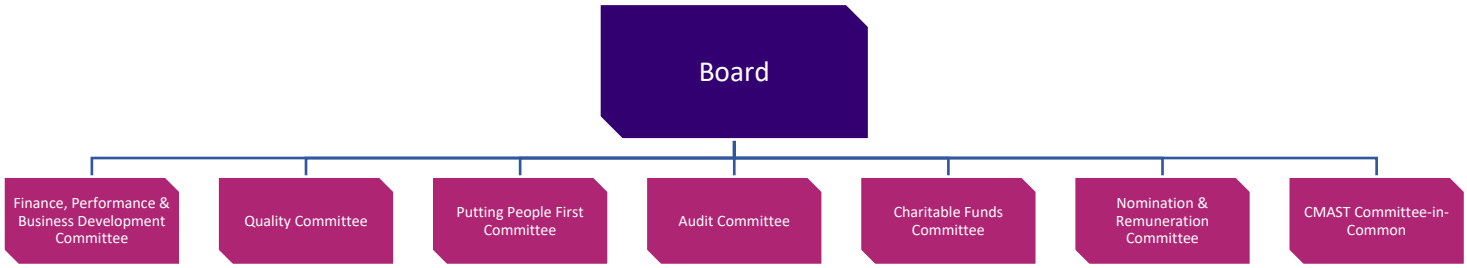
Liverpool Women's
NHS Foundation Trust

Trust Board

14 December 2023, 9.00am
Boardroom, LWH & Virtual, via Teams



Liverpool Women's NHS Foundation Trust

Trust Board

Location	Boardroom and Virtual (via Teams)
Date	14 December 2023
Time	9.00am

AGENDA					
Item no. 23/24/	Title of item	Objectives/desired outcome	Process	Item presenter	Time
PRELIMINARY BUSINESS					
211	Introduction, Apologies & Declaration of Interest	Receive apologies & declarations of interest	Verbal	Chair	09.00 (5 mins)
212	Meeting Guidance Notes	To receive the meeting attendees' guidance notes	Written	Chair	
213	Minutes of the previous meeting held on 9 November 2023	Confirm as an accurate record the minutes of the previous meeting(s)	Written	Chair	
214	Action Log and matters arising	Provide an update in respect of on-going and outstanding items to ensure progress	Written	Chair	
215a	Board Thank You	Staff recognition	Verbal	Chair	09.05 (5 mins)
215b	Patient Story	To receive a patient story	Verbal	Chief Nurse	09.10 (20 mins)
216	Chair's announcements	Announce items of significance not found elsewhere on the agenda	Verbal	Chair	09.30 (5 mins)
217	Chief Executive Report	Report key developments and announce items of significance not found elsewhere on the agenda	Written	Chief Executive	09.35 (5 mins)
MATERNITY					
218	Maternity Incentive Scheme (CNST) Year 5 2023 – Update Paper	To receive	Written	Chief Nurse	09.40 (10 mins)
QUALITY & OPERATIONAL PERFORMANCE					
219a	Chair's Report from the Quality Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	09.50 (30 mins)
219b	Quality & Operational Performance Report	For assurance – To note the latest performance measures	Written	Chief Operating Officer	
219c	Guardian for Safe Working Hours Quarterly Report – Q1 & Q2, 2023/24	For assurance	Written	Medical Director	

BREAK					
PEOPLE					
220a	Chair's Report from the Putting People First Committee and Terms of Reference Review	For assurance, any escalated risks and matters for approval	Written	Committee Chair	10.25 (15 mins)
220b	Workforce Performance Report	For assurance – To note the latest performance measures	Written	Chief People Officer	
FINANCE & FINANCIAL PERFORMANCE					
221a	Chair's Report from the Finance, Performance and Business Development Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	10.40 (30mins)
221b	Chair's Report from the Charitable Funds Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	
221c	Finance Performance Review Month 7 2023/24	To note the current status of the Trust's financial position	Written	Chief Finance Officer	
BOARD GOVERNANCE					
222	Board Assurance Framework	For assurance	Written	Trust Secretary	11.10 (5 mins)
CONSENT AGENDA (all items 'to note' unless stated otherwise) *All these items have been read by Board members and the minutes will reflect recommendations, unless an item has been requested to come off the consent agenda for debate; in this instance, any such items will be made clear at the start of the meeting.*					
223a	Integrated Governance Report – Q2 2023/24	For assurance	Written	Chief Nurse	Consent
223b	Corporate Governance Manual Update	For approval	Written	Trust Secretary	
CONCLUDING BUSINESS					
224	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair	11.15 (5 mins)
225	Chair's Log	Identify any Chair's Logs	Verbal	Chair	
226	Any other business & Review of meeting	Consider any urgent items of other business	Verbal	Chair	
227	Jargon Buster	For reference	Written	Chair	
Finish Time: 11.20					

Date of Next Meeting: 11 January 2024

11.20 – 11.30	*Questions raised by members of the public*	To respond to members of the public on matters of clarification and understanding.	Verbal	Chair

Liverpool Women's
NHS Foundation Trust

Meeting Guidance Notes

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

Before the Meeting:

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

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

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

During the Meeting:

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

Standards and Obligations

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

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

After the Meeting:

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

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

Liverpool Women's
NHS Foundation Trust

Board of Directors

Minutes of the meeting of the Board of Directors held in the Boardroom and Virtually via Teams at 9.30am on 9 November 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 (from item 185a)
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
James Sumner	Designate Chief Executive
Yana Richens	Director of Midwifery
Gina Barr	Voluntary Services Manager (item 180 only)
Gillian Walker	Patient Experience Matron (item 180 only)
Nashaba Ellahi	Deputy Director of Nursing and Midwifery (item 184c only)
Felicity Dowling	Member of the Public
Teresa Williams	Member of the Public
Lesley Mahmoud	Member of the Public
Rebecca Smyth	Member of the Public
Mark Grimshaw	Trust Secretary (minutes)

APOLOGIES:

Sarah Walker	Non-Executive Director

Core members	**Nov 22**	**Dec**	**Jan**	**Feb**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov 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	🏳	🏳	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/	
176	**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.
177	**Meeting guidance notes** The Board received the meeting attendees' guidance notes.
178	**Minutes of the previous meeting held on 12 October 2023** The minutes of the Board of Directors meeting held on 12 October 2023 were agreed as a true and accurate record.
179	**Action Log and matters arising** Updates against action log were noted.
180	**Patient Story** The Board received an outline of the work undertaken by volunteers in the Trust. This included work around supporting the equality, diversity, and inclusion agenda, providing bilingual support to patients, and performing pharmacy runs. The 'Volunteer to Career' programme was highlighted, and it was noted that there were currently nine volunteers in the first cohort. Each received a personal development plan and guaranteed interviews as parts of the Trust's positive action schemes and talent spotting. The Trust had recently started the use of therapy dogs in the gynaecology outpatient department following the necessary infection, prevention and control measures being applied and these were introduced to the Board. Plans for developing the volunteer service included introducing: • Bereavement support volunteers • Neonates Story Time volunteers • Neonates Dads Matter Peer Support volunteers The Chair asked what support the Board could provide to continue the growth of the volunteering service. The Voluntary Services Manager noted that the additional activities performed by the

	volunteers had been made possible by employing additional support in the volunteering team. This was on a fixed-term basis following funding being provided by NHS England. For the service to continue to develop, the importance of maintaining this resource was stated. Chair's Log: For the Charitable Funds Committee to explore the potential opportunities to support the Trust's Volunteer Service. The Chief Information Officer queried if the 'Volunteer to Career' scheme included corporate areas. This was confirmed to be the case. Non-Executive Director, Gloria Hyatt, highlighted the commendable work that the Honeysuckle Team had undertaken in partnership with Liverpool FC to support bereaved fathers and suggested exploring opportunities to replicate this model in other areas. The Chief Executive concluded by stating the importance of volunteers to the Trust's work and services. The Board noted the presentation and thanked the Voluntary Services Manager and therapy dog handlers for their time and attendance.
181	Chair's announcements The Chair noted that it was Kathy Thomson's last Board meeting as Chief Executive and James Sumner (designate Chief Executive) was welcomed to the meeting. It was noted that the Council of Governors had met in October 2023 to discuss and approve two matters: • The appointment of James Sumner as Chief Executive • To progress with a recruitment process for a Joint Chair with Liverpool University Hospitals NHS Foundation Trust. The Board noted the update.
182	Chief Executive Report The Chief Executive presented the report which detailed local, regional, and national developments. The following key issues were highlighted: • The Trust had been celebrating Black History Month during October 2023 with colleagues, with staff talking about their background, heritage and achievements. The Trust had also recently launched its 'Call it Out, stamp it out' anti-racism campaign. • As the Trust marked World Menopause Day (Wednesday 18th October) it had pledged to support its employees going through menopause in the workplace. This was through creating awareness and education through events and a menopause club network as well as offering Flexible Working Arrangements and Health and Wellbeing resources such as Occupational Health. • 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. It was stated that this was an exciting development for the city supporting the continued growth of Liverpool's Knowledge Quarter. The Board of Directors noted the Chief Executive update.
183a	NHSE Maternity Diagnostic Review The 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. A visit took place 24-27 July 2023 and the team of Maternity Specialist Advisors noted that overall, the Trust had 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. Areas of concern were also highlighted. The Family Health Division had devised a local improvement action plan, which was managed by Maternity and Neonatal Transformation Workstream 3, reporting to Maternity and Neonatal Transformation Board. Assurance was provided that action had been taken to close out the areas of concern. There would be continued monitoring via the Maternity Transformation Board on these issues and the other areas of improvement that the Trust had identified internally. The Chief Executive highlighted the increase of C-Sections and the induction of labour (IoL) rate and stated that the Trust needed to plan and adapt for the changing trends. The Board discussed the importance of horizon scanning to understand increasing complexity and trends and to ensure that the Maternity and Neonatal Transformation Programme was considering this when exploring service pathways and redesign. It was queried if the Trust had been included on the Maternity Safety Support Programme (MSSP). The Chief Nurse confirmed that the Trust was not formally part of the MSSP. Discussions were underway with NHS England and the ICB on the most effective mechanism for continued oversight and monitoring. The Chair asked if progress had been made on a potential CQC re-visit to review the warning notice and a potential change to the Trust's ratings. The Chief Executive confirmed that the CQC were currently updating their inspection regime and it was likely that this would be in place for the North of England in the New Year. The Trust had a new inspection manager, and they were due to visit the Trust at the end of November 2023. The Chief Executive referenced a recent MBRRACE-UK report which noted the following as a key message 'Treat women who may become pregnant, are pregnant, or who have recently been pregnant the same as a non-pregnant person unless there is a very clear reason not to'. It was asserted that this message resonated with the Trust's own risk assessments and the challenges posed by operating on an isolated site. The Board received the update.
183b	Maternity Incentive Scheme (CNST) Year 5 – Scheme Update The Board received an outline of 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 compliance status against each. The following key issues were highlighted: • Safety Action 1 – There was acknowledgment of the effect of Industrial Action on ability to commence two PMRT cases. It was noted that the Family Health Division would submit an action plan and a review of the PMRT process in December 2023, in response to NHSr letter dated 24.10.2023. • Safety Action 2 – It was acknowledged that 11 of 11 CQIM metrics on the provisional MSDS CNST Scorecard had passed data quality criteria • Safety Action 6 – The current Trust position in relation to Saving Babies Lives Care Bundle V3 and the Implementation Tool was noted.

	• Safety Action 9 – It was noted that the Board Safety Champions were meetings with the Perinatal Quad leadership team on a quarterly basis. An action plan continued to be monitored and there were no particular issues to highlight to the Board for further support. The Chair queried the most significant current risk to compliance. The Chief Nurse confirmed that training compliance rates were an on-going challenge, mainly because of post graduate anaesthetist rotations. This issue was well known, and mitigations were in place. There also remained 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. Immediate actions had been implemented from the management team to mitigate this risk and this included requesting mutual aid from other providers, introduction of telephone clinics, pathway, and service redesign meetings underway to safeguard future service provision. Chair's Log: For the Quality Committee to receive a report on the key risks to Year 5 CNST compliance. The Chief Finance Officer confirmed that the Trust had received an additional £1.2m rebate as a result of meeting compliance requirements for Year 4. A proportion of this had been re-invested into the service to enhance safety, with a particular focus on those areas that were providing the most significant challenge. The Board of Directors resolved to: • Note the current position in relation to the Maternity Incentive Scheme (CNST) Year 5 and the current compliance position, along with the associated papers found within the appendices. • Noted the assurances provided by the report and that evidence would be in place for all ten safety elements in advance of final Board submission in the New Year.
184a	Chair's Reports from the Quality Committee The Board considered the Chair's Reports from the Quality Committee meetings held on 26 September 2023 and 24 October 2023. Non-Executive Director, Jackie Bird, who chaired the October 2023 meeting, noted the following key points: • A concern had been raised in relation to the patient pathways and performance within the Gynaecology Emergency Department (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. • The 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 reflect these cases more accurately. • 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 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. The Board of Directors received and noted the Chair's Report from the Quality Committee meetings held on 26 September 2023 and 24 October 2023.

184b	Quality & Operational Performance Report The Board considered the Quality and Operational Performance Report. The Chief Operating Officer highlighted the following key points: • 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) and a presentation was scheduled to be given at the next Quality Committee on current and future developments to address known risks. • 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. The theatre and outpatient transformation programmes had supported this. • 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. A reduction in over 62 day wait had been seen since early October 2023 and the Trust was now ahead of its internally set trajectory. The Chief Nurse highlighted that infection, prevention and control performance continued to be positive. It was noted that the Patient Safety Incident Response Framework (PSIRF) metrics would replace the current Serious Incident Framework metrics in future reports. Some improvements to Friends and Family Test performance were also noted, a recent move of the Early Pregnancy Assessment Unit (EPAU) supporting this. It was noted that whilst not on trajectory, C-GULL recruitment was progressing. Recruitment was expected to start to meet the desired trajectory as all ethical considerations had now been consolidated and finalised. Non-Executive Director, Louise Martin, sought assurance that the Trust was reviewing trends from serious incident data. The Chief Nurse stated that the key issue with incidents was repeat causality and was looking to ensure that the data reported to the Board and Committee reflected this. The Chief Nurse added that some recent Serious Incidents had involved the care of three to four separate organisations. The need to ensure shared learning and analysis was emphasised. The Medical Director added that a deep dive into Serious Incidents was scheduled for the December 2023 Quality Committee. Louise Martin noted that whilst the 28-day faster diagnosis standard was improving, it remained off target. It was therefore queried if the Trust was well-placed to offer diagnostic mutual aid as suggested in the report. The Chief Operating Officer noted that whilst the Trust remained committed to supporting the most effective patient pathways across the system, no offers of mutual aid had yet been offered. The Chief Information Officer noted the significant increase in urgent biopsy samples and queried whether this was solely because of hysteroscopy. It was requested that future reports provide a breakdown of sample type. Action: For future performance reports to provide a breakdown of the sample type when reporting on diagnostic performance. The Chief Executive acknowledged that despite the high number of safeguarding referrals, and some recent changes to the team, there had been some positive outcomes which was encouraging. The Chair requested that future reports be enhanced by ensuring that the narrative and analysis provided the operational and strategic implications.

	The Board of Directors received and noted the Quality & Operational Performance Report.
184c	**Bi-annual staffing paper update, January 2023-June 2023 (Q4 &Q1)** The Board 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. The Deputy Director of Nursing and Midwifery highlighted the following key points: • Vacancy rate had positively reduced • Bank and Agency demand had reduced, which was likely due to substantive staff in post and lower sickness rates. • Sickness rates although above threshold reflected a downward trajectory from previous reporting period. • Long-term sickness rates (28 calendar days or more) continued to remain the greatest challenge. • Turnover remained under the Trust threshold of 13% • Age profile had marginally shifted due to recruitment activity in divisions. • Staff Training and Personal Development Review performance measures had improved significantly from previous reporting period. • 227 clinical incidents related to staffing or staff sickness were noted compared to 391 in previous reporting period. • Complaints and compliments: 26 formal complaints received highlighting a reduction of 14 from previous reporting period. 79 compliments were received, which reflected an increase of 22 from previous reporting period. • 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. The Deputy Director of Nursing and Midwifery reflected that appropriate staffing levels within departments had demonstrably supported improvements in all workforce metrics and quality indicators as identified above. The Chair remarked on the impact of the Midwifery Preceptorship scheme and highlighted that it was an example that investments into people often produced positive consequences in other areas. Non-Executive Director, Jackie Bird, commended the quality of report but requested that reporting timescales be reviewed to ensure that it was received at the Board closer to the reporting period covered. Jackie Bird continued to query if ward managers were involved in establishing and monitoring adequate staffing levels. It was confirmed that ward managers were involved at the pre-budget setting stage and during a six-month review. Non-Executive Director, Louise Martin, noted that some of the highest risk scores for staffing related to the Clinical Support Services (CSS) Division and that these areas also had high incidences of incident reporting for missed breaks. The Deputy Director of Nursing and Midwifery noted that many of the areas within the CSS Division employed a dynamic roster and that a breaks audit had been completed. Anecdotally potential challenges in theatres during night shifts had been identified and a further review was planned to understand this better. The Board of Directors resolved 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.
184d	**Seven Day Working Board Assurance**

	The Medical Director noted that Boards should assess at least once a year whether their acute services were meeting the seven-day service (7DS) clinical standards to demonstrate performance to commissioners and regulators. Whilst assurance was received that there was no difference in length of stay or discharges at the weekend, the Trust was not currently able to demonstrate full compliance, predominantly due to the lack of co-located services e.g., the lack of access to onsite diagnostic test and consultant led interventions. It was also reported that despite consultant job plans providing for medical cover across all seven days, there was a reduced consultant presence at the weekend compared to weekdays in areas such as Medical Assessment Unit/Post-natal ward and the Gynaecology Emergency Department. Divisional medical workforce strategies were in place to increase consultant presence at the weekend and out of hours. There were however competing challenges of where resource should be allocated within current financial budgets. The Chief Executive stated that it would be important to ensure that commissioners were aware of the work the Trust was undertaking to reduce the risk whilst also outlining areas that would remain non-compliant if the Trust remained on an isolated site. Non-Executive Director, Jackie Bird asked if assurances could be provided that a care plan was in place for patients in the High Dependency Unit (HDU). The Medical Director confirmed that the Trust's gynaecology consultants undertook daily ward rounds. Complex work was profiled at the beginning of each week additional support requested from partners if required. A key challenge was whether the gynaecology consultants had the requisite skill set to identify and escalate (if required) non-gynaecology related issues. It was agreed that the Quality Committee should receive an update on the work underway to review the model of care currently provided at the HDU and for this to also consider the evolving health needs of the population. Chair's Log: The Quality Committee to receive an update on the work underway to review the model of care currently provided at the HDU and for this to also consider the evolving health needs of the population. The Board of Directors resolved to: • Note that the Trust was not fully complaint with the 7-day service standards and this would remain the case whilst the Trust was on an isolated site. • Note the assurances that the Trust was cognisant of the variances from the 7-day service standards and the mitigations that were currently in place and were being developed. *Michelle Turner, Chief People Officer, joined the meeting.*
	Board Thank you The following Board Thank You's were presented: 1) Vicky Clarke – Presented by Dianne Brown for exceptional leadership shown for the Family Health Division. 2) Puru Natarajan – Presented by Gary Price. Noted that Puru was always willing to go above and beyond and help with not just oncology but also general gynaecology patients. Puru had also been supportive in the Trust's hysteroscopy FDS plans (sedation).
185a	Chair's Report from the Putting People First Committee The Board considered the Chair's Report from the PPF Committee meeting held on 18 September 2023. Committee Chair, Gloria Hyatt, noted the following key issues: • Whilst there had been no harm identified because of Industrial Action, this had required a considerable level of management oversight.

	• 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 enabled 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. • Received a positive Workforce Performance report noting positive trends in performance against PDR, mandatory training, clinical and local training, sickness, and turnover. The Board of Directors received and noted the Chair's Report from the PPF Committee meeting held on 18 September 2023.
185b	Workforce Performance Report The Board considered the Workforce Performance Report, noting the positive direction for most metrics. The Chief People Officer reported that there had been a further reduction in the sickness rate during September 2023. It was asserted that an increase in the completion of Return-to-Work interviews and a move away from a punitive approach to short term absence was having a positive impact. There had also been improvements to the mandatory and clinical training compliance rates. The Covid-19 and Flu vaccine rates were significantly below target. Whilst it was noted that the Trust was not an outlier regionally or nationally, it was acknowledged that the position required improvement. The Trust was exploring several mechanisms in order to improve the take up rate. The Chief People Officer reported that the 4th 'Big Conversation' took place on 28th September (some departments received visits at later dates). Thirty departments received a visit from a Board Director or senior manager and where possible, colleagues visited departments they had been to before to develop existing relationships. A key finding was that departments were improving at utilising the fortnightly '3 key Messages' and engaging with the 'You said, we did' (YSWD) process. Departments would be encouraged to ensure feedback was acted on and communicated via YSWD - supported by the HR team. Overall – feedback was noted that the 'Big Conversation' was valued and there had been an overall improvement in morale in many clinical areas, notably maternity and gynaecology though still concerns about staffing levels in maternity, particularly mat base and delivery suite). Non-Executive Director, Louise Martin, highlighted that she had received feedback that the newly implemented Electronic Patient Record (EPR) had impacted on the coding team. The Chief Information Officer acknowledged this factor and noted that vacancies had also impacted on the morale of the coding team. Retention funding had been applied and work was progressing across the system to ensure a consistency of Agenda for Change banding for these roles. The Chief Executive suggested that future workforce reports could be enhanced by providing a more granular understanding of staff morale, break compliance and frequency of shift changes in areas beyond maternity. Action: For future workforce reports to include a more granular understanding of staff morale, break compliance and frequency of shift changes in areas beyond maternity. The Board noted the workforce performance report.

186a	**Chair's Reports from the Finance, Performance and Business Development Committee** The Board considered the Chair's Reports from the FPBD Committee meetings held on 27 September and 25 October 2023. It was noted that at both meetings there had been significant focus on scrutinising the Trust's approach to financial recovery and the progress being made to recover the Trust's 2023/24 financial position. The following key points were highlighted from the October 2023 meeting by the Committee Chair, Louise Martin. • 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. • 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. • 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. The Chief Executive highlighted that whilst the Trust continued to report in line with plan at Month 6, the Committee had been 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 to the ICS, the risks to achieving the financial position. The Board of Directors received and noted the Chair's Reports from the FPBD Committee meeting held on 27 September and 25 October 2023.
186b	**Chair's Report from the Audit Committee** The Board considered the Chair's Report from the Audit Committee meeting held on 18 October 2023. The Committee Chair, Non-Executive Director Tracy Ellery, highlighted the following: • The internal audit programme for 2023/24 was noted as being slightly behind schedule but there were no concerns for delivery by year-end. • One internal audit report received: 2023/24 Raising Concerns/Speaking Up (Substantial Assurance Level) • 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. The Board of Directors: • noted the Chair's Report from the Audit Committee meeting held on 18 October 2023.
186c	**Finance Performance Review Month 6 2023/24** The Chief Finance Officer informed the Board 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 £2.5m 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 was £11.6m. The drivers of the variance remained consistent from previous months.

	The Trust had produced a financial recovery plan, approved by the Trust Board in September 2023. This plan indicated that to return to a breakeven financial position, the Trust required 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 key area of work related to exploring potential safe areas of disinvestment, but no material opportunities had yet to present. The Trust had a cost improvement programme target of £8.3m. This equates to 5.3% of expenditure. At Month 6 there was an adverse variance of £1.2m against the £3.2m target. The Trust remained focussed on identifying and implementing robust schemes through a programme of targeted financial recovery, that would deliver savings on an ongoing basis. The risk associated with delivery of the CIP programme was currently estimated to be £2.0m. The forecast outturn was currently £15.5m deficit, which was in line with the submitted plan, however despite financial recovery actions put in place by the Trust, there was significant risk in achieving this position. Reference was made to a recent announcement of additional funding that had been made available to support costs incurred because of industrial action. Targets relating to elective recovery had also been reduced (from 106% to 103%). The implications of both issues for the Trust were being reviewed. On the latter, it was explained that whilst there might be more funding to support increased activity, pursuing this could result in unintended deleterious financial consequences. The Chief Executive confirmed that the Trust would seek the option that helped to reduce patient waiting times whilst not worsening the financial position as much as was practicable. The Board of Directors: • Noted and received the Month 6 2023/24 Finance Performance Review
186d	Progress towards Delivery of Strategic and Corporate Objectives The Board received the report which provided both a qualitative and quantitative approach to summarising the progress made towards delivering the overarching strategic objectives to date and the annual corporate objectives in the first six months of this financial year. It also noted some of the achievements that have been made in the last year which helped move the Trust closer towards achieving its ambitions and vision. It was noted that one corporate objective had been rated as being 'off track' - '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. The Chief Executive added that due to resource constraints, there may be a requirement for the Trust to test its commitment against the set corporate objectives and potentially prioritise if necessary. It was suggested that the Putting People First Committee should assess the deliverability of the Trust's established Equality, Diversity & Inclusion corporate objectives. Chair's Log: For the Putting People First Committee to assess the deliverability of the Trust's established Equality, Diversity & Inclusion corporate objectives. The Board of Directors resolved 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.
186e	Community Diagnostic Centre 2024/25 The Board received an options appraisal report for the Community Diagnostic Centre for 2024/25. The Chief Operating Officer informed the Board that the CDC model provided a significant opportunity to support elective recovery for Cheshire & Merseyside whilst also providing a solution

	to support safety on site for inpatients. It was noted that the service had not and would not (in the proposed 2024/25 plan) fully cover overhead costs incurred. The preferred model, Option 1, presented the least financial impact whilst also allowing the Trust to run CT and MRI for 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 Trust staff, mitigating a primary cause of workforce turnover and mutual aid for the Cheshire & Merseyside system. The Medical Director noted that the scans that had been performed on Trust patients had been urgent and therefore the availability of the MRI and CT scanners was pivotal to increasing safety on the Crown Street site. Non-Executive Director, Louise Martin, highlighted concerns with the preferred option. It was noted that the option was predicated on the following factors: a seven-day service being delivered, a reduction in the 'Did Not Attend' (DNA) rate, and activity and productivity levels that were dependent on other partner organisations. The Trust was also not being compensated for the activity being undertaken e.g., being paid for one patient when there might be multiple scan sites. Louise Martin asserted that whilst the clinical and quality case was understood and well evidenced, proceeding with option 1 would result in increased pressure on the Trust's financial position, with limited evidence of a sustainable funding model in the future. It was stated that such decisions would be better placed with commissioners rather than single provider trusts. Non-Executive Director, Tracy Ellery, suggested that the Trust should pursue further assurances on a more equitable risk share basis for the DNA rate before agreeing to the model outlined in Option 1. The Chief Executive acknowledged the points raised regarding the financial implications of progressing with Option 1. However, it was asserted that the increased safety that the MRI and CT scanners provided to the Trust justified the potential financial risks. It was confirmed that should Option 1 be agreed, the Executive team would continue to seek further assurances and risk share arrangements with commissioners and partner organisations. The Chair remarked that this discussion was emblematic of the challenges facing Boards throughout the country when attempting to appropriately apportion risk appetite in terms of quality, safety, workforce, and financial considerations. Following a vote, the Board of Directors resolved to: • approve the Community Diagnostic Centre at LWH 24/25 Plan (option 1) (two abstentions – Louise Martin and Tracy Ellery) • request that the Executive Team continue to seek further assurances and risk share arrangements with commissioners and partner organisations for the CDC operating model for 2024/25.
187	Board Assurance Framework The Board of Directors received the Board Assurance Framework. The Board of Directors • reviewed the BAF risks and agreed on their contents and actions. *The following items were considered as part of the consent agenda*
188	2023/24 Operational Plan 6-month update The Board of Directors • noted progress on the operational plan to date and to continue to receive assurances on specific areas of challenge.

189	**Integrated Governance Assurance Report Quarter 1 2023/24** The Board of Directors • reviewed the contents of the paper and • took assurance that there were adequate governance processes in place and the positive progress in managing risk had been made with Senior Management having oversight of such risks.
190	**Review of risk impacts of items discussed** The Chair identified the following risk items: • Delays to Induction of Labour and the C-Section rate. • The CQC Warning Notice remained in place • Non-compliance with 7-day service standards • The impacts of industrial action • The Trust's 2023/24 financial position, CIP under delivery, challenges with unwinding investments and the cash position. Positive assurances, from the meeting, were noted around the value of volunteers, the improvements highlighted by the national maternity safety team visit and the evidence that investing in staff was having a positive impact throughout the organisation.
191	**Chair's Log** The following Chair's Logs were noted: • For the Charitable Funds Committee to explore the potential opportunities to support the Trust's Volunteer Service. • For the Quality Committee to receive a report on the key risks to Year 5 CNST compliance • The Quality Committee to receive an update on the work underway to review the model of care currently provided at the HDU and for this to also consider the evolving health needs of the population. • For the Putting People First Committee to assess the deliverability of the Trust's established Equality, Diversity & Inclusion corporate objectives.
192	**Any other business & Review of meeting** The meeting concluded with a celebration of Kathy Thomson's time as Chief Executive of the Trust. On behalf of the organisation, the Chair expressed his thanks to Kathy, remarking on her many achievements and on-going integrity. **Review of meeting** No comments noted.
193	**Jargon Buster** Noted.

Liverpool Women's
NHS Foundation Trust

Action Log

Trust Board - Public
14 December 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
9 November 2023	23/24/185b	Workforce Performance Report	For future workforce reports to include a more granular understanding of staff morale, break compliance and frequency of shift changes in areas beyond maternity.	Chief People Officer	February 2024	On track	
9 November 2023	23/24/184b	Quality & Operational Performance Report	For future performance reports to provide a breakdown of the sample type when reporting on diagnostic performance.	Chief Operating Officer	December 2023	Complete	Narrative on diagnostic performance provides explanation – see item 219a.
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	January 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	23/24/134a	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~~ February 2024	Risks identified	Requested that this action be deferred due to current capacity challenges in the obstetric consultant workforce.
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	February 2024	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	February 2024	On track	

Chair's Log

Received / Delegated	Meeting Date	Issue and Lead Officer	Receiving / Delegating Body	Action Deadline	RAG Open/Closed	Comments / Update
Delegated	09.11.2023	To assess the deliverability of the Trust's established Equality, Diversity & Inclusion corporate objectives. Executive Lead: Chief People Officer	PPF	January 2024	Open	
Delegated	09.11.2023	To receive an update on the work underway to review the model of care currently provided at the HDU and for this to also consider the evolving health needs of the population.	Quality Committee	February 2024	Open	
Delegated	09.11.2023	To receive a report on the key risks to Year 5 CNST compliance	Quality Committee	December 2023	Open	
Delegated	09.11.2023	To explore the potential opportunities to support the Trust's Volunteer Service.	CFC	January 2024	Open	
Delegated	14.09.2023	To undertake a full review of the current speak up arrangements and the underpinning cultural	PPF	January 2024	Open	

		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				
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	Closed	Received at November's Quality Committee.

Liverpool Women's
NHS Foundation Trust

CEO Report

Trust Board
December 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*

An introductory message

I am delighted to have this opportunity to introduce myself as I begin my role as the new Chief Executive of Liverpool Women's.

Firstly, thank you to everyone for giving me such a warm welcome.

Although I only started in post last week, I have spent some time here over recent months visiting the Trust to meet with members of the Executive Team following my appointment. I can already see what a special place this is, but I know over the coming weeks and months that I will appreciate this even more.

As most of you will be aware following my appointment earlier in the year, I will be performing my new Chief Executive role here alongside my existing Chief Executive role at Liverpool University Hospitals NHS Foundation Trust (LUHFT). This means both Trusts now share a Chief Executive.

Naturally, as with any shared role, my time will be split between Liverpool Women's and LUHFT, but I am planning on spending plenty of time here as I get settled into the role. I am really looking forward to meeting colleagues across the Trust and to learn more about the amazing services we provide.

Early Pregnancy Assessment Unit (EPAU) Relocation

The Early pregnancy Assessment Unit (EPAU) provides nurse led outpatient care to women with problems or concerns in early pregnancy (6 - 12 weeks).

The Early Pregnancy Assessment Unit (EPAU) has been relocated from the ground floor to the second floor, this is to enhance the patient experience and provide a more comfortable and calmer environment for patients and their families. The new unit has its own access and is located next to the Hewitt Fertility Centre (HFC), the unit has two scanning rooms, waiting area and opened its doors in its new location on Monday 6th November 2023.

You can find further information on the EPAU by visiting our website HERE.

Section A - *Internal*

Liverpool Women's boasts Zero Vacancies in Maternity Services despite national shortage

Liverpool Women's is one of a small number of Trusts throughout the country currently carrying no vacancies within their Maternity services department.

Despite a national shortage of midwives, Liverpool Women's NHS Foundation Trust is currently carrying no vacancies and are confidently retaining their existing workforce. By actively encouraging and supporting retired employees to return to work offering flexible working and a free breakfast & parking for all student midwives, the Trust is thriving.

The Trust is also seeing low levels of Staff turnover rates (6.1%) below the national target) indicating a stable midwifery workforce.

Yana Richens, Director of Midwifery and Heledd Jones, Head of Midwifery at Liverpool Women's said: *"We pride ourselves on developing our workforce here at Liverpool Women's, and we have introduced several new posts in the midwifery structure during the past 12 months. These include Maternal Medicine Specialist Midwife, Diabetes Specialist Midwife, Clinical Lead Midwife for the Midwifery Led Unit and Clinical Lead Midwife for the Fetal Medicine Unit to name but a few. We feel these additional posts are having a positive impact throughout maternity, and our commitment to excellence continues to strengthen our team and enhance the care we provide."*

Maternity team scoops top Nursing Times award

We are delighted for Liverpool Women's NHS Foundation Trust's Maternity Team who scooped a top award at the Nursing Times Workforce Awards on 21 November 2023 for Preceptorship Programme of the Year.

The Nursing Times Workforce Awards are held each year to recognise and reward the excellent work that is being done to support the nursing and midwifery workforce. The event inspires and rewards organisations for excellence in supporting the future of the health and care workforce. This year's summit and awards event were held on Tuesday 21st November 2023 at the Hilton London Metropole.

Liverpool Women's Midwifery Preceptorship Programme Team was shortlisted for the support and success the Trust has had with its Preceptorship programme, which is now in its 3rd year and has achieved a 98% staff retention rate, providing support and development to newly qualified midwives. The positive feedback received from the Trust's Newly Qualified Midwives was also part of the award entry.

Alison Murray is the Trust's Deputy Head of Midwifery and was at the event to help the team collect the award. She commented: *"We are absolutely thrilled with this award which acknowledges the multidisciplinary team approach within our Maternity service and for making the vision we had for midwifery preceptorship come to life. We are proud that we have a team of leaders who are supporting and inspiring the next generation of newly qualified midwives at Liverpool Women's and for the benefit of the wider NHS in the future."*

Section B - *Local*

NHS Cheshire and Merseyside Blog

CEO of NHS Cheshire and Merseyside
Graham Urwin

With the nights drawing in and temperatures starting to drop, we are beginning to enact our 2023-24 winter plans.

November-February is always a particularly busy time for the NHS and we will be working hard to support frontline services to maintain quality and safety standards amid additional seasonal pressures.

You can help too. Please do all you can to look after yourself and others this winter. If you are eligible for flu and COVID-19 vaccinations, for example, please come forward when invited. Vaccinations not only help to protect you, but those around you too.

Campaigns such as Ask Your Pharmacy Week and Self Care Week also provide a timely reminder of the simple actions we can all take to help prevent ill-health.

For those who do need to access primary care services this winter, we've recently been highlighting how new roles such as social prescribers, physios and mental health practitioners are broadening the range of support available via GP practices. More below.

Finally, and most importantly - it is Remembrance Sunday this weekend - our national opportunity to reflect on the service and sacrifice of all those that have defended our freedoms and protected our way of life.

We remember the Armed Forces and their families, the vital role played by the emergency services and all those who have lost their lives as a result of conflict both on Remembrance Sunday and all year round.

Graham Urwin - Chief Executive

Full November 2023 update available here - https://mailchi.mp/b90dd09d5e45/stakeholder-brief-6151228?e=a09b917c78

NHS Cheshire and Merseyside Integrated Care Board meeting

Papers and recording for the meeting held on 30 November 2023.

https://www.cheshireandmerseyside.nhs.uk/get-involved/meeting-and-event-archive/nhs-cheshire-and-merseyside-integrated-care-board/30-november-2023/

Section B - *Local*

HSJ awards success for Cheshire and Merseyside provider collaborative

Cheshire and Merseyside's provider collaborative gained national recognition after winning Provider Collaborative of the Year at last night's HSJ Awards.

Health Service Journal (HSJ) judges praised Cheshire and Merseyside Acute and Specialist Trust Alliance (CMAST) for its "strong and effective collaboration" and its potential for further growth and co-production.

Between 2022 and 2023, by working together the provider collaborative eliminated the 104-week wait and reduced the 78-week wait for nearly 40,000 people, meaning more people received the care they needed much quicker.

Provider collaboratives are partnerships that bring Trusts together to work at scale to benefit patients.

CMAST brings together 13 trusts, serving a population 2.6 million across nine Local Authority areas.

The awards were judged by more than 190 leading health and care figures including NHS England chair Richard Meddings, Department of Health and Social Care director general for NHS performance and policy Matthew Style and National Institute for Health and Care Excellence chief executive Sam Roberts.

You can find out more about CMAST and its individual trusts here.

You can find out more about the HSJ Awards here.

CMAST Leadership Board Update - November 2023

The Leadership Board met on 3 November and received two presentations related to the available data, emerging priorities and activities being coalesced within C&M on digital and workforce.

The need to prioritise and to target activity was discussed as was the opportunity for Trusts to consider the best way to maximise effort, secure improvements and, if possible, to achieve efficiency. The Board welcomed the presentations and identified the need for a facilitated exploratory and prioritisation discussion on these subjects at its next meeting.

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

Please see the appendix to this report.

Section C – *National*

NHS Providers annual State of the provider sector survey findings

On 14 November 2023 NHS Providers published their findings of their annual State of the provider sector survey, which provides a snapshot of the issues facing leaders of hospital, mental health, ambulance and community services across England.

According to new findings, trust leaders are warning that more strikes, staff burnout and relentlessly rising demand for care amid a severe funding squeeze could hamper progress in cutting delays for patients.

The survey found that:

- Eight in ten leaders (80%) say this winter will be tougher than last year (66% said last year was the most challenging they had ever seen)
- 95% are concerned about the impact of winter pressures
- Most (78%) are worried about having enough capacity to meet demand over the next 12 months - higher than before the pandemic in 2019 (61%).
- Most are concerned about the current level of burnout (84%) and morale (83%) in the workforce.
- Almost nine in 10 (89%) are worried that not enough national investment is being made in social care in their local area
- Fewer than one in three (30%) think that the quality of health care they can provide in the next two years will be high.

You can read our the full survey findings here and our press release here.

A message from Amanda Pritchard, NHS Chief Executive

In an update from Amanda Pritchard in November 2023, it was stated that the NHS aims to eliminate cervical cancer by 2040 by intensifying HPV vaccination and advancing screening. The goal is to eradicate HPV, the cause of 99% of cervical cancers, within 17 years. The success of school vaccination teams, preventing 450 cancers and 17,200 pre-cancers, enables this ambitious target. Amanda highlighted progress in dementia diagnosis rates, with over 50,000 more diagnoses in the past year, aiding support for affected individuals and families. Looking ahead, attention is on the Autumn Statement for additional NHS Talking Therapies investment. Amanda anticipates updates on the Federated Data Platform, benefiting Integrated Care Systems and Trusts. The NHS has achieved the goal of transitioning 90% of Trusts to modern Electronic Patient Records. Additionally, the Life Sciences Council discusses a new Voluntary Scheme for Branded Medicines Pricing, with expectations of cross-cutting actions supporting commercial clinical trials to maintain England's global prowess in healthcare innovation.

Section C – *National*

Statement on information on health inequalities

NHS England (NHSE) published a statement on information on health inequalities (duty under section 13SA of the National Health Service Act 2006) on 27 November 2023.

A briefing from NHS Providers provides an overview of the statement and highlights the specific actions trusts are expected to take to improve data capture, analysis and reporting on health inequalities. It sets out the powers available to trusts around data, provides a list of data indicators that trusts will be expected to report on, and identifies opportunities for how trusts could make use of these data. Trusts will be expected to report on these data indicators within their annual reports.

ndb-statement-on-information-on-health-inequalities.pdf (nhsproviders.org)

Alarm raised over approach to scrutiny of maternity services

The HSJ reported on 30 November 2023 that NHS trust chairs and chief executives have said the management of fragile maternity services is being challenged by a lack of clear standards and direction from government and regulators.

NHS Providers called for ministers to act on confusing rules and regulations.

Miriam Deakin from NHS Providers said: "Trusts need government support to invest in their workforce and the design of services plus recognition that the regulatory environment has become very complex and difficult to navigate. Trusts need support in making maternity services positive and attractive places to work, with oversight focused on the needs and outcomes of mothers and babies.“

Thirlwall Inquiry - Transcript of the Chair’s opening statement

On 22 November 2023, Lady Justice Thirlwall made her opening statement. The public inquiry into the Lucy Letby murders will seek changes to NHS services and culture next year. The opening statement notes that the inquiry will "look for necessary changes to be made to the system of neonatal care in this country in real time and at the earliest opportunity, avoiding delays in making meaningful change".

https://thirlwall.public-inquiry.uk/2023/11/22/transcript-of-the-chairs-opening-statement/

CMAST
Cheshire and Merseyside Acute and Specialist Trusts

Cheshire and Merseyside
Health and Care Partnership

CMAST Briefing

October 2023

ICB Update

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

Opening the meeting, Chair Raj Jain paid tribute to the 70,000 NHS staff across Cheshire and Merseyside and pointed to the developing partnerships at both Place-level and across the sub-region.

Chief Executive Graham Urwin then led a presentation about the performance of NHS Cheshire and Merseyside in 2022-23.

With specific reference to CMAST, Graham mentioned elective recovery stating, NHS Cheshire and Merseyside was the first Integrated Care Board in the Northwest to eliminate both two-year and 18-month waits following the pandemic.

On diagnostics, Cheshire and Merseyside's growing network of Community Diagnostics Centres was cited as rapidly improving access to key diagnostic tests, with £119m worth of funding secured during 2022-23 for additional mobile X-Ray machines and MRI and CT scanners. Improvements in diagnostics are having a positive impact on cancer care, with people across Cheshire and Merseyside now more likely than ever to have cancer detected in its earliest stages.

CMAST Update

The Leadership Board met on 03rd November and received two presentations related to the available data, emerging priorities and activities being coalesced within C&M related to digital and workforce.

The need to prioritise and to target activity was discussed as was the opportunity for Trusts to consider the best way to maximise effort, secure improvements and, if possible, to achieve efficiency. The Board welcomed the presentations and identified the need for a facilitated exploratory and prioritisation discussion on these subjects at its next meeting.

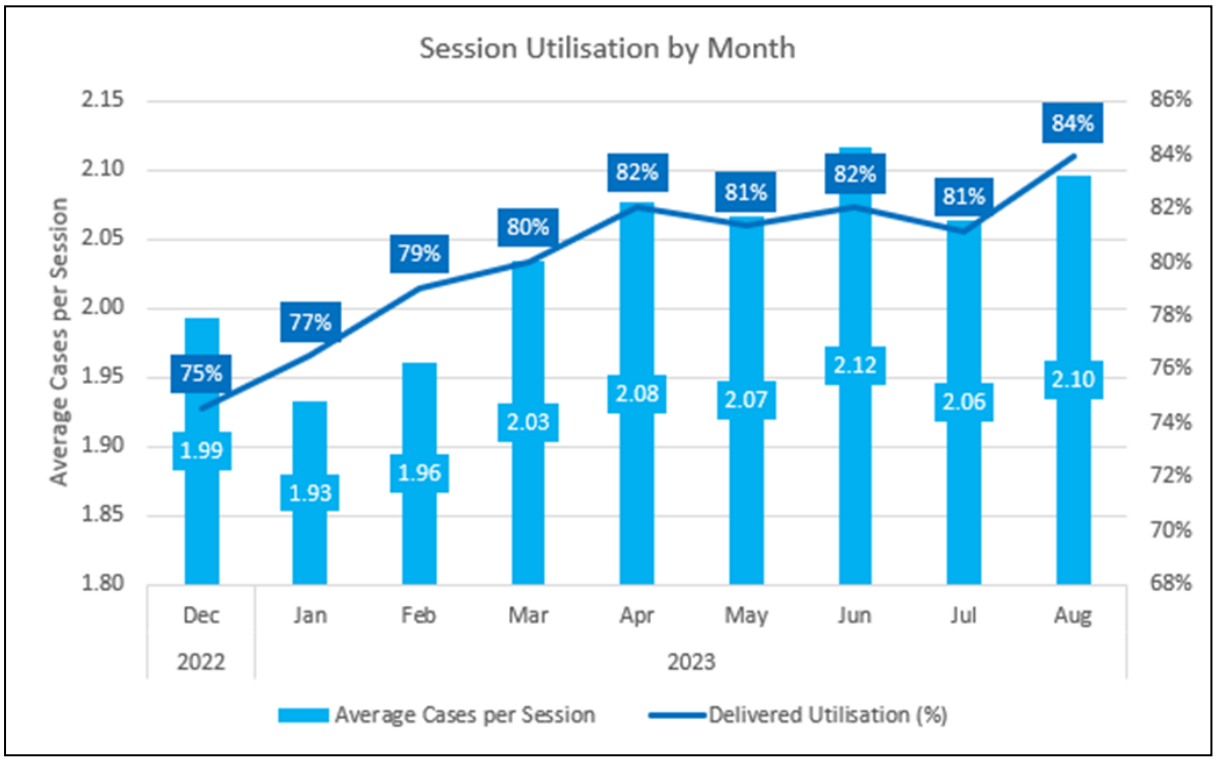
Elective Recovery and Transformation Programme

Waiting times reduction

- We now have less than 55,000 patients to clear before the end of March in order to achieve the target of no people waiting over 65 weeks. Our average clearance rate has reduced slightly due to the high levels of industrial action and the summer holidays; 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.
- Industrial action has hit hard, with a total of 76,145 cancellations due to strike action. We have experienced the highest levels across the country, compared with Greater Manchester at 52,666 and Lancashire & South Cumbria at 25,895.
- Liverpool University Hospitals is one of two national early implementer sites for the Alternative Choice programme which enables patients to request an alternative provider. The trust sent SMS texts to 300 patients that had been waiting over 40 weeks inviting them to respond if they would like to be seen by another trust. So far only 6 patients have responded. All trusts will "go live" with this initiative on the 31st October.

Theatres

- Our theatre utilisation performance is improving again, although we are still in the 3rd quartile. Some trusts that perform well have not submitted data for this period, so we believe the "real" performance is higher.
- Our session utilisation has improved through August, and we are expecting this to continue when the September data is available.



- The theatre academy training programme continues with good engagement. Another round has commenced, and we have over 30 more people being trained from a range of clinical and operational backgrounds.

Clinical Pathways

The CPP Programme continues to work with orthopaedics, dermatology, ENT and gynaecology.

Orthopaedics

- C2Ai risk stratification programme is progressing and has been pivotal in helping select patients for different clinical environments. Provisional work has tested the methodology and processes with WUHT in the Clatterbridge Surgical Hub and the process is being rolled out to the other trusts.
- Options for management of Open Fractures is being discussed by the Orthopaedic Alliance. A paper is being produced by the Alliance and will be taken to Medical Directors.

Dermatology

- Teledermatology implementation is expected to be 80% by end of year.
- An options paper has been prepared to consider future models for the service. The recommendation proposes that an independent evaluation of IT platforms is undertaken prior to procurement of system for 2024.
- Two teledermatology image capture hubs are being established through the Community Diagnostic Centres programme and these will commence in December.

Gynaecology

- Gynaecology collaboration workshop took place in September. 53 attendees from across Acute, Primary care, Place and Local Authority came together to agree priority areas for further improvement including development of women's health hubs and implementation of the Women's Health Strategy.
- A detailed implementation plan is being prepared to set out the next steps.

ENT

- The ENT GIRFT Gateway review identified key actions, and these have been confirmed, including: 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.

Other news

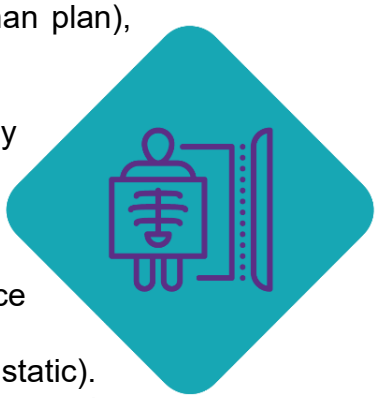
- Many of our specialty level clinical leads have reached the end of their agreed term, so we have been through a process to appoint clinical leads. Some of the clinical leads will continue in their role, and we also have a number of new leads. We will be working closely with them to induct and "on-board" them over the next month.
- The second phase of the Clatterbridge Elective Hub has now opened, and has been visited by Professor Tim Briggs, the clinical director for the national GIRFT programme. The team were highly commended by Professor Briggs on the quality of the facility, and the evident team working.
- We have established an additional programme of work focussed on utilisation of the elective hubs / cold sites to ensure we make best use of those through the winter. This work will focus on all aspects of the hubs, including the clinical and commercial models for the long term.

Diagnostics Programme

Key Performance Headlines

(Aug 2023 DMO1)

- 104,043 tests have been delivered in month.
- YTD over performance all tests combined (9%). CT (6% higher than plan), Ultrasound (4% higher than plan) and MRI (7% higher than plan).
- YTD under performance in colonoscopy (-18%) and echos (-7%).
- 77% of patients have waited 6 weeks or less for a test. (Decreased by 1% since July 2023)
- Ranked 16th out of 42 ICSs for waiting time performance. Increased from 18th since July 2023.
- 16,188 patients have waited 6 weeks or more (slight increase since July 2023).
- The total number of patients waiting for all tests is 75,393 (relatively static).
- STHK has the highest number and percentage of patients waiting 6 weeks+ (6630 patients 41%).



(8 October WLMDS)

- Only 62 40 weeks+ waiters remain. Patients are waiting as follows: 48 Mid Cheshire, 2 MWL ,6 COCH, 6 WHH

Endoscopy

- Eight bids supported as part of the Endoscopy Transformation Programme - £8.13m awarded to C&M.
- Additional capacity for colonoscopy commissioned to be delivered at LUFT Broadgreen, COCH, and Mid Cheshire. Warrington and Halton and Wirral to begin early November. This capacity will be directed to longest waiting patients and cancer pathway patients.
- Expression of Interest shared for transforming prescribing and distribution of Bowel Prep.

Pathology

Digital and IT

- **LIMS**: LIMS specification shared with suppliers as part of Early Market engagement (EME). Evaluation documents have been developed and shared with stakeholders to review.
- **Digital Exec Group reps** – COC Cathy Chadwick, WUTH Hayley Kendall, LUFHT Rob Forster, MWL Christine Walters, WHH Lucy Gardner
- **GP Order Comms:** working group established with roll out plan under construction.
- **Digital Pathology**: IMS upgrade to v.4.2.3 completed, with the remaining site's upgrade scheduled. SG scanners installed at MWL and LCL.
- **Digital Resource:** Expressions of Interest have been confirmed. MWL will host the central team with a meeting scheduled to confirm next steps.
- **CMPN Workforce Strategy**: Thematic analysis following engagement activities with over 300 members of CMPN (Cheshire and Merseyside Pathology Network) has been completed. A summary of key themes has been shared with wider stakeholders for comments. A first draft of the strategy has been developed.
- **CMPN TOM Delivery Plan**: The TOM Delivery Plan has been developed and has been shared for comments with Chief Execs, SROs. The Plan was taken through the CMPN Management Group and C&M DDB as part of the formal governance routes in September with endorsement.

- **CMPN Comms and Engagement**: A monthly newsletter has been produced for printing and sharing via lab noticeboards for operational staff.
- **Histopathology Review**: Significant data template completion progress made by all Trusts. Report due December 2023.

Physiological Science

- **Network Development –** workshop to develop the purpose and, vision and values held 28 Sept 2023. Next steps is to establish a working group to finalise the terms of reference, network composition and fully map out the existing networks. A second workshop is being planned for Dec 2023 to further develop the workplan.
- **Artificial Intelligence in Echocardiology Clinics -** A proof of concept for the use of AI in echocardiology clinics is in development. This proof of concept is part of joint plans with the C&M cardiac network to trial one-stop shop community heart failure clinics across 3 C&M locations. An expression of interest process to identify the 3 providers is currently underway. The deadline for providers to submit an expression of interest is Sunday 19 November 2023 (midnight).

Radiology

- **CAMDASH –** work is continuing to ensure the phase one deployment of CAMDASH (a C&M radiology BI dashboard) remains on schedule; Trusts are being asked for availability to attend showcase sessions to ensure Trust feedback in used to make further iterations of the CAMDASH design. Conversations are in progress with other diagnostic networks to look to encompass their data into the tool.
- **Interventional Radiology –** CAMRIN hosted the interventional radiology summit on 06/10/2023, we have completed the feedback report and returned this to attendees with a summary of the IR Summit, the next steps and work completed in group discussions during the summit.
- **Radiology Clinical Reference Group (RCRG) –** the group met on 25th September. Agenda items discussed were National Optimum Stroke Imaging Pathway update; Emergency presentation of brain tumours; Metastatic Spinal cord Compression; MR service requirements for suspected Cauda Equina referrals.
- **Diagnostic IT Network –** a further number of circuits have been installed for the Diagnostic IT Network, along with further delivery dates for outstanding sites, meeting with BT – committed to delivering all remaining circuits that are currently held by BT/Open reach by end of October 23, Pilot site for edge switch connections (MWL; Whiston) has been installed successfully.
- **GP Direct Access –** CAMRIN has worked with Lancashire and South Cumbria Imaging Network to understand what data needed to be acquired for the GP Direct Access project, this data has been obtained and processed to provide referral rate by individual GP, place and PCN and the number of tests needed to reach quintile 2.

Community Diagnostic Centres (CDCs)

- Activity plans confirmed with national team for H2 23/24
- System has been accepted for pilots for CDC gynae pathway and cardio-respiratory echo work.
- Activity is above income plan year to date, and site variation for activity levels has management plans in place.
- Additional capital to support risks for Southport CDC (£1m in 23/24) and Halton (£1m in 24/25) have been authorised by the national team.

Finance, efficiency and value workstream

The overall C&M Financial position has worsened in September (month 6) with an overall deficit of £128m against a £71.5m plan, £59m worse than plan. This deficit has slowed down compared to earlier months, but C&M remains the fourth highest deficit in England.

Month 6	Plan (£m)	Actual (£m)	Variance (£m)	FYE Plan (£m)	FYE Forecast (£m)	Variance (£m)
CMAST (deficit)	(110.0)	(126.5)	(16.5)	(126.7)	(126.7)	0.0
CMHCD surplus	4.0	2.9	(1.1)	6.6	6.6	0.0
Total Provider (deficit)	**(106.0)**	**(123.6)**	**(17.6)**	**(120.1)**	**(120.1)**	**0.0**
Total System (deficit)	**(71.5)**	**(128.2)**	**(56.7)**	**(51.2)**	**(51.2)**	**0.0**

It should be noted that once non-recurrent CIPs are adjusted for, the underlying deficit is £191m. At this stage C&M is forecasting a year end position in line with its overall plan (£51.2m deficit) – this is very high risk.

The main drivers for the deficit include:

- Undelivered CIP
- Industrial action cover
- Continuing health care activity and inflation
- Prescribing
- MH packages of care

Good progress made on reductions in agency expenditure which now sits at 3.18% of the total bill pay.

CIP

Month 6	Plan (£m)	Actual (£m)	Variance (£m)	FYE Plan (£m)	FYE Forecast (£m)	Variance (£m)
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Risk continues around underlying financial position given the unidentified CIP, reliance on non-recurrent savings and back year loaded CIP plans.

Financial Sustainability and Strategy – update on four pillars work

Pillar one – drivers of deficit – work progressing supported by E+Y.

Pillar two – behaviors and accountabilities - slow progress.

Pillar three - productivity and efficiency - balance sheet and CIP work complete, focus now on productivity.

Pillar four – transformation – recognition this is a bigger piece than just finance and needs to link in with clinical strategies.

A roadmap is in progress to set out plans to January 2024.

Capital and Cash

Expenditure is slow with spends behind plan in the majority of providers thus focus is needed to ensure allocation are spent in full or this will impact 2024/5.

High starting cash balances are reducing month on month with 4 providers requesting ongoing cash support (total £52.9m to date) scrutiny is placed on C&M in relation to its aggregate cash position.

Efficiency at Scale

Overarching Programme

The ICB Transformation Committee support and funding for 23/24 and 24//25 has now been formally secured for the E@S programme and Medicines Optimisation. Options to support the procurement workstream are being explored.

The programme continues to engage with stakeholder across the C&M system, regionally and nationally. Bi-weekly meetings are continuing with the national team and there is a plan to commence the provider collaborative data pack work in the next 6-8 weeks. The programme attended a meeting with all provider collaboratives Managing Directors from the North on the 18 October and has been asked to share further information on the work taking place across C&M. An action was also taken to seek the establishment of a network for corporate services efficiency leads.

Finance/Legal

The data sharing agreement for all corporate service information is now in place across C&M. 2022/23 Corporate service reports have now been released to all Trusts and will be reviewed by the E@S programme to understand potential opportunities.

The national team have issued a procurement notice relating to early-stage work on the national legal programme to make NHS legal services more efficient. This would support the work already being completed with C&M and be aided by the strong relationship the system already has with the national team.

Workforce

A workforce data review was completed with all Trusts in C&M and was reviewed at a recent HRD event. It was agreed further work is required with the HRDs to determine the key priorities for scaling up people services and identify which programmes will be included in the scope of the E@S Workforce Group moving forwards, a further workshop is planned in mid-October.

Medicines Optimisation

Discussions have taken place with colleagues outside of pharmacy to inform and support a C&M Polypharmacy strategy moving forward. A pilot is underway in Sefton for patients to be identified utilising business intelligence software and outcomes will inform future work. The programme is linking closely with the ICB Director of Population Health, and a community of practice date is arranged for November incorporating speakers from C&M.

Procurement

Introductory and engagement meetings with key stakeholders are being held by the new Chief Procurement Officer, including Directors of Estates, Chief Pharmacists and Chief People Officers.

The procurement workstream has agreed a set of priorities which includes a multi-year workplan, a procurement strategy and development of robust governance and reporting. The current scheme pipeline has identified £4.9m (FYE) of savings/cost reductions.

Workforce

CMAST Workforce Programme

The CMAST Workforce Programme Board took place on 11th October and Jan Ross, CEO The Walton Centre, chaired the meeting for the first time in her role as SRO. A summary of the Developing Band 6 Nurses in C&M project and Elective Recovery Strategic Workforce Planning work were shared with the group. An update following the Chief People Officer meeting was also presented and confirmation received that the HEE funding can be repurposed for CMAST workforce projects.

Development of Band 6 Ward & Department Nurse Roles

A draft Development Toolkit was presented at the CMAST Workforce Programme Board in October and received positive feedback. A workshop to review and sign-off a final draft of the Toolkit is scheduled to take place on Thursday 26th October. Following this workshop, a pilot of the Development Toolkit will be launched across several Trusts in C&M in November.

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. An outline programme of work has been submitted to NHS England to access AHP Workforce, Training and Education funding for 2023/24 and the team are awaiting feedback.

Elective Recovery Workforce

Support from Attain has been mobilised and they are focusing on the following three key areas of work until the end of December: Theatres Workforce Transformation, Surgical Hubs and Clinical Pathways Programme. A prioritisation exercise is currently underway to identify the initiatives which are likely to have the greatest impact on the long-term sustainability of the Cheshire & Merseyside workforce.

Workforce Efficiency at Scale

A workforce data review has been completed with all Trusts in C&M providing information. The data will be reviewed at the HRD event w/c 16th October with the aim of setting system workforce priorities. The group will be merged with the overarching Workforce Programme from November to avoid duplication and support collaboration going forward.

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.
- **Industrial action after action review** – Decision taken to focus on key action relating to 'Monitoring patient harm- Implementing a governance process across Cheshire and Merseyside'. A steering group is being established to explore ideas and solutions.
- **Patient Engagement Portals** – Support being provided to the C&M outpatient team on Patient Engagement Portals (PEPs) as part of the National outpatient transformation

work. Visiting outpatient departments at two green sites, ECHT and LUHFT, to gain patient feedback regarding use of the digital portals.

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 a deterioration for patients admitted, transferred, or discharged within 4 hours, with September performance at 71.0% compared to August 73.2% this is against a 2023/24 year-end national recovery target of 76%. Current performance is slightly below 2023/24 plans, however, is performing better than the North West (70.3%).

The percentage of beds occupied by patients with a length of stay over 14 days was 34.6% at the end of September 2023, whilst length of stay over 21 days continues to account for around a quarter of occupied beds (23.9%) against the 2023/24 Operational Plan of 17%.

NHS
Liverpool Women's
NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	23/24/218	Date: 14th December 2023
Report Title	Maternity Incentive Scheme (CNST) Year 5 2023 – Update Paper	
Prepared by	*Angela Winstanley – Maternity Quality & Safety Matron* *Vicky Clarke – Divisional Manager* *Heledd Jones – Head of Midwifery* *Yana Richens – Director 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. **Key information** **The trust is compliant in 9 of 10 areas.** **The following information relating to SA1 is for information.** SA1 – Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard? A. 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. - 32/34 Cases reported to MBRACCE – 94.11 % Compliance presently. Noncompliant Acknowledgment of effect of Industrial Action on ability to commence and complete the reviews of two cases and the associated action plan required in response to the NHSr Letter dated 24.10.2023. A divisional review of the PMRT process and associated action plan has been completed and can be found in Appendix 1, This action plan has been shared at the FHDB and Board Executives. The Maternity Incentive Scheme, released annually, defines and outlines Trusts to use the PMRT tool for deaths in the scheme period. Within the scheme period, Trusts are mandates to ensure the following: - 100% of deaths are reported within 7 days with all relevant surveillance information completed within one month - 95% of deaths of babies in our Trust their parents should have their views sought on the care provided. - 95% of deaths – reviews should be started within 2 months - 60% (minimum) reviews completed to draft report within 4 months and published within 6 months. The Division have always evidenced adherence to the above standards, above and beyond what is expected within the MIS Scheme requirements. For this year, we have missed the deadlines for assigning the review for 2 babies within the specified period. We have achieved 92 % compliance and, given that no further deaths will be included in the denominator, this will be our final percentage compliance. In October 2023, NHS Resolutions circulated an email outlining the potential mitigations for the PMRT element of MIS Year 5. The correspondence stated, "***where MDT PMRT meetings have needed to be rescheduled due to the direct impact of industrial action, and this has an impact on MIS reporting timescales, this will be accepted provided that there is an action plan approved by Trust boards to reschedule these meetings to take place within a 12-week period from the end to the MIS compliance period."*** The deaths of the babies discussed, and the timescales outlined above spanned 3 separate periods of industrial action. There was no PMRT meeting in August, and the lead consultants were required to contribute additional	

	clinical time to maintain a safe clinical service during industrial action. In recognition of the need to achieve CNST compliance, an additional PMRT meeting was scheduled for October. In relation to the outstanding reports, there are no mandates for completion; the Trust only has to demonstrate the above timescales whilst the MIS scheme period is active. **The following information relating to SA6 is not discussion and assurance.** SA 6 – 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 V3 and the Implementation Tool. To progress Safety Action 6 (SBLCBV3) in Element 4 Fetal Monitoring, we are required to be compliant to 50%. Current compliance is 40%. Final Check-point meeting with LMNS scheduled 11.12.23- during which evidence will be presented demonstrating compliance of 50% There are three interventions within this element that are weighted to 20% each. The FHD anticipate that 2 of the following interventions will be signed off by the LMNS/ICB on 11.12.2023 reaching 80% which is the requirement.

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: • ***Receive the current position in relation to CNST Year 5*** • ***Note key risks to compliance and assist with solutions for unblocking.***			
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
Maternity Transformation Programme	Monthly	DoM	Monthly progress updates from scheme safety action leads.
Maternity Transformation Workstream 3	Monthly	HoM	Monthly progress updates to Maternity Transformation Programme
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.

EXECUTIVE SUMMARY

This report outlines the requirements for compliance of the Maternity Incentive Scheme and their associated standards for the Maternity Incentive Scheme Year 5 and the Trust's current status against these 10 areas.

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.

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 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 should take 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.

MAIN REPORT

Introduction.

NHS Resolution (NHSr) is operating year five of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme (MIS) 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. 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 will recover an 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 MNSI 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 relationship 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 be led by the Trust Secretary.

Current Position for MIS Year 5 – December 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: B. **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. C. **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 D. 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. b) **95%** of reviews should be started within two months of the death. - 32/34 Cases reported to MBRACCE – 94.11 % 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 has been completed and can be found in Appendix 1, This action plan has been shared at the FHDB and Board Executives. c) **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 – 80% of eligible cases. - Fully published within six months – 100% of eligible cases.	**December 2023 –** There is currently an identified concern with compliance for this safety action.

	E. Quarterly reports submitted to Trust Executive Board from 30th May 2023. 100% Compliant A full breakdown of al PMRT eligible cases can be found in Appendix 2	
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. ***December 2023 –*** The Trust are in receipt of FINAL data submitted based on July data. This data indicates full compliance with **11 of the 11** metrics. COMPLIANT 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) ***December 2023*** – Submitted July data to MSDS demonstrates a **96.2%** compliance with this indicator. 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 Maternity CoC pathways, these criteria (A&B) is not applicable*** 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 Evidence to support the Trusts position for this Safety Action can be found in the Appendix 3	**DECEMBER 2023 POSITION** – 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. **December 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.	**DECEMBER 2023 POSITION** – Full compliance.

Anna Paweletz– Consultant Neonatologist Sarah Brownrigg – ANNP Paula Nelson – ANNP	**December 2023 Update** – A multidisciplinary review and audit of all term admissions to NICU is conducted weekly and has been well embedded in the Division for several years (preceding the Maternity Incentive schemes). **Compliance** 100% Quarterly reporting to the FHDB has continued and the 2022-2023 ATAIN audit report was sighted and noted at Trust Board in September 2023. **Compliance** 100% The 2022 – 2023 ATAIN and Transitional Care Audit and Action plan plus the q1 23/24 report has been shared with the LMNS on 30th October 2023 with further recent submission to the Future NHS LMNS Submission Portal.. **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. **December 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 COMPLIANT ***The LMNS have reviewed all evidence pertaining to this safety action and have confirmed to the Chief Nurse and Family Health Division in email dated 23.11.2023 that we are fully compliant with this safety action.***	
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 **December 2023 Update** – The Temporary Staffing Policy (available on Intranet) addresses the requirements of this safety action. The Medical HR department reviewed all agency bookings between the dates 1st March 2023 – 1st August 2023. The review identified no agency doctors were booked to work a shift at Liverpool Women's Hospital on the middle tier 2 (ST3- ST5) rota or the Senior Tier 3 (ST6 – ST7 rota. This audit will continue throughout the year collecting date via health roster and any shortfalls in this action will be reported. Full report and review findings can be found in the appendix 4. COMPLIANT 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. **December 2023 Update** – Between the audit dates, the Trust did not engage a long-term agency locum doctor or a locum bank doctor. Should the Trust engage a locum agency or locum bank doctor for a period of time greater than 2 weeks, the RCOG monitoring and	**DECEMBER 2023 POSITION –** FULL COMPLIANCE

	effectiveness tool will be utilised. Full report and review findings can be found in Appendix 4. COMPLAINT 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. December 2023 Update – Currently, the Division of Family Health, do not employ specialty or specialist doctors for obstetrics. The Maternity Consultants are job planned to work twilight shifts. This pattern of work factors in a minimum of 11 hours rest between shifts as evidenced in job plans and rosters. COMPLAINT 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. Trust positions with the requirements should be shared with the Trust Board, the Board-level safety champions as well as the LMNS. December 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. The Trust Board should expect an updated position in relation to July 2023 and January 2024 in March 2024. COMPLETED 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) December 2023 Update – Between May 2023 and October 2023 (inclusive) anaesthetic rotas have been provided and reviewed to assure the Board that a duty anaesthetist is available for the obstetric unit 24 hours a day. A review of these rosters has demonstrated no gaps in service provision. COMPLIANT 100% 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) December 2023 Update: The Neonatal Unit at LWH complies with the requirements of BAPM. A neonatal workforce review has been completed for this MIS Year 5 scheme and 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. This updated Neonatal Workforce Review paper is added to the Appendix 5. COMPLAINT 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). **December 2023 Update**: The Neonatal SLT have completed a nursing workforce review using the CRG Workforce Calculator. An action plan for maintaining safe staffing levels and provision of quality roles has been formulated and will be reviewed regularly for compliance and achievement of targets, and progress updates provided to the FHD. Trust Board must receive the Neonatal Nursing Staffing Paper and associated action plan in Appendix 6. COMPLIANT	
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. **December 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. This paper and Board Minutes have been submitted to the LMNS/ICB.	**DECEMBER 2023 POSITION** – Full Compliance

	The LMNS have reviewed all evidence pertaining to this safety action and have confirmed to the Chief Nurse and Family Health Division in email dated 23.11.2023 that we are fully compliant with this safety action.	
SA.6 Can you demonstrate compliance with all five elements of the Saving 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	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, national implementation tool has been developed and is in use to help maternity services to track and evidence improvement and compliance with the requirements set out in Version Three. 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.** **December 2023** – The Division now has access to the Implementation Tool. All SBLCBV3 elements have assigned leads, with oversight being monitored within the Family Health Division and Maternity Transformation Board and Senior Leadership Team. In partnership with the LMNS arm of the ICB, the Division have completed a full review of the implementation tool with LWH Self-Assessment and LMNS Validation review checkpoints reached. Liverpool Women's current position with respect to the interventions is as follows: To progress Safety Action 6 (SBLCBV3) in Element 4 Fetal Monitoring, we are required to be compliant to 50%. Current compliance is 40%. There are three interventions within this element that are weighted to 20% each. The FHD anticipate that 2 of the following interventions will be signed off by the LMNS/ICB on 11.12.2023 giving LWH final position as 80% in the non-compliant element, I. K2 Competency Assessments – All staff groups, caring for intrapartum women, must be compliant to >80%. Current compliance - Midwifery Staff 91%, ST1-7 97% and Consultant Obstetrician 91%. This progress has been successfully achieved and uploaded to the SBLCBV3/Future Generations Portal and will progress this intervention towards full compliance. II. Completion of a spot check audit demonstrating **>80%** compliance with a maternal and fetal risk assessment completed at onset of labour. This audit has been completed and we current compliances sits at 92%. This audit has been uploaded to the SBLCBV3/Future Generations Portal and will progress this Safety Action to full compliance. III. Completion of an audit demonstrating >80% with ongoing risk assessments in labour at 1-hour intervals. Audit completed and uploaded to portal but does not demonstrate 80% compliance. Action plan has been developed and is to be monitored through the FHDB.	**DECEMBER 2023**. Awaiting final LMNS/ICB sign off. On 11th December

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)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Partially implemented	60%	Partially implemented	50%	CNST Met
Element 2	Fetal growth restriction	Fully implemented	100%	Partially implemented	90%	CNST Met
Element 3	Reduced fetal movements	Fully implemented	100%	Partially implemented	50%	CNST Met
Element 4	Fetal monitoring in labour	Partially implemented	80%	Partially implemented	40%	CNST Not Met
Element 5	Preterm birth	Partially implemented	93%	Partially implemented	81%	CNST Met
Element 6	Diabetes	Partially implemented	83%	Partially implemented	67%	CNST Met
All Elements	TOTAL	Partially implemented	89%	Partially implemented	74%	CNST Met

	2. Hold quarterly quality improvement discussions with the ICB, using the new national implementation tool once available. COMPLETED **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. - **December 2023 Update** – The Senior Leadership Team have met with the LMNS/ICB on26th September 2023 and November 14th 2023, where all of the above requirements where discussed. ***The next meeting is planned for December 11th, 2023, where an updated, validated position of our compliance with every intervention of the SBLCBV3 Implementation Tool will be provided.***	
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. **December 2023 Update** – The Head of Midwifery has progressed this safety action in collaboration with the MVNP Chair and Deputy Chair 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. ***The LMNS have reviewed all evidence pertaining to this safety action and have confirmed to the Chief Nurse and Family Health Division in email dated 23.11.2023 that we are fully compliant with this safety action.***	**December 2023** FULL COMPLIANCE.
SA.8 Can you evidence that at least 90% of each maternity unit staff group attendance an 'in-house' multi-professional maternity	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. COMPLETED 2. The plan has been agreed with the quadrumvirate before sign-off by the Trust Board and the LMNS/ICB. COMPLETED 3. The plan is developed based on the "How to" Guide developed by NHS England	**DECEMBER 2023** Full Compliance.

emergencies training session within the last year.

Leads:
Alison Murray – Midwifery
Jonathon Hurst – Neonatal

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.

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

December 2023 Update:

Current compliance with MPMET and Fetal Surveillance Training is outlined above. Encouragingly, all staff groups have now met the required standards to declare compliance with this safety action. The Maternity TNA has been submitted to both the FHDB, Trust Board and LMNS/ICB.

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

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

December 2023 - There are currently no identified concerns with compliance for this safety action.

Angela Winstanley – Midwifery Safety Champion Srinivasarao Babarao – Neonatal Safety Champion. Heledd Jones – Head of Midwifery Vicky Clare – Family Health Divisional Manager	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 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. **December 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. Completed 100% 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. Completed 100% **December 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	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	**December 2023** - There are currently no identified concerns with compliance for this safety action.

Family Health – Clare Louise Murray Governance Manager Legal Services for NHSr Reporting.	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:** **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. **December 2023 Update**: The Division have reported all eligible cases to HSIB with legal services ensuring all eligible cases are also reported to NHSR and the EN Scheme. 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 can be found in Appendix 7.	

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
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 Position - Neonatal Nursing 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

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 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 should take 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.

Safety Action 1

Due to industrial action 2 cases for PMRT were delayed, the PMRT meeting was rescheduled as the following month in line with information received from NHSr in October 2023

Safety Action 6

Final Check-point meeting with LMNS scheduled 11.12.23- during which evidence will be presented demonstrating compliance of 50%

Appendices.

Safety Action 1 – Perinatal Mortality Reporting Tool.

- **Appendix 1 – PMRT Action plan – Industrial Action**
- **Appendix 2 – PMRT CNST Data Spreadsheet Redacted**

Safety Action 2 – MSDS Scorecard Submission.

- **Appendix 3 -**

Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS): Year 5
Safety Action 2 Scorecard

Last Updated: **26 October 2023**

NHS England

This scorecard is to support the second safety action which is: **Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?**
After the results are published for the final assessment month of July 2023 MSDS data this dashboard will continue, with the contents evolving over time to reflect changing MSDS DQ priorities.
This relates to the quality and completeness of the submission to the Maternity Services Data Set (MSDS) and ongoing plans to make improvements.
Only records which passed validation at the Strategic Data Collection Service (SDCS) are included.
Submitters will have been notified of record rejections at the time of submission and can review the data by downloading the pre-deadline extract.
This scorecard contains a summary and more detailed breakdown of each trust's progress against the criteria given below. Feedback on this scorecard can be provided to maternity.dq@nhs.net

Criteria

The documentation for CNST MIS Year 5 can be found here.
The full construction for each of the CQIMs and other measures is available within the metadata file published in the guidance hub

Criteria	Standard	Construction
1	**(CQIMs)**: 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 this "CNST Scorecard" which accompanies the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023. The final data for July 2023 will be published during October 2023	The number of CQIMs where the provider has met the requirements of all associated data quality criteria. **Achievement** - Where this is 10 or more mark this Pass "Pass". If this is less than 10, mark as "Fail". Please note that the newly created CQIM Breastfeeding 6 to 8 weeks does not form part of the assessment criteria.
2	**(Ethnicity):** July 2023 data contains valid ethnic category (Mother) for at least 90% of women booked in the reporting 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 / MSD101)	Numerator: Number of MSD101 records in the reporting period with an antenatal appointment in the reporting period with a corresponding record in MSD001 where EthnicCategoryMother is recorded Denominator: Number of MSD101 records in the reporting period with an antenatal appointment in the reporting period **Achievement** - Where a provider achieves **90%** or higher for this mark to "Pass", otherwise "Fail"
3	**(MCoC)**: Trust Boards to confirm to NHS Resolution that they have passed the associated data quality criteria in this "CNST Scorecard" which accompanies the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023 for the following metrics: Midwifery Continuity of Carer (MCoC) - i. Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks and have the CoC pathway indicator completed. ii. 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, criteria ii is not applicable.	**COC_DQ04** - Percentage of women who had an antenatal care plan in place for which continuity of carer indicator status was known, by 29 weeks gestation. **Achievement** - Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks and have the CoC pathway indicator completed **COC_DQ05** - Percentage of women with an antenatal care plan in place and the continuity of carer indicator completed by 29 weeks gestation, who have a named lead midwife and team **Achievement** - Over 5% of women recorded as being placed on a CoC pathway where both Care Professional ID and Team ID have also been provided
4	**Provisional Window Submission:** Trusts to make an MSDS submission before the provisional processing deadline for July 2023 data by the end of August 2023.	This dashboard will show whether a trust made an MSDS submission before the provisional processing deadline, including for final July 2023 data.
5	**Submission Portal Registration**: Trusts to have at least two people registered to submit data to SDCS cloud who must still be working in the trust.*	This dashboard will show whether each trust has two people registered to submit data at the end of each submission window, but will not validate this criteria for CNST. You will need to instead provide assurance to your board that you are meeting this criteria as part of the board declaration process.

* We have updated criteria 5 information to specify that while this scorecard includes information about the number of submitters, it will not provide validation of this criteria for CNST. Trusts instead need to provide this via their Trust Board Declarations.

Organisation Name: LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

Reporting Period: July 2023

NHS England

Notes: The most recent available reporting period is based on the final July 2023 data for the final assessment. For the purposes of CNST the CQIMs are measured only on a single month's data. see the FAQs on page 5 in this scorecard for more information.

1.

CQIMApgar

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMApgar	5	505			Passed
CQIMDQ14	565	635	89.0		Passed
CQIMDQ15	550	550	100.0		Passed
CQIMDQ16	510	550	92.7		Passed
CQIMDQ24	505	510	99.0		Passed

CQIMBreastfeeding

Indicator	Numerator	Denominator	Rate	Result
CQIMBreastfeeding	385	535	72.0	Passed
CQIMDQ08	535	585	91.5	Passed
CQIMDQ09	565	635	89.0	Passed

CQIMPPH

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ10	565	635	89.0		Passed
CQIMDQ11	205	565	36.3		Passed
CQIMDQ12	30	565	5.3		Passed
CQIMPPH	20	565		32	Passed

CQIMPreterm

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ09	565	635	89.0		Passed
CQIMDQ22	550	550	100.0		Passed
CQIMDQ23	510	550	92.7		Passed
CQIMPreterm	40	545		73	Passed

CQIMTears

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ14	565	635	89.0		Passed
CQIMDQ15	550	550	100.0		Passed
CQIMDQ16	510	550	92.7		Passed
CQIMDQ18	315	550	57.3		Passed
CQIMDQ20	5	300	1.7		Passed
CQIMTears	5	300			Passed

CQIMVBAC

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ14	565	635	89.0	Passed
CQIMDQ15	550	550	100.0	Passed
CQIMDQ16	510	550	92.7	Passed
CQIMDQ18	315	550	57.3	Passed
CQIMDQ26	550	550	100.0	Passed
CQIMDQ27	630	630	100.0	Passed
CQIMDQ28	285	630	45.2	Passed
CQIMVBAC	5	55	9.1	Passed

CQIMRobson01

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ30	565	635	89.0	Passed
CQIMDQ31	585	585	100.0	Passed
CQIMDQ32	520	585	88.9	Passed
CQIMDQ33	585	585	100.0	Passed
CQIMDQ34	320	585	54.7	Passed
CQIMDQ36	565	565	100.0	Passed
CQIMDQ37	230	565	40.7	Passed
CQIMDQ38	585	585	100.0	Passed
CQIMDQ39	565	565	100.0	Passed
CQIMRobson01	5	50	10.0	Passed

CQIMRobson02

Indicator	Numerator	Denominator	Rate	Result
CQIMRobson02	75	135	55.6	Passed

CQIMRobson05

Indicator	Numerator	Denominator	Rate	Result
CQIMRobson05	65	75	86.7	Passed

CQIMSmokingBooking

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ03	630	635	99.2	Passed
CQIMDQ04	600	630	95.2	Passed
CQIMDQ05	65	600	10.8	Passed
CQIMSmokingBooking	65	600	10.8	Passed

CQIMSmokingDelivery

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ06	560	565	99.1	Passed
CQIMSmokingDelivery	40	560	7.1	Passed

2.

EthnicityDQ

Indicator	Numerator	Denominator	Rate	Result
EthnicityDQ	610	630	96.8	Passed

3.

MCoC i

Indicator	Numerator	Denominator	Rate	Result
COC_DQ04	675	680	99.3	Passed

MCoC ii

Indicator	Numerator	Denominator	Rate	Result
COC_DQ05	135	135	100.0	Passed

4.

Provisonal Window Submission

Indicator	Result
Provisional Submission	Passed

5.

Submission Portal Registration

Indicator	Result
Registered Submitters	Passed

Maternity Services Data Set information for Maternity incentive scheme (CNST) Year 5: Safety Action 2

The table below summarises the number of criteria met by each maternity service provider by month. There are 5 criteria to meet on MSDS data submission. This scorecard will be updated and published each month. The final assessment is based on the final data for **July 2023** for which the submission deadline was **30 September 2023**.

Organisation Name: LIVERPOOL WOMEN'S NHS FOUNDATION ...

Notes:

For the assessment month (July 2023), additional analysis has taken place to ensure organisations that are not currently providing Midwifery Continuity of Carer services (MCoC) are not penalised for being unable to meet the second element of this criterion (COCDQ05) if they have no women recorded as receiving MCoC.

A pass for criteria 5 in this dashboard indicates that two data submitters were recorded at the end of the relevant submission window, but will not count as validation of this criteria for CNST. Instead, this criteria will need to be evidenced in CNST Trust Board Declarations.

All Provisional figures are subject to change and will be reassessed after the final submission window has closed.

There was a maximum possible score of 4 for March 2023 as provisional window submissions

	Final	Final	Final	Final	**Final** (assessment month)
Organisation Name	March 2023	April 2023	May 2023	June 2023	July 2023
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	4	5	5	5	5

Safety Action 4 – Medical and Nursing Workforce

- Appendix 4 - Obstetric Workforce Audit Report.
- Appendix 5 - Neonatal Medical Workforce Report
- Appendix 6 - Neonatal Nursing Workforce Report

Safety Action 10 – HSIB and EN/NHSr Reporting.

- Appendix 7- HSIB/NHSr/EN Cases Governance Record.

HSIB Cooled Baby Reporting - 6th December 2022 to 7th December 2023

Name	Baby W	Mum W Number	DOB	Eligibility	Gestation	Location of Birth	HSIB Reported	HSIB Referral	DOC/HSIB/EN INFO	NHSR/ EN Reference Number
[redacted]			03.01.2023	Cooled	41/40	Delivery Suite	Yes	MI-020613	05.01.2023	M22CT320/035
			09.01.2023	Severe HIE	40/40	Delivery Suite	Yes	MI-034708	18.10.2023	M23CT320/012
			09.01.2023	Cooled	37/40	LWH Theatre	N/R - Not in Labour.	NR	NR	NR
			21.02.2023	Intrapartum SB	38/40	LWH Theatre	Yes	MI-022857	22.02.2022	NA - Stillbirth
			07.04.2023	Cooled	41/40	Homebirth	Yes	MI-025399	11.04.2023	M23CT320/005
			10.04.2023	Cooled	40/41	LWH Theatre	Yes - Rejected Not in Labour	NR	11.04.2023	NR
			19.05.2023	Cooled	37/40	LWH Theatre	N/R - Not in Labour.	NR	NR	NR
			20.07.2023	Cooled	39/40	LWH Theatre	Yes	MI 028863	21.06.2023	M23CT320/004
			31.08.2023	Cooled	40/40	LWH Theatre	Yes - Rejected Not in Labour	NR	NR	NR
			29.11.2023	Cooled	39+6	LWH DS	Yes	MI 036561	05.12.2023	TBC

Perinatal Quality Surveillance Highlight Report November 2023 (October 2023 Data)

Introduction

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

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

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

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

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

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

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

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

Provider Trusts and their Boards, supported by the senior maternity and neonatal triumvirate and the board-level perinatal safety champion at its centre, ultimately remain responsible for the quality of the services provided and for ongoing improvement.

Family Health Clinical Dashboard (October 2023)

Areas of concern

Very Concerning – Investigate & Take Action.		
Metric	**Position**	**Narrative**
Outpatients: First appointment cancelled by Hospital – Maternity	19.56% (target <=10)	Quality Improvement project ongoing, led by the operational Divisional Manager for neonatal, which is aligned to Trust wide Outpatient Improvement project. We have seen a downward trend in month and will continue to implement improvement initiatives.
Outpatients: Subsequent appointment cancelled by Hospital – Maternity	17.63% (target <=10)	QI project ongoing, led by DDGM for neonatal, which is aligned to Trust wide Outpatient Improvement Project. We have seen a downward trend in month and will continue to implement improvement initiatives.
Concerning – Investigate and understand		
Flu vaccinations offered to pregnant women	79.46% (target >=90%)	8% increase during the past month. Drop-in flu vaccination clinics available in the Antenatal Clinic. All women who attend ANC, are offered the flu vaccination. Women who are low risk in pregnancy are signposted to their community midwife to have a flu vaccination in a community location.
Friends and Family Test: Maternity % positive	83.33% (target >= 95%)	Feedback remains low percentage average 7-9%. Themes include lack of information for women when going home from Mat Base which is being addressed through the provision of a postnatal information leaflet, which is currently being revised in partnership with the MNVP Chair. Other themes include delays in the process of ongoing induction of labour. An IOL QI project has been registered led by a newly appointed IOL midwifery coordinator. Increased capacity has been made available for IOL beds away from the Delivery Suite, which in turn increases the capacity on Delivery Suite for women undergoing surgical IOL. Another element is midwifery workforce, from the 30th October there are nil midwifery vacancies therefore we should be seeing a decrease in the number of red flags reported for delay in IOL.
LMS: Percentage women receiving personalized care plan	94.92% (target >=100%)	Community midwifery team leaders are auditing documentation on K2. Some midwives not completing the personalized care plan entry on K2. Community team leaders contact individual midwives to ensure that they are aware of the need to complete this section on K2.
Maternity services – percentage of Black, Asian or Mixed	33.33%	There are currently approximately 850 women booked onto a COC pathway, which is approximately 17% of all women that are booked to deliver at LWH. This cohort of women is generated based on those that are registered under one of 16 GPs in Liverpool. The GPs were originally selected due to

women at 29 weeks on CoC Pathway		location and percentage of women that are BAME or live in the bottom decile of deprivation. 19% of women in the bottom decile and 33% of BAME women are currently booked onto one of the MCoC teams. Whilst there are only 4 MCoC teams in place there is a limit to how these KPIs can be improved as the caseload of women only fluctuates slightly each month. A further 20% of women who are Black, Asian, or mixed ethnicity are cared for by the NEST team. The NEST team also provide antenatal and postnatal care to some of the most vulnerable women booked with LWH. All women cared for by the NEST team are non-English speaking with a large percentage also living in the most deprived areas of the city and often seeking asylum. The team do not currently work in the intrapartum areas therefore do not meet the criteria of a MCoC. To see a significant improvement on these KPIs, it would be necessary to move to phase 2 of the roll out of MCoC which was outlined in the Quality Committee Board paper in June 2022. Phase 2 involves rolling out 4 more MCoC teams and targeting more areas of the city that have high numbers of women that are either BAME or live in the bottom decile of deprivation. When the workforce skill mix improves and the current preceptors move towards completing their programme and become a band 6, the roll out of phase 2 could be facilitated using the same shift base model of MCoC.
Newborn blood sampling – Avoidable repeat tests	5.35% (target <=2%)	Newborn blood spot error rate increasing over the past 10 months. Highest error rate is within Neonatal Unit at 12%. Improvement Plan drafted that entails fresh eyes being applied to each blood sample before sending to Alder hey for testing. Fresh eyes is also being applied to all newborn blood spot samples that are taken on Mat Base.
Outpatients – DNA rates new - Maternity	17.63% (target <=10%)	SBAR complete: Actions to reduce DNA include: **Communication Enhancement:** • Implement reminder phone calls, text messages, or email reminders for glucose tolerance testing and phlebotomy appointments. Emphasize the importance of these tests during pregnancy and provide clear information on their significance. **Educational Materials:** • Develop and distribute educational materials in various formats, ensuring patients are well-informed about the purpose and benefits of glucose tolerance testing and phlebotomy appointments. **Accessibility Improvement:** • Consider offering flexible scheduling options to accommodate diverse patient needs. Evenings and

		weekend appointments, more clinics within the community accessible to patients. **Patient Feedback** • Involve patient experience for targeted survey during clinics on issues attending appointments and ask for feedback on service design. • Establish a support program encouraging patient engagement, creating a community where expectant mothers can share experiences and motivate each other to attend essential appointments, including glucose tolerance testing and phlebotomy. **Clinic Location** • Use patient DNA postcode to understand best suited additional satellite clinic opportunities. **Midwife Communication:** • Strengthen communication between the Midwife and patient to highlight the importance of glucose tolerance testing and phlebotomy appointments during their pregnancy. • Regularly assess the impact of these recommendations and adjust strategies based on feedback to improve attendance rates and ensure comprehensive maternal and fetal health monitoring. **Further data** • Information on patient attendance after 1st, 2nd, 3rd DNA. • Postcode DNA data for maternity review. **Wider Trust Initiatives Ongoing** • Patient Experience Portal. • Two Way appointment reminder text. • Automatic letter sending with Translation capability.
Outpatients – DNA rates: follow up – Neonates	16.93% (target <=10)	SBAR complete: Actions to reduce DNA include: **Communication** • PAs/coordinators to pick up phoning patients on Monday (Tues bank holiday) to confirm weekly appointments for Neonatal and BCG . • PAs/Coordinator to gain access to BT Text Message system to be able to send tailored texts to patients if call missed. • Include bus fare information in clinic letter, confirm if policy works in reality, social media comms trust wide.

		Clinic Location • Use patient DNA postcode to understand best suited satellite clinic opportunities. • BCG clinic at Aintree LWH site. • Explore low risk and ANNP clinics in Cheshire and Merseyside Womens and Childrens hubs. These are in a development stage so is an ideal time to consider opportunities. • Explore scope for some virtual appointments combined with face to face if clinically appropriate. ANNP 2nd appointment possibly? **Policy and Process** • Clinicians to bring completing clinical outcome form to Team Meeting to ensure all are completed at clinics where required. • Access policy reviewed to ensure patients are contacted before giving new appointment after DNA, update to only give 2 DNA rebooking's instead of 3, aligning and considering WNB policy in all neonatal clinics**.** **Patient Feedback** • Involve patient experience for targeted survey during clinics on issues attending appointments and ask for feedback on service design. • Pas to phone DNA patients and collecting reasons for attendance and book suitable appointment time/date. **Further data** • Information on patient attendance after 1st, 2nd, 3rd DNA. • Postcode DNA data for Neonates review. **Wider Trust Initiatives Ongoing** • Patient Experience Portal. • Two Way appointment reminder text. • Automatic letter sending with Translation capability.
Serious Untoward Incidents: Total number of overdue actions (rolling year total)	3 (target <=0)	**Action 1:** relates to and audit of pregnant women attending Gynae managers have been asked for an update. **Action 2:** requires a SOP for opening a second obstetric emergency theatre and CSS input has been requested. **Action 3:** relates to instrumental births and plan will be discussed at Maternity Risk Meeting scheduled 24.11.23.
Women whom have seen a	94.40% (target >=92%)	Performance is above the target rate of 92%. Some women present later in pregnancy as they were not aware that they were pregnant. Community midwifery team leaders canvass all

midwife by 12 weeks (+6 days)		women who present late in pregnancy to ask if there were any barriers to them presenting to their community midwife for antenatal care.

Areas of improvement

Sickness Absence

Sickness across the division has increased in month to stand at 6.56% overall – this translates to 7.01% in Maternity and 5.56% in Neonates. Neonates had reported under the Trust target in August (3.70%) and September (3.89%).

Weighting in Maternity is towards LTS cases at 53% with short term sickness more prevalent in Neonates in September 2023 at 65% and October 2023 at 52%.

Both service areas attend Divisional LTS management meeting led by HR and in month meetings also take place with the HR advisors. Escalation meetings for short term absence patterns are also ongoing as required. The updated Employee Attendance & Well-Being policy has also been shared.

Robust management practice continues, and assurance can be provided that where there is LTS sickness, cases are managed in line with policy. The majority of current LTS cases are in the 0–3-month timescale.

RTW data for Maternity shows that whilst LTS case numbers remain largely static, RTWs are occurring regularly therefore the data is fluid.

The increase in short term absence across the Division is corroborated by BI data whereby short-term absence occurrences have increased, the top reason for absence in month cold/cough/flu and this also correlates to the increase noted. Anxiety/stress remains the second highest reason and this is comparable to absence reasons regionally.

Core Mandatory, Clinical Mandatory and Specialty Specific Training Compliance

As at 09/11/2023, the core and clinical mandatory training compliance by competency for the division stood at 89.56% compliance overall. The single module under 50% compliance is Enhanced Maternal Care (EMC) at 25.93%, where training requirements are being discussed and agreed as part of the HDU/Enhanced Maternal Care Task and Finish group. Aseptic Non -Touch Technique is at 81.77% and Collecting Blood / Blood Components for Transfusion at 80.62%, these are identified on the below adjacent graph.

All managers have access to this live data via https://app.powerbi.com/home and training has taken place for managers. Validation meetings took place in October 2023.

As of the above date, medical training overall stands at 74.87% (decrease) and this translates to 76.73% for local modules (decrease), 74.22% for clinical core training (decrease), 81.96% for core mandatory training (decrease) and 66.67% for PDR's (decrease). There is a downward trend with Medical Training and therefore, the Medical Education Manager has been requested to provide commentary on this for further discussion / action.

The divisional compliance rates are below and are available on Power Bi which is real-time, therefore figures vary to those as detailed in the monthly KPI reports.

92.58% in Core Mandatory (increase) this equates to **90.51% in Maternity** (0.65% increase) and **97.05% in Neonates** (static) with compliance reached & maintained.

91.73% in PDR (decrease) which equates to **89.07% Maternity** (0.20% decrease) and **97.49% in Neonates** (0.58% decrease however compliance reached and maintained)

87.12% in Clinical Mandatory (increase); **Maternity at 86.12%** (1.54% increase) and **Neonates at 89.64%** (2.54% decrease)

89.79% in Specialty specific/local training (increase); this equates to **88.12% in Maternity** (2.96% increase, 13% cumulatively across five months) and **93.76% in Neonates** (0.34% increase)

Training remains a risk for the division, and it is noted on the divisional risk register however, positive improvements are acknowledged across all modules in month with Neonates achieving and maintaining compliance for both Core Mandatory training and PDR's.

Training compliance continues to be monitored weekly at the Senior Midwifery Leadership meeting chaired by the HOM. The service is also due to address matters locally whereby training time is allocated and non-compliance remains. The service has a weekly education newsletter which provides detailed updates on progress and this information has been received positively.

Overall, there remains 2030 modules to be completed, of which 289 modules expired in the last three months. 1325 modules expired over 12 months ago and of these, 642 have never been completed. These areas will be a priority focus as validity needs to be given to the training requirement if modules have either never been accessed or are 12 months out of date. All colleagues are provided with training time and staff who remain non-compliant are approached by their line manager to clarify the reason for non-compliance and to arrange for the training to be completed.

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

NHS Resolution have published Year 5 of the Maternity incentive Scheme. As in previous years there are ten key safety actions with several evidential requirements and standards. The scheme is Led by the Chief Nurse and fortnightly compliance/assurance meetings scheduled, led by the Quality and Safety Midwifery Matron, to which safety action leads are required to attend to provide progress updates.

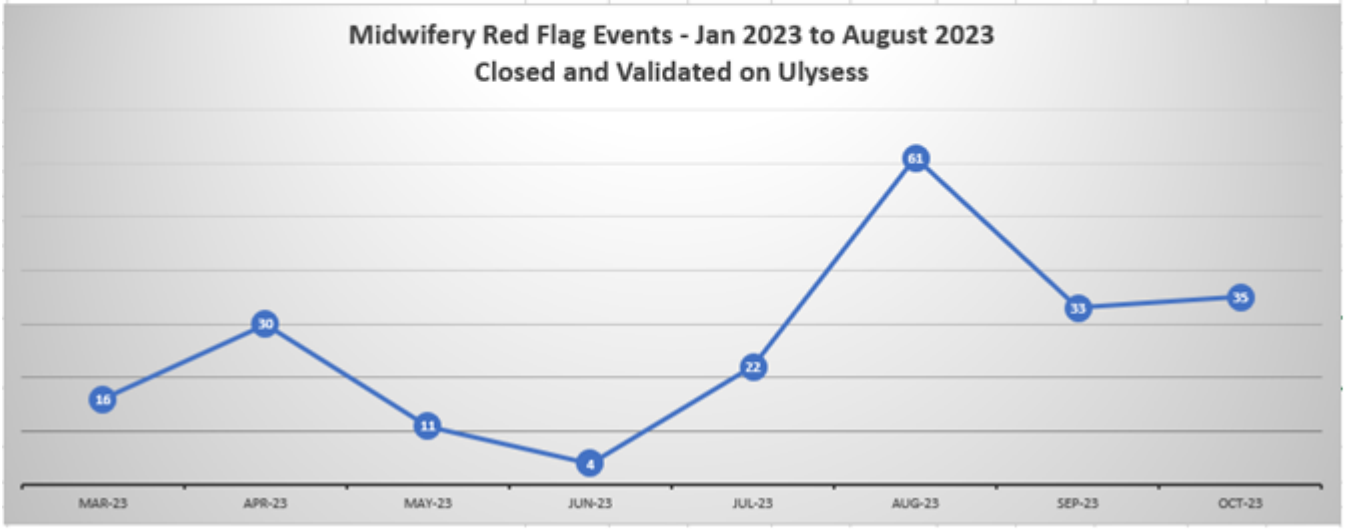
Safety Action 8 requires >90% staff attendance at Obstetric emergencies (MPMET), Fetal Surveillance and Newborn Life Support (NLS) training by the 30th November.

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

Midwifery Red Flags

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

Midwifery Red Flag Event - Validated	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
1:1: Care in Labour Not Supported	5	2	2	2	1	0	0	5	0	4
>30 min Delay in Presentation to Triage	6	2	5	12	1	2	1	5	0	6
>2 hour delay in admission to IOL	5	2	0	0	0	0	2	12	5	6
>4 hour delay in ongoing IOL (LWH MRF)	0	10	6	14	9	1	18	36	28	17
Delay in time critical activity	0	0	1	0	0	0	0	3	0	0
Delay in pain relief >30 mins	0	0	1	0	0	1	1	0	0	0
Missed medication during hospital admission	0	0	0	0	0	0	0	0	0	0
Delayed recognition of and action on abnormal vital signs	0	0	0	0	0	0	0	0	0	2
Full clinical examination - presenting in labour	0	0	0	0	0	0	0	0	0	0
Missed or Delay Care (Suturing)	0	0	1	2	0	0	0	0	0	0
Total	16	16	16	30	11	4	22	61	33	35



Midwifery red flags during October remained stable at 35 reported incidents directly correlated to midwifery staffing issues.

This month sees the last inclusion of MRF events in relation to delays of IOL more than four hours. In November this reporting matrix will see the introduction of delays >12 hours to align with national and regional reporting. The maternity team are focusing on the delayed recognition of abnormal vital signs and therefore numbers in this MRF may increase.

Family Health Safety Reporting

There were 472 incidents reported in October 2023. The number has continually increased month on month since October 2022 and we have reported significantly over the monthly average of 365 for the past three months.

517 incidents were closed during October. All incidents are overseen as per Trust process with issues being escalated for MDT review at the weekly Trust Safety Meeting.

At the time of writing this report, the web holding file stands at 160. The target for the Division is 30% (which would be 141 for October). Whilst is it recognised that this remains a high number it should be acknowledged that, as a division, significant improvements have been made in reducing the time between review of the incident and closing it on Ulysses. We will continue to review the web holding file number to ensure we maintain the progress we have made.

Perinatal Mortality – Intrauterine Deaths >24weeks.

During October 2023, there was one still birth reported. This has been reviewed and will be taken through the Perinatal Mortality and Morbidity Meeting (PMRT) in January 2024.

All cases have been reported to MBRRACE and parental support continues to be provided by the Honeysuckle Team. Details and action plans of every death are detailed in the Regional Quarterly Mortality Report presented by the Deputy Medical Director at Quality Committee and Trust Board.

Maternity and Neonatal Safety Investigations (MNSI) – previously known as Healthcare Safety Investigation (HSIB)

There were no cases accepted for investigation by MNSI in October 2023. We did report a maternal death, however they have confirmed that as the patient had stage 4 lung cancer at 15-16 weeks gestation, and that the physiological effects of pregnancy did not aggravate the existing disease, they have rejected this case.

All cases reported prior to October are currently on track for completion within the timeframes set out by MNSI.

Serious Incident Reporting

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

There were no clinical incidents that met the PSII criteria reported throughout October. The process of allocating an Investigating Officer has been difficult due to the limited staff that have completed the training needed for investigating PSIIs.

There are two outstanding actions in relation to SIs undertaken in previous years. One is regarding an audit required of GED patients and one is in relation to a SOP for opening a second emergency theatre. Both are being monitored and updates are requested regularly from the relevant Leads.

Across the Family Health Division, as of 21 November 2023, there were no outstanding risks on the risk register. All Risk owners are asked to provide updates and support is provided by the Governance team in navigating the Ulysses system if required. Risk actions are also examined, and regular catch ups are in the Risk owner's diaries, to ensure we are capturing timely updates for all risks. These are monitored via Family Health Divisional Board on a monthly basis.

Conclusion

The Family Health Division requests that the Trust Board receive this paper and seek assurance that perinatal quality safety is a key Divisional priority, and this report provides sufficient evidence of our ongoing compliance and progress with the implementation of a perinatal quality dashboard and framework. The data provided within this report is monitored monthly and features on the Family Health Divisional Board meeting agenda and includes review and monitoring of compliance against all Maternity and Neonatal KPIs that are included within the Power BI dashboards.

Recommendation

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

Perinatal Quality Surveillance Highlight Report October 2023 (September 2023 Data)

Introduction

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

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

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

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

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

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

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

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

Provider Trusts and their Boards, supported by the senior maternity and neonatal triumvirate and the board-level perinatal safety champion at its centre, ultimately remain responsible for the quality of the services provided and for ongoing improvement.

Family Health Clinical Dashboard (September 2023)

Areas of concern

Very Concerning – Investigate & Take Action.		
Metric	**Position**	**Narrative**
Outpatients: First appointment cancelled by Hospital – Maternity	20.94% (target <=10)	A- Community Midwives often rearrange their booking appointments due to commitments and flexibility for the patient. This results in the admin team having to cancel and reschedule the patient's appointments to match the correct date and time on the system. B- New bookers are allocated to a midwifery team via the location of their GP, and per guidelines and we aim to book between 8-10 weeks gestation. We receive a relatively high number of people booking close to this gestation, or possibly further along to register their pregnancy. To ensure that the patient is not missed the team allocates them to the next available slot, which may be over the 8-10 week target, just to ensure patients aren't missed. The team then works to rearrange to try and offer an appointment that falls within, or closer to the 8-10 week guidance. This will result in a cancellation and ALTHOSP when rescheduling the appointment.
Outpatients: Subsequent appointment cancelled by Hospital – Maternity	16.49% (target <=10)	Joint consultant and junior doctor strikes were over 19-22 September and as a result most clinics were cancelled.
Concerning – Investigate and understand		
Flu vaccinations offered to pregnant women	71.23% (target >=90%)	Flu vaccination for pregnant women in Maternity Services has been agreed. LWH asked Liverpool CC Public Health team for targeted vaccination plan of pregnant women, not confirmed as yet. All community midwives to signpost pregnant women to be vaccinated for flu. Opportunistic vaccination and spoke clinic running alongside NEST and Diabetic clinics. Improving trend noted.
Inborn term babies admitted to NICU	5.37% (target <=5%)	This is just above the target of 5%. All term admissions are reviewed weekly by the MDT and exceptions are reported. There have been no TC staffing issues.
Maternity services – percentage of Black, Asian or Mixed women at 29 weeks on CoC Pathway	30.09%	Midwifery continuity of care teams suspended from May 2023 for a period of 6 months. Continuity of care continues in both the antenatal and postnatal period and whilst but not the intrapartum period. A review of this suspension will take place in November 2023 and will be presented to Trust Board.

Newborn blood sampling – Avoidable repeat tests	4.19% (target <=2%)	NICU continues to be an area with a higher percentage error rate. This is being focused on by the NICU ward manager with a continued focus on the initiatives outlines in the previous quarter's report. The competency framework continues to run and photographs are used to feedback of samples that are rejected. Work also continues in the low dependency team as this has been the highest area for having samples rejected.
Outpatients – DNA rates: New – Maternity	9.43% (target <=8)	During September, the franking machine used to send out appointment letters was broken resulting in patients being unaware of their appointment times or dates.

Areas of improvement

Sickness Absence

The increase seen in Maternity sickness in August 2023 improved in September 2023 to stand at **6.53%** (1.41% improvement) and this takes the service back to a comparable % as seen in July 2023. As previously, bar LTS absence (28 days +), the most absences in month occurred at 0-1 day (21 occurrences) and 2 days (18 occurrences). The RTW compliance in the service in month is 62.92% which whilst an improvement (6.92%), it is not deemed an acceptable level and the requirement to complete a RTW following all sickness absence is being reiterated at the weekly leadership meeting. RTW compliance has also seen an increase in Neonates to 81.82% which is an 18% improvement – work also continues to ensure full compliance.

The Neonates service continues to report under the sickness absence target at **3.89%** which is a three-month positive trend which correlates with ongoing improved training metrics and RTW compliance as noted above. Neonates is aware of the need to sustain attendance of the workforce / complete timely RTW's and similar to Maternity, hold escalation meetings for those whereby patterns of absence have been identified. To address short-term absence in Maternity, a number of spotlight meetings are being held to discuss each absence pattern with the Matron and agree next steps of action – focus in month has been on MAU and Community. Flexible working arrangements are also being input into ESR so we can robustly review in light of any changing workforce requirements and / or individual changes in circumstances.

The medical teams for the division continue to have minimal to nil absence levels therefore there are no concerns to note.

Core Mandatory, Clinical Mandatory and Specialty Specific Training Compliance

As at 12/10/2023, the division stood at 88.77% compliance overall. Modules under 50% are ANTT Bolus at 50% and Enhanced Maternal Care 14.29%. Aseptic Non Touch Technique is at 79.28% and Collecting Blood/Blood Components for Transfusion at 76.20%. All managers have access to this live data via Power BI and training has taken place for managers.

As of the above date, medical training overall stands at 80.26% (decrease) and this translates to 80.11% for local modules (increase), 79.24% for clinical core training (decrease), 82.57% for core mandatory training (decrease) and 71.82% for PDR's (increase). The Medical Education Manager continues to support the teams with compliance.

The divisional compliance rates are below and are based on Power BI, which is real time, therefore figures vary to those as detailed in the monthly KPI reports

• **92.29% in Core Mandatory (increase)** this equates to 89.86% in Maternity (0.62% increase) and 97.03% in Neonates (static) **with compliance reached**
• **92.09% in PDR (increase)** which equates to 89.27% Maternity 0.97% (increase) and 98.07% in Neonates (21.44% increase and 28% cumulatively across five months) with **compliance reached**
• **86.75% in Clinical Mandatory (increase).** Maternity at 84.58% (1.89% increase) and Neonates at 92.19% (static)
• **87.67% in Specialty specific/local training (increase)**. This equates to 85.16% in Maternity 3.05% increase, 10% cumulatively across four months) and 93.42% in Neonates (1.44% increase)

Training remains a risk for the division and it is noted on the divisional risk register however, positive improvements are acknowledged across all modules in month with Neonates achieving compliance for both Core Mandatory training and PDR's Training compliance continues to be monitored weekly at the Maternity Leadership meeting chaired by the HOM The service is also due to address matters locally whereby training time is allocated and non compliance remains The service has a weekly education newsletter which provides detailed updates on progress and this information has been received positively.

Training remains on the Putting People First agenda which is a sub committee of the Trust Board, with the next discussion taking place in November 2023 at which the Family Health Workforce Assurance report will be presented.

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

NHS Resolution have published Year 5 of the Maternity incentive Scheme. As in previous years there are ten key safety actions with several evidential requirements and standards. The scheme is Led by the Chief Nurse with monthly compliance/assurance meetings planned with all safety action leads. This is managed through the Maternity Transformation Board as a sub-group to workstream 3 and reported via the Maternity Transformation Board, Quality Committee and upwards to Trust Board.

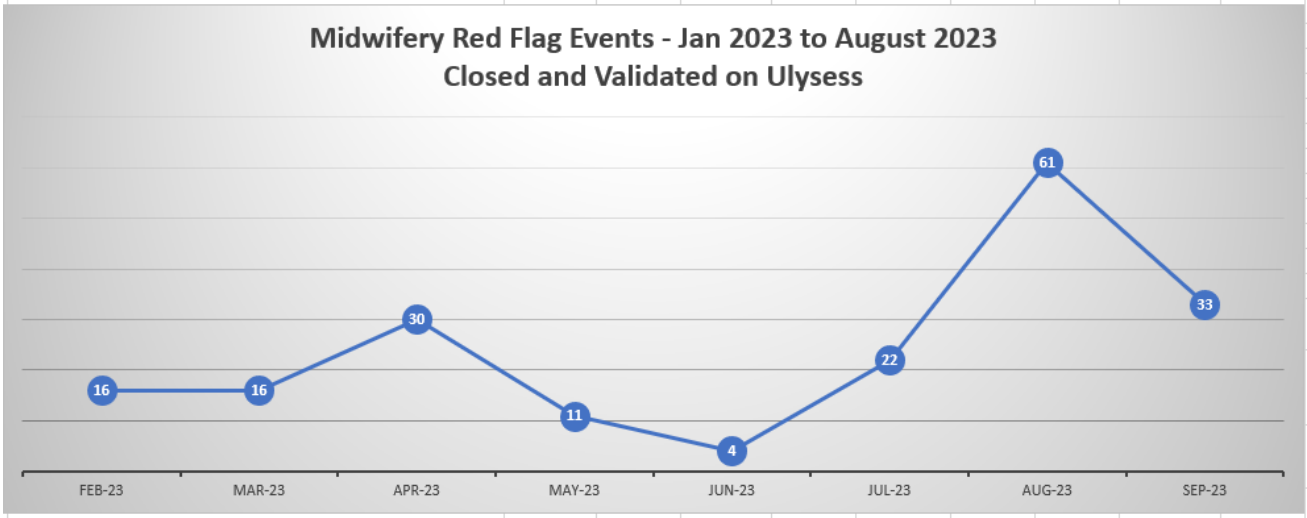
In relation to Maternity Incentive Scheme SA8 elements, for each of the requirements all staff groups have a trajectory to be >90% attendance as defined by the scheme end date on the 30th November. However, the ongoing uncertainty around industrial action remains a risk in terms of the release of faculty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

CNST SA8	Staff Group	31 Jul 23	31 Aug 23	30 Sep 23	31 Oct 23	30 Nov 23	
SA 8b. MPMET	Midwives	79%	87%	89%	94%		NQM B5, B6, B7, B8, B9
	Maternity HCA	75%	79%	77%	80%		B2, B3, B4
	Cons Obstetrician	53%	59%	71%	86%		
	Trainee Obstetrician	x	58%	61%	79%		New rotation in Aug
	Cons Anesthetists	28%	27%	47%	73%		
	Trainee Anesthetists	x	36%	40%	60%		New rotation in Aug and Nov
SA 8c. Fetal Surveillance	Midwives	77%	83%	87%	89%		NQM B5, B6, B7, B8, B9
	Cons Obstetrician	62%	59%	71%	77%		
	Trainee Obstetrician	x	29%	64%	77%		New rotation in Aug
SA 8d. NLS	Midwives	81%	88%	89%	93%		
	Cons Neonatologist	100%	100%	100%	100%		
	Trainee Neonatologist	100%	100%	100%	100%		New rotation Mar & Sept
	ANNPs	93%	93%	100%	100%		
	Neonatal Nurses	95%	98%	96%	9%		

Midwifery Red Flags

All staff are encouraged to report midwifery red flags using the Ulysses System and maternity managers strive to investigate incidents in a timely fashion. All reported incidents are reviewed and monitored on a four hourly basis. Staff are supported to report all incidents and are provided with feedback. The number of red flag incidents relating to delays in induction of labour has reduced but still remains higher than average. This is a reflection of the continued significant increases in acuity. All incidents will continue to be monitored and all trends and themes will be shared with staff.

Midwifery Red Flag Event - Validated	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
1:1: Care in Labour Not Supported	5	2	2	2	1	0	0	5	0
>30 min Delay in Presentation to Triage	6	2	5	12	1	2	1	5	0
>2 hour delay in admission to IOL	5	2	0	0	0	0	2	12	5
>4 hour delay in ongoing IOL (LWH MRF)	0	10	6	14	9	1	18	36	28
Delay in time critical activity	0	0	1	0	0	0	0	3	0
Delay in pain relief >30 mins	0	0	1	0	0	1	1	0	0
Missed medication during hospital admission	0	0	0	0	0	0	0	0	0
Delayed recognition of and action on abnormal vital signs	0	0	0	0	0	0	0	0	0
Full clinical examination - presenting in labour	0	0	0	0	0	0	0	0	0
Missed or Delay Care (Suturing)	0	0	1	2	0	0	0	0	0
Total	16	16	16	30	11	4	22	61	33



The rate of IOL is increasing due to changes in national pathways, and therefore creates the need for further capacity in the Induction and Intrapartum Areas. As part of the service improvement, an IOL Coordinator has been appointed to lead on improvements and manage service user expectations with the IOL Capacity. Estates work has commenced to increase the capacity for IOL inpatients. The first set of doors have now been widened to enable a bed to be easily taken in or out of the room. The work is scheduled to be completed in January 2024.

Family Health Safety Reporting

There were 506 incidents reported in September 2023. The number has continually increased month on month since October 2022.

340 incidents were closed during September. All incidents are overseen as per Trust process with issues being escalated for MDT review at the weekly Trust Safety Meeting.

At the time of writing this report, the web holding file stands at 269. The target for the Division is 30%. The number within the WHF can fluctuate and despite over 300 incidents being reviewed and closed during September, the target remains difficult to achieve.

Perinatal Mortality – Intrauterine Deaths >24weeks.

During September 2023, there were no still birth cases reported. All cases reported prior to September have been reviewed and been through a MDT via the Perinatal Mortality and Morbidity Meeting (PMRT). All cases have been reported to MBRRACE and parental support continues to be provided by the Honeysuckle Team. Details and action plans of every death are detailed in the Regional Quarterly Mortality Report presented by the Deputy Medical Director at Quality Committee and Trust Board.

Maternity and Neonatal Safety Investigations (MNSI) – previously known as Healthcare Safety Investigation Referrals (HSIB)

There was one case reported to MNSI in September 2023. This was following a maternal death following transfer to LUFT. Whilst it is acknowledged that MNSI will be investigating this as per their usual process, we have commissioned a review of the care provided and this is being undertaken by a Consultant from LUFT. This is on track and is ongoing.

All current cases are on track for completion within the timeframes set out by MNSI.

Serious Incident Reporting

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

There were two clinical incidents that met the PSII criteria throughout September. The ICB requested that Trusts continue to report these on StEIS. The incidents escalated included a pressure ulcer reported by a maternity patient and an ITU transfer out. The process of allocating an Investigating Officer has been difficult due to the limited staff that have completed the training needed for investigating PSIIs. The pressure ulcer case has been allocated to a member of the Corporate Governance wider team but the other case remains on hold.

There are two outstanding actions in relation to SIs undertaken in previous years. One is regarding an audit required of GED patients and one is in relation to a SOP for opening a second emergency theatre. Both are being monitored and updates are requested regularly from the relevant Leads.

Across the Family Health Division, as of 1 October 2023, there were no outstanding risks on the risk register. All Risk owners are asked to provide updates and support is provided by the Governance team in navigating the Ulysses system if required. Risk actions are also examined, and regular catch ups are in the Risk owner's diaries to ensure we are capturing timely updates for all risks. These are monitored via Family Health Divisional Board on a monthly basis.

Conclusion

The Family Health Division requests that the Trust Board receive this paper and seek assurance that perinatal quality safety is a key Divisional priority, and this report provides sufficient evidence of our ongoing compliance and progress with the implementation of a perinatal quality dashboard and framework. The data provided within this report is monitored monthly and features on the Family Health Divisional Board meeting agenda and includes review and monitoring of compliance against all Maternity and Neonatal KPIs that are included within the Power BI dashboards.

Recommendation

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

S	There are two situations around the PMRT process that require escalation. These are being combined within this SBAR as there are common themes which emerge. The first poses a threat to the being able to declare full compliance with MIS Year 5. Within this year there have been 2 cases of babies whose review needed to be assigned to other units where the deadline for assigning the cases was missed. This means that there is 94.11% compliance for an element of the PMRT process where 95% compliance is required. There second situation does not pose a threat to compliance. There are a small number of perinatal deaths whose PMRT death report requires completion and publication on the MBRRACE/PMRT Database. The PMRT Board report, downloadable from the database, requires submission to the Saving Babies Lives Care Bundle Portal notes the following (downloaded 31.10.2023), see screenshots below: **2021 Deaths –** **PMRT - Perinatal Mortality Reviews Summary Report** This report has been generated following mortality reviews which were carried out using the national Perinatal Mortality Review Tool Liverpool Women's NHS Foundation Trust Report of perinatal mortality reviews completed for deaths which occurred in the period: 1/1/2021 to 31/12/2021 Summary of perinatal deaths* Total perinatal* deaths reported to the MBRRACE-UK perinatal mortality surveillance in this period: 79 Summary of reviews** Stillbirths and late fetal losses Number of stillbirths and late fetal losses reported: 54 Not supported for Review: 16 Reviews in progress: 0 Reviews completed ***: 38 Grading of care: number of stillbirths and late fetal losses with issues with care likely to have made a difference to the outcome for the baby: 2 Neonatal and post-neonatal deaths Number of neonatal and post-neonatal deaths reported: 56 Not supported for Review: 0 Reviews in progress: 15 Reviews completed ***: 40 Grading of care: number of neonatal and post-neonatal deaths with issues with care likely to have made a difference to the outcome for the baby: 0 *Late fetal losses, stillbirths and neonatal deaths (does not include post-neonatal deaths which are not eligible for MBRRACE-UK surveillance) – these are the total deaths reported and may not be all deaths which occurred in the reporting period if notification to MBRRACE-UK is delayed. Deaths following termination of pregnancy are excluded. **2022 Deaths –** **PMRT - Perinatal Mortality Reviews Summary Report** This report has been generated following mortality reviews which were carried out using the national Perinatal Mortality Review Tool Liverpool Women's NHS Foundation Trust Report of perinatal mortality reviews completed for deaths which occurred in the period: 1/1/2022 to 31/12/2022 Summary of perinatal deaths* Total perinatal* deaths reported to the MBRRACE-UK perinatal mortality surveillance in this period: 75 Summary of reviews** Stillbirths and late fetal losses Number of stillbirths and late fetal losses reported: 70 Not supported for Review: 33 Reviews in progress: 0 Reviews completed ***: 37 Grading of care: number of stillbirths and late fetal losses with issues with care likely to have made a difference to the outcome for the baby: 1 Neonatal and post-neonatal deaths Number of neonatal and post-neonatal deaths reported: 48 Not supported for Review: 3 Reviews in progress: 10 Reviews completed ***: 34 Grading of care: number of neonatal and post-neonatal deaths with issues with care likely to have made a difference to the outcome for the baby: 0 *Late fetal losses, stillbirths and neonatal deaths (does not include post-neonatal deaths which are not eligible for MBRRACE-UK surveillance) – these are the total deaths reported and may not be all deaths which occurred in the reporting period if notification to MBRRACE-UK is delayed. Deaths following termination of pregnancy are excluded. The full reports, downloadable from the MBRRACE website (embedded into this SBAR below), provide Trusts with information, gradings of care, themes, trends and actions taken into all Perinatal Deaths. Whilst the Division submit Quarterly Learning from Perinatal Death reports to the Quality Committee and Trusts Boards, this MBRRACE developed report cannot be used as it does not consider incomplete reports.

	PMRT_BoardReport_Liverpool Women's NH 2021 Report	PMRT_BoardReport_Liverpool Women's NH 2022 Report
B	The Family Health Division use the national mandated MBRRACE and PMRT database for the surveillance, monitoring and review of all **inhouse (born and die at LWH)** neonatal and perinatal mortality cases. This tool was mandated for use, by NHS England in 2019 and has been a requirement of the Maternity Incentive Scheme since its publication. The Maternity Incentive Scheme, released annually, defines and outlines Trusts to use the PMRT tool for deaths in the scheme period. Within the scheme period, Trusts are mandates to ensure the following: - 100% of deaths are reported within 7 days with all relevant surveillance information completed within one month - 95% of deaths of babies in our Trust their parents should have their views sought on the care provided. - 95% of deaths – reviews should be started within 2 months - 60% (minimum) reviews completed to draft report within 4 months and published within 6 months. The Division have always evidenced adherence to the above standards, above and beyond what is expected within the MIS Scheme requirements. For this year, we have missed the deadlines for assigning the review for 2 babies within the specified period. We have achieved 92 % compliance and, given that no further deaths will be included in the denominator, this will be our final percentage compliance. In October, NHS Resolutions circulated an email outlining the potential mitigations for the PMRT element of MIS Year 5. The correspondence stated, "where MDT PMRT meetings have needed to be rescheduled due to the direct impact of industrial action, and this has an impact on MIS reporting timescales, this will be accepted provided that there is an action plan approved by Trust boards to reschedule these meetings to take place within a 12-week period from the end to the MIS compliance period." The deaths of the babies discussed, and the timescales outlined above spanned 3 separate periods of industrial action. There was no PMRT meeting in August, and the lead consultants were required to contribute additional clinical time to maintain a safe clinical service during industrial action. In recognition of the need to achieve CNST compliance, an additional PMRT meeting was scheduled for October. For nearly 2 years there has been no, or very minimal, governance or administrative support for the neonatal PMRT process. In relation to the outstanding reports, there are no mandates for completion; the Trust only has to demonstrate the above timescales whilst the MIS scheme period is active. There is an expectation that these reports are considered at Trust Board as per the MIS Scheme.	
A	The amount of work that is required to ensure that the reporting, surveillance, administration, reviewing and completion of a PMRT Report within any deadlines must not be underestimated. LWH, being the tertiary Cheshire & Mersey level unit, often have to assign the PMRT cases to other Trusts, who have provided antenatal care to the families. Ensuring that this is done consistently, accurately and in a timeframe that aligns with the MIS scheme is labour intensive. The volume of cases that LWH manages, far out weights that of other Trusts in the region. A proportion of babies born at LWH are not eligible for CNST, due to being >28 days of age when they die or following FMU referral due to congenital anomalies, who subsequently transfer and die at AHCH, whilst not included in CNST,	

	also require a review of their care and meaning the neonatal PMRT workload is beyond what is seen on the MBRRACE database. The administrative side of the co-ordination of MDT, Multi-Trust reviews with external Obstetric, Midwifery and neonatal representation is also time consuming. The co-ordination of external reviewers was once a function of the regional NWC admin teams and supported all C&M Trust, but has now come into Trusts to be co-ordinated, a task often picked up by already stretched clinicians and governance managers. The investigation and preparation of case presentations requires a huge amount of time by the Consultant Obstetrician and Neonatologists, with the Governance Managers support and at present there is no administrative role within the Divisional that can support this work. Finalisation and completion of the PMRT report requires completion by the Consultant Obstetrician or Neonatologist, often incorporating points made from external reviewers, sensitive responses to parental questions, development of SMART actions. Completion and finalisation of the PMRT reports, with the administrative time required, in additional to clinical commitments has sometime meant that when the MIS scheme period is in 'downtime' that there is a less of a time pressure to complete, leading to some reports not progressing to final, published status. **It must be noted, that although these reports haven't been finalised, they have been through a full MDT Review.** When the MIS scheme period has completed, there are no national requirements or timeframes for the process of PMRT reviews to be completed.
R	The Family Health Divisional Leads for PMRT request the following: - Recognition of the application of the above mitigation related to Industrial Action and an assurance that additional meetings have already taken place to comply with the requirements of this mitigation. - A dedicated admin post to support the PMRT process. This would ensure that the process was more robust to keep an oversight of the timelines for the investigation of each death and escalate any anticipated delays to the neonatal governance manager as part of the monthly PMRT meetings. This role would allow a dedicated point of contact for enquiries related to the review process. It would also allow for more seamless co-ordination of joint family debrief appointments and the administration associated with this. - A review of the consultant time available for job planning for the aforementioned process. In the meantime, the Clinical Lead for Neonatology will meet with the Neonatal Mortality Lead to review the timescales of the PMRT process on a monthly basis for all babies and will report into the FHDB. It is anticipated that once the neonatal governance manager is in post, ideally with the addition of an administrative role, the Clinical Lead will not be part of this process and this new group will report directly into FHDB.

														100% of Surveillance Information to be completed within one calendar month of the death 08.11.2023 - 100% 17.11.2023 - 100% 29.11.2023 - 100% 30.11.2023 - 100% 06.12.2023 - 100%		95% of deaths in Trust - Parents reviews sought: 08.11.2023 - 53.3% 17.11.2023 - 100% 29.11.2023 - 97% 30.11.2023 - 97% (35/36 Cases)		95% of Reviews started within two months of death 08.11.2023 - 91% 17.11.2023 - 93.3% 29.11.2023 - 93.5% 30.11.2023 - 94.11% 06.12.2023 - 94.11% (32/34 Cases - 94.11%) or (20/22 Cases - 91%)		60% of Reviews -report to draft within 4 months. 08.11.2023 - 67% 17.11.2023 - 67% 30.11.2023 - 80% 06.12.2023 - 80% (12/15 - Cases)		60% Final report published within 6 months 08.11.2023- 100% 17.11.2023 - 100% 30.11.2023 - 100% 06.12.2023 -100% (10/10 Cases)	
Mother's family name	Live birth	Date of death	Responsible Trust at birth	Responsible Trust when baby died	Surveillance case status	Date surveillance first closed	Review status	Date review opened	Factual questions currently complete d (%)	HSIB case	Eligible for CNST standards	Surveillance in standard	Review in standard	Standard a surveillance complete	Standard a complete deadline	Standard b parents informed	Standard b parents input sought	Standard c review started	Standard c started deadline	Standard c report drafted	Standard c drafted deadline	Standard c report published	Standard c published deadline
[redacted]	Yes	04/12/2023	Liverpool	Liverpool	Surveillance started,	Not Set	Reviewing	05/12/2023	44%		Yes	Not	Yes	Not applicable	Not applicable	Not yet met	Not yet met	Not applicable	Post-qualifying date	Not applicable	Post-qualifying date	Not applicable	Post-qualifying date
[redacted]	Yes	28/11/2023	Liverpool	\Liverpool	\Surveillance complete	29/11/2023	Reviewing	29/11/2023	94%		Yes	Not eligible	Yes	Not applicable	Not applicable	Not yet met	Not yet met	Met	Not applicable	Not applicable	Post-qualifying date	Not applicable	Post-qualifying date
[redacted]	No	21/11/2023	Liverpool	\Liverpool	\Surveillance complete	22/11/2023	Reviewing	22/11/2023	100%		Yes	Yes	Yes	Met	Not applicable	Met	Met	Met	Not applicable	Not applicable	Post-qualifying date	Not applicable	Post-qualifying date
[redacted]	Yes	18/11/2023	Liverpool	\Liverpool	\Surveillance complete	21/11/2023	Reviewing	20/11/2023	100%		Yes	Not eligible	Yes	Not applicable	Not applicable	Met	Not yet met (assigned t	Met	Not applicable	Not applicable	Post-qualifying date	Not applicable	Post-qualifying date
[redacted]	Yes	19/11/2023	Liverpool	\Liverpool	\Surveillance complete	19/11/2023	Reviewing	19/11/2023	100%		Yes	Yes	Yes	Met	Not applicable	Met	Met	Met	Not applicable	Not applicable	Post-qualifying date	Not applicable	Post-qualifying date
[redacted]	No	13/11/2023	Liverpool	\Liverpool	\Surveillance complete	13/11/2023	Reviewing	13/11/2023	100%		Yes	Yes	Yes	Met	Not applicable	Met	Met	Met	Not applicable	Not applicable	Post-qualifying date	Not applicable	Post-qualifying date
[redacted]	Yes	06/11/2023	Liverpool	\Liverpool	\Surveillance complete	08/11/2023	Reviewing	08/11/2023	100%		Yes	Yes	Yes	Baby died in a non-clinic	Not applicable	Met	Met	Baby died in a non-clinic set	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
[redacted]	Yes	27/10/2023	Liverpool	\Liverpool	\Surveillance complete	29/10/2023	Reviewing	29/10/2023	100%		Yes	Yes	Yes	Met	27/11/2023	Met	Met	Met	Not applicable	Not applicable	Post-qualifying date	Not applicable	Post-qualifying date
[redacted]	No	01/11/2023	Liverpool	\Liverpool	\Surveillance complete	01/11/2023	Reviewing	01/11/2023	100%		Yes	Yes	Yes	Met	01/12/2023	Met	Met	Met	Not applicable	Not applicable	Post-qualifying date	Not applicable	Post-qualifying date
[redacted]	No	22/10/2023	Liverpool	\Liverpool	\Surveillance complete	23/10/2023	Reviewing	23/10/2023	100%		Yes	Yes	Yes	Met	22/11/2023	Met	Met	Met	Not applicable	Not applicable	Post-qualifying date	Not applicable	Post-qualifying date
[redacted]	Yes	20/10/2023	Liverpool	\Liverpool	\Surveillance complete	21/10/2023	Reviewing	21/10/2023	100%		Yes	Yes	Yes	Met	20/11/2023	Met	Met	Met	Not applicable	Not applicable	Post-qualifying date	Not applicable	Post-qualifying date
[redacted]	Yes	18/10/2023	Liverpool	\Liverpool	\Surveillance complete	19/10/2023	Reviewing	20/10/2023	100%	Reported t	Yes	Yes	Yes	Met	18/11/2023	Met	Met	Met	Not applicable	Not applicable	Post-qualifying date	Not applicable	Post-qualifying date
[redacted]	No	19/10/2023	Liverpool	\Liverpool	\Surveillance complete	19/10/2023	Reviewing	19/10/2023	100%		Yes	Yes	Yes	Met	19/11/2023	Met	Met	Met	Not applicable	Not applicable	Post-qualifying date	Not applicable	Post-qualifying date
[redacted]	No	18/10/2023	Liverpool	\Liverpool	\Surveillance complete	19/10/2023	Reviewing	19/10/2023	100%		Yes	Yes	Yes	Met	18/11/2023	Met	Met	Met	Not applicable	Not applicable	Post-qualifying date	Not applicable	Post-qualifying date
[redacted]	Yes	03/10/2023	Liverpool	\Liverpool	\Surveillance complete	17/10/2023	Reviewing	22/10/2023	100%		Yes	Not eligible	Yes	Not applicable	Not applicable	Met	Met	Met	03/12/2023	Not applicable	Post-qualifying date	Not applicable	Post-qualifying date
[redacted]	No	02/10/2023	Liverpool	\Liverpool	\Surveillance complete	03/10/2023	Reviewing	03/10/2023	100%		Yes	Yes	Yes	Met	02/11/2023	Met	Met	Met	02/12/2023	Not applicable	Post-qualifying date	Not applicable	Post-qualifying date
[redacted]	Yes	11/09/2023	Liverpool	\Liverpool	\Surveillance complete	12/09/2023	Reviewing	15/09/2023	100%		Yes	Yes	Yes	Met	11/10/2023	Met	Met	Met	11/11/2023	Not applicable	Post-qualifying date	Not applicable	Post-qualifying date
[redacted]	Yes	14/08/2023	Liverpool	\Liverpool	\Surveillance complete	23/08/2023	Reviewing	30/08/2023	100%		Yes	Not eligible	Yes	Not applicable	Not applicable	Met	Met	Not met	14/10/2023	Not applicable	Post-qualifying date	Not applicable	Post-qualifying date
[redacted]	Yes	14/08/2023	Liverpool	\Liverpool	\Surveillance complete	16/08/2023	Reviewing	16/08/2023	89%		Yes	Not eligible	Yes	Not applicable	Not applicable	Met	Met	Met	14/10/2023	Not applicable	Post-qualifying date	Not applicable	Post-qualifying date
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[redacted]	No	09/08/2023	Liverpool	\Liverpool	\Surveillance complete	10/08/2023	Review co	10/08/2023	100%		Yes	Yes	Yes	Met	09/09/2023	Met	Met	Met	09/10/2023	Met	Not applicable	Met	Not applicable
[redacted]	Yes	05/08/2023	Liverpool	\Liverpool	\Surveillance complete	05/09/2023	Reviewing	14/11/2023	100%		Yes	Not eligible	Yes	Not applicable	Not applicable	Met	Not yet met (assigned t	Not met	05/10/2023	Not Met	05/12/2023	Not applicable	Post-qualifying date
[redacted]	No	05/08/2023	Liverpool	\Liverpool	\Surveillance complete	07/08/2023	Review co	07/08/2023	100%		Yes	Yes	Yes	Met	05/09/2023	Met	Met	Met	05/10/2023	Met	05/12/2023	Met	Not applicable
[redacted]	No	26/07/2023	Liverpool	\Liverpool	\Surveillance complete	26/07/2023	Review co	26/07/2023	100%		Yes	Yes	Yes	Met	26/08/2023	Met	Met	Met	26/09/2023	Met	26/11/2023	Met	Not applicable
[redacted]	Yes	15/07/2023	Liverpool	\Liverpool	\Surveillance complete	17/07/2023	Writing re	17/07/2023	100%		Yes	Yes	Yes	Met	15/08/2023	Met	Met	Met	15/09/2023	Met	15/11/2023	Not applicable	Post-qualifying date
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[redacted]	No	08/07/2023	Liverpool	\Liverpool	\Surveillance complete	10/07/2023	Review co	10/07/2023	100%		Yes	Yes	Yes	Met	08/08/2023	Met	Met	Met	08/09/2023	Met	08/11/2023	Met	Not applicable
[redacted]	No	07/07/2023	Liverpool	\Liverpool	\Surveillance complete	08/07/2023	Review co	10/07/2023	100%		Yes	Yes	Yes	Met	07/08/2023	Met	Met	Met	07/09/2023	Met	07/11/2023	Met	Not applicable
[redacted]	Yes	27/06/2023	Liverpool	\Liverpool	\Surveillance complete	28/06/2023	Writing re	28/06/2023	100%		Yes	Yes	Yes	Met	27/07/2023	Met	Met	Met	27/08/2023	Not met	27/10/2023	Not applicable	Post-qualifying date
[redacted]	Yes	26/06/2023	Liverpool	\Liverpool	\Surveillance complete	07/07/2023	Review pr	19/07/2023	100%		Yes	Not eligible	Yes	Not applicable	Not applicable	Met	Met	Met	26/08/2023	Not met	26/10/2023	Not applicable	Post-qualifying date
[redacted]	No	20/06/2023	Liverpool	\Liverpool	\Surveillance complete	21/06/2023	Review co	21/06/2023	100%		Yes	Yes	Yes	Met	20/07/2023	Met	Met	Met	20/08/2023	Met	20/10/2023	Met	Not applicable
[redacted]	No	20/06/2023	Liverpool	\Liverpool	\Surveillance complete	21/06/2023	Review co	21/06/2023	100%		Yes	Yes	Yes	Met	20/07/2023	Met	Met	Met	20/08/2023	Met	20/10/2023	Met	Not applicable
[redacted]	Yes	15/06/2023	Liverpool	\Liverpool	\Surveillance complete	20/06/2023	Writing re	19/06/2023	100%		Yes	Yes	Yes	Met	15/07/2023	Met	Met	Met	15/08/2023	Met	15/10/2023	Not applicable	Post-qualifying date
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[redacted]	No	06/06/2023	Liverpool	\Liverpool	\Surveillance complete	07/06/2023	Review co	07/06/2023	100%		Yes	Yes	Yes	Met	06/07/2023	Met	Met	Met	06/08/2023	Met	06/10/2023	Met	06/12/2023
[redacted]	Yes	05/06/2023	Liverpool	\Liverpool	\Surveillance complete	06/06/2023	Review co	09/06/2023	100%		Yes	Not eligible	Yes	Not applicable	Not applicable	Met	Met	Met	05/08/2023	Met	05/10/2023	Met	05/12/2023

APPENDIX 4

Introduction

The purpose of this paper is to provide assurance that the Trust is compliant with the national maternity incentive scheme year five, **safety action 4** ***'Demonstrate an effective system of clinical workforce planning to the required standard'***.

The paper will provide an overview of the standards and actions taken to ensure compliance with safety action 4 with regards to the obstetric medical workforce. The reporting period is 1st March 2023 to 1st August 2023.

Safety Action 4 – Demonstrates an effective system of clinical workforce planning to the required standard'.

NHS Resolution is operating year five of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) to continue to support the delivery of safer maternity care. The MIS 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.

The scheme incentivises ten maternity safety actions as referenced in previous years' schemes. Trusts that can demonstrate they have achieved **all** of the **ten** safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

The required standard for **safety action 4** is detailed below.

Required Standard - 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:

a. currently work in their unit on the tier 2 or 3 rota

or

b. 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

c. hold an Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums.

Review and Response:
The Medical HR department reviewed all agency bookings between the dates 1st March 2023 – 1st August 2023. The review identified no agency doctors were booked to work a shift at Liverpool Women's Hospital on the middle tier 2 (ST3- ST5) rota or the Senior Tier 3 (ST6 – ST7 rota. This audit will continue throughout the year collecting date via health roster and any shortfalls in this action will be reported.

All Postgraduate doctors in training progress through a satisfactory annual review of competency progressions (ARCP). For assurance, educational supervisors and the Director of Medical Education have access to the individuals E portfolio to review progression and sign off.

At Liverpool Women's Hospital all Trust employed doctors working on the tier 2 and tier 3 rota are given access to E portfolio and their progression through competencies reviewed. In addition to this, the Director of Medical Education and Director of Research are in the process of setting up a review panel for all Trust Grade Doctors to ensure all competencies are reviewed.

The Trust recently implemented direct engagement for all agency medical staff. The platform enables the Trust to mandate a certificate of Eligibility for any booking on the tier 2 and / or tier 3 rota. All bookings are managed locally within the medical HR team providing assurance that all paperwork is correct at the time of booking. The temporary staffing policy has been updated to reflect the necessity of a certificate of eligibility.

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.
https://www.rcog.org.uk/media/uuzcbzg2/rcog-guidance-on-the-engagement-of-long-term-locums-in-mate.pdf

Review and Response:
The RCOG has developed this guidance on the engagement of locums in maternity care in collaboration with the NHS. The guidance outlines roles and responsibilities for healthcare providers, healthcare organisations and individual doctors undertaking locum positions within the NHS. It has been approved by NHS England, Wales and Scotland. For the purposes of this guidance, a locum refers to a doctor who:

- Is placed by a locum agency or a locum bank to work in a healthcare organisation
- Directly engages with healthcare organisations for short-term work.
- Is a doctor in training who undertakes locums outside their training

In this guidance a long-term locum is one where the placement is for longer than two weeks duration. This is an opportunity for doctors to obtain the evidence they require to meet the criteria for a Certificate of Eligibility for Locums (CEL) outlined in the Royal College of Obstetricians and Gynaecologists' Guidance on the Engagement of Short-Term Locums in Maternity Care. Locum doctors do not have to provide a CEL for a long-term locum position.

Between the audit dates, the Trust did not engage a long-term agency locum doctor or a locum bank doctor. Should the Trust engage a locum agency or locum bank doctor for a period of time greater than 2 weeks, the below form will be attached to the doctor's induction and completed by the clinical lead and held on file.

Monitoring of compliance/effectiveness

The RCOG/NHS recommends that units monitor compliance with this guidance.

The following is a simple tool which can be adapted for local use and retained as evidence of a robust process of assessment for all locum appointments. This could be completed by the lead consultant with support from a medical administrator

Compliance	Completed Y/N	Date
Locum doctor CV reviewed by consultant lead prior to appointment		
Discussion with locum doctor re clinical capabilities by consultant lead prior to starting or on appointment		
Departmental induction by consultant on commencement date		
Access to all IT systems and guidelines and training completed on commencement date		
Named consultant supervisor to support locum	Name:	
Supernumerary clinical duties undertaken with appropriate direct supervision		
Review of suitability for post and OOH working based on MDT feedback		
Feedback to locum doctor and agency on performance		

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.

rcog-guidance-on-compensatory-rest.pdf

Review and Response:
Currently, the Division of Family Health, do not employ specialty or specialist doctors. The maternity consultants are job planned to work twilight shifts. This pattern of work factors in a minimum of 11 hours rest between shifts as evidenced in job plans.
This is supported by the https://intranet.liverpoolwomens.nhs.uk/plugins/extranet/widgets/policies/uploads/2023-6422c0ea935434.48113945.pdf policy.

4) Trusts organisations should monitor their compliance of Consultant attendance for the clinical situations listed in the RCOG workforce document 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/ 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.

Review and Response:
Consultant attendance at the situations listed in the RCOG guidance is directly monitored through Power BI with 6 monthly updates an action plan developed and sighted at FHDD, MRC and Trust Board in line with MIS Scheme requirements.

- January to June 2023 – Attendance report and action plan sighted at Trust Board in September 2023 and onwards to LMNS in October 2023
- July 2023 to December 2024 – Will be progressed within Division and sent to Trust Board in February next year.

Attendance data to date:

Reporting period	Number of cases identified	Compliance (%)
1: January – June 2022	59	81
2: July – December 2022	60	87
3: January – June 2023	82	93

Conclusion

This paper sets out the required standards of safety action 4 *'Demonstrate an effective system of clinical workforce planning to the required standard'* as detailed in the Maternity Incentive Scheme – year five. It provides assurances that the Trust is following the Royal College of Obstetrics and Gynaecology guidance on the engagement of short- and long-term locums working on the tier 2 and tier 3 rotas. There is a clear evidence-based tool such as electronic rostering and or direct engagement electronic platform to produce audits. All bookings are processed centrally through the medical HR team, and the relevant senior leadership team informed of all bookings. There is a clear process for the sign off of agency locum CVs.

The maternity consultant workforce is job planned effectively factoring in compensatory rest when working non-resident on call work.

Recommendations

To ensure all agency and or bank locum doctors working 2 weeks, or more are monitored via the RCOG compliance form, this form will be adapted for the Trust and completed alongside the individual's local induction and retained on file.

APPENDIX 5

This report is to provide assurance and information that Liverpool Women's NHS Foundation Trust meets Safety Action 4 of the Maternity Incentive Scheme Year 5 (aka CNST) with regards to Neonatal Medical Workforce.

Safety Action 4 – ''The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing. If this is not met an action plan to address deficiencies is in place and agreed at Board Level'.

The content of report details the standards required and its supporting evidence to meet the BAPM framework or neonatal medical staffing.

It 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 is no requirement for a Trust Board approved action plan.

The Trust is required to formally record in Trust Board Minutes whether it meets the recommendations of the neonatal medical workforce training action and should take assurance from this report that this is met. The Executive Summary should be capable from standing alone from the report.

Introduction.

The Maternity Incentive Scheme supports the delivery of safer maternity care through an incentive element to trusts contributions to the CNST. The scheme, rewards trusts that meet ten safety actions designed to improve the delivery of best practice in maternity and neonatal services.

Safety Action 4 is that Trusts can demonstrate an effective system of clinical workforce planning to the required standards across Obstetrics, Anaesthesia, Midwifery, Neonatal Nursing and Neonatal Medical Workforces

Below, are the requirements, as referenced within the Maternity Incentive Scheme specifically for Neonatal Medical Workforces:

c) Neonatal medical workforce

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).

Neonatal medical workforce

A review has been undertaken of any 6 month period between **30 May 2023 – 7 December 2023**

The following information and narrative provides assurance that LWH meet the recommendations for both the BAPM standards and the requirements for the Maternity Incentive Scheme.

Compliance with BAPM Medical Staffing Standards for Maternity Incentive Scheme (CNST).

Reference is made to the current BAPM Framework for Practice:

"Optimal Arrangements for Neonatal Intensive Care Units in the UK including guidance on their Medical Staffing" (Revised April 2021)

Adherence to the following criteria is made by reference to and evidenced by staffing rotas for the six-month period 30th May 2023 – 7th December 2023.

Criterion: Minimum NICU resident out-of-hours care should comprise one tier 1 clinician (ANNP/ST1-3 junior doctor), *and* a tier 2 clinician (appropriately-trained specialty doctor/ANNP/ST4-8 junior doctor.

*LWH Response - At Liverpool Women's Hospital NICU, out-of-hours staffing (*i.e. *beyond 1700, and overnight), there will be a minimum of two tier 2 clinicians (comprised of ST4-5 paediatric trainees, and Band 8 ANNPs/neonatal grid trainees) and two tier 1 clinicians (comprised of ST1-3 paediatric trainees/Band 7/8 ANNPs).*

No actions required to meet this standard: Fully Compliant

Criterion: NICUs with more than 2500* intensive care days per annum should double tier 2 cover at night by adding a second experienced junior doctor ST4-8 or appropriately trained specialty doctor or ANNP. A consultant present and immediately available on NICU in addition to tier 2 staff would be an alternative.

LWH Response: In view of intensive care days at Liverpool Women's Hospital NICU exceeding >2500 per annum (~3800), we currently have double tier 2 cover. In addition, a neonatal consultant is resident on site in an on-call capacity.

No actions required to meet this standard: Fully Compliant.

Criterion: NICUs co-located with a maternity service delivering more than 7000 deliveries per year should augment their tier 1 cover at night by adding a second junior doctor, an ANNP and/or by extending nurse practice.

LWH Response: In view of deliveries at Liverpool Women's Hospital exceeding ~8000 per annum*, the tier 1 cover has been accordingly doubled from the minimum outlined. (one tier 1 clinician out-of-hours) to that described above (two tier 1 clinicians).*

No actions required to meet this standard: Fully Compliant

Criterion: It is recommended that all NICUs implement consultant presence on the unit for at least 12 hours per day (generally expected to include two ward rounds / handovers), or more as resources allow and depending on patient numbers and intensity.

LWH Response: At Liverpool Women's Hospital NICU, on-unit Consultant Neonatologist presence is 24 hours per day.

No actions required to meet this standard: Fully Compliant.

Criterion: NICUs undertaking more than 4000* intensive care days per annum with onerous on call duties should consider having a consultant present in addition to tier 2 staff and immediately available 24 hours per day.

LWH Response: Not currently applicable on the NICU at Liverpool Women's Hospital as NICU Intensive care days equal to 3,800 but there is already consultant presence 24 hours per day.

No actions required to meet this standard: Not applicable to LWH.

Criterion: NICUs undertaking more than 2500 intensive care days *per annum* should consider the presence of at least 2 consultant-led teams during normal daytime hours.

LWH Response: At Liverpool Women's Hospital NICU, care is delivered on a mixed acuity basis, where babies receiving intensive-level care are cared for in the same clinical area as those receiving high-dependency-level care. After progressing to special-level care, babies will be transferred to the adjacent Low Dependency Unit. In the mixed acuity area (capacity 24 cots), care is delivered by two consultant-led teams, with a third consultant leading on the Low Dependency Unit.

No actions required to meet this standard: Fully Compliant.

Criterion: NICUs undertaking more than 4000 intensive care days *per annum* should consider the presence of three consultant-led teams during normal daytime hours.

LWH Response: Not currently applicable on the NICU at Liverpool Women's Hospital.

No actions required to meet this standard: Not applicable to LWH.

Additional Evidence to Support Neonatal Medical Workforce Requirements.

In addition, reference is made to the 2010 document detailing: Service Standards for Hospitals Providing Neonatal Care, which provides additional guidance on medical staffing levels.

https://www.nna.org.uk/assets/bapm_standards_final_aug2010.pdf

Criterion 5.4.1: All staffing roles should be limited to neonatal care at all levels, i.e. no cross cover with general paediatrics.

It is anticipated that teams at each tier will be made up from the following groups:
• Tier 1: Staffing can be from paediatric ST1-3, ENNPs or ANNPs, specialty doctors.
• Tier 2: Staffing from paediatric ST4-8, specialty doctors, other non-training grade doctors, ANNPs (with appropriate additional skills and training), resident neonatal consultants.
• Tier 3: Consultant neonatologists. There will be 24/7 availability of a consultant neonatologist for Tier 3.
LWH Response: At Liverpool Women's Hospital NICU, all staff work solely on the neonatal unit, with no general paediatric service located on site.
Roles on the tier 1 rota are fulfilled by ST1-3 paediatric trainees, and Band 7/8a ANNPs.
Roles on the tier 2 rota are fulfilled by ST4-8 paediatric trainees, and Band 8a/b ANNPs.
Tier 3 requirements : Consultant neonatologists are available on site 24 hours per day.
No actions required to meet this standard: Fully Compliant.

Criterion 5.4.2: Recommended numbers of staff for a Neonatal Intensive Care Unit:

• Tier 1: Separate neonatal rotas with a minimum of 8 staff.
• Tier 2: Separate neonatal rota with a minimum of 8 staff.
• Tier 3: A minimum of 7 consultants on the on call rota with resident consultants on the tier 2 rota additional to this number. All tier 3 consultants should be identified neonatal specialists.
LWH Response: The tier 1 rota in the specified period is a 9 person ST1-3 doctors rota, with 9 ST1-3 doctors working 8.2 working time equivalents (WTE) between 30th May- 5th Sept and 11 ST1-3 doctors working 9.8 working time equivalents (WTE) from 6th Sept to 7th Dec 2023 . The 0.8 WTE gaps within this initial period are fully covered by either the complementary tier 1 ANNP workforce, or locum cover to ensure the 9 person rota is run as intended. Additionally, roles within the tier 1 rota are supplemented by a group of 9 tier 1 ANNPs who undertake the same roles across the neonatal unit, on a separate but complementary 9 person rota.
The tier 2 rota in the specified period is comprised of 11 ST4-8 doctors, working 9.2 WTE on a separate rota between 30th May and 5th Sept 2023 and 12 ST4-8 doctors working 9 working time equivalent (WTE) from 6th Spet to 7th December 20223. This is alongside a 12 senior tier 2 ANNPs who work on a complementary 9 person oncall rota in additon to the tier 2 doctors.
No actions required to meet this standard: Fully Compliant.

Criterion 5.4.3: For larger NICUs, special consideration should be given to the number of staff required at each tier throughout the 24 hours and giving due consideration to the time required at each handover. With increasing size, at some point, essentially the whole of the staffing structure described in 5.4.2 should be doubled.

LWH Response: In recognition of the number of cots and deliveries at Liverpool, as recommended by BAPM, the staffing levels have been essentially doubled from baseline, with 18 WTE tier 1 clinicians (ST1-3 doctors and Band 7/8a ANNPs); 18 WTE tier 2 clinicians (ST4-5 doctors, neonatal grid trainees and Band 8a/b ANNPs), and 19 consultants (WTE 15).

No actions required to meet this standard: Fully Compliant.

Conclusion.

The neonatal medical workforce and the staffing of the neonatal unit complies with the BAPM standards.
The requirements for CNST Year 5 are fully met and can be evidenced with rota spreadsheets.
There is no requirement for an action plan to be formulated and signed off by the Trust Board.

APPENDIX 6

Neonatal Nursing has become one of the most prescribed areas of nursing over the last years. In line with other intensive care specialities.

The CRG Workforce Calculator (2020) is used by commissioners to define staffing establishments in line with activity for NICU (Neonatal Intensive Care Unit) 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 (NHS England) Neonatal Service Specification e08 (2015); DH (2009); BAPM (British Association of Perinatal Medicine) (2010); NICE (2010). There is a mandatory annual review by the Northwest Neonatal Operational Delivery Network (NWNODN). It is a requirement of CNST (Clinical Negligence Scheme for Trusts) that the CRG tool is used, BAPM has set clear standards around the minimum number of nurses required to care for our client group.

The NICU at LWH (Liverpool Women s Hospital) average occupancy on the neonatal unit exceeded 80% with an activity in the reporting period to end of September 2023 of 86.11 %.

Based on BAPM standards for neonatal nursing provision, The CRG workforce calculator identified the following;

89.1 % of LWH NICU workforce are registered nurses however, based on current activity the staffing tool would suggest that establishment needs to increase by 21.7 wte nurses to 92.6% This gap is reflective of current levels of activity and acuity and both NWNODN and Specialist commissioners are aware.

The Liverpool Neonatal Partnership received commissioned funding for recruitment of qualified nurses to staff the planned neonatal surgical unit on the Alder Hey site. They are working across LWH and Alder Hey neonatal units and have bridged the gap of trained staff required to provide safer staffing levels over the period of higher acuity and occupancy.

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 roles 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 (retinopathy of prematurity), infant feeding etc.

The activity within the calculator is 3-year average data supplied by NWNODN.

An action plan for maintaining safe staffing levels and provision of quality roles has been formulated and will be reviewed regularly for compliance and achievement of targets, and progress updates provided to the committee.

MAIN REPORT

1. Introduction

This paper is to provide assurance to the Committee that the Neonatal Service can demonstrate an effective system of clinical workforce planning which is based on BAPM standards for neonatal nursing and is shared with the NWNODN annually.

2. Background

The number of registered nurses and non-registered staff required to provide nursing care to patients on a neonatal unit can vary on each shift as the level of neonatal care a baby needs will vary from minimal intervention for a few minutes or hours through to considerable support over many weeks, or months. A one-size-fits-all approach is not appropriate. Guidance and recommendations for staffing are provided by 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. The CRG Workforce Calculator (2020) is used by commissioners to define staffing establishments in line with activity for NICU across England (section 3.0)
The Neonatal unit at LWH is commissioned for 44 cots 12 providing Intensive Care (ITU) level care, 12 providing High Dependency (HDU) level Care and 20 Providing Low Dependency (LDU) level care.
Effective nursing leadership is key and neonatal nursing leaders have a complex task at hand to consider multiple factors when planning staffing – from getting the ratios right to considering the impact of the physical environment of the ward, the skill mix, productivity, and efficiency of the team, and measuring the quality of the team to develop staffing plans. Nursing leaders have a responsibility and remain accountable for ensuring that babies and families receive high quality care in the right place at the right time, delivered by staff equipped to provide safe, dignified, and compassionate care.

2.1 Nursing

- 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;

https://hubble-live-assets.s3.eu-west-1.amazonaws.com/bapm/file_asset/file/101/BAPM_Guidance_on_Cot_Capacity_and_use_of_Nurse_Staffing_Standards_24-10-19.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.

BAPM Nursing standards for nursing care advise nursing to patient ratios of

1:1 ITU

1:2 HDU

1:4 LDU

1:4 TC

https://www.england.nhs.uk/wp-content/uploads/2021/04/safe-staffing-neonatal.pdf

Non registered staff, i.e. nursery nurses, nurse associates and healthcare assistants provide care in the low dependency and TC (Transitional Care) areas under the supervision of the qualified nursing staff. They are adept at supporting mums to breastfeed and parent education in preparation for discharge home. They are valuable members of the team who have since 2018 also been supported the registered nurses / midwives in providing in-reach support to babies on the postnatal ward who are reluctant to feed or require blood sugar measurements or feeding support to babies on small baby and risk of hypoglycaemia pathways. These posts are not reflected within the CRG workforce calculator.

The vacancy at band 5 has had approval at trust vacancy panel for the recruitment of 6 band 5 nurses to be interviewed in October 2023.

The current Nursing Establishment is outlined in Figure 1. which highlights current vacancy situation for registered and non-registered staff providing direct patient care

Role Title	Band	WTE Budget	WTE In post	Vacancy
Sister / Charge Nurse	7	9.14	8.6	0.54
Deputy Sister / Charge Nurse or Senior Staff Nurse	6	42.06	41.4	0.66
Staff Nurse QIS	5 QIS	39	39	39
Subtotal QIS		**90.2**	**89.4**	**1.2**
Staff Nurse NON QIS	5 NON QIS	31.46	25.33	6.13
Subtotal Non QIS		**31.46**	**25.33**	**6.13**
Nursing Associate	4	2	2	0
Nursery Nurse	4	6.89	6.22	0.67
Healthcare Support Worker	3	11.97	11.96	0.01
Subtotal Non-Reg		**20.86**	**20.18**	**0.68**
TOTAL DIRECT PATIENT CARE		**142.52**	**134.91**	**7.61**

Figure 1

2.2 Staffing / Activity 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 which was submitted to NWNODN in September 2023.

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.

CRG calculator calculations have identified the following shown in figure 2 in relation to the Neonatal Service at LWH for the last 6 months to September 2023.

Activity (HRG 2016)		
	Activity	Commissioned cots
HRG 1 (IC)	3,893	12
HRG 2 (HD)	3,001	12
HRG 3 - 5 (SC)	6,936	20
Total	**13,830**	**44**

Staffing numbers (WTE) DIRECT PATIENT CARE ONLY		
	Budget	In post
Total QIS	90.20	89.40
Total Non QIS	31.46	25.33
Total Non Reg	20.86	20.18
Total	**142.52**	**134.91**

Activity calculations (HRG 2016)							
	Activity	*For calculations*		Commissioned cots	Occupancy for period	Cots required to meet activity at average 80% occupancy	Variance: declared cots against required
		80% of daily activity	*WTE (6.07 / BAPM)*				
HRG 1	3,893	*13.3*	*6.07*	12	88.88%	14	-2
HRG 2	3,001	*10.3*	*3.04*	12	68.52%	10	2
HRG 3	6,936	*23.8*	*1.52*	20	95.01%	24	-4
Total	**13,830**			**44**	**86.11%**	**48**	**-4**

Nursing workforce calculations (WTE) DIRECT PATIENT CARE ONLY					
NB total nurse staffing required to staff declared cots = 145.68, of which 101.98 (70%) should be QIS					
	Current position		Required to meet activity at average 80% occ	Variance: budget against required	Variance: in post against required
	Budget	In post			
Total nursing staff	142.52	134.91	154.23	-11.71	-19.32
Total reg nurses	121.66	114.73	143.42	-21.76	-28.69
Total QIS	90.20	89.40	118.19	-27.99	-28.79
Total non-QIS	31.46	25.33	25.23	6.23	0.10
Total non-reg	20.86	20.18	10.81	10.05	9.37
Reg nurses as % nursing staff	85.4%	85.0%	93.0%		
QIS as % reg nurses	74.1%	77.9%	82.4%		

Figure 2

These figures indicate the following:

- Average occupancy on the neonatal unit exceeded 80% with an activity in the reporting period of 86.11 %.

- 89.1 % of our workforce are registered nurses. Based on current activity the staffing tool would suggest that our establishment needs to increase to 21.7 wte nurses. 92.6% This gap is reflective of current levels of activity and acuity. The Liverpool Neonatal Partnership has received commissioned funding for recruitment of qualified nurses to staff the planned neonatal surgical unit on the Alder Hey site. 25 wte nurses were employed in September 2022. They are working across LWH and Alder Hey neonatal units and have bridged the gap of trained staff required to provide safer staffing levels over the period of higher acuity and occupancy.

- 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 November 2023 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 roles 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, governance etc.

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 have been approved through the Trust recruitment process advertisement has completed and shortlisting and interview processes are underway.

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.

Preterm Optimisation

One of lead ANNP team along with medical and obstetric teams support are leading on preterm optimisation within the Trust. The Lead ANNP has been given time to help support this work and currently job descriptions are being reviewed to reflect the important and value that is place up this piece of work.

3.0 Action Plan

Issue	Action needed	Responsible	Led By	Date	Update
Increased intensive care activity	To review activity, capacity and demand with network and specialist commissioners Continue to monitor staffing against activity quarterly	J. Deeney S O'Neil	S. O'Neil J. Harrison J. Balmer	Apr 24 Ongoing	New ACD info should be available in April 2024
Development of Quality roles within the service	To work with ODN and Trust to develop fully funded quality role: • RoP • Bereavement • Governance • Breastfeeding • FiCare	J. Deeney/S. O'Neil	S.O'Neil /J. Balmer	Jun 24 Nov 24 Jan 24 Nov 24 Nov 24	RoP project with NWNODN Funding in place
Increase number of nurses QIS	Continue to put team forward to train in speciality to meet standard required for activity	S.O'Neil	S. O'Neil	May 2024	
Recruitment of band 5 nurses	To continue to proactively recruit new band 5 nurses	S. O'Neil	J. Balmer	Ongoing	
Retention of nurses at all levels	To understand the needs of nurses at all levels that make	S. O'Neil	J. Balmer	ongoing	

	then want to remain within their post Exit interviews Stay interviews Career conversations				

Quality Committee Chair's Highlight Report to Trust Board
28 November 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:
  ○ Cancer performance continues to be challenged particularly with waits for first outpatient appointment being impacted in September by high referral rates. This would impact performance for Faster Diagnosis Standard and 62 days based on the current backlog clearance. A revised trajectory had been submitted to NHSE as part of Tier 2 monitoring.
  ○ Disappointment in relation to the staff uptake of the flu and covid vaccination programme, despite numerous efforts to improve vaccination rates.
  ○ A reduction in positive Friends and Family Test (FFT) responses across maternity and Gynaecology (ED). Both divisions were focussed on improvements from the displeased comments and actions underway to support the areas of repeated concern. It was noted that the information taken from the FFT test should be triangulated with other patient feedback to provide a holistic position as per IGR.
• The Committee received an overview of the current services provided by the Gynaecology Emergency Department (GED) and Early Pregnancy Assessment Unit (EPAU) which identified areas of good practice and areas of risk. The Committee noted the areas of risk and solutions undertaken in the short term and the medium to long term proposals to make the service fit for future. It had been expected that the proposals from the review would have been further developed ahead of submission to the Quality Committee. Further work and clarity over the future direction of the service was requested to a future meeting.
	• Concern in relation to compliance rates of Safeguarding training, specifically Mental Capacity Act training, following a review and remapping exercise from the Head of Safeguarding. It was confirmed that the Trust was meeting the ICB metrics for safeguarding training, and comprehensive monthly information was provided. Additional information was shared with the Committee following the meeting for assurance.
	• Noted the inclusion of the Trust in the following key strategic meetings: the inaugural System Oversight Board, and the Rapid Quality Review.
	• It was agreed that an informal session on quality performance metrics would be beneficial.
	• Informed that the 18week RTT non-admitted completed pathway would continue to perform under target as the Trust prioritises the clearance of long waits in line with national planning priorities. Further consideration to the appropriateness of maintaining the metric on the performance report would be taken.

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. An engagement meeting with the Care Quality Commission had taken place on 23 November 2023. During the visit the CQC held a staff focus group, had a hospital walkabout, and received an executive presentation. The CQC verbally confirmed that there had visible progress on the Maternity Assessment Unit but no confirmation on the potential impact on the status of the warning notice could be provided at the current time. It was confirmed that no new areas of risk had been identified to the CQC in relation to services at the Trust. (WELL LED) • The Committee noted the following matters from the Quality Performance report:	• None

○ Positively significant reductions with the 62-day backlog was noted during Month 7 due to the pause in industrial action and increasing capacity. • Took positive assurance from the review of the revised model of care for midwifery continuity of care which had in place for six months. The Committee supported the request to continue with the revised model for a further six-months and submit an annual review to the Committee. (ALL) • Received the Maternity and Neonatal Transformation plan update and the perinatal dashboard noting progress against the targets and assurance that effective systems of control are in place to monitor quality and safety in Maternity and Neonatal Services. (ALL) • The Committee received the integrated governance report for quarter 2 noting a focus on repeat causality incidents, embedding learning within divisions, and improving quality and safety of services and patient outcomes. (ALL) • Significant development of work on the patient equality and diversity and inclusion EDS22 requirements, and a focus on working towards EDS23. Positive engagement with diverse communities evidenced.	
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.	
Comments on Effectiveness of the Meeting / Application of QI Methodology	
• Timeliness of report submission • Clarity of purpose of the reports	

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
138.	Review of BAF risks: Quality related risks	Information	143.	Review of the Revised Model of Care for Midwifery Continuity of Care (MCoC)	Assurance
139.	Sub-Committee Chair Reports	Assurance	144.	Maternity and Neonatal Services Update a) Maternity and Neonatal Transformation plan b) Perinatal Dashboard	Information
140.	Quality and Regulatory Update	Information	145.	Integrated Governance Assurance Report Quarter 2, 2023/24	Assurance
141.	Quality Performance Report Month 7 2023/24	Information	146.	Patient Equality Diversity and Inclusion (EDI) update report	Information
142.	Gynaecology Emergency Department (GED) service review	Information	147.	Safeguarding Quarterly Report Quarter 2	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	✓	✓	✓	✓	A	✓				
Louise Kenny, Non-Executive Director	✓	✓	A	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	A				
Jenny Hannon, Chief Finance Officer	✓	✓	✓	✓	✓	✓	✓				
Michelle Turner, Chief People Officer	✓	✓	✓	✓	A	✓	A				
Nashaba Ellahi, Deputy Director of Nursing & Midwifery	A	✓	✓	✓	✓	✓	✓				
Philip Bartley, Associate Director of Quality & Governance	A	✓	✓	✓	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)	*23/24/219b*		Date: 14/12/2023	
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:	Comment:

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Key metrics reviewed and discussed at the Board Committees in November 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 7 performance was continuing to see the impact of Industrial Action that took place in Quarter 2. It was noted that further industrial action would continue to impact the Trusts performance if announced through Q3.

Gynaecology Elective recovery was noted to be continuing to deliver a positive trajectory for 65+ weeks in line with the 2023/24 plan submitted to the ICB however as noted in previous reports, the impact of Industrial Action and Digi Care go live in Q2 had seen an impact on the number of 52+ weeks patients increasing above the Trust trajectory. Committees were informed of additional capacity in M8 which will result in a reduction to bring the Trust back into line with agreed trajectory numbers although unlikely to achieve this until M9. Committees were informed of the progress with PIDMAS and the reduction in overdue Follow-Ups. Queries were raised regarding 18-week metrics with a discussion regarding trajectory for improvement and likely timescales. Further discussion regarding inclusion of these measures in Performance report need to take place and whether these are included for 24/25. Discussions with ICB as part of 24/25 planning to address this.

Updates were given regarding Cancer performance with the inclusion of the Tier 2 Cancer Performance slides for discussion. Committees were notified of the current FDS position being low due to the clearing of a backlog of patients over 28 days and that this would be continuing into Q3, with improvements to be seen towards the end of Q3 into Q4. Assurance was given of the significant work being undertaken with inclusion of Cancer Improvement Group Chairs report and ongoing Improvement Plan. Committees were informed of significant referral increases in M6 which will create further pressure on the Cancer PTL and capacity. Quality committee requested that 104-day breaches and information related to late referrals was picked up through Cancer Improvement Group for review and further assurance. Performance against Pathology demand was noted within the slides and committees were

informed of continued capacity pressures at LCL whilst maintaining improved performance. The increase in Urgent biopsies being completed by LCL was noted to have increased.

Performance related to Urgent Care metrics including AED 4-hour standard and the MAU 15- & 30-minute triage targets were discussed with MAU triage times noted to be consistently improving and this will continue into M8. AED 4-hour performance was noted to have reduced in M7 with challenges related to Junior Doctor gaps, Industrial Action and increased attendances placing pressure on the department. Committees were reminded of the move of EPAU on 6th November which was noted to be having some improvement to the 4-hour performance metric for M8. Discussion took place regarding the increase in patient time spent in department and appropriate escalation. It was agreed that GED escalation policy would be reviewed to ensure fit for purpose.

Assurance was given to committees regarding Quality metrics and improvements being made in several areas including Infection Control, MUST and reducing numbers of complaint actions overdue. Concerns were raised from committee members regarding the reduction in positive FFT within Gynaecology (ED) and the low maternity response rate, with actions noted as part of performance report response but further updates on progress against these actions requested for future committees.

The increasing overnight stay rate for patients listed as Day Case was noted as an area of concern. It was noted for the Committees that an audit of the data is currently underway, and results of this audit would be reviewed in December with feedback to committees in January 2024 with any associated actions for improvement.

Discussion regarding metrics noted to be Good or Average required further assurance that these were being monitored and actions being taken were evidenced rather than just a focus on Concerning/Very Concerning. Where targets and trajectories were not so clear and how these impacted ratings require more work and will be developed further for future committees. Deputy COO will take this forward with Associate Director of Information.

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.
(neutral)	**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

November 2023

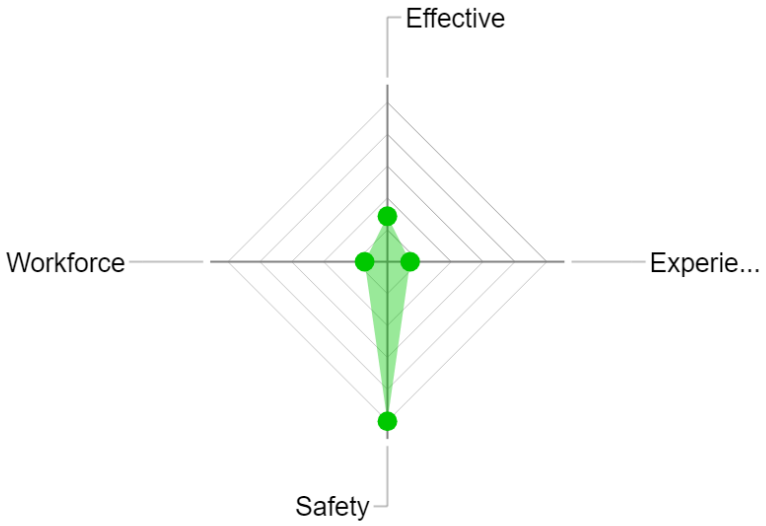
Section 1: Assurance Radar Charts by Trust Values

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'.

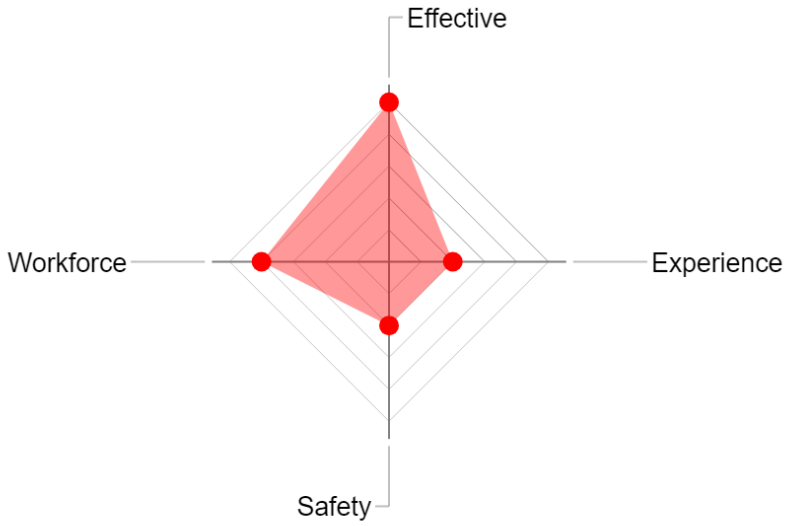
KPIs Passing Target for Six Months	11
KPIs Failing Target	13
KPIs Hit and Miss	10
KPIs No Target	5

KPIs Improving Variation	13
KPIs Concerning Variation	5
KPIs Common Cause Variation	21

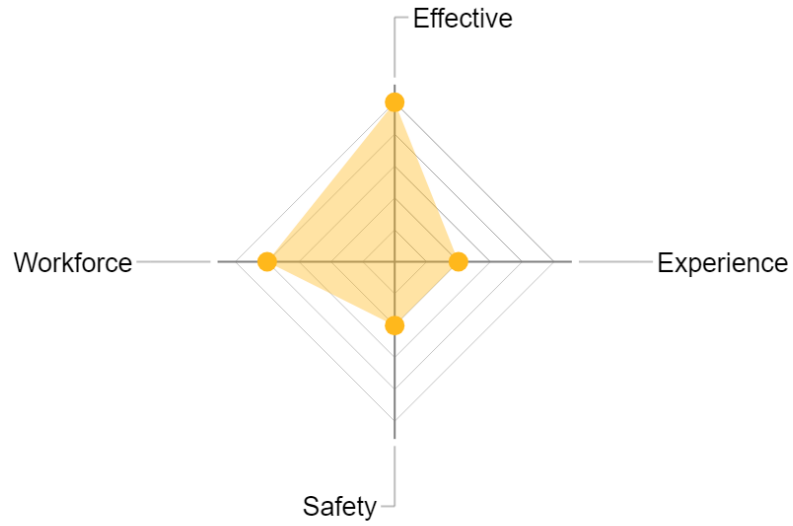
Consistently Passing



Consistently Failing



Hit and Miss



Section 2: Integrated Performance Metrics

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

Excellent - Celebrate & Learn

KPI	Target < or >	Target	P	A	V
18 Week RTT: Incomplete Pathway > 104 Weeks	<=	0	0	P	L
MAU - Face to face Maternity Triage within 30 Mins	>=	>= 95%	98.69%	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%	9.16%	P	L

Good - Celebrate & Understand

KPI	Target < or >	Target	P	A	V
18 Week RTT: Incomplete Pathway > 65 Weeks	<=	0	344	P	
Complaints: Number Received	<=	<= 15	6	P	
Diagnostic Tests: 6 Week Wait	>=	>= 99%	94.63%	?	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%	93.96%	?	H

Average - Investigate & Understand

KPI	Target < or >	Target	P	A	V
Neonatal deaths per 1,000 total live births	<=		4.8		
Neonatal Unit Deaths > 22wks Gest Inborn	<=		4		
Neonatal Unit Deaths > 22wks Gest Inborn and Out Born	<=		6		
Neonatal Unit Deaths > 22wks Gest Out Born	<=		2		
18 Week RTT: Incomplete Pathway > 52 Weeks	<=	0	1662	?	
A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge	>=	>= 95%	83.30%	?	
C-Gull Recruitment	<=		156	?	
Friends & Family Test: In-patient/Daycase % positive	>=	95%	84.68%	?	
Neonatal deaths 24-31+6 Weeks Inborn babies	<=	0.063	12.50%	?	
Number of Open Patient Safety Incident Investigations	<=	8	10	?	
Proportion of patient activity with an ethnicity code	>=	>=96%	98.48%	?	
Total Number of Patient Safety Incident Investigations (Rolling)	<=	30	0	?	

Integrated Performance Metrics

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

Concerning - Investigate

KPI	Target < or >	Target	P	A	V
18 Week RTT: Incomplete Pathway > 78 Weeks	<=	0	5	F	L
Cancer: 31 Days from Diagnosis to 1st Definitive Treatment	>=	>=96%	62.96%	F	
Cancer: 62 day wait for first treatment from urgent GP Referral for suspected cancer (After Re-allocation)	>=	>=85%	10.71%	F	
Friends & Family Test: A&E % positive	>=	95%	61.90%	F	
Friends & Family Test: Maternity % positive	>=	95%	83.33%	F	
Mandatory Training	>=	>= 95%	93.90%	F	H
Mandatory Training (Clinical)	>=	>= 95%	87.88%	F	H
Serious Untoward Incidents: Open	<=	<5	9	F	L
Sickness Absence Rate	<=	<= 4.5%	5.99%	F	L
Overall size of Elective Waiting List	<=		19954		H

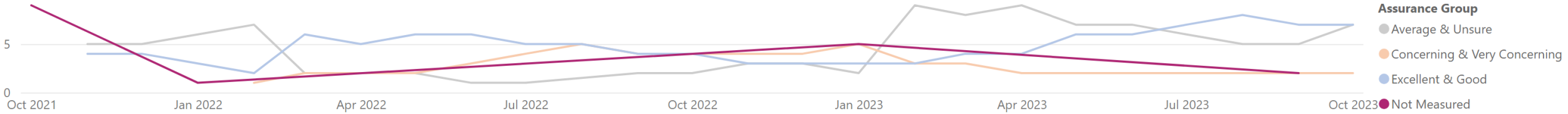
Very Concerning - Investigate & Take Action

KPI	Target < or >	Target	P	A	V
Cancer: 104 Day Breaches	<=	0	8.5	F	H
Cancer: 28 Day Faster Diagnosis	>=	>= 75%	29.32%	F	L
Prevention of Ill Health: Flu Vaccine Front Line Clinical Staff	>=	>= 80%	30.46%	F	L
Serious Untoward Incidents: New (Rolling per year)	<=	24 /year	36	F	H

Investigate & Understand

KPI	Target < or >	Target	P	A	V

Section 3: To deliver **Safe** Services

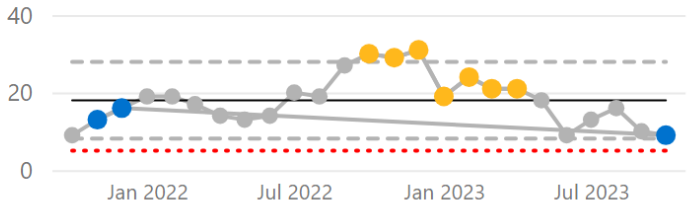


KPI	Assurance Category	Date	Target	Target < or >	Performance	Assurance	Variation	Trend
MAU - Face to face Maternity Triage within 30 Mins	Excellent	October 2023	>= 95%	>=	98.69%			
Never Events	Excellent	October 2023	0	<=	0			
Serious Untoward Incidents: Number of SUI's reported to CCG within agreed timescales	Excellent	August 2023	100%	>=	100.00%			
Serious Untoward Incidents: Number of SUI's with actions outstanding	Excellent	October 2023	0	<=	0			
Infection Control: Clostridium Difficile	Good	October 2023	0	<=	0			
Infection Control: MRSA	Good	October 2023	0	<=	0			
NHSE / NHSI Safety Alerts Outstanding	Good	October 2023	0	<=	0			
Venous Thromboembolism (VTE)	Good	October 2023	>= 95%	>=	93.96%			
Neonatal deaths 24-31+6 Weeks Inborn babies	Average	October 2023	0.063	<=	12.50%			
Neonatal deaths per 1,000 total live births	Average	October 2023		<=	4.8			
Neonatal Unit Deaths > 22wks Gest Inborn	Average	October 2023		<=	4			
Neonatal Unit Deaths > 22wks Gest Inborn and Out Born	Average	October 2023		<=	6			
Neonatal Unit Deaths > 22wks Gest Out Born	Average	October 2023		<=	2			
Number of Open Patient Safety Incident Investigations	Average	October 2023	8	<=	10			
Total Number of Patient Safety Incident Investigations (Rolling)	Average	October 2023	30	<=	0			
Serious Untoward Incidents: Open	Concerning	October 2023	<5	<=	9			
Serious Untoward Incidents: New (Rolling per year)	Very Concerning	October 2023	24 /year	<=	36			

To deliver **Safe** Services - Exceptions

Serious Untoward Incidents: Open - Chief Nurse

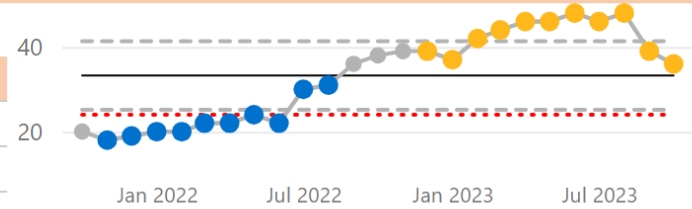
Assurance Category	Concerning
Date	October 2023
Target	<5
Target < or >	<=
Performance	9
Assurance	F
Variation	L



There are 9 ongoing SUI's 5 with Gynaecology and 4 within Maternity, 1x final report has been submitted by Gynae in October. All SI are expected to be submitted to the ICB by 27/12/023.
The Trust have declared 5 PSII for October, 2 within gynae both relating to Ectopic Pregnancies, 1 Neonatal SUDI, 2 Maternity MNSI Cases.
2 further cases were reported to the ICB that were declared in September, this was due to a change in reporting requirements . 1x CSS and 1x Maternity ITU Transfer

Serious Untoward Incidents: New - Chief Nurse

Assurance Category	Very Concerning
Date	October 2023
Target	24 /year
Target < or >	<=
Performance	36
Assurance	F
Variation	H



The Trust initially saw a rise in SUIs as a result of Future Generations and single site issues, the majority of these incidents have been submitted as final reports to the ICB. All SUI are expected to be submitted by 27/12/2023.

Assurance Category	
Date	
Target	
Target < or >	
Performance	
Assurance	
Variation	

Assurance Category	
Date	
Target	
Target < or >	
Performance	
Assurance	
Variation	

To deliver Safe services - Safer Staffing

October 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	95.16%	78.49%	146.77%	95.16%	*/**October staffing fill rate on days is reflective of the increase this month of long-term sickness, alongside maternity leave. Safe staffing has been maintained due to the low bed occupancy of 48.87% in the inpatient area. Safe care additionally supported by the ability to flexibly rotate staff from the HDU area due to the low bed occupancy which was recorded as 25.23%. The fill rate of 146.77% RN on nights remains above the 100% as this is reflective of senior RN cover rotating between GED and inpatient area.
Induction & Delivery Suites	77.63%	87.10%	80.00%	96.77%	*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. Following the commencement of the NQM cohort at the beginning of October and a period of induction, they were all rostered to work in the clinical areas on Days. Although taking the lead for care, they are not counted in the overall establishment fill rate until their supernumerary orientation period completed (this is in line with recommendations from Ockenden Report) 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	94.35%	101.61%	87.50%	98.39%	*/**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. The additional care staff via bank arrangements supported the mitigation of the registered midwives reduced fill rate, due to contributions made to postnatal care. The position for next month is expected to alter with the commencement of NQM
MLU	83.87%	67.74%	81.45%	83.87%	*/**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)	88.29%	114.52%	91.85%	69.35%	*/**Fill rates reflect the neonatal unit occupancy in October. Total occupancy over the month was 71%. Occupancy in ITU and LDU areas increased to 78% and 75.5% respectively. The number and acuity of babies on the unit is reflected in the RN fill rates. Care staff fill rates in October are reflective of the higher low dependency activity in October. Safe staffing was maintained and CHPPD (Care Hours Per Patient Day) are as would be expected.
Transitional Care	80.65%	100.00%	80.65%	93.55%	**Fill rates reflect the transitional care occupancy in October. Most of the care is provided by clinical support workers in this area thus higher numbers than registered staff. Safe staffing was maintained and CHPPD (Care Hours Per Patient Day) are as would be expected.

To deliver Safe services - Safer Staffing

Gynaecology: October Fill Rate

Fill rate – The staffing fill rate for October on days reflects the Long-term sickness alongside maternity leave. Safe staffing was maintained due to the low bed occupancy in the inpatient ward (48.87%) and the High Dependency Unit (HDU) bed occupancy recorded as 25.23%. The low bed occupancy allowed the manager to rotate staff from the HDU to support the inpatient area. The high fill rate 146.77% 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 October was reported as 11.84% an increase from September sickness by 2.22%. Long term sickness contributed to the high levels of sickness at 68% whilst short-term sickness at 32%. Reviewing the previous months sickness indicates that long-term sickness has reduced and maternity leave accounts for 1.61%wte staff.
Vacancies – RN vacancies remain at 2.11 wte with active recruitment in progress.
Red Flags – 0 red flags
Bed Occupancy –Bed occupancy for the Gynaecology inpatient unit is recorded as 48.87%, with the High Dependency Unit bed occupancy recorded as 25.23%.
CHPPD –CHPPD overall was reported at 7.3, a decrease on previous month reported as 8.5. The split between Registered and unregistered care staff was 4.5 for Registered Nurse staff and 2.8 hr for Health Care Assistant. Safe care was provided throughout the month.

Neonates: October Fill Rate

Fill-rate – Occupancy increased slightly from September to October across the acute and low dependency areas of the neonatal unit. Safe staffing has been maintained and fill rates are reflective of acuity and occupancy. The escalation policy has not been used in October. There were 4 incidents reported of delay in repatriation of babies to their local neonatal units, which were escalated appropriately to the Northwest Neonatal ODN.
Attendance/Absence – Sickness was reported at 5.56% in October which is an increase from the previous month, with the top reasons for sickness in October as cough cold and influenza. Long term sickness has increased to 48.07 with all sickness managed in line with the attendance management policy.
Vacancies – Turnover remains below the trust target of 13%, at 9% in October. There was successful recruitment of Band 5 vacancies with 5 new nurses who commenced employment on the neonatal unit in October 2023, with 3 of the recruits being newly qualified nurses who had completed a student placement on the unit and identified a preference to seek employment with us. There are band 5 vacancies on Transitional care and band 2 support workers with a plan to authorise at vacancy control panel in November. 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 has been withdrawn and a plan to move to hybrid clinical fellow/ ANNP posts made. Shortlisting for these posts is underway.
Red Flags – There are no Neonatal Nursing red Flags reportable.
Bed Occupancy – Occupancy remained below the expected 80% at 71% in October. Occupancy rates for October per area were: ITU 78%; HDU 59%; LDU 75.5% and TC 61.7%. An increase was seen in ITU and LDU capacity in September with rates remaining below expected at 61.7% in TC. All of which is reflective of the care staff fill rates.
CHPPD – Within the critical care areas the care hours provided in October are as would be expected for babies being nursed in ITU with 13.8hours combined Care hours per patient day (CHPPD). The breakdown shows higher hours of registered nurse care and lower non-registered care. This split of 12.5hrs of registered nurses and 1.3hrs of healthcare support workers, is what is expected considering that most of these babies require care by a nurse qualified in speciality.
The Transitional care CHPPD is reflective of the way in which non- registered HCSWs lead care in TC, supported by registered staff and parents. For this reason, 4.5hrs provided by HCSWs and less by registered nurses of 3.8 hrs, however appropriate for care delivery with overall care hours at 8.3 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: October 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 98.7%, and 91.7% of those within 15min BSOTS target with attendances increasing by 11% in the previous two months. 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 temporary staffing solutions. Following a period of Induction, during week 3 of the month NQM were deployed to their first area of work rostered to day shifts. Although encouraged to take the lead for clinical care, they were supported by a buddy midwife, retaining a supernumerary status whilst completing orientation in the ward ensuring a structured transition from Student to Registrant in line with the recommendations of Ockenden Report. 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 increased in October to 7.01% in month, or which STS accounts for 47%, with the top reasons for short term absence being cough/cold or gastrointestinal issues and LTS is 53%. Divisional LTS management meetings led by HR and DHoM also take place with the Managers/ Matrons, with escalation meetings for short term absence patterns also ongoing as required. Robust management practice continues, and assurance can be provided that where there is LTS sickness, cases are managed in line with policy with the majority of current LTS cases in the 0–3-month timescale. Maternity leave equates to 17.19wte all of whom are within the Registered Midwives staffing group and is reflective of a changing age profile of the workforce.

Vacancies – The Maternity Service has zero vacancies for either Midwives or MSWs at month end.

Red Flags – During October 35 Midwifery Red Flags were identified. This included 6 delays of >2hrs from admission to commencement of IOL and 17 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 which will support the capacity and flow for those admitted for IOL. Mutual aid was requested from other LMNS providers to support delay in IOLs at LWH due to capacity, however this increase in demand was also reflected across the system and therefore could not be supported by other providers.

CHPPD – Since April 2021, CHPPD in Maternity has included the number of babies in the total number of patients per inpatient ward at the 23.59hrs data capture. For Intrapartum Areas, Delivery and MLU care during established labour is required to be 1:1 with a registered midwife, with support staff utilised to assist with the functioning of the ward or help in the postnatal period once the birth care episode is completed prior to transfer to Maternity Ward. CHPPD was reported at 15.6 in October for Delivery Suite which is an increase from September (14.2). 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. Due to high levels of activity and acuity there were 4 breaches of 1:1 care being provided for periods in established labour, all of which were reported as Red Flags, and staff redeployed when able to do so. All cases were reviewed by the Intrapartum Matron and no harm was identified, with escalations by the bleep holder to redeploy staff as soon as able. 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 3.6 for October a slight increase from the previous month. Nationally the refresh of the BirthRate Plus Ward Based Accuity Tool which will provide real time evidence-based data to support staffing deployment decisions on Maternity Ward is nearing completion and is expected to be available to us in December. This will provide safe staffing assurance on the changing complexity of ward-basedcare 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						

Notes:

1. Summary of compliance rates.

Month	Water	General PPM's	Reactive maintenance
M1 - 04/23	100%	91%	80%
M2 - 05/23	99%	86%	72%
M3 – 06/23	100%	90%	77%
M4 – 07/23	100%	84%	76%
M5 – 08/23	100%	95%	86%
M6 – 09/23	91%	82%	67%
M7 – 10/23	99%	80%	67%
M8 – 11/23			
M9 – 12/23			
M10 – 01/24			
M11 – 02/24			
M12 – 03/24			

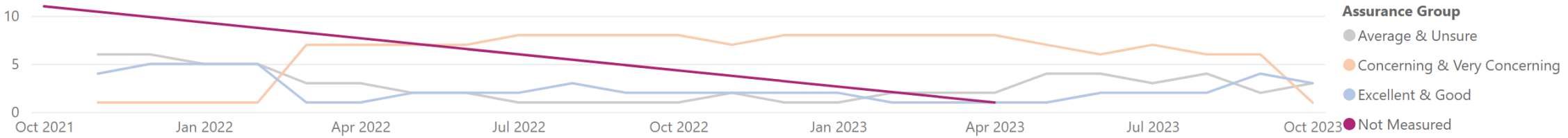
2. Fire strategy - capital confirmed for various projects on 7th June - schedule of works now agreed and ongoing. Fire audit undertaken August 2023 resulted in
REGULATORY REFORM (FIRE SAFETY) ORDER 2005

Risk register:
2469 - allocation of resources to carry out water safety checks has not achieved full compliance.
2368 - Hot water may not be delievred at high tempertaure cause - the original trace heating system on the domestic hot water pipe work is at end of life.
All three risks have an impact on resource levels within the department - and although significant improvement has been made the department has experienced some staff turnover with recruitment ongoing, therefore these will remain on risk register until it can be assurred that compliance will be maintained.

Given the continued improvement in water safety and general PPM's compliance it was anticipated that we would be abe to review these risks with a view to reducing or removing them. However, given the decline in compliance, although now improving, a review of these risks will take place in month 10.

FIRE	
Fire Alarm Testing (W, 3M)	Weekly testing to ensure that all panels sound alarms and all panels talk to each other and send a fire signal to the Fire Alarm Receiving Centre to alert th
Fire Doors (M)	Monthly inspection of all fire doors.
Fire Damper Inspection Test	Annual fire damper inspecion of all dampers in ventilation ductwork.
Fire Fighting Equipment (12m)	Annual inspection of all fire extiguishers.
Dry Risers (12M)	Annual inspection of all dry risers.
Fire Hydrants (12M)	Annual inspection of all fire hydrants.
Emergency Light test (M,12M)	Monthly test of all emergency lights in the hospital. Annual 3 hour battery discahrge test of all emergency lights in the hospital. There are approx 2000 ligh
WATER	
Water Treatment (M) (heating and cooling)	Monthly test of the quality and condition of our heating and cooling water to ensure that it is treated with the correct chemcials to prevent corrosion of the
Water Tank Cleaning (12M)	Annual clean and disinfection of all our potable water tanks used for drinking water.
Water Sampling (M)	Monthly water sampling in kitchns, staff rooms, water fountains, birthing pools, NICU and HDU for water quality testing for e-coli, coliforms, Legionella pne
Water Safety PPMs	Weekly, monthly, 3 monthly and 6 monthly servicing and testing of water heaters, water temperatures, water safety devices, such as thermostaic mixing v
SECURITY	
Access Control System (3M)	3 monthly servicing and testing of access control system.
CCTV (3M)	3 monthly servicing and testing of CCTV system, 110 cameras.
Intruder Alarm (6M)	6 monthly service and testing of our Intruder alarm and panic buttons.
Baby Tagging System (3M)	3 monthly service and testing of our baby tagging system.
LIFTS	
Passengers & Goods Lift (M, 12M)	Monthly and annual service and testing of our lifts.
Ladder & Access Platforms (6M)	6 monthly inspection of ladders and step ladders.
ELECTRICAL	
Commercial Dishwashers (6M)	6 monthly service and inspection of our diswashers.
Commercial Washing Machine Dryers (6M)	6 monthly service and inspection of our washig machines and dryers.
Electric Boilers (12M)	Annual service of our water boilers in staff room and kitchens.
Kitchen Equipment (6M)	6 monthly service of all equipment in Main kitchen and ward/department kitchens.
Portable Appliances Testing (12M)	Annual portable applinace testing (PAT).
Food Trolleys (6M)	6 monthly service of meal trolleys.
Weighing Equipment (3M)	3 monthly service and calibration of patient weighing scales.
Fixed Appliance Testing (12M)	Annual test and inspection of electrical installations.
Bed Pan Washers service (6M)	6 monthly service of bed pan washer/disinfectors.
Bed Pan Washers Testing (3M)	3 monthly testing of bed pan wash/disinfectors.
Nurse Calling System (3M)	3 monthly service and testing of all nurse call systems.
External Light Cleaning (12M)	Annual clean of all car park and road way lighting.
Internal Light Cleaning (12M)	Annual clean of all internal light fittings.
Lightning Protection (12 M)	Annual service and testing of the lighting protection system.
Generator Testing (W,M,6M,12M)	Weekly, monthly, 6 monthly and annual service and testing of our emergency generators.
Trend Building Management System (M)	Monthly service on our Building Management System (BMS) for conrolling all heating /ventilation and hot water.
LV Distribution System (12M)	Annual inspection of our Low Voltage distribution systems (230 volts)
HV Distribution System (12M)	Annual service and inspectiom of our High Voltage distribution system (1000 to 11000 volts)
Refridgeration (6M) Catering/Domestic	6 monthly service and inspectionof our refrigeration systems.
MEDICAL GASES	
Medical Gases (3M)	3 monthly service and testing of our Medical Gases systems, Medical Air compressors, Oxygen, Nitrous Oxide, Entonox (50% Oxygen and 50% Nitrous C
HVAC (Heating, ventilation and air conditioning)	
Boiler Burners (6M)	6 monthly service on our heating boilers gas and oil burners.
Pressure Units (6M)	6 monthly servic and inspection of our pressure units associated with heating and hot water systems.
Main chiller unit (6M)	6 monthly service and inspection of our chillers for air conditioning and ventilation systems.
Air conditioning (6M)	6 monthly service and inspection of all our air condituioning units in clinical, non clinical departments and IT data centres and comms rooms.
Ventilation System(6M) (AHU)	6 monthly and annual service and inspection of 42 ventilation systems to critical and non critical clinical and non clinicial wards and departments.
NICU Chiller Units (3M)	3 montly service and inspection of the chillers for NICU's ventilation systems.
Ceiling Grills Extract Fans (6M)	6 monthly clean of all ceiling ventilation grills in all departments.
OTHER	
Car Park Pay & Display (6M)	6 monthly service and inspection on our car park barriers and equipment.
Grass Cutting and Grounds Maintenance	Grass cutting and grounds and gardens seasonal maintenance.
Windows maintenance (12M)	Annual inspection of all window restrictors in clinical areas on the first and second floor.

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	October 2023	0	<=	0			
Cancer: 62 day wait for first treatment from urgent GP Referral for suspected cancer (After Re-allocation)	Concerning	September 2023	>=85%	>=	10.71%			
Cancer: 28 Day Faster Diagnosis	Very Concerning	September 2023	>= 75%	>=	29.32%			
Cancer: 31 Days from Diagnosis to 1st Definitive Treatment	Concerning	September 2023	>=96%	>=	62.96%			
Diagnostic Tests: 6 Week Wait	Good	October 2023	>= 99%	>=	94.63%			
A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge	Average	October 2023	>= 95%	>=	83.30%			
Proportion of patient activity with an ethnicity code	Average	October 2023	>=96%	>=	98.48%			
Cancer: 104 Day Breaches	Very Concerning	September 2023	0	<=	8.5			
18 Week RTT: Incomplete Pathway > 78 Weeks	Concerning	October 2023	0	<=	5			
18 Week RTT: Incomplete Pathway > 65 Weeks	Good	October 2023	0	<=	344			
18 Week RTT: Incomplete Pathway > 52 Weeks	Average	October 2023	0	<=	1662			
Overall size of Elective Waiting List	Concerning	September 2023		<=	19954			

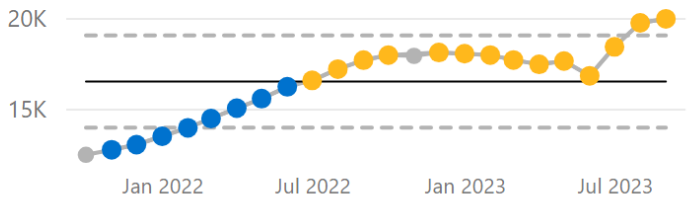
*Following KPI's have nationally set targets as part of Operational Planning Guidance for 23/24:

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

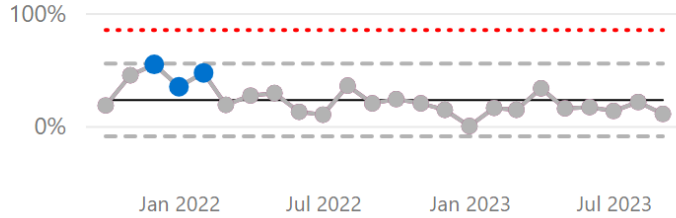
Assurance Category	Concerning
Date	September 2023
Target	
Target < or >	<=
Performance	19954
Assurance	
Variation	H



PTL increased due to Digi care changes and user practice changing, resulting in some patients not being removed correctly. BI team working with Divisional teams to address and bring PTL size back down to pre-digicare levels. Total numbers being monitored through Access sub-committee

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

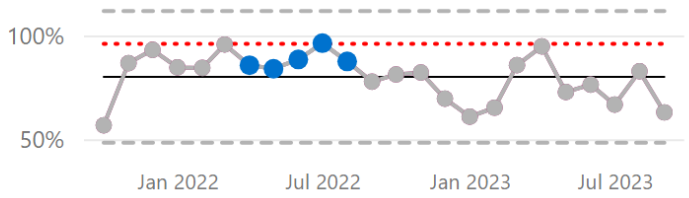
Assurance Category	Concerning
Date	September 2023
Target	>=85%
Target < or >	>=
Performance	10.71%
Assurance	F
Variation	



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

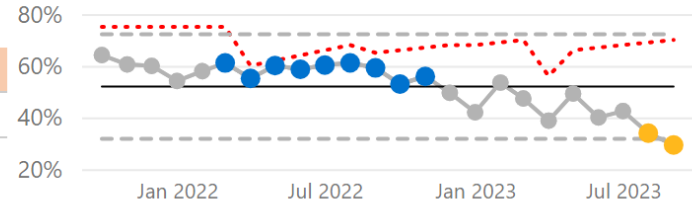
Assurance Category	Concerning
Date	September 2023
Target	>=96%
Target < or >	>=
Performance	62.96%
Assurance	F
Variation	



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	September 2023
Target	>= 75%
Target < or >	>=
Performance	29.32%
Assurance	F
Variation	L

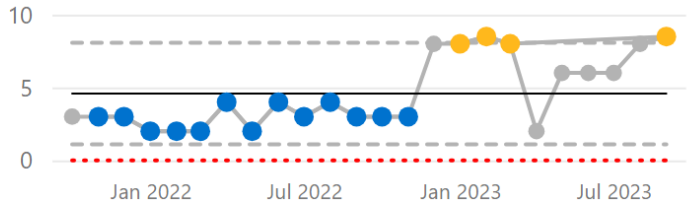


Number of hysteroscopy procedures performed has doubled since July. Weekly tracker of activity being monitored. All routine activity has been converted to Rapid Access to support the position. Impacy of actions is demonstrated in KPI467.

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

Cancer: 104 Day Breaches - Chief Operating Officer

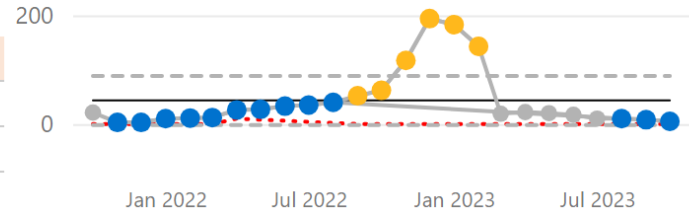
Assurance Category	Very Concerning
Date	September 2023
Target	0
Target < or >	<=
Performance	8.5
Assurance	F
Variation	H



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	October 2023
Target	0
Target < or >	<=
Performance	5
Assurance	F
Variation	L

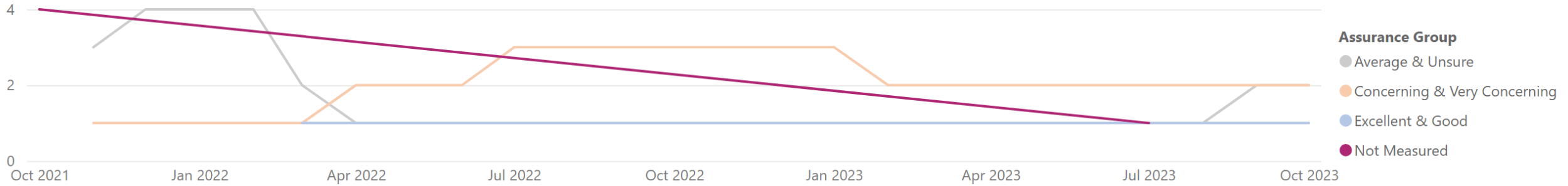


Small numbers of patients over 78 weeks for clinical or patient choice reasons. 78+ weeks monitored through fortnightly Access Sub-Committee. Increase in Elective capacity in November 2023 will improve capacity for long waits

Assurance Category	
Date	
Target	
Target < or >	
Performance	
Assurance	
Variation	

Assurance Category	
Date	
Target	
Target < or >	
Performance	
Assurance	
Variation	

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

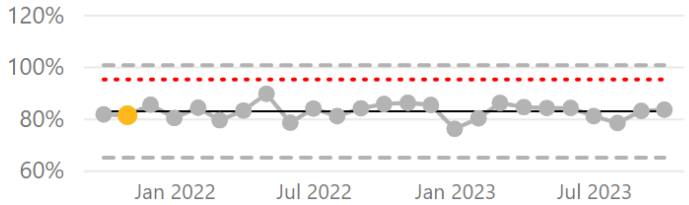


KPI	Assurance Category	Date	Target	Target < or >	Performance	Assurance	Variation	Trend
Complaints: Number Received	Good	October 2023	<= 15	<=	6			
C-Gull Recruitment	Average	October 2023		<=	156			
Friends & Family Test: In-patient/Daycase % positive	Average	October 2023	95%	>=	84.68%			
Friends & Family Test: A&E % positive	Concerning	October 2023	95%	>=	61.90%			
Friends & Family Test: Maternity % positive	Concerning	October 2023	95%	>=	83.33%			

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

Friends & Family Test: Maternity % positive - Chief Nurse

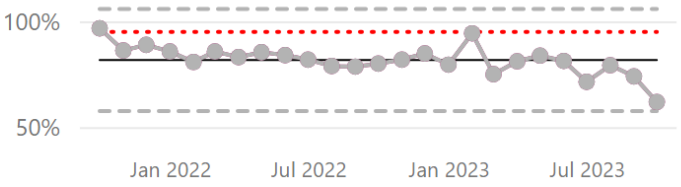
Assurance Category	Concerning
Date	October 2023
Target	95%
Target < or >	>=
Performance	83.33%
Assurance	
Variation	



Feedback remains at a low percentage- average 7-9% . Themes include:
Lack of information going home from Mat Base.
24hr visiting
Delays with ongoing induction of labour.
Improvement groups in place to target the above themes.

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

Assurance Category	Concerning
Date	October 2023
Target	95%
Target < or >	>=
Performance	61.90%
Assurance	
Variation	



We have seen a particularly busy month in October as the attendances increased from1220 in September to 1371 in October. This resulted in an increase in waiting times which has caused the feedback seeing a theme around long waits within the department. Due to the estate there is limited space so capacity was requested within OPD to facilitate medics reviewing patients. Notices remain in place asking patients to request to speak with the shift lead/dpt manager if they wish to raise concerns.

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

Agenda Item	**23/24/219c**			**Date: 14/12/2023**
Report Title	**Guardian of Safe Working Hours (Junior Doctors) Quarterly Report – Q1+ Q2 23/24**			
Prepared by	***Kat Pavlidi, Guardian of Safe Working Hours***			
Presented by	***Kat Pavlidi, Guardian of Safe Working Hours***			
Key Issues / Messages	**The Guardian of Safe Working advises the Board that in her view although the hours and templates of work schedules are safe and compliant in each service and in line with the Junior Doctor contract, there are ongoing concerns intensified by the continued rota gaps which need covering to ensure patient care is provided**			
Action required	**Approve ☐**	**Receive ☐**	**Note ☐**	**Take Assurance ☒**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	***To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it***	***For the intelligence of the Board / Committee without in-depth discussion required***	***To assure the Board / Committee that effective systems of control are in place***
	Funding Source (If applicable):			
	For Decisions - in line with Risk Appetite Statement – Y/N ***If no – please outline the reasons for deviation.***			
	The Board is asked to receive and note this report from the Guardian of Safe Working Hours.			
Supporting Executive:	***Lynn Greenhalgh, Medical Director***			

Equality Impact Assessment *(if there is an impact on E,D & I, an Equality Impact Assessment **MUST** accompany the report)*					
Strategy ☐	Policy ☐	Service Change ☐	Not Applicable ☒		
Strategic Objective(s)					
To develop a well led, capable, motivated and entrepreneurial ***workforce***	☒	To participate in high quality research and to deliver the most ***effective*** Outcomes	☐		
To be ambitious and ***efficient*** and make the best use of available resource	☐	To deliver the best possible ***experience*** for patients and staff	☒		
To deliver ***safe*** services	☒				
Link to the Board Assurance Framework (BAF) / Corporate Risk Register (CRR)					
Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* 1 – Inability to recruit & maintain a highly skilled & engaged workforce that is representative of our local communities		Comment:			

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

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Issues raised at PPF Committee in November 2023.			

EXECUTIVE SUMMARY

The Board are advised:

- This report alludes to concerns raised at the PPF Committee meeting regarding the increasing gaps within the Junior Doctor cohort in all specialities, work being done to address these gaps, as well as the outcomes from the GMC survey 2023 which has focused on the PGDs concerns regarding training and supervision.
- Rota establishment continues to fluctuate throughout the year with processes in place to mitigate the use of high-cost agency locums wherever possible by using internal bank, doctors in training and ANNPs.
- Exception reports continued to be submitted but at lower rates than previously; all 13 were submitted on extra hours worked. No educational exception reports were submitted, and no work schedule reviews took place.
- This report does not include data on gaps caused by the ongoing Industrial Action both by the Junior Doctor or Consultant cohorts, but is worth mentioning regarding the overall concerns Doctors have regarding their working lives, including access to training.

The Guardian of Safe Working advises the Board that in her view although the hours and templates of work schedules are safe and compliant in each service and in line with the Junior Doctor contract, there are ongoing concerns intensified by the continued rota gaps which need covering to ensure patient care is provided.

REPORT

1. Introduction

The 2016 contract requires the Guardian of Safe Working Hours (GoSWH) to report to the Trust Board and Sub Board Committee on a quarterly basis, with the following information;

- Aggregated exception reports including outcomes
- Details of fines levied
- Data on rota gaps
- Data on locum usage
- Other relevant data
- Qualitative narrative highlighting areas of good practice or persistent concern

This report covers all of the above for the reporting period 1st April – 30th September 2023, and relates to the first and second quarters of the year.

2. Guardian Report

2.1. Aggregated exception reports including outcomes

During quarters 1 + 2, 13 exception reports were made, all from O&G trainees.

Period	Specialty	Grade	Reason	#exceptions	No: hours	Outcome
Q1	O&G	Tier 1	Hours	12	16.5	Payment for extra hours/TOIL/No action
Q2	O&G	Tier 3	Hours	1	3.25	TOIL

There were no ERs relating to lack of breaks, however the GoSWH does acknowledge that doctors frequently do not submit reports relating to lost breaks or even working over their hours. All Post Graduate Doctors (PGDs) are encouraged regularly to Exception Report when they work outside of their contracted work schedule. The newer groups of PGDs are more in tune with the Junior Doctors Contract and are more likely to complete ERs when working outside of their contracted hours.

Work is ongoing by the GoSWH and DME to improve acceptance of using ERs by all doctors and education for Supervisors to encourage their PGDs to submit ERs regularly. Anecdotally there are many issues but as they are not always reported, it can be difficult to lead any positive change.

2.2. Details of fines levied

To date, the Guardian has not issued any fines in the last two quarters.

2.3. Data on rota gaps

As referenced in previous reports, the number of gaps requiring cover fluctuate throughout the year due the number of times each specialty rotates, maternity leave, long-term absences and completion of training (CCT). Therefore, as the year progresses, all services expect to work with increasing gaps.

This concern has been reviewed through the Medical Workforce Report that was presented at last month's Committee meeting. It focuses on the number of PGDs required to maintain a safe service within all specialities in the Trust, as well as how the workforce should be expanded to provide both service provision, maintain training opportunities and allow for non-clinical activities and learning for all PGDs to fulfil guidance by Royal Colleges, balanced with the overall cost required for the Trust.

The most recent figures suggest that an increase of the following WTE PGDs needed to maintain a safe and quality service are:

- *O&G – 70 (current 51)*
- *Neonates – 17.9 (current 18 – no change required)*
- *Anaesthetics – 24.8 (current 15)*

2.4. Data on cover for rota gaps

The below tables give context to the number of unsocial shifts requiring a doctor or ANNP to work, the number of gaps in each month and who covered the shift. As in previous reports, this data excludes shifts worked due to Industrial Action (Junior Doctors and Consultants).

Anaesthetics

Month	Number of unsociable shifts	Number of shift gaps	Dr's in training/bank/ trust Dr cover	Consultant cover	Unfilled
April 23	120	4	4	0	0
May 23	120	19	19	0	0
June 23	120	12	12	0	0
July 23	120	9	9	0	0
August 23	120	3	3	0	0
September 23	120	7	7	0	0

Neonates

Month	Number of unsociable shifts	Number of shift gaps	Dr's in training Dr's/ANNPs cover	Consultant cover	Unfilled
April 23	168	11	11	0	0
May 23	168	29	29	0	0
June 23	168	24	24	0	0
July 23	168	20	20	0	0
August 23	168	7	7	0	0
September 23	168	8	8	0	0

Genetics

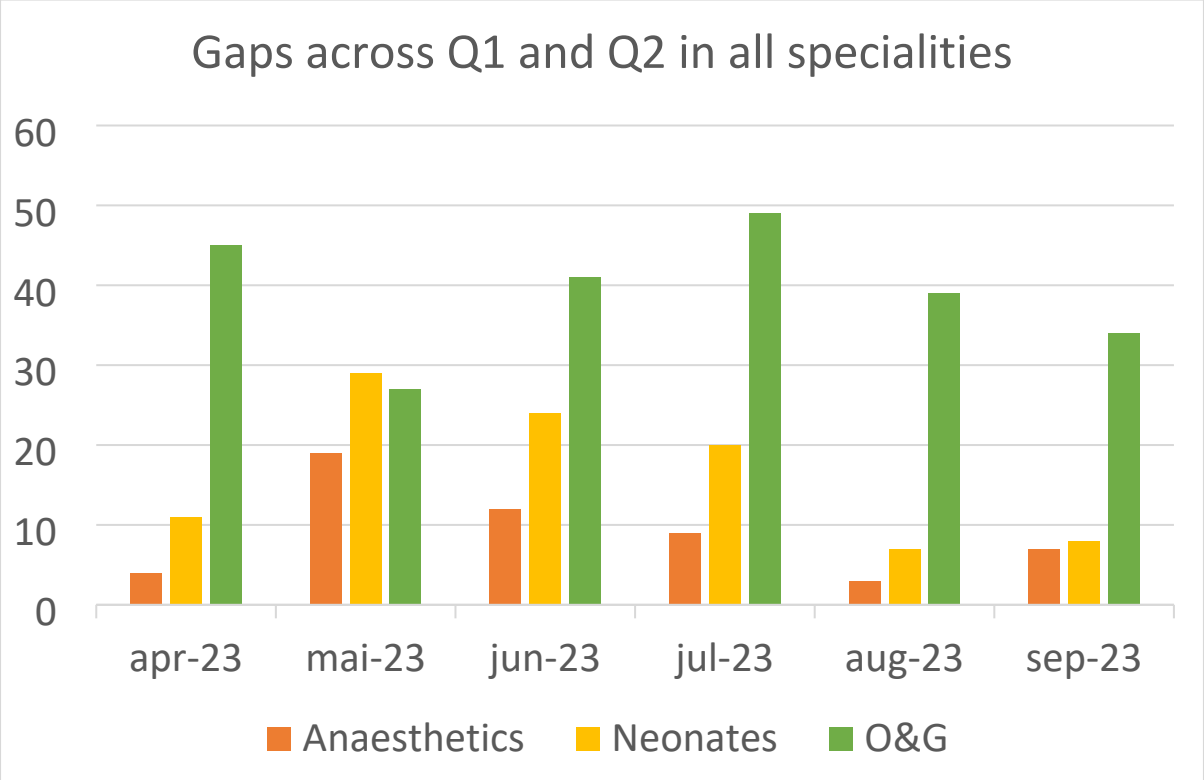
Currently, there is no requirement for locum cover as genetic doctors do not work unsocial hours.

Obstetrics and Gynaecology

Month	Number of unsociable shifts	Number of shift gaps	Dr's in training/bank/ trust Dr cover	Consultant cover	Unfilled
April 23	252	45	45	0	4
May 23	252	27	27	0	0
June 23	252	41	41	0	1
July 23	252	49	42	0	7
August 23	252	39	38	0	1
September 23	252	34	32	0	2

It is also noted that there was a significant increase in the number of unfilled gaps within the O&G service, with the majority being weekend Tier 1 shifts that had been previously agreed would not be filled if sickness occurred.

Summary of all gaps in all specialities (bar Genetics)



This shows the fluctuation of gaps across each month. As expected, O&G as the largest speciality has the highest number of gaps per month. There is also no pattern to predict when gaps will be at their highest (even relating to changeover periods being different for all specialities)

As predicted all services saw a continued absence rate due to issues such as sickness and doctor burnout. This is a trend that is being noted throughout the last few years, with this issue becoming unsustainable for the Trust, and within the PGD group. This leads to continued low morale and has increased the overall support for ongoing Industrial Action, in turn affecting the care patients receive and the Trust's financial position even further.

These concerns have been raised with the publication of the most recent GMC survey, as well as previous HEE NETS surveys. This report highlighted the significant deterioration in results compared to previous years, with focus on concerns around wellbeing, discriminatory behaviours, and rota design.

They highlight that nearly a quarter of trainees are now measured to be at high risk of burnout, an increase of four percentage points since 2022. More than half of trainers are measured to be at high or moderate risk of burnout, the same level as 2022. A third said their work frustrates them to a high/very high degree.

https://www.gmc-uk.org/-/media/documents/national-training-survey-2023-initial-findings-report_pdf-101939815.pdf

3. Other relevant data

The Doctors Mess is now open and available to be used by all non-consultant PGDs in the Trust since July, allowing for a quiet space for rest and relaxation, as well as boosting the social bond between the doctors in the Trust. It is situated on the second floor in a space previously held by the Research department.

4. Qualitative narrative highlighting areas of good practice or persistent concern

All services continue to cover locum shifts within the PGD and ANNP workforce via the Bank system to reduce the need for agency staff. This has been successful in both the first two quarters of the year and hopefully will continue to ensure financial savings for the Trust.

All services continue to engage with doctors and offer supportive and safe environments for them to work. The doctors have access to the Guardian of Safe Working Hours, the Medical Staffing team and the Freedom to Speak up Guardian.

Currently, the concern around the doctor medical workforce (and particularly within O&G) is the ongoing need for extra shifts to be worked, affecting levels of stress, reduction in time available for training, and therefore leaving shifts empty due to ongoing sickness or long term gaps. Rota coordinators work hard to ensure that even through extra shifts worked, the PGDs do not work in excess of 72 hours within 7 days (average 48 hours).

5. Conclusion

The Board are advised:

- the number of gaps fluctuates between months but has shown a cautiously optimistic decrease in the second quarter of the year, compared to Q1.
- should the rota establishment continue to fluctuate throughout the year there are processes in place to mitigate the use of high-cost agency locums wherever possible by using internal bank, doctors in training and ANNPs, as well as appointment of clinical fellows and post-CCT doctors on a fixed term contract.
- There are several expected gaps in Q3 of 2023-2024 and this has already been escalated to the Clinical Divisions and Executive teams, with short term and longer term plans to help staff the service.

This report advises the Board that doctors in training are safely rostered at the start of their placement at LWH and enabled to work hours that are safe and in compliance with their contract.

However, the GoSWH notes that the service is still at breaking point and this is not expected to improve any time soon without swift action and financial support. Although rotas are created to be safe, the number of gaps and shifts needing to be covered at short notice is not safe. Although the working of extra shifts outside of the doctor's agreed work schedules at the start of their placement is technically allowed when the general shift rules are not broken (or at the agreement of the PGD if they are), this is still an unsafe practice on a regular basis and presents a significant risk to both the doctors, patients, and the wider Trust staff team.

This ongoing risk of gaps is being closely monitored and doctors are offered support by LWH and Occupational Health where possible. Workforce planning is ongoing and should hopefully see an improvement with regards to gaps and how the Trust is judged by PGDs during the annual survey. This will also hopefully balance carefully the need for safe and quality care for patients, as well as adequate training opportunities for Junior Doctors.

6. Recommendations

The Board is asked to receive and note this report from the Guardian of Safe Working Hours.

Putting People First (PPF) Committee Chair's Highlight Report to Trust Board
20 November 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 received the Access Workforce update. The team had been required to respond to significant pressures relating to growing waiting lists due to the pandemic and more recently from periods of industrial action with limited additional resource and challenged retention levels. The Committee was informed of recent process change which had noticeably improved the working culture within the Access Centre. The Committee had been assured by the verbal update provided and requested the same level of assurance within the written report. Oversight on corporate workforce benchmarking was identified as an area to be strengthened as staff continue to leave the Trust for similar roles in other NHS organisations, often for a better rate of pay. • The Gynaecology Division had been identified as an outlier for sickness absence and turnover rates from the workforce performance report and required further investigation by the Gynaecology senior leadership team. • The Committee had a robust discussion in relation to the Medical Workforce Project (Strategy) noting the significant work undertaken to quantifiably assess the time required to provide service cover by the post graduate doctors (PGD's), recruit locally employed doctors (LEDs) to mitigate the gaps, and diversify the clinical workforce e.g. utilising Advanced Clinical practitioners (ACPs) and Physicians Associates (PAs) where appropriate to mitigate gaps. The Committee supported the proposal to develop a business case to support the immediate approval for appointment of a number of LEDs to mitigate the gaps within the PGD workforce and develop a business case to support the expansion of ACP/ PAs. • The Committee received the Guardian of Safe Working Hours (Junior Doctors) quarterly report – Quarter 2 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. The ongoing risk of gaps was being closely monitored and doctors are offered support by LWH and Occupational Health where possible. Workforce planning was ongoing to allow for expansion of the clinical teams to help ease the pressure created by ongoing doctor gaps in all services. • The Committee noted a significant deterioration in overall results from the GMC Survey, which provides feedback on the quality of training provided at the Trust. An action plan to address areas of concern was being developed and would be agreed with the Deputy Medical Director and monitored by the Education Governance Sub-Committee. The consequence of having a significant and sustained volume of rota gaps and the impact on the doctors in training as identified by the GFSWH report and the Medical Workforce Project was reflective in the GMC survey results.	• The Committee noted that NHS England had confirmed additional funding to recognise the financial impact of industrial action on trusts. The Trust would be required to submit efficiency and elective plans to demonstrate how they would deliver financial and performance targets within the revised framework. • The Post Investment Review Workstream continues to focus on reviewing and reducing the headcount beyond the budgeted establishment. • The Trust was working towards implementation of the Oliver McGowan training package. Significant requirement in terms of time had been identified as a challenge nationally for all NHS organisations to implement. Finance would incorporate financial implications into budget setting.
Positive Assurances to Provide Identify in brackets should the assurance provide evidence against the CQC Key Questions – SAFE | EFFECTIVE | CARING | RESPONSIVE | WELL LED	**Decisions Made**

• Received a positive staff story from a midwife who had joined the Trust on the International Recruitment Programme and was currently on the preceptorship programme. She described her positive journey joining the UK midwifery workforce and added that support and guidance was always available when she commenced working at the Trust. She noted that an introductory guide for international recruits to provide advice on local clinical etiquette, common abbreviations etc. would be beneficial and further improve support. (WELL LED) • The Committee received an overview of the current workforce position of the Maternity and Neonatal services. The report outlined the challenge with KPI metrics such as sickness absence, core mandatory training and mandatory clinical training along with outlining ongoing/planned activity that will influence and drive improvement. The Committee commended the zero-midwifery vacancy position which provided flexibility to the service to focus on training and preceptorship programmes and improve workforce retention rates. (ALL) • The Committee noted the Freedom to Speak Up Guardian update and themes identified. The Committee took positive assurance following the Mersey Internal Audit Agency (MIAA) recent review of control processes over Freedom to Speak Up (FTSU) within the Trust and provided a 'substantial assurance' rating. (ALL)	• The Committee noted an addition to its terms of reference in response to a recommendation from the Freedom to Speak Up internal audit. The Committee also requested an amendment to the meeting frequency section to clarify that meetings shall be held at least 6 times per year. The Committee recommend that the Board approve the updated PPF Committee terms of reference. • The Committee approved the Education Governance Sub-Committee terms of Reference.

Summary of BAF Review Discussion (Board Committee level only)

- The Committee reviewed the PPF aligned BAF risks, noting no new or closed risks.

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
73.	Board Assurance Framework (BAF): Workforce related risks	Assurance		79.	Freedom to Speak Up Guardian Update	Information	
74.	Staff Story – deferred	Information		80.	Medical Appraisal & Revalidation Quarterly Report, Quarter 2 2023/24	Information	
75.	Service Workforce Assurance Report: Family Health Division Chief People Officer Report	Assurance		81.	Medical Workforce Project (Strategy)	Assurance	
76.	Access Workforce Update	Assurance		82.	Guardian of Safe Working Hours (Junior Doctors) Quarterly Report – Quarter 2 2023/24	Assurance	
77.	Chief People Officer Report	Information		83.	GMC Survey Feedback Report 2023	Information	
78.	PPF Workforce Performance Report	Information		84.	Sub Committee Chair Reports & Terms of Reference	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	✓	✓	A		
Michelle Turner, Chief People Officer	✓	✓	✓	✓		
Dianne Brown, Chief Nurse	A	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*

PUTTING PEOPLE FIRST COMMITTEE
TERMS OF REFERENCE

Constitution:	The Committee is established by the Board of Directors and will be known as the Putting People First Committee (the Committee).
Duties:	The Committee is responsible for: a. Developing and overseeing implementation of the Trust's People Strategy (integrated workforce, wellbeing and organisational development strategy) and plan and providing assurance to the Board of Directors that this is being delivered in line with the annual planning process b. Oversight of the strategic implementation of multi-disciplinary education and training and gaining assurances that the relevant legislative and regulatory requirements are in place (Education Governance Committee) c. Approving, monitoring and reviewing policies, procedures and guidance documents relating to the management of the Trust's workforce d. Monitoring and reviewing workforce key performance indicators to ensure achievement of the Trust's strategic aims and escalate any issues to the Board of Directors e. Reviewing any changes in practice required following any internal enquiries that significantly impact on workforce issues f. Oversight of the strategic implementation and monitoring of staff engagement levels as evidenced by the results of the national and any other staff surveys g. Reviewing and approving partnership agreements with staff side h. Ensuring that the Trust fulfils all legislative and regulatory requirements pertaining to workforce and organisational development issues i. Monitor and evaluate compliance with the public sector equality duty and delivery of equality objectives to improve the experience of staff with protected characteristics j. Approving the terms of reference and membership of its reporting groups and overseeing the work of those groups, receiving reports from them for consideration and action as necessary and routinely receiving the minutes of their meetings k. Receipt and review of relevant risks (including those referred from other Committees or subcommittees) concerned with workforce and organisational development matters as identified through the Board Assurance Framework. Monitor progress made in mitigating those

	risks, identifying any areas where additional assurance is required, escalating to the Board of Directors as required. l. Receiving and considering issues from other Committees when appropriate and taking any necessary action. ~~l.~~m. Monitoring and oversight of the trust commitments relating to freedom to speak up / whistleblowing and escalate any issues or concerns to the Board of Directors
Membership:	The Committee membership will be appointed by the Board of Directors and will consist of: • Non-Executive Director (Chair) • 2 other Non-Executive Director • *Chief People Officer • * Chief Nurse & Midwife • *Chief Operating Officer • Staff Side Chair • Medical Staff Committee representative • Deputy Chief Finance Officer *or their nominated representative who will be sufficiently senior and have the authority to make decisions. Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. The Board of Directors will appoint a Non-Executive Director as Chair of the Committee. Should the Chair be absent from a meeting of the Committee, the Committee may appoint a Chair of the meeting from amongst the Non-Executive Directors present.
Quorum:	A quorum shall be four members including: • The Chair or at least one other Non-Executive Director • At least one from either Chief People Officer Chief Nurse • Chief Operating Officer or their Deputy • Either Staff Side Chair or Medical Staff Committee representative • The Chair of the Trust may be included in the quorum if present.
Voting:	Each member will have one vote with the Chair having a second and casting vote, if required. Should a vote be necessary a decision will be determined by a simple majority.
Attendance:	**a. Members**

	Members will be required to attend a minimum of 75% of all meetings. **b. Officers** HR & OD Senior Team, Education Governance Chair, and a representative from the Nursing & Midwifery Board shall normally attend meetings. Members may send a nominated representative to attend meetings on their behalf when they are not available, provided they are sufficiently senior and have the authority to make decisions. Other executive directors, officers and staff of the Trust will be invited to attend the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed. Representatives from partner organisations or other external bodies may be invited to attend as appropriate. Such representatives will not have voting rights.
Frequency:	Meetings shall be held at least ~~10~~ 6 times per year. Additional meetings may be arranged from time to time, if required, to support the effective functioning of the Trust.
Authority:	The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of representatives from partner organisations or other external bodies or organisations with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities.
Accountability and reporting arrangements:	The Putting People First Committee will be accountable to the Board of Directors. A Chair's Report will be submitted to the subsequent Board of Directors for assurance. Approved minutes will be made available to all Board members upon request. Approved chairs reports will also be circulated to members of the Audit Committee.

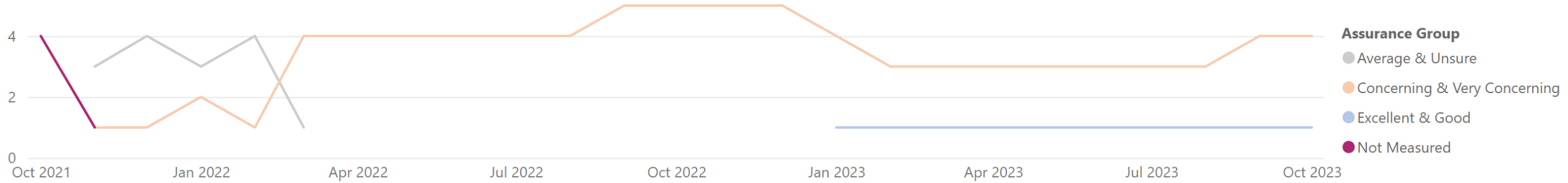
	The Committee will report to the Board annually on its work and performance in the preceding year. Trust standing orders and standing financial instructions apply to the operation of the Putting People First Committee.
Reporting Committees and Groups	The sub committees/groups listed below are required to submit the following information to the Committee: a) Chairs Report; b) an Annual Report setting out the progress they have made and future developments; c) Terms of reference The following sub committees/groups will report directly to the Committee: • Equality, Diversity & Inclusion Sub-Committee • Partnership Forum • Professional Forum of Nurses, Midwives & AHP's • Educational Governance Sub-Committee • Joint Local Negotiating Sub-Committee • Great Place to Work Group
Monitoring effectiveness:	The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements.
Review:	These terms of reference will be reviewed at least annually by the Committee.
Reviewed by Putting People First Committee:	20 March 2023
Approved by Board of Directors:	*6 April 2023*
Review date:	March 2024
Document owner:	Mark Grimshaw, Trust Secretary Email: mark.grimshaw@lwh.nhs.uk Tel: 0151 702 4033

Liverpool Women's
NHS Foundation Trust

Trust Board

Workforce Performance Report
November 2023

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

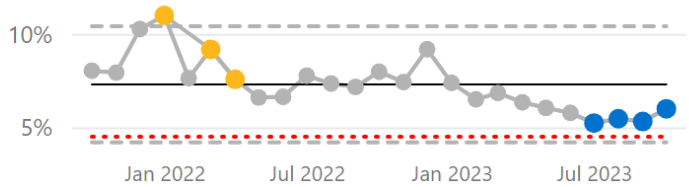


KPI	Assurance Category	Date	Target	Target < or >	Performance	Assurance	Variation	Trend
Turnover Rate	Excellent	October 2023	<= 13%	<=	9.16%	P	L	
Mandatory Training	Concerning	October 2023	>= 95%	>=	93.90%	F	H	
Mandatory Training (Clinical)	Concerning	October 2023	>= 95%	>=	87.88%	F	H	
Sickness Absence Rate	Concerning	October 2023	<= 4.5%	<=	5.99%	F	L	
Prevention of Ill Health: Flu Vaccine Front Line Clinical Staff	Very Concerning	October 2023	>= 80%	>=	30.46%	F	L	

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

Sickness - Chief People Officer

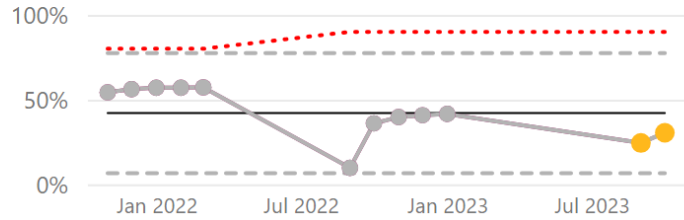
Assurance Category	Concerning
Date	October 2023
Target	<= 4.5%
Target < or >	<=
Performance	5.99%
Assurance	
Variation	



Sickness increased by 0.68% in Oct and is now at 5.99%. At a divisional level the following increased, Corporate by (0.69%), Family Health by (0.89%), and Gynaecology by (1.39%) while Clinical Support Services decreased by (0.99%). All 3 large areas saw increases Maternity (0.48%), Gynaecology (1.84%) and Neonatal (1.67%). COVID sickness increase to 0.34%,Long Term sickness has reduced Neonatal (13.69%), while increase where seen in Gynaecology (0.91%), and Maternity (14.46%).

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

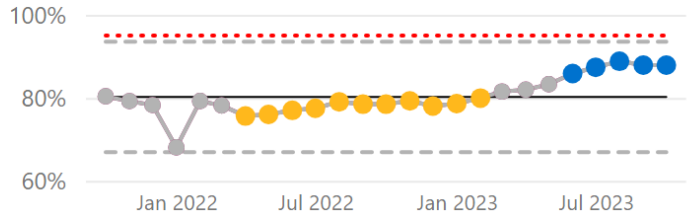
Assurance Category	Very Concerning
Date	October 2023
Target	>= 80%
Target < or >	>=
Performance	30.46%
Assurance	
Variation	



Performance reflects the flu and covid vaccination programme which includes 2 vaccination weekly drop in's on a Monday and Thursday. Alongside ward managers and matrons supporting team and department vaccinations and support for out of hours provided by site managers. Regular communications are sent out across the Trust and vaccines uptake shared at SMT and divisional board. Oversight will be provided by divisions

Mandatory Training (Clinical) - Chief People Officer

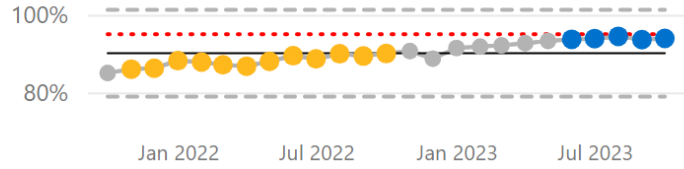
Assurance Category	Concerning
Date	October 2023
Target	>= 95%
Target < or >	>=
Performance	87.88%
Assurance	
Variation	



Compliance remained constant at 87.88%. All directorates have reported decreases in their compliance figures except for Family Health who increased by 1.43%. Maternity also reported an increase in compliance of (4.65%) and is currently at 85.62%. Compliance continues to be reviewed on a weekly basis by divisional management teams. Validation sessions have just taken place and will impact on CMT figures until staff can update their training.

Mandatory Training - Chief People Officer

Assurance Category	Concerning
Date	October 2023
Target	>= 95%
Target < or >	>=
Performance	93.90%
Assurance	
Variation	



Compliance increased by 0.33% up to 93.90%. All the main divisions have reduced in October but are above the target figure, while Family Health increased by (1.43%), but is still falling short of the Trust figure of 95%. The following areas saw decreases, Gynaecology by (0.77%) and Neonatal by (0.13%), while Maternity saw an increase of (2.37%).

Finance, Performance & Business Development Chair's Highlight Report to Trust Board
29 November 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 18week RTT non-admitted completed pathway would continue to underperform against target as the Trust prioritises the clearance of long waits in line with national planning priorities. Further consideration would be given to the appropriateness of maintaining this metric on the performance report.
  ○ Cancer performance continues to be challenged, as high referral rates impact upon faster diagnosis standard and the 62-day metric performance based on current backlog clearance. A revised trajectory has been submitted to NHSE as part of Tier 2 monitoring.
  ○ Urgent care targets continue to be challenged, with increasing numbers of attendances through the Gynaecology Emergency Department (GED), because of winter pressures and access to Primary Care. Improvements anticipated following the relocation of EPAU out of GED from early November 2023. A meeting with ICB Place Performance Lead to review GED pathways and future models to reduce number of attendances has been planned.
• The Committee noted that at Month 7 2023/24 the Trust was reporting an overall net position £11,929k deficit, which represents a £2,294k adverse variance to plan year to date, supported by £2,579k of non-recurrent items of which £1,954k is unplanned. The reported forecast outturn at Month 7 is £15,450k deficit, which is in line with the submitted plan. This position has been reported to Cheshire and Merseyside Integrated Care Board.
• Noted the H2 planning exercise undertaken and the Trust has submitted an additional £7.2m negative variance which has been acknowledged by the ICB.
• The Trust requires cash support in 2023/24 while maintaining a deficit plan. The Committee considered the application to NHS England for distressed finance and supported the request.
	• Noted that Cohort 2 rollout of the Patient Initiated Digital Mutual Aid System (PIDMAS) project had been placed on hold by the National team until at least March 2024. Following go live of Cohort 1 in October 2023, messages had been sent to 2500 patients, with 106 (4%) contacting the Trust through the PIDMAS portal. Patients had been reviewed and those suitable for potential transfer are being sent weekly to the regional NHSE team.
	• Agreed a review of performance metrics would be beneficial to validate continued relevancy, aid trajectories and align to corporate strategy.
	• The Committee noted the update provided regarding the Trust's National Cost Collection (NCCI) submission for 2022/23. The NCCI is an indication of how efficiently a Trust delivers its' services, with a score of 100 indicating the national average. The 2022/23 NCC exercise has been completed and submitted in accordance with national timescales and requirements. It was noted that costs had increased overall in comparison to the 2021/22 submission. The Trust's revised score would be made available during 2024.

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)	• Recommend approval of the application for distressed finance in Quarter 4 2023/24 to the Trust Board.

○ Gynaecology Elective recovery has plateaued but continues to deliver a positive trajectory in line with the 2023/24 plan submitted to the ICB. A pause in industrial action and increased capacity should improve the position in Month 8. ○ Cancer performance continues to be challenged, with high referral rates impacting upon faster diagnosis ○ Detailed statutory compliance metrics within the Performance report and the fire inspection action plan • The Committee took positive assurance from the Digital Services Update noting positive feedback from NHS England on the Trusts data migration work during the EPR implementation, ensuring smooth transition of internal and national compliance reporting. (ALL) • The Committee noted positive progress taken towards improving the third-party service provider assurance and controls. (ALL) • The Committee noted the post implementation review of the cost improvement programme for H1 2022/23. A robust process has been implemented to manage CIP schemes and, at the mid-year point ,29 schemes are delivering savings. (ALL) • The Committee noted the post implementation review of Business cases during 2022/23. The Committee noted lessons learnt and significant development of the business case process into 2023/24 providing more robust grip and control due to the recovery programme. (ALL) •	• Confirm to the Audit Committee that, where possible, a phased approach to SLA settlement is being pursued for all Third-Party contracts. • Approved the latest terms of reference of the Financial Recovery Board.

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.

Comments on Effectiveness of the Meeting / Application of QI Methodology

- Noted that standard of papers produced was of a high quality.
- Positive levels of participation, debate and reflection from all members and attendees.

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
139.	Review of BAF risks: FPBD related risks	Assurance	145.	Post Implementation Review of Cost Improvement Programme (CIP) H1	Information
140.	Operational Performance Report Month 7, 2023/24	Information	146.	Annual Business Case Post Implementation Reviews	Information
141.	Digital Services Update	Assurance	147.	National Cost Collection (NCC) Exercise Final Submission	Information
142.	Finance Performance Report Month 7, 2023/24	Information	148.	Crown Street Enhancement Progress Review	Information
143.	Distressed Finance Application	Approval	149.	Sub-Committee Chair Reports & TOR	Assurance
144.	Third Party Service Provider Controls – Service Level Agreements update	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	✓	A	✓				
Jenny Hannon, Chief Finance Officer	✓	✓	✓	✓	A	✓	✓	✓				
Kathryn Thomson, Chief Executive	✓	✓	A	A	✓	✓	✓	NM				
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*

Charitable Funds Committee Chair's Highlight Report to Trust Board
23 November 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 raised a query in relation to the proportion of distribution of charity monies on staff welfare compared to patient welfare. It was agreed that the primary purpose of the Charity should be to support patient welfare.	• Received a review of Funds and Fund Signatories' as per HFMA recommendations. Work would continue to review each fund and make a decision on whether to maintain or merge. The Committee queried what percentage of funds related to patient welfare or staff welfare. This would be included in future charity integrated reports. • The Committee requested additional clarity and information in relation to the charity risks. • Noted ongoing work on the funding application for the Mona Lisa Laser. Consideration on the research element of the application would be taken through the business case process.
Positive Assurances to Provide	**Decisions Made**
• Noted overall positive performance against the Investment Portfolio • The year-to-date income of £250k exceeds the comparable period in 2022/23. This includes ticket sales for the Strictly event and a £90k legacy received in September 2023. The importance of legacy donations was noted, as the year-to-date income would be significantly less against the comparable period if the legacy donation had not been received. • Received the Charitable Funds Strategy 2023-2027 and noted significant improvement to the content of the Strategy. The Committee provided additional feedback ahead of submission to the Board.	• Agreed with the principle to share the legacy fund equally with the three operational divisions. • Recommended approval of the Charity Annual report and Accounts to the Board of Trustees, subject to some minor amendments and inclusion of the independent examination letter. • Recommended approval of the Charity Strategy 2023 – 2027 to the Board of Trustees, subject to minor additions.
Comments on Effectiveness of the Meeting / Application of QI Methodology	
• Commented on the Charity Strategy to support the work of the Committee going forward.	

2. Summary Agenda

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
24.	Investment Position Update	Information	27.	Review of Funds and Fund Signatories'	Assurance
25.	Quarterly charity and finance integrated report	Information	28.	Liverpool Women's Charity Strategy 2023 – 2027	Approval
26.	Charity Annual Report and Accounts	Approval			

3. 2023/24 Attendance Matrix

Core members	June 2023	November 2023	January 2024
Zia Chaudhry (Chair), Non-Executive Director	✓	✓	
Louise Martin, Non-Executive Director	✓	✓	
Jackie Bird, Non-Executive Director	A	✓	
Jenny Hannon, Chief Finance Officer	A	✓	
Jennifer Huyton, Deputy Chief Finance Officer	✓	✓	
Dianne Brown, Chief Nurse	✓	A	
Matt Connor, Chief Information Officer	A	✓	
Claire Deegan, Head of Financial Services	✓	✓	
Kate Davis, Head of Fundraising	✓	✓	

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	**23/24/221c**		**Date: 14/12/2023**	
Report Title	**Finance Performance Month 7 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 7 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 7 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	29/11/23	Chief Finance Officer	The Committee noted the contents of the report.
Executive Committee	08/11/23	Chief Finance Officer	N/A

EXECUTIVE SUMMARY

The Trust has a challenging financial plan for 2023/24 of a £15.5m deficit. At Month 7 the Trust reported a year to date (YTD) deficit of £11.9m which represents a £2.3m adverse variance to plan. This position is supported by £2.6m of non-recurrent (one off) items. The full year forecast outturn reported at Month 7 was a £15.5m deficit, which is in line with the currently accepted plan. Subsequent to Month 7 reporting, the Trust submitted a revised full year position to the Cheshire and Merseyside Integrated Care Board for onward submission to the National team. This full year submission indicated a variance to the agreed plan of £7.2m.

Cost Improvement Programme (CIP) delivery is behind the YTD target by £0.8m. 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 £9.0m at the end of Month 7.

MAIN REPORT

1. Summary Financial Position

	Plan	Actual	Variance	RAG	R	A	G
Surplus/(Deficit) YTD	-£9.6m	-£11.9m	-£2.3m	6	*>10% off plan*	*Plan*	*Plan or better*
I&E Forecast M7	-£15.5m	-£15.5m	£0.0m	1	*>10% off plan*	*Plan*	*Plan or better*
I&E Forecast H2	-£15.5m	-£22.6m	-£7.2m	6	*>10% off plan*	*Plan*	*Plan or better*
NHS I/E Rating	3	3	0	1	*4*	*3*	*2+*
Cash	£4.3m	£9.0m	£4.7m	5	*<£1m*	*£1m-£4.5m*	*£4.5m+*
Total CIP Achievement YTD	£4.0m	£3.3m	-£0.8m	5	*>10% off plan*	*Plan*	*Plan or better*
Recurrent CIP Achievement YTD	£4.0m	£2.1m	-£2.0m	6	*>10% off plan*	*Plan*	*Plan or better*
Aligned Payment Incentive	106%	99%	-7%	6	*>10% off plan*	*<10% off plan - plan*	*Plan or better*
Non-Recurrent Items YTD	£0.6m	£2.6m	£2.0m	1	*>£0*		*<£0*
Capital Spend YTD	£4.4m	£2.5m	-£2.0m	6	*>10% off plan*	*Plan*	*Plan or better*

At Month 7 the Trust is reporting a £11.9m deficit, which represents a £2.3m adverse variance to plan year to date (YTD). This is supported by £2.6m of non-recurrent items. The reported forecast outturn at Month 7 was £15.5m deficit, which is in line with the submitted plan. This position was reported to Cheshire and Merseyside Integrated Care Board (C&M ICB), noting significant risk in achieving this position, as outlined in previous months.

On 8 November 2023 it was announced that to cover the costs of NHS industrial action to date the following actions had been agreed with Government:

- Allocating a total of £800 million to systems sourced from a combination of reprioritisation of national budgets and new funding.
- Reducing the elective activity target for 2023/24 to a national average of 103%

Subsequently on 21 November 2023 a revised forecast outturn was submitted to the ICB for inclusion in their revised system forecast outturn. The revised forecast outturn for the Trust is £22.6m deficit, which represents an adverse variance to plan of £7.2m.

2. Revised Forecast Outturn

The Trust has been reporting the underlying financial forecast and most likely recovery position throughout the year. Following the announcement of the measures outlined above all providers and systems have been assessing the full year impact of the above support and the impact on forecast outturn.

At Month 7, the Trust's 'do nothing' forecast outturn position was a £10.9m adverse variance to plan (Appendix 1). The revised position (£7.2m adverse variance to plan) as a result of the announcement was presented to an extraordinary meeting of the Trust Board on 17 November 2023, and submission of the revised forecast to the ICB was approved. The Trust did not request any derogations to the projected delivery of activity targets and intends to maintain current trajectories. This forecast outturn assumes no further industrial action and work continues to agree the overall position.

3. Financial Recovery

Underlying Position

As noted above, the YTD position is supported by £2.6m of non-recurrent items, of which £2.0m was unplanned. The adjusted position in Month 7 (following removal of key non-recurrent items) is a deficit of £14.5m, which represents an adverse variance of £4.9m against plan.

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

- Undelivered CIP (£0.8m); non-pay and income CIP targets.
- Industrial action costs (£0.5m) and net income impact (£0.4m)
- API underperformance excluding industrial action impact (£0.5m)
- Impact of pay award (£0.2m)
- Unwinding of 2022/23 pay investment (£1.0m)
- Investment in maternity post CQC inspection (£0.4m)
- Excess inflation and other non-pay pressures (£0.3m)
- Operational pressures (£0.7m) including nursing & midwifery, medical staffing, unfunded cost pressures in corporate areas and estates non-pay related pressures, off-set by £0.5m anaesthetic consultant vacancies and £0.2m interest receivable above plan.

The above drivers are offset by £1.6m non-recurrent items resulting in the actual adverse YTD variance from plan of £2.3m.

Whole Time Equivalents (WTE)

Whole Time Equivalents are shown in Appendix 1. At Month 7 WTEs total 1,705, compared to 1,688 at M12 2022/23, with a shift away from temporary (bank and agency) towards substantive staff. Between Month 6 and Month 7, WTEs have increased by 7.1, driven by substantive recruitment in midwifery and nurse staffing.

Cost Improvement Programme (CIP)

The Trust has a cost improvement programme target of £8.3m. This equates to 5.3% of expenditure. At Month 7, there is an adverse variance of £0.8m against the £4m YTD target.

The Trust remains focussed on identifying and implementing robust schemes through a programme of targeted financial recovery. The risk associated with delivery of the CIP programme is currently estimated to be £2.3m.

Finance Recovery Actions

The Trust produced a financial recovery plan, approved by the Trust Board in September 23. 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.

4. Divisional Summary Overview

Family Health
The Family Health Division has an adverse variance of £0.4m YTD. This includes recognition of £0.8m non-recurrent favourable impact related to receipt of non-recurrent CNST MIS funds relating to Year 4.

£0.9m of the adverse variance relates to Maternity, offset by £0.4m favourable variance in Neonatal. The maternity variance continues to be driven by pay pressures in medical staffing (caused by junior doctor rota gaps and step-down costs in relation to industrial action) and midwifery staffing (caused by cover for sickness, vacancies earlier in the year, and maternity leave). The Neonatal favourable variance is driven predominantly by vacancies in ICU nurse staffing. Posts have been approved through vacancy control panel, active recruitment is underway and is reflected in the forecast.

The Family Health Division have well-managed agency usage and have made substantial progress in recruiting to substantive posts to reduce risk of reliance on temporary staffing solutions.

Gynaecology
The Gynaecology Division has an adverse variance to plan of £2.4m YTD, comprised of £2.2m in Gynaecology and £0.2m in the Hewitt Fertility Centre. The Gynaecology variance continues to be driven by medical staffing (in relation to junior doctor pressures, industrial action, and costs of recovery), nursing and support staff pay pressures, and income underperformance (related to Aligned Payment and Incentive (API) and industrial action.)

Clinical Support Services (CSS)
CSS are overall £1m adverse to plan YTD, driven by adverse variances in Imaging pay (£0.4m) in relation to staffing pressures, increased activity in pathology services (£0.2m), and Theatres pay (£0.6m), driven by nursing, Operating Department Practitioner (ODP) and support staff costs partially mitigated by vacancies in anaesthetic medical staffing. Adverse variances are partially offset by favourable variances in Genetics (£0.2m), related to vacancies and income overperformance.

5. 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 7 is at 99% 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.

The impact of the national reduction in income targets by 4% will be reflected in the reported position from Month 8.

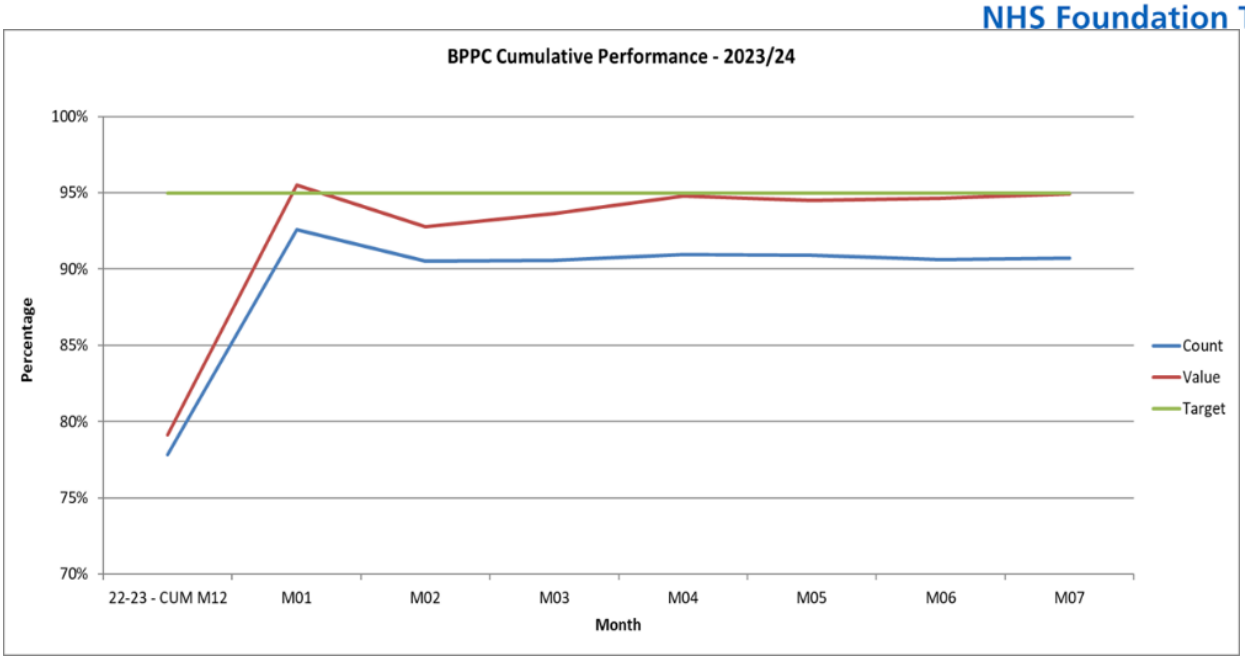
6. Cash and Borrowings

The Trust's cash and bank balance at the end of Month 7 was £9.0m. This was £4.7m ahead of plan, driven by receipt of Maternity incentive Scheme Funds (referenced above) and capital spend behind plan (see below).

The Trust has agreed in-year cash advances with the C&M ICB. Cash support of £21.4m is estimated to the end of December. In quarter four (Q4) the ICB will no longer be able to support the Trust with cash advances and the Trust will repay the funds received to date. Board approval has been given to apply for national distressed finance to support the Trust in Q4. The additional impact on Public Dividend Capital (PDC) is reflected within the Trust's forecast.

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



8. Balance Sheet

Other balance sheet movements in month remain consistent with the quarterly billing cycle. The sales and purchase ledgers are consistent month on month. The increase in deferred income includes the cash advances from the ICB (£18.4m to the end of Month 7). The Trust's remaining Independent Trust Financing Facility (ITFF) loans will be fully paid off by September 2024.

9. Capital Expenditure

The Trust's capital programme for 2023/24 totals £5.2m. YTD expenditure is £2.0m behind plan. The Trust is still forecasting to meet the plan by year end.

Work on the Midwifery Led Unit (MLU) refurbishment scheme has now commenced, later than planned, which is a key driver of the YTD position. The Estates capital programme is ongoing with purchase orders in place for most of the significant projects. Medical equipment orders have now been placed.

Digital expenditure is ahead of plan following the investment in the Digicare project and overall infrastructure investment.

10. Agency

The Trust has strong controls in place governing the use of temporary staffing. At Month 7, the Trust has a favourable variance of £969k against plan. Actual costs of £396k YTD are predominantly driven by theatres (vacancy), and maternity (sickness and vacancy).

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 7 position.

Appendices

Appendix 1 – Board Finance Pack, Month 7

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

FINANCE REPORT: M7

YEAR ENDING 31 MARCH 2024

Liverpool Women's
NHS Foundation Trust

Contents

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST NHS ENGLAND RATIOS: M7 YEAR ENDING 31 MARCH 2024	1

USE OF RESOURCES RISK RATING	YEAR TO DATE Actual
CAPITAL SERVICING CAPACITY (CSC)	
(a) EBITDA + Interest Receivable	(6,914)
(b) PDC + Interest Payable + Loans Repaid	1,875
CSC Ratio = (a) / (b)	**(3.69)**
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	(25,597)
(b) Expenditure	90,110
(c) Daily Expenditure	421
Liquidity Ratio = (a) / (c)	**(60.8)**
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)	12,037
Total Income	(82,863)
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)	-11.40%
I&E Variance Margin	**-3.10%**
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)	1,365
YTD Agency Expenditure	396
	-71%
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: M7
YEAR ENDING 31 MARCH 2024

INCOME & EXPENDITURE £'000	Month 7 Budget	 Actual	 Variance	YTD Budget	 Actual	 Variance	YEAR Budget	 Forecast	 Variance
Income									
Clinical Income	(11,501)	(11,209)	(292)	(80,013)	(78,407)	(1,606)	(137,517)	(139,384)	1,867
Non-Clinical Income	(636)	(577)	(59)	(4,234)	(4,456)	222	(7,416)	(7,283)	(133)
Total Income	**(12,138)**	**(11,786)**	**(352)**	**(84,247)**	**(82,863)**	**(1,384)**	**(144,933)**	**(146,667)**	**1,735**
Expenditure									
Pay Costs	7,544	8,141	(597)	53,455	57,557	(4,102)	91,102	96,504	(5,402)
Non-Pay Costs	3,216	3,012	205	22,545	20,798	1,747	38,631	36,479	2,152
CNST	1,800	1,794	6	12,602	11,755	847	21,603	20,356	1,247
Total Expenditure	**12,561**	**12,948**	**(387)**	**88,602**	**90,110**	**(1,508)**	**151,337**	**153,340**	**(2,003)**
EBITDA	**423**	**1,162**	**(738)**	**4,356**	**7,247**	**(2,892)**	**6,404**	**6,673**	**(268)**
Technical Items									
Depreciation	548	447	101	3,838	3,568	270	6,579	6,466	113
Interest Payable	2	1	1	14	10	4	21	19	2
Interest Receivable	(17)	(66)	49	(116)	(333)	217	(200)	(485)	285
PDC Dividend	221	220	1	1,544	1,559	(15)	2,645	2,881	(236)
Profit/Loss on Disposal or Transfer Absorption	0	0	0	0	(122)	122	0	(105)	105
Total Technical Items	**754**	**602**	**152**	**5,280**	**4,682**	**598**	**9,045**	**8,777**	**268**
(Surplus) / Deficit	**1,178**	**1,764**	**(586)**	**9,636**	**11,929**	**(2,294)**	**15,450**	**15,450**	**0**

NHS
Liverpool Women's
NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 2a
UNDERLYING INCOME & EXPENDITURE: M7
YEAR ENDING 31 MARCH 2024

INCOME & EXPENDITURE £'000	Month 7 Budget	Month 7 Actual	Month 7 Variance	YTD Budget	YTD Actual	YTD Variance	DO NOTHING FOT Budget	DO NOTHING FOT Forecast	DO NOTHING FOT Variance	REFORECAST SUBMISSION Budget	REFORECAST SUBMISSION Forecast	REFORECAST SUBMISSION Variance
Income												
Clinical Income	(11,501)	(11,209)	(292)	(80,013)	(78,190)	(1,823)	(137,517)	(135,409)	(2,108)	(137,517)	(138,760)	617
Non-Clinical Income	(636)	(577)	(59)	(4,234)	(4,329)	95	(7,416)	(7,185)	(230)	(7,416)	(7,260)	(133)
Total Income	**(12,138)**	**(11,786)**	**(352)**	**(84,247)**	**(82,519)**	**(1,728)**	**(144,933)**	**(142,595)**	**(2,338)**	**(144,933)**	**(146,021)**	**1,088**
Expenditure												
Pay Costs	7,544	8,097	(553)	53,455	57,772	(4,317)	91,102	101,447	(10,345)	91,102	101,158	(10,556)
Non-Pay Costs	3,216	2,988	229	22,545	21,967	578	38,631	38,301	331	38,631	38,271	361
CNST	1,800	1,794	6	12,602	12,483	119	21,603	20,356	1,247	21,603	20,356	1,247
Total Expenditure	**12,561**	**12,880**	**(319)**	**88,602**	**92,222**	**(3,620)**	**151,337**	**160,104**	**(8,768)**	**151,337**	**159,785**	**(8,449)**
EBITDA	**423**	**1,094**	**(670)**	**4,356**	**9,703**	**(5,348)**	**6,404**	**17,510**	**(11,105)**	**6,404**	**13,765**	**(7,361)**
Technical Items												
Depreciation	548	447	101	3,838	3,568	270	6,579	6,466	113	6,579	6,466	113
Interest Payable	2	1	1	14	10	4	21	19	2	21	19	2
Interest Receivable	(17)	(66)	49	(116)	(333)	217	(200)	(485)	285	(200)	(485)	285
PDC Dividend	221	220	1	1,544	1,559	(15)	2,645	2,881	(236)	2,645	2,881	(236)
Profit/Loss on Disposal or Transfer Absorption	0	0	0	0	0	(0)	0	(42)	42	0	(42)	42
Total Technical Items	**754**	**602**	**152**	**5,280**	**4,804**	**476**	**9,045**	**8,840**	**205**	**9,045**	**8,840**	**205**
(Surplus) / Deficit	**1,178**	**1,696**	**(518)**	**9,636**	**14,507**	**(4,872)**	**15,450**	**26,350**	**(10,900)**	**15,450**	**22,605**	**(7,155)**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 2b
WTE: M7
YEAR ENDING 31 MARCH 2024

TYPE	DESCRIPTION	M12	M1	M2	M3	M4	M5	M6	M7	Movement M6 - M7	Movement M12 - M7
SUBSTANTIVE	REGISTERED NURSING, MIDWIFERY & HEALTH VISITING STAFF	631.94	648.33	649.61	645.49	636.13	640.11	636.48	658.66	22.18	26.72
	ALLIED HEALTH PROFESSIONALS	82.04	81.95	81.35	83.27	83.57	85.45	86.39	86.27	(0.12)	4.23
	OTHER REGISTERED SCIENTIFIC, THERAPEUTIC & TECHNICAL STAFF	11.78	11.31	11.31	12.31	11.31	12.31	14.31	12.31	(2.00)	0.53
	REGISTERED HEALTH CARE SCIENTISTS	49.22	53.62	54.54	54.34	55.34	57.34	60.98	65.47	4.49	16.25
	HCA & SUPPORT TO CLINICAL STAFF	234.51	237.51	244.48	237.49	242.70	241.16	247.75	242.56	(5.19)	8.05
	MANAGERS & SENIOR MANAGERS	59.92	63.32	64.32	61.32	59.02	62.57	62.09	60.39	(1.70)	0.47
	ADMIN AND ESTATES STAFF	13.00	13.00	13.00	14.00	14.00	15.00	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	275.93	(2.66)	(12.19)
	MEDICAL AND DENTAL	185.09	190.90	191.67	193.80	190.34	197.14	200.02	195.05	(4.97)	9.96
	ANY OTHER STAFF	14.00	14.00	14.00	14.00	14.00	14.00	14.00	13.60	(0.40)	(0.40)
SUBSTANTIVE TOTAL		**1,569.62**	**1,602.02**	**1,608.45**	**1,601.11**	**1,585.66**	**1,601.86**	**1,615.61**	**1,625.24**	**9.63**	**55.62**
BANK	REGISTERED NURSING, MIDWIFERY & HEALTH VISITING STAFF	47.33	37.81	43.37	45.40	34.57	30.12	36.07	36.62	0.55	(10.71)
	ALLIED HEALTH PROFESSIONALS	17.42	13.00	16.78	15.67	11.15	10.48	13.45	13.31	(0.14)	(4.11)
	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	1.16	(0.44)	0.88
	HCA & SUPPORT TO CLINICAL STAFF	31.22	25.76	25.13	24.57	21.87	19.20	18.79	19.07	0.28	(12.15)
	MANAGERS & SENIOR MANAGERS	-	-	-	-	-	-	-	-	0.00	0.00
	ADMIN AND ESTATES STAFF	-	0.23	0.12	0.09	-	0.05	-	-	0.00	0.00
	OTHER INFRASTRUCTURE & SUPPORT STAFF	6.25	7.27	6.44	4.36	4.89	6.82	4.20	2.34	(1.86)	(3.91)
	MEDICAL AND DENTAL	2.00	2.80	2.80	2.00	2.00	1.94	1.97	0.93	(1.04)	(1.07)
	ANY OTHER STAFF	-	-	-	-	-	-	-	-	0.00	0.00
BANK TOTAL		**104.50**	**87.78**	**95.28**	**92.55**	**74.85**	**68.88**	**76.08**	**73.43**	**(2.65)**	**(31.07)**
AGENCY	REGISTERED NURSING, MIDWIFERY & HEALTH VISITING STAFF	8.23	10.49	2.03	0.08	2.11	2.76	2.68	3.14	0.46	(5.09)
	ALLIED HEALTH PROFESSIONALS	4.04	1.23	3.26	3.26	2.92	2.60	3.28	2.90	(0.38)	(1.14)
	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**	**6.04**	**0.08**	**(7.33)**
TRUST TOTAL		**1,687.49**	**1,703.25**	**1,709.02**	**1,697.00**	**1,665.54**	**1,676.10**	**1,697.65**	**1,704.71**	**7.06**	**17.22**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 3
EXPENDITURE: M7
YEAR ENDING 31 MARCH 2024

EXPENDITURE £'000	MONTH 7 Budget	MONTH 7 Actual	MONTH 7 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	491	435	55	3,371	3,480	(109)	5,573	5,619	(46)
Medical	2,182	2,096	86	15,277	16,068	(791)	26,188	27,679	(1,491)
Nursing & Midwifery	3,152	3,406	(253)	22,246	23,813	(1,566)	38,400	41,009	(2,609)
Healthcare Assistants	555	618	(63)	3,882	4,402	(520)	6,655	7,363	(708)
Other Clinical	224	762	(538)	2,094	3,686	(1,592)	3,036	5,075	(2,039)
Admin Support	792	793	(2)	5,482	5,712	(230)	9,403	9,298	105
Agency & Locum	149	30	119	1,103	396	707	1,848	462	1,385
Total Pay Costs	**7,544**	**8,141**	**(597)**	**53,455**	**57,557**	**(4,102)**	**91,102**	**96,504**	**(5,402)**
Non Pay Costs									
Clinical Suppplies	840	849	(8)	5,875	6,335	(459)	10,085	10,861	(776)
Non-Clinical Supplies	740	782	(42)	5,271	4,164	1,107	8,876	7,646	1,230
CNST	1,800	1,794	6	12,602	11,755	847	21,603	20,356	1,247
Premises & IT Costs	867	715	151	6,080	5,463	617	10,413	9,785	628
Service Contracts	769	721	48	5,318	4,836	482	9,257	8,187	1,070
Total Non-Pay Costs	**5,017**	**4,806**	**210**	**35,147**	**32,553**	**2,594**	**60,235**	**56,836**	**3,399**
Total Expenditure	**12,561**	**12,948**	**(387)**	**88,602**	**90,110**	**(1,508)**	**151,337**	**153,340**	**(2,003)**

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

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 4
BUDGET ANALYSIS: M7
YEAR ENDING 31 MARCH 2024

INCOME & EXPENDITURE	MONTH 7			YEAR TO DATE			YEAR - Underlying			YEAR - Recovery		
£'000	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Actual	Variance
Maternity												
Income	(4,467)	(4,124)	(343)	(29,467)	(28,956)	(511)	(50,625)	(49,940)	(685)	(50,625)	(49,940)	(685)
Expenditure	2,520	2,682	(162)	17,630	18,052	(422)	30,232	31,968	(1,736)	30,232	31,968	(1,736)
Total Maternity	**(1,947)**	**(1,442)**	**(505)**	**(11,837)**	**(10,904)**	**(933)**	**(20,393)**	**(17,972)**	**(2,421)**	**(20,393)**	**(17,972)**	**(2,421)**
Neonatal												
Income	(1,855)	(1,957)	102	(12,929)	(13,171)	243	(22,162)	(23,065)	904	(22,162)	(24,715)	2,554
Expenditure	1,514	1,448	66	10,597	10,350	247	18,167	18,118	48	18,167	18,118	48
Total Neonatal	**(341)**	**(509)**	**168**	**(2,332)**	**(2,821)**	**489**	**(3,995)**	**(4,947)**	**952**	**(3,995)**	**(6,597)**	**2,602**
Division of Family Health - Total	**(2,288)**	**(1,951)**	**(337)**	**(14,169)**	**(13,725)**	**(444)**	**(24,388)**	**(22,919)**	**(1,469)**	**(24,388)**	**(24,569)**	**181**
Gynaecology												
Income	(2,402)	(2,299)	(103)	(15,971)	(14,922)	(1,049)	(27,361)	(25,941)	(1,420)	(27,361)	(25,941)	(1,420)
Expenditure	1,464	1,453	11	10,292	11,453	(1,161)	17,611	19,597	(1,985)	17,611	19,597	(1,985)
Total Gynaecology	**(938)**	**(847)**	**(92)**	**(5,679)**	**(3,469)**	**(2,211)**	**(9,750)**	**(6,344)**	**(3,405)**	**(9,750)**	**(6,344)**	**(3,405)**
Hewitt Centre												
Income	(927)	(1,074)	147	(6,088)	(5,956)	(132)	(10,609)	(10,709)	100	(10,609)	(11,209)	600
Expenditure	811	799	12	5,678	5,688	(10)	9,733	10,172	(439)	9,733	9,972	(239)
Total Hewitt Centre	**(116)**	**(275)**	**159**	**(410)**	**(268)**	**(143)**	**(876)**	**(537)**	**(339)**	**(876)**	**(1,237)**	**361**
Division of Gynaecology - Total	**(1,054)**	**(1,121)**	**67**	**(6,090)**	**(3,736)**	**(2,353)**	**(10,626)**	**(6,881)**	**(3,745)**	**(10,626)**	**(7,581)**	**(3,045)**
Theatres												
Income	0	0	0	0	0	0	0	0	0	0	0	0
Expenditure	1,021	997	24	7,286	7,885	(599)	12,390	13,771	(1,381)	12,390	13,771	(1,381)
Total Theatres	**1,021**	**997**	**24**	**7,286**	**7,885**	**(599)**	**12,390**	**13,771**	**(1,381)**	**12,390**	**13,771**	**(1,381)**
Genetics												
Income	(4)	(43)	40	(25)	(100)	75	(42)	(130)	88	(42)	(130)	88
Expenditure	166	158	8	1,163	979	184	1,993	1,717	276	1,993	1,717	276
Total Genetics	**163**	**115**	**48**	**1,138**	**879**	**259**	**1,951**	**1,587**	**365**	**1,951**	**1,587**	**365**
Other Clinical Support												
Income	(621)	(569)	(52)	(4,175)	(4,016)	(159)	(7,147)	(6,970)	(177)	(7,147)	(6,970)	(177)
Expenditure	898	1,043	(146)	6,358	6,918	(560)	10,754	12,446	(1,692)	10,754	11,783	(1,029)
Total Clinical Support	**277**	**475**	**(198)**	**2,183**	**2,902**	**(718)**	**3,607**	**5,476**	**(1,868)**	**3,607**	**4,813**	**(1,205)**
Division of Clinical Support - Total	**1,460**	**1,587**	**(127)**	**10,607**	**11,666**	**(1,058)**	**17,948**	**20,833**	**(2,885)**	**17,948**	**20,170**	**(2,222)**
Corporate & Trust Technical Items												
Income	(1,861)	(1,726)	(135)	(15,594)	(16,558)	964	(26,987)	(26,660)	(327)	(26,987)	(28,410)	1,423
Expenditure	4,921	4,975	(54)	34,880	34,282	598	59,502	61,976	(2,474)	59,502	55,839	3,663
Total Corporate	**3,060**	**3,249**	**(190)**	**19,286**	**17,725**	**1,562**	**32,516**	**35,316**	**(2,801)**	**32,516**	**27,429**	**5,086**
(Surplus) / Deficit	**1,178**	**1,764**	**(586)**	**9,636**	**11,929**	**(2,294)**	**15,450**	**26,349**	**(10,900)**	**15,450**	**15,449**	**0**
Of which is hosted;												
Income	0	(6)	6	0	(814)	814	0	(821)	821	0	(821)	821
Expenditure	0	6	(6)	0	814	(814)	0	820	(820)	0	820	(820)
Total Corporate	**0**	**(0)**	**0**	**0**	**(0)**	**0**	**0**	**(0)**	**0**	**0**	**(0)**	**0**

NHS
Liverpool Women's
NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 5
CIP: M7
YEAR ENDING 31 MARCH 2024

TYPE	Scheme	MONTH 7			YTD			FOT			H2 FOT		
		Target	Actual	Variance	Target	Actual	Variance	Target	Actual	Variance	Target	Actual	Variance
Income	Income Non-Patient Care	89	67	-21	400	356	-43	842	663	-179	842	663	-179
	Income Private Patient	63	140	77	155	173	19	470	555	85	470	555	85
	Income Patient Care	-	34	34	-	34	34	-	229	229	-	229	229
	Income Other	61	13	-47	409	104	-304	713	2,071	1,359	713	1,071	359
	Unidentified - Income	38	-	-38	74	-	-74	267	-	-267	267	-	-267
	TOTAL INCOME	**250**	**254**	**4**	**1,037**	**667**	**- 370**	**2,292**	**3,517**	**1,226**	**2,292**	**2,517**	**226**
Pay	Service re-design - pay	18	9	-10	127	60	-67	217	209	-8	217	209	-8
	Establishment reviews	4	- 4	-7	3	309	306	20	572	551	20	572	551
	E-Rostering	2	0	-2	15	1	-14	25	14	-11	25	14	-11
	Other - pay	-	-	0	-	-	0	200	-	-200	200	-	-200
	Unidentified - pay	277	-	-277	1,114	-	-1,114	2,502	256	-2,246	2,502	256	-2,246
	TOTAL PAY	**301**	**5**	**-296**	**1,258**	**369**	**- 889**	**2,965**	**1,051**	**-1,914**	**2,965**	**1,051**	**-1,914**
Non-Pay	Medicines optimisation	14	7	-7	95	37	-59	164	115	-49	164	115	-49
	Procurement (excl drugs) -non-clinical	4	1	-4	30	1	-29	51	4	-47	51	4	-47
	Procurement (excl drugs) - medical devices and clinical consumables	15	2	-13	101	7	-93	175	81	-95	175	81	-95
	Service re-design - Non-pay	190	170	-20	1,310	1,977	666	2,262	2,856	594	2,262	2,856	594
	Digital transformation non-pay	10	-	-10	71	-	-71	122	13	-109	122	13	-109
	Pathology & Imaging networks	0	-	0	3	-	-3	5	-	-5	5	-	-5
	Fleet optimisation	2	3	1	9	14	6	20	29	9	20	29	9
	Other - Non-pay	19	29	10	85	199	114	182	671	490	182	671	490
	Unidentified - non-pay	11	-	-11	45	-	-45	100	-	-100	100	-	-100
	TOTAL NON-PAY	**266**	**211**	**-55**	**1,750**	**2,235**	**486**	**3,080**	**3,767**	**688**	**3,080**	**3,767**	**688**
	TOTAL CIP DELIVERY	**817**	**470**	**- 347**	**4,045**	**3,272**	**- 773**	**8,336**	**8,336**	**(0)**	**8,336**	**7,336**	**(1,000)**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 6
BALANCE SHEET: M7
YEAR ENDING 31 MARCH 2024

BALANCE SHEET £'000	YEAR TO DATE Opening	M7 Actual	Movement
Non Current Assets	102,405	101,179	(1,226)
Current Assets			
Cash	9,790	9,019	(771)
Debtors	9,647	9,144	(503)
Inventories	839	1,019	180
Total Current Assets	**20,276**	**19,182**	**(1,094)**
Liabilities			
Creditors due < 1 year - Capital Payables	(2,002)	(1,201)	801
Creditors due < 1 year - Trade Payables	(26,820)	(17,225)	9,595
Creditors due < 1 year - Deferred Income	(4,492)	(24,887)	(20,395)
Creditors due > 1 year - Deferred Income	(1,530)	(1,511)	19
Loans	(918)	(607)	311
Loans - IFRS16 leases	(50)	(50)	0
Provisions	(628)	(567)	61
Total Liabilities	**(36,440)**	**(46,048)**	**(9,608)**
TOTAL ASSETS EMPLOYED	**86,241**	**74,313**	**(11,928)**
Taxpayers Equity			
PDC	79,115	79,115	0
Revaluation Reserve	8,679	8,679	0
Retained Earnings	(1,553)	(13,481)	(11,928)
TOTAL TAXPAYERS EQUITY	**86,241**	**74,313**	**(11,928)**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 7
CASHFLOW STATEMENT: M7
YEAR ENDING 31 MARCH 2024

CASHFLOW STATEMENT	
£'000	**Actual**
Cash flows from operating activities	(10,815)
Depreciation and amortisation	3,568
Impairments and reversals	0
Income recognised in respect of capital donations (cash and non-cash)	0
Movement in working capital	10,852
Net cash generated from / (used in) operations	**3,605**
Interest received	323
Purchase of property, plant and equipment and intangible assets	(3,255)
Proceeds from sales of property, plant and equipment and intangible assets	245
Net cash generated from/(used in) investing activities	**(2,687)**
PDC Capital Programme Funding - received	0
Loans from Department of Health - repaid	(306)
Interest paid	(10)
PDC dividend (paid)/refunded	(1,373)
Net cash generated from/(used in) financing activities	**(1,689)**
Increase/(decrease) in cash and cash equivalents	**(771)**
Cash and cash equivalents at start of period	9,790
Cash and cash equivalents at end of period	**9,019**

Finance Support	Qu1 ACTUAL	Qu2 ACTUAL	Qu3 CONFIRMED	Qu4 FORECAST	Total
	£000	£000	£000	£000	£000
ICB cash support	6,800	9,600	5,000	0	21,400
ICB cash repayment	0	0	0	(21,400)	(21,400)
Nattional cash support	0	0	0	24,000	24,000
Total support required					**24,000**
DH Loan repayment	0	306	0	306	612
DH Loan outstanding at year end					306

**Note cash support in above table is as at M7, the final submitted request was £22.6m*

Liverpool Women's NHS Foundation Trust

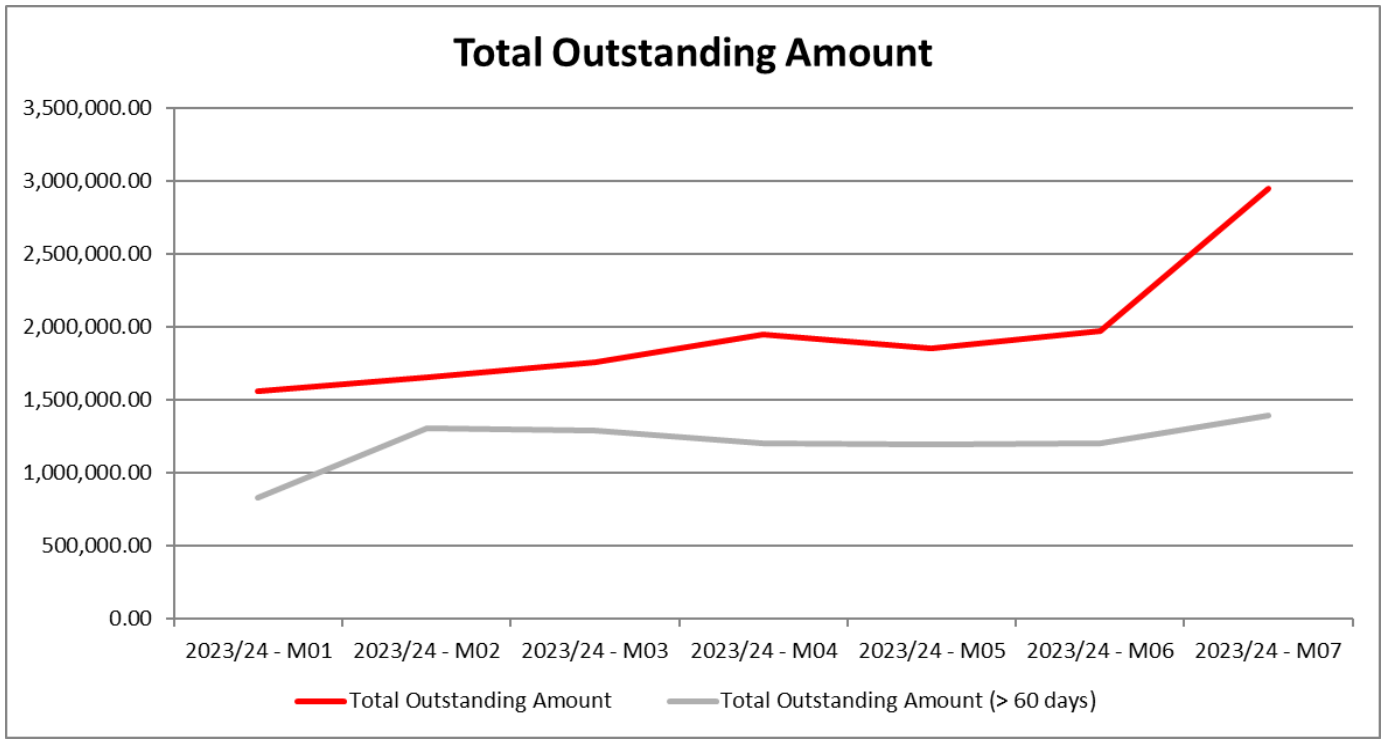
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 8
CAPITAL EXPENDITURE: M07
YEAR ENDING 31 MARCH 2024

		YTD			YEAR		
Area	Capital Scheme	PLAN	ACTUAL	VARIANCE	PLAN	FOT	VARIANCE
Digital	EPR frontline digitisation	519	642	(123)	560	660	(100)
Digital	IT/digital investment - infrastructure	450	974	(524)	1,290	1,290	0
Digital	IT/digital investment - hardware	280	79	201	280	80	200
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	950	10	940	950	350	600
Estates	Building works/refurbishment - Neonatal	140	0	140	180	80	100
Estates	Building works/refurbishment - Gynaecology	78	20	58	300	240	60
Estates	Estates programme	420	151	269	686	686	0
Medical Equipment	Medical equipment - Clinical Support - Fluoroscopy	262	0	262	0	0	0
Medical Equipment	Medical equipment - Clinical Support - Theatres	107	107	0	126	126	0
Medical Equipment	Medical equipment - All other clinical areas	738	446	292	1,167	1,167	0
Medical Equipment	Medical equipment - leased blood gas analysers	139	37	102	139	139	0
Other	Other	0	(11)	11	(860)	0	(860)
Total capital charged to CDEL		**4,336**	**2,454**	**1,881**	**5,035**	**5,035**	**0**
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		**4,420**	**2,454**	**1,965**	**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

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 9
AGED DEBTORS BALANCE: M07
YEAR ENDING 31 MARCH 2024

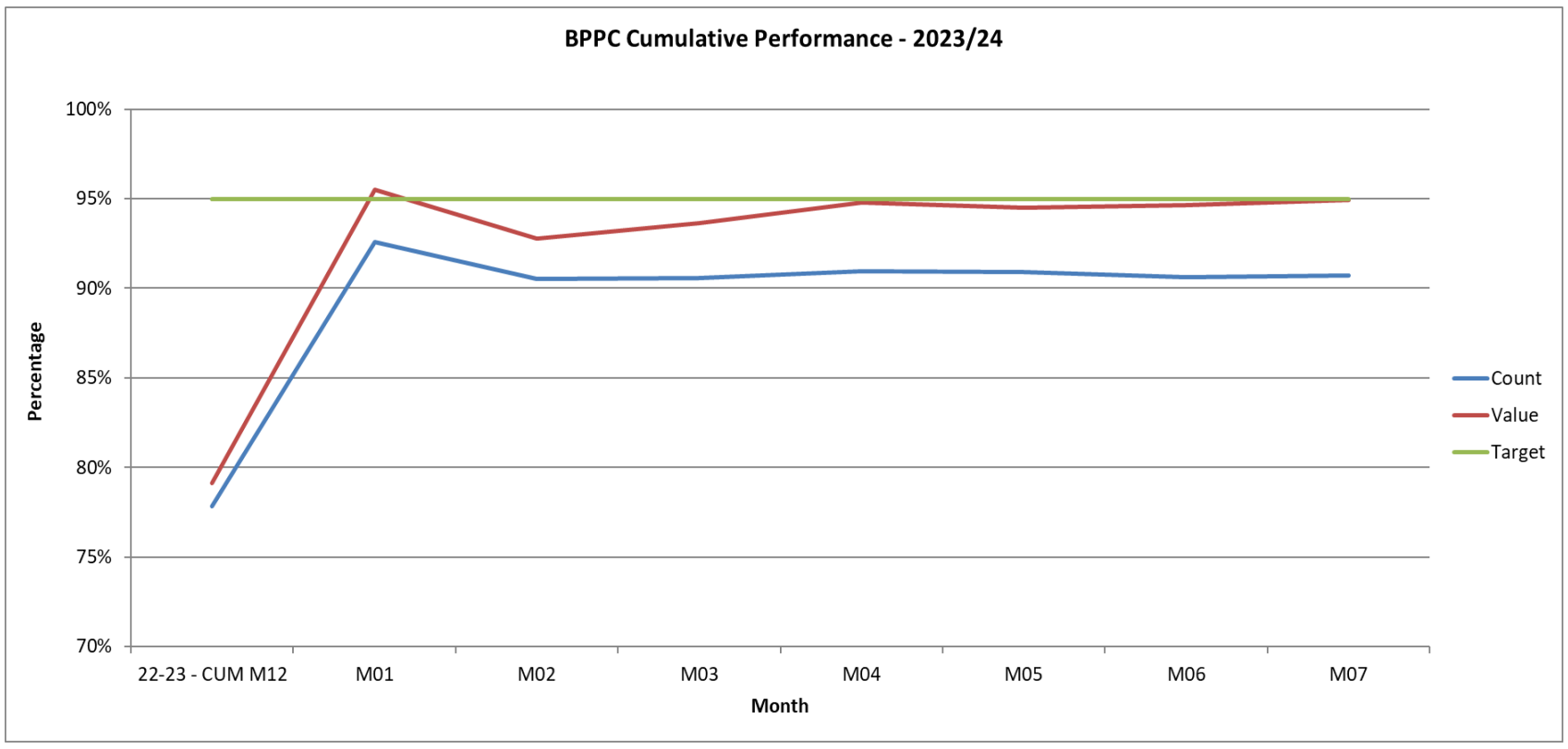


The underlying aged debtors is shown in the graph above. The level of debtor within the sales ledger has increased since April, from £1.5m to £2.9m.

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 10
BETTER PAYMENT PRACTICE CODE (BPPC) - CUMULATIVE PERFORMANCE FOR M07
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%	91%					
Cumulative Performance - Value (£)	96%	93%	94%	95%	94%	95%	95%					

2023/24 performance TOTAL

NHS
Liverpool Women's
NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 11
AGENCY USAGE: M7
YEAR ENDING 31 MARCH 2024

		MONTH 7			YTD			FOT		
Division	Directorate	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Actual	Variance
Family Health	Maternity	0	26	(26)	-	162	(162)	-	188	(188)
Gynaecology	Gynaecology	0	2	(2)	-	19	(19)	-	27	(27)
Gynaecology	HFC	0	4	(4)	-	15	(15)	-	22	(22)
CSS	Theatres	0	17	(17)	-	109	(109)	-	176	(176)
CSS	CDC	0	(2)	2	12	16	(4)	12	17	(5)
CSS	Imaging	0	(14)	14	-	70	(70)	-	108	(108)
Corporate	All Corporate Directorates	149	(2)	151	942	4	938	1,835	4	1,831
Total Agency		**149**	**30**	**119**	**954**	**396**	**558**	**1,848**	**542**	**1,306**
Performance against cap/plan		**195**	**30**	**165**	**1,365**	**396**	**969**	**2,333**	**542**	**1,791**

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*23/24/222*		**Date: 14/12/2023**	
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.*			
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 November 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 proposed Q2 risk scores were consolidated and agreed at the November 2023 Board meeting. No further significant updates have been made for this month's report.

A significant review of the BAF is planned during January 2024 and the outputs from this will report to the January 2024 Committees and onto the February 2024 Board. The proposed Quarter 3 scores will also be included in this update for consideration.

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 proposed Q2 risk scores were consolidated and agreed at the November 2023 Board meeting. No further significant updates have been made for this month's report.

A significant review of the BAF is planned during January 2024 and the outputs from this will report to the January 2024 Committees and onto the February 2024 Board. The proposed Quarter 3 scores will also be included in this update for consideration.

Closed Risks or Strategic Threats

No closed risks.

Recommendation

The Board requested to

- review the BAF risks and agree on their contents and actions.

Liverpool Women's
NHS Foundation Trust

Board Assurance Framework 2023/24

Trust Board

December 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

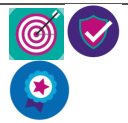
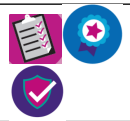
Director Lead	
CEO	Chief Executive
CPO	Chief People Officer
COO	Chief Operating Officer
CFO	Chief Finance Officer
CIO	Chief Information Officer
CN	Chief Nurse
MD	Medical Director

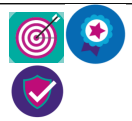
Key to lead Committee Assurance Ratings	
	Green = Positive assurance: the Committee / Board is satisfied that there is reliable evidence of the appropriateness of the current risk treatment strategy in addressing the threat or opportunity - no gaps in assurance or control AND current exposure risk rating = 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.

Matters to consider when reviewing the Q3 score –

- Big Conversation outputs
- Inclusive Employers ranking
- Junior medical workforce reports scheduled to be received in November 2023.

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
- 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
- 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

		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**		
	Bi-annual Speak Up Guardian Reports.	**2**		
	Annual Report whistle blowing report to PPF and Audit Committee	**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)

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

	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) 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) 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
	KPI reports from all outsourced services, Recruitment, Payroll and Occupational Health	**2**				
	Reports and feedback from Big Conversation into the Board and Divisional Boards	**2**				
	A suite of KPIs which measure the performance of the People Services including customer feedback based on the nationally developed questions	**2**				
	Assurance that MT competencies are assigned correctly via sign off from practice educators and Heads of Nursing	**2**				

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	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.	Deputy Chief People Officer	~~January 2023~~ March 2024	Process in place to ask staff with protected characteristics to join interview panels for Band 8A and above. Employees with protected characteristics have been invited to take part in national training to participate in recruitment processes in other NHS Trusts. Access to pool of interviewers via the ICB in addition to REACH network. Will audit consistency of application (new deadline suggested)	
1.1 / 9	Enhance availability and quality of training across all protected characteristics including disability and inter-sectionality	Deputy Chief People Officer	~~December 2022~~ April 2024	Enhanced training for senior leaders developed, additional baseline training in development, additional training around neurodiversity etc required. Roll out to subject to budget setting (new date suggested)	
1.1 / 11	Development of ED&I Strategy	Deputy Chief People Officer	~~January 2023~~ April 2024	This will be included as a major strand of a revised PPF Strategy – to be rolled out by April 2024	
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 and this is now tracked and monitored. Evidence via Big Conservation that these methods are being utilised.	
1.2 / 2	To receive assurance that Divisional Boards are effectively reviewing and updating workforce plans	Deputy Chief People Officer	February 2023	HR Business Partners regularly review and update annual workforce plan with Divisions. Workforce plans aligned with Operational Plans.	
1.2 / 3	E-rostering system for doctors - Allocate is implemented for medical staffing	Deputy Chief People Officer	~~November 2022~~ April 2024	O&G implemented, Neonates and Anaesthetics to roll out by April 2024	
1.2 / 5	Respond to Ockenden recommendations relating staffing	Deputy Chief People Officer	~~September 2022~~ April 2024	Midwifery staffing levels are compliant – no current vacancies and we are adherent to BR+ recommendations. Additional roles being funded via CNST monies to support Ockenden recommendations. 24/7 Obs cover remains in development.	

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

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~~

Return to Dashboard

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 to improve the 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) review outcome prioritising the sustainability of women's services as one of the top clinical risks in the system • 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	**2**				
	Mapping of requirements from and interdependencies with LUHFT across all Trust specialties	**2**				
	Single Site risk reports – provided to QC and Board since July 2022 on a regular basis	**2**				
	Corporate Risk Committee – wider opportunity to review significant risk	**1**				
	Engagement from appropriate Executives in designated working groups	**2**				

						Need to improve the sustainability and deliverability of the dietetic service provided at LWH

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	
	Improvements to the sustainability and delivery of Dietetic Service required	Chief Nurse	February 2024		

Consequence	Likelihood				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic			2316, 2232, 2323, 2599, 2598, 2604	2178, 1635	2641
4 Major			2088, 2087, 2709/10, 1966, 2329, 2085	2684, 2572, 2321, 2430, 2296	
3 Moderate	2488	2469	2086		2395
2 Minor		2726	2084		2606
1 Negligible					

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
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.

	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 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	Dec 23		
3/7	QI projects need to be developed from patient voices and experience-based co-design.	Quality Manager	Dec 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 2024		

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
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.

	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 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.

	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 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					

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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)	***23/24/223a***		**Date: 14/12/2023**	
Report Title	**Integrated Governance Assurance Report Quarter 2 2023/24**			
Prepared by	***Allan Hawksey, Acting Associate Director of Governance and Quality***			
Presented by	***Dianne Brown, Chief Nurse***			
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*	Comment:

3. Failure to deliver an excellent patient and family experience to all our service users	Q1 score 12, Q2 score 8 (meeting 23/24 target)

EXECUTIVE SUMMARY

The following Integrated Governance Assurance report covers Quarter 2 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 in previous quarters. There was a significant increase in incident reporting of 615 incidents in Q2 compared to Q1. This increase related to blood sampling errors. Of the 2361 patient safety incidents reported during Q2, there were 27 near misses, 1971 no harm incidents and 274 low / minor harms. There were 14 moderate harms, 2 severe and 1 death caused by a patient safety incident. This incident is subject to serious incident investigation (maternal death) and is subject to a Health Service Safety Investigation Branch investigation.**

- A key area of risk for Q2 was within the investigations cause group (671) relating to:
  Inadequately Labelled Sample (432) of which Maternity (339) relate to Community (178) and Delivery Suite (68) and Gynaecology (59) relate to Gynaecology Unit (25) and Gynaecology Emergency Department (23) / Haemolysed Sample (66) of which Maternity (53) relate to Delivery Suite (27) and Maternity Assessment Unit (10) and Gynaecology (8) relate to Gynaecology Emergency Department (5) **The Trust has merged the blood sampling errors group with Pathology Steering Group who have overall accountability of the work that is led by Joe Downie (DCOO), meeting monthly. Liverpool Clinical Laboratories and LWH are looking at Digicare including ordering, results and mobile phlebotomy. This work has progressed well with data reflecting improvements seen with training and education delivered. It is anticipated that this will have an impact moving forward and a reduction in repeat blood sampling errors reported from Q3.**

- Recurrent medication incidents around controlled drugs (CDs) were discussed at MSG and MMG during Q2. Two main themes were identified across the organisation relating to the role of the second checker when administering CDs and the diligence and accuracy when completing CD documentation (registers). **Strategies have been discussed regarding improvement work which included promoting management of controlled drugs during planned Medicines Safety Week in November and a review of the training and education programme for the management of CDs for clinical staff with proposals to improve content, infrastructure, and delivery. (Key actions are reported within the main body of the report)**

- In Q2, there were 21 non-clinical health and safety related incidents reported, a reduction of 14 incidents from the previous quarter. The majority of incidents were reported by Family Health, with Gynaecology and the Corporate Function reporting between 4 and 3 incidents respectively. All incidents were appropriately managed, and all processes were followed. There were 2 RIDDOR reportable staff

incidents involving slips and falls, which were appropriately investigated with prompt actions taken to reduce further risks of similar incidents occurring. **Work remains ongoing 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. An audit was completed by Mersey Fire Service Inspectors during this quarter, the findings of which were reflective of the work that has been undertaken to improve fire safety awareness and arrangements across the organisation in order to manage and mitigate fire risks. A number of actions, however, are required to be completed within the next two quarters and are being managed by a live action plan. A Fire Safety Group is to be established, linking into the Health and Safety Group to ensure continuous improvement in fire safety compliance. The Central Alerting System (CAS) continued to be well managed, and alerts actioned within defined deadlines.**

- Complaints in Q2 23/24 saw an increase of 14 complaints compared to the previous quarter, and an increase of 3 compared to the same quarter in 22/23. Gynaecology Services division, which incorporates Gynaecology and the Hewitt Fertility Centre services, accounted for 60% of the received volume, although The Trust are starting to see a decrease in the number of complaints received relating to the Hewitt Fertility Centre when comparing to previous increased levels. **A Task and Finish group was requested to be set up by the Chief Nurse after escalation of the appointment issues being identified. This is to look at how we can instigate more effective communications with patients who are currently on the associated wait lists. The aim is to provide more proactive communication with our patients to keep them informed of the delays being experienced. Divisions are continually 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.**

- Divisional Friends and Family Test (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. **There are several actions and initiatives detailed within the patient experience section of the report.**

- Within Clinical audit, there was more than 80% overall compliance following the trust guidance in administrating Anti-D. As part of National Neonatal Audit Programme (NNAP), delayed cord clamping rate at LWH was outstanding in UK at 76.2% compared to national average of 43%. There was very good use (91%) of antenatal steroids at LWH. **Where audits have determined that the level of expected standards have not been met, there are significant Divisional action plans formulated to address issues highlighted. All audits are reviewed by the Quality Improvement Group (QIG) and actions either approved or amended and updated where required. These are divisionally led and monitored by the Clinical Audit and Effectiveness (CAE) Department. The outcome of such action plans is subsequently reported back in to QIG where a further audit may be required. There is considerable oversight of all audits by QIG and the Continuous Improvement Team Department.**

- The Trust has made significant progress in its stated aim of embedding improvement into process and practice. The work with AQUA will continue throughout Q3 and Q4 to ensure we have the capacity and capability to support an embedded culture of improvement across the Trust. The development of the Quality Strategy will further enhance the Trust's ability to deliver improvement in accordance with

priorities established by key stakeholders. Processes to register and manage improvement projects will be reviewed and simplified to facilitate rapid improvement activities. Platforms are being created to recognise and celebrate improvement projects with a view to sharing the learning with internal and external partners. The Trust is represented at the newly formed Cheshire and Merseyside Improvement Network. This network provides a platform for collaboration, sharing of best practice and resources. **The team will maximise the opportunities for learning and efficiencies afforded by engagement with local networks. They will continue to make more efficient use of the limited resources available through a further review of key processes, the development of skills and knowledge within the team, and an increasingly flexible approach to the work of the Governance and Quality Team.**

- As of 30 September 2023, there were 158 active, "open" claims. 153 Clinical claims, 4 non-clinical claims and 1 class action claim. **The 2023 Trust Scorecard was released in August 2023 and circulated with the divisions. NHS Resolution are scheduled to present the Scorecard to the Family Health Division at the Learning from Claims Task & Finish Group in October 2023 and to Gynaecology and CSS in November 2023.**

- There were 10 serious incidents and 3 Patient Safety Incident Investigations declared to the Integrated Care Board (ICB) during Q2 (an increase of 5 incident investigations from Q1) – 6 in July, 4 in August and 3 Patient Safety Incident Investigations (PSII) in September. There were 8 SI investigations submitted to the ICB in Q2. **There were 4 overdue serious incident submissions due with the ICB from Gynaecology. The Senior Leadership Team had requested short extension from the ICB to facilitate Trust sign off and submission. The delay in submission had partly been due to the impacts of industrial action and gynaecology governance cover within the Division.**

- Of the incident investigations declared, and in addition to any future generation's cases, there were 3 incidents of skin injuries identified within Maternity services. **Initial review findings have highlighted supervision of new midwifery staff and agency staff to ensure delivery of care and appropriate documentation. These issues have been identified and shared with the maternity governance team for the service develop a plan for supervision of such staff.**

- 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 01 October 2023, there were 11 ongoing action plans that had actions overdue or 1 not added to Ulysses. These were subsequently escalated to all Heads of NMAHP, 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.**

- 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 continues to significantly improve 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 and 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

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.

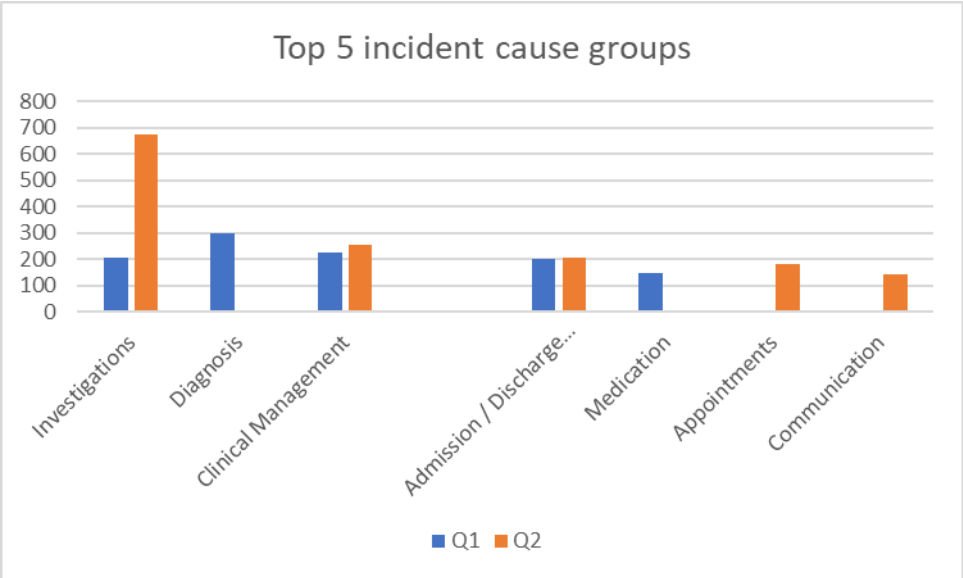
KEY THEMES AND AREAS OF RISK ACROSS THE TRUST

1. Incidents

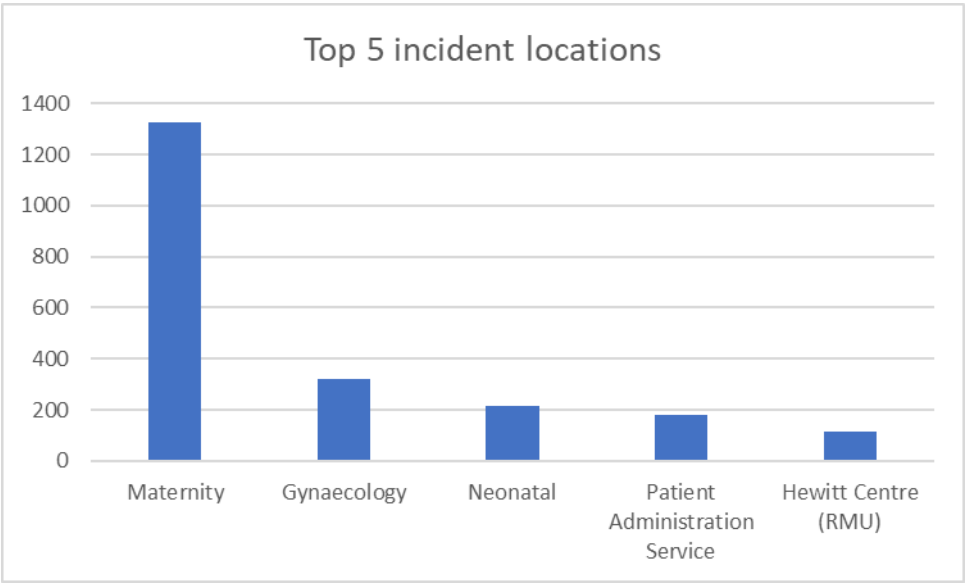
HEADLINE - A key area of risk for Q2 was within the investigations cause group (671) relating to:

1. **Inadequately Labelled Sample (432) of which Maternity (339) relate to Community (178) and Delivery Suite (68) and Gynaecology (59) relate to Gynaecology Unit (25) and Gynaecology Emergency Department (23)**
2. **Haemolysed Sample (66) of which Maternity (53) relate to Delivery Suite (27) and Maternity Assessment Unit (10) and Gynaecology (8) relate to Gynaecology Emergency Department (5)**

- 2552 incidents reported in total.
- Increase of 615 incidents compared to Quarter 1 23/24



Cause Group	Q1	Q2
Investigations	204	672
Diagnosis	298	
Clinical Management	225	256
Admission / Discharge / Transfer	201	208
Medication	145	
Appointments		180
Communication		141



Maternity	1327
Gynaecology	323
Neonatal	216
Patient Administration Service	179
Hewitt Centre (RMU)	114

Total	2159

Total number of incidents reported across Q2 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	726	898	928							**4489 to date**
Quarterly	**1937 (<67)**			**2552 (>615)**									

Patient Safety Incidents

2361 total PSI for Q2 (Trust wide) and an increase of 599 when compared to Q1

Family health (1497)	Gynae (Inc HFC) (549)	CSS (212)
Investigations 535	Appointments 119	Patient Records / Identification 38
Clinical Management 173	Investigations 98	Investigations 38
Admission / Discharge / Transfer 147	Communication 58	Clinical Management 28
Midwifery Red Flag 119	Diagnosis 52	Communication 22
Medication 98	Admission / Discharge / Transfer 49	Medication 16

Analysis of the key themes (PSI)

- Investigations – 672 incidents across all divisions

Inadequately Labelled Sample	433
Haemolysed Sample	66
Incorrect Details On Report - Investigations	43
Inappropriate Labelling	20
Clotted Sample	18

- Clinical Management – 250 incidents across all divisions

Failure To Follow Clinical Guidelines	47
Delay In Medical Review On The MAU	31
Failure To Follow Clinical Pathway	27
Treatment / Procedure - Delay/Failure	18
Communication Issue (Clinical Management)	14

- Admission / discharge / transfer – 204 across all divisions

Term Baby Admitted To Neonatal Unit	62
Admission - Planning Failure	37
Transfer - Delay	19
Transfer To Other Trust	12
Transfer - Inappropriate	11

- Appointments – 170 across all divisions

Appointment Omission/Not Made	39
Appointment Delay	35
Appointment Made In Wrong Clinic	31
Appointments Overbooked	14
Appointment Not Cancelled	12

- Medication – 139 across all divisions

5 Medication Administration	64
4 Medication Prescribing	42
2 Medication Storage	11
3 Medication Dispensing (Pharmacy)	8
External Pharmacy	4

Improvements and actions

The Trust has merged the blood sampling errors group with Pathology Steering Group who have overall accountability of the work that is led by Joe Downie (DCOO), meeting monthly. Liverpool Clinical Laboratories and LWH are looking at Digicare including ordering, results and mobile phlebotomy. This work has progressed well with data reflecting improvements seen with training and education delivered. It is anticipated that this will have an impact moving forward and a reduction in repeat blood sampling errors reported from Q3.

2. Medicines Safety

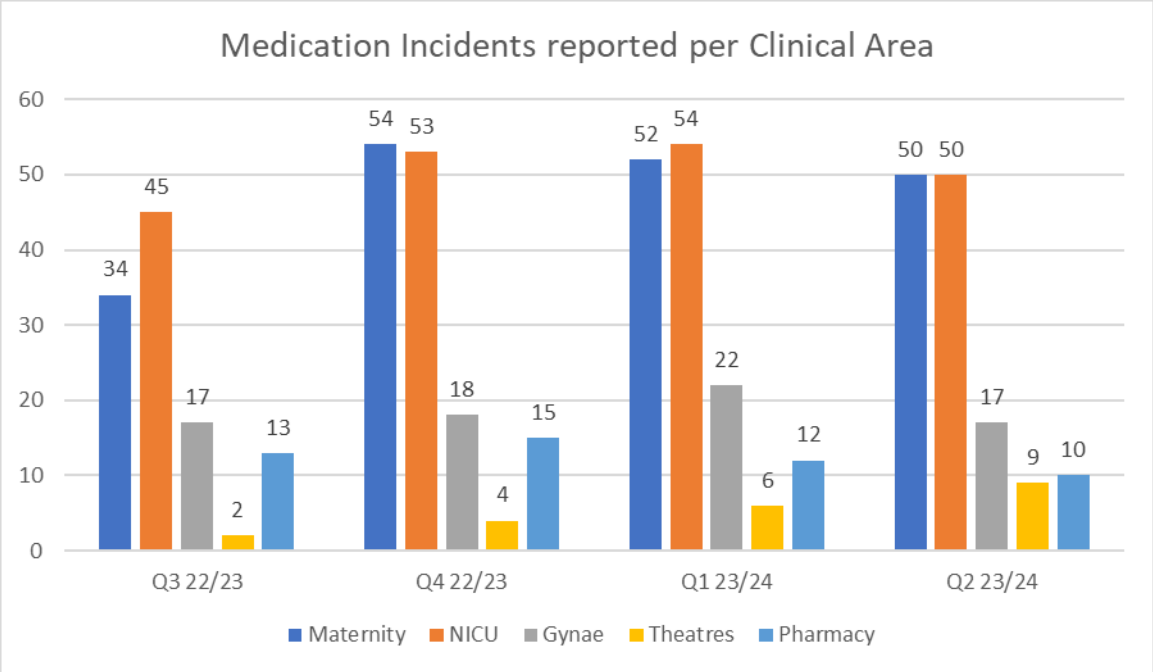
HEADLINE: Recurrent medication incidents around controlled drugs (CDs) were discussed at MSG and MMG during Q2. Two main themes were identified across the organisation relating to the role of the second checker when administering CDs and the diligence and accuracy when completing CD documentation (registers).

Total number of medication incidents reported per quarter to-date.

Q1 23/24	Q2 23/24	Q3 23/24	Q4 23/24
146	136		

Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23
110	99	111	144

Q1 21/22	Q2 21/22	Q3 21/22	Q4 21/22
114	80	80	76



Improvements and actions

Strategies have been discussed regarding improvement work which included promoting management of controlled drugs during planned Medicines Safety Week in November and a review of the training and education programme for the management of CDs for clinical staff with proposals to improve content, infrastructure, and delivery.

Division	Area noted for improvement	What are we doing to improve the position both short and long term	Committee/division/person responsible
All areas	Safe Use Of Insulin	A new interactive eLearning module on the Safe Use of Insulin had been developed in collaboration with an external training company and implemented for clinical staff in the organisation via ESR.	MSG - **Ongoing monitoring of ESR compliance**
All areas	digiCare functionality	Following the implementation of DigiCare, a number of improvement ideas were suggested relating to TTO prescribing	MMG – **These additional safety measures are currently being considered as part of ongoing Digicare**

		across Maternity and the number of warnings that the system alerted the end user.	**upgrades**
All areas	Learning from medication incidents across the Trust	The creation of a Medication Error Assessment Tool (MEAT) for incidents relating to adult patients was proposed. The tool has been used across NICU for several years and has contributed to significant improvement work and learning around medicine incident management.	MSG – **The MEAT tool is currently under review for adaptation by Gynaecology and Maternity. There is a new working group that is leading on this work**
All areas	Learning from medication incidents across the Trust	LOTW shared with senior staff across all areas for dissemination across teams; *How to obtain medicines out of hours and the correct documentation process on digiCare for IV medicines administration.*	MSG – **Weekly communication are sent Trust wide from the MSG. The MSG frequently take the Medications Safety Bus into departments to discuss medication prescribing and administration issues**
All areas	Learning from medication incidents across the Trust	Weekly Safety Check In covering topics including; *Influencing in-hospital prescribing errors; NSAID usage in pregnancy; defective medicine reporting and the staff vaccination programme.*	MSG – **There is a regular slot whereby the Deputy Chief Pharmacist shares identified learning**
Family Health	Learning from medication incidents across Maternity	Introduction of a monthly medication incident MDT group on Matbase working collaboratively with Pharmacy. The meeting reviews all medication incidents across Matbase so learning and themes can be identified to prioritise improvement work.	MSG – **The MDT process reports into MSG. It's effectiveness is subject to continuous review.**

3. Health & Safety

HEADLINE - In Q2, there were 21 non-clinical health and safety related incidents reported, a reduction of 14 incidents from the previous quarter. The majority of incidents were reported by Family Health, with Gynaecology and the Corporate Function reporting between 4 and 3 incidents respectively. All incidents were appropriately managed, and all processes were followed. There were 2 RIDDOR reportable staff incidents involving slips and falls, which were appropriately investigated with prompt actions taken to reduce further risks of similar incidents occurring.

A breakdown of all non-clinical health and safety incidents, reported in quarter 2, are detailed in the table below:

	FAMILY HEALTH	GYNAECOLOGY & RMU	CSS	CORPORATE FUNCTION	TOTAL
PERSONAL INJURY/ILL HEALTH	3	2		1	6
NEEDLESTICK INCIDENTS	4	2			6
SLIPS, TRIPS & FALLS	7			2	9
TOTAL	14	4	0	3	21

Improvements and actions:

Work remains ongoing 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.

An audit was completed by Mersey Fire Service Inspectors during this quarter, the findings of which were reflective of the work that has been undertaken to improve fire safety awareness and arrangements across the organisation to manage and mitigate fire risks. Several actions, however, are required to be completed within the next two quarters and are being managed by a live action plan. A Fire Safety Group is to be established, linking into the Health and Safety Group to ensure continuous improvement in fire safety compliance.

CAS continued to be well managed, and alerts actioned within defined deadlines.

4. Patient Experience

a. Complaints, PALS, and PALS+

HEADLINE: Complaints in Q2 23/24 saw an increase of 14 complaints compared to the previous quarter, and an increase of 3 compared to the same quarter in 22/23. Gynaecology Services division, which incorporates Gynaecology and the Hewitt Fertility Centre services, accounted for 60% of the received volume, although The

Trust are starting to see a decrease in the number of complaints received relating to the Hewitt Fertility Centre when comparing to previous increased 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. A refund policy has been developed and was approved in June 2023 and it is hoped this is having the desired impact.

The number of PALS + cases dealt with this quarter has increased by 15, with the Gynaecology Division are still 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.

715 PALS cases were received in this quarter which is an increase of 9 cases overall. Initial end of quarter review has highlighted a few areas which have contributed towards this:

- The team have seen a significant increase in patients contacting PALS trying to gain information about appointments and associated delays due to capacity.
- Appointment issues are now the queries recorded as the main category in this quarter. Communication is usually the category that dominates PALS cases as it covers such a wide variety of issues, so this is a notable difference. Appointment issues account for 38% of the total cases for the quarter with communications accounting for 37% of the cases recorded.
- The main issues are:
- The extended waiting time for initial appointments following referral,
- The difficulties patients are having getting in touch with people/departments. These are usually numbers/people we have told them to contact or provided this information and this causes massive frustration when they either are stuck in queues or leave messages that are never returned.
- Difficulties getting surgery dates, sometimes having 2 or 3 pre op appointments (as they had expired) whilst they wait for their surgery date.
- The most cases received by a division was 385 (45%) PALS cases which were received this quarter by Gynaecology. With the busiest month being noted as August 23.
- 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 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.

Improvements and actions:

A Task and Finish group was requested to be set up by the Chief Nurse after escalation of the appointment issues being identified. This is to look at how we can instigate more effective communications with patients who are currently on the associated wait lists. The aim is to provide more proactive communication with our patients to keep them informed of the delays being experienced.

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.

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 was Patient Experience representation on the workstream looking at the MAU improvements and this is already underway and showing positive results. We have seen a reduction of abandoned calls to the MAU 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.

For GED, the telephone triage service was a temporary move during COVID due to national guidance re: face to face appointments/attendances. Following COVID and returning back to BAU, the 24/7 service has been a challenge to staff in existing workforce establishment. Since that time, the GED Service review has been ongoing and there is a paper and presentation going to Quality Committee (scheduled for 28/11/2023). Part of the recommendations is to look at an alternative model for Primary Care which will explore the use of Single Point of Access i.e. Clinical Telephone triage prior to an acceptance of referrals. The telephone triage will be moved to the new EPAU location to support. This will enable more rapid response to telephone queries which is away from the Main GED. However for out of hours it will be proposed to step down the service moving forward. Following the presentation to QC, the Division are going to return to pre-COVID arrangements with an agreed communications plan for patients and primary care.

Face to face availability for the PALS service continues to be provided and utilised by patients.

b. <u>Patient Experience</u>

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 Q2 2023/24

Number of responses received. * *Please note that during July 2023 the FFT text service was not operational to allow for DigiCare to be implemented. This was non-operational for approximately 14 days.*

Total	Maternity	Gynaecology	Genetics	Reproductive Medicine (RMU)
1449	281	817	23	152

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) %
88 ↓	81 ↓	88 ↓	91 ↓	92 ↑

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 ←	86 ↓	91 ↓	93 ↓	95 ↑

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 encourage more responses and patients being able to view the feedback supporting making improvements.

Below are some examples shared at the PIESC covering Q2 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.

<u>Maternity Base - what we heard</u>

- Through feedback from our services users via many different avenues including MNVP, FFT, Picker Survey, and Matron ward round, our service users requested that we increase support person visiting including

overnight. 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.

Maternity base – What we did

- Through feedback from Picker, FFT and MNVP, perceived delayed discharge was a concern for many of our service users. The reasons for delayed discharge were partly due to delay in the NIPE and this was extending the time service users had to wait to be discharged home. 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.

Delivery Suite- what we heard

- The Delivery Suite undertake all induction of labour process within maternity. With a national increase of IOL, this has meant that birth rooms on the delivery suite were allocated to increase IOL beds, this as impacted on the flow through the delivery suite and caused delays in the IOL process. Feedback through complaints, PAL' and FFT from our service users highlighted this as a concern. 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. Plans include providing a window of time to be managed as an outpatient and called in when IOL to be commenced. The current estate has been reviewed and funding agreed to move low risk IOL to a new area to increase capacity for the delivery suite, with a view to reduce waiting times and increase patient experience.

Delivery Suite - What we did

- Currently IOL delays of attendance to commencement of IOL >2hrs is a national maternity red flag, and additionally LWH introduced a local red flag of >4hrs delay during ongoing IOL which are reported through the Ulysses system. As part of the improvement project qualitative and quantitative data will be collected

MAU- what we heard

- Attendance to triage >30mins is also a Midwifery Red Flag. Breaches were reported with feedback from via complaints and PALS. With the introduction of BSOTS which recommends a 15min target to be prioritised, a move was made in June 2023 for this to be the new target which would be expected to be >95% by September. However, since introduction >95% compliance is being achieved, and this and is monitored continuously to ensure this is maintained and drive any further improvement work.

MAU – What we did

- Patient feedback also provided the manager with information regarding service user concerns, in that that they were not kept up to date with information regarding any potential delays whilst waiting for medical review in the MAU. With this information 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.
- Matron is arranging meeting with Patient Experience Lead to review how to increase patient feedback for the area, and a MNVP 15 Steps is planned for September.

Community- what we heard

- Women informed the midwifery managers that they were unaware that they were required to book their own 15-week GP appointment following Dating Scan. A simple intervention of Midwifery staff now providing a reminder to all to ensure 15-week appointment is booked has improved timely attendance.
- Our Community Matron is arranging meeting with patient experience lead to review how to increase patient feedback for the area other than phone calls which may go unanswered and not gain a wide view of the service which represents the population we care for.

Community teams – What we did

- Midwifery staff now provide a reminder to all service users to ensure 15-week appointment is booked. This information is captured within power BI team leader awaiting response from data team to review compliance.

5. Continuous Improvement

a. CLINICAL AUDIT AND EFFECTIVENESS

HEADLINE: The Trust received 3 Clinical Audit Reports including Action Plans in Quarter 2

1. Key successes from Clinical Audits completed Quarter 2

- There was more than 80% overall compliance in following the trust guidance in administrating Anti-D.
- As part of National Neonatal Audit Programme (NNAP), delayed cord clamping rate at LWH was outstanding in UK at 76.2% compared to national average of 43%. There was very good use (91%) of antenatal steroids at LWH.

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

- There was more than 5% lag in documentation, prescription, and administration of Anti-D despite there being Trust guidance in place, and one third women were not tested for their blood group during their treatment period. These audit results have since been presented at Trust-wide meetings to promote education. A review of how Digicare can be used to improve guideline implementation and compliance is also underway.

- Improved/expanded facilities were required to enable LWH to offer Transitional Care parents the same level of convenience already offered to NICU parents. Further discussions were held with the maternity base matron and in March 2023 TC was moved to a more suitable area within the postnatal ward, with the room being decorated in a baby friendly way.

- Trial has been undertaken as part of Transitional Care of small, portable incubators (mOm incubator) as part of the maternity based QIP to reduce admissions due to hypothermia from postnatal ward, delivery suite and recovery areas. Overall, the incubators were well received and there is a further plan to purchase for use in TC and within the hypothermia QIP through ATAIN.

- Need to monitor the rates of Bronchopulmonary dysplasia, Intraventricular hemorrhage and Cystic periventricular leukomalacia in yearly National Neonatal Audit Programme (NNAP). Plan in place to monitor data monthly in Liverpool Neonatal Partnership meeting and in yearly NNAP report.

- There were documentation issues within 2021 NNAP data for parental presence in ward rounds. There is a documentation QI (started April 2023) ongoing in the unit to address this issue.

Improvements and actions:

Where audits have determined that the level of expected standards have not been met, there are significant Divisional action plans formulated to address issues highlighted. All audits are reviewed by the Quality Improvement Group (QIG) and actions either approved or amended and updated where required. These are divisionally led and monitored by the Clinical Audit and Effectiveness (CAE) Department. The outcome of such action plans is subsequently reported back in to QIG where a further audit may be required. There is considerable oversight of all audits by QIG and the Continuous Improvement Team Department.

b. QUALITY IMPROVEMENT

HEADLINE: The Trust has made significant progress in its stated aim of embedding improvement into process and practice.

- The lack of capacity and capability to deliver and lead improvement projects is in the process of being addressed in partnership with AQuA through a range of Quality Improvement learning programmes.
- Learning is being delivered at basic level via an online module, and at practitioner and leadership levels through programmes which started in Q3 and will conclude in December and March, respectively. The second cohorts are scheduled to start in Q4.
- Work has progressed with AQUA in developing a new Quality Strategy which will serve to address quality through a safety lens. Engagement to support the development of the strategy is ongoing. The draft strategy will be available in Q4.
- The Quality & Safety Facilitator is now providing practical support and guidance to the team and coordinating a more flexible approach to the provision of administrative support. This has enabled greater productivity and responsiveness in the wider Governance and Quality functions.
- 16 additional improvement projects were registered in Q2, which is the same as Q1.

Plans for Q3 and beyond – incorporating improvement in every Trust process.

The work with AQUA will continue throughout Q3 and Q4 to ensure we have the capacity and capability to support an embedded culture of improvement across the Trust. The development of the Quality Strategy will further enhance the Trust's ability to deliver improvement in accordance with priorities established by key stakeholders. Processes to register and manage improvement projects will be reviewed and simplified to facilitate rapid improvement activities. Platforms are being created to recognise and celebrate improvement projects with a view to sharing the learning with internal and external partners. The Trust is represented at the newly formed Cheshire and Merseyside Improvement Network. This network provides a platform for collaboration, sharing of best practice and resources.

Priorities to make this happen continue to be:

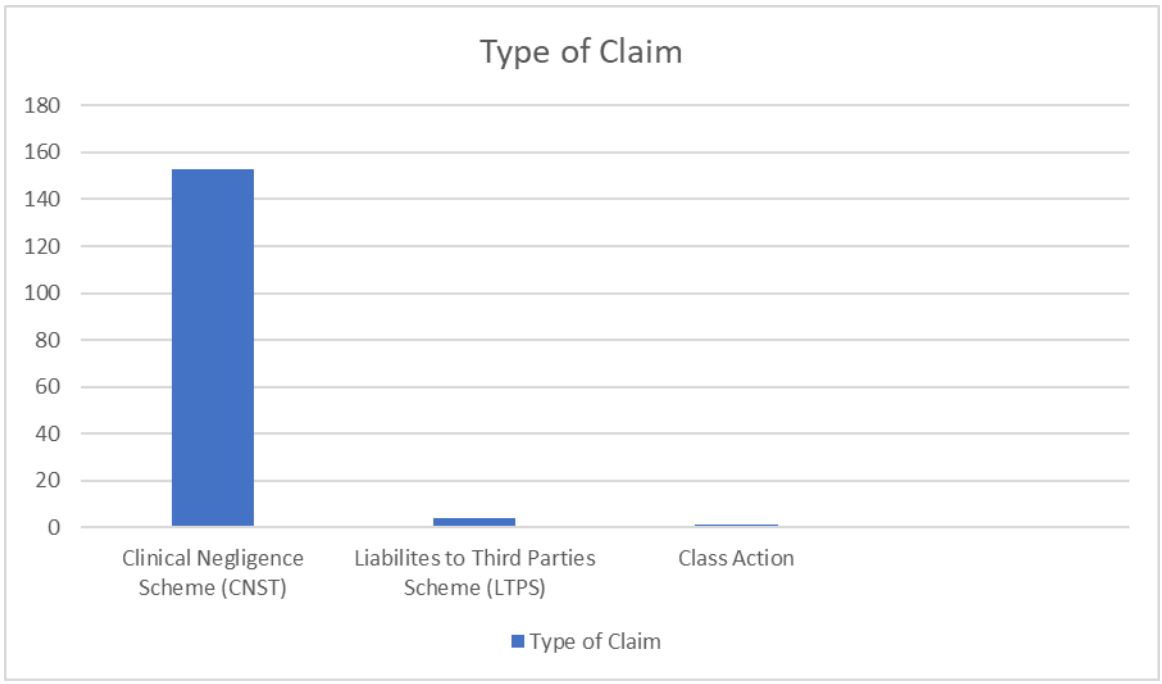
- Completion of the AQUA QI learning at basic, practitioner and leadership level
- Development of a shared language and approach to improvement
- An improved focus on safety and health inequalities within projects
- Clearer evidence of embedded learning as a requirement for all improvement projects
- 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:

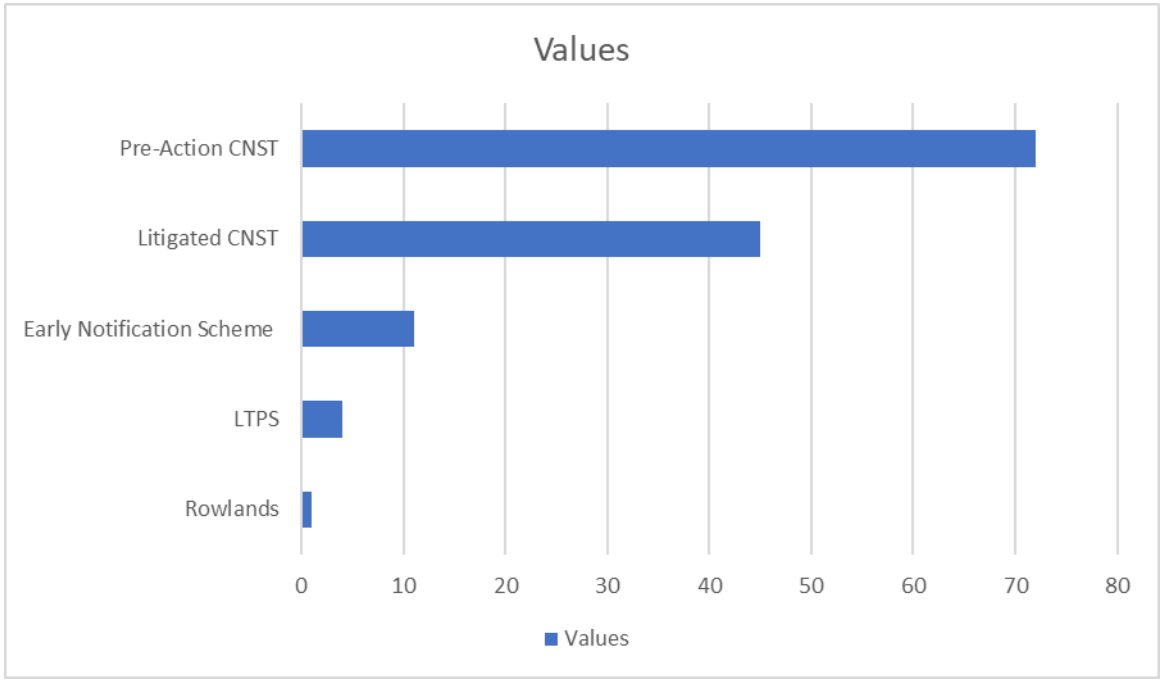
The team will maximise the opportunities for learning and efficiencies afforded by engagement with local networks. They will continue to make more efficient use of the limited resources available through a further review of key processes, the development of skills and knowledge within the team, and an increasingly flexible approach to the work of the Governance and Quality Team.

6. Legal Services

1) **HEADLINE: As of 30 September 2023, there were 158 active, "open" claims. 153 Clinical claims, 4 non-clinical claims and 1 class action claim.**



1) The current procedural position of these claims are as follows:



The following table presents all new and settled Clinical Negligence Scheme for Trusts (CNST), Liabilities to Third Parties Scheme (LTPS), Early Notification Scheme (EN) and Inquest cases between 1 July 2023 and 30 September 2023.

Month	CNST		LTPS		ENS		Inquest	
	New	Settled/Closed	New	Settled	New	Closed	New	Closed
July 2023	3	3	0	0	3	0	0	0
August 2023	1	3	0	0	0	0	0	0
September 2023	7	5	0	0	1	0	2	0

Legal Services are continuing to circulate claims data to the divisions on a monthly basis which incorporates both new and settled/closed claims. Upon receipt of a new Letter of Claim, Legal Services will notify the relevant division enclosing the Letter of Claim, NHS Resolution's initial financial reserves and whether any incident or complaint documentation to ensure triangulation and learning.

Trust Scorecard from NHS Resolution

The scorecards are quality improvement tools which provides insight into the Trusts claims over the past 10 years to support learning from where there has been harm. The scorecard can support the Trust's organisations clinical governance and quality assurance processes. The data within them can help the Trust understand, monitor and minimise risks to patients and staff, for example, clinicians can interrogate the scorecard data to access the clinical effectiveness of the care they provide and identify any areas where new guidance and standards may be required to help prevent errors. The data within the scorecard can be evaluated against audit data and other sources of information to help identify other areas of interest or concern, it can then be combined with external data sets to provide more in-depth insight and context, for example; whether previous actions/lesson learning actions to improve the safety and quality of patient care have been effective. The scorecard can be used to identify trends and themes which can in turn be incorporated into education and training programmes for the Trust to support staff to learn from claims.

Improvements and actions:

The 2023 Trust Scorecard was released in August 2023 and circulated with the divisions. NHS Resolution are scheduled to present the Scorecard to the Family Health Division at the Learning from Claims Task & Finish Group in October 2023 and to Gynaecology and CSS in November 2023.

7. Serious Incidents and identified learning

***HEADLINE* – There were 10 serious incidents and 3 Patient Safety Incident Investigations declared to the Integrated Care Board (ICB) during Q2 (an increase of 5 incident investigations from Q1) – 6 in July, 4 in August and 3 Patient Safety Incident Investigations (PSII) in September.**

Serious Incidents / Patient Safety Incident Investigations declared and final reports submitted to the ICB

All Serious Incidents / Patient Safety Incident Investigations had full duty of candour completed in accordance with the current Trust policy.

Of the incident investigations declared, and in addition to any future generation's cases, there were 3 incidents of skin injuries identified within Maternity services. Initial review findings have highlighted supervision of new midwifery staff and agency staff to ensure delivery of care and appropriate documentation. These issues have been identified and shared with the maternity governance team for the service develop a plan for supervision of such staff.

Overdue actions from previous submitted SI's / Serious Incidents

There were 4 overdue serious incident submissions due with the ICB from Gynaecology. The Senior Leadership Team had requested short extension from the ICB to facilitate Trust sign off and submission. The delay in submission had partly been due to the impacts of industrial action and gynaecology governance cover within the Division.

There was 1 Serious Incidents Submitted in July 2023 and 2 maternity cases de-escalated from a Serious Incident Investigation, as approved by the ICB.

There were 1 Serious Incident Submitted in August 2023.

There were 6 Serious Incidents Submitted in September 2023.

As of 01 October 2023, the following Serious Incidents remain ongoing within the divisions.

Clinical Support Services have no ongoing Serious Incidents / Patient Safety Incident Investigations

Neonatal Services have no ongoing Serious Incidents / Patient Safety Incident Investigations

StEIS No.	Never Event?	Date reported to STEIS	RCA Due Date	STEIS extension date	Division / Directorate
202314301	N	27/07/2023	18/10/2023	08/11/2023	Maternity
202315836	N	18/08/2023	10/11/2O23	/ /	Maternity
202315842	N	18/08/2023	10/11/2O23	/ /	Maternity
202316109	N	23/08/2023	27/12/2023	/ /	Maternity

StEIS No.	Never Event?	Date reported to STEIS	RCA Due Date	STEIS extension date	Divison / Directorate
2023487	N	09/01/2023	29/09/2023	Extension requested	Gynaecology
20237171	N	05/04/2023	02/10/2023	Extension requested	Gynaecology
20239394	N	10/05/2023	02/08/2023	23/10/2023	Gynaecology
202313028	N	05/07/2023	28/09/2023	Extension requested	Gynaecology
202313024	N	05/07/2023	28/09/2023	Extension requested	Gynaecology
202315109	N	08/08/2023	31/10/2023	/ /	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 01 October 2023, there were 11 ongoing action plans that had actions overdue or 1 not added to Ulysses. 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.

8. Divisional Triangulation and Integrated Governance Reports Q1

Key learning / assurance / messages identified.

a. Family Health

Maternity

- Investigations is the most reported cause group with 499 incidents compared to 129 in the previous quarter. Sampling incidents have been affected with the implementation of Digi care. Mobile phlebotomy is being rolled out with training provision.
- The weekly ATAIN meetings continue to take place to review the term admissions which makes up 39% of the Admission / Discharge / Transfer incidents.
- The division have introduced a monthly Matbase Medication Incident MDT working collaboratively with Pharmacy. The meeting takes place on the ward and ward staff input is welcomed. The first meeting was well received by both the ward and pharmacy staff. During the reviews, learning and themes are identified. Following the meeting feedback is given to the Matron and actions assigned to address any issues identified. Monthly meetings will continue.
- There were 6 new complaints received in July and August. There were no closed complaints. All complaints are on target for completion. The learning continues to be shared at the Maternity Risk meeting using the maternity 'Learning from complaints' form.
- Each month a report is generated detailing learning from claims. This is shared at Maternity Risk and the invite has been extended to include band 7 midwives which gives greater dissemination.
- Midwifery Red Flags have increase due to acuity causing delays in IOL. The rate of IOL is increasing due to changes in national pathways, and therefore creates the need for further capacity in the Induction and Intrapartum Areas. As part of the service improvement, an IOL Coordinator has been appointed to lead on improvements and manage service user expectations with the IOL Capacity. Estates work has commenced to increase the capacity for IOL inpatients.
- Maternity Voice Partnership (MVP) continue with the move from MVP to MNVP and have given thanks to neonatal colleagues who are supporting the work. The trial of 24/7 visiting on Mat Base continues. This is proving to be popular with service users according to feedback on social media and verbally to MVP. The patient experience team will complete a full evaluation of the pilot phase.
- On Monday 11th September MVP undertook a "15 steps of MAU". This was a quality review of the area from the perspective of service users undertaken by a team of local parents. The feedback of this will be collated and shared with LWH.

- There were 281 FFT tests received in Q2, a reduction from the 374 responses received in Q1. The satisfaction score was 88% and the recommendation score was 91%. The Maternity Base Matron has written a paper detailing "You said, we did" in response which will be shared at the patient experience subcommittee. The report details the steps taken to address the issues raised which included: Staffing levels – successful recruitment of midwives commencing in post on 2nd October 2023. 24 hour visiting – the pilot continues and all findings from FFT, MNVP and Ulysses will be reviewed to agree next steps. Delays in IOL – the feedback will feed into the intrapartum working group.
- There are 2 Quality Improvement Projects in Maternity: QIProj/0096 - Golden Hour QI Project and QIProj/0106 Comfort rounding. Trends in incidents highlighted a lapse in basics of fundamentals aspects of care. The QI is to establish a two-hour comfort round check for maternity patients.

Neonates

- All neonatal medication incidents are reviewed daily by the neonatal governance manager. The neonatal MEAT tool (Medication error assessment tool) is used to help gauge the seriousness of the error then actions are implemented according to this tool score. This can be a reflection, extra training, a statement, re-attend the neonatal intravenous administration study day and complete further competencies and assessed during completion of these competencies. The staff member involved in the incident will also verbally discuss the incident with a senior member of staff so that they can reflect on their error. Other divisions within the trust are planning to implement the MEAT tool in their department.
- The neonatal blood sampling task and finish group address all blood sampling errors. We have addressed the way we take our blood samples by introducing new blood lancets, we are also planning a Quality Improvement project. The group meet monthly and is an MDT approach with doctors and nurses in the group. We attend the monthly trust blood sampling working group meetings. We have produced a blood sampling competency workbook for all neonatal staff to complete. We have also reviewed the journey of the blood sample to address any issues in relation to collection transportation and receipt of the blood sample when it leaves the neonatal unit. Blood sampling has been added to the neonatal staff induction programme and the neonatal Intravenous administration study day. Blood sample taking is also discussed during the doctor's induction to the unit.
- The neonatal skin injury interest group have been meeting this quarter to commence a QIP. 13 members of the team with an MDT approach Dr's and nurses. The team have been researching regarding prevention of skin injuries. The team is led by a consultant Neonatologist. The trust's tissue viability nurse is working closely with the neonatal department to develop pathways and offer advice and guidance.
- One complaint received this quarter regarding care of baby within the neonatal unit. Not following a pre-birth plan. The complaint was managed quickly and has been closed.
- There are 3 ongoing quality improvement projects within the Directorate. There has been a 50% reduction in accidental extubation incidents since the associated QI project commenced.
- The neonatal team work closely with maternity services around PMRT which ensure that there is a clear line of sight on neonatal mortality (Risk 2430) throughout the division, working together to see how we can improve care delivery, outcomes, and family experience.
- The neonatal digital team work closely with the maternity digital team with regards to K2 (risk 2419) to ensure that all mother and baby information is accessible to the right person at the right time in the right location. This is not completely resolved but is significantly improved with joint working.
- The LNP Integrated Governance report is shared with Family Health Divisional Board.

b. Gynaecology

- There were 124 incidents reported regarding appointments within Q2, with 23 of these were regarding appointment delays. To reduce the number of incidents reported regarding issues with appointments, several actions have been implemented within the Division.
- All SOP's are being reviewed due to the implementation of Digicare. To be completed by April 24
- Issues with letters that are being printed in Digicare. Automated letters turned off and now being completed manually.
- Team training/away day planned 2023 – ALL staff PAC, Genetics, reception.
- Text messaging validation service in place for patients to confirm if they still wish to attend their appointments.
- Review of Netcall to see how best to utilise the system. This will help with DNA's and last-minute patient cancellations.
- Ongoing project for booking out. All patients booked out prior to Digicare go live, there was a focus on antenatal (GDM) booking out and outcomes.
- Booking out for antenatal outcomes escalated to Family Health Risk Register
- Issues with interpreter services due to the change in provider
- Weekend Theatre lists and Ambulatory clinics implemented to reduce the waiting lists.

There were 98 Investigation incidents reported within Q2. 66 of these incidents relate to blood sampling issues, e.g. Inadequately labelled samples and Haemolysed samples. There have been several actions implemented across the division to support with blood sampling issues.

- Attendance at Task and finish group
- Divisional action plan co-ordinated by Quality and Safety Matron
- Clinical Walkabout completed by Quality and Safety Matron delivering on the job training, ensuring mobility phlebotomy is connected and operational.

There were 79 Communication incidents reported regarding communication within Q2, 36 of these were regarding communication failure within teams.

- The division have introduced daily Nurse in Charge and Consultant Handovers
- Weekly safety and governance meetings taking place within the clinical areas.
- Monthly newsletter introduced in Hewitt Centre soon to be introduced across Gynaecology.

There were 70 Diagnosis incidents reported within Q2. 65 of these incidents are due to the backlog of reporting CRIS and PACS incidents.

- 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 completing daily checklist of Nurse Scanners
- GED Consultant Leads to ensure documentation standards are raised at AM huddle and checked at PM.
- Flow chart for process for reporting on CRIS/PACS circulated to clinicians.

Matrons have met with and listened to the experiences of three women who recently accessed care at the Gynaecology Emergency Department, specific experiences have been shared wider across the Nursing and Medical Team. We have recognised that improvement both environmentally and from a pathway perspective is required for women who attend with either miscarriage or fearful of miscarriage. As a result, our patients experience alongside recent DoH publications regarding Miscarriage care in Early pregnancy are providing us with foundations for relocating the Early Pregnancy Assessment Unit as well as the improving the continuity of care for

these women. Additional actions regarding information to patients as well as the provision of compassionate care kits is also being completed.

The Division continue to place patient experience as an important quality measure and the additional workstreams are ongoing that contribute to this.

- Implementing Access contraceptive clinic in Gynaecology outpatients Department
- Continue to build upon provision of care for under 18-year-old patients against KSF standards.
- Stakeholder engagement in Ultrasound improvement group
- Lead in Menopause special interest group.
- Second Trimester Miscarriage project role out
- Gynaecology Consultants are leading on system wide improvement projects for the Women's Health strategy, Menopause, Under 18's Gynaecology, Endometriosis, Colposcopy all of which will improve patient experience
- In addition to the work detailed with in this report the Division were delighted to receive exceptional National Inpatient Survey results by performing better than expected. When compared to national NHS results, the Gynaecology Inpatient Ward scored better than other acute and specialist NHS Trusts in 20 questions, and 5 of the 11 overall themes covered in the survey.

The Senior Leadership Team is committed to supporting staff to undertake formal learning opportunities in Quality Improvement Methodology facilitated by the AQUA programme. One Matron has recently commenced on the programme thus enabling the division to adopt the process for positive change.

c. <u>Clinical Support Services</u>

- Patient Records in Admin Genetics has been a theme in some of the previous quarters and actions were taken to help reduce the rate of errors. However, the rate of incidents in this quarter are higher than previous. This is due to a retrospective audit into previous correspondence being conducted to analyse errors and detect any themes and trends. It was found during the audit that most errors were attributable to one member of staff. An Action Plan has been put in place to attempt to reduce the rate of future incidents by the individual, in line with the fair and just culture guide.

- The Gynaecology Pre-Op Manager continues to discuss incidents at regular meetings with staff and highlights any themes or trends from sample errors to try to reduce future incidents. Staff are being offered further training where they think this is required. Issues identified with samples because the labs have been asked to be highlighted for us to feedback to LCL where appropriate. In terms of sample errors for Gynae Pre-Op, even though there has been an increase in errors reported throughout the quarter, we recognise July/August had a reduction in clinical activity compared to September (which may have been a result of Digicare). We are working on sharing of the New Order of Draw chart from LCL.

- With regards to Pharmacy there has been a 30% reduction in dispensing incidents since the last quarter. There are ongoing plans to increase resource across Pharmacy team to undertake medicine audits across the Trust. Deep dive review of incidents within the Pharmacy team are undertaken to review any incident themes and implement improvements.

- Genetics - FFT 23 responses, of those that were submitted 91% satisfaction score and 93% recommendation score. CDC – FFT 176 responses, 173 positive responses given with a positive response rate of 98%. The Division is still working with getting other services registered for friends and family data going forward.

- The Division's Training Needs Analysis for 23-24 include Governance and Quality items, such as QIP practitioner, Risk Management, Complaints Management, and the upcoming NHS Patient Safety Incident Response Framework (PSIRF).

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

Trust Board

COVER SHEET

Agenda Item (Ref)	*23/24/223b*		**Date: 14/12/2023**	
Report Title	**Corporate Governance Manual – Update**			
Prepared by	*Mark Grimshaw, Trust Secretary*			
Presented by	*Mark Grimshaw, Trust Secretary*			
Key Issues / Messages	*For the Board to approve the proposed amendments to the Trust's Corporate Governance Manual.*			
Action required	**Approve ☒**	**Receive ☐**	**Note ☐**	**Take Assurance ☐**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable): N/A			
	For Decisions - in line with Risk Appetite Statement – Y *If no – please outline the reasons for deviation.*			
	The Board is asked to approve the proposed amendments to the Trust's Corporate Governance Manual.			
Supporting Executive:	*Mark Grimshaw, Trust Secretary*			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

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

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

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

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
The Board undertook its significant review of the CGM in September 2023 and approved a series of updates.			

EXECUTIVE SUMMARY

Amendment to the Corporate Governance Manual was last presented and agreed at the Board in September 2023.

A review of the document had been undertaken with input from the Trust Secretary, Finance Team and Head of Procurement & Contracts.

It has subsequently been highlighted that the Procurement of services and supplies threshold was set at an incorrect value. This paper seeks approval to rectify to the correct threshold value.

MAIN REPORT

The following table provides a summary of the amendments that were approved by the Board in September 2023.

Version control			
Version	**Section**	**Changes made**	**Date**
12.0	**Throughout**	**References to Head of Governance & Legal amended to Associate Director of Quality and Governance**	**July 2023**
12.0	**Throughout**	**References to the Chief Nurse & Midwife amended to Chief Nurse**	**July 2023**
12.0	**5.0 Table B (section 6)**	**Changes to thresholds and permissions on the recommendation from the Head of Procurement & Contracts**	**July 2023**
12.0	**5.0 Table B**	**Procurement of services and supplies threshold changed to £138,760 (inclusive of VAT) from £122,976**	**July 2023**
12.0	**Throughout**	**Reference of Head of Estates and Facilities replaced with Estates and Facilities Manager**	**July 2023**
12.0	**6.7**	**Removal of the reference to external audit being required to audit the Trust's quality account**	**July 2023**
12.0	**4.0**	**Approved committee membership and terms of reference added.**	**July 2023**
12.0	**Throughout**	**References to NHS Improvement and/or Monitor replaced with NHS England**	**July 2023**

Procurement of services and supplies threshold

The Procurement of services and supplies threshold changed to £138,760 (inclusive of VAT) from £122,976 in the September 2023 annual update. This figure relates to Central Government Bodies. It has

been subsequently highlighted that foundation trusts are not included within this definition and therefore the threshold should be set at £213,477 (inc. VAT).

The relevant section would be updated to the following:

6. Quotation, tendering and contract procedures		
a. Quotations: *Obtaining* a minimum of 3 written quotations for goods / services	£10,000 up to £40,000 including VAT	Head of Procurement & Contracts
b. Competitive tenders: *Obtaining* a minimum of 3 written competitive tenders for goods / services (in compliance with EC directives as appropriate)	£40,000 - Prevailing OJEU Limit(s) Currently £213,477 including VAT	Head of Procurement & Contracts
c. Competitive Tenders: OJEU Tender process or use of compliant framework where applicable	> £213,477 including VAT	Head of Procurement & Contracts
d. Waiving requirements for tenders, subject to full compliance with standing orders: Tenders	£5,000 up to £213,477 (including VAT)	The Chief Finance Officer in the first instance. Should the Chief Finance Officer be absent for an extended period of time; or absent when an urgent requirement occurs relating to either service continuity or patient care Deputy Chief Finance Officer or any Executive Director will have delegated authority to authorise the use of a waiver.

Recommendation

The Board is asked to approve the proposed amendment regarding the procurement of services and supplies threshold (£213,477 inc. VAT) within the Trust's Corporate Governance Manual.

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