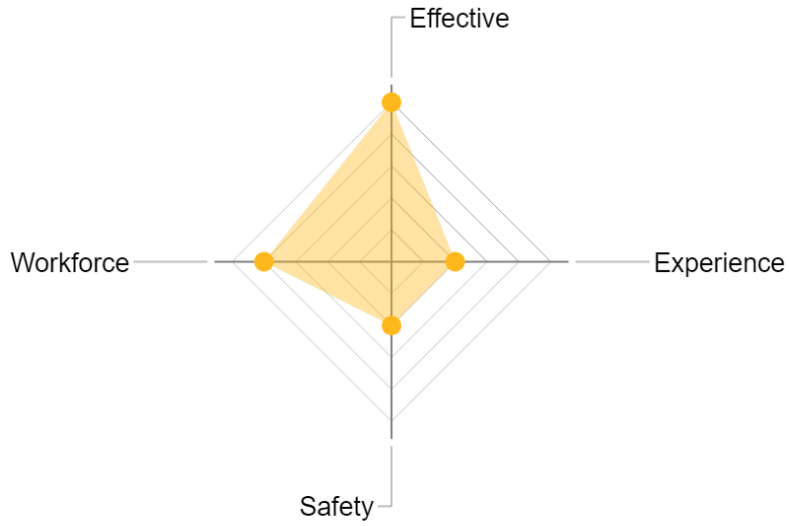
Consistently Passing



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
MAU - Face to face Maternity Triage within 30 Mins	>=	>= 95%	99.56%	P	H
Never Events	<=	0	0	P	L
Serious Untoward Incidents: Number of SUI's reported to CCG within agreed timescales	>=	100%	100.00 %	P	H
Serious Untoward Incidents: Number of SUI's with actions outstanding	<=	0	0	P	L
Turnover Rate	<=	<= 13%	9.53%	P	L

Good - Celebrate & Understand

KPI	Target < or >	Target	P	A	V
Complaints: Number Received	<=	<= 15	12	P	
Diagnostic Tests: 6 Week Wait	>=	>= 99%	90.47%	?	H
Infection Control: Clostridium Difficile	<=	0	0	P	
Infection Control: MRSA	<=	0	0	P	
NHSE / NHSI Safety Alerts Outstanding	<=	0	0	P	

Average - Investigate & Understand

KPI	Target < or >	Target	P	A	V
Neonatal deaths per 1,000 total live births	<=		6.38		
Neonatal Unit Deaths > 22wks Gest Inborn	<=		4		
Neonatal Unit Deaths > 22wks Gest Inborn and Out Born	<=		4		
Neonatal Unit Deaths > 22wks Gest Out Born	<=		0		
18 Week RTT: Incomplete Pathway > 52 Weeks	<=	0	1339	?	
18 Week RTT: Incomplete Pathway > 65 Weeks	<=	0	304	?	
A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge	>=	>= 95%	91.10%	?	
Friends & Family Test: In-patient/Daycase % positive	>=	95%	96.05%	?	
Neonatal deaths 24-31+6 Weeks Inborn babies	<=	0.063	25.00%	?	
Proportion of patient activity with an ethnicity code	>=	>=96%	97.78%	?	
Venous Thromboembolism (VTE)	>=	>= 95%	92.61%	?	

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	10		
Cancer: 104 Day Breaches	<=	0	6		
Cancer: 31 Days from Diagnosis to 1st Definitive Treatment	>=	>=96%	66.67%		
Cancer: 62 day wait for first treatment from urgent GP Referral for suspected cancer (After Re-allocation)	>=	>=85%	13.33%		
Friends & Family Test: A&E % positive	>=	95%	79.25%		
Friends & Family Test: Maternity % positive	>=	95%	78.18%		
Mandatory Training	>=	>= 95%	94.43%		
Mandatory Training (Clinical)	>=	>= 95%	88.81%		
Prevention of Ill Health: Flu Vaccine Front Line Clinical Staff	>=	>= 80%	41.54%		
Serious Untoward Incidents: Open	<=	<5	16		
Sickness Absence Rate	<=	<= 4.5%	5.46%		
Overall size of Elective Waiting List	<=		19735		

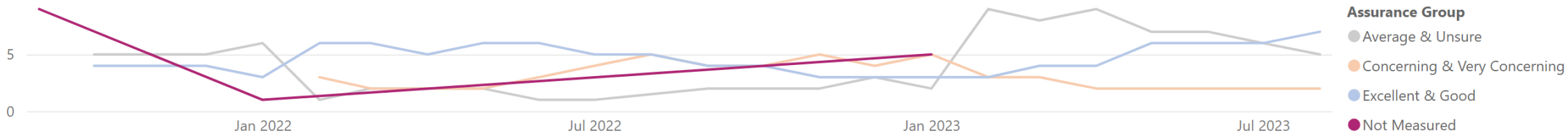
Very Concerning - Investigate & Take Action

KPI	Target < or >	Target	P	A	V
Cancer: 28 Day Faster Diagnosis	>=	>= 75%	42.48%		
Serious Untoward Incidents: New (Rolling per year)	<=	24 /year	48		

Investigate & Understand

KPI	Target < or >	Target	P	A	V

Section 3: To deliver **Safe** Services

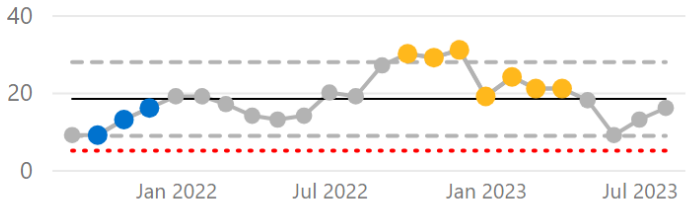


KPI	Assurance Category	Date	Target	Target < or >	Performance	Assurance	Variation	Trend
MAU - Face to face Maternity Triage within 30 Mins	Excellent	August 2023	>= 95%	>=	99.56%	P	H	
Never Events	Excellent	August 2023	0	<=	0	P	L	
Serious Untoward Incidents: Number of SUI's reported to CCG within agreed timescales	Excellent	August 2023	100%	>=	100.00%	P	H	
Serious Untoward Incidents: Number of SUI's with actions outstanding	Excellent	August 2023	0	<=	0	P	L	
Infection Control: Clostridium Difficile	Good	August 2023	0	<=	0	P		
Infection Control: MRSA	Good	August 2023	0	<=	0	P		
NHSE / NHSI Safety Alerts Outstanding	Good	August 2023	0	<=	0	P		
Neonatal deaths 24-31+6 Weeks Inborn babies	Average	August 2023	0.063	<=	25.00%	?		
Neonatal deaths per 1,000 total live births	Average	August 2023		<=	6.38			
Neonatal Unit Deaths > 22wks Gest Inborn	Average	August 2023		<=	4			
Neonatal Unit Deaths > 22wks Gest Inborn and Out Born	Average	August 2023		<=	4			
Neonatal Unit Deaths > 22wks Gest Out Born	Average	August 2023		<=	0			
Venous Thromboembolism (VTE)	Average	June 2023	>= 95%	>=	92.61%	?		
Serious Untoward Incidents: Open	Concerning	August 2023	<5	<=	16	F		
Serious Untoward Incidents: New (Rolling per year)	Very Concerning	August 2023	24 /year	<=	48	F	H	

To deliver **Safe** Services - Exceptions

Serious Untoward Incidents: Open - Chief Nurse

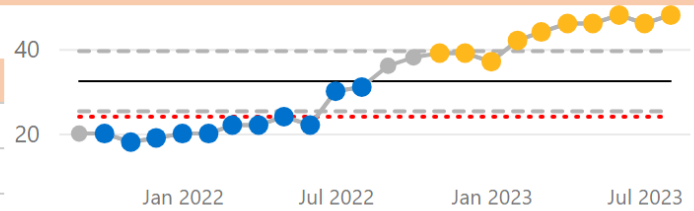
Assurance Category	Concerning
Date	August 2023
Target	<5
Target < or >	<=
Performance	16
Assurance	F
Variation	



There are 16 ongoing SUIs, 9 sit within Gynaecology and 7 within Maternity all SIs are expected to be submitted to the ICB by 18th October 2023.
Maternity have added 3 new SUIs in August, detailed within KPI196T, Gynaecology have added 1 new and submitted 1 to the ICB. 5 of the ongoing SI will fall into the future generations works (Maternity). Any new PSII will follow the PSIRF Process.

Serious Untoward Incidents: New - Chief Nurse

Assurance Category	Very Concerning
Date	August 2023
Target	24 /year
Target < or >	<=
Performance	48
Assurance	F
Variation	H



There were 4 SUIs reported in August 3x Maternity,1 relating to a placental Haematoma, 1 inappropriate follow up and 1 4ltr PPH at AUH involving LUHFT and NWAS. 1 for Gynaecology in regards to communication within the team.
PSIRF has now gone live and any new PSII will follow the PSIRF process ,any exisiting reported SI will still be submitted to the ICB by their given date.

Assurance Category	
Date	
Target	
Target < or >	
Performance	
Assurance	
Variation	

Assurance Category	
Date	
Target	
Target < or >	
Performance	
Assurance	
Variation	

To deliver Safe services - Safer Staffing

August 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	84%	76%	142%	98%	* Staffing fill rates are reflective of the bed occupancy on HDU and inpatient ward allowing for redeployment of RN to support the ward and Ward Manager working clinically covering short term sickness, all shifts out to NHSP bank to cover vacancies * Overfill rates on nights are to allow for senior nurse cover to rotate between ward and GED
Induction & Delivery Suites	77%	89%	79%	97%	*The template from RM in DS changed from 13 to 15 MW per shift due to the temporary pause of MCOC model of care in May 2023, and no longer having the availability of 4 on call midwives. Midwives who continued working in the hybrid model are rostered for one Intrapartum shift per week and contribute to the overall establishment for Delivery Suite. 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	82%	111%	84%	109%	*/**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. During August several NQM offered contracts completed all elements of their education and training and opted to commence their employment at LWH in unregistered posts whilst awaiting their NMC PIN. The additional care staff via this route or temporary staffing arrangements supported the mitigation of the registered midwives reduced fill rate due to contributions made to postnatal care
MLU	80%	81%	87%	71%	*/**There were no episodes of closure during the month, occupancy was reduced which allowed the safe delivery of Intrapartum and early postnatal care. Due to high acuity in Delivery Suite on occasions staff were redeployed meeting the needs of complexities of women using our service. Within Intrapartum Care the clinician is a 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. The lower fill rate of Care Staff is attributed to LTS, of which recruitment of fixed term contracts has occurred- with the MSW currently completing their orientation and training period.
Neonates (ExTC)	89%	102%	95%	61%	*Fill rates reflect the neonatal unit occupancy in August. Occupancy in ITU and HDU was just below 80% for the 2nd month in succession, staffing to 80% occupancy is reflected in the RN fill rates. LDU occupancy is reduced from July which is reflected in the lower fill rates in August. The requirement for care staff who provide care in LDU was reduced from July. Safe staffing was maintained and CHPPD (Care Hours Per Patient Day) are as would be expected.
Transitional Care	65%	113%	84%	84%	**Fill rates reflect the transitional care occupancy in July, with the majority of care being provided by clinical support workers in this area. Safe staffing was maintained and CHPPD (Care Hours Per Patient Day) are as would be expected

To deliver Safe services - Safer Staffing

Gynaecology: August Fill Rate

Fill rate – RN and HCA day fill rate has been impacted by both short-term sickness (RN) and long-term sickness absence (HCA). Safe staffing levels have been maintained through daily review of activity and acuity and supported with inter -Divisional moves including usage of HDU Registered Nurses available due to low bed occupancy on the HDU unit. Health roster meetings continue to support planned assignment counts and any shifts vacant due to short notice absence are sent to NHSP bank as they arise. The RN night-time overfill rate of 142% is the reflection of senior RN cover rotating between GED and inpatient areas.

Attendance/ Absence – Sickness and absence rate during August has decreased month on month and is recorded at 12.23% for Gynaecology ward, above threshold. Short term sickness accounts for 27.81% and long term 72.19%, with long term sickness reflecting higher levels in the HCA workforce. The top causes in the Department are recorded as Anxiety/Stress and Cough/Cold/Flu. Timely sickness management is monitored in keeping with sickness and absence policy and reported on monthly by Divisional Matrons and HR. Maternity leave equates to 1.22 WTE.

Vacancies – No RN or HCA vacancy.

Red Flags – No red flags reported.

Bed Occupancy – The Gynaecology ward has a total of 24 inpatients beds, August 2023 average bed occupancy equating to a 54%.

CHPPD – 8.5

Neonates: August Fill Rate

Fill-rate – Occupancy saw a reduction in August to below 80% across all areas of the neonatal unit. LDU and TC areas, safe staffing has been maintained and fill rates are reflective of acuity and occupancy. The lower acuity and activity are reflected in a reduction of the use of Bank staff which fell by a further 29.2% from August. The escalation policy has not had to be used this month there were 2 delays in repatriation of babies to their local neonatal units, which were escalated appropriately to the Northwest Neonatal ODN.

Attendance/Absence –Sickness was reported at 3.7% in August which is below the trust's target of 4.5% and the lowest rate since 2019. Long term sickness accounts for 50.36 % of the total sickness is being managed in line with the attendance management policy.

Vacancies – Turnover remains well below the trust target of 13 % at 8% in August. There have been ongoing challenges recruiting to vacant ANNP posts, with 5 WTE posts out to advert and only 1 applicant in 9 months, therefore the advert was withdrawn and a plan to move to hybrid clinical fellow/ANNP posts made. There was successful recruitment to five Band 5 vacancies with 5 new nurses to commence employment on the neonatal unit in October 2023.

Red Flags – No Red Flags

Bed Occupancy – Occupancy was below the expected 80% at 70.6 % down from 83 % in July. ITU occupancy was 71.2% %HDU at 64.8%, a reduction was seen in LDU and TC capacity in august with rates reducing from 93.1 to 68.9 in LDU and 69 % to 61.3 % in TC. All if which is reflective of the care staff fill rates.

CHPPD – Within the critical care areas the care hours provided in August are as would be expected for babies being nursed in ITU with 14.6 Care hours per patient day (CHPPD) overall. The breakdown shows higher hours of registered nurse care and lower non- registered care. This split of 13.4 hrs of registered nurses and 1.2 healthcare support workers, is as expected considering that most of these babies need care by a nurse qualified in speciality. The Transitional Care CHPPD is reflective of the way in which non- registered staff leads TC supported by registered staff and parents, hence why we see 4.6 hrs by non-registered nurse and less by registered nurses 3.5 hrs, but appropriate for care delivery with overall care hours at 8.1 care hours per patient day. Care in TC is more about supporting the family to provide care for their baby.

To deliver Safe services - Safer Staffing

Maternity: August 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 planned 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 99.5%, and 95.2% of those within 15min BSOTS target, with the average length of triage <8mins. Additional care staff were provided to support clinical postnatal care delivery for postnatal women on Maternity Ward when RM shifts were unable to be filled utilising a combination of temporary staffing solutions and NQM who opted for early start dates into Band 4 posts whilst awaiting receipt of their NMC PIN. 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 increased to 7.94% in month, or which STS accounts for 30%, with the top reasons for short term absence being cough/cold or gastrointestinal issues. LTS is 70%. Ward managers/matrons have individual sickness reviews and are planning return to work programmes with all LT employees to facilitate appropriate returns, with 9 planned resolutions to LTS into September. Maternity leave equates to 12.59wte all of whom are within the Registered Midwives staffing group.

Vacancies – 34.72wte Midwives at Band 5 are currently undergoing recruitment processes and awaiting NMC PIN, and Maternity is expected to exceed full establishment by M7 when all new starters are in post.

Red Flags – During August 61 Midwifery Red Flags were identified, a significant increase on the previous month which reflected the high acuity and occupancy seen across the service. This included 5 triage breaches of >30mins, with all undergoing analysis to drive quality improvement as part of the MAU workstreams. There were 36 delays of >4hrs for ongoing IOL (local red flag), which affected patient experience, and 12 delays of >2hrs from admission to commencement of IOL. IOL Coordinator Project Lead has been appointed with specific focus on improving processes, estate and patient experience. Due to ongoing delays mutual aid from the wider Local Maternity Neonatal System providers were offered to support IOL, however only one woman chose to be transferred and birth in an alternative provider with others choosing to remain for care at LWH.

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 15.1 in August for Delivery Suite for Registered staff which is an increase from July. 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 99% of women in month within the hospital environment.

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 3.4 for Aug. Nationally the refresh of the BirthRate Plus Ward Based Accuity Tool which will provide a real time evidence-based data to support staffing deployment decisions on Maternity Ward is in test in several units. Once available to us, this will provide safe staffing assurance on the changing complexity of ward-based care in Maternity services here at Liverpool Womens.

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

KPI	Assurance Category	Date	Target	Target < or >	Performance	Assurance	Variation	Trend
Cancer: 62 day wait for first treatment from urgent GP Referral for suspected cancer (After Re-allocation)	Concerning	July 2023	>=85%	>=	13.33%			
18 Week RTT: Incomplete Pathway > 104 Weeks	Excellent	August 2023	0	<=	0			
Cancer: 28 Day Faster Diagnosis	Very Concerning	July 2023	>= 75%	>=	42.48%			
Cancer: 31 Days from Diagnosis to 1st Definitive Treatment	Concerning	July 2023	>=96%	>=	66.67%			
Diagnostic Tests: 6 Week Wait	Good	August 2023	>= 99%	>=	90.47%			
A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge	Average	August 2023	>= 95%	>=	91.10%			
Proportion of patient activity with an ethnicity code	Average	August 2023	>=96%	>=	97.78%			
Cancer: 104 Day Breaches	Concerning	July 2023	0	<=	6			
18 Week RTT: Incomplete Pathway > 78 Weeks	Concerning	August 2023	0	<=	10			
18 Week RTT: Incomplete Pathway > 65 Weeks	Average	August 2023	0	<=	304			
18 Week RTT: Incomplete Pathway > 52 Weeks	Average	August 2023	0	<=	1339			
Overall size of Elective Waiting List	Concerning	August 2023		<=	19735			

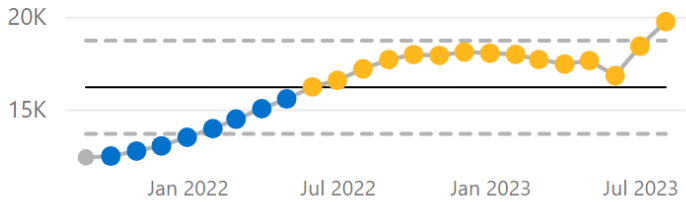
*Following KPI's have nationally set targets as part of Operational Planning Guidance for 23/24:

18 Week RTT: Incomplete Pathway > 52 Weeks (KPI002T)
18 Week RTT: Incomplete Pathway > 65 Weeks (KPI498)
Diagnostic Tests: 6 Week Wait (KPI204)
Cancer: 28 Day Faster Diagnosis (KPI359)
A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge (KPI008)

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

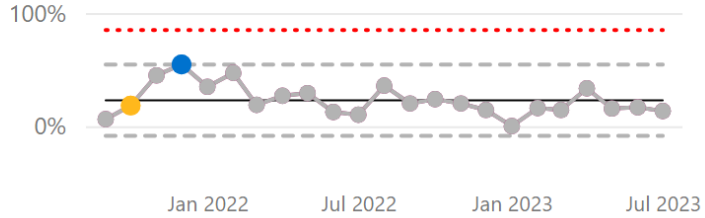
Overall size of Elective Waiting List - Chief Operating Officer

Assurance Category	Concerning
Date	August 2023
Target	
Target < or >	<=
Performance	19735
Assurance	
Variation	H



Cancer: 62 day wait for first treatment from urgent GP Referral for suspected cancer (After Re-al...

Assurance Category	Concerning
Date	July 2023
Target	>=85%
Target < or >	>=
Performance	13.33%
Assurance	F
Variation	

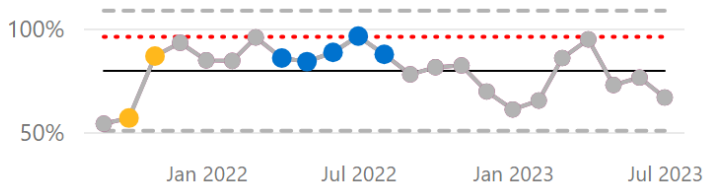


Performance for July 2023 is 22% which will update once refreshed.

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.

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

Assurance Category	Concerning
Date	July 2023
Target	>=96%
Target < or >	>=
Performance	66.67%
Assurance	F
Variation	

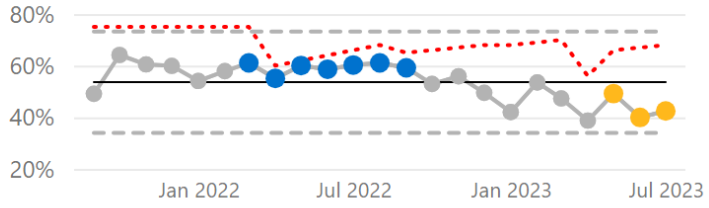


Position under pressure due to increased levels of IA and also external referrals not currently suitable for surgery due to co-morbidities.

The division continue to try and protect cancer activity during IA however this depends on Anaesthetist availabilty and also ensuring non-elective services are covered

Cancer: 28 Day Faster Diagnosis - Chief Operating Officer

Assurance Category	Very Concerning
Date	July 2023
Target	>= 75%
Target < or >	>=
Performance	42.48%
Assurance	F
Variation	L

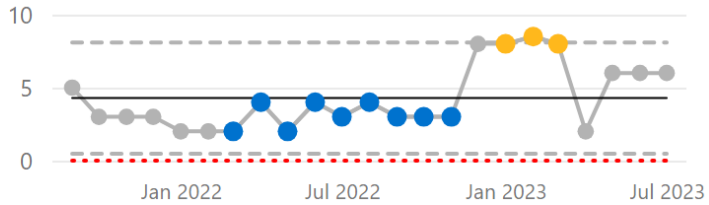


Significant challenges with Hysteroscopy capacity and Histology turnaround. Trust in Tier 2 meeting with NHSE with first meeting held 26th June. This outlined existing pressures and key areas of challenge for the Trust. Trust will be meeting monthly with NHSE to monitor. Weekly tracker of activity being monitored. All routine activity has been converted to Rapid Access to support the position.

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

Cancer: 104 Day Breaches - Chief Operating Officer

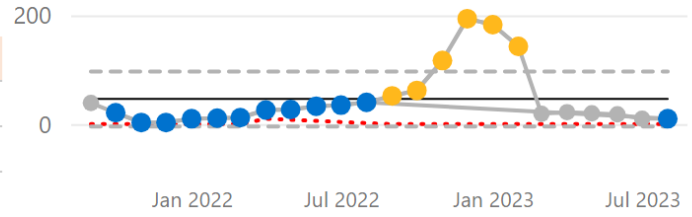
Assurance Category	Concerning
Date	July 2023
Target	0
Target < or >	<=
Performance	6
Assurance	
Variation	



Due to complexity of patients and late referrals from other trusts, patients continue to breach 104 days. Harm reviews conducted for all patients. Paper presented to Quality Committee in July outlining key pressures on pathways and actions being taken to mitigate. Whilst current 62 day backlog is cleared there will continue to be patients that breach 104+ days

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

Assurance Category	Concerning
Date	August 2023
Target	0
Target < or >	<=
Performance	10
Assurance	
Variation	

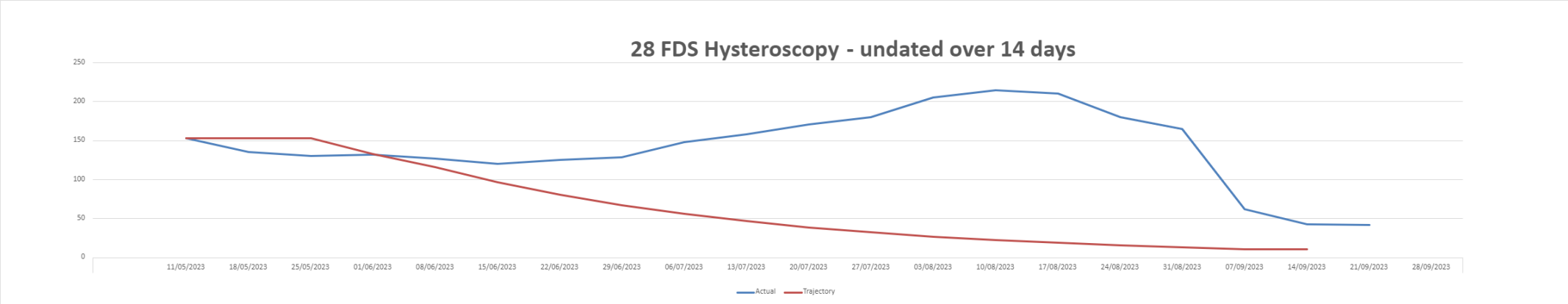


Small number of patients currently over 78 weeks for patient choice or clinical reasons. Plans in place to clear by end of October 2023. Daily management of PTL and at Access sub-committee. Ongoing Industrial action impacting capacity to clear long waiters

Assurance Category	
Date	
Target	
Target < or >	
Performance	
Assurance	
Variation	

Assurance Category	
Date	
Target	
Target < or >	
Performance	
Assurance	
Variation	

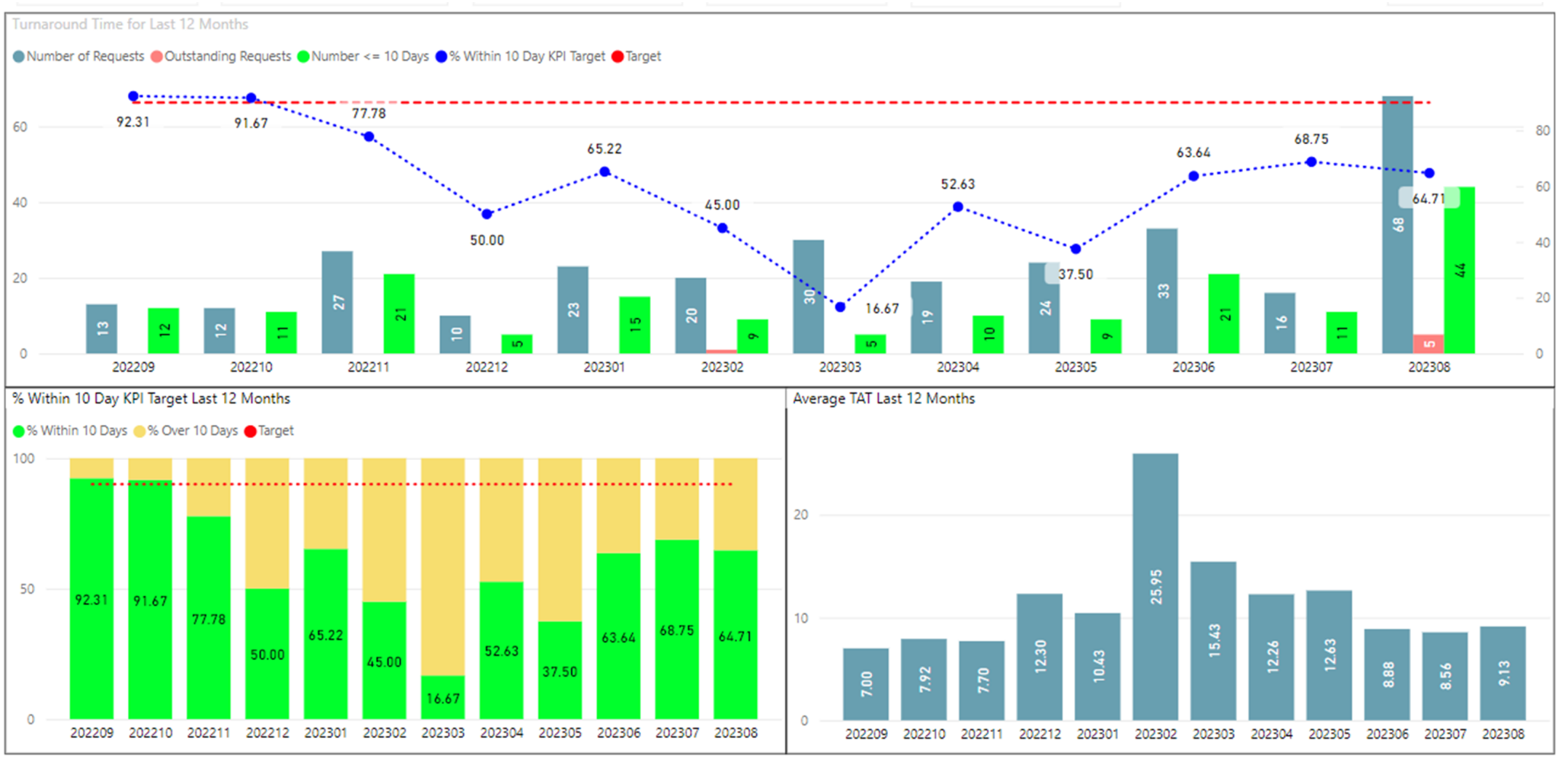
28 Day Faster Diagnosis Standard: Hysteroscopy Undated over 14 Days



This graph demonstrates the drive to ensure all long waiting Hysteroscopy patients are dated

LCL Improvements

Last 12 Months TAT for Urgency biopsies from Liverpool Women's Hospitals

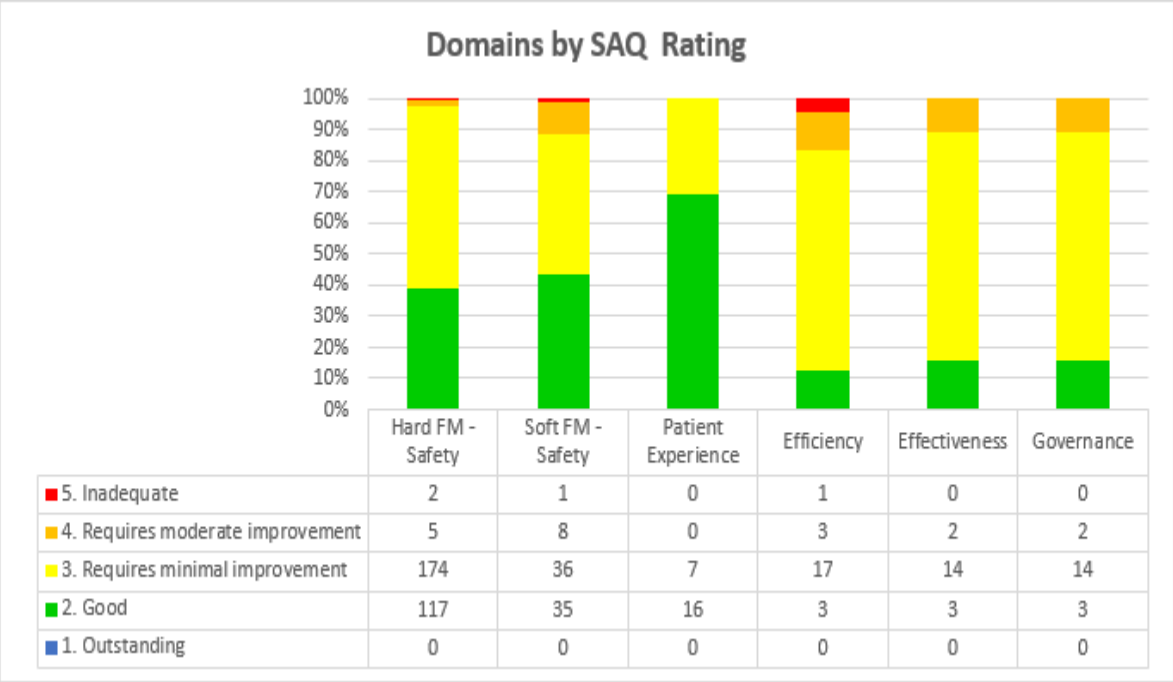


Planned Preventative maintenance

PPM Description	Responsibility	Accountable	Contractors	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
FIRE																		
Fire Alarm Testing (W, 3M)	Estates/Contractor	Estates Manager	Tailored Fire	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Fire Doors (M)	Estates	Estates Manager		1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Fire Damper Inspection & Test (12M)	Contractor		VSS/Swegon															
Fire Fighting Equipment (12m)	Contractor		Tailored Fire									12						
Dry Risers (12M)	Contractor		Tailored Fire									12						
Fire Hydrants (12M)	Contractor		Tailored Fire									12						
Emergency Light test (,M,12M)	Estates	Estates Manager		1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
WATER																		
Water Treatment (M) (heating and cooling)	Contractor		Aquaserv	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Water Tank Cleaning (12M)	Contractor		Aquaserv										12					
Water Sampling (M)	Contractor		Aquaserv	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Water Safety PPMs	Estates	Estates Manager	Estates	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
SECURITY																		
Access Control System (3M)	Contractor		Clarion		3			3			3			3			3	
CCTV (3M)	Contractor		HESIS		3			3			3			3			3	
Intruder Alarm (6M)	Contractor		Clarion					6						6				
Baby Tagging System (3M)	Contractor		X-Tag		3			3			3			3			3	
LIFTS																		
Passengers & Goods Lift (M, 12M)	Contractor		Rubax lifts	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Ladder & Access Platforms (6M)	Contractor	Estates Manager							6						6			
ELECTRICAL																		
Commercial Dishwashers (6M)	Contractor		JLA					6						6				
Commercial Washing Machine Dryers (6M)	Contractor		JLA					6						6				
Electric Boilers (12M)	Contractor		JLA											12				
Kitchen Equipment (6M)	Contractor		JLA					6						6				
Portable Appliances Testing (12M)	Estates/Contractor	Estates Manager	OCS							12								
Food Trolleys (6M)	Contractor		Socomel					6						6				
Weighing Equipment (3M)	Contractor		Accurate weight		3			3			3			3			3	
Fixed Appliance Testing (12M)	Contractor		Parr Group											12				
Bed Pan Washers service (6M)	Contractor		Dekomed					6						6				
Bed Pan Washers Testing (3M)	Contractor		Dekomed		3			3			3			3			3	
Nurse Calling System (3M)	Contractor		Austco		3			3			3			3			3	
External Light Cleaning (12M)	Estates	Estates Manager			12													
Internal Light Cleaning (12M)	Estates	Estates Manager			12													
Lightning Protection (12 M)	Contractor		PTSG									12						
Generator Testing (W, M,6M,12M)	Estates/Contractor	Estates Manager	Ingrams	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Trend Building Management System (M)	Contractor		BTS	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
LV Distribution System (12M)	Estates	Estates Manager												12				
HV Distribution System (12M)	Contractor		Ipsum											12				
Refridgeration (6M) Catering/Domestic	Contractor		Effective Air					6						6				
MEDICAL GASES																		
Medical Gases (3M)	Contractor		Medi-teknique		3			3			3			3				
HVAC (Heating, ventilation and air conditioning																		
Boiler Burners (6M)	Contractor		Equans			6						6						6
Pressure Units (6M)	Contractor		Equans					6						6				
Main Chiller Unit (6)	Contractor		Equans	6														
Air conditions (6M)	Contractor		Effective Air					6						6				
Ventilation System(6M) (AHU)	Estates	Estates Manager						6						6				
NICU Chillers Unit (3M)	Contractor		Carrier		3			3			3			3			3	
Ceiling Grills Extract Fans (6M)	Estates	Estates Manager						6						6				
OTHER																		
Car Park Pay & Display (6M)	Contractor		Newpark					6						6				
Grass Cutting and Grounds Maintenance	Contractor		Rice lane landsc	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Windows maintenance (12M)	Estates/Contractor	Estates Manager	Fenestral						12									

A review of the 2023 NHS PAM return was carried out by the Soft FM and Compliance Manager within the Estates and Facilities department. Meetings were undertaken with all specialities to gain a true reflection of the Trusts position in terms of the questions and evidence provided to determine the correct scoring for the model. i.e., Patient Experience Matron, Decontamination Lead, Estates Manager, Head of Estates and Facilities, OCS Contracts Manager, and review of the recently completed Food and Nutrition audit undertaken within the Trust.
The results of this scoring for the 5 domains are as follows:

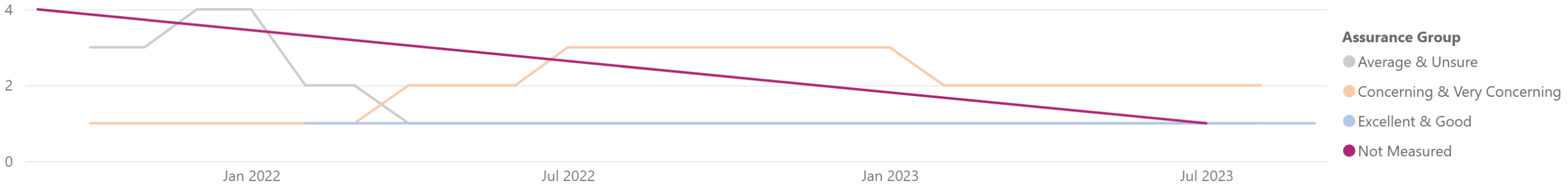
Table 1



	Hard FM - Safety	Soft FM - Safety	Patient Experience	Efficiency	Effectiveness	Governance
5. Inadequate	2	1	0	1	0	0
4. Requires moderate improvement	5	8	0	3	2	2
3. Requires minimal improvement	174	36	7	17	14	14
2. Good	117	35	16	3	3	3
1. Outstanding	0	0	0	0	0	0

The Trust demonstrated good compliance across the five domains. 93% of the questions resulted in good or minimal improvement, whilst 5.7% resulted in requires moderate improvement and 1.3% inadequate

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

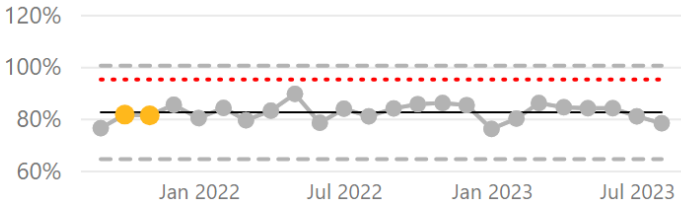


KPI	Assurance Category	Date	Target	Target < or >	Performance	Assurance	Variation	Trend
C-Gull Recruitment	Not Measured	July 2023		<=	64			
Complaints: Number Received	Good	September 2023	<= 15	<=	12			
Friends & Family Test: In-patient/Daycase % positive	Average	August 2023	95%	>=	96.05%			
Friends & Family Test: A&E % positive	Concerning	August 2023	95%	>=	79.25%			
Friends & Family Test: Maternity % positive	Concerning	August 2023	95%	>=	78.18%			

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

Friends & Family Test: Maternity % positive - Chief Nurse

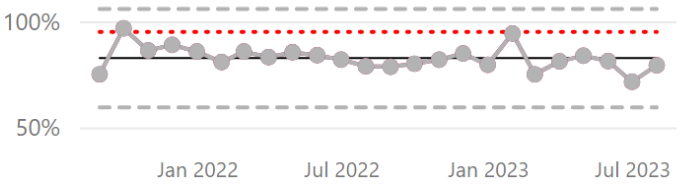
Assurance Category	Concerning
Date	August 2023
Target	95%
Target < or >	>=
Performance	78.18%
Assurance	
Variation	



All Firends and Family feedback reviewed by the maternity matron team on a weekly basis. Some improvement evident in administration of timely pain relief. Number of feedback received remains low.

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

Assurance Category	Concerning
Date	August 2023
Target	95%
Target < or >	>=
Performance	79.25%
Assurance	
Variation	



This month we have seen the percentage improve from 71.43% in the previous month up to 79.25% this demonstrates that some of the local actions now inplace are starting to become inbedded. Also, EPAU remains to be situated with the foot print of the department so once EPAU moves out of the department we do anticipate an improvement in overall satisfaction.

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	
Cancer: 104 Day Breaches	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 wait for first treatment from urgent GP Referral for suspected cancer (After Re-allocation)	Effective	5	Y	Y	Y				Y	
Complaints: Number Received	Experience	5	Y		Y					
Diagnostic Tests: 6 Week Wait	Effective	5	Y	Y	Y			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	Workforce	5	Y		Y	Y				
Mandatory Training (Clinical)	Workforce	5	Y		Y	Y				
MAU - Arrival to Triage within 30 Mins	Safety	5	Y	Y	Y		Y			Y
Neonatal deaths 24-31+6 Weeks Inborn babies	Safety	5	Y				Y			
Neonatal deaths per 1,000 total live births	Safety	5	Y				Y			
Neonatal Unit Deaths > 22wks Gest Inborn	Safety	5	Y				Y			
Neonatal Unit Deaths > 22wks Gest Inborn and Out Born	Safety	5	Y				Y			
Neonatal Unit Deaths > 22wks Gest Out Born	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: New	Safety	5	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 Incidents: Open	Safety	5	Y		Y					
Sickness	Workforce	5	Y		Y	Y				
Turnover	Workforce	5	Y			Y				
Venous Thromboembolism (VTE)	Safety	5	Y		Y					
C-Gull Recruitment	Experience		Y		Y		Y			
Prevention of Ill Health: Flu Vaccine Front Line Clinical Staff	Workforce		Y	Y	Y	Y				

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*22/23/164*		Date: 12/10/2023	
Report Title	Mortality and Learning from Deaths Report Quarter 1, 2023/24			
Prepared by	**Chris Dewhurst, Deputy Medical Director.** Lidia Kwasnicka, Gynaecologist; Ai-Wei Tang, Consultant Obstetrician; Rebecca Kettle, Consultant Neonatologist and			
Presented by	**Lynn Greenhalgh, Medical Director**			
Key Issues / Messages	The Board is asked to review the contents of the paper and take assurance that there is adequate processes and progress against the requirements laid out by the National Quality Board			
Action required	Approve ☐	Receive ☐	Note ☒	Take Assurance ☒
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable): N/A			
	For Decisions - in line with Risk Appetite Statement – Y *If no – please outline the reasons for deviation.*			
	It is requested that the Board review the contents of the paper and take assurance that there are adequate governance processes in place when learning from deaths. *Given the paper identifies several deaths related to non- co-location of maternity and adult/paediatric acute services, the Board is asked to note the following for additional assurance:* *1.The last 18 months learning from deaths papers have been reviewed to identify deaths which may have been contributed to by non-colocation.* *2. A retrospective review of gynaecology SIs identified 2 deaths. In neither was non-colocation identified as learning however in one case the woman was transferred to another hospital for ongoing care as this care was unable to be provided on the LWH site.* *It is recommended:* *1. There is a wide-ranging review of the IUT pathways and discussion with the NWODN and LMNS regarding the discrepancies seen across the system and why LWH receives 3.5X the IUTs than other similar local providers.* *2. Consideration from the Trust Board regarding where the learning from deaths information relating to learning from non-colocation is shared.* *In addition, as per The Learning from Deaths framework requirements the Board are requested to note:* *• number of deaths in our care* *• number of deaths subject to case record review* *• number of deaths investigated under the Serious Incident framework* *• number of deaths that were reviewed/investigated and as a result considered due to problems in care* *• themes and issues identified from review and investigation* *• actions taken in response, actions planned and an assessment of the impact of actions taken.* *• the care issues identified in the antenatal management from referring trusts. It is recommended that a review of antenatal care findings from the previous PMRT reviews is undertaken and if any common themes identified that this is presented to the local maternity and neonatal system*			
Supporting Executive:	Lynn Greenhalgh Medical Director			

Equality Impact Assessment *(if there is an impact on E,D & I, an Equality Impact Assessment **MUST** accompany the report)*							
Strategy	☐	Policy	☐	Service Change	☐	Not Applicable	☒

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

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

EXECUTIVE SUMMARY

This “Mortality and Learning from Deaths” paper presents the mortality data for Q1 2023/24 with the learning from the reviews of deaths from Q4 2022/23 The ‘learning’ can take some time after the death occurs due to the formal processes and MDT reviews that occur. Learning from SI reviews, Coroner’s inquests, HSIB investigations and elsewhere may take longer to be reported. This results in the learning being presented at least one quarter behind the data.

In quarter 1 there were the following deaths:

Adult deaths	**1 (expected death)**
Direct Maternal Deaths	**0**
Stillbirths	**3 (excluding ToP)**
Neonatal deaths (inborn)	**12 (6.8/1000 live births)**

The updated learning from 3 **maternal deaths** in 2021/22 is included in this paper. Not being co-located with surgical and

There were two **unexpected gynaecology deaths** in women who underwent surgery at LWH and were then transferred to RLUH due to post operative complications in Q2 2022/23. The lack of co-location with an acute hospital trust was identified as a root cause in the SI review.

The **stillbirth** rate for this quarter was 1.7/1000. This is the lowest rate for the previous 3 years. Incomplete stillbirth investigations being completed were identified as a care issues.

The **neonatal mortality** rate for inborn babies was 6.8/1000 livebirths. The mortality for in-born preterm infants (24 to 31+6 weeks) was 7.1% mortality. This is above the NWODN benchmark of 6.3%, however discussions with the appropriateness of this benchmark with the ODN have commenced.

The review of neonatal deaths from Q4 22/23 identified 5 examples of care issues identified which may have made a difference to the outcome (Grade C), two of these cases have been referred for a SUI investigation. Delay in performing radiology investigations was highlighted as a recurring safety issue and has resulted in executive approval for a 24/7 radiology on-site presence.

This paper includes an overview of **in-utero transfers (IUTs) and the impact on mortality**. Over a 2-year period, IUTs accounted for nearly half (26/55, 47%) of all deaths at LWH. IUTs were 6x more likely to die than non-IUTs (1.5% vs 8.8%). The excess mortality is mainly seen in the more mature infants related to the presence of congenital anomalies.

On reviewing all of the learning from deaths for this recent quarter, the **lack of co-location** of LWH services with both adult and paediatric acute services has been highlighted as contributory factor to the following:

1. a maternal death in Q4 2022/23 related to a woman presenting at 18 weeks gestational age with bowel ischaemia.
2. two unexpected gynaecology deaths in women with post-operative complications in Q2 2022/23
3. A stillbirth occurring in a 14-year-old girl presenting to another trust in the city
4. A neonatal death related to transfer between Alder Hey and Liverpool Women’s Hospital

Recommendation: It is requested that the Board review the contents of the paper and take assurance that there are adequate governance processes in place when learning from deaths.

Given the paper identifies several deaths related to non- co-location of maternity and adult/paediatric acute services, the Board are asked to note the following for additional assurance:

1. The last 18 months learning from deaths papers have been reviewed to identify deaths which may have been contributed to by non-colocation.
2. A retrospective review of gynaecology SIs identified 2 deaths. In neither was non-colocation identified as learning however in one case the woman was transferred to another hospital for ongoing care as this care was unable to be provided on the LWH site.

It is recommended:

1. There is a wide-ranging review of the IUT pathways and discussion with the NWODN and LMNS regarding the discrepancies seen across the system and why LWH receives 3.5X the IUTs than other similar local providers.
2. Consideration from the Trust Board regarding where the learning from deaths information relating to learning from non-colocation is shared.

In addition, as per The Learning from Deaths framework requirements the Board are requested to note:

- number of deaths in our care
- number of deaths subject to case record review
- number of deaths investigated under the Serious Incident framework
- number of deaths that were reviewed/investigated and as a result considered due to problems in care
- themes and issues identified from review and investigation
- actions taken in response, actions planned and an assessment of the impact of actions taken.
- the care issues identified in the antenatal management from referring trusts. It is recommended that a review of antenatal care findings from the previous PMRT reviews is undertaken and if any common themes identified that this is presented to the local maternity system

MAIN REPORT

This is the quarter 1 2022/23 mortality report for adults, stillbirths and neonates. The report is part of the regular reporting schedule of the Trust to ensure that there is oversight and assurance monitoring of the mortality rates related to the clinical activity of the Trust. This is in accordance with recommendations by the National Quality Board “National Guidance on Learning from Deaths” and the Care Quality Commission. It outlines the work taking place operationally and being overseen by the Safety and Effectiveness Sub - Committee and Quality Committee.

The data presented in this report relates to Q1 2022-23. The learning relates to deaths in Q4 22/23 2022-23. This is due to the multidisciplinary review of deaths not occurring in the quarter when the death occurred.

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

1 Adult Mortality

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

The requirement is to report adult deaths that occur at LWH. However given the isolated nature of our services, women who deteriorate whilst an in-patient at LWH will be transferred to other hospitals for ongoing care any may die at external trusts. The learning from deaths report now also includes information related to these deaths. These deaths may not be reported the quarter after the death occurs due to data collection and sharing and this is highlighted.

1.1 Obstetric Mortality Data Q1 2023/24

There were no maternal deaths in Q1 2023/24.

1.2 Learning from Obstetric Mortality Data

Due to the significant time delay for investigations to conclude following a maternal death, the deaths will continue to be reported through this paper until the learning is concluded.

Case 1 Q4 2022/23

This related to the death of a woman at 18 weeks gestational age who deteriorated whilst an in-patient at LWH. She was transferred to LUFHT where she sadly died. This death is being investigated via a HSIB investigation, a Serious Untoward Incident investigation (led by the Gynaecology division due to her presenting the GED) and also by the Coroner. The cause of death has been recorded as

1A- acute intestinal ischaemia
1B- Thrombophilia and pregnancy.

The SI report (2023/5813) identified the following as a root cause of the incident:

- The lack of onsite surgical team and managing the patient in isolation and not ‘shared care’ with other acute specialties.
- Lack of co-location of LWH with acute trust.

The Lessons Learned and Recommendations are as follows:

Lessons Learned

- Acute surgical abdomen needs to be suspected and investigated appropriately.
- Patients who are unwell or cause for concern should be prioritised on the morning ward round
- Arranging Inter-hospital transfer and reviews by external consultants should be expected to be challenging during times of high clinical pressure on both Hospital Trusts and may require senior medical input.
- Pain assessment was not undertaken and documented on the NEWS observation chart.

The learning from the HSIB investigation and Coroner’s Inquest will be included in future reports.

Case 2 Q3 2022/23

This was a death of a woman who was originally booked in a hospital outside of the Cheshire and Merseyside network. She delivered at LWH due to a fetal/neonatal condition which resulted in a neonatal death. She was discharged to her local hospital subsequently home, where she died unexpectedly. This is not recorded as an LWH maternal death due to the antenatal and postnatal care being provided by another organisation.

The DRAFT HSIB report has been provided and although the patient did not receive input from LWH following discharge there were some key learning points relevant to the reporting trust that we have taken and outlined in the appendix paper on maternal mortality. We have used this case at the MPMET training days to reiterate the need for the appropriate investigations to be done in a timely fashion.

This death will continue to be investigated via the coroner with the Trust contributing to that investigations.

Case 3 Q4 2021/22
In Q4 22/23 2021/22, there was one death of a woman who died approximately 8 weeks after delivery. This case is subject to a Coronial investigation and, as per the requirements of the Ockenden review, a multiagency review has been completed. The Coroner's inquest has not yet taken place but is planned for Q2/3 22/23. The internal SI has been completed with learning included in previous 'Learning from Deaths' report. The outcome from the Coroner's investigation will be included in this report when available.

1.3 Gynaecology Mortality data Q1 2022/23

There was 1 expected deaths within Gynaecology Oncology in Q1 2023/24.
There were 0 unexpected deaths within Gynaecology services in Q1 2023/24.

2023/24	Expected	Unexpected	Deaths of LWH patients transferred as in-patients
Q1	1	0	0
Q2			
Q3			
Q4			
ANNUAL	**1**	**0**	**0**

1.4 Learning from Gynaecology Mortality Q4 22/23 2022/23

There were two unexpected deaths of women who underwent surgery at LWH and then subsequently deteriorated post-operatively (both in Q2 2022/23). These were both subject to SIs that provided learning in Q1 23/24. (NB Details of one of these deaths was included in the previous Learning from Deaths report).

Both were transferred to the Royal Liverpool Hospital where they died later. Joint SI investigations were completed for both. The root cause for both incidents was the lack of an onsite surgical team, CT scanner (at the time) and radiology department on the LWH site t resulting in the post operative management of potential bowel obstruction/ complication being managed in isolation and not as "shared care" with other surgical specialties.

Given the identification of lack of co-location with adult acute services being a contributor to the above 2 deaths, a retrospective review of SIs since 2018 from the gynaecology and clinical support services divisions was undertaken. This review identified two post operative deaths since 2018. In 2020, one woman died at LWH following a deterioration in the post operative period. She had several co-morbidities. The cause of death was a pulmonary embolus. She was managed by LWH teams with no

input from adult acute services (2020 – 25044). A second woman deteriorated post-operatively with sepsis. She was transferred to St Helens and Knowsley hospital for support and further surgery (SI 2019-11592). Neither of these two cases identified lack of co-location with adult services as a root cause of the death. However the woman in the second case was transferred for ongoing care as the care required could not be provided on the LWH site due to lack of on-site adult acute services.

2 Stillbirths

2.1 Stillbirth data

There were 4 stillbirths, excluding terminations of pregnancy (TOP) in Q1 2022/2023. This has resulted in an adjusted stillbirth rate of 2.3/1000 live births for Q4 22/23. This is the lowest stillbirth rate for past 3 years although caution must be taken in interpreting small numbers.

STILLBIRTHS	July-22	Aug-22	Sept-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-22	May - 22	June-22	TOTAL 2023/24
Total Stillbirths	7	3	3	2	2	6	2	4	1	5	4	10	19
Stillbirths (excluding TOP)	**3**	**3**	**1**	**1**	**2**	**5**	**1**	**3**	**0**	**0**	**2**	**1**	**3**
Births	645	659	656	649	596	619	630	519	613	613	599	554	1766
Overall Rate /1000	10.9	4.6	3.0	4.7	6.7	9.7	3.2	7.7	1.6	8.2	6.7	18.1	10.8
Rate (excluding TOP)/1000	**4.7**	**4.6**	**1.5**	**1.6**	**3.4**	**8.1**	**1.6**	**5.8**	**0**	**0**	**3.3**	**1.8**	**1.7**
Pregnancy loss 22-24 weeks (excluding TOP)	0	0	1	1	1	1	1	0	0	1		2 (twins)	3

Table 1 Stillbirth rates for 2022-23. The stillbirth rate is 1.7/1000 births

Quarter	Rate 2019/20	Rate 2020/21	Rate 2021/22	Rate 2022/23	Rate 2022/23
Q1	4.0	5.5	4.0	3.7	1.7
Q2	4.1	2.5	5.3	3.6	
Q3	1.5	2.7	5.1	4.3	
Q4	1.7	3.2	5.0	2.3	
ANNUAL	2.9	3.4	4.9	3.5	

Table 2: Quarter and Annual Stillbirth rate/1000 births since 2019/20 (excluding terminations)

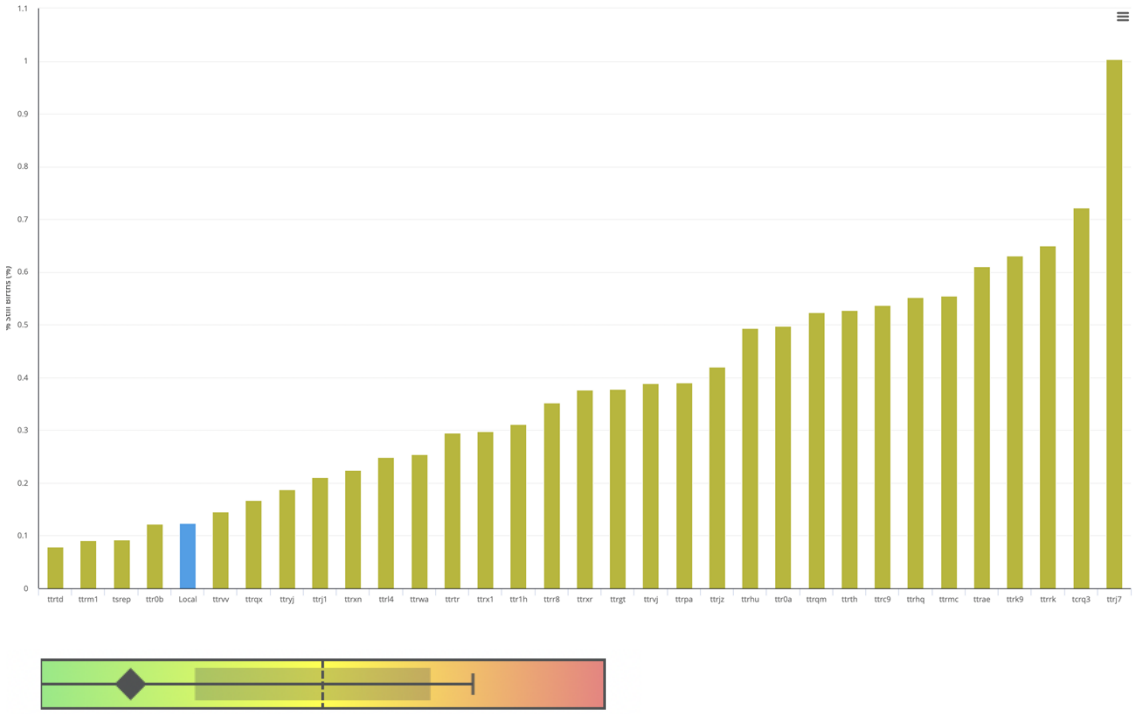


Figure 1 and 2. Stillbirth data with LWH benchmarked against other large maternity services (>7000 deliveries) Q1 2023-24. The blue bar and triangle are LWH data demonstrating the observed rate is within the lowest quartile for stillbirths.

The stillbirth rate for Q1 23/24 is the lowest since 2019/20. When benchmarked against similar large organisations, we are below the interquartile range and at the lower end for stillbirth mortality. Whilst this is encouraging, the numbers are small and future quarters data will need to be reviewed.

Two stillbirths related to antepartum haemorrhage, one of these was an unbooked pregnancy in a woman of Asian Bangladeshi origin who did not speak English as her first language. Translation services were used appropriately.

Of note, there was a case of stillbirth of a 14-year-old girl who received antenatal care in LWH, but had presented septic and managed in another trust. She sadly experienced a stillbirth at 28 weeks in Alder Hey Hospital. This case is planned to be a region wide review coordinated by ICB due to the issue of non-colocation nature of the maternity services in Liverpool.

2.1 Learning from Stillbirth and PMRT reviews Q4 22/23 2022-23 N=11

All eligible cases (Stillbirths > 22 weeks but excluding ToPs) underwent a full multidisciplinary team PMRT review with external clinician presence. Care from across the antenatal and intrapartum period was subject to clinical and managerial scrutiny. All bereaved parents were invited to be involved in the review process by submitting comments and questions via the Honeysuckle Team for discussion at the MDT Review.

The reviews of Q4 22/23 stillbirths (n=5) identified that 2 (40%) cases had no antenatal care issues identified and 3 (60%) had care issues identified which would not have changed the outcome of the pregnancy. The postnatal care in all cases (5/5, 100%) was graded B, including arranging stillbirth investigations, including genetic tests, which remains a recurrent issue. The team has met to discuss an action to address this, building this into the training of honeysuckle support champions.

Grade	Care in antenatal period	Percentage (%)	Care provided after Stillbirth	Percentage (%)
A	2	40	0	0
B	3	60	5	100
C	0	0	0	0
D	0	0	0	0

Table 3 PMRT review panel grading of care provided in cases of Stillbirth (N=5)

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

3. Neonatal Mortality

3.1 Neonatal mortality Data Q1 2022/23

Neonatal deaths can be reported in several ways. The population can include in-born babies only, LWH booked pregnancies or all babies cared for in LWH (including babies transferred to LWH from other care providers). Deaths may be those within 28 days (reported in MBRRACE), those occurring prior to discharge from the NICU and those who die following transfer to another hospital. The population examined may be defined by weight and/or gestational age. The data may include or exclude babies with congenital anomalies. Due to the complexities of measuring neonatal mortality, a board development session is taking place in September 23 to educate and update around neonatal mortality.

The table below presents the total number of deaths at LWH, the mortality for babies born at LWH, the number of deaths eligible to report to MBRRACE and the number of deaths of inborn babies born at between 24 to 31+6 weeks gestational age. This last group is reported national by the national neonatal audit project and monitored locally by the ODN. The benchmark of 6.3% is locally derived bu thte ODN. The threshold was the overall mortality in the UK between 2015 – 2018 for the population of 24 – 31+6 week babies. As LWH receives IUTs of (higher risk) preterm mortality it is unlikely that our mortality would be below the average for the whole population. This issue is being discussed with the ODN to identify a more suitable benchmark.

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	March-24	Total
Births	**613**	**599**	**554**										**1766**
Total mortality on NICU	3	1	6										**10**
INBORN Neonatal Mortality (all live births)	2	1	9*										**12**
INBORN Neonatal Mortality Rate/1000LB	3.2	1.7	10.8										**6.8**
MBRRACE eligible deaths *Excl. cong anom*	*0* *0*	*1* *1*	*3* *2*										*4*
Benchmark: MBRRACE data 2021 ***3.36/1000LBs*** ***(excl. cong anom) 1.44/1000LBs***	 *0* *0*	 *1.7* *1.7*	 *5.4* *3.6*										 ***2.3*** ***1.7***
NWNODN benchmark 24-31 w	*0*	*1*	*2*										*3*
Benchmark % (NNAP >6.3% of admissions)	*0*	*5.3*	*14.2*										*7.1*
NWNODN benchmark 24-27 w	*0*	*1*	*1*										*2*
Benchmark (NNAP >15%	*0*	*20*	*50*										*18.2*

**2 deaths in AHCH, 1 from surgical congenital anomaly, 1 from NEC; 1 death in YGC after re-patriation*

Table 4: NICU Mortality by month for the past 12 months. Red indicates breaching the NWODN threshold. This threshold however is being challenged as not appropriate for level 3 NICUs.

Quarter	NMR *in born*
Q1 (23_24)	6.8
Q2 (23_24)	
Q3 (23_24)	
Q4 (23_24)	

Table 5: Neonatal Mortality Rate per quarter.

In this quarter there was a total of 10 deaths on the NICU. There were 12 babies who were born at LWH who died before discharge – 2 deaths occurred in Alder Hey Hospital and 1 at Ysbyty Glan Clwyd.

There were 3 deaths in the preterm population (24 to 31+6 weeks). This resulted in a 7.1% mortality figure. The benchmark figure of 6.3% is derived from the overall mortality in this population nationally, however as LWH receives the majority of extreme preterm babies from Cheshire and Merseyside, the mortality in our inborn population would be expected to be higher than the national average. The use of this benchmark is being discussed with the ODN.

3.3. Learning from neonatal mortality reviews for Q4 22/23

There were 13 deaths subject to a PMRT review. There were no cases identified with care issues which were likely to have made a difference to the outcome.

There was 1 case (8%) where issues were identified in the antenatal care that may have affected the outcome. This was related to the escalation the timeliness of removal of a cervical suture. This case is being investigated through a maternity SI.

There were 4 cases (31%) where issues were identified in the neonatal care that may have affected the outcome. These issues were:

- In one case there was a delay in performing a chest x-ray due to lack of 24/7 radiographer provision. This has been escalated as a safety issue with executive approval for the on-site radiography cover to commence in Q2/3 2023/24.
- Non-colocation with surgical services and transfer between alder hey and Liverpool women's Hospital

- A femoral vessel bleed following an attempt at femoral line insertion. A serious incident review of this case has been concluded with an action plan developed.
- A delay in the management of hypotension and metabolic acidosis.

3.4 Update regarding mortality action plans.

The updated action plans from the Birmingham Women's Hospital review of mortality and the NWODN review of mortality are included in thois paper. The actions from the Birmingham Women's Hospital review were superseded by those from the ODN.

The Birmingham Women's action plan is complete. The NWODN action plan is complete or in progress and on track for completion. Of note, there has been recent approval to proceed with the 24/7 radiology cover for the LWH site. There remains the issue of non-colocation with neonatal surgical services. The planned opening for the neonatal intensive care unit at Alder Hey children's Hospital is January 2025.

The NWODN action plan is currently monitored through the neonatal integrated governance meeting and the LNP board.

4. Impact of In-utero transfers (IUTs) (see Appendix for report)

For this paper, in-utero transfers includes all women who originally booked their pregnancy elsewhere, but then delivered at LWH. This will include women who transfer their pregnancy following an antenatal diagnosis of congenital anomaly who will have a high mortality associated with them, as well as extreme preterm infants who require level 3 neonatal intensive care.

The previous external review of mortality by the NWODN highlighted that LWH received over 3.5x the number of IUTs than St Mary's Hospital, Manchester (134 vs 38 between 2019 - 2021). The reasons for this discrepancy are unclear and this has been raised with the NWODN to investigate further.

The data related to the two populations of babies IUT vs non-IUT is below.

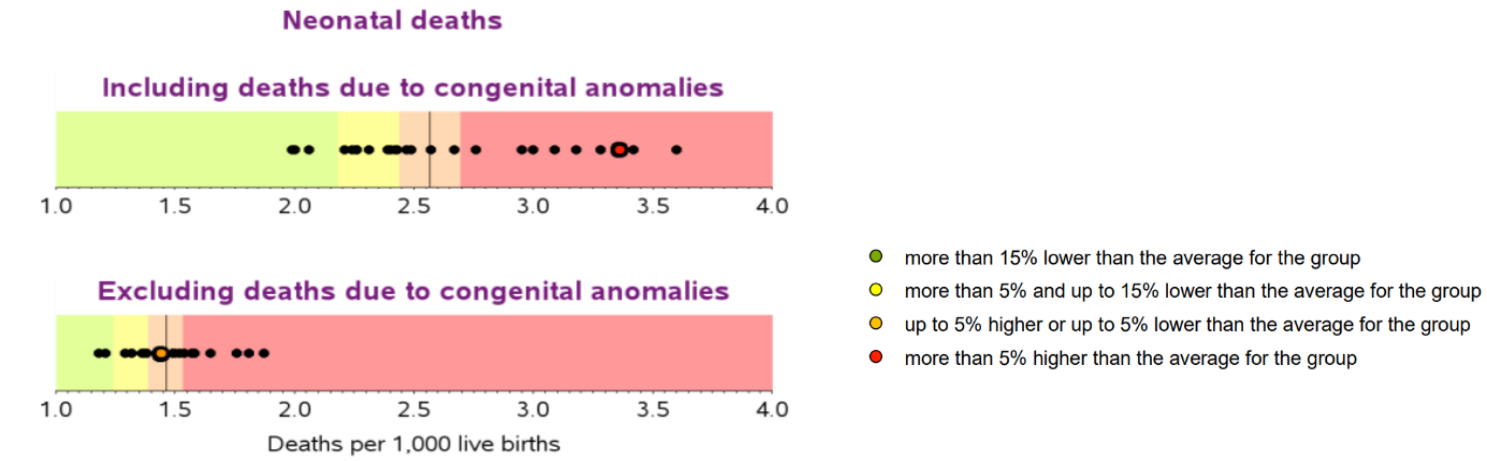
	Non-IUT admissions N=1965	IUT admissions N=295	Non-IUT mortality N=29	IUT mortality N= 26	Non-IUT mortality %	IUT Mortality %
Gestation	Range 22-42 w Median 37w	Range 22-41w Median 35 w	Range 22-41w Median 27w	22-40w Median 26w		
Female	877	124	7	8		
Male	1088	171	22	18		
<1500 g	144	98	26	15	18.1	15.3
<1000g	49	70	22	14	44.9	20
<750 g	24	29	15	11	62.5	37.9
<500g	2	2	2	2	100	100
22-23w	16	4	9	4	56.3	100
24-27w	40	61	15	10	37.5	16.4
28-31w	127	29	2	1	1.6	3.4
32-36w	694	69	2	5	0.3	7.2
>37w	1089	132	1	6	0.1	4.5
ALL					**1.5%**	**8.8%**

These data highlight the following:

- Over a 2-year period (2021 – 2023), IUTs accounted for nearly half (26/55, 47%) of all deaths at LWH.
- IUTs were 6x more likely to die than non-IUTs (1.5% vs 8.8%).
- The excess mortality is seen in the more mature infants (> 28 weeks) related to the presence of congenital anomalies.
- 37% (14/38) of the deaths in preterm infants (22 to 27 weeks) occurred in the IUT population.
- The mortality for the IUT population in this extremely preterm group was 22% (14/65) and in the non-IUT population was 43%.

In summary, the excess mortality for IUTs is mainly seen in the more mature infants related to the presence of congenital anomalies. This is to be expected as LWH is a tertiary/quaternary referral centre. Discussions with the NWODN and LMS are ongoing regarding the referral pathways into the fetal medicine unit as there are discrepancies between the planned pathways and the actual pathways followed from some referral centres outside of the Cheshire and Mersey network.

These data help to explain the MBRRACE data that shows LWH as an outlier for deaths overall, but not once congenital anomalies are removed. In other words, the overall mortality is high because we accept a large number of IUTs into our service who have congenital anomalies.



The IUTs do not explain the mortality seen in the extremely preterm population that benchmarks higher than the UK average.

On reviewing the grading of antenatal care related to IUTs there were care issues identified which may have made a difference to the outcome for the baby in 2/27 (7%) non-IUT and 3/21 (14%) IUTs. We have therefore not identified a difference in AN care gradings however these numbers are too small to make any meaningful interpretation.

5. Retrospective Review of Learning from Deaths reports since Q3 21/22

Given this learning from deaths paper has identified non co-location with acute services in 5 deaths/stillbirths, a retrospective review of the learning from Death papers since Q3 21/22 (when the current report author commenced writing the reports) was conducted. This identified there was 1 further death of a neonate in Q3 22/23 where non-colocation with paediatric services was deemed to be contributory to the death. (see table below).

	Q3 21/22	Q4 21/22	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23	Q1 23/24
Adult Deaths	0	2	2	2	0	1	1
Adult deaths where non-colocation idenitifed in the learning	0	0	0	2	0	1	
Stillbirths (excl TOP)	10	9	10	7	8	4	3
Stillbirths non-colocation	0	0	0	0	0	0	
Neonatal Deaths (total)	11	13	13	17	16	17	
Neonatal Deaths where non-colocation idenitifed in the learning	0	0	0	0	1	1	

6. Recommendations

It is requested that the members of the Board review the contents of the paper and take assurance that there are adequate governance processes in place when learning from deaths.

Given the paper identifies several deaths related to non- co-location of maternity and adult/paediatric acute services, the Board is asked to note the following for assurance:

1. The last 18 months learning from deaths papers have been reviewed to identify deaths which may have been contributed to by non-colocation.
2. A retrospective review of gynaecology Sis identified 2 deaths. In neither was non-colocation identified as learning however in one case the woman was transferred to another hospital for ongoing care as this care was unable to be provided on the LWH site.

It is recommended:

1. There is a wide-ranging review of the IUT pathways and discussion with the NWODN and LMNS regarding the discrepancies seen across the system and why LWH receives 3.5X the IUTs than other similar local providers.
2. Consideration from the Trust Board regarding where the learning from deaths information relating to learning from non-colocation is shared.

In addition, as per The Learning from Deaths framework requirements the Board is requested to note:

- number of deaths in our care
- number of deaths subject to case record review
- number of deaths investigated under the Serious Incident framework
- number of deaths that were reviewed/investigated and as a result considered due to problems in care
- themes and issues identified from review and investigation
- actions taken in response, actions planned and an assessment of the impact of actions taken.
- the care issues identified in the antenatal management from referring trusts. It is recommended that a review of antenatal care findings from the previous PMRT reviews is undertaken and if any common themes identified that this is presented to the local maternity system

3. Appendices

NHS
North West Coast
Clinical Networks

Cheshire and Mersey Maternity Provider Standardised Quarterly Perinatal Board Report
– Q1 (April – June 2023)

Contents

PROVIDER:	LIVERPOOL WOMEN'S HOSPITAL
COMPLETED BY:	AI-WEI TANG
DATE COMPLETED:	AUGUST 2023

1. EXECUTIVE SUMMARY:

a. There were 3 stillbirths, excluding terminations of pregnancy (TOP), in the 1st Quartile (Jan – March 2023) of 2022/2023. This results to an adjusted stillbirth rate of 1.7/1000 for this Quartile.

b. In this quartile, there were 3 pregnancy losses (excluding TOP) born between 22-24 weeks gestation.

c. All stillbirths in Q4 of 2022/23 (N=4) have been subject to a full multidisciplinary review panel meeting utilising the PMRT tool with external clinician presence.

d. All bereaved parents were invited to be involved in the review process by submitting comments and questions via the Honeysuckle Team for discussion at the MDT Review. 2 families in Q4 submitted questions and comments which were discussed by the MDT panel.

e. The MDT reviews of 4 Stillbirths and 1 pregnancy loss in Q4 have found no antenatal care issues identified in 2 cases, and care graded B (*care issues identified which would have made no difference to the outcome of the pregnancy*) in 3 cases, in accordance with the MBBRACE Grading system.. Postnatal care were graded B in all cases, with a recurrent theme of incomplete stillbirth investigations.

f. There has been no Grade C or D (*care issues identified which may have, or were likely to have made a difference to the outcome of the pregnancy*) in the review of any cases.

NHS
North West Coast
Clinical Networks

2. DASHBOARD AND BENCHMARKING

Table. 1 Stillbirths (>24 weeks) dashboard for 2023/24

STILLBIRTHS	July-22	Aug-22	Sept-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-22	May -22	June-22	TOTAL 2023/24
Total Stillbirths	7	3	3	2	2	6	2	4	1	5	4	10	19
Stillbirths (excluding TOP)	**3**	**3**	**1**	**1**	**2**	**5**	**1**	**3**	**0**	**0**	**2**	**1**	**3**
Births	645	659	656	649	596	619	630	519	613	613	599	554	1766
Overall Rate /1000	10.9	4.6	3.0	4.7	6.7	9.7	3.2	7.7	1.6	8.2	6.7	18.1	10.8
Rate (excluding TOP)/1000	**4.7**	**4.6**	**1.5**	**1.6**	**3.4**	**8.1**	**1.6**	**5.8**	**0**	**0**	**3.3**	**1.8**	**1.7**
Pregnancy loss 22-24 weeks (excluding TOP)	0	0	1	1	1	1	1	0	0	1		2 (twins)	3

Table 2: Stillbirths (excluding terminations)

Quarter	Rate 2019/20	Rate 2020/21	Rate 2021/22	Rate 2022/23	Rate 2022/23
Q1	4.0	5.5	4.0	3.7	1.7
Q2	4.1	2.5	5.3	3.6	
Q3	1.5	2.7	5.1	4.3	
Q4	1.7	3.2	5.0	2.3	
ANNUAL	2.9	3.4	4.9	3.5	

Table 3: Stillbirth (>24 weeks) by Cause (Q4, 2022/23)

Reported cause of death (based on CESDI 2018)	No.	Transferred care for delivery in LWH
Termination of pregnancy for fetal abnormality	3	
Fetal/chromosomal abnormality	0	
Pre-eclampsia	0	
Antepartum haemorrhage (abruption)	2 (1x vasa praevia)	1
Medical disorder	0	
Multiple pregnancy	0	
SGA (<10th centile)	1	
Mechanical	1	
Infection	0	
Specific placental condition	0	
Unclassified	0	

In Q4, there was 1 pregnancy losses between 22-24 weeks, reviewed through the PMRT process, and the cause of death was:

- Fetal growth restriction with placental insufficiency

3. MORTALITY REVIEWS AND KEY THEMES (Q4 cases, including 1x pregnancy loss 22-24 weeks)

Table 4. PMRT review panel grading of care provided in cases of Stillbirth (N=5)

Grade	Care in antenatal period	Percentage (%)	Care provided after Stillbirth	Percentage (%)
A	2	40	0	0
B	3	60	5	100
C	0	0	0	0
D	0	0	0	0

Table 5. Reasons for review panel grading B,C&D

Antenatal Care

Review panel grading	Reason for grading	Level of investigation (StEIS/Level 2/PMRT with external)	HSIB (yes/no)	Learning	Actions / QI plan aligned to theme
B	Communication issue at diagnosis of SB	PMRT	No	Improved communication at breaking bad news	'The deafening silence' educational video on communication at bereavement shared with imaging department
B	No USS imaged saved in MAU	PMRT	No	Importance of USS images to be stored as is a form of documentation	LOTW and learning shared through MAU on saving all MAU scans on PACS, with a laminated step-by-step guide on saving images
B	Unawareness of readmission of patient	PMRT/Formal review	No		Learning shared within MAU and poster on door to remind staff not to allow any patients through to DS from MAU

Postnatal/Bereavement Care

Review panel grading	Reason for grading	Level of investigation (StEIS/Level 2/Level 1/PMRT with external)	HSIB (yes/no)	Learning	Action / QI plan aligned to theme
B	Lack of complete Stillbirth Investigations performed (recurrent)	PMRT	No	Understand the importance of the need to perform SB investigations in trying to identify a cause	Developed a pictogram with all the investigations required and sampling blood bottles required
B	Unattended birth as one to one care not provided	PMRT	No	Need for regular review of service to aim provide one to one care for all pregnancy loss	NA for PMRT Ongoing review of midwifery staffing at trust level
B	Prolonged 3rd stage	PMRT	No	Provision of ability to open 2nd theatre out of hours	Reminder on ability to open 2nd theatre out of hours shared in maternity risk clinical meeting

a. PMRT PANEL ATTENDANCE and PARENTAL ENGAGEMENT

There was the presence of at least an external Obstetrician or Midwife in the PMRT reviews of all 5 cases of Q4 reviewed

4. INTRAPARTUM & TERM STILLBIRTHS (Q1 cases)

There were no intrapartum or term stillbirths in the 1st Quartile of 2023/24

5. SAFEGUARDING/UNBOOKED AND LATE BOOKERS (Q1 cases)

In Q1, there were no cases of ongoing safeguarding concerns.

There was one woman of Asian Bangladeshi ethnicity who did not book her pregnancy. She had a history of mental health problems that had just moved to Liverpool, and she had appropriate care after admission to the hospital.

There was also a case of stillbirth of a 14 year old girl who received antenatal care in LWH, but had presented septic and managed in another trust, and sadly experienced a stillbirth at 28 weeks, and delivered in the other trust. This case is planned to be a

region wide review coordinated by ICB due to the issue of non-colocation nature of the maternity services in Liverpool

6. SOCIO-DEMOGRAPHICAL (Q1 cases)

Gestational age at delivery of Stillbirths and pregnancy loss 22-24 weeks gestation

Gestation at Stillbirth	Number (N=6)
<24 weeks	3
<28 weeks	0
28-31 weeks	2
32-36 weeks	1
> 37 weeks	0

All these women did not smoke in pregnancy, and the IMD score for residential addresses were evenly distributed in this quartile.

7. LANGUAGE BARRIERS (Q1 cases)

In this quartile, there was one woman of Asian Bangladeshi ethnicity and did not speak English as her first language. She was the same woman who did not book her pregnancy, but this was not related to any language barrier. Language line was used appropriately from admission.

8. SMALL FOR GESTATIONAL AGE (Q1 >24 weeks, N=4)

There were 2 cases of FGR associated with placental insufficiency. One was a diagnosed FGR which was monitored, while the other experienced pregnancy loss at 23 weeks, before the initiation of any scans.

9. FETAL ABNORMALITIES DEATHS (known and unknown)

In Q1 of 2023/24, there were no congenital anomalies diagnosed antenatally or after birth.

10. LEARNING FROM DEATHS from Q4 of 2022/23

Areas for learning in the antenatal period are as summarised in Table 5 in the report, and all the actions have been completed, as described below.

In the care provided after delivery, areas of learning remains:

- Arranging stillbirth investigations in the PN period, including genetic tests, which remains a recurrent issue, and the team has met to discuss an action to address this, building this into the training of honeysuckle support champions.

11. LEARNING / GOOD PRACTICE / COMPLETED ACTIONS

Completed actions and recommendations from the last quarterly report include:

- Computerised DR CTG guideline completed and ratified
- Agreement with FMU and LOTW shared on the need to have complete fetal assessments for all reviews in FMU
- Ability to have 2 theatres open at night
- 'The deafening silence' educational video on communication at bereavement shared with imaging department
- LOTW and learning shared through MAU on saving all MAU scans on PACS, with a laminated step-by-step guide on saving images
- Learning shared within MAU and poster on door to remind staff not to allow any patients through to DS from MAU

Ongoing actions that are in progress, and discussed in various working groups include:

- Capacity and demand review of services in FMU, including appointment waiting times for general clinic and specialised joint neonatal, FMU and Alder Hey services clinic; and addressing of MW staffing issues to ensure one-to-one care in DS

- Plan for recommencement of simulation training, to including Major Obstetric Haemorrhage

- Training of bereavement support champions to provide additional support to Honeysuckle team, and also ensure stillbirth investigations, including genetic tests have been appropriately requested for.

12. Benchmarking and CNST Compliance

As part of intelligence gathering the following sources were used for horizon scanning:
CQC, NCEPOD,NHS Digital, NHSE/I (includes LMS), NHSR, PHE, RCOG, RCM, MBRRACE-UK, HSIB, Ockenden, CNST Maternity Incentive Scheme

The CNST MIS for this year has completed, and we have submitted evidence that we were compliant with all elements of it. The criteria for the coming year has been released (30/5/23 to 7/12/23), and we will continue to ensure compliance.

NHS
North West Coast
Clinical Networks

CNST compliance for Year 4 (from 30th May 2023 to current, 31/8/23)

Parameters	No. Cases	Completed (Percentage)
Reported to MBBRACE (7 days) – 100%	8	8 (100%)
PMRT MDT review started (2 months) – 95%	8	8 (100%)
PMRT report in Draft (4 months) – 50%	None due yet (1st due 6/10/23)	
PMRT report Published (6 months) – 50%	None due	
Parents informed of review – 95%	8	8 (100%)

NHS
North West Coast
Clinical Networks

Cheshire and Mersey Maternity Provider Standardised Quarterly Perinatal Board Report Template

(includes Perinatal Mortality Review Tool summary – see Appendix)

REPORT ALL DEATHS IN THAT QUARTER NOT THE REVIEWS COMPLETED IN THAT QUARTER

Contents

PROVIDER:	**LWH**
COMPLETED BY:	**DR REBECCA KETTLE**
DATE COMPLETED:	**30TH AUGUST 2023**

NHS
North West Coast
Clinical Networks

1. EXECUTIVE SUMMARY: Key findings section at the start of report to include

a. Quarter 1 neonatal mortality rate is 6.8 /1000 LB for inborn births
b. There were 9 grade C ‘s from Q4 reviews (2 antenatal, 3 neonatal, 3 bereavement)
c. There were 0 grade D for Q1

NHS
North West Coast
Clinical Networks

2. DASHBOARD AND BENCHMARKING

Table. 1 Neonatal mortality dashboard

	Apr-23	*May-23*	*Jun-23*	*Jul-23*	*Aug-23*	*Sep-23*	*Oct-23*	*Nov-23*	*Dec-23*	*Jan-24*	*Feb-24*	*March-24*	*Total*
Births	**613**	**599**	**554**										**1766**
Total mortality on NICU	3	1	6										**10**
INBORN Neonatal Mortality (all live births)	2	1	9*										**12**
INBORN Neonatal Mortality Rate/1000LB	3.2	1.7	10.8										**6.8**
MBRRACE eligible deaths *Excl. cong anom*	*0* *0*	*1* *1*	*3* *2*										*4*
Benchmark: MBRRACE data 2021 ***3.36/1000LBs*** ***(excl. cong anom) 1.44/1000LBs***	*0* *0*	*1.7* *1.7*	*5.4* *3.6*										***2.3*** ***1.7***
NWNODN benchmark 24-31 w	*0*	*1*	*2*										*3*
Benchmark (NNAP >6.3% of admissions)	*0*	*5.3*	*14.2*										*7.1*
NWNODN benchmark 24-27 w	*0*	*1*	*1*										*2*
Benchmark (NNAP >15%	*0*	*20*	*50*										*18.2*

**2 deaths in AHCH, 1 from surgical congenital anomaly, 1 from NEC; 1 death in YGC after re-patriation*

Table 2: Neonatal Death Rate per quarter

Quarter	NMR *in born*
Q1 (23_24)	6.8
Q2 (23_24)	
Q3 (23_24)	
Q4 (23_24)	

Table 3: Neonatal Mortality by MCCD A. cause Q1 23_24

Reported cause of death (based on CESDI 2018)	No.	IUT / PNT	Other information
Prematurity	6	2 IUT	4 babies 22 weeks gestation
Respiratory			
Congenital malformation	1		Osteogenesis imperfecta
Neurological	1	PNT	HIE
Abdominal			
Renal	1		Acute renal failure in extreme prem
Other	1		Coroners case – pending conclusion

3. MORTALITY REVIEWS AND KEY THEMES

Table 4.1. PMRT review panel grading of care provided in cases of Neonatal Death Q4 (22_23)

PMRT grading	Care provided to the mother up to the point that the baby was confirmed as having died	Care provided to the baby up to the point that the baby was confirmed as having died	Care provided to the mother following confirmation of the death of her baby
PMRT grade A	7	3	8
PMRT grade B	3	6	2
PMRT grade C	2	4	3
PMRT grade D	0	0	0
Total cases	12*	13	13

**1 AN care not fully graded as no representation from local DGH*

Babies who transfer to AH for ongoing care are also reviewed through the PMRT process up to the point of transfer of care, these are not included in the above table. These review findings feed into the AH HMRG meeting.

Table 5. Reasons for review panel grading C&D

(Neonatal PMRT may involve multiple service providers; learning for LWH only included in this report)

Review panel grading	Antenatal / Intrapartum Neonatal Bereavement	Reason for grading	Level of investigation(StEIS/ Level 2/Level 1/PMRT with external)	HSIB (yes/ no)	Learning	Actions / QI plan aligned to theme
C	Antenatal / intrapartum	Delay in cervical suture removal	StEIS	No	See maternity SI	
B	Antenatal / intrapartum	Communication between teams in theatre	PMRT with external	No	Team feedback	
C	Neonatal	Delay in CXR and identification of tension pneumothorax	PMRT with external	No	Trust working towards resident radiographer cover	
C	Neonatal	Critical femoral vessel bleed after attempted femoral line insertion	StEIS	No	See SI report for full action plan and learning	Difficult IV access guideline development
C	Neonatal	Non co-location with paediatric surgical services	PMRT with external	No	Regular reviews and discussions	

		Repatriation within 48 hours of operation associated with significant clinical deterioration			between PICU / NICU regarding timing of repatriation	
C	Neonatal	Delay in management of metabolic acidosis and hypotension	Formal review pending	No	Specific learning pending further review	
B	Neonatal	Unplanned extubation / ventilation failure during re-orientation	PMRT with external	No	Equipment being checked and back up options explored	UE QI not designed for this scenario (baby passed between family members during family time in honeysuckle room)
B	Neonatal	IV fluids / PN / Abx not given within 1 hour of birth	PMRT with external	No	Extreme preterm pathway under review to optimise these goals	Golden hour QI and extreme preterm pathway
B	Neonatal	IV fluids / PN / Abx not given within 1 hour of birth	PMRT with external	No	Extreme preterm pathway under review to optimise these goals	Golden hour QI and extreme preterm pathway
B	Neonatal	Delay in PN commencing after admission	PMRT with external	No	Extreme preterm pathway under review to optimise these goals	Golden hour QI and extreme preterm pathway
B	Neonatal	Unplanned extubation / bicarb extravasation / UVC dislodgement	PMRT with external	No	UE – ongoing monitoring Sodium bicarb – incident under review UVC dislodgement – new fixation being brought in	UE QI

B	Neonatal	Consideration of non-escalation / ceiling of	PMRT with external	No	Extreme preterm pathway – away discussions and joint obs meeting for approach to peri viable gestations	Extreme preterm pathway development

a. PMRT PANEL ATTENDANCE

4 MDT Neonatal PMRT panels held for Q3 babies, all had at least 1 external representative. All meetings had an external neonatologist,1 of the 4 meetings had an obstetric, midwife and neonatal external panel member, 2 meetings had an external neonatologist and midwife and 1 meeting had an external obstetrician and neonatologist.

Panel meeting	External Neonatologist	External Obstetrician	External Midwife
April	✓		✓
May	✓		✓
May	✓	✓	✓
June	✓	✓	✓
July	✓	✓	✓

4. TERM NEONATAL DEATHS (in-hospital deaths – for Level 3 units add deaths in Alder Hey)

There was 1 term in born neonatal death and 1 death in AHCH in Q1. The inborn death was a baby with osteogenesis imperfecta, a congenital anomaly associated with neonatal mortality, the death in AHCH was also due to a congenital anomaly, exomphalos major. There was also 1 term neonatal death on NICU following post-natal transfer with hypoxic ischaemic encephalopathy (HIE).

5. SAFEGUARDING/UNBOOKED AND LATE BOOKERS

0 babies who died in the neonatal period during Q1 were born to women who had safeguarding issues identified. No late bookers or unbooked pregnancies.

6. SOCIO-DEMOGRAPHICAL

9/13 babies were extremely premature (<28 weeks), 5 of those babies were born at 22 weeks gestation.

Ethnicity data available shows 11 / 13 babies born to mothers of white -british background, 1 Asian and 1 Indian.

Age of death for the 13 babies ranged from 0-69 days, 9/13 were within 28 days of life and died prior to discharge from hospital, 4 of which were <72 hours of age. 12 / 13 deaths were within 44 weeks CGA.

Of the 3 deaths in Q1 live in the lowest decile index of multiple deprivation according to booking postcode. 1 is in the second lowest decile, 6 were in 5th or greater decile, IMD data was not available for 3 postcodes.

7. LANGUAGE BARRIERS

All families spoke English and did not require interpretation.

8. FETAL ABNORMALITIES DEATHS (known and unknown)

2 deaths were from congenital anomalies including osteogenesis imperfecta and exomphalos major.

9. LEARNING / GOOD PRACTICE.

Below are comments received from families through the PMRT parent feedback process.

FAMILY 1:

Care after birth:

Faultless.

Care, compassion, & kindness from all professions helped us beyond words at the saddest time of our lives.

FAMILY 2:

Any aspects of your care that were most supportive:

Everyone in the women's were really helpful and supportive from delivery right up to neonatal and the honeysuckle team.

Staff were caring throughout and the doctors and nurses on the neonatal and honeysuckle team done an amazing job.

FAMILY 3:

The care I received at Liverpool Women's Hospital was excellent. In every department, fetal medicine, Induction ward, delivery suite and the neonatal unit. I felt completely safe and felt that [redacted] received the best care.

Neonatal Mortality – IUTs

Introduction

LWH is a tertiary level surgical neonatal intensive care unit (NICU), as such we look after babies not just of our local population but also from the wider region when the mother is transferred to LWH as the baby is known or anticipated to need NICU level care after birth, these are referred to as in utero transfers (IUTs).

This group of babies are often high risk for mortality, the women have been transferred to a place where higher level neonatal care is available when the baby is born, either due to extreme prematurity or known congenital anomalies. This paper will detail the proportion and characteristics of babies born following IUT within the LWH neonatal mortality in addition following case review the grading of care associated with those cases.

Data: 2 years *01.04.2021-31.03.2023 (Inborn admissions only)*

	Non-IUT admissions N=1965	IUT admissions N=295	Non-IUT mortality N=29	IUT mortality N= 26	Non-IUT mortality %	IUT Mortality %
Gestation	Range 22-42 w Median 37w	Range 22-41w Median 35 w	Range 22-41w Median 27w	22-40w Median 26w		
Female	877	124	7	8		
Male	1088	171	22	18		
<1500 g	144	98	26	15	18.1	15.3
<1000g	49	70	22	14	44.9	20
<750 g	24	29	15	11	62.5	37.9
<500g	2	2	2	2	100	100
22-23w	16	4	9	4	56.3	100
24-27w	40	61	15	10	37.5	16.4
28-31w	127	29	2	1	1.6	3.4
32-36w	694	69	2	5	0.3	7.2
>37w	1089	132	1	6	0.1	4.5
ALL					**1.5%**	**8.8%**

As would be expected the majority of IUTs are for extreme prematurity, notably 60% of our 24-27w admissions are following an IUT for level NICU care. Whilst IUTs account for more than half of the 24-27w admissions we have not seen a higher proportion of deaths in this group, overall the mortality rate for 24-27w admissions is 25% for the last 2 years, the IUT subgroup mortality rate is just 16%. There is a higher mortality rate in the term and near term IUT subgroup compared to the overall mortality rate but these IUT mortalities are all related to congenital anomalies and have been transferred for that reason so the IUT admissions and mortalities in term and near term babies represent a high risk selected group of babies.

Of the 295 IUTs to LWH between April 2021 and March 2023, 203 were from within in the Northwest Neonatal Operational Delivery Network (NWNODN), 148 from the Cheshire and Mersey locality. 92 (31%) of the IUTs were from outside the NWNODN.

Mortality by cause

	Non-IUT	IUT
Extreme prematurity (<28 w)	24	14
Congenital anomaly	4	10
Congenital surgical anomaly	*2*	*4*
Congenital cardiac anomaly	*1*	*1*
Other congenital anomaly	*1*	*5*
Other	1 HIE	1 severe IUGR
Total	**29**	**26**

The table above displays that in both LWH booked pregnancies and IUTs to LWH the majority of the deaths in both groups relate to extreme prematurity and / or complications associated with extreme prematurity. Of the 14 deaths related to congenital anomalies of all causes only 4 were related to pregnancies booked at LWH, 10 (70%) were babies born following IUT of women whose pregnancies was booked elsewhere.

PMRT Grading of care *(inborn only)*

Of the 55 in born deaths, 54 cases have been reviewed through the PMRT process to date, 52 are detailed in the table below excluding the 2 unbooked pregnancies in this time. Below is a breakdown of the grading. The reviews were done jointly with other care provider representatives included in the panel meetings.

	Care provided to the mother up to the birth of the baby		**Care provided to the baby up to the point the baby is confirmed to have died**		**Care provided to the mother following confirmation of the death of her baby**	
	Non-IUT	***IUT***	*Non-IUT*	*IUT*	*Non-IUT*	*IUT*
Grade A *-no care issues identified*	**14**	**18**	5	6	22	19
Grade B *-care issues identified that would not have made a difference to the outcome*	**11**	**4**	18	15	2	5
Grade C *-care issues identified that may have made a*	**2**	**3**	4	4	3	1

difference to the outcome						
Grade D *-care issues identified that are likely to have made a difference to the outcome*	**0**	**0**	0	0	0	0

Issues identified in AN care include:

- Grade C - LWH related issues
    - Delay in removal of cervical suture (LWH related)
    - Missed opportunity for antenatal steroids (LWH related)
    - Preterm labour presentation not escalated appropriately
- Grade C – non-LWH related care issues
    - Missed diagnosis of MCDA twins and delay in diagnosis of twin to twin transfusion syndrome
    - Missed opportunity for preterm labour assessment and potential intervention

Whilst the numbers are small, we have not identified a difference in AN care gradings between LWH booked cases and IUT cases <u>which may have made a difference</u> to the outcome for the baby (grade C).

We will continue to conduct joint PMRT reviews of all cases to identify care issues for learning and development across all care providers for a mother and baby. All learning will be shared accordingly.

NWNODN LWH Mortality Report Action Plan July 2022

Jennifer Deeney (JD), Joanne Minford (JM), Rebecca Kettle (RK), Jennifer Vose (JV), Jill Harrison (JMH), Alison Bedford Russell (ABR), Lowri Lloyd Preston (LLP), Richard Hutchinson (RH), Jonathan Hurst (JH), Eleanor Walker (EW), Tim Neal (TN), Nim Subhedar (NS), Balamurugan Palanisami (BP), Sue O'Neill (SON), Fauzia Paize (FP), Julie Kearney (JK), Louise Weaver-Lowe (LWL), Heather Martin (HM), Emma Coombes (EC), Emily Hoyle (EH), Sally Ogden (SO), LNP Senior Leadership Team (SLT) / DE (Debbie Edwards) / SP (Sam Peters) / SK (Siobhan Kelly) VW (Virginia Wallace), AR ?,

	Issue	Action	Lead	Operational Manager	Operational Lead	RAG	Completion date	Update
SERVICE PROVISION	Non co-location of the NICU with paediatric surgery/sub-speciality	- Record on Risk register	JD	Vicky Clarke	JMH/JD/JM/ABR		March 2023	Complete
		- Develop functional clinical care pathways with relevant paediatric sub-specialities	ABR / JM / RK/JV				March 2023 - ongoing	Meetings held with radiology / ID / anaesthetics / general medicine / endocrinology
		- Ensure SLAs are in place with relevant paediatric sub-specialities	JV				March 2023	
		- Ensure SLAs are in place with AHPs	JV				March 2023	Physio, dietician, psychologist SLAs in place
		- Further development of AHP Teams	JD/RK/JD				Dec 2024	1 WTE psychologist appointed to LNP, 0.8 dietician, 0.6 WTE physio, further 0.6 physio appointed, OT and SALT appointed
SERVICE	Radiology	- Record on risk register	JD / ABR / JMH	Ellen Gerrad	Lowri Lloyd		October 2022	Complete

NWNODN LWH Mortality Report Action Plan July 2022

Jennifer Deeney (JD), Joanne Minford (JM), Rebecca Kettle (RK), Jennifer Vose (JV), Jill Harrison (JMH), Alison Bedford Russell (ABR), Lowri Lloyd Preston (LLP), Richard Hutchinson (RH), Jonathan Hurst (JH), Eleanor Walker (EW), Tim Neal (TN), Nim Subhedar (NS), Balamurugan Palanisami (BP), Sue O'Neill (SON), Fauzia Paize (FP), Julie Kearney (JK), Louise Weaver-Lowe (LWL), Heather Martin (HM), Emma Coombes (EC), Emily Hoyle (EH), Sally Ogden (SO), LNP Senior Leadership Team (SLT) / DE (Debbie Edwards) / SP (Sam Peters) / SK (Siobhan Kelly) VW (Virginia Wallace), AR ?,

PROVISION	services not currently meeting the expected standards.	- Review of current provision - Audit OOH response time with off-site radiography - CSS to agree a maximal response time - Explore provision of 24/7 radiographer cover	JD/JV/EG/LLP/JMH JMH / EG/LLP EG/LLP Trust SMT	Vicky Clarke	Preston /Jen Vose		March 2023 December 2023 March 2023 March 2023	CT / MRI on site, not yet available for neonatal access, but in progress On audit forward plan for 23/24 45 minute response time from contacting OOH agreed Awaiting update on progress from Trust SMT / CSS
SERVICE PROVISION	Lack of on-site pathology service and blood bank.	- Record on risk register - Trust are building on-site blood bank facility	JD / ABR / JMH LWH Corporate	Ellen Gerrard Vicky Clarke	Jen Vose/Jill Harrison		October 2022 September 2023	In development as part of Crown Street

NWNODN LWH Mortality Report Action Plan July 2022

Jennifer Deeney (JD), Joanne Minford (JM), Rebecca Kettle (RK), Jennifer Vose (JV), Jill Harrison (JMH), Alison Bedford Russell (ABR), Lowri Lloyd Preston (LLP), Richard Hutchinson (RH), Jonathan Hurst (JH), Eleanor Walker (EW), Tim Neal (TN), Nim Subhedar (NS), Balamurugan Palanisami (BP), Sue O'Neill (SON), Fauzia Paize (FP), Julie Kearney (JK), Louise Weaver-Lowe (LWL), Heather Martin (HM), Emma Coombes (EC), Emily Hoyle (EH), Sally Ogden (SO), LNP Senior Leadership Team (SLT) / DE (Debbie Edwards) / SP (Sam Peters) / SK (Siobhan Kelly) VW (Virginia Wallace), AR ?,

	Delays in processing transfusion and timeliness of sample processessing	- Quality improvement work: timing of samples and clear identification of LWH samples for AHCH lab - Audit blood result turn around time after QI work - QI project on time taken for blood transfusion	BP / RH RH RH				March 2023 March 2023 March 2023	enhancement programme Time to Transfusion Service Evaluation - See appendix 1 See appendix 1
SERVICE PROVISION	Surgical neonatal care not co-located with tertiary neonatal services. Babies having multiple transfers to ensure	- LNP NICU services on AHCH site being developed ahead of new build - To reduce the number of transfers required.	JD / ABR / JM/RK/JV JD/ABR/RK/JV	Vicky Clarke	LNP SLT		January 2025 September 2023	In progress, increased consultant hours at AHCH from Jan 2023, education and simulation programme in development NICU planned to open autumn / Winter 2024

NWNODN LWH Mortality Report Action Plan July 2022

Jennifer Deeney (JD), Joanne Minford (JM), Rebecca Kettle (RK), Jennifer Vose (JV), Jill Harrison (JMH), Alison Bedford Russell (ABR), Lowri Lloyd Preston (LLP), Richard Hutchinson (RH), Jonathan Hurst (JH), Eleanor Walker (EW), Tim Neal (TN), Nim Subhedar (NS), Balamurugan Palanisami (BP), Sue O'Neill (SON), Fauzia Paize (FP), Julie Kearney (JK), Louise Weaver-Lowe (LWL), Heather Martin (HM), Emma Coombes (EC), Emily Hoyle (EH), Sally Ogden (SO), LNP Senior Leadership Team (SLT) / DE (Debbie Edwards) / SP (Sam Peters) / SK (Siobhan Kelly) VW (Virginia Wallace), AR ?,

	appropriate care	- FiCare implementation and accreditation across LNP to help improve family experience	EH					Briefing Paper to Support workforce r Green FiCare accreditation at both LNP sites achieved May 2023
CLINICAL CARE	Late Onset Sepsis antibiotic policy not in line with national neonatal guidance.	- Audit time to antibiotics from decision to treat (<1 hour) - Neonatal infection guideline updated in line with NICE guidance - Education to implement new infection guideline	ABR / EW ABR / TN / AH ID team ABR	JMH	ABR		March 2023 March 2023 April 2022	Poster updated-Feb 2023 1.pptx ABR QI Golden hour 2023.pptx V5 Infection Guideline with Flow charts Jan 2
CLINICAL CARE	The use of femoral arterial and	- Femoral line audit to be discussed at consultant away day	NS	JMH	NS		June 2022	Discussed in consultant away day

NWNODN LWH Mortality Report Action Plan July 2022

Jennifer Deeney (JD), Joanne Minford (JM), Rebecca Kettle (RK), Jennifer Vose (JV), Jill Harrison (JMH), Alison Bedford Russell (ABR), Lowri Lloyd Preston (LLP), Richard Hutchinson (RH), Jonathan Hurst (JH), Eleanor Walker (EW), Tim Neal (TN), Nim Subhedar (NS), Balamurugan Palanisami (BP), Sue O'Neill (SON), Fauzia Paize (FP), Julie Kearney (JK), Louise Weaver-Lowe (LWL), Heather Martin (HM), Emma Coombes (EC), Emily Hoyle (EH), Sally Ogden (SO), LNP Senior Leadership Team (SLT) / DE (Debbie Edwards) / SP (Sam Peters) / SK (Siobhan Kelly) VW (Virginia Wallace), AR ?,

	venous lines and how they are monitored within guidelines.	- All femoral lines injuries to be reported through Ulysses for monitoring	FP / VW				Ongoing reporting occurring	and presented at hospital wide M+M M+M Feb 2021.pptx Femoral Arterial Line Audit report 4 1 2020.
CLINICAL CARE	Education around diagnosis and treatment of metabolic acidosis and blood gas management	- Dedicated metabolic acidosis teaching at ANNP away day - Junior Dr teaching sessions. Presentation added to My-Pediatrics App - Metabolic acidosis guideline to be produced	ABR ABR ABR	JMH/JD/RK	JMH/JD/RK		October 2023 August 2023 May 2022	V4 Management of metabolic Acidosis in
CLINICAL CARE	Use of morphine and midazolam is not always in line with	- Undertake a review of local sedation guidance and ensure the use of morphine and midazolam	FP/JMH/MT	JMH/RK	JV		March 2023	National guidance: NICE NG124 . LWH guideline inline with this.

NWNODN LWH Mortality Report Action Plan July 2022

Jennifer Deeney (JD), Joanne Minford (JM), Rebecca Kettle (RK), Jennifer Vose (JV), Jill Harrison (JMH), Alison Bedford Russell (ABR), Lowri Lloyd Preston (LLP), Richard Hutchinson (RH), Jonathan Hurst (JH), Eleanor Walker (EW), Tim Neal (TN), Nim Subhedar (NS), Balamurugan Palanisami (BP), Sue O'Neill (SON), Fauzia Paize (FP), Julie Kearney (JK), Louise Weaver-Lowe (LWL), Heather Martin (HM), Emma Coombes (EC), Emily Hoyle (EH), Sally Ogden (SO), LNP Senior Leadership Team (SLT) / DE (Debbie Edwards) / SP (Sam Peters) / SK (Siobhan Kelly) VW (Virginia Wallace), AR ?,

	national guidance.	is in line with national guidance. - Audit compliance with neonatal pain and sedation guideline - Review pain and sedation guideline with MDT including nursing, medical and pharmacy team	FP / BP RK / JMH/ SON	JMH/RK			September 2023 September 2023	Audit approved to commence July 2023 – in progress Await audit findings to inform this guideline review and re-write guideline
CLINICAL CARE	Recording of unplanned extubation (UE)	- Ensure unit has mechanism for identifying cases of unplanned extubation and continue quality improvement - Safety message of the week: all UE to be reported to Ulysses - QI project on reducing UE	RK / JH RK/JK LH / RK	JMH/RK	JV		September 2022 October 2022 April 2023	All UE are reported through Ulysses and staff reflections requested to enhance learning Complete UE QI report.docx

NWNODN LWH Mortality Report Action Plan July 2022

Jennifer Deeney (JD), Joanne Minford (JM), Rebecca Kettle (RK), Jennifer Vose (JV), Jill Harrison (JMH), Alison Bedford Russell (ABR), Lowri Lloyd Preston (LLP), Richard Hutchinson (RH), Jonathan Hurst (JH), Eleanor Walker (EW), Tim Neal (TN), Nim Subhedar (NS), Balamurugan Palanisami (BP), Sue O'Neill (SON), Fauzia Paize (FP), Julie Kearney (JK), Louise Weaver-Lowe (LWL), Heather Martin (HM), Emma Coombes (EC), Emily Hoyle (EH), Sally Ogden (SO), LNP Senior Leadership Team (SLT) / DE (Debbie Edwards) / SP (Sam Peters) / SK (Siobhan Kelly) VW (Virginia Wallace), AR ?,

WORKFORCE	Very lean senior neonatal nursing team, with potential gaps in oversight.	- Deputy HON appointed	JD	Vicky Clarke	JD		June 2022	
		- Increasing Matron complement to support education and governance	JD/SON				Apr 23	Additional matron post approved, pending advertisement
		- Matron to be appointed for the LNP AHCH site in addition to LWH Matron	JD/SON				Apr 23	Additional matron post approved, pending advertisement
		- Review of senior cover on nights	JD/SON				Dec 22	Supernumary shift leader on all shifts Do not have the establishment currently to guarantee a band 7 on all shifts

NWNODN LWH Mortality Report Action Plan July 2022

Jennifer Deeney (JD), Joanne Minford (JM), Rebecca Kettle (RK), Jennifer Vose (JV), Jill Harrison (JMH), Alison Bedford Russell (ABR), Lowri Lloyd Preston (LLP), Richard Hutchinson (RH), Jonathan Hurst (JH), Eleanor Walker (EW), Tim Neal (TN), Nim Subhedar (NS), Balamurugan Palanisami (BP), Sue O'Neill (SON), Fauzia Paize (FP), Julie Kearney (JK), Louise Weaver-Lowe (LWL), Heather Martin (HM), Emma Coombes (EC), Emily Hoyle (EH), Sally Ogden (SO), LNP Senior Leadership Team (SLT) / DE (Debbie Edwards) / SP (Sam Peters) / SK (Siobhan Kelly) VW (Virginia Wallace), AR ?,

WORKFORCE	Difficulty in maintaining medical BAPM standards across a non-co-located service	- Review medical staffing to ensure latest BAPM standards are met across both LNP sites. - Review the vulnerabilities of the service due to non-colocation - LWH 24/7 on site consultant presence - Future staffing model for LNP to maintain 24/7 middle grade / ANNP presence at LWH, with on call consultant at AHCH	JMH/ RK/ ABR LNP SMT	Vicky Clarke	JMH/ABR/RK		January 2024 January 2022 December 2024	3.4 Consultant posts for LNP 2 posts to be advertised Sep /Oct 23 Regarding the medical staffing.docx (support from GIRFT chair) ANNP / Clinical fellow post to be re-advertised Sep / Oct 2023 Liverpool Neonatal Consultant Staffing
WORKFORCE	Reduced numbers of	- 2 Band 7 nurse educators appointed	JD	Vicky Clarke	JD		June 2022	

NWNODN LWH Mortality Report Action Plan July 2022

Jennifer Deeney (JD), Joanne Minford (JM), Rebecca Kettle (RK), Jennifer Vose (JV), Jill Harrison (JMH), Alison Bedford Russell (ABR), Lowri Lloyd Preston (LLP), Richard Hutchinson (RH), Jonathan Hurst (JH), Eleanor Walker (EW), Tim Neal (TN), Nim Subhedar (NS), Balamurugan Palanisami (BP), Sue O'Neill (SON), Fauzia Paize (FP), Julie Kearney (JK), Louise Weaver-Lowe (LWL), Heather Martin (HM), Emma Coombes (EC), Emily Hoyle (EH), Sally Ogden (SO), LNP Senior Leadership Team (SLT) / DE (Debbie Edwards) / SP (Sam Peters) / SK (Siobhan Kelly) VW (Virginia Wallace), AR ?,

	quality roles within nursing to support bedside nursing	- 0.8WTE Band 7 Governance nurse lead - 2 Lead ANNPs in QI oversight roles - Bid will be put forward to NCCR for funding to increase quality role support across the LNP	JD JD JD				June 2022 July 2022 Jan 23	
WORKFORCE	Lack of AHPs within the LNP	- 1 WTE psychologist, 1 Dietician and 0.8WTE physio appointed across LNP - Discuss with commissioners regarding funding for an additional pharmacist for LNP across 2 sites, SALT, occupational therapy and neuro-physiotherapy provision	JD JD	LNP SMT	JD		July 2022 January 2024	PT, OT and SLT have been appointed 09/23

NWNODN LWH Mortality Report Action Plan July 2022

Jennifer Deeney (JD), Joanne Minford (JM), Rebecca Kettle (RK), Jennifer Vose (JV), Jill Harrison (JMH), Alison Bedford Russell (ABR), Lowri Lloyd Preston (LLP), Richard Hutchinson (RH), Jonathan Hurst (JH), Eleanor Walker (EW), Tim Neal (TN), Nim Subhedar (NS), Balamurugan Palanisami (BP), Sue O'Neill (SON), Fauzia Paize (FP), Julie Kearney (JK), Louise Weaver-Lowe (LWL), Heather Martin (HM), Emma Coombes (EC), Emily Hoyle (EH), Sally Ogden (SO), LNP Senior Leadership Team (SLT) / DE (Debbie Edwards) / SP (Sam Peters) / SK (Siobhan Kelly) VW (Virginia Wallace), AR ?,

GOVERNANCE	Lack of senor nurse leadership within the governance structures	- Governance structures should be reviewed to understand the benefit of senior nursing/ANNP input - Band 7 governance nurse lead - Band 6 governance secondment - 4 ANNPs in core mortality review group - Appointment of Governance and education Matron to support governance team	JD JD JD RK JD/SON	Vicky Clarke	JD		December 22 June 2022 June 2022 January 2022 April 2023	
GOVERNANCE	Presence of the education team within	- Review governance terms of reference to ensure education teams are included.	JD / RK	JMH/RK/JD	JMH/RK/JD		September 2022	

NWNODN LWH Mortality Report Action Plan July 2022

Jennifer Deeney (JD), Joanne Minford (JM), Rebecca Kettle (RK), Jennifer Vose (JV), Jill Harrison (JMH), Alison Bedford Russell (ABR), Lowri Lloyd Preston (LLP), Richard Hutchinson (RH), Jonathan Hurst (JH), Eleanor Walker (EW), Tim Neal (TN), Nim Subhedar (NS), Balamurugan Palanisami (BP), Sue O'Neill (SON), Fauzia Paize (FP), Julie Kearney (JK), Louise Weaver-Lowe (LWL), Heather Martin (HM), Emma Coombes (EC), Emily Hoyle (EH), Sally Ogden (SO), LNP Senior Leadership Team (SLT) / DE (Debbie Edwards) / SP (Sam Peters) / SK (Siobhan Kelly) VW (Virginia Wallace), AR ?,

	the governance structures.	- Education team to join monthly risk meeting, PMRT meeting, integrated governance meeting - QI ANNPs and education team to co-ordinate educational activities on the unit - Simulation programme to be structured allowing for integration with learning from governance activities	JK/SON EC / DE / SP / SK SO / SP / SK				October 2022 December 2022 April 2023	
GOVERNANCE	Lack of truly external review: reviewer is not always truly external as they have	- Discuss with wider NWNODN regarding external support for PMRT - Use LMNS network to gain a greater range of external representatives	RK RK	Lynn Greenhalgh	JMH		December 2022 August 2022	

NWNODN LWH Mortality Report Action Plan July 2022

Jennifer Deeney (JD), Joanne Minford (JM), Rebecca Kettle (RK), Jennifer Vose (JV), Jill Harrison (JMH), Alison Bedford Russell (ABR), Lowri Lloyd Preston (LLP), Richard Hutchinson (RH), Jonathan Hurst (JH), Eleanor Walker (EW), Tim Neal (TN), Nim Subhedar (NS), Balamurugan Palanisami (BP), Sue O'Neill (SON), Fauzia Paize (FP), Julie Kearney (JK), Louise Weaver-Lowe (LWL), Heather Martin (HM), Emma Coombes (EC), Emily Hoyle (EH), Sally Ogden (SO), LNP Senior Leadership Team (SLT) / DE (Debbie Edwards) / SP (Sam Peters) / SK (Siobhan Kelly) VW (Virginia Wallace), AR ?,

	trained or worked closely with the hospital that they are reviewing yet works in an equivalent setting.	- Discuss with national PMRT team regarding a national network of external representatives for greater variety and range of opinion	RK				December 2022	Not yet a network for this to occur.
NETWORK	Mortality data should continue to be monitored at network level allowing comparison between similar activity units annually.	- NWNODN dashboard to be reviewed quarterly - NWNODN to highlight if LWH continues to be an outlier for mortality - MBRRACE report to be reviewed annually and response provided by LWH	HM / LWL / NS HM / LWL/ NS RK	Lynn Greenhalgh	Rebecca Kettle		Ongoing June 2023 Ongoing	Reviewed through LNP IG meeting Preterm mortality specific section to be included in annual mortality report Annual Neonatal Mortality Report 202 MBRRACE perinatal mortality report on 2

NWNODN LWH Mortality Report Action Plan July 2022

Jennifer Deeney (JD), Joanne Minford (JM), Rebecca Kettle (RK), Jennifer Vose (JV), Jill Harrison (JMH), Alison Bedford Russell (ABR), Lowri Lloyd Preston (LLP), Richard Hutchinson (RH), Jonathan Hurst (JH), Eleanor Walker (EW), Tim Neal (TN), Nim Subhedar (NS), Balamurugan Palanisami (BP), Sue O'Neill (SON), Fauzia Paize (FP), Julie Kearney (JK), Louise Weaver-Lowe (LWL), Heather Martin (HM), Emma Coombes (EC), Emily Hoyle (EH), Sally Ogden (SO), LNP Senior Leadership Team (SLT) / DE (Debbie Edwards) / SP (Sam Peters) / SK (Siobhan Kelly) VW (Virginia Wallace), AR ?,

Action plan relating to external review of LWH mortality by Birmingham Women's Hospital

Action required for completion	By whom?	Target Date/ Completion date	Progress/Evidence	Update	RAG
1. Arrange session to discuss review findings with senior neonatal team.	**Chris Dewhurst**	**Oct 30th 2020**	**Date set for 12th October for senior team to meet and discuss. Further actions may arise from this meeting.**		
2. Review femoral line policy.	**Bill Yoxall and Ben Shaw**	**Oct 30th 2020**	**Femoral line issues have already been identified from recent SIs. The guideline is now updated. Restriction to < 1000g to be included in guideline.**	Peripheral Arterial Cannula.pdf Neonatal Central Venous access guid	
3. Audit use of sodium bicarbonate in extreme premature infants .	**Bala Palanisami**	**Nov 30th 2020**	**To initiate audit proposal by this date**	2020 049 Sodium Bicarbonate Report	
4. Guidance on when to use Na HCO3. A. Review TPN guideline re:sodium bicarbonate indication. B. Review sodium bicarbonate formulary.	**A Prof Morgan B Fauzia Paize**	**Nov 30th 2020**		Sodium Bicarbonate.pdf	

5. Review use of DNRs on the neonatal unit and advice of when these should be initiated. Devleop education package around this.	**Fauzia Paize**	**Nov 30th 2020**			
6. Initiate SI for case 3.3.1	**Chris Dewhurst**	**Sept 30th**	**SI 2020/16403 initiated and review panel on 16th October**	SI Report and Action Plan 2020_16	
7. Audit use of sodium bicarbonate in extreme premature infants	**Bala Palanisami**	**Nov 30th 2020**	**To initiate audit proposal by this date.**	2020 049 Sodium Bicarbonate Report	

BRAG Rating Key:

GREEN = Action Completed

Amber – Active and on track for completion

Red – Active with concerns for achievement or not achieved by target date

Trust Board

COVER SHEET

Agenda Item (Ref)	*23/24/165*		Date: 12/10/2023	
Report Title	Annual Safeguarding Report 2022/23			
Prepared by	***Deborah Ward, Head of Safeguarding***			
Presented by	***Deborah Ward, Head of Safeguarding***			
Key Issues / Messages	To present the Annual Safeguarding Report 2022/23			
Action required	Approve ☒	Receive ☐	Note ☐	Take Assurance ☒
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable):			
	For Decisions - in line with Risk Appetite Statement – Y *If no – please outline the reasons for deviation.*			
	Request that the Board approve the Safeguarding Annual Report ahead of publication. ***Once approved, it is recommended to submit the report to the Liverpool, Sefton and Knowsley Safeguarding Children's Partnerships and the Liverpool, Sefton and Knowsley Safeguarding Adult Boards.***			
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* N/A	Comment:
Link to the Corporate Risk Register (CRR) – CR Number:	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Quality Committee	Jul 23	Chief Nurse	Recommendation for approval by the Board

EXECUTIVE SUMMARY

The Safeguarding Annual Report for Children, Young People and Adults provides an overview of Safeguarding activity within the Trust for the period 1st April 2022 to the 31st March 2023. The intention of the report is to assure our Board of Directors that the Trust has effective systems and processes in place to safeguard those at risk of abuse who access services provided by Liverpool Women's NHS Foundation Trust.

Safeguarding remains a fundamental component of all care within the Trust and we have again this year responded effectively and efficiently to the challenges of safeguarding both our patients and our staff in what has a challenging year.

The Trust Safeguarding Sub-committee (TSSC) and Safeguarding Operational Group (SOG) continue to provide the Board of Directors, Clinical Commissioning Group (CCG) and External Safeguarding Boards with assurance of our ability to respond effectively and demonstrate accountability, for all aspects of Safeguarding Children, Young People and Adults.

The report will outline the progress against the 2022/23 priorities and set out the key priorities for the coming 12 months. These are central to supporting core safeguarding activities and demonstrate the organisations compliance with Section 11 of the Children Act (2004) and the Care Act (2014).

I would request the Trust Board receives and approves this Annual Report. Once approved the report will be submitted to the Liverpool, Sefton and Knowsley Safeguarding Children's Partnership's and the Liverpool, Sefton and Knowsley Safeguarding Adults Board's.

Dianne Brown

Chief Nurse

MAIN REPORT

Liverpool Women's
NHS Foundation Trust

Safeguarding Children, Young People and Adults Annual Report

2022/23

Deborah Ward
Head of Safeguarding

Executive Summary

The Safeguarding Annual Report for Children, Young People and Adults provides an overview of Safeguarding activity within the Trust for the period 1st April 2022 to the 31st March 2023. The intention of the report is to assure our Board of Directors that the Trust has effective systems and processes in place to safeguard those at risk of abuse who access services provided by Liverpool Women's NHS Foundation Trust.

Safeguarding remains a fundamental component of all care within the Trust and we have again this year responded effectively and efficiently to the challenges of safeguarding both our patients and our staff in what has been a challenging year.

The Trust Safeguarding Sub-committee (TSSC) and Safeguarding Operational Group (SOG) continue to provide the Board of Directors, Intergrated Care Board (ICB) previously known as the Clinical Commissioning Group (CCG) and External Safeguarding Boards with assurance of our ability to respond effectively and demonstrate accountability, for all aspects of Safeguarding Children, Young People and Adults.

The report will outline the progress against the 2022/23 priorities and set out the key priorities for the coming 12 months. These are central to supporting core safeguarding activities and demonstrate the organisations compliance with Section 11 of the Children Act (2004) and the Care Act (2014).

I would request the Trust Board receives and approves this Annual Report. Once approved the report will be submitted to the Liverpool, Sefton and Knowsley Safeguarding Children's Partnership's and the Liverpool, Sefton and Knowsley Safeguarding Adults Board's.

Dianne Brown,
Executive Chief Nurse

Contents

Introduction

1.1 One of the fundamental responsibilities in providing quality healthcare services is to ensure that the public are protected from harm whilst receiving care. This is an important responsibility for each member of staff, whatever their role, and for the Trust as a partner in the wider health and social care system.

1.2 The 2022/23 Safeguarding Annual Report for Liverpool Women's Hospital NHS Foundation Trust will reflect the safeguarding work undertaken by the organisation during the reporting period.

1.3 The purpose of this report is to offer assurance to the Trust Board that the organisation is fulfilling its responsibilities to promote the safety and welfare of people and families who use our services.

1.4 The Liverpool Women's Hospital NHS Foundation Trust safeguarding team provides support, advice and guidance for all aspects of safeguarding including radicalisation, domestic abuse and Mental Capacity Act/Deprivation of Liberty Safeguards.

1.5 Safeguarding activity is underpinned by the statutory guidance outlined below, this is not an exhaustive list but outlines the key legislation and statutory guidance that the Trust is required to follow to ensure statutory safeguarding responsibilities are achieved.

- Children Act 1989/2004
- Children and Social Work Act 2017
- Working Together to Safeguard Children 2018
- Promoting the Health and Wellbeing of Looked After Children 2020
- Care Act 2014
- Mental Capacity Act 2005
- Mental Capacity Act Deprivation of Liberty Safeguards 2009
- Mental Capacity Amendment Act 2019
- Care Quality Commission Registration Standards: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:
    - Regulation 9: Person Centred Care
    - Regulation 10: Dignity and Respect
    - Regulation 11: Need for Consent
    - Regulation 12: Safe Care and Treatment
    - Regulation 13: Safeguarding Service Users from Abuse and Improper Treatment

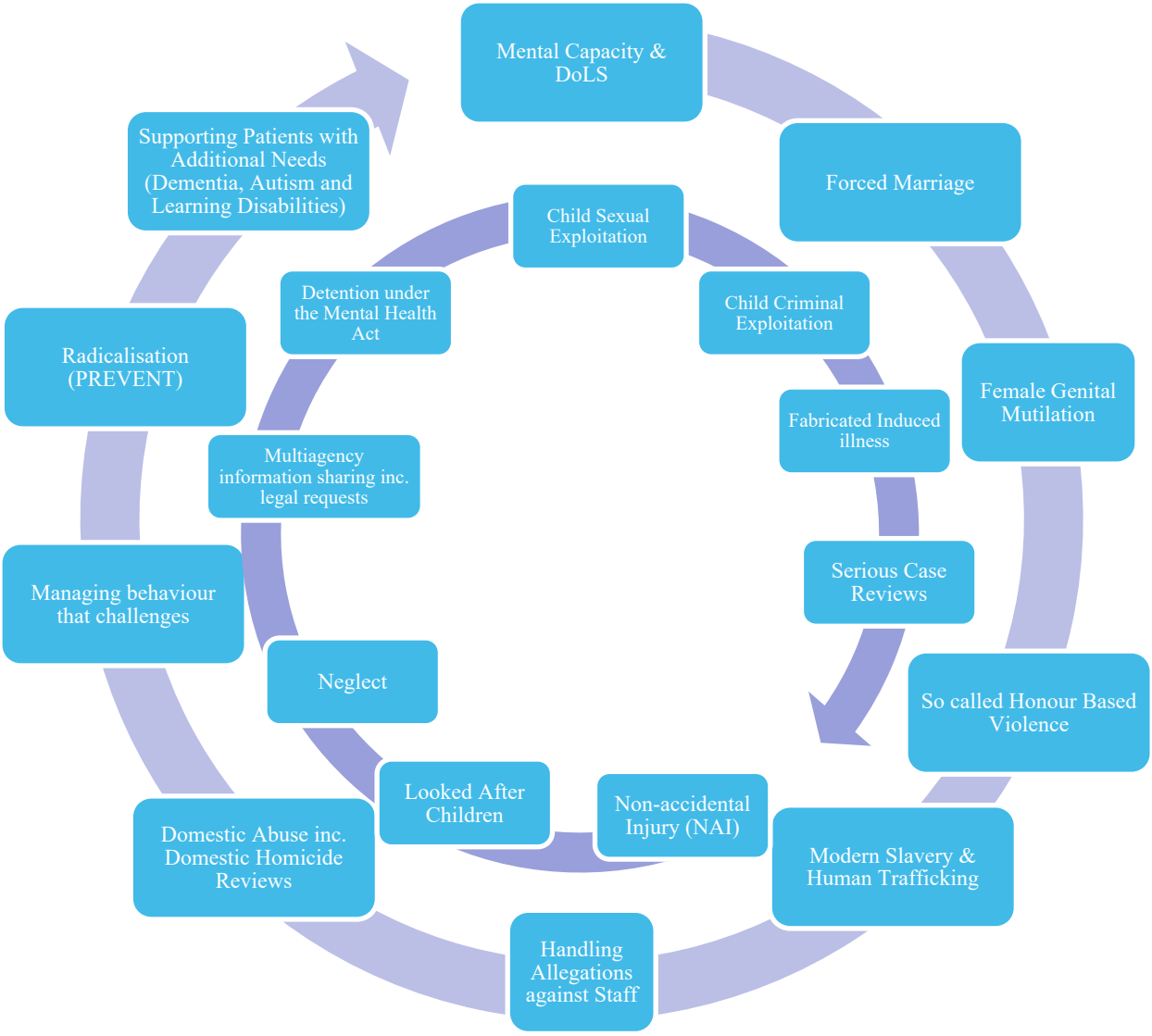
The Service

2.1 Liverpool Women's Hospital NHS Foundation Trust Safeguarding Service.

2.1.1 The safeguarding service is an established, fully integrated, multi professional service comprising of a health and social care professionals who have extensive experience across midwifery, accident & emergency, critical care, care of the elderly and social care.

2.1.2 The relevant skill mix and experience across the safeguarding portfolio ensure that all members of the team can act both strategically and operationally in preventing and investigating potential harm and abuse.

2.1.3 The following reflects the scope of service provided by the Safeguarding Team:



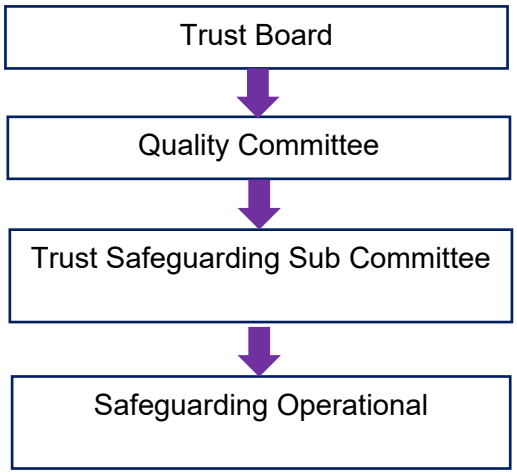
2.2 Trust Safeguarding Sub Committee (TSSC)

2.2.1 The Trust Safeguarding Sub Committee met quarterly throughout 2022/23. The sub-committee provides exception reports directly to the Quality Committee.

2.2.2 The agreed assurance schedule ensured members were presented with regular safeguarding reports, audits and associated action plans, agreed safeguarding policy that required ratification and enabled dissemination of information from local safeguarding boards and partnerships.

2.2.3 The Safeguarding Operation Group continued to meet quarterly as a sub-group of the Trust Safeguarding Sub Committee.

2.2.4 At the end of the Reporting period the governance structure for Safeguarding is:



2.3 Risk Register

2.3.1 At the end of the reporting period there were two risks on the safeguarding risk register which can be seen in table 1 below:

Table 1: Safeguarding Risk Register

Risk Number	Risk Description	Risk Score
2302	**Condition**: Workforce not trained to identify safeguarding concerns. **Cause**: Staff not attending relevant mandatory training **Consequence**: Workforce not receiving mandatory training pertaining to the safeguarding of children & adults. Patients at risk of potential harm, loss of reputation to the Trust	10
2637	**Condition**: Women and Babies could be at increase safeguarding risk **Cause**: The delay in information sharing from the Local Authority, leading to the Trust not	12

	receiving child protection plans or additional information **Consequence**: Trust staff are unable to plan and deliver safe care	

2.3.2 The risk register will be reviewed in quarter 1 2023/24 to ensure all risks have been appropriately identified with mitigation in place to minimise the risk.

2.4 Review of Priorities from 2022/2023

2.4.1 Throughout the reporting period for 2022/23, the Trust safeguarding team has continued to progress the safeguarding children, young people and adult's work plans. This has ensured that the Trust has remained compliant with its overall objective to:

> …Ensure that Liverpool Women's NHS Foundation Trust safeguarding arrangements are statutory compliant with appropriate legislation and national/local guidance in respect of those identified as at risk…

2.4.2 Table 2 below shows the key objectives identified as priorities within the 2022/2023 Safeguarding Annual Report and the progress made towards each objective.

Table 2: 2022/2023 Priorities and Progress Update

No.	Objective	RAG	Progress
1	Working closely with our commissioners and the domestic abuse steering group, implement and embed the recommendations and subsequent changes to practice following the review of Liverpool Multi agency risk assessment conference (MARAC) process		
2	To prepare the necessary infrastructure, policies, procedures, workforce development and legal literacy necessary to implement the Liberty Protection Safeguards in 23/24.		This Objective is no longer applicable due to the Government delay in publishing the Code of Practice. The Department of Health identified that the change in legislation would not be implemented during this parliament. There is no date set for implementation.
3	To achieve 90% compliance for all safeguarding training		At the end of the reporting period the Trust have achieved 90% training compliance in all but one element of safeguarding training. The end of year compliance for Mental Capacity Act Training was 88%. It is hoped that 90% compliance will be achieved in quarter 1 2023/24.
4	Support the Trust with the sharing of resources to redevelop the security strategy.		Resources from within the Safeguarding service have been shared with Estates and Facilities who have management and oversight of the

			Security Team. This has enabled partnership working in relation to the security strategy.
5	To assist the Trust Digital Team in delivering a safe and effective electronic patient record to further improve the documentation and communication to support patients who suffer harm/abuse.		The safeguarding team have worked in partnership throughout the year to support the development of the new electronic patient record which is due to go live in early quarter 2 2023/34.
6	Embed the updated Safeguarding Accountability and Assurance Framework (Due in July 2022)		This objective will roll over into 2023/24 due to the delay in implementation by Cheshire and Merseyside Integrated Care Board. Information shared in Quarter 4 identified the update framework will be implemented with the 2023/24 key performance indicators and submission will be required in quarter 3 2023/24.
7	Self-assess the safeguarding service/Trust against updated Safeguarding Accountability and Assurance Framework (expected in July 2022)		This objective will roll over into 2023/24 due to the delay in publication of the updated self-assessment framework. Completion of the self-assessment tool will be required Quarter 3 2023/24.

2.5 Commissioning Requirements

2.5.1 Liverpool Women's Hospital NHS Foundation Trust is commissioned by Liverpool Place within the Cheshire and Merseyside Integrated Care Board (ICB). The ICB replaced the Clinical Commissioning Groups from 1st July 2022.

2.5.2 Monitoring arrangements by the ICB include a detailed quality Key Performance Indicator (KPI) submission, the annual submission of a self-assessment against the safeguarding commissioning standards and a quarterly business meeting with the designated safeguarding nurses.

2.5.3 The KPI template was submitted in the month following the end of the quarterly period, and required evidence to provide assurance across multiple areas including (list not exhaustive):

- Policy and procedure
- Safeguarding adult referrals to the Local Authority
- Safeguarding Audit
- Safeguarding children's referrals to the Local Authority
- Action plan against the Cheshire and Merseyside Safeguarding Commissioning Standards
- Training needs analysis and training compliance
- Applications under Deprivation of Liberty Safeguards

2.5.4 At the end of the reporting period, feedback from the ICB has identified that the Trust has given significant assurance against 20 of the 23 KPI requirements. The remaining 3 requirements have been classed as limited assurance due to the training compliance for those specific requirements being less than 90%.

Further details of the training compliance can be seen in the Training section 2.7 below.

2.6 Safeguarding Training

2.6.1 Throughout the reporting period, level 1 and level 2 safeguarding adult, children and trust specific training was delivered via e-learning, with level 3 safeguarding adult and level 3 safeguarding children training being delivered face to face in a classroom format.

2.6.2 Prevent basic awareness is incorporated within the level 1 and level 2 training with Prevent WRAP training and Mental Capacity Act training being delivered as a stand-alone e-learning packages.

2.6.3 All training is required on a 3 yearly cycle and the level of training required is dependent on the role the staff member has within the Trust.

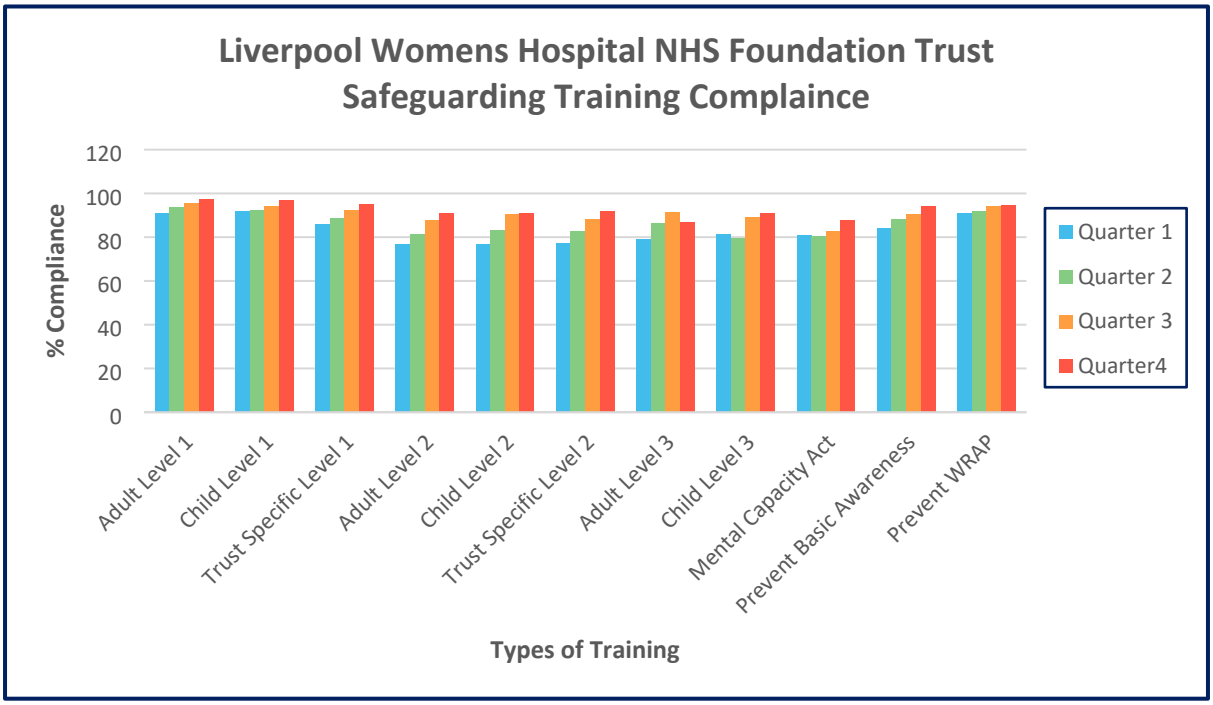
2.6.4 Training compliance has been closely monitored through the year, with weekly reports being sent to divisional leads to enable divisions to report compliance within divisional governance meetings. In addition, safeguarding training compliance has continued to be a standard agenda item at the Trust Safeguarding Sub Committee.

2.6.5 Full organisational safeguarding training data can be seen in Chart 1. As can be seen, with exception of Mental Capacity Act (88%) all safeguarding training requirements are above 90% Key Performance Indicator requirement.

2.6.6 Quarterly data was not captured per division, this will be reported within the quarterly reports throughout 2023/24.

2.6.7 A full review of safeguarding training will occur in quarter 1 2023/24 with a view to streamlining requirements for front line staff, ensuring the training meets intercollegiate requirement whilst releasing time to care.

Chart 1: Safeguarding Training Compliance 2022/23



3 Safeguarding Audits

3.1 Domestic Abuse Audit

In total 50 cases were reviewed as part of the audit with a total of 96% (48) containing evidence of routine enquiry asking the individual if they feel safe at home. 30 cases identified a disclosure of domestic abuse and 100% of these were referred to safeguarding for review.

90% (45) identified patient partner details including name, address and date of birth, with the remaining 10% (5) containing name and date of birth but not address details.

In all cases where domestic abuse had been disclosed, 100% contained evidence of a safety plan.

Conclusion

Full assurance has been provided in relation to following current Trust domestic abuse policy. 100% of cases with identified domestic abuse had been referred to safeguarding, with 100% containing the name and date of birth of the patient partner and 90% containing an address of the partner. 100% of cases with identified domestic abuse also contained evidence of a protection plan.

3.2 MCA Referral Quality Audit

In total 50 case notes were included in the Audit of which all had recorded a diagnosis of Learning Disability, Autism or Dementia. Of the 50 records, 74% (37) identified the patient was able to provide informed consent leaving 26% (13) to progress with the audit.

92% (12) clearly demonstrated the opinions of those interested in the welfare of the individual, with the remaining case (8%) documenting conversation with family but not documenting conversation with those who provided care for the individual who lived in supported living.

100% of cases had documented evidence of capacity assessment and subsequent best interest decision with 77% using the MCA form on PENS with 23% utilising consent form 4.

Conclusion

The findings of the audit provided assurance that the legal standard for establishing a lack of capacity to make the required decisions were met. The outcome of the assessment and decision is clearly documented in accordance with the Mental Capacity Act 2005. The audit author was assured in all cases review, an assessment identifying the need for reasonable adjustments to be made to support communication and assist in demonstrating capacity had been completed.

3.3 Safeguarding Children Procedures in Accordance with Statutory Guidance Audit

In total 50 safeguarding referrals were included in the Audit of which 20% (10) identified no new safeguarding concerns with 4 of them being used as a method of communicating with the safeguarding team. The remaining 40 cases progressed through the audit process.

25% (10) cases were immediately identified as meeting concerns that required a safeguarding referral to the Local Authority for consideration under Section 47 of the Children Act.

47% (19 cases) the safeguarding team made direct contact with the Local Authority to gain additional information. On review of this additional information 21% (4) of these cases were referred to the Local Authority for assessment, 26% (5) were already known and open to social care meaning a referral from the Trust was not required, 10% were identified as requiring early help with the remaining 43% (8) requiring no further action from the safeguarding team or social care.

The remaining 28% (11) referrals to the safeguarding team identified no level 4 concern requiring a referral to the Local Authority with advice to consider early help alongside referrals to other supportive services e.g. Perinatal Mental Health Team.

In 100% of cases where the case was open to the safeguarding team a safeguarding professional letter was completed and shared with the identified GP and with Paediatric Liaison to share with the allocated Health Visitor and/or School Nurse.

Conclusion

The findings of the audit provided partial assurance that staff have the confidence to identify and report concerns based on a disclosure or previous information being available to inform their decision. The number of referrals to safeguarding that did not meet the threshold for referral to the Local Authority suggests that front line staff may not have confidence in assessing the Level of Needs as per the Local Safeguarding Partnership Procedures.

4 Safeguarding Adult at Risk of Abuse

4.1 Key Work Activities

- Support and Advice
- Mental Capacity Act Implementation
- Domestic Violence and Abuse
- Domestic Homicide Reviews / Safeguarding Adult Reviews
- Safeguarding Adult Boards/Partnerships
- Managing Allegations Against Professionals in a Position of Trust
- Training
- Deprivation of Liberty Safeguards

4.2 Safeguarding Adult Support and Advice

4.2.1 Safeguarding adult advice and support is offered by all members of the safeguarding team. Contact for advice and support can be received by telephone, email or when a member of the safeguarding team is visiting a ward/department area.

4.2.2 The safeguarding team receive safeguarding referrals/notifications of concern from front line practitioners via Ulysses incident reporting system.

4.2.3 Table 3 below captures the total number of safeguarding adult notifications made to the safeguarding team and the total number of referrals made to the relevant Local Authority for consideration of Section 42 enquiry.

4.2.4 The end of year comparison can be seen with 2021/2022. As can be seen from the data the number of safeguarding adult notifications to the team has reduced when compared to the previous year. This figure will be monitored in the first 6 months of 2023/24 to identify any themes/trends that may lead to a reduction in referrals.

Table 3: Quarterly Breakdown of Trust Safeguarding Adult Notifications and Onward Referrals to the Local Authority.

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total 2022/23	Total 2021/22
Total number of Safeguarding Adult Notifications to Safeguarding Team	51	62	48	90	251	391
Total number of Safeguarding Adult Referrals to the Local Authority	0	5	0	3	8	9

4.3 Safeguarding Adult Local Authority Enquiries (Section 42 Enquiries)

4.3.1 The Care Act 2014 gives all Local Authorities the duty to either make a safeguarding enquiry or cause an enquiry to be made. These are known as Section 42 enquiries due to the section of the Care Act 2014.

4.3.2 If a safeguarding concern is raised against care and/or treatment given by the Trust, the Local Authority will liaise directly with the safeguarding team and request the incident be reviewed.

4.3.3 There were no requests in 2022/2023 to undertake any Section 42 Enquiries at Liverpool Women's Hospital.

4.4 Mental Capacity Act

4.4.1 The safeguarding team supports the continued implementation of the Mental Capacity Act into clinical practice. The Mental Capacity Act 2005 ensures that all adults are assumed capable of making a decision unless they have been deemed to lack capacity for a specific decision.

4.4.2 When an individual (aged 16 or over) is thought to lack mental capacity and support is required front line staff will complete a referral to the safeguarding team. This referral may lead to the safeguarding team completing a complex assessment and/or ensuring a referral to the Independent Mental Capacity Advocacy (IMCA) service is completed.

4.4.3 Data in table 4 identifies the number of referrals received relating to the Mental Capacity Act, the number of complex assessments completed by the safeguarding team and the number of IMCA referrals completed.

Table 4: Mental Capacity Act Data

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total 2022/23	Total 2021/22
Total number of Mental Capacity Act referrals to Safeguarding Team	7	9	6	9	31	51
Total number of complex assessments completed by safeguarding team	6	7	3	4	20	12
Total number of IMCA referrals from LWH	1	0	2	0	3	7

4.4.4 As can be seen from the data the total number of referrals to the safeguarding team relating to the Mental Capacity Act has reduced but the number of complex assessments completed has increased. This would identify that staff are appropriately managing individuals who require assessment under the Mental Capacity Act and are referring to the team when additional support is required due to the complexity of the case.

4.4.5 The referral figures will continue to be closely monitored over the first 6 months of 2023/24 to identify themes/trends to ensure all individuals who require assessment under the Mental Capacity Act are receiving appropriate assessment and the implementation of reasonable adjustments when required.

4.5 Supporting Patients with Additional Needs

4.5.1 The Trust strategy for supporting people with additional needs was published in 2021/22. The strategy identified three strategic priorities with multiple requirements being required for each priority to be fully implemented.

4.5.2 The priorities are:

- Respecting and Protecting Rights
- Inclusion and Engagement
- Develop our Workforce

4.5.3 Following a national campaign to raise awareness of supporting people living with a learning disability and/or autism, the government have published recommendations relating to all health and social care professionals receiving a standardised training programme. Nationally this is known as the Oliver McGowan Learning Disability and Autism Awareness Training.

4.5.4 The Code of Practice is due to go for consultation in late quarter 1 2023/24 and it is expected to have a 12-week public consultation process. The Trust are fully

aware of the responsibilities to deliver Learning Disability and Autism Awareness Training in line with the Code of Practice with the plan to develop an appropriate training package in line with the recommendations once the draft code has been published.

4.6 Deprivation of Liberty Safeguards

4.6.1 Liverpool Women's Hospital NHS Foundation Trust is a managing authority under Deprivation of Liberty Safeguards legislation. If a deprivation of liberty is identified, the Trust has a duty to make an application to the relevant local authority in which the person resides who act as the supervisory body.

4.6.2 Over the reporting period, the Safeguarding Service has been preparing to implement the proposed legislative changes to Deprivation of Liberty Safeguards within the Mental Capacity Amendment Act 2019, Liberty Protection Safeguards. However in January 2023, the government announced an indefinite delay to the implementation of the legislation publishing this will not occur within the current parliament.

4.6.3 Throughout 2023/24 the Trust will continue to focus on ensuring the Mental Capacity Act is fully embedded into clinical practice and support the use of Deprivation of Liberty Safeguards when appropriate.

4.6.4 During 2022/2023, the Trust made 1 urgent authorisation and followed this with a standard application under Deprivation of Liberty Safeguards.

4.7 Safeguarding Adult Boards/Partnerships

4.7.1 Throughout 2022/2023 the local Safeguarding Adult Boards that were formed the previous year continued to evolve and develop work plans and internal structures. Liverpool Women's Hospital NHS Foundation Trust feed into three local boards, Knowsley, Liverpool and Sefton. The Named Nurse for Safeguarding Adults represented the Trust at the Health Sub-Group which links to the 3 boards.

4.7.2 Over 2023/2024 the safeguarding service will review all the associated sub-groups to ensure representation on key groups to ensure the view of the Trust is considered across the wider health and social care economy.

4.8 Safeguarding Adult Reviews (SAR)

4.8.1 Local Authority Safeguarding Adult Boards have a duty to undertake Safeguarding Adult Reviews under Section 44 of the Care Act. The responsibility of oversight of these reviews transferred from the Merseyside Safeguarding Adult Review Panel in April 2022 to each Local Authority Safeguarding Adult Board.

4.8.2 During 2022/2023 the Trust received 6 requests for information relating to safeguarding adult reviews. The Trust returned relevant information following a scoping exercise for each request. In total 2 cases were known to the Trust, and the Safeguarding Service ensured appropriate information sharing as requested from the reviewing panel and chair.

4.9 Domestic Homicide Reviews (DHR)

4.9.1 Domestic Homicide Reviews are commissioned by the Home Office to identify if a death of a person over the age of 16, perpetrated by a partner or close family member who resides in the same home could have been prevented or foreseen. The aim of the review is to identify any lessons that can be learnt to support change within provider organisations.

4.9.2 During the reporting period the Trust received 17 requests to share information related to potential domestic homicide reviews. Of which 6 had individuals known to the Trust.

4.9.3 In the reporting period, 2 reviews were published. The first was a joint SAR/DHR relating to a death in 2020; with the following learning identified by the Trust during the review process.

- To inform staff on the links between domestic abuse and suicide
- To include the possibility of unconscious bias and domestic abuse in same sex relationships in current training
- To embed trauma informed practice.

4.9.4 The second DHR related to a death in 2017 and highlighted the issue of domestic abuse and the risk of domestic homicide for individuals who are isolated, may have care and support needs and/or are hidden from support. The following learning was identified during the review process.

- Improving awareness of self-neglect
- Recognition of hoarding as a sign of vulnerability
- The prevalence of females with long term disabilities or illness.

4.9.5 Action plans for both cases were developed and monitored via Trust Safeguarding Sub-Committee, and at the end of the reporting period all actions had been implemented.

5 Safeguarding Children and Young People

5.1 Key Work Activities

- Child Protection
- Protection of the Unborn
- Domestic Abuse
- Managing Allegations Against Professionals
- Multi Agency Safeguarding Hub (MASH)
- Safeguarding Children Partnerships

- Child Practice Reviews / Critical Incident Reviews
- Supervision
- Support and Advice
- Training

5.2 Safeguarding Children and Young People Support and Advice

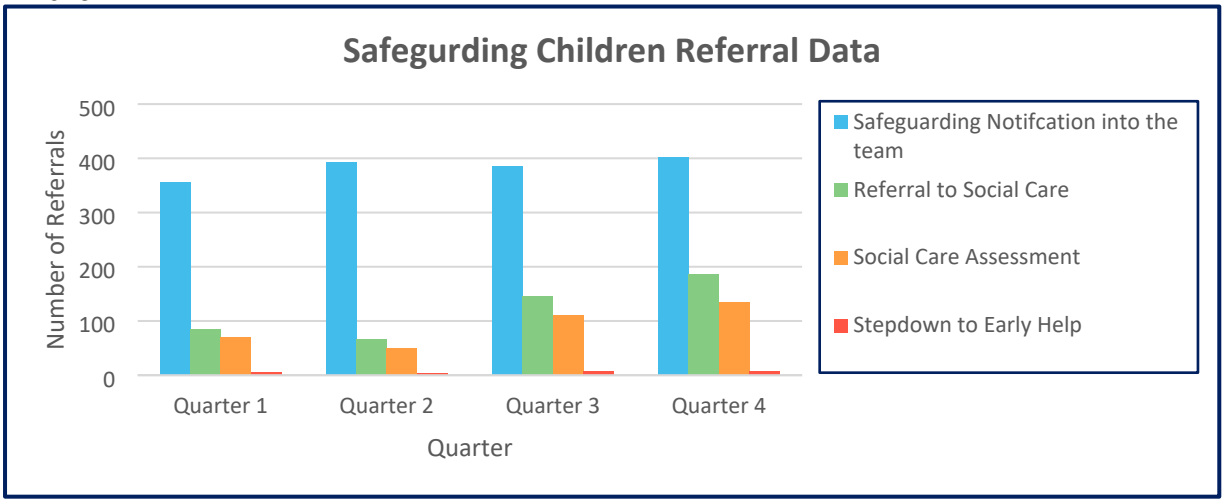
5.2.1 The safeguarding team received safeguarding children and young people queries following direct contact with a young person or if an adult attends the trust and safeguarding concerns are identified in relation to the immediate protection of the child.

5.2.2 Safeguarding children's advice and support is offered by all members of the safeguarding team. Contact for advice and support can be received by telephone, email or when a member of the safeguarding team is visiting a ward/department area.

5.2.3 The safeguarding team receive safeguarding referrals/notifications of concern from front line practitioners via Ulysses incident reporting system.

5.2.4 Chart 2 captures the total number of safeguarding children's notifications made to the safeguarding team, the total number of referrals made to the relevant Local Authority for consideration of child protection enquiries under Section 47 of the Children's Act 1989/2004, the number that proceeded to assessment and the number which were stepped down to early help.

Chart 2:



5.2.5 The end of year comparison can be seen against the 2021/2022 data in table 5.

Table 5: Safeguarding Children Referral Data

	2021/2022	2022/2023
Safeguarding Child Referrals to the Team	1240	1535

Referrals to children's social care	383	484
Social Care assessments commenced	294	362
Stepdown by social care to early help	27	25

5.2.6 As can be seen from the data the number of safeguarding children's notifications to the team has increased when compared to the previous year. However, the conversion rate to referrals has remained static with 31% of cases being referred to children's social care. Of those 75% have progressed each year to formal social care assessment.

5.3 Multi Agency Safeguarding Hub – Information Sharing

5.3.1 In addition to the internal safeguarding children referrals Liverpool Women's Hospital NHS Foundation Trust receive requests from information sharing from Sefton, Liverpool and Knowsley Safeguarding Hubs.

5.3.2 If the Local Authorities receive information relating to a potential safeguarding concern they hold a strategy meeting to identify if the concerns meet the threshold for safeguarding enquiry under Section 47 of the Children Act (1989/2004). Prior to the strategy meeting, the Local Authority Multi Agency Safeguarding Hubs (MASH) request information from all provider health organisations which could include all members of the family (parents and siblings of the child).

5.3.3 Data relating to information sharing requests can be seen in Table 6.

Table 6:

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
Number of cases researched 2022/23	54	66	68	54	241

5.3.4 In comparison during 2021/2022, 383 requests were received to research cases prior to a MASH strategy meeting.

5.3.5 The number of requests will involve multiple family members that require research. This will identify what involvement the individuals had with the Trust to identify if there were any missed opportunities to potentially safeguarding a child from the risk of harm.

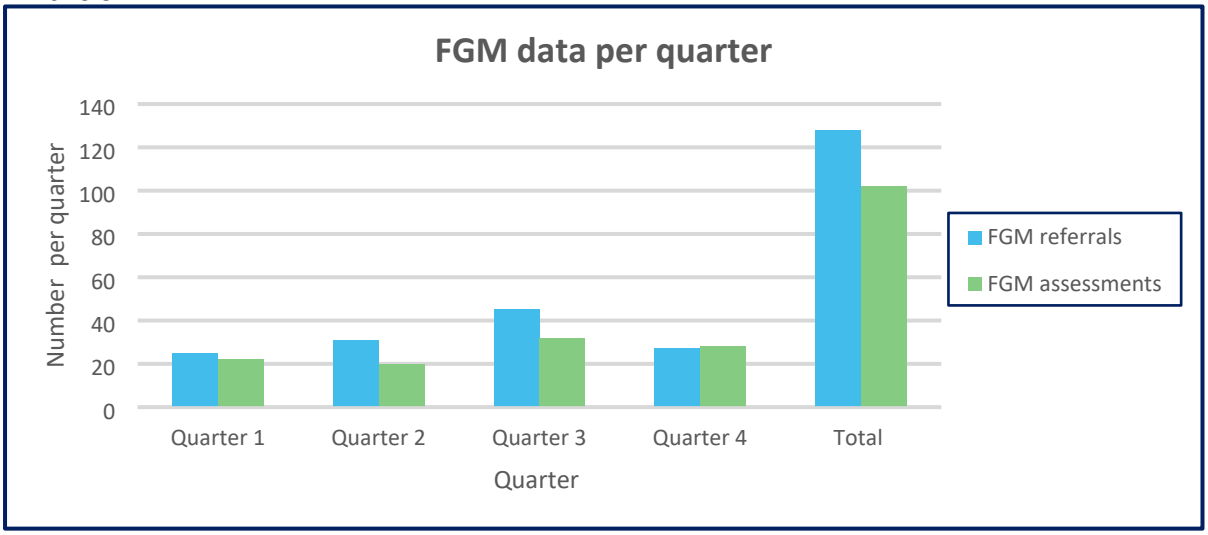
5.4 Female Genital Mutilation (FGM)

5.4.1 In line with mandatory reporting requirements Liverpool Women's Hospital NHS Foundation Trust are required to submit quarterly data relating to FGM to Information Standards Board for Health and Social Care.

5.4.2 The purpose of this data is to enable identification of the prevalence of FGM in-order to improve the NHS response.

5.4.3 Data relating to the number of FGM cases identified at the Trust can be seen in chart 3.

Chart 3:



5.4.4 No data was captured for the number of FGM assessments completed in quarter 2.

5.4.5 As a comparison in 2021/22 there were a total of 136 individuals who were referred to the safeguarding team due to having had FGM, with 93 having a full FGM assessment, which equates to 68.38% of identified individual having an assessment. In this reporting period, there were a total of 128 individuals who were referred to the safeguarding team due to having had FGM, with 102 having a full FGM assessment, which equates to 79.68% of individuals having an assessment.

5.4.6 The data relates to the number reported within the quarter, therefore it needs to be noted that individuals who were reported as having FGM in quarter 1 could have had the FGM assessment completed in quarter 2.

5.4.7 To ensure all women receive an assessment the specific clinic receive regular reports for all women with identified FGM to ensure a clinic appointment has been offered.

5.5 Local Safeguarding Children's Partnerships

5.5.1 Liverpool Women's Hospital NHS Foundation Trust continue to be an active member of Liverpool Safeguarding Children's Partnership and the associated sub-groups.

5.5.2 Under Section 11 of the Children Act (1989/2004) the Safeguarding Partnerships are required to seek assurance from partner agencies that they

have appropriate governance and policies/procedure to protect children from harm. In quarter 4, the Safeguarding Partnership completed a Section 11 Audit including a site visit from two members of the Partnership.

5.5.3 At the end of the reporting period, the Trust had not received the formal feedback, however verbal feedback on the day of the visit was extremely positive and no immediate concerns were raised requiring action.

5.5.4 During the reporting period, Sefton Safeguarding Children's Partnership underwent review and reverted to a model in which providers were invited to attend the partnership meetings. This has been welcomed by Liverpool Women's Hospital NHS Foundation Trust who ensured representation at the Partnership Board.

5.6 Child Safeguarding Practice Reviews

5.6.1 Local Safeguarding Children's Partnerships Boards have a duty to notify the national Child Safeguarding Practice Review Panel if a child has died or been seriously harmed, and abuse or neglect of the child is known or suspected.

5.6.2 The purpose of a review is to identify improvements to be made to safeguard and promote the welfare of children, and they should seek to prevent or reduce the risk of recurrence of similar incidents.

5.6.3 Each Local Safeguarding Children's Partnership have a specific sub-group to review potential Child Safeguarding Practice Reviews for recommendation to the national panel to commission a review (Critical Incident Group – CIG). If the local group identify learning but the threshold for recommendation to panel is not met, the group can recommend a local review is commissioned by the Safeguarding Partnership Board.

5.6.4 During the reporting period, the Trust received 7 requests from CIG to share information for consideration of cases. Of those none met the threshold for recommendation to the national Safeguarding Practice Review Panel. In addition, the CIG recommended 2 have a local learning review, one was a health only review which the Trust are participating with the other review being a multi-agency review.

5.6.5 At the end of the reporting period, 2 of the CIG requests for information had not concluded and the Trust are awaiting the outcome from the ICB if it progressing to a review.

5.6.6 Liverpool Women's hospital submitted a return in relation to all 7 cases and have had directed involvement with all cases.

5.6.7 In total 1 Safeguarding Practice Review has been published across Sefton, Liverpool and Knowsley in the reporting period. the Trust did not have direct involvement with this case however learning was relevant as it related to a 12 week old baby and the risks of unsafe co-sleeping. At the end of the reporting period the Trust received and circulated a 7 minute briefing to share relevant learning.

5.6.8 Local learning has identified a priority focus on raising awareness of the 'unseen male', improving multi-agency working and improving communication between agencies.

6 Domestic Abuse

6.1.1 The domestic abuse agenda has remained a priority across Merseyside and the Safeguarding Team has ensured regular attendance and participation with

Liverpool, Sefton and Knowsley Multi Agency Risk Assessment Conference (MARAC) process.

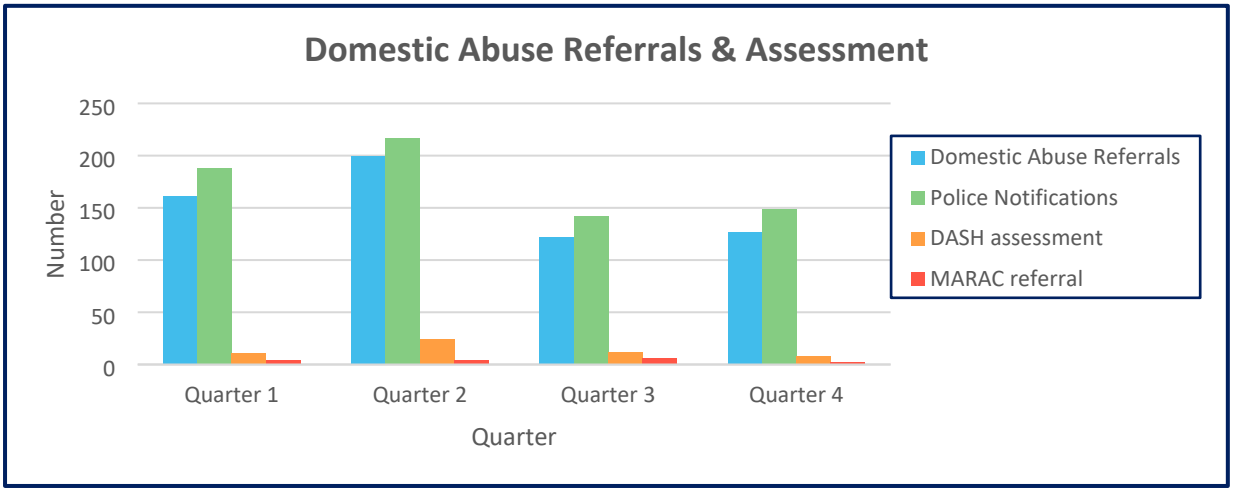
6.1.2 On attendance at Liverpool Women's Hospital NHS Foundation Trust all individuals are asked routine enquiry relating to the risk of domestic abuse. The Nurse/Midwife/Doctor will usually ask the patient if they feel safe at home.

6.1.3 Depending on the response to this question and after reviewing historical safeguarding information contained within the electronic patient record system the staff member may complete the Domestic Abuse Risk Assessment (DASH). This is a simple questionnaire with the individual getting one point per question and if the score is 14 or greater, the assessment identifies high risk of domestic abuse.

6.1.4 In addition to internal identification of domestic abuse, the Trust receive police notifications from Merseyside Police. On receipt of these notifications the safeguarding team review all cases and update the electronic patient record with relevant information.

6.1.5 All data relating to domestic abuse can be seen in chart 4.

Chart 4:



6.1.6 When compared to 2021/2022, the Safeguarding Team have noted an increase of internally completed domestic abuse referrals, police notifications and completion of domestic abuse risk assessments (DASH). However, there was a decrease in referrals to the Multi Agency Risk Assessment Conference (MARAC). Comparison data can be seen in table 7.

Table 7:

	2021/2022	2022/2023
Domestic Abuse Referrals	586	610
Police Notifications	694	696
Domestic Abuse Assessments	52	55
MARAC referral	26	16

6.1.7 As can be seen from the data in table 7, the safeguarding team processed 610 domestic abuse referrals and 696 police notifications during the reporting period.

6.1.8 If during assessment, a pregnant woman is identified as being high risk of domestic abuse, the safeguarding team will liaise with children's social care to ensure a safeguarding plan of care is in place prior to delivery.

6.1.9 In some instances, the Local Authority may close the safeguarding during the antenatal period following risk assessment. In these situations, or if an individual has been referred to MARAC within the previous 12 months, the safeguarding team will develop a safeguarding plan of care to ensure Trust staff are aware of any identified risks and any actions required to reduce the risks.

6.1.10 Data relating to domestic abuse plans of care can be seen in Table 8:

Table 8:

	Domestic Abuse Referrals to LA	Domestic Abuse Plan of Care	Plan of Care no Local Authority Involvement
Quarter 1	25	25	5
Quarter 2	26	24	14
Quarter 3	18	22	12
Quarter 4	16	26	15

7 Prevent

7.1 Prevent is one of the four key strands of the government's counter terrorism strategy known as CONTEST. Within CONTEST health services have been identified as a key partner in Prevent, which encompasses all parts of the NHS.

7.2 Prevent works in the 'pre criminal' space and aims to identify people and behaviour before it becomes criminal. The purpose of the national Prevent Strategy is to support effective information sharing and early intervention.

7.3 The Home Office have identified Prevent priority areas across the country, of which the City of Liverpool is a priority area. This has led to Liverpool Women's Hospital NHS Foundation Trust being required to provide quarterly data to the NHS via the national reporting system.

7.4 The Trust return includes the total number of staff trained at both levels of Prevent training, the total number of staff who have completed training in quarter and the number of referrals referred to the Police under Prevent.

7.5 In total during 2022/2023, the Trust made 0 Prevent referrals for Police consideration.

8 Conclusion

8.1 Throughout 2022/2023, the Safeguarding team have continued to raise awareness of all aspects of safeguarding across the organisation which has maintained the level of demand on the service. This is evidenced through the consistent number of referrals to the team throughout the year.

8.2 Post covid, the Trust implemented a safeguarding training recovery plan, which ensured the Divisional leads received weekly training figures. The Trust improved training figures across all requirements of safeguarding training, however 90% compliance requirement was not achieved in Mental Capacity Act Training or Safeguarding Adults Level 3. This will be closely monitored throughout quarter 1.

8.3 The Trust has continued to have a presence at partnership meetings within the local area with both Safeguarding Children's Partnership and the Safeguarding Adults Board including the associated sub-groups.

8.4 The Trust Board and Senior Leadership Team continue to articulate the vision for safeguarding and safeguarding our patient population and our staff remains a high priority across the Trust.

9 Priorities for 2023/24

1. Review the Safeguarding Structure including review of Job Descriptions.
2. Develop safeguarding audit plan and undertake relevant audits to improve safeguarding provision across the organisation.
3. Work in partnership with IT services to further develop electronic systems to streamline safeguarding process.
4. Continue to support Local Safeguarding Adult Boards/Children's Partnerships to embed identified priority work streams across both the safeguarding adult and safeguarding children's agenda.
5. Self-assess the Trust against the updated Safeguarding Accountability and Assurance Framework (Expected KPI for 2023/24).

10 Recommendations

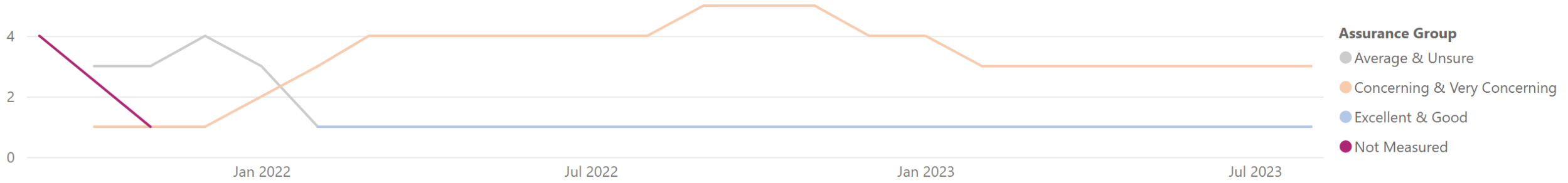
- The Board is requested to receive and approve annual report and to publish on the public web site.
- Once approved, it is recommended to submit the report to the Liverpool, Sefton and Knowsley Safeguarding Children's Partnerships and the Liverpool, Sefton and Knowsley Safeguarding Adult Boards.

Liverpool Women's
NHS Foundation Trust

Trust Board

Workforce Performance Report
September 2023

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

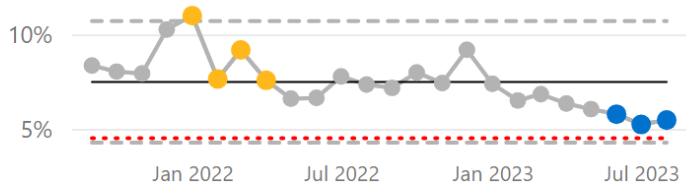


KPI	Assurance Category	Date	Target	Target < or >	Performance	Assurance	Variation	Trend
Turnover Rate	Excellent	August 2023	<= 13%	<=	9.53%	P	L	
Mandatory Training	Concerning	August 2023	>= 95%	>=	94.43%	F	H	
Mandatory Training (Clinical)	Concerning	August 2023	>= 95%	>=	88.81%	F	H	
Prevention of Ill Health: Flu Vaccine Front Line Clinical Staff	Concerning	January 2023	>= 80%	>=	41.54%	F		
Sickness Absence Rate	Concerning	August 2023	<= 4.5%	<=	5.46%	F	L	

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

Sickness - Chief People Officer

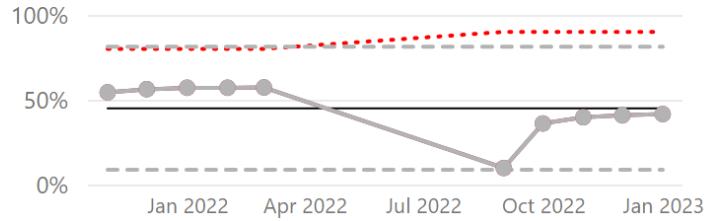
Assurance Category	Concerning
Date	August 2023
Target	<= 4.5%
Target < or >	<=
Performance	5.46%
Assurance	F
Variation	L



Sickness increased by 0.23% in Aug, increasing to 5.46%. At a divisional level, Family Health increased by (0.46%), Gynaecology increased (0.39%) and Clinical Support Services increased by (0.74%) but increased in Corporate divisions reduced by (0.80%). Neonatal saw a decrease in sickness while Maternity and Gynaecology both saw increases. COVID sickness remained at 0.14%. Anxiety/stress are now the main reason for absence in the Trust closely followed by Gastrointestinal problems.

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

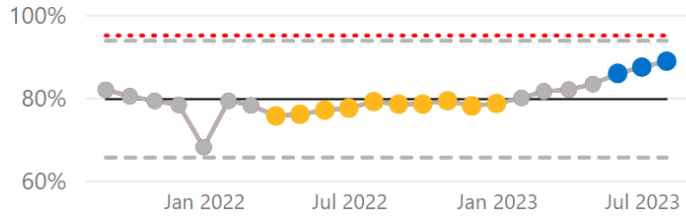
Assurance Category	Concerning
Date	January 2023
Target	>= 80%
Target < or >	>=
Performance	41.54%
Assurance	F
Variation	



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 (Clinical) - Chief People Officer

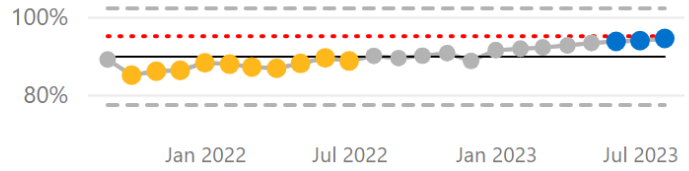
Assurance Category	Concerning
Date	August 2023
Target	>= 95%
Target < or >	>=
Performance	88.81%
Assurance	F
Variation	H



Compliance increased by 1.44%, giving a Trust-wide figure of 88.81%. All directorates have reported an increase in their compliance figures. 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.

Mandatory Training - Chief People Officer

Assurance Category	Concerning
Date	August 2023
Target	>= 95%
Target < or >	>=
Performance	94.43%
Assurance	F
Variation	H



Compliance increased by 0.58% up to 94.43%, which is now just 0.57% 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 91.94% this month, while Gynae decrease by 0.02% but remained above the Trust's 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 expired over 12 months ago or have never been comp

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	**23/24/167**		**Date: 12/10/2023**	
Report Title	**Finance Performance Month 5 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 5 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 5 Financial Position.			
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* 5 – Inability to deliver the 2023/24 financial plan and 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	27/09/23	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 5 the Trust is reporting a £8,660k deficit which represents a £1,474k adverse variance to plan. This position is supported by £2.2m of non-recurrent items. The forecast outturn is £15,450k deficit, in line with the submitted plan.

Cost Improvement Programme (CIP) delivery is behind the year to date (YTD) target. The Trust has a full year target of £8.3m and remains focussed on rapid recovery to deliver robust, recurrent savings both in year and in the long term.

The cash balance was £3.7m at the end of Month 5. The average cash balance through the month was £9.7m.

MAIN REPORT

1. Summary Financial Position

	Plan	Actual	Variance	RAG	*R*	*A*	*G*
Surplus/(Deficit) YTD	-£7.2m	-£8.7m	-£1.5m	6	*>10% off plan*	*Plan*	*Plan or better*
I&E Forecast	-£15.5m	-£15.5m	£0.0m	1	*>10% off plan*	*Plan*	*Plan or better*
NHS I/E Rating	3	3	0	1	*4*	*3*	*2+*
Cash	£4.4m	£3.8m	-£0.7m	1	*<£1m*	*£1m-£4.5m*	*£4.5m+*
Total CIP Achievement YTD	£2.5m	£1.8m	-£0.7m	6	*>10% off plan*	*Plan*	*Plan or better*
Recurrent CIP Achievement YTD	£2.5m	£1.5m	-£1.0m	6	*>10% off plan*	*Plan*	*Plan or better*
Aligned Payment Incentive	106%	105%	-1%	6	*>10% off plan*	*Plan*	*Plan or better*
Non-Recurrent Items YTD	£0.4m	£2.2m	£1.9m	5	*>£0*		*<£0*
Capital Spend YTD	£3.0m	£1.9m	-£1.0m	6	*>10% off plan*	*Plan*	*Plan or better*

At Month 5 the Trust is reporting an £8,660k deficit, which represents a £1,474k adverse variance to plan YTD. This is supported by £2,248k 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 position is supported by £2.2m of non-recurrent items. The adjusted position in Month 5 (following removal of key non-recurrent items) is a deficit of £10.9m, which represents an adverse variance of £3.7m against plan.

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

- CIP and additional savings targets required to achieve financial position.
- Industrial action costs and income impact.
- Income underperformance.
- Impact of pay award.
- Operational pay pressures, including investment in nursing & midwifery staffing, medical staffing, and unfunded cost pressures in corporate areas.
- Operational non-pay pressures, including additional inflation and increased pathology activity.

Whole Time Equivalents (WTEs)

At Month 5 WTEs total 1,676, compared to 1,688 at M12 2022/23, with a shift away from temporary (bank and agency) towards substantive staff. There are favourable movements in admin and clerical and 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. At Month 5, there is an adverse variance of £698k against the £2,519k target. The Trust is focussed on identifying and implementing robust schemes through a programme of targeted financial recovery, that will deliver on an ongoing basis.

Finance Recovery Actions

The Trust has produced a financial recovery plan, approved by the Trust Board in September. This plan indicates that to return to a breakeven financial position, the Trust requires system support and structural change, particularly in relation to income.

The Trust is taking action on financial recovery and has implemented a financial recovery programme with enhanced infrastructure, documentation, and governance, to enable the pace of change required to deliver the challenge. A Project Management Office (PMO) has been established (from within existing resources), recovery workstreams have been initiated and new savings opportunities have been identified. A Quality Impact Assessment Assurance Committee has been established to review all Quality Impact Assessments for all transformational schemes and will focus on ensuring the Trust does not lose focus on quality during the financial recovery process.

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

3. Divisional Summary Overview

Family Health
The Family Health Division has an adverse variance of £1,503k YTD. £1,335k of this relates to Maternity, with £169k relating to Neonatal. The maternity variance is driven by pay pressures in medical staffing and midwifery staffing, as well as under-delivery of non-pay CIP.

Within Neonatal, increased activity within higher acuity cots is driving an increase in costs, despite overall activity being in line with plan.

Gynaecology
The Gynaecology Division has an adverse variance to plan of £1,995k YTD, comprised of £1,658k in Gynaecology and £337k in the Hewitt Fertility Centre. The Gynaecology variance is driven 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, additional activity, and some cost pressures.

Clinical Support Services (CSS)
CSS are £1,035k adverse to plan YTD, driven by Imaging pay (£326k) in relation to staffing pressures, increased activity within pathology services (£200k), Theatres pay (£534k), driven by nursing, Operating Department Practitioner (ODP) and support staff costs partially mitigated by vacancies in anaesthetic medical staffing, and clinical supplies (£170k).

Further impacts of industrial action are anticipated in Months 6 and 7.

4. Aligned Payment and Incentive (API)

Activity targets are set against a baseline of activity delivered in 2019/20 (prior to the impact of COVID). Average activity delivered YTD at Month 5 is 105% of 2019/20 levels, compared to 95% in the same period last year. The average activity target for 2023/24 is 106%. Income underperformance to date is driven predominantly by the impact of industrial action.

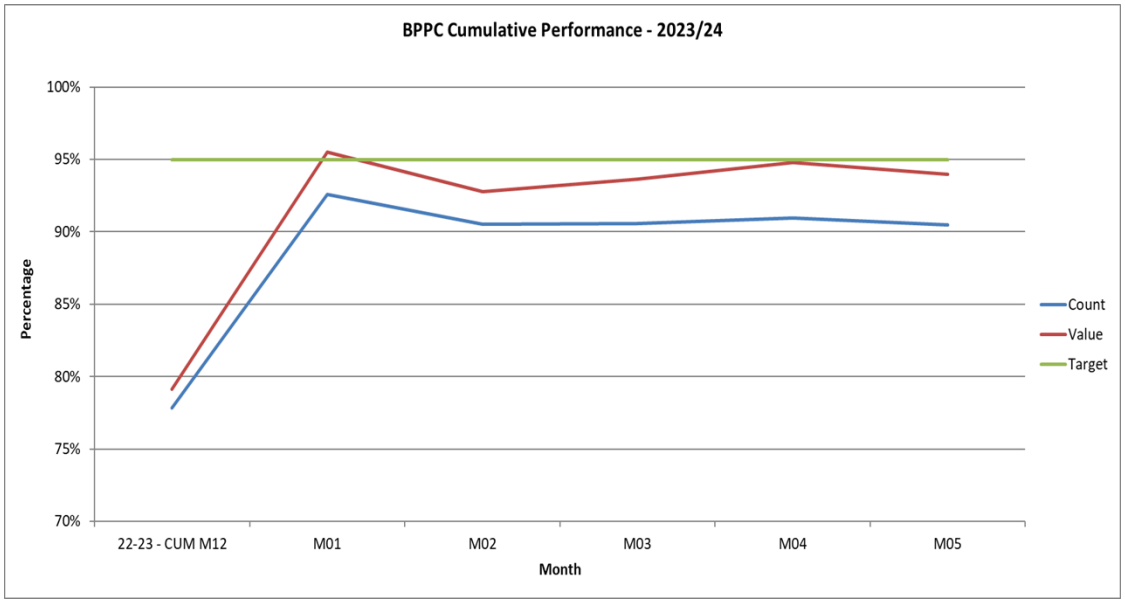
5. Cash and Borrowings

Total cash at the end of Month 5 was £3.8m. This was £0.7m behind plan and is driven by the higher deficit position YTD, offset by working capital movements, the receipt of the final VAT refund for 2022/23 and cash advanced from the ICB. The average cash balance in Month 5 was £9.7m.

As the Trust has a deficit plan for 2023/24, cash support is required throughout the year. Cash levels are closely monitored on a rolling 13-week basis and cash levels are monitored daily. 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 (BPPC)

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 table below shows the cumulative performance percentages by both count and value for the current and previous financial year.



7. Balance Sheet

Other balance sheet movements in month are consistent with the quarterly billing cycle. The sales and purchase ledgers are consistent month on month; however, prepayments and accruals have increased. The deferred income balance reflects the cash advance from the ICB.

8. Capital Expenditure

The Trust's overall capital programme for 2023/24 totals £5.154m. YTD expenditure is £1.046m behind plan. The Trust is still forecasting to meet the plan by year end.

Digital expenditure is ahead of plan following implementation of the Trust's Electronic Patient Record project in quarter 1, and overall infrastructure investment. There is an opportunity to bid for additional funds to support the project. The Trust has also been successful in a bid for "donated" IT equipment, which will reduce the level of capital funding required for IT hardware.

Estates works are ongoing; one refurbishment scheme is behind schedule but is expected to complete early in Quarter 3. Medical equipment purchases remain behind schedule; however, work is progressing to ensure equipment is scoped and ordered.

9. Agency

The Trust has strong controls in place governing the use of temporary staffing. At Month 5, the Trust has a favourable variance of £680k against plan. Actual costs of £295k YTD are predominantly driven by theatres (vacancy), and maternity (sickness and vacancy).

10. Board Assurance Framework (BAF) Risk

There are no proposed changes to the BAF score.

11. Conclusion & Recommendation

The Board is asked to note the Month 5 position.

Appendices

Appendix 1 – Board Finance Pack, M5

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

FINANCE REPORT: M5

YEAR ENDING 31 MARCH 2024

Liverpool Women's
NHS Foundation Trust

Contents

USE OF RESOURCES RISK RATING	YEAR TO DATE Actual
CAPITAL SERVICING CAPACITY (CSC)	
(a) EBITDA + Interest Receivable	(5,073)
(b) PDC + Interest Payable + Loans Repaid	1,103
CSC Ratio = (a) / (b)	**(4.60)**
NHSE 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	(22,620)
(b) Expenditure	64,668
(c) Daily Expenditure	423
Liquidity Ratio = (a) / (c)	**(53.5)**
NHSE 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)	8,660
Total Income	(59,377)
I&E Margin	**-14.6%**
NHSE 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)	-14.80%
I&E Margin (Plan)	-12.20%
I&E Variance Margin	**-2.60%**
NHSE I&E MARGIN VARIANCE SCORE	**4**
Ratio Score 1 = > 0% 2 = (1) - 0% 3 = (2) - (1)% 4 = < (2)%	
Note: NHSE assume the score of the I&E Margin variance from Plan is a 1 for the whole year and year to date budget. This is because NHSE recognise the fact that an organisation would not "plan" to have a variance from plan and have not applied a calculated ratio to the budgeted columns of this metric.	
AGENCY SPEND	
YTD Providers Cap (Equal to Plan)	975
YTD Agency Expenditure	295
	-70%
NHSE 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

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 2
INCOME & EXPENDITURE: M5
YEAR ENDING 31 MARCH 2024

INCOME & EXPENDITURE £'000	Month 5 Budget	Month 5 Actual	Month 5 Variance	YTD Budget	YTD Actual	YTD Variance	YEAR Budget	YEAR Forecast	YEAR Variance
Income									
Clinical Income	(11,204)	(11,332)	128	(55,924)	(56,078)	154	(134,750)	(137,689)	2,938
Non-Clinical Income	(603)	(652)	49	(2,995)	(3,299)	304	(7,416)	(7,431)	15
Total Income	**(11,807)**	**(11,984)**	**177**	**(58,919)**	**(59,377)**	**458**	**(142,166)**	**(145,119)**	**2,953**
Expenditure									
Pay Costs	7,300	9,097	(1,798)	37,228	41,282	(4,054)	88,336	94,173	(5,838)
Non-Pay Costs	3,225	2,553	673	16,103	14,395	1,708	38,631	36,499	2,132
CNST	1,800	1,801	(1)	9,001	8,992	10	21,603	21,605	(1)
Total Expenditure	**12,325**	**13,451**	**(1,126)**	**62,333**	**64,668**	**(2,335)**	**148,570**	**152,277**	**(3,707)**
EBITDA	**518**	**1,467**	**(949)**	**3,414**	**5,291**	**(1,877)**	**6,404**	**7,158**	**(753)**
Technical Items									
Depreciation	548	513	35	2,741	2,606	135	6,579	6,132	448
Interest Payable	2	(5)	7	10	1	9	21	14	7
Interest Receivable	(16)	(41)	25	(82)	(218)	136	(200)	(371)	171
PDC Dividend	221	220	1	1,103	1,102	1	2,645	2,639	6
Profit/Loss on Disposal or Transfer Absorption	0	64	(64)	0	(122)	122	0	(122)	122
Total Technical Items	**755**	**751**	**5**	**3,772**	**3,369**	**403**	**9,045**	**8,292**	**753**
(Surplus) / Deficit	**1,274**	**2,218**	**(944)**	**7,186**	**8,660**	**(1,474)**	**15,450**	**15,450**	**(0)**

NHS
Liverpool Women's
NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 2A
WTE: M5
YEAR ENDING 31 MARCH 2024

TYPE	DESCRIPTION	M12	M1	M2	M3	M4	M5	Movement M12 - M5
SUBSTANTIVE	REGISTERED NURSING, MIDWIFERY & HEALTH VISITING STAFF	631.94	648.33	649.61	645.49	636.13	640.11	8.17
	ALLIED HEALTH PROFESSIONALS	82.04	81.95	81.35	83.27	83.57	85.45	3.41
	OTHER REGISTERED SCIENTIFIC, THERAPEUTIC & TECHNICAL STAFF	11.78	11.31	11.31	12.31	11.31	12.31	0.53
	REGISTERED HEALTH CARE SCIENTISTS	49.22	53.62	54.54	54.34	55.34	57.34	8.12
	HCA & SUPPORT TO CLINICAL STAFF	234.51	237.51	244.48	237.49	242.70	241.16	6.65
	MANAGERS & SENIOR MANAGERS	59.92	63.32	64.32	61.32	59.02	62.57	2.65
	ADMIN AND ESTATES STAFF	13.00	13.00	13.00	14.00	14.00	15.00	2.00
	OTHER INFRASTRUCTURE & SUPPORT STAFF	288.12	288.08	284.17	285.09	279.25	276.78	(11.34)
	MEDICAL AND DENTAL	185.09	190.90	191.67	193.80	190.34	197.14	12.05
	ANY OTHER STAFF	14.00	14.00	14.00	14.00	14.00	14.00	0.00
SUBSTANTIVE TOTAL		**1,569.62**	**1,602.02**	**1,608.45**	**1,601.11**	**1,585.66**	**1,601.86**	**32.24**
BANK	REGISTERED NURSING, MIDWIFERY & HEALTH VISITING STAFF	47.33	37.81	43.37	45.40	34.57	30.12	(17.21)
	ALLIED HEALTH PROFESSIONALS	17.42	13.00	16.78	15.67	11.15	10.48	(6.94)
	OTHER REGISTERED SCIENTIFIC, THERAPEUTIC & TECHNICAL STAFF	-	-	-	-	-	-	0.00
	REGISTERED HEALTH CARE SCIENTISTS	0.28	0.91	0.64	0.46	0.37	0.27	(0.01)
	HCA & SUPPORT TO CLINICAL STAFF	31.22	25.76	25.13	24.57	21.87	19.20	(12.02)
	MANAGERS & SENIOR MANAGERS	-	-	-	-	-	-	0.00
	ADMIN AND ESTATES STAFF	-	0.23	0.12	0.09	-	0.05	0.05
	OTHER INFRASTRUCTURE & SUPPORT STAFF	6.25	7.27	6.44	4.36	4.89	6.82	0.57
	MEDICAL AND DENTAL	2.00	2.80	2.80	2.00	2.00	1.94	(0.06)
	ANY OTHER STAFF	-	-	-	-	-	-	0.00
TOTAL BANK		**104.50**	**87.78**	**95.28**	**92.55**	**74.85**	**68.88**	**(35.62)**
AGENCY	REGISTERED NURSING, MIDWIFERY & HEALTH VISITING STAFF	8.23	10.49	2.03	0.08	2.11	2.76	(5.47)
	ALLIED HEALTH PROFESSIONALS	4.04	1.23	3.26	3.26	2.92	2.60	(1.44)
	OTHER REGISTERED SCIENTIFIC, THERAPEUTIC & TECHNICAL STAFF	-	-	-	-	-	-	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	-	-	-	-	-	(1.00)
	OTHER INFRASTRUCTURE & SUPPORT STAFF	-	1.73	-	-	-	-	0.00
	MEDICAL AND DENTAL	0.10	-	-	-	-	-	(0.10)
	ANY OTHER STAFF	-	-	-	-	-	-	0.00
AGENCY TOTAL		**13.37**	**13.45**	**5.29**	**3.34**	**5.03**	**5.36**	**(8.01)**

TRUST TOTAL	**1,687.49**	**1,703.25**	**1,709.02**	**1,697.00**	**1,665.54**	**1,676.10**	**(11.39)**

NHS
Liverpool Women's
NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 3
EXPENDITURE: M5
YEAR ENDING 31 MARCH 2024

EXPENDITURE £000	MONTH 5 Budget	MONTH 5 Actual	MONTH 5 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	490	557	(67)	2,360	2,572	(211)	5,465	5,612	(147)
Medical	2,092	3,019	(926)	10,460	11,704	(1,244)	25,105	27,567	(2,463)
Nursing & Midwifery	2,991	3,391	(399)	15,397	17,081	(1,684)	37,313	40,300	(2,987)
Healthcare Assistants	547	649	(102)	2,735	3,177	(442)	6,565	7,518	(953)
Other Clinical	289	573	(284)	1,691	2,327	(636)	2,962	3,417	(455)
Admin Support	728	857	(128)	3,778	4,125	(347)	9,078	9,267	(189)
Agency & Locum	161	52	109	805	295	510	1,848	491	1,356
Total Pay Costs	**7,300**	**9,097**	**(1,798)**	**37,228**	**41,282**	**(4,054)**	**88,336**	**94,173**	**(5,838)**
Non Pay Costs									
Clinical Suppplies	835	870	(35)	4,173	4,637	(464)	10,031	10,928	(897)
Non-Clinical Supplies	714	274	440	3,779	2,375	1,404	8,876	6,819	2,056
CNST	1,800	1,801	(1)	9,001	8,992	10	21,603	21,605	(1)
Premises & IT Costs	871	713	158	4,369	4,023	346	10,467	10,723	(256)
Service Contracts	806	751	55	3,782	3,360	422	9,257	8,029	1,229
Total Non-Pay Costs	**5,026**	**4,354**	**672**	**25,105**	**23,387**	**1,718**	**60,235**	**58,104**	**2,131**
Total Expenditure	**12,325**	**13,451**	**(1,126)**	**62,333**	**64,668**	**(2,335)**	**148,570**	**152,277**	**(3,707)**

NHS
Liverpool Women's
NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
BUDGET ANALYSIS: M5
YEAR ENDING 31 MARCH 2024

INCOME & EXPENDITURE	MONTH 5			YEAR TO DATE			YEAR - Underlying			YEAR - Recovery		
£'000	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Actual	Variance
Maternity												
Income	(4,434)	(4,680)	246	(20,762)	(20,877)	116	(50,625)	(50,541)	(84)	(50,625)	(50,541)	(84)
Expenditure	2,434	2,978	(544)	12,179	13,630	(1,450)	29,216	32,238	(3,022)	29,216	32,238	(3,022)
Total Maternity	**(2,000)**	**(1,702)**	**(298)**	**(8,582)**	**(7,248)**	**(1,335)**	**(21,408)**	**(18,303)**	**(3,106)**	**(21,408)**	**(18,303)**	**(3,106)**
Neonatal												
Income	(1,849)	(2,016)	167	(9,197)	(9,298)	101	(22,093)	(22,300)	207	(22,093)	(22,300)	207
Expenditure	1,470	1,627	(156)	7,351	7,621	(270)	17,643	18,251	(608)	17,643	18,251	(608)
Total Neonatal	**(379)**	**(390)**	**11**	**(1,846)**	**(1,677)**	**(169)**	**(4,450)**	**(4,049)**	**(401)**	**(4,450)**	**(4,049)**	**(401)**
Division of Family Health - Total	**(2,379)**	**(2,092)**	**(287)**	**(10,428)**	**(8,925)**	**(1,503)**	**(25,858)**	**(22,351)**	**(3,507)**	**(25,858)**	**(22,351)**	**(3,507)**
Gynaecology												
Income	(2,402)	(2,099)	(303)	(11,270)	(10,747)	(522)	(27,361)	(26,433)	(928)	(27,361)	(26,433)	(928)
Expenditure	1,425	1,851	(425)	7,145	8,281	(1,136)	17,123	19,464	(2,341)	17,123	19,464	(2,341)
Total Gynaecology	**(977)**	**(249)**	**(728)**	**(4,125)**	**(2,466)**	**(1,658)**	**(10,238)**	**(6,969)**	**(3,269)**	**(10,238)**	**(6,969)**	**(3,269)**
Hewitt Centre												
Income	(885)	(946)	61	(4,294)	(4,044)	(250)	(10,609)	(9,837)	(772)	(10,609)	(9,837)	(772)
Expenditure	794	710	84	3,969	4,057	(87)	9,527	9,938	(411)	9,527	9,938	(411)
Total Hewitt Centre	**(91)**	**(236)**	**145**	**(325)**	**12**	**(337)**	**(1,083)**	**100**	**(1,183)**	**(1,083)**	**100**	**(1,183)**
Division of Gynaecology - Total	**(1,068)**	**(485)**	**(584)**	**(4,450)**	**(2,454)**	**(1,995)**	**(11,321)**	**(6,869)**	**(4,453)**	**(11,321)**	**(6,869)**	**(4,453)**
Theatres												
Income	0	0	0	0	0	0	0	0	0	0	0	0
Expenditure	1,012	1,167	(155)	5,201	5,818	(618)	12,285	14,164	(1,879)	12,285	14,164	(1,879)
Total Theatres	**1,012**	**1,167**	**(155)**	**5,201**	**5,818**	**(618)**	**12,285**	**14,164**	**(1,879)**	**12,285**	**14,164**	**(1,879)**
Genetics												
Income	(4)	0	(4)	(18)	(55)	37	(42)	(55)	13	(42)	(55)	13
Expenditure	161	129	32	803	690	113	1,928	1,740	187	1,928	1,740	187
Total Genetics	**157**	**129**	**29**	**786**	**635**	**150**	**1,886**	**1,686**	**200**	**1,886**	**1,686**	**200**
Other Clinical Support												
Income	(221)	(562)	341	(2,934)	(2,857)	(77)	(7,147)	(6,745)	(402)	(7,147)	(6,745)	(402)
Expenditure	549	998	(449)	4,439	4,930	(491)	10,469	11,880	(1,411)	10,469	11,880	(1,411)
Total Clinical Support	**328**	**436**	**(108)**	**1,505**	**2,073**	**(568)**	**3,322**	**5,135**	**(1,813)**	**3,322**	**5,135**	**(1,813)**
Division of Clinical Support - Total	**1,497**	**1,731**	**(234)**	**7,491**	**8,526**	**(1,035)**	**17,493**	**20,984**	**(3,492)**	**17,493**	**20,984**	**(3,492)**
Corporate & Trust Technical Items												
Income	(2,011)	(2,178)	167	(10,444)	(12,681)	2,237	(24,288)	(27,407)	3,119	(24,288)	(30,398)	6,110
Expenditure	5,235	5,241	(5)	25,017	24,194	823	59,425	61,407	(1,982)	59,425	54,083	5,342
Total Corporate	**3,224**	**3,063**	**162**	**14,573**	**11,513**	**3,060**	**35,137**	**34,000**	**1,136**	**35,137**	**23,685**	**11,451**
(Surplus) / Deficit	**1,274**	**2,218**	**(944)**	**7,186**	**8,660**	**(1,474)**	**15,450**	**25,765**	**(10,315)**	**15,450**	**15,450**	**(0)**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
CIP: M5
YEAR ENDING 31 MARCH 2024

		MONTH 5			YTD			FOT		
TYPE	**Scheme**	**Target**	**Actual**	**Variance**	**Target**	**Actual**	**Variance**	**Target**	**Actual**	**Variance**
Income	Income Private Patient	21	2	(19)	70	31	(39)	470	106	(364)
Income	income non-patient care	55	30	(25)	256	267	11	842	673	(169)
Income	Income Other	61	13	(47)	286	67	(219)	710	660	(50)
Income	Unidentified - Income	14	0	(14)	27	0	(27)	270	1,031	760
Total Income		**151**	**45**	**(105)**	**639**	**365**	**(274)**	**2,292**	**2,470**	**177**
Pay	Service re-design - pay	18	28	10	91	43	(48)	217	103	(114)
Pay	Establishment reviews	4	13	10	(4)	269	273	20	490	470
Pay	Unidentified - pay	277	0	(277)	559	0	(559)	2,502	2,502	0
Pay	Other - pay	0	0	0	0	0	0	200	200	0
Pay	E-Rostering	2	0	(2)	10	0	(10)	25	0	(25)
Total Pay		**301**	**41**	**(260)**	**656**	**312**	**(344)**	**2,965**	**3,296**	**331**
Non-Pay	Other - Non-pay	11	29	18	53	142	89	181	400	220
Non-Pay	Medicines optimisation	14	0	(14)	68	0	(68)	164	0	(164)
Non-Pay	Service re-design - Non-pay	190	13	(177)	930	996	66	2,262	2,026	(236)
Non-Pay	digital transformation non-pay	10	0	(10)	51	0	(51)	122	0	(122)
Non-Pay	Pathology & imaging networks	0	0	(0)	2	0	(2)	5	0	(5)
Non-Pay	Procurement (excl drugs) - medical devices and clinical consumables	15	1	(14)	71	6	(65)	175	41	(134)
Non-Pay	Fleet optimisation	2	0	(2)	4	0	(4)	20	0	(20)
Non-Pay	Procurement (excl drugs) -non-clinical	4	0	(4)	21	0	(21)	51	4	(47)
Non-Pay	Unidentified - non-pay	11	0	(11)	24	0	(24)	100	100	0
Total Non-Pay		**257**	**43**	**(214)**	**1,224**	**1,144**	**(80)**	**3,079**	**2,571**	**(508)**
Total CIP Delivery		**709**	**129**	**(580)**	**2,519**	**1,821**	**(698)**	**8,336**	**8,336**	**(0)**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 6
BALANCE SHEET: M5
YEAR ENDING 31 MARCH 2024

BALANCE SHEET £'000	YEAR TO DATE Opening	M5 Actual	Movement
Non Current Assets	102,405	101,666	(739)
Current Assets			
Cash	9,790	3,754	(6,036)
Debtors	9,647	10,019	372
Inventories	839	842	3
Total Current Assets	**20,276**	**14,615**	**(5,661)**
Liabilities			
Creditors due < 1 year - Capital Payables	(2,002)	(1,198)	804
Creditors due < 1 year - Trade Payables	(26,820)	(17,997)	8,823
Creditors due < 1 year - Deferred Income	(4,492)	(16,445)	(11,953)
Creditors due > 1 year - Deferred Income	(1,530)	(1,516)	14
Loans	(918)	(913)	5
Loans - IFRS16 leases	(50)	(50)	0
Provisions	(628)	(582)	46
Total Liabilities	**(36,440)**	**(38,701)**	**(2,261)**
TOTAL ASSETS EMPLOYED	**86,241**	**77,580**	**(8,661)**
Taxpayers Equity			
PDC	79,115	79,115	0
Revaluation Reserve	8,679	8,679	0
Retained Earnings	(1,553)	(10,214)	(8,661)
TOTAL TAXPAYERS EQUITY	**86,241**	**77,580**	**(8,661)**

**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 7
CASHFLOW STATEMENT: M5
YEAR ENDING 31 MARCH 2024

CASHFLOW STATEMENT £000	Actual
Cash flows from operating activities	(7,897)
Depreciation and amortisation	2,606
Impairments and reversals	0
Income recognised in respect of capital donations (cash and non-cash)	0
Movement in working capital	1,593
Net cash generated from / (used in) operations	**(3,698)**
Interest received	230
Purchase of property, plant and equipment and intangible assets	(2,754)
Proceeds from sales of property, plant and equipment and intangible assets	186
Net cash generated from/(used in) investing activities	**(2,338)**
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	**(6,036)**
Cash and cash equivalents at start of period	9,790
Cash and cash equivalents at end of period	**3,754**

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**

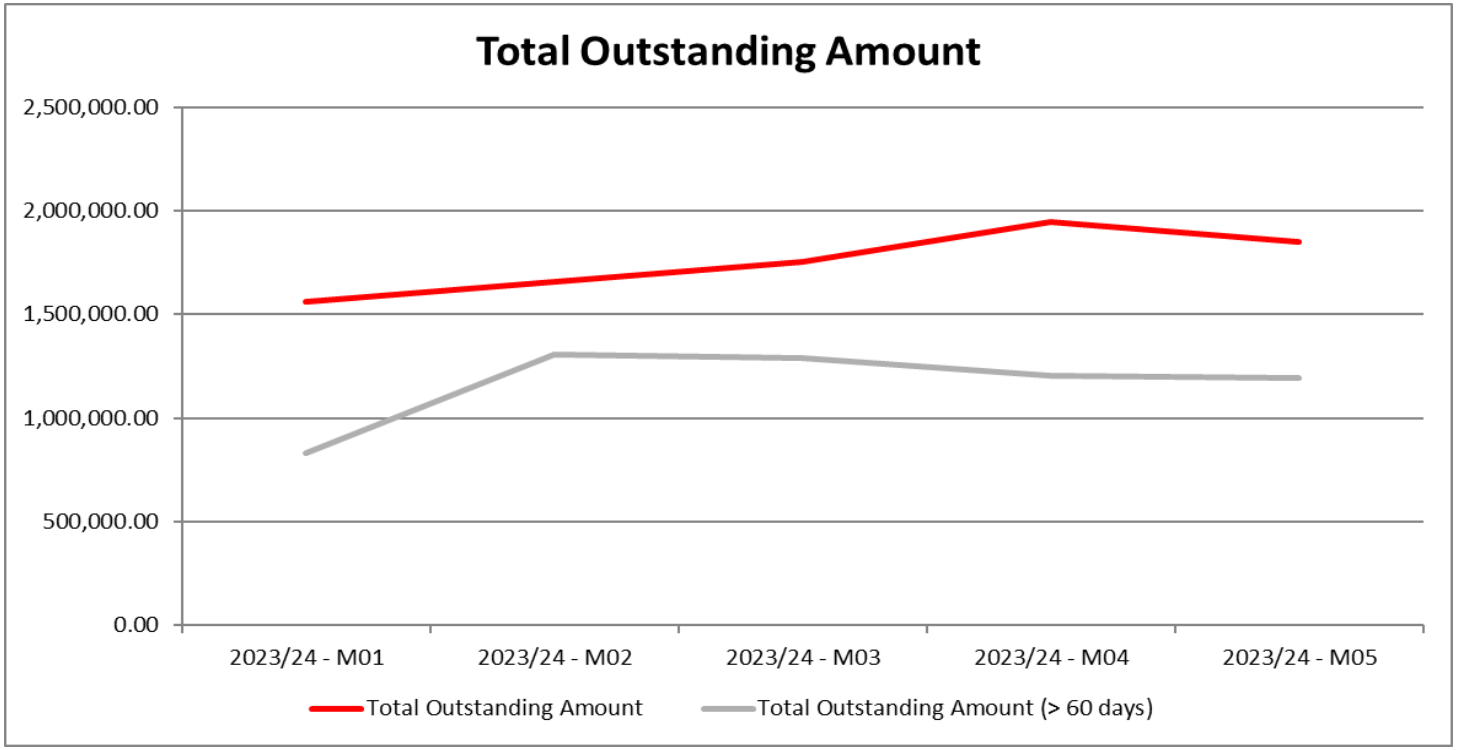
Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 8
CAPITAL EXPENDITURE: M05
YEAR ENDING 31 MARCH 2024

		YTD			YEAR		
Area	Capital Scheme	PLAN	ACTUAL	VARIANCE	PLAN	FOT	VARIANCE
Digital	EPR frontline digitisation	497	487	9	560	560	0
Digital	IT/digital investment - infrastructure	320	776	(456)	1,290	1,290	(0)
Digital	IT/digital investment - hardware	150	73	77	354	280	74
Digital	Community diagnostic equipment	153	0	153	153	153	0
Digital	Community diagnostic IT	100	0	100	65	65	0
Digital	PACS - image sharing - CAMRIN programme	49	0	49	49	49	0
Estates	Building works/refurbishment - Maternity	575	12	563	950	950	0
Estates	Building works/refurbishment - Neonatal	80	0	80	180	180	0
Estates	Building works/refurbishment - Gynaecology	70	0	70	300	300	0
Estates	Estates programme	210	75	135	560	560	(0)
Estates	Charity funded bereavement suite works	35	0	35	70	70	0
Medical Equipment	Medical equipment - Clinical Support - Fluoroscopy	0	0	0	241	241	0
Medical Equipment	Medical equipment - Clinical Support - Theatres	107	55	52	107	107	0
Medical Equipment	Medical equipment - All other clinical areas	473	413	60	1,041	1,100	(59)
Medical Equipment	Medical equipment - leased blood gas analysers	139	23	116	139	139	(0)
Other	Other	0	(2)	2	(905)	(891)	(14)
TOTAL CAPITAL		**2,958**	**1,912**	**1,046**	**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.

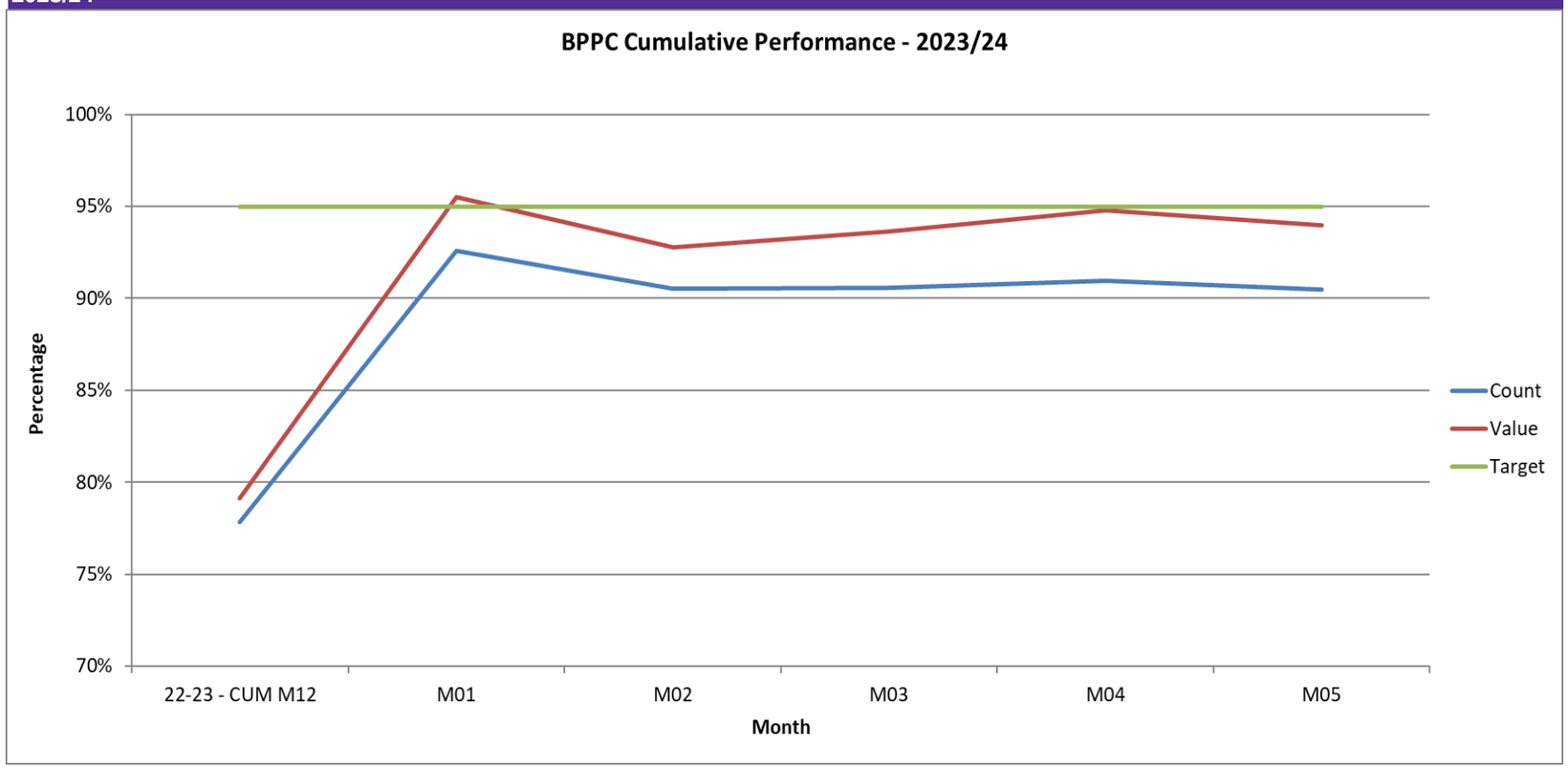
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 9
AGED DEBTORS BALANCE: M5
YEAR ENDING 31 MARCH 2024



LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 10
BETTER PAYMENT PRACTICE CODE (BPPC) - CUMULATIVE PERFORMANCE FOR M5
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	M04	M05	M06	M07	M08	M09	M10	M11	M12
Cumulative Performance - Count	93%	91%	91%	91%	90%							
Cumulative Performance - Value	96%	93%	94%	95%	94%							

2023/24 performance TOTAL

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 11
AGENCY USAGE: M5
YEAR ENDING 31 MARCH 2024

		MONTH 5			YTD			FOT		
Division	Directorate	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Actual	Variance
Family Health	Maternity	0	29	(29)	-	106	(106)	-	117	(117)
Gynaecology	Gynaecology	0	0	0	-	16	(16)	-	44	(44)
Gynaecology	HFC	0	(1)	1	-	10	(10)	-	- 28	(28)
CSS	Theatres	0	12	(12)	-	73	(73)	-	144	(144)
CSS	CDC	(37)	(1)	(36)	12	16	(4)	12	16	(4)
CSS	Imaging	0	14	(14)	-	68	(68)	-	134	(134)
Corporate	All Corporate Directorates	198	(1)	199	793	6	787	1,835	6	1,829
Total Agency		**161**	**52**	**109**	**805**	**295**	**510**	**1,848**	**491**	**1,357**
Performance against cap/plan		**195**	**52**	**143**	**975**	**295**	**680**	**2,333**	**491**	**1,842**

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*23/24/168*	**Date: 12/10/2022**
Report Title	**Fit and Proper Person Test Requirements Update**	
Prepared by	*Mark Grimshaw, Trust Secretary*	
Presented by	*Mark Grimshaw, Trust Secretary*	
Key Issues / Messages	• **The report outlines the Trust's compliance with the Fit and Proper Person (Regulation 5) requirements.** • **NHS England published a revised Fit and Proper Persons Test (FPPT) Framework for all board members on 2 August 2023** • **A new standardised board member reference form to be held on file for leaving, retiring or resigning from 30 September 2023, further elements to be implemented by 31 March 2024** • **An enhanced annual FPPT checks is to be completed as part of the annual appraisal and a summary submitted to NHS England Regional Director by 31 March 2024** • **The Trust policy has been updated and approval is sought from the Board**	

Action required	**Approve ☒**	**Receive ☐**	**Note ☐**	**Take Assurance ☐**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable):			
	For Decisions - in line with Risk Appetite Statement – Y/N ***If no – please outline the reasons for deviation.***			
	The Board is asked to: • ***Note the 2023 compliance status for the Fit and Proper Person Requirements*** • ***Note the key issues relating to the NHS England Fit and Proper Person Test Framework for board members*** • ***Approve the updated Fit and Proper Person Policy***			
Supporting Executive:	*Mark Grimshaw, Trust Secretary*			

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

Strategy ☐ Policy ☒ Service Change ☐ Not Applicable ☐

Strategic Objective(s)

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

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

REPORT DEVELOPMENT:

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

EXECUTIVE SUMMARY

The Fit and Proper Person Requirement (FPPR) for directors of NHS bodies was established in response to the Francis Report and became effective in 2014 under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Its aim is to ensure that individuals in director-level roles responsible for care quality and safety meet the necessary standards.

The Care Quality Commission (CQC) issued guidance on FPPR, emphasizing that NHS Bodies are responsible for ensuring compliance. CQC's role is to monitor and evaluate how well NHS Bodies fulfil this duty. The recent CQC Well-Led inspection found no issues with the Trust's FPPR compliance.

NHS England (NHSE) introduced a new Fit and Proper Person Framework in August 2023, with a phased implementation starting from September 30, 2023, and full adoption by March 31, 2024. The Trust has reviewed its FPPR policy in line with the new guidance.

Directors whose data will be included in ESR and local records from October 2023 onward must be informed, and any concerns raised will be considered for necessary adjustments. A link to the full framework and guidance is provided in the document's Appendix A.

MAIN REPORT

BACKGROUND

The Fit and Proper Person Requirement (FPPR) for directors of NHS bodies was a direct response to the Francis Report. The FPPR came into force in 2014, brought into being by Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The intention of this regulation is to ensure that people who have director level responsibility for the quality and safety of care, and for meeting the fundamental standards are fit and proper to carry out this important role.

The Care Quality Commission (CQC) issued its own guidance on FPPR. The guidance makes it clear that it is a matter for NHS Bodies to ensure that the FPPR is met. CQC's role is to monitor and assess how well NHS Bodies discharge their responsibility.

The Trust has processes to meet these requirements and in September 2022, approved a separate policy (previously elements had been factored into the recruitment and selection policy). The Trust's compliance against the FPPR was reviewed during the most recent CQC Well-Led

inspection and no issues were noted in the final report. Our annual process has now concluded, and the report outlines the compliance position.

NHS England (NHSE) published a new Fit and Proper Person Framework on 2 August 2023 alongside guidance for Chairs and staff on implementation. NHSE expect elements of the framework to be used from 30th September 2023 for new appointments, with full implementation by 31st March 2024.

We have reviewed the LWH Fit and Proper Person Policy and processes in conjunction with new guidance. This paper sets out the main changes and the revised Trust policy is appended for Board of Directors' review and approval.

NHS organisations, as data controllers, must communicate to all directors whose details will be included in ESR and local records from October 2023 onwards. LWH Directors are asked to raise any concerns regarding the proposed use of their data, to enable NHSE and participating data controllers (i.e., The Trust) to consider these concerns and amend their approach if necessary.

A link to the full framework and supporting guidance is provided in Appendix A.

2023 Compliance

Completed packs and checks are in place for all Directors and Deputy Directors.

Electronic copies of the completed and signed packs are saved together with hard copies in personal files. These are made available for review and audit by the CQC.

Lessons learned and identified improvements

There have been challenges in accessing confirmation that a Director has a DBS check in place (LWH does this annually rather than every three years). This process would be greatly simplified, and assurance strengthened if each Director signed up to the DBS update service. Currently 13 of 15 Directors are signed up to this service so this aspect will significantly improve for the 2024 process.

New Fit and Proper Person Framework – summary of changes

The fundamental elements of the FPP processes are already in place within the Trust. However, from review of the new framework, the main changes are:

- The framework introduces a new standardised board member reference. These should be created whenever a board member leaves an NHS organisation, regardless of whether they are moving immediately to another NHS role and should be sought by employing NHS organisations when making a job offer. The reference is based on the NHS standard reference template but includes additional questions relevant to the FPPT. The template has been included within the updated policy.
- The Electronic Staff Record (ESR) will be used to store information related to FPPT checks and references. This will provide a standard way to record and report compliance internally. Retrospective population of data is not proposed. The policy has been updated to reflect this.
- The framework provides a new template for the self-attestation, and this has replaced our current self-assessment template.

- The Chair's responsibility has been expanded within our policy to reflect the emphasis placed on this within the new framework.
- There is a requirement for an annual submission to the NHS England Regional Director (for 2024 the deadline is 31st March 2024 but going forward this is expected to align with appraisals in Q1 of the following year).
- Several additions have also been made to provide further clarity, including the respective requirements for joint appointments. A letter of confirmation is required from the lead employing organisation and this approach will be considered for the proposed joint CEO appointment.
- Social media declaration form – whilst this is not a requirement this is often the most challenging aspect of the due diligence to conduct robustly. This new form will support the identification of accounts and effective searches.

The full implementation of the framework is reliant on

- National changes to ESR, which have now been implemented and are available for local use (apart from the function to save references for departed directors).
- DPIA (data protection impact assessment) has been completed by the NHS Business Services Authority (NHSBSA) who host ESR and NHS England.
- Publication of the forthcoming NHS Leadership Competency Framework (expected Autumn 2023) and the Board Appraisal Framework (expected later in 2023/24).

RECOMMENDATION

The Board is asked to:

- Note the 2023 compliance status for the Fit and Proper Person Requirements
- Note the key issues relating to the NHS England Fit and Proper Person Test Framework for board members
- Approve the updated Fit and Proper Person Policy

Liverpool Women's NHS Foundation Trust

Appendix A – link to new FPP Framework

NHS England » NHS England Fit and Proper Person Test Framework for board members

Liverpool Women's
NHS Foundation Trust

FIT & PROPER PERSONS REQUIREMENTS POLICY

Version	2.0
Designation of Policy Author(s)	Trust Secretary
Policy Development Contributor(s)	Trust Secretary
Designation of Sponsor	Trust Secretary
Responsible Committee	Board of Directors
Date ratified	TBC
Date issued	TBC
Review date	October 2024
Coverage	Trust Wide

The Trust is committed to a duty of candour by ensuring that all interactions with patients, relatives, carers, the general public, commissioners, governors, staff and regulators are honest, open, transparent and appropriate and conducted in a timely manner. These interactions be they verbal, written or electronic will be conducted in line with the NPSA, 'Being Open' alert, (NPSA/2009/PSA003 available at www.nrls.npsa.nhs.uk/beingopen and other relevant regulatory standards and prevailing legislation and NHS constitution)

It is essential in communications with patients that when mistakes are made and/or patients have a poor experience that this is explained in a plain language manner making a clear apology for any harm or distress caused.

The Trust will monitor compliance with the principles of both the duty of candour and being open NPSA alert through analysis of claims, complaints and serious untoward incidents recorded within the Ulysses Risk Management System.

Content

1 Executive Summary

1.1 Policy Scope

1.2 This policy and procedure applies to all Board appointments i.e. Executive and Non-Executive Directors and those senior managers which are recognised as part of the Trust Board. This includes permanent, interim and associate positions.

1.3 The following posts are subject to the arrangements outlined in this policy:

a) the Chair of the Trust;

b) Non-Executive Directors appointed to the Board of Directors (including Associate Non-Executive Directors);

i) the Chief Executive of the Trust,

ii) Executive Directors who can vote at the Board of Directors,

iii) non-voting Directors who attend the Board of Directors,

iv) the Trust Secretary,

v) Deputy Directors who would be expected to 'act up' in the absence of an Executive Director

2 Introduction

2.1 The Fit and Proper Person Requirement (FPPR) for directors of NHS bodies is a direct response to the Francis Report. The FPPR came into force in 2014, brought into being by Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (updated 2022). The intention of this regulation is to ensure that people who have director level responsibility for the quality and safety of care, and for meeting the fundamental standards are fit and proper to carry out this important role. A new Fit and Proper Framework was introduced by NHS England in 2023.

2.2 The Care Quality Commission (CQC) issued its own guidance on FPPR. The guidance makes it clear that it is a matter for NHS Bodies to ensure that the FPPR is met. CQC's role is to monitor and assess how well NHS Bodies discharge their responsibility.

For the full regulation visit: https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-5-fit-proper-persons-directors

2.3 The Fit and Proper Person Requirements focus on assessing the applicant's honesty, integrity, suitability and fitness, for example that they have the right level of qualifications, skills and experience, and that, with all reasonable adjustments, is

able to undertake the roles and responsibilities of the position being offered.

3 Policy Objectives

3.1 The aim of this policy document is to ensure a clear process is in place to provide assurance that individuals within Director (and Deputy Director) positions at Liverpool Women's NHS Foundation Trust comply with the Fit and Proper Persons requirements.

4 Duties / Responsibilities

4.1 The **Chair** has overall accountability for arrangements in their organisation. They are required to:

a) Ensure assessments carried out for board members on appointment and annually, and at any time that something new comes to light
b) Ensure that the Board Member Reference is completed for any board member who leaves the board for whatever reason, whether or not a reference has been requested
c) Conclude on assessments for the whole board (executive and non-executive, permanent or temporary, voting or non-voting) and update ESR
d) Submit annual summary to relevant regional director

4.2 The **Senior Independent Director** is responsible for carrying out the FPPT assessment of the Chair.

4.3 The **Trust Secretary** supports the Chair in establishing arrangements for the FPPT and specifically for:

a) Accessing and entering information onto ESR
b) Testing elements of FPPT assessment and recording outcome and evidence for chair to review and conclude
c) Completing the annual submission form

4.4 The **Chief Executive** carries out the initial assessment of the FPPT for executive board members and shares with the Chair for overall assessment of board member FPP status. They also support the Chair in the overall process.

4.5 **Governors** take the annual trust submission and other information relating to FPPT into account as part of their role in appointment and removal of chairs and non-executive directors and their role in receiving information about the performance appraisal process

4.6 **Nominations Committee** - The Trust has two Nominations and Remuneration Committees dealing with the appointment of Non-Executive Directors and Executive Directors respectively. These Committees are responsible for ensuring the assessment of candidates for Board positions and in the case of Non-Executive Directors, the recommendation of candidates for appointment by the Council of Governors. Each committee must ensure that the appropriate

due diligence is undertaken in respect of the preferred candidate, prior to appointment. Where any issue comes to light, this must be investigated and documented in support of the final recruitment decision.

For issues arising in respect of existing Directors, the Chair may refer any concerns of on-going tenure to the relevant Nominations Committee. Any interim arrangements required pending a Fit and Proper Person investigation will be considered by the relevant Nominations Committee.

The removal of an Executive/Associate Director will be a decision for the Nomination & Remuneration Committee (Executive).

4.7 **NHS Regional Directors** have an oversight role covering elements of:
a) Appointment and initial FPPT assessment
b) Receipt of the annual FPPT Submission forms
c) Where required, in relation to disputes and appeals

4.8 **Individuals covered by the scope of this policy** are responsible for:
a) signing the Fit and Proper Person Self-Attestation form (Appendix 2) to confirm that they are a fit a proper person, both on appointment and on an annual basis
b) providing evidence of their qualifications, experience, and identity documents on appointment or on request to confirm the competencies relevant to their position
c) identifying any issues which may affect their ability to meet the statutory requirements on appointment and bringing these issues on an ongoing basis and without delay to the Chief People Officer, Trust Secretary, Chief Executive or the Chair

5 Main Body of Policy

5.1 Definitions

a) CQC Care Quality Commission
b) FPPR Fit and Proper Person Requirement

5.2 The Requirements

5.3 The Care Quality Commission states that unless an individual satisfies all the requirements set out in Regulation 5, a service provider must not appoint or have in place an individual

- as a director of the service provider, or
- performing the functions of or functions equivalent or similar to the functions of a director.

The requirements that are referred to are that:

- the individual is of good character
- the individual has the qualifications, competence, skills, and experience

which are necessary for the relevant office or position or the work for which they are employed,

- the individual is able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed,
- the individual has not been responsible for, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) while carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity, and where an individual who holds a relevant position but no longer meets the requirements, the Trust must:
    - take such action as is necessary and proportionate to ensure that the position in question is held by an individual who meets such requirements, and
    - if the individual is a health care professional, social worker or other professional registered with a health care or social care regulator, inform the regulator in question.
- None of the grounds of unfitness specified in part 1 of Schedule 4 the provider licence apply to the Individual.

See Appendix 1 for examples of misconduct or mismanagement.

5.4 The grounds of unfitness specified in Part of Schedule 4 to the Regulated Activities Regulations are:

a) the person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged;
b) the person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland;
c) the person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986;
d) the person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it;
e) the person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland;
f) the person is prohibited from holding the relevant office or position, or in the case of an individual for carrying on the regulated activity, by or under any enactment.

The good character requirements referred to in Regulation 5 as specified in Part 2 of Schedule 4 to the Regulated Activities Regulations relate to:

a) whether the person has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committee in

any part of the United Kingdom, would constitute an offence

b) whether the person has been erased, removed or struck off a register of professionals maintained by a regulator of health care or social work professionals.

5.6 **Process for Assessing FPPR Compliance**

5.7 The FPPR must be applied to an individual before appointment. There is then a requirement to ensure FPPR is complied with during the employment relationship.

5.8 **New Appointments**

5.9 Where a post is subject to FPPR, candidates will be notified as part of the Trust's recruitment processes. It is important when making appointments that consideration is given to the values of the organisation and the extent to which the candidate fits with these values. It is therefore expected that the interview process will incorporate values-based questions.

5.10 The Trust's comprehensive pre-employment checking processes are determined by the NHS employment standards and include the following:

1. Full employment history with documented explanation of any gaps
2. Obtaining two references (using the Board member reference template), one of which should be from the most recent employer;
3. qualification and professional registration checks;
4. right to work checks;
5. proof of identity;
6. occupational health clearance;
7. appropriate DBS clearance;

In addition, the following registers will be checked:

a) Disqualified directors

b) Bankruptcy and insolvency

c) Removed Charity Trustees

d) A web search of the individual including Google, news searches, and social media checks. For the latter, individuals will be asked to complete a social media declaration form (Appendix 4)

5.11 A detailed checklist will be completed at appointment and will be retained on the post holder's personal file for the purposes of audit. Detailed assurance checks on appointment are outlined in Appendix 5.

5.12 The FPPR requires new employees to complete a Fit and Proper Person's Self-Attestation form (Appendix 2). This form and summary guidance will be included with the application pack and form part of the application process for the

position.

5.13 Where specific qualifications are deemed by the Trust as necessary for a role, the Trust will make this clear and will only appoint those individuals that meet the required specification; including any requirements to be registered with a professional body.

5.14 Where the Trust considers that an individual can be appointed to a role based on their qualification, skills and experience but there is an expectation that they will be required to develop specific competencies to undertake the role within a specified timescale, any such discussions or recommendations will be recorded in minutes of either the Council of Governor's Nominations & Remuneration Committee or the Nomination and Remuneration Committee for other Board appointments where confirmation of appointment is discussed.

5.15 If the candidate has a physical or mental health disability, wherever possible, reasonable adjustments will be made to enable the individual to carry out the role that they have been appointed to. Any discussion or decision as to whether a candidate is appointable on grounds of health will be recorded in the minutes of either the Council of Governor's Nominations & Remuneration Committee or the Nomination and Remuneration Committee for other Board appointments.

5.16 **Requirement for Assessment of continued Fitness**

5.17 The annual appraisal process will provide an opportunity to discuss continued "fitness", competence and how the post holder displays the Trust values and behaviour standards including the leadership behaviour expected.

5.18 The Chief Executive will be responsible for appraising the Executive Directors, and the Chair will be responsible for appraising the Non-Executive Directors. The Chief Executive will be appraised by the Chair. The Chair's appraisal will be coordinated by the Senior Independent Director working with the Lead Governor through the agreed 360º appraisal process that includes feedback from Governors, Non-Executive Directors, Executive Directors, and external partners.

5.19 On an annual basis, all relevant post holders will be asked to complete the FPPR Self-Attestation form (Appendix 2).

5.20 Individuals are required to make the Trust aware as soon as practicable of any incident or circumstances which may mean they are no longer to be regarded as a 'fit and proper person', and provide details of the issue, so that this can be considered by the Trust.

5.21 Checks of the Insolvency Register, Disqualified Directors and Charitable

Trustees register, and a web / social media search will be completed annually. The Trust will review other checks carried out on appointment every three years, or annually, as appropriate and as outlined on the checklist.

5.22 Annual checks will be carried at in line with the checklist is detailed in Appendix 5. This will be kept on the post holder's personal file for audit purposes. The Trust Secretary will be responsible for ensuring the Trust is compliant with these checks and provide completed files for review by the Chair and Chief Executive (the Senior Independent Director and Deputy Chief Executive will complete these checks for the Chair and Chief Executive files respectively).

5.23 **Joint Appointments across different NHS organisations**

5.24 For joint appointments across different NHS organisations, the full FPPT would need to be completed by the designated host/employing NHS organisation and in concluding their assessment they will need input from the chair of the other contracting NHS organisation to ensure that the board member is fit and proper to perform both roles.

5.25 The host/employing NHS organisation will then provide a 'letter of confirmation' to the other contracting NHS organisation to confirm that the board member in question has met the requirements of the FPPT.

5.26 The chair of the other contracting NHS organisation has the responsibility to keep the host/employing NHS organisation abreast of changes and any matters that may impact the FPPT assessment of the board member.

5.27 For the avoidance of doubt, where two or more organisations employ or appoint (in the case of a chair or NED) an individual for two or more separate roles at the same time, each organisation has a responsibility to complete the FPPT.

5.28 If the FPPT assessment at one organisation finds an individual not to be FPP, the Chair should update their counterpart of any other NHS organisation(s) where the individual has a board-level role and explain the reason. To note, the issue at one organisation may be one of role-specific competence, which may not necessarily mean the individual is not FPP at the other organisation.

5.29 **Concerns Regarding an Individual's Continued FPPR Compliance**

5.30 If, either at the time of appointment or later, it becomes apparent that circumstances exist or have arisen whereby an individual Director may not be considered to meet all the requirements of a 'fit and proper person', the Trust Secretary shall inform the Chair (or the Senior Independent Director, if the concern relates to the Chair).

5.31 The Chair will lead on addressing these concerns on a case-by-case basis and will need to consider whether an investigation is necessary or appropriate given the allegation.

5.32 Where it is necessary to investigate or act, the Trust's current processes will apply using the Trust's capability process (managing performance or sickness absence), Trust's Disciplinary procedure or afforded a similar process to this if the potential discontinuation could be due to 'some other substantial reason'. There may be occasions where the Trust would contact NHS England for advice or to discuss a case directly.

5.33 The Trust reserves the right to suspend a Director or restrict them from duties on full pay to allow the Trust to investigate the matters of concern. Suspension or restriction from duties will be for no longer than necessary to protect the interests of service users or the Trust and/or where there is a risk that the Director's presence would impede the gathering of evidence in the investigation.

5.34 Should the Chair consider the individual to be suitable, despite existence of information relevant to issues identified in Schedule 4, Part 2 of the FPPR, the Chair's reasons should be recorded for future reference and made available.

5.35 Should there be sufficient evidence to support the allegation(s), then the Trust may terminate the appointment of the Director with immediate effect, in line with the Trust's Disciplinary policy. Where an individual who is registered with a professional regulator (General Medical Council (GMC), Nursing & Midwifery Council (NMC) etc.) no longer meets the fit and proper person's requirement the Trust must inform the regulator and take action to ensure the position is held by a person meeting the requirements.

5.36 The criteria and process around the removal of Non-Executive Directors, including the Chair, is outlined in section 28 of the Trust's Constitution.

5.37 **Personal Data**

5.38 Personal data relating to the FPPT assessment will be retained in local record systems and specific data fields in the NHS Electronic Staff Record (ESR).

5.39 FPPT outcomes must be entered onto ESR and ESR FPPT Dashboard generated for Chair review. Once satisfied with the test the Chair must update and sign off each Board member on ESR. An annual submission form will be generate for Chair sign off and submitted to the NHSE Regional Director. The NHSE FPPT central team will collate records from NHSE regions.

5.40 **Board Member Reference Request**

5.41 NHS organisations will need to request board member references (Appendix 2), and store information relating to these references so that it is available for future checks; and use it to support the full FPPT assessment on initial

appointment.

5.42 NHS organisations should maintain complete and accurate board member references at the point where the board member departs, irrespective of whether there has been a request from another NHS employer and including in circumstances of retirement. Both the initial and board member references should be retained locally on ESR.

5.43 Board member references will apply as part of the FPPT assessment when there are new board member appointments, either internal to a particular NHS organisation, internal to the NHS, or external to the NHS. This applies whether permanent or temporary where greater than six weeks; specifically:

a. New appointments that have been promoted within an NHS organisation.

b. Existing board members at one NHS organisation who move to another NHS organisation in the role of a board member.

c. Individuals who join an NHS organisation in the role of board member for the first time from an organisation that is outside of the NHS.

d. Individuals who have been a board member in an NHS organisation and join another NHS organisation not in the role of board member, that is, they take a non-Board level role.

5.44 **Board Assurance**

5.45 The Board of Directors Nomination & Remuneration Committee, depending on the type of appointment, will receive a report to confirm implementation of the Fit and Proper Persons Regulations for existing post holders.

5.46 The Committee will also receive reports regarding new appointments and the annual checking process. The Chair is the accountable officer for ensuring compliance for new starters. An annual compliance report will be received by both the Board of Directors and Council of Governors. A summary of compliance will appear in the Trust's annual report.

6 Key References

- NHS England Fit and Proper Person Test Framework for board members 2023
- The Care Act 2014
- The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- The Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2015
- Companies Act 2006
- NHS Provider Licence May 2014

- NHS Employment Check Standards (NHS Employers)
- Standards of conduct, performance and ethics (Health and Care Professions Council)
- The seven principals of public life (Committee on standards for public life)
- CQC Frequently asked questions: Enhanced Disclosure and Barring Service (DBS) checks and fit and proper person requirement (FPPR)
- CQC Guidance - Fit and proper persons: directors

7 Associated Documents

7.1 This policy should be read in conjunction with the following Trust policies, procedures and guidance:

- Recruitment and Selection Policy
- Secondary Employment Policy and Procedure

8 Training

8.1 A notification of any policy revisions will be provided via the Trust Intranet to promote awareness of the policy and procedure. This policy and procedure will be regularly monitored and reviewed and will be assessed annually with the intention of improving its effectiveness.

9 Policy Administration

9.1 Consultation, Communication and Implementation

Consultation Required	Authorised By	Date Authorised	Comments
Impact Assessment	N/A	N/A	
GDPR	N/A		
Have the relevant details of the 2010 Bribery Act been considered in the drafting of this policy to minimise as far as reasonably practicable the potential for bribery?	**Yes** ✓		~~No~~
External Stakeholders	N/A		
Trust Staff Consultation via Intranet	N/A		N/A

Describe the Implementation Plan for the Policy (and guideline if impacts upon policy) (Considerations include; launch event, awareness sessions, communication / training via CBU's and other management structures, etc)	By Whom will this be Delivered?
Disseminated to relevant parties.	Trust Secretary

Version History

Date	Version	Author Name and Designation	Summary of Main Changes
October 23	2.0	Trust Secretary	Updates made following renewed NHS England guidance
Aug 22	1.0	Trust Secretary	Policy Creation

9.2 Monitoring Compliance with the Policy

Describe Key Performance Indicators (KPIs)	Target	How will the KPI be Monitored?	Which Committee will Monitor this KPI?	Frequency of Review	Lead
Annual review of compliance by the BoD Nomination & Remuneration Committee & BoD/CoG	100%	Review	BoD Nomination & Remuneration Committee	Annual	Trust Secretary

9.3 Performance Management of the Policy

Who is Responsible for Producing Action Plans if KPIs are Not Met?	Which Committee Will Monitor These Action Plans?	Frequency of Review (To be agreed by Committee)
Trust Secretary	Nomination & Remuneration Committee	Annual

10 Appendices

Appendix 1 – Examples of misconduct or mismanagement

Appendix 2 – FPP self-attestation form

Appendix 3 – Board Member Reference

Appendix 4 – Social Media Declaration

Appendix 5 – FPP Checklist

Appendix 6 – Process and Breach flowcharts

11 Initial Equality Impact Assessment Screening Tool

Name of policy: Fit and Proper Persons Requirements Policy	**Details of policy:** The aim of this policy document is to ensure a clear process is in place to provide assurance that individuals within Director (and Deputy Director) positions at Liverpool Women's NHS Foundation Trust comply with the Fit and Proper Persons requirements.	
Does the policy affect: (please tick)	**Patients** **Staff** ✓ **Both**	
Does the proposal, service or document affect one group more or less favourable than another on the basis of:	**Yes/No**	**Justification/evidence and data source**
Age	no	The FPPR came into force in 2014, brought into being by Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. It applies to all staff regardless of any protected characteristics. There are references within the policy when reasonable adjustments are appropriate.
Disability: including learning disability, physical, sensory or mental impairment.	no	
Gender reassignment	no	
Marriage or civil partnership	no	
Pregnancy or maternity	no	
Race	no	
Religion or belief	no	
Sex	no	
Sexual orientation	no	
Human Rights – are there any issues which might affect a person's human rights?		**Justification/evidence and data source**
Right to life	no	

Right to freedom from degrading or humiliating treatment	no	
Right to privacy or family life	no	
Any other of the human rights?	no	
EIA carried out by: Quality assured by: PGP	Date 21.12.2 2	Contact details of person carrying out assessment. ext. 4389

Appendix 1

Serious Mismanagement or misconduct

1 What is misconduct?

"Misconduct" means conduct that breaches a legal or contractual obligation imposed on the director. It could mean acting in breach of an employment contract, breaching relevant regulatory requirements (such as mandatory health and safety rules), breaching the criminal law or engaging in activities that are morally reprehensible or likely to undermine public trust and confidence.

2 What is mismanagement?

“Mismanagement” means being involved in the management of an organisation or part of an organisation in such a way that the quality of decision making and actions of the managers falls below any reasonable standard of competent management.

The following are examples of behaviour that may amount to mismanagement:

- Transmitting to a public authority, or any other person, inaccurate information without taking reasonably competent steps to ensure it was correct.
- Failing to interpret data in an appropriate way.
- Suppressing reports where the findings may be compromising for the organisation.
- Failing to have an effective system in place to protect staff who have raised concerns.
- Failing to learn from incidents, complaints and when things go wrong.
- Failing to model and promote standards of behaviour expected of those in public life, including protecting personal reputation, or the interests of another individual, over the interests of people who use a service, staff or the public.
- Failing to implement quality, safety and/or process improvements in a timely way, where there are recommendations or where the need is obvious.

3 When proven misconduct or mismanagement should be assessed as "serious"

Providers will have to reach their own decision as to whether any facts that are alleged reach the threshold of being "serious misconduct or mismanagement".
Serious: Important, grave, having (potentially) important especially undesired consequences, giving cause for concern of significant, degree, amount, worthy of consideration.
Source: The Shorter Oxford English Dictionary

Misconduct differs from mismanagement, in that a single incident of misconduct may be so serious that it amounts to serious misconduct, whether the provider also concludes that this was incompatible with continued employment or not. However, any serious misconduct renders a director unfit within the terms of the fit and proper person requirement.

However, an isolated incident is unlikely to constitute serious mismanagement unless it is so serious that it calls into question the confidence of the organisation and the public in the individual concerned.

Serious mismanagement is likely to consist of a course of conduct over time. Any assessment of its seriousness needs to consider the impact of the mismanagement on the quality and safety of care for people who use the service, the safety and well-being of staff, and the effect on the viability of the provider.

Not all misconduct or mismanagement in which a director has had some involvement will reach the threshold of “serious”. Where there is evidence of misconduct or mismanagement

that is not judged to be “serious”, the provisions of Regulation 5(3)(d) do not apply. However, it will be for the provider (as the employer) to determine the most appropriate response, in order to ensure that performance is managed and the quality and safety of services is assured.

A provider could consider isolated incidences of the following types of behaviour to amount to misconduct or mismanagement that does not reach the required threshold of seriousness:

- intermittent poor attendance
- minor breaches of security
- minor misuse of an employer’s assets
- failure to follow agreed policies or processes when undertaking management functions where the failures had limited repercussions or limited effects, or were for a benevolent or justifiable purpose.

The following are examples of misconduct and mismanagement that providers would be expected to conclude amounted to serious misconduct or mismanagement, unless there are exceptional circumstances that make it unreasonable to determine that there is serious misconduct or mismanagement:

- fraud or theft
- any criminal offence other than minor motoring offences
- assault
- sexual harassment of staff
- bullying
- victimisation of staff who raise legitimate concerns
- any conduct that can be characterised as dishonesty, including:
- deliberately transmitting information to a public authority or to any other person, which is known to be false
- submitting or providing false references or inaccurate or misleading information on a CV
- disregard for appropriate standards of governance, including resistance to accountability and the undermining of due process
- failure to make full and timely reports to the board of significant issues or incidents, including clinical or financial issues
- repeated or ongoing tolerance of poor practice, or failure to promote good practice, leading to departure from recognised standards, policies, or accepted practices
- continued failure to develop and manage business, financial, or clinical plans.

As part of reaching an assessment as to whether any actions of omissions of the director amount to “serious misconduct or mismanagement”, providers should consider whether an individual director played a central or peripheral role in any wider misconduct or mismanagement. The more central the role of the director, the more likely it is that the conduct of the director should be assessed to be serious misconduct or mismanagement. The provider should also consider whether there are any mitigating factors that could be relied on to downgrade conduct that should otherwise be assessed to be serious misconduct or mismanagement so that the conduct did not meet that threshold of seriousness.

4. Factors to consider around concerns regarding serious misconduct or mismanagement Please note the following points:

- The relevant matters can arise either in the director’s current role, in a former role within the provider’s organisation, when the director carried out any role where he or she was concerned with a service that is regulated by CQC or which, if provided outside the UK, would be a regulated activity if the activity was carried out within the UK.

Appendix 2

Fit and Proper Person's Self-Attestation

Fit and Proper Person Test annual/new starter* self-attestation **[LIVERPOOL WOMEN'S HOSPITAL NHS FOUNDATION TRUST]**	
I declare that I am a fit and proper person to carry out my role. I: • am of good character • have the qualifications, competence, skills and experience which are necessary for me to carry out my duties • where applicable, have not been erased, removed or struck-off a register of professionals maintained by a regulator of healthcare or social work professionals • am capable by reason of health of properly performing tasks which are intrinsic to the position • am not prohibited from holding office (eg directors disqualification order) • within the last five years: – I have not been convicted of a criminal offence and sentenced to imprisonment of three months or more – been un-discharged bankrupt nor have been subject to bankruptcy restrictions, or have made arrangement/compositions with creditors and has not discharged – nor is on any 'barred' list. • have not been responsible for, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity. The legislation states: if you are required to hold a registration with a relevant professional body to carry out your role, you must hold such registration and must have the entitlement to use any professional titles associated with this registration. Where you no longer meet the requirement to hold the registration, any if you are a healthcare professional, social worker or other professional registered with a healthcare or social care regulator, you must inform the regulator in question. Should my circumstances change, and I can no longer comply with the Fit and Proper Person Test (as described above), I acknowledge that it is my duty to inform the chair.	
Name and job title/role:	
Professional registrations held (ref no):	
Date of DBS check/re-check (ref no):	
Date of last appraisal, by whom:	
Signature of board member:	

Date of signature of board member:	
For chair to complete	
Signature of chair to confirm receipt:	
Date of signature of chair:	

*Delete as appropriate

Appendix 3

Board Member Reference

STANDARD REQUEST: To be used only AFTER a conditional offer of appointment has been made.

[Date]

Human resources officer/name of referee

Recruitment officer

External/NHS organisation receiving request

HR department initiating request

Dear [HR officer's/referee's name]

Re: [applicant's name] - [ref. number] – [Board Member position]

The above-named person has been offered the board member position of [post title] at the [name of the NHS organisation initiating request]. This is a high-profile and public facing role which carries a high level of responsibility. The purpose of NHS boards is to govern effectively, and in so doing build patient, staff, public and stakeholder confidence that the public's health and the provision of healthcare are in safe hands.

Taking this into account, I would be grateful if you could complete the attached confirmation of employment request as comprehensively as possible and return it to me as soon as practically possible to ensure timely recruitment.

Please note that under data protection laws and other access regimes, applicants may be entitled to information that is held on them.

Thank you in advance for your assistance in this matter.

Yours sincerely

[Recruitment officer's name]

Board Member Reference request for NHS Applicants:
To be used only AFTER a conditional offer of appointment has been made.
Information provided in this reference reflects the most up to date information available at the time the request was fulfilled.

1. Name of the applicant (1)	
2. National Insurance number or date of birth	

3. Please confirm employment start and termination dates in each previous role
A:(if you are completing this reference for pre-employment request for someone currently employed outside the NHS, you may not have this information, please state if this is the case and provide relevant dates of all roles within your organisation)
B: (As part of exit reference and all relevant information held in ESR under Employment History to be entered)

Job Title:
From:
To:

Job Title
From:
To:

Job Title:
From:
To:

Job Title:
From:
To:

Job Title:
From:
To:

4. Please confirm the applicant's current/most recent job title and essential job functions (if possible, please attach the Job Description or Person Specification as Appendix A):
(This is for Executive Director board positions only, for a Non-Executive Director, please just confirm current job title)

5. Please confirm Applicant remuneration in current role (*this question only applies to Executive Director board positions applied for)*	Starting:	Current:
6. Please confirm all Learning and Development undertaken during employment: *(this question only applies to Executive Director board positions applied for)*		
7. How many days absence (other than annual leave) has the applicant had over the last two years of their employment, and in how many episodes? ***(only applicable if being requested after a conditional offer of employment)***	Days Absent:	Absence Episodes:
8. Confirmation of reason for leaving:		

9. Please provide details of when you last completed a check with the Disclosure and Barring Service (DBS) (This question is for Executive Director appointments and non-Executive Director appointments where they are already a current member of an NHS Board)		
Date DBS check was last completed.	Date	
Please indicate the level of DBS check undertaken (basic/standard/enhanced without barred list/or enhanced with barred list)	Level	
If an enhanced with barred list check was undertaken, please indicate which barred list this applies to	Adults □ Children □ Both □	
10. Did the check return any information that required further investigation?	Yes □	No □
If yes, please provide a summary of any follow up actions that need to/are still being actioned:		
11. Please confirm if all annual appraisals have been undertaken and completed (This question is for Executive Director appointments and non-Executive Director appointments where they are already a current member of an NHS Board)	Yes □	No □

Please provide a summary of the outcome and actions to be undertaken for the last 3 appraisals:		
12. Is there any relevant information regarding any outstanding, upheld or discontinued complaint(s) or other matters tantamount to gross misconduct or serious misconduct or mismanagement including grievances or complaint(s) under any of the Trust's policies and procedures (for example under the Trust's Equal Opportunities Policy)? (For applicants from outside the NHS please complete as far as possible considering the arrangements and policy within the applicant's current organisation and position)	Yes □	No □
If yes, please provide a summary of the position and **(where relevant)** any findings and any remedial actions and resolution of those actions:		
13. Is there any outstanding, upheld or discontinued disciplinary action under the Trust's Disciplinary Procedures including the issue of a formal written warning, disciplinary suspension, or dismissal tantamount to gross or serious misconduct that can include but not be limited to: • **Criminal convictions for offences leading to a sentence of imprisonment or incompatible with service in the NHS** • **Dishonesty**	Yes □	No □

• **Bullying** • **Discrimination, harassment, or victimisation** • **Sexual harassment** • **Suppression of speaking up** • **Accumulative misconduct** (For applicants from outside the NHS please complete as far as possible considering the arrangements and policy within the applicant's current organisation and position)		
If yes, please provide a summary of the position and **(where relevant)** any findings and any remedial actions and resolution of those actions:		
14. Please provide any further information and concerns about the applicant's fitness and propriety, not previously covered, relevant to the Fit and Proper Person Test to fulfil the role as a director, be it executive or non-executive. Alternatively state Not Applicable. (Please visit links below for the CQC definition of good characteristics as a reference point) (7)(12) **Regulation 5: Fit and proper persons: directors - Care Quality Commission (cqc.org.uk)** **The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (legislation.gov.uk)**		

15. The facts and dates referred to in the answers above have been provided in good faith and are correct and true to the best of our knowledge and belief.

Referee name (please print): …….. Signature: ……

Referee Position Held:

Email address: Telephone number:

Date:

Data Protection:

This form contains personal data as defined by the Data Protection Act 2018 and UK implementation of the General Data Protection Regulation). This data has been requested by the Human Resources/ Workforce Department for the purpose of recruitment and compliance with the Fit and Proper Person requirements applicable to healthcare bodies. It must not be used for any incompatible purposes. The Human Resources/Workforce Department must protect any information disclosed within this form and ensure that it is not passed to anyone who is not authorised to have this information.

Liverpool Women's NHS Foundation Trust

Appendix 4

SOCIAL MEDIA CHECK AND DECLARATION

1. Do you have a Facebook account? Yes No

If yes, please provide your name as displayed on your profile.....

2. Do you have a X/Twitter account? Yes No

If yes, please provide your name as displayed on your profile.....

3. Do you have any other social media accounts? Yes No

Please provide details of the social media accounts and the name displayed on your profile below:

Social Media Platform	Display Name

Name: Signature: Date:

Appendix 5

FPPT Area	Record in ESR	Local evidence folder	Recruitment Test	Annual Test	ED	NED	Source	Notes
First Name	✓	✓	✓	x – unless change	✓	✓	Application and recruitment process.	Recruitment team to populate ESR. For NHS-to-NHS moves via ESR / Inter- Authority Transfer/ NHS Jobs. For non-NHS – from application – whether recruited by NHS England, in-house or through a recruitment agency.
Second Name/Surname	✓	✓	✓	x – unless change	✓	✓		
Organisation (ie current employer)	✓	x	✓	N/A	✓	✓		
Staff Group	✓	x	✓	x – unless change	✓	✓		
Job Title Current Job Description	✓	✓	✓	x – unless change	✓	✓		
Occupation Code	✓	x	✓	x – unless change	✓	✓		
Position Title	✓	x	✓	x – unless change	✓	✓		
Employment History Including: • job titles • organisation/ departments • dates and role descriptions • gaps in employment	✓	x	✓	x	✓	✓	Application and recruitment process, CV, etc.	Any gaps that are because of any protected characteristics, as defined in the Equality Act 2010, do not need to be explained. The period for which information should be recorded is for local determination, taking into account relevance to the person and the role. It is suggested that a career history of no less than six years and covering at least two roles would be the minimum. Where there have been gaps in employment, this period should be extended accordingly.

FPPT Area	Record in ESR	Local evidence folder	Recruitment Test	Annual Test	ED	NED	Source	Notes
Training and Development	✓	✓	✓	✓	✓	*	Relevant training and development from the application and recruitment process; that is, evidence of training (and development) to meet the requirements of the role as set out in the person specification. Annually updated records of training and development completed/ongoing progress.	* NED recruitment often refers to a particular skillset/experience preferred, eg clinical, financial, etc, but a general appointment letter for NEDs may not then reference the skills/experience requested. Some NEDs may be retired and do not have a current professional registration. At recruitment, organisations should assure themselves that the information provided by the applicant is correct and reasonable for the requirements of the role. For all board members: the period for which qualifications and training should look back and be recorded is for local determination, taking into account relevance to the person and the role. It is suggested that key qualifications required for the role and noted in the person

								specification (eg professional qualifications) and dates are recorded however far back that may be. Otherwise, it is suggested that a history of no less than six years should be the minimum. Where there have been gaps in employment, this period should be extended accordingly.
References Available references from previous employers	✓	✓	✓	x	✓	✓	Recruitment process	Including references where the individual resigned or retired from a previous role

Last Appraisal and Date	✓	✓	✓	✓	✓	*	Recruitment process and annual update following appraisal	* For NEDs, information about appraisals is only required from their appointment date forward. No information about appraisals in previous roles is required.

FPPT Area	Record in ESR	Local evidence folder	Recruitment Test	Annual Test	ED	NED	Source	Notes
Disciplinary Findings That is, any upheld finding pursuant to any NHS organisation policies or procedures concerning employee behaviour, such as misconduct or mismanagement	✓	✓	✓	✓	✓	✓	Reference request (question on the new Board Member Reference). ESR record (high level)/ local case management system as appropriate.	The new BMR includes a request for information relating to investigations into disciplinary matters/ complaints/ grievances and speak-ups against the board member. This includes information in relation to open/ ongoing investigations, upheld findings and discontinued investigations that are relevant to FPPT. This question is applicable to board members recruited both from inside and outside the NHS.
Grievance (upheld) against the board member	✓	✓	✓	✓	✓	✓		
Whistleblowing claim(s) (upheld) against the board member	✓	✓	✓	✓	✓	✓		
Behaviour not in accordance with organisational values and behaviours or related local policies	✓	✓	✓	✓	✓	✓		

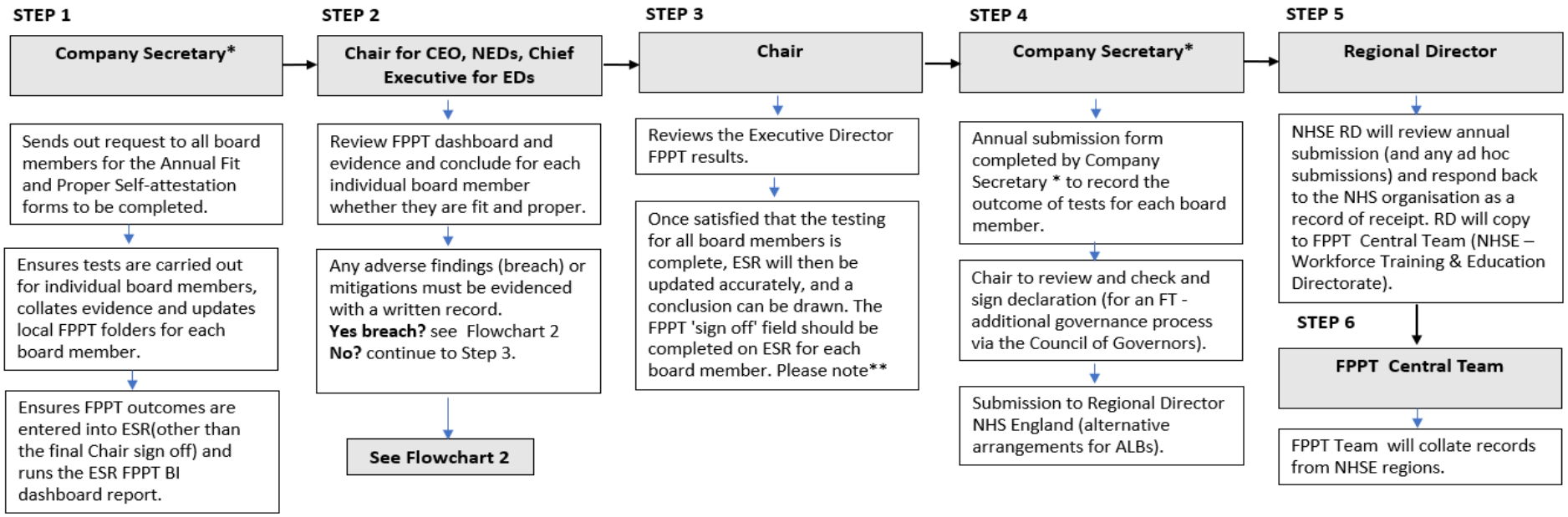
Type of DBS Disclosed	✓	✓	✓	✓	✓	✓	ESR and DBS response.	Frequency and level of DBS in accordance with local policy for board members. Check annually whether the DBS needs to be reapplied for. Maintain a confidential local file note on any matters applicable to FPPT where a finding from the DBS needed further discussion with the board member and the resulting conclusion and any actions taken/required.
Date DBS Received	✓	✓	✓	✓	✓	✓	ESR	
Date of Medical Clearance* (including confirmation of OHA)	✓	X	✓	x – unless change	✓	✓	Local arrangements	
Date of Professional Register Check (eg membership of professional bodies)	✓	X	✓	✓	✓	X	Eg NMC, GMC, accountancy bodies.	

FPPT Area	Record in ESR	Local evidence folder	Recruitment Test	Annual Test	ED	NED	Source	Notes
Insolvency Check	✓	✓	✓	✓	✓	✓	Bankruptcy and Insolvency register	Keep a screenshot of check as local evidence of check completed. Use of social media form
Disqualified Directors Register Check	✓	✓	✓	✓	✓	✓	Companies House	

Disqualification from being a Charity Trustee Check	✓	✓	✓	✓	✓	✓	Charities Commission	(appendix 4)
Employment Tribunal Judgement Check	✓	✓	✓	✓	✓	✓	Employment Tribunal Decisions	
Social Media Check	✓	✓	✓	✓	✓	✓	Various – Google, Facebook, Instagram, etc.	
Self-Attestation Form Signed	✓	✓	✓	✓	✓	✓	Template self-attestation form	Appendix 3 in Framework
Sign-off by Chair/CEO	✓	x	✓	✓	✓	✓	ESR	Includes free text to conclude in ESR fit and proper or not. Any mitigations should be evidence locally.
Other Templates to be Completed								
Board Member Reference	✓	✓	x	x	✓	✓	Template BMR	To be completed when any board member leaves for whatever reason and retained career-long or 75th birthday whichever latest. Appendix 2 in Framework.
Letter of Confirmation	x	✓	✓	✓	✓	✓	Template	For joint appointments only - Appendix 4 in Framework.
Annual Submission Form	x	✓	✓	✓	✓	✓	Template	Annual summary to Regional Director - Appendix 5 in Framework.

FPPT Area	Record in ESR	Local evidence folder	Recruitment Test	Annual Test	ED	NED	Source	Notes
Privacy Notice	x	✓	x	x	✓	✓	Template	Board members should be made aware of the proposed use of their data for FPPT – Example in Appendix 6.
Settlement Agreements	x	✓	✓	✓	✓	✓	Board member reference at recruitment and any other information that comes to light on an ongoing basis.	Chair guidance describes this in more detail. It is acknowledged that details may not be known/disclosed where there are confidentiality clauses.

Appendix 6



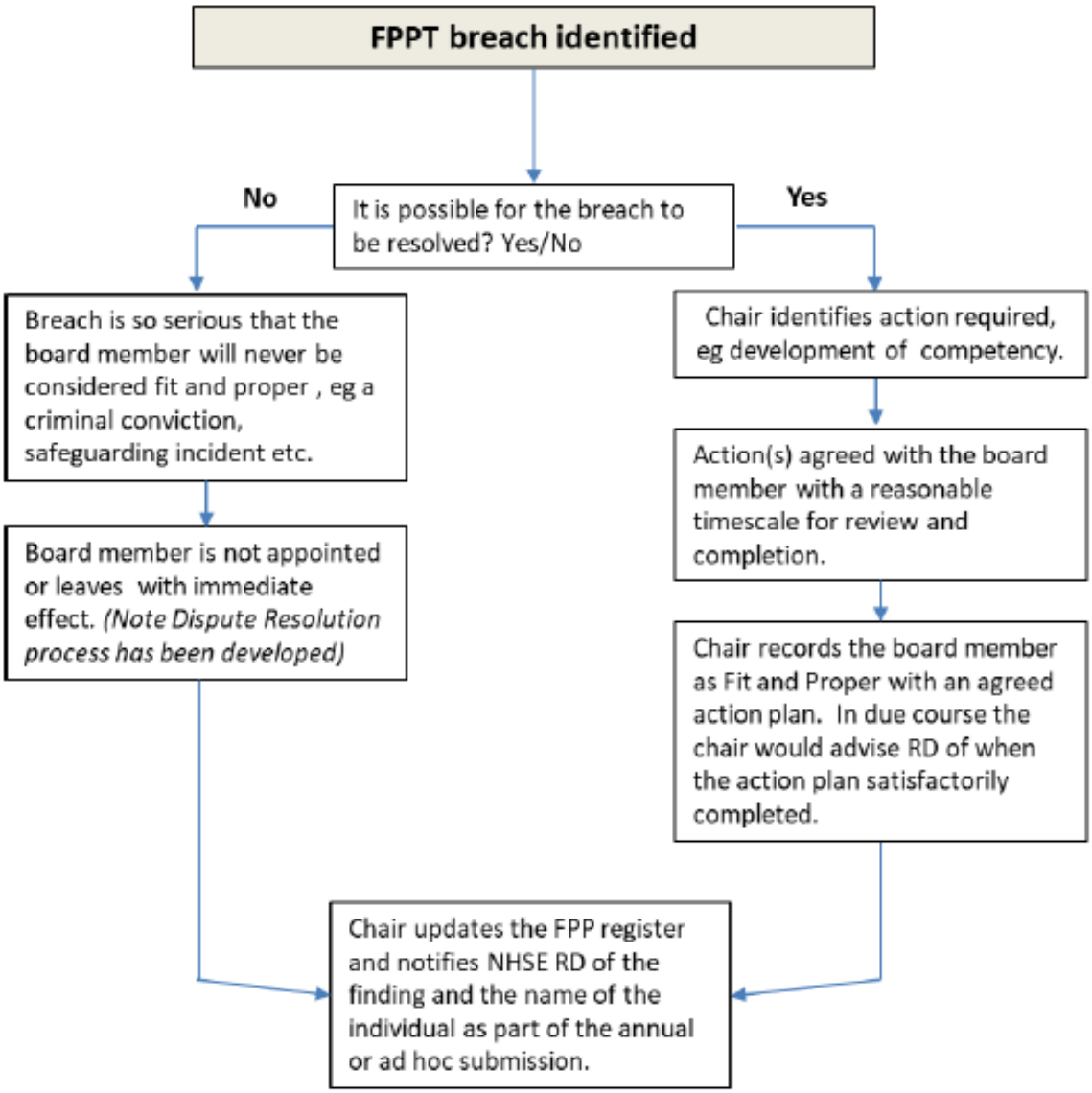
*Or senior member of staff nominated by and behalf of, the Chair, e.g. HRD

** SID/Deputy Chair to carry out FPPT on the Chair and 'sign off'

SID = Senior Independent Director

ESR= Electronic Staff Record

Flowchart 2: FPPT breach identified process



Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	**23/24/169**		**Date: 12/10/2023**	
Report Title	Emergency Preparedness, Resilience & Response Core Standards Annual Assurance Board Report			
Prepared by	Steve Dobie, EPRR Lead			
Presented by	Gary Price, Chief Operating Officer / Accountable Emergency Officer			
Key Issues / Messages	NHS Trusts are required to complete an annual assurance process against the NHSE Emergency Preparedness, Resilience & Response (EPRR) Core Standards. The process is managed and monitored by NHSE and involves NHS Trusts completing a self-assessment of compliance against the core standards. The process is supported by Peer Review meetings and confirm and challenge procedures.			
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 requested to take assurance that effective systems of control are in place in relation to achieving compliance to the NHSE EPRR Core Standards.			
Supporting Executive:	Gary Price Chief Operating Officer / Accountable Emergency Officer			

Equality Impact Assessment *(if there is an impact on E,D & I, an Equality Impact Assessment **MUST** accompany the report)*			
Strategy ☐	Policy ☐	Service Change ☐	Not Applicable ☒

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

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

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Lead	Outcome
EPRR Sub-committee September 23	Gary Price	For submission to Board

EXECUTIVE SUMMARY

1. Define the issue

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

2. Key Findings

The Trust submitted an overall compliance rating of '84% / Partially Compliant'. This submission will be subject to a confirm and challenge process with outcomes confirmed by NHSE.

3. Solutions / Actions

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

4. Recommendations

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

MAIN REPORT

INTRODUCTION

- This report provides a summary of the Trust's assessment and compliance rating against the NHSE EPRR Core Standards based on a self-assessment conducted in September 2023.

- As a Category 1 Responder under the Civil Contingencies Act (CCA) 2004, the Trust is required to prepare for emergency and business continuity incidents and ensure that it has the capability to respond to emergencies in a way that preserves life and operates within a framework that is safe, effective, caring, responsive and well-led. Whilst managing emergency situations, the Trust must, as far as is reasonably practicable maintain business continuity, prioritising safety and critical service delivery. The EPRR Core Standards are designed to support NHS Trusts in meeting the above duties.

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

- The EPRR national annual assurance process is based on self-assessment against the NHSE EPRR Core Standards audit tool. Specialist Trusts were required to self-assess against 58 core standards and an additional 10 'deep dive' criteria. The deep dive criteria for 2023 relates to EPRR Training. The outcomes for the deep dive criteria are not included within the overall compliance rating.

- The Trust submitted a compliance rating of '84% / Partially Compliant' in September 2023. An action plan has been developed and submitted (Appendix 1), to support achievement of outstanding standards. The Core Standards action plan will be monitored by the EPRR Sub-committee with oversight via the Finance, Performance and Business Development Committee.

ANALYSIS

- The NHSE EPRR Core Standards were revised for 2023 including those standards relating to training.

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

- NHS Trusts have been required to submit evidence for each standard

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

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

- An overall compliance rating of '84% / Partially Compliant' was submitted to NHSE. The Trust fully met 49 of the 58 EPRR core standards with a rating of 'Green'. Including 8 standards partially met with a rating of amber and 1 standard rated as non-compliant / Red. In addition, the Trust fully met 3 of the 10 deep dive criteria with a rating of Green, and 7 criteria were partially met with a rating of amber. As detailed above, deep dive criteria are not included in the overall rating. Further information on the partially met and non-compliant criteria is detailed within the action plan (Appendix 1) for the core standards,

Action Plan

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

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

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

    - NHSE required NHS Acute Trusts to deliver a hospital evacuation table top exercise with multi-agency attendance in 2022, with subsequent hospital evacuation exercises to be delivered by NHS Specialist Trusts in 2023/24. This workstream is therefore within the Trust EPRR work plan for 2023/24.

    - NHSE require Trusts have resilient and dedicated on-call mechanisms, this workstream for a Trust on-call policy is under review and within the EPRR workplan for 2023/24.

    - NHSE requires a process in place to assess the effectiveness of the Business Continuity Management System and take corrective action to ensure continual improvement. This workstream is therefore within the Trust EPRR work plan for 2023/24.

    - NHSE require NHS Specialist Trusts to ensure that the exercising of Hazmat/CBRN training, plans and arrangements are incorporated in the organisations EPRR exercising and testing programme, as a result, a training needs analysis is under review for 2024 workplan.

RECOMMENDATION

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

- EPRR activities for 2024 will focus on meeting the outstanding standards and deep dive criteria in order to achieve an increased level of compliance to the NHSE EPRR Core Standards and other relevant audits and assurances. Specific actions will be directed towards exercising of Hazmat/CBRN training.

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

Appendix 1

EPRR Core Standards Action Plan 2023-24

September 2023 Action Plan

No	Standard	Compliance	Status	Action	Responsibility	Target Date
4	**EPRR work programme**	Partially compliant	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes	The work programme will be updated to reflect the core standards submission	EPRR committee	November 23
10	**Incident Response**	Partially compliant	The Trust has an approved Major Incident Plan including action cards in place. The Plan is available on the Trust intranet and available to on-call managers via paper copy /shared drive. Update due November 2023	Sign off due November 23	EPRR committee	November 23

20	**On-call mechanism**	Partially compliant	The Trust On-call policy is currently being reviewed and updated.	Sign off from the EPRR subcommittee November 2023	EPRR Committee	November 23
24	**Responder training**	Partially compliant	Training records maintained of staff attending EPRR on-call training. Attendance at Principles of Health Command Training monitored.	Remaining staff to be trained booked on November 23	EPRR committee	November 23
52	**BCMS continuous improvement process**	Partially compliant	The Trusts effectiveness of BCMS is evaluated for improved continuity	EPRR Work programme to include evaluation	EPRR Committee	December 23
63	**Hazmat/CBRN training resource**	Partially compliant	Training needs analysis under review	Trust to identify potential training resource	EPRR Committee	December 23
64	**Staff training - recognition and decontamination**	Partially compliant	Training needs analysis under review	Trust to develop training for all staff who could come into contact with potentially contaminated patients	EPRR Committee	December 23

66	**Exercising**	Non-Compliant	Trust to incorporate Hazmat/CBRN plans within testing programme	Trust to develop schedule for Hazmat/CBRN training with external partners	EPRR Committee	January 24

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*23/24/170*		Date: 12/10/2023	
Report Title	Annual Self-Assessment for Placement Providers 2023 for Submission to NHSE			
Prepared by	***Linda Watkins Director of Medical Education***			
Presented by	***Linda Watkins Director of Medical Education***			
Key Issues / Messages	In line with the previous Health Education England (HEE) national quality framework, all placement providers are required to complete an annual Self-Assessment Review (SAR).			
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): NHSE			
	For Decisions - in line with Risk Appetite Statement – Y/N *If no – please outline the reasons for deviation.*			
	The board is asked to support the submission of the Self-Assessment Report to Health Education England.			
Supporting Executive:	***Lynn Greenhalgh, Medical Director***			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

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

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

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

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
PPF Committee	Sept 23	Medical Director	Recommended for approval.

EXECUTIVE SUMMARY

The Quality Framework identifies the standards that organisations are expected to have in place to provide a quality learning environment for the learners they have responsibility for. Every organisation is expected to have assessed which standards are fully or partially in place via the use of an annual self-assessment review (SAR). There is an expectation, via the Learning and Development Agreement (LDA), that organisations will refresh their SAR every year as good practice.

NHSE expect the governance of clinical education and training to directly link to the Placement Provider Board given both the importance of ensuring all learners and educators are fully supported as well as the significant financial investment made by NHSE each year via the LDA.

The Director of Medical Education is requesting approval of the Board for submission to NHSE on 31st October 2023.

SARS Report

In line with the previous Health Education England (HEE) national quality framework, all placement providers are required to complete an annual Self-Assessment Review (SAR).

The SAR is an online survey. For this to be approved by the Board, we have completed a word version of the survey for review and signature by the Medical Director our Board level representative for education.

Please see the signed report in its entirety presented with this document.

The board is asked to support the submission of the Self-Assessment Report to Health Education England.

NHS England Self-Assessment for Placement Providers 2023

1. The Placement Provider Self-Assessment Tool

Introduction

The Placement Provider Self-Assessment (SA) is a process by which providers carry out their own quality evaluation against a set of standards. It is based on the philosophy of continuous quality improvement, the identification of quality improvement potential, the development of action plans, implementation, and subsequent evaluation.

Providers are asked to complete this online form indicating where they have or have not met the standards as set out in the SA. There is the opportunity under most of the questions to provide comments to support your answer.

Completing the SA

This year the self-assessment **saves your progress at the end of each page - please use the save and next page button**. You can come back and amend or change your responses at any time prior to completing the final submission box in section 12 (just remember to save at the end of the page for any changes you make). Anyone completing any part of this self-assessment can do so using the same link, supplied to you by your regional NHS England WT&E quality team. **Please note only one person should use the link at any one time (you must close the web link in order for someone else to access the survey questions) this will avoid overwriting previous entries.**

Your region and trust name has been pre populated - **please do not amend this.**

You can print a copy of the self-assessment (on the last page, please skip through to the end and use the print button) at any time prior to and after submission. Please note that only questions with responses will print.

To support a flexible approach to completing the SA, you can move freely around the SA without being forced to complete questions or sections prior to moving to another section (**just remember to save each update at the end of each section, even if you only partially complete a section**). All sections are however mandatory so it is important that you undertake a final check that every question has been completed prior to submission. In the event that a question or section has not been answered after submission, the SA will be returned to you for completion.

Where free text comments are available the word or character limits are shown within each question.

The SA does not support the upload of attachments, in the event that we require any evidence as part of your submission we will contact you separately after submission.
This submission should be completed for the whole organisation, it is therefore important that those responsible for each section are able to feed into and contribute to the response.

The sections of the SA

Section 1. This section asks you to provide details of (up to) 3 challenges within education and training that you would like to share with us.

Section 2. This section asks you to provide details of (up to) 3 achievements or good practice within education and training that you would like to share with us.

Section 3. This section asks you to confirm your compliance with the contractual key performance indicators of the NHS Education Contract. This **should be completed once on behalf of the whole organisation.**

Section 4. This section asks you to confirm your compliance with the quality, library, reporting concerns and patient safety training contractual key performance indicators of the NHS Education Contract. **This should be completed once on behalf of the whole organisation**. It is important that those responsible for these areas are able to feed into this section.

Section 5. This section asks about your policies and processes in relation to equality, diversity and inclusion and should **normally be completed by your nominated placement provider EDI lead.**

Section 6 - 11. These sections ask you to self-assess your compliance against the Education Quality Framework and standards. Each section must be completed once on behalf of the whole organisation.

There is an opportunity to share examples of good practice. You are asked to confirm whether you meet the standard
for all professions / learner groups, or provide further details where you do not meet or partially meet the standard (s). Where you are reporting exceptions you are asked to provide the professions impacted and a summary of the challenges you face in meeting the standard.

Section 12. Final sign-off.

Further Questions
If you have any queries regarding the completion of the SA, please review the FAQ document. If you still require further information, you can contact your regional NHS England WT&E quality team.

Question 2 – 9 Region and Provider Selection

Please do not amend the region you have been allocated to. If you feel this is incorrect please continue to complete the SA and email your regional NHS England WT&E quality team. *

10. Training profession selection

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

Please select from the list below those professional groups your organisation currently train, please select all those which apply. Please select only one option for each row.

	Yes we train in this professional group	N/A we do NOT train in this professional group
Advanced Clinical Practice	x	
Allied Health Professionals	x	
Dental		x
Healthcare Science	x	
Medical Associate Professions	x	
Medicine Postgraduate	x	
Medicine Undergraduate	x	
Midwifery	x	
Nursing	x	
Paramedicine	x	
Pharmacy	x	
Psychological Professions		x

11. Section 1 - Provider challenges

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

This section asks you to provide details of (up to) 3 challenges within education and training that you would like to share with us. Please consider whether there are any challenges which impact your ability to meet the education quality framework standards. Please select the category which best describes the challenge you are facing, along with a brief description/narrative of the challenge (*the character limit is set at 1000 characters*). In the event you cannot find an appropriate category select other and add the category at the start of your narrative.

Example 1: Please choose the most appropriate category for your challenge.

Please provide your narrative in the comments box

Category- Developing and supporting supervisors

It has been a challenge for staff to attend the appropriate training to be a Practice Supervisor (Nusing and Midwifery) due to workload pressures and being freed up to attend training

Example 2: Please choose the most appropriate category for your challenge.

Please provide your narrative in the comments box

Development of technology enhanced learning (TEL)

There has been improvement in wifi connection and access however we are aware there are areas we would like to develop further. We are aware that NHS England would like Trust to have a TEL Lead but as a small specialist Trust we do not have the funding or the capacity to support this.

Example 3: Please choose the most appropriate category for your challenge.

Please provide your narrative in the comments box

GMC Survey

The GMC Survey results have deteriorated this year particularly in Obstetrics and Gynaecology we are aware that improvements are needed across the Trust. There has been an increase requirement for training in O & G and Anaesthetics in relation to the Ockenden Report, and an increased demand on acute services, such as maternity assessment and the gynaecology emergency room. Job planned time for educational supervision has increased this year, new rotas have been developed and we are introducing Physician Associates. The Trust is currently reviewing headroom for junior doctor's roles and the role of allied health and medical associate professions in supporting service provision and rotas.

12. Section 2 - Provider achievements and good practice

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

This section asks you to provide details of (up to) 3 achievements within education and training that you would like to share with us. Please select the category which best describes the achievement you wish to share, along with a brief description/narrative (*the word limit is set at 1000 characters*). In the event you cannot find an appropriate category select other and add the category at the start of your narrative.

Example 1: Please choose the most appropriate category for your achievement.

Please provide your narrative in the comments box

Category- developing and supporting learners

We manage our students collaboratively across undergraduate groups to ensure appropriate experience and opportunities for learning.

We are one of the top providers in the north west of undergraduate medical sessions per consultant despite being a small specialist Trust.

Over the last 2 years we have increased overall student midwifery capacity by 19% which will support the future workforce at LWH.

Example 2: Please choose the most appropriate category for your achievement.

Please provide your narrative in the comments box

Category- Ed Gov and commitment to quality

Implemented a team of Practice Assessor's within maternity who are overseen by the PEF team. This has allowed the PEF team to quality assure the assessment process and allowed for any issues to be highlighted at the earliest opportunity so the correct support can be put in place. The PEF's have completed all final year student assessments which has allowed for any themes in gaps in knowledge to then become a focus for MDT student teaching sessions. The feedback from these has been extremely positive.

Example 3: Please choose the most appropriate category for your achievement.

Please provide your narrative in the comments box

We have developed a Teams channel to improve the onboarding of Postgraduate Doctors in training and Trust Clinical Fellows. The information provided includes, virtual tours, training videos, HR handbooks and access to useful links to guidelines and policies relating to Induction.

13. Section 3 - Contracting and the NHS Education Contract

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

This section asks you to confirm your compliance with the contractual key performance indicators of the NHS Education Contract (2021-24). This should be completed once on behalf of the whole organisation. Please select only one option for each row. There is an option to provide additional comments to support your answer, this is restricted to 2000 characters.

Please confirm your compliance with the contractual key performance indicators of the NHS Education Contract.
This should be completed once on behalf of the whole organisation. Please select only one option for each row.

	Yes	No
There is board level engagement for education and training at this organisation.	x	
The funding provided via the education contract to support and deliver education and training is used explicitly for this purpose.	x	
We undertake activity in the Education Contract which is being delivered through a third party provider		x
We have NOT reported any breaches in relation to the requirements of the NHS Education Contract for any sub-contractor		na

	Yes	No
We are fully compliant with all education and training data requests	na	
There have been NO health and safety breaches that involve a student, trainee or learner	x	
We continue to engage with the ICS for system learning	x	

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

1. There is board level engagement with learning and education, all educational activities are reported to sub-board workforce committee (Putting People First). Education Governance Committee also reports to into PPF as a subcommittee.
2. There is oversight of funding provided at Education Governance Committee. While all funding can be accounted for specific posts and utilisation. There could be more clarity regarding funding provided to divisions for education and training.
3. We do not undertake any activity in the education contract from a third party.
4. We do not use subcontractors as part of the education contract.
5. We respond to data requests regarding education as required.
6. To date there have been no health and safety breeches in the Trust involving students, trainees, or learners.
7. The patient safety team engages with the ICB and the local maternity system.

Signature

x I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.

Name, email address and role of the person completing this section

Linda Watkins DME Linda.watkins@lwh.nhs.uk

14. Section 4 - Education Quality

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

This section asks you to confirm your compliance with the quality, library, reporting concerns and patient safety training contractual key performance indicators of the NHS Education Contract. This should be completed once on behalf of the whole organisation. It is important that those responsible for these areas are able to feed into this section. There is an option to provide additional comments to support your answer, this is restricted to 1000 characters.

Can you confirm as a provider that you...
Please select only one option for each row.

	Yes	No	N/A
Are aware of the requirements and process for an education quality intervention, including who is required to attend and how to escalate issues.	x		
Have developed and implemented a service improvement plan to ensure progression through the Quality and Improvement Outcomes Framework for NHS Funded Knowledge and Library Services	x		
Have a Freedom to Speak Up Guardian and they actively promote the process for raising concerns through them to their learners	x		
Have a Guardian of Safe Working (if postgraduate doctors in training are being trained), and they actively promote the process for raising concerns through them to their learners	x		

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

1. We have education supervision policies and good links with our Associate Dean. Putting People First have oversight and provide challenge for action plans regarding education quality.
2. We review the feedback from the Library Quality Framework report each year and we are due to meet with them in November this year.
3. We have two Freedom to Speak Up Guardians, Srinivastarao.babarao@lwh.nhs.uk and Kevin.robinson@lwh.nhs.uk. Both are active in their role and provide support for all learners in the Trust.
4. Our Guardian of Safe Working is kat.pavlidi@lwh.nhs.uk, she chairs Junior Doctors Forum and encourages PGDT to complete exception reports.

As an organisation, have you been referred to a regulator for education and training concerns in the last 12 months (with or without conditions) (e.g., GMC, GDC, HCPC, NMC, etc)
Note: we are not seeking information about the referral of an individual learner.

x **We have not** been referred to a regulator

We have been referred to a regulator and the details are shared below.

If you have received conditions from a regulator please provide more details including the regulator, the profession involved and a brief description

Did you actively promote the National Education and Training survey (NETS) to all healthcare learners?

x Yes

No

Please briefly describe your process for encouraging responses; including your organisations response rate (for the 2022 NETS) and your plans to improve this for the next NETS:

Email out to all trainees and students via PEFs, DME, Medical Education Manager with regular reminders, also on closed student Facebook group.

Have you reviewed and where appropriate taken action on the outcome of the results of the National Education and Training Survey (NETS)

x Yes

No

Please provide a brief description of the action you have taken as a result; if 'no' please provide further details including your plans to use the NETS data for quality improvement activity in the future:

The NETS data is reviewed by Education Governance Committee, reports and action plans are provided at sub-board level, via Putting People First.

Patient Safety and the promotion of a Patient Safety culture is integral to the Education Quality Framework. Please provide the following information:

Name and email address of your Board representative for Patient Safety	Dianne Brown Dianne.brown@lwh.nhs.uk (Chief Nurse) Phil Bartley Associate Director of Governance and Quality Phil.bartley@lwh.nhs.uk
Name and email address of your non executive director representative for Patient Safety	Louise Kenny NED louise.kenny@lwh.nhs.uk
Name and email address of your Patient Safety Specialist/s	Allan Hawksey allan.hawksey@lwh.nhs.uk Rachel McFarland rachel.mcfarland@lwh.nhs.uk (Ockenden) Daniel Collins Daniel.collins@lwh.nhs.uk
What percentage of your staff have completed the patient safety training for level 1 within the organisation (%)	87.41%

Signature

x I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.

Name, email address and role of the person completing this section

15. Section 5 - Equality, Diversity and Inclusion

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

This section asks about your policies and processes in relation to equality, diversity and inclusion and should normally be completed by your nominated EDI lead. There is an option to provide additional comments to support your answer, this is restricted to 1000 characters.

Please confirm whether your organisation has an Equality, Diversity and Inclusion Lead (or equivalent):

x Yes

No

If 'yes' please add comments to support your answer sharing details of governance and links with education and training alonside the nominated name of your EDI lead for education and training; if 'no' please provide further detail

Lisa Shoku is our ED& I Lead

The EDI Committee reports to PPF (Putting People First) Committee, Lisa is also invited to the Education Governance Committee.

Please confirm that you liaise with your Equality, Diversity and Inclusion Lead (or equivalent) to...
Please select only one option for each row.

	Yes	No
Ensure reporting mechanisms and data collection take learners into account?	x	
Implement reasonable adjustments for disabled learners?	x	
Ensure policies and procedures do not negatively impact learners	x	

	Yes	No
who may share protected characteristics?		
Ensure International Graduates (including International Medical Graduates) receive a specific induction into your organisation?	x	
Ensure policies and processes are in place to manage with discriminatory behaviour from patients?	x	
Ensure a policy is in place to manage Sexual Harassment in the Workplace?	x	

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

1. Learners are included as "staff". We currently do not receive ED&I data for learners attending placements from external HEI's.
2. Where we are aware of adjustments needed they are implemented.
3. EIAs are carried out on all policies to the best of our ability
4. Internationally educated staff/graduates receive an Induction and a period of shadowing and supernumerary work. We use the GMC and NHS England resources to support Internationally educated doctors.
5. FTSUG- Freedom to speak up allows anonymous reporting and we have an ongoing campaign in the organisation promoting FTSUG.
   We have a Ulysses reporting system to report all incidents
   Staff are also encouraged to report incidents to their managers
   ECI/HR support mechanisms are also in place.
6. We have a robust Equality and Human Rights Policy and EIAS.

Postgraduate Deans and their teams are keen to consider responses and initiatives and share good practice. Please share details on EDI initiatives that are specific to or have an impact on education and training in your organisation and the email address for someone we can contact to discuss this further.

1. We have group Induction FTSUG and EDI are presented as part of the programmes.
2. EDI is mandatory, inclusive, and compassionate leadership is part of our managers training.

3. We have regular ED&I lead Great Days (Trust teaching) these cover various themes including, Anti-Racism, Asylum Seekers, gender, mental health, maternity race and Best for Baby Too collaborative (refugees and the NHS).

For education and training, what are the main successes for EDI in your organisation?

1. Volunteers to careers a project to encourage members of the local community to work at Liverpool Women's NHS Foundation Trust
2. Patient & Staff lived experience stories used at board and sub board meetings to increase awareness of ED&I issues.
3. Supported Internship – a structures workplace study programme for 16-24 year olds with special educational needs or disability. To build confidence and self-esteem.
4. Diversity interview panels and plans for inclusive recruitment.
5. We have secured funding for accessible environment audit.

For education and training, what are the main challenges for EDI in your organisation?

1. Resourcing (i.e. purchasing specialised equipment)
2. Competing priorities (i.e. training capacity)
3. Accessible information standards for all our staff.

Signature

x I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.

Name, email address and role of the person completing this section

Lisa Shoko lisa.shoko@lwh.nhs.uk

16. Section 6 - Assurance Reporting: learning environment and culture

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

For each standard, please confirm whether you meet the following standards from the Education Quality Framework. There is an option to provide additional comments to support your answer, this is restricted to 2000 characters per text box. **This section should be completed once on behalf of the whole organisation,** however it is important that those responsible for these areas are able to feed into this section.

Thinking about the learning environment and culture of your organisation, we are keen to hear about initiatives and good practice that are specific to or have an impact on education and training. If you would like to share any examples, please provide a very brief description of the initiative/good practice, the professional group(s) this relates to and the email address for someone we can contact to discuss this example further.

1. GREAT Day meeting designed for all staff to learn together; clinical activity is reduced to allow attendance. This includes case presentations and morbidity and mortality.
2. Use of the Advance Training Platform for the introduction of new IT systems.
3. Safety check-in meeting to learn from incidents, recorded and can be accessed anytime.
4. Preceptorship for new starters in Midwifery and Nursing
5. The introduction of Physicians Associates and development of clinical and education and governance policies and development strategy.
6. Ongoing development of trust Leadership development programme, to develop talent. Courses aimed at future leaders, aspiring leaders, advanced leadership programme. All courses are Chartered Management Institute (CMI) registered.
7. We also submit learners to the leadership academy Edward Jenner programme.

Quality Framework Domain 1 - Learning environment and culture
Please select only one option for each row.

	We meet the standard for all professions / learner groups	**We have exceptions to report** and provided narrative below
The learning environment is one in which education and training is valued and championed.	x	
The learning environment is inclusive and supportive for learners of all backgrounds and from all professional groups.	x	
The organisational culture is one in which all staff, including learners, are treated fairly, with equity, consistency, dignity and respect.	x	

	We meet the standard for all professions / learner groups	**We have exceptions to report** and provided narrative below
There is a culture of continuous learning, where giving and receiving constructive feedback is encouraged and routine.	x	
Learners are in an environment that delivers safe, effective, compassionate care and prioritises a positive experience for patients and service users.	x	
The environment is one that ensures the safety of all staff, including learners on placement.	x	
All staff, including learners, are able to speak up if they have any concerns, without fear of negative consequences.	x	
The environment is sensitive to both the diversity of learners and the population the organisation serves.	x	
There are opportunities for learners to take an active role in quality improvement initiatives, including participation in improving evidence led practice activities and research and innovation.	x	
There are opportunities to learn constructively from the experience and outcomes of patients and service users, whether positive or negative.	x	
The learning environment provides suitable educational facilities for both learners and supervisors, including space and IT facilities, and access to library and knowledge services and specialists.	x	

	We meet the standard for all professions / learner groups	We have exceptions to report and provided narrative below
The learning environment promotes multi-professional learning opportunities.	x	
The learning environment encourages learners to be proactive and take a lead in accessing learning opportunities and take responsibility for their own learning.	x	

Areas of exception
Please select which professional group(s) are impacted from the list below.
Where you have multiple sites, if the issue is site specific, please select 'site specific' and enter the site name in the comments box.
If required you can add the details of the sub professions / specific specialties in the comments box.

All professions

Site specific

Advanced Clinical Practice

☐ Allied Health Professionals

Dental

☐ Healthcare Science

☐ Medical Associate Professions

☐ Medicine Postgraduate

☐ Medicine Undergraduate

☐ Midwifery

☐ Nursing

☐ Paramedicine

Pharmacy

Psychological Professions

Please provide the details of the learner groups (and site if applicable) in the comments box e.g. mental health nursing, undergraduate dental training, operating department practitioners, pathology, dental nurses

For the exceptions listed above, please provide further details including; a brief summary of the issues and challenges that are impacting your ability to meet the standard, any barriers you are facing and what (if any) support do you need from WT&E.

No exceptions to report.

Signature

x I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.

Name, email address and role of the person completing this section

Linda Watkins DME Linda.watkins@lwh.nhs.uk

Laura Stoddart PEF Laura.Stoddart@lwh.nhs.uk

Sarah Parnell PEF sarah.Parnell@lwh.nhs.uk

17. Section 7 - Assurance Reporting: educational governance and commitment to quality

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

For each standard, please confirm whether the you meet the following standards from the Education Quality Framework. There is an option to provide additional comments to support your answer, this is restricted to 250 words per text box. **This section should be completed once on behalf of the whole organisation,** however it is important that those responsible for these areas are able to feed into this section.

Thinking about the educational governance and commitment to quality of your organisation, we are keen to hear about initiatives and good practice that are specific to or have an impact on education and training. If you to would like share any examples, please provide a very brief description of the initiative/good practice, the professional group(s) this relates to and the email address for someone we can contact to discuss this example further.

Introduction of raising concerns SOP for staff with regards to learners- promote open and honest culture and ensure correct procedures are being followed.

Extra support offered to learners following CQC report and recent Lucy Letby trial- students offered further drop in clinics for support, trust comms shared out and also clinical psychologist details shared with students for extra support if needed.

MDT student teaching sessions- attended by student nurses, midwives, ODP's and medical students, "those whose work together should train together" topics included obstetric emergency management, medication management, scrubbing in theatre, pharmacy, Human Factors, PMHT, diabetes and Sepsis to name a few.

Safety check in. Weekly trust wide teams meeting focusing on patient safety. This is available as a recording to all staff via a link. These where accessed 894 times last year and 132 times so far this year.

Quality Framework Domain 2 - Educational governance and commitment to quality
Please select only one option for each row.

	We meet the standard for all professions / learner groups	**We have exceptions to report** and provided narrative below
There is clear, visible and inclusive senior educational leadership, with responsibility for all relevant learner groups, which is joined up and promotes team-working and both a multi-professional and, where appropriate, inter-professional approach to education and training.	x	
There is active engagement and ownership of equality, diversity and inclusion in education and training at a senior level.	x	
The governance arrangements promote fairness in education and training and challenge discrimination.	x	
Education and training issues are fed into, considered and represented at the most senior level of decision making.	x	

	We meet the standard for all professions / learner groups	We have exceptions to report and provided narrative below
The provider can demonstrate how educational resources (including financial) are allocated and used.	x	
Educational governance arrangements enable organisational self-assessment of performance against the quality standards, an active response when standards are not being met, as well as continuous quality improvement of education and training.	x	
There is proactive and collaborative working with other partner and stakeholder organisations to support effective delivery of healthcare education and training and spread good practice.	x	
Consideration is given to the potential impact on education and training of service changes (i.e. service re-design / service reconfiguration), taking into account the views of learners, supervisors and key stakeholders (including WT&E and Education Providers).	x	

Areas of exception
Please select which professional group(s) are impacted from the list below.
Where you have multiple sites, if the issue is site specific, please select 'site specific' and enter the site name in the comments box.
If required you can add the details of the sub professions / specific specialties in the comments box.

All professions

Site specific

- [ ] Advanced Clinical Practice
- [ ] Allied Health Professionals

NHS England

Dental

☐ Healthcare Science

☐ Medical Associate Professions

☐ Medicine Postgraduate

☐ Medicine Undergraduate

x Midwifery

x Nursing

☐ Paramedicine

Pharmacy

Psychological Professions

Please provide the details of the learner groups (and site if applicable) in the comments box e.g. mental health nursing, undergraduate dental training, operating department practitioners, pathology, dental nurses

Nursing and Midwifery

For the exceptions listed above, please provide further details including; a brief summary of the issues and challenges that are impacting your ability to meet the standard, any barriers you are facing and what (if any) support do you need from WT&E.

Unable to tick yes to allocation of monies generated from students fed back into education. DDON has ongoing meetings with finance in an attempt to reclaim HEE income as currently does not sit in correct income stream.

Signature

x I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.

Name, email address and role of the person completing this section

Linda Watkins DME Linda.watkins@lwh.nhs.uk

Laura Stoddart PEF Laura.Stoddart@lwh.nhs.uk

Sarah Parnell PEF sarah.Parnell@lwh.nhs.uk

18. Section 8 - Assurance Reporting: developing and supporting learners

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

For each standard, please confirm whether you meet the following standards from the Education Quality Framework. There is an option to provide additional comments to support your answer, this is restricted to 250 words per text box. This section should be completed once on behalf of the whole organisation, however it is important that those responsible for these areas are able to feed into this section.

Thinking about how you develop and support learners within your organisation, we are keen to hear about initiatives and good practice that are specific to or have an impact on education and training. If you would like to share any examples, please provide a very brief description of the initiative/good practice, the professional group(s) this relates to and the email address for someone we can contact to discuss this example further.

Nursing and Midwifery Students

As above examples re team of practice assessors, MDT sessions.

Over recent years have introduced new placements such as leadership week, exposures to research team, 104 bleep holder, NIPE week, governance, urodyanmics, bereavement, screening, FMU, twin clinic. These exposures all help students achieve MORA proficiencies and become better prepared for practice.

Leaning and development prospectus

Highlights learning opportunities across the trust including extensive leadership development courses.

Coaching and mentoring opportunities.

Staff trained in Mental health first aid, resilience training (including power of the positive mind set) ongoing courses offered.

Increased postgraduate educational supervision now job planned in line with HEE requirements from April 2023. This has increased time available for educational Supervision for medical learners.

Apprentices

The trust is active in developing apprentice programmes in all areas where ever possible.

Care certificate is now offered to all Health care assistants.

Quality Framework Domain 3 - Developing and supporting learners
Please select only one option for each row.

	We meet the standard for all professions / learner groups	**We have exceptions to report** and provided narrative below
There is parity of access to learning opportunities for all learners, with providers making reasonable adjustments where required.	x	
The potential for differences in educational attainment is recognised and learners are supported to ensure that any differences do not relate to protected characteristics.	x	
Supervision arrangements enable learners in difficulty to be identified and supported at the earliest opportunity.	x	
Learners receive clinical supervision appropriate to their level of experience, competence and confidence, and according to their scope of practice.	x	
Learners receive the educational supervision and support to be able to demonstrate what is expected in their curriculum or professional standards to achieve the learning outcomes required.	x	
Learners are supported to complete appropriate summative and/or formative assessments to evidence that they are meeting their curriculum, professional and regulatory standards, and learning outcomes.	x	

	We meet the standard for all professions / learner groups	**We have exceptions to report** and provided narrative below
Learners are valued members of the healthcare teams within which they are placed and enabled to contribute to the work of those teams.	x	
Learners receive an appropriate, effective and timely induction and introduction into the clinical learning environment.	x	
Learners understand their role and the context of their placement in relation to care pathways, journeys and expected outcomes of patients and service users.	x	
Learners are supported, and developed, to undertake supervision responsibilities with more junior staff as appropriate.	x	

Areas of exception
Please select which professional group(s) are impacted from the list below.
Where you have multiple sites, if the issue is site specific, please select 'site specific' and enter the site name in the comments box.
If required you can add the details of the sub professions / specific specialties in the comments box.

All professions

Site specific

Advanced Clinical Practice

Allied Health Professionals

☐ Dental

Healthcare Science

Medical Associate Professions

Medicine Postgraduate

Medicine Undergraduate

☐ Midwifery

☐ Nursing

Paramedicine

Pharmacy

Psychological Professions

Please provide the details of the learner groups (and site if applicable) in the comments box e.g. mental health nursing, undergraduate dental training, operating department practitioners, pathology, dental nurses

No exceptions

For the exceptions listed above, please provide further details including; a brief summary of the issues and challenges that are impacting your ability to meet the standard, any barriers you are facing and what (if any) support do you need from WT&E.

No exception

Signature

x I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.

Name, email address and role of the person completing this section

Linda Watkins DME Linda.watkins@lwh.nhs.uk

19. Section 9 - Assurance reporting: developing and supporting supervisors

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

For each standard, please confirm whether you meet the following standards from the Education Quality Framework. There is an option to provide additional comments to support your answer, this is restricted to 250 words per text box. This section should be completed once on behalf of the whole organisation, however it is important that those responsible for these areas are able to feed into this section.

Thinking about how you develop and support supervisors within your organisation, we are keen to hear about initiatives and good practice that are specific to or have an impact

on education and training. If you would like to share any examples, please provide a very brief description of the initiative/good practice, the professional group(s) this relates to and the email address for someone we can contact to discuss this example further.

- At LWH we have continued with the annual supervision update for all staff, this is part of their mandatory training and is led by the PEF's. This is delivered on Clinical Corporate Mandatory Training so combines RM's and RN's, AHP's also have updates.
- Bi-Monthly drop in sessions for PEF support for supervisors.
- 6 hour Supervision workshop for all NQ staff in how to better support students on practice and raise concerns etc.

- We provide Educational Supervisors training twice a year to keep them up to date with any new initiatives and support their trainee doctors during their rotation in the Trust.
- Annual Undergraduate Med ed update to support supervisors of recent changes to curriculum
- Undergraduate Educational supervisors have a monthly Drop in session.
- All medical staff involved with education are invited to bimonthly Med Ed faculty meetings

Quality Framework Domain 4 - Developing and supporting supervisors
Please select only one option for each row.

	We meet the standard for all professions / learner groups	**We have exceptions to report** and provided narrative below
Formally recognised supervisors are appropriately supported, with allocated time in job plans/ job descriptions, to undertake their roles.	x	
Those undertaking formal supervision roles are appropriately trained as defined by the relevant regulator and/or professional body and in line with any other standards and expectations of partner organisations (e.g. Education Provider, WT&E).	x	
Clinical Supervisors understand the scope of practice and expected competence of those they are supervising.	x	
Educational Supervisors are familiar with, understand and are up-to-date with the curricula of	x	

	We meet the standard for all professions / learner groups	We have exceptions to report and provided narrative below
the learners they are supporting. They also understand their role in the context of learners' programmes and career pathways, enhancing their ability to support learners' progression.		
Clinical supervisors are supported to understand the education, training and any other support needs of their learners.	x	
Supervisor performance is assessed through appraisals or other appropriate mechanisms, with constructive feedback and support provided for continued professional development and role progression and/or when they may be experiencing difficulties and challenges.	x	

Areas of exception
Please select which professional group(s) are impacted from the list below.
Where you have multiple sites, if the issue is site specific, please select 'site specific' and enter the site name in the comments box.
If required you can add the details of the sub professions / specific specialties in the comments box.

All professions

Site specific

Advanced Clinical Practice

Allied Health Professionals

Dental

Healthcare Science

Medical Associate Professions

Medicine Postgraduate

Medicine Undergraduate

Midwifery
Nursing

Paramedicine

Pharmacy

Psychological Professions

Please provide the details of the learner groups (and site if applicable) in the comments box e.g. mental health nursing, undergraduate dental training, operating department practitioners, pathology, dental nurses

No exceptions.

For the exceptions listed above, please provide further details including; a brief summary of the issues and challenges that are impacting your ability to meet the standard, any barriers you are facing and what (if any) support do you need from WT&E.

No exceptions

Signature

x I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.

Name, email address and role of the person completing this section

Linda Watkins DME Linda.watkins@lwh.nhs.uk

Laura Stoddart PEF Laura.Stoddart@lwh.nhs.uk

Sarah Parnell PEF sarah.Parnell@lwh.nhs.uk

20. Section 10 - Assurance reporting: delivering programmes and curricula

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

For each standard, please confirm whether you meet the following standards from the Education Quality Framework. There is an option to provide additional comments to support your answer, this is restricted to 250 words per text box. This section should be completed once on

behalf of the whole organisation, however it is important that those responsible for these areas are able to feed into this section.

Thinking about how you deliver programmes and curricula to support training within your organisation, we are keen to hear about initiatives and good practice that are specific to or have an impact on education and training. If you would like to share any examples, please provide a very brief description of the initiative/good practice, the professional group(s) this relates to and the email address for someone we can contact to discuss this example further.

Consultants from trust actively involved in development and review of undergraduate curriculum for University of Liverpool.

Quality Framework Domain 5 - Delivering programmes and curricula
Please select only one option for each row.

	We meet the standard for all professions / learner groups	**We have exceptions to report** and provided narrative below
Practice placements must enable the delivery of relevant parts of curricula and contribute as expected to training programmes.	x	
Placement providers work in partnership with programme leads in planning and delivery of curricula and assessments.	x	
Placement providers collaborate with professional bodies, curriculum/ programme leads and key stakeholders to help to shape curricula, assessments and programmes to ensure their content is responsive to changes in treatments, technologies and care delivery models, as well as a focus on health promotion and disease prevention.	x	

	We meet the standard for all professions / learner groups	We have exceptions to report and provided narrative below
Placement providers proactively seek to develop new and innovative methods of education delivery, including multi-professional approaches.	x	
The involvement of patients and service users, and also learners, in the development of education delivery is encouraged.	x	
Timetables, rotas and workload enable learners to attend planned/ timetabled education sessions needed to meet curriculum requirements.	x	

Areas of exception
Please select which professional group(s) are impacted from the list below.
Where you have multiple sites, if the issue is site specific, please select 'site specific' and enter the site name in the comments box.
If required you can add the details of the sub professions / specific specialties in the comments box.

- [ ] **All professions**
- [ ] **Site specific**
- [ ] Advanced Clinical Practice
- [ ] Allied Health Professionals
- [ ] Dental
- [ ] Healthcare Science
- [ ] Medical Associate Professions
- [x] Medicine Postgraduate
- [ ] Medicine Undergraduate
- [ ] Midwifery
- [ ] Nursing
- [ ] Paramedicine
- [ ] Pharmacy
- [ ] Psychological Professions

Please provide the details of the learner groups (and site if applicable) in the comments box e.g. mental health nursing, undergraduate dental training, operating department practitioners, pathology, dental nurses

Medical postgraduate O&G specifically Specialty trainees.

For the exceptions listed above, please provide further details including; a brief summary of the issues and challenges that are impacting your ability to meet the standard, any barriers you are facing and what (if any) support do you need from WT&E.

Delivering some aspects of surgical curricula for postgraduate Gynaecology has been more challenging in the last year. Some of this is out of our control as some operations in urogynacology are no longer performed or very rarely perfomed but have not yet been taken out of the curriculum .

We are mindful of the feedback from last years GMC survey re curriculum coverage for O&G. Although we are not aware of anyone meeting an outcome 2 or 3 in May – July 23 because of difficulty attending theatre or clinics we appreciate it can be more difficult. Work force review is currently being under taken to ensure trainees have adequate access to training in particular attendance in clinics and Theatre appropriate to their level of training.

Signature

x I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.

Name, email address and role of the person completing this section

Linda Watkins DME Linda.watkins@lwh.nhs.uk

21. Section 11 - Assurance reporting: developing a sustainable workforce

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

For each standard, please confirm whether you meet the following standards from the Education Quality Framework. There is an option to provide additional comments to support your answer, this is restricted to 250 words per text box. This section should be completed once on behalf of the whole organisation, however it is important that those responsible for these areas are able to feed into this section.

Thinking about developing a sustainable workforce within your organisation, we are keen to hear about initiatives and good practice that are specific to or have an impact on

education and training. If you would like to share any examples, please provide a very brief description of the initiative/good practice, the professional group(s) this relates to and the email address for someone we can contact to discuss this example further.

- Increased PEF team from 1 to 2 WTE
  Business case going through for further 0.6 WTE PEF to support nursing and AHP students
- PEFs link in with preceptorship team for final year students so they are supported when newly qualified.

- The apprenticeship lead holds Sixth form open days to showcase NHS careers and encourage local students to apply for NHS jobs.
- All Local Midwifery Students are invited to a trust midwifery recruitment open day.
- All new midwifery recruits have extensive onboarding including a two week induction, followed by working with supernumerary status for four weeks (in line with Okendon requirements) and access to support from a preceptor within the first year.
- Increased pastoral support is also provided to International recruits in Midwifery and nursing from HR.
- The trust has appointed a clinical psychologist to support staff. In particular following clinical incidents which can be devastating and career ending from a psychological perspective especially within obstetrics. This has been felt by the trust to be particularly effective in enabling staff to continue at work.
- The trust had also employed wellbeing coaches using covid funding and are now looking for alternative resource to continue this.

Quality Framework Domain 6 - Developing a sustainable workforce
Please select only one option for each row.

	We meet the standard for all professions / learner groups	**We have exceptions to report** and provided narrative below
Placement providers work with other organisations to mitigate avoidable learner attrition from programmes.	x	
Does the provider provide opportunities for learners to receive appropriate careers advice from colleagues	x	
The provider engages in local workforce planning to ensure it supports the development of learners who have the skills, knowledge and behaviours to meet the changing needs of patients and service.	x	
Transition from a healthcare education	x	

	We meet the standard for all professions / learner groups	We have exceptions to report and provided narrative below
programme to employment and/or, where appropriate, career progression, is underpinned by a clear process of support developed and delivered in partnership with the learner.		

Areas of exception
Please select which professional group(s) are impacted from the list below.
Where you have multiple sites, if the issue is site specific, please select 'site specific' and enter the site name in the comments box.
If required you can add the details of the sub professions / specific specialties in the comments box.

All professions

Site specific

Advanced Clinical Practice

Allied Health Professionals

Dental

Healthcare Science

Medical Associate Professions

Medicine Postgraduate

Medicine Undergraduate

Midwifery

Nursing

Paramedicine

Pharmacy

Psychological Professions

Please provide the details of the learner groups (and site if applicable) in the comments box e.g. mental health nursing, undergraduate dental training, operating department practitioners, pathology, dental nurses

No exceptions

For the exceptions listed above, please provide further details including; a brief summary of the issues and challenges that are impacting your ability to meet the standard, any barriers you are facing and what (if any) support do you need from WT&E.

No exceptions

Signature

x I confirm I have completed this section accurately and can provide evidence to support my responses if requested by NHS England Workforce, Training and Education.

Name, email address and role of the person completing this section

Linda Watkins DME Linda.watkins@lwh.nhs.uk

Laura Stoddart PEF Laura.Stoddart@lwh.nhs.uk

Sarah Parnell PEF sarah.Parnell@lwh.nhs.uk

22. Section 12 - Final Submission

Please remember to save your progress using the save button at the bottom of this page. You can come back and amend this page (and re-save) at anytime prior to submission.

Before completing your final submission please ensure you have:
1. Completed all questions within the Self-Assessment (including the free text sections)
2. Received Board level sign off for your submission

Board level sign-off

I confirm that the responses in this SA have been signed off at board level

Name, email address and role of Board representative for education and training

Lynn Greenhalgh Lynn.Greenhalgh@lwh.nhs.uk

Please confirm the date that board level sign off was received:

DD/MM/YYYY

Final Submission (please only tick this box when you ready to submit your self-assessment)

I confirm that all sections of this self-assessment have been completed and that this is the final version for submission

23. Thank you for your time

Thank you for your time on this Annual Provider Self-Assessment

Thank you for taking the time to contribute to this provider annual Self-Assessment. If you would like to print a version of your draft submission at any time, please use the print button on the next page (note that you will only print those sections currently completed)

You can continue to update this self-assessment using the link supplied to your by your regional NHS England WT&E education quality team.

Once you have completed all sections in full of this self-assessment please ensure that you complete section 7 final submission and tick the box Complete Submission. At which point your final response will be sent to your regional NHS England WT&E education quality team.

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*23/24/171*		Date: 12/10/2023	
Report Title	Medical Appraisal and Revalidation Annual Report 2022/23			
Prepared by	Lynn Greenhalgh, Responsible Officer & Medical Director Janine Elson, Appraisal Lead Lynn Johnson, Revalidation Support Manager			
Presented by	Dr Lynn Greenhalgh, Medical Director			
Key Issues / Messages	1. Medical appraisal and revalidation processes are robust despite ongoing waves of COVID 19. 2. Annex D for approval			
Action required	Approve ☒	Receive ☐	Note ☐	Take Assurance ☒
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable):			
	For Decisions - in line with Risk Appetite Statement – Y/N *If no – please outline the reasons for deviation.*			
	1. Trust Board is asked to receive the report noting it will be shared with the Higher Level RO. *2.* To approve the '2022-2023 Annual Submission to NHS England North West: Appraisal and Revalidation and Medical Governance compliance statement' confirming that the organisation, as a designated body, is in compliance with the regulations and to note that the '2022-2023 Annual Submission to NHS England North West: Appraisal and Revalidation and Medical Governance compliance statement' (Appendix A)			
Supporting Executive:	Dr Lynn Greenhalgh, Medical Director			

Equality Impact Assessment *(if there is an impact on E,D & I, an Equality Impact Assessment **MUST** accompany the report)*							
Strategy	☐	Policy	☒	Service Change	☐	Not Applicable	☐

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

Link to the Board Assurance Framework (BAF) / Corporate Risk Register (CRR)	
Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* 1 – Inability to recruit & maintain a highly skilled & engaged workforce that is representative of our local communities	Comment:
Link to the Corporate Risk Register (CRR) – CR Number:	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
PPF Committee	Sept 23	Medical Director	Recommended to the Board for approval

EXECUTIVE SUMMARY

Executive summary – 2022/23 Revalidation and Appraisal annual report

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

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

During this revalidation year April 2022 to March 2023, the team supporting revalidation for the Trust was:
Dr Lynn Greenhalgh, Responsible Officer (RO),
Dr Janine Elson, Appraisal Lead,
Lynn Johnson Revalidation Support Manager and
a team of 17 trained appraisers who each will undertake between 4-7 appraisals/year.

Liverpool Women's NHS Foundation Trust as a designated body had 117 doctors with a prescribed connection in the revalidation year April 2021 to March 2022. All doctors but 1 were engaged with the process and all doctors were accounted for in terms of their participation.

For the time period of this report doctors were expected to have an appraisal and a conversation regarding wellbeing.

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

The Trust Board receives these two papers for approval.

The Trust's 2022-2023 Annual Submission to NHS England North West: Appraisal and Revalidation and Medical Governance compliance statement has been completed and is attached as Appendix A.

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

Revalidation recommendations:

23 doctors' revalidation date fell during this year. 17 received a positive recommendation.

5 recommendations were deferred due to the RO having insufficient evidence. 1 deferral was because the practitioner was not engaging with the appraisal and revalidation process. They have subsequently completed their appraisal and been recommended for revalidation.

Governance and Quality Assurance:

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

Appraisal update training

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

Internal quality assurance is performed by a peer review of a random sample of 10% of completed appraisals. For the year 2022/23 this was done using the NHSE SUPPORT tool. This provides not only feedback to individual appraisers but also a learning and discussion opportunity for the reviewing appraisers. All appraisers are expected to attend at least one peer review session a year.

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

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

Implementation of L2P – a new Appraisal and Revalidation management system

The L2P appraisal and Revalidation Management system has been in place for a year now and has been embedded. Feedback from the appraisees and appraisers has been positive. The administration function of the system is superior to that of Equiniti and the system incorporates the delivery and management of the 360 degree feedback process. Progress with revalidation can also be monitored.

Recommendations:

- Trust Board is asked to receive the report noting it will be shared with the Higher Level RO.
- To approve the '2022-2023 Annual Submission to NHS England North West: Appraisal and Revalidation and Medical Governance compliance statement' confirming that the organisation, as a designated body, is in compliance with the regulations and to note that the '2022-2023 Annual Submission to NHS England North West: Appraisal and Revalidation and Medical Governance compliance statement' (Appendix A)

.

MAIN REPORT

Purpose of the paper

As part of the framework for quality assurance and for the purpose of revalidation, NHS England requests an Annual Report together with the 2023 Annual Submission to NHS England North West: Appraisal and Revalidation and Medical Governance compliance statement This usually follows the completion of the Annual organisation Audit (AOA) exercise.

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

Background

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

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

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

The RO oversees compliance by:

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

Governance Arrangements

The current Responsible Officer is Dr Lynn Greenhalgh. The Trust responsible Officer is appraised by an external appraiser nominated by NHS England. Her 2023 appraisal is booked for the end of July 2023. She took over being RO in April 2021 after a period of 3 months acting as RO in an interim capacity.

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

Lynn Johnson was appointed to the post of Revalidation Support Manager in 2017, with the remit to provide support and advice to the RO and doctors on matters relating to appraisal and revalidation.

The Trust's Responsible Officer, Appraisal Lead and Revalidation Support Manager attend regular external Responsible Officer/Appraisal Lead Network meetings with other ROs and representatives from GMC and NHS England

The RO, Appraisal lead and Revalidation Support Manager meet regularly as a team, several times a month. Revalidation Team meetings have been established and meet at least twice a year. The purpose of the meeting is to provide appraiser peer support and to discuss any issues arising relating to the appraisal systems/processes as well as cascading any information provided but the NHSE/I Responsible Officer and Appraisal Lead meetings.

The Medical Appraisal/Revalidation Team reports to the Putting People First Committee and the minutes are formally recorded and submitted.

NHS England requests an Annual Report together with the compliance statement (Annex D). This usually follows the completion of the Annual organisation Audit (AOA) exercise. Due to Covid-19 the AOA has not been completed however it is suggested that providers might want to complete an Annex D compliance statement.

There is a process to support the appropriate transfer of information about a doctor's practice to and from the doctor's responsible officer. It is designed to be used to share information with the doctor's responsible officer in the following situations:

- When a doctor's prescribed connection changes
- When a concern arises about the doctor's practice in any place where the doctor is practising I

The Trust has an established team and system to record all incidents and complaints through the Risk and Safety Team.

The Trust also has a dedicated Audit team to assist the doctors and contribute to their clinical performance.

Policy and Guidance

The 2017 Medical Appraisal and Revalidation policy has been updated in line with current national policy and was presented for ratification to PPF Committee (approved). This had been recently updated and ratified through the Joint Local Negotiating Committee. (Appendix B).

Quality Assurance

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

Internal quality assurance is performed by a peer review of a random sample of 10% of completed appraisals. For the year 2022/23 this will be done using the NHSE SUPPORT tool. This provides not only feedback to individual appraisers but also a learning and discussion opportunity for the reviewing appraisers. All appraisers are expected to attend at least one peer review session a year.

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

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

The Appraisal and Revalidation Management System, L2P has now been in use for approximately 1 year. This new system has now been embedded.

Medical Appraisals

Appraisal and Revalidation Performance Data

The Revalidation Support Manager maintains a database of all appraisal dates. Doctors receive timely notification and reminder emails with the request to undertake an annual appraisal, in accordance with NHSE guidance.

The data on the appraisal is shown in the table below.

	Number	Completed appraisals	Incomplete/missed appraisal Authorised	Incomplete/missed appraisal Not Authorised
Consultant	93	86	6	1
Staff Grade, Associate Specialist Speciality Doctor	17	15	2	
Temporary or Short-term Contract holders.	7	5	2	
Total	117	106	10	1

Reasons for the incomplete/missed appraisal authorised were:

There were 10 approved late appraisals. Circumstances for late appraisals include maternity leave, personal or family illness, bereavements. The majority of the late approved completed within 3 months of their original date but sought approval from the RO.

The overall rate of unauthorised missed/incomplete appraisal is just under 1% which is the same as the

previous year. This will be actively managed by the revalidation team.

The Revalidation team has a reminder letter system which now clarifies that discussion with the GMC liaison officer takes place regarding possible referral to the GMC as a consequence of unauthorised late appraisal.

Appraiser training

As part of the Revalidation process, every doctor will undergo a formal appraisal process each year facilitated by a trained appraiser. The Trust has 17 trained appraisers.

The GMC recommends that each appraiser perform a maximum of 8 appraisals, minimum 6 appraisals per year. Due to our size our appraisers undertake between 4-7 appraisals a year.

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

The new Revalidation and Appraisal management system L2P has in-built resources and training videos to help support appraisees and appraisers when navigating the system. Also enclosed is a comprehensive checklist for doctors and appraisers to ensure they are uploading relevant information/data throughout the system. L2P also offer in-house training via Teams or face-to-face.

Appraisee

Doctors upload documentation into a portfolio on RMS (Revalidation Management System) covering the GMC domains as outlined in Good Medical Practice. RMS requires the completion of pre-appraisal documentation by doctors regarding their own probity and health. Their PDP and Job plan are part of the portfolio. This portfolio is submitted to their appraiser prior to their appraisal meeting.

In each revalidation cycle, each doctor is obliged to gather patient and colleague feedback once. There is a system built into RMS to facilitate this, the feedback is discussed at appraisal, and feeds into the personal development plans.

Appraisees that are new to the Trust as supported by the Revalidation Manager and the Appraisal Lead with training on L2P and the expectations of the Trust with regards the supporting information necessary for appraisal submission.

Access, security and confidentiality

The Trust has an implemented framework of Information Governance to ensure all the information held on staff members are complaint with the Data protection and confidentiality, information security and information quality on an annual basis.

10 Issues for Board consideration

- The number of doctors with a prescribed connection and requiring appraisal has increased to 117 from 101 in 21/22, and 97 in 20/21.
- The team have worked hard to maintain the appraiser numbers as trained experienced appraisers have left the Trust. This is tracked by the Revalidation team.

- Appraiser time is accounted for within job plans with a currency of 0.25 PA. The Appraisal lead currency is 0.5 PA.

- The Revalidation Support Manager, Appraisal Lead and Appraisers have managed to support doctors through the appraisal system.

11 Conclusions

Medical Revalidation is in its second cycle. The Trust has seen a significant improvement in managing doctors who do not seek approval for late/incomplete appraisals. This is thanks to the efforts of the team and is reflected in the performance data.

12. Recommendations

- Trust Board is asked to receive the report noting it will be shared with the Higher Level RO.
- To approve the '2022-2023 Annual Submission to NHS England North West: Appraisal and Revalidation and Medical Governance compliance statement' confirming that the organisation, as a designated body, is in compliance with the regulations and to note that the '2022-2023 Annual Submission to NHS England North West: Appraisal and Revalidation and Medical Governance compliance statement' (Appendix A)

Appendix A – 2022-2023 Annual Submission to NHS England North West: Appraisal and Revalidation and Medical Governance compliance statement 2022/2023

NHS England North West
Medical Directorate
Professional Standards Team

2022-2023 Annual Submission to NHS England North West:

Appraisal and Revalidation and Medical Governance

Contents

Introduction:
The Annual Organisational Audit (AOA) has been stood down for the 2022/23 year. A refreshed approach is in development. It still remains a requirement for each Designated Body to provide assurance to their Board about the governance arrangements in place in relation to appraisal, revalidation and managing concerns. In addition, NHS England North West use information previously provided in the AOA to inform a plan for assurance visits to Designated Bodies.

Amendments have been made to Board Report template (Annex D) with the intention of making completion of the submission straightforward whilst retaining the goals of the previous report:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

This template for an Annual Submission to NHS England North West should be used as evidence for the Board (or equivalent management team) of compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) or appended to your own board report where a local template exists.

This completed document is required to be submitted electronically to NHS England North West by **31st October 2023** and should be sent to england.nw.hlro@nhs.net

Section 1: General

2022-2023 Annual Submission to NHS England North West:

Appraisal, Revalidation and Medical Governance

Please complete the tables below:

Name of Organisation:	**Liverpool Women's NHS Foundation Trust**
What type of services does your organisation provide?	Obstetric & Gynaecology, Neonatology and Genomic Medicine.

	Name	**Contact Information**
Responsible Officer	Lynn Greenhalgh	0151 702 4417
Medical Director	Lynn Greenhalgh	0151 702 4417
Medical Appraisal Lead	Janine Elson	0151 709 9988
Appraisal and Revalidation Manager	Lynn Johnson	0151 709 9988 ex 4268
Additional Useful Contacts		

Service Level Agreement

Do you have a service level agreement for Responsible Officer services?

No

If yes, who is this with?

Organisation: **Please describe arrangements for Responsible Officer to report to the Board:** **Date of last RO report to the Board:** **Action for next year:**

Section 2a: Appraisal Data

The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Total number of doctors with a prescribed connection as at 31 March 2023?	117
Total number of appraisals undertaken between 1 April 2022 and 31 March 2023?	96
Total number of agreed exceptions granted between 1 April 2022 and 31 March 2023?	10
Total number of missed appraisals* between 1 April 2022 and 31 March 2023?	1
Total number of appraisers as at 31 March 2023?	19 including 4 p/time

*A missed appraisal is an appraisal that is not completed and no exception has been granted in that appraisal year (1 April 2022-31 March 2023).

Section 2b: Revalidation Data

Timely recommendations are made to the General Medical Council (GMC) about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Total number of recommendations made to the GMC between 1 April 2022 and 31 March 2023?	
Total number of positive recommendations submitted between 1 April 2022 and 31 March 2023?	17
Total number of recommendations for deferral submitted between 1 April 2022 and 31 March 2023?	5
Total number of recommendations for non-engagement submitted between 1 April 2022 and 31 March 2023?	1
Total number of recommendations submitted after due date between 1 April 2022 and 31 March 2023?	3

Section 3: Medical Governance
Concerns data

How many doctors have been through the Maintaining High Professional Standards (MHPS) or equivalent process between 1 April 2022 and 31 March 2023?	**2**
How many doctors have been referred to the GMC between 1 April 2022 and 31 March 2023?	**0**
How many doctors have been referred to the Practitioner Performance Advice Service (PPA) between 1 April 2022 and 31 March 2023?	**3**
How many doctors have been excluded from practice between 1 April 2022 and 31 March 2023?	**0**

Organisational Policies

List your policies to support medical appraisal and revalidation	Implementation date	Review date
Medical Appraisal and Revalidation policy	21/09/2021	21/09/2024
Study Leave Professional Leave Policy for Consultants and Trust Speciality Doctors	18/07/2022	18/07/32025

List your policies to support MHPS and managing concerns	Implementation date	Review date
Maintaining High Professional Standard Policy	20/09/2021	20/09/2024

Other relevant policies	Implementation date	Review date

How do you socialise your policies?

On our Trust intranet and RMS system (L2P)

Trust Policies are socialised via the Trust Intranet and through Trust wide and local meetings. Policies relating to medical appraisal and revalidation are also reviewed at the JLNC (Joint Local Negotiating Committee).

Section 4: General Information

The board / executive management team can confirm that:

4.1 An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Yes: Dr Lynn Greenhalgh, Medical Director, continues to be the Responsible Officer. The Deputy Medial Director is undergoing Responsible Officer Training to support the RO.
Action for next year (1 April 2023 – 31 March 2024). The support the Deputy Medical Director once trained to take on some RO work.

4.2 The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes: L2P is now embedded as the Trust's Appraisal and Revalidation System. The Trust also employs a Revalidation Manager and allocated time for an appraisal lead. All Appraisers are given an allocation within their job plans.
If No, please provide more detail:

4.3 An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained?

Yes
The revalidation manager completes this task which is held within the appraisal and revalidation system.
If no, what are you plans to implement a record keeping process? (Action for next year (1 April 2023 – 31 March 2024).

4.4 Do you have a peer review process arranged with another organisation?

No The Trust is looking to explore this is 2023/2024

4.5 Is there a process in place to ensure locum or short-term placement doctors working in the organisation are supported, including those with a prescribed connection to another organisation?

Yes

4.6 How do you ensure they are supported in their continuing professional development, appraisal, revalidation, and governance?

Short term post graduate doctors who are not under going ARCP are treated the same as those in long term posts as regards appraisal and revalidation. The same governance structure applies. They are added and managed through the L2P appraisal/revalidation management system. Where this is not possible due to time constraints their Educational Supervisor is asked to perform an exit appraisal so that they have documentation to take forwards to their next placement and we have evidence of their work at LWH.

Section 5: Appraisal Information

5.1 Have you adopted the Appraisal 2022 model?

Yes
If no, what are your plans to implement this? (Action for next year (1 April 2023 – 31 March 2024).

5.2 Do you use MAG 4.2?

No
If yes, what are your plans to replace this? (Action for next year (1 April 2023 – 31 March 2024).

5.3 Please describe any areas of good practice or improvements made in relation to appraisal and revalidation in the last year (1 April 2022 to 31 March 2023).

Peer review sessions for appraisers have been established and provided good check and challenge and support for appraisers.

New appraisers have been trained.

5.4 Have you any plans for any changes/ improvements in the coming year (1 April 2023 to 31 March 2024)?

There is a plan to use more data from the Model Hospital and the National Consultant Information Programme to aid benchmarking.

The hospital has moved to a new EPR which may also help to give more accurate information for doctors for their appraisal. Once this system is embedded this will be looked at.

5.5 How do you train your appraisers?

All appraisers are currently trained by Miad Healthcare.

5.6 How do you Quality Assure your appraisers?

There are regular appraiser update meetings. The appraisal lead has set up a series of peer review sessions where appraisers review the quality of each others appraisals performance using the SUPPORT tool. In addition 1:1 sessions are given by the appraisal lead for any appraiser who is identified as needing additional training or support.

5.7 How are your Quality Assurance findings reported to the board?

The results of the quality assurance findings can be included in the Quarterly report to the Putting People First Committee.

5.8 What was the most common reason for deferral of revalidation?

The most common reason for deferral is inadequate information and this most frequently occurs when consultants are returning from a maternity leave or and extended period of leave.

5.9 How do you manage doctors that are difficult to engage in appraisal and revalidation?

The Revalidation manager will send out letters to all consultants and if they do not engage will actively seek out the doctor to offer support.

There is a weekly meeting between the appraisal/revalidation team where doctors who are struggling to engage are discussed and a plan put in place to engage with these doctors.

Section 6: Medical Governance

6.1 What systems and processes are in place for monitoring the conduct and performance of all doctors?

Concerns from patients can be raised through PALS or patient complaints or direct feedback.

Concerns from colleagues can be made by speaking with the doctor's line manager, clinical director or directly to the Responsible Officer/Medical Director or Deputy Medical Director.

Post Graduate doctors can raised concerns via their educational supervisor and medical students through their medical supervisor. Medical Students also give feedback via the University and Post Graduate doctors via the GMC trainees survey.

The Trust has 2 Freedom to Speak up Guardians, one of whom is a doctor to help staff to raise concerns.

The Trust uses the Ulysses system for incident reporting and this can be triangulated with complaints and serious incidents.

Each practitioner is provided with a summary of complaints and serious incident prior to appraisal.

6.2 How is this information collated, analysed and shared with the board? (Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors).

Information is reported to the Board regarding those doctors who are referred to the GMC and those being investigated by the GMC. To date the protected characteristics have not been detailed but this will commence in 2023-2024.

6.3 How do you ensure that any concerns are managed with compassion?

The Trust has adopted a Fair and Just culture which supports a compassionate response. All practitioners, where a concern has been raised about their practice, are offered help and support from Occupational Health and psychological support from Staff Support Services. If appropriate they are offered a colleague for peer support.

6.4 How do you Quality Assure your system for responding to concerns?

Significant concerns are discussed with PPA (Practitioner Performance Association) for independent advice and guidance.

6.5 How if this Quality Assurance information reported to the board?

Currently this is not but will be included in the Quarterly Board reports in 2022-2023.

6.6 What is the process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility)?

The MIPT form is used to transfer information quickly and effectively between Responsible Officers.

6.7 What safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination?

The Trust is adopting a 'Fair and Just' culture with training for this being mandatory across the Trust. The principles of this are used in responding to concerns about practitioners. The Trust has a 'Maintaining High Professional Standards' Policy which clearly defines the governance process for responding to concerns about a doctors practice. The Trust has used either external practitioners with protected characteristics or colleagues within the Trust with protected characteristics to quality assure processes around responding to concerns about a practitioner.

6.8 Please describe any areas of good practice or improvements made in relation to medical governance in the last year (1 April 2022 to 31 March 2023)?

The ongoing adoption of the principles of the 'Fair and Just Culture'.

6.9 Have you any plans for any changes/ improvements in the coming year (1 April 2023 to 31 March 2024)?

Details of protected characteristics of those doctors under going formal investigation will be included in the quarterly Responsible Officer Report as will the numbers and cases that were discussed with PPA. This report is submitted to the Putting People First Committee.

Section 7: Employment Checks

What is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties?

All recruitment undertaken either directly or via agencies is fully compliant with the NHS Pre-Employment Checks Standards.

Do you collate EDI data around recruitment and /or concerns information?

Yes
We monitor ED&I data pertaining to workforce primarily through the WRES data set which is reported to our People Committee and Board- medical staff are highlighted as a staff group within this report. We also have in place a BAME staff network which is chaired by a clinician. We have commenced a positive discrimination scheme whereby staff from BAME backgrounds will be automatically shortlisted if they meet the essential criteria of the role.

Section 8: Summary of comments and overall conclusion

Please use the table below to detail any additional information that you wish to share.

L2P continues to become embedded for medical appraisal.
The Responsible Officer report will be developed to include further detail on those protected characteristics of those doctors under formal investigation and those where advice is being sought from PPA.

Section 9: Statement of Compliance:
The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body
[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: ……..…….

Name: ……

Role: ……..

Date: ……..

Liverpool Women's
NHS Foundation Trust

Jargon Buster

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

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

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

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

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

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

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

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

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

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

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

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

G

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

H

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

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

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

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

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

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

N

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

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

O

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

P		
PALS	Patient Advice & Liaison Service	offers confidential advice, support and information on health-related matters to patients, their families, and their carers within trusts
PAS	Patient Administration System	the automation of administrative paperwork in healthcare organisations, particularly hospitals. It records the patient's demographics (e.g. name, home address, date of birth) and details all patient contact with the hospital, both outpatient and inpatient
PbR	Payment by Results or 'tariff'	a way of paying for health services that gives a unit price to a procedure
PCN	Primary care network	A key part of the NHS long term plan, whereby general practices are brought together to work at scale
PDSA	Plan, do, study, act	A model of improvement which develops, tests and implements changes based on the scientific method
PFI	Private Finance Initiative	a scheme where private finance is sought to supply public sector services over a period of up to 60 years
PHE	Public Health England	a body with the mission to protect and improve the nation's health and wellbeing and reduce health inequalities
PHSO	Parliamentary and Health Service Ombudsman	an organisation which investigates complaints that individuals have been treated unfairly or have received poor service from government departments and other public organisations and the NHS in England
PICU	Psychiatric Intensive Care Unit *or* Paediatric Intensive Care Unit	a type of psychiatric in-patient ward with higher staff to patient ratios than on 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