Liverpool Women's
NHS Foundation Trust

Trust Board

11 July 2024, 09.30am

The June Henfrey Suite

Blackburne House

Liverpool Women's
NHS Foundation Trust

Trust Board

Location	The June Henfrey Suite, Blackburne House
Date	11 July 2024
Time	9.30am

AGENDA					
Item no. 24/25/	Title of item	Objectives/desired outcome	Process	Item presenter	Time
PRELIMINARY BUSINESS					
077	Introduction, Apologies & Declaration of Interest	Note	Verbal	Chair	09.30 (5 mins)
078	Patient Story – Menopause Journey	Note	Presentation	Chief Nurse	09.35 (20 mins)
079	Minutes of the previous meeting held on 09 May 2024	Approve	Written	Chair	09.55 (5 mins)
080	Action Log and any urgent matters arising	Note	Written	Chair	
PERFORMANCE					
081	Chief Executive Report • Integrated Performance Report • Executive Risk & Assurance Group Reports	Note	Written	Chief Executive	10.00 (30 mins)
082	Finance Performance: Month 03, 2024/25	Note	Written	Chief Finance Officer	10.30 (10 mins)
083	LWH Improvement Plan Highlight Report 2	Note	Written	Chief Transformation Officer	10.40 (15 mins)
QUALITY, SAFETY & EFFECTIVENESS					
084	Maternity Incentive Scheme Year 6 – June 2024 Compliance Update	Assurance	Written	Chief Nurse	10.55 (10 mins)
085	Guardian of Safe Working Hours (Junior Doctors) Quarterly Report – Q4 2023/24	Note	Written	Chief Medical Officer	11.05 (10 mins)
BREAK – 11.15– 11.25 Board Thank you – 11.25 – 11.30					
086	Mortality and Learning from Deaths Report Quarter 4, 2023/24	Assurance	Written	Chief Medical Officer	11.30 (10 mins)
087	Safeguarding Annual Report 2023/2024	Assurance & Approve	Written	Chief Nurse	11.40 (15 mins)
PEOPLE & CULTURE					

088	WRES & WDES 2024 Report	Assurance	Written	Chief People Officer	11.55 (10 mins)
089	Sexual Safety Charter	Approve	Written	Chief People Officer	12.05 (5 mins)
GOVERNANCE					
090	Women's Health Taskforce and Strategy Development	Approve	Written	Chief Nurse	12.10 (10 mins)
091	LUHFT/LWH/Alder Hey Partnership Update	Approve	Written	Chief Executive	12.20 (15 mins)
092	Committee Chair's Reports	Note	Written	Trust Secretary	12.35 (5 mins)
093	Board Assurance Framework & Risk Appetite Statement 2024/25	Approve	Written	Trust Secretary	12.40 (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.*					
094	Integrated Governance Report Quarter 4 2023/24	Assurance	Written	Chief Nurse	Consent
095	Infection Prevention and Control Annual Report 2023/24	Assurance & Approve	Written	Chief Nurse	Consent
096	Complaints Annual Report 2023/24	Assurance & Approve	Written	Chief Nurse	Consent
097	Emergency Planning Resilience and Response Annual Board Report 2023/24	Note	Written	Chief Operating Officer	Consent
098	Health & Safety Annual Report 2023/24	Assurance	Written	Chief Operating Officer	Consent
CONCLUDING BUSINESS					
099	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair	12.55 (5 mins)
100	Chair's Log	Identify any Chair's Logs	Verbal	Chair	
101	Any other business & Review of meeting	Consider any urgent items of other business	Verbal	Chair	
102	Jargon Buster	For reference	Written	Chair	
Finish Time: 13.00					

Date of Next Meeting: 12 September 2024

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 9 May 2024

PRESENT

David Flory CBE	Chair
James Sumner	Chief Executive
Jenny Hannon	Chief Finance Officer / Executive Director of Strategy & Partnerships / Deputy Chief Executive
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
Prof. Louise Kenny CBE	Non-Executive Director / SID
Sarah Walker	Non-Executive Director

IN ATTENDANCE

Matt Connor	Chief Digital Information Officer
Tim Gold	Chief Transformation Officer
Nashaba Ellahi	Deputy Director of Nursing & Midwifery
Gillian Walker	Patient Experience Matron (item 038 only)
Amanda Wharton	EPAU Team Leader (item 038 only)
Danielle Ahmed	Gynaecology Matron (item 038 only)
Dr Alex J Cleator	Consultant Neonatologist (item 045 only)
Vicky Clarke	Divisional Manager, Family Health
Andrew Duggan	Head of Communications
Peter Norris	Public Governor
Felicity Dowling	Member of the Public
Mark Grimshaw	Trust Secretary (minutes)

APOLOGIES:

Dianne Brown	Chief Nurse
Zia Chaudhry MBE	Non-Executive Director

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

Prof Louise Kenny - Non-Executive Director	A	A	⚑	⚑	⚑	⚑	⚑	A	⚑	⚑	A	⚑
Dianne Brown – Chief Nurse	⚑	⚑	⚑	⚑	⚑	⚑	⚑	A	⚑	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	⚑	⚑	⚑	⚑	⚑	⚑	⚑	⚑	⚑	⚑	⚑	A
Gloria Hyatt – Non-Executive Director	⚑	⚑	⚑	⚑	⚑	⚑	⚑	⚑	⚑	⚑	⚑	⚑
Sarah Walker – Non-Executive Director	⚑	⚑	A	⚑	⚑	A	⚑	⚑	⚑	A	A	⚑
Jackie Bird – Non-Executive Director	⚑	⚑	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/	
037	**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.
038	**Patient Story** The EPAU Team Leader explained that the Early Pregnancy Assessment Unit (EPAU) team assisted women with early pregnancy complications, providing both medical assessments and emotional support. Previously, the unit within the Gynaecology Emergency Department faced significant limitations due to space constraints, impacting the ability to offer comprehensive care. Despite initial plans for relocation being delayed due to funding issues, the team persevered, and in November 2023, EPAU became a separate department on the second floor of the Crown Street site. This move had enhanced patient privacy, dignity, and care continuity, allowing the Trust to offer improved medical management for miscarriages and better overall patient experiences. The Chief People Officer queried the next steps that were planned. The Gynaecology Matron noted that the team continued to seek feedback from patients to seek further improvements to their experience. The Chief Operating Officer noted that the EPAU being a standalone service was providing additional opportunities for professional development which was an additional positive impact of the change. The Chair thanked the EPAU Team for their time in attending the Board to share their story and for their continued hard work in improving the service for patients. The Board of Directors noted the patient story.
039	**Minutes of the previous meeting held on 11 April 2024**

	The minutes of the Board of Directors meeting held on 11 April 2024 were agreed as a true and accurate record. In terms of matters arising, Non-Executive Director, Jackie Bird noted that issues relating to staffing had been highlighted during a Maternity Safety Champion visit. The staff had asserted that this was being partly driven by a higher emergency C-Section rate, following a failed Induction of Labour. The Chief Medical Officer noted that this issue had been reported anecdotally via other reporting mechanisms and a capacity and demand analysis was being undertaken. The Chair asked how staffing challenges were reported and escalated. The Deputy Chief Nurse & Midwife explained that there were four hourly reviews and a daily huddle for immediate operational management purposes. Issues from these were escalated to the Deputy Chief Nurse & Midwife for action. A detailed review was undertaken on a six-monthly basis and reported to the Board. It was noted that meetings were scheduled with the Family Health Division Senior Leadership Team to explore and understand the drivers behind the recent shortages.
040	Action Log and matters arising Updates against action log were noted.
041	Chief Executive Report The Chief Executive provided an update on several significant developments affecting the Trust. It was noted that this was the first iteration of a new way of working in terms of receiving the key performance reports (integrated Performance Report, Executive Risk and Safety Group Report and the Improvement Plan Highlight Report) at the beginning of the meeting. This was intended to frame the key issues and risks impacting the Trust and provide an opportunity for triangulation in the Board discussion. The Chief Executive reported that in a letter received on 26 April 2024, NHS England confirmed that, following a review of cancer performance, the Trust would move to Tier 1 for Cancer from 29 April 2024. This involved regular meetings for progress discussions and support. Despite improvements in patient backlog and diagnosis times, the Trust remained below targets. The Trust would collaborate with Cheshire & Merseyside Cancer Alliance and regional NHS teams to accelerate performance improvements. Updates on the Cancer Improvement Project within the Improvement Plan would provide a mechanism for the Board to receive detailed oversight and assurance. The Chair asked if there was clarity on the targets that needed to be met to de-escalate the Trust from Tier 1. The Chief Operating Officer stated that the 75% Faster Diagnostic Standard (FDS) was the national target (to be met by March 2025). The Trust was aiming to meet and exceed this target as quickly as possible. Actions being taken included increasing capacity to focus on the largest cancer query pathways and to improve the efficiency of the pre-operative process. The Chief Executive added that the tiering process had an element of subjectivity and took into consideration operational context. Therefore, it would be important for the Trust to remain cognisant of benchmarking information when assessing performance. Non-Executive Director, Tracy Ellery, asked if there was a need to re-prioritise efforts and available resources within the cancer improvement project. The Chief Executive confirmed that the appropriate resource had been identified for the cancer improvement project and that all workstreams would need to be completed as there were several interdependencies. Non-Executive Director, Sarah Walker, sought further information on whether the Trust was an outlier in relation to the number of referrals received. The Chief Operating Officer reported that the Trust was receiving a high level of referrals on the cancer pathway and attention was on both reducing inappropriate referrals and improving FDS compliance. Non-Executive Director, Louise Martin, queried if there would be an impact on the Trust's National Oversight Framework (NOF) segmentation. It was confirmed that an exit criterion from NOF segmentation level three was being out of the cancer tiering process.

	Providing an update on the Women's Hospital Services in Liverpool Programme, it was noted that a clinical engagement event took place on 3 May 2024. Participants included approximately sixty clinicians from across the city's NHS organisations, Healthwatch representatives and individuals with lived experience. Risks across the system for women's health were discussed with a focus on the immediate and medium-term actions that were required in recognition that a new hospital located adjacently to an adult acute site was not deliverable for several years. The Chief Executive summarised the risks identified in the event as follows: • Lack of appropriate infrastructure • The need to meet new standards • The risk of pregnant women presenting at other (non-Crown St) sites Outlining the outputs from the Executive Risk and Assurance Group (ERAG), the Chief Executive asserted that there were positive indications that risk discussions were becoming increasingly prominent in the organisation and that it was being used as a tool for escalation and prioritisation. Non-Executive Director, Louise Martin, noted the environmental issues relating to the maternity base that had been highlighted in the ERAG report and asked if these had been factored into the capital plan. The Chief Operating Officer confirmed that the Family Health Division had been asked to articulate the level of risk to a future ERAG meeting. If necessary, capital could be reallocated in-year, however, a more likely route would be for the Division to develop a business case for capital funding to be allocated in the 2025/26 plan. Drawing attention to the performance report, the Chief Executive stated that Personal Development Review compliance had been identified as a concern and actions were in place to drive immediate improvements. The Chair queried if the target set for theatre utilisation was realistic. The Chief Operating Officer confirmed that the target was appropriate and that there were opportunities for improvement that were being sought. The Board of Directors noted the report.
042	Finance Performance: Month 12 2023/24, 2025/25 Plan The Chief Finance Officer reported that the Trust had faced a challenging financial plan for 2023/24 with a £15.5m deficit, which was revised to £22.6m after a national re-forecasting exercise in November 2023. By Month 12, the Trust reported a £22.6m deficit, a £7.1m adverse variance from the plan, supported by £3.9m of non-recurrent items. The Cost Improvement Programme (CIP) achieved £7.4m in savings, £1.0m short of the £8.3m target. Of these savings, £3.7m were recurrent. The cash balance was £2.0m at the end of Month 12. For 2024/25, the Trust Board had approved a finance, activity, and workforce plan on 24 April 2024. The plan included a £29.5m income and expenditure deficit, a £5.3m CIP, and a £9.8m capital plan, with £4.8m from Public Dividend Capital and £5.0m from the Capital Departmental Expenditure Limit. The workforce plan aimed for 1,784.2 Whole Time Equivalents (WTE) by Month 12, with activity projected at 109% of the 2019/20 adjusted baseline. The Chief Finance Officer noted that uplifts to the number of WTE staff related to quality and safety requirements, and Liverpool Neonatal Partnership and Community Diagnostic Centre resourcing, and could therefore be fully articulated. Overall, it was asserted that whilst the plan was challenging, it was realistic and deliverable. Non-Executive Directors Louise Martin and Tracy Ellery queried if there had been any further requests from the Integrated Care Board and whether the final 2023/24 outturn at a system level had been published. The Chief Finance Officer confirmed that the final system outturn had yet to be published and that whilst there had been an indication that there was residual total that remained outstanding across the system for 2024/25 planning, there had yet to be a specific ask of the Trust. The Chair remarked that a £29.5m deficit was a significant proportion of the Trust's turnover and that it would be important to remain focused on the opportunities for internal efficiencies whilst also participating in more system-level discussions. Non-Executive Director, Sarah Walker, noted that the

	Finance, Performance and Business Development Committee had highlighted a concern regarding a dependency on non-recurrent CIP items. The Committee was moving to focus attention on matters relating to medium term planning and issues that would elicit structural change in the Trust's financial position. The Board of Directors noted the 2023/24 Month 12 financial position and 2024/25 plan.
043	LWH Improvement Plan Highlight Report 1 The Chief Transformation Officer reported that the 10-week Improvement Plan Mobilisation had completed and that it was now in a delivery stage. The work undertaken within the Mobilisation Phase had been summarised in an Improvement Plan Portfolio Definition Document which was appended to the Highlight Report. Whilst further work was required to fully operationalise the underpinning systems and processes e.g. risk and benefit mapping, all projects were underway and working against their defined milestones. The heatmap element of the report was explained, noting that this was a tool with RAYG ratings driven by algorithms, that would support the Board by providing focus to areas requiring scrutiny. An initial Improvement Plan Portfolio Board had met on the 8 May 2024 and additional risks had been identified through the discussions on the various projects. Key areas for future development included maturing the risk profile and developing the performance dashboard. The Board commented that the heatmap was showing predominantly 'green' ratings across the various projects and it was queried whether this was reflective of the Trust's current performance in these areas. The Chief Transformation Officer explained that the current ratings were not reflective of the current performance or level of risk for the various areas of business but rather a reflection of the current state of project delivery. As the projects were at the beginning of a delivery stage, the current ratings were not unexpected, and it was likely that a more dynamic heatmap would be seen in future reports. The Chair remarked that the Improvement Plan Highlight Reports, if used effectively, would support the Board in being structured its deliberations. The Board of Directors: • noted the completion of the Mobilisation Phase of the Improvement Plan, and • received the first Highlight Report which summarised delivery progress and key points to note.
044	Maternity Incentive Scheme (CNST) Year 6 2024 – Scheme Release Position May 2024 The Deputy Director of Nursing & Midwifery outlined 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 provided a position statement for all standards and clarity on Board reporting for the forthcoming year. It was noted that a dashboard was in development that would provide the Board with greater clarity regarding on-going compliance as part of the Integrated Performance Report. Non-Executive Director, Jackie Bird, remarked that there was a significant amount of responsibility placed on the Family Health Division to provide operational oversight on compliance issues and escalate when necessary. The Deputy Director of Nursing & Midwifery asserted that there were mature governance oversight processes in place and Non-Executive Director, Sarah Walker, added that a good level of assurance had been provided to the Quality Committee for previous years. The Board of Directors: • Noted the current position in relation to the recently published Maternity Incentive Scheme Year 6. • Agreed the proposed reporting timescales to ensure compliance with the scheme.

045	**Service Outline – Pre-Term Optimisation** The Neonatal Consultant attended to outline the Preterm Optimisation Group (POG) at Liverpool Women's Hospital, which was established in January 2023, to focus on improving outcomes for preterm infants through evidence-based interventions. The group, comprising obstetricians, neonatologists, nurses, and data leads, met monthly to review data on preterm births and discuss quality improvement (QI) initiatives. The group had successfully implemented several interventions, such as early caffeine administration for infants born before 30 weeks and volume-targeted ventilation for those born before 34 weeks requiring invasive ventilation. Key achievements included maintaining good temperature control and ensuring early administration of maternal breast milk. The POG also organised an annual Preterm Optimisation Week to raise awareness and provide education on preterm care. Future plans included developing new care pathways for the smallest babies and enhancing regional training to reduce bronchopulmonary dysplasia rates. The POG was also working with The Tiny Baby Collaborative, an external group of exemplar institutions that aimed to foster collaboration and mutual learning among hospitals with exceptional outcomes for the most premature neonates. The Chief Transformation Officer remarked that the POG was a good example of effectively managing a program of change and continuous improvement. The ambitions of the POG were queried, and it was asked if there were plans to join The Tiny Baby Collaborative. The Neonatal Consultant confirmed that the POG was liaising with the Collaborative and was aiming to have the best neonatal survival rate in the UK. The Chief Medical Officer noted that the POG was a good example of multi-disciplinary working. Noting that there was a challenge having access to meaningful data around the delivery of prophylactic antibiotics, the Chief Digital Information Officer asked whether discussions were taking place with the supplier. It was confirmed that discussions were on-going. The Chief People Officer noted that it was positive that the POG was analysing data through an ethnicity lens and Non-Executive Director, Gloria Hyatt, asked if this intelligence was being applied. The Neonatal Consultant confirmed that the POG would seek support and guidance should the data highlight a particular concern. The Chair stated that it was positive to see teams in the Trust providing strong leadership in the region and being open to new ideas and ways of operating. The Board of Directors noted the service outline.
046	**Committee Chair's Reports** The Board received the following Committee Chair Reports: Quality Committee • 23 April 2024 – Chaired by Sarah Walker Finance Performance & Business Development Committee • 24 April 2024 – Chaired by Louise Martin The Board of Directors noted the Committee Chair's Reports.
047	**Board Assurance Framework** The Board Assurance Framework (BAF) report outlined the proposed risk scoring for Q4 2023/24 and the planned changes for 2024/25. Key proposed Q4 scores included maintaining a risk score of 12 for workforce recruitment, 20 for clinical service sustainability, and 8 for patient experience, among others. Notably, the risk score for digital systems and cyber security was proposed to be reduced from 16 to 12, indicating progress in EPR system optimization.

	For 2024/25, proposed changes to the BAF included reframing the risk related to clinical service sustainability to separate the issues of the isolated site and patient deterioration. Additionally, the financial sustainability risk would be adjusted to focus on long-term financial health. There was also consideration of integrating patient experience into other risk areas and refining the partnership effectiveness risk. These changes would aim to ensure that the BAF accurately reflected the Trust's strategic environment and risk profile. The Board of Directors: • reviewed the BAF risks and agreed on their contents and actions. • agreed the suggested Q4 scores
048	Review of risk impacts of items discussed No new risk items identified.
049	Chair's Log None noted.
050	Any other business & Review of meeting None noted. Review of meeting No comments noted.
051	Jargon Buster Noted.

Liverpool Women's
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Action Log

Trust Board - Public
11 July 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~~ September 2024	On track	Opportunity to hold this in September owing to the availability of the NHSE Team
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	Complete	Benchmarking information has been built into PowerBI and has been included in the updated IPR.
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	Complete	Update provided in the CEO Report since action agreed. Formal report from the Programme Board to be made available in future meetings (added to work programme).
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~~ September 2024	On track	Six monthly midwifery staffing report scheduled for September 2024 Board.
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	Complete	Updated workforce KPIs have been built into PowerBI and have been included in the updated IPR.

Liverpool Women's
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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
None received or delegated.						

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Meeting Date	Thursday, 11 July 2024	**Item Reference**	24/25/081
Report Title	**Chief Executive's Report**		
Author	***James Sumner, Chief Executive Officer***		
Responsible Director	***James Sumner, Chief Executive Officer***		

Purpose of Report	To provide the Board of Directors with details of key activities and issues from the Chief Executive since the last update in May 2024.
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 May 2024.
Key Areas of Concern	No areas of concern noted.
Trust Strategy and System Impact	The Chief Executive Report provides the Board with crucial updates and highlights the Chief Executive's activities since May 2024, aligning with the Trust's strategy and NHS Cheshire and Merseyside system priorities by addressing health and wellbeing, service quality, and resource efficiency. It ensures compliance with the 'triple aim' by considering impacts on health inequalities, service benefits, and sustainability.

Links to Board Assurance Framework		**-**
Links to Corporate Risk Register (scoring 10+)		**-**

Assurance Level	1. SUBSTANTIAL - Good system of internal control applied to meet existing objectives

Action Required by the Board	The Board of Directors is asked to: • note the content of the report • note the Integrated Performance Report • note the Executive Risk and Assurance Group Reports

REPORT DEVELOPMENT:

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

MAIN REPORT

ITEMS FOR INFORMATION

System Oversight Group Meeting

The National Oversight Framework (NOF) was established by NHS England to monitor Integrated Care Boards (ICBs) and NHS trusts. It aims to ensure quality care, access, financial stability, and effective leadership and uses five national themes for assessment: quality, access, prevention, resources, and leadership. Trusts are placed in a segment following assessment with a sliding scale of autonomy and intervention from segment one (least) to segment four (most). The Trust has been placed in segment 3 and as a result the Trust attends System Oversight Group meetings with the Cheshire & Merseyside Integrated Care Board (ICB) to discuss progress against the exit criteria that was agreed in April 2024.

The latest System Oversight Group meeting is scheduled for 10 July 2024 and therefore I will provide a verbal update on the key headlines at the Board meeting.

Women's Hospital Services in Liverpool Programme

The Women's Hospital Services in Liverpool (WHSIL) Programme aims to develop a clinically sustainable model of care for hospital-based maternity and gynaecology services that are delivered in Liverpool. This will involve assessing the current clinical risks and issues in hospital-based maternity and gynaecology services in Liverpool and developing short, medium, and long-term solutions and proposals for mitigating, controlling, and resolving the risks and issues.

A significant amount of work has been undertaken since the previous report to the Board in May 2024. A draft Case for Change was considered by the Board in a private session in June 2024 and this has also been reviewed by the Boards of Liverpool University Hospitals NHS FT, Alder Hey Children's Hospital NHS FT and Clatterbridge Cancer Centre NHS FT, with all noting their support. Ongoing progress with the case is expected until September 2024 as additional evidence and comparative data become available.

Other actions taken in the period include:

- A strategic plan for communications and engagement has been developed.
- The plan for recruiting lay advisers and establishing a lived experience panel is ready but recruitment is on hold until after the election.
- A draft plan for pre-consultation and engagement has been reviewed and will be presented to the programme board in July 2024.

Future action will be focused on finalising the Case for Change and the continued recruitment of lay advisers and establishment of the lived experience panel.

Executive Risk and Assurance Group

The Executive Risk and Assurance Group has met twice since the previous Board meeting – on the 12 June 2024 and 3 July 2024. There has been good engagement from attendees and whilst the meeting

will continue to develop, there is clear evidence of the risk-focussed approach becoming increasingly embedded.

The Executive Risk & Assurance Group (ERAG) meeting on 12 June 2024 discussed several key issues. The Gynaecology Division's Duty of Candour compliance dropped due to a governance facilitator change, necessitating a re-audit. Personal Development Review rates were below expectations, particularly in non-clinical areas. Maternity base challenges, including estate configuration and medication management, are under review with immediate actions and weekly audits. Out-of-date policies remained a concern, with a goal of zero overdue policies set for July 2024. Additionally, acute out-of-hours medical cover risks in Gynaecology and CSS were noted.

The ERAG meeting was again held on 3 July 2024, and it was agreed that the updated risk management approach has led to a more transparent understanding of risks, allowing for better management and control within the organisation. Significant progress was made in reducing overdue policies from 57 to 13, with Maternity and Gynaecology now achieving zero overdue policies. The Group will now receive a report by exception due to a new tracking dashboard included within the Integrated Performance Report. Concerns were raised about the integration of digital systems, particularly affecting pharmacy operations and reporting. There is an ongoing review to address these issues, with a focus on improving system connectivity and mitigating potential risks. Clarification was provided on the Maternity Estate risk, distinguishing between clinical safety risks and experiential risks due to estate limitations. A commitment was made to resolve these issues, not confined by capital constraints, to ensure patient safety and experience. The CSS Division reported progress in addressing the anaesthetics capacity out of hours risk, with Task and Finish groups in place to review Gynaecology and Obstetrics capacity and clinical patient pathways. Ongoing recruitment is underway in Anaesthetics with an aim to increase middle grade presence.

Please see Appendix B for further detail.

‘Big Conversation’

For a number of years, the Trust hosted quarterly Listening events, face to face in the Blair Bell where staff were required to book a place in advance. During covid we adapted this to a virtual listening event, utilising MS teams. In response to feedback and limited levels of engagement, a decision was taken in 2022 to host a **24-hour Big Conversation** on a bi-annual basis. This requires volunteers from the Executive team, Non-Executive Directors, Senior Leaders, and the Workforce team to visit different teams / departments throughout the 24-hour period (with some follow ups over the week).
The most recent Big Conversation took place during May 2024 and the top five themes were as follows:

- **Staffing:** Increase headcount for clinical staff and add more Ward Clerk/Administrative support across various departments.
- **Processes:** Address issues with interpreter services, improve email etiquette, implement green strategies, reduce recruitment delays, and standardise pay dates.
- **Leadership:** Increase senior leadership presence, set realistic work timelines, and clarification on future Trust strategy.
- **Space:** Update changing/shower facilities, improve staffrooms, and enhance patient facilities with private spaces and larger rooms.
- **Estates:** Improve response times, cleanliness, signage, ventilation, and car parking conditions.

All divisions and their areas are now in receipt of their feedback packs and have been asked to draft an action plan on some of the identified areas of improvement. HR will support the areas with the "You Said, Together We Will…" updates, to feed back to staff.

The attached infographic (Appendix C) has been circulated to all staff.

PERFORMANCE SUMMARY

The Executive Team with the Informatics Team have undertaken a review of Key Performance Indicators (KPI) for 2024/25. The updated Board integrated performance report includes additional metrics and makes better use of statistical process control (SPC) and benchmarking to improve the understanding and escalation of these metrics.

All Key performance metrics have been through all Trust Executive Groups for review. Below are the key metrics/areas where statistical variation has been noted and were escalated for further oversight and assurance.

Operational Performance

Overall size of the waiting list – The waiting list continues an improving trend, showing statistical reduction since a peak seen in October 2023 and introduction of the Trust Improvement Plan. Forecast data for June 2024 demonstrates that the waiting list size has reduced further to 17687, showing a better-than-expected figure against the Trust set trajectories with NHS England for 24/25. The key focus through Q2 24/25 will be increased validation of the waiting list and ensuring that Data Quality principles and processes are adhered to alongside increased activity in Gynaecology to reduce outpatient wating times.

Elective Recovery – 65+ weeks continue to demonstrate statistical improvement with further reductions made including a 50% reduction from M1 and in line with NHSE set trajectories. Cheshire & Merseyside ICB requested that the Trust support the regional gynaecology position by providing mutual aid to other Trusts of which 50 patients >65+ weeks were accepted. 52+ weeks continues to statistically show a sustained reduction and significantly ahead of NHSE targets.

Cancer – All metrics show an improving position in May albeit unvalidated at this stage. The 28 Day Faster Diagnosis Standard continues its positive trend over the last 5 months with May performance demonstrating further improvement at 63%. 31 Day has significantly improved to >90% and whilst 62 Day has improved by 15% on the previous month there is still further work to do to improve performance. The Trust continues to be monitored through national Tier 1 performance oversight. A review of tiering is due to take place in mid-July. The Trust has been awarded >£500k of national funding to support continued improvements in performance. The Cancer Improvement Plan continues to be reviewed and accelerated where possible to ensure trajectories are met.

Quality

Never Events – There are currently 3 ongoing Never Event investigations. All investigations are being progressed and in accordance with the Trust governance processes. The Quality Committee have received a detailed summary of immediate actions taken and will be updated on conclusion of the investigation findings.

Number of Open PSIIs – 23 open with investigations ongoing, reflecting no significant change in assurance, however high numbers of variation noted will decrease when a review of PSIRF is completed in Q1/Q2, 24/25 as the review will refine priorities and what we declare as a full investigation. All PSII have been reported to the ICB and received an initial target date of completion.

Number of PSII (rolling) - the position reflects the cumulative number of PSIIs declared since launching PSIRF in September 2023. This number is expected to reduce and therefore be capable of remaining under threshold, with planned review of PSIRF.

FFT A&E Percentage Positive – Deterioration of FFT in A&E at 65.91% from previous month, reflecting the process is missing the target with a special cause variation of a concerning nature. Themes noted include long waits to be seen during evenings and lack of availability of scans out of hours and weekends. The divisional senior leadership team are well sighted on themes and the GED improvement plan will draw together and monitor progress to meet the target and sustain position when met.

FFT Maternity Percentage positive - Maternity have deteriorated (86.17%) from previous improvements being made, reflecting a position of consistently failing to meet the target with no significant change to common cause variation. 8 displeased comments received and analysed with no correlation or themes noted from the displeased comments and none related to the previous themes of IOL. Maternity continues to be sighted on issues and improve.

3rd and 4th Degree Tears - The reported tear rates have previously been much lower than the national average and Maternity have had a good culture for using the Obstetric and Sphincter Injury (OASI) bundle and access to Episcissors (adapted surgical scissors used for episiotomy). The division are aware of the increase in rates and have already received audit findings for the management of tears from diagnosis, presented to the clinical meeting in June 2024. All individual cases are reviewed to identify risk factors and ensure the Postnatal care is to the level expected whilst also looking at rates in cohorts of clinical staff. However, due to the increase in rates, and the limitations of learning from reviewing individual cases, a thematic analysis has been commissioned to be undertaken by the Consultant Midwife and an Obstetric Trainee that will provide clinician level detail to support continuous understanding of the position and support any recommended improvements, including supportive training.

Workforce

Clinical Mandatory Training – Although this figure has remained static over the preceding 12 months, it is under the 95% target. Recruitment to a new role within the practice education team is expected to deliver an improvement in the planning and delivery of mandatory training and opportunities cross-division and cross-speciality maximised. PODEG reviewed and supported a recommendation to reduce the targets for mandatory training compliance for core, clinical and local mandatory training from **95% to 90%** to ensure alignment with the region, following a benchmarking exercise with other Trusts in C&M.

Sickness Absence – At 4.86%, this metric is improving and although below the 4.5% target, the rate is the lowest recorded since 18/19. Adherence to policy and process remains in place, with a focus on quality return to work interviews and wellbeing conversations (65% compliant) with additional training being provided to managers on wellbeing conversations by the Health and Wellbeing Coach. Prevalence of anxiety/stress/depression has reduced as the primary reason for absence, supporting the rationale for focused psychological intervention through the staff support service. Significantly reduced vacancies within clinical areas and further extension of flexible working in clinical areas can also be seen as a positive contributor.

PDR Rate - PDR compliance remained a concern with an overall Trust performance of 79% against target of 90% and a deteriorating trend over the last 12 months. Engagement with staff and managers confirmed support for a group PDR model for some staff groups and bands and this is in the process of being rolled out. Improved compliance with the PDR window of March and April for Band 8as and above is required to ensure consistent and targeted objective setting across the organisation.

The Integrated Performance Report is included at Appendix A.

Equality, Diversity & Inclusion Implications
Not applicable

Quality, Financial or Workforce implications
Not applicable

RECOMMENDATION

The Board of Directors is asked to:

- note the content of the report
- note the Integrated Performance Report.
- Note the Executive Risk and Assurance Group Reports

SUPPORTING DOCUMENTS

Appendix A – Integrated Performance Report
Appendix B – Executive Risk and Assurance Group Reports

- *12 June 2024*
- *3 July 2024*

Appendix C – Big Conversation Infographic

Liverpool Women's
NHS Foundation Trust

Trust Board

Performance Report

July 2024

Integrated Performance Report

Contents

Section 1: Statistical Variation Summary

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'.

Positive Higher or Lower Variation

KPI	P	A	V
18 Week RTT: Incomplete Pathway > 52 Weeks	998	?	L
18 Week RTT: Incomplete Pathway > 65 Weeks	91	?	L
18 Week RTT: Incomplete Pathway > 78 Weeks	0	?	L
Cancer: 28 Day Faster Diagnosis	63.43%	?	H
Hypoxic Encephalopathy (Grade 2,3)	0		L
Overall Staff Vacancies WTE	31.88		L
Sickness Absence Rate	4.86%	F	L

Common Cause Previously Concerning

KPI	Target	P	A	V
Cancer: 31 Day decision to treat to treatment	>=96%	93.94%	F	

Concerning Higher or Lower Variation

KPI	P	A	V
3rd and 4th Degree Tears	3.85%	?	H
Mandatory Training (Clinical)	83.60%	F	L
Never Events (Rolling 12 Months)	3	F	H
Number of Open Patient Safety Incident Investigations	23		H
PDR Rate	79.00%	F	L
Proportion of staff in senior leadership roles BME background	5.88%		L
Total Number of Patient Safety Incident Investigations (Rolling)	23	P	H

Liverpool Women's NHS Foundation Trust

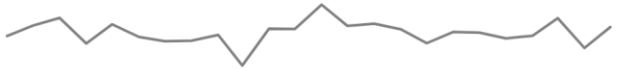
Quality & Safety Indicators

Executive Leads:
Dianne Brown, Chief Nurse
Lynn Greenhalgh, Chief Medical Officer

LWH Quality & Safety Indicators Summary

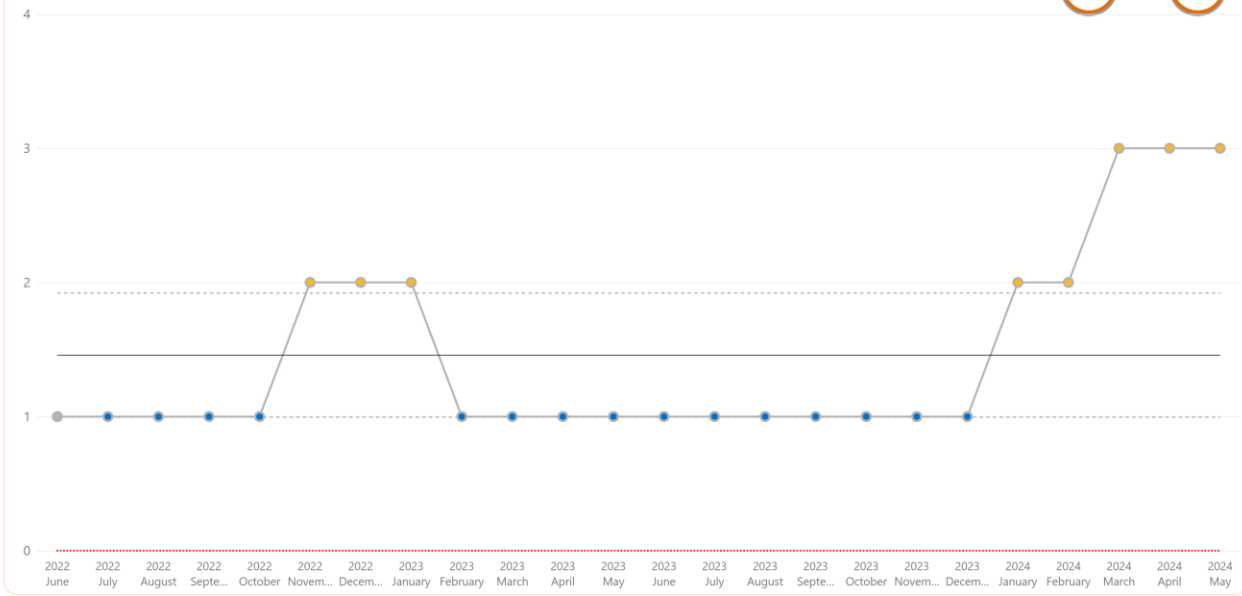
Domain	Date	Target < or >	Performance	Assurance	Variation	Assurance Category	Trend
Governance							
Never Events (Rolling 12 Months)	May 2024	<=	3	F	H	Take Action	
NHSE / NHSI Safety Alerts Outstanding	May 2024	<=	0	P		Celebrate	
Number of Open Patient Safety Incident Investigations	May 2024	<=	23		H	Take Action	
Patient Safety Incident Investigations (PSII's) Completed Within 60 Working Days							
PSII Action Plans Completed Within The Prescribed Timescales							
Total Number of Patient Safety Incident Investigations (Rolling)	May 2024	<=	23	P	H	Take Action	
Infection Control							
Infection Control: Clostridium Difficile	May 2024	<=	0	P		Celebrate	
Infection Control: MRSA	May 2024	<=	0	P		Celebrate	
Patient Experience							
Complaints: Number Received	May 2024	<=	1	P		Celebrate	
Friends & Family Test: A&E % positive	May 2024	>=	65.91%	F		Take Action	
Friends & Family Test: In-patient/Daycase % positive	May 2024	>=	93.10%	?		Watch	
Friends & Family Test: Maternity % positive	May 2024	>=	86.17%	F		Take Action	
Patient Safety							
Venous Thromboembolism (VTE)	May 2024	>=	94.76%	?		Watch	

LWH Quality & Safety Indicators Summary

Domain	Date	Target < or >	Performance	Assurance	Variation	Assurance Category	Trend
Maternity Signals Chart							
3rd and 4th Degree Tears	May 2024	<=	3.85%			Take Action	
Hypoxic Encephalopathy (Grade 2,3)	May 2024	<=	0			Celebrate	
Inborn term babies admitted to NICU	May 2024	<=	5.55%			Watch	
Number of births	May 2024		648			Watch	
Number of stillbirths per 1,000 total births	May 2024	<=	7.72			Watch	
PPH > 1500 (per 1000)	May 2024	<=	23.55			Watch	

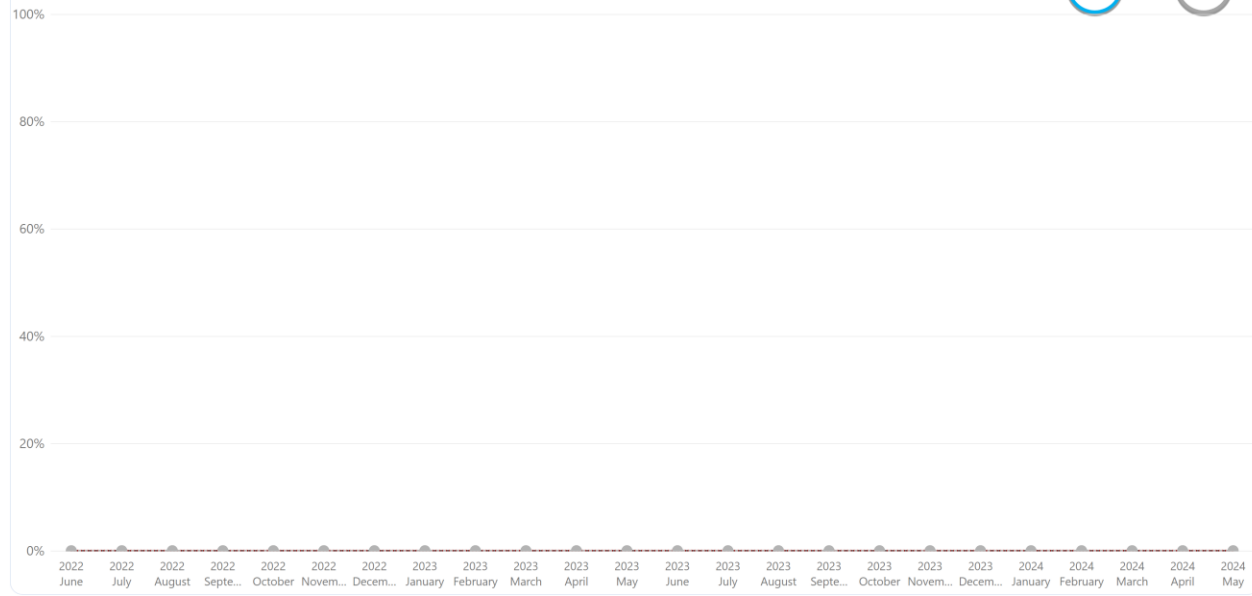
Never Events (Rolling 12 Months) - Medical Director

Target	Target < or >	Performance	Assurance	Variation
0	<=	3	F	H



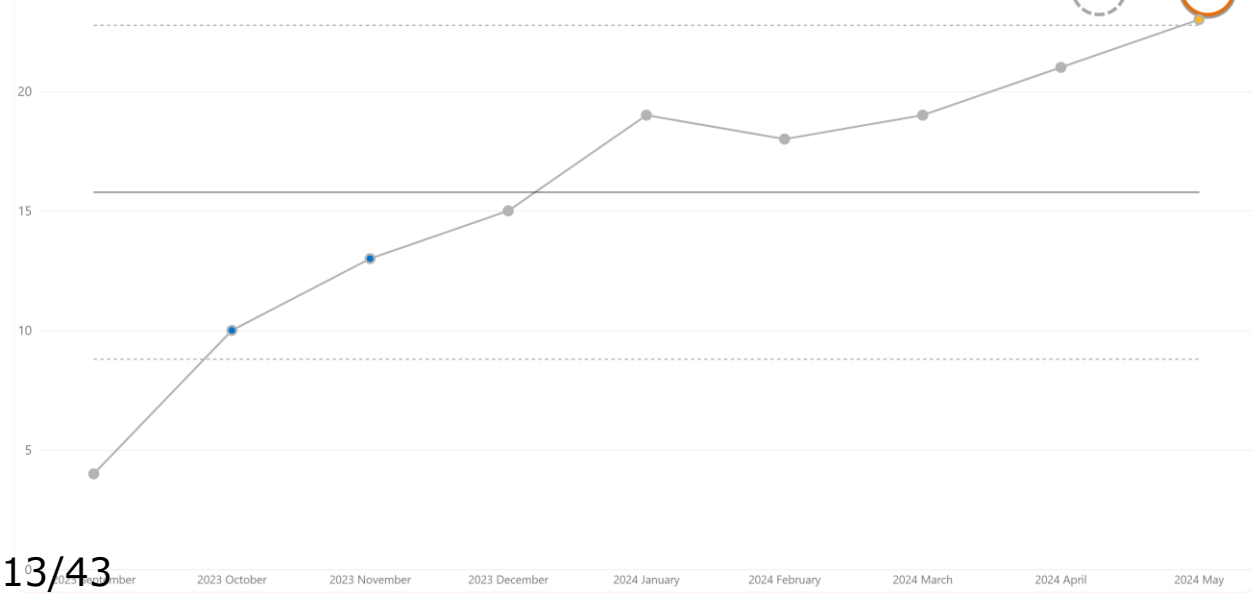
NHSE / NHSI Safety Alerts Outstanding - Chief Nurse

Target	Target < or >	Performance	Assurance	Variation
0	<=	0	P	



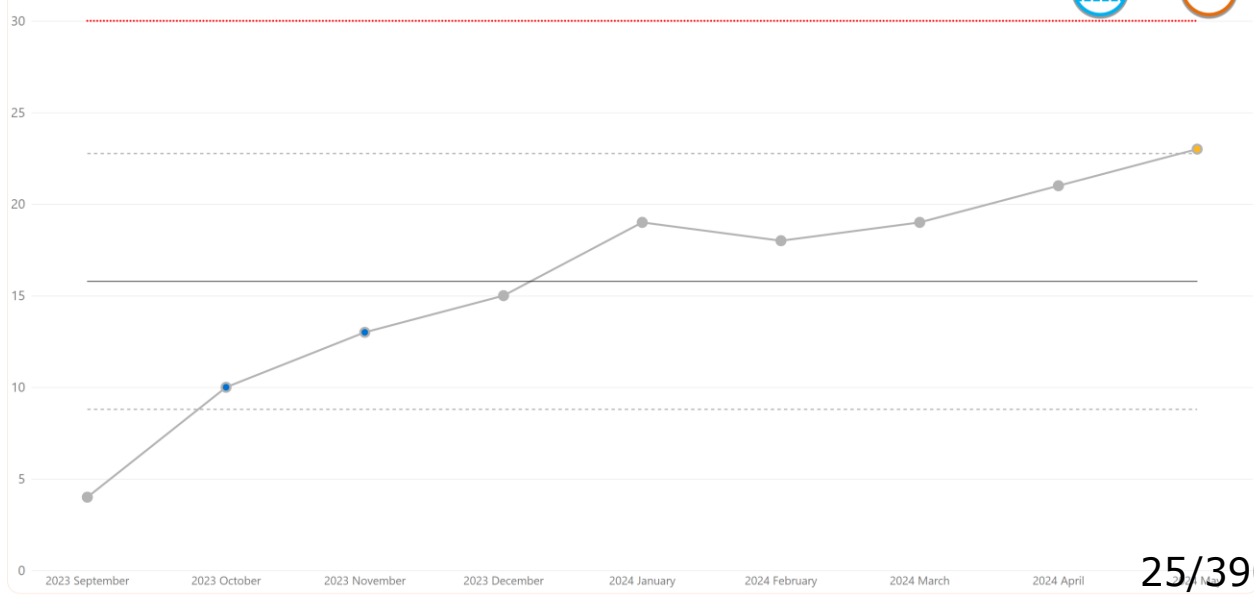
Number of Open Patient Safety Incident Investigations - Chief Nurse

Target	Target < or >	Performance	Assurance	Variation
8	<=	23		H



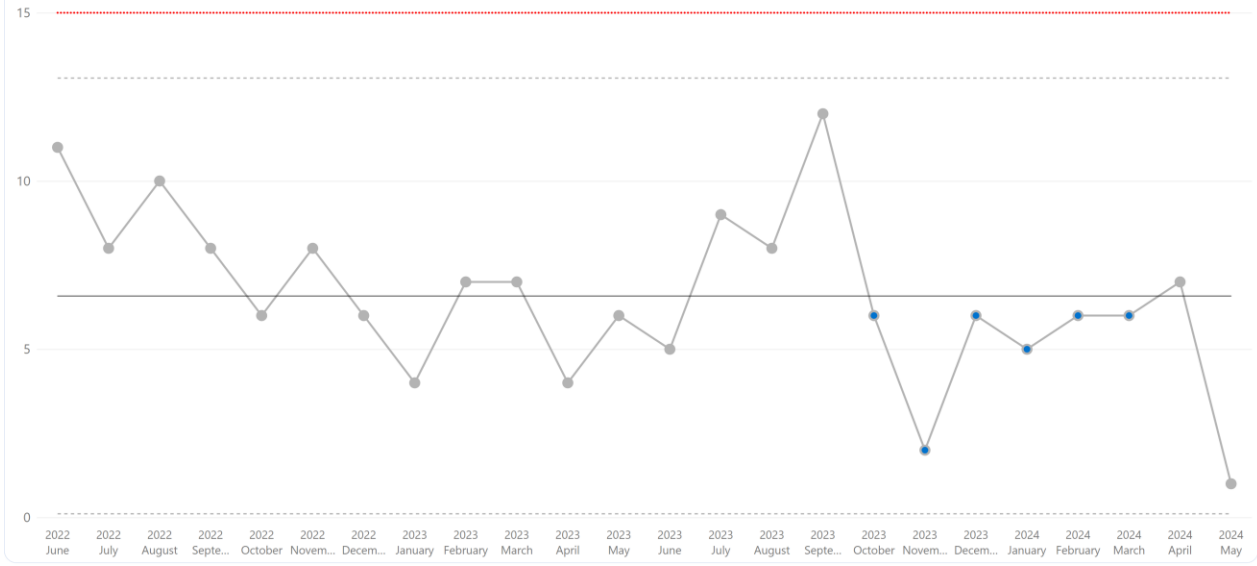
Total Number of Patient Safety Incident Investigations (Rolling) - Chief Nurse

Target	Target < or >	Performance	Assurance	Variation
30	<=	23	P	H



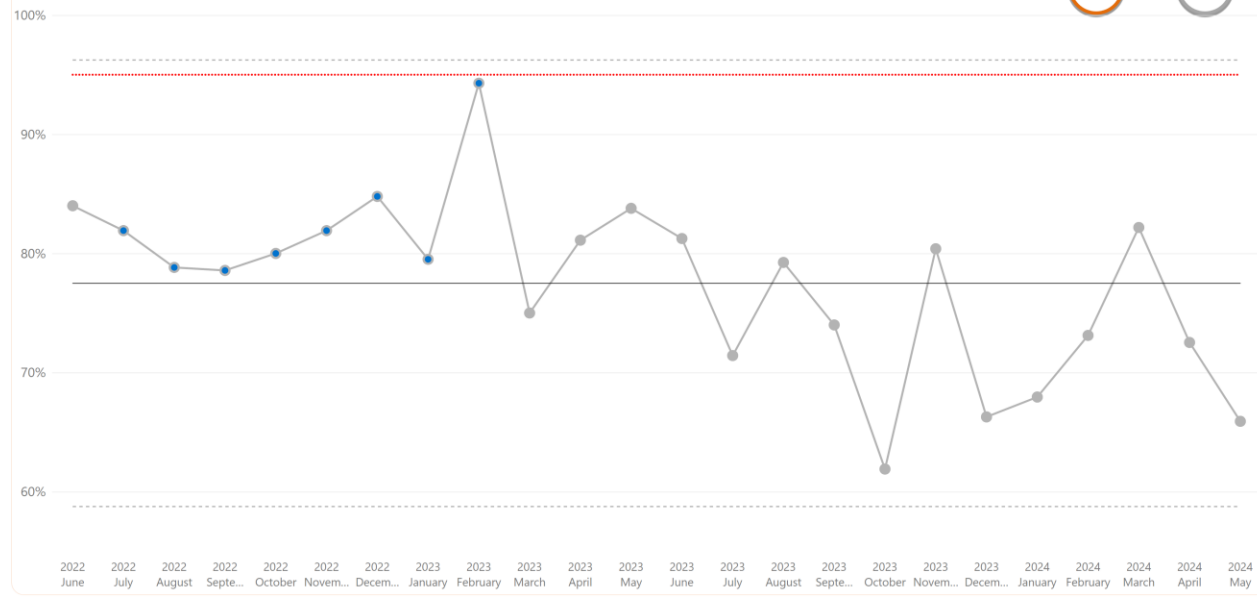
Complaints: Number Received - Chief Nurse

Target	Target < or >	Performance	Assurance	Variation
<= 15	<=	1	P	



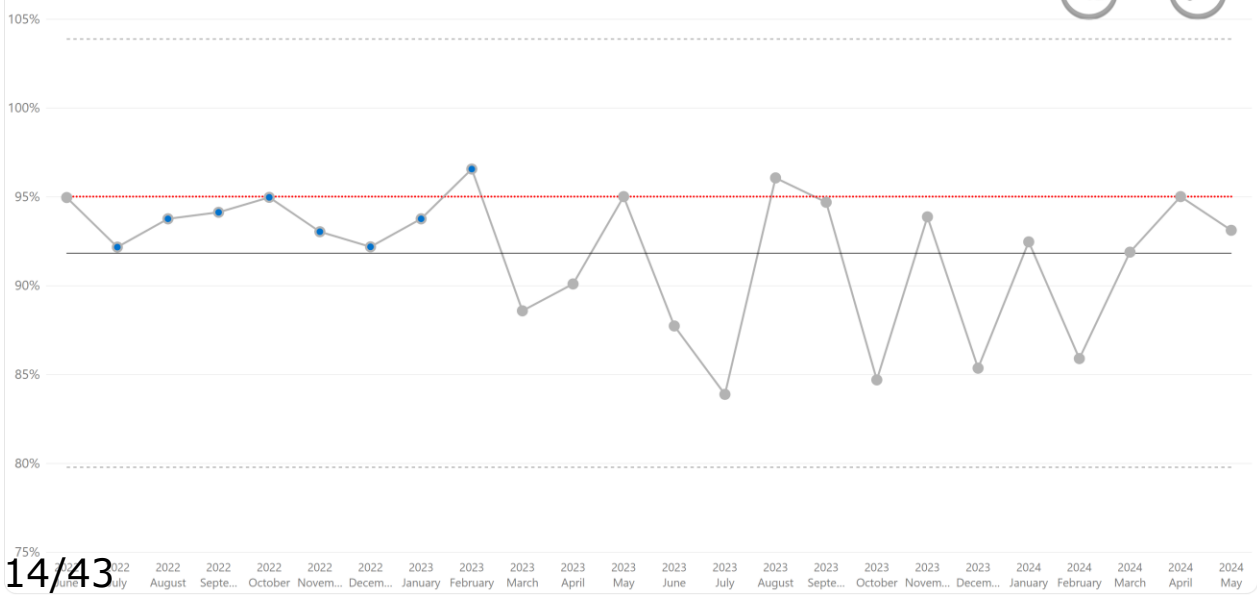
Friends & Family Test: A&E % positive - Chief Nurse

Target	Target < or >	Performance	Assurance	Variation
95%	>=	65.91%	F	



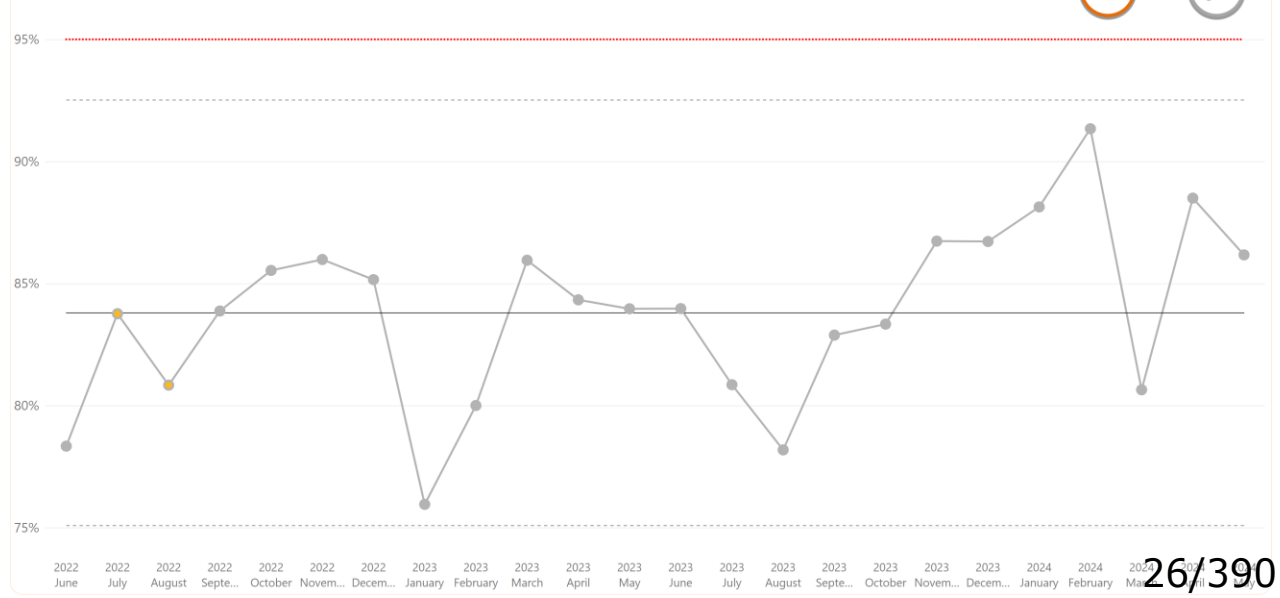
Friends & Family Test: In-patient/Daycase % positive - Chief Nurse

Target	Target < or >	Performance	Assurance	Variation
95%	>=	93.10%	?	



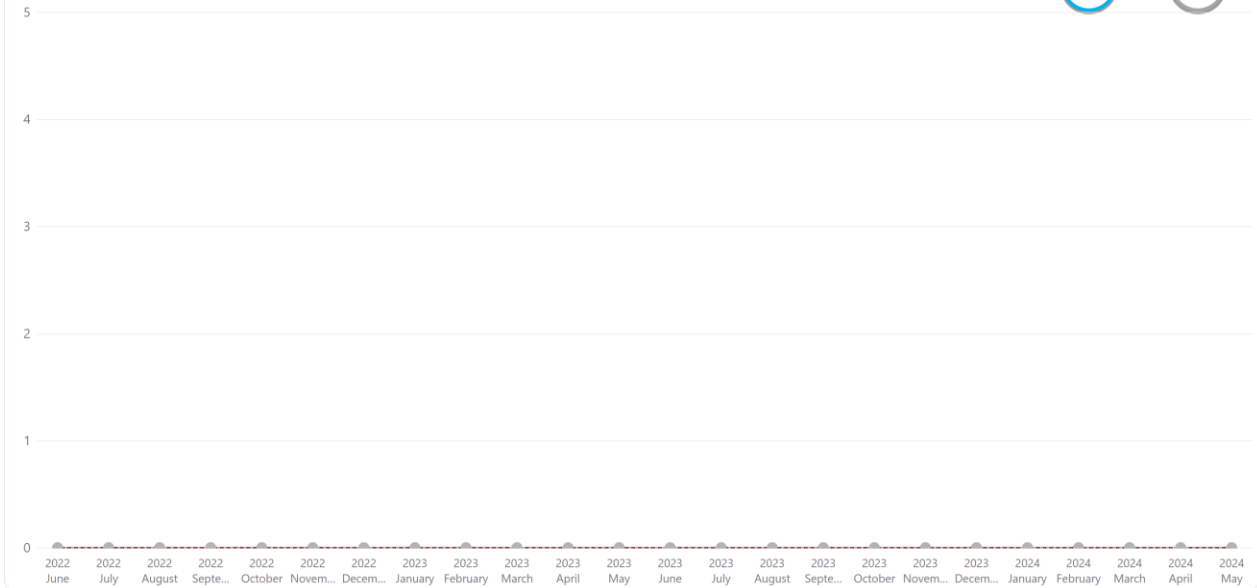
Friends & Family Test: Maternity % positive - Chief Nurse

Target	Target < or >	Performance	Assurance	Variation
95%	>=	86.17%	F	



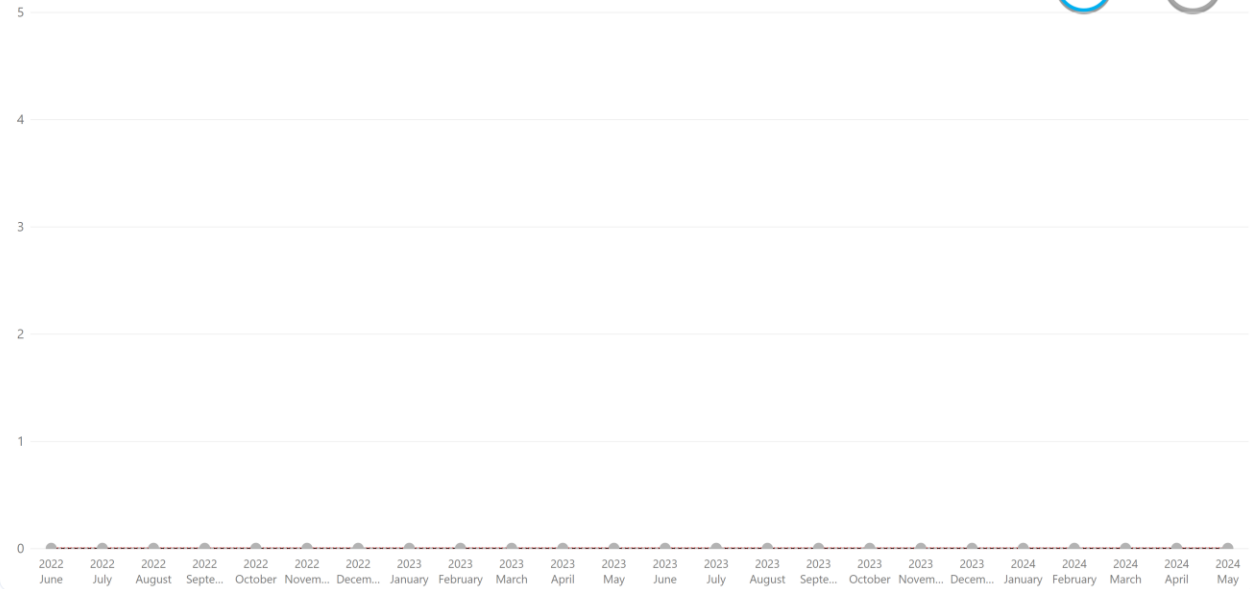
Infection Control: Clostridium Difficile - Chief Nurse

Target	Target < or >	Performance	Assurance	Variation
0	<=	0	P	



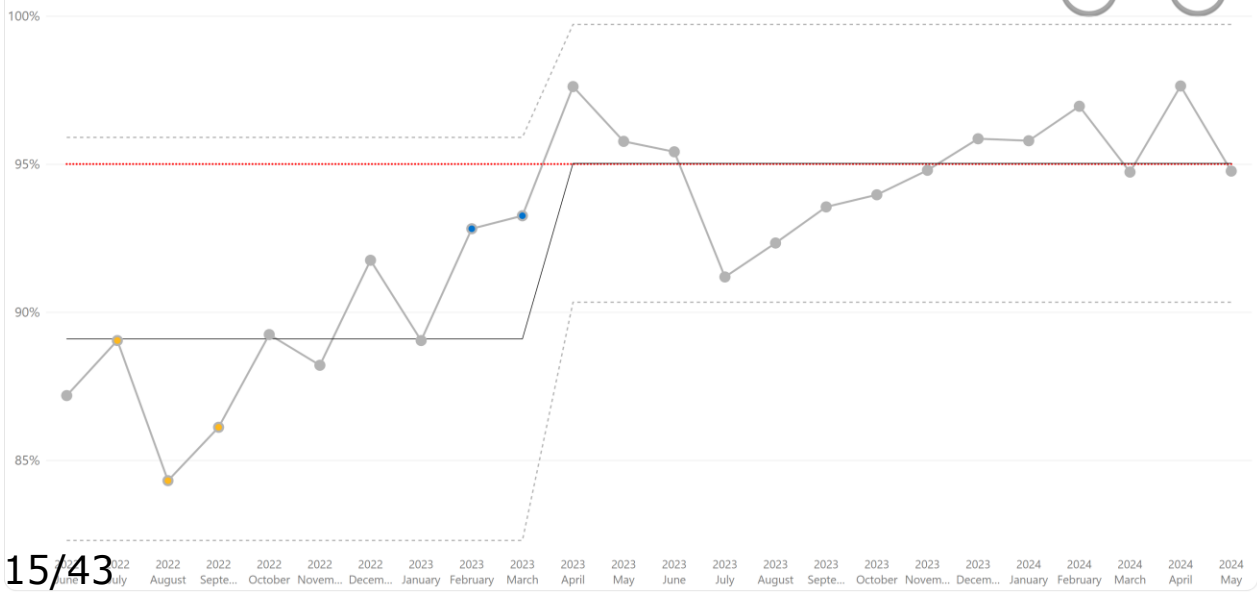
Infection Control: MRSA - Chief Nurse

Target	Target < or >	Performance	Assurance	Variation
0	<=	0	P	



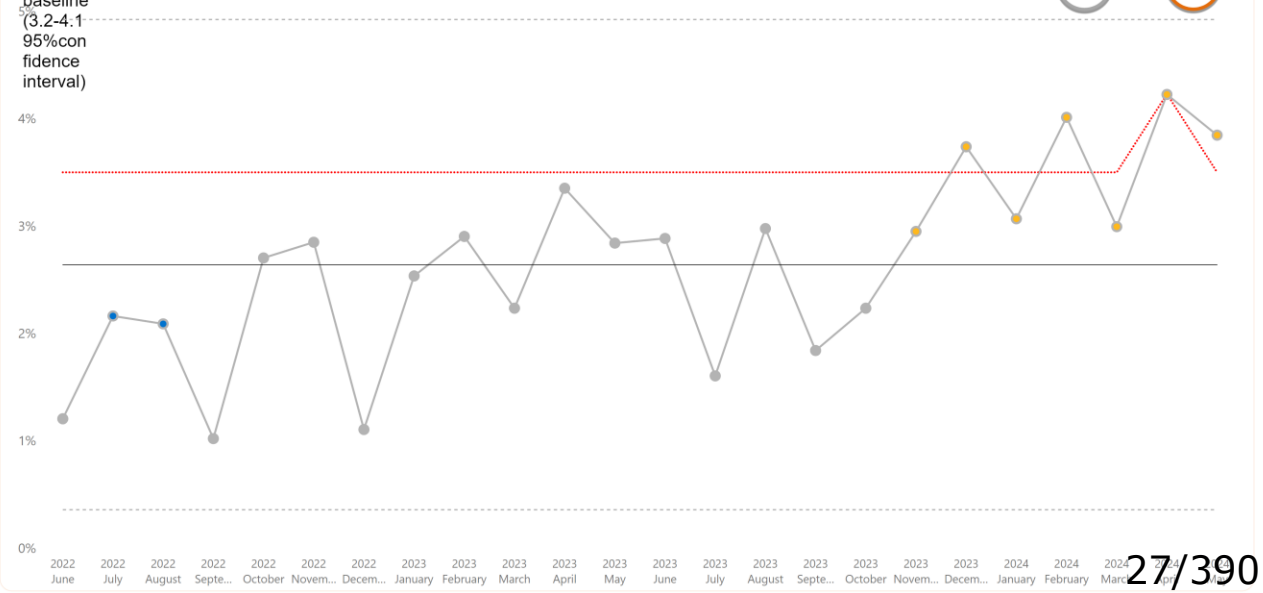
Venous Thromboembolism (VTE) - Medical Director

Target	Target < or >	Performance	Assurance	Variation
>= 95%	>=	94.76%	?	



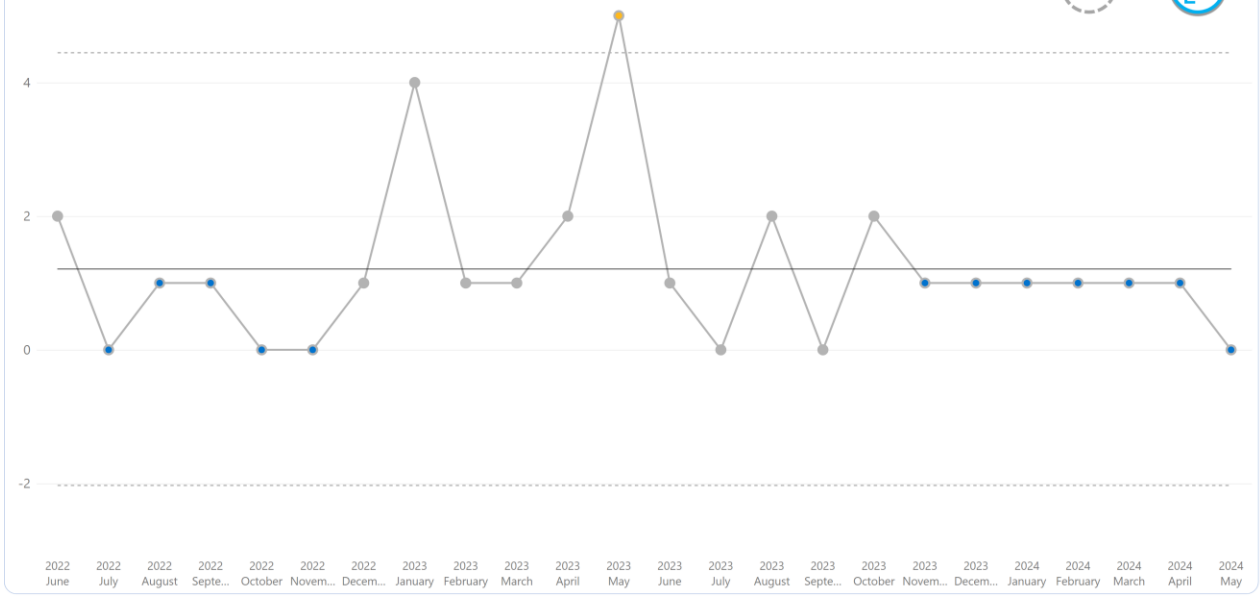
3rd and 4th Degree Tears - Medical Director

Target	Target < or >	Performance	Assurance	Variation
3.5% NMPA baseline (3.2-4.1 95%confidence interval)	<=	3.85%	?	H



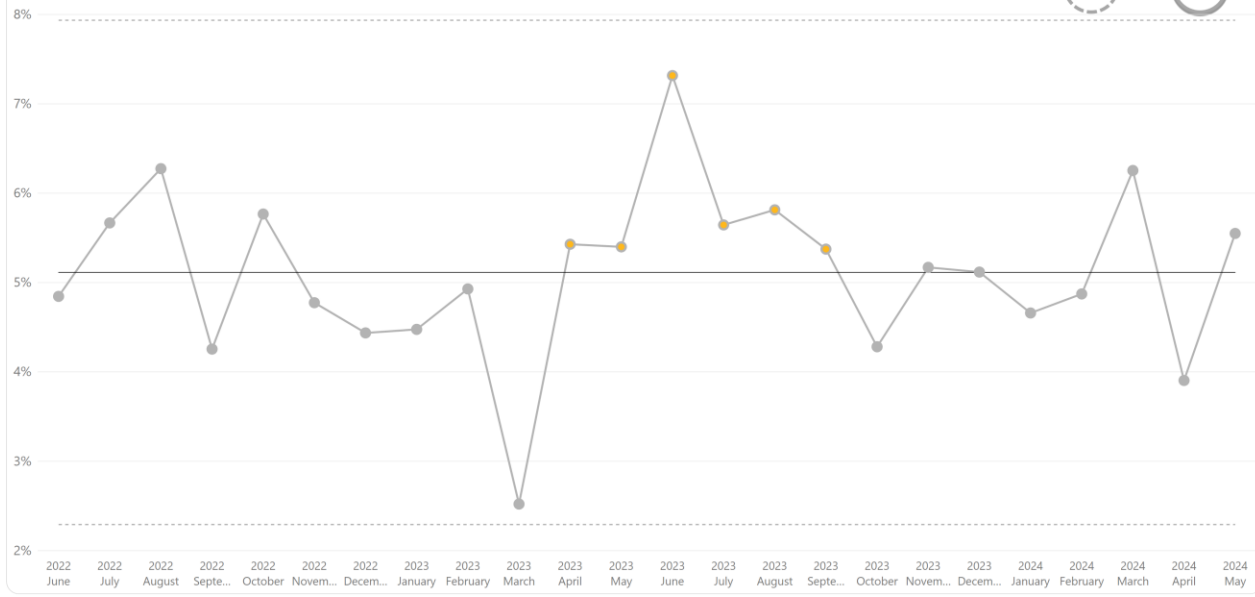
Hypoxic Encephalopathy (Grade 2,3) - Medical Director

Target	Target < or >	Performance	Assurance	Variation
TBA	<=	0		



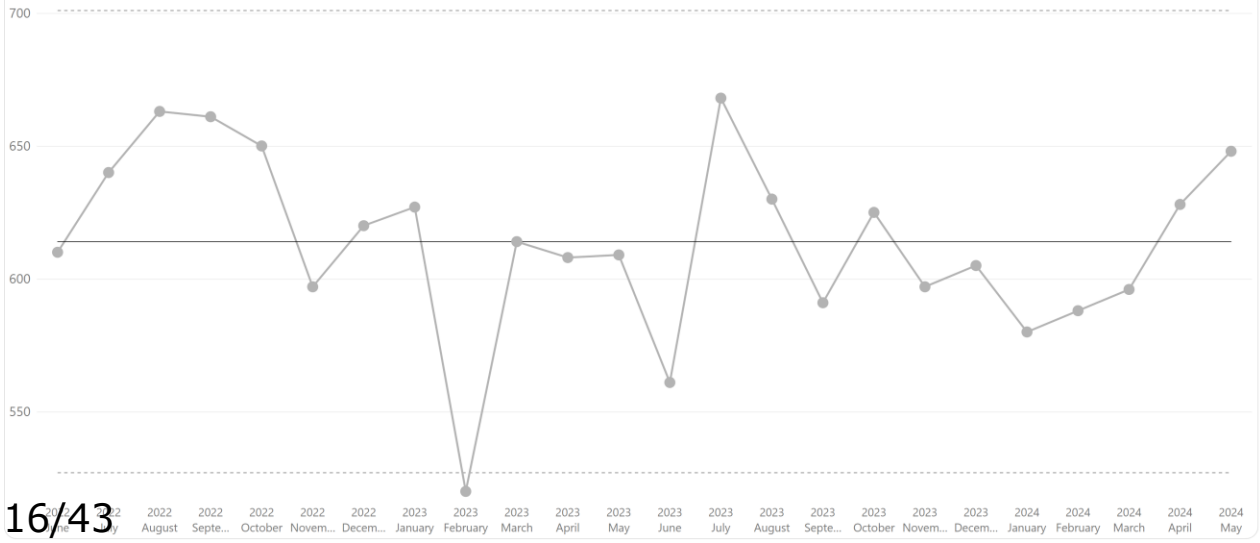
Inborn term babies admitted to NICU - Chief Nurse

Target	Target < or >	Performance	Assurance	Variation
<= 5%	<=	5.55%		



Number of births - Medical Director

Target	Target < or >	Performance	Assurance	Variation
		648		

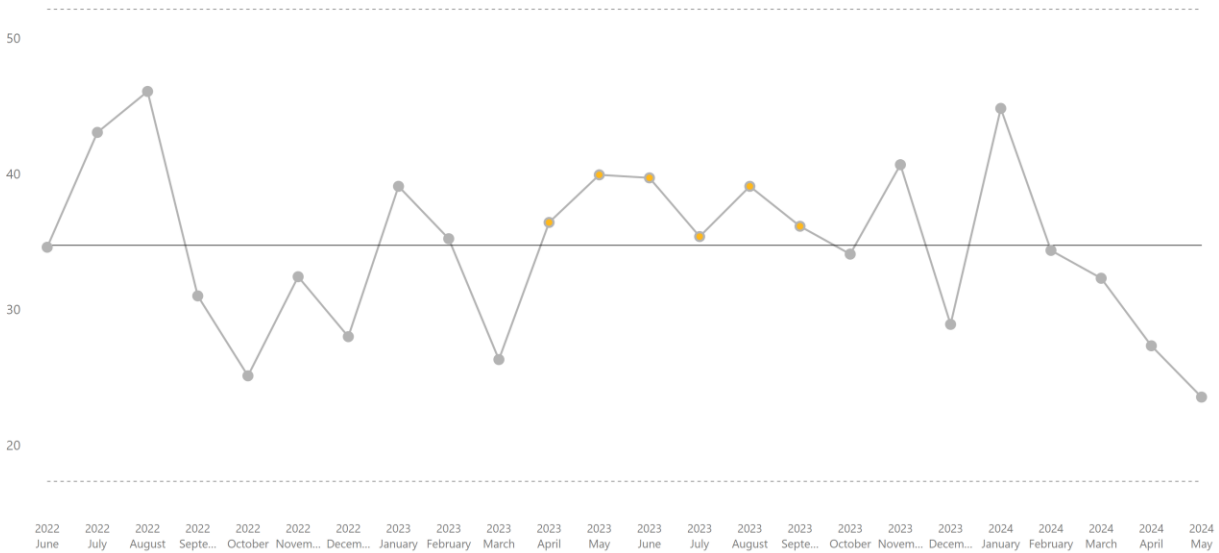


Number of stillbirths per 1,000 total births - Medical Director

Target	Target < or >	Performance	Assurance	Variation
	<=	7.72		

PPH > 1500 (per 1000) - Medical Director

Target	Target < or >	Performance	Assurance	Variation
	<=	23.55		



People Indicators

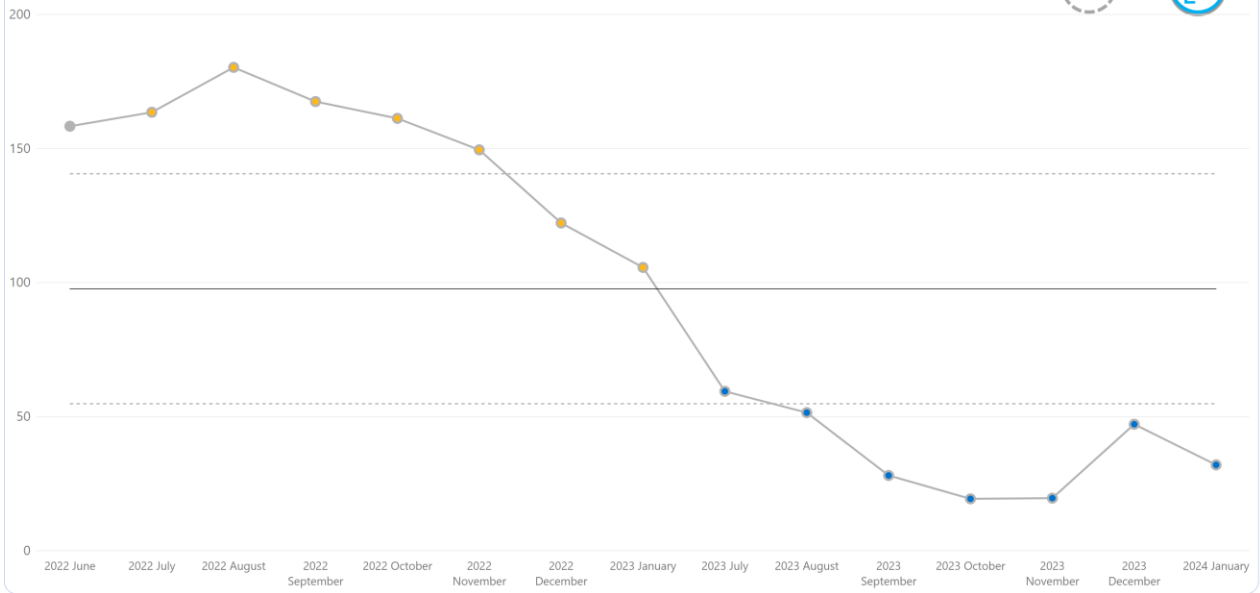
Executive Lead:
Michelle Turner, Chief People Officer

LWH Integrated Performance Report - People Indicators Summary

Domain	Date	Target < or >	Performance	Assurance	Variation	Assurance Category	Trend
Workforce Planning							
Overall Staff Vacancies WTE	January 2024	<=	31.88		L	Celebrate	
Workforce Retention							
Engagement Pulse survey response rate	December 2023		1	?		Unsure	
Number of staff leaving within 12 months	May 2024		16	?		Watch	
Proportion of staff in senior leadership roles BME background	May 2024	>=	5.88%		L	Take Action	
Turnover	May 2024	<=	11.20%	P		Celebrate	
Workforce Training							
EDI Training Compliance	May 2024		57.07%	?		Unsure	
Mandatory Training	May 2024	>=	92.00%	F		Take Action	
Mandatory Training (Clinical)	May 2024	>=	83.60%	F	L	Take Action	
Workforce Wellbeing							
Prevention of Ill Health: Flu Vaccine Front Line Clinical Staff	February 2024	>=	40.88%	F		Take Action	
Sickness	May 2024	<=	4.86%	F	L	Take Action	

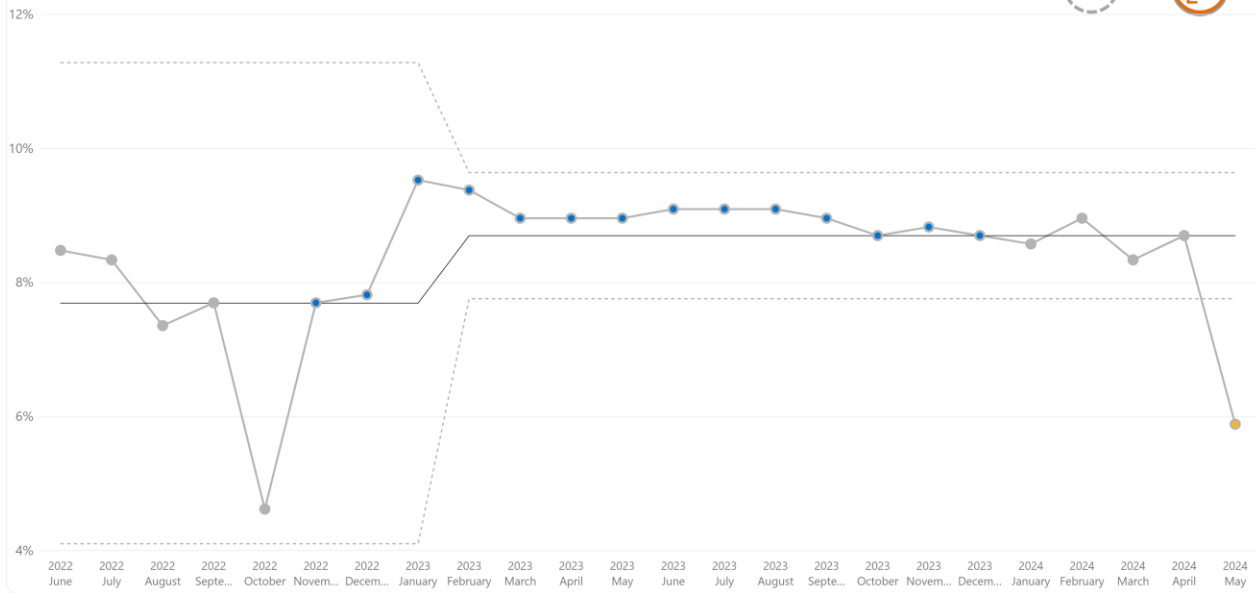
Overall Staff Vacancies WTE - Chief People Officer

Target	Target < or >	Performance	Assurance	Variation
	<=	31.88		



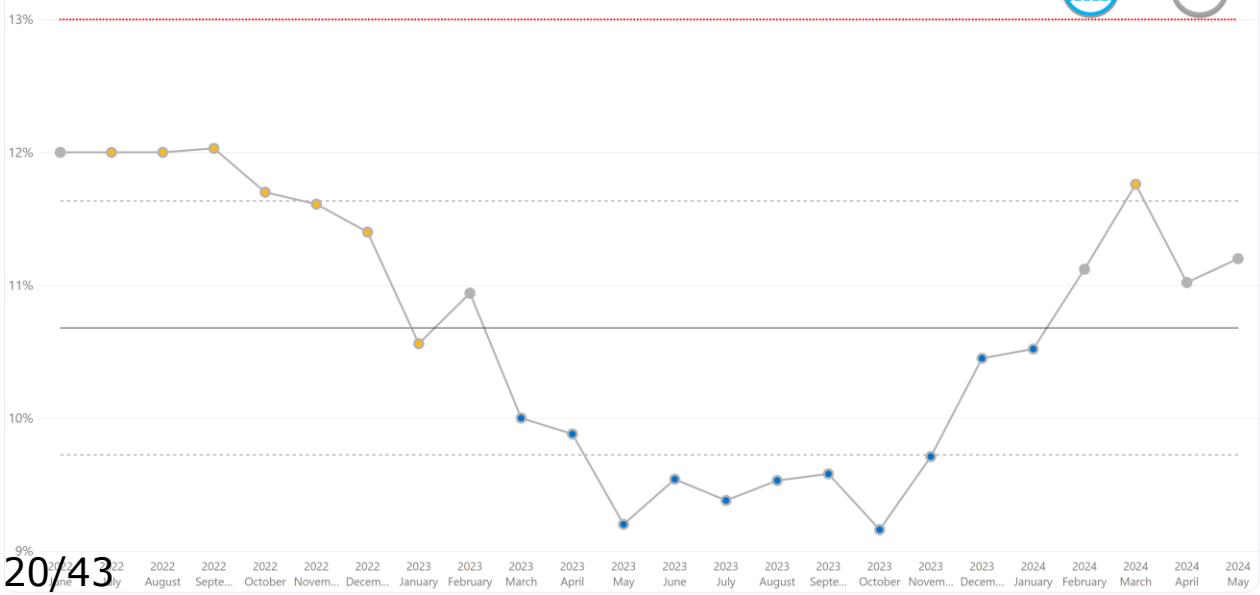
Proportion of staff in senior leadership roles BME background - Chief People Officer

Target	Target < or >	Performance	Assurance	Variation
	>=	5.88%		



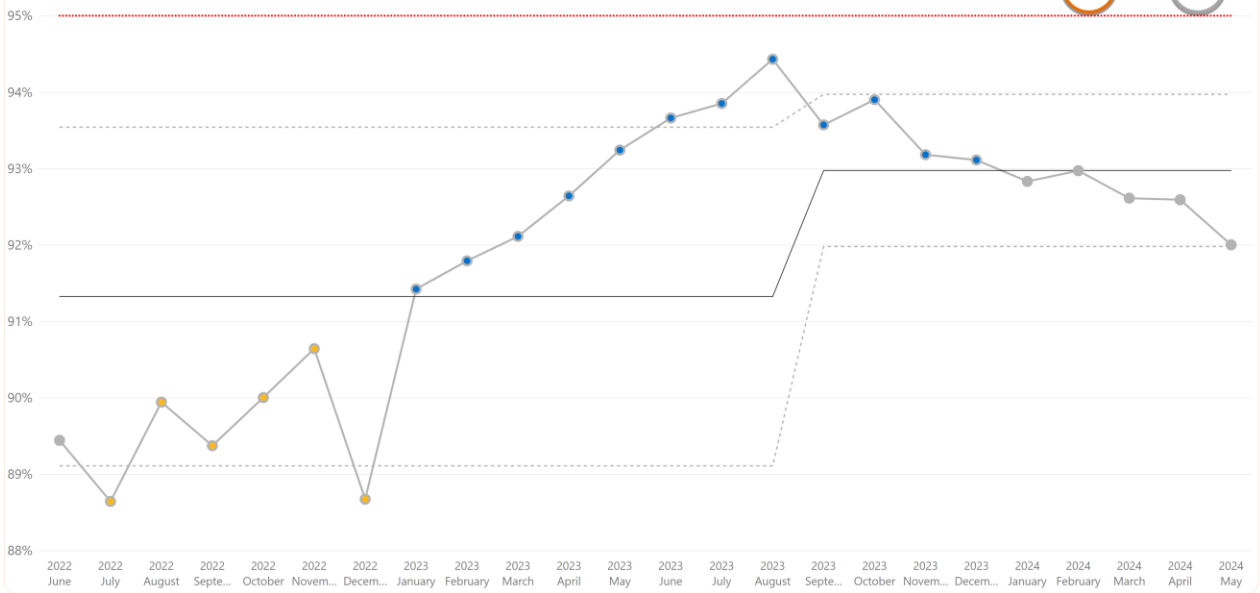
Turnover - Chief People Officer

Target	Target < or >	Performance	Assurance	Variation
<= 13%	<=	11.20%		



Mandatory Training - Chief People Officer

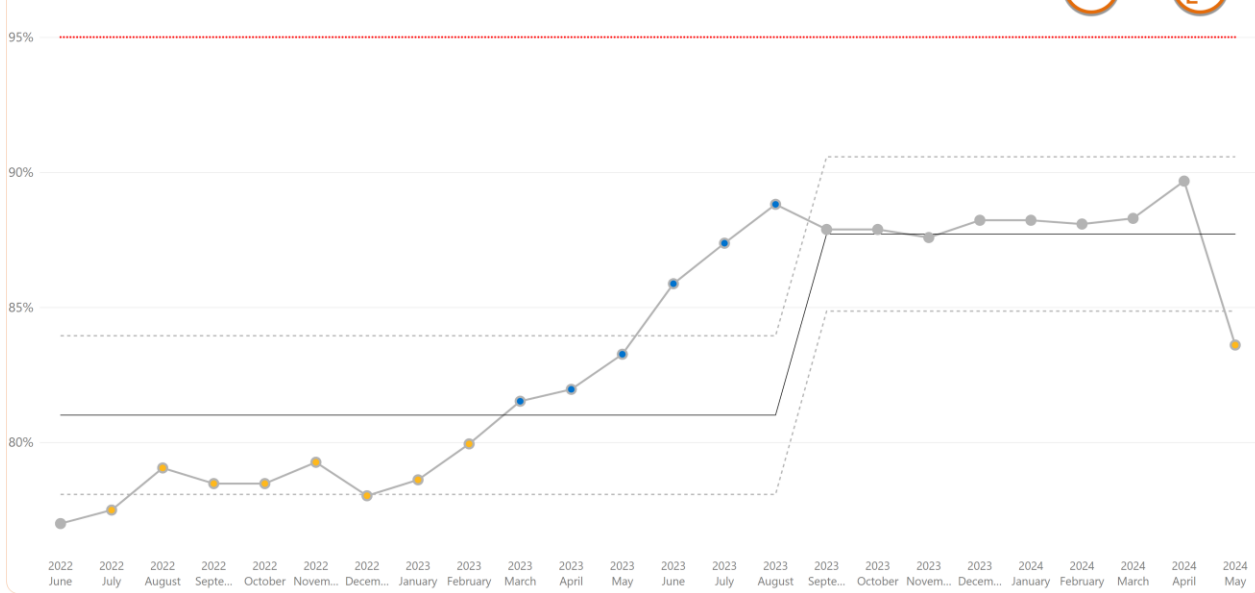
Target	Target < or >	Performance	Assurance	Variation
>= 95%	>=	92.00%	F	



Target	Target < or >	Performance	Assurance	Variation

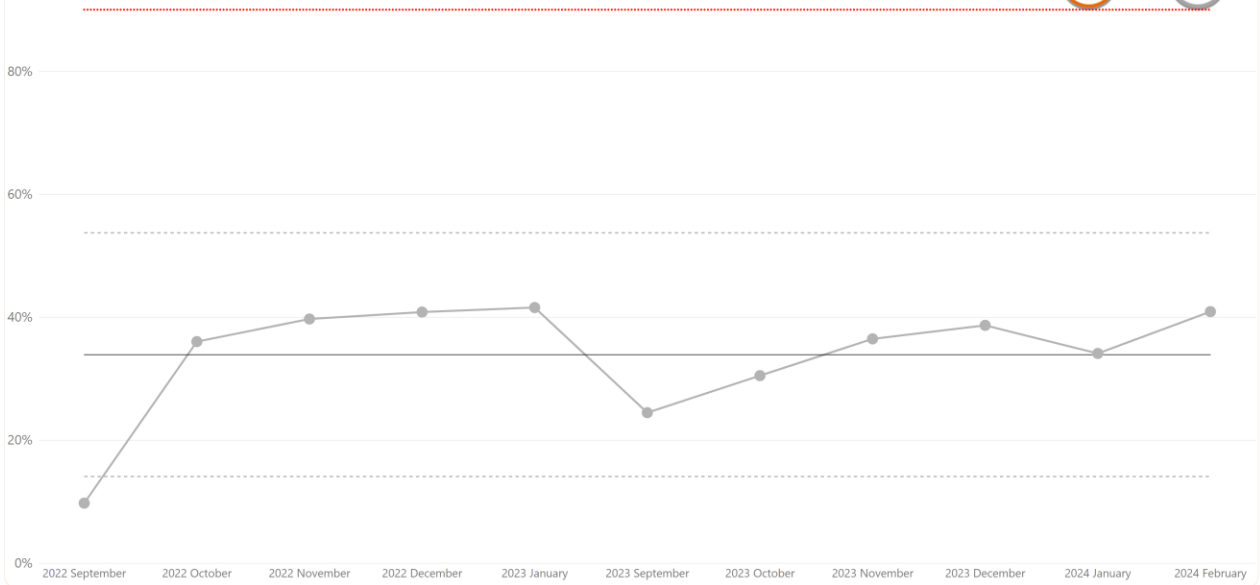
Mandatory Training (Clinical) - Chief People Officer

Target	Target < or >	Performance	Assurance	Variation
>= 95%	>=	83.60%	F	



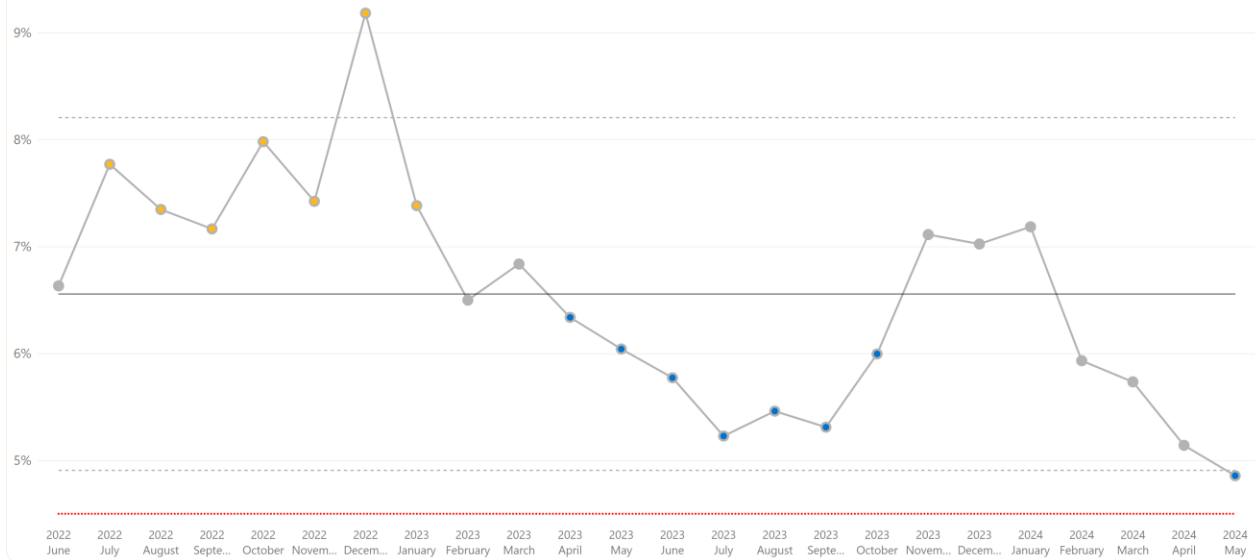
Prevention of Ill Health: Flu Vaccine Front Line Clinical Staff - Chief People Officer

Target	Target < or >	Performance	Assurance	Variation
>= 80%	>=	40.88%	F	



Sickness - Chief People Officer

Target	Target < or >	Performance	Assurance	Variation
<= 4.5%	<=	4.86%	F	L

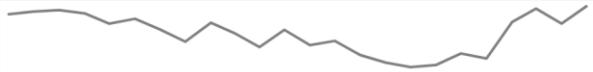
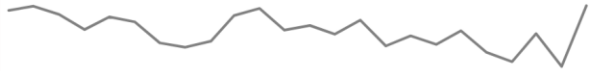
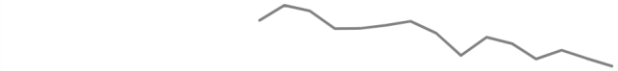
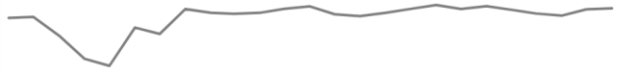


Liverpool Women's NHS Foundation Trust

Operational Performance Indicators

Executive Lead:
Gary Price, Chief Operating Officer

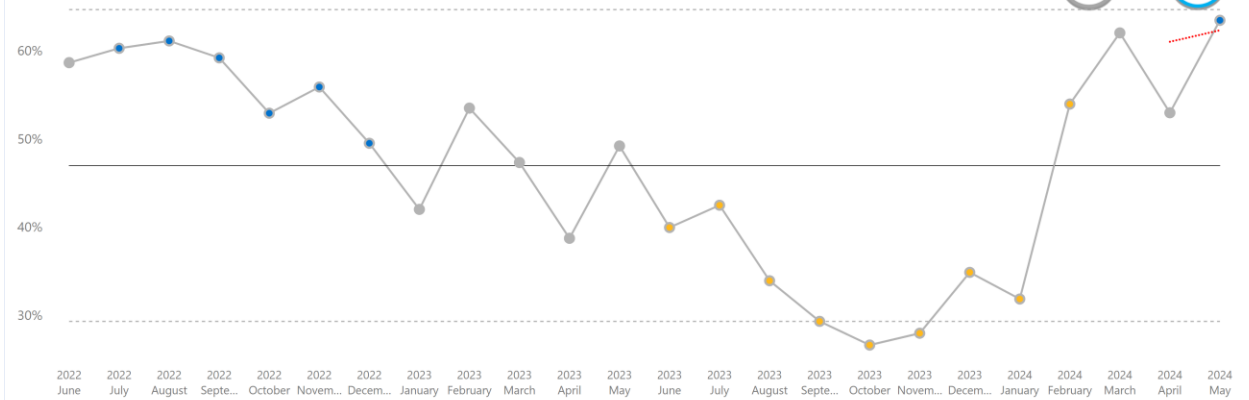
LWH Integrated Performance Report - Operational Indicators Summary

Domain	Date	Target < or >	Performance	Assurance	Variation	Assurance Category	Trend
Cancer							
Cancer: 28 Day Faster Diagnosis	May 2024	>=	63.43%	?	H	Celebrate	
Cancer: 31 Day decision to treat to treatment	May 2024	>=	93.94%	F		Take Action	
Cancer: 62 Day referral to Treatment	May 2024	>=	35.56%	?		Watch	
Planned Care							
18 Week RTT: Incomplete Pathway > 52 Weeks	June 2024	<=	998	?	L	Celebrate	
18 Week RTT: Incomplete Pathway > 65 Weeks	June 2024	<=	91	?	L	Celebrate	
18 Week RTT: Incomplete Pathway > 78 Weeks	June 2024	<=	0	?	L	Celebrate	
Diagnostic Tests: 6 Week Wait	June 2024	>=	94.98%	?		Watch	
Overall size of active patient waiting list	June 2024	<=	17687	?		Watch	
Urgent Care							
A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge	May 2024	>=	87.13%	?		Watch	
MAU - Arrival to Triage within 15 Mins	May 2024	>=	93.46%	?		Watch	
MAU - Arrival to Triage within 30 Mins	May 2024	>=	99.34%	P		Celebrate	

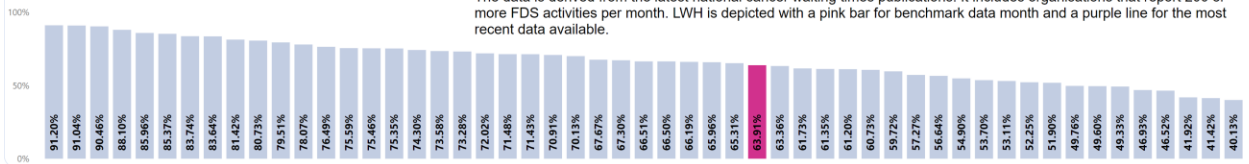
Please note: Cancer KPI's for May 2024 are the unvalidated position.

Cancer: 28 Day Faster Diagnosis - Chief Operating Officer

Target	Target < or >	Performance	Assurance	Variation
>= 75%	>=	63.43%	?	H



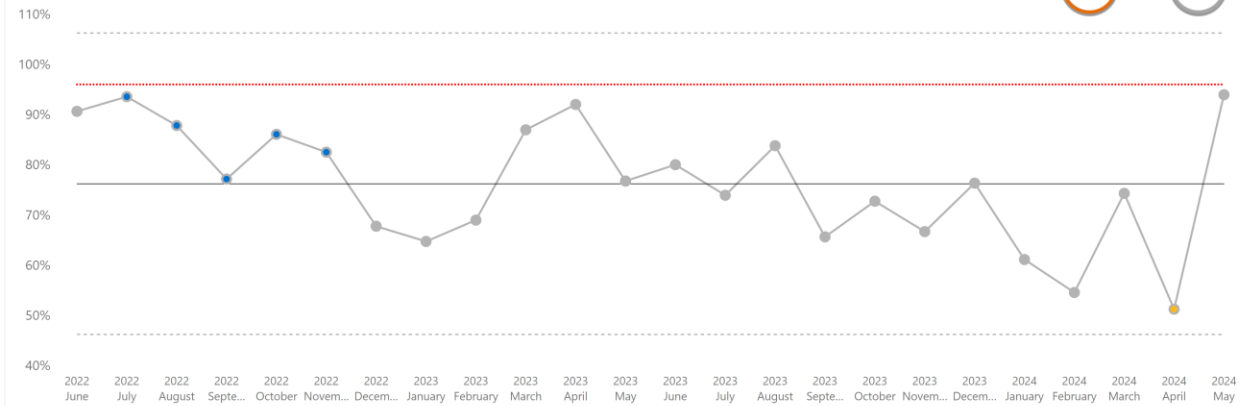
CWT % Compliant by ORG CODE



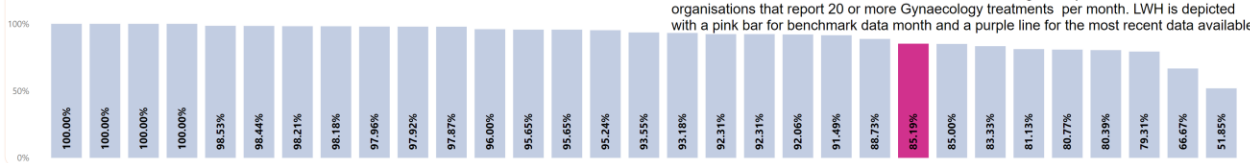
The data is derived from the latest national cancer waiting times publications. It includes organisations that report 200 or more FDS activities per month. LWH is depicted with a pink bar for benchmark data month and a purple line for the most recent data available.

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

Target	Target < or >	Performance	Assurance	Variation
>=96%	>=	93.94%	F	



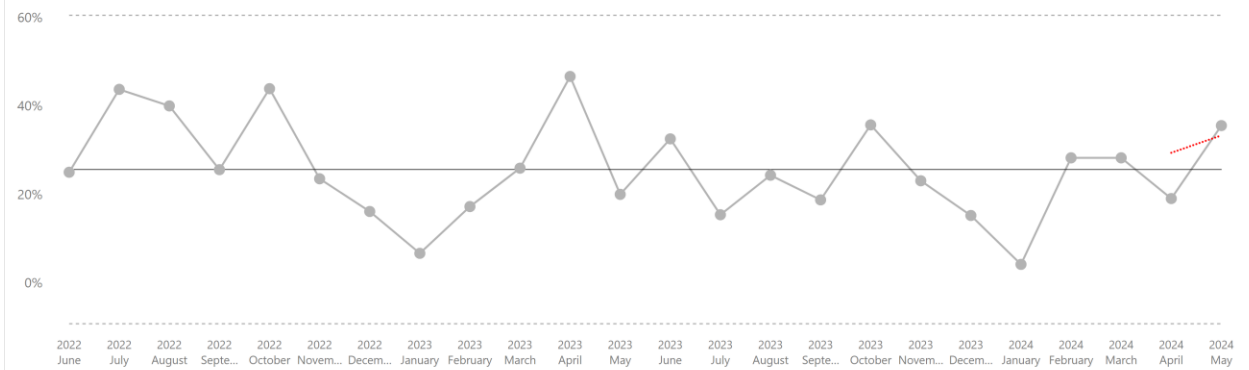
CWT % Compliant by ORG CODE



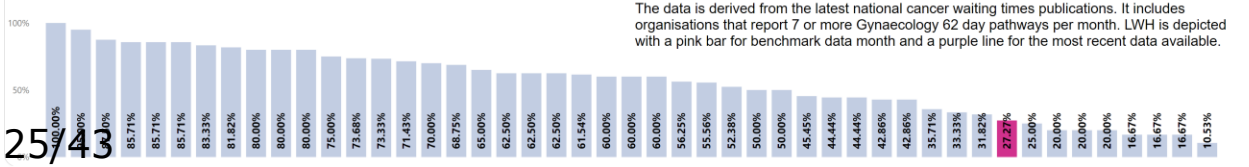
The data is derived from the latest national cancer waiting times publications. It includes organisations that report 20 or more Gynaecology treatments per month. LWH is depicted with a pink bar for benchmark data month and a purple line for the most recent data available.

Cancer: 62 Day referral to Treatment - Chief Operating Officer

Target	Target < or >	Performance	Assurance	Variation
>=85%	>=	35.56%	?	



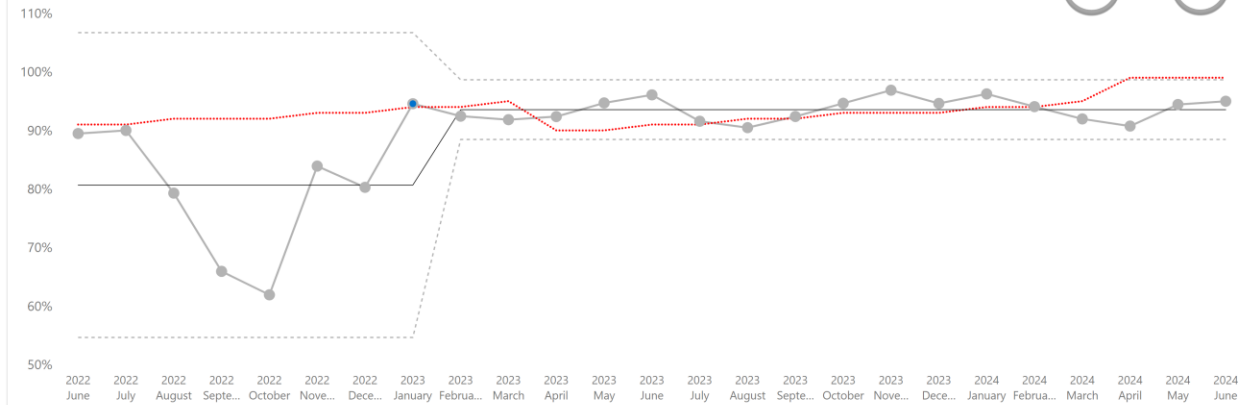
CWT % Compliant by ORG CODE



The data is derived from the latest national cancer waiting times publications. It includes organisations that report 7 or more Gynaecology 62 day pathways per month. LWH is depicted with a pink bar for benchmark data month and a purple line for the most recent data available.

Diagnostic Tests: 6 Week Wait - Chief Operating Officer

Target	Target < or >	Performance	Assurance	Variation
>= 99%	>=	94.98%	?	

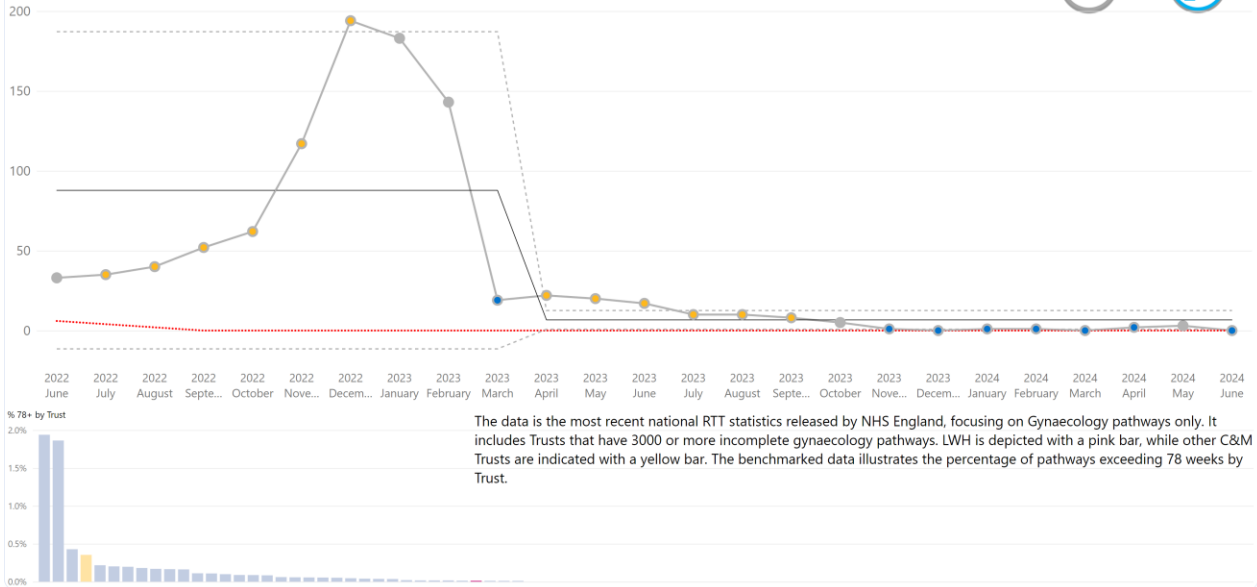


Percentage waiting 6+ weeks by Provider Name

The data is derived from the latest diagnostic waiting times publications. It includes all C&M organisations

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

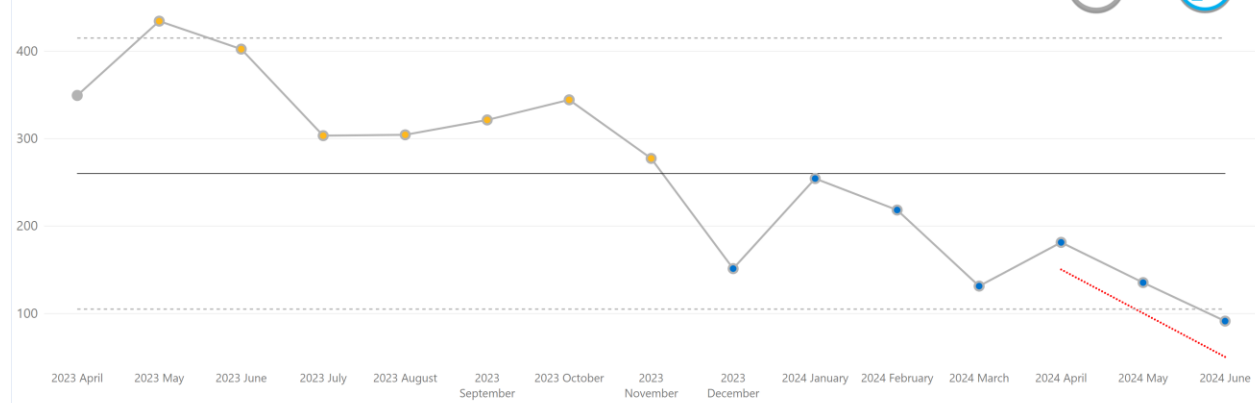
Target	Target < or >	Performance	Assurance	Variation
0	<=	0		



The data is the most recent national RTT statistics released by NHS England, focusing on Gynaecology pathways only. It includes Trusts that have 3000 or more incomplete gynaecology pathways. LWH is depicted with a pink bar, while other C&M Trusts are indicated with a yellow bar. The benchmarked data illustrates the percentage of pathways exceeding 78 weeks by Trust.

18 Week RTT: Incomplete Pathway > 65 Weeks - Chief Operating Officer

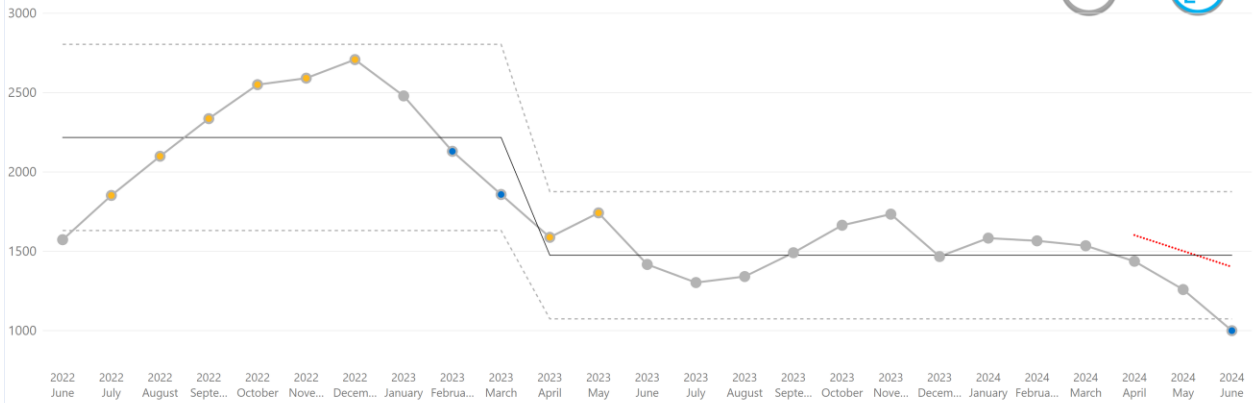
Target	Target < or >	Performance	Assurance	Variation
0	<=	91		

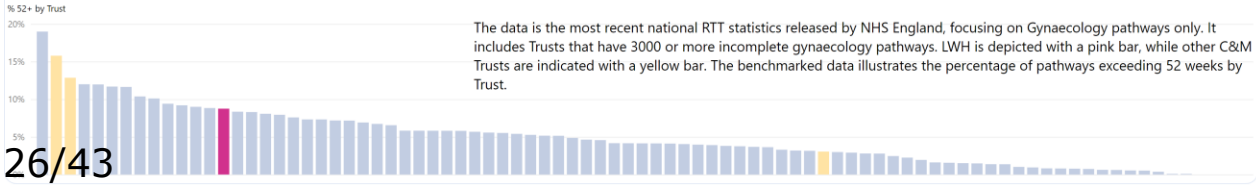


The data is the most recent national RTT statistics released by NHS England, focusing on Gynaecology pathways only. It includes Trusts that have 3000 or more incomplete gynaecology pathways. LWH is depicted with a pink bar, while other C&M Trusts are indicated with a yellow bar. The benchmarked data illustrates the percentage of pathways exceeding 65 weeks by Trust.

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

Target	Target < or >	Performance	Assurance	Variation
0	<=	998		

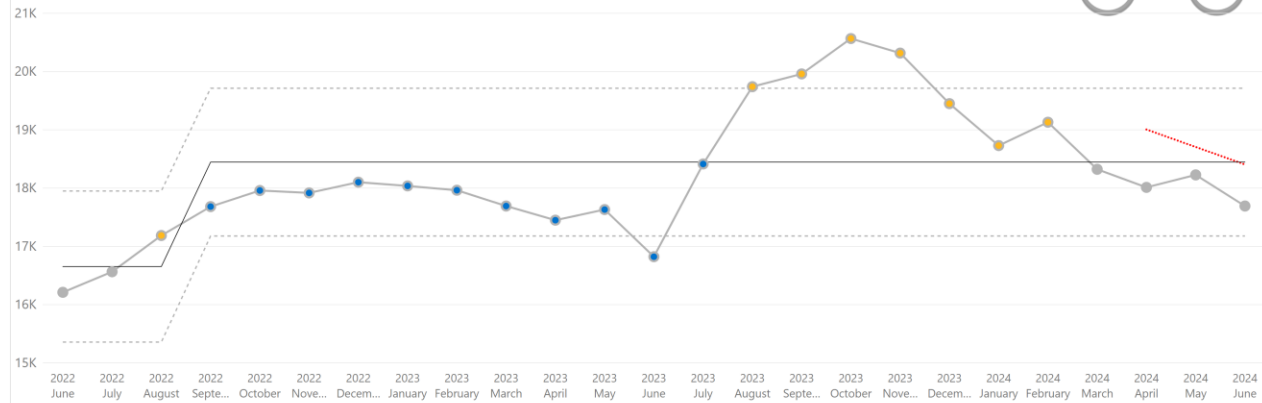


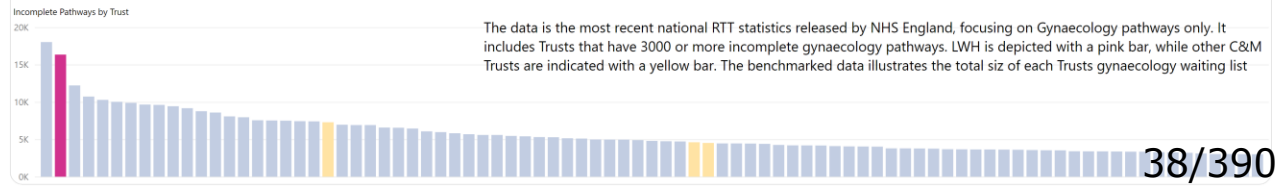


The data is the most recent national RTT statistics released by NHS England, focusing on Gynaecology pathways only. It includes Trusts that have 3000 or more incomplete gynaecology pathways. LWH is depicted with a pink bar, while other C&M Trusts are indicated with a yellow bar. The benchmarked data illustrates the percentage of pathways exceeding 52 weeks by Trust.

Overall size of active patient waiting list - Chief Operating Officer

Target	Target < or >	Performance	Assurance	Variation
<= 16500	<=	17687		

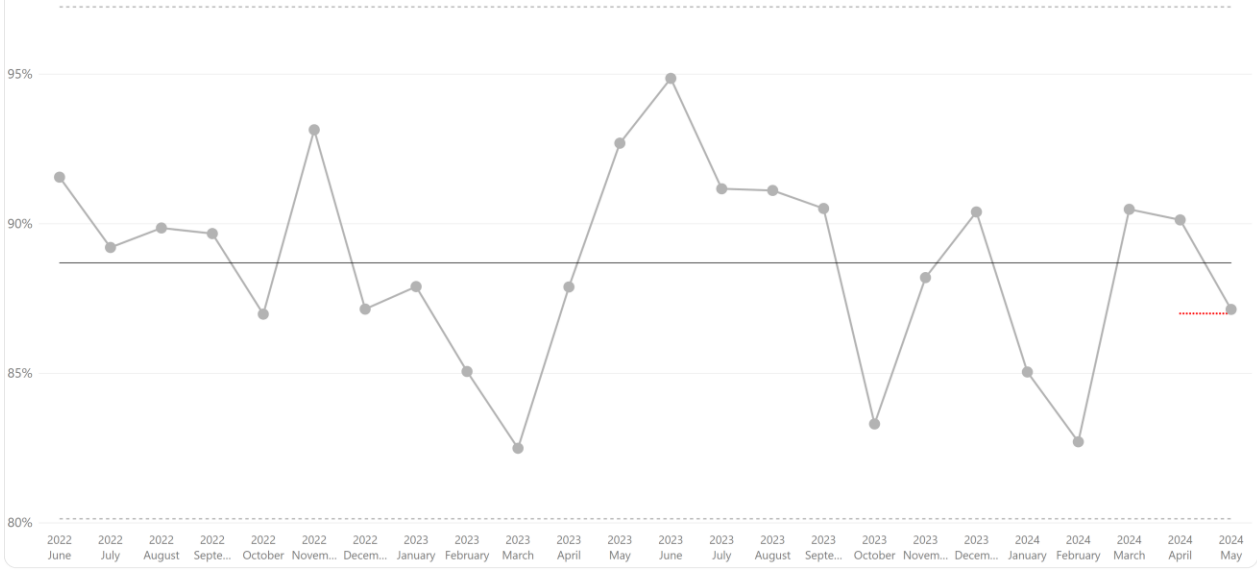




The data is the most recent national RTT statistics released by NHS England, focusing on Gynaecology pathways only. It includes Trusts that have 3000 or more incomplete gynaecology pathways. LWH is depicted with a pink bar, while other C&M Trusts are indicated with a yellow bar. The benchmarked data illustrates the total siz of each Trusts gynaecology waiting list

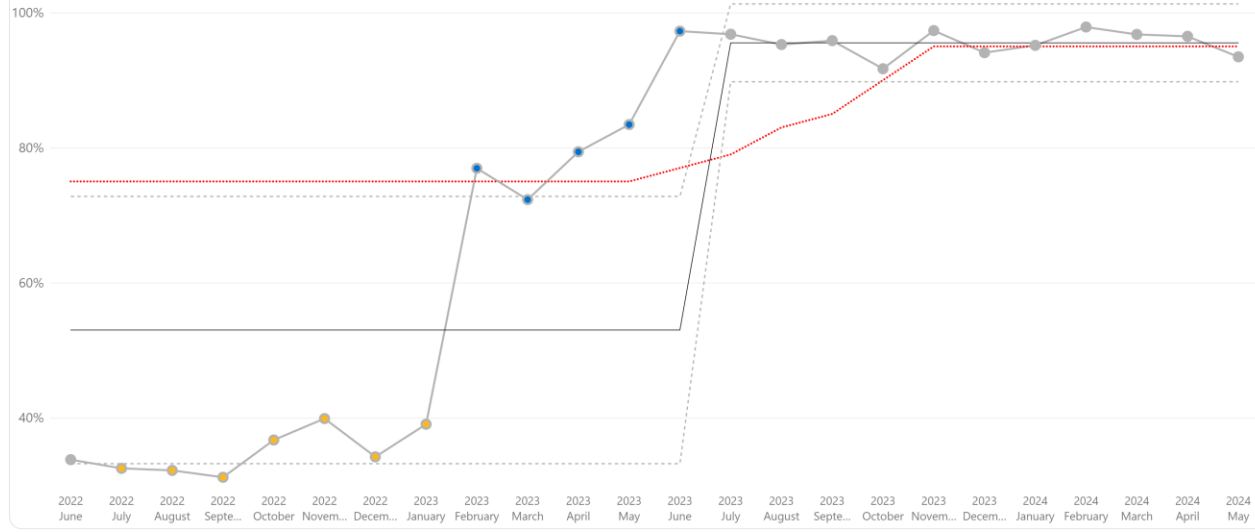
A&E Maximum waiting time of 4 hours from arrival to admission, transfer or discharge - Chief Operating Officer

Target	Target < or >	Performance	Assurance	Variation
>= 90%	>=	87.13%		



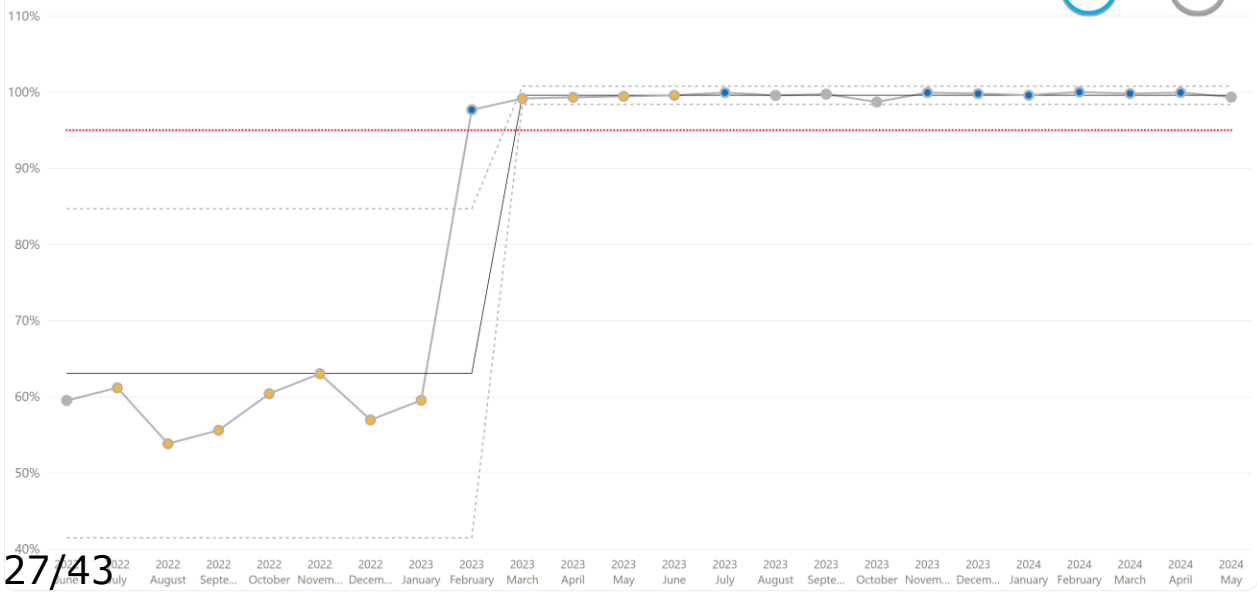
MAU - Arrival to Triage within 15 Mins - Chief Operating Officer

Target	Target < or >	Performance	Assurance	Variation
>= 95%	>=	93.46%		



MAU - Arrival to Triage within 30 Mins - Chief Operating Officer

Target	Target < or >	Performance	Assurance	Variation
>= 95%	>=	99.34%		

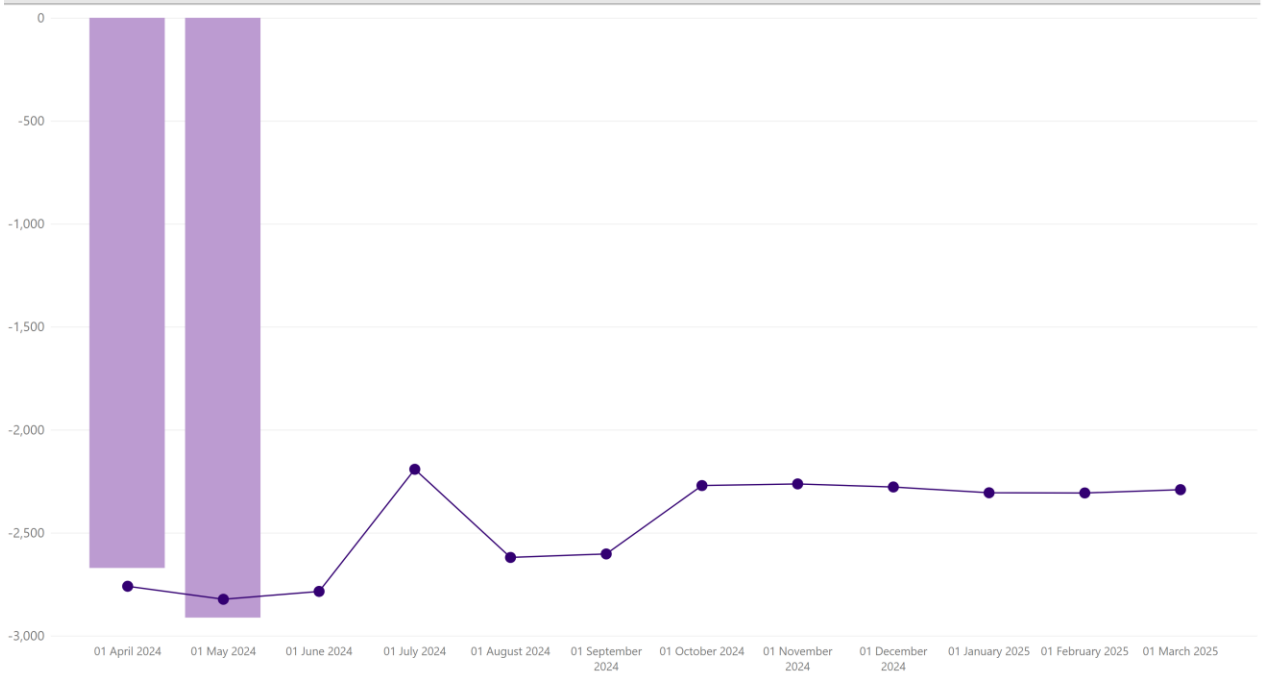


Target	Target < or >	Performance	Assurance	Variation

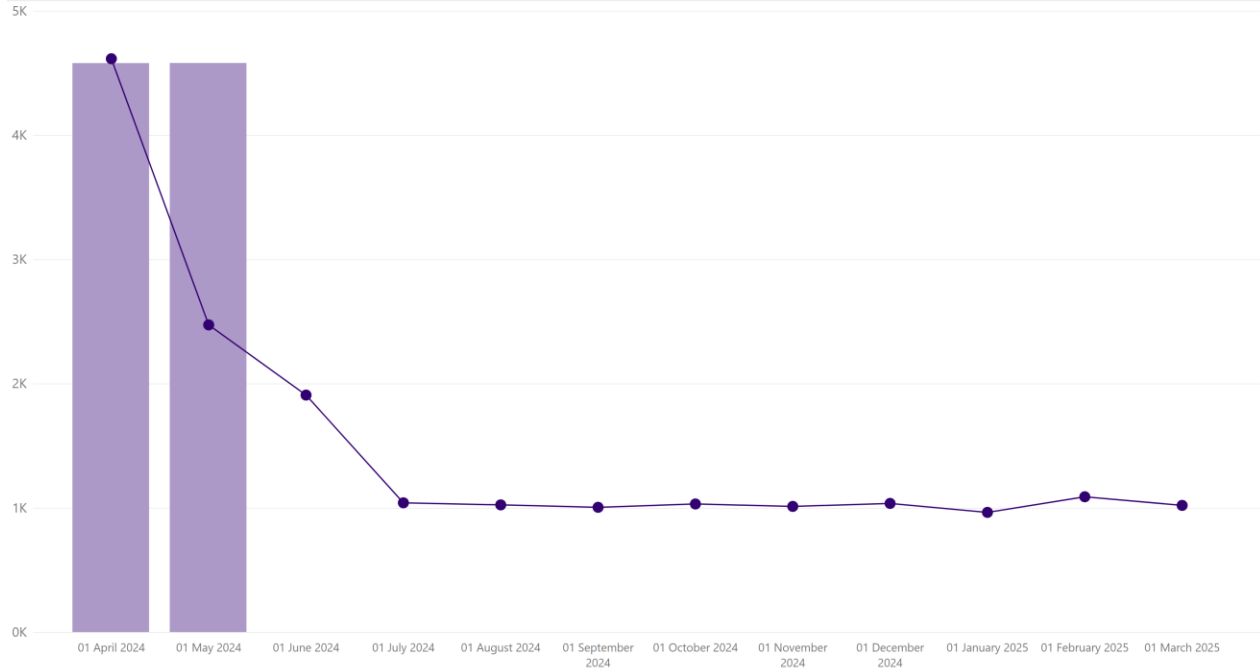
Financial Duty Indicators

Executive Lead:
Jenny Hannon, Chief Finance Officer

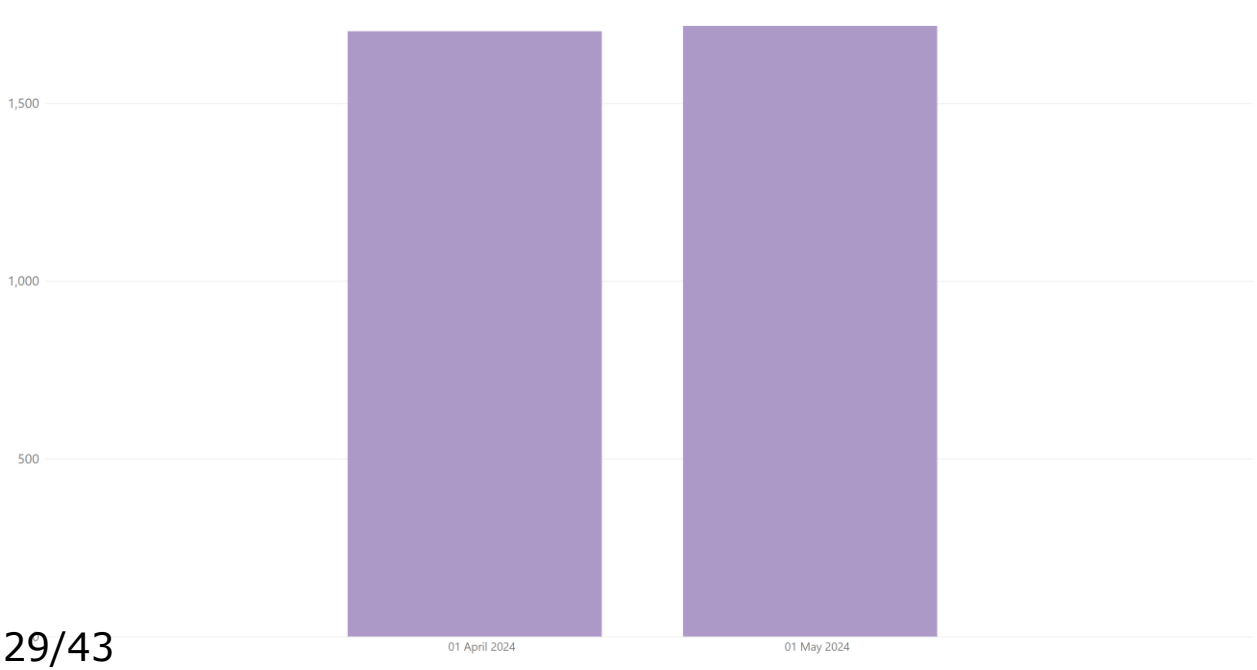
I&E Actual vs Plan



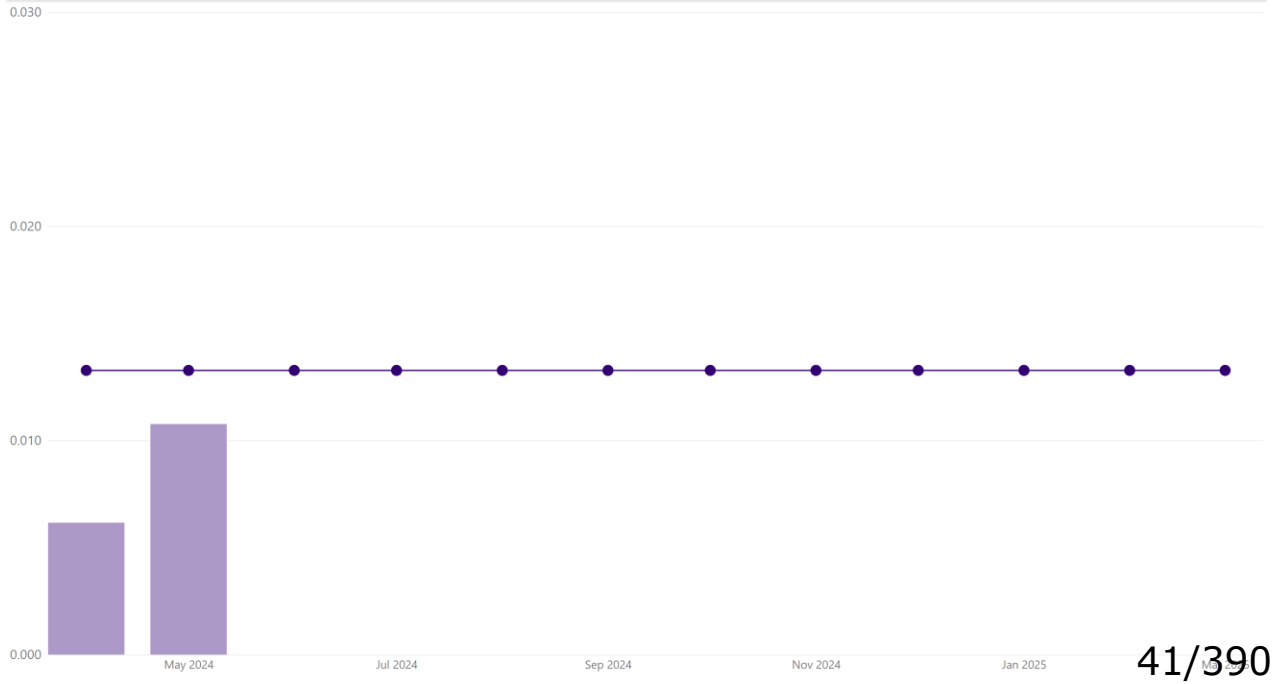
Cash Actual vs Plan



WTEs actual vs plan



Agency % of total pay, by month



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

Appendix 3: Benchmarking Guidance

Overview

Benchmarking data is incorporated within the report for specific KPIs. This will increase to all KPIs where national data is available. The benchmarking data is visualised as a bar chart and can be seen underneath the charts for these specific KPIs. Each of the bars represents an organisation with Liverpool Women's highlighted in pink, Cheshire & Merseyside organisations in yellow, and all other Trusts in blue.

Rules are applied to each KPI to identify relevant organisations and activity to benchmark against LWH. The following rules have been applied within this report:

Cancer

28 Day Faster Diagnosis: Speciality is Gynaecology and organisations have 200 or more reported within the most recent months data.
31 day decision to treat to treatment: Speciality is Gynaecology and organisations have 20 or more treatments within the most recent months data.
62 day referral to treatment: Speciality is Gynaecology and organisations have 7 or more treatments within the most recent months data.

Referral to Treatment KPIs

For all metrics related to RTT standards only Gynaecology is included and organisations with 3000 or more incomplete pathways within the most recent months data.

6 Week Diagnostics

Only organisations in the North West are included.

Maternity Signals

The data is sourced from NHS Maternity Statistic Publication. Data is usually 2-3 months behind. Trusts with 500 or more births within the reporting month are included.

Executive Risk & Assurance Group Assurance Report

Report to	Trust Board
Date	11 July 2024
Meeting Name	Executive Risk & Assurance Group
Date of Meeting	12 June 2024
Chair's Name & Title	James Sumner, Chief Executive

Agenda Items

The following agenda items were discussed by the meeting:

1. High Scoring Risk Report – Corporate Services
2. Executive Group Reports
    a. Finance & Performance
    b. Quality, Risk & Safety
    c. People & Organisational Development
    d. Research
3. Divisional Board Reports
    a. Family Health
    b. Gynaecology
    c. Clinical Support Services
4. Communications Risks
5. Policy Update Exception Report

Matters for Escalation from ERAG to the Board

Duty of Candour Compliance
It was highlighted that there had been a drop in compliance for duty of candour in the Gynaecology Division. The group acknowledged a recent governance facilitator change, which had contributed to the backlog of incidents. A re-audit of duty of candour compliance was scheduled, and the divisions were reminded of the importance of updating records. It was queried if action could be taken to track improvements with the duty of candour compliance ahead of the scheduled 3-month re-audit. It was suspected that Duty of Candour was being completed but was being filed on several systems and therefore not being reflected on the Ulysses report. This was being explored and would report back to a future meeting.

Personal Development Review Compliance
The Group noted concerns about the Personal Development Review (PDR) completion rates, which were below the organisational expectation. It was highlighted that clinical areas had outperformed non-clinical areas and the need for continued focus was emphasised.

Maternity Base (Matbase) Challenges
The Family Health Divisional Manager reported on efforts to manage risks within the maternity base, breaking them down into estate configuration, observational compliance, and medication management issues. Immediate actions included weekly audits and oversight meetings. The division was exploring estate reconfiguration by visiting peer organisations for

insights. A further update to fully articulate the estate risk was requested to be reported to the July 2024 meeting.

Out of Date Policies:
Whilst the number of out-of-date policies had decreased by 17 since the previous month, the pace of improvement was noted as being slow. The importance of divisions proactively managing upcoming reviews was emphasised and new governance KPIs for future monitoring were in development – a target of zero overdue policies had been set by the end of June 2024. A session on roles and responsibilities was planned to ensure accountability in policy management.

Other issues

The following issues were noted during the meeting:

- There was evidence of positive action being taken in response to COSHH incidents.
- Positive feedback on the Trust's Be Brilliant [Ward] Accreditation Scheme (BBAS) was noted with work being undertaken to explore how best to ulitise the data produced.
- There had been discussions on developing an innovation hub with the University of Liverpool, focusing on device innovation.
- The Generation Study, a national genomic study on newborns, was progressing, with Liverpool Women's preparing to participate.
- Recruitment rates for the Children Growing Up in Liverpool study were improving, supported by outreach clinics and enhanced engagement strategies.
- Workforce issues in the neonatal partnership had been resolved through a revised model agreed with Alder Hey partners.
- A new risk for the Family Health Division related to the magnesium sulphate dosing issue was highlighted, with external advice being sought.
- The Family Health Division's sickness rate was the lowest it has been since 2017.
- The Gynaecology Divisional Manager highlighted the acute out-of-hours medical cover risk, which had seen an increase in incidents and consultant step-downs. The division had received approval for agency doctors to cover gaps and was working on longer-term solutions.
- The Group requested that further detail be provided on the increased IG incidents within the Hewitt Centre.
- The Interim CSS Divisional Manager reported on the highest risk related to anaesthetics out-of-hours cover for emergencies, noting the need for immediate action plans and longer-term solutions.
- The CSS Division has successfully integrated sonography services, improving governance processes.
- The CSS Division was addressing consultant shortages in anaesthetics, with ongoing recruitment efforts and discussions on integration with LUHFT.
- Attendees were reminded of the pre-election period communication guidelines.

Decisions Made

It was agreed to undertake a review of the ERAG meeting structure's effectiveness after a few months.

The Executive Research Group 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	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											
Head of Information	✓	✓									

Executive Risk & Assurance Group Assurance Report

Report to	Trust Board
Date	11 July 2024
Meeting Name	Executive Risk & Assurance Group
Date of Meeting	3 July 2024
Chair's Name & Title	James Sumner, Chief Executive

Agenda Items

The following agenda items were discussed by the meeting:

1. Executive Group Reports
    a. Finance & Performance
    b. Quality, Risk & Safety
    c. People & Organisational Development
2. Divisional Board Reports
    a. Family Health
    b. Gynaecology
    c. Clinical Support Services
3. Risk Horizon Scan
4. Policy Update Exception Report

Matters for Escalation from ERAG to the Board

Policy Management: Significant progress was made in reducing the number of overdue policies from 57 to 13, with special commendations to Maternity and Gynaecology for achieving zero overdue policies. The Group agreed to receive reports by exception on policy management moving forward, given the implementation of a new dashboard for tracking.

Digital Systems: Concerns were raised about the integration of digital systems, particularly affecting pharmacy operations and reporting. There's an ongoing review to address these issues, with a focus on improving system connectivity and mitigating potential risks.

Maternity Estate: Clarification was provided on the Maternity Estate risk, distinguishing between clinical safety risks and experiential risks due to estate limitations. A commitment was made to resolve these issues, not confined by capital constraints, to ensure patient safety and experience. The ERAG requested further updates at its next meeting.

Anaesthetics Capacity: The CSS Division reported progress in addressing the anaesthetics capacity out of hours risk, with Task and Finish groups in place to review Gynaecology and Obstetrics capacity and clinical patient pathways. Ongoing recruitment is underway in Anaesthetics with an aim to increase middle grade presence.

Personal Development Review (PDR) Compliance: PDRS were highlighted last month as an area of concern and there was no improvement reported in May 2024 with compliance remaining at 79% against a target of 90%. The Group was informed that significant

improvements were expected for June 2024 – this would be tracked and monitored at the next ERAG meeting.

Other issues

The following issues were noted during the meeting:

- A potential increased cost for the ambulatory project had been identified but following discussions with the contractor and some changes to the layout, this was expected to be mitigated with minimal delays.
- Risks to identifying Cost Improvement Programme (CIP) projects identified and the finance team were meeting with the Divisional Managers to explore how best to expedite progress.
- The Quality, Risk and Safety Executive Group had reported a limited assurance rating relating to the number of overdue incidents in the web holding file. The Group was informed that progress had been made and there had been a significant reduction. The Group would continue to seek assurance that the improvements were embedded.
- An improved position for sickness of 4.86% was noted, this is the lowest rate of sickness achieved in the last 4 financial years. Both maternity (5.24%) and gynaecology (5.94%) saw an improved position with the Divisional Manager for gynaecology noting that a tightened approach to sickness reporting had supported compliance.
- It was agreed that 'staff turnover' was a limited metric and that other more meaningful metrics e.g. 'leavers within one year', would be a more effective measure of Trust culture.
- A potential risk to CNST compliance was identified as a result of Industrial Action impacting the ability of clinical staff to attend the requisite training.
- Magnesium sulphate dosing - Rapid review has been carried out and the preliminary actions were presented to FH Divisional Board.
- CSS Division highlighted issues with decontamination processes, particularly around the ageing of equipment and the need for a preventative maintenance plan. A task and finish group has been initiated to address these concerns and establish a more proactive approach to equipment maintenance.
- Acute Gynaecology out of hours medical cover risk de-escalated from 12 to 8 following the recruitment of agency doctors.
- Hewitt Centre – potential financial pressures identified by the Gynaecology Division. Division to evaluate the risk and add the necessary controls / mitigations.

Decisions Made

The meeting noted the successful implementation of a new risk scoring system across divisions, leading to a more streamlined and effective risk management process. This has resulted in a clearer understanding of risks and their management within the organization.

Following benchmarking with other Trusts in C&M, it was agreed to reduce the targets for mandatory training compliance for core, clinical and local mandatory training from 95% to 90% to ensure alignment with the region.

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	✓	✓	A								
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	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	✓	✓	**A**								
Clinical Director, CSS	✓	✓	**A**								
Clinical Director, Gynaecology	✓	✓	**A**								
Trust Secretary	✓	✓	✓								
Other Attendees											
Head of Information	✓	✓	✓								

Our Big Conversation

NHS Liverpool Women's NHS Foundation Trust

BIG CONVERSATION

ONE BIG CONVERSATION =

- **46 AREAS JOINED THE CHAT**
- **OVER 600 PIECES OF FEEDBACK RECEIVED**
- **16 KEY TRUST THEMES IDENTIFIED**

WHAT YOU LOVE THE MOST ABOUT WORKING AT OUR TRUST

- *"Great working relationships across the divisions"*
- *"People value and respect each other"*
- *"Supportive Management and Leadership"*
- *"The work we do is amazing"*
- *"A great learning culture for training and development"*

WHAT YOU THINK ARE OUR BIGGEST OPPORTUNITIES FOR IMPROVEMENT:

- *Staffing: though vacancy rates have improved, more resource to support the workload is required*
- *Processes: some local and internal processes feel like a barrier to achieving excellence and need to be reviewed*
- *Leadership: support from management feels good but more visibility from leadership would be appreciated*
- *Space: our staff recognise that structural changes are difficult to make, however some TLC is required to changing, toilet and break areas*
- *Estates: a priority system is in place to triage estates issues, our staff would like to see better signage and better ventilation across the Trust*

WHAT HAPPENS NEXT?

All feedback has been shared with divisional leadership teams and immediate actions will be progressed. Please look out for ***'You said, together we will'*** communications in your areas.

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Meeting Date	Thursday, 13 July 2023	**Item Reference**	24/25/082
Report Title	**Finance Performance: Month 03, 2024/25**		
Author	***Jen Huyton, Deputy Chief Finance Officer / Deputy Director of Strategy***		
Responsible Director	***Jenny Hannon, Chief Finance Officer / Deputy Chief Executive Officer***		

Purpose of Report	The report presents the financial position at Month 2.
Executive Summary	At Month 2 the Trust reported a £5.6m deficit, which represents a breakeven to plan position. This position has been reported to the Cheshire and Merseyside Integrated Care Board (C&M ICB). £0.4m of Cost Improvement Programme (CIP) savings have been delivered to date, resulting in a £0.1m favourable variance to the CIP target of £0.3m. The cash balance was £4.6m at the end of Month 2.
Key Areas of Concern	None
Trust Strategy and System Impact	This links to the sustainable and efficient use of resources by both the Trust and other relevant bodies.

Links to Board Assurance Framework	*BAF Risk 4 – Financial Sustainability*	***10***
Links to Corporate Risk Register (scoring 10+)		**-**

Assurance Level	1. SUBSTANTIAL - Good system of internal control applied to meet existing objectives

Action Required by the Committee	The Trust Board is asked to note the Month 2 position.

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome

MAIN REPORT

1. Summary Financial Position

	Plan	Actual	Variance	RAG	R	A	G
Surplus/(Deficit) YTD	-£5.6m	-£5.6m	£0.0m	1	*>10% off plan*	*Plan*	*Plan or better*
I&E Forecast M2	-£29.5m	-£29.5m	£0.0m	1	*>10% off plan*	*Plan*	*Plan or better*
Cash	£7.0m	£4.6m	-£2.4m	6	*<£1m*	*£1m-£4.5m*	*£4.5m+*
Total CIP Achievement YTD	£0.3m	£0.4m	£0.1m	5	*>10% off plan*	*Plan*	*Plan or better*
Recurrent CIP Achievement YTD	£0.2m	£0.2m	£0.1m	1	*>10% off plan*	*Plan*	*Plan or better*
Aligned Payment Incentive	107%	111%	4%	1	*>10% off plan*	*<10% off plan - plan*	*Plan or better*
Capital Spend YTD	£0.2m	£0.2m	£0.0m	1	*>10% off plan*	*Plan*	*Plan or better*

At Month 2 the Trust reported a £5.6m deficit, which is in line with plan. At Month 2, the Trust's plan was set at £29.5m deficit. The plan and forecast will be adjusted at Month 3 to reflect the revised plan submitted on 12 June (forecast of £28.5m deficit). This position has been reported to the Cheshire and Merseyside Integrated Care Board (C&M ICB).

2. Drivers of the Position

Key Drivers

After exclusion of services treated as 'pass through' (where income matches expenditure), the key drivers of the underlying year to date position are:

- Income £0.3m favourable variance to plan, driven by early achievement of efficiency schemes.
- Pay £0.1m adverse variance to plan, driven by increased bank usage across Maternity and Theatres.
- Non-pay £0.2m adverse variance to plan, driven by increased drug and clinical supplies costs.

Workforce

Whole Time Equivalents (WTEs) are shown in Appendix 1. At Month 2, WTEs totalled 1,718, compared to 1703 at Month 1, and 1,687 at M12 2023/24. This increase is driven by ongoing maternity and theatres bank usage, and agency medical staff covering gaps in rotas. There is a favourable variance of 50WTEs compared to plan at Month 2; this favourable variance is driven by the Liverpool Neonatal Partnership and therefore has a nil financial impact, as income is received to match expenditure in this service.

Enhanced controls remain in place regarding agency spend including Divisional oversight and enhanced senior approvals required, and there is a favourable variance against the Trust plan (£0.1m) and against the national cap of 3.2% of total pay bill (£0.4m).

Cost Improvement Programme (CIP)

Within the current agreed plan, the Trust has a cost improvement programme target of £5.3m (3.1% of expenditure), phased towards the end of the year. This has been increased to £5.9m in the final board-approved plan and will be shown at Month 3.

In Month 2 the Trust delivered £0.4m of CIP, leading to a favourable a variance against plan of £0.1m. This is driven by earlier than anticipated achievement of an out of area income scheme. Full delivery of the CIP target is forecast.

The efficiency programme is a key priority for the Trust, with significant focus placed on development and delivery.

3. Cash and Borrowings

The Trust's cash and bank balance at the end of Month 2 was £4.6m. From August 2024 onwards the Trust will require cash support, reflecting the Trust's deficit financial position. The Trust submitted a distressed finance application on 17 June for £6.6m in quarter 2. The total forecast cash requirement for 2024/25 is £23.9m.

4. Capital Expenditure

Year to date capital expenditure is in line with plan at £0.2m, and the Trust expects to fully expend the capital plan of £9.8m by 31 March 2025.

5. Board Assurance Framework (BAF) Risk

The previous BAF risk relating to the 2023/24 financial position has been closed and replaced with BAF Risk 4 – Financial Sustainability. This risk highlights that non-delivery of the Trust's financial plan may result in a detrimental impact on medium/long term sustainability and effective system collaboration.

The initial risk score is proposed at 11 (Likelihood 4, Impact 4, Control 3). The current score is proposed at 10 (Likelihood 3, Impact 4, Control 3), given that the Trust has reported a breakeven position for Month 2 and is currently forecasting to deliver the plan.

6. Conclusion & Recommendation

The Trust has delivered a breakeven position at Month 2, as well as delivering its CIP target. The Trust Board is asked to note this position.

Appendices

Appendix 1 – Board Finance Pack, Month 1

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

FINANCE REPORT: M2

YEAR ENDING 31 MARCH 2025

Liverpool Women's
NHS Foundation Trust

Contents

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
INCOME & EXPENDITURE: M2
YEAR ENDING 31 MARCH 2025

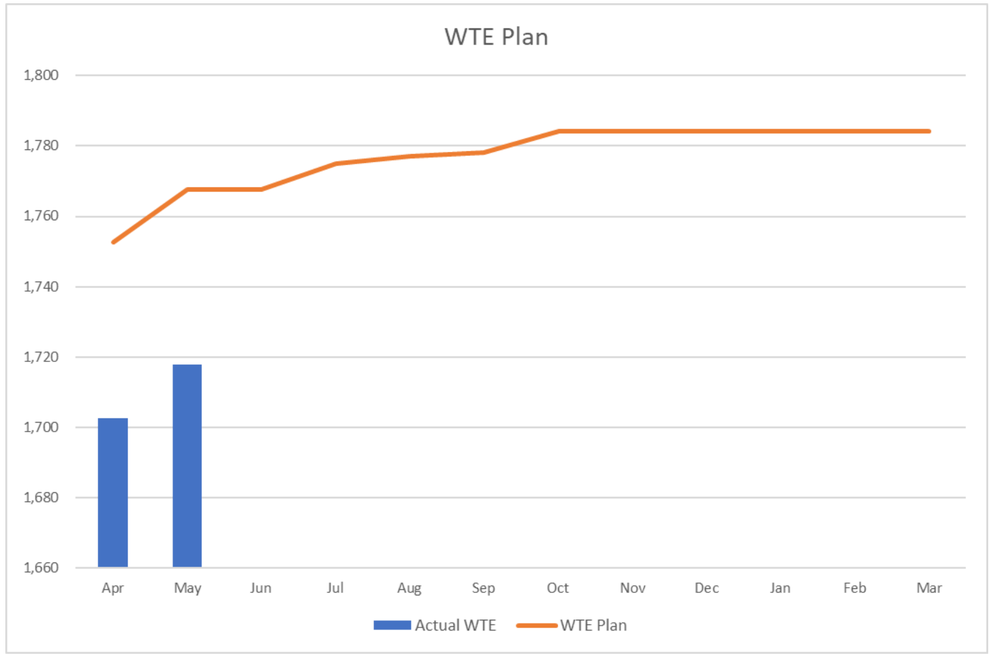
INCOME & EXPENDITURE £'000	MONTH 2 Budget	 Actual	 Variance	YTD Budget	 Actual	 Variance	FULL YEAR Budget	 Actual	 Variance
Income									
Clinical Income	(11,743)	(11,900)	157	(23,482)	(23,470)	(12)	(141,499)	(141,499)	0
Non-Clinical Income	(613)	(657)	44	(1,225)	(1,222)	(3)	(7,365)	(7,365)	0
Total Income	**(12,356)**	**(12,557)**	**202**	**(24,707)**	**(24,692)**	**(15)**	**(148,864)**	**(148,864)**	**0**
Expenditure									
Pay Costs	9,018	9,012	6	17,970	17,781	189	107,237	107,237	0
Non-Pay Costs	3,481	3,793	(312)	6,960	7,126	(167)	38,965	38,965	0
CNST	1,897	1,897	0	3,793	3,793	0	22,760	22,760	0
Total Expenditure	**14,395**	**14,702**	**(307)**	**28,723**	**28,701**	**22**	**168,963**	**168,963**	**0**
EBITDA	**2,040**	**2,145**	**(105)**	**4,016**	**4,009**	**7**	**20,099**	**20,099**	**0**
Technical Items									
Depreciation	564	581	(17)	1,128	1,171	(43)	6,768	6,768	0
Interest Payable	2	1	1	4	1	2	21	21	0
Interest Receivable	(17)	(49)	32	(34)	(84)	51	(203)	(203)	0
PDC Dividend	235	235	(0)	469	486	(17)	2,815	2,815	0
Profit/Loss on Disposal or Transfer Absorption	0	0	0	0	0	0	0	0	0
Total Technical Items	**783**	**767**	**16**	**1,567**	**1,574**	**(7)**	**9,401**	**9,401**	**0**
(Surplus) / Deficit	**2,823**	**2,912**	**(89)**	**5,583**	**5,582**	**1**	**29,500**	**29,500**	**0**

NHS
Liverpool Women's
NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST **2a**
WTE: M2
YEAR ENDING 31 MARCH 2025

TYPE	DESCRIPTION	M12	M1	M2	Movement M1 - M2	Movement M12 - M2
SUBSTANTIVE	REGISTERED NURSING, MIDWIFERY & HEALTH VISITING STAFF	664.88	665.08	657.66	(7.42)	(7.22)
	ALLIED HEALTH PROFESSIONALS	83.29	84.23	84.95	0.72	1.66
	OTHER REGISTERED SCIENTIFIC, THERAPEUTIC & TECHNICAL STAFF	11.31	12.31	15.31	3.00	4.00
	REGISTERED HEALTH CARE SCIENTISTS	61.48	59.39	58.39	(1.00)	(3.09)
	HCA & SUPPORT TO CLINICAL STAFF	229.76	233.51	233.87	0.36	4.11
	MANAGERS & SENIOR MANAGERS	61.19	65.53	70.13	4.60	8.94
	ADMIN AND ESTATES STAFF	13.00	13.00	13.00	0.00	0.00
	OTHER INFRASTRUCTURE & SUPPORT STAFF	285.33	280.55	284.68	4.13	(0.65)
	MEDICAL AND DENTAL	195.69	189.96	186.91	(3.05)	(8.78)
	ANY OTHER STAFF	13.50	13.50	13.00	(0.50)	(0.50)
SUBSTANTIVE TOTAL		**1,619.43**	**1,617.06**	**1,617.90**	**0.84**	**(1.53)**
BANK	REGISTERED NURSING, MIDWIFERY & HEALTH VISITING STAFF	28.56	37.21	39.69	2.48	11.13
	ALLIED HEALTH PROFESSIONALS	10.18	11.79	13.57	1.78	3.39
	OTHER REGISTERED SCIENTIFIC, THERAPEUTIC & TECHNICAL STAFF	-	-	-	0.00	0.00
	REGISTERED HEALTH CARE SCIENTISTS	0.15	-	0.01	0.01	(0.14)
	HCA & SUPPORT TO CLINICAL STAFF	14.05	23.32	25.03	1.71	10.98
	MANAGERS & SENIOR MANAGERS	-	-	-	0.00	0.00
	ADMIN AND ESTATES STAFF	0.23	-	0.10	0.10	(0.13)
	OTHER INFRASTRUCTURE & SUPPORT STAFF	8.84	6.97	10.75	3.78	1.91
	MEDICAL AND DENTAL	1.44	1.41	1.80	0.39	0.36
	ANY OTHER STAFF	-	-	-	0.00	0.00
BANK TOTAL		**63.45**	**80.70**	**90.95**	**10.25**	**27.50**
AGENCY	REGISTERED NURSING, MIDWIFERY & HEALTH VISITING STAFF	-	-	-	0.00	0.00
	ALLIED HEALTH PROFESSIONALS	3.87	3.93	4.50	0.57	0.63
	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	-	-	-	0.00	0.00
	OTHER INFRASTRUCTURE & SUPPORT STAFF	-	-	-	0.00	0.00
	MEDICAL AND DENTAL	-	1.00	4.40	3.40	4.40
	ANY OTHER STAFF	-	-	-	0.00	0.00
AGENCY TOTAL		**3.87**	**4.93**	**8.90**	**3.97**	**5.03**
					-	-
TRUST TOTAL		**1,686.75**	**1,702.69**	**1,717.75**	**15.06**	**31.00**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 2b
WTE PLAN: M2
YEAR ENDING 31 MARCH 2025



Note:WTE figures include bank and agency

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 3
INCOME & EXPENDITURE RUN RATE: M2
YEAR ENDING 31 MARCH 2025

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

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
CIP: M2
YEAR ENDING 31 MARCH 2025

GBP	Month 2			Month 2 YTD			Forecast		
Status	Target	Actual	Variance	Target	Actual	Variance	Target	Actual	Variance
Pay	14	13	-1	29	22	-7	1,513	1,513	-
Non-Pay	60	71	11	120	175	55	1,799	1,799	-
Income	6	16	10	8	16	8	655	655	-
Total Recurrent Schemes	**81**	**101**	**20**	**157**	**213**	**56**	**3,968**	**3,968**	**-**
Pay	51	79	27	103	157	54	617	617	-
Non-Pay	3	3	0	6	6	0	723	723	-
Income	1	-	-1	1	-	-1	6	6	-
Total Non-Recurrent Schemes	**55**	**82**	**27**	**110**	**163**	**53**	**1,346**	**1,346**	**-**
Total CIP	**136**	**183**	**47**	**267**	**376**	**109**	**5,314**	**5,314**	**-**

2. Total Efficiencies by scheme

GBP	Month 2			Month 2 YTD			Forecast		
Status by scheme	Target	Actual	Variance	Target	Actual	Variance	Target	Actual	Variance
Pay - Service re-design	46	71	26	92	142	50	1,391	1,391	-
Pay - Corporate services transformation	5	5	0	10	10	0	359	359	-
Pay - Bank - increase bank supply	-	-	-	-	-	-	200	200	-
Pay - Pay - Other	15	16	1	30	27	-3	180	180	-
Total Pay Schemes	**66**	**92**	**26**	**132**	**179**	**47**	**2,130**	**2,130**	**-**
Non-Pay - Medicines efficiencies	2	0	-2	4	2	-2	26	26	-
Non-Pay - Procurement (excl drugs) - non-clinical directly achieved	58	6	-51	115	13	-103	1,319	1,302	-17
Non-Pay - Procurement (excl drugs) - non-clinical through NHS Supply Chain	-	1	1	-	3	3	-	17	17
Non-Pay - Estates and Premises transformation	-	-	-	-	-	-	-	-	-
Non-Pay - Service re-design	3	67	63	7	164	157	1,177	1,177	-
Total Non-Pay Schemes	**63**	**74**	**11**	**126**	**181**	**55**	**2,522**	**2,522**	**0**
Income - Non-Patient Care	1	-	-1	2	-	-2	396	396	-
Income - Overseas Visitors	1	-	-1	3	-	-3	15	15	-
Income - Private Patient	5	-	-5	5	-	-5	250	250	-
Income - Income - Other	-	16	16	-	16	16	-	-	-
Total Income Schemes	**7**	**16**	**9**	**9**	**16**	**7**	**661**	**661**	**-**
Total CIP	**136**	**183**	**47**	**267**	**376**	**109**	**5,314**	**5,314**	**0**

3. Efficiency Plan Risk

GBP	Month 2			Month 2 YTD			Forecast		
Risk	Target	Actual	Variance	Target	Actual	Variance	Target	Actual	Variance
High	-	-	-	-	-	-	1,599	1,599	-
Medium	59	16	-43	113	16	-96	2,588	2,588	-
Low	77	167	90	154	360	206	1,126	1,126	-
Total CIP	**136**	**183**	**47**	**267**	**376**	**109**	**5,314**	**5,314**	**-**

4. Efficiency Plan Status

GBP	Month 2			Month 2 YTD			Forecast		
Risk	Target	Actual	Variance	Target	Actual	Variance	Target	Actual	Variance
Fully Developed - In Delivery	75	167	91	151	358	207	1,105	1,105	-
Plans in progress	56	16	-40	112	18	-93	2,260	2,260	-
Opportunity	5	-	-5	5	-	-5	1,949	1,949	-
Unidentified	-	-	-	-	-	-	-	-	-
Total CIP	**136**	**183**	**47**	**267**	**376**	**109**	**5,314**	**5,314**	**-**

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 5a
CASHFLOW STATEMENT: M2
YEAR ENDING 31 MARCH 2025

CASHFLOW STATEMENT	
£'000	**Actual**
Cash flows from operating activities	(5,179)
Depreciation and amortisation	1,171
Impairments and reversals	0
Income recognised in respect of capital donations (cash and non-cash)	0
Movement in working capital	7,975
Net cash generated from / (used in) operations	**3,967**
Interest received	68
Purchase of property, plant and equipment, ROU and intangible assets	(1,504)
Proceeds from sales of property, plant and equipment and intangible assets	0
Net cash generated from/(used in) investing activities	**(1,436)**
PDC distressed funding received	0
PDC Capital Programme Funding - received	0
Loans from Department of Health - repaid	0
Interest paid	0
PDC dividend (paid)/refunded	0
Net cash generated from/(used in) financing activities	**0**
Increase/(decrease) in cash and cash equivalents	**2,531**
Cash and cash equivalents at start of period	2,049
Cash and cash equivalents at end of period	**4,580**

Finance Support	2023/24 Year £000	2024/25 Qu1 PLAN £000	2024/25 Qu2 PLAN £000	2024/25 Qu3 PLAN £000	2024/25 Qu4 PLAN £000	2024/25 Total £000
ICB cash support	21,400	0	0	0	0	0
ICB cash repayment (LMS)	(21,400)	0	0	(1,132)	0	(1,132)
Alder Hey cash support	0	4,623	0	0	0	4,623
Alder Hey deferred income movement	0	(1,156)	(1,156)	(1,156)	(1,156)	(4,623)
National cash support	20,100	0	6,600	9,700	7,600	23,900
Total support required						**22,768**
DH Loan repayment	612	0	301	0	-	301
DH Loan outstanding at year end	301					0

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 5b
CASHFLOW ROLLING FORECAST: M2
YEAR ENDING 31 MARCH 2025

	Actual Apr-24 £000	Actual May-24 £000	Forecast Jun-24 £000	Forecast Jul-24 £000
Opening cash	**1,948**	**4,776**	**6,984**	**4,573**
Income flows				
ICB income	8,244	8,244	8,281	8,244
NHS England	2,341	2,341	2,341	2,341
NHS Trust/FT	354	1,816	268	530
Private patients	252	291	183	391
Overseas	4	0	10	10
ICR/RTA scheme	1	4	4	4
Non-NHS (Wales/Man)	257	229	224	257
R&D	133	133	133	133
HEE/other E&T - paid via NHSE	1,417	120	107	178
Other	14	109	81	148
Bank interest	33	36	36	36
Total operating inflows	**13,050**	**13,323**	**11,668**	**12,272**
Expenditure flows				
Wages and salaries	(4,308)	(4,358)	(4,365)	(4,400)
HMRC	(2,081)	(1,943)	(1,950)	(1,944)
Pensions	(1,241)	(1,250)	(1,350)	(1,250)
CNST - cash movement	(2,477)	(2,276)	(2,276)	(2,276)
Other expenditure (ex depn)	(5,203)	(3,750)	(4,340)	(4,436)
VAT recovery	465	0	202	110
PDC/Loan (inc Ambulatory PDC)	0	0	0	0
Interest payable	0	0	0	0
Total operating outflows	**(14,845)**	**(13,577)**	**(14,079)**	**(14,196)**
Other cash in/outflows				
National/local distressed finance support	0	0	0	0
National payroll	0	0	0	0
Accrued/Deferred income	4,623	0	0	0
NHS Resolution MIS	0	2,462	0	0
TOTAL CASH IN GBS ACCOUNT	**4,776**	**6,984**	**4,573**	**2,649**
Barclays, bank rec and cash in hand*	(197)	(2,404)	50	50
TOTAL CASH HOLDING	**4,579**	**4,580**	**4,623**	**2,699**

**the ledger closes two days before month end. On 30 May the NHS Resolution payment for the maternity incentive scheme was paid in and is adjusted in the bank reconciliation*

NHS
Liverpool Women's
NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 6
Capital Expenditure: M2
YEAR ENDING 31 MARCH 2025

			YTD			Full Year - Revised Plan		
Funding Source	NHSI Ref	Capital Scheme	Sum of YTD Plan	Sum of Current YTD Actual	Sum of YTD Variance	Sum of Capital Allocation	Sum of Forecast	Sum of Variance Plan to FOT
			£000	£000	£000	£000	£000	£000
CDEL	Estates backlog	NHSI Scheme 4	0	0	0	862	862	862
CDEL	Medical equip - ultrasound	NHSI Scheme 7	0	29	0	535	535	535
CDEL	Medical equipment - general	NHSI Scheme 6	104	27	0	586	586	586
CDEL	Medical equip - transfusion on site	NHSI Scheme 8	0	0	0	252	252	252
CDEL	Medical equip - fluoroscopy	NHSI Scheme 9	0	0	0	400	400	400
CDEL	Other building	NHSI Scheme 11	0	1	1	90	90	90
CDEL	Digital tangible	NHSI Scheme 2	10	0	0	1,100	1,100	1,100
CDEL	Digital intangible	NHSI Scheme 3	87	133	-12	1,209	1,209	1,209
CDEL Total			**201**	**190**	**-10**	**5,035**	**5,035**	**5,035**
NON CDEL FUNDED PROJECTS	Ambulatory	NHSI Scheme 1	0	11	11	4,640	4,640	4,640
NON CDEL FUNDED PROJECTS	CAMRIN	NHSI Scheme 5	0	0	0	49	49	49
NON CDEL FUNDED PROJECTS	Charitable funded	NHSI Scheme 10	0	0	0	87	87	87
NON CDEL FUNDED PROJECTS Total			**-**	**11**	**11**	**4,776**	**4,776**	**4,776**
Grand Total			**201**	**201**	**1**	**9,811**	**9,811**	**9,811**

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Meeting Date	Thursday, 11 July 2024	**Item Reference**	24/25/083
Report Title	Improvement Plan Highlight Report 2		
Author	Tim Gold, Chief Transformation Officer		
Responsible Director	Tim Gold, Chief Transformation Officer		

Purpose of Report	To provide a delivery progress update on the Trust's Improvement Plan
Executive Summary	The Trust's Improvement Plan, designed for the next 12-18 months, aims to address key clinical challenges and risks while embedding a culture of continuous improvement and safety. The plan, launched in May 2024, focuses on immediate priorities to pave the way for a longer-term strategy. Recent efforts include establishing effective project monitoring systems and processes. The next period will emphasize quality assurance, ensuring risk calibration, and actively managing project plans. Significant risks and progress on project benefits have been identified and addressed.
Key Areas of Concern	All projects are progressing well and no significant barriers to milestones have yet to be identified. There is currently one 'high' (12+) risk identified and this relates to the Trust being able to recruit consultant anaesthetists to create 24/7 cover. This has been a long-standing risk for the organisation.
Trust Strategy and System Impact	The Improvement Plan aligns with the Trust Strategy and the triple aim by focusing on enhancing health and wellbeing, improving service quality, and promoting sustainable, efficient resource use. This alignment ensures that the Improvement Plan not only supports the Trust's strategic goals but also contributes to the broader objectives of the NHS. By prioritizing these areas, the Trust can foster equity, better health outcomes, and operational efficiency, which are essential for meeting the needs of the community it serves.

Links to Board Assurance Framework		**-**
Links to Corporate Risk Register (scoring 10+)	*N/A*	**-**

Assurance Level	1. MODERATE - Adequate system of internal control applied to meet existing objectives

Action Required by the Group	The Board of Directors is asked to note the Improvement Plan Highlight Report.

REPORT DEVELOPMENT:

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

MAIN REPORT

INTRODUCTION

The Trust has developed its Improvement Plan to provide a clear direction of travel for the next 12-18 months, with a focus on making improvements in some key priority areas, particularly where we have clinical challenges and risks.

The vision for Our Improvement Plan is to:

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

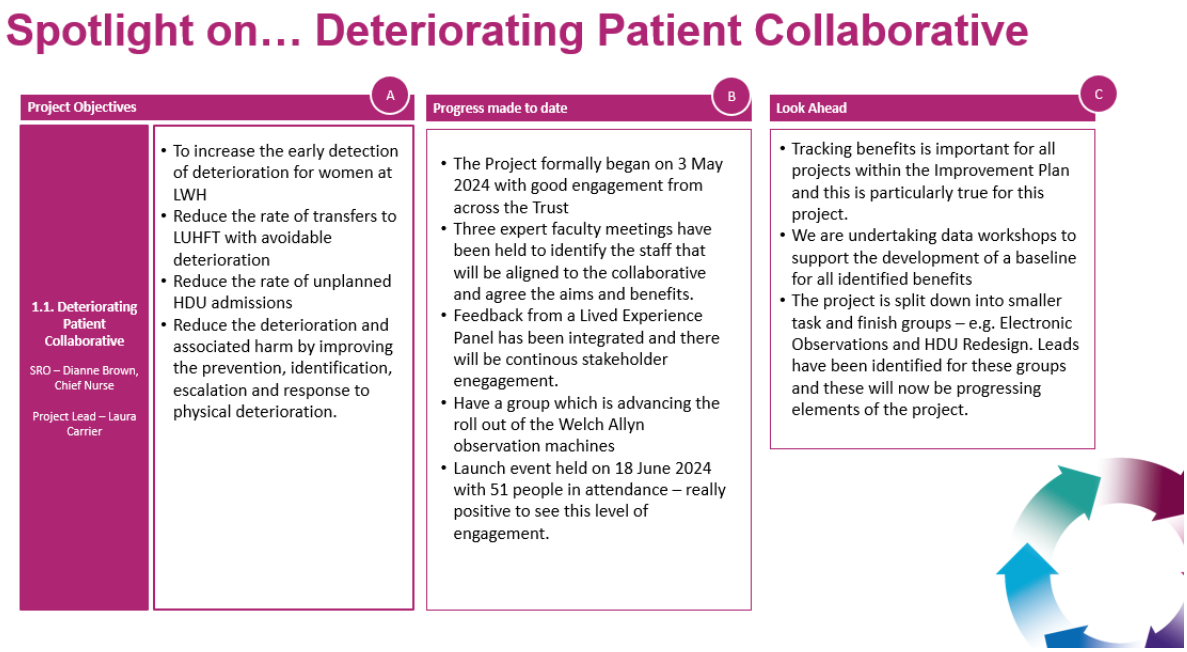
Our Improvement Plan is not a long-term strategy for the Trust but a roadmap for the short-medium term. Focussing on the immediate priorities for the Trust will allow us to then look at a longer-term strategy for the next 3-5 years.

This report provides an overview of the progress made since the previous update (May 2024) and outlines the key areas of focus for the next period.

The Improvement Plan Highlight Report can be found in Appendix A.

KEY FOCUS LAST PERIOD

At the last reporting point in May 2024, the Improvement Plan was nearing the end of its mobilisation phase. Since then, Our Improvement Plan has been formally launched within the Trust, beginning with the 'In the Loop' Briefing. These briefings have been ongoing, leveraging internal communication channels and other crucial meetings such as the Trust Management Group and the Senior Leadership Forum. Rather than providing a general update each month, there is a focus on one or two projects to highlight what progress is being made and how it is helping to transform services. An example is provided below:



A significant focus during this period has been on establishing the key processes and systems necessary for effective project monitoring. This includes identifying both qualitative and quantitative benefits to track progress, setting up programme huddles, and identifying risks. These efforts have advanced the plan significantly, instilling confidence in the accuracy of reporting through tools such as the heat map.

KEY FOCUS THIS PERIOD

All projects are progressing well, with no significant barriers to milestones identified so far. A change process has been implemented to ensure that any amendments to project scope or milestone dates are governed appropriately.

With systems and processes now established and reporting mechanisms maturing and gaining understanding across the organisation, the upcoming focus for the next month will shift towards quality assurance. This entails reviewing risk articulation and calibration to ensure scoring is as effective as possible. As project milestones are achieved, the Transformation Delivery Unit will work to ensure these updates are verified, providing assurance and evidence of their integration and sustainability. Additionally, in some areas, further work is required to ensure that project plans are actively managed and maintained. The huddle meetings are a fundamental part of the effective governance of the Improvement Plan and whilst these have matured significantly since the previous update, there remains an opportunity for improvement in terms of the use of set agendas, action tracking and 'in the moment' check and challenge of milestones.

Key points to note from the respective programmes:

- The CQC/MSSP project plan has moved from a 'red' to 'green' rating. A previously overdue milestone relating to BSOTS implementation has been closed as evidence of implementation has been provided by the Family Health Division. Further milestones will be included within the plan for a review pending the release of the new national BSOTS guidance.
- The Safety Culture project plan is rated as 'red' due to the need for milestones to be added for the controlled drugs element.
- The CIP project plan is rated as 'red' owing to outstanding PIDs and insufficient opportunity recognition. Meetings are scheduled between the finance team and Divisional SLTs to progress on 5 July 2024.
- The period saw the launch of the learning session for the Deteriorating Patient Collaborative with 55 attendees.
- The Transfusion Lab project has made good progress during the period with the 'amber' plan rating a result of several milestones requiring 'gateways' to be passed ahead of moving forward e.g. MHRA compliance.
- Good progress has been made on the Waiting List project with a full project plan now in place.
- Progress in relation to enhancing the workforce includes appointing 6 Obstetric ACPs, with 10 starting courses in Autumn 2024, and 7 out of 10 Obs and Gynae clinical fellows starting in Autumn 2024. A 24/7 consultant obstetrician cover consultation has been undertaken. Looking ahead, interviews for 4 Gynae ACPs are scheduled, and plans for 24/7 cover aim to be in place by Autumn 2024. Additionally, 10 anaesthetics fellow posts have been offered, with 8 accepted, starting by Spring 2025.

RISK & ISSUE PROFILE

Two risks scoring 12+ were identified over the reporting period. Both are linked to the 2.1 Enhanced Workforce for Acute Workload project and concern the recruitment of consultant anaesthetists, PGDs, and ACPs. The risk related to PGDs and ACPs has been mitigated and reduced to a score of '9', but the risk concerning the recruitment of consultant anaesthetists remains the highest scoring risk within the Improvement Plan.

There is a growing issue regarding the delivery of the CIP programme, resulting in two risks (previously rated at '8') being escalated to '10'. Meetings have been scheduled for next week to discuss control measures.

A Clinical Digital Risk has also been added to the Deteriorating Patient Collaborative Project Risk Register with an initial score of '11'. Concerns were raised in a recent huddle about the integration of digital systems operations and reporting. There is an ongoing review to address these issues, with a focus on improving system connectivity and mitigating potential risks.

BENEFITS PROFILE

Two face-to-face sessions have been held with project leads to develop a benefits profile for each project. The aim of creating the benefit profile has been not to re-create the Integrated Performance Report, but rather identify metrics that will help the Board to gain assurance that the actions being taken in each project are delivering the desired impact. The report has been updated with the proposed KPIs, which have now been finalised with the respective SROs.

Two projects (Medicine Safety and LWH Transfusion Lab) will have benefits identified at a gateway point further into the project. As can be seen throughout the report, several KPIs remain either in development or in production – where identified, these will be available in the next iteration of the report. It is important that the benefits within the Improvement Plan do not simply repeat the Integrated Performance Report but can provide a good level of assurance regarding causality.

Other projects such as 'streamlined governance' and 'partnership governance' will rely more on qualitative and subjective judgements rather than quantitative measures.

Equality, Diversity & Inclusion Implications – DO NOT DELETE [state N/A if necessary)
N/A

Quality, Financial or Workforce implications - DO NOT DELETE [state N/A if necessary)
N/A

RECOMMENDATION

The Board of Directors is asked to note the Improvement Plan Highlight Report.

SUPPORTING DOCUMENTS

Appendix A - LWH Improvement Plan Highlight Report

OUR IMPROVEMENT PLAN

SAFETY | QUALITY | SUSTAINABILITY

NHS
Liverpool Women's
NHS Foundation Trust

Liverpool Women's NHS FT

Improvement Plan Highlight Report

HEATMAP

Organisation	Overall	Overall DoT	Plan	Plan DoT	Benefits	Benefits DoT	Issues	Issues DoT	Risk	Risk DoT	Resource	Resource DoT	Stake holders	Stake holders DoT
LWH	Y	→	Y	↘	G	→	G	→	Y	↘	G	→	G	→
1. Quality and Safety	G	→	G	→	G	→	G	→	Y	→	G	→	G	→
1.1 Deteriorating Patient Collaborative	Y	↘	Y	→	G	→	G	→	A	↘	G	→	G	→
1.2 CQC and MSSP Actions	G	→	G	→	G	→	G	→	G	→	G	→	G	→
2. Clinical Effectiveness	Y	→	Y	↘	G	→	G	→	A	↓	Y	→	G	→
2.1 Enhanced Workforce for Acute Workload	Y	↘	Y	↘	A	→	G	→	R	↓	A	↓	G	→
2.2 Acute Gynae Services	Y	↘	Y	↘	G	→	G	→	R	↓	G	→	G	→
2.3 LWH Transfusion Lab	Y	↘	A	↓	G	→	G	→	R	↓	G	→	G	→
2.4 Medicines Safety	G	→	Y	↘	G	→	G	→	G	→	G	→	G	→
3. Operational Performance	Y	→	Y	↘	G	↗	G	→	A	→	G	→	G	↗
3.1 Cancer Improvement	Y	→	G	→	A	↑	G	→	R	↘	G	→	G	↑
3.2 Reduced Waiting List	Y	↘	A	↓	G	→	G	→	G	→	G	→	G	→
4. People and Culture	Y	↘	A	↓	A	→	G	→	A	↘	G	→	Y	↘
4.1 Safety Culture	Y	↘	R	↓	A	→	G	→	A	↓	G	→	G	→
4.2 Actively Anti-Racist Organisation	Y	↘	A	↓	A	→	G	→	A	↘	G	↗	A	↓
5. Financial Sustainability	Y	→	A	↓	G	→	G	→	Y	→	G	→	G	→
5.1 Delivering the Three Year Financial Plan	G	→	Y	↘	G	→	G	→	G	→	G	→	G	→
5.2 2024/25 CIP Delivery	Y	↘	R	↓	G	→	G	→	A	↘	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	→

MILESTONES

LWH Improvement Portfolio

(Blank) | Complete | Future | Late | On Track | Overdue

Project	Milestones Count	Overdue Milestones	Late Milestones	On Track Milestones	Future Milestones	Completed Milestones	Start	Finish	Link	Progress	Project SRO
1.1 Deteriorating Patient Collaborative	11	1		1	6	3	08/05/2024	07/05/2025		18%	Dianne Brown
1.2 CQC and MSSP Actions	29			2		27	15/04/2024	31/03/2025		92%	Dianne Brown
2.1 Enhanced Workforce for Acute Workload	4			4			15/04/2024	31/03/2026		30%	Lynn Greenhalgh
2.2 Acute Gynae Services	11		2	3	3	3	15/04/2024	14/04/2025		22%	Lynn Greenhalgh
2.3 LWH Transfusion Lab	9	1		3	4	1	15/04/2024	28/03/2025		25%	Lynn Greenhalgh
2.4 Medicines Safety	6	2			4		15/04/2024	28/02/2025		6%	Lynn Greenhalgh
3.1 Cancer Improvement	26		1	11	8	6	15/04/2024	27/03/2026		56%	Gary Price
3.2 Reduced Waiting List	23	2	1	1	12	7	15/04/2024	31/07/2025		40%	Gary Price
4.1 Safety Culture	9	1	1	3	1	3	15/04/2024	31/03/2025		31%	Michelle Turner
4.2 Actively Anti-Racist Organisation	19	2	3	3	5	6	15/04/2024	31/03/2025		42%	Michelle Turner
5.1 Delivering the Three Year Financial Plan	9		1	2	1	5	15/04/2024	30/09/2024		38%	Jenny Hannon
5.2 2024/25 CIP Delivery	10	3			1	6	15/04/2024	31/10/2024		71%	Jenny Hannon
6.2 Streamlined Governance	7			1		6	15/04/2024	31/10/2024		41%	James Sumner
6.3 Risk Management	11				1	10	15/04/2024	30/05/2025		59%	James Sumner
6.4 Partnership Governance	8		1		7		04/06/2024	02/12/2024		0%	James Sumner

TRUST 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

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A significant focus during this period has been on establishing the key processes and systems necessary for effective project monitoring. This includes identifying both qualitative and quantitative benefits to track progress, setting up programme huddles, and identifying risks. These efforts have advanced the plan significantly, instilling confidence in the accuracy of reporting through tools such as the heat map.

Key Focus Next Period

All projects are progressing well, with no significant barriers to milestones identified so far. A change process has been implemented to ensure that any amendments to project scope or milestone dates are governed appropriately. With systems and processes now established and reporting mechanisms maturing and gaining understanding across the organisation, the focus for the upcoming month will shift towards quality assurance. This entails reviewing risk articulation and calibration to ensure scoring is as effective as possible, with controls identified. As project milestones are achieved, the Transformation Delivery Unit will work to ensure these updates are verified, providing assurance and evidence of their integration and sustainability. Additionally, in some areas, further work is required to ensure that project plans are actively managed and maintained. The huddle meetings are a fundamental part of the effective governance of the Improvement Plan and whilst these have matured significantly since the previous update, there remains an opportunity for improvement in terms of the use of set agendas, action tracking and 'in the moment' check and challenge of milestones.

Key points to note from the respective programmes:

- The CQC/MSSP project plan has moved from a 'red' to 'green' rating. A previously overdue milestone relating to BSOTS implementation has been closed as evidence of implementation has been provided by the Family Health Division. Further milestones will be included within the plan for a review pending the release of the new national BSOTS guidance.
- The Safety Culture project plan is rated 'red' due to the need for milestones to be added for the controlled drugs element.
- The CIP project plan is rated as 'red' owing to outstanding PIDs and insufficient opportunity recognition. Meetings are scheduled between the finance team and Divisional SLTs to progress on 5 July 2024.
- The period saw the launch of the learning session for the Deteriorating Patient Collaborative with 55 attendees.
- The Transfusion Lab project has made good progress during the period with the 'amber' plan rating a result of several milestones requiring 'gateways' to be passed ahead of moving forward e.g. MHRA compliance.
- Good progress has been made on the Waiting List project with a full project plan now in place.
- Progress in relation to enhancing the workforce includes appointing 6 Obstetric ACPs, with 10 starting courses in Autumn 2024, and 7 out of 10 Obs and Gynae clinical fellows starting in Autumn 2024. A 24/7 consultant obstetrician cover consultation has been undertaken. Looking ahead, interviews for 4 Gynae ACPs are scheduled, and plans for 24/7 cover aim to be in place by Autumn 2024. Additionally, 10 anaesthetics fellow posts have been offered, with 8 accepted, starting by Spring 2025.

TRUST 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

IP Risk & Issue Profile

There were two 12+ risks that have been identified over the reporting period. These both linked to the 2.1 Enhanced Workforce for Acute Workload project and relate to a risk of being able to recruit consultant anaesthetists, PGDs and ACPs. The risk relating to PGDs and ACPs has been reduced to a '9' following mitigation but the risk regarding the recruitment of consultant anaesthetists remains the highest scoring risk across the Improvement Plan.

There is a growing issue around the delivery of the CIP programme which has resulted in two risks (previously rated at 8) being escalated to 10. Meetings have been scheduled next week to discuss controls.

A Clinical Digital Risk has also been added to the Deteriorating Patient Collaborative Project Risk Register with an initial score of '11'. Concerns were raised in a recent huddle about the integration of digital systems operations and reporting. There is an ongoing review to address these issues, with a focus on improving system connectivity and mitigating potential risks.

IP Benefits Profile

Two face-to-face sessions held with project leads to progress a benefits profile for each project. The report has been updated with the proposed KPIs and these have now been finalised with the respective SROs. As can be seen throughout the report, several KPIs remain either in development or in production – where identified, these will be available in the next iteration of the report. It is important that the benefits within the Improvement Plan do not simply repeat the Integrated Performance Report but can provide a good level of assurance regarding causality.

Two projects (Medicine Safety and LWH Transfusion Lab) will have benefits identified at a gateway point further into the project.

TRUST IMPROVEMENT PLAN SUMMARY UPDATE SIGNIFICANT RISKS & ISSUES (>= 12/15)

ID	Project Name	Description	Score	Controls in Place	Manager
2842	2.1 Enhanced Workforce for Acute Workload	Insufficient available consultant anaesthetists to recruit to cover for delivery suite and unable to agree hours of work.	12	1) Use of locum/bank where possible to minimise impacts of rostering gaps 2) Introduction of new roles in anaesthetics to mitigate some gaps 3) Recruitment of overseas medical staffing to support workforce growth	Christopher Dewhurst

Quality & Safety Programme Update

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

Organisation	Overall	Overall DoT	Plan	Plan DoT	Benefits	Benefits DoT	Issues	Issues DoT	Risk	Risk DoT	Resource	Resource DoT	Stake holders	Stake holders DoT
LWH	Y	→	Y	↘	G	→	G	→	Y	↘	G	→	G	→
1. Quality and Safety	G	→	G	→	G	→	G	→	Y	→	G	→	G	→
1.1 Deteriorating Patient Collaborative	Y	↘	Y	→	G	→	G	→	A	↘	G	→	G	→
1.2 CQC and MSSP Actions	G	→	G	→	G	→	G	→	G	→	G	→	G	→

Key Focus Last Period

Deteriorating Patient Collaborative:
The DPC Launch event took place on 18th June with 55 attendees. Teams have developed seven Tests of Change to take forward. BI have completed data workshops with clinical teams to better understand our data and BI are engaging with teams that were unable to attend these. Action Period 1 has commenced with QI walkabouts to support teams with their Tests of Change. The HDU Task & Finish group has drafted an options appraisal to present to the steering group. Reality rounding has been completed to better understand the escalation process; this will be fed back to the steering group with proposed next steps.

CQC/MSSP:
The Action Plan is now largely complete. Narratives to be drafted by Chief Nurse to provide assurance regarding management of longer term MSSP actions. The Trust is now compliant with the latest BSOTS policy. Further milestones will be included in the plan for a review pending the release of new national BSOTS guidance.

Key Focus Next Period

Deteriorating Patient Collaborative:
Launch of Learning Session 1, 55 attendees with agreed Tests of Change in Action Period 1. Focus on appointing an MET Lead and planning Task & Finish meetings for the year with invites to relevant internal and external stakeholders. An emerging risk has been identified relating to the use of clinical digital systems and inconsistencies in how data is being recorded. A DPC digital systems risk has been added to reflect this and will be reviewed with the clinical and digital teams.

CQC/MSSP:
A review and update of the evidence repository is underway, to be completed by the end of July for review by members of the Executive Team as part of the Trust's CQC compliance and preparedness work.

Key Points to Note

Deteriorating Patient Collaborative:
Clinical Digital Risk added with an initial score of 11 (current score: L4+S3+C4). Quality Improvement leads are supporting teams with Tests of Change during Action Period 1 across FHD and Gynaecology. Plans in place for interviews for MET Team Lead. Focus on baseline data progressing as expected.

CQC/MSSP:
The CQC are appraised of the current position through monthly engagement meetings and are assured with the progress made to date. CQC did not re-rate the service during their inspection earlier this year despite the significant improvements made. The rating for the trust (Requires Improvement) and the safety of maternity services (Inadequate) remains the same. This can impact on public confidence, the reputation of the trust and the contractual requirements with other external bodies. Executives have been candid with CQC, requesting that the ratings be reviewed at the earliest opportunity in line with our timescales for completion of our improvement plan. CQC have not yet provided a firm timeframe for any re-inspection or regulatory activity in line with their new framework and methodology for inspection.

Quality & Safety Benefits Update

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

Project Name	Date	Target < or >	Performance	Assurance	Variation
1.1 Deteriorating Patient Collaborative					
% of patient with a MOEWS of more than 7 to be reviewed by the medical team caring for the patient as per policy					
% of patient with a NEWS of more than 7 to be reviewed by the medical team caring for the patient as per policy					
% of patients with MOEWS of 3 in one single parameter/5 overall viewed by a medic team caring for that patient as per policy					
% of patients with NEWS of 3 in one single parameter/5 overall to be reviewed by a medic team caring for the patient as per policy					
Sepsis Golden hour – % patients identified as requiring antibiotics and antibiotics delivered within one hour					
Sepsis Golden hour – % patients identified as requiring Sepsis bundle have bundle delivered within one hour					
1.2 CQC and MSSP Actions					
% of Clinical Areas with a BBAS Accreditation Completed					
% of Clinical Areas with a Good or Outstanding BBAS Accreditation					

KPIs in production – to be available in future reports

Clinical Effectiveness Programme Update

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.

Organisation	Overall	Overall DoT	Plan	Plan DoT	Benefits	Benefits DoT	Issues	Issues DoT	Risk	Risk DoT	Resource	Resource DoT	Stake holders	Stake holders DoT
LWH	Y	→	Y	↘	G	→	G	→	Y	↘	G	→	G	→
2. Clinical Effectiveness	Y	→	Y	↘	G	→	G	→	A	↓	Y	→	G	→
2.1 Enhanced Workforce for Acute Workload	Y	↘	Y	↘	A	→	G	→	R	↓	A	↓	G	→
2.2 Acute Gynae Services	Y	↘	Y	↘	G	→	G	→	R	↓	G	→	G	→
2.3 LWH Transfusion Lab	Y	↘	A	↓	G	→	G	→	R	↓	G	→	G	→
2.4 Medicines Safety	G	→	Y	↘	G	→	G	→	G	→	G	→	G	→

Key Focus Last Period

Acute Gynae
Interview held on 26th June for AMD in quality and risk, with an interim Clinical Lead for the project for one year then made available. Expected to be in post by end of July 2024.

Blood Transfusion Lab
The three key gateway challenges have been addressed and which has enabled the team to complete a full project plan. The challenges raised concerning digital integration have been resolved. The team has recruited an expert in MHRA to ensure that appropriate national standards around blood storage, clinical standards, auditing and policies can all be completed to support the project. The project team has agreed to commence the procurement process for the Diabots installation. An estates review has been undertaken to assess the feasibility of the current location.

Medicines Safety
Subject matter expert in post and review of medicines optimisation and pharmacy services (MOP) commenced. Partial completion of staff interviews and visits to wards and clinics also commenced. First Pharmacy Governance meeting held.

Enhanced Workforce
Two Tier 3 Clinical Fellows have been appointed. Consultants have agreed to 24/7 obstetric cover, which in on course for implementation on 9th September. From the seven shortlisted Gynae ACPs, six have been selected for interview on 5th July. Nine PGD candidates have been offered Speciality level anaesthetics posts, with eight of the nine having accepted.

Key Focus Next Period

Acute Gynae ED
A revised gap analysis of the acute services and EPAU was recently completed, with further work on this to take place this period.

LWH Transfusion Lab
Final repertoire of testing to be completed end July 24. Visit from German team to review the estate prior to installation end July 24. Training schedule for all staff who may use the new equipment to be completed end Aug 24. Business continuity plan to be reviewed during installation period.

Medicines Safety
Scoping exercises to continue across wards and clinics. Risks identified in scoping exercise to date to be documented. Controlled Drug Accountable Officer Report to be finalised. Development of dashboards for improvement areas to be scoped. Consideration of immediate high risk gaps in service delivery and SLAs (procurement/ clinical governance / fertility (Hewitt NHS and private)).

Enhanced Workforce
The availability of a suitable rest room for consultants is a priority. Christopher Dewhurst liaising with Estates for an update, with the aim to complete by mid August. Finalisation of the recruitment for all outstanding roles.

Key Points to Note

Acute Gynae ED
Workgroup meetings for the project are due to start early July, with stakeholders identified and confirmed.

LWH Transfusion Lab
Procurement for the Diabots solution to commence imminently, with a projected delivery date of October 2024, to be operational by November 2024.

Medicine Safety
Development of a Medicines Safety Dashboard is now required with support from BI and nursing. Escalation of risk concerning a lack of a pharmacy procurement function to be escalated via the Executive Risk and Assurance Group (ERAG).

Enhanced Workforce
Recruitment progressing in line with plan. Preparations for commencement of AMD role are underway.

Clinical Effectiveness Benefits

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.

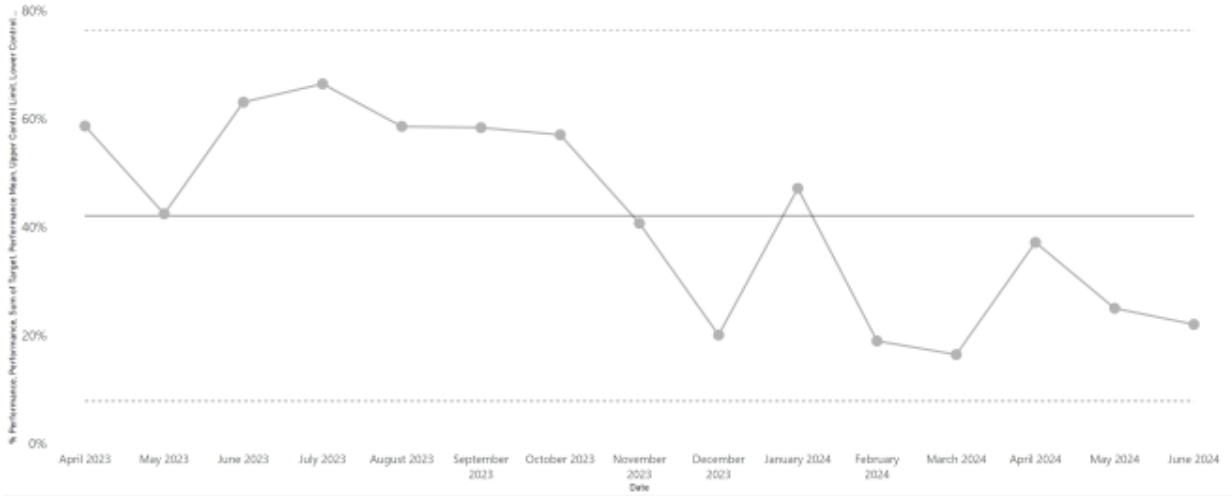
Project Name	Date	Target < or >	Performance	Assurance	Variation
2.1 Enhanced Workforce for Acute Workload	KPIs to be defined.				
2.2 Acute Gynae Services					
EPAU patients seen within 24 hours of referral	June 2024	>=	22.03%		
GED 15 Minutes to Triage	June 2024	>=	42.11%		
GED 4 hours from arrival to admission, transfer or discharge	June 2024	>=	90.35%		
GED Decrease in Time Taken to Treat	June 2024	<=	118		
GED Increased patient satisfaction (Friends & Family Scores)	June 2024	>=	71.23%		
Increased staff satisfaction	KPIs in development – to be available in future reports				
Reduction of risk score 2732					
2.3 LWH Transfusion Lab	KPIs to be defined.				
2.4 Medicines Safety					

Clinical Effectiveness Benefits

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.

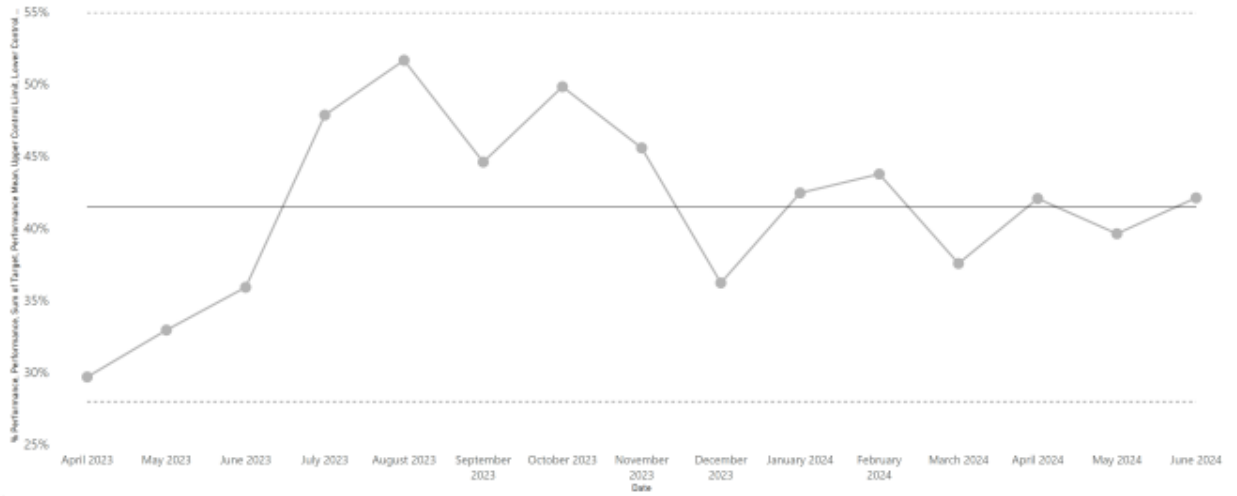
EPAU patients seen within 24 hours of referral -

Target	Target < or >	Performance	Assurance	Variation
	>=	22.03%		



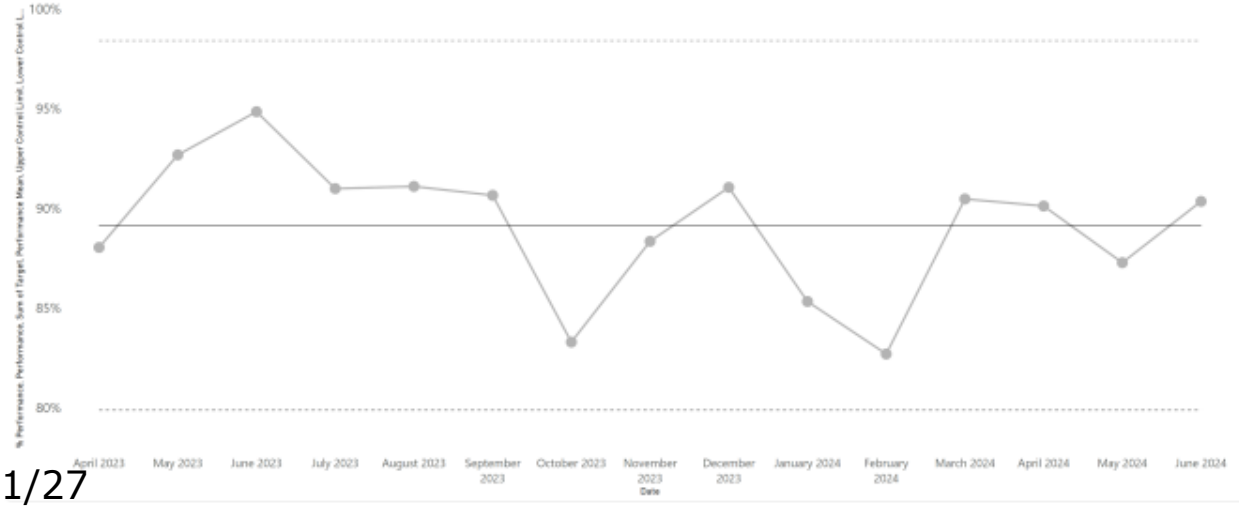
GED 15 Minutes to Triage -

Target	Target < or >	Performance	Assurance	Variation
	>=	42.11%		



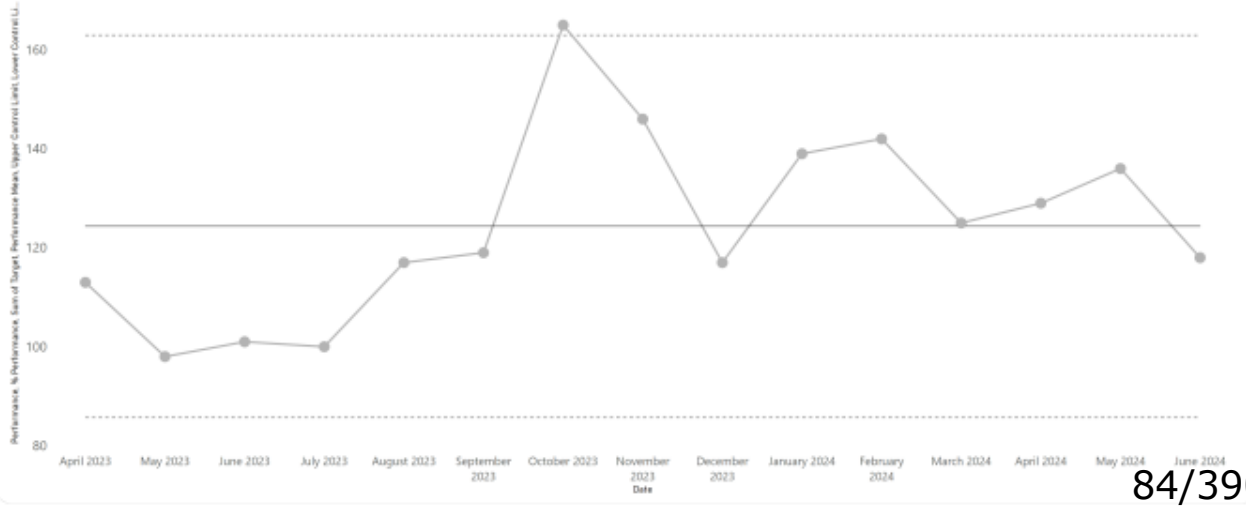
GED 4 hours from arrival to admission, transfer or discharge -

Target	Target < or >	Performance	Assurance	Variation
	>=	90.35%		



GED Decrease in Time Taken to Treat -

Target	Target < or >	Performance	Assurance	Variation
	<=	118		

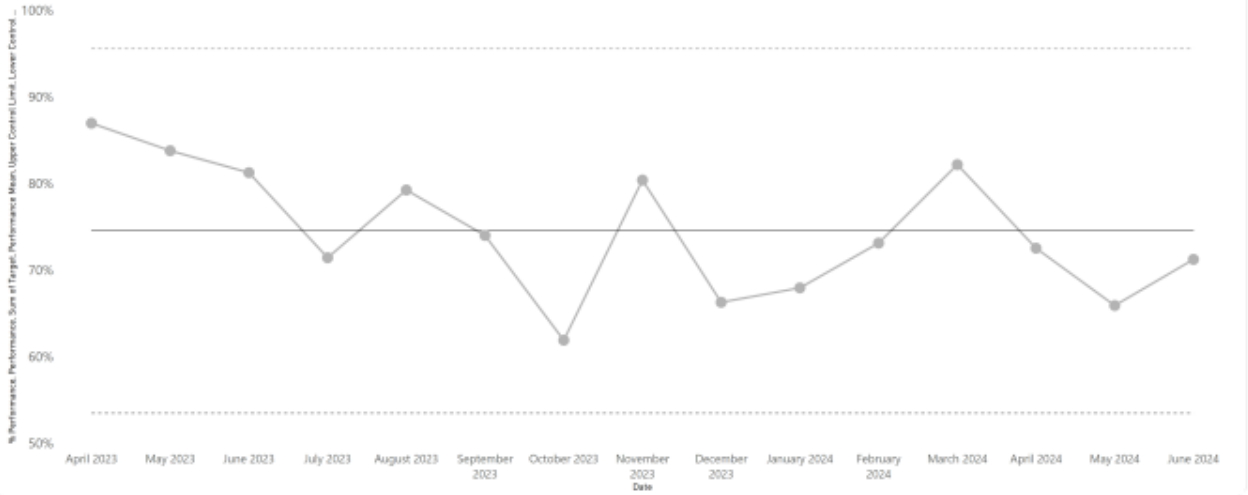


Clinical Effectiveness Benefits

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.

GED Increased patient satisfaction (Friends & Family Scores) -

Target	Target < or >	Performance	Assurance	Variation
	>=	71.23%		



Operational Performance Programme Update

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

Organisation	Overall	Overall DoT	Plan	Plan DoT	Benefits	Benefits DoT	Issues	Issues DoT	Risk	Risk DoT	Resource	Resource DoT	Stake holders	Stake holders DoT
LWH	Y	→	Y	↘	G	→	G	→	Y	↘	G	→	G	→
3. Operational Performance	Y	→	Y	↘	G	↗	G	→	A	→	G	→	G	↗
3.1 Cancer Improvement	Y	→	G	→	A	↑	G	→	R	↘	G	→	G	↑
3.2 Reduced Waiting List	Y	↘	A	↓	G	→	G	→	G	→	G	→	G	→

Key Focus Last Period

Cancer Improvement
In May, the Trust achieved 62.4% compliance with the 28-day faster diagnosis standard and is on track to reach the 70% target by the end of March 2025. A comparative analysis with other Gynaecology Cancer Units nationally indicated competitive performance, while considering LWH is a single tumour site provider that incurs additional pressure. Performance improvement is attributed to changes in the new Endometrial Cancer pathway, which captures around 70% of referrals received, with further tumour type specific pathway analysis and transformation planned for ovarian, cervical, vulval and vaginal referrals. Use of Pre-Op questionnaires in clinics has improved hysteroscopy waits, with 30% of patients being marked as 'fit to list' in clinic, reducing demand on Pre-Op services. The Cancer Digital Plan has introduced an interface between Digicare and Somerset to reduce manual entry workload of coordinators/trackers, improve data quality and increase capacity for pathway management. A new Bariatric bed in Outpatients allows improved patient access and dignity for patients with mobility issues and disabilities. Recent challenges (operational pressures on hysteroscopy due to an external sterilisation issue, staffing capacity issues in Access Centre due to absence) have action plans initiated to mitigate impact to performance.

Reduced Waiting List
Significant progress has been made in reducing the backlog of long-waiting patients, with only 111 individuals now waiting over 65 weeks. This improvement is largely attributed to the implementation of Medinet. We acknowledge that the overall waiting list continues to experience growth. This is primarily driven by an increase in patient referrals and scheduling practices that inadvertently contribute to delays. A robust governance structure has been established for booking and scheduling, outpatient transformation, and theatre utilisation workstreams aligned with the Further Faster guidelines.

Key Focus Next Period

Cancer Improvement
The next month will focus on improving the 62 day and 31 day standard performance position through enabling additional hysteroscopy capacity, pre-op process improvements, surgical fitness streamlining and the evaluation of the new endometrial cancer pathway. Improvements to the cross training and cover of the Access Team will also progress and be added to the plan, to prevent delays through team absence and improve the stability of the cancer service appointment booking.

Reduced Waiting List
To gain a deeper understanding of patient flow and service utilisation, a comprehensive analysis of waiting periods and referral patterns across various services is planned. This analysis will delve into factors that contribute to wait times, including referral practices at the primary care level and scheduling efficiencies within each service department.

Key Points to Note

Cancer Improvement
The Endometrial pathway is currently under evaluation, with initial data showing 30% being discharged without needing a full RAC clinic appointment, and 33% identified as higher risk and directed straight to hysteroscopy, reducing waiting time on the pathway.

Reduced Waiting List
Progress is being monitored through dedicated dashboards that benchmark our performance against model hospital data. Action is being taken to address the factors contributing to the increase in the overall waiting list.

Operational Performance Benefits Summary - Cancer Improvement

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

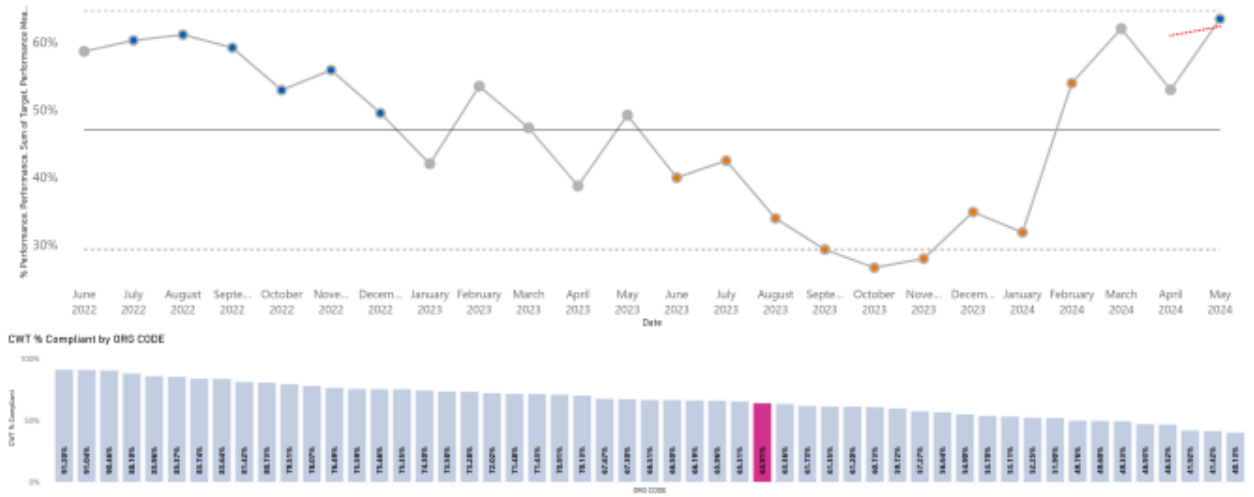
Project Name	Date	Target < or >	Performance	Assurance	Variation
3.1 Cancer Improvement					
% of confirmed cancer cases diagnosed within 28 days	KPI in development – to be available in future reports				
Cancer: 28 Day Faster Diagnosis	May 2024	>=	63.43%		
Cancer: 28 Day Faster Diagnosis (Int)	May 2024	>=	63.43%		
Cancer: 28 Day Faster Diagnosis Benchmarked Percentile	March 2024	>=	35.09%		
Cancer: 28 Day Faster Diagnosis INTERNAL	KPI in development – to be available in future reports				
Cancer: 31 Day decision to treat to treatment	May 2024	>=	93.94%		
Cancer: 31 Day decision to treat to treatment Benchmarked Percentile	March 2024	>=	14.89%		
Cancer: 31 Day decision to treat to treatment INTERNAL	KPI in development – to be available in future reports				
Cancer: 62 Day referral to Treatment	May 2024	>=	35.56%		
Cancer: 62 Day referral to Treatment Benchmarked Percentile	March 2024	>=	11.69%		
Cancer: 62 Day referral to Treatment INTERNAL					
Liverpool 62 day pathway vs external 62 day pathway (referred to LWH and not referred to LWH) with supporting data by Trust.	KPIs in development – to be available in future reports				

Operational Performance Benefits - Cancer

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

Cancer: 28 Day Faster Diagnosis - Chief Operating Officer

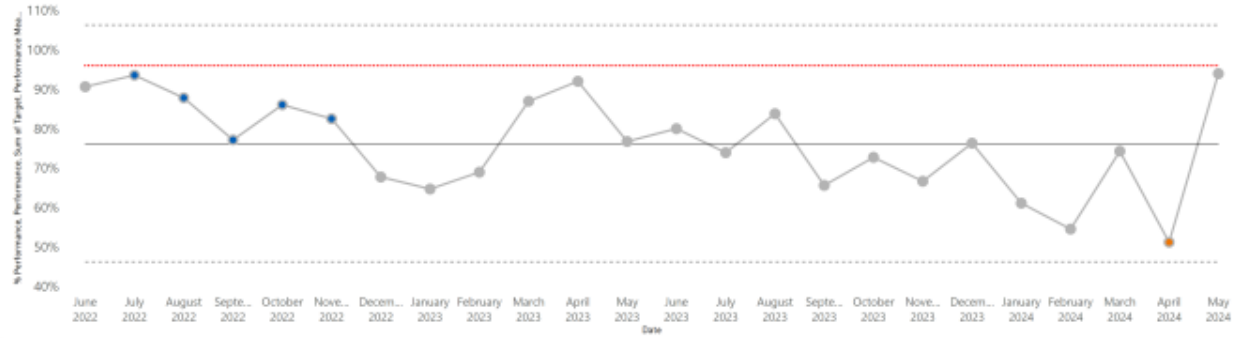
Target	Target < or >	Performance	Assurance	Variation
>= 75%	>=	63.43%	?	H



CWT % Compliant by ORG CODE

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

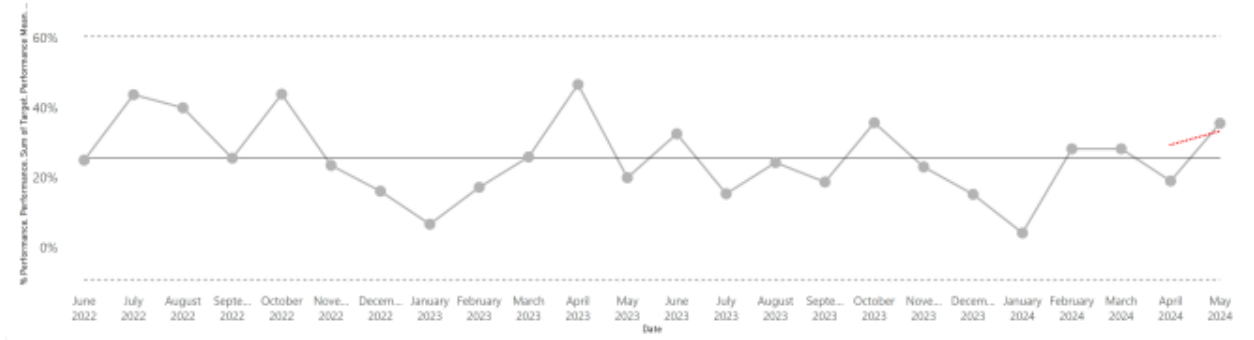
Target	Target < or >	Performance	Assurance	Variation
>=96%	>=	93.94%	F	



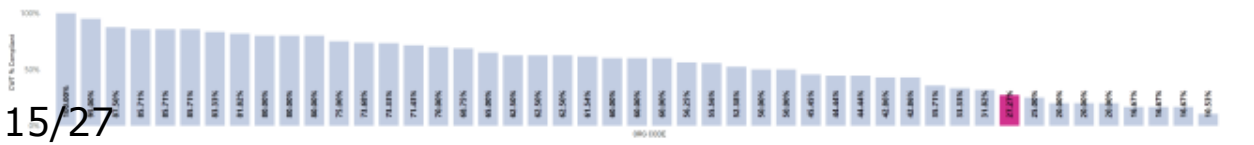
CWT % Compliant by ORG CODE

Cancer: 62 Day referral to Treatment - Chief Operating Officer

Target	Target < or >	Performance	Assurance	Variation
>=85%	>=	35.56%	?	



CWT % Compliant by ORG CODE



Operational Performance Benefits Summary - Reduced Waiting List

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

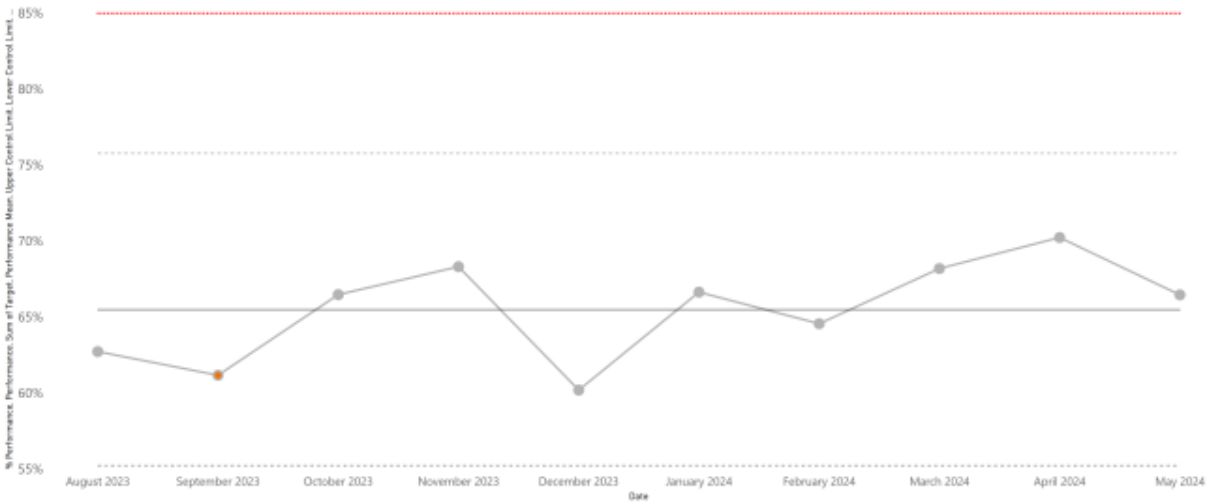
Project Name	Date	Target < or >	Performance	Assurance	Variation
3.2 Reduced Waiting List					
1st Appointment Waiting Times	June 2024	<=	143		H
Capped Theatre Utilisation rate	May 2024	>=	66.45%	F	
Moved or discharged outpatient attendances to PIFU pathways	May 2024	>=	2.84%	P	H
Number overdue follow up appointments	May 2024	<=	8047		
Overall size of active patient waiting list	June 2024	<=	17687	?	
Overall size of the Inpatient Waiting List	June 2024	<=	3268		H
Uncapped Theatre Utilisation rate	May 2024	>=	70.74%	F	

Operational Performance Benefits

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

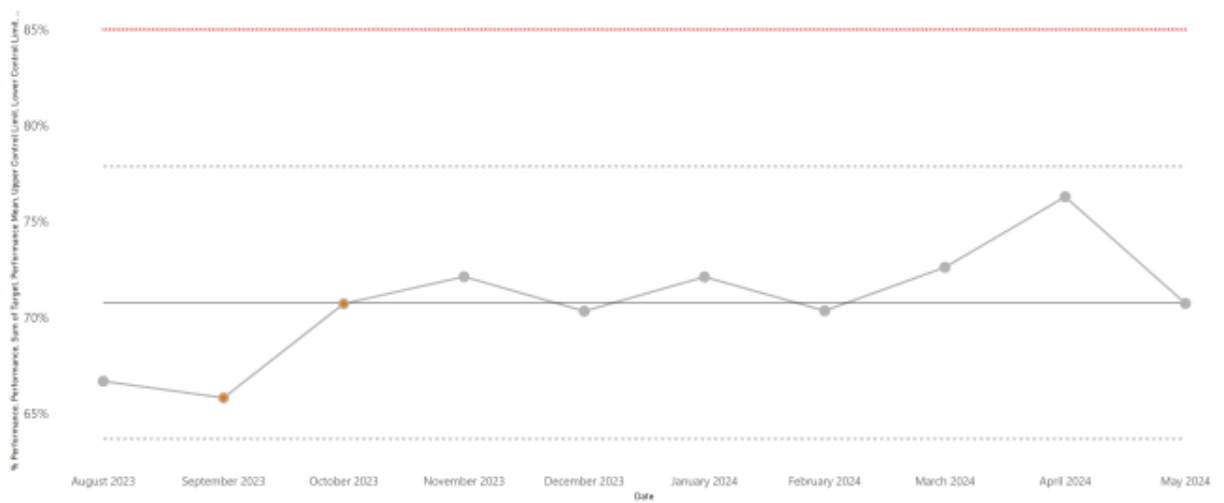
Capped Theatre Utilisation rate - Chief Operating Officer

Target	Target < or >	Performance	Assurance	Variation
>= 85%	>=	66.45%	F	



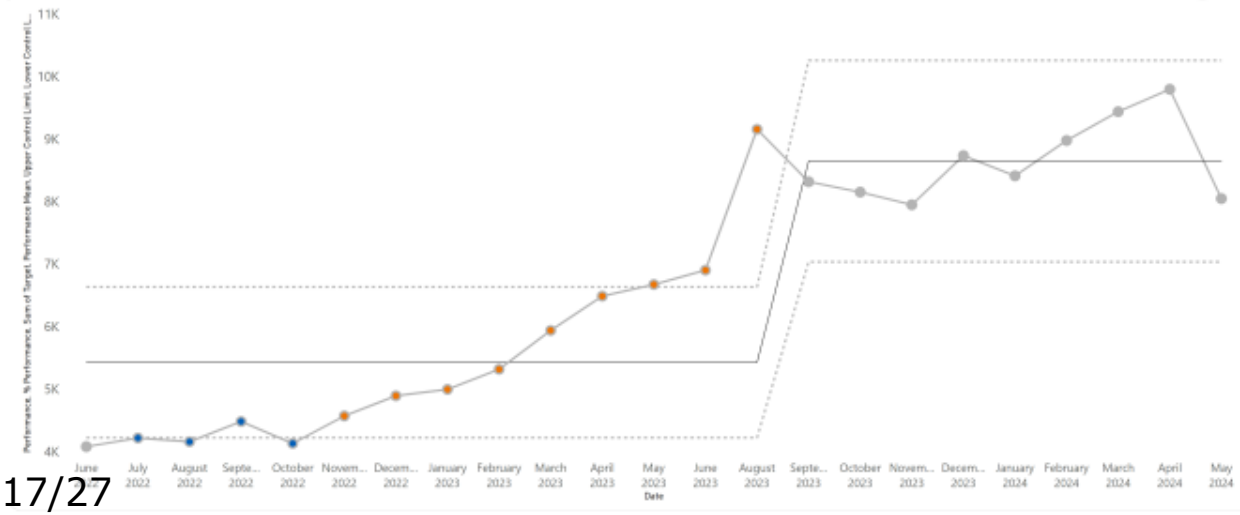
Uncapped Theatre Utilisation rate - Chief Operating Officer

Target	Target < or >	Performance	Assurance	Variation
>= 85%	>=	70.74%	F	



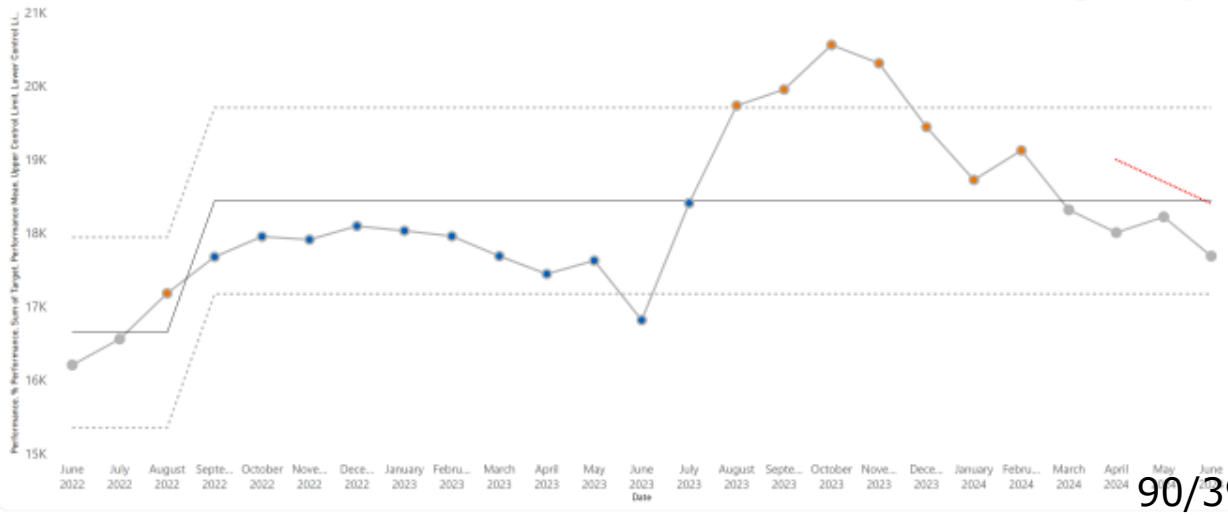
Number overdue follow up appointments - Chief Operating Officer

Target	Target < or >	Performance	Assurance	Variation
	<=	8047		



Overall size of active patient waiting list - Chief Operating Officer

Target	Target < or >	Performance	Assurance	Variation
<= 16500	<=	17687	?	

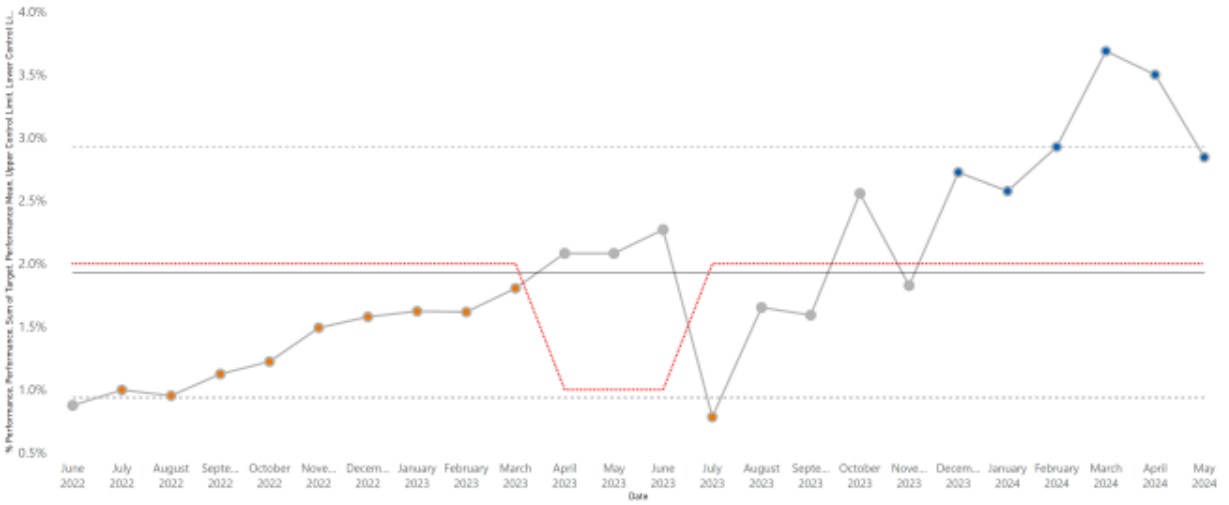


Operational Performance Benefits

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

Moved or discharged outpatient attendances to PIFU pathways - Chief Operating Officer

Target	Target < or >	Performance	Assurance	Variation
>=2%	>=	2.84%	P	H



People & Culture Programme Update

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.

Organisation	Overall	Overall DoT	Plan	Plan DoT	Benefits	Benefits DoT	Issues	Issues DoT	Risk	Risk DoT	Resource	Resource DoT	Stake holders	Stake holders DoT
LWH	Y	→	Y	↘	G	→	G	→	Y	↘	G	→	G	→
4. People and Culture	Y	↘	A	↓	A	→	G	→	A	↘	G	→	Y	↘
4.1 Safety Culture	Y	↘	R	↓	A	→	G	→	A	↓	G	→	G	→
4.2 Actively Anti-Racist Organisation	Y	↘	A	↓	A	→	G	→	A	↘	G	↗	A	↓

Key Focus Last Period

Safety Culture
Meetings with staff and managers on Matbase undertaken to discuss safety culture. Met with Chief Pharmacist regarding controlled drugs aspect of project. Recruitment of Safety Culture leads for digital, nursing/AHP and medical has now been completed.

Anti Racism
Agreement of scope and costings for external contractor to undertake cultural baseline work (focus groups and interviews with staff, patients, community, analysis of existing work and position in relation to racism at LWH). Development of action learning set programme for managers. Attendance at Africa Oye community event, spoke to over 30 members of public about LWH. Development of referral form for staff to escalate concerns about race discrimination. Attendance at community events for Roma and refugee communities. Recruitment of ED&I facilitator.

Key Focus Next Period

Safety Culture
Collection of data on top five repeat causality incidents is underway, to be reviewed to enable definition of improvement measures. A second round of the literature review is underway.

Anti Racism
Development of additional training for staff who require extra support re Anti Racism. Updating of all policies with Anti Racism statements. Development of patient focused SOP re Anti Racism. Referral form to be added onto the intranet and launched.

Key Points to Note

Safety Culture
Recruitment of Safety Leads now complete. Timescales for the Controlled Drugs Project to be provided by Chief Pharmacist to enable accurate reporting of project plan status.

Anti Racism
There is a risk to project progress due to a lack of dedicated resource (Risk ID 2855); this will be partially resolved with the return of the Trust's ED&I Lead.

People & Culture Programme Update

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.

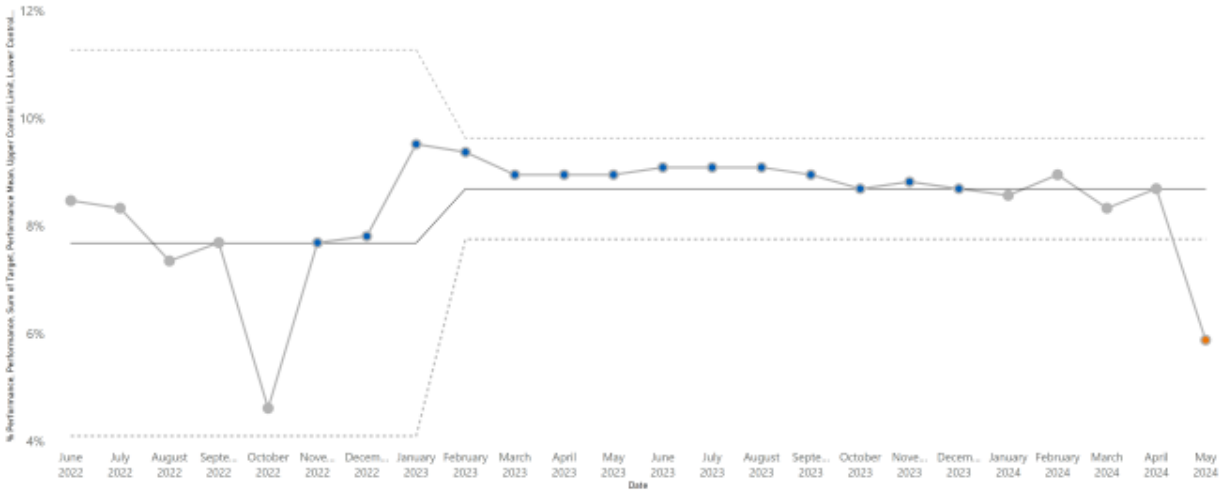
Project Name	Date	Target < or >	Performance	Assurance	Variation
4.1 Safety Culture					
BBAS score for questions indicating a positive safety culture	KPI in development – to be available in future reports				
4.2 Actively Anti-Racist Organisation					
Overall BAME % in workforce	May 2024		12.16%		
Proportion of staff in senior leadership roles BME background	May 2024	>=	5.88%		

People & Culture Benefits

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.

Proportion of staff in senior leadership roles BME background - Chief People Officer

Target	Target < or >	Performance	Assurance	Variation
	>=	5.88%		



Financial Sustainability Programme Update

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

Organisation	Overall	Overall DoT	Plan	Plan DoT	Benefits	Benefits DoT	Issues	Issues DoT	Risk	Risk DoT	Resource	Resource DoT	Stake holders	Stake holders DoT
LWH	Y	→	Y	↘	G	→	G	→	Y	↘	G	→	G	→
5. Financial Sustainability	Y	→	A	↓	G	→	G	→	Y	→	G	→	G	→
5.1 Delivering the Three Year Financial Plan	G	→	Y	↘	G	→	G	→	G	→	G	→	G	→
5.2 2024/25 CIP Delivery	Y	↘	R	↓	G	→	G	→	A	↘	G	→	G	→

Key Focus Last Period

2024/25 CIP Delivery
The last QIA Committee took place on 18th June. All seven PIDs submitted were approved by the committee. The CFO met with Divisional Managers and Department Heads to outline the current status of the programme, discuss distance from target, and reiterate the need for urgent completion of scheme documentation to prevent falling further behind. A post implementation review of CIP schemes from 2023/24 is underway.

Delivering the Three-Year Financial Plan
During the last period a programme of work has been established between LWH, LUHFT, CCC, WC, and LHCH to produce a consolidated financial recovery plan and generate plans to deliver an additional £18.5m of savings in 2024/25, to ensure plans submitted on 12th June are collectively met. CFOs are meeting regularly, and a work programme has been produced, with areas of focus, leads, indicative savings and timescales.

Key Focus Next Period

2024/25 CIP Delivery
Focus this period will remain on the urgent completion of the remainder of Wave 2 PIDs for approval for review at the July QIA Committee, and on identifying plans to meet divisional and departmental CIP target in full, including identifying replacements for any schemes currently on the tracker not deemed feasible. Monthly meetings will be held with Divisions to provide additional scrutiny on the efficiency programme, as well as provide an opportunity for escalation and to make requests for support.

Delivering the Three-Year Financial Plan
Focus this period will be on firming up specific workstreams and modelling savings identified through the Liverpool Financial Plan work.

Key Points to Note

Completion of PIDs for CIP schemes and identification of plans to meet divisional and departmental targets is urgently required in order to deliver the overall 2024/25 CIP target.

Financial Sustainability Programme Update

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

Project Name	Date	Target < or >	Performance	Assurance	Variation
5.1 Delivering the Three Year Financial Plan					
Cash actual vs Distressed finance Forecast					
Delivery of FT responsibility – financial sustainability					
Exit NOF 3					
Improved integration in Liverpool Place (corporate and clinical)					
Improved productivity outcomes					
Reduced system deficit					
Reduced underlying Trust deficit					
5.2 2024/25 CIP Delivery					
CIP Actual vs Plan					
CIP actual recurrent vs planned recurrent					

KPIs in production – to be available in future reports

Well Led Programme Update

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.

Organisation	Overall	Overall DoT	Plan	Plan DoT	Benefits	Benefits DoT	Issues	Issues DoT	Risk	Risk DoT	Resource	Resource DoT	Stake holders	Stake holders DoT
LWH	Y	→	Y	↘	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	→

Key Focus Last Period

Risk Management
All Trust risks were transferred over to the new 5+5+5 scoring mechanism. Benefits have been identified for this project to provide an indication of growing maturity in the Trust's risk management approach.
Streamlined Governance
The meeting structures are now in place and functioning. The communication regarding
the updated structures and templates was distributed on 26 June 2024.
Partnership Governance
The Project Charter was reviewed and approved by the Improvement Plan Portfolio Board on 5th June.

Key Focus Next Period

Risk Management
The Project Charter will now require a review to determine 'phase 2' (embedding and auditing risk scoring) and 'phase 3' (movement to a joint risk management system). A meeting will be established with the Project Lead to update the project charter to move into a quality assurance phase.
Streamlined Governance
The majority of this project is now complete. Outstanding actions relate to seeking feedback on the effectiveness of the new arrangements. This will start with staff feedback and will continue with the Audit Committee and MIAA providing a second and third line of assurance.
Partnership Governance
The Project Charter was agreed at the last Portfolio Board meeting. Milestones have now been created. The report scheduled for the Board on 11 July 2024 will need to be factored into this project.

Key Points to Note

Programme on track – no key points of escalation this period.

Well Led Programme Update

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.

Project Name	Date	Target < or >	Performance	Assurance	Variation
6.2 Streamlined Governance	KPI to be defined				
6.3 Risk Management					
Risk Register - % of risks where the current version is over 6 months old	KPIs in development – to be available in future reports				
Risk Register - % of risks with innefective controls which have no actions in place					
Risk Register - % of risks with no controls in place					
Risk Register - Number of risks with out of date actions or out of date review					
6.4 Partnership Governance	KPI to be defined				

OUR IMPROVEMENT PLAN

SAFETY | QUALITY | SUSTAINABILITY

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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**

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Meeting Date	Thursday, 11 July 2024	**Item Reference**	24/25/084
Report Title	Maternity Incentive Scheme Year 6 – June 2024 Compliance Update		
Author	Angela Winstanley – Quality & Safety Matron Maternity Yana Richens – Director of Midwifery		
Responsible Director	Dianne Brown – Executive Chief Nurse		

Purpose of Report	This paper outlines the progress updates in relation to 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.
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 Quality Committee and Trust Board 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.
Key Areas of Concern	Identified Risk: There are concerns identified with the ability to meet the compliance targets within the medical workforce (Obstetric and Anaesthetic) of attendance at PROMPT and Fetal Surveillance Study Days due to ongoing industrial action (IA). A risk further posed is that of the availability of an MDT within the education faculty and the deliverance of PROMPT training days because of ongoing Industrial action. To mitigate this, staff who had planned to attend the cancelled session have been allocated to other PROMPT days, which in the short term is manageable. However, further cancellations and the potential requirement to deliver 'extra' sessions, in response to further IA, will mean taking the faculty away from clinical rota hours. With the uncertainty of future IA and ability to deliver sessions to an MDT group, with an appropriate MDT faculty, this poses a risk to Year 6 Scheme compliance. This has been escalated to the Educational Governance Committee".
Trust Strategy and System Impact	The report aligns with the Trust's strategy by promoting quality improvement, patient safety, and workforce development. It supports the triple aim by enhancing patient outcomes, improving population health, and ensuring cost-effective, high-quality maternity care, ultimately contributing to overall healthcare excellence.

Links to Board Assurance Framework	*None*	***n/a***
Links to Corporate Risk Register (scoring 10+)	*NA*	***n/a***

Assurance Level	1. SUBSTANTIAL - Good system of internal control applied to meet existing objectives

Action Required by the Committee	The Board is asked to • Note the current position in relation to the recently published Maternity Incentive Scheme Year 6. • Note the identified risk to SA8 in relation to IA and delivery and compliance with PROMPT Training • Take assurance that the Family Health Division has clear oversight and management of the scheme requirements.

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Quality Committee	25.06.24	Director of Midwifery	Noted
Divisional CNST Oversight Committee	Twice Monthly	Director of Midwifery	Weekly 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.

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).

Family Health Division Scheme Management and Leadership

On 02.04.2024, NHSr published scheme guidance relating to Year 6 of the Maternity Incentive Scheme. 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.

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.

ANALYSIS

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

An updated table of MIS year 6 scheme progress can be found below:

- **Table 1 Current Position MIS for Year 6 –June 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 – 44 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 15 cases reported, that are eligible for full PMRT review, all 15 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 – 15 Cases all have had PMRT Reviews commenced.

b) 60% of multi-disciplinary reviews should be completed and published within six months.
4 Cases - 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 – QI Proj / 0107.
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 July 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, in a time frame 6 months post April.	**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.	**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 **four** quality improvement discussions with scrutiny of progress monitored using the national SBLCBV3 Implementation Tool through the NHS Future Portal. On 03.06.2024, the FHD met with the LMNS and received commendation on the continued positive progress with implementation of SBLCV3. An update position table is awaited at this time, but assurance from the LMNS notes there are no anticipated compliance issues. A full compliance table will be provided for the July Trust Board and Quality Committee. Sustained success was seen 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.

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 (MNVP) 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 a co-produced action plan has been developed with the MNVP. This is to be shared with the LMNS on 24th June 2024. Further meeting with HoM, DoM and MNVP has been undertaken on 17.06.2024 and the annual work plan has been agreed.

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.

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

CNST SA8	Staff Group	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Notes
SA 8b. MPMET	Midwives	96%	93%	94%							
	Maternity HCA	82%	80%	92%							
	Cons Obstetrician	87%	74%	50%							
	Trainee Obstetrician	87%	91%	93%							New rotation in August
	Cons Anaesthetist	100%	82%	82%							
	Trainee Anaesthetist	47%	53%	28%							New rotation every 3 months including November
SA 8c. Fetal Surveillance	Midwives	91%	92%	93%							This figure includes all NQM, B6, B7, B8, B9
	Cons Obstetrician	81%	68%	50%							
	Trainee Obstetrician	94%	93%	93%							New rotation in August
SA 8d. NLS	Midwives	96%	93%	94%							Delivered on MPMET/PROMPT Day
	Cons Neonatologist	100%	90%	100%							
	Trainee Neonatologist	100%	100%	100%							New rotation March & September
	ANNPs	93%	97%	97%							
	Neonatal Nurses	93%	93%	100%							

Table 2
Monitoring of attendance at each of the three training days using local held records or ESR

The FH Division need 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. Table 2, outlines the current training compliance with MPMET, Fetal Surveillance Day and New-born Life support.

Identified Risk: There are concerns identified with the ability to meet the compliance targets within the medical workforce (Obstetric and Anaesthetic) attendance at PROMPT and Fetal Surveillance Study Days due to ongoing industrial action(IA) A risk further posed is that of the availability of an MDT within the education faculty and the delivery of PROMPT training days because of ongoing IA. To mitigate this, staff who had planned to attend the cancelled session have been allocated to other PROMPT days, which in the short term is manageable.
However, further cancellations and the potential requirement to deliver 'extra' sessions, in response to further IA, will mean taking the faculty away from clinical rota hours. With the uncertainty of future IA and ability to deliver sessions to an MDT group, with an appropriate MDT faculty, this poses a risk to Year 6 Scheme compliance. This has been escalated to the Educational Governance Committee to the People and Organisational Development Executive Group and is an identified risk of the risk register".

SA.9 Can you demonstrate that there are robust processes in place

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

The FH Division needs to undertake additional actions to achieve this standard.

to provide assurance to the Board on Maternity and neonatal safety and quality issues?	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. **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 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 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 meetings that members of the FHD attend. The Trust meets regularly with our partners in the LMNS and NHSE at a monthly meeting. 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.

	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 HoM and DM, both integral part of the perinatal quadrumvirate team, attend the monthly Safety Champions Meeting, where the BLSC is in attendance.
SA.10 Have you reported 100% of qualifying cases to MNSI and NHS Resolution's Early Notification (EN) scheme?	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; and ii. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.	**The FH Division needs to undertake additional actions to achieve this standard.** There have two cases reported MNSI at the time of this report, both of whom have been informed of NHSr and EN scheme requirements. A update of compliance will be maintained through the scheme year within this update report and full breakdown of MNSI, NHSr and Duty of Candour information will be provided in December 2024.

Equality, Diversity & Inclusion Implications

The Maternity Incentive Scheme and its ten safety actions, aim to reduce variation in the provision of care in NHS Maternity Care. The safety actions are designed to enable Trusts to develop robust assurance processes in relation to clinical care and its delivery. It is designed to have a positive impact on pregnant women and their families. Upon review of the whole Maternity Incentive Scheme, it's clear that the safety actions are designed to be inclusive, span across a wide range of disciplines, staff and service users groups. It mandates Trusts to ensure that there are clear strides being taken to reduce inequalities and therefore improve access to and provision of maternity care.

There do not appear to be any negative impacts on the protected characteristics.

Quality, Financial or Workforce implications

Failure to comply with all 10 safety standards within the scheme, can pose a risk to the deliverance of safe and effective maternity & neonatal care and as such invite increased oversight from external regulators and stakeholders. As outlined in the introduction, failure to comply with all 10 safety actions will lead to a non-re-imbursement of 10% of the Trusts annual contribution to the CNST premium.

RECOMMENDATION

The Board is asked to:

- Note the current position in relation to the recently published Maternity Incentive Scheme Year 6.
- Note the identified risk to SA8 in relation to IA and delivery and compliance with PROMPT Training
- Take assurance that the Family Health Division has clear oversight and management of the scheme requirements.

SUPPORTING DOCUMENTS

- Perinatal Quality Surveillance & Safety dashboard

Perinatal Safety Surveillance Dashboard - Data to April 2024.

The table below, demonstrates key safety KPIS, as recommended by NHS England in the perinatal quality surveillance model (see link document on page 3) to be reported to Trust Board. To achieve standardisation of reporting across the LMNS, the Division have requested further information from our collaborative partners at the LMNS and WHaM, for a standardised set of quality and safety KPIS that should be reported monthly.

A maintained monthly stillbirth rate, at 3.40% in March and April, with a Q4 23/24 stillbirth rate of 1.1% per 1,000, demonstrates a downward trend in our SB rate, with rates now lower than we saw in pre-covid years. This is testament to the hard work of the whole maternity and obstetrics team and demonstrates that as quality improvement programmes in service delivery care continue, i.e. introduction of SBLCBV3, we are seeing demonstrable reduction in stillbirth.

We continue to see a positive trend in the protection of a supernumerary shift leader on the intrapartum area and that we still maintain a level of continuity of carer provision in those women who are deemed socially deprived or are part of an ethnically diverse community.

	Metric	Standard/ National Standard	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
Perinatal	1:1 Care in Labour	100% CNST	100.00%	100.00%	100.00%	100.00%	99.70%
	Stillbirth Number >24 weeks (Adjusted)	Actual Number	3	2	1	0	2
	Stillbirth Adjusted % per 1,000 Birth		5.10%	5.20%	1.72%	3.40%	3.40%
	Apgar <7 @ 5 Minutes (>37wks)	<1.6%	1.30%	1.53%	1.48%	1.32%	1.06%
	Term Admission to NICU	<6%	5.11%	4.66%	4.87%	6.25%	3.90%
	Women in receipt of COC	No standard	18.80%	16.96%	20.92%	19.52%	19.57%
	BAME in receipt of COC	No standard	39.60%	32.22%	43.68%	37.00%	33.70%
	Social Depravation of CoC	No standard	20.62%	18.69%	20.92%	22.06%	24.32%
	Total number of women attended by anaesthetist after request for an epidural within 60 minutes	>=90%			91.20%	91.20%	91.20%
	Coroner Reg 28 Made to Trust	Actual Number	0	0	0	0	0
	MNSI Referals Accepted	Actual Number	1	0	0	1	0
Workforce	MNSI Completed Reports Returned	Actual Number	0	2	1	0	1
	Supernumary Shift Leader	100% CNST	100%	100%	100%	100%	100%
	Midwifery Sickness	% of Workforce <=5%	8.61%	7.91%	7.09%	5.95%	5.42%
	Midwifery Vacancy	% of Workforce	2.20%	0.00%	0%	0%	0%
Feedback	Rostered Cons Hrs on DS	>60	106.5	106.5	106.5	106.5	106.5
	Number of Formal Complaints	Actual Number	1	1	1	1	3
	Number of Maternity Incidents over 30 days	Actual Number	26	26	45	28	43
	Number of PALS/PALS +	Actual Number	43	43	36	29	0

Midwifery Red Flags:	59 red flags were reported during April 2024, a reduction from the 67 reported in March 2024. Of the April 2024, incidents 47 were reported in relation to delays in ongoing induction of labour > 12hours (7 less in comparison to March 24) and 11 delays in commencing the induction of labour process (same number as March 2024). There was one occasion of midwifery red flag, where 1:1 Care in labour was not supported. A review of the care provided was undertaken, where it was ascertained that the patient was cared for in the induction suite and laboured rapidly. There was no harm caused to the patient or to her newborn baby. An updated action plan in relation to 1:1 Care Provision is under development with the Deputy HoM and Quality & Safety Matron. and will be presented at Family Health Divisional Board in July 2024. In order to reduce the amount of delays we are reporting in relation to IOL and complaints received that detail IOL delays as an issue, the Division have undertaken a QI Project and have a dedicated midwifery improvement lead. A number of key interventions have been introduced: including but not limited to, updated IOL Guidance, estates reconfiguration in relation to IOL Suite and Intrapartum Area (freeing up beds on intrapartum area), introduction of alternative methods of IOL for non-hormonal induction, pre-labour aromatherapy and acupressure clinics. A designated IOL clinical unit comprising of 5 single ensuite rooms will open on the 24th of June 2024, which will free up labour and birthing rooms on Delivery Suite, to create capacity for women who require Induction of Labour. Midwifery red flags are reported on the Trust Board Bi-Annual Staffing Reports, of which the TB and QC are expected to receive later in the year.
MNSI Referral Details:	No cases required external reporting to MNSI in April 2024. Five cases are currently being actively investigated by MNSI. All cases are on track and progressing within the timeframes set out by MNSI. The Division received, in draft, one report of which the Trust are now in the process of reviewing for factual accuracy.
Maternity Serious Safety Incidents	There were no PSII declared in April 2024 for the Maternity Division. There are 57 incidents that remain open 30 days after they were reported onto the system, all incidents are in the process of being review, triaged, and investigated further where required. The Division continues to support managerial and lead clinician and staff to ensure timely review and closure of clinical incidents. All incidents are reviewed daily (Monday to Friday) at the Trust daily huddle where any issues for escalation are highlighted. There are currently 2 staff members currently providing focused support for reviewing and investigating the incidents in 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 Stillbirth Perinatal Deaths in March and April 2024: 2 Number of Neonatal Perinatal Deaths in March and April 2024: 0 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. The annual stillbirth rate for 2023/2024 has demonstrated a decrease in the stillbirth rate, now at 1.1%. In comparison with pre-covid rates, of the 2019/2020 of 1.7%. This is a significant improvement and is the lowest stillbirth rate LWH have reported for 6 years.
FHD Risk Register.	All maternity risks are monitored at the Family Health Divisional Board and at the Liverpool Neonatal Partnership) LNP Operational Programme demonstrate mitigation and provide assurance that risks remain on track. Family Health Division have a total of 42 open risks on the Risk Register, with maternity services holding 32 Risks and Neonatal holding 8. All Risk Status have been reviewed are in date, with risk owners using protected time with the Governance managers to monitor and updates r actions and controls where necessary. A new Risk Management process was implemented in the Trust on 1 May 2024 and as a result, all risks have been reviewed, their scores. refreshed in line with the new 5+5+5 matrix and aligned to the current risks sat within the Division.
Family Health Safety Champions.	A Safety Champions walkaround took place on the 7th of May 2024 by the Director of Midwifery (DoM) and Board Level NED Safety Champion. Issues raised included delay in completion of the MLU estates reconfiguration and observational capacity in Mat Base. Staff reported that there were higher than expected numbers of women attending MAU between 18-20 weeks gestation, however data reflects the numbers projected which is an average of 16 per month. The Maternity Base (Postnatal and Antenatal Care wards) is subject to weekly divisional oversight, focusing on improving fundamentals of care on the combined antenatal and postnatal ward. An options appraisal paper for Maternity Base has been drafted which is to be discussed at Family Health Divisional Board, that will review current estates provision. The Divisional Manager and Head of Midwifery attend the monthly safety champions meeting, where updates on the perinatal quadrumvirate programme are provided.

MNVP Feedback.	Meetings held on a fortnightly basis. A 15 steps review was undertaken in Antenatal Clinic with positive feedback and some actions highlighted, which are in the process of being addressed by the ANC Midwifery Manager and Matron. Sarah Farrell Midwife Clinical PhD Fellow was invited to attend the MNVP meeting and present her findings entitled 'Maternity Experiences of M Ethnic Women in Liverpool'. Following the presentation and discussion, it was agreed consideration should be given to combat issues pertainin service users' worries about consequences for them because of their feedback. It was suggested that community midwives would be best suite collate this due to their regular contact with pregnant women. The MNVP are planning to meet with the HoM and DoM to discuss the annual co-production workplan and the CQC Patient Survey SMART Ac Plan a key element of Safety Action 7 in the MIS Year 6 scheme,
Midwifery Sickness	Sickness across the division is on a three-month positive downward trend and stands at 5.42%, this is attributable to the decrease seen across the maternity division with both services (maternity and neonatal) standing at 5.42% in April 2024. It is noted that Family Health are reporting the lowest sickness absence rate in month across the Trust. Weighting for both services is towards long-term absence – it is more balanced in Maternity with 53% towards long-term cases whereas Neonates sees the weighting at 71%. Monthly escalation absence meetings continue across the division and in Maternity, there were 8 absences resolved through return-to-works or final meetings in month with a further 4 returns scheduled in May 2024. Neonates currently has 8 long term cases with nil planned returns. Divisional sickness reviews continue as does the emphasis on completing RTW interviews, please see the adjacent graph for RTW % on a rolling 12-month period. It can be seen from the RTW data that completion is not consistent in either service area and concern is currently in Maternity where compliance is 45% and Neonates at 58%. This requires immediate improvement from local management.
Saving Babies Lives	On 03.06.2024, the FHD met with the LMNS and received commendation on the continued positive progress with implementation of SBLCV3. An update position table is awaited, but assurance from the LMNS notes there are no anticipated compliance issues. A full compliance table will be provided for the July Trust Board and Quality Committee within the MIS Year updated paper.

Trust Board

COVER SHEET

Meeting Date	Thursday, 11 July 2024	**Item Reference**	24/25/085
Report Title	Guardian of Safe Working Hours (Junior Doctors) Quarterly Report – Q4 2023/24		
Author	Kat Pavlidi, Guardian of Safe Working Hours		
Responsible Director	Lynn Greenhalgh, Chief Medical Officer		

Purpose of Report	The 2016 contract requires the Guardian of Safe Working Hours (GoSWH) to report to the Trust Board and Sub Board Committee on a quarterly basis, with the following information; • Aggregated exception reports including outcomes • Details of fines levied • Data on rota gaps • Data on locum usage • Other relevant data • Qualitative narrative highlighting areas of good practice or persistent concern
Executive Summary	The Committee are advised: • Rota establishment continues to fluctuate throughout the year with processes in place to mitigate the use of high-cost agency locums wherever possible by using internal bank, doctors in training and ANNPs, with 216 shifts being put out for cover in all three specialities out of hours. • Nineteen exception reports were submitted relating to difference in hours of work and loss of natural breaks. Two educational exception reports were submitted and one relating to service support available to doctors. This is an increase compared to Q3. • This report does not include data on gaps caused by the ongoing Industrial Action both by the Junior Doctor or Consultant cohorts, as with previous reports since IA started taking place. The Guardian of Safe Working advises the Committee that in her view the hours and templates are safe and compliant in each service and in line with the Junior Doctor contract, however there are still concerns intensified by the continued rota gaps which need covering to ensure patient care is provided, mostly within the O&G service.
Key Areas of Concern	The Guardian of Safe Working advises the Committee that in her view the hours and templates are safe and compliant in each service and in line with the Junior Doctor contract, however there are still concerns intensified by the continued rota gaps which need covering to ensure patient care is provided, mostly within the O&G service.
Trust Strategy and System Impact	*N/A*

Links to Board Assurance Framework	BAF 1 - Workforce	***10***
Links to Corporate Risk Register (scoring 10+)		**-**

Assurance Level	1. MODERATE - Adequate system of internal control applied to meet existing objectives

Action Required by the Committee	The Board is asked to note the report from the Guardian of Safe Working Hours.

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Putting People First Committee	**08.07.24**	**GFSWH**	**Noted**

MAIN REPORT

INTRODUCTION

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

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

This report covers all of the above for the reporting period 1st January – 31st March 2024, and relates to the fourth quarter of the year.

ANALYSIS

1. Guardian Report

1.1. Aggregated exception reports including outcomes

During this quarter, 19 exception reports were made, 14 from O&G doctors and 5 from neonatal doctors.

Period	Specialty	Grade	Reason	#exceptions	No: hours	Outcome

Q4	O&G	Tier 1	Hours	5	9	TOIL Payment
Q4	Neonates	Tier 1	Hours	5	7	TOIL
Q4	O&G	Tier 3	Hours	2	4	TOIL Payment
Q4	O&G	Tier 1	Natural breaks	4	-	No action
Q4	O&G	Tier 3	Education	2	-	Work schedule review
Q4	O&G	Tier 1	Service support	1	-	No action

There have been 4 exception reports submitted for natural breaks in this quarter. Doctors are encouraged to submit ERs when natural breaks are not able to be taken, but this is still underreported across all Tiers. Owing to workload, breaks are not always taken, and some doctors do not manage to take the whole of their breaks either. This is made worse by the inability to give on-call bleeps to a different member of staff to ensure an uninterrupted break.

The Junior Doctor contract stipulates minimum 30 minute breaks for each shift: 1 break in a shift lasting less than 9 hours, 2 breaks in a shift lasting longer than 9 hours, and 3 breaks on a night shift of any length. An inability to take 25% or more breaks over a 4 week reference period should incur a fine, however this depends on doctors submitting ERs. Doctors are continued to be encouraged to take breaks where possible throughout their shift, and to continue to submit exception reports where breaks are unable to be taken.

Details of fines levied
To date, the Guardian has not issued any fines in this quarter.

1.2. Data on rota gaps

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

Each specialty continues to be supported by fixed term clinical fellows, clinical research doctors and other locally employed doctors who are either out of programme or in between training. There continues to be other PGDs commencing their posts throughout the quarter to help fill expected long term gaps and reduce the need for external locum cover.

1.3. Data on locum usage

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

Anaesthetics

Month	Number of unsociable shifts	Number of shift gaps	Dr's in training/bank/ trust Dr cover	Consultant cover	Unfilled
January 24	120	8	8	0	0
February 24	120	9	9	0	0
March 24	120	6	6	0	0

Of the 23 locum shifts in Q4, all shifts were covered by the current PGD cohort undertaking additional shifts, bank doctors, and Trust doctors. During this reporting period, no shifts remained uncovered due to short term sickness. The number of gaps in this reporting period has decreased compared to the previous quarter (39).

Neonates

Month	Number of unsociable shifts	Number of shift gaps	Dr's in training Dr's/ANNPs cover	Consultant cover	Unfilled
January 24	168	1	1	0	0
February 24	168	1	1	0	0
March 24	168	0	0	0	0

Of the 2 locum shifts in Q4, all shifts were covered by the current PGD cohort undertaking additional shifts, ANNPs, bank doctors, and Trust doctors. During this reporting period, no shifts remained uncovered due to short term sickness. The number of gaps in this reporting period has significantly decreased due to all other shifts being covered by swapping shift cover around throughout the service (Q3 gaps numbered 13).

Genetics

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

Obstetrics and Gynaecology

Month	Number of unsociable shifts	Number of shift gaps	Dr's in training/bank/ trust Dr cover	Consultant cover	Unfilled
January 24	252	28	26	0	2
February 24	252	55	46	0	9
March 24	252	44	38	0	6

Of the 191 locum shifts in Q4, shifts were covered by the current PGD cohort undertaking additional shifts, bank doctors, and Trust doctors. This reporting period, 16 shifts remained uncovered; these are usually either weekend ward Tier 1, MAU Tier 1 evening or Tier 2 weekend shifts, which at the time of the shifts were not a formal rota gap. The number of gaps in this reporting period has continued to increase compared to the previous quarter (179).

This quarter has seen an improvement with shifts needing to be covered within the neonatal and anaesthetic service, which has been attributed to an increase in locally employed doctors and better service planning. Rotas within the O&G service are changing from August 2024, both to make certain shifts formal, but with the addition of twilight shifts. The GoSWH will continue to ensure all rotas are safe and in line with the Junior Doctor contract.

2. Other relevant data

The GoSWH has also noted that no ERs were submitted for lack of adequate rest hours in between shifts that occurred during the clock change weekend. The JD contract states that the minimum continuous rest between shifts should be 11 hours and TOIL within 24 hours given to provide the extra time missed. This has been a regular occurrence that the GoSWH has brought up for both clock change shifts, however this has not been agreed upon by any service. The GoSWH continues to encourage submission of ERs for the clock change shifts.

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

All services continue to cover locum shifts within the PGD and ANNP workforce via the Bank system to reduce the need for agency staff. This has been successful in this quarter as with previous months and continues to ensure financial savings for the Trust.

As with previous quarters, the concern around the doctor medical workforce (and particularly within O&G) is the ongoing need for extra shifts to be worked, affecting levels of stress, reduction in time available for training, and therefore leaving shifts empty due to ongoing sickness or long-term gaps. This also has a knock-on effect on other service providers such as consultants,

frequently leading to extra work being done alongside the Junior Doctors, especially during the time of Industrial Action.

4. Conclusion

The Committee are advised:

- the number of gaps in this quarter has decreased within the Anaesthetic and Neonatal services, due to increased staffing and better service planning.
- The Trust continues to appoint locally employed doctors to help reduce the long-term gaps and therefore help with service provision, with a significant number of doctors due to start their jobs within the next few months.
- There are positive changes due to occur within the O&G rotas in the next few months which looks to ensure better doctor cover therefore improving patient safety and allowing for reduced workload amongst all staff.

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

However, the GoSWH notes that the service continues to be at breaking point as noted in previous reports. Although rotas are created to be safe, the number of gaps and shifts needing to be covered at short notice is not safe. There is hope that with an increase in the number of PGDs within the services that this issue will start to resolve.

Equality, Diversity & Inclusion Implications
N/A

Quality, Financial or Workforce implications
The report demonstrates the number of gaps and shifts requiring to be covered at short notice is not safe and continues to create workforce difficulties for the medical workforce and has the potential to impact on quality of care and workforce culture.

RECOMMENDATION

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

SUPPORTING DOCUMENTS

None

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Meeting Date	Thursday, 11 July 2024	**Item Reference**	24/25/086
Report Title	Mortality and Learning from Deaths Report Quarter 4, 2023/24		
Author	Chris Dewhurst, Deputy Chief Medical Officer. Lidia Kwasnicka, Gynaecologist; Ai-Wei Tang, Consultant Obstetrician; Rebecca Kettle, Consultant Neonatologist		
Responsible Director	Lynn Greenhalgh, Chief Medical Officer		

Purpose of Report	As per The Learning from Deaths framework requirements the Board is requested to note: • number of deaths in our care • number of deaths subject to case record review • number of deaths investigated under the Serious Incident framework • number of deaths that were reviewed/investigated and as a result considered due to problems in care • themes and issues identified from review and investigation • actions taken in response, actions planned and an assessment of the impact of actions taken.
Executive Summary	In Quarter 4 there were the following deaths: • Adult Deaths 3 (all expected) • Direct Maternal Deaths 0 • Stillbirths 2 (excluding TOP, rate 1.1/1000births) • Neonatal Deaths (inborn) 3 (0.6/1000 live births) This is the lowest stillbirth rate per quarter in the last 5 years. This is the lowest neonatal mortality rate per quarter for several years.
Key Areas of Concern	No areas of concern to note.
Trust Strategy and System Impact	*N/A*

Links to Board Assurance Framework		-
Links to Corporate Risk Register (scoring 10+)		-

Assurance Level	1. MODERATE - Adequate system of internal control applied to meet existing objectives

Action Required by the Board	The Board is asked to take assurance that there are adequate processes and progress against the requirements laid out by the National Quality Board.

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Quality Committee	**25.06.24**	**CMO**	**Assured**

MAIN REPORT

INTRODUCTION

This 'Mortality and Learning from Deaths' paper presents the mortality data for Q4 2023/24. The learning from review of deaths will be from deaths that occurred in Q4 2023/24 or earlier.

As per The Learning from Deaths framework requirements the Board is requested to note:

- number of deaths in our care
- number of deaths subject to case record review
- number of deaths investigated under the Serious Incident framework
- number of deaths that were reviewed/investigated and as a result considered due to problems in care
- themes and issues identified from review and investigation
- actions taken in response, actions planned and an assessment of the impact of actions taken.

In Quarter 4 there were the following deaths:

Adult Deaths	**3 (all expected)**
Direct Maternal Deaths	**0**
Stillbirths	**2 (excluding TOP, rate 1.1/1000births)**
Neonatal Deaths (inborn)	**3 (0.6/1000 live births)**

This is the lowest stillbirth rate per quarter in the last 5 years.
This is the lowest neonatal mortality rate per quarter for several years.

The annualised stillbirth rate (excluding TOP) is 2.2/1000 births. This is the lowest annual stillbirth rate for the past 5 years.

The annualised neonatal mortality rate for inborn babies who died at LWH is 3.6/1000 live births. This is a reduction form the mortality rate of 6.4/1000 in 2022/23 and the same as in 2021/22.

Learning from a maternal death from Q1 2023/24 is included. The Coroner's investigation has concluded as the death being a natural one due to multi-organ failure of uncertain aetiology. The MNSI report has identified learning for the trust that is included in the appendix.

The PMRT review of stillbirths in Q3 identified three cases with care issues which may have made a different to the outcome. One of these related to mis-interpretation of a CTG and triggered a PSII.

The PMRT review of neonatal deaths identified learning but there were no LWH neonatal care issues identified that may or did impact upon the outcome.

The annualised data for ethnicity and stillbirths/neonatal deaths has shown that there is not an increased risk of stillbirth or neonatal death in the non-white population who book their pregnancies at LWH. Subgroup analysis is not appropriate due to the small numbers involved.

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

The Board is asked to note that the requirements for submission to MIS for the reporting timescales have been met for this quarter.

The Board is also asked to take assurance regarding the ethnicity data around both neonatal deaths and stillbirths that does not show a significant difference between white and non-white populations.

ANALYSIS

This is the Quarter 4 2023/24 mortality report for adults, stillbirths and neonates. The report is part of the regular reporting schedule of the Trust to ensure that there is oversight and assurance monitoring of the mortality rates related to the clinical activity of the Trust. This is in accordance with recommendations by the National Quality Board 'National Guidance on Learning from Deaths' and the Care Quality Commission. It outlines the work taking place operationally and being overseen by the Safety and Effectiveness Sub-Committee and Quality Committee.

The data presented in this report relates to Q4 2023-24. The learning relates to deaths in Q3 2023-24 or earlier. This is due to the multi-disciplinary review of deaths not occurring in the quarter when the death occurred. Additional data/information relating to mortality is presented in the embedded word documents.

1. Adult Mortality

1.1 Obstetric Mortality Data Q4 2023/24

There were **0 maternal deaths in Q4 2023/24**.

1.2 Learning from Maternity Deaths

GO maternal death Q2 2023/24

G was a 29-year-old Black African woman in her third pregnancy who delivered by elective caesarean section at 40 weeks. She was admitted with suspected urosepsis on day 9 of her postnatal period and discharged after 48 hours with oral antibiotic cover. She re-attended on postnatal day 23 significantly unwell. Due to rapid deterioration in her clinical condition she was transferred to the Royal Liverpool University Hospital (RLBUH) for intensive care treatment and sadly died in the following day.

The coroner has now concluded their investigation. After post mortem examination which did not identify any evidence of infection/sepsis, the cause of death has been recorded as:

i. Multiple organ failure of uncertain aetiology

The MNSI report for this death has been received with the following identified as recommendations for LWH.

1. ensure that escalation pathways are consistently used regardless of any changes to service provision.
2. ensure that the care provided is in response to the clinical condition of a mother, and not restricted by her location.
3. ensure that mothers, who are critically unwell, have early escalation and review to support urgent multi-disciplinary care and discussion with intensive care services.
4. ensure (LWH) has the ability to provide high dependency services for enhanced maternal care in line with guidance with regards to environment and staffing resource.

The MNSI report is included as appendix to this paper. An action plan has been developed and will be monitored through the maternity risk meeting and family health divisional board.

1.3 Gynaecology Mortality data Q4 2023/24

There were 3 expected deaths within Gynaecology Oncology in Q4 2023/24.
There was 0 unexpected death within Gynaecology services in Q4 2023/24.

1.4 Learning from Gynaecology Deaths

There were no deaths in Q3 2023/24 for learning to be gained from.

2. Stillbirths

2.1 Stillbirth data

There were two stillbirths, excluding terminations of pregnancy (TOP) in Q4 2023/2024. This has resulted in an adjusted stillbirth rate of 1.1/1000 live births for Q4 23/24, the lowest rate for several years. There were an additional 2 late fetal losses at 22 – 23+6 weeks gestational age.

Quarter	Rate 2019/20	Rate 2020/21	Rate 2021/22	Rate 2022/23	Rate 2022/23
Q1	4.0	5.5	4.0	3.7	1.7
Q4	4.1	2.5	5.3	3.6	2.2
Q4	1.5	2.7	5.1	4.3	3.3
Q4	1.7	3.2	5.0	2.3	1.1
ANNUAL	**2.9**	**3.4**	**4.9**	**3.5**	**2.2**

Table 2: Quarter and Annual Stillbirth rate/1000 births since 2019/20 (excluding terminations). The stillbirth rate for the 23/24 is 2.2/1000 births.

Demographic information for the 4 stillbirths and late fetal losses:

- 1/4 cases was an unbooked pregnancy
- 1/4 women were of non-white ethnicity.
- 2/3 where IMD scores were available lived in the most deprived decile.

The small number of stillbirths in this quarter make any meaningful interpretation of these data impossible.

On reviewing the previous Learning from death reports for 23-24, 9/25 (36%) stillbirths and late fetal losses have occurred in non-white women. The percentage of non-white women booking at LWH is 24% (MSDS data 2023-24). This is not statistically significant (chi-square at 5% level). In other words, there is no increased risk of stillbirth/late fetal loss in the non-white population who book their pregnancies at LWH. Due to the small numbers, it would not be appropriate to analyse subgroups within the non-white population.

2.1 Learning from Stillbirths

All eligible cases from Q3 23/24 (Stillbirths > 22 weeks but excluding ToPs, n=10) underwent a full multi-disciplinary team PMRT review with external clinician presence. Care from across the antenatal and intrapartum period was subject to clinical and managerial scrutiny. All bereaved parents were invited to be involved in the review process by submitting comments and questions via the Honeysuckle Team for discussion at the MDT Review.

The PMRT review grades care in the antenatal, neonatal (for neonatal deaths) and post-bereavement care, assigning a grade for each aspect:

- A. No issues with care identified.
- B. Care issues that would have made no difference to the outcome.
- C. Care issues which may have made a different to the outcome.
- D. Care issues which were likely to have made a difference to the outcome.

The MDT reviews of 7 Stillbirths and 3 late fetal losses (22-24 weeks gestation) found no antenatal care issues identified (Grade A) in 4 cases, and care Graded B in 3 cases. There were 3 cases where care was graded C, one of these cases which related to CTG mis-interpretation is being investigated through a PSII. The other 2 'C' graded cases have contributed to a QI project for induction of labour and a thematic review of electronic GROW charts to be conducted. Detail of the learning is included in the appendix report.

3. Neonatal Mortality

3.1 Neonatal mortality Data Q4 2022/23

Neonatal deaths can be reported in several ways. The population can include in-born babies only (includes in-utero transfers) LWH booked pregnancies or all babies cared for in LWH (including babies transferred to LWH from other care providers). Deaths may be those within 28 days (reported in MBRRACE) those occurring prior to discharge from the NICU and those who die following transfer to another hospital. The population can be further refined by weight and/or gestational age. The data may include or exclude babies with congenital anomalies (MBRRACE).

The table below presents the total number of deaths at LWH, the mortality for babies born at LWH, the number of deaths eligible to report to MBRRACE and the number of deaths of inborn babies born at between 24 to 31+6 weeks gestational age. This last group is reported nationally by the National Neonatal Audit Project and monitored locally by the ODN. The benchmark of 6.3% is locally derived by the ODN. The threshold was the overall mortality in the UK between 2015 – 2018 for the population of 24 – 31+6 week babies. As LWH receives IUTs of (higher risk) preterm mortality it is unlikely that our mortality would be below the average for the whole population. In addition, as this is an absolute measure, it would be expected that 50% of neonatal units would be above this figure. As can be seen in the chart, 1 death in the last quarter has resulted in being higher than the population measure.

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	March-24	Total
Births	613	599	554	629	612	587	619	594	591	573	583	586	7140
INBORN Neonatal Mortality (all live births)	2	1	9*	3*	4	1	6*	6*	3	0	1	2*	38
Total mortality on NICU	3	1	6	3	4	1	6	5	2	1	1	2	35
INBORN + DIED LWH Neonatal mortality	2	1	6	2	4	1	4	4	1	0	1	0	26
IUT Mortality	0	0	5*	0	4	0	2	3	1	0	1	0	16
PNT Mortality	1	0	0	1	0	0	2	1	1	2	0	3	11
INBORN (+died LWH) Neonatal Mortality Rate/1000LB	3.2	1.7	10.8	4.8	6.5	1.7	6.5	6.7	1.7	0	1.7	0	3.6
MBRRACE eligible deaths *Excl. congenital anomaly*	*0* *0*	*1* *1*	*3* *2*	*1* *0*	*4* *2*	*1* *1*	*6* *4*	*3* *2*	*1* *0*	*0* *0*	*1* *1*	*1* *0*	*22* *13*
Benchmark: MBRRACE data 2021 ***3.36/1000LBs*** ***(excl. congenital anomaly)*** ***1.44/1000LBs***	*0* *0*	*1.7* *1.7*	*5.4* *3.6*	*1.6* *0*	*6.5* *3.3*	*1.7* *1.7*	*9.7* *6.5*	*5.1* *3.4*	*1.7* *0*	*0* *0*	*1.7* *1.7*	*1.7* *0*	*3.1* *1.8*
NWNODN benchmark INBORN 24-31 w	*0*	*1*	*2*	*0*	*3*	*1*	*3*	*3*	*1*	*0*	*1*	*0*	*15*
Benchmark (NNAP >6.3% of admissions)	*0*	*8.3*	*14.2*	*0*	*25*	*10*	*37.5*	*23*	*10*	*0*	*14*	*0*	*11.6%*
NWNODN benchmark INBORN 24-27 w	*0*	*1*	*1*	*0*	*1*	*1*	*3*	*2*	*1*	*0*	*1*	*0*	*11*
Benchmark (NNAP >15% of admissions)	*0*	*20*	*50*	*0*	*25*	*25*	*60*	*50*	*33.3*	*0*	*33.3*	*0*	*19%*

**Includes babies inborn at LWH then transferred to another hospital who died in the neonatal period prior discharge*

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

Quarter	NMR *in born*
Q1 (23_24)	5.1
Q2 (23_24)	3.8
Q3 (23_24)	5.0
Q4 (23_24)	0.6
Total	**3.6/1000**

Table 5: Neonatal Mortality Rate per quarter (born and died at LWH)

There were 3 babies who were born at LWH who died in this quarter. This results in the lowest mortality figure recorded at LWH since current recording methods began. (0.6/1000 live births). One of these deaths was following an in-utero transfer (IUT). A further 5 babies were transferred to LWH and died either at LWH or elsewhere following transfer.

There was 1 baby who died after being born at 24 – 31+6 weeks gestational age.

Demographic data (n = 8 babies cared for at LWH)

- 2/8 (25%) babies were born to mothers of non-white background

For the year 2023-24, 10/46 (22%) neonatal deaths (where data was available) were born to non-white women. This is not statistically significantly different from the booking population. Comparison to the neonatal unit admission population will be presented in the annual report, but this is unlikely to be significantly different to the booking population.

3.3. Learning from neonatal mortality reviews for neonatal deaths from Q4 23/24

There were 15 deaths in Q3 23/24 subject to a PMRT review. There was no cases in which neonatal care issues at LWH identified were graded C or D. There were 4 antenatal issues and 6 neonatal care issues identified that didn't make a difference to the outcome with associated learning included in the appendix.

The majority of cases there were no issues identified in either antenatal or postnatal care.

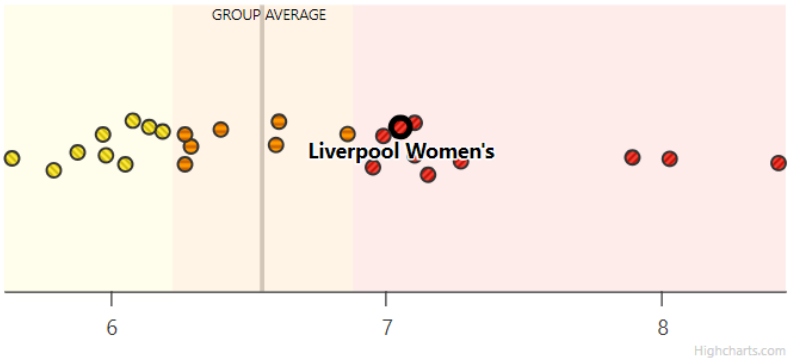
There were several examples of parental feedback received about the high quality of care they received with examples included in the attached appendix.

4. MBRRACE data 2022

The data from 2022 MBRRACE report were published in Q4 23-24. These data show that the extended perinatal mortality (stillbirths and neonatal mortality within 28 days) at LWH is >5% higher than comparator trusts. However, this is explained by the high incidence of lethal congenital anomalies delivered at LWH due to the services provided at both LWH and Alder hey Children's Hospital; 60% of neonatal deaths were in babies with congenital anomalies.

Mortality rates, Level 3 NICU & neonatal surgery, 2022

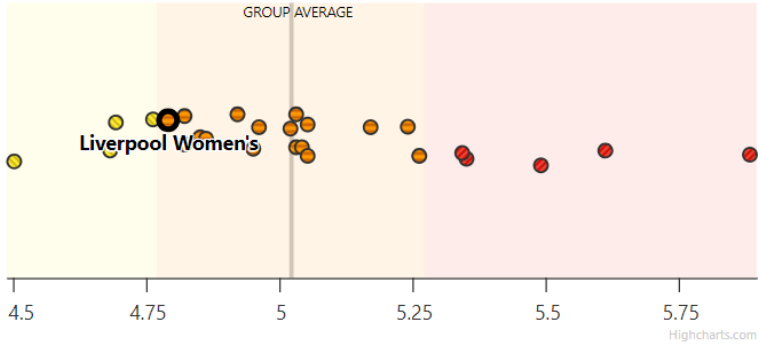
Stabilised & adjusted extended perinatal mortality rate per 1,000 total births



Once congenital anomalies are removed, LWH has a lower than average mortality for extended perinatal mortality and the neonatal mortality is between 5 and 15% lower than comparator trusts.

Mortality rates excluding congenital anomalies, Level 3 NICU & neonatal surgery, 2022

Stabilised & adjusted extended perinatal mortality rate per 1,000 total births excluding congenital anomalies



A separate paper has been submitted to Quality Committee on the MBRRACE data.

5. Recommendations

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

As per the Learning from Deaths framework requirements, the Board is requested to note:

- number of deaths in our care
- number of deaths subject to case record review
- number of deaths investigated under the Serious Incident framework
- number of deaths that were reviewed/investigated and as a result considered due to problems in care
- themes and issues identified from review and investigation
- actions taken in response, actions planned and an assessment of the impact of actions taken.

The Board is also asked to take assurance regarding the ethnicity data around both neonatal deaths and stillbirths that does not show a significant difference between white and non-white populations.

6. Appendices


Q4 SB report 2023-24.docx


Q4 23_24_1 (1).docx

NHS
North West Coast
Clinical Networks

Cheshire and Mersey Maternity Provider Standardised Quarterly Perinatal Board Report Template

(includes Perinatal Mortality Review Tool summary – see Appendix)

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

Contents

PROVIDER:	**LWH**
COMPLETED BY:	**DR REBECCA KETTLE**
DATE COMPLETED:	**16TH MAY 2024**

NHS
North West Coast
Clinical Networks

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

- Quarter 4 neonatal mortality rate is 0.6 /1000 LB for inborn births
- There were 0 cases in which neonatal care issues at LWH identified were considered may have made a difference to the outcome (grade C) or where care issues were likely to have made a difference to the outcome (grade D)
- LWH preterm mortality is above the NWNODN benchmarking flags for the year to date – there is ongoing work to further understand this
- 2 highest causes of death are this quarter are congenital anomalies (4) and respiratory complications of extreme prematurity (2)

NHS
North West Coast
Clinical Networks

2. DASHBOARD AND BENCHMARKING

Table. 1 Neonatal mortality dashboard with benchmarking data

	Apr-23	*May-23*	*Jun-23*	*Jul-23*	*Aug-23*	*Sep-23*	*Oct-23*	*Nov-23*	*Dec-23*	*Jan-24*	*Feb-24*	*March-24*	*Total*
Births	613	599	554	629	612	587	619	594	591	573	583	586	7140
INBORN Neonatal Mortality (all live births)	2	1	9*	3*	4	1	6*	6*	3	0	1	2*	38
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MBRRACE eligible deaths *Excl. congenital anomaly*	*0* *0*	*1* *1*	*3* *2*	*1* *0*	*4* *2*	*1* *1*	*6* *4*	*3* *2*	*1* *0*	*0* *0*	*1* *1*	*1* *0*	*22* *13*
Benchmark: MBRRACE data 2021 ***3.36/1000LBs*** ***(excl. congenital anomaly) 1.44/1000LBs***	*0* *0*	*1.7* *1.7*	*5.4* *3.6*	*1.6* *0*	*6.5* *3.3*	*1.7* *1.7*	*9.7* *6.5*	*5.1* *3.4*	*1.7* *0*	*0* *0*	*1.7* *1.7*	*1.7* *0*	*3.1* *1.8*
NWNODN benchmark INBORN 24-31 w	*0*	*1*	*2*	*0*	*3*	*1*	*3*	*3*	*1*	*0*	*1*	*0*	*15*
Benchmark (NNAP >6.3% of admissions)	*0*	*5.3*	*14.2*	*0*	*25*	*10*	*37.5*	*23*	*10*	*0*	*14*	*0*	*11.6%*
NWNODN benchmark INBORN 24-27 w	*0*	*1*	*1*	*0*	*1*	*1*	*3*	*2*	*1*	*0*	*1*	*0*	*11*
Benchmark (NNAP >15% of admissions)	*0*	*20*	*50*	*0*	*25*	*25*	*60*	*50*	*33.3*	*0*	*33.3*	*0*	*19%*

**Includes babies inborn at LWH then transferred to another hospital who died in the neonatal period prior discharge*

Table 2: Neonatal Death Rate per quarter

Quarter	NMR *in born*
Q1 (23_24)	5.1
Q2 (23_24)	3.8
Q3 (23_24)	5.0
Q4 (23_24)	0.6

Table 3: Neonatal Mortality by MCCD A. cause Q3 23_24 (all deaths)

Reported cause of death (based on CESDI 2018)	No.	IUT / PNT	Other information
Prematurity	1	1 PNT	
Respiratory	2	1 IUT 1PNT	Both respiratory complications of extreme prematurity
Congenital anomaly	4	2 PNT	2 Complex congenital heart disease 2 Congenital neuromuscular disorders
Neurological	1	1 PNT	Severe HIE
Infection			
Abdominal			
Other			

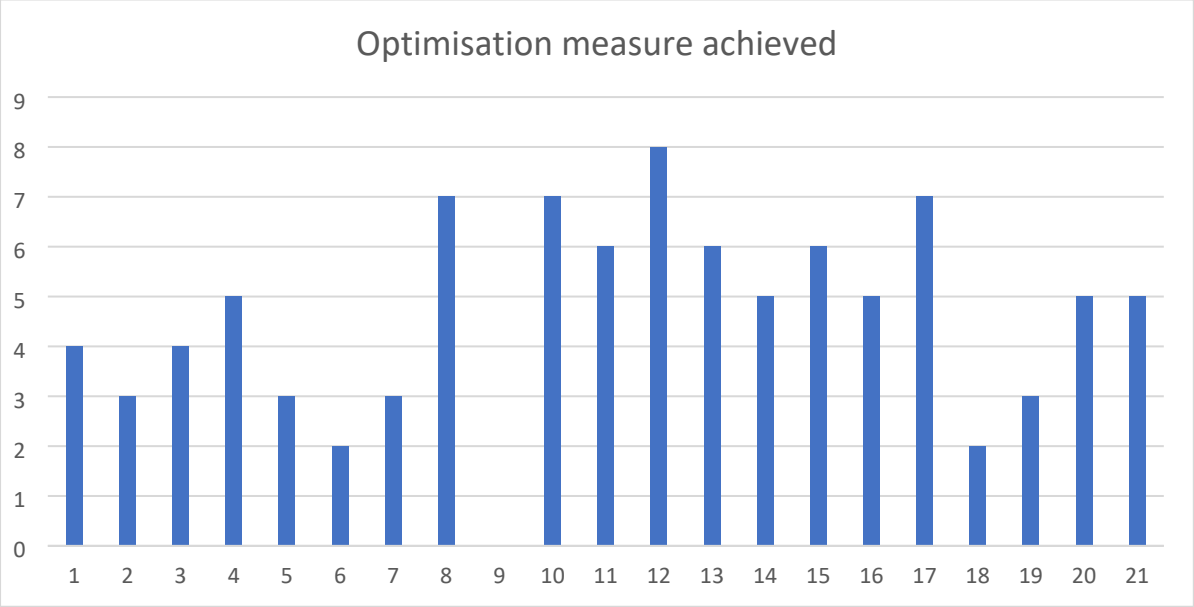
Coroners Cases 23_24:

Month	Case	Updates
June	AR	Referred to coroner, raised as SUDI PM found bacterial meningitis closed by coroner as natural causes
August	EM	Hydrops fetalis, cervical dislocation – PM has been shared with the trust and a PSII has been initiated. Coroners inquest – date TBC
October	KH	SUDI declared by coroner; Police and social aspects stepped down PM report returned. Coroners case closed as natural causes.

Preterm optimisation data:

In 23_24 there have been 24 inborn babies <32 weeks eligible for optimisation measures, 1 with missing data, 3 data pending. 9 optimisation interventions include:

- Birth in appropriate setting
- Maternal Steroids (24 hours – 7 days prior to birth)
- Maternal magnesium sulphate
- Maternal IV antibiotics
- Delayed cord clamping (>1 minute)
- Admission temperature (36.5-37.5^{0}C)
- Time to maternal breast milk (within 24 hours)
- Caffeine in first 24 hours
- *Use of volume guarantee ventilation (if appropriate) * recent addition*



3. MORTALITY REVIEWS AND KEY THEMES

Table 4.1. PMRT review panel grading of care provided in cases of Neonatal Death Q3 (23_24)

PMRT grading	Care provided to the mother up to the point that the baby was confirmed as having died	Care provided to the baby up to the point that the baby was confirmed as having died	Care provided to the mother following confirmation of the death of her baby
PMRT grade A	9	8	12
PMRT grade B	4	6	1
PMRT grade C	0	1	2
PMRT grade D	2*	0	0
Total cases	15	15	15

*relates to care provided at another hospital.

Alder Hey Mortality after transfer of care from NICU

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

- In quarter 3 23_24 there were 2 deaths at Alder Hey following transfer from LWH. On review of the neonatal care prior to transfer there were no issues identified in 1 case and in the other there were issues identified which would not have made a difference to the outcome.
- The outcomes of these reviews have been shared with Alder Hey as part of their mortality review.

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

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

Review panel grading	Antenatal / Intrapartum Neonatal Bereavement	Reason for grading	Level of investigation (PSII / PMRT with external / HSIB)	HSIB (yes/ no)	Learning	Actions / QI plan aligned to theme
B	Antenatal / Intrapartum	Missed opportunity for neonatal counselling	PMRT with external	No	Agree process when neonatal counselling cannot occur at time of FMU review	K2 documentation guide shared with Neonatal team to inform on documentation
B	Antenatal / Intrapartum	Timing of delivery (complex cardiac delivered in middle of night) panel commented could have considered CTG to reassure to allow delivery in morning	PMRT with external	No	Need to liaise with neonatal team prior to any delivery of congenital anomalies out of hours.	Discussion at Obstetric Consultant meeting- now included as part of the midnight MDT huddle
B	Antenatal / Intrapartum	MgSO4 overdose	PMRT with external	No	Given overdose of MgSO4 at initial presentation of threatened PTL	Discussed with clinician involved, and ensure all staff compliant with mandatory training for completion of medicine management module
C	Neonatal	Expired lipid ran for 10 hours K+ infusion incident at LWH –PSII	PMRT with external PSII	No	 Awaiting PSII report	WYNTK Board Awaiting PSII report
B	Neonatal	Delay in giving admission drugs as incorrect	PMRT with external	No		Ongoing training and sharing of processes

		number assigned to baby by delivery suite			Individual feedback by IT midwives
		Kink in line impacting adrenaline infusion			Brilliant basics focus with nursing staff
		Lipid dosing not following guidance (reduced levels for raised TRG then increased not per policy)			Medicines management review and practitioner reflection
		skin injury			Review 26 week pathway regarding medical devices. Neonatal skin injury group will be addressing all skin injuries.
		Delay in blood transfusion as name change on after re-patriation from AH			Blood transfusion practice reminder to practitionners.
B	Neonatal	Unplanned extubation	PMRT with external	No	QI reminders via LOTW
		Skin injuries - MASD			Neonatal skin injury group will be addressing all skin injuries.
		No harm drug frequency error			Nursing staff reminded for the need for vigilance when checking charts and administering medications
		Morphine prescribing error – no harm			Practionner reflection and repeat competency assessment

B	Neonatal	Blood removed from fridge but not scanned out	PMRT with external	No	Comms email to nursing staff and Lesson of the Week compiled regarding correct procedure for removing blood products from the Blood Fridge
		2 no harm drug errors			Learning - Two nurses to check drug timetable. If room is busy, escalate to Shift Leader.
		Episode of hypothermia on NICU			Thermoregulation QI focusing on post-admission period
C	Bereavement	Baby taken by funeral director without their knowledge.	PMRT with external	No	Honeysuckle process updated to ensure parents consent given prior to moving a baby.
B	Bereavement	No genetics blood samples taken.	PMRT with external	No	SOP to be developed for obtaining postnatal genetics samples, to include alternative options if cord blood sample is unobtainable.
B	Bereavement	Nursing bereavement checklist not completed until 24 hrs after death.	PMRT with external	No	Bereavement process reminders to the team

a. PMRT PANEL ATTENDANCE

4 MDT Neonatal PMRT panels held for Q3 babies, unfortunately 1 panel had no external representative, these cases will presented in more detail to the NWNODN Clinical Effectiveness Group for further discussion and consideration of the grading. The other panels ll had external representatives present as detailed in the table below.

Panel meeting	External Neonatologist	External Obstetrician	External Midwife
January	✓	✓	
January			
February	✓	✓	✓
March	✓	✓	✓

4. PMRT / CNST compliance

Livebirth PMRT cases on record (not TOP) – LWH reporting hospital	17
Livebirth PMRT cases – LWH responsible hospital	12
Livebirth PMRT cases – eligible for CNST standards	11
Livebirth PMRT cases – within CNST standards	6
- Days to report (<7days)	100%
- Parents informed	3/6
- Parents input sought	3/6
- Factual questions completed	100% 5/6 78% 1/6
- Review started (standard met)	5/6
- Report published (standard met)	1/6

**Timelines remain active in 5/6 cases and there have been no missed targets to date*

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

There was 1 term neonatal death in LWH of a post-natal transfer with severe hypoxic ischaemic encephalopathy.

6. SAFEGUARDING/UNBOOKED AND LATE BOOKERS

None of the babies who died were born to families with known to have safeguarding concern. There were no late bookers.

7. SOCIO-DEMOGRAPHICAL

3 babies were extremely premature (<28 weeks), 1 inborn 2 post-natal transfers.

No babies died within the first 7 days of life, 6 died in the neonatal period (7-28days) and 2 in the post-neonatal period (>28 days of life).

Ethnicity data available shows 5 babies were born to mothers of white british origin, 2 mothers were of black African origin and 1 recorded as white-other.

Of the 8 deaths in Q4 IMD data was available for 5 based on home postcode at booking, those 5 were spread as follows from the lowest decile upwards 1,2,3,4 and 7.

8. LANGUAGE BARRIERS

1 family did not speak English as first language and were offered video language line but after they declined interpretation and wished to continue conversations in English without interpretation.

9. FETAL ABNORMALITIES DEATHS (known and unknown)

4 deaths were associated congenital anomalies including 2 complex congenital heart disease, both babies were transferred to AHCH under cardiology but died within 28 days of life. There were 2 post-natal transfers of babies who were subsequently diagnosed with congenital neuromuscular disorders.

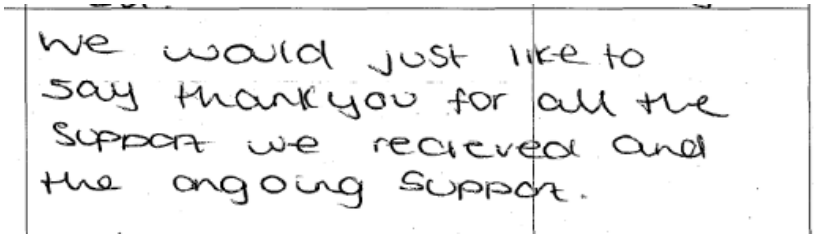
10. LEARNING / GOOD PRACTICE

I would like to thank all staff for their help and support during and after samira's death expecially how who helpped me have memories all mums have with their babies. washing, changing and dressing samira ment so much to me.

- *we want to ensure that we are very grateful of the care that [redacted] received and of the effort of every single member of the MDT in providing high standard care*
- We would like to express our gratitude to all the staff at both [redacted] hospitals, for the care, consideration and support we were shown throughout the process. Nurses who we feel deserve a special mention for their exemplary care and support are [redacted] and we pass our endless thanks to the team for the work that you do.

we appreciated how much we were included in Lucas's care during the pregnancy. Being booked in for regular scans put us at ease making sure the baby was okay. The nurses and doctors in the fetal medicine unit were really supportive and you could

The support we recieved after the passing of our baby boy Luca was fantastic. Before we left the hospital, we were informed we can recieve bereavement counselling from the


We would just like to
say thankyou for all the
support we received and
the ongoing support.

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Cheshire and Mersey Maternity Provider Standardised Quarterly Perinatal Board Report – *Q4 (Jan – March 2024)*

REPORT ON DEATHS IN CURRENT QUARTER AND REVIEWS OF DEATHS IN QUARTER BEFORE

Contents

PROVIDER:	**LIVERPOOL WOMEN'S HOSPITAL**
COMPLETED BY:	**AI-WEI TANG**
DATE COMPLETED:	**MAY 2024**

1. EXECUTIVE SUMMARY:

a. There were 2 stillbirths, excluding terminations of pregnancy (TOP), in the 4th Quartile (January – March 2024) of 2023/2024. This results to an adjusted stillbirth rate of 1.1/1000 for this Quartile.

b. In this quartile, there were 2 pregnancy loss (excluding TOP) born between 22-24 weeks gestation.

c. All stillbirths and late fetal loss (22-24 weeks) in Q3 of 2023/24 (N=10) have been subject to a full multidisciplinary review panel meeting utilising the PMRT tool with external clinician presence.

d. All bereaved parents were invited to be involved in the review process by submitting comments and questions via the Honeysuckle Team for discussion at the MDT Review. 6 of 10 families in Q3 submitted questions and comments which were discussed by the MDT panel.

e. The MDT reviews of 7 Stillbirths and 3 late fetal losses (22-24 weeks gestation) in Q3 have found no antenatal care issues identified (Grade A) in 4 cases, and care Graded B (*care issues identified which would have made no difference to the outcome of the baby)* in 3 cases, in accordance with the MBBRACE Grading system. There were 3 cases where care was graded C (*care issues identified which may have made a difference to the outcome of the baby)* one of which is in progress through a PSI investigation. Learning and action from the other 2 cases is detailed in Table 5 and in the report, and include a QI project on induction of labour and a thematic review on the utility of GROW charts in the community.

f. In the reviews of postnatal care provided, all women received good bereavement support, but care issues were identified in the clinical care provided, where care were Graded B in 8 of the cases. Details of the care issues identified are explained in Table 5. There was one case where care was Grade C, and have identified a need to develop clear communication pathways with primary care and other professional care providers to inform and share information of adverse outcomes.

g. There were no Grade D (*care issues identified which were likely to have made a difference to the outcome of the pregnancy*) in all the reviews of Q3 cases.

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2. DASHBOARD AND BENCHMARKING

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

STILLBIRTHS	Apr-23	May -23	June - 23	July - 23	Aug - 23	Sept – 23	Oct - 23	Nov - 23	Dec – 23	Jan - 24	Feb - 24	Mar - 24	TOTAL 2023/24
Total Stillbirths	5	5	10	5	3	3	4	3	4	3	1	2	48
Stillbirths (excluding TOP)	**0**	**2**	**1**	**3**	**1**	**0**	**2**	**3**	**2**	**1**	**1**	**0**	**16**
Births	613	599	554	629	612	587	619	594	591	573	583	586	7140
Overall Rate /1000	8.2	6.7	18.1	7.9	4.9	5.1	6.4	5.1	5.1	5.2	1.7	3.4	6.7
Rate (excluding TOP)/1000	**0**	**3.3**	**1.8**	**4.8**	**1.6**	**0**	**3.2**	**5.1**	**1.7**	**1.7**	**1.7**	**0**	**2.2**
Late Fetal Loss 22-24 weeks (excluding TOP)	1	0	2 (twins)	0	1	0	2	0	1	0	1	1	9

Table 2: Stillbirths (>24 weeks, excluding terminations)

Quarter	Rate 2019/20	Rate 2020/21	Rate 2021/22	Rate 2022/23	Rate 2023/24
Q1	4.0	5.5	4.0	3.7	1.7
Q2	4.1	2.5	5.3	3.6	2.2
Q3	1.5	2.7	5.1	4.3	3.3
Q4	1.7	3.2	5.0	2.3	1.1
ANNUAL	2.9	3.4	4.9	3.5	2.2

Table 3: Stillbirth (>24 weeks) by Cause (Q3, 2023/24)

Reported cause of death (based on CESDI 2018)	No	Transferred care for delivery in LWH
Termination of pregnancy for fetal abnormality	4	
Fetal/chromosomal abnormality	0	
Pre-eclampsia	0	
Antepartum haemorrhage (abruption)	1	
Medical disorder	0	
Multiple pregnancy	1	
SGA (<10th centile)	4 (3 <3rd centile)	
Mechanical	1	
Infection	0	
Specific placental condition	0	
Unclassified	0	

In Q3, 3 cases of pregnancy loss between 22-24 weeks were reviewed through the PMRT process, and the cause of death were:

- Placental abruption
- Intraplacental haematoma
- Congenital anomaly of Sacrococcygeal Teratoma

3. MORTALITY REVIEWS AND KEY THEMES (Q3 cases, including 3x pregnancy loss 22-24 weeks)

Table 4. PMRT review panel grading of care provided in cases of Stillbirth (N=10)

Grade	Care in antenatal period	Percentage (%)	Care provided after Stillbirth	Percentage (%)
A	4	40	1	10
B	3	30	8	80
C	3	30	1	10
D	0	0	0	0

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

Antenatal Care

Review panel grading	Reason for grading	Level of investigation (PSIII/AAR/PMRT with external)	HSIB (yes/ no)	Learning	Actions / QI plan aligned to theme
B	Unclear documentation of capacity	PMRT	No	Ensure all clinicians confident in assessing capacity through mandatory training	LOTW to remind all staff regarding importance of documentation of assessment of capacity *(completed)*
B	Missed GDM diagnosis on admission for steroids	PMRT	No	Clear EPR documentation of GDM diagnosis and when CBG meter provided	LOTW shared within GDM team on consistency in documentation on EPR when GDM is diagnosed and CBG meter provided *(completed)*
B	Anatomy scan cancelled and unclear if DNA policy followed as scan not rescheduled	PMRT	No	Need to clarify DNA scan pathway, and ensure pathway followed for scans to be rearranged	Discussed with imaging lead who has reassured that DNA policy is for EPR referral to CMW for review and rearranging. and will monitor if this was a

					recurrent theme *(completed)*
C	Unclear information provided for counselling on offering IOL by 41 weeks	PMRT	No	Provision of adequate information on risks and benefits of postdates IOL	IOL QI project to include PIL and decision aid for counselling on postdates IOL *(in progress)*
C	Lack of holistic view on interpretation of CTG	PSIII	No	Importance of holistic interpretation of CTG rather than sole dependence on computerised DR analysis	Please refer to PSIII report *(in progress)*
C	Missed opportunity to refer for growth USS when alerted from SFH GROW chart	PMRT	No	To understand issues with utility of electronic GROW charts in the community	Thematic review on the utility of electronic GROW charts in the community *(awaited)*

Postnatal/Bereavement Care

Review panel grading	Reason for grading	Level of investigation (PSIII/AAR/PMRT with external)	HSIB (yes/no)	Learning	Action / QI plan aligned to theme
B	Incomplete PN Stillbirth Ix	PMRT	No	Appreciate importance of arranging for SB PN Investigations, and utilising the EPR Stillbirth pathway as checklist	Training on utility of EPR pathways and LOTW reminder on importance of complete SB Ix *(on-going)*
B	PN HbA1c not tested although requested as part of SB Investigations	PMRT	No	Clarify digital request for HbA1c testing with laboratory	Clarified with laboratory and identified an error on requests during an EPR update which is now corrected *(completed)*

B	Incomplete electronic Stillbirth pathway	PMRT	No	Familiarity with the Stillbirth pathway in EPR	Ongoing training on utility of EPR Stillbirth pathways *(completed)*
B	Wrong dose of Misoprostol used for IOL	PMRT	No	Awareness of different Misoprostol IOL regime in 2nd and 3rd trimester losses	Displayed laminated flowcharts of the different Misoprostol regimes for 2nd and 3rd trimester losses for reference, and LOTW shared (*completed)*
B	PMRT engagement letter not provided in patient's own language	PMRT	No	Need for appropriate communication to invite parental engagement in review process	NA – not routine practice and appears to be an isolated case
B	Lack of utility of partogram in labour	PMRT	No	Familiarity of charting labour progress even for Stillbirths on EPR	Discussed with individual involved. Is not a recurrent theme and will continue to monitor (*completed)*
C	Not all professionals involved in care of patient was informed of adverse outcome	PMRT	No	Lack of clear communication with GP and relevant care providers following adverse outcomes	Review pathways for notifying GP and relevant care providers following adverse outcomes *(discussed at bereavement committee meeting)*

a. PMRT PANEL ATTENDANCE (Q3 reviews)

There was 1 PMRT panel without the presence of either an external Obstetrician or Midwife in reviewing 2 of 10 Q3 cases

b. PARENTAL ENGAGEMENT (Q3 reviews)

Of the 10 cases reviewed, 6 families have engaged in the review process and submitted questions and comments that were considered by the review panel

4. INTRAPARTUM & TERM STILLBIRTHS (Q4 cases)

There was 1 case of intrapartum stillbirth of a breech presentation spontaneous labour at 34+4 weeks gestation, which is currently being investigated through the PSII route.

There were no term stillbirths in Q4.

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

Gestation at Stillbirth	Number (N=4)
<24 weeks	2
<28 weeks	0
28-31 weeks	0
32-36 weeks	2
> 37 weeks	0

5. SAFEGUARDING/UNBOOKED AND LATE BOOKERS (Q4 cases)

In Q4, there was 1 case known to safeguarding and the appropriate support were put in place. There was also 1 case where pregnancy was unbooked, and there were no safeguarding concerns surrounding the reasons for this.

6. SOCIO-DEMOGRAPHICAL (Q4 cases)

Half (2 women) of these women live in the lowest decile IMD score for residential address (1 case had no IMD as resides in Wales).

Of these 4 women, 3 were of white ethnicity, and one is of black African ethnicity, and all communicated well in English.

In this cohort, all women had their CO monitored. Only 1 woman was reported to be smoking at booking, but she declined referral to smoking cessation services. This woman was also known to the safeguarding team and social services, with additional support required and provided in the antenatal period.

7. SMALL FOR GESTATIONAL AGE <10th centile (Q4 cases)

There were no cases of SGA, although 1 case was an unbooked pregnancy.

8. FETAL ABNORMALITIES DEATHS (known and unknown)

In Q4 of 2023/24, there was a case of amniotic band disruption sequence confirmed at postmortem.

9. LEARNING FROM DEATHS from Q3 of 2023/24

Areas for learning in the antenatal and postnatal care provided and actions planned are detailed in Table 5 in the report. Some of the actions have been completed, while some are in progress, and discussed in various working groups.

Actions in progress are:

- IOL QI project to include PIL and decision aid for counselling on postdates IOL
    - Ongoing project where a PIL including risks and benefits of IOL and adverse outcomes has been developed to equip midwife and clinicians in having consistency in information provided and counselling during discussion on offering of IOL. This document is currently in circulation for comments.

- Perform a thematic review on the utility of electronic GROW charts in the community
    - Discussed at the clinical risk meeting and awaiting to be assigned

- Ongoing training of bereavement support champions to provide additional support to Honeysuckle team, utility of 2nd and 3rd trimester pregnancy loss pathways on K2 EPR, which acts as checklists to ensure stillbirth investigations, including genetic tests have been appropriately requested for

- Review pathways for notifying GP and relevant care providers following adverse outcomes to ensure appropriate information sharing
    - Requested for discussion as an agenda item in the Bereavement committee meeting for these pathways to be developed

10. SAVING BABIES' LIVES ELEMENTS (Q4 cases, N=4)

ELEMENTS	CASES	NARRATIVE
Reducing Smoking	1	Declined referred to smoking cessation, had regular CO monitoring and supported by CMW
Fetal Growth Restriction		
Awareness of RFM		
Fetal monitoring in labour	1	Lack of appreciation of labour and missed opportunity for CTG monitoring
Reducing PTB	1	Spontaneous labour 23 weeks after a coincidental finding of an open cervix at routine 20 week scan
Management of DM		

11. Benchmarking and CNST Compliance

CNST MIS conditions and target for Year 6 has been published, which applies to cases between 8th Dec 2023 to 30th Nov 2024.

The team have met all the requirements, detailed as below:

CNST MIS compliance for Year 6 (from 8th Dec 2023 to current)

Parameters	No. Cases (N=10)	Completed (Percentage)
Reported to MBBRACE (7 days) – 100%	10	100%
Parents informed of review – 95%	8	80% (no dateline)
PMRT MDT review started (2 months) – 95%	10	100%
PMRT report Published (6 months) – 60%	4	100% (no others due, next dateline 12/8/24)

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Meeting Date	Thursday, 11 July 2024	**Item Reference**	24/25/087
Report Title	Safeguarding Annual Report 2023/2024		
Author	Deborah Ward, Head of Safeguarding		
Responsible Director	Dianne Brown, Chief Nurse		

Purpose of Report	To provide assurance that the Trust is meeting its statutory safeguarding duties.
Executive Summary	Key Issues, Recommendations and Areas of Concern The Safeguarding Annual Report for Children, Young People and Adults provides an overview of Safeguarding activity within the Trust for the period 1st April 2023 to the 31st March 2024. The intention of the report is to provide assurance to the Board of Directors that the Trust has effective systems and processes in place to safeguard those at risk of abuse who access services provided by Liverpool Women's NHS Foundation Trust. The Board of Directors is requested to receive the report and approve dissemination as detailed below ; Once approved, the Head of Safeguarding will submit the report to the Liverpool, Sefton and Knowsley Safeguarding Children's Partnerships and the Liverpool, Sefton and Knowsley Safeguarding Adult Boards. The report will also be published on the Trust web page.
Key Areas of Concern	Training compliance for safeguarding level 3 adults and Mental Capacity Act are below 90% compliance. This is due to revalidation and alignment of training requirements in line with Intercollegiate documents. Divisions have developed training trajectories to provide assurance re achieving compliance which will be monitored at Safeguarding Committee and reported into Quality, Risk & Safety Executive Group
Trust Strategy and System Impact	*N/A*

Links to Board Assurance Framework	*None*	***N/A***

Links to Corporate Risk Register (scoring 10+)	*2637 – score 11* *2751 – score 11* *2709 – score 10* *2774 – score 10* *Detains of risks contained within body of report*	***11*** ***11*** ***10*** ***10***

Assurance Level	1. MODERATE - Adequate system of internal control applied to meet existing objectives

Action Required by the Committee	The Trust Board is asked to receive assurance the Trust is meeting its statutory safeguarding function and recommend publishing the annual report on the Trust internet page.

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Trust Safeguarding Sub Committee	14/05/2024	Deborah Ward	Recommend annual report is presented to Quality Committee
Quality Committee	25/06/2024	Dianne Brown	Recommend annual report is presented to Trust Board pre-publication

Liverpool Women's
NHS Foundation Trust

Safeguarding Children, Young People and Adults Annual Report

2023/2024

Executive Summary

The Safeguarding Annual Report for Children, Young People and Adults provides an overview of Safeguarding activity within the Trust for the period 1st April 2023 to the 31st March 2024. The intention of the report is to assure our Board of Directors that the Trust has effective systems and processes in place to safeguard those at risk of abuse who access services provided by Liverpool Women's NHS Foundation Trust.

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

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

The report will outline the progress against the 2023/24 priorities and set out the key priorities for the coming 12 months. These are central to supporting core safeguarding activities and demonstrate the organisations compliance with Section 11 of the Children Act (2004) and the Care Act (2014).

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

Dianne Brown,
Chief Nurse

Contents

Introduction

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

1.2 The 2023/24 Safeguarding Annual Report for Liverpool Women's Hospital NHS Foundation Trust will reflect the safeguarding work undertaken by the organisation during the reporting period.

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

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

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

- Children Act 1989/2004
- Children and Social Work Act 2017
- Working Together to Safeguard Children 2023
- Promoting the Health and Wellbeing of Looked After Children 2020
- Care Act 2014
- Mental Capacity Act 2005
- Mental Capacity Act Deprivation of Liberty Safeguards 2009
- Mental Capacity Amendment Act 2019
- Domestic Abuse Act 2021
- Care Quality Commission Registration Standards: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:
    - Regulation 9: Person Centred Care
    - Regulation 10: Dignity and Respect
    - Regulation 11: Need for Consent
    - Regulation 12: Safe Care and Treatment
    - Regulation 13: Safeguarding Service Users from Abuse and Improper Treatment

The Service

2.1 Liverpool Women's Hospital NHS Foundation Trust Safeguarding Service

2.1.1 The safeguarding service is a fully integrated, multi professional service comprising of a health and social care professionals who have extensive experience across midwifery, nursing and social care.

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

2.1.3 The service has been through significant change over the reporting period, the Associate Director Nursing for Safeguarding (also held the role of Named Midwife/Named Nurse Safeguarding Children) retired from the NHS mid Quarter 1. On 1st May 2023, an Interim Head of Safeguarding commenced in post to provide overarching leadership and support in the absence of the substantive post holder.

2.1.4 Head of Safeguarding recruitment commenced with the Interim Head of Safeguarding successfully gaining the substantive post formally commencing in post on 1st August 2023.

2.1.5 In Quarter 2, the Lead Nurse for Children and Young People post transitioned into the safeguarding team from being divisionally based as it was recognised the work required by the post holder was organisational wide and not individual responsibility of a single division.

2.1.6 Quarter 3 had multiple staff changes for various reasons including team members leaving the Trust to work closer to home, relocating to another area of the UK and promotion. These changes led to a need to structure review to ensure any recruitment supported the team to meet the increasing safeguarding demands on the organisation.

2.1.7 The structure was approved by the Executive Lead for Safeguarding and the Head of Safeguarding commenced recruitment. The Senior Safeguarding Midwife transitioned into the Named Midwife for Safeguarding Children with the following posts going through external recruitment process:

- Named Nurse Safeguarding Adults
- Named Nurse Safeguarding Children and Young People
- Deputy Named Midwife Safeguarding Children
- Safeguarding Practitioner (2 posts in reporting period)
- Safeguarding Administrator

2.1.8 At the end of the reporting period, two posts remain vacant with recruitment ongoing, 1 x Safeguarding Practitioner post and 1 x Deputy Named Professional post. The end of year safeguarding team structure can be found in appendix 1.

2.2 Named Doctors

2.2.1 A vital aspect of the safeguarding service is the function of the Named Doctors. The Trust currently has a Neonatal Consultant as Named Doctor Safeguarding Children and a Urogynacology Consultant as Named Doctor Safeguarding Adults. Both roles currently have 1 x 4-hour session per week for safeguarding related activity.

2.2.2 The Named Doctors have met regularly with the senior members of the safeguarding team to develop a programme of work to support the safeguarding agenda.

2.2.3 Priorities over the reporting period have been:

- Development of the restrictive practice policy including sedation and rapid tranquilisation
- Continuous implementation of the Mental Capacity Act across medical staff
- Raising awareness of the Named Doctor role across the medical directorate
- Development of the missing person (child and adult) policy and associated pathways
- Attendance and input into Sudden Unexpected Death of Infants & Children (SUDIC) strategy meetings
- Liaison with partners to improve SUDIC pathways across Cheshire and Merseyside

2.2.4 In addition to the above priorities, the Named Doctor Safeguarding Children has taken the lead in undertaking an After Action Review following the identification of an incident relating to the transfer of care across the Liverpool Neonatal Partnership and the sharing of information.

2.2.5 The Named Doctor roles will continue to be integral to the running of the Trust safeguarding service, and priorities for the upcoming year will be planned in partnership with the wider organisation.

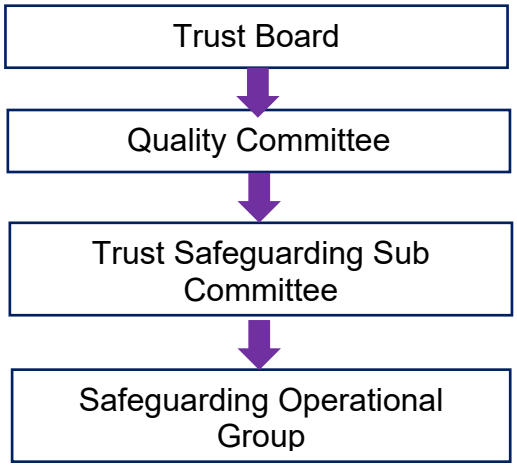
2.3 Trust Safeguarding Sub Committee (TSSC)

2.3.1 The Trust Safeguarding Sub Committee met quarterly throughout 2023/24. The sub-committee provides exception reports directly to the Quality Committee.

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

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

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



2.3.5 Following a full review of organisational governance structures in Quarter 4, the reporting structure for safeguarding will be amended from Quarter 1 2024/25. The Safeguarding Annual Report will continue to be presented to Trust Quality Committee, however quarterly reports and Safeguarding Sub Committee Chair's reports will be presented to the newly developed Quality, Risk & Safety Executive Group (QRSEG).

2.4 Risk Register

2.4.1 At the end of the reporting period there were four risks on the safeguarding risk register which can be seen in table 1 below. In addition a risk associated with the implementation of Specialist Learning Disability and Autism awareness training is overseen by Education and Training but is reported into Trust Safeguarding Sub Committee (risk 2752)

Table 1: Safeguarding Risk Register

Risk Number	Risk Description	Risk Score
2637	**Risk**: Women and Babies could be at increase safeguarding risk **Cause**: The delay in information sharing from the Local Authority, leading to the Trust not receiving child protection plans or additional information **Consequence**: Trust staff are unable to plan and deliver safe care	12
2709	**Risk:** Families and children are at risk of not receiving a co-ordinated approach to early help.	9

	Cause: The Trust are not in a position to evidence early help work undertaken by front line staff. **Consequence:** The Local Authority and Safeguarding Children's Partnership have raised concerns against the Trust that multi agency policy is not being appropriately implemented which can lead to reputational damage.	
2751	**Risk:** Staff are not fully Safeguarding trained in line with Intercollegiate requirements. **Cause:** Review of training alignment through Head of Safeguarding validation process identified staff who were incorrectly aligned to a lower level of safeguarding training for the role. Trust wide review completed which has lead to a reduction in training compliance for multiple levels of safeguarding adult, safeguarding children and Mental Capacity Act training. **Consequence:** The review has led to a reduction in compliance below 90% KPI requirements for multiple areas of safeguarding training. The staff who have not been aligned to the correct level of training will be required to complete appropriate training impacting on time away from patient care. In addition until trained appropriately they could lack knowledge and skills to manage a safeguarding concern/incident.	12
2774	**Risk:** Not all services have access to safeguarding information for a baby who was born at LWH or who received care within the neonatal services **Cause:** Pre-birth safeguarding information is documented on maternal k2 clinical record and duplicated onto maternal Digicare record (previously bulletin board note) Safeguarding information for a neonatal patient is documented on badger clinical record. This information does not pull through onto child's Digicare record. **Consequence:** Staff in areas that only utilise Digicare e.g. genetics / gynaecology do not have access to safeguarding information for a child receiving care / treatment from our services. This could lead to harm being caused to the child as relevant information cannot be considered e.g. a child may be in care and not living at parental address and communication	9

	could still go out to parent / services will not know that a child is on a child protection plan or open to social care etc.	
2752	**Risk:** 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) **Cause:** National review identified all staff who work in health or social care must have accredited LD and Autism training. This training must be delivered in 2 parts, e-learning aspect for all employees and tier 1 or tier 2 part 2. Both the versions of part 2 must be delivered by a trained facilitator and 2 people with lived experience (LD and Autism). The training requirement has rolled out nationally however staff and people with lived experience have not received required training to deliver part 2 (tier 1 or tier 2). Time frame for training is significant in addition to 90 min e-learning tier 1 training is 90 mins virtual webinar and tier 2 is 1 full day face to face. All staff who have contact with public require tier 2. **Consequence:** Trust is non compliant with legislation which could lead to reputation damage. Trust is non compliant with CQC requirement for workforce to be trained.	12

2.4.2 The risk register will be reviewed in quarter 1 2024/25 to ensure all risks have been appropriately identified with mitigation in place to minimise the risk and the risk score is realigned to the newly implemented Trust Risk Scoring System.

2.5 Review of Priorities from 2023/2024

2.5.1 Throughout the reporting period for 2023/24, the Trust safeguarding team has continued to progress the safeguarding children, young people and adult's work plans. This has ensured that the Trust has remained compliant with its overall objective to:

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

2.5.2 Table 2 below shows the key objectives identified as priorities within the 2023/2024 Safeguarding Annual Report and the progress made towards each objective.

Table 2: 2023/2024 Priorities and Progress Update

No.	Objective	RAG	Progress
1	Review the Safeguarding Structure including review of Job Descriptions.		Action complete. All job descriptions reviewed and updates. Structure review completed and agreed. Recruitment to structure commenced and will be completed quarter 1 2024/25.
2	Develop safeguarding audit plan and undertake relevant audits to improve safeguarding provision across the organisation.		Audit plan implemented inline with KPI requirements. Following audits completed: • Early Help Audit • Multi agency Neglect Audit • Response to Multi Agency Safeguarding Hub Requests Audit • Domestic Abuse Audit • Safeguarding Children Referral Audit
3	Work in partnership with IT services to further develop electronic systems to streamline safeguarding process.		Work has commenced and will continue into 2024/25.
4	Continue to support Local Safeguarding Adult Boards/Children's Partnerships to embed identified priority work streams across both the safeguarding adult and safeguarding children's agenda.		The Trust has been an active participant with both Liverpool and Sefton Safeguarding Children's Partnership Boards and associated sub-groups. This will remain a priority for 2024/25.
5	Self-assess the Trust against the updated NHS E Safeguarding Accountability and Assurance Framework (Expected KPI for 2023/24).		The NHS E Safeguarding Accountability and Assurance Framework was completed as part of Key Performance Indicator requirements and submitted to the Integrated Care Board as part of the Quarter 3 submission. At time of writing formal feedback has not been received. In completing the framework it was identified that actions are required to ensure full compliance with 5 standards. All actions are on track for completion in line with timeframes set within the associated action plan.

2.6 Commissioning Requirements

2.6.1 Liverpool Women's Hospital NHS Foundation Trust is commissioned by Liverpool Place within the Cheshire and Merseyside Integrated Care Board (ICB).

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

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

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

2.6.4 At the end of the reporting period, feedback from the ICB has identified that the Trust has given significant assurance against 21 of the 23 KPI requirements. The remaining 2 requirements have been classed as limited assurance due to the training compliance for Level 3 Safeguarding Adults (73.14%) and Mental Capacity Act (87.5%) being less than 90%. Further details of the training compliance can be seen in the Training section 2.6 below.

2.7 Safeguarding Training

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

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

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

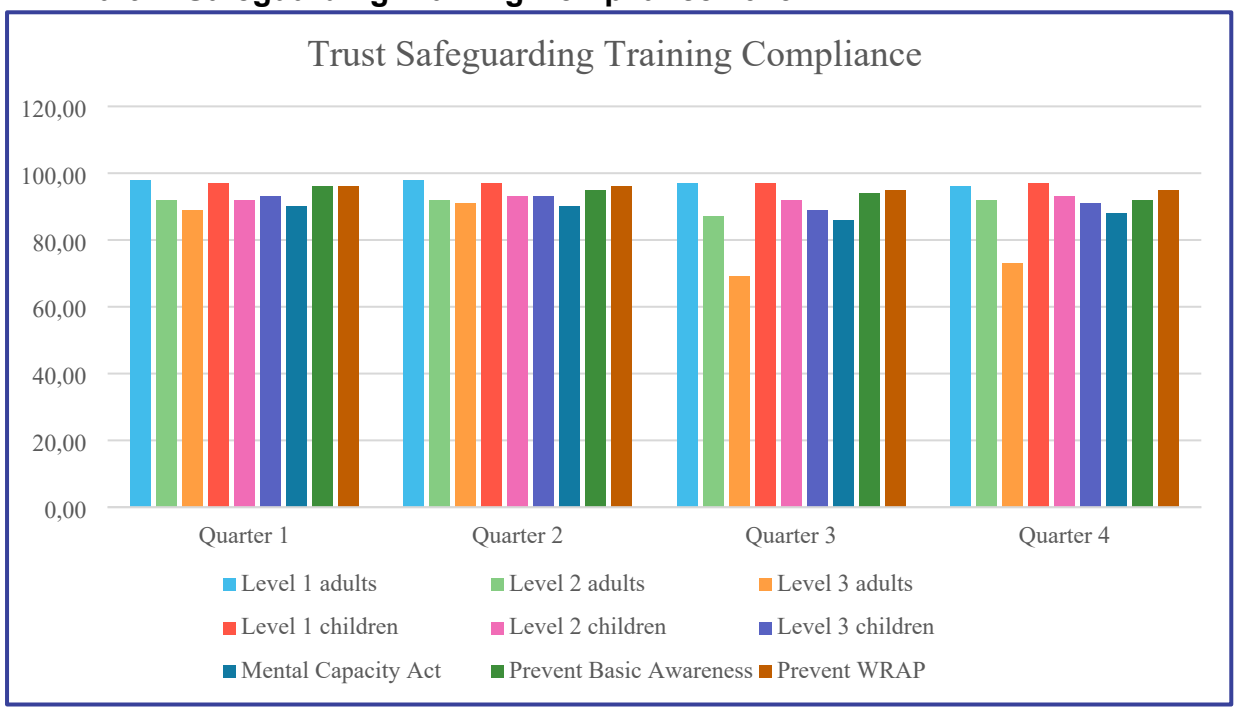
2.7.4 Training compliance has been closely monitored through the year, with bi-monthly reports being sent to divisional leads to enable divisions to report compliance within divisional governance meetings. In addition, safeguarding training compliance has continued to be discussed at the Safeguarding Sub Committee as part of the quarterly report presented by the Head of Safeguarding.

2.7.5 The Head of Safeguarding completed a full validation review of training requirements per job role in early quarter 3 and this led an increase in the number of staff requiring Level 3 Safeguarding Adult, Level 3 Safeguarding Children, Level 2 Safeguarding Adults and Mental Capacity Act. This caused the compliance figures for all 4 training requirements to fall below 90% compliance.

2.7.6 Information was shared with each division who were required to complete a training trajectory to achieve 90% compliance across all training requirements. At the end of the reporting period, Level 3 Safeguarding Children and Level 2 Safeguarding Adults have achieved 90% compliance.

2.7.7 Full organisational safeguarding training data per quarter can be seen in Chart 1, and Divisional breakdown of safeguarding training data contained in Table 3.

Chart 1: Safeguarding Training Compliance 2023/24



2.7.8 Training compliance remains an organisational priority with divisional leads receiving training figures twice monthly to identify staff who are required to attend

training. Compliance will be closely monitored at TSSC with escalation to QRSEG if there are any concerns trajectories will not be achieved.

Table 3: Divisional Safeguarding Training Compliance 2023/24 by Quarter

Training	Clinical Support Services				Gynaecology				Maternity				Neonatal				Medical			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Level 1 Adults	100	100	98	94	99	97	97	95	98	89	94	97	98	99	97	97	100	100	100	33
Level 2 Adults	99	99	99	100	98	98	96	96	85	88	90	91	85	76	67	95	90	81	74	75
Level 3 Adults	100	100	91	97	93	96	78	81	83	87	71	70	83	100	25	33	81	94	50	78
Level 1 Children	100	100	100	96	99	98	98	97	91	87	94	94	91	89	88	88	100	100	100	33
Level 2 Children	99	100	98	100	98	98	96	96	90	90	90	93	90	96	98	98	86	78	72	71
Level 3 Children	100	100	89	95	99	92	81	77	92	93	94	98	92	93	93	94	93	87	66	59
Mental Capacity	96	100	95	100	99	98	94	92	86	88	86	95	86	92	88	98	87	78	64	70
Prevent WRAP	100	100	100	100	99	99	98	98	95	93	94	95	95	99	99	100	96	96	83	86

*Note, Maternity and Neonatal Quarter 1 data was captured as Family Health Division and not as individual departments.

2.7.8 Oliver McGowan Learning Disability and Autism Awareness Training was incorporated into the mandatory training requirement across the Trust from early quarter 4. At the end of the reporting period, the Trust had achieved 77.83% compliance with the e-learning element (part 1 of both tier 1 and tier 2 training). Further information relating to this training requirement can be found in section 3.4 (Supporting Patients with Additional Needs).

3 Safeguarding Adult at Risk of Abuse

3.1 Key Work Activities

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

3.2 Safeguarding Adult Support and Advice

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

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

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

3.2.4 The end of year comparison can be seen with 2022/2023. As can be seen from the data the number of safeguarding adult notifications to the team has significantly increased reduced when compared to the previous year. This is due to ensuring all referrals are appropriately classified as adult safeguarding concerns for example a referral due to domestic abuse involving a pregnant woman is now being appropriately classified as a safeguarding adult concern although it may not lead to a referral to adult social care for section 42 enquiry.

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

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total 2023/24	Total 2022/23
Total number of Safeguarding Adult Notifications to Safeguarding Team	90	91	149	128	458	251
Total number of Safeguarding Adult Referrals to the Local Authority	1	1	4	1	7	8

3.3 Safeguarding Adult Local Authority Enquiries (Section 42 Enquiries)

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

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

3.3.3 There were a total of 8 referrals into adult social care over the reporting period, however none of these referrals related to care and treatment concerns relating to Liverpool Women's Hospital.

3.4 Supporting Patients with Additional Needs

3.4.1 The Trust 3year strategy for supporting people with additional needs was published in 2021/22. The Named Nurse Safeguarding Adults reviewed the strategy on commencement of post in January 2024 and has made the recommendation to separate the document into two separate documents. The first focusing on Supporting People Living with a Learning Disabilities and/or Autism and the second focusing on Supporting People Living with Dementia. The current strategy has been extended until July 2024 with the aim of the new documents being presented to Trust Safeguarding Sub Committee for ratification in July 2024.

3.4.2 Data is captured through coding to identify individuals with additional needs who are admitted to the Trust. This raw data can be seen in Table 4:

Table 4: Individuals Admitted to the Trust with Additional / Complex Needs

Diagnosis	Quarter 1	Quarter 2	Quarter 3	Quarter4
Learning Disability	27	25	34	37
Dementia	1	6	1	2
Autism	30	24	36	35

3.4.3 During the reporting period the Trust has been supported through the regional and local Oliver McGowan Learning Disability and Autism training implementation groups to implement both Tier 1 and Tier 2 Learning Disability and Autism Training.

3.4.4 This training requirement is now a mandatory requirement following the campaign that was started by Oliver McGowan's mother following his tragic death in NHS care. His mother launched a petition to address the need that she believed all health and social care professionals need appropriate and meaningful training to help them understand people who have a learning disability and/or autism.

3.4.5 The associated code of practice is still awaiting publication, however it is believed nationally that the final publication will mirror the draft code of practice that was out for consultation as per governmental process. Although the specific training is not mandated, the requirement will be for NHS and Social Care professionals to receive training based on job role.

3.4.6 Tier 1 requirement for non-patient facing staff is to receive basic awareness training via e-learning (part 1) in addition to an hour-long training session (part 2) that has been developed and co-delivered by individuals with both a learning disability and autism (delivered via a webinar as a trio with a facilitator for support).

3.4.7 Tier 2 requirement is for all patient facing staff irrelevant of role, again with the requirement to receive basic awareness training via e-learning (part 1) followed by a full day training session (part 2) that has been developed and is co-delivered by an individual with both a learning disability and autism. Again the proposal is for the full day training to be facilitated by an experienced training coordinator with the person with a learning disability supporting delivery of the morning session and the person with autism supporting delivery of the afternoon session.

3.4.8 At time of reporting, part 1 (e-learning) has been rolled out across the Trust. This commenced in early quarter 4 and at the end of the quarter the Trust had achieved 77.83% compliance.

3.4.9 The Trust are working in partnership with Cheshire and Merseyside Integrated Care Board (ICB) to implement part 2 of both tier 1 and tier 2, however this is dependent on the ICB supporting individuals with lived experience to become trainers to support the roll out.

3.5 Mental Capacity Act

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

3.5.2 When an individual (aged 16 or over) is thought to lack mental capacity and support is required front line staff will complete a referral to the safeguarding team. These referrals are including in the figures contained in table 3.

3.5.3 To support front line staff who work within the MCA 2005 legislation, an electronic capacity assessment form and best interest decision tool were built into the new Electronic Patient Record (EPR) which rolled out across the Trust in July 2023.

3.6 Deprivation of Liberty Safeguards

3.6.1 Liverpool Women's Hospital NHS Foundation Trust is a managing authority under Deprivation of Liberty Safeguards legislation. If a deprivation of liberty is

identified, the Trust has a duty to make an application to the relevant local authority in which the person resides who act as the supervisory body.

3.6.2 During 2023/2024, the Trust made 1 urgent authorisation and followed this with a standard application under Deprivation of Liberty Safeguards. This application was not authorised by the Local Authority as the individual was discharged prior to assessments being completed by the Mental Health Assessor and Best Interest Assessor.

3.6.3 Throughout 2024/25 the Trust will continue to focus on ensuring the Mental Capacity Act is fully embedded into clinical practice and support the use of Deprivation of Liberty Safeguards when appropriate.

3.7 Safeguarding Adult Boards/Partnerships

3.7.1 Throughout 2023/2024 the local Safeguarding Adult Boards have continued to evolve and develop work plans and internal structures. Liverpool Women's Hospital NHS Foundation Trust feed into three local boards, Knowsley, Liverpool and Sefton. The Named Nurse for Safeguarding Adults represented the Trust at the Health Sub-Group which links to the 3 boards.

3.7.2 Over 2024/2025 the safeguarding service will review all the associated sub-groups to ensure representation on key groups to ensure the view of the Trust is considered across the wider health and social care economy.

3.8 Safeguarding Adult Reviews (SAR)

3.8.1 Local Authority Safeguarding Adult Boards have a duty to undertake Safeguarding Adult Reviews under Section 44 of the Care Act.

3.8.2 During 2023/2024 the Trust received 0 requests for information relating to safeguarding adult reviews.

3.9 Domestic Homicide Reviews (DHR)

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

3.9.2 During the reporting period the Trust received requests to share information to support the scoping of multiple reviews to identify which organisations had relevant information to support the review. Appropriate information was shared

following all requests, however the Trust was not required to provide a detailed chronology in relation to any of the requests received due to limited involvement with the individuals.

3.9.3 During the reporting period 1 DHR remained ongoing that had significant Trust involvement with the individual, however the review has not been completed at the time of writing and any overarching learning and recommendations will be identified and reporting into Trust Safeguarding Sub Committee.

4 Safeguarding Children and Young People

4.1 Key Work Activities

- Child Protection
- Protection of the Unborn
- Domestic Abuse
- Managing Allegations Against Professionals
- Multi Agency Safeguarding Hub (MASH)
- Safeguarding Children Partnerships
- Child Practice Reviews / Critical Incident Reviews
- Supervision
- Support and Advice
- Training

4.2 Safeguarding Children and Young People Support and Advice

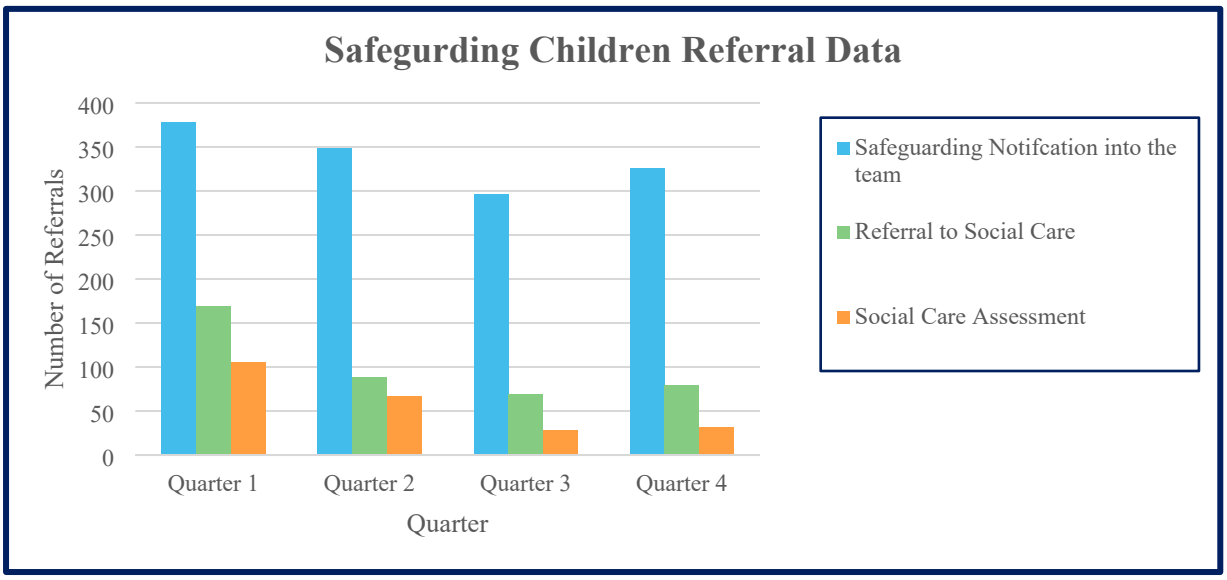
4.2.1 The safeguarding team received safeguarding children and young people queries following direct contact with a young person or if an adult attends the trust and safeguarding concerns are identified in relation to the immediate protection of the child / baby or unborn.

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

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

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

Chart 2:



4.2.5 The end of year comparison can be seen against the 2022/2023 data in table 5.

Table 5: Safeguarding Children Referral Data

	2022/2023	2023/2024
Safeguarding Child Referrals to the Team	1535	1347
Referrals to children's social care	484	405
Social Care assessments commenced	362	230

4.2.6 As can be seen from the data the number of safeguarding children's notifications to the team has decreased by just under 200 notification when compared to the previous year. This is due to reclassification of some referrals to adults which has in turn increased when compared to the previous year (see table 3 page 13).

4.2.7 The conversion rate to referrals has remained static with 30% of cases being referred to children's social care. Of those 57% have progressed to formal social care assessment which is a reduction on the 75% which led to social care assessment the previous year.

4.3 Multi Agency Safeguarding Hub – Information Sharing

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

4.3.2 If the Local Authorities receive information relating to a potential safeguarding concern they hold a strategy meeting to identify if the concerns meet the threshold for safeguarding enquiry under Section 47 of the Children Act (1989/2004).

4.3.3 Prior to the strategy meeting, the Local Authority Multi Agency Safeguarding Hubs (MASH) request information from all provider health organisations which could include all members of the family (parents and siblings of the child).

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

Table 6:

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total 2023/24	Total 2022/23
Number of cases researched	78	140	89	230	537	241

4.3.5 As can be seen from the data there was over 100% increase in requests for information sharing when compared to the previous year.

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

4.3.7 An aspect of the Annual Key Performance Indicators includes the requirement to undertake an audit of MASH returns to identify the return rate response within required timeframes as stipulated when the request is received.

4.3.8 The Audit identified that 86.4% of returns were made within the requested time frames, with 11.05% being return however they were returned after the requested return time. In addition, 2.51% were received by the team after the time frame stipulated for the return.

4.4 Special Education Needs and Disability (SEND)

4.4.1 The Special Education Needs and Disability (SEND) agenda was moved under the remit of safeguarding in early quarter 2 of the reporting period with the transfer of the Children and Young Person Nurse into the team.

4.4.2 During quarter 1, the Children and Young Person Nurse had completed significant work in relation to the agenda ensuring pathways for transition from paediatric services were in place for each division.

4.4.3 A SEND action plan was developed identifying 10 recommendations which had a total of 17 actions. At the end of the reporting period, 6 action have been completed and are embedded into practice, 9 are completed with assurance to be provided to Trust Safeguarding Sub Committee they have been embedded into practice with the remaining 2 actions on track for completion as planned by October 2024.

4.4.4 During the reporting period the Trust was invited to present to the Integrated Care Board in respect of work undertaken to support the SEND agenda. These presentations occurred in July 2023 and January 2024. On both occasions the Trust received positive feedback into the work taken to date.

4.4.5 Throughout 2024/25, the safeguarding team will formally provide an update on the SEND agenda within the safeguarding quarterly reports.

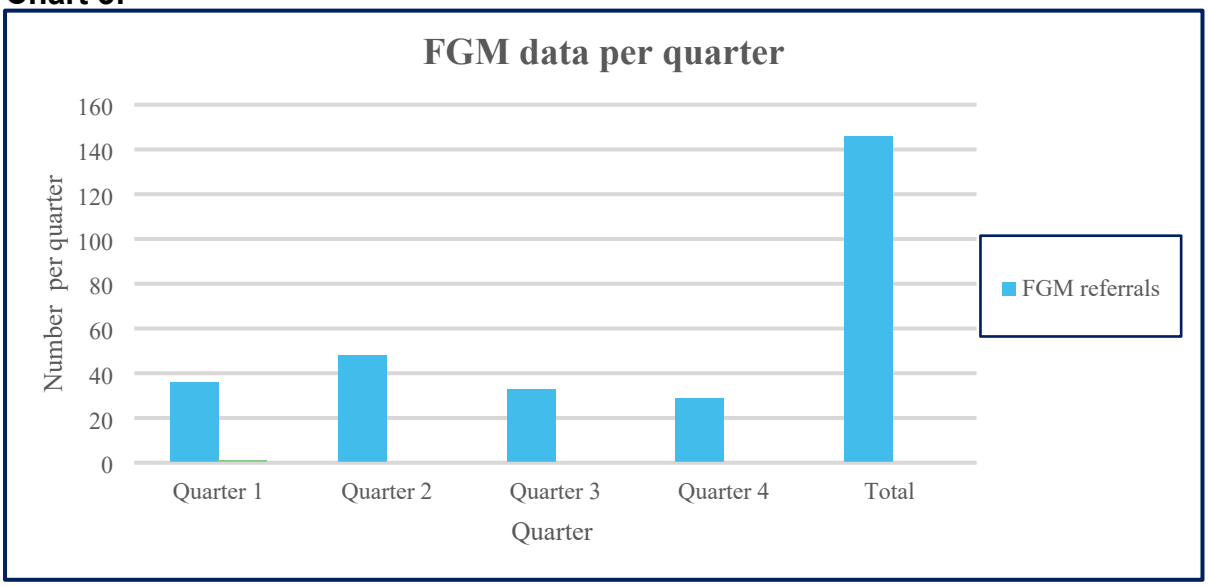
4.5 Female Genital Mutilation (FGM)

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

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

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

Chart 3:



4.5.4 As a comparison in 2022/23 there were a total of 128 individuals who were referred to the safeguarding team due to being identified as having had FGM.

4.5.5 All pregnant women who attend LWH who have been identified as being a victim of FGM receive information from the booking midwife in relation to FGM being an illegal practice and to seek the views of the woman and wider family. This conversation is then documented within the clinical records.

4.5.6 If any concerns are identified following this conversation the Midwife will complete a child safeguarding referral to the relevant Local Authority Children's Social Care.

4.5.7 If the baby is female, this conversation is revisited following the birth. A safeguarding referral would only be required if concerns are raised in relation to the woman's or families' views indicating they would consider FGM being appropriate practice for their child.

4.5.8 A Safeguarding Professional Letter is sent to the woman's General Practitioner following the birth of a baby girl to notify them the woman has disclosed she has been victim of FGM and that she had had a baby girl.

4.6 Local Safeguarding Children's Partnerships

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

4.6.2 Under Section 11 of the Children Act (1989/2004) the Safeguarding Partnerships are required to seek assurance from partner agencies that they have appropriate governance and policies/procedure to protect children from harm. As this review was completed late in quarter 4 2022/23 the review was not repeated in the reporting period.

4.6.3 During quarter 1, the Trust received formal feedback from the Section 11 review that occurred in quarter 3 2022/23. There were no actions or recommendations identified following the review.

4.6.4 Extracts from the report include:

"The visitors were provided with robust information that met all of the standards of Working Together 2018"

"Staff reported positively on the appointment of the Children and Young People's nurse and identified that they had provided additional training around Gillick competence and that they were developing a standard operating procedure around Early Help"

"Staff were engaged with the safeguarding process, could give clear case examples and understood the learning from reviews and demonstrated that they had direct access to safeguarding advice and support within the Trust"

Areas of Good Practice Recognised During Visit:

- Development of the post of Children and young people's nurse
- Change in training delivery was beneficial to staff
- IT systems in place that had clear links to 7 minute briefings
- Safeguarding staff accessible to the trust
- Improvements made to the delivery of safeguarding advice and support when issues are experienced out of hours.

4.7 Managing Allegations Against Professionals who work with Children

4.7.1 If an allegation of abuse towards a child or adult is raised against any member of staff, Liverpool Women's Hospital NHS Foundation Trust have an obligation to report the allegation.

4.7.2 If the staff member primary focus of work is with children (anyone under the age of 18 years) the concerns must be referred to the relevant Designated Officer at Liverpool Local Authority. If the allegation relates to a member of staff who primary work is with adults the allegation must be referred to Liverpool City Council Adult Social Care department as a safeguarding concern.

4.7.3 During 2022, the criteria for referring to the Designated Officer was widened to include behaviour that may indicate a person may not be suitable to work with children, this includes allegations of domestic abuse in the private life of the individual, criminal offences relating to class A drugs, sexual offences against adult and mental ill health in which the person presents at risk of harm.

4.7.4 During the reporting period the Trust made 5 referrals to Liverpool City Council Designated Officer. Of these referrals, 1 was not taken forward as the concerns related to someone who was unlikely to work with anyone under the age of 18. This case was reported through safeguarding adults process who requested an internal review of the allegations as per Human Resources (HR) process.

4.7.5 The remaining 4 cases were all accepted by the Designated Officer as being an appropriate referral. Multi Agency Strategy Meetings were held including Social Care, Police and Trust representation from Safeguarding HR and line management of the individual.

4.7.6 The conclusion of all cases identified that appropriate action had been taken / remained ongoing by the Trust with the case being closed to the Local Authority as the individual was not deemed to be at risk to children.

4.8 Child Safeguarding Practice Reviews

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

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

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

4.8.4 During the reporting period, the Trust submitted 1 request to SIRG for consideration of a practice review. Although this review was not commissioned, the consideration at panel did identify learning and recommendations for organisations across the partnership.

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

5 Domestic Abuse

5.1.1 The domestic abuse agenda has remained a priority across Merseyside and the Safeguarding Team has ensured regular attendance and participation with Liverpool, Sefton and Knowsley Multi Agency Risk Assessment Conference (MARAC) process.

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

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

5.1.4 In addition to internal identification of domestic abuse, the Trust receive police notifications from Merseyside Police. These notifications are reviewed by the Safeguarding Team when either:

a) the alleged victim or perpetrator is pregnant or
b) if the household has an infant under the age of 1 years.

5.1.5 All data relating to domestic abuse can be seen in chart 4 and table 7.

Chart 4:

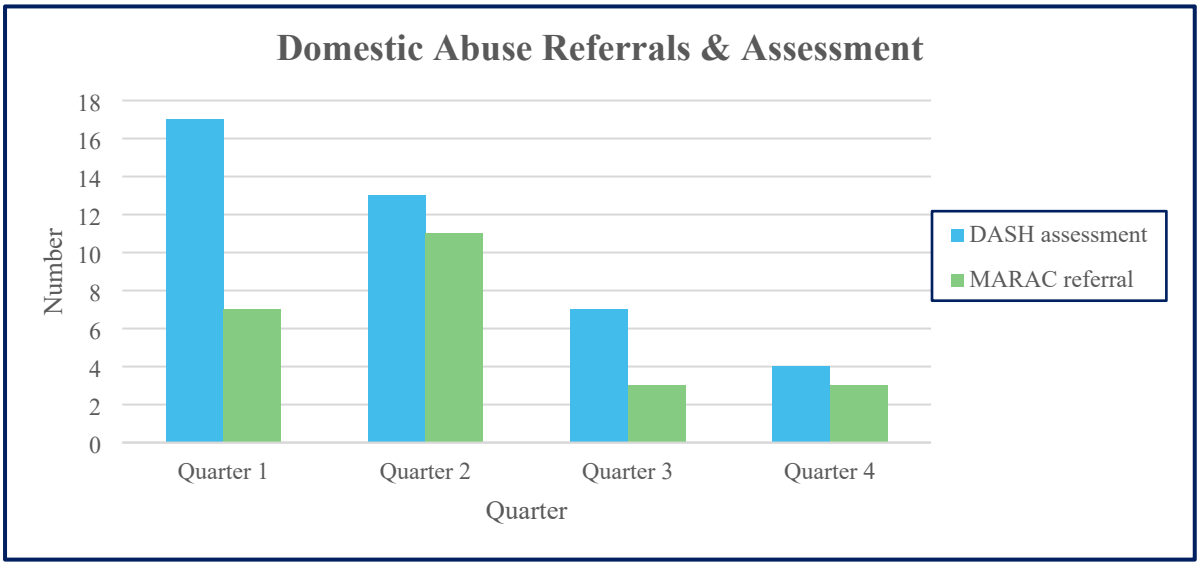


Table 7:

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total 2023/2024	Total 2022/2023
Police Notifications	148	148	205	129	630	696
No MARAC cases researched	Data not collected		700	904	1604 (Q3 & 4 only)	No data

5.1.6 As can be seen from the data in chart 4, Quarter 2 led to a reduction in the completion of SafeLives DASH risk assessments and this reduction continued into quarters 3 and 4. The safeguarding team have been raising awareness of the DASH risk assessment and this will continue into quarter 1 2024/25. It has been identified when asking staff why they are not completing the forms when they recognise risk, it has become apparent that staff have not known where to locate the form following the roll out of the new electronic patient record in early July 2023.

5.1.7 Following this identification communications has been shared across the Trust to raise awareness of how the form can be accessed.

5.1.8 If during assessment, a pregnant woman is identified as being high risk of domestic abuse, the safeguarding team will liaise with children's social care to identify if a specific safeguarding plan of care is required.

5.1.9 During the reporting period the Trust signed up to NHS England Sexual Violence and Domestic Abuse Charter. The charter has identified 10 principles which the Trust are committed to embedding across all service areas.

5.1.10 A GAP analysis has been completed by the Head of Safeguarding in partnership with a Human Resource Business Partner which identified good evidence in relation to meeting the requirements of the Charter by the implementation date set by NHS England (30th June 2024).

5.1.11 A task and finish group has been developed with members from across Governance, Equality and Diversity, Human Resources, Organisational Development and Freedom to Speak Up. The group have developed an action plan and work to achieve full alignment to the Charter will continue throughout quarter 1 2024/25.

6 Prevent

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

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

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

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

6.5 In total during 2023/2024, the Trust made 1 Prevent referral for Police consideration.

7 Conclusion

7.1 Throughout 2023/2024, the Safeguarding team has been through significant change which started with the recruitment of a new Head of Safeguarding. Following a service review, a new structure has been approved and implemented over the full reporting period. The organsiation would like to thank those who have left the team for the service over many years.

7.2 Training compliance has remained a priority for the Trust through the reporting period, achieving over 90% for all aspects of safeguarding training requirement at the end of quarter 2. However, compliance levels dropped below 90% following revalidation and remapping of training requirements by the new Head of Safeguarding.

7.3 This process identified some staff required a higher level of training than previously assigned. Through quarter 3 and 4, divisions have received bi-monthly training figures to support identification of staff who require training. At the end of quarter 4, the Trust have achieved 90% or above compliance in 7 of 9 training requirements, with Mental Capacity Act Training reaching 88% and Safeguarding Adults improving and is currently 73%.

7.4 Training will continue to be a priority for the coming year and additional training sessions have been planned to achieve 90% compliance across all levels of safeguarding training.

7.5 Safeguarding notifications for adult and children continue to be made to the safeguarding team in high numbers from across all areas of the organisation. This identifies embedded process and good consideration of safeguarding concerns.

7.6 The Trust has signed up to the NHS England Sexual Violence and Domestic Abuse Charter, with the task and finish group being on track to achieve full implementation by 30th June 2024.

7.7 The Trust has a continued presence at partnership meetings within the local area with membership at both Liverpool and Sefton's Safeguarding Children's Partnership and the associated sub-groups. The Trust participate virtually with safeguarding adult subgroups across the partnership.

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

8 Priorities for 2024/25

1. Develop safeguarding workplan for 2024/25 to raise awareness of all aspects of safeguarding across the Trust including wider knowledge of MCA and Deprivation of Liberty, completion of SafeLives DASH and the SEND agenda.
2. Work in partnership with IT services to further optimise electronic systems to streamline safeguarding process including the development of safeguarding internal referral process and Deprivation of Liberty Safeguards documentation within patient record systems.
3. Continue to support Local Safeguarding Adult Boards/Children's Partnerships to embed identified priority work streams across both the safeguarding adult and safeguarding children's agenda.
4. Continue to implement identified requirements against the Safeguarding Accountability and Assurance Framework and ensure full compliance providing appropriate evidence to Trust Safeguarding Sub Committee and the Integrated Care Board as part of Key Performance Indicator submission.
5. Implement requirements to ensure Trust compliance with NHS England Sexual Violence and Domestic Abuse Charter.

9 Recommendations

- The Committee is requested to received and recommend approval of this annual report and on the Trust Board Approval the report is to be published on the public web site.
- Once approved, it is recommended to submit the report to the Liverpool, Sefton and Knowsley Safeguarding Children's Partnerships and the Liverpool, Sefton and Knowsley Safeguarding Adult Boards.

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Meeting Date	Thursday, 11 July 2024	**Item Reference**	24/25/088
Report Title	WRES & WDES 2024 Report		
Author	Rachel London, Deputy Chief People Officer		
Responsible Director	Michelle Turner, Chief People Officer		

Purpose of Report	Publication of the Workforce Race Equality Standard (WRES), the Workforce Disability Standard (WDES) and the Medical Workforce Equality Standard (MWRES) are mandatory requirements for all NHS Trusts in England. Action Plans related to the above reports must be published on organisational websites by 31.10.24.
Executive Summary	The paper outlines our performance against the specific mandatory WRES and WDES targets, and sets this in the context of our wider programme of activity in ED&I including the Anti Racism Improvement Plan
Key Areas of Concern	In respect of WRES and our corporate objectives, we are not increasing the number of BME staff in the overall workforce or in leadership roles, at the rate we had planned.
Trust Strategy and System Impact	The report outlines progress against the stated aim of the Trust to be one of the most inclusive employers in the country.

Links to Committee Assurance Framework		-
Links to Corporate Risk Register (scoring 10+)		-

Assurance Level	1. SUBSTANTIAL - Good system of internal control applied to meet existing objectives

Action Required by the Committee	The Board is asked to note the assurances within the report.

MAIN REPORT

1. INTRODUCTION

Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) are annual statutory reports required from all NHS Trusts which collate a pre-prescribed set of data in relation to race and disability within the NHS workforce. In 2023 an additional national data requirement, the Medical WRES was added which was not undertaken in 2024.

The WRES and WDES data is collated using data as of 31st March 2024 except for data taken from the 2023 National Staff Survey. We are required to publish this data with associated action plans however the Committee is asked to recognise that the organisational focus for ED&I for the next 2 years is the Anti Racism Improvement Programme, and all actions pertaining to race equality are included in the Anti Racism project plan which will be used as our action plan for WRES.

This paper demonstrates the Trust's current position in relation to the ED&I strategic ambitions outlined within the Trust Strategy, presents the annual data pertaining to the Workforce Race Equality Standard (WRES) and the Workforce Disability Standard (WDES) and sets out the priority actions for the next 12 months.

To note, the term 'BME' is used in this paper to reflect the terminology in WRES and WDES reports. The preferred terminology in LWH is 'global majority'.

The WRES data is measured against the following metrics:

- Band distribution of clinical and non-clinical staff
- Committee member and non-Executive Director data
- Likelihood of being appointed from interview.
- Likelihood of entering formal disciplinary process.
- Number of staff experiencing harassment, bullying or abuse from staff
- Equal opportunities for career progression

The WDES data is measured against the following metrics:

- Band distribution
- Likelihood of being appointed from interview.
- Likelihood of entering formal capability process .
- Number of staff experiencing harassment, bullying or abuse from staff
- Equal opportunities for career progression

2. ANALYSIS OF KEY FINDINGS

WRES data 2024

i. Band distribution of clinical and non-clinical staff –no change in position from previous year.

- There has been an overall increase in BME staff in the workforce from 184 to 210 which represents **11.9% of the workforce.** This is against a stated target for 23/24 of 13% and our overall aim of 25%.

- There has been no change in the number of BME staff in leadership roles at Band 7 – 9 in either the clinical or non-clinical workforce (excluding medical staff) at 31 staff (8.4% of the Band 7-9 workforce)

The table below outlines Non-Clinical Grades by ethnicity.

	2023				2024		
Indicator 1a Non Clinical Workforce	**White**	**BME**	**Ethnicity/Unknown/ Null**	**Indicator 1a** Non Clinical Workforce	**White**	**BME**	**Ethnicity/Unknown/Null**
Under Band 1	0	0	0	Under Band 1	0	0	0
Band 1	0	0	0	Band 1	0	0	0
Band 2	91	6	2	Band 2	89	12	2
Band 3	63	8	1	Band 3	70	3	1
Band 4	87	3	0	Band 4	83	6	2
Band 5	45	6	1	Band 5	42	5	0
Band 6	19	5	0	Band 6	20	4	0
Band 7	31	2	2	Band 7	26	2	1
Band 8a	22	1	0	Band 8a	23	1	1
Band 8b	12	0	0	Band 8b	9	0	0
Band 8c	8	2	0	Band 8c	11	2	0
Band 8d	4	0	0	Band 8d	2	0	0
Band 9	2	0	0	Band 9	1	0	0
VSM	6	1	0	VSM	11	2	0
TOTAL	390	34	6	**TOTAL**	387	37	7

- Overall, the number of BME non-clinical staff has increased from 34 to 37.
- There has been no change in the number of BME non-clinical staff at Band 7-9 (5 in both 2023 and 2024)
- The Band with the greatest increase in BME staff was band 2 (6-12 staff)

The table below outlines Clinical Grades by ethnicity.

18		2023				2024		
19	**Indicator 1b** Clinical Workforce	**White**	**BME**	**Ethnicity/Unknown/ Null**	**Indicator 1b** Clinical Workforce	**White**	**BME**	**Ethnicity/Unknown/Null**
20	Under Band 1	0	0	0	Under Band 1	0	0	0
21	Band 1	0	0	0	Band 1	0	0	0
22	Band 2	89	10	0	Band 2	45	4	0
23	Band 3	114	6	4	Band 3	150	11	1
24	Band 4	39	6	0	Band 4	34	7	1
25	Band 5	222	37	9	Band 5	225	47	6
26	Band 6	380	27	5	Band 6	388	29	4
27	Band 7	169	12	0	Band 7	183	13	0
28	Band 8a	48	11	1	Band 8a	53	11	0
29	Band 8b	24	0	1	Band 8b	24	0	0
30	Band 8c	4	0	0	Band 8c	3	0	0
31	Band 8d	0	1	0	Band 8d	0	1	0
32	Band 9	2	0	0	Band 9	2	1	0
33	VSM	6	2	0	VSM	0	0	0
34	**TOTAL**	1097	112	20		1107	124	12

- Overall, there has been an increase in BME clinical staff from 112 to 124.
- There has been no change in the number of BME non-clinical staff at Band 7- 9 (26 in both 2023 and 2024)
- There have been marginal increases in the number of staff at Band 6 and 7
- The Band with the greatest increase in BME staff was Band 5 (37 to 47). International recruitment in theatres and maternity explains much of this increase.
- The increase in Band 2 to Band 3 staff reflects a Trust wide re-banding of these roles.

The table below outlines the Medical Grades by ethnicity.

There has been an increase in the number of consultant medical staff from a BME background, this has increased from 31 in 2023 to 34 in 2024. There has also been an increase in the number of BME doctors in non-consultant career grade posts, from 6 to 10.

	2023			2024			
Indicator 1 Medical and Denta	**White**	**BME**	**Ethnicity/Unknown/ Null**	**Indicator 1** Medical and Dental C	**White**	**BME**	**Ethnicity/Unknow n/Null**
Medical & Dental Consultants	61	31	3	Medical & Dental Consultants	54	34	1
of which senior Medical Mana	0	0	0	of which senior Medical Manage	4	2	0
Non Consultant Career Grade	13	6	1	Non Consultant Career Grade	8	10	1
Trainee Grades	3	1	0	Trainee Grades	0	3	0
Other	0	0	0	Other	0	0	0

ii. Committee member and non-Executive Director data –from previous year.

There has been no change in BME representation at Board level, which is comprised of 2 Non-Executive Directors (and no Executive Directors)

iii. Likelihood of being appointed from interview –improvement from previous year.

The relative likelihood of a white candidate being appointed at interview has reduced from being 1.24 times more likely to 1.1 times more likely (with 1.0 meaning there is no difference in likelihood of either a white candidate or a BME candidate being appointed). A new programme of inclusive recruitment training and our ongoing positive action scheme for shortlisting should support continued improvement.

iii. Likelihood of entering formal disciplinary process – improvement from previous year.

In 2023 there were 9 people enter the formal disciplinary process, of these 2 were from a BME background. In 2024 there were 21 people enter the formal disciplinary process, 2 were from a BME background. Therefore, the relative likelihood of BME staff entering the formal disciplinary process is 0.7 (a figure above 1 indicates that BME staff are more likely than white staff to enter the formal disciplinary process).

iv. Number of staff experiencing harassment, bullying or abuse from staff – improvement from previous year. (*Based on Staff Survey 2023 data)*

23% of staff reported experiencing harassment, bullying or abuse from staff in 2023 compared to 31% in 2022. Although a positive decrease, the figure remains concerning as there were no B&H cases brought to HR or F2SU from BME staff in this time-period.

	2019	2020	2021	2022	2023
White staff: Your org	17.07%	17.99%	23.29%	19.52%	15.64%
All other ethnic groups*: Your org	33.90%	23.88%	21.54%	31.17%	23.71%
White staff: Average	23.18%	21.57%	21.54%	20.38%	19.75%
All other ethnic groups*: Average	29.41%	28.72%	27.81%	27.32%	24.23%
White staff: Responses	744	706	700	866	793
All other ethnic groups*: Responses	59	67	65	77	97

v. **Equal opportunities for career progression – decrease in position from previous year**

	2019	2020	2021	2022	2023
White staff: Your org	60.54%	60.85%	59.63%	62.73%	60.43%
All other ethnic groups*: Your org	50.00%	48.48%	52.31%	46.75%	39.80%
White staff: Average	59.69%	62.11%	61.07%	59.07%	60.55%
All other ethnic groups*: Average	49.39%	44.29%	44.52%	46.92%	46.44%
White staff: Responses	745	705	701	864	786
All other ethnic groups*: Responses	58	66	65	77	98

There has been a decrease in the number of staff reporting equal opportunities for career progression from 46% to 39%, in addition to a decrease between 2022 and 2023.

WDES Data 2024

i. **Band distribution –slight improvement from previous year.**

There were 9 non- clinical staff in Band 7-9 who had declared a disability in both 2023 and 2024. 25 people had not disclosed their status in both years.

There were 15 clinical staff, in Band 7-9 who had declared a disability in 2024 compared to 12 in 2023. 155 staff in this group had not disclosed if they had a disability in 2023 compared to 135 in 2024. Therefore, showing a minor positive improvement in reporting.

ii. **Likelihood of being appointed from interview – improvement in position from previous year.**

Out of 32 disabled and 318 non-disabled candidates, **non-disabled candidates are 0.80** more likely to be appointed at interview**.** A figure below 1.00 indicates that disabled staff are more likely than non-disabled staff to be appointed from shortlisting, which demonstrates a **significant positive improvement** from 2023 when non-disabled staff were 1.56 times more likely to be appointed.

iii. **Likelihood of entering formal capability process – – improvement in position from previous year.**

There were 0 staff entering formal capability process who had declared on ESR as having a disability compared to 4 in the previous year. It should be noted that there were overall zero staff in the formal capability process last year.

iv. **Number of staff experiencing harassment, bullying or abuse from staff – improvement in position from previous year.**

The number of staff with a disability or long-term condition reporting they have experienced bullying, harassment or abuse in the workplace from other staff has **decreased from 22.3%in 2023 to 19.8% in 2024.** This is positive, however remains significantly higher than non-disabled staff (nearly a 8% difference).

	2019	2020	2021	2022	2023
Staff with a LTC or illness: Your org	22.63%	21.31%	26.53%	22.34%	19.80%
Staff without a LTC or illness: Your org	12.69%	11.88%	16.48%	15.43%	11.56%
Staff with a LTC or illness: Average	27.30%	25.39%	26.53%	24.22%	21.83%
Staff without a LTC or illness: Average	16.64%	16.63%	16.48%	15.43%	15.19%
Staff with a LTC or illness: Responses	137	122	147	197	202
Staff without a LTC or illness: Responses	662	648	613	739	675

v. Equal opportunities for career progression – decrease in position from previous year.

In line with the decrease for BME staff, there was a reduction in the number of disabled staff who believed the organisaton offered equal opportunities for career progression from 55.7% to 50.5%.

	2019	2020	2021	2022	2023
Staff with a LTC or illness: Your org	53.24%	54.92%	55.78%	55.78%	50.50%
Staff without a LTC or illness: Your org	60.81%	60.37%	59.25%	62.28%	59.82%
Staff with a LTC or illness: Average	52.29%	51.17%	52.29%	52.34%	51.90%
Staff without a LTC or illness: Average	58.87%	59.25%	59.25%	59.28%	59.82%
Staff with a LTC or illness: Responses	139	122	147	199	200
Staff without a LTC or illness: Responses	666	651	616	745	677

4. CONCLUSIONS FROM WRES AND WDES DATA

There is a clear message from the WRES data that we are not diversifying our overall workforce, or our leadership cohort at the pace intended. Two key pieces of ongoing work are expected to improve this position:

- Working with a trusted, high-profile community partner, a detailed diagnostic is taking place to gain a qualitative picture of the experiences of staff, patients and community members of Liverpool Women's. This will help us to understand why we are not an employment option for some groups, and along with the other community listening events, will support the building of trust.

- Targeted leadership programmes will launch in September for BME colleagues and successful completion of programmes will enable career progression into ring fenced roles.

More broadly, there were a number of areas of positive improvement, but in all areas, we recognise there is further work to do, and this is reflected in our ongoing actions.

5. ACTIONS PLANNED AND ONGOING

For the next 2 years, the Trust has a clear commitment outlied in the Anti-Racism Improvement Programme, to undertak a programme of cultural change where diversity and anti-discrimination becomes embedded in the organisatonal climate of Liverpool Women's.

Concurrently, it is clearly essential that programmes of work in other areas of ED&I contiunue, and that we continue to meet our statutory and mandatory obligations under the Public Sector Equality Duty.

The Anti- Racism Project Plan (Appendix A) outlines in detail the planned actions for the next 2 years in the sphere of Anti-Racism. There are a number of other ongoing projects designed to further our objective to be amongst the most inclusive NHS organsiations in the UK in creating an inclusive culture that harnesses and encourages diverse leadership at all levels in the organisation.

Key themes of work are as follows:

1) **Recruitment** – Roll out of inclusive recruitment training for managers, agree ring fenced roles for GM candidates, embed positive action, introduce alternative selection methods.
2) **Development** – provide access for up to 20 staff from diverse backgrounds to access one of three bespoke development opportunities.
3) **Education** – complete ED&I training for all staff and consolidate the leader and bespoke offer.
4) **Cultural change** – improve the reporting culture, effectively address B&H

a) Overall actions in relation to Equality, Diversity and Inclusion

- A full review of the Staff Networks is being undertaken in line with best practice. This will include identifying an Executive Sponsor, ensuring a mechanism of reporting into a board level committee, identifying new network chairs and providing them with training and protected time.

- Rolling out a programme of transgender awareness training led by individuals with lived experience.

- Continuing to analyse the efficacy of the positive action scheme in relation to race (guaranteed interview if meet essential shortlisting criteria of person spec) which has been in place for a year, and where LWH is one of only Trusts with such a scheme.

- Continuing to promote positive increases in self-declaration, particularly in relation to disability, to ensure ESR data accurately reflects our staffing population.

- Re-launch the mentoring / reverse mentoring scheme so that every member of BME staff has an identified coach or mentor (or has actively declined one)

- Ongoing and increased presence at community and employment events with a clear career proposition attractive to diverse staff seeking a career in healthcare.

- Focused pre-employment programmes and school mentoring programmes targeted at diverse groups in the local community.

- Delivery of the BAME Assembly Framework actions and the High Impact actions (this includes publication of gender and disability pay gap information in 2024)

b) Actions to support WRES indicators

- Delivery of the Anti-Racism Improvement Plan (Appendix B)

- Roll out 3 development opportunities for BME staff (the Elevate Leadership Programme, the Global Majority Equity Pilot, Mid-Career-Development programme) all of which will create a talent pool of individuals who can be supported into internal promotions at LWH.

- Launch the discrimination reporting tool and guarantee a review of issues within 72 hours of reporting.

c) Actions to support WDES indicators

- Continuing to promote positive increases in self-declaration, particularly in relation to disability, to ensure ESR data accurately reflects our staffing population.

- Reviewing recruitment practices to better support neuro-diverse candidates including circulation of questions in advance

- Process for obtaining reasonable adjustments has already changed with a subject matter expert in place to provide guidance to managers and a central ordering system for equipment requests.

5. RECOMMENDATIONS

The Committee is asked to note the contents of the report, be assured that appropriate actions are being taken, and support the ongoing work on the ED&I agenda.

This report is required to be approved by the Trust Committee as compliant and authorised for publication on the Trust website to fulfil the National requirements for WDES and WRES.

6. APPENDICES

Anti Racism Improvement Plan - Project Deliverables

Deliverable	Outline Specification	Owner	Commenced by
Commission cultural baseline survey	External partner to be commissioned to undertake the baseline cultural survey	Michelle Turner	June 2024
Identify expert partner to support the programme in its first phase	Secure the support of credible expert partner to work alongside us as a critical friend & test the throughout the first phase of the programme	Michelle Turner	June 2024
Establish Anti Racism Hub	Recruit to the anti racism hub through which the delivery and activities of the programme will be co-ordinated	Rachel London/Dianne Brown	May 2024
Establish Anti racism Clinical Reference Group	Identify medical lead for programme who will be responsible for establishing a clinical reference group to review actions which may change existing pathways or clinical practice	tbc	June 2024
Engage local community in our actively anti racist ambition	Commence three x a year Engagement/Listening Events on the actively anti racist work of the Trust and opportunity to improve, with the local community and key groups	Michelle Rushby	June 2024
Revitalise the GM Staff Network	To commission a trusted external partner eg Race Equity Hub to facilitate listening event(s) with GM workforce as a precursor to a relaunch of the Network	Rachel London	August 2024
Align actively anti racist programme to the Fair & Just Culture principles	To align the actively anti racist programme and zero tolerance commitment to the Trust's Fair & Just Culture principles	Michelle Turner	September 2024
Develop Communications, Engagement & Stakeholder Plan	To ensure that there is a compelling and consistent narrative, internally and externally, which describes the rationale for and the aims of the Programme; to include stakeholder identification and management	Andrew Duggan	June 2024
Actively Anti Racist toolkit	To develop an actively anti racist toolkit, commencing with conversational prompts to aid clinical staff in conversations with women and families who have anxieties or	Clinical Leads	August 2024

	concerns about perceived racism at LWH		
Analysis of access data to identify bias or barrier to services	To commence the analysis of access data through the anti-racism lens to identify subsequent actions to be taken through the programme to reduce, remove and address any bias or barrier to services for women from the GM	Gary Price	September 2024
To ensure that our services are provided in the most accessible way to women from the GM	To review our requirements for women to attend either the LW and Aintree site for appointments, and consider the potential for reducing the requirement to travel by increasing the offer of services in the community	Gary Price	July 2024
Executive Actively Anti Racism Team Coaching 6 x year	Continue Executive Team Coaching to further develop understanding and competence in the Actively Anti Racist space	Lisa Shoko	Ongoing - recommenced from April 2024
Leadership cohort to undertake Actively Anti Racism coaching	To commence, through the Senior Leadership Forum, all leaders completing Actively Anti Racist coaching sessions	Rachel London/Lisa Shoko	July 2024
All workforce to undertake face to face Inclusion & Anti Racism training	To ensure that 80% of workforce has completed face to face Inclusion & Anti Racism training within 12 months	Rachel London	March 2025
Develop & roll out EDI KPIs and dashboard (Board to Ward)	To develop and roll out meaningful Board to Ward KPIs for Diversity and Inclusion to form part of overall performance dashboard	Head of Inclusion/Deputy CIO	September 2024
Agree Board Directors personal EDI Objectives	All Board Directors to have a personal objective aligned to the furtherance of equality, diversity and inclusion in the Trust and the wider NHS system	Mark Grimshaw, Board Secretary	June 2024
Identify and address bias and potential for detriment in policies, processes and practice	To review key policies, processes and practice through an anti racism lens and where potential for bias, detriment or increased risk is identified, agree and implement action to address	Dianne/Rachel/clinical lead	November 2024
Positive Action in Recruitment	To review current recruitment practice and identify positive actions to remove barriers to employment @ LWH with particular focus on simplifying application processes, and interview to appointment stages	Rachel London/HRBP	November 2024

Widen Participation	Review current widening participation programmes and implement • Ringfenced space/opportunity on work experience for students from the L8 GM • Implement mentorship programme for L8 schools and community organisations (B7 and above staff to participate) • Work with DWP/LCR Race Equity Hub to grow GM representation on pre employment programme delivered in partnership at the Trust	Rachel London	October 2024 (Date in line with EDI Framework High Impact Actions)
Ensure racial trauma psychological support is available to staff	To pilot a racial trauma psychological support offer and evaluate to inform a future business case.	Emma Evans Lead Psychologist	September 2024
To take positive action to develop & advance our GM staff	Implement a targeted development programme or existing GM staff looking to progress into leadership roles To ensure participation in ELEVATE programme	Kathy Franey	July 2024
Achieve NHSE BAME Assembly Bronze accreditation	Ensure submission of robust evidence against the criteria required to attain Bronze accreditation (June 24) and to commence work to achieve Silver and Gold within the overall timescale of the programme	Lisa Shoko EDI lead	June 2024
Deliver NHSE EDI Framework High Impact Actions	To deliver the High Impact Actions required by the NHSE EDI Framework in accordance with the timescale set out in the report • Create and implement a talent management plan to improve the diversity of executive and senior leadership teams. • Implement Pay Gap Reporting for Race • Review Staff Survey data by protected characteristic on bullying, harassment and	Lisa Shoko EDI lead RL LS RL	Various timescales. Deadlines for 2024 actions below June 2024 December 2024 April 2024

	violence and set reduction targets. • Ensure safe and effective policies and processes are in place to support staff affected by domestic abuse and sexual violence. • Boards to review Freedom to Speak up Data by Protected Characteristic and take steps to ensure parity for all staff. • Implement the recommendations of 'Mend the Gap', gender pay gap in medicine, and develop a plan to implement recommendations for senior non-medical staff • Provide comprehensive psychological support for individuals who report that they have been a victim of bullying, harassment, discrimination, or violence.	HRBP F2SU lead RL Staff Support Service	June 2024 March 2024 June 2024 March 2024
Commence roll out of Actively Anti Racist Clinical Practice Education	To define and agree content, and commence the roll out of actively anti racist clinical practice education utilising the clinical members of the Actively Anti Racist Hub	Alison Murray	June 2024
Implement Cultural Adjustment in clinical practice	To define and implement cultural adjustment in clinical practice in women's healthcare @ LWH (including Culturally Adjusted Care Bundles)	Medical lead (tbc)	July 2024
Develop & publish 3 Year Anti Racism Plan	To develop and publish a 3 year Anti Racism Plan	Michelle Turner Chief People Officer	Commence July 2024 & publish Dec 2024
Establish Actively Anti Racist Lived Experience Panel	Through community and patient engagement, establish a panel of service users and community leaders to help shape the future programme , education, policy and practice	Michelle Rushby Head of Patient Experience	June 2024
Work with HEI partners to ensure midwifery workforce is more diverse and representative of the community	Working with LMNS and HEIs develop a plan to take positive action to diversity the midwifery workforce of the future	Yana Richens Director of Midwifery	September 2024

Implement a positive action to address an identified health inequality within each clinical service	Each clinical division to identify a key health inequality within their service and to agree and implement a positive action to address.	Divisional clinical lead (tbc)	July 2024

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Meeting Date	Thursday, 11 July 2024	**Item Reference**	24/25/089
Report Title	Sexual Safety Charter		
Author	Rachel London, Deputy Chief People Officer		
Responsible Director	Michelle Turner, Chief People Officer		

Purpose of Report	To inform the Board of actions in progress to comply with the requirements of the Sexual Safety Charter.
Executive Summary	Training and education, updating of policies and a clear reporting mechanism are all key actions in progress.
Key Areas of Concern	Training is being provided by LUHT and therefore we are working to their timescales which will be in late July 2024. National Policy and communications materials are awaited.
Trust Strategy and System Impact	*N/A*

Links to Board Assurance Framework	None	**n/a**
Links to Corporate Risk Register (scoring 10+)	None	**n/a**

Assurance Level	1. HIGH - Strong system of internal control applied to meet existing objectives

Action Required by the Board	The Board is asked to review the paper and support the recommendations to ensure compliance with the Sexual Safety Charter.

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Putting People First Committee	08.07.24	Rachel London	Noted and supported recommendations.

MAIN REPORT

INTRODUCTION

This paper outlines the requirements of the NHS Sexual Safety Charter and how LWH is responding to the actions required of charter signatories and progress against this plan.

On the 4th September 2023, NHS England wrote to all Trusts and Integrated Care Boards to announce the launch of the new NHS Sexual Safety Charter (see Appendix 1). In this letter organisations were asked to sign the charter and commit to implementing the following ten commitments by July 2024:

1. We will actively work to eradicate sexual harassment and abuse in the workplace.

2. We will promote a culture that fosters openness and transparency, and does not tolerate unwanted, harmful and/or inappropriate sexual behaviours.

3. We will take an intersectional approach to the sexual safety of our workforce, recognising certain groups will experience sexual harassment and abuse at a disproportionate rate.

4. We will provide appropriate support for those in our workforce who experience unwanted, inappropriate and/or harmful sexual behaviours.

5. We will clearly communicate standards of behaviour. This includes expected action for those who witness inappropriate, unwanted and/or harmful sexual behaviour.

6. We will ensure appropriate, specific, and clear policies are in place. They will include appropriate and timely action against alleged perpetrators.

7. We will ensure appropriate, specific, and clear training is in place.

8. We will ensure appropriate reporting mechanisms are in place for those experiencing these behaviours. Launch of the NHS Sexual Safety Charter Page 3 of 7

9. We will take all reports seriously and appropriate and timely action will be taken in all cases.

10. We will capture and share data on prevalence and staff experience transparently. These commitments will apply to everyone in our organisation equally and where any of the above is not already in place, the Trust must commit to working towards ensuring provision is in place to fulfil these commitments by July 2024

More than 270 organisations have already signed up to the Sexual Safety in Healthcare Charter launched by NHS England in September 2023, which commits to 10 key actions including taking a zero-tolerance approach to any unwanted, inappropriate or harmful sexual behaviours within the workplace.

There has been significant work in this area by Surviving in Scrubs who published the 'Surviving in Healthcare' report in 2023. The organisation was born from a 2021 report from the BMA which reported "*91% of women doctors had experienced sexism in the last 2 years and 47% felt they had been treated less favourably due to their gender'.*

National findings from the NHS Staff Survey and National Education and Training Survey (NETS) revealed that 58,000 staff reported unwarranted sexual approaches from patients or other members of the public last year – that's 1 in every 12 NHS workers. 1 in 26 reported experiencing similar harassment from work colleagues.

ANALYSIS

For the first time, Trusts received important intelligence in early 2024 in relation to sexual safety, via the NETS and national Staff Survey reports.

The National Education and Training Survey (NETS) an annual survey sent to all learners in all professional groups at LWH was undertaken in November 2023.

As part of this year's survey, learners were asked two questions regarding their experiences during their placement/ training posts: 1. Have you experienced unwanted, harmful, and/or inappropriate sexual behaviours during your placement/training post? 2. Have you witnessed unwanted, harmful, and/or inappropriate sexual behaviours during your placement/training post?

Out of 62 respondents overall, **one** O&G trainee answered yes to question (1). This had not been reported to the Division / Clinical Supervisor / Director of Medical Education.

The 2023 national NHS Staff Survey contained a question on sexual safety for the first time.

The questions below indicate that:

- 11 staff have experienced unwanted conduct of a sexual nature from patients.
- 17 staff have experienced unwanted conduct of a sexual nature from staff.

There have been no reported incidents in the last 12 months via safeguarding relating to unwanted behaviour from patients, and one reported case to HR relating to a staff member therefore indicating an issue with reporting.

In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace from patients/ public.

Your org	1.29%
Best result	1.29%
Average result	4.90%
Worst result	9.04%
Responses	904

In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace from staff / colleagues.

Your org	1.91%
Best result	1.47%
Average result	3.71%
Worst result	6.97%
Responses	899

In respect of developing the Action Plan, Safeguarding and HR leads have worked closely together to ensure the requirements of the plan are adhered to. We are awaiting a national policy and communications materials which will support our 'launch' throughout July / August/ September where members of the HR and safeguarding teams will provide training to key managers across the Trust.

Detailed actions can be viewed in Appendix A.

CONCLUSION

The organisation is committed to creating a culture of inclusion and is confident that the requirements of the sexual safety charter will be in place no later than September 2024.

Equality, Diversity & Inclusion Implications – DO NOT DELETE [state N/A if necessary)

Whilst unwanted behaviour of a sexual nature can affect both sexes, it is recognised by the reports referenced in this paper, that women are more usually the target. It is also recognised that female medical trainees are particularly vulnerable and particular support is being instigated in this area.

Quality, Financial or Workforce implications - DO NOT DELETE [state N/A if necessary)

NA

RECOMMENDATION

The Board is asked to review the paper and support the recommendations to ensure compliance with the Sexual Safety Charter.

SUPPORTING DOCUMENTS

A) Domestic Abuse and Sexual Violence Charter Implementation Action Plan

Action Required	Lead	Timeframe for completion	Update	RAG
Sign Sexual Safety at Work Charter	Rachel London	1/4/24		
Develop Sexual Safety at work policy / SOP	Rachel London	TBC	Awaiting national policy	
Generic statement to be added to all trust JD's to reference the DASV charter	Rachel London	01/07/2024		
HR policies to be reviewed and updated to reflect Sexual Safety approach in relation to staff conduct and managing allegations against staff	Rachel Reave / Rachel London	1/8/2024	Resolution policy Disciplinary policy EDI Policy	
Domestic abuse policy to be reviewed and updated to reflect sexual violence and domestic abuse charter	Deborah Ward / Maria Clegg	1/7/2024	Change name to sexual violence and domestic abuse	
Staff handbook to be reviewed and updated to reflect the sexual violence and domestic abuse charter	Rachel London	1/8/2024	Updating document – will include reference to charter	
Chaperone policy to be updated to include how the Trust will manage, document and respond to allegations from children, young people and adults regarding abuse, sexual harassment and sexual abuse	Deborah Ward / Clare Jones	30/06/2024	Link in with Sue Roberts to include reference to the managing allegations policy	
Staff trust wide communications to be developed to advise staff of avenues to report within the Trust. Trust Intranet page to be developed to inform staff about the domestic abuse and sexual violence charter	Rachel London / Andrew Duggan	01/06/2024	Intranet page in development	
Develop online form to report sexual harassment	Rachel London	1/7/24	Form completed and circulated to stakeholders for comment, ready for intranet	
Develop Comms plan and dedicated area on intranet	Andrew Duggan	30/06/2024	In progress	
Establish central recording and data collection system for	Rachel	1/7/2024	In discussion	

reported incidents against patients and staff.	London / Deborah Ward			
Review staff responses to sexual safety questions within the 2023 NHS staff survey	Rachel London	01/06/2024	Response reviewed. 1% lowest benchmark and Trust reported 1% for patients / 2% staff. Action no tolerance but want to ensure safe reporting culture.	
Ensure domestic abuse and sexual violence charter is incorporated into appropriate training - Junior Doctors Induction - Trust Induction	Rachel London	01/07/2024	Induction slides updated, booked onto Junior doctors induction for August	
Legal update for senior leader forum	Rachel London	June 24	Took place 3.6.24	
Develop training session in conjunction with LUHT	Rachel London / Deborah Ward	June/July 24	LUHT developed training with RASA and will do train the trainer for HR and safeguarding team in July 24	
Deliver training to key clinical and divisional meetings	Rachel London / Deborah Ward	July / August 24	Divisions contacted, training plan in development	
Add information into safeguarding ward packs / safeguarding boards	Deborah Ward / Jodie Hollywood	1/6/24	…	

Liverpool Women's NHS Foundation Trust

Board of Directors

COVER SHEET

Meeting Date	Thursday, 11 July 2024	**Item Reference**	24/25/090
Report Title	Women's Health Taskforce and Strategy Development		
Author	Dr Emer Coffey Associate Director of Public health Liverpool. Dianne Brown Chief Nurse Liverpool Women's NHS FT		
Responsible Director	Dianne Brown Chief Nurse		

Purpose of Report	The purpose of this report is to brief Board Members on the planned development of a system-wide Liverpool Women's Health Strategy to improve health outcomes for women and girls, as recommended in the 'Health 2040' report from Liverpool's Director of Public Health.
Executive Summary	The report sets out the proposed strategic response to the recent 'State of Health in the City: Liverpool 2040' report, which outlined stark predications in terms of outcomes for women health over the projected period (2040). These include: • By 2040 we will see a further fall in women's life expectancy, by one year. • By 2040 we will see a fall in women's healthy life expectancy – by four years. • Both life expectancy and healthy life expectancy remain strongly linked to deprivation. • Women are projected to live 53.8 years in good health, compared to 60.1 years for men by the time we reach 2040. Following the mandate of the 'State of Health in the City: Liverpool 2040' report and informed by the national Women's Health Strategy, we propose to develop a system-wide Women's Health Strategy for Liverpool. The local strategy will be broader in scope than the national strategy and will be developed by a local taskforce working in collaboration with several key partners across public health, education, social care and academia. The Board is recommended to support the development of the Liverpool Women's Health Strategy, including: • Active membership of the Women's Health Taskforce. • Contribution of data, experience, expertise, ideas, and relationships as appropriate to the Needs Assessment, Engagement work and Stakeholder Workshops. • Ownership of relevant actions as deemed appropriate once agreed in the Strategy and Plan.
Key Areas of Concern	N/A
Trust Strategy and System Impact	The proposed approach will support the key priorities defined within the Cheshire and Merseyside ICB Health and Care Partnership Strategy and aligns to their four strategic key objectives as defined below. 1. Improve population health and healthcare.

	2. Tackle health inequality, improving outcomes and access to services. 3. Enhancing quality, productivity, and value for money 4. Helping the NHS to support broader social and economic development. The development of this strategy will also support and inform the vison for women's services across the city as described within the Carnell Farrah review.

Links to Board Assurance Framework	BAF Risk 7 If the Trust does not actively address health inequalities and support the anti-racism agenda, it risks perpetuating disparities in healthcare access and outcomes.	***Risk score 10***
Links to Corporate Risk Register (scoring 10+)	*N/A*	

Assurance Level	1. MODERATE - Adequate system of internal control applied to meet existing objectives

Action Required by the Board	The Board is recommended to support the development of the Liverpool Women's Health Strategy, including: • Active membership of the Women's Health Taskforce. • Contribution of data, experience, expertise, ideas, and relationships as appropriate to the Needs, Assessment, Engagement work and Stakeholder Workshops. • Ownership of relevant actions as deemed appropriate once agreed in the Strategy and Plan.

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Executive Team Meeting	**03/07/2024**	**Chief Nurse**	**Approved for Board consideration**

MAIN REPORT

INTRODUCTION

The intention of this paper is to brief Board Members on the planned development of a system wide Liverpool Women's Health Strategy to improve health outcomes for women and girls, as recommended in the 'Health 2040' report from Liverpool's Director of Public Health (DPH), Professor Matt Ashton, and as discussed at a Special Council meeting on 17th January 2024.
The paper outlines the proposed next steps in relation to the development of the first Joint Strategic Needs assessment for women's health in the city and the development of a specific Liverpool Women's Health strategy.

Background

The recent 'State of Health in the City: Liverpool 2040' report outlines how health in the city has evolved since 1984, describes the current state of health in 2024 and, for the first time, projects to 2040 to give a picture of future health and wellbeing based on current trends.

The report presents some stark findings for all residents across the city. However, it also details the significant challenges faced by women, and the poor outcomes many experiences. The 2040 report is our clear mandate for change, and for levering system action around a range of issues, including improving women's health outcomes:

- By 2040 we will see a further fall in women's life expectancy, by one year.
- By 2040 we will see a fall in women's healthy life expectancy – by four years.
- Both life expectancy and healthy life expectancy remain strongly linked to deprivation.
- Women are projected to live 53.8 years in good health, compared to 60.1 years for men by the time we reach 2040.

The reasons behind the decline in healthy life expectancy for women are highly complex and are not specific to Liverpool. Poverty/income and deprivation play a significant role in poorer health outcomes. Liverpool is the third most deprived local authority in England and the 'Health 2040' report illustrates how this influences the health of our city. Nationally we know women's health is disproportionately influenced by poverty. Women are more likely to live in poverty and be in insecure employment than men and are more likely to have caring responsibilities and prioritise resource towards their families, going without themselves[1]. The socio-economic environments in which we live influence health-related behaviours and create inequalities.

Our local data shows us that women are more likely than men to have major illness and develop this at an earlier age. The Global Burden of Disease Study 2019[1] estimates the leading risk factors for poor health for women aged 50-69 years in Liverpool were smoking, diet, malnutrition, low physical activity, and obesity. Uptake of cervical and breast cancer screening in Liverpool are also low, for example less than 2/3 (64.5%) of eligible women aged 25-49 take up cervical screening, with inequalities across the city. Our local data projects that double the number of adults in the city will be experiencing depression by 2040. Pre- and post-pandemic data show that women experience worse mental health and wellbeing than men and deterioration in mental health during the pandemic was greater for women than men.

[1] https://vizhub.healthdata.org/gbd-compare/

These data provide a small snapshot of the inequalities experienced by women in our city. They are a call to action for us to understand the drivers of these inequalities and to address them.

National Policy Context

The new Women's Health Strategy for England was launched in July 2022, and sets out 10-year ambitions for boosting the health and wellbeing of women and girls, and for improving how the health and care system listens to women. The strategy takes a life course preventative approach to improving access and care for women and reducing inequalities amongst women, and prioritising listening to women's voices.

Initial national priorities for Year 1 and into Year 2 are:

- Encouraging the expansion of women's health hubs
- Improving access to contraception, including post-birth contraception
- Improving information provision on women's health, including improvements to the NHS website
- Supporting women's health in the workplace
- Pregnancy loss, including the development of a pregnancy loss certificate.
- Fertility, including improving access to NHS fertility treatment for female same sex couples.
- Improving access to hormone replacement treatment (HRT) via the HRT prescription pre
- prepayment certificate in April and boosting HRT supply.
- Healthy ageing and long-term conditions
- Boosting research and evidence into women's health, and improving women's participation in all
- research

Proposed Approach to the Women's Health Strategy

Following the mandate of the 'State of Health in the City: Liverpool 2040' report and informed by the national Women's Health Strategy, we propose to develop a system-wide Women's Health Strategy for Liverpool. The local strategy will be broader in scope than the national strategy.

The ambition of a healthier, happier, fairer Liverpool for all is set out in the One Liverpool Plan (2019-2024), and the Council Plan (2023-27) focussing not just on access to health and care services, but also the social determinants of health such as housing and employment. Development of the Liverpool Women's Health strategy will facilitate a focus on improving health outcomes for women and girls across the strategies and work of the whole system.

The local strategy development will be guided by core principles as follows:

- Ensure women's voices are heard in the strategy development.
- Focus on reducing inequalities.
- Consider the wider determinants of health – the root cause of poor health.
- Take a life course approach to prevention.
- Consider assets as well as needs.
- Strengthen the application of a women's health lens to all work in the city - ensuring women's' voices are heard in policy and service design.

We use the term 'women's health' to refer to opportunities, enablers, risks, and conditions differently or disproportionately affecting women and girls. We recognise that these factors and associated services may also affect and serve men, boys, people who are gender diverse, non-binary, with variations in sex

characteristics (VSC) or who are intersex. We are committed to ensuring that our approach is inclusive, considering the needs of all.

Strategy development will be led by a multi-agency Liverpool Women's Health Taskforce, chaired by Dr Emer Coffey, Associate Director of Public Health, Liverpool City Council, on behalf of the DPH, with representation from Liverpool City Council, Cheshire, and Merseyside Integrated Care Board (ICB) - Liverpool Place, Liverpool University Hospitals NHS Foundation Trust, Liverpool Women's Hospital, Alder Hey Children's Hospital, Mersey Care and Liverpool Community and Voluntary Sector. Engagement with wider stakeholders will be through a series of workshops, and insight and engagement exercises with women.

The Taskforce will report to the Health & Wellbeing Board in Liverpool, which will have oversight of the system response to the 'Health 2040' report.
To support whole system engagement and ownership, strategy development updates will also be provided to partner boards through taskforce members.

Our ambition is to launch the Liverpool Women's Health Strategy in May 2025, following the outline timetable below.

Element	Deadline
Establish Strategy Steering Group/Taskforce	June 24
Rapid Needs Assessment	June – Sep 24
Behavioural Insight & Engagement Exercises	Plan July, to Aug-Oct 24
Stakeholder Workshops	Oct 24 – Feb 25
Final document approved	Mar – Apr 25
Launch	May 2025
Implementation	2025-2030

Equality, Diversity & Inclusion Implications – DO NOT DELETE [state N/A if necessary)

It is anticipated that the development of the JSNA and future strategy for women and girls in Liverpool will drive improvements in outcomes related to health inequalities. The identification of key priorities based on population need will drive through risk-based strategies that align a systems and life course approach as defined within the National Women's Health Strategy for England

Quality, Financial or Workforce implications - DO NOT DELETE [state N/A if necessary)

There are no funding requests or specific considerations framed as part of this initial commitment. Following Strategy development, specific elements of action plan delivery may have financial implications, but a costed ask with clear business case will be developed and considered by the appropriate organisation(s) at the relevant time in the delivery phase.

RECOMMENDATION

The Board is recommended to support the development of the Liverpool Women's Health Strategy, including:

- Active membership of the Women's Health Taskforce.
- Contribution of data, experience, expertise, ideas, and relationships as appropriate to the Needs Assessment, Engagement work and Stakeholder Workshops.
- Ownership of relevant actions as deemed appropriate once agreed in the Strategy and Plan.

SUPPORTING DOCUMENTS

Women's Health Strategy for England – https://assets.publishing.service.gov.uk/media/6308e552e90e0729e63d39cb/Womens-Health-Strategy-England-web-accessible.pdf

Alder Hey Children's NHS Foundation Trust

Liverpool Women's NHS Foundation Trust

Board of Directors

COVER SHEET

Meeting Date	Thursday, 11 July 2024	**Item Reference**	24/25/091
Report Title	LUHFT/LWH/Alder Hey Partnership Update		
Author	Chief Executive of Alder Hey Chief Executive of Liverpool Women's		
Responsible Director	Chief Executive of Alder Hey Chief Executive of Liverpool Women's		

Purpose of Report	The purpose of this paper is to provide a briefing as to progress made to date and to set out the direction of travel for the partnership between Alder Hey/LUHFT/LWH.
Executive Summary	It was agreed between the CEOs and Chairs of the organisations that there was an important partnership agenda that should be pursued and reinvigorated. The key areas of collaboration that needed focused attention were; • The Liverpool Neonatal Partnership. • Women's hospital services in Liverpool Programme. • Community Services and the Integration of PLACE agenda (*with Mersey Care*). • Opportunities for shared Research and Innovation.
Key Areas of Concern	N/A
Trust Strategy and System Impact	Aligned with Trust Strategy and Triple Aim.

Links to Board Assurance Framework	BAF Risk 7 If the Trust does not actively address health inequalities and support the anti-racism agenda, it risks perpetuating disparities in healthcare access and outcomes.	***Risk score 10***
Links to Corporate Risk Register (scoring 10+)	*N/A*	

Assurance Level	1. MODERATE - Adequate system of internal control applied to meet existing objectives

Action Required by the Board	The Board is asked to approve the next steps as outlined in the report.

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
AHCH Board	04/07/2024	Chief Executive	To be noted at the meeting.

MAIN REPORT

1. Current position

Liverpool Neonatal Partnership

The CEOs and Chief Medical Officer met in mid-June to agree the process by which we would review the Liverpool Neonatal Partnership progress and begin to create a clearer strategic direction for this partnership. There are four workstreams where work has been refreshed over the last 6 months and the output of this will be presented to a meeting of the two Executive Teams in mid-July. A programme director currently working with Alder Hey and with experience of national work in this area is going to present a potential strategic direction for the LNP to both Exec teams in this same meeting. From there a plan will be developed to move to a much more integrated single service approach.

Women's hospital services in Liverpool Programme

A clinical workshop was held in May with representation from Liverpool Women's, Alder Hey, Clatterbridge Cancer Centre and LUHFT to test and develop the final case for change for the above programme.

The case for change has been approved by the respective boards at Alder Hey, Liverpool Women's and LUHFT with some suggested improvements..

The case for change will next be presented to the NHSE Stage one assurance process at which both CEOs for Alder Hey and LUHFT/LWH will be present.

Community Services and Integration of PLACE

LUHFT and Mersey Care have been working through a partnership board to align their strategy on Integrated Care in the local community. LUHFTs new strategy focuses on the need for a future integrated care partnership which Alder Hey, Mersey Care and LUHFT/LWH must try and align on. The three CEOs are meeting with the Value Circle (already engaged by LUHFT/MC) to try and understand the priorities for re-organising the local community services landscape. The key objectives of this are:

Trying to understand the current service offering in Community which has been fragmented due to pre and post Covid commissioning arrangements, procurement being targeted on individual organisations rather than partnerships and the post Covid financial regime of separate innovation pots e.g. Community Diagnostic Centres. We are still operating in a model where women's health hubs are being proposed without clarity on how children fit into the model.

It is proposed that the four organisations now map all of the community facing provision, sense check the current configurations and then collaborate on how we can integrate provision to create a better offer for our diverse community.

The first meeting of the CEOs will be in July to begin this mapping exercise and start to create a vision for what a partnership could look like in the future.

2. Summary

- There has been progress in several areas since the Chairs & CEOs met at the start of the year to begin to shape our partnership agenda.
- Joint work on the Women's case for change has led to multi-organisational agreement on the key issues and a clearer rationale supported by data than previously experienced.

- We agree that the LNP needs to be stronger and centred around a single service with a strategy based on excellence in partnership working. There is agreement between the two organisations on how to take this forward and an independent resource in place to support the work.
- We have reached an agreement that the four organisations (AH, LWH, LUHFT, MC) need to now create a strong partnership that can prevent isolated procurement and different commissioning strategies create fragmentation of community services and will now explore how we can formulate a partnership to deliver better family focused services together.

3. Next Steps

It is envisaged that there will be sufficient progress in our joint agenda to meet as two Boards in September and receive updates on these items outlined and also discuss the future shape of our joint governance to oversee this work.

Louise Shepherd CBE
Chief Executive Alder Hey

James Sumner
Chief Executive LUHFT/LWH

28th June 2024

Equality, Diversity & Inclusion Implications
N/A

Quality, Financial or Workforce implications
N/A

RECOMMENDATION

The Board is asked to approve the next steps as outlined in the report.

SUPPORTING DOCUMENTS

None.

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Meeting Date	Thursday, 11 July 2024	**Item Reference**	24/25/092
Report Title	Committee Chair's Reports		
Author	Mark Grimshaw, Trust Secretary		
Responsible Director	Mark Grimshaw, Trust Secretary		

Purpose of Report	This report highlights key matters, issues, and risks discussed at Committees since the last report in May 2024
Executive Summary	The Chair reports for the following Board committees are included in this report and attached at Appendix 1. Charitable Funds Committee • 8 June 2024 – Chaired by Zia Chaudhry MBE The Board is asked to approve the Terms of Reference and Workplan for this Committee. Quality Committee • 25 June 2024 – Chaired by Jackie Bird MBE Finance Performance & Business Development Committee • 26 June 2024 – Chaired by Louise Martin
Key Areas of Concern	N/A
Trust Strategy and System Impact	*N/A*

Links to Board Assurance Framework	None	**n/a**
Links to Corporate Risk Register (scoring 10+)	None	**n/a**

Assurance Level	1. SUBSTANTIAL - Good system of internal control applied to meet existing objectives

Action Required by the Board	The Board of Directors is asked to - • note the Committee Chair's Reports. • Approve the Charitable Funds Committee Terms of Reference and 2024/25 workplan

REPORT DEVELOPMENT:

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

MAIN REPORT

Charitable Funds Committee Assurance report

Report to	Trust Board
Date	11 July 2024
Meeting Name	Charitable Funds Committee
Date of Meeting	08 June 2024
Chair's Name & Title	Zia Chaudhry, Non-Executive Director

Agenda Items

The following agenda items were discussed by the meeting:

1. Mona Lisa Laser Application
2. Investment Position Update
3. Annual Review of Investments
4. Charity and Finance Integrated Report
5. Committee Effectiveness Review and Terms of Reference

Matters for Escalation

No matters highlighted for escalation.

Key Issues

Mona Lisa Laser Application
Received an application to purchase a Mona Lisa Laser and associated equipment to enable the Trust to provide an advanced medical technology aimed at providing treatment for women with urogenital atrophy and Lichen sclerosis et atrophicus (LSA). The investment would facilitate the establishment of a comprehensive research trial, as well as self-funded provision within Liverpool Women's Hospital, with a view to developing an NHS-commissioned service in the future. The Committee noted the business case process undertaken which included divisional and executive approval, Business Case Review Panel and Research and Development review and approval. It was noted that appropriate governance processes had been completed and that the investment would not have any ongoing revenue consequences for the Trust. The Committee approved the expenditure of £50k in line with SFI's.

The Committee reiterated concerns in relation to the significant length of time between fund raising and application approval and the potential implication of not spending funds on designated fundraising campaigns in a timely manner. The Committee was assured that lessons had been learnt and noted a revised process in place that ensured appropriate governance procedures were adhered to ahead of initiating any future fundraising campaigns.

Investment Position Update
Received a presentation update on investment performance from the Investment Director, Rathbones. No changes to the investment mandate was recommended and a diversified portfolio with good exposure to 'real' assets had been maintained. Investments continued to adhere to ethical restrictions, excluding investments in tobacco, armaments, and oil and gas stocks. The income yield was at 2.4% as at June 2024.

Annual Review of Investments
The Committee received an annual review of the charity investment arrangements. The Committee noted that the Charity continued to invest funds with Investec Wealth and Investment UK (part of Rathbones Group Plc) and remained satisfied with the level of performance. The Charity adopts a medium risk approach to the investment portfolio, balancing the need to be prudent in terms of handling charitable funds against the need to maximise investment income for the benefit of patients and staff under the objects of the Charity. The Committee noted the regular updates received during the year from the investment management experts providing intelligence on investment performance and market/global trends.

Charity and Finance Integrated Report
Received the Charity and Finance Integrated report which included the financial summary for 2023/24 and charity activity undertaken during January to May 2024. The draft Charity Annual Report and Accounts would be presented to the next Committee meeting. Significant fundraising activity undertaken and continued focus on developing corporate engagement was noted.

Committee Effectiveness Review and Terms of Reference
The Committee received and approved the Committee Annual Report, Business Cycle for 2024/25 and its Terms of Reference. See Appendix 2 for Board approval.

Decisions Made

- Approved the Mona Lisa Laser Application for charitable funds.
- Approved the Committee workplan 2024/25 and terms of reference.

Recommendations

The Board is asked to:

- note the contents of this report and the decisions taken by the Charitable Funds Committee
- Approve the Committee Terms of Reference and Workplan 2024/25, and note the Committee Effectiveness review (Appendix 2).

Appendix 1: Attendance Matrix

Core member	Job Title	17 June 2024	21 Oct 2024	20 Jan 2025	% Attendance
Zia Chaudhry	CHAIR Non-Executive	✓			
Louise Martin	Non-Executive	✓			
Jackie Bird	Non-Executive	✓			
Jenny Hannon	Chief Finance Officer	✓			
Matt Connor	Chief Information Officer	✓			
Dianne Brown	Chief Nurse	✓			
Claire Deegan	Head of Financial Services	✓			
Kate Davis	Head of Fundraising	✓			

Appendix 2: Committee Effectiveness report; Terms of Reference; and Workplan 2024/25

Charitable Funds Committee

Annual Report 2023/24

Background

This report covers the period April 2023 to March 2024. There were three meetings held during this period. The May 2023 Committee was cancelled due to significant constraints on the financial team during that time period. Subsequently only three of the four planned meetings took place.

The Committee has been established to exercise the Foundation Trust's functions as sole corporate trustee of the Liverpool Women's Charity (registered charity number 1048294). The Trust Board is regarded as having responsibility for exercising the functions of the Trustee. The Trust Board delegates these functions to the Committee, within any limits set out in these terms of reference and the sections of the standing financial instructions pertaining to charitable funds.

In discharging these duties, the Committee is responsible for:

Compliance

a. Manage the affairs of the Liverpool Women's Charity in accordance with appropriate legislation and ensure statutory compliance with the Charity Commission regulations.
b. Ensure systems and processes are in place to receive, account for, deploy and invest charitable funds in accordance with charity law.
c. Scrutinise requests for use of charitable funds to ensure that any such use is in accordance with the aims and purposes of any charitable fund or donation and are clinically and ethically appropriate. Committee members will bear in mind due diligence to Charity Commission and Trust guidance regarding the ethical use of funds and acceptance of donations.

Budget, Income & Expenditure

d. Review and approve an Annual Business plan and budget
e. Receive and approve periodic income and expenditure statements, ensuring that performance is in line with the Charity's budget and plan.
f. Receive and consider the Annual Accounts including the Annual Report from the auditors, before submission to the Board of Directors for approval.

Fundraising

g. Ensure a fundraising strategy is prepared and monitored which complies with Charity Commission guidance and legislation and which includes appropriate communication and marketing plans;

h. ensure systems and processes are in place to receive, account for, deploy and invest funds raised in accordance with charity law;
i. ensure systems, processes and communication are in place around fundraising, staff engagement and funding commitments;
j. ensure a cohesive policy around external media and communication;
k. encourage a culture of fundraising and raise the profile of the Charity within the Trust and with external partner organisations
l. ensure effective communication regarding 'whistleblowing' relating to fundraising, donations or subsequent use of funds.

Investment Management
m. Consider and agree an investment strategy for the safe and secure investment of funds not immediately required for use, taking into account any appropriate ethical considerations.
n. Appoint and review external investment advisors and operational fund managers.
o. Review the performance of investments on a regular basis (utilising comparator information) with the external investment advisors to ensure the optimum return from surplus funds.

This remit is achieved through the Committee being appropriately constituted and complying with the duties delegated by the Board of Directors through its terms of reference.

Constitution

The Charitable Funds Committee is accountable to the Board of Directors. Membership during the year comprised:

- Non-executive Director Chair
- Two other Non-executive Directors
- Chief Finance Officer (or nominated deputy)
- Chief Nurse
- Financial Accountant
- Head of Fundraising
- Chief Information Officer

Meetings were also attended by other executives and senior management staff as appropriate.

The Committee's constitution allows for members to participate by two-way audio link on occasion where appropriate which is deemed to constitute presence in person per the Committee's Terms of Reference. Meetings were held on a hybrid basis throughout 2023/24.

The Terms of Reference requires that all members of the committee attend a minimum of 75% of the meetings held. The table at appendix A lists the names of the members of the Committee and the meetings they attended during 2023/24 together with the names of senior management who were invited to attend during the year. The majority of members attended 75% or more of the meetings.

Key achievements / activity

The key items discussed and reviewed by the Committee during 2023/24 were as follows:

- Regular investment updates have been received from the Charity's Fund Manager.
- Ethical implications of investments made on behalf of the Charity considered.
- Regular reports have been received on the financial performance of the charity and fundraising activity.
- The Committee noted and approved the appointment of Dame Lorna Muirhead as Patron of the Charity.
- Committee received a Costs and Assumptions Review noting a new process to receive, approve and monitor fundraising projects and related expenditure. The process would ensure full engagement of divisions/departments throughout the project and would ensure that all required information was known ahead of submitting expenditure applications to the Committee.
- The Committee received the Annual Benchmarking Review of Financial Services Support Costs and agreed that the amount recharged to the Charity for financial service support was reasonable.
- Supportive of the plan to develop a legacy strategy
- The Committee provided oversight of the Charity Strategy 2023/27. The lack of an approved Strategy for the majority of the year was identified and the Committee strived to ensure completion within 2023/24.
- Assured by the introduction of an Operational Plan 2024/25 to support delivery of the Charity Strategy objectives.
- Review of the Charitable Funds Annual Report and Accounts and recommendation for approval by the Trust Board.
- Review of fundraising team expenditure received

The Committee had difficulties to approve formal applications received during 2023/24 due to insufficient detail provided to allow for thorough deliberation and consideration. The Committee was supportive of a revised process to receive, approve and monitor fundraising projects and related expenditure to ensure full engagement of divisions/departments throughout the project and ensure that all required information was known ahead of submitting expenditure applications to the Committee.

Chair Log
The Committee had utilised the Chairs Log during 2023/24 and received one chair action from the Trust Board and delegated one chair action to the Trust Board/Committees during 2023/24 to seek additional assurances.

Proposed Amendments to the Terms of Reference

The Committee last reviewed its Terms of Reference in June 2023 and were approved by the Board in July 2023.

No amendments to the terms of reference are suggested. The Board reviewed the draft terms of reference in March 2024 as part of the Governance and Assurance review.

The draft Terms of Reference is included at Appendix b.

Proposed Amendments to the Committee Business Cycle

Each of the Committees established by the Board of Directors has an annual business cycle which is subject to review each year. The business cycle forms the 'core' agenda for Committee meetings throughout the year with scheduled business ensuring that the Committee discharges its responsibilities as set out in the Terms of Reference.

The Charitable Funds Committee last reviewed its annual business cycle in June 2023 and is therefore scheduled to complete a further review in order to set the business cycle for 2024/25.

Based on matters of business taken during 2023/24 it is recommended that the Committee reduce its meeting frequency to three times a year. Any applications requiring approval can be undertaken by the Committee out with of a formal Committee meeting.

There are currently no recommended changes to the business cycle for 2024/25, however the addition of the Annual Operational Plan should be noted, which was newly introduced to the workplan in January 2024.

The draft Business Cycle is included at Appendix c.

Conclusion

In the final analysis, it is concluded that the Charitable Funds Committee has achieved its objectives for the Financial Year 2023/24.

Zia Chaudhry CHAIR
Charitable Funds Committee
June 2024

Appendix A

Charitable Funds Committee, Attendance at Committee: April 2023 – March 2024

Committee Member	Job Title	**15 May 2023**	**22 June 2023**	**23 Nov 2023**	**22 Jan 2024**	**% Attendance**
Zia Chaudhry	CHAIR Non-Executive		✓	✓	✓	100
Louise Martin	Non-Executive		✓	✓	✓	100
Jackie Bird	Non-Executive		A	✓	✓	75
Jenny Hannon	Chief Finance Officer		A	✓	✓	75
Matt Connor	Chief Information Officer		A	✓	A	30
Jen Huyton	(Or CFO Nominated Deputy for quorum)		✓	✓	✓	
Dianne Brown	Chief Nurse		✓	A	✓	75
Claire Deegan	Head of Financial Services		✓	✓	✓	100
Kate Davis	Head of Fundraising		✓	✓	✓	100
Invited Attendees						
Mark Grimshaw	Trust Secretary		✓	✓		
Andrew Maxwell	Investment Director, Investec		✓	✓	✓	
Josh Ingham	Financial Accountant		✓	A	✓	
Nasha Ellahi	Deputy Chief Nurse			✓		
Orlagh McGrattan	Fundraising Admin Assistant			✓	✓	
Loren Slade	Fundraising Manager			✓	✓	

CHARITABLE FUNDS COMMITTEE (Appendix B)

TERMS OF REFERENCE (DRAFT)

Authority/Constitution

1. The Committee has been established to exercise the Foundation Trust's functions as sole corporate trustee of the Liverpool Women's Charity (registered charity number 1048294).

2. The Trust Board is regarded as having responsibility for exercising the functions of the Trustee. The Trust Board delegates these functions to the Committee, within any limits set out in these terms of reference and the sections of the standing financial instructions pertaining to charitable funds.

Purpose

3. The Committee's primary purpose is to:

    - Oversee the management and monitoring of the charitable funds held by the Trust on behalf of the Charity.
    - Provide assurance to the Board that the administration of the Charity is conducted in accordance with:
        - Applicable legislation, including the Charity Commission Act 2011, the Trustee Act 2000, and any relevant NHS regulations.
        - The Charity's governing document.
        - Principles of good governance and financial management.
    - Support the achievement of the Charity's objectives, as outlined in its governing document, to enhance patient care and services provided by the Trust.

Duties

4. The Committee's responsibilities fall broadly into the following areas:

5. **Compliance**
    a) Manage the affairs of the Liverpool Women's Charity in accordance with appropriate legislation and ensure statutory compliance with the Charity Commission regulations.
    b) Ensure systems and processes are in place to receive, account for, deploy and invest charitable funds in accordance with charity law.
    c) Scrutinise requests for use of charitable funds to ensure that any such use is in accordance with the aims and purposes of any charitable fund or donation and are clinically and ethically appropriate. Committee members will bear in mind due diligence to Charity Commission and Trust guidance regarding the ethical use of funds and acceptance of donations.

6. **Budget, Income & Expenditure**
   d) Review and approve an Annual Business plan and budget
   e) Receive and approve periodic income and expenditure statements, ensuring that performance is in line with the Charity's budget and plan.
   f) Receive and consider the Annual Accounts including the Annual Report from the auditors, before submission to the Board of Directors for approval.

7. **Fundraising**
   g) Ensure a fundraising strategy is prepared and monitored which complies with Charity Commission guidance and legislation and which includes appropriate communication and marketing plans;
   h) ensure systems and processes are in place to receive, account for, deploy and invest funds raised in accordance with charity law;
   i) ensure systems, processes and communication are in place around fundraising, staff engagement and funding commitments;
   j) ensure a cohesive policy around external media and communication;
   k) encourage a culture of fundraising and raise the profile of the Charity within the Trust and with external partner organisations
   l) ensure effective communication regarding 'whistleblowing' relating to fundraising, donations or subsequent use of funds.

8. **Investment Management**
   m) Consider and agree an investment strategy for the safe and secure investment of funds not immediately required for use, taking into account any appropriate ethical considerations.
   n) Appoint and review external investment advisors and operational fund managers.
   o) Review the performance of investments on a regular basis (utilising comparator information) with the external investment advisors to ensure the optimum return from surplus funds.

Membership

9. The Committee membership will be appointed by the Board of Directors and will consist of:
   - Non-Executive Director (Chair)
   - Two additional Non-Executive Directors
   - Chief Finance Officer (or nominated deputy)
   - Chief Nurse
   - Head of Financial Services
   - Head of Fundraising
   - Chief Information Officer

10. Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum.

11. The Board of Directors will appoint a Non-Executive Director as Chair of the Committee. Should the Chair be absent from a meeting of the Committee, the Committee may appoint a Chair of the meeting from amongst the Non-Executive Directors present.

12. A quorum shall be three members including two Non-Executive Directors and one Executive Director. The Chair of the Trust may be included in the quorum if present.

13. **Voting**

14. Each member will have one vote with the Chair having a second and casting vote, if required. Should a vote be necessary a decision will be determined by a simple majority.

Requirements of Membership

15. Members

16. Members will be required to attend a minimum of 75% of all meetings.

17. Officers

18. The Committee will co-opt additional members to attend as and when required.

19. Other executive directors (including the Chief Executive) and officers of the Trust will be invited to attend and contribute to the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed.

20. Representatives from partner organisations or other external bodies may be invited to attend as appropriate. Such representatives will not have voting rights.

21. The Trust Secretary will attend to provide appropriate support to the Chair and Committee members.

Equality Diversity & Inclusion

22. In conducting its business, members must demonstrably consider the equality and diversity implications of decisions they make and consider whether in the management of risk control, the Trust achieves positive change around inclusion, equality, and diversity.

Conflicts of Interest

23. If any of the Members has an interest, financial or otherwise, in any matter and is due to be present at the meeting at which the matter is under discussion, he/she will declare that interest as early as possible and act in accordance with the Trust's Conflicts of Interests Policy. The Chair of the meeting will determine how a conflict of interest

should be managed. The Chair of the meeting may require the individual to withdraw from the meeting or part of it. The individual must comply with these arrangements, which must be recorded in the minutes of the meeting.

Reporting

24. The Charitable Funds Committee will be accountable to the Board of Directors.

25. A Chair's Report will be submitted to the next following Board of Directors for assurance. Approved minutes will be made available to all Board members.

26. The Committee will report to the Board annually on its work and performance in the preceding year.

27. Trust standing orders and standing financial instructions apply to the operation of the Committee.

Administration of Meetings

28. Meetings shall be held seven times per year. Additional meetings may be arranged from time to time, if required, to support the effective functioning of the Trust.

29. The Secretary will plan to ensure that Committee is supported administratively. Duties in this respect will include taking minutes of the meeting and providing appropriate support to the Chair and members.

30. Agendas and papers will be circulated at least five working days in advance of the meeting.

31. Minutes will be circulated to members as soon as is reasonably practicable.

Review

32. The Terms of Reference of the Charitable Funds Committee shall be reviewed and submitted for approval to the Board of Directors at least annually.

Version Control Schedule

Date	Version no	Main changes proposed	Date approved by Audit Committee	Date ratified by Board of Directors (thereby come into force)
March 2024	1	Development of the Terms of Reference – alignment with updated template		

Liverpool Women's NHS Foundation Trust

Appendix C

Charitable Funds Committee	WORKPLAN 2024/25								
							Quarter 1	Quarter 3	Quarter 4
						2024/25 MEETING DATE	17 June 2024	21 Oct 2024	20 Jan 2025
						PAPER/REPORT DEADLINE	10 June	14 Oct	13 Jan

	Action	Item purpose	Outline areas to be considered within report		Report to Board	Executive Lead			
STANDING ITEMS									
Minutes of Previous meeting	Approval	N/A	N/A			TS	✓	✓	✓
Actions/Matters Arising	Noting	N/A	N/A			TS	✓	✓	✓
Chairs Report - Verbal	Noting	Announce items of significance not found elsewhere on the agenda	N/A			Chair	✓	✓	✓
Review of risk impacts of items discussed	Noting	Identify any new risk impacts	N/A			Chair	✓	✓	✓
Any other business	Noting	Consider any urgent items of other business	N/A			Chair	✓	✓	✓
Review of meeting	Noting	N/A	N/A			Chair	✓	✓	✓
MATTERS FOR DISCUSSION									
Charity Strategy Review	Assurance	Monitoring of the Charity Strategy	Progress monitoring of Charity Strategy			CFO			✓
Charitable Funds Operational Plan 2025/26	Assurance	To consider the operational plan.	Progress monitoring of Charity Strategy			CFO			✓
Charity and Finance Integrated Report	Assurance	To consider the financial and fundraising position	• Financial accounts • Fundraising activity • Review of expenditure: fundraising costs versus other			CFO	✓	✓	✓
Approval of Annual Report and Accounts (include independent investigating accountant report/letter with final report)	Approval	To consider and if deemed appropriate recommend approval of the Annual Accounts.	Audited accounts		✓	CFO	✓ (Draft)	✓	
Revenue & Capital Budget for 2023/24	Information	Approval of the annual budget.	Process undertaken to develop the budget and operating plan			CFO			✓

Liverpool Women's NHS Foundation Trust

Charitable Funds Committee			WORKPLAN 2024/25						
							Quarter 1	Quarter 3	Quarter 4
			2024/25 MEETING DATE				17 June 2024	21 Oct 2024	20 Jan 2025
			PAPER/REPORT DEADLINE				10 June	14 Oct	13 Jan
	Action	**Item purpose**	**Outline areas to be considered within report**		**Report to Board**	**Executive Lead**			
			Proposed income and expenditure budgets for the year for recommendation						
CF Applications Impact Annual review	Information	Review provides an assessment of the impact of charitable fund applications.	Reviews to consider whether the cases achieved their objectives, final cost implications, any unintended consequences, and impacts on clinical quality, safety, and staff and patient experience, and lessons learned.			CFO	✓		
Financial Services Support Costs: Annual Benchmarking Review	Information	To review the costs to provide financial services to the charity	Benchmarked data Analysis			CFO	✓		
Investment Report	Information	To monitor investment position	Investment portfolio Update from external investment company provider			CFO	✓	✓	✓
Annual review of investments	Information	To review the investment position	Investment portfolio			CFO			✓
Authorisation of funding applications expenditure (as required)	Approval	To review and approve funding applications	Fund application forms and applicants.			CFO	✓	✓	✓
Review of Fundholders and Funds	Information	To consider and agree	Fundholder signatory list Charitable Funds			CFO		✓	
General Governance Arrangements									
CFC Effectiveness Review, Terms of Reference & Business cycle	Information	To evaluate the effectiveness of the Committee and the terms of reference.	Process Analysis Outcomes Recommendations		✓	TS			✓

Liverpool Women's
NHS Foundation Trust

KEY CODE
Deferred
Item considered as planned
Item considered following deferral

Q=Quarter WP=Work plan AR=Annual Report
AP=Annual Plan OS=Objective Setting

Red text: new to workplan

Quality Committee Assurance Report

Report to	Trust Board
Date	11 July 2024
Meeting Name	Quality Committee
Date of Meeting	25 June 2024
Chair's Name & Title	Jackie Bird, Non-Executive Director

Agenda Items

The following agenda items were discussed by the meeting:

1. Infection Prevention and Control Annual Report 2023/24 **(Substantial Assurance)**
2. Safeguarding Annual Report 2023/24 **(Substantial Assurance)**
3. Complaints Annual Report 2023/24 **(Substantial Assurance)**
4. Board Assurance Framework **(Substantial Assurance)**
5. Improvement Plan Highlight report – Quality Areas
6. Integrated Performance Report Quarter 4, 2023/24 **(Substantial Assurance)**
7. Annual Quality Account
8. Maternity Incentive Scheme Update and Perinatal Quality Surveillance & Safety Dashboard **(Substantial Assurance)**
9. Response to MBRRACE 2022 **(Substantial Assurance)**
10. CQC Action Plan Update **(Moderate Assurance)**
11. Quality and Regulatory Update
12. Learning from deaths report Quarter 4
13. Equality, Diversity and Inclusion Update – patients
14. Research and Development Annual Report 2023/24 **(Substantial Assurance)**
15. NICE Annual Report 2023/24 **(Substantial Assurance)**
16. Clinical Audit Annual Report 2023/24 **(Substantial Assurance)**
17. Integrated Performance Report

Matters for Escalation

No matters highlighted for escalation.

Key Issues

Annual Reports 2023/24

The Committee discussed and approved the following Annual Reports:

- Infection Prevention and Control Annual Report 2023/24
- Safeguarding Annual Report 2023/24
- Complaints Annual Report 2023/24
- Research and Development Annual Report 2023/24

- NICE Annual Report 2023/24
- Clinical Audit Annual Report 2023/24

Board Assurance Framework (BAF)
Received a revision of BAF risks for 2024/25 which aimed to clarify the Trust's most significant risks and new risk scores reflective of the changed risk scoring mechanism as approved in the Risk Management Strategy. The Committee agreed with the proposed changes to risks 2,3 & 7, noting that the revision of BAF 7 included relocation of oversight to the Finance, Performance and Business Development Committee and the introduction of a new BAF risk 5 to be aligned to the Quality Committee.

The Committee recommended Executive consideration to include an additional risk in relation to Regulatory Compliance.

The Committee noted a review of the Risk Appetite Statement which had been aligned with the Good Governance Institute risk appetite matrix. The Committee agreed with the risk appetite judgements made.

Improvement Plan Highlight report – Quality Areas
Received a progress update against the Quality and Safety Programme and the Clinical Effectiveness Programme noting development of the underpinning workstreams to drive forward improvements. Assurance was provided that actions had been taken which would improve the position of the three red rag rated areas reported within the Clinical Effectiveness programme.

Integrated Performance Report Quarter 4, 2023/24
The report provided an overview of governance monitoring across the Trust and identified areas of risk and learning outcomes. Key areas of concern related to failure to follow clinical guidelines and pathways, controlled drugs management, and overdue serious incident investigation actions. Developing actions were underway to address the risks identified. The positive introduction of the legal claims' scorecard and a continuous positive reporting culture demonstrated by Ulysses data was noted.

Annual Quality Account 2023/24
The Committee reviewed and provided comments in relation to the draft Annual Quality Account 2023/24. It was confirmed that the Quality Account had been presented to the ICB and external stakeholders on 17 May 2024 as required. The Committee recommended approval to the Audit Committee.

Clinical Negligence Scheme for Trusts (CNST) Progress Update and Perinatal Quality Surveillance & Safety Dashboard
Received the current position in relation to the Maternity Incentive Scheme Year six. Assurance of progress against each of the ten safety standards along with a schedule of reporting to ensure compliance was provided. A risk was identified in relation to the ability to meet the compliance targets within the medical workforce (Obstetric and Anaesthetic) of attendance at PROMPT and Fetal Surveillance Study Days due to ongoing industrial action. The risk had been escalated to the Educational Governance Committee. The Committee also received 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.

Response to MBRRACE 2022
The Committee took positive assurance from the MBRRACE 2022 report which had benchmarked extended perinatal mortality data. The data demonstrated that the Trust was performing as average amongst comparator trusts for stillbirth rates and below average for extended perinatal mortality once congenital anomalies are removed. It was acknowledged as a specialist Trust it supports a significantly higher volume of delivering babies with high-risk congenital anomalies than its comparator trusts.

Care Quality Commission (CQC) Action Plan Update
Received an update in relation to the CQC action plan following the January 2024 inspection. Oversight and monitoring of the CQC action plan would be provided by the Trust Improvement Programme Portfolio Group. The Committee took moderate assurance noting further work required to ensure robust evidence repository in place to support the improvements.

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

Learning from deaths report Quarter 4
Received the Learning from Deaths report Quarter 4, 2023/24. As per previous Committee action, the ethnicity data for both neonatal deaths and stillbirths had been reviewed and showed no significant difference between white and non-white populations. No matters to escalate identified.

Equality, Diversity and Inclusion (EDI) Update – patients
The Committee noted the ongoing work in EDI including the completed actions in the Patient EDI Action Plan and the successful delivery against the EDI objectives set for 2023/24. Due to the strengthened position and governance arrangements in place the Committee agreed to discontinue reporting to the Committee and allow for routine reporting to the Patient Involvement and Experience Group and statutory EDS reporting mechanisms with the option to escalate if required.

The following reports were considered on a consent agenda, no issues raised.

- Integrated Performance Report

Decisions Made

- Recommend Board approval of the Infection Prevention and Control Annual Report 2023/24; Safeguarding Annual Report 2023/24 and Complaints Annual Report 2023/24
- Approved the Research and Development Annual Report 2023/24; NICE Annual Report 2023/24; Clinical Audit Annual Report 2023/24
- Agreed with the revised BAF 2024/25 and recommended consideration to include an additional risk in relation to Regulatory Compliance

- Agreed the revised Risk Appetite Statement
- Recommend Audit Committee approval of the Annual Quality Account 2023/24

Recommendations

The Board is asked to:

- note the contents of this report and the decisions taken by the Quality Committee.
- approve the following Annual Reports prior to website publication
    - Infection Prevention and Control Annual Report 2023/24
    - Safeguarding Annual Report 2023/24
    - Complaints Annual Report 2023/24
- approve the BAF 2024/25 Quality related risks and the risk appetite statement

Appendix 2: Attendance Matrix

Core members	Apr	June	July	Oct	Nov	Jan	March
Sarah Walker, Non-Executive Director CHAIR	✓	A					
Jackie Bird, Non-Executive Director	✓	✓					
Louise Kenny, Non-Executive Director	A	A					
Gloria Hyatt, Non-Executive Director	✓	A					
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	11 July 2024
Meeting Name	FPBD Committee
Date of Meeting	26 June 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. Financial Planning Update
3. Analytical review of unaudited Annual Accounts
4. Third party controls: CDC and SLA's
5. EPRR Annual Report 2023/24 **(Substantial Assurance)**
6. Health and Safety Annual Report 2023/24 **(Moderate Assurance)**

Matters for Escalation

No matters highlighted for escalation.

Key Issues

Board Assurance Framework (BAF)
Received a revision of BAF risks for 2024/25 which aimed to clarify the Trust's most significant risks and new risk scores reflective of the changed risk scoring mechanism as approved in the Risk Management Strategy. The Committee agreed with the proposed changes to risks 2, 4, 6 & 7, noting that the revision of BAF 7 to be replaced with BAF 6 included relocation of oversight to the Finance, Performance and Business Development Committee.

The Committee noted and agreed with the Quality Committee recommendation to include an additional risk in relation to Regulatory Compliance.

The Committee recommended a review of BAF risk 3 – Digital Sustainability, to reflect on the control score of 2 in light of potential cyber-attack on third party providers and controls in place.

The Committee noted a review of the Risk Appetite Statement which had been aligned with the Good Governance Institute risk appetite matrix. The Committee agreed with the risk appetite judgements made.

Financial Planning Update
The report summarised the final agreed financial plan for 2024/25 and provided an update in respect of the Trust's recovery plan. The Committee noted the final submitted plan for 2024/25, comprising of a deficit plan of £28.5m and efficiency target of 3.4%. The Committee had been assured by the rigorous process undertaken by the internal team to provide the financial plan. The Committee identified the cash position as the most significant risk to the organisation throughout 2024/25.

Analytical review of unaudited Annual Accounts
The Committee received an analytical review of key elements of the annual accounts 2023/24 for comments ahead of submission to the Audit Committee and Trust Board for approval. No issues or concerns raised.

Third party controls: CDC and SLA's
Further update received on third-party service provider controls in place, specifically related to the Service Level Agreements (SLAs) and the Community Diagnostic Centre (CDC). The Chief Operating Officer confirmed that revised processes in place ensured effective management going forward and requested that the matter be de-escalated from the Finance Committee and ongoing monitoring to be via the Finance & Performance Executive Group. It was also requested that the CDC monitoring reports be de-escalated to the Divisional Board based on controls and processes in place. The Committee approved the request to de-escalate reporting to executive and divisional level and advised that robust monitoring needed to be sustained to ensure that controls did not go off-track.

Emergency Planning Resilience and Response (EPRR) Annual Report 2023/24
The Emergency Preparedness, Resilience and Response (EPRR) Annual Report provided a summary of EPRR approach and activities for 2023/24. The Committee was assured that the Trust was focused on continuing to meet its duties under the Civil Contingencies Act 2004 and noted the aim to increase the level of compliance to the newly revised NHSE EPRR Core Standards for 2024. EPRR workstreams going forward would remain focused on completing actions identified within the Core Standards action plan, planning for and responding to arising situations and maintaining and improving compliance to the NHSE EPRR Core Standards for 2024.

Health and Safety Annual Report 2023/24
Received the Health and Safety Annual Report for 2023/24 which included an overview of compliance and governance of health and safety arrangements, activities, performance and improvements demonstrated. A focus on developing managers responsibility to adhere to health and safety requirements would be further supported by the introduction of the Ulysses risk and safety management module and corresponding QI project due to be launched in June 2024. Moderate assurance was taken; although significant amount of information had been provided in terms of process, further compliance information was required which would provide additional assurance. The Chief Operating Officer agreed to update the Annual Report ahead of submission to the Trust Board in July 2024.

Decisions Made

- Agreed with the revised BAF for 2024/25
- Agreed to de-escalate third party control monitoring reports to the Finance & Performance Executive Group
- Agreed to de-escalate CDC monitoring reports to the Divisional Board and escalation through Executive Risk & Assurance Group as required
- Noted the EPRR Annual Report 2023/24
- Noted the Health and Safety Annual Report 2023/24 and addition of compliance data to provide additional assurance

Recommendations

The Board is asked to:

- note the contents of this report and the decisions taken by the FPBD Committee.
- approve the BAF 2024/25 Finance related risks and the risk appetite statement
- note the EPRR Annual Report 2023/24 and the Health and Safety Annual Report 2023/24

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	✓	A					
Jenny Hannon, Chief Finance Officer	✓	✓					
Dianne Brown, Chief Nurse	✓	A					
Gary Price, Chief Operating Officer	✓	✓					
Matt Connor, Chief Digital Information Officer	✓	✓					
Present (✓) Apologies (A) Representative (R) Nonattendance (NA) *Non-quorate meetings highlighted in greyscale*							

Trust Board

COVER SHEET

Meeting Date	Thursday, 11 July 2024	**Item Reference**	24/25/093
Report Title	Board Assurance Framework & Risk Appetite Statement 2024/25		
Author	Mark Grimshaw, Trust Secretary		
Responsible Director	Mark Grimshaw, Trust Secretary		

Purpose of Report	The report outlines any updates relating to the Board Assurance Framework and any key areas for consideration for the Board.
Executive Summary	The Board Assurance Framework (BAF) is a monitoring tool used by the Board to assess the organisation's capacity to achieve its strategic objectives, and to ensure it has appropriate oversight of the Trust's risk profile and risk management arrangements. The BAF has been updated for 2024/25 to clarify the Trust's most significant strategic risks. This has resulted in predecessor BAF risks that were reported throughout 2023/24 being amended, replaced and added to.
Key Areas of Concern	None
Trust Strategy and System Impact	A Board Assurance Framework (BAF) report aligns with the NHS Trust strategy and the 'triple aim' by systematically identifying and managing risks to achieving key objectives. It ensures patient safety, improves health outcomes, and enhances the patient experience, while maintaining financial sustainability. By providing a structured approach to governance, the BAF supports the Trust's mission to deliver high-quality care, address health inequalities, and optimise resource utilisation, thereby fulfilling the 'triple aim' of better care, health, and value.

Links to Board Assurance Framework	All BAF risks	
Links to Corporate Risk Register (scoring 12+)	In development	n/a

Assurance Level	1. SUBSTANTIAL - Good system of internal control applied to meet existing objectives

Action Required by the Board	The Board is requested to • review the BAF risks and agree on their contents and actions. • Agree the suggested Q1 2024/25 scores • Agree the Risk Appetite Statement 2024/25

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
The BAF has been discussed at a Board Development session and at the June/July Board Committees.			

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 12 and above 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.

Drivers for the Year-End Review

Good Practice to Review at Year-End
Conducting a review at the end of the year is a recognized best practice for ensuring that governance processes remain robust and relevant. This periodical evaluation allows the Trust to assess the effectiveness of existing controls and frameworks, identify areas for improvement, and ensure that all strategic objectives are being met. It helps maintain a proactive approach to risk management by keeping the Board Assurance Framework (BAF) aligned with the Trust's evolving needs and priorities.

Risk Scoring Mechanism Has Changed
The recent changes in the risk scoring mechanism necessitate a thorough review of the BAF. These adjustments can significantly impact how risks are identified, assessed, and prioritized. By updating the BAF to reflect the new scoring system, the Trust can ensure that risk evaluations are accurate and that the Board has a clear and current understanding of the Trust’s risk landscape. This change aims to enhance the precision and reliability of risk assessments.

Long-Term Aim to Simplify the BAF to Support Effective Use for Board Discussion
Simplifying the BAF is a strategic objective to make it more user-friendly and effective for Board discussions. A streamlined BAF can help Board members quickly grasp key risks and the measures in place to mitigate them. This simplification can lead to more focused and productive discussions, ensuring that the Board's time is spent on strategic rather than administrative issues. The ultimate goal is to enhance decision-making and oversight capabilities.

Request at May 2024 Board to reframe several BAF Risks to Better Align to the Current Strategic Risk Profile
In May 2024, the Board requested a reframing of several BAF risks to better align them with the current strategic risk profile. This alignment is crucial to ensure that the BAF accurately reflects the Trust's present challenges and priorities. By reframing these risks, the Trust can ensure that its risk management strategies are relevant and effective, addressing the most pressing issues faced by the organization.

Request at May 2024 Board for Better Alignment Between the BAF, Risk Register, Improvement Plan, and Integrated Performance Report
The May 2024 Board also highlighted the need for better alignment between the BAF, Risk Register, Improvement Plan, and Integrated Performance Report. This integration ensures that all documents and processes are coherent and supportive of each other, providing a comprehensive view of the Trust's performance and risk management efforts. By aligning these elements, the Trust can ensure that risk management strategies are effectively integrated into its overall strategic and operational plans.

Need to Review Risk Appetite Statement
A review of the Risk Appetite Statement is necessary to ensure that it remains aligned with the Trust's strategic goals and current risk environment. This statement defines the level of risk the Trust is willing to accept in pursuit of its objectives. By periodically reviewing and updating this statement, the Trust can ensure that its risk-taking activities are aligned with its strategic priorities and capacity to manage risk. This review can help in setting clear boundaries for decision-making and risk management practices.

Changes to the BAF

The following outlines the proposed changes to the 2023/24 BAF risks and the suggested 2024/25 BAF risks.

2023/24 BAF Risk	Q4 Score	Suggested action	2024/25 BAF Risk	Q1 Score (see rationale under each BAF Risk in Appendix A)
1 – Inability to recruit & maintain a highly skilled & engaged workforce that is representative of our local communities	**12/25**	**Close and replace with…**	**Risk 1 – Workforce**	**10/15**
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.	**20/25**	**Close and replace with…**	**Risk 2 – Isolated Site**	**12/15**
3 – Failure to deliver an excellent patient and family experience to all our service users	**8/25**	**Close and replace with…**	**Risk 7 - Health Inequalities**	**10/15**
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.	**12/15**	**Close and replace with…**	**Risk 3 – Digital Sustainability** ***Note: The FPBD Committee requested an increase in control score from '2' to '3' to reflect the lessons from the recent London cyber-attack. Further detail is in the June 2024 Chair's Report***	**10/15**
5 – Inability to deliver the 2023/24 financial plan and ensure our services are financially sustainable in the long term	**20/25**	**Close and replace with…**	**Risk 4 – Financial Sustainability**	**10/15**
6 – The right partnerships are not developed and maintained to support the success of the Cheshire &	**6/25**	**Close and replace with…**	**Risk 8 – Organisational Change** ***Note: This was agreed post the Board Development session held in June 24.***	**10/15**

Merseyside ICB and the CMAST Provider Collaborative				
7 - Failure to meet patient waiting time targets	**16/25**	**Close and replace with…**	**Risk 5 - Cancer Recovery**	**10/15**
			Risk 6 – Waiting Times	**10/15**
		Add new BAF risk…	**Risk 9 – Well-Led** ***Note: This was recommended by the Quality Committee following their discussion – see June 2024 Chair's Report for further detail.***	**9/15**

Key changes to BAF format

- Use of inherent and residual risk score (recommended by MIAA)
- Simplified risk descriptor
- Controls themed and mapped directly to assurances with enhanced justification.
- Separate gaps in control and action tracker section replaced with links to the Improvement Plan, Risk Register and Long-term actions – this is to try and provide greater triangulation and remove duplication.
- Benchmarking a section for each BAF risk rather than a separate appendix.

Further work is required to map the Trust's risk register to the respective BAF risks and to also identify the medium to long-term actions required to improve the control environment. These should be finalised ahead of the next iteration of the report.

Risk Appetite

In line with the updated Risk Management Strategy (agreed by the Board in April 2024), the risk appetite statements and ratings have been aligned with the Good Governance Institute risk appetite matrix (included with the appendices to the BAF). Board members are asked to review and approve the 2024/25 statement.

Conclusions

Board members are asked to comment on the current content and where required make further recommendation for change and agree the current BAF risks.

Equality, Diversity & Inclusion Implications

N/A

Quality, Financial or Workforce implications

N/A

RECOMMENDATION

The Board is requested to

- review the BAF risks and agree on their contents and actions.
- Agree the suggested Q1 2024/25 scores
- Agree the Risk Appetite Statement 2024/25

SUPPORTING DOCUMENTS

Appendix 1 –Board Assurance Framework 2024/25

Liverpool Women's
NHS Foundation Trust

Board Assurance Framework 2024/25

Trust Board

July 2024

Board Assurance Framework Dashboard 2024/2025

Full Risk Description	Risk Appetite		Q1 2024/25 Risk Score	Q2 2024/25 Risk Score	Q3 2024/25 Risk Score	Q4 2024/25 Risk Score	Rating
Risk 1 – Workforce If the Trust is unable to address staffing challenges and EDI inequalities, it may fail to deliver safe, high-quality care, meet organisational objectives, and engage effectively with patients and staff. This can lead to reduced patient trust, lower staff morale, legal consequences, and failure to recruit, promote, and retain diverse talent.	**Cautious**		**3+4+3 = 10**				**Serious**
Risk 2 – Isolated Site If the Trust does not address the challenges of an isolated site, it risks inadequate medical coverage, delayed response to emergencies, and potential failure to meet care standards, leading to serious incidents, regulatory scrutiny, and reputational damage	**Minimal (ALARP)**		**4+5+3 = 12**				**Significant**
Risk 3 – Digital Sustainability If the Trust fails to embed aims and objectives in its digital strategy, sub-optimal clinical records systems, insufficient resources, and major IT system failures due to cyber-attacks may occur, compromising patient safety, disrupting operations, and causing reputational harm, thereby missing opportunities to enhance care efficiency, quality, and safety.	**Cautious**		**3+4+3 = 10**				**Serious**
Risk 4 – Financial Sustainability 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.	**Open**		**3+4+3 = 10**				**Serious**
Risk 5 - Cancer Recovery If we do not deliver cancer recovery in line with national planning guidance through the reduction in access times for our longest waiting patients, there is a risk of negative impact on health outcomes and patient experience.	**Minimal (ALARP)**		**3+4+3 = 10**				**Serious**
Risk 6 – Waiting Times If the Trust does not reduce patient waiting times and overall list size, it risks compromising patient outcomes, care standards, and incurring regulatory penalties.	**Minimal (ALARP)**		**3+4+3 = 10**				**Serious**
Risk 7 - Health Inequalities If the Trust does not actively address health inequalities and support the anti-racism agenda, it risks perpetuating disparities in healthcare access and outcomes.	**Minimal (ALARP)**		**3+4+3 = 10**				**Serious**
Risk 8 – Organisational Change If the Trust does not effectively manage the transition to a more integrated working relationship with Liverpool University Hospitals NHS Foundation Trust, there is a risk of potential misalignment of organisational cultures, disruption to service delivery during the integration phase, and challenges in maintaining clear communication across both entities.	**Open**		**3+4+3 = 10**				**Serious**

Risk 9 – Well-Led If corporate and quality governance arrangements do not meet the requirements of the Well-Led Framework, the Trust's assurance and escalation processes may not be fit for purpose, impacting on the provision of high-quality, sustainable, harm-free care.	**Cautious**		**3+3+3=9**				**Moderate**

BAF Risk 1 – Workforce

Risk Description and Impact on Strategic Aims

If the Trust is unable to address staffing challenges and EDI inequalities, it may fail to deliver safe, high-quality care, meet organisational objectives, and engage effectively with patients and staff. This can lead to reduced patient trust, lower staff morale, legal consequences, and failure to recruit, promote, and retain diverse talent.

Responsibility for Risk

Committee:	Putting People First Committee	Lead Director:	Chief People Officer

Risk Scoring

Inherent Score				Residual Score				Target Score				Appetite
L	C	RC	RPS	L	C	RC	RPS	L	C	RC	RPS	
3	4	3	10	3	4	3	10	3	4	2	9	Cautious

Rationale for risk score and quarterly update – Q1 2024/25

Rationale for LIKELIHOOD score of 3

The likelihood score has been adjusted based on recent positive developments. The 'big conversation' held in September 2023 indicated an improvement in staff culture, and the Trust's recognition among the top 50 inclusive employers for the third consecutive year demonstrates a commitment to diversity and inclusivity. The 2023 Staff Survey's indicative data, though subject to change, shows signs of improvement.

Rationale for CONSEQUENCE score of 4

The consequence score reflects the potential impact of failing to address staffing challenges and EDI inequalities. The Trust's inability to deliver safe, high-quality care, meet organisational objectives, and engage effectively with patients and staff could lead to reduced patient trust, lower staff morale, legal consequences, and failure to recruit, promote, and retain diverse talent.

Rationale for CONTROLS score of 3

The control score is informed by the Trust's assurance of robust mitigating plans for risks, particularly concerning postgraduate doctors and rota gaps. The development of a business case for securing additional roles further supports the score of 3. These measures, along with continued vigilance and proactive management, justify the lowered risk score and suggest a favourable trajectory for workforce engagement and satisfaction.

Key Controls and Assurance Framework

Key Controls:	Assurances	Assurance Level	Assurance Rating	Overall Assurance Rating
Strategy and Planning • Putting People First Strategy: Articulates actions to support a skilled and motivated workforce with a new iteration in development. • Workforce Planning Processes: Aligned to annual planning processes and divisional workforce plans to ensure safe staffing. • Medical Workforce Review Group: Reviews development of alternative roles and undertakes roster reviews for effective workforce planning. • Utilisation of Workforce Tools: Utilizes methodologies like Birthrate Plus and BAPM for safe staffing planning.	• PPF Strategy and Action Plan: Monitored by the PPF Committee, ensuring alignment with strategic workforce goals. • Ownership of Workforce Plans at Divisional Level: Reported via Divisional performance reviews to ensure local alignment and accountability.	1		
Leadership and Development • Appraisal Systems: Structured career conversations, mandatory PDR training, and re-validation processes for clinical staff. • Leadership Programmes: Tiered and compulsory for new leaders at all levels, ensuring high attendance and effective leadership. • Targeted OD Interventions: Support areas in need to enhance overall workforce performance	• Annual Quality of Appraisal Audit (November 2022): Assures the effectiveness of appraisal processes and identifies areas for improvement.	2		

Training and Compliance • Comprehensive Mandatory Training: Competencies linked to roles, with quarterly validation and detailed reporting at core, clinical, and specialty-specific levels. • Pay Progression: Linked to mandatory training compliance to incentivise completion. • Advanced Practitioner Roles: Introduction of roles like Advanced Practitioners, Surgical Assistants, and Physicians Associates.	• Annual Mandatory Training Audit (November 2022): Validates training compliance and ensures alignment with required competencies. • Assurance that MT Competencies are Assigned Correctly: Sign off from practice educators and Heads of Nursing ensures proper assignment and completion.	**2**		
Wellbeing and Support • LWH Staff Support Service: A trauma-informed wellbeing service including psychologists and health and wellbeing coaches. • Freedom to Speak Up Guardians: Promotes a culture of openness and transparency, supported by the Whistleblowing Policy. • Staff Inclusion Networks: Promotes diversity and inclusion, supported by local Trust collaborations and the launch of LGBTQ Network.	• Bi-annual Speak Up Guardian Reports: Provide insights into the culture of openness and transparency. • Annual Whistleblowing Report to PPF and Audit Committee: Ensures the whistleblowing process is effective and transparent.	**2**		
Engagement and Communication • Annual NHS Staff Survey and Pulse Surveys: Regular feedback mechanisms to assess and improve staff experience. • Bi-Annual Trust-wide Listening Events: Big Conversation events led by Executive and Non-Executive Directors. • Two-way Communication Systems: With postgraduate doctors, junior doctors forums, and monitoring through GMC Survey and Guardian of Safe Working.	• Range of Internal and Two-way Staff Communications: Enhances engagement and ensures staff voices are heard. • Quarterly Internal Staff Survey (Let's Talk): Regular feedback mechanisms to assess and improve staff experience • Reports and Feedback from Big Conversation: Ensures insights from staff listening events are considered in decision-making. • Bi-annual Speak Up Guardian Reports: Facilitates ongoing dialogue and transparency. • Report from Guardian of Safe Working: Provides feedback on junior doctors' working conditions and experiences.	**2**		
Diversity and Inclusion • ED&I Annual Improvement Plan: Focused on increasing diversity at all levels, with specific actions like positive discrimination schemes and diverse interview panels. • WDES and WRES Action Plans: Delivery in line with NHS England's timescales. • Celebration of Key EDI Events: Black History Month, Disability History Month, LGBT+ History Month, and key faith observance days.	• ED&I Sub-committee: Oversees progress against ED&I actions, ensuring commitment to diversity and inclusion. • WRES and WDES Submissions: Regular reporting ensures compliance and progress on diversity initiatives. • EDI Lead and Monitoring through the ED&I Action Plan Networks: Ensures dedicated oversight and progress tracking on ED&I initiatives. • Annual Quality of Appraisal Audit: Includes components related to diversity and inclusion to ensure equitable treatment in career development.	**2**		
Operational Efficiency • NHSP Utilisation: Reduces agency expenditure and improves governance through bank staff utilization. • Industrial Action Planning: Managed via the strike planning committee to ensure continuity of services. • Establishment Control Process: Ensures accurate reporting of vacancy levels and effective recruitment strategies.	• KPI Reports from All Outsourced Services: Recruitment, Payroll, and Occupational Health ensure efficiency and accountability. • Policy Schedule for All HR Policies: Ensures timely updates and compliance with regulations. • Policy Review Process Reported to PPF: Provides oversight and assurance on the relevance and effectiveness of HR policies. • Monthly KPIs for Controls: Track performance against key operational metrics. • Chair's Reports to PPF Committee: Regular updates on workforce-related matters. • Divisional Board and Divisional Performance Reviews: Ensure operational efficiency and alignment with organizational goals.	**3**		
Collaborations and Partnerships • Shared Appointments: Across a range of clinical and corporate services with other providers. • Positive Culture of Partnership Working: Includes shared decision-making with JLNC and Partnership Forum. • Local Governance Structures: Support compliance with HR KPIs, including mandatory training reviews.	• Great Place to Work Minutes to PPF: Document collaborative efforts and initiatives to enhance workplace culture. • A Suite of KPIs Measuring People Services Performance: Includes customer feedback, ensuring service quality and stakeholder satisfaction.	**3**		

Gaps in Control and Assurances – Links to the Improvement Plan

Aligned Projects:

- 2.1 – Enhanced Workforce for the Acute Workload
- 4.1 – Actively Anti-Racist Organisation
- 4.2 – Safety Culture

Gaps in Control and Assurances - Links to Risk Register

Links to Risks on the Risk Register				
Low (3-5)	Moderate (6-9)	Serious (10-11)	Significant (12-15)	Total
In development				

Linked >12 risks					
Risk	**Controls**	**Gaps in Control**	**Assurance**	**Actions**	**Oversight**
In development					

Gaps in Control – Medium to Long Term Actions

Action	Timescale	Oversight
In development		

Benchmarking with local Trusts

Trust	Aligned BAF Risk(s)	Q1 Score	Q2 Score	Q3 Score	Q4 Score
LUHFT	**Risk 5: Health & Wellbeing** 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.	3+3+2=8			
	Risk 6: Equality, Diversity & Inclusion If we do not address Equality Diversity & Inclusion (EDI) inequalities affecting our workforce, we may fail to improve the experience of staff from diverse backgrounds and fail to recruit, promote and retain diverse talent**.**	4+2+2=8			
	Risk 7: Leadership 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.	3+3+1=7			
Walton Centre	**Leadership Development** Inability to attract, retain and develop sufficient numbers of qualified staff	12			
LHCH	**BAF4** 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	12			
Clatterbridge	**BAF 8** If the Trust is unable to train, develop and retain staff then there is a risk that workforce capacity and capability will not meet demand resulting in undue pressure on staff and adverse impacts on patient safety, effectiveness of care and patient and staff experience.	12			
	BAF 9 If the Trust is unable to provide a positive, supportive and inclusive culture, where individuals wellbeing needs are met and individuals feel valued and rewarded for their contributions there is a risk that this will result in an adverse impact on staff performance, wellbeing, engagement, retention, trust reputation, and the ability to deliver services and patient care.	8			
AHCH	**Workforce Sustainability and Development**	15			
	Failure to deliver the best experience for Staff, Children and Young People and their Families	9			
	Workforce Equality, Diversity & Inclusion	15			

BAF Risk 2 – Isolated Site

Risk Description and Impact on Strategic Aims
If the Trust does not address the challenges of an isolated site, it risks inadequate medical coverage, delayed response to emergencies, and potential failure to meet care standards, leading to serious incidents, regulatory scrutiny, and reputational damage.

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

Risk Scoring												Appetite
Inherent Score				Residual Score				Target Score				Minimal (ALARP)
L	C	RC	RPS	L	C	RC	RPS	L	C	RC	RPS	
4	5	3	12	4	5	3	12	4	5	2	11	

Rationale for risk score and quarterly update – Q1 2024/25

Rationale for LIKELIHOOD score of 4
The isolated location presents immediate-term threats to patient safety, particularly for those requiring specialised care that is not available on-site. The risk of delayed access to specialist care and reduced resource access increases the likelihood of short-term patient harm. However, the Trust's proactive horizon scanning and strategic planning, aims to enhance preparedness and potentially reduce the likelihood of such incidents.

Rationale for CONSEQUENCE score of 5
The potential impact of not addressing the challenges of an isolated site is significant. Inadequate medical coverage and delayed response to emergencies could lead to serious incidents, regulatory scrutiny, and reputational damage. The Trust's substantial immediate-term risks to the organization and patient safety, despite proactive measures, necessitate ongoing vigilance.

Rationale for CONTROLS score of 3
The Trust has implemented significant investments to enhance the safety of the Crown Street site, including improvements to the emergency department and the addition of a new neonatal intensive care unit. These measures demonstrate a proactive approach to mitigating the risks associated with geographic isolation. The independent review in February 2022 confirms that, despite these efforts, some immediate-term risk persists due to the site's remoteness. The Trust's Improvement Plan outlines immediate actions that are currently in the early phase of delivery, indicating a commitment to ongoing risk management. The impacts of these projects should be visible during the year.

Key Controls and Assurance Framework

Key Controls:	Assurances	Assurance Level	Assurance Rating	Overall Assurance Rating
Partnerships and Collaboration • Neonates Partnership with AHCH: Supports collaboration between LWH and AHCH sites, reducing risk for transfers. • Formal Partnership with Liverpool Universities Hospitals: Established board to support shared recognition of risks and collaborative mitigation strategies. • SLAs with LUHFT: Clinical support services provided through Service Level Agreements to ensure continuity of care.	**Transfers out monitored by Partnership**: Ensures collaboration and communication between LWH and partner organizations for patient transfers. **Partnership Activity to Report Through to Board on a Quarterly Basis**: Regular updates on collaborative efforts to the Board. **LWH Working as Part of NW Maternal Medicine Network**: Demonstrates collaboration within the regional network for maternal medicine. **Partnership Board Meetings and Involvement in Wider Estates Strategy**: Ongoing collaboration with external partners to align strategic estate planning.	3		

Enhanced Staffing and Training
• Investments in 24/7 Staffing:
  ○ Anaesthetics: Joint appointments with LUHFT.
  ○ Gynaecology: Additional ANP roles within GED.
  ○ Neonates: Increased staffing levels for round-the-clock coverage.
• Enhanced Resuscitation Training: Provision of adult resuscitation training to reduce risks of critically ill patients.
• Appointment of Resus Officers: Upgrading of resus trolleys and provision of automated defibrillator trolleys.
	Staff Staffing Levels Reports to Board: Regular updates on staffing levels ensure adequate coverage and highlight any gaps.
	
	Training Compliance Rates Reported to PPF Committee: Ensures staff are adequately trained, maintaining high standards of care and safety.
		2		

• Upskilling of HDU Staff: Expanded role of anaesthetists and training for HDU staff to manage critical patients.				
Operational Enhancements and Planning • Crown Street Enhancements Programme: Oversees progress against improvement programmes and horizon scans for additional opportunities. • Community Diagnostic Centre at Crown Street: Provides additional diagnostic capacity, reducing the need for transfers and speeding up access to diagnostics. • Operational Planning Process: Ensures structured and forward-looking operational strategies.	**Operational Plans and Budgets**: Detailed operational plans and budgets support structured and effective resource allocation. **Divisional Board Meetings with Divisional Risk Meeting Themes Reporting**: Provides a forum for discussing and addressing operational risks at the divisional level. **Crown Street Enhancements Programme Progress**: Monitored to ensure timely and effective improvements. **Community Diagnostic Centre Oversight Group Reviews Progress on a Fortnightly Basis**: Ensures ongoing monitoring and timely completion of projects. **Single Site Risk Reports Provided to QC and Board Since July 2022 on a Regular Basis**: Regular updates on risks specific to the isolated site.	**2**		
Innovative Medical and Diagnostic Solutions • Theatre Slots at LUHFT: Access to colorectal surgeons for specialized surgeries. • Sentinel Node Biopsy and 3D Laparoscopic Kit: Investments in advanced medical equipment to enhance surgical capabilities. • Use of Telemedicine: Facilitates remote consultations for Neonates and other specialties, improving access to care. • Cell Salvage & ROTEM: Innovative blood management techniques to enhance patient safety during surgeries. • Early Order of Blood Products: Protocols in place to manage blood product availability and reduce wastage. • Use of Bedside Clotting Analysis and Fibrinogen Concentrates: Enhances immediate response to bleeding complications.	**Mapping of Requirements from and Interdependencies with LUHFT Across All Trust Specialties:** Ensures necessary medical and diagnostic solutions are identified and integrated into operational plans.	**2**		
Data-Driven Workforce and Service Planning • Availability of Service Trends and Demographic Data: Informs workforce plans and operational strategies. • Workforce Plans Informed by Data: Trends and intelligence-driven workforce planning. • Deep-Dive Reports on Isolated Site Risks and Incidents: Maintains a live view of risk levels and contributing factors, enabling timely and informed decision-making.	**Operational Plans and Budgets:** Informed by data on service trends and demographic needs. **Staff Staffing Levels Reports to Board:** Uses data-driven insights to manage and optimize staffing.	**2**		
Critical Care and Emergency Response • **Blood Product Provision and Protocols**: Motorized vehicle transport and revised protocols for prioritizing blood product transport. • **Out of Hours Transfusion Lab**: Provided off-site by LCL to ensure availability during emergencies. • **SOP for Paediatric Resus Provision**: Standard Operating Procedures in place to manage paediatric resuscitation. • **Ambulance Transfer for Urgent Imaging/Diagnostics**: Ensures timely access to necessary diagnostics not available on-site. • **Transfer of Patients for Critical Care**: Efficient processes for transferring critically ill patients to appropriate facilities.	**Transfers Out Monitored at HDU Group:** Regular monitoring ensures efficient and safe patient transfers. **Critical Care Transfers Subject to PSII:** Reviews ensure high standards and identify areas for improvement. **Serious Incidents Tracked and Reported Through Governance Framework:** Ensures incidents are investigated, and lessons learned are applied. **ERAG:** Provides a broader review of significant risks, including those related to critical care.	**2**		
Support for Remote and Isolated Services • Outreach Midwife Post: Enhances maternity care outreach and support. • Gynaecology Tier 2 Rota: Provides cover for LWH and Liverpool Place, ensuring consistent care. • Expanded Role of Anaesthetists: Coverage for HDU patients and provision of pain services.	**Engagement from Appropriate Executives in Designated Working Groups:** Ensures leadership involvement in addressing the challenges of operating on an isolated site. **Partnership Board Meetings and Involvement in Wider Estates Strategy:** Supports infrastructure planning and service delivery improvements for isolated services.	**2**		

Gaps in Control and Assurances – Links to the Improvement Plan

Aligned Projects:

- 1.1. Deteriorating Patient Collaborative
- 2.1 Enhanced Workforce for the Acute Workload
- 2.3 LWH Transfusion Lab
- 2.4 Medicines Safety
- 4.1 Safety Culture

Gaps in Control and Assurances - Links to Risk Register

Links to Risks on the Risk Register				
Low (3-5)	**Moderate (6-9)**	**Serious (10-11)**	**Significant (12-15)**	**Total**
In development				

Linked >12 risks					
Risk	**Controls**	**Gaps in Control**	**Assurance**	**Actions**	**Oversight**
In development					

Gaps in Control – Medium to Long Term Actions

Action	Timescale	Oversight
In development		

Benchmarking with local Trusts

Trust	Aligned BAF Risk(s)	Q1 Score	Q2 Score	Q3 Score	Q4 Score
LUHFT	**Risk 3: Fundamentals of Care** 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 the length of patient stay and positive health outcomes for patients.	**3+3+3=9**			
	Risk 2: Urgent & Emergency Care 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.	**4+4+4=12**			
Walton Centre	**Quality Patient Care** Impact on patient outcomes and experience	**12**			
LHCH	**BAF1** Failure to maintain safety and quality and avoid harm would result in poorer patient & family experience	**6**			

BAF Risk 3 – Digital Sustainability

Risk Description and Impact on Strategic Aims
If the Trust fails to embed aims and objectives in its digital strategy, sub-optimal clinical records systems, insufficient resources, and major IT system failures due to cyber-attacks may occur, compromising patient safety, disrupting operations, and causing reputational harm, thereby missing opportunities to enhance care efficiency, quality, and safety.

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

Risk Scoring												Appetite
Inherent Score				Residual Score				Target Score				
L	C	RC	RPS	L	C	RC	RPS	L	C	RC	RPS	Cautious
3	4	3	10	3	4	3	10	2	4	2	8	

Rationale for risk score and quarterly update – Q1 2024/25

Rationale for LIKELIHOOD score of 3

Despite the robust controls in place, the likelihood of a cyber-attack has increased recently due to external factors:

- Increased Global Cyber Threats: Recent world events, particularly increased cyber threats from Russia, have elevated the environmental risk. This is reflected in the NHS's guidance issued to all providers and arm's length bodies in March 2022.
- Assessment Adjustments: The likelihood score increased from possible (3) to likely (4) in the last quarter due to these heightened threats, despite the effective controls in place.

However, the maturation of the EPR system's optimisation phase has reduced the risk posed by multiple clinical systems, demonstrating ongoing progress in mitigating this aspect of the risk.

Rationale for CONSEQUENCE score of 4

The consequence of a successful cyber-attack remains significant, but recent measures have mitigated the potential impact:

- Impact Reduction from Catastrophic to Major: The multi-layered technical controls have proven effective, reducing the assessment of consequence from catastrophic to major. This means that while the impact would still be severe, it is less likely to result in the most extreme outcomes.
- Operational Dependency on Digital Systems: Given the increasing dependency of clinical services on digital systems, any disruption due to a cyber-attack would still have a major negative impact on Trust services. This could compromise patient safety, disrupt operations, and cause reputational harm.
- Integration Improvements: The improved systems integration through the MEDITECH Expanse EPR and ongoing DigiCare programme helps mitigate some risks, but the overall impact remains major (4) due to the critical nature of these systems in clinical operations.

Rationale for CONTROLS score of 3

The Trust's Digital Services department has implemented robust controls to mitigate the risk of cyber-attacks and ensure the security and reliability of clinical records systems. Key measures include:

- Cyber Security Management: The department places cyber security management at the core of its operations, maintaining its Cyber Essentials standard. This involves multi-layered technical controls that have proven effective in alerting and protection, allowing the department to contain the impact of successful attacks in some scenarios.
- MEDITECH Expanse EPR: The introduction of this system has significantly improved systems integration with other Trust systems. The ongoing DigiCare programme, which focuses on the stabilisation and optimisation phases, has further mitigated risks associated with multiple systems.
- Process Refinement and Security Technologies: Continuous strengthening of controls through process refinement and the introduction of new security technologies enhances the Trust's capability to prevent and respond to cyber threats.
- Prioritisation Based on Safety Assessment: Activities to control digital adoption and staff engagement are prioritised based on safety assessments, ensuring that critical areas receive the necessary focus and resources.

However, as demonstrated by the recent cyber-attack in London, there is a significant risk when Trust systems interact with third parties (NHS or otherwise). This requires further assessment ahead of improving the overall control score.

Key Controls and Assurance Framework

Key Controls:	Assurances			
		Assurance Level	Assurance Rating	Overall Assurance Rating
Implementation and Integration of Digital Systems	Approved EPR Business Case: Defines a clear direction and preferred solution for the EPR, ensuring alignment with digital integration goals.	**2**		

• Successful Implementation of digiCare MEDITECH EPR: Ensures a modern and secure electronic patient record system. • Enhanced Integration between MEDITECH EPR and Other Trust Systems: Provides seamless and secure communication between different digital platforms. • PACS Upgrade: Removes a separate login for that system, reducing multiple system issues and improving security. • Optimisations to K2 System and Refinements Implemented: Ensures that the K2 system operates efficiently and securely. • digiCare MEDITECH Expanse Optimisations Programme Established: Continuous improvement of the EPR system for optimal security and functionality. • Task and Finish Groups for Pathology and Radiology Reporting: Focused efforts to improve digital reporting and integration.	digiCare EPR Programme Board Chaired by CIO: Provides high-level oversight and strategic direction for the implementation and integration of the EPR system.			
Governance and Strategic Oversight • Stabilisation and Optimisation Phases with Oversight at digiCare EPR Programme Board: Ensures the system is used as intended with proper oversight. • Clinical Safety Officer Processes: Established to identify and mitigate clinical risks through digital design and use. • Approved EPR Staffing Business Case: Ensures sufficient staffing to support the digital systems. • Approved Digital Generations Strategy: Provides a roadmap for digital transformation and security. • Approved Meditech Expanse Business Case: Supports the financial and operational planning for the EPR system. • Approved Trust Cyber Strategy: Establishes a comprehensive approach to cybersecurity	• **FPBD Committee Overview and Scrutiny**: Ensures financial and strategic oversight of digital initiatives. • **Digital Hospital Committee Oversight**: Provides comprehensive oversight of the digital transformation initiatives. • **digiCare EPR Programme Board Chaired by CIO**: Provides governance and ensures strategic alignment with digital transformation goals. • **Clinical Safety Officer Governance**: Mitigates clinical risk through digital use by ensuring safety protocols are in place. • **IMT Risk Management Meeting**: Regularly assesses and manages IT-related risks. • **MIAA Critical Application Audit (Rolling Programme Across Trust Systems)**: Ensures continuous improvement and compliance with best practices for critical applications. • **MIAA Cyber Controls Review**: Provides an independent review of the Trust's cyber controls, ensuring robust governance.	**3**		
Network and Infrastructure Security • Fully Resilient External (Internet/Clinical) Network Links: Ensures continuous and secure connectivity. • Improved Community Network Connectivity: Enhances secure communication within the community network. • Network Switches and Firewalls Firmware Updates: Ensures up-to-date network security. • Externally Managed Network Service Provider: Provides secure network management. • Network Perimeter Controls (Firewall): Protects against unauthorized external intrusion. • Enhanced VPN Solution: Secures home working connections. • Robust Implementation Plan for Secure Boundary (Web Filtering): Ensures safe internet usage and protection from malicious sites.	• Cyber Essentials Plus Standards/KPIs: Establish benchmarks for network and infrastructure security. • Cyber Essentials Plus Accreditation: Validates the Trust's adherence to essential cybersecurity standards. • Cyber Penetration Test: Identifies vulnerabilities in the network and infrastructure to prevent potential breaches. • NHS Care Cert Compliance: Ensures the Trust follows NHS guidelines for network security. • MIAA Cyber Controls Review: Provides continuous assessment and improvement of cybersecurity controls.	**3**		
Cybersecurity Measures • CareCert Process: Enacts advice from NHS Digital regarding imminent threats. • Malware Protection: Identifies and removes known cyber threats and viruses. • Cyber Security Monitoring System: Identifies suspicious network and potential cyber threat behavior. • Mobile Device Management: Provides enhanced security for mobile devices. • Implementation of Multi-Factor Authentication (MFA): Reduces the risk of unauthorized system access.				
System Maintenance and Updates • Microsoft Windows Security and Critical Patches Applied Monthly: Ensures all servers, laptops, and desktops are secure. • Mobile End Devices Patched as Released by Vendor: Maintains the security of mobile devices. • Network Switches and Firewalls Firmware Updates: Regularly updated to protect against vulnerabilities.	• Quarterly Risk Assessments Completed: Ensure ongoing evaluation and updating of system vulnerabilities. • MIAA Critical Application Audit: Regular audits to ensure systems are up-to-date and secure. • Cyber Penetration Test: Regularly tests system resilience against potential attacks	**3**		
User Access and Authentication • **Fast User Logon Project (Imprivata)**: Simplifies multi-application logon experiences for staff, enhancing security. • **Virtual Desktop Technology**: Supports flexible and secure staff working. • **Effective USB Port Control Implemented**: Prevents unauthorized use of USB ports.	• Cyber Essentials Plus Standards/KPIs: Include measures for secure user access and authentication. • Cyber Essentials Plus Accreditation: Ensures adherence to secure access protocols. • Cyber Penetration Test: Evaluates the effectiveness of user access controls.	**3**		
Training and Awareness • Robust Information Governance Training: Educates staff on information security and cyber security good practices. • Regular Staff Educational Communications on Cyber Threats: Keeps staff informed about the latest cyber threats and secure working practices. • Additional Cybersecurity Communications During Covid Phishing/Scams: Advises staff on diligence regarding specific threats. • Review and Updating of Information Security Policies: Ensures policies are current and relevant, supporting remote working.	• Effective Staff Communications on digiCare: Keeps staff informed and engaged with digital security practices. • Independent Lessons Learnt Positive Review: Uses feedback to improve staff training and awareness. • Medical Devices Committee: Ensures staff are trained on the secure use of medical devices.	**2**		

Gaps in Control and Assurances – Links to the Improvement Plan

Aligned Projects:

N/A

Gaps in Control and Assurances - Links to Risk Register

Links to Risks on the Risk Register				
Low (3-5)	Moderate (6-9)	Serious (10-11)	Significant (12-15)	Total
In development				

Linked >12 risks					
Risk	Controls	Gaps in Control	Assurance	Actions	Oversight
In development					

Gaps in Control – Medium to Long Term Actions

Action	Timescale	Oversight
In development		

Benchmarking with local Trusts

Trust	Aligned BAF Risk(s)	Q1 Score	Q2 Score	Q3 Score	Q4 Score
LUHFT	**Risk 9: Digital Sustainability** If we are unable to develop cyber-secure and compatible patient information systems due to resourcing and lead time limitations, this may result in a detrimental impact on service continuity and consistency.	**3+4+3=10**			
Walton Centre	**Cyber Security** Inability to prevent Cyber Crime	**15**			
	Digital Inability to deliver the Digital Substrategy ambitions	**12**			
LHCH	**BAF9** 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	**8**			
Clatterbridge	**BAF 10** There is a risk of limited development and adoption of digitisation across the Trust, which would constrain service improvements and reduce the benefits for patients	**9**			
	BAF 11 There is a risk of major security breach arising from increasing digitisation and cyber threats, which could disable the Trust's systems, disrupt services and result in data loss.	**12**			
AHCH	**Digital and Data Strategic Development & Delivery**	**12**			

BAF Risk 4 – Financial Sustainability

Risk Description and Impact on Strategic Aims
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.

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

Risk Scoring												Appetite
Inherent Score				Residual Score				Target Score				
L	C	RC	RPS	L	C	RC	RPS	L	C	RC	RPS	Open
4	4	3	11	3	4	3	10	3	4	2	9	

Rationale for risk score and quarterly update – Q1 2024/25

Rationale for LIKELIHOOD score of 3

1. Significant Financial Deficit Plan: The Trust has submitted a significant deficit plan for 2024/25, indicating the severity of the financial situation. While there is confidence in the controls and mitigations, the scale of the deficit presents a substantial risk.
2. Primary Drivers of Financial Risk: Key factors contributing to the risk to delivery of the plan include:
    - Ongoing requirements from previous workforce investments, and workforce pressures.
    - Risk to delivery of a challenging cost improvement programme and plan stretch targets. Financial impact of industrial action.
3. Historical and Structural Financial Challenges: The Trust faces long-standing financial issues due to its size, lack of economies of scale, and the specific mix of services it provides. These structural challenges exacerbate the financial risk each year.
4. Exacerbating Factors: Additional pressures such as capital investment needs, ongoing revenue investments, and reductions in top-up income further increase the likelihood of financial instability.

Given these factors, the likelihood score accurately reflects the possibility that the Trust may not be able to deliver its financial plan.

Rationale for CONSEQUENCE score of 4

1. **Medium/Long-Term Sustainability**: Failure to achieve financial sustainability could compromise the Trust's ability to deliver high-quality services in the long term. This may lead to reduced service availability, potential cuts in essential services, and overall diminished patient care quality.
2. **Effective System Collaboration**: Financial instability could hinder the Trust's ability to collaborate effectively with system partners. This collaboration is crucial for implementing strategic solutions and securing additional income necessary for recovery.
3. **Capital and Revenue Investment Pressures**: Ongoing capital and revenue investment pressures, coupled with the inability to generate sufficient income, could result in a continuous cycle of financial deficits. This would make long-term financial recovery increasingly difficult.
4. **Reputation and Trust**: Persistent financial challenges can damage the Trust's reputation, affecting stakeholder confidence and potentially leading to a loss of trust among patients, staff, and partners.
5. **Regulatory and Compliance Risks**: Inability to meet financial targets may result in increased scrutiny from regulatory bodies, potentially leading to sanctions or other regulatory actions.

Considering these significant potential impacts, the impact score reflects the serious consequences of not achieving financial sustainability, justifying a high impact score in the risk assessment.

Rationale for CONTROLS score of 3

- **Long-Term Financial Recovery Plan**: The Trust has developed a comprehensive financial recovery plan that outlines strategic, system-wide solutions and the necessity for additional income to cover the costs of delivering maternity care and associated CNST costs. This plan demonstrates proactive steps towards addressing the underlying financial issues.
- **Targeted Financial Recovery Program**: Introduced in July 2023, this program aims to support both the in-year and long-term financial positions. It shows the Trust's commitment to addressing immediate financial challenges while laying the groundwork for future stability.
- **Strong Financial Grip and Control Processes**: The Trust maintains rigorous financial controls and continuously seeks opportunities for increased productivity and efficiency. This includes regular monitoring and reporting of financial performance, which ensures timely identification and mitigation of adverse variances.
- **System Collaboration**: The Trust is working closely with system partners to resolve underlying deficit issues, highlighting a collaborative approach to financial sustainability.

These controls are well-defined and evidence-backed, providing a solid foundation for managing financial risk. However, the inherent financial challenges, such as the lack of economies of scale and the costs of delivering specialized services, limit the overall effectiveness of these controls, resulting in a control score that reflects both strengths and limitations.

Key Controls and Assurance Framework				
Key Controls:	**Assurances**			
		Assurance Level	**Assurance Rating**	**Overall Assurance Rating**
Financial Planning and Monitoring • Financial Recovery Plan: Produced and shared with the ICS with ongoing dialogue regarding solutions, ensuring proactive management of financial sustainability. • Monthly Reporting and Monitoring of Position: Includes taking corrective actions where required to maintain financial health. • Monthly Review of Financial Position with Divisional Leadership and CFO, with additional scrutiny on CIP delivery: Ensures comprehensive oversight and timely interventions ahead of financial close down. • CIP progress reported fortnightly under the Trust's Improvement Plan. • Regular review of efficiency programme progress and delivery under the Trust's Portfolio Board.	• Long-Term Financial Recovery Plan Produced and Submitted (Sept 23): Provides a strategic roadmap for achieving financial sustainability. • Recovery Plan with Agreed Actions in Place: Monitored through the FPEG, Executive Team, and Finance, Performance and Business Development Committee, and reported to the Board, ensuring structured oversight and accountability. • FPEG, FPBD and Board (Monthly Reports): Regular reporting ensures continuous monitoring and timely interventions to address financial issues. • ERAG Receives Monthly Reports: Includes chair's reports from FPEG and specific performance-centred reports for detailed oversight. • Active Participation in C&M Planning Processes: Ensures alignment and coordination with regional financial planning efforts. • Ongoing Regular Review of Financial Position at System Level: Facilitates proactive management of financial risks and opportunities.	**2**		
Governance and Accountability • Trust Improvement Plan: Pillar focused on CIP delivery and long-term financial recovery, addressing the drivers of the deficit, each supported by Executive Sponsors for accountability. • Sign-off of Budgets by Budget Holders and Managers: Ensures responsibility and accountability against those budgets. • Internal Audit Reports: Provide assurance regarding financial controls, reporting, and Cost Improvement Plans. • Internal Audit Plan Shared with ICB: Highlights cash/treasury management as a key area for review, ensuring transparency and accountability.	• **Establishment of Women's Services Committee**: Addresses medium to long-term issues, providing focused governance on key service areas impacting financial sustainability. • **Internal Audit - High Assurance for majority of Finance Related Internal Audit Reports**: In 2020/21, 2021/22, and 2022/23, substantial assurance in 2022/23 in relation to the Recovery Plan, indicating strong financial controls and governance. • **External Audit – VFM report** reflects robust financial reporting and management practices. • **Enhanced Grip and Control to Manage Influenceable Spend**: Ensures effective management and oversight of discretionary expenditures. Full compliance with national and local measures evidenced.	**3**		
Cost Control and Efficiency Measures • Cost Improvement Identification Process: Includes QIA and EIA processes supported by an internal PMO to ensure targeted and effective cost reductions. • Agency and Premium Pay Control: Demonstrated by low overall usage, indicating efficient management of staffing costs. • Vacancy Control Panel: Meets weekly to review and approve all posts, ensuring controlled staffing expenditures. • Revised Non-pay Expenditure Controls: In place to manage and minimize unnecessary spending.	• Focus on Benchmarking and Efficiencies: Includes joint working where possible to identify and implement cost-saving opportunities. • Agency Use Monitored Regularly: Ensures controlled use of agency staff to manage costs effectively. • Mitigations Being Worked Up in Case of Identified Risks Materialising: Proactive measures to address potential financial risks. • Process in Place Regarding CNST MIS: Prior achievement of MIS and engagement with NHS Resolution, learning from claims and incidents to maintain financial incentives.	**2**		
Collaboration and Partnership • Collaboration and Efficiency at Scale Across Liverpool and C&M: Underpinned by findings of the Liverpool Clinical Services Review, promoting regional efficiency. • Partnership Working with Other Providers: Enhances efficiency and minimizes duplication, leveraging collective resources.	• Place-Based Focus on Resources Initiated (Jan 24): Enhances resource allocation and efficiency through localized planning. • Active Participation in C&M Planning Processes: Ensures alignment with regional strategies and leverages collective resources for financial sustainability. • Focus on Benchmarking and Efficiencies: Joint working where possible to optimize resources and reduce duplication.	**3**		
Operational Controls • Detailed Log of Investments Since 2019/20: Post-implementation reviews ensure that investments are yielding expected returns and adjustments can be made if necessary. • 'No PO No Pay' Policy: Re-enforced to ensure proper procurement controls and avoid unauthorized expenditures. • Review of Services and Related Costs and Income: Ensures alignment of service delivery with financial sustainability goals.	• Enhanced Grip and Control to Manage Influenceable Spend: Strengthened controls to ensure financial discipline and accountability. • Approval of Cash Support: Demonstrates proactive financial management to secure necessary funding and maintain liquidity. • Mitigations Being Worked Up in Case of Identified Risks Materialising: Ensures preparedness and resilience against potential financial shocks.	**2**		

Cash Management • **Cash Management Controls**: Include a 13-week cashflow updated weekly, showing the impact of cash advances and requested cash support. • **Cash Balances Reviewed Daily**: By the CFO and DCFO, ensuring vigilant cash flow management. • **Successful Application for Central Cash Revenue Support in 2023/24**: Demonstrates proactive steps taken to ensure sufficient cash flow. • **Explanation of Need for Cash**: Provided with triangulation to financial position, ensuring clarity and justification for cash management decisions.	• Approval of Cash Support: Ensures adequate liquidity to support ongoing operations and address financial shortfalls. • Enhanced Grip and Control to Manage Influenceable Spend: Tightened controls to maintain financial stability and manage cash flow effectively.	**2**		
Risk Management and Assurance • Consistent Achievement of CNST Maternity Incentive Scheme Safety Standards: Ensures ongoing compliance and financial incentives. • Reference Costs at 103 (2021/22): Latest data indicating cost efficiency in the context of an isolated site compared to other Trusts. • Trust Participation in System-wide Expenditure Controls Group with ICB: Reviews grip, control, and expenditure monthly, providing an additional layer of oversight and risk management.	• Process in Place Regarding CNST MIS: Prior achievement of MIS, engagement with NHS Resolution, and learning from claims and incidents to manage financial risks associated with maternity services. • Internal Audit - High Assurance for majority of Finance Related Internal Audit Reports: Provides confidence in the effectiveness of financial controls and risk management processes. • External Audit and VFM report - Validates the integrity of financial management and reporting practices. • Mitigations Being Worked Up in Case of Identified Risks Materialising: Proactive development of risk mitigations to address potential financial challenges.	**3**		

Gaps in Control and Assurances – Links to the Improvement Plan

Aligned Projects:

- **5.1 Delivering the Three-year Financial Plan**
- **5.2 2024/25 CIP Delivery**

Gaps in Control and Assurances - Links to Risk Register

Links to Risks on the Risk Register				
Low (3-5)	**Moderate (6-9)**	**Serious (10-11)**	**Significant (12-15)**	**Total**
In development				

Linked >12 risks					
Risk	**Controls**	**Gaps in Control**	**Assurance**	**Actions**	**Oversight**
In development					

Gaps in Control – Medium to Long Term Actions

Action	Timescale	Oversight
In development		

Benchmarking with local Trusts

Trust	Aligned BAF Risk(s)	Q1 Score	Q2 Score	Q3 Score	Q4 Score
LUHFT	**Risk 8: Financial Sustainability** 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.	**4+5+2=11**			
Walton Centre	**System Finance** Inability to deliver financial plan for year	**9**			
	Capital Funding Inability to secure capital funding to maintain the estate to support patient needs	**9**			
LHCH	**BAF5** Failure to deliver financial plans and changes in the funding regime and commissioning landscape could impact sustainability for the Trust and system partners	**12**			
	BAF3 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	**12**			
Clatterbridge	**BAF 3** There is a risk that the Trust does not deliver its financial target because it has either insufficient income to cover costs, and/or it does not achieve the required level of recurrent efficiency savings.	**15**			
AHCH	**Financial Environment**	**16**			

BAF Risk 5 – Cancer Recovery

Risk Description and Impact on Strategic Aims

If we do not deliver cancer recovery in line with national planning guidance through the reduction in access times for our longest waiting patients, there is a risk of negative impact on health outcomes and patient experience.

Responsibility for Risk

Committee:	Quality Committee	Lead Director:	Chief Operating Officer

Risk Scoring

Inherent Score				Residual Score				Target Score				Appetite
L	C	RC	RPS	L	C	RC	RPS	L	C	RC	RPS	Minimal (ALARP)
3	4	3	10	3	4	3	10	2	4	2	8	

Rationale for risk score and quarterly update – Q1 2024/25

Rationale for LIKELIHOOD score of 3
The likelihood of not delivering cancer recovery in line with national planning guidance is impacted by several factors. The Trust's efforts to clear backlogs and improve cancer performance demonstrate a focused approach to managing this risk. However, the ongoing challenges such as industrial action and staffing issues increase the likelihood of delays.

Rationale for CONSEQUENCE score of 4
The impact of failing to deliver cancer recovery according to national planning guidance is significant. Delays in treatment can lead to negative health outcomes and a poor patient experience.

Rationale for CONTROLS score of 3
The Trust has been actively working to reduce access times for the longest waiting patients - 65-week and 52-week wait targets are being met ahead of the trajectory. This indicates that control measures are in place and effective. However, the presence of industrial action and workforce availability issues suggests that while controls are effective, they are not fully robust against external factors.

Key Controls and Assurance Framework

Key Controls:	Assurances	Assurance Level	Assurance Rating	Overall Assurance Rating
Implementation of a Comprehensive Cancer Improvement Plan: A detailed plan outlining steps to recover and improve cancer care services.	**Regular Monitoring and Reporting:** The Cancer Improvement Plan is monitored regularly with bi-monthly progress reports submitted to the IPPB and Trust Board.	2		
Investment in Diagnostic and Treatment Capacity	**Performance Metrics**: Tracking of diagnostic and treatment wait times to measure impact of investments.	2		
Cancer Pathway Improvement Initiatives	**Pathway Audit Reports:** Regular audits of cancer pathways to identify bottlenecks and areas for improvement. **Patient Feedback**: Collection and analysis of patient feedback on their care pathway	2		
Robust Data Collection and Analysis: Enhanced data collection and analysis to monitor performance and outcomes in cancer care.	**Performance Dashboards:** Regular updates to dashboards tracking key performance indicators (KPIs). **Benchmarking Reports:** Comparing Trust performance against national standards and other trusts.	2		

Gaps in Control and Assurances – Links to the Improvement Plan

Aligned Projects:

- **3.1 Cancer Improvement**
- **3.2 Reduced Waiting List**

Gaps in Control and Assurances - Links to Risk Register

Links to Risks on the Risk Register				
Low (3-5)	Moderate (6-9)	Serious (10-11)	Significant (12-15)	Total
In development				

Linked >12 risks					
Risk	**Controls**	**Gaps in Control**	**Assurance**	**Actions**	**Oversight**
In development					

Gaps in Control – Medium to Long Term Actions

Action	Timescale	Oversight
In development		

Benchmarking with local Trusts

Trust	Aligned BAF Risk(s)	Q1 Score	Q2 Score	Q3 Score	Q4 Score
LUHFT	**Risk 13: Cancer Recovery** If we do not deliver cancer recovery in line with national planning guidance through the reduction in access times for our longest waiting patients, there is a risk of negative impact on health outcomes and patient experience and a risk of negative impact on finances through the ongoing reliance on high-cost capacity	**4+5+2=11**			
Walton Centre	**Operational Performance** Inability to deliver the operational plan	**9**			
LHCH	**BAF2** 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.	**12**			

BAF Risk 6 – Waiting Times

Risk Description and Impact on Strategic Aims

If the Trust does not reduce patient waiting times and overall list size, it risks compromising patient outcomes, care standards, and incurring regulatory penalties.

Responsibility for Risk

Committee:	Finance, Performance & Business Development Committee	Lead Director:	Chief Operating Officer

Risk Scoring

Inherent Score				Residual Score				Target Score				Appetite
L	C	RC	RPS	L	C	RC	RPS	L	C	RC	RPS	
3	4	3	10	3	4	3	10	2	4	2	8	Minimal (ALARP)

Rationale for risk score and quarterly update – Q1 2024/25

Rationale for LIKELIHOOD score of 3

The likelihood of not reducing patient waiting times and list size is heightened by the backlog created due to the COVID-19 pandemic, which led to delayed treatments and appointments. The Trust has faced challenges in clinical capacity, which has been strained due to increased referrals and the backlog from the pandemic, impacting the ability to meet national Referral to Treatment (RTT) standards.

Rationale for CONSEQUENCE score of 4

Should the Trust fail to reduce the waiting times and list size, the consequences could be severe, compromising patient outcomes and care standards. There is a risk of regulatory penalties and a negative impact on the Trust's reputation.
The Trust's performance against national cancer waiting times standards and the 4-hour AED target is critical, and failure to meet these could result in significant consequences, including financial penalties and loss of public trust.

Rationale for CONTROLS score of 3

The Trust has implemented several measures to control the increasing patient waiting times and list size, such as the integration of the NHSE programme 'Further Faster' into the Outpatient Transformation & Theatre Productivity groups, which aims to enhance patient access and experience, increase activity, and reduce the outpatient PTL.

Key Controls and Assurance Framework

Key Controls:	Assurances			
		Assurance Level	Assurance Rating	Overall Assurance Rating
Performance Monitoring and Reporting • Fortnightly Access Board Meetings: These meetings with Divisional Operational Teams and Information present monitor key performance metrics, ensuring regular and systematic oversight. • Daily Monitoring of Performance through Power BI Dashboards: Provides daily and weekly updates on key performance metrics, enabling timely interventions. • Weekly Patient Tracking List (PTL) Meetings: Regular meetings with Divisional Operational teams and Patient Access ensure ongoing tracking and management of patient waiting times. • IoL Metrics Included on Executive and SLT Live Dashboards: Ensures real-time visibility and accountability for induction of labour metrics at the executive level.	• Fortnightly Access Board Meetings: These meetings ensure regular oversight and discussion of key performance metrics, helping to identify and address issues that may affect waiting times. • Daily Monitoring of Performance through Power BI Dashboards: Real-time data provided through dashboards allows for daily and weekly updates on key performance metrics, enabling quick responses to emerging issues. • Weekly Patient Tracking List (PTL) Meetings: These meetings with divisional teams ensure continuous tracking and management of patient flow, helping to reduce waiting times. • IoL Metrics Included on Executive and SLT Live Dashboards: Real-time visibility of induction of labour metrics ensures that senior leadership is aware of and can address waiting time issues promptly.	2		
Strategic Improvement Programs • Elective Recovery Programme: A comprehensive program with workstreams designed to improve performance and reduce waiting times.	• **Elective Recovery Programme**: This program includes specific workstreams aimed at improving overall performance and reducing patient waiting times through targeted actions and strategic initiatives.	2		

• Sub-specialisation of Gynaecology and Sub-specialty Recovery Plans: Focus on specific areas within Gynaecology to monitor actions and risks at a sub-specialty level, establishing performance trajectories for improvement.	• **Sub-specialisation of Gynaecology and Sub-specialty Recovery Plans**: Focuses on specific areas within Gynaecology to create detailed recovery plans and performance trajectories, ensuring targeted improvements in waiting times for specialized services.			
Capacity and Resource Management • Review of Medical & Nursing Job Plans: Ensures adequate capacity is in place to treat patients in a timely manner. • Increased Staffing Capacity in MAU: Enhances the ability to manage and reduce waiting times through additional staffing resources.	• Review of Medical & Nursing Job Plans: Regular review of job plans ensures that sufficient capacity is allocated to meet patient needs, directly impacting waiting times. • Increased Staffing Capacity in MAU: Additional staffing resources in the Maternity Assessment Unit (MAU) help manage patient flow more effectively, reducing waiting times.	**2**		
Utilization and Efficiency • Theatre Utilisation Group: Focuses on optimizing the use of theatre space to increase capacity and reduce waiting times. • Controls to Monitor Length of Stay for Women in Induction of Labour: Specific controls to manage and reduce the length of stay, improving throughput and reducing delays.	• Theatre Utilisation Group: This group focuses on optimizing the use of theatre resources, increasing efficiency and capacity, which helps reduce waiting times for surgeries and procedures. • Controls to Monitor Length of Stay for Women in Induction of Labour: These controls help manage and reduce the length of stay for women in labour, improving patient flow and reducing delays.	**2**		
External Review and Validation • External Validation Programme: Reviews all admitted and non-admitted pathways to ensure RTT guidance is applied correctly, with audits by MIAA to ensure compliance and accuracy.	**External Validation Programme:** This program reviews all admitted and non-admitted pathways to ensure correct application of RTT guidance, with MIAA audits providing additional assurance of compliance and accuracy	**3**		
Specialty-specific Oversight and Management • **Cancer Committee**: Meets bi-monthly to review Cancer performance and track actions for improvement. • **C&M Weekly Maternity Escalation Cell**: Provides a focused and regular review of maternity services to ensure timely care and reduce waiting times.	• Cancer Committee: The committee meets bi-monthly to review cancer performance and track actions for improvement. This ensures focused attention on reducing waiting times in cancer care. • C&M Weekly Maternity Escalation Cell: Provides regular, focused review of maternity services, ensuring timely interventions and reduced waiting times for maternity patients.	**2**		
Operational and Safety Controls • Daily Safety Huddles: Regular meetings to address immediate safety concerns and operational issues, ensuring that waiting times do not compromise patient safety. • Increased Staffing Capacity in MAU: Enhances operational capacity, directly contributing to reduced waiting times.	• Daily Safety Huddles: These meetings address immediate safety concerns and operational issues, ensuring that waiting times do not compromise patient safety. • Increased Staffing Capacity in MAU: Enhances operational capacity to manage patient flow effectively, contributing to reduced waiting times.	**2**		

Gaps in Control and Assurances – Links to the Improvement Plan

Aligned Projects:

- **3.2 Reduced Waiting List**
- **2.2 Acute Gynae Services**
- **2.1 Enhanced Workforce for Acute Workload**

Gaps in Control and Assurances - Links to Risk Register

Links to Risks on the Risk Register				
Low (3-5)	Moderate (6-9)	Serious (10-11)	Significant (12-15)	Total
In development				

Linked >12 risks					
Risk	**Controls**	**Gaps in Control**	**Assurance**	**Actions**	**Oversight**
In development					

Gaps in Control – Medium to Long Term Actions

Action	Timescale	Oversight
In development		

Benchmarking with local Trusts

Trust	Aligned BAF Risk(s)	Q1 Score	Q2 Score	Q3 Score	Q4 Score
LUHFT	**Risk 1: Elective Activity Plans** 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 the potential increase in demand for social care	**3+3+2=8**			
Walton Centre	**Operational Performance** Inability to deliver the operational plan	**9**			
LHCH	**BAF2** 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.	**12**			
Clatterbridge	**BAF 2** There is a risk of demand exceeding available resources that could impact the quality and safety of services and patient outcomes.	**12**			
AHCH	**Children and young people waiting beyond the national standard to access planned care and urgent care**	**20**			
	Access to Children and Young People's Mental Health	**15**			

BAF Risk 7 – Health Inequalities

Risk Description and Impact on Strategic Aims
If the Trust does not actively address health inequalities and support the anti-racism agenda, it risks perpetuating disparities in healthcare access and outcomes.

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

Risk Scoring												Appetite
Inherent Score				Residual Score				Target Score				
L	C	RC	RPS	L	C	RC	RPS	L	C	RC	RPS	
3	4	3	10	3	4	3	10	2	4	2	8	Minimal (ALARP)

Rationale for risk score and quarterly update – Q1 2024/25

Rationale for LIKELIHOOD score of 3
The likelihood of perpetuating disparities in healthcare access and outcomes is mitigated by the Trust's proactive measures, such as the creation of multilingual and accessible digital platforms to ensure all patients can engage with healthcare services. Workshops and work plans focusing on site equity for patients and support for staff indicate a structured approach to addressing health inequalities.

Rationale for CONSEQUENCE score of 4
The consequences of not actively addressing health inequalities and supporting the anti-racism agenda could lead to serious disparities in healthcare access and outcomes, which would be contrary to the Trust's ambition to become one of the most inclusive organizations in the NHS. The Trust's efforts to strengthen leadership capacity in the Division and the co-ordinated approach to continuous improvement in maternity services demonstrate the potential impact of these initiatives on reducing health inequalities.

Rationale for CONTROLS score of 3
The Trust has shown a commitment to addressing health inequalities and supporting the anti-racism agenda, as evidenced by the investment in Equality, Diversity, and Inclusion (EDI) expertise and the development of EDI Objectives focused on improving access to services and outcomes for ethnically diverse communities. Initiatives like the Maternity Transformation and Outpatients Transformation Workstreams are ongoing efforts to address health inequalities within the Trust.

Key Controls and Assurance Framework

Key Controls:	Assurances			
		Assurance Level	Assurance Rating	Overall Assurance Rating
Inclusive Digital and Communication Platforms • Multilingual and Accessible Digital Platforms: Websites and engagement platforms in multiple languages, ReachDeck tool implementation to support various accessibility needs, ensuring all patients can access information and engage with healthcare services. • Fertility Patient Portal: Multilingual support to ensure detailed information about fertility treatments is accessible to all patients. • Outpatients Transformation Workstream with InTouch Check-In Kiosks: Supports multiple languages and aids in reducing reception lines, improving access for non-English speakers and deaf patients.	Regular user feedback and usage statistics show increased engagement from non-English speakers and those with disabilities.	**2**		
Targeted Health Programs and Initiatives • Elective Recovery Programme: Includes specific workstreams designed to improve performance and reduce waiting times. • Outpatient Transformation Workstream (DNA Plan): Incorporates initiatives to reduce DNAs, considering all protected characteristics, enhancing inclusivity. • Menopause Service Pilot in the Community: Collaboration with Primary Care to bring services closer to patients' homes, particularly in areas of higher deprivation.	Regular performance reviews and outcome measurements show reduced waiting times and improved service delivery.	**2**		

• Continuity of Carer Teams: Deployed in high deprivation areas and for racially minoritized groups to improve pregnancy and birth outcomes.				
Community Engagement and Consultation • Collaboration with Local Community Engagement Leads: Developing action plans through meaningful consultation with partners and service users. • Menopause Service Design Involvement: Engaging communities in designing services to ensure they meet local needs and are more inclusive. • Antenatal Classes in Different Languages: Offering classes in languages like Arabic and Tigrinya to meet the needs of diverse communities.	Action plans developed with community input show increased participation and satisfaction from local communities.	**2**		
Supportive Infrastructure and Tools • Interpreter On Wheels and Language Line App: Supporting translation needs in both spoken language and British Sign Language, facilitating better communication and care. • Help Hub at Hospital Entrance: Provides easy access to interpreters and support for non-English speakers and those needing assistance.	Positive feedback from patients using the Help Hub shows improved access to immediate support.	**2**		
Data-Driven Decision Making and Monitoring • EDI Dashboard: Developed by the Information Team, showing live anonymized data for all departments, filterable by protected characteristics. • Patient Friends and Family Test (FFT) Data Collection: Collected quarterly and broken down by age, ethnicity, and disability to monitor patient experience and inclusion in decision-making processes. • Power BI for Actionable Insights: Detailed reports and comments from FFT are available for departmental leaders to review and act upon.	Regular analysis of dashboard data shows trends and disparities being addressed promptly.	**2**		
Culturally Sensitive and Anti-Racist Initiatives • **Commitment to Anti-Racism**: Providing education and training programs on racism, unconscious bias, and systemic racism. Reviewing policies and practices to eliminate discrimination. • **Culturally Sensitive Care**: Embedding cultural awareness and sensitivity in all aspects of care delivery. • **Workshops for Leaders**: To increase awareness and understanding of racism and promote inclusive practices.	Participation rates and feedback from anti-racism training sessions show increased awareness and positive behavioural changes. Post-workshop evaluations show increased understanding and commitment to inclusive practices among leaders.	**2**		
Collaborative and Strategic Partnerships • Engagement with NHS Resolution for CNST MIS: Learning from claims and incidents to improve service delivery. • Involvement in Cheshire & Merseyside Elective Recovery and Inequalities Group: Presenting and refining initiatives to reduce health inequalities. • Collaboration with Central Liverpool PCN for Menopause Services: Engaging community leads to design inclusive services.		**2**		

Gaps in Control and Assurances – Links to the Improvement Plan

Aligned Projects:

Gaps in Control and Assurances - Links to Risk Register

Links to Risks on the Risk Register				
Low (3-5)	**Moderate (6-9)**	**Serious (10-11)**	**Significant (12-15)**	**Total**
In development				

Linked >12 risks					
Risk	**Controls**	**Gaps in Control**	**Assurance**	**Actions**	**Oversight**
In development					

Gaps in Control – Medium to Long Term Actions

Action	Timescale	Oversight
In development		

Benchmarking with local Trusts

Trust	Aligned BAF Risk(s)	Q1 Score	Q2 Score	Q3 Score	Q4 Score
LUHFT	**Risk 11: Population Health Inequalities** 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.	**3+3+3=9**			
Walton Centre	**Prevention and Inequalities:** Inability to improve equitable access to services	**12**			

BAF Risk 8 – Organisational Change

Risk Description and Impact on Strategic Aims
If the Trust does not effectively manage the transition to a more integrated working relationship with Liverpool University Hospitals NHS Foundation Trust, there is a risk of potential misalignment of organisational cultures, disruption to service delivery during the integration phase, and challenges in maintaining clear communication across both entities.

Responsibility for Risk			
Committee:	**Putting People First Committee**	**Lead Director:**	**Chief People Officer**

Risk Scoring												Appetite
Inherent Score				Residual Score				Target Score				
L	C	RC	RPS	L	C	RC	RPS	L	C	RC	RPS	
3	4	3	10	3	4	3	10	2	4	2	8	Open

Rationale for risk score and quarterly update – Q1 2024/25

Rationale for LIKELIHOOD score of 3

The likelihood score of 3 indicates a moderate probability that the risks associated with the organisational change will materialise. This score is justified because:

- **Previous Experiences**: There have been previous instances within the NHS where similar integrations have faced challenges, suggesting that while the risk is not guaranteed, it is plausible based on historical data.
- **Complexity of Integration**: The integration involves multiple layers of operational, cultural, and administrative alignment, increasing the likelihood of issues arising.
- **Current Preparedness**: While the Trust has some measures in place to manage the transition, there are still uncertainties and potential gaps in the readiness for such a significant change.

Rationale for CONSEQUENCE score of 4

The consequence score of 4 reflects a high impact on the Trust if the risks do occur. This score is warranted due to the following considerations:

- **Service Delivery Disruption**: Any misalignment or disruption during the integration phase could significantly affect service delivery, leading to delays, reduced patient satisfaction, and potential impacts on patient care.
- **Organisational Culture**: A misalignment in organisational cultures can lead to staff dissatisfaction, reduced morale, and increased turnover, further exacerbating operational challenges.
- **Communication Challenges**: Difficulties in maintaining clear communication across both entities can lead to misunderstandings, inefficiencies, and potentially critical mistakes in patient care coordination.

Rationale for CONTROLS score of 3

The controls score of 3 suggests that there are some controls in place, but they may not be fully sufficient to mitigate the risks completely. This score is appropriate because:

- **Established Protocols**: There are existing protocols and plans to manage the transition, including working groups, integration committees, and stakeholder engagement strategies.
- **Training and Support**: Efforts are being made to provide training and support to staff to navigate the change effectively, which helps mitigate some risks.
- **Monitoring and Evaluation**: Ongoing monitoring and evaluation mechanisms are in place to identify and address issues as they arise during the integration process.

However, the effectiveness of these controls is not yet fully proven, and there is room for improvement, particularly in areas like cultural alignment initiatives and enhanced communication strategies.

Key Controls and Assurance Framework

Key Controls:	Assurances	Assurance Level	Assurance Rating	Overall Assurance Rating
Establishment of a Dedicated Integration Team/Task and Finish Group - Forming a dedicated team with representatives from both Liverpool Women's NHS FT and Liverpool University Hospitals NHS Foundation Trust ensures focused attention on the integration process. This team can coordinate efforts, address issues promptly, and facilitate smoother transitions.	• Regular progress reports and updates from the integration team to senior management. • Clear documentation of the team's objectives, milestones, and timelines. • Regular meetings and collaboration sessions between representatives of both trusts.	2		
Regular Risk Assessments; Conducting regular risk assessments (with consistent methodology) helps in early identification and mitigation of potential issues. It allows the Trust to proactively address risks before they escalate, ensuring smoother integration.	• Detailed risk assessment reports and action plans. • Periodic reviews and updates to the risk register.	2		

Alignment of Policies and Procedures: Ensuring that policies and procedures are consistent across both trusts (when necessary / relevant)	• Policy review and alignment documentation. • Approval and sign-off from both trusts' leadership on aligned policies.	**2**		
Communication Plan Documentation: ensures transparency, mitigates cultural misalignment, reduces service disruption, facilitates feedback, supports crisis management, and enhances collaboration and morale.	• Communication strategy documents outlining the plan's objectives, methods, and key messages. • Logs of communication activities, including newsletters, meetings, and briefings. • Feedback reports summarising stakeholder responses and engagement levels.	**2**		

Gaps in Control and Assurances – Links to the Improvement Plan

Aligned Projects:

6.2 – Risk Management
6.3 – Streamlined Governance
6.4 – Partnership Governance

Gaps in Control and Assurances - Links to Risk Register

Links to Risks on the Risk Register				
Low (3-5)	**Moderate (6-9)**	**Serious (10-11)**	**Significant (12-15)**	**Total**
In development				

Linked >12 risks					
Risk	**Controls**	**Gaps in Control**	**Assurance**	**Actions**	**Oversight**
In development					

Gaps in Control – Medium to Long Term Actions

Action	Timescale	Oversight
In development		

Benchmarking with local Trusts

Trust	Aligned BAF Risk(s)	Q1 Score	Q2 Score	Q3 Score	Q4 Score
LUHFT	**Risk 10: Partnership & Collaboration** 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.	**3+3+3=9**			
Walton Centre	**Collaborative Pathways** Inability to develop further regional care pathways	**9**			
LHCH	**BAF8** System working and provider landscape changes may present challenges in ensuring LHCH continues to be positioned as a strong system partner, with priorities aligned to system partners across Cheshire & Merseyside and beyond.	**9**			
AHCH	**System working to deliver 2030 Strategy**	**16**			
	Failure to fully realise the Trust's Vision for the Park and Alder Hey Campus	**12**			

BAF Risk 9 – Well-Led

Risk Description and Impact on Strategic Aims
If corporate and quality governance arrangements do not meet the requirements of the Well-Led Framework, the Trust's assurance and escalation processes may not be fit for purpose, impacting on the provision of high-quality, sustainable, harm-free care.

Responsibility for Risk			
Committee:	**Quality Committee**	**Lead Director:**	**Chief Nurse**

Risk Scoring												Appetite
Inherent Score				Residual Score				Target Score				
L	C	RC	RPS	L	C	RC	RPS	L	C	RC	RPS	
3	3	3	9	3	3	3	9	2	3	2	7	Cautious

Rationale for risk score and quarterly update – Q1 2024/25

Rationale for LIKELIHOOD score of 3

The likelihood score of 3 reflects a moderate probability that the Trust's corporate and quality governance arrangements may not meet the Well-Led Framework requirements. This score is justified by the following factors:

- **Ongoing Changes and Adaptations**: The Trust is constantly evolving, with ongoing changes in policies, procedures, and leadership roles. These continuous adaptations can create a moderate risk of not fully aligning with the Well-Led Framework at all times.
- **Previous Audits and Inspections**: Past inspections and audits have identified areas for improvement in governance, indicating that while systems are generally effective, there is a reasonable possibility of occasional lapses.

Rationale for CONSEQUENCE score of 4

The consequence score of 3 indicates a moderate impact on the Trust if the governance arrangements do not meet the Well-Led Framework requirements. This score is appropriate due to the following considerations:

- **Quality of Care**: Governance is crucial in ensuring high-quality, harm-free care. Any deficiencies in governance could lead to moderate disruptions in care provision, potentially impacting patient outcomes and satisfaction.
- **Reputation and Stakeholder Confidence**: Failing to meet the Well-Led Framework could moderately affect the Trust's reputation and stakeholders' confidence, including patients, staff, and regulatory bodies.
- **Operational Efficiency**: Effective governance supports operational efficiency. Deficiencies could lead to moderate inefficiencies, affecting the Trust's ability to provide sustainable and seamless services.

Rationale for CONTROLS score of 3

The controls score of 3 suggests that there are adequate measures in place, but they may not be fully sufficient to mitigate the risk completely. This score is appropriate for the following reasons:

- **Governance Structures**: The Trust has established corporate and quality governance structures, including committees, groups and reporting mechanisms, which provide a solid foundation for meeting the Well-Led Framework requirements.
- **Regular Audits and Reviews**: The Trust conducts regular internal and external audits and reviews to ensure compliance with governance standards. These processes help in identifying and addressing gaps.
- **Training and Development**: Ongoing training and development programs for staff and leadership ensure that everyone is aware of and adheres to governance requirements. However, maintaining consistency in training and implementation can be challenging.

Key Controls and Assurance Framework

Key Controls:	Assurances			
		Assurance Level	Assurance Rating	Overall Assurance Rating
In development				

Gaps in Control and Assurances – Links to the Improvement Plan

Aligned Projects:

4.1 – Safety Culture
6.2 – Risk Management
6.3 – Streamlined Governance
6.4 – Partnership Governance

Gaps in Control and Assurances - Links to Risk Register

Links to Risks on the Risk Register				
Low (3-5)	Moderate (6-9)	Serious (10-11)	Significant (12-15)	Total
In development				

Linked >12 risks					
Risk	Controls	Gaps in Control	Assurance	Actions	Oversight
In development					

Gaps in Control – Medium to Long Term Actions

Action	Timescale	Oversight
In development		

Benchmarking with local Trusts

Trust	Aligned BAF Risk(s)	Q1 Score	Q2 Score	Q3 Score	Q4 Score
LUHFT	**Risk 4: Well-Led** If corporate and quality governance arrangements do not meet the requirements of the Well-Led Framework, the Trust's assurance and escalation processes may not be fit for purpose, impacting on the provision of high-quality, sustainable, harm-free care.	3+2+3=8			

Appendix 1 - 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

Control Score (RC)

1	2	3	4	5
Risk is fully under control	Risk is adequately controlled	Action to control risk adequately has started and appears to be effective	Action to control risk is agreed but no action started	No actions to controls risk identified

Risk scoring = Likelihood + Consequence + Control Scores

For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

3 - 5	Low risk
6 - 9	Moderate risk
10 - 11	Serious risk
12 - 15	Significant risk

Appendix 2 – Risk Appetite Statement & Matrix

Risk Appetite Statement 2024/25

The Trust operates in a high-risk environment and the day-to-day management of risk is an expected and integral part of the business of any healthcare provider. Overall, the Board has a CAUTIOUS appetite for risk in relation to the achievement of its objectives and takes active and ongoing actions as part of our daily operational management and strategic planning to reinforce our risk controls in order to minimise risk to a tolerable level.

Our Board Assurance Framework and risk registers will continue to reflect material risks that may prevent the Trust from fulfilling its role in delivering clinical services which meet regulatory and NHS Constitutional standards and the expectations of our stakeholders and patients.

However, within the boundaries of regulatory constraints, the Trust has an OPEN appetite to take well-considered and balanced risks to pursue innovation and opportunities where positive gains can be expected, whilst being confident that through good risk management the threats can be averted Using the Good Governance Institute 'Risk Appetite Matrix', the 'Risk Appetite Statement 2024/25' outlines the amount of risk that the Trust is willing to accept in pursuit of its strategic objectives. We have defined our appetite for risk in relation to our strategic objectives as follows:

To develop a well-led, capable, and motivated workforce:

- **Previous Risk Appetite:** Moderate
- **Revised Statement:** Liverpool Women's NHS Foundation Trust operates in a challenging environment, necessitating a balanced approach to risk. We adopt a **Cautious (2)** risk appetite, preferring safe and proven methods while remaining open to moderate levels of risk where it can lead to improved healthcare services. Our commitment to innovation, creativity, and clinical research is measured, ensuring that any risks taken are calculated and aligned with our strategic objectives to enhance patient outcomes and service sustainability.

To deliver the best possible experience for patients and staff:

- **Previous Risk Appetite**: Low
- **Revised Statement**: Liverpool Women's NHS Foundation Trust is dedicated to providing an exceptional experience for both patients and staff. We maintain a **Minimal (ALARP)** (1) risk appetite, ensuring that any actions or decisions are ultra-safe and subject to thorough risk assessment and Senior Management Team approval.

To deliver safe services:

- **Previous Risk Appetite**: Low
- **Revised Statement**: Patient and staff safety is our paramount concern. We adhere to a **Minimal (ALARP)** (1) risk appetite, emphasizing strict safety protocols and a commitment to learning from incidents to continually enhance the quality of our services

To participate in high-quality research and to deliver the most effective outcomes:

- **Previous Risk Appetite:** High
- **Revised Statement:** The Trust actively supports high-quality research and effective outcomes through a **Seek (4)** risk appetite. We are eager to pursue innovative and creative solutions that promise higher rewards and improved patient care.

To be ambitious and efficient and make the best use of available resources:

- **Previous Risk Appetite:** Moderate
- **Revised Statement:** Our approach to resource utilization is characterized by a **Open (3)** risk appetite. We are open to considering all potential delivery options that demonstrate value for money and contribute to our strategic goals, while maintaining quality and safety.

Risk Appetite for NHS Organisations
A matrix to support better risk sensitivity in decision taking

Developed in partnership with the board of Southwark Pathfinder CCG and Southwark BSU – January 2012

Good Governance Institute

Risk levels ▶ / Key elements ▼	0 **Avoid** Avoidance of risk and uncertainty is a Key Organisational objective	1 **Minimal** (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	2 **Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	3 **Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	4 **Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	5 **Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
Financial/VFM	Avoidance of financial loss is a key objective. We are only willing to accept the low cost option as VfM is the primary concern.	Only prepared to accept the possibility of very limited financial loss if essential. VfM is the primary concern.	Prepared to accept possibility of some limited financial loss. VfM still the primary concern but willing to consider other benefits or constraints. Resources generally restricted to existing commitments.	Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities.	Investing for the best possible return and accept the possibility of financial loss (with controls may in place). Resources allocated without firm guarantee of return – 'investment capital' type approach.	Consistently focussed on the best possible return for stakeholders. Resources allocated in 'social capital' with confidence that process is a return in itself.
Compliance/ regulatory	Play safe, avoid anything which could be challenged, even unsuccessfully.	Want to be very sure we would win any challenge. Similar situations elsewhere have not breached compliances.	Limited tolerance for sticking our neck out. Want to be reasonably sure we would win any challenge.	Challenge would be problematic but we are likely to win it and the gain will outweigh the adverse consequences.	Chances of losing any challenge are real and consequences would be significant. A win would be a great coup.	Consistently pushing back on regulatory burden. Front foot approach informs better regulation.
Innovation/ Quality/Outcomes	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems/ technology developments.	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations.	Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems / technology developments limited to improvements to protection of current operations.	Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.	Innovation the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice.
Reputation	No tolerance for any decisions that could lead to scrutiny of, or indeed attention to, the organisation. External interest in the organisation viewed with concern.	Tolerance for risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior management distance themselves from chance of exposure to attention.	Tolerance for risk taking limited to those events where there is little chance of any significant repercussion for the organisation should there be a failure. Mitigations in place for any undue interest.	Appetite to take decisions with potential to expose the organisation to additional scrutiny/interest. Prospective management of organisation's reputation.	Willingness to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation.	Track record and investment in communications has built confidence by public, press and politicians that organisation will take the difficult decisions for the right reasons with benefits outweighing the risks.
APPETITE	**NONE**	**LOW**	**MODERATE**	**HIGH**	**SIGNIFICANT**	

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Trust Board

COVER SHEET

Meeting Date	Thursday, 11 July 2024	**Item Reference**	24/25/094
Report Title	Integrated Governance Assurance Report - Quarter 4 2023/24		
Author	Allan Hawksey, Head of Risk and Safety		
Responsible Director	Dianne Brown, Chief Nurse		

Purpose of Report	This report provides information of oversight and assurance monitoring of Integrated Governance and highlights key risks to the Trust evidencing improvement and embedded learning divisionally and cross divisionally.
Executive Summary	The Integrated Governance Assurance Report for Quarter 4 2023/24 forms part of the regular reports received by the Board to provide oversight and assurance in relation to Quality, Safety and Risk Management The Trust is actively addressing challenges, promoting a positive reporting culture, and implementing initiatives to enhance patient safety, health and safety, and overall quality of care, all detailed within the appendices of the report. Ongoing monitoring and collaboration are key elements of the organisation's strategy for continuous improvement. Following approval of the reviewed Risk Management Strategy in April 2024, this report will become increasingly risk and less data focussed. The data currently within the report will be used to drive the risk profiles of the Trust and focussed on key actions within those risks, to manage, mitigate and drive quality and safety improvements, and will align more with the Trust improvement plan for 24/25 and beyond. The Board is requested to note the contents of the paper and take assurance that there are sufficient governance processes in place consisting of divisional and corporate oversight to mitigate and manage risks. The Board is asked to take note that feedback from the previous reports has been acted upon, and the additional information requested has been incorporated into the latest report.
Key Areas of Concern	1. **Failure to follow clinical guidelines and pathways:** Poses a key risk to patient safety although there were no identified harms of moderate or above at the time of reporting. This is a key risk developing. 2. **Controlled Drugs Management:** Issues around the administration and documentation of controlled drugs pose potential risks, requiring robust management within workstreams incorporated into the Trust improvement plan. **3. 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.
Trust Strategy and System Impact	The report covers several areas within the Trust improvement plan, particularly within the deteriorating patient collaborative.

Links to Board Assurance Framework	N/A	**-**
Links to Risk Register (scoring 10+)	There are currently 23 associated serious risks scored at 10 +, and 5 significant risks scored at 12+ that report into the Quality, Risk and Safety Executive Group	**-**

Assurance Level	1. MODERATE - Adequate system of internal control applied to meet existing objectives

Action Required by the Board	The Board is asked to receive the report, note the contents and take assurance from the systems of control and learning evidenced across the Trust

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Quality, Risk and Safety Executive Group (Divisional Integrated Governance Reports)	**14/06/2024**	**All divisions**	**Approved - moderate assurance**
Quality Committee	**25.06.2024**	**Phil Bartley**	**Noted and assured.**

MAIN REPORT

The report highlights the following key areas to the Committee:

1. **Incident Reporting and Patient Safety:** There has been a decrease of 332 incidents during Q4, particularly related to a significant decrease blood sampling errors. There has been an increase in failure to follow clinical guidelines and pathways, however, no harm has occurred graded as moderate or above. The report outlines the types and severity of incidents, including two further never events that are now under a Patient Safety Incident investigation (PSII). An overview of the never events has already been provided to the Committee by the Deputy Chief Medical Officer.
2. **Controlled Drugs Management:** The report highlights a theme identified across the Gynaecology medication incidents relates to prescribing of medicines. Specific issues include patients own medication not prescribed in a timely manner on admission to the ward and delays in the prescribing of discharge prescriptions leading to poor patient experiences on discharge from the hospital. A medicines safety project has been initiated as part of the Trust improvement plan.
3. **Health and Safety:** The organisation has made efforts to enhance health and safety awareness, evidenced by an increased reporting in non-clinical incidents. The department has plans to introduce health and safety advocated to support the health and safety agenda throughout 24/25.
4. **Complaints and Patient Communication**: Complaints in Q4 23/24 saw an increase of 4 complaints compared to the previous quarter, and an increase of 1 in same quarter in 22/23. Gynaecology Services Division, which incorporates Gynaecology and the Hewitt Fertility Centre Services, accounted for 83% of the received volume, the Trust are working really hard with addressing concerns raised at source and working to achieve local resolutions.
5. **Clinical Audits and Quality Improvement:** Compliance with clinical audits is emphasized, Parental interaction was documented in 99% of cases as part of the Parental Involvement and

skin to skin provision initiative, and very positive free text comments in the survey regarding staff in NICU.

6. **Legal Claims and Scorecard:** Following on from our Learning from Claims and Reducing Harm Task & Finish Group, the Trust signed a Memorandum of Understanding to join the Liverpool Legal Services Collaborative in December 2023. This is initially alongside LUHFT and Liverpool Heart and Chest. Since then, there have been workstreams on going in Q4 in relation to Information Governance/IT, Finance and the scope of services including staffing and stakeholders. This work will underpin how the model will look going forwards. We are expecting to go live with the new model in Q2 24/25.
7. **Incident Investigations:** The report provides insights into serious incidents, Patient Safety Incident Investigations, levels of patient harm and challenges related to ongoing action plans.

Risks:

1. **Failure to follow clinical guidelines and pathways:** Poses a key risk to patient safety although there were no identified harms of moderate or above at the time of reporting. This is a key risk developing.
2. **Controlled Drugs Management:** Issues around the administration and documentation of controlled drugs pose potential risks, requiring robust management within workstreams incorporated into the Trust improvement plan
3. **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.

Positive Assurances:

1. **Positive Reporting Culture:** The Ulysses data reflects a continuous positive reporting culture, (despite a decrease in incident reported related to blood sampling errors) with more incidents of no harm, low harm and near misses. The levels of harm have also decreased since Q3.
2. **Learning and Improvement:** The report highlights embedded learning from incidents, divisional plans to manage risks, and evidence of positive changes in practice and culture.
3. **Quality Improvement Initiatives:** The commitment to ongoing quality improvement initiatives and collaboration through networks are aligned to the trust's improvement priorities.

CONCLUSION

This report seeks to provide assurance as to the Governance Systems in place in LWH and that staff are being open by reporting incidents, clinical and non-clinical, to ensure patients and staff safety is maintained. The Ulysses data clearly demonstrates a continuous positive reporting culture across all Clinical Divisions and Corporate Services

There remains ongoing work across all Divisions via their integrated governance reports, but triangulation has significantly improved since the last quarter. The divisions have been able to demonstrate:

- Key areas of risk affecting patient safety and quality of services
- Divisional plans to manage and mitigate those risks.
- Evidence of embedded learning Divisionally and cross Divisionally
- Plans for audit of embedded learning within 6 months of learning being identified (As per Ockenden within Maternity but that expectation is across all Divisions) and how assurance is gained, 6 months, 12 months and beyond that learning is embedded, practice and culture has changed and there is clear tangible evidence of improved patient safety outcomes.

RECOMMENDATION

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The Board is asked to receive the report, note the contents, and take assurance from the systems of control and learning evidenced across the Trust.

SUPPORTING DOCUMENTS

IGR Appendices

1. *Incidents*
2. *Medicine Safety*
3. *Health & Safety*
4. *Patient Experience*
5. *Continuous Improvement*
6. *Legal Services*
7. *Serious Incidents, Patient Safety Incident Investigations and identified learning*
8. *Divisional Triangulation*

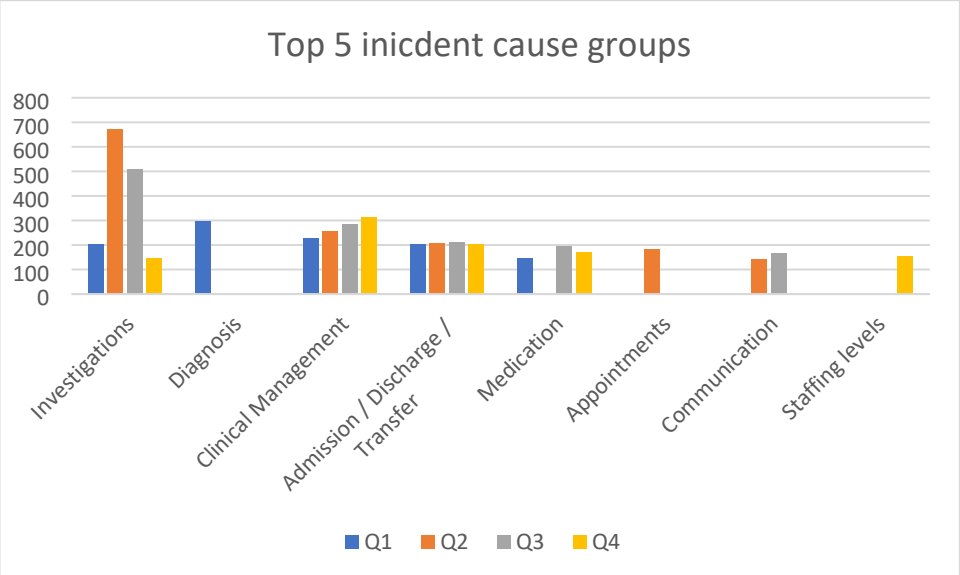
APPENDICES

1. Incidents

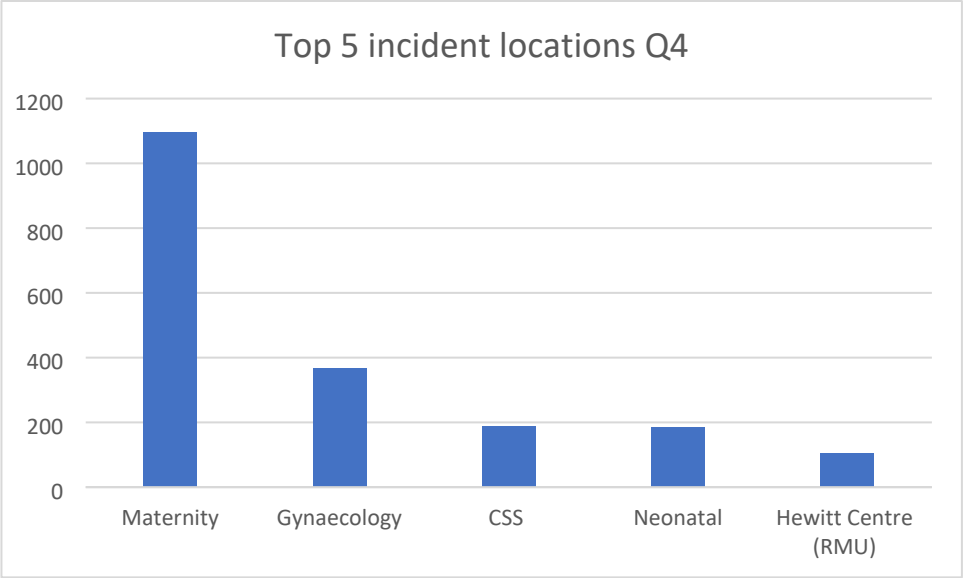
HEADLINE - A key area of risk for Q4 was within the clinical management cause group (313– a slight increase from 285 in Q3) relating to:

1. Failure to follow clinical guidelines (85) of which – Maternity (68), Gynaecology (5), Imaging (4), Genetics (2), clinical Support Services (2), HFC (2), Patient administration Service (1) and Neonatal (1)
2. Failure to follow clinical pathway (45) of which - Maternity (35), Gynaecology (4), HFC (4), Neonatal (1), and Clinical Support Services (1)
3. Of these 130 incidents, 5 were near misses, 92 were no harm, 28 were low harm / minor and 5 remain under review. None have resulted in further investigations as a patient safety incident

- 2174 incidents reported in total.
- Decrease of 332 incidents compared to Quarter 3 23/24



Cause Groups	Q1	Q2	Q3	Q4
Investigations	204	672	508	145
Diagnosis	298			
Clinical Management	225	256	285	313
Admission / Discharge / Transfer	201	208	209	204
Medication	145		193	168
Appointments		180		
Communication		141	165	
Staffing levels				154



Maternity	1095
Gynaecology	367
CSS	189
Neonatal	186
Hewitt Centre (RMU)	104
Total	1941

Total number of incidents reported across Q4 for 2023/24 compared to 2022/23 and 2021/22.

2021-22	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Total	557	636	498	510	468	835	597	718	577	686	657	657	**7396**
Quarterly	**1691(>279)**			**1813 (>122)**			**1892 (>79)**			**2000 (>108)**			**(>2626)**
2022-23	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**total**
Total	641	693	500	700	658	627	849	665	509	616	653	735	**7846**
Quarterly	**1834 (<166)**			**1985 (>151)**			**2023 (>38)**			**2004 (<19)**			**(>450)**
2023-24	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**total**
Total	502	658	777	726	898	928	885	931	690	738	770	666	**9169**
Quarterly	**1937 (<67)**			**2552 (>615)**			**2506 (<46)**			**2174 (<332)**			**(>1323)**

The tables above indicate the key areas of risk for the trust and the numbers of incidents reported since 2022/23 for comparison. Of note, blood sampling errors has significantly reduced from a peak in Q2, throughout 23/24.

Patient Safety Incidents (PSI's)

1805 total PSI for Q4 (Trust wide) and a decrease of 420 when compared to Q3 in 2023/24

Family health (1139)	Gynae (Inc HFC) (418)	CSS (159)
Clinical Management 225	Appointments 68	Patient Records / Identification 24

Admission / Discharge / Transfer 139	Clinical management 52	Clinical Management 21
Midwifery Red Flag 134	Diagnosis 48	Communication 19
Investigations 108	Communication 45	Medication 19
Medication 102	Admission / Discharge / Transfer 35	Equipment 18

This gives the key themes for the incidents across the divisions who review the incidents for themes, patterns, and trends, acting as appropriate. These are reviewed cross divisionally to provide any particular focus of trust wide actions. The are detailed within the divisional updates towards the end of this report.

Actual impact of Patient Safety Incidents

Row Labels	Count of Actual Impact Q4
2 No Harm	1223
3 Low Harm / Minor	402
1 Near Miss	46
4 Moderate Harm - Moderate	10
5 Severe Harm / Major (Serious)	2
7 Death (NOT Caused By A Patient Safety Incident)	1

Improvements and actions

As reported within the Q3 report, the Trust has merged the blood sampling errors group with Pathology Steering Group who have overall accountability of the work meeting monthly. Liverpool Clinical Laboratories are looking at Digicare including ordering, results and mobile phlebotomy.

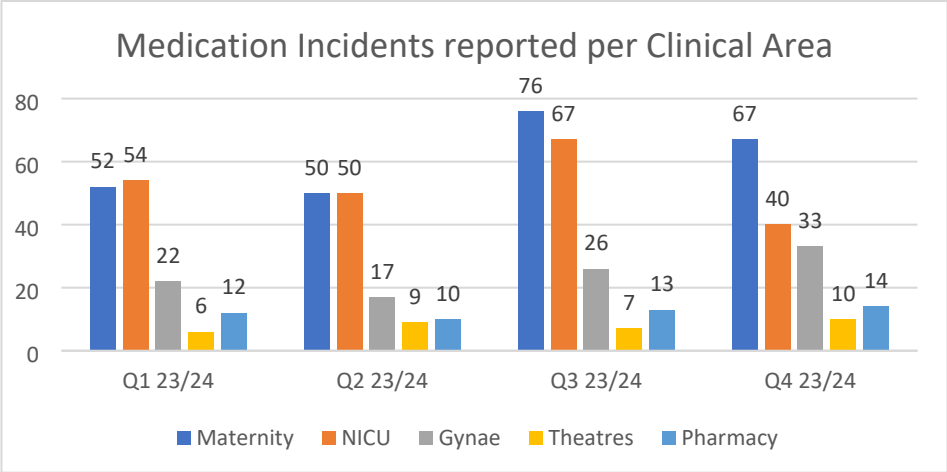
This work has progressed well with data reflecting improvements seen with training and education delivered. This has had a significant impact and a reduction of blood sampling errors being reported during Q4.

2. Medicines Safety

HEADLINE: Medication incident reporting decreased during Q4 for Maternity (76 to 67) and Neonates (67 to 40) but increased for Gynaecology (26 to 33). Incident reporting across Theatres and Pharmacy in Q4 was stable compared to previous quarters. The total number of incidents reported in this quarter is still high when compared to previous years (see data below) and continues a general rise in reporting of medication incidents which signals an improving safety culture.

A theme identified across the Gynaecology medication incidents relates to prescribing of medicines. Specific issues include patients own medication not prescribed in a timely manner on admission to the ward and delays in the prescribing of discharge prescriptions leading to poor patient experiences on discharge from the hospital.

A Medicines Safety project has been established as part of the LWH Improvement Plan for 24/25 and falls under the Clinical Effectiveness Programme led by the Chief Medical Officer.



Actions & Improvements

Division	Area noted for improvement	What are we doing to improve the position both short and long term	Committee/division/person responsible
Gynaecology	Prescribing of medication	Analysis of medication incidents across Gynaecology to understand causes and identify trends.	Gynaecology governance team
Maternity	Safe and secure storage of medications	Funding has been identified to develop a new medicine storage room for the ward area. Colleagues from LUHFT are supporting work to design the room and to ensure it meets national regulations.	Matbase senior team
Pharmacy	Safe and secure storage of medications	An independent inspection of the pharmacy dispensary was undertaken to check compliance with national standards and regulations. A final report is expected in Q1 of 24/25.	Pharmacy senior team
Neonates	Prescribing and administration of parenteral nutrition (PN)	An after action review (AAR) was undertaken following an incident relating to PN to identify learning and shared with NICU colleagues.	NICU governance team
All areas	Attendance at NMP	Raising profile of NMP work across Trust and increasing CPD opportunities for staff.	NMPs & MMG

	Educational Forum in March		
Maternity	Safe and secure storage of medications	An MIAA review in late March identified several discrepancies across Maternity. Immediate actions were undertaken to correct any issues and a draft report is expected in April.	Maternity senior team
All areas	Learning from medication incidents across the Trust	Safety Check In covering topics including; *Valproate NPSA alert; Entonox exposure for staff; Clinical Guidelines; Medicine Interactions; PGDs.*	MSG

3. Health & Safety

HEADLINE – HEADLINE – In Q4, there were 24 non-clinical health and safety related incidents reported, a decrease of 9 incidents from the previous quarter. Family Health Division reported the highest number of incidents of 13, Gynaecology and Corporate Support Services reported 4 incidents per division; with Clinical Support Services reporting 3 incidents. All incidents were appropriately managed, and all processes were followed. There was 1 RIDDOR reportable staff accident involving a trip that resulted in multiple MSK injuries. A thorough investigation was undertaken with prompt actions taken to reduce further risks of similar incidents occurring.

A breakdown of all non-clinical health and safety incidents, reported in quarter 4, are detailed in the table below:

	FAMILY HEALTH	GYNAECOLOGY & RMU	CSS	CORPORATE FUNCTION	TOTAL
PERSONAL INJURY/ILL HEALTH	4		2	1	7
NEEDLESTICK INCIDENTS	7	3	1	1	12
SLIPS, TRIPS & FALLS	2			1	3
COSHH					
EQUIPMENT		1			1
COLLAPSE/COLLISION				1	1
TOTAL	13	4	3	4	24

Improvements and actions:

Work remains ongoing to increasingly raise the profile of the Health and Safety Team, making Health and Safety everyone's business and growing the Trust network of health and safety advocates. The Health

and Safety Group meeting, chaired by the Head of Risk and Safety, continued to be well attended by all Divisions.

Two departments took part in piloting the new electronic Ulysses risk assessment form which, once trialled, will be rolled out Trust wide alongside the Ulysses Risk Management Module for Health and Safety, creating an electronic repository for all statutory health and safety workplace audits and risk assessments.

MHRA central patient safety alerts continued to be well managed, and all alerts were actioned within defined deadlines with no exceptions.

4. Patient Experience

a. Complaints, PALS, and PALS+

HEADLINE – Complaints in Q4 23/24 saw an increase of 4 complaints compared to the previous quarter, and an increase of 1 in same quarter in 22/23. Gynaecology Services Division, which incorporates Gynaecology and the Hewitt Fertility Centre Services, accounted for 83% of the received volume, the Trust are working really hard with addressing concerns raised at source and working to achieve local resolutions.

The number of PALS + cases dealt with this quarter has increased by 17, with the Gynaecology Division still conducting the majority of these, with the hope that these address concerns at an earlier stage. Work continues to promote the PALS + process provisions to achieve early resolution of concerns and provide more timely outcomes for people raising concerns. The trends show that this has a positive impact on reducing the number of complaints needing to be raised when it is consistently used.

588 PALS cases were received in this quarter which is a decrease of 2 cases overall. Initial end of quarter review has highlighted a few areas which have been highlighted as main concerns raised:

- Communication continues to be the highest category for concerns raised, communication with patient and Information requests are the top concerns raised in this category.
- Appointment availability is also one of the highest concerns raised through the PALs service with appointment availability and failure to follow up being high.
- The key issues are:
- the extended waiting time for initial appointments following referral and follow up appointments.
- The most cases received by Division was 353 (60%) PALS cases which were received this quarter by Gynaecology, with the busiest month being noted as January 24.
- The PALS service has seen an increase of Hewitt Centre patients since the communication regarding the Treatment (frozen embryo transfer). There are currently discussions about this and there is a potential for more concerns being raised over the coming months.
- The PALS service has experienced an increase of women contacting due to lack of availability for Elective Caesarean Section dates.

In January 24 LWH have started to send validation texts to patients on the follow-up waiting lists- sending to patients that are overdue their follow-up appointment or have been on the follow up WL for over 12 weeks.

- Patients that respond NO will be discharged. General Gynae have confirmed they do not require clinical review after this response. Menopause have asked for a list on NO patients for review before discharge.
- Patients that respond YES, and patients that **do not respond**, will have absolutely **no action taken and will remain on the waiting list**.

This will hopefully help to start to show a decrease the concerns raised regarding appointments and the impact will be seen over the coming months.

Improvements and actions:

Face to face availability for the PALS service continues to be provided and utilised by patients and a Help Hub at the main entrance has been created that is more open and more interactive by reducing the barriers of doors and windows. The feedback has been good and both staff and patients are really enjoying using the new facility. There is also the opportunity to discuss concerns with charities who are working with the Patient Experience Team who are great support for staff and patients.

There has also been a poster designed with over 20 different languages, this has really seen an increase in non-English-speaking people accessing the help and support from the PALS team. An Interpreter on Wheels was also procured to ensure non-English-Speaking people have the opportunity for translation services to help with any concerns that need to be raised.

Patient Experience

HEADLINE – FFT reports are scheduled and sent to all divisions from the Ulysses System on a weekly basis highlighting both the positive and negative comments that need reviewing and addressing. All FFT information is displayed on Power Bi to enable Divisions to view the data and act on any poor performance.

FFT results for Q4 2023/24

Total	Maternity	Gynaecology	Genetics	Reproductive Medicine (RMU)
2456 ↓	423 ↑	1526 ↓	75 ↑	119 ↓

Overall experience score (satisfaction report) – this score is based on the responses to the question "Please rate your overall experience (Poor=1 to Good=10)"

Trust score %	Maternity %	Gynaecology %	Genetics %	Reproductive Medicine (RMU) %
89 ↑	86 ↑	89 ↑	93 ↑	86 ↓

Recommendation score - this score is based on the responses to the question "*Thinking about the service we provided, overall, how was your experience of our service*?"

Trust score %	Maternity %	Gynaecology %	Genetics %	Reproductive Medicine (RMU) %
92	88	92	94	89

The FFT ask patients some equality monitoring questions to enable us to monitor if any of these characteristics are having a detrimental impact on their experience by comparing both overall experience and recommendation scores. These are reviewed under three categories:

- Age
- Ethnicity
- Disability

**Please note all respondents are allowed to leave these sections blank when completing the FFT. These blank responses are still stored but are not reported in these figures.*

Age
Overall Experience Score (all figures are in %)

Age Range	Jan 2024	Feb 2024	Mar 2024
0-18	90	76	98
19-64	88	88	87
65 and over	96	96	94

Recommendation score (all figures are in %)

Age Range	Jan 2024	Feb 2024	Mar 2024
0-18	96	89	84
19-64	91	91	90
65 and over	97	97	96

Ethnicity
Overall Experience Score (all figures are in %)

Ethnicity	Jan 2024	Feb 2024	Mar 2024
BAME	89	90	83
Unknown	85	85	83
White	90	91	89

Recommendation score (all figures are in %)

Ethnicity	Jan 2024	Feb 2024	Mar 2024
BAME	91	91	87
Unknown	87	85	89
White	93	92	92

Disability
Overall Experience Score (all figures are in %)

Disability	Jan 2024	Feb 2024	Mar 2024
Yes	90	93	89
No	90	90	89
Unknown	89	88	84

Recommendation score (all figures are in %)

Disability	Jan 2024	Feb 2024	Mar 2024
Yes	92	94	92
No	93	92	92
Unknown	92	87	88

Improvements and actions:

Divisional FFT "you said, we did" reports are a standing item on the Patient Involvement and Experience Subcommittee (PIESC). This enables greater visibility and promotion of the improvements being implemented from the FFT and allows this learning to be shared across the various divisions who attend this meeting. These are also displayed in the patient and public areas of the relevant area. This is to promote the work done and encourage more responses and patients see their feedback making a difference.

Below are some examples shared at the Patient Involvement and Experience Sub Committee.

Genetics

You said:

Patients still reporting difficulty and upset with waiting in the antenatal OPD. We had one F&F response in January that scored their overall experience as 10, hospital experience as pleased and recommend rating as 5 but in the improvements comments section stated that having the appointment for their 12-year-old daughter in the antenatal clinic was distressing as her daughter was worried that people would think she was pregnant.

We did:

Reconsider alternative locations for our clinic area within the hospital. Lead GC and Head of AHPs met on 9th January 24 to review options and are raising this at Trust Space Utilisation to try to further improve current space or move entirely.
Genetics regularly remind staff to mention F&F to patients during their appointment. They now have the QR code for the F&F message that Genomic Medicine patients receive, and this has been displayed on the notice boards in the patient waiting area. Staff have all been reminded of the importance of booking outpatients immediately after their appointment to ensure F&F text will be sent. It has also been confirmed that patients in peripheral clinics do get F&F.

GED/ EPAU

You said:

The themes from previous displeased FFT are again evident and include waiting time to see the doctor in the department, no doctor in the department and availability of ultrasound scan with some patients recording that they left the department prior to being reviewed.

We did:

Contributing factors are monitored and can be challenging when activity outweighs capacity during out of hours when there is a reduction in Medic cover particularly in senior decision makers. Department activity is however reported into daily Bed meetings and in the event patient waits are increasing, Matrons request all available doctors as a resource to support the department.

Gynaecology OPD

You said:

Issues with Waiting time / Appointment cancellations

We did:

Waiting list management continues to be a Challenge regionally for Gynaecology. A daily review of all waiting times is a core component of activity management within the division. Increased demand for RAC appointments due referral volume has led to cancellations on occasion of general Gynaecology. In addition, lost days due to industrial action has seen a loss of 620 patient appointments. This continues to be a focus for the division and an overview report of the contributory factors/ challenges is being prepared by the admissions team manager.

A recent quality improvement project has been launched with the aim of text message validation of appointments for patients, this project was presented at the recent Quality strategy event and has already demonstrated improvements in terms of supporting patient advancing and being manged through waiting lists correctly.

Furthermore, when a patient attends and there has been a clinic cancellation or appointment scheduling error the divisional operational team and admissions team manger are immediately made aware so that an understanding of the cause can be identified.

Hewitt Centre

You said:

Issues regarding HFEA questions

We did:

HFEA led questions are now embedded into the feedback questionnaire texted to people who have attended clinics. The comments and compliments we receive are really encouraging – giving assurance of what great care we are providing; however, this platform also provides an opportunity for us to reflect, learn and improve when things haven't gone as well. One of our new questions is 'What could we do better?' which is a great way to learn and explore small changes that can make a big difference.

You said:

We recently received some disappointing feedback from a patient who is profoundly deaf and felt we hadn't offered her a good level of support for her appointment. On this occasion we used her husband as an interpreter, instead of following the Trust guidance and offering to provide a trained BSL interpreter.

We did:

Meeting individual needs and adjusting is important to help ensure people's experiences are the best they can be, including any necessary support for good communication. Signalise Co-op is the service we use to support the Deaf community, ensuring person centred care. Their interpretation services are available on-demand 24 hours a day, seven days a week for all BSL and deafblind communication support. Booking can be secured in advance if we aware support is required, or on demand if a patient has already arrived – providing support via video call. An information sheet with details of how-to book is being placed in all clinical areas across Liverpool and Knutsford site.

You said:

A patient told us - During most of my treatment my partner was not allowed into the scan despite me asking if he could come in. We both found this distressing.

We did:

Similar feedback was received from various patients and this seemed an inconsistent rule and very much dependant on staff member. This did apply during Covid for distancing reasons, but no longer in place. Staff communication shared with all staff across sites and partners are allowed in the scan room with partners.

You said:

Received feedback about being kept informed about waiting times received from several patients.

We did:

We are exploring TV screens and digital message boards to help keep patients in waiting rooms updated with any delays/staff on duty etc. Currently admin and reception staff are telling patient verbally on arrival.

Maternity

Antenatal care:

- IOL Delays.

You Said: "Extremely understaffed. Waited 48hrs on induction suite for a room on delivery. Didn't quite get the delivery I wanted as I was induced."

We did:

Quality Improvement Project for Induction of Labour:

- As part of the induction of labour quality improvement project the IOL coordinator has been in contact with other service providers and with the wider team including the MVNP.
- Formulation of bespoke IOL information in various formats to enable personalised choice care plans to be discussed at key points in the antenatal period.
- Plans include bitesize videos that can be accessed in other languages, patient information to be available through digital platforms, K2, Trust website and Essential Parent app in up to 75 languages.

- Re-design and re-configuration of MLU and IOL Suite to improve patient flow.
- Revision of IOL appointments to ensure equitable appointments through the day.
- Full establishment of Midwifery staffing against Birth Rate Plus report.

Post natal care:

You Said: *"I don't agree with partners being able to stay overnight, there should be an option to stay on a ward with men or not if this is going to continue"*

You Said*: "Aftercare needs an overhaul, plus letting partners stay overnight is awful, like a huge free for all, chaotic, noisy & unsafe"*

We did:

The current visiting provision has been designed in collaboration with the MNVP after feedback from service users that overnight visiting for partners would increase satisfaction with their stay at LWH. Visitors are asked to abide by the contents of a 'contract' where they are expected to behave in a way that is respectful to other patients and staff. This feedback, along with an increase in reported Ulysses incidents from staff of inappropriate dress, behaviour and attitude of visitors will be considered at an MNVP meeting scheduled 12.2.24. The views of all service users must be considered and where an increase in aggression and complaints to staff incidents are raised these are heard.

- **Medication Administration.**

You Said*: "I received no pain relief. I ended up sobbing in the corridor to get any attention from staff. I did not receive the abx that I had been told I'd be started on until late evening after insisting they had been prescribed."*

You Said: *"Sometimes took 2 hours to get pain relief and it wasn't given regularly".*

You Said*: "Staff took ages to answer call bells, everything was delayed. Asked for pain meds and I'd have to ask several times and they would take hours to deliver them."*

We did:

The Ward Manager and Deputy Ward Manager are working to embed a culture of safety and effective medicine management on the Maternity Base. This includes the re-introduction of regular, scheduled medicine rounds to ensure that patients have their medications at the prescribed times. There is a long-term goal to introduce self-administration of medication; this is a complex process and is being considered as a quality improvement project led by the Maternity Lead Pharmacist. A project to supply some take home medication from the ward by pharmacy staff is currently taking place.

- **Staff Attitudes and Behaviours.**

You Said*: "Staff were very judgemental, and communication was very limited."*

You Said*: "Quality of care was shocking. Staffs attitude stinks."*

We did:

The Lead Professional Midwifery Advocate, as part of her new role, will be introducing education and support in relation to civility and psychological safety in the workplace. The Division continue to support

the Trust 'Be Kind' objective, and where behaviours are nor exemplar of the Trust Values, this is challenged, and staff supported to reflect.

Divisional Managers use the feedback obtained from FFT in respect of behaviour and this is fed back to staff members both on a one-to-one basis and within divisional meetings.

5. Continuous Improvement

a. CLINICAL AUDIT AND EFFECTIVENESS

HEADLINE – The Trust received 7 Clinical Audit Reports including Action Plans in Quarter 4.

Key successes from Clinical Audits completed Quarter 4

- Parental interaction was documented in 99% of cases as part of the Parental Involvement and skin to skin provision initiative, and very positive free text comments in the survey regarding staff in NICU.
- As part of the Central Line positions in Radiographs, line positions were reviewed well on subsequent X-rays and lines were removed or repositioned if required, repeat x-rays were taken when lines were repositioned.
- Women early in their pregnancy presenting with vaginal bleeding or a background of vaginal bleeding are now being offered progesterone supplementation to prevent early pregnancy loss.
- As part of the Management of obstetric anal sphincter injuries, all perineal tears were classified as per standardised Royal College of Gynaecologists guidance, all patients that sustained OASI had laxatives prescribed for 10 days and antibiotics prescribed.
- There has been significant improvement in the number of patients achieving Optimal Cytoreduction and receiving primary surgery. The ESGO audit is compliant with most of the standards except recording the operation notes in the structured way.
- Overall improvement has been shown in all aspects of the growth audit, nearly at the expected level of 100% requirement in all areas demonstrating a great standard of image quality.
- It was found that Patients receiving predictive and diagnostic genetic testing for inherited breast cancer risks receive good quality, safe genetic counselling overall and compliance was noted in family tree drawings, pre-test counselling undertaken by suitably trained professionals, appropriate correct screening recommendations, and timescale and meaning of genetic test results.

Key themes to be actioned as a result of Clinical Audit reports received in Quarter 4 which are monitored via the Continuous Improvement Team and Quality, Risk & Safety Executive Group (QRSEG).

- A plan to incorporate the prospective survey into V-create account for parents to get an automatic reminder about the survey during the first week of admission as part of the Parental Involvement and skin to skin provision.
- A lesson of the week planned to highlight to staff the importance of documentation of lines, particularly after repositioning and removal.

- Audit findings for vaginal progesterone prescribing are to be disseminated to Gynae Emergency Department and junior doctors, and a reminder to consider prescribing when needed as per the latest NICE guidance.

- Recommendation for the Obstetric team to design and implement a proforma within K2MS specifically tailored for the management of Women with OASI in line with LWH standards.

- A plan has been put in place to create a new operation record in Digicare to avoid duplication and facilitate recording data more easily.

- A QI project to be carried out to standardise placental site imaging with the help of the Fetal Medicine Unit.

- BRCA1 and BRCA2 leaflets are currently being reviewed and details of risks have been included. For diagnostic patients the standard letter will be updated to include this information.

Improvements and actions:

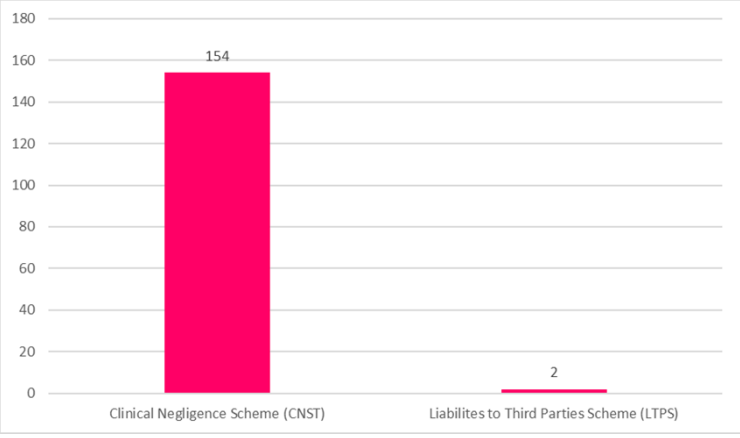
Where audits have determined that the level of expected standards have not been met, there are significant Divisional action plans formulated to address issues highlighted. All audits are reviewed by the QRSEG and actions either approved or amended and updated where required. These are divisionally led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

6. Legal Services

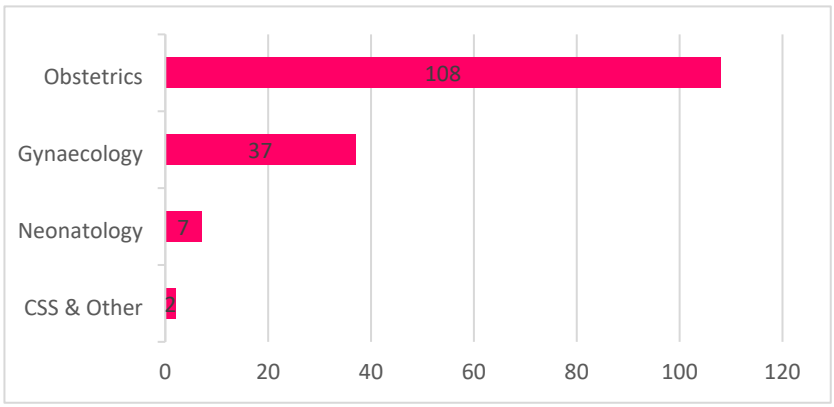
HEADLINE - The Trust signed a Memorandum of Understanding to join the Liverpool Legal Services Collaborative in December 2023. This is initially alongside LUHFT and Liverpool Heart and Chest. Since then, there have been workstreams on going in Q4 in relation to Information Governance/IT, Finance and the scope of services including staffing and stakeholders. This work will underpin how the model will look going forwards. We are expecting to go live with the new model in Q2 24/25.

This report provides an update on claims and inquests during Q4 January to March 2024. This data has been extracted from the Legal Services database and NHS Resolution's Claims Management System.

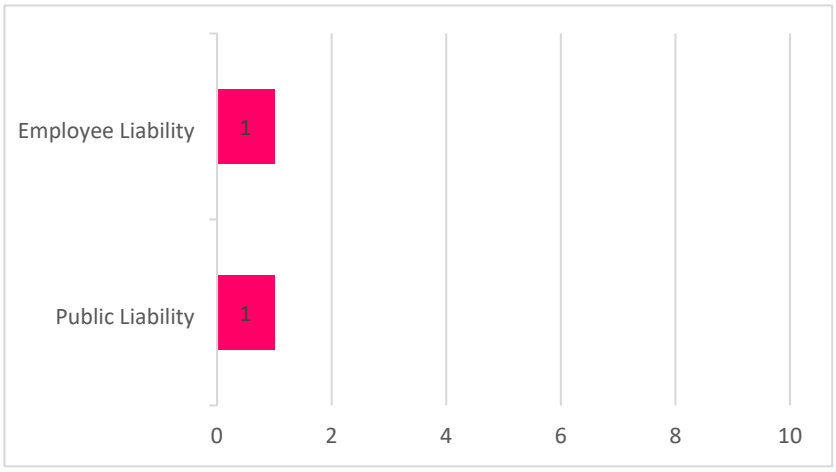
1) As of 31 March 2024, there were 156 active, 'open' claims: 154 clinical claims and 2 non-clinical claims.



2) The 154 clinical claims can be divided into the following specialities:



3) The 2 non-clinical claims can be divided into the following categories:



The Legal Services team continue to circulate claims data to the divisions on a monthly basis, incorporating both new and closed claims data. Upon receipt of a Letter of Claim, Legal Services will notify the relevant division providing a copy of the Letter of Claim, NHS Resolution's initial financial reserves and any incident or complaint documentation, if any, to ensure triangulation and learning.

Improvements & Actions
A task & finish group commenced last year in relation to learning from claims & reducing harm. We reported the outputs of this group into Finance Recovery Board as one of the objectives was to work towards reducing our CNST premium which was extremely high.

As such, a significant amount of work has been undertaken and subsequently the Trust signed a Memorandum of Understanding to join the Liverpool Legal Services Collaborative in December 2023. This is initially alongside LUHFT and Liverpool Heart and Chest. Since then, there have been workstreams on going in Q4 in relation to Information Governance/IT, Finance and the scope of services including staffing and stakeholders. This work will underpin how the model will look going forwards.

We are expecting to go live with the new model in Q2 in 24/25. Additional resource will be provided to the Trust to support the new ways of working. in addition to our colleagues having access to a legal learning hub, there will be a suite of new SOP's and policies in relation to claims management, inquests, coroners, instructing external legal advice. This will be launched alongside MIAA who are supporting us and partner Trusts with this piece of work.

7. Serious Incidents, Patient Safety Incident Investigations and identified learning

***HEADLINE* – There were 8 Patient Safety Incident Investigations declared to the Integrated Care Board (ICB) during Q4 (a decrease of 3 incident investigations from Q3) – 6 in January , 1 in February and 1 Patient Safety Incident Investigations (PSII) in March.**

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

All Patient Safety Incident Investigations had initial duty of candour completed accordance with the current Trust policy.

Although deadlines to complete investigations are not nationally mandated, the Trust has set itself a target of concluding its investigation within 60 working days. This was not achieved in Q4 due to competing priorities for the investigators who front line colleagues delivering patient care. There has been a request from the chief nurse and medical director to factor this work in as part of job planning for 24/25. All extensions/delays have been discussed and agreed with the patients with the ICB no longer required to approve them. This process will be reviewed further as part of the first PSIRF review to be completed throughout June 2024.

Of the incident investigations declared, and in addition to any future generation's cases, there were 2 never events declared within maternity services relating to retained articles. The never events are currently under investigation and part of an ongoing thematic review. (NOTE: There was a paper submitted to the March 2024 Quality Committee by the chair of the LocSSIPS group and DCMO, providing an overview of recent never events, themes and actions to be taken).

Overdue actions from previous submitted SI's / Serious Incidents

All Serious Incidents have been formally submitted to the ICB.

Whilst the Trust ongoing action plans are not currently externally reportable, the Ulysses System is now being used more effectively to manage divisional action plans. All action plans are updated on to the system following SI submission to the ICB and are monitored Divisionally and Corporately for compliance and reported to the Safety and Effectiveness Sub Committee monthly.

As of 1 April 2024, there were 40 ongoing action plans that had actions overdue. These were subsequently escalated to all Heads, Divisional Managers and Safety Leads to action and all Divisions agreed to have a plan in place to resolve overdue actions which will be monitored via Divisional Governance meetings in addition to the Executive Risk and Assurance Executive Group.

Dissemination of learning from serious incidents

The Trust communicates learning from serious incidents via a few ways such as the following:

- Learning and engagement teams events held in person and online Trust wide for all services to present and discuss learning.
- The weekly safety check-in for all services to present and discuss learning
- Governance Boards within the divisions to share learning.
- Trust wide shared learning portal to upload all divisional learning such as 7-minute briefings accessible to all staff
- The Safety and Effectiveness Sub Committee (now QSREG) serious incident report
- Staff communications via secure social media
- SBARS

Improvements and actions:

Learning from all incidents is key to being able to demonstrate that the Trust is a Learning Organisation. The Corporate Team continues to work in detail with the divisions to recognise how learning from incidents is captured and evidenced, how it is disseminated to new and existing colleagues, that is becomes embedded as part of practice and culture and that there is tangible evidence that learning has been addressed immediately, embedded after 6, 12 months and beyond and that learning continually evolves from current intelligence and is used to mitigate recurrences as much as practicable.

This has been an area of concern for the trust. As such, a new divisional governance structure was being proposed towards the end of Q4 and a Trust wide review of governance is currently being undertaken by the Associate director of Governance and Quality. This is expected to be completed with any change implemented within mid Q2 24/25.

8. Divisional Triangulation and Integrated Governance Reports Q4

Key learning / assurance / messages identified.

Maternity:

MEWS

There has been an underlying theme relating to lack of MEWS, in this quarter there were 2 incidents where MEWS were not completed, and the patients deteriorated. This has led to MatBase going into oversight. Regular meetings are taking place and an action plan is underway. At the time of writing the report there are 11 open actions, 5 of which are overdue. There have been 6 actions completed, these include;

- Preceptorship team and competency sign off process for NQM linked to MEWS compliance targets, NQM not to be signed off until we are satisfied MEWS compliance has improved and being carried out by each individual in line with trust policy.
- Introduce a hybrid approach to reporting with a mix of real time and retrospective audits carried out on a weekly basis – completed real time audits and feedback has taken place.
- Rapid review of 2x cases of MEWS– completed and shared at TSM for exec oversight.
- CD Registers to be merged wherever possible in accordance with Medicines Management Governance process - completed 4 CD registers in place. SL checking daily.
- Shift Leader Medicines management checklist to be included start and end of shift completed and medicines room checked on each shift.
- Budgeted and actual midwifery and support staff establishment on Mat Base completed workforce planning updated. Mat Base staffing currently exceeds BR+ recommendations as the department is benefiting from International Midwives being assigned to their workforce model whilst they await receipt of their midwifery pin. This cohort has been assigned to Maternity Base establishment and are performing Band 4 duties before they can formally practice as midwives.

MNSI Findings

An MNSI (HSIB) investigation was completed. This raised concern with the CTG being undertaken on the MLU leading to a potential delay in delivery. The CTG was not categorised which may have impacted on appropriate escalation. It was also identified that the placenta was not sent for histology which is national guidance.

The following recommendations were made:

1. The Trust should ensure that when there are concerns with the fetal heart rate for mothers on the MLU, there is a robust and clear process of escalation including transfer to the delivery suite.

2. The Trust should clearly define the criteria under which CTGs can be performed in the MLU, taking into consideration all risk factors that might require an obstetric review.

3. The Trust to ensure that staff are supported to consistently follow local and national guidance for sending placentae for histological examination.

CTGs are no longer performed on the MLU and there is designated room on the delivery suite to facilitate transfer.

There has been additional storage provided to ensure that placentas are not disposed of too quickly and increase in awareness of those that require examination.

Neonates:

Medication incidents

- TPN Education – bespoke training for nurses, doctors, ANNP's is in progress across NICU (linked with AAR)
- Vancomycin /Gentamicin – Completed training re revised guidelines which has seen reduced incident reporting for these medications.
- All medication incidents are discussed at MET.

Skin injuries

As a result of the increased skin injuries the skin core group meeting is to be reestablished to provide focused learning within the unit. An initial meeting has identified the following actions:

- A bespoke rapid review template is being developed to capture key performance indicators for skin,
- The unit has developed a weekly spot check review of clinical documentation which is completed by the skin link nurse.
- An overarching improvement plan remains under development.
- The revised process to reactively evaluate skin documentation is in progress and data is being collected by the TVN and TVN Link Nurse

After Action Review

An After-Action Review has been completed relating to the arterial insertion of a long line using Seips methodology / reflective practice session for those staff involved. Key learning was identified, and actions are being monitored until completion. Key learning identified is detailed below :

- Perform an urgent blood gas to confirm that the line has not been inserted into an artery inadvertently, if any suspicion about the line.
- Radiology confirmation of longline (a-f)
- LocSSIPS checklist should be completed contemporaneously on badgernet after every PICC line insertion.
- Self-reflection from all clinical staff involved in insertion and removal of the PICC line.
- Radiologist to contact the on-call clinical team to verbally inform any abnormal findings of line positions in x-rays, in addition to reporting the findings on PACS.

Gynaecology:

Positive news

- The division has launched a Safety Huddle to monitor and manage any high-risk patients. These occur twice daily and have representation from Nursing, Medical and Operations to identify any issues, escalate any concerns and improve control.
- To improve grip an oversight the division has initiated a weekly Harm Review meeting to discuss any serious incidents, rapid reviews, and identify appropriate management pathways.
- All Gynaecology departments within the division have now been inspected using the BBAS accreditation system achieving Gold status.
- All Hewitt Fertility Centre departments within the division have now been inspected using the BBAS accreditation system achieving Silver status.

Workstreams identified and actions planned

Workstream identified	Improvements underway
Emergency Gynaecology Executive oversight (*February – April 2024*)	• GED Transformation Group
Risk assessment completed due to awareness that the Gynaecology Emergency staff (Nursing and Medical) do not have the right skills, knowledge, or processes in place to support the prompt recognition and treatment in accordance with the National Sepsis Pathway	• Nursing training completed to escalate amber/red sepsis flags. • Validation of data used to evaluate learning needs. • Daily report in place to review patients triggering on NEWS. • Safety huddle twice per day to revie acute service acuity and capacity – red and amber flags highlighted. • Escalation policy in place – obstetric and on call consultants to be contacted if required
Lack of standardised process for internal referrals within Digicare	• Amend Trust Admission Teams policy and process (digital change required)
Risk assessment completed due to GED triage line will not be covered consistently	Improve communication to patients. Proposal to change model of triage line service to meet the needs of pregnant patients. Current EPAU service development – scheduling of Early pregnancy care where safe and appropriate to do so.
Lack of responsiveness from Trust bleep holders (Gynae Medical)	Audit completed and feedback shared with junior doctors via Clinical Director
Ensure NEWS assessment or completed and tracked	Twice daily audit via safety huddle. Identified changes to Digicare

Staff reporting issues with new module for medications within Digicare	Issues shared with Digital to assess. Pharmacy aware and providing additional support.

Clinical Support Services

Positive news:

- The Resuscitation Team have recently secured a licence to be a course centre that will deliver a new Acute Illness Management AIM Course.
- New Dietetics Manager has been appointed and is now in post.
- Physio Department has undergone a number of renovations to improve patient experience when visiting the trust and to also provide staff with better working facilities.
- CSS completed the first Patient Safety Incident Investigation in the trust, which received positive feedback from Exec colleagues.

Workstreams identified and actions planned

Workstream identified	Improvements underway
No latex free gloves for latex free theatres	Departments should be monitoring their NHSSC purchase orders which show the status of all orders and the items requested. If the portal shows that items are not being supplied, they are requested to contact Procurement for assistance.
Issues with sutures snapping mid procedure	Possible user error of which training being arranged, sutures have reverted to old supplier whilst current sutures are under investigation to mitigate any potential risk with product.
Patient letter not saved on UCR system	Task/tools factors such as lack of automation and sequence of manual processes which are repetitive can lead to human error which result in admin errors. Process to be reviewed to look at how this can be minimised.
Patient has no medication prescribed on MAR despite having been to theatre today for a major operation	Importance of prescribing post op drugs on DigiCare
Glycine 1.5% connected to patient instead of sterile water	Staff should ensure prior to connecting the medication to the patient that this is checked and witnessed. Lookalike medication should be separated as much as possible to avoid confusion.
Request received for trimethoprim tablets and vaginal estrogen. Labels got mixed up and dispenser labelled tablets with the secondary label for the vaginal estrogen which stated 'not to be taken orally'. Not picked up	Incident discussed with pharmacy staff involved in dispensing processes to aid learning. Reflection included activity of dispensary at time of incident and ongoing refurbishment works in dept.

on final check. Patient's mother noticed before leaving pharmacy.	

Trust Board Meeting

Liverpool Women's NHS Foundation Trust

COVER SHEET

Meeting Date	Thursday, 11 July 2024	**Item Reference**	24/25/095
Report Title	Infection Prevention & Control Annual Report 2023-2024		
Author	Dr Tim Neal, Director of Infection Prevention & Control (DIPC)		
Responsible Director	Dianne Brown, Chief Nurse		

Purpose of Report	To provide an overview of the performance related to Infection Prevention & Control and exception reporting during 2023-24.
Executive Summary	In 23/24 the following can be noted: • The Trust has met its key IPC metrics (*C.difficile* infection & MRSA bacteraemia) There have been no Trust acquired *C.difficile* infections in 2023-24 (Target = zero) • 100% of Infection Prevention & Control Team Audits were completed in accordance with the Trust plan. • 547 clinical practice ward audits of 5 moments for hand hygiene and local environment have been completed in accordance with the Trust plan. • The average weekly water flushing compliance for 2023-24 was 96%. • Overall Surgical Site Infection percentage for Maternity and Gynaecology divisions combined was 2.7%, lower than the 5% Trust threshold. • The ventilation safety group received assurance from the estates department on the planned preventative maintenance and annual validation of all critical and specialised ventilation systems.
Key Areas of Concern	The Trust has marginally exceeded *E.coli* and *P.aeruginosa.* trajectories as indicated below.

ORGANISM	Target (HCAI)	LWH 2023-24	
		Healthcare Associated	Total
E.coli	5	8	10
Klebsiella spp	1	1	2
Pseudomonas aeruginosa	0	1	1

Trust Strategy and System Impact	The report demonstrates compliance against the 10 criterion of the Health and Social Care Act 2008, code of practice on the prevention and control of infections and related guidance. It reports progress against the objectives of the programme in the DIPC's annual report and links with the Trust strategic aims to deliver safe services ensuring our patients get the best care and best possible experience. There is a national ambition to reduce Gram-negative bacteraemia (particularly *E. coli*) by 50%. The Trust has been set trajectories for the some of the main organisms in this category. LWH exceeded the target marginally this year with small increases against each organism. This increase has occurred regionally, and nationally, and is not specific to Liverpool Women's Hospital. All cases are reviewed by a multidisciplinary team to ensure any Trust attributable factors are addressed.

Links to Board Assurance Framework	Links to Infection Prevention Control Board Assurance Framework (IPC BAF) and monitored though Infection Prevention & Control Group meeting. Partial compliance in sections: **2.9** System and process are in place to ensure that food hygiene training is commensurate with the duties of staff as per food hygiene regulations. If food is brought into the care setting by a patient/service user, family/carer or staff this must be stored in line with food hygiene regulations. **6.5** Systems and processes are in place to ensure that all identified staff are fit-tested as per Health and Safety Executive requirements and that a record is kept. **6.6** If clinical staff undertake procedures that require additional clinical skills, for example, medical device insertion, there is evidence staff are trained to an agreed standard and the staff member has completed a competency assessment which is recorded in their records before being allowed to undertake the procedures independently.	***Partial compliance***
Links to Corporate Risk Register (scoring 10+)	**N/A**	***N/A***

Assurance Level	1. HIGH - Strong system of internal control applied to meet existing objectives

Action Required by the Board	The Trust Board is requested to approve the Infection Prevention and Control Annual Report 23/24 prior to its publication.

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
IPC Group	26/04/24	Tim Neal	Approved
Quality Risk and Safety Executive Group (formerly Safety & Effectiveness Group (SEG) receive IPCG chairs report.	14/06/24	Tim Neal	Approved
Quality Committee (Minutes from QRSEG)	25/06/24	Tim Neal	Approved

Liverpool Women's
NHS Foundation Trust

Infection Prevention & Control Annual Report 2023 - 2024

Dr Tim Neal, Director of Infection Prevention & Control

Contents Page

TABLE OF ABBREVIATIONS

ANTT	Aseptic Non-Touch Technique
CPE	Carbapenamase-Producing Enterobacteriales
CQC	Care Quality Commission
DIPC	Director of Infection Prevention and Control
HCA	Health Care Act
HCAI	Health Care Associated Infection
HII	High Impact Intervention
ICB	Integrated Care Board
IPC	Infection Prevention & Control
IPCG	Infection Prevention and Control Group
IPCN	Infection Prevention and Control Nurse
IPCT	Infection Prevention & Control Team
IPS	Infection Prevention Society
KPI	Key Performance Indicator
LWFT	Liverpool Women's NHS Foundation Trust
MMG	Medicines Management Group
MRSA & MSSA	Meticillin Resistant (Sensitive) Staphylococcus Aureus
NICERS	New Infection Control environmental reporting system
NICM	National Infection Control Manual
NLMS	National Learning Management System
NUMIS	Nursing & Midwifery Information System
OLM	Oracle Learning Management System
SI	Serious Incident
SEG	Safety and Effectiveness Group
SWSG	Strategic Water Safety Group

SSI	Surgical Site Infection
TNA	Training Needs Analysis
UKHSA	UK Health Security Agency (previously Public Health England)

1 Summary of Key Achievements and Main Findings

1.1 Key Achievements

The Trust was compliant with the prescribed C.*difficile* and MRSA bacteraemia target

Table 1: Trust Attributable Infections 2021 - 2024

Organism	Target/Trajectory	April 2021 - March 2022	April 2022 - March 2023	April 2023 - March 2024
Clostridioides difficile infection	0	0	0	0
Staphylococcus aureus Sepsis				
MRSA	0	0	0	0
MSSA	Adult = 0 (local target) No target for NICU	1	1	1
Gram-negative Sepsis				
E.coli sepsis	5	4	9	8
Klebsiella spp	1	0	2	1
Pseudomonas aeruginosa	0	0	0	1

1.2 Main Findings

The Trust has met its key IPC metrics (*C.difficile* infection & MRSA bacteraemia) but exceeded *E.coli* and *P.aeruginosa.* trajectories.

1.2.1 Education

The IPCT has maintained current induction and mandatory training.

The IPCT has contributed to local training as required and identified.

The IPCT have commenced a QI Link staff project.

1.2.2 Guidelines

All IPC policies, guidelines and SOP's are in date. The following were updated in 2023-24:

-Infection Prevention and control Policy

-Seasonal and Pandemic Influenza

-Adult Skin decontamination at Venepuncture SOP has become Venepuncture SOP

-Management of Inpatients with Viral and Infection Rashes

All IPC patient information leaflets were reviewed and updated in 2023-24

1.2.3 Infection Prevention and Control Audits and Clinical Practice Audits

60 (100%) Infection Prevention and Control Audits were completed in accordance with the Trust plan.

547 clinical practice ward audits of 5 moments for hand hygiene and local environment have been completed in accordance with the Trust plan.

1.2.4 MRSA

51 adult patients were identified in the Trust with MRSA, 41 (80%) were identified by pre-emptive screening, 4 neonates were identified with MRSA colonisation.

1.2.5 C. difficile

There have been no Trust acquired *C.difficile* infections in 2023-24 (Target = zero)

1.2.6 Bacteraemia

There has been 1 MRSA bacteraemia in 2023-24, (0 Trust Attributable)

There were 2 neonatal MSSA bacteraemias in 2023-24, (1 Trust Attributable)

10 neonates had significant Gram-negative sepsis (2 congenital) and 6 neonates had significant Gram-positive infections (4 congenital).

There were 10 *E. coli* bacteraemias in 2023-24. (8 Trust attributable).

There were 2 *Klebsiella spp* bacteraemias in 2023-24 (1 Trust Attributable)

There was 1 *Pseudomonas aeruginosa* bacteremia in 2023-24

1.2.7 Surgical Site Infection Surveillance

Overall SSI percentage for Maternity and Gynaecology divisions combined was 2.7% being lower than the 5% Trust target.

Review of coding data by IPCT/TVN identified that 3093 Caesarean Sections were undertaken in 2023-24 with 96 SSI (3.1%) and 1641 abdominal Gynaecology surgeries were undertaken with 31 SSI (1.9%).

2 Infection Prevention & Control Team Members

Mrs R May

Infection Control Analyst and Surveillance Officer (1 WTE – 37.5 hours) commenced in post October 2023

Dr T J Neal

Consultant Microbiologist – Infection Prevention & Control Doctor and Director of Infection Prevention and Control (DIPC) (2 sessions / week worked on LWFT site)

Mrs Anne-Marie Roberts

Infection Prevention and Control Practitioner (1 WTE – 37.5 hours)

Mrs Eleanor Walker

Infection Prevention and Control Neonatal Nurse (0.40 WTE – 15 hours)

Ms Jenny McLaughlin

Infection Prevention and Control Nurse (0.80 WTE – 30 hours)

The IPCT is represented at the following Trust Groups and Committees:

Safety Huddle	Daily
Safety and Effectiveness Group	Monthly
Infection Prevention & Control	Quarterly
Water Safety Group	Quarterly
Strategic Water Safety Group	Quarterly
Medicines Management	Monthly
PLACE	Ad-hoc
Building Planning	Ad-hoc
Health and Safety Committee	Quarterly
Nursing and Midwifery Forum	Monthly
Education Governance Meeting	Quarterly
Cleaning National Standards	Ad Hoc
Matrons Group	Monthly
Cleaning / AUDIM audits	Weekly
Medical Devices Meeting	Monthly
Combined Infection Review Meeting	Monthly
Medical Equipment and POCT meeting	Monthly
Space utilization meeting	Monthly
Ultrasound improvement meeting	Bimonthly
IPC Link staff meeting	Biyearly
Measles Oversight Meeting	Adhoc

The Team is managed by the Assistant Director of Nursing and Midwifery. There are no Trust costs associated with the Infection Prevention and Control doctor and DIPC.

3 Role of the Infection Prevention & Control Team

The following roles are undertaken by the IPC team: -

- Education
- Surveillance of hospital infection
    - Surgical Site data collection
    - National bacteraemia data reporting
    - PHE data reporting
- Investigation and control of outbreaks
- Development, implementation and monitoring of Infection Prevention and Control policies
- Audit
- Assessment of new items of equipment
- Assessment and input into service development and buildings / estate works
- Patient care/ incident reviews

Infection Prevention and Control advice is available from the Infection Prevention & Control team and 'on-call' via the DIPC or duty Microbiologist at Liverpool University Hospitals NHS Foundation Trust

4 Infection Prevention and Control Group

The IPC Group meets quarterly and is chaired by the Chief Nurse. The group receives regular reports on Infection Prevention and Control activities from clinical and non-clinical divisions/departments.

Reports received include those from:

- Estates and Operational Services
- Health and Safety
- Occupational Health
- Decontamination
- Divisions/departments
- Link Group
- Water Safety group
- Infection Prevention and Control team members

The Terms of Reference of the IPCG are included as **Appendix A**

The IPCT report quarterly to IPCG and the DIPC reports quarterly to SEG which also receive a 'Chair's Report' from the IPCG meetings. The Quality Committee receives minutes from SEG. The Trust Board also receives an annual presentation and report from the DIPC.

Trust IPC issues, processes and surveillance data are relayed to the public via Infection Prevention and Control posters, patient information leaflets, the Trust website (copy of this report) a notice board in the main reception, which is updated monthly, and departmental notice boards in ward areas.

Throughout the year many changes in practice have been initiated, facilitated, supported or mandated through the work of the IPCT and IPCG. Some of these are on a large scale, such as input of the IPCT into large capital projects undertaken by the Trust (see section 9.3) however many appear smaller and take place in the clinical areas as a consequence of audit, observations and recommendations. These interventions equally contribute to the provision of clean and safe care in the organisation.

5 External Bodies

5.1 Health Care Act & Care Quality Commission

The Health Care Act (HCA) was published in October 2006 and most recently revised in December 2022. This code of practice sets out the criteria by which managers of NHS organisations are to ensure that patients are cared for in a clean environment where the risk of HCAI is kept as low as possible.

The Health Care Act action plan is a standing item on the IPCG agenda.

5.2 Integrated Care Board (ICB) Assurance Framework

Assurance data is reported monthly to the ICB and Quarterly at IPCG, it incorporates performance data, exception reporting, audit data and screening compliance.

5.3 Mandatory Surveillance

The Trust submits data on MRSA, MSSA, *E.coli, Klebsiella spp*. and *Pseudomonas aeruginosa* bacteraemia and *Clostridioides difficile* infections by the 15th day of each month to the UKHSA via an online Health Care Associated Infection Data Capture System. HCAI data is also submitted each month for the Trust Quality Report and Corporate Information.

6 Education

6.1 Mandatory training and Induction:

Mandatory training in Infection Prevention and Control is a requirement for all Trust staff including clinical, non-clinical staff and contractors. The IPCT review the training package annually and ensure that it reflects best practice, national recommendations and issues identified as non-compliant in the previous year. All staff receive training in Infection Prevention and Control every three years via electronic learning. The electronic package is incorporated into the NLMS and linked to OLM.

Training continues to be provided by the IPCT for medical staff which includes consultants, trainees and ad-hoc mandatory training for corporate services. Four formal teaching sessions have been delivered by the DIPC throughout 2023-24

The IPCT has provided eight IPC training sessions in 2023-24

Although the majority of mandatory training is delivered by the IPC team a number of Link Staff also provide training including hand hygiene within their areas.

The IPCT continue to provide a monthly 'Bug-Bulletin' as a mechanism of communicating relevant and topical IPC issues to staff.

The DIPC contributes monthly to the Trust 'Safety Check-In' programme highlighting any issues of importance to IPC which may impact patient safety.

6.2 Link Staff

The IPC link staff meeting was held twice this year at the end of the Professional Development day. The programme is organised to reflect current initiatives, implementation of new guidance and reinforcement of any non-compliance relating to IPC. The number of attendees was 9 in July 2023 and 12 in January 2024. Link Staff meetings and Professional Development days are included in the TNA provision for Link Staff and will be twice yearly moving forward in October and April.

6.3 ANTT Training

Twenty ANTT assessor training sessions were provided in 2023-24 by the Infection prevention and control team. Each department has ANTT assessors who have been trained to assess ANTT in clinical practice. ANTT is a core clinical competency which includes yearly ANTT e-learning training and assessment in clinical practice). Results of ANTT training and assessment can be viewed on Power BI and are reported and monitored in Divisional reports. ANTT assessment can also be completed on the Clinical Corporate mandatory training days.

6.4 Guidelines/Policies

The below Policies SOP have been reviewed in line with the Trust policy process.

- Assessment and management of wounds (adults)
- Decontamination of Medical Devices Policy
- Cleaning Policy
- Covid -19 during a period of low prevalence SOP
- Common Infectious agents in hospital patients SOP
- Infection Prevention & Control Policy
- Seasonal and Pandemic Influenza SOP
- Adult Venepuncture SOP

All other IPC policies, guidelines and SOP's are in date

The IPCT continue to review the National Infection Control Manual' NICM and reflect the contents of this in Trust policies as they are updated.

7 Audits

7.1 ICNA Trust audit programme

The IPCT continue to use the updated IPS audit tools. The audit programme for the year is established and agreed by the IPCG.

From 1st April 2022 the IP&C clinical practice and hand hygiene audits were redesigned and incorporated into the Liverpool Women's Nursing & Midwifery audit system. Local IPC hand hygiene and environment audits are completed monthly. Matrons' complete monthly audits of clinical areas and IPC KPI's are audited within the monthly KPI audit. IPCT assist in undertaking the overarching BBAS audits.

Results from this audit system feed into Power BI and will be included in divisional reports.

283 Hand Hygiene audits and 281 local IPC environment audits have been carried out in 2023-24 by departmental staff. In all instances deficiencies identified through the audit programme generate an action plan which is monitored via Divisional reports to IPCG.

The Infection Prevention and Control environmental audits are carried out a minimum of twice a year in each clinical area unannounced by the IPC team. A total of 60 Infection Prevention and Control audits in 23 clinical areas have been undertaken.

IPC audit scores range from 70-100%.

In all instances deficiencies identified through the audit programme generate an action plan which is monitored via Divisional reports to IPCG.

7.2 Mattress audits

Mattress audits are completed in all areas in the Trust. The audit examines cleanliness and mattress integrity.

Results are available on Power BI and reported through the Divisional report to IPCG. Local areas have ownership for replacement and condemning of any mattress not fit for purpose. There is a system in place for the provision and storage of replacement mattresses across the Trust.

8 Antimicrobial Stewardship

The organisation reports on antimicrobial issues via the Trust Medicines Management Group (chaired by the Deputy Chief Pharmacist). The DIPC is a member of the MMG and there are named pharmacists who lead on antimicrobial issues.

9 Infection Prevention and Control and the Environment

9.1 Water Safety

The Trust has a local Water Safety Group which met quarterly until quarter 2. From Quarter 3 the Trust WSG merged with, and reported through, the WSG at LUHFT, which provided a more robust forum for discussion and expertise. The WSG is chaired by the DIPC, and the Independent Authorising Engineer (water) supports both LUHFT and LWH. Quarterly WSG reports provide assure on compliance with the Trust Water Safety Plan (planned preventative maintenance, flushing compliance, rectification of system defects and surveillance).

The average weekly water flushing compliance for 2023-24 was 96%.

Water sampling (surveillance) is undertaken in accordance with the timetable outlined in the water safety plan. Positive results are managed in accordance with national guidance.

9.2 Ventilation Safety

The Trust ventilation Safety Group is combined with that of LUHFT and is chaired by the DIPC. The ventilation safety group received assurance from the estates department on the planned preventative maintenance and annual validation of all critical and specialised ventilation systems.

9.3 Building Projects & Design Developments

The team remain reliant on the Estates department and the Divisions alerting and involving the team in impending projects via the Infection Prevention and Control group meetings.

2023-24 projects requiring IPC Team involvement included:

- Imaging / Colposcopy department – major refurbishment to move bone density room and colposcopy rooms and incorporate CT scanner / MRI Scanner
- Ongoing refurbishments following the Aintree Obstetric / Gynaecology Outpatient Department merge.
- GOPD Ambulatory project
- MLU project
- Genetics laboratory
- Physiotherapy improvements project
- EPAU project
- Changing places project

10 Surveillance of Infection

Hospital infection (or possible infection) is monitored in the majority of the hospital by 'Alert Organism Surveillance' this involves scrutiny of laboratory reports for organisms associated with a cross infection risk e.g., MRSA, *Clostridioides difficile* etc.

On the Neonatal Unit, which houses most of the long-stay patients, surveillance is undertaken by both 'Alert Organism' and by prospective routine weekly surveillance of designated samples. The IPCT examines results of these samples and action points are in place for the unit based on these results.

Surveillance of bacteraemias (blood stream infections) for both national mandatory and in house schemes is also undertaken. National mandatory reporting of blood stream infections includes *Klebsiella* and *Pseudomonas* in addition to *E.coli* and *S.aureus.*

10.1 Clostridioides difficile

Mandatory reporting of this disease commenced in January 2004 and includes all patients over 2 years old. Historically the number of cases at LWFT has been low. The prescribed trajectory for this disease for the Trust in 2023-24 was zero.

During the period April 2023 – Mar 2024 there were no patients identified with *C.difficile* infection in the Trust. The last reported positive *C.difficile* patient in LWH was in 2017-18

10.2 Bacteraemia Surveillance

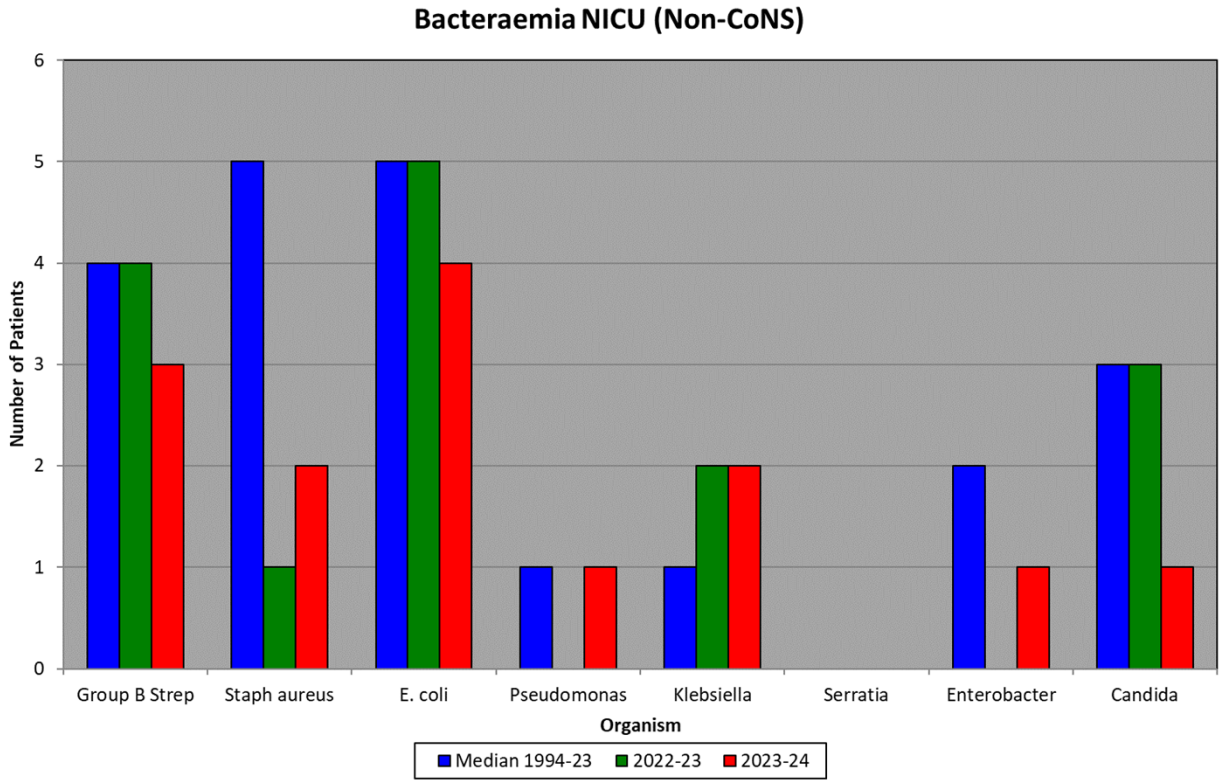
10.2.1 Neonatal Bacteraemia

As always, the commonest organism responsible for Neonatal sepsis was the common skin organism, coagulase-negative staphylococcus (CoNS). In the period April 2023 – March 2024 10 babies (10 in 2022-23 and 13 in 2021-22) had infections with Gram-negative organisms, two of these infections (*E. coli* occurred in the first week of life and were congenitally acquired. The remaining 8; (2 *E. coli,* 2 *Klebsiella spp* and 1 *Acinetobacter sp*. 1 *Burkholderia* sp, 1 *Enterobacter* sp. and 1 *P.aeruginosa.*) occurred after 5 days of life. The *Burkholderia* bloodstream infection was part of a national incident (see section 10.4).

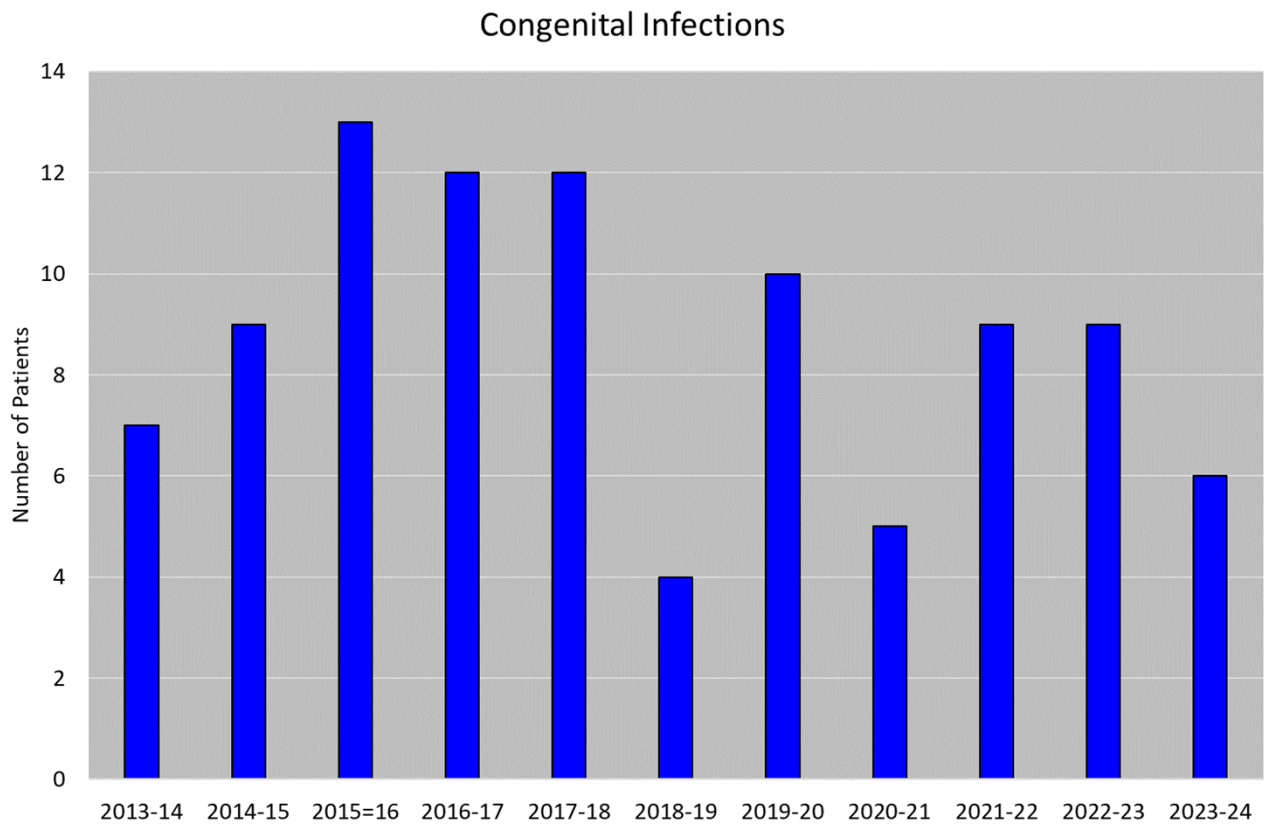
There were 6 episodes of infection with significant Gram-positive pathogens (6 in 2022-23 and 7 in 2021-22); 4 of these infections (3 Group B Streptococcus, and 1 *Streptococcus pneumoniae*) were congenitally acquired and 2 (*Staphylococcus aureus*) occurred after day 5.

All non-coagulase-negative Staphylococcal sepsis on the unit is subject to a review to determine the focus of infection, precipitating causes and the appropriateness of care.

The bar chart below describes the pattern of 'definite-pathogen' Neonatal bacteraemia in the current year in comparison to last year and the median value for each organism for preceding years. There is considerable variability in the figures from year to year (probably reflecting the complexity of pathogen host relationship in this group).



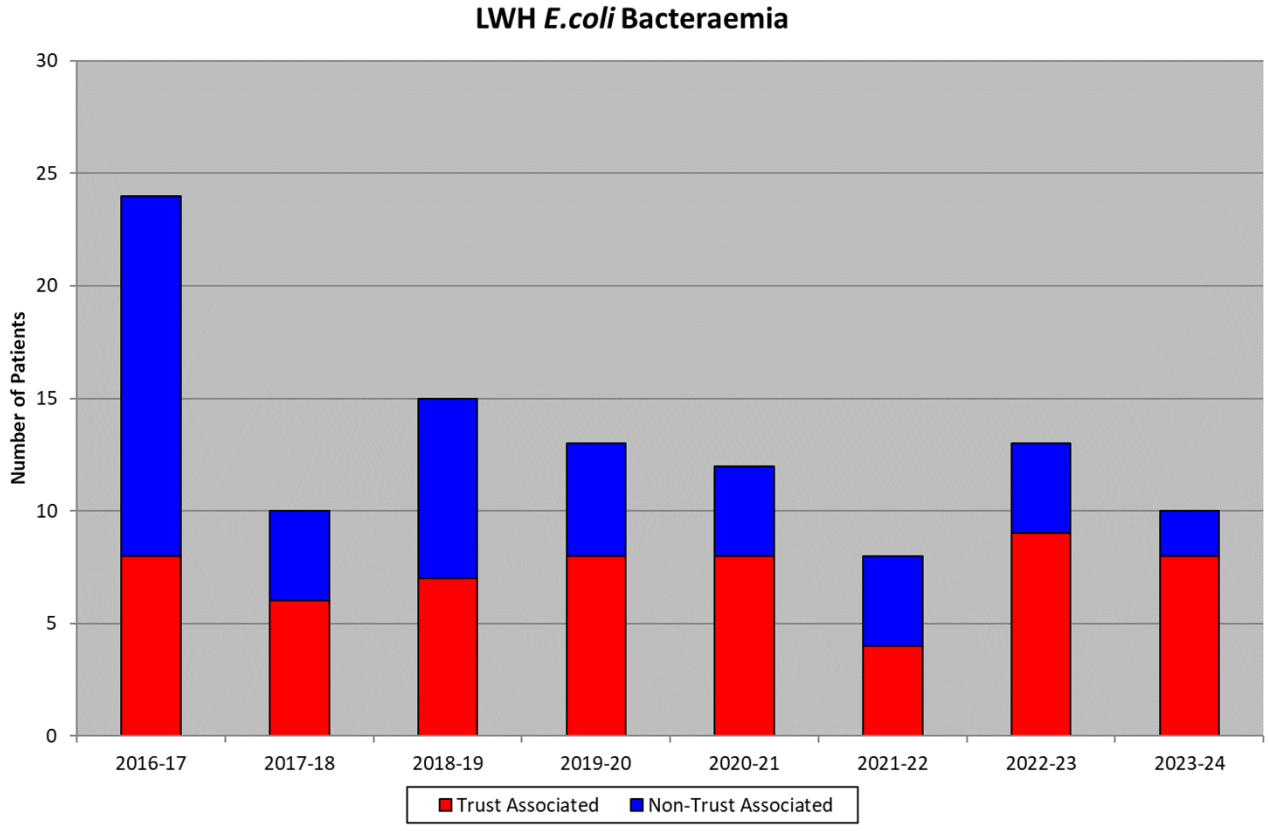
The IPCT have been monitoring the number of Neonatal infections classified as 'congenital' i.e., presenting in the first 5 days of life. 6 babies this year had congenital infection.



10.2.2 Adult Bacteraemia Surveillance

There have been no hospital onset MRSA or MSSA bacteraemias in adult patients in the period April 2023 to March 2024. One patient presented to the Trust with a community onset MRSA bacteraemia.

There is a national ambition to reduce Gram-negative bacteraemia (particularly *E.* coli) by 50%. Although this is not a specific Trust target the IPCT have been working with regional groups facilitated by the ICB to reduce *E. coli* sepsis and local trajectories have now been applied. In 2023-24 the Trust reported 10 *E. coli* bacteraemias (8 Trust associated) compared to 9 Trust associated in 2022-23. The given trajectory for this infection is 5 Trust-associated cases.

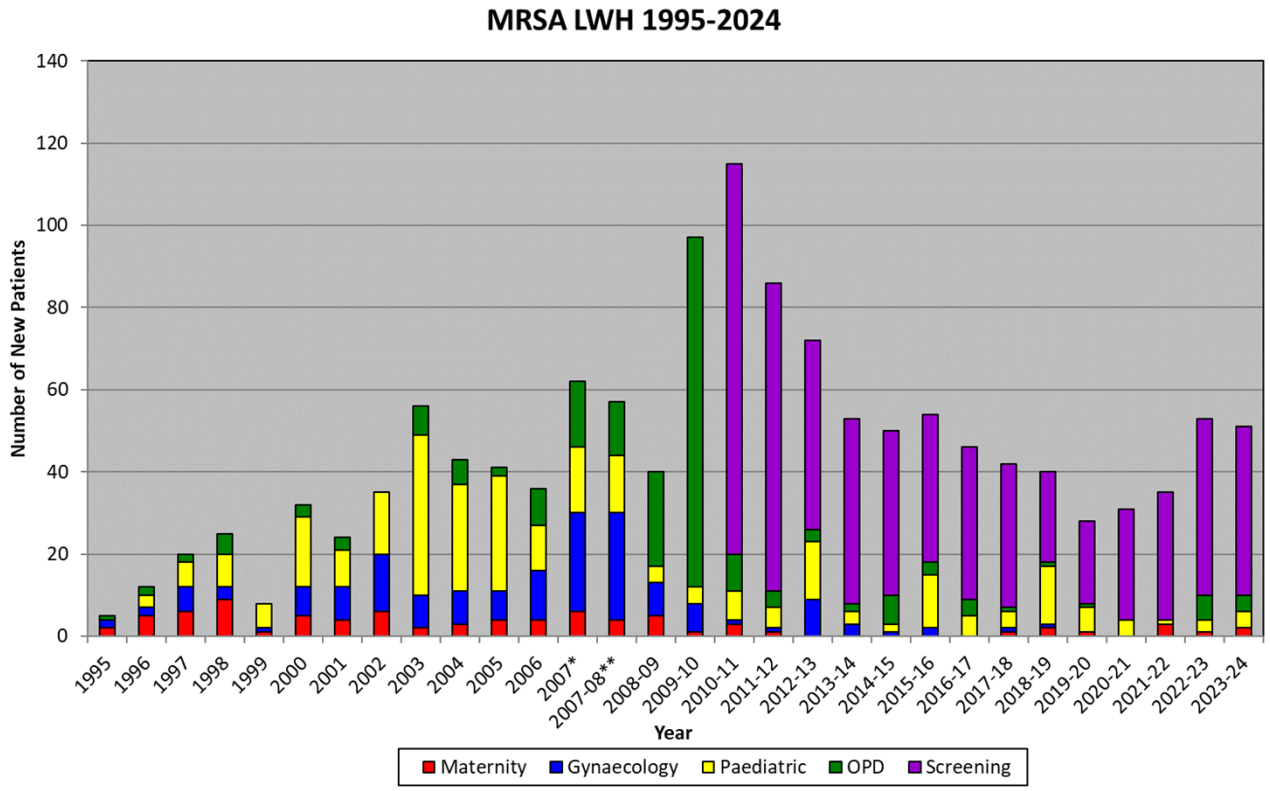


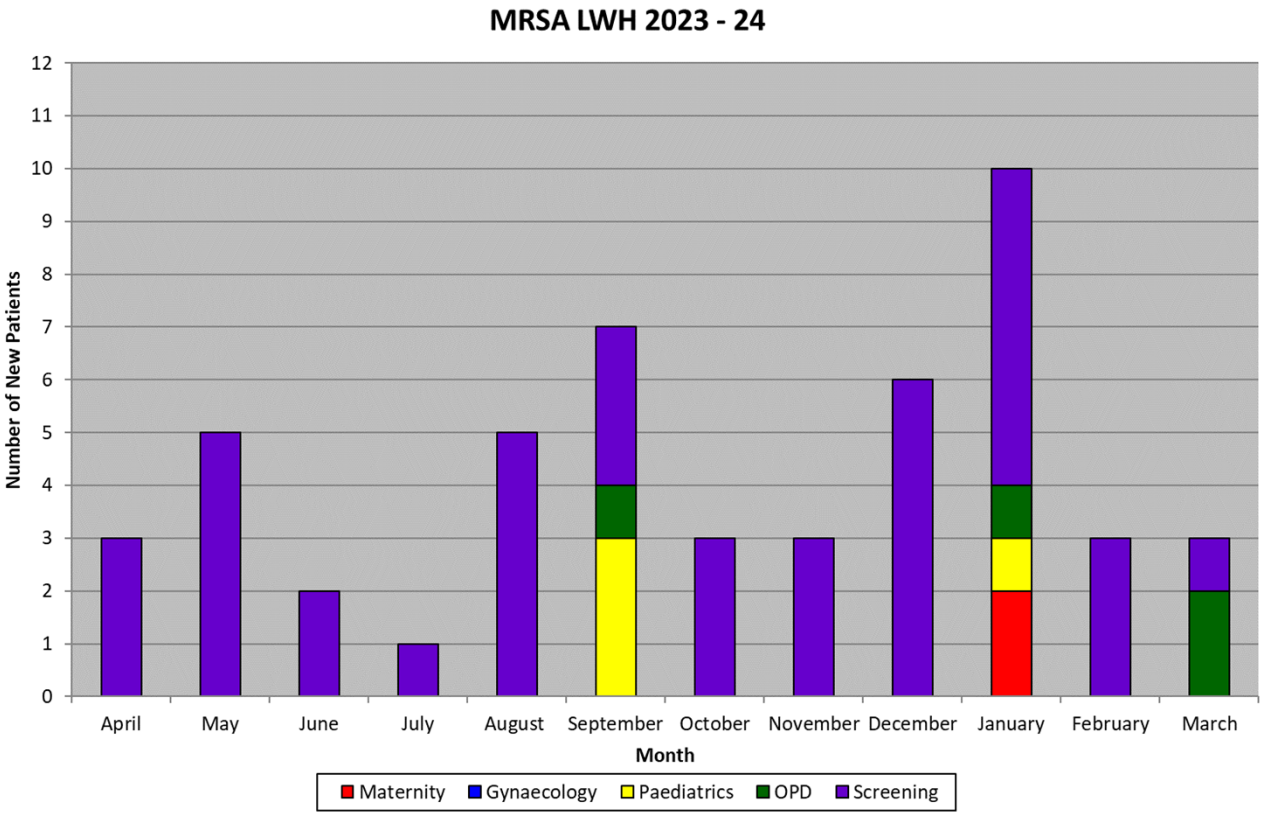
In addition to the mandatory surveillance the IPCT has been collecting clinical data on bacteraemic adults in the Trust; 42 patients were identified with positive blood cultures from 561 cultures submitted (9.1%). 21 (50% of positives, 3.7% of total) of these were contaminated with skin organisms.

10.3 Alert Organism Surveillance

10.3.1 MRSA

The total number of patients identified carrying MRSA in the Trust during the year 2023-24 was 51 (53 in 2022-23). Forty one of the 47 adult patients were identified by routine screening either on, or prior to, admission. Three unlinked patients had MRSA identified in wounds. The charts below show the number of new patients identified with MRSA and the annual totals for the period 1995 – 2024





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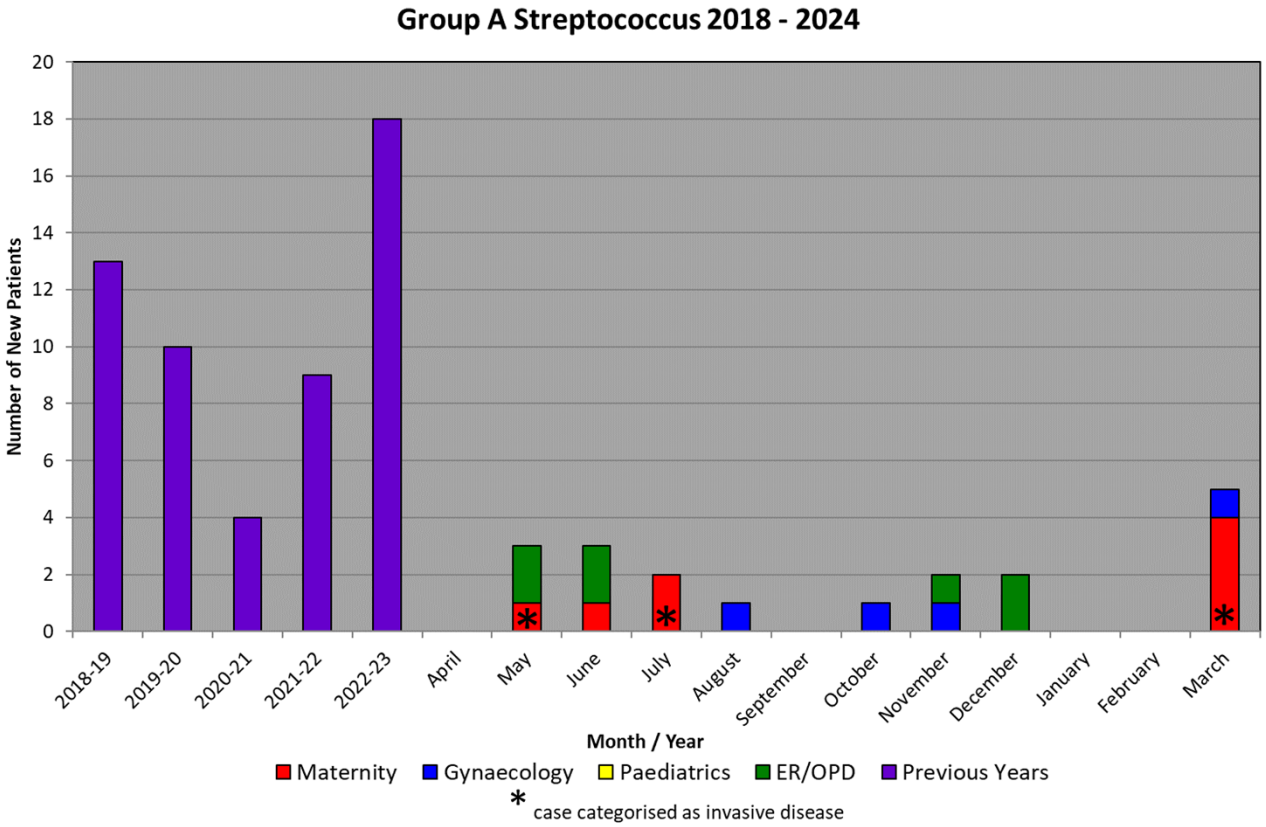
During the period of this report 4 neonates were identified with MRSA, including one pair of twins, no other links were established between these cases.

10.3.2 Group A Streptococcus

In the period April 2023 to March 2024, 19 patients were identified with Group A streptococcus as detailed below. This is a small increase on the number reported in 2022-23 and is consistent with a significant rise in Group A Streptococcal infections and Scarlet Fever recognised in the community. All patients with Group A Streptococcal infection are reviewed. Three patients were categorised as invasive disease (iGAS), including one patient with bacteraemia, review of these cases identified good care and no preventable factors. The majority of other patients had genital tract infection.



10.3.3 Carbapenemase Producing Enterobacteriales

The Trust had no new cases of CPE in 2023-24.

10.3.4 Covid-19

2023-24 saw continued Covid-19 activity however the success of the vaccination programme and changes in the virus lessened the clinical impact of the disease.

In 2023-24 the Trust managed 13 patients with Covid-19 infection. There were no hospital acquired cases.

10.4 Routine Neonatal Surveillance

Nearly all infection on the Neonatal unit is, by definition, hospital acquired although a small proportion is maternally derived. Routine weekly colonization surveillance has continued this year on the Neonatal unit. Results are shown in Appendix B

As colonisation is a precursor to invasive infection the purpose of this form of surveillance is to give an early warning of the presence of resistant or aggressive organisms and to ensure current empirical antimicrobial therapy remains appropriate. Action points are embedded in the Neonatal unit and IPC policies linked to thresholds of colonisation numbers to limit spread of resistant or difficult to treat organisms.

As well as resistant or aggressive organisms focus has remained on both *Pseudomonas aeruginosa*. and *Staphylococcus aureus* as potential serious pathogens. The median number of babies colonized with *Pseudomonas* each week was 0, and with *S.aureus* was 2 (both metrics unchanged from last 2022-23).

In October 2023 routine neonatal surveillance detected 2 babies colonised with an environmental organism; *Burkholderia cepacia* complex (Bcc). Investigations commenced into the provenance of this organism and in November it became clear that the neonatal cases were part of an international outbreak linked to a contaminated eye gel. In total four babies were involved (one with a positive blood culture). The incident was managed by a national team from UKHSA.

10.5 Surgical Site Surveillance

Given the static nature of the wound infection rate over several years, and the favourable Trust position when benchmarked against other organisations in the national GIRFT survey, a decision was taken to reduce continuous prospective wound surveillance

Wound infections are discussed at monthly review meetings where any themes are highlighted and fed back to Divisions through 'Lessons of the week' information.

From coding data, the Trust SSI rate for the period 01.04.2023 – 31.03.24 is 2.7%.

11 Health & Wellbeing

The Trust Health & Wellbeing Department report monthly to the IPCG including vaccination updates. Staff have historically been screened for TB, Hepatitis B and Rubella immunity. Guidance on Measles, Chicken pox, HIV and Hepatitis C have been incorporated for all 'new starters' and a catchup exercise is in place for staff already employed. The IPCG supports the Health & Wellbeing team in ensuring that workers in designated areas have appropriate vaccinations and immunity.

12 Infection Control Team Work Plan

12.1 Infection Control Team Work Plan 2023-24

Work Plan	Completion Date	Comments
Training • Provide Trust mandatory & induction training • Review and continue to support IPC / ANTT Link staff role and professional development •	Ongoing Ongoing	Section 6
Audit • Continue to audit in line with the IPS Audit programme • Support BBAS accreditation audits • Support CQC mock assessments	Ongoing Ongoing Ongoing	Section 7
Reporting • Continue to support and monitor the nursing & midwifery local audit programme	Ongoing	Section 7.1
Engage • Continue active engagement with Link staff, managers, and matrons • Provide opportunities for Link staff to accompany IPC Team on IPC environmental and BBAS audits for professional development	Ongoing Ongoing	Section 6
Surveillance • Continue 'Alert Organism' surveillance focused on resistant pathogens • Continue to monitor cases mandatorily reportable infections • Implement actions identified through RCA of bacteremia's and *C.difficile* infections • Work with the CCG and Trust Sepsis lead to deliver their target reduction in Gram-negative sepsis. • Work with Pharmacy Lead / clinical divisions to deliver the CQUIN03 target for 2023/23 of prompt IV to oral switch Support and expand on the collaboration with pharmacy to support the AMR agenda	Ongoing Ongoing Ongoing Ongoing Ongoing	Section 9

Health Act & NICE • Review compliance and evidence in IP&C Board assurance framework • Review and ensure Trust maintains its compliance with current NICE guidance relating to infection, infection control, sepsis, and antimicrobial stewardship.	Ongoing Ongoing	Section 5.1

12.2 Infection Control Team Work Plan 2024-25

Work Plan	Completion Date	Comments
Training • Provide Trust mandatory & induction training • Review and continue to support IPC / ANTT Link staff role and professional development • Support 3rd year cohort of students on Leadership placements		
Audit • Continue to audit in line with the IPS Audit programme • Support BBAS accreditation audits • Support CQC mock assessments • Support Audim efficacy audits		
Reporting • Continue to support and monitor the nursing & midwifery local audit programme		
Engage • Continue active engagement with Link staff, managers, and matrons • Provide opportunities for Link staff to accompany IPC Team on IPC environmental and BBAS audits for professional development		
Surveillance • Continue 'Alert Organism' surveillance focused on resistant pathogens • Continue to monitor cases mandatorily reportable infections		

• Implement actions identified through RCA of bacteremia's and *C.difficile* infections • Work with the CCG and Trust Sepsis lead to deliver their target reduction in Gram-negative sepsis. • Work with Pharmacy Lead / clinical divisions to deliver the CQUIN03 target for 2023/23 of prompt IV to oral switch Support and expand on the collaboration with pharmacy to support the AMR agenda		
Health Act & NICE • Review compliance and evidence in IP&C Board assurance framework • Review and ensure Trust maintains its compliance with current NICE guidance relating to infection, infection control, sepsis, and antimicrobial stewardship.		

13 Appendices

13.1 Appendix A – Terms of Reference - Infection Prevention and Control Group Terms

INFECTION PREVENTION AND CONTROL GROUP

TERMS OF REFERENCE

Constitution:	The Group is established by the Effectiveness and Safety Committee and will be known as the Infection Prevention and Control group.
Duties:	The Group is responsible for: providing assurance to the Trust Board in relation to those systems and processes it monitors and ensure compliance with external agency's standards e.g.: CQC etc. 1. Agree and disseminate the systems and processes for effective Infection Prevention and Control. 2. Develop the strategic direction of Infection Prevention and Control, ensuring that the team is resourced sufficiently to achieve improvement in performance. 3. Review and approve the work of the Infection Prevention & Control team members in line with Trust objectives through the IPCC team work plan. 4. Review and endorse all policies relating to Infection Prevention & Control and evaluate their implementation. 5. Receive and review regular reports of infection incidents or outbreaks and ensure that reports are forwarded to appropriate external authorities. 6. Ensure that lessons identified from incidents, outbreaks, or reports from external organisations are actioned by relevant Divisions in the organisation. 7. Implement a regular reporting timetable including comprehensive Division reports and reports from support services at regular intervals.

	8. Ensure that effective Infection Prevention and Control is being delivered in Divisions and monitor evidence of prevention and control practice. 9. Promote and facilitate the education of staff of all grades in hand hygiene Infection Prevention & Control and related topics Receive, discuss and endorse the annual Infection Prevention & Control report produced by the Infection Prevention & Control team prior to submission to the Effectiveness and Safety Committee and Trust Chief Executive.
Membership:	The Group membership will be appointed by the [Safety and Effectiveness Committee] and will consist of: • The Chair – Director of Nursing, Midwifery or Representative of CEO • Director of Infection Prevention and Control • Infection Prevention & Control practitioner • Trust Decontamination Lead • Representative of UKHSA • Estates or Patient Facilities Manager • Health and Safety Advisor • Occupational Health Nurse • Deputy Director of Nursing and Midwifery • Head of Nursing Gynaecology Division • Head of Midwifery Maternity • Head of Nursing Neonates • Head of Nursing Clinical Support Division • Antibiotic Pharmacist • Representative from Clinical Commissioning Group • Safety Lead from Family Health Division • Safety Lead from Gynaecology Division • Safety Lead from Clinical Support Division Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum
Quorum:	A quorum shall be 6 members including: Chair (or approved Deputy)

	IPCN or DIPC Representative from each Division Representative from Facilities Department
Voting:	Each member will have one vote with the Chair having a second and casting vote, if required. Should a vote be necessary a decision will be determined by a simple majority.
Attendance:	**a. Members** Members will be required to attend a minimum of 75% of all meetings. **b. Officers** Other officers and staff of the Trust will be invited to attend the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed. Representatives from partner organisations or other external bodies may be invited to attend as appropriate. Such representatives will not have voting rights.
Frequency:	Meetings shall be held [4] times per year. Additional meetings may be arranged from time to time, if required, to support the effective functioning of the Trust.
Authority:	The Group is authorised by the Effectiveness and Safety Committee to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Group.
Accountability and reporting arrangements:	The Group will be accountable to the Effectiveness and Safety Committee The minutes of Group will be formally recorded and submitted to the Effectiveness and Safety Senate. The Chair of the Group shall draw to the

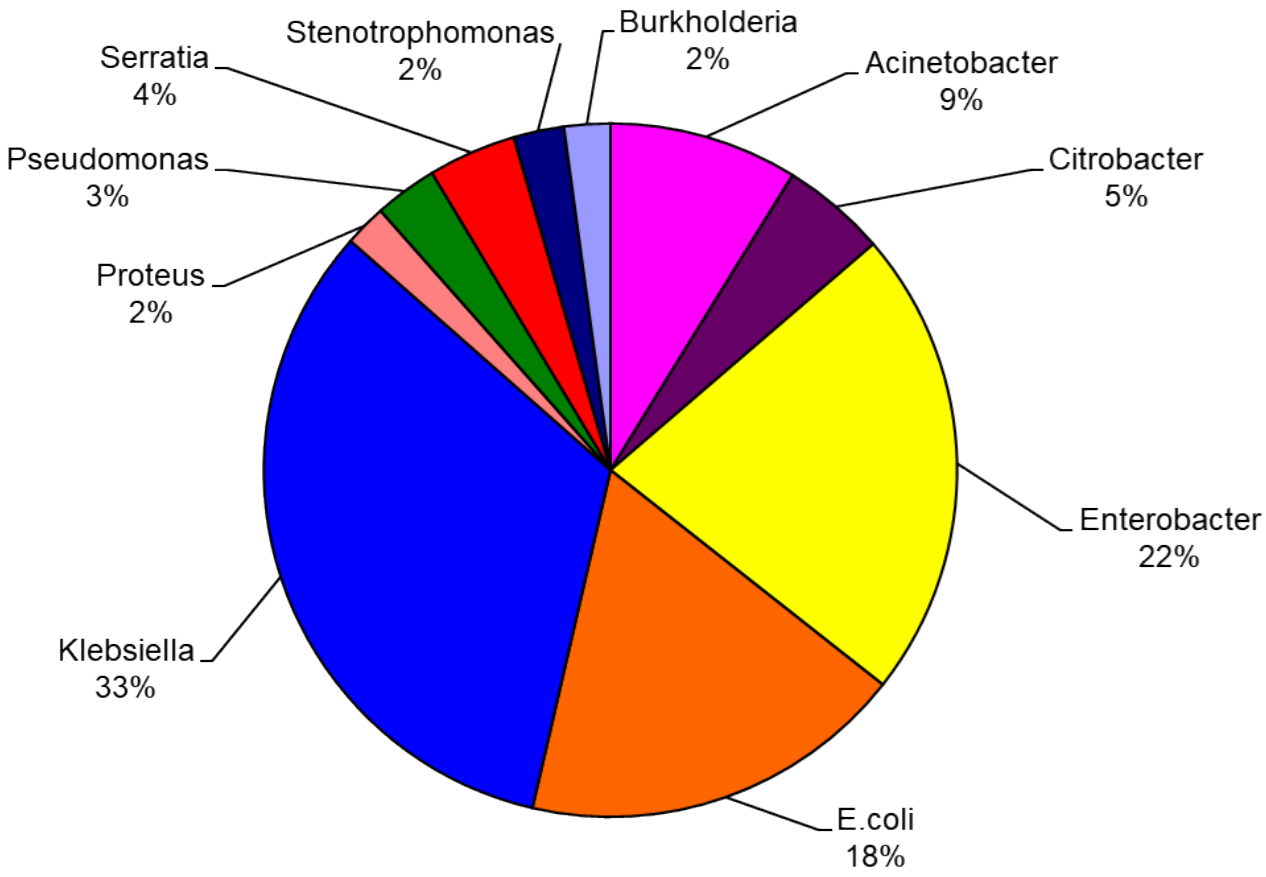
	attention of the Effectiveness and Safety Committee any issues that require disclosure to it or require executive action. The Group will report to the Effectiveness and Safety Committee annually on its work and performance in the preceding year. Trust standing orders and standing financial instructions apply to the operation of the Group.
Reporting Committees/Groups	The sub-committees/groups listed below are required to submit the following information to the Infection Prevention and Control Group: a) Chairs Report [and/or] minutes of meetings; and b) an Annual Report setting out the progress they have made and future developments. The following sub committees/groups will report directly to the Committee: • Local Water Safety Group • Link Staff Meeting / Professional Development Day
Monitoring effectiveness:	The Group will undertake an annual review of its performance against its duties in order to evaluate its achievements.
Review:	These terms of reference will be reviewed at least annually by the Effectiveness and Safety Committee.
Reviewed by Infection prevention and Control Group:	29/04/2022
Approved by Effectiveness and Safety Committee:	IPC group

Review date:	April 2024
Document owner:	Dianne Brown, Chief Nurse Email: dianne.brown@lwh.nhs.uk Tel: 01517024010

13.2 Appendix B - Neonatal Colonisation Surveillance

Organism	2013/14	2014/15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24
Acinetobacter	3	6	3	3	3	3	3	3	3	6	9
Citrobacter	4	3	4	7	4	6	3	4	6	5	5
Enterobacter	17	14	17	22	19	18	23	20	19	20	22
E.coli	30	27	21	22	28	23	20	26	18	17	18
Klebsiella	34	39	41	35	31	34	39	33	31	37	33
Proteus	1	1	1	1	1	0	2	1	1	0	2
Pseudomonas	5	4	3	3	4	6	3	5	7	6	3
Serratia	2	1	3	2	5	3	2	3	6	3	4
Stenotrophomonas	4	4	7	5	5	7	5	5	9	6	2

Percentage Colonisation 2023-24



Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Meeting Date	Tuesday, 11 July 2023	**Item Reference**	24/25/
Report Title	Complaints Annual Report 2023/24		
Author	Michelle Rushby, Head of Patient Involvement and Experience		
Responsible Director	Dianne Brown, Chief Nurse		

Purpose of Report	To provide information relating to the Complaints Annual Report for 2023/24 outlining an overview of complaints and feedback that Liverpool Women's NHS FT(LWH) has received from patients, relatives, and users.
Executive Summary	In 2023/24 the following can be noted: • 64 complaints received which saw a reduction from previous year (77). • Most complaints (75%) were attributed to Gynaecology, and this also includes the Hewitt Centre, this is an increase from the previous year. Maternity seeing a decrease in the number of complaints in 2023-24 by 20 as compared to 2022-23. CSS had 2 complaints and no complaints in Neonatal in 23/24. • The primary issue in most complaints relates to communication. • 2674 PALS and PALS+ cases raised with the Patient Experience Team, an increase of 409 cases from the previous year. • 108 compliments formally registered through the Patient Experience Team; this is a decrease from 127 in the previous year. • The percentage of complainants recorded as "British – White" has increased from 62% in 2022-23 to 66% this year. Complainants from global majority groups (previously referred to as BME/BAME) made up 9% of the complainants recorded this year and this is a decrease from 12% recorded in 2022-23. • Since Q1, 23/24 extensive improvements to complaint response times achieved and maintained at 100% • Work to address Health Inequalities and improvements Trust wide continues with the introduction of a Help Hub to support non-English-speaking people to raise concerns. • Focus remains on Lessons Learnt and Quality Improvement tests of change to support areas of repeated themes of concern within divisions.
Key Areas of Concern	*Hewitt Fertility Centre (HFC) Increased numbers of complaints – weekly* meetings were put in place between HFC and the Patient Experience Team to address any concerns raised but there continues to be an upward trend with complaints for HFC. There was a change in policy with refunds and additionally with sibling funding and this has contributed to and generated more concerns being raised by service users.
Trust Strategy and System Impact	Complaints at LWH are managed in accordance with the NHS Regulations and is published and made available on the Trust website.

Links to Board Assurance Framework	*None*	***NA***
Links to Corporate Risk Register (scoring 10+)	*None*	***NA***

Assurance Level	1. HIGH - Strong system of internal control applied to meet existing objectives

Action Required by the Committee	The Trust Board is asked to approve the Complaints Annual Report 23/24 prior to its publication.

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
Quality Committee	25.06.24	Michelle Rushby	Approved at Quality Committee
Patient Involvement & Engagement Group	07.05.24	Michelle Rushby Gillian Walker	Approved

Liverpool Women's NHS Foundation Trust

Complaints Annual Report: 2023-24

Contents

Summary

This annual report provides an overview of complaints and feedback that Liverpool Women's NHS Foundation Trust (LWH) has received from patients, relatives, and users from 01 April 2023 to 31 March 2024. The report is written in accordance with the NHS Regulations and is made available on the LWH website.

Complaints are a valuable source of information on the quality of service the Trust is providing. This report looks at complaints to understand the factors that may lead to them, what can be done to address these factors, and whether the Trust's response to complaints can be deemed to be both appropriate and sufficient.

Making a complaint is never easy and it is important that there is an effective and sympathetic process for dealing with complaints. Those who complain should feel that they have been listened to and that learning has taken place. The Trust continues to work hard to ensure that its complaint process is personal and responds to the needs of the individual to ensure that their experience is listened to and put right simply and quickly. This philosophy aligns with the Health Service Ombudsman's Principles of Good Complaints Handling which promotes a customer focused complaints system.
The report provides: -

- A summary of complaints received between April 2023 and March 2024
- Details of the areas of the Trust the complaints focus on
- The primary causes of complaints
- Future Plans
- Lesson Learnt

The key findings in 2023-24 are: -

- There were 64 complaints received which shows a decrease from the 77 the previous year.
- The primary issue in the majority of complaints related to communication. Individual instances of these were noted a total of 121 times in the 64 complaints received.
- 77 complaints were resolved in the last year which includes complaints received in 2022-23. This is an increase from 66 the previous year.
- Of the 77 complaints closed, 7 complaints have been upheld, 15 complaints have not been upheld and 47 complaints have been partially upheld. 8 complaints were withdrawn.

The primary conclusions of the report are: -

- There are well established mechanisms to capture the experience of patients and their families to drive continuous improvement. These include the “Friends and Family” patient feedback programme, use of information gathered through complaints and PALS, information gathered from Care Opinion, listening to patient stories at the start of the Trust Board meeting and National and Local Patient Surveys. There has also been a lot more involvement and engagement with the communities that we serve and listening events have been held with both local and city-wide groups, these include the hard-to-reach groups with protected characteristics. All patient experience is used to motivate and drive service improvement.
- Complaints received during 2023-24 have continued to see a wide-ranging number of HOC per complaint.
- There continues to be a need to focus on evidencing and promoting the changes that occur in practice from the Trust learning lessons from complaints. New processes around action plan monitoring have been introduced which show positive improvements, and in 2023-24 a Trust level KPI continues to monitor this.

Complaint Levels

The Trust received 64 complaints in 2023-24, which is decrease from the previous year figure of 77.

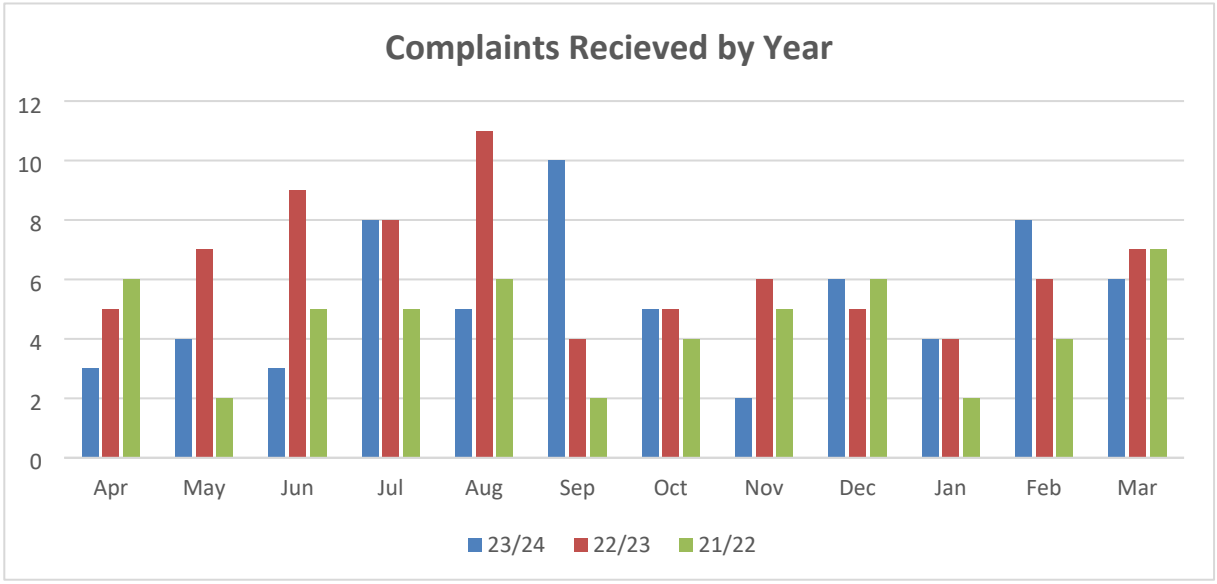


Figure 1: LWHFT Complaints comparison by month

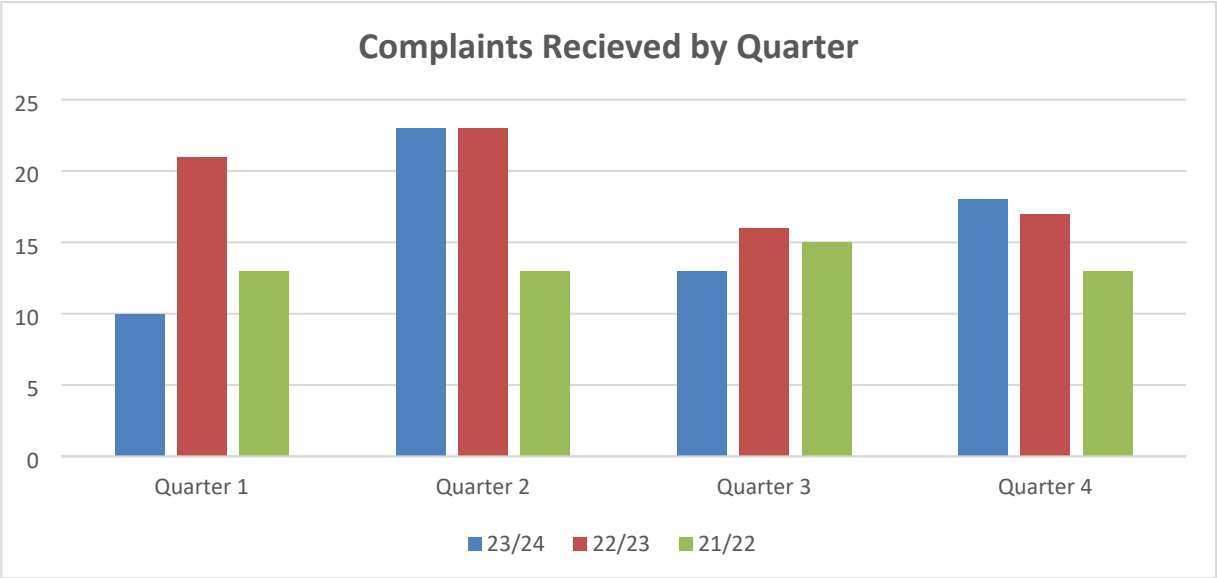
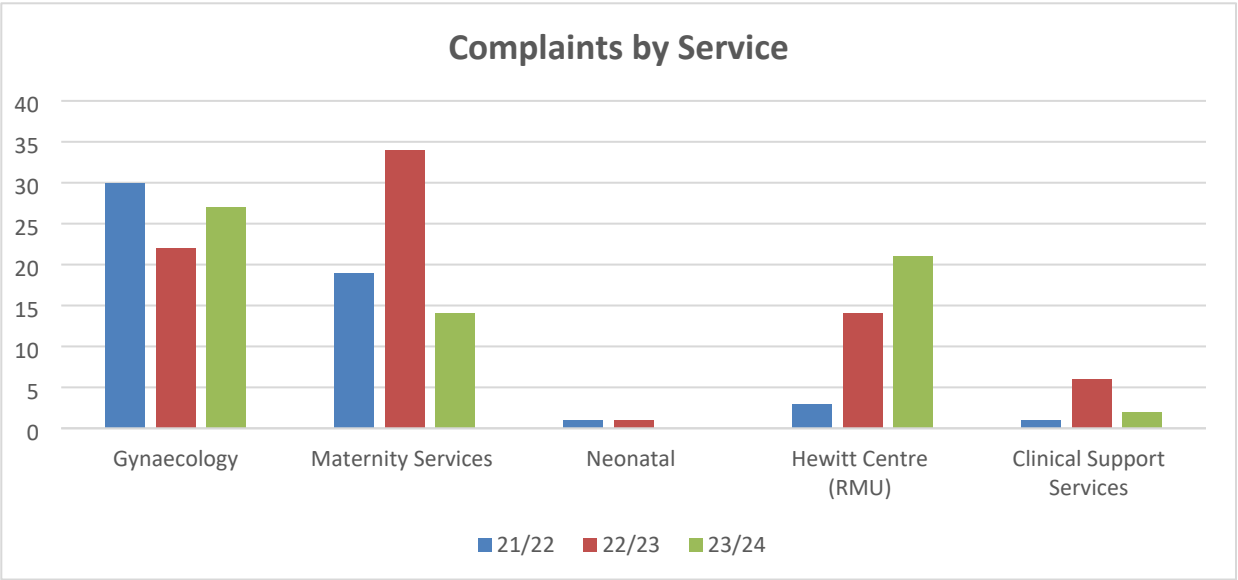


Figure 2: LWHFT Complaints by Quarter, yearly comparison

The Trust is committed to widening the number of channels through which patients can access the complaints arena. It continues to receive feedback via Care Opinion websites and its Twitter and Facebook accounts which can in turn be registered formally. There has also been a Help Hub introduced at the main entrance to the Hospital. This is an open desk with Happy to Help in many languages displayed, there is also an Interpreter on Wheels that can support non English speaking people to be able to raise concerns. Nevertheless, the specifics of all complaints are continually analysed to ensure problem areas are identified with appropriate actions drawn up and implemented to effect change.

Figure 3: Complaints Breakdown by Service



**Clinical Support Services include Genetics, Imaging, Theatres and Pharmacy*

Figure 3 gives a full breakdown of complaints with comparisons against the figures for the previous two 12-month periods. Most complaints (75%) were attributed to Gynaecology and this also includes the Hewitt Centre, this is an increase from the previous year. Hewitt Centre are increasing year on year with Complaints and this year has seen another rise. Although the main area of complaint is recorded in the table above, a complaint may have elements attributed to other services. These are recorded as Heads of Complaint and recorded against those services to enable full review of the feedback concerned.

Maternity Services

There has been a decrease in the number of complaints in 2023-24 by 20 as compared to 2022-23. There was a total of 14 formal complaints with the following themes:

- Clinical treatment
- Communication
- Patient care
- Access to treatment/drugs.

Complaints received related to postoperative concerns following caesarean section, commencing medication treatment on time, alleged failure to treat infection in a timely manner, misdiagnosis of a cleft palate, lack of patient information leaflets for women undergoing induction of labour (IOL) and communication with patients and their families. Themes identified align to feedback from the CQC National Patient Survey (February 2023) which gives LWH the opportunity to benchmark against other organisations. In response to this Quality Improvement Projects have been started which are clinically led and supported by the operational team and consist of representatives from the multidisciplinary team, with engagement and collaboration of service users, through the Maternity Neonatal Voices Partnership (MNVP).

QI projects include:

- Induction of Labour
- Maternity Base improvement group focusing on medicines management, achieving full and sustained compliance with completion of MEWS observations, with appropriate escalation, handover SBAR and checking of pressure ulcers assimilated to intentional rounding.
- Thermoregulation of the newborn, to avoid term admissions to the Neonatal unit.

Actions and improvements implemented:

- Development of a scheduled wound review clinic in the Maternity Assessment Unit, to provide women with consistent, evidence based wound care and management.
- Development of an Induction of Labour (IOL) patient information leaflet and video.

- Creation of a designated IOL clinical area, consisting of 5 single ensuite rooms, which is scheduled to open from 1.5.24. Additional IOL capacity will release labour and birthing rooms on Delivery Suite for women who are waiting for surgical IOL. There should be a reduced number of delays in IOL and improved patient experience, by allocating women to single rooms.
- In addition to formal complaints, Maternity services received and addressed 441 PALS queries. Meetings were arranged with a designated staff member/ lead with the aim of supporting the service user to resolve their concern. All learning is shared with maternity staff at the Maternity Risk and Clinical monthly meeting.
- Education and updates for midwives who complete NIPE (Newborn and Infant Physical Examination).
- 4hrly medication rounds (during the day) on Maternity Base.

Gynaecology Services

There has been an increase of 5 complaints in 2023-24 compared to 2022-23. There was a total of 27 formal complaints The highest department groups for the receipt of the formal complaints during this period was related to Outpatient services and Gynaecology Medical. Themes within the complaints highlight the following:

- Appointments
- Communication

Actions taken to improve upon complaint themes:

Upon completion of a complaint investigation actions are assigned on Ulysses to address any areas whereby learning and improvement can be implemented. At present current Divisional performance is good for actions completed with only one action currently outstanding in relation to discharge checklists from Gynaecology ward.

Appointments / Communication

- Waiting list management continues to be a challenge regionally for Gynaecology. A daily review of all waiting times is a core component of activity management within the Division. Increased demand for Rapid Access Clinic (RAC) appointments due to referral volume has led to cancellations on occasion of general Gynaecology. In addition, lost days due to industrial action has seen a loss of 620 patient appointments. This continues to be a focus for Gynaecology Division.
- A recent quality improvement project has been launched with the aim of text message validation of appointments for patients, this project was presented at the recent Quality Strategy event and has already demonstrated improvements in terms of supporting patient advancing and being managed through waiting lists correctly.

- Furthermore, when a patient attends and there has been a clinic cancellation or appointment scheduling error the Divisional Operational team and Admissions Team manager are immediately made aware so that an understanding of the cause can be identified.
- Introduction of medinet services to support appointment and scheduling.
- Admissions attendance at twice daily safety huddle to ensure To Come In (TCI) and appointment activity is efficient, issues picked up and rectified immediately as to not inconvenience the patient.

In addition to formal complaints, Gynaecology services received and addressed 30 pals plus and 1018 pals queries. Meetings were arranged with a designated staff member/ lead with the aim of supporting the service user to resolve concerns. All learning is shared with Gynaecology staff at Divisional Governance as well as local safety and governance huddles as a 'you said' 'we did' approach.

As a result, the following quality improvement work is either completed or ongoing:

- Three phases to improving and optimising the Gynaecology Emergency Department Telephone Triage line. The key aim of doing so is to increase the quality of the service as well as ensure patients are directed to the most efficient route of receiving safe and timely care.
- Continue to build upon provision of care for under 18-year-old patients against KSF standards.
- Stakeholder engagement in Ultrasound improvement group
- Lead in Menopause special interest group. - women's Hub working with GPS
- Second Trimester Miscarriage project role out
- Tea and teach sessions on Gynaecology ward – re wound care and discharge advice.
- Colposcopy systems interface project
- Outpatient Locssip QI

Hewitt Fertility Centre (HFC)

There was a substantial increase of 7 complaints over this period, this is a significant increase over the last 2 years by an extra 18 complaints compared to 21/22 which was 3 Complaints. There was a total of 21 formal complaints.

The main theme of the Heads of Complaint continues to be 'communication'. In an attempt to address this complaint theme, HFC has introduced safety huddles and feedback to staff from complaints themes, this has also been disseminated through the clinical break sessions/staff meetings and within the training day agendas. HFC is currently implementing a range of tools which will help to improve communication with patients (examples ; the HFC patient portal, e-leaflet library and the use of QR codes) and continues to attempt to further improve patient and staff learning tools via the Fertility Consent package.

A further three members of the senior team have been trained as investigating officers this year although, on occasion, it has been difficult to assign an investigating officer within the specified time frame. Regular

meetings continue to take place between the Quality manager and the Patient Experience Team to help with complaints and PALS issues, to ensure patients have a timely and satisfactory resolution.

In June 2023, the HFC Complaint Refund Policy was updated and ratified. In line with SFI and following a request from the Director of Finance, all refund or reimbursement of funds to patients requires a formal investigation prior to any reimbursement being awarded. Whilst the number of formal complaints was increasing prior to this date, the change in policy has seen a continuation of increased complaint numbers as patients are required to submit a formal complaint before any request for reimbursement of payment can be considered.

HFC has implemented an increase in patient de-briefs to allow patients to discuss their concerns and possible reduce the number of formal complaints. These are attended by a Consultant, Senior Nurse and HFC Quality manager and Lead Embryologist if required. A representative of PALS may also be in attendance. HFC will continue to monitor the number of debriefs that take place and review any possible impact on complaint numbers.

HFC has an extremely busy Nurse triage telephone system which is now embedded within the patient pathway processes. However, HFC still faces issues with regards to this, as nurse staffing levels can impact on the accessibility/call waiting time/return call times for patients. This is often a theme within the patient complaints. A capital funds request has been submitted for the next financial year with the aim of further roll-out of the 'Netcall' system to aid patients access to the service. The 'patient portal' will have a positive impact on accessibility to patient information, removing (on some occasions) the need to speak to a clinician.

Review of complaints and complaint responses shows that the majority of complaints concerning care at HFC are from Private patients. It is also important to note that the majority of 'Heads of Complaints' are not upheld therefore no reimbursement or refund is awarded.

Further work continues with pathway reviews for NHS and private patients for the clinical transformation group. The gamete donation and recipient pathways are also being reviewed. These will be recorded as Quality Improvement projects as all aspects of HFC are reviewed and evaluated as required.

There is also an improved 'contact us' page on the HFC website, increased use of social media channels, Patient Engagement Group / Patient Representatives and Patient surveys and interaction for feedback and insight.

Neonatal Services

Neonatal have received 0 complaints during 2023-24, this is consistent with the numbers being very low in the previous years. This is due to the continuing proactive measures taken by staff within Neonatal. Staff are always with families within the clinical areas, and this helps build relationships and promotes trust. The relationships formed with all staff allows families to raise concerns/ issues which the staff respond to promptly. The staff continue to provide timely feedback, updating parents before a solution

has been reached, this promotes reassurance that the staff are still investigating and taking all concerns seriously. The promotion and maintenance of family integrated care enhances relationships with families. Parents are involved in ward rounds with the multi-disciplinary teams and feel involved in decision making with their baby's care. The Neonatal team continue with '*You said we did'* board but also plan to start bi-weekly questionnaires to capture any suggestions for improvement in a more timely manner. The Neonatal team also promote family engagement through celebrating special occasions through the calendar year. The most recent was a family board game and pizza evening which proved to be the most successful evening to date.

Clinical Support Services (CSS)

Clinical Support Services have received 2 complaints during 2023-24, this is a decrease from 6 in 2022-23, these numbers have returned to the low levels that have been seen in previous year. Clinical Support Services (CSS) encompasses various departments in the Trust and includes theatres, anaesthetics, genomics, physiotherapy, imaging, pathology, resus, transfusion and dietetics. Both complaints were recorded in Anaesthetics only. Due to the nature of the services under CSS, there were several elements of other complaints that CSS assisted with during the year. Concerns raised during the year centred on the process and procedures being undertaken in relation to the provision of a variety of appointments. The Division is keen to improve the feedback that is received from patients and have implemented bespoke solutions in all departments to generate additional feedback. It is very pleasing to hear about the advantages that the new Patient Experience Portal will bring as well. As CSS provide critical functions to other Divisions, they continue to work hard to improve the experience for patients, in ways such as developing improved patient information, providing improved patient facilities, as well as sharing leaflets and reviewing digital solutions that could possibly be implemented to make services more efficient.

PALS +

The PALS+ model continues to be utilised for dealing with complaints and concerns and is having a positive impact for both patients and the Trust. By implementing the PALS+ model it has given LWH the opportunity to address patients concerns in a proactive and dynamic way. The patient is put in contact with senior medical, nursing, midwifery, and operational staff to discuss the concerns raised, answer questions they have and find a rapid solution to assist with the concern raised. The national complaint standards framework supports this proactive method of addressing concerns raised.

It is not for the member of staff to go immediately and speak to the patient, but for PALS to arrange a suitable method of contact with the patient for these conversations to take place. It would not be the member of staff whom the issue was about who would make this contact. These conversations would

usually occur after some initial fact-finding reviews had taken place to understand the full circumstances around the issues. This contact may be face to face, by phone, email, or letter, whichever is most suitable for the person's needs.

Causes of Complaints

Each complaint received is often multi-faceted with concerns expressed about several aspects of the patient's experience of LWH. This is particularly true of inpatient concerns which may cover the multi-disciplinary teams and relate to events over a short or extended period of time. With this in mind a great deal of thought goes into how complaints are categorised to ensure it is appropriate to the concerns raised.

Fig 4. Main Complaint Category 2023/24

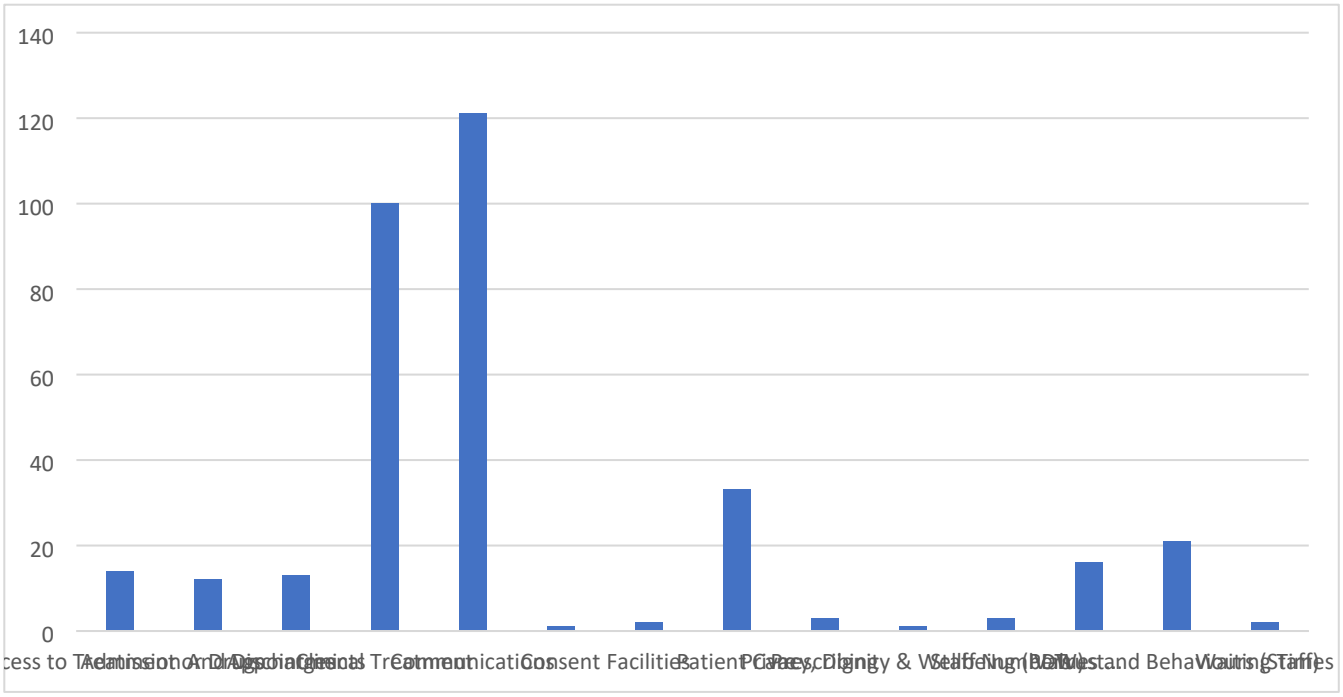
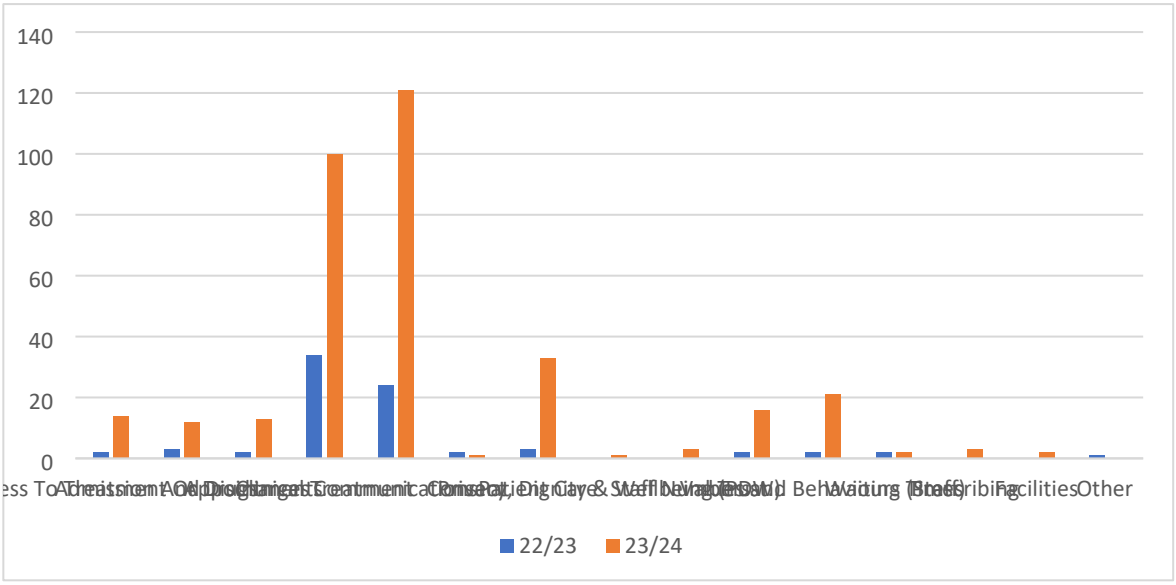


Fig. 5 Main category of complaints between 2022-23 and 2023-24



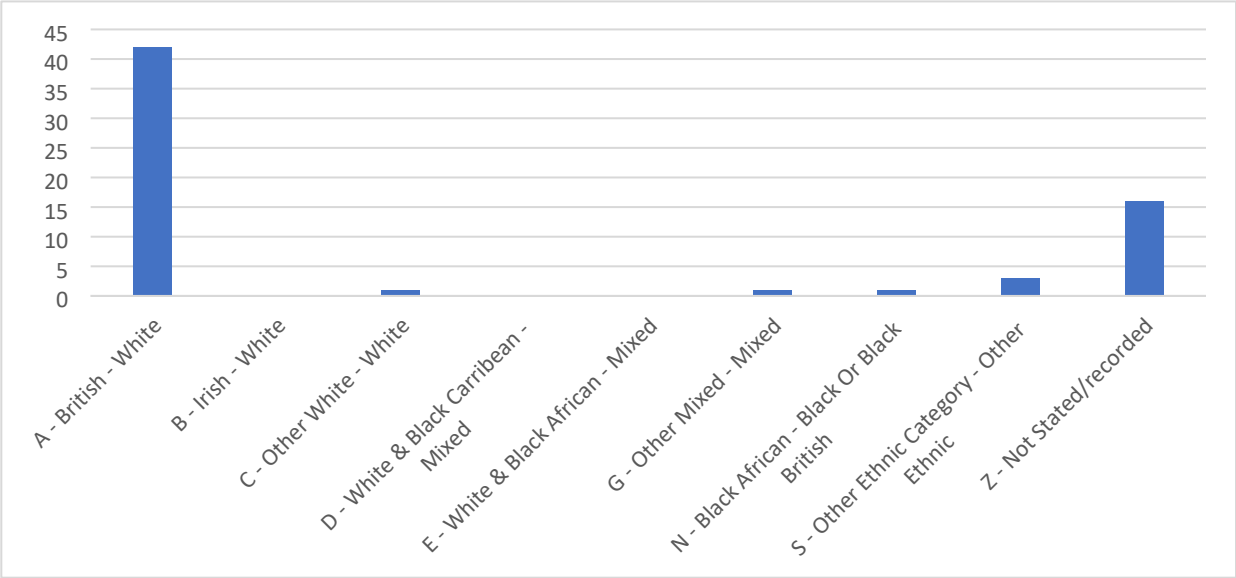
For the ease of reporting in this report the categories in Figures 4 and 5 are assigned based on the main issue only. Reporting in the Trust does cover all issues raised in the complaint and the departments these concerns are raised against, allowing for more in depth analysis.

The main recorded issue relates to Communication, accounting for 33%. The top main category in this area is Communication with the patient. All issues identified after investigation have been addressed with an appropriate action plan to facilitate improvement.

The second main recorded issue relates to Clinical Treatment, accounting for 29%. The top main category is Failure to Follow Up. All issues identified after investigation have been addressed with an appropriate action plan to facilitate improvement.

Each quarter the Patient Involvement and Experience Subcommittee receives a report detailing the themes from Complaints and PALS concerns. The Chairs report from Patient Involvement and Experience Subcommittee was received at the Quality Committee.
Patient Involvement and Experience Subcommittee will make recommendations to address any themes or trends that reoccur and progress on these will be reported to Patient Involvement and Experience Subcommittee at agreed intervals until completion.

Ethnicity of complainants in 2023-24



The percentage of complainants recorded as “British – White” in 2023/24 has increased from 62% in 2022-23 to 66% this year. In 2023-24, complainants from global majority groups (Previously referred to as BME/BAME) made up 9% of the complainants recorded this year and this is a decrease from 12% recorded in 2022-23.

LWH would expect to see the percentage of people from various recorded ethnicities who complain, to largely mirror the overall patient population treated that year. For example, if you saw a significantly higher or lower percentage of complaints from a particular ethnic group, then that may point to issues such as service provision/design or barriers being placed in the way of raising concerns. However, what LWH have seen in the data from 2023-24 is a significant rise in complainants’ ethnicity not being stated/recorded. This rose from 22% in 2022-23, to 25% in this reporting year. The complaint ethnicity data is obtained from the central patient record held by LWH. This issue is being addressed on a wider Trust level to improve the overall ethnicity recording for all patients and as such should produce more comprehensive patient monitoring data.

Assessing the cause of Complaints

Following changes made to the reporting systems more accurate reporting of the total concerns that are raised in a whole complaint can be identified. The total number of causes of a complaint usually exceeds the overall total number of complaints received. This is because all complaints are multifaceted and identify various areas of concern that need review and investigation. For example, a patient may raise 4 allegations in their complaint of communication issues. Under the new reporting regime each instance will be noted and recorded as 4 separate causes of the complaint.

Improved reporting has also enabled identification of the outcome of each of the individual HOC reviewed during the complaint investigation. This is particularly useful in partially upheld complaints where LWH can clearly see the areas for improvement.

Timeliness of Complaints Response

LWH Policy for Managing Complaints & Concerns states that all complaints should be acknowledged within 3 working days. The complaints policy, which was developed in 2017, and reviewed and updated in 2023, has removed the previously specified rigid timescale to ensure a more patient centric personalised response target for the Trust to adhere to. The Trust commits to providing a written response within a timeframe agreed with the patient. Should an investigation take longer than expected or become more complex during the investigation process, this timescale is discussed with the patient and a revised timescale is agreed upon.

There was work undertaken 2023-24 to address the challenges in the previous year regarding adherence to complaint timescales, in Q1 2023/24 the average compliance was 40%, since the review was undertaken and actions put into place the compliance has been 100% in the remaining 3 Quarters of the year. There are weekly Complaint meetings that each Division attend and is chaired by the Head of Involvement and Experience.

Responding quickly is a key factor in the Trust ensuring its complaints process remains personal and responsive to the needs of the individual. Ensuring the experiences of those contacting the Trust are listened to and put right is central to the Health Service Ombudsman's Principles of Good Complaints Handling which promotes a customer focused complaints system. A response to all complaints that is speedy, simple and details clear findings, conclusions and recommendations is a key aim of every complaint investigation.

Lessons Learnt

Repairing relationships is the primary focus of complaint handling. An investigation is concerned with establishing the facts to reach a judgment in the matter of complaint and organisational learning is a by-product of the activity. The trust is committed to implementing the learning and recommendations from every complaint where improvements have been identified and recommended.

During 2023-24 some examples of the lessons learnt, and the actions taken are:

Lesson Learnt	Summary of Action Taken
Poor care of the patients' belongings after transfer had been identified.	Process introduced for recording patient belongings to prevent recurrence

Sepsis assessment tool not completed on admission	Audit the use of the sepsis tool is undertaken monthly. To assist with compliance a recent modification of the training has been introduced to include completion of the sepsis assessment and sepsis six wizards. There have also been more computers on wheels purchased so the sepsis tools can be opened simultaneously to show the CTG for women who are in labour. Completion of the tool has been highlighted and been a recent 'lesson of the week'.
Screening information currently given to patient regarding pre/ post egg collection is unclear	Patient Information Leaflet updated so patients are aware of screening required and the risks/benefits of delayed genetic screening. SOP also updated.
The interpretation of NHS fertility funding found to be unclear.	Agreed that further clinical information will now be included in the IFR request letter to funding to provide clarity.
Visitors being asked multiple times if they were allowed to be on the ward.	Partners to stay on the ward 24/7 within Maternity which should reduce this issue
Post-mortem protocols were not clear to staff	Training for staff to consent post-mortem. Alder Hey Childrens Hospital pathology department to make sure all gender reports are forwarded to the Honeysuckle Team as soon as known.
Lack of specific information leaflet for women who present with Pre-labour Pre-term Rupture of Membranes	Patient Information Leaflet created.
Regular communication and updates were not being undertaken for all women who are undergoing Induction of Labour.	Multidisciplinary (MDT) ward rounds on Delivery Suite will now discuss with patients' plans for ongoing or delayed Induction of Labour.
Delay in prescription completion resulting in delay to patient	Review of process undertaken. Amendments made to process. In addition to daily prescription completion, all patients due imminent treatment will have their prescription completed in clinic by the Consultant / Medical staff / Nurse prescribers that have seen the patient. This should prevent delays.

Delay in prescription completion resulting in delay to patient	Changes made to prescription process surrounding invoices. This will have a positive turnaround time for prescription arriving in finance office and being sent to patients in a timely manner. Invoices being sent via email rather than relying on the mail service for delivery.
Documentation on the digital platform needs to be more thorough	Digital midwives continue to educate and share updates/comms related to all aspects of K2 on an ongoing basis, particularly in response to incidents. Monthly K2 training sessions for new starters and existing staff are available.
New starters do not receive training for the maternity electronic paper record at induction	Managers now advised how to request training once induction date has been confirmed.
Delays identified for complex joint surgeries that require LUHFT colleagues	Meetings with LUHFT already instigated and in place to ensure cases are actively monitored
Failure to maintain accurate and contemporaneous records	Audit of notes with Preceptorship Midwife and reflective discussion undertaken to assist and support staff member.
Conflicting information regarding catheter care identified.	All intrapartum staff informed of correct information. Lesson of the week circulated to ward staff and discussed at ward huddles
No Gelatine free alternative Vitamin K supplied as stock to wards	Stock of Neokay supplied to Delivery suite. All intrapartum staff informed via email of stock/supply/location
Gamete and embryo donation SOP's needed updating, specifically outline that restrictions on donations that conflict with the Equality Act will not be accepted. Initial donor checklists and Patient Information Leaflets need updating to clearly reflect this also.	SOP's updated along with changes made to initial donor checklist and patient information leaflets.

No support with visiting Neonatal Unit and storing of breast milk	Neonatal feeding meet regularly with infant feeding lead for maternity to support and trouble shoot. Maternal resources regarding breast milk are included with the expressing packs provided. Regular staff updates and education for infant feeding occurs on Neonatal, with neonatal nursing staff also supporting in-patient Mothers when expressing and storing milk etc.
No explanation or demonstration on how to administer blood thinning injections	Discharge checklist changed to include discussion and demonstration of injections if required.
Pressure ulcer risk recorded retrospectively	K2 maternity pressure ulcer risk assessment template adjusted to show the individual risks and scores to reflect the Trust guideline when assessed and prompt action to be taken.
No recorded documentation of pressure area checks	Addition to K2 documentation now includes pressure ulcer prevention changes of position template for documentation of evidence of position and change of position.
Conversations with patient allowed the patient to feel that they lack integrity or misinformed.	Named staff members to reflect on conversations discussed.
Practitioner performing egg collection in this case was not aware that laparoscopic egg collection had been discussed with patient as possible procedure	Introduced a template for MDT to include type and route of egg collection to ensure consistency of information
Pain assessment documentation is duplicated whereby it has the potential for staff to be able to record information in an incorrect place therefore creating the risk of duplication or recordings being missed.	A full review of the pain assessment documentation was undertaken. Updated documentation now on DigiCare EPR system
Lack of assurance that comfort rounds are being utilised correctly	Communicated with ward managers to allocate senior staff to ensure comfort rounds are done. Teach new starters to ensure it is completed
Not all staff appear to be familiar with the Pain assessment document	Formal training has taken place for all staff
Patient unclear of clinical management plan	Clinical Director to discuss with clinicians at consultant meetings and share through lesson of the week.
Patient not listened to and reason for conducting own investigations was not explained.	Clinician conducted a reflective piece in writing and discussed with Clinical Director

Patient struggled to contact GED following procedure	Reviewed information regarding pain and post-procedure contact details on Hysteroscopy leaflet. The leaflet now states where a patient can seek further advise following Hysteroscopy if they need it.
Patient found procedure painful and felt ill informed regarding this.	Reviewed LWH hysteroscopy leaflet and adapted for ambulatory patients.
Patient did not receive adequate information regarding wound care.	Lunch and learn sessions have been commenced on the ward, wound care will be one of the topics covered.
Patient left to wait in Gynaecology Outpatients in pain with no alternative option offered.	Notification for patients now displayed in the waiting area for patients to request assistance from the nursing team via the receptionist if in pain or uncomfortable
Conflicting information regarding catheter care identified.	Ward managers now perform monthly audit of SBAR completion for every shift change and transfer between clinical areas.
Patient personal information not updated to show changes	Training for administration staff and nursing staff around updating patient information to be undertaken.
Lack of understanding from complainant re discharge process	Poster created to put in each room to explain the discharge process and why there can be delays
Patient was not provided with additional information leaflets following diagnosis of ectopic pregnancy	Learning to be shared with GED team to ensure staff are aware of the importance of information leaflets being provided at the correct point of care.
Issue regarding SBAR completion between clinical areas.	Audit of SBAR completion by midwifery managers on a monthly basis and results discussed at Maternity Risk meeting on a quarterly basis.
Wrong information given regarding attending appointment as a single person.	Ensure all staff are made aware that having a partner in attendance is not a prerequisite for a fertility screening appointment/access to the service
Midwife on MAU did not review notes sufficiently to be able to identify place of birth.	LOTW reminding all staff of importance of checking the risk status of every patient attending via triage on MAU
Documentation not sent to GP in a timely manner regarding anti-depressant medication	Clinical Break Session regarding the process to be followed when patients require counselling referral
Error made with date of embryo transfer – incorrect date initially given to patient	Training session regarding frozen embryo transfers completed on Clinical Break Day.
NICE guidance to be reflected in the Antenatal Care policy regarding not sending urine samples at the booking appointment	Antenatal care policy amended and agreed, to be ratified at Maternity Clinical meeting 2024
Patient missed antenatal appointment whilst named midwife on leave	SOP has been created for management of caseloads of staff who have unexpected leave.

Patient required side room for postnatal stay which was not clearly communicated.	Email sent to midwifery and medical staff regarding clear communication to patients.

Access for Complainants

The Trust is committed to allowing access to its complaints system to all patients. The Trust and the Patient Experience Team aim to increase confidence of patients by having a flexible approach to resolving concerns. There is extensive work with staff on the wards and in departments to help prevent complaints by listening to and being responsive when issues need to be put right.

When further support is needed the Trust aims to ensure that the complaints process is signposted locally so that patients know how or where to complain. LWH are constantly continuing to improve access to information for patients on a range of patient experience initiatives, including complaints, this a key focus for the Trust following the Francis Report.

The predominant method for making a complaint remains by letter, email, or by telephone, but by signposting other options such as the Trust's website, social media, Healthwatch and Care Opinion websites, LWH ensure that patients are given a choice.

Where contact is initially made in person or by telephone, the Patient Experience Team supports the complainant in registering their concerns formally with the Trust.

PALS

The Trust is continuing to promote the PALS and PALS+ service which continues to see a robust number of contacts

2023-2024 has seen 2674 PALS and PALS+ cases raised with the Patient Experience Team. This is an increase of 409 cases from the previous year.

Compliments

The Trust continues to report on the number of compliments that the Trust receives which are collected from several sources. The Patient Experience Team oversees the triangulation of compliments to feed into one report. The compliments are shared with the relevant teams at the Trust. In 2023-2024 there were 108 compliments formally registered through the Patient Experience Team, this is a decrease from 127 in the previous year.

Progress on priorities reported for 2022- 23

The focus and the additional steps that were put in place in the complaints process in Q1 2023-24 to support Trust wide has made extensive improvements and the agreed response timeframes continue to be 100%.

The Patient Experience Team now have weekly meeting with the access team to support the issues of the clinical and administration telephone lines. This continues to be a challenge so intelligence from the complaints will be able to help shape and improve the performance in this area.

Weekly meetings were put in place between HFC and the Patient Experience Team to address any concerns raised but there continues to be an upward trend with complaints for HFC. There was a change in policy with refunds and also with sibling funding and this has generated more concerns being raised by service users.

Work to address Health Inequalities and improvements Trust wide continues and a new Help Hub was introduced in January 24. This helps support non English speaking people to be able to raise concerns, there is also an Interpreter on Wheels that has been procured specifically for this area.

Priorities for 2023-24

To ensure Divisions have the correct access to information pertaining to Complaints without having to ask the Patient Experience Team for information, Power BI is going to be utilised to ensure the information is easily and readily available.

Divisions to ensure Complaints and Concerns raised are discussed at Divisional Level and Lessons Learnt reported on.

A process to be put in place to resolve concerns raised within the Hewitt Centre before they become a formal complaint.

Poster that allow people to access how to complain in different languages to be displayed Trust wide and to encourage use of the Help Hub and Interpreter on Wheels for Non-English Speaking Families.

Patient Experience Team to work with the Digital Team on the new Patient Information Portal to help address the many concerns raised with regards to Communication.

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Meeting Date	Thursday, 11 July 2024	**Item Reference**	24/25/097
Report Title	Emergency Planning Resilience and Response Annual Board Report 2023/24		
Author	Steven Dobie, Overseas Visitor Manager		
Responsible Director	Gary Price, Chief Operating Officer		

Purpose of Report	This Emergency Preparedness, Resilience and Response (EPRR) Annual Report provides a summary of EPRR approach and activities for 2023/24.
Executive Summary	The EPRR Strategy implemented by the EPRR Committee aims to support the Trust to meet its duties under the Civil Contingencies Act 2004. These duties are supported by the requirement for compliance to the NHSE EPRR Core Standards.
Key Areas of Concern	No areas to escalate

Links to Board Assurance Framework		-
Links to Corporate Risk Register (scoring 10+)		-

Assurance Level	1. HIGH - Strong system of internal control applied to meet existing objectives

Action Required by the Committee	The Board is asked to note the annual report.

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
FPBD	**26/7/24**	**Gary Price**	**For Trust Board for noting**

MAIN REPORT

INTRODUCTION

- As a category 1 responder under the civil contingencies Act 2004 the Trust is required to prepare for emergency and business continuity incidents and ensure that it has the capacity and capability to respond effectively to emergency situations including major incidents. Whilst managing emergency situations the Trust must as far as is reasonably practicable maintain business continuity, prioritising critical service delivery when necessary.
  - The Trust aims to meet its duties within a framework that is safe, effective, caring, responsive and well-led. The Trust EPRR agenda is led by the EPRR Accountable Emergency Officer (Chief Operating Officer) supported by the Emergency Planning, Resilience & Response Team. In order to meet its legal duties, the Trust holds a portfolio of emergency and business continuity plans which have been developed by divisional teams and relevant corporate leads.
  - The Trust is required to work in cooperation with other Category 1 Responders including other NHS Trusts and the emergency services, in relation to emergency planning processes and incident response. The Trust is represented at the Merseyside Local Health Resilience Partnership at both strategic and operational level. The partnership led by the Integrated Care Board and Director of Public Health with NHSE in attendance aims to coordinate and direct cooperative working including in relation to risk management and shared learning from exercises and incident response.

  EPRR work streams continue to focus on compliance with the newly revised NHSE EPRR Core Standards requirements. The new approach requires commissioners and providers of NHS commissioned care to submit evidence against each of the core standards to ensure a full, partial or non-compliance rating.

  EPRR objectives for 2024 are detailed below.

    - Core Standard Compliance
    - EPRR Risk Review
    - Departmental Business Continuity Plans Review
    - Policies & Standard Operating Procedures
    - Training and Exercise Programmes

ANALYSIS

Core Standards

In 2022 the NHS Midlands Region introduced a pilot which focused on an amended EPRR assurance process which involved a new and detailed analysis of compliance evidence which needed to be submitted against each EPRR core standard, alongside the organisations self-assessment which had previously been used to assess the organisations assurance.

The outcome of the pilot identified substantial differences between the self-assessment results and the evidential review of the documentation provided by participating organisations.

As a result of the pilot, it was extended to Northeast & Yorkshire and Northwest regions for the 2023/24 EPRR assurance assessment.

The Trust was assessed against the revised standards and approach which required substantial evidence to be uploaded for external assessment.

The increase robustness and scrutiny of the newly introduced assessment process has deemed areas assessed in previous years as partially compliant to now be non-compliant based on the evidence provided.

Summarised across the fifty-eight core standards, LWH scored as follows:

- Nineteen standards self-assessed were assessed as fully compliant, with no gap in evidence.
- Thirty-Eight were assessed as partially compliant and partial achievement can be evidenced.
- One assessed as non-compliant and requires an exercise with external partners to comply with the EPRR testing and exercising programme.

To support an increase in compliance across the new assessment process, Cheshire and Merseyside (C&M) Integrated Care Board have created a monthly regional core standards task and finish group including a standardised core standards checklist to support providers when collecting evidence against each of the standards. This regional group provides collaboration, support and shared best practice for organisations within the C&M footprint.

Risk Review

EPRR risks are regularly reviewed and updated including consultation at the EPRR Sub-Committee. Specific risks continue to be reviewed and monitored by the EPRR Sub-Committee.

Departmental Business Continuity Plans Review

The annual review of business continuity plans (BCP) took place between January – March 2024. A newly implemented centralised EPRR management information system tracks and records BCPs providing notifications to the EPRR team prior to annual review dates, as a result, the system informs BCP owners two months prior to the annual review deadline and provides owners to update and respond. The review is an annual continuous cycle to ensure valid BCP’s throughout the organisation. Any outstanding actions identified by departments will be incorporated into an action plan and monitored via the EPRR Sub-Committee.

Policy & Standard Operating Procedure Review

Manager on call Policy

NHS England Core Standards for Emergency Preparedness, Resilience and Response suggest that an On Call Policy for such staff is good practice. The Trust has put in place plans that will enable it to manage incidents or serious disruptions to service delivery while maintaining services to patients, of which the On Call Management team will facilitate/carry out.

Bleep System Failure SOP

A standard operating procedure has been developed and implemented for staff to tactically manage or respond to a bleep system failure.

Training and Exercises

In accordance with NHSE EPRR Framework, Training needs to be an ongoing process to ensure skills are maintained; it is a fundamental element of embedding resilience within organisations as part of the cycle of emergency planning. Exercises allows organisations to respond efficiently and effectively must be tested regularly using a variety of processes, such as table-top and live play exercises. Through the exercising process individuals can practise their skills and increase their confidence, knowledge and skill base in preparation for responding to a live incident.

The organisation has conducted and participated in the below training and exercises:

- Manager on call Exercise December 2023 – The development of a newly created Manager on call policy led to the creation of an on-call forum to help guide on call managers, and others, with roles and responsibilities and processes related to on-call. The policy will exist to support managers on call and aid decision making.

- Maternity Infant Abduction Exercise December 2023 - A group of staff formed an Infant Abduction Exercise Test Team after being approached by the Trust's Security, Violence Prevention and Reduction Lead and Maternity Matron. The Test Team then completed a set exercise to test the infant abduction system, procedures, and response.

- Neonatal Fire Exercise (Desktop) January 2024 – A desktop exercise conducted by the Trust Fire Safety Advisor provided an internal fire exercise consisting of three phases, discussions for each phase took place and considerations on how it should be managed, this desktop exercise provided the foundations for a live test due to take place in June.

- Divisional face Fit Testing February 2024 – As part of the measles oversight and preparedness meetings the Health and Safety Manager provided face fit mask testing including an updated resource pack for divisional testers.

- Exercise Hermes (C&M ICB) March 2024 – Liverpool Women's NHS FT took part in a regional exercise, the aim of Exercise Hermes was to test the NHS C&M communications systems, out-of-hours hours and at no notice. This forms part of the annual Emergency Preparedness, Resilience and Response training and exercise schedule.

- Bleep System Failure Test April 2024 - A newly created Trust wide Bleep System Failure SOP was tested against a planned IT system update to ensure staff had the appropriate procedure in the event of bleep system failure.

- Exercise Toucan (NHSE) May 2024 - Liverpool Women's NHS FT took part in a national provider level communications exercise to support NHS EPRR Framework and core standards requirements.

- Neonatal Fire Exercise (Practical) June 2024 – Following on from the desktop exercise, a simulated fire evacuation exercise took place on Wednesday 12th June within room 5 of the

neonatal unit, staff practised the safe transfer of 4 cots, with each baby having different clinical needs. The exercise was recorded and observed, followed by a debrief of all participants to understand what worked and did not work, with updated actions and processes to follow upon a full review by the unit.

Industrial Action

As was seen nationally, the Trust was significantly impacted by the high levels of Industrial Action that took place from Q4 2022/23 into 2023/24. Industrial Action took place across a range of professional disciplines and Liverpool Women's Hospital was impacted by Industrial Action taken by the following groups of staff

- RCN – Dec 2022 to May 2023
- Ambulance Services – January 2023 – June 2023
- Unison – February to March 2023
- Post Graduate Doctors in training – March 2023 to present day.
- Consultants – April 2023 to October 2023

As well as the specific Healthcare industrial action taken, a range of other public services took industrial action during the same timeframe e.g., Teachers/Education, which also had a significant impact on service delivery for the Trust.

As part of the Trusts response, Incident Command & Control cells were held to co-ordinate and manage the response to impending Industrial Action and its impact on trust services. This was to ensure that safety of patients remained priority and that emergency/critical services were maintained with the required staffing levels. Particularly with the RCN Industrial Action, derogation processes for essential service delivery were followed with the Trust working closely with regional trade union colleagues. Major incident processes were followed in line with EPRR guidance to provide structure for the organisation and ensure all appropriate actions and risks were captured/delivered to maintain safe services.

Industrial Action resulted in a significant loss in activity, particularly for Gynaecology Elective services, which for 2023/24 equated to almost 2 months of contracted activity. This impacted routine waits however despite this, the Trust was able to continue to run some activity prioritising Cancer and Non-Elective.

RECOMMENDATION

The EPRR activities and achievements discussed within this report demonstrate that the Trust remains focused on continuing to meet its duties under the CCA 2004 and aims to increase the level of compliance to the newly revised NHSE EPRR Core Standards for 2024.

Specific objectives for 2024 include:

- Evidence collection to support new core standards requirements.
- Review EPRR Risks via EPRR sub-Committee.
- Review of Trust emergency plans and arrangements based on lessons learned / shared learning.

- Annual review of business continuity plans
- Provision of EPRR training including delivery of a tabletop and live exercises to rehearse incident response.
- Collaborative working and support with Cheshire & Merseyside ICB
- Continued working in cooperation with other healthcare responders.

The Board is asked to note the annual report.

Liverpool Women's NHS Foundation Trust

Trust Board

COVER SHEET

Meeting Date	Thursday, 11 July 2024	**Item Reference**	24/25/098
Report Title	Health & Safety Annual Report 2023/24		
Author	Tracy Bryning, Health and Safety Manager		
Responsible Director	Gary Price, Chief Operating Officer		

Purpose of Report	Annual report for compliance and assurance.
Executive Summary	This report gives an overview of compliance and governance assurance regarding the health and safety arrangements, activities, performance, and improvements for Liverpool Women's NHS Foundation Trust (LWH) for the financial year 2023/2024. As in the previous reporting year, the Trust faced ongoing challenges frequently responding to changing guidance and collaborations between the HSE, PHE, DHSC and TUC. Actions have been taken to remain compliant with the Department of Health and Social Care's (DHSC) mandated resilience principles for face fit mask testing, provision and EPRR Standard 12. Managers are responsible for the regular review, monitoring and updating of workplace risk assessments. The new Ulysees Risk Management Module will support this. The module will act as a repository for all workplace risk assessments and health and safety workplace audits and will reflect compliance across the Trust from Summer 2024. This will support managers knowledge of their health and safety duty and responsibilities. There is an extensive work plan for health and safety, reflecting some of the higher priority plans for future improvements and activities, demonstrating the Trust's commitment to effective health and safety management and continuing improvements in health and safety performance. There remains scope for improvement, particularly in relation to compliance with the overall organisation's safety management system, managers knowledge of duty and responsibilities, risk assessment/risk management, audit, and communication.
Key Areas of Concern	No areas to escalate

Links to Board Assurance Framework		-
Links to Corporate Risk Register (scoring 10+)		-

Assurance Level	1. SUBSTANTIAL - Good system of internal control applied to meet existing objectives

Action Required by the Board	The Board is asked to note the annual report.

REPORT DEVELOPMENT:

Committee or meeting report considered at:	Date	Lead	Outcome
FPBD	**26/7/24**	**Gary Price**	**For Trust Board for noting**

MAIN REPORT

Liverpool Women's
NHS Foundation Trust

Health and Safety Annual Report 2023/2024

Tracy Bryning
Health and Safety Manager

29th May 2024

Executive Summary

This report gives an overview of compliance and governance assurance regarding the health and safety arrangements, activities, performance, and improvements for Liverpool Women's NHS Foundation Trust (LWH) for the financial year 2023/2024.

As in the previous reporting year, the Trust faced ongoing challenges frequently responding to changing guidance and collaborations between the HSE, PHE, DHSC and TUC.

Actions have been taken to remain compliant with the Department of Health and Social Care's (DHSC) mandated resilience principles for face fit mask testing, provision and EPRR Standard 12.

Managers are responsible for the regular review, monitoring and updating of workplace risk assessments. The new Ulysees Risk Management Module will support this. The module will act as a repository for all workplace risk assessments and health and safety workplace audits and will reflect compliance across the Trust from Summer 2024. This will support managers knowledge of their health and safety duty and responsibilities.

There is an extensive work plan for health and safety, reflecting some of the higher priority plans for future improvements and activities, demonstrating the Trust's commitment to effective health and safety management and continuing improvements in health and safety performance.

There remains scope for improvement, particularly in relation to compliance with the overall organisation's safety management system, managers knowledge of duty and responsibilities, risk assessment/risk management, audit, and communication.

Report

Key Objectives and Current Situation

1.1 Risk Assessments & Audits

i. Annual health and safety workplace audits are conducted however the timeliness of these has been identified as an issue to be addressed as part of the workplan. Workplace risk assessments are completed on a day-to-day basis; fire risk assessments and audits frequently identify issues of general health and safety housekeeping that are acted upon within acceptable timescales.

ii. The roll out of the Ulysses Risk and Safety Management will include benefits such as

- Ulysses is fully supported by both I.T. and the Governance Risk Team
- All staff are familiar with its functionality.
- There are no limits to user licences.
- Training is fully supported.
- It is fully customisable, and we could benefit from other users' development of the module and vice versa.

- It can manage any of our risk assessments; staff will be able to use their existing log in detail to complete annual departmental audits, manage actions and complete risk assessments.
- The module links to relevant incidents, risk register entries and risk assessments and provides an overall compliance dashboard.
- Easy to interrogate from a reporting perspective and matches corporate reporting for incidents, risks, safeguarding, legal, alerts and complaints.
- Reports will be available through Power Bi

1.2 Fit Mask Testing

i. **Overview**

The Trust is required to meet its statutory health and safety duty and infection prevention and control duty, to meet the FFP3 Resilience Principles and fulfil the criteria required of EPRR Standard 12 – *duty to maintain plans/infection control: in line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.*

Staff undertaking aerosol generating procedures on patients with a confirmed or suspected respiratory infection should be face fit mask tested in line with current national practice.

The resilience principles for fit mask testing requires staff to be retested at two yearly intervals or when there is a significant change their face shape and to be successfully tested and have access to a minimum of two mask types, preferably three. There has also been a mandated requirement to be able to report on fit testing activity across the organization. There would be a minimum requirement of 1 team per shift fit mask tested and whilst there is no target good practice is for the majority of staff to be tested.

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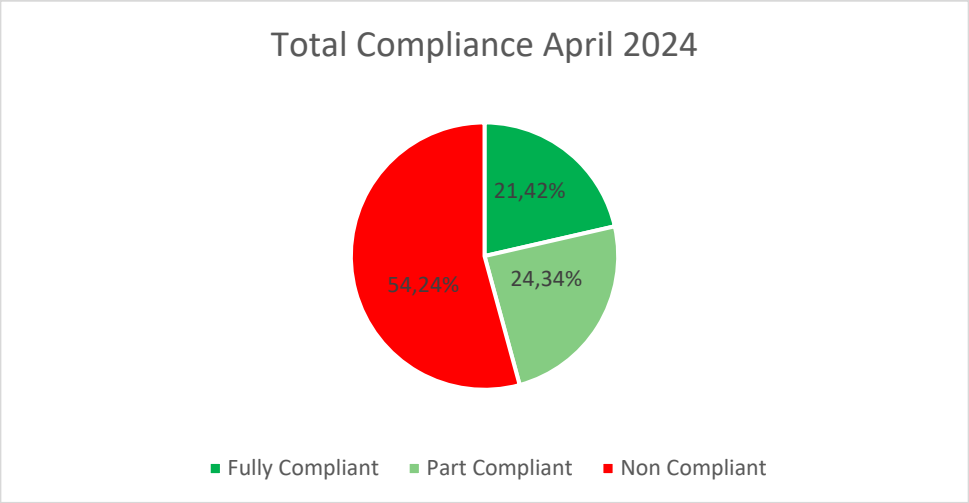
Table 1 - *staff requiring fit testing at end of March 2024:*

Division	Total staff testing required	Total tests completed	Passed on 2 masks	Passed on 1 mask	Staff untested
Maternity	339	246	81	84	150
Gynaecology	156	157	42	73	17
NICU	268	219	46	127	71
CSS	119	118	34	50	1
Medical Staffing inc. Trainees	226	81	31	19	24
Total	**1108**	**821**	**234**	**353**	**263**

The table below demonstrates compliance across the Trust:

Chart 1 *shows fit testing figures at close of March 2024:*

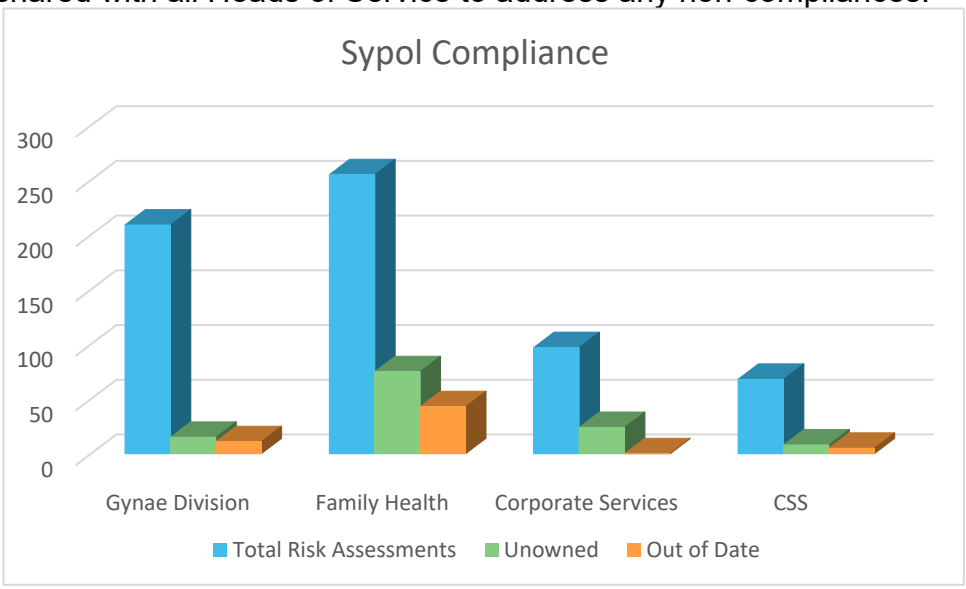


1.2 COSHH

i. Alcumus Sypol COSHH Management Software

The Trust has utilised the Alcumus Sypol COSHH management software since October 2021. The Health and Safety Manager, who is co-ordinator for the Alcumus Sypol System, monitors usage of the system and has established meaningful compliance reports for system users and managers.

Out of date risks are flagged via the system for managers action In the Unowned Assessment Index there are a number of unowned COSHH risk assessments, meaning that the staff and manager identified as risk assessors for the area have not followed up risk assessments assigned to their sub work areas. This is addressed by a monthly sitrep is shared with all Heads of Service to address any non-compliances.



1.3 DSE

i. The Health and Safety (Display Screen Equipment) Regulations apply to workers who use DSE daily, for continuous periods of an hour or more. We describe these workers as 'DSE users'. The regulations do not apply to workers who use DSE infrequently or only use it for a short time.

ii. As an employer, we must protect our staff from the health risks of working with display screen equipment (DSE), such as PCs, laptops, tablets, and smartphones.

iii. Annual DSE (display screen equipment) risk assessments are required to be undertaken for all DSE users across the organisation and for those who are homeworking, on an annual basis or when there is a significant change in software, hardware, or a person's individual circumstances, as is a requirement of the Display Screen Regulations 1992 (amended 2002).

iv. Individualised risk assessments are conducted for staff who may require additional support, specialised equipment, or reasonable adjustments.

1.4 Fire Safety

i. The Trust achieved compliance with fire safety, evidenced through Mersey Fire & Rescue Service inspectors audit in February 2024, with final sign off in March 2024.

ii. March 2024, the Fire Safety Adviser resigned from their post which ended the Trust's collaboration with Alder Hey Children's NHS Foundation Trust in sharing the Fire Safety Advisor post. New arrangements have been agreed with provision of fire safety advice and guidance being provided by Liverpool University Hospitals NHS Foundation Trust through a service level agreement.

2. Health and Safety Training

i. Manual Handling (People and Inanimate Objects)

The Manual Handling Operations Regulations (1992) sets out a hierarchy of measures to reduce the risks of manual handling in the workplace, so far as are reasonably practicable. These measures include access to specialist advice, access to suitable and sufficient training programs, provision of people and inanimate object handling equipment to reduce the risks and adequate risk assessments.

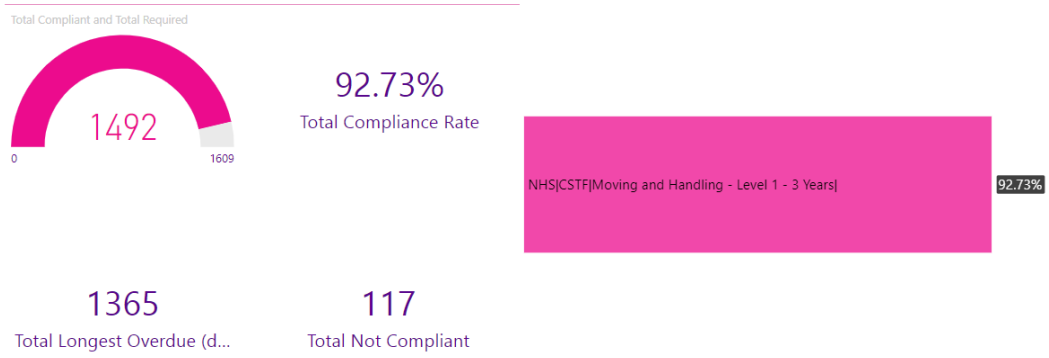
LWH has maintained a service level agreement (SLA) with Liverpool University Hospitals Foundation Trust (LUHFT) to provide update training for our manual handling cascade trainers and delivery of training for newly nominated manual handling cascade trainers. The SLA includes provision of ad hoc guidance and advice from LUHFTs Manual Handling Advisor.

There is a three yearly requirement for all staff to complete an e-learning package for Moving and Handling Level 1 certificate to support safe moving and handling practices.

Clinical staff are required to complete a two yearly practical moving and handling competency, which in the main is delivered by cascade moving and handling trainers.

At 92.73% overall compliance for moving and handling training, there remains a target to significantly improve completion of this training. Training compliance is monitored and escalated through the Health and Safety Group.

Table 2 *shows compliance with Moving and Handling Training*



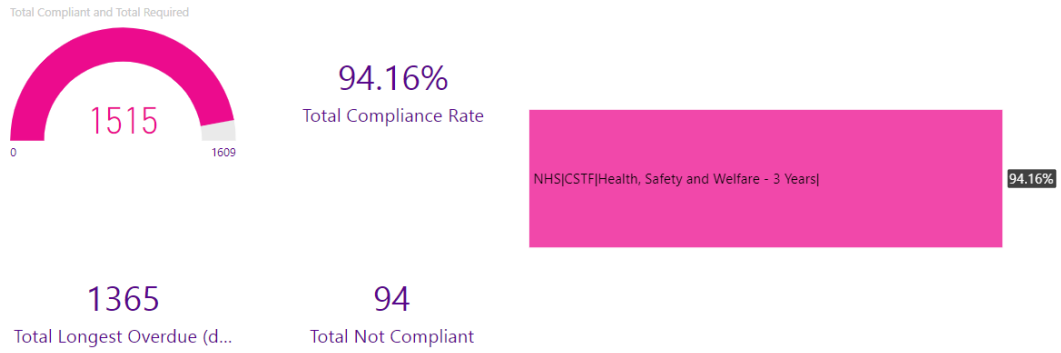
ii. First Aid

First Aid training continues to be provided externally via the Health and Safety Training Manager. A revalidation exercise of qualified first aiders and Appointed Persons for Frist aid has been completed in this reporting period.

iii Health, Safety & Welfare Mandatory Training

Health and Safety legislation requires employers to provide adequate health and safety training and employers have a general duty to provide information, instruction, and training and to provide a safe place of work, under Section 2 of the Health and Safety at Work Act (1974).

Table 3 *shows compliance with Health and Safety Training*



There have been notable improvements in the latter end of the reporting year; managers and governance staff are committed to improving compliance. Mandatory training compliance is reviewed and escalated through the quarterly Health and Safety Group.

iv Executive Health & Safety Training

As part of the Health and Safety Regulations and the Care Quality Commission Well Led Domain, a training session has been designed for executives and non-executive

directors which is offered on an annual basis to ensure that the board members remain up to date with their legal responsibilities under the Health and Safety at Work Act.

vi **Training Needs Analysis 2024/25**

The Health and Safety Training Needs Analysis has been completed and submitted for 2024/25 and includes provision for the delivery of the following health and safety related training in addition to mandatory health and safety training requirements:

- DSE (Display Screen Equipment) Assessor Training
- Health and Safety Awareness Training for Managers, Supervisors, Team Leaders
- First Aider Training and Update Training
- Manual Handling Cascade Trainers Training – new and refresher training
- Ladder Safety Training

vii Failure of staff to attend a health and safety funded training place without contact or acceptable mitigation results in a cross charge being made to the service area.

2. Policies & Standard Operating Procedures

i. Health and safety related policies and standard operating procedures are reviewed and updated in line with any significant changes in practice, law or Trust policy and procedures.

ii. A schedule for auditing health and safety related policies and standard operating procedures has been introduced in the latter quarter of this reporting period. A rolling audit schedule to ensure policies are suitable and sufficient, that KPI's are being achieved and the policies and standard operating procedures are being complied with is underway.

3. Health & Safety Management System

Employers have a duty to consult with their employees, or their representatives, on health and safety matters. Communication is key to an effective health and safety system and industry best practice is to apply a reflective and collaborative learning stance to health and safety incident investigations. It is good practice for large organisations to establish and maintain a Health and Safety Committee, where the Committee should provide a link between staff doing the work and the people directing it.

The Health and Safety Group meet on a quarterly basis throughout the reporting period and was well attended.

The health and safety profile continues to improve across the Trust:

- Regular place on Safety Check in meetings
- Creating a list of health and safety related questions for interview candidates of all levels and grades
- Regular articles and toolbox talks through the staff weekly Digest.
- Items shared through Executive and In the Loop messaging.

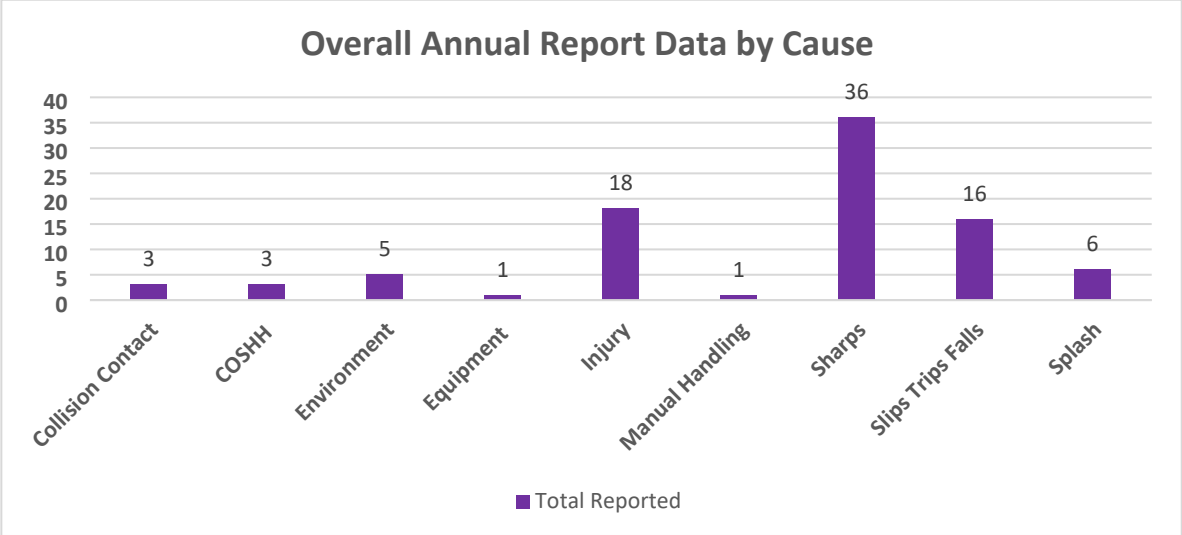
- Several other initiatives are currently being explored including reintroducing the requirement for all band 7's and above to complete an IOSH Managing for Safety qualification.
- Development of the new Trust intranet to provide access to information, advice, and guidance along with toolbox talks and risk assessment guidance.
- Embedding NHS Workforce Health and Safety Standards

4. Reported Non-Clinical Health and Safety Incidents

In the reporting period 2023/24 there were 89 health and safety related incidents reported, which sees a decrease in reported incidents of 8 incidents from the 2022/23 period.

The majority of incidents were reported in the Family Health Division (62), Gynaecology Division reported 17 incidents, Corporate Services reported 11 incidents and Clinical Support Services reported 11 incidents.

Table 4 – *Health & Safety Incidents by Cause*



The three primary causes of incidents are categorised as needlestick incidents, injury and slips, trips, and falls. The following section reflects the findings of some of the primary causes.

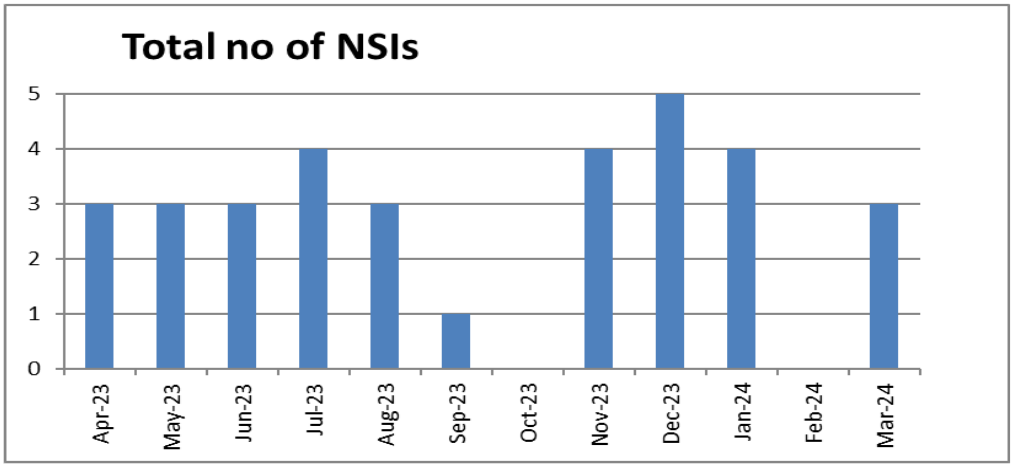
6.1 Needlestick Injuries

Inoculation incidents may be subdivided into two categories. Those resulting from percutaneous exposure which occurs as a result of a needlestick or a medical sharp contaminated with blood or bodily fluid; and those resulting from mucocutaneous exposure which occur when bodily fluids come in to contact with open wounds or mucous membranes such as the mouth and eyes. There are more than twenty pathogens that can be transmitted following a needlestick (NSI) or sharps injury. The

most common are Hepatitis B, Hepatitis C and HIV and, therefore, are a significant occupational hazard to healthcare professionals.

The total number of needlestick injury incidents formally reported via the Ulysses reporting system in 2023/24 was 36 which is an increase of 10 reported incidents than the previous year.

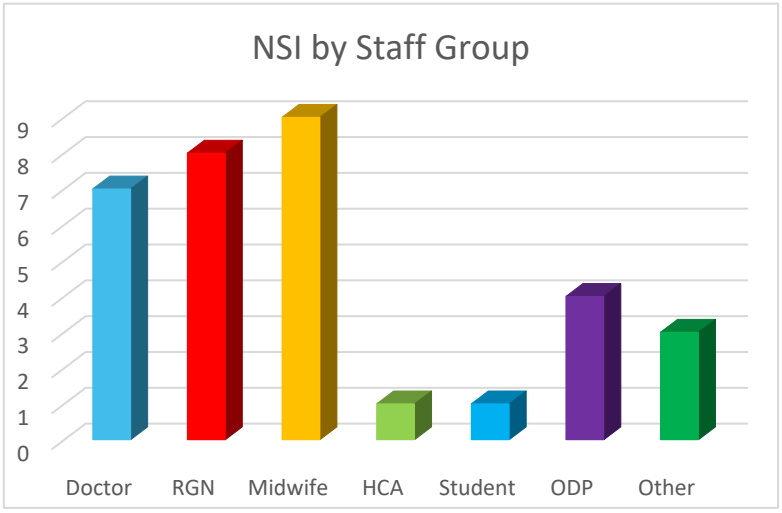
Table 5 – *Needlestick Incidents 2023/24*



A quarterly summary of needlestick injuries including cause, equipment failure, poor disposal methods, staff on staff injury and where good practice can be improved is shared with all clinical Heads, Natrons, Infection Control Team and the Medical Director. It is expected that services respond to the report by sharing the lessons learned, areas for improvement or where there is a gap in training.

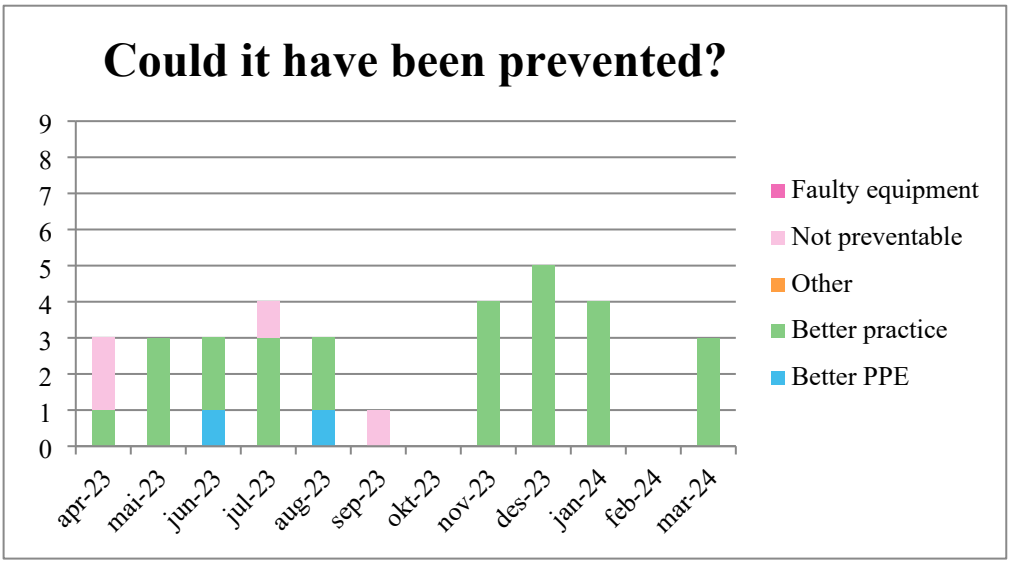
The majority of needlstick injuries were sustained by staff within the Family Health Division. Nine doctors reported injuries during this reporting period.

Table 6 – *Needlestick Incidents by Staff Group 2023/24*



The majority of needlestick/sharps injuries could have been prevented with better practice, two could have been prevented with better PPE and the remaining four were not preventable, e.g. patient moved during procedure.

Table 7 – *Could the injury have been prevented?*



All incidents were of a low risk nature and the Sharps Injury and BBV Policy was followed in each case with exception that in several incidences staff were delayed in contacting Occupational Health or the Emergency Department due to staffing pressures and their not being released from duty. This is contrary to policy as staff must be released from duty and managers must manage the situation. PEP, a short-term antiretroviral treatment to reduce the likelihood of HIV infection, should be initiated as soon as possible after exposure, preferably within 24 hours and under 72 hours.

The use of the Sharpsmart disposal system still offers good value. Ongoing audits are conducted at factory level where the containers are opened, photographed, and checked for non-compliant contents. The onsite audits look at usage and whether the documentation is correct and complete.

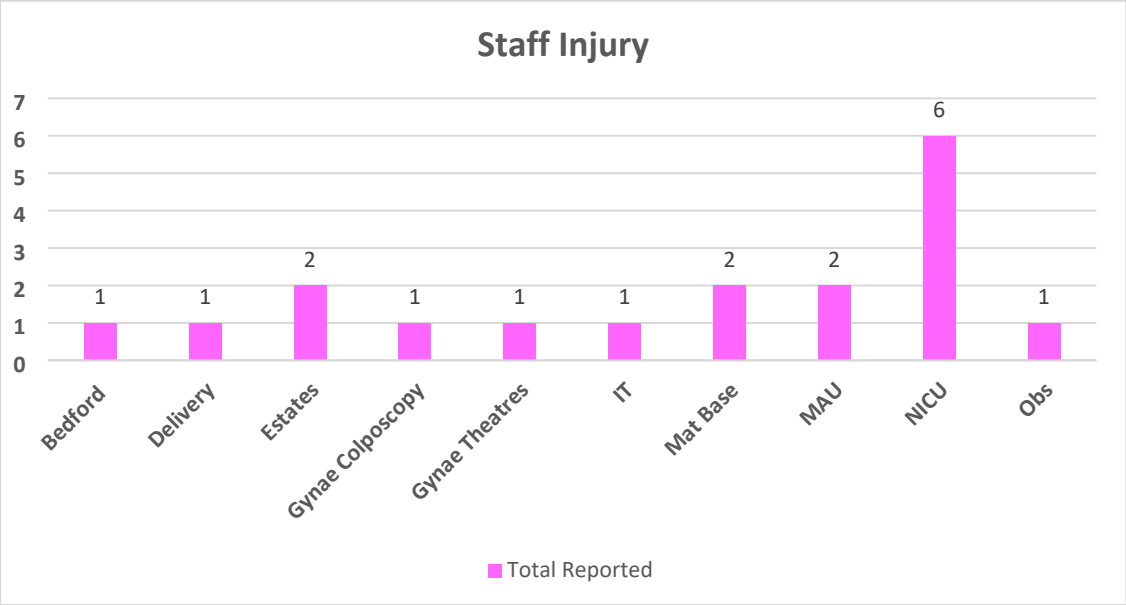
Ongoing training continues to be delivered by the auditor whenever any 'bad practices' are observed or evidenced.

No issues have been raised over any safety aspects of the system.

6.2 Personal Injury

There was a total of 18 personal injuries in this reporting period. From the details of the incidents there were no themes or trends identified.

Table 8 – *Injury Incidents by Area*

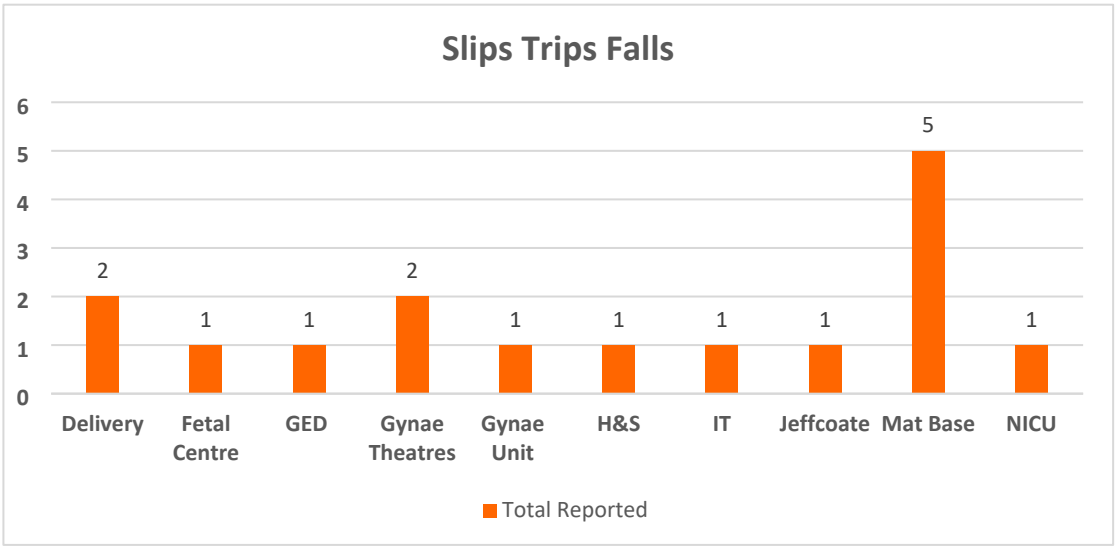


All incidents of personal injury were dealt with appropriately, within protocols and first aid was applied, where necessary.

6.3 Slips, Trips & Falls

There was a total of 15 slips, trips, and falls incidents reported during 2023/24. The majority of slip, trips and falls incidents were reported by the Family Health Division (10).

Table 9 – *Slips, Trips, Falls incidents by Area*



There was a theme of staff falling from pc operator chairs or stools. These incidents were followed up by the Health and Safety Manager and appropriate guidance given to prevent further incidents. User error was the main cause in these incidents.

6 RIDDORS (Reporting of Injuries, Diseases and Dangerous Occurrences)

The Trust is required to submit RIDDOR reportable incidents to the HSE within prescribed timescales. Persistent late reporting exposes the Trust to potential prosecution for non-compliance with the regulations.

In this reporting year there were 5 RIDDOR reports made to the HSE which was an increase of 1 from the previous annual report.

Staff members received appropriate care and support in all incidents. Investigations were completed, where required and appropriate communications made with all staff to prevent similar occurrences in the future, such as guidance for preventing slips, trips, and falls.

8. Legal Claims

The Health and Safety Manager provided investigation reports in response to one employer liability claim.

9. Health and Safety Work Plan for 2024/25

The Health and Safety workplan for the new financial year 2024/25 is overseen by the Safe and Sustainable Environment group.

10. Recommendations

The Board is asked to note the contents of the report and seek assurance that the Trust has appropriate Health and Safety processes in place. This includes to:

- Support the continuous review of the Trust's Health and Safety Management System arrangements.
- Support the continuing development and promotion of a positive health and safety management system and culture.
- Encourage managers and staff to commit to attendance of health and safety related training and the fit mask testing programme.
- Promote health and safety duty and responsibilities across the Trust.

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