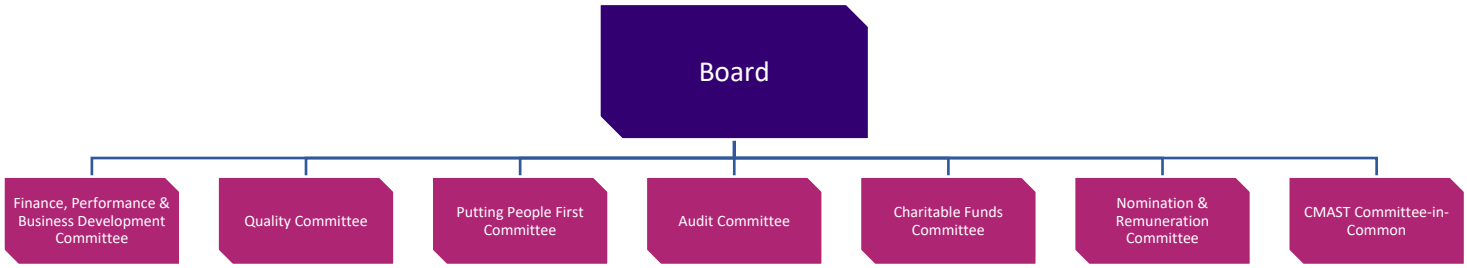
Liverpool Women's
NHS Foundation Trust

Trust Board

9 November 2023, 9.30am
Boardroom, LWH & Virtual, via Teams



Liverpool Women's NHS Foundation Trust

Trust Board

Location	Boardroom and Virtual (via Teams)
Date	9 November 2023
Time	9.30am

AGENDA					
Item no. 22/23/	Title of item	Objectives/desired outcome	Process	Item presenter	Time
PRELIMINARY BUSINESS					
176	Introduction, Apologies & Declaration of Interest	Receive apologies & declarations of interest	Verbal	Chair	09.30 (5 mins)
177	Meeting Guidance Notes	To receive the meeting attendees' guidance notes	Written	Chair	
178	Minutes of the previous meeting held on 12 October 2023	Confirm as an accurate record the minutes of the previous meeting(s)	Written	Chair	
179	Action Log and matters arising	Provide an update in respect of on-going and outstanding items to ensure progress	Written	Chair	
180	Patient Story	To receive a patient story	Verbal	Chief Nurse	09.35 (20 mins)
181	Chair's announcements	Announce items of significance not found elsewhere on the agenda	Verbal	Chair	09.55 (5 mins)
182	Chief Executive Report	Report key developments and announce items of significance not found elsewhere on the agenda	Written	Chief Executive	10.00 (5 mins)
MATERNITY					
183a	NHSE Maternity Diagnostic Review	To receive	Written	Chief Nurse	10.05 (15 mins)
183b	Maternity Incentive Scheme (CNST) Year 5 – Scheme Update	To receive	Written	Chief Nurse	10.20 (10 mins)
QUALITY & OPERATIONAL PERFORMANCE					
184a	Chair's Reports from the Quality Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	10.30 (40 mins)
184b	Quality & Operational Performance Report	For assurance – To note the latest performance measures	Written	Chief Operating Officer	
184c	Bi-annual staffing paper update, January 2023-June 2023 (Q4 22/23 & Q1 23/24)	For assurance	Written	Chief Nurse	

184d	Seven Day Working Board Assurance	For assurance	Written	Medical Director	
BREAK					
Board Thank You					
PEOPLE					
185a	Chair's Report from the Putting People First Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	11.20 (5 mins)
185b	Workforce Performance Report	For assurance – To note the latest performance measures	Written	Chief People Officer	11.25 (10 mins)
FINANCE & FINANCIAL PERFORMANCE					
186a	Chair's Reports from the Finance, Performance and Business Development Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	11.35 (60 mins)
186b	Chair's Report from the Audit Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	
186d	Finance Performance Review Month 6 2023/24	To note the current status of the Trust's financial position	Written	Chief Finance Officer	
186e	Progress towards Delivery of Strategic and Corporate Objectives	To note and approve	Written	Chief Finance Officer	
186f	Community Diagnostic Centre 2024/25	To approve	Written	Chief Operating Officer	
BOARD GOVERNANCE					
187	Board Assurance Framework	For assurance	Written	Trust Secretary	12.35 (10 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.*					
188	2023/24 Operational Plan 6-month update	To note	Written	Chief Operating Officer	Consent
189	Integrated Governance Assurance Report Quarter 1 2023/24	For assurance	Written	Chief Nurse	
CONCLUDING BUSINESS					
190	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair	12.55 (5 mins)
191	Chair's Log	Identify any Chair's Logs	Verbal	Chair	
192	Any other business & Review of meeting	Consider any urgent items of other business	Verbal	Chair	
193	Jargon Buster	For reference	Written	Chair	

Finish Time: 13.00					

Date of Next Meeting: 14 December 2023

13.00 – 13.10	***Questions raised by members of the public***	To respond to members of the public on matters of clarification and understanding.	Verbal	Chair

The Board of Directors is invited to adopt the following resolution:

'That the Board hereby resolves that the remainder of the meeting to be held in private, because publicity would be prejudicial to the public interest, by reason of the confidential nature of the business to be transacted'. [Section (2) of the Public Bodies (Admission to Meetings) Act 1960]

Liverpool Women's
NHS Foundation Trust

Meeting 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 12 October 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
Louise Martin	Non-Executive Director
Jackie Bird MBE	Non-Executive Director

IN ATTENDANCE

Matt Connor	Chief Information Officer
Dr Chris Dewhurst	Deputy Medical Director
Alison Murray	Deputy Head of Midwifery (until item 163)
Jan Bentley	Preceptorship Lead (until item 161)
Deborah Ward	Head of Safeguarding (item 165 only)
Annie Gorski	Public Governor
Felicity Dowling	Member of the Public
Teresa Williams	Member of the Public
Mark Grimshaw	Trust Secretary (minutes)

APOLOGIES:
None noted.

Core members	**Nov 22**	**Dec**	**Jan**	**Feb**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct 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/	
155	**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.
156	**Meeting guidance notes** The Board received the meeting attendees' guidance notes.
157	**Minutes of the previous meeting held on 14 September 2023** The minutes of the Board of Directors meeting held on 14 September 2023 were agreed as a true and accurate record.
158	**Action Log and matters arising** Updates against action log were noted.
159	**Chair's & CEO announcements** The Chair provided an update regarding a meeting of the Nomination & Remuneration Committee that had been held earlier in the day. The Committee had continued to discuss arrangements for the Joint Chief Executive appointment. James Sumner had attended the meeting to meet with Committee members as part of their due diligence processes. A recommendation would be progressing to the Council of Governors for their consideration. The Chair also highlighted the following matters: • The Annual Member's Meeting had been held on 21 September 2023. This had provided an opportunity to reflect on 2022/23 and several constitutional amendments had been approved. • The bi-annual 'Big Conversation' with staff had taken place on 28 September 2023. The intelligence gathered from staff would be collated and reported through the appropriate governance processes. Initial impressions from the discussions suggested that staff believed the Trust was making positive progress in several areas. • It was currently Baby Loss Awareness Week and the remembrance service had been held on 10 October 2023. Thanks were extended to the Honeysuckle Team for their work in facilitating the service.

	The Chief Executive noted that Gill Walton, the Chief Executive of the Royal College of Midwives, had attended the remembrance service. She had remarked on the safe staffing levels at the Trust and that this was testament to the Board's commitment to safe staffing. The Chief Executive noted that the Report by Counter Terrorism Policing North West into the explosion outside the Liverpool Women's Hospital in November 2021had recently been published. The Trust continued to learn lessons from the incident and the findings from the report would support this. The Trust had received confirmation that it had achieved compliance with the NHS Resolution Maternity Incentive Scheme Year 4. After assessing the Trust's evidence in its resubmission (requested following the recent CQC Report), NHS Resolution had remarked positively on the Trust's governance and oversight arrangements for maternity services. The Chief Executive confirmed that conversations would continue with the CQC regarding reinspection timelines and a reassessment of the Warning Notice. The Board noted the update.
160	Preceptorship Update The Deputy Head of Midwifery highlighted that Liverpool Women's Hospital had been facing a concerning decline in registered midwives, with a loss of 122 midwives from April 2021 to April 2022. Key concerns revolved around the high turnover rate among early career midwives, which posed a significant cost and performance threat, along with a considerable number of midwives nearing retirement age. Dissatisfaction was noted, particularly among those with less than five years of NHS service, with 57% of midwives contemplating leaving the profession. To address these challenges, the Trust had implemented an innovative preceptorship program that included a two-week induction program focusing on patient safety, team building, and support. The program, which also provided continuity through a dedicated preceptorship team, had seen substantial success, with a 98% retention rate for preceptees and a notable impact on reducing sickness, turnover, and midwifery vacancies within the Trust. This comprehensive approach aligned with the National Preceptorship Framework for Midwives, and its success had been a key factor in achieving Liverpool Women's Hospital's workforce goals, with no midwifery vacancies reported as of October 2023, while the national average stood at 11%. The Chief Operating Officer highlighted that it was encouraging that the team continued to review the programme and seek improvements. He noted that thought would need to be given as to how the Trust could support the wider system who may be experiencing higher midwifery vacancies. Non-Executive Director, Louise Martin, queried what action was being taken to increase the diversity of the intake. The Preceptorship Lead reported that there was a lack of diversity of individuals studying midwifery at university and therefore the Trust was working with universities on their recruitment practices. The Chief Information Officer asked if senior staff had been offered coaching and support for the most effective ways to communicate with newly qualified midwives. The Chief Executive confirmed that there had been a cultural shift and that this had taken hard work and persistence to achieve. It was suggested that it would be important to retain oversight on whether this was sustained. Non-Executive Directors Jackie Bird and Sarah Walker remarked that this was a good example of 'invest-to-save' principles considering the impact that the successful preceptorship had had on reducing agency usage. It was noted that this demonstrated the importance of the Board taking a longer-term approach for investment decisions when appropriate.

	The Board encouraged the team in pursuing the academic publication of the scheme to support wider learning across the NHS and to also explore the possibility of delivering the scheme across a wider system footprint. The Board noted the update.
161	Maternity Staffing report 1 January-30 June 2023 The Maternity Staffing paper outlined the Trust's position regarding midwifery staffing in the context of the Maternity Incentive Scheme (MIS) Year 5, Safety Action 5 (SA5). Covering the period from January 1, 2023, to June 30, 2023, the report emphasized the importance of effective midwifery workforce planning, with Birth Rate Plus (BR+) being the recognized evidence-based tool in maternity services. A Birth Rate Plus refresh audit was conducted in April 2023, and the final report was received in May 2023. The Deputy Head of Midwifery highlighted various aspects, including budgeted posts, the need to align with BR+ recommendations, plans to address deficiencies, vacancy rates, sickness absence management, midwife-to-birth ratios, and the reduction in red flags related to delays in Induction of Labour. The report also highlighted the positive impact of measures taken, such as maintaining a supernumerary shift coordinator on the Delivery Suite, achieving high compliance rates in 1:1 care during labour, and significantly improving Triage assessment performance. The paper recommended that the Board accepted the information as assurance of robust systems and processes in place to fulfil the requirements of MIS Year 5, SA5. Non-Executive Director, Jackie Bird, noted that delays to Induction of Labour (IoL) seemed to be a consistent issue highlighted in the report and queried what remedial action was being taken. The Deputy Head of Midwifery noted that a key driver of the delays was the configuration of the Trust estate. Work commenced in September 2023 to repurpose the current Midwifery Led Unit (MLU) into a multipurpose area which would include an Induction of Labour lounge. This would reduce bottlenecks within the Delivery Suite which could contribute to delays. In addition, there are several improvement actions ongoing within the Maternity division, including the development of a task and finish group, led by the newly appointed Induction of Labour Co-Ordinator and our Intrapartum Obstetric Lead. This group was exploring, amongst other things, current acuity and occupancy challenges, capacity demand on booking lists, and how these could be managed to reduce delays. The Chief Nurse added that ensuring patient flow was vital to the most effective distribution of staffing. The Chief Executive suggested that it would be useful for future reports to provide additional context including C-Section and IoL rates and how this impacted staffing models. Action: For future bi-annual maternity staffing reports to include additional context including C-Section and IoL rates and how these impact staffing models. The Board received the report.
162	Perinatal Quality Surveillance & Safety Dashboard The Chief Nurse presented the dashboard highlighting key performance issues, midwifery red flags, and Healthcare Safety Investigation (HSIB) referrals. It was reported that were plans behind each area of concern identified in the report to drive improvements. The Board of Directors: • Noted the Perinatal Quality Surveillance & Safety Dashboard for August 2023.
163	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 was above set trajectories. The Trust continued to be impacted by industrial action, but this had been managed well to date. • 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 drew attention to the LocSSIPs (Local Safety Standards for Invasive Procedures) performance and queried the impact of poor compliance. The Deputy Medical Director explained that the low compliance was predominantly because of challenges of recording checks during urgent surgery. Whilst there was confidence that the checks were being undertaken, the importance of recording was recognised, and the Quality Committee was monitoring compliance levels. The Chair noted that improvements to cancer performance had plateaued in recent months. The Chief Operating Officer explained that there had been a hysteroscopy backlog, but it was expected that the wait time would reduce to three weeks in the coming months. This would have a significant impact on the 28-day diagnostic performance. The Board of Directors received and noted the Quality & Operational Performance Report.
164	Mortality and Learning from Deaths Report Quarter 1, 2023/24 The Deputy Medical Director presented the mortality data for Q1 2023/24 with the learning from the reviews of deaths from Q4 2022/23. It was explained that the 'learning' could take some time after the death occurred due to the formal processes and Multi-Disciplinary Team (MDT) reviews that occur. Learning from Serious Incident (SI) reviews, Coroner's inquests, HSIB investigations and elsewhere could take longer to be reported. This results in the learning being presented at least one quarter behind the mortality 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 learning from obstetric mortality (three cases) and gynaecology mortality (two cases) was outlined. In terms of the latter, given the identification of lack of co-location with adult acute services being a contributor to the two deaths, a retrospective review of SIs since 2018 from the gynaecology and clinical support services divisions had been undertaken. Neither of the 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. Non-Executive Director, Louise Martin, drew attention to the lessons learned identified in the Obstetric Mortality Case 1 and suggested that they seemed to reference medical practice that should already be in situ. The Medical Director explained that the Trust's teams did not have other specialists available during a post-operative period and therefore the recognition, treatment and recovery of

the deteriorating patient was a significant risk. There was a need to train and support staff to mitigate risks as far as possible but without co-location, they would never be fully closed out. It was suggested that the Trust may be required to have lower thresholds for commencing escalation in recognition of the risks.

The Chief People Officer stated that it was important that ethnicity was more explicitly included in future reports with commentary on whether it was a contributing factor. The Chief Executive referenced the 'MBRRACE-UK Saving Lives Improving Mothers' Care - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2019-21' report noting that black women continued to have poorer maternal outcomes.

Action: To ensure that commentary regarding ethnicity being a potential contributory factor to mortality be included within future learning from deaths reports.

The Deputy Medical Director continued to report that the stillbirth rate for this quarter was 1.7/1000. This was the lowest rate for the previous 3 years. 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 was planned to be a region wide review coordinated by the ICB due to the issue of non-colocation nature of the maternity services in Liverpool.

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 was above the NWODN benchmark of 6.3%, however discussions with the appropriateness of this benchmark with the ODN had commenced. This included the fact that when babies with congenital abnormalities were removed from the data, the Trust benchmarked within range.

An overview of in-utero transfers (IUTs) and the impact on mortality had been provided within the report. Over a 2-year period, IUTs accounted for nearly half (26/55, 47%) of all deaths at LWH. IUTs were six times more likely to die than non-IUTs (1.5% vs 8.8%). The excess mortality was mainly seen in the more mature infants related to the presence of congenital anomalies.

The Board received an additional overview from the Deputy Medical Director to aid their understanding of neonatal mortality. The Board remarked that external reviews had been commissioned in recent years when variability in the mortality rate had been identified. Assurance was sought that the learning from the external reviews was fully embedded. The Board acknowledged the challenges in identifying variances and concerns in neonatal mortality. Several issues were noted, including the importance of data accuracy and completeness, the complexity of neonatal cases and their contributing factors, and the importance of transparent communication between clinical teams and management. The Board asked that additional clarity to be provided on the oversight framework in place at Trust, System and Regional levels.

Action: For additional clarity to be provided on the oversight framework in place at Trust, System and Regional levels for neonatal mortality.

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

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

	The Board of Directors resolved to: • Note – o number of deaths in our care o number of deaths subject to case record review. o number of deaths investigated under the Serious Incident framework. o number of deaths that were reviewed/investigated and as a result considered due to problems in care. o themes and issues identified from review and investigation. o actions taken in response, actions planned and an assessment of the impact of actions taken. • Agree that 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 be undertaken. • Agree that the learning from deaths information relating to learning from non-colocation be shared with system partners.
165	Annual Safeguarding Report 2022/23 The Board received the Safeguarding Annual Report for Children, Young People and Adults which provided an overview of safeguarding activity within the Trust for the period 1 April 2022 to 31 March 2023. The Head of Safeguarding stated safeguarding remained a fundamental component of all care within the Trust and the team had again this year responded effectively and efficiently to the challenges of safeguarding both for patients and staff in what had been a challenging year. The Chief Executive asked what support was available to the team. The Head of Safeguarding stated that work was on-going to re-establish a local network for peer support. The Chief Finance Officer queried where referrals were received from. It was explained that most referrals were received from staff but also from the police and social services. The Chief Executive remarked that the Trust should explore partnership working to reduce the need for referrals e.g., campaigns with local football clubs. Non-Executive Director, Jackie Bird, asked when the Trust's Oliver McGowan training would be going live. The Head of Safeguarding reported that an options appraisal had been written and the impact on the Trust was being assessed. The Board received a presentation on its statutory safeguarding duties and responsibilities. The Board of Directors approved the Annual Safeguarding Report 2022/23 and its publication on the Trust website.
	Board Thank you The following Board Thank You's were presented: 1) Ann Bridson – presented by the Chief People Officer – for all the work undertaken in establishing and delivering the supported intern programme – noted as being 'outstanding' by the CQC. Ann had also been instrumental in the Trust achieving Silver for the Armed Forces accreditation 2) Allan Hawksey and the Governance Team – presented by the Chief Nurse - for the development of the Trust's PSIRF – a key change to how the Trust will manage incidents going forward. 3) Rosemary Namwanje – presented by the Chief Nurse – providing exemplary care to a patient on the gynaecology ward. Noted as treating the patient with a smile and being kind, dedicated and efficient in her work.
166	Workforce Performance Report

	The Board considered the Workforce Performance Report, noting the positive direction for most metrics. The Chief People Officer noted that a campaign was in place to increase the staff take up of both the flu and Covid-19 vaccines. The Board noted the workforce performance report.
167	Finance Performance Review Month 5 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 August 2023. At Month 5 the Trust was reporting a £8,660k deficit which represented a £1,474k adverse variance to plan. This position was supported by £2.2m of non-recurrent items. The forecast outturn was a £15,450k deficit, in line with the submitted plan. The Year-to-date (YTD) position was supported by £2.2m of non-recurrent items. The adjusted position in Month 5 (following removal of key non-recurrent items) was a deficit of £10.9m, which represented an adverse variance of £3.7m against plan. If the Trust did not improve the current monthly run-rate, there would be a £10m adverse variance to the plan. The Trust was acting on financial recovery and positive actions were in place. The Recovery Director had now left the Trust, but the enhanced infrastructure, documentation, and governance remained in place. Recovery workstreams had been initiated and new savings opportunities had been identified. 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. A post investment review was also in progress and would report to the October 2023 FPBD Committee. The Committee would receive the Month 6 position which would help to inform a realistic forecast outturn (FOT) position. Total cash at the end of Month 5 was £3.8m. This was £0.7m behind plan and was 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 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 and cash levels were monitored daily. The Trust was liaising closely with the ICB and the national cash team to ensure cash levels were sufficient to meet operational needs. The Chair noted that he had attended a recent NHS Cheshire & Merseyside finance session and the challenges that trusts were facing with delivering Cost Improvement Programmes and reversing the increase in head counts were referenced. The Chief Executive confirmed that the Executive Team had reviewed in detail the staff investments made since 2019/20 and the rationale for the investment, which overall were made for safety reasons. The Executive Team had also reviewed the most challenging cost reduction schemes and made a judgement on deliverability. The Board of Directors: • Noted and received the Month 5 2023/24 Finance Performance Review
168	Fit and Proper Person Test Requirements Update The Trust Secretary reported that NHS England (NHSE) had introduced a new Fit and Proper Person (FPP) Framework in August 2023, with a phased implementation starting from September 30, 2023,

	and full adoption by March 31, 2024. The implications of the new framework were outlined and the Trust's policy had been updated to reflect this. The Trust's 2023 FPP compliance was noted. The Board of Directors: • Noted the 2023 compliance status for the Fit and Proper Person Requirements • Noted the key issues relating to the NHS England Fit and Proper Person Test Framework for board members • Approved the updated Fit and Proper Person Policy *The following items were considered as part of the consent agenda*
169	Emergency Preparedness, Resilience & Response Core Standards Annual Assurance Board Report The Board of Directors • noted assurance that effective systems of control were in place in relation to achieving compliance to the NHSE EPRR Core Standards.
170	Annual Self-Assessment for Placement Providers 2023 for Submission to NHSE The Board of Directors • supported the submission of the Self-Assessment Report to Health Education England.
171	Medical Appraisal and Revalidation Annual Report 2022/23 The Board of Directors • received the report noting it would be shared with the Higher-Level RO. • approved 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, was in compliance with the regulations
172	Review of risk impacts of items discussed The Chair identified the following risk items: • Delays to Induction of Labour and the C-Section rate. • Whilst performance metrics were improving, there was a need to continue to monitor cancer performance. • On-going challenges resulting from Industrial Action. • Mortality and the Trust's isolated site as a contributing factor. • Management and escalation of the deteriorating patient. • The quantity of safeguarding referrals. • The Trust's 2023/24 financial position, CIP under delivery, challenges with unwinding investments and the cash position. Positive assurances were noted around the preceptorship scheme and the application of a continuous improvement approach.
142	Chair's Log None noted.
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
9 November 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
12 October 2023	23/24/164	Mortality and Learning from Deaths Report Quarter 1, 2023/24	For additional clarity to be provided on the oversight framework in place at Trust, System and Regional levels for neonatal mortality.	Medical Director	December 2024	On track	
12 October 2023	23/24/164	Mortality and Learning from Deaths Report Quarter 1, 2023/24	To ensure that commentary regarding ethnicity being a potential contributory factor to mortality be included within future learning from deaths reports.	Medical Director	February 2024	On track	
12 October 2023	23/24/161	Maternity Staffing report 1 January-30 June 2023	For future bi-annual maternity staffing reports to include additional context including C-Section and IoL rates and how these impact staffing models.	Chief Nurse	January 2024	On track	
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	Completed	COO has met with the guardians and walked round the organization and identified several options which are being progressed through space utilization
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	Briefing to be provided to Board members by end of November 2023.

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	
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	

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	Scheduled for November's Quality Committee.

Liverpool Women's
NHS Foundation Trust

CEO Report

Trust Board
November 2023

Executive Summary:

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

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

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

Section A - *Internal*

Trust announces departure of Chair, Robert Clarke

Liverpool Women's NHS Foundation Trust has announced that the Trust's Chair, Robert Clarke, is to leave at the end of February 2024 when his current term of office comes to an end after eight years in the role.

Robert joined Liverpool Women's in March 2016 after seven years as a Non-Executive Director and Vice-Chair at Lancashire Teaching Hospital NHS Foundation Trust. Outside of his NHS role, Robert is the managing partner of a family dairy farm.

It has been a privilege to work with Robert as our Chair over the last eight years. His commitment to the Trust and, most importantly, to ensuring that our patients and families are looked after by holding everyone to account, has been invaluable. We have been fortunate to benefit from Robert's compassion and integrity in his role and he will be missed across the Trust when he leaves. I would like to say a huge thank you for his support for me personally, along with my Board colleagues past and present."

Robert will remain in his role until his current term of office ends in February 2024.

Liverpool Women's has reached agreement with Liverpool University Hospitals NHS Foundation Trust (LUHFT) to pursue a joint-Chair appointment which will commence from March 2024.

The Trust's Council of Governors' Nomination and Remuneration Committee has now taken joint responsibility with LUHFT to undertake the recruitment process for a joint-Chair.

The recruitment process is due to start in early November, with interviews scheduled for December. The successful candidate is expected to start in the role from March 2024. Further updates on this appointment will be shared in due course.

Section A - *Internal*

LWH Black History Month 2023

Black History Month is an opportunity to recognise and celebrate the invaluable contributions of black people to society and to the NHS. It also serves as an opportunity to inspire and empower future generations. This year, Black History Month is dedicated to honouring the achievements of black women who are often forgotten.

The theme of 'Saluting our Sisters' highlights the crucial role that black women have played in shaping history, inspiring change, and building communities.

We have been celebrating with our colleagues talking about their background, heritage and achievements.

https://liverpoolwomens.nhs.uk/news/celebrating-black-history-month-2023-saluting-our-sisters/

Anti-racism campaign 'Call it out, stamp it out'

We have recently launched our '*Call it out, stamp it out'* anti-racism campaign, you can view the campaign on our social media channels here.

The Women's View' October / November 2023

Bringing you the latest news, updates and all things LWH

https://liverpoolwomens.nhs.uk/media/5168/hg-issue-19-v2.pdf

Inside this issue…

- Robotic-assisted surgeries
- Fear of Childbirth Study - volunteers needed
- NHS 75th Birthday Celebrations
- Merseyside Police commendation for Chief Executive

Section A - *Internal*

Trust midwife invited to reception hosted by His Majesty The King

Camila Benavides-Gamnoa has been invited to the reception hosted by His Majesty The King to celebrate the contribution of Nurses and Midwives (notably International Nurses and Midwives) working in the UK's Health and Social Care Sector on Tuesday 14th November, from 4pm at Buckingham Palace.

Employee/Team of the Month August 2023

Congratulations to our Employee of the Month, Katie Lowe, MAU Midwife. Katie is an amazing midwife who always cares for our women with a smile on her face.

Team of the Month - the Research Midwives. This team who go above and beyond putting women and their families at the heart of everything they do. Well done to you all.

Supporting our employees through Menopause

As we marked World Menopause Day (Wednesday 18th October) we have pledged to support our employees going through menopause in the workplace.

Recording Menopause Sickness

In HealthRoster and ESR managers are now able to record Menopause as a reason for sickness. We are encouraging staff to report absences that are menopause related to their managers so we can better support staff.

As a Trust we can support colleagues with menopause through the following ways: Creating awareness and education through events and our menopause club network as well as offering Flexible Working Arrangements and Health and Wellbeing resources such as Occupational Health.

You can read more information here - British Menopause Society | For healthcare professionals and others specialising in post reproductive health (thebms.org.uk)

Section B - *Local*

NHS Cheshire and Merseyside Blog

Last week (28 September 2023), we welcomed more than 60 people to our Annual General Meeting. Thanks again to all those who joined us at the Halliwell Jones rugby stadium in Warrington to find out more about our performance in 2022-23. A full summary can be found below.

Like many other areas up and down the country, Cheshire and Merseyside continues to feel the impact of NHS industrial action.

While we continue to respect the right of staff to take part, frontline care is suffering as a result. On a typical day of NHS industrial action across Cheshire and Merseyside, up to 3,000 planned outpatient, day-case or inpatient activities are lost.

I would like to reiterate my thanks to service managers at every level for their continued hard work to help maintain safe levels of care and good relationships with staff.

As the nights start to draw in and we finalise our winter plan for 2023-24, I'd like to remind all those who are eligible to get their COVID-19 and flu vaccinations when invited and take care of those around you this winter.

Expanding the use of our 'virtual wards' - in which patients receive support from the comfort of their own home - is just one key focus of our 2023-24 winter plan.

Since January 2023 Virtual Wards have:

- Prevented 2,359 patients from being needlessly admitted to an inpatient bed
- Enabled 2,000 patients to be discharged earlier

Finally, as you may have already seen, Cheshire Police have confirmed that the Countess of Chester Hospital NHS Foundation Trust is now being investigated for corporate manslaughter in connection with the Lucy Letby case.

As ever, the thoughts of everyone at NHS Cheshire and Merseyside are with the children at the heart of this case and their families and loved ones.

NHS Cheshire and Merseyside will continue to work closely with colleagues at the Countess of Chester to support the day-to-day delivery of safe and effective care and ensure any learning is shared across both Cheshire and Merseyside and the wider NHS.

Graham Urwin - Chief Executive

[Full October 2023 update available here]

CEO of NHS Cheshire and Merseyside
Graham Urwin

NHS Cheshire and Merseyside Integrated Care Board meeting

Papers and recording for the meeting held on 28 September 2023.

https://www.cheshireandmerseyside.nhs.uk/get-involved/meeting-and-event-archive/nhs-cheshire-and-merseyside-integrated-care-board/28-september-2023/

Section B - *Local*

Women's Services Committee Chair's Briefing - October 2023

Welcome to the second Women's Services Committee Chair's briefing.

The most recent meeting of the committee was due to take place at the end of September, however we took the decision not to go ahead with this. Instead, we're using the next few weeks to take a more detailed look at the scope of the women's services programme, the plan for delivering this work, and the roles that different NHS organisations locally will play in making it happen.

We recently appointed an independent clinical lead and a programme director for women's services, and they have been helping us review where we have got to so far. In addition, a shared interim Chief Executive for Liverpool Women's NHS Foundation Trust has now been announced, and it's important that we take the impact of this new leadership into consideration. We'll be discussing how we move forward at the next meeting of the Women's Services Committee in early November, and I'll provide another update on this page afterwards.

Finally, you might be aware that a march about several NHS-related issues, including the future of Liverpool Women's Hospital, took place in Liverpool on 7 October. In light of this, it's really important that we're clear about where the programme is up to, and stress that at this stage no decisions or proposals have been made about women's services. Although this issue has been looked at in the past, we need to fully consider the situation as it stands now, and develop potential options for the future, and we'll be involving patients, carers, the public, and other stakeholders in this work. Kathryn Thomson, Chief Executive of Liverpool Women's, shared a message on the trust's website, which sets out what has happened to date.

I look forward to providing a further update on the work of the committee in a few weeks' time.

Raj Jain

Chair, NHS Cheshire and Merseyside ICB, and Women's Services Committee

Cheshire & Merseyside Acute and Specialist Trusts (CMAST) Provider Collaborative Newsletter – September 2023

Please see the appendix to this report.

Section B - *Local*

University and Liverpool University Hospitals announce plan to improve healthcare in region

Senior leaders from the University of Liverpool and Liverpool University Hospitals NHS Foundation Trust (LUHFT) have signed a memorandum of understanding (MoU) to advance plans for an Academic Health Sciences Campus on the site of the former Royal Liverpool University Hospital.

The MoU will build on a long-standing collaboration between these Liverpool City Region anchor institutions, for the benefit of patients, students and the people of the region. In partnership with North West NHS trusts providing placements to Liverpool students, it will also help to answer challenges laid out in the recently published NHS Workforce Plan, the biggest recruitment drive in health service history

It will support the continued growth of Liverpool's Knowledge Quarter, creating jobs and seeking to attract investment in this world-leading innovation district which brings together the city region's key partners to collaborate in a creative environment and close the economic gap with London and the South East.

The facility would house the University's medical, dental, nursing and allied health professional students, enabling new opportunities for interprofessional learning, thereby enhancing students' clinical understanding and professional development within the context of a clinical team.

It would also feature flexible teaching spaces, clinical teaching facilities and simulation facilities, such as mock wards and patient homes, supported by state-of-the-art IT to train students to be part of a workforce that will increasingly use robotics, artificial intelligence and data. As part of our Health Innovation LiverpooL (HILL) programme, it would also provide vital clinical research space for health professionals seeking to address regional and global healthcare challenges.

Section C – *National*

CQC's State of Care 2022/23 report

Amanda Pritchard, NHS Chief Executive, made the following comments on the report.

As the report acknowledges, NHS staff faced an unprecedented combination of pressures and rising demand last year, including a record 25.3 million A&E attendances, 14 million more GP appointments and tens of thousands more mental health appointments, as well as ongoing challenges in enabling patients to leave hospital when they no longer need to be there, with more than 13,200 beds occupied by patients who were medically fit to leave each day.

And while the NHS has made improvements to maternity outcomes over the last decade, with fewer stillbirths and neonatal deaths, we know that – as the report makes clear – too many women and families do not get the level of care and experience we would all want to see. That's why the actions set out in the Three Year Delivery Plan for Maternity and Neonatal Services and the significant investment that is going into growing our maternity workforce, strengthening leadership and improving culture will continue to be so important.

The CQC's findings also serve as a reminder about the importance of continuing to focus on our recovery plans, including staying on track to add thousands more core beds ahead of winter, increasing diagnostic and elective activity, and widening access to primary care. Significant progress has already been made but, again, we are not yet where we would want to be. While the report quite rightly focuses on the experience of patients, I was also struck by the picture that it painted of the experience of NHS staff – as well as our colleagues working in social care. We have all said it so much over the last few years, but we can do nothing without our staff, and it has been an incredibly difficult time for many people – not just because of what has been going on at work.

Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries report

Responding to the new Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries report, which shows increasing inequalities in maternity services across the UK, Miriam Deakin, director of policy and strategy at NHS Providers said:

"While giving birth in the UK remains safe by global standards, the worsening health and race inequalities within maternity services are unacceptable.

"Women from black ethnic backgrounds are four times more likely to die, and women from Asian ethnic backgrounds are twice as likely to die, compared with white women.

"Maternal mortality rates are also highest for women living in the most deprived areas.

"Trust leaders are committed to addressing these disparities and improving the quality of care in maternity services, but much more needs to be done to ensure all mothers receive the same level of care and support during pregnancy and childbirth.

"National support for a holistic approach to maternal mental health, including education for new mothers, could help prevent suicide – the leading cause of post-pregnancy deaths.

"Collaboration with the local community, charities, and other healthcare providers could help trusts implement measures to improve access and experiences of personalised care, especially in deprived areas."

The full report can be found on the following link - Reports | MBRRACE-UK | NPEU (ox.ac.uk)

The overarching message in the report is – 'Treat pregnant, recently pregnant, and breastfeeding women the same as non-pregnant women unless there is a very clear reason not to'. It is important that the Trust and its partners listen to this and continue putting the care of women at the centre of what we do.

CMAST
Cheshire and Merseyside Acute and Specialist Trusts

Cheshire and Merseyside
Health and Care Partnership

CMAST Briefing

September 2023

ICB Update

Region-wide AI deal to help tackle waiting lists

The Cheshire and Merseyside Integrated Care System has signed a new agreement with its technology provider C2-Ai, to significantly expand a high-impact waiting list initiative across all of its acute hospitals. An AI-backed decision support model will help find, prioritise and support the highest-risk patients on waiting lists. Scaling successes already achieved by several Trusts.

Improved outcomes, fewer A&E admissions and shorter hospital stays are just some of the outcomes recorded at early adopter hospitals.

NHS Cheshire and Merseyside's Annual General Meeting 2023

More than 60 people attended NHS Cheshire and Merseyside's first Annual General Meeting at the Halliwell Jones stadium in Warrington on Thursday, September 28th, 2023.

You can read a full summary of the event here, and the ICB's 2023/24 Annual Report and Accounts is now available to view on their website.

NHS Cheshire and Merseyside Board meeting - September 2023

NHS Cheshire and Merseyside's latest Board meeting was held in Warrington on Thursday 28th September.

Board meetings are held in public, with live streams and webcasts of each meeting made available via the ICB's YouTube Channel. A recording of the latest Board meeting is available above. The papers from the meeting are available here.

The next Board meeting will be held on 30th November in Knowsley.

CMAST Update

The Leadership Board welcomed Trust Chairs to its October meeting and used the session to consider a mid-year review of delivery and progress against work plan commitments. A summary of these deliverables follows:

Diagnostics Programme

2023/4 delivery headlines:

- Against a backdrop of an overall increase in activity there has been a reduction in waiting times across specialities, including 100% reduction in patients waiting 79 weeks+ and 74% reduction in patients waiting 26 weeks+.
- Increased productivity has been achieved through the introduction of single guidelines and productivity tools meaning performance can be monitored more accurately across C&M
- System first thinking is enabling innovation across C&M through increased:
    - capital investment
    - screening opportunities
    - cost avoidance through efficiency
- A number of key decisions on significant direction of travel issues have been taken in the first part of the year to further the following workstreams within the diagnostics programme:
    - Pathology target operating model
    - Pathology LIMS (Laboratory Information System)
    - Endoscopy transformation

Anticipated 2023/4 next steps and delivery milestones:

- Enhanced mutual aid offer to harmonise waiting times
- Continued development of shared digital systems
- Workforce – interventional radiology, workforce growth and development
- Development and testing of risk and gain share mechanisms
- Increased use of AI deployment across diagnostics

<u>Elective Recovery</u>

2023/4 delivery headlines:

- Waiting lists and PTL management:
    - C&M were one of the only ICBs in the country to eliminate 104 week waits in line with deadlines
    - C&M ERF performance has tracked 2% higher than the England average since May
- Reducing variation in care:
    - Mutual aid for over 6500 patients from 8 different trusts throughout C&M has been facilitated
- System resources:
    - C&M theatre utilisation performance started in the 2nd quartile a year ago, and rose to 4th best in the country during August
    - Over 2,600 patients have been treated in the shared elective hub

Anticipated 2023/4 delivery milestones:

- Waiting lists and PTL management
    - C&M are on track to eliminate 65 week waits by the end of March 2024
    - Over 110,000 patients have been cleared from the potential breach cohort since April
- System resources:
    - The second cohort of attendees will be starting Theatre Academy to ensure the spread of best practice techniques throughout C&M

Clinical Pathway

2023/4 delivery headlines:

- The CPP Programme continues to follow its established methodology while continuing to follow identified road maps for orthopaedics, dermatology, and ENT
- A current state assessment has been undertaken for gynaecology with the first workshop held over the summer

Anticipated 2023/4 next steps and delivery milestones:

- Orthopaedics - C2Ai risk stratification project currently ongoing in all Trusts that deliver orthopaedic services will conclude and further pathway standardisation will be progressed
- Dermatology – Continued focus on exploring the potential use of technology within the specialty, through establishment of pilots and stocktaking existing projects
- ENT – Further development of the collaborative alliance with key focus on workforce with support from the workforce programme
- Gynaecology – Prioritisation and evaluation of opportunities to agree an improvement roadmap
- Connecting with other workstreams to maintain connection when identifying and scoping of further specialties for inclusion in the programme

Finance, Efficiency & Value – Efficiency at Scale

2023/4 delivery headlines:

- Programme Director is in place and funding for the programme has been secured for 2023/4 and 2024/5
- Principles and a workplan for 2023/24 have been established for efficiency at scale. The workplan is aligned to the National Corporate Services Transformation Programme
- Highlights from workstreams include:
    - Funding for the medicine's optimisation workstream has been secured for 2023/4 and 2024/5, a single governance structure is now in place for medicines to support this
    - A full procurement governance structure is in place and ICB Chief Procurement Officer commenced in September
    - An additional indemnity insurances review has been completed and £2.1m identified for review across C&M
    - A business case in under development for a single financial ledger and is supported by all trusts in C&M

Anticipated 2023/4 key targets include system delivery and contribution to:

- Medicines management will deliver an estimated £10m of savings in 2023/4, subject to continuation of ICB investment in infrastructure
- Procurement initiatives will deliver a £5m full year effect although the full value will not be realised until 2024/5
- Planning to support finance and legal workstreams to potentially release up to £1m in savings in 2024/25

Workforce

2023/4 delivery headlines:

- A detailed analytical review of workforce and benchmarking exercise has been completed with all C&M providers in conjunction with the ICB and the efficiency at scale programme
- AHP Faculty has been established with a robust system wide workplan
- Clear priorities and strategic workforce plan have been developed and aligned to support focus areas for the elective recovery and clinical pathway programmes
- A number of pilot sites have been identified to facilitate testing of a career pathway aimed at Band 6 ward nurses to support retainment and career progression
- After undertaking scoping exercises and in conjunction with system partners it has been agreed not to pursue projects at this time around developing a HCA collaborative bank or midwifery trainee nursing associate role

Anticipated 2023/4 delivery milestones will support delivery of objectives by:

- Ongoing funding will not be provided for the workforce programme in 2024/5
- A refocusing of the programme to identify commitments moving beyond 2023/4 has commenced

A discussion also took place on system learning and assurance from incidents.

Elective Recovery and Transformation Programme

ERF / Activity improvement

Our recovery of activity levels is measured against the same period in 19/20. We continue to deliver 2% higher improvement on our restoration levels than the England average, despite a disproportionate rate of industrial action impact. This contributes to our financial reward through the ERF scheme.

Waiting times reduction

We have sustained our zero 104-week wait position and are making excellent progress eliminating the 78 week waits, with only a small number remaining – mostly patient choice and clinically complex cases. We are now expecting around 6 capacity breaches by the end of the month. This is down from over 40 last month.

We have less than 60,000 65 week waits to clear before the end of March. Our average clearance rate has reduced slightly due to the summer effect, and industrial action, however we are still clearing more than needed to reach our 65-week target at the end of March. Significant risks exist around winter, continued industrial action and covid.

Theatres

Our theatre utilisation (capped) performance has dipped slightly due to some data issues and non-submission from some of our stronger performing organisations. This is being addressed with the trusts directly.

Outpatients

Our text validation system continues to focus on over 52 week waits, and a total of 12,719 patients have received a validation text. We have had a response rate of 72%. Patients are being asked to clarify whether they still need their appointment / treatment, and also if they would be willing to travel to another location for their care. So far 675 patients have responded to say they no longer

need their appointment and have been discharged. Of those who replied to the text 44% have stated they would be willing to travel for a mutual aid opportunity

We have a comparable focus on no patients wating longer than 65-weeks by the end of March.

Clinical Pathways

The Clinical Pathways work in ENT, Dermatology, Orthopaedics and Gynaecology continues to progress. Members of the Clinical Pathways team attended the Medical Directors and Strategy Directors workshop held on 15th September to provide an update to the work underway within these specialties.

ENT

We have received our GIRFT Gateway review outcome. These will be the focus, along with development of the network into a collaborative alliance, of the next network meeting which is taking place on 12th October in-person. Key actions include: the engagement of services across C&M, a demand and capacity exercise to better understand the demand from primary care & subsequent pressures on waiting lists, strengthening the mutual aid approach and referral management & optimisation.

Dermatology

Dermatology have been progressing their roadmap workstreams, this month concentrating on the technology enhanced pathways with a stock take review of teledermatology implementation, the review identified current progress which to date include 51% of GP practices going live with a further 25% due to go live by the end of the year. There are still pockets of C&M without teledermatology in place leading to inequity across the system and C&M currently have three different IT systems on which GP's can refer in using teledermatology. The recommendations from the review include for C&M to consider an independent evaluation of the IT platforms and decision regarding procurement of a system wide solution for 2024. The team are also completing an options appraisal paper to consider alternative service delivery models to ensure teledermatology is effectively implemented across the whole of C&M. This includes consideration of a hub based model, extending the role of GPwSI in PCN level hubs and options for centralised triage and advice and guidance. The Dermatology network has evolved to strengthen its work by becoming a collaborative alliance with agreed TOR and membership from across acute, intermediate, and primary care. They have also developed a primary and community care subgroup to take that workstream forward.

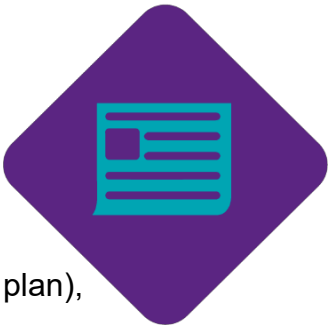
Gynaecology

Gynaecology review has been carried out and the corresponding intelligence pack completed, the review identified key areas for further exploration and improvement including commissioning and contracts, referral pathways, GIRFT implementation and workforce. We held a collaboration workshop 14th September with 53 people in attendance. Representatives from acute, primary care and Place attended alongside local authority sexual health commissioners. The day supported the gynaecology network leads to explore key areas for improvement including the implementation of women's health hubs, the women's health strategy, development of the future workforce and ideas around co-commissioning between health and local authority. Further support will be needed, and a further workshop planned to enable the network to turn these workstreams into an improvement roadmap and action plan.

Orthopaedics

Progress is being made to roll out the C2Ai Risk Stratification tool and process including prehabilitation using Surgery Hero across all orthopaedic providers in Cheshire and Merseyside. This is being managed and monitored through the C&M Orthopaedic Alliance (OA) along with the GIRFT improvement workstreams and cold site collaboration work previously highlighted in this briefing. The C&M OA have a trial membership of the National Orthopaedic Alliance (NOA) in progress and a decision will be made based on the benefits experienced whether to join the NOA as full members in the next two months. In November the C&M OA will hold a face to face meeting which aims to focus on risk stratification and winter planning for orthopaedics across C&M.

Diagnostics Programme



Key Performance Headlines

(July 23 DMO 1)

- 99,759 tests have been delivered in month.
- YTD over performance all tests combined (7%) in CT (5% higher than plan), Ultrasound (3% higher than plan) and MRI (3% higher than plan).
- 78% of patients have waited 6 weeks or less for a test. (This has decreased by 1% since June 2023)
- The ICS ranking is not yet available.
- 16,188 patients have waited 6 weeks or more (slight increase since June 2023).
- The total number of patients waiting for all tests is 77,046 (relatively static).

(13 September WLMDS)

- Only 15 52 weeks+ waiters remain. 4 Mid Cheshire, 3 WHH, 2 East Cheshire and 6 at LWH. Trusts are asked to ensure increased scrutiny prior to submitting so that C&M doesn't inaccurately report.
- Only 142 40 weeks+ waiters remain. All patients are waiting for an endoscopy, cystoscopy or urodynamics. 91 Mid Cheshire, 28 COCH, 11 WHH, 7 LWH.

Pathology - Digital and IT

- A collaborative, in principle, decision has been made for Cheshire and Merseyside to procure a **one pan-pathology Laboratory Information System (LIMS).** The convergent plan spans several years with sites joining the solution at appropriate points in line with their current contract has been agreed by Directors of Finance and CMAST governance. It has also been agreed that MWL will be the host organisation for this joint contract. The LIMS procurement strategy and business case are being developed.
- Target Operating Model (TOM) Connectivity and Interoperability proposals have been taken through governance.
- A working Group has been established to progress GP Order Comms, the revised implementation plan for Digital Pathology has been approved.

Workforce Strategy

Engagement activities (inc. site visits, focus groups and appreciative enquiry surveys) have been completed, with conversations taking place with over 200 members of staff from across the network. Thematic analysis of this qualitive data is ongoing, with further engagement with trust HR Business Partners ahead of wider circulation for comments and action.

Target Operating Model (TOM) Delivery Plan

The TOM Delivery Plan (which refers to the 3 hub pathology model) has been developed and has been shared for comments with Chief Execs. The Plan has been taken through CM Pathology Network Management Group and C&M Diagnostics Delivery board and will now be provided to individual trusts to be taken through each organisation's governance.

Histopathology Review

The data template has been agreed and shared with labs for completion, and engagement is ongoing with trust HRD's and IG teams to assist the collection of workforce data.

Procurement Workstream

The workstream has recommenced with an Interim Procurement Plan: 2023-2026

Endoscopy

- Twelve bids submitted to NHSE/I for £15m Transformation Funding.
- 1400 additional network colonoscopy slots commissioned across C&M to be delivered by December 2023.
- 4 additional Clinical Endoscopists appointed for C&M who will be in post from September 2023 (based at Whiston, Leighton, LUFT Royal and Aintree with an additional post to be appointed to in September 2023.

Radiology

Workforce Delivery Group

Liverpool University Hospitals presented their experience of implementing radiographer led discharge which resulted in an average 40-minute reduction in waiting times for patients with minor injuries. Plans are being worked up for this to be expanded across Cheshire and Merseyside.

Artificial Intelligence (AI) Diagnostic Fund

A bid has been worked up for the national AI Diagnostic Fund to support the integration of an AI Tool for the analysis of chest x-ray images, the total funding within the bid is £1.2 million. The bid is now being socialised with other groups including Medical Directors and Directors of Finance.

Interventional Radiology

A Cheshire and Mersey Interventional Radiology Summit is to take place on 6 October 2023. The summit will work through issues including aging equipment, staffing, clinical safety, and collaborative opportunities to ensure that our services are established in the most effective way to ensure that our patients (from all geographies) receive the best service. We anticipate that this listening event will be the start of many required to construct a system wide plan to ensure these services are resilient, safe, and delivered collaboratively.

Radiology Clinical Reference Group (RCRG)

Clinical Lead, Dr Sacha Niven and Deputy Dr James Hare are visiting imaging departments to discuss local issues and identify areas of work that might benefit from a standardised Cheshire and Merseyside approach.

Community Diagnostic Centres (CDCs)

- Sites continue to deliver activity in lines with plans.
- System has been accepted for pilots for CDC gynecology pathway and cardio-respiratory echo work.
- Sites have reprofiled activity in line with updated guidance and tests for H2 2023/24 and this is with the national team for approval.
- Congleton CDC has been formally announced, and the CDC Programme Board has reviewed the plan for delivery of initial activity and capital plans.
- Income for sites has been received, reconciled and successful transacted for H2 23/24

Finance, efficiency and value workstream

The overall C&M Financial position continues to deteriorate. At the end of August (month 5) the overall position is a £124m deficit against a plan of £74m, £50m worse than plan.

Month 5	Plan (£m)	Actual (£m)	Variance (£m)	FYE Plan (£m)	FYE Forecast (£m)	Variance (£m)
CMAST (deficit)	(105.8)	(123.5)	(17.7)	(126.7)	(126.7)	0.0
CMHCD surplus	3.4	2.3	(1.1)	6.6	6.6	0.0
Total Provider (deficit)	**(102.4)**	**(121.2)**	**(18.8)**	**(120.1)**	**(120.1)**	**0.0**
Total System (deficit)	**(73.7)**	**(123.7)**	**(50.0)**	**(51.2)**	**(51.2)**	**0.0**

Key Drivers of this are:

- Industrial action
- Undelivered CIP
- Prescribing Inflation
- Continuing health care activity and inflation
- Mental health packages of care

At this stage all providers are forecasting delivery of plan – this is high risk.

Providers are now reporting deficits against Month 5 plans, meetings are scheduled week commencing 2nd October to include CEO, CFOs, and ICB leadership.

CIP

Cost Improvement Plans are slow to progress with £132.7m (plan £137.3) delivered to date but only £84.2m recurrent.

CIP	Recurrent CIP			Non- Recurrent CIP			Total CIP		
Month 4	Plan (£m)	Actual (£m)	Var (£m)	Plan (£m)	Actual (£m)	Var (£m)	Plan (£m)	Actual (£m)	Var (£m)
CMAST	59.4	41.0	(18.4)	0.0	0.0	0.0	227.3	206.8	(20.5)
CMHCD	11.0	10.7	(0.3)	0.0	0.0	0.0	33.5	37.9	4.4
Total Provider	**70.4**	**51.6**	**(18.8)**	**0.0**	**0.0**	**0.0**	**260.8**	**244.7**	**(16.2)**

Expenditure Controls

Trusts have now confirmed commitment to the NHSE issued expenditure controls letter.

Financial Sustainability and Strategy

The ICB financial strategy will have the following aims:

- deliver a 3-year recovery plan and 5-year forecast
- enable delivery of the wider HCP objectives

- support value for money and productivity

The strategy is driven by the 4 work pillars of modeling and analysis; behaviors and accountability; efficiency and productivity and transformation. The work is driven through the C&M DoF forum, including all providers, and chaired by Claire Wilson. Engagement with partners will occur October to December 2023. The C&M Finance, Resources and Investment Committee will provide detailed review and scrutiny in advance of the November 2023 ICB meeting.

In parallel, the enabling workstreams will continue (see below) with Board review anticipated in January:

- allocations
- investment and benefits realisation
- funds flow
- capital prioritisation

Individual Provider Boards will need to schedule in time to review the draft strategy and the enabling workstreams.

Efficiency at Scale

Overarching Programme

Funding from the ICB Transformation Committee has been confirmed for the overarching E@S programme for 23/24 and 24/25. The work programme for 23/23 has been finalised and C&M is now being acknowledge as a system with a high potential E&S programme and robust governance structure.

The programme continues to engage with stakeholders and professional leadership forums across C&M, which included the Liverpool Joint Committee, C&M Digital SRO and Estates Directors of Estates in September.

Discussions continue with the national Corporate Services Transformation Programme team, and monthly meetings will now take place to support and develop work programmes. The national team have also confirmed they would like to use C&M as a pilot site to produce provider collaborative level corporate service data following the internal Liverpool system review completed by the C&M E@S team.

Finance/Legal

The development of a business case to a single financial ledger across Cheshire and Merseyside continues, and further meeting with the national team are planned in October.

The legal collaborative are engaging with specialist Trusts in terms of ‘Healthcare’ legal support focusing on coronial claims and court of protection. Initially includes LUHFT, LWH & LHCH. A delivery group has now been established and will feedback to E@S via a highlight report monthly. Discussions are on-going across the system and national team regarding the additional indemnity insurance review and potential next steps.

The programme has engaged with the C&M Company Secretary Group and a workshop will take place in November to look at further opportunities which will be supported by the national team.

Workforce

A workforce data review has been completed with all Trusts in C&M providing information. This data was reviewed at the HRD event on Wednesday 6th September. All Trusts are now completing a self-assessment to assist the prioritisation of workstreams for 23/24 and 24/25. The work plan will be finalised in mid-October with all HRDs.

Medicines Optimisation

Medicines Place level programmes continue with a workplan in place to support the £10m required cost avoidance for 23/24. A single medicines optimisation dashboard is being developed to track all benefits, including financial savings.

New projects to support the Efficiency at Scale programme are currently being considered including Outpatient Parental Antimicrobial Therapy (OPAT) and homecare optimisation and are part of the Transformation bids previously submitted to the system.

A business case has been developed for a Medicines Value Team to ensure use/management of High-Cost Drugs are optimised across the region, together with more consist use of supporting IT systems. Funding from the current budget has been identified to enable the first 'Medicines Value Pharmacist' at Liverpool University Hospitals FT with a focus on high-cost drugs, with an estimated full year savings of £0.5m.

Procurement

The new Chief Procurement Officer for the ICB has started in post and handover discussions are taking place. Additional funding has been identified via E@S and CMAST to support additional strategic support until the end of March 2023 to fast-track the development of the rolling workplan. Currently the scheme pipeline has been identified £4.1m (FYE) of savings/cost reductions.

Working groups focussing on specific priorities continue to meet for the following areas: CIPs/Efficiencies, Out of Hospital, Clinical Consumables, Sustainable Procurement, Governance, Data & Systems and NHS Supply Chain Operational Group.

Workforce

CMAST Workforce Programme

Jan Ross, CEO The Walton Centre, has officially transitioned into the role of programme SRO.

Development of Band 6 Ward & Department Nurse Roles

A draft Development Toolkit has been produced by the working group and will be presented at the next CMAST Workforce Programme Board. A workshop was planned for the end of September to review the draft and finalise this document but unfortunately stood down due to planned industrial action. The group plan to meet in October to finalise and sign-off the toolkit before launching the pilot in November.

Midwifery - Trainee Nurse Associate (TNA) Role

Following discussions with the regional midwifery team it was agreed that this project would be stood down due whilst a national approach on TNA roles in midwifery is considered.

Confirmation from the C&M People Board is awaited as to whether the allocated funding can be repurposed for other CMAST Workforce programmes.

Allied Health Professionals Faculty

A workplan for 2023-24 has been completed and mapped against the C&M ICP Interim Strategy, meanwhile a funding bid has been submitted to the C&M People Board for an extension of the AHP Faculty Team until the end of March 2024.

Elective Recovery Workforce

A piece of work has been mobilised to support strategic workforce planning across theatres, surgical hubs, and priority clinical pathway specialties. The work will consider future workforce model development and alternative / new role design.

Workforce Efficiency at Scale

A workforce data review has been completed and was presented to the July project board. The key information was also shared with the Chief People Officers at their September meeting. Further work is required with the HRD network to determine which key areas should be prioritised and progressed by the workforce efficiency at scale group.

Quality Focus

There are various pieces of work in place that have a focus on quality for our patients across Cheshire and Merseyside. Highlights from this month include:

- **Patient Care and Experience -** Continued engagement with each of the CMAST Programme Boards for Patient Care and Experience. Programme level task and finish groups have been set up for Diagnostics and ERTP regarding the creation of infographics. Discussions taking place to agree quantitative and qualitative data to be captured within the infographics.
- **Section 136 multi-agency Task and Finish Group** – a second round table was held with provider organisations to agree actions required prior to the cease of the current Prometheus contract (ICB) on October 31st.
- **Patient Engagement Portals** – scoping work to support C&M outpatient team with the patient experience and feedback element of Patient Engagement Portals (PEPs) as part of the National outpatient transformation work.

Urgent and Emergency Care – System Control Centre

The urgent and emergency care (UEC) system continues to experience significant pressure across the whole of NHS Cheshire & Merseyside, with the majority of trusts across C&M consistently reporting at OPEL 3 during 2023 to date. The system has been escalated overall at OPEL 3, which is defined as ‘the local health and social care system is experiencing major pressures compromising patient flow’.

C&M has shown improvement for patients admitted, transferred, or discharged within 4 hours, with August performance at 73.4% against a 2023/24 year-end national recovery target of 76%. Current performance is better than anticipated at the time of setting 2023/24 plans and better than the performance for the North West (72.0%) and England at 73.0%.

The percentage of beds occupied by patients with a length of stay over 14 days was 33.1% at the end of August 2023, whilst length of stay over 21 days continues to account for around a quarter of occupied beds against the 2023/24 Operational Plan of 17%.

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	***23/24/183a***		**Date: 09/11/2023**	
Report Title	**NHSE Maternity Diagnostic Review**			
Prepared by	Vicky Clarke, Divisional Manager			
Presented by	Dianne Brown, Chief Nurse			
Key Issues / Messages	The Family Health Division provides an update on progress made in the development of its local action plan following the NHSE Diagnostic MSSP supportive visit that took place 24th to 27th July 23 and output report received into the Division in September 23. 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 receives the information in this paper.			
Supporting Executive:	***Dianne Brown, Chief Nurse***			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

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

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

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

REPORT DEVELOPMENT:

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

EXECUTIVE SUMMARY

Liverpool Women's NHS Foundation Trust underwent a focused Safe and Well-Led CQC Inspection in January 2023 receiving an overall rating of Requires Improvement.

In Maternity Services the Safety domain rating reduced from Good to Inadequate and the Well Led domain reduced from Good to Requires Improvement.

A request was made to the National NHS England Maternity Safety Support Programme, supported by the regional team and ICB to perform a proactive review of maternity services to provide opportunities for improvement and to ensure high quality and safe delivery of care.

1.0 Introduction

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Methodology

During the visit that took place 24th-27th July, the national inspection team met with key members of The Family Health Division Leadership team. The team consisted of 8 specialist Advisors focusing on core domains of leadership, workforce, governance and communication, improvement methods, location of services and access as a standalone unit (WE SEE)

- ✓ Focus Groups across all areas of Maternity and Neonatal Services
- ✓ Interviews with all members of Leadership Team
- ✓ Observation in Clinical areas
- ✓ Attendance at Safety Huddles
- ✓ Review of Documentation - including Policies and Procedures, Board Papers and Mins, Safety Champion Meetings, Rosters, Mandatory Training Compliance, Job Descriptions, CNST evidence submissions

Areas of Good practice

Preliminary feedback was provided on 27th July by the inspection team when the visit was concluded. The following immediate areas of good practice and areas of concern were highlighted.

- ✓ NHSE Team witnessed and observed examples of the staff working as functional clinical teams, with a good MDT culture.
- ✓ Good oversight, knowledge, and engagement in the service by the Executive team
- ✓ Service User engagement- Visible Maternity and Neonatal Voices Partnership committed to co-production and design of services
- ✓ Development of Research, AMP role and Preceptorship Programme
- ✓ A Matron team that was highly visible and well respected

Immediate Concerns Escalated

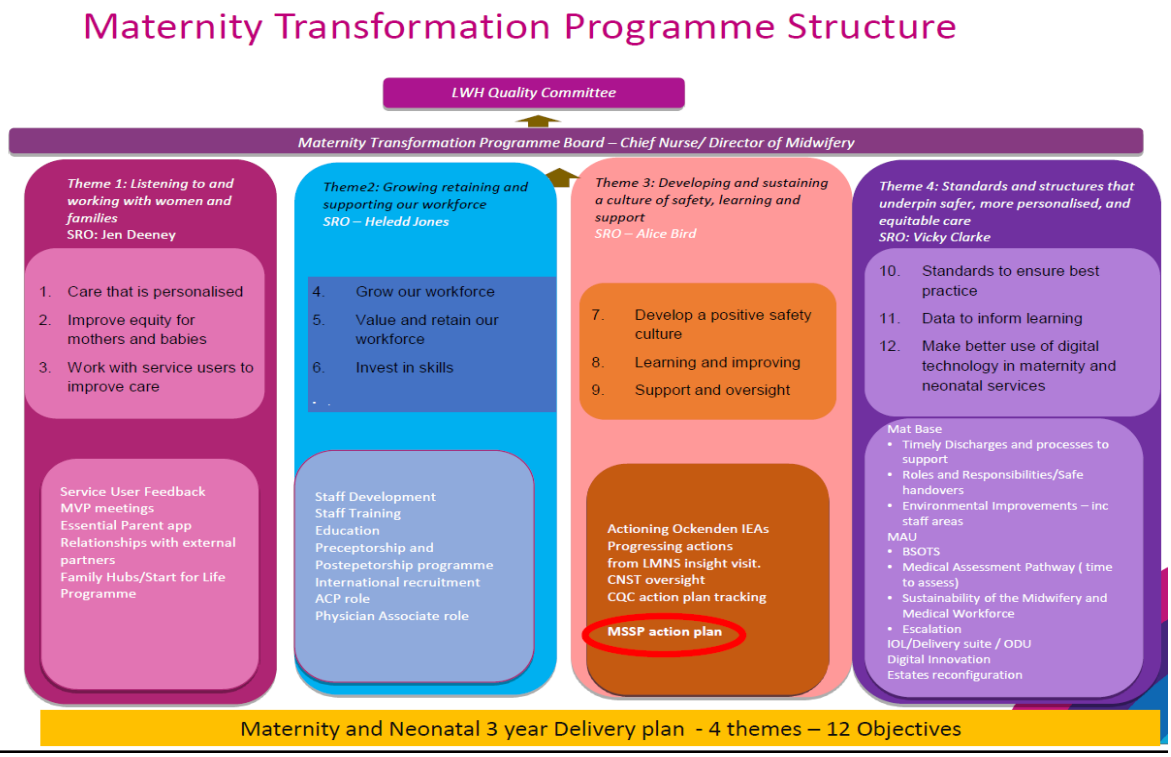
3 areas of concern were noted with immediate actions undertaken:

- Delay in Outcome of appts in ANC following Digicare implementation.
- Security access on Maternity Base
- CTG and Instrumental Births taking place in MLU.

Oversight & Ongoing monitoring and Management

The Family Health Division has devised a local improvement action plan, which is managed by Maternity and Neonatal Transformation Workstream 3, reporting to Maternity and Neonatal Transformation Board, which is a subordinate of Trust quality Committee where Trust Board assurance is provided.

This has been included within the existing Maternity and Neonatal Transformation Workstream 3 – see diagram below:



Next steps

- Delivery against MSSP action plan and ongoing monitoring via Maternity and Neonatal Transformation workstream 3
- CQC action plan and recommendations
- Delivery of Induction of labour programme of works
- Delivery against Maternity and Neonatal 3 year plan objectives
- Ongoing monitoring and oversight via the Maternity Transformation board
- Regular progress updates and Trust Board oversight at Quality Committee

- Provide quarterly progress updates to Cheshire & Mersey LMNS

Conclusion

The team of Maternity Specialist Advisors noted that overall, the Trust had a good oversight of the areas of concern and understanding of the population needs and demographic makeup of service users. They praised all staff for being welcoming open and transparent about their challenges and achievements.

The Family Health Division seeks to provide assurance of the ongoing management of the MSSP action plan within Division.

Recommendation

The Trust Board is asked to receive the update.

NHSE Diagnostic Visit

November 2023

Presented by: Yana Richens Director of Midwifery
Vicky Clarke Divisional Manager FHD
Heledd Jones Head of Midwifery
Richard Haines Clinical Lead

MSSP Diagnostic Review

Background

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Methodology

On Site visit to meet with key members of team 24th-27th July by a team of 8 specialist Advisors focusing on core domains of leadership, workforce, governance and communication, improvement methods, location of services and access as a standalone unit (WE SEE)

- ✓Focus Groups across all areas of Maternity and Neonatal Services
- ✓Interviews with all members of Leadership Team
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- Development of Research, AMP role and Preceptorship Programme
- A Matron team that were highly visible and well respected

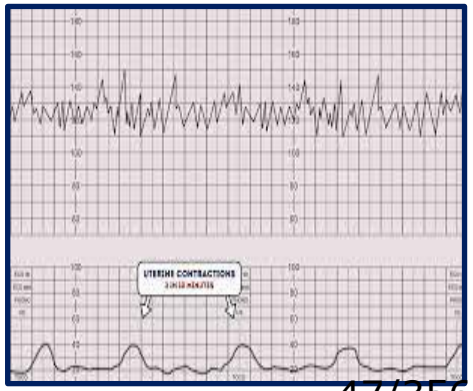
Oversight & Ongoing monitoring and Management

- Maternity and Neonatal Transformation Workstream 3

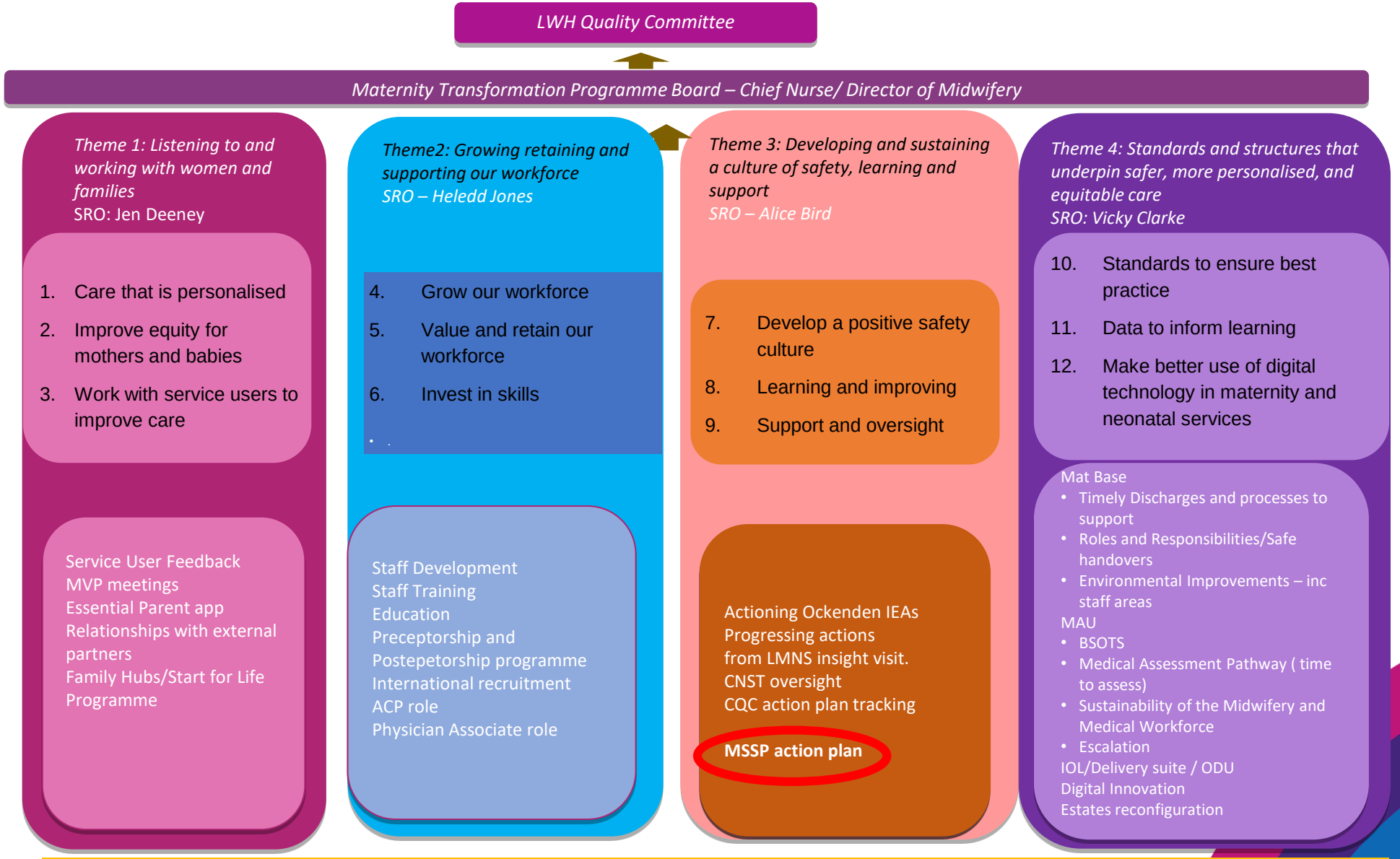
Immediate Concerns and action – *"You said we did"*

Immediate Concerns

- Delay in Outcome of appts in ANC following Digicare implementation
- Security access on Mat Base
- CTG and Instrumental Births taking place in MLU



Maternity Transformation Programme Structure



Action Plan – *"You said we did"*

Workforce

Recommendation	Action taken	Timescales	Measurement of success
Recommended a review of Midwifery Leadership structure and responsibilities	Review has been concluded Roles and Responsibilities defined Recommendation paper prepared	Immediate	Patient and Staff experience Quality & Safety
Enhance Communication Strategy with Maternity Staff	Weekly Ward Managers Meeting commenced together with the Senior Leadership meetings to disseminate key information from Leadership meeting. Schedules of Department Meetings circulated by Ward Managers to all staff. Implementation of Maternity Education Newsletter Midwifery Forum – monthly led by DoM and HoM	Immediate	Patient and Staff experience Quality & Safety Staff Survey FFT
Revise Meeting Structure	Monthly Maternity Professional Forum implemented for Band 7 and above. All Senior Midwives and ACPs invited and encouraged to attend Maternity Risk and Clinical meetings	Immediate	Patient and Staff experience Quality & Safety
Stability in Manager and Team Leader roles	Appointed MAU and Community Managers to substantive roles Introduced Supernumerary shift leader role in all areas to have helicopter view of units	Immediate	Patient and Staff experience Quality & Safety
No Substantive PMA Lead Role	Staff Supporters PMAs established and play a key role in that day-to-day support of staff Recruitment underway for lead PMA	Ongoing	Patient and Staff experience Quality & Safety
Need for further recruitment in Obstetrics to meet aspiration of 24/7 Consultant On Call Cover	Recruited 2 additional obstetric consultants Executive support to move to 24/7 consultant cover model by April 24	Ongoing	Quality & Safety

Action Plan – "You said we did"

Recommendation	Action taken	Timescales	Measurement of success
Safety Huddles did not always have required MDT presence	Relaunched and refocused to maximise attendance and regularly monitored and reviewed	Ongoing	Patient and Staff experience Quality & Safety
Increase collaboration with Maternity and Neonatal Governance	Lead Governance Manager for Family Health Division now established in post and appointed to Governance Lead 8a for Neonatal Family Health senior Leaders from Maternity and Neonatal collocated Weekly senior leadership meetings take place to improve communication	Immediate	Team culture Patient and Staff experience Quality & Safety
Maternity Incentive Scheme (CNST Year 4) declared as compliant	MIS year 4 achieved and the trust were commended for the quality of data and their governance and assurance processes and strong safety culture	Immediate	Quality & Safety Financial sustainability
Single Site working	Future Generations C&M Collaborative working Investments in optimising on site safety built into Financial plan	Ongoing	Quality & Safety
Admin of Outcomes in ANC	Real time reporting Increased admin provision ANC outcomes managed by Family Health Division ANC separate reporting desk erected to capture patients real time	Immediate	Patient and Staff experience Quality & Safety
Safety Huddles did not always have required MDT presence	Clinical Safety Huddles for Maternity NICU and Theatres introduced twice daily with ongoing audit	Immediate	Quality & Safety
MLU Instrumental Births	Instrumental births ceases with immediate effect and MLU escalation room now in place on Delivery Suite	Immediate	Quality & Safety
Security of exits on Maternity Base	Increased security system in Maternity base with immediate effect and plan in place	Ongoing	Patient and Staff

Action Plan – *"You said we did"*

Effective

Recommendation	Action taken	Timescales	Measurement of success
FMU had state of the art facilities with an engaged team providing outreach activities virtually to support clinicians in local hospitals and close relationships with Neonatal and Alder Hey	Continue to develop strong working relationships with Alder Hey and Neonatal Service development bi weekly meetings in place Lead Midwife appointed for Fetal Medicine and a triumvirate structure put in place for Fetal Medicine unit Clinical Lead for FMU appointed Liverpool Neonatal Partnership	Immediate	Positive team culture Quality & safety Patient and staff experience Financial sustainability
Mature Neonatal Partnership Development with Alder Hey to improve care of babies requiring surgical intervention with rotational and collaborative MDT staffing model	New building development has commenced and will be completed 2025 ANNP and Medical workforce model agreed with Commissioner Strong governance and assurance arrangements in place	Ongoing	Quality & safety Patient and staff experience
Maternal Medicine Hub	Midwife and Obstetric Physician now in post within team Strong link with Maternal Medicine network SLA arrangement in place with partnering organisations	Ongoing	Quality & safety Patient and staff experience
Audit and Guidelines	Policies and Guidelines group have been established reporting to Mat Risk and Clinical to Review of process to ensure guidelines are updated timely and appropriately and consideration of a guidelines group	Immediate	Quality & safety Patient and staff experience
QI- Service Improvement groups in place	Programme Manager recruitment underway to deliver Maternity and Neonatal 3 year plan and other service development projects	Ongoing	Quality & safety Patient and staff

Action Plan – “You said we did”

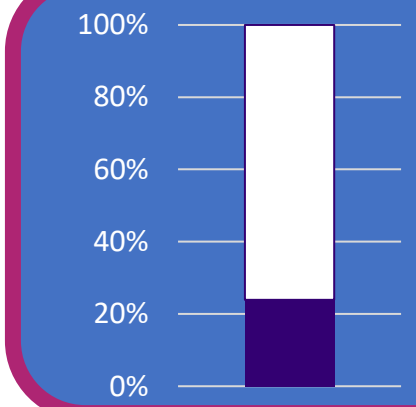
Patient Experience

Recommendation	Action taken	Timescales	Measurement of success
Complaint numbers relatively low- however themes relate to delay in discharge's, medication and IOL	All themes sighted in service improvement groups with service user involvement and steady progress to improvements	Ongoing	Quality & safety Patient and staff experience Financial sustainability (CNST) FFT Patient survey MNVP improved feedback
Staff have pride in working for the Trust	Regular staff communications “Wellbeing Wednesday” and “feel good Friday” relaunched Invested in wellbeing coaches/PMA and psychologist posts Staff newsletter and briefing sessions Strong preceptorship pastoral programme	Immediate	Quality & safety Patient and staff experience FFT Patient survey MNVP improved feedback
Students describe a positive experience- feeling happy and supported and spoke highly of MDT working and exposure to a range of clinical experiences	Regular staff communications “Wellbeing Wednesday” and “feel good Friday” relaunched Invested in wellbeing coaches/PMA and psychologist posts Staff newsletter and briefing sessions Strong preceptorship pastoral programme	Immediate	Quality & safety Patient and staff experience FFT Patient survey MNVP improved feedback
MNVP engaged and visible with examples of co-production with service leaders	Further invested in MNVP team and appointed Vice Chair for MNVP commenced in October	Immediate	FFT Patient survey MNVP improved feedback

Financial sustainability

£1.989m
saved so far

471 ideas
generated



1,036
PO requests reviewed by the Grip & Control panel

375 ideas
being explored

£7m worth of
potential savings
identified

2 Schemes
signed off at
QIAC

30 Schemes
on the
unpalatable
list

Family Health Measurements of Successes

	We've already done	The next… …2 months	The next… …6 months	…Year
Expedited Discharge	Increase the number of discharges before 14.00pm	10%	25%	50%
Improve Patient Flow	Reduce LOS	5%	15%	20%
Patient Feedback	Improve FFT and Picker survey results	20%	30%	50%
Reduce the number of incidents relating to staffing shortages	Revised staffing model has been signed off and staff engaged	New roster in place	50% reduction (currently 20 per month)	Zero
Improve staff satisfaction	Improve staff satisfaction survey	5%	20%	40%

Family Health Measurements of success

	We've already done	The next… …2 months	The next… …6 months	…Year
Time to Triage	Achieved 15 minutes	85% 100%	Consistently achieve 15 minutes	Fully embedded and seek to identify further improvement
Time to treatment – achieve BSOTs targets (medical review)	Developing suite of real time reporting metrics	Red – Immediate (100%) Orange - 15 -30 minutes Yellow – 1hour (75% of patients) Green – 4 hour (75% of patients)	Consistently achieve BSOTS target for medical reviews	Fully embedded and seek to identify further improvement
Telephone triage	Dedicated telephone triage in place 24/7	Triage fully covered Reduce number of calls abandoned after 10 minutes by 50%	Review of telephone triage data to determine overnight demand	Telephone Capacity meets demand
Reduce the number of incidents relating to staffing shortages	Revised staffing model has been signed off and staff engaged	New roster in place	50% reduction (currently 15 per month)	Zero
Improve patient satisfaction	Baseline survey conducted – 42 out of 51 responses are positive for waiting times	Repeat survey – target 90% satisfaction	Repeat survey – target 95% satisfaction	Repeat survey – target 100% satisfaction

Focus on midwifery workforce

√ Midwifery vacancies November 2023 (Month 8 FY23/24): zero vacancy

√ Nil vacancies Maternity Support Workers.

√ Sickness rate 6.53% which is above the target rate.

√ Turnover rate: 6.38% which is lower than the target rate.

√ Maternity leave: 12.59wte (14 heads).

√ Appointment to Diabetes Specialist Midwife role, Induction of Labour Midwifery Co-ordinator, Clinical Lead, Midwife Midwifery Led Unit, Maternal Medicine and additional Fetal Surveillance midwife post.

√ Recruited to Tobacco Dependency Advisors, and appointed Smoking Cessation Lead Midwife to support training .

√ ACP's successfully completed course and embedded in their roles in the MAU.

√ Allocation of midwife to administer medication on each shift on Mat Base (Maternity Ward).

√ Smoking cessation Midwife recruitment underway

√ Extended fixed term appointments in preceptorship team to accelerate the development of 'posteptorship' programme

√Supernumerary shift leader role available in all Maternity areas

Family Health Successes to date

√ Successful ongoing recruitment programme resulting zero vacancies by November 2023

√ 40% improvement in PDR and training compliance since May 23

√ Achievement of CNST requirement 2022

√ Achievement and sustainability of MAU triage standard of >85% 15minutes by September 23

√ Maternity Base estates work concluded which seen the introduction of staff changing facilities, MDT room and staff breakout area

√ MLU/IOL Estate work to commence 18/9/23

√ Honeysuckle room refurbishment

√ 24/7 partners staying on Maternity Base

√ Reintroduction of ANC reception desk at Crown street, to improve patient experience and ensure patients leave LWH with next appointment

√ Regular staff listening Sessions established in Neonatal and have now been replicated and embedded across Maternity

√ Refresh of Maternity and Neonatal Transformation Workstreams in line with 3-year plan

√ Staff Supporters PMAs established and play a key role in that day-to-day support of staff

√ Establishment of specialist roles such as Retention Midwife, Diabetes Specialist Midwife, maternal Medicine Midwife

√ Successful recruitment of 25wte Nurses to Neonatal Partnership

√ A number of successful research studies underway in Neonatal services

√ Liverpool Neonatal Partnership recruitment models agreed with commissioners for Nursing and Medical

√ **NHSE diagnostic visit output report and action plan**

Key area of focus – Induction of Labour

Maternity Transformation Workstream IOL

Date	SRO	Programme Lead	Stage of Development	Overall Status	Confidence rating in delivery of benefits
09/10/23	Dianne Brown	Vicky Clarke	Implementation		

The primary objectives of this workstream are:

- Improved estates/environment
- Improved patient experience
- Improve staff experience
- Future proof services
- Link to regional and national maternity safety objectives

Project KPI's:

- FFT and PEx
- LoS by mode of delivery
- Discharges within 24 hours & Discharges / sections at weekends
- Patients that return through MAU – breakdown of infant feeding and transitional care babies NIPE's

Key updates this month

- Commenced phase 1 of the planned estates work to create additional IOL beds on the MLU footprint.
- Released 3 intrapartum beds on delivery suite by reallocating the elective section lounge from mat base to room 15 on delivery suite.
- The elective section lounge is now being used to accommodate up to 3 IOL patients
- IOL Coordinator commenced in post
- Site visit to Birmingham Women's Hospital to review IOL pathways
- MNVP input into planned comms for new induction of labour pathway

Key actions next month

- Continue phase 1 of the planned estates work to create additional IOL beds on the MLU footprint
- IOL Coordinator to commence in post 9th October
- Complete data review of IOL delays
- Register QI project
- IOL guidelines revised
- Red Flags reporting metrics to be revised in line with Cheshire and Mersey reporting

Risks & Issues

- **Known delays in IOL monitored through maternity red flags & on risk register 2736**

- **Maternity bleep holder oversight of delayed IOL**
- **Daily MDT by Consultant for delivery suite, shift leader and maternity bleep holder.**

Next Steps

- Delivery against MSSP action plan and ongoing monitoring via Maternity and Neonatal Transformation workstream 3
- CQC action plan and recommendations
- Delivery of Induction of labour programme of works
- Delivery against Maternity and Neonatal 3 year plan objectives
- Ongoing monitoring and oversight via the Maternity Transformation board
- Regular progress updates and Trust Board oversight at Quality Committee
- Provide quarterly progress updates to Cheshire & Mersey LMNS

NHS
Liverpool Women's
NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	23/24/183b	Date: 9 November 2023
Report Title	Maternity Incentive Scheme (CNST) Year 5 – Scheme Update	
Prepared by	*Angela Winstanley – Maternity Quality & Safety Matron* *Vicky Clarke – Divisional Manager* *Heledd Jones – Head of Midwifery*	
Presented by	*Dianne Brown – Chief Nurse*	
Key Issues / Messages	This report outlines the scheme requirements for compliance required to achieve all ten safety actions and their associated standards for the Maternity Incentive Scheme Year 5 and the Trust's current RAG status. This paper will outline any identified key risks to the Trusts' ability to declare compliance against the current scheme and detailed discussion of identified risks should be minuted as noted below: Detailed Trust Board Minutes must be made available, with evidence to the following safety action detail: SA1 – Acknowledgment of effect of IA on ability to commence two PMRT cases. Note that FHD will submit action plan and review of PMRT process in December 2023, in response to NHSr letter dated 24.10.2023. SA 2 - Acknowledgement and discussion that 11 of 11 CQIM metrics on the provisional MSDS CNST Scorecard have passed data quality criteria. SA 6 – The Minutes to note that the Trust Board are to receive the information in relation to current Trust position in relation to Saving Babies Lives Care Bundle V5 and the Implementation Tool. SA 9 – Trust Board Minutes to note that the Board Levels Safety Champions are meeting with the Perinatal Quad leadership team, quarterly and that any support of the Trust Board has been identified and implemented.	

Action required	Approve ☐	Receive ☒	Note ☐	Take Assurance ☐
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	For Decisions - in line with Risk Appetite Statement – Y			
	The Trust Board is asked to note the current position in relation to the Maternity Incentive Scheme (CNST) Year 5 and our current compliance position, along with the associated papers found within the appendix. ***The Trust Board is asked to be assured by the oversight, detail and governance updates within the paper that that the Division are prepared in their response to the maternity incentive scheme.*** ***The Trust Board is asked to assurance that out current position, with regards to all the safety elements and actions can be supported by evidence, which will be scrutinised prior to final board submission.***			
Supporting Executive:	*Dianne Brown Chief Nurse*			

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

Strategy ☐	Policy ☐	Service Change ☐	Not Applicable ☐

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

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

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Family Health Maternity Transformation Board	Monthly	HOM	Monthly progress updates from scheme safety action leads.
Family Health Divisional Board	Monthly	Clinical Director for Family Health and Divisional Manager	Monthly updates to be provided to the FHDB and where required, issues for noncompliance to be escalated and resolved.
Quality Committee	Monthly	Chief Nurse	

EXECUTIVE SUMMARY

This report outlines the scheme requirements for compliance required to achieve all ten safety actions and their associated standards for the Maternity Incentive Scheme Year 5 and the Trust's current status against this.

This paper provides an update to the Board of Directors in relation to the requirements of the Maternity Incentive Scheme Year 5. This report will set out the findings from completed GAP analysis of the scheme requirements against the Trust current position.

MAIN REPORT

Introduction.

NHS Resolution (NHSr) is operating year five of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care. The maternity incentive scheme applies to all acute Trusts that deliver maternity services and are members of the CNST.

As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund. As in all previous years, the scheme incentivises the completion and embedding of ten maternity and neonatal safety actions.

Trusts that can demonstrate they have achieved all ten safety actions and will recover the element of their contribution relating to the CNST maternity incentive fund and will receive a share of any unallocated funds.

Trusts that do not meet the ten-out-of-ten threshold will not recover their contribution to the CNST maternity incentive fund but may be eligible for a small discretionary payment from the scheme to help them to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the incentive fund

Conditions of the scheme.

The Trust Board of Directors must also be aware of the conditions of the scheme, some have been added and are detailed in the July V2.0 2023 release. These are as follows:

- Trusts must achieve all ten maternity safety actions

- There is a scheme end declaration process, which will be overseen by the Chief Nurse and Trust Secretary.

- Trust submissions will be subject to a range of external validation points, these include cross checking with: ---
    - MBRRACE-UK data (safety action 1 standard a, b and c),
    - NHS England & Improvement regarding submission to the Maternity Services Data Set (safety action 2, standard 2 to 7 inclusive),
    - National Neonatal Research Database (NNRD)
    - HSIB for the number of qualifying incidents reportable (safety action 10, standard a).
    - Trust submissions will also be sense checked with the CQC, and for any CQC visits undertaken within the time period, the CQC will cross-reference to the maternity incentive scheme via the key lines of enquiry.

• The Regional Chief Midwives will provide support and oversight to Trusts when receiving Trusts' update at Local Maternity System (LMNS) and regional meetings, focusing on themes highlighted when Trusts have incorrectly declared MIS compliance in previous years of MIS.

- Trusts will need to report compliance with MIS between **25th January 2024 and 1 February 2024** at 12 noon and associated approval and governance oversight will led by the Trust Secretary.

Current Position for Year 5 – October/November 2023

RAG Rating Guidance	Description
	All workstreams / Safety actions on target. Evidence collated to demonstrate compliance.
	Workstreams ongoing, forecasted compliance expected with some evidence collated.
	Risk of Non-Compliance /Safety Action requiring escalation / No evidence to support compliance.

Safety Action Point & Description	Issue / Update for consideration	Status RAG
SA.1 Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard? Leads: Ae Wei Tang – Consultant Obstetrician Rebecca Kettle – Consultant Neonatologist	All eligible births and deaths, from 30.05.2023 to 07.12.2023 must meet the following conditions: A. **100%** all deaths have been reported to MBRRACE within the seven working day timeframe with 100% of deaths having surveillance completed within one month to date from 30.05.2023 - Reporting to MBRRACE has continued as per usual process with no lapses in reporting. –100% Compliance. B. **95%** of all the deaths of babies in your Trust eligible for PMRT review, parents should have their perspectives of care and any questions they have sought from 30.05.2023 onwards. - Parental perspectives of care and questions have continued to be collated by the Honeysuckle Team and incorporated into the PMRT reports. All parents have been informed that a review of their care is being performed. 100% Compliance C. For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 30 May 2023. a) **95%** of reviews should be started within two months of the death - 22 Cases reported to MBRACCE – 91.2% Compliance presently. **Identified risk:** Two cases of neonatal death have missed the deadline for commencement of the review. These babies died in August and the time period spanned three separate periods of industrial action, diverting consultant time towards maintaining a safe clinical service, thereby impacting the timescales for the PMRT review process. One of these cases presently remains assigned to an external trust, whilst the second case now is now under review and started. A letter from NHSr dated 24.10.2023, notes "Where MDT PMRT review panel meetings (as detailed in standard C) have needed to be rescheduled due to the direct impact of industrial action, and this has an impact on the MIS reporting compliance time scales, this will be accepted provided there is an action plan approved by Trust Boards to reschedule these meetings to take place within a maximum 12-week period from the end of the MIS compliance period". A divisional review of the PMRT process and associated action plan is in development and will be shared at FHDB and Trust Executives to identify any areas for learning and any further resources required with submission to Trust Board in December 2023. b) **60%** of multi-disciplinary reviews should be completed to the draft report stage within four months of the death and published within six months. - Draft format within four months – NA at present - Fully published within six months – NA at present D. Quarterly reports submitted to Trust Executive Board from 30th May 2023. 100% Compliant **Q4 22/23 –** Learning from Deaths Report - Submitted to QC - 30.05.2023. **Q1 23/24** – Learning from Deaths Report – Submitted to QC 26.09.2023 & TB 12.10.23	**Oct/Nov 2023 –** There is currently an identified concern with compliance for this safety action.

SA.2 Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard? Leads: Head and Deputy of Information Richard Strover & Hayley McCabe	1. Trust Boards to assure themselves that at least 10 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023. Final data for July 2023 will be published during October 2023. ***October 2023 –*** The Trust are in receipt of provisional data submitted based on July data. This data indicates full compliance with 11 of the 11 metrics. issue since the introduction of Digicare/Meditech expanse and will be COMPLIANT ***SEE Appendix for data Spreadsheet from NHS England/NHS Digital*** 2. MSDS data for July 2023 data contained valid ethnic category (Mother) for at least 90% of women booked in the month. Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001) ***October 2023*** – Submitted July data to MSDS demonstrates a 96.2% compliance with this indicator. Anticipated to be COMPLAINT 3. Trust Boards to confirm to NHS Resolution that they have passed the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023 for the following metrics: A) Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks and also have the CoC pathway indicator completed. *B)* Over 5% of women recorded as being placed on a CoC pathway where both Care Professional ID and Team ID have also been provided. Note: *If maternity services have suspended all MCoC pathways, this criteria is not applicable* If the data quality for criteria 3 are not met, Trusts can still pass safety action 2 by evidencing sustained engagement with NHS England which at a minimum, includes monthly use of the Data Quality Submission Summary Tool supplied by NHS England (see technical guidance for further information). C) Trusts to make an MSDS submission before the Provisional Processing Deadline for July 2023 data by the end of August 2023. COMPLETED D) Trusts to have at least two people registered to submit MSDS data to SDCS Cloud who must still be working in the Trust. COMPLIANT	**Oct/Nov 2023 position** – There are currently no identified concerns with compliance for this safety action. Remain on target for full compliance.
SA.3 Can you demonstrate that you have transitional care services to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme? Leads:	A) Pathways of care into transitional care (TC) have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care. **October 2023 Update**– Transitional Care pathways are very well embedded at LWH. A designated, five bed ward, located within the Maternity Base provides Transitional Care. A supporting Transitional Care on the Postnatal Ward SOP is available. – **Compliance** – 100% B) A robust process is in place which demonstrates a joint maternity and neonatal approach to auditing all admissions to the NNU of babies equal to or greater than 37 weeks. The focus of the review is to identify whether separation could have been avoided. An action plan to address findings is shared with the quadrumvirate (clinical directors for neonatology and obstetrics, Director or Head of Midwifery (DoM/HoM) and operational lead) as well as the Trust Board, LMNS and ICB.	**Oct/Nov 2023** - There are currently no identified concerns with compliance for this safety action. Remain on target for full compliance

Anna Paweletz– Consultant Neonatologist Sarah Brownrigg – ANNP Paula Nelson – ANNP	**October 2023 Update** – A multidisciplinary review of all term admissions is conducted weekly and has been well embedded in the Division for several years (preceding the Maternity Incentive schemes). Quarterly reporting to the FHDB has continued and the 2022-2023 ATAIN audit report and action plan, based on the findings of the reviews can be found in the Appendix 4 to this paper. This has been sighted at Family Health Division and will be shared with the LMNS and ICB after Trust Board approval. Quarterly reports on progress with ATAIN audit will be shared with Trust Board within this MIS scheme update. The Transitional Care and ATAIN Audit Report and action plan has been shared with the LMNS on 31.08.2023 via the Year 5 MIS scheme return. **Compliance** – 100% C) Drawing on the insights from the data recording undertaken in the Year 4 scheme, which included babies between 34+0 and 36+6, Trusts should have or be working towards implementing a transitional care pathway in alignment with the BAPM Transitional Care Framework for Practice for both late preterm and term babies. There should be a clear, agreed timescale for implementing this pathway. **October 2023 Update** As per Transitional Care Admission Criteria: Babies eligible for TC from Neonatal unit and DS include: - Babies from 33 weeks gestation who have been stable for 72 hours and only require an apnoea mattress for monitoring to be removed at 34 weeks gestation - Babies from 33 weeks gestation who are in air and stable for a period of 24 hours following any form of oxygen therapy. - Palliative care when parent/carer doing most of the care - Birth weight below 1.8Kg OR 34-35/40 and well. - Late preterm and term baby admissions are reviewed/audited in the ATAIN audit **Compliance** 100%	
SA.4 Can demonstrate an effective system of clinical workforce planning to the required standard? Leads: Richard Haines Clinical Lead Obstetrics Jill Harrison Clinical Lead Neonatology Jen Deeney Neonatal Nursing Rakesh Parikh Anaesthetic Workforce	**Obstetric Medical Workforce** 1. NHS Trusts/organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas: - i. currently work in their unit on the tier 2 or 3 rota or - ii. have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP) or - iii. hold an Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums **October 2023 Update** – The Temporary Staffing Policy (available on Intranet) addresses the requirements of this safety action. Audit to be completed after 6 months of activity with action plan to address any lapses. Audit findings and action plan to PPF if required, QC and Trust Board in December 2023. 2. Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings. **October 2023 Update** – Audit is planned to be completed, using the monitoring and effectiveness tool, after 6 months of activity with action plan to address any lapses. Audit findings and action plan to FFP if required, QC and Trust Board in December 2023. 3. Trusts/organisations should implement RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day. Services should provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings.	**Oct/Nov 2023** - There are currently no identified concerns with compliance for this safety action. Remain on target for full compliance

	October 2023 Update – Audit is planned to be completed after 6 months of activity with action plan to address any lapses. Audit findings and action plan to FFP and Trust Board in December 2023 and detailed minutes should be made available. Consideration of development of SOP or amendment to current obstetric staffing policies to highlight requirements of safety action. 4. Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations 27 listed in the RCOG workforce document: *'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology'* into their service when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance. **Evidence Required**: Trust positions with the requirements should be shared with the Trust Board, the Board-level safety champions as well as the LMNS. COMPLETED **October 2023 Update** – Audits of compliance of consultant attendance continue within the Division. Audit findings of attendance between January 2023 to July 2023 and associated action plan has previously been sighted at QC and Trust Board in September 2023. **Anaesthetic Medical Workforce** 1. A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should always have clear lines of communication to the supervising anaesthetic consultant. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1) **October 2023 Update** – An anaesthetic workforce paper will be prepared by Clinical Director for Anaesthetics and presented in November 2023 scheme update paper and detailed minutes should be made available. Rotas can be used as compliance with this standard. **Neonatal Medical Workforce** 1. The neonatal unit meets the relevant British Association of Perinatal Medicine (BAPM) national standards of medical staffing. If the requirements have not been met in year 3 and or 4 or 5 of MIS, Trust Board should evidence progress against the action plan developed previously and include new relevant actions to address deficiencies. If the requirements had been met previously but are not met in year 5, Trust Board should develop an action plan in year 5 of MIS to address deficiencies. Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN) **October 2023 Update**: The Neonatal Unit at LWH complies with the requirements of BAPM and was evidenced in scheme year 4 with a medical workforce review. The review concludes that the BAPM standards required to meet the optimal arrangements for neonatal intensive care medical staffing are in place at LWH and that there was no requirement for a Trust Board approved action plan. An update will be provided to Trust Board in December 2024 and detailed minutes should be made available. **Neonatal Nursing Workforce** 1. The neonatal unit meets the BAPM neonatal nursing standards. If the requirements have not been met in year 3 and or year 4 and 5 of MIS, Trust Board should evidence progress against the action plan previously developed and include new relevant actions to address deficiencies. If the requirements had been met previously without the need of developing an action plan to address deficiencies, however they are not met in year 5 Trust Board should develop an action plan in year 5 of MIS to address deficiencies. Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN). **October 2023 Update**: In April 2023, the Trust Board received (after submission to PPF in March 2023) a biannual staffing paper which contained the Neonatal nursing review and	

	action plan as per the Year 4 scheme. The Trust Board will receive the up to date neonatal workforce review in December 2023. .	
SA.5 Can demonstrate an effective system of midwifery workforce planning to the required standard? Leads: Heledd Jones – Head of Midwifery Alison Murray – Deputy Head of Midwifery	A. A systematic, evidence-based process to calculate midwifery staffing establishment is completed. B. Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above. C. The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service. D. All women in active labour receive one-to-one midwifery care. E. Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year five reporting period. **Evidence Required:** Report submitted to Trust Board will comprise evidence to support A, B and C progress or achievement and should include: - A clear breakdown of BirthRate+ 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 BirthRate+ or equivalent calculations. - Where Trusts are not compliant with a funded establishment based on BirthRate+ 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 BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified must be shared with the local commissioners. - Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staffing. o The midwife to birth ratio o The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives. - Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator status and the provision of one-to-one care in active labour. Must include plan for mitigation/escalation to cover any shortfalls. **October 2023 Update** – A refreshed Birth-rate Plus report has been received by Quality Committee and Trust Board in September 2023 with all safety action standards addressed and sign off full compliance completed.	**Oct/Nov 2023** - There are currently no identified concerns with compliance for this safety action. Remain on target for full compliance.
SA.6 Can you demonstrate compliance with all five elements of the Saving	1. Provide assurance to the Trust Board and ICB that you are on track to fully implement all 6 elements of SBLv3 by March 2024. **Evidence Required:** A new implementation tool will be available by the end of June to help maternity services to track and evidence improvement and compliance with the requirements set out in Version Three. The tool will be based on the interventions, key process and outcome measures identified within each element, so providers can begin implementation of the Care	**Oct/Nov 2023** - There are currently some identified concerns with compliance for this safety

Babies' Lives Care Bundle Version 2? Leads: Clinical Director Alice Bird – Obstetrics Umber Agarwal Consultant obstetrician and SBLCBV3 Implementation Lead Angela Winstanley – Quality & Safety Matron	Bundle Version 3 now with confidence, while the tool undergoes final user testing. Providers should use the new national implementation tool to track and compliance with the care bundle once this is made available and share this with the Trust Board and ICB. To evidence adequate progress against this deliverable by the submission deadline in February, providers are required to demonstrate implementation **of 70% of interventions across all 6 elements overall, and implementation of at least 50% of interventions in each individual element.** **October 2023** – The Division now have access to the Implementation Tool and are in the process of reviewing the RAG status. All SBLCBV3 elements have assigned leads, with oversight being monitored within the Family Health Division Maternity Transformation Board and Senior Leadership Team. In partnership with the LMNS arm of the ICB, the Division have completed the first review of the implementation tool with LWH Self-Assessment and LMNS Validation review checkpoints reached. After a period of in-depth reviews of the SBLCBV3, LWH have self-assessed as 91% compliant with the bundle in totality, with each individual element meeting demonstrating compliance with at least 60%, therefore meeting the MIS scheme compliance of 50%. This position will continue to be reviewed and stringent evidence collation continue to support this position. LMNS have started a validation process on the evidence submitted by the Trust and have checked 50% of the evidence to date. This gives us a 19% progress with more evidence to be collated and uploaded. The evidence portal closed on 30.10.2023 and the Division await further update from the LCB/LMNS in relation to the most up to date compliance percentages. Please see Appendix 1 for Implementation Tool Validation Tool. **Identified Risks:** There remain some risks associated with the full implementation of SBLCBV3, especially in respect of the provision of a fully functioning pre-existing and gestational diabetic Service, of which are articulated on the FHD Risk Register. The Diabetic service is affected presently by a lack dietician and diabetic nurse support. We are reliant upon external trust (LUFHT) provision of DSNs. Short term sickness within partnering DGH for diabetes nurse provision has led to diabetes service risk score being increased on the Family Health Risk Register. Immediate actions have been implemented from FH management team to mitigate this risk and include requesting mutual aid from other providers, introduction of telephone clinics, pathway and service redesign meetings underway to safeguard future service provision. Recruitment of a dietician within the Crown Street site by the CSS division has concluded, but there remains a longer-term risk posed by the lack of diabetic's specialist nurse provision at Crown Street. There is peer to per collaborative discussions taking place with colleagues at LUFHT to devise a longer term plan for the service provision and sustainability. 2. Hold quarterly quality improvement discussions with the ICB, using the new national implementation tool once available. ONGOING **Evidence Required:** Confirmation from the ICB with dates, that two quarterly quality improvement discussions have been held between the ICB (as commissioner) and the Trust using the implementation tool that included the following: - Use of the implementation tool once it is made available. - Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element. - Progress against locally agreed improvement aims. - Evidence of sustained improvement where high levels of reliability have already been achieved. - Regular review of local themes and trends with regard to potential harms in each of the six elements. -	action especially in relation to the Diabetic Service at both Crown Street and Aintree Sites.

	October 2023 Update – The Senior Leadership Team met with the LMNS/ICB on 26th September 2023, where all of the above requirements where discussed. The next meeting is planned for November 14th 2023.	
SA.7 Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services? Lead: Heledd Jones Head of Midwifery Yana Richens Director of Midwifery Mahdieh Irvine – MNVP Chair	1. Ensure a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place which is in line with the Delivery Plan and MNVP Guidance (due for publication in 2023). Parents with neonatal experience may give feedback via the MNVP and Parent Advisory Group. 2. Ensuring an action plan is coproduced with the MNVP following annual CQC Maternity Survey data publication (due each January), including analysis of free text data, and progress monitored regularly by safety champions and LMNS Board. 3. Ensuring neonatal and maternity service user feedback is collated and acted upon within the neonatal and maternity service, with evidence of reviews of themes and subsequent actions monitored by local safety champions. **October 2023 Update** – The Head of Midwifery will progress this safety action in collaboration with the MVNP Lead. Weekly meetings are held chaired by MVP Chair with attendance from Trust representatives. Quarterly service user meetings led by MVP Chair. 15 steps for Maternity Services completed in April 2023, with a full report submitted by MVP Chair. The HoM and MNVP Lead, as part of the Maternity Transformation Programme will progress an action plan developed in response to the CQC Maternity Annual Survey. A Deputy Chair has been appointed due to commence in late October.	**Oct/Nov 2023** - There are currently no identified concerns with compliance for this safety action. MNVP and user feedback work is progressing through the Maternity Transformation Programme and FHDB.
SA.8 Can you evidence that at least 90% of each maternity unit staff group attendance an 'in-house' multi-professional maternity emergencies training session within the last year. Leads: Alison Murray – Midwifery Jonathon Hurst – Neonatal	1. A local training plan is in place for implementation of Version 2 of the Core Competency Framework. A training plan should be in place to cover all six core modules of the Core Competency Framework over a 3- year period, starting from MIS year 4 in August 2021 and up to July 2024. 2. The plan has been agreed with the quadrumvirate before sign-off by the Trust Board and the LMNS/ICB. 3. The plan is developed based on the "How to" Guide developed by NHS England Relevant Time scale: 12 consecutive months from the end date used to calculate percentage compliance to meet Safety Action 8 in the Year 4 scheme.	**Oct/Nov 2023** - There are some identified concerns with compliance for this safety action. Extra MPMET sessions have been planned to support the CSS Division for anaesthetic attendance.

%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%	94%	98%	NQM B5, B6, B7, B8, B9
	Maternity HCA	75%	79%	77%	80%	93%	B2, B3, B4
	Cons Obstetrician	53%	59%	71%	86%	97%	
	Trainee Obstetrician	x	58%	61%	79%	100%	New rotation in Aug
	Cons Anesthetists	28%	27%	47%	73%	100%	
	Trainee Anesthetists	x	36%	40%	60%	100%	New rotation in Aug and Nov
SA 8c. Fetal Surveillance	Midwives	77%	83%	87%	89%	94%	NQM, B6, B7, B8.
	Cons Obstetrician	62%	59%	71%	77%	92%	
	Trainee Obstetrician	x	29%	64%	77%	98%	New rotation in Aug
SA 8d. NLS	Midwives	81%	88%	89%	93%	98%	
	Cons Neonatologist	100%	100%	100%	100%	100%	
	Trainee Neonatologist	100%	100%	100%	100%	100%	New rotation Mar & Sept
	ANNPs	93%	93%	100%	100%	100%	
	Neonatal Nurses	95%	98%	96%	98%	100%	

October/ November 2023 Update:

Current compliance with MPMET and Fetal Surveillance Training is outlined above. Encouragingly, midwifery attendance has now met the required standards for training. The red data above denotes the current trajectory of compliance, with attendances planned in November 2023.

A risk posed is that of the availability of an MDT approach to the training days also because of ongoing Industrial action, to which presently await the publication of further IA. To mitigate these several additional training sessions have been planned. This is also clearly articulated on the FHD Risk register.

A further trajectory and compliance percentage will be provided in the next scheme update, after the next planned MPMET Session on 31.10.2023.

SA.9 Can you demonstrate that there are robust processes in place to provide assurance to the Board on Maternity and neonatal safety and quality issues?

Leads:
Dianne Brown Chief Nurse

Rachel McFarland – Obstetric Safety Champion

Angela Winstanley – Midwifery Safety Champion

A) All six requirements of Principle 1 of the Perinatal Quality Surveillance Model must be fully embedded.

Evidence Required: The six points are as follows:

1. To appoint a non-executive director to work alongside the board-level perinatal safety champion to provide objective, external challenge and enquiry. COMPLETED
2. That a monthly review of maternity and neonatal safety and quality is undertaken by the Trust Board. COMPLETED
3. That all maternity Serious Incidents (SIs) are shared with trust boards and the LMNS, in addition to reporting as required to HSIB. COMPLETED
4. To use a locally agreed dashboard to include, as a minimum, the measures set out in Appendix 2 of the Perinatal Implementation Surveillance Model, drawing on locally collected intelligence to monitor maternity and neonatal safety at board meetings. COMPLETED
5. Having reviewed the perinatal clinical quality surveillance model in full, in collaboration with the local maternity system (LMNS) 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. COMPLETED
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. COMPLETED

B) Evidence that discussions regarding safety intelligence; concerns raised by staff and service users; progress and actions relating to a local improvement plan utilising the Patient Safety

Oct/Nov 2023 - There are currently no identified concerns with compliance for this safety action.

Srinivasarao Babarao – Neonatal Safety Champion.	Incident Response Framework are reflected in the minutes of Board, LMNS/ICS/ Local & Regional Learning System meetings. **Evidence Required**: Trust's claims scorecard is reviewed alongside incident and complaint data. Scorecard data is used to agree targeted interventions aimed at improving patient safety and reflected in the Trusts Patient Safety Incident Response Plan. These discussions must be held at least twice in the MIS reporting period at a Trust level quality meeting. This can be a Board or directorate level meeting. **October 2023** The Maternity Safety Lead (RMc) develops a monthly Learning from Claims Report that is based on information provided in the Trust Scorecard. It details settled claims, summary of the case, shares learning with the Mat Risk and Clinical Groups and is disseminated to all clinicians across the Division. An example of this can be found in the Appendix. C) Evidence that the Maternity and Neonatal Board Safety Champions (BSC) are supporting the perinatal quadrumvirate in their work to better understand and craft local cultures. **Evidence Required:** - Evidence that both the non-executive and executive maternity and neonatal Board safety champion have registered to the dedicated FutureNHS workspace to access the resources available no later than July 2023. Completed 100% - Evidence in the Board minutes that the work undertaken to better understand the culture within their maternity and neonatal services has been received and that any support required of the Board has been identified and is being implemented. **October 2023 Update –** The Family Health Divisional Safety Champions have reviewed all the workstreams relating to Safety Champions. An action plan and a Safety Champions Annual Forward plan has been developed. A detailed action plan has been developed, that will be monitored at the Safety Champions Meetings which will track progress with safety champion requirements. The Perinatal Surveillance Safety Update and Dashboard will continue to be presented at every Trust Board, with updates from the Safety Champions within this paper. The Maternity Safety Champions have asked for clarification from the LMNS how sharing information with the ICB and LMNS will be facilitated, and this is planned to be developed with the introduction of a regional Maternity Safety Oversight Group. The Quadrumvirate attended the Perinatal Culture and Leadership programme module programme on 11-13th October, followed by further modules Nov 2023 and Feb 2024. The Perinatal Safety Dashboard Paper will contain further information relating to the progress and programme. The Quadrumvirate are invited to attend the monthly Safety Champions Meetings.	
SA.10 Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification (EN) scheme? Leads: Lead Governance Manager for Family Health – Clare Louise Murray	A) Reporting of all qualifying cases to HSIB/CQC//MNSI from 30 May 2023 to 7 December 2023. B) Reporting of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 30 May 2023 until 7 December 2023. C) For all qualifying cases which have occurred during the period 30 May 2023 to 7 December 2023, the Trust Board are assured that: i. the family have received information on the role of HSIB/CQC/MNSI and NHS Resolution's EN scheme; and ii. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour. **Evidence Required:**	**Oct/Nov 2023** - There are currently no identified concerns with compliance for this safety action.

Governance Manager Legal Services for NHSr Reporting.	**Trust Board** sight of Trust legal services and maternity clinical governance records of qualifying HSIB/CQC/MNSI/EN incidents and numbers reported to HSIB/CQC/MNSI and NHS Resolution **Trust Board** sight of evidence that the families have received information on the role of HSIB/CQC/MNSI and EN scheme. **Trust Board** sight of evidence of compliance with the statutory duty of candour. **October 2023 Update**: The Division have reported all cases to HSIB since 30.05.2023. A 72 hour review has been undertaken with oversight from Trust Harm and Safety meeting and all activities pertaining to reporting to NHSr, HSIB and Duty of Candour have been executed. A update of compliance will be maintained through the scheme year within this update report and full breakdown of HSIB, NHSr and Duty of Candour information will be provided in December 2023.	

Family Health Division Scheme Management and Leadership

- Every action has been nominated a lead, with associated actions being given to action owners. Action Leads and owners who are responsible for ensuring their progress, challenges and completions are presented and overseen by the FHD Maternity Incentive Oversight Group with reporting to the Maternity Transformation Board and Family Health Divisional Board where available

Schedule of Reporting

Date	Other Relevant Committee	Quality Committee: Reports to receive	Trust Board: Reports to receive.
June 2023	NA	Receive and discuss full current compliance position and requirements of Year 5 MIS scheme.	
July 2023		- MIS Year 5 Scheme Progress	- Perinatal Dashboard - MIS Year 5 Scheme Progress
Aug 2023	NA	No meeting.	No meeting.
Sept 2023	NA	MIS Year 5 Scheme Progress - Q1 ATAIN Audit report and action plan - Q1 Learning from Deaths Report - Consultant Attendance Audit and Action Plan (Jan to July 2023)	- Perinatal Dashboard inclusive of Safety Champion Update - MIS Year 5 Scheme Progress - Q1 ATAIN Audit report and action plan - Q1 Learning from Deaths Report - Consultant Attendance Audit and Action Plan (Jan to July 2023)
Oct 2023		- MIS Year 5 Scheme Progress	- Perinatal Dashboard - MIS Year 5 Scheme Progress
Nov 2023		- MIS Year 5 Scheme Progress	- Perinatal Dashboard - MIS Year 5 Scheme Progress - Neonatal Nursing Workforce Paper
Dec 2023		- MIS Year 5 Scheme Progress - Neonatal Workforce Review - Anaesthetic Workforce Paper - Obstetric Workforce Audit of Compliance	- Perinatal Dashboard - MIS Year 5 Scheme Progress - Neonatal Workforce Review - Anaesthetic Workforce Paper - Obstetric Workforce Audit of Compliance - PMRT Action plan in response to IA.
Jan 2024		- Final MIS Year 5 Scheme Progress Paper	*ICB Accountable Officer for ICB and Programme Lead for LMNS to be invited.*

			- HoM, DoM & CD Scheme presentation. - Final MIS Year 5 Scheme Progress Paper with completed Board Declaration Form - Perinatal Dashboard

Conclusion and Recommendation

The Trust Board is asked to note the current position in relation to the Maternity Incentive Scheme (CNST) Year 5 and our current compliance position, along with the associated papers found within the appendix.

The Trust Board is asked to be assured by the oversight, detail and governance updates within the paper that that the Division are prepared in their response to the maternity incentive scheme.

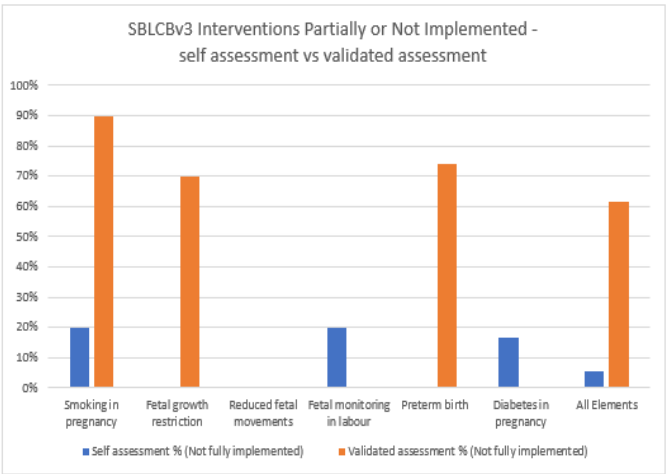
The Trust Board is asked to assurance that out current position, with regards to all the safety elements and actions can be supported by evidence, which will be scrutinised prior to final board submission.

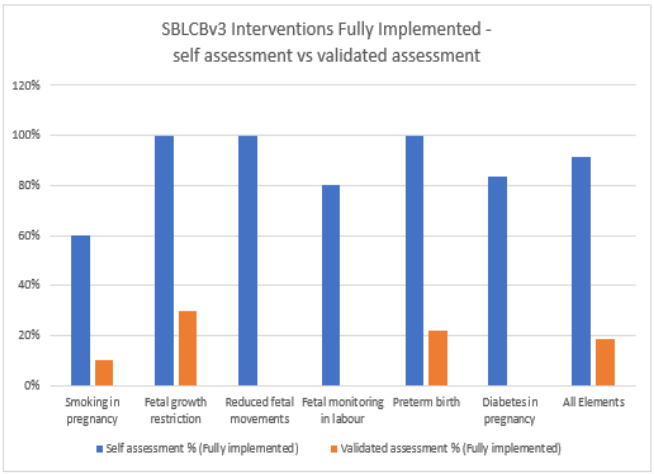
Appendix 1.

SBLCBV3 Implementation Progress (18.10.2023) of SBLCBV3.

Implementation Progress

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)
Element 1	Smoking in pregnancy	Partially implemented	60%	Partially implemented	10%
Element 2	Fetal growth restriction	Fully implemented	100%	Partially implemented	30%
Element 3	Reduced fetal movements	Fully implemented	100%		0%
Element 4	Fetal monitoring in labour	Partially implemented	80%		0%
Element 5	Preterm birth	Fully implemented	100%	Partially implemented	22%
Element 6	Diabetes	Partially implemented	83%		0%
All Elements	TOTAL	Partially implemented	91%	Partially implemented	19%





Quality Committee Chair's Highlight Report to Trust Board
26 September 2023

Liverpool Women's NHS Foundation Trust

1. Highlight Report

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

• The Committee noted the following matters from the Quality Performance report:
  ○ continued Industrial Action for both Junior Doctors and Consultants took place in August 2023, further impacting on capacity and would continue into September and October 2023 following release of further industrial action dates
  ○ implementation of DigiCare Meditech Expanse which went live in July 2023 and included an activity reduction for the first 2 weeks post go live had impacted upon performance in August 2023
  ○ the Trust remained in Tier 2 Cancer performance management with NHSE. Cancer performance continued to be challenged. The Cancer Improvement Group continue to review key areas of pressure and identify improvements.
• The Committee received a detailed update in relation to the Learning from deaths quarterly report and appended reports including an in-uterine transfer deepdive and external mortality reviews. The Committee reflected on the learning presented and the risks identified within the local system due to the lack of co-location of Trust services with both adult and paediatric acute services which had been highlighted as a contributory factor for a number of deaths. The Committee noted that the Trust would continue to escalate the matter to the ICB towards improving women's health services in the region.
	• The Committee noted that the Executive Team had reviewed and agreed an option to introduce the Oliver McGowan disability and autism mandatory training. The approach would allow a phased rollout to align with existing training schedules while ensuring compliance with the government-recommended training. There would be financial implications to introduce the training associated with the face-to-face training. A final report on the Oliver McGowan Mandatory Training would be submitted to the Putting People First Committee in November 2023.
	• The Committee noted significant work required to progress and deliver the Maternity Incentive Scheme (CNST) Year 5 scheme. The Committee queried whether the division could make use of any rebate from the scheme to support delivery against year 5 requirements.
	• Noted that the Maternity Picker Patient Survey had been completed. The results would be embargoed until November 2023, when the results and action plan would be considered by the appropriate divisional and corporate groups.
	• The Committee received a review of Clinical incidents attributable to the isolation of Trust services from other specialist services during the period Quarter 1 2023/24. The recommendations and actions to continue regular monitoring and mapping of incidents to the LUHFT LWH Joint risk register were noted.

Positive Assurances to Provide Identify in brackets should the assurance provide evidence against the CQC Key Questions – SAFE | EFFECTIVE | CARING | RESPONSIVE | WELL LED	**Decisions Made**

• The Committee received the Quality and Regulatory update noting reportable key issues in month. (WELL LED)
• The Committee noted the following matters from the Quality Performance report:
  ○ Gynaecology Elective recovery continued to deliver a positive trajectory in line with the 2023/24 plan submitted to the ICB. Performance against both the 65 weeks wait and the 52 weeks wait continue to achieve better than the trajectory. Patients waiting 78+ weeks remained low and related to patient choice or for clinical reasons. (ALL)
  ○ the introduction of Pipelle usage to prevent unnecessary hysteroscopy procedures, which had improved capacity and patient outcomes
	• The Committee recommended Board approval of revised BAF risks 2 and 3.
	• The Committee approved the Corporate Risk Sub-Committee terms of reference.
	• The Committee recommended further Board discussion on the Learning from Deaths report.

○ improved turnaround times for urgent biopsies and urgent resections demonstrating improved collaborative working with Liverpool Clinical Laboratories • Positive assurance from the Maternity and Neonatal Transformation and Improvement Update noting that the remit of the programme had been expanded and a revised structure, programme governance and infrastructure had been agreed. Progress made by the Induction of Labour (IOL) Improvement Group was noted towards improving the patient experience. The division was congratulated on their achievement of becoming finalists at the Nursing Times Workforce Summit and Awards for the Preceptorship Programme of the year 2023 (ALL) • The Committee received the Integrated Governance Assurance Report – Quarter 1 2023/24 and noted significant improvement demonstrated by the report evidencing a cultural shift in outcomes and learning. • The Committee noted and took assurance from the following reports: Safeguarding Quarterly report; Clinical Audit Annual report 2022/23; Research, Development and Innovation Strategy Review; CNST year 5 update; and the Perinatal Quality Surveillance & Safety Dashboard. (ALL)	

Summary of BAF Review Discussion (Board Committee level only)

- The Committee reviewed the related BAF risks. No risks closed on the BAF for Quality Committee.
- Committee agreed a proposed new title for BAF risk 2 to better reflect the immediate risk to patient harm.
- Committee agreed to reduce the risk score of BAF risk 3 from 12 to 8 (likelihood 2; consequence 4).

Comments on Effectiveness of the Meeting / Application of QI Methodology

- Appropriate and improved debate due to shortened agenda .

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
96.	Review of BAF risks: Quality related risks	Assurance	**103.**	Clinical incidents attributable to the isolation of LWH services from other specialist services – Quarter 1	Information
97.	Sub-Committee Chair Reports	Assurance	**104.**	Safeguarding Quarterly Report – Quarter 1 2023/24	Assurance
98.	Quality and Regulatory Update	Information	**105.**	Clinical Audit Annual Report 2022/23	Assurance
99.	Quality Performance Report Month 5 2023/24	Information	**106.**	Research and Innovation Strategy Review	Assurance
100.	Maternity and Neonatal Services Update	Assurance	**107.**	Maternity Incentive Scheme (CNST) Year 5 2023	Information
101.	Mortality and Perinatal Report (Learning from Deaths) Quarter 1 2023/24	Assurance	**108.**	Perinatal Quality Surveillance & Safety Dashboard (includes Safety Champion Update)	Assurance

102.	Integrated Governance Assurance Report – Quarter 1 2023/24	Assurance			

3. 2023/24 Attendance Matrix

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

Quality Committee Chair's Highlight Report to Trust Board
24 October 2023

Liverpool Women's NHS Foundation Trust

1. Highlight Report

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

• The Safety and Experience Sub-Committee escalated a risk in relation to medical equipment competencies, training and recording. An options appraisal was being undertaken go be presented back to the S&E Sub-Committee and it was confirmed that the risk had been added to the Risk Register.
• Concern raised in relation to the patient pathways and performance within the GED from multiple reports received by the Committee. It was noted that a review of GED services was underway and would be presented to the Committee in November 2023. This would include pressures related to the Post Graduate Doctors and Emergency Nurse Practitioners workforce.
• The Committee expressed disappointment that the Care Quality Commission (CQC) had not yet revisited the Trust to review the Section 29A warning notice issued following the inspection in February 2023. In accordance with CQC guidance a further un-announced inspection of Maternity services should be expected within three months of receipt of the warning notice. However, a reinspection had not yet taken place. Immediate remedial actions had been taken which have continued to demonstrate reliable and sustained improvements within the maternity assessment unit.
• The Committee noted the following matters from the Quality Performance report:
  ○ Number of overdue appointments had disproportionately increased following the implementation of DigiCare. This was due to a significant number of patients on the PIFU pathway remaining on the follow-up waiting list until they could be discharged. Operational teams were working through the lists to ensure all patients were being managed appropriately and work was ongoing with the performance team to redefine the metric to more accurately reflect these cases.
  ○ Noted an escalation would be made to the Commissioning Lead at PLACE to add pace to the primary care review of appropriate referrals and the pathway as the volume of cancer referrals continued to increase significantly. It was noted that the number of referrals had increased however the number of cancer patients had remained the same.
• Limited assurance was taken from the Medicines Management quarterly assurance report due to the attendance representation at the Medicines Management Sub-Committee as the responsible Committee. Work was ongoing to engage the clinical workforce and add flexibility to the meeting dates.
	• The Committee noted progress made towards embedding the Trust "Be Brilliant Accreditation Scheme." The Committee supported the decision to revise the framework and scoring to align with CQC methodology. It was confirmed that consultation with staff and service users had been undertaken.
	• Positive assurance from the Maternity and Neonatal Transformation and Improvement Update noting progression with estates works to improve the Induction of Labour provision. The Committee reflected on the improvement demonstrated by the MAU team to significantly improve triage waiting times. The division was working through the feedback provided from the Maternity Safety Support Programme (MSSP) after their visit to the Trust and would report the Trust response to the Committee when available.

Positive Assurances to Provide Identify in brackets should the assurance provide evidence against the CQC Key Questions – SAFE | EFFECTIVE | CARING | RESPONSIVE | WELL LED	Decisions Made

• The Committee received a presentation from Neonatal Consultants describing a recent neonatal coroner case, noting in particular the positive feedback from the coroner's office in relation to how team presented the case and the transparency of information. (WELL LED)
• The Committee received the Quality and Regulatory update noting reportable key issues in month. (WELL LED)
• Positive assurance as to significant progress to address the actions identified following the inspection by the CQC. Work progressed with divisions through Divisional Boards and reported to Executive Committee every two weeks. (ALL)
• The Committee noted the following matters from the Quality Performance report:
  ○ Gynaecology Elective recovery continued to deliver a positive trajectory in line with the 2023/24 plan submitted to the ICB. Performance against both the 65 weeks wait and the 52 weeks wait continue to achieve better than the trajectory. Patients waiting 78+ weeks remained low and a steady improvement against the 18-week RTT metric was also demonstrated. These metrics would continue to be closely monitored throughout quarter 3.
  ○ although Cancer performance continued to be challenged, improvements had been demonstrated and the team would remain focussed on clearing backlogs throughout September and October 2023. Liverpool Clinical Laboratories turnaround times to provide results continued to improve. The Committee noted that the Trust had been recently commended, by formal letter, for achieving over 80% compliance in 2022/23 Q4 data for its Cancer Staging Data Completeness, of which the data helps to further support cancer programmes for early-stage diagnosis.
  ○ noted positive infection control indicators (CDIFF and MRSA) continue to perform well with zero reported.
  ○ positive reporting of MAU triage times within 30 mins and triage time within 15 mins at 95.86% for both. Indicator target for both was >=95%.
• Legal Services annual report provided an overview of claims data with an emphasis on learning. The Committee noted the introduction of the Early Notification Scheme as of April 2022 and received an update against the Class Group Action. The Committee had been assured by the contents of the report noting the progress made to the provision of data and evidence of learning in comparison to previous reports.
• The Committee took positive assurance from the Local and National Safety Standards for Invasive Procedures report noting the improvements demonstrated by each division and improved accuracy of data. (ALL)
	• The Committee noted the performance to date against the Corporate Objectives aligned to its terms of reference. It was agreed to add additional quantifiable data against the nursing & midwifery participation in research ahead of submission to Board of Directors in November 2023.
	• Committee requested succinct narrative and a focus on actions and decisions made to be provided within future sub-committee chair reports.
	• Committee noted a future Board development session with NHS Resolution and Legal Services.
	• The Committee members noted the Seven Day Hospital Services Clinical Standards and that the position remained unchanged. The report had been provided within the 'consent' section of the meeting, it was agreed to consider the report 'for discussion' at the next Board meeting.

Summary of BAF Review Discussion (Board Committee level only)
• The Committee reviewed the related BAF risks. No risks closed on the BAF for Quality Committee.

2

- It was recommended that BAF risk 2 - Inability to ensure the on-going sustainability of clinical services and prevent patient harm by maintaining a high standard of care at the current Crown Street site, should be reviewed to provide additional clarity due to the complexity the risk involves.
- Agreed to consider a reduction of the risk score for BAF risk 3 - Failure to deliver an excellent patient and family experience to all our service users, based on consistent evidence of improved performance demonstrated within the MAU.
- The Committee received the latest Joint Register between the Trust and LUHFT. The Committee reflected on areas within this risk register that should be reflected in the BAF going forward. An updated Joint Register would be discussed at the next Partnership Board with LUFT and shared again with the Committee.

Comments on Effectiveness of the Meeting / Application of QI Methodology

- Appropriate and improved debate due to shortened agenda .

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
117.	Quality Experience Story	Information	124.	Legal Services Annual Report including Learning from Claims	Assurance
118.	Review of BAF risks: Quality related risks	Assurance	125.	Medicines Management Assurance Report Q2	Assurance
119.	Corporate Objectives Quality Committee mid-year review	Information	126.	Local And National Safety Standards for Invasive Procedures – Quarter 1 & 2 2023/24	Assurance
120.	Sub-Committee Chair Reports	Assurance	127.	Ward Accreditation Scheme Update	Assurance
121.	Quality and Regulatory Update	Information	128.	Maternity and Neonatal Services Update	Information
122.	CQC Inspection Report and Improvement Plans Update	Information	129.	Seven Day Working Board Assurance – 6 monthly	Assurance
123.	Quality Performance Report Month 6 2023/24	Information			

3. 2023/24 Attendance Matrix

Core members	April	May	Jun	Jul	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Sarah Walker, (Chair) Non-Executive Director	A	✓	✓	✓	✓	A					
Louise Kenny, Non-Executive Director	✓	✓	A	A	A	✓					
Gloria Hyatt, Non-Executive Director	✓	✓	✓	✓	A	A					
Jackie Bird, Non-Executive Director	✓	✓	A	✓	✓	✓					
Dianne Brown, Chief Nurse	✓	✓	✓	✓	✓	✓					
Lynn Greenhalgh, Medical Director	✓	✓	✓	✓	A	✓					
Gary Price, Chief Operating Officer	✓	A	✓	✓	✓	A					
Jenny Hannon, Chief Finance Officer	✓	✓	✓	✓	✓	✓					

Michelle Turner, Chief People Officer	✓	✓	✓	✓	A	✓					
Nashaba Ellahi, Deputy Director of Nursing & Midwifery	A	✓	✓	✓	✓	✓					
Philip Bartley, Associate Director of Quality & Governance	A	✓	✓	✓	A	A					
Yana Richens, Director of Midwifery	A	✓	A	✓	A	✓					
Heledd Jones, Head of Midwifery	A	✓	✓	A	✓	✓					

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*23/24/184b*		Date: 09/11/2023	
Report Title	Quality & Operational Performance Report			
Prepared by	*Joe Downie, Deputy Chief Operating Officer*			
Presented by	*Gary Price, Chief Operating Officer, Dr Lynn Greenhalgh, Medical Director and Dianne Brown, Chief Nurse*			
Key Issues / Messages	*Key headlines from the Integrated Performance Report, noted within the report.*			
Action required	Approve	Receive X	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.*			
	To receive the report.			
Supporting Executive:	Gary Price, Chief Operating Officer			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

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

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

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

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Key metrics reviewed and discussed at the Board Committees in October 2023. Information provided in the Executive Summary.			

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 6 performance was noted to have seen continued impact of Industrial Action for both Junior Doctors and Consultants. It was noted that further industrial action would continue to impact the Trusts performance if announced through Q3. At this stage no further dates have been announced.

Gynaecology Elective recovery was noted to be continuing to deliver a positive trajectory in line with the 2023/24 plan submitted to the ICB however Committees were notified of the likely deterioration in performance in M7 as a result of the Industrial Action during summer period. It was noted that additional capacity in the form of Permanent and Locum Consultants would be in place from November 2023 to mitigate the risk of further deterioration and to bring the Trust back in line with NHSE trajectories. FPBD committee was informed of the Trust go live with PIDMAS (Patient Initiated Digital Mutual Aid System) on 31st October 2023. Further updates on the impact of this will be referenced in future Access sub-committee chairs reports. There was also discussion regarding the Overdue follow-ups with issues noted around the separation of patients on the PIFU (Patient Initiated Follow Up) pathway and increase in follow-up requests due to changes in process following Digi Care go-live, leading to an increase in numbers over the last 3 months. These are being addressed through the Access sub-committee and Outpatients workstream lead with improvements already being seen in M7.

Updates were given regarding Cancer performance with robust discussion regarding 28 Day Faster Diagnosis and dating of Hysteroscopy, as noted in the performance report. Committees were notified of the improvements being made to dating of patients and the increase of activity being seen. Whilst not reflected in the current performance, will improve by the end of Q3. Committees were briefed on the improving 62-day backlog reduction, noting a 21% reduction in total patients since the start of Tier 2 monitoring in July 2023. Assurance was noted of some of the improvements seen regarding Histology Turnaround Times and the significant increase in number of biopsies being

processed with the Trusts Laboratory partner. The Chairs report from the Cancer Improvement Group was noted at committees including current challenges and ongoing projects. Committees were reminded 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. There was a robust discussion regarding Gynaecology Emergency Department (GED). A presentation will be given at the next Quality Committee on current and future developments to address known risks.

Updates were given to committees regarding Quality metrics which demonstrated improvements made with MUST and Falls. Whilst these areas were showing improvements, there was further work to meet the targets and assurance was given regarding the approach being taken for daily oversight. The number of overdue Complaints actions was noted to be reducing with strong governance in place to monitor this with Clinical Divisions.

As per previous committees, further information and assurance was provided on actions being taken to improve flu vaccination uptake with the start of drop-in clinics commencing in late September. Further clinics and rollout throughout October will improve the performance.

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

Liverpool Women's
NHS Foundation Trust

Trust Board

Performance Report

October 2023

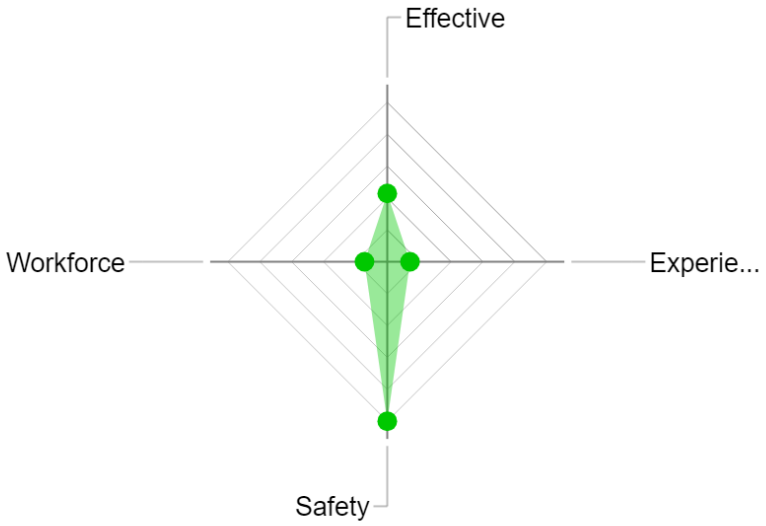
Section 1: Assurance Radar Charts by Trust Values

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'.

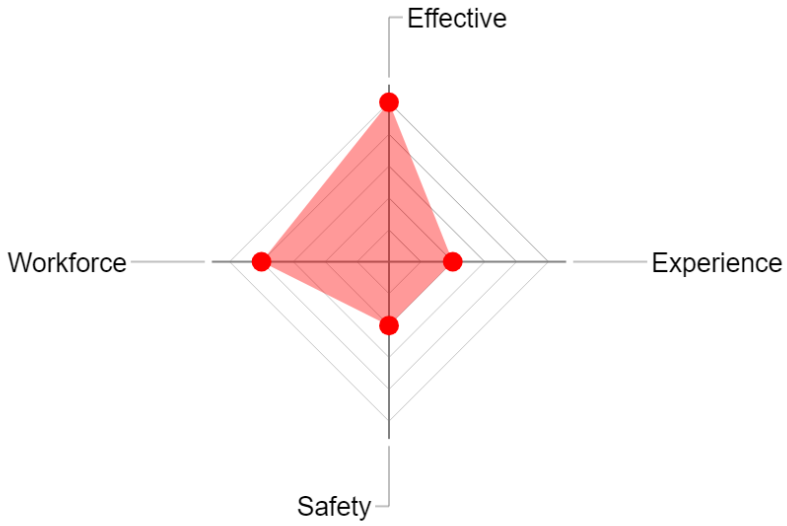
KPIs Passing Target for Six Months	12
KPIs Failing Target	13
KPIs Hit and Miss	9
KPIs No Target	5

KPIs Improving Variation	12
KPIs Concerning Variation	5
KPIs Common Cause Variation	20

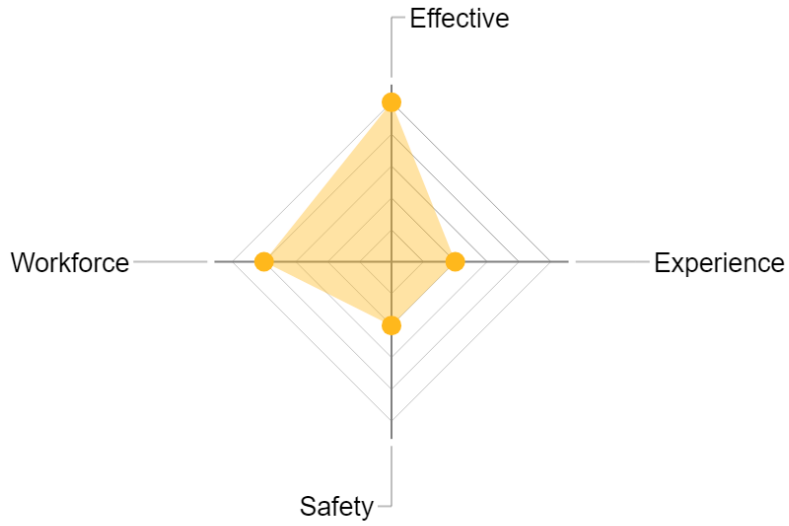
Consistently Passing



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%	95.86%	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%	9.58%	P	L

Good - Celebrate & Understand

KPI	Target < or >	Target	P	A	V
18 Week RTT: Incomplete Pathway > 52 Weeks	<=	0	1489	P	
18 Week RTT: Incomplete Pathway > 65 Weeks	<=	0	321	P	
Complaints: Number Received	<=	<= 15	12	P	
Diagnostic Tests: 6 Week Wait	>=	>= 99%	92.38%	?	H
Infection Control: Clostridium Difficile	<=	0	0	P	
Infection Control: MRSA	<=	0	0	P	
NHSE / NHSI Safety Alerts Outstanding	<=	0	0	P	
Venous Thromboembolism (VTE)	>=	>= 95%	93.55%	?	H

Average - Investigate & Understand

KPI	Target < or >	Target	P	A	V
Neonatal deaths per 1,000 total live births	<=		1.7		
Neonatal Unit Deaths > 22wks Gest Inborn	<=		2		
Neonatal Unit Deaths > 22wks Gest Inborn and Out Born	<=		2		
Neonatal Unit Deaths > 22wks Gest Out Born	<=		0		
A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge	>=	>= 95%	90.50%	?	
C-Gull Recruitment	<=		130	?	
Friends & Family Test: In-patient/Daycase % positive	>=	95%	94.68%	?	
Neonatal deaths 24-31+6 Weeks Inborn babies	<=	0.063	20.00%	?	
Proportion of patient activity with an ethnicity code	>=	>=96%	98.33%	?	

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	8	F	L
Cancer: 31 Days from Diagnosis to 1st Definitive Treatment	>=	>=96%	82.76%	F	
Cancer: 62 day wait for first treatment from urgent GP Referral for suspected cancer (After Re-allocation)	>=	>=85%	21.21%	F	
Friends & Family Test: A&E % positive	>=	95%	74.00%	F	
Friends & Family Test: Maternity % positive	>=	95%	82.88%	F	
Mandatory Training	>=	>= 95%	93.57%	F	H
Mandatory Training (Clinical)	>=	>= 95%	87.88%	F	H
Serious Untoward Incidents: Open	<=	<5	10	F	
Sickness Absence Rate	<=	<= 4.5%	5.31%	F	L
Overall size of Elective Waiting List	<=		19954		H

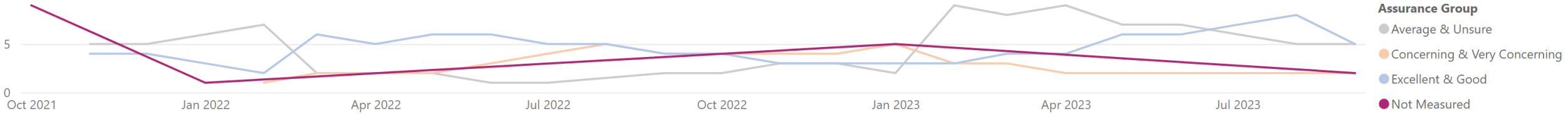
Very Concerning - Investigate & Take Action

KPI	Target < or >	Target	P	A	V
Cancer: 104 Day Breaches	<=	0	8	F	H
Cancer: 28 Day Faster Diagnosis	>=	>= 75%	33.92%	F	L
Prevention of Ill Health: Flu Vaccine Front Line Clinical Staff	>=	>= 80%	15.18%	F	L
Serious Untoward Incidents: New (Rolling per year)	<=	24 /year	39	F	H

Investigate & Understand

KPI	Target < or >	Target	P	A	V

Section 3: To deliver **Safe** Services

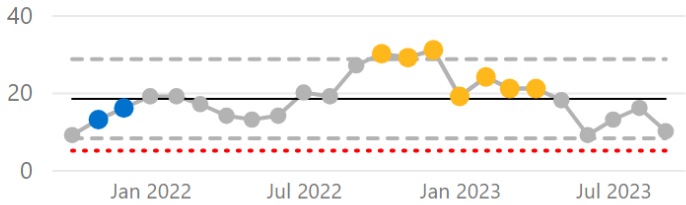


KPI	Assurance Category	Date	Target	Target < or >	Performance	Assurance	Variation	Trend
Number of Open Patient Safety Incident Investigations	Not Measured	September 2023	8	<=	4			
Total Number of Patient Safety Incident Investigations (Rolling)	Not Measured	September 2023	30	<=	0			
MAU - Face to face Maternity Triage within 30 Mins	Excellent	September 2023	>= 95%	>=	95.86%			
Never Events	Excellent	September 2023	0	<=	0			
Serious Untoward Incidents: Number of SUI's reported to CCG within agreed timescales	Excellent	August 2023	100%	>=	100.00%			
Serious Untoward Incidents: Number of SUI's with actions outstanding	Excellent	September 2023	0	<=	0			
Infection Control: Clostridium Difficile	Good	August 2023	0	<=	0			
Infection Control: MRSA	Good	August 2023	0	<=	0			
NHSE / NHSI Safety Alerts Outstanding	Good	September 2023	0	<=	0			
Venous Thromboembolism (VTE)	Good	September 2023	>= 95%	>=	93.55%			
Neonatal deaths 24-31+6 Weeks Inborn babies	Average	September 2023	0.063	<=	20.00%			
Neonatal deaths per 1,000 total live births	Average	September 2023		<=	1.7			
Neonatal Unit Deaths > 22wks Gest Inborn	Average	September 2023		<=	2			
Neonatal Unit Deaths > 22wks Gest Inborn and Out Born	Average	September 2023		<=	2			
Neonatal Unit Deaths > 22wks Gest Out Born	Average	September 2023		<=	0			
Serious Untoward Incidents: Open	Concerning	September 2023	<5	<=	10			
Serious Untoward Incidents: New (Rolling per year)	Very Concerning	September 2023	24 /year	<=	39			

To deliver **Safe** Services - Exceptions

Serious Untoward Incidents: Open - Chief Nurse

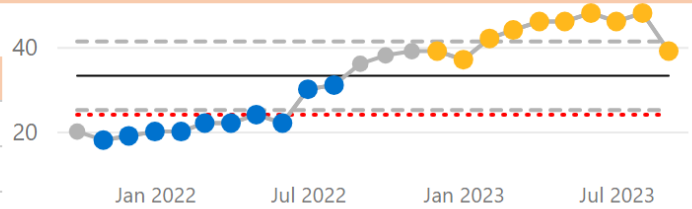
Assurance Category	Concerning
Date	September 2023
Target	<5
Target < or >	<=
Performance	10
Assurance	F
Variation	



There are 10 ongoing SUIs, 6 within Gynaecology and 4 within Maternity. Maternity have declared 2 PSII in September both relating to Pressure Ulcer incidents and Gynaecology has declared one in relations to a Medication Incident. All new PSIIs will follow PSIRF process.

Serious Untoward Incidents: New - Chief Nurse

Assurance Category	Very Concerning
Date	September 2023
Target	24 /year
Target < or >	<=
Performance	39
Assurance	F
Variation	H



Trust saw a rise in SUIs as a result of Future Generations and signgle site issues.

Assurance Category	
Date	
Target	
Target < or >	
Performance	
Assurance	
Variation	

Assurance Category	
Date	
Target	
Target < or >	
Performance	
Assurance	
Variation	

To deliver Safe services - Safer Staffing

September 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	86.67%	75.56%	143.33%	100.00%	*September staffing fill rate on days is reflective of the increase this month of long-term and short- term sickness, alongside maternity leave. Safe staffing has been maintained due to the ability to flexibly rotate staff from the HDU area. The fill rate 143.44% RN on nights remain above the 100% as this is reflective of senior RN cover rotating between GED and inpatient area.
Induction & Delivery Suites	80.22%	88.89%	77.78%	103.33%	*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	79.58%	109.17%	84.29%	105.83%	*/**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 September 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 prior to their induction. 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	72.50%	83.33%	65.83%	60.00%	*/**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 vacancy and LTS- which has now been recruited to.
Neonates (ExTC)	91.58%	110.00%	94.74%	78.33%	*Fill rates reflect the neonatal unit occupancy in September. Occupancy in ITU and HDU reduced for the 3rd month in succession to just under 70%, staffing to 80% occupancy is reflected in the RN fill rates. **Care staff fill rates in September are reflective of the Low dependency activity in September. Safe staffing was maintained and CHPPD (Care Hours Per Patient Day) are as would be expected.
Transitional Care	86.67%	93.33%	53.33%	113.33%	*/**Fill rates reflect the transitional care occupancy in September, with most of the 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: September Fill Rate

Fill rate – The staffing fill rate for September on days reflects the long-term and short -term sickness coinciding with maternity leave. Safe staffing was maintained. The low bed occupancy allowed the manager to flexibly rotate staff from the HDU to support the inpatient area. The high fill rate 143.33% RN on nights remains above the 100% as this is reflective of senior RN cover rotating between GED and inpatient area to provide senior leadership out of hours.

Attendance/ Absence – sickness and absence for the month of September was reported as 9.62% a decrease 2.61% reported in August 2023. Long term sickness contributed to the high levels of sickness at 81.76% and short-term sickness contributed to 18.24%, reviewing the previous months sickness indicates that those recorded as short-term sick had since moved into long-term sick as not yet returned to work. Maternity leave accounted for 2.23 WTE staff.

Vacancies –2.11 WTE RN and 0 HCA vacancies. All vacancies are out to recruitment.

Red Flags – No red flags raised in September.

Bed Occupancy – data not available at time of reporting

CHPPD – For the month of September the CHPPD overall was reported to be 8.5 a decrease on previous month reported as 9.6. The split between Registered and unregistered care staff was 5.1 for Registered Nurse staff and 3.4 hr for Health Care Assistant.

Neonates: September Fill Rate

Fill-rate –Occupancy was just below 70% across all areas of the neonatal unit in September including transitional care. Safe staffing has been maintained and fill rates are reflective of acuity and occupancy. The escalation policy has not had to be used this month and there was 1 delay in repatriation of babies to their local neonatal units, which was escalated appropriately to the Northwest Neonatal ODN.

Attendance/Absence –Sickness was reported at 3.89% in September which is below the trust's target of 4.5%. Long term sickness reduced to 34.3%. All sickness is being managed in line with the attendance management policy.

Vacancies – Turnover remains below the Trust target of 13%, at 10% in September. 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 the five Band 5 vacancies with 5 new nurses to commence employment on the neonatal unit in October 2023.

Red Flags – There are no Neonatal Nursing red Flags reportable.

Bed Occupancy – Occupancy was below the expected 80% down slightly at 69.4% from 70.6 % in August. ITU occupancy was 71.1%, HDU at 84.7%, and a reduction was seen in LDU and TC capacity in September with rates remaining below expected at 59.2 % in LDU and 69.2 % in TC. This is reflective of the care staff fill rates.

CHPPD – Within the critical care areas the care hours provided in September are as would be expected for babies being nursed in ITU with 14.8 Care hours per patient day (CHPPD) overall. The breakdown shows higher hours of registered nurse care and lower non- registered care. This split of 13.8 hrs of registered nurses and 1.4 healthcare support workers, is what is 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 care leads TC, supported by registered staff and parents, hence why we see 4.3hrs by non-registered nurse and less by registered nurses of 2.9 hrs, that is appropriate for care delivery with overall care hours at 7.2 care hours per patient day. Care in TC is more about supporting the family to provide care for their baby, therefore less care hours provided by registered and non-registered nursing staff.

To deliver Safe services - Safer Staffing

Maternity: September 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 99.7%, and 98.2% of those within 15min BSOTS target- an improving position from the previous month despite a 5% increase in attendances. 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, with daily reporting into the LMNS and consideration of mutual aid to other providers if able to support.

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 improved in September to 6.53% in month, or which STS accounts for 32%, with the top reasons for short term absence being cough/cold or gastrointestinal issues. LTS is 68%. Ward managers/matrons have individual sickness reviews and are planning return to work programmes with all LT employees to facilitate appropriate returns, with 6 resolutions occurring in September. Maternity leave equates to 16.31wte 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.

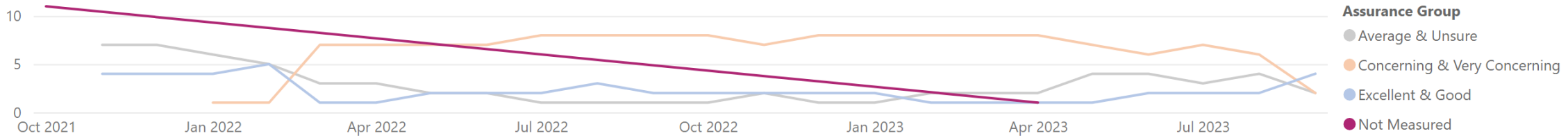
Red Flags – During September 33 Midwifery Red Flags were identified, a significant decrease on the previous month. This included 5 delays of >2hrs from admission to commencement of IOL and 28 delays of >4hrs for ongoing IOL (local red flag), which affected patient experience. IOL Coordinator Project Lead has commenced in post with specific focus on improving processes, estate, and patient experience. Estates work for the new IOL Suite to be converted from existing MLU estate has been commenced. A paper was approved at Quality Committee which supported the amendment of the local midwifery red flag to be amended from delay >4hrs for ongoing IOL to a delay in >12hrs for ongoing IOL which reflects outward reporting to the LMNS and is in line with other Maternity providers in the system. This change will be implemented on the 1 st of November.

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 11.9 in September for Delivery Suite for Registered staff which is a decrease from August. As CHPPD calculation combines hours provided by registered and care staff it is not the most sensitive indicator for Intrapartum Care. 1:1 Care provided by a Midwife to all women is a more accurate measure and this was achieved for 100% of women in month within the hospital environment and improving since August when there were 5 breaches of this.

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 3.5 for Aug a slight increase from the previous month. 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.

Planned Preventative maintenance		Compliant	partial compliant	Non Compliant			
PPM Description	Responsibility/ Contractor	HTM/HBN Reference	Frequency				Comments
			Annual	6-Monthly	Quarterly	Monthly	
FIRE							
Fire Alarm Testing (W, 3M)	Tailored Fire						Contractor complete the yearly testing and maintenance team complete the weekly testing recorded on PPM system
Fire Doors (M)	Estates						Fire door audit complete - action plan to rectify faults in place - external fire audit in process of being undertake, Maintenance training being booked for maintenance staff
Fire Damper Inspection Test	VSS & Swegon						Contracts now in place and schedules progressing. Some restricted access being addressed.
Fire Fighting Equipment (12m)	Tailored Fire						contractor completes
Dry Risers (12M)	Tailored Fire						contractor completes
Fire Hydrants (12M)	Tailored Fire						contractor completes
Emergency Light test (M,12M)	Estates						Now on PPM system and on target
WATER							
Water Treatment (M) (heating and cooling)	Cheshire Scientific						
Water Tank Cleaning (12M)	Cheshire Scientific						
Water Sampling (M)	Cheshire Scientific						Undertaken by maintenance staff monthly
Water Safety PPMs	Estates						Undetaken by maintenance staff as per programme
SECURITY							
Access Control System (3M)	Clarion						
CCTV (3M)	HESIS						Contract now in place and works scheduled. Security review being undertaken following MI
Intruder Alarm (6M)	Clarion						
Baby Tagging System (3M)	Xtag						
LIFTS							
Passengers & Goods Lift (M, 12M)	Rubax						Contractor completes process as per policy
Ladder & Access Platforms (6M)	Ladder Safety Services						Contractor completes process as per policy
ELECTRICAL							
Commercial Dishwashers (6M)	JLA						
Commercial Washing Machine Dryers (6M)	JLA						
Electric Boilers (12M)	JLA						
Kitchen Equipment (6M)	JLA						
Portable Appliances Testing (12M)	OCS						Completed yearly
Food Trolleys (6M)	Socomel						
Weighing Equipment (3M)	Accurate weight						
Fixed Appliance Testing (12M)	Parr group						Contractor completes process as per policy
Bed Pan Washers service (6M)	Dekomed						Contractor completes process as per policy
Bed Pan Washers Testing (3M)	Dekomed						
Nurse Calling System (3M)	Austco						being undertaken only a couple of areas left to complete
External Light Cleaning (12M)	Estates						Maintenance team in process to be completed
Internal Light Cleaning (12M)	Estates						Maintenance team in process to be completed
Lightning Protection (12 M)	PTSG						
Generator Testing (W,M,6M,12M)	Ingrams/Estates						completed weekly by maintenance team and services 6 monthly by contractor, last services July 2023
Trend Building Management System (M)	BTS						
LV Distribution System (12M)	Estates						maintenance team complete
HV Distribution System (12M)	Ipsum						contractor completes
Refridgeration (6M) Catering/Domestic	Effective Air						
MEDICAL GASES							
Medical Gases (3M)	Medigas Services						
HVAC (Heating, ventilation and air conditioning)							
Boiler Burners (6M)	Engie						contractor completes
Pressure Units (6M)	Engie						contractor completes
Main chiller unit (6M)	Engie						contractor completes
Air conditioning (6M)	Effective Air						Contract now in place.
Ventilation System(6M) (AHU)	Estates / Effective Air						maintenance team complete PPMs, contractor completes validation
NICU Chiller Units (3M)	Carrier						
Ceiling Grills Extract Fans (6M)	Estates						Now on PPM system and schedule in place to complete
OTHER							
Car Park Pay & Display (6M)	Newpark						car parks being reviewed as a project to ensure correct staffing allocated, and barriers working across the trust
Grass Cutting and Grounds Maintenance	Rice lane landscapes						Monthly during March - October
Windows maintenance (12M)	Fenestral						

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



KPI	Assurance Category	Date	Target	Target < or >	Performance	Assurance	Variation	Trend
18 Week RTT: Incomplete Pathway > 104 Weeks	Excellent	September 2023	0	<=	0			
Cancer: 62 day wait for first treatment from urgent GP Referral for suspected cancer (After Re-allocation)	Concerning	August 2023	>=85%	>=	21.21%			
Cancer: 28 Day Faster Diagnosis	Very Concerning	August 2023	>= 75%	>=	33.92%			
Cancer: 31 Days from Diagnosis to 1st Definitive Treatment	Concerning	August 2023	>=96%	>=	82.76%			
Diagnostic Tests: 6 Week Wait	Good	September 2023	>= 99%	>=	92.38%			
A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge	Average	September 2023	>= 95%	>=	90.50%			
Proportion of patient activity with an ethnicity code	Average	September 2023	>=96%	>=	98.33%			
Cancer: 104 Day Breaches	Very Concerning	August 2023	0	<=	8			
18 Week RTT: Incomplete Pathway > 78 Weeks	Concerning	September 2023	0	<=	8			
18 Week RTT: Incomplete Pathway > 65 Weeks	Good	September 2023	0	<=	321			
18 Week RTT: Incomplete Pathway > 52 Weeks	Good	September 2023	0	<=	1489			
Overall size of Elective Waiting List	Concerning	September 2023		<=	19954			

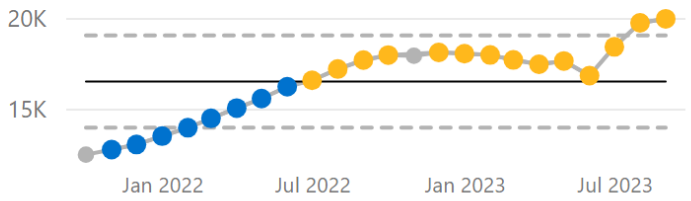
*Following KPI's have nationally set targets as part of Operational Planning Guidance for 23/24:

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

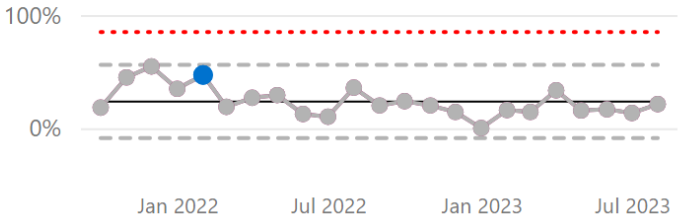
Overall size of Elective Waiting List - Chief Operating Officer

Assurance Category	Concerning
Date	September 2023
Target	
Target < or >	<=
Performance	19954
Assurance	
Variation	H



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

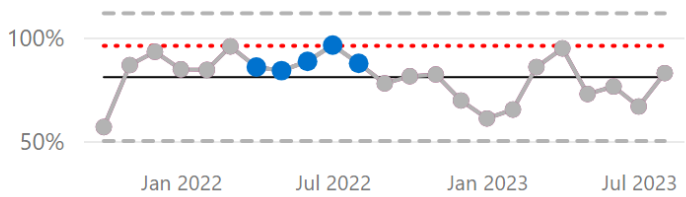
Assurance Category	Concerning
Date	August 2023
Target	>=85%
Target < or >	>=
Performance	21.21%
Assurance	F
Variation	



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

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

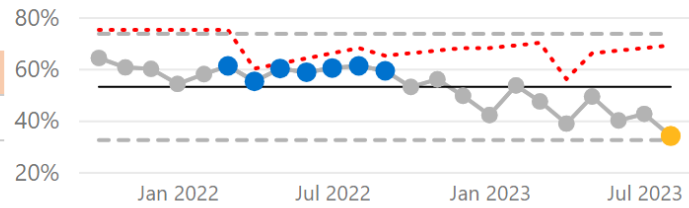
Assurance Category	Concerning
Date	August 2023
Target	>=96%
Target < or >	>=
Performance	82.76%
Assurance	F
Variation	



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	August 2023
Target	>= 75%
Target < or >	>=
Performance	33.92%
Assurance	F
Variation	L

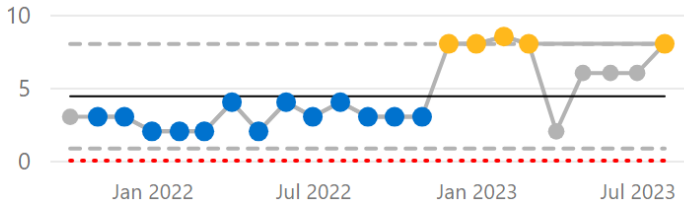


Significant challenges with Hysteroscopy capacity and Histology turnaround. Trust in Tier 2 meeting with NHSE with first meeting held 26th June. This outlined existing pressures and key areas of challenge for the Trust. Trust will be meeting monthly with NHSE to monitor. Weekly tracker of activity being 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

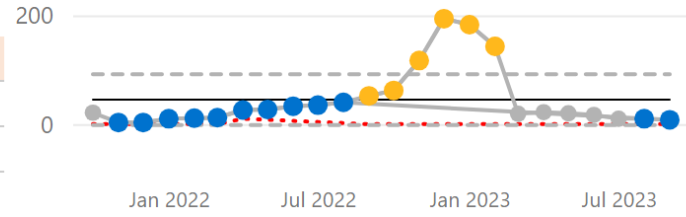
Assurance Category	Very Concerning
Date	August 2023
Target	0
Target < or >	<=
Performance	8
Assurance	
Variation	



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

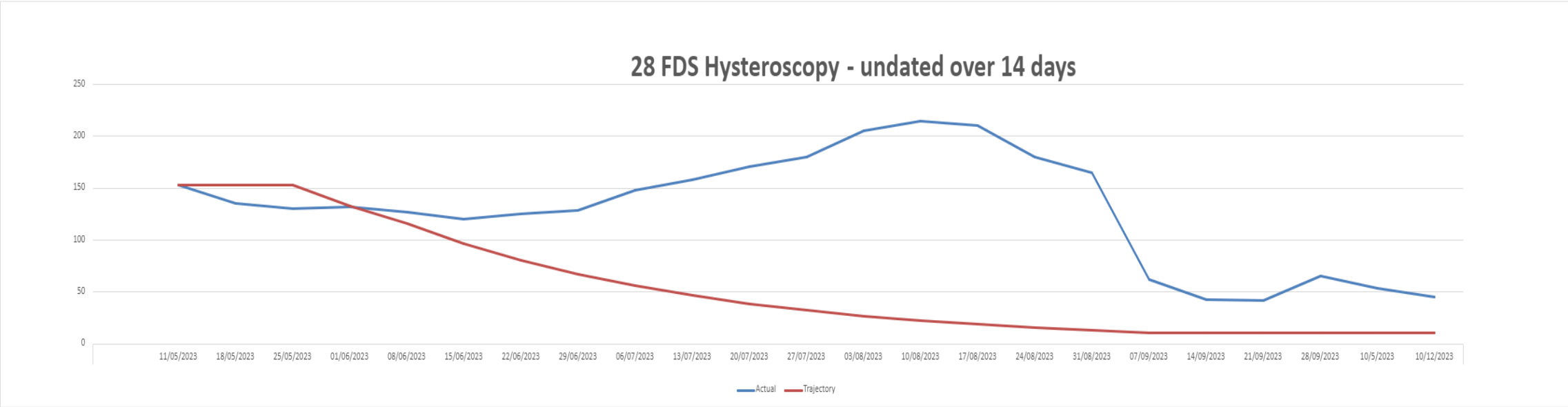
Assurance Category	Concerning
Date	September 2023
Target	0
Target < or >	<=
Performance	8
Assurance	
Variation	



Assurance Category	
Date	
Target	
Target < or >	
Performance	
Assurance	
Variation	

Assurance Category	
Date	
Target	
Target < or >	
Performance	
Assurance	
Variation	

28 Day FDS: Hysteroscopy



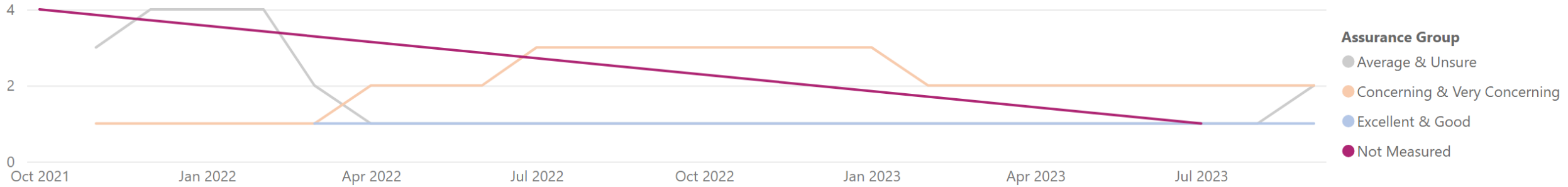
- Improving position re: undated patients for Hysteroscopy – further work to do but improvements being made
- Undated patients impacted by Industrial Action and Significant Consultant sickness in September and ongoing into October
- Locum Consultant commencing 23/10/23 will improve capacity as noted in table
- Average wait for Hysteroscopy now reduced to 4 weeks
- Small numbers at this stage but some patients now being given a date under 14 days.

Overview

- dramatic increase in urgent biopsy samples and associated improvement in TAT below

The team have highlighted that the shift in demographics with hysteroscopy has increased workload this month, so that may account for some of the increase in outstanding results, as well as the unanticipated leave

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

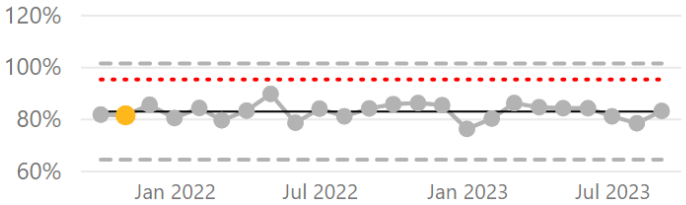


KPI	Assurance Category	Date	Target	Target < or >	Performance	Assurance	Variation	Trend
Complaints: Number Received	Good	September 2023	<= 15	<=	12			
C-Gull Recruitment	Average	September 2023		<=	130			
Friends & Family Test: In-patient/Daycase % positive	Average	September 2023	95%	>=	94.68%			
Friends & Family Test: A&E % positive	Concerning	September 2023	95%	>=	74.00%			
Friends & Family Test: Maternity % positive	Concerning	September 2023	95%	>=	82.88%			

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

Friends & Family Test: Maternity % positive - Chief Nurse

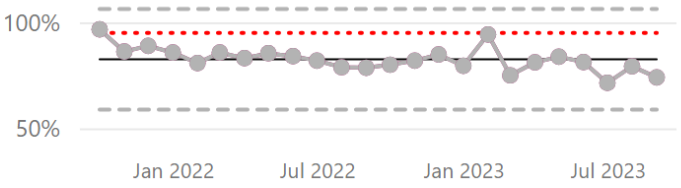
Assurance Category	Concerning
Date	September 2023
Target	95%
Target < or >	>=
Performance	82.88%
Assurance	
Variation	



All Firends and Family feedback reviewed by the maternity matron team on a weekly basis. Feedback not always attributed to correct touchpoint Number of feedback received remains approximately 10% which is less than target of 20%. Themes identified all have attributed QI projects.

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

Assurance Category	Concerning
Date	September 2023
Target	95%
Target < or >	>=
Performance	74.00%
Assurance	
Variation	



There has been a reduction in postive feedfack from the previous month, the common theme being around wait times within the department. The reason for this coincides with doctor strikes and also an increase in doctor sickness. Resulting in a reduction in medical cover.

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			
Number of Open Patient Safety Incident Investigations	Safety		Y		Y					
Prevention of Ill Health: Flu Vaccine Front Line Clinical Staff	Workforce		Y	Y	Y	Y				
Total Number of Patient Safety Incident Investigations (Rolling)	Safety		Y		Y					

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*23/24/184c*	Date: 09/11/2023
Report Title	Bi-annual staffing paper update, January 2023-June 2023 (Q4 &Q1)	
Prepared by	Nashaba Ellahi, Deputy Director of Nursing and Midwifery	
Presented by	Nashaba Ellahi, Deputy Director of Nursing and Midwifery	
Key Issues / Messages	The bi-annual Nursing, Midwifery and Allied Health Professional (AHP) staffing report is provided to the Board of Directors through the Putting People First (PPF) Committee. The report sets out the Liverpool Women's NHS Foundation Trust (LWH) position in the context of the National Nursing, Midwifery and AHP workforce challenges	

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): NA

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 contents of the paper and take assurance of the actions undertaken to effectively manage and provide safe staffing within Nursing, Midwifery and AHP to support the delivery of safe care.

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* 1. Inability to recruit and maintain a highly skilled and engaged workforce that is representative of our local communities	Comment: Risk score of 16; target 12
Link to the Corporate Risk Register (CRR) – CR Number: The below are service level risks, however for context are highlighted. **FH (Maternity)** Risk number: 1705 – midwifery staffing "insufficient midwifery staffing levels as recognised by birth rate plus. Risk score of 12; target 6 **Gynaecology** Risk number: 2256 – Risk to staff the Telephone Triage Line (GED). Risk score of 12; target 3 Risk number: 2395 - OPD ambulatory staffing Risk score of 15; target 12 **CSS** Risk number: 2549 – Staff shortages in the Imaging Dept. Risk score of 12; target 12 Risk number: 2579 – Staffing for CDC. Risk score of 12; target 5 Risk number: 2519 – Risk to staffing the X-Ray on call rota. Risk score of 12; target 10 Risk number: 2546 – Reduction of staff in genetic counselling. Risk score of 12; target 4 **Neonates** Risk number: 2161 – Lack of access to AHP support services. Risk score of 6; target 2	Since the previous reporting period the following risk scores have reduced or closed: **2546** – this action has been controlled and therefore closed

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Putting People First Committee	18.09.2023	Chief Nurse	Approved with recommendations agreed and supported

EXECUTIVE SUMMARY

The bi-annual Nursing, Midwifery and Allied Health Professional (AHP) staffing report is provided to the Board of Directors through the Putting People First (PPF) Committee. The report sets out the Liverpool Women's NHS Foundation Trust (LWH) position in the context of the National Nursing, Midwifery and AHP workforce challenges. This report covers the period from January 2023 to June 2023 (Quarter 4 and Quarter 1). The report provides assurance that there are robust systems and processes in place throughout the year to monitor and manage Nursing, Midwifery and AHP staffing requirements. The report will demonstrate the adoption of a triangulated approach to the bi-annual staffing report and therefore includes discussion of evidence-based tools, professional judgement, and outcomes (e.g., complaints, incidents) to support understanding.

Adoption of principles within National Quality Board (2016), NICE Guidance (2014;2015) and Delivering Workforce Safeguards (2018) to support workforce planning, care hours per patient per day (CHPPD) requirements and the operational oversight of staffing and acuity-based care is embedded in the Trust.

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

- Vacancy rate (June 2023) has positively reduced reflecting 4.66% (wte 48.00) a reduction from previous reporting position of 10.12% (105.53wte, Dec 2022), with Family Health Division reflecting the greatest vacancies (Neonatal, 29.65wte and Maternity, 15.53wte).
- Demand for Bank and Agency has reduced by 12% in June 2023 compared to January 2023, which is likely due to substantive staff in post and lower sickness rates. Bank fill rates have increased with agency fill rates decreasing due to tighter controls in place.
- Maternity leave fluctuates between 37.81-42.92wte on maternity leave per month, which is similar to the previous reporting period. Maternity leave in June 2023 is 40wte across all NMAHP staff groups which reflects 3.14% of total NMAHP staff.
- Sickness has been above target of 4.5% with a combined NMAHP sickness position of 6.97% in June 2023. Although above threshold it reflects a downward trajectory from previous reporting period where sickness peaked for NMAHP groups in Dec 2022 at 11.12%.
- Long-term sickness (LTS) rates (28 calendar days or more) continue to remain the greatest challenge with high levels of LTS noted across all staff groups, however it must be noted that AHPS are a smaller cohort, therefore the LTS appears disproportionately elevated. June 2023 LTS reflects NMC, 64.84%; HCA, 65.47% and AHP, 80.10%. LTS in June 2023 is higher than that recorded in previous reporting period with Dec 2022 LTS at 52.20% (NMC), 51.70% (HCA) and 53.09% (AHP).
- Turnover in June 2023 for NMAHP staff groups remains under the Trust threshold of 13% reflecting HCA, 12.84%; NMC, 8.77%; AHP, 9.38%
- Age profile has marginally shifted due to recruitment activity in divisions. There remains a risk in Nursing and Midwifery (NMC/HCA) to those who may retire now or in the next five years. As a percentage of the NMAHP workforce this is represented as 7.32% within 56-60 age bands and 4.20% within 61-65 age bands in NMC.
- Staff Training and Personal Development Review performance measures have improved significantly from previous reporting period, albeit all staff groups have not met all thresholds for indicators. In June 2023, mandatory training was achieved in HCA/AHP staff group and PDR achieved in NMC staff group.
- 227 clinical incidents related to staffing or staff sickness were noted compared to 391 in previous reporting period, with highest seen in Maternity Services (157) which reflects a reduction from previously reported (311) and is likely due to improvements made with gross unavailability of staff. Red Flag events (93) were all reported from Maternity services and reflect a reduction of 170 red flags. There were 15 (previously 27) Serious Incidents with 7 in Gynaecology; 5 in Maternity; 3 in Neonatal.
- Patient experience – 23 comments (from 5361) a reduction from previous reporting (40 comments from 5217 responses) received in Friends and Family Test (FFT) mentioned staffing numbers or staffing shortages in the patients' experience, 16 of these were in Maternity with the common theme of a lack of support which patients

attributed to being understaffed. 79 comments (from 3460) reflect a reduction from previous reporting (107 comments from 3223 responses) relating to the Trust question "please tell us anything we could have done better" also related to staffing numbers or staff shortages. The majority were in Maternity (47), then Gynaecology (30) identifying themes such as waiting for pain relief, delayed discharge and waiting times for appointments and in GED. Maternity and Gynaecology have Quality Improvements underway to support the improvement work to address the themes notes.

- Complaints – 26 formal complaints received highlighting a reduction of 14 from previous reporting period. No PALS+ recorded (from 23) noted staffing in the issue raised. No PALS cases (from 1362) noted staff shortages in issues raised. 79 Compliments were received, which reflect an increase of 22 from pervious reporting.
- Staff experience – 13 reported violence and aggression incidents (previously 25), all relating to non-physical violence or aggression towards staff. No themes or trends identified across incidents.

Recruitment and Retention – ongoing recruitment across the Trust continues with successful early recruitment of Midwives with Maternity on track to fill all existing vacancies by October 2023. LWH continues to participate in International Recruitment (IR) in Theatres and Midwifery. The current position reflects that during January 2023-June 2023, ten IRs arrived (6 nurses, 4 midwives) with all receiving a full onboarding programme.

All Divisions receive locally owned data which is reflected in Divisional summaries (Appendix 4-7).

MAIN REPORT

1.0 Introduction

To provide the Putting People First Committee with a six-monthly update of the 2023/2024 staffing establishment reviews in relation to the Nursing, Midwifery and Allied Health Professional (AHP) workforce requirements. To report against the workforce requirements identified in 2023/2024 to achieve safe staffing across services within the Trust.

2.0 Background

NHS organisations have a responsibility to undertake an annual comprehensive Nursing and Midwifery skill mix review to ensure that there are safe care staffing levels to provide assurance to the Trust Board and stakeholders that the organisation is safe to provide high quality care.

The annual Nursing and Midwifery staffing establishment review considers relevant guidance and resources available to support NHS providers to deliver the right staff, with the right skills, in the right place at the right time (National Quality Board (NQB), 2016) through effective staffing (NICE, 2014; NICE, 2015; NHSI, 2018).

The annual comprehensive Nursing and Midwifery workforce planning skill mix review was underway in Quarter 4 (2023/2024) ahead of budget setting to effectively inform any changes before staffing establishments are reviewed and signed off by the Chief Nurse and Trust Board.

The bi-annual Nursing and Midwifery staffing report details the Trusts position against the requirements of NICE guidance for adult wards (2014); NICE Guidance for maternity settings (2015), NQB Safer Staffing Guidance (2016) and NHSI, Developing Workforce Safeguards (2018).

The Trust Board receives twice-yearly staffing review papers; one which confirms a complete Nursing and Midwifery establishment review was undertaken via Divisional overviews (appendices 4-6) and a further comprehensive staffing report to ensure workforce plans are still appropriate across the clinical workforce, allowing for seasonal variance to be captured and reviewed appropriately.

Additionally, separate twice-yearly Midwifery staffing oversight reports are presented to Trust Board that update on staffing/safety issues, as a requirement for the Maternity Incentive Scheme, Year Five, Safety Action 5. Neonatal services report staffing to Trust Board yearly in line with Clinical Negligence Scheme for Trusts (CNST) requirements.

Each month the Trust Board receive an overview of the Nursing and Midwifery staffing including fill rates, attendance/absence, vacancies, red flags, and bed occupancy. The information is presented within the Integrated Performance Report.

Developing Workforce Safeguards (NHSI, 2018) additionally recommends:

- Adoption of the principles of safe staffing utilising a ‘triangulated’ approach to staffing, utilising evidence-based tools, and data, where available, professional judgement and outcomes (e.g., nurse sensitive indicators, complaints, incidents)
- implementation of care hours per patient day (CHPPD) as a metric as recommended by Lord Carter’s review of NHS productivity, however with the caution that it should not be used in isolation

Safe, Effective, Caring, Responsive and Well Led Care		
Measure and Improve -patient outcomes, people productivity and financial sustainability- -report investigate and act on incidents (including red flags) - -patient, carer and staff feedback-		
-implement Care Hours per Patient Day (CHPPD) - develop local quality dashboard for safe sustainable staffing		
Expectation 1	**Expectation 2**	**Expectation 3**
Right Staff 1.1 evidence based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	**Right Skills** 2.1 mandatory training, development and education 2.2 working as a multi-professional team 2.3 recruitment and retention	**Right Place and Time** 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

Table 1: National Quality Board (2016)

3.0 Workforce planning - Setting evidenced based establishments

Evidence based workforce planning is supported using available tools such as Safer Nursing Care Tool (SNCT, 2014) developed to assist NHS hospitals measure patient acuity and dependency on adult inpatient areas and Emergency Departments to inform decision making on staffing and workforce as part of a triangulated approach. SNCT is not suitable for day-case patients.

Following training, Liverpool Women's Hospital participated in beta-testing of the Safer Nursing Care Tool within Gynaecology in-patient areas supported by NHSI. The results of the tool demonstrated that ward level care was level 0 (recognising patients require hospitalisation and ward level care) with High Dependency unit acuity noted as level 1B (patients who are in a stable condition but are dependent on nursing care to meet most or all activities of daily living). As a result of the findings the Nursing workforce for the Gynaecology Ward has been under review and the division is exploring the development of an enhanced care facility to reduce the requirement for high dependency beds.

National guidance (Intensive Care Society, 2019) supports staffing recommendations in Level 2 care facilities (High Dependency Units) as a registered nurse/patient ratio of a minimum of 1:2 to deliver direct care.

Maternity Services are assessed using Birthrate Plus®. The Birthrate Plus® methodology is based on an assessment of clinical risk and the needs of women and their babies during labour, delivery, and the immediate post-delivery period. Birthrate Plus® utilises the accepted standards of one midwife to one woman to determine the total midwife hours and therefore the staffing required to deliver midwifery care to women across the whole maternity pathway using NICE guidance (2015) and acknowledged best practice (RCM, 2018). A Birthrate Plus® refresh audit was completed in April 2023 with report received in May 2023 and reflected that the Maternity budgeted establishment in 2023/24 was 5.35wte below the audit recommendation which Maternity are addressing.

British Association of Perinatal Medicine (BAPM) standards have been utilised to provide the benchmark for staffing within the Neonatal Unit.

Theatre staffing is based on the Association for Perioperative Practice (AfPP) guidance. This methodology adopted supports efficient management of elective and scheduled operating sessions by effective use of resources and clinical efficiency in operating departments.

3.1 Care Hours Per Patient Per Day (CHPPD) and Actual versus Planned Care

From April 2016, following the Carter Review all Trusts were required to publish staffing fill rates of RN/RM and Care Staff by hours and percentages (Actual versus Planned) and CHPPD via the Strategic Data Collection Service (SDCS), run by NHS Digital. A summary of the submission is uploaded onto the Trust website each month. Appendix 1 highlights data submitted from January 2023-June 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 nurses/ midwives and nursing assistants 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.

Trustwide CHPPD in Q4 and Q1 (Appendix 1) has overall shown higher rates when compared to that in Q2 and Q3, which is positive given that lower rates can indicate a potential patient safety risk. When CHPPD is compared further on Model Hospital (April 2023 latest published data) it reflects LWH provider value is 9.2 (Quartile 3), with provider median 8.7. When LWH CHPPD is compared it highlights that 'My Region' peer median value is 9.0 (Quartile 3). When compared further to Birmingham Womens and Children's NHS Foundation Trust (My Peer) it highlights that LWH CHPPD value of 9.2 is lower than 'My Peer' with Birmingham Womens and Children's have a peer median of 12.8 (Quartile 4). Although it can be worthwhile comparing data on Model Hospital as very high rates of CHPPD may suggest an organisation has several unproductive wards or inefficient staff rostering processes, it is important to be mindful of comparing different types of wards and trusts.

4.0 Operational oversight of staffing and acuity-based care

A series of actions implemented in the Trust are undertaken on a monthly, weekly, and daily basis to manage safe and effective staffing and optimise care for women and babies across services and divisions. This is captured as:

- Monthly rosters sign off meetings undertaken by Heads of Nursing, Midwifery and AHP (NMAHPS) across all divisions, where roster effectiveness is challenged against roster compliance KPIs. Final roster approvals are signed off by Heads of NMAHPs.
- Weekly forward view of staffing overseen by Heads of NMAHP and Matrons.
- Maternity and Neonatal services provide information for staffing on a weekly basis to NHS Gold command.
- Staffing reported to Bronze (staffing meetings) twice daily (Mon-Fri) and recorded on Power BI (RAG rated). Any identification of risk is addressed and where not resolved escalated to Silver (daily huddle) for resolution. First on call manages staffing at weekends and bank holidays with support from site managers.
- RAG rated staffing matrix in place for Neonatal and Maternity. Acuity and activity review is undertaken at 10am/10pm and 12am/12pm each day with MDT jointly in NNU and Maternity; focusing on staffing, activity,

dependency, and ability to take women and babies recorded.

- Maternity operational oversight (104 bleep holder) completes 4 hourly oversight reviews of acuity, dependency and staffing to determine appropriate midwifery care across all areas. Helicopter role oversees and supports staff moves, staff breaks and care ratios
- Neonatal services adhere to national reporting to Cot Bureau three times daily
- Silver (daily huddle) informed of staffing position forecasted as they arise, into the following shift and ahead of a weekend.

4.1 Temporary Staffing

Since 22nd November 2021, NHS Professionals (NHSP) service commenced in the Trust. Operational oversight on a weekly basis continues and allows early resolution to issues arising. Early commencement of actions to reduce agency expenditure are in place.

The ongoing focus on recruitment and retention further aims to reduce the reliance on agency usage alongside the following actions:

- NHSP attendance at twice daily staffing meetings to support priority shift allocation
- NHSP team proactively manage agencies and cancellations
- Review and agree competitive incentives through NHSP Operational Group to support increase in fill rate
- NHSP Recruitment Team who will support with Bank Only recruitment
- Maternity roster management/forward view meeting to support decision making on shifts escalating to agency

NHSP continue to have a specific focus on Bank recruitment. The following is a summary of activity during Q4/Q1:

- NHSP reviewed agency cascade and removed higher cost agencies/ negotiated lower rates with agencies. Further review of high-cost agency including off framework usage to provide recommendations to cost save and utilised framework agency
- Weekly updates on agency spend provided to directorates/divisions.
- Weekly engagement ward walks from NHSP local team including seasonal promotional events to reward bank workers and encourage substantive staff sign up, ongoing with additional drop-in sessions held in depts to facilitate joining process
- Engagement with ward managers and matrons to maximise positive booking behaviours (encouraging high lead time and minimising bank member cancellations), ongoing- specific focus on booking behaviours and roster usage
- Worked with HealthRoster to support successful rollout of Allocate Software
- Bank midwife sponsored adverts on Indeed for Liverpool Region- Repeated in Q4
- Continued within Northwest region to promote LWH to current bank staff registered with NHSP
- Ongoing- Regionally sponsored adverts via Indeed and attendance at region recruitment fairs (universities etc.)
- Seeking midwife testimonials to support promotion of working at LWH
- Supporting review of bank pay rates and options for incentivized pay to reduce overall cost
- Seeking opportunity to migrate agency staff to NHSP where possible- 2 completed

All new starters broken down by role and recruitment type from January 2023-June 2023 are noted in Table 2. The figures reflect that overall, from the last reporting period (July-December 2022) there has been an increase in 5 more individuals on NHSP Bank..

Roles	Bank	Multi-post Holder (MPH)	Total
HCAs Band 2&3	35	10	45
Midwives	0	13	13
Nurses	5	8	13
Theatres	1	2	3
Radiographers	0	1	1
Total	41	33	75

Table 2: Number of individuals added new to NHSP Bank between January-June 2023

The performance of bank and agency demand and fill rate by directorate/division is reflected in Appendix 2.

The graphs (Appendix 2, Trustwide graph) reflect that overall that there has been a decrease in demand. Demand has decreased as we have moved through 2023 by 12% January 2023 versus June 2023. This is common moving from winter pressures into the summer period, where vacancy rates, and sickness rates fluctuate and improve which influences demand.

Year on year for the same complete 6-month period we have seen an overall increase of demand by 10% in 2023 compared to January - June 2022. However, within the last two months (May and June 2023) demand has aligned and slightly reduced from May-June 2022, which is positive and likely a reflection of substantive staff in post reducing demand.

Bank fill year on year increased by 30%. This has led to a total bank fill for Q4/Q1 of 61.4% compared to 51.8% for the same period in 2022. Agency fill within this period has decreased by 75% due to tighter controls inputted and maintained by the Trust and NHSP in partnership. Utilisation during Q4/Q1 demonstrates an average of 383.2 Bank workers (substantive staff on Bank as well as Bank only staff) were booking shifts each month. This is an increase of 65 individuals who booked at LWH on average per month January-June 2023.

The Trust has invested in the interface from Allocate Software as this enables unfilled shifts to be sent directly from HealthRoster to NHSP and then once filled they will interface to HealthRoster. Following a successful pilot of testing the interface between the systems, this has now been configured across all units managed on HealthRoster. Following the successful implementation of the interface, this is now the only option available for requesting NHSP staff. As end user access rights within the NHSP system have now been restricted, removing the facility of creating shifts and filling them outside of the HealthRoster process.

5.0 Trustwide Nursing, Midwifery and AHP Workforce Measures (January 2023-June 2023 data; Q4 & Q1 position)

5.1 Vacancy position

The data highlights the vacancy position in June 2023 (Table 3) for Nursing, Midwifery and AHP of 48.00wte, which is a reduction from previous reporting period (105.53wte in December 2022). This demonstrates a vacancy rate of 4.66%. Reassuringly, the vacancy rate has reduced from the previous reporting period (December 2022) where it was 10.12%.

The vacancy position of 48.00wte is largest in Family Health Division combined with 45.18wte (Neonatal, 29.65wte and Maternity, 15.53wte), followed by CSS Division (3.55wte) and Gynaecology Division including Hewitt Fertility Centre (over established by 0.73wte).

All divisions are actively recruiting to their vacancy positions.

Sum of Wte Budget	Sum of Wte Contracted	Sum of Vacancy
1,029.89	981.89	48.00

Table 3: June 2023 Trustwide NMAHP vacancy position

5.2 Maternity Leave

Table 4 highlights the rolling and relatively static position of staff on maternity leave across each staff group and Trustwide. The group of staff with the largest maternity leave are those who are registered midwifes or nurses. The overall maternity leave in June 2023 which is 40wte combined across all NMAHP staff groups reflects 3.14% of staff.

	Jan-23			Feb-23			Mar-23			Apr-23			May-23			Jun-23		
Figures based on 3 staff groups within clinical areas	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP
Overall Maternity of All 3 Staff Group WTE	6.00	30.21	1.60	6.00	31.21	2.20	6.00	30.29	3.00	6.00	29.21	4.55	6.00	32.37	4.55	5.00	30.45	4.55
	37.81			39.41			39.29			39.76			42.92			40.00		

Table 4: Maternity leave

5.3 Sickness absence

The combined sickness absence of NMAHP staff groups over the reported six-month period (Table 5) has remained high and above the Trust threshold of 4.50%, currently at 6.97% in June 2023. However, when compared with the previous six months, sickness is on a downward trajectory with the largest peak in sickness seen in January 2023 at 8.88% compared to that in the previous reporting period where peak sickness was at 11.12% (December 2022).

The lowest combined overall sickness rate was seen in May 2023 (6.74%) in the last six months.

Covid-19 related sickness remains very low and under 1% with June 2023 reflecting 0.23% and much improved overall from previous reporting period.

The overall percentage of sickness across the 3 staff groups in June 2023 is 6.97% with further breakdown of this illustrating the following:

- 6.74% was all non-covid related sickness
- 0.23% was covid-19 related sickness
- 0% was covid -19 special leave (this is not calculated in the sickness recorded)

	Jan-23			Feb-23			Mar-23			Apr-23			May-23			Jun-23		
	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP
Sickness	11.07%	8.03%	10.74%	10.10%	6.30%	7.52%	9.72%	7.07%	9.97%	11.02%	6.08%	6.93%	9.83%	5.64%	7.00%	10.12%	5.78%	8.21%
Overall Absence of All 3 Staff Group		8.88%			7.28%			7.87%			7.34%			6.74%			6.97%	
COVID Sickness	0.63%	0.96%	0.93%	0.83%	0.89%	0.16%	0.57%	0.58%	0.59%	1.16%	0.38%	0.00%	0.95%	0.07%	0.00%	0.71%	0.08%	0.09%
Overall Absence of All 3 Staff Group		0.88%			0.84%			0.84%			0.84%			0.28%			0.23%	
Sickness WITHOUT COVID Sickness	10.44%	7.07%	9.81%	9.26%	5.41%	7.36%	9.15%	6.50%	9.38%	9.86%	5.70%	6.93%	8.88%	5.56%	7.00%	9.41%	5.70%	8.12%
Overall Absence of All 3 Staff Group		8.00%			6.44%			7.03%			6.50%			6.46%			6.74%	
COVID Special Leave	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Overall Absence of All 3 Staff Group		0.00%			0.00%			0.00%			0.00%			0.00%			0.00%	

Table 5: All sickness absence

5.4 Long-term and short-term sickness

Sickness over the reporting period reflects that long-term sickness continues to remain the greatest challenge across all staff groups and has been for over 12 months. January 2023 (Table 6) shows the lowest long-term sickness rate at 61.41% for NMC staff group with May 2023 reflecting the highest levels of long-term sickness at 70.50%. The HCA

group reflects the lowest long-term sickness was recorded in February 2023 at 57.78% with highest rate recorded at 79.18% in May 2023. AHPs reflect significantly higher levels of long-term sickness when compared to other professional groups which is reflective of AHP's being a relatively small cohort of staff, which skews the data to appear disproportionately elevated when reviewing. May 2023 saw long-term sickness at its highest in the reporting period at 87.11%, this is lower than the highest long-term sickness reported in previous six months (93.21% in August 2022).

The Deputy Director of Nursing and Midwifery, alongside the Deputy Director of People have undertaken divisional long term sickness review meetings to ensure actions are in line with policy and appetite for alternative considerations to support earlier returns.

	Jan-23		Feb-23		Mar-23		Apr-23		May-23		Jun-23	
	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term
NMC Staff Group Trust Total	38.59%	61.41%	36.88%	63.12%	33.43%	66.57%	37.40%	62.60%	29.50%	70.50%	35.16%	64.84%
HCA Staff Group Trust Total	33.11%	66.89%	42.22%	57.78%	33.31%	66.69%	33.31%	66.69%	20.82%	79.18%	34.53%	65.47%
AHP Staff Group Trust Total	27.59%	72.41%	33.43%	66.57%	29.09%	70.91%	17.39%	82.61%	12.89%	87.11%	19.90%	80.10%

Table 6: Long-term and short-term sickness proportions

5.5 Turnover

The Trust turnover threshold is 13%. The position has fluctuated over the last six months (Table 7) with the AHP workforce reflecting higher turnover than threshold during January 2023-April 2023, however this is still much lower than had been seen in previous reporting period when peak of turnover in AHPs had been seen at 22.89% (October 2022). Since May 2023, AHPs have remained under turnover threshold noting that AHPs are a relatively small cohort of staff in small teams which artificially raises the percentage of turnover when the numbers of leavers may be only 1-2 staff. NMC staff groups have remained under threshold for the past 12 months whereas HCA staff group has been over threshold om November 2022 – February 2023 (4 months) 2022 over the last 12 months (July 2022 – June 2023.

	Jan-23			Feb-23			Mar-23			Apr-23			May-23			Jun-23		
	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP
Staff Group Trust Total	13.46%	9.89%	13.49%	13.45%	10.62%	15.09%	12.78%	9.37%	13.53%	11.78%	8.88%	16.16%	12.88%	9.00%	0.00%	12.84%	8.77%	9.38%

Table 7: Turnover

5.6 Age profile

Table 8 reflects the position overall across all NMAHP staff groups. The age profile in the staff groups overall have marginally shifted over most of the age bands, with recruitment having seen an increase in NMC filled posts within 26-30 and 31-35 age bands. There remains a risk in Nursing and Midwifery (NMC/HCA) to those who may retire now or in the next five years. As a percentage of the NMAHP workforce this is represented as 7.32% within 56-60 age bands and 4.20% within 61-65 age bands in NMC.

Headcount	Jan-23			Feb-23			Mar-23			Apr-23			May-23			Jun-23		
	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP
<=20 Years	3	0	0	3	0	0	4	0	0	4	0	0	4	0	0	3	0	0
21-25	28	70	1	28	69	1	27	68	4	28	69	4	28	69	0	30	70	3
26-30	32	90	3	38	96	3	36	101	3	35	102	3	35	101	4	33	99	4
31-35	27	131	14	28	130	14	28	136	15	29	140	14	32	136	3	29	143	15
36-40	33	94	6	38	92	6	37	100	9	37	99	9	36	91	15	36	90	10
41-45	29	93	10	28	92	10	33	97	10	32	99	10	31	93	9	32	95	9
46-50	25	78	6	24	75	6	24	75	5	24	77	5	26	68	9	23	70	8
51-55	31	78	7	35	76	8	33	85	9	34	84	8	34	81	7	35	77	10
56-60	25	84	4	26	88	4	26	92	3	27	90	2	26	85	8	24	82	2
61-65	28	40	2	28	41	3	27	44	3	27	45	3	27	45	2	26	47	3
66-70	5	3	0	5	3	0	6	3	0	6	3	0	6	4	3	6	4	0
>=71 Years	1	1	0	1	1	0	1	1	0	1	1	0	1	1	0	1	1	0
Total	267	762	53	282	763	55	282	802	61	284	809	58	286	774	60	278	778	64
Total of all 3 Staff Groups	1082			1100			1145			1151			1120			1120		

Table 8: NMAHP age profile data

6.0 Trustwide Nursing, Midwifery and AHP Training and Personal Development Review (January 2022-June 2022)

Across all staff groups it can be seen (Table 9) that the achievement and performance of training (MT, CMT, LMT) and Personal Development Reviews (PDRs) has been a fluctuating position across the six-months. Trust thresholds for indicators are as follows:

- Core Mandatory Training (CMT) – 95%
- Local Mandatory Training (LMT) – 95%
- Mandatory Training (MT) – 95%
- PDR – 90%

Over the reporting period it is evident that compliance has improved across all areas albeit all staff groups have not met the thresholds for all indicators.

In June 2023 the following indicators have been achieved:

- MT – in HCA and AHP staff group
- PDR – NMC staff group

When comparing June 2023 position across all four indicators with previous reporting period (December 2022) it is evident significant improvement in percentage compliance has been made across all indicators except for only one that is LMT in HCA group only which reflects a lower compliance rate of 78.06% in June 2023 compared to 82.52% in December 2022. The below data does not reflect where small teams in divisions may have met all targets within the reported periods. Divisional updates included (Appendix 4-7) reflect compliance within division and continued actions being taken to support a focus on improvement.

	Jan-23				Feb-23				Mar-23				Apr-23				May-23				Jun-23			
	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR
NMC Staff Group Trust Total	77.57%	74.91%	89.49%	74.40%	78.81%	74.67%	89.79%	73.50%	78.52%	73.98%	89.26%	66.91%	81.21%	79.97%	91.66%	71.69%	81.62%	81.28%	92.01%	76.50%	85.50%	83.96%	91.94%	90.00%
HCA Staff Group Trust Total	86.37%	83.15%	95.49%	72.22%	85.83%	81.05%	95.84%	72.85%	84.87%	77.54%	93.51%	72.94%	86.00%	78.37%	95.41%	67.11%	86.57%	80.36%	95.69%	69.20%	88.13%	78.06%	95.34%	79.75%
AHP Staff Group Trust Total	91.28%	94.79%	97.47%	81.40%	91.58%	92.55%	97.67%	90.48%	94.35%	87.88%	97.40%	91.11%	93.29%	87.16%	97.64%	86.96%	93.17%	92.59%	97.64%	86.96%	93.92%	93.51%	98.50%	86.27%

Table 9: Training and PDR data

7.0 Measurement of Quality of Care

7.1 Clinical Incident Reporting

The Trust has a local incident reporting system (Ulysses) that staff access to report any patient safety incident that is unintended or unexpected which could have (near miss) or did lead to harm, allowing the organisation to investigate, learn and take action to prevent re-occurrence. Incidents related to staffing levels are an example of incidents reported. The caveat to all incidents exists that validation and possible re-categorisation of cause groups may alter from when an incident was initially reported. This occurs following the review and closing of the incident by the division and merging subsequent upload to the National Reporting and Learning System (NRLS) by the Corporate Governance Team, therefore the data presented is still subject to potential minor changes, however, reflects an accurate record when downloaded.

The number of Trustwide clinical incidents reported within the last six months (January 2023-June 2023) can be seen in Table 10. The data further highlights the incidents related to staffing levels and/or staff sickness affecting staffing levels and is drawn from the overall incidents reported within the timeframe.

Since previous reporting period (July 2022-December 2022) a significant reduction of clinical incidents related to staffing has been seen with 227 incidents reported in this reporting period across divisions compared to 391 previously.

Of the total clinical incidents related to staffing, Family Health Division had the largest volume of 161; (Maternity, 157; Neonatal, 4), Clinical Support Services (CSS) Division reported 24 and Gynaecology Division reported 41. The greatest reduction in staffing related clinical incidents from previous reporting period was seen in Maternity and is likely a reflection of the improvements made with gross unavailability of staff.

Reporting Period January 2023- June 2023
Total clinical incidents reported = 3655
Total staffing levels/staff sickness incidents reported related to clinical incidents (combined divisions) = 227

Table 10**:** Trustwide overview of incidents

7.2 Red flag events

NICE guidance (2014, 2015) recommends that the Trust have a mechanism to capture “red flag” events (Appendix 3). The Trust has incorporated the reporting of red flag events into the Trust incident reporting system. Incidents can be triangulated against acuity and dependency and planned versus actual staffing levels for the day. Triangulation of data assists with informed decision making related to staffing.

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. All the red flags noted have been reported from Maternity services.

On closer analysis of reported red flags in Maternity between January 2023-June 2023, the 3 highest reported red flags following appropriate review are related to the delay in ongoing process of induction of labour >4 hours (40), delay of 30 minutes or more between presentation and triage (26) and occasions where one midwife is not able to provide continuous 1:1 care and support during established labour not met (12).

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 (v10). 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.

Divisional oversight of Red Flags is reported into the Trust Integrated Performance Report each month.

7.3 Serious Incidents

As highlighted by the Serious Incident Framework (NHSE, 2015) serious incidents in health care are events where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant that they warrant attention to ensure these incidents are identified correctly, investigated thoroughly and trigger actions that will prevent them from happening again. From September 2023 the Trust will launch the Patient Safety Incident Response Framework (PSIRF) under the NHS Standard Contract. As part of the NHS Patient Safety Strategy (NHSE/I, 2019) the Trust will see PSIRF replace the Serious Incident Framework (NHSE, 2015). Future reporting will reflect a hybrid of reporting via both approaches, until such time when only PSIRF reporting will be in place.

There was a total of Fifteen agreed serious incidents (SIs) in the Trust between January 2023-June 2023, which is a decrease from previous reporting period where the Trust had twenty-seven SIs. Of the fifteen SIs, five occurred in Maternity of which 2 related to ITU transfers and therefore to the Trusts single site challenge; 1 related to a patient suffering a Transfusion Associated Circulatory Overload (TACO) with the investigation still underway that will identify any learning. Two more SIs occurred where there were no common themes, 1 related to a missed dose of Anti-D and 1 related to an incorrect VTE assessment, leading to a postnatal Pulmonary Embolus. Neonates had three SIs (1 related to an invasive medical procedure carried out by medical staff and 2 related to skin injuries) and neither was impacted by staffing or single site risk.

Gynaecology Division had seven SIs of with the breakdown as follows: 1 emergency to Warrington from HFC, 1 relates to communication/patient deviation from protocol, 1 delay to follow up, 1 diagnosis delay, 1 misdiagnosis and 1 related to a control drug. In addition, there was 1 unexpected maternal death in this reporting period, patient was brought in by ambulance to GED with upper right upper quadrant and lower abdominal pain, she was 18 weeks pregnant the patient deteriorated and died. Actions from the Serious Incidents will be implemented and shared for lessons learned. CSS division reported no SIs.

7.4 Patient Experience - Friends and Family Test (FFT)

The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. Guidance sets out the requirement of FFT under the NHS Standard Contract for organisations (NHSE/I, 2019).

A total of **5361** "Overall Experience" comments were received during the period January 2023 to June 2023 from the overall **5770** FFT responses received.

Of these **337** (6.2%) comments were received by patients noting themselves as "displeased". Of these displeased comments **23** (7%), 16 were in Maternity, 6 in Gynaecology/Hewitt Fertility Centre and 1 classed as other mentioned staffing numbers/shortages in their description of their experience. These mainly related to Maternity but did cover other areas as well. The common theme of these continues to be a lack of support on the ward which the patients attributed to being understaffed.

The FFT asks patients "please tell us anything we could have done better". In the period from January 2023 to June 2023, **3460** comments were left in this section covering both Pleased and Displeased results. Of these **79** (2.3%) identified staffing numbers/shortages as something that needed to be improved, this is a reduced volume to that

reported in the previous reporting period. The majority of these related to Maternity services (47), followed by Gynaecology (30) and CSS (2).

Maternity mainly attributed to Maternity Base with common themes such as:

- Patients being concerned about the wellbeing of staff due to workload.
- waiting for pain relief/call bells/support
- delayed discharge

Gynaecology themes were:

- Struggling to contact GED/appointment lines
- Waiting time for clinic appointments
- Waiting times in GED

Maternity and Gynaecology have Quality Improvements underway to support the improvement work to address the themes notes.

7.5 Complaints, Concerns and Compliments

There were **26** formal complaints received in the Trust during January 2023– June 2023 which was a reduction of fourteen from previous six months (40). The breakdown reflects: Gynaecology 17 (10 of these were Hewitt), Maternity 8 and Corporate 1 (estates and facilities). These contained 102 individual categories of concerns that required investigation within these 26 complaints, a decrease of 186 individual concerns from the previous reporting period. An average of 4 categories of concerns raised per complaint (previously 7). Response rates for complaints answered in timeframe agreed with the complainants during this reporting period reflects 36% compliance (previously 50%). There were no complaint categories where staffing levels were raised specifically.

There were **23** PALS+ recorded during the reporting timeframe (a decrease of 12 from previous reporting) with no cases noting staffing in the issue raised. There were **1362** PALS cases noted within January 2023-June 2023 which is an increase from the previous reporting period (1174 reported). There were no PALS cases noted where shortages of staff were highlighted as the issue raised (4 in previous reporting period).

There was a total of **79** compliments Trustwide received (via PALS) within the timeframe which broadly covered general satisfaction of the service provided, which includes staff groups and individuals. Compared to the previous reporting period this is an increase 22 compliments. Of the 79 compliments the clinical divisions breakdown is: Gynaecology, 24; Maternity, 39; and CSS, 2. The remainder were in more than one area or in corporate services. All compliments, where possible when individuals are identified, are shared with the individual and their manager/leaders.

7.6 Staff Experience

Recognising that there can be challenges working in busy clinical roles at LWH, several interventions are in place to support staff and managers. We recognise safe staffing is the single most important determinant of employee morale, closely followed by supportive line management. LWH has implemented several strands of work to support the working lives of staff. Key actions taken over the reporting period include:

Health and Wellbeing – The LWH Staff Support Service is now established, led by a Consultant Psychologist, and supported by two externally funded wellbeing coaches and an Assistant Psychologist. Additionally, the decision to bring counselling provision back in house, recognising that the single biggest reason for absence is mental health. The team have supported the delivery of wellbeing conversations, completion rates for which currently stand at 54% (June

2023). The team are supporting individuals and services and is currently piloting trauma prevention workshops. They will work closely with PNAs and PMAs to ensure there is a joined-up offer of support for the N&M workforce.

Leadership and Management - Every N&M/AHP leader (alongside other professionals) are invited to undertake one of 3 programmes, which are accredited by the Chartered Management Institute. Over 100 staff have either completed or are currently engaged on a programme

- Aspiring leaders – Colleagues at the start of their leadership journey or considering leadership in their future career (anyone)
- First Line Emerging Leaders – New leaders or existing leaders who need to further skills and knowledge and learn the fundamentals of leadership
- Middle to Senior Leaders – Senior established Leaders looking to progress into more senior leadership roles

Flexible Working – Unlimited requests are now in place and working well in maternity, giving staff more control over their work life balance, similar schemes will be rolled out across other N&MAHP areas in the next quarter.

Breaks Audits - Breaks continue to be closely monitored, with a programme of ongoing audits and feedback on progress at Professional Forum. The next update is due to be received in July and August from audits undertaken in each division within June 2023.

Communications and engagement - The Trust continues to facilitate *Trust forums* designed to support staff or enable them to share their views including the *Great Place to Work Group* and *Schwartz Rounds,* however there is a continued need to achieve greater presence from N&MAHP. A focus on improved internal communication has taken place with the launch of '*3 key messages'*, a mix of Trust, divisional and local communications which is disseminated to staff through huddle and handover. Staff Survey action plans focus on 3 key areas of improvement and are tracked through Divisional Boards. 'Big Conversations' take place 2 or 3 times a year and is an opportunity for colleagues at all areas to have a voice and be part of making positive changes.

7.7 Staff reported incidents (Violence and Aggression)

During January 2023–June 2023 the number of reported incidents related to verbal or physical acts of violence or aggression against NMAHP staff is recorded as **13**. This is a reduction of 12 when compared with the previous reporting period (25), which continues to be a reduction over the past 12 months. Of the 13 incidents none of the incidents related to physical violence, with 8 recorded as visitor on staff incidents and 5 recorded as patient on staff. There were no trends or themes as all related to individual circumstances. Security was requested to attend on 3 occasions.

The breakdown of the 13 reported incidents in current reporting period (January 2023-June 2023) reflects Gynaecology services, 6; Neonates, 1; Maternity, 3 and CSS with 3.

There is continued emphasis on hearing staff views to make improvements on the experience of health and wellbeing as we recognise the low reporting may reflect under-reporting rather than simply an improvement in violence and aggression incidents in the Trust.

8.0 Attraction, Recruitment and Retention

The Learning and Development Facilitator in the Trust has a role in supporting the Trust attraction, recruitment, and retention plans. They do this in the following ways:

- Widening participation – aimed at people who may not possess academic qualifications yet have the attitude and values congruent to the NHS by supporting people and providing opportunities for development. The Trust has supported internship schemes for young people with additional needs. In the reporting period 6 interns have been supported to complete an 8-month placement with LWH in June 2023.

All interns identified as neurodiverse with one individual also identifying as having physical disabilities. The interns worked in areas of reception, kitchen stores, ward hostess, portering and estates. Of the 6 interns one is returning to LWH to undertake a supported apprenticeship, one has obtained a job as a maintenance assistant in a care home whilst studying at college. A further intern is going to college to learn carpentry, and another is going to undertake a catering course with the final student joining the step into work programme for 18- to 25-year-olds with learning difficulties, which combines work and education placements to ensure trainees are truly work ready.

- Acorns/Cadets – providing placements to 16–19-year-old college students studying a Level 3 Extended BTEC Diploma in Healthcare considering a career in the NHS. The Trust accommodated 3 learner placements during the reporting period in Neonatal Unit, MatBase Ward and Maternity Assessment Unit. It is too soon to measure the success of where the learners may go on to gain places in courses within Health
- Work Experience – During this reporting period work experience has slowly re-opened further to work directly with those schools where students have shown an interest in a career in health. We have provided one-week placements to 25 students, in areas such as Neonatal, Maternity, Gynaecology, Pharmacy and Corporate services. In addition, a group of Year 10 students visited the Trust and met professionals including those within HR, Finance, Pharmacy, Theatre (ODPs), Neonatal (nurses).
- Apprenticeships – 3 places filled with staff working in the areas of Finance, Digital and Clinical Advanced Practitioner from Gynaecology.
- Recruitment fairs and Careers events – the Trust actively attends and participates in fairs to share opportunities to communities on job availabilities. During January 2023-June 2023 the Trust attended a Careers event at Archbishop Beck where approximately 1,000 individuals attended to learn about the different careers available within Health. LWH attended with staff from the areas of Neonatal, Theatres, Pharmacy, HR, and Genetics. An additional careers event at St John Bosco was attended by LWH that involved approximately 800 students and included representation across divisions and corporate services also.
- Supporting schools – three staff from LWH attended Archbishop Blanch High School to take part in providing mock interviews for year 11 students.

In addition to the work led by the Learning and Development Facilitator the Trust also engages through wider teams an ambition to increasing diversity of new entrants across roles and salary bands as a priority. LWH has recently introduced a positive recruitment scheme based on race.

During the reporting period LWH was awarded funding for a 'volunteers to careers' programme which is focussed in transitioning volunteers into employment within maternity. In June 2023, Nine Volunteers formed our first cohort taking part in the new Volunteer to Career (VtC) programme. Many have already taken advantage of the training that's been made available to them i.e., Basic Life Support, Career Development (includes applying for jobs and interview techniques), National Volunteer Certificate, Supporting Patients with Additional Needs and Customer Care. We are also working towards them completing elements of the Care Certificate (excluding observations). In addition to the training the volunteers will each build a portfolio that includes a record of their training, certificates, witness statements from staff and patients, a list of objectives to achieve, templates for recording meetings with clinical staff and other useful information that could increase their chances of gaining employment within the trust or other healthcare organisations. The VtC volunteer's role is a newly created role on Maternity Base where they receive the support of Midwives and support workers. This is an ideal opportunity for the VtC volunteers to experience working in a clinical environment whilst supporting a multi-disciplinary team and patients. Within the cohort is a mixture of interest in registered and non-registered careers. For those who are aiming to work in the NHS in non-registered roles, they will be guaranteed interviews for support worker roles advertised within the hospital. We also expect to see those interested in registered roles, progress into further or higher education.

LWH also continues to recruit International Theatre Nurses through Cheshire International Recruitment Collaborative (CIRC). The current position reflects that during January 2023-June 2023, ten IRs arrived (6 nurses, 4 midwives) and

commenced in the Trust. Unfortunately, LWH had an attrition within the successfully appointed Theatre nurses (9/10 currently recruited to overall), however, has since successfully recruited to the 1 outstanding vacancy, with plans to be fully recruited when they arrive in the UK on 7th September 2023. On arrival to LWH all IRs have a full onboarding programme.

Ongoing recruitment of newly qualified nurses and midwives continues as students qualify and in line with vacancy position across all divisions. With the successful round of international recruitment within theatres and midwifery supported by a programme of onboarding and pastoral care coupled with vacancy levels and skill mix considerations, no further international recruitment is being undertaken at this juncture. Maternity are on track to fill all existing vacancies by October 2023.

9.0 Actions and recommendations:

The following actions are proposed during next six months (July 2023-December 2023):

- Succession planning across all divisions in line with business planning cycle
- Continued focus to recruiting to vacancy position
- Divisions to continue to review trajectories of improvement in Training and PDRs to be reviewed through monthly Divisional Performance Reviews
- Several actions related to ongoing work with NHSP such as:
    - Rolling adverts with focus on full bank recruitment and increase substantive staff registration
    - Attendance at future jobs fairs in region and attend any relevant LWH recruitment events.
- Continued focus on the nursing and midwifery self-assessment tool/retention improvement and action plan
- Learning and action to be taken forward from high profile trial related to baby deaths in Neonatal services with a review of revalidation policy and professional/practice competencies aligned to posts
- Creation of a NMAHP workstream planned to commence in September 2023 to support the Trust's Strategic Objective in relation to maximising the potential of our workforce, additionally the workstream will look to understand investments and leadership requirements of the future

10.0 Conclusions

The Board is asked to recognise that managing Nursing, Midwifery and AHP staffing is not without risk (as noted on the CRR), however this is effectively managed by utilising a triangulated approach and through a series of actions, escalations, and mitigations to support delivery of safe patient care.

The Board is requested to agree and support the actions and recommendations highlighted in Section 9.0 of the report.

Furthermore, the Board requested to gain assurance from the divisional level staffing reviews provided in Appendices 4-7 that further supports divisional level oversight and actions to address areas of challenge. Specifically noting that Maternity services report staffing twice yearly directly to Trust Board to fulfil requirements as outlined by The Maternity Incentive Scheme (MIS) Year 5, Safety Action 5. Neonatal services provide Trust Board with a yearly Clinical Negligence Scheme for Trusts (CNST) compliance report.

Appendix 1 – CHPPD and Actual versus Planned Fill Rates

The NHS Digital Return via Strategic Data Collection Service (SDCS) - Safe Staffing Fill Rate each month are noted as per below from July 2022–December 2022. The data is presented monthly to Trust Board via the Integrated Performance Report, supported by a detailed narrative and triangulation of information from the Heads of Nursing and Midwifery.

January 2023

WARD	Fill Rate Day% RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff
Gynae Ward	96.0%	92.5%	150.0%	98.4%
Induction & Delivery Suites	77.4%	92.5%	85.9%	98.4%
Maternity & Jeffcoate	95.6%	68.5%	77.0%	85.5%
MLU	81.5%	61.3%	82.3%	67.7%
Neonates (ExTC)	96.8%	91.9%	99.7%	79.0%
Transitional Care	29.0%	125.8%	61.3%	93.5%

February 2023

WARD	Fill Rate Day% RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff
Gynae Ward	92.0%	85.7%	146.4%	100.0%
Induction & Delivery Suites	81.3%	86.9%	92.6%	98.2%
Maternity & Jeffcoate	93.8%	93.8%	82.1%	91.1%
MLU	82.1%	60.7%	82.1%	75.0%
Neonates (ExTC)	96.4%	92.9%	99.2%	76.8%
Transitional Care	21.4%	139.3%	42.9%	114.3%

March 2023

WARD	Fill Rate Day% RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff
Gynae Ward	88.7%	90.3%	145.2%	101.6%
Induction & Delivery Suites	86.1%	82.8%	90.1%	91.9%
Maternity & Jeffcoate	89.1%	109.7%	90.3%	102.4%
MLU	86.3%	61.3%	78.2%	67.7%
Neonates (ExTC)	100.3%	95.2%	101.0%	87.1%
Transitional Care	35.5%	90.3%	51.6%	58.1%

April 2023

WARD	Fill Rate Day% RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff
Gynae Ward	90.8%	83.3%	130.0%	100.0%
Induction & Delivery Suites	85.9%	85.6%	87.9%	95.0%
Maternity & Jeffcoate	84.6%	112.5%	89.0%	100.8%
MLU	85.8%	86.7%	76.7%	80.0%
Neonates (ExTC)	100.7%	126.7%	100.4%	106.7%
Transitional Care	30.0%	83.3%	43.3%	70.0%

May 2023

WARD	Fill Rate Day% RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff
Gynae Ward	96.0%	93.5%	150.0%	96.8%
Induction & Delivery Suites	83.0%	90.3%	76.3%	85.5%
Maternity & Jeffcoate	93.5%	113.7%	84.8%	112.9%
MLU	87.1%	64.5%	87.9%	77.4%
Neonates (ExTC)	101.0%	111.3%	100.7%	122.6%
Transitional Care	48.4%	106.5%	35.5%	93.5%

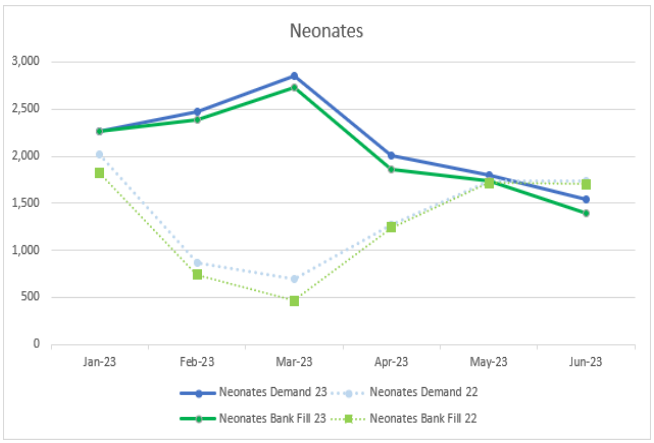
June 2023

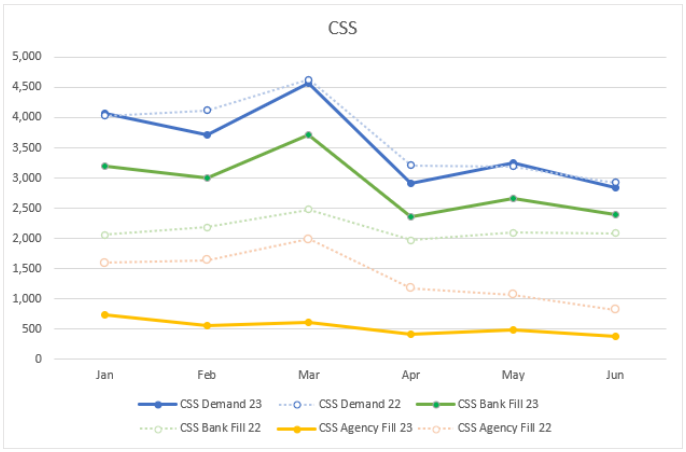
WARD	Fill Rate Day% RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff
Gynae Ward	85.8%	78.9%	133.3%	98.3%
Induction & Delivery Suites	79.8%	83.3%	82.9%	96.7%
Maternity & Jeffcoate	77.1%	111.7%	82.4%	106.7%
MLU	87.5%	60.0%	92.5%	56.7%
Neonates (ExTC)	94.9%	115.0%	96.5%	105.0%
Transitional Care	26.7%	110.0%	40.0%	93.3%

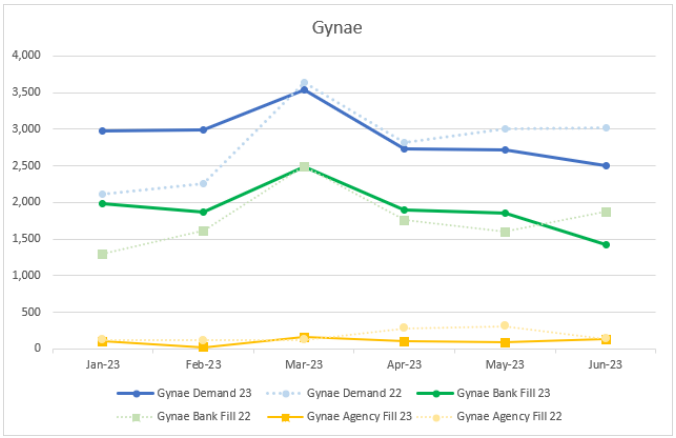
Trustwide CHPPD

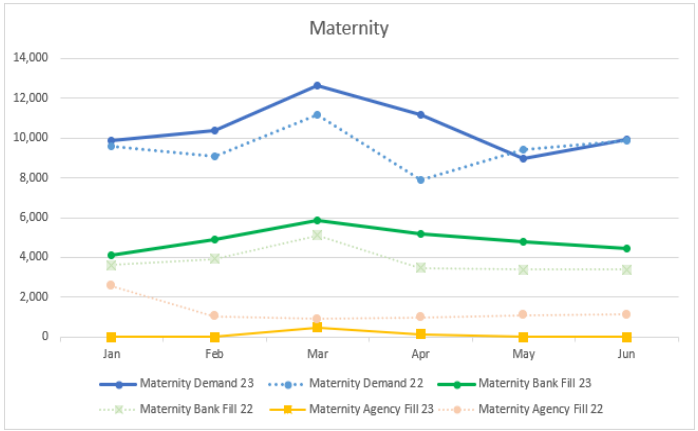
CHPPD	January 23	February 23	March 23	April 23	May 23	June 23
Trust wide	10.6	8.8	8.7	9.2	9.7	9.9

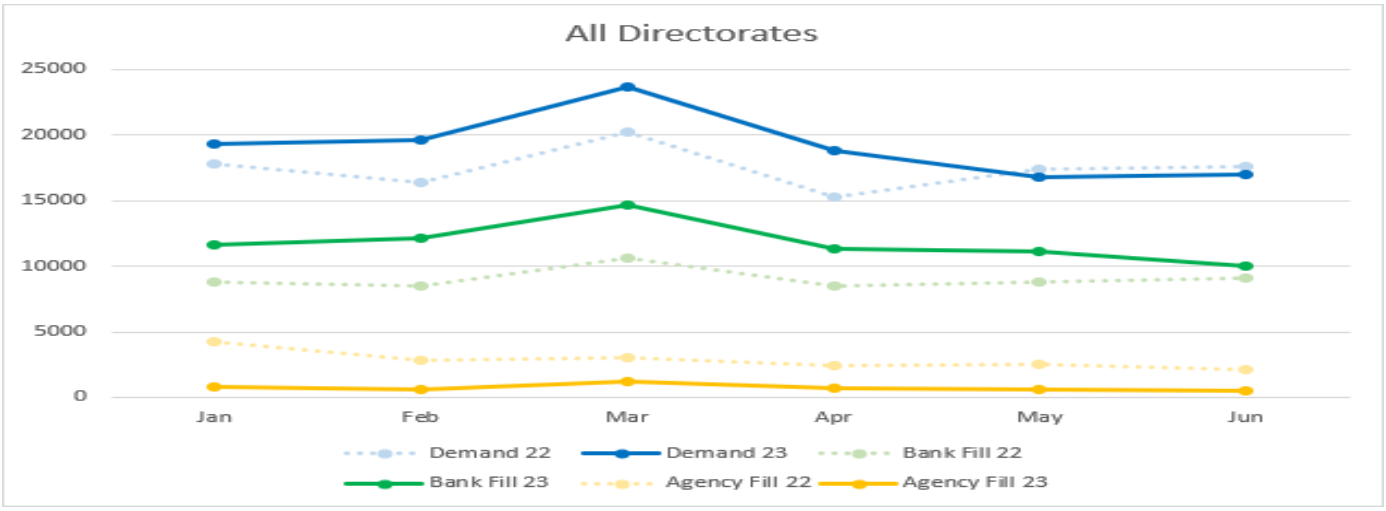
Appendix 2: NHSP January 2023- June 2023 Bank and Agency demand and fill rates by Division and Trustwide











Appendix 3: NICE Guidance on Red Flag Events

Midwifery Red Flag Events (NICE NG54-Safe midwifery staffing for maternity settings, 2015)

A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing. If a midwifery red flag event occurs, the midwife in charge of the service should be notified. The midwife in charge should determine whether midwifery staffing is the cause, and the action that is needed.

- Delayed or cancelled time critical activity.
- Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing).
- Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication).
- Delay of more than 30 minutes in providing pain relief.
- Delay of 30 minutes or more between presentation and triage.
- Full clinical examination not carried out when presenting in labour.
- Delay of 2 hours or more between admission for induction and beginning of process.
- Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output).
- Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour.

Other midwifery red flags may be agreed locally.

Nursing Red Flag Events (Nice SG1 – Safe staffing for nursing in adult inpatient wards in acute hospitals, 2014)

A nursing red flag event is a warning sign that something may be wrong with nurse staffing. If a red flag event occurs, the nurse in charge of the service should be notified. The nurse in charge should determine whether nurse staffing is the cause, and the action that is needed.

- Unplanned omission in providing patient medications.
- Delay of more than 30 minutes in providing pain relief.
- Patient vital signs not assessed or recorded as outlined in the care plan.
- Delay or omission of regular checks on patients to ensure that their fundamental care needs are met as outlined in the care plan. Carrying out these checks is often referred to as 'intentional rounding' and covers aspects of care such as:
    - Pain: asking patients to describe their level of pain level using the local pain assessment tool.
    - Personal needs: such as scheduling patient visits to the toilet or bathroom to avoid risk of falls and providing hydration.
    - Placement: making sure that the items a patient needs are within easy reach.
    - Positioning: making sure that the patient is comfortable, and the risk of pressure ulcers is assessed and minimised.
- A shortfall of more than 8 hours or 25% (whichever is reached first) of registered nurse time available compared with the actual requirement for the shift. For example, if a shift requires 40 hours of registered

nurse time, a red flag event would occur if less than 32 hours of registered nurse time is available for that shift. If a shift requires 15 hours of registered nurse time, a red flag event would occur if 11 hours or less of registered nurse time is available for that shift (which is the loss of more than 25% of the required registered nurse time).

- Less than 2 registered nurses present on a ward during any shift.

Other nursing red flag events may be agreed locally.

Appendix 4: Maternity staffing overview January 2023-June 2023

1.0 Introduction

To provide the Putting People First Committee with a six-monthly update of the 2023/2024 staffing establishment reviews in relation to midwifery workforce requirements. To report against the workforce requirements identified in 2023/2024 to achieve safe staffing across Maternity Services in the Trust.

2.0 Workforce planning- Birth Rate Plus

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 April 2023 and the report received in May 2023. Included in the assessment is the staffing required for antenatal, intrapartum, and postnatal inpatient and outpatient services, including community births. Birth Rate+ calculates the clinical establishment based on agreed standards of care and includes the midwifery management and specialist roles required to manage maternity services. A skill mix of 90/10 is applied to clinical staffing between midwives and maternity support workers (Band 3). 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 for midwives and 21.4% uplift for MSW's has been calculated to enable this.

3.0 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 348.18wte which is **5.35wte below** the BR+ audit recommendation. 5.00wte clinical midwifery posts have been allocated by finance to a Cost Improvement Programme (CIP).

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.

Midwifery and MSW funded establishment 2023/24 compared to the Birth Rate Plus audit requirements May 2023. Also illustrated in Table 1 is the contracted staffing establishment for month 3, financial year 23/24.

Table 1 - Funded Establishment	2023/24 BRP Reccomendation Wte	2023/24 LWH Funded Establishment Wte	2023/24 Variance Budget to BRP Wte	M3 Contracted Establishment Wte	M3 Variance to Budget Wte
Clinical	287.87	287.37	- 0.50	267.29	20.08
Clinical - Support Staff	30.11	30.06	- 0.05	30.87	- 0.81
Total Direct Care Giving Midwives	317.98	317.43	- 0.55	298.16	19.27
Non-Direct Care	35.55	35.75	0.20	34.92	0.83
Total Budget to BRP Model	353.53	353.18	- 0.35	333.08	20.10
Clinical - CIP		- 5.00	- 5.00	-	- 5.00
Total Budget to BRP Model Inc CIP Targ	353.53	348.18	- 5.35	333.08	15.10
Clinical		8.17		6.24	1.93
Clinical - Support Staff		54.98		52.56	2.42
A&C		28.20		25.05	3.15
Total Funded Roles outside of the BRP	-	91.35	-	83.85	7.50
Total Establishment	353.53	439.53	- 5.35	416.93	22.60

Table 1- Funded establishment 2023/24

All midwifery budget holders/managers have reviewed their budgeted establishments for financial year 2023/24 and signed them off with caveats.

3.1 Care Hours Per Patient Per Day (CHPPD)

	DAY Average fill rate Midwives (%)	DAY Average fill rate Support staff (%)	NIGHT Average fill rate Midwives (%)	NIGHT Average fill rate Support staff (%)
Induction of Labour and Delivery Suite	82.25%	86.9%	85.95%	94.2%
Maternity Base and Jeffcoate	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.

CHPPD data is rarely referenced in Maternity Services, and not included in national reports. However, maternity services do review CHPPD and comment on this within the monthly fill rates report submitted within the integrated board report that Trust Board receives each month.

3.2 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 shift 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

4.1 Midwifery vacancies:

Reflected in Table 3 is the midwifery vacancy rate against the midwifery establishment and maternity leave rate in month 3, financial year 23/24.

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.

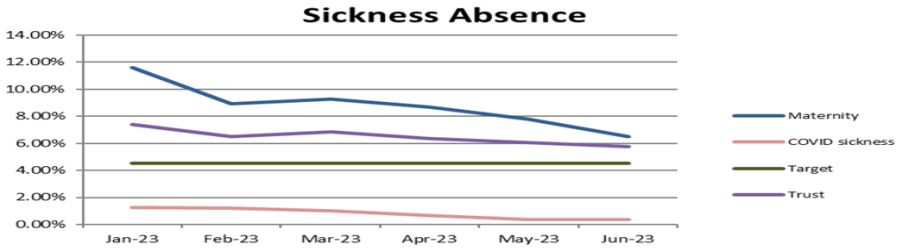


Table 5: Sickness absence

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 a further seven planned 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.

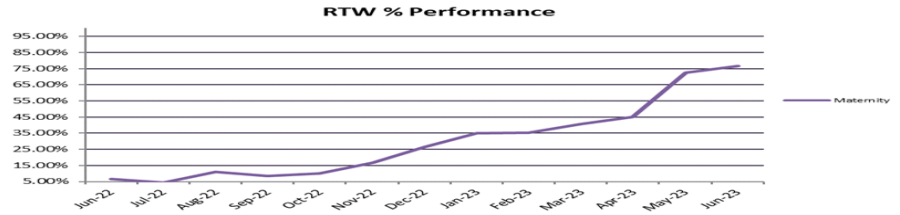


Table 6: Return to work interviews

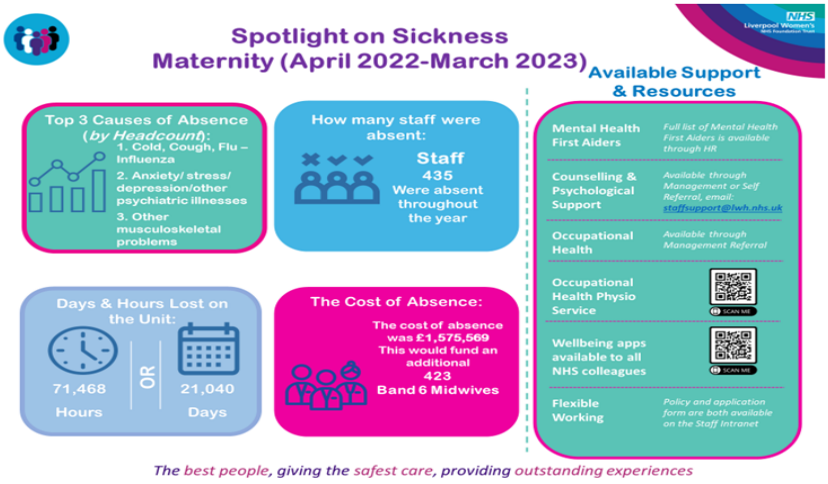
There has also been a focus on ensuring all staff have an annual Health and Wellbeing conversation. Health and Wellbeing conversations are supportive, coaching-style one to one conversations that focus on the wellbeing of our staff, they are also an integral part of the NHS wide People Plan as the overall 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 Health & Wellbeing 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.

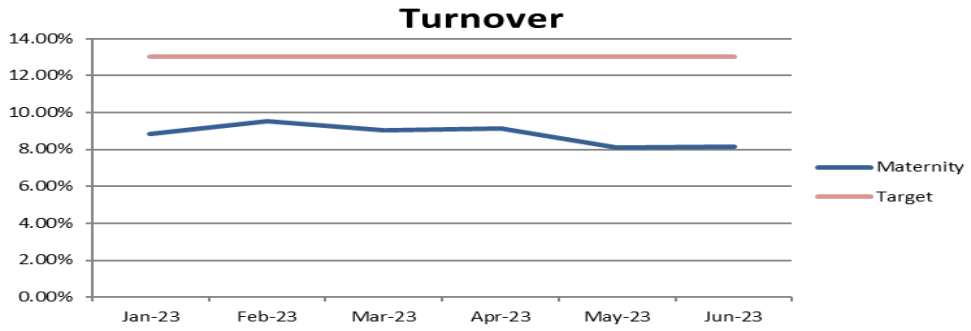


Table 7: Turnover

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 10. The Division have 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.

	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%↑

Table 9: Training and PDR

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 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 27 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: 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).

7.0: 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.

Midwifery Red flag reporting is a key component indicator reported against in the Maternity Incentive Scheme (MIS), Year 5 papers presented to Trust Board in the Bi- Annual Maternity Safe Staffing Report. 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	

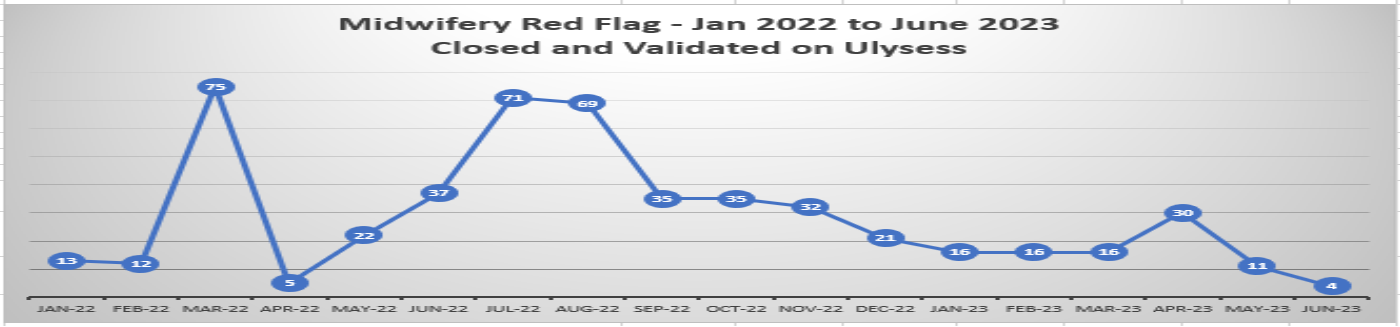


Table 13: Red flag themes

7.1: 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.

8.0: Patient Experience

8.1 Complaints and Compliments

During this period the Maternity Directorate received a total of eight complaints with seven received between January-March 2023. Three complaints were received between April-May 2023 which related to clinical treatments, admissions and discharges and communication. All complaint investigations have been completed and closed. Identified leads are currently working on addressing and completing SMART actions derived from the complaint investigations.

In addition to the formal complaints received, the Maternity Directorate received and addressed 107 PALS queries. Meetings were arranged with a designated staff member/ lead with the aim of supporting the service user to resolve their concern. All learning is shared with maternity staff at the Maternity Risk and Clinical monthly meeting.

8.2 Maternity Voice Partnership (MVP)

Maternity staff meet with the MVP Chair on a weekly basis to discuss and address any issues raised by service users. On Sunday 30th April the Maternity Voices Partnership (MVP) undertook 'Fifteen Steps for Maternity inspection' on Maternity Base which was reported to be successful. There was positive feedback in relation to staff who were described as warm, friendly, attentive, and polite. The Chair of the MVP has written a report including some

recommendations from the 15 steps that took place on Maternity Base. A further Fifteen Steps is to take place on MAU in the Autumn.

A pilot project is in place on Maternity Base, 24hr visiting for birthing partners. Feedback to the MVP has been positive and a full evaluation will be conducted by the Patient Experience Team.

The next MVP quarterly meeting will be held in July, with the invitation extended to neonatal colleagues. Part of the meeting will be discussing the transition from a Maternity Voices Partnership (MVP) to a Maternity and Neonatal Voices Partnership (MNVP).

8.3 Friends and Family Feedback

A total of 1088 FFT responses were received during the six-month period January-June 2023. 78% (856) responses said they were pleased with the care and treatment they received, 12% (133) were displeased with the remaining 10% stating neither pleased or displeased or having been left blank. Many responses acknowledge that staff were caring and kind, but there was a view from the families that reduced staffing had contributed to the lack of support and delays in care particularly on the postnatal ward.

Top 4 Themes for Maternity Services based on displeased comments:

- Delays in administration of medication/pain relief. To address this concern a midwife is allocated on each shift on Maternity Base to administer medication.
- Delays in discharge- this area of concern is included in the Maternity Base improvement group where Pharmacy are now present on Maternity Base from 10am to 12 noon to support discharges and TTOs.
- Staff attitude and behaviour- Intentional Rounding has been introduced on Maternity Base, which involves the Matron, Ward Manager or shift leader speaking to every inpatient daily to ask them about their experience on the ward, and to address at the point of care any concerns that they may have.
- Patients requesting that their birthing partner be permitted to stay with them on the ward to provide support. A pilot project is in place in partnership with the MVP allowing 24hr visiting for birthing partners.

The Maternity Transformation programme have a wide-ranging plan to improve many areas of patient experience including improving information, discharge processes and physical/ digital support to patients. The results of this work as it is implemented should be evident in improved FFT satisfaction and recommendation scores.

9.0: Maternity Triage performance

Significant improvement has been achieved since the 28 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 31 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 31 July 2023, performance has superseded the trajectory with 83.39% compliance in 15minutes triage achieved by the 17 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 28 January 2023.

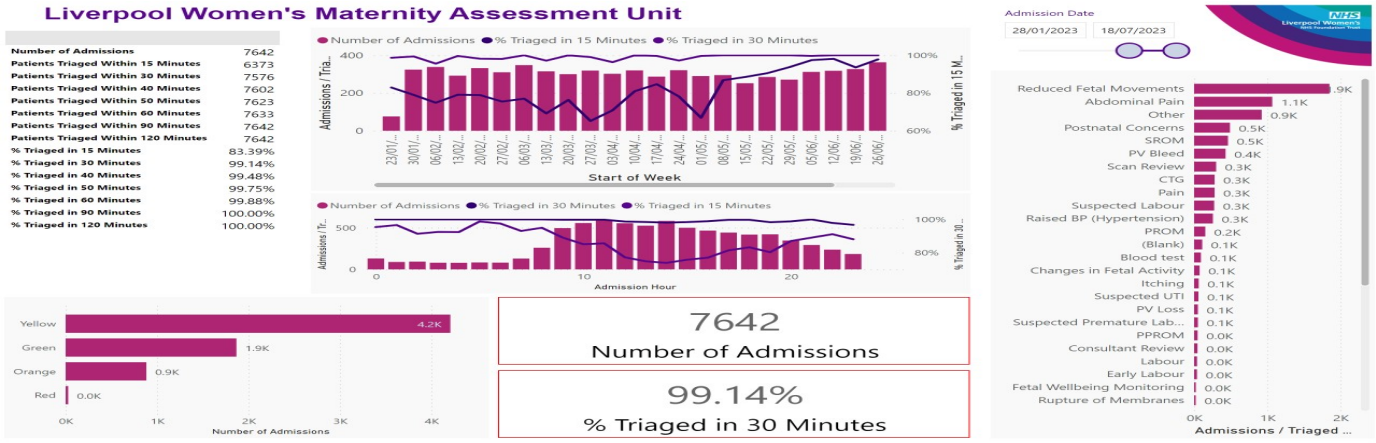


Table 14: MAU admissions and Triage assessment times

10.0: 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.

11.0: Actions and recommendations:

Update against previously reported actions taken during January 2023-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.

Actions to be taken July 2023-December 2023:

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.

12.0: Conclusion

It is recommended that the Putting People First Committee 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.

Appendix 5: Neonatal staffing overview January 2023-June 2023

1.0 Introduction

This paper is to provide assurance to the Committee that the Neonatal Services workforce is safe and sustainable and can deliver services now and into the future.

2.0 Background

2.1 Nursing

The workforce with the Neonatal Intensive Care Unit (NICU) comprises of both registered and non-registered nurses. The registered staff are made up of Advanced Neonatal Nurse Practitioners (ANNP) and Nurses from a background Adult, Children, and midwifery training. Over 70% of the nurses on the unit have completed a speciality course in the care the preterm and sick babies this allows them to be registered as nurses who are qualified in speciality (QIS).

Currently, we have a small number of non-registered staff who work within the low dependency (LD) nursery and the transitional care unit (TC). They are responsible for most of the delivery of care to the babies within these areas with the only limitation being the inability to give certain medications. LWH has a standalone TC with its own budget and staffing.

Neonatal Community Outreach is also supported by the TC team. This is provided 6-7 days a week for babies from both the Neonatal Unit and Transitional Care, this allows for earlier and a smooth and confident transition home.

At LWH we continue to be very successful in the recruitment of staff and currently have a very low vacancy rate across all bands. We have also had great success with internal recruitment and have embedded our talent pool into our recruitment process (internal candidates). Turnover remains below the national average at 7% and we have reduced the aging age profile of the unit.

For newly qualified staff or those appointed without previous neonatal experience they are enrolled on the Neonatal Induction Programme, this is run jointly with NorthWest Neonatal Operational Delivery Network (NWNODN). Following a 12-month consolidation period, staff are then progressed on to the Neonatal Qualification in Speciality course (QIS) to enhance their knowledge and skills. This is run at LWH and validated by Liverpool John Moore's University at Level 6, and it is a requirement that at least 70% of our staff hold this qualification. (DoH, 2009, Toolkit for High Quality Neonatal Services).

Nurses on NICU are also responsible for the delivery of the IV antibiotics and BCG immunisations for all eligible babies born at Liverpool Women's.

2.2 Advanced Clinical Practice (ACP)

The role of the ANNP is an integral part of safe and effective care delivery at LWH.

Currently there are 25.08 wte ANNPs plus 4 in year 2 of training and another 4 that have just commenced their first year of training.

The team is well established with levels of experience within the existing team of ANNPs ranging from new to post to 26 years post qualification. The team has been led by a Team of 8b Lead ANNP's. Seven 8b lead ANNPs (6.28 WTE), with the Nurse Consultant undertaking the Deputy Head of Nursing post. This reflects the ambition of the new national framework for ACP.

The British Association of Perinatal Medicine acknowledges that ANNPS work at both Tier 1 and Tier 2 level. Tier 2 ANNPs work at registrar level (ST 3-8) undertaking senior responsibilities both day and night. Tier 1 ANNPs work at ST 1-3 level, working under direct supervision of a tier 2 ANNP or doctor.

The current ANNP team at LWH comprises of:

- Band 8b – 6.28 wte
- Band 8a - 14.96 wte
- Band 7 – 4.84 wte
- Band 6 – 4 wte

The team have been awarded a further 4 trainee ANNP funding for course to start in Jan 2024.

Recruitment of trained and experienced ANNP's is a challenge and with more options now available at higher banding, there is a slight drift in retention. To address this issue relating to difficulty in recruitment when post has been out to advert previously, the team will prepare a business case to highlight the need to develop a band 8b team that works on tier 2 of the medical rota. This is an integral piece of work to ensure safer staffing at ANNP level and to ensure the safe practice and care of neonates across the partnership.

2.3 Transport

Tier 2 ANNPS currently provide Tier 2 medical cover (1.6 WTE) for out of hours emergency transport for connect NW the northwest ODN Neonatal Transport team. This will reduce to 1 wte in November 2023 and will be a tier 1 ANNP. The service will go off site in November due to the large footprint coverage of the team requirements and intention of one central base at Warrington. This has been agreed through the network and commissioners, therefore LWH is supporting this service through 1wte.

3.0 Workforce planning - Setting evidenced based establishments

Neonatal Nursing has become one of the most prescribed areas of nursing over the last years. In line with other intensive care specialities BAPM has set clear standards around the minimum number of nurses required to care for our client group. This is set in the national specification for neonatal care and is clearly defined by the specialist commissioners in hospital contracts. BAPM standards can be reviewed in the link below:
http://www.bapm.org/publications/documents/guidelines/BAPM_Standards_Final_Aug2010.pdf

Neonatal Units have also seen the introduction of the safer staffing guidance for Neonatal services, this reflects the requirements of the BAPM guidance but also addresses ways in which professional judgement should be used to ensure safer staffing on units. This way of working has been in use on the NICU since early 2017 and has helped ensure we maintain safe and appropriate levels of staffing.
https://improvement.nhs.uk/resources/safe-staffing-neonatal-care-and-children-and-young-peoples-services/

There is also a requirement to have quality roles extra to the establishment; these include education, breast feeding, infection control, development care.

Neonatal staffing establishments have been reviewed closely by the Matron and Assistant Head of Nursing and agreed with some caveats which are being worked through.

The above requirements have been highlighted with some provision in the Neonatal staffing budgets for 2022/23. These budgets are rota based as reviewed and agreed by the Head of Neonates and the Deputy Director of Nursing & Midwifery.

3.1 Staffing Tool

The CRG Workforce Calculator (2020) is used by commissioners to define staffing establishments in line with activity for NICU across England. It is intended to support neonatal nurse managers and their colleagues by providing a consistent method for the calculation of nursing establishment requirements which meet national standards i.e., NHSI (2018); NHSE Neonatal Service Specification e08 (2015); DH (2009); BAPM (2010); NICE (2010). There is a mandatory annual review by the NWNODN and it is a requirement of CNST that the CRG tool is used. Below are the figures for this period of reporting.

CRG calculator calculations have identified the following in relation to the Neonatal Service at LWH for the last 6 months.

- 89.1 % of our workforce are registered nurses, this needs to increase to 92.6%. This gap will be reflective of current levels of activity and acuity.
- 74.6% are Qualified in speciality this again needs to increase to 81.4%, this will also be reflective of increased activity and acuity. Once the current cohort qualify in September this threshold will be met.
- The tool informs us that while occupancy and acuity have increased, we have the required workforce to maintain safer staffing levels. What the tool does not highlight, is the need for quality role within the service. Therefore, often to support some of the quality roles cotside nurses are used when acuity and occupancy allow. This includes bereavement, FiCare, ROP, infant feeding etc.

The CRG tool focuses on the cotside nurses and what is evident is over the last 6 months activity on the NICU has continued to be increased, this has meant that the number of cotside nurses required has increased. Since this is activity out of the normal expectations when compared with previous 3 years, no recruitment has been requested against this activity. This activity has been supported with increased use of bank staff. There has been no agency staff used. The NWNODN and specialist commissioners have recognised this activity in year and have supported this financially. NWNODN and specialist commissioners do not believe that this increase in activity will continue in long term.

The team have reviewed quality roles and agreed that within these roles there are some essential roles and should be removed from cotside numbers, these include FICare, palliative care, ROP screening, breast feeding, clinic support. Other than palliative care all these roles are less than 0.5wte. Funding toward governance nurse and education (1.5wte) have been awarded through the NCCR. These posts are awaiting approval through the Trust recruitment process.

Establishment is reviewed and discussed with network throughout the year. Recruitment and training plans are in place to continue to develop and support all roles within the Liverpool neonatal partnership.

3.2 Care Hours Per Patient Per Day (CHPPD) and Actual versus Planned Care

CHPPD hours are recorded monthly as per national requirements and are used as a tool to help ensure safer staffing. This numbers have been consistent and reviewed monthly throughout the year. They are reflective of the occupancy and acuity of the unit.

Unit occupancy over the period from has been high, with mean occupancy rates for the 6-month period of 82%. Of ITU occupancy was at > 85% for the entire 6-month period. Staffing fill rates were reflective of this high acuity to ensure safety was maintained.

Transitional care occupancy has been variable, mean occupancy 44.2%, in addition care was extended to babies on the small baby pathway, ward antibiotics and babies on risk of hypoglycaemia pathway. Staffing rates reflected this activity throughout the period

3.3 Operational oversight of staffing and acuity-based care

A series of actions are taken on a yearly, monthly, weekly, and daily basis to manage safe and effective staffing and optimise care for women, babies across services and divisions. This is captured as:

- Yearly oversight by the Northwest Neonatal Operational Deliver Network (NWNODN) using the CRG Nursing calculator
- Monthly rosters sign off meetings undertaken Head of Nursing across all rotas where roster effectiveness is challenged against roster compliance KPIs. Final roster approvals are signed off by Heads of Nursing (HoN).
- Weekly forward view of staffing overseen by Matron and Ward Manager.
- Neonatal services provide information for staffing on a weekly basis to NHS Gold command.
- Staffing reported to Bronze (staffing meetings) twice daily (Mon-Fri) and recorded on Power BI (RAG rated). Any identification of risk is addressed and where not resolved escalated to Silver (daily huddle) for resolution. First on call manage staffing at weekends and bank holidays.
- RAG rated staffing matrix in place for NICU. Acuity and activity review is undertaken at 10am/10pm and 12am/12pm each day with MDT jointly in NNU and Maternity; focusing on staffing, activity, dependency, and ability to take women and babies recorded.
- Neonatal services adhere to national reporting to Cot Bureau three times daily
- Silver (daily huddle) informed of staffing forecasts position as they arise, into the following shift and ahead of a weekend.

3.4 Temporary Staffing

The neonatal service use NHSP for any shifts that have not been filled due to vacancy, sickness, maternity leave and special leave. Due to increased sickness, activity and acuity we can see below the levels of bank staff required to ensure safer staffing. All shifts were covered by staff on substantive contract or staff who were previously employed on the unit. No agency staff were used. Specialised commissioners recognised the increased activity at the of year and £1.3 was added to support those extra cost. The specialised commissioners are fully aware of the continued increase in acuity and activity and the relevant business partners are discussing how those financial needs are met.

Banding	GBP					
	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
809500-B5 Qualified Bank Nurse	£ -	£ 53,873	£ 57,852	£ 29,138	£ 36,443	£ 25,488
809600-B6 Qualified Bank Nurse	£ 61,146	£ 6,241	£ 40,053	£ 18,932	£ 20,163	£ 15,178
809700-B7 Qualified Bank Nurse	£ 2,189	£ 7,683	£ 9,009	£ 738	£ 2,010	£ 2,972
809800-B8 Qualified Bank Nurse	£ -	£ -	£ -			
811300-B3 Unqualified Bank Nurse	£ -	£ -	£ -			
811920-B2 Unqualified Bank Midwives	£ 218	£ 1,313	-£ 1,530	£ -	£ 895	-£ 895
811960-B6 Qualified Bank Midwives	-£ 244	-£ 1	£ -			
811970-B7 Qualified Bank Midwives	£ -	£ -	£ -			
Total	£ 63,308	£ 69,109	£ 105,983	£ 48,808	£ 59,511	£ 42,743

Table 1: Bank requirements

4.0 Neonatal Nursing Workforce Measures January 2023-June 2023

4.1 Vacancy position

The data highlights the vacancy position at end of June 2023 (Table 2) for Nursing with a total of 15.21 wte registered nursing staff and 7.96 ANNP's, 2 wte are allocated to the LNP, and 5.94 wte non- registered staff. Delays in the approval process has seen these number rise to higher levels than usual. All posts are out to advert.

⊟NEONATAL	B2 HEALTHCARE ASSISTANT	10.39	6.80	5.53	3.59
	B2 SUPPORT STAFF	0.00	0.00	0.00	0.00
	B3 HEALTHCARE ASSISTANT	11.97	12.04	12.11	-0.07
	B4 UNQUALIFIED NURSE	10.49	8.07	8.14	2.42
	B5 QUALIFIED NURSE	82.57	75.01	68.14	7.56
	B6 QUALIFIED NURSE	57.62	48.37	46.44	9.25
	B7 QUALIFIED NURSE	14.99	16.05	16.08	-1.06
	B8 QUALIFIED NURSE	31.52	23.56	19.90	7.96
NEONATAL Total		**219.55**	**189.90**	**189.49**	**29.65**

Table 2: June 2023, Neonatal vacancy position

4.2 Maternity Leave

Table 3 shows a consistent picture of maternity leave on the neonatal unit, of our registered nurses on maternity leave each month, ranging from 5.43%-6.85%. This approximately 11-14 wte each month. This is a picture reflective of the age profile of our registered nurses.

			2023 / 01	2023 / 02	2023 / 03	2023 / 04	2023 / 05	2023 / 06
			Absence FTE %	Absence FTE %	Absence FTE %	Absence FTE %	Absence FTE %	Absence FTE %
159 Family Health L2	159 Neonates L3	Additional Clinical Services	4.04%	3.50%	3.55%	3.55%	3.55%	1.30%
159 Family Health L2	159 Neonates L3	Nursing and Midwifery Registered	6.85%	6.41%	5.90%	5.43%	6.41%	6.13%
159 Family Health L2			4.26%	3.99%	3.95%	3.71%	3.91%	3.58%
Overall Trust Total			**3.45%**	**3.16%**	**3.19%**	**3.10%**	**3.24%**	**3.14%**

			2023 / 01	2023 / 02	2023 / 03	2023 / 04	2023 / 05	2023 / 06
			# Absence Occurrences	# Absence Occurrences	# Absence Occurrences	# Absence Occurrences	# Absence Occurrences	# Absence Occurrences
159 Family Health L2	159 Neonates L3	Additional Clinical Services	1	1	1	1	1	1
159 Family Health L2	159 Neonates L3	Nursing and Midwifery Registered	14	13	12	11	13	12
159 Family Health L2			30	28	27	26	29	25
Overall Trust Total			**61**	**58**	**56**	**59**	**60**	**57**

Table 3: Maternity leave

4.3 Sickness absence

Sickness absence (Table 4) over the last 6 month has steadily reduced, however remains above the expected Trust average for registered nurses, running on average at 4.49% down from 9.61% each month from previous 6 months, and within the Trust threshold of 4.5%. With covid sickness accounting for less than 1% each month, this has reduced over the last 6 months. There is approximately 40/60% split in short-term, long-term sickness (Table 5) respectively. There is a higher rate of long-term sickness in our non- registered group. Teams Leaders have managed sickness according to policy and with direct support from the HR Business partners, all those on long term sickness have a plan in place and there continues to be a reduction in long term sickness over the last 6 months.

	Jan-23			Feb-23			Mar-23			Apr-23			May-23			Jun-23		
	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP
Sickness	15.83%	5.93%		11.65%	3.78%		8.15%	5.00%		6.80%	4.50%		11.49%	3.62%		13.48%	4.16%	
Total	**11.07%**	**8.03%**	**10.74%**	**10.10%**	**6.30%**	**7.52%**	**9.73%**	**7.05%**	**9.45%**	**11.08%**	**6.07%**	**6.56%**	**9.83%**	**5.64%**	**7.00%**	**10.12%**	**5.78%**	**8.21%**
Overall Absence of All 3 Staff Group		**8.88%**			**7.28%**			**7.84%**			**7.33%**			**6.74%**			**6.97%**	

	Jan-23			Feb-23			Mar-23			Apr-23			May-23			Jun-23		
	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP
COVID Sickness	0.00%	0.92%		0.00%	0.18%		0.00%	0.22%		0.00%	0.36%		0.00%	0.00%		0.47%	0.29%	
Total	**0.63%**	**0.96%**	**0.93%**	**0.83%**	**0.89%**	**0.16%**	**0.57%**	**0.58%**	**0.56%**	**1.17%**	**0.38%**	**0.00%**	**0.95%**	**0.07%**	**0.00%**	**0.71%**	**0.08%**	**0.09%**
Overall Absence of All 3 Staff Group		**0.88%**			**0.84%**			**0.58%**			**0.55%**			**0.28%**			**0.23%**	

	Jan-23			Feb-23			Mar-23			Apr-23			May-23			Jun-23		
	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP
Sickness WITHOUT COVID Sickness	15.83%	5.01%	0.00%	11.65%	3.60%	0.00%	8.15%	4.78%	0.00%	6.80%	4.14%	0.00%	11.49%	3.62%	0.00%	13.01%	3.87%	0.00%
Total	**10.44%**	**7.07%**	**9.81%**	**9.26%**	**5.41%**	**7.36%**	**9.16%**	**6.47%**	**8.90%**	**9.91%**	**5.69%**	**6.56%**	**8.88%**	**5.56%**	**7.00%**	**9.41%**	**5.70%**	**8.12%**
Overall Absence of All 3 Staff Group		8.00%			6.44%			7.27%			6.77%			6.46%			6.74%	

	Jan-23			Feb-23			Mar-23			Apr-23			May-23			Jun-23		
	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP
COVID Special Leave	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Total	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**
Overall Absence of All 3 Staff Group		0.00%			0.00%			0.00%			0.00%			0.00%			0.00%	

Table 4: Sickness absence

	Jan-23		Feb-23		Mar-23		Apr-23		May-23		Jun-23	
	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term
NMC	53.10%	46.90%	58.06%	41.94%	40.18%	59.82%	36.70%	63.30%	46.11%	53.89%	46.77%	53.23%
NMC Staff Group Trust Total	**38.59%**	**61.41%**	**36.88%**	**63.12%**	**32.98%**	**67.02%**	**34.73%**	**65.27%**	**29.50%**	**70.50%**	**35.16%**	**64.84%**

	Jan-23		Feb-23		Mar-23		Apr-23		May-23		Jun-23	
	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term
HCA	0.00%	100.00%	23.59%	76.41%	27.38%	72.62%	18.67%	81.33%	6.42%	93.58%	42.38%	57.62%
HCA Staff Group Trust Total	**33.11%**	**66.89%**	**42.22%**	**57.78%**	**33.31%**	**66.69%**	**25.27%**	**74.73%**	**20.82%**	**79.18%**	**34.53%**	**65.47%**

	Jan-23		Feb-23		Mar-23		Apr-23		May-23		Jun-23	
	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term
AHP												
AHP Staff Group Trust Total	**27.59%**	**72.41%**	**33.43%**	**66.57%**	**29.09%**	**70.91%**	**17.39%**	**82.61%**	**12.89%**	**87.11%**	**19.90%**	**80.10%**

Table 5: Long Term v Short Term Sickness

4.4 Turnover

The Trust Turnover threshold is 13%, however, the turnover rate on the neonatal unit sits consistently below the Trust threshold in a range of 6.25- 8.32% in registered staff and 10.56-14.2% in Support staff. Much of the movement in support staff has been around retirements and internal promotion.

	Jan-23			Feb-23			Mar-23			Apr-23			May-23			Jun-23		
	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP
Turnover	12.14%	6.25%		14.20%	8.00%		14.20%	6.30%		10.65%	6.95%		10.73%	8.24%		10.76%	8.32%	
Staff Group Trust Total	**13.46%**	**9.89%**	**13.49%**	**13.45%**	**10.62%**	**15.09%**	**12.78%**	**9.37%**	**13.53%**	**11.78%**	**8.88%**	**16.16%**	**12.88%**	**9.00%**	**0.00%**	**12.84%**	**8.77%**	**9.38%**

Trust Target 13%

Table 6: Turnover

4.5 Age profile

The age profile of the staff on the neonatal unit has remained static over the last six months. Most of the registered staff are 50 years or under.

Neonates	Jan-23			Feb-23			Mar-23			Apr-23			May-23			Jun-23		
	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP
<=20 Years	0.00%	0.00%		0.00%	0.00%		0.00%	0.00%		0.00%	0.00%		0.00%	0.00%		0.00%	0.00%	
21-25	0.44%	10.57%		0.87%	9.57%		0.87%	9.09%		0.88%	8.77%		0.89%	8.44%		0.89%	8.04%	
26-30	2.64%	9.25%		3.04%	10.43%		3.03%	10.82%		3.07%	10.53%		3.11%	10.67%		3.13%	10.71%	
31-35	1.32%	20.26%		1.30%	20.00%		1.30%	19.05%		1.32%	20.18%		1.33%	20.89%		1.34%	20.98%	
36-40	3.08%	11.01%		3.48%	10.00%		3.46%	10.82%		3.51%	10.53%		3.11%	10.22%		3.13%	10.27%	
41-45	2.20%	11.01%		2.17%	10.43%		2.16%	10.39%		2.19%	10.53%		2.67%	10.22%		2.68%	10.27%	
46-50	0.88%	8.37%		0.87%	7.83%		0.87%	7.79%		0.88%	7.46%		0.89%	7.11%		0.89%	7.14%	
51-55	0.88%	7.49%		1.30%	8.26%		1.30%	8.23%		1.32%	8.33%		1.33%	8.00%		1.34%	8.04%	
56-60	0.44%	6.61%		0.43%	6.09%		0.43%	6.49%		0.44%	6.14%		0.44%	6.67%		0.45%	6.70%	
61-65	1.76%	1.76%		1.74%	2.17%		1.73%	2.16%		1.75%	2.19%		1.78%	1.78%		1.79%	1.79%	
66-70	0.00%	0.00%		0.00%	0.00%		0.00%	0.00%		0.00%	0.00%		0.00%	0.44%		0.00%	0.45%	
>=71 Years	0.00%	0.00%		0.00%	0.00%		0.00%	0.00%		0.00%	0.00%		0.00%	0.00%		0.00%	0.00%	
Total	**13.66%**	**86.34%**		**15.22%**	**84.78%**		**15.15%**	**84.85%**		**15.35%**	**84.65%**		**15.56%**	**84.44%**		**15.63%**	**84.38%**	

Table 7: Age profile data

5.0 Neonatal Nursing, Midwifery and AHP Training and Personal Development Review (January 2023-June 2023 data; Q4 & Q1 position)

	Jan-23				Feb-23				Mar-23				Apr-23				May-23				Jun-23			
	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR
NMC	83.13%	89.58%	96.82%	88.68%	84.30%	90.13%	96.82%	86.79%	85.41%	91.11%	97.21%	71.17%	85.19%	91.68%	97.39%	77.44%	84.94%	92.68%	96.25%	79.64%	91.14%	90.74%	96.34%	91.72%
NMC Staff Group Trust Total	77.57%	74.91%	89.49%	74.40%	78.81%	74.67%	89.79%	73.50%	78.52%	73.98%	89.26%	66.91%	81.21%	79.97%	91.66%	71.69%	81.62%	81.28%	92.01%	76.50%	85.50%	83.96%	91.94%	90.00%

	Jan-23				Feb-23				Mar-23				Apr-23				May-23				Jun-23			
	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR
HCA	89.14%	87.50%	97.49%	91.67%	88.71%	85.29%	97.12%	92.00%	92.51%	86.03%	97.67%	96.15%	90.15%	86.84%	94.95%	78.57%	93.66%	87.34%	97.84%	64.29%	92.46%	90.23%	95.97%	76.67%
HCA Staff Group Trust Total	86.37%	83.15%	95.49%	72.22%	85.83%	81.05%	95.84%	72.85%	84.87%	77.54%	93.51%	72.94%	86.00%	78.37%	95.41%	67.11%	86.57%	80.36%	95.69%	69.20%	88.13%	78.06%	95.34%	79.75%

	Jan-23				Feb-23				Mar-23				Apr-23				May-23				Jun-23			
	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR
AHP																								
AHP Staff Group Trust Total	91.28%	94.79%	97.47%	81.40%	91.58%	92.55%	97.67%	90.48%	94.35%	87.88%	97.40%	91.11%	93.29%	87.16%	97.64%	86.96%	93.17%	92.59%	97.64%	86.96%	93.92%	93.51%	98.50%	86.97%

Table 8: Mandatory Training and PDR

Across all staff groups it can be seen (Table 8) that the achievement and performance of training (MT, CMT, LMT) and Personal Development Reviews (PDRs) has been a fluctuating position across the six-months. Trust targets for indicators are as follows:

- Core Mandatory Training (CMT) – 95%
- Local Mandatory Training (LMT) – 95%
- Mandatory Training (MT) – 95%
- PDR – 90%

PDR compliance has been a struggle over the last 6 months however compliance has been achieved by registered staff in June with a trajectory for August 2023 for other groups. In the last 6 months teams have been challenged with achieving core, local and mandatory training due to the increased activity and acuity seen on the unit, there was also validation of the clinical mandatory training required. This has now been completed and we are expected to meet compliance on Local mandatory training, and clinical mandatory training by August 2023. Compliance on mandatory training has been met by all groups.

Blockbuster days have been reinvigorated, a cleanse of the training profile has been undertaken and all staff are reminded about outstanding training required

6.0 Measurement of Quality of Care

6.1 Clinical Incident Reporting

There has been a total of 427 incident reported over the last 6 months this has increased from the previous 6 months from 329, this is a 23% increase. The expect incident reporting rate on a NICU is 4% of the admission rate. The graph below (Table 9) shows that other than in July and August the NICU has an above expected reporting rate. This is consistent with a good reporting culture. It is though that increase leave, occupancy and acuity resulted in low reporting in July and August.

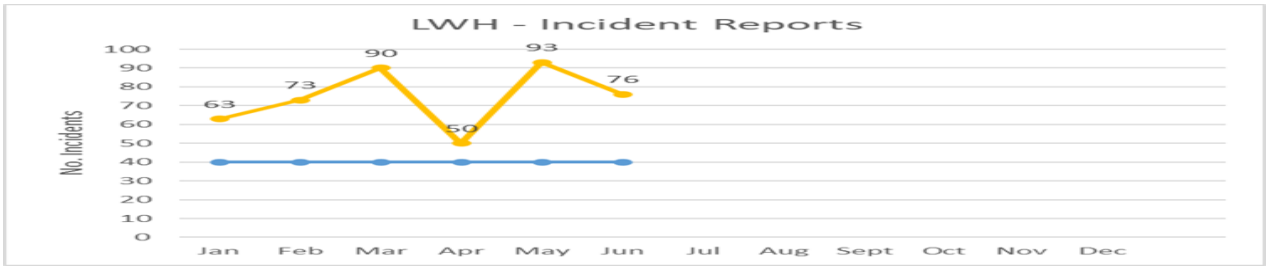


Table 9: Incident reporting

The top 5 cause group has changed slightly over the last 6 months. The table below shows that medication errors continue to be our top incident. There are robust processes in place and the team review all incidents regularly with pharmacy and consultant team. Medicine errors are a mixture of prescribing and administration, including near misses.

There have been increased incidents around equipment and this is being address with procurement team and will be added to risk register around the appropriateness of alternative stock. The reporting of injuries has increased as this now included skin injuries which previously had been reported under invasive procedures.

Investigations included blood sampling and we have seen significant improvement over the previous 6 months

	July-Dec 2022	**Jan-Jun 2023**
Total clinical incident	329	427
Total clinical incident relating to staffing	2	4
Top 5 Incidents		
	Medication -84	Medication 108
	Investigation - 47	Equipment 53
	Equipment - 41	Injury 44
	Invasive procedure - 33	Investigations 31
	Clinical management - 23	Admission / Discharge / Transfer 28

Table 10: Overview top 5 Incidents over 12 months

There were four incidents relating to staffing this was during periods of high occupancy and acuity. These incidents were based around heavy workloads during periods of high activity and acuity. Ratios were maintained however during an acute period extra support was required and at times this was challenging.

All incidents are reviewed by the Matron and Safety Lead with a report formulated and presented to the Liverpool Neonatal Risk Meeting monthly. The report is also submitted to the LNP Integrated Governance Meeting each month which reports into the LNP Board, Family Health Divisional Board and Alder Hey Surgical Divisional Board.

Lessons learnt are shared in a variety of ways, including:

- Lesson of the week
- Governance boards
- What you need to know board
- 7@7 safety huddles
- My Paediatrics App
- Room communication folders
- Closed Facebook group (where appropriate)

6.2 Red flag events

There are no national reportable red flags for Neonates.

6.3 Serious Incidents (SIs)

There were 3 Serious Incidents during the previous 6 months, these included 1 invasive medical procedure that was carried out by the medical team and 2 SI's related to skin injuries. Nurse staffing issues did not contribute to either of these SI's.

7.0 Patient/Family Experience

The neonatal unit has continued to embrace FiCare over the last 6 and received FICare reaccreditation in April 2023. FiCare allows the department to work in partnership with the parents and families we care for in the delivery of care for their baby. The neonatal unit also have an active Facebook peer support group with over 600 members.

Over the last 2 quarters the team have implemented a new focused discharge survey. The parent discharge survey is a way for the neonatal team to gain feedback which can be used to improve and develop our model of care on the neonatal unit. Gaining feedback from families who have experienced every aspect of the neonatal journey provides us with direct feedback as part of the parent voice. The feedback relates to Jan- Mar 2023 the further 3 months were not completed at time of this report. Some themes continue to be developed and some have been highlighted since last report

Things we need to focus on are:

1. Gaining feedback from both parents, rather than the mother only as each parent may have different experiences and comments to provide. In addition, we need to ensure increased accessibility to non-English speaking families and this is something we are working hard to develop through use of translated surveys for individuals to complete. We are also implementing V-Create, a secure video messaging service for families which has the facility to translate text into different languages and will be implemented w/c 1st May 2023.
2. Identify barriers and challenges to providing support pre-delivery to families. This is being addressed through regular communication with obstetric teams to provide counselling antenatally for those families where admission to neonatal unit is expected. However, some admissions will be unexpected and unplanned and therefore it is important that on these occasions, updates and good communication with families is undertaken to provide regular support and information.
3. For those families whose babies are known antenatally to require admission, it is important that we offer unit tours prior to delivery, if possible and appropriate. These had been stopped during covid however are now offered to families. For families seen in FMU, unit tours are offered and arranged. A virtual tour of the neonatal unit has also been undertaken by the NWNODN and is now available on the Trust intranet and neonatal network website for families to access.
4. Hospitality provision is an area that needs to be improved and developed, and a case is currently being made to provide a hot meal to all parents on the neonatal unit per day, especially as catering facilities are very limited within the trust, especially overnight and at the weekend. Having a baby on the neonatal unit can cause great financial difficulty to families, and we are therefore keen to try and assist families with this in some way. This has been escalated to Senior leadership team for review.
5. Improved psychosocial support for families is being undertaken as part of the work across the LNP. We now have dedicated peer supporters for the neonatal unit, unit counsellor and clinical psychologists for families to access. With covid restrictions lifted, we are also providing support and social events on the unit, and events for siblings to attend to provide a family integrated support model on the neonatal unit. This is a work in progress but we have held many sibling and family events over the past few months to integrate families back onto the neonatal unit at LWH.
6. Dedicated discharge survey for Transitional care families has been created and distributed for use to capture the experiences of families utilising this facility during their stay. Further reminders have been sent to remind staff to ask families on TC to complete these as uptake has been poor in this quarter since implementation.
7. Use of community neonatal nursing team to capture families that did not complete the survey as inpatient to enable a 'true voice' to be heard. Further emails have been sent to community team to kindly ask if this could be undertaken and QR code for survey provided.
8. Further work to be undertaken to ensure delivery room cuddles are facilitated at delivery (unless criteria for exclusion). This is essential work as the FiCare model and journey should commence antenatally and delivery room cuddles enable empowerment to families prior to admission to the neonatal unit.

There are plans in place for these areas to be addressed over the next 12months, with some actions already in place. We will continue to review the feedback from these surveys regularly to enable ongoing development and improvement of the care we provide for our families and their infants across the LNP.

7.1 Complaints, Concerns and Compliments

There were no formal complaints received in the Neonates from January 2023-June 2023. There was however 1 complaint logged with maternity which identified an issue with the discharge process from the neonatal unit. The

discharge element of the complaint has been investigated by the neonatal matron. The discharge policy has been reviewed, and this will be circulated to all nursing and medical staff, who are to be reminded of the correct process and documentation of discharges from the neonatal unit.

There were **14** PALS cases noted within timeframe and none were around shortage of staffing. The main themes were around communication. This has been addressed with the team in various ways, 1:1, team meetings, discussions with psychologist and debriefs. There were no complaints around staffing issues.

There was 1 compliment from a family about the care given by one of the neonatal consultants. The patient acknowledged the time, care and advocacy provided allowed a family to spend precious time with their baby whose prognosis was poor whilst the mother was unconscious.

8.0 Staff Experience

There has been a real focus on staff well-being over the last year, with dedicated time each week focused on well-being, well-being Wednesday, feel good Friday. Staff have been listened too and these events have happened at different times of day and night and over weekends. Staff well-being conversations, questionnaire have been used frequently.

This has been a very busy period for the unit, and we have had increased acuity, with this we have seen some attitudes and behaviours from parents and families that is not acceptable towards staff members. This has been addressed at the time by the Consultant on service and followed up by the HoN/DHoN and Lead Clinician with a face-to-face conversation with parents. We have discussed with staff 1:1 and at unit meeting. We have also enlisted the help of the psychologist to support parents and help team understand how to support families who are going through a trauma.

The PNA has been developed and embedded on the unit. We have 2 qualified PNA's with a further 5 in training. The PNA's are providing 1:1 and group session support. This is proving very successful, and feedback has been positive. We will need approximately 20 PNA's within NICU.

There has been no formal staff survey during this period.

8.1 Attraction, Recruitment and Retention

As a tertiary centre and working in partnership with Alder Hey Children's hospital this makes the service at LWH a really great place to work to allow for experience and development, hence we attract the best students and staff in the region. To maintain our staff, we offer great opportunities for training, development, and progression. We also offer flexible working opportunities and career breaks.

We have supported the development of a further 5 Professional Nurse Advocates (PNA), 4 neonatal Nurse Practitioners, education roles, FiCare role, Palliative Care Nurse, and governance nurse. We have also supported secondments to Meditech expanse and the NWNODN Education team. We are in the process of developing specialist neonatal tissue viability nurses.

Turnover remains relatively static at approximately 8% on the NICU.

9.0 Actions and Recommendations

The following actions were proposed during the previous reporting period to be undertaken within January 2023 – June 2023. Updates provided as follows:

- Appoint a substantive matron, have Governance lead in post and secure funding for the governance nurse.
  Update: Matron appointed to substantive post.
  Funding secured from network for Governance nurse following Neonatal Critical Care Review**.**
- Substantive palliative care nurse
  Update: No funding secured as yet this is still required**.**
- Continue to develop the training and recruitment plans to support new nurses that will join the LNP nursing team over the next 12 months.
  Update: Full time educator in post for LNP who is has preceptorship responsibilities for all new starters to the LNP. Recruitment to LNP is in progress with 25 band 5 nurses appointed to date.
- Work with parents and families to ensure they feel we are communicating in a way that they feel heard and understood.
  Update: Online survey completed at discharge, data collected and audited by ficare team. Matron walk abouts, You said we did board, patient experience walkabouts
- Continue to develop our Neonatal Community Outreach team and supporting dietetic service that supports it.
  Update: Funding for dietetic support still required. Dietician in post provides support to patients on both neonatal units and is unable to cover outreach in addition to current workload.
- Development of the quality roles to support the cotside to deliver outstanding care.
  Update: No extra funding available, quality roles provided from existing establishment where possible, depending on activity.
- Continue to meet the flexible needs of our staff where possible.
  Update: Ongoing wellness conversations, wellbeing checking and one to one meetings with matron, DHoN and HoN provided.
- Compliance with PDR and mandatory training within the NICU service.
  Update: Continuing to monitor compliance, reminders issued by team leaders, followed up by matron for non-compliant staff, followed up by face-to-face meeting if ongoing non-compliance.
- Review staff survey and see how we can continue to improve staff experience in the workplace, with a focus on listening to and communicating effectively with our staff.
  Update: Wellbeing events continue as well-being Wednesday / Feel good Friday monthly. PNA sessions have been well received. Band 6 away days held in this period gave staff the opportunity to feedback their ideas of how their experience in work could be improved, e.g., inconsistencies in allocation of patients/ room leaders, these inconsistencies have been addressed. Band 5 away days are planned for the next quarter.

The following areas of actions are proposed during the next six months (July 2023-December 2023) within the Neonatal Unit: Appoint substantive governance lead and governance nurse, funded by current post and NCCR monies

- Substantive palliative care nurse – funding will need to be secured
- Continue to development the training and recruitment plans to support new nurses that will join the LNP nursing team over the next 12 months.
- Continue to develop our ANNP team and to ensure recruitment and retention look at how we can further develop Band 8b posts to ensure retention at tier 2 level of the medical rota. This will require a full business case
- Continue to meet the flexible needs of our staff where possible.
- Compliance with PDR and mandatory training within the NICU service.
- Continue to develop our Neonatal Community Outreach team and supporting dietetic service that supports it.
- Development of the quality roles to support the cotside to deliver outstanding care.
- Work with the Northwest Neonatal ODN to develop Network approach to ROP service delivery.
- Development of a digital nurse team, this will require 1 wte Band 7.
- Work with parents and families to ensure they feel we are communicating in a way that they feel heard and understood.

10.0 Conclusions

The Putting People First Committee are asked to gain assurance from the Neonatal report that the staffing levels and delivery of nursing care on the neonatal unit is meeting and exceeding the expected standards and the service is delivering good family experience. Additionally, the committee is asked to take assurance that there is sufficient oversight in Neonatal services of where improvements can be made with plans in place to action those changes. The staffing review undertaken has not highlighted any risks when complaints, incidents, training, and staffing have been triangulated, however, it has been noted that the team could do more around effective communication with parents and families. The continued high acuity and occupancy will continue to challenge the NICU service but adequately trained and appropriate numbers of staff it is felt this challenge can be met.

Appendix 6: Gynaecology staffing overview January 2023-June 2023

1.0 Introduction

The Gynaecology Division services consist of the following areas:

- Gynaecology Emergency Department (GED) & Early Pregnancy Assessment Unit (EPAU)
- In-patient ward (24 beds)
- High Dependency Unit Level 2 care (2 beds)
- Day Case Surgery Unit (6 trolleys)
- Outpatient department (includes Colposcopy, Ambulatory, Endometriosis and Urodynamics) based at LWH Crown Street and Aintree Hospital
- A Colposcopy and Hysteroscopy Unit is also situated on the Crown Street and Aintree site.
- Bedford day-case unit
- Hewitt Fertility Centre based at Crown Street and a standalone Knutsford facility.
- Macmillan oncology services

The workforce within the Gynaecology Division consists of both registered and unregistered nurses, professional development continues across the division with several registered nurses moving and stepping up into critical roles as Emergency Nurse Practitioners (ENP), Advanced Nurse Practitioners (ANP) and Nurse Colposcopists. All new leaders in post are enrolled onto the Trust leadership programme.

2.0 Workforce planning - Staffing Tool

The Safer Nursing Care Tools (SNCT) is utilised to calculate the nursing establishment requirements for the inpatient Gynaecology unit, patient acuity and dependency alongside professional judgement serves as a guidance to plan safe staffing for the unit.

Within the Gynaecology Unit there is a two bedded High Dependency Unit, safe critical care staffing levels are laid out in the Guidelines for the Provision of Intensive Care Services (GPICS) which is adhered to for level 2 care.

3.0 Setting evidenced based establishments.

Staffing establishments are reviewed and agreed in Gynaecology and Fertility by all ward and department managers, Matrons as well as the Head of Nursing as part of the annual budget review and where any disagreement arises this is sought for resolution, so all managers agree with the establishments set. Assurance that safe staffing has improved from the previous period and maintained throughout this reporting period is evidenced by the RN fill rates on days, reported at the highest 96% and RN on night duty 150%. The fill rate 150% RN on nights is the reflection of senior RN cover rotating between GED and inpatient area, providing a safety net for the stand-alone areas. The improvement of fill rates is due to the successful recruitment to vacant posts. (Table 1)

Care Hours Per Patient Per Day (CHPPD) are recorded which relate to the hours staff spend providing direct care to patients in a 24hr period, for the Gynaecology inpatient ward. From January 2023 to June 2023 the CHPPD is reported at the highest to be 10.9hrs per day. A review of the data available on Model Hospital and benchmarking similar wards it highlights in April 2023, Nursing and Midwifery Gynaecology Ward sits in Quartile 3 whereas in comparison 'peer group' sits in Quartile 4. When taking into account the bed occupancy on the Gynaecology Ward and the level of dependency and acuity on the ward which mainly reflects SNCT level 0 care, the Head of Nursing is assured that safe and efficient care is delivered.

Gynaecology Ward	Fill Rate Day% RN	Fill Rate Day % HCSW	Fill Rate Night % RN	Fill Rate Night % HCSW
January 23	96%	92.5%	150%	98.4%
February 23	92%	86%	146%	100%
March 23	88.71%	90.23%	145.26%	101.61%
April 23	90.83%	88.33%	130%	100%
May 23	95.97%	93.55%	150%	96.77%

Table 1: Fill Rates for Gynaecology inpatient Ward

4.0 Operational oversight of staffing and acuity-based care

To provide full oversight of staffing across the division the Head of Nursing leads a monthly roster sign off meeting to ensure an effective, safe, and fair health roster is created to ensure patient and staff safety. In attendance in this meeting is the Ward/Department manager, Matron, HRBP and health roster manager. This is not a process completed in isolation and involves a review of activity and bed occupancy. Following analysis of the roster the Head of Nursing approves the roster ready for release to staff. Alongside this, the divisional Matrons attend a twice daily trust wide staffing huddle to provide assurance of safe staffing to the chair of the Trust daily huddle.

4.1 Temporary Staffing

Bank and agency spend for the Division is illustrated in Table 2 below from January 2023 to June 2023, the largest areas of spend is from the Gynaecology Emergency Department and the Gynaecology Inpatient Ward, the request for temporary staffing has been to cover the Short- and Long-Term sickness. The Division have been undertaking weekly oversight meetings with the Matrons and Managers to focus on Return-to-Work sickness meetings and reviewing new ways of staff working flexibly across the division, the table illustrates reductions in bank and agency spend whilst maintaining patient safety and quality.

Sum of Journal Line Amount NET		Years	Accounting P						
		2023				2024			Grand Total
Cost Centre Description	Subjective Description	Jan	Feb	Mar	Apr	May	Jun		
Bedford	B5 Qualified Bank Nurse		60.79	143.56	-	5.94			210.29
	B6 Qualified Bank Nurse	0.02	- 60.80	539.57	- 7.42	119.56			590.93
Crown Street Nursing	B5 Qualified Bank Nurse		1,177.43	369.26	370.31	546.56	208.42		2,671.98
	B6 Qualified Bank Nurse	455.38	172.74	245.36					873.48
Emergency Room	B5 Qualified Bank Nurse		7,891.67	8,334.94	5,465.37	10,241.80	6,010.66		37,944.44
	B6 Qualified Bank Nurse	8,929.73	422.95	5,501.13	3,453.30	3,779.08	2,739.17		24,825.36
	B7 Qualified Bank Nurse			292.98	382.05	334.80			1,009.83
Gynae Admin		118.26	- 70.65						47.61
Gynae Day Ward	B5 Qualified Bank Nurse		1,100.32	275.16	573.07	286.57	300.31		2,535.43
	B6 Qualified Bank Nurse	1,255.58	- 286.46						969.12
Gynae Inpatients	B5 Qualified Bank Nurse		23,052.89	26,564.53	12,758.30	13,158.04	6,706.50		82,240.26
	B6 Qualified Bank Nurse	20,043.37	- 2,177.30	5,794.35	3,408.30	3,727.35	3,865.37		34,661.44
Gynae Opd	B5 Qualified Bank Nurse		241.76						241.76
	B6 Qualified Bank Nurse	155.33							155.33
Knutsford Nursing	B5 Qualified Bank Nurse						392.64		392.64
	B6 Qualified Bank Nurse		230.91				287.18		518.09
Grand Total		30,957.67	31,756.25	48,060.84	26,403.28	32,199.70	20,510.25		189,887.99

Table 2: Temporary Staffing Spend

5.0 Divisional Nursing Workforce Measures (July-December 2022 data; Q2 & Q3 position)

5.1 Vacancy position

The breakdown of current vacancies reported in month 3 for Gynaecology are reflected in Table 3.

The current vacancy position is 2.44 WTE which equates a vacancy rate of 1.5% against budgeted establishment.

Division	Directorate	Subjective Code Desc	Sum of Wte Budget	Sum of Wte Contracted	Sum of Wte Actual	Sum of Vacancy
⊟GYNAECOLOGY	⊟GYNAECOLOGY	B2 HEALTHCARE ASSISTANT	41.08	25.13	23.72	15.95
		B2 SUPPORT STAFF	0.00	1.43	1.43	-1.43
		B3 HEALTHCARE ASSISTANT	12.64	18.76	19.05	-6.12
		B4 HEALTHCARE ASSISTANT	0.74	0.61	0.61	0.13
		B4 UNQUALIFIED NURSE	3.93	7.52	7.42	-3.59
		B5 QUALIFIED NURSE	53.39	48.24	44.50	5.15
		B6 MIDWIVES	1.43	1.16	1.16	0.27
		B6 QUALIFIED NURSE	15.93	18.01	18.01	-2.08
		B7 QUALIFIED NURSE	22.95	23.37	21.10	-0.42
		B8 CLINICAL SCIENTIST	0.60	0.60	0.60	0.00
		B8 QUALIFIED NURSE	8.54	14.40	14.17	-5.86
		B6 QUALIFIED BANK MIDWIVES	0.00	0.00	0.00	0.00
		SUPPORT STAFF BANK	0.00	0.00	7.01	0.00
		B5 QUALIFIED BANK NURSE	0.00	0.00	3.81	0.00
		AGENCY ALLIED HEALTH PROFESSIONALS	0.00	0.00	0.47	0.00
		AGENCY CONSULTANTS	0.00	0.00	0.00	0.00
		B7 QUALIFIED BANK NURSE	0.44	0.00	0.00	0.44
		B6 QUALIFIED BANK NURSE	0.00	0.00	1.59	0.00
		AGENCY NURSING	0.00	0.00	0.08	0.00
	GYNAECOLOGY Total		161.67	159.23	164.73	2.44

Table 3: Vacancy position as of Month 3

5.2 Maternity Leave

Compared to the previous reporting period where Maternity Leave was at its highest, recorded at 17% for NMC staff, for the period of January 2023 to June 2023, maternity leave for the NMC staff group within the Gynaecology division reduced to 10.93% as staff had returned to work. This reduced further to 9.82% in May 2023, however due to further Maternity leave this has increased to 10.53% in June 2023. Maternity leave amongst the HCA workforce this has been consistent in comparison between 2.33% to 2.64% from January 2023 to June 2023.

Jan-23			Feb-23			Mar-23			Apr-23			May-23			Jun-23		
HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP
2.64%	10.93%		2.54%	10.69%		2.55%	10.72%		2.52%	10.60%		2.33%	9.82%		2.50%	10.53%	

Table 4: Gynaecology Maternity leave.

For this reporting period The Hewitt Fertility Centre NMC workforce maternity leave stayed consistently above 5% reflecting an increase in staff commencing Maternity leave in September 2022. The HCA staff group maternity leave was recorded at 2.50% in June 2023.

Jan-23			Feb-23			Mar-23			Apr-23			May-23			Jun-23		
HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP
2.64%	5.29%		2.54%	5.07%		2.55%	5.09%		2.52%	5.03%		2.33%	4.66%		2.50%	5.00%	

Table 5: Hewitt Maternity Leave.

5.3 Sickness absence, including LTS/STS

Between January 2023 and June 2023 (Table 6), Healthcare Assistant (HCA) sickness within the Gynaecology Division reduced significantly compared to the previous 6 months. In January 2023 sickness absence was recorded as 9.20% compared to January 2022 recorded as 13.68%. From February 2023 sickness began to rise and recorded at the highest rate of 15.94% % in June 2023. Conversely NMC sickness absence improved in comparison to the previous reporting period. In December 2022 sickness was recorded as 13.47% which has reduced to the lowest at 5.77% in May 2023 although increased to 7.70% in June 2023.

The 3 main causes of sickness recorded as Anxiety, Stress and depression, Gastrointestinal problems, and Genitourinary and Gynaecology disorders. Having awareness of the reasons for sickness allows the division to provide support for staff. Alongside the Matrons and the Ward Managers the Head of Nursing and Divisional Manager have joined weekly meetings with the divisional HRBP to ensure robust Return to Work and Health and Wellbeing meetings are held with staff.

Sickness in Hewitt Fertility Centre (Table 7) reflects HCA and NMC sickness has mostly remained above threshold within the reporting period with June 2023 reflecting best performance for HCA staff group at 0.99%. Reversely, NMC staff group has an above threshold sickness of 10.27% (June 23).

Jan-23		Feb-23		Mar-23		Apr-23		May-23		Jun-23	
HCA	NMC	HCA	NMC	HCA	NMC	HCA	NMC	HCA	NMC	HCA	NMC
9.20%	7.31%	13.34%	6.05%	10.04%	6.53%	12.56%	5.73%	11.11%	5.77%	15.94%	7.70%
11.07%	**8.03%**	**10.10%**	**6.30%**	**9.73%**	**7.05%**	**11.08%**	**6.07%**	**9.83%**	**5.64%**	**10.12%**	**5.78%**

Table 6: Sickness Absence in Gynaecology

Jan-23		Feb-23		Mar-23		Apr-23		May-23		Jun-23	
HCA	NMC	HCA	NMC	HCA	NMC	HCA	NMC	HCA	NMC	HCA	NMC
4.40%	9.38%	7.30%	6.13%	8.75%	11.21 %	6.61%	9.72%	1.56%	3.87%	0.99%	10.27 %
11.07 %	**8.03%**	**10.10 %**	**6.30%**	**9.73%**	**7.05%**	**11.08 %**	**6.07%**	**9.83%**	**5.64%**	**10.12 %**	**5.78%**

Table 7: Sickness Absence in Hewitt

5.4 Short-term and long-term sickness

During this reporting period Short and long-term sickness for NMC workforce within Gynaecology sickness fluctuated, short-term in January 2023 was recorded at 45.29% then reduced to 38.36% in June 2023 just under 7% however this has converted to Long- term sickness which has increased by 15%. For the Healthcare Assistants in Gynaecology Short-term sickness was at 67.22 % in January and decreased to 40.62% in June a reduction of 26.6%, Long-term sickness began to increase in February at 43.31% and upward trajectory until May at 75.30% and in June reduced to 59.38% a 16.30% decrease (Table 8)

Similarly with Hewitt (Table 9) for the reporting period NMC Short and Long-term sickness fluctuated, short-term sickness recorded as 18.57% in January increased month on month until April reducing to 12.02% a reduction of 6.55%, increasing again to 38.06% in June 23. Long-term sickness was highest in May at 87.98% reducing in June to 61.94%. Health care assistant Short and Long-term sickness again fluctuated, Short-term sickness increased from 54.49% in January to 100% in June a 45.51% increase, Long-term sickness fluctuated to 0% in June due to staff returning to work. The division including HFC continues to work with the HR Business Partners and Managers to oversee that sickness absence is being managed in line with Trust policy. The weekly review of sickness with the HRBP explore return to work options for those off long term sick. The Matrons are now able to extract data detailing who requires return to work and meet with their managers to ensure these are completed alongside the timely completion of the health and well-being conversations and Occupational Health Reviews.

NMC Jan-23		Feb-23		Mar-23		Apr-23		May-23		Jun-23	
Short Term	Long Term	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term
45.29%	54.71%	52.16%	47.84%	55.57%	44.43%	46.01%	53.99%	30.44%	69.56%	38.36%	61.64%

HCA Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23

Short Term	Long Term	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term
67.22%	32.78%	56.69%	43.31%	38.22%	61.78%	29.22%	70.78%	24.70%	75.30%	40.62%	59.38%

Table 8: Short- and Long-Term sickness Gynaecology

NMC Jan-23		Feb-23		Mar-23		Apr-23		May-23		Jun-23	
Short Term	Long Term	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term
18.57%	81.43%	21.19%	78.81%	38.26%	61.74%	39.66%	60.34%	12.02%	87.98%	38.06%	61.94%

HCA Jan-23		Feb-23		Mar-23		Apr-23		May-23		Jun-23	
Short Term	Long Term	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term
54.49%	45.51%	87.36%	12.64%	46.18%	53.82%	23.68%	76.32%	37.50%	62.50%	100.00%	0.00%

Table 9: Short- and Long-Term sickness Hewitt

5.5 Turnover

NMC and HCA Turnover in Gynaecology for the six-month period January 2023-June 2023 (Table 10) although improved compared to previous months, the NMC staff group remained above the Trust threshold of 13%, with the highest staff turnover recorded in April 2023 for the NMC staff group (18.58%). Conversely the highest staff turnover for the HCA workforce was (11.17%) which is below the Trust threshold.

In Hewitt Fertility Centre (Table 11) HCA turnover remains above the Trust threshold at the highest recorded in March and April at 20.19%, although turnover is high this has improved from the previous months in the reporting period. In May 2023 turnover dipped to 10.73% for HCAs, however this increased again to 19.22% in June 2023. In Comparison Registered Nurse turnover has remained below the threshold and was at its lowest within the reporting period at 6.11% in March 2023. The Hewitt Centre staff continue to work through a transformational action plan that will support staff development.

The introduction of the Professional Nurse Advocate role for the division commenced in January 2023 aiming to provide monthly restorative supervision to colleagues to support staff wellbeing in turn serving to aid staff retention and reduce staff turnover.

New recruits are offered rotational posts working across all services in Gynaecology, to gain a broader knowledge of women's health conditions and the services offered in the division to support retention through staff development and succession planning.

Jan-23		Feb-23		Mar-23		Apr-23		May-23		Jun-23	
HCA	NMC	HCA	NMC	HCA	NMC	HCA	NMC	HCA	NMC	HCA	NMC
9.18%	17.50%	10.98%	18.75%	11.17%	18.56%	9.24%	18.58%	11.09%	16.36%	11.09%	15.60%
13.46%	**9.89%**	**13.45%**	**10.62%**	**12.78%**	**9.37%**	**11.78%**	**8.88%**	**12.88%**	**9.00%**	**12.84%**	**8.77%**

Table 10: Staff Turnover Gynaecology

Jan-23		Feb-23		Mar-23		Apr-23		May-23		Jun-23	
HCA	NMC	HCA	NMC	HCA	NMC	HCA	NMC	HCA	NMC	HCA	NMC
17.53%	6.29%	17.53%	6.29%	20.19%	6.11%	20.19%	9.59%	10.73%	8.24%	19.22%	6.20%
13.46%	**9.89%**	**13.45%**	**10.62%**	**12.78%**	**9.37%**	**11.78%**	**8.88%**	**12.88%**	**9.00%**	**12.84%**	**8.77%**

Table 11: Staff Turnover Hewitt

5.6 Age profile

The largest staff group who can potentially retire under terms and conditions (Table 12) are within 56-60 age group. In June 2023 there were 20 members of NMC and HCA combined that were eligible to retire, which has reduced from the previous 6 months. In the 61-65 age group we have seen staff (19 in total) within Gynaecology and Hewitt combined working in this age range.

The continuing focus for the division is to develop and prepare staff for the future providing training opportunities to allow the division to succession plan into the critical roles to maintain clinical services. The division are committed to invest in staff to prevent gaps in service and strengthen staff retention.

Gynaecology	Jan-23		Feb-23		Mar-23		Apr-23		May-23		Jun-23	
	HCA	NMC	HCA	NMC	HCA	NMC	HCA	NMC	HCA	NMC	HCA	NMC
<=20 Years	2	0	2	0	3	0	3	0	3	0	2	0
21-25	8	6	7	5	7	6	7	6	7	7	8	7
26-30	3	14	4	15	4	15	4	15	5	15	6	14
31-35	8	18	7	18	7	18	7	19	6	19	6	18
36-40	4	14	4	14	4	14	4	13	4	12	4	13
41-45	6	11	6	11	6	12	6	12	6	13	6	13
46-50	9	10	9	9	9	9	9	10	9	9	8	9
51-55	8	14	8	13	7	14	7	14	7	15	7	15
56-60	6	14	7	15	7	14	7	12	7	13	7	13
61-65	5	14	5	14	4	14	4	15	4	15	4	15
66-70	2	1	2	1	3	1	3	1	3	1	3	1

Table 12: Age Profile for Gynaecology and HFC

6.0 Divisional Nursing, Midwifery and AHP Training and Personal Development Review

Overall, for Gynaecology Division and the Hewitt Centre there has been great improvement in all training performance from January 2023 to June 2023 compared to July 2022 - December 2022 (Tables 13-16). This is due to the increased focus from the Divisional Matrons, Department Managers and HRBP who have continued to attend weekly oversight meetings to review all training compliance. Improvement in PDR compliance for this period is evident in Gynaecology, however the division recognise further focus is required to improve the PDR compliance in the Hewitt Centre, therefore this will be included for discussion in the weekly oversight meetings in the division.

Jan-23				Feb-23				Mar-23				Apr-23				May-23				Jun-23			
CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR
92.13%	83.78%	97.54%	94.90%	93.27%	85.24%	97.49%	93.75%	94.49%	86.48%	97.13%	88.89%	95.25%	87.73%	96.91%	88.54%	94.32%	94.55%	96.05%	81.44%	95.17%	95.44%	96.12%	89.22%
77.57%	**74.91%**	**89.49%**	**74.40%**	**78.81%**	**74.67%**	**89.79%**	**73.50%**	**78.52%**	**73.98%**	**89.26%**	**66.91%**	**81.21%**	**79.97%**	**91.66%**	**71.69%**	**81.62%**	**81.28%**	**92.01%**	**76.50%**	**85.50%**	**83.96%**	**91.94%**	**90.00%**

Table 13: Gynaecology NMC training/ PDR (Trust performance on Blue Line)

Jan-23				Feb-23				Mar-23				Apr-23				May-23				Jun-23			
CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR
96.76%	93.05%	98.93%	96.15%	95.00%	92.63%	98.53%	96.23%	95.28%	90.91%	99.35%	94.12%	95.27%	90.91%	98.70%	86.27%	93.90%	93.28%	97.74%	73.47%	96.23%	93.33%	97.82%	82.35%
86.37%	**83.15%**	**95.49%**	**72.22%**	**85.83%**	**81.05%**	**95.84%**	**72.85%**	**84.87%**	**77.54%**	**93.51%**	**72.94%**	**86.00%**	**78.37%**	**95.41%**	**67.11%**	**86.57%**	**80.36%**	**95.69%**	**69.20%**	**88.13%**	**78.06%**	**95.34%**	**79.75%**

Table 14: Gynaecology HCA training /PDR (Trust performance on Blue Line)

Jan-23				Feb-23				Mar-23				Apr-23				May-23				Jun-23			
CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR
86.94%	78.38%	94.95%	69.70%	91.44%	80.85%	97.22%	71.88%	90.63%	81.55%	97.49%	77.42%	92.13%	82.51%	97.04%	76.67%	90.13%	87.45%	95.56%	83.33%	87.66%	88.89%	94.62%	70.97%
77.57%	**74.91%**	**89.49%**	**74.40%**	**78.81%**	**74.67%**	**89.79%**	**73.50%**	**78.52%**	**73.98%**	**89.26%**	**66.91%**	**81.21%**	**79.97%**	**91.66%**	**71.69%**	**81.62%**	**81.28%**	**92.01%**	**76.50%**	**85.50%**	**83.96%**	**91.94%**	**90.00%**

Table 15: Hewitt NMC training /PDR (Trust performance on Blue Line)

Jan-23				Feb-23				Mar-23				Apr-23				May-23				Jun-23			
CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR
94.03%	81.48%	98.34%	63.64%	94.78%	81.48%	98.76%	68.18%	94.29%	83.33%	97.06%	72.73%	94.53%	83.33%	97.52%	73.68%	91.45%	100.00%	98.21%	76.19%	91.45%	100.00%	99.11%	71.43%
86.37%	**83.15%**	**95.49%**	**72.22%**	**85.83%**	**81.05%**	**95.84%**	**72.85%**	**84.87%**	**77.54%**	**93.51%**	**72.94%**	**86.00%**	**78.37%**	**95.41%**	**67.11%**	**86.57%**	**80.36%**	**95.69%**	**69.20%**	**88.13%**	**78.06%**	**95.34%**	**79.75%**

Table 16: Hewitt HCA training /PDR (Trust performance on Blue Line)

7.0 Measurement of Quality of Care

There is positive assurance gained from Business Intelligence indicating that good quality care is provided particularly during the admission process of risk assessments for patients admitted into the inpatient ward, whereby all patients are assessed for risks associated with Falls, Nutrition, Tissue Viability.

For the reporting period January 2023 to June 2023 there were four incidents reported of which three related to the patient skin inspection and integrity following examination on admission however, there were no Hospital Acquired Pressure Ulcers reported. Key performance indicators for Falls and Must assessments have been above 98% with no incidents reported. Venous Thromboembolism (VTE) Assessments completed by the Medical Team have improved in the reporting period currently at 88% compared to 78% in December 2022 with no Hospital Associated VTE harms reported. A further measure of quality of care is evidenced by the recent Gold 'Being Brilliant Accreditation System' awarded to the Gynaecology inpatient ward, Bedford Unit and Gynaecology Emergency Department.

7.1 Clinical Incident Reporting

From January 2023 to June 2023, 996 clinical incidents were reported across the division, in comparison this shows an increase from those reported in the previous 6 months, The Top 5 cause groups are noted to be: Diagnosis, Appointments, Communication, Clinical Management, Admissions, Transfer, and discharges. The main theme identified in the incidents reported are the non-reporting of Ultrasound Scan results on the PACS and CRIS system, this has been escalated to the Clinical Director and Clinical Lead and actions have been put in place and entered on Ulysses to notify clinicians to complete and the governance team keep a record of actions to follow up.

Of those incidents those that relate to staffing were 41 incidents across the division which was a decrease of 13 from the previous reporting period. The incidents were mostly related to medical staffing, however a small number of incidents related to nursing staffing in the GED department and Hewitt Knutsford Centre. No themes identified.

There were no nursing red flags incidents reported during January 2023-June 2023.

7.2 Serious Incidents

Seven Serious incidents were declared within the division between January 2023 and June 2023. The breakdown is as follows: 1 emergency to Warrington from HFC, 1 relates to communication/patient deviation from protocol, 1 'delay to follow up', 1 diagnosis delay, 1 misdiagnosis and 1 related to a control drug. In addition, there was 1 unexpected maternal death in this reporting period, patient was brought in by ambulance to GED with upper right

upper quadrant and lower abdominal pain, she was 18 weeks pregnant the patient deteriorated and died. Actions from the Serious Incidents will be implemented and shared for lessons learned.

7.3 Patient Experience - Friends and Family Test (FFT)

A total of 6 displeased comments were received during the period January 2023 to June 2023 for the division with comments relating to "staffing numbers" in the departments. In addition, there were 30 comments received relating to "please tell us anything we could have done better" where staffing numbers/shortages were raised as something that needed to be improved. Difficulty in contacting GED/appointment lines, waiting times for clinic appointments and waiting times in GED are also reported. To support improvement the division have introduced daily Matron walkabouts to gather timely feedback aiming to resolve and capture themes of the day. The PALs team in addition are able to contact the Matron of the day via a mobile telephone if a call is received to enable concerns to be resolved on the day.

7.4 Complaints, Concerns and Compliment

The Division received seventeen formal complaints between January 2023 – June 2023, the main theme of the complaints being delays for surgery and requests for reimbursements for fertility treatment, there were no formal complaints regarding staffing concerns.

Between January and June 2023 there were 893 PALs concerns raised for the Division of Gynaecology and Hewitt, top themes identified were Appointment booking and Communication with the patient. There were no PALs concerns relating to staffing for this recording period.

24 compliments were received for the Gynaecology and Hewitt Division in particular the Outpatient Department, thanking staff for their compassionate care as per below demonstrates.

"Would just like to say how lovely the staff that I saw today (27th February 2023) at the hysteroscopy clinic were. The consultant gynaecology nurse, Gillian, put me at ease and made the whole experience as pleasant as it could be. She is a credit to your hospital".

8.0 Staff Experience

The results of the National Staff Survey conducted in September 2022 was received in the previous quarter. The themes that emerged focused on the request for Flexibility and Work life Balance, Wellbeing and Being Proud to work in Gynaecology and LWH. The survey results were shared across the division to all staff and actions planned are as follows:

- Look to offer unlimited flexible requests in all areas of the Division to promote flexible working to improve work life balance.
- Identify wellbeing and engagement champion from each area.
- Produce a quarterly poster to highlight the good work that takes place in Gynaecology Division, highlighting the recent CQC inspection, ward accreditation and thanking staff for their contribution and identify any staff suggestions which have improved employee's experience at work.

Break audits have been undertaken through this reporting period across all departments. The findings highlighted that Nursing and HCA staff in Gynaecology can take planned breaks during their working hours. To support staff further

during financial difficulties a staff pantry has been introduced alongside the daily delivery of breakfast provisions allocated to all departments.

8.1 Staff reported incidents (Violence and Aggression)

All incidents are reported through the Ulysses system. For the period of January 2023 to June 2023 there were 6 violence and aggression (non- physical Assault) incidents reported during this reporting period with the breakdown reflecting that 5 were in Gynaecology ED, and 1 Gynaecology OPD with the main issue of concern to patients noted as the waiting times in the departments. Actions taken reflect notifications displayed within the clinical areas to notify patients and members of the public that violence and aggression aimed towards members of staff will not be tolerated. The Matron and Manager of the Gynaecology ED department have met with the Head of Security to discuss violence prevention strategies in the department and have implemented a 2 hourly welfare check of the department

8.2 Attraction, Recruitment and Retention

In accordance with the Cheshire and Merseyside NMAHP strategy the Division of Gynaecology operationalised the four domains of Workforce Development, Professional Practice, Continuous Improvement, and Person and Family Centred Care, (see Appendix A) aims of the strategy are to empower staff to reach their potential through development and training and ensuring staff are well equipped to deliver the right care to patients, as well as the Cheshire and Merseyside NMAHP strategy the division have adopted the NHS Long Term Workforce Plan with a focus on three themes to train, retain and reform. The primary objective being to recruit and retain staff and creating new ways of working flexibly.

Furthermore, by investing in two trainee Advanced Clinical Practitioners in Gynaecology who are clinically supervised by the Nurse Consultant team demonstrates the commitment of the division to continuously retain and develop staff. Hewitt Fertility Centre have also recruited two Trainee Advanced Nurse Practitioners. Specialist nurse roles within the division have been reviewed alongside age profiles of those staff and plan to invest further in training and development to succession plan. Job planning for the specialist nurse roles are undertaken annually to ensure clear job plans are in place.

9.0 Actions and Recommendations:

Update against previous actions to take during January-June 2023:

- The Senior Management Team will continue to work with HR and Finance Business Partners to create a succession plan for specialist services across Gynaecology as part of a wider workforce review **Update: A workforce plan is in place to ensure budget set to include requirements for succession planning.**
- Rotational opportunities for registered and unregistered staff have commenced and will continue which is embraced by staff helping to widen experience, knowledge, and awareness across the division **Update: All new recruited staff are offered rotational opportunities to work in all departments, established staff rotate across the division to support the teams.**
- Further ANP and ACP recruitment continues for succession planning and retention **Update: A further 2 ACP have been recruited.**
- On-going recruitment to vacancies and deep dive into areas of highest sickness to ensure managing sickness absence is in line with policy **Update: The Current vacancy rate is 1.5%, weekly sickness absence meetings**

with managers and HRBP have been introduced reviewing sickness and absence management is robust and RTW and health and wellbeing conversations are being undertaken.

- In conjunction with HR Business Partners and OD&L, develop staff through appraisal process (PDR), including talent management and developing future leaders through career conversations. **Update: PDR's are ongoing, staff have been identified by managers as aspiring leaders and undertaking in house leadership courses**
- Appropriate use of CPD/HEE spend noted in Divisional Training Needs Analysis with HoN oversight to support clinical, academic, and managerial development **Update: TNA's have been reviewed and training prioritised according to service needs and development for staff.**
- Review of the Endometriosis service and the requirement for investment in increase specialist nursing team **Update: incorporated as part of the workforce plan for division**
- Trainee Colposcopy Nurse to succession plan retiree in the next 2 years **Update: Part of the workforce plan**
- Trainee Urodynamic specialist nurse to succession plan in the next 2 years **Update: Part of the workforce plan**
- Focused Quality Improvement for the telephone triage (Netcall) system on GED **Update: this forms part of the review of GED option appraisal submitted.**
- Further work to be undertaken to review bed occupancy across HDU and Gynae in-patient ward with use of CPD/HEE monies to develop staff **Update: in progress, staff have completed training in Variable Rate Insulin Infusion (VRII) and step one critical care competencies.**
- Adoption of Enhanced Care model of care to manage patients who require enhanced care, but not HDU and combine staffing establishment **Update: In progress - once staff are trained to care for patients requiring enhanced care an enhanced care area within the ward bed base will be identified to care for patients so they will not require HDU**

Actions to take July 2023-December 2023:

- The Workforce plan for specialist nurses will be approved and recruitment will be undertaken.
- To continue and progress with the actions above that are deemed on-going and in progress.
- Include the Cheshire and Merseyside NMAHP and NHS Long Term Workforce Plan in the recruitment process.

10.0 Conclusions

The Putting People First committee are asked to gain assurance from the Gynaecology Division and the Hewitt Fertility Centre in relation to safer staffing. The committee are asked to note the report reflects the staffing levels and delivery of nursing care is meeting and exceeding the expected standards and the services are delivering good quality care and patient experience. Assurance should be further gained by the recent BBAS Gold achievements awarded to the Bedford Unit, Gynaecology Inpatient Unit, and the Gynaecology Emergency Department. The Committee is asked to take assurance that there is sufficient oversight in the Division of where improvements can be made with plans in place to action those changes. The division request the Committee take assurance from the contents of the paper, actions over the next six months, including continued support to the succession planning for the critical roles to future proof services.

Appendix A – Cheshire and Merseyside NMAHP Strategy Progress Update

Workforce Development	Professional Practice
• Divisional TNA review undertaken and to include RCN Education standards for areas to develop such as those Highlighted in Women's Health strategy e.g., Endometriosis and access to contraceptives • Review of critical and vulnerable roles and development of ACP workforce to strengthen (2 ACP and 2 TACP) advanced practice roles that support operational plans ✅ • Department mangers Leadership course for all band 7s ✅ • Development of HCA workforce – Care certificate ✅ • Secondment of Digital Matron – 2 days per week to support Gynaecology Future process mapping and Build. (Expanse project) ✅ • Divisional participation in flexible working survey and trial of unlimited off duty requests ✅ • RCA training completed across Nursing and medical, awareness of second victim impact as well as engagement in PSIRF adoption to support professional practice section of C&M strategy ✅ • Trial period of Shelford acuity audit – Gynaecology ward ✅ • Development of Nursing staff to level 1 step competencies completed ✅	• Band 7 Recruitment strengthened to develop a compassionate and values-based leadership team; Leadership style supported in positive BBAS feedback and supportive of creating a culture of safety. ✅ • OD work initiated for Gynaecology ward across both Nursing and Medical ✅ • Safety and Governance weekly meetings embedded and evidenced so that Nursing professionals can relate to and understand data for their clinical area and how this relates to them ✅ • Divisional PNA lead and PNA forum established to strengthen the availability of restorative/ reflective learning, ✅ • Monthly PNA sessions in Gynaecology, 2 staff qualified and a total of 7 more registered with ongoing training arrangements ✅ • Referral pathway in place for staff to access LWH psychologist support and or refer to CMI resilience Hub ✅ • Monthly 1:1 Matron and Manager established ✅ • Monthly group clinical supervision with ward managers and matrons established ✅ • Department Vision that links to Trust wide strategic vision on Display in all Departments. ✅
Continuous Improvement	**Person and Family Centred Care**
• Lessons Learned Log established to strengthen sources of improvement projects and or service change ✅ • Gynaecology research programmes utilised to shape service provision e.g., GED Mife/ Miso Trial for Miscarriage ✅ • Scoping of staff skill set in relation to Change/ innovation and transformation knowledge and skills completed ✅ • PDSA tool promoted as per QI strategy however some further focus required in to how this becomes a core component of everyday core business and how in interlinks with change/innovation and digitalisation ✅ • Quality and Safety Matron now in post to support Departments in bench marking services against NICE guidance and highlight for use at Divisional planning in terms of improvement priorities. ✅	• Stakeholder engagement in WHAM – Access to contraception post TOP being developed as is a key population/ regional need ✅ • Patient information on how to contact Department Matron with any feedback and or concerns visible in all Departments ✅ • PICKER / Impatient survey action plan ✅ • Operational review of GED to ensure services are appropriately resourced and developed to meet the needs of the community, telephone lines staffed ✅ • Engagement in Future Generations and Crown Street enhancement project to represent the needs of Gynaecology patients ✅ • Pathway change to support Urogynaecology patients post discharge (Urogynae team utilised to support TWOC management) ✅

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Appendix 7: Clinical Support Services Staffing overview January2023-June 2023

1.0 Introduction

The Clinical Support services division consists of the following services and clinical roles:

- Anaesthetics – Medical
- Imaging and CDC – Radiographers, Sonographers and Healthcare Assistants (also known as RDAs – Radiology Assistants)
- Pharmacy – Pharmacy technicians, Pharmacists, and Pharmacy assistants
- Physiotherapy – Specialist Physiotherapists
- Genetics – Medical, Genetic counsellors and assistants
- Surgical Services, which includes
    - Gynaecology and Obstetrics theatres – Nursing, Operating Department Practitioners and Healthcare assistants
    - Hospital Sterile Services unit – Healthcare assistants
    - Pre-operative assessment – Nursing and Healthcare assistants
    - Resuscitation training team - Operating Department Practitioners
    - Blood Transfusion training team - Operating Department Practitioners
- Dietetics team – employed by LUHFT via SLA
- Pathology – employed by LCL via SLA

2.0 Workforce planning - Staffing Tool

Unlike other professional groups, there is not yet an adapted national tool for AHPs and other CSS staffing that are able to provide a daily score or RAG rating to establish daily staffing levels, this is instead monitored via the Healthroster KPIs, and staffing issues escalated via trust daily huddles, with use of bank and agency where required to mitigate risk. Staffing levels and workforce planning for each department within CSS division takes direction from professional guidelines, where available, as well as activity/demand for each specialty, and professional knowledge, as recommended by the NHS Guidelines for Developing workforce safeguards (2018) as per Figure 1 below:

Figure 1: Principles of safe staffing

Theatres staffing follows the Association for Perioperative Practice (AfPP) guidelines (2022-2023), including recommendations for roles and skills mix for different subspecialties, such as the recommended roles for Obstetric procedures (2009).

An external review of theatres staffing took place in 2021, with a business case approved with the agreed option for annual incremental budget until recommendation is met for achievement of optimum staffing levels. This has led to a successful recruitment campaign, including the onboarding of 10 international nurses. The recent change in staffing levels has allowed for increased out of hours obstetric theatres capacity to allow a second operating room for out of hours emergencies. However, there is still capacity shortfall as there are rare occasions where a third emergency obstetric theatre is required, which is not currently staffed. The Trust has recently introduced theatres coordinator roles 24/7, previously only in place in hours, this has positively impacted more senior oversight for the out of hours teams, as well as acting as a contingency to cover clinical duties when required. Overall, the theatres budget is not yet in line with the external recommendation as to fully meet the AFPP guidelines and service demands. CSS intends to conduct a gap analysis to deliver a new business case to work towards the full allocation in the 2024/25 financial year.

Resuscitation guidelines for delivery of resuscitation training for NHS are based on the Quality Standards (Resuscitation Council, 2021). The Trust currently fulfil this requirement as the team is funded for 2.0WTE which is the recommendation for the size of the Trust.

The Society of Radiographers provides generic guidelines for safe staffing recommendation (2019). Recent changes have been made to ensure there are at least 2 Radiographers on-site during core hours, with the additional out of hours being covered via on-call. This has allowed for adequate safe staffing for this team. With regards to Ultrasound, the role of a Shift lead provides much needed cover for emergency scans, as well as allowing to cover some activity in the event of short notice absence, to maintain Diagnostic Waiting Times and Activity (DMO1) diagnostic timeframes, cancer pathways, and obstetric dating scans timeframes. The Trust's position on DMO1 at the end of June was 96%, being in a much better position than most trusts in the region despite ongoing vacancies.

In addition, British Medical Ultrasound Society (BMUS) provides guidelines for Chaperoning during intimate Ultrasound examinations (2022). Unfortunately, there is insufficient budget in 2023/24 for HCAs to cover this requirement, which has been identified in the CSS risk register. Alternatives are being explored such as trainee healthcare assistants or potentially the use of volunteers to support chaperoning duties.

The Chartered Society of Physiotherapy issued generic safe staffing guidelines and is currently testing a national tool for optimum staffing levels which CSS will review for potential introduction at the Trust if it can be adapted to specialties. The current staffing levels for Physiotherapy allow for adequate cover of inpatient support; however, the waiting times for Pelvic Floor are currently up to 6 months, which is not ideal, and has been identified as a risk in the CSS risk register, requiring further investment in the team to meet service demand. Other options have been explored and delivered, such as delivery of virtual pre-recorded classes, and use of other educational materials to mitigate the risk.

The General Pharmaceutical Council provides guidelines for Pharmacy safe and efficient staffing (2018). The Pharmacy staffing is divided between the team that cover the Pharmacy department, which dispenses medication to patients, as well as the Wards based Pharmacy team, which supports prescription and administration processes for inpatients. Pharmacy department cover has been increased in the last year to allow some weekend cover; however, this is not a full day cover and still has a shortfall in budgeted staffing to allow extension of hours in line with weekend discharges demand. In addition, further Medicines management improvements and support could be better provided with increased funding for all inpatient areas.

The British Dietetic Association (BDA) provides a guideline relevant to safe staffing workload for Dietitians (2017). Other relevant guidelines are the recently issued National Standards for Food and Drink (2022) as well as dietetic service requirements in Version 3 of the Saving Babies Lives bundle (2023). This service currently has significant shortfalls due to unfilled vacancies, shortage of budgeted capacity versus demand, and recent changes in guidelines requiring further dietetic support for patients. The Trust has an ongoing plan as to mitigate this, however, a further

business case is required to articulate changes in demand and risks. The dietetic service is highlighted on the CSS risk register.

Overall, apart from Obstetrics theatres, the CSS services are not yet fully compliant with the NHS 7-day services recommendations to deliver 7-day services. However, all services have arrangements for out of hours on-call which cover immediate clinical needs and emergencies.

The workforce budget for 2023-24 has been reviewed by all service leads and divisional senior management team, with ongoing queries for Imaging and Pharmacy, due to unfunded posts being worked through. All other budgets have been signed off and agreed.

3.0 Setting evidenced based establishments

3.1 Care Hours Per Patient Per Day (CHPPD) and Actual versus Planned Care

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 nurses/ midwives and nursing assistants 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. In CSS there is no requirement to measure CHPPD due to the division having no in-patient wards.

There are no benchmarked KPIs for activity versus staffing in place for the CSS services. As there is no national template for these services, further work with the Business Intelligence team is recommended for creation of dashboards to identify HPP (hours per patient) if possible, to establish Trust baseline and ongoing benchmarking.

Further work is required to establish capacity versus demand for each service to provide a gap analysis and form a baseline for future planning and business case delivery.

4.0 Operational oversight of staffing and acuity-based care

4.1 Temporary Staffing

The areas with highest use of Bank and Agency are Imaging and Theatres – which is in line with vacancies, staff on long term sickness or maternity leave and associated clinical demand to maintain activity.

In Imaging, temporary staff for HCA cover is in place to mitigate the risk of shortage of HCA support and non-compliance with BMUS guidelines and associated clinical risk, as reflected on the risk register. The plan to reduce this will be based on delivery of a business case to align budget with the demand to allow recruitment into temporary roles. With regards to Sonographers, there is a national and regional shortage of qualified professionals for this role; the Northwest Imaging Academy has been created to support transformation and planning for future workforce and advises increasing the number of clinical tutors to continue to expand the number of trainees; as well as robust induction and preceptorship programme to allow recruitment of candidates from direct Ultrasound access course routes. At the Trust, the Imaging department has recently undergone a Quality and Innovation transformation which includes a robust preceptorship and peer audit programme and is now able to start supporting candidates from direct ultrasound course who are now being considered as candidates for open vacancies. However, the team remains with only one budgeted Clinical Tutor, who is already supporting 3 rather than the standard 2 trainees; and further plans to implement a second Clinical Tutor to be prioritised for the following financial year.

In theatres, a successful recruitment campaign has taken place, which included he recruitment of 10 international nurses, as well as local recruitment for ODPs and Theatre HCAs. The high influx of new start, many of these without previous theatres experience, has led to up to 26 supernumerary staff at some point in the six-month period, which

has increased the demand of bank and agency to backfill the roles with experienced and competent staff during training periods. The theatres education team has introduced a supernumerary timeline and robust documentation for competency assessment and mentorship which is reviewed monthly to assess against trajectory targets. The trajectory expects to be significantly reduced by December 2023; although not completely removed due to ongoing staffing recruitment through turnover rates.

5.0 Divisional Nursing Workforce Measures (July-December 2022 data; Q2 & Q3 position)

5.1 Vacancy position

The data provided by Finance as to the overall position for vacancies across CSS is reflected in Table 1:

Directorate	Subjective Code Desc	Sum of Wte Budget	Sum of Wte Contracted	Sum of Vacancy
GENETICS SERVICES	B5 OTHER HEALTHCARE SCIENTIST	1.00	1.00	0.00
	B6 OTHER HEALTHCARE SCIENTIST	0.00	1.00	-1.00
	B7 CLINICAL SCIENTIST	0.00	4.60	-4.60
	B7 QUALIFIED NURSE	8.60	4.30	4.30
	B8 QUALIFIED NURSE	3.40	4.30	-0.90
GENETICS SERVICES Total		**13.00**	**15.20**	**-2.20**
IMAGING	B2 HEALTHCARE ASSISTANT	4.59	6.44	-1.85
	B6 RADIOGRAPHER	3.63	5.99	-2.36
	B7 RADIOGRAPHER	14.96	10.36	4.60
	B8 Radiographer	2.42	3.18	-0.76
IMAGING Total		**25.60**	**25.97**	**-0.37**
PHYSIOTHERAPY	B6 PHYSIOTHERAPIST	1.58	1.43	0.15
	B7 PHYSIOTHERAPIST	2.00	2.27	-0.27
	B8 PHYSIOTHERAPIST	1.00	1.00	0.00
PHYSIOTHERAPY Total		**4.58**	**4.70**	**-0.12**
THEATRES	B2 HEALTHCARE ASSISTANT	22.45	20.90	1.55
	B3 HEALTHCARE ASSISTANT	4.93	9.95	-5.02
	B4 OTHER HEALTHCARE SCIENTIST	0.00	1.00	-1.00
	B5 OTHER HEALTHCARE SCIENTIST	20.03	10.56	9.47
	B5 QUALIFIED NURSE	24.20	31.92	-7.72
	B6 OTHER HEALTHCARE SCIENTIST	18.65	14.11	4.54
	B6 QUALIFIED NURSE	23.57	18.35	5.22
	B7 OTHER HEALTHCARE SCIENTIST	4.53	1.53	3.00
	B7 QUALIFIED NURSE	1.00	4.80	-3.80
	B8 QUALIFIED NURSE	1.00	1.00	0.00
	SUPPORT STAFF BANK	0.00	0.00	0.00
	B5 QUALIFIED BANK NURSE	0.00	0.00	0.00
	B6 QUALIFIED BANK NURSE	0.00	0.00	0.00
	AGENCY NURSING	0.00	0.00	0.00
	AGENCY OPERATING DEPT PRACTITIONER	0.00	0.00	0.00
THEATRES Total		**120.36**	**114.12**	**6.24**

Table 1: Month 3 CSS Vacancies

Upon local review, the data for budget, over establishment and vacancies has a variation from that noted in Table 1.

The budget has not been aligned to account for some recently introduced roles, particularly Pharmacy technicians and HCAs in some departments. In addition, some roles where staff are on maternity leave have not been approved to be backfilled, causing impact in activity and overtime as added pressures.

The following clinical vacancies are of significance which impact staffing levels and patient waiting times:

- 3 WTE in Imaging – Sonographers
- 0.5 WTE Physiotherapist
- 2.2 WTE Dietitians
- 0.7 WTE Genetics Counsellor
- 7 WTE Theatres staffing (RN/ODP)

5.2 Maternity Leave

The following tables show the rates and number for maternity leave across the division from January to June 2023.

		2023 / 01	2023 / 02	2023 / 03	2023 / 04	2023 / 05	2023 / 06
		Absence FTE %	Absence FTE %	Absence FTE %	Absence FTE %	Absence FTE %	Absence FTE %
159 Clinical Support Services L2	Additional Clinical Services	3.55%	5.00%	4.92%	4.60%	4.51%	4.87%
159 Clinical Support Services L2	Allied Health Professionals	3.26%	3.53%	5.28%	9.07%	8.90%	8.93%
159 Clinical Support Services L2	Nursing and Midwifery Registered	2.54%	2.98%	2.83%	3.26%	3.91%	3.81%
159 Clinical Support Services Grand Total		3.47%	4.02%	4.43%	5.27%	5.38%	5.48%

Table 2: Maternity absence rates per professional group

			2023 / 01	2023 / 02	2023 / 03	2023 / 04	2023 / 05	2023 / 06
			# Absence Occurrences	# Absence Occurrences	# Absence Occurrences	# Absence Occurrences	# Absence Occurrences	# Absence Occurrences
159 Clinical Support Services L2	159 Genetics L3	Additional Clinical Services	2	2	2	2	2	2
159 Clinical Support Services L2	159 Genetics L3	Nursing and Midwifery Registered	0	0	0	0	0	0
159 Clinical Support Services L2	159 Imaging L3	Additional Clinical Services	0	0	0	0	0	0
159 Clinical Support Services L2	159 Imaging L3	Allied Health Professionals	0	1	1	3	3	3
159 Clinical Support Services L2	159 Imaging L3	Nursing and Midwifery Registered	0	0	0	0	0	0
159 Clinical Support Services L2	159 Pharmacy L3	Additional Clinical Services	0	0	0	0	0	0
159 Clinical Support Services L2	159 Physiotherapy L3	Allied Health Professionals	0	0	1	1	1	1
159 Clinical Support Services L2	159 Surgical Services L3	Additional Clinical Services	1	1	1	1	1	1
159 Clinical Support Services L2	159 Surgical Services L3	Allied Health Professionals	2	2	3	3	2	2
159 Clinical Support Services L2	159 Surgical Services L3	Nursing and Midwifery Registered	2	2	2	3	3	3
Total			7	8	10	13	12	12

Table 3: Maternity absence rates per department and staff group

The data shows that maternity leave accounts for approximately 5% of workforce absence, with higher prevalence in Imaging and Theatres. In Imaging, vacancies due to maternity leave have not been backfilled due to inability to recruit to short term contracts and ongoing permanent vacancies. In theatres due to timeframe required for staff training this makes short-term contracts inefficient due to shortages of already experienced staffing. In Genetics, a cost versus benefit approach was taken to determine the necessity to keep within budget rather than backfill.

5.3 Sickness absence, including LTS/STS

Whilst sickness rates have decreased since the previous period, with an overall average of 8.35%. the division continues to work with the HRBP to continue improvements and monitor reasons for sickness as well as provide adequate support, particularly for long term sickness, as per data below in Table 4 and Table 5.

	Jan-23			Feb-23			Mar-23			Apr-23			May-23			Jun-23		
	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP
Sickness	6.11%	5.33%	10.82%	6.23%	3.53%	6.84%	6.90%	6.48%	8.72%	5.68%	4.22%	6.55%	7.28%	5.86%	7.04%	6.08%	3.37%	9.13%
Staff Group Trust Total	**11.07%**	**8.03%**	**10.74%**	**10.10%**	**6.30%**	**7.52%**	**9.73%**	**7.05%**	**9.45%**	**11.08%**	**6.07%**	**6.56%**	**9.83%**	**5.64%**	**7.00%**	**10.12%**	**5.78%**	**8.21%**

Table 4: Sickness rates for CSS division (Jan-Jun 23)

	Jan-23		Feb-23		Mar-23		Apr-23		May-23		Jun-23	
	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term
NMC	62.27%	37.73%	54.90%	45.10%	43.92%	56.08%	51.90%	48.10%	53.93%	46.07%	49.20%	50.80%
NMC Staff Group Trust Total	**38.59%**	**61.41%**	**36.88%**	**63.12%**	**32.98%**	**67.02%**	**34.73%**	**65.27%**	**29.50%**	**70.50%**	**35.16%**	**64.84%**

	Jan-23		Feb-23		Mar-23		Apr-23		May-23		Jun-23	
	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term
HCA	41.61%	58.39%	63.80%	36.20%	54.22%	45.78%	42.07%	57.93%	43.67%	56.33%	10.29%	89.71%
HCA Staff Group Trust Total	**33.11%**	**66.89%**	**42.22%**	**57.78%**	**33.31%**	**66.69%**	**25.27%**	**74.73%**	**20.82%**	**79.18%**	**34.53%**	**65.47%**

	Jan-23		Feb-23		Mar-23		Apr-23		May-23		Jun-23	
	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term	Short Term	Long Term
AHP	25.74%	74.26%	37.95%	62.05%	25.21%	74.79%	19.46%	80.54%	14.32%	85.68%	20.13%	79.87%
AHP Staff Group Trust Total	**27.59%**	**72.41%**	**33.43%**	**66.57%**	**29.09%**	**70.91%**	**17.39%**	**82.61%**	**12.89%**	**87.11%**	**19.90%**	**80.10%**

Table 5: Sickness rates for CSS division per staff group (Jan-Jun 23)

The top 3 absence reasons in the last 6 months noted in CSS division are as follows:

- Anxiety / Stress/ Depression
- Gastrointestinal Problems
- Cold / Cough / Flu

Since April 2023 Musculoskeletal as an absence reason has replaced Cold / Cough / Flu as one of the top 3.

5.4 Turnover

CSS Staff turnover for January to June 2023 is detailed in Table 6:

	Jan-23			Feb-23			Mar-23			Apr-23			May-23			Jun-23		
	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP
Turnover	25.51%	16.56%	13.93%	23.51%	12.65%	15.56%	20.82%	8.37%	13.91%	19.22%	6.34%	16.63%	21.17%	7.91%	0.00%	21.88%	7.91%	9.67%
Staff Group Trust Total	13.46%	9.89%	13.49%	13.45%	10.62%	15.09%	12.78%	9.37%	13.53%	11.78%	8.88%	16.16%	12.88%	9.00%	0.00%	12.84%	8.77%	9.38%
Trust Target 13%																		

Table 6: CSS overall staff turnover (Jan-Jun 23)

The overall average for turnover for CSS Jan-June 2023 is **11.19%**, which is below the Trust threshold and has improved in this period for registered professionals across CSS. However, HCA turnover remains as the highest staff group turnover across the division.

5.5 Age profile

The tables below demonstrate the age profile across the NMAHP staff groups in CSS division:

Clinical Support Services	Jan-23			Feb-23			Mar-23			Apr-23			May-23			Jun-23		
	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP
<=20 Years	0.56%	0.00%	0.00%	0.54%	0.00%	0.00%	0.50%	0.00%	0.00%	0.52%	0.00%	0.00%	0.51%	0.00%	0.00%	0.52%	0.00%	0.00%
21-25	5.65%	1.69%	0.56%	5.41%	1.62%	0.54%	4.02%	1.51%	2.51%	4.12%	1.55%	2.06%	3.54%	2.02%	2.02%	3.61%	2.06%	1.55%
26-30	6.78%	2.82%	1.69%	6.49%	2.70%	1.62%	7.04%	3.02%	2.01%	6.19%	3.61%	1.55%	6.06%	3.54%	1.52%	5.15%	3.61%	2.06%
31-35	5.65%	4.52%	7.91%	5.95%	4.32%	7.57%	5.03%	5.03%	8.04%	5.67%	5.67%	7.22%	7.58%	5.56%	7.58%	6.70%	7.22%	7.22%
36-40	5.08%	3.95%	3.39%	5.95%	3.78%	3.24%	5.53%	3.52%	4.52%	5.67%	3.61%	4.64%	5.56%	3.03%	4.55%	5.15%	3.09%	5.15%
41-45	3.95%	6.21%	5.08%	3.78%	5.95%	4.86%	3.52%	5.53%	4.52%	4.12%	6.70%	4.64%	4.55%	6.57%	4.04%	4.64%	6.70%	4.12%
46-50	1.13%	6.21%	3.39%	1.08%	5.95%	3.24%	1.01%	5.03%	2.51%	1.03%	4.12%	2.58%	1.52%	4.04%	3.03%	1.55%	3.61%	3.61%
51-55	3.95%	3.95%	3.39%	4.86%	4.32%	3.78%	4.02%	5.03%	4.52%	4.12%	5.15%	3.61%	3.54%	5.05%	3.54%	3.61%	4.12%	4.64%
56-60	1.69%	3.39%	2.26%	1.62%	3.24%	2.16%	2.01%	3.02%	1.51%	2.06%	2.58%	1.03%	1.52%	2.53%	1.01%	1.03%	2.58%	1.03%
61-65	2.26%	1.13%	1.13%	2.16%	1.08%	1.62%	2.01%	1.51%	1.51%	2.06%	2.06%	1.55%	2.02%	2.02%	1.52%	1.03%	2.06%	1.55%
66-70	0.56%	0.00%	0.00%	0.54%	0.00%	0.00%	0.50%	0.00%	0.00%	0.52%	0.00%	0.00%	0.51%	0.00%	0.00%	1.03%	0.00%	0.00%
>=71 Years	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Total	**37.29%**	**33.90%**	**28.81%**	**38.38%**	**32.97%**	**28.65%**	**35.18%**	**33.17%**	**31.66%**	**36.08%**	**35.05%**	**28.87%**	**36.87%**	**34.34%**	**28.79%**	**34.02%**	**35.05%**	**30.93%**

Table 7: Age Profile in CSS as a percentage of total workforce (Jan-Jun 23)

Clinical Support Services	Jan-23			Feb-23			Mar-23			Apr-23			May-23			Jun-23		
	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP	HCA	NMC	AHP
<=20 Years	1	0	0	1	0	0	1	0	0	1	0	0	1	0	0	1	0	0
21-25	10	3	1	10	3	1	8	3	5	8	3	4	7	4	4	7	4	3
26-30	12	5	3	12	5	3	14	6	4	12	7	3	12	7	3	10	7	4
31-35	10	8	14	11	8	14	10	10	16	11	11	14	15	11	15	13	14	14
36-40	9	7	6	11	7	6	11	7	9	11	7	9	11	6	9	10	6	10
41-45	7	11	9	7	11	9	7	11	9	8	13	9	9	13	8	9	13	8
46-50	2	11	6	2	11	6	2	10	5	2	8	5	3	8	6	3	7	7
51-55	7	7	6	9	8	7	8	10	9	8	10	7	7	10	7	7	8	9
56-60	3	6	4	3	6	4	4	6	3	4	5	2	3	5	2	2	5	2
61-65	4	2	2	4	2	3	4	3	3	4	4	3	4	4	3	2	4	3
66-70	1	0	0	1	0	0	1	0	0	1	0	0	1	0	0	2	0	0
>=71 Years	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total HC - CSS	66	60	51	71	61	53	70	66	63	70	68	56	73	68	57	66	68	60

Table 8: Age profile by wte in CSS (Jan-Jun 23)

Overall, the tables show a good distribution. As of June 2023, 5.67% of staff were above the age of 60.

6.0 Divisional Nursing, Midwifery and AHP Training and Personal Development Review

Table 9 demonstrates training and PDR compliance across CSS:

	Jan-23				Feb-23				Mar-23				Apr-23				May-23				Jun-23			
	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR
NMC	96.79%	97.40%	97.96%	95.92%	97.29%	97.50%	98.69%	94.12%	96.65%	96.67%	100.00%	94.23%	95.57%	91.01%	97.14%	94.74%	96.87%	96.58%	99.63%	95.00%	98.71%	98.17%	98.94%	84.13%
NMC Staff Group Trust Total	77.57%	74.91%	89.49%	74.40%	78.81%	74.67%	89.79%	73.50%	78.52%	73.98%	89.26%	66.91%	81.21%	79.97%	91.66%	71.69%	81.62%	81.28%	92.01%	76.50%	85.50%	83.96%	91.94%	90.00%

	Jan-23				Feb-23				Mar-23				Apr-23				May-23				Jun-23			
	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR
HCA	97.58%	92.86%	96.45%	94.00%	97.27%	92.68%	99.05%	92.68%	97.52%	91.30%	98.22%	100.00%	97.63%	88.00%	98.28%	98.25%	92.90%	90.00%	98.10%	98.25%	97.87%	100.00%	99.47%	96.43%
HCA Staff Group Trust Total	86.37%	83.15%	95.49%	72.22%	85.83%	81.05%	95.84%	72.85%	84.87%	77.54%	93.51%	72.94%	86.00%	78.37%	95.41%	67.11%	86.57%	80.36%	95.69%	69.20%	88.13%	78.06%	95.34%	79.75%

	Jan-23				Feb-23				Mar-23				Apr-23				May-23				Jun-23			
	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR	CMT	LMT	MT	PDR
AHP	92.43%	94.79%	97.35%	85.37%	91.62%	92.55%	97.62%	94.12%	94.76%	93.00%	97.42%	97.62%	94.77%	91.38%	97.46%	93.02%	93.14%	93.33%	98.02%	90.91%	94.90%	94.67%	98.86%	89.58%
AHP Staff Group Trust Total	91.28%	94.79%	97.47%	81.40%	91.58%	92.55%	97.67%	90.48%	94.35%	87.88%	97.40%	91.11%	93.29%	87.16%	97.64%	86.96%	93.17%	92.59%	97.64%	86.96%	93.92%	93.51%	98.50%	86.97%

Table 9: CSS Training and PDR compliance (Jan-June 23)

The numbers demonstrate that training compliance is above the 90% target on average for the period. This is possibly due to a good culture of monitoring, scheduling, and prioritisation, including protected time for completion of modules. Further efforts are required to slightly improve the PDR compliance position, which should be expected in line with new ePDR process introduced Trustwide.

7.0 Measurement of Quality of Care

All Clinical KPIs are reviewed monthly via the Power BI Divisional Performance review, as well as the Monthly Governance report. Weekly governance meetings take place to monitor progression of incidents, risks, and action plans.

7.1 Clinical Incident Reporting

Total clinical incidents reported	348
Total clinical incidents related to staffing	25
Top 5 cause groups	
Investigations	52
Clinical Management	45
Communication	41
Medication	36

Patient Records / Identification	25

Table 10: Reported Clinical incidents per group type across CSS (Jan-Jun23)

In the six-month period, the division has had a total of 25 clinical incidents that are directly related to staffing with some of the key themes that impact staff directly noted as:

- Staffing level concerns
- Inability to take breaks
- Impact to staff due to activity delay or overruns

7.2 Red flag events

Red flag reporting is not applicable to CSS division as the division has no inpatient areas.

7.3 Serious Incidents

There have been no Serious Incidents (SIs) or Never Events reported for CSS between January and June 2023. 3 previous SIs and 1 Never Event have been finalised and closed by the Integrated Care Board during this period.

There are 20 ongoing actions from previous SIs / Never Events, with ongoing monthly monitoring for progression.

7.4 Patient Experience - Friends and Family Test (FFT)

Figure 2 demonstrates the satisfaction scores from FFT for Genetics, with an average of 92.38% over the January to June period. Further developments are required to obtain data from the remaining CSS departments.

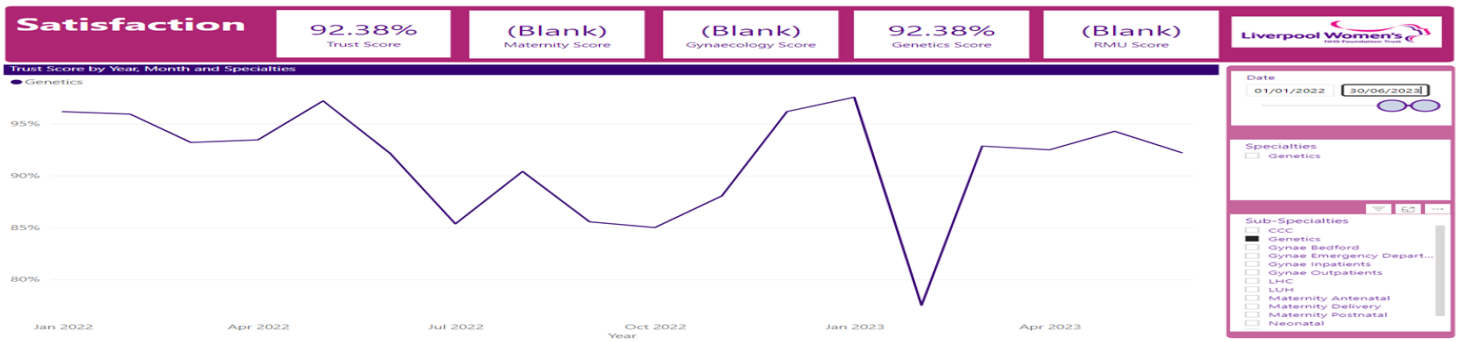


Figure 2: Genetics FFT scores (Jan-Jun 23)

7.5 Complaints, Concerns and Compliments

For CSS there were no formal complaints and no PALS + cases received with 81 PALS cases recorded in this period overall. None of the PALs cases related to staffing issues being raised by the patient/carer.

CSS received 2 compliments in the period.

7.6 Staff Experience

The CSS has introduced a Staff Newsletter which shares learning and news relevant to the workforce, such as list of new starters, trust wide role opportunities, excellence reports, award winners, winners of departmental employee of the month schemes as well as upcoming events, information about wellbeing and employee benefits. The newsletter is circulated widely and keeps staff updated on local news as well as updating on any relevant Trustwide and National news. Good feedback from corporate teams has been received on the content.

7.7 Staff reported incidents (Violence and Aggression)

The data for January-June 2023 highlights 3 reported incidents of Violence and Aggression within CSS division. Of the 3 reported incidences all were recorded as non-physical assault but rather verbal abuse (visitor on staff) of which 2 incidences occurred in Imaging department and 1 in the Genetics department.

The Trust has recently introduced a Task and Finish group aimed at reducing violence and aggression. CSS division has supported this group by sending two representatives, one member from Pharmacy and one from Imaging. They will support the implementation of a Trustwide action plan, raise awareness, and influence training delivery to tackle issues and improve employee safety and wellbeing in the workplace.

8.0 Attraction, Recruitment and Retention

CSS has recruited a total of 25 staff in the reported 6 month-period, of which 22 are NMAHP clinical roles across different departments (Table 11). Overall, the retention rate has improved since last period, with further effort required particularly around HCA roles in Imaging and Theatres, mostly derived from being under the regional benchmark for HCA Agenda for Change banding.

The division actively promotes staff wellbeing initiatives and internal development opportunities, with 6 staff currently undertaking internal leadership programmes and a Training Needs Analysis programme which prioritises funding for attendance to external courses and CPD opportunities. Initial steps for identification of talent have been initiated with the L&D team, however, further development is required for establishment of succession planning across the specialist leads and managerial roles.

CSS NMAHP Starters January - June 2023	
CSS Management - Head of AHPS	1
Imaging	4
Pharmacy	4
Physiotherapy	1
Surgical Services	12
Total	22

Table 11: New starters per department (Jan-Jun23)

9.0 Actions and Recommendations:

Update against previous actions to take during January-June 2023 (Table 12):

Action	Update comments	Status
1. Support the Practice Education Facilitators to mitigate the risk of delays in preceptorship and staff we have recently recruited in theatre from leaving prematurely.	The preceptorship and competencies package has been updated and a supernumerary timeline created to monitor progress of the induction and supervision process, with good progress of the candidates. Review of the documentation now includes escalation steps for delays in competency achievement, and adequate early identification of issues and HR involvement where required	Completed
2. Recruitment drive in radiography due to fragility of workforce	Bank Radiographer recruitment was prioritised whilst working up the workforce plan to include CDC radiography.	Ongoing
3. Agreeing the workforce model for the Community Diagnostic Centre (CDC) and communicating this to radiographers with clarity on opportunities to cover CT and MRI for career progression to support on-going recruitment and retention in the Radiography Service.	Workforce plan and Imaging options paper were delivered and awaiting Regional Partnership board decisions for next steps	Ongoing
4. Review scope of HCA role within CDC to improve retention across Imaging HCA workforce.	On hold whilst Imaging / CDC options discussed regionally	On Hold
5. Expansion of HCA workforce within the Imaging department to ensure best clinical practice.	Increase of workforce to match service demands was not accommodated as budget growth for 23-24. Alternative options for support workforce are being explored whilst waiting for CDC/Imaging workforce decisions	Ongoing
6. Improving staffing for the X-ray on-call rota and agreeing requirements to be resident on site for on-call if staff cannot guarantee a 30 min response time. Agreeing payment for staff who are resident during their on-call.	Location for residential on-call has been agreed with trust, the space is not ready for use as pending furniture installation. Discussions with HR and Finance are ongoing to model out payment for residential on-call with lack of benchmarking due to no similar models across the region	Ongoing
7. Monitoring risks across all areas that relate to safe staffing.	Risk register updated and included risks in areas of concern for safe staffing, particularly Imaging and Dietetics	Complete
8. Planned focus on Dietetic Service to futureproof LWH requirements.	Service Improvement plan delivered, and Phase I budget agreed for 23 24, recruitment via LUHFT ongoing to fill current vacancies and progress with Phase II business case.	Ongoing
9. Planning the welcome and onboarding of 10 international scrub nurses.	9 International nurses were onboarded up to June, with a further nurse expected in the following period. All nurses were provided with peer support and a welcoming package with ongoing pastoral support	Complete
10. Support a dedicated pharmacist within the Meditech Expanse project to aid the EPR team following the roll out of the project.	Pharmacist roles supporting digital, with a plan to make the roles permanent for further digital pharmacy support, including electronic prescribing and auditing.	Ongoing
11. Recruitment of Quality and Safety lead in Imaging for a fixed term period of 12 months to support ongoing improvement work following the SI's reported in July 22.	An internal Sonographer has been appointed as Quality and Safety lead in April 2023 and the role will be reviewed ahead of the next financial year.	Completed
12. Business case for additional staff in Genomic Medicine including genetic counsellor posts to ensure all aspects of the new service specification can be met.	The national service specification release date has been postponed.	On Hold

Table 12: Action updates

The report findings demonstrate the following recommended actions:

1. Capacity and demand modelling for each service in line with safe staffing guidelines for each professional category
2. Delivery of business cases to align budget with service demands
3. Continued review of risks where budget does not incorporate guidelines and recommendations, as well as areas where vacancies are difficult to recruit, such as Sonographers
4. Development of KPI benchmarks for activity versus staffing to use as a staffing tool
5. Ongoing action planning for training and preceptorship programmes as well as retention initiatives as to reduce turnover, volume of supernumerary staff, and as a result high utilisation of temporary staffing
6. Budget realignment as per pre-existing establishments
7. Agenda for Change job matching of HCA roles in Theatres and Imaging
8. Work with OD and Finance to support re-calculation on an annual basis of headroom
9. Continue to work with HRBP for staff on LTS with timelines and action plans to support staff, ensuring Occupational Health involvement takes place at an early stage
10. Maintain good standards and culture around mandatory training compliance
11. Improve PDR compliance in line with new timetables for ePDR process
12. Monitor trends of incidents related to workforce
13. Progression and closure of SI / Never Event action plans
14. Engagement with the trust wide violence reduction task and finish group
15. Quarterly review of the TNA budget and prioritisation

10.0 Conclusions

It is recommended that the putting People First Committee receive and note the information provided in this paper.

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*23/24/184d*		Date: 24/10/2023	
Report Title	Seven Day Working Board Assurance			
Prepared by	Chris Dewhurst, Deputy Medical Director			
Presented by	Lynn Greenhalgh, Medical Director			
Key Issues / Messages	Trust Boards should assess at least once a year whether their acute services are meeting the four priority 7DS clinical standards to demonstrate their performance against the four priority 7DS clinical standards to their commissioners and to their regulators.			
Action required	Approve ☐	Receive ☐	Note ☒	Take Assurance ☒
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable): N/A			
	For Decisions - in line with Risk Appetite Statement – Y *If no – please outline the reasons for deviation.*			
	The Trust Board are recommended to review the contents of this paper and be assured that: *i. There is no statistically significant variation in the length of stay nor number of discharges at the weekend.* *ii. There are fewer discharges at the weekend of maternity patients. The support for the timely discharge of women at the weekend will be included in the Maternity Transformation board work.* *iii. The reduced number of discharges on Sunday in Gynaecology reflects the reduced number of admissions at the weekend.* *iv. There are medical staffing strategies in place to increase consultant presence out of hours.* *v. It remains a corporate objective to provide 24/7 consultant presence for Obstetrics in 2024/245.*			
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)	Comment: N/A
Link to the Corporate Risk Register (CRR) – CR Number: 2323	The Trust is currently non-compliant with standards 2,5,6 of the seven day service standards Cause: There is insufficient number of consultants to run consultant of the week rota, the Trust is non co-located which is affecting seven day access to

	diagnostic services and 24hr access to consultant delivered interventions Consequence: Non-compliance with requirements, impact on reputation, impact on patient safety, lack of equity of service presence across locality. Extreme Risk. Scored at 15.

EXECUTIVE SUMMARY

The Seven Day Hospital Services (7DS) Clinical Standards were developed to support providers of acute services to deliver high quality care and improve outcomes on a seven-day basis for patients admitted to hospital in an emergency. The importance of ensuring that patients receive the same level of high-quality care every day is reflected in the inclusion of these standards in the NHS Standard Contract. Delivery of the 7DS clinical standards should also support better patient flow through acute hospitals.

Ten 7DS clinical standards were originally developed by the NHS Services, in 2013 with four priority standards selected

1. to ensure that patients have access to consultant-directed assessment (Clinical Standard 2),
2. diagnostics (Clinical Standard 5),
3. interventions (Clinical Standard 6) and
4. ongoing review (Clinical Standard 8) every day of the week.

Trust Boards should assess at least once a year whether their acute services are meeting the four priority 7DS clinical standards to demonstrate their performance against the four priority 7DS clinical standards to their commissioners and to their regulators.

The findings of the 7-day service review demonstrate that there are no differences in the average length of stay for emergency patients admitted at the weekend. There are fewer maternity patients discharged at the weekend and the need to support weekend discharges will be reviewed in the Maternity Transformation Board.

The provision of urgent in-patient CT scans at the weekend has been developed with the introduction of these imaging modalities in the CDC. However, other diagnostic tests and consultant led interventions are not available on-site but are provided within the local networks. It is recognised that several of these requirements will not be on-site until LWH is co-located with another adult acute provider.

Consultant Job plans provide for medical cover across all 7 days. However, there is reduced consultant presence at the weekend compared to weekdays in areas such as Medical Assessment Unit/Post-natal ward and the Gynaecology Emergency Department. It is decided if a corporate objective to provide 24/7 obstetric cover in 24/25. Divisional medical workforce strategies are in place to increase consultant presence at the weekend and out of hours. There are however competing challenges of where resource should be allocated within current financial budgets.

It is recommended that the Board are assured that this paper highlights the variance from the 7-day service standards.

MAIN REPORT

1. Background

A substantial body of evidence exists which indicates significant variation in outcomes for patients admitted to hospitals in an emergency, at the weekend across the NHS in England. This variation is seen in mortality rates, patient experience, length of hospital stay and re-admission rates. Additionally medical, nursing, other health professional and managerial staffing levels, as well as trainee doctors' perceptions of supervision by consultants, also vary by day of the week.

To tackle this, in 2013 the NHS Services, Seven Days a Week Forum developed 10 clinical standards to end variations in outcomes at the weekend. The 10 standards are below.

1. Patients, and where appropriate families and carers, must be actively involved in shared decision making and supported by clear information from health and social care professionals to make fully informed choices about investigations, treatment and on-going care that reflect what is important to them. This should happen consistently, seven days a week.

2. All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.

3. All emergency inpatients must be assessed for complex or on-going needs within 14 hours by a multi-professional team, overseen by a competent decision-maker, unless deemed unnecessary by the responsible consultant. An integrated management plan with estimated discharge date and physiological and functional criteria for discharge must be in place along with completed medicines reconciliation within 24 hours.

4. Handovers must be led by a competent senior decision maker and take place at a designated time and place, with multi-professional participation from the relevant in-coming and out-going shifts. Handover processes, including communication and documentation, must be reflected in hospital policy and standardised across seven days of the week.

5. Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week:

6. Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.

7. Liaison mental health services should be available to respond to referrals and provide urgent and emergency mental health care in acute hospitals with 24/7 Emergency Departments 24 hours a day, 7 days a week.

8. All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.

9. Support services, both in the hospital and in primary, community and mental health settings must be available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken.

10. All those involved in the delivery of acute care must participate in the review of patient outcomes to drive care quality improvement. The duties, working hours and supervision of trainees in all healthcare professions must be consistent with the delivery of high-quality, safe patient care, seven days a week.

Trust Boards should demonstrate their performance against. four priority standards;

1. Ensure that patients have access to consultant-directed assessment (Clinical Standard 2),
2. Diagnostics (Clinical Standard 5),
3. Interventions (Clinical Standard 6) and
4. Ongoing review (Clinical Standard 8).

2. Assurance Framework

In February 2022 a revised Board Assurance framework was developed which reduced the internal data collection. This framework is available here; https://www.england.nhs.uk/wp-content/uploads/2022/02/B1231-board-assurance-framework-for-seven-day-hospital-services-08-feb-2022.pdf

The assurance framework consist of the following 9 key lines of enquiry.

1. **The daily hospital sitrep shows significant variation in LOS associated with the day of the week patients are admitted. NO**

   Length of Stay (LoS) and Discharge data for the 6 month period April – Oct 2023 is demonstrated in the charts table. Each chart represents a clinical speciality and presents the data for each day along with 2-standard deviations (error bars) for the 7-day period. The data relates to emergency admissions for gynaecology, but to all admissions for maternity (due to the classification of admission for pregnant women). The neonatal data relates to all babies admitted to the neonatal unit.

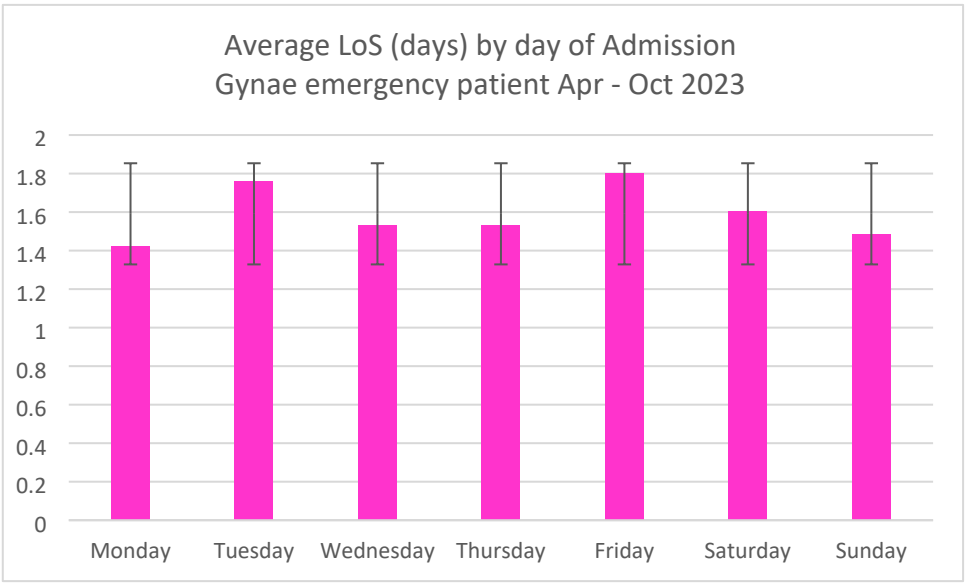


Chart 1. Length of stay (LoS) following an emergency Gynaecology admission is not different depending upon the day of admissions (n = 616)

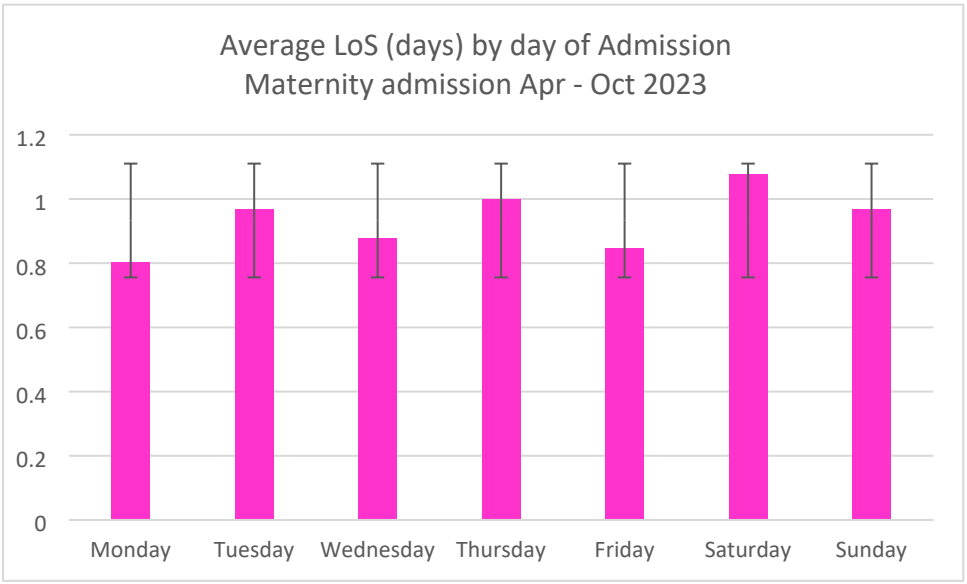


Chart 3. Length of stay following an Obstetric admission is not different dependant upon the day of the week (n = 10937)

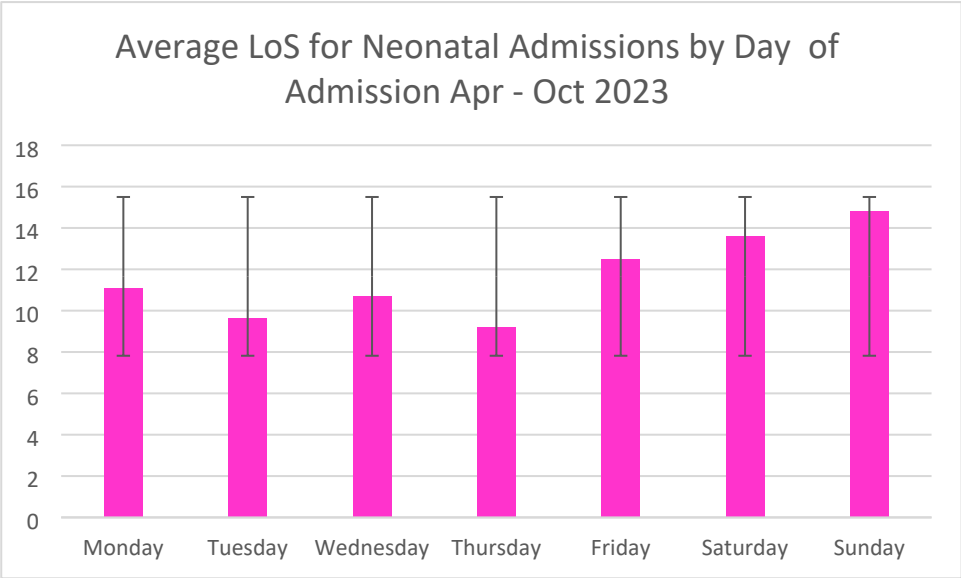
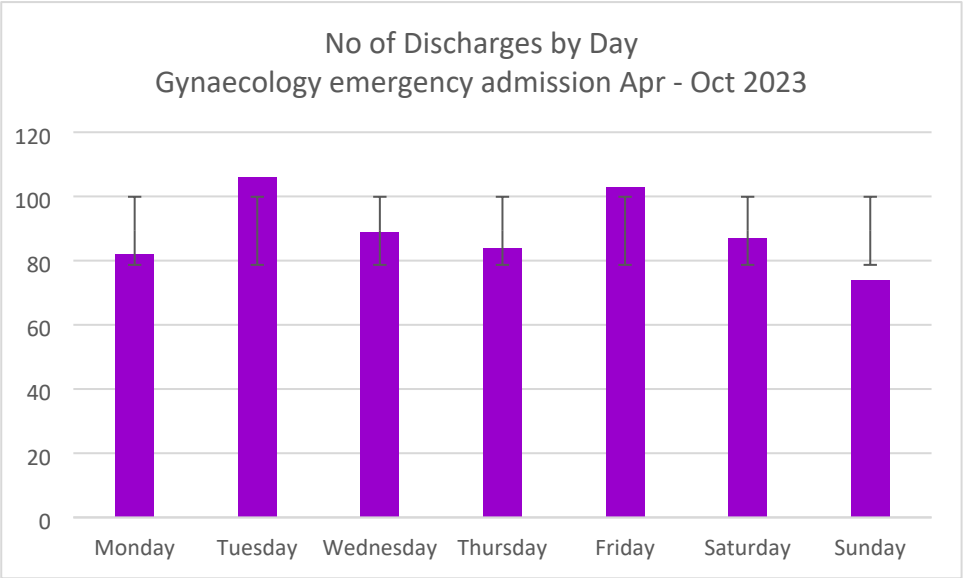


Chart 4. Length of stay following a Neonatal admission does not differ by day of admission.

There is not a statistically significant difference in the length of stay by day of admission for gynaecology emergency patients, maternity patients nor neonates . Neonates admitted on Sunday stay circa 4.8 days longer than those admitted Monday to Friday but this probably reflects the patient demographic than the service provision.

2. **The daily hospital sitrep shows significant variation in the number of discharges by day of the week. NO**

The following charts represent the number of discharges over a 12-month period (22-23) grouped by day of the week.



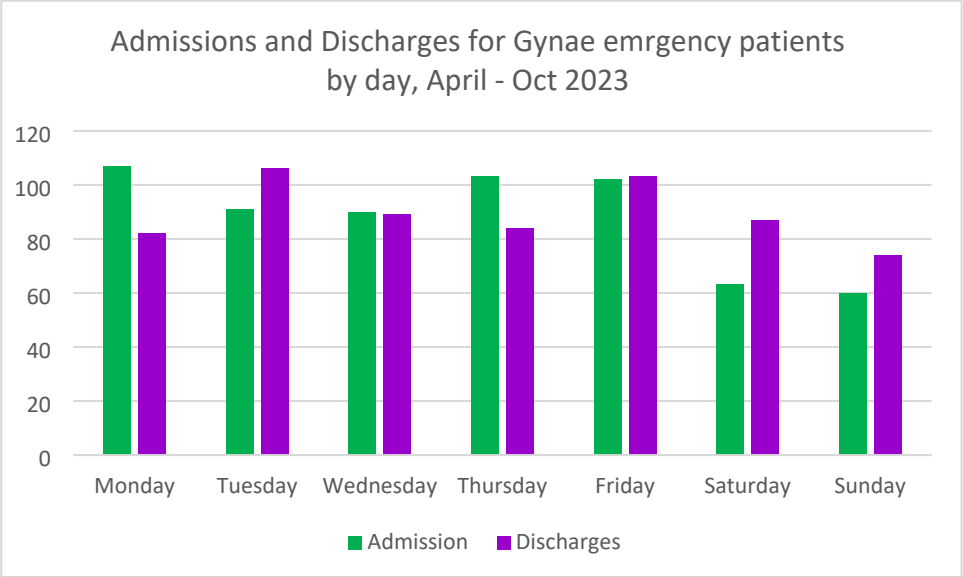
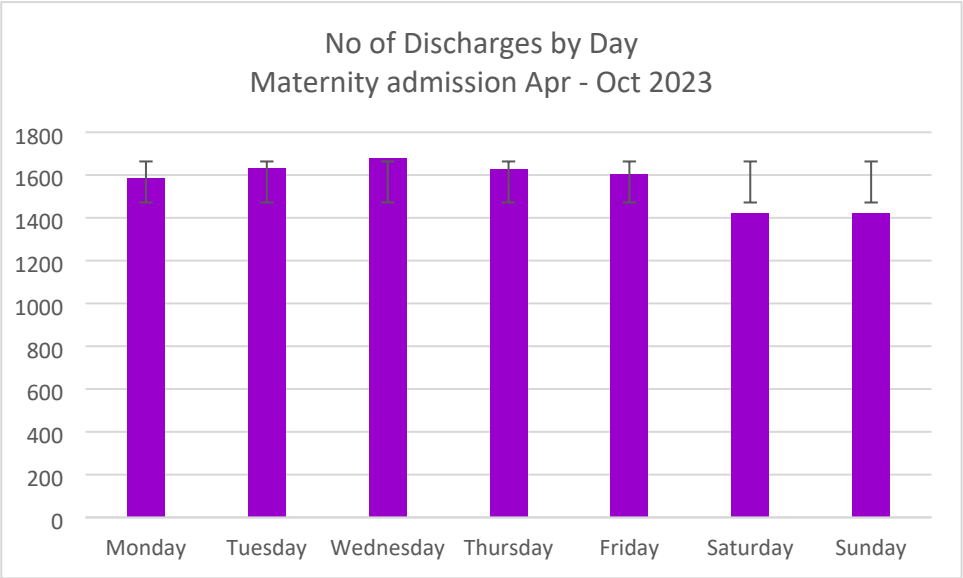


Chart 5 (top) There are fewer discharges for emergency admissions on Sunday compared to the rest of the week.

Chart 6 (bottom) This chart demonstrates that there is also variation in the number of emergency gynaecology admissions, with fewer patients admitted at the weekend. The reduced number of discharges on Sunday likely reflect the reduced admissions at the weekend.



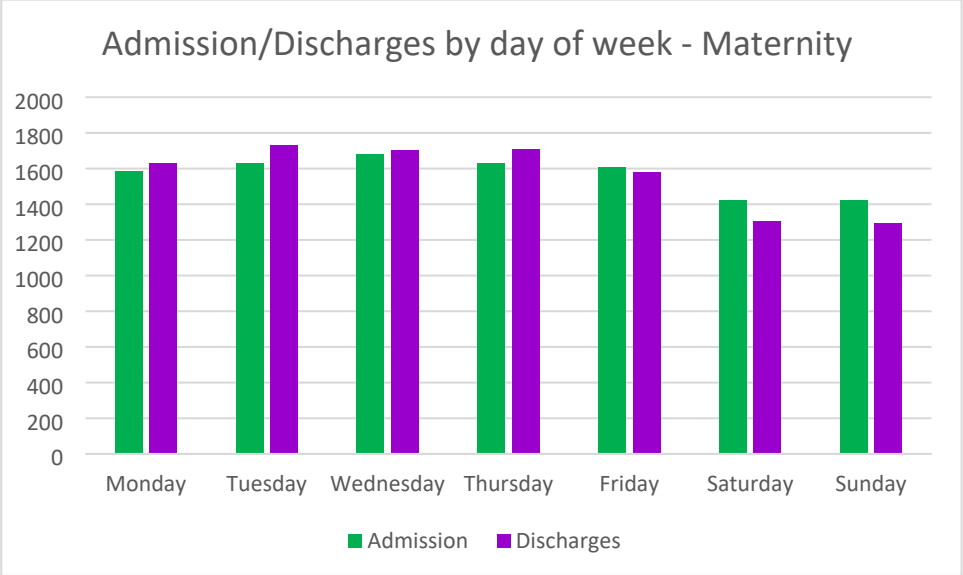


Chart 6. There are fewer maternity patients discharged at the weekend than the rest of the week. These data include all maternity admissions due to the coding not being separated into elective and emergency admissions.

Chart 7 (bottom). This chart demonstrates that there are fewer maternity admissions at the weekend than during the week. However were as during the week the admissions/discharges are balanced or there are more discharges than admissions, the opposite is true of the weekend when more women are admitted than discharged home.

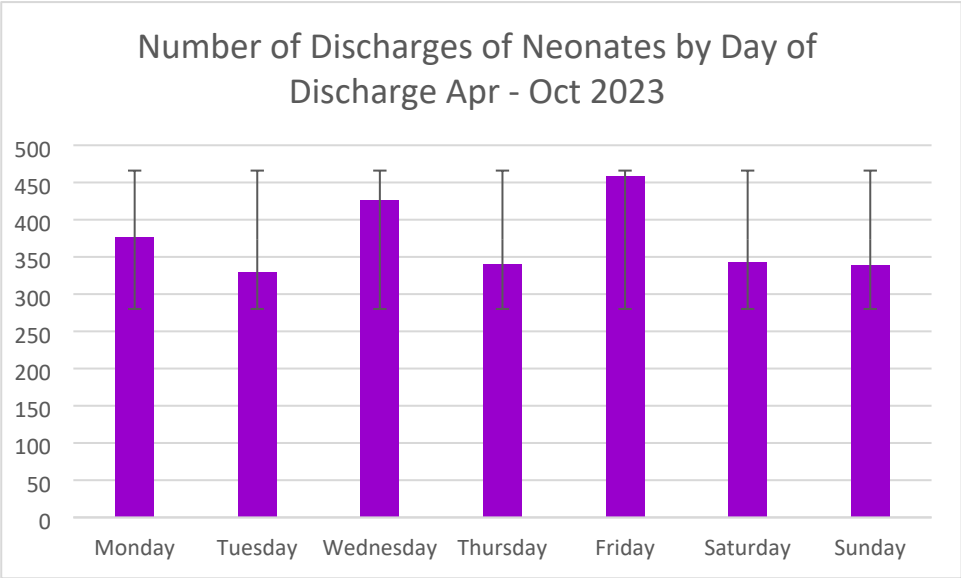


Chart 8. These data relate to babies discharged. There is no difference in the number discharged at the weekend.

It is recommended that the board are assured that there is no significant variation in discharges by day of the week patients.

3. **Job plans for consultants in all acute specialties provide scheduled on-site consultant cover every day that reflects the likely demand for that specialty. No**

Obstetrics No
Job plans include a resident consultant for 15.5 hours 7-days/week for delivery suite. The medical assessment unit and maternity base ward have consultant cover for 7 days/week in job plans since April 2023. However, the job plans only include cover for 3 hours at the weekend and Bank Holidays, compared to 6 hours Monday to Friday. An increase of circa 120 PAs (c 0.4 WTE) would be required provide the same cover across 7 days ..

There remains a corporate objective to move to 24/7 consultant on-site presence by 2024/25.

Neonatology Yes
The neonatal unit has 24/7 consultant cover with two consultants covering the ITU and HDU areas 7 days/week.

Gynaecology No
The Gynaecology emergency department is routinely staffed with a consultant Monday to Friday but not at the weekend. There is also no consultant presence in the evening/overnight. At the weekend the on-call gynaecology consultant conducts a ward round and is available to manage emergencies. This is covered within the PA allocation for being “on-call” but not as a separate activity.

A review of the GED services is due to be completed and presented in Q3 23/24.

Anaesthetics No

The Ockenden review identified that multidisciplinary working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward. The final report confirmed that this MDT included participation by anaesthetists, though didn't specify if this should be a consultant. This Ockenden requirement is currently fulfilled by a consultant anaesthetist Mon and Tuesday, and a post graduate doctor Wednesday to Sunday.

There is a resident Anaesthetist present 0800 to 22:00 Mon and Tuesday. There is an on-call Anaesthetic presence at the weekend. A corporate objective is to achieve cover into the evening 7 days/week by March 2025.

4. 24/7 access to emergency diagnostic tests

Emergency diagnostic test	Available on site at weekends	Available via network at weekends	Not available
USS		X	
CT*	X	X	
MRI#	X		
Endoscopy		X	
Echocardiography		X	
Microbiology		X	

* CT scanning is now available on-site for urgent in-patient procedures at the weekend

The MRI scan is in situ but as of April 2023 is unable to provide MRI scans at the weekend.

5. **24/7 access to emergency consultant-led interventions**

Emergency diagnostic test	Available on site at weekends	Available via network at weekends	Not available
Intensive care		**X**	
Interventional radiography		**X**	
Interventional endoscopy		**X**	
Surgery*	**X**	**X**	
Renal Replacement therapy		**X**	
Stroke thrombectomy		**X**	
PCI for MI		**X**	
Cardiac pacing		**X**	

***** Gynaecological surgery and caesarean section are available on site. All other surgery is provided by other acute providers

6. **If the answers to questions 1,2 or 3 above are 'No' please provide evidence here from suitable deep dive audits on relevant specialties to demonstrate the level of compliance with Standard 2 and Standard 8.**
   See above.

7. **The Executive Medical Director has approved derogation regarding Standard 8 for the following specialties. List the specialties and the details of the derogation here. Note such derogations should be reviewed at least annually and examined in relation to any relevant patient safety issues.**
   If there are insufficient consultants in a specialty to meet Standard 8, the Executive Medical Director may grant a derogation to allow the inclusion of Specialty Doctors and doctors in higher specialist training at ST4 and above to provide some of the daily ward rounds.

   The MD at LWH does not approve any derogation for HDU patients due to the isolated nature of our site.

8. **Narrative section to include any other aspects of 7-day services to draw to the Board's attention**
   The main hospital site at Crown Street, Toxteth, is isolated from other adult services and consequently, is less able to manage acutely ill or rapidly deteriorating patients, women with complex surgical needs and women with significant additional medical conditions. Therefore, women continue to be transferred to and from other Trusts for the care they need, often when they are at their most clinically vulnerable.

LWH is the only specialist obstetric and gynaecology service provider in the country in this isolated position. This creates inequalities in access and reduced quality of care for women and their families. It also increases the risks that staff have to manage at the Crown Street site and other acute sites across Liverpool.

In summary, there is a current lack of:

- A wide range of specialist clinicians on site to provide assistance when needed
- Intensive care facilities and critical care services
- 24-hour laboratory services
- Therapies and recovery support
- A blood transfusion laboratory

In 2020 we completed a £15m refurbishment to improve and upgrade our existing Neonatal Unit and we have recently commenced a £6.5m Crown Street Enhancements Programme to further address some of the clinical challenges we face on the current Liverpool Women's site. This will see a number of additional services added to the Crown Street site including services available through the CDC (including CT/MRI) and Colposcopy Suites. We also have potential plans to develop a Blood Bank on site. However, only co-location with an adult acute site will provide on-site access to specialist services including intensive care, consultant led interventions and diagnostics.

9. Action plan section to describe the key actions being undertaken to address issues identified in sections 1-8

Consultant Job plans are reviewed on an annual basis. The divisional Leadership teams have developed 5-year strategies and aligned medical staffing strategies.

The continuing requirement for a second obstetric consultant at the weekend to cover MAU/Matbase will be assessed and reviewed following receipt of data about medical escalation.

Increased consultant anaesthetic presence is required to fulfil 7 day working and to enable twice daily ward round reviews as per the Ockenden requirements.

The plan for GED should be presented and reviewed along with an appropriate staffing model.

The priority for staffing 7-day services will be reviewed by the divisional leadership teams to determine where additional resource should be allocated within the current financial budget. For example, provision of a 24/7 obstetric consultant service may be more appropriate than having a second consultant available at the weekend.

The Future generations strategy remains the key priority for the Trust. The information presented in this paper highlight the deficiencies in access to urgent diagnostic tests and consultant led interventions that are not available on site. The Trust will continue to pursue the aim to relocate to an adult acute site within the city.

3. Recommendation

The Trust Board are recommended to review the contents of this paper and be assured that:

i. There is no statistically significant variation in the length of stay nor number of discharges at the weekend.
ii. There are fewer discharges at the weekend of maternity patients. The support for the timely discharge of women at the weekend will be included in the Maternity Transformation board work.
iii. The reduced number of discharges on Sunday in Gynaecology reflects the reduced number of admissions at the weekend.
iv. There are medical staffing strategies in place to increase consultant presence out of hours.
v. It remains a corporate objective to provide 24/7 consultant presence for Obstetrics in 2024/25

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

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Planned industrial action: consultants will strike on 19 and 20 September 2023 and junior doctors on 20, 21 and 22 September 2023, meaning there will be one day (20 September) when both will be on strike. There will then follow a co-ordinated joint strike action by both consultants and junior doctors on 02, 03 and 04 October 2023. This is the first time there has been a joint strike for junior doctors and consultants. Services would operate as a minimum Christmas Day level of cover. • The Committee considered the higher level of turnover within the Access Centre (30.56%). They were informed that a benchmarking review was underway and requested a focussed update on this workforce to be provided at the next meeting. • The Committee received the Guardian of Safe Working Hours (Junior Doctors) quarterly report – Quarter 1 2023/24 noting that doctors in training are safely rostered at the start of their placement and enabled to work hours that are safe and in compliance with their contract. It was identified that although rotas are created to be safe the number of gaps and shifts requiring cover at short notice was not safe. Workforce planning to allow for expansion of the clinical teams to help ease the pressure created by ongoing doctor gaps in all services was underway.	• Flu Campaign commences end of September 2023 for both flu and covid vaccinations for staff. A wide range of communications will be issued, with positive messages about the importance of vaccination led by the Chief Nurse and Medical Director. • NHS England had published a new Fit and Proper Persons Test Framework in response to recommendations made in the Kark Review in 2019. The Trust was broadly compliant with the new recommendations and would ensure it meets all requirements as of when the Framework becomes effective on 30 September 2023. • Noted that the Birthrate Plus® refresh audit was completed in April 2023 with report received in May 2023 and reflected that the Maternity budgeted establishment in 2023/24 was 5.35wte below the audit recommendation. The Maternity Division was addressing the gap with finance colleagues. • The Committee received a Nursing, Midwifery and AHP Leadership ward management structure review in response to a Board Chair action to ensure that the structure enables effective management relationships. A baseline assessment had been undertaken which identified some emerging themes and areas of good practice. Overall, the divisional leads reported sufficient capacity to undertake the managerial role. The Committee noted action underway to further understand the need for investment in terms of leadership development for improvement and performance. • The Committee took partial assurance from the outsourced services contract review noting challenges across the outsourced contracts in terms of KPIs. Performance against the contracts would continue to be monitored to address issues and develop services.
Positive Assurances to Provide Identify in brackets should the assurance provide evidence against the CQC Key Questions – SAFE | EFFECTIVE | CARING | RESPONSIVE | WELL LED	**Decisions Made**

• Received a positive Workforce Performance report noting positive trends in performance against PDR, mandatory training, clinical and local training, sickness, and turnover. The Committee noted the introduction of the health roster system had significantly tightened controls and improved staff management. The Committee reflected that appropriate staffing levels within departments had demonstrably supported improvements in all workforce metrics. (ALL)
• The Committee received the bi-annual Nursing, Midwifery and Allied Health Professional (AHP) staffing report (Quarter 4 and Quarter 1). The report provided triangulated evidence demonstrating sufficient staffing establishment and improved quality indicators. (ALL)
• The Committee received the Annual Self-Assessment for Placement Providers 2023 noting challenges and achievements in year. The self-assessment replaces the site visit. Difficulties
	• The Committee recommended to the Trust Board:
	  ○ approval of the Annual Self-Assessment for Placement Providers 2023 prior to submission to NHS England on 31 October 2023
	  ○ approval of the Annual Appraisal and Revalidation and Medical Governance compliance statement 2022/2023 prior to Submission to NHS England on 31 October 2023.
	• The Committee approved the following policies:
	  ○ Mandatory Training and Learning and Development Policy
	  ○ Temporary Staffing Policy
	  ○ Employee Attendance and Wellbeing Policy
	  ○ Apprenticeship Policy

to track allocation of educational funding received by the Trust was noted. The Committee requested an update from finance department to provide assurances in relation to the flow of educational funding. (ALL)

- The Committee received and approved the Annual Appraisal and Revalidation and Medical Governance report 2022/23 and received the Responsible Officer Report, Quarter 1 2023/24 noting that the Trust continues to fulfil NHS England's reporting requirements. (ALL)
- Received the Pharmacy Revalidation Annual Report 2022/23 noting that the requirements for revalidation of pharmacists and pharmacy technicians are completed as per rules made under the Pharmacy Order 2010. (ALL)
- The Committee received an update of planning towards the Staff Survey 2023, a progress update of actions identified by the Staff Survey 2022 and an update of recent engagement activities. The next Big Conversation event was planned for the 28 September 2023 and would continue on a bi-annual basis, with Divisions taking forward feedback based on a 'You said, together we will' format. (WELL LED)

Summary of BAF Review Discussion (Board Committee level only)

- The Committee reviewed the PPF aligned BAF risks, noting no new or closed risks.
- The Committee noted a significant review of controls, assurances and actions had been undertaken of BAF Risk 1.

Comments on Effectiveness of the Meeting / Application of QI Methodology

- The Committee received detailed reports allowing for robust discussion

2. Summary Agenda

No.	Agenda Item	Purpose	Rating	No.	Agenda Item	Purpose	Rating
50.	Board Assurance Framework (BAF): Workforce related risks	Assurance		58.	Medical Appraisal and Revalidation Annual Report 2022/23 (Annual Submission to NHS England Northwest)	Approval	
51.	Staff Story – deferred	Information		59.	Medical Appraisal & Revalidation Quarterly Report - Quarter 1, 2023/24	Information	
52.	Chief People Officer Report	Information		60.	Pharmacy Revalidation Annual Report	Information	
53.	Workforce KPI Dashboard Report	Information		61.	Staff Survey Planning 2023 and review of recent engagement activities	Information	
54.	Bi-Annual Safer Staffing Review	Assurance		62.	Outsourced Services Contract Review	Assurance	
55.	Nursing, Midwifery and AHP Leadership structure review	Information		63.	Policies for Approval & Policy Audit Update	Approval	
56.	Annual Self-Assessment for Placement Providers 2023 (Annual Submission to NHS England)	Approval		64.	Sub Committee Chair Reports & Terms of Reference	Assurance	
57.	Guardian of Safe Working Hours (Junior Doctors) Quarterly Report – Quarter 1 2023/24	Assurance					

3. 2023 / 24 Attendance Matrix

Core members	May	Jun	September	Nov	Jan	Mar
Gloria Hyatt, Chair, Non-Executive Director	✓	✓	✓			
Louise Martin, Non-Executive Director	✓	A	A			
Zia Chaudhry, Non-Executive Director	A	✓	✓			
Michelle Turner, Chief People Officer	✓	✓	✓			
Dianne Brown, Chief Nurse	A	A	A			
Gary Price, Chief Operations Officer	✓	A	✓			
Jen Huyton, Deputy Chief Finance Officer	A	A	✓			
Liz Collins, Staff Side Chair	✓	✓	✓			
Dyan Dickins, MSC Chair	A	A	A			

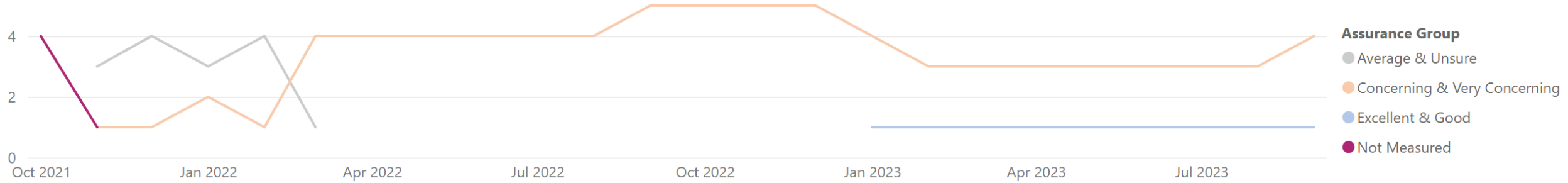
Present (✓) Apologies (A) Representative (R) Nonattendance (NA) Non-Member (NM) *Non-quorate meetings highlighted in greyscale*

Liverpool Women's
NHS Foundation Trust

Trust Board

Workforce Performance Report
October 2023

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

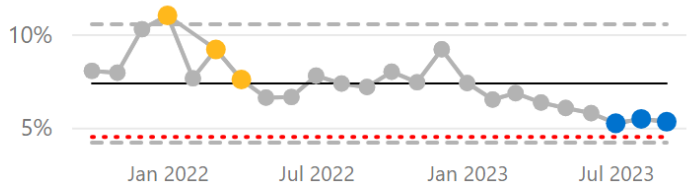


KPI	Assurance Category	Date	Target	Target < or >	Performance	Assurance	Variation	Trend
Turnover Rate	Excellent	September 2023	<= 13%	<=	9.58%	P	L	
Mandatory Training	Concerning	September 2023	>= 95%	>=	93.57%	F	H	
Mandatory Training (Clinical)	Concerning	September 2023	>= 95%	>=	87.88%	F	H	
Sickness Absence Rate	Concerning	September 2023	<= 4.5%	<=	5.31%	F	L	
Prevention of Ill Health: Flu Vaccine Front Line Clinical Staff	Very Concerning	September 2023	>= 80%	>=	15.18%	F	L	

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

Sickness - Chief People Officer

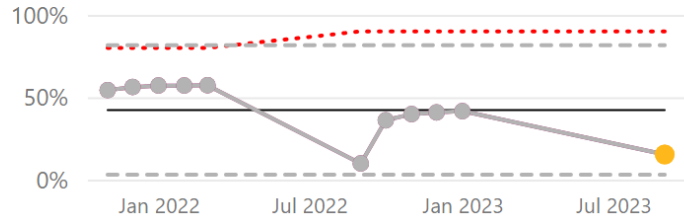
Assurance Category	Concerning
Date	September 2023
Target	<= 4.5%
Target < or >	<=
Performance	5.31%
Assurance	
Variation	



Sickness decreased by 0.15% in Sep and is now at 5.31%. At a divisional level, Clinical Support Services increased by (1.47%) and Corporate increased by (0.69%), while Family Health decreased by (0.90%), and Gynaecology decreased by (0.72%). Both Maternity (1.41%) and Gynaecology (1.23%) both saw decreases, while Neonatal saw a slight increase of (0.19%). COVID sickness decreased to 0.10%, the roll out of COVID & Flu vaccinations is currently being undertaken, it is expected this will support

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

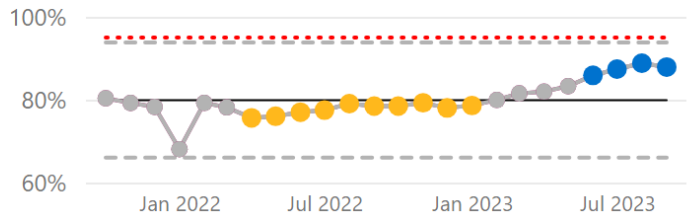
Assurance Category	Very Concerning
Date	September 2023
Target	>= 80%
Target < or >	>=
Performance	15.18%
Assurance	
Variation	



The performance reflects the recent launch of the flu and covid vaccination programme incorporating 2 vaccination clinics held on 26th and 27th September. In addition, the plan this year includes availability of further drop in vaccination clinics, ward managers/matrons supporting team/dept vaccinations and site managers supporting the out of hours offer. Oversight of vaccinations for Flu and Covid will be supported by divisions.

Mandatory Training (Clinical) - Chief People Officer

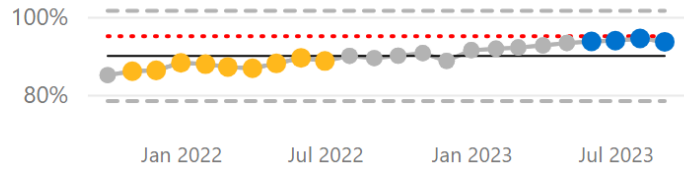
Assurance Category	Concerning
Date	September 2023
Target	>= 95%
Target < or >	>=
Performance	87.88%
Assurance	
Variation	



Compliance decreased by 0.93%, giving a Trust-wide figure of 87.88%. All directorates except for Gynaecology have reported decreases in their compliance figures. Maternity reported a decrease in compliance of (4.72%) and is currently at 80.97%. 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	September 2023
Target	>= 95%
Target < or >	>=
Performance	93.57%
Assurance	
Variation	



Compliance reduced by 0.56% down to 93.57%. All the main divisions have reduced in September but are above the target figure except for Family Health, who decreased to 90.82%, Maternity also decrease by 1.65% and is now at 87.59%. 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.

Big Conversation September 2023

- The 4th LWH Big Conversation took place on 28th September (some departments received visits at later dates).
- 30 departments received a visit from a Board Director or senior manager. Where possible, colleagues visited departments they had been to before.
- Overall, departments are improving at utilising the fortnightly ‘3 key Messages’ and engaging with the ‘You said, we did’ process.
- Departments need to ensure feedback is acted on and communicated via YSWD- supported by HR team
- Overall – feedback that the Big Conversation was valued and an overall improvement in morale in many clinical areas, notably maternity and gynaecology though still concerns about staffing levels in maternity (Matbase and DS)

What is going well?

- Value opportunities to go for ODP training (theatres)
- New band 5's in maternity have been excellent
- Unlimited requests on the roster have been helpful
- 'Accessibility of management, good culture and focus on health and wellbeing, free cake on a Thursday'. (GED)
- More flexibility and better work life balance. Now able to work from home which is really beneficial (Safeguarding)
- Since the last Big Conversation managers have implemented 'mad, sad and glad' boxes which facilitate feedback, this has been really well received. Staff feel there is good open conversation with manager (Bedford)
- Everywhere described good team working and generally good or improved management although visibility of senior management still an issue

What could be better?

- Trust food offer needs to be improved (multiple comments about this – choice, healthy options, timings, cost)
- Staff remain unhappy with on call arrangements in theatres
- Aintree- feelings of isolation / lack of awareness of divisional managers
- Constant daily battle with the scheduling of lists – click a button and see a TCI list would be helpful. Access team / Admissions need to sort their processes for listings (Gynae Ward)
- Staffing levels in GED- though understood that is being addressed and new starters coming.
- Impact of EPR on efficiency and productivity on coding now about 12 weeks behind (from a 2 days turnaround) (Coding)
- Concerns about admin cover, single point of failure (FMU and Bedford)
- Shift leader needs to be supernumerary and not always the case (Matbase)

Suggestions and Comments

- Clinicians need to be given time to get involved in quality, service change etc – this might require stopping clinical activity.
- Need consistency of senior managers.
- Would like to have own budget for training (nurses and midwives)
- Facilities for staff in theatres, lockers, changing rooms, wellbeing room
- Need supernumerary shift leader on GED
- Need better succession planning in specialist areas (FMU)
- Better de-briefing for staff after traumatic events
- Concerns expressed about plan to move Day Ward to ANC (MAU)

Finance, Performance & Business Development Chair's Highlight Report to Trust Board
27 September 2023

Liverpool Women's NHS Foundation Trust

1. Highlight Report

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

• The Committee noted the following matters from the operational performance report:
  ○ Cancer metrics: a short-term negative impact on Faster Diagnosis and 62-day performance during August and September 2023 to recover backlogs which should improve during quarter 3 2023/24.
• The Committee noted the following key matters from the Finance performance report for Month 5 2023/24:
  ○ the Trust was reporting an overall net position of a £8,660k deficit which represented a £1,474k adverse variance to plan. The cash balance (£3.7m at 31 August 2023) was below the minimum level set out in the Treasury Management Policy however the average cash balance through the month was c£9.7m.
  ○ CIP was behind the year-to-date target by £698k and included recognition of 50% achievement against the CNST Maternity Incentive Scheme (£161k ahead of plan). At present the Trust was forecasting to deliver the £8.3m (5.3%) target, with delivery managed through the financial recovery programme. The significant volume of schemes required to be undertaken and managed compared to previous years was noted.
• Concern stated following the update on Third Party Service Provider Controls in relation to the lack of progress made. An update was requested for the November 2023 Committee meeting and the frequency of the report increased to receive on a quarterly basis due to limited assurance provided.
	• The Committee noted several national objectives announced and implemented to improve waiting times, including the a) Patient Initiated Digital Mutual Aid System (PIDMAS) which would launch at the end of October 2023 and would offer patients the choice to change providers if they have been waiting a length of time, and b) NHSE Outpatient Recovery Trust Checklist, a new requirement from NHS England to submit a self-assurance template of oversight on key measures related to Outpatients and Elective Recovery.
	• Noted the recent issues identified by the Care Quality Commission at Newcastle Upon Tyne NHS Foundation Trust relating to a number of documents in the electronic patient record which might not have been sent to GPs. It was confirmed that no issues in relation to patient letters had been raised at this Trust, or by the ICS or PLACE. A review of recommendations and lessons learnt from this incident would be undertaken when the information has been shared with the wider NHS.
	• Noted detailed work underway with divisions ahead of month 6 on capturing costs of industrial action, costs of recovery of activity, cost of the response to CQC recommendations, and progress in reviewing the prior year investment. The post pay investment review was underway and findings would be shared with the Committee.
	• The Committee noted that the Trust had accepted a variation to contract for additional fertility services with commissioners.
	• Received a detailed presentational update on the Financial Recovery programme of work, noting a continued focus on non-pay costs and the implementation of a strict temporary intervention process to change behaviours of spending. Noted appropriate grip and control processes in place for pay-costs.
	• Noted that a benefits realisation review on the impact of digiCare EPR was actively underway with NHS England.
	• The Committee noted the work undertaken to complete the National Cost Collection pre-submission planning report for 2022/23 and the Trust Costing Strategy for 2023/24. A final submission report would be presented to the Committee in November 2023 for approval ahead of submission.

Positive Assurances to Provide Identify in brackets should the assurance provide evidence against the CQC Key Questions – SAFE | EFFECTIVE | CARING | RESPONSIVE | WELL LED	Decisions Made

• The Committee noted the following positive assurances from the operational performance report: (ALL)
  ○ progress with the Hysteroscopy pathways noting the positive introduction of Pipelle usage to prevent unnecessary hysteroscopy procedures, which had improved capacity.
  ○ continued improvements of turnaround time for urgent biopsies from Liverpool Clinical Laboratories (LCL), noting a significant increase of biopsies required during August 2023 whereby LCL had maintained the turnaround time.
  ○ Submission of the NHS Premises Assurance Model return 2023 evidencing good compliance across the five domains
• The Committee took assurance that there had been appropriate focus and pace of change on the financial recovery programme as requested by the Committee in August 2023. (WELL LED)
• The Committee took assurance from progress of delivery against digital programme activities including the digiCare EPR programme, digiCare Digital Maternity (K2) and GDE Programme. Specific positive initiatives included the implementation of single sign-on to mitigate the risk of using multiple systems; and the successful launch of a Hewitt Centre Patient Portal which represented a major digital milestone to enhance patient care through technology. (ALL)
	• Recommended to the Trust Board to reduce the risk scores of BAF risk 4 and BAF risk 6.

Summary of BAF Review Discussion (Board Committee level only)

- The Committee reviewed the related BAF risks. No risks closed on the BAF for FPBD Committee.
- The Committee recommended the reduction of the risk score of BAF risk 4 – Inadequate digital strategy and sub-optimal clinical records systems, from 20 to 16.
- The Committee recommended the reduction of the risk score of BAF risk 6 - The right partnerships are not developed and maintained to support the success of the Cheshire & Merseyside ICB and the CMAST Provider Collaborative, from 9 to 6.

Comments on Effectiveness of the Meeting / Application of QI Methodology

- All matters on the meeting agenda discussed fully, valuable contributions and quality of debate.

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
99.	Review of BAF risks: FPBD related risks	Assurance	104.	Digital Services Update	Assurance
100.	Operational Performance Report Month 5, 2023/24	Assurance	105.	2022/23 National Cost Collection pre-submission planning report and Trust Costing Strategy 2023/24	Assurance
101.	Financial Recovery	Information	106.	Soft Fm Contract Extension	Information
102.	Finance Performance Report Month 5, 2023/24	Information	107.	Sub-Committee Chairs Reports	Assurance
103.	Update on Third Party Service Provider Controls	Information			

3. 2023 / 24 Attendance Matrix

Core members	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Louise Martin, Non-Executive Director (Chair)	✓	✓	✓	✓	✓	✓						
Tracy Ellery, Non-Executive Director	✓	✓	✓	✓	A	✓						
Sarah Walker, Non-Executive Director	A	✓	A	✓	A	✓						
Jenny Hannon, Chief Finance Officer	✓	✓	✓	✓	A	✓						
Kathryn Thomson, Chief Executive	✓	✓	A	A	✓	✓						
Gary Price, Chief Operations Officer	✓	A	✓	✓	✓	✓						
Dianne Brown, Chief Nurse	✓	✓	✓	A	✓	✓						
Matt Connor, Chief Information Officer	✓	✓	✓	✓	A	✓						

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

Finance, Performance & Business Development Chair's Highlight Report to Trust Board
25 October 2023

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• The Committee noted the following matters from the operational performance report: ○ The number of overdue appointments had disproportionately increased following the implementation of DigiCare. This was largely due to a significant number of patients on the Patient Initiated Follow-Up (PIFU) pathway remaining on the follow-up waiting list until the patient requests an appointment or until they are discharged. Operational teams were working through the lists to ensure all patients were being managed appropriately and work was ongoing with the performance team to redefine the metric to reflect these cases more accurately. • The Committee noted that at Month 6 2023/24 the Trust was reporting an overall net position of a £10,174k deficit which represented a £1,716k adverse variance to plan and was supported by non-recurrent items. The cash balance (£6.3m at 30 September 2023) was marginally below the minimum level set out in the Treasury Management Policy however the average cash balance year to date is £11.6m. • The Committee expressed concern that providers within the region had been requested to report a forecast position in line with plan at Month 6 until negotiations regarding potential financial settlements were finalised. The Committee was informed that despite financial recovery actions, achievement of the financial plan at year-end would be extremely challenging. It was confirmed that the Trust had been transparent when reporting the risks to achieving the financial position to the ICS. • The Committee received an options appraisal report for the Community Diagnostic Centre for 2024/25. After detailed debate the Committee noted that, without additional assurances in relation to funding, it was not able to support the approval of Option 1 without significant financial risk to the Trust. Further work with the CDC national team was requested ahead of reporting to the Trust Board and seeking approval.	• Noted that the Patient Initiated Digital Mutual Aid System (PIDMAS) project will go live on 31 October 2023. This will target all patients over 40+ weeks. Clarification on the internal process and with the ICB had been undertaken and the project is on target for delivery. • The Committee noted the whole time equivalent (WTE) position at Month 6 of 1,697 compared to 1,688 at M12 2022/23. The increase in WTEs were in clinical roles with a shift away from temporary (bank and agency) towards substantive staff appointments. • The Committee received an update on Financial Recovery; noting nine workstreams in place to support delivery of financial savings. • A detailed update on the Post Investment Review Workstream was provided led by the Executive Sponsor. The Committee was assured that the review was being undertaken robustly and that a Post Investment Review process had been implemented and lessons learned from this would become part of the scheduled (November 23) annual review processes moving forward. • The Committee considered the Ambulatory Business Case to support a bid for funding to the NHSE national team. The bid had been supported by the regional NHSE team. The Committee considered the benefits that conversion of the department would provide to patients and supported the proposal to put forward a bid. The Committee advised that additional information would be required to provide assurances in relation to implementation should the Trust be successful with the bid.
Positive Assurances to Provide Identify in brackets should the assurance provide evidence against the CQC Key Questions – SAFE | EFFECTIVE | CARING | RESPONSIVE | WELL LED	**Decisions Made**
• The Committee noted the following positive assurances from the operational performance report: (ALL) ○ Gynaecology Elective recovery continued to deliver a positive trajectory in line with the 2023/24 plan submitted to the ICB. Increased focus during	• The Committee supported the proposal regarding the Trust's Soft Facilities Management Provision noting alignment with a wider C&M 'Collaboration at Scale' initiative. Recommendation would be submitted to the Board for approval in due course.

Quarter 3 to reduce the number of long waits as these will temporarily increase due to the challenging cancer position and the impact of industrial action and availability of workforce. This would continue to be closely monitored. ○ Although Cancer performance continued to be challenged, improvements had been demonstrated and the team would remain focussed on clearing backlogs throughout September and October 2023. Liverpool Clinical Laboratories turnaround times continue to improve. The Committee considered actions underway and focus of the operational team to support the Trust to move out of Tier 2 performance management. • The Committee noted the Crown Street Enhancement Progress Review. • Positive assurance was taken from the Digital Services Update. (ALL) • The Committee received a six-month update against the operational planning objectives. The Committee took positive assurance from the update noting the significant work undertaken by the teams to achieve this position. (ALL) • The review of progress made against the Marketing Strategy was noted. (WELL LED)	• Subject to suggested amendments to the narrative of the report, the Committee recommended approval of the Ambulatory Business Case to the Board. • The Committee noted the performance to date against the Corporate Objectives aligned to its terms of reference. It was agreed to amend the RAG rating to 'off track' against the '*Ensure efficient and effective use of all available resources, meeting agreed financial targets and working across the Cheshire and Mersey system for optimum outcomes for the region'* objective due to the significant risk to full year delivery against the financial plan.

Summary of BAF Review Discussion (Board Committee level only)

- The Committee reviewed the related BAF risks. No risks closed on the BAF for FPBD Committee.
- It was recommended that BAF risk 6 - The right partnerships are not developed and maintained to support the success of the Cheshire & Merseyside ICB and the CMAST Provider Collaborative, should be reviewed to provide additional clarity to better reflect the position and maturity of partnerships.

Comments on Effectiveness of the Meeting / Application of QI Methodology

- All matters on the meeting agenda discussed fully, with full participation of all members.
- Considered the functionality of allocating timings to reports on the agenda template. It was agreed to trial a different approach and section the agenda into broader timings for a group of reports to allow the Committee to generate discussion as required and also provide an indication of timings to invited attendees and keep pace. The meeting invite would be maintained at 3hrs in diaries.

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
116.	Review of BAF risks: FPBD related risks	Assurance	124.	Crown Street Enhancement Progress Review	Information
117.	Operational Performance Report Month 6, 2023/24	Assurance	125.	Digital Services Update Including Information Governance Update	Assurance
118.	Finance Performance Report Month 6, 2023/24	Information	126.	Operational Planning: Six monthly review	Information
119.	Financial Recovery	Information	127.	Corporate Objectives Bi-annual review	Information
120.	Post Investment Review Deepdive	Information	128.	Review Marketing Strategy	Information
121.	Soft FM Contract Extension	Approval	129.	NHS Insights Update	Information
122.	CDC Options Paper	Approval	130.	Sub-Committee Chairs Reports	Information
123.	Ambulatory Business Case	Approval			

3. 2023 / 24 Attendance Matrix

Core members	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Louise Martin, Non-Executive Director (Chair)	✓	✓	✓	✓	✓	✓	✓					
Tracy Ellery, Non-Executive Director	✓	✓	✓	✓	A	✓	✓					
Sarah Walker, Non-Executive Director	A	✓	A	✓	A	✓	A					
Jenny Hannon, Chief Finance Officer	✓	✓	✓	✓	A	✓	✓					
Kathryn Thomson, Chief Executive	✓	✓	A	A	✓	✓	✓					
Gary Price, Chief Operations Officer	✓	A	✓	✓	✓	✓	✓					
Dianne Brown, Chief Nurse	✓	✓	✓	A	✓	✓	✓					
Matt Connor, Chief Information Officer	✓	✓	✓	✓	A	✓	A					

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

Audit Committee Chair's Highlight Report to Trust Board
18 October 2023

Liverpool Women's NHS Foundation Trust

1. Highlight Report

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Executive owners attend the Committee to explain the rationale for internal audit recommendation deadline extension requests. The Committee noted some challenges with the completion of recommendations and stated the importance of management being cognisant of the deliverability of recommendations and clarity of the ask ahead of final sign off.	• The Committee asked that narrative on the status 2021/22 External Audit actions be included in the next Follow up of Internal Audit and External Audit Recommendations report. • The Internal Auditor undertook to review a national position on the appropriateness of trusts providing, or not providing, confidential information during audits on sensitive matters. • The external auditor noted that there would be additional audit fees due to additional work undertaken. The Committee noted the importance of learning lessons in an attempt to avoid additional costs for future audit cycles. • The Committee noted the on-going oversight of Service Level Agreements by the FPBD Committee.
Positive Assurances to Provide	**Decisions Made**

• One internal audit reports were received:
  ○ 2023/24 Raising Concerns/Speaking Up (Substantial Assurance Level)
  ▪ Overall, the review identified that the Trust has a process in place to enable staff to raise concerns and two Freedom to Speak Up (FTSU) Guardians who have completed the National Guardian Office FTSU training course have been appointed.
• The internal audit programme for 2023/24 was noted as being slightly behind schedule but there were no concerns for delivery by year-end.
• The Committee noted the anti-fraud update.
• The Committee noted that there was a general trend of reducing waiver volume.
• In receiving the 2022/23 Clinical Audit Annual Report and the 2023/24 mid-year report, the Committee received assurance that the process for identifying and completing audits had strengthened, particularly in relation to setting more deliverable programmes of work and ensuring prioritisation of resources.
• A mid-year review of the Trust's Assurance Framework was received. This included information on the developing system governance landscape and the implications for the Trust. Noted as being good practice ahead of developing the Annual Governance Statement at Year-End.
• The Committee received outputs from the conflicts of interest checks process. There had been no reportable breaches during the reporting period.
• The Committee reviewed the effectiveness of its internal audit function utilising a series of questions and checkpoints. No issues of concern raised.
	• None noted.

Comments on Effectiveness of the Meeting / Application of QI Methodology	
• No issues raised.	

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
043	Follow up of Internal Audit and External Audit Recommendations	To receive and review an update of actions taken.	047	Conflicts of Interest Controls	For assurance
043	MIAA Internal Audit Reports a) Internal Audit Progress Report b) Anti-Fraud Progress Report 2023/24 c) Insight Update	To note the contents and any recommendations from the report.	048	Clinical Audit Annual report 2022-23 & Interim Progress report 2023-24	To receive update
044	External Auditor Update	To receive update	050	Chairs reports of the Board Committees	Review of Chair's Reports for overarching assurance.
045	Waiver Report – Q2 Financial Year 2023/24 and Summary 2023/24	To note	051	Board Assurance Framework (BAF)	To receive assurance
046	Assurance processes, governance, risk management and internal control	For assurance	052	Review of Internal Audit	To discuss

3. 2023 / 24 Attendance Matrix

Core members	June	July	October	January	March
Tracy Ellery	✓	A	✓		
Zia Chaudhry	✓	✓	✓		
Jackie Bird	A	✓	✓		
Present (✓) Apologies (A) Representative (R) Nonattendance (NA) *Non-quorate meetings highlighted in greyscale*					

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	**23/24/186d**		**Date: 09/11/2023**	
Report Title	**Finance Performance Month 6 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 6 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 6 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	25/10/23	Chief Finance Officer	The Committee noted the report.

EXECUTIVE SUMMARY

The Trust has a challenging financial plan for 2023/24 of £15.5m deficit for the year. At Month 6 the Trust is reporting a £10.2m deficit which represents a £1.7m adverse variance to plan. This position is supported by £2.5m of non-recurrent items. The forecast outturn is £15.5m deficit, which is in line with the submitted plan however this is under review given the levels of risk and uncertainly in relation to the achievement of the full year outturn.

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 £6.3m at the end of Month 6. The average cash balance during the month was £12.0m.

MAIN REPORT

1. Summary Financial Position

	Plan	Actual	Variance	RAG	*R*	*A*	*G*
Surplus/(Deficit) YTD	-£8.5m	-£10.2m	-£1.7m	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	£2.8m	£6.3m	£3.5m	5	*<£1m*	*£1m-£4.5m*	*£4.5m+*
Total CIP Achievement YTD	£3.2m	£2.0m	-£1.2m	1	*>10% off plan*	*Plan*	*Plan or better*
Recurrent CIP Achievement YTD	£3.2m	£1.6m	-£1.6m	1	*>10% off plan*	*Plan*	*Plan or better*
Aligned Payment Incentive	106%	103%	-3%	6	*>10% off plan*	*Plan*	*Plan or better*
Non-Recurrent Items YTD	£0.5m	£2.5m	£2.0m	5	*>£0*		*<£0*
Capital Spend YTD	£3.9m	£2.1m	-£1.8m	6	*>10% off plan*	*Plan*	*Plan or better*

At Month 6 the Trust is reporting a £10.2m deficit, which represents a £1.7m adverse variance to plan year to date (YTD). This is supported by £2.5m of non-recurrent items. The forecast outturn is currently £15.5m deficit, which is in line with the submitted plan, however despite financial recovery actions put in place by the Trust, there is significant risk in achieving this position.

The position has been reported to Cheshire and Merseyside Integrated Care Board (C&M ICB), noting the risk to delivery of the forecast outturn.

2. Financial Recovery

Underlying Position

As noted above, the YTD position is supported by £2.5m of non-recurrent items, of which £2.0m was unplanned. The adjusted position in Month 6 (following removal of key non-recurrent items) is a deficit of £12.7m, which represents an adverse variance of £4.3m against plan.

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

- Undelivered CIP (£1.2m); non-pay and income CIP targets.
- Industrial action costs (£0.5m) and net income impact (£0.4m).
- Aligned Payment Incentive (API) underperformance excluding industrial action impact (£0.3m).
- Impact of pay award (£0.2m).
- Unwinding of 2022/23 pay investment (£0.8m).
- Investment in maternity post CQC inspection (£0.4m).
- Excess inflation and other non-pay pressures (£0.3m).
- Operational pressures (£0.2m net) including nursing & midwifery, medical staffing, unfunded cost pressures in corporate areas and estates non-pay related pressures.

The above drivers are offset by £2.5m non-recurrent items (balance after planned non-recurrent items have released and excluding industrial action), resulting in the actual adverse YTD variance from plan of £1.7m.

Whole Time Equivalents (WTEs)

Month 6 WTEs total 1,697, compared to 1,688 at M12 2022/23, with a shift away from temporary (bank and agency) towards substantive staff.

Between Month 5 and Month 6 WTEs have increased by 21.6 in relation to clinical posts:

- 6.6WTE increase in healthcare assistant numbers; these posts are planned recruitment of midwives who are included as a healthcare assistant whilst awaiting their pin numbers.
- 3.6WTE healthcare scientists due to maternity leave cover and a planned replacement.
- 6.0WTE increase in nursing and midwifery bank costs primarily covering sickness and supernumerary cover which should reduce once the staff noted above receive their pin.
- 2.9WTE increase in medical staffing due to an increase in post graduate doctors.

Cost Improvement Programme

The Trust has a cost improvement programme target of £8.3m. This equates to 5.3% of expenditure. At Month 6, there is an adverse variance of £1.2m against the £3.2m target. The Trust remains focussed on identifying and implementing robust schemes through a programme of targeted financial recovery, that will deliver savings on an ongoing basis. The risk associated with delivery of the CIP programme is currently estimated to be £2.0m.

Finance Recovery Actions

The Trust 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 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 £120k YTD. £441k of the adverse variance relates to Maternity, offset by a £322k favourable variance in Neonatal. The maternity variance continues to be driven by pay pressures in medical staffing and midwifery staffing (caused by sickness, vacancies, and maternity leave), as well as under-delivery of non-pay CIP, but has improved in month due to receipt of additional funds relating to the 2022/23 Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme. Remaining scheme funds are redistributed to those Trusts which successfully met the requirements of the scheme in the preceding year.

The Neonatal favourable variance is driven predominantly by vacancies in nurse staffing. Active recruitment is underway and is reflected in the forecast.

Gynaecology

The Gynaecology Division has an adverse variance to plan of £2,420k YTD, comprised of £2,119k in Gynaecology and £301k in the Hewitt Fertility Centre. The Gynaecology variance continues to be driven by medical staffing (in relation to industrial action and premium costs of delivering additional activity), nursing and support staff pay pressures, and income underperformance (related to Aligned Payment Incentive and industrial action (see below for further details).

Clinical Support Services (CSS)

CSS are £932k adverse to plan YTD, driven by adverse variances in Imaging pay (£376k) in relation to staffing pressures, increased activity within pathology services (£207k), and Theatres pay (£560k), driven by nursing, Operating Department Practitioner (ODP), and support staff costs, partially mitigated by vacancies in anaesthetic medical staffing.

Industrial Action

National discussions continue in relation to the treatment of activity baselines and expenditure cost pressures due to the impact of industrial action. At Month 6, the Trust has assessed industrial action impact to date as £0.9m, comprised of £0.5m expenditure impact and £0.4m income impact. Further impacts of industrial action are anticipated in future months.

4. Income Performance

Aligned Payment 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 6 is 103% of 2019/20 levels. The average activity target for 2023/24 is 106%. Income underperformance to date is driven predominantly by the impact of industrial action.

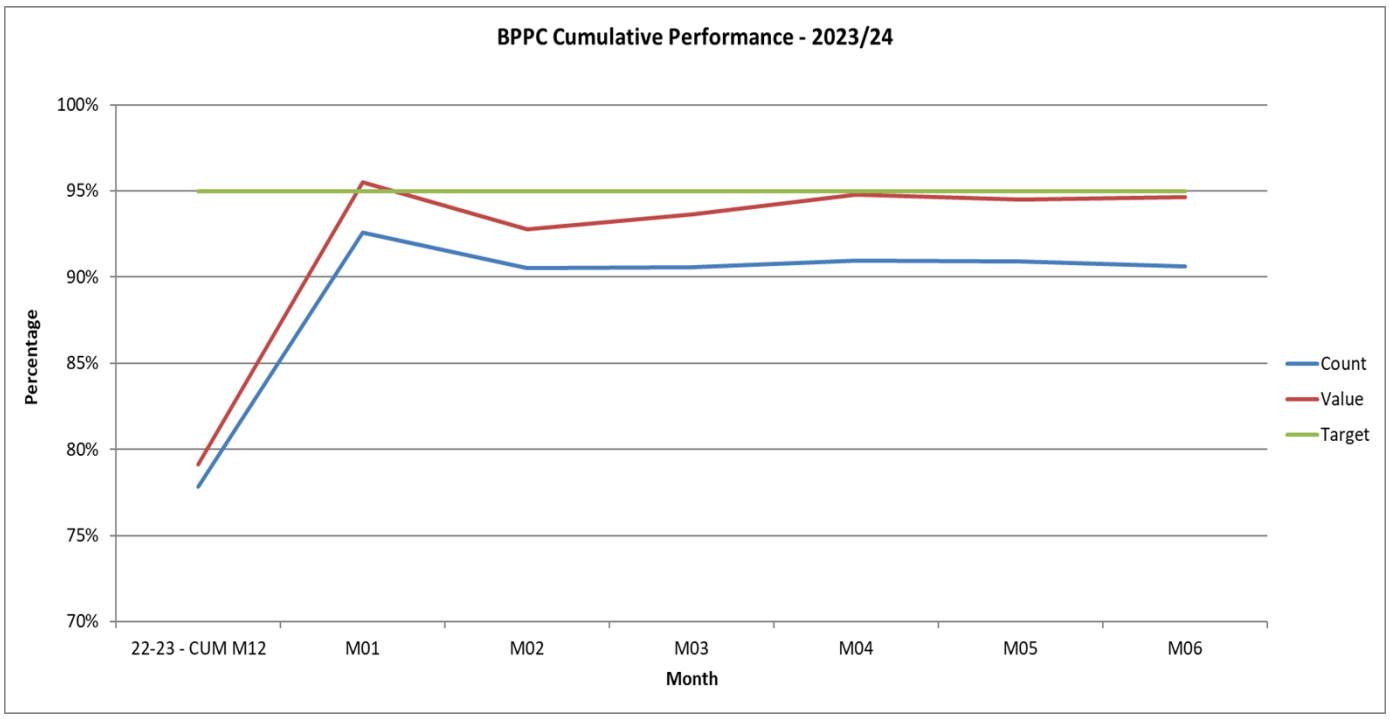
5. Cash and Borrowings

Total cash at the end of Month 6 was £6.3m. This was £3.5m ahead of plan, driven by receipt of Maternity incentive Scheme Funds (referenced above), lower payment runs in-month, and capital spend behind plan (see below).

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.

8. Capital Expenditure

The Trust's capital programme for 2023/24 totals £5.2m. YTD expenditure is £1.8m behind plan. The Trust is still forecasting to meet the plan by year end.

Digital expenditure is significantly ahead of plan following the significant investment in the Digicare project in quarter 1, and overall infrastructure investment. The Trust has 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; work on the Midwifery Led Unit refurbishment scheme (to improve patient flow and experience of the environment) has now commenced, which will accelerate capital spend in the next period. Medical equipment purchases remain behind plan, but equipment (including replacement hysteroscopes and ultrasound machines) has now been ordered.

9. Agency

The Trust has strong controls in place governing the use of temporary staffing. At Month 6, the Trust has a favourable variance of £804k against plan. Actual costs of £366k YTD are predominantly driven by theatres (vacancy), and maternity (sickness and vacancy).

10. Virements

There was national agreement from NHS England for Trusts to amend their plan figures to take into account the impact of staff pay awards. This is a net neutral impact in terms of plan figures and has been transacted into budgets in month.

Additionally, 5 WTE midwifery posts have been added to the Family Health budget to ensure full compliance with Birth Rate Plus.

11. Board Assurance Framework (BAF) Risk

There are no proposed changes to the BAF score.

12. Conclusion & Recommendation

The Board is asked to note the Month 6 position.

Appendices

Appendix 1 – Board Finance Pack, Month 6

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

FINANCE REPORT: M6

YEAR ENDING 31 MARCH 2024

Liverpool Women's NHS Foundation Trust

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12 Virements

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST NHS ENGLAND RATIOS: M6 YEAR ENDING 31 MARCH 2024	1

USE OF RESOURCES RISK RATING	YEAR TO DATE Actual
CAPITAL SERVICING CAPACITY (CSC)	
(a) EBITDA + Interest Receivable	(5,827)
(b) PDC + Interest Payable + Loans Repaid	1,654
CSC Ratio = (a) / (b)	**(3.52)**
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	(23,908)
(b) Expenditure	77,171
(c) Daily Expenditure	422
Liquidity Ratio = (a) / (c)	**(56.7)**
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)	10,282
Total Income	(71,077)
I&E Margin	**-14.5%**
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)	-14.50%
I&E Margin (Plan)	-11.70%
I&E Variance Margin	**-2.80%**
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)	1,170
YTD Agency Expenditure	366
	-69%
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
INCOME & EXPENDITURE: M6
YEAR ENDING 31 MARCH 2024

INCOME & EXPENDITURE	Month 6			YTD			YEAR		
	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Forecast	Variance
Income									
Clinical Income	(12,587)	(11,120)	(1,467)	(68,511)	(67,198)	(1,313)	(137,517)	(139,371)	1,854
Non-Clinical Income	(603)	(580)	(23)	(3,598)	(3,879)	281	(7,416)	(7,222)	(193)
Total Income	**(13,190)**	**(11,700)**	**(1,490)**	**(72,109)**	**(71,077)**	**(1,032)**	**(144,933)**	**(146,594)**	**1,661**
Expenditure									
Pay Costs	8,683	8,135	548	45,911	49,416	(3,505)	91,102	96,272	(5,170)
Non-Pay Costs	3,225	3,400	(175)	19,329	17,795	1,534	38,631	36,506	2,125
CNST	1,800	969	831	10,802	9,961	841	21,603	20,373	1,230
Total Expenditure	**13,709**	**12,504**	**1,205**	**76,042**	**77,171**	**(1,130)**	**151,337**	**153,152**	**(1,815)**
EBITDA	**518**	**804**	**(285)**	**3,932**	**6,094**	**(2,162)**	**6,404**	**6,558**	**(154)**
Technical Items									
Depreciation	548	515	33	3,290	3,121	169	6,579	6,486	94
Interest Payable	2	8	(6)	12	9	3	21	20	1
Interest Receivable	(17)	(49)	32	(99)	(267)	168	(200)	(450)	250
PDC Dividend	220	237	(17)	1,323	1,339	(16)	2,645	2,878	(233)
Profit/Loss on Disposal or Transfer Absorption	0	0	0	0	(122)	122	0	(42)	42
Total Technical Items	**753**	**711**	**42**	**4,526**	**4,080**	**446**	**9,045**	**8,892**	**153**
(Surplus) / Deficit	**1,272**	**1,514**	**(243)**	**8,458**	**10,174**	**(1,716)**	**15,450**	**15,450**	**(0)**

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LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 2a
WTE: M6
YEAR ENDING 31 MARCH 2024

TYPE	DESCRIPTION	M12	M1	M2	M3	M4	M5	M6	Movement M5 - M6	Movement M12 - M6
SUBSTANTIVE	REGISTERED NURSING, MIDWIFERY & HEALTH VISITING STAFF	631.94	648.33	649.61	645.49	636.13	640.11	636.48	(3.63)	4.54
	ALLIED HEALTH PROFESSIONALS	82.04	81.95	81.35	83.27	83.57	85.45	86.39	0.94	4.35
	OTHER REGISTERED SCIENTIFIC, THERAPEUTIC & TECHNICAL STAFF	11.78	11.31	11.31	12.31	11.31	12.31	14.31	2.00	2.53
	REGISTERED HEALTH CARE SCIENTISTS	49.22	53.62	54.54	54.34	55.34	57.34	60.98	3.64	11.76
	HCA & SUPPORT TO CLINICAL STAFF	234.51	237.51	244.48	237.49	242.70	241.16	247.75	6.59	13.24
	MANAGERS & SENIOR MANAGERS	59.92	63.32	64.32	61.32	59.02	62.57	62.09	(0.48)	2.17
	ADMIN AND ESTATES STAFF	13.00	13.00	13.00	14.00	14.00	15.00	15.00	0.00	2.00
	OTHER INFRASTRUCTURE & SUPPORT STAFF	288.12	288.08	284.17	285.09	279.25	276.78	278.59	1.81	(9.53)
	MEDICAL AND DENTAL	185.09	190.90	191.67	193.80	190.34	197.14	200.02	2.88	14.93
	ANY OTHER STAFF	14.00	14.00	14.00	14.00	14.00	14.00	14.00	0.00	0.00
SUBSTANTIVE TOTAL		**1,569.62**	**1,602.02**	**1,608.45**	**1,601.11**	**1,585.66**	**1,601.86**	**1,615.61**	**13.75**	**45.99**
BANK	REGISTERED NURSING, MIDWIFERY & HEALTH VISITING STAFF	47.33	37.81	43.37	45.40	34.57	30.12	36.07	5.95	(11.26)
	ALLIED HEALTH PROFESSIONALS	17.42	13.00	16.78	15.67	11.15	10.48	13.45	2.97	(3.97)
	OTHER REGISTERED SCIENTIFIC, THERAPEUTIC & TECHNICAL STAFF	-	-	-	-	-	-	-	0.00	0.00
	REGISTERED HEALTH CARE SCIENTISTS	0.28	0.91	0.64	0.46	0.37	0.27	1.60	1.33	1.32
	HCA & SUPPORT TO CLINICAL STAFF	31.22	25.76	25.13	24.57	21.87	19.20	18.79	(0.41)	(12.43)
	MANAGERS & SENIOR MANAGERS	-	-	-	-	-	-	-	0.00	0.00
	ADMIN AND ESTATES STAFF	-	0.23	0.12	0.09	-	0.05	-	(0.05)	0.00
	OTHER INFRASTRUCTURE & SUPPORT STAFF	6.25	7.27	6.44	4.36	4.89	6.82	4.20	(2.62)	(2.05)
	MEDICAL AND DENTAL	2.00	2.80	2.80	2.00	2.00	1.94	1.97	0.03	(0.03)
	ANY OTHER STAFF	-	-	-	-	-	-	-	0.00	0.00
TOTAL BANK		**104.50**	**87.78**	**95.28**	**92.55**	**74.85**	**68.88**	**76.08**	**7.20**	**(28.42)**
AGENCY	REGISTERED NURSING, MIDWIFERY & HEALTH VISITING STAFF	8.23	10.49	2.03	0.08	2.11	2.76	2.68	(0.08)	(5.55)
	ALLIED HEALTH PROFESSIONALS	4.04	1.23	3.26	3.26	2.92	2.60	3.28	0.68	(0.76)
	OTHER REGISTERED SCIENTIFIC, THERAPEUTIC & TECHNICAL STAFF	-	-	-	-	-	-	-	0.00	0.00
	REGISTERED HEALTH CARE SCIENTISTS	-	-	-	-	-	-	-	0.00	0.00
	HCA & SUPPORT TO CLINICAL STAFF	-	-	-	-	-	-	-	0.00	0.00
	MANAGERS & SENIOR MANAGERS	-	-	-	-	-	-	-	0.00	0.00
	ADMIN AND ESTATES STAFF	1.00	-	-	-	-	-	-	0.00	(1.00)
	OTHER INFRASTRUCTURE & SUPPORT STAFF	-	1.73	-	-	-	-	-	0.00	0.00
	MEDICAL AND DENTAL	0.10	-	-	-	-	-	-	0.00	(0.10)
	ANY OTHER STAFF	-	-	-	-	-	-	-	0.00	0.00
AGENCY TOTAL		**13.37**	**13.45**	**5.29**	**3.34**	**5.03**	**5.36**	**5.96**	**0.60**	**(7.41)**
TRUST TOTAL		**1,687.49**	**1,703.25**	**1,709.02**	**1,697.00**	**1,665.54**	**1,676.10**	**1,697.65**	**21.55**	**10.16**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 3
EXPENDITURE: M6
YEAR ENDING 31 MARCH 2024

EXPENDITURE £'000	MONTH 6 Budget	MONTH 6 Actual	MONTH 6 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	520	473	47	2,880	3,044	(164)	5,555	5,771	(216)
Medical	2,634	2,268	367	13,095	13,972	(877)	26,188	27,949	(1,761)
Nursing & Midwifery	3,697	3,326	371	19,094	20,407	(1,313)	38,506	41,031	(2,526)
Healthcare Assistants	592	607	(15)	3,328	3,784	(457)	6,655	7,462	(807)
Other Clinical	178	597	(418)	1,870	2,924	(1,054)	2,963	4,285	(1,321)
Admin Support	912	793	118	4,690	4,919	(228)	9,388	9,266	122
Agency & Locum	149	71	78	954	366	588	1,848	508	1,339
Total Pay Costs	**8,683**	**8,135**	**548**	**45,911**	**49,416**	**(3,505)**	**91,102**	**96,272**	**(5,170)**
Non Pay Costs									
Clinical Suppplies	862	849	13	5,035	5,486	(451)	10,085	10,946	(861)
Non-Clinical Supplies	752	1,126	(374)	4,531	3,446	1,085	8,876	7,185	1,691
CNST	1,800	969	831	10,802	9,961	841	21,603	20,373	1,230
Premises & IT Costs	844	725	119	5,213	4,748	466	10,413	10,120	294
Service Contracts	767	755	12	4,549	4,115	434	9,257	8,256	1,001
Total Non-Pay Costs	**5,026**	**4,369**	**657**	**30,130**	**27,756**	**2,375**	**60,235**	**56,879**	**3,355**
Total Expenditure	**13,709**	**12,504**	**1,205**	**76,042**	**77,171**	**(1,130)**	**151,337**	**153,152**	**(1,815)**

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

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LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 4
BUDGET ANALYSIS: M6
YEAR ENDING 31 MARCH 2024

INCOME & EXPENDITURE £'000	MONTH 6 Budget	MONTH 6 Actual	MONTH 6 Variance	YEAR TO DATE Budget	YEAR TO DATE Actual	YEAR TO DATE Variance	YEAR - Underlying Budget	YEAR - Underlying Actual	YEAR - Underlying Variance	YEAR - Recovery Budget	YEAR - Recovery Actual	YEAR - Recovery Variance
Maternity												
Income	(4,238)	(3,954)	(284)	(24,999)	(24,831)	(168)	(50,625)	(50,243)	(382)	(50,625)	(50,243)	(382)
Expenditure	3,003	1,833	1,170	15,182	15,455	(273)	30,377	32,361	(1,984)	30,377	32,361	(1,984)
Total Maternity	**(1,235)**	**(2,121)**	**886**	**(9,817)**	**(9,376)**	**(441)**	**(20,248)**	**(17,882)**	**(2,366)**	**(20,248)**	**(17,882)**	**(2,366)**
Neonatal												
Income	(1,876)	(1,916)	40	(11,074)	(11,215)	141	(22,162)	(22,948)	787	(22,162)	(24,598)	2,437
Expenditure	1,732	1,281	451	9,083	8,903	181	18,167	18,108	58	18,167	18,108	58
Total Neonatal	**(144)**	**(635)**	**490**	**(1,990)**	**(2,312)**	**322**	**(3,995)**	**(4,840)**	**845**	**(3,995)**	**(6,490)**	**2,495**
Division of Family Health - Total	**(1,379)**	**(2,756)**	**1,377**	**(11,808)**	**(11,688)**	**(120)**	**(24,243)**	**(22,722)**	**(1,521)**	**(24,243)**	**(24,372)**	**129**
Gynaecology												
Income	(2,299)	(1,875)	(424)	(13,569)	(12,622)	(946)	(27,361)	(25,954)	(1,407)	(27,361)	(25,954)	(1,407)
Expenditure	1,682	1,719	(37)	8,828	10,001	(1,173)	17,611	19,968	(2,357)	17,611	19,968	(2,357)
Total Gynaecology	**(616)**	**(155)**	**(461)**	**(4,741)**	**(2,622)**	**(2,119)**	**(9,750)**	**(5,985)**	**(3,764)**	**(9,750)**	**(5,985)**	**(3,764)**
Hewitt Centre												
Income	(866)	(837)	(29)	(5,161)	(4,882)	(279)	(10,609)	(10,621)	12	(10,609)	(11,121)	512
Expenditure	897	832	65	4,866	4,889	(22)	9,733	10,123	(390)	9,733	9,923	(190)
Total Hewitt Centre	**31**	**(5)**	**36**	**(294)**	**7**	**(301)**	**(876)**	**(499)**	**(378)**	**(876)**	**(1,199)**	**322**
Division of Gynaecology - Total	**(586)**	**(160)**	**(425)**	**(5,035)**	**(2,615)**	**(2,420)**	**(10,626)**	**(6,484)**	**(4,142)**	**(10,626)**	**(7,184)**	**(3,442)**
Theatres												
Income	0	0	0	0	0	0	0	0	0	0	0	0
Expenditure	1,064	1,069	(5)	6,265	6,887	(622)	12,390	14,034	(1,644)	12,390	13,928	(1,538)
Total Theatres	**1,064**	**1,069**	**(5)**	**6,265**	**6,887**	**(622)**	**12,390**	**14,034**	**(1,644)**	**12,390**	**13,928**	**(1,538)**
Genetics												
Income	(4)	(2)	(2)	(21)	(56)	35	(42)	(56)	14	(42)	(56)	14
Expenditure	193	131	62	997	821	176	1,993	1,668	325	1,993	1,668	325
Total Genetics	**190**	**129**	**61**	**976**	**764**	**211**	**1,951**	**1,611**	**340**	**1,951**	**1,611**	**340**
Other Clinical Support												
Income	(619)	(590)	(30)	(3,553)	(3,447)	(107)	(7,147)	(6,979)	(168)	(7,147)	(6,979)	(168)
Expenditure	1,021	944	77	5,460	5,874	(414)	10,754	12,319	(1,565)	10,754	9,020	1,734
Total Clinical Support	**402**	**355**	**47**	**1,907**	**2,427**	**(521)**	**3,607**	**5,340**	**(1,732)**	**3,607**	**2,041**	**1,567**
Division of Clinical Support - Total	**1,656**	**1,553**	**103**	**9,147**	**10,079**	**(932)**	**17,948**	**20,985**	**(3,037)**	**17,948**	**17,580**	**368**
Corporate & Trust Technical Items												
Income	(3,288)	(2,151)	(1,137)	(13,732)	(14,832)	1,099	(26,987)	(26,706)	(280)	(26,987)	(28,456)	1,470
Expenditure	4,869	5,029	(160)	29,886	29,230	656	59,357	61,523	(2,167)	59,357	57,881	1,475
Total Corporate	**1,581**	**2,878**	**(1,297)**	**16,154**	**14,398**	**1,756**	**32,370**	**34,817**	**(2,447)**	**32,370**	**29,425**	**2,945**
(Surplus) / Deficit	**1,272**	**1,514**	**(243)**	**8,458**	**10,174**	**(1,716)**	**15,450**	**26,596**	**(11,147)**	**15,450**	**15,449**	**0**
Of which is hosted;												
Income	0	375	(375)	0	(808)	808	0	(815)	815	0	(815)	815
Expenditure	0	(375)	375	0	808	(808)	0	814	(814)	0	814	(814)
Total Corporate	**0**	**(0)**	**0**	**0**	**(0)**	**0**	**0**	**(0)**	**0**	**0**	**(0)**	**0**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 5
CIP: M6
YEAR ENDING 31 MARCH 2024

		MONTH 6			YTD			FOT		
TYPE	Scheme	Target	Actual	Variance	Target	Actual	Variance	Target	Actual	Variance
Income	Income Private Patient	21	2	-19	92	33	-58	470	605	135
Income	Income non-patient care	55	31	-24	311	277	-34	842	595	-247
Income	Income Other (balance - please provide description)	61	24	-36	347	91	-256	710	2,020	1,310
Income	Unidentified - Income (please provide commentary)	13	0	-13	37	0	-37	267	0	-267
	Total Income	**150**	**57**	**-93**	**786**	**401**	**-385**	**2,289**	**3,220**	**931**
Pay	Service re-design - pay	18	9	-10	109	51	-57	217	103	-114
Pay	Establishment reviews	4	43	40	-1	312	313	20	505	485
Pay	Unidentified - pay (please provide commentary)	277	0	-277	837	0	-837	2,502	1,886	-616
Pay	Other - pay (balance - please provide description)	0	0	0	0	0	0	200	0	-200
Pay	E-Rostering	2	0	-2	13	1	-12	25	1	-24
	Total Pay	**301**	**52**	**-249**	**957**	**364**	**-593**	**2,965**	**2,494**	**-471**
Non-Pay	Other - Non-pay (balance - please provide description)	11	28	17	67	170	103	184	429	245
Non-Pay	Medicines optimisation	14	30	16	82	30	-52	164	39	-125
Non-Pay	Service re-design - Non-pay	190	9	-181	1,120	1,005	-115	2,262	2,082	-179
Non-Pay	digital transformation non-pay	10	0	-10	61	0	-61	122	0	-122
Non-Pay	Pathology & imaging networks	0	0	0	3	0	-3	5	0	-5
Non-Pay	Procurement (excl drugs) - medical devices and clinical consumables	15	0	-15	86	6	-80	175	23	-152
Non-Pay	Fleet optimisation	2	3	1	7	12	5	20	29	9
Non-Pay	Estates and Premises transformation	0	0	0	0	0	0	0	14	14
Non-Pay	Procurement (excl drugs) -non-clinical	4	1	-4	25	1	-25	51	5	-45
Non-Pay	Unidentified - non-pay (please provide commentary)	11	0	-11	35	0	-35	100	0	-100
Total Non-Pay		**258**	**70**	**(188)**	**1,485**	**1,223**	**(262)**	**3,082**	**2,622**	**(460)**
Total CIP Delivery		**709**	**180**	**(529)**	**3,228**	**1,988**	**(1,240)**	**8,336**	**8,336**	**(0)**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 6
BALANCE SHEET: M6
YEAR ENDING 31 MARCH 2024

BALANCE SHEET £'000	YEAR TO DATE Opening	M6 Actual	Movement
Non Current Assets	102,405	101,367	(1,038)
Current Assets			
Cash	9,790	6,347	(3,443)
Debtors	9,647	9,671	24
Inventories	839	915	76
Total Current Assets	**20,276**	**16,933**	**(3,343)**
Liabilities			
Creditors due < 1 year - Capital Payables	(2,002)	(1,201)	801
Creditors due < 1 year - Trade Payables	(26,820)	(17,990)	8,830
Creditors due < 1 year - Deferred Income	(4,492)	(20,288)	(15,796)
Creditors due > 1 year - Deferred Income	(1,530)	(1,514)	16
Loans	(918)	(607)	311
Loans - IFRS16 leases	(50)	(50)	0
Provisions	(628)	(582)	46
Total Liabilities	**(36,440)**	**(42,232)**	**(5,792)**
TOTAL ASSETS EMPLOYED	**86,241**	**76,068**	**(10,173)**
Taxpayers Equity			
PDC	79,115	79,115	0
Revaluation Reserve	8,679	8,679	0
Retained Earnings	(1,553)	(11,726)	(10,173)
TOTAL TAXPAYERS EQUITY	**86,241**	**76,068**	**(10,173)**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
CASHFLOW STATEMENT: M6
YEAR ENDING 31 MARCH 2024

CASHFLOW STATEMENT £'000	Actual
Cash flows from operating activities	(9,215)
Depreciation and amortisation	3,121
Impairments and reversals	0
Income recognised in respect of capital donations (cash and non-cash)	0
Movement in working capital	6,864
Net cash generated from / (used in) operations	**770**
Interest received	272
Purchase of property, plant and equipment and intangible assets	(2,984)
Proceeds from sales of property, plant and equipment and intangible assets	187
Net cash generated from/(used in) investing activities	**(2,525)**
PDC Capital Programme Funding - received	0
Loans from Department of Health - repaid	(306)
Interest paid	(9)
PDC dividend (paid)/refunded	(1,373)
Net cash generated from/(used in) financing activities	**(1,688)**
Increase/(decrease) in cash and cash equivalents	**(3,443)**
Cash and cash equivalents at start of period	9,790
Cash and cash equivalents at end of period	**6,347**

Finance Support	Qu1 ACTUAL £000	Qu2 ACTUAL £000	Qu3 ACTUAL £000	Qu4 F/C £000	Total £000
ICB cash support	6,800	9,600	5,000	1,000	22,400
ICB cash repayment	0	0	0	(22,400)	(22,400)
Nattional cash support	0	0	0	22,400	22,400
Total support required					**22,400**
DH Loan repayment	0	306	0	306	612
DH Loan outstanding at year end					306

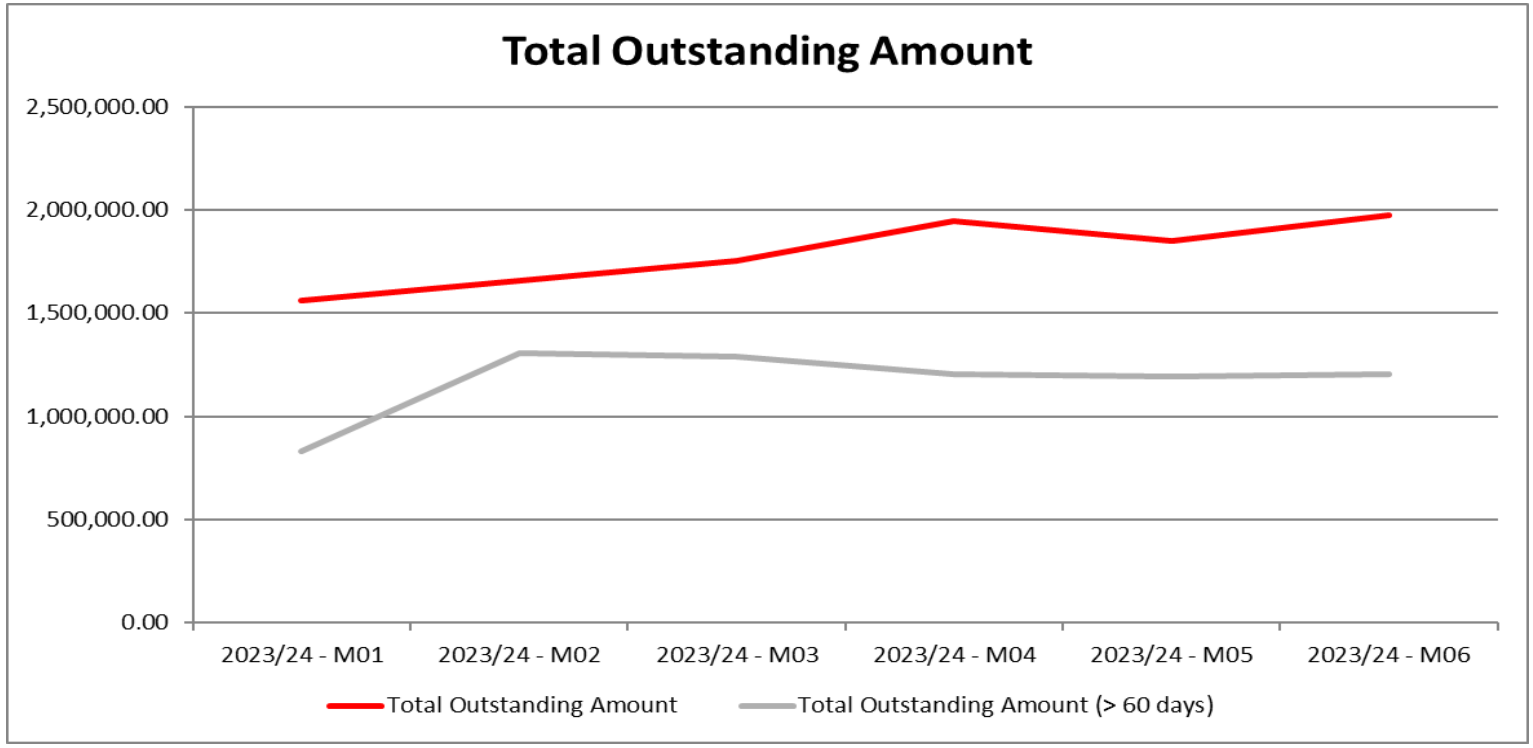
Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 8
CAPITAL EXPENDITURE: M6
YEAR ENDING 31 MARCH 2024

		YTD			YEAR		
Area	Capital Scheme	PLAN	ACTUAL	VARIANCE	PLAN	FOT	VARIANCE
Digital	EPR frontline digitisation	509	585	(77)	560	661	(101)
Digital	IT/digital investment - infrastructure	385	881	(496)	1,290	1,290	(0)
Digital	IT/digital investment - hardware	180	73	107	354	180	174
Digital	Community diagnostic equipment	153	0	153	153	153	0
Digital	Community diagnostic IT	100	0	100	65	65	0
Estates	Building works/refurbishment - Maternity	900	8	892	950	950	0
Estates	Building works/refurbishment - Neonatal	100	0	100	180	180	0
Estates	Building works/refurbishment - Gynaecology	74	4	70	300	300	0
Estates	Estates programme	420	77	343	560	560	(0)
Medical Equipment	Medical equipment - Clinical Support - Fluoroscopy	0	0	0	241	241	0
Medical Equipment	Medical equipment - Clinical Support - Theatres	107	59	48	107	113	(6)
Medical Equipment	Medical equipment - All other clinical areas	738	413	325	1,041	1,112	(71)
Medical Equipment	Medical equipment - leased blood gas analysers	139	23	116	139	139	(0)
Other	Other	0	9	(9)	(905)	(910)	5
Digital -PDC	PACS - image sharing - CAMRIN programme	49	0	49	49	49	0
Estates - charity	Charity funded bereavement suite works	35	0	35	70	70	0
TOTAL CAPITAL		**3,889**	**2,132**	**1,756**	**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: M6
YEAR ENDING 31 MARCH 2024

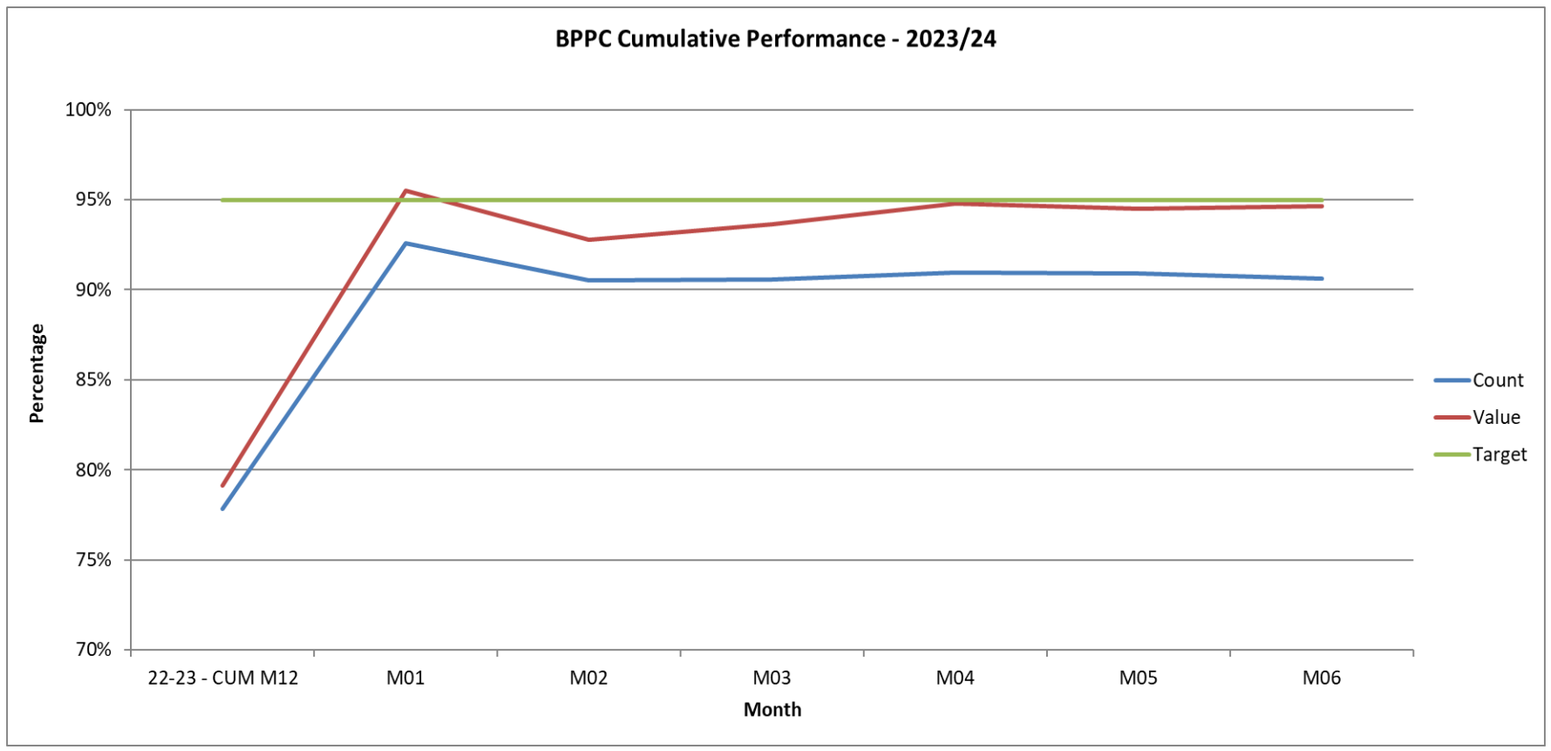


Liverpool Women's
NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST **10**
BETTER PAYMENT PRACTICE CODE (BPPC) - CUMULATIVE PERFORMANCE FOR M6
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%	91%	91%						
Cumulative Performance - Value (£)	96%	93%	94%	95%	94%	95%						

2023/24 performance TOTAL

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 11
AGENCY USAGE: M6
YEAR ENDING 31 MARCH 2024

		MONTH 6			YTD			FOT		
Division	Directorate	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Actual	Variance
Family Health	Maternity	0	31	(31)	-	136	(136)	-	188	(188)
Gynaecology	Gynaecology	0	1	(1)	-	17	(17)	-	24	(24)
Gynaecology	HFC		2	(2)		12	(12)		21	(21)
CSS	Theatres	0	19	(19)	-	92	(92)	-	174	(174)
CSS	CDC	0	2	(2)	12	18	(6)	12	20	(8)
CSS	Imaging	0	16	(16)	-	85	(85)	-	153	(153)
Corporate	All Corporate Directorates	149	0	149	942	6	936	1,835	6	1,829
Total Agency		**149**	**71**	**78**	**954**	**366**	**588**	**1,848**	**588**	**1,260**
Performance against cap/plan		**195**	**71**	**124**	**1,170**	**366**	**804**	**2,333**	**588**	**1,745**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 12
VIREMENTS: M6
YEAR ENDING 31 MARCH 2024

Cost Centre	Account Code/Type	Total	Description
Foundation Trusts Income	FOUNDATION TRUSTS INCOME	(68,281)	AFC and Medical Staffing Pay Uplift
Cheshire and Merseyside ICB Contract	ICB INCOME PATIENT CARE	(2,075,304)	AFC and Medical Staffing Pay Uplift
NHS England Income	NHS ENGLAND INCOME	(623,002)	AFC and Medical Staffing Pay Uplift
Trustwide Pay	PAY	2,766,587	AFC and Medical Staffing Pay Uplift
Central Cost Pressures	PAY	(280,775)	Bith Rate Plus Maternity Staff
Maternity Management	PAY	280,775	Bith Rate Plus Maternity Staff
Total		**0**	

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*23/24/186e*		**Date: 09/11/2023**	
Report Title	**Progress towards Delivery of Strategic and Corporate Objectives**			
Prepared by	*Helen Chainey, Strategic Projects Manager* *Jennifer Huyton, Deputy Chief Financial Officer / Deputy Director of Strategy*			
Presented by	*Jenny Hannon, Chief Financial Officer / Executive Director of Strategy and Partnerships*			
Key Issues / Messages	*To inform the Board of delivery against the overarching Trust strategy over the last 12 months*			
Action required	**Approve ☒**	**Receive ☐**	**Note ☒**	**Take Assurance ☐**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable): N/A			
	For Decisions - in line with Risk Appetite Statement – Y *If no – please outline the reasons for deviation.*			
	The Trust Board are asked to: • *Note the progress towards delivery of Our Strategy and its strategic and corporate objectives* • *Note the wider progress towards achievement of the Trust's ambitions* • *Approve the proposed changes to the strategic objectives.*			
Supporting Executive:	*Jenny Hannon, Chief Financial 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* All	Comment:
Link to the Corporate Risk Register (CRR) – CR Number: N/A	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Discussed at the Executive Team. Corporate Objectives have been reviewed at the Board Committees during October 2023.			

EXECUTIVE SUMMARY

The Trust's overarching strategy, referred to as "Our Strategy," sets out the Trust's plan to achieve its vision of becoming the recognised leader in healthcare for women, babies and their families. This strategy is supported by ten strategic objectives and 31 specific SMART targets, which are delivered through enabling strategies, specific programmes, and departmental plans. The annual corporate objectives are aligned to the strategic objectives and provide short term focus and prioritisation. This report provides an overview of the organisation's progress in delivering these objectives and also provides an opportunity for the Trust Board to provide further input which will support the Trust's annual operational plan.

The Trust is making good progress towards delivery of the strategic objectives however, some objectives are classed as 'at risk'. Where this is the case, plans are in place to address the barriers to delivery. In the areas of People, Safety, Experience, and Effectiveness, the Trust is making notable progress.

The Trust Board is asked to note progress and approve proposed changes to strategic objectives.

MAIN REPORT

1. Introduction

The Trust's overarching strategy, Our Strategy, has been in place since 2021 and is the roadmap the Trust follows to achieve its vision of becoming the recognised leader in healthcare for women, babies and their families. Our strategy contains 5 strategic aims, enhanced by 5 aligned ambitions for the organisation:

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

The aims and ambitions are supported by 10 strategic objectives, with 31 underpinning SMART targets.

The Trust then has a set of annual corporate objectives, aligned to its strategic objectives and the annual operational plan, which provide focus and prioritisation in the short term.

Strategic and corporate objectives are delivered in three ways:

- Enabling strategies and plans.
- Specific programmes and workstreams designed to deliver objectives.
- Divisional and departmental plans, which are all clearly aligned to the ambitions and objectives in Our Strategy.

The specific supporting strategies, plans, programmes and workstreams through which each of the objectives is being delivered are detailed in Appendix 1. More broadly, the strategy is delivered through ensuring that everyone in the organisation understands our focus on people, safety, and experience, and by encouraging the values and behaviours necessary to achieve our vision.

Both the strategic and corporate objectives are aligned to relevant Board Committees who provide scrutiny and oversight through a regular corporate objective monitoring cycle.

This paper takes both a qualitative and quantitative approach to summarising the progress made towards delivering both the overarching strategic objectives to date and the annual corporate objectives in the first 6 months of this financial year. It also notes some of the many achievements that have been made in the last year which help move us closer towards achieving our ambitions and vision.

2. Delivery Against Corporate Objectives

The Board of Directors reviewed and approved the corporate objectives for 2023/24 at its meeting on 11 May 2023. The cycle of periodic review involves the Board reviewing progress on the corporate objectives on a six-monthly basis. Prior to this review each of the Board Committees has reviewed the objectives aligned to it during October 2023 and performance to date is summarised in Appendix 2.

There are 20 corporate objectives. The majority (14) are on track for delivery, 5 have identified risks to delivery, and 1 of the objectives had been identified as 'off track'. The objective noted as off track is to ensure 'efficient and effective use of all available resources, meeting agreed financial targets and working across the Cheshire and Mersey system for optimum outcomes for the region'. This is due to current financial performance; at Month 6 the Trust has an adverse variance to plan of £1.7m year-to-date and significant risk to delivery of the full year plan. The Trust is taking action on financial recovery, with a financial recovery programme in place supported by enhanced grip and control measures, compliant with national stipulations regarding expenditure control. The Trust is also regularly engaging with the Cheshire and Merseyside Integrated Care Board (C&M ICB) regarding financial performance.

The 5 objectives identified as having risks to delivery each have an agreed plan in place to ensure delivery by the end of the financial year.

3. Delivery Against Strategic Objectives

Overall, the Trust continues to make good progress towards delivery of the strategy, despite the recognised national and local challenges of workforce, elective and financial recovery.

Current monitoring of delivery indicates that the Trust:

- Has completed 1 objective in full
- Is on target to meet 5 objectives
- Has 3 objectives at risk of delivery
- Has 1 objective behind target.

Of the underpinning SMART targets, the Trust has increased its completed targets from 5 reported last year to 9 this year, however there has been an increase in the number of targets rated as at risk or behind plan.

Delivery against objectives and underpinning SMART targets has been RAG rated, according to the key below:

Status	2023		2022	
	Objectives	Targets	Objectives	Targets
Complete	1	9	-	5
On track	5	12	6	18
At risk	3	5	4	3
Behind target	1	2	-	2
Not delivered	-	1	-	-
Removed/Paused	-	2	0	3
Total	**10**	**31**	**10**	**31**

This section of this paper summarises performance in each of our priority areas, referencing both quantitative delivery against objectives and supporting SMART targets, as well as providing a flavour of some of the successes the Trust has delivered while working towards realising its ambitions.

Narrative in this section focuses on those areas rated as 'at risk' or 'behind target', however detailed information regarding performance against all SMART targets is provided in Appendix 3[1].

People

Ambition: We will be an outstanding employer

[1] Note the proposed amendments to strategic objectives in section 4 of this paper

	Objective	Overall RAG	Exec Sponsor	SMART Target	RAG
People	Be recognised as the most inclusive organisation in the NHS with Zero discrimination for staff and patients (zero complaints from patients, zero investigations)		Chief People Officer	Increase staff from ethnic minority backgrounds in leadership roles by 10 each year, until at least 25% of our leadership workforce are from ethnic minority backgrounds	
				Ensure our workforce matches the ward of Riverside in terms of % of staff from ethnic minority backgrounds by 2025	
	Recruit and retain key clinical staff		Chief People Officer	Be in the top 10% of NHS organisations for staff engagement as evidenced by the Annual National NHS Staff Survey by 2024	
				Grow the consultant workforce to achieve 24/7 consultant cover *Propose date amended to 2025*	Amend date
				Provide an excellent education and clinical experience for all staff	

While these objectives are rated as at risk overall, there are a range of factors which influence delivery (including those out with the Trust's control), and this rating reflects the significant workforce challenges experienced by the whole NHS over the last three years. Despite this, there is encouraging progress towards delivery, with the most recent NHS Staff Survey results showing LWH as being the joint most improved Trust in relation to staff engagement in the UK and achievement of 34th place in 'Inclusive Employers' accreditation.

The proportion of staff identifying as having ethnic minority backgrounds has increased from 9% in January 2023 to 11% in October 2023, however, there remains a significant gap with the local population (23.4%). Staff from ethnic minority backgrounds in senior leadership roles has fallen from 31 in January 2023 to 27 currently. Further co-ordinated engagement work is taking place between the patient experience, Human Resources and Equality, Diversity, and Inclusion teams, in partnership with health, education, local authority and community partners, to increase awareness of employment and volunteering opportunities at the Trust. Additionally, work is underway with leaders in the organisation, in particular within nursing and midwifery, to ensure all staff members have a career plan and those who wish to progress into leadership roles receive targeted support to do so.

Plans to achieve 24/7 consultant cover continue to progress, with 24/7 obstetric cover expected to be delivered by March 2024. Achieving 24/7 anaesthetic cover is more challenging due to national workforce constraints, as well as recruitment and retention challenges related to the Trust's isolated site. The Trust now has a plan in place to achieve twilight cover in anaesthetics by March 2025.

Additional progress made since the launch of the strategy towards achieving our ambition to be an outstanding employer includes:

- Launch of a new staff intranet and electronic personal development record (e-PDR) system.
- Introduction of the on-site, psychology led Staff Support Service including counselling and wellbeing coaches.
- Roll out of wellbeing conversations across the Trust and additional support for staff on long term sickness.
- Improvement of the onboarding process through an ESR applicant dashboard.
- Launch of Anti- Racism framework.
- Successful support for an internship programme giving young people with disabilities work placements along with re-launch of work experience and other pre-employment programmes.

Safety

Ambition: Our services will be the safest in the country

	Objective	Overall RAG	Exec Sponsor	SMART Target	RAG
Safety	Progress our plans to build a new hospital co-located with an adult acute site		Medical Director	Complete refresh of site options appraisal and business case for a new Liverpool Women's Hospital in 2022 *Proposed refreshed target - Participate in and drive forward the work of the Cheshire and Merseyside Integrated Care Board's (C&M ICB) Women's Services Committee.*	Refresh Target
				Contribute to the development and delivery of the Liverpool-wide estates plan during 2021	
	Develop our model of care to keep pace with developments and respond to a changing environment		Chief Operating Officer	Review Future Generations model of care for all services, taking account of all post-COVID learning and changes to care delivery models by 2022 *Propose target is marked as complete.*	
				Consult and engage patients, staff and families during and subsequent to the development process 2023 *Propose date amended to 2025*	Amend Date
				Deliver the Quality and Clinical strategy in line with the timescales set out therein	
				Provide our hospital with the best digital capabilities and embed a digital first culture through delivering the Digital.Generations strategy by 2025	
	Implement all feasible mitigations to ensure services delivered from the Crown Street site are as safe as possible, developing our facilities for the benefit of our patients as well as those across the system		Chief Finance Officer	Secure investment to develop CT and blood bank services on site by 2021	
				Maximise the Gynaecology workforce to deliver timely, safe and effective care to our patients.	

All three safety objectives are rated as on track, with three (of eight) SMART targets complete, and the remaining five on track. A new Trust-wide electronic patient record system was successfully implemented during this summer which will enhance the digital capabilities of the Trust. The Trust has also identified an opportunity to extend the quality of care and experience of our women, babies, and their families through the development of a new Trust Quality Strategy. The new strategy will also allow for closer alignment to system priorities.

Additional actions and achievements delivered under this objective include:

- Establishment of the Staff Hub; where a staff led group identify and work on staff improvement initiatives.
- Achievement of the Informatics Skills Development Network (ISDN) Excellence in Informatics Level 2 standard.
- Adoption of the new national Patient Safety Incident Response Framework (PSIRF).

Experience

Ambition: Every patient will have an outstanding experience

	Objective	Overall RAG	Exec Sponsor	SMART Target	RAG
Experience	Deliver an excellent patient and family experience to all our service users		Chief Nurse and Midwife	Achieve Family Integrated Care accredition by 2022	
				Achieve the Unicef Baby Friendly Initiative by 2025	
				Achieve full delivery of the Patient Experience Framework by 2025	
				Pro-actively seek the views of diverse communities to inform the design of our services for the future, ensuring we champion the voices of our future service users	

This objective remains on track for delivery with all targets making good progress this year. The UNICEF Baby Friendly Initiative level 1 assessment of our Neonatal Intensive Care Unit took place recently and is the first step toward achieving full re-accreditation in 2025.

Additional actions and achievements delivered under this objective include:

- Introduction of an annual calendar of Involvement and Engagement sessions and Events for patients, their families and the public available on the Trust website.
- Project to develop the visibility of bi-lingual volunteers to support visitors to the Trust (N.B. this will not replace the use of interpreters required from a clinical perspective).
- Development of an action plan to address the needs of our deaf community when accessing Trust services.

Efficiency

Ambition: We will deliver maximum efficiency

	Objective	Overall RAG	Exec Sponsor	SMART Target	RAG
Efficiency	Ensure our services are financially sustainable in the long term		Chief Finance Officer	Ensure efficient and effective use of all available resources	
				Ensure the Trust has an updated, balanced long term financial plan in place by 2021/22	
				Pursue appropriate opportunities to maximise Trust income for the benefit of our patients	
				Appraise options for future organisational form (up to and including merger) by 2022 *Propose re-instating target: "Consider options for delivering increased value through strengthening existing partnerships and reviewing options for organisational form by 2025"*	Re-instate and Amend Target
				Develop the Trust's commercial strategy during 2022	PAUSED

This objective is currently rated as at risk to delivery due to the financial recovery and long-term sustainability challenges faced by the Trust.

The Trust maintains good grip and control, with strengthened measures implemented, including enhanced pay and non-pay spend controls. There is a Financial Recovery Programme in place with several underpinning workstreams led by executive sponsors, and the Trust continues to undertake detailed post-implementation review of investments to ensure value for money is achieved. The Trust has a National Cost Collection Index of 103, with several areas reported as less than 100 (indicating a greater than average level of efficiency in these areas). Internal Audit opinions are consistently 'High Assurance' in relation to financial control and systems.

Despite this, the Trust has an underlying structural financial deficit. The drivers of the underlying deficit are well understood and are closely linked to its clinical sustainability challenges. In summary, there are three key drivers:

- Income and tariff is insufficient to cover the costs of delivering services, particularly in maternity
- The Trust's isolated site has necessitated additional investment to improve clinical safety.
- There are limited opportunities for economies of scale due to organisational size.

The structural deficit has been supported in recent years through the receipt of non-recurrent income and other non-recurrent solutions, however as these have reduced the underlying deficit (calculated at c30m) is further emerging and the Trust has a deficit plan of £15.4m in 2023/24.

The Trust has undertaken detailed financial modelling shared with Cheshire and Merseyside ICS which indicates that financial recovery and sustainability cannot be achieved without system support to secure long-term strategic system solutions, while at the same time addressing national maternity tariff, income top ups and clinical negligence costs. The Trust will continue to work with system partners to deliver the change required to resolve both clinical and financial sustainability issues.

In addition, while the Trust's Commercial strategy was paused during COVID-19 and the subsequent recovery period this will be reinvigorated as part of the program of financial recovery to explore opportunities to further support the delivery of NHS care.

Effectiveness

Ambition: Our outcomes will be best in class

	Objective	Overall RAG	Exec Sponsor	SMART Target	RAG
Effectiveness	Expand our existing partnerships, building on learning and partnership working throughout the COVID-19 pandemic, playing a key role in establishing any ICP or ICS	Complete	Chief Operating Officer	Develop a clear plan for all desirable partnerships during 2021, ensuring robust governance structures are in place	
	Progress our research strategy and foster innovation within the Trust		Medical Director	Increase the number of staff across the multidisciplinary clinical workforce who hold a substantive university contract by 50% by 2025	
				Provide clear evidence of senior nursing and midwifery research leadership by 2021	
				Demonstrate full recovery of the research, development and innovation activities during 2021 following the COVID-19 pandemic	
				Provide clear evidence of the Trust's research and development response to COVID-19 pertaining to the specific needs of the Liverpool population, during 2021	
				Refresh the research, development and innovation strategy, engaging with stakeholders throughout	
	Fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership		Chief Nurse and Midwife	Achieve a well-led 'good' rating by 2021	Not Feasible
				Achieve a well-led 'outstanding' rating by 2023 *Propose target is marked as 'Not Achieved'*	Not Achieved
				Achieve an overall rating of outstanding by 2025	

The majority of SMART targets under Effectiveness are now complete, with one overall objective also completed.

The objective relating to the Care Quality Commission (CQC) well-led framework is currently marked as 'behind target'. The 2021 Target was deemed 'not feasible' as no inspections were carried out in 2021. The Trust underwent CQC inspection in January/February 2023. When the finalised inspection report was published in June the well-led rating remained at its 2020 rating of 'Requires Improvement'. Achievement of the objective remains at significant risk, however the Trust has a plan in place to deliver the actions outlined in the recent CQC report and is making progress towards delivery.

Additional actions and achievements delivered under these objectives include:

- Roll out of coaching and mentoring scheme with over 70 trained mentors.
- Chartered Management Institute accreditation for the Trust Leadership Programme, over 100 leaders have taken part.
- Director of Midwifery and an Advanced Neonatal Nurse Practitioner awarded places on the NIHR Senior Research Leader Programme 2023-2026.
- Three Research Midwives awarded places on the NIHR Early Career Researcher Development programme.

4. Summary of Proposed Changes to Strategic Objectives

During the development of Our Strategy, which took place during a period of significant uncertainty in the health service, it was agreed that a review would be undertaken annually to ensure objectives remained suitable and appropriate, and to ensure the Trust was able to adapt to meet new requirements. Objectives have been considered as part of this annual review of delivery, and the majority were found to be suitable and appropriate, however it is proposed that two target dates are amended, one paused objective is reinstated, and one objective is amended, as follows:

	Ambition	Objective	Executive Sponsor	SMART Target	Proposed Action
People	We will be an outstanding employer	Recruit and retain key clinical staff	Chief People Officer	Grow the consultant workforce to achieve 24/7 consultant cover by ~~2023~~ 2025	Amend Date
Safety	Our services will be the safest in the country	Progress our plans to build a new hospital co-located with an adult acute site	Medical Director	~~Complete refresh of site options appraisal and business case for a new Liverpool Women's Hospital in 2022~~ Participate in and drive forward the work of the Cheshire and Merseyside Integrated Care Board's (C&M ICB) Women's Services Committee.	Refresh Target
		Develop our model of care to keep pace with developments and respond to a changing environment	Chief Operating Officer	Consult and engage patients, staff and families during and subsequent to the development process ~~2023~~ 2025	Amend Date
Efficiency	We will deliver maximum efficiency	Ensure our services are financially sustainable in the long term	Chief Finance Officer	~~Appraise options for future organisational form (up to and including merger) by 2022~~ Consider options for delivering increased value through strengthening existing partnerships and reviewing options for organisational form by 2025	Reinstate and Amend Target

It is proposed that the target date in respect of growing the consultant workforce is amended to take account of the national challenges regarding the anaesthetic workforce. The Trust has a plan in place to deliver 24/7 obstetric cover by March 2024 and twilight anaesthetic cover by March 2025.

It is proposed that the remaining three targets are amended or reinstated following the publication of the Liverpool Clinical Services Review in early 2023, to ensure the Trust's objectives are aligned to the actions set out in the review and subsequent program of work.

5. Look Forward 2024

The Trust is about to enter the annual operational planning cycle for 2024/25. There are a range of national, regional, and local factors which will influence the operational plan and ongoing strategic direction of the Trust including the Women's Health Strategy, Cheshire and Merseyside 5-year Joint Forward Plan, One Liverpool Strategy and the NHS Operating Framework. A key focus will be placed on partnership working within the Liverpool City Region in response to the recommendations set out within the Liverpool Clinical Services Review as well as continued partnership working across the wider Cheshire and Merseyside and Regional landscape.

Over the next 12 months there will be opportunities for stakeholders to contribute to the further development of Trust priorities as the Trust refreshes its Quality, Estates, Putting People First, and Charitable Funds strategies. Further engagement on future planning of the Trust's strategic direction will be undertaken with the Council of Governors later in November.

6. Conclusion and Recommendation

Substantial progress has been made towards delivery of the Trust strategy since its launch in April 2021, despite significant challenges and pressures during this period, such as elective recovery, financial recovery, and national workforce challenges, which have impacted both the Trust and its partners.

The majority of strategic and corporate objectives are on track for delivery, and where objectives are rated as 'at risk', plans are in place to address issues. Delivery of the strategy has been well embedded into the Trust's day-to-day activities and future planning cycles.

The Trust Board are asked to:

- Note the progress towards delivery of Our Strategy and both its strategic and corporate objectives.
- Note the wider progress towards achievement of the Trust's ambitions.
- Approve the proposed changes to the strategic objectives.

Appendices

Appendix 1 – Strategic Objective Delivery Vehicles

Appendix 2 – Detailed Performance Against Corporate Objectives

Appendix 3 – Detailed Performance Against Strategic Objectives

	Ambition	Objective	Executive Sponsor	Primary Delivery Vehicles
People	We will be an outstanding employer	Be recognised as the most inclusive organisation in the NHS with Zero discrimination for staff and patients (zero complaints from patients, zero investigations)	Chief People Officer	-Putting People First Strategy -Talent Management Strategy -Clinical and Quality Strategy -Women, Babies and Familes Experience Framework
		Recruit and retain key clinical staff	Chief People Officer	-Divisional Service Transformation Plans -Putting People First Strategy -Future Generations -Crown Street Enhancements -Community Diagnostic Centre Programme -Talent Management Strategy -Clinical and Quality Strategy
Safety	Our services will be the safest in the country	Progress our plans to build a new hospital co-located with an adult acute site	Medical Director	-Future Generations Programme
		Develop our model of care to keep pace with developments and respond to a changing environment	Chief Operating Officer	-Future Generations Programme -Digital Generations Strategy -LUHFT Partnership Board -Liverpool Neonatal Partnership -Community Diagnostic Centre Programme -Divisional Service Transformation Plans
		Implement all feasible mitigations to ensure services delivered from the Crown Street site are as safe as possible, developing our facilities for the benefit of our patients as well as those across the system	Chief Finance Officer	-Future Generations Programme -LUHFT Partnership Board -Liverpool Neonatal Partnership -Crown Street Enhancements Programme -Community Diagnostic Centre Programme -Divisional Service Transformation Plans
Experience	Every patient will have an outstanding experience	Deliver an excellent patient and family experience to all our service users	Chief Nurse	-Women, Babies and Families Experience Framework -Clinical and Quality Strategy -Divisional 5 Year Service Transformation Plans -Patients with Additional Needs Strategy -Patient Involvement and Experience Committee
Efficiency	We will deliver maximum efficiency	Ensure our services are financially sustainable in the long term	Chief Finance Officer	-Future Generations Programme -Finance and Procurement Strategy -Financial Recovery Board -Divisional Service Transformation Plans
Effectiveness	Outcomes will be the best in class	Expand our existing partnerships, building on learning and partnership working throughout the COVID-19 pandemic, playing a key role in establishing any ICP or ICS	Chief Operating Officer	-LUHFT Partnership Board -Liverpool Neonatal Partnership -FPBD Partnership Oversight -Community Diagnostic Centre Programme
		Progress our research strategy and foster innovation within the Trust	Medical Director	-R,D & I Strategy -Divisional 5 Year Service Transformation Plans
		Fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership	Chief Nurse	-Putting People First Strategy -Leadership development programmes

NHS
Liverpool Women's
NHS Foundation Trust

Corporate Objectives

2023 – 2024

Our Vision

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

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

Our Values	**Care**	**Ambition**	**Respect**	**Engage**	**Learn**

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

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

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

Key	Complete	On track	Risks identified but	Off Track

To develop a Well Led, capable, motivated, and entrepreneurial Workforce					
Strategic Aim	**Proposed Corporate Objective**	**Executive Lead**	**Relevant Strategy**	**Board Committee**	**6-month review**
Be recognised as one of the most inclusive organisation in the NHS with Zero discrimination for staff and patients (zero complaints from patients, zero investigations)	Moving closer to our aim of 25% of leaders (Band 7 or above) being from a racially minoritized background, by increasing to 13% in 2023/24	CPO	Putting People First Strategy	PPF	The original corporate objective has been modified to increase by 10 leadership roles each year until 25% of our leadership workforce is made up of colleagues from a racially minoritised background As at January 2023 there were 31 staff from an ethnically diverse background in roles at band 7 and above. As at September 23 this figure has dropped to 27. Further analysis will be undertaken to identify the reasons for the leavers This underlines the need to work with leaders in the organisation, in particular N&M leaders to ensure every nurse / midwife/ AHP has a clearly identified career plan and those who wish to progress into leadership roles receive targeted support to do so. Career conversations will be offered to every racially minoritised nurse and midwife beginning in October 2023 as part of Black History Month.
	Increasing the number of employees from a racially marginalised background by 5%, moving to 13% in 2023/24	CPO	Putting People First Strategy	PPF	As at September 23, 201 / 1764 of our staff have declared themselves to be non-white. This represents 11% of our workforce which is an increase from 9% which was reported in January 23 but falls short of the 13% target. Further co-ordinated engagement work between the patient experience / HR/ EDI teams is required alongside working in partnership with health, education, local authority and community partners to increase awareness of employment and volunteering opportunities at LWH.
	Ensure all new leaders (B7 and above) undertake active anti-racist training within their induction programme and ensure all existing B7 and above leaders undertake that training within the next 12 months	CPO	Putting People First Strategy	PPF	Anti-racism is module at corporate induction which all staff undertake. All Band 7 and above nursing, midwifery, AHP and corporate leaders are enrolled in the LWH leadership programme which includes an anti-racism module. To date 65 leaders have attended EDI within the Leadership Programmes.
Recruit and retain key clinical staff	Demonstrate continued improvement from the 2022 NHS Staff survey in relation to staff engagement measures.	CPO	Putting People First Strategy	PPF	The 2022 national Staff Survey placed LWH as one of the most improved Trusts in the country in respect of the engagement score.
	Work towards establishing 24/7 consultant obstetric workforce by March 2024 and 8pm-12pm (twilights) for anaesthetic workforce by March 2025.	MD	Medical Workforce Strategy	PPF	Good progress made towards delivery 24/7 consultant cover. Neonatal was compliant from April 2022 and maternity has

					provided twilight consultant cover up to midnight since this time. It is estimated that it will take 4 new consultants posts and negotiation around resident overnight cover to complete the transition to resident consultant cover. A paper is to come to the Executive meeting in November to describe the exact numbers required with the plan to go to advert late in Quarter 4 20/23. . In respect of anaesthetics, the aim is to achieve consultant cover onsite for four days per week until 22:00 hrs. The medium term ambition is to achieve twilight cover on the 5th day and over the week end. There have been 2 Specialist doctor appointments and the hope is that they will be able to support the twilight rota over time.

To deliver Safe services					
Strategic Aim	**Proposed Corporate Objective**	**Executive Lead**	**Relevant Strategy**	**Board Committee**	**6-month review**
Progress our plans to build a new hospital co-located with an adult acute site Develop our model of care to keep pace with developments and respond to a changing environment	Support and be a major contributor to the NHS Cheshire & Merseyside ICB Women's Services Committee	CFO	Future Generations Strategy	FPBD	Trust colleagues fully participating in WSC and supporting groups, including Programme Delivery Group, Estates and Finance and Capital Group. In addition to attending all meetings, the Trust has attended all meetings, provided information to support report production, supported an informal meeting to bring members up to speed with the clinical case, and reviewed the estates assumptions in partnership with Liverpool University Hospitals NHS FT.
	Embed and maximise the integrated digiCare EPR system and technologies ensuring systems are optimised for care delivery, secure, data accurate and that staff and patients are digitally supported to maximise digital benefits.	CIO	Digital Generations Strategy	FPBD	The new EPR was successfully implemented in July 2023, which is a key milestone. The programme is concluding it's stabilisation activities by the end of October, ensuring support is transferred to 'business-as-usual'. The programme will shift to an optimisation phase which will centre on integration, use of data, training and maximising benefits, fundamentally driving adoption and good practice.
	Deliver on key national waiting time targets included within the national 2023/24 NHS planning guidance and demonstrate progress towards the three-year delivery plan for maternity and neonatal services, published by NHSE in March 2023.	COO	Our Strategy	FPBD	Urgent Care targets against trajectory are being met for Gynaecology Emergency Department and MAU triage. Elective recovery continues above the regionally agreed trajectory. Routine Diagnostic Performance is overachieving against the nationally agreed trajectory. The Trust is in Tier 2 for Cancer Performance due to the failure to meet the 28 day Faster Diagnostic Standard with an ambition to be out of Tier 2 in

					Q4. There is a Trust Wide Cancer Improvement Plan in Place.
	Benchmark Trust's carbon footprint in Q1 and use this to set carbon footprint reduction targets through the implementation of sustainable practices across all areas of our operations.	COO	Green Plan	FPBD	The Trust has refreshed our Green Plan aims and ambitions in Q2. Benchmarking of our Carbon Footprint has been completed in Q2 and will now inform future measurement.
	To lead on the development of a refreshed Quality Strategy with associated delivery plan and supported by a suite of monitoring metrics and dashboard. Including a focus on patient experience, safety, health inequalities and clinical outcomes	Chief Nurse	Clinical & Quality Strategy	QC	The Trust is working closely with AQUA in the development and refresh of the Trust Quality Strategy. Several engagement events are planned building on the triangulation and review of data packs provided for each clinical service. The QS will also ensure thee is a focus on the how we will embed and sustain change and quality improvements to ensure the Trust has a clear vision and plan to embed a culture of continuous Improvement

To deliver the best possible Experience for patients and staff					
Strategic Aim	**Corporate Objective**	**Executive Lead**	**Relevant Strategy**	**Board Committee**	**6-month review**
Deliver an excellent patient and family experience to all our service users	Actively seek and use the diverse views of, patients, their families, and our communities to design and deliver services that best meet their needs. To ensure that services are utilising the findings of this intelligence to identify areas for service improvement and that we can demonstrate communication of the actions we have taken because of the feedback received.	Chief Nurse	Clinical & Quality Strategy	QC	Robust Programme of community engagement events started and in place with a range of stakeholders across all communities. Learning disseminated and monitored through the PEIC. Early indications suggest improvements in national in-patient survey scores. Work ongoing and will inform patient experience and engagement priorities of the refreshed Quality Strategy 2024 – 2027

To be ambitious and Efficient and make best use of available resources					
Strategic Aim	**Proposed Corporate Objective**	**Executive Lead**	**Relevant Strategy**	**Board Committee**	**6-month review**
Ensure our services are financially sustainable in the long term	Ensure efficient and effective use of all available resources, meeting agreed financial targets and working across the Cheshire and Mersey system for optimum outcomes for the region.	CFO	Our Strategy	FPBD	Off plan by £1.7m year-to-date at month 6, with significant risk to full year delivery. Financial Recovery Programme in place with enhanced grip and control measures, compliant with national stipulations regarding expenditure control. Trust participates in C&M expenditure control group.
	Ensure the Trust has an updated, long-term financial plan in place during 2023/24 with clear views and actions in place in relation to long-term sustainability and with alignment to the Liverpool Clinical Services Review.	CFO	Our Strategy	FPBD	Long-term financial model updated, and 3-year Recovery Plan produced, indicating system support and change required to return to breakeven.
	Develop the Trust's commercial strategy during 2023/24 and pursue appropriate opportunities to maximise Trust income and expertise for the benefit of our patients	CFO	Our Strategy	FPBD	Commercial principles agreed and embedded in Finance and Procurement Strategy. Commercial workstream in place under Financial Recovery Programme.

To participate in high quality research in order to deliver the most Effective outcomes					
Strategic Aim	**Proposed Corporate Objective**	**Executive Lead**	**Relevant Strategy**	**Board Committee**	**6-month review**
Expand our existing partnerships, building on learning and partnership working throughout the COVID-19 pandemic, playing a key role in establishing any ICP or ICS	Maintain and develop key partnerships, ensuring robust governance structures are in place and effective reporting through the Trust's assurance framework.	CFO	Our Strategy	FPBD	LUHFT Partnership in place and continuing to develop following appointment of joint CEO. Partnership with Alder Hey also in development, building on Liverpool Neonatal Partnership. Partnerships Oversight discussed by Executive Committee on a quarterly basis.
	Support the ICS for C&M and work with the system to improve outcomes for Women's Health including Maternal and Neonatal care.	CFO	Our Strategy	FPBD	Trust fully engages with system work improving women's health; for example, prevention work, LMNS workstreams, Women's Health Hubs etc.
Progress our research strategy and foster innovation within the Trust	Increase nursing & midwifery participation in research as per the Trust's R&D Strategy	MD	Research & Innovation Strategy	QC	Since April 2023 the number of nurses, midwives and AHPs directly employed or formally contributing to research has increased from 25 to 35. This does not include those who contribute as part of their normal role. It is also of note that in April 2023 there were 8 development opportunities for researchers in nursing midwifery and AHPs, this has increased to 19 and include opportunities such as NIHR Associate Principle Investigator scheme., PhDs, LSTM research secondment, early career research development programme, NHIR senior research leader programme, HEE/NIHR pre-doctoral integrated clinical practitioner academic fellowship, RCM small research award, RCM priority setting committee member, sessional lecturer at LMJU for research teaching module.
	Work towards achieving University Hospital Accreditation by March 2025	MD	Research & Innovation Strategy	QC	Good progress made. One further academic consultant employed.
Fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership	The ambition is to fully implement and embed the Trust's accreditation programme by ensuring all wards and departments have, as a minimum, had a baseline assessment undertaken by September 2023	Chief Nurse	Clinical & Quality Strategy	QC	To date a total of 25 accreditations have taken place in the inpatient settings since July 2022. Most areas have demonstrated gradual or significant improvements in most of the standards. Thirteen outpatient areas are scheduled for a baseline assessment which are planned for completion in Q4. The slight delay has been an effect of the AND supporting midwifery leadership throughout the CQC Inspection in early 2023
	Ensure delivery across all Maternity Transformation Programme workstreams, with good communication and engagement of the plan and work completed.	Chief Nurse	Clinical & Quality Strategy	QC	The Maternity Transformation Programme continues to deliver across the identified objectives which include the delivery of

					Ockenden Essential Actions and CQC Action plan . The plan was refreshed in September 2023 to include the three years single delivery plan for maternity and neonatal services. The Board of Directors receives a monthly update through the Quality Committee in relation to the programmes of work and outcomes

	Ambition	Objective	Overall RAG		Executive Sponsor	Detail	RAG		2023 Comments	2022 Comments
			2023	2022			Oct-23	Oct-22		
People	We will be an outstanding employer	Be recognised as the most inclusive organisation in the NHS with Zero discrimination for staff and patients (zero complaints from patients, zero investigations)			Chief People Officer	Increase staff from ethnic minority backgrounds in leadership roles by 10 each year, until at least 25% of our leadership workforce are from ethnic minority backgrounds		OBJECTIVE AMENDED	As at January 2023 there were 31 staff from an ethnically diverse background in roles at band 7 and above. As at October 2023 this figure has reduced to 27. Further analysis will be undertaken to identify the reasons for the leavers. This underlines the need to work with leaders in the organisation, in particular N&M leaders to ensure every nurse / midwife/ AHP has a clearly identified career plan and those who wish to progress into leadership roles receive targeted support to do so.	The original corporate objective has been modified to increase by 10 leadership roles each year until 25% of our leadership workforce being from a racially minoritised background is reached (to at least match the ward of Riverside, aligning wih tthe objective below). Agreed by the PPF Committee. Between April 2020 and April 2022, staff in post increased from 16 to 25. Whilst this is good progress, it does fall short of the aim, therefore this objective has been rated as 'at risk'.
						Ensure our workforce matches the ward of Riverside in terms of % of staff from ethnic minority backgrounds by 2025			Ethnic data by ward/ city/ region is not published on an annual basis. Riverside ethnicity as detailed in a CCG report 2018 states 23.4% of the population are not white British/Irish, the fourth highest level in the city and 4.4% are 'other ethnic group (including Arab)' ethnicity. As at September 2023, 201 / 1764 of our staff have declared themselves to be non-white. This represents 11% of our workforce which is an increase from 9% which was reported in January 2023. Further co-ordinated engagement work between the patient experience / HR/ EDI teams is required alongside working in partnership with health, education, local authority and community partners to increase awareness of employment and volunteering opportunities at LWH. We have committed to increasing our ethnically diverse workforce by 5% year on year to ensure we achieve Riverside representation by 2025. This represents a significant challenge, therefore this objective has been rated as 'at risk'.	Riverside ethnicity as detailed in a CCG report 2018 states 23.4% of the population are not white British/Irish, the fourth highest level in the city and 4.4% are 'other ethnic group (including Arab)' ethnicity. Currently 9.5% of the LWH workforce is from a racially minoritised background, therefore further working in partnership with health, education, local authority and community partners is needed to increase the number of employees from a racially minoritised background by 5% year on year to ensure we achieve Riverside representation by 2025. This represents a significant challenge, therefore this objective has been rated as 'at risk'.
		Recruit and retain key clinical staff			Chief People Officer	Be in the top 10% of NHS organisations for staff engagement as evidenced by the Annual National NHS Staff Survey by 2024			The score for staff engagement in the 2022 staff survey increased from 6.9 to 7.1. LWH were the joint most improved Trust in relation to the staff engagement score in the UK. The national average score for all Trusts was 7. Nonetheless, we remain outside of the top 10% and continue to focus on improving the employee experience through wellbeing, leadership, engagement and involvement and positive people policies and practices.	The 2021 national Staff Survey results did not demonstrate the progress on engagement that we hoped to achieve and there was a need to understand some of the qualitative intelligence behind the data. As a result, the Trust decided to implement the 'Big Conversation' series of listening events, commencing in June 2022, to learn more from the staff about about working at Liverpool Women's and where improvements can be made. Good feedback was received from these events and they were repeated in September 2022. Staff survery results are influenced by a range of factors, including those outside of the Trust's control (e.g. national focus on maternity services, national worksforce shortages etc). The next staff survey is due shortly and it is hoped that the result will represent an improvement, however at present this objectuve has been rated as 'behind target'.
						Grow the consultant workforce to achieve 24/7 consultant cover by 2023	DATE AMENDED		Anaesthetic consultant cover until 10pm is in place on 2 days per week. To achieve twilight cover of 8am to midnight 7 days per week will require 7 additional consultants. Anaesthetic consultant numbers have remained static at 11. Two additional specialist doctors have been recruited to this year. Additional recruitment within maternity has increased by 21 to 26. Propose date amended to 2025	Good progress made towards delivery 24/7 consultant cover. Neonatal was compliant from April 2022 with Maternity to achieve twilight cover shortly. Improvements have been made in both recruitment and retention within the gynae consultant workforce (where 24/7 cover is not planned for or needed at the present time). The Division are continuing to consider the workforce model against the service demands. Progress has been made to extend anaesthetic consultant cover onsite for four days per week until 22:00 hrs with the ambition to achieve a fifth day and then weekends over time. Achieving 24/7 cover within anaesthetics remains the biggest challenge, however this objective has been rated as 'on track' due to the good progress made overall.
						Provide an excellent education and clinical experience for all staff			TBC	The Trust monitors the results from a range of surveys regarding its educational experience, including the GMC survey and NET survey. Feedback is reviewed and actions put in place to address any issues raised. Feedback has been recieved that the curriculum received by O&G trainess is good, but some concerns were raised re meeting surgical targets (due to impact of COVID). Changes in the curriculum for anaestheticvs trainees are a challenge for LWH, and it is difficult to attract senior trainees. Additional PAs for educational supervisors have been agreed (including within anaesthetics). The Trust receives good feedback from the university, as well as from midwifery and nursing practice educators, and provides an excellent post grad educational offer through the GP education scheme (e.g. menopause CPD offered by Dr Paula Briggs). An education strategy is to be drafted to to capture plans, for example regarding simulation training and headroom/time to train. Given the good feedback received and range of actions in place, this objective has been rated as 'on track'.

Safety	Our services will be the safest in the country	Progress our plans to build a new hospital co-located with an adult acute site			Medical Director	Complete refresh of site options appraisal and business case for a new Liverpool Women's Hospital in 2022	REFINE TARGET	DATE AMENDED	In January 2023, following the Liverpool Clinical Services Review and at the request of the Cheshire and Merseyside Integrated Care Board (C&M ICB), the Trust paused its internal Future Generations (FG) programme, handing responsibility for the programme to the ICB's newly established Women's Services Committee (WSC). Resolving the long term clinical sustainability issues of women's services within the Liverpool City Region was designated the highest system priority alongside reviewing emergency pathways during the Review. The Committee has recently appointed several key roles including a Programme Director and the Independent Clinical SRO, and has a programme plan in place with associated enabling workstreams in place. The Trust continues to play an active role in this programme and recently provided an overview of the work undertaken throughout the FG programme to the WSC at an informal workshop. Proposed target refined to reflect system changes - "Participate in and drive forward the work of the Cheshire and Merseyside Integrated Care Board's (C&M ICB) Women's Services Committee."	The majority of the work to complete a Strategic Outline Case has been completed, with options appraisal carried out through the Future Generations Clinical Advisory Group. The Trust agreed in September 2022 to take the lead on development of the Pre-Consultation Business Case, working closely with colleagues at Place. At the time of writing, governance arrangements for the PCBC are to be agreed. The Trust is working closely with ICB colleagues to ensure they are engaged with the programme and production of the case. Refresh of the case is now scheduled for completion in 2022, to align with the New Hospitals Building Programme EOI process and the formation of ICBs. The work of the FG Programme is reported on a monthly basis in detail to both the Quality and FPBD Committees (who each oversee different parts of the programme).
						Contribute to the development and delivery of the Liverpool-wide estates plan during 2021			The Trust successfully contributed to Liverpool and Cheshire and Merseyside Strategic Estates plans, through direct participation in estates strategy development workshops, it's role in the LUHFT Estates Strategy and the continued development of the future vision for Crown Street. While this objective as stated was completed during 2021, the Trust continues to engage wiht strategic estates planning and delivery at Place and system levels.	The Trust has successfully contributed to Liverpool and Cheshire and Merseyside Strategic Estates plans, through direct participation in estates strategy development workshops, it's role in the LUHFT Estates Strategy and the continued development of the future vision for Crown Street. While this objective as stated was completed during 2021, the C&M Estates Strategy and associated capital programme remains under development by the ICB, and therefore work in this area will continue throughout 2022 and beyond.
		Develop our model of care to keep pace with developments and respond to a changing environment			Chief Operating Officer	Review Future Generations model of care for all services, taking account of all post-COVID learning and changes to care delivery models by 2022	Complete	DATE AMENDED	The LWH future model of care was refreshed via two Clinical Summits held with LWH clinicians in Q2 2022/23. The output of this work was used to inform the Liverpool Clinical Services Review who reached the same conclusion regarding the model of care during their development workshops. Since the Liverpool Clinical Services Review, C&M ICB has introduced site specific committees to consider the refresh of the emergency pathways within the City region and has tasked the Women's Services Committee (WSC) with taking forward the long term sustainability of women's services as detailed above. The Trust continues to play a very active role in contributing to the work of the WSC.	Work to refresh the Future Generations model of care is well underway with initial outputs received used to inform estates modelling. This work will be an itterative process, completed in line with business case and FGCAG timescales. Workstream Terms of Reference and work plan are in place, aligned to the wider FG Programme. This workstream is clinically led.
						Consult and engage patients, staff and families during and subsequent to the development process 2023	DATE AMENDED	DATE AMENDED	Stakeholder consultation relating to the long term sustainability of women's services within the Liverpool City region has been identified as a key workstream within the WSC's programme workplan Propose date amended to 2025	Some public engagement has been undertaken, however recruitment to the planned FG Patient Reference Group has been challenging. Therefore there are now plans in place to utilise the newly formed Trust-wide Patient and Public Engagement Group for feedback and participation in the options appraisal exercise. This work will take place during Q3 of 2022/23, in line with the wider FG Programme timeframes.
						Deliver the Quality and Clinical strategy in line with the timescales set out therein			The Trust has identified an opportunity to extend the quality and experience ambitions set out in the 'Women, Babies and their Families Experience Strategy' and the 'Clinical and Quality Strategy' and drive closer alignment to system priorities, through the development of a new Quality Strategy for Liverpool Women's Hospital. This new strategy will streamline the Trust's strategic framework, combining and replacing the existing Clinical and Quality Strategy 2020-2025 and the Women, Babies, and their Families Experience Strategy 2021-2026, focusing on the three dimensions of quality (as defined in the Health and Social Care Act 2012): clinical effectiveness, safety, and patient experience. It is anticipated that the new Quality strategy will be launched in March 2024.	The work plan is regularly reviewed by the Quality Committee and provides assurance that evidence is being collated, delivery of the strategy remains within agreed timescales and that the plans have been reviewed, scrutinised, and signed off by the relevant clinical services. Divisions have 5 Year Service Transformation Plans in place to ensure that the Clinical Serrvice Priorities set out wihtin the Clinical and Quality Strategy are embedded into divisional programmes of work.
						Provide our hospital with the best digital capabilities and embed a digital first culture through delivering the Digital.Generations strategy by 2025			There is an effective Digital. Generations strategy in place which regularly reports to the FPBD Committee. The Trust successfully delivered on its key objective to implement a new Trust-wide electronic patient record. The digiCare MEDITECH Expanse EPR went live during July 2023, and Digital Services priorities has moved into a phase of stabilisation and systems optimisation which will result in the perceived benefits being delivered, including reducing the complexity of multiple systems, enhancing the digital capabilities of the Trust through a modern and data rich electronic patient record. The Trust continues to focus on supporting staff with developing digital first culture. There has been demonstrable progress in establishing a robust clinical digital network and supporting governance.	There is an effective Digital. Generations strategy in place which regularly reports to the FPBD Committee. Key progress has been achieved through working towards the Informatics Skills Development Network (ISDN) Excellence in Informatics Level 2 accreditation, improving the IT infrastructure including the data network refresh and the cloud backup project, and the successful digital bidding which has resulted in approximately 2 million of additional investment secured for improving digital maturity across the Trust. Service desk improvement has not progressed as quickly as desired but there is a robust plan in place to further develop this work. The Meditech Expanse project is progressing and has an intensive work plan is in place to provide assurance and ensure delivery within agreed timescales.
		Implement all feasible mitigations to ensure services delivered from the Crown Street site are as safe as possible, developing our facilities for the benefit of our patients as well as those across the system			Chief Finance Officer	Secure investment to develop CT and blood bank services on site by 2021			Complete	Complete. Bid for emergency capital funding was submitted by the Trust in early 2021, and re-submitted in July following a request from NHSI/E. Funding was approved in December 2021, and work to complete permenant CT facilities is now due to complete in December 2022.
						Maximise the Gynaecology workforce to deliver timely, safe and effective care to our patients.			The Division continue to review all workforce requirements, reviewing job plans, roles and responsibilities plus any other training needs. Recent recruitment includes one General Gynaecology Consultant plus the addition of advanced nurse practitioners (ANPs). All Consultant job plans were reviewed last November and are due to be reviewed again in the near future. This will ensure capacity is maximised. Specialist nurse roles are being reviewed with the intention of increasing capacity to support the elective recovery programme. During the Trust's CQC inspection in June 2023 the gynaecology rating moved from 'Requires Improvement' to 'Good' reflecting the hard work which the Division have undertaken to deliver the improvements required from the previous inspection in 2019.	The Division continue to review all workforce requirements, reviewing job plans, roles and responsibilities plus any other training needs. Recent recruitment includes two Consultant oncologists plus the addition of advanced nurse practitioners (ANPs). All Consultant job plans were reviewed last November and are due to be reviewed again in the near future. This will ensure capacity is maximised. Specialist nurse roles are being reviewed with the intention of increasing capacity to support the elective recovery programme.

Experience	Every patient will have an outstanding experience	Deliver an excellent patient and family experience to all our service users			Chief Nurse and Midwife	Achieve Family Integrated Care accredition by 2022		OBJECTIVE AMENDED	Complete	The Division agreed with the Chief Nurse to not pursue formal Bliss accreditation as the value it would add to the service was not commensurate with the expense. Bliss Accreditation is not recognised by the Royal College or BAPM. It was agreed to work with the NWNODN to achieve Family Integrated Care (FiCare) accreditation instead as this was more comprehensive and more applicable to Neonatal services. Formal accreditation was received in May 2022.
						Achieve the Unicef Baby Friendly Initiative by 2025			UNICEF BFI level 1 assessment for the re-acreditation of NICU will took place in September 2023, with results anticipated on XXX. This will set us on path toward achieving full BFI accreditation in 2025.	BFI accreditation achieved in 2014 and re-accreditation in 2016. Re- assessment in October 2019 where 8 standards had not met the require 80%. A remote BFI assessment as planned on standards not met in April 2020, however BFI re-assessments were suspended due to the Covid pandemic. Presently working on preparing for BFI re-accreditation in Q4 2022/23.
						Achieve full delivery of the Patient Experience Framework by 2025			The Trust's Women, Babies and Families Experience Strategy was developed (aligned to the national Patient Experience Framework) and published during 2021/22, with specific objectives in place. Delivery against the strategy is monitored through the Patient Involvement and Experience Sub Committee (PIESC) on a regular basis. The Patient Experience Matron is involved in planning a number of QI projects in relation to delivery of the strategy, these include Bi – Lingual Volunteers being introduced. 'You Said We Did' information has been displayed in clinical areas with a related KPI in place. This ensures that all areas across the Trust review their Friends and Family feedback and report to PIESC on a regular basis. Regular reports are received from each of the areas at PIESC evidencing their progress against the Strategy. This objective is on track to be delivered and has potential to deliver in full prior to the target date of 2025. As outlined above, the Patient Experience Framework will be incorporated into the new Trust Quality Strategy with patient experience being a key pillar of the strategy.	The Trust's Women, Babies and Families Experience Framework was developed (aligned to the national Patient Experience Framework) and published during 2021/22, with specific objectives in place. Delivery against the strategy is monitored through the Patient Involvement and Experience Committee on a regular basis. The newly recruited Patient Experience Matron is involved in planning a number of QI projects in relation to delivery of the strategy, and in reviewing and supporting completion of Equality impact Assessments for transformational programmes such as the Community Diagnostic Centre development. Work is underway to establish a Carer's Passport, 'You Said We Did' information has been displayed in clinical areas with a new related KPI in place. This objective is on track to deliver and has potential to deliver in full prior to the target date of 2025.
						Pro-actively seek the views of diverse communities to inform the design of our services for the future, ensuring we champion the voices of our future service users			There has been significant work over the last year engaging and involving the diverse communities that we serve. The Patient experience team are pro-actively seeking the views of diverse communities to inform the design of our services for the future. Due to feedback received, a Trust engagement event on Endometriosis was delivered in September 2023 at LWH which had high levels of attendance from a diverse range of communities. A calendar of events is maintained and added to on a frequent basis. Over the coming months there will be opportunities for stakeholders to contribute to the development of the new Trust Quality, Estates, Putting People First and Charitable Funds strategies	Patient Experience Matron has been successful in building strong links with a range of community groups and relevant charities, and in ensuring better and wider representation of patient stories at Trust Board. The Trust is in the process of establishing a Public and Patient Engagement Group, to inform service design, provide feedback and inform programmes such as the Future Generations Programme.
Efficiency	We will deliver maximum efficiency	Ensure our services are financially sustainable in the long term			Chief Finance Officer	Ensure efficient and effective use of all available resources			The Trust has a NCCI of 103, with several areas reported as less than 100 (indicating a greater than average level of efficiency). The Trust's External Auditors concluded that there were no significant weaknesses in improving economy, efficiency and effectiveness during the VfM audit (however did note financial sustainability risks linked to deliverability of the Trust's annual plan). Strong grip and control measures implemented, Financial Recovery Programme in place. Post Investment Review for past investments underway.	Positive VfM opinion received from external auditors for 2021/22. High assurance received on all finance internal audit assurance reports for 21/22. Robust processes in place for management of expenditure eg annual budget setting process, Business Case Review Panel, and Financial Recovery Board. The Trust has manintained a national cost collection index close to 100 for a number of years demonstrating that it is relatively financially efficient despite structural issues due to size and location. Strong track record of CIP delivery. Progress monitored by FPBD and Audit Committees.
						Ensure the Trust has an updated, balanced long term financial plan in place by 2021/22			The Trust has updated it's LTFM and completed a financial recovery plan. This modelling shows that there are structural underlying causes of the Trust's deficit which cannot be addressed without strategic, system-wide solutions. Modelling has shown that a return to breakeven is only feasible in 3 years with significant support to address income levels and tariff.	A long term financial model has been produced but there remains uncertainty in the medium term in relation to inflation and other key assumptions. In addition the new structures within the NHS mean that there is some uncertainty around planning assumptions. This is continually updated and worked on but not concluded.
						Pursue appropriate opportunities to maximise Trust income for the benefit of our patients			Activity is monitored to ensure that income streams are approriately planned for. Furthermore the Trust has an Income and tariff workstream in place as part of Financial Recovery, with the Chief Finance Officer as Executive Sponsor to support appropriate income reimbursement as well as the pursuit of commercial income to support the delivery of NHS services.	The Trust has been successful in securing significant system income both via the Integrated Care Board and other provider organisations; this has been in recognition of the financial challenges faced by Liverpool Women's and some of the structural issues which are beyond the Trust's control. Separately, the Trust has done extremely well at increasing private fertility income over the last few years. However there is still scope to increase private patient income in other areas and also explore other commercial income opportunities. Opportunities in respect of private physiotherapy income are currently being explored.
						Appraise options for future organisational form (up to and including merger) by 2022	Re-instate and Amend Objective	DEFER OBJECTIVE	Following the LSCR in 2022, closer collaboration between Liverpool providers (for both clinical and corporate services) was advised. Site-based Joint Committees have been established as well as a single Liverpool Joint Committee. Propose re-instating objective: "Consider options for delivering increased value through strengthening existing partnerships and reviewing options for organisational form by 2025"	It is proposed that this objective is paused/deferred, as pursuit of this is not currently appropriate following the recent merger of Liverpool University Hospitals NHS Trust, the formation of Integrated Care Boards in July 2022 and the ongoing Liverpool Clinical Services Review. Any future discussion regarding organisational form will likely take place from a system perspective.
						Develop the Trust's commercial strategy during 2022	PAUSE OBJECTIVE	PAUSE OBJECTIVE	Commercial principles have been included within the new Finance and Procurement Strategy, launched in summer 2023. The Trust has a Commercial workstream in place as part of finacial recovery, with the Chief Finance Officer as Executive Sponsor.	It is proposed that this objective is paused/deferred. The Trust has a high number of competing priorities to manage at the present time (including the Future Generations Programme, Community Diagnostic Centre Programme, Crown Street Enhancements Programme, Elective Recovery and the implementation of Ockenden actions), and therefore expansion of commercial activities is not a primary focus. Reference to an approach to commercial activities will be included within the Finance and Procurement Strategy (currently under development), in order to

Effectiveness	Outcomes will be the best in class	Expand our existing partnerships, building on learning and partnership working throughout the COVID-19 pandemic, playing a key role in establishing any ICP or ICS			Chief Operating Officer	Develop a clear plan for all desirable partnerships during 2021, ensuring robust governance structures are in place	Complete		In February 2023 the Trust Board agreed that going forward, partnerships would be managed through the Executive Committee, with a quarterly review, supplemented with general updates and decisions through normal Committee meetings as required. A record of key partnerships has been created and is being developed to include a summary of the aims and intended benefits of each partnership (from a Liverpool Women's Hospital perspective), as well as any key risks. Partnerships will then be regularly reviewed against their recorded aims and intended benefits, on a rolling annual basis, with a view to providing assurance to the Executive Committee and the Trust Board regarding benefits realisation, value for money, risk, and overall effectiveness. This will provide information to inform decisions regarding the Trust's partnerships portfolio, including participation in existing partnerships, and requirements to develop new partnerships.	The Trust has a number of highly successful partnerships in place with a range of clinical networks, and with local Trusts, including with LUHFT & LHCH for CDC, Alder Hey for the Liverpool Neonatal Partnership, and Mersey Care for the provision of specific services and future development of estate. The Trust is also working closerly with Place and the ICB regarding it's long term strategy. Progress in developing partnerships and associated governance is now reported on a quarterly basis to the FPBD Committee, and an Executive Lead has been identified. The Trust's approach to partnership working needs to remain dynamic at present, to enable a flexible response to a changing environment.
		Progress our research strategy and foster innovation within the Trust			Medical Director	Increase the number of staff across the multidisciplinary clinical workforce who hold a substantive university contract by 50% by 2025		OBJECTIVE AMENDED	Continued progress has been made against this objective with seven staff now holding a substantive university contract meaning that the Trust is on target to reach it's aim of reaching nine members of staff by 2025.	This objective as originally stated is now not feasible, due to the minimum number of staff required to have been granted professorship. This number is not adjusted for the size of an organisation, and has recently been increased to 20, making it virtually impossible for a Trust the size of LWH to meet. Therefore, the objective has been amended to an ambitious, but more realistic target, which will support the Trust to maintain and build on existing good links with local universities. At present, 6 staff hold a substantive university contract.
						Provide clear evidence of senior nursing and midwifery research leadership by 2021	Complete		Excellent progress continues to be made towards delivery of this objective, with good support and engagement seen across the Trust. Specific examples include: - Director of Midwifery and an Advanced Neonatal Nurse Practitioner awarded places on the NIHR Senior Research Leader Programme 2023-2026 - Continued engagement with four professors of midwifery / nursing (Liverpool John Moors, LTSM, Edge Hill, UCLAN), which has driven greater collaboration and willingness to progress nursing and midwifery-led research. - The first joint research midwifery post with LSTM has been completed. This has led to the individual being successful in attending a Wellcome Trust Clinical PhD opportunity - A second joint research midwifery post with LSTM has been created and the individual has started in role - Three Research Midwives awarded places on the NIHR Early Career Researcher Development programme - One Research Midwife awarded a Health Education England/NIHR Pre-doctoral Integrated Clinical and Practitioner Academic Fellowship - Two midwives and one nurse undertaking Phds in conjunction with Liverpool John Moores and Edge Hill Universities respectively - Three neonatal nurses and one gynaecology nurse enrolled in the NIHR Associate Principal Investigator Scheme - Research placements are now available for nurses and midwives.	Really good progress has been made towards delivery of this objective, with good support and engagement seen across the Trust. Specific examples include: -Three professors of midwifery attend the RD&I Committee (for UCLAN, Liverpool John Moors, LTSM), which has driven greater collaboration and willingness to progress nursing and midwifery-led research. -A joint research midwifery post has been developed wiht LSTN and commenced Jan 2022. -Trial ongoing re speculum for 3rd/4th degree tears - created opportunity for midwife PhD. -Meetings have taken place wiht PEFs in Trust to make research placements available for nurses and midwives, to be implemented in 2022. There are still further opportunities to fully embed and further expand this workstream, therefore this objective is rated as 'on track'.
						Demonstrate full recovery of the research, development and innovation activities during 2021 following the COVID-19 pandemic			Complete	All research activities were initally put on hold in April 2020. All projects were reviewed and risk assessments undertaken to determine whether some could continue safely and without adverse impact (for example studies involving retrospective data analysis). This was followed by a period of 'managed recovery' to re-start all research placed on hold. This process has been completed, and by 2021 all research activities had been re-started, with new projects initiated.
						Provide clear evidence of the Trust's research and development response to COVID-19 pertaining to the specific needs of the Liverpool population, during 2021			Complete	The Trust carried out a range of research and development activities in response to the COVID-19 pandemic, including: -Secondment of nurses to LUHFT to support research on COVID actue wards -Participation in, supply of factilities for and seconment of staff to the Astra Zenneca vaccine trial (led by the Liverpool School of Tropical Medicine) -Vaccine in pregnancy trial - research team worked in tandem with clinical service offering vaccines at LWH to provide extra reassurance for patients (provision of additional follow ups). The team was the second highest recruiter to the trial nationally. Research activities in repsonse to COVID were documented by the RD&I Committee (and onward Chair's reportsa to Quality Committee), the Executive Committee and Liverpool Health Partnership weekly meetings between April 2020 and summer 2021.
						Refresh the research, development and innovation strategy, engaging with stakeholders throughout	Complete		New strategy launched March 2023	Work to refresh the Trust's Research, Development and Innovation strategy has been underway for the past year. Recent consultation work regarding the strategy has been undertaken wiht a range of stakeholder groups, including the Trust's Council of Governors and representatives from all locla universities. The final version of the strategy is due to be presented to the Research and Development Committee in November 2022, prior to approval by the Quality Committee or Trust Board as appropriate. The strategy covers a 5-year period, contains 5 themes with underpinning objectives, and once the strategy is agreed a clear plan will be in place for delivery of each.
		Fully implement the CQC well-led framework throughout the Trust, achieving maximum compliance and delivering the highest standards of leadership			Chief Nurse and Midwife	Achieve a well-led 'good' rating by 2021	NOT FEASIBLE	NOT FEASIBLE		This objective was not possible to achieve as no inspections were carried out in 2021. The Trust also has an objective to achieve an outstanding rating by 2023, which remains in place.
						Achieve a well-led 'outstanding' rating by 2023	Not Achieved		The Trust underwent CQC inspection in January/February 2023. When the finalised inspection report was published in June the well-led rating remained at its 2020 rating of 'Requires Improvement'.	The Trust has made really good progress in embedding the well-led framework. There has been significant investment in leadership development, e.g. Reach for the Stars programme, B7/8a leadership development, leadership forum, and the launch of the Talent Management strategy. The Trust has also made good progress in respect of increased public engagement (see above) and implementation of QI methodology (new QI Framework completed and launched in 2022). There are clear governance processes in place for managing risks, issues and performance (e.g. risks related to isolated site reported quarterly to Trust Board, Divisional Performance Reviews & Financial Recovery Board in place). The Trust strategy was refreshed and launched in 2021, is supported by a cohesive framework of credible supporting strategies and plans, and includes a clear focus on ensuring sustainable delivery of services in the long term. This objective is currently rated as 'at risk', as we are aware there is further work to do to act on and address the feedback received in the most recent staff survey.
						Achieve an overall rating of outstanding by 2025			The 2023 CQC inspection downgraded the overall Trust to 'Requires Improvement' due to the 'Requires Improvement' rating within both the safe and well-led domains. Achievement of this objective remains at risk.	See above. Objective to be reviewed in more detail following the Trust's next CQC inspection.

Complete
On track
At risk
Behind target

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	***23/24/186f***		**Date: 9.11.23**	
Report Title	**Community Diagnostic Centre 2024/25**			
Prepared by	***Tom White, Acting Divisional Manager, CSS*** ***Charlotte Bond, Finance Business Partner, CSS*** ***Claire Butler, Head of Strategic Finance***			
Presented by	**Gary Price Chief Operating Officer**			
Key Issues / Messages	***To seek approval on the Community Diagnostic Centre at LWH 24/25 Plan***			
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): CDC Funding			
	For Decisions - in line with Risk Appetite Statement – Y ***If no – please outline the reasons for deviation.***			
	The Board is asked to approve the Community Diagnostic Centre at LWH 24/25 Plan (option 1).			
Supporting Executive:	**Gary Price, Chief Operating Officer**			

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

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

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

Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* 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
FPBD	**28/10/23**	**COO**	**The Committee sought further assurances ahead of recommending approval (see Committee report on public agenda)**

EXECTUTIVE SUMMARY

This report provides a recommendation to the Board for the Crown Street Community Diagnostic Centre (CDC) 2024/25 plan.

The proposed CDC model provides a significant opportunity to support elective recovery for C&M (as it has done for 2022/23 and 2023/24) whilst also providing a solution to support safety on site for LWH inpatients. In 2023/24 it will see circa 10,000 diagnostic outpatient episodes for C&M plus up to 200 inpatient episodes for LWH patients. These inpatients would have to be transferred to neighbouring Trusts for urgent scans if the resource was not in place therefore this model contributes towards supporting an element of safety on site. There will always remain a cohort if inpatients that do need transfer for imaging however.

The preferred model, option 1, presents the least financial impact whilst also allowing the Trust to run CT and MRI for LWH inpatients, introducing hysteroscopies to support elective recovery and work towards financial sustainability, as well as offering the potential for general ultrasound as a service provided by LWH staff, mitigating a primary cause of workforce turnover and mutual aid for Cheshire & Merseyside system.

It is noted that in year (23/24) the C&M system has supported LWH with additional financial resource to enable a 7 day CDC model for outpatient and inpatients.

MAIN REPORT

1. Background

Following the revision of the CDC plan for 2023/24, LWH has been exploring options to improve the financial sustainability of the CDC. The CDC currently delivers CT and MRI services. Under the original plan, the CDC planned to implement 5 services to deliver circa 34k diagnostic tests in 2023/24. However, due to the new funding model proposed this was no longer affordable to the Trust.

On the 15th of May, the national team advised that all CDCs are required to deliver 3 different services. The Trust therefore had to implement one further service to meet the guidance of spoke CDCs. Gynaecology Diagnostics are now funded through CDC models and the Trust has therefore implemented hysteroscopy as an alternative to respiratory testing – thus reducing potential financial or clinical risks by delivering a service that already has the established infrastructure and governance in place.

LWH have also been approached about the possibility of providing non-obstetric ultrasound services (NOUS) as part of the CDC due to waiting time pressures across the Cheshire and Merseyside system. This represents an opportunity to expand our ultrasound service to include CDC services, with the future potential to expand into general ultrasound modalities (non-gynaecology), which would mitigate a fundamental workforce risk for our current sonography staff. Therefore, for 2024/25, it is being proposed for the CDC to include CT, MRI, hysteroscopy, and non-obstetric ultrasound services.

2. Workforce Model

As part of the national CDC programme, a set of core principles were established to sign up to, one of which being to work collaboratively when recruiting workforce, to minimise risk and destabilisation to other parts of the system. As per previous updates given to the FPBD Committee, this informed LWH's decision to procure external staffing solutions to provide our workforce, Radiology Management Solutions (RMS) for one year. This was to enable further options to be developed, to ensure a more cost effective and sustainable workforce solution that would be delivered from 2024 onwards. Whilst an outsourced workforce model is more expensive, the costs of delivering it substantively also comes with costs related to recruitment and retention premiums, as well as an increased risk of sickness and absence. Whilst there is an ongoing piece of work to look at workforce across the system and with our local partners, this has a risk of not being operational from April 2024 and therefore the outsourcing model costs are included.

Through annual planning and collaboration with partner trusts, we are exploring permanent workforce options for Imaging teams, in 2024/25 through a clinically led partnership model.

For hysteroscopy, this would be provided through substantive staff given that existing infrastructure is already in place. For non-obstetric ultrasound, this would be delivered by an additional 1.82 WTE band 7 sonographers, which is the minimum workforce required to reach the mandatory activity targets established in the 24/25 CDC revenue funding policy.

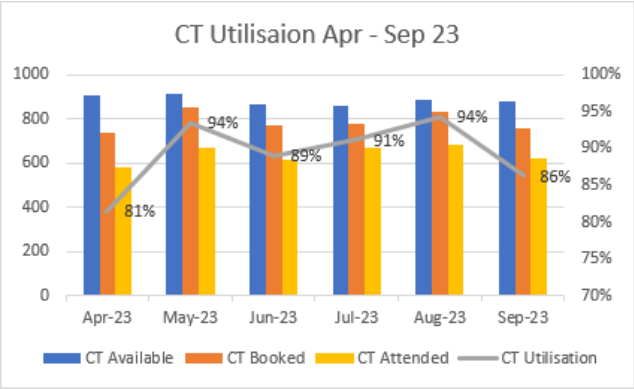
3. Current Activity Model

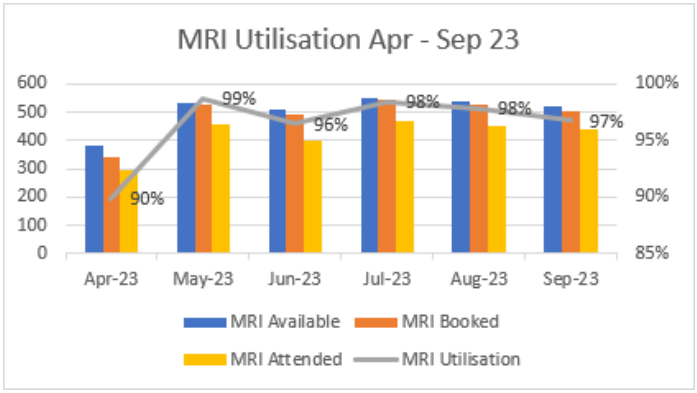
To ensure the future sustainability of the CDC, several options have been developed to reduce the current deficit of the CDC. These are outlined in the Options section of this paper.

For CT/MRI activity, the plan is dependent upon partner engagement to ensure lists are filled to template and that DNAs are kept to a minimum. To ensure full utilisation of activity, an improvement plan and trajectory will be in with partner trusts to maximise contract values set.

The Trust has been closely monitoring the utilisation for MRI and CT and following improved working with system partner operational teams, there has been an increase in the capacity that is being used by our partner Trusts. This is outlined in the tables below.

Figure 1:





*Please note April to September 2023 data only.

As at M6, the Trust is circa 300 up on the activity plan. the acuity of the scans means that income is down. Current run rate on the budget is showing a positive variance year to date.

INCOME & EXPENDITURE £'000	MONTH Budget	MONTH Actual	MONTH Variance	YEAR TO DATE Budget	YEAR TO DATE Actual	YEAR TO DATE Variance	YEAR Budget	YEAR FOT	YEAR Variance
TOTAL EXPENDITURE	217	174	43	1,348	1,202	145	2,530	2,405	125
(CONTRIBUTION) / LOSS	(36)	(102)	66	(30)	(151)	121	(247)	(249)	2

Whilst utilisation from May onwards has significantly improved (Fig. 1), the current DNA and cancellation rates need to reduce further. There is a regional & national drive to utilise CDC capacity to support the Cancer waiting times metrics. Trust will be working with partner organizations to s to enable activity plans to be met. Collaboration with CCC CDC is under way to address this.

The existing 7-day model supports LWH inpatients having access to CT and MRI facilities over the weekend as well as Monday to Friday. This addresses some of the long-standing clinical risks associated with the Future Generations strategy.

There has been confirmation from CCC that the implementation of their CDC site at Paddington Village will not impact the volumes of CT and MRI patients that they currently send to us.

4. Options

Several options have been modelled to show what activity would look like for a range of operational hours. This is based on available capacity.

Option 1 – 7-day model

- **Continue level of CT/MR capacity over 7-days**
- **Hysteroscopy**
- **Non-Obstetric Ultrasound Mon-Fri Daytime from April**

Option one includes CT and MRI activity based on what the Trust believes can be delivered within capacity. With a DNA rate of 10%.

This operating model would enable the CDC to progress and support with mutual aid activity, which is a request from the regional team, contributing to overall system recovery within the Cheshire and Mersey footprint. It also offers the community the flexibility and option for them to attend their diagnostic test at a time that suits them.

This option will also enable Liverpool Women's patients to be scanned over the weekend, without the need for paying 24 hour On-Call (daytime activity). CT Waiting lists within the Cheshire and Mersey region reach show around 8000 patients. This option will enable us to support the region effectively.

Option 2 – 5-day model

- **Remove Tuesday and Thursday activity from CT/MR option 1**
- **1 Hysteroscopy sessions per week from April**
- **Non-Obstetric Ultrasound Mon-Fri Daytime from April**

Option 2 sees the removal of the two days of lists.

Other Factors for Consideration

- **Removal of Out of Hours -** The removal of out of hours would equate to a financial saving of approx. £80k, however this would mean that the Trust would have no cover for Liverpool Women's inpatients outside of core hours. This creates a clinical risk, which has previously been mitigated by the establishment of the CDC. To mitigate this, the trust has started discussions with LUHFT to explore the option of a 24 hour on-call model over the two weekdays the CDC would not be operational. This would be for CT only as not required for MRI and would involve a rotational model across the workforce. Exploration of this option is still within its infancy stage and further information regarding the associated financial model will be provided once we are in a more informed position.

- **24 hour on-call weekend cover -** If the Trust choose to proceed with option 2, there would be a requirement to increase the workforce costs to ensure Liverpool Women's inpatients can be scanned out of hours.

- **General Non-Obstetric Ultrasound** – LWH currently delivers circa 22,000 non-obstetric ultrasound scans per year. These scans are almost exclusively gynaecology. Unfortunately, as LWH can only offer obstetrics and gynaecology specialties to its sonographers, this significantly reduces the pool of sonographers that would consider working at LWH. Bringing non-obstetric ultrasound scans online through the CDC provides the opportunity to expand into general non-obstetric ultrasound into the Trust, mitigating recruitment, retention, and turnover risks.

- **Sonography recruitment –** the NOUS activity is dependent on the recruitment of two additional sonographers.

5. Finance

2023/24 Position

On submission of the original CDC business case in 2020/21, the Trust had been clear on its position to only take the CDC forward if the appropriate funding would follow.

In 2022/23 the Trust was allocated £4.6m of revenue funding to deliver the services set out in the original business case. The Trust had to focus on building the infrastructure to support the CDC in year. The funding guidance changed mid-year to a cost per test basis and despite the Trust being clear that £3.8m was required to continue delivering

CT/MR and some Respiratory services, the funding allocation was reduced to £2.1m leaving the Trust with a £1.7m funding gap in 2022/23.

In 2023/24 the national CDC team published a cost per test tariff to review value for money and consistency across CDCs. The tariff that was published did not cover the full costs that LWH had put in place. There were also delays in setting up some of the high volume, low-cost respiratory services.

A review of CDC options was assessed in July 2023 including decommissioning of the services. The least adverse financial option was agreed as a 5-day CT and MRI service (closing Tuesdays and Thursdays) and submission of 20 hysteroscopy diagnostics per month from September onwards. Discussions had taken place with Cheshire & Mersey ICB imaging teams and an agreement reached for C&M to fund the CT and MRI service for 2 days per week for 5 months to keep the service open 7 days per week to reduce backlogs across the system.

Table one shows the revised plan set for 2023/24 based on the 5-day model. This was a positive contribution of £123k however an overall deficit of £402k. Cheshire & Mersey funding then contributed to an additional £124k for the five-month period which has been extended to 7 days.

Table One

	23/24 Revised Budget		
	5 day plan	**2 day plan**	**combined plan**
activity	- 1,724	- 128	- 1,852
central	- 775	- 25	- 800
total inc	- 2,499	- 153	- 2,652
exp	1,549	180	1,729
central	775	25	800
total exp	2,324	205	2,529
total	**- 175**	**52**	**- 123**
overheads variable			340
overheads fixed			185
(surplus)/deficit			402

2024/25 Planning

2024/25 will be the final year of submitting Trust plans to the Cheshire & Mersey regional CDC team and then into the national team. From 2025/26 onwards, C&M will receive a set CDC funding allocation and the regional planning for CDCs should integrate into the usual contract negotiation planning round.

The national team have set the following timetable to ensure timely approval of CDC plans for 2024/25: -

CDC submissions to C&M programme team for review	19th October 2023
C&M Programme Board for review and sign-off	20th October 2023
System Submissions to region	27th October 2023
KLOES and System Response	2 weeks from submission (first round – further repeats may be requested)
National Decision	Final Decision no later than COP Monday 18th December 2023.

The Trust has been clear with the regional team that any plans submitted are all subject to Trust Board approval and changes may be required following Board discussion.

A revenue funding policy has been released for 2024/25 which has been reviewed and used to formulate the financial options and Trust position below. The three key factors within the guidance that have an impact on the financial options are:-

1. Tariffs have increased significantly from 2023/24 as shown in table two.

Table Two

	HRG Code	23.24 National Tariff	23.24 CDC Tariff	23.24 CDC Tariff adjusted for MFF	24.25 CDC Proposed Tariff	24.25 Tariff Increase
CT - Static Scanner - with contrast	RD24Z	99.00	112.00	115.32	150.30	134%
CT - Static Scanner - without contrast	RD20A	74.00	92.00	94.73	136.90	149%
MRI - Static Scanner - with contrast	RD01A	121.00	220.00	226.53	271.80	124%
MRI - Static Scanner - without contrast	RD02A	177.00	149.00	153.42	182.30	122%
					Average Increase	132%

RD24Z - based on scanning 2 areas and includes reporting costs

RD20A - scan of 1 area including reporting

RD01A - scan of 1 area including reporting

RD02A - scan of 1 area including reporting

2. Central costs are costs funded in addition to tariff to support CDC set-up costs. The Trust has been in receipt of c£850k of central costs in 2023/24 and the costs are fixed rather than initial set-up costs. The tariff increase could indicate that the national team are expecting Trusts to cover all costs from within tariff in 2024/25 rather than have additional funded central costs.
3. Minimum productivity numbers are included in the policy for CT, MR and Non-obstetric ultrasound as shown in table three. This is a risk for the Trust as we are currently underperforming against the national productivity targets due to workforce, acuity and high rates of DNAs and cancellations. As per previous references, the CDC are seeing longer scan times in MRI due to the complexity of the patient cohorts, and the need for many patients to be scanned multiple times on different body parts, which are not funded by the CDC model. In addition we have seen high rates of DNAs and cancellations.

Table Three

	5-Day Working Week	7-Day Working Week
CT	165	231
MR	110	154
NOUS	110	154

Based on the two options noted in the paper above if the Trust used the national productivity targets, removed the central costs, and uplifted the tariffs and costs in line with the guidance, the service would deliver a contribution to overheads, as shown in table four below:

Table Four

		Option 1	Option 2
		7 Days a week CT/MR CT/MR/Hyst/NOUS	5 Days a week CT/MR CT/MR/Hyst/NOUS
Income from Activities			
	CT/MR	(3,247)	(2,319)
	Hysteroscopy	(122)	(122)
	Non Obstetric Ultrasound	(300)	(300)
Total Income		**(3,669)**	**(2,742)**
Direct Service Costs			
	CT/MR	2,874	2,231
	Hysteroscopy	53	53
	Non Obstetric Ultrasound	346	346
Total Expenditure		**3,274**	**2,631**
(Contribution)/Loss		**(395)**	**(111)**
Overheads - Variable		253	192
(Contribution)/Loss to fixed overheads		**(142)**	**81**
Overheads - Fixed		256	256
Cost of Capital		227	227
Funded cost of capital		(227)	(227)
(Surplus)/Deficit		**114**	**338**

This shows that the 7-day model is the more favourable financial model out of the two options and that both options deliver a positive contribution. The 7-day model would deliver a £142k contribution to fixed overheads.

However, due to the operational issues noted above, the Trust would be unable to meet this level of productivity. The service is also seeing more contrast scans than the 2023/24 plan had assumed which take longer to deliver. Based on this change and the current operational model, the teams have reviewed the current levels of activity being provided and have developed the following financial options for consideration for 2024/25: -

Table Five

		Option 1	Option 2
		7 Days a week CT/MR CT/MR/Hyst/NOUS	5 Days a week CT/MR CT/MR/Hyst/NOUS
Income from Activities			
	CT/MR	(2,683)	(1,870)
	Hysteroscopy	(135)	(135)
	Non Obstetric Ultrasound	(283)	(283)
Total Income		**(3,100)**	**(2,287)**
Direct Service Costs			
	CT/MR	2,757	2,138
	Hysteroscopy	32	32
	Non Obstetric Ultrasound	283	283
Total Expenditure		**3,073**	**2,453**
(Contribution)/Loss		**(28)**	**166**
Overheads - Variable		253	192
(Contribution)/Loss to fixed overheads		**226**	**358**
Overheads - Fixed		256	256
Cost of Capital		227	227
Funded cost of capital		(227)	(227)
(Surplus)/Deficit		**482**	**614**

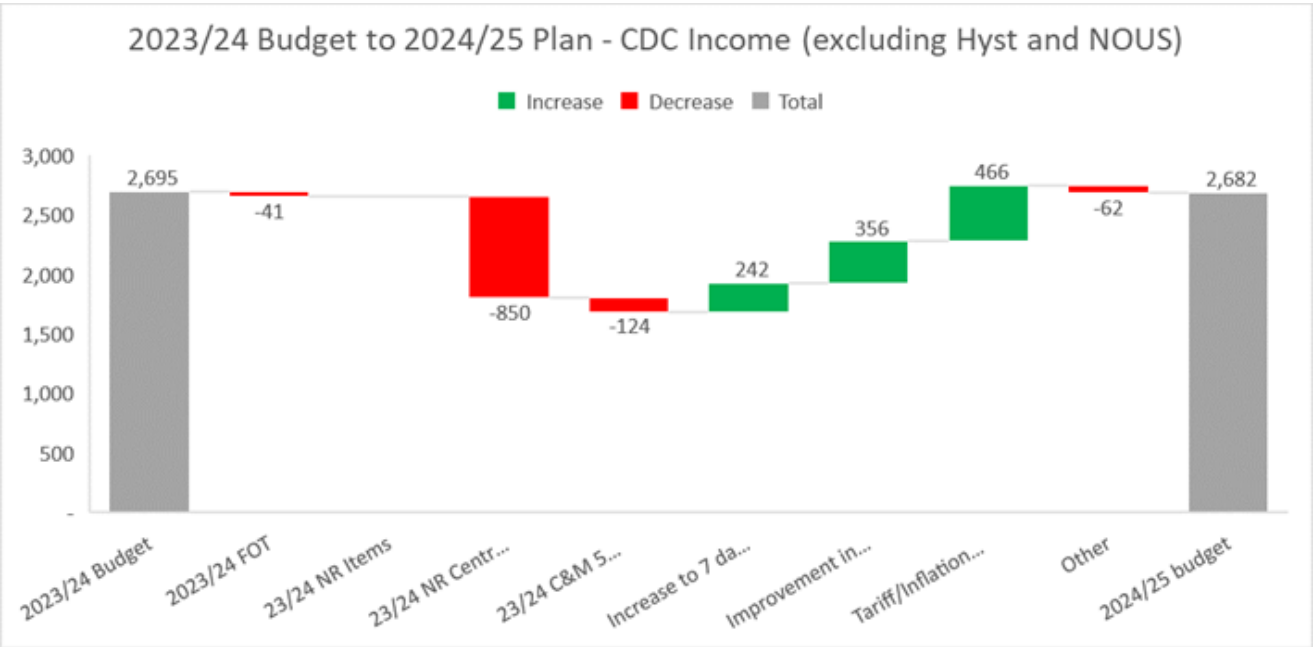
This shows that the 7-day model is the more favourable financial model out of the two options with the five-day model now showing as delivering a negative contribution due to the change in type of scans (from non-contrast to contrast). The 7-day model would deliver a £226k loss to fixed overheads. The £256k of fixed overheads would be incurred regardless if the CDC was delivering activity or not.

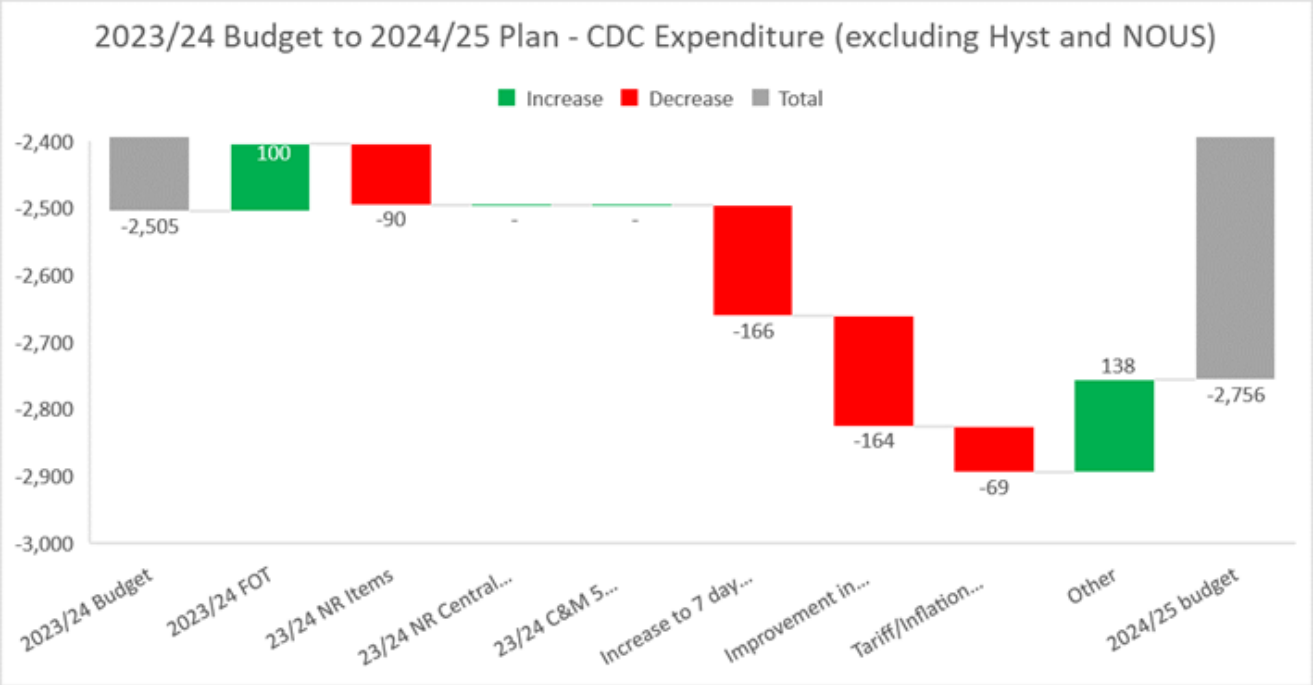
Table 6 shows a breakdown of fixed and variable overheads for each option:

Table Six

	Option 1 7-Day £'000's	Option 2 5-Day £'000's
Exec Oversight	9	9
Finance & Procurement	28	28
IT	53	53
Division	39	39
Estates	127	127
Total Fixed Overheads	**256**	**256**
Estates	63	27
Governance	114	88
IT	39	39
Pharmacy	14	14
L&D	25	25
Total Variable Overheads	**253**	**192**
Total LWH Unfunded	**510**	**449**
Cost of Capital	227	227
Total LWH Funded	**227**	**227**

The charts below bridge the key changes in income and expenditure for CT and MR services from the 2023/24 budget and revised outturn to the 2024/25 proposed option 1.





6. Conclusion and Recommendation

Building from previous updates, the CDC is proposing to expand its service repertoire to include hysteroscopy as well as including Non-Obstetric Ultrasound to support diagnostic recovery and mitigate LWH workforce risks. These two services align closely with LWH waiting list pressures and offer the best opportunity to LWH in terms of income, workforce retention and supporting the system through elective recovery. Options presented highlight the pressures re: income and costs to deliver. There is a requirement for LWH to reduce its DNA and cancellation rates for CDC services to improve throughput and the financial income associated. Reducing the number of days is only financially viable if weekend sessions were to continue and 2 days in the week reduced. This however presents a clinical risk on the days when the service is not available to LWH inpatients and collaboration with LUHFT is underway to ensure a service on those days.

Option 1 is asked to be considered as the recommended option.

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*23/24/187*		**Date: 09/11/2023**	
Report Title	**Board Assurance Framework**			
Prepared by	*Mark Grimshaw, Trust Secretary*			
Presented by	*Mark Grimshaw, Trust Secretary*			
Key Issues / Messages	*The report outlines any updates relating to the Board Assurance Framework and any key areas for consideration for the Board.*			
Action required	**Approve ☐**	**Receive ☐**	**Note ☐**	**Take Assurance ☒**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable): N/A			
	For Decisions - in line with Risk Appetite Statement – Y *If no – please outline the reasons for deviation.*			
	The Board requested to • *review the BAF risks and agree on their contents and actions.* • *Agree the suggested Q2 scores*			
Supporting Executive:	*Mark Grimshaw, Trust Secretary*			

Equality Impact Assessment *(if there is an impact on E,D & I, an Equality Impact Assessment **MUST** accompany the report)*					
Strategy ☐	Policy ☐	Service Change ☐	Not Applicable ☒		
Strategic Objective(s)					
To develop a well led, capable, motivated and entrepreneurial ***workforce***	☐	To participate in high quality research and to deliver the most ***effective*** Outcomes	☐		
To be ambitious and ***efficient*** and make the best use of available resource	☐	To deliver the best possible ***experience*** for patients and staff	☐		
To deliver ***safe*** services	☐				
Link to the Board Assurance Framework (BAF) / Corporate Risk Register (CRR)					
Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* All		Comment:			
Link to the Corporate Risk Register (CRR) – CR Number: N/A		Comment:			

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome

BAF discussed at the PPF, FPBD and Quality Committees since the previous version was presented to Board in September 2023.

EXECUTIVE SUMMARY

The Board Assurance Framework (BAF) is a monitoring tool used by the Board to assess the organisation's capacity to achieve its strategic objectives and to ensure it has appropriate oversight of the Trust's risk profile and risk management arrangements.

The BAF was significantly updated for 2023/24 to clarify the Trust's most significant strategic risks. This has resulted in predecessor BAF risks that were reported throughout 2022/23 being either replaced or merged into the new BAF risks for 2023/24. The Quarter 1 BAF scores were agreed in July 2023 and the Committees have continued to scrutinise the BAF content monthly. Scores for Quarter 2 were debated and agreed for recommendation to the Board. This report provides an outline of each BAF risk, the proposed scoring for Quarter 2 2023/24 and any comments made by the Board's Committees during recent meetings.

MAIN REPORT

Introduction

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

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

Process for reviewing BAF areas during the meeting

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

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

Changes to BAF

The following provides an outline of each BAF risk, the proposed scoring for Quarter 2 2023/24 and any comments made by the Board's Committees during recent meetings:

1 – Inability to recruit & maintain a highly skilled & engaged workforce that is representative of our local communities

Proposed Q2 Score – Likelihood 4 x Consequence 4 = 16 (No Change)

- Progress has been made in the year (particularly to workforce metrics), but further work is required to achieve the target risk score. There remains a particular concern regarding the post graduate medical workforce.
- No proposed changes to the BAF title
- Controls have received a thorough review
- Key assurances updated
- Gaps in control / assurances updated with links made to 'further actions'
- Further actions updated

2 - Inability to ensure the on-going sustainability of clinical services and prevent patient harm by maintaining a high standard of care at the current Crown Street site

Proposed Q2 risk score is 20 – Likelihood 4 x Consequence 5 (No change)

- Proposed change to the risk title to better reflect immediate risk to patient harm
- Score proposed to remain at '20'.
- Update to risk description and rationale made – again this reflects the ask to better reflect the immediate risk to patient harm
- Significant update to the controls and assurance framework in an attempt to better articulate the 'so what' aspect

At the October 2023 Quality Committee, it was recommended that this BAF, should be reviewed to provide additional clarity due to the complexity the risk involves. This particularly relates to whether the risk to the deteriorating patient is adequately reflected.

3 – Failure to deliver an excellent patient and family experience to all our service users

Proposed Q2 risk score is 8 – Likelihood 2 x Consequence 4 (reduction from 12)

- Rationale updated as follows: The reduction in the risk rating from 12/25 to 8/25 reflects significant progress in strengthening controls and assurances within the organization. Several actions addressing gaps in control and assurance have been successfully closed out, contributing to this improvement. Additionally, recent positive external assurances, such as the 2022 inpatient survey results indicating improved patient satisfaction, a decrease in complaints, and an increase in compliments, have contributed to the overall reduction in risk.

  However, to further enhance risk mitigation, it remains imperative that the organization continues to prioritize listening to patient voices and the local community while ensuring services remain responsive to diverse needs. The evidence of how effectively the organization accomplishes this must be further bolstered from its current position.

  The Ockenden Final Report emphasized the critical importance of trusts effectively listening to the patient voice. Accordingly, strengthening the Trust's approach in this area will be a significant focus in 2023/24 and an updated Patient Experience Strategy is in development.
- Assurance and control framework updated
- Several actions have been marked as 'closed'

4 – Inadequate digital strategy and sub-optimal clinical records systems increase the risk of major IT system failures due to cyber-attacks, compromising patient safety and Trust operations

Proposed to reduce the Q2 risk score to '20' from '16'.

- Rationale updated as follows: The Trust's Digital Services department places cyber security management at the core of operational activities, ensuring it maintains its Cyber Essentials standard. Various controls are implemented that are considered effective and this reduces the likelihood of a cyber-attack impact. The assessment of consequence from a cyber threat perspective has resulted in a rating reduction from catastrophic to major based on the multi-layered technical controls which have proven effective in terms of alerting and protection resulting capability to contain the impact of a successful in some scenarios. However, if a cyber-attack was successful the impact would likely have a major negative impact on Trust services, likely rendering digital systems that clinical services are increasingly dependent on, unavailable for a period. The Digital Services department continue to strengthen controls through process refinement and the introduction of security technologies.

  Contributing to the consequence reduction is the successful introduction of the MEDITECH Expanse EPR which by design has improved systems integration with other Trust systems. Whilst there is ongoing programme to further improve integration and system adoption (through the stabilisation and optimisation phases of the digiCare programme), there is a demonstrable progress to mitigate the multiple systems elements of this risk.

  Based on this, the impact is considered major (4). Due to recent world events, the environment risk or likelihood for a cyber-attack has increased from possible (3) to likely (4) due to increased cyber threats from Russia. The NHS has reflected the increased threat through guidance issued to all NHS providers and arm's length bodies during March 2022. The current situation with regards to adopting of a new EPR system influences the likelihood remaining 4 for this reporting period.
- Assurance and control framework updated
- Actions have been marked as 'closed'

5 – Inability to deliver the 2023/24 financial plan and ensure our services are financially sustainable in the long term

The proposed Q2 risk score is 16 – Likelihood 4 x Consequence 4 (No change)

- No changes proposed to the overall score or assurance ratings
- Update to rationale
- Assurance and control framework updated
- Actions updated

6 – The right partnerships are not developed and maintained to support the success of the Cheshire & Merseyside ICB and the CMAST Provider Collaborative

Proposed to reduce the risk score to '9' from '6'.

- Rationale updated as follows: The Trust has well defined partnerships and relationships with a number of key stakeholders. These have been strengthened and added to during the Covid-19 pandemic response. The Trust has strengthened partnerships further during Q2 by securing agreement to appoint a shared Accountable office with partners Liverpool University Hospital NHS FT. ToRs have been drafted for a new Partnership Board with AHCH. In addition, the ICB's Women's Services Committee has begun making progress towards delivery.
- Assurance and control framework updated

In October 2023, the FPBD Committee recommended that this risk should be reviewed to provide additional clarity to better reflect the position and maturity of partnerships.

7 - Failure to meet patient waiting time targets

Proposed Q2 risk score is 16 – Likelihood 4 x Consequence 4 (No change)

- No changes proposed to scoring or assurance ratings – risk descriptor and rationale updated accordingly.

Other issues

The October 2023 Quality Committee received the latest Joint Register between the Trust and LUHFT. The Committee reflected on areas within this risk register that should be reflected in the BAF going forward.

Closed Risks or Strategic Threats

No closed risks.

Recommendation

The Board requested to

- review the BAF risks and agree on their contents and actions.
- Agree the suggested Q2 scores

Liverpool Women's
NHS Foundation Trust

Board Assurance Framework 2023/24

Trust Board

November 2023

Board Assurance Framework Key

Risk Rating Matrix (Likelihood x Consequence)					
Consequence	Likelihood				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic	5 Moderate	10 High	15 Extreme	20 Extreme	25 Extreme
4 Major	4 Moderate	8 High	12 High	16 Extreme	20 Extreme
3 Moderate	3 Low	6 Moderate	9 High	12 High	15 Extreme
2 Minor	2 Low	4 Moderate	6 Moderate	8 High	10 High
1 Negligible	1 Low	2 Low	3 Low	4 Moderate	5 Moderate

1 - 3	Low risk
4 - 6	Moderate risk
8 - 12	High risk
15 - 25	Extreme risk

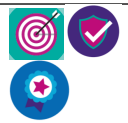
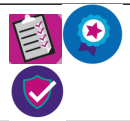
Director Lead	
CEO	Chief Executive
CPO	Chief People Officer
COO	Chief Operating Officer
CFO	Chief Finance Officer
CIO	Chief Information Officer
CN	Chief Nurse
MD	Medical Director

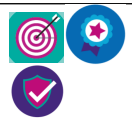
Key to lead Committee Assurance Ratings	
	Green = Positive assurance: the Committee / Board is satisfied that there is reliable evidence of the appropriateness of the current risk treatment strategy in addressing the threat or opportunity - no gaps in assurance or control AND current exposure risk rating = target OR - gaps in control and assurance are being addressed
	Amber = Inconclusive assurance: the Committee is not satisfied that there is sufficient evidence to be able to make a judgement as to the appropriateness of the current risk treatment strategy
	Red = Negative assurance: the Committee is not satisfied that there is sufficient reliable evidence that the current risk treatment strategy is appropriate to the nature and/or scale of the threat or opportunity

This approach informs the agenda and regular management information received by the relevant lead committees, to enable them to make informed judgements as to the level of assurance that they can take and which can then be provided to the Board in relation to each BAF Risk and also to identify any further action required to improve the management of those risks.

Board Assurance Framework: Legend	
Strategic Aim	The 2021/25 strategic aim that the BAF risk has been aligned to.
BAF Risk:	The title of the strategic risk that threatens the achievement of the aligned strategic priority
Rationale for Current Risk Score:	This narrative is updated on a quarterly basis and provides a summary of the information that has supported the assessment of the BAF risk.
Controls:	The measures in place to reduce the risk likelihood or risk consequence and assist secure delivery of the strategic priority.
Assurances:	The measures in place to provide confirmation that the controls are working effectively in supporting the mitigation of the risk. Level 1 – Operational oversight Level 2 - Board / Committee oversight Level 3 – external (independent) oversight
Gaps in Controls / Assurance:	Areas that require attention to ensure that systems and processes are in place to mitigate the BAF risk Areas where there is limited or no assurance that processes and procedures are in place to support the mitigation of the BAF risk.
Required Action:	Actions required to close the gap in control/ assurance
Lead:	The person responsible for completing the required action.
Implemented By:	Deadline for completing the required action.
Progress:	A RAG rated assessment of how much progress has been made on the completion of the required action.

Board Assurance Framework Dashboard 2023/2024

BAF Risk	Strategic Aim(s)	Committee	Lead	May 2023	Q2	Q3	Q4	Q2Q Movement	2023/24 Target
1 – *Inability to recruit & maintain a highly skilled & engaged workforce that is representative of our local communities*		PPF Committee	Chief People Officer	16 (I4 x c4)	16 (I4 x c4)			⟷	12 (I3 x c4)
2 - Inability to ensure the on-going sustainability of clinical services and prevent patient harm by maintaining a high standard of care at the current Crown Street site.		Quality Committee	Chief Operating Officer / Medical Director	20 (I4 x c5)	20 (I4 x c5)			⟷	15 (I3 x c5)
3 – *Failure to deliver an excellent patient and family experience to all our service users*		Quality Committee	Chief Nurse	12 (I3 x c4)	8 (I2 x c4)			↓	8 (I2 x c4)
4 – *Inadequate digital strategy and sub-optimal clinical records systems increase the risk of major IT system failures due to cyber-attacks, compromising patient safety and Trust operations*		FPBD Committee	Chief Information Officer	20 (I4 x c5)	16 (I4 x c4)			↓	15 (I3 x c5)
5 – *Inability to deliver the 2023/24 financial plan and ensure our services are financially sustainable in the long term*		FPBD Committee	Chief Finance Officer	16 (I4 x c4)	16 (I4 x c4)			⟷	12 (I3 x c4)
6 – *The right partnerships are not developed and maintained to support the success of the Cheshire & Merseyside ICB and the CMAST Provider Collaborative*		FPBD Committee	Medical Director / Chief Finance Officer	9 (I3 x c3)	6 (I2 x c3)			↓	6 (I2 x c3)

7 - Failure to meet patient waiting time targets		Quality Committee	Chief Operating Officer	16 (I4 x c4)	16 (I4 x c4)				12 (I3 x c4)

BAF HEAT MAP

Consequence	Likelihood				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic				BAF 2	
4 Major		BAF 3		BAF 4 BAF 7 BAF 1 BAF 5	
3 Moderate		BAF 6			
2 Minor					
1 Negligible					

BAF Risk 1 – *Inability to recruit & maintain a highly skilled & engaged workforce that is representative of our local communities*

Risk Description and Impact on Strategic Aims		
Cause (likelihood)	**Event**	**Effect (Consequences)**
Challenges with Workforce Supply, particularly in relation to medical and other clinical staff, combined with a lack of staff engagement, may result in an inability to deliver safe, high quality care and organisational objectives.	The Trust may struggle to provide safe and effective care, achieve organisational objectives, and engage effectively with patients and staff due to the staffing challenges.	If the Trust is unable to address these staffing challenges, it may result in negative outcomes for patients and staff, including reduced trust in the quality of care provided, a negative impact on staff morale, and potential legal and regulatory consequences for failing to create a diverse workforce that is representative of the community it serves. Additionally, it may negatively impact the Trust's reputation and lead to reduced patient confidence.

	We will be an outstanding employer	✓		**Our services will be the safest in the country**	✓
	Every patient will have an outstanding experience	✓		**To be ambitious and efficient and make the best use of available resources**	
	To participate in high quality research in order to deliver the most effective outcomes				

Responsibility for Risk			
Committee:	**Putting People First Committee**	**Lead Director:**	**Chief People Officer**

Risk Scoring and Tolerance							
Quarter / Score	**Q1**	**Q2**	**Q3**	**Q4**	**Target**	**Target Date**	**Risk Tolerance Statement**
Likelihood	**4**	**4**			**3**	**March 2024**	Our risk appetite for workforce **is moderate.** Liverpool Women's NHS Foundation Trust has a moderate appetite for risk to this objective. The Trust operates in a complex environment in which it faces challenging financial conditions and changing demographics alongside intense political and regulatory scrutiny. However, the continued delivery of high-quality healthcare services and service sustainability requires some moderate risk to be accepted where this is likely to result in better healthcare services for patients. Support for moderate risk in service redesign that requires innovation, creativity, and clinical research to improve patient outcomes are considered by Liverpool Women's NHS Foundation Trust to be an essential part of the risk profile of the Trust.
Consequence	**4**	**4**			**4**		
Risk Level	**16**	**16**			**12**		

Rationale for risk score and quarterly update – *September 2023*

The Liverpool Women's NHS Foundation Trust is facing acute and chronic staffing challenges in various areas, which have been exacerbated by factors such as low morale, high sickness absence rates, and maternity staffing issues. The Trust is also dealing with an increase in turnover, challenges associated with specialist obstetric anaesthesia recruitment and theatre staffing, insufficient numbers of doctors in training, a national shortage of nurses and midwives, and the clinical risk associated with an isolated site. Additionally, the recent pandemic and the associated recovery of elective activity are impacting the Trust's operations. Over recent months, the Trust has also been managing the impact of industrial action. For these reasons, staffing relating risks on Trust's previous BAF iterations have been scored highly with Risk 1.2 Failure to recruit & maintain a highly skilled & engaged workforce – scored as a '20'. The Trust recently received the outcome from the 2022 Staff Survey, and this started to show areas of improvement in several areas. The Trust's sickness and mandatory training rate has also shown signs of improvement in the last quarter of 2022/23. It is for this reason, that the opening score for this risk as part of the 2023/24 BAF was suggested to be set at '16'.

This is further strengthened by the level of assurance that can be provided that the Trust is making progress in terms of the diversity and inclusivity of its workforce. For example, during 2022/23, for the second year running the Trust benchmarked within the top 50 inclusive places to work (improving from 2021/22). Recognising that that Trust could make continued progress on the mechanisms that it has in place to hear the views and voices of its diverse staffing groups and ensure that these voices have an impact on service improvement and development, this risk was scored at a '12'.

As these elements had been combined into a single BAF risk, it was felt germane that an appropriate opening score for Q1 of 2023/24 would be '16' with a view that there is the scope that this can be reduced to '12' during the year. For Q2 it is felt that it remains too early to reduce this score, but it is recognised that the Trust is progressing well against several trajectories. A developing issue that may continue to impact the scoring is the risk relating to the junior medical workforce. The Committee has received several recent reports relating to rota gaps and to deteriorating GMC survey outcomes for several speciality areas. Strengthened controls and assurances will be required in response to this to support a reduction in the overall scoring level.

Key Controls and Assurance Framework

Key Controls:

- Putting People First Strategy articulates the actions the Trust will take to support the development of a skilled and motivated workforce. A new iteration of this strategy for 2024 onwards is in development.
- Appraisal policy, paperwork and systems for delivery and recording are in place for medical and non-medical staff which includes a structured career conversation enabling identification of future talent. Consultants and other clinical staff also undertake a re-validation process. All new starters complete mandatory PDR training as part of corporate induction ensuring awareness of responsibilities.
- PDR window for Band 7 and above to support the clear dissemination of shared divisional objectives
- A tiered leadership programme is in place which is compulsory for new leaders at all levels of seniority and has had high levels of attendance
- A long-standing set of values linked to a behavioural framework. Great Place to Work Group Launched as a cross section of staff committed to improving staff experience and a source of two-way communication
- Comprehensive review of mandatory training undertaken with competencies linked to roles and detailed reporting at 3 levels, core, clinical and speciality specific. Training data validated on a quarterly basis by workforce and senior nursing / midwifery team.
- Pay progression linked to mandatory training compliance
- Targeted OD intervention for areas in need to support.
- LWH Staff Support Service in place, a trauma informed staff wellbeing service including psychologists and health and wellbeing coaches
- Workforce planning processes aligned to annual planning processes and Divisional Workforce Plans in place in place to deliver safe staffing.
- Utilisation of workforce tools and methodologies to plan safe staffing including Birthrate Plus and BAPM
- Medical Workforce Review Group to review development of alternative roles and undertake roster reviews to enable effective workforce planning
- Introduction of Advanced Practitioners, Surgical Assistants and Physicians Associates
- Nursing, Midwifery & AHP Review Group focused on recruitment and retention
- Establishment control process underway to ensure accurate reporting of vacancy levels
- Positive culture of partnership working including shared decision making with JLNC and Partnership Forum.
- Systems of 2-way communication with postgraduate doctors including junior doctors forum and monitoring of junior doctors working hours and experience through the GMC Survey and Guardian of Safe Working.
- Director of medical Education (DME) to ensure training requirements are met, reporting to the Trust Medical Director and externally to HEN
- Two Freedom to Speak Up Guardians (including representation from a diverse and clinical background) which supports a culture of openness and transparency, supported by the Whistleblowing Policy
- Annual NHS Staff Survey, supported by 3 Pulse surveys in the other quarters.
- Bi-Annual Trust wide listening events - Big Conversation- led by Executive and Non-Executive Directors
- Local governance structures to support compliance with HR KPIS including review of mandatory training in senior nursing/ midwifery meetings
- Shared appointments with other provider across a range of clinical and corporate services
- Extension of opportunities for new ways of working including hybrid working and an increase in flexible working in clinical areas
- NHSP utilisation for bank staff has reduced agency expenditure and improved governance
- Award winning preceptorship programme for midwifery staff
- Industrial action working group
- Commitment to Anti-Racism and an ED&I annual improvement plan focused on increasing diversity at all levels, specifically leadership roles. Associated actions include a positive discrimination scheme, career conversations , reciprocal mentoring, diverse interview panels and widening participation programmes Links with community leaders established to improve under-representation and a range of pre-employment programmes and work experience opportunities
- WDES and WRES action plan delivery in line with timescales presented from NHS England
- Establishment of staff inclusion Networks and work in collaboration with local Trusts to promote staff networks and LGBTQ Network to be launched in 2022.
- Education and celebration of the key EDI events: Black History Month, Disability History Month, LGBT+ History Month and key faith observance days/festival
- Utilising widening participation programmes and alternative ways to advertise and promote our job opportunities to attract local population to work at LWH.
- Management of industrial action planning via the strike planning committee

		Assurance Level	Assurance Rating	Overall Assurance Rating
Key Assurances:	The ED&I sub-committee oversee progress against ED&I actions	**2**		
	Annual quality of appraisal audit (November 2022)	**2**		
	Annual mandatory training audit (November 2022)	**2**		
	WRES and WDES submissions	**2**		
	PPF Strategy and action plan – monitored by PPF Committee	**2**		
	Policy schedule for all HR policies	**2**		
	Policy review process reported to PPF	**2**		
	Range of internal and 2-way staff communications	**1**		
	EDI Lead and monitoring through the ED&I Action Plan networks	**1**		
	Monthly KPI's for controls.	**2**		
	Great Place to work minutes to PPF	**2**		
	Divisional Board and Divisional Performance Reviews	**2**		
	Chair's Reports to PPF Committee	**2**		
	Report form Guardian of Safe Working	**2**		

Gaps in Control / Assurance:

To ensure that there are robust processes in place to target advertising, work shadowing opportunities, pre-application training and offering career advice (Action 1.1 / 1)

To simplify the EIA process (Action 1.1 / 2)

To further widen opportunities for the local community to join the LWH workforce (Action 1.1 / 3)

To continue to develop more diverse recruitment and selection processes (Action 1.1 / 4)

Enhance availability and quality of training across all protected characteristics including disability and inter-sectionality (Action 1.1 / 5)

Embedding of LWH as an Anti-Racist Organisation (Action 1.1 / 6)

Development of ED&I Strategy (Action 1.1 / 7)

	Bi-annual Speak Up Guardian Reports.	**2**				Need to ensure that career conversations are being undertaken for all staff, particularly racially minoritized staff with a focus on their development and talent management
	Annual Report whistle blowing report to PPF and Audit Committee	**2**				
	Quarterly internal staff survey (Let's Talk)	**1**				To provide assurance regarding Patient Information Leaflet audit to PIEG on an annual basis (Action 1.1 / 5)
	KPI reports from all outsourced services, Recruitment, Payroll and Occupational Health		Green			
	Reports and feedback from Big Conversation into the Board and Divisional Boards	**2**				Local ownership of staff survey and pulse check results to enable improvements to be created and implemented at a local level (Action 1.1 / 6)
	A suite of KPIs which measure the performance of the People Services including customer feedback based on the nationally developed questions		Red			
	Assurance that MT competencies are assigned correctly via sign off from practice educators and Heads of Nursing	**2**				Quality of appraisals requires further improvement and monitoring (Action 1.2 / 1) Further evidence required that robust workforce plans are being reviewed regularly at Divisional Board level (Action 1.2 / 2) Maximise the benefits of using rostering and job planning systems (Action 1.2 / 3) Requirement for assurance that workforce plans are reviewing regularly at Divisional Board level (Action 1.2 / 4) Requirement to respond effectively to Ockenden recommendations regarding staffing (Action 1.2 / 5) Clinical risks associated with isolated site impact upon recruitment & retention of specialist medical staff (Action 1.2 / 6) Implement establishment control and revised integrated workforce report to improve workforce planning processes Recognise that some people services are better delivered at scale and look at the potential to further collaborate or outsource

Further Actions (Additional Assurance or to reduce likelihood / consequences)					
Ref:	**Action required**	**Lead**	**Due Date**	**Quarterly Progress Update**	**RAG**
1.1 / 1	Robust targeting of job adverts – engagement in health and careers fairs with local community groups for example Pakistani Centre, Al Ghazali Centre	Deputy Chief People Officer	February 2023 (ongoing)	Wellbeing Coach and Assistant Psychologist vacancies will be targeted via universities with specific focus on racially minoritised communities. Review piece with Patient Experience to identify and prioritise communities within which to target entry level roles. HCA and admin roles- specific careers event in Toxteth (small numbers of roles). Advertisement of key roles via Inclusive Companies jobs page in place. Supported internships for BAME individuals from the local area to commence in January 2023.	
1.1 / 4	Exploration and implementation of more diverse recruitment and selection processes including diverse interview panels and alternative recruitment methods Diverse interview panels have commenced but are yet to be consistently applied to all senior roles. Employees with protected characteristics have been invited to take part in national training to participate in recruitment processes in other NHS Trusts.(COMPLETED)	Deputy Chief People Officer	January 2023	Targeted recruitment days in partnership with local authority to take place from early 2023 onwards.	
1.1 / 9	Enhance availability and quality of training across all protected characteristics including disability and inter-sectionality	Deputy Chief People Officer	December 2022	Enhanced training for senior leaders developed, additional baseline training in development, additional training around neurodiversity etc required.	
1.1 / 11	Development of ED&I Strategy	Deputy Chief People Officer	January 2023	This will be included as a major strand of a revised PPF Strategy – to be developed in January 2023	
1.1 / 7	Local ownership of staff survey and pulse check results to enable improvements to be created and implemented at a local level	Head of Audit, Effectiveness and Patient Experience	January 2023	The results are reporting through to Divisions but further work required before this can be moved to an embedded control	
1.2 / 2	To receive assurance that Divisional Boards are effectively reviewing and updating workforce plans	Deputy Chief People Officer	February 2023	Workforce plans for medical and non-medical staff to be presented as part of the annual planning process. HR Business Partners to regularly review and update annual workforce plan with Divisions	
1.2 / 3	E-rostering system for doctors - Allocate is implemented for medical staffing	Deputy Chief People Officer	November 2022	Roll out of the e-rostering system Allocate for Neonatal and Anaesthetics is ongoing. Project resource has been identified to progress and this work will be completed by Autumn 22 – *evidence required to move this into controls.*	
1.2 / 4	To provide evidence that robust workforce plans are being reviewed regularly at Divisional Board	Deputy Chief People Officer	April 23	Workforce planning is a regular item at each Divisional Board – the evidence of this is reported through to DPRs. More evidence required that this 'robust' and can demonstrate maturity.	

				Will be assessed as part of Divisional Governance maturity assessment – propose that deadline is amended accordingly.	
1.2 / 5	Respond to Ockenden recommendations relating staffing	Deputy Chief People Officer	September 2022	See Maternity Staffing report on February 23 Board agenda for more detail. Funding to fulfil Ockenden staffing requirements not yet fully secured – negotiations continue as part of budget setting.	
1.2 / 6	To ensure that staffing issues are included and noted as a key risk in discussions regarding the single site risk.	CPO	On-going		
1.2 / 7	To ensure that workforce data tracks the key indicators and areas of risk through development of integrated workforce report	Deputy Chief people Officer	November 2023	**Report in development**	
12 / 8	To work collaboratively within the C&M and NW system to implement shared services or ways or working to improve quality and / or efficiency	CPO	Ongoing	**LWH actively participating in regional workstreams**	
1.2 / 9	To introduce scrutiny of the performance of the people function through KPIS (in addition to the existing workforce KPIS)	Deputy Chief People Officer	November 2023	Review national KPIS when published	

Linked Corporate and High Scoring Divisional Risks Heat Map

Return to Dashboard

Consequence	Likelihood				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic			2491		
4 Major		2660	2087 1704	~~2467~~	
3 Moderate				2641 2549	2645
2 Minor					
1 Negligible					

Ref	Description	Risk Rate Score
	Corporate Risks	
2641	Condition: There is a significant risk to the dietetic service and delivery of patient care at LWH	12
2660	In November Occupational Health alerted the Trust via Infection Prevention Committee that there were clinical staff in the organisation who were not compliant with screening / evidence of immunity/ up to date vaccination for a) EPP procedures and b) HEP B	8
2087	Condition: Uncertainty about provision of a safe Maternity service able to give more effective interventions with 24/7 Consultant presence on Delivery suite and sufficient consultant cover for 10 elective caesarean lists per week and high-level MAU cover.	12
2491	Noncompliance with mandated level of fit mask testers qualification, accreditation and competency.	15
1704	Effective management systems are not in place or sufficient to ensure all employees complete and keep up to date with their mandatory training requirements.	12
2549	Condition: Staff shortages in the Ultrasound Team within the Imaging Department due to Vacancies and 5 staff members leaving in May & June 22	12
2645	NWAS INDUSTRIAL ACTION FOR 21 AND 28 DECEMBER 2022 Condition: National ambulance and NHS trade unions recently announced two days of strike action. GMB, Unite, and Unison members will take part in industrial action on the 21 December, with GMB also taking a further 24 hours of action on the 28 December. Specifically, as follows: _GMB - 21 and 28 December 00.01 to 23.59 _Unite - 21 December 00.01 to 23.59 _Unison - PES staff only 21 December 12:00 - 00.00	15
	High Scoring (15+) Divisional Risks	
~~2467~~	~~Condition: Inability to recruit specialised allied health professions in a timely manner for blood bank~~	~~16~~

BAF Risk 2 – *Inability to ensure the on-going sustainability of clinical services and prevent patient harm by maintaining a high standard of care at the current Crown Street site.*

Risk Description and Impact on Strategic Aims		
Cause (likelihood)	**Event**	**Effect (Consequences)**
Inadequate comprehension of the evolving healthcare requirements of the local population, along with a failure to adequately consider the needs of marginalized groups or communities during the formulation of clinical service strategies, increases the risk of patient harm. The omission of all viable precautions to guarantee the safety of services delivered from the Crown Street site, while enhancing our facilities for the well-being of our patients and the broader system, exacerbates this risk.	Clinical service strategies that do not adequately foresee the changing healthcare needs of the local population and do not address health disparities may lead to patient harm. Moreover, the current services' location, size, layout, and accessibility may not support sustainable integrated care or the safe delivery of high-quality services. The failure to implement all feasible measures to ensure the safety of services provided from the Crown Street site, while enhancing our facilities for the benefit of patients throughout the system, amplifies the risk of patient harm.	The consequences of these issues include suboptimal patient outcomes, heightened health disparities, and the unsustainability of clinical services. This could lead to inefficient care delivery, jeopardized patient safety, and a diminished patient experience. Failing to optimize the Trust's available facilities and ensure their safety could result in adverse events, an increased threat to patient safety, and potential damage to the Trust's reputation.

	We will be an outstanding employer			**Our services will be the safest in the country**	✓
	Every patient will have an outstanding experience	✓		**To be ambitious and efficient and make the best use of available resources**	✓
	To participate in high quality research in order to deliver the most effective outcomes				

Responsibility for Risk			
Committee:	**Quality Committee**	**Lead Director:**	**Chief Operating Officer**

Risk Scoring and Tolerance							
Quarter / Score	**Q1**	**Q2**	**Q3**	**Q4**	**Target**	**Target Date**	**Risk Tolerance Statement**
Likelihood	**4**	**4**			**3**	**March 2024**	Our risk appetite for safety is **low.** Our fundamental strategic aim describes our commitment to patient and staff safety. When and wherever possible we will apply strict safety protocols for all clinical and non-clinical activity. We will not compromise the safety of our patients, we will report, record, and investigate our incidents and we will ensure that we continue to learn lessons to improve the safety and quality of our services.
Consequence	**5**	**5**			**5**		
Risk Level	**20**	**20**			**15**		

Rationale for risk score and quarterly update – ***September 2023***

One of the most critical risks facing the Trust stems from its location on an isolated site, detached from an acute centre, posing an immediate-term threat to patient safety. Beyond geographical remoteness, patient harm risks encompass:

- Delays in accessing specialist care: Patients needing unavailable specialized treatment may experience critical delays, especially endangering critically ill individuals.
- Reduced resource access: Isolated hospitals contend with limited resources, leading to diagnostic and treatment delays, heightening short-term patient harm risk.

Mitigation measures include significant investments in enhancing the Crown Street site's safety, with emergency department improvements and a new neonatal intensive care unit. Additionally, proactive horizon scanning, and strategic planning enhance preparedness.

Despite robust efforts, some immediate-term risk persists due to geographic isolation, as confirmed by an independent review in February 2022. The Trust faces substantial immediate-term risks to the organization and patient safety, despite proactive measures, necessitating ongoing vigilance.

Key Controls and Assurance Framework

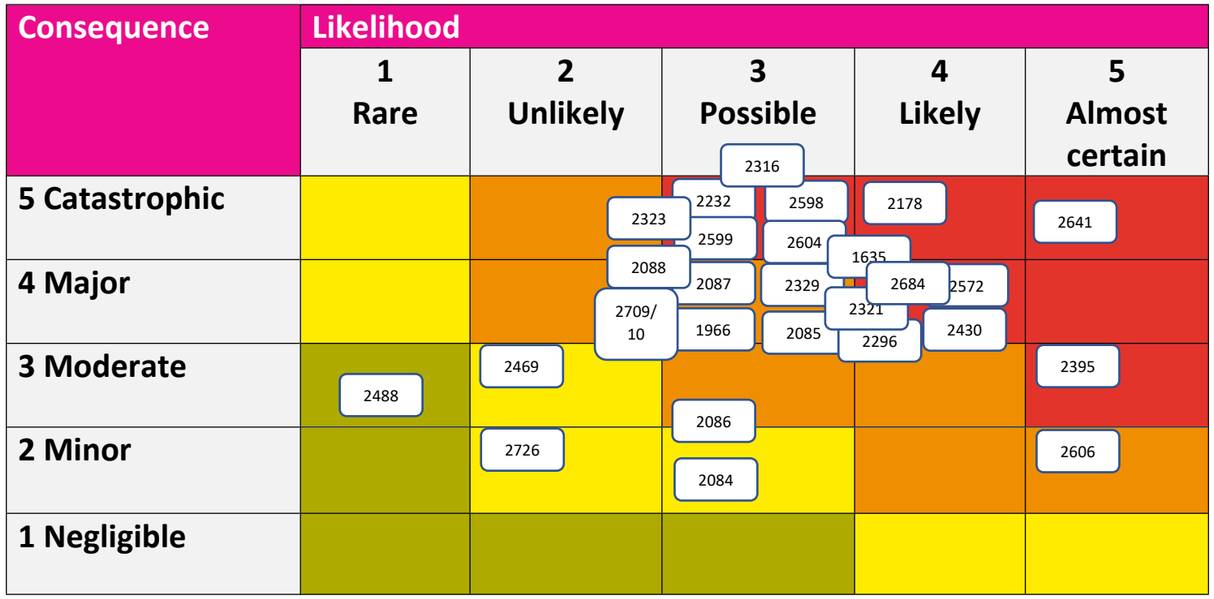
Key Controls:	• Programme for a partnership in relation to Neonates with AHCH has been established which supports collaboration between the LWH and AHCH sites reducing risk for transfers • £15m capital investment in neonatal estate to address infection risk • Formal partnership and board established with Liverpool Universities Hospitals to support shared recognition of risks and ways that collaboration can be utilised to help mitigate this • Blood product provision by motorised vehicle from nearby facility, with revised protocols in place to prioritise transport of blood products. • Investments in additional staffing inc. towards 24/7 cover - Anaesthetics joint anaesthetic appointments with LUHFT • Investments in additional staffing inc. towards 24/7 cover – Gynaecology, including additional investment in ANP roles within GED • Investments in additional staffing inc. towards 24/7 cover - Neonates • LWH appointed at C&M Maternal Medicine Centre • Enhanced resuscitation training provision – Adult – to reduce risk of critically ill patient on site • Crown Street Enhancements Programme Board established to oversee progress against existing improvement programmes and horizon scan for additional opportunities: • Community Diagnostic Centre established at Crown Street, for additional diagnostic capacity, reducing transfers and speeding up access. • Theatre slots at LUHFT with access to colorectal surgeons • Purchase of sentinel node biopsy and 3D laparoscopic kit • Operational 'Plans on a page' for Divisions – incorporates horizon scanning section • Operational planning process • Availability of data on service trends and demographics • Workforce plans are informed by trends and data led intelligence Deep-dive reports on isolated site risks and incidents maintaining a 'live' view of the level of risk and contributing factors				• A telemedicine pilot has been implemented to provide additional support for pregnant women on ITU at the Royal Liverpool Hospital. • SOP implemented for paediatric resus provision • Liverpool Clinical Services Review (LCSR) established • Divisional Operational Plans complete • Use of telemedicine to facilitate consultations both at Crown Street and other sites (for Neonates) • Use of cell salvage & ROTEM • Innovative use of bedside clotting analysis and fibrinogen concentrates • Early order of blood products (high wastage) • Out of hours transfusion lab provided off-site by LCL • Outreach midwife post • AN & Gynae outpatient service at Aintree Hospital • Gynaecology Tier 2 rota providing cover for LWH and Liverpool Place • Expanded role of anaesthetists to cover HDU patients and provide pain service • Additional pain service provided by Walton Centre, with psychologist input • Upskilling of HDU staff • Joint clinics • SLAs in place for clinical support services from LUHFT • Ambulance transfer of patients for urgent imaging or other diagnostics not currently provided on site • Planned pre-op diagnostics provided off-site by LUHFT • Appointment of resus officers, upgrading of resus trolleys and provision of automated defibrillator trolleys • Transfer of patients for urgent imaging and critical care •

		Assurance Level	**Assurance Rating**	**Overall Assurance Rating**		
Key Assurances:	Divisional Board meetings with divisional risk meeting themes reporting	**1**			**Gaps in Control / Assurance:**	Ability of clinical staff to engage with the system development due to time and financial impact (Action 2.1) To ensure that Divisions are fully utilising data to understand changing service demands (Action 2.1) Transfers are often subject to delay due to the Trust being considered a 'place of safety'. Transfer of adults requires accompanying clinical staff, which can lead to staffing pressures on the ward. (Action 2.3) Onsite and partnership mitigations cannot fully address the clinical risk - this can only be achieved through co-location. Arrangements not formally agreed and underpinned by detailed SLA. (Action 2.3) Lack of 24/7 transfusion laboratory on site leads to delay in patients receiving transfusion. (Action 2.5) Emerging clinical standard leading to potential loss of services and increase in difficulty in relation to recruitment of consultants. Twilight cover to be in place from April 2022 (Maternity) and January 2022 (Neonates). There remains an on-going challenge in relation to Anaesthetics and Obstetrics recruitment. (Action 2.6) Financial and workforce constraints for delivery of additional facilities on site. (Action 2.3) 24/7 transfusion laboratory not yet established (Action 2.4) Full CDC Services not yet implemented (Action 2.8) Signed SLA with LUHFT required (Action 2.3)
	Operational plans and budgets	**2**				
	Neonatal partnership updates provided to the Board	**2**				
	IPC Reports	**1**				
	Transfers out monitored by Partnership Transfers out monitored at HDU Group	**1**				
	Serious incidents, should they occur are tracked and reported through the governance framework,	**1**				
	Partnership activity to report through to Board on a quarterly basis	**2**				
	Staff Staffing levels reports to board	**2**				
	Training compliance rates reported to PPF Committee	**2**				
	LWH working as part of NW Maternal Medicine Network	**3**				
	Crown Street Enhancements Programme progress	**2**				
	Community Diagnostic Centre Oversight Group reviews progress on a fortnightly basis. Progress also reported to and monitored by regional CDC Programme Board.	**2**				
	Mobile CT and respiratory testing operational.	**1**				
	Partnership Board meetings and involvement in wider Estates Strategy Safety and Effectiveness Senate – received update in January 2022	**2**				
	Mapping of requirements from and interdependencies with LUHFT across all Trust specialties	**2**				
	Single Site risk report – provided to July 2022 Board	**2**				
	Corporate Risk Committee	**1**				
	Engagement from appropriate Executives in designated working groups	**2**				

Further Actions (Additional Assurance or to reduce likelihood / consequences)

Ref:	Action required	Lead	Due Date	Quarterly Progress Update	RAG
2/1	To ensure that Divisions are fully utilising data to understand changing service demands	Deputy COO	September 2023	5 year transformational plans include section on horizon scanning to support future planning – further evidence required that data is being utilised as effectively as possible to support this. Updated performance reports will support this. Suggest that deadline is amended to reflect the need to assess the maturity of this process.	
2/3	Detailed agreements to form part of SLA with LUHFT, clearly explaining routes of access and expectations of both organisations.	Deputy Chief Finance Officer	September 2023	SLA management improving – will be taken forward as part of the LWH/LUHFT Partnership Board. Process to be agreed.	
2/4	Project to establish 24/7 transfusion laboratory on site at Crown Street	Head of AHPs	March 2023	Staffing continues to be an issue that requires resolution Currently exploring robotic solution for cover	
2/5	Implement remote issue of blood products to minimise delay in transfusion	Head of AHPs	TBC (pending information from Liverpool Clinical Laboratories regarding training)	Additional IT issues encountered Still ongoing as IT barriers not yet resolved	
2/6	Continue to recruit to secure 24/7 Anaesthetics cover	Clinical Directors	January 2023	Resource pressures continue to restrict progress in this area	
2/8	Deliver CDC project plan to establish CDC services: -Imaging – CT, MR, X-ray, ultrasound -Physiological – ECHO, ECG, BP monitoring, Spiro, FeNO, Sleep studies -Phlebotomy	Deputy Chief Operating Officer	September 2023	CDC delivery model continues to be developed with commissioners	

Linked Corporate and High Scoring Divisional Risks Heat Map



Ref	Description	Risk Rate Score
	Corporate Risks	
2641	Condition: There is a significant risk to the dietetic service and delivery of patient care at LWH	20
2087	Condition: Uncertainty about provision of a safe Maternity service able to give more effective interventions with 24/7 Consultant presence on Delivery suite and sufficient consultant cover for 10 elective caesarean lists per week and high level MAU cover.	12
2469	Condition: Allocation of resources to carry out water safety checks and maintenance has failed to achieve required targets despite prioritising this work and reducing resources for other tasks - see risk 2274.	6
2329	Condition: There is a risk to the Trust is not meeting it requirements for the safe and proper management of medicines	12
1966	Condition: Risk of safety incidents occurring when undertaking invasive procedures.	12
2085	Condition: Uncertainty around access to dedicated diagnostic capacity and physiological measurement needed to support needs of a changing patient demographics and an increase in complex multiple co-morbidities, and meeting the pre-operative assessment standards of the Association of Anaesthetists of GB & Ireland (AAGBI) and the Royal College of Anaesthetists (RCoA), to asses patients' clinical risk and plan for additional requirements for their safety and provide an optimal experience.	12
2232	Condition: There is a risk that due to a number of causes the Trust is unable to meet the safety requirements related to Blood Transfusion	15
2488	Condition: Failure to meet clinical demand for red blood cells	3
2296	Condition: The LWH laboratory autoview analyser (the machine used to process Blood Group and Save samples on site) will no longer be supported as of 1st march 2020. This machine cannot continue to be used after this date.	12

2086	Condition: Uncertainty about provision of adequate on-site Blood bank stocking all major blood products necessary to support the needs of the Maternity service.	9
2321	Condition: Due to the Trust not being located next to or with acute services, it is unable to meet the National Recommendations for Maternal Medicine.	12
1635	Risk of delays to treatment due to significant problems with the junior doctor rotas-vacancies and maternity leave.	16
2084	Condition: Uncertainty of adequacy of 24/7 access to specialist input to support changing patient profiles and needs, new guidance and the Chief Medical Officer's recommendation of the specialist multidisciplinary team approach to treatment planning and co-ordination, including pre-operative, surgical and up to level 3 post-operative care for improved patient safety and improved outcomes.	6
2088	Condition: Lack of on-site specialist staff and services	12
2323	Condition: The Trust is currently non-compliant with standards 2,5,6 of the seven-day service standards	15
2395	Condition: Ambulatory gynaecology demand is exceeding current capacity	15
2606	Failure to comply with national infection trajectory specifically in relation to E. coli bacteraemia	10
~~2708~~	~~The Child Protection Information Sharing (CPIS) System is not being accessed for every unplanned care attendance anyone aged under 18 or all pregnant women. This will lead to children, young people and unborn infants not being identified as being on a child protection plan or being a looked after child.~~	~~12~~
2709	Families and children are at risk of not receiving a co-ordinated approach to early help. The trust is not in a position to evidence early help work undertaken by Front Line Staff leading to the LA and Safeguarding Children Partnership Board raising concerns against the Trust that multi agency policy is not being appropriately implemented.	12
2710	Safeguarding information contained on Bulletin Board within Meditech and the associated safeguarding flags cannot be migrated onto Digicare. This will lead to front line staff being required to check the old system when patients attend and transcribe information onto new record. This is open to human error risk.	12
2726	Lack of administration, analyst and surveillance support for IP&C Team due to an open vacancy since 19/05/2023. Risk of compliance in regards to the Hygiene Code for the provision of suitable accurate information on infections (reporting locally, to ICB and into the HCAI DCS system)	4
High Scoring (15+) Divisional Risks		
2735	Condition: Lack of emergency call bells in part of the Imaging department.	20
2178	Condition: Lack of a robust system to ensure that ultrasound scanning performed by non-Sonographer practitioners is monitored and reviewed/audited and appropriate subsequent action taken.	20
2724	Condition: 20-minute appointment slots at dating scans is insufficient for all required duties. Out of area patient's growth charts and care summary reports not generated.	15
2728	Cause: Current ambulatory estate is insufficient to meet demand for ambulatory activity	16
2572	Condition - there is a lack of strategic leadership and robust procedures to ensure the safety of people and assets within the Crown Street and Knutsford sites.	16
2598	Condition: Risk relating to the Trusts Emergency Response	15
2599	Condition: Risk relating to the Trusts Internal Security (Premises)	15
2604	Condition: Risk relating to Trust Security Systems	15

Return to Dashboard

2743	In ability to comply with National guidance for the management of women with pre-existing and pregnancy related diabetes leading to poor outcomes and failure of implementation of SBL3	16
2732	Following the CQC review (January 2023) it was again identified and highlighted within the CQC initial report regarding the lack of medical cover out of hours within GED.	16
2485	Condition: Limited access to MRI scan (currently 5-6 weeks wait) needed for cancer patient pre treatment (both surgical and radiotherapy treatment). MRI requested and undertaken at CCC as per pathway, as expertise in reporting is there and feeds into specialist MDT. Of note MRI added into clinical pathway as part of BGCS stratification for surgery during the first wave of COVID pandemic - this is considered best practice.	16

BAF Risk 3 – *Failure to deliver an excellent patient and family experience to all our service users*

Risk Description and Impact on Strategic Aims		
Cause (likelihood)	**Event**	**Effect (Consequences)**
Inadequate systems and processes in place to listen to patient voices and our local communities, including lack of patient and community engagement mechanisms. Failure to act on the feedback provided by patients, carers, and the local communities. Inadequate systems and processes for timely patient care and inability to effectively engage with patient groups with protected characteristics.	Inability to adequately listen to patient voices and our local communities, and failure to act on the feedback provided by patients, carers, and the local communities. Inability to effectively engage with our patient groups to understand further the needs of individuals with protected characteristics and respond proactively to identified needs.	Decreased patient satisfaction, lack of trust in the Trust's ability to provide effective care, and negative impact on the Trust's reputation. Failure to effectively engage with patient groups with protected characteristics may result in poor patient experience and reduced access to appropriate care, as well as potential legal or regulatory issues. Overall, the risk is the inability of the Trust to provide patient-centred care that meets the needs of the local population, including those with protected characteristics, leading to decreased patient outcomes, decreased patient satisfaction, and potential legal or regulatory issues.

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	Every patient will have an outstanding experience	✓		**To be ambitious and efficient and make the best use of available resources**	
	To participate in high quality research in order to deliver the most effective outcomes	✓			

Responsibility for Risk			
Committee:	**Quality Committee**	**Lead Director:**	**Chief Nurse**

Risk Scoring and Tolerance							
Quarter / Score	**Q1**	**Q2**	**Q3**	**Q4**	**Target**	**Target Date**	**Risk Tolerance Statement**
Likelihood	**3**	**2**			**2**	**March 2024**	Our risk appetite for experience is **low.** Liverpool Women's NHS Foundation Trust has a low-risk appetite for actions and decisions that, whilst taken in the interests of ensuring quality and sustainability of the Trust and its patients, may affect the experience of our patients, the reputation of the Trust or the reputation of the wider NHS. Such actions and decisions would be subject to a rigorous risk assessment and be signed off by the Senior Management Team. Despite retaining this a 'low' risk appetite the Quality Committee agreed that the Trust would need to be more ambitious in its attempts to better understand the views of patients and local communities.
Consequence	**4**	**4**			**4**		
Risk Level	**12**	**8**			**8**		

Rationale for risk score and quarterly update – September 2023
The reduction in the risk rating from 12/25 to 6/25 reflects significant progress in strengthening controls and assurances within the organization. Several actions addressing gaps in control and assurance have been successfully closed out, contributing to this improvement. Additionally, recent positive external assurances, such as the 2022 inpatient survey results indicating improved patient satisfaction, a decrease in complaints, and an increase in compliments, have contributed to the overall reduction in risk. However, to further enhance risk mitigation, it remains imperative that the organization continues to prioritize listening to patient voices and the local community while ensuring services remain responsive to diverse needs. The evidence of how effectively the organization accomplishes this must be further bolstered from its current position. The Ockenden Final Report emphasized the critical importance of trusts effectively listening to the patient voice. Accordingly, strengthening the Trust's approach in this area will be a significant focus in 2023/24 and an updated Patient Experience Strategy is in development

Key Controls and Assurance Framework

Key Controls:

- Women, Babies, and their Families Strategy 2021 - 2026
- PALs and Complaints data
- Patient Stories to Board
- Friends and Family Test
- National Patient Surveys
- Healthwatch feedback
- Social media feedback
- Membership feedback
- Patient Experience Matron in place to build relationships with local community leaders and mechanisms for hearing feedback on the Trust's services
- Bespoke Patient Surveys
- Patient experience review reports produced by the Divisions and reported to PIESC
- BBAS – Ward Accreditation Scheme
- PLACE assessment
- MVP
- Care Opinion
- Patient Experience Walkabouts
- Matron Walkabouts
- Non-Executive Director Quality Walkabouts
- Managing Concerns and Complaints Policy
- Annual Quality Schedule returns to the ICB (WELL-LED-01CARING-01)
- Bi-monthly update on status of patient leaflet at the Patient Involvement and Experience Sub Committee

- Women, Babies and their Families experience Strategy 2021 - 2026
- KPI for displeased Friends and Family and Bi-Monthly reports from the Divisions at the Patient Involvement and Experience Sub Committee.
- KPI for Complaint responses
- KPI for Complaint action plans
- K041 national return
- Patient information leaflets are accessible for all protected groups. Patient leaflets are on the website that can translate this information into various languages/ fonts and read aloud versions.
- Utilisation of the Health Inequalities data within power BI to lead work between the Patient Experience Team and the EDI Manager to target areas of disparity.
- Engagement with local groups lead by the Patient Experience Matron to listen to the concerns and required adjustments and improvements desired. These include the Whitechapel Homeless (Liverpool), Rotunda (deprived areas and different ethnic minorities), Irish Community and Travellers, Deaf Society, Chinese Community, North Liverpool, Storrington Avenue, Norris Green (deprived areas), Women's Health and Social Care Groups (WHISK), Women's Muslim Association, Brain charity, Chinese community and other groups that show Health Inequalities are forming part of the Trust Schedule of Involvement Events.
- FFT Data now included EDI monitoring to allow experience reviews to be compared between groups with and without a protected characteristic
- Enhanced communication and patient experience for people with disabilities coming for care at the Trust as part of Reasonable Adjustment activities
- Barriers removed to access/health inequalities to maternity services for all with specific focus to migrant and asylum-seeking women as part of the NEST work.
- Role created in patient experience team to improve engagement with the local community groups
- Regular Divisional reporting on protected characteristics for staff and their experience

		Assurance Level	Assurance Rating	Overall Assurance Rating
Key Assurances:	Annual audit of patient leaflets to ensure accessibility and usability	1		
	Personalised Maternity Care Budgets/ Maternity Early Adopter and Pioneer site – LMS Cheshire and Mersey	1		
	Patients with learning difficulties, mental health or autism spectrum are allowed relatives to stay with them throughout their stay. Pro-active admissions for these groups with preadmission and discharge planning	1		
	Admission procedures and assessments e.g. MUST /VTE/ FALLS / risk assessment Maternity	1		
	Pre-operative assessments	1		
	Development of a Supporting Patients with Additional Needs Strategy Barriers identified and measures put in place to remove e.g. Presence of representatives from MRANG in the antenatal clinic to support asylum seekers	1		
	Patient Involvement & Experience Sub-Committee review the progress against the Women's, Babies and Families Experience Strategy. This is undertaken in June of each year and any concerns are escalated to the Quality Committee via the Chairs report.	2		
	Patient Involvement & Experience Sub-Committee review PALs and Complaint data quarterly via the Themes and Trend report, and any concerns raised are escalated to the Quality Committee via the Chairs report.	2		
	The Trust Board Meeting has a patient/women's story to Board most months throughout the year	2		
	Patient Involvement & Experience Sub-Committee review the Friends and Family themes and trends quarterly. Friends and Family also form part of the Trust Performance report that each Division must review. More recently	2		

Gaps in Control / Assurance:

Work being undertaken to review the pathway for trans patients going through fertility prior to the commencement of hormone therapy.

All information should be reviewed by the Divisional Board prior to coming to PIESC

Evidence how the divisions are using this data to influence their service design and improvements – Outpatient Transformation is a good example of this

QI projects need to be developed from patient voices and experience-based co-design

MVP review needed of complaints actions and themes for improvement presented at PIESC – MVP on the distribution list for all PIESC papers

Gaps in effective delivery of Access Policy including training of staff associated with RTT pathway management

Gaps in Standard Operating Procedures for management of patient pathways

Timescales for delivery of key elective recovery programme actions

3.1/10 – Work to reconfigure the MLU estate to maximise efficiencies for IOL.

	a new KPI regarding displeased comments has been added. This has given each area the opportunity to review displeased comments and act on them. This also enables the areas to display the 'you said we did' data out in the areas. The Patient Involvement and Experience Sub Committee has a standing agenda item for the relevant Divisions to discuss the key findings from the Friends and Family and show what improvements have been made as a result.					
	Patient Involvement & Experience Sub-Committee review the results of the National Maternity Survey, National Inpatient Survey and the National Cancer Survey Annually. All surveys are also reviewed by the Trust Quality Committee.	**2**				
	Patient Involvement & Experience Sub-Committee have both Healthwatch Sefton and Healthwatch Liverpool on the group as active participants.	**2**				
	Patient Involvement & Experience Sub-Committee review as part of the quarterly themes and trends reports as working with the Communications team all social media comments are sent through to PEX to review and action.	**2**				
	Reports on community engagement and relationships via the Patient Involvement and Experience Sub-Committee and attends CoG Comms and Engagement Group to share experiences	**2**				
	Patient Involvement & Experience Sub-Committee listen to the Patient Experience Strategy updates from each Division via the Patient Experience review paper and any patient experience intelligence that they have.	**2**				
	Safety and Effectiveness Sub Committee review the BBAS quarterly and any issues are escalated to the Quality Committee via the chairs report. Patient Experience Matron forms part of the accreditation team	**2**				
	Patient Involvement & Experience Sub-Committee review the outcomes form the PLACE assessment, this is also on the Quality Committee	**3**				
	Patient Experience Matron attends the MVP meetings and MVP chair is part of the circulation list for PIESC	**2**				
	Patient Involvement & Experience Sub-Committee review the Friends and Family themes and trends quarterly	**2**				
	Matrons' operation group reviews the feedback gained and issues escalated on the chairs report to the Nursing and Professional forum	**1**				
	Complaints annual report is approved by Quality Committee and the Quarterly themes and trends report is discussed at Patient Involvement and Experience Sub Committee. The Integrated Governance report included Patient Experience data and is reviewed at Quality Committee.	**2**				
	The Quality schedule is reviewed by the ICB and this covers an annual submission for Well Led 01 and Caring 01. The reports are also discussed at the CQPG.	**2**				
	External to NHSE digital to monitor the complaints activity	**3**				

Further Actions (Additional Assurance or to reduce likelihood / consequences)

Ref:	Action required	Lead	Due Date	Quarterly Progress Update	RAG
3/5	Divisional Boards to review Patient Experience Data prior to being reviewed by the Patient Involvement and Experience Sub Committee	Divisional Management Teams	Feb 23		
3/7	QI projects need to be developed from patient voices and experience-based co-design.	Quality Manager	Feb 23	Patient Experience Team have met with the QI manager and Ulysses is to be updated to included Patient Experience QI prior the Patient Experience projects being registered.	
3/8	Improvement of compliance against Trust KPI relating to displeased comments in FFT and to ensure that Power BI is updated so the 'You said we did data' can be extracted	Divisional Management Teams	Feb 2023		
3/10	Continue to provide updates to the Board regarding the Elective Recovery Plan through Divisional Performance Reviews and to FPBD on a monthly basis through the Integrated Performance Report	Deputy COO	On-going		
3/11	Work to reconfigure the MLU estate to maximise efficiencies for IOL.	FH Div Manager	January 2023		

Linked Corporate and High Scoring Divisional Risks Heat Map

Consequence	Likelihood				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic			2316, 2667		
4 Major			2087	2485, 2418	
3 Moderate					
2 Minor			2084		
1 Negligible					

Return to Dashboard

Ref	Description	Risk Rate Score
	Corporate Risks	
2087	Condition: Uncertainty about provision of a safe Maternity service able to give more effective interventions with 24/7 Consultant presence on Delivery suite and sufficient consultant cover for 10 elective caesarean lists per week and high-level MAU cover.	12
~~2649~~	~~Condition: There is little evidence to support Audim audits are being undertaken as required in line with National Standards of Healthcare Cleanliness (2021)~~	~~9~~
2084	Condition: Uncertainty of adequacy of 24/7 access to specialist input to support changing patient profiles and needs, new guidance and the Chief Medical Officer's recommendation of the specialist multidisciplinary team approach to treatment planning and co-ordination, including pre-operative, surgical and up to level 3 post-operative care for improved patient safety and improved outcomes.	6
	High Scoring (15+) Divisional Risks	
2418	Condition: Lack of support and appropriate care for patients presenting with mental health conditions	16
2485	Condition: Limited access to MRI scan (currently 5-6 weeks wait) needed for cancer patient pre-treatment (both surgical and radiotherapy treatment). MRI requested and undertaken at CCC as per pathway, as expertise in reporting is there and feeds into specialist MDT. Of note MRI added into clinical pathway as part of BGCS stratification for surgery during the first wave of COVID pandemic - this is considered best practice.	16
2316	Condition: Risk of women needing to access emergency care with pregnancy complications and not being able to be triaged in the MAU within 30 minutes of presenting at the department as per BSOTS. Impact on the safety of patients (physical and psychological);	15
2667	Risk: Delay in access to timely radiography out of hours	15

BAF Risk 4 – *Inadequate digital strategy and sub-optimal clinical records systems increase the risk of major IT system failures due to cyber-attacks, compromising patient safety and Trust operations*

Risk Description and Impact on Strategic Aims		
Cause (likelihood)	**Event**	**Effect (Consequences)**
Sub-optimal clinical records system, including both paper and electronic systems. Inability to embed aims and objectives in the Trust's digital strategy.	Major and sustained failure of essential IT systems due to a cyber-attack, leading to the inability to access patient records, deliver care, and support administrative functions. Sub-optimal clinical records systems, including difficulty in accessing or locating information, duplication of effort, and potential errors or omissions in patient care. Failure to embed aims and objectives in the Trust's digital strategy may lead to ineffective use of technology and missed opportunities to improve patient outcomes and experiences.	Patient safety compromised due to inability to access critical clinical information in a timely and accurate manner. Disruption to Trust operations and reduced capacity to deliver care. Reputational harm to the Trust, as well as potential regulatory or legal issues. Failure to embed aims and objectives in the Trust's digital strategy may result in missed opportunities to improve efficiency, quality, and safety of patient care. Overall, the risk is the inability of the Trust to effectively manage and utilize digital systems, including clinical records, leading to potential patient safety issues, operational disruption, and reputational harm.

	We will be an outstanding employer			**Our services will be the safest in the country**	✓
	Every patient will have an outstanding experience			**To be ambitious and efficient and make the best use of available resources**	✓
	To participate in high quality research in order to deliver the most effective outcomes				

Responsibility for Risk			
Committee:	**Finance, Performance & Business Development Committee**	**Lead Director:**	**Chief Information Officer**

Risk Scoring and Tolerance							
Quarter / Score	**Q1**	**Q2**	**Q3**	**Q4**	**Target**	**Target Date**	**Risk Tolerance Statement**
Likelihood	**4**	**4**			**3**	**March 2024**	Our risk appetite for safety is **low.** Our fundamental strategic aim describes our commitment to patient and staff safety. When and wherever possible we will apply strict safety protocols for all clinical and non-clinical activity. We will not compromise the safety of our patients, we will report, record, and investigate our incidents and we will ensure that we continue to learn lessons to improve the safety and quality of our services.
Consequence	**5**	**4**			**5**		
Risk Level	**20**	**16**			**15**		

Rationale for risk score and quarterly update – September 2023

The Trust's Digital Services department places cyber security management at the core of operational activities, ensuring it maintains its Cyber Essentials standard. Various controls are implemented that are considered effective and this reduces the likelihood of a cyber-attack impact. The assessment of consequence from a cyber threat perspective has resulted in a rating reduction from catastrophic to major based on the multi-layered technical controls which have proven effective in terms of alerting and protection resulting capability to contain the impact of a successful in some scenarios. However, if a cyber-attack was successful the impact would likely have a major negative impact on Trust services, likely rendering digital systems that clinical services are increasingly dependent on, unavailable for a period. The Digital Services department continue to strengthen controls through process refinement and the introduction of security technologies.

Contributing to the consequence reduction is the successful introduction of the MEDITECH Expanse EPR which by design has improved systems integration with other Trust systems. Whilst there is ongoing programme to further improve integration and system adoption (through the stabilisation and optimisation phases of the DigiCare programme), there is a demonstrable progress to mitigate the multiple systems elements of this risk.

Based on this, the impact is considered major (4). Due to recent world events, the environment risk or likelihood for a cyber-attack has increased from possible (3) to likely (4) due to increased cyber threats from Russia. The NHS has reflected the increased threat through guidance issued to all NHS providers and arm's length bodies during March 2022. The current situation with regards to adopting of a new EPR system influences the likelihood remaining 4 for this reporting period.

Key Controls and Assurance Framework

Key Controls:

- Successful implementation of digiCare MEDITECH EPR
- Enhanced integration between MEDITECH EPR and other Trust systems over the legacy environment.
- Stabilisation and optimisation phases planned and underway to ensure system is 'used as intended', with oversight at digiCare EPR Programme board.
- Clinical Safety Officer processes established and operating, ensuring clinical risk through digital design and use is identified and mitigated.
- Approved Digital Generations Strategy
- Approved Meditech Expanse Business Case
- Maintenance of present system
- Development of individual / service solutions e.g. PENs (Gynaecology) and Staff training
- Incident reporting
- Tactical solutions including the implementation of K2 Athena system
- Exchange/LHCRE enables for patent information sharing
- Virtual Desktop technology to aid staff working flexibly.
- Additional network resilience for LUHFT supplied systems (K2/PENS/CRIS) to reduce risk of unplanned systems downtime
- PACS upgrade removes a separate login for that system, reducing multiple systems issues.
- Task and Finish group established to ensure that clinical investigation undertaken at external trusts have been actioned accordingly.
- Appropriate task and finish groups established as required by Safety and Effectiveness sub-committee
- Digital clinical leadership business case developed
- Optimisations to K2 system and refinements implemented
- Ongoing review of systems and mitigations quarterly
- Microsoft Windows security and critical patches applied to all Trust servers on all servers\laptops and desktop devices on a monthly basis.
- Network switches and firewalls have firmware updates as and when required installed. Wifi network firmware patches applied for Controllers and Access points.
- Mobile end devices patched as and when released by the vendor.
- Externally managed network service provider to ensure network is a securely managed with underpinning contract.
- Robust CareCert process to enact advice from NHS Digital regarding imminent threats.
- Network perimeter controls (Firewall) to protect against unauthorised external intrusion.
- Robust Information Governance training on information security and cyber security good practice.
- Regular staff educational communications on types of cyber threats and advice on secure working of Trust IT systems.
- Additional cybersecurity communications in relation to Covid phishing/ scams, advising diligence.
- Enhanced VPN solution including increased capacity to secure home working connections into the Trust.
- Review and updating of information security policies and home working IG guidance to support staff who are remote working.
- Malware protection identifies and removes known cyber threats and viruses within the Trust's network and at the network boundaries.
- Cyber Security Monitoring System identifies suspicious network and potential cyber threat behaviour.
- National CareCert alerts inform of known and imminent cyberthreats and vulnerabilities
- Mobile device management – providing enhanced security for mobile devices
- Cyber Security Strategy
- Implementation of Multi-Factor Authentication (MFA) to support reduction of risk of unauthorised or privileged system access due to user account credentials being compromised.

		Assurance Level	Assurance Rating	Overall Assurance Rating
Key Assurances:	Quarterly risk assessments completed	1		
	FPBD Committee overview and scrutiny	2		
	Digital Hospital Committee oversight	2		
	Approved EPR Business case which define clear direction and preferred solution.	2		
	digiCare EPR programme board chaired by CIO	2		
	Clinical Safety Officer governance to mitigate clinical risk through digital use.	2		
	Independent lessons learnt Positive review	3		
	MIAA Critical Application Audit (rolling programme across trust systems)	3		
	Effective Staff communications on Digicare	1		
	Cyber Essentials Plus Standards/KPIs	3		
	IMT Risk Management Meeting	2		
	Medical Devices Committee	2		
	MIAA Cyber Controls Review	3		
	Cyber Essentials Plus Accreditation	3		
	Cyber Penetration Test	3		
	NHS Care Cert Compliance	3		

Gaps in Control / Assurance:

Multiple Clinical Systems issues remain (Action 2.2 / 2)

Ability of clinical staff to engage with the system development due to time and financial impact (Actions 2.2 / 1, 2.2 / 3, 2.2 / 4)

ICS wide Shared Care Record programme not fully implemented/ active programme of work)

Lack of Cyber Security strategy (Action 2.4 / 1)

Lack of Network Access Controls within the physical network (Action 2.4 / 2)

Effective USB port control (Action 2.4/ 3)

Lack of visibility of medical devices (Action 2.4 / 4)

Further Actions (Additional Assurance or to reduce likelihood / consequences)

Ref:	Action required	Lead	Due Date	Quarterly Progress Update	RAG
4/4	Improve grip, control and governance on medical devices	CIO	December 2023	Digital attendance at Medical Devices Committee. Asset inventory of medical devices under review. Funding for Digital solution to protect medical devices submitted to ICS in October.	

Linked Corporate and High Scoring Divisional Risks Heat Map

Consequence	Likelihood				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic			2604		
4 Major				2655, 2531	1960
3 Moderate			2603		2386
2 Minor					
1 Negligible					

Ref	Description	Risk Rate Score
Corporate Risks		
2603	Condition - Current Intranet in poor condition and no longer fit for purpose.	9
High Scoring (15+) Divisional Risks		

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BAF Risk 5 – *Inability to deliver the 2023/24 financial plan and ensure our services are financially sustainable in the long term*

Risk Description and Impact on Strategic Aims		
Cause (likelihood)	**Event**	**Effect (Consequences)**
Insufficient funding, or failure to secure funding, from external sources. Inadequate cost control and/or cost reduction measures. Inadequate financial management and controls, including lack of effective financial planning and forecasting.	Risk that the Trust will not have sufficient cash resources in the 2023/24 financial year, resulting in inability to pay suppliers, staff, or meet other financial obligations. Risk that the Trust will not deliver agreed plan in the 2023/24 financial year, including inability to meet operational targets or clinical quality standards. The Trust is not financially sustainable in the long term, potentially leading to intervention from external regulators and the Trust no longer being a going concern.	The Trust fails to meet its financial plan and is unable to secure sufficient resource to safely deliver its clinical services, resulting in negative outcomes for patients and staff, reduced trust in the quality of care provided.

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	Every patient will have an outstanding experience			**To be ambitious and efficient and make the best use of available resources**	✓
	To participate in high quality research in order to deliver the most effective outcomes				

Responsibility for Risk			
Committee:	**Finance, Performance & Business Development Committee**	**Lead Director:**	**Chief Finance Officer**

Risk Scoring and Tolerance							
Quarter / Score	**Q1**	**Q2**	**Q3**	**Q4**	**Target**	**Target Date**	**Risk Tolerance Statement**
Likelihood	**4**	**4**			**3**	**March 2024**	Our risk appetite for efficient is **moderate** This is in respect to meeting our statutory financial duties of maintaining expenditure within the allocated resource limits and adherence to departmental and internal expenditure and financial controls. This includes the demonstration of value for money in our spending decisions, while ensuring quality and safety is maintained.
Consequence	**4**	**4**			**4**		
Risk Level	**16**	**16**			**12**		

Rationale for risk score and quarterly update

The Trust has a well-defined and evidence-backed case that it is not financially sustainable due to the size of the organisation and particular mix of services, while remaining on an isolated site. This situation is exacerbated each year due to prior capital investment, ongoing revenue investment, and other pressures including a reduction in top up income. The Trust is facing a significant financial challenge in 2023/24 and is at risk of not being able to deliver its financial plan.

The likelihood of this risk has been assessed as 'likely' rather than 'almost certain'. At Month 5, the Trust is reporting an adverse variance to plan of £1.5m, however this is supported by £2.2m of non-recurrent items, meaning the underlying variance to plan is equivalent to £3.7m. Expenditure run rates will need to improve significantly to achieve the plan by year-end, and is becoming increasingly challenging. The Trust has produced a long-term financial recovery plan which demonstrates that recovery is not possible without implementation of strategic, system-wide solutions including additional income. The Trust introduced a targeted program of Financial Recovery in July 2023 to support the in year and long term position and will review the forecast outturn at month 6 in terms of deliverability of the full year plan in this context.

Key Controls and Assurance Framework

Key Controls:

- 5 Year financial model produced giving early indication of issues
- Multiple iterations of the Future Generations business case have demonstrated that the Trust's long-term financial viability will be improved if the preferred option of co-location with an adult acute site is funded
- Early and continuing dialogue with NHSE/I and Cheshire and Merseyside ICS
- Engagement in place with Cheshire and Mersey Partnership to review system solutions
- Clinical Engagement and support for proposals
- Working within ICS/system to ensure issues understood and Trust secures required amount of available funding.
- Trust is part of the system-wide expenditure controls group.
- Agency and Premium Pay: There are several workstreams underway to reduce this spend and costs are well controlled. These include ensuring all approvals for usage are made by senior leaders, recruitment campaigns for permanent staff, a programme to support retention, management of sickness, removal of

	• Reduction in CNST Premium and achievement of Maternity Incentive Scheme. • Reduction in corporate overheads costs. • Agreed financial plan for 2023/24 with NHSE and C&M • Finance Recovery Board in place with multiple workstreams to address the identified drivers of the deficit, each supported by Executive Sponsors. • Rapid transformation workstreams identified. • External Financial Recovery Support • Enhanced financial recovery communications • Collaboration and efficiency at scale is developing across Liverpool and C&M, underpinned by findings of Liverpool Clinical Services Review. • Internal audit reports • CIP process in place, including QIA and EIA process • Monthly reporting and monitoring of position including taking corrective action where required. • Monthly review of financial position with divisional leadership and CFO ahead of financial close down • Sign off of budgets by budget holders and managers, and holding to account against those budgets • Divisional performance reviews • Cash management controls in place: • 13-week cashflow updated weekly showing impact of cash advances received to date and any requested cash support • Explanation of need for cash provided with triangulation to financial position • Internal Audit plan for the year shared with ICB, showing cash/treasury management as a key area for review. • Cash balances reviewed by the CFO and DCFO on a daily basis				incentive payments and review of premium pay rates. Executive Committee review agency spend on a regular basis. • Establishment reviews carried out as part of budget setting process with detailed review of rotas by Deputy Director of Nursing. Monthly reviews of rota with e-Roster manager and Heads of Nursing in place. • Deferral of Investment: Investments in 2023/24 were limited to only those contractually committed or mandated. These remain under constant review from a safety and quality perspective. • Non-clinical vacancy freeze in place. • Vacancy control panel in place, meeting weekly to consider all posts, with Executive Committee review and approval. • All consultant job plans reviewed and are compliant with current policies. • New process to be implemented for WLIs; requested and approved on Allocate roster system, with reasons for WLIs accurately recorded. • Revised non-pay expenditure controls in place: ○ Short term suspension of all budget-holder approval limits ○ Redefined criteria for drafting and submitting a requisition ○ Submission of authorised requisition to either a divisional or a central panel predicated on value ○ Review of content by a multidisciplinary panel daily ○ Audit review on run rate impact including unexamined returns and KPI monitoring ○ No ordering can occur though bypassing this process and breaches are sanctioned. • Detailed log of investments since 2019/20 and prior has been produced with post-implementation review underway. • Income: A detailed look at all aspects of income has been undertaken and has already yielded some successes, e.g. updating arrangements and ensuring all billing is undertaken for service provided. • Non-Pay, Procurement and Contracts: Contracts have been looked at to ensure the Trust is not paying for any goods or services that are not required, and that prices charged are reasonable. Enhanced spending controls are in place with additional monitoring and oversight. The 'No PO No Pay' policy has been re-enforced. • Balance Sheet and Non-Recurrent Items: A full review of the balance sheet to ensure, for example, that accruals, provisions and deferred income has been appropriately released.		
		Assurance Level	**Assurance Rating**	**Overall Assurance Rating**		
	Future Generations Clinical Strategy and Business Plan (BoD Nov 15, PCBC 2016/17, case and LTFM refreshed in 2021/22)	**2**				
	Submission of Cheshire and Mersey STP capital bid Summer 2018 ranked no1 of schemes	**2**				
	Active participation in C&M planning processes	**2**				
	Northern Clinical Senate Report supporting preferred option both in 2017 and 2022.	**3**				
	Process in place regarding CNST MIS. Prior achievement of MIS. Engagement with NHS Resolution and learning from claims and incidents.	**2**				
	Direct engagement with NHS Resolution.	**2**				
	Focus on benchmarking and efficiencies, including joint working where possible.	**2**				
	FPBD and Board (monthly reports)	**2**				
	Recovery plan with agreed actions in place; monitored through Financial Recovery Board, Executive Team and Finance, Performance and Business Development Committee and reported to Board.	**2**				
	FPBD Committee receives monthly reports, chair's reports from the Financial Recovery Board and specific recovery centred reports.	**2**				
	Internal Audit- high assurance for all finance related internal audit reports in 2020/21, 2021/22 and 2022/23. Substantial Assurance 2022/23 in relation to Recovery Plan	**3**				
	External Audit – no amends to accounts and largely low rated recommendations in ISA260.	**3**				

	Mitigations being worked up in case of identified risks materialising	**2**				
	Agency use monitored weekly at Executive Team meetings and via regular meetings with the Divisions	**2**				
	Quality impact assessments are underway to prevent deleterious effects of deferrals	**2**				

Further Actions (Additional Assurance or to reduce likelihood / consequences)

Ref:	Action required	Lead	Due Date	Quarterly Progress Update	RAG
5/4	Deliver outcomes from Financial Recovery Board workstreams	CFO	March 2024	Ongoing	
5/5	Identify full CIP programme	CFO/COO	April 2023	Ongoing – workshops held	
5/6	Monitoring and management of existing CIP programmes	CFO/COO	Ongoing	Ongoing – through financial recovery programme	
5/7	Delivery of activity and income targets	COO	Ongoing	Ongoing, delivery at risk due to industrial action	
5/8	Careful monitoring of cashflow forecast and close working with ICB to manage cash in year	CFO	Monthly	Ongoing, with additional discussions with system partners regarding options for cash support	
5/9	Negotiation of CDC contract for 2024/25 and beyond	COO	February 2024		
5/10	Active participation in the Women's Services ICB Sub-Committee	MD	Ongoing	Ongoing – meetings held in September 2023, workstreams established.	
5/11	Progression of estates workstream with LUHFT	CFO	December 2023	Ongoing - outputs reported to LWH/LUH Partnership board in September 2023, with further work agreed.	

Linked Corporate and High Scoring Divisional Risks Heat Map

Consequence	Likelihood				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic					
4 Major				1635	
3 Moderate			2301		
2 Minor					
1 Negligible					

Ref	Description	Risk Rate Score
Corporate Risks		
2301	Condition: There is both an operational and a financial risk related to the position in relation to contracts and SLAs for services provided to and by the Trust.	12
1635	Risk of delays to treatment due to significant problems with the junior doctor rotas-vacancies and maternity leave. This is placing severe strain on the ability to fulfil the on-call rota as well as covering in hours duties. There is an increased reliance on locums, causing financial pressures. The risk include potential gaps in the rota which may put patients at risk, regular locum use which may result in potential compromise to the quality of the service provided and risk to the training provision of junior doctors if they are being moved around to fulfil the basic rota.	16
High Scoring (15+) Divisional Risks		
2722	Condition: There is a risk to the division being overspent against budget due to unfunded cost pressures identified as part of the annual planning process.	16
2725	The division have identified cost pressures of approx. £2.35m that are unfunded for 2023/24. This is now a significant pressure to the division and the overall Trusts financial position. A large proportion of the pressures are staff already in substantive roles (for several years) and further inflationary costs.	16

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BAF Risk 6 – *The right partnerships are not developed and maintained to support the success of the Cheshire & Merseyside ICB and the CMAST Provider Collaborative*

Risk Description and Impact on Strategic Aims		
Cause (likelihood)	**Event**	**Effect (Consequences)**
Conflicting priorities and objectives among clinical services providers in the Integrated Care System (ICS), including differing views on clinical strategy, resource allocation, and accountability. Ineffective governance structures or processes that do not facilitate effective decision-making or resource allocation.	The Trust may struggle to engage effectively with provider, commissioner, and other partners across the system. The Trust may also struggle to maintain those partnership relationships required to safely deliver its services from an isolated site.	If the Trust is unable to engage effectively with system partners, this could result in limitations in the Trust's ability to influence system plans and decision-making, including during contract negotiation with commissioners and agreement regarding capital funding to deliver the Future Generations Programme. Additionally, if the Trust is unable to maintain partnership relationships with providers, it may have a negative impact on the Trust's ability to deliver safe care, resulting in negative outcomes for patients and staff, reduced trust in the quality of care provided.

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	Every patient will have an outstanding experience			**To be ambitious and efficient and make the best use of available resources**	✓
	To participate in high quality research in order to deliver the most effective outcomes	✓			

Responsibility for Risk			
Committee:	**Finance, Performance & Business Development Committee**	**Lead Director(s):**	**Chief Finance Officer & Medical Director**

Risk Scoring and Tolerance							
Quarter / Score	**Q1**	**Q2**	**Q3**	**Q4**	**Target**	**Target Date**	**Risk Tolerance Statement**
Likelihood	**3**	**2**			**2**	**March 2024**	Our risk appetite for effective is **high.** A level of service redesign to improve patient outcomes that requires innovation, creativity, and clinical research are considered by Liverpool Women's NHS Foundation Trust to be an essential part of the risk profile of the Trust.
Consequence	**3**	**3**			**3**		
Risk Level	**9**	**6**			**6**		

Rationale for risk score and quarterly update

The Trust has well defined partnerships and relationships with a number of key stakeholders. These have been strengthened and added to during the Covid-19 pandemic response. The Trust has strengthened partnerships further during Q2 by securing agreement to appoint a shared Accountable office with partners Liverpool University Hospital NHS FT. ToRs have been drafted for a new Partnership Board with AHCH. In addition, the ICB's Women's Services Committee has begun making progress towards delivery.

Key Controls and Assurance Framework		
Key Controls:	• Appointment of Joint Accountable Officer with Liverpool University Hospitals NHS FT • Robust engagement with ICS discussions and developments through CEO and Chair • Evidence of cash support for the Trust's 2022/23 position • Chair of the Maternity Gold Command for Cheshire and Merseyside • C&M Maternal Medicine Centre • Liverpool Trusts Joint Committee • Neonatal partnership in place with Alder Hey, with developing partnership board arrangements • Partnership Board in place with LUHFT and involvement in wider Estates Plan • Crown Street Community Diagnostic Centre Partnership	**Future Generations Specific** • Clinical Sustainability in Women's Services ICB Sub-Committee, chaired by ICB Chair • Future Generations Strategy in place • Continuing dialogue with regulators • Continuing partnership with Liverpool University Hospitals • Future Generations Programme re-set as a system priority through Liverpool Clinical Services Review

	• Positive and developing relationship with Merseycare NHS FT • Signed up to CMAST Joint Working Agreement and Committee in Common • Participation in CMAST networks and workstreams • LMNS Hosting Arrangement • Liverpool Clinical Services Review • Finance Directors Group • Health care partnership are using existing memorandum of understanding in relation to staff movement between local hospital at time of staffing need. • LWH have provided assistance to LUFT by taking over LWH non obstetric Ultrasound scanning activity • LWH identified as Gynaecology Oncology Hub for Cheshire and Mersey. • Theatre sessions provided at LWH for other Trusts such as Colorectal for LUFT • Provision of mutual aid to NWAST by supporting staff testing on LWH site for them • Provision of Mutual aid to NWAST for staff Covid-19 vaccinations					
		Assurance Level	**Assurance Rating**	**Overall Assurance Rating**		
Key Assurances:	Quarterly Partnership Reporting to Board	**2**			**Gaps in Control / Assurance:**	Governance arrangements are developing (Action 6.2) There is limited capital available to deliver the Trust's Future Generations Strategy. To progress delivery, it is likely that capital funding will need to be identified within the local system. This will require alignment across all system partners regarding priorities for capital funding, and at present there are competing priorities. Some partnership arrangements are not yet underpinned by formal governance arrangements and/or service level agreements. (Action 6.2)
	LNP Assurance meeting	**2**				
	Future Generations Strategy has been included within refreshed overall corporate strategy and is a key supporting strategy within Trust strategic framework. The ICB is now leading the programme of work to address the clinical sustainability challenges related to the isolated site.	**2**				
	The majority of dialogue with regulators will be led by the ICB in future. Chair and CEO will maintain ongoing dialogue with relevant key stakeholders at both national and regional level, as appropriate. Trust Communications Team has established good links with respective teams at Place and the ICB and will support any future communication and engagement activities regarding the programme.	**2**				
	Partnership with Liverpool University Hospitals in place and strengthening. Shared dashboard and risk register under development. Shared review of relevant SIs	**2**				
	Active engagement with commissioners ongoing via newly established sub-committee of ICB	**2**				

Further Actions (Additional Assurance or to reduce likelihood / consequences)					
Ref:	**Action required**	**Lead**	**Due Date**	**Quarterly Progress Update**	**RAG**
6/1	Continue to provide updates to the Board regarding the development of the ICS, highlighting when decision points are likely	CEO	On-going		
6/2	Underpin all partnership arrangements with formal governance and service level agreement where appropriate	CFO	Dec-23	Limited progress made towards putting SLA documentation in place. AHCH Tors and workplan in development	

Linked Corporate and High Scoring Divisional Risks Heat Map

Consequence	Likelihood				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic					
4 Major					
3 Moderate					
2 Minor					
1 Negligible					

Ref	Description	Risk Rate Score
Corporate Risks		
High Scoring (15+) Divisional Risks		

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BAF Risk 7 – *Failure to meet patient waiting time targets*

Risk Description and Impact on Strategic Aims		
Cause (likelihood)	**Event**	**Effect (Consequences)**
Inadequate clinical systems, processes and governance to ensure delivery of national waiting time standards. Insufficient management capacity. External factors that cannot be easily influenced.	The event occurs when the demand for services exceeds the Trust's capacity to deliver timely care, leading to increased waiting times for patients. This can manifest in various ways, such as delayed appointments, extended waiting lists, or increased waiting times for diagnostic tests or treatments.	Prolonged waiting times at Liverpool Women's NHS Foundation Trust can result in patient dissatisfaction, negative feedback, and loss of confidence in the Trust's services. Delays in accessing care can compromise patient outcomes, leading to increased pain, discomfort, and complications. Breaches of regulatory targets and standards, such as NHS maximum waiting time targets, may trigger regulatory scrutiny and financial penalties. The Trust may incur additional costs and resource utilization to address the backlog, impacting its budget and sustainability. Persistent waiting time issues can also damage the Trust's public perception and relationships with stakeholders.

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	Every patient will have an outstanding experience	✓		**To be ambitious and efficient and make the best use of available resources**	✓
	To participate in high quality research in order to deliver the most effective outcomes				

Responsibility for Risk			
Committee:	**Quality Committee**	**Lead Director:**	**Chief Operating Officer**

Risk Scoring and Tolerance							
Quarter / Score	**Q1**	**Q2**	**Q3**	**Q4**	**Target**	**Target Date**	**Risk Tolerance Statement**
Likelihood	**4**	**4**			**3**	**March 2024**	Our risk appetite for experience is **low.** Liverpool Women's NHS Foundation Trust has a low-risk appetite for actions and decisions that, whilst taken in the interests of ensuring quality and sustainability of the Trust and its patients, may affect the experience of our patients, the reputation of the Trust or the reputation of the wider NHS. Such actions and decisions would be subject to a rigorous risk assessment and be signed off by the Senior Management Team. Despite retaining this a 'low' risk appetite the Quality Committee agreed that the Trust would need to be more ambitious in its attempts to better understand the views of patients and local communities.
Consequence	**4**	**4**			**4**		
Risk Level	**16**	**16**			**12**		

Rationale for risk score and quarterly update – September

Following the operational pressures faced as a result of the COVID pandemic, a large number of patients had their treatment and appointments delayed as a result of changes to clinical capacity. This has led to an increasing number of patients waiting beyond 52 weeks to receive their treatment. Continued rises in referrals from Primary Care and an increasing backlog of patients to be seen has led to increased delays in care and deterioration of Trust performance in relation to national Referral to Treatment (RTT) standards.

Key Controls and Assurance Framework

Key Controls:

- Fortnightly Access Board meetings with Divisional Operational Teams and Information present monitoring key performance
- Daily monitoring of performance through Power BI dashboards – daily and weekly updates on key performance metrics
- Weekly Patient Tracking List (PTL) meetings with Divisional Operational teams and Patient Access
- Elective Recovery Programme in place with workstreams to improve performance and reduce waits
- Theatre Utilisation Group
- Text reminder service to reduce DNA's and ensure patients still require appointments – facility in place if they wish to change or cancel appointments
- Patient Initiated Follow-Ups – to minimise numbers of patients who no longer require follow up to release capacity
- Medinet in place for Gynaecology to increase clinical capacity

	• External validation programme of work reviewing all admitted and non-admitted pathways to ensure RTT guidance being applied correctly • Review of Medical & Nursing job plans to ensure capacity in place to treat patients in a timely manner • Cancer Committee – meets bi-monthly to review Cancer performance and track actions to improve performance • Increased staffing capacity in MAU				• Sub-specialisation of Gynaecology and sub-specialty recovery plans in place to monitor actions/risks at a sub specialty level and establish performance trajectories to deliver improvements • Controls in place to monitor length of stay for women in induction of labour - Daily safety huddles - IoL metrics included on Executive and SLT live dashboards • C&M weekly maternity escalation cell	
		Assurance Level	**Assurance Rating**	**Overall Assurance Rating**		
Key Assurances:	Access Board reporting	**2**			**Gaps in Control / Assurance:**	Work underway to explore most effective Gynae ED model
	Escalation through to FPBD and Board	**2**				

Further Actions (Additional Assurance or to reduce likelihood / consequences)

Ref:	Action required	Lead	Due Date	Quarterly Progress Update	RAG
7/1	Continue to provide updates to the Board regarding the Elective Recovery Plan through Divisional Performance Reviews and to FPBD on a monthly basis through the Integrated Performance Report	Deputy COO	On-going		
7/2	Access Policy review and delivery of SOP's via Waiting List Management audit action plan	Patient Access Lead	September 2023		
7/3	Work to reconfigure the MLU estate to maximise efficiencies for IoL.	FH Div Manager	September 2023		

Linked Corporate and High Scoring Divisional Risks Heat Map

Consequence	Likelihood				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic			2316, 2667		
4 Major			2087	2485	
3 Moderate					
2 Minor			2084		
1 Negligible					

Return to Dashboard

Ref	Description	Risk Rate Score
Corporate Risks		
2087	Condition: Uncertainty about provision of a safe Maternity service able to give more effective interventions with 24/7 Consultant presence on Delivery suite and sufficient consultant cover for 10 elective caesarean lists per week and high-level MAU cover.	12
~~2649~~	~~Condition: There is little evidence to support Audim audits are being undertaken as required in line with National Standards of Healthcare Cleanliness (2021)~~	~~9~~
2084	Condition: Uncertainty of adequacy of 24/7 access to specialist input to support changing patient profiles and needs, new guidance and the Chief Medical Officer's recommendation of the specialist multidisciplinary team approach to treatment planning and co-ordination, including pre-operative, surgical and up to level 3 post-operative care for improved patient safety and improved outcomes.	6
High Scoring (15+) Divisional Risks		
2728	Cause: Current ambulatory estate is insufficient to meet demand for ambulatory activity	16
2485	Condition: Limited access to MRI scan (currently 5-6 weeks wait) needed for cancer patient pre treatment (both surgical and radiotherapy treatment). MRI requested and undertaken at CCC as per pathway, as expertise in reporting is there and feeds into specialist MDT. Of note MRI added into clinical pathway as part of BGCS stratification for surgery during the first wave of COVID pandemic - this is considered best practice.	16

Appendix 1 – System BAF risk mapping

	LWH BAF 1				LWH BAF 2				LWH BAF 3				LWH BAF 4				LWH BAF 5				LWH BAF 6				LWH BAF 7			
	Inability to recruit & maintain a highly skilled & engaged workforce that is representative of our local communities				Inability to ensure the on-going sustainability of clinical services and maintain a high standard of care at the current Crown Street site.				Failure to deliver an excellent patient and family experience to all our service users				Inadequate digital strategy and sub-optimal clinical records systems increase the risk of major IT system failures due to cyber-attacks, compromising patient safety and Trust operations				Inability to deliver the 2023/24 financial plan and ensure our services are financially sustainable in the long term				The right partnerships are not developed and maintained to support the success of the Cheshire & Merseyside ICB and the CMAST Provider Collaborative				Failure to meet patient waiting time targets			
	Target				Target				Target				Target				Target				Target				Target			
	Actual Risk Score (LxC)				Actual Risk Score (LxC)				Actual Risk Score (LxC)				Actual Risk Score (LxC)				Actual Risk Score (LxC)				Actual Risk Score (LxC)				Actual Risk Score (LxC)			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
LWH BAF	20				20		8		12				20				20				9				16			
LUHFT BAF	8 (8)				1 (9)				6 (10)				10 (10)				5 (9)				11 (9)				2 (9)			
					3 (12)				7 (10)								9 (12)											
					4 (9)				12 (7)																			
					13 (9)																							
WC BAF	5 (12)				2 (9)				1 (12)				11 (15)				3 (9)											
	8 (9)				4 (9)				6 (12)				12 (6)				7 (9)											
	9 (12)				10 (12)																							
LHCH BAF	4 (12)				2 (12)		9 (4)		1 (6)				11 (12)				3 (12)				9 (4)							
	5 (12)				8 (12)		10 (9)										7 (12)				10 (9)							
	6 (12)																											
AHH BAF	2.1 (15)				1.1 (9)		3.2 (12)						4.2 (16)				3.4 (16)				3.2 (12)							
	2.2 (9)				1.2 (15)																3.5 (16)							
	2.3 (15)				1.3 (12)		3.6 (9)														3.6 (9)							
CCC BAF	10 (12)				1 (15)		6 (12)						13 (12)				3 (16)				6 (12)							
	11 (16)				2 (12)								14 (12)															
MC BAF	p.8 (15)				s.8 (16)		f.7 (8)		s.5 (12)				r.12 (8)				p.7 (16)				f.7 (8)							
	p.5 (12)				r.11 (12)		f.5 (12)		s.9 (12)								r.9 (15)				f.5 (12)							
									p.9 (12)								r.13 (15)											
ICB BAF	TBC				TBC		TBC		TBC				TBC				TBC				TBC							

LUHFT BAF Risks Summary	
1	If we do not enhance the systems and processes employed to deliver planned care at elective activity plans level, we will not reduce patient delays, negative impact on health outcomes, negative impact on finances, and potential increase in demand for social care
2	If we do not introduce innovative solutions to address the safety concerns within Urgent & Emergency Care, we may not see improvements in the delivery of safe care and the health and safety of staff.
3	If we do not embed the plans to achieve improvements in the fundamentals of nursing care (falls, pressure ulcers, nutrition and hydration), we may not achieve a reduction in length of patient stay and positive health outcomes for patients.
4	If corporate and quality governance arrangements do not meet the requirements of the Well-Led Framework, the Trusts assurance and escalation processes may not be fit for purpose, impacting on the provision of high quality, sustainable, harm free care.
5	If we do not support the wellbeing and resilience of our people, then our ability to recruit and to provide safe staffing levels in order to provide safe, caring and effective care may be compromised
6	If we do not address Equality Diversity & Inclusion (EDI) inequalities affecting our workforce, we may fail to improve the experience of staff from diverse background and fail to recruit, promote and retain diverse talent.
7	If we are unable to embed agreed leadership behaviours throughout the organisation, we may fail to strengthen our current leadership capability, which will have a negative impact on our ability to recruit and retain the best people.
8	If we do not deliver the agreed financial plan this may result in a detrimental impact on medium/long term sustainability and effective system collaboration.
9	If we are unable to develop cyber secure and compatible patient information systems due to resourcing and lead time limitations, this may result in detrimental impact on service continuity and consistency.
10	If we are unable to build and sustain effective partnerships with other health, care, voluntary sector and other key organisations, this may impact adversely on our ability to deliver the Trust strategy and the Liverpool Clinical Services Review
11	If we are unable to fulfil our responsibilities as an anchor organisation to the wider community, this may result in missed opportunities to support the Liverpool system and its people to improve health outcomes and address health inequalities.
12	If we do not deliver agreed milestones in line with the Research Strategy to become a clinically research active organisation, this may reduce the patient access to clinical research and reduce opportunities to improve patient care and treatment options.
13	If we do not deliver agreed milestones in line with the Research Strategy to become a clinically researchactive organisation, this may reduce the patient access to clinical research and reduce opportunities to improve patient care and treatment options

WC BAF Risks Summary	
1	Impact on patient outcomes and experience
2	Inability to develop further regional care pathways
3	Inability to deliver financial plan for year
4	Inability to deliver the operational plan
5	Inability to attract, retain and develop sufficient numbers of qualified staff
6	Inability to improve equitable access to services
7	Inability to secure capital funding to maintain the estate to support patient needs
8	Inability to develop a national training offer
9	Inability to develop and attract world class staff
10	Inability to grow an innovative culture
11	Inability to prevent Cyber Crime
12	Inability to deliver the Digital Aspirant plan and associated benefits

LHCH BAF Risks Summary	
1	Failure to maintain safety and quality and avoid harm would result in poorer patient & family experience
2	Inability to recover operational services in line with 22/23 planning guidance could result in poorer patient outcomes, inability to address the backlog of patients waiting and deliver financial consequences to the Trust
3	Inability to achieve the five year capital programme within a challenging and uncertain operating environment and deliver an Estates Strategy that supports the provision of outstanding services
4	A deterioration in the physical and mental wellbeing of our workforce would hinder our ability to provide the best possible care, experience and outcomes for patients
5	If delivery of people development programmes continues to be constrained, workforce morale and quality of care may suffer
6	Challenges in retaining and recruiting a high quality, diverse and inclusive workforce would affect our ability to deliver world class care
7	Failure to deliver financial plans and changes in the funding regime could impact sustainability for the Trust and system partners
8	Inability to drive the Research and Innovation agenda to exploit future opportunities
9	Failure to be recognized as an Anchor Institution, demonstrating social value, sustainable green strategy and contribution to population health may increase costs in the longer term and disappoint public, staff and regulatory expectations
10	The priorities of the ICS are developing and may present tensions for our strategic plans and collaborations and divert leadership capacity
11	Failure to ensure strong digital transformation and IT service resilience could erode LHCH's position as a world-class provider of specialist care delivering services for patient needs

Alder Hey BAF Risks Summary	
1.1	Inability to deliver safe and high-quality services
1.2	Children and young people waiting beyond the national standard to access planned care and urgent care
1.3	Building and infrastructure defects that could affect quality and provision of services

Clatterbridge Cancer Centre BAF Risks Summary	
1	Quality governance
2	Demand exceeds capacity
3	Insufficient funding

Merseycare BAF Risks Summary	
s.5	Failure to achieve continuous improvement and learning against the STEEEP and CQC domains will result in the Trust not archiving clinical excellence.
s.8	There is a risk of unstable pressure on our services due to rising levels of need within our communities resulting in an exacerbating workforce; affordability challenges and an Inability to shift resource whilst managing high levels of demand and acuity.
s.9	There is a risk that Trust won't be able to address unwarranted variation in access and waiting times across services due to the COVID backlog limiting the ability of staff to shift their attention upstream.

1.4	Access to Children and Young People's Mental Health		4	Board governance		p.8	There is a risk of reduced workforce availability, retention, and wellbeing due to staffing constraints leading to a failure to innovate our workforce models and address wellbeing and culture.
2.1	Workforce Sustainability and Development		5	Environmental sustainability		p.5	Failure to create a workforce that is representative of the communities that we serve and does not take a just and learning approach to reduce the gap in outcomes and experience of BAME staff and patients, resulting in continuing inequalities.
2.2	Employee Wellbeing		6	Strategic influence within ICS		p.7	If the Trust continues to see an overspend in senior medical staffing and medication, there is a risk that the Trust's control total will not be achieved.
2.3	Workforce Equality, Diversity & Inclusion		7	Research portfolio		p.9	There is a risk of poor patient experience and culturally inappropriate services due to our preventative model of care note being adequately co-produced with patients.
3.1	Failure to fully realise the Trust's Vision for the Park		8	Research resourcing		r.11	There is a risk to the modernisation of our inpatient and community estates across an enlarged footprint due to capital constraints limiting investment to support the new models of care.
3.2	Failure to deliver 'Our Plan' objectives to develop a Healthier Future for Children & Young People through leadership of 'Starting Well' and Children & Young People's systems partnerships		9	Leadership capacity and capability		r.12	There is a risk that the Trust will not be able to meet its strategic ambitions around digitally enabled care due to our current platforms not being strong enough to support the use of intelligence to predict and prevent the need for acute care.
3.4	Financial Environment		10	Skilled and diverse workforce		r.9	The CIP target associated with Mersey Care is not delivered recurrently, there is a risk the Trusts control total will not be achieved. Risk Score 15 over 5 years
3.5	ICS: New Integrated Care System NHS legislation/system architecture; Risk of inability to control future in system complexity and evolving statutory environment		11	Staffing levels		r.13	There is a risk of less autonomy in the new financial system due to the need for all NHS organisations to support national financial recovery after COVID19, resulting in less flexibility for the Trust to make strategic investments.
3.6	Risk of partnership failures due to robustness of partnership governance		12	Staff health and wellbeing		f.7	There is a risk to Integrated care reforms due to the Trust not working effectively in partnership at Cheshire and Merseyside and Place levels with other organisations, resulting in effective collaboration being hampered and misalignment with Mersey Care's own strategy.
4.1	Failure to deliver against the Trust's strategy and deliver game changing Research and Innovation that has a positive impact for Children and Young People		13	Development and adoption of digitisation		f.4	Failure to maximise on our intellectual assets, through research and development, reduces our ability to reinvest in the delivery of our clinical strategy to improve the experience and outcomes for service users.
4.2	Digital Strategic Development & Delivery		14	Cyber security		f.5	Failure to realise the opportunities from the acquisition of North West Boroughs and in so doing miss the opportunity to create an at-scale provider of outstanding integrated physical and mental health services for the community.
			15	Subsidiaries companies and Joint Venture			

Appendix 2 – Corporate Risks and High Scoring Divisional Risks

Ref	Description	Severity	Likelihood	Risk Rate Score	Directorate	Review Date	Next Review Date	BAF Link(s)
Corporate Risk Register								
2641	Condition: There is a significant risk to the dietetic service and delivery of patient care at LWH	4 Major	5 Almost Certain	20	Clinical Support Service	12/09/2023	12/10/2023	1 & 2
2087	Condition: Uncertainty about provision of a safe Maternity service able to give more effective interventions with 24/7 Consultant presence on Delivery suite and sufficient consultant cover for 10 elective caesarean lists per week and high-level MAU cover.	4 Major	3 Possible	12	Maternity	07/09/2023	07/12/2023	1, 2 & 3
2469	Condition: Allocation of resources to carry out water safety checks and maintenance has failed to achieve required targets despite prioritising this work and reducing resources for other tasks - see risk 2274.	3 Moderate	2 Unlikely	6	Facilities & Estates	12/07/2023	12/10/2023	2
2301	Condition: There is both an operational and a financial risk related to the position in relation to contracts and SLAs for services provided to and by the Trust.	4 Major	3 Possible	12	Financial Services	12/08/2023	12/11/2023	5
~~2649~~	~~Condition: There is little evidence to support Audim audits are being undertaken as required in line with National Standards of Healthcare Cleanliness (2021)~~	~~3 Moderate~~	~~3 Possible~~	~~9~~	~~Governance IPC~~	~~28/06/2023~~	~~28/07/2023~~	~~3~~
2329	Condition: There is a risk to the Trust is not meeting it requirements for the safe and proper management of medicines	4 Major	3 Possible	12	Pharmacy	24/09/2023	24/10/2023	2
1966	Condition: Risk of safety incidents occurring when undertaking invasive procedures.	4 Major	3 Possible	12	Governance	13/09/2023	14/09/2023	2
2085	Condition: Uncertainty around access to dedicated diagnostic capacity and physiological measurement needed to support needs of a changing patient demographics and an increase in complex multiple co-morbidities, and meeting the pre-operative assessment standards of the Association of Anaesthetists of GB & Ireland (AAGBI) and the Royal College of Anaesthetists (RCoA), to asses patients' clinical risk and plan for additional requirements for their safety and provide an optimal experience.	4 Major	3 Possible	12	Theatres & Anaesthesia	18/05/2023	16/08/2023	2
2232	Condition: There is a risk that due to a number of causes the Trust is unable to meet the safety requirements related to Blood Transfusion	5 Catastrophic	3 Possible	15	Pathology	23/08/2023	23/11/2023	2
2491	Noncompliance with mandated level of fit mask testers qualification, accreditation and competency.	5 Catastrophic	3 Possible	15	Governance	21/08/2023	21/10/2023	1
2488	Condition: Failure to meet clinical demand for red blood cells	3 Moderate	3 Possible	3	Clinical Support Service	12/07/2023	12/10/2023	2
2296	Condition: The LWH laboratory autoview analyser (the machine used to process Blood Group and Save samples on site) will no longer be supported as of 1st march 2020. This machine cannot continue to be used after this date.	3 Moderate	3 Possible	12	Pathology	03/07/2023	01/01/2024	2
2603	Condition - Current Intranet in poor condition and no longer fit for purpose.	3 Moderate	3 Possible	9	Human Resources	14/08/2023	14/12/2023	4
1704	Effective management systems are not in place or sufficient to ensure all employees complete and keep up to date with their mandatory training requirements.	4 Major	3 Possible	12	Human Resources	21/06/2023	19/09/2023	1
2549	Condition: Staff shortages in the Ultrasound Team within the Imaging Department due to Vacancies and 5 staff members leaving in May & June 22	4 Major	4 Likely	16	Clinical Support Service	03/07/2023	01/10/2023	1
2086	Condition: Uncertainty about provision of adequate on-site Blood bank stocking all major blood products necessary to support the needs of the Maternity service.	3 Moderate	3 Possible	9	Maternity	30/05/2023	28/11/2023	2
2321	Condition: Due to the Trust not being located next to or with acute services, it is unable to meet the National Recommendations for Maternal Medicine.	4 Major	3 Possible	12	Maternity	13/09/2023	13/11/2023	2
1635	Risk of delays to treatment due to significant problems with the junior doctor rotas- vacancies and maternity leave. This is placing severe strain on the ability to fulfil the on-call rota as well as covering in hours duties. There is an increased reliance on locums, causing financial pressures. The risk include potential gaps in the rota which may put patients at risk, regular	4 Major	4 likely	16	Human Resources	05/05/2023	24/09/2023	1, 2 & 5

	locum use which may result in potential compromise to the quality of the service provided and risk to the training provision of junior doctors if they are being moved around to fulfil the basic rota.							
2084	Condition: Uncertainty of adequacy of 24/7 access to specialist input to support changing patient profiles and needs, new guidance and the Chief Medical Officer's recommendation of the specialist multidisciplinary team approach to treatment planning and co-ordination, including pre-operative, surgical and up to level 3 post-operative care for improved patient safety and improved outcomes.	2 Minor	3 Possible	6	Gynaecology	05/07/2023	05/10/2023	1, 2 & 3
2088	Condition: Lack of on-site specialist staff and services	4 Major	3 Possible	12	Neonatal	06/09/2023	06/10/2023	1 & 2
2323	Condition: The Trust is currently non-compliant with standards 2,5,6 of the seven-day service standards	5 Catastrophic	3 Possible	15	Governance	18/04/2023	18/10/2023	2
2395	Condition: Ambulatory gynaecology demand is exceeding current capacity	3 Moderate	5 Almost Certain	15	Gynaecology	07/08/2023	07/10/2023	2
2606	Failure to comply with national infection trajectory specifically in relation to E. coli bacteraemia	2 Minor	5 Almost Certain	10	Governance	13/09/2023	13/09/2024	2
2607	There is a risk of disruption to services as a result of industrial action from a number of trade unions in relation to matters relating to pay and conditions of service. The RCN are the first union who have undertaken a ballot for industrial action which closed on 2nd November 2022, 97% of members voted in favour (167 nurses). Industrial action is expected to begin before the end of this year and the RCN's mandate to organise strikes runs until early May 2023, six months after members finished voting. Ballots for other unions are due to take place on the following dates -GMB 24th October - 29th November -Unite 26th October-30th November -Unison 26th October- 25th November -CSP 7th November- 12th December -RCM 11th November- 9th December -BMA- Early January There an indication that unions may take the decision to co-ordinate strike action which would heighten the potential disruption to services at LWH. Exemptions and derogations are to be agreed at a local level, if these are in line with previous years, maternity and neonatal services would be exempted, some activity across gynaecology and fertility will be stood down. We are working in partnership at a system level to agree a shared approach to managing industrial action, as well as ongoing liaison with our staff side colleagues. Additional Risk Update 28/04/2023 Confirmed RCN strike action planned between 20:00 30.04.2023 and 01.05.2023 23:59, Gynaecology and Neonatal Services enacting Business Continuity Plans due to staffing and the potential for the Trust to declare a Major Incident to NHS England. Additional Risk Update 5/5/23 RCN action took place on 30th April and 1st May. Trusts had been informed that no derogations would be agreed on a national level. On 30th April a safety critical mitigation was agreed for the Neonatal Unit and staff were called back in to work to maintain patient safety. The National Pay Award has now been agreed by the NHS Staff Council. The RCN and Unite unions did not agree the pay deal . The RCN will ballot its members for further industrial action later this month. Unite has said the council's vote will not affect action it has planned. In respect of Junior Doctors, the BMA undertook industrial action from 11th to 15th April. Services were maintained due to consultants acting down and support from advanced nursing staff. The BMA will ballot NHS Consultants in England for strike action from the 15th May	4 Major	3 Possible	12	Human Resources	18/08/2023	18/09/2023	1

~~2708~~	~~The Child Protection Information Sharing (CPIS) System is not being accessed for every unplanned care attendance anyone aged under 18 or all pregnant women. This will lead to children, young people and unborn infants not being identified as being on a child protection plan or being a looked after child.~~	~~3 Moderate~~	~~4 Likely~~	~~12~~	~~Safeguarding~~	~~05/07/2023~~	~~04/08/2023~~	~~2~~
2709	Families and children are at risk of not receiving a co-ordinated approach to early help. The trust is not in a position to evidence early help work undertaken by Front Line Staff leading to the LA and Safeguarding Children Partnership Board raising concerns against the Trust that multi agency policy is not being appropriately implemented.	3 Moderate	3 Possible	9	Safeguarding	07/09/2023	07/12/2023	2
2710	Safeguarding information contained on Bulletin Board within Meditech and the associated safeguarding flags cannot be migrated onto Digicare. This will lead to front line staff being required to check the old system when patients attend and transcribe information onto new record. This is open to human error risk.	4 Major	3 Possible	12	Safeguarding	01/08/2023	04/01/2024	2
2726	Lack of administration, analyst and surveillance support for IP&C Team due to an open vacancy since 19/05/2023. Risk of compliance in regards to the Hygiene Code for the provision of suitable accurate information on infections (reporting locally, to ICB and into the HCAI DCS system)	2 Minor	2 Unlikely	4	Infection Control	06/09/2023	06/10/2023	2
High Scoring Divisional Risks								
2722	Condition: There is a risk to the division being overspent against budget due to unfunded cost pressures identified as part of the annual planning process.	4 Major	4 Likely	16	Clinical Support Services	02/10/2023	31/12/2023	5
2735	Condition: Lack of emergency call bells in part of the Imaging department.	5 Catastrophic	4 Likely	20	Clinical Support Services	18/09/2023	18/10/2023	2
2178	Condition: Lack of a robust system to ensure that ultrasound scanning performed by non-Sonographer practitioners is monitored and reviewed/audited and appropriate subsequent action taken.	5 Catastrophic	4 Likely	20	Clinical Support Services	02/10/2023	31/12/2023	2
2724	Condition: 20-minute appointment slots at dating scans is insufficient for all required duties. Out of area patient's growth charts and care summary reports not generated.	3 Moderate	5 Almost Certain	15	Clinical Support Services	27/09/2023	26/12/2023	2
2728	Cause: Current ambulatory estate is insufficient to meet demand for ambulatory activity	4 Major	4 Likely	16	Corporate Services	/ /	/ /	2 & 7
2572	Condition - there is a lack of strategic leadership and robust procedures to ensure the safety of people and assets within the Crown Street and Knutsford sites.	4 Major	4 Likely	16	Corporate Services	06/09/2023	06/10/2023	2
2598	Condition: Risk relating to the Trusts Emergency Response	5 Catastrophic	3 Possible	15	Corporate Services	22/06/2023	20/09/2023	2
2599	Condition: Risk relating to the Trusts Internal Security (Premises)	5 Catastrophic	3 Possible	15	Corporate Services	22/06/2023	20/09/2023	2
2604	Condition: Risk relating to Trust Security Systems	5 Catastrophic	3 Possible	15	Corporate Services	06/09/2023	06/10/2023	2
2743	In ability to comply with National guidance for the management of women with pre-existing and pregnancy related diabetes leading to poor outcomes and failure of implementation of SBL3	4 Major	4 Likely	16	Family Health	/ /	/ /	2
2732	Following the CQC review (January 2023) it was again identified and highlighted within the CQC initial report regarding the lack of medical cover out of hours within GED.	4 Major	4 Likely	16	Gynaecology	13/10/2023	12/11/2023	1 & 2
2725	The division have identified cost pressures of approx. £2.35m that are unfunded for 2023/24. This is now a significant pressure to the division and the overall Trusts financial position. A large proportion of the pressures are staff already in substantive roles (for several years) and further inflationary costs.	4 Major	4 Likely	16	Gynaecology	11/09/2023	10/11/2023	5
2485	Condition: Limited access to MRI scan (currently 5-6 weeks wait) needed for cancer patient pre treatment (both surgical and radiotherapy treatment). MRI requested and undertaken at CCC as per pathway, as expertise in reporting is there and feeds into specialist MDT. Of note MRI added into clinical pathway as part of BGCS stratification for surgery during the first wave of COVID pandemic - this is considered best practice.	4 Major	4 Likely	16	Gynaecology	/ /	/ /	2 & 7

Changes to Risk Summary (Quarterly)

Closed risks

Since the last meeting in July 2023, 2 risks have been removed register and closed. The following risks are highlighted to the Sub Committee for approval.

1. Risk 2649 Infection Prevention and Control

Condition: There is little evidence to support Audim audits are being undertaken as required in line with National Standards of Healthcare Cleanliness (2021)

Cause: The undertaking of Audim audits is via OCS contract. The workforce within OCS has been reduced due to vacancies that remain unfilled and further reduction due to sickness in existing team

Consequence: Potential for breaching Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) and Regulations 2014 which requires that healthcare premises be clean, secure, suitable and used properly and that a provider maintains standards of hygiene appropriate to the purposes for
which they are being used.

a. Rationale for closure:

Following the IPC assurance Committee on 28/7/23 the group are assured that Audim audits are now being undertaken at the frequency recommended in line with Trust Policy and National standards of Healthcare Cleanliness (2021) using the joint monitoring system.

b. Closed 09/08/2023 as achieved.

2. Risk 2708 Safeguarding

The Child Protection Information Sharing (CPIS) System is not being accessed for every unplanned care attendance anyone aged under 18 or all pregnant women. This will lead to children, young people and unborn infants not being identified as being on a child protection plan or being a looked after child.

a. Rationale for closure:

Following implementation of Digi care, CPIS check is automated pending age or identification of pregnancy. Review of the system has identified it is working and CPIS checks are occurring.

b. Closed 01/08/2023 as controlled.

New risks

Since the last meeting in July 2023, 1 risk has been added to the register. The following risk is highlighted to the Sub Committee for approval.

1. Risk 2726 Infection Prevention and Control (Version 1)

Lack of administration, analyst, and surveillance support for IP&C Team due to an open vacancy since 19/05/2023. Risk of compliance regarding the Hygiene Code for the provision of suitable accurate information on infections (reporting locally, to ICB and into the HCAI DCS system)

a. Rationale for escalation: Identified and escalated on 19/07/2023 following the meeting of the Infection Prevention and Control Group.

Contingency - Kate Hindle to support IP&C Team with admin duties in interim until candidate appointed for job and in place.

Appendix 3 - Risk Descriptors

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long- term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on many patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards

Human resources/organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day)	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days)	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff
			Low staff morale Poor staff attendance for mandatory/key training	Loss of key staff Very low staff morale No staff attending mandatory/ key training	No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10– 25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met

Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Likelihood score (L)

What is the likelihood of the consequence occurring?
The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	***23/24/188***		**Date: 09/11/2023**	
Report Title	**2023/24 Operational Plan 6-month update**			
Prepared by	***Gary Price, Chief Operating Officer***			
Presented by	**Joe Downie, Deputy Chief Operating Officer**			
Key Issues / Messages	***This paper is for the Trust Board to be appraised of progress to date against the 2023/24 operational plan***			
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): NA			
	For Decisions - in line with Risk Appetite Statement – Y/N *If no – please outline the reasons for deviation.*			
	The Board is asked to note progress on the operational plan to date and to continue to receive assurances on specific areas of challenge.			
Supporting Executive:	**Gary Price, Chief Operating Officer**			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

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

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

Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* N/A	Comment:

EXECUTIVE SUMMARY

The purpose of this report is to update the Committee on progress to date on the 2023/24 operational plan.

The operational plan 23/24 supports year 2 of the 5-year clinical strategy. The purpose of the clinical strategy is to support the Trust to achieve our strategic aims.

The Trust Board, via the subcommittees receives regular updates on Trust business through the normal assurance cycle. This paper is to summarise progress to date and highlight the key areas of focus for the 2nd half of the operational year.

For 2023/24 each clinical Division has updated their progress on their operational plan. A summary for each Division is included in Appendix 1. Summary narrative is also included in the main report.

Progress to date is overall positive, however challenges remain. These challenges largely relate to balancing the triple aim of supporting our workforce and the continued striving for financial efficiency whilst balancing delivering quality and timely care for our patients.

The first half of the year has also been dominated by responding to the challenge of industrial action.

The Board is asked to note progress on the operational plan to date and to continue to receive assurances on specific areas of challenge.

MAIN REPORT

Introduction

The 2023/24 operational plans by Division were taken through Trust Board at the start of the year. The purpose of operational planning is to support the delivery of the Trusts strategic objectives, via the 5-year clinical strategy in a considered and planned manner, whilst also demonstrating progress on the national NHS operational plan requirements.

Most notably for this year the plans concern themselves with recovery from the Covid-19 pandemic whilst also driving the services to be safe for Future Generations in line with the Trust Strategy.

For 2023/24 each clinical division has produced an annual plan which is summarised on their “plan on a page”. This plan considers the Trust objectives, key national performance metrics, the financial envelope, quality service initiatives (including patient experience and reducing waiting times), workforce requirements, key enablers e.g., IT and Estates, plus horizon scanning.

Three improvement programmes have been key to supporting the delivery of the operational plan which are now in year 2. Theatres Improvement, Outpatient Improvement and Maternity Transformation.

The Executive team reviews progress against the operational plans through monthly Divisional performance reviews with each clinical Division. This is supported by key data against performance metrics.

Operational performance of our services is monitored monthly externally mainly through the ICB, Liverpool Place Team and Specialist Commissioners. Key performance metrics are monitored through Access Board which reports to FPBD.

Quarter 2 has seen the most significant operational change Trust wide in recent times in how we deliver clinical care with the introduction of Digicare patient information system. The efforts of the successful implementation demonstrated significant collaboration with Clinical, Operational and Digital Teams and can not be underestimated. The second half of the year will see the journey commence to optimise this implementation that will benefit patients for years to come.

Progress to date

During the first half of 2023/24 all key leadership posts have been maintained in the Divisional Management Teams (Clinical and Operational Leadership). This consistency in leadership supports sustained service improvement. This has been a key enabler to the success in delivery to date against a challenging background. In addition, the commencement of an out of hours site management team has been fundamental in maintaining out of hours grip and safety on our services.

The support from the OD team in identifying several leadership development opportunities for the Divisional Management Teams has contributed significantly to retention.

Corporate support to the Divisional Teams has also increased in terms of substantive posts being filled at business partner level and has been well received.

Family Health

During the first half of the year the service has been able to recruit to a full complement of midwives with no vacancies at the time of this report. This is a tremendous achievement against a national shortage of midwives. Our preceptorship programme has received national recognition and undoubtably played a part in recruitment and retention. This contributes to significant reduction in bank and agency usage. Additional new Consultant appointments have been made, however with still more required for 24/7 Consultant cover.

Neonatal occupancy and acuity has been high over the past 12 months and the team has been able to consistently respond with appropriate levels of clinical staffing

CNST Year 4 was successfully delivered, a key quality standard, against a backdrop of approximately ½ Trusts achieving this nationally.

The Children Growing Up in Liverpool (CGUL) study has formally commenced in partnership with the University of Liverpool with our Maternity and Obstetric teams providing significant input. This is a major opportunity for the profile of the City of Liverpool and the research outcomes that will be of international interest.

Family Health has begun to see the benefit of the appointment to the new post of Director of Midwifery with increased raising of our profile regionally and nationally.

A key focus in the response to our January 2023 CQC assessment of Maternity services has been the acceleration of our focus on improving triage times. Our triage times have since remained consistently high and are amongst the best in the country.

Estates and Facilities are enabling a successful response to improving clinical flow through the planning of a new Induction of Labour Suite that will be delivered in the second half of the year.

Informatics has played a key role in the first half of the year in enabling a focus on flow by using real time data, particularly around Induction of Labour and Maternity Flow. The Trust continues to Chair the Cheshire and Mersey regional Maternity Escalation cell that looks to support the system in times of pressures, as has been seen through industrial action. The learning from this cell has been shared with ICS patches outside of the Northwest.

Progress on the Liverpool Neonatal partnership remains positive with the Medical Director as SRO and the Board continues to receive regular updates.

The Maternity Transformation Board oversees all key Maternity activities and considers the significant national reporting and regulatory requirements including CNST, Ockenden etc. The second half of the operational year will continue to see the Transformation Board developing our services.

Gynaecology and Hewitt

The Gynaecology services is seeking to build on its "good" CQC assessment. Broadly the Gynaecology service has achieved all the national asks to date in terms of elective recovery. This has however been challenged due to industrial action and it is likely that the service would have overdelivered in the first half of the year had it not been for the days lost in planned clinical activity during this period which now equates to over 30 days.

Cancer services are challenged in terms of the ability to meet the 28 day Faster Diagnostic standard. This is driven by an increase to 130% in cancer referrals from previous years. The Trust is in national Tier 2 monitoring for cancer performance. The Trust has a Cancer Improvement Plan which involves the C&M Cancer Alliance. Liverpool Clinical Laboratory, Liverpool Place and Primary Care. The diagnostic backlog has reduced in Q2 as the plan delivers and improvements in Q3 are expected in the 28 day Faster Diagnostic Standard against national trajectories.

It the halfway point in 2023/24 the Gynaecology and Theatre teams have delivered 1000 robotic since the service began in 2021. Most notably delivering 4 major cases as day cases in one day in August making the Trust the first in the North West to achieve this for Gynaecology. In addition, the team continue to work closely with LUHFT performing joint surgical cases on and off site. The team will host the British Gynaecological Cancer Conference in 2024.

As routine waiting times remain high the emergency pathways are under considerable pressure which also compromises elective recovery as resources have to be diverted to more urgent cases. As with other Trusts in the country attendances to Emergency Departments have increased between 5 and 10%. Despite this the 4-hour emergency target has seen sustained improvement and now is consistently in 90% range which places the Trust as one of the best Type 2 emergency departments nationally.

Our Hewitt Fertility services successfully maintained HFEA accreditation for our Crown Street site with planning ongoing for forthcoming inspection of our Knutsford site.

The fertility service has successfully acquired the delivery of Western Cheshire fertility services and continues to grow.

A significant focus in Quality Improvement across the services has seen Bedford service being the first in the Trust to achieve Gold Ward accreditation.

Clinical Support

Our theatre team has benefited from improved staffing from previous years. This has supported improvements in elective recovery and theatre utilization although more is required in the 2nd half of the year. Improving start times and patient experience has been a key focus of this work.

There has been significant work with our partners in Liverpool Clinical Laboratories to improve turnaround times for samples with metrics consistently improving.

The routine diagnostic 6-week standard is ahead of the national recovery trajectory for the year with the target of 90% achieved already.

Our genetics service are one of the only services nationally to have recovered fully to the 18 week national standard.

The Division are in year 2 of Community Diagnostic Centre Delivery with over 20000 scans delivered for the C&M system to support other Trusts with elective recovery. The CDC model has also allowed LWH inpatient scanning to be undertaken for a cohort of cases supporting on site safety and reducing transfers. Work is ongoing to secure the CDC model through 2024/25 and beyond.

Half 2 2023/24

There remain several key pan divisional priorities for the second half of 2022/23. These are:

- Improving the financial position whilst still maintaining a focus on safe staffing and quality care with support of the Programme Management Office to deliver our financial recovery plan.
- Improving Divisional Quality Governance and a focus on Continuous Quality Improvement
- Developing our Partnerships.
- Improving mandatory training and PDR rates
- Dealing with unplanned challenges, e.g., Industrial action
- Further Covid waves/Winter pressures
- Realising the benefits of Meditech expanse

RECOMMENDATION

The Board is asked to note progress on the operational plan to date and to continue to receive assurances on specific areas of challenge.

Family Health: The Last 6 Months…

- Digicare roll out with Division
- Further development of the Liverpool neonatal Partnership and agreement of workforce model
- Refresh of Maternity and Neonatal Transformation plan
- Embedding Physician Associate Role on Maternity Base and Neonatal
- Ongoing 24 hours visiting for partners on Mat Base. Pilot project in the process of being evaluated
- Improved DNA rates for new and follow up maternity & neonatal appointments
- Capacity & Demand & Operational Grip
- Enhanced collaboration between Imaging and FMU
- Estates remedial works concluded on Mat Base, Honeysuckle DS, Antenatal Reception
- ACP's successfully completed course and embedded in their roles in the MAU.
- Appointment to Diabetes Specialist Midwife role, Induction of Labour Midwifery Co-ordinator, Clinical Lead Midwife Midwifery Led Unit and additional Fetal Surveillance midwife, Maternal Medicine Midwife post.
- Allocation of midwife to administer medication on each shift on Mat Base (Maternity Ward).

Family Health: The Next 6 Months…

- Training of Medics and Midwives for Midwife Facilitated Discharge (MFD)
- Work with MNVP to explore how service users can be involved in patient complaint process
- Service review and evaluation, Maternal Medicine, Diabetes, FMU
- Conclude IOL/MLU Estates work
- Deliver CNST Year 5
- Participate in NHSE Perinatal cultural workshops
- Theatre Utilisation programme Obstetric theatres
- Outpatient Transformation – Synertec
- Finalists Nursing Times Workforce summit and awards - Preceptorship programme of 2023
- Collaboration with LCC Family Hubs/ Start for life Programme
- Review of services to see what can be delivered as part of Liverpool One project at St Chads
- SBLv3

Clinical Support Services: The Last 6 Months…

- **CDC – operational static MRI and CT**
- **DigiCare implementation and safely managing Industrial Action**
- **Theatres international recruitment and induction, Physio rotational posts**
- **Enhanced collaboration between Imaging and FMU**, e.g. uterine artery doppler pathway
- **Overachieving on all HR KPIs compared to the overall trust average**
- **North West first**: high-intensity major robotic list completed Saturday 16th September
- **Estates - Obstetric theatres staff room & Imaging on-call room**
- **Medical: Anaesthetic Specialty and Specialist recruitment, locum Genetic Consultant appointment**
- **Dietetics SLA review, Pathology service specification refreshed**
- **Performance: sustained 6-month improvements in capped theatre utilisation, DM01, Genetics RTT and workforce KPIs**

Clinical Support Services: The Next 6 Months…

Workforce: Review of trainee/apprenticeship roles and supporting educational roles for ongoing workforce improvement. Introduction of Leadership Passport to support development of new/existing leaders. Further 'grow your own' models in Imaging and Physio. Continue with recruitment and retention for imaging. Medical: ongoing Anaesthetics recruitment with Associate Practitioner review.

Governance & Quality: Clinical Audits, QI project per service, CQC self-assessment, Ockenden, BBAS accreditation. Divisional Governance action plan and calendar. Anaesthetic Clinical Service Accreditation.

Service Expansion: CDC – approval and operationalising of third service, Dietetics SLA Phase II, 24/7 robotic lab cover, electronic ordering and resulting. Operationalise Radiometer Blood Gas Analysers.

Key decisions: CDC/Imaging partnership with LUHFT, Laboratory SLA negotiations,

Contracts & Finances: full Contracts/SLA breakdown across relevant divisions – Pathology SLAs to be complete by the end of financial year.

Recovery: acceleration of **Theatre Utilisation Programme** through Theatre PMO Workstream, **capacity and demand modelling across all services, management of capital and contracts that span across all divisions. Performance: sustain recovery trajectories in capped theatre utilisation, DM01, Genetics RTT and workforce KPIs.**

Collaboration: Further review of services and rotational posts in Anaesthetics, Dietetics, Pharmacy, Physiotherapy and Genetics, further collaboration with LUFHT on Pathology transformation, Imaging, Dietetic and Pharmacy services. Cross-divisional working with Family Health and Gynae to support shared objectives. Partnership working with CAMRIN, C&M Pathology Network, local Specialist Trusts and the Genomic Medicine Service Alliance.

Gynaecology & Hewitt: The Last 6 Months…

- Digicare roll out within Division
- Excellent CQC report
- Newly qualified ANP's integrated into the service.
- Positive HFEA feedback
- Full engagement with WHAM – 3 LWH Consultants regional chairs for specialist interests
- Cancer recovery plan implemented
- Improved DNA rates for new and follow up
- Capacity & Demand & Operational Grip
- Enhanced collaboration between divisional teams
- Continue elective recovery
- Activity Plan on target

Gynaecology and Hewitt: The Next 6 Months…

- Work towards GIRFT delivery plan
- Job Planning and Annual Plan 2024/25
- Continued CIP identification and delivery
- Transfer of Fertility activity from West Cheshire
- Eliminate all patients waiting over 65 weeks for elective care
- Continue with the Hewitt Transformation work
- Theatre Utilisation programme
- Outpatient Transformation
- Continued development of Women's Health Strategy
- Review of services to see what can be delivered as part of Liverpool One project at St Chads
- Review of gynaecology emergency services

Trust Board

COVER SHEET

Agenda Item (Ref)	***23/24/189***		**Date: 09/11/2023**	
Report Title	**Integrated Governance Assurance Report Quarter 1 2023/24**			
Prepared by	***Allan Hawksey Head of Risk and Safety***			
Presented by	***Phil Bartley, Associate Director of Governance and Quality***			
Key Issues / Messages	This report provides information of oversight and assurance monitoring of Integrated Governance and highlights key risks to the Trust.			
Action required	Approve ☐	Receive ☐	Note ☒	Take Assurance ☒
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable):			
	For Decisions - in line with Risk Appetite Statement – Y *If no – please outline the reasons for deviation.*			
	It is requested that the members of the Board review the contents of the paper and take assurance that there are adequate governance processes in place and the positive progress in managing risk has been made with Senior Management having oversight of such risks.			
Supporting Executive:	***Dianne Brown, Chief Nurse***			

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

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

EXECUTIVE SUMMARY

The following Integrated Governance Assurance report covers Quarter 1 of 2023/24. The report is part of the regular reporting schedule of the Trust to ensure that there is oversight and assurance monitoring of Integrated Governance across the Trust.

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

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

- Incident reporting within the Ulysses system continues to increase across all Divisions reflecting staff awareness of what constitutes an incident supported by ongoing training within the system from the Corporate Team. **There have been no Serious Incidents declared as a result of potential / perceived incident under reporting. There was a slight decrease of 67 incidents from Q4 and this position will be monitored by the Corporate Governance Team. Of the 1762 patient safety incidents reported during Q1, there were 39 near misses, 1381 no harm incidents and 301 low / minor harms. There were 13 moderate harms, 2 severe and 1 death caused by a patient safety incident. This incident is subject to serious incident investigation and remains ongoing.**
- A key area of risk for Q1 related to a significant number of PACS and CRIS imaging incidents whereby imaging reports and images were not being fully completed and closed. **PACS and CRIS imaging incidents have reduced, due to real time audits having been recommenced and directed support / education from the Imaging Team to resolve areas of non / poor compliance. This has also reduced the potential risk of a significant delays in potential diagnosis and the potential for harm to occur.**
- Since Q4, the number of medication incidents reported has decreased by 6 incidents to 145. Members of the Medicines Safety Group (MSG) continue to encourage the reporting of medication incidents so The Trust can learn from these incidents and prevent patient harm. This includes recognising and reporting near misses. **Of the 145 incidents, 139 were classified as patient safety incidents. There were no incidents classified as moderate harm or above. In relation to medication administration, 49 or the total 61 incidents identified potential for improvement. 21 incidents resulted in informal discussion and 9 in further teaching / training.**
- In Q1, there were 35 non-clinical health and safety related incidents reported, an increase of 12 incidents from the previous quarter. The majority of incidents were reported by Maternity, with Gynaecology, Neonates, Clinical Support Services and Corporate function reporting between 3 and 8 incidents. **All incidents were appropriately managed, and all processes were followed.**
- Appointments and difficulties in contacting the trust about these continue to be prevalent themes in the PALS cases received by the Trust. Patients are all aware nationally of the waiting lists across the NHS and that fear of not getting their own appointment is leading to an increase in more forceful queries being raised to try and expedite their own case. **Divisions are continuing reviewing appointment capacity and increasing weekend appointment slot. There has also been a launch of a text messaging system to remind patients of their appointments slots with the opportunity for patients to respond and to either confirm or cancel and reduce non-attendance.**
- The Trust received 10 Clinical Audit Reports including Action Plans in Quarter 1. Examples of outstanding practice were appropriate categorization of OHSS cases were made, with all severe cases receiving LMWH and being reported to HFEA. 100% of Turners Syndrome patients were referred to and seen by Cardiology. The HLRCC re-audit enabled us to further protect the health of at-risk individuals by informing

known pathogenic FH variant carriers of the latest surveillance guidelines and enabling them to better communicate the associated risks and screening advice to their relatives. 100% of Domestic Abuse cases contained evidence of requesting partner/alleged perpetrator details. Full assurance has also been given regarding the completion of safeguarding referrals, risk assessments and safety. Where audits have determined that the level of expected standards have not been met, there are significant divisional action plans formulated to address issues highlighted. **All audits are reviewed by the Quality Improvement Group (QIG) and actions either approved or amended and updated where required. These are divisionally led and monitored by the Continuous Improvement Team (CIT). The outcome of such action plans is subsequently reported back in to QIG where a further audit may be required. There is considerable oversight of all audits by QIG and the CIT. There is a proposal in development which will seek to improve performance and accountability through a revised escalation process. The proposal will ensure there is improved divisional reporting and less reliance on administrators within the CIT to prompt leads when audits are at risk of missing key milestones.**

- The work with AQUA has continued throughout Q1 in preparation for a roll-out of learning and development over the course of the year. Plans are in place to provide access to a range of learning programmes for staff across the Trust. This increase in capacity and capability will be supported by a revised project proposal process and associated paperwork to ensure we do not inadvertently inhibit improvement activity. Improvement projects will be required to demonstrate a clear link to safety, strategy, and Trust' priorities. The concept of continuous improvement will be increasingly promoted to ensure we are best placed to maximise the impact of our increased capacity and capability. **The team will maximise the opportunities for learning and efficiencies afforded by engagement with local networks. They will make more efficient use of the limited resources available to the team through a review of key processes and a greater focus on accountability for project leads.**
- As of 30 June 2023, there were 164 active, "open" claims. 159 Clinical claims, 4 non-clinical claims and 1 class action case. **The 2023 Trust scorecards have been released and a deep dive review of these claims alongside the GIRFT claims data are being analysed for the purpose of producing a report to embed into the Trust lesson learning processes. Legal Services are arranging for NHS Resolution to present the scorecard to the divisions in October 2023.**
- Divisional FFT "you said, we did" reports are now a standing item on the Patient Involvement and Experience Subcommittee. This enables greater visibility and promotion of the improvements being implemented from the FFT and allows this learning to be shared across the various divisions who attend this meeting. **A number of these reports are detailed within the patient experience section of the report**
- There were 8 serious incidents declared to the Integrated Care Board (ICB) during Q1 (**a decrease of 6 from Q4) – 2 in April 3 in May and 3 in June. There were 17 SI's submitted in Q1.**
- Whilst the Trust ongoing action plans are not currently externally reportable, the Ulysses System is now being used more effectively to manage divisional action plans. All action plans are updated on to the system following SI submission to the ICB and are monitored Divisionally and Corporately for compliance and reported to the Safety and Effectiveness Sub Committee monthly. **As of 30 June 2023, there were 8 out of 23 ongoing action plans that had actions overdue (5) or not added to Ulysses (3). These were subsequently escalated to all Heads, Divisional Managers and Safety Leads to action and all Divisions agreed to have a plan in place to resolve overdue actions which will be monitored via Divisional Governance meetings in addition to the Safety and Effective Sub Committee.**
- There remains ongoing work across all Divisions via their integrated governance reports, with a particular focus on Maternity and Gynaecology to be able to demonstrate:
  Key areas of risk affecting patient safety and quality of services
  Divisional plans to manage and mitigate those risks

Evidence of embedded learning Divisionally and cross Divisionally

Audit of embedded learning within 6 months of learning being identified (As per Ockenden within Maternity but that expectation is across all Divisions) and how assurance is gained, 6 months, 12 months and beyond that learning is embedded, practice and culture has changed and there is clear tangible evidence of improved patient safety outcomes

This report does not reflect the associated risks in relation to the Trust's Future Generations Strategy. Work is on-going between governance, patient experience, finance & transformation & strategy which may support further additions to this paper throughout 2023/24 and beyond in relation to this piece of work.

The Board is requested to note the contents of the paper and take assurance that there are sufficient governance processes in place consisting of divisional and corporate oversight to mitigate and manage risk and to take assurance that ongoing feedback provided by the Quality Committee following the previous reports has been acted upon and the additional information requested has been incorporated into the latest report.

MAIN REPORT

INTRODUCTION

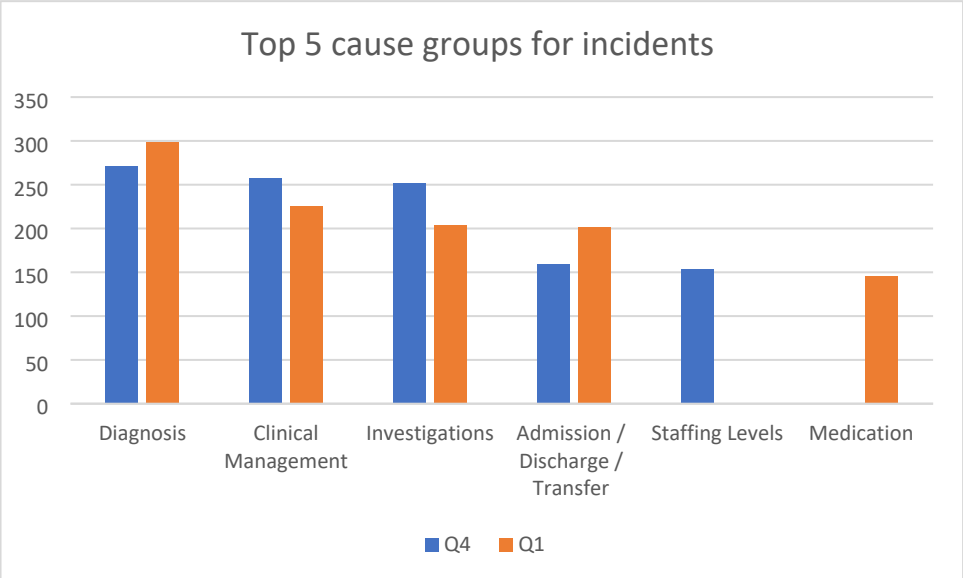
This integrated governance report is a quarterly integrated review of quality governance and the standard of care at Liverpool Women's Hospital. The intention of the report is to complement the monthly quality governance dashboards and performance reports by providing a longer term, thematic analysis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

KEY THEMES AND AREAS OF RISK ACROSS THE TRUST

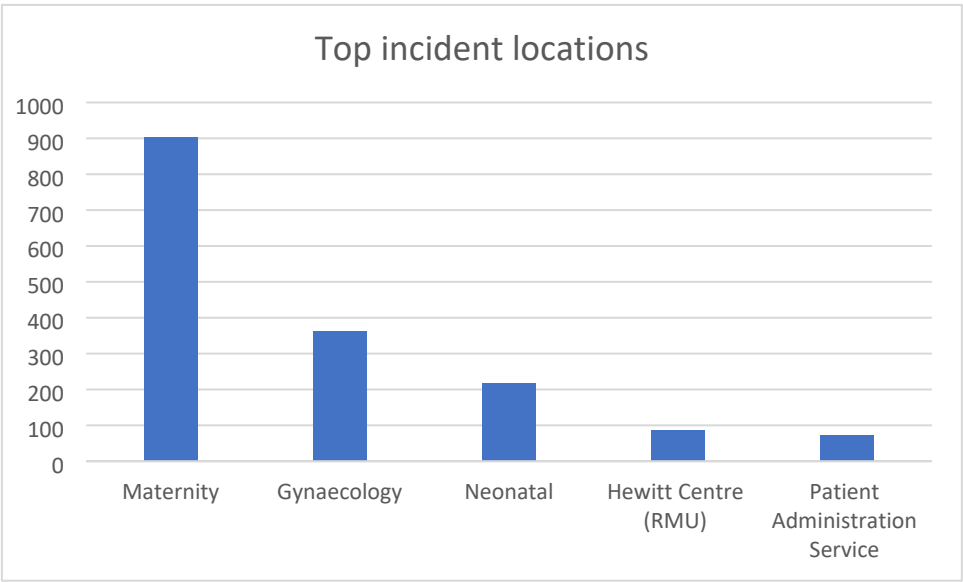
1. Incidents

HEADLINE - A key area of risk for Q1 was within the diagnosis cause group (298) relating to diagnosis delay / failure to (229), PACS / CRIS issues (59), diagnosis missed (6), diagnosis wrong (2) with 179 in Gynaecology (including Hewitt) and 105 in Maternity.

- 1937 reported in total
- Decrease of 67 incidents compared to Quarter 4 22/23



	Q4	Q1
Diagnosis	271	298
Clinical Management	257	225
Investigations	252	204
Admission / Discharge / Transfer	159	201
Staffing Levels	154	
Medication		145



Maternity	904
Gynaecology	363
Neonatal	217
Hewitt Centre (RMU)	86
Patient Administration Service	73
Grand Total	**1643**

Total number of incidents reported across Q1 for 2023/24 compared to 2022/23 and 2021/22.

2021-22	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Total	557	636	498	510	468	835	597	718	577	686	657	657	**7396**
Quarterly	**1691(>279)**			**1813 (>122)**			**1892 (>79)**			**2000 (>108)**			**(>2626)**
2022-23	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**total**
Total	641	693	500	700	658	627	849	665	509	616	653	735	**7846**
Quarterly	**1834 (<166)**			**1985 (>151)**			**2023 (>38)**			**2004 (<19)**			**(>450)**
2023-24	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**total**
Total	502	658	777										**1937 to date**
Quarterly	**1937 (<67)**												

Patient Safety Incidents

1762 total PSI for Q1 (Trust wide) and a decrease of 153 when compared to Q4

Family health (1069))	Gynae (Inc HFC) (473)	CSS (165)
Clinical management 165	Diagnosis 175	Investigations 24
Adm / Disch / Trans 155	Appointments 57	Clinical management 21
Investigations 142	Adm / Disch / Trans 35	Communication 21
Medication 103	Investigations 34	Medication 15
Diagnosis 103	Clinical management 34	Patient records / identification 15

Analysis of the key themes (PSI)

- Diagnosis – 283 incidents across all divisions

Diagnosis - Delay / Failure To	216
PACS / CRIS Issues	57
Diagnosis - Missed	6
Diagnosis Appropriate	2
Diagnosis - Wrong	2

Note – PACs and CRIS accounted for 255 incidents in total when the incident narrative has been reviewed including the 57 Cause Group 1 PACS / CRIS issues

- Clinical Management – 222 incidents across all divisions

Failure To Follow Clinical Guidelines	37
Failure To Follow Clinical Pathway	32
Delay In Medical Review On The MAU	20
Third Degree Tear	15
Treatment / Procedure - Delay/Failure	12

- Investigations – 201 incidents across all divisions

Inadequately Labelled Sample	109
Incorrect Details on Report - Investigations	19
Haemolysed Sample	16
Inappropriate Labelling	9
Test Not Performed	7

- Admission / discharge / transfer – 195 across all divisions

Term Baby Admitted To Neonatal Unit	52
Unplanned Admission	22
Unplanned Admission-Specialist Care Unit LWH	17
Admission - Planning Failure	16
Transfer - Delay	13

- Medication – 139 across all divisions

5 Medication Administration	61
4 Medication Prescribing	37
2 Medication Storage	20
3 Medication Dispensing (Pharmacy)	17
1 Medication Advice	3

Improvements and actions

Trust Wide – A key area of risk for Q1 related to a significant number of PACS and CRIS imaging incidents whereby imaging reports and images were not being fully completed and closed. **PACS and CRIS imaging incidents have reduced, due to real time audits having been recommenced and directed support / education from the Imaging Team to resolve areas of non / poor compliance. This has also reduced the potential risk of a significant delays in potential diagnosis and the potential for harm to occur.**

2. Medicines Safety

HEADLINE - Three new risks were added to the Medicines Management risk register following the CQC visit in January. These related to the following.

- There is a lack of assurance of compliance with Trust oxygen guidance because there is no regular audit review of oxygen prescriptions across the Trust – **Risk approved at MMG. Risk owner Deputy Chief Pharmacist (DCP). Risk target date is 30/09/2023 and the risk has 2 ongoing actions currently being managed by the DCP**

  Q1 update - Audit data collection undertaken across Maternity and Gynaecology for oxygen prescriptions. Report to be completed for MMG meeting. Initial discussions with NICU about oxygen and medical gas prescribing for babies on unit. Staff use functionality on Badger to document administration.

- There is a lack of assurance that all inpatients in an acute setting have a reconciled list of their medicines within 24 hours of admission because there is inaccurate performance information for medicines reconciliation rates across the Trust and no regular audit review - **Risk approved at MMG. Risk owner Deputy Chief Pharmacist (DCP). Risk target date is 30/09/2023 and the risk has 4 ongoing actions currently being managed by the DCP**

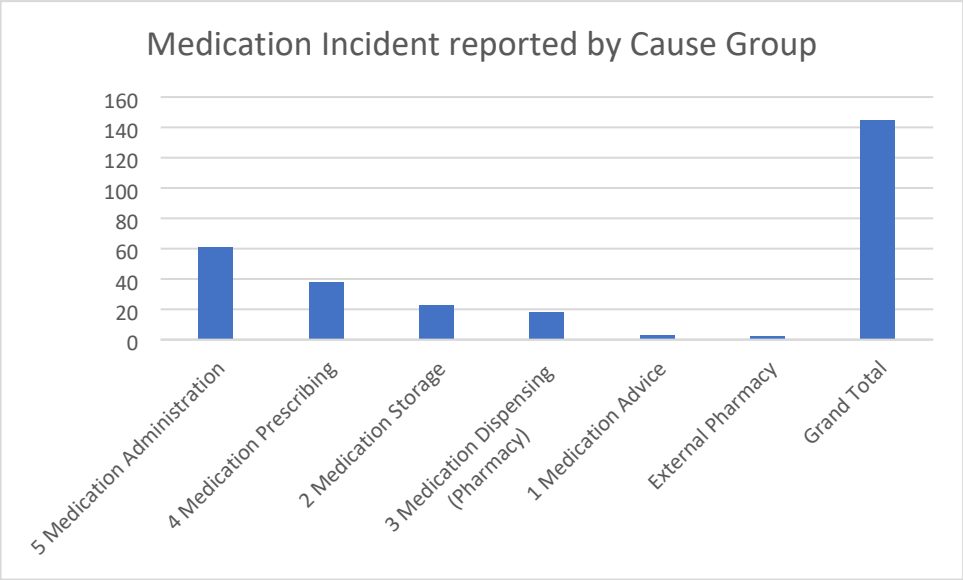
Q1 update - Initial meeting with BI regarding accuracy of current KPI for meds recs and wider use on Matbase. Plan for annual audit of meds recording rates across Gynaecology and Maternity.

- There is a lack of assurance that patients who are prescribed treatments for medical termination of pregnancy do not receive their medication as intended because patients who are undergoing early medical termination of pregnancy do not receive follow up communication from the external pharmacy provider to ensure compliance with prescribed treatments - **Risk approved at MMG. Risk owner Deputy Chief Pharmacist (DCP). Risk target date is 30/09/2023 and the risk has 2 ongoing actions currently being managed by the DCP**

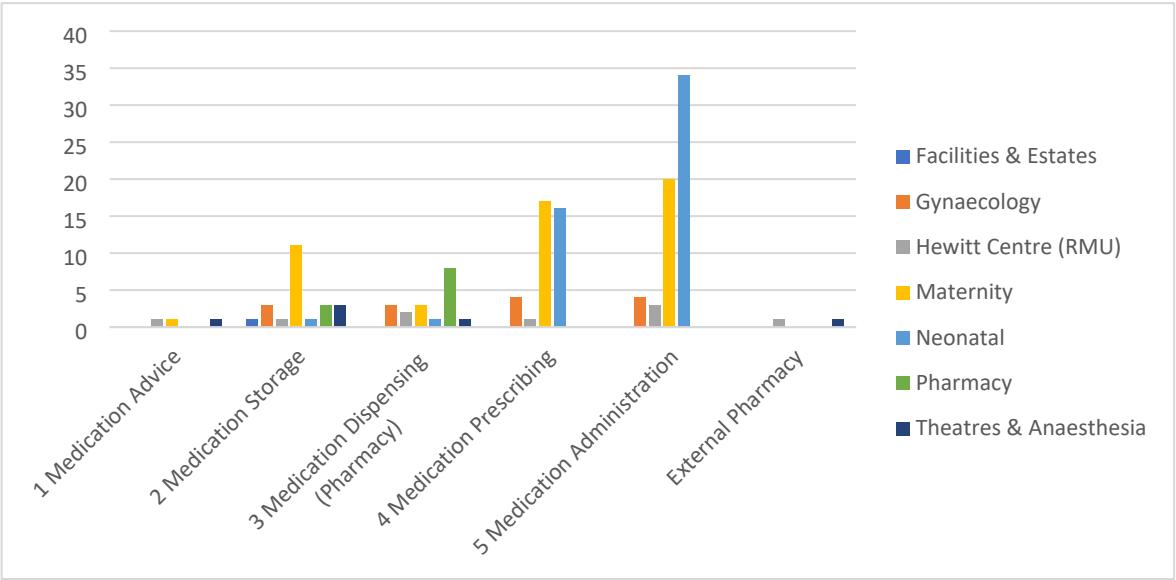
Q1 update - SLA review meeting on 8th June with Dial a Chemist staff. New superintendent pharmacist in post at organisation (Joanne Heyes). Dial a Chemist to send daily DPD delivery extract data and monthly KPI data to DA. "Push through letterbox" instructions have now been removed from DPD instructions and there have been no recent incidents of delivery to wrong addresses. The new PIN system for DPD will hopefully be implemented by end of 2023 according to recent comms from DPD. Some discrepancies between dispensing data held by Dial a Chemist when compared with Bedford stats - to follow up. Next SLA review meeting in September.

Ulysses Data

Total number of medication incidents reported for Q1 23/24 by Cause Group



Medication incidents reported by Area

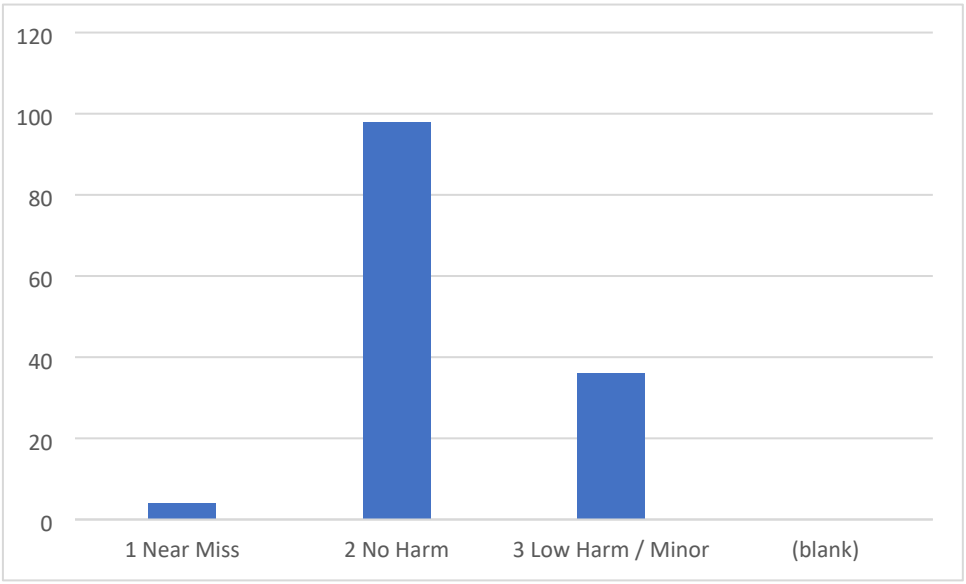


Key Themes

Since Q4, the number of medication incidents reported has decreased by 6 incidents to 145. Members of the Medicines Safety Group (MSG) continue to encourage the reporting of medication incidents so The Trust can learn from these incidents and prevent patient harm. This includes recognising and reporting near misses.

Of the 145 incidents, 139 were classified as patient safety incidents. There were no incidents classified as moderate harm or above.

In relation to medication administration, 49 or the total 61 incidents identified potential for improvement. 21 incidents resulted in informal discussion and 9 in further teaching / training.



Actions & Improvements

Division	Area noted for improvement	What are we doing to improve the position both short and long term	Committee/division/ person responsible	Timescales for completion
All areas	Learning from medication incidents across the Trust.	LOTW shared with senior staff across all areas for dissemination across teams. *Oxygen patient safety & physical safety following recent NatPSA Alert regarding the use of oxygen cylinders; Compliance aids.*	MSG	Ongoing as per Risk Register.
All areas	Learning from medication incidents across the Trust.	Weekly Safety Check In covering topics including. *Oxygen cylinder alert; VTE assessments; Vitamin K documentation; CD incidents; PGDs; Look a Like & Sound a Like (LASA) medicines; Antiplatelets & Anticoagulants.*	MSG	Ongoing as per Risk Register.
All areas	Safe and secure storage of medications.	Matrons to complete monthly nursing audit (Medicines 2nd week of month). Actions discussed and reviewed at MSG.	MSG	Ongoing. Subject to monthly review at MSG.
All areas	Safe and secure storage of medications.	Trust wide audit of safe and secure storage of medications in all clinical areas. Action plans discussed and reviewed at MMG.	MMG	Ongoing. To be discussed at MMG scheduled in July for potential closure.
All areas	Support for prescribing during junior doctor strikes across NHS.	Increased workload for NMPs across the Trust to ensure ongoing patient safety for prescribing and efficient discharges of patients from hospital.	Pharmacy & MMG	Closed. Support in place. Ulysses will continue to be monitored for any emerging themes, patterns, or trends.
All areas	Change to single practitioner checks for the administration of Fragmin.	Education and training of staff around the importance of following the six rights of administration when giving Fragmin to patients across the hospital.	MSG & MMG	Closed. Support in place. Ulysses will continue to be monitored for any emerging themes, patterns, or trends.

Theatres	Safe and secure storage of medications.	In accordance with national guidance all local anaesthetic agents must now be stored separately from other drugs and intravenous fluids.	MSG & MMG	Closed. Meds storage in Theatres has now been improved with new drugs cupboards. Ulysses will continue to be monitored for any emerging themes, patterns or trends.
All areas	Attendance at NMP Educational Forum in March.	Raising profile of NMP work across Trust and increasing CPD opportunities for staff.	MMG	Ongoing. Next Educational Forum scheduled for July 23.

3. Health & Safety

HEADLINE – In Q1, there were 35 non-clinical health and safety related incidents reported, an increase of 12 incidents from the previous quarter. The majority of incidents were reported by Maternity, with Gynaecology, Neonates, Clinical Support Services and Corporate function reporting between 3 and 8 incidents. All incidents were appropriately managed, and all processes were followed.

A breakdown of all non-clinical health and safety incidents, reported in quarter 1, are detailed in the table below:

	MATERNITY	GYNAECOLOGY & RMU	CLINICAL SUPPORT SERVICES	NEONATES	CORPORATE FUNCTION	TOTAL
STAFF INCIDENTS						
PERSONAL INJURY/ILL HEALTH	1	3	1	1		6
COSHH					1	1
ENVIRONMENT	3	1	1		2	7
EQUIPMENT	3				1	4
NEEDLESTICK INCIDENTS	4	3	2	1	1	11
SLIPS, TRIPS & FALLS	1		1	1		3
MANUAL HANDLING		1				1

DRUGS	1					1
COLLISION / CONTACT	1					1
TOTAL	14	8	5	3	5	35

Improvements and actions:

Work remains ongoing within the team to increasingly raise the profile of the Health and Safety Team making Health and Safety everyone's business and growing the Trust network of health and safety champions. The Health and Safety Group meeting chaired by the Head of Risk and Safety continues to be well attended by all Divisions. The Ulysses data demonstrates increased reporting which demonstrates an increased awareness of recognising health and safety incidents and positive actions to manage and mitigate health and safety risks.

CAS continued to be well managed, and alerts actioned within defined deadlines.

4. Complaints, PAL's & PALS +

HEADLINE - Complaints in 1 23/24 saw a decrease 7 complaints compared to the previous quarter, and an decrease of 10 compared to the same quarter in 22/23. Gynaecology Services division, which incorporates Gynaecology and the Hewitt Fertility Centre services, accounted for 91% of the received volume, although The Trust are continuing to see a sustained increase in the number of complaints received relating to the Hewitt Fertility Centre when comparing previous levels.

These continue to be almost exclusively from fee paying patients where they are requesting part or full reimbursement of the costs incurred due to their dissatisfaction with the services provided. Discussions are continuing with the Gynaecology Divisional team and Patient Experience team to try and understand the reasons for the increase and how they can be managed, including how we can speed up the responses in relation to these requests. A refund policy has been developed and was approved in June 2023.

The number of PALS + cases dealt with this quarter is consistent, with the Gynaecology department conducting the majority of these, with the hope that these address concerns at an earlier stage. Work continues to promote the PALS + process provisions to achieve early resolution of concerns and provide more timely outcomes for people raising concerns. The trends show that this has a positive impact on reducing the number of complaints needing to be raised when it is consistently used.

706 PALS cases were received in this quarter which is an increase of 50 cases overall. Initial end of quarter review has highlighted a few areas which have been repeatedly raised in this quarter:

Initial end of quarter review has highlighted a few areas which have contributed towards this:

- Patients continuing to contact PALS trying to gain information about appointments and associated delays due to capacity.
- Communications queries were recorded as the main category in 46% of the total cases for the quarter with appointments accounting for 30% of the cases recorded. Communications cases have increased by 5% although appointment issues have decreased 4% since last quarter.

- The most cases received by a division was 352 (50%) PALS cases which were received this quarter by Gynaecology. With the busiest month being noted as May 23.
- Appointment provision is continuing to be a point of dissatisfaction from patients who feel they are experiencing extended waits and the severity of their own condition is not being considered in this decision. Towards the end of June, we began to see contacts from patients who were now being cancelled for the July 23 strikes and were worried about when they would be seen. Some of these patients were experiencing their second or third cancellation of their appointment.
- The PALS service is seeing an additional increase of contacts with patients who, after speaking to other staff in the hospital, both clinical and non-clinical, were advised to contact PALS to get their delayed appointment issues addressed. This is creating unrealistic expectations for patients that the Patient Experience Officers can overrule procedures and expedite appointments, which they cannot.
- Patients are continuing to contact the patient experience team due to being unable to contact the correct admin or clinical area or having left messages, no return calls being made, or experiencing long waits when contacting GED and MAU.

Improvements and actions:

As telephony software (Netcall) allows for greater reporting capabilities which allows greater scrutiny and reporting of any issues. 2 workstreams are still underway reviewing the clinical call performance in both the Maternity Assessment Unit (MAU) and the Gynaecology Emergency Department (GED). Patient Experience Team have requested to be involved in both groups. There is Patient Experience representation on the workstream looking at the MAU improvements and this is already underway. We have seen a reduction of abandoned calls to both the MAU and GED in the latter part of last year and first period of this year compared to previous data. This coincides with the implementation of actions from the MAU workstream and planned workstreams for GED from Q4. For Q2 there will be task and finish group meeting chaired by the Deputy Head of Patent Experience.

Appointments and difficulties in contacting the trust about these continue to be prevalent themes in the PALS cases received by the Trust. Patients are all aware nationally of the waiting lists across the NHS and that fear of not getting their own appointment is leading to an increase in more forceful queries being raised to try and expedite their own case. **Divisions are continuing reviewing appointment capacity and increasing weekend appointment slot. There has also been a launch of a text messaging system to remind patients of their appointments slots with the opportunity for patients to respond and to either confirm or cancel and reduce non-attendance.**

5. Clinical Effectiveness and Audit

HEADLINE – The Trust received 10 Clinical Audit Reports including Action Plans in Quarter 1.

1. Key successes from Clinical Audits completed Quarter 1

- The majority of our ectopic pregnancy patients are seen in a timely manner by either our EPAU or GED service, and most receive a definitive diagnosis on the first visit, with an offer of the gold standard way of diagnosis (transvaginal USS).
- All patients suitable for laparoscopic surgery had successful treatment with this method which reduces their morbidity and mortality for the future.
- There was good documentation in the hospital notes regarding the decision of DNACPR, and extensive discussions with families in all cases.

- Appropriate categorization of OHSS cases were made, with all severe cases receiving LMWH and being reported to HFEA.
- 100% of Turners Syndrome patients were referred to and seen by Cardiology.
- The HLRCC re-audit enabled us to further protect the health of at-risk individuals by informing known pathogenic FH variant carriers of the latest surveillance guidelines and enabling them to better communicate the associated risks and screening advice to their relatives.
- 100% of Domestic Abuse cases contained evidence of requesting partner/alleged perpetrator details. Full assurance has also been given regarding the completion of safeguarding referrals, risk assessments and safety planning. LWH are reporting over 90% compliance for Safeguarding training.
- As part of the Postpartum bladder care audit, 96% of women who had retention were referred to urogynaecology and were followed up by the link midwives either directly or by telephone consultation and adequate follow up arranged if warranted.
- LWH demonstrated good compliance with the extreme preterm pathway and guideline, particularly with the appropriate seniority of intubator and the early Consultant led reviews of these babies after birth.

2. Key themes to be actioned as a result of Clinical Audit reports received in Quarter 1 which are monitored via the Clinical Audit & Effectiveness Team and Quality Improvement Group (QIG).

- Provision of surgical management for ectopic pregnancies is poor, and there is a current lack of support for women following diagnosis**. UPDATE:** An action plan has been approved by the Division and is currently being progressed to address the issues identified following the audit. Action plan is currently being monitored by the Continuous Improvement Team.
- A lack of documentation was an issue throughout several audits. **UPDATE**: Staff training, lessons of the week and additional fields on Meditech Expanse have been implemented across divisions to tackle documentation issues.
- 100 % compliance with HFEA reporting was not achieved in the OHSS audit. **UPDATE:** An action plan has been approved by the Division and is currently being progressed to address the issues identified following the audit. Action plan is currently being monitored by the Continuous Improvement Team.
- There are not enough Turners Syndrome MDT clinics for patients to be seen annually. **UPDATE**: The number of clinics has since been increased to 8 per year to combat this.
- Where the Duty of Candour process is not monitored then there is reduced compliance, which has significantly declined since the 2021 DOC audit. Further, where there is a defined process which is managed directly with knowledgeable staff, DOC does not meet the required regulations, and some DOC incidents are still being incorrectly categorised. **UPDATE**: There has since been a relaunch of the Duty of Candour Policy across the Divisions via the Divisional Governance Managers to increase DOC compliance rates. A reaudit is currently being progressed by the Head of Risk and Safety.
- For the Extreme Preterm Pathway, multiple intubation attempts occurred, achieving timely venous access worsened and the aetiology of this is unclear as there is no current location on the pathway to record a reason for delay. Achieving the golden hour occurred in only 7% of babies. **UPDATE**: The extreme preterm pathway has since been modified to highlight golden hour concepts. Staff focus groups have also been set up, and the Neonatal department have acquired digital timers as a visual reminder of the golden hour progress.

Improvements and actions:

Where audits have determined that the level of expected standards have not been met, there are significant divisional action plans formulated to address issues highlighted. All audits are reviewed by the Quality Improvement Group (QIG) and actions either approved or amended and updated where required. These are divisionally led and monitored by the Continuous Improvement Team (CIT). The outcome of such action plans is subsequently reported back in to QIG where a further audit may be required. There is considerable oversight of all

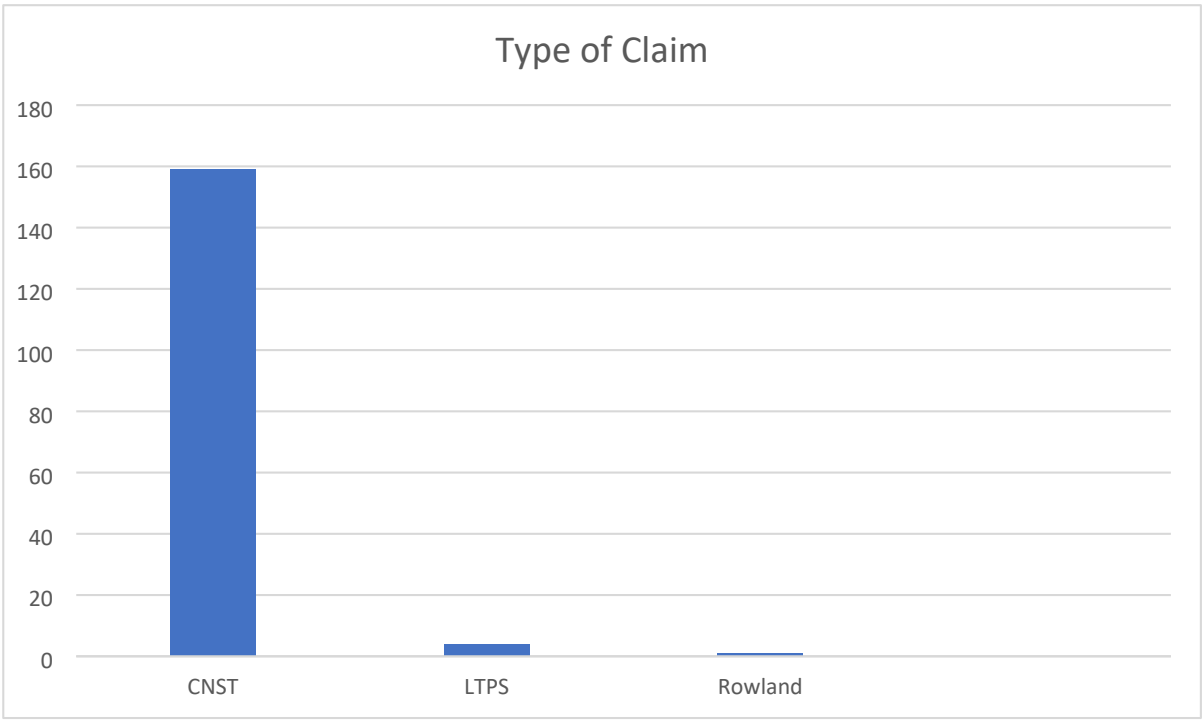
audits by QIG and the CIT. There is a proposal in development which will seek to improve performance and accountability through a revised escalation process. The proposal will ensure there is improved divisional reporting and less reliance on administrators within the CIT to prompt leads when audits are at risk of missing key milestones.

6. Legal Services

HEADLINE – As of 30 June 2023, there were 164 active, "open" claims. 159 Clinical claims, 4 non-clinical claims and 1 class action case.

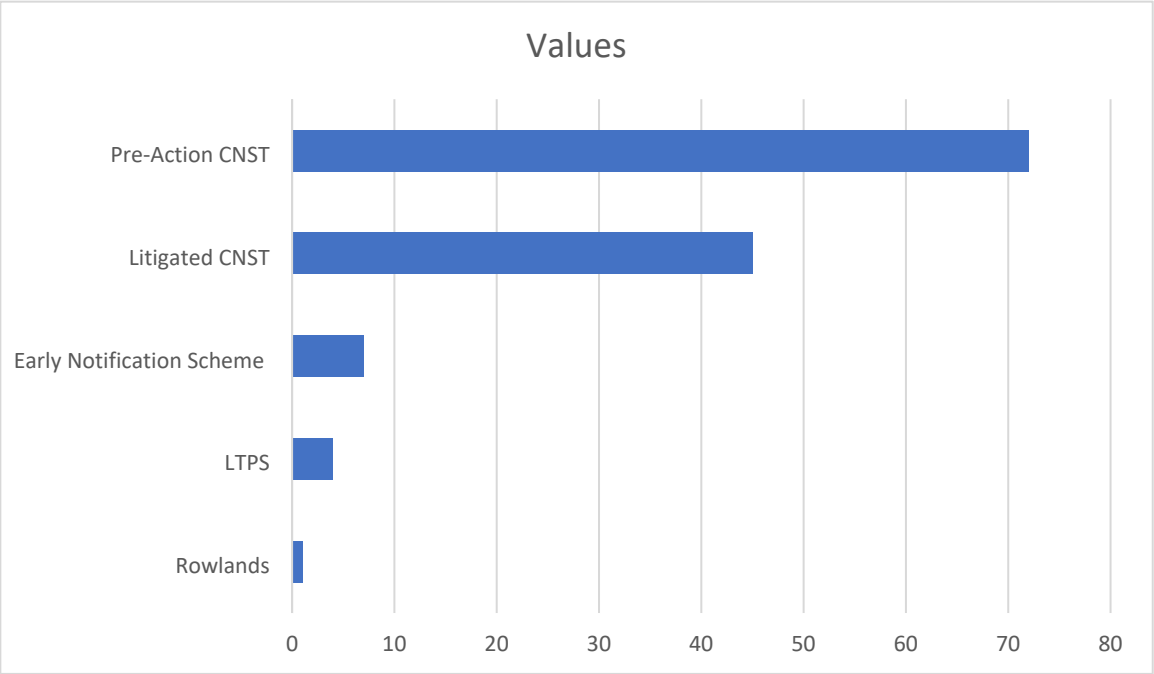
The Claims data has been generated using data extracted from the legal team's local database, supplemented by the NHS Resolution (NHSR) claims management system.

1) As of 30 June 2023, there were 164 active, "open" claims. 159 Clinical claims, 4 non-clinical claims and 1 class action (Rowlands) case.



CNST (Clinical Negligence Scheme for Trusts), LTPS (Liability to Third Parties Scheme), ENS (Early Notification Scheme)

2) The current procedural position of these claims are as follows:



The following table represents new and settled CNST (Clinical Negligence Scheme for Trusts), LTPS (Liability to Third Parties Scheme), ENS (Early Notification Scheme) and Inquest files between 1 April 2023 and 30 June 2023.

Month	CNST		LTPS		ENS		Inquest	
	New	Settled/Closed	New	Settled	New	Closed	New	Closed
April 2023	6	8	0	0	0	0	0	0
May 2023	4	2	0	1	0	0	0	0
June 2023	2	2	2	0	0	1	1	0

Improvements and actions:

Following training provided by both Hill Dickinson and NHSR, the Trust are emphasising a new approach to continuous analysis of claims and ensuring lesson learning is developed throughout the division. The legal team are assisting the divisions with this by sending ongoing new monthly claims data as well as monthly settled and closed claims data – this contains admissions made and financial information. Alongside this, in real time new claim notifications are provided to divisions which encloses a copy of the proceedings to assist with early evaluation and review. Engagement with the divisional and governance teams has increased allowing the sharing and evaluation of data between the legal and clinical teams to increase.

Early identification continues to remain a focused area, with the review of SI's for potential early reporting to NHSR. The legal team are working with the governance team mangers with this, which supports the GIRFT best practice guidance.

The scorecards contine to provide insight on Trust themes and trends and can be utiliesed as quality and improvement tools which provides insight into the Trusts claims over the past 10 years to support learning from where there has been harm.

The 2023 Trust scorecards have been released and a deep dive review of these claims alongside the GIRFT claims data are being analysed for the purpose of producing a report to embed into the Trust lesson learning processes. Legal Services are arranging for NHS Resolution to present the scorecard to the divisions in October 2023.

7. Patient Experience

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

Friends and Family Test (FFT) – overview

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

FFT results for Q1 2023/24

Number of responses received.

Total	Maternity	Gynaecology	Genetics	Reproductive Medicine (RMU)
3048	376	2024	125	140

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

Trust score %	Maternity %	Gynaecology %	Genetics %	Reproductive Medicine (RMU) %
90 ←	83 ↑	90 ←	93 ↓	91 ↑

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

Trust score %	Maternity %	Gynaecology %	Genetics %	Reproductive Medicine (RMU) %
91 ←	88 ←	92 ←	95 ←	93 ↑

Improvements and actions:

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

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

Below are some examples shared at the PIESC covering Q1 23/24.

Access to Scanning services GED
Patient expectation during Early pregnancy indicates that access to an immediate ultrasound scan when attending the emergency Department is preferred in terms of a definitive confirmation that there are no significant concerns regarding their pregnancy. Whilst this is not clinically always indicated, the patient feedback indicated that this would be an expectation. Providing a 24hour service that allows for instant ultrasound scanning facilities is challenging however plans have been made to increase clinics in the Early Pregnancy Assessment Unit (EPAU) on a demand-based schedule to avoid any women waiting longer than 72 hours for their early pregnancy scan..

Doctor attitude and behaviour, not listening to patients- OPD
Upon review of the feedback, comments have been made highlighting poor experience in relation to doctor attitude and behaviours, not listening to patients because of this the Department Matron and Manager have met to discuss with senior members of the medical team to discuss concerns raised, the result of this meeting was that relationships between patient and medic will be closely monitored by the nursing teams. The Matron has also increased visibility in the department so she is accessible to patients, so concerns and issues can be discussed at the time of the incident.

You said - Through feedback from our services users via many different avenues including FFT, our service users requested that we increase support person visiting including overnight.
We Did- Maternity ward has piloted the 24-hour visiting in response to our service users, the pilot was extended and remains in place. Matron is currently working with MNVP, and patient experience midwife and a report will be presented at the PIESC with the outcomes and both patient and staff feedback.

You said - Perceived delayed discharge was a concern for many of our service users. The reasons for delayed discharge were partly due to delay in the new-born examination(NIPE) and this was extending the time service users had to wait to be discharged home.
We Did - Maternity reviewed the current staffing structure and from data provided it was determined that a twilight NIPE would support early discharge, pilot undertaken. This has now been extended to 24/7 cover with ongoing evaluation.

You said – there were delays in the Induction of labour (IOL) process.
We did - As part of the IOL improvement group a six-month post for a senior midwife as an IOL coordinator has been appointed, with priorities to review the IOL process, expanding use of IOL agents, and ongoing information provision.

You Said – Patients in the Maternity Assessment Unit (MAU) advised that they were not kept up to date with information regarding any potential delays whilst waiting for medical review in the MAU.
We did - Comfort rounds throughout the day have been introduced, ensuring patients are frequently updated if any delays are to occur and refreshments offered. Monthly Matrons audits are reported through the maternity transformation MAU work stream.

8. Quality Improvement

HEADLINE – The creation of NHS Impact and the introduction of PSIRF have reinforced the need for improvement to be embedded throughout the Trust and its processes.

Key areas of activity from Q1 2023/24

- The review of capacity and capability in relation to recognised improvement methodologies identified significant shortfalls within staff teams in all areas of the Trust.
- Work has progressed with AQUA in identifying suitable learning to address the gaps through improved capacity and capability. The learning programmes at intermediate and advance/leader will start in Q3.
- The Quality & Safety Facilitator is scheduled to provide additional support to the Continuous Improvement Team in Q2. The activity will be initially focussed on improving the efficiency of administrative functions within the team.
- The team and its functions are now represented as part of each corporate induction session.
- 16 additional improvement projects registered in Q1, with a continued upward trend.

Plans for Q1 and beyond – incorporating improvement in every Trust process

The work with AQUA has continued throughout Q1 in preparation for a roll-out of learning and development over the course of the year. Plans are in place to provide access to a range of learning programmes for staff across the Trust. This increase in capacity and capability will be supported by a revised project proposal process and associated paperwork to ensure we do not inadvertently inhibit improvement activity. Improvement projects will be required to demonstrate a clear link to safety, strategy, and Trust' priorities. The concept of continuous improvement will be increasingly promoted to ensure we are best placed to maximise the impact of our increased capacity and capability.

Priorities to make this happen are as follows.

- Completion of the AQUA QI learning
- Development of a shared language and approach to improvement
- An improved focus on safety and health inequalities within projects
- Clearer evidence of embedded learning as a requirement for all improvement projects
- Fuelling staff motivation through the communication of success stories, positive feedback, and actions
- Being data driven, being clear about post benefit analysis
- Creation of digital platforms to support our continuous improvement work
- Learning from other organisations, locally & nationally

Improvements and actions:

The team will maximise the opportunities for learning and efficiencies afforded by engagement with local networks. They will make more efficient use of the limited resources available to the team through a review of key processes and a greater focus on accountability for project leads.

9. Serious Incidents and identified learning

***HEADLINE* – There were 8 serious incidents declared to the Integrated Care Board (ICB) during Q1 (a decrease of 6 from Q4) – 2 in April 3 in May and 3 in June.**

Serious Incidents declared and final reports submitted to the ICB

All Serious Incidents had full duty of candour completed and an investigating officer appointed by the Divisions at the point of declaration to the ICB. This enabled investigations to be expedited as quickly as possible to ensure any immediate learning identified could be implemented and shared across the Divisions.

There were no particular themes, patterns or trends identified within quarter 1 in addition to future Generations concerns.

Overdue actions from previous submitted SI's / Serious Incidents

There were no overdue serious incident submissions due with the ICB that had not had an appropriate extension request during Q1.

There were 2 Serious Incidents Submitted in April 2023.

There were 3 Serious Incidents Submitted in May 2023.

There were 12 Serious Incidents Submitted in June 2023.

As of 01 July 2023, the following Serious Incidents remain ongoing within the divisions

Clinical Support Services have no ongoing Serious Incidents

StEIS No.	Never Event?	Date reported to STEIS	RCA Due Date	STEIS extension date	Divison / Directorate
20236129	N	22/03/2023	Submitted 03/07/2023 - to be reported on next month	/ /	Neonates

StEIS No.	Never Event?	Date reported to STEIS	RCA Due Date	STEIS extension date	Division / Directorate
202310533	N	26/05/2023	18/08/2023	/ /	Maternity
202311311	N	09/06/2023	01/09/2023	/ /	Maternity
202311649	N	14/06/2023	06/09/2023	/ /	Maternity

StEIS No.	Never Event?	Date reported to STEIS	RCA Due Date	STEIS extension date	Division / Directorate
2023487	N	09/01/2023	03/04/2023	28/07/2023	Gynaecology
20235813	N	17/03/2023	09/06/2023	31/08/2023	Gynaecology
20237171	N	05/04/2023	28/06/2023	26/07/2023	Gynaecology
20239394	N	10/05/2023	02/08/2023	/ /	Gynaecology
202310747	N	31/05/2023	23/08/2023	/ /	Gynaecology
202312034		21/06/2023	13/09/2023	/ /	Gynaecology

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

As of 30 June 2023, there were 8 out of 23 ongoing action plans that had actions overdue (5) or not added to Ulysses (3). These were subsequently escalated to all Heads, Divisional Managers and Safety Leads to action and all Divisions agreed to have a plan in place to resolve overdue actions which will be monitored via Divisional Governance meetings in addition to the Safety and Effective Sub Committee.

Dissemination of learning from serious incidents

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

- Learning and engagement teams events held online Trust wide for all services to present and discuss learning
- The weekly safety check in for all services to present and discuss learning
- Governance Boards within the divisions to share learning
- Trust wide shared learning portal to upload all divisional learning such as 7-minute briefings accessible to all staff
- The Safety and Effectiveness Sub Committee serious incident report
- Staff communications via secure social media
- SBARS

Improvements and actions:

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

10. Divisional Triangulation and Integrated Governance Reports Q1

Key learning / assurance / messages identified

a. **Family Health**

- There is one extreme risk for Maternity
  Risk 2316 - Risk of women needing to access emergency care with pregnancy complications and not being able to be triaged in the MAU within 30 minutes of presenting at the department as per BSOTS.
- Revised staffing model in place in the MAU, which includes a supernumerary shift leader, 4 midwives, 1 midwife for telephone triage, 2 support workers and a receptionist to provide cover on a 24/7 basis. All breaches are analysed to identify areas for improvement.
- In June 99.94% of women were seen and triage assessment within 30 minutes of attendance. Performance monitored on a 4hlry basis and weekly updates provided to CQC.
- Blood sampling errors continue to be an issue with 129 reported incidents. This is being monitored via the Trust Blood Sample Errors Working Group and Maternity Services are drafting a QI project to address the maternity specific issues. The QI project is due to be discussed at the Trust Blood Sampling Errors Working Group on Monday 10th July 2023 for Trust oversight and input.
- There has been a focus on MatBase to increase the reporting of medication incidents as they occur. The themes include medication being stored incorrectly and issues with discharge and TTOs. Pharmacy are now dispensing on Matbase from 10am – 12 noon to improve the discharge process.
- Each month Maternity Services complete a report aiming to provide greater triangulation and understanding of themes within clinical incidents and legal cases. The report will help to target work that is being undertaken as part of the Maternity Transformation programme.

- Aprils settled claims identified the following themes that are currently incorporated into maternity workstreams:
- MAU triage
- Matbase improvements
- Delay in transfer to theatre
- Documentation, improved use of K2

- Some of the issues raised in these cases are linked to recognised risks on the risk register and these include:
- MAU triage
- Obstetric Consultant workforce, aim of 24/7 consultant cover
- Delay in transfer to obstetric theatre (due to be added June 2023)
- Delays in updates to the K2 system

There are two cases in the report that identify potential delays in the recognition and treatment of PPROM. This will be highlighted to the MAU team and the cases used to support teaching sessions for the team working on MAU, aiming to recognise the difficulties in identification of PPROM.

- On Sunday 30th April the MVP undertook a Fifteen Steps for Maternity inspection of MatBase which was reported to be successful. There was positive feedback in relation to staff who were described as warm, friendly, attentive and polite. MVP have written a report detailing recommendations identified.

- There are 3 Quality Improvement Projects in Maternity. There are two new QI projects in the proposal stage for Blood Sampling and Cold Babies Being Admitted to Neonatal.

b. <u>Gynaecology</u>

- Divisional Manager has been working with CSS to establish a service within CDC with regards to MRI scan waits
- Senior Safety monthly meetings have been introduced with department Managers

- Three departments within the division have now been inspected using the BBAS accreditation system, with all 3 areas achieving GOLD status, Bedford, Gynae Ward and GED.
- Gynaecology's CQC rating improved from Requires Improvement to Good following the recent inspection.

There were 179 Diagnosis incidents reported within Q1. 164 of these incidents are due to the backlog of reporting CRIS and PACS incidents. 10 of these incidents were related to a delay or failure to diagnose.

- Deep dive and review of incidents ongoing
- Actions assigned to consultants who are required to report on the images
- Scanners identified, which has been escalated to Clinical Director
- GED Manager completed daily checklist of Nurse Scanners
- GED Consultant Leads to ensure documentation standards are raised at AM huddle and checked at PM
- Review of Quality control measure underway (Early Pregnancy Imaging and Bedford Imaging policy)
- HFC Scanning incidents being reviewed

There were 55 incidents reported regarding appointments within Q1, with 27 of these were regarding appointment delays.
To reduce the number of incidents reported regarding issues with appointments, several actions have been implemented:

- SOP completed and ratified to outline 1 avenue for New patient DNA's
- SOP completed and ratified for managing repeat patient cancellations
- SOP completed Booking and scheduling of appointments – including cancelling appointments
- Team training/away day planned 2023 – ALL staff PAC, Genetics, reception
- 144 new patients seen over a weekend by Medinet to reduce waiting times. This contract is in place for 7 months to reduce the waiting lists
- Text messaging service now in place for patients to confirm if they still wish to attend their appointments. This has also contributed to the reduction in waiting lists
- Weekend Theatre lists and Ambulatory clinics implemented to reduce the waiting lists

There were 38 Communication incidents reported regarding communication within Q1, 12 of these were regarding communication failure within teams.

- The division have introduced Nurse in Charge and Consultant Handovers – Sit rep and task list which is discussed daily.
- Medics are encouraged to be part of the weekly safety and governance meetings taking place within the clinical areas.

There were 36 Investigation incidents reported within Q1. 14 of these incidents relate to blood sampling issues, e.g. Inadequately labelled samples and Haemolysed samples. There have been a number of actions implemented across the division to support with blood sampling issues.

- Task and finish group involvement and action planning
- Divisional action plan co-ordinated by Quality Matron
- Sample Log in place
- Managers receiving weekly reports however no longer in receipt of photocopied completed forms which allowed for identification of individual sample takers
- Managers have completed supervisory training to observe local practice in action

There are a number of projects within Gynaecology to improve patient experience and ensure we provide the best possible care to our patients. Some of these projects are detailed below:

Utilising Research to improve the experience and provide further choice for patient treatment following Miscarriage

- Spurred on by the Covid-19 Pandemic, Gynaecology Emergency Department made some adaptations to the provisions in the care for pregnant women, this was in line with guidance from the Royal College of Obstetricians and Gynaecologists (RCOG). One of these adaptations made by GED was to offer women who have had a missed miscarriage the option of having medical management as an outpatient. This has been successful and patient feedback has been positive and now forms part of the treatment choices on offer to our patients.

Listening to Women's Voices

- Women's health strategy, improving access to contraceptives. Bedford can offer a choice of Depo injection, Progesterone only tablets, or implant/coyle on site. For any women undecided a direct referral can be made to LARC service where a choice of contraceptives can be discussed at a later date.
- A postal service has been devised for Bedford – Choice for patients

Patient feedback

- Inpatient Survey Gynaecology. When compared to average scores, LWH scored better than other Trusts in 20 areas that included: waiting times for a bed on a ward, having peace and quiet at night, being involved with decisions on discharge, being provided with the appropriate information when leaving the hospital, and knowing who to contact if they become worried or concerned.

Under 18s

- Focus on CSE in key departments GED and Bedford
- Bespoke DASH training for key areas to ensure key signs of DV are flagged and appropriately risk assessed by front line staff
- Mapping of all services completed to ensure care for under 18's in Gynaecology is at an optimum
- Outpatients have a flagship transitional service for young people accessing care from Alderhey into LWH

Investing in the health of our staff to support the best people delivering the safest care and providing outstanding experiences to our patients

- Legacy Mentorship available from retired Nurse Manager
- Direct referral route to Trust psychologist and CMI resilience hub
- Menopause friendly employer that embraces the need for reasonable adjustments for menopausal staff, supports health and well being
- Developing ward staff to level 1.5 competencies
- Care certificate of all HCA staff – designated HCA clinical tutor
- Leadership course for all band 7 staff
- Investment in succession- ANP's and ACP

Matron representation in WHAM to ensure we grasp any opportunity for secondary care provision working with primary care

BBAS highlights a leadership culture of compassion and values-based leadership

The Gynaecology division plan to implement several Service Improvement and Quality Improvement projects over the coming months. These are the following:

- Miscarriage management within 2nd trimester pregnancy loss
- Digital benefits for colposcopy review
- Expansion of my kit check for essential equipment
- Standardisation of Triage in GED
- Development of PGD's within GED
- Blood transfusion simulation
- Methotrexate administration for treatment of Ectopic pregnancy
- De-brief proforma within GED
- New SEPSIS documentation

c. Clinical Support Services

- The departments have a good approach to Incident reporting and staff can use the system to report incidents, with this forming part of their induction process. Service Managers take accountability of incident investigation, with oversight of Governance Manager and Head of AHPs, who also receive incident notifications.

- CSS have declared 0 Serious Incidents within this quarter.

CSS have introduced a new Divisional Newsletter this Quarter which is published on a monthly basis which shares things such as Divisional news/ announcements, shared learning/ key messages/ well-being information and achievements across the Division

_Staff Newsletter June 23.pdf

Blood sampling

- There has been an establishment of a Blood Sample Errors Working Group which is being led by the Deputy Chief Nurse, which oversees the improvement plans for each Division as well as any benefits to this process that will derive from the Digi care system upgrade scheduled for July 2023, given that pathology requests will convert from manual to digital
- There are a number of associated quality improvement actions associated with this working group, in order to reduce the likelihood of sample errors.
- A more robust sample error reporting system has been built with the aid of LCL labs and external pathology Consultant advisor, the purpose of this is to highlight areas of opportunity and to give local managers oversight of the level of errors in their area.
- A diary system has been implemented in Gynae Pre-Op, which incorporates a second checker to verify the blood samples and ensure the information is accurate.

Medication incidents

- Ongoing plans to increase resource across Pharmacy team to undertake medicine audits across the Trust.

- Deep dive review of incidents within the Pharmacy team and review of stock availabilities for wards.
- Staff reminders issued regarding the process around CD deliveries to clinical areas.
- Improved labelling of fridge items for clinical areas.
- Digi care should mean that we won't find ourselves in similar situations in regards to stock as it has a minimum stock level and re-ordering will automatically be triggered when stocks are low.
- It is acknowledged there seems to be a general misunderstanding of how to order medications, which can result in incidents being reported unnecessarily. It is recognised that there could be further education around this issue in order to reduce incidents such as these from being reported. This education and further resources will be provided by the Pharmacy team to all relevant areas across the divisions.

Patient records

- The majority of Admin – Genetics Incidents relate to administrative errors being made with patient correspondence.
- All correspondence will now be Quality Checked by a second checker to reduce the rate of administrative errors occurring.
- Themes from Quality Checks are being tracked to discuss and highlight to the team to try to reduce the rate of errors.
- SOP for this process is currently being drafted to help standardise the process to make this easier for staff to follow.
- It is unclear if administrative errors around letters is an issue exclusive to Genetics Admin team or if this demonstrates a higher culture of reporting these errors within the team.

Imaging

- ¾ of the incidents reported by Imaging this Quarter relate to issues producing GROWTH charts at appointments for out of area patients.
- This particular theme of incidents has already been highlighted within the Division and a Risk has been added to the Risk Register. Actions are in place to help mitigate this risk and reduce the number of incidents associated, such as exploring whether out of area midwives are able to access K2 directly.

Embedded learning

- Clinical Management is not within the Top 5 Cause Groups of incidents for Q1.
- Failure to follow clinical guidelines was the most common theme of this cause group over the previous two Quarters.
- The main area in which this theme was occurring was within Imaging. Improvements were made to the Department following an SI which included things such as peer audits, review of Imaging SOP's and a competency assessment framework to help prevent further SI's and address issues earlier, including training issues and service provisions.
- The Division noted in Q4 report that following the improvements we expected to see a further reduction in incidents which has been demonstrated. This evidences that the improvement works / action plans which have been mentioned in both Q3 and Q4 reports have been implemented and learning has been embedded.

Quality improvement

- **0098 Imaging** - Agreeing the staffing model for Radiographers working in the Trust to improve recruitment and retention and staffing for the Xray On call service. The project aims to present to Execs and agree appraisals for staffing radiography safely. As such actions have been added to the action plan such as;

- Undertaking a retrospective audit of x-ray response times
- Determine payment for residential on call and benchmark against local trusts
- Workforce group has been set up with partner trusts to discuss the CDC workforce which involves Radiography

- There are 5 other Quality improvement workstreams currently ongoing which are not currently on Ulysses:

- **Ultrasound Improvement Project (UIP) group** – aiming at standardising practices, competencies and training across all staff groups performing Ultrasound as part of their role within the Trust
- **Theatre Utilisation Programme –** began in July 2022 with a multi-disciplinary programme team following the NHSE model 'The Productive Operating Theatre'. The programme has four workstreams ongoing and one workstream complete, each workstream is using data to identify opportunities and then implementing pilot Plan, Do, Study, Act (PDSA) cycles to find working solutions. The programme is currently focusing on the 'Start-Up' and 'Scheduling' modules.
- **Dietetics workforce and SLA review** – task and finish group which includes LUFT and LWH representatives as to review the existing SLA and service delivery for improvement of dietetic service provision
- **Physio – patient DNA improvement** – aimed at decreasing the DNA rate within the physiotherapy service
- **Theatres – Surgical Tray Rationalization (STR)** - consists of a systematic reduction in the number of surgical instruments to perform specific procedures without compromising patient safety while reducing losses in the sterilization and assembly of trays.

Divisional plans

- **EPMA Pharmacy team** – Pharmacist and Pharmacy Technician recruitment to deliver specifically EPMA and electronic prescription implementation within the Trust – this project will sit within the IM&T team
- **Dietetics SLA & care model review –** CSS is working with local partners and our Dieticians to establish a model of care which suits our patient's and ensures we have sufficient staffing to meet antenatal and gynaecology demand.
- **Pre-Op –** Anaemia pathway review has been conducted to ensure we are complying with NICE Quality Standard QS138 and CQUIN CCG 6 by ensuring that patients with low haemoglobin levels receive the appropriate treatment. A validation process has been brought in for potentially anaemic patients undergoing major surgery and we have been CQUIN CCG 6 compliant for the whole of 2023. A new SOP and policy for management of pre-op anaemia has been ratified at CSS Governance in March 23 and is awaiting approval via policies committee. Once this has been approved the policy will be shared with wider Divisions and any necessary training will be arranged.
- CSS utilise a Risk Heat map as to have oversight of all divisional and departmental risks on the register. CSS have met with all Service Leads and reviewed all current risks on the risk register to ensure these are accurate, robust and up to date and will be holding regular meetings to review meetings going forward.
- The Division's Training Needs Analysis for 23-24 will include Governance and Quality items, such as QIP practitioner, Risk Management, Complaints Management, and the upcoming NHS Patient Safety Incident Response Framework (PSIRF).
- CSS is in the process of collating all CSS Policies which are held on the intranet and held locally requiring uploading to the intranet. We will also be completing a gap analysis on policies for each service. As a division, we will be creating a central tracker in order to ensure we have oversight of all policies within each service and to ensure these are more easily monitored going forward.
- CSS is centralising all data collection, such as:
- Imaging and Pharmacy to be added to the Friends and Family feedback portal via QR code
- CSS have audited all of their services in regards to audits they complete whether local or clinical. After reviewing the findings, we are looking at ways in which all local audits can be stored and managed

electronically this will allow actions generated to be tracked and managed through to completion (this is a work in progress and there have been ongoing discussions with QI Lead).
- Staff competency to be added to ESR (date of completion / expiry).

CONCLUSION

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

There remains ongoing work across all Divisions via their integrated governance reports but triangulation has significantly improved since the last quarter. The divisions have been able to demonstrate:

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

It 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 with ongoing support from the Corporate Team and that there is positive progress in managing risk across the Divisions with Senior Management having oversight of such risk.

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