Liverpool Women's
NHS Foundation Trust

Trust Board

9 May 2024, 09.30am

The June Henfrey Suite

Blackburne House

NHS
Liverpool Women's
NHS Foundation Trust

Trust Board

Location	The June Henfrey Suite, Blackburne House
Date	9 May 2024
Time	9.30am

AGENDA					
Item no. 24/25/	Title of item	Objectives/desired outcome	Process	Item presenter	Time
PRELIMINARY BUSINESS					
037	Introduction, Apologies & Declaration of Interest	Note	Verbal	Chair	09.30 (5 mins)
038	Patient Story – EPAU move	Note	Presentation	Deputy Chief Nurse	09.35 (20 mins)
039	Minutes of the previous meeting held on 11 April 2024	Approve	Written	Chair	09.55 (5 mins)
040	Action Log and any urgent matters arising	Note	Written	Chair	
PERFORMANCE					
041	Chief Executive Report • Operational, Quality & Workforce Report • Executive Risk & Assurance Group Report	Note	Written	Chief Executive	10.00 (30 mins)
042	Finance Performance: Month 12 2023/24, 2025/25 Plan	Note	Written	Chief Finance Officer	10.30 (15 mins)
043	LWH Improvement Plan Highlight Report 1	Note	Written	Chief Transformation Officer	10.45 (15 mins)
BREAK – 11.00 – 11.15 Board Thank you – 11.15 – 11.20					
QUALITY, SAFETY & EFFECTIVENESS					
044	Maternity Incentive Scheme (CNST) Year 6 2024 – Scheme Release Position May 2024	Assurance	Written	Chief Nurse	11.20 (10 mins)
045	Service Outline – Pre-Term Optimisation	Note	Presentation	Chief Medical Officer	11.30 (20 mins)
GOVERNANCE					
046	Committee Chair's Reports	Note	Written	Committee Chairs	11.50 (10 mins)
047	Board Assurance Framework	Approve	Written	Trust Secretary	12.00 (15 mins)

CONSENT AGENDA (all items 'to note' unless stated otherwise) *All these items have been read by Board members and the minutes will reflect recommendations, unless an item has been requested to come off the consent agenda for debate; in this instance, any such items will be made clear at the start of the meeting.*					
None					Consent
CONCLUDING BUSINESS					
048	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair	12.15 (5 mins)
049	Chair's Log	Identify any Chair's Logs	Verbal	Chair	
050	Any other business & Review of meeting	Consider any urgent items of other business	Verbal	Chair	
051	Jargon Buster	For reference	Written	Chair	
Finish Time: 12.20					

Date of Next Meeting: 11 July 2024

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

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

Liverpool Women's
NHS Foundation Trust

Board of Directors

Minutes of the meeting of the Board of Directors held in The June Henfrey Suite, Blackburne House at 9.30am on 11 April 2024

PRESENT

David Flory CBE	Chair
James Sumner	Chief Executive
Jenny Hannon	Chief Finance Officer / Executive Director of Strategy & Partnerships / Deputy Chief Executive
Zia Chaudhry MBE	Non-Executive Director
Michelle Turner	Chief People Officer
Gary Price	Chief Operating Officer
Gloria Hyatt MBE	Non-Executive Director
Jackie Bird MBE	Non-Executive Director
Dr Lynn Greenhalgh	Chief Medical Officer
Louise Martin	Non-Executive Director
Tracy Ellery	Non-Executive Director / Vice-Chair

IN ATTENDANCE

Matt Connor	Chief Digital Information Officer
Tim Gold	Chief Transformation Officer
Nashaba Ellahi	Deputy Director of Nursing & Midwifery
Alice Bird	Clinical Director, Family Health (Item 002 only)
Gillian Walker	Patient Experience Matron (Item 002 only)
Allan Hawksey	Head of Risk and Patient Safety
Lesleyanne Saville	Corporate Affairs Manager
Lesley Mahmood	Member of the Public
Felicity Dowling	Member of the Public
Teresa Williams	Member of the Public
Mark Grimshaw	Trust Secretary (minutes)

APOLOGIES:

Sarah Walker	Non-Executive Director
Dianne Brown	Chief Nurse
Prof. Louise Kenny CBE	Non-Executive Director / SID

Core members	**May 23**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr 24**
David Flory CBE	Non-member										🏳	🏳
Robert Clarke - Chair	🏳	🏳	🏳	🏳	🏳	🏳	🏳	🏳	🏳	🏳	NM	
James Sumner – Chief Executive	Non-member							🏳	🏳	🏳	🏳	🏳
Kathryn Thomson - Chief Executive	🏳	🏳	🏳	🏳	🏳	🏳	🏳	Non-member				
Tracy Ellery - Non-Executive Director / Vice-Chair	A	🏳	A	🏳	🏳	🏳	🏳	🏳	🏳	A	A	🏳
Louise Martin - Non-Executive Director	🏳	🏳	A	🏳	A	🏳	🏳	🏳	🏳	🏳	A	🏳

Prof Louise Kenny - Non-Executive Director	✓	A	A	✓	✓	✓	✓	✓	A	✓	✓	A
Dianne Brown – Chief Nurse	✓	✓	✓	✓	✓	✓	✓	✓	A	✓	A	
Gary Price - Chief Operating Officer	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Michelle Turner - Chief People Officer	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dr Lynn Greenhalgh – Chief Medical Officer	✓	A	✓	✓	✓	✓	✓	✓	✓	✓	A	✓
Zia Chaudhry – Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Gloria Hyatt – Non-Executive Director	A	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Sarah Walker – Non-Executive Director	✓	✓	✓	A	✓	✓	A	✓	✓	✓	A	A
Jackie Bird – Non-Executive Director	✓	✓	✓	A	A	✓	✓	✓	✓	✓	✓	✓
Jenny Hannon - Chief Finance Officer / Executive Director of Strategy & Partnerships	✓	A	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Matt Connor – Chief Digital Information Officer (non-voting)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Tim Gold – Chief Transformation Officer (non-voting)	Non-Member										✓	✓

24/25/	
001	**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.
002	**Patient Story** A patient, supported by the Family Health Clinical Director and the Patient Experience Matron, attended to relay their experience at the Trust. The patient explained that she had an incident free first pregnancy but sadly, her baby had died following a hypoxic brain injury incurred during birth at another setting. This has led to challenges in trusting health professionals and the patient had significant concerns about giving birth in a hospital. In her subsequent pregnancy, the patient was cared for in the Rainbow Clinic (a specialist service for women and their families in a subsequent pregnancy after a baby dies) and received midwifery care at the Trust. The patient stated that the professional approach and experience demonstrated by the staff had made her feel safe and restored confidence. The patient was keen to assert that services such as the Rainbow Clinic could not be viewed as a luxury or 'add on' but rather were an essential practice. The Family Health Clinical Director outlined plans to enhance the service currently provided by the Trust and Non-Executive Director Jackie Bird stated that it would be important to learn lessons to apply across the whole system, not just at one setting. The Chair thanked the patient for her bravery and for her time in attending the Board to share her story. The Board of Directors noted the patient story.

003	**Minutes of the previous meeting held on 14 March 2024** The minutes of the Board of Directors meeting held on 14 March 2024 were agreed as a true and accurate record.
004	**Action Log and matters arising** Updates against action log were noted. The Chief People Officer provided assurance that work was being undertaken to close action 23/24/185b via an updated Integrated Performance Report – scheduled to report to the May 2024 Board. The Chief Medical Officer provided a verbal update against action 23/24/134a noting that the long-term increase in the C-Section and Induction of Labour rate was due to the following factors: • As a result of increased safety measures, predominantly in place for the Saving Babies Lives Care Bundle • Increased maternal choice • Increase of health challenges with women e.g. increase in maternal diabetes. The Board of Directors noted the updates to the action log.
005	**Chief Executive Report** The Chief Executive provided an update on several significant developments affecting the Trust. Attention was drawn to the recently finalised exit criteria for the Trust to move from segment three to segment two under the National Oversight Framework. The Chief Executive stated the Trust was currently on track to meet the criteria but noted that financial recovery would be a particular challenge. Once fully operational, the Improvement Plan report would provide the Board with oversight of progress against the key measures. Non-Executive Director, Tracy Ellery, highlighted Exit Criteria 1.1 'financial recovery' and noted that the timeframe being applied to the development of a recovery plan could be seen as potentially ambiguous. The Chief Executive confirmed that the ICB was using generic criteria phrasing for all trusts to try and provide a level of consistency. The Trust had been clear in its Improvement Plan that the Financial Recovery Plan would span three years. Work was underway to refresh the financial recovery plan to identify the areas that the Trust could deliver, and which areas may require system support. The Chair remarked that the ICB had been required to achieve a balance between consistency and relativism when setting the exit criteria across the system footprint. The Chief Executive updated the Board regarding the Women's Hospital Services in Liverpool Programme. As part of the roadmap, the initial phase of the programme had been outlined, with an emphasis on the importance of openness, transparency, and continuous engagement with the public. The development of a clinical case for change was scheduled for the spring and summer of 2024, with publication expected later in the same year. Feedback from this engagement phase, gathered during the winter of 2024/25, would then inform the approach to designing future services, with further development of potential options anticipated to commence in early 2025. The Chief Medical Officer remarked that there was demonstrable system and partner collaboration within the Programme Board and a strengthened understanding of risks amongst members for pregnant women who presented at hospital sites outside of Crown Street. It was noted that the Trust had submitted a position of compliance for all current Board members following a comprehensive assessment against the Fit and Proper Person criteria. Entries into the Register of Sealings during 2023/24 were also noted. The Chief Executive presented the draft Terms of Reference for the Executive Risk and Assurance Group and the Improvement Plan Portfolio Board, both new meetings that would report to the Board to provide assurance and escalation on key issues, risks, and progress with key projects.

	Non-Executive Director, Louise Martin, asked that a reference to seeking assurance regarding the Trust's areas of statutory compliance be added to the 'duties' section of the Executive Risk and Assurance Group Terms of Reference. It was also asked that it be made clear which individual in the membership was responsible for the oversight of estates. Key issues from the performance summary were noted as follows: • As at the end of March 2024, the Trust reported 140 patients waiting over 65 weeks for elective treatment, above the internal trajectory of 85, due to earlier industrial actions and a recent locum staff shortage. With increased resources from April 2024, the Trust aimed to eliminate these extended waits by the end of Q1 2024/25, surpassing the national target of September 2024. Subsequently, work would take place to address waits over 52 weeks throughout 2024/25. o The Chair and Non-Executive Director, Tracy Ellery, queried the confidence of achieving no 65 week waits by the end of Q1 2024/25 and the potential risks to delivery. The Chief Operating Officer confirmed that the capacity was in place to deliver against this target and that this was monitored daily. Unplanned sickness and potential further Industrial Action were potential variables. o The Chief Executive noted that the Trust was exploring initiatives to increase capacity further and develop an upgraded pathway model to make significant progress against the wait list quantum. Examples provided included the ambulatory project and the work being undertaken with Primary Care. • The Cancer 28 day Faster Diagnostic target had seen sustained improvements for a full quarter and as of March 24 this was within the national average for Gynaecology (62%) despite a sustained increase in referrals. The aim was to continue this improvement with further schemes planned. • The 31-day cancer standard has showed statistical deterioration. It was explained that the 31 Day DTT performance for February 2024 demonstrated an unvalidated position of 53%. Ongoing validation had identified patients that were not breaches and therefore the position would improve to 60% once finalised. The unvalidated position for March 2024 was currently 65%, with potential further improvement once fully validated. • Mandatory Training metrics were showing a static position (following statistically significant improvements over the last 12 months). In the development of the new Trust Integrated Performance Report there would need to be a consideration of the benchmark the Trust wished to set in this regard. The Chief Executive remarked that work was underway to improve the data analysis and presentation of the Integrated Performance Report which would also include increased benchmarking data. It was suggested that a refresher training session for the Board on the 'making data count' methodology would be helpful. Action: To arrange a Board training session on the 'making data count' methodology. The Board of Directors: • noted the report • subject to the suggested amendments, approved the Terms of Reference for the Executive Risk and Assurance Group and Improvement Plan Portfolio Board.
006	Finance Report & Financial Planning The Chief Finance Officer reported that the financial position for M11 2023/24 indicated a small improvement from Month 10, in line with the revised deficit forecast of £22.6m, a betterment by £0.8m. Despite these efforts, the Cost Improvement Programme (CIP) had not met its targets recurrently, which would affect the 2024/25 outlook, being £1.0m behind the full year target at Month 12. Agency usage had been well-managed with strong controls in place, resulting in agency

	spend constituting only 0.7% of total pay costs, well below the national expectation of 3.7%. The cash position was challenged, standing at £4.5m, under the policy minimum of £6m, despite receiving £20.1m in national support. Capital expenditure was mostly accounted for, with most of the allocated £5.4m expected to be spent by the year-end, despite currently being £1.4m behind the planned schedule. The Chair queried if lessons had been learned from the need to revise the forecast outturn position in-year. The Chief Finance Officer stated that the Trust accepted a CIP target at a level that had not been delivered in previous years and a challenging stretch target to unwind pay commitments. The key lesson was for the Board to ensure that approved plans were realistic with delivery levels underpinned by evidence. The Chief Finance Officer continued to outline the current planning position for 2024/25. For 2024/25, the Trust was projecting a deficit of £29.5m, improving from initial estimates. Challenges included delivering a Cost Improvement Programme (CIP) target of £5.3m, representing 3.1% of the expenditure base, amid risks like maintaining vacancy factors, managing inflation, and ensuring consistent delivery of the Aligned Payment Incentive (API). Opportunities would lie in enhancing productivity, insourcing inpatient services, and leveraging mutual aid to improve financial performance. The outlined plan involved managing immediate quality and safety actions costing £2.5m and a capital expenditure of £5.0m, alongside a proposed 'stretch' CIP increase of £2m to address excess inflation and other emerging costs. The approach aimed to streamline operations and sustain service delivery while navigating financial constraints and operational challenges. Non-Executive Director, Louise Martin, noted that despite the significant deficit being planned for, the Finance, Performance & Business Development Committee had received assurance that the Trust could demonstrate that it was exploring all available avenues. There was recognition that the most significant opportunities for improvement would require a level of system support. Louise Martin continued to outline that the Committee wished to explore further potential opportunities through collaboration – noting that the Trust should demonstrate ambition in this aspect. The Chair stated that it was vital for the Board to understand the justifications for increasing the headcount, remaining cognisant of the numbers involved and ensuring that this was monitored throughout the year. Non-Executive Director, Zia Chaudhry, noted that the Trust had not accepted a request from the ICB to set a 5% CIP target and queried if further pressure to increase the target was likely. The Chief Finance Officer confirmed that there might be increased pressure but noted the previous comments regarding the Board needing to feel confident regarding the realistic level of delivery. It was noted that the final plan would need to be submitted on 24 April 2024 and therefore an Extraordinary Board meeting would be necessary to provide approval ahead of or on this date. The Board of Directors: • noted the Month 11 position • noted the 2024/25 planning update
007	LWH Improvement Plan Mobilisation Update 2 The Chief Transformation Officer presented the report highlighting the progress of the 10-week Improvement Plan Mobilisation, currently in its 5th week. Progress had been made in defining strategic objectives and detailing the 16 projects within the Improvement Plan. Key actions included the formal establishment of governance frameworks, initiation of Project Initiation Documents / project charters for each project, and the setup of a robust reporting system to ensure transparency and accountability. The Board of Directors noted progress on the work undertaken by the Executive and wider organisation to mobilise a Trust wide Improvement Plan.

008	**Mortality and Learning from Deaths Report Quarter 3, 2023/24** The Chief Medical Officer presented the report which provided the mortality data for Q3 2023/24 and the learning from review of deaths that occurred in Q2 2023/24 or earlier. Attention was drawn to a finding that of the 27 stillbirths (including Termination of Pregnancies (TOPs)) and neonatal deaths (including all deaths where babies were cared for at the Trust) 11 (41%) were in non-white British mothers/babies. This was higher than the birthing population for 2021/22 (c 15.5%). This was the first time an excess of deaths in the non-white population had been observed and the Chief Medical Officer counselled that caution should be used when interpreting data for one quarter. However, the Quality Committee had recognised the importance of viewing the data through a health inequalities lens and a longer-term period would be reviewed in the Q4 2023/24 report. The Chief People Officer confirmed that any relevant outcomes from this review would feed into the Anti-Racism Project within the Improvement Plan in which patient experiences would also be considered. It was noted that the latest benchmarked data for stillbirths (Q2 2023/24) was demonstrating that the Trust was within the lowest quartile for stillbirth rates. The Board of Directors: • Took assurance that there were adequate governance processes in place when learning from deaths • As per the Learning from Deaths framework requirements, noted: o number of deaths in the Trust's care o number of deaths subject to case record review o number of deaths investigated under the Serious Incident framework o number of deaths that were reviewed/investigated and as a result considered due to problems in care o themes and issues identified from review and investigation o actions taken in response, actions planned and an assessment of the impact of actions taken. • approved the recommendations relating to improving the clarity of reporting for neonatal deaths.
009	**Integrated Governance Report Quarter 3 2023/24** The Board received the report which provided information of oversight and assurance monitoring of Integrated Governance and highlights of key risks to the Trust evidencing any embedded learning divisionally and cross divisionally. The following key risk areas were identified: • Blood Sampling Errors: The continued high level of blood sampling errors posed a key risk to patient safety although there were no identified delays to patient safety care. • Controlled Drugs Management: Issues around the administration and documentation of controlled drugs posed potential risks, requiring robust management of improvement strategies. • Overdue Serious Incident Investigation Actions: Identified as a risk to the Trust being able to demonstrate robust responses to learning and embedding change as a result of findings identified as a risk. However, positive assurances were also highlighted including evidence of a positive reporting culture, improvements in learning from incidents and embedding change, and evidence of quality improvement initiatives. Non-Executive Director, Jackie Bird, queried what action the Trust was taking in response to the issue with controlled drugs. The Chief Medical Officer confirmed that there was a discrete project that had been included within the Safety Culture project within the Improvement Plan. There was also a separate Medicines Safety Project within the Improvement Plan that would help the Trust to identify the actions required to make long-term and sustainable changes.

	Non-Executive Director, Louise Martin, referenced the Control of substances hazardous to health (COSHH) incidents and asked what action was being taken in response. The Chief Operating Officer stated that learning from the incidents had taken place. The Board of Directors received the report, noting the content and took assurance from the systems of control and learning evidenced across the Trust.
010	Bi-annual staffing paper update, July 2023-December 2023 (Q2 &Q3) The Board of Directors received the bi-annual Nursing, Midwifery, and Allied Health Professional (AHP) staffing report for the Trust which covered the period from July to December 2023. The Deputy Director of Nursing & Midwifery outlined the headlines from a detailed analysis that had utilised evidence-based tools, professional judgment, and outcomes to manage staffing needs effectively. Key highlights included a 14% reduction in Bank and Agency demand due to increased substantive staff and lower sickness rates. However, there were ongoing challenges with a 4.87% vacancy rate, high long-term sickness rates, and a slight turnover increase in the HCA group to 13.65%. Additionally, 245 clinical incidents were noted, with an increase in Red Flag events, mainly from Maternity services. The report also discussed patient and staff feedback on staffing issues, with ongoing Quality Improvement actions to address these concerns. The Board was asked to acknowledge the robust systems in place for monitoring and managing staffing to ensure safe patient care. Non-Executive Director, Louise Martin, suggested that the report could be enhanced through making links with the National Oversight Framework exit criteria and the identified safe staffing actions. Louise Martin also remarked that the links with the identified actions and the most significant staffing risks e.g. Long-Term Sickness could be made more explicit. The Board of Directors: • Took assurance from the oversight in place to support safe staffing and deliver safe patient care. • Subject to the comments being reflected regarding strengthening links between actions and key risks, agreed and supported the actions and recommendations within Section 9.0 of the report.
011	Equality & Diversity Reports The report outlined the Trust's compliance with the Equality Act 2010 and the Public Sector Equality Duty (PSED), emphasising its obligations to publish key reports including the EDS 2022, the EDI Annual Report, and Equality Objectives. Additionally, it addressed the requirement to publish the Gender Pay Gap report to meet government standards. The report aimed to showcase the Trust's 2023/24 achievements in equality, diversity, and inclusion (EDI) and outlined plans for the upcoming year. Included appendices, should approval be forthcoming, would be published on the Trust website. The report also highlighted that progress on the Actively Anti Racist programme would be regularly reviewed by the Board, underscoring its significance as a component of the Trust Improvement Programme. Non-Executive Director, Louise Martin remarked that the EDI Annual Report, whilst showcasing some significant achievements, was mainly focussed on work undertaken with staff. It was suggested that future reports would benefit from examples of work done with patients and the community. Non-Executive Director, Gloria Hyatt, noted that whilst the reports could evidence significant progress, the Trust had not achieved its intended goals for 2023/24. Gloria Hyatt therefore suggested that for future iterations, there was a need to establish realistic ED&I goals and then ensure that the Trust held itself to account for these. The Chief People Officer noted that the Improvement Plan would provide additional visibility of progress, or otherwise. The Board of Directors approved the following reports for publication on the Trust's website:

	• Equality Delivery System (EDS) 2022 • EDI Annual Report • Gender Pay Gap Report
012	Corporate Governance Manual The Trust Secretary reported that the Corporate Governance Manual, a key resource since 2005, alongside the 2023 Governance and Performance Framework, had undergone significant updates following Board-approved changes to the Governance and Assurance Framework in March 2024. These updates aimed to consolidate governance documentation into a singular, comprehensive manual to avoid confusion and streamline access to governance information for staff. The revision enhanced sections on corporate governance, integrated all codes of conduct, and introduced new guidelines for conducting Trust business. The updated manual, expected to enhance clarity and accessibility, required Board approval for its amendments and the discontinuation of the separate Governance and Performance Framework. The Board of Directors: • approved the proposed amendments to the Trust's Corporate Governance Manual • approved the close of the Governance and Performance Framework
013	Risk Management Strategy The proposed Risk Management Strategy for 2024/25 had been updated to enhance the Trust's approach to risk assessment, management, and mitigation. Key amendments included a revised statement of intent by the Chief Executive, updated roles and responsibilities at individual and committee levels, and an updated governance structure that introduced the categorisation of Serious and Significant risks while eliminating the Corporate Risk Register. Notably, the strategy introduced a new risk scoring system, "5 + 5 + 5", which assessed the effectiveness of controls, aiming to foster a proactive risk management culture within the Trust. The strategy also sought greater alignment with system partners and there were plans for refreshed risk management training and a risk summit to support these transitions. Non-Executive Director, Jackie Bird, relayed the views of the Quality Committee which had recommended the document for approval by the Board. The Committee had stressed that the changes were not only part of an annual update but rather should be seen in the context of a longer-term ambition for the Trust's approach to risk management. There was recognition that ensuring buy-in from across the organisation to the new approach would be a key part of the first-year implementation. Drawing attention to the roles and responsibilities section, Non-Executive Director, Louise Martin, queried if the Trust was able to delegate responsibility for an area of risk management to an individual who was not a direct employee. The Chief Executive acknowledged this issue and stated that it would be important to have clear lines of accountability when there was a joint role or in a Service Level Agreement arrangement. The Board of Directors approved the Risk Management Strategy.
014	Committee Chair's Reports The Board received the following Committee Chair Reports: Quality Committee • 27 February 2024 – Chaired by Sarah Walker • 26 March 2024 – Chaired by Jackie Bird Finance Performance & Business Development Committee • 28 February 2024 – Chaired by Louise Martin

	• 27 March 2024 – Chaired by Louise Martin Putting People First Committee • 18 March 2024 – Chaired by Gloria Hyatt Audit Committee • 21 March 2024 – Chaired by Tracy Ellery The Board of Directors noted the Committee Chair's Reports. *The following items were received as part of the consent agenda.*
015	Corporate Objectives 2023/24: Final Outturn Review The Board of Directors received the performance / progress to date against the 2023/24 Corporate Objectives.
016	Board Committee Annual Reports, 2024/25 Cycles of Business and Terms of Reference The Board of Directors received and approved the following documents: • Committee Annual Reports for the Quality, Finance, Performance & Business Development, and Putting People First Committees • Committee Business Cycles for 2024/25 for the Quality, Finance, Performance & Business Development, Putting People First, and Audit Committees • Committee Terms of Reference for the Quality, Finance, Performance & Business Development, Putting People First, and Audit Committees
017	Digital.Generations Strategy Review The Board of Directors received the report regarding the progress of the Digital.Generations strategy implementation.
018	Board Assurance Framework The Board of Directors reviewed the BAF risks and noted their content and actions.
019	Review of risk impacts of items discussed The Chair identified the following risk items: • On-going financial sustainability challenges and the need for the Board to maintain a clear understanding of the financial situation. • The importance of effectively engaging with the public and stakeholders in the work of the Women's Hospital Services in Liverpool Programme Board • The substantial nature of the Trust's waiting list.
020	Chair's Log None noted.
021	Any other business & Review of meeting None noted. Review of meeting No comments noted.
022	Jargon Buster Noted.

Liverpool Women's
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Action Log

Trust Board - Public
9 May 2024

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
11 April 2024	24/25/005	Chief Executive Report	To arrange a Board training session on Making Data Count	TS	June 2024	On track	
14 March 2024	23/24/273	Quality, Operational & Workforce Performance Report	To review benchmarking data and utilise this to help set trajectories for key performance indicators within an updated Integrated Performance Report.	CDO	May 2024	On track	Benchmarking information has been built into PowerBI and will be included in the report received by the Board in June 2024.
14 March 2024	23/24/272	Chief Executive Announcements	To receive a report from the Women's Service Programme Board at each public Board meeting.	CEO	~~May 2024~~ July 2024	On track	Update provided in the CEO Report since action agreed. Formal report from the Programme Board to be made available for the July 2024 Board.
8 February 2024	23/24/250	Maternity Staffing report 1st July- 31st December 2023	For future midwifery staffing reports to include benchmarking on operative rates including assisted delivery.	Chief Nurse	July 2024	On track	
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	~~April 2024~~ May 2024	Risks identified	Updated workforce KPIs have been built into PowerBI and will be included in the report received by the Board in June 2024.

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Chair's Log

Received / Delegated	Meeting Date	Issue and Lead Officer	Receiving / Delegating Body	Action Deadline	RAG Open/Closed	Comments / Update
Delegated	11.01.2024	To receive an overview of the Trust's approach for compliance with the Maternity Incentive Scheme Year 6 once the criteria is made available ensuring that this demonstrates adequate ambition.	Quality	~~March 2024~~ May 2024	Closed	Quality Committee received update in April 2024.

Trust Board

COVER SHEET

Agenda Item (Ref)	***24/25/041***		**Date: 09/05/2024**	
Report Title	**Chief Executive's Report**			
Prepared by	***James Sumner, Chief Executive Officer***			
Presented by	***James Sumner, Chief Executive Officer***			
Key Issues / Messages	***To provide the Board of Directors with details of key activities and issues from the Chief Executive since the last update in April 2024.***			
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 of Directors is asked to: • ***note the content of the report*** • ***note the Operations, Quality and Workforce Report*** • ***note the Executive Risk and Assurance Group***			
Supporting Executive:	***James Sumner, Chief Executive Officer***			

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

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

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

REPORT DEVELOPMENT:

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

EXECUTIVE SUMMARY

The report sets out details of key issues the Board need to be appraised of, and activity which the Chief Executive has been involved in, since April 2024.

MAIN REPORT

ITEMS FOR INFORMATION

Cancer Tier 1

NHS England's tiering process for cancer performance is designed to provide accountability and additional central support for trusts that are most at risk of missing national cancer targets. Trusts are categorised into tiers based on their performance, with Tier 1 being the most challenged and requiring the most support. Trusts may move between tiers based on their performance improvements or deteriorations.

In a letter received on 26 April 2024 from NHS England, it was confirmed that following a review of cancer performance, and in agreement with the regional team, the Trust will be in Tier 1 for Cancer from the week commencing 29 April 2024. The move to Tier 1 will involve regular meetings to discuss delivery progress and any required support from the relevant parts of NHS England.

NHS England acknowledged that they had seen steady improvement in the Trust in reducing the backlog of patients waiting for treatment and an increasing proportion of patients who receive a diagnosis within 28-days. They noted that whilst this was encouraging the Trust remained considerably below the cancer performance and FDS ambitions, which has resulted in a movement from Tier 2 to Tier 1 for cancer.

Board members will recall that moving out of tier 2 (out of oversight arrangements) is an exit criterion to move the Trust from National Oversight Framework segmentation +three to two, so this is clearly disappointing. In response, the Trust will work collaboratively with Cheshire & Merseyside Cancer Alliance and the regional NHS England teams to accelerate performance improvements.

Women's Hospital Services in Liverpool Programme

I reported last month that the development of a clinical case for change is scheduled for the spring and summer of 2024, with publication expected later in the same year. Feedback from this engagement phase, gathered during the winter of 2024/25, will inform our approach to designing future services, with further development of potential options anticipated to commence in early 2025.

The first step in the development of a clinical case for change was the first engagement event that took place at the Trust on 3 May 2024. The purpose of engagement event 1 was to:

- Share the draft clinical case for change
- Hear from a broad range of clinicians and people with lived experience and ask what important information is missing and should be included in the case for change?
- Seek support for the case for change and ownership of the risks that are being managed across the system.

I will provide feedback from the event at the Board meeting.

The Women's Hospital Services in Liverpool Programme Board will produce a report following each of its meetings and the first of these will be tabled to the July 2024 Board meeting to ensure consistent communication of the key messages.

Executive Risk and Assurance Group

The Executive Risk and Assurance Group had its inaugural meeting on 1 May 2024. There was good engagement from attendees and whilst the meeting will continue to develop, there was evidence of the risk-focussed approach becoming increasingly embedded.

The key issues and areas for escalation included a discussion on workforce challenges, including high staff turnover, diabetes and dietetics service staffing issues, and anaesthetics capacity. Staffing challenges in diabetes and dietetics are being addressed through collaboration with Liverpool University Hospitals NHS FT to develop sustainable staffing models. Research performance is not meeting the NIHR target, impacting potential funding opportunities, while Maternity Base faces environmental issues requiring potential capital investment. Escalation was also deemed necessary for cancer performance and outdated policies, with both needing immediate action to meet national standards and improve operational compliance, respectively.

Please see Appendix B for further detail.

PERFORMANCE SUMMARY

The Executive Team with the Informatics Team have undertaken a review of Key Performance Indicators (KPI) for 2024/25. Future iterations of the Board integrated performance report (to be made available in June 2024) will include additional metrics and make better use of statistical process control (SPC) and benchmarking to improve the understanding and escalation of these metrics.

The Operational, Quality & Workforce Report is included at Appendix A.

Overall size of the waiting list – Although still concerning the waiting size list continues an improving trend, showing reduction since a peak seen in October 2023. Data for April 2024 demonstrate that the waiting list size has reduced further to 18300, showing a better-than-expected figure against the Trust set trajectories with NHS England for 2024/25 and 500 fewer than the previous month. The key focus through Q1 2024/25 will be to deliver key actions identified in the Trusts Improvement Plan to continue the improving trend.

Cancer – The 28 day and 31-day standard for the March unvalidated position have risen to 62% and 74% respectively. This is an improvement on the validated February 2024 performance. Whilst improving, performance remains under the national set cancer waiting time targets and as such the Trust has been moved to national Tier 1 performance oversight. Trajectories agreed with the North West Cancer Alliance of 70% for the 28 day Faster Diagnostic Standard and 50% for the 62 day standard will look to be accelerated through the Cancer Improvement Plan

Quality Metrics

Never Events – There are currently 3 ongoing Never Event investigations, with the most recent case occurring in February 2024 but being declared (StEIS reported) in March 2024. All investigations are being progressed and in accordance with the Trust governance processes. The

Never Events reflect special cause variation of a concerning nature and therefore is reflective of the cluster of Never Events had over a short period of time within a rolling 12-month timeframe.

Complaint actions overdue – work continues to reduce out-of-date actions across Gynaecology/Hewitt and Maternity, with only 4 remaining (reduced from 11) reflecting a special cause variation of an improving nature. Improvements required continue to be addressed at the weekly complaint meeting to support changes in the process.

Workforce metrics

- Positive trends with minimal vacancies across nursing & midwifery areas continue. Maternity leave, whilst not reflected in these figures, remains a challenge for these areas. There are a number of medical roles at junior / middle grade level out to advert as part of our approach to proactively fill vacancies and respond to a rota review identifying additional doctors are required in line with increased activity and acuity levels. Turnover continues to be assessed in respect of areas of concern, and retention and turnover are being specifically looked at in N&M as part of an NHSE funded 12 month post 'People Promise Manager'.
- Mandatory Training metrics are showing a static position (following statistically significant improvements over the last 12 months). The updated Trust Integrated Performance Report will include benchmark data to provide further context and identify opportunities for improvement.
- Sickness is in normal variation having been statistically reduced in the last 18 months. Again, benchmark data will be included in the updated Integrated Performance Report.
- In March 2023 PDR rates were at 69%. They reached a peak of 86% in September 23 and rates have remained stable since this point with February 24 data at 83.67%. The PDR rates reflect the greater emphasis on delivery of mandatory training in clinical areas and some challenges with scheduling. Staff survey results reflected that although most staff stated they have had a PDR, the majority were dissatisfied with the quality. In response, a review is currently underway to move to a model of group PDRS for many clinical staff groups, supplemented by optional career conversations.

RECOMMENDATION

The Board of Directors is asked to:

- note the content of the report
- note the Quality, Operational and Workforce Performance Report.
- Note the Executive Risk and Assurance Group Report

Appendices

Appendix A - Quality, Operational and Workforce Performance Report

Appendix B - Executive Risk and Assurance Group Report – May 2024

Liverpool Women's
NHS Foundation Trust

Trust Board

Performance Report

April 2024

Integrated Performance Report

Contents

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	8
KPIs Failing Target	15
KPIs Hit and Miss	5
KPIs No Target	1

KPIs Improving Variation	9
KPIs Concerning Variation	4
KPIs Common Cause Variation	16

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
Complaints: Number Received	<=	<= 15	6	P	L
MAU - Face to face Maternity Triage within 30 Mins	>=	>= 95%	99.81%	P	H
Proportion of patient activity with an ethnicity code	>=	>=96%	97.24%	P	H

Good - Celebrate & Understand

KPI	Target < or >	Target	P	A	V
18 Week RTT: Incomplete Pathway > 78 Weeks	<=	0	0	?	L
Diagnostic Tests: 6 Week Wait	>=	>= 99%	91.96%	?	H
Infection Control: Clostridium Difficile	<=	0	0	P	
Infection Control: MRSA	<=	0	0	P	
NHSE / NHSI Safety Alerts Outstanding	<=	0	0	P	
Total Number of Patient Safety Incident Investigations (Rolling)	<=	30	19	P	
Turnover Rate	<=	<= 13%	11.76%	P	
Venous Thromboembolism (VTE)	>=	>= 95%	94.73%	?	H

Average - Investigate & Understand

KPI	Target < or >	Target	P	A	V
Number of Open Patient Safety Incident Investigations	<=	8	19		
18 Week RTT: Incomplete Pathway > 65 Weeks	<=	0	140	?	
A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge	>=	>= 90%	90.47%	?	

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 > 52 Weeks	<=	0	1600	F	
Cancer: 62 Day referral to Treatment	>=	>=85%	28.26%	F	
Capped Theatre Utilisation rate	>=	>= 85%	67.10%	F	
Friends & Family Test: A&E % positive	>=	95%	82.18%	F	
Friends & Family Test: In-patient/Daycase % positive	>=	95%	91.88%	F	
Friends & Family Test: Maternity % positive	>=	95%	80.65%	F	
Mandatory Training	>=	>= 95%	92.61%	F	H
Mandatory Training (Clinical)	>=	>= 95%	88.29%	F	H
Prevention of Ill Health: Flu Vaccine Front Line Clinical Staff	>=	>= 80%	40.88%	F	
Sickness Absence Rate	<=	<= 4.5%	5.73%	F	
Uncapped Theatre Utilisation rate	>=	>= 85%	73.03%	F	H

Very Concerning - Investigate & Take Action

KPI	Target < or >	Target	P	A	V
Cancer: 28 Day Faster Diagnosis	>=	>= 75%	53.94%	F	L
Cancer: 31 Day decision to treat to treatment	>=	>=96%	54.55%	F	L
Never Events (Rolling 12 Months)	<=	0	3	F	H
Overall size of active patient waiting list	<=	<= 16500	18887	F	H

Investigate & Understand

KPI	Target < or >	Target	P	A	V

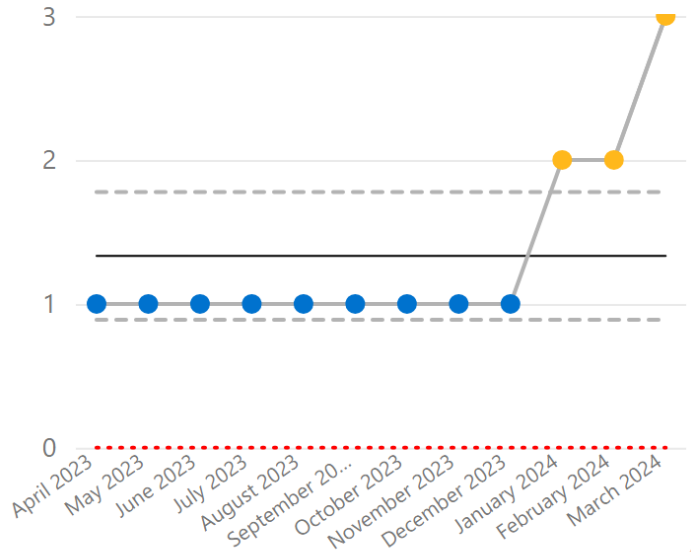
Section 3: To deliver **Safe** Services

KPI	Assurance Category	Date	Target	Target < or >	Performance	Assurance	Variation	Trend
Infection Control: Clostridium Difficile	Good	March 2024	0	<=	0	P		
Infection Control: MRSA	Good	March 2024	0	<=	0	P		
MAU - Face to face Maternity Triage within 30 Mins	Excellent	March 2024	>= 95%	>=	99.81%	P	H	
Never Events (Rolling 12 Months)	Very Concerning	March 2024	0	<=	3	F	H	
NHSE / NHSI Safety Alerts Outstanding	Good	March 2024	0	<=	0	P		
Number of Open Patient Safety Incident Investigations	Average	March 2024	8	<=	19			
Total Number of Patient Safety Incident Investigations (Rolling)	Good	March 2024	30	<=	19	P		
Venous Thromboembolism (VTE)	Good	March 2024	>= 95%	>=	94.73%	?	H	

To deliver **Safe** Services - Exceptions

Never Events (Rolling 12 Months) - Medical Director

Assurance Category	Very Concerning
Date	March 2024
Target	0
Target < or >	<=
Performance	3
Assurance	
Variation	



To deliver Safe services - Safer Staffing

March 2024					
WARD	Fill Rate Day % RN/RM *	Fill Rate Day % Care staff **	Fill Rate Night % RN/RM *	Fill Rate Night % Care staff **	Supporting narrative (RN/RM = *; Care staff = **)
Gynae Ward	86.29%	80.11%	92.47%	103.23%	*/**March staffing fill rates are reflective of the increase this month of both long- and short-term sickness, alongside maternity leave. Safe staffing has been maintained due to the low bed occupancy of 60.22% in the inpatient area and the ability to flexibly rotate staff from the HDU which is based on the inpatient ward when there are no patients, the bed occupancy on HDU was recorded as 63.65%.
Induction & Delivery Suites	84.52%	83.87%	82.37%	93.55%	*Staffing in this department has been affected by sickness in March , the maternity bleepholder will match acuity by movement of registered staff to achieve 1:1 care in labour (of which there were no incident reports in March of inability to provide). MLU shift leaders have moved rosters to be based on DS and this has increased planned DS staffing to 16 per day. Vacant shifts are requested to be filled with NHSP up to planned staffing numbers.
Maternity & Jeffcoate	80.00%	106.45%	84.27%	91.13%	*/**As per supporting narrative for other wards. it is imperative that this ward is supported with staffing to maintain clinical safety and to ensure appropriate discharge flow. Redeployment of registered staff by the Maternity bleepholder, from areas with low acuity, gave additional registered staff to support the vacant shifts. All of these vacant shifts were requested to be filled with NHSP at earliest opportunity.
MLU	79.03%	96.77%	73.39%	77.42%	*/**MLU was fully operational day and night in the month of March. Band 7 shift leaders have now been moved to Delivery Suite roster and means MLU staff now planned at 3 per day and night which is a better match for acuity. Occupancy remains low in this department, which also further allows staff to be redeployed when required to support 1:1 care in DS and NIPE provision on Matbase.
Neonates (ExTC)	93.21%	100.00%	93.89%	101.61%	*/**Fill rates reflect the neonatal unit occupancy in March. Total occupancy over the month was at 82.8%, which is an increase in total occupancy since February. Occupancy in ITU areas was above the expected 80%. The number of and acuity of the babies on the unit is reflected in the RN and care staff fill rates throughout the month. Safe staffing was maintained and CHPPD (Care Hours Per Patient Day) are as would be expected.
Transitional Care	32.26%	135.48%	67.74%	100.00%	*/**Fill rates reflect the transitional care occupancy in March, most of the care is provided by care staff who are clinical support workers in this area thus higher numbers of care staff than registered staff. TC occupancy increased slightly to 61.7%, therefore some shifts only required 1 member of staff which was either a clinical support worker or a RN, hence the increased percentage of fill rates in care staff. Safe staffing was maintained and CHPPD (Care Hours Per Patient Day) are as would be expected

To deliver Safe services - Safer Staffing

Gynaecology: March Fill Rate

Fill rate – The underfilled staffing rate for March reflects the Long-term sickness and Maternity Leave. Safe staffing has been maintained due to the low bed occupancy in the inpatient ward and the High Dependency Unit (HDU). The low bed occupancy allowed for the rotation of staff from the HDU to support the inpatient area.

Attendance/ Absence – overall sickness and absence for the month of March was recorded as 13.85% an increase of 4.75% from February sickness, no themes were able to be determined from the rise. Long term sickness marginally increased in March which accounted for 60.08%, with short-term sickness marginally decreasing to 39.92%. Maternity leave in March remains at 1.61% WTE staff.

Red Flags – No Red Flags raised in March.

Bed Occupancy –Bed occupancy for the Gynaecology inpatient unit is recorded as 60.22%, The High Dependency Unit bed occupancy is recorded as 63.65%

CHPPD - For the month of March the CHPPD was reported to be 7.5 overall, a slight decrease on the previous month, which was 7.8. The split between Registered and unregistered care staff was 4.4 for Registered Nurse staff and 3.2 for Health Care Assistant.

Neonates: March Fill Rate

Fill rate – Occupancy increased across the acute area of the neonatal unit in March with occupancy in all areas being at 82.8%. Safe staffing has been maintained and fill rates are reflective of acuity and occupancy. There were no patients transferred out of LWH to deliver elsewhere due to capacity. There was 1 incident reported of a delay in repatriation of a baby to their local neonatal unit, which was escalated appropriately to the Northwest Neonatal ODN.

Attendance/ Absence – Sickness was reported at 6.34 % which is a slight increase from the previous month, the top reason for sickness in March was anxiety, stress, and depression. Long term sickness increased to 69.51% of all sickness. All sickness is being managed in line with the attendance management policy. In cases where staff are experiencing stress, anxiety, and depression, they have been signposted to LWH staff support and are being contacted regularly by team leaders.

Vacancies – Rolling annual turnover increased to 13.08% with three leavers and three new starters in March. There were 6.45 band 6 vacancies, and 22 band 5 vacancies on the neonatal unit at the beginning of the month. All band 5 vacancies have been successfully recruited to following interviews in March. Most of the vacancy was due to staff being promoted to newly created band 6 and 7 posts for the Liverpool Neonatal Partnership (total of 18 posts with 15 nurses from LWH being successfully appointed). The band 6 interviews are due to take place in April 2024. There have been ongoing challenges recruiting to seven 8a vacant ANNP posts therefore the advert was withdrawn and Clinical Fellows appointed to the vacant ANNP posts. Interviews for these posts took place in December 2023. 3 applicants were successful and will commence in July 2024. The remaining 8a vacancy has been converted to 8b posts and have been approved at vacancy panel in early February. Interviews will take place in early April.

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

Bed Occupancy –The total unit occupancy was above the expected 80% at 82.8% in March, occupancy in the acute ITU area was 91.1% and HDU at 78.5% Occupancy rates for March per area were: ITU 82.80%; HDU 78.50%; LDU 80.3% and TC 61.7%.

CHPPD – Within the critical care areas the care hours provided in March are as would be expected for babies being nursed in ITU with 12.5 Care hours per patient day (CHPPD)overall. The breakdown shows higher hours of registered nurse care and lower non- registered care. This split of 11.2 hrs of registered nurses and 1.3 healthcare support workers. This is as expected considering that most of these babies need care by a nurse qualified in speciality. In Transitional care, the care hours per patient day provided in March shows higher hours of care provided by non-registered carers than registered nurses with total care hours per patient day of 7.8 hours, the split is 5.5 care hours provided by the care staff and 2.3 hours provided by registered nurses which is reflective of the care model in transitional care.

To deliver Safe services - Safer Staffing

Maternity: March Fill Rate

Fill-rate – Where planned staffing requirements could not be met due to unavailability, all vacant shifts were escalated to NHSP to attempt to cover with temporary staffing solutions. Maternity continued to undertake a minimum 4-hourly activity /acuity review, which allows senior midwifery staff to maintain safety by rotating staff to the areas of highest clinical need using risk based responsive decision making, with daily reporting and weekly Gold command meetings with the LMNS. Mutual aid was requested by other providers on 3 occasions in March of which LWH declined due to acuity at time of request. LWH did not send any patients to other providers during March for mutual aid.

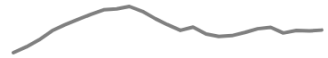
Attendance/ Absence – Maternity continues to report levels of sickness above the Trust threshold of 4.5% which is included in the headroom, within its Midwifery and support staff group. Sickness in month decreased to 5.95%, from February and at the same point last year, sickness was 9.25%. The leading cause of absence remains the same for STS, cough/cold/flu, which due to short notice reporting provided challenges in fill with temporary staffing solutions for both registered and care staff. Maternity LTS is 43% which represents 20 cases, of which 2 will be resolved early April. Divisional LTS management meeting led by HR and DHoM place with Managers/ Matrons, with escalation meetings for short term absence patterns ongoing. 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 within the 0–3-month timescale. Maternity leave equates to 15.28 wte (18 headcount) 16 are within the Registered Midwives staffing group and 2 within unregistered support staff and is reflective of the age profile of the workforce. It is important to note that AL was significantly higher in March due to a number of factors (new starters, LTS return and staff using up allocation). The directive from SLT is to apply a consistent 15% AL requirement within roster approval process. All staff communications has directed staff to book AL for 24/25 and for ward managers to approve by end of April 24.

Vacancies – The Maternity Service has recruited into all current and projected vacancies.

Red Flags – During March, 38 Midwifery Red Flags were identified which is a significant increase, these are attributed to IOL delays over 12hrs and increased reporting through the IOL QI project lead. The QI has a planned implementation date of 30/4/24. 1:1 Care in Labour was maintained at 100%. There were no triage breaches of over 30 minutes in MAU and 15 minutes triage was recorded at 96.77%. The department had 1550 admissions in March and is remaining consistent in its performance.

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. 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. 100% of women received 1:1 care by a Midwife. 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 combined for March which is consistent with the previous months. The BirthRate Plus Ward Based Acuity Tool is underway on Matbase but has taken time and training for Shift leaders to become accustomed to using it correctly therefore data is not able to be analysed currently but will be reflected in future reporting when available.

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

KPI	Assurance Category	Date	Target	Target < or >	Performance	Assurance	Variation	Trend
18 Week RTT: Incomplete Pathway > 52 Weeks	Concerning	March 2024	0	<=	1600	F		
18 Week RTT: Incomplete Pathway > 65 Weeks	Average	March 2024	0	<=	140	?		
18 Week RTT: Incomplete Pathway > 78 Weeks	Good	March 2024	0	<=	0	?	L	
A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge	Average	March 2024	>= 90%	>=	90.47%	?		
Cancer: 28 Day Faster Diagnosis	Very Concerning	February 2024	>= 75%	>=	53.94%	F	L	
Cancer: 31 Day decision to treat to treatment	Very Concerning	February 2024	>=96%	>=	54.55%	F	L	
Cancer: 62 Day referral to Treatment	Concerning	February 2024	>=85%	>=	28.26%	F		
Diagnostic Tests: 6 Week Wait	Good	March 2024	>= 99%	>=	91.96%	?	H	
Overall size of active patient waiting list	Very Concerning	March 2024	<= 16500	<=	18887	F	H	
Proportion of patient activity with an ethnicity code	Excellent	March 2024	>=96%	>=	97.24%	P	H	

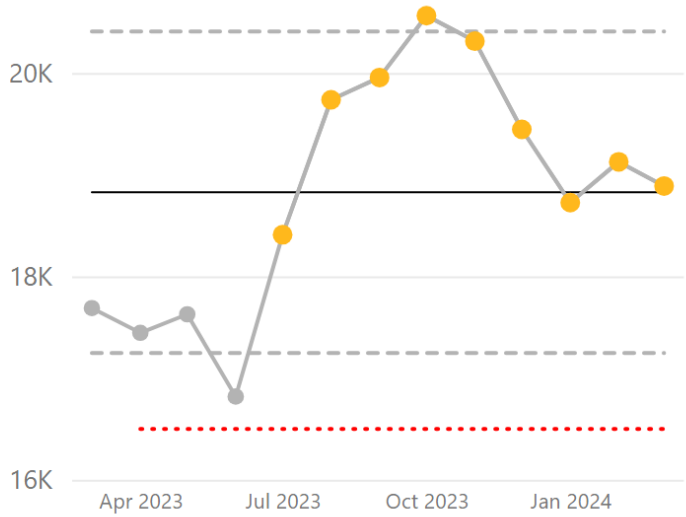
*Following KPI's have nationally set targets as part of Operational Planning Guidance for 23/24:

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

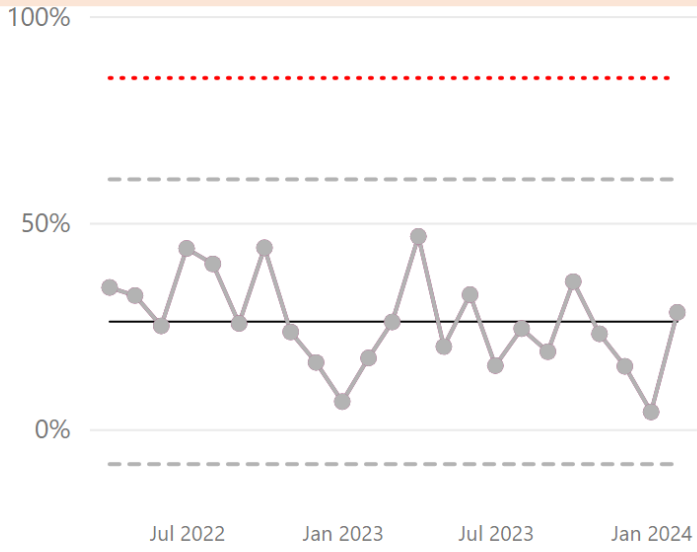
Overall size of active patient waiting list - Chief Operating Officer

Assurance Category	Very Concerning
Date	March 2024
Target	<= 16500
Target < or >	<=
Performance	18887
Assurance	F
Variation	H



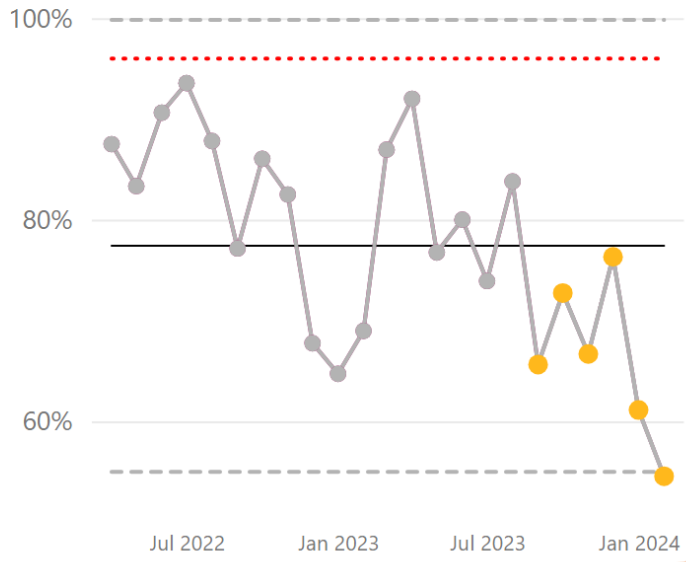
Cancer: 62 Day referral to Treatment - Chief Operating Officer

Assurance Category	Concerning
Date	February 2024
Target	>=85%
Target < or >	>=
Performance	28.26%
Assurance	F
Variation	



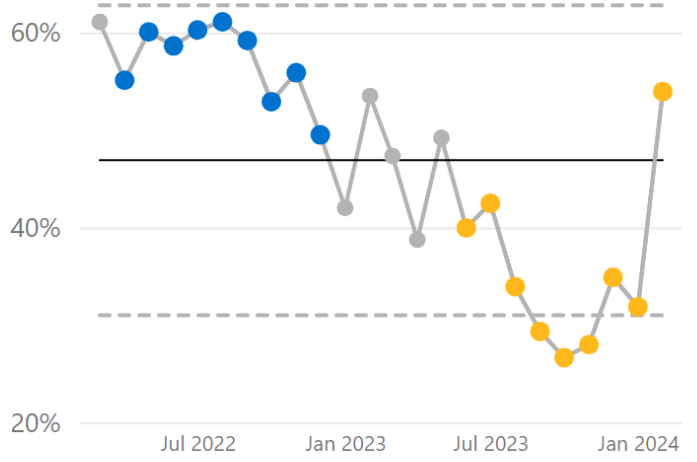
Cancer: 31 Day decision to treat to treatment - Chief Operating Officer

Assurance Category	Very Concerning
Date	February 2024
Target	>=96%
Target < or >	>=
Performance	54.55%
Assurance	F
Variation	L



Cancer: 28 Day Faster Diagnosis - Chief Operating Officer

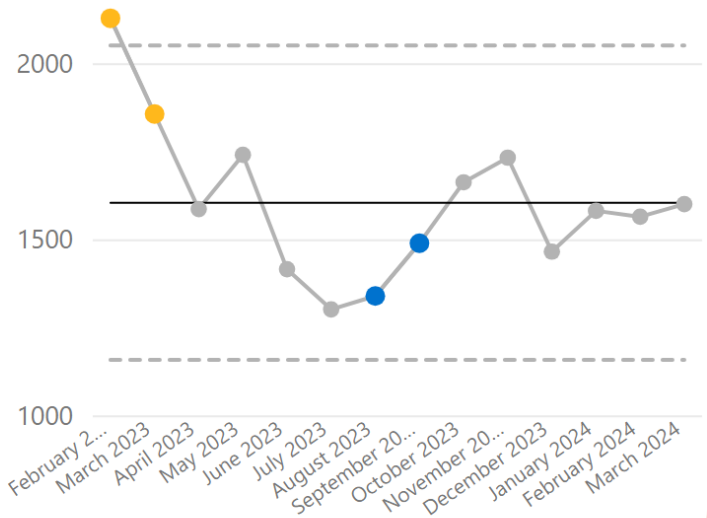
Assurance Category	Very Concerning
Date	February 2024
Target	>= 75%
Target < or >	>=
Performance	53.94%
Assurance	F
Variation	L



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

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

Assurance Category	Concerning
Date	March 2024
Target	0
Target < or >	<=
Performance	1600
Assurance	
Variation	



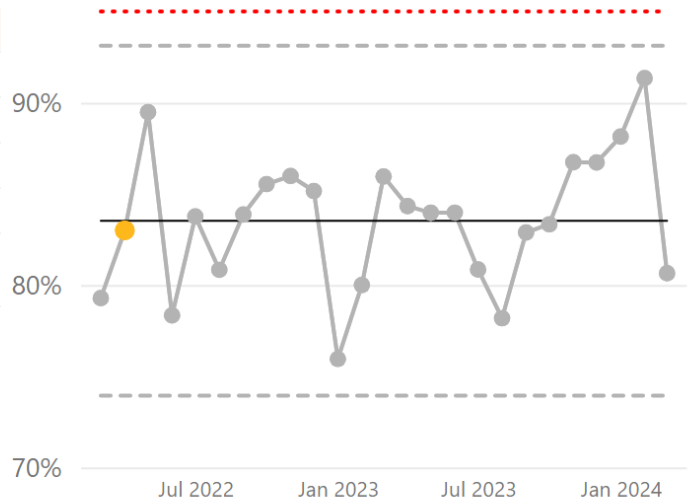
Section 5: To deliver the best possible **Experience** for patients and staff

KPI	Assurance Category	Date	Target	Target < or >	Performance	Assurance	Variation	Trend
Complaints: Number Received	Excellent	March 2024	<= 15	<=	6	P	L	
Friends & Family Test: A&E % positive	Concerning	March 2024	95%	>=	82.18%	F		
Friends & Family Test: In-patient/Daycase % positive	Concerning	March 2024	95%	>=	91.88%	F		
Friends & Family Test: Maternity % positive	Concerning	March 2024	95%	>=	80.65%	F		

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

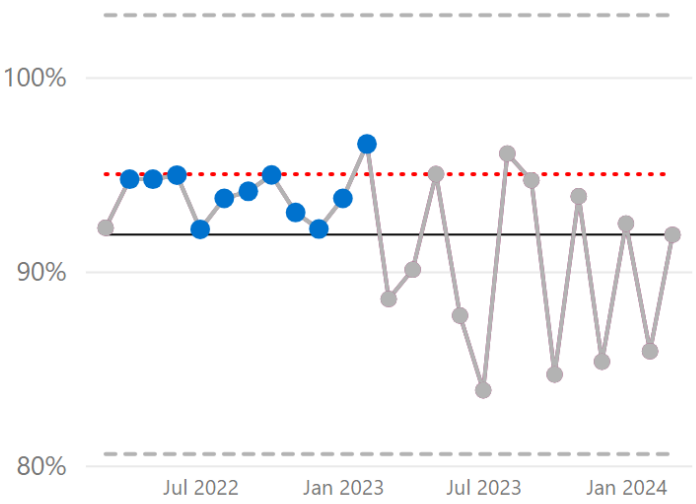
Friends & Family Test: Maternity % positive - Chief Nurse

Assurance Category	Concerning
Date	March 2024
Target	95%
Target < or >	>=
Performance	80.65%
Assurance	
Variation	



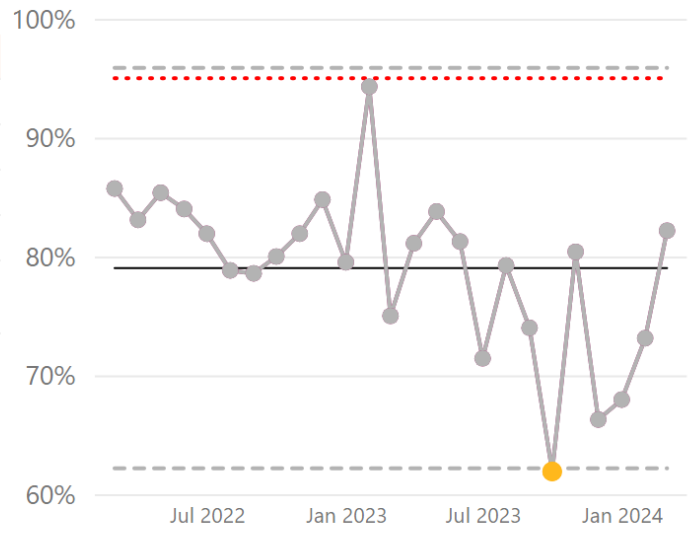
Friends & Family Test: In-patient/Daycase % positive - Chief Nurse

Assurance Category	Concerning
Date	March 2024
Target	95%
Target < or >	>=
Performance	91.88%
Assurance	
Variation	



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

Assurance Category	Concerning
Date	March 2024
Target	95%
Target < or >	>=
Performance	82.18%
Assurance	
Variation	



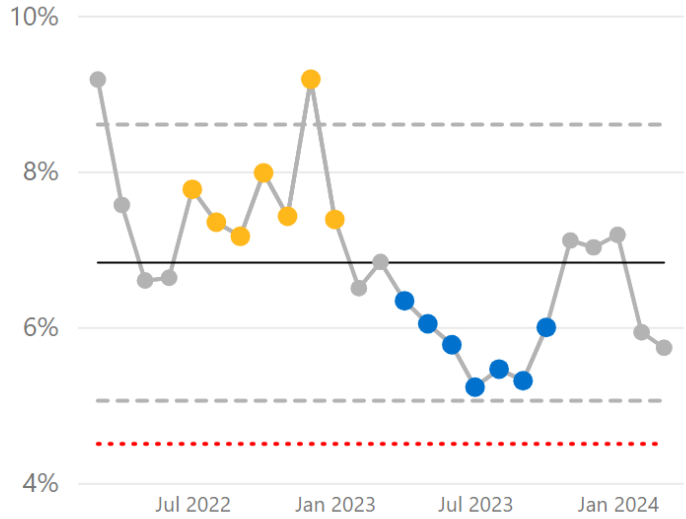
Section 6: To develop a well led, capable, motivated and entrepreneurial **Workforce**

KPI	Assurance Category	Date	Target	Target < or >	Performance	Assurance	Variation	Trend
Mandatory Training	Concerning	March 2024	>= 95%	>=	92.61%	F	H	
Mandatory Training (Clinical)	Concerning	March 2024	>= 95%	>=	88.29%	F	H	
Prevention of Ill Health: Flu Vaccine Front Line Clinical Staff	Concerning	February 2024	>= 80%	>=	40.88%	F		
Sickness Absence Rate	Concerning	March 2024	<= 4.5%	<=	5.73%	F		
Turnover Rate	Good	March 2024	<= 13%	<=	11.76%	P		

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

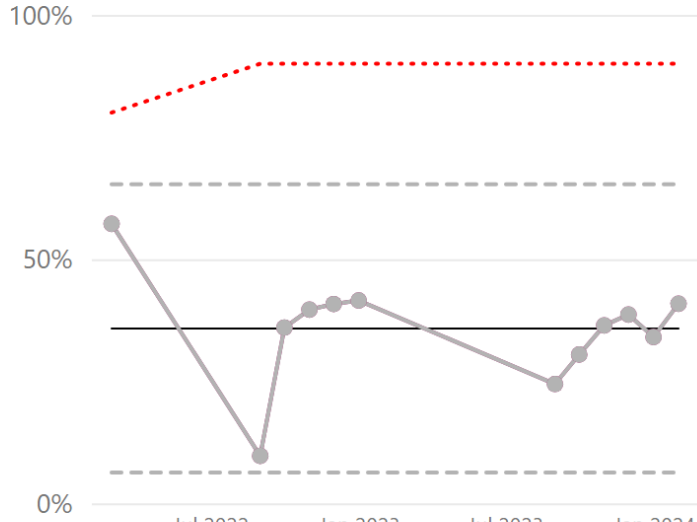
Sickness - Chief People Officer

Assurance Category	Concerning
Date	March 2024
Target	<= 4.5%
Target < or >	<=
Performance	5.73%
Assurance	
Variation	



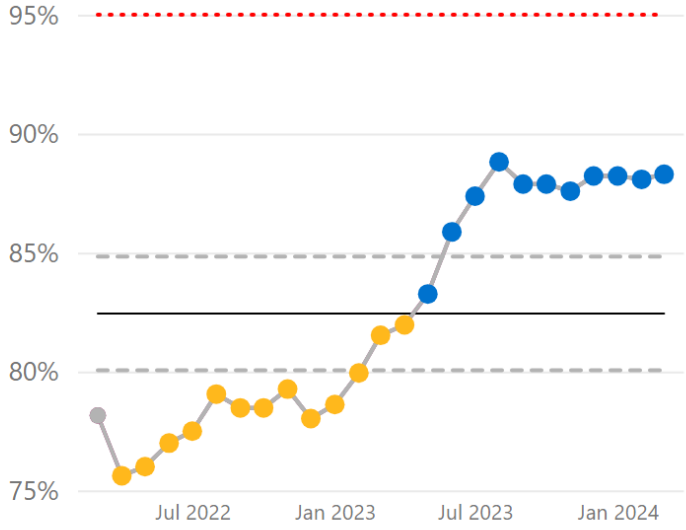
Prevention of Ill Health: Flu Vaccine Front Line Clinical Staff - Chief People Officer

Assurance Category	Concerning
Date	February 2024
Target	>= 80%
Target < or >	>=
Performance	40.88%
Assurance	
Variation	



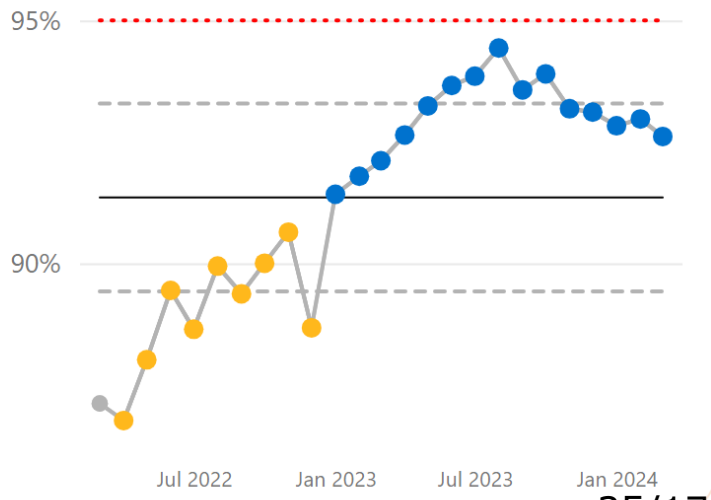
Mandatory Training (Clinical) - Chief People Officer

Assurance Category	Concerning
Date	March 2024
Target	>= 95%
Target < or >	>=
Performance	88.29%
Assurance	
Variation	



Mandatory Training - Chief People Officer

Assurance Category	Concerning
Date	March 2024
Target	>= 95%
Target < or >	>=
Performance	92.61%
Assurance	
Variation	



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

Executive Risk & Assurance Group Assurance Report

Report to	Trust Board
Date	9th May 2024
Meeting Name	Executive Risk & Assurance Group
Date of Meeting	16th April 2024
Chair's Name & Title	Jenny Hannon, CFO & Deputy CEO

Agenda Items

The following agenda items were discussed by the meeting:

1. Executive Risk and Assurance Group Terms of Reference and Work Plan 2024/25
2. Executive Group Terms of Reference and Work Plans 2024/25
3. High Scoring Risk Report – Corporate Services
4. Executive Group Reports
    a. Finance & Performance
    b. People & Organisational Development
    c. Research
5. Divisional Board Reports
    a. Family Health
    b. Gynaecology
    c. Clinical Support Services
6. Policy Update
7. Board Assurance Framework
8. Operational, Quality and Workforce Report

Matters for Escalation from ERAG to the Board

Workforce Issues

1) Staff Turnover: The issue of staff turnover was discussed, with particular focus on the challenges posed by having a turnover ceiling higher than comparator trusts (13%). The potential impact on the organisation's National Oversight Framework segment three exit criteria was flagged, and consideration was given to setting a more ambitious, yet realistic target based on benchmarking data. It was agreed that there would need to be appropriate strategies in place to manage turnover and maintain operational efficiency.

2) Diabetes Service Staffing: There were concerns expressed about the sustainability of the diabetes service due to staffing challenges. This was linked to workforce-related risks impacting clinical services.

3) Dietetics Staffing: Concerns about the dietetic service staffing were raised. This issue was escalated to the ERAG to ensure that action could be taken to ensure continuity of service and appropriate staffing.

For both the diabetes and dietetics staffing risks, work was underway with Liverpool University Hospitals NHS FT to develop sustainable staffing models.

4) Anaesthetics Staffing: A high-risk issue was identified regarding anaesthetics capacity out of hours. The discussion noted a lack of capacity during in-hours leading to increased out-of-hours activity. Actions relating to this risk are included within the Trust Improvement Plan.

Research Performance
It was noted that whilst the Trust was exceeding pre-Covid-19 levels for research performance, it was not meeting the NIHR target of 80% for time and target metrics, which may affect the bidding for NIHR infrastructure funding. This has been recognised by the Research Executive Led Group and the necessary improvements would be monitored closely.

Maternity Base (Matbase) Challenges
The challenges around Matbase were highlighted, and it was reported that Family Health Divisional Board had noted limited assurance on the progress of the improvement actions. Consequently, the meeting was informed that a business case is being prepared to address the environmental issues on Matbase. Further updates would be provided on the action needed to secure the necessary resources and capital investment to address these challenges.

Cancer Tier Deterioration
The meeting discussed the implications of being escalated to tier one for cancer performance. It was agreed to escalate this issue to the Board to ensure the necessary actions are taken at all levels to improve cancer care outcomes.

Out of Date Policies:
An increase in out-of-date policies was noted. There was agreement that this required immediate action as it could negatively impact the organisation's operations and compliance with regulatory standards. Assurance was provided to the meeting that there was enhanced grip in place with corporate areas and divisions and improvements were expected by the next ERAG meeting.

Decisions Made

The Executive Risk and Assurance Group Terms of Reference and Workplan were agreed, noting the amendments that had been requested by the Board.

The Executive Led Groups (Finance and Performance, Quality, Risk & Safety, People & Organisational Development, and Research) terms of reference and workplans were agreed.

Recommendations

The Board of Directors is asked to note the content of the report.

Appendix 1: Attendance Matrix

Core members	May 24	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar 25
Chief Executive	A										
Chief Finance Officer / Deputy Chief Executive	✓										
Chief Medical Officer	✓										
Chief Nurse	✓										
Chief Operating Officer	✓										
Chief People Officer	✓										
Chief Transformation Officer	✓										
Chief Digital Information Officer	A (R)										
Deputy Chief Operating Officer	✓										
Deputy Director of Nursing	✓										
Deputy Medical Director	A										
Deputy Chief Finance Officer	✓										
Deputy Director of Workforce	✓										
Head of Communications	✓										
Associate Director of Quality & Governance	A										
Head of Risk & Patient Safety	✓										
Divisional Manager, Gynaecology	✓										
Divisional Manager, CSS	A										
Divisional Manager, Family Health	✓										
Head of Nursing, Gynaecology	✓										
Head of Midwifery	✓										

Head of Nursing, Neonates	**A**										
Head of AHPs – Clinical Support Services	✓										
Clinical Director, Family Health	✓										
Clinical Director, CSS	✓										
Clinical Director, Gynaecology	✓										
Trust Secretary	✓										
Other Attendees											

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	**24/25/042**		**Date: 09/05/2024**	
Report Title	**Finance Performance: Month 12 2023/24, 2025/25 Plan**			
Prepared by	***Jen Huyton, Deputy Chief Finance Officer / Deputy Director of Strategy***			
Presented by	***Jenny Hannon, Deputy Chief Executive Officer / Chief Finance Officer***			
Key Issues / Messages	***To note the Month 12 financial position and the approved 2024/25 financial plan submission.***			
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 2023/24 Month 12 financial position and 2024/25 plan.			
Supporting Executive:	***Jenny Hannon, Deputy Chief Executive Officer / Chief Finance Officer***			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

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

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

Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* 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
Trust Board Extraordinary Meeting (2024/25 plan only)	24/04/24	CFO	2024/25 financial plan approved.
Finance, Performance and Business Development Committee	24/04/24	CFO	2024/25 financial plan recommended for approval. 2023/24 Month 12 position noted.
Finance and Performance Executive Group	16/04/24	DCFO	2024/25 financial plan received. 2023/24 Month 12 position received.

EXECUTIVE SUMMARY

2023/24 Month 12 Position

The Trust had a challenging financial plan for 2023/24 of £15.5m deficit. In November 2023 the Trust participated in the national re-forecasting exercise, resulting in a revised forecast outturn position of £22.6m deficit. The forecast outturn remained consistent throughout the remainder of the financial year, and at Month 12 the Trust reported a £22.6m deficit. This represents a £7.1m adverse variance to plan. This position is supported by £3.9m of non-recurrent items.

£7.4m of Cost Improvement Programme (CIP) savings were delivered, resulting in a £1.0m adverse variance to the CIP target of £8.3m (which equated to 5.3% of operating expenditure). £3.7m of savings were delivered recurrently.

The cash balance was £2.0m at the end of Month 12.

2024/25 Plans

The Trust Board approved the finance, activity, and workforce plan submission on 24 April 2024, summarised below:

- Income and expenditure deficit plan of £29.5m.
- Cost Improvement Programme of £5.3m.
- Capital plan of £9.8m, comprised of £4.8m Public Dividend Capital (PDC) and £5.0m Capital Departmental Expenditure Limit (CDEL).
- Workforce plan reaching 1,784.2 Whole Time Equivalents (WTEs) by Month 12 in 2024/25.
- Activity at 109% of the 2019/20 adjusted baseline.

Introduction

The Trust's financial, activity, and workforce plans for 2024/25 were approved by the Trust Board on 24 April 2024, and submitted to the Cheshire and Merseyside Integrated Care Board (C&M ICB) on the same day. The plans were formally submitted to NHS England (NHSE) on 2 May 2024, in accordance with national planning timescales.

This paper summarises both the 2023/24 Month 12 financial position and notes key elements from the 2024/25 plans.

Part A – 2023/24 Month 12 Financial Position

1. Summary Financial Position

	Plan	Actual	Variance	RAG	*R*	*A*	*G*
Surplus/(Deficit) YTD	-£15.5m	-£22.6m	-£7.1m	5	*>10% off plan*	*Plan*	*Plan or better*
I&E Forecast M12	-£15.5m	-£22.6m	-£7.1m	5	*>10% off plan*	*Plan*	*Plan or better*
NHS I/E Rating	3	3	0	1	*4*	*3*	*2+*
Cash	£4.1m	£2.0m	-£2.0m	5	*<£1m*	*£1m-£4.5m*	*£4.5m+*
Total CIP Achievement YTD	£8.3m	£7.4m	-£1.0m	5	*>10% off plan*	*Plan*	*Plan or better*
Recurrent CIP Achievement YTD	£8.3m	£3.7m	-£4.6m	6	*>10% off plan*	*Plan*	*Plan or better*
Non-Recurrent Items YTD	£1.0m	£3.9m	£2.9m	5	*>£0*		*<£0*
Capital Spend YTD	£5.1m	£4.9m	-£0.1m	6	*>10% off plan*	*Plan*	*Plan or better*

At Month 12 the Trust reported a £22.6m deficit, which represents a £7.1m adverse variance to plan. This is supported by £3.9m of non-recurrent items (net position), of which £2.9m is unplanned. This is in line with both the forecast reported at Month 11 and the Trust's revised 'H2' forecast outturn submitted in November. This position has been reported to the C&M ICB.

The Trust is currently in NHS Oversight Framework segment 3 (NOF3) and has jointly developed exit criteria with the ICB.

2. Drivers of the Position

As noted above, the position is supported by £3.9m of non-recurrent items, of which £2.9m was unplanned. The adjusted position in Month 12 (following removal of key non-recurrent items) is a deficit of £26.5m.

The key drivers of the underlying year to date position remain consistent with those reported in prior months:

- Undelivered CIP.
- Inability to unwind prior year pay investment.
- Investment in maternity post CQC inspection.
- Operational pressures; including medical staffing, unfunded cost pressures in corporate areas and estates non-pay related pressures, off-set by anaesthetic consultant vacancies and interest receivable above plan.
- API underperformance excluding industrial action impact, offset by impact of reduction in activity targets by 4%.
- Impact of pay award.

Workforce

Whole Time Equivalents (WTEs) are shown in Appendix 1. At Month 12 WTEs totalled 1,687, compared to 1,688 at M12 2022/23, with an overall shift away from temporary (bank and agency) towards substantive staff. Between

Month 11 and Month 12, WTEs have increased by 13, driven by substantive recruitment in nursing and midwifery to replace leavers from prior periods.

Enhanced controls have been implemented regarding agency spend including Divisional oversight and enhanced senior approvals required. At Month 12, the Trust reported a favourable variance of £1.6m against the agency plan. Actual agency costs of £0.7m equate to 0.7% of the Trust's overall pay costs, which benchmarks well regionally and nationally. Costs are predominantly driven by theatres (vacancy), imaging, and maternity (sickness and vacancy).

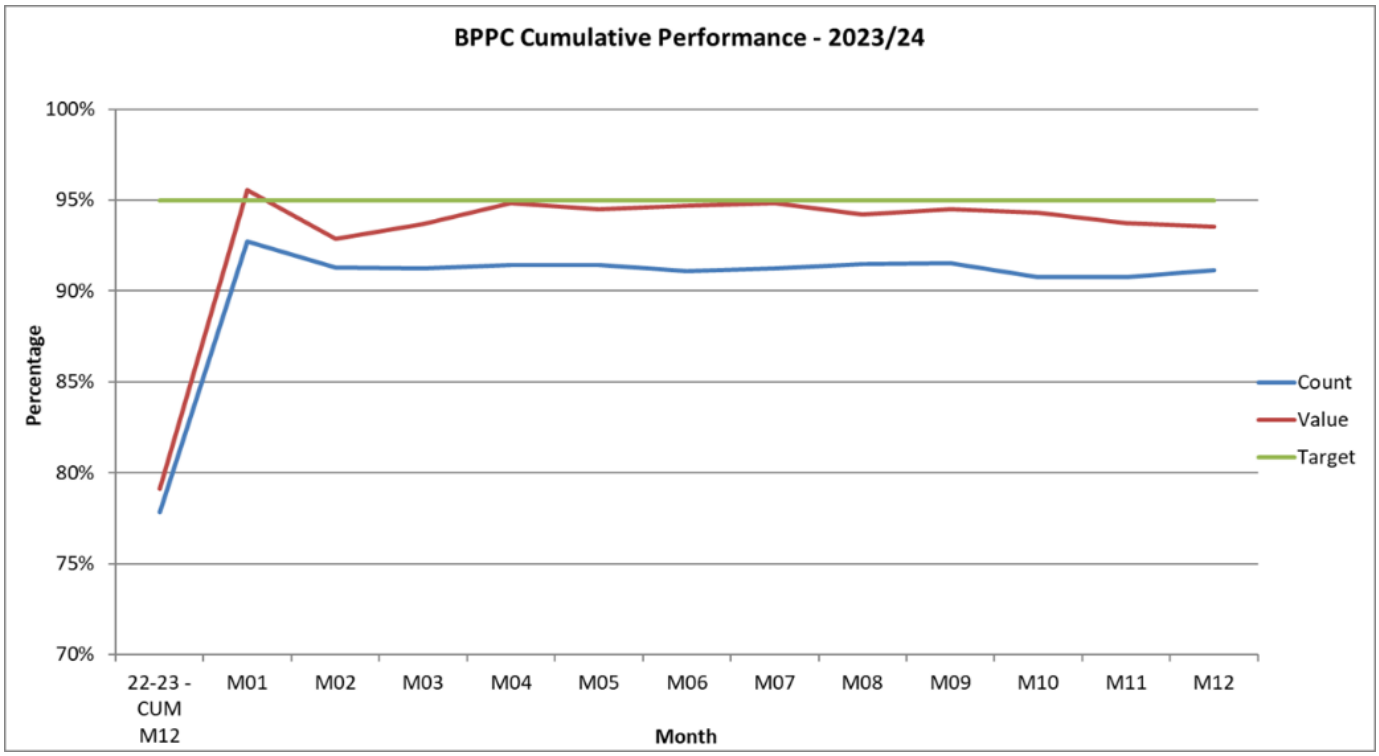
Cost Improvement Programme (CIP)
The Trust had a cost improvement programme target of £8.3m in 2023/24 (5.3% of expenditure). The Trust delivered £7.4m of CIP, which equates to 4.3% of operating expenditure and represents an adverse variance to target of £1.0m. Of this, 51% was delivered recurrently.

3. Cash and Borrowings

The Trust's cash and bank balance at the end of Month 12 was £2.0m. The Trust forecasts cashflow on a rolling 13-week basis and cash levels are monitored daily. The average cash balance throughout 2023/24 was £11.5m. During the year, the Trust received cash advances from the C&M ICB, which were repaid during quarter 4, and replaced with £20.1m of national revenue support payments. The requirement for cash support will continue in 2024/25 and is expected to be required from quarter 2 onwards.

4. 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.



5. Balance Sheet

In Month 12 debtors reduced by £3.7m as NHS debtors invoiced for quarter 4 were paid. Payables reduced by £2.9m in line with expectations. Deferred income has reduced by £8.9m; this is driven by final repayment of ICB cash support received in-year.

6. Capital Expenditure

The Trust completed the year with gross capital spend of £5.1m against its CDEL cap of £5.0m. However, spend was offset by the net book value of disposals of fixed assets in year (£0.2m), resulting in a favourable variance against the CDEL-funded capital plan of £0.1m. A further £0.3m of capital was spent on PDC-funded projects, including the Ambulatory service development which will continue in 2024/25.

7. Board Assurance Framework (BAF) Risk

There are no proposed changes to the BAF score this period, which remains at 20 (likelihood 5, consequence 4).

Part B – 2024/25 Plan

1. Plan Development and Overview

The 2024/25 financial planning round has been challenging, at Trust, local, and national levels. Multiple submissions have been required to date, both to the Cheshire and Merseyside Integrated Care Board (C&M ICB) and to NHS England (NHSE).

Increasingly challenging efficiency and savings targets have been set for Trusts in recent years. After careful consideration of historic efficiency delivery, a 3.1% target (equating to £5.3m) was included in the plan, resulting in an overall deficit plan of £29.5m. As a percentage of revenue (19.8%), this deficit remains significant when compared to other providers both regionally and nationally.

The Trust is required to deliver an increase in activity (an average of 109% of 2019/20 adjusted baseline activity), to address the backlog and elective recovery, and the NHS has been charged with delivering on financial plans, activity and access targets, and quality, with equal focus.

The proposed capital programme for 2024/25 is £9.8m, comprised of £5m business as usual capital and £4.8m of Public Dividend Capital for the ambulatory project.

The 2024/25 workforce plan includes growth of 113 whole time equivalents (WTE) (compared to actual WTEs at Month 9 2023/24), relating primarily to immediate quality and safety measures and funded service developments.

Each iteration of the plan has been scrutinised internally and considered by both the Finance, Performance, and Business Development Committee, as well as the Trust Board. Triangulation between plan elements and productivity measures have been reviewed, and risks and opportunities within the plan considered. The finance, workforce, and activity plans were formally approved for submission by the Trust Board on 24 April 2024.

2. Income and Expenditure

The Trust was required to use the 2023/24 outturn position (as projected at Month 9) as a starting point for the 2024/25 plan. This was a deficit of £23.4m. Movement between 2023/24 outturn and 2024/25 plan is summarised below:

2023/24 Outturn		£m
	-	23.4
23/24 Impact to 2024/25		
Non-recurrent items 2023/24	-	2.3
Core capacity 2023/24	-	1.0
Commissioner income changes		0.3
CNST above tariff assumptions	-	1.1
New pressures 2024/25		
Depreciation	-	0.5
Distressed finance	-	0.2
Immediate quality and safety invetsment	-	2.5
Other (e.g., activity delivery, excess inflation)	-	1.4
Tariff and convergence factor impact	-	2.8
CIP		5.3
2024/25 Plan	-	29.5

3. Cost Improvement Programme

The CIP target for 2024/25 is £5.3m, which represents 3.1% of expenditure budgets (following adjustment for pass through costs). A Project Management Office (PMO) approach is being taken to ensure rapid identification and validation of CIP schemes and completion of documentation, as part of the Trust's overall improvement programme.

4. Capital Budgets

The Trust's overall capital budget for 2024/25 is £9.8m, comprising £5.0m CDEL allocation and £4.8m PDC in respect of the ambulatory project. Capital allocations remain significantly constrained, in line with 2022/23 and 2023/24, and are capped at a lower level than internally generated capital. As a result, there is a constraint on non-essential capital investment with only schemes rated as critical included in the programme for 2024/25.

5. Cash and Working Capital

Given the scale of the deficit plan, cash support will be required during 2024/25. The financial regime is in place to allow NHS organisations to access revenue support in the form of PDC if required. This form of revenue support does not need to be paid back however it does incur a dividend payment (3.5%). An increase in PDC costs has been included in the 2024/25 plan, and the Trust will continue to work with system partners and explore alternate options for cash support to reduce the requirement for PDC support.

6. Workforce

The 2024/25 workforce plan totals 1,784.2 WTEs by Month 12 2024/25. This includes net growth of 113.4 compared to actual WTEs at Month 9 (the required starting point for 2024/25 plans), and 97.2 compared to actual WTEs at Month 12 2023/24. This growth relates to:

- Immediate quality and safety measures (47.2WTE, approved by the Trust Board).
- Funded service developments, including the Liverpool Neonatal Partnership, Cheshire West fertility transfer, and the Community Diagnostic Centre (58.6WTE).
- Other (net of efficiency savings) (7.6WTE).

7. Activity and Access Targets

The 2024/25 activity plan assumes that the Trust will achieve 109% of the 2019/20 elective recovery fund (ERF) GBP baseline. Base/core capacity assumes 100% delivery, plus a productivity stretch of 2% and a change in

pathway/insourcing model for outpatients delivers an additional 7%. Note that whilst this delivers 109% of activity in income, this is equivalent to 108.3% in activity unit terms.

Conclusion & Recommendation

The Trust Board is asked to note the Month 12 position and the financial, activity, and workforce plans for 2024/25.

Appendices

Appendix 1 – Board Finance Pack, Month 12

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

FINANCE REPORT: M12

YEAR ENDING 31 MARCH 2024

Liverpool Women's
NHS Foundation Trust

Contents

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
INCOME & EXPENDITURE: M12
YEAR ENDING 31 MARCH 2024

INCOME & EXPENDITURE £'000	MONTH 12 Budget	 Actual	 Variance	YTD Budget	 Actual	 Variance	FULL YEAR Budget	 Actual	 Variance
Income									
Clinical Income	(11,495)	(10,802)	(693)	(137,517)	(136,944)	(573)	(137,517)	(136,944)	(573)
Non-Clinical Income	(636)	(871)	235	(7,416)	(7,682)	266	(7,416)	(7,682)	266
Total Income	**(12,132)**	**(11,673)**	**(458)**	**(144,933)**	**(144,626)**	**(306)**	**(144,933)**	**(144,626)**	**(306)**
Expenditure									
Pay Costs	7,414	8,547	(1,134)	91,102	99,646	(8,544)	91,102	99,646	(8,544)
Non-Pay Costs	3,220	3,964	(743)	38,631	38,286	346	38,631	38,286	345
CNST	1,800	1,483	317	21,603	20,432	1,172	21,603	20,432	1,172
Total Expenditure	**12,434**	**13,994**	**(1,560)**	**151,337**	**158,363**	**(7,026)**	**151,337**	**158,364**	**(7,027)**
EBITDA	**303**	**2,321**	**(2,018)**	**6,404**	**13,737**	**(7,333)**	**6,404**	**13,738**	**(7,333)**
Technical Items									
Depreciation	548	826	(278)	6,579	6,712	(133)	6,579	6,712	(133)
Interest Payable	1	9	(8)	21	23	(2)	21	23	(2)
Interest Receivable	(16)	(34)	18	(200)	(564)	364	(200)	(564)	364
PDC Dividend	220	191	29	2,645	2,746	(101)	2,645	2,746	(101)
Profit/Loss on Disposal or Transfer Absorption	0	12	(12)	0	(57)	57	0	(57)	57
Total Technical Items	**753**	**1,004**	**(251)**	**9,045**	**8,860**	**185**	**9,045**	**8,860**	**185**
(Surplus) / Deficit	**1,056**	**3,325**	**(2,269)**	**15,450**	**22,597**	**(7,148)**	**15,450**	**22,598**	**(7,148)**

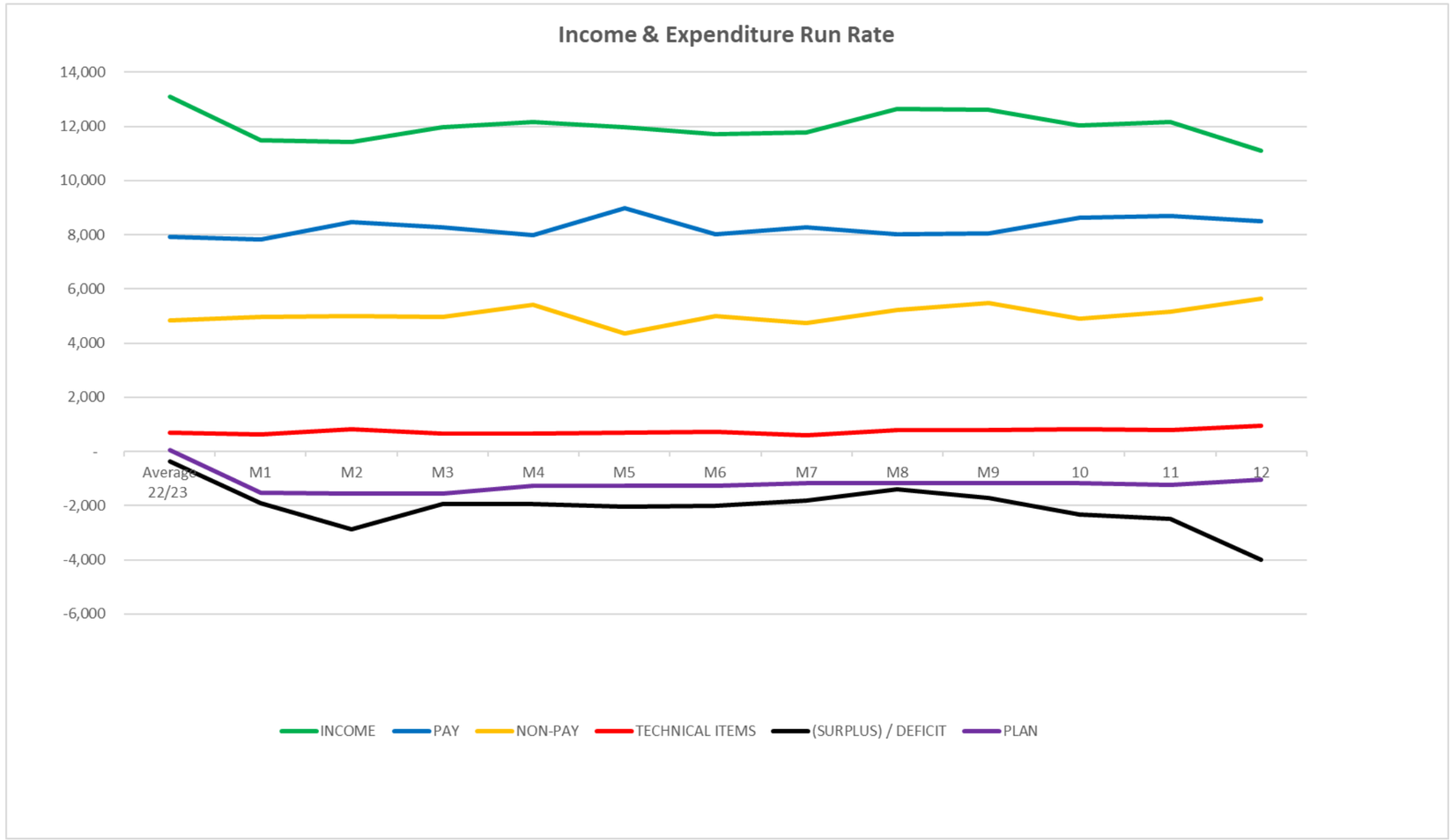
NHS
Liverpool Women's
NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 2
WTE: M12
YEAR ENDING 31 MARCH 2024

TYPE	DESCRIPTION	M12	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	Movement M11 - M12	Movement M12 - M12
SUBSTANTIVE	REGISTERED NURSING, MIDWIFERY & HEALTH VISITING STAFF	631.94	648.33	649.61	645.49	636.13	640.11	636.48	658.66	668.25	655.72	654.84	648.06	664.88	16.82	32.94
	ALLIED HEALTH PROFESSIONALS	82.04	81.95	81.35	83.27	83.57	85.45	86.39	86.27	85.87	84.95	84.68	82.91	83.29	0.38	1.25
	OTHER REGISTERED SCIENTIFIC, THERAPEUTIC & TECHNICAL STAFF	11.78	11.31	11.31	12.31	11.31	12.31	14.31	12.31	14.31	14.31	13.31	12.81	11.31	(1.50)	(0.47)
	REGISTERED HEALTH CARE SCIENTISTS	49.22	53.62	54.54	54.34	55.34	57.34	60.98	65.47	67.23	67.63	65.43	63.87	61.48	(2.39)	12.26
	HCA & SUPPORT TO CLINICAL STAFF	234.51	237.51	244.48	237.49	242.70	241.16	247.75	242.56	235.98	232.33	233.53	230.10	229.76	(0.34)	(4.75)
	MANAGERS & SENIOR MANAGERS	59.92	63.32	64.32	61.32	59.02	62.57	62.09	60.39	57.99	60.69	62.59	65.09	61.19	(3.90)	1.27
	ADMIN AND ESTATES STAFF	13.00	13.00	13.00	14.00	14.00	15.00	15.00	15.00	15.00	15.00	15.00	14.00	13.00	(1.00)	0.00
	OTHER INFRASTRUCTURE & SUPPORT STAFF	288.12	288.08	284.17	285.09	279.25	276.78	278.59	275.93	276.62	276.69	275.37	280.35	285.33	4.98	(2.79)
	MEDICAL AND DENTAL	185.09	190.90	191.67	193.80	190.34	197.14	200.02	195.05	195.72	194.66	193.97	194.47	195.69	1.22	10.60
	ANY OTHER STAFF	14.00	14.00	14.00	14.00	14.00	14.00	14.00	13.60	13.99	13.99	13.00	14.50	13.50	(1.00)	(0.50)
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**	**1,630.96**	**1,615.97**	**1,611.72**	**1,606.16**	**1,619.43**	**13.27**	**49.81**
BANK	REGISTERED NURSING, MIDWIFERY & HEALTH VISITING STAFF	47.33	37.81	43.37	45.40	34.57	30.12	36.07	36.62	39.71	32.91	43.19	26.92	28.56	1.64	(18.77)
	ALLIED HEALTH PROFESSIONALS	17.42	13.00	16.78	15.67	11.15	10.48	13.45	13.31	14.60	10.70	16.84	9.93	10.18	0.25	(7.24)
	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	0.60	0.45	0.22	0.39	0.15	(0.24)	(0.13)
	HCA & SUPPORT TO CLINICAL STAFF	31.22	25.76	25.13	24.57	21.87	19.20	18.79	19.07	21.07	18.64	25.08	13.40	14.05	0.65	(17.17)
	MANAGERS & SENIOR MANAGERS	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00	0.00
	ADMIN AND ESTATES STAFF	-	0.23	0.12	0.09	-	0.05	-	-	0.07	0.07	-	0.07	0.23	0.16	0.23
	OTHER INFRASTRUCTURE & SUPPORT STAFF	6.25	7.27	6.44	4.36	4.89	6.82	4.20	2.34	5.35	3.17	3.79	11.35	8.84	(2.51)	2.59
	MEDICAL AND DENTAL	2.00	2.80	2.80	2.00	2.00	1.94	1.97	0.93	0.03	0.03	2.15	1.44	1.44	0.00	(0.56)
	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**	**81.43**	**65.97**	**91.27**	**63.50**	**63.45**	**(0.05)**	**(41.05)**
AGENCY	REGISTERED NURSING, MIDWIFERY & HEALTH VISITING STAFF	8.23	10.49	2.03	0.08	2.11	2.76	2.68	3.14	-	-	-	-	-	0.00	(8.23)
	ALLIED HEALTH PROFESSIONALS	4.04	1.23	3.26	3.26	2.92	2.60	3.28	2.90	2.95	0.21	1.05	3.10	3.87	0.77	(0.17)
	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	-	-	-	-	-	-	-	0.95	-	-	0.89	-	(0.89)	(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**	**3.90**	**0.21**	**1.05**	**3.99**	**3.87**	**(0.12)**	**(9.50)**

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**	**1,716.29**	**1,682.15**	**1,704.04**	**1,673.65**	**1,686.75**	**13.10**	**(0.74)**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
INCOME & EXPENDITURE RUN RATE: M12
YEAR ENDING 31 MARCH 2024



Note: Non-recurrent items have been removed from the figures above

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 4
CIP: M12
YEAR ENDING 31 MARCH 2024

	YTD			FULL YEAR		
	Target	Actual	Variance	Target	Actual	Variance
Income	2,965	1,167	(1,798)	2,965	1,167	(1,798)
Pay	3,082	87	(2,995)	3,082	87	(2,995)
Non-Pay	2,289	2,463	174	2,289	2,463	174
Total Recurrent	**8,336**	**3,717**	**(4,619)**	**8,336**	**3,717**	**(4,619)**
Income	0	325	325	0	325	325
Pay	0	1,508	1,508	0	1,508	1,508
Non-Pay	0	1,812	1,812	0	1,812	1,812
Total Non-Recurrent	**0**	**3,645**	**3,645**	**0**	**3,645**	**3,645**
TOTAL CIP DELIVERY	**8,336**	**7,362**	**(974)**	**8,336**	**7,362**	**(974)**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
CASHFLOW STATEMENT: M12
YEAR ENDING 31 MARCH 2024

5a

CASHFLOW STATEMENT £'000	Actual
Cash flows from operating activities	(20,466)
Depreciation and amortisation	5,886
Impairments and reversals	0
Income recognised in respect of capital donations (cash and non-cash)	0
Movement in working capital	(5,192)
Net cash generated from / (used in) operations	**(18,963)**
Interest received	584
Purchase of property, plant and equipment, ROU and intangible assets	(6,636)
Proceeds from sales of property, plant and equipment and intangible assets	256
Net cash generated from/(used in) investing activities	**(5,796)**
PDC distressed funding received	20,100
PDC Capital Programme Funding - received	299
Loans from Department of Health - repaid	(612)
Interest paid	(23)
PDC dividend (paid)/refunded	(2,746)
Net cash generated from/(used in) financing activities	**17,018**
Increase/(decrease) in cash and cash equivalents	**(7,741)**
Cash and cash equivalents at start of period	9,790
Cash and cash equivalents at end of period	**2,049**

Finance Support	2023/22 Q4 £000	2023/24 Q1 ACTUAL £000	2023/24 Q2 ACTUAL £000	2023/24 Q3 ACTUAL £000	2023/24 M10 ACTUAL £000	2023/24 M11 ACTUAL £000	2023/24 M12 ACTUAL £000	2023/24 Total £000
ICB cash support	6,000	6,800	9,600	5,000	0	0	0	21,400
ICB cash repayment	(6,000)	0	0	0	(5,850)	(7,775)	(7,775)	(21,400)
National cash support	4,500	0	0	0	6,000	6,000	8,100	20,100
Total support required	**4,500**	**6,800**	**9,600**	**5,000**	**150**	**(1,775)**	**325**	**20,100**
DH Loan repayment	612	0	306	0	0	0	306	612
DH Loan outstanding year end	918							306

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST **5b**
CASHFLOW ROLLING FORECAST: M12
YEAR ENDING 31 MARCH 2024

	Plan Apr-24 £000	Plan May-24 £000	Plan Jun-24 £000	Plan Jul-24 £000
Opening cash	**1,948**	**5,249**	**3,023**	**1,068**
Income flows				
NHS England	2,279	2,279	2,279	2,279
ICB Income	8,308	8,308	8,308	8,308
NHS Trust/FT	529	530	529	530
Private patients	391	391	391	391
Overseas	10	10	10	10
ICR/RTA scheme	3	4	4	4
Non-NHS (Wales/Man)	257	257	257	257
R&D	133	133	133	133
HEE/other E&T - paid via NHSE	377	378	377	378
Other	100	99	100	99
Bank interest	17	17	17	17
Total operating inflows	**12,404**	**12,406**	**12,405**	**12,406**
Expenditure flows				
Wages and salaries	(4,300)	(4,400)	(4,400)	(4,400)
HMRC	(2,050)	(2,050)	(2,050)	(2,050)
Pensions	(1,250)	(1,250)	(1,250)	(1,250)
CNST - cash movement	(2,276)	(2,276)	(2,276)	(2,276)
Other expenditure (ex depn)	(3,316)	(3,365)	(3,364)	(3,339)
VAT recovery	50	100	100	75
PDC/Loan (inc Ambulatory PDC)	250	500	500	1,000
Interest payable	(2)	(2)	(2)	(2)
Capital plan	(641)	(981)	(1,210)	(1,297)
Total operating outflows	**(13,535)**	**(13,724)**	**(13,952)**	**(13,539)**
Other cash in/outflows				
National/local distressed finance support	0	0	0	1,500
National payroll	0	0	0	0
Accrued/Deferred income	4,632	(408)	(408)	(408)
Capital creditors	(200)	(500)	0	0
NHS Resolution MIS	0	0	0	0
TOTAL CASH IN GBS ACCOUNT	**5,249**	**3,023**	**1,068**	**1,026**
Barclays, bank rec and cash in hand	50	50	50	50
TOTAL CASH HOLDING	**5,299**	**3,073**	**1,118**	**1,076**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 6
CAPITAL EXPENDITURE: M12
YEAR ENDING 31 MARCH 2024

			Full Year - Original Plan			Full Year - Revised Plan		
Funding source	**Area**	**Capital Scheme**	**PLAN**	**ACTUALS**	**VARIANCE**	**PLAN**	**ACTUALS**	**VARIANCE**
CDEL	IT	EPR frontline digitisation	560	891	-331	910	891	19
CDEL	IT	IT/digital investment - Infrastructure Investment	1,290	1,022	268	1,118	1,022	96
CDEL	IT	IT/digital investment - Hardware	354	142	212	140	142	-2
CDEL	IT	Community diagnostic equipment	153	0	153	0	0	0
CDEL	IT	Community diagnostic IT	65	0	65	0	0	0
CDEL	Estates	Building works/refurbishment - Maternity	950	392	558	350	392	-42
CDEL	Estates	Building works/refurbishment - Neonatal	180	75	105	80	75	5
CDEL	Estates	Building works/refurbishment - Gynaecology	300	111	189	111	111	-0
CDEL	Estates	Estates programme	560	930	-370	933	930	3
CDEL	Medical Equipment	Medical equipment - Clinical Support - Fluoroscopy	241	0	241	0	0	0
CDEL	Medical Equipment	Medical equipment - Clinical Support - Theatres	107	83	24	89	83	6
CDEL	Medical Equipment	Medical equipment - All other clinical areas	1,041	1,355	-314	1,341	1,355	-14
CDEL	Medical Equipment	Medical equipment - leased blood gas analysers	139	65	74	139	65	74
CDEL	F&F	Furniture & Fittings	0	92	-92	80	92	-12
CDEL		Contingency/VAT savings/slippage to 2024-25/accommodate in 2022/23	-905	-70	-835	-71	-70	-1
			5,035	**5,089**	**(54)**	**5,220**	**5,089**	**131**
CDEL	Accounting	Disposals at NBV - Impact on CDEL	0	-185	185	-185	-185	0
			5,035	**4,904**	**131**	**5,035**	**4,904**	**131**
Other funding sources								
PDC	CSE	Ambulatory Scheme	0	250	-250	250	250	0
PDC	CSS	PACS - image sharing - CAMRIN programme	49	49	0	49	49	0
CHARITY	Gynaecology	Bereavement Suite - gynaecology - CHARITY	70	0	70	0	0	0
			5,154	**5,203**	**(49)**	**5,334**	**5,203**	**131**

Trust Board

COVER SHEET

Agenda Item (Ref)	***24/25/043***		**Date: 09/05/2024**	
Report Title	LWH Improvement Plan Highlight Report 1			
Prepared by	***Tim Gold; Chief Transformation Officer LUHFT & LWH***			
Presented by	***Tim Gold; Chief Transformation Officer LUHFT & LWH***			
Key Issues / Messages	***To provide a delivery progress update on the Trust's Improvement Plan***			
Action required	Approve ☐	Receive ☐	Note ☒	Take Assurance ☐
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable): n/a			
	*For Decisions - in line with Risk Appetite Statement – Y/**N*** *If no – please outline the reasons for deviation.*			
	The Board of Directors is asked to note the completion of the Mobilisation Phase of the Improvement Plan, and receive the first Highlight Report which summarises delivery progress and key points to note. ***The work undertaken within the Mobilisation Phase has been summarised in an Improvement Plan Portfolio Definition Document which is appended to the Highlight Report.***			
Supporting Executive:	***Tim Gold; Chief Transformation Officer LUHFT & LWH***			

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

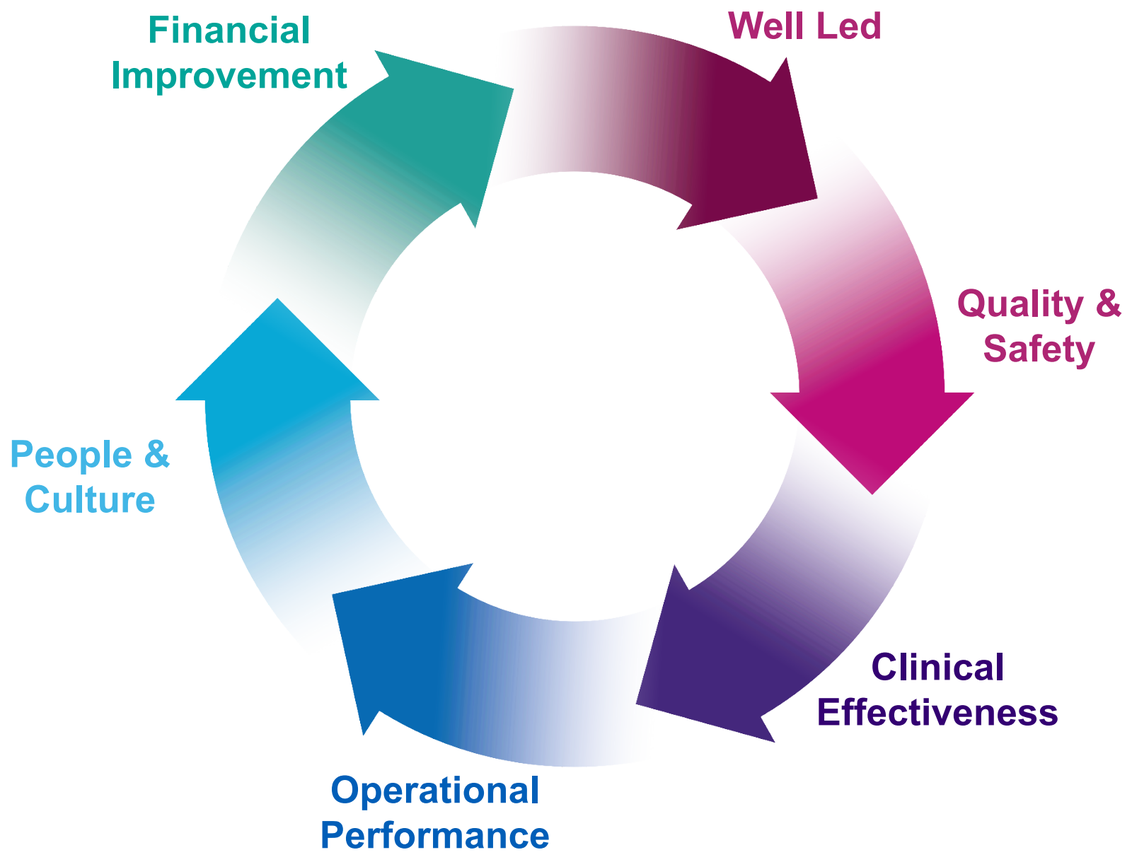
REPORT DEVELOPMENT:

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

OUR IMPROVEMENT PLAN

SAFETY | QUALITY | SUSTAINABILITY

NHS
Liverpool Women's
NHS Foundation Trust



Liverpool Women's NHS FT

Improvement Plan Highlight Report
Trust Board – 9 May 2024

Highlight Report 1

Heatmap

LWH Improvement Plan	Overall		Plan		Benefits		Issues		Risks		Resources		Stakeholders	
	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔
1. Quality & Safety	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔
1.1 Deteriorating Patient Collaborative	G	↔	Y	↔	G	↔	G	↔	Y	↔	G	↔	G	↔
1.2 CQC & MSP Actions	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔
2. Clinical Effectiveness	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔
2.1 Enhanced Workforce for Acute Workload	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔
2.2 Acute Gynae Services	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔
2.1 Medicines Safety	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔
2.2 LWH Transfusion Lab	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔
3. Operational Performance	Y	↔	G	↔	Y	↔	G	↔	Y	↔	G	↔	Y	↔
3.1 Cancer Improvement	Y	↔	G	↔	A	↔	G	↔	A	↔	G	↔	A	↔
3.2 Reduced Waiting List	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔
4 People & Culture	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔
4.1 Safety Culture	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔
4.2 Actively Anti-Racist Organisation	G	↔	G	↔	G	↔	G	↔	Y	↔	Y	↔	G	↔
5. Financial Improvement	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔
5.1 Delivering the Three Year Financial Plan	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔
5.2 2024/25 CIP Delivery	G	↔	G	↔	G	↔	G	↔	Y	↔	G	↔	G	↔
6. Well Led	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔
6.2 Streamlined Governance	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔
6.3 Risk Management	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔
6.4 Partnership Governance	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔

Improvement Plan Summary Update

Embed a culture of continuous improvement and safety for all, minimising risks and ensuring high-quality, sustainable services through collaboration, challenge, and openness

KEY FOCUS – LAST PERIOD

At the April Board, the Improvement Plan Mobilisation was at the halfway point of a 10-week schedule. Notably, the Plan had defined its Vision and Strategic Objectives and established 16 constituent projects aimed at improving service delivery and financial stability.

Governance structures were being refined, with the first Improvement Plan Portfolio Board meeting scheduled for early May to review project initiation documents. The Transformation Delivery Unit has also been established to support and drive effective delivery of the LWH Improvement Plan.

It was noted that the first Improvement Plan Highlight Report would report to the Board in May 2024 to ensure transparency and Project to Board reporting of the Improvement Plan.

KEY FOCUS – NEXT PERIOD

Launching the Improvement Plan Performance Dashboard with Improvement Plan Target Benefits in SPC charts and Peer Comparators where appropriate.

Formal launch of *Our Improvement Plan* within LWH starting with In The Loop Briefing. The Trust will also attend it's third System Oversight Group (SOG) meeting with the ICB on May 15th.

Key programme activities include:

- Setting and tracking revised cancer FDS and 62 day trajectories
- Defining Deteriorating Patient PDSA cycles
- Design work for gynae ED pathways
- Preparing to install the Diabots blood transfusion solution
- Anti-racism cultural baseline work
- Detailed planning and implementation of 24/25 CIP schemes
- Harmonisation of new Risk Management processes

IP RISK & ISSUE PROFILE

Changes to the Improvement Plan delivery and risk profile will be reporting here now that the programme is operational – there are currently no 12+ risks or issues to report.

IP BENEFITS PROFILE

The Trust is in the process of identifying qualitative and quantitative benefits for the Improvement Plan and associated Key Performance Indicators (KPIs). Appendix 2 sets out the Target Benefits that will be summarised in an Improvement Plan Performance Dashboard for future Board meetings.

SIGNIFICANT RISKS AND ISSUES (>=12/15)

ID	Project Name	Issue Title	Score	Controls in Place	Manager	Last reviewed
There are no 12+ Improvement Plan Issues to report.						

ID	Project Name	Risk Title	Score	Controls in Place	Manager	Last reviewed
There are no 12+ Improvement Plan Risks to report.						

Quality & Safety Programme Update – SRO: Dianne Brown

To minimise risks, optimise on site safety and deliver high quality care.

LWH Improvement Plan	Overall		Plan		Benefits		Issues		Risks		Resources		Stakeholders	
	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔
1. Quality & Safety	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔
1.1 Deteriorating Patient Collaborative	G	↔	Y	↔	G	↔	G	↔	Y	↔	G	↔	G	↔
1.2 CQC & MSP Actions	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔

LAST PERIOD

N/A – Mobilisation Phase just completed

NEXT PERIOD

The Deteriorating Patient Collaborative launched on 3 May 2024 with good engagement. Digital recognised as a key enabler and therefore it has been noted that digital milestones needs to be further specified within the delivery plan.

KEY POINTS TO NOTE

A progress update on CQC and MSSP actions is to be provided to the System Oversight Group on 15th May.

Clinical Effectiveness Programme Update – SRO: Lynn Greenhalgh

To strengthen healthcare delivery through an enhanced workforce for acute services, with a strong focus on Medicine Safety, and establishing a Blood Transfusion Laboratory on site.

LWH Improvement Plan	Overall		Plan		Benefits		Issues		Risks		Resources		Stakeholders	
	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔
2. Clinical Effectiveness	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔
2.1 Enhanced Workforce for Acute Workload	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔
2.2 Acute Gynae Services	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔
2.1 Medicines Safety	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔
2.2 LWH Transfusion Lab	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔

LAST PERIOD

N/A – Mobilisation Phase just completed

NEXT PERIOD

The Acute Gynae improvement plan has seen the introduction of the new project manager who will start in mid-May, and the ongoing resolution of pushback on job plans. The failure to appoint a lead for the acute gynae service is being addressed.

The Enhanced Workforce initiative is awaiting feedback on the proposal for a 24/7 resident consultant obstetrician. Recruitment of postgraduate doctors is in progress, and a meeting with consultant anaesthetists is scheduled to discuss increased consultant cover.

In Medicines Safety, the identified project lead's return from annual leave will see them addressing service gaps and supporting the first formal meeting of the pharmacy board on 17 May. The establishment of a monthly governance meeting and the creation of a medicines safety dashboard are also anticipated.

The Blood transfusion laboratory has initiated biweekly task and finish meetings, with the first meeting set for the immediate future, which will be an important focus in the current period.

KEY POINTS TO NOTE

The unresolved issues in the Acute Gynae improvement plan, particularly the unfilled lead role and job plan pushback are under close review and may require additional controls.

The outcome of the feedback on the 24/7 consultant proposal and the discussions with consultant anaesthetists could have significant implications for the Enhanced Workforce plan.

The successful establishment of the pharmacy board, governance meetings, and the medicines safety dashboard are critical to the Medicines Safety plan – progress will be updated through future Highlight Reports..

Operational Performance Programme Update – SRO: Gary Price

Improve the Trust's Elective & Cancer Performance to reduce the amount of time patients are waiting for diagnosis and treatment.

LWH Improvement Plan	Overall		Plan		Benefits		Issues		Risks		Resources		Stakeholders	
	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔
3. Operational Performance	Y	↔	G	↔	Y	↔	G	↔	Y	↔	G	↔	Y	↔
3.1 Cancer Improvement	Y	↔	G	↔	A	↔	G	↔	A	↔	G	↔	A	↔
3.2 Reduced Waiting List	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔

LAST PERIOD

N/A – Mobilisation Phase just completed

NEXT PERIOD

Work has progressed against the National GIRFT Gynaecology Further Faster checklist which has identified areas for attention to support the waiting list reduction. Delivery against these identified areas will now be taken forward with milestones focussed on capacity building.

KEY POINTS TO NOTE

In a letter received on 26 April 2024 from NHS England, it was confirmed that following a review of cancer performance, and in agreement with the regional team, the Trust will be in Tier 1 for Cancer from the week commencing 29 April 2024.

In response, the Trust will work collaboratively with Cheshire & Merseyside Cancer Alliance and the regional NHS England teams to accelerate performance improvements, and this will be tracked and monitored via the Improvement Plan report.

The ongoing risk to cancer recovery, including potential impact on NOF3 Exit is being assessed and will be included in future Highlight Reports.

People & Culture Programme Update – SRO: Michelle Turner

To drive a truly inclusive culture, underpinned by shared values and respect for diversity, with strong leadership and teamwork, and an openness to learning in a psychologically safe setting.

LWH Improvement Plan	Overall		Plan		Benefits		Issues		Risks		Resources		Stakeholders	
	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔
4 People & Culture	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔
4.1 Safety Culture	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔
4.2 Actively Anti-Racist Organisation	G	↔	G	↔	G	↔	G	↔	Y	↔	Y	↔	G	↔

LAST PERIOD

N/A – Mobilisation Phase just completed

NEXT PERIOD

The Safety Culture Project Initiation Document (PID) has been finalised, and the Anti-racism Hub is now operational, with recruitment including clinical staff successfully completed. A community engagement event to promote active anti-racism is scheduled for 14 May 2024, and is eagerly anticipated.

Compliance with our online Equality, Diversity, and Inclusion (EDI) training is strong, with 93% of the workforce now trained. Additionally, 600 staff members have completed the more intensive 3.5-hour face-to-face EDI training, accounting for 44% of our targeted group.

Finally, negotiations are underway with a potential external partner to further support our initiatives.

KEY POINTS TO NOTE

Actively anti-racism project lead scheduled to be on a long-term absence from next month which has the potential to impact capacity and resources. This has been identified as a project risk.

Financial Improvement Programme Update – SRO: Jenny Hannon

Development and delivery of a Three-Year Plan to improve and sustain the financial position of the Trust.

LWH Improvement Plan	Overall		Plan		Benefits		Issues		Risks		Resources		Stakeholders	
	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔
5. Financial Improvement	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔
5.1 Delivering the Three Year Financial Plan	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔
5.2 2024/25 CIP Delivery	G	↔	G	↔	G	↔	G	↔	Y	↔	G	↔	G	↔

LAST PERIOD

N/A – Mobilisation Phase just completed

NEXT PERIOD

In the 2024/25 financial year, the Trust is facing significant financial challenges and is undertaking strategic efforts to address these through a Long Term Financial Plan and a Cost Improvement Programme (CIP). In the period, the Trust has submitted a deficit plan of £29.5 million, which incorporates a CIP target of £5.3 million, aiming for a 3.1% efficiency target across operating expenditures.

Over the next quarter, the Trust plans to continue refining and implementing its financial strategies. This includes identifying and validating further schemes to meet the CIP target, with an ongoing emphasis on productivity improvements and cost management. Additional work will focus on solidifying partnerships and system integration to leverage collective resources and capabilities, aiming to optimise financial and operational outcomes in a constrained funding environment.

The CIP for 2024/25 has been distributed across divisions, with specific targets for each division to meet their portion of the overall CIP goal.

KEY POINTS TO NOTE

The Trust continues to identify and validate the CIP total for 2024/25.

Work is underway to explore how best to integrate the oversight of the CIP programme into the Improvement Plan reporting architecture.

Work is underway to refresh the long-term financial plan that was presented to the Board in September 2023 to take into account the most recent developments and approaches to sustainability.

Well Led Programme Update – SRO: James Sumner

To strengthen our processes that escalate risks effectively from service level to Boardroom, driven by a robust Improvement Plan, streamlined governance, and clear partnership arrangements.

LWH Improvement Plan	Overall		Plan		Benefits		Issues		Risks		Resources		Stakeholders	
	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔
6. Well Led	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔
6.2 Streamlined Governance	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔
6.3 Risk Management	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔
6.4 Partnership Governance	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔	G	↔

LAST PERIOD

N/A – Mobilisation Phase just completed

NEXT PERIOD

Risk Management
The Board approved the Risk Management Strategy, leading to the introduction of a new risk management approach across the Trust- socialised with the Trust Management Group. Senior management and governance leads participated in a training session focused on these new risk management processes. Additionally, the Ulysses risk management system was updated to integrate a new risk scoring system. Looking ahead, the next month will focus on reviewing all Trust risks to update their scores using the new process and aligning risks with the new ERAG structure to streamline reporting.

Streamlined Governance
The inaugural meeting of the Executive Risk and Assurance Group (ERAG) was held on May 1. The ERAG now has a robust structure, complete with Terms of Reference and Workplans for subsequent meetings, as well as a finalised meeting schedule. This structure is designed to enhance the effectiveness of governance within the organisation.

KEY POINTS TO NOTE

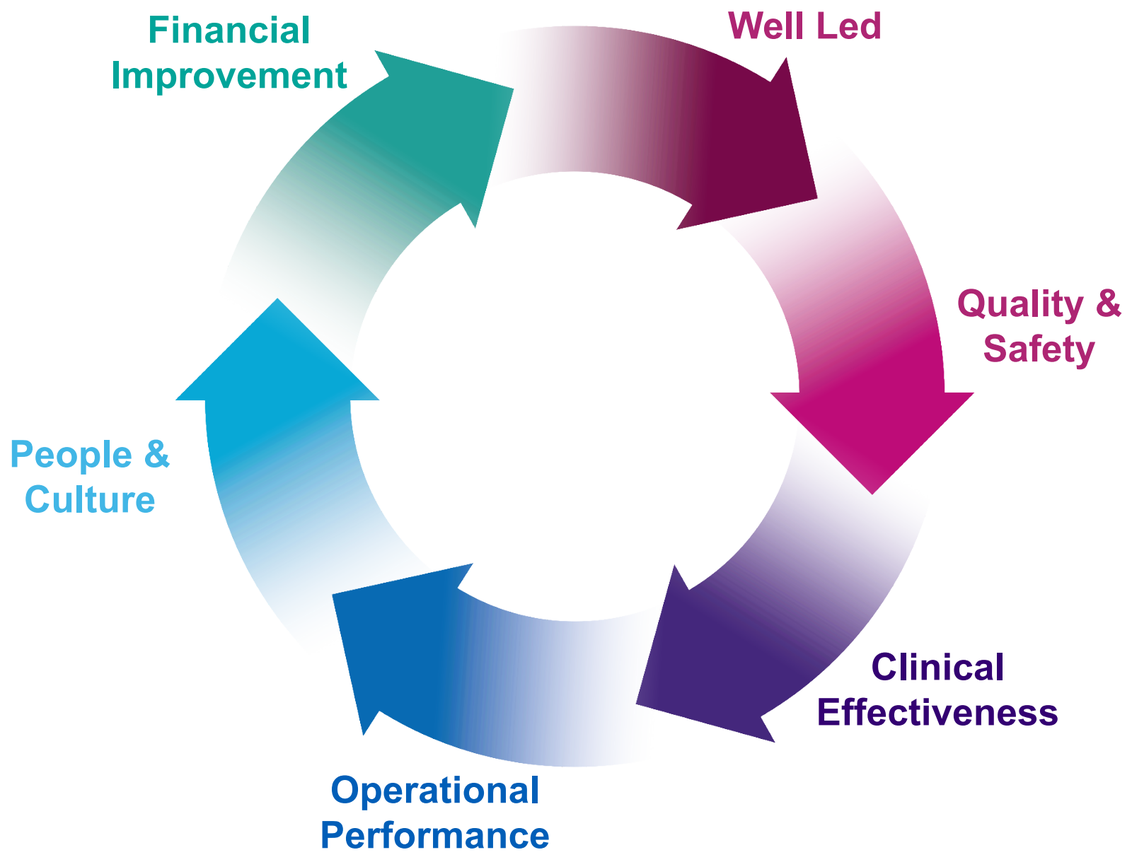
The Improvement Plan Mobilisation Phase has been completed, with formal governance and reporting now in place.

OUR IMPROVEMENT PLAN

SAFETY | QUALITY | SUSTAINABILITY

NHS
Liverpool Women's
NHS Foundation Trust

Appendices



Appendix 1 - Improvement Plan RAYG Definitions

Delivery Domains	Green (G) On Track 4 Points	Yellow (Y) Slightly Off-Track 3 Points	Amber (A) Off-Track 2 Points	Red (R) Requires Intervention 1 Point
Overall Delivery Health	Portfolio/programme/project is on track across all delivery areas- no areas assessed as *requires intervention.* **≥12**	Portfolio/programme/project is slightly off track in some delivery areas - no more than one area assessed as *requires intervention.* **≥11 ≤8**	Portfolio/programme/project is off track in some delivery areas - no more than one area assessed as *requires intervention.* **≥7 ≤4**	Portfolio/programme/project is significantly off track. Two or more areas are assessed as *requires intervention. Exception report required.* **≤3**
Plan	Portfolio/programme/project is delivering to the plan and milestones set within the Project Initiation Document and/or approved change request document. **≥85% ON TRACK**	Portfolio/programme/project is slightly off track the plan delivery timeframes set within the Project Initiation Document and/or approved change request document. **≥70% ≤84% ON TRACK**	Portfolio/programme/project plan has experienced some slippage (tolerance breeched) to delivery milestones but critical path could be maintained with recovery actions. **≥55% ≤69% ON TRACK**	Portfolio/programme/project plan has breached agreed tolerances and is unlikely deliver to the current delivery plan. **≤54% ON TRACK**
Benefits	Portfolio/programme/project is on track to deliver (or delivering) the KPIs defined in the PID. All agreed KPIs are 'passing' or are trending in a positive direction. **≥85% PASSING / POSITIVE TRENDING**	Portfolio/programme/project is on track to deliver (or delivering) the KPIs defined in the PID. Most agreed KPIs are 'passing' or are trending in a positive direction. **≥70% ≤84% PASSING / POSITIVE TRENDING**	Portfolio/programme/project is on track to deliver (or delivering) the KPIs defined in the PID. Some agreed KPIs are 'passing' or are trending in a positive direction. **≥55% ≤69% PASSING / POSITIVE TRENDING**	Portfolio/programme/project is on track to deliver (or delivering) the KPIs defined in the PID. Some agreed KPIs are 'passing' or are trending in a positive direction. **≤54% PASSING / POSITIVE TRENDING**
Issues	Portfolio/programme/project has a weighted average 'Issue Score' of **≤5**	Portfolio/programme/project has a weighted average 'Issue Score' of **≥6 ≤9**	Portfolio/programme/project has a weighted average 'Issue Score' of **≥10 ≤11**	Portfolio/programme/project has a weighted average 'Issue Score' of **≥12**
Risks	Portfolio/programme/project has a weighted average 'Risk Score' of **≤5**	Portfolio/programme/project has a weighted average 'Risk Score' of **≥6 ≤9**	Portfolio/programme/project has a weighted average 'Risk Score' of **≥10 ≤11**	Portfolio/programme/project has a weighted average 'Risk Score' of **≥12**
Resources	The sum of the Portfolio/programme/project weighted average 'Risk Score' and 'Issue Score' for risks/issues categorised as 'resource' is **≤5**	The sum of the Portfolio/programme/project weighted average 'Risk Score' and 'Issue Score' for risks/issues categorised as 'resource' is **≥6 ≤9**	The sum of the Portfolio/programme/project weighted average 'Risk Score' and 'Issue Score' for risks/issues categorised as 'resource' is **≥10 ≤11**	The sum of the Portfolio/programme/project weighted average 'Risk Score' and 'Issue Score' for risks/issues categorised as 'resource' is **≥12**
Stakeholders	The sum of the Portfolio/programme/project weighted average 'Risk Score' and 'Issue Score' for risks/issues categorised as 'stakeholders' is **≤5**	The sum of the Portfolio/programme/project weighted average 'Risk Score' and 'Issue Score' for risks/issues categorised as 'stakeholders' is **≥6 ≤9**	The sum of the Portfolio/programme/project weighted average 'Risk Score' and 'Issue Score' for risks/issues categorised as 'stakeholders' is **≥10 ≤11**	The sum of the Portfolio/programme/project weighted average 'Risk Score' and 'Issue Score' for risks/issues categorised as 'stakeholders' is **≥12**

Appendix 2 – Improvement Plan Target Benefits (1 of 2)

Quality & Safety (1)

- To increase the early detection of deterioration for women at LWH
- Reduce the rate of Unplanned HDU admissions
- Reduce the rate of transfers to LUHFT with avoidable deterioration
- A reduction in Cardio-Pulmonary resuscitation rate
- Women with a NEWS / MEOWS of 4 or more to be reviewed by ST3 or above within 30 mins and discussed with Consultant
- All patients admitted through the acute Gynaecology Service to be seen by a Consultant within 14 hours of admission
- Improved reporting of performance and managing escalations
- Reduction in the number of PSII's in the Acute Gynaecological Service compared to Oct 23 – April 24.

Clinical Effectiveness (2)

- Increased Obstetric Consultant cover on DS
- Improved Safety on Delivery Suite
- Development of ACP workforce
- Improved Experience and Supervision out of hours for Obstetric Trainees
- Reduced Spend on Agency Doctors
- Reduced workforce Gaps in O+G rota
- Increased consultant Anaesthetic cover on DS
- Improved clinical care for deteriorating patients

- Reduced attendances at GED
- Triage within 15 minutes of arrival
- Decrease in 4 hour wait breeches
- Decrease in time taken to treat
- Increase in patients accessing telephone triage
- Increase in patients accessing EPAU and not GED
- EPAU patients seen within 24 hours of referral
- Decrease in the number of clinics delivered within GED
- SBAR used for transfer of patient care from GED to the gynaecology ward
- All patients admitted through the acute gynaecology service to be seen by a consultant within 14 hours of admission
- ST3 doctor or above to be available within 30 minutes to review when requested
- Women with a NEWS/MEOWS of 4 or more to be reviewed by ST3 or above within 30 mins and discussed with consultant
- Increase in patients being treated according to NCPOD 1-3 criteria
- A formal protocol for ensuring gynaecology team are informed of and review all gynaecology patients that are outlying away from gynaecology wards ie not at LWH
- All gynaecology patients must be reviewed by a consultant during a normal working day and by a doctor ST3 or above otherwise.
- Women to be given a discharge summary to take home with a copy sent to GP
- Increased patient satisfaction
- Increased staff satisfaction
- Reduction in the number of PSII's in the Acute Gynaecological Service when compared to Oct 23- April 24

- The ability to offer 24/7 core laboratory services principally transfusion
- Reduction in cost of operating the laboratory when compared to staffing 24/7 (Haem and Transfusion Only)
- Expansion of Clinical relevant repertoire performed onsite
- Improved Turn around time for samples not currently processed at LWH site

Operational Performance (C)

- Faster Diagnosis Standard Improvement
- 62 Day Referral to Treatment Improvement
- Enhanced patient experience
- Streamlining of Admin Process
- Improved patient outcomes & patient experience
- Reduced number of urgent calls to EDSW/GPs/GED
- Improved patient outcomes & patient experience
- Reduced number of urgent calls to CNS/GPs/GED
- Reduction in patient complaints and urgent calls from patients
- Freeing up of EDSWs to provide patient support

- Missed Appointment Rate (Trust total)
- PIFU (Patient Initiated Follow Up)
- Remote Appointment rates (sustain)
- Theatre Utilisation increase
- Day Case Utilisation rate improvement
- 1st Appointment Waiting Times reduced
- PTL size (active pathways) reduced

Appendix 2 – Improvement Plan Target Benefits (2 of 2)

People & Culture

4

- Consistent and shared understanding of the safety behaviours and expectations of leaders and healthcare professionals
- (Safety Behaviour Framework)
- Alignment of Safety Culture & Continuous quality improvement methodology
- Agreed set of Safety Improvement metrics
- Engagement with Leadership Development Programme 'Leading for Safety'
- Speaking Up culture improvement
- Optimisation of digital opportunity to drive safety practice and behaviours
- To establish our Cultural Baseline to inform our priorities, allow us to measure our progress and to shape our future programmes of work

- Increased leadership cohort completing role specific training/education/coaching
- Reduction in number of GM staff reporting discrimination at work
- Reduction in number of patient PALS/complaints where discrimination is referenced or identified
- Increase in number of GM staff employed
- Increase in number of GM in leadership roles
- Reduction in number of incidents/adverse outcomes involving patients from GM
- Evidence of increasing trust and confidence measured by patient feedback eg National Patient Surveys, Local Patient Surveys, Feedback from Listening Events with local community and Improvement in GM staff perception of LW as a good place to work (Annual Staff Survey)

Financial Improvement

5

- Reduced underlying Trust deficit
- Reduced system deficit
- Improved integration in Liverpool Place (corporate and clinical)
- Reduced need for Trust and System cash support (credibility)
- Exit NOF 3
- Delivery of FT responsibility – financial sustainability
- Improved productivity outcomes

- Delivery of the 24/25 CIP target
- Delivery of recurrent CIP in 24/25
- Identification of Yr 2&3 outline plans
- Improved Board reporting
- Improved Governance and Processes
- Improved engagement & accountability

Well Led

C

- Improvement Plan launched in May 2024
- Demonstrable reduction in management time taken up with meetings
- Feedback from staff regarding meeting efficacy
- Enhance risk visibility
- Increased staff engagement

OUR IMPROVEMENT PLAN

SAFETY | QUALITY | SUSTAINABILITY

NHS
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LWH Improvement Plan

Portfolio Definition Document

Document Purpose:

Provide an overview of the LWH Improvement Plan vision, objectives, scope, governance and delivery approach.

What is an Improvement Plan?

A mechanism for delivering a trust-wide transformation programme to drive improvement consistently at scale and pace.

May, 2024
V1.0

Contents

What is the Improvement Plan trying to achieve?

Vision

Embed a culture of continuous improvement and safety for all, minimising risks and ensuring high-quality, sustainable services through collaboration, challenge, and openness.

Programme		Strategic Objectives
Quality & Safety	1	*To minimise risks, optimise on site safety and deliver high quality care.*
Clinical Effectiveness	2	*To strengthen healthcare delivery through an enhanced workforce for acute services, with a strong focus on Medicine Safety, and establishing a Blood Transfusion Laboratory on site.*
Operational Performance	3	*Improve the Trust's Elective & Cancer Performance to reduce the amount of time patients are waiting for diagnosis and treatment.*
People & Culture	4	*To drive a truly inclusive culture, underpinned by shared values and respect for diversity, with strong leadership and teamwork, and an openness to learning in a psychologically safe setting.*
Financial Improvement	5	*Development and delivery of a Three-Year Plan to improve and sustain the financial position of the Trust.*
Well Led	6	*To strengthen our processes that escalate risks effectively from service level to Boardroom, driven by a robust Improvement Plan, streamlined governance, and clear partnership arrangements.*

LWH Improvement Plan Portfolio

LWH Improvement Plan

SRO: James Sumner

Senior Responsible Owner:	Di Brown	Lynn Greenhalgh	Gary Price	Michelle Turner	Jenny Hannon	James Sumner
Programme:	1. Quality & Safety	2. Clinical Effectiveness	3. Operational Performance	4. People & Culture	5. Financial Improvement	6. Well Led
Project:	1.1 Deteriorating Patient Collaborative	2.1 Enhanced Workforce for Acute Workload	3.1 Cancer Improvement	4.1 Safety Culture	5.1 Delivering the Three Year Financial Plan	6.1 Improvement Plan Mobilisation
	1.2 CQC & MSSP Actions	2.2 Acute Gynae Services	3.2 Reduced Waiting List	4.2 Actively Anti-racist Organisation	5.2 24/25 CIP Delivery	6.2 Streamlined Governance
		2.3 Medicines Safety				6.3 Risk Management
		2.4 LWH Transfusion Lab				6.4 Partnership Governance

LWH Improvement Plan

Exit Criteria

The Improvement Plan is targeting a broad suite of benefits and KPIs (see section 2 below) to evidence successful delivery, however the four exit criteria set out opposite need to be met for LWH to exit segment 3 of the NHS Oversight Framework (NOF3).

1 Financial Improvement

- Development of a recovery plan that clearly articulates and defines the key drivers of the deficit and shows sustainable improvement addressing all agreed influenceable areas of deficit drivers (as agreed with ICB).
- Delivery of at least 2 quarters of the recovery plan to demonstrate sustainable improvement.
- Remain on I&E plan for at least 2 quarters (I&E plan as agreed within the overall system plan and in line with recovery plan).
- Compliance with national, regional and system expenditure control regimes.
- Production of rolling 13 week cashflow underpinning ongoing cash requirement (for scrutiny) and internal audit review of cashflow management processes.

2 Operational Performance

- Exit NHSE's Cancer Tier 2.
- Delivery of at least 2 quarters of locally agreed planning requirements 2024/25.

3 Quality

- Close out of CQC / MSSP Actions – Trust Board and SOG sign off of completed action plan.

4 Workforce

- Agency spend - no more than 3.2 % of total pay for 3 quarters in succession.
- Turnover - under Trust ceiling (13%) for 3 quarters in succession.
- On track delivery of Actively Anti racist Programme learning sets (within Inclusion Training Programme) delivered to 20% of workforce in each of Q1 and Q2 (24/25), demonstrating consistent progress towards target to achieve 80% of workforce trained within 24/25.

Exit Criteria

Evidence Required

Contents

Programme Scope: Quality & Safety

Programme Objective

A

To minimise risks, optimise on site safety and deliver high quality care.

Projects

B

1.1. Deteriorating Patient Collaborative	Project Objectives: • To increase the early detection of deterioration for women at LWH • Reduce the rate of transfers to LUHFT with avoidable deterioration • Reduce the rate of unplanned HDU admissions • Reduce the deterioration and associated harm by improving the prevention, identification, escalation and response to physical deterioration.
1.2 CQC & MSSP Actions	Project Objectives: • Evidence delivery of the CQC & MSSP Actions, evidenced through Trust Board & System Oversight Group sign-off.

Target Benefits

C

- To increase the early detection of deterioration for women at LWH
- Reduce the rate of Unplanned HDU admissions
- Reduce the rate of transfers to LUFT with avoidable deterioration
- A reduction in Cardio-Pulmonary resuscitation rate
- Women with a NEWS / MEOWS of 4 or more to be reviewed by ST3 or above within 30 mins and discussed with Consultant
- All patients admitted through the acute Gynaecology Service to be seen by a Consultant within 14 hours of admission
- Improved reporting of performance and managing escalations
- Reduction in the number of PSII's in the Acute Gynaecological Service compared to Oct 23 – April 24.

Programme Scope: Clinical Effectiveness

Programme Objective

A

To strengthen healthcare delivery through an enhanced workforce for acute services, with a strong focus on Medicine Safety, and establishing a Blood Transfusion Laboratory on site.

Projects

B

2.1 Enhanced Workforce for Acute Workload	Project Objectives: • Provide 24/7 consultant Obstetrician presence on the LWH site. • Increase the Post Graduate Doctor/Advanced Clinical Practitioner workforce to provide a reliable and robust O+G cover for clinical services. • Implement Senior PGD Anaesthetic cover for a Medical Emergency Team. • Provide 7-day Consultant Anaesthetic cover for Delivery Suite
2.2 Acute Gynae Services	Project Objectives: • provide a high quality acute gynaecology service at LWH and to those LWH patients at other providers in Liverpool in accordance with the RCOG standards: *Patient care gynaecology standards: providing quality care for women,* 2016. https://www.rcog.org.uk/media/mgnejcft/gynaestandards.pdf
2.3 LWH Transfusion Lab	Project Objectives: • Deliver ALR to improve patient safety and equality around access to services. • Provide a solution with minimal staffing requirements capable of running all year round. • Significantly reduce requirement for state registered biomedical scientists. • Optimise pathology diagnostic services using an automated workflow. • Make best use of the technical resource available at the CSSB/AUH sites 24/7. • Improve turn around times for samples processed at the LWH site.
2.4 Medicines Safety	Project Objectives: • Define the vision, ambition and aims of the LWH Medicines and Pharmacy Transformation and Improvement Programme. • Assess the staffing resource required to deliver the statutory medicines function alongside appropriate clinical pharmacy services to deliver safe, effective and sustainable medicines services at LWH.

Target Benefits

C

- Increased Obstetric Consultant cover on DS
- Improved Safety on Delivery Suite
- Development of ACP workforce
- Improved Experience and Supervision out of hours for Obstetric Trainees
- Reduced Spend on Agency Doctors
- Reduced workforce Gaps in O+G rota
- Increased consultant Anaesthetic cover on DS
- Improved clinical care for deteriorating patients

- Reduced attendances at GED
- Triage within 15 minutes of arrival
- Decrease in 4 hour wait breeches
- Decrease in time taken to treat
- Increase in patients accessing telephone triage
- Increase in patients accessing EPAU and not GED
- EPAU patients seen within 24 hours of referral
- Decrease in the number of clinics delivered within GED
- SBAR used for transfer of patient care from GED to the gynaecology ward
- All patients admitted through the acute gynaecology service to be seen by a consultant within 14 hours of admission
- ST3 doctor or above to be available within 30 minutes to review when requested
- Women with a NEWS/MEOWS of 4 or more to be reviewed by ST3 or above within 30 mins and discussed with consultant
- Increase in patients being treated according to NCPOD 1-3 criteria
- A formal protocol for ensuring gynaecology team are informed of and review all gynaecology patients that are outlying away from gynaecology wards ie not at LWH
- All gynaecology patients must be reviewed by a consultant during a normal working day and by a doctor ST3 or above otherwise.
- Women to be given a discharge summary to take home with a copy sent to GP
- Increased patient satisfaction
- Increased staff satisfaction
- Reduction in the number of PSII's in the Acute Gynaecological Service when compared to Oct 23- April 24

- The ability to offer 24/7 core laboratory services principally transfusion
- Reduction in cost of operating the laboratory when compared to staffing 24/7 (Haem and Transfusion Only)
- Expansion of Clinical relevant repertoire performed onsite
- Improved Turn around time for samples not currently processed at LWH site

Programme Scope: Operational Performance

Programme Objective

A

Improve the Trust's Elective & Cancer Performance to reduce the amount of time patients are waiting for diagnosis and treatment.

Projects

B

3.1 Cancer Improvement	Project Objectives: • Improve LWH Quality Cancer Care. • Improve patient experience and outcomes. • Improve cancer performance tracking and visualisation of data. • Improve cancer pathway processes. • Improve FDS and 62 Day target in order to exit from NHSE Tiering Programme
3.2 Reduce Wait Times	Project Objectives: • Implement Further Faster Guidelines • Improve Outpatient & Theatre Performance Tracking • Optimising Pathway Processes: outpatient, theatre & surgical pathways • Maximise Theatre Utilisation • Achieve Elective Recovery Ambitions • Reduce Gynaecology 1st Appointment wait time • Reduce waiting list size to by >15% by March 2025 • Embed the Golden threads of the Programme: Staff welfare, Equality and Diversity, Patient centred care, sustainability and governance

Target Benefits

C

- Faster Diagnosis Standard Improvement
- 62 Day Referral to Treatment Improvement
- Enhanced patient experience
- Streamlining of Admin Process
- Improved patient outcomes & patient experience
- Reduced number of urgent calls to EDSW/GPs/GED
- Improved patient outcomes & patient experience
- Reduced number of urgent calls to CNS/GPs/GED
- Reduction in patient complaints and urgent calls from patients
- Freeing up of EDSWs to provide patient support

- Missed Appointment Rate (Trust total)
- PIFU (Patient Initiated Follow Up)
- Remote Appointment rates (sustain)
- Theatre Utilisation increase
- Day Case Utilisation rate improvement
- 1st Appointment Waiting Times reduced
- PTL size (active pathways) reduced

Programme Scope: People & Culture

Programme Objective

A

To drive a truly inclusive culture, underpinned by shared values and respect for diversity, with strong leadership and teamwork, and an openness to learning in a psychologically safe setting.

Projects

B

4.1 Safety Culture	Project Objectives: • To ensure inclusive, compassionate and collaborative leadership behaviours aligned to a co-created LWH Safety Behaviour Leadership Framework • To develop and embed a cohesive single system approach linking safety and quality improvement • To develop a consistent system of safety culture measurement • To ensure effective teamworking based on respectful, inclusive, two way communication across disciplines, professions and grades • To ensure ensuring psychological safety and trust within the workforce underpinned by the principles of civility, respect, fairness and kindness with a focus on wellbeing, psychological support and positive promotion of speaking up • Develop a culture which is inclusive and empowering for all, promotes equality, identifies and works to address inequality and inequity • To optimise digital systems to enhance safety behaviours
4.2 Actively Anti-Racist Organisation	Project Objectives: • To establish our Cultural Baseline to inform our priorities, allow us to measure our progress and to shape our future programmes of work • To embed cultural competence and an actively anti racist mindset within our leadership cohort, our wider workforce and our organisational ethos through targeted programmes of education and coaching • To ensure through innovative positive action and learning from best practice, that our employment offer and our employee experience is inclusive, welcoming and actively anti racist • To increase the diversity of our leadership cohort and our wider workforce, making it more representative of the community we serve • To identify inherent bias in our practice, our processes and our systems, and wherever possible to remove or reduce that • To build increasing trust and confidence in our organisation in those from the global majority who access our care, our services and our employment

Target Benefits

C

- Consistent and shared understanding of the safety behaviours and expectations of leaders and healthcare professionals
- (Safety Behaviour Framework)
- Alignment of Safety Culture & Continuous quality improvement methodology
- Agreed set of Safety Improvement metrics
- Engagement with Leadership Development Programme 'Leading for Safety'
- Speaking Up culture improvement
- Optimisation of digital opportunity to drive safety practice and behaviours
- To establish our Cultural Baseline to inform our priorities, allow us to measure our progress and to shape our future programmes of work

- Increased leadership cohort completing role specific training/education/coaching
- Reduction in number of GM staff reporting discrimination at work
- Reduction in number of patient PALS/complaints where discrimination is referenced or identified
- Increase in number of GM staff employed
- Increase in number of GM in leadership roles
- Reduction in number of incidents/adverse outcomes involving patients from GM
- Evidence of increasing trust and confidence measured by patient feedback eg National Patient Surveys, Local Patient Surveys, Feedback from Listening Events with local community and Improvement in GM staff perception of LW as a good place to work (Annual Staff Survey)

Programme Scope: Financial Improvement

Programme Objective

A

Development and delivery of a Three-Year Plan to improve and sustain the financial position of the Trust.

Projects

B

5.1 Delivering the Three Year Financial Plan	Project Objectives: • Improve the financial sustainability of services in the medium to long term by developing an updated and robust 10 year financial plan. • Deliver year 1 of the long term financial plan
5.2 24/25 CIP	Project Objectives: • Develop a 3-year Cost Improvement Programme: to deliver recurrent savings and enable delivery of the 24/25 in-year plan (in line with NOF 3 exit criteria) and the three year financial recovery plan • Embed robust processes and documentation for identification, delivery and monitoring of CIP • Drive engagement and ownership of, and accountability for CIP development and delivery throughout the Trust • Identify areas for more efficient delivery of services by wider collaboration with partners across Liverpool & C&M (predominantly YR 2 & 3)

Target Benefits

C

- Reduced underlying Trust deficit
- Reduced system deficit
- Improved integration in Liverpool Place (corporate and clinical)
- Reduced need for Trust and System cash support (credibility)
- Exit NOF 3
- Delivery of FT responsibility – financial sustainability
- Improved productivity outcomes

- Delivery of the 24/25 CIP target
- Delivery of recurrent CIP in 24/25
- Identification of Yr 2&3 outline plans
- Improved Board reporting
- Improved Governance and Processes
- Improved engagement & accountability

Programme Scope: Well Led

Programme Objective

A

To strengthen our processes that escalate risks effectively from service level to Boardroom, driven by a robust Improvement Plan, streamlined governance, and clear partnership arrangements.

Projects

B

6.1 Improvement Plan Mobilisation	Project Objectives: • Define the Improvement Plan scope, programmes, governance, reporting and target benefits to support effective delivery.
6.2 Streamlined Governance	Project Objectives: • Separate Operational Management from Assurance Activities • Reduce Frequency of Board and Committee Meetings • Streamline Operational Oversight • Update Governance Documentation • Enhance Communication and Training
6.3 Risk Management	Project Objectives: • Simplify the risk management processes to increase efficiency and clarity across all departments. • Integrate the latest risk management methodologies and tools, adapting to the evolving healthcare environment. • Develop comprehensive training programmes to ensure that all staff are equipped with the necessary skills to manage risks effectively. • Establish clear channels for reporting and discussing risks at all levels, promoting a culture of transparency and proactive management. • Explore and implement a new risk management system in collaboration with LUHFT to streamline risk reporting and tracking.
6.4 Partnership Governance	Project Objectives: • To define and implement future partnership working objectives and programmes with key partners, e.g. LUHFT and Alder Hey (LNP)

Target Benefits

C

- Improvement Plan launched in May 2024
- Demonstrable reduction in management time taken up with meetings
- Feedback from staff regarding meeting efficacy
- Enhance risk visibility
- Increased staff engagement

Contents

Improvement Plan Governance & Reporting

Portfolio:

Assurance updates to System Oversight Group & Trust Board

SRO: James Sumner

LWH Improvement Plan Portfolio Board

A

Format:
1. Chaired by Chief Executive
2. Attended by SROs or nominated deputy in absence
3. 1.5 Hour Fortnightly within existing LWH ETM Time
4. Standard fortnightly highlight report
5. Monthly sign-off of IP Reporting Pack for Trust Board and SOG

Chief Transfomation Officer Tim Gold

Transformation Delivery Unit

Head of Transformation Delivery Unit: TBC

Programme:

B

Format:
1. Chaired by SRO (1hr)
2. Attended by Project Leads & other stakeholders as required
3. Product & Action Tracker for huddles
4. Monthly Highlight report for Programme Board

SRO: Dianne Brown	SRO: Lynn Greenhalgh	SRO: Gary Price	SRO: Michelle Turner	SRO: Jenny Hannon	SRO: James Sumner
Quality & Safety Weekly Huddle	Clinical Effectiveness Weekly Huddle	Operational Performance Weekly Huddle	People & Culture Weekly Huddle	Financial Improvement Weekly Huddle	Well Led Weekly Huddle

Project:

1.1 Deteriorating Patient Collaborative	2.1 Enhanced Workforce for Acute Workload	3.1 Cancer Improvement	4.1 Safety Culture	5.1 Delivering Three-Year Financial Plan	6.1 Improvement Plan Mobilisation
1.2 CQC & MSSP Actions	2.2 Acute Gynae Services	3.2 Reduce Wait Times	4.2 Actively Anti-racist Organisation	5.2 24/25 CIP Delivery	6.2 Streamlined Governance
	2.3 LWH Blood Transfusion Lab				6.3 Risk Management
	2.4 Medicines Safety				6.4 Partnership Governance

C

Format:
1. Project Leads to choose most appropriate format to drive delivery, e.g. Daily Huddles, Delivery Group, Project Board, Task & Finish Group etc
2. Mandatory for all Projects to update Fortnightly Highlight Report in standard format (Advice, guidance and QA provided by TDU as required).

Terms of Reference – Improvement Plan Portfolio Board

Purpose (A)

- The IPPB will ensure delivery of the outputs and benefits of the Improvement Plan in line with meeting National Oversight Framework (NOF) 3 exit criteria.
- The IPPB is accountable for the effective delivery of the LWH Improvement Plan and for managing risks and issues that are impacting programme delivery.
- The IPPB reports to the Trust Board and will inform the Board of key decisions, risks and mitigations associated with the delivery and outputs of the LWH Improvement Plan.

Membership (B)

- Chief Executive (Chair)
- Senior Responsible Owners from Improvement Plan Programmes
- LWH Executives
- Head of Transformation Delivery Unit
- Nominated Deputies for Members

Responsibilities (C)

- Ensuring delivery of the plan through the Programme Governance Structure.
- Defining acceptable risk profile, benefit profiles, and Realisation Plan.
- Specific duties of this group include monitoring delivery of implementation plans in accordance with timescales; ensuring the work remains on track and that an escalation process is used to highlight areas where intervention is required to progress plans.
- Monitoring defined benefits within the Realisation Plan.
- Produce and review a Programme Dashboard for key performance metrics and regularly review alongside effective delivery of the plan.
- To provide challenge and suggestion in respect of the identification and mitigation/control of related risks and issues.
- Support the co-ordination of activities across the Improvement Plan Programmes and Projects.
- Resolve strategic and directional issues which need the input and agreement of several stakeholders to ensure progress of the Programme.
- Supporting application of and compliance with constitutional/clinical standards.
- Enable the projects and programmes within the Improvement Plan to be appropriately resourced, optimizing/prioritising Improvement Plan resource as required.
- Provide oversight and scrutiny for any external suppliers used on the Improvement Plan.
- Creating and delivering a Stakeholder and Engagement plan to allow timely internal and external communications and engagement to support effective delivery of the Improvement Plan. Includes cascade of key messages across the organization as required.
- Oversee a robust change control process to allow the scope of the Improvement Plan to be effectively managed.

Terms of Reference – Weekly Delivery Huddles

A Purpose

- The Improvement Plan Programme Huddles operate support the formal governance and reporting structure.
- Delivering an agile project and programme management approach whilst maintaining a formal assurance, approval and escalation route through to the Portfolio Board.
- Rapid escalation of emerging risks and issues, to facilitate unblocking and support project progress.
- Provide SROs a real-time view of project progress and enable intervention/additional support where required.

B Membership

- SRO(Chair)
- Project Leads for each project within the IP Programme
- Transformation Delivery Unit (TDU) Support

C Responsibilities

- Monitor delivery of the implementation plans in accordance with timescales; ensuring the work remains on track and that an escalation process is used to highlight areas where intervention is required to progress plans.
- Monitoring defined benefits within the realisation plan.
- To provide challenge and suggestion in respect of the identification and mitigation/control of related risks and issues.
- Huddles will be chaired by the Programme SRO or a nominated deputy.
- Huddles will not be minuted, but an action tracker will be maintained.
- No additional reports are required for the Huddles; however project leads may wish to use the latest highlight report to guide conversation and help focus on key areas for escalation (i.e. red indicators).
- Project leads will report by exception and can flag emerging risks and issues
- Huddles should not be used for approval of new risks or issues - these should be escalated to the Portfolio Board as required.
- Huddles should not be used for approval of change requests - these should be escalated to the Portfolio Board as required.

Contents

Transformation Delivery Unit

Dedicated LWH team to track the delivery of the Improvement Plan projects and programmes, provide insight into whether the projects are moving the dial on metrics (outcomes) and support into the 6 Programmes within the Improvement Plan.

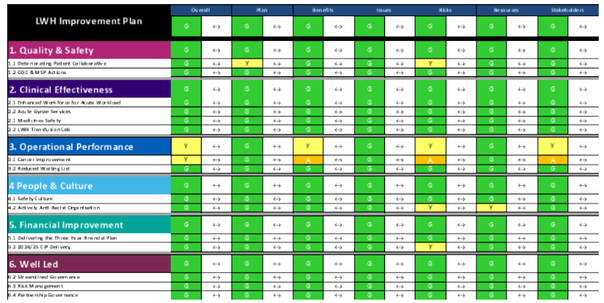
Delivery Rigour: regular Highlight Reports, Risk and Issue Management, plans/action trackers to manage delivery of products on the Transformation Map and benefits realisation.

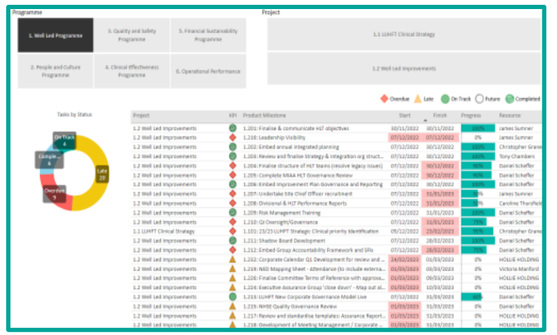
IP Performance Dashboard - key performance metrics for the Improvement Plan, aligned to the 4 Exit and Target Benefits to provide assurance to Portfolio Board, SIB and Trust Board.

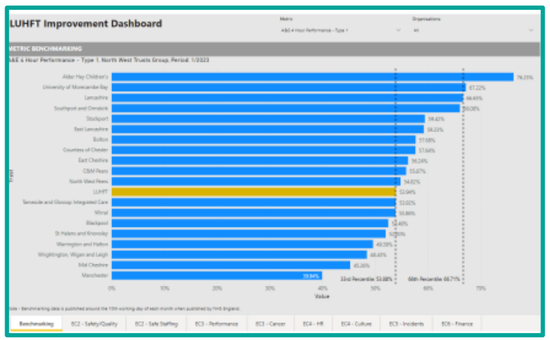
IP Stakeholder & Communications Plan – tailored communications support to support delivery of the Improvement Plan and timely engagement of key stakeholders.

Driving effective delivery through…

1. Improvement Plan Delivery Heat Map
2. Robust Milestone based delivery
3. Target Benefits benchmarked against Relevant Peer Trusts
4. Improvement Plan Communications Toolkit to support big conversation with staff







Improvement Plan Communications & Engagement Strategy

Brand Identity and Templates

OUR IMPROVEMENT PLAN

SAFETY | QUALITY | SUSTAINABILITY

- The Improvement Plan now has a unique brand identity that will be used throughout the life of the plan.
- There is a set of template documents which will be used by the Comms Team, SROs, and project leads.
- The templates include programme specific branding so individual projects can receive dedicated comms attention as well as the Improvement Plan as a whole.
- All templates and materials will be launched across the Trust in due course (mid-May onwards).
- A toolkit will be provided to help leaders think about the application of the branding and the production of narrative and messaging to support the comms activities.

Summary of the Communications & Engagement Plan

- Key messages and narrative for senior leaders
- A supporting Communications Grid to plot C&E opportunities throughout the year and comms schedule
- Planned Trust wide launch date of 15th May for the Improvement Plan which will start with In The Loop and wider launch activities thereafter
- An Intranet Hub is being built for the Improvement Plan to be the main signposting resource for all archive briefings and other materials relevant to the plan which will be highly visible via the homepage.
- Mix of tools and channels being employed to cater for all audience preferences.
- From June 2024 onwards the Comms Team will link with SROs and programme leads to agree a regular schedule for comms updates (this will be mapped on the Comms Grid).
- Comms Team member assigned to each IP programme support, with the Head of Comms overseeing.
- A stakeholder engagement map is in development to keep key stakeholders informed on progress and achievements (NHSE, MPs etc)
- The achievements within the Improvement Plan will be a focus for good news and media opportunities throughout 2024-25 to showcase success.

Comms and Engagement Touch Points

The following is a summary of the main tools and channels that will be used to promote the Improvement Plan, and to keep people involved and informed. Some but not all will be managed by the Comms Team. The below illustrates all the main touch points within the organisation where the Improvement Plan should have a presence:

- Board reports
- Portfolio Board
- Senior Leadership Forums (SLF) – IP focussed sessions throughout the year.
- Top Management Group (TMG)
- In The Loop – IP agenda item each month delivered by CEO/CTO
- General IP staff briefings – broad updates on the programme as a whole (1 per month or quarter)
- Programme specific staff briefings – Regular briefings on specific project updates under each programme (regular as and when required by SRO/TDU)
- Improvement Plan Intranet Hub – Dedicated section (accessible via homepage banner) with sub-sections for all programmes/projects
- Utilisation of the IP brand identity on template documents, presentations, reports
- Staff social media (Staff Facebook, Whatsapp) – Used to amplify other updates and to reach staff via multiple channels
- Public social media and website news – Success/achievement/good news focussed updates primarily on patient care improvements
- Stakeholder briefings – Regular (quarterly) updates for key stakeholders including NHSE, NHS C&M, local MPs on IP progress

NHS
Liverpool Women's
NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	24/25/044		Date: 9 May 2024	
Report Title	Maternity Incentive Scheme (CNST) Year 6 2024 – Scheme Release Position May 2024			
Prepared by	***Angela Winstanley – Maternity Quality & Safety Matron*** ***Yana Richens – Director of Midwifery*** ***Heledd Jones – Head of Midwifery***			
Presented by	***Dianne Brown – Executive Chief Nurse***			
Key Issues / Messages	This paper outlines the requirements of the Trust to demonstrate compliance with the defined 10 safety actions and standards of the Maternity Incentive Scheme Year 6. The paper also provides a position statement for all standards and clarity on Board reporting for the forthcoming year.			
Action required	Approve ☐	Receive ☒	Note ☐	Take Assurance ☒
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	For Decisions - in line with Risk Appetite Statement – Y			
	The Trust Board is asked to: • ***Note the current position in relation to the recently published Maternity Incentive Scheme Year 6.*** • ***Agree the proposed reporting timescales to ensure compliance with the scheme.***			
Supporting Executive:	***Dianne Brown – Executive Chief Nurse***			

Equality Impact Assessment *(if there is an impact on E,D & I, an Equality Impact Assessment **MUST** accompany the report)*							
Strategy ☐		Policy ☐		Service Change ☐		Not Applicable ☒	
Strategic Objective(s)							
To develop a well led, capable, motivated and entrepreneurial ***workforce***	☒		To participate in high quality research and to deliver the most ***effective*** Outcomes	☒			
To be ambitious and ***efficient*** and make the best use of available resource	☒		To deliver the best possible ***experience*** for patients and staff	☒			
To deliver ***safe*** services	☒						

Link to the Board Assurance Framework (BAF) / Corporate Risk Register (CRR)	
Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* 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
Quality Committee	Monthly	Chief Nurse	Presented and discussed at the Quality Committee 23.04.2024. Paper noted and contents approved.
Divisional CNST Oversight Committee	Twice Monthly	Director of Midwifery	Twice monthly progress updates from scheme safety action leads.
Family Health Divisional Board	Monthly	Clinical Director for Family Health	Monthly updates to be provided to the FHDB and where required, risks for non-compliance escalated
LMNS Oversight	Quarterly	Head of Midwifery Quality & Safety Matron	Quarterly Oversight and Improvement Meeting in relation to Safety Action 6. Last Meeting held in March 2024. Next meeting planned June 2024. Further guidance around LMNS Oversight and assurance is awaited.

EXECUTIVE SUMMARY

This paper presents the requirements and progress required to achieve compliance with the ten safety actions and their associated standards for the Maternity Incentive Scheme Year 6. It is a requirement of the scheme that the Board of Directors receive regular reports highlighting progress against the 10 Safety Standards and that they ensure appropriate oversight, scrutiny, and support to ensure full compliance by the scheme sign off on 03.03.2025.

Appendix 1 Maternity Incentive Scheme Guidance: Version 1.0 April 2024

MAIN REPORT

Introduction.

NHS Resolution (NHSr) is operating year six of the Maternity Incentive Scheme for Trust (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 Clinical Negligence Scheme for Trusts (CNST).

As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund. As in all previous years, the scheme incentivises the completion and embedding of ten maternity and neonatal safety actions.
Trusts that can demonstrate they have achieved all ten safety actions and will recover the element of their contribution relating to the CNST maternity incentive fund and will receive a share of any unallocated funds. Since 2021, successful compliance of Maternity Incentive Schemes, NHSr has returned monies of over £5.5million to Liverpool Women's NHS Foundation Trust.
Trusts that do not meet the ten-out-of-ten threshold will not recover their contribution to the maternity incentive (CNST) 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.

The Trust Board must also be aware of the conditions of the scheme and are detailed in the April 2024 release (Appendix 3). These are as follows:

- Trusts must achieve all ten maternity safety actions.
- The declaration form must be submitted to Trust Board with an accompanying joint presentation detailing position and progress with maternity safety actions by the Head of Midwifery, Director of Midwifery and Clinical Director for Maternity Services
- The **Board Declaration Form** must be sent to NHS Resolution via email between **17th February 2025 and 3rd March 2025 at 12 Noon.**
- The Board declaration form must be signed and dated by the Trust's **Chief Executive Officer** (CEO) to confirm that:

- ✓ The Trust Board are satisfied that the evidence provided to them demonstrates achievement of the ten maternity safety actions and meets the required safety actions' sub-requirements as set out in the safety actions and technical guidance document.
- ✓ There are no reports covering either 2023/24 or 2024/2025 that relate to the provision of maternity services that may subsequently provide conflicting information to the declaration (e.g., Care Quality Commission (CQC) inspection report, Healthcare Safety Investigation Branch (HSIB) investigation reports etc.). All such reports should be brought to the MIS team's attention before **3rd March 2025**
- ✓ NB Any reports covering an earlier time may prompt a review of a previous MIS submission.

The Trust Board must give their permission to the CEO to sign the declaration form prior to submission to NHS Resolution (NHSr).

- The CEO of the Trust will ensure that the Accountable Officer (AO) for the (ICB) is appraised of the MIS safety actions' evidence and declaration form. The CEO and AO, both are required to sign the Board declaration form as evidence that they are both fully assured and in agreement with the compliance submission to be submitted to NHS Resolution on **17th February 2025 and 3rd March 2025 at 12 Noon.**

NHSr External verification process.

Whilst Trusts' will self -certify their position with the scheme compliance in the Board Declaration form, there are a number of external checks that NHSr will complete upon their validation process.

NHSr will cross reference the Trust Board Declaration form in relation to the following safety actions and in collaboration with the appropriate national scheme leads;

- Safety Action 1 - MBRRACE-UK data (safety action 1 standard a, b and c)
- Safety Action 2 - Maternity Services Data Set (safety action 2 all criteria)
- Safety Action 10 - NHSr Early Notification Scheme data
- Safety Action 10 – MNSI for the number of qualifying incidents reportable

Trust submissions will be sense checked with the CQC, and any CQC visits undertaken within the timescales the CQC will cross-reference to the maternity incentive scheme via the key lines of enquiry.

Family Health Division Scheme Management and Leadership

On 02.04.2024, NHSr published scheme guidance relating to Year 6 of the Maternity Incentive Scheme (Appendix 1). The guidance contains the same ten safety actions, with reduction of some evidential requirements in comparison to year 5.

Each of the 10 safety actions has been allocated a senior lead who is responsible for ensuring their progress and delivery. Any risks to delivery are presented and overseen by the FHD MIS Progress and Escalation Group. This bimonthly meeting is chaired by the Director of Midwifery and the Quality & Safety Matron who will provide updates and assurance to the FHD Board, with regular reporting to Quality Committee and Trust Board as per schedule.

As part of the maturing process in relation to reporting and oversight there will be the development of a CNST dashboard, which will include the perinatal dashboard, which will enable leaders to track compliance and trajectories against expected standards.

Regular meetings are held between the Trust leadership teams and the Local Maternity Neonatal System (LMNS) who act as oversight and scrutiny on behalf of the ICB. The meetings provide scrutiny and challenge, and as required eventual sign off, including evidence and data review.

10 Safety Actions – Current Position in relation to MIS Year 6 guidance

A deep dive and review of MIS year 6 scheme has been undertaken (Table 1) ten safety actions for MIS Yr. 6 and timescales for completion. Table 2 outlines the reporting schedule for MIS year 6
Appendix 1 Maternity Incentive Scheme Guidance: Version 1.0 April 2024

Conclusion

The Board of Directors is asked to.

- Note the current position in relation to Maternity Incentive Scheme (MIS) Year 6
- Note the development of a Maternity Incentive Scheme dashboard.
- Take assurance from the robust oversight and scrutiny in place internally and externally to ensure delivery of the scheme, and that there is a robust process in place for timely review of evidence which will be scrutinised prior to the Board finally signing off and submission.

- **Table 1 Current Position MIS for Year 6 – April 2024.**

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

<table>
<tr><th>Safety Action Point & Description</th><th>Required Standard</th><th>Status and Actions Required.</th></tr>
<tr><td rowspan="4">SA.1 Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?</td><td>All eligible births and deaths (born and died at LWH), must meet the following conditions:

A. 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 08.12.2024 until 30th November 2024</td><td>This standard is on target to be achieved.
100% Compliance – 26 Deaths eligible for notification, at this time, all reported within the time frame required.</td></tr>
<tr><td>B. 95% of all the deaths of babies in your Trust eligible for PMRT review, parents should have their perspectives of care and any questions they have sought from 08.12.2023 onwards.
- Parental perspectives of care and questions have continued to be collated by the Honeysuckle Team and incorporated into the PMRT reports –</td><td>This standard is on target to be achieved.
100% Compliance – Of 12 cases reported, that are eligible for full PMRT review, all 12 families have been informed and perspectives of care sought.</td></tr>
<tr><td>C. For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 08.12.2023.
a) 95% of reviews should be started within two months of the death.
- 100% Cases started within two months – 12 Cases all have had PMRT Reviews commenced.

b) 60% of multi-disciplinary reviews should be completed and published within six months.
- Fully published within six months – NA at present. No issues identified.</td><td>The FH Division needs to undertake additional actions to achieve this standard.
-Deaths reported in scheme period to be progressed to completed and published.
The PMRT Team have weekly oversight to ensure that all reports are started within 2 months of the death and reports published within 6 months.</td></tr>
<tr><td>D) Quarterly reports submitted to Trust Executive Board from 08.12.2023.
<table><tr><th colspan="3">Learning from Perinatal Deaths Reports</th></tr><tr><td>Quarter</td><td>Received by Quality Committee</td><td>Received by Trust Board</td></tr><tr><td>Q2 2023 - 2024</td><td>January 2024</td><td>February 2024</td></tr><tr><td>Q3 2023 - 2024</td><td>April 2024</td><td>April 2024</td></tr><tr><td>Q4 2023 - 2024</td><td>June 2024</td><td>July 2024</td></tr><tr><td>Q1 2024 - 2025</td><td>July 2024</td><td>Sept 2024</td></tr></table></td><td>This standard is on target to be achieved.
Learning from Deaths Reports are scheduled for Quality Committee throughout the forthcoming scheme period.</td></tr>
</table>

SA.2 Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	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 2024. Final data for July 2024 will be published during October 2024 2. July 2024 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)	**This standard is on target to be achieved.** NHS Digital issue a monthly scorecard to Trusts which is used by NHS Digital to assess whether each MSDS data quality criteria has been met. No update available at present as is based on future data submission. No issues anticipated. Ethnic category data entry is a mandatory field within the K2 Maternity Information System.
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?	1 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.	**This standard is on target to be achieved.** Transitional Care pathways are 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 with admission criteria can be found on the Trust Intranet.
	2 Drawing on the insights from the themes identified from any term admissions to the neonatal unit, undertake at least one quality improvement initiative to decrease admissions and/or length of stay. Progress on initiatives must be shared with the Safety Champions and the LMNS **Evidence Required:** - By 6 months into MIS Year 6, register the QI project with local Trust quality/service improvement team. - By end of the reporting period, present an update to the LMNS and Safety Champions regarding development and any progress.	**This standard is on target to be achieved.** The Family Health Division have a very well embedded ATAIN (Avoiding Term Admission into Neonatal Unit) and TC (Transitional Care) audit programmes. An identified theme from this audit noted an increase in babies at >37 weeks admitted to NICU with a degree of hypothermia. A QI Project has been registered and is progressing well within the Division. A presentation to the Safety Champions in May 2024 and with the LMNS
SA.4 Can demonstrate an effective system of clinical workforce planning to the 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 **Evidence Required:** Trusts/organisations should audit their compliance via Medical Human Resources.	**The FH Division needs to undertake additional actions to achieve this standard.** 1. The Temporary Staffing Policy addresses the requirements of this safety action. Audit to be completed after 6 months of activity in November 2024.

	2. Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance to the Trust Board, Trust Board level safety champions and LMNS meetings. **Evidence Required:** Trusts should use the monitoring/effectiveness tool contained within the RCOG guidance to audit their compliance, using 6 months of activity from 02.04.2024 to 30.11.2024	**The FH Division needs to undertake additional actions to achieve this standard.** Audit to be completed, using the monitoring and effectiveness tool, after 6 months of activity. Audit findings to FFP if required, QC and Trust Board in November 2024.
	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. **While this will not be measured in Safety Action 4 this year, it remains important for services to develop action plans to address this guidance.** **Evidence Required:** Trusts/organisations should be working towards developing standard operating procedures, to assure Boards that consultants/senior SAS doctors working as non-resident on-call out of hours are not undertaking clinical duties following busy night on-calls disrupting sleep, without adequate rest. This is to ensure patient safety as fatigue and tiredness following a busy night on-call can affect performance and decision-making. Evidence of compliance could also be demonstrated by obtaining feedback from consultants and senior SAS doctors about their ability to take appropriate compensatory rest in such situations	**This standard is on target to be achieved.** At this time, Currently, the Division of Family Health, do not employ specialty or specialist doctors and it is not anticipated in the next 12 months that any will be employed. 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. Emergency Cover Arrangements for Senior Medical Staff Covering Post

	4. Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations 27 listed in the RCOG workforce document: *'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology'* into their service when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance. **Evidence Required**: Trust positions with the requirements should be shared with the Trust Board, the Board-level safety champions as well as the LMNS.	**This standard is on target to be achieved.** Audits of compliance of consultant attendance continue within the Division. 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 FHDB, MRC and Trust Board in line with MIS Scheme requirements. July 2023 to December 2023 audit is currently underway and will be reported to Trust Board in May 2024. Previous Compliance: Jan to June 2022 – 81% Compliance July to Dec 2022 – 87% Compliance January 23 to June 23 – 93% Compliance.
	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) **Evidence Required:** The rota should be used to evidence compliance with ACSA standard 1.7.2.1, Trusts to evidence position by 30th November 2024	**The CSS Division needs to undertake additional actions to achieve this standard.** A six month period of anaesthetic rotas will be reviewed to assure there are no gaps in service provision. It is not anticipated there will be any gaps as the obstetric unit currently has 24/7 unit obstetric anaesthetic cover.
	Neonatal Medical Workforce **1.** The neonatal unit meets the relevant British Association of Perinatal Medicine (BAPM) national standards of medical staffing or if the standards are not met, there is an action plan with progress against any previously developed action plans. **Evidence Required:** Trust is required to formally record in Trust Board minutes whether it meets the relevant BAPM recommendations of the neonatal medical workforce. If the requirements are not met, Trust Board should agree an action plan and evidence progress against any action plan developed previously to address deficiencies. A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal Operational Delivery Network (ODN). A review should be undertaken of any 6-month period between 02.04.2024 and 30.11.2024	**The FH Division needs to undertake additional actions to achieve this standard.** The Neonatal Unit at LWH complied with the requirements of BAPM and was evidenced in scheme year 5 with a medical workforce review. An updated position and report will be provided to Trust Board in November 2024 and detailed minutes.

	Neonatal Nursing Workforce 1. The neonatal unit meets the BAPM neonatal nursing standards or if the standards are not met, there's an action plan with progress against any previously developed action plan. **Evidence Required:** The Trust is required to formally record to the Trust Board minutes compliance to BAPM Nurse staffing standards annually using the Neonatal Nursing Workforce Calculator (2020). For units that do not meet the standard, the Trust Board should agree an action plan and evidence progress against any action plan previously developed to address deficiencies. A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal Operational Delivery Network (ODN).	**The FH Division needs to undertake additional actions to achieve this standard.** In January 2024, the Trust Board received a biannual staffing paper which contained the Neonatal nursing review using the CRG Workforce Calculator and action plan as per the Year 5 scheme. An update paper and action plan will be prepared and will be progressed through Family Health Division Board and to Trust Board in October 2024.
SA.5 Can demonstrate an effective system of midwifery workforce planning to the required standard?	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 rostered, planned supernumerary co-ordinator and an actual supernumerary coordinator at the start of every shift) to ensure there is an oversight of all birth activity within the service. An escalation plan should be available and must include the process for providing substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift. 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.	**The FH Division needs to undertake additional actions to achieve this standard.** A refreshed Birth-rate Plus midwifery staffing report was received by Quality Committee and Trust Board in February 2024, covering the period July to December 2023, with all safety action standards addressed and sign off of full compliance completed. An updated paper, consisting of January to July 2024 data period, will be progressed to Trust Board through FHDB in September 2024.

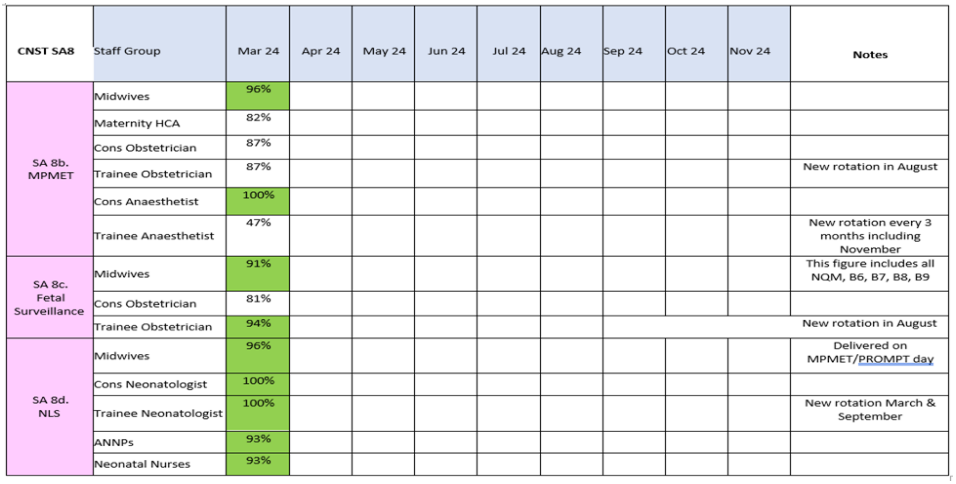
SA.6 Can you demonstrate compliance with all five elements of the Saving Babies' Lives Care Bundle Version 2?	1. Provide assurance to the Trust Board and ICB that you are on track to achieve compliance with all six elements of SBLCV3 through quarterly quality improvement discussions with the ICB. **Evidence Required:** Trusts should be able to demonstrate that at least two (and up to three) quarterly quality improvement discussions have been held between the ICB (as commissioner) and the Trust. These discussions should include the following: • 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. • Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB, neighbouring Trusts and NHS Futures where appropriate. The Three-Year Delivery Plan for Maternity and Neonatal Services set out that providers should fully implement Saving Babies Lives Version Three by March 2024. However, where full implementation is not in place, compliance can still be achieved if the ICB confirms it is assured that all best endeavours – and sufficient progress – have been made towards full implementation, in line with the locally agreed improvement trajectory. Trusts should be able to provide a signed declaration from the Executive Medical Director declaring that Saving Babies' Lives Care Bundle, Version 3 is fully / will be in place as agreed with the ICB. **Implementation Progress** .	**The FH Division needs to undertake additional actions to achieve this standard.** The Division have worked closely with the LMNS and have, to date, held **three** quality improvement discussions with scrutiny of progress monitored using the national SBLCBV3 Implementation Tool through the NHS Future Portal. On the 28.03.2024, FHD received an updated, fully validated position of current SBL3 compliance and assessed as 94% compliant with all interventions across the 5 elements. Success was seen this quarter (Q4) with the progress made against Element 1, Smoking in Pregnancy. The introduction of an inhouse smoking cessation and tobacco dependency support service increased our compliance within this element from 60% to 90%, with excellent audit data available to support our position. We have seen sustained compliance in relation to management of reduced fetal movements and diabetes in pregnancy management, both of which are 100% compliant The table 1 , in March 2024 provides an overview of the current position in relation to the percentage of interventions delivered. In relation to the Maternity Incentive Scheme Year 6, the Trust will continue with the quarterly improvement discussions with the LMNS/ICB of all elements

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	90%	CNST Met
Element 2	Fetal growth restriction	Fully implemented	100%	Partially implemented	95%	CNST Met
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 4	Fetal monitoring in labour	Partially implemented	80%	Partially implemented	80%	CNST Met
Element 5	Preterm birth	Partially implemented	93%	Partially implemented	96%	CNST Met
Element 6	Diabetes	Partially implemented	83%	Fully implemented	100%	CNST Met
All Elements	TOTAL	Partially implemented	89%	Partially implemented	94%	CNST Met

Table 1 LMNS SBLCBV3 Validated Position: March 2024

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?	1. Trusts should work with their LMNS/ICB to 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 (published November 2023) including supporting: a. Engagement and listening to families. b. Strategic influence and decision-making. c. Infrastructure. 2. Ensure an action plan is coproduced with the MNVP following annual CQC Maternity Survey data publication (due each January), including joint analysis of free text data, and progress monitored regularly by safety champions and LMNS Board.	**The FH Division needs to undertake additional actions to achieve this standard.** The CQC maternity Survey data (2024) has been shared and a meeting is planned to develop a collaborative action plan with the MNVP in May 2024 with onwards reporting to LMNS in June 2024.

<table>
<tr>
<td>SA.8 Can you evidence that at least 90% of each maternity unit staff group attendance an ‘in-house’ multi-professional maternity emergencies training session within the last year.</td>
<td>Requirements that 90% of attendance in each relevant staff group at:
1. Fetal monitoring training
2. Multi-professional maternity emergencies training
3. Neonatal Life Support Training See technical guidance for full details of relevant staff groups.
ALL staff working in maternity should attend annual training. A 90% minimum compliance is required for MIS. It is important for units to continue to implement all six core modules of the Core Competency Framework, but this will not be measured in Safety Action 8.

Evidence Required:
- Monitoring of attendance at each of the three training days using local held records or ESR
- Time period 01.12.2023 to 30.11.2024
 
<table>
<tr><th>CNST SA8</th><th>Staff Group</th><th>Mar 24</th><th>Apr 24</th><th>May 24</th><th>Jun 24</th><th>Jul 24</th><th>Aug 24</th><th>Sep 24</th><th>Oct 24</th><th>Nov 24</th><th>Notes</th></tr>
<tr><td rowspan="6">SA 8b. MPMET</td><td>Midwives</td><td>96%</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Maternity HCA</td><td>82%</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Cons Obstetrician</td><td>87%</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Trainee Obstetrician</td><td>87%</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>New rotation in August</td></tr>
<tr><td>Cons Anaesthetist</td><td>100%</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Trainee Anaesthetist</td><td>47%</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>New rotation every 3 months including November</td></tr>
<tr><td rowspan="3">SA 8c. Fetal Surveillance</td><td>Midwives</td><td>91%</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>This figure includes all NQM, B6, B7, B8, B9</td></tr>
<tr><td>Cons Obstetrician</td><td>81%</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Trainee Obstetrician</td><td>94%</td><td></td><td></td><td></td><td></td><td></td><td colspan="4">New rotation in August</td></tr>
<tr><td rowspan="5">SA 8d. NLS</td><td>Midwives</td><td>96%</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>Delivered on MPMET/PROMPT day</td></tr>
<tr><td>Cons Neonatologist</td><td>100%</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Trainee Neonatologist</td><td>100%</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>New rotation March & September</td></tr>
<tr><td>ANNPs</td><td>93%</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Neonatal Nurses</td><td>93%</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
</table>
Table 2
Monitoring of attendance at each of the three training days using local held records or ESR</td>
<td>The FH Division needs to undertake additional actions to achieve this standard.
The Trust have invested in the PROMPT model of MDT training within Family Health. PROMPT provides training for maternity units, helping midwives, maternity support workers, obstetricians, anaesthetists and other members of the maternity team to provide safe and effective obstetric care to women and babies. The table 2 below the current training compliance with MPMET, Fetal Surveillance Day and New-born Life support.</td>
</tr>
<tr>
<td>SA.9 Can you demonstrate that there are robust processes in place to provide assurance to the Board on Maternity and</td>
<td>A) All Trust requirements of the Perinatal Quality Surveillance Model must be fully embedded.

B) The expectation is that discussions regarding safety intelligence take place at the Trust Board (or at an appropriate sub-committee with delegated responsibility), as they are responsible and accountable for effective patient safety incident management and shared learning in their organisation. These discussions must include ongoing monitoring of services and trends over a longer time frame; concerns raised by staff and service users; progress and actions relating to a local improvement plan utilising the Patient Safety Incident Response Framework (PSIRF). With evidence of reporting/escalation to the LMNS/ICB/ Local & Regional Learning System meetings.</td>
<td>The FH Division needs to undertake additional actions to achieve this standard.

The Quality Committee and Trust Board receive the Perinatal Quality Surveillance Dashboard, and Integrated Governance paper detailing , themes and trends in relation to PSII, Ulysses Incidents, Complaints and legal updates</td>
</tr>
</table>

neonatal safety and quality issues?	**Evidence Required for Point A and B** ▪ Evidence that a non-executive director (NED) has been appointed and is working with the BSC to develop trusting relationships between staff, the frontline maternity, neonatal and obstetric safety champions, the perinatal leadership team 'Quad', and the Trust Board to understand, communicate and champion learning, challenges, and best practice. ▪ Evidence that a review of maternity and neonatal quality and safety is undertaken by the Trust Board (**or an appropriate Trust committee with delegated responsibility**) using a minimum data set at every meeting. This should be presented by a member of the **perinatal leadership team** to provide supporting context. This must include a review of thematic learning informed by PSIRF, themes and progress with plans following cultural surveys or equivalent, training compliance, minimum staffing in maternity and neonatal units, and service user voice feedback. ▪ Evidence of collaboration with the LMNS/ICB lead, showing evidence of shared learning and how Trust-level intelligence is being escalated to ensure early action and support for areas of concern or need, in line with the PQSM. ▪ Evidence of ongoing engagement sessions with staff as per year 5 of the scheme. Progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users from no later than July 2024. ▪ Evidence that in addition to the regular Trust Board/sub-committee review of maternity and neonatal quality as described above, the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level (Board or directorate) meeting. Scorecard data is used to agree targeted interventions aimed at improving patient safety and reflected in the Trusts Patient Safety Incident Response Plan. These quarterly discussions must be held at least twice in the MIS reporting period at a Board or directorate level quality meeting.	The Family Health Division, with the LMNS Team, attend shared meetings where trust and system level intelligence is shared. The newly introduced Maternity Safety Oversight Group, Saving Babies Lives Oversight Meeting, Quality Safety Surveillance Group and LMNS Touch Point Meetings are examples of meeting that members of the FHD attend. The Safety Champions and MNVP undertake monthly walkarounds and engage with staff. Details of safety escalations discussed and logged at the Safety Champions Meeting and feedback to staff is completed through a wide variety of comms channels. The Annual Legal Claims Scorecard is regularly reviewed, and all closed, ongoing and settled legal claims are regular reviewed at both the Maternity Risk & Governance meeting in addition to the Family Health Divisional Board. Details of learning from Legal Claims are regularly communicated to staff via a number of routes and local MPMET/PROMPT training is based on locally identified cases. The March 2024 Perinatal Dashboard Paper, received by Quality Committee April 2024, can be found in Appendix 2.
	C) All Trusts must have a visible Maternity and Neonatal Board Safety Champion (BSC) who is able to support the perinatal leadership team in their work to better understand and craft local cultures. **Evidence Required**: Evidence that the Maternity and Neonatal Board Level Safety Champions (BLSC) are supporting the perinatal quadrumvirate in their work to better understand and craft local cultures, including identifying and escalating safety and quality concerns and offering relevant support where required.	**The FH Division needs to undertake additional actions to achieve this standard.** The Perinatal Quadrumvirate Team are required to continue to work with the BLSC and plan to meet at the Safety Champions meeting within the scheme period.
SA.10 Have you reported 100% of qualifying cases to MNSI and NHS Resolution's Early	A) Reporting of all qualifying cases to MNSI from 08.12.2023 to 30.11.2024 B) Reporting of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 08.12.2023 to 30.11.2024 C) For all qualifying cases which have occurred during the period 08.12.2023 to 30.11.2024, the Trust Board are assured that: i. the family have received information on the role of MNSI and NHS Resolution's EN scheme;	**The FH Division needs to undertake additional actions to achieve this standard.** There have two cases reported MNSI at the time of this report. A update of compliance will be maintained

Notification (EN) scheme?	ii.	and 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.	through the scheme year within this update report and full breakdown of HSIB, NHSr and Duty of Candour information will be provided in December 2024.

Table 2 Schedule of Reporting to ensure compliance of MIS Year 6

Quality Committee: Reports to receive.	Trust Board: Reports to receive.
23rd April 2024 - MIS Year 6 Scheme Release Paper -Perinatal Quality Surveillance Dashboard	9th May 2024 - Perinatal Quality Surveillance Dashboard - MIS Year 6 Scheme Release Paper
	11th July 2024 -MIS Year 6 Scheme Update -Perinatal Quality Surveillance Dashboard into Integrated Performance Report -Consultant Attendance Compliance (July 2023 – January 2024)
23rd July 2024 MIS Year 6 Scheme Progress Paper -Midwifery Workforce Bi-Annual Review -	No August meeting planned.
No August meeting planned.	12th September 2024 - Perinatal Quality Surveillance Dashboard into Integrated Performance Report - MIS Year 6 Scheme Progress Paper -Midwifery Workforce Bi-Annual Review
29th October 2024 MIS Year 6 Scheme Progress Paper - MSDS Data Confirmation.	14th November 2024 Perinatal Quality Surveillance Dashboard into Integrated Performance Report - MIS Year 6 Scheme Progress - MSDS Data Confirmation.
26th November 2024 MIS Year 6 Scheme Progress Paper - Neonatal Workforce Review - Obstetric Workforce Audit Paper. - Neonatal Nursing Workforce review -SBLCBV3 Update Q2 (TBC)	December 12th 2024 - Perinatal Quality Surveillance Dashboard into Integrated Performance Report. - MIS Year 6 Scheme Progress - Neonatal Workforce Review - Obstetric Workforce Audit Paper. -Neonatal Nursing Workforce Review -SBLCBV3 Update Q2 (TBC)
No December meeting planned.	09th January 2025 - MIS Year 6 Scheme Progress --Perinatal Quality Surveillance Dashboard into Integrated Performance Report
28th January 2024 - MIS Year 6 Scheme Progress Paper - HoM, DoM & CD presentation.	- 13th February 2025 *ICB Accountable Officer for ICB and Programme Lead for LMNS to be invited.* - HoM, DoM & CD Scheme presentation. - Final MIS Year 6 Scheme Progress Paper with completed Board Declaration Form - Perinatal Quality Surveillance Dashboard into Integrated Performance Report.
▪ Signed Board declaration form to be submitted to NHS Resolution on **17th February 2025 and 3rd March 2025 at 12 Noon.**	

Appendix 1: Maternity Incentive Scheme Guidance: Version 1.0 April 2024

https://resolution.nhs.uk/wp-content/uploads/2024/04/MIS-Year-6-guidance.pdf

Appendix 2: Perinatal Dashboard Paper March (Feb Data) 2024.

Perinatal Dashboard Quality 1

INTRODUCTION

Purpose of the Report
The scorecard is produced in line with the Perinatal Quality Surveillance Model designed by NHS England to support sharing safety intelligence Board to Frontline / Frontline to Board.

The scorecard includes the minimum dataset as described within Maternity Incentive Scheme (MIS), in addition. to local insights, operational activity, and neonatal workforce.

Work is progressing on the Induction of Labour (IOL) quality improvement project with a focus on improving. timeliness and experience for families.

Recommendations
The Board are asked to:

Be assured by the progress made to date and support the plans for improvement. To note work is in progress to continue to develop the perinatal quality scorecard in line with NHSR Maternity Incentive Scheme

MAIN BODY

	Metric	Standard/ National Standard	Dec-23	Jan-24	Feb-24
Perinatal	1:1 Care in Labour	100% CNST	100.00%	100.00%	100.00%
	Stillbirth Number >24 weeks (Adjusted)	Actual Number	3	2	1
	Stillbirth Adjusted % per 1,000 Birth		1.65	1.72%	1.72%
	Apgar <7 @ 5 Minutes (>37wks)	<1.6%	1.30%	1.53%	1.48%
	Term Admission to NICU	<6%	5.11%	4.66%	4.87%
	Women in receipt of COC	No standard	18.80%	16.96%	20.92%
	BAME in receipt of COC	No standard	39.60%	32.22%	43.68%
	Social Depravation of CoC	No standard	20.62%	18.69%	20.92%
	Total number of women attended by anaesthetist after request for an epidural within 60 minutes	90%			91.20%
	Coroner Reg 28 Made to Trust	Actual Number	0	0	0
	MNSI Referals Accepted	Actual Number	1	0	0
Workforce	MNSI Completed Reports Returned	Actual Number	0	2	1
	Supernumary Shift Leader	100% CNST	100%	100%	100%
	Midwifery Sickness	% of Workforce <=5%	8.61%	7.91%	7.09%
	Midwife to Birth Ratio (in Post)	<=28	20	19	20
	Midwifery Vacancy	% of Workforce	2.20%	0.00%	0%
Feedback	Rostered Cons Hrs on DS	>60	106.5	106.5	106.5
	Number of Formal Complaints	Actual Number	1	1	1
	Number of Maternity Incidents over 30 days	Actual Number	26	26	45
	Number of PALS/PALS +	Actual Number	43	43	36

Liverpool Women's NHS Foundation Trust

Perinatal Quality Surveillance & Safety narrative

Midwifery Red Flags:	24 red flags were reported during February 2024, of which 22 were reported in relation to delays in ongoing induction of labour (IoL). The two remaining incidents were regarding a delay in suturing and a delay between admission and induction. An IoL Quality Improvement Project Manager commenced in post 1 November 2023, to oversee a designated IoL clinical unit comprising of 5 single ensuite rooms this will open in May 2024, which will provide an additional 5 beds for IOL and free up labour and birthing rooms on Delivery Suite, to allow room for women who are assessed as being ready to progress from medical IOL to surgical IOL. This will reduce delays in ongoing IOL and improve patient experience.
MNSI Referral Details:	There were no cases reported to MNSI in February 2024. There are five cases currently being investigated by MNSI. These are on track and progressing within the timeframes set out by MNSI. One has been received in draft and will be reviewed and returned as per process.
Maternity Serious Safety Incidents	There was one PSII declared during February 2024 within maternity. This is in relation to a 34+4-week Intrapartum Stillbirth. As is the Cheshire & Merseyside LMNS agreement, all intrapartum stillbirths are required to be investigated. There are 45 incidents that remain open 30 days after they were input onto the system, all are in the process of being investigated. Whilst this appears to indicate a marked increase in the number of incidents over 30 days since reported, the reporting process of the number held by Divisions has been updated and is now correctly showing the current position. Previously, the number was not accurately reported as PowerBi had not refreshed. All incidents are reviewed daily (Monday to Friday) at the Trust Daily Huddle any issues for escalation are highlighted. There are two staff members currently providing focused support for reviewing and investigating the incidents within the Web Holding File. The Divisional Governance Team provide support and guidance for any member of staff that needs assistance in updating or closing incidents.
Perinatal Mortality.	Number of Neonatal Perinatal Deaths in February 2024: **0** Number of Stillbirth Perinatal Deaths in February 2024**: 1** All cases have been reported to MBRRACE and parental support continues to be provided by the Honeysuckle Team. The process for reporting PMRT cases has been reviewed and strengthened, particularly in Neonatal, to ensure all timeframes are met and reviews are held in a timely manner.
FHD Risk Register.	Risks are reported and monitored at Family Health Divisional Board and at the LMP Operational Programme Board, to demonstrate mitigation and risks remain on track. There are currently eight out of 33 risks scoring at 15 or above, as detailed below:

Number	Department	Description	Rating
2667	Neonatal Unit	Delay in access to timely radiography out of hours	15
2430	Neonatal Unit	Network outlier for pre-term mortality - rate is higher than the national average	16
2743	Ante Natal Clinic LWH	Noncompliance 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
2746	Ante Natal Clinic LWH	Lack of DSN due to short- and long-term sickness leading to no DSN support for the women with diabetes in pregnancy, failure to comply with local and national guidelines	16
2372	Ante Natal Clinic ACWH	Inability to safely provide a joint obstetric/endocrine/diabetes ANC across both Aintree University Hospital and LWH sites for women with pre-existing and gestational diabetes	16
2772	Maternity Base	Lack of IT equipment available on Mat Base to enable staff to complete contemporaneous documentation. Additional computers on wheels purchased end of 2023, but there remains an insufficient number of IT equipment available.	16
2783	Maternity Medical	Delay in recognition and escalation of deteriorating maternity patient. MEWS - national guidance awaited.	16
2088	Neonatal Unit	Lack of on site specialist staff and services Non-colocation between neonatal and paediatric services	20

Family Health Division have a total of 41 open risks on the Risk Register - Maternity services have 33 Risks and Neonatal have 8.
All Risk Status are in date.

In light of the planned changes to the Trust Risk Management Strategy, Governance Managers have been working with current risk owners to ensure their risks are u to date and relevant. The changes being introduced will have implications for the scoring of risks and the approach to testing the controls of those risks. Further traini sessions are planned in April with the expectation that all risks are aligned within the new framework by the end of May 2024.

Family Health Safety Champions.	Full schedule of Safety Champion Walkabouts is planned over the next 12 months, including night shifts to capture the voice of all clinical staff. The Safety Champions have undertaken two safety walkarounds. One on Maternity Base and one on Delivery Suite. Discussions with staff included feedback on LOCSIPPS and swab counting incidents. Safety champions identified gaps in knowledge with staff around LOCSIPS compliance. The Safety Champions introduced the forthcoming QI Project in relation to swab counts in maternity and what the aim of the QI project (Zero Never Events in Maternity in relation to swab counts). The walkaround team was joined. by the Associate Director of Quality & Governance, who discussed the introduction and roll out of PSIRF and gained feedback from staff around the awareness of the new framework for investigating PSII. Staff on the maternity base, reported issues with equipment, particularly in relation to catheters leaking onto patient beds and the number of CTG monitors available on the ward. Both issues have been escalated to divisional leads and matrons for the appropriate areas. Several CTGs have been located and have been made available to the Maternity Base, doubling the CTG monitors on the ward to 6. The malfunctioning catheters have been replaced and an alternative now in use.
MNVP Feedback.	A formal evaluation of the overnight visiting trial on Mat Base has concluded recommending that 24hr visiting continue as per feedback from service users. Positive feedback was obtained from a listening event with families at the NEST (Non-English-speaking antenatal clinic). 15 steps undertaken on the Neonatal Unit which was positively evaluated by service users.
Midwifery Sickness	Sickness across the division is on a two-month downward trend to stand at 6.71% – this is attributable to the decreases seen across both services with Maternity at 7.09% (0.82% decrease) and Neonates at 5.84% (1.63% decrease). As in previous months, weighting in Maternity is largely balanced with 55% of absence long-term related – there have been 5 RTW's in February 2024 with a further 5 RTW's planned for March 2024. In Neonates, short-term absence continues to be the most prevalent at 55%, the current average days taken is 3 days and in the last two months, absence reporting is most evident on a Tuesday. Patterns of absence continue to be monitored across the division.
Saving Babies Lives	Progress with all interventions and elements is monitored and assured through the LMNS and review of evidence submissions to the Portal, with quarterly improvement and assurance meetings embedded with the Division and the LMNS. In Q3/Q4 of 2023, the Division have been assessed as 94% compliant with all interventions across the whole bundle, demonstrating excellent progress in the embedding of the clinical requirements of the Bundle. Success was seen this quarter (Q4) with the progress made against Element 1, Smoking in Pregnancy. The introduction of an inhouse smoking cessation and tobacco dependency support service increased compliance within this element from 60% to 90%, with excellent audit data available to support our position. We have seen sustained compliance in relation to management of reduced fetal movements and diabetes in pregnancy management, both of which we are pleased to announce 100% compliance. Table 1 demonstrates the current position in relation to the percentage of the 6 interventions which have been ratified by the LMNS

Implementation Progress

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Partially implemented	60%	Partially implemented	90%	CNST Met
Element 2	Fetal growth restriction	Fully implemented	100%	Partially implemented	90%	CNST Met
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 4	Fetal monitoring in labour	Partially implemented	80%	Partially implemented	60%	CNST Met
Element 5	Preterm birth	Partially implemented	93%	Partially implemented	89%	CNST Met
Element 6	Diabetes	Partially implemented	83%	Partially implemented	83%	CNST Met
All Elements	TOTAL	Partially implemented	89%	Partially implemented	87%	CNST Met

Table 1 Table 1 Current position in relation to the percentage of the 6 interventions in progress and ratified by the LMNS

Conclusion

The Family Health Division requests that the Trust Board receive this paper and seek assurance that perinatal quality surveillance and safety is a key Divisional priority, and evidence of ongoing compliance and progress with the implementation of a perinatal quality dashboard and framework.

Trust Board

COVER SHEET

Agenda Item (Ref)	***24/25/046***		**Date: 09/05/2024**	
Report Title	**Committee Chair's Reports**			
Prepared by	***Mark Grimshaw, Trust Secretary***			
Presented by	***Committee Chairs***			
Key Issues / Messages	***This report highlights key matters, issues, and risks discussed at Committees since the last report in April 2024.***			
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 of Directors is asked to note the Committee Chair's Reports.			
Supporting Executive:	***Mark Grimshaw, Trust Secretary***			

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

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

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

REPORT DEVELOPMENT:

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

EXECUTIVE SUMMARY

The Chair reports for the following Board committees are included in this report and attached at Appendix 1.

Quality Committee

- 23 April 2024 – Chaired by Sarah Walker

Finance Performance & Business Development Committee

- 24 April 2024 – Chaired by Louise Martin

MAIN REPORT

Liverpool Women's NHS Foundation Trust

Quality Committee Assurance Report

Report to	Trust Board
Date	09 May 2024
Meeting Name	Quality Committee
Date of Meeting	23 April 2024
Chair's Name & Title	Sarah Walker, Non-Executive Director

Agenda Items

The following agenda items were discussed by the meeting:

1. Learning case study - PSII
2. Board Assurance Framework
3. Quality and Regulatory Update
4. CNST Progress Update and Perinatal Quality Surveillance & Safety Dashboard **(Substantial Assurance)**
5. Clinical Audit Forward Plan 2024/25

Matters for Escalation

No matters highlighted for escalation.

Key Issues

Learning case study
Received a case study of a clinical incident utilising the newly introduced Patient Safety Incident Response (PSIRF) Framework. Key differences had been the inclusion of patient involvement from the beginning of the process and undertaking witness interviews. Several lessons taken from the PSIRF process, included ensuring that the information collected by the investigation officer was saved centrally to avoid delays and duplication, use several methods of information collection (walkthrough, interviews, witness statements), involve subject matter experts in investigation and action planning, introduce post incident reviews to ensure changes in practice had been embedded and write a patient-centred report. The benefit of the new process was noted by the division, specifically the introduction of the patient-centred report and the information collection process.

Board Assurance Framework (BAF)
BAF 2 - proposed to maintain the risk score at '20' and note that the target score would not be achieved, as although actions identified it remained in the mobilisation phase.
BAF 3 – The Committee proposed to maintain the risk score at '8' and noted the target score had been achieved for 2023/24.
BAF 7 – It was proposed to maintain the risk score at '16' and noted the target score had been achieved for 2023/24.

The Committee agreed the quarter 4 2023/24 BAF risk scores and considered whether the scope of these risks remained appropriate or whether there was an opportunity for them to be reframed for 2024/25. The 2024/25 BAF would be considered at a future Board workshop. It was identified that the Risk Appetite Statement should be agreed to support development of the BAF.

Quality and Regulatory Update
The report provided an overview of key issues of note. No matters to escalate identified.

Clinical Negligence Scheme for Trusts (CNST) Progress Update and Perinatal Quality Surveillance & Safety Dashboard
Received the current position in relation to newly released Maternity Incentive Scheme Year six. A deep dive and gap analysis against the newly released scheme had been undertaken against each of the ten safety actions along with a schedule of reporting to ensure compliance by the date of submission. The Perinatal Quality Surveillance and Safety Dashboard includes the minimum dataset as described within the Maternity Incentive Scheme, in addition to local insights, operational activity, and neonatal workforce. The Committee noted ongoing compliance and progress with the implementation of a perinatal quality dashboard and framework. The Family Health Division would continue to oversee CNST requirements.

Clinical Audit Forward Plan 2024/25
The Clinical Audit Forward Plan focussed on mandated 'must do' and highest priority clinical audits. The plan includes 37 audits with priority levels set against each. The Committee approved the forward plan.

Decisions Made

- Agreed the Quarter 4 BAF scores of the Quality related risks.
- Approved the Clinical Audit Forward Plan 2024/25.

Recommendations

The Board is asked to:

- note the contents of this report and the decisions taken by the Quality Committee.
- approve Quarter 4 BAF scores (Quality related risks: BAF 2,3,7)

Appendix 2: Attendance Matrix

Core members	Apr	June	July	Oct	Nov	Jan	March
Sarah Walker, Non-Executive Director CHAIR	✓						
Jackie Bird, Non-Executive Director	✓						
Louise Kenny, Non-Executive Director	A						
Gloria Hyatt, Non-Executive Director	✓						
Dianne Brown, Chief Nurse	✓						
Nashaba Ellahi, Deputy Chief Nurse	✓						
Gary Price, Chief Operating Officer	✓						
Lynn Greenhalgh, Chief Medical Officer	✓						
Jenny Hannon, Chief Finance Officer	✓						
Michelle Turner, Chief People Officer	A						
Philip Bartley, Associate Director of Quality and Governance	A						
Yana Richens, Director of Midwifery	✓						
Present (✓) Apologies (A) Representative (R) Nonattendance (NA) *Non-quorate meetings highlighted in greyscale*							

Liverpool Women's NHS Foundation Trust

Finance, Performance and Business Development Committee Assurance Report

Report to	Trust Board
Date	09 May 2024
Meeting Name	FPBD Committee
Date of Meeting	24 April 2024
Chair's Name & Title	Louise Martin, Non-Executive Director

Agenda Items

The following agenda items were discussed by the meeting:

1. Board Assurance Framework **(Substantial Assurance)**
2. Month 12 Finance Performance Report
3. 2024/25 Plan, Revenue and Capital Budgets

Matters for Escalation

No matters highlighted for escalation.

Key Issues

Board Assurance Framework (BAF)
BAF 4 – The Committee proposed to reduce the risk score to '12' from '16' and noted that the 2023/24 target score had been achieved.
BAF 5 – The Committee proposed to maintain the risk score at '20' and noted that the 2023/24 target risk score had not been achieved for 2023/24.
BAF 6 – The Committee proposed to maintain the risk score at '6' and noted the 2023/24 target score had been achieved for 2023/24.

The Committee agreed the quarter 4 2023/24 BAF risk scores and considered whether the scope of these risks remained appropriate or whether there was an opportunity for them to be reframed for 2024/25. The 2024/25 BAF would be considered at a future Board workshop.

Month 12 Finance Performance Report
The report provided the Month 12 Financial Position. At Month 12 the Trust reported a £22.6m deficit which represents a £7.1m adverse variance to plan. This position is supported by £3.9m of non-recurrent items.

£7.4m of Cost Improvement Programme (CIP) savings were delivered, resulting in a £0.9m adverse variance to the CIP target of £8.3m (which equated to 5.3% of operating expenditure). £3.7m of savings were delivered recurrently.

The cash balance (£2.0m at the end of Month 12) was below the minimum level set out in the Treasury Management policy (current policy states 15 days expenditure or c£6m minimum cash level).

2024/25 Plan, Revenue and Capital Budgets

The Committee received a detailed report on the 2024/25 financial plan including the revenue and capital budgets. The figures were noted as being consistent with those previously presented to the Board on 11 April 2024. The Committee evaluated several key financial components proposed for Board approval:

- Income and expenditure deficit plan of £29.5m.
- Cost Improvement Programme of £5.3m.
- Capital plan of £9.8m, comprised of £4.8m Public Dividend Capital (PDC) and £5.0m Capital Departmental Expenditure Limit (CDEL).

The Committee was reassured about the thorough vetting and testing of the plan's feasibility. Consequently, the Committee was inclined to endorse the plan to the Board of Directors, albeit with reservations about progressing final approval ahead of receiving assurances of additional support to help the Trust to move towards a more sustainable financial trajectory.

Decisions Made

- Agreed the Quarter 4 BAF scores of the Finance related risks.
- Supported the 2024/25 Plan, Revenue and Capital Budgets.

Recommendations

The Board is asked to:

- Note the contents of this report and the decisions taken by the FPBD Committee.
- Approve Quarter 4 BAF scores (Finance related risks: BAF 4, 5, 6).

Appendix 1: Attendance Matrix

Core members	Apr	June	July	Oct	Nov	Jan	March
Louise Martin, Non-Executive Director CHAIR	✓						
Tracy Ellery, Non-Executive Director	✓						
Sarah Walker, Non-Executive Director	✓						
Jenny Hannon, Chief Finance Officer	✓						
Dianne Brown, Chief Nurse	✓						
Gary Price, Chief Operating Officer	✓						
Matt Connor, Chief Digital Information Officer	✓						
Present (✓) Apologies (A) Representative (R) Nonattendance (NA) *Non-quorate meetings highlighted in greyscale*							

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Agenda Item (Ref)	*24/25/047*		**Date: 09/05/2024**	
Report Title	**Board Assurance Framework**			
Prepared by	*Mark Grimshaw, Trust Secretary*			
Presented by	*Mark Grimshaw, Trust Secretary*			
Key Issues / Messages	*The report outlines any updates relating to the Board Assurance Framework and any key areas for consideration for the Board.*			
Action required	**Approve ☐**	**Receive ☒**	**Note ☐**	**Take Assurance ☐**
	To formally receive and discuss a report and approve its recommendations or a particular course of action	*To discuss, in depth, noting the implications for the Board / Committee or Trust without formally approving it*	*For the intelligence of the Board / Committee without in-depth discussion required*	*To assure the Board / Committee that effective systems of control are in place*
	Funding Source (If applicable): N/A			
	For Decisions - in line with Risk Appetite Statement – Y *If no – please outline the reasons for deviation.*			
	The Board requested to • *review the BAF risks and agree on their contents and actions.* • *Agree the suggested Q4 scores*			
Supporting Executive:	*Mark Grimshaw, Trust Secretary*			

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

Strategy ☐ Policy ☐ Service Change ☐ Not Applicable ☒

Strategic Objective(s)

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

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

Link to the BAF (positive/negative assurance or identification of a control / gap in control) *Copy and paste drop down menu if report links to one or more BAF risks* 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 FPBD, and Quality Committees in April 2024 and the Executive Risk and Assurance Group in May 2024.

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.

This report provides an outline of each BAF risk, the proposed scoring for Quarter 4 2023/24 and any comments made by the Board's Committees during recent meetings.

A review of the BAF is planned for the 2024/25 iteration and the Board is asked to comment on this process.

MAIN REPORT

Introduction

The following report provides an update to Board members on the latest review of the BAF items.

The report is intended to allow the members of the Board to review any proposed changes or additions and agree them moving forward. The report is also an opportunity for the Board to make informed judgements as to the level of assurance that they can take and to identify any further action required to improve the management of the identified risks.

Process for reviewing BAF areas during the meeting

As the Board works through the agenda, members are requested to consider the BAF areas contained in Appendix 1 and the associated interdependent 15 and above risks / CRR risks. Keeping these risks in mind should support consideration of whether any assurances provided through the reports received could contribute to mitigation (or escalation) of the BAF risks. These can be noted when the BAF itself is discussed.

In addition, members should consider whether because of the review of assurances and/or identification of risks, whether there is a need to commission additional assurance to be reported to future Board and / or Committee meetings. In particular, the Board needs to ask itself whether it is attaining adequate assurance against its highest scoring risks i.e., are these areas of risk driving the Board and Committee agendas. Any information that has been discussed in the meeting that needs to be shared with other corporate governance meetings should be included in the Chair's Log.

Changes to BAF

The following provides an outline of each BAF risk, the proposed scoring for Quarter 4 2023/24 and any comments made by the Board's Committees during recent meetings:

1 – Inability to recruit & maintain a highly skilled & engaged workforce that is representative of our local communities

- Proposed to maintain this at 12. It was reduced from 16 in Q3.

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

- Score proposed to remain at '20'. This would mean that the target score is not achieved. Rationale is that whilst actions have been identified – these remain in a mobilisation phase.
- This will be further supported by the development of the Trust's Improvement Plan – to be reflected in 2024/25.
- The Quality Committee was asked to consider whether the scope of this risk remains appropriate or whether there is an opportunity for it to be reframed. The Committee agreed that it might be more germane to have a BAF risk relating to the issues presented by the isolated site and another related to the issues relating to patient deterioration and developing a safety culture – as these are two of the most pertinent strategic risks to the Trust.

3 – Failure to deliver an excellent patient and family experience to all our service users

- Proposed to maintain the risk score at '8'. This would mean that the target score has been met for 2023/24.
- Whilst patient experience remains a significant priority for the Trust, the Quality Committee was asked to consider whether it is necessary to have this as a separate BAF risk in 2024/25. There was agreement that issues relating to delivering an excellent patient and family experience could potentially be factored into other BAF risk areas.

4 – Impact to the safety of patient care services due to the lack of effective Digital Systems adoption, Strategy implementation and Cyber Security breaches influenced through cyber threats, staffing and financial resources

- Proposed to reduce the risk score to '12' from '16'. This means that the target score has been achieved.
- Rationale as follows: The optimisation phase of the EPR system has matured over the quarter and this has reduced the likelihood of the risk posed by multiple clinical systems.
- This was agreed by the FPBD Committee and recommended to the Board for approval.

5 – Inability to deliver the 2023/24 financial plan and ensure our services are financially sustainable in the long term

- Proposed to maintain the score at '20'. This means that the target score has not been achieved.
- The FPBD Committee was asked to reflect on whether this risk could be reframed for 2024/25 to ensure that it is focussed on the strategic risk facing the Trust i.e. long term financial sustainability. This point was acknowledged and agreed to factored into the review process for the 2024/25 BAF risk scores.

6 – The right partnerships are not developed and maintained to support the success of the Cheshire & Merseyside ICB and the CMAST Provider Collaborative
• Proposed to maintain the risk score as '6'. This means that the target score has been achieved. • The FPBD Committee was asked to reflect on whether this remains an area of strategic risk for 2024/25 and / or whether this could be reframed to better reflect the Trust's risk profile. The Committee agreed that the strategic risk would be better focused on how effective the Trust was working collaboratively to achieve support to mitigate its quality, safety, and financial risks.
7 - Failure to meet patient waiting time targets
• Proposed to maintain the risk score at '16' This would mean that the target score is not achieved. The Trust remains in tier 2 for Cancer performance for example. • The Quality Committee was asked to consider whether this BAF risk could be reframed. There was agreement that focusing on waiting time targets could be seen as operational and potentially a more appropriate strategic risk would relate to the overall waiting list quantum.

Considering the comments from the Board's Committees, there is an opportunity to review the BAF ahead of establishing Q1 2024/25 scores to ensure that the risks are as reflective of the strategic environment as possible. There is also a need to consider setting the risk appetite against the respective BAF items. It is suggested that consideration is given to the Board discussing the development of the BAF at the scheduled Board Development session in June 2024, with outcomes reporting to the July 2024 Board.

Closed Risks or Strategic Threats

No closed risks.

Recommendation

The Group is requested to review the BAF risks and note their contents and actions.

Liverpool Women's
NHS Foundation Trust

Board Assurance Framework 2023/24

Trust Board

May 2024

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

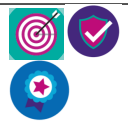
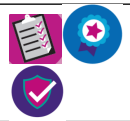
Director Lead	
CEO	Chief Executive
CPO	Chief People Officer
COO	Chief Operating Officer
CFO	Chief Finance Officer
CIO	Chief Information Officer
CN	Chief Nurse
MD	Medical Director

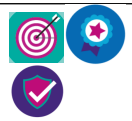
Key to lead Committee Assurance Ratings	
	Green = Positive assurance: the Committee / Board is satisfied that there is reliable evidence of the appropriateness of the current risk treatment strategy in addressing the threat or opportunity - no gaps in assurance or control AND current exposure risk rating = 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)	12 (I3 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)	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)	8 (I2 x c4)		8 (I2 x c4)
4 – *Impact to the safety of patient care services due to the lack of effective Digital Systems adoption, Strategy implementation and Cyber Security breaches influenced through cyber threats, staffing and financial resources.*		FPBD Committee	Chief Information Officer	20 (I4 x c5)	16 (I4 x c4)	16 (I4 x c4)	12 (I3 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)	20 (I5 x c4)	20 (I5 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)	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)	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 BAF 5	
4 Major		BAF 3	BAF 1 BAF 4	BAF 7	
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	3	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	4	4		
Risk Level	16	16	12	12	12		

Rationale for risk score and quarterly update – *April 2024*

The reduction from '16' to '12' from Q2 to Q3 was justified by several positive developments. First, the 'big conversation' held in September 2023 revealed a positive sentiment among the staff, reflecting an improvement in the overall staff culture. Second, the Trust's consistent recognition among the top 50 inclusive employers for the third consecutive year signifies sustained efforts in fostering diversity and inclusivity. Additionally, the indictive data (subject to change) from the 2023 Staff Survey shows promising signs of improvement. While acknowledging that risks persist, particularly in relation to postgraduate doctors and rota gaps, the Trust has received assurance regarding robust mitigating plans, instilling confidence in effective risk management. A business case for securing the required additional roles is also in development.

These positive indicators collectively suggest a favourable trajectory for workforce engagement and satisfaction. Therefore, the proposed reduction in the risk score from '16' to '12' is supported by tangible evidence of progress. Continued vigilance and proactive measures, especially in addressing issues related to the junior medical workforce, will be crucial for sustaining and building upon these improvements throughout the year.

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
- 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

	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					• 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 • Local ownership of staff survey and pulse check results to enable improvements to be created and implemented at a local level
		Assurance Level	**Assurance Rating**	**Overall Assurance Rating**		
Key Assurances:	The ED&I sub-committee oversee progress against ED&I actions	**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 / 11) To further widen opportunities for the local community to join the LWH workforce (Action 1.1 / 4) 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 / 9) Embedding of LWH as an Anti-Racist Organisation – *actions to be defined as part of the Improvement Programme* Development of ED&I Strategy (Action 1.1 / 11) 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 (action 1.1 / 9) Maximise the benefits of using rostering and job planning systems (Action 1.2 / 3) 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 (Action 1.2 / 9) Recognise that some people services are better delivered at scale and look at the potential to further collaborate or outsource(Action 1.2 / 8)
	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**				
	Quarterly internal staff survey (Let's Talk)	**1**				
	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**				
	Ownership of workforce plans at Divisional Level (reported via Divisional performance reviews).	**1**				

						Business Case for additional clinical roles to support 24/7 cover to be developed (Action 1.2 / 10)

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	
1.2 / 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	
1.2/10	Business Case for additional clinical roles to support 24/7 cover to be developed	CPO / MD	April 2024		

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
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

Consequence	Likelihood				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic			2491	2641	
4 Major		2660	2087, ~~1704~~, 2549	2760, 2732, 2578	2768, 2770, 2645
3 Moderate					
2 Minor					
1 Negligible					

Return to Dashboard

~~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
2732	Condition: 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
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
High Scoring (15+) Divisional Risks		
2768	Condition: Shortage of middle grade and Consultant level Anaesthetics medical workforce	20
2760	Condition: Lack of on-site leadership and governance structure for MRI and CT	16
2770	Condition: Risk to Anaesthetics capacity for out of hours emergency Obstetrics and Gynaecology procedures	20
2758	Condition: Lack of on-site Imaging Medical Cover, currently dependant on 3 external providers for Radiologist support	16

BAF Risk 2 – *Inability to ensure the on-going sustainability of clinical services and prevent patient harm by maintaining a high standard of care at the current Crown Street site.*

Risk Description and Impact on Strategic Aims		
Cause (likelihood)	**Event**	**Effect (Consequences)**
Inadequate comprehension of the evolving healthcare requirements of the local population, along with a failure to adequately consider the needs of marginalized groups or communities during the formulation of clinical service strategies, increases the risk of patient harm. The omission of all viable precautions to guarantee the safety of services delivered from the Crown Street site, while enhancing our facilities for the well-being of our patients and the broader system, exacerbates this risk.	Clinical service strategies that do not adequately foresee the changing healthcare needs of the local population and do not address health disparities may lead to patient harm. Moreover, the current services' location, size, layout, and accessibility may not support sustainable integrated care or the safe delivery of high-quality services. The failure to implement all feasible measures to ensure the safety of services provided from the Crown Street site, while enhancing our facilities for the benefit of patients throughout the system, amplifies the risk of patient harm.	The consequences of these issues include suboptimal patient outcomes, heightened health disparities, and the unsustainability of clinical services. This could lead to inefficient care delivery, jeopardized patient safety, and a diminished patient experience. Failing to optimize the Trust's available facilities and ensure their safety could result in adverse events, an increased threat to patient safety, and potential damage to the Trust's reputation.

	We will be an outstanding employer			**Our services will be the safest in the country**	✓
	Every patient will have an outstanding experience	✓		**To be ambitious and efficient and make the best use of available resources**	✓
	To participate in high quality research in order to deliver the most effective outcomes				

Responsibility for Risk			
Committee:	**Quality Committee**	**Lead Director:**	**Chief Operating Officer**

Risk Scoring and Tolerance							
Quarter / Score	**Q1**	**Q2**	**Q3**	**Q4**	**Target**	**Target Date**	**Risk Tolerance Statement**
Likelihood	4	4	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	5	5		
Risk Level	20	20	20	20	15		

Rationale for risk score and quarterly update – ***April 2024***

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 specialised 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 organisation and patient safety, despite proactive measures, necessitating ongoing vigilance.

Immediate actions have been identified and are being delivered via the Trust’s Improvement Plan. These are currently in a mobilisation phase and therefore it is not appropriate to propose a reduction in risk score during this quarter.

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
- 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
- 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
- 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
- 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
- Gynaecology Tier 2 rota providing cover for LWH and Liverpool Place
- Expanded role of anaesthetists to cover HDU patients and provide pain service
- Upskilling of HDU staff
- 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 critical care
- 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

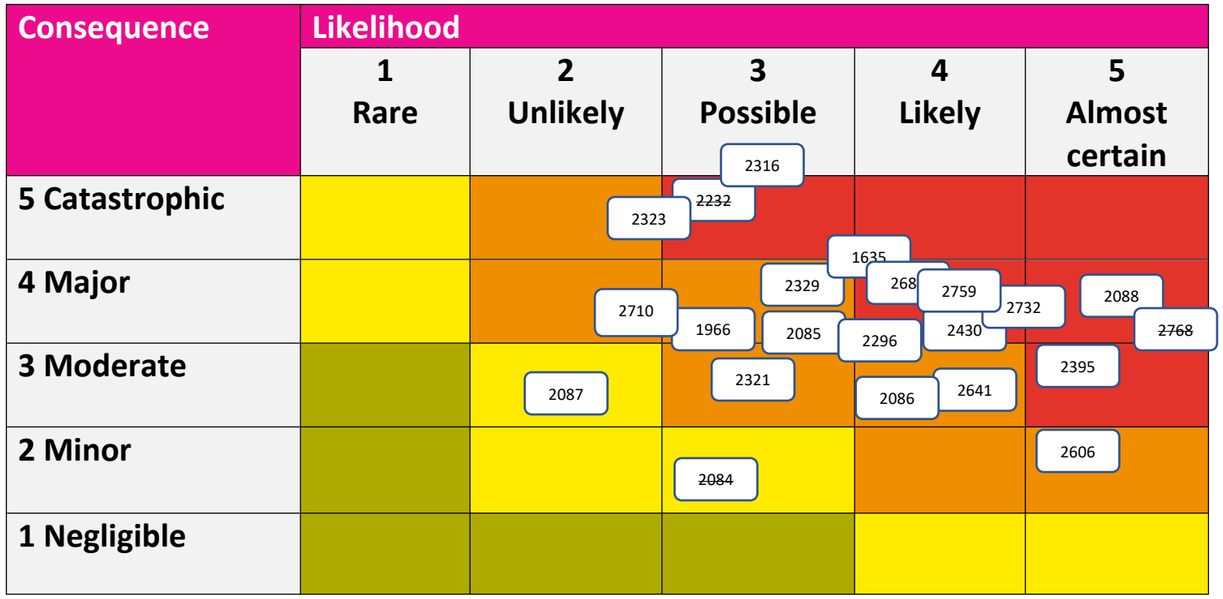
		Assurance Level	Assurance Rating	Overall Assurance Rating		
Key Assurances:	Divisional Board meetings with divisional risk meeting themes reporting	1			**Gaps in Control / Assurance:**	Delivery of the short-term actions identified and agreed by the Women's Services Programme Board regarding isolated site clinical risks (Action 2/10) To ensure that Divisions are fully utilising data to understand changing service demands (Action 2.1) Need to improve the sustainability and deliverability of the dietetic service provided at LWH (Action 2/9) Assurance regarding process to develop and oversee the medium – long term actions regarding the isolated site clinical risks (Action 2/11)
	Operational plans and budgets	2				
	Transfers out monitored by Partnership Transfers out monitored at HDU Group Critical Care transfers subject to PSII	3				
	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				
	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				

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	April 2024	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.	
2/9	Improvements to the sustainability and delivery of Dietetic Service required	Chief Nurse	April 2024		
2/10	Assurance regarding delivery of short-term actions identified and agreed by the Women's Services Programme Board regarding isolated site clinical risks	Medical Director	September 2024		
2/11	Assurance regarding process to develop and oversee the medium – long term actions regarding the isolated site clinical risks (Action 2/11)	Medical Director	September 2024		

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	12
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.	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~~
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.	12
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.	9
1635	Risk of delays to treatment due to significant problems with the junior doctor rotas-vacancies and maternity leave.	16
2088	Condition: Lack of on-site specialist staff and services	20
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

Return to Dashboard

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~~
High Scoring (15+) Divisional Risks		
~~2768~~	~~Condition: Shortage of middle grade and Consultant level Anaesthetics medical workforce~~	~~20~~
2759	Condition: Risk of sustainability of HSSU service	~~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**	**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**	**4**	**4**		
Risk Level	**12**	**8**	**8**	**8**	**8**		

Rationale for risk score and quarterly update – April 2024

The reduction in the risk rating from 12/25 to 6/25 (Q1 to Q2) 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 (published in August 2023) 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 organisation 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 Quality 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 and Patient Involvement and Experience Facilitator 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 Patient Involvement and Experience Sub Committee
- BBAS – Ward Accreditation Scheme
- PLACE assessment
- MNVP
- 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 community groups led by the Patient Experience Matron and Patient Involvement and Experience Facilitator 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.
- An Involvement calendar produced that reflects all listening and engagement events that the Trust participates in.
- 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			**Gaps in Control / Assurance:**	Work being undertaken to review the pathway for trans patients going through fertility prior to the commencement of hormone therapy - The trans female pathway for sperm storage has been reviewed and is now a scientific led pathway, avoiding unnecessary delays due to waiting times to see a Consultant medic. The patients are often referred with NHS funding in place or funding is requested by the Hewitt funding team and are then booked into the sperm cryopreservation clinic. From referral to completion of sperm storage will take approx. 12 weeks as this includes extended screening for potential donation to ensure the patient has all reproductive choices for future relationships. Now the pathway is working well, the trans male pathway (egg storage) now needs further attention as we work with CMagic and GPs with special interest in gender identity, to ensure secondary investigations are managed appropriately. This includes further training for our nursing team to again, ensure we avoid unnecessary delays in waiting for a Consultant appointment as this can be nurse-led. We expect this piece of work to be completed by April 2024, monitoring progress through our Clinical Transformation team. The education starts on Weds 20th December with Adrian Harrop a GP-SI presenting at the Hewitt annual training day on 'Healthcare for trans patients'. All referrals for fertility preservation for gender reassignment are over the age of 18 MNVP oversight of complaints actions and themes for improvement presented at PIESC – MNVP on the distribution list for the Patient Involvement and Experience Sub Committee. Gaps in effective delivery of Access Policy including training of staff associated with RTT pathway management – Access policy currently under review for sign off in April 2024. Reviewed following implementation of digi care and revision of SOPs to reflect new system and processes. RTT validation audit took place in September 2022 by external company which demonstrated that application of
	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 data as part of the Themes and Trends report that is reviewed quarterly. Friends and Family themes and trends from each Division are reviewed at every Patient Involvement & Experience Sub-Committee meeting. Friends and Family also form part of the Trust Performance report that each Division must review. A KPI regarding displeased comments has also 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 and to also discuss any Quality Improvement Projects that they are undertaking	**2**				RTT rules against patient pathways was excellent with less than 2% error rate, noted as best Gynaecology PTL management from 56 Trusts audited. This report was submitted to Executive team to demonstrate effectiveness of PTL management. Timescales for delivery of key elective recovery programme actions – Trajectories for Elective Recovery have been set and monitored weekly & monthly with regional NHSE colleagues and through Access sub-committee. These are reported monthly to Trust sub-committees through the Integrated Performance Report. Actions noted at Access sub-committee for delivery of recovery actions and progress against targets is provided by Operational teams. Work to reconfigure the MLU estate to maximise efficiencies for IOL - Work is ongoing and phase 1 of the development has been completed. Phase 2 is likely to be delivered by April 2024
	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**				
	Communications team and Patient Experience Team work together reviewing the social media comments and these form part of the quarterly themes and trends reports that are reviewed at Patient Involvement and Experience Sub Committee.	**2**				
	Patient Experience Matron reports on community engagement and relationships via the Patient Involvement and Experience Sub-Committee report 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 MNVP meetings and MNVP chair is part of the circulation list for Patient Involvement and Experience Sub Committee.	**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 includes 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 reporting 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	Head of Patient Involvement and Experience and Patient Experience Matron are on Divisional Boards.	
3/7	QI projects need to be developed from patient voices and experience-based co-design.	Quality Manager	April 2024	Patient Experience Team have registered QI projects as part of patient voices and a Lived Experience Panel is in development.	

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	All Divisions report on the Displeased Comments at the Patient Involvement and Experience Sub Committee. The compliance against this KPI has improved over time and current performance 76% (November 23)	
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	Updates on Elective Recovery are provided to the Board and FPBD through the Integrated Performance Report – a paper summary is submitted every month which highlights actions delivered and progress against trajectory. Also, a Chairs report is produced monthly from Access sub-committee which is submitted to FPBD which gives updates on positive assurances and key risks associated with elective recovery delivery.	
3/11	Work to reconfigure the MLU estate to maximise efficiencies for IOL.	FH Div Manager	April 2024	Work is ongoing and phase 1 of the development has been completed. Phase 2 is likely to be delivered by April 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				2485 2418	
3 Moderate		2087			
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.	6
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 – *Impact to the safety of patient care services due to the lack of effective Digital Systems adoption, Strategy implementation and Cyber Security breaches influenced through cyber threats, staffing and financial resources.*

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. Insufficient financial and staffing resources to adequately support and protect the digital service provision.	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	4	3	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	4	4	5		
Risk Level	20	16	16	12	15		

Rationale for risk score and quarterly update – April 2024

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 from Q1 and Q2 assessments. 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. There remains to risk to adoption due to staff engagement, availability, and digital staffing resources, however, to control these activities are prioritised based on safety assessment.

Based on this, the impact is considered major (4). Due to recent world events, the environment risk or likelihood for a cyber-attack increased in the last quarter 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 optimisation phase of the EPR system has matured over the quarter and this has reduced the likelihood of the risk posed by multiple clinical systems.

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 EPR Staffing business case.
- Approved Digital Generations Strategy.
- Approved Meditech Expanse Business Case.
- Approved Trust Cyber Strategy.
- Fully resilient external (Internet/Clinical) network links.
- Improved Community Network connectivity.
- Incident reporting based on clinical safety focus.
- Tactical solutions including the implementation of K2 Athena system.
- Exchange/LHCRE enables for patent information sharing.
- Virtual Desktop technology to aid staff working flexibly.
- PACS upgrade removes a separate login for that system, reducing multiple systems issues.
- Task and Finish group established to improve Order and Results reporting for Pathology, Radiology.
- Appropriate task and finish groups established as required by Safety and Effectiveness sub-committee
- Digital clinical leadership business case approved.
- Optimisations to K2 system and refinements implemented
- Fast User Logon Project (Imprivata) successfully rolled out to majority (75%) of Trust, simplifying multi-application logon experiences for staff.
- 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.
- Effective USB Port Control implemented.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.
- Mobile device management – providing enhanced security for mobile devices
- Implementation of Multi-Factor Authentication (MFA) to support reduction of risk of unauthorised or privileged system access due to user account credentials being compromised.
- digiCare MEDITECH Expanse optimisations programme established.
- Ongoing review of systems and mitigations quarterly
- Robust implementation plan for Secure Boundary (Web Filtering)

		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 4/5)

Variation in training experience and capability (4/6)ICS wide Shared Care Record programme not fully implemented/ active programme of work)

Lack of visibility of Internet of Things (IoT) and medical devices (Action 2.4 / 4)

Resilience / single points of failure within the IT staffing. (4/7)

Ineffective service desk provision (4/8)

Lack of effective local asset ownership (4/9)

Additional resilience improvements to back up solution required. (4/10)

Conclude implementation, adoption of Secure Boundary (4/11)

Improve network segmentation (4/12)

Improve User Account Directory Services hygiene (4/13)

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 2024	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. External MIAA audit concluded in Dec, with review of recommendations underway,	
4/5	Optimise digiCare MEDITECH Expanse to reduce multiple systems effect through efficient processes and integration.	Associate Dir - Information	March 2025	EPR staffing business case approved, optimisation programme underway. Task and finish groups established.	
4/6	Establish effective digital training capability and end user experience	EPR Systems Manager	March 2024	EPR staffing business case approved, training booking on processes currently being optimised.	
4/7	Review IT staffing structure and identify potential options to improve resilience and capacity	Associate Dir - Technology	March 2024	To be considered during financial planning for 24/25	
4/8	Address the Ineffective service desk provision	CIO	July 2024	Commence collaborative work with LUHFT to resolve.	
4/9	Implement an Information Asset Ownership workshop and awareness campaign	Head of Records & IG	March 2025	Cultural shift in organisational asset ownership mindset to be challenged through 24/25 as digital objective.	
4/10	Enhance backup solution resilience	Associate Dir - Technology	December 2025	Business case underway for 24/25 capital planning consideration	
4/11	Conclude implementation of Web Filtering (Secure Boundary)	Associate Dir - Technology	September 2024	Implementation is underway. Careful consideration of impact – mitigation is place in monitoring mood initially.	
4/12	Improve Network segmentation	Associate Dir - Technology	March 2025	Business case underway for 24/25 capital planning consideration	
4/13	Improve User Account Directory Services hygiene	Associate Dir - Technology	March 2025	Review of options including collaboration with LUHFT to be undertaken initially.	

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				2772	
3 Moderate			~~2603~~		2531
2 Minor					
1 Negligible					

Ref	Description	Risk Rate Score
Corporate Risks		
High Scoring (15+) Divisional Risks		
2531	Condition - Inadequate and unsustainable IT Helpdesk Provision	15
2772	Lack of IT equipment available on Mat Base to enable staff to complete contemporaneous documentation.	16

Return to Dashboard

BAF Risk 5 – *Inability to deliver the 2023/24 financial plan and ensure our services are financially sustainable in the long term*

Risk Description and Impact on Strategic Aims		
Cause (likelihood)	**Event**	**Effect (Consequences)**
Insufficient funding, or failure to secure funding, from external sources. Inadequate cost control and/or cost reduction measures. Inadequate financial management and controls, including lack of effective financial planning and forecasting.	Risk that the Trust will not have sufficient cash resources in the 2023/24 financial year, resulting in inability to pay suppliers, staff, or meet other financial obligations. Risk that the Trust will not deliver agreed plan in the 2023/24 financial year, including inability to meet operational targets or clinical quality standards. The Trust is not financially sustainable in the long term, potentially leading to intervention from external regulators and the Trust no longer being a going concern.	The Trust fails to meet its financial plan and is unable to secure sufficient resource to safely deliver its clinical services, resulting in negative outcomes for patients and staff, reduced trust in the quality of care provided.

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	Every patient will have an outstanding experience			**To be ambitious and efficient and make the best use of available resources**	✓
	To participate in high quality research in order to deliver the most effective outcomes				

Responsibility for Risk			
Committee:	**Finance, Performance & Business Development Committee**	**Lead Director:**	**Chief Finance Officer**

Risk Scoring and Tolerance							
Quarter / Score	**Q1**	**Q2**	**Q3**	**Q4**	**Target**	**Target Date**	**Risk Tolerance Statement**
Likelihood	**4**	**4**	**5**	**5**	**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**	**4**	**4**		
Risk Level	**16**	**16**	**20**	**20**	**12**		

Rationale for risk score and quarterly update – April 2024

The Trust has a well-defined and evidence-backed case that it is not financially sustainable due to the size of the organisation and resulting lack of economies of scale, the particular mix of services including the costs of delivering maternity services as well as remaining on an isolated site. This situation is exacerbated each year due to capital investment, ongoing revenue investment in delivery of services, 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 at Quarter 3 as '5 - almost certain' rather than '4 - likely. At Month 9, the Trust is reporting an adverse variance to plan of £2.7m year to date and a full year adverse variance forecast of £8m. The Trust has applied for Cash Support from the Department of Health to ensure liabilities are met on an ongoing basis. The primary drivers leading to the adverse variance to plan include ongoing requirements in previous workforce investments, addressing CQC actions and the costs associated with Industrial Action. 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 into the Trust to support the costs of delivering maternity care and associated CNST costs. The Trust introduced a targeted program of Financial Recovery in July 2023 to support the in-year and long-term position and continues to work with system partners to resolve the underlying deficit issues. The Trust continues to maintain strong financial grip and control processes on expenditure and identify further opportunities for increased productivity and efficiency.

Key Controls and Assurance Framework		
Key Controls:	• Financial Recovery Plan produced and shared with ICS with ongoing dialogue in relation to solutions • Consistent achievement of the safety standards associated with the CNST Maternity Incentive Scheme. • Reference costs at 103 (latest data) indicating cost efficiency in the context of an isolated site and compared to other Trusts	• Trust is part of the system-wide expenditure controls group with the ICB reviewing grip and control and expenditure on a monthly basis. • Agency and Premium Pay is well controlled as demonstrated in the low overall usage (0.7% of pay budget at M8).

	• 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.
	• Collaboration and efficiency at scale is developing across Liverpool and C&M, underpinned by findings of Liverpool Clinical Services Review.
	• Internal audit reports giving strong assurance in relation to financial controls and reporting and Cost Improvement Plans
	• Cost Improvement identification process in place, including QIA and EIA process, supported by the establishment of and internal PMO.
	• 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
					• Vacancy control panel in place, meeting weekly to consider all posts, with Executive Committee review and approval.
					• Revised non-pay expenditure controls in place
					• Detailed log of investments since 2019/20 and prior has been produced with post-implementation review underway.
					• Review of services and related costs and income
					• The 'No PO No Pay' policy has been re-enforced.
					• Partnership working with other providers to enhance efficiency and minimise duplication
					• 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
					  • Successful application for central Cash Revenue Support

		Assurance Level	**Assurance Rating**	**Overall Assurance Rating**	
	Long term financial recovery plan produced and submitted (Sept 23)	**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**			
	Establishment of Women's Services Committee to address medium to long term issues	**2**			
	Place based focus on resources initiated (Jan 24)	**2**			
	Active participation in C&M planning processes and ongoing regular review of financial position at system level	**2**			
	Process in place regarding CNST MIS. Prior achievement of MIS. Engagement with NHS Resolution and learning from claims and incidents.	**2**			
	Focus on benchmarking and efficiencies, including joint working where possible.	**2**			
	FPBD and Board (monthly reports)	**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 regularly	**2**			
	Enhanced grip and control to manage influenceable spend	**2**			
	Approval of cash support	**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.	
5/12	Focussed review of productivity to support 24/25 planning	COO	March 2024	Completed – see financial planning	

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, 2722, 2730	
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
2730	Condition: Trust has insufficient internally generated capital to expand ambulatory estate	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.

	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(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**	**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**	**3**	**3**		
Risk Level	**9**	**6**	**6**	**6**	**6**		

Rationale for risk score and quarterly update – April 2024

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. A shared Chair and joint Chief Digital Officer and Chief Transformation Officer roles confirmed during Q3. 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 2023/24 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
- Positive and developing relationship with Merseycare NHS FT
- Women's Services ICB Sub-Committee, chaired by ICB Chair
- Women's Services Programme Board established to oversee delivery of short-, medium- and long-term actions relating to the isolated site risks.
- Signed up to CMAST Joint Working Agreement and Committee in Common
- Participation in CMAST networks and workstreams
- 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.
- Effective relationships with Higher Education institutions for research activity and staff development

		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) Some partnership arrangements are not yet underpinned by formal governance arrangements and/or service level agreements. (Action 6.2)
	LNP Assurance meeting	**2**				
	The ICB is providing oversight on 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	~~April 2023~~ July 2024	Good progress made with SLA documentation. Hope to close out by end of Q1 2024/25.	

Linked Corporate and High Scoring Divisional Risks Heat Map

Consequence	Likelihood				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic			2757		
4 Major					
3 Moderate					
2 Minor					
1 Negligible					

Ref	Description	Risk Rate Score
Corporate Risks		
High Scoring (15+) Divisional Risks		
2757	Condition: Trust wide Pathology services are dependent on third party providers	15

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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**	**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**	**4**	**4**		
Risk Level	**16**	**16**	**16**	**16**	**12**		

Rationale for risk score and quarterly update – April 2024

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
- Theatre Utilisation Group
- 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

	• Elective Recovery Programme in place with workstreams to improve performance and reduce waits • External validation programme of work reviewing all admitted and non-admitted pathways to ensure RTT guidance being applied correctly – audited by MIAA. • Review of Medical & Nursing job plans to ensure capacity in place to treat patients in a timely manner				- IoL metrics included on Executive and SLT live dashboards • C&M weekly maternity escalation cell • Cancer Committee – meets bi-monthly to review Cancer performance and track actions to improve performance. Tier 2 multi partner cancer oversight meets monthly to oversee a cancer action plan. • Increased staffing capacity in MAU	
		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**				Work against checklists within 'Further Faster - Gynaecology Handbook'

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	April 2024		
7/3	Work to reconfigure the MLU estate to maximise efficiencies for IoL.	FH Div Manager	**April 2024**		
7/4	Work against checklists within 'Further Faster - Gynaecology Handbook'	COO	July 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					
4 Major					2770
3 Moderate		2087			
2 Minor					
1 Negligible					

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.	6
High Scoring (15+) Divisional Risks		
2770	Condition: Risk to Anaesthetics capacity for out of hours emergency Obstetrics and Gynaecology procedures	20

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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 prevent patient harm by maintaining 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				Impact to the safety of patient care services due to the lack of effective Digital Systems adoption, Strategy implementation and Cyber Security breaches influenced through cyber threats, staffing and financial resources.				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 12 (I3 x c4)				Target 15 (I3 x c5)				Target 8 (I2 x c4)				Target 15 (I3 x c5				Target 12 (I3 x c4)				Target 6 (I2 x c3				Target 12 (I3 x c4)			
	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	16	16	12		20	20	20		12	8	8		20	16	16		16	16	20		9	6	6		16	16	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)	5 (12)			2 (9)	2 (9)			1 (12)	1 (12)			11 (15)	11 (15)			3 (9)	3 (9)										
	8 (9)	8 (9)			4 (9)	4 (9)			6 (12)	6 (12			12 (12)	12 (12)			7 (9)	7 (9)										
	9 (12)	9 (12)			10 (12)	10 (12)																						
LHCH BAF	4 (12)	4 (16)			8 (9)	8 (9)			1 (6)	1 (6)			9 (12)	9 (12)			3 (12)	3 (12)			7 (4)	7 (4)			2 (12)	2 (12)		
					6 (12)	6 (12)											5 (12)	5 (12)										
AHH BAF	2.1 (15)	2.1 (20)			1.1 (9)	1.1 (9)							4.2 (16)	4.2 (16)			3.4 (16)	3.4 (16)			3.2 (12)	3.2 (12)			1.2 (15)	1.2 (20)		
	2.2 (9)	2.2 (9)			1.3 (12)	1.3 (12)															3.5 (16)	3.5 (12)						
	2.3 (15)	2.3 (15)																										
CCC BAF	10 (12)	10 (16)			1 (15)	1 (10)							13 (12)	13 (9)			3 (16)				6 (12)	6 (8)						
	11 (16)				2 (12)	2 (12)							14 (12)	14 (12)														
MC BAF	P1 (16)	P1 (16)			S3 (12)	S3 (12)			S1 (12)	S1 (12)			R2 (12)	R2 (12)			R1 (12)	R1 (12)			F2 (16)	F2 (12)			S4 (16)	S4 (16)		
									S2 (12)	S2 (12)																		
									P2 (12)	P2 (12)																		
ICB BAF	P9 (16)	P9 (12)			P1 (16)	P1 (16)			P4 (15)	P4 (10)			P2 (12)	P2 (6)			P7 (20)	P7 (16)							P3 (25)	P3 (15)		
					P8 (12)	P8 (12)			P5 (20)	P5 (20)															P6 (20)	P6 (16)		

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 deliver annual planning activity and performance targets could result in poorer patient outcomes, inability to address the backlog of patients waiting and result in 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	Challenges in recruiting, developing, retaining and ensuring the wellbeing of a high quality, diverse and inclusive workforce would affect our ability to deliver world class care
5	Failure to deliver financial plans and changes in the funding regime could impact sustainability for the Trust and system partners
6	Inability to delivery the Research and Innovation agenda to exploit future opportunities
7	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
8	System architecture is still maturing and may present tensions for our LHCH leadership role, alignment of priorities with the ICS and system partners, and ensuring wider view to Cheshire & Merseyside and beyond.
9	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

Clatterbridge Cancer Centre BAF Risks Summary	
1	Quality governance
2	Demand exceeds capacity

Merseycare BAF Risks Summary	
S1	There is a risk we will not deliver the best clinical practice to the people we serve, due to the Trust not understanding thehealth needs of it's local population, resulting in increased risk in the identification and reduction of safety and quality issues and the continuesimprovement of medical care and leadership.
S2	There is a risk that Mersey Care will not improve the quality of our health services, due to us not considering the wider issuesthat impact on health and wellbeing, resulting in the unfair and unjust differences in access and outcomes for the communities we serve.

1.3	Building and infrastructure defects that could affect quality and provision of services		3	Insufficient funding		S3	There is a risk that the care for people with complex health and social needs will be fragmented and poorly coordinated, due to a focus on treatment which misses opportunities for earlier intervention, resulting in poorer coordination and less integration of wholeperson care at all ages. Executive Lead Trish Bennett
1.4	Access to Children and Young People's Mental Health		4	Board governance		S4	There is a risk of delivering the winter/resilience plan, due to demand exceeding expected levels, reduction in workforce capacity and data inaccuracies impacting decision making, resulting in the Trust not being able to address the immediate challenges of winter and the significant changes to the acute bed base across the system.
2.1	Workforce Sustainability and Development		5	Environmental sustainability		P1	There is a risk of reduced health and wellbeing of staff, due to workforce pressures and the Trust not address sickness absence and vacancy hot spots within our services, resulting in a working environment that struggles to be restorative, safe, supportive and inclusive.
2.2	Employee Wellbeing		6	Strategic influence within ICS		P2	There is risk that the trust fails to tackle the rising demand, due to a lack of insight into the experiences of our service users and communities, resulting in great inequality in access and enabling people to have greater control of their care.
2.3	Workforce Equality, Diversity & Inclusion		7	Research portfolio		R1	There is a risk to the modernisation of our inpatient and community estates, due to changes to the financial framework withinthe NHS meaning that the Trust will have less autonomy in prioritising its investments, resulting in potentially less capital for buildings thatsupport new models of care
3.1	Failure to fully realise the Trust's Vision for the Park		8	Research resourcing		R2	There is a risk that the Trust doesn't utilise the benefits of digital technology, due to the challenges in balancing growingdemand for finite resources and moving away from a 'one size fits all', technological solutions, resulting in delays in transforming the way wedeliver clinical excellence, population health, and care coordination within our services.
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		F1	There is a risk that the trust will not increase its research capacity and capability, due to us not capitalising on new interventions with, academic and industry partners in real-world settings, resulting in us not advancing research and innovation in mental health and our understanding of how mental, physical, and social conditions are interlinked.
3.4	Financial Environment		10	Skilled and diverse workforce			
3.5	System working to deliver 2030 Strategy		11	Staffing levels			
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		12	Staff health and wellbeing			
4.2	Digital Strategic Development & Delivery		13	Development and adoption of digitisation			
			14	Cyber security			
			15	Subsidiaries companies and Joint Venture			

C&M ICB BAF Risks Summary

P1	The ICB is unable to meet its statutory duties to address health inequalities
P2	The ICB is unable to address inadequate digital and data infrastructure and interoperability which inhibits development of system-wide population health management and effective targeting of initiatives to reduce health inequalities
P3	P3: Acute and specialist providers across C&M may be unable to reduce backlogs for elective and cancer care, due to capacity constraints related to industrial action or other supply side issues or the impact of winter Urgent and Emergency Care pressures. This may result in inability to meet increased demand, increase in backlogs of care, resulting in poor access to services, increased inequity of access, and poor clinical outcomes
P4	Major quality failures may occur in commissioned services resulting in inadequate care compromising population safety and experience
P5	Lack of Urgent and Emergency Care capacity and restricted flow across all sectors (primary care, community, mental health, acute hospitals and social care) results in patient harm and poor patient experience
P6	Demand continues to exceed available capacity in primary care, exacerbating health inequalities and equity of access for our population
P7	The Integrated Care System is unable to achieve its statutory financial duties
P8	The ICB is unable to resolve current provider service sustainability issues resulting in poorer outcomes for the population due to loss of services

P9	**Unable to retain, develop and recruit staff to the ICS workforce reflective of our population and with the skills and experience required to deliver the strategic objectives**						
P10	**ICS focus on responding to current service priorities and demands diverts resource and attention from delivery of longer-term initiatives in the HCP Strategy and ICB 5-year strategy on behalf of our population**						

Commentary

In development.

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								
2766	Condition: There is a risk of occupational exposure to excessive levels of Entonox for prolonged periods of time to clinical and non clinical staff across all Clinical Divisions	4 Major	3 Possible	12	Corporate	06/03/2024	20/03/2024	n/a
2741	Condition: Non-compliance with the National Standards for Food and Drink issued in October 2022	3 Moderate	4 Likely	12	Clinical Support Service	20/02/2024	20/04/2024	3
2732	Condition: 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	01/03/2024	31/03/2024	2
2641	Condition: There is a significant risk to the dietetic service and delivery of patient care at LWH	3 Moderate	4 Likely	12	Clinical Support Service	26/02/2024	27/03/2024	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.	3 Moderate	3 Unlikely	6	Maternity	06/03/2024	04/06/2024	1, 2 & 3
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	10/01/2024	09/04/2024	5
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	20/02/2024	21/03/2024	2
2223	Condition: LWH has been involved in a police investigation of public and media interest as a Neonatal Nurse on the Local Neonatal Unit at Chester who has alleged involvement in the murder and harm of babies.	3 Moderate	4 Likely	12	Neonatal	20/02/2023	20/05/2023	N/A
1966	Condition: Risk of safety incidents occurring when undertaking invasive procedures.	4 Major	3 Possible	12	Governance	21/02/2024	22/03/2024	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	26/02/2024	26/05/2024	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~~	~~29/12/2023~~	~~28/03/2024~~	~~2~~
2491	Noncompliance with mandated level of fit mask testers qualification, accreditation and competency.	5 Catastrophic	3 Possible	15	Governance	12/03/2024	11/05/2024	1
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	04/12/2023	27/06/2024	2
~~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 Possible~~	~~12~~	~~Clinical Support Service~~	~~28/12/2023~~	~~27/03/2024~~	~~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	12	Maternity	27/02/2024	27/08/2024	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	9	Maternity	06/03/2024	04/06/2024	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 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.	4 Major	4 likely	16	Human Resources	21/02/2024	21/05/2024	1, 2 & 5

2088	Condition: Lack of on-site specialist staff and services	4 Catastrophic	5 Almost Certain	20	Neonatal	20/02/2024	20/05/2024	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	10/01/2024	10/07/2024	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	12/09/2024	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. 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.	4 Major	3 Possible	12	Human Resources	21/02/2024	22/03/2024	1
High Scoring Divisional Risks								
2775	Condition: Non-compliance with regulatory requirements for management of BBraun theatres stacker which has been highlighted via MIAA audit	3 Moderate	5 Almost Certain	15	Gynaecology	16/04/2024	15/06/2024	
2599	Condition: Risk relating to the Trusts Internal Security (Premises)	5 Catastrophic	3 Possible	15	Security	10/04/2024	09/07/2024	
2604	Condition: Risk relating to Trust Security Systems	5 Catastrophic	3 Possible	15	Security	10/04/2024	10/05/2024	
2549	Condition: Staff shortages within the Imaging Department across multiple workforce groups including radiographers, Sonographers, Administrative and Healthcare Assistants (HCA) to cover both the main department as well as community sites.	4 Major	4 Likely	16	Imaging	26/03/2024	24/06/2024	
2783	Condition: Delay in recognition and escalation of deteriorating maternity patient	4 Major	4 Likely	16	Maternity		20/04/2024	
2372	Condition: Inability to safely provide a joint obstetric/endocrine/diabetes ANC across BOTH Aintree University Hospital and LWH sites for women with pre-existing and gestational diabetes	4 Major	4 Likely	16	Maternity	12/01/2024	09/06/2024	
2743	Inability 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	Maternity		05/05/2024	
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	08/01/2024	07/01/2025	
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	Security	10/04/2024	10/05/2024	
~~2768~~	~~Condition: Shortage of middle grade and Consultant level Anaesthetics medical workforce~~	~~4 Major~~	~~5 Almost Certain~~	~~20~~	~~Clinical Support Services~~	~~NEW~~	~~NEW~~	Rescored to 4x3=12
2760	Condition: Lack of on-site leadership and governance structure for MRI and CT	4 Major	4 Likely	16	Clinical Support Services	11/03/2024	10/05/2024	
2770	Condition: Risk to Anaesthetics capacity for out of hours emergency Obstetrics and Gynaecology procedures	4 Major	5 Almost Certain	20	Clinical Support Services	26/03/2024	25/04/2024	
~~2759~~	~~Condition: Risk of sustainability of HSSU service~~	~~4 Major~~	~~4 Likely~~	~~16~~	~~Clinical Support Services~~	~~NEW~~	~~NEW~~	Rescored to 4x2=8
2758	Condition: Lack of on-site Imaging Medical Cover, currently dependant on 3 external providers for Radiologist support	4 Major	4 Likely	16	Clinical Support Services	20/03/2024	19/05/2024	
2048	Condition: Risk to patients and staff of not having availability of a chaperone when performing intimate examinations in the main department or Community sites.	3 Moderate	5 Almost Certain	15	Clinical Support Services	28/12/2023	27/03/2024	
2757	Condition: Trust wide Pathology services are dependent on third party providers	3 Moderate	5 Almost Certain	15	Clinical Support Services	24/01/2024	07/04/2024	
~~2730~~	~~Condition: Trust has insufficient internally generated capital to expand ambulatory estate~~	~~4 Major~~	~~4 Likely~~	~~16~~	~~Corporate~~	~~NEW~~	~~NEW~~	Rescored to 4x1=4
2752	Condition: Staff are not trained in supporting people with a learning disability / autism in line legislative requirements. Recommended training is Oliver McGowan Mandatory Training, however other training can be delivered but must be in line with code of practice (including co delivered face to face with person with lived experience both LD and Autism)	4 Major	5 Almost Certain	20	Corporate	04/03/2024	28/03/2024	
2684	T5, T8, Compact fluorescent lamps are becoming obsolete from October 2023 to February 2024. Stocks of lamps will become depleted and then non-existent.	4 Major	4 Likely	16	Estates and Facilities	11/12/2023	10/03/2024	
2418	Condition: Lack of support and appropriate care for patients presenting with mental health conditions	4 Major	4 Likely	16	Governance	26/02/2024	26/05/2024	

2386	Condition: Data Loss Prevention	3 Moderate	5 Almost Certain	15	Information Governance	11/04/2024	10/07/2024	
~~2531~~	~~Condition - Inadequate and unsustainable IT Helpdesk Provision~~	~~4 Major~~	~~4 Likely~~	~~16~~	~~IT~~	~~27/12/2023~~	~~26/01/2024~~	Rescored to 3x4=12
2372	Condition: Inability to safely provide a joint obstetric/endocrine/diabetes ANC across BOTH Aintree University Hospital and LWH sites for women with pre-existing and gestational diabetes	4 Major	4 Likely	16	Family Health	12/01/2024	09/06/2024	
2746	Condition: Lack of DSN due to short and long term sickness leading to no DSN support for the women with diabetes in pregnancy - failure to comply with local and national guidelines	4 Major	4 Likely	16	Family Health		18/04/2024	
2772	Lack of IT equipment available on Mat Base to enable staff to complete contemporaneous documentation.	4 Major	4 Likely	16	Family Health	14/03/2024	13/05/2024	
2430	Condition: Network outlier for pre-term mortality - rate is higher than the national average	4 Major	4 Likely	16	Family Health	14/03/2024	12/09/2024	
2667	Delay in access to timely radiography out of hours	5 Catastrophic	3 Possible	15	Family Health	20/02/2024	20/05/2024	
~~2769~~	~~Risk of inability to use laboratory and procedure rooms at the Knutsford site.~~	~~5 Catastrophic~~	~~3 Possible~~	~~15~~	~~Hewitt~~			Rescored to 4x2=8

Changes to Risk Summary (Quarterly)

Since the January 2024 meeting, there have been the following developments in various risks.

NEW RISKS

1. Risk 2776 Health and Safety (Current score 12, initial score 16))

Condition: There is a risk of occupational exposure to excessive levels of Entonox for prolonged periods of time to clinical and non-clinical staff across all Clinical Divisions.

Cause: Due to continued clinical use, inadequate ventilation and scavenging of waste gases and inadequate and inconsistent monitoring of workplace exposure limits for staff.

Consequence: Potential for adverse health effects from exposure, that may include: decreased mental performance, audio-visual ability, and manual dexterity, addiction from repeated administration or exposure to nitrous oxide, megaloblastic anaemia and neurological toxic effects (myelopathy) due to inactivation of vitamin B12, prolonged exposure may result in bowel distension, middle ear damage and rupture of ear drums, agranulocytosis, reduced fertility where they have been repeatedly exposed to levels of nitrous oxide above the specified occupational exposure limits in inadequately ventilated rooms.

Risk Manager Allan Hawksey, Head of Risk and Safety

a. Rationale for escalation – Risk approved 25/01/2024 at medical gases group and escalated on to the Corporate Risk Register due to potential risk to staff across all clinical divisions and actions required to mitigate the risks from exposure.

Risk reviewed with COO. Following control processes identified across maternity services (greatest user of Entonox) it has been agreed to reduce the risk score to 12. Control processes as follows: Entonox PGD circulated to all midwives. Midwifery staff education on mitigating exposure to Entonox (ensuring that fans are always switched on in each birthing room in MLU when Entonox is in use) completed. DS has scavenging units which are automatically triggered with use of Entonox. Entonox masks purchased to enable the transition from mouth pieces to masks to reduce the level of Entonox release in the immediate environment. Health surveillance for the 3 staff members who were tested and had high exposure levels. All affected staff referred to OH. Line managers received reports via Cohort OH system. Intrapartum matron sits on Medicines and medical gases group, who are initially recommending monitoring of Entonox levels on a ¼ basis. Phase 2 of work remains within Gynaecology and CSS to identify control processes as per maternity.

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

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