Meeting of the Board of Directors
HELD IN PUBLIC
Friday 7 December 2018 at
0900hrs Liverpool Women's
Hospital Board Room

Item no. 2018/	Title of item	Objectives/desired outcome	Process	Item presenter	Time	CQC Domain
	Thank you	To provide personal and Team thank you – above and beyond			0900 (10mins)	caring
278	Apologies for absence Declarations of interest	Receive apologies	Verbal	Chair		-
279	Meeting guidance notes	To receive the meeting attendees' guidance notes	Written guidance	Chair		Well Led
280	Patient Story	To receive a patients story	Presentation	Patient's parent	0910 (20mins)	Safe, Experience, Well led
281	Minutes of the previous meeting held on 5 October 2018	Confirm as an accurate record the minutes of the previous meetings	Written	Chair	0930 (5mins)	Well Led
282	Action Log and matters arising	Provide an update in respect of on-going and outstanding items to ensure progress	Written	Chair		Well Led
283	Chair's announcements	Announce items of significance not elsewhere on the agenda	Verbal	Chair	0935 (10mins)	Well Led
284	Chief Executive Report	Report key developments and announce items of significance not elsewhere	Written	Chief Executive	0945 (10mins)	Well Led

Item no. 2018/	Title of item	Objectives/desired outcome	Process	Item presenter	Time	CQC Domain
BOARD COMMITTEE ASSURANCE						
285	Chair's Report from Finance, Performance and Business Development Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair		Well Led
286	Chair's Report from Quality Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair		Safe Well Led
287	Chair's Report from Putting People First Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair		Well Led
288	Chair's Report from Audit Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	0955 (30mins)	Well Led
TO DEVELOP A WELL LED, CAPABLE AND MOTIVATED WORKFORCE; TO DELIVER SAFE SERVICES; TO DELIVER THE BEST POSSIBLE EXPERIENCE FOR OUR PATIENTS AND OUR STAFF						
289	Better Births compliance – Community Midwifery Update	For information and assurance	Written/Presentation	Claire Fitzpatrick Head of Midwifery	1025 (20mins)	Safe Well Led
290	Mortality Report Q2 2018/19	For information and assurance	Written	Devender Roberts, Deputy Medical Director	1045 (10mins)	Safe Well Led
291	EPRR Assurance Report	For approval	Written	Director of Operations	1055 (10mins)	Well Led
TRUST PERFORMANCE - TO DELIVER THE MOST EFFECTIVE OUTCOMES; TO BE EFFICIENT AND MAKE BEST USE OF AVAILABLE RESOURCES						
292	Safer Nurse/Midwife Staffing Monthly Report period 7 2018/19	For assurance and to note any escalated risks	Written	Director of Nursing and Midwifery	1105 (10mins)	Safe Well Led
293	Performance Report period 7, 2018/19	For assurance –To note the latest performance measures	Written	Director of Operations	1115 (10mins)	Well Led
294	Finance Report period 7, 2018/19	For assurance - To note the current status of the Trusts	Written	Director of Finance	1125 (10mins)	Well Led

Item no. 2018/	Title of item	Objectives/desired outcome	Process	Item presenter	Time	CQC Domain
		financial position				
TRUST STRATEGY						
295	Operational Plan and Corporate Objectives – 6 monthly reviews.				1135 (15mins)	
296	Future Generations	For noting.	Verbal	Deputy Chief Executive	1150 (5mins)	Well Led
BOARD GOVERNANCE						
297	Board Assurance Framework	For assurance and approval	Written	Trust Secretary	1155 (10mins)	
298	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair	1205	Well Led
HOUSEKEEPING						
299	Any other business & Review of meeting	Consider any urgent items of other business	Verbal	Chair	1215 Meeting ends	Well Led

Date, time and place of next meeting Friday 1 February 2019

Meeting to end at 1215

1215-1225	Questions raised by members of the public observing the meeting on matters raised at the meeting.	To respond to members of the public on matters of clarification and understanding.	Verbal	Chair

Board of Directors

Minutes of the meeting of the Board of Directors
held in public on Friday 5 October 2018 at 1000 hrs
at Liverpool Women's NHS Foundation Trust, Crown Street Liverpool.

PRESENT

Mr Robert Clarke	Chair
Mrs Kathryn Thomson	Chief Executive
Mr Tony Okotie	Non-Executive Director/SID
Mr Phil Huggon	Non-Executive Director
Mrs Michelle Turner	Director of Workforce & Marketing
Mrs Jenny Hannon	Director of Finance
Dr Andrew Loughney	Medical Director & Deputy Chief Executive
Mrs Caron Lappin	Director of Nursing and Midwifery
Mr Jeff Johnston	Director of Operations
Dr Susan Milner	Non-Executive Director
Mr Ian Knight	Non-Executive Director

IN ATTENDANCE

Mr Colin Reid	Trust Secretary

APOLOGIES:

Ms Jo Moore	Non-Executive Director & Vice Chair

2018	
	Thank You **Alison Carroll, OD & People Development Facilitator** -The Director of Workforce & Marketing, thanked Alison Carroll for her continuing commitment to the Trust's Health & Wellbeing agenda, specifically the recent formation of the Trust's Rock Choir. The Rock Choir met weekly and provided an informal opportunity for clinical and non-clinical staff to get together in an enjoyable activity. Alison was ably supported in running the choir by Anne Johnstone, one of the Trust's R&D team. **Jennifer Huyton Head of Finance – Strategy and Transformation** – The Director of Finance thanked Jennifer Huyton on behalf of the Board for her for all her work in reviewing where the Trust was as an organisation against current clinical standards in light of our Future Generations Strategy. She comments that those of the Board members who saw the presentation yesterday would have seen just how much effort went in to the update and the number of standards that had to review and understood. The Director of Finance advised that Jennifer co-ordinated this works, working tirelessly to pin down busy clinicians to perform the review. The Director of Finance thanked Jennifer for her hard work, perseverance and dedication and consistently going above and beyond.
249	**Apologies** – as above. **Declaration of Interests** – None **Welcome:** The Chair opened the meeting and welcomed members of the public and staff to the meeting held in public. He advised those present and attending the meeting that the meeting would be filmed by the production team for the BBC 'Hospital' documentary and anyone wishing not to be

filmed, would they please advise the production team.

250 **Meeting guidance notes**

The Board received the meeting attendees' guidance notes.

251/259 **Baby Saver Presentation**

Andrew Weeks, Consultant Obstetrician joined the meeting and provided a presentation on the BabySaver equipment developed in conjunction with the University of Liverpool, which provided for resuscitation on neonatal babies available in all parts of the world. He provided an insight into the cord clamping paradox that Obstetricians like himself had to deal with daily and how providing immediate neonatal care and resuscitation at birth beside the mother was hugely important.

Andrew Weeks explained the process in the development of the equipment and its importance of being portable and reusable, providing an insight in its use in Uganda and the potential use of the equipment in developed countries that promote community midwifery.

The Board discussed the development of the BabySaver and its importance in the care of babies. The Chief Executive commented on the great work the Trust and the University of Liverpool had done in Uganda and the difference the BabySaver had made and suggested that a board development session was used in the future to show case the work in Uganda.

The Chair thanked Andrew Weeks for his presentation which was noted. Andrew Weeks thanked the Board for allowing him the opportunity to present to the Board today and advised that the BabySaver was a credit to the continued support of staff and Board in allowing innovation to thrive.

252 **Minutes of previous meeting held on Friday 7 September 2018**

The minutes of the board meetings held on 7 September 2018 were approved.

253 **Matters arising and action log.**

The Board noted that all actions had either been completed, were on the agenda for the meeting or were for action at a future meeting.

254 **Chair's Announcements**

The Chair reported on the following matters:

Meeting of Specialist Trust NEDs – 19 September: The Chair reported on the meeting he had attended with Ina Knight with other NEDs and Chairs from specialist trusts including Alder Hey, Clatterbridge, Liverpool Heart and Chest and the Walton Centre at which learning and idea sharing took place. The areas covered included NED recruitment, how NEDs receive assurance on performance and efficiency and getting the best from working with the Council of Governors. He advised that it was a successful event and would share learnings with the Board.

Governor elections: The Chair advised that the Trust had received nominations in all but one of the public and staff constituencies. Three constituencies would need to go to a ballot and three governors have been appointed uncontested. Appointments of new Governors would be announced at the forthcoming Annual Member Meeting on 13 October, following which their appointments would commence.

Non-Executive Directors on Board Committees: The Chair reported that following David Astley's resignation as a Non-Executive Director, a number of changes to the membership of the Board committees had been made and would be effective from today. He advised that the committee membership that requires the formal approval of the Board was the Audit Committee and proposed that Jo Moore was appointed to the Committee. The Board approved the proposal noting that the

membership of the Audit Committee comprised of Ian Knight, Chair; Tony Okotie; and Jo Moore.

The Chair reported on future dates for the diary and advised that the next Council of Governors Meeting was on 24 October 2018 and the next meeting of the Board in public was 7 December 2018.

The Board noted the Chair's verbal update.

255 Chief Executive's report

The Chief Executive referred to her report and commented on the following:

Butterfly Awards 2018: The Chief Executive congratulated Terri Thompson, Neonatal Nurse who had been shortlisted in the Butterfly Awards, voting opens on 1st October 2018.

Service of Remembrance: The Chief Executive reported on the Service of Remembrance organised by the Honeysuckle team which was to be held on Wednesday 10th October 2018 at St Georges Hall. She explained that this year anyone wishing to attend should obtain a ticket from the Trust which was different to previous years. The Chief Executive commented that this was always a well-attended event which afforded families the opportunity to take time to remember lost ones.

Mental Health Awareness Day 10 October 2018: The Chief Executive advised that the Trust Wellbeing team were holding a mental awareness event during the day on 10 October 2018 and asked that Board members attend if they were available on the day to support the event.

Annual Members Meeting: The Chief Executive advised that the next Annual Members meeting of the Trust was to be held on 13 October 2018; notifications of the meeting would be issued to members of the public in the usual way.

Staff Coast to Coast Challenge: The Chief Executive reported on the staff coast to coast challenge that was held on the weekend of 22 and 23 September that saw 18 staff members from areas such as Purchasing, Estates, Finance, Communications, IT, Community Midwives and Theatres taking part in the Coast to Coast cycle ride in their own time to raise money for Liverpool Women's Charity. She advised that to date the Challenge had raised £1,245.00.

Operation Christmas Child 2018: The Chief Executive reminded the Board of the Operation Christmas Child which provides children's gifts and necessities to children around the world, in a shoe box. She asked that all Directors get involved and provide at least one box. Arrangements would be made for flat packed shoe boxes to be provided to Board members.

Save Liverpool Women's Leaflets: The Chief Executive advised that she had been passed some "Save Liverpool Women's" leaflet that had been given out to patients and staff this morning at the entrance to the Hospital. She advised that the staff that had passed the leaflet to her were concerned by the content which stated that the preferred option for financing the new build was PFI. The Chief Executive was perplexed by this statement as the Trust had never stated its preferred financing option to be PFI. The Director of Finance supported the comment and reported that the preferred option had always been receiving the necessary capital from the Centre and that this had been a constant statement by the Trust. The Board noted the comments from the Chief Executive and was extremely concerned that the information contained in the leaflet was both inaccurate and misleading to the public.

Links with the Royal Liverpool Hospital: The Chief Executive asked the Medical Director if he could update the Board on his work at the Royal Liverpool Hospital. The Medical Director reported on the direct links he had been facilitated with Bowel Surgeons at the Royal, with respect to joint operating in complex benign gynaecology cases. Referring to anaesthetics, the Medical Director advised that he

was discussing with the Royal the formation of new joint consultant posts and reported that a joint Anaesthetist appointment had been made which would provide 50% of his job plan at the Trust and the remaining 50% at the Royal.

Referring to the Medical Education teams across both sites, the Medical Director felt that closer co-operation could be achieved towards the common goal of improving care and discussions were ongoing regarding the synergies between the two departments. In response to a question from Phil Huggon, the Medical Director advised that it was absolutely vital that the links with the Royal continue and develop, explaining that undertaking complex surgery on an isolated site would be impossible given the risks.

224 Chair's Report from Finance, Performance and Business Development Committee (FPBD)

The Chair asked that the Chairs report from the FPBD be taken as read and asked for any comments.

Phil Huggon commented on the assurance received by the Committee on delivering CIP for the current financial year. He advised that the committee was concerned surrounding delivery of CIP for 2019/20.

The Chair referred to the work undertaken by the Trust in order to receive a rebate against CNST and asked for a status position on the receipt of the rebate. In response the Director of Finance reminded the Board on the process the Trust had taken to provide a submission to NHS Resolution relating to reducing stillbirths, neonatal and maternity deaths and brain injuries which would have seen the Trust qualifying for at least a 10% discretionary rebate of CNST maternity contributions for 2018/19. She explained that the Trust was measured against ten criteria and a submission was made following review by the Quality Committee where the Trust was able through, a robust and transparent process to confirm delivery against nine of the ten criteria. She advised that the maximum rebate would be £1m; however this would be adjusted downwards if any of the criteria were not met. The Director of Finance reminded the Board that, following the submission, the Trust received notification from NHS Resolution that as the Trust could not deliver against all ten criteria it would receive no rebate at all, it would however receive £174k in relation to the delivery of an action plan to achieve the outstanding action. The Director of Finance advised that the Trust had appealed against the decision; however the appeal was unsuccessful and would continue to lobby to ensure there was a robust system in place going into 2019/20, which the Trust could access, in line with the aims of the incentive.

The Chair's Report from Finance, Performance and Business Development Committee was noted.

225 Chair's Report from Quality Committee (QC)

Susan Milner, Chair of the Quality Committee presented her report for the meeting held on 24 September 2018 and ran through the assurances received.

Referring to the review of Francis Report recommendations, Susan Milner advised that the Committee received assurance surrounding the Trust's compliance with the recommendations with the exception of one relating to patients access to own records through an electronic patient records system. She explained that it was unlikely that the Trust would be able to deliver this recommendation and felt that it would be appropriate to look at whether the outstanding action could be reviewed through a different mechanism. Regarding the annual review of the recommendations a check was being made on whether it required such a review or whether it could be closed off. The Chief Executive agreed on the proposal to close the action plan; however recommended that the Committee undertake a deep dive review of one of the recommendations each year.

With regards to the Board Assurance Framework, Susan Milner advised that there were no changes recommended to the Board. She advised that the Committee had noted the suggestion from the

previous acting Director of Nursing and Midwifery that risk score for the 'patient experience' risk (2167) was reduced from 9 to 6. The Committee agreed that before it makes any recommendation to the Board on the change of risk score that the risk was reviewed by the Director of Nursing and Midwifery. The Director of Nursing and Midwifery advised that she had reviewed the risk following the Quality Committee and did not agree with the proposal to reduce the risk score from 9 to 6.

The Chair thanked Susan Milner for her report which was noted.

227 Chair's Report from Putting People First Committee (PPF)

Tony Okotie, Chair of the PPF Committee held on 28 September 2018, highlighted the key items contained in his report. He apologised for the lateness of the written report which was due to the timing of the papers being sent out, which was on the same day as the PPF meeting.

Tony Okotie reported on the deep dive the Committee undertakes for each of the Services in relation to staffing matters. He advised that the committee received a staff story from an ANNP staff member on Neonates who provided a positive picture of the leadership of the Service and an acknowledgement of her contribution as part of the Neonatal team. The Committee also received the Neonatal Service Workforce Review which provided assurance to the Committee that the Service had a good grip on the management of its workforce with no key workforce risks identified. The Chair asked whether any points of learning from Neonates could be disseminated into other services. The Director of Nursing and Midwifery advised that she was working with the Neonatal Head of Nursing to identify any points of learning that could be used elsewhere. The Director of Workforce and Marketing advised that the Neonatal Head of Nursing was also part of the Leadership Programme presenting to Trust staff through the programme on her leadership style.

Tony Okotie referred to the actions required by the Board: to ratify the decision by the Committee to adjust the Trust sickness absence target to align to the NHSI Sickness Improvement Project and the Quality Schedule (Year 1 - 4.5%, Year 2 - 4.0%, with aspirational Year 3 - 3.5%); and to note that the Committee had approved, on behalf of the Board, the Medical Appraisal & Revalidation Annual Report Designated Body Statement of Compliance.

With regards to the sickness absence target, Tony Okotie advised that the Trust had hit a plateau and was not able to hit the current target which on reflection was very much a stretch target. He informed the Board that the Trust had been asked to participate in a NHSI Sickness Improvement Project, which sought to align sickness targets to be more realistic, whilst undertaking targeted interventions to deliver the re-aligned targets over a three year period. He explained that although the Trust target would be realigned during the first two years, he felt that delivery would still be difficult to achieve. The Director of Workforce and Marketing advised that the Project was seeking to focus on specific drivers to reduce sickness absenteeism. Responding to the areas of focus, the Chief Executive commented on the need to review how the flexible working policy was being implemented and whether members of staff were taking sick leave for matters that could have been dealt with under the policy. The Chief Executive suggested that the policy should be monitored to see how the policy was interpreted and whether it was interpreted differently in the Services.

Tony Okotie referred to the work of the Committee in the development of the Workforce Strategy and advised that the new strategy would be ready for review by the Board in January 2019. In response to a question from Phil Huggon, the Director of Workforce and Marketing advised that the Strategy would have flexibility and resilience built into it and would relate to the whole of the workforce.

The Board ratified the decision of the Committee to adjust the Trust sickness absence target to align to the NHSI Sickness Improvement Project and the Quality Schedule (Year 1 - 4.5%, Year 2 - 4.0%, with aspirational Year 3 - 3.5%); and noted the Committee's approval, on behalf of the Board, of the

Medical Appraisal & Revalidation Annual Report Designated Body Statement of Compliance.

The Chair thanked Tony Okotie for his report which was noted.

260 Mortality Report Q1, 2018/19

Devender Roberts, Associate Medical Director presented the Mortality Report for Q1, 2018/19 and reported that there were no deaths in the quarter.

Devender Roberts ran through the report highlighting the key aspects of the Report. The Chief Executive felt that the content of the Report had been improving over the last year and noted the improved position for the number of out of date policies.

Referring to the Q2 report, Devender Roberts advised that the report would include benchmarking information with Birmingham Women's which would help in developing greater learnings from deaths.

The Chair thanked Devender Roberts for her report commenting on the trajectory to have no policies out of date by quarter 2. The Board noted the Mortality Report Q1, 2018/19.

261 Neonatal Build GMP Approval

The Director of Operations presented his report on the Neonatal Build Guaranteed Maximum Price (GMP) Approval. He advised on the Projects key achievements to date and reported that with the design phase now completed the total cost of the project would be £14.74M with the GMP totalling £12.026M before VAT and excluding professional and project costs. The Director of Operations advised that due to the timing of the Neonatal Project Board the following additional checks and balances still needed to be completed: financial validation by LWH of the quantity surveyors supporting calculations; a strengthening of the derogations risk log to be clearer regarding rationale, mitigation and potential impact; and confirmation that the structure of the Procurement 22 (P22) Scheme negated the need for the purchase of a construction performance bond; and sought the Board approval of the GMP subject to the above work being undertaken which was subject to the Director of Finance and Director of Operations to sign off.

The Chair asked what the GMP meant if the final cost was below the GMP, in response it was advised that the first 5% under the GMP would be shared between the contractor and the Trust, anything below the 5% would be retained by the Trust. The Chief Executive advised that all the risk was with the contractor once the GMP was agreed; the exception to this would be if the Trust decided to change the design. She advised that the clinicians had been fully involved in the design and were fully signed up to it.

The Board noted the progress made to date and approved the GMP was subject to the Director of Finance and Director of Operations to sign off the additional work reported above.

262 Safer Nurse/Midwife Staffing Monthly Report Period 5 2018/19

The Director of Nursing and Midwifery reported on the safer staffing report for month 5.

The Director of Nursing and Midwifery referred to the safer staffing fill rate shown in appendix 1, which provides the established versus actual fill rate on wards split by registered and unregistered staffing hours both day and night. Fill rates were accompanied by supporting narrative by exception at ward level, and a number of related factors were displayed alongside fill rates to provide an overall picture of safe staffing. The Director of Nursing and Midwifery advised that sickness rate and vacancy rates were the two main factors affecting fill rates together with a growing trend in maternity leave, especially within maternity division, all of which was being closely monitored.

Referring to the Red flags during August, the Director of Nursing and Midwifery reported that there

were a total of 16 incidents, which was an increase on the last 2 months. 4 incidents related to gynaecology involving staff shortages, theatre overruns impacting on patient cancellations and a full emergency list requiring second emergency theatre to be opened; 6 incidents related to midwifery involving staffing shortages, missing documentation and missed prescription; and 6 incidents relating to neonates again involving staffing shortages, missed medications and issues around capacity and the unit being on red alert. The Director of Nursing and Midwifery advised that investigations into these incidents concluded that staffing levels and skill mix were safe at that time.

With regards to vacancies, the Director of Nursing and Midwifery reported that there were currently 38 whole time equivalent (WTE) registered nurse vacancies, 14 midwifery vacancies and 9 unregistered vacancies. She advised that presently 17 midwives were within the recruitment process and 15 of these had a start date. Referring to the nursing vacancies, the Director of Nursing and Midwifery reported that 28 trained nurses were in the recruitment process, 13 of which had received conditional offers and a start date agreed.

In summing up her report, the Director of Nursing and Midwifery advised that during the month of August all wards were considered safe with either low/no levels harm; there had been a noted decrease in fill rates being due to long term sickness, a spike in short term sickness and the current vacancy rate. The Director of Nursing and Midwifery advised that as with previous reports Gynaecology continued to remain a focus.

In response to the Chair's question on retention of staff, the Director of Nursing and Midwifery advised that retention rates in nursing and midwifery staff was very good at the Trust, this was not the case for medical staff.

The Chair thanked the Director of Nursing and Midwifery for her report which was noted and received assurance that the Trust had the appropriate number of nursing and midwifery staffing to manage the current activity.

263 Performance Report Period 5 2018/19

The Director of Operations presented the Performance Report for period 5 2018/19 and reported that the Trust was continuing to deliver the national targets to date with the exception of RTT 18 weeks and a number of the cancer targets. The Director of Operations advised that the management of the backlog queues continued; however with reduced capacity it was no longer possible to eradicate them in previously stated timeframes. He explained that at the beginning of September, the queues were 614 for new appointments and 617 for follow up appointments; as in previous months the backlog number would increase on the first of the month as the following month's patients were added.

The Director of Operations reported on the arrangements being put in place for weekend working with an independent sector provider, Medinet. He advised that Medinet employ NHS consultants who provide a locum styled service to NHS providers and explained that 230 new, low risk patients had been identified as possible weekend clinics using the Medinet arrangements. In response to questions on the governance arrangements being put in place, the Director of Operations advised that a formal agreement was currently being negotiated together with detailed governance arrangements wrapped around it. He felt that given where the Trust was at this point in time, there was no other viable option available to the Trust to reduce the waiting time lists. Referring to the cost of using Medinet, Ian Knight asked what the financial impact would be. The Director of Finance advised that much of the additional cost would be covered through the vacancies the Trust had on its books. The Director of Operations advised that there were currently four vacancies and noted that in order for the Trust to get back on track to deliver RTT targets by 31 March 2019, three experienced permanent consultants needed to be appointed and supported by the short term mitigations being put in place. He further advised that the Trust had recently appointed two good quality locums who

were also looking for permanent positions. The Medical Director commented on the recruitment of Gynaecology consultants and advised that if the Trust was not successful in the appointment process, then it would need to consider what complex work the Trust could continue to do at Crown Street.

The Director of Operations summed up his report advising that 18 week RTT and Cancer recovery plans had improved and the backlog queues had also significantly reduced. However, due to further reductions in capacity there were delays and risks in the recovery of these targets back to full compliance, noting that the recovery plans assume that consultant appointments would be made in October and that the service utilise the capacity of an independent sector provider.

The Board noted the Performance Report for period 5 2018/19, noting in particular the risk of non-delivery of RTT and Cancer due to both lack of consultant capacity and diagnostics. The Chair thanked the Director of Operations for his report.

264 Financial Report & Dashboard Period 5 2018/19

The Director of Finance presented the Finance Report and financial dashboard for month 5, 2018/19 and reported that at month 5 the Trust was reporting a deficit of £1.1m against a deficit budget of £2.3m, giving a year to date favourable variance of £1.2m. She advised that this was a sustained improvement and there was reasonable assurance that the control total would be met for the year, despite the known risks to the cost improvement program and other know cost pressures.

The Director of Finance advised that the Trust was continuing to benefit from a level of financial stability secured through the 'Acting as One' contract arrangement with Liverpool CCG and the NHSE block contract, which collectively account for 72% of total Trust income. Referring to the Acting as One contract, the Director of Finance reported that the block payment for 2017/18 year was £3.8m higher than it would have been under Payment by Results (PbR) and this had continued in 2018/19 with £1.6m additional income earned year to date than would have been earned under PbR. The Director of Finance advised that discussions were ongoing with Liverpool CCG over the future 'Acting as One' contract for 2019/20 and she felt that the contract would be rebalanced and would not be as beneficial as it had been over the last two years and there would be a need to reduce to a commensurate level costs the Trust would incur.

Referring to delivery of CIP, the Director of Finance referred to the earlier discussion in the meeting and advised that the Trust was delivering its CIP year to date, however warned that there were risks to delivery of the full year target, citing the CNST incentive payment mentioned earlier in the meeting that had not been awarded and accounted for £1m of the CIP for 2018/19. The Director of Finance reported on the work of the Turnaround Transformation Committee to address the shortfall, together with the continued engagement with staff to support them in finding the additional CIP.

The Chief Executive, referring to the Trust's debtors, asked the Director of Finance for an update on the recovery of money owed by One2One. The Director of Finance advised that One2One had not been paying its debts to the Trust through the appropriate provider to provider payment procedures. She explained that this had been reported previously to the Board and that consideration was now being given to recover the money owed through the courts. The Director of Finance advised that there were a number of NHS providers who were in the same position as the Trust where One2One owed some considerable amount of money to each. She advised that she was working with those other local providers to see whether a joint action was feasible.

The Chief Executive advised that NHS Improvement were fully aware of the situation the Trust was finding itself in with regards to the debt and advised that she was considering whether the matter should be addressed with NHS England. Susan Milner asked whether the patients seen under the arrangement were planned or emergency activity. The Director of Finance advised that both planned and emergency cases were dealt with and reported that no patient was turned away from treatment.

The Chair thanked the Director of Finance for presenting the Financial Report & Dashboard Period 5 2018/19 which was noted.

265 Future Generations

The Chief Executive provided an update on public consultation process and the matters that required addressing before NHS England gives its consent to allow Liverpool CCG to go out to public consultation.

The Chief Executive reminded the Board on the journey the Trust had been on from the work undertaken by the clinicians and staff in 2014/15 leading to the development of the Future Generations Strategy and approval by the Board in December 2015 and thereafter Liverpool Clinical Commissioning Group undertaking the review of Women and neonatal services that commenced in March 2016.

The Chief Executive reported that the move towards public consultation remained on hold whilst the capital funding arrangements were finalised. She advised that, as previously reported, the Trust had been prioritised by the Cheshire and Merseyside Health and Care Partnership to receive capital funding and reported that the Trust had the full support of the partnership. The Chief Executive advised that all capital schemes would be reviewed and appraised at national level within the next few months and she hoped that following this Liverpool CCG would be able to progress to public consultation.

The Chief Executive advised that given the length of time the overall process had taken since the clinical sustainability issues had been raised in 2014, the Board had embarked, over the summer months, on a review of the clinical standards that should be delivered within each of the clinical services. She reported on the range of presentations given to the Board from clinical leaders, highlighting where the Trust was against the clinical standards within the service and the receipt of case studies that provided additional evidence.

The Chief Executive advised that the Board had seen some deterioration in standards across most of the Services and further work needed to be done to assess the impact this had on the clinical sustainability of the Trust. The Chief Executive thanked all the clinicians and staff members who supported the review and provided the presentations to the Board and commented on the accountability and responsibility of the Board to listen to what the clinicians were saying and to act upon the issues raised so that the women of Liverpool received the best standards of care possible.

The Medical Director also passed on his thanks to the clinicians involved in the review, he felt that the presentations highlighted clearly the needs of the Trust to move from an isolated site and cited the problems of recruitment in Gynaecology as only one of a large number of the key issues faced by the Trust.

The Chair thanked the Chief Executive and Medical Director for the update and commented on the greater awareness the Board had received regarding the deterioration of clinical standards and the inter-reliance of the adult acute providers and the Trust. He felt it was imperative that a solution was found for Liverpool and the patients it served.

266 Board Assurance Framework

The Board considered the Board assurance Framework (BAF) and noted actions taken by the Board Committees to review each of the risks within their remit.

The Board noted that there were no amendment made to the risk scores and received assurance that the risks were being properly managed.

267 Review of risk impacts of items discussed

The Board noted that no additional risks had been identified during the meeting. The Chair however felt it appropriate to note the risks discussed during the meeting that included:

1. Gynaecology consultant recruitment and the impact on the Gynaecological services provided by the Trust
2. Delivery of the Cost Improvement Plans for 2018/19 and development of Cost Improvement plan for 2019/20

268 Any other business & Review of meeting

Fair and Just Culture: The Director of Workforce advised the Board that they would be receiving homework for the Board workshop on 2 November. She also advised on the staff training offered by David Marx which he would provide free of charge but would be provided in New York State. The training would encompass the methodology of the fair and just culture and training staff on how to train the methodology.

Audit Committee Effectiveness: Ian Knight asked that all those who had received a questionnaire on the effectiveness of the Audit Committee would they please complete them in time for the next Audit Committee meeting on 22 October 2018.

The Board noted the honest, transparent, frank and challenging discussion on items presented.

Date of next meeting

The Chair reported that the next meeting of the Board in public would be 7 December 2018.

Agenda Item 2018/282

TRUST BOARD
7 December 2018 Action Plan

Meeting date	Minute Reference	Action	Responsibility	Target Dates	Status
1 June 2018	2018/167	The acting Director of Nursing and Midwifery to provide an update on progress made on the implementation of the National Maternity Review continuity of care pathway at the Board meeting on 2 November 2018	Director of Nursing and Midwifery	~~2 November 2018~~ now 7 December 2018	See agenda item 289

	Completed actions: concluded before the next board or on the agenda of the next Board
	In Progress - either at Committee stage or awaiting presentation at Board or Board workshop
	in progress - missed original deadlines agreed at Board

Agenda Item	2018/284

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Chief Executive Report**
DATE OF MEETING:	Friday, 07 December 2018
ACTION REQUIRED	**For Noting**
EXECUTIVE DIRECTOR:	Kathy Thomson, Chief Executive
AUTHOR(S):	Colin Reid, Trust Secretary
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** 1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☒ 2. To be ambitious and *efficient* and make the best use of available resource ☒ 3. To deliver *safe* services ☒ 4. To participate in high quality research and to deliver the most *effective* Outcomes ☒ 5. To deliver the best possible *experience* for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust…….* ☒ ***2.*** *Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have sufficient numbers of junior medical staff with the capability and capacity to deliver the best care. ……* ☒ ***3.*** *The Trust is not financially sustainable beyond the current financial year……* ☒ ***4.*** *Failure to deliver the annual financial plan ……* ☒ ***5.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision ……* ☒ ***6.*** *Ineffective understanding and learning following significant events……* ☒ ***7.*** *Inability to achieve and maintain regulatory compliance, performance and assurance……* ☒ ***8.*** *Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) ……* ☒ ***9.*** *Inability to deliver the best clinical outcomes for patients……* ☒ ***10.*** *Potential for poorly delivered positive experience for those engaging with our services..* ☒
CQC DOMAIN	***Which Domain?*** ***SAFE-*** *People are protected from abuse and harm* ☐ ***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☐ ***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☐ ***RESPONSIVE –*** *the services meet people's needs.* ☐ ***WELL-LED -*** *the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care,* ☐

	supports learning and innovation, and promotes an open and fair culture. ***ALL DOMAINS*** ☒			
LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution ☒ **2.** Operational Plan ☒ **3.** NHS Compliance ☒		**4.** NHS Constitution ☒ **5.** Equality and Diversity ☒ ***6.*** Other: **Click here to enter text.**	
FREEDOM OF INFORMATION (FOIA):	1. This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting			
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	***Board is asked to note the content of the report.***			
PREVIOUSLY CONSIDERED BY:	**Committee name**	Not Applicable		
	Date of meeting			

Executive Summary

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

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

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

Kathy Thomson.
Chief Executive.

Report

SECTION A - Internal

Freedom to Speak Up Guardian: Chris McGhee, the Trust's Freedom to speak up Guardian was invited to attend attend the House of Commons as part of Speak Up Month, on Tuesday 16th October, and was able to promote her role not only as Guardian but also in the development of the Fair and Just culture project.

Awards: The Trust was shortlisted in two categories in the recent Healthcare People Management Association awards: Rochelle Collins, Medical Staffing Manager for 'Rising Star'; and the Trust for its talent management and aspirant talent programme.

The Co-op Local Community Fund Team: Liverpool Women's Charity has been chosen for the next round of the Co-op Local Community Fund. The funding round started from **28 October 2018**. From this date, Co-op Members can choose your cause to give their 1% to when they spend on selected own-brand products and services. The funding period will run for 12 months until the **26 October 2019**.

Staff Flu Vaccination Campaign 2018: The campaign is now well underway. The CQUIN target is to achieve 75% of frontline staff vaccinated by March 2019, and as at 15th November, the Trust has already reached 74.4%.

Bump Booster Campaign: Babies in the womb can hear their parents and the world about them. Parents are being asked to take time and give their child an early start by singing and talking to them before they are born.

Liverpool Women's Winter Wonderland: The Charity's annual Christmas Fayre will return to the main hospital reception for three days this year from Wednesday 12th – Friday 14th December with a huge selection of stall holders in the Christmas Market, a Santa's grotto, children's crafts, chances to win fantastic prizes on our raffle & tombola and a special visit from the hospital's very own Rock Choir! There will be an opportunity for 'late night shopping' on the Thursday when the market stalls will be open till 6pm!

Christmas Jumper Day!: We are asking all staff to don their Christmas jumpers on Friday 14th December and make a £1 donation to Liverpool Women's Charity to support the hospital's services and get in the festive spirit!

Festive Knit & Natter: We will be holding our Festive Knit & Natter from 12pm – 2pm on Monday 3rd December for the Trust's wonderful knitting volunteers! Staff are welcome to join the event in the Blair Bell for a visit from Great Crosby Primary School choir!

33rd Annual NHS Carol Concert, Wednesday 12th December, Liverpool Cathedral 7:30pm: NHS Staff past and present from across the North West will mark the end of the 70th Anniversary of the NHS, and celebrate the Christmas season with festive carols and readings in the beautiful surroundings of Liverpool Cathedral, (St James's Mount) Special guest Lady Ann Dodd.

New Divisional Structure: As the Board will be aware the Trust has recently gone through a consultation process to revise the Trust's Divisional Structure, resulting in Maternity, Neonatal, Gynaecology, Theatres, Fertility, Genetics, and all other clinical support services being restructured within three main clinical divisions.

The key objective of this new structure is to:

- maintain and improve safety, experience and effectiveness for our patients;
- create simplified structures where accountability and responsibility is clear;
- strengthen divisional management teams with medical, operational and nursing/midwifery leaders having clear, shared objectives;
- simplify divisional reporting and meeting requirements in response to your feedback regarding the demands of servicing the current organisational structure; and
- improve divisional governance processes, ensuring a clear line of sight from 'ward to board'.

We are pleased to inform you that the consultation process for this piece of work is now complete and following a period of transition the new organisational structure will be formally implemented with effect from Monday 3rd December 2018 with a transitional phase for full implementation on 1 April 2019.

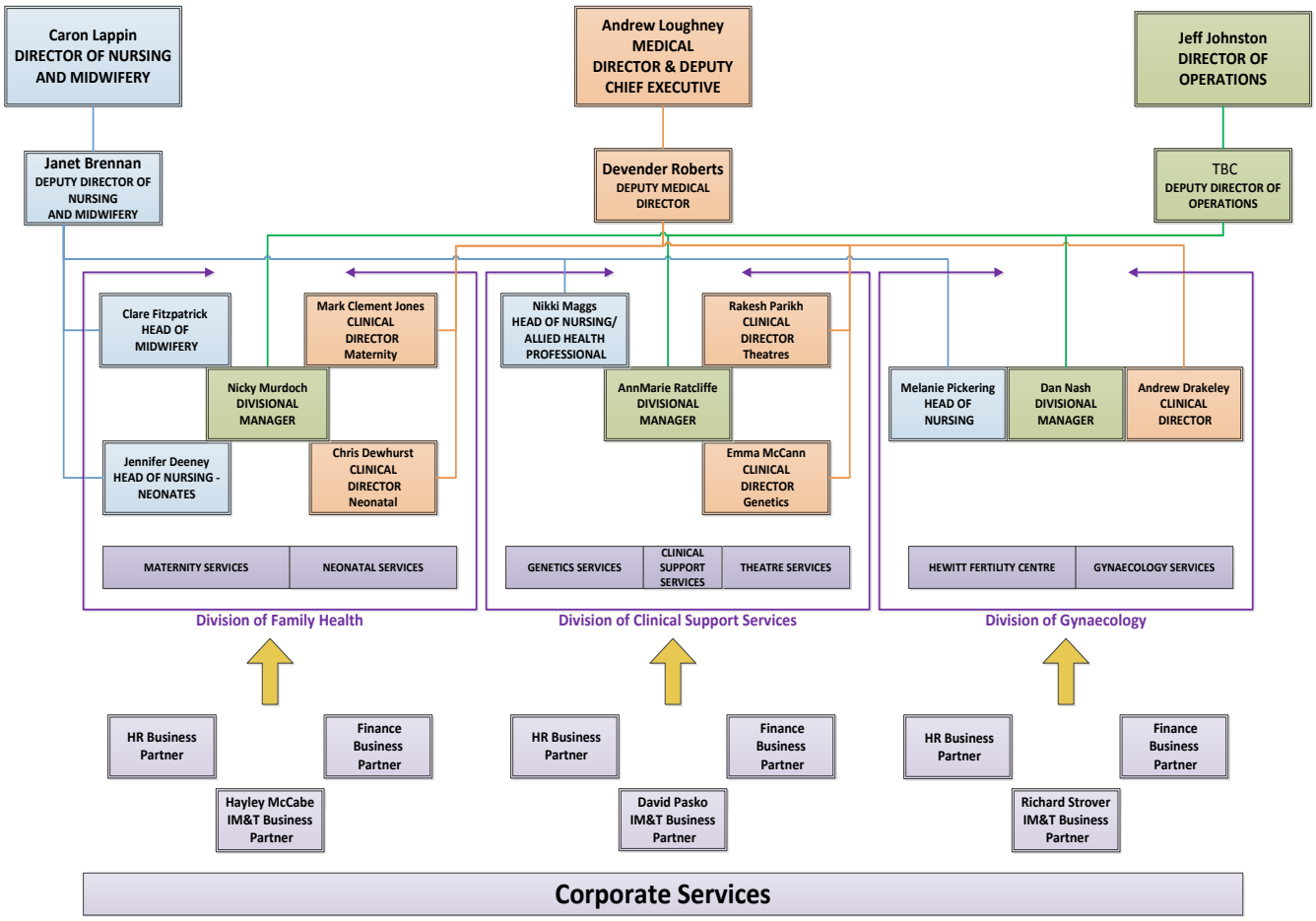
The three clinical divisions are:

- **Division of Family Health** - Comprising the Maternity and Neonatal directorates.
- **Division of Gynaecology** - Comprising the Gynaecology and Hewitt Fertility Centre directorates.
- **Division of Clinical Support Services** - Comprising Pharmacy, Therapies, Theatres, Genetics, all other clinical support services, as well as the Administration and Access Centre.

As part of the transitional phase a non-clinical Executive Director has been assigned to each division to provide focused support and challenge. The lead member of the Executive Team for each Division is as follows:

- **Division of Family Health** – Jenny Hannon, Director of Finance
- **Division of Gynaecology** – Michelle Turner, Director of Workforce and Marketing
- **Division of Clinical Support Services** – Jeff Johnston, Director of Operations

The chart below shows the new divisional make up and clinical and operational reporting lines.



*NB: **Janet Brennan** will join the Trust in December to take up the role of Deputy Director of Nursing & Midwifery reporting to Caron Lappin, Director of Nursing and Midwifery. **Melanie Pickering** will join the Trust as Head of Nursing for the Division of Gynaecology in December. **Dan Nash** will take up the role of Divisional Manager for the Division of Gynaecology in February 2019. **Chris Dewhurst** will become Clinical Director for the Division of Family Health (Neonatal Services), replacing **Bill Yoxall** from December. Bill Yoxall is stepping down from his role as Clinical Director but will remain as a Consultant Neonatologist. **Rakesh Parikh** will become Clinical Director for the Division of Clinical Support Services (Anaesthesia), replacing **Ed Djabatey** from December. Ed Djabatey is stepping down from his role as Clinical Director but will remain in his role as a Consultant Anaesthetist.*

Access restrictions due to Neonatal Unit redevelopment: There will be restricted access and disruption whilst the building work commences for the redevelopment of the Neonatal Unit over the next few weeks and months. The Trust website will detail the restrictions so that all staff, patients and visitors will be made aware. The following is the current position although this may change.

- The rear entrance doors of the main hospital are due to be closed from Monday 3rd December for approximately 12 months.
- Ambulances are being diverted to the side entrance next to the main hospital entrance as a permanent solution for the ambulance entrance from Monday 3rd December onwards. There will be some minor footpath adjustment works in this side entrance area over the coming weeks.

- There is likely to be increased congestion on site over the next few weeks due to construction lorry access/deliveries so please bear this in mind when entering and leaving the site as it may impact on your journey time.
- To increase traffic flow on site, patients, visitors, and staff are welcome to use the Mulgrave Street car park temporarily during periods of significant congestion so please consider this if you are struggling to access parking on the main site.
- Signage will be in place across all affected areas to provide clear wayfinding and information on the hospital site.

Visual plans of the Neonatal re-development can be viewed from the Trusts website.

SECTION B – Local

Salford Royal Foundation Trust: Sir David Dalton has announced he will retire as chief executive of Salford Royal Foundation Trust and Pennine Acute Hospital Trust (PAHT) in March 2019. Sir David is one of the longest serving chief executives in the provider sector and was *HSJ*'s chief executive of the year for three successive years to 2016. He has led Salford Royal for 18 years, and PAHT for three years. The two trusts are set to merge under a new "group" structure named the Northern Care Alliance.

North West Ambulance Service announces new Chief Executive and CQC report: Following the retirement earlier this year of North West Ambulance Service (NWAS) Chief Executive, Derek Cartwright; NWAS has announced the appointment of Daren Mochrie who will be joining NWAS in spring of next year. Daren Mochrie, currently the Chief Executive of South East Coast Ambulance Service, was appointed following an intensive recruitment process which took place in the summer, involving commissioners, non-executive directors and external representatives. Daren Mochrie has worked for the NHS since the age of 17. He has extensive experience of managing ambulance services in both rural and urban settings. Prior to joining South East Coast Ambulance Service he was Director of Operations for the Scottish Ambulance Service and the lead for ambulance provision in the 2014 Commonwealth Games in Glasgow. Daren Mochrie has also held the position of specialist advisor with the Care Quality Commission (CQC), leading four recent CQC inspections of ambulance trusts in England.

North West Ambulance Service NHS Trust has been rated as 'good' following its latest inspection from the healthcare regulator, Care Quality Commission (CQC), after receiving 'requires improvement' during its first official inspection two years ago (press release attached)

The Clatterbridge Cancer Centre ("CCC"): CCC has recently published its strategic plan 2018-2022 and aspirations to 2027. This can be found on CCC's website at https://www.clatterbridgecc.nhs.uk/about-centre/corporate-matters/public-documents/forward-planning.The attached letter articulates the direction of travel CCC is following.

Liverpool Health Partners: Liverpool Health Partners has appointed Dr Dawn Lawson as Chief Executive Officer. Dr Lawson, who has a PhD in health psychology and a Masters' in Public Administration, has a wealth of experience working in research and innovation across academia and the NHS.

Liverpool Provider Alliance: The MOU between providers within the Liverpool Provider Alliance has now been finalised and agreed by all the parties to the MOU to collaborate to deliver the Liverpool Provider Alliance Plan in support of the One Liverpool plan. The most recent newsletter for October 2018 is attached for information.

C&M Carter at Scale: Benchmarked performance across the region was analysed with reference to back-office functions of finance, governance and risk, HR, IM&T, legal services, procurement and payroll. At the meeting it was agreed that across the region, a joint payroll service could deliver savings and a subgroup will be established to progress this item. Discussions were also held around a greater collaboration with respect to procurement.

Northwest Genomics Strategic Partnership Board: The Medical Director attended the November 2018 Strategic Partnership Board on behalf of the Trust. There was a good sense of partnership evident with an acknowledgement that significant volumes of work would continue to be delivered in Liverpool for the foreseeable future. The terms of reference and membership of a Clinical Advisory Board were agreed, which included a significant presence of senior clinical, academic and scientific personnel from Liverpool. A discussion was held around the need for clinical engagement with respect to HODS DNA samples potentially being processed centrally in Manchester, with reassurance needed that patients in Liverpool would not be disadvantaged. A brief financial update was also received with challenges noted ahead. There was agreement centrally that no changes would be made to funding amounts for the delivery of genomic testing prior to April 2019. A mobilisation fund had been provided by NHSE, amounting to £1M for the part year up to April 2019 and £2M for the full year 2019/2020.

NW Medical Directors' Forum (November 2018): The Medical Director attended on behalf of the Trust. Items discussed included the UoL request for an increase in students' face to face time with consultants, which the Trust had already complied with. An innovative app-based locum booking service for doctors across all specialties was demonstrated at the meeting. This had been introduced in the South of England across a number of trusts, with significant savings gained. If adopted region-wide, the service would provide wider access to potential locum staff, at trainee and Consultant grades.

SECTION C – National

NHS Providers: Briefing on Wholly Owned Subsidiaries: NHS Improvement (NHSI): NHSI has published an addendum to its transactions guidance, detailing its regulatory approach to wholly owned subsidiaries. This follows a consultation carried out by the regulator in October 2018. The new rules come into effect immediately and apply to both NHS trusts and foundation trusts. The attached briefing summarises the new approach to regulating subsidiaries and includes an NHS Providers press statement.

Performance of the NHS provider sector, June to September 2018: NHS Improvement has published the latest financial and operational performance data for NHS trusts, as well as data on nursing and medical staff vacancies. The data will cover the period of 1 June to 30 September 2018 ('quarter two') and explores how well the NHS in England has cared for patients and managed its finances in one of the most challenging summers it has ever experienced Quarterly performance of the NHS provider sector: quarter 2 2018/19 | NHS Improvement.

Between July and September 2018, hospitals admitted more emergency patients and discharged more patients from their services sooner. However, largely due to the increase in demand, waiting times for planned treatment increased and the sector was £1.23 billion in deficit at the end of the quarter.

Key findings between July and September 2018:

- There were 940 more emergency admissions per day compared to the same quarter last year. A total of 6.18 million people visited A&E during the quarter — 252,360 (4.3%) more than the same period last year. NHS staff treated more emergency patients within the four-hour A&E standard — 5.52 million patients, compared with 5.34 million for the previous quarter.

- Largely due to the increase in demand, the sector was £1.23 billion in deficit at the end of September. Trusts have identified further savings they can make throughout the year and are therefore planning to end the year £80 million better than they were at the start of the financial year. At the of the year the sector forecasts a deficit of £558 million.
- As reported last quarter, the sector's 'underlying deficit' has been reported by trusts as £4.3 billion. This is the financial position of the sector without one-off savings such as selling off land or non-recurrent funding such as the Provider Sustainability Fund (PSF). The Provider Sustainability Fund (PSF) has been primarily allocated to trusts to support the delivery of emergency care for the last two years. If this funding is treated as recurrent, the underlying deficit reduces to £1.85 billion.
- Hospitals freed up the equivalent of 682 beds by improving discharge arrangements for patients whose discharge was delayed. So far this year, hospitals freed up the equivalent of 2,470 beds that were occupied by patients that had been in a hospital bed for more than three weeks.
- High A&E demand meant that people had to wait longer for planned treatment. The number of people waiting more than a year for treatment at the end of September was 3,156, compared to 1,778 for the same period last year.
- The number of vacancies across NHS trusts fell to 102,821 at the end of September, from 107,463 at the end of June.
- NHS trusts have saved £1.2 billion from their budgets by becoming more efficient, such as by moving from using agency staff to NHS bank staff, and through better procurement for everyday items like syringes and disposable gloves.

Ian Dalton, Chief Executive of NHS Improvement said: '*The NHS is working flat out to ensure record numbers of patients get the care they need. Frontline staff and managers deserve tremendous praise for their heroism. But this achievement continues to come at a cost with performance targets not being met nationally and hospitals being unable to balance their books to cover the increased demand on their services. The Long Term Plan is our opportunity to fundamentally redesign how the NHS works so that it can continue to provide high-quality care for patients.*'

Attachments

27 November 2018

OUTSTANDING WORK BY PARAMEDICS HELPS NORTH WEST AMBULANCE SERVICE NHS TRUST ACHIEVE GOOD CQC RATING

North West Ambulance Service NHS Trust has been rated as ‘good’ following its latest inspection from the healthcare regulator, Care Quality Commission (CQC), after receiving ‘requires improvement’ during its first official inspection two years ago.

The improved rating comes after an inspection of the trust in June 2018 and resulted in an overall rating of ‘good’ as well as ‘good’ ratings for three of the trust’s core services; urgent and emergency care, emergency operations centres and resilience teams. The service’s patient transport service and NHS 111 service were not inspected so their rating remains ‘good’.

Alongside ratings for the trust’s core functions, CQC asked ‘is the service well-led, safe, effective, caring and responsive?’ NWAS was rated ‘good’ in all areas which means inspectors found evidence that safety and leadership at the trust had improved since its last inspection in 2016.

Highlights from the inspection include the observation by CQC of polite, caring and respectful frontline ambulance staff, holding the hands of patients who were scared and acting with compassion and respect towards patients. In the emergency operations centres, CQC saw that staff demonstrated compassion, kindness and respect towards callers and patients, including those in mental health crisis.

Ambulance staff demonstrated a genuine desire to help people in need and understood the anxieties of patients and families who received treatment or were in ambulances to support loved ones.

CQC saw clear processes in place so that staff looked after each other’s welfare too. There was a strong emphasis on the safety and wellbeing of staff both in operational management and at senior management level.

All staff CQC spoke to said they were proud of their profession and felt that this was reflected in them providing good quality care.

Improvements in the culture of the organisation were recognised with CQC finding that NWAS staff overall felt valued and listened to and had a voice in the organisation. This was helped by the introduction of senior paramedic team leaders (SPTLs) to support and advise ambulance crews.

Clinical staff were found to be well supported to deliver effective care and treatment. Whilst at an incident they could contact the trust's clinical support hub using their mobiles, or speak to an advanced paramedic on their personal radios, or through the control rooms.

CQC also found the service follows evidence based practice and provided safe care and treatment. Innovation was encouraged and staff were supported to join national improvement groups to influence changes in protocols, processes, equipment and training.

Outstanding practice was noted where community specialist paramedics worked as members of multidisciplinary teams with community nurses, mental health nurses, doctors and teachers amongst others, and in care homes on preventative measures aimed at reducing the number of admittances to emergency departments.

An internal educational publication for clinical staff called 'CLEAR Vision' and the trust's 'Invest in Yourself' health and wellbeing programme were found to be outstanding practice too.

CQC said that highly effective working relationships with partner agencies such as the police and fire were outstanding in the trust's resilience function which incorporates two of England's dedicated hazardous area response teams which comprise of paramedics with special training to provide care in the event of a major incident such as a terrorist attack.

Good levels of cleanliness, hygiene and infection prevention and control in ambulance stations and on vehicles were witnessed too.

Interim Chief Executive at North West Ambulance Service, Michael Forrest, said: "We are delighted with a 'good' rating from the Care Quality Commission which we feel reflects the way we deliver services for patients and values the dedication of our hardworking staff who work under ever increasing demand.

"CQC said that our staff are proud to work for the organisation, and we're extremely proud of them too! We are thrilled CQC noticed the high levels of care by our frontline staff, where patients were treated with respect and compassion.

“We are particularly happy with improved ‘well-led’ and ‘safe’ ratings, and that CQC noted staff were engaged with our strategic vision to do the right thing for every patient, every time.

“There’s still a lot of work to do to achieve our aim of becoming the best ambulance service in the country, but this rating assures us, and the people we serve in the North West, that we’re heading in the right direction.”

In term of improvements, the regulator said NWAS should improve systems to ensure vehicles are safe, clean and ready to go, ensure consistent performance measurement and monitoring across the trust and standardise care for patients with mental health issues as staff knowledge was found to be varied.

CQC also identified a need to improve engagement with other local services so the trust can contribute to the development of strategy reviews.

View the full report at www.nwas.nhs.uk/cqc.

NHS
The Clatterbridge Cancer Centre
NHS Foundation Trust

Clatterbridge Road
Bebington
Wirral
CH63 4JY

Tel: 0151 556 5000
Web: www.clatterbridgecc.nhs.uk

AF053/18/SJ

19th November 2018

Dear Colleagues

Strategic Direction 2018-2022

We are delighted to share The Clatterbridge Cancer Centre's Strategic Direction, 2018-2022, approved by the Board, last month. This sets out an ambitious programme of change for the next four years and beyond. This is now available on our website:

https://www.clatterbridgecc.nhs.uk/about-centre/corporate-matters/public-documents/forward-planning

This direction of travel builds on the excellent work developed by our teams and our partners across Cheshire & Merseyside. This positive collaborative approach will enable The Clatterbridge Cancer Centre to realise the opportunities to transform our models of care to meet the challenges which we face within the changing NHS and deliver better outcomes, experiences and efficiency for our patients and our 2.4 million population.

This direction of travel has been strengthened to take account of the prominent themes arising from the engagement (from staff and partners), the key themes are :

- Clearer articulation of the benefits of our new clinical model.
- Increasing profile of our work leading change across the system in both care models and research.
- Our leadership role in the development of a ten-year plan for cancer services across C&M.
- Our research collaborations locally, regionally and more widely.
- Our leadership role in system-wide initiatives, including palliative care and lead cancer nursing.
- Articulating how our new hospital contributes economic and social value to the local economy.
- Increasing the profile of our digital transformation programme.
- Increasing our profile of our highly innovation and high quality outcomes.
- Our commitment to explore the development of a comprehensive education and training.

Thank you for your feedback and support and we look forward to continuing to work in partnership to realise the benefits for our patients and population.

Yours sincerely

Ann Farrar
Interim Chief Executive

Phil Edgington
Chair

Enc.
Strategic Direction 2018-2022

cc.
Sheila Lloyd, Director of Nursing & Quality
Sheena Khanduri, Medical Director
Barney Schofield, Director of Transformation and Operations
John Andrews, Acting Director of Finance
Jenny Grant, Head of HR and OD

Liverpool Provider Alliance

Newsletter

October 2018

INTEGRATED CARE TEAM PILOTS

Aintree and Childwall have been selected as pilot neighbourhoods for testing components of an enhanced integrated model of community care. These sites are currently using standard quality improvement methodology engaging: GPs, voluntary sector, social care and existing neighbourhood teams in each area, to test out areas that have previously been identified as requiring improvement.

Aintree pilot is currently testing out how current community services can work differently together. For example, looking at the role of the social worker/assistant social worker, district nursing referral processes, single point of contact arrangements etc. The Aintree neighbourhood team is also looking at social prescribing and neighbourhood profiles so that the principle of maximising community assets is realised for the population living in Aintree.

Lead GP supporting Aintree pilot is Dr Mark Wigglesworth.

Childwall pilot area is currently working with social care to look at how best to integrate social workers within the health team. This pilot is currently looking at potential co-location opportunities as well as MDT processes being reviewed. Meet and greet session have commenced so health and social care colleagues can really get to know one another better. Social workers now attend safety huddles as a consequence of this work. Childwall is also looking at the development of an enhanced social prescribing offer in the neighbourhood by developing an electronic platform for the population.

Lead GP supporting Childwall pilot is Dr Lucy Joyes.

TRANSFORMATION FUNDING SECURED

The Alliance has secured an additional £500k non-recurrent funding from the Cheshire and Merseyside Transformation Fund to support implementation of our new community model of care. This will be used to undertake bespoke neighbourhood level analytics, identify those people that will most benefit from early intervention, engage with local people about the compact between them and services and develop a city-wide digital platform for social prescribing.

This bid follows in the success of a wave one bid which has brought £410k non-recurrently to support the pilot implementation of the community integrated care teams.

COMMUNITY AND VOLUNTARY SECTOR LEADERSHIP

Following an initial engagement event held in the Women's Organisation on 13 July, a Voluntary Sector Leadership Group has been established, led by Helen Millne from the Women's Organisation. The group has subsequently met on two occasions and will be developing a proposal in relation to social innovation for consideration by the Provider Alliance.

EVALUATION OF THE NEW MODEL OF CARE

We are in discussion with academic partners regarding the evaluation of the new community model of care, making use of an action research approach. More information to follow once the approach is confirmed.

Liverpool Provider Alliance Newsletter

October 2018

CARE HOME IMPROVEMENT STRATEGY

All partners are working together to improve the quality and safety of care homes in Liverpool. We have held two workshops in September and October with care home staff and care home managers looking at how we can improve health in-reach to support residents and staff.

A new Care Home Delivery Group has also been established to review the care home health model pilots that have previously been in place, for example West Derby, and to develop a proposal for an enhanced standardised health care model for the Provider Alliance to consider.

PROVIDER ALLIANCE WORKING/ SUBGROUPS

A small number of working groups have been established to support the delivery of the Provider Alliance Plan:

- **Delivery group** - focussed on implementation of provider alliance plan, particularly integrated care teams and supporting work
- **Governance working group** (time limited)- agreeing reporting arrangements and mapping relationships with other system groups
- **Transformation fund steering group** (wave 2) - delivery of the proposals funded within the bid
- **Community and Voluntary Sector Leadership Group.**

We will keep these groups under review in order to streamline the way we work and keep meetings to a minimum.

ESTABLISHING COMMUNITY RESOURCES BASELINE

Liverpool CCG has commissioned analysis to support the alliance in establishing the baseline level of community team resources at neighbourhood level. Using data from community physical and mental health services and social care, this baseline data will support future decisions about resourcing within the community teams and in identifying opportunities for efficiency.

PAEDIATRIC DATA ANALYSIS

Bespoke analysis has been commissioned to support this Alliance work stream, led by Louise Shepherd and Mags Barnaby, Alder Hey, and an update will be brought to the Alliance meeting in January 2019.

STRATIFY - POPULATION HEALTH ANALYSIS

We are in discussions with PWC regarding a test of concept in the use of their Stratify Population Health Analysis tool, which is part of their Artificial Intelligence (AI) Health Suite. In the first instance we propose making use of community data, with a potential expansion to wider system data following discussions at the Alliance meeting in October 2018. For more information contact: Wes.baker@merseycare.nhs.uk

CONTACT S:

For general queries about the Provider Alliance, please contact Helen Bennett, Deputy Director of Strategic Planning and Intelligence at Mersey Care – Helen.bennett@merseycare.nhs.uk

For queries regarding the implementation of the community model of care, please contact Pat McGuinness, Deputy Director of Integration at Mersey Care – Pat.mcguinness@merseycare.nhs.uk

Regulatory approach to wholly owned subsidiaries: on the day briefing

NHS Improvement (NHSI) has published an addendum to its transactions guidance, detailing its regulatory approach to wholly owned subsidiaries. The process detailed in this document applies to both trusts and foundation trusts looking to establish a wholly owned subsidiary, or those looking to changing an existing subsidiary company. The new rules come into effect immediately from 26 November 2018 and NHSI will begin reviewing trust plans that are currently paused.

The regulatory approach will be reviewed within a year. If you have any questions about our work in this are or would like to share your experience of the regulatory process, please contact david.williams@nhsproviders.org and adam.wright@nhsproviders.org.

Key changes to the process

- The creation of all wholly owned subsidiaries (WOSs), and 'material changes' to existing WOSs, are now reportable to NHSI.
- Trusts will be required to submit board-approved business cases detailing the proposals, the underlying financial projections and inherent risks to the regulator.
- An NHSI panel review will deem whether a planned WOS is 'significant' or 'material' based on the inherent risks of the proposal. The outcome of this review will determine what level of oversight and review NHSI will next seek from a trust.
- NHS trusts will also need to demonstrate that its WOS proposal will generate additional income. This will involve a further submission to the Department of Health and Social Care (DHSC).
- A WOS proposal deemed as 'material' will require the submission of a trust board certification confirming that the board has satisfied itself in relation to the inherent risks.
- A 'significant' WOS proposal will require a board certification alongside a more detailed review covering four key domains: strategy, transaction execution, quality and finance.
- Once the detailed review of a 'significant' WOS proposal is complete, NHSI will assign a risk rating which will determine how much NHSI oversight it will be subject to as it proceeds.
- If a proposal is rated as 'red' the trust will be required to restructure the proposal to address the risks concerned. NHSI will look to use its regulatory powers to stop a transaction if required.
- NHSI has committed to reviewing the approach within a year, and intends to align with the existing transactions guidance once there is a better understanding of the inherent risks of subsidiary proposals.

Guidance overview

Panel review process

Any NHS trust or foundation trust looking to establish a WOS, regardless of its size, will now have to report its plans to NHSI. This is also true for trusts looking to establish joint ventures and partly owned subsidiaries that operate as separate and distinct legal entities from trusts (in terms of taxation, regulation and liability).

Trusts will now have to submit a board-approved business case alongside its underlying financial projections and inherent risks to NHSI. These are reviewed by an NHSI panel that will include governance, finance and subject matter experts, as well as members of NHSI's transactions review team. In some cases, trusts will be able to challenge and refuse particular experts.

NHSI will determine the level of scrutiny for a WOS once it has determined the level of inherent risk in the proposal. NHSI will inform a trust of the key risks it has identified, and will classify lower risk transactions as 'material' and higher risk transactions as 'significant'. The panel review should take around three weeks.

Material versus significant

Material

Lower risk WOS proposals will be deemed 'material' and will require the submission of a new and amended trust board certification. The board certification will require the trust to consider WOS plans within wider system plans, and will require a commitment to detail the WOS commercial strategy independent of VAT. This is not something currently required of trusts for other types of transactions.

Trusts may also be required to provide additional evidence on an ad hoc basis. A trust will not be able to establish its subsidiary until NHSI has approved its board certification.

Significant

If the initial panel review deems a WOS proposal to be 'significant', NHSI will scrutinise the plans further. In addition to submission of a trust board certification, a further detailed review will be undertaken across four domains:

- Strategy - *is there a clear strategic rationale for the subsidiary transaction and is the trust board assured that there is the capability, capacity and experience to deliver the strategic objectives of the transaction?*
- Transaction execution - *are the trust and the subsidiary able to execute and implement the transaction successfully?*
- Quality - *is quality maintained or improved as a result of the subsidiary transaction?*
- Finance - *does the transaction result in a financially viable trust and subsidiary?*

NHSI may also undertake a detailed review of the financial projections and will interrogate underlying assumptions and key risks to financial forecasts.

This detailed review will involve interviews and meetings with the trust and other key stakeholders involved in the subsidiary. Toward the end of the review, NHSI will also look to meet or speak with appropriate executives from the trust board.

NHSI intends for the review to last no longer than six weeks. Once the trust has had the ability to respond to the detailed review, NHSI will assign a risk rating of 'green' or 'amber', with the latter meaning the plans will require additional oversight and monitoring as they proceed. If a proposal is rated as 'red' the trust will be required to restructure the proposal to address the risks concerned. NHSI will look to use its regulatory powers to stop a transaction if required

Additional requirements for NHS trusts

Under the NHS Act 2006, NHS trusts are only allowed to establish a subsidiary company to generate additional income. This means that any NHS trust WOS must be profitable, with all profit invested into improving health services. Existing guidance also states that income should be generated *outside* of the NHS and not from the delivery of core healthcare provision. NHSI has asked trusts not to seek legal advice on this aspect.

NHS trusts will therefore also need to submit a business case to the secretary of state for health and social care for approval. Proposals will need to demonstrate the WOS is able to generate additional income for the trust, and consent will be given on a case-by-case basis. Further guidance will be published shortly, involving next steps and timescales. It's not yet clear whether the NHSI review will take place before the Department of Health and Social Care undertaking. NHS trusts cannot establish a WOS until consent has been given by the secretary of state.

Material changes to existing subsidiary companies

The process detailed in the addendum does not apply to existing subsidiaries, but NHSI does intend to apply this approach to any trust seeking to make a 'material change' to an existing subsidiary company. A 'material change' has not yet been defined, however NHSI recognise they will need to provide further clarification on this.

A panel review process, as detailed above, will take place for subsidiaries that will be 'materially changed'. But for existing subsidiaries, the panel will consider the extent to which the current trust and subsidiary governance process may mitigate against risk.

Next steps

NHSI do not intend for the establishment of all subsidiaries to remain reportable, and in future may set a 'bar' for when proposals should be reported. There is also an intention to set clearer parameters over the

level of review required for those WOSs deemed reportable, and clarify expectations over the risk rating system. NHSI therefore plans to review this new regulatory approach after one year and possibly align the process with the existing transactions guidance. We will look to ensure that trusts play a full role in this review to ensure it is fit for purpose and proportionate.

NHS Providers press statement

The deputy chief executive of NHS Providers, Saffron Cordery said:

"The guidance for overseeing the creation of wholly owned subsidiaries (WOSs) set out today by NHS Improvement rightly acknowledges that WOSs are an appropriate, legitimate and innovative way for NHS trusts to meet the challenges they face. Trusts can and should have the option to set up these entities where there is a proven need.

"Our response to the consultation on this guidance, like that of many other respondents, warned that the regulation and oversight of WOSs must therefore be proportionate and not undermine the benefits they can bring to the sector.

"We are concerned that the level of detail and the steps outlined in the new review process go a long way beyond what is normally expected of trusts and what is required for other transactions and commercial activities. There are many reasons why a trust may choose to establish a WOS. These go well beyond just making tax savings. The process NHS Improvement is choosing to adopt here sets the bar too high and introduces an unwelcome extra administrative burden into the sector. There is a danger that trusts will abandon innovative WOS plans and instead look to less preferable alternatives.

"Many will also see this guidance as part of a worrying trend where the decision making power and autonomy of trusts and foundation trust boards continues to be eroded with more and more control shifted towards the centre. Unitary trust and foundation boards, working as part of local systems, are fully and legally accountable for the services their trusts deliver for good reason – they are in the best position, by far, to ensure that high quality care is provided to the communities their trusts serve. The task of arms length bodies is to support and enable provider boards to fulfil these responsibilities, not unnecessarily restrict them from doing so.

"We welcome the commitment to eventually align the WOS review process with existing transactions guidance. But this should happen as soon as possible. Trusts need a clear understanding on these regulatory requirements.

"Finally, we are pleased that NHS Improvement remains committed to reviewing this process within a year. Trusts must play a full role in any such review."

Ends.

Liverpool Women's NHS Foundation Trust

Board of Directors

Committee Chair's report of Finance, Performance and Business Development Committee meeting held 26 November 2018

1. Was the quorate met? Yes

2. Agenda items covered

- ~ **Operational Performance Month 6 2018/19 including RTT and Cancer Targets:** The Committee received Month 7 performance dashboard and noted the trust's performance for RTT and Cancer. The Committee received assurance on the performance of the outsource organisation Medinet who had undertaken weekend clinics at the Trust. Friends and Family survey results had been very good and Trust staff had not identified any concerns. The Committee had noted that clinical outcomes and conversion rates would be monitored to make sure the use of Medinet was effectively managed. The Committee had requested an update on the review of clinical resource availability and received assurance that a report on the resourcing gap within Gynaecology was being prepared and would be available to the Committee and Board following review by the Executive team.
- ~ **Finance Performance Review Month 7 2018/19 including CIP:** The Committee received Month 6 2018/19 finance position and received assurance that the trust was on target to deliver the control total set by NHSI assuming receipt of £3.6m of PSF.
- ~ **Strategic Outline Case Update:** The Committee received a status update on the trust's capital bid which had been submitted via the STP in May 2018. An announcement was expected in November 2018.
- ~ **Review IM and T:** The Committee received a status update on the EPR Programme. The Committee noted the challenges faced, the actions being taken and proposals to move forward. There was recognition that there had been no significant movement in the EPR programme since the last meeting.
- ~ **Review Marketing Strategy:** this item was held over to the November meeting.
- ~ **Treasury Management Quarterly Report:** The Committee had received assurance that Trust continued to manage cash appropriately and that aged debt was being controlled. The Committee agreed a cash reserve of 15 days expenditure.
- ~ **Information Governance Update:** the Committee received assurances regarding the Trusts compliance with GDPR and whilst some work continues the essential work had been completed. The Committee received an update on the Trust's introduction of the Data Security and Protection (DSP) Toolkit, which superseded the Information Governance Toolkit. The Committee heard that the DSP Toolkit, released in June 2018, was 'bedding in' and that overall compliance against it was not yet known. The Committee were re-assured that the Trust would be able to report compliance at the financial year end given that for the last two years it had achieved 'Significant Assurance' in its most recent annual Information Governance Toolkit audit and was ISO9001, ISO22301 and ISO27001 compliant.
- ~ **EPRR Core Assurance Framework:** The Committee reviewed the report and requested additional information in support of the assurances provided in the self-assessment. This would be provided to the next meeting of the Committee in November.

- o **Sub Committee Chairs reports received:**
  - o Turnaround and Transformation Committee held 17th September 2018 and 1st October 2018
  - o Emergency Planning Resilience and Response Committee held 1st October 2018
  - o Information Governance Committee held on 28th September 2018

NHS

- Digital Hospital Sub-Committee held 28th September 2018

The Committee noted and approved the above Chairs reports of its reporting sub-committees.

3. Board Assurance Framework (BAF) risks reviewed

~ The Committee reviewed the BAF risks it is responsible for on behalf of the Board. No changes were recommended.

4. Escalation report to the Board on FPBD Performance Measures

~ None.

5. Issues to highlight to Board

~ None.

6. Action required by Board

~ None.

Jo Moore
Chair of FPBD
October 2018

Liverpool Women's NHS Foundation Trust

Board of Directors

Committee Chair's report of Finance, Performance and Business Development Committee meeting held 26 November 2018

1. Was the quorate met? Yes

2. Agenda items covered

~ **Operational Performance Month 7 2018/19 including RTT and Cancer Targets:** The Committee received Month 7 performance dashboard and noted that RTT performance has improved by 1% and was reporting a performance rate of 87%. The Committee noted that capacity continued to remain a problem due to consultant vacancies; however the Committee was assured that the Trust was doing all it could to address this and noted that two new locum consultants had joined the Trust in October which would provide the much needed capacity particularly in Hysteroscopy and general Gynaecology. The Committee noted that the outcomes from the clinics undertaken by Medinet had been reviewed by the Trust and no concerns raised. Any future use of Medinet would be considered if the Trust were unable to provide clinical capacity. The Committee noted that the waiting lists for Urogynaecology was a concern and noted the actions taken by the Access Board to extend polling range from 6 weeks to 10 weeks. The Committee received an update on delivery of the Cancer targets and noted that they remained a challenge. Delays in Histology results from an external provider had resulted in delays in diagnosis. The Committee noted the actions taken to address the delays. The Committee noted that the Trust was unlikely to deliver all its Cancer targets by the financial year end.

~ **Finance Performance Review Month 7 2018/19 including CIP:** The Committee received Month 7 2018/19 finance position. It was noted that at Month 7, the Trust was reporting a year to date deficit of £0.8m against a deficit budget of £2.2m. The Committee noted that whilst the Trust-wide financial position remains ahead of plan year-to-date; activity continues to be lower than plan. The Committee reviewed the BAF risks and agreed to the changes recommended in the paper. With regard to the current risk level for the delivery of the annual plan the Committee agreed to reduce the risk score to 20 by reducing the likelihood of the risk from 5 to 4. The committee noted that the risk score for delivery of the annual plan was expected to continue to fall as the Trust moved towards 31 March 2019.

~ **CIP Post Implementation Review 2018-19:** The Committee received the mid-year review, noting schemes with elevated or potentially elevated risk and those having a positive impact. The Trust was forecasting delivery of the full £3.6m cost improvement programme target, equating to a recurrent saving equivalent to 1.5% of expenditure budgets, however £2m of this was on a non-recurrent basis. The Committee were assured that plans were in place to monitor and review schemes which were not delivering. The Committee was also assured that lessons learned from the last review were in place.

~ **Operational Plan and Corporate objectives 6 Monthly Review:** The Committee received a presentation from Director of Operations and Director of Finance relating to the Trusts 6 month review of its delivery of the Operational Plan 2018/19. A paper and or presentation would be provided to the Board at its meeting on 7 December 2018 together with the 6 montly review of the corporate objectives.

~ **2019-20 Planning Assumptions:** The Committee received the 2019/20 planning assumptions and noted that was still some uncertainty surrounding the many changes to the financial regime and how this would impact on the Trust. The Committee noted that this uncertainty is exacerbated by

the Trusts activity under performance against the block activity and the ongoing resource impacts whist the Trust remained on the Crown Street Site. The Committee noted that further national guidance would be provided from NHSI in due course.

~ **Strategic Outline Case Update:** The Committee received an update on the timing of the decision for the capital funding for the proposed new build and noted that the timing of the decision had moved to a date to be determined in December 2018.

~ **Review IM and T – Implementation of Business Case (EPR):** The Committee received a presentation from the Chief Information Officer, outlining progress to date and current levels of risk to implementation. The committee was briefed on the next steps.

~ **Review Marketing Strategy:** The Committee received a review of the Marketing Strategy and Communications Performance Dashboard for April-September 2018 from the Head of Communications, Marketing and Engagement. The Committee was assured that there are 20 main activities being undertaken which show achievement of the 2018-19 objectives to date.

~ **EPRR Core Assurance Framework:** The Committee received assurance of the Trust's EPRR self-assessment undertaken in October 2018 and noted the level of compliance with NHSE core standards. The Committee agreed that the Trust's performance against the national standards would be presented to the Board at the December Board meeting.

o **Sub Committee Chairs reports received:**
  - o Turnaround and Transformation Committee held 15th October, 29th October and 12th November 2018
  - o Emergency Planning Resilience and Response Committee held 5th November 2018
  - o Digital Hospital Sub-Committee held 26th October 2018

The Committee noted and approved the above Chairs reports of its reporting sub-committees.

3. Board Assurance Framework (BAF) risks reviewed

~ The Committee reviewed the BAF risks and agreed to the changes recommended in the paper. With regard to the current risk level for the "delivery of the annual plan 2018/19" the Committee agreed to reduce the risk score to 20 by reducing the likelihood of the risk from 5 to 4 and recommends this to the Board for approval.

4. Escalation report to the Board on FPBD Performance Measures

~ Non-delivery of the 62 day cancer targets by the financial year end due to external what?

5. Issues to highlight to Board

~ The Committee noted that the Trust was unlikely to deliver all its Cancer targets by the financial year end.

6. Action required by Board

~ None.

Jo Moore
Chair of FPBD

2018/286(i)

Board of Directors

Committee Chair's report of Quality Committee meeting held 23 October 2018

1. **Chaired by** Phil Huggon

2. **Was the quorate met?** Yes

3. **Agenda items covered**

~ **Subcommittee Chairs Reports:**
- Safety Senate held 12 October 2018
- Effectiveness Senate held 19 October 2018
- Experience Senate held 9 October 2018
- Corporate Risk Committee – 25 September 2018

The Committee noted and approved the above Chairs reports of its reporting sub-committees.

~ **Quality & Regulatory Improvement Requirements:** The Committee noted and reviewed the contents of the update as to progress made. It was noted that an issue had arisen in maternity relating to delays to telephone calls being answered from patients. The Committee was assured that necessary steps were being taken to address this operationally and that a technical solution had been identified and would be implemented.

~ **Legal Services Annual Report 2018**. The Committee received the Legal Services Annual Report 2018 which had already been reviewed by the Safety Senate. The Committee noted the downward trend in claims being received due to improved clinical practices and the positive contribution of PALs and PALs+.

~ **Monthly Quality Performance Review M6 2018/19:** The Committee received Month 6 Performance Dashboard and noted the contents of the report. The Committee noted that additional weekend clinics provided by Medinet to improve capacity was reported to be going well. Patient and staff feedback was positive. The Committee had agreed that it further reporting on Medinet performance should be presented to the Committee to inform on any future in-house requirements given the difficulties the Trust was finding in recruiting gynaecology consultants.

~ **Serious Incidents & Learning Reports Q2:** the Committee received the Q2 Serious Incidents & Learning Report, noting the actions and learning taken. The Committee received assurance that the divisional Boards were reviewing how serious incidents were categorised so that learnings from incidents not classified as serious could be garnered.

~ **Q2 Mortality Report:** The Committee received and considered the Q2 Mortality Report noting that the report would be presented to the December Board meeting due to the Board workshop in November.

~ **National In-patient Survey – Maternity:** The Committee received and noted the contents of the Report. The Committee raised a number of questions regarding the outcomes of the survey which would be taken offline and benchmarked.

4. **Board Assurance Framework (BAF) risks reviewed**

The Committee reviewed the quality related BAF risks it is responsible for on behalf of the Board and agreed that no changes would be made.

5. Escalation report to the Board on Quality Committee Performance Measures
None

6. Issues to highlight to Board
None

7. Action required by Board
The Board would receive the Q2 Mortality Report at its meeting on 7 December 2018.

Chair of Quality Committee

Liverpool Women's NHS Foundation Trust

Board of Directors

Committee Chair's report of Quality Committee meeting held 26 November 2018

1. Was the quorate met? Yes

2. Agenda items covered

~ Subcommittee Chairs reports:
   - Safety Senate held 9 November 2018
   - Effectiveness Senate held 16 November 2018
   - Experience Senate held 9 October 2018
   - Corporate Risk Committee 15 November 2018

   The Committee noted and approved the above Chairs reports of its reporting sub-committees.

~ Quality & Regulatory Improvement Requirements: The Committee received assurance on the progress against the CQC inspection action plan, and noted that ongoing focused work was required with service leads to ensure the completion of the recommendations.

~ Monthly Quality Performance Review M7: The Committee noted the contents of the Monthly Quality Performance Report and received an update in delivery of the RTT and Cancer targets. The Committee noted that RTT performance had improved by 1% and was reporting a performance rate of 87%. The Committee noted that capacity continued to remain a problem due to consultant vacancies; however the Committee was assured that the Trust was doing all it could to address this and noted that two new locum consultants had joined the Trust in October which would provide the much needed capacity particularly in Hysteroscopy and general Gynaecology. The Committee noted that the outcomes from the clinics undertaken by Medinet had been reviewed by the Trust and no concerns raised. Any future use of Medinet would be considered if the Trust were unable to provide clinical capacity. The Committee noted that the waiting lists for Urogynaecology was a concern and noted the actions taken by the Access Board to extend polling range from 6 weeks to 10 weeks. The Committee received an update on delivery of the Cancer targets and noted that they remained a challenge. Delays in Histology results from an external provider had resulted in delays in diagnosis. The Committee noted the actions taken to address the delays. The Committee noted that the Trust was unlikely to deliver all its Cancer targets by the financial year end.

~ National Patient Survey – In-patient – Cancer: The Committee noted the contents of the survey, presented by Chris Webster, Lead Cancer Nurse. The Committee was assured that recommendations in the CCG action plan were complete and noted the progress of the Quality Improvement Checklist.

~ Patient Walk-around Proposal: The Committee received a proposal for a Patient Safety Walk-around from the Head of Governance. The Committee agreed to ask Executive Team to consider this further, weighing the benefits against the risk of duplication.

~ Integrated Governance Assurance Report Quarter 2 2018/19: The Committee received the report noting the level of incidents and thematic trends, and was assured as to the governance systems in place.

NHS

- **Review of Quality Strategy Quarter 2 2018/19:** The Committee noted progress made against the Quality Strategy and the revised action plan.

- **Review of Equality and Human Rights Goals 1&2, Quarter 2 2018/19:** The Committee noted the Quarter 2 2018/19 position. The Committee was assured that 8 of 9 outcomes had been achieved to date and that the remaining outcome relating to transitions from one service to another was graded as 'Developing'.

- **Corporate Objectives 2018/19 6 Monthly Review:** The Committee noted the contents of the 6 Monthly review of performance against the Corporate Objectives aligned to its terms of reference, prior to approval of the Board on 7th December 2018.

3. **Board Assurance Framework (BAF) risks reviewed**
   The Committee reviewed the quality related BAF risks it is responsible for on behalf of the Board. There was no recommendation from the Committee to amend the risk scores.

4. **Escalation report to the Board on Quality Committee Performance Measures**
   None.

5. **Issues to highlight to Board**
   None.

6. **Action required by Board**
   None.

Susan Milner
Chair of Quality Committee
November 2018

2018/287

Board of Directors

Committee Chair's report of Putting People First Committee meeting held on 30 November 2018

1. **Was the quorate met? YES**

2. **Agenda items covered**

Staff Story – Genetics
Presentation from Katie Jones, Genetic Scientist. Katie described her career to date, the support she had received in developing her career since moving from Manchester to Liverpool, her current training to become a Consultant Scientist and her anxieties about the future as the genetic laboratories merge.

Service report – Pharmacy
The Committee noted strong performance on workforce metrics and clear focus on developing a talent pipeline and career pathway for pharmacists. The workforce challenges of working in a small specialist organisation were understood with the leadership team exploring new ways of working, including rotational posts where possible. Longstanding cultural issues within the department remain a focus of attention.

Director of Workforce Report
The Committee noted a flu vaccine uptake rate of 74.4% and a staff survey return rate of 61%

Putting People First Strategy 2019-2024
Approved the final draft of the PPF Strategy developed following extended period of engagement with stakeholders. The Strategy built on achievements to date and focused on flexibility, resilience and appetite for change as the Trust implements its clinical strategy in the coming years. The Strategy would be presented to Board in February 2019 for approval.

Brexit Workforce Planning
Review undertaken of the workforce implications and risks associated with Brexit. Concluded that the Trust's current EU workforce is stable and, with limited although potentially growing reliance on overseas workers, there are minimal workforce risks for the Trust associated with Brexit.

Workforce KPIs
The Committee identified underperformance on PDRs and Mandatory Training compliance. A technical issue between OLM and ESR is currently under investigation which potentially is having some consequence on the accuracy of recording.

Freedom to Speak Up Guardian's Annual Report
The Committee received the F2SUG Annual report, detailing the work undertaken in the year to date, the number of concerns raised and from which staff groups and the development of the Guardian role to include the development of a Fair & Just Culture.

Clinical Education Self-Assessment Report
The Committee received the Trust's Self-Assessment Report submitted to Health Education England reporting on the quality of the Trust's clinical learning environments. The Report identifies good practice areas, challenges and actions to be taken. The SAR will be reviewed regularly by the Education Governance Committee. It is anticipated that HEE will provide a rating following review of the report.

Guardian of Safe Working – Q2 2018/19 Report
0 exception reports received from doctors in training (new contract) for Q2. No fines levied. Work to be undertaken with Junior Doctor Forum to understand any blockers to recording overrunning shifts. Committee were assured that doctors were safely rostered and in compliance with their contracts.

Sub Committee Chairs Reports

- **Health & Wellbeing 2.10.18**– Membership to be reviewed to ensure appropriate divisional and professional representation to drive forward key agenda for the Trust
- **Joint Local Negotiating Committee – 25.10.18**

Corporate Objectives 6 monthly review
The Committee reviewed the progress made against the workforce related corporate objectives.

3. Board Assurance Framework (BAF) risks reviewed

Reviewed. No changes identified. No new risks identified.

4. Escalation report to the Board on PPF Performance Measures

PDRs and Mandatory Training Compliance consistently below target for the previous 12 months. Recovery plans requested for PDR. Technical issue identified as having potential impact on mandatory training recording. IT to expedite review and provide assurance..

5. Issues to highlight to Board

None

6. **Action required by Board**

None

AUTHOR NAME Tony Okotie, Chair, Putting People First Committee

DATE 3 December 2018

Liverpool Women's NHS Foundation Trust

Board of Directors

Committee Chair's report of Audit Committee meeting held 22 October 2018

1. Was the quorate met? Yes

2. Agenda items covered
   - ~ **Follow up of Internal Audit and External Audit Recommendations:** The Committee received an updated position on audit recommendations from 2017/18. It was noted that there were currently six outstanding to be delivered over the remainder of the year, two of which were being delivered later than originally planned. The Committee was assured that these were not high risk actions and raised no concerns.
   - ~ **Internal Audit Agency Progress Reports:** The Committee received five finalised reports: Critical Application Review (Baby tagging) (briefing note opinion – not assessed for assurance); Cyber Security (briefing note – not assessed for assurance); Consultant Job Planning (Moderate Assurance); Financial Reporting and Integrity (High Assurance); and Financial Systems Key Controls Review (High Assurance).
   - ~ **MIAA Insights Briefing:** The Committee noted the events and benchmarking update.
   - ~ **Counter Fraud Progress Report:** The Committee received the progress report and noted recent activity nationally relating to email cloning techniques.
   - ~ **External Audit Technical Update:** The Committee received the report noting the sector updates, actions required and what steps would need to be taken by the Trust, if any.
   - ~ **Register of Waivers of standing orders:** The Committee received the register of waivers covering the period quarter 2 2018/19. Noting that the level of waivers was consistent with Q1 and the same period in 2017/18. No concern was raised.
   - ~ **Assurance processes, governance, risk management and internal control arrangements:** the Committee received assurance on the operation and governance arrangements within the Trust.
   - ~ **Clinical Audit Annual Report 2017/18:** The Committee received the report noting that it had also been presented to the Quality Committee and assurance was received by that Committee on the clinical audits carried out over the year. The Committee was assured that processes and procedures were in place that supported the undertaking of effective clinical audits and that action plans arising from the audits were being carried out appropriately.
   - ~ Review of effectiveness of internal audit: The Committee considered the effectiveness of the internal audit provider with Trust representatives. It was agreed that performance is satisfactory.

3. Board Assurance Framework (BAF) risks reviewed
   - ~ The BAF was not reviewed

4. Escalation report to the Board on Audit Performance Measures
   - ~ None

5. Issues to highlight to Board
   - ~ None

6. Action required by Board
   - ~ None

Ian Knight
Chair of Audit Committee

NHS

Agenda Item	2018/289

MEETING	Board of Directors
PAPER/REPORT TITLE:	Better Births compliance – Community Midwifery Update
DATE OF MEETING:	Monday, 26 November 2018
ACTION REQUIRED	For Assurance
EXECUTIVE DIRECTOR:	Caron Lappin, Director of Nursing and Midwifery
AUTHOR(S):	Sue Roberts Matron
STRATEGIC OBJECTIVES:	*Which Objective(s)?* **1.** To develop a well led, capable, motivated and entrepreneurial *workforce* ☒ **2.** To be ambitious and *efficient* and make the best use of available resource ☒ **3.** To deliver *safe* services ☒ **4.** To participate in high quality research and to deliver the most *effective* Outcomes ☒ **5.** To deliver the best possible *experience* for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	*Which condition(s)?* ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust…….* ☒ ***2.*** *Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have sufficient numbers of junior medical staff with the capability and capacity to deliver the best care. ……* ☐ ***3.*** *The Trust is not financially sustainable beyond the current financial year……* ☐ ***4.*** *Failure to deliver the annual financial plan ……* ☐ ***5.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision……* ☐ ***6.*** *Ineffective understanding and learning following significant events……* ☐ ***7.*** *Inability to achieve and maintain regulatory compliance, performance and assurance……* ☐ ***8.*** *Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) ……* ☐ ***9.*** *Inability to deliver the best clinical outcomes for patients……* ☒ ***10.*** *Potential for poorly delivered positive experience for those engaging with our services..* ☐
CQC DOMAIN	*Which Domain?* *SAFE- People are protected from abuse and harm* ☒ *EFFECTIVE - people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☒ *CARING - the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☒ *RESPONSIVE – the services meet people's needs.* ☒ *WELL-LED - the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care,* ☒

	supports learning and innovation, and promotes an open and fair culture. *ALL DOMAINS* ☒	
LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution ☐ **2.** Operational Plan ☒ **3.** NHS Compliance ☒	**4.** NHS Constitution ☒ **5.** Equality and Diversity ☐ ***6.*** Other: Cheshire and Merseyside LMS strategy
FREEDOM OF INFORMATION (FOIA):	1. This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting	
RECOMMENDATION: *(eg: The Board/Committee is asked to:-….)*	***The Board is asked to note the progress to date of the Better Births project arising from the National Maternity Review***	
PREVIOUSLY CONSIDERED BY:	Committee name	Not Applicable Or type here if not on list: *Click here to enter text.*
	Date of meeting	*Click here to enter a date.*

Executive Summary

This paper is to provide an update to the Board of Directors to the progress of the community redesign project and to provide an update on the implementation of recommendations from the National Maternity Review "Better Births". The community redesign aims to ensure that our services meet the needs of women and families, providing a service that offers choice, high quality, safe and effective care. The recommendations from Better Births: improving outcomes of maternity services in England (NHS England 2016), the report of the National Maternity Review is one of the key drivers in shaping the maternity service going forward.
Other significant drivers include:

- NHS 5 year forward plan
- CQC recommendations following inspection in 2015
- Current NICE guidance
- Cheshire and Merseyside Women's and Children's Partnership (Vanguard)
- Healthy Liverpool Programme
- Future Generations – Liverpool Women's Hospital
- Early Adopter site status.
- Each Baby Counts
- Saving Babies Lives – Care Bundle

Report

Better births sets out a vision for safe, efficient models of Maternity care: safer care, joined up across disciplines, reflecting women's choices and offering continuity of care along the pathway. Commissioners are asked to work across areas as local Maternity systems (LMS). The aim is to ensure women have equitable access to the services they choose and need, as close to home as possible.

The review calls for:

1. Personalized care – women should have a personalized care plan and use of a digital maternity tool. They suggest a 'NHS Personal Maternity Care Budget' which would allow women to choose the provider of their care.

2. Continuity of care - every woman should have a midwife who follows her through her pregnancy and each team of midwives should have an identified obstetrician. (This has recently been enhanced and more prescriptive following recommendations from Kirkup and the National Maternity review, regarding 20% of all bookable women are required to be part of a care stream providing all aspects of midwifery care).

3. Safer care – each board should have a champion for maternity services and teams should routinely collect data on the quality and outcomes of their services. A national standardized investigation process is also needed for when things go wrong.

4. Better postnatal and perinatal mental health care – they call for significant investment in perinatal and post-natal mental health services.

5. Multi-professional working - multi-professional learning should be a core part of all pre-registration training for midwives and obstetricians and electronic maternity record should be rolled out.

6. Working across boundaries - community hubs should be established creating a one-stop shop for women. They also call for clinical networks where professionals, providers and commissioners can come together on a larger geographical area.

7. A payment system that fairly and adequately compensates providers **for delivering high quality care to all women efficiently** - the review acknowledges that different services in different areas have different cost structures and states that the money needs to follows the woman and her baby as far as possible, to ensure women's choices drive the flow of money, whilst supporting organizations to work together.

LWH position against Better Births

Recommendation	Trust position	Actions
1. Personalised Care	Compliant	• Further actions: The Directory of Services have replaced the Personalised maternity care budgets and have now been approved by the Vanguard and Heads of Midwifery – this is to be rolled out across Cheshire and Merseyside as a digital tool to allow women to choose provider expected January 2019 .
2. Continuity of Care	Partially Compliant from a green status (Due to recent recommendations and enhancement to the COC pathway, mandated by NHS E)	• The Current community midwife teams provide antenatal and postnatal continuity for women in their care. However the Better Births calls for a continuity of carer model which follows the woman and her family through her pregnancy journey through the antenatal, intrapartum and postnatal period. • Identification of phase 1 care streams completed. (LINK clinic, Home Birth team, Ele Cs by postcode). • Further continuity of care models to be implemented to meet maternity datasets. • Ambition and trajectory completed
3. Safer Care	Compliant	• Designated each baby counts process • Board level non-executive safety champion • Director of Nursing and Midwifery heading safer care for maternity services
4. Better Postnatal and perinatal Mental health	Compliant	• Perinatal mental health specialist midwife in post working collaboratively with perinatal mental health team. • Perinatal mental health guidelines and referral pathway under review to reflect regional pathway. • CPN and Psychologist support available to women • Strengthened Consultant presence through links with Merseycare • Nominated Consultant Obstetrician
5. Multi Professional Working (including Electronic patient record)	Compliant	• Human Factors multi-disciplinary training is being delivered and well received by staff as part of the maternity safety funding. • Pre-hospital emergency course to be delivered 2019 working collaboratively with other neighboring trusts and NWAS this will provide multi-disciplinary collaborative training for community midwives and paramedics on obstetric emergencies in the community setting.

Recommendation	Trust position	Actions
	Partially compliant (Due to IT implementation)	• Digital maternity hand held notes part of the EPR project estimated time for implementation Jan 2019.
6. Working across boundaries	Compliant (For LWH Trust) Noncompliance noted for CCG's	• We are part of the Early adopter Vanguard for CM • Successful bid for Community hub in the north of the city including free standing MLU, and community offer. • Work expected on pop up midwife led unit St Chads – to start December 2018. • Engaging with Commissioners to look at cross boundary working to support women in their choice of provider for all aspects of maternity care. • Engaging with the Clinical care streams within the CM vanguard to share best practice and implement best practice. • To explore a team of midwives to provide continuity of care in the antenatal and postnatal period for women choosing to give birth at LWH but who live across geographical boundaries - Jan 2019
7. A payment system that fairly and adequately compensates providers for delivering high quality care to all women efficiently	Non-Compliant	• Awaiting clarification from a national perspective in relation to maternity tariff payments expected advice from DOH early 2019.

The results of the National Maternity review overwhelmingly noted that continuity of care was the single biggest request from women throughout the review of all maternity services within the United Kingdom. The national maternity review set out a clear recommendation that all maternity providers, should roll out continuity of carer, starting at 20% of all bookable women should be part of a COC care stream. NHS E have provided maternity units with evidence regarding the outcome data in respect of higher satisfaction rates for service users, and also the clinical outcomes of continuity of care.

<u>Continuity of Care progress including update of Community redesign</u>

In December 2017 Implementing Better Births: Continuity of Carer set out guidance for Local Maternity Systems to define and implement continuity of carer based on a local ambition and trajectory. To help generate momentum and ensure that the NHS is on track to deliver the ask that most women receive continuity of carer by March 2021, Refreshing NHS Plans for 2018/19 (p30) requires LMS to ensure that from March 2019, 20% of women at booking are placed onto continuity of carer pathways and receive continuity of the person caring for them during pregnancy, birth, and postnatally.

Liverpool Women` have submitted the attached Continuity of Care ambition and trajectory to Cheshire and Merseyside LMS. (Appendix 1)

CM CoC Sept update with quantitative data

Which demonstrates LWH is on track to deliver the requested 20% of women, by March 2019 who will be on a COC clinical pathway. Described below is the LWH COC maternity care streams and how we envisage operational delivery of this mandated NHS E target, including community redesign, to support us in our delivery.

Midwife at Home team established 26th November

The current home birth rate is currently around 1% of the total births, we recognise that we need to increase the uptake of home births and more importantly the offer of home birth to women accessing LWH maternity services. We need to redesign our low risk midwifery offer to ensure that home birth, and low risk midwifery offer, is one of the three COC care streams. We also recognise that women may choose to access this service throughout any part of the AN journey, and we feel by the modal of care and modal of midwifery staffing we are offering the women of Liverpool the opportunity. A team of 6 WTE midwives will provide continuity of care to women considering to birth at home or in a community setting. The team will provide continuity of care throughout the antenatal, intrapartum and postnatal period for low risk women.

The caseload for each WTE will be 35-40 women, this is based on birth rate+ and equates to approximately 4 births per WTE a month. For a team of 6.2 this caseload equates to approximately 217-248 women.

The team will work flexibly and self -manage their workload and time based on the woman`s needs, which will mirror the AN pathway of independent midwifery services, based on the Wirral. This can include antenatal visits and bookings at a suitable venue of the woman`s choice, visits at a time to suit the women, providing on call cover during the day and night for women requesting a birth at home and providing drop in education appointments at local hubs and parent education classes tailored to women considering a birth at home. Time management and caseloads will be monitored on a weekly basis by the team leader and community matron. Community on calls will be redesigned as part of this care stream with a proposed reduction in general on calls for midwifery staff, as part of the community CIP programme. Presently, this is at staff consultation stage.

Link Team

Within LWH, 30% of bookable women access maternity services and English is not the first language, this clinic is known as the LINK clinic, it comprises of midwives, medical staff, translators, community support workers employed by the local authority. We aim to operational change this service in line with national and local intelligence regarding non English speaking women, including reducing a high DNA rate, reduction in late bookers, increase in BF rates, increase in AN attendance in the first 13 weeks, reduction in the SGA rate for these client group. We also aim, as part of the Vanguard work, to introduce a social prescribing model for support to this vulnerable group. We have undertaken engagement works within these communities and understand what women and families require from a maternity service. We have applied for ESOL funding through the Vanguard and await a decision. We have also undertaken

collaborative working with the local GPs to understand issues with access and continuity and aim to provide this vulnerable group a 'one stop shop' service, including, benefits advice, healthy eating, social isolation.

Elective caesarean section team by postcode

The team will provide a hybrid model of care, as we presently have a 15% elective CS rate, and we feel we require a pilot for a small number of women to ensure we have the case mix and midwifery support at the correct level. AN/PN continuity will be provided by the current midwifery service, this will then link into a team of 5 midwives who will provide care for women and families undergoing an elective CS, this will include pre-operative assessment and parent education tailored for women who require an elective CS, - this is from direct patient feedback and women and families are part of the process for tailoring this parent education.

Evaluation /Monitoring of Data by maternity services

The *'Better Births; Monitoring the implementation of continuity of carer'* v6 report which has introduced a standardised framework to help Local Maternity Systems and the Maternity Transformation Programme to measure, consistently, the level of continuity of carer being provided over time, not only to monitor delivery, but also to help evaluate the extent to which particular models realise the benefits set out in evidence. This will be monitored by the Maternity Clinical group, and by the safety senate. Work is currently in progress with the information team to record the information required on Meditech. This will allow accurate recording of the data for the maternity dataset and framework which is required to be submitted to the LMS by March 2019.

Free standing Midwife led unit /Community Hub

LWH have been successful with two external bids as part of the Cheshire and Merseyside LMS work streams, for wave 2 of improving care across the region.

- Bid 1 – We have been successful to provide a free standing MLU in the north of the city (Kirkby St Chads), as part of a midwifery community hub offer. This will allow women choice of four places of birth as recommended by the National Maternity Review and will provide the opportunity for women to exercise choice and personalisation for their maternity care and will allow babies to continue to be born locally whilst providing the best start in life through a holistic approach to the delivery of, antenatal, postnatal care. The community hub will also offer care closer to home, clinical initiatives, postnatal clinics, EON clinics, which sits as part of the CIP programme for community services. The maternity community hub will also improve the universal maternity offer to the women and families of Liverpool and Knowsley, by better co-ordination, more consistency, and increased consultation and collaboration between services, which will all be housed within one location.

  Services to be provided in the hub will include infant feeding, tongue tie clinic, community clinics (midwifery), extended booking hours, aromatherapy clinic, a safeguarding hub, post-natal clinics (midwifery) PNMH clinics and midwife assessment clinics. Work is expected to begin December 2018.

- Bid 2 – as part of the Children's Transformation Board winning bid, we are part of the collaboration of hospitals/services that will offer to provide more community led care for the 0-19 children of the city, in a bid to improve overall children's well-being. For maternity services this will include bespoke midwife clinics in the designated areas of Garston/Speke and Aintree, again in an aim to provide care closer to home.

IT update (As part of community redesign)

- New mobile phones now rolled out to community midwives and support workers

- Discussions in place with IT project management team to explore introduction of electronic scheduling office 365 for postnatal contacts

Conclusion

A significant number of developments have been made to support the recommendations from the National Maternity Review as part of the community redesign. Ongoing work across Cheshire and Merseyside partnership is intrinsically linked to the redesign of community services at LWH and will continue to steer some of the work streams. This includes the implementation of continuity of care across the LMS, the development of community hubs, development of digital apps and the implementation of the single point of access to allow women to exercise choice over provider of care.

C&M CoC benchmark data (May 18) and request for updated provider information (Sept 18)

Provider info MAY 2018	Cheshire and Mersey baseline model plans for the implementation of Better Births: Continuity of Carer (CoC) May 2018	MODEL update September 2018	Number of women	Ratio	No of Midwives on team	Other information
EXAMPLE	***EXAMPLE***	*Team 1 Case loading, low risk women*	*240*	*1:36*	*6 WTE*	*Ooperational*
ANOTHER provider		*Team 2 Case loading, complex social factors*	*576*	*1:32*	*9 WTE x 2 team*	*Pilots completed*
		Team 3 Case loading, mothers with gestational diabetes	*210*	*1:35*	*6 WTE*	*Awaiting results for sustainabilit*
		Hybrid linking LW and community MW		*1:50*	*6 x WTE community,6 x WTE LW*	

Wirral University Teaching Hospital (WUTH)	**Implemented** • Pop up FMU • Highfield Continuity of carer team **Exploring the development of** • Elective caesarean section team to include pre-op and theatre care • The Butterfly Team is currently setting up a Rainbow clinic • Peri-natal mental health • Teenage pregnancy.					
Mid-Cheshire Hospitals NHS Foundation Trust (MCHFT)	**Implemented** • 95% continuity achieved during ante natal and post-natal period **Implementing** • Midwifery led unit (MLU) team to be implemented in November 2018 **Exploring the development of** • Homebirth team • An elective caesarean section team					

Warrington & Halton Hospitals (W&HH)	**Implemented** • Elective CS team providing CoC through pre-op, theatre, postnatal care in hospital • BR+ team have developed CoC models with WHH team **Implementing** • Integrated teams (5 small teams) community, birth centre, assessment at home (offer choice of place of birth at this point- midwifery led). Offering CoC for all women receiving midwifery led care • Caseloading team for women with mental health issues **Exploring development of** • CoC across complex care areas- Birth Suite and Ward * Extending elective cs team into community					

Liverpool Women's Hospital (LWH)	**Implemented**- good continuity exists antenatally and postnatally for women on the following pathways. • Twins • Tocophobia • Elective caesarean section • Enhanced midwifery team – vulnerable women and perinatal mental health LWH are currently exploring the development of improved Intrapartum care **Implementing by November 2018** CoC teams with a focus on • Home Birth • Women booked or on an Elective Caesarean section Pathway • Non English Speaking Women • Named midwife to provide COC for surrogacy – approx. 5-6 a year .	Team 1- Home Birth – planned and unplanned	2017 figures – 98 combined planned and unplanned	1:35-40	6 WTE	Pilot to be implemented November 2018
		Team 2 – Link Team – Non English Speaking Women	Est 650 women PA	1:95-100	7 WTE	Phase 1 – To provide antenatal and postnatal continuity to this cohort of women – To be implemented November 2018. Phase 2 – To explore the possibility of intrapartum continuity to be reviewed May 2019.
		Team 3 – Women booked on or transferred on an elective caesarean pathway.		1:95-100	3 teams 6 wte Midwives per locality	Exploring options of team who provide

	Exploring the development of • Development of a rainbow clinic and bereavement team • A cardiac team • Integrated MLU /community team • VBAC team • Research study Team • Out of area /cross boundary team • Smoking Cessation Team • Development of enhanced team to include intrapartum care • Twins Team • Fetal Anomaly Team		Est 1300			AN/PN and attend elec c/s or a hybrid team – one team for AN/PN care and one for elec c/s lists and pre op clinic.
Countess of Chester (CoC)	**Exploring the development of** • An elective caesarean section team • Teams focusing on areas of deprivation • Homebirth • MLU					

St Helen's & Knowsley	**Exploring the development of** CoC teams with a focus on • MLU • Enhanced recovery • VBAC (Vaginal Birth After Caesarean) • Twins • Bereavement					
One to One (Northwest) Ltd	**Implemented** • Existing 98% AN continuity • Existing 92% PN continuity • Existing 25% Homebirth Rate • Existing 8% named midwife at all Homebirths Aspiring to accompany and birth women in a local maternity unit					
Bridgewater	• Focus on the provision of antenatal and post-natal care and facilitating Homebirth					

Southport & Ormskirk	**Exploring the development of** CoC teams with a focus on • Homebirth • Vulnerable Women • Safeguarding • Bereavement • Improving the Midwifery led Pathway • Out of area CoC teams that cross geographical boundaries					

Agenda Item	2018/290

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Adult and Perinatal Mortality Report Q2**
DATE OF MEETING:	Friday, 07 December 2018
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	Andrew Loughney, Medical Director
AUTHOR(S):	Devender Roberts Amanda Cringle Louise Robertson
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** 1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☐ 2. To be ambitious and *efficient* and make the best use of available resource ☒ 3. To deliver *safe* services ☒ 4. To participate in high quality research and to deliver the most *effective* Outcomes ☒ 5. To deliver the best possible *experience* for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust…….* ☐ ***2.*** *Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have sufficient numbers of junior medical staff with the capability and capacity to deliver the best care. ……* ☐ ***3.*** *The Trust is not financially sustainable beyond the current financial year……* ☐ ***4.*** *Failure to deliver the annual financial plan ……* ☐ ***5.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision ……* ☒ ***6.*** *Ineffective understanding and learning following significant events……* ☒ ***7.*** *Inability to achieve and maintain regulatory compliance, performance and assurance……* ☒ ***8.*** *Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) ……* ☐ ***9.*** *Inability to deliver the best clinical outcomes for patients……* ☐ ***10.*** *Potential for poorly delivered positive experience for those engaging with our services..* ☐
CQC DOMAIN	***Which Domain?*** ***SAFE-*** *People are protected from abuse and harm* ☐ ***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☒ ***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☐ ***RESPONSIVE –*** *the services meet people's needs.* ☐

	WELL-LED** - the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.* ☒ ***ALL DOMAINS ☐			
LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution ☐ **2.** Operational Plan ☒ **3.** NHS Compliance ☒		**4.** NHS Constitution ☐ **5.** Equality and Diversity ☐ ***6.*** Other: **Click here to enter text.**	
FREEDOM OF INFORMATION (FOIA):	1. This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting			
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	***The Board:*** ***a.*** ***Take assurance that there is adequate progress against the requirements laid out by the National Quality Board*** ***b.*** ***Confirm that the Board are confident that there are effective processes in place to assure the board regarding governance arrangements in place to drive quality and learning from the deaths of patients in receipt of care at the Trust***			
PREVIOUSLY CONSIDERED BY:	**Committee name**	Quality Committee		
	Date of meeting	Monday, 22 October 2018		

Executive Summary

The Board have previously been informed that both the National Quality Board and the Care Quality Commission have made clear that trusts should be developing systems and processes to review and learn from the deaths of patients under their care. It is expected that the Board of Directors oversee this work and receive quarterly reports on progress.

This report details how the trust is meeting the requirements laid down externally and provides details of mortality within the Trust during Quarter 2 of 2018-19. It concludes that there is currently evidence available that adequate progress is being made and that mortality rates are within expected ranges. The report outlines the work taking place operationally and is being overseen by Quality Committee.

Report

Introduction

This report updates the Board regarding the Trust systems and processes to review and learn from deaths of patients under their care. This is in accordance with recommendations by the National Quality Board and the Care Quality Commission. It outlines the work taking place operationally and being overseen by Effectiveness Senate and Quality Committee.

Key findings:

- Refinement of alert processes in the reporting of an expected death
- The stillbirth rate for 2018/19 to date is 3.37 (3.13/1000 births if we exclude fetal abnormality)
- PMRT has been used for all stillbirths in Q1 &Q2

Progress / Learning from Adult Deaths

1) A draft LeDeR SOP has been finalised and currently going through the internal ratification processes.
2) The two adult deaths in quarter 1, were expected gynaecology oncology patients and had chosen LWH as their preferred place of death.
3) There was an out of hospital death in August 2018, a multi-disciplinary review panel was convened. A timeline of events was produced and reviewed, the review team discussed the below in detail.
    - Decision for surgery
    - Surgery
    - Post-operative Care
    - Transfer to the Royal

    Following discussion on the care provided in relation to the above it was agreed that all decision making was appropriate. There were a number of lessons to be learnt which were agreed at the review however the panel felt this would not have changed the outcome. It was agreed that the incident does not meet the criteria for a SI. However when further information from the review at RLBUHT and post mortem are available, this decision will be revisited.

    The below learning outcomes were identified.

    - Escalation and communication issues
    - Observations, an audit of observations charges for regularity of observations post operatively.
    - Consistency of administering Fragmin, review SOP for peri-operative Fragmin.

    All information is to be developed into a report format, pending further information from the Royal with regards to their investigation and conclusion of post mortem results.

4) The mortality review reports for the three expected gynaecology oncology deaths in quarter 2 are complete, the third report is still under review and waiting to be finalised.

5) Benchmarking discussions have commenced with Birmingham Women's Hospital on all obstetrics, gynaecology and gynaecology oncology deaths. This will also include shared learning processes in these fields. We anticipate including their benchmarking data in the next quarter 3 mortality report.

Progress / Learning from Perinatal Deaths

1. In the babies from 2018-19 there has been one formal review to date. This was into the care received in the Maternity Assessment Unit (MAU) of a mother with a twin pregnancy. This has prompted a review of the escalation policy in the MAU for medical review.
2. There have been no SI's (Serious Incident Reviews) associated with stillbirth in the first 2 quarters.
3. There will be an analysis of the themes identified from the babies in the Q4 report as the numbers are too small at present to identify meaningful themes.

Recommendations

It is recommended that the Board:

a. Take assurance that there is adequate progress against the requirements laid out by the National Quality Board

b. Confirm that the Board are confident that there are effective processes in place to assure the board regarding governance arrangements in place to drive quality and learning from the deaths of patients in receipt of care at the Trust

Adult Mortality Quarterly Report

18/19 Quarter 2 – (July, Aug & Sept)

- Adult Mortality Q2, 2018 - 2019 report prepared by A. Cringle
- Clinical Author: D. Roberts

Executive Summary

This report updates the Board regarding the Trust systems and processes to review and learn from deaths of patients under their care. This is in accordance with recommendations by the National Quality Board and the Care Quality Commission. It outlines the work taking place operationally and being overseen by Effectiveness Senate and Quality Committee.

Key findings:

- Refinement of alert processes in the reporting of an expected death
- Learning from a recent unexpected death

1. Mortality Dashboard

Due to the small number of in-hospital deaths, it has been agreed with the Head of Governance and Associate Medical Director, that the following table showing the total mortality and the rate of death per 1000 discharges will be used as the mortality dashboard.

Table 1: Obstetric Mortality

This includes all obstetric activity across all the clinics and wards.

501 - OBS	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	TOTAL
Total Mortality	0	0	0	0	0	0	0	0	0	0	0	0	0
Discharges	1712	1900	2005	2006	1886	1905	0	0	0	0	0	0	11413
Rate per 1000 Discharges	0.0	0.0	0.0	0.0	0.0	0.0							0.0

Table 2: Gynaecology Mortality (non-oncology)

502 - GYNAE	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	TOTAL
Total Mortality	0	0	0	0	0	0	0	0	0	0	0	0	0
Discharges	883	955	905	908	897	895	0	0	0	0	0	0	5444
Rate per 1000 Discharges	0.0	0.0	0.0	0.0	0.0	0.0							0.0

Table 3: Gynaecology Oncology

503 - GYNAE ONC	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	TOTAL
Total Mortality	1	1	0	2	1	0	0	0	0	0	0	0	5
Discharges	63	69	73	78	54	71	0	0	0	0	0	0	408
Rate per 1000 Discharges	15.9	14.5	0.0	25.6	18.5	0.0							12.3

2. Out of hospital deaths 2017-18 Quarters 2

There was one reported out of hospital deaths for quarter 2, see section 4, bullet point 3 below for details of the review and lessons learnt. (Out of hospital refers to patients who have died either expected or unexpected within 12 months post partem for maternity cases and within 30 days after treatment at LWH for all other adult conditions.)

3. Mortality reviews and Key Themes

Since 2017 each in-hospital gynaecology death has a mortality review using the adult mortality proforma is completed indicating any potential for improvement in care, unexpected adult gynaecology deaths trigger a serious incident investigation and are recorded on Ulysses (Trust risk management and incident recording system).

All direct maternal deaths trigger serious incident investigation.

A mortality review tool has been developed for the risk and incident reporting system Ulysses.

Number of reviews		
	Maternity	**Gynaecology**
No of Adult Deaths	0	3
No of Mortality Reviews completed	0	3
No of deaths requiring RCA's	0	1
No of deaths due to deficiencies in care	0	0
Mortality Themes	N/A	N/A

Progress v Smart Plans	N/A	N/A
Mortality Outcomes	N/A	N/A
Measures for ongoing scrutiny	N/A	N/A

4. Progress / Learning from Deaths

1) A draft LeDeR SOP has been finalised and currently going through the internal ratification processes.

2) The two adult deaths in quarter 2 were expected gynaecology oncology patients and had chosen LWH as their preferred place of death.

3) There was an out of hospital death in August 2018; a multi-disciplinary review panel was convened. A timeline of events was produced and reviewed, the review team discussed the below in detail.

- Decision for surgery
- Surgery
- Post-operative Care
- Transfer to the Royal

Following discussion on the care provided in relation to the above it was agreed that all decision making was appropriate. There were a number of lessons to be learnt which were agreed at the review however the panel felt this would not have changed the outcome. It was agreed that the incident does not meet the criteria for a SI. However when further information from the review at RLBUHT and post mortem are available, this decision will be revisited.

The below learning outcomes were identified.

- Escalation and communication issues
- Observations, an audit of observations charges for regularity of observations post operatively.
- Consistency of administering Fragmin, review SOP for peri-operative Fragmin.

All information is to be developed into a report format, pending further information from the Royal with regards to their investigation and conclusion of post mortem results.

4) The mortality review reports for the three expected oncology deaths in quarter all are complete.

5) Benchmarking discussions have commenced with Birmingham Women's Hospital on all obstetrics, gynaecology and gynaecology oncology deaths. This will also include shared learning processes in these fields. We anticipate including their benchmarking data in the next quarter 3 mortality report.

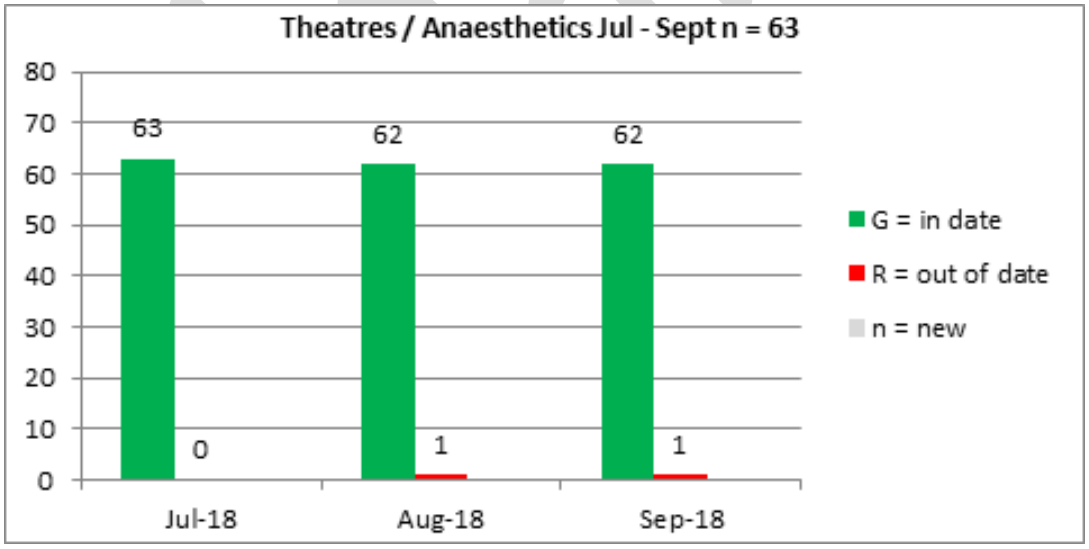
5. Prevention – What does Liverpool Women's do to Mortality

The Trust guidelines and SOPs (Standard Operating Procedures) have undergone scrutiny, merging and updating as they have migrated onto a new on-line easy access intranet for clinical staff to access 24/7. The phase commenced with Maternity department during 2017/18, this has been successful; it is now planned to commence work to roll out for gynaecology and neonatal departments for all their guidelines and SOPs to be fully accessible on line.

This section reports on the status of mortality related guidelines and SOPs (this includes critical care and anaesthetics).

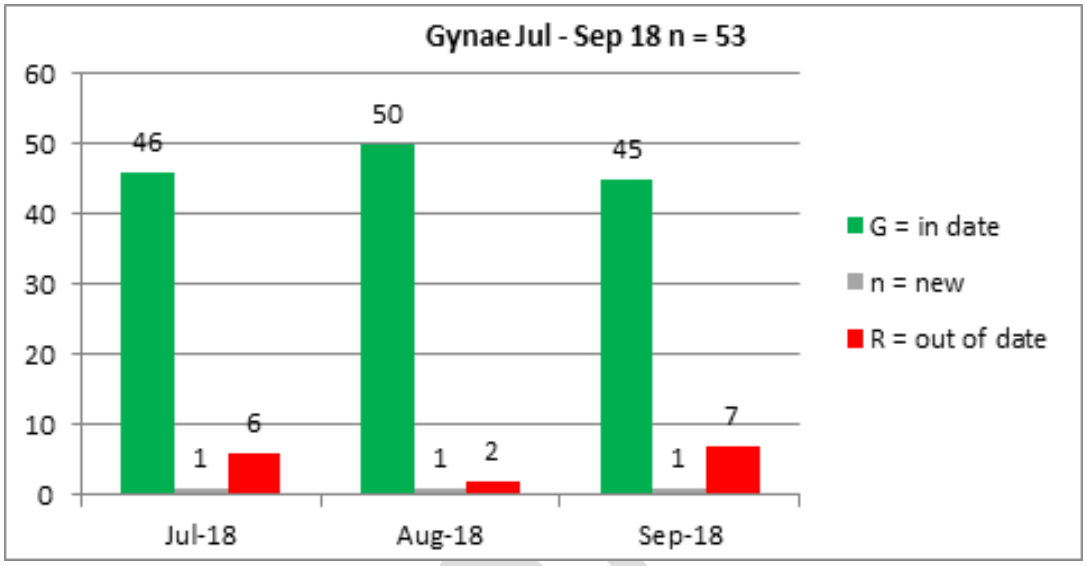
Anaesthetics / Theatres

The chart below shows the number of Anaesthetics mortality related policies or guidelines for each month of quarter 2



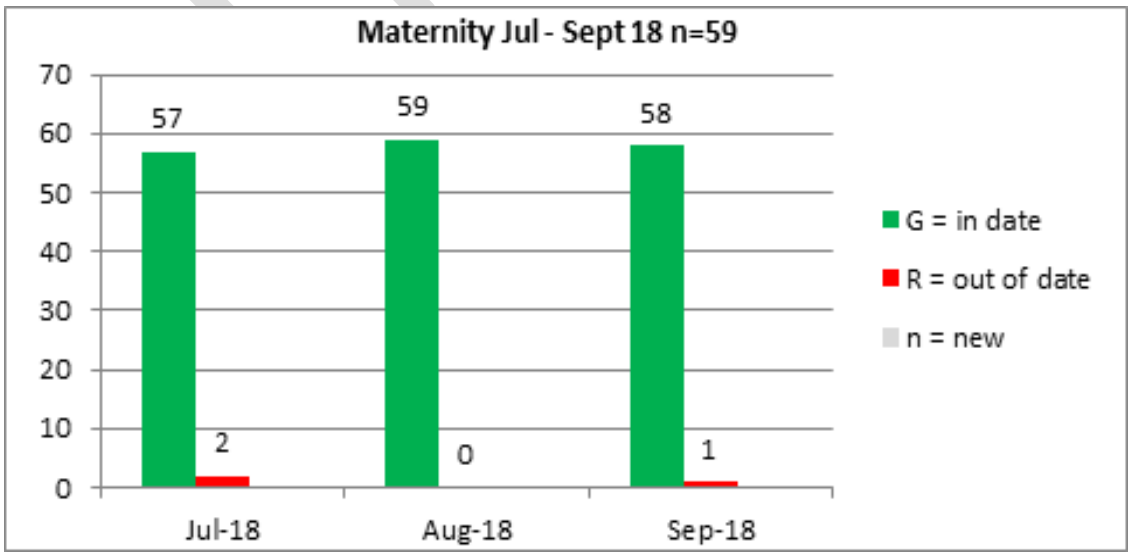
Gynaecology

The chart below shows the number of Gynaecology mortality related policies or guidelines for each month of quarter 2. Quarter 2 (Jul – Sept); 5 of these documents are cancer guidelines that had been reviewed, updated and awaiting ratification at the time of completing this report.



Maternity

The chart below shows the number of Maternity mortality related policies or guidelines for each month of quarter 2,



6. Audit

From April 2017 the Trust has committed to the principle that it must include work of relevance to the highest risk areas for adult mortality in the Clinical Audit Forward plans - including:

- Haemorrhage
- Sepsis
- Venous thromboembolism
- Cardiac
- Neurological
- Psychiatric

The below table is The Annual Audit Programme for 2018 – 2019.

Adult Mortality – Clinical Audit Q1

Topic	Clinical Audit Title/s	Progress
Haemorrhage	Use of O Negative blood	Audit and actions completed from 2017-18. Re-audit registered. Awaiting Final Report and action plan.
	Bedside transfusion (including consent)	Audit and actions completed from 2017-18. Re-audit scheduled to start late 2018 – this will also capture data in relation to TACO and NICE QS138 & NG24.
	SHOT NCA of TACO prevention Require evidence presented	Audit and actions completed from 2017-18. Re-audit data will be captured as part of the annual Bedside transfusion audit.

	National Comparative audit of blood transfusion programme – Audit of Massive Haemorrhage Autumn 2018	National Audit due to commence Sep-18. Received audit pack and data collection due to commence Qtr 3.
Psychiatric disease	Antenatal Perinatal mental health management and outcome at Liverpool Women's Hospital	Audit registered. Data collection in progress. Awaiting report and action plan.
	Trust wide Mental Health	Audit planned to start Qtr 3 for submission Qtr 4.
Sepsis	Audit of the management of pregnant women with asymptomatic bacteriuria at booking visit *(Previously titled: "Maternal and Congenital sepsis")*	Audit and actions completed from 2017-18. Re-audit scheduled for 2019-20.
	SEPSIS bundle – Maternity	Data being captured via NUMIS.
	Audit of the management of patients with sepsis/compliance to the 1 hour Sepsis Bundle – Gynaecology	Ongoing monitoring by HDU/Sepsis via NUMIS.
Venous thromboembolism	Assess LWH Gynaecology admissions against NICE QS 03 – VTE in Adults; reducing the risk re-audit	Audit and actions completed from 2017-18. Re-audit scheduled to start late 2018.
Neurological Disease	An audit of outcomes in women who attend the Joint Obstetrics/Neurology clinic	Audit proposal in progress – to be submitted to Audit Dept. Nov 2018
Cardiac Disease	No audit planned for this audit cycle. Proposed for 2019/20.	

7. Horizon Scanning

Subject(s): Adult mortality (Maternity/ Gynaecology)

Period: July 2018 – September 2018.

Sources: CQC, NCEPOD, NHS Digital, NHS Resolution, Public Health England, RCOG.

CQC – No updates on these subjects for the period covered.

NCEPOD – No updates on these subjects for the period covered.

NHS Digital – The following reports are available:

- Compendium – mortality from cervical cancer available here
- Compendium – mortality from breast cancer available here
- Compendium – maternal mortality available here

NHS Resolution – No updates on these subjects for the period covered.

Public Health England – No updates on these subjects for the period covered.

RCOG – No updates on these subjects for the period covered**.**

8. Recommendations

It is recommended that the Board:

a. Take assurance that there is adequate progress against the requirements laid out by the National Quality Board

b. Confirm that the Board are confident that there are effective processes in place to assure the board regarding governance arrangements in place to drive quality and learning from the deaths of patients in receipt of care at the Trust

Perinatal Mortality Quarterly Report

18/19 Quarter 1 & 2

- Perinatal Mortality Q1 & Q2, 2018 - 2019 report prepared by L. Robertson
- Clinical Author: L. Robertson

Executive Summary

This report updates the Board regarding the Trust systems and processes to review and learn from deaths of patients under their care. This is in accordance with recommendations by the National Quality Board and the Care Quality Commission. It outlines the work taking place operationally and being overseen by Effectiveness Senate and Quality Committee.

Key findings:

- The stillbirth rate for 2018/19 to date is 3.37 (3.13/1000 births if we exclude fetal abnormality)
- PMRT has been used for all stillbirths in Q1 &Q2

9. Mortality Dashboard

In 2017-2018 the stillbirth rate excluding termination of pregnancy was 3.6/1,000. If we were to exclude all fetal abnormality the rate is reduced to 3.31/1,000.

To date in 2018-19 the rate is 3.37 adjusted for terminations, 3.13 adjusted for fetal abnormalities.

Table 1: Stillbirths >24 weeks

501 - OBS	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	TOTAL
Total stillbirths	7	6	0	3	4	2	-	-	-	-	-	-	22
Stillbirths (excluding terminations	4	3	0	2	3	2	-	-	-	-	-	-	14
Births	628	692	710	748	685	694	-	-	-	-	-	-	4157
Rate per 1000 births	11.1	8.7	0	4.0	5.8	2.9	-	-	-	-	-	-	5.29
Rate (excluding TOP) per 1000	6.4	4.4	0	2.7	4.4	2.9							3.37

There have been 2 early neonatal deaths in term babies. Both of which were associated with fetal abnormalities that were identified antenatally and were none compatible with life.

10. Mortality reviews and Key Themes

The Maternity Services recognise the need to review any cases that have resulted in poor or unexpected outcomes for either mother or baby related to the antenatal period and through the postnatal / neonatal period. This includes stillbirths from 22 weeks gestation and term babies who have undergone active therapeutic cooling and who meet the criteria for Each Baby Counts.

These reviews require close co-ordination between Midwives, Obstetricians, Neonatologists, Neonatal Nurses and Ultra-Sonographers. The Pathology Team at Alder Hey Children's Hospital will also be invited to participate in the reviews and when required external Midwife, Obstetrician and Neonatologist will also be asked to attend.

This is achieved through monthly multi-disciplinary review meetings to discuss perinatal mortality, morbidity and pathology.

Aims

- To review recent cases focusing on those, which resulted in perinatal mortality or morbidity
- To provide a forum for multi-disciplinary discussion and learning
- To provide a forum to discuss the recommendations of MBRRACE, other National Confidential Enquiries and relevant national or local documents.
- To develop an increased knowledge and understanding of high risk obstetric and neonatal complications.
- To provide a forum to recognise the need for changes to practice and to forward learning points to the relevant maternity and neonatal governance groups for action.
- To serve as the forum to inform completion of both Stillbirth (MBRRACE) and RCOG 'Each baby counts' and Child Death (CPOD) review paperwork.

Membership

Meetings are multi-disciplinary and open to all interested health care professionals. The meetings will uphold an environment of mutual respect for personal and professional opinions expressed with the aim of inter professional learning. They are held monthly and representatives from the following disciplines are expected at every meeting.

- Obstetricians
- Paediatricians
- Midwives
- Neonatal Nurses
- Ultra-sonographers (as appropriate to the individual cases)
- Anaesthetists (as appropriate to the individual cases)
- Governance Facilitator

A record of attendance will be kept and members will be required to sign the attendance sheet at each meeting.

Meeting format Meetings will consist of:-

Case Reviews

- Stillbirths (This includes intrapartum stillbirth from 22 weeks gestation)
- Early neonatal death (days 0–6)
- Severe brain injury, (grade III (HIE), Actively therapeutically cooled and babies who had all three of the following signs: decreased central tone, comatose; seizures of any kind)

An anonymised record of cases presented and multi-professional discussions will be kept along with any relevant presentations. Recommendations for changes in practice or guidelines may be presented to the Maternity Risk Meeting for ratification.

The PMRT will be completed and cases will be graded in line with MBRRACE grading system. Both the antenatal and postnatal care a mother receives is graded. The postnatal care is focused on the bereavement care the family receives.

Any cases graded D will automatically be reported as a Serious Incident and added to Steis. A root cause analysis, (RCA), investigation will be completed

Table 2: MBRRACE - UK Care Grading

Care Grade	Description
Grade A	No improvements in care identified
Grade B	Improvements in care identified that would not have changed the outcome
Grade C	Improvements in care identified that **may** have changed the outcome
Grade D	Improvements in care provided that **would** have changed the outcome

Table 4: Grading of care for babies in 2018-2019 (Q1 &Q2)*

Grade	No. of babies (AN)	No. of Babies (PN)
A	**6**	**12**
B	**3**	**0**
C	**2**	**0**
D	**0**	**0**
UNK	**1**	**0**
Total	**12**	**12**

*2 babies are due to be reviewed in November's Panel

Cause of stillbirth	Number of babies
Cord prolapse	1
Fetal abnormality	1
Multiple pregnancy	1
Placental abruption	4
SGA alone	3 (all undetected)

SGA associated with hypertension	1
Unknown	1

Progress / Learning from Deaths

In the babies from 2018-19 there has been one formal review to date. This was into the care received in the Maternity Assessment Unit (MAU) of a mother with a twin pregnancy. This has prompted a review of the escalation policy in the MAU for medical review.

There has been no Serious Incidents (SI's) associated with stillbirth in the first 2 quarters.

There will be an analysis of the themes identified from the babies in the Q4 report as the numbers are too small at present to identify meaningful themes.

11. Prevention – What does Liverpool Women's do to reduce mortality

An action tracker has been created that will monitor the progress with actions that arise from the perinatal meetings. This will be discussed at the start of every meeting. The intention is that this will be presented at the risk meeting bi-annually. Any delay or deviations would be escalated to safety senate. (please see attached)

An action plan for our approach to NHS England's Saving Babies' Lives care bundle is being formulated.

12. Horizon Scanning

- **Sources**: CQC, NCEPOD, NHS Digital, NHS Resolution, Public Health England, RCOG.
- **CQC** – no updates found for the period covered
- **NCEPOD** – no updates found for the period covered
- **NHS England –** Saving Babies' Lives Care Bundle 2
- **NHS Digital –** no updates found for the period covered
- **NHS Resolution** – no updates found for the period covered
- **Public Health England** – no updates found for the period covered
- **RCOG –** Each Baby Counts Annual Report Due November 2018

13. Recommendations

It is recommended that the Board:

c. Take assurance that there is adequate progress against the requirements laid out by the National Quality Board

d. Confirm that the Board are confident that there are effective processes in place to assure the board regarding governance arrangements in place to drive quality and learning from the deaths of patients in receipt of care at the Trust

e. Discuss the Saving Babies' Lives care bundle action plan as part of the CNST maternity safety incentive scheme requirements

Agenda Item	2018/291

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Annual Assurance Emergency Preparedness, Resilience & Response**
DATE OF MEETING:	Friday, 07 December 2018
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	Jeff Johnston, Director of Operations
AUTHOR(S):	Lorraine Thomas, Emergency Planning & Business Continuity Manager
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** 1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☐ 2. To be ambitious and *efficient* and make the best use of available resource ☐ 3. To deliver *safe* services ☒ 4. To participate in high quality research and to deliver the most *effective* Outcomes ☐ 5. To deliver the best possible *experience* for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust…….* ☐ ***2.*** *Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have sufficient numbers of junior medical staff with the capability and capacity to deliver the best care. ……* ☐ ***3.*** *The Trust is not financially sustainable beyond the current financial year……* ☐ ***4.*** *Failure to deliver the annual financial plan ……* ☐ ***5.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision ……* ☐ ***6.*** *Ineffective understanding and learning following significant events……* ☐ ***7.*** *Inability to achieve and maintain regulatory compliance, performance and assurance……* ☒ ***8.*** *Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) ……* ☐ ***9.*** *Inability to deliver the best clinical outcomes for patients……* ☐ ***10.*** *Potential for poorly delivered positive experience for those engaging with our services..* ☐
CQC DOMAIN	***Which Domain?*** ***SAFE-*** *People are protected from abuse and harm* ☐ ***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☐ ***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☐ ***RESPONSIVE –*** *the services meet people's needs.* ☐

	WELL-LED *- the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.* ☐ ***ALL DOMAINS*** ☒			
LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution ☐ **2.** Operational Plan ☐ **3.** NHS Compliance ☒		**4.** NHS Constitution ☐ **5.** Equality and Diversity ☐ ***6.*** Other: Click here to enter text.	
FREEDOM OF INFORMATION (FOIA):	1. This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting			
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	***The Board is asked to receive the annual assurance outcome of 'Substantial Compliance' against the NHSE EPRR Core Standards that demonstrates that the Trust remains focused on continuing to meet its duties under the CCA and to achieve a rating of 'full compliance' against the NHSE EPRR Core Standards for 2019/20.***			
PREVIOUSLY CONSIDERED BY:	**Committee name**	Finance Performance and Business Development Committee		
	Date of meeting	Monday, 26 November 2018		

Executive Summary

This report and a subsequent report was presented to the Finance Performance and Business Development Committee on 22 October 2018 and 26 November 2018 at which the Committee received assurance on the Trust's performance to date on delivery of the NHSE Emergency Preparedness, Resilience and Response (EPRR) Core Standards. The Board is required, under guidance from NHSE, to receive the Report following its journey through the Trust's governance processes.

The report provides a summary of the Trust's compliance to the NHSE Emergency Preparedness, Resilience and Response (EPRR) Core Standards based on a self-assessment conducted in October 2018.

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 capability to respond to emergency situations. Whilst managing emergency situations the Trust must as far as is reasonably practicable maintain business continuity, prioritising critical service delivery when necessary.

The NHSE EPRR Core Standards underpin the requirements of the Civil Contingencies Act and are utilised as an audit tool to measure compliance rates for NHS funded organisations. The NHSE EPRR annual assurance process for 2018/19 took the form of a self-assessment against the EPRR Core Standards with NHS providers required to provide responses based on a range of assessment criteria.

Report

Assurance Process

NHS organisations were required to complete a self-assessment of compliance against the NHSE EPRR Core Standards. Specialist Trusts were required to self-assess for compliance against 55 EPRR Core Standards. In addition

all NHS organisations were required to self-assess against 8 'deep dive' additional criteria. For 2018/19 the deep dive criteria related to command and control arrangements. Compliance against the deep dive criteria does not contribute to the overall compliance rating.

The NHSE EPRR Core Standards assessment process was completed by the Emergency Planning and Business Continuity Manager in conjunction with the EPRR Accountable Emergency Officer. Responses were based on activities monitored via the EPRR Committee and include activities and achievements reported within the EPRR Annual Board Report to the Finance, Performance and Business Development Committee in July 2018. The EPRR Committee standing agenda items, specifically the EPRR work plan which includes development and revision of emergency and business continuity plans and arrangements, delivery of training and monitoring of EPRR risk register items directly support the annual assurance requirements.

Assurance Process Outcome

Of the 55 EPRR Core Standards applicable to Specialist Trusts the Trust met 53 standards with a rating of 'Green'. Two standards were partially met and therefore rated as 'Amber'. In addition the Trust met all of the 8 'deep dive' criteria with a rating of 'Green'. The Trust therefore submitted an overall rating to NHSE of 'Substantial Compliance' against the EPRR Core Standards. On conclusion of the national assurance process which includes facilitation of a 'confirm and challenge' process by NHSE, the Trust will receive confirmation of the assessment outcome.

Action Plan

An integral part of the annual assurance process is the development of an action plan to ensure achievement of compliance against any outstanding core standards. An action plan has therefore been developed and submitted and progress will be monitored towards completion of the two EPRR Core Standards rated as amber. Actions in relation to these standards are in progress and will continue to be monitored via the EPRR Committee.

EPRR Activities

EPRR activities going forward will aim to maintain a high level of compliance to the NHSE EPRR Core Standards and other EPRR audits and assurances. The focus will remain on review of current emergency plans including incorporation of any lessons learned from incidents and exercises and the EPRR committee will continue to ensure delivery of appropriate training to relevant staff members and monitor current and evolving risks.

The NHSE EPRR Annual Assurance Guidance (July 2018) states that for 2019/20 the 'deep dive' additional assurance criteria will be based on adverse weather. The Trust has an Adverse Weather Plan in place which was reviewed in 2018 and will be subject to further review as required based on publication of revised national plans.

Conclusion & Recommendation

The annual assurance outcome of 'Substantial Compliance' against the NHSE EPRR Core Standards demonstrates that the Trust remains focused on continuing to meet its duties under the CCA. Current and continuing EPRR work streams including the 2018/19 Core Standards Action Plan aim to achieve a rating of 'full compliance' against the NHSE EPRR Core Standards for 2019/20.

The Board is asked to receive the annual assurance outcome of 'Substantial Compliance' against the NHSE EPRR Core Standards that demonstrates that the Trust remains focused on continuing to meet its duties under the CCA and to achieve a rating of 'full compliance' against the NHSE EPRR Core Standards for 2019/20.

	Agenda Item	**2018/292**

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Safer Nurse/Midwife Staffing Monthly Report**
DATE OF MEETING:	7th December 2018
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	Caron Lappin Director of Nursing and Midwifery
AUTHOR(S):	
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** 1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☐ 2. To be ambitious and *efficient* and make the best use of available resource ☐ 3. To deliver *safe* services ☒ 4. To participate in high quality research and to deliver the most *effective* Outcomes ☐ 5. To deliver the best possible *experience* for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust* ☒ ***2.*** *The Trust is not financially sustainable beyond the current financial year* ☐ ***3.*** *Failure to deliver the annual financial plan* ☐ ***4.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision* ☐ ***5.*** *Ineffective understanding and learning following significant events* ☐ ***6.*** *Inability to achieve and maintain regulatory compliance, performance and assurance* ☒ ***7.*** *Inability to deliver the best clinical outcomes for patients* ☒ ***8.*** *Poorly delivered positive experience for those engaging with our services* ☒
CQC DOMAIN	***Which Domain?*** ***SAFE-*** *People are protected from abuse and harm* ☐ ***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☒ ***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☐ ***RESPONSIVE –*** *the services meet people's needs.* ☐ ***WELL-LED -*** *the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.* ☒ ***ALL DOMAINS*** ☐
LINK TO TRUST STRATEGY, PLAN AND	**1.** Trust Constitution ☐ **4.** NHS Constitution ☐ **2.** Operational Plan ☐ **5.** Equality and Diversity ☐

EXTERNAL REQUIREMENT	**3.** NHS Compliance ☒	***6.*** Other: **NHS England Compliance**
FREEDOM OF INFORMATION (FOIA):	1. This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting	
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	The Board is asked to note: • The content of the report and be assured appropriate information is being provided to meet the national and local requirements. • The organization has the appropriate number of nursing & midwifery staff on its inpatient wards to manage the current clinical workload as assessed by the Director of Nursing & Midwifery	
PREVIOUSLY CONSIDERED BY:	**Committee name**	***Choose an item.*** Or type here if not on list: ***Click here to enter text.***
	Date of meeting	***Click here to enter a date.***

Executive Summary

Data presented in this report demonstrates the effective use of current Nursing & Midwifery resources for all inpatient clinical areas. The monthly report identifies staffing fill rates to demonstrate nursing and midwifery and care support levels. Fill rates of 100% mean that all planned staff were on duty. Fill rates of greater than 100% represent increased staffing levels to meet unplanned demand to meet patient care needs.

Fill rates of less than 100% reflect unplanned sick leave, vacancy or when staff are moved to work in another clinical area of greater clinical needs, due to low occupancy rates on their own area, or where by demands are greater in another clinical area.

Where there is a variance against planned rates the reallocation of nursing and midwifery resources are implemented where necessary to maintain safe staffing levels.

Nurse sensitive indicators continue to highlight the good practice of reporting medication errors especially in the neonatal unit. All errors are investigated and appropriate action taken. No error resulted in harm to any patient.

The use of CHPPD as a benchmark within and against other organisations is still under development by NHS Improvement and subsequent reports will be amended accordingly, presently CHPPD is featured alongside fill rates for each ward and department.
Care hours per day remain at a sustained level indicating a consistent level of care nursing/midwifery resource to provide care to our patients. The staffing across the inpatient ward areas for June 2018 remained appropriate to deliver safe and effective high quality family centred patient care day and night.

Ward Staffing Levels – Nursing and Midwifery Report

1.0 Purpose

1.1 Introduction

This report provides a monthly summary of Safe Staffing on all inpatient wards across the Trust. It includes the safe staffing exception report related to staffing levels, incidents and red flags which are triangulated with a range of quality indicators for both nursing and midwifery.

2.0 Safer staffing exception report

The safer staffing fill rate (appendix 1) provides the established versus actual fill rates on wards split by registered and unregistered staffing hours and by day and night shifts. Fill rates are accompanied by supporting narrative by exception at ward level, and a number of related factors are displayed alongside fill rates to provide an overall picture of safe staffing.

- Sickness rate and vacancy rate are the two main factors affecting fill rates, a growing trend is maternity leave, especially within maternity division, and this is being closely monitored.
- The monthly audit of nursing indicators was suspended in September 2017 by the previous DON. The trust has been developing a ward accreditation system which is required to support the collection of quality indicators alongside real time patient safety flags. This work is currently being reviewed by the new DON&M It is envisaged that this work will be re launched in April 2019 with the introduction of Ward Accreditation.
- ACE incident submissions related to staffing and red flags, are monitored daily at the huddle
- Nurse sensitive indicators demonstrate outcome for patients measuring harm these include;
    - Pressure Ulcers grade 1&2/Grades 3&4
    - Falls resulting in harm / not resulting in physical harm
    - Medication errors resulting in harm/ not resulting in harm
    - Babies requiring thermo cooling resulting in an Each Baby counts report
    - Cases of Clostridium Difficile (CDT)
    - In line with the National Quality Board 2016 the trust publishes nursing and midwifery staffing data on a daily basis at entrances to wards, staffing data is also submitted on a monthly basis through a unify submission to the NHS choices site.

2.1 Summary of fill rates

The inpatient wards have been able to maintain safe fill rates during the month October 2018.

The average fill rate for registered staff in Gynaecology was down to 77.4% day time, but an increase in 97.85% night time, and the average fill rate non registered staff 108.06% day time, 96.77% night time suggesting that RGN gaps were substituted with HCSW for safety purposes during the day shifts. Primarily these gaps were due to staff waiting to commence in post and completion of supernumerary status. Currently across the Gynaecology wards there are 3 RGN vacancies.

Maternity division displayed the same fill rate as the previous month 79.3%, however mat base was higher at 91.9%. The reason for this is mainly due to an increase in short term sickness in October and waiting for new starters to be in place.

Safe staffing for each ward is assessed on a daily basis by the relevant Divisional Matrons. The duty manager is responsible for the evenings and weekends within the divisions and, the on call senior manager has the responsibility for ensuring safe staffing of all ward areas across the Trust.

2.2 Red Flags

October 2018 – Red Flags

There were a total of 18 incidents, reported under the Nursing/Midwifery red flag staffing criteria. 5 incidents in total relating to staffing shortfalls across Gynaecology, Neonates and Maternity.

The main themes across the organisation not related to staffing, were delays in induction but this was due capacity issues within the department and issues around lack of capacity in the Neonatal unit.

Investigations into these concluded that staffing levels and skill mix were safe at the time and did not contribute directly to any incidents. All incidents were reviewed within the recommended timeframes and action plans commenced if appropriate.

3.0 National information

There is no nationally agreed measure of the shortfall in the nursing and midwifery workforce in England, however, Health Education England state that there are 36,000 nursing vacancies in the NHS in England equating to a vacancy rate of 11%

4.0 Vacancies

There is currently no Midwifery vacancies, 3 WTE registered nurses in Gynaecology and 11.6 WTE band 5 vacancies in Neonates. There are robust recruitment plans to appoint into these posts.

Some appointments that have been offered a conditional job offer are being progressed through the Trusts recruitment process.

Retaining staff is a key element in addressing the workforce position and we commenced a retention programme with NHSI starting in Nov 2018 to review our data and processes around recruitment and retention.

Further work is planned over the next 6 months to improve the quality of the staff rosters via the Health Roster system which will then provide more detailed accurate information that will assist in supporting safer staffing across the organisation.

5.0 Summary

During the month of October 2018 all wards were considered safe with low/no levels of harm and positive patient experience across all inpatient areas indicating that safe staffing has been maintained. There has been a noted slight decrease in fill rate within inpatient maternity services, due to long term sickness, a spike in short term sickness, seasonal demands, maternity leave and vacancy rate. Recruitment within maternity is ongoing to address vacancy and maternity leave cover, 1:1 care in established labour remains a green KPI, and midwifery indicators such as Breast-feeding rates have seen an improvement in performance.

Gynaecology continues to remain the focus for monitoring recruitment, due to the National shortages of Registered Nurses and a recent increase in leavers. Reporting of incidents are encouraged ensuring that red flags are discussed and acted on with the Gynaecology Head of Nursing and Management team.

6.0 Recommendations

The board is asked to receive the paper for information and discussion

Safer Staffing Fill Rate - Gynaecology

		Day		Night	
	Ward name	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
Oct-18	Gynaecology	77.4%	108.06%	97.85%	96.77%

Safer Staffing Fill Rate - Maternity

		Day		Night	
	Ward name	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
Oct-18	Induction&Delivery Suites	75.3%	81.7%	84.5%	87.1%
	Maternity Base	91.9%	76.1%	95.8%	98.9%
	MLU & Jeffcoate	72.6%	100.0%	74.7%	96.8%
	Maternity Total	79.3%	80.6%	85.2%	93.5%

Safer Staffing Fill Rate - Neonatal Care

		Day		Night	
	Ward name	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
Oct-18	Neonatal Care	105.4%	90.3%	105.4%	90.3%

Reporting Month Staffing Levels: **Oct-18**
Reporting Month CHHPD: **Oct-18**

Standard	**Patient Safety is delivered through consistent, appropriate**				
Ward	RN/RM		Non Registered		
	Fill Rate Day%	Fill Rate Night %	Fill Rate Day%	Fill Rate Night %	Total Workforce CHHPD
Delivery & Induction Suite	75.27%	84.52%	81.72%	87.10%	21.8
Mat base	91.94%	95.77%	76.13%	98.92%	6.5
MLU & Jeffcoate	72.58%	74.73%	100.00%	96.77%	30.1
NICU	105.44%	105.44%	90.32%	90.32%	12.0
Gynae Ward	77.42%	97.85%	108.06%	96.77%	5.7

Day		Night	
Average Fill Rate	Average Fill Rate	Average Fill Rate	Average Fill Rate
Registered Nurses/Midwives	Care Staff	Registered	Care Staff
87.7%	86.4%	92.9%	93.2%

Agenda Item	2018/293

MEETING	**Trust Board**
PAPER/REPORT TITLE:	**Performance Report month 7**
DATE OF MEETING:	Friday, 07 December 2018
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	Jeff Johnston, Director of Operations
AUTHOR(S):	Jeff Johnston Director of Operations
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** 1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☒ 2. To be ambitious and *efficient* and make the best use of available resource ☒ 3. To deliver *safe* services ☒ 4. To participate in high quality research and to deliver the most *effective* Outcomes ☒ 5. To deliver the best possible *experience* for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust…….* ☐ ***2.*** *Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have sufficient numbers of junior medical staff with the capability and capacity to deliver the best care. ……* ☒ ***3.*** *The Trust is not financially sustainable beyond the current financial year……* ☐ ***4.*** *Failure to deliver the annual financial plan ……* ☐ ***5.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision ……* ☒ ***6.*** *Ineffective understanding and learning following significant events……* ☐ ***7.*** *Inability to achieve and maintain regulatory compliance, performance and assurance……* ☒ ***8.*** *Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) ……* ☐ ***9.*** *Inability to deliver the best clinical outcomes for patients……* ☐ ***10.*** *Potential for poorly delivered positive experience for those engaging with our services..* ☒
CQC DOMAIN	***Which Domain?*** ***SAFE-*** *People are protected from abuse and harm* ☒ ***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☒ ***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☐ ***RESPONSIVE –*** *the services meet people's needs.* ☒

	WELL-LED *- the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.* ☐ ***ALL DOMAINS*** ☐	
LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution ☐ **2.** Operational Plan ☒ **3.** NHS Compliance ☒	**4.** NHS Constitution ☐ **5.** Equality and Diversity ☐ ***6.*** Other: Click here to enter text.
FREEDOM OF INFORMATION (FOIA):	*Choose an item.*	
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	***To note the content and be assured that every effort is being made to improve access targets***	
PREVIOUSLY CONSIDERED BY:	**Committee name** **FPBD** **Quality committee**	*Choose an item.* Or type here if not on list: *Click here to enter text.*
	Date of meeting **24/09/18**	*Click here to enter a date.*

1. Introduction

The Trust Board dashboard is attached in **Appendix 1** below.

2. Performance

The three areas to highlight to the Committee are as follows:-

2.1 NHSI Targets – Access Targets including Cancer targets

2.1.1 18 weeks RTT – 52 week breaches

The Trust has reported the RTT 18 week target as 87% for September a 1% improvement from August. As reported in Board in September reduced consultant capacity will delay the recovery of the target. The shortage of clinical capacity has been previously articulated.

Two locum consultants have now started in the Trust in October and will start to provide much needed capacity in both General Gynaecology and Hysteroscopy to enable earlier Cancer diagnosis. This additional capacity will start to have a positive impact on waiting times and queues from November onwards.

The Trust has also insourced a further two NHS consultants from a company (Medinet) specialising in providing additional capacity for RTT performance. Two weekends were completed and 200 patients were seen for General Gynaecology. The outcomes from those attendances have been reviewed by the Clinical Lead and patients have been slotted into available capacity in Nurse clinic's for follow up treatment or appointments. Capacity for consultant treatment has been reviewed and considered the optimal solution and is currently being arranged.

The Urogynaecology consultants and nurses have now planned additional weekend and evening capacity to start to reduce the queue for first outpatient appointments. General Gynaecology consultants are also providing additional Urogynaecology capacity and this will need to continue until the consultant vacancy is appointed.

The number of 52 week breaches in September is now 12. This has reduced from 21 in August and is a significant improvement. It is anticipated that this will continue to reduce each month eventually to zero by February 2019.

2.1.2 Backlogs

The service has been maintaining a consistent queue of 600 for both first appointments and follow ups for the last 8 weeks. The longest and largest queue is for Urogynaecology due to the vacant post and the relatively small size of the team. Even with the additional capacity provided above it is uncertain that the backlog will be addressed. The Access Board recommended that the polling range (number of weeks that appointment slots are made available in advance – currently six weeks) be extended to 10 weeks and this was approved by FPBD on the 26/11/18. The Access Board took in too consideration the impact on patients in terms of experience, safety and ability to deliver 18 weeks for this sub speciality.

With the additional capacity in General Gynaecology the queues are predicted to reduce and a 6 week polling range will be maintained. Polling ranges will be reviewed weekly by the Access Board.

The Access Board have agreed to pause any further work with Medinet and monitor progress with the internal solutions.

2.1.3 Cancer Targets

All figures for October remain provisional until final sign off via Open Exeter (November 2018) and potential of further impact of diagnosed patients and shared breach allocations with other Trusts.
Confirmed performance for **September** 2018 was as follows:-

- 2 week wait – **Target 93%** - **performance 86.33%** (200 out of 256 patients seen within 2 weeks)
- 31 days DTT – **Target 96% - performance 66.7%** (16 out of 24 patients treated within 31 days of decision) – marginally failed 96% standard due to availability of operating time and patient availability.
- 62 days – **Target 85% - performance 35%** (4 out of 11.5 patients treated within 62 days of urgent referral.)– significant failure due to delays in diagnostics meaning late diagnosis on pathway and complexity of patients requiring input from outside the Trust before being optimised for surgery. This is the post breach reallocation position, and includes 4.5 patients who breached 104 days (RCA undertaken.)
- 62 day upgrade – **local Target 85% - performance 30%** (1.5 out of 5 patients treated within 62 days of upgrade decision) – reasons as above.

Performance against all of the above cancer standards **provisional October 2018 position:-**

- 2 week wait **– 96.33%** (210 out of 218 patients seen within 2 weeks)
- 31 days DDT – **48%** (14 out of 29 patients treated within 31 days of decision)
- 62 days – **27%** (2 out 7.5 patients treated within 62 days of urgent referral). This is subject to change as a result of reallocation between Trusts and delays in diagnostic reporting confirming or excluding a cancer diagnosis of patients treated in month.
- 62 day upgrade – **14%** (0.5 out of 3.5 patients)

These are provisional figures and as has been seen in previous reports will change due to validation of information as part of the access target sign off process.

A significant increase (19%) in the number of 2 week referrals in the month has impacted the ability to achieve this target in month, however, October and November's provisional figures are expected to be above target.

The Access Board has requested that the Cancer Patient Tracking team review breaches of targets to get a better understanding of the 31 day targets performance. Delays in diagnostics can explain a failure to achieve a 62 day target and the 4.5 breaches of the 104 day target.

The additional Hysteroscopy capacity will start to have a positive impact on time to wait for diagnostics (plan to move from 4 weeks to 1 week). However, due to issues with vacancies at the trusts pathology provider (LCL), histology results are being delayed by up to 14 days. This has been escalated to the highest level at LCL with the intention to find an agreeable solution.

3 Conclusion

The achievement of both RTT and Cancer targets are reliant on providing sufficient consultant capacity to treat patients within the specified timeframes. The Trust is increasing capacity from a number of different sources until the permanent consultant recruitment is resolved. Uro gynaecology sub speciality has the longest queues and waits for treatment and additional available capacity may still not be sufficient to fully address the issue. Extending the polling range to 10 weeks will improve patient access to an appointment but will have an impact on the achievement of 18 weeks for this sub speciality.

4 Recommendation

The committee is requested to note the contents of this report.

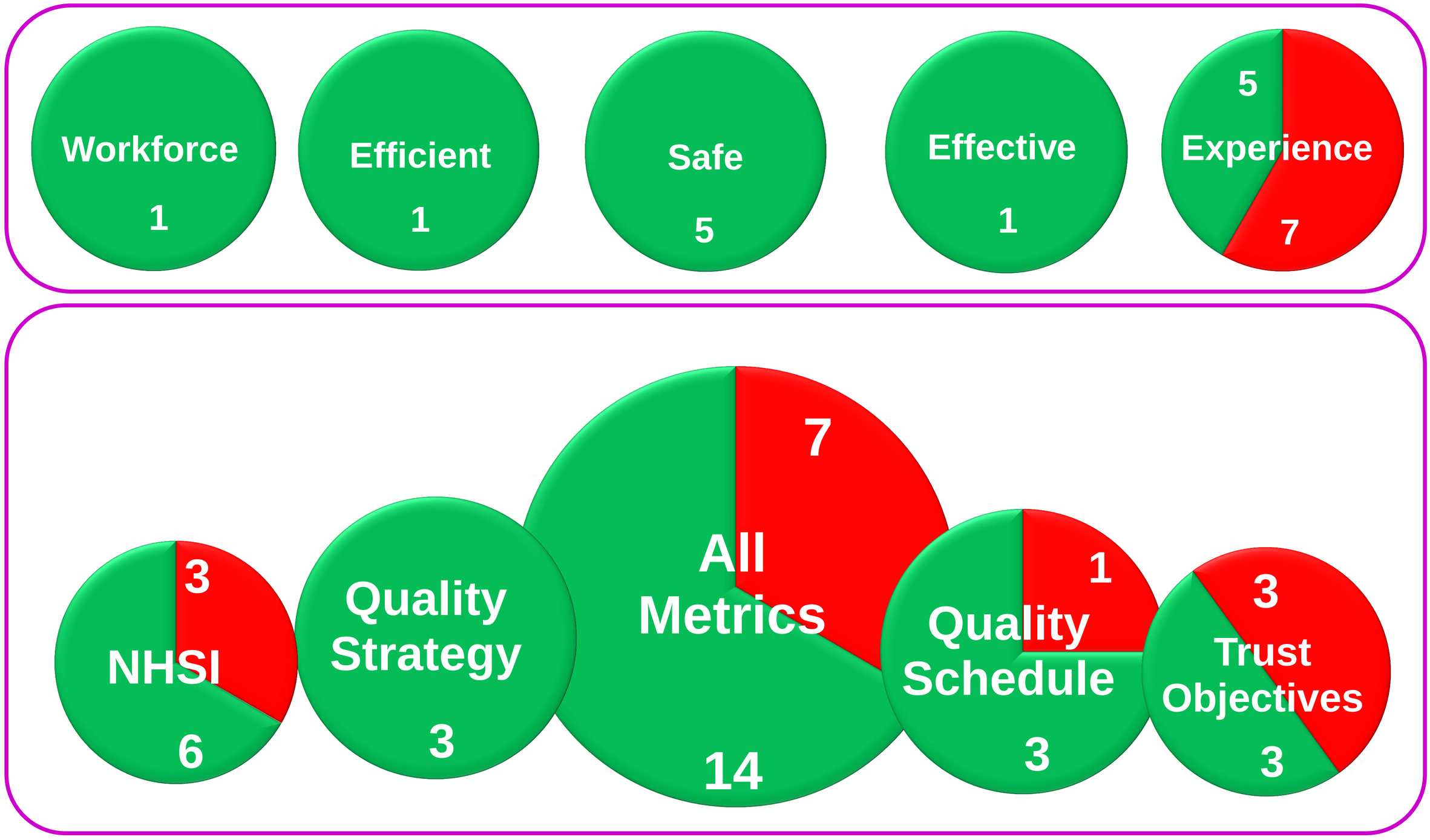
Appendix 1 – Scorecard

Performance Dashboard TB - Octol

Performance and Information Department
Performance Team

Liverpool Women's NHS Foundation Trust

Performance Report for Trust Board — Month 07 - October 2018



* HR Sickness is shown in both NHSI and Quality Schedule but only recorded once in the All Metrics pie chart. Also only showing once in the Workforce chart.

Liverpool Women's NHS Foundation Trust

##

NHS Improvement 2018/19 Month 07 - October 2018

To be EFFICIENT and make the best use of available resources

Indicator Name	Ref	Owner of KPI	Target	Apr-18	May-18	Jun-18	Qtr1	Jul-18	Aug-18	Sep-18	Qtr2	Oct-18	Nov-18	Dec-18	Qtr3	Jan-19	Feb-19	Mar-19	Qtr4
Financial Sustainability Risk Rating: Overall Score	KPI087	Head of Finance	3	3	3	3		3	3	3		3							

To deliver SAFER services

Indicator Name	Ref	Owner of KPI	Target	Apr-18	May-18	Jun-18	Qtr1	Jul-18	Aug-18	Sep-18	Qtr2	Oct-18	Nov-18	Dec-18	Qtr3	Jan-19	Feb-19	Mar-19	Qtr4
Infection Control: Clostridium Difficile (Number)	KPI104 (EAS5)	Infection Control Lead	Refer to Infection Control	Reported in separate report by Infection Control															
Infection Control: Clostridium Difficile - infection rate (12-month rolling) 1 Qtr Behind	KPI320	Infection Control Lead	Refer to Infection Control	Reported in separate report by Infection Control															
Meticillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate (12-month rolling) 1 Qtr Behind	KPI351	Infection Control Lead	Refer to Infection Control	Reported in separate report by Infection Control															
Meticillin-sensitive Staphylococcus aureus (MSSA) rates (12-month rolling) 1 Qtr Behind	KPI335	Infection Control Lead	Refer to Infection Control	Reported in separate report by Infection Control															
Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI) rates (12-month rolling) 1 Qtr Behind	KPI336	Infection Control Lead	Refer to Infection Control	Reported in separate report by Infection Control															
Never Events	KPI181	Head of Governance	0	0	0	0		0	0	1		0							
NHSE / NHSI Safety Alerts Outstanding	KPI193	Head of Governance	0	0	0	0		0	0	0		0							
Mortality Rates: Hospital Standardised Mortality Rates (HSMR) Gynaecology (1 Month Behind)	KPI321	Medical Director	Refer to qtrly Mortality report																
Mortality Rates: Summary Hospital Mortality Indicator (SHMI) (1 Month behind)	KPI322	Medical Director	Refer to qtrly Mortality report																

To develop a well led, Capable, Motivated and Entrepreneurial WORKFORCE

Indicator Name	Ref	Owner of KPI	Target	Apr-18	May-18	Jun-18	Qtr1	Jul-18	Aug-18	Sep-18	Qtr2	Oct-18	Nov-18	Dec-18	Qtr3	Jan-19	Feb-19	Mar-19	Qtr4
HR: Sickness Absence Rate	KPI101	Head of Workforce	4.5%	4.52%	3.6%	4.3%		4.1%	4.3%	4.2%		3.6%							

To deliver the best possible EXPERIENCE for patients and staff

Indicator Name	Ref	Owner of KPI	Target	Apr-18	May-18	Jun-18	Qtr1	Jul-18	Aug-18	Sep-18	Qtr2	Oct-18	Nov-18	Dec-18	Qtr3	Jan-19	Feb-19	Mar-19	Qtr4
Maximum time of 18 weeks from point of referral to treatment in aggregate - Incompletes	KPI003 (EB3)	Access Turnaround Manager	92%	89.41%	89.09%	87.80%		87.73%	86.45%	87.18%									
KPI003 Numerator				4137	4130	4238		4288	4312	4616									
KPI003 Denominator				4627	4636	4827		4888	4988	5295									
All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (Before re-allocation) Final Reported Position	KPI031 (EB12)	Access Turnaround Manager	>= 85%	52.63%	34.78%	63.64%		51.52%	30.77%	34.78%									
KPI1031 Final Numerator				5.0	4.0	10.5		8.5	2.0	4.0									
KPI1031 Final Denominator				9.5	11.5	16.5		16.5	6.5	11.5									
All Cancers: 62 day wait for first treatment from urgent GP Referral for suspected cancer (After Re-allocation) Final Reported Position	KPI030 (EB12)	Access Turnaround Manager	85%	52.63%	33.33%	56.76%		60.98%	28.57%	34.78%									
KPI1030 Final Numerator				5.0	4.0	10.5		12.5	2.0	4.0									
KPI1030 Final Denominator				9.5	12.0	18.5		20.5	7.0	11.5									
All Cancers: 62 day wait for first treatement from NHS Cancer Screening Service referral - Numbers (if > 5, the target applies)	KPI033 (EB13)	Access Turnaround Manager	< = 5	0	1	0		7	1	0									
All Cancers: 62 day wait for first treatement from NHS Cancer Screening Service referral - Percentage Final Position	KPI034 (EB13)	Access Turnaround Manager	>= 90%	N/A	N/A	N/A		100%	N/A	N/A									
KPI1034 Numerator				0	1	0		7.0	1.0										
KPI1034 Denominator				0	1	0		7.0	1.0										
Complaints: Number Received	KPI038	Head of Nursing / Midwifery	<= 15	10	4	8		6	3	2		6							

Performance and Information Department
Performance Team

Liverpool Women's NHS Foundation Trust

LWH Quality Schedule 2018/19 LWH Quality Schedule

To develop a well led, Capable, Motivated and Entrepreneurial WORKFORCE				Key: TBA = To Be Agreed. TBC = To Be Confirmed, TBD = To Be Determined, ID = In Development											
Indicator Name	**CCG Ref**	**Owner of KPI**	**Target 2017/18**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**
HR: Sickness Absence Rate	KPI101 (KPI_27)	Head of Workforce	<= 4.5%	4.52%	3.6%	4.34%	4.1%	4.3%	4.2%	3.6%					

To deliver the best possible EXPERIENCE for patients and staff															
Indicator Name	**Ref**	**Owner of KPI**	**Target 2017/18**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**
18 Week RTT: Incomplete Pathway > 52 Weeks	KPI002 EBS4)	Head Of Operations Gynaecology	0	19	20	19	25	21	12						
A&E: Total Time Spent in A&E 95th percentile	KPI012 (KPI_62)	Head of Nursing	<= 240	230	235	225	225	236	229	238					
Friends & Family Test (Upper quartile will recommend)	KPI089	Head of Nursing	>= 75%	94.6%	96.4%	98.7%	96.9%	89.9%	97.4%	96.1%					

LWH Quality Strategy 2018/19 LWH Quality Strategy

To develop a well led, Capable, Motivated and Entrepreneurial WORKFORCE — Key: TBA = To Be Agreed. TBC = To Be Confirmed, TBD = To Be Determined, ID = In Development

Indicator Name	CCG Ref	Owner of KPI	Target 2017/18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Sickness & Absence Rate	KPI101	Head of Workforce	<= 4.5%	4.52%	3.61%	4.34%	4.09%	4.27%	4.23%	3.63%					

To deliver SAFER services

Indicator Name	Ref	Owner of KPI	Target 2017/18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Never Events	KPI181	Head of Governance	0	0	0	0	0	0	1	0					
Mortality Rates: Summary Hospital Mortality Indicator (SHMI) (1 Month behind)	KPI322	Medical Director	Refer to qtrly Mortality report												

To deliver the best possible EXPERIENCE for patients and staff

Indicator Name	Ref	Owner of KPI	Target 2017/18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Complaints: Number Received	KPI038	Head of Nursing	<= 15	10	4	8	6	3	2	6					

Liverpool Women's NHS Foundation Trust

LWH Trust Objectives 2018/19 Month 07 - October 2018

To deliver SAFER services

Indicator Name	Ref	Owner of KPI	Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Deaths (All Live Births within 28 Days) All live births	KPI168	Clinical Director Neonates	< 6.1%	0.0%	0.42%	0.28%	0.13%	0.00%	0.56%	0.28%					
Deaths (All Live Births within 28 Days) Booked births	KPI168	Clinical Director Neonates	< 4.6%	0.0%	0.28%	0.14%	0.13%	0.00%	0.42%	0.29%					

To deliver the most EFFECTIVE outcomes

Indicator Name	Ref	Owner of KPI	Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Intensive Care Transfers Out (Cumulative)	KPI107	HDU Lead	8 per year (Rolling year)	14	13	11	9	7	6	6					

To deliver the best possible EXPERIENCE for patients and staff

Indicator Name	Ref	Owner of KPI	Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Cancer: Patients waiting 104 days or more from referral to the first definitive treatment	KPI352	Access Turnaround Manager	0	1	3	2	3	2	4.5						
18 Week RTT: Admitted	KPI001	Access Turnaround Manager	>= 90%	85.3%	90.6%	93.1%	93.0%	86.7%	86.7%						
KPI1001 Numerator				412	465	416	436	455	456						
KPI1001 Denominator				483	513	447	469	525	526						
18 Week RTT: Non-Admitted	KPI004	Access Turnaround Manager	>= 95%	91.0%	94.6%	91.9%	90.7%	81.2%	88.5%						
KPI1004 Numerator				1580	1684	1551	1742	1354	1450						
KPI1004 Denominator				1737	1781	1687	1921	1667	1639						

Agenda Item	2018/294

MEETING	**Trust Board**
PAPER/REPORT TITLE:	Finance Performance Review Month 7 2018/19
DATE OF MEETING:	Friday, 07 December 2018
ACTION REQUIRED	**For Discussion**
EXECUTIVE DIRECTOR:	Jenny Hannon, Director of Finance
AUTHOR(S):	Claire Scott, Head of Management Accounts Eva Horgan, Deputy Director of Finance
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** 1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☐ 2. To be ambitious and *efficient* and make the best use of available resource ☒ 3. To deliver *safe* services ☐ 4. To participate in high quality research and to deliver the most *effective* outcomes ☐ 5. To deliver the best possible *experience* for patients and staff ☐
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust…….* ☐ ***2.*** *Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have sufficient numbers of junior medical staff with the capability and capacity to deliver the best care. ……* ☐ ***3.*** *The Trust is not financially sustainable beyond the current financial year……* ☒ ***4.*** *Failure to deliver the annual financial plan ……* ☒ ***5.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision ……* ☐ ***6.*** *Ineffective understanding and learning following significant events……* ☐ ***7.*** *Inability to achieve and maintain regulatory compliance, performance and assurance……* ☒ ***8.*** *Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) ……* ☐ ***9.*** *Inability to deliver the best clinical outcomes for patients……* ☐ ***10.*** *Potential for poorly delivered positive experience for those engaging with our services.* ☐
CQC DOMAIN	***Which Domain?*** ***SAFE-*** *People are protected from abuse and harm* ☐ ***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☐ ***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☐ ***RESPONSIVE –*** *the services meet people's needs.* ☐ ***WELL-LED -*** *the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care,* ☒

	supports learning and innovation, and promotes an open and fair culture. ***ALL DOMAINS*** ☐	
LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution ☐ **2.** Operational Plan ☒ **3.** NHS Compliance ☒	**4.** NHS Constitution ☐ **5.** Equality and Diversity ☐ ***6.*** Other:
FREEDOM OF INFORMATION (FOIA):	2. This report will not be published under the Trust's Publication Scheme due to exemptions under S21 of the Freedom of Information Act 2000, because the information contained is reasonably accessible by other means	
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	***The Board is asked to note the Month 7 Financial Position.***	
PREVIOUSLY CONSIDERED BY:	**Committee name**	Finance Performance and Business Development Committee
	Date of meeting	26/11/2018

Executive Summary

The 2018/19 Board-approved budget set out a control total deficit of £1.6m for the year after the delivery of £3.7m CIP, and receipt of £3.6m Provider Sustainability Funding (PSF). The control total includes £0.5m of agreed investment in the costs of the clinical case for change identified in the 2018/19 operational plan, in addition to the £1.0m 2017/18 investment.

At Month 7 the Trust is reporting a year to date (YTD) deficit of £0.8m against a deficit budget of £2.2m, giving a year to date favourable variance of £1.4m. This is a sustained improvement on prior months and there is reasonable assurance that the control total will be met for the year. However the underlying position going into future years remains a cause for concern. The key areas of financial performance are summarised below.[1]

	Plan	Actual	Variance	RAG
Surplus/(Deficit) YTD	-£2.2m	£-0.8m	£1.4m	⇣
Surplus/ (Deficit) FOT	-£1.6m	-£1.6m	£0.0m	↔
NHSI Rating	3	3	-	↔
Cash	£1.0m	£4.5m	£3.5m	⇣
Total CIP Achievement YTD	£1.5m	£1.5m	£0.0m	↔
Recurrent CIP Achievement YTD	£1.5m	£1.0m	-£0.5m	⇣
Capital Spend YTD	£7.9m	£4.7m	£3.2m	↔

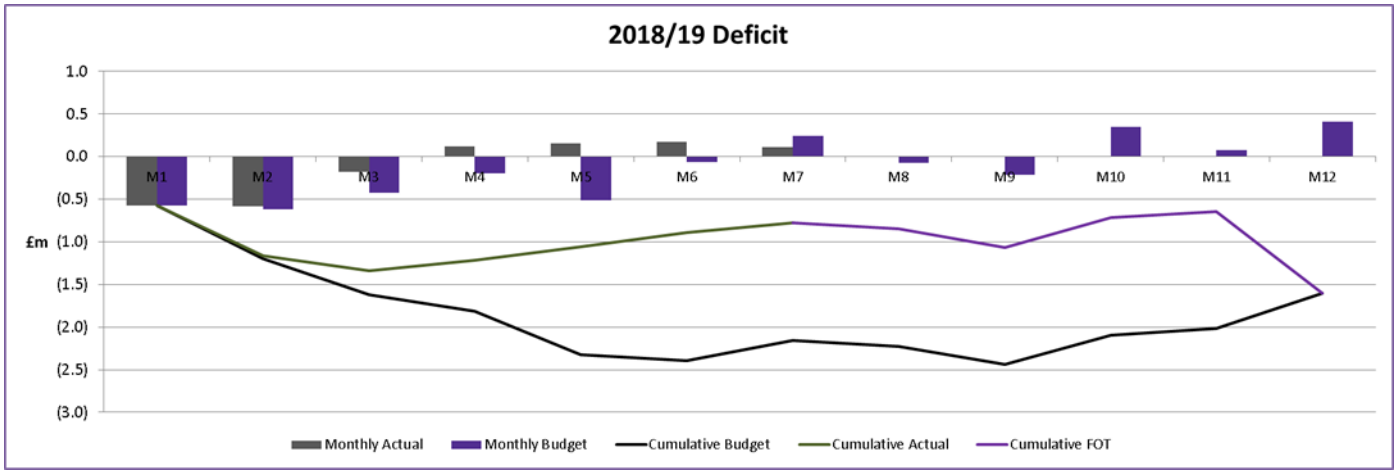
[1] NHSI Rating: Red is 4 or 5, Amber 3 and Green 2 or 1. Cash: Red is <£1m, Amber £1m-£4m and Green £4m+. Capital is not RAG rated. All other KPIs: Red is >10% off plan, Amber 0-10% off plan and Green at plan or better. Arrows denote movement from the prior month.

The Month 7 financial submission to NHSI is consistent with the contents of this report.

Report

1. Summary Financial Position

At Month 7 the Trust is reporting a deficit of £0.8m YTD against a deficit budget of £2.2m. The Trust is forecasting delivery of the £1.6m control total assuming receipt of £3.6m PSF.



In 2018/19 the Trust continues to benefit from the 'Acting as One' contract arrangement with main CCG Commissioners, and the NHSE block contract, which collectively account for 72% of total Trust income.

During 2017/18, the 'Acting as One' block payment was £3.8m higher than would have been received under Payment by Results (PbR). This has continued into 2018/19 with £2.4m additional income earned YTD to Month 7, than would have been earned under PbR. This continued contract under-performance presents a significant financial risk to the Trust from 2019/20, and work is underway to address this, through the 'Right Size' programme and Operational Planning.

Achievement of CIP remains a key risk. Failure to deliver CIP and any subsequent failure to achieve the control total would result in the loss of £3.6m PSF. The Trust has a £3.7m CIP target for 2018/19 which has been delivered at Month 7, but there are risks to full year achievement. Recurrent achievement is behind plan.

2. Divisional Summary Overview

Whilst the Trust-wide financial position remains ahead of plan YTD and is forecast to achieve full year, there are areas of divisional performance which are behind plan or forecasting to be behind.

Division of Family Health: Maternity income improved marginally in month. Overall the directorate position remains ahead of plan YTD (£0.3m) and is forecast to be £0.2m underspent full-year. Neonatal income was slightly below plan again in Month 7. Expenditure was close to plan YTD. Overall the directorate is underspent by £0.1m YTD and is expected to overspend by £0.2m full year, leaving the forecast for the division as a whole marginally overspent.

Division of Gynaecology: The forecast for the division as a whole is a £1.2m overspend, which would represent an improvement on the £0.9m YTD position. Gynaecology income was behind plan again in month (£0.1m), partly driven by consultant vacancies. Pay is on plan, with vacancies offset by agency expenditure. Non pay is slightly overspent leaving the directorate overspent overall YTD (£0.2m).

The financial position in the Hewitt Fertility Centre has worsened to £0.7m YTD and £0.8m full year adverse to plan. The position is forecast to recover somewhat, although there are risks to this.

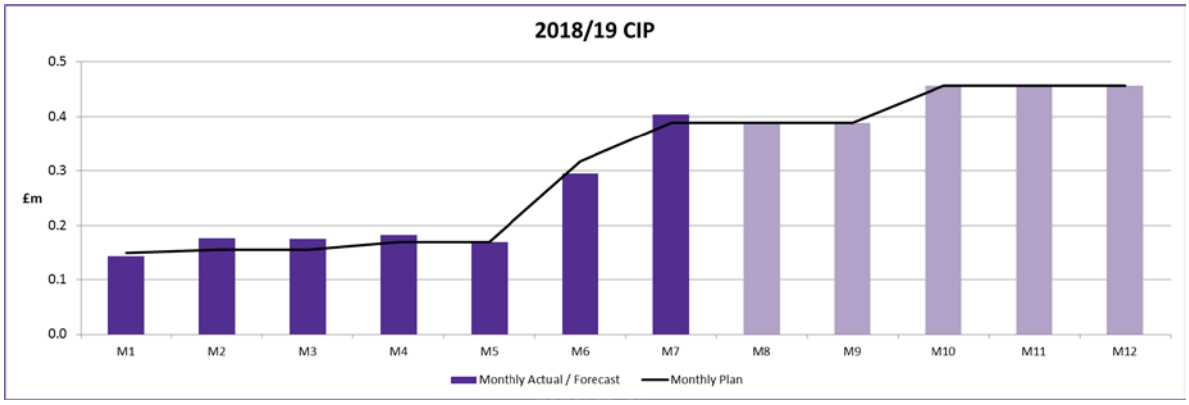
Division of Clinical Support: There is a continued underspend on both pay and non-pay YTD in Theatres, reflective of lower activity in both Gynaecology and Obstetrics. Other areas are forecast to overspend due to use of agency, and the impact of the loss of the anticipated £1m of CNST Maternity Incentive.

Corporate Services and Technical Items: Overall these are within plan in-month, YTD and in the forecast.

Agency: Expenditure against agency staff remains well within the limits set by NHSI, with £0.7m incurred to date against the £1.8m annual cap. The Trust forecasts that it will continue to operate within this limit in 2018/19, although it is anticipated that costs will be above internally set budgets, driven by agency medical staff and operational management.

3. CIP

At Month 7 the Trust has delivered £0.4m against the in-month target of £0.4m, and is forecasting full delivery of the £3.7m CIP, albeit with significant non-recurrent elements (£2m in the full year forecast). The 2018/19 CIP has been profiled in line with planned delivery, which shows the target increasing throughout the year as follows.



4. Contract Performance

Income YTD is £2.4m higher than would have been received under PbR. This is driven by both Gynaecology and Maternity, but proportionately, Gynaecology has the most support from this arrangement.

Directorate	CCG	Month 7 Block	Month 7 Actual	Month 7 Variance	YTD Block Block	YTD Block Actual	YTD Block Variance
Maternity	Liverpool	2,499	2,481	(18)	17,547	16,682	(865)
Maternity	Knowsley	358	305	(53)	2,511	2,352	(159)
Maternity	South Sefton	594	594	(0)	4,173	3,797	(376)
Maternity	Southport & Formby	49	107	58	343	419	76
Maternity Total		**3,500**	**3,486**	**(14)**	**24,573**	**23,250**	**(1,324)**
Gynaecology	Liverpool	1,052	996	(56)	7,157	6,658	(499)
Gynaecology	Knowsley	227	181	(46)	1,546	1,263	(283)
Gynaecology	South Sefton	279	277	(2)	1,899	1,786	(114)
Gynaecology	Southport & Formby	40	47	7	270	234	(35)
Gynaecology Total		**1,599**	**1,501**	**(98)**	**10,873**	**9,941**	**(932)**
Hewitt	Liverpool	141	136	(5)	939	917	(22)
Hewitt	Knowsley	40	33	(7)	264	208	(57)
Hewitt	South Sefton	36	28	(8)	240	229	(11)
Hewitt	Southport & Formby	24	11	(12)	157	126	(31)
Hewitt Total		**240**	**208**	**(32)**	**1,600**	**1,479**	**(121)**
Other	Liverpool	11	10	(1)	77	63	(14)
Other	Knowsley	3	1	(1)	20	11	(9)
Other	South Sefton	3	3	(0)	21	15	(6)
Other	Southport & Formby	0	0	(0)	3	1	(2)
Other Total		**18**	**14**	**(4)**	**121**	**90**	**(31)**
Total		**5,357**	**5,210**	**(147)**	**37,166**	**34,760**	**(2,407)**

Block contract under-performance represents a significant financial risk to the Trust from 2019/20, when the existing 'Acting as One' contract will come to an end. Action plans to address this through Operational Planning which will be reported through FPBD and Trust Board.

5. Forecast Out-turn

The forecast out-turn at M7 remains broadly in line with M5 and M6 with no significant changes in month.

6. Cash and Borrowings

The cash balance at the end of Month 7 was £4.5m compared to a 2017/18 year end position of £6.0m and is ahead of plan, due to the improved I&E position and higher than anticipated creditors and accruals.

Total borrowings stand at £11.3m, following repayment of £5.6m of Distressed Financing in July 18 and a planned payment of £0.3m in September 18.

7. Capital Expenditure

Of the total £12.5m capital plan, £4.7m has been spent YTD, primarily on GDE Fast Follower infrastructure and implementation costs. A total of £1m has now been spent YTD on the Neonatal Redevelopment. Following agreement of the Guaranteed Maximum Price (GMP), the forecast for this programme for 2018/19 has been revised to £3.9m (against an original plan of £7.3m). Loan drawdown will be revised accordingly.

8. Balance Sheet

Creditors are higher than at year end, primarily due to the Trust paying down creditors at year end and an expected increase in-year. A focus remains on recovery of debt, and debtors remain lower than the year end position and than plan.

9. BAF Risk

It is proposed that the BAF score for the in-year risk to delivery of the position be revised down to a likelihood of 4 - likely (from 5 – almost certain). This would result in an overall reduction in the risk score of 25 to 20. This is due to sustained over-performance against plan over a number of months, and the crystallisation and management of a number of key risks. This will be kept under close review over the coming months with a view to further reduction as the year progresses.

10. Conclusion & Recommendation

The Board are asked to note the Month 7 financial position.

Appendix 1 – Board Pack

Board Finance Pack M7.xlsx

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

FINANCE REPORT: M7

YEAR ENDING 31 MARCH 2019

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1 NHSI Score

2 Income & Expenditure

3 Expenditure

4 Divisional Performance

5 CIP

6 Balance Sheet

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LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
NHS IMPROVEMENT RATIOS: M7
YEAR ENDING 31 MARCH 2019

USE OF RESOURCES RISK RATING	YEAR TO DATE Budget	YEAR TO DATE Actual	YEAR Budget	YEAR FOT
CAPITAL SERVICING CAPACITY (CSC)				
(a) EBITDA + Interest Receivable	1,665	3,057	5,053	4,972
(b) PDC + Interest Payable + Loans Repaid	1,493	6,987	2,684	8,092
CSC Ratio = (a) / (b)	**1.12**	**0.44**	**1.88**	**0.61**
NHSI CSC SCORE	**4**	**4**	**2**	**4**
Ratio Score 1 = > 2.5 2 = 1.75 - 2.5 3 = 1.25 - 1.75 4 = < 1.25				
LIQUIDITY				
(a) Cash for Liquidity Purposes	(5,492)	(11,551)	(2,385)	(8,235)
(b) Expenditure	65,704	63,826	111,627	111,650
(c) Daily Expenditure	307	298	306	306
Liquidity Ratio = (a) / (c)	**(17.9)**	**(38.7)**	**(7.8)**	**(26.9)**
NHSI LIQUIDITY SCORE	**4**	**4**	**3**	**4**
Ratio Score 1 = > 0 2 = (7) - 0 3 = (14) - (7) 4 = < (14)				
I&E MARGIN				
Deficit (Adjusted for donations and asset disposals)	2,151	759	1,601	1,601
Total Income	(67,355)	(66,852)	(116,656)	(116,581)
I&E Margin	**-3.2%**	**-1.1%**	**-1.4%**	**-1.4%**
NHSI I&E MARGIN SCORE	**4**	**4**	**4**	**4**
Ratio Score 1 = > 1% 2 = 1 - 0% 3 = 0 - (-1%) 4 < (-1%)				
I&E MARGIN VARIANCE FROM PLAN				
I&E Margin (Actual)		-1.10%		-1.40%
I&E Margin (Plan)		-3.20%		-1.40%
I&E Variance Margin	**0.00%**	**2.10%**	**0.00%**	**0.00%**
NHSI I&E MARGIN VARIANCE SCORE	**1**	**1**	**1**	**1**
Ratio Score 1 = 0% 2 = (1) - 0% 3 = (2) - (1)% 4 = < (2)%				
AGENCY SPEND				
YTD Providers Cap	1,053	1,053	1,805	1,805
YTD Agency Expenditure	750	733	1,284	1,377
	-28.8%	**-30.4%**	**-28.9%**	**-23.7%**
NHSI AGENCY SPEND SCORE	**1**	**1**	**1**	**1**
Ratio Score 1 = < 0% 2 = 0% - 25% 3 = 25% - 50% 4 = > 50%				
Overall Use of Resources Risk Rating	**3**	**3**	**3**	**3**

Note: NHSI assume the score of the I&E Margin variance from Plan is a 1 for the whole year and year to date budget. This is because NHSI recognise the fact that an organisation would not "plan" to have a variance from plan and have not applied a calculated ratio to the budgeted columns of this metric.

Note: scoring a 4 on any of the metrics will lead to a financial override score of 3.

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
INCOME & EXPENDITURE: M7
YEAR ENDING 31 MARCH 2019

INCOME & EXPENDITURE £'000	MONTH Budget	MONTH Actual	MONTH Variance	YEAR TO DATE Budget	YEAR TO DATE Actual	YEAR TO DATE Variance	YEAR Budget	YEAR FOT	YEAR Variance
Income									
Clinical Income	(9,092)	(8,752)	(340)	(61,676)	(60,472)	(1,205)	(106,086)	(104,687)	(1,399)
Non-Clinical Income	(958)	(1,071)	112	(5,679)	(6,381)	701	(10,570)	(11,894)	1,324
Total Income	**(10,051)**	**(9,823)**	**(228)**	**(67,355)**	**(66,852)**	**(503)**	**(116,656)**	**(116,581)**	**(75)**
Expenditure									
Pay Costs	5,779	5,629	150	40,600	39,025	1,575	69,491	68,793	698
Non-Pay Costs	2,342	2,247	95	16,474	15,877	598	27,868	27,558	310
CNST	1,128	1,275	(147)	8,630	8,924	(295)	14,268	15,299	(1,031)
Total Expenditure	**9,249**	**9,152**	**97**	**65,704**	**63,826**	**1,878**	**111,627**	**111,650**	**(23)**
EBITDA	**(802)**	**(672)**	**(130)**	**(1,651)**	**(3,026)**	**1,375**	**(5,029)**	**(4,931)**	**(98)**
Technical Items									
Depreciation	388	394	(6)	2,631	2,737	(106)	4,586	4,696	(110)
Interest Payable	31	17	14	186	150	36	356	286	70
Interest Receivable	(2)	(3)	1	(14)	(31)	17	(24)	(41)	17
PDC Dividend	143	133	10	1,001	931	71	1,716	1,595	121
Profit / Loss on Disposal	0	0	0	0	0	0	0	0	0
Total Technical Items	**560**	**541**	**19**	**3,804**	**3,787**	**17**	**6,634**	**6,536**	**98**
(Surplus) / Deficit	**(242)**	**(131)**	**(111)**	**2,153**	**761**	**1,391**	**1,605**	**1,605**	**0**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
EXPENDITURE: M7
YEAR ENDING 31 MARCH 2019

EXPENDITURE £'000	MONTH Budget	MONTH Actual	MONTH Variance	YEAR TO DATE Budget	YEAR TO DATE Actual	YEAR TO DATE Variance	YEAR Budget	YEAR FOT	YEAR Variance
Pay Costs									
Board, Execs & Senior Managers	361	312	49	2,526	2,370	157	4,331	4,099	232
Medical	1,377	1,254	123	9,637	9,068	569	16,521	16,252	269
Nursing & Midwifery	2,469	2,459	10	17,426	16,902	524	29,768	29,605	163
Healthcare Assistants	390	399	(9)	2,739	2,720	19	4,690	4,782	(92)
Other Clinical	558	545	13	3,906	3,741	164	6,696	6,514	182
Admin Support	168	153	15	1,174	1,131	43	2,013	2,036	(23)
Corporate Services	349	334	15	2,443	2,361	82	4,187	4,128	59
Agency & Locum	107	173	(66)	750	733	17	1,285	1,376	(91)
Total Pay Costs	**5,779**	**5,629**	**150**	**40,600**	**39,025**	**1,575**	**69,491**	**68,793**	**698**
Non Pay Costs									
Clinical Suppplies	753	854	(102)	5,232	5,242	(9)	8,930	8,750	180
Non-Clinical Supplies	493	501	(7)	3,547	3,330	217	6,009	5,801	208
CNST	1,128	1,275	(147)	8,630	8,924	(295)	14,268	15,299	(1,031)
Premises & IT Costs	458	505	(47)	3,212	3,533	(321)	5,303	5,920	(616)
Service Contracts	638	388	250	4,483	3,772	711	7,626	7,088	538
Total Non-Pay Costs	**3,470**	**3,522**	**(52)**	**25,104**	**24,801**	**303**	**42,136**	**42,857**	**(721)**
Total Expenditure	**9,249**	**9,152**	**97**	**65,704**	**63,826**	**1,878**	**111,627**	**111,650**	**(23)**

INCOME & EXPENDITURE £'000	MONTH Budget	MONTH Actual	MONTH Variance	YEAR TO DATE Budget	YEAR TO DATE Actual	YEAR TO DATE Variance	YEAR Budget	YEAR FOT	YEAR Variance
Division of Family Health									
Maternity									
Income	(4,000)	(3,951)	(49)	(28,083)	(27,771)	(311)	(47,997)	(47,665)	(332)
Expenditure	1,930	1,799	131	12,599	11,959	640	21,591	21,068	523
Total Maternity	**(2,070)**	**(2,152)**	**82**	**(15,484)**	**(15,812)**	**328**	**(26,406)**	**(26,597)**	**191**
Neonatal									
Income	(1,367)	(1,327)	(41)	(9,573)	(9,523)	(50)	(16,388)	(16,305)	(82)
Expenditure	1,088	981	108	7,165	7,017	148	12,276	12,430	(154)
Total Neonatal	**(279)**	**(346)**	**67**	**(2,408)**	**(2,506)**	**98**	**(4,112)**	**(3,876)**	**(236)**
Total Division of Family Health	**(2,348)**	**(2,498)**	**149**	**(17,892)**	**(18,318)**	**427**	**(30,518)**	**(30,473)**	**(45)**
Division of Gynaecology									
Gynaecology									
Income	(2,243)	(2,161)	(81)	(15,202)	(15,024)	(178)	(26,139)	(26,234)	95
Expenditure	927	973	(46)	6,289	6,269	20	10,659	11,153	(494)
Total Gynaecology	**(1,316)**	**(1,189)**	**(127)**	**(8,913)**	**(8,755)**	**(158)**	**(15,480)**	**(15,081)**	**(399)**
Hewitt Centre									
Income	(946)	(867)	(79)	(6,219)	(5,578)	(641)	(10,555)	(9,774)	(781)
Expenditure	673	759	(86)	4,455	4,540	(85)	7,627	7,672	(44)
Total Hewitt Centre	**(273)**	**(108)**	**(165)**	**(1,764)**	**(1,038)**	**(726)**	**(2,928)**	**(2,102)**	**(826)**
Total Division of Gynaecology	**(1,589)**	**(1,297)**	**(292)**	**(10,677)**	**(9,793)**	**(884)**	**(18,408)**	**(17,183)**	**(1,225)**
Division of Clinical Support									
Theatres									
Income	(39)	(39)	0	(272)	(275)	2	(467)	(473)	5
Expenditure	702	702	(0)	4,726	4,464	262	8,088	7,843	244
Total Theatres	**663**	**662**	**0**	**4,454**	**4,189**	**265**	**7,621**	**7,371**	**250**
Genetics									
Income	(604)	(625)	21	(4,226)	(4,308)	82	(7,246)	(7,351)	105
Expenditure	503	529	(26)	3,314	3,269	45	5,680	5,571	110
Total Genetics	**(100)**	**(96)**	**(5)**	**(912)**	**(1,039)**	**127**	**(1,565)**	**(1,780)**	**215**
Other Clinical Support									
Income	(28)	(28)	(1)	(190)	(172)	(18)	(330)	(307)	(23)
Expenditure	770	806	(36)	5,324	5,458	(134)	8,987	9,303	(316)
Total Clinical Support & CNST	**742**	**779**	**(37)**	**5,134**	**5,286**	**(152)**	**8,657**	**8,996**	**(339)**
Total Division of Clinical Support	**1,304**	**1,345**	**(41)**	**8,676**	**8,437**	**239**	**14,712**	**14,586**	**126**
Corporate & Trust Technical Items									
Income	(823)	(825)	2	(3,591)	(4,202)	610	(7,534)	(8,472)	937
Expenditure	3,215	3,144	71	25,637	24,638	999	43,353	43,146	207
Total Corporate	**2,391**	**2,318**	**73**	**22,046**	**20,436**	**1,609**	**35,819**	**34,674**	**1,144**
Trust Total (Surplus) / Deficit	**(242)**	**(131)**	**(111)**	**2,153**	**761**	**1,391**	**1,605**	**1,605**	**0**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 5
CIP: M7
YEAR ENDING 31 MARCH 2019

SCHEME	MONTH 7			YTD			YEAR		
	TARGET	ACTUAL	VARIANCE	TARGET	ACTUAL	VARIANCE	TARGET	FOT	VARIANCE
Legal Premium Reduction	147	0	(147)	294	0	(294)	1,030	0	(1,030)
Patient Flow & Demand	16	0	(16)	16	0	(16)	95	65	(30)
Service Development Income	11	3	(8)	69	30	(39)	124	64	(56)
Service Development Non Pay	49	31	(18)	238	216	(22)	482	377	(104)
Service Development Pay	34	4	(29)	73	29	(44)	240	50	(191)
System & Environmental Income	7	7	0	40	39	(1)	73	69	(5)
System & Environmental Non Pay	20	20	0	45	84	39	147	152	4
Technology	26	26	0	181	175	(6)	515	309	(206)
Workforce	80	61	(18)	551	426	(125)	949	744	(202)
Non-recurrent Mitigation	0	252	252	0	549	549	0	1,827	1,821
TOTAL	**389**	**404**	**15**	**1,507**	**1,548**	**41**	**3,656**	**3,656**	**0**

*Scheme names as per NHSI return

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
BALANCE SHEET: M7
YEAR ENDING 31 MARCH 2019

BALANCE SHEET £'000	YEAR TO DATE Opening	M07 Actual	Movement
Non Current Assets	**76,313**	**78,193**	1,880
Current Assets			
Cash	6,013	4,478	(1,535)
Debtors	8,407	8,134	(273)
Inventories	452	436	(16)
Total Current Assets	**14,872**	**13,048**	**(1,824)**
Liabilities			
Creditors due < 1 year	(11,257)	(19,329)	(8,072)
Creditors due > 1 year	(1,686)	(31)	1,655
Loans	(17,221)	(11,316)	5,905
Provisions	(4,514)	(4,819)	(305)
Total Liabilities	**(34,678)**	**(35,495)**	(817)
TOTAL ASSETS EMPLOYED	**56,507**	**55,746**	**(761)**
Taxpayers Equity			
PDC	38,451	38,451	0
Revaluation Reserve	15,367	15,367	0
Retained Earnings	2,689	1,928	(761)
TOTAL TAXPAYERS EQUITY	**56,507**	**55,746**	**(761)**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
CASHFLOW STATEMENT AND BORROWINGS: M7
YEAR ENDING 31 MARCH 2019

CASHFLOW STATEMENT	YEAR TO DATE		
£'000	Budget	Actual	Variance
Cash flows from operating activities	(979)	289	(1,268)
Depreciation and amortisation	2,631	2,738	(107)
Movement in working capital	(1,108)	6,322	(7,430)
Net cash generated from / (used in) operations	**544**	**9,349**	**(8,805)**
Interest received	14	31	(17)
Purchase of property, plant and equipment and intangible assets	(7,892)	(4,028)	(3,864)
Proceeds from sales of property, plant and equipment and intangible assets	0	0	0
Net cash generated from/(used in) investing activities	**(7,878)**	**(3,997)**	**(3,881)**
PDC Capital Programme Funding - received	0	0	0
Loans from Department of Health Capital - received	2,994	0	2,994
Loans from Department of Health Capital - repaid	(306)	(306)	0
Loans from Department of Health Revenue - received	644	0	644
Loans from Department of Health Revenue - repaid	0	(5,600)	5,600
Interest paid	(152)	(150)	(2)
PDC dividend (paid)/refunded	(858)	(831)	(27)
Net cash generated from/(used in) financing activities	**2,322**	**(6,887)**	**9,209**
Increase/(decrease) in cash and cash equivalents	**(5,012)**	**(1,535)**	**(3,477)**
Cash and cash equivalents at start of period	6,013	6,013	0
Cash and cash equivalents at end of period	**1,001**	**4,478**	**(3,477)**

LOANS SUMMARY £'000	Loan Principal Drawndown	Loan Principal Repaid	Loan Principal Outstanding
Loans from Department of Health Capital (ITFF)- 2.0% Interest Rate	5,500	(1,835)	3,665
Loans from Department of Health Capital (Neonatal)- 2.54% Interest Rate	1,000	0	1,000
Loans from Department of Health Revenue - 1.50%	14,612	(7,962)	6,650
Total	**21,112**	**(9,797)**	**11,315**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 8
CAPITAL EXPENDITURE: M7
YEAR ENDING 31 MARCH 2019

CAPITAL EXPENDITURE £'000	Full Year Budget	YTD Budget	Year to Date Actual	Residual Capital Budget	YTD Variance
Neonatal New Building	6,968	3,801	984	5,984	2,817
Other Building Projetcs	293	209	0	293	209
Estates & Environmental Projects	441	383	102	339	281
Global Digital Examplar Fast Follower Technology & IT	3,200	1,867	3,042	158	(1,175)
Medical Equipment	1,640	1,618	523	1,117	1,095
Total	**12,542**	**7,878**	**4,651**	**7,891**	**3,227**

Note: The Capital Expenditure is shown on an "Accruals" basis based on the date of receipt of the capital item by the Trust. This figure differs to the capital expenditure figure shown in the cashflow statement which is on a "Cash" basis.

Agenda Item	2018/295(i)

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Operational Plan - 6 Monthly Review**
DATE OF MEETING:	Friday, 07 December 2018
ACTION REQUIRED	**For Noting**
EXECUTIVE DIRECTOR:	Jeff Johnston, Director of Operations
AUTHOR(S):	Executive
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** 1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☒ 2. To be ambitious and *efficient* and make the best use of available resource ☒ 3. To deliver *safe* services ☒ 4. To participate in high quality research and to deliver the most *effective* Outcomes ☒ 5. To deliver the best possible *experience* for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust…….* ☒ ***2.*** *Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have sufficient numbers of junior medical staff with the capability and capacity to deliver the best care. ……* ☒ ***3.*** *The Trust is not financially sustainable beyond the current financial year……* ☒ ***4.*** *Failure to deliver the annual financial plan ……* ☒ ***5.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision ……* ☒ ***6.*** *Ineffective understanding and learning following significant events……* ☒ ***7.*** *Inability to achieve and maintain regulatory compliance, performance and assurance……* ☒ ***8.*** *Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) ……* ☒ ***9.*** *Inability to deliver the best clinical outcomes for patients……* ☒ ***10.*** *Potential for poorly delivered positive experience for those engaging with our services..* ☒
CQC DOMAIN	***Which Domain?*** ***SAFE-*** *People are protected from abuse and harm* ☒ ***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☒ ***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☒ ***RESPONSIVE –*** *the services meet people's needs.* ☒

	WELL-LED** - the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.* ☒ ***ALL DOMAINS ☒			
LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution ☒ **2.** Operational Plan ☒ **3.** NHS Compliance ☒		**4.** NHS Constitution ☒ **5.** Equality and Diversity ☒ ***6.*** Other: **Click here to enter text.**	
FREEDOM OF INFORMATION (FOIA):	1. This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting			
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	***The Board is asked to note the performance against the Corporate Objectives 2018/19 for the first 6 months of the financial year 2018/19***			
PREVIOUSLY CONSIDERED BY:	**Committee name**	Finance, Performance and Business Development Committee		
	Date of meeting	Monday, 26 November 2018		

The Board of Directors reviewed the Operation Plan 2018/19 and formally approved it in April 2018.

Following document sets out the Operational Plan and the Executives responses to each section following a 6 monthly review.

Recommendation

The Board is asked to note the current status of the Trusts delivery against the Operational Plan 2018/19.

Operational Plan 2018-19

Liverpool Women's NHS Foundation Trust

[FINAL April 2018]

Contents

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1. Executive Summary

Liverpool Women's NHS Foundation Trust (LWH) is a specialist acute trust dedicated to the care of women, babies and their families. The Trust provides maternity, gynaecology and neonatal services as well as reproductive medicine and genetics. The Trust has turnover of £116m (17/18 with £5.5m Sustainability Funding), employs circa 1,400 staff and delivers care to circa 60,000 patients each year. The Trust had an actual deficit in 17/18 of £1.3m after receipt of £5.5m of sustainability and transformation funding. The underlying recurrent deficit is £7.2m.

The Trust has a strong track record of operational and financial control delivering levels of cost improvement above the national average for several years. In 17/18 the Trust delivered £3.7m of CIP in addition to the £20m delivered in the preceding five years without adversely impacting on quality of care. National benchmarking shows that the Trust has consistently demonstrated that it is an efficient organisation, however as a small specialist organisation the Trust carries proportionally high overheads.

In June 2014 the Trust formally notified regulators and commissioners that it was no longer clinically or financially sustainable in the long term. The Trust has undertaken several detailed reviews since that time which all came to the same conclusion. In November 2015 the Trust published the Future Generations Strategy which detailed the clinical case for change and recommended that services be relocated to the Central University Hospital Campus (Royal Liverpool hospital site). Commissioners and regulators have accepted the clinical case for change.

Liverpool CCG have produced a further pre consultation business case, approved in November 2016, which also concluded that the preferred option would be to relocate services to the Central University Hospital Campus. This involved a capital cost of approximately £104m and resulting revenue savings of £4.6m pa.

NHS England whilst accepting the clinical case for change require assurance regarding the affordability and availability of capital, and are not prepared to move to public consultation until this is addressed. As a result additional work has been performed during 17/18 to satisfy these concerns. A Strategic Outline Case was produced by the Trust in September 17 which demonstrated both the availability and affordability of capital. At the same time an independent peer review by the North England Senate confirmed the findings contained within the Trust's clinical case. This information is with NHS England for consideration and the Trust is hoping to go to public consultation in summer 18 on the option(s).

However, even if public consultation were to proceed immediately, the relocation of services would require a minimum of five years given the application process for capital which the Trust would need to follow and the site and build requirements. The clinical case for change has now been known and accepted by the Trust's Board for over four years. The clinical risks associated with the clinical case for change are now being mitigated as far as is possible within the resources available to the Trust. This has included investment in staffing and an immediate £15m investment in the neonatal estate as set out in the 17/18 operational plan. Liverpool CCG, NHS England and NHS Improvement accept the do nothing option is no longer sustainable.

The Board have carefully assessed the immediate clinical risk, taking advice from the clinicians at the Trust, and believe that the plans for mitigation must continue to be pursued. The Trust will therefore continue to invest in mitigating actions whilst approval for the preferred option continues.

In 17/18 the Trust invested £1m recurrently into staffing and enhanced arrangements with local trusts. The Trust's control total was adjusted by this amount in 17/18 to support this.

A further investment of £0.5m is required in 18/19 which the Trust is funding by an increase to the cost improvement target. This approach however is not sustainable and a long term solution must be reached. During 18/19 the Trust will refresh its plans for mitigations on site which are expected to add significant revenue and capital cost pressures to the Trust whilst the long term solution is enacted.

On this basis the Trust has agreed the 18/19 control total of £1.6m deficit supported by £3.6m of Provider Sustainability Funding (PSF).

The following sections of the operational plan provide an update to the Trust's approach to clinical risk, quality planning, workforce issues, patient activity and the financial forecast for 18/19.

In the following sections in bold and italics a six monthly update is provide under each section if appropriate.

2. Vision and Values

The Vision, Aims and Values have been developed over a long period of time with input from the Board, Staff, Governors and Stakeholders.

Our vision:		To be the recognised leader in healthcare for women, babies and their families
Our strategic aims – WE SEE	W	To develop a well led, capable, motivated and entrepreneurial Workforce;
	E	To be ambitious and Efficient and make best use of available resources;
	S	To deliver Safe services;
	E	To participate in high quality research in order to deliver the most Effective outcomes;
	E	To deliver the best possible Experience for patients and staff.
Our values – We CARE and We LEARN:		Caring – we show we care about people; Ambition – we want the best for people Respect – we value the differences and talents of people; Engaging – we involve people in how we do things; Learn – we learn from people past, present and future.

3. Future Generations

Review of Women's and Neonatal Services

The Trust submitted a five year plan to Monitor (now NHSI) in June 2014 which set out the financial and clinical challenges faced by the Trust. The Trust reviewed the strategic options and produced a report in November 14. However the Trust clinicians requested further time to review the clinical evidence.

Throughout 15/16, the Trust continued the development of the 'Future Generations' strategic plan which aimed to address the achievement of long term clinical and financial sustainability.

In December 15, the resulting business case received formal approval from the Trust Board and was submitted to Monitor and Liverpool CCG for review. Liverpool CCG accepted the case for change and commissioned its own review into Women's and Neonatal services.

The review was supported by an external consultancy and a wide range of clinicians and commissioners. The overall governance was undertaken by a Project Oversight Group at which all stakeholder groups were

represented. This was supported by a Clinical Reference Group, again clinicians from all stakeholder groups were represented. The review followed a standard option appraisal methodology.

Liverpool CCG concluded the Pre-consultation Business Case (PCBC) in November 16. The PCBC presents four short listed options including;

- Enhancing the Crown Street site to meet the clinical case for change
- Minimum enhancements to the Crown Street site, which did not meet the clinical case for change
- Relocating services to Alder Hey Children's NHS FT in a new build and
- Relocating services to Royal Liverpool and Broadgreen University Hospitals NHS Trust in a new build

Of the four short listed options the PCBC contains evidence which clearly demonstrates that one option, relocation to a new build co-located with the Central University Campus, scored highest in all domains under consideration within the options appraisal framework, those being quality, feasibility, financial sustainability and strategic fit.

In September 17 the Trust produced a Strategic Outline Case to demonstrate the availability and affordability of capital in relation to the options. At the same time the Northern England Clinical Senate issued a report on its findings in relation to the clinical sustainability of services at the Trust. This concluded that 'the current isolated position of both Women's and Neonatal services at LWH means both services have very significant clinical risks'. The independent Clinical Senate also recognised that the current configuration of services at the Trust and workarounds in place are unsustainable and that a change in the clinical model 'is needed to ensure safety, quality and clinical sustainability'.

The Senate concluded that there is a strong clinical argument for change, emphasising the risks with delivering care for women and newborns on a stand-alone site away from other related services, as is currently the case at Liverpool Women's. Among the range of issues it highlights are the problems that the Trust faces recruiting anaesthetics specialists, due to its isolated position; the fact that Liverpool Women's does not have CT or MRI scanning facilities, a blood bank or an adult intensive care unit; and the lack of space in the neonatal unit.

The Trust and Liverpool CCG are pursuing agreement from NHS England to proceed to public consultation on the preferred option during 18/19. In the meantime the Trust has been awarded £15m in the form of a capital loan to address the immediate clinical risks on the neonatal unit. Whilst this is a welcome step, it does not negate the overall clinical requirement to co-locate with the adult acute.

Whilst the Trust awaits a decision to proceed to consultation and enact the longer term vision there are actions identified to enhance the safety of the workarounds on site in the interim as set out below.

Management of clinical Risk as Identified through the clinical Case for Change (Future Generations Strategy)

Two comprehensive in-house and CCG-led service reviews in the last three years, as well as independent peer review from the Northern England Clinical Senate, have highlighted several important, escalating clinical safety weaknesses. These are outlined service-by-service below together with planned and on-going measures to mitigate the clinical risks. These mitigations, while significant, will nevertheless fall well short of the full benefit that would be realised by relocation of the services to a hospital site already providing multidisciplinary acute adult care. This is because relocation would give rapid access to medical and surgical teams from other specialties to assist with a full range of acute and sub-acute medical or surgical complications, access to a specialised cardiac arrest team and access to a Level 3 Intensive Care Unit, none of

which can be provided at Crown Street. Relocation would also obviate the need for the high-risk ambulance transfer of acutely ill women between hospital sites.

Neonatology

It is incumbent upon the health service to provide the best possible quality of care to newborn babies who have medical needs. The neonatal unit at Liverpool Women's Hospital receives a high volume of babies facing the most severe medical challenges. At the Crown Street site, there are two key areas of concern. The first relates to deficiencies in the estate. The second relates to the provision of specialised staff.

The current estate at LWH is not fit for the purpose of providing neonatal intensive care. There is insufficient floor space for neonatal cots - this increases the risk of life-threatening infection. One such infective event has already led to the need for a four-cot reduction in capacity at LWH and in other UK sites, similar estate deficiencies have resulted in more extensive outbreaks of infection. In addition, there is a shortage of parental accommodation. The unit does not comply with Hospital Building Note (HBN) specifications, despite previous investments. Following the submission of a business case to make the estate fit for purpose, £15m capital investment has been agreed and a two year programme of rebuilding and refurbishment is now underway.

The £15M extension has completed the design phase and the GMP has been agreed, building works will commence in December 2018 with a completion for July 2020.

The current provision of Consultant Neonatologist resident cover falls short of the 12/7 standard recommended by the British Association of Perinatal Medicine (BAPM). An investment in five additional Consultant Neonatologists is required for this purpose. This previously agreed position is now being acted upon, with an active programme of recruitment underway. The present availability of senior trainees in the specialty is low so a step-wise increase in numbers is being undertaken at a rate of one new consultant per year in five consecutive years.

Two additional consultants above the starting baseline have already been appointed and an extended consultant presence on the neonatal unit is now being enacted, with increased late evening hours being provided on site

In addition, developing an Advanced Neonatal Nurse Practitioner (ANNP) team is seen as a key local strategy to counter a nationally experienced shortfall in the numbers of neonatologists in the medical workforce. Such a workforce redesign could exacerbate existing neonatal nursing shortages in Cheshire and Merseyside and would require investment in backfill of posts.

An additional 2 ANNP's have been recruited to training and the total ANNP establishment has increased by x to y over the last a years. The service has also maintained nursing staff levels and is reporting shift patterns at BAPM standards on a regular basis.

Work is progressing towards the provision of a single NICU service across two sites, Liverpool Women's and Alder Hey, with this work being overseen by the ODN.

A business case has been submitted to NHSE for the development of a single NICU service across two sites, Liverpool Women's and Alder Hey. The Trusts have agreed a Memorandum of Understanding and governance framework and have started the implementation of some aspects of the business case in advance of approval. This will result in uniform standards of care being provided to neonates across the city, a uniform governance structure and an enhanced fit-for-purpose estate being provided at the Alder Hey site. This model will better serve the neonatal population, increasing standards of care and reducing the need for transfer between sites as the now Alder Hey facility will have the capacity to care for its own postoperative neonatal patients.

Maternity

The escalating problem facing the maternity service relates to the fact that major risk factors for serious maternal morbidity and mortality are increasing. These include population factors such as increasing levels of obesity and delay of pregnancy to a later age, plus more specific medical factors such as an increase in the numbers of women with severe medical co-morbidities who are now choosing to reproduce. These are nationally encountered phenomena but they are particularly relevant to the Liverpool population because of its high-risk socio-economic profile. To mitigate, an increase in Consultant Obstetrician numbers is underway as previously detailed, to provide twenty-four hour Delivery Suite presence on seven days per week. To achieve this, eight WTE Consultant Obstetricians will be required in addition to the present quota. It is acknowledged that the present availability of senior trainees in the specialty is low so a step-wise increase in numbers is taking place at a rate of one new consultant per year in eight consecutive years. Improvements to crucial support services would also be required for optimal clinical benefit, to include: provision of an on-site blood bank, provision of on-site CT and MRI facilities and provision of on-site laboratory services for blood testing. Each of these facilities would require an initial capital outlay then full personnel support, which may not presently be achievable.

An increase of two consultants has been achieved and this has allowed an increase in weekend cover, so that 13 hours a day are now provided by consultants on site, seven days per week.

Gynaecology

The escalating problem facing elective and semi-elective gynaecological services relates to the fact that a rising number of women are accessing care, who have multiple medical co-morbidities and/or risk factors for severe surgical complications. As a result, the service has become increasingly reliant upon specialist input from other medical and surgical specialties to ensure that treatment is carried out in the safest way. In addition, the volume and complexity of emergency work being dealt with through the Gynaecology Emergency Department has risen steadily in recent years, while gynaecological support for the management of acute, life-threatening obstetric haemorrhage on the Delivery Suite also has to be provided. These factors are placing significant demands upon the Consultant Gynaecologists who presently, at times, have to continue performing their elective work while simultaneously covering emergencies. To mitigate and as set out in the 17/18 plan, an increase in Consultant Gynaecologist numbers is underway: funding the attendance of Gynaecological Oncologists at specialised MDTs, funding the attendance of Consultant Gynaecologists at joint operating lists at RLUBH and increasing the number of sessions provided by Consultant Gynaecologists in the Emergency Department., An increase in the provision of acute surgical operating lists is now required at the Crown Street site from one to two per week and provision must be made for two acute care ward rounds to take place per day in keeping with the Seven Day national agenda. This plan will ultimately require the employment of two WTE Consultant Gynaecologists in addition to 2017 numbers. The present availability of senior trainees in the specialty is low so a step-wise increase in numbers would be required at a rate of one new consultant per year in two consecutive years.

An active drive to recruit consultants with specialist skills in gynaecological cancers and Urogynaecology has therefore been undertaken. A new consultant member of the oncology team is commencing work with the Trust imminently and interviews for a subspecialist in Urogynaecology will take place within the next two months. In

keeping with these changes, a 'consultant of the week' model has now been adopted by the consultant workforce for acute gynaecological cases and an increase in the provision of acute surgical operating lists is being introduced at the Crown Street site, from one to two per week.

The provision of medical leadership in gynaecology has also been enhanced, which will improve safety and efficiency. A new CD is in post and clinical leads have been appointed in benign gynaecology, oncology and urogynaecology, all of whom will be working in the Trust's new divisional structure.

In addition, the purchase of clinical sessions from specialists in colorectal surgery (3.0 PA), urology (2.5 PA) and radiology (with specialised pelvic imaging expertise, 2.0 PA) is underway together with support from a dermatologist, psychologist and HDU Educator. Finally, the purchase of sentinel node biopsy equipment is planned for diagnostic use in the cancer services. This group of measures will bring the service into closer alignment with nationally accepted standards of care, although not fully closing that gap.

The oncology service maintain the theatre sessions at the royal with support from specialist clinicians and are developing a joint business case for Ultra Radical procures for 2019/20.

Anaesthesia

There are no physicians or surgical specialty doctors present on the Crown Street site and no support from the Critical Care Network to provide a Level 3 Intensive Care Unit on that site. In addition, Modernising Medical Careers has brought about early specialisation in recent years, so present trainees in Obstetrics and Gynaecology are significantly less likely to have had training in acute medicine and critical care compared to their equivalents in previous years. The twenty-four hour presence of a Consultant Anaesthetist in the Trust on seven days per week is therefore planned, to allow for the safer provision of anaesthesia but also to allow for the most effective response to physiological deterioration across a range of life-threatening obstetric, gynaecological, medical and surgical conditions when these arise. To achieve this goal, the plan is to increase the present quota of Consultant Anaesthetists by 7.5 WTEs. It is acknowledged that recruitment into Consultant Anaesthetics posts is difficult, therefore, any additional staff to support an increase in out of hours cover would have to be done in conjunction with RLBUH and recruitment would have to be phased at a rate of one additional new consultant per year. This project is now underway.

One and a half newly appointed WTE post holders having joined the team in the last month, both of whom have skills vital to the delivery of safe services in the Trust.

Costs Associated with Meeting the Clinical Case for Change

As detailed above the Trust's clinical body have assessed the clinical risks and determined mitigations required the planning period. As noted above the mitigations outlined below will not resolve the clinical risk, this will not occur until the Trust services are relocated to the Central University Hospital Campus.

The costs of mitigating the clinical case for change are summarised below and have been re-profiled since the 17/18 operational plan submission to reflect the re-profiled timing of investment. As part of the refresh performed as part of the Trust's Strategic Outline Case, and in consultation with the Medical Director, the Trust deferred some costs into future years. This was on the basis that if the Trust secured approval during this time to undertake the preferred option of a move to the Central University Hospital Campus, this investment on site could be avoided.

The revised profile (denoting in the case of revenue a recurrent investment in each year) is as follows.:

Capital costs of addressing immediate clinical risks

	PER 17/18 OPERATIONAL PLAN	2017/18	2018/19	Total cost
1	Costs of upgrading to the neonatal unit to address risk of infection and meet HBN standards	£7.0m	£8.0m	£15.0m
2	Capital cost of blood bank and diagnostics in 2, 3 and 4 below	£2.9m	£2.8m	£5.7m
3	Backlog maintenance to address eg fire safety, water hygiene and domestic hot water	£1.0m	£1.0m	£2.0m
	TOTAL CAPITAL IMPACT	**£10.9m**	**£11.8m**	**£22.7m**

	REVISED FOR 18/19 OPERATIONAL PLAN	2017/18	2018/19	Total cost
1	Costs of upgrading to the neonatal unit to address risk of infection and meet HBN standards	£1.0m	£6.0m	£15.0m
2	Capital cost of blood bank and diagnostics in 2, 3 and 4 below	-	-	£5.7m
3	Backlog maintenance to address eg fire safety, water hygiene and domestic hot water	£0.5m	£0.5m	£1.0m
	TOTAL CAPITAL IMPACT	**£1.5m**	**£6.5m**	**£22.7m**

The total cost impact to address the risks remains the same but now materialises later in 19/20.

Revenue costs of addressing immediate clinical risks

	PER 17/18 OPERATIONAL PLAN	2017/18	2018/19	Annual recurrent cost
1	Costs associated with addressing safety risks of multiple medical co-morbidities. Predominantly staff costs and including colorectal, urologist and radiologist consultant cover	£0.5m	£0.5m	£0.5m
2	On site blood bank to mitigate in instances of eg sepsis and haemorrhage	-	£1.0m	£1.0m
3	Enhanced laboratory diagnostics on site to include rapid processing of eg FBC, UE, blood clotting and cardiac enzymes	-	£0.7m	£0.7m
4	Enhanced on-site imaging capability to mitigate in instances of eg sepsis, thrombosis and haemorrhage	-	£0.5m	£0.7m
5	24/7 consultant cover to deliver more effective interventions and reduce surgical complication rates	£0.5m	£0.7m	£2.7m
6	Additional depreciation in relation to capital upgrade requirements	-	£0.5m	£0.7m
7	Additional interest costs in relation to capital borrowings	-	£0.5m	£0.5m
	TOTAL COST IMPACT	**£1.0m**	**£4.4m**	**£6.8m**

REVISED FOR 18/19 OPERATIONAL PLAN	2017/18	2018/19	Annual recurrent cost
Costs associated with addressing safety risks of multiple medical co-morbidities. Predominantly staff costs and including colorectal, urologist	£0.5m	-	£0.5m

and radiologist consultant cover			
On site blood bank to mitigate in instances of eg sepsis and haemorrhage	-	-	£0.9m
Enhanced laboratory diagnostics on site to include rapid processing of eg FBC, UE, blood clotting and cardiac enzymes	-	-	£0.7m
Enhanced on-site imaging capability to mitigate in instances of eg sepsis, thrombosis and haemorrhage	-	-	£0.7m
24/7 consultant cover to deliver more effective interventions and reduce surgical complication rates	£0.5m	£0.5m	£2.7m
Additional depreciation in relation to capital upgrade requirements	-	-	£0.7m
Additional interest costs in relation to capital borrowings	-	-	£0.5m
TOTAL COST IMPACT	**£1.0m**	**£0.5m**	**£6.7m**

The revenue costs are predominantly investments in staffing which would be transferable across to a new site.

The Trust has continued to invest in the clinical case for change, although in year there has been underspends against the plan, particularly arising from the timing of the appointment of consultants and recharges from other Trusts.

Capital investment has begun in the neonatal unit following the approval of £15m to upgrade the unit to address infection risks and HBN standards. The full capital allocation will not be required for the year due to the timings and phasing of the project. NHSI have been informed of a £3.4m underspend against this budget in year. This will be spent in future years as part of the overall plan.

Given the time that had elapsed since the original clinical standards review the Trust performed a further review against these standards which was presented to the Trust Board in October 2018.

A revised plan is being developed to accommodate and update the current investment position taking into account the feasibility of the mitigations and changes since the first review was performed in 2014/15. This will be impacted by the outcome of the most recent capital bid submitted in the summer of 2018 for the funds to enact the preferred option (subject to public consultation). The outcome of this is expected in December 2018.

4. Quality Planning

Approach to quality improvement

The Director for Nursing and Midwifery is the Trust's named executive lead for quality improvement.

Regulations 4 to 20A of Part 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (as amended), are subject to an audit programme of assessment using external and internal resources. This is completed by adopting the full CQC methodology in terms of Regulations and process (KLOE), and is Trust wide to evidence 'board to ward' transparent, evidential learning used to inform Quality improvement and improve the current 'Good' CQC rating.

The Trust analyses its own performance using key quality indicators and has benchmarked these indicators against national and international comparators.

It is recognised that many different change models exist to frame the delivery of transformation and quality improvement. LWH is embracing a lean PDSA model of quality change with Prince light methodology. Service improvements are coordinated by the Trusts Transformation team and this team uses organisation-wide

Master Classes to provide front line staff with a range of simple tools and techniques to deliver quality and service improvement.

Following the Unannounced and well Led inspections by the CQC in February and March 2018 the Trust once again as awarded Good Status in relation to compliance with the Health and Social Care Regulation's (2014). The Gynaecology service received requires improvement and there is a plan in place to make improvements and develop the current service, supported by a new divisional structure, including new Head of Nursing for Gynaecology, Divisional Manager and Clinical Director. The new leadership structure will assist in implementing improvements with the Gynaecology service with an aim that the outcome from the next CQC Inspection for the Trust is achieving Outstanding overall.

From the inspection, the Trust received notification of 1 breach of section 10 of the regulations relating to dignity and Privacy. A number of other recommendations were made and all these have been placed into an action plan, which is being led by the Head of Governance and Quality.

All area of quality improvements are monitored via the Quality Committee and Effectiveness and Safety Senates. The Trust continues to use the PDSA and Prince light methodologies with the Quality Improvement Lead managing the service evaluations which are being completed regularly within the services. There has been an increase in the number of service evaluations being completed during the past 12 months, with the process becoming more established within the services.

Summary of the quality improvement plan (including compliance with national quality priorities)

The Trust's quality improvement plans in relation to local and national initiatives include:

- Continued participation in all Clinical Audits that form part of the National Clinical Audit Programme as a sub section of the Healthcare Quality Improvement Programme (HQUIP).
- Care hours per patient per day have been recorded and reported appropriately and will be continued to be monitored and benchmarked to ensure the most effective utilisation of clinical teams.
- Systems are in place for the review of mortality in Gynaecology, Maternity and Neonatology. The Quality Senate and Trust Board of Directors receive quarterly and annual reports in relation to mortality. Work is ongoing to triangulate with post discharge deaths in other organisations.
- The Infection Control Team implements and follows an annual work plan which is approved by the Board of Directors and is publicly available. This includes all elements of the provision of safe care with regards to infection control in addition to audits and compliance with external standards e.g. Health Care Act and NICE QS 61 & QS113. There is additional scrutiny for all areas in light of the concerns and risk identified through the Future Generations clinical case for change and specifically within Neonatal services, where the reduction in cot capacity continues due to estate limitations and risks. This will be addressed through the £15m Neonatal capital investment.
- Regular audits of antimicrobial usage are conducted by Pharmacy and reported to medicines management and to the CCG (monthly). The Trust utilises an antimicrobial formulary which directs and controls antimicrobial usage. CQUIN targets for 72 hour review are being met. The Trust's antimicrobial strategy will be updated in year.

There are no changes to this one apart from identifying that we do not have an Antimicrobial Strategy in place. We follow the formulary and the HCAI Framework.

- The forward plan for End of life care includes:
  - Ongoing annual review of End of Life Care for adults dying at the Trust
  - Annual relatives survey

- Implementation and roll out of Advanced Care Planning and documentation within the Trust
- Considering the use of Patient Reported Outcome Measures (PROMs) as part of patients ongoing assessment
- Review of Educational Plans
- Progressing towards the use of EPaCCs (Electronic Palliative Care Coordination system)
- Inclusion in subsequent reports EoL care provision within Neonatal and Maternity Services.

The Palliative Care consultant and Nurses undertake an annual review of care provided to dying patient within the Gynaecology unit. The audit is completed on a calendar year basis and the 2017/18 reported showed significant achievement across all required areas.

Advanced care planning is in place as part of the palliative care process.

PROMS are currently ongoing with discussion on a wider locality basis as to best way to proceed.

Educational provision is in place.

EPaCC's is currently being discussed with Aintree and the Royal Palliative Care teams and is linked to the ongoing EPR workflows.

Neonatal service follows the North West Neonatal Palliative Care guideline and pathway, which includes plans for the death of a bay at home, hospice and on the Neonatal Unit. This is not formally reported on at this time.

There is no specific palliative care guideline currently related to maternity care. An Adult Bereavement Guideline is in place, this is not formally reported on at this time.

All Neonatal and Maternal death are reported as part of the mortality strategy and all have a mortality case reviews completed.

- The Trust's improvement priorities as described in the Quality Strategy, Quality Report and CQuINs are monitored through the monthly performance report. Prior to closure intended corrective action reports are submitted and addressed through the relevant Senate (Safety, Effectiveness & Experience). Further monitoring and scrutiny is provided through reporting of associated risks to the Corporate Risk Committee.

These are reported as part of performance reports at board and sub committees' of the Board.

- The Combined Quality and Performance Group, with CCG membership consider the Trust's Quality and Performance reports and the metrics included in the Quality Strategy, Quality Report and CQuINs. Further, the Local Authority OSC's and CCGs are able to comment on and influence the metrics included in the Quality report and priorities for the upcoming periods. This ensures that the Trust's priorities are consistent with those of the STP.

Better Births- National Maternity Review – Implementation plans for Liverpool Women's NHS Foundation Trust

- LWH in partnership with the local Maternity Vanguard one of 7 Pioneer sites for better births in the country
- Community Redesign based on better births and to provide care closer to home across boundaries
- The pilot of the personalised maternity care budgets starting December 2016

- Bespoke enhanced midwifery service to wrap around the whole service specifically focussing on vulnerable women with perinatal mental health issues
- Working with the local vanguard towards single point of access for choice and personalisation
- Bespoke parent education services as part of the personalised maternity care budget offer – choice and personalisation
- Pilot of a homebirth team to address the continuity of carer / choice / personalisation element of choice of place of birth
- LWH in partnership with the local Maternity Vanguard one of 7 Pioneer sites for better births in the country
- Cheshire and Merseyside STP just named as one of the 7 early adopter sites of which LWH is a primary partner with the Regional Head of Midwifery/Gynaecology Lead Nurse and Clinical Director / Obstetrician
- Pilot of pop up Freestanding Maternity Units as part of the early adopter partnership work.

The Trust is on track with the implementation of better births, 7 requested elements, 5 are green, 1 amber due to IT issues, 1 red due to payments, awaiting clarification from DOH regarding tariff and cross boundary charges. One element continuity of care NHS E have produced further guidance surrounding the continuity element of midwifery care, stating that 20% of all booked women at LWH are required to be on a COC pathway (whereby the same midwife or small caseload of midwives provide all aspects of midwifery care, namely, Antenatal, Inpatient and Post Natal). We have recently undertaken interviews for existing midwifery staff to form part of these teams:

- Home birth team

- Elective Cs pathway by postcode

- LINK clinic.

NHSE vision is that this 20% will increase year on year,, the remaining red elements of Better births, namely digital and payment we should receive further clarification to enable LWH to produce green compliance.

Summary of quality impact assessment process

The Trust has an established Transformation and Turnaround Committee providing the governance assurance for change and transformation schemes impacting all areas across the Trust. The Committee meets formally on a fortnightly basis and reports to Finance, Performance and Business Development Committee as a subcommittee of the Board of Directors.

The Turnaround and Transformation team work in a number of ways to support contributors in the development and assessment of potential schemes which may result in changes to service construct. The team has developed a pan trust communications strategy, undertaken road shows and master classes and has supported the annual planning process with director colleagues.

The Trust's current Quality Impact Assessment (QIA) process is considered to be robust and appropriate by Internal Audit and thus in keeping with the spirit reflected by the CQC. In order to ensure consistent quality of application the Turnaround and Transformation team coordinate many of the QIA's required for service related schemes across the Trust. There is a robust QIA for all projects which are required to be reviewed and signed off by both the Medical Director and Director of Nursing and Midwifery.

The Finance Performance and Business Development committee received the 6 monthly impact assessment in November 2018.

Summary of triangulation of quality with workforce and finance

The Trust's performance metrics are presented in a combined format including quality, workforce and financial indicators. This is reviewed on a monthly basis by the Trust Management Group with oversight by sub-Board Committees. The Turnaround and Transformation Committee has added additional scrutiny to this process with oversight across all of these strands led there by the Medical Director and Director for Nursing and Midwifery.

The reviewed indicators include inputs from NHSI, Trust Quality Strategy, Quality Schedule and CQUINs.

The Board receives regular reports across all of the corporate aims. The Trust governance meeting structure is aligned to ensure Ward to Board reporting and appropriate escalation of risks and management.

The Board uses this information both in the operational management of services and in its risk management processes. Triangulation allows themes emerging from quality, workforce and finance to be aligned and dealt with in collaboration rather than through separate processes. Further more detailed reviews are then commissioned by the Board of Directors through the sub board committees and governance structure and reported back including improvement trajectories and outcomes that provides the requisite assurance on the quality of care and enhanced productivity.

5. Workforce

Fit for Future Generations

In line with the Trust's strategic direction 'Future Generations', a transformational programme was launched, 'Fit for Future Generations'. This programme has the objective of delivering new ways of working in order to achieve financial sustainability whilst maintaining quality of patient care.

The Trust continues to closely review workforce expenditure in line with its quality and financial management processes. Robust management of agency, bank and temporary staffing continues and a vacancy control panel consisting of senior clinical and non-clinical managers reviews every prospective vacancy before it is approved by the Executive Team.

The Trust continues to look at how we can use our staff more efficiently and flexibly. We have commenced a Strategic Workforce Review group to provide senior medical and nurse oversight of all clinical posts in the Trust to deliver co-ordinated, multidisciplinary workforce planning.

Transformation schemes continue to deliver workforce efficiencies. Projects which will impact upon workforce numbers in 18/19 include an automated outpatient reminder system and the Community Midwifery redesign project. Planned relocation of a ward and co-location of the gynaecology and maternity assessment units overnight will release further staffing efficiencies.

Staffing reviews reflect the impact of changing activity levels across all clinical services. There has been a particular reduction in gynaecology nursing staffing as a result of the inpatient redesign and merging of two wards. This has been carefully planned and managed through attrition and holding of vacancies to ensure that no redundancies or redeployments were required.

A Trust wide review of Healthcare Assistants will take place in 2018/ 19 to deliver two clear grades of HCAs who can be utilised flexibly across the Trust. A review of Specialist Nurses will better align specialist nurse capacity with service demand and deliver a long term succession plan for this hard to recruit to workforce. We are embarking on a programme to give nurses in gynaecology flexible competencies to work across the division, as activity requires.

In addition, a MARS scheme will again be offered to staff in 18/19, taking the opportunity to achieve cost savings in roles which do not have an impact on clinical outcomes or performance.

All CIP workforce related schemes and those arising from organisational change are subject to Quality and Equality Impact Assessments.

Key workforce challenges

In common with other NHS Trusts, the most significant risk for LWH is the ongoing shortages and fluctuating supply of junior doctors, specifically in Obstetrics and Gynaecology

The Trust is pursuing three main approaches to address these deficits:

- Continuing with the planned increases in the consultant establishment in obstetrics, neonatal, gynaecology and anaesthetics.
- Recruitment of innovative Trust grade doctor posts, including a partnership with the Liverpool School of Tropical Medicine and a programme for Doctors from India to undertake a MSc at Edgehill University
- Increase of specialist, advanced and consultant nursing roles and expansion of these roles into new areas including Advanced Midwifery Practitioners in triage and assessment

The Trust is working towards the requirement of seven day working with a long term programme of investment, recruiting an additional consultant posts in each clinical specialty in line with the requirements detailed in the 17/18 operational plan.

Achieving stability and sustainability within the workforce whilst ensuring we continue to be ambitious about our services is a primary objective of the Trust in the next financial year.

A joined up approach to budget setting, operational planning and workforce planning has been established with operational and financial colleagues to deliver more accurate predictions of workforce needs for the next 1-3 years. The Strategic Workforce Review Group has proved valuable in adopting a Trust wide, multidisciplinary approach to the development and planning of new and specialist roles to ensure there is a planned approach to training for roles such as consultant nurses. The group is enabling promotion of apprenticeships and has supported the achievement of regional funding to create the first Advanced Midwifery Practitioners in the UK. As part of this group we are developing an annual plan for the establishment and recruitment of attractive Trust grade doctor posts, drawing on our successes in recruiting doctors internationally, in partnership with the Liverpool School of Tropical Medicine and in tailored research posts.

Health and wellbeing remains a strategic priority for the organisation. Following investment in the development of mental health first aiders and Trust wide health and wellbeing initiatives including a H&WB App, resilience training, pamper days, walking groups and exercise classes, the focus moving forward is to focus resilience training and physiotherapy interventions in those 'hotspot' areas identified by sickness data and workforce surveys. The Trust is also participating in the NHSI sickness project which supports the organisation to review policy and practice around sickness absence management. Practical support around supporting staff with disabilities and implementing reasonable adjustments has been a focus for the operational HR Team.

The implementation of the Fair and Just Culture project is in its early stages and will have a material impact on the organisational approach to people management and employee relations and the HR department is reviewing policy and practice to support the adoption of a culture where there is accountability rather than blame and learning rather than disciplinary sanction is the focus.

Developing and retaining our workforce

The Trust will further roll out its talent management programme in 18/19. This programme identifies clear timescales for career progression and staff are supported to undertake the Trust Leadership programme. In recognition of the difficulty in recruiting to the ward manager and matron level, we have developed a specific 'Aspirant Talent' programme for our future clinical leaders to prepare them for the challenges of a management role in the future. We continue to develop our apprenticeship strategy and are focused on pathways including Assistant Practitioner and Advanced Practitioner to meet future service needs.

Talent management and developing our workforce in house continues to be an area of focus. Talent management is now embedded within the PDR framework and the programme for Aspirant Ward Managers/ Matrons is now established with seven participants' part way through the programme, enabling the delivery of a succession plan for hard to recruit matron and ward manager posts.

Retention is another area of focus and in order to understand the reasons why our staff leave and encourage them to stay, we have implemented or revised our current approaches to exit interviews, 'stay' conversations and new starter welcome events. New approaches to retire and return and career conversations are in development.

In the spirit of developing and retaining talent, the Trust will embark on a Shadow Board programme from April onwards, enabling existing senior managers as well as more junior staff to experience the process of a Trust board and have the opportunity to contribute to decision making at the most senior level.

Following the introduction of a revised management 'triumvirate' structure, a programme of training and development has been put in place to support the new teams to function effectively, this includes a bespoke development programme for new Clinical Directors.

Working in partnership

The Trust has been pro-active in outsourcing and sharing a range of corporate and support services in support of our future strategic direction and to make cost savings and quality improvements. These include recruitment services (outsourced in January 18) payroll services and occupational health services continue who are all provided by neighbouring NHS Trusts as well as legal services which are now provided by a law firm at reduced cost. We share a Chief Information Officer and Chief Pharmacist post with a neighbouring NHS Trust.

Both our estates and procurement management is also provided by a neighbouring Trust and we provide management support to the safeguarding services at the same NHS Trust.

Our Imaging Services Manager has been appointed as Citywide Lead for Imaging Services in a new shared post to deliver efficiencies in radiography and sonography across a number of Trusts.

In order to ensure our posts are remain attractive to the best candidates, and address the clinical risk factors of being a stand-alone tertiary unit we have created a number of jointly appointed Consultant posts with other Trusts. These include two posts in neonatal, four in anaesthetics and one post with the Liverpool School of Tropical Medicine as well as a number of consultants who undertake sessional commitments.

We continue to participate in regional projects to improve efficiency and sustainability including the Cheshire and Merseyside streamlining project. We are reviewing our arrangements for rostering and bank and agency usage and working collaboratively in these areas with other Trusts to drive down costs and improve quality of service.

Engagement and Communication

We continue to listen and engage with staff views regarding the strategic direction of the organisation. We are currently involving staff in the refresh of our 'Putting People First Workforce Strategy' to determine key workforce priorities for the next 3 years. The engagement score has remained static in the 2016 and 2017 Annual Staff Survey. The Trust is investing a new system, 'Go Engage' to be launched in April 18 which is an online survey tool and team development programme to identify issues and trends in the organisation and provide teams with the tools to improve their own performance.

The Trust continues to achieve response rates for the national staff survey far in excess of the national average. In order to gain staff feedback on a more regular basis we have recently implemented a quarterly survey system called 'Listening to our People' which will give detailed feedback on levels of engagement in the organisation and enable managers to take timely action.

Quarterly Listening events are now well established and offer an opportunity for discussion of key issues with staff of all grades with executive and non-executive colleagues.

In developing the Trust 'Putting People First' strategy for the next 3-5 years, there has been extensive engagement with staff, and stakeholders including governors to ensure our workforce aims are achieved.

We continue to strive to ensure we are an inclusive employer, representative of the communities we serve and have established two successful pre- employment programmes, one of which offers training and placements within the Trust to individuals with disabilities. We remain focused on offering ways in which our BAME staff members can be supported to grow into leadership and management roles.

6. Activity

Contract and activity 2018/19

The Trust used 16/17 forecast outturn to plan activity levels for 17/18 and 18/19. These plans were supported by local population figures and demographic data.

The contracts with main commissioners include growth of 1% for 17/18 and a further 1.5% for 18/19.

Capacity and Demand

There has been a change in referral patterns and Maternity bookings that continues to be actively monitored and reviewed against capacity. This is done with consideration to the wider NHS economy and risks being managed by other local Trusts. The Trust is also participating in the wider Cheshire and Merseyside conversations regarding acute care collaborations across Cheshire and Merseyside and mindful of the impact these may have.

In 2019/20 the Maternity bookings have stabilised and are forecast deliveries at 8200 for the year. The Trust has re engaged with other local providers in terms of longer terms strategies and potential collaborations.

The Trust will complete a new Capacity and Demand model as part of the "right sizing" project for the Operational plan for 2019/20.

Gynaecology

Inpatient and outpatient transformational programmes were completed in 17/18 and continue to be monitored and reviewed for further improvements.

Changes in referrals to the service and increased medical intervention requires further capacity modelling particularly in the Outpatient and Ambulatory settings to ensure that demand is met.

There have been significant challenges in 17/18 in terms of consultant vacancies and gaps in junior doctor rota's that have impacted capacity in year. Recruitment to these posts is a priority as well as training additional specialist nursing posts for succession planning and as an alternative to parts of junior doctor roles.

As part of a service improvement programme plans are being developed to provide a single service gynaecology emergency room service and a maternity assessment unit out of hours. This will provide a more resilient and sustainable workforce model and will provide a platform to explore a single service 24/7. Other service improvements which will also improve utilisation of the estate include outpatients, termination of pregnancy services and inpatient day case services.

The service continues to work closely with The Royal Liverpool and Broadgreen University Hospitals in the development of complex gynaecological cancer. Both Trusts are also exploring beneficial use of estate to provide a quality environment for patients of both Trusts, plans for a new Royal outpatient facility are at early stages of planning.

There has been a change in referrals to Cancer 2 week rules with increases on this pathway up by 25%. This has seen the activity in oncology increase. However, although referrals in the first two quarters have increased marginally to the rest of gynaecology, activity is below plan. This is mainly due to the reduced capacity caused by vacancies and sickness but also changes in medical practice (ie, reduce follow up's , Nurse checks transferring to the community). Activity analysis is also highlighting the move from inpatients to day cases and ambulatory as medical practice changes.

Gynaecology has seen a number of significant challenges in terms of the Serious Incidents declared in February 2018 in respect to 18 weeks RTT and Cancer targets. The significant reduction in consultant capacity has caused a delay in the recovery of national access targets. Progress has been made in the appointment of additional General Gynaecology and Oncology consultants. The impact of these appointments and additional locum capacity will have a positive impact on waiting lists and access targets in Q4. Overall, this has also impacted the services ability to achieve the CCG contracted activity plan; this is being reviewed as part of the "right sizing project" for the 2019/20 operational plan.

The Gynaecology emergency room has merged with the Maternity assessment Unit in the evenings as a test pilot for a potential full merger. The Results of the pilot will be published in quarter 4 and next steps agreed.

The service is currently developing an Ultra Radical Business Case jointly with RLBUH which is planned to be complete in Q4.

Neonatal

Gaps in the middle grade junior doctor rota's continues to be a challenge, however, the service has a rolling programme to train additional Advanced Neonatal Nurse Practitioners

The service continues to develop a Transitional Care offering and Neonatal Outreach Service that over time has been seen to help reduce admissions to the unit and enable earlier discharge home and improve patient experience.

The service has worked closely with Alder Hey Children's Hospital to develop a business case for a single level 3 Neonatal Unit on two sites for submission to NHSE Specialist Commissioners. This is expected to be a phased approach to developing specialist Neonatal care at Alder Hey over a number of years starting early in 18 dependent on approval of finances by commissioners.

The service has also seen approval of a £15M capital bid to extend and improve the current footprint of the service so that the environment meets building and neonatal standards. The contract has recently been awarded under P22 procurement and is expected to take two years to complete.

Both ANNP and junior doctor's numbers have improved and the service is now well resourced in these areas'.

Neonatal services have agreed a MOU with Alder Hey for a single Neonatal Service, have submitted a business case to NHSE and have started implementation of the plans at risk until commissioner approval. Governance arrangements have been established.

The £15M extension has completed the design phase and the GMP has been agreed, building works will commence in December 2018 with a completion in July 2020.

Maternity

The service dynamically reviews inpatient capacity and its ability to flex workforce to meet seasonal demand. Unlike most other Trusts locally, seasonal variation sees an increase in activity in Maternity in the summer/autumn months rather than during the winter period. The service has a plan that allows both staffing and the environment to be flexed to meet the seasonal variation. Work was completed in 17/18 to improve discharge pathways to ensure an efficient and safe flow of patients.

The service closely monitors bookings and deliveries as well as the capacity in other local services. Although deliveries were lower in 2017/18 than expected there has been no downsizing of the service due to the nature of the service and the risk and capacity of other local services. Activity trends and local providers situation will be considered in any changes to the capacity offered during 18/19.

The Trust is currently mid-way through a redesigning of its Community Midwifery Services in line with recommendations from the National Maternity review: "Better Births". This will see more activity moving to strategically located community hubs and reducing attendances in the hospital, which is also in line with Liverpool CCG's Healthy Liverpool programme. This will result in reducing the number of sites used for patient care in the community whilst increasing the scale of community services offered. The Trust is working closely with the Cheshire and Merseyside Women's and Children's Partnership (Vanguard) on the recommendations in the review and also leading for the region the "Pioneer Project" and "Early Adopter" initiatives.

Maternity activity has reduced as anticipated and is expected to have deliveries in the region of 8200 (2017/18 8600). The service has reduced costs in terms of pay and non pay and will also review service income and costs as part of the "right size project" for 2019/20.

General

The services continue to recruit to additional consultant posts to increase presence 24/7 as part of mitigating the current risks and preparing for "Future Generations Strategy"

The Trust is mindful of the requirement to maintain or reduce waiting lists from March 2018 levels and reduce 52 week waits by half.

The Trust is managing waiting lists with plans to reduce by March 2019; it is unlikely this will reduce below the March 2018 number due to the SUI's. The Trust has a plan to eradicate all 52 week waits by February 2019.

Genetic services have successful bid in Partnership with services in the Northwest to win the laboratory services for the North West. Central Manchester is the lead provider and a mobilisation plan is being developed to meet the NHSE timeframes for full implementation. Plans are being developed in partnership to TUPE staff to the lead provider.

7. Financial Forecast and Modelling

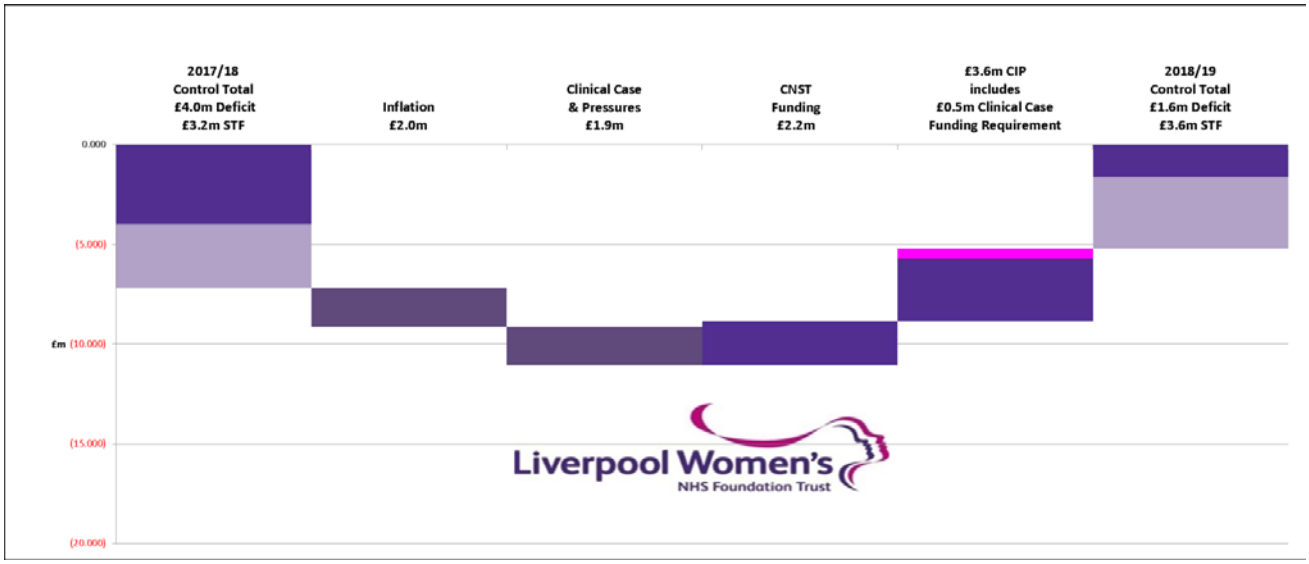
OVERVIEW

In 17/18 the Trust had a deficit budget of £4m in line with the agreed control total set by NHSI. This control total reflected an adjustment of £1m acknowledging the requirement to invest in the mitigation of risks arising from being on a stand-alone site as articulated in the clinical case for change. This position was after £3.2m of Sustainability and Transformation Funding (STF) indicating an underlying deficit of £7.2m.

For 18/19 the Trust has been set a control total deficit of £1.6m. This is after additional STF/PSF income and CNST adjustments of £2.6m.

Financial planning has been underway since December 17 and £3.6m of CIP has been identified to support delivery of the Trust's 18/19 plan. The underpinning schemes have been through the Trust's internal processes with Project Initiation Documents, Equality Impact Assessments and Quality Impact Assessments agreed. It is noted that this is a very challenging but attainable cost improvement target for the Trust. The Trust therefore believes that the Control Total deficit of £1.6m set by NHSI is achievable and has indicated acceptance of this in the financial plan.

The 18/19 financial outlook is summarised below.



Using the metrics set out in the Single Oversight Framework which came into effect on 1 October 2016, delivery of the above financial plans will give the Trust a score of 3 for 'finance and use of resources'.

The Trust continues to require distressed financing in 18/19.

ASSUMPTIONS

Within these totals are the following assumptions.

Contracts & Activity Performance

The Trust has in place two year contracts covering 17-19 which were signed in December 16.

The agreed contract with the Trust's main commissioners, including the lead commissioner Liverpool CCG, is a block 'Acting as One' contract. This represents c85% of all CCG income received by the Trust. The Trust has re-confirmed this contract for 18/19 with commissioners.

The Trust also has a two year agreement with NHS England for its Specialist services which has been confirmed for 18/19.

During 18/19 the Trust will continue to adapt ways of working in line with demand, national protocols, looking at care closer to home and reduced follow up appointments amongst other initiatives. The Trust will use this period to adapt to these changes ahead in which the Trust expects to see some wider scale changes arising from the developing Cheshire and Mersey system initiatives.

Inflation

Cost uplifts have been applied in line with national economic assumptions.

CNST Premium

The CNST premium for 18/19 has been confirmed at £15.2m. The Trust has had the control total target adjusted by £2.2m which reflects the tariff increase relating to CNST in the Acting as One Contract.

Cost pressures

The Trust faces a number of unavoidable cost pressures for 2018/19 including

- Costs associated with introduction of NICE guidelines in Maternity
- Pressures within the medical budget arising from Junior Doctor cover
- Increased estates maintenance and utilities costs

Clinical Case

The 18/19 budgets make provision for additional 24/7 Medical Cover (4 x Consultants) as set out in the Trust's Strategic Outline Case of September 17, which re-profiled the requirements set out in the original Operational Plan (see section 4).

These costs are ongoing and will require further significant investment from 19/20 onwards. Elements of these costs could be avoided subject to the outcome of the assurance processes in relation to the Trust's preferred option.

2017/18 undelivered CIP

CIP schemes to the value of £0.2m are forecast to not deliver on a recurrent basis in 18/19. This has been added to the 18/19 CIP target.

2018/19 Cost Improvement Program (CIP)

Included within the 18/19 financial plan is a total CIP requirement of £3.6m. This represents 3.3% of the Trust's operational cost base and is an incredibly stretching target in terms of what the Trust can deliver in its current form.

The Trust has approached CIP with vigour over recent years, delivering £23m since 12/13 through a combination of cost reductions and commercial growth. This was supported by a turnaround approach for

14/15 and 15/16 which identified and delivered £11m of improvement. Subsequently the Trust has used nationally recognised tools such as GIRFT, model hospital, FIP and the ten point efficiency plan to examine further opportunities.

Schemes are subject to detailed project plans, Quality Impact Assessment and Equality Impact Assessment both before and during implementation. The schemes are signed off by the Medical Director and Director of Nursing and Midwifery before implementation. Internal audit reports have demonstrated that there are good controls over CIP identification and processes.

These processes have been further strengthened with the appointment of a Turnaround and Transformation Director in 2016, the establishment of a programme management office to support identification and delivery of savings and greater oversight from a Turnaround and Transformation Committee. Clinical engagement remains critical to the delivery of the challenging efficiency programme and a robust communication and engagement strategy has been developed.

Despite this the identification and delivery of CIP has become increasingly difficult year on year as the Trust exhausts its options to make significant improvements.

A summary of the targeted efficiency savings in 18/19 is set out in the table below.

CIP Scheme - recurrent delivery	2018/19
Legal premium reduction	£1.0m
Workforce	£0.8m
Service development	£0.8m
Technology	£0.6m
System and environmental projects	£0.3m
Patient flow and demand	£0.1m
Total	**£3.6m**

The Trust aims to explore further a more transformational approach during 18/19 necessary to deliver the required targets going forward. It is the aim of the Trust to deliver savings through consolidation of corporate service functions with a view to reducing corporate overhead to 7% as per the Carter recommendations. The Trust will also pursue a review of organisational form with a view to releasing the optimum amount of savings which can then be targeted towards frontline services.

Sustainability and Transformation Funding (now Provider Sustainability Funding)

The Trust is planning for receipt of £3.6m Provider Sustainability Funding (PSF)

Use of agency and achievement of agency cap

The Trust expects there to be a requirement to use agency staff in areas where there are national shortages. The Trust is also mindful of the impact of the Future Generations strategy on staff turnover and the ability to attract new staff substantively into posts. The Trust will continue to take all steps to minimise agency spending and adhere to national guidance. As a result the Trust is planning to be within its agency financial cap of £1.8m.

Capital planning

The Trust's ongoing capital plan remains restricted in light of the deficit position and requirement for distressed finance support. Plans for 18/19 are for critical items only and are subject to review and approval by the Medical Director and Director of Nursing and Midwifery. The total operational capital spend for each year is within annual depreciation levels. This includes £0.5m to address risk adjusted backlog maintenance.

In December 17 the Trust had a DH loan approved for £15m to extend and refurbish the neonatal unit in response clinical concerns. The spend profile in 18/19 is expected to be £7m.

The Trust was also awarded Fast Follower status a part of the Global Digital Exemplar initiative. This will attract £5m of matched expenditure and will support investment in digital innovation, electronic patient records and clinical transformation ensuring the Trust remains digitally mature over the next 4 years.

The Trust's capital requirements are set out in the table below:

Area	2018/19
Neonatal Build (in year)	£7.0m
IM&T – Digital Strategy (inc Fast Follower)	£3.2m
Critical medical equipment	£1.6m
Other estates	£0.7m
Total	**£12.5m**

The items included in the plan have been identified by service leads as critical. Medical equipment, which accounts for the majority of the internally generated spend, generally consists of items which are expected to require replacement during the planning years, however this is reviewed on an item by item basis at the time of replacement.

Cash flow

The sustained deficit means that the Trust will require further cash support over the planning period. This is in addition to a total of £14.6m of distressed financing drawn down at the end of 2017/18.

Requirement	Interim Revenue Support required
2015/16 actual	£5.6m
2016/17 actual	£7.0m
2017/18 actual	£2.0m
2018/19 planned	£1.6m
Total cash funding required	**£16.2m**

The Trust agreed a control total of a deficit of £1.6m for 2018/19, inclusive of a cumulative investment of £1.5m in the Clinical Case for Change, a CIP programme of £3.7m and Provider Sustainability Fund income of £3.6m. As at Month 6 the Trust was ahead of plan. Agency spend is well within the cap set by NHSI and the Trust is achieving its planned Use of Resources Score.

Two significant CIP schemes- the CNST Maternity Incentive Scheme and EPR- will not deliver in 2018/19. Overall, the CIP programme is expected to significantly under-deliver recurrently but non-recurrent mitigations have been utilised.

This puts more pressure onto 2019/20. Note that a large component of non-delivery is the CNST Maternity Incentive, which the Trust is both lobbying NHS Resolution to implement fairly in 2019/20, and ensuring adherence against the standards for 2018/19 (which may change in 2019/20).

The forecast remains on plan. Although a slight deterioration in expenditure is expected in the second part of the year due to ongoing recruitment and other issues, there is a possibility that the Trust may over-perform and there is upside opportunity not yet reflected in the forecast. This will be kept under review during the remainder of the year.

The Trust has achieved Q1 and Q2 Provider Sustainability Fund of £1.3m – this cannot now be clawed back. It is anticipated that the remaining £2.3m in Q2 and Q3 will be achieved. Should the Trust over-perform, it has been indicated that additional incentive PSF may be available.

Due to achievement of the 2017/18 Sustainability and Transformation Fund, and an improved cash position through improved I&E position, the Trust was in a position to repay £5.6m of distressed finance borrowings. Cash at Month 6 was significantly ahead of plan at £5m (against a plan of £1m) and there are no current concerns about liquidity or cash.

As at Month 6, capital expenditure of £3.8m had been incurred, against the total plan of £12.5m for the full year. Of this, the majority (£2.4m) related to the Global Digital Exemplar Fast Follower programme. Expenditure on the Neonatal build was behind the original plan. The expected expenditure in 2018/19 has subsequently been re-profiled, with £3.4m of the overall plan now expected to be incurred in 2019/20. Other areas were largely within plan YTD, with a higher level of expenditure anticipated in the second half of the year.

The Trust continues to benefit from the block contract with activity levels £2.2m below blocked income at Month 6. This is being factored in to the Right Size program underway within the organisation. The Right Size program aims to rebase the budgets based on expected levels of activity, demand and capacity considerations, and workforce issues. This will also factor in external influences and initiatives.

Cost pressures and non-delivery of CIP have been managed in year, partly due to the block income cover and due to the management of risk within the Trust's overall budget.

KEY RISKS TO THE FINANCIAL PLAN

Changes in activity

The Trust has entered block contracts with its main commissioners which include c1% for activity growth, however if growth exceeds this level the financial risk will fall to the Trust

The remainder of the CCG contracts are of a PbR nature, if activity drops below plan so will Trust-wide income. A number of CCGs have also indicated their intention to review procedures of limited clinical value, including gynaecology and fertility services, this may lead to a reduction in income for the Trust. Reducing the cost base accordingly within rapid timescales will be difficult.

Delivery of Cost Improvement Program

The Trust has delivered £23m of CIP since 12/13. The target of £3.6m in 18/19 represents 3.0% of operational expenditure and is recognised as difficult to deliver.

The Trust will face significant challenges in 19/20 to deliver the anticipated levels of improvement without much more transformational change which will involve collaboration with other providers.

Electronic Patient Record (EPR)

The Trust is planning to go live with a new EPR in October 18 as part of a three trust implementation. Delays to this will lead to cost pressures in 18/19 arising from the extension of the Trust's current system agreements and staffing and implementation costs.

Genetics National Laboratory Reconfiguration

The 18/19 plan currently assumes that the net impact of the national reconfiguration of Genetics Laboratories Reconfiguration does not impact on the deficit of the Trust in 18/19. There is a risk that in the final configuration the Trust is financially disadvantaged.

Neonatal Single Service

The Trust is developing a single service arrangement across two sites with a neighbouring trust for the provision of neonatal services. It is envisaged that any incremental costs in relation to this will be funded from within the current network envelope or funded by commissioners. If not this may result in a cost pressure to the Trust.

Supporting the wider system

The Trust continues to support the work being undertaken by the Vanguard in response to staff shortages within the area. This could lead to an impact on the Trust's services and the associated costs and revenues.

Availability of staff

There is a national shortage of staff in some key areas. It is also conceivable that the Trust will find it increasingly difficult to recruit and retain the required levels of staff in view of the strategic direction of the Trust. Despite a good track record to date, availability of staffing in a difficult climate and strategic change may lead to increased agency usage.

Availability of cash support

The Trust will require ongoing cash support in light of the planned deficit.

KEY MITIGATIONS

The mitigations in place to reduce the level of risk noted above are as follows;

- Robust management of activity and waiting list numbers, together with joint working with commissioners to manage the levels of demand.
- Close working with commissioners to maintain current contracts for gynaecology and fertility services demonstrating value for money to commissioners.
- Robust processes in place to manage the ongoing delivery of CIP, including engagement and communication strategy and fortnightly Turnaround and Transformation Committees.
- Enhanced governance procedures over the implementation of EPR
- Ongoing relationships with partners and oversight bodies in the development of services
- Continued tight control over agency usage, as evidenced by the current agency spend
- A number of risks have materialised as anticipated.

Activity is well below plan with under delivery £2.2m at Month 6 and anticipated at c£4m for the full year. This is being factored into operational planning for 2019/20 as previously noted through the Right Size program.

The Trust is in total delivering £2.0m of the 2018/19 CIP program non-recurrently which will add to the burden of delivery in 2019/20. At the moment there are no plans for organisational form changes in 2019/20 with the key collaboration partners set to merge in that year without the Trust. This is on the advice of NHSI and will make savings targets difficult in 2019/20.

The EPR implementation has been delayed and will not go live within this financial year. The EPR program board is currently considering a revised plan which will be presented to the Trust later in the year. The cost implications in relation to this are being developed.

The Genetics Laboratory reconfiguration is underway. While this is not expected to have a financial impact in the current year there may be implications into future years.

NHSE are yet to confirm their funding of the single service arrangements, and while developments have begun these may emerge as cost pressures going forward if NHSE do not agree sufficient funding for the service.

Whilst agency is within the NHSI cap it is expected to exceed budget due to staffing issues in some areas which have materialised. Further additional pressure emerged in this area due to additional operational support requirements arising from RTT issues noted above.

The Trust is managing this risk within the deficit for the year, however these issues will impact on future planning assumptions

There has been no requirement for cash support in the year to date.

8. Operational Plan within the context of the Health & Care Partnership for Cheshire & Merseyside

The Cheshire and Mersey 5YFV includes a number of issues which directly relate to Liverpool Women's, most importantly a review of women and neonatal services which has been led by Liverpool CCG. In addition the Trust is identified in the plan as part of a merger proposal with Aintree University Hospital NHS Foundation Trust and the Royal Liverpool and Broadgreen University Hospitals NHS Trust. The Partnership five year plan also references the work of the Women and Children's Vanguard. The Trust remains committed to ensuring that the operational and strategic plans already put forward form a prominent part of the Partnership's future work.

Liverpool Women's capital bid for relocation was submitted as high priority from the partnership.

Merger with Aintree and the Royal

The Cheshire and Mersey plan also contains proposals for a three way merger between Liverpool Women's, Aintree and the Royal, which will potentially release £70m of savings. The Strategic Outline Case has been approved by all three Trusts. The Royal and Aintree have submitted an Outline Business Case for a two way merger. Currently Liverpool Women's is not part of this process, at NHSI's instruction, however this remains the strategic direction for Liverpool Women's.

Cheshire and Mersey Women's and Children's Vanguard

The Trust is actively participating in the Cheshire and Merseyside Women and Children's Services (Maternity and Paediatrics multi-specialty network). The Vanguard aims to develop a clinically managed network for Women's and Children's services (including Maternity, Gynaecology, Neonatal and Paediatric services) across Cheshire and Merseyside in order to further improve quality and ensure services are clinically and financially sustainable.

The partnership supports the strategic direction and the CEO's of Liverpool Womens and Alder Hey have recently become SRO's of the multi-speciality network

The Trust is committed to working collaboratively within the Partnership.

9. Membership and Elections

Governor Elections

The Trust has 14 Public Governors elected by the Trust's public membership who represents the local community from: Central Liverpool; North Liverpool; South Liverpool; Sefton; Knowsley; and the rest of England and Wales. In addition there are 5 Staff Governors elected by the Trust's staff, from the following staff areas: Doctors; Nurses; Midwives; Scientists, technicians and allied health professionals; and administrative, clerical, managers, ancillary and other support staff. The Trust also has 7 appointed governors representing stakeholders.

The election process for Governors is undertaken in accordance with the Trust's constitution and follows the Model Election Rules. The Trust appoints the Electoral Reform Service as the returning officer for all Governor Elections. During 2017/18 the Trust undertook an election process for 10 constituencies (8 public and 2 staff) and was able to fill 6 positions. The Trust has found it difficult to recruit to one of its public constituencies, Knowsley over the last 12 months. The Council of Governors will actively engage with the membership and the public in order to support an active election process in that public constituency.

Alongside formal meetings of the Council of Governors, the Council approved the creation of sub groups below it that mirrors the Board committee structure which has been operating since April 2017. The sub groups provide the Council with assurance and training with regards to Quality, Safety, Patient Experience and Financial and Operational performance. Additional to the sub groups and Council of Governors; a range of briefing sessions and workshops take place to both inform the governors of Trust initiatives and to gain their views. Governors receive induction training on appointment and meet with the Trust Secretary to identify specific needs.

The 2018 election resulted in all but two of the public and staff constituencies being filled. The two vacancies related to the Public Constituency of Knowsley and the Staff Constituency of Scientists, technicians and allied health professionals. Consideration should be given to whether the merge the Scientists, technicians and allied health professionals constituency into Administrative, clerical, managers, ancillary and other support staff constituency and have two posts for the merged area.

As required by the Trust Constitution a bi-election will be required for the two vacant constituencies.

Currently the Trust is without an appointed Governor from the University of Liverpool. Action is being taken to address this with the Vice Chancellor.

Knowsley Council have taken a view that they will not be making an appointment to the post of Appointed Governor at this time. The Trust Secretary will continue to keep in contact with the Council.

The Governor Group Meetings have been a great success with positive comments from Governors that they are able to be more challenging and get more from the Group meetings due to the size of each group and the access to both NEDs (hold to account) and Executive/senior managers.

Training requirements for Governors are currently being met within the Groups; a training plan is being developed to complement the Groups understandings. All Governors recently appointed to the role had been offered an induction, undertaken with LH&C and Clatterbridge, four attended. One to One with the Trust Secretary takes place with all new appointees.

Membership Strategy and engagement

A three year Membership Strategy was launched in 2017/18 with an overall objective of engaging with as many existing members and potential new members as possible to keep them informed and involved on various aspects of Liverpool Women's.

During year one of the strategy (2017/18), there was a focus on maintaining membership numbers and targeting recruitment in under-represented groups, namely students and young adults (17-29), ethnic minorities, and residents of Sefton. The table below sets out the course of action the Governors were advised to take for these priorities and other aims in line with the strategy.

Year One, 2017 – 2018	
1.	Proactively encourage members to consider standing for election to the Council of Governors.

2.	Consult and involve members in relevant engagement opportunities with respect of the Trust's Fit For Future Generations programme.
3.	Maintain membership numbers and aim to recruit to under-represented groups through the use social media and appropriate governor supported public events and campaigns to support achievement of this.
4.	Analyse the quality of contact information the Trust has and target regular communications, aligned to members' areas of interest.
5.	Introduce multi-channel communication broadcast from Governors to members in their constituency to achieve better visibility and more productive engagement with members.
6.	Introduce a dedicated and regular communication feature within the Trust's standard channels that showcases membership and Governor news, and the benefits of getting involved in order to increase recruitment.

During 2017/18 there was an intention to make the intensity of some of the above activities dovetail with the ongoing progress of the Trust's Future Generations Strategy. However, as progress on this has slowed down due to issues outside of the Trust's control, there have not been as many public engagement opportunities as intended.

Achievements during 2017/18 include the changing format of the Annual Members Meeting which took place in a Saturday afternoon and was preceded by a marketplace breakfast event which attracted approximately 100 attendees including members, governors, staff and members of the public. The Annual Members Meeting itself was also attended by approximately 50 people, whilst the video recorded version of the meeting also attracted over 200 views.

In addition, a data cleanse was also commenced which aims to improve the quality of contact information the Trust has for members. This piece of work identified that the Trust membership database only has a small proportion of email addresses for its members, meaning that in the absence of regular direct mail communication, a large proportion of our members will have limited engagement with us. Following up this work with a long-term effort to secure a range of contact methods for existing members will allow for more regular engagement via digital means. This piece of work will continue into 2018-19 due to the volume of members that need to be contacted for this information.

Going into year two of the strategy (2018-19) there will be a continued focus on achieving the objectives outlined for year one, in addition to further objectives below, as outlined in the Membership Strategy. These objectives for 2018-19 are focussed on increasing involvement of members and patients within the Trust's operations where appropriate, and to engage closely with the education sector to reach young people directly.

Year Two, 2018 – 2019	
7.	Involve more members and patients in a number of identified committees/groups within the Trust that is concerned with quality of service.
8.	Link with local schools, colleges and universities, possibly in collaboration with other local Trusts to serve as a 'Membership Open Space' where young people can pursue information about careers in the NHS whilst also learning the benefits of membership.

The Membership Strategy has continued to focus on recruiting new members via a range of promotional and engagement activities. Between April – September 2018 66 new members have been recruited.

A 'Get Involved' campaign has been launched during the year as part of the Communications & Engagement Plan 2018/19. This is attempting to promote Membership, Volunteering and the Charity. Promotional items have been

produced for this as well as a promotional stand which is accessible to all staff and Governors to use on request for their own engagement activities.

The first Get Involved event took place in August 2018 in Liverpool City Centre in partnership with Radio City. The Get Involved day consisted of a promotional media bus with many members of staff supporting the event to promote involvement, recruit members, and to share news on the Trust's developments and plans for the future with the public. Get Involved social media and email contact reached approximately 55,000 people in the lead up and on the day. Direct 'Get Involved' website visits was approximately 1,100, £175 was raised towards Liverpool Women's Charity, and 55 new members were recruited on the day.

Further engagement activities are being planned for the remainder of 2018/19 and 2019/20. Existing links to Asda and Tesco supermarkets have been developed allowing representatives from the Trust to host a promotional stand which will be useful to reach our under-represented areas and groups. GDPR laws may restrict how we can obtain personal information from customers for membership recruitment but the overall 'Get Involved' campaign promotion will be the focus.

The Trust's Annual Members Meeting (AMM) took place in October. In the lead up to the event a 'Back to the Future Generations' theme was promoted which focussed on a children's art competition and invited children to design a hospital for the future. By the end of September prior to the event, the competition received almost 50 entries from a range of schools in the local area.

There has been limited progress on specifying what further involvement Trust Members should have or should be offered and how that can be accommodated although this is a regular item for discussion within the Communications & Membership Engagement Group meetings and will be focussed on for the remainder of the year to determine an agreed approach.

Agenda Item	2018/295(ii)

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Corporate Objectives 2018/19 - 6 Monthly Review**
DATE OF MEETING:	Friday, 07 December 2018
ACTION REQUIRED	**For Noting**
EXECUTIVE DIRECTOR:	Kathy Thomson, Chief Executive
AUTHOR(S):	Executive
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** 1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☒ 2. To be ambitious and *efficient* and make the best use of available resource ☒ 3. To deliver *safe* services ☒ 4. To participate in high quality research and to deliver the most *effective* Outcomes ☒ 5. To deliver the best possible *experience* for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust…….* ☒ ***2.*** *Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have sufficient numbers of junior medical staff with the capability and capacity to deliver the best care. ……* ☒ ***3.*** *The Trust is not financially sustainable beyond the current financial year……* ☒ ***4.*** *Failure to deliver the annual financial plan ……* ☒ ***5.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision ……* ☒ ***6.*** *Ineffective understanding and learning following significant events……* ☒ ***7.*** *Inability to achieve and maintain regulatory compliance, performance and assurance……* ☒ ***8.*** *Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) ……* ☒ ***9.*** *Inability to deliver the best clinical outcomes for patients……* ☒ ***10.*** *Potential for poorly delivered positive experience for those engaging with our services..* ☒
CQC DOMAIN	***Which Domain?*** ***SAFE-*** *People are protected from abuse and harm* ☒ ***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☒ ***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☒ ***RESPONSIVE –*** *the services meet people's needs.* ☒

	WELL-LED** - the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.* ☒ ***ALL DOMAINS ☒			
LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution ☒ **2.** Operational Plan ☒ **3.** NHS Compliance ☒		**4.** NHS Constitution ☒ **5.** Equality and Diversity ☒ ***6.*** Other: **Click here to enter text.**	
FREEDOM OF INFORMATION (FOIA):	1. This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting			
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	***The Board is asked to note the performance against the Corporate Objectives 2018/19 for the first 6 months of the financial year 2018/19***			
PREVIOUSLY CONSIDERED BY:	**Committee name**	Quality Committee Finance, Performance and Business Development Committee Putting People First Committee		
	Date of meeting	Monday, 26 November 2018 Friday, 30 November 2018		

The Board of Directors reviewed the corporate objectives 2018/19 and formally approved them on 2 May 2018.

The Board agreed that each Board Committee would review the performance of the Trust against those objectives that they are aligned to within its terms of reference.

Following receipt of the corporate objectives by each of the Board Committees, the responses to each of the objectives were reviewed by the Board committees on 26 November 2018 (FPBD and QC) and 30 November 2018 (PPF) and are presented to the Board for its consideration and approval.

Recommendation

The Board is asked to note the performance to date against the Corporate Objectives.

STRATEGIC AIMS AND OUR CORPORATE OBJECTIVES 2018/19

The Vision, Aims and Values have been developed over a long period of time with input from the Board, Staff, Governors and Stakeholders. These were commended by both CQC and Deloitte's (when they undertook the Well Led Governance review in 2014)

Our vision:		To be the recognised leader in healthcare for women, babies and their families
Our strategic aims – WE SEE:	W	To develop a well led, capable, motivated and entrepreneurial **W**orkforce;
	E	To be ambitious and **E**fficient and make best use of available resources;
	S	To deliver **S**afe services;
	E	To participate in high quality research in order to deliver the most **E**ffective outcomes;
	E	To deliver the best possible **E**xperience for patients and staff.
Our values – We CARE and we LEARN:		Caring – we show we care about people; Ambition – we want the best for people Respect – we value the differences and talents of people; Engaging – we involve people in how we do things; LEARN – we learn from people past, present and future.

Corporate Objective To develop a WELL LED, capable, motivated and entrepreneurial Workforce;	Executive Lead	Relevant Strategy	Board Committee	6 monthly review
Improving the Health & Wellbeing of the workforce by moving to upper quartile performance for % sickness absence and stress related absence incrementally between 2018-2021 as measured by the Annual Staff Survey	DoW&M	People Strategy	Putting People First	• This year's HWB priority is mental wellbeing. A separate stress management group has been established to focus on this area which remains the most prevalent reason for sickness absence (33% in 17/18) • The Trust is engaged in an NHSI sickness project and a multidisciplinary steering group is reviewing all aspects of sickness management and making recommendations. • We have trained 49 Mental Health first Aiders to identify and take action in their local areas. • There has been an increased number of occupational health management referrals, average of 37 per month. • Proactive targeted staff physio sessions will be undertaken in areas where sickness related to musculoskeletal issues is high. • The staff support (counselling) service is undertaking pro-active sessions around individual and collective stress management and resilience will be targeted at areas where sickness related to stress and anxiety is high. • For 17/18, the overall absence rate remained slightly over target at 4.67%. Year to date the figure is 4.16%. • Freedom to Speak Up Guardian service actively promoted and known to staff
Improving the organisation's climate and increasing the overall staff engagement score (as measured by Annual Staff Survey & the Staff Friends & Family Test) to upper quartile for acute specialist Trusts incrementally between 2018-2021	DoW&M	People Strategy	Putting People First	• Fair and Just Culture project has commenced in partnership with internal expert, David Marx. Focus on developing a culture where staff take accountability and ownership when mistakes are made. • A new quarterly 'Listening to our People' survey was rolled out in July which gives managers detailed breakdown of levels of engagement within their own teams, enabling targeted support and intervention to be provided. Also provides SFFT evidence • Launch of team development programme focused on equipping teams with the core skills needed for them to be successful based on feedback from the local survey • Staff Survey results due in February 2019.
Expanding the Trust's reach into its communities through extending its work experience, work training, guaranteed interview and apprenticeship schemes	DoW&M	People Strategy	Putting People First	• Our long standing work experience programme continues to be very successful, with an average of 160 placements offered per year and universally positive feedback received. • We offer regular careers days to local school students, most recently in July 2018, giving them a taste of hospital life, and attend careers fairs on a regular basis. • We have received £40K funding from Health Education England to support 25 people on schemes to help them into work. The first cohort of 14 pre-employment participants commenced in October. All will be guaranteed interviews and feedback for any vacancies. Participants will also be guided to vacancies in

				other Trusts. Apprenticeships will be attached to new starts. • We have commenced an internship programme in partnership with a local college and will offer 3 placements of 24 weeks to people with a recognised disability. • 13 posts have been offered to date as apprenticeships, and although this does not meet our target of 31, we have a 5 year period over which to achieve this. We continue to promote posts as apprenticeships and this is built into our vacancy control process.
Shaping workforce to meet operational needs through effective workforce planning and partnerships	DoW&M	People Strategy	Putting People First	• A new approach to workforce planning was adopted in 17/18 with finance, HR and operational colleagues working closely together to define and plan future workforce needs. • The Trust has participated in developing and modifying Health Education England's national workforce planning data collection processes. • A high level workforce group has been established to look at medium and long term planning around specialist and hard to fill roles, focused on sharing good practice across the organisation, making bids for external funding, developing training and education opportunities and working collaboratively with other organisations • PPF continues deep dives into workforce risks & mitigation • Funding secured from Leadership Academy for Shadow Board project to develop Board directors for the future

Corporate Objective To be ambitious and Efficient and make best use of available resources	Executive Lead	Relevant Strategy	Board Committee	6 monthly review
Deliver the financial plan for 2018/9	DoF	Operational Plan 18/19	Finance, Performance and Business Development	• The deficit control total of £1.6m was planned to be achieved through making a deficit of £2.4m in M1-M6 and a surplus of £0.8m in M7-M12. The more favourable position in the second half of the year was primarily related to CIP phasing and in particular the CNST Incentive. • The Trust has delivered a deficit of £0.9m to M6. Whilst this is significantly ahead of plan, the Trust is not now expecting to significantly improve the position through CIP in the second part of the year. • The forecast remains on plan. The Trust has achieved Q1 and Q2 Provider Sustainability Fund of £1.3m – this cannot now be clawed back. It is anticipated that the remaining £2.3m in Q2 and Q3 will be achieved. Should the Trust over-perform, it has been indicated that additional incentive PSF may be available.
Deliver the operational plan for 2018/9	DoO	Operational Plan 18/19	Finance, Performance and Business Development	• Gynaecology has seen a number of significant challenges in terms of the SUI's declared in February 2018 in respect to 18 weeks RTT and Cancer targets. Then a significant reduction in capacity caused by consultants vacancies and long term sickness which has delayed recovery of national access targets. Progress has been made in appointment of additional General gynaecology and Oncology consultants. The impact of these appointments and additional locum capacity will have a positive impact on waiting lists at the end of Q3 and the beginning of Q4. Overall, this has also impacted the services ability to achieve the CCG contracted activity plan; this is being reviewed as part of the "right sizing project" for the

				2019/20 operational plan. • The Gynaecology emergency room has merged with the Maternity assessment Unit in the evenings as a test pilot for a potential full merger. • Gynaecology is currently developing a business case with RLBUH for Ultra Radical operations this is expected to be complete by Q4. • Maternity activity has reduced as anticipated and is expected to have deliveries in the region of 8200 (2017/18 8600). The service has reduced costs in terms of pay and non-pay and will also review service income and costs as part of the "right size project". • Community midwifery services have been reviewed as per "Better Births" and a plan to transform services is now in place. • Genetic services have successful bid in Partnership with services in the Northwest to win the laboratory services for this area. Central Manchester are the lead provider and a mobilisation plan is being developed to meet the NHSE timeframes for full implementation. Plans are being developed in partnership to TUPE staff to the lead provider. • Neonatal services have agreed a MOU with Alder Hey for a single Neonatal Service, have submitted a business case to NHSE and have started implementation of the plans. Governance arrangements have been established. The £15M extension has completed the design phase and the GMP has been agreed, building works will commence in December 2018 with a completion for July 2020.
Demonstrate the effective use of resources in providing high quality, efficient and sustainable care in line with the recommendations of Lord Carter's review of Operational productivity and current National initiatives (Model Hospital/GIRFT)	DoF	Operational Plan 18/19	Finance, Performance and Business Development	• Benchmarking work is well underway and the Trust is engaged in the STP/H&CP Carter Work stream. • This will underpin the Trust's review of CIP and control total achievability moving into 2019/20

Corporate Objective To deliver Safe services	Executive Lead	Relevant Strategy	Board Committee	6 monthly review
Maintain regulatory confidence & compliance	CEO	All	All	• The Trust continually keeps NHSI and CQC up to date with developments within the Trust and confidence in management and compliance is high. • Regular monthly meetings with NHSI on matters pertaining to the Trust's financial position and future Generations is ongoing. Recognition that the Trust is doing all things necessary to delivery sustainable services. • Achieved Overall 'Good' rating following CQC inspection in February 2018 • Monthly and annual submissions to NHSI completed within timeframes set • Annual Report and Accounts 2017/18 submitted to Parliament within required timeframes.

Successfully delivering year 1 of the Neonatal new build	MD/DoO /DoF	Future Generations	Finance, Performance and Business Development	• The program remains on track. The Guaranteed Maximum Price has been agreed and enabling works have begun. A plan to minimise disruption of clinical activities in the Neonate and the rest of the trust is in place.
Delivery of in year Quality Strategy objectives	MD/ DoN&M	Quality Strategy	Quality	• The Trust has completed the first year of the 2017/2020 Quality Strategy. The strategy objectives have been monitored on a quarterly basis via the Quality Committee. The strategy consists of 9 key areas. Progress against each at the end of year 1; - 2 were completed (Neonatal Mortality and Still Birth reduction and Learning form Experience), - 6 have processes in place (Learning form Incidents, Sepsis, Adult Mortality, Quality Standards/Indicators, Health and Well Being and Engagement) - 1 which remains red as no action to date (Unplanned admissions and readmissions). • Progress has been made in Quarter 1 and Quarter 2 of the 2nd year of the Strategy. This is considered to be 'on plan' for full delivery in year 3.
Maintain Safe Staffing levels	DoN&M	Quality & People Strategies	Putting People First	• Continue to provide monthly safer staffing papers to the Board, triangulating red flags against staffing levels and monitoring areas of high vacancies as mirrored with the National Picture of workforce across Nursing and Midwifery. • Networking with other DON&M across Cheshire and Merseyside by attending Nursing and Midwifery Workforce Programme Board Meeting
Working in partnership with providers and commissioners to ensure quality safe services are delivered to the population of the region. This will include working closely with the following :- • Cheshire and Merseyside Partnership (STP) to develop and influence regional strategy • North West Genetics Partnership - for the tender for genetics services • Alder Hey to implement the Neonatal Single Service on two sites	DoO	Operational Plan	All	• The Cheshire and Merseyside Women's and Children's Partnership agreed in Octobers 2018 meeting to provide a resolution to the STP that the LWH strategic case was fully supported by the partnership. • The Northwest Genetics Partnership has been successful in its bid to be the Northwest Genetic Hub. The mobilisation plan is currently being developed and key staff from LWH are influencing at every level. • Neonatal services have agreed a MOU with Alder Hey for a single Neonatal Service, have submitted a business case to NHSE and have started implementation of the plans. Governance arrangements have been established. Regular meetings with the Director for the Neonatal ODN has ensured high levels of support with regard to assuring the commissioners NHSE of the partnerships plans.

Electronic Patient Records project delivery and implementation with required timeframe • To ensure that the modules provided in the new EPR are fit for clinical purpose • To ensure the services are fully prepared to continue delivering services as usual when the new EPR system goes live. • Finance - Deliver the technical solution within the agreed budget	MD DoO DoF	EPR Project Plan	Finance, Performance and Business Development	• The EPR project is a three-trust plan to introduce an electronic recording system which would work seamlessly across the three organisations. The Program has slipped predominantly due to design and build issues which have arisen for a number of reasons; largely out of the control of the three trusts. These have been reported through Digital Hospital Committee and up to Finance, Performance and Business Development. • The Trust is currently assessing delivery against a revised plan and exploring a number of options. These include the use of K2 as a maternity EPR solution in the short term, which would have clinical benefit but a cost implication for the Trust.

Corporate Objective To participate in high quality research in order to deliver the most Effective outcomes	Executive Lead	Relevant Strategy	Board Committee	6 monthly review
Develop closer working relationships with University of Liverpool with respect to research and innovation	MD	R&D	Quality	• The Liverpool Health Partners board (represented by LWH CEO) have agreed and given a directive for the development of a Joint Research Service (JRS) across Liverpool bringing together all Trust and HEI RD&I departments. • A Task & Finish (T&F) Steering Group has been established in September 2018 - the main remit of which is to ensure that identified work streams are well led and delivered according to plan in order to produce a detailed modus operandi to implement a joint research service for LHP by the first half of 2019. The LWH R&D Manager is a member of the T&F Steering Group and has active participation in a number of work streams. • Work has now commenced to foster greater links with Alder Hey in the 'Starting Well' work stream for R&D
Successful implementation of the Trust's Research and Development Strategy to	MD	R&D	Quality	• Work towards implementation of the Trust's Research and Development strategy has been ongoing throughout the first half of 2018/19. A full report of progress to date will be submitted for consideration by the Quality Committee at the January 2019 meeting. There has however already been an investment

enhance the Research and Innovation capabilities of the Trust				of Pas to consultants in the Trust with an interest in R&D and R&D leadership within the nursing and midwifery workforce is currently under review in line with the R&D strategy.

Corporate Objective To deliver the best possible Experience for patients and staff	Executive Lead	Relevant Strategy	Board Committee	6 monthly review
Providing a patient led experience, continuously seeking feedback to further enhance our service provision.	DoN&M	Patient Experience Strategy	Quality	• The Trust launched it new Patient Experience Strategy in the Summer of 2018. Within this new strategy for 2018-2021 there are 5 new always events which have been generated with patient and public feedback. This will be monitored through PPF. • To increase patient feedback as part of Friends and Family the Head of Patient experience and IT have developed a text alert system for patient to be able to provide feedback on line to the Trust rather than just eh card system in place. The first wave of this new process is schedule to be rolled out the beginning of December 2018. This will also be monitored via PPF and also by the CCG at CQPG. • Regular monitoring and review of trends and themes form patient complaints and PALs contacts are provided to PPF and to the Quality committee to ensure that we are able to put actions in place in response to a trends or themes. Further work is ongoing in relation to the collation and collation of theme and trends form PALs+ meetings to ensure all areas receive appropriate feedback to plan actions.

Corporate Objective Delivery of the Future Generations Strategy	Executive Lead	Relevant Strategy	Board Committee	6 monthly review
Support Commissioners and Regulators to agree strategic direction for Trust services, commencing with public consultation and Commissioner Decision Making Business Case.	CEO	Future Generations	Board specific	• Clinical review of standards undertaken issues identified that quantified issues of remaining on an isolated site. • Issues relating to the skills and age profile of the consultant body have also been explored; this has highlighted the need for a move, more decisively, to a multidisciplinary hospital site within 5-10 years.
Work jointly with other providers and regulators to consider options for future collaborations and organisational form.	DoF	Future Generations	Board specific	• Collaboration has continued, with relationships with STP strengthened following a change in leadership. The Trust awaits the results of a capital bid submission which was ranked first of the C&M large schemes and third overall. • NHSI are reluctant to allow the Trust to address organisational form in the near future but the dialogue remains open. • Dialogue is ongoing with NHSE, MPs, councillors and other stakeholders to ensure the case for change is

				well understood
Retain Public and Staff Confidence through an effective Communications and Engagement Strategy	DoW&M	Future Generations	Board specific	• The Future Generations communications plan was updated in 2017/18 to cover the period 2017-20. • The revised communications plan acknowledged that with limited progress on a move to public consultation and a decision on the future of Liverpool Women's services, the focus needed to shift to a series of simple, clear and effective key messages which reassure all stakeholders including patients, visitors and staff. • A series of key messages were produced and continue to be consistently referred to – these messages are broadly; We are not closing, we want to make our services better for the future, our staff have shaped our plans for the future, and any potential move to a new hospital will be some time away which means we will be on our current site for a number of years to come. • These key messages have been and will continue to be referred to at regular intervals for both consistent messaging and also at times of significant interest such as during any political periods where the future of Liverpool Women's is being discussed, or when any developments take place relating to a potential public consultation. • Recent developments of note where these key messages were used occurred during September 2018 in advance of the Labour Party Conference. The Trust referred to the key messages to counter a planned demonstration against the plans for the future by a local campaign group. • The Trust's key messages received significant media, online, social media and public exposure with an overall average reach/audience for TV/radio/printed news of over 410k and an average reach/audience for LWH social media and website posts of almost 40k. • The impact of the demonstration march was perceived to be less than the campaign group's previous activities due to our proactive factual messaging and anecdotally the Trust feels that stakeholder understanding about our future is now more clearly understood as a result.

Agenda Item	2018/297

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Board Assurance Framework**
DATE OF MEETING:	Friday, 07 December 2018
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	Colin Reid, Trust Secretary
AUTHOR(S):	Christopher Lube, Head of Governance
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** 1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☐ 2. To be ambitious and *efficient* and make the best use of available resource ☐ 3. To deliver *safe* services ☒ 4. To participate in high quality research and to deliver the most *effective* Outcomes ☐ 5. To deliver the best possible *experience* for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust…….* ☒ ***2.*** *Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have sufficient numbers of junior medical staff with the capability and capacity to deliver the best care. ……* ☒ ***3.*** *The Trust is not financially sustainable beyond the current financial year……* ☒ ***4.*** *Failure to deliver the annual financial plan ……* ☒ ***5.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision ……* ☒ ***6.*** *Ineffective understanding and learning following significant events……* ☒ ***7.*** *Inability to achieve and maintain regulatory compliance, performance and assurance……* ☒ ***8.*** *Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) ……* ☒ ***9.*** *Inability to deliver the best clinical outcomes for patients……* ☒ ***10.*** *Potential for poorly delivered positive experience for those engaging with our services..* ☒
CQC DOMAIN	***Which Domain?*** ***SAFE-*** *People are protected from abuse and harm* ☐ ***EFFECTIVE -*** *people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.* ☐ ***CARING -*** *the service(s) involves and treats people with compassion, kindness, dignity and respect.* ☐ ***RESPONSIVE –*** *the services meet people's needs.* ☐

	WELL-LED** - the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.* ☐ ***ALL DOMAINS ☒			
LINK TO TRUST STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**1.** Trust Constitution ☒ **2.** Operational Plan ☒ **3.** NHS Compliance ☒		**4.** NHS Constitution ☒ **5.** Equality and Diversity ☒ ***6.*** Other: Click here to enter text.	
FREEDOM OF INFORMATION (FOIA):	1. This report will be published in line with the Trust's Publication Scheme, subject to redactions approved by the Board, within 3 weeks of the meeting			
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	1. Note the assurance presented re process and proposal(s) within this report. 2. Advise the Governance team of approval /views in respect of the process, proposals and rationale.			
PREVIOUSLY CONSIDERED BY:	**Committee name**	Sub Committees of the Board		
	Date of meeting	During November 2018		

Executive Summary

The Board Assurance Framework (BAF) is one of the tools that the Trust uses to track progress against the organisations Strategic Aims. As part of the development of the BAF, each financial year, the Key priorities of the year are identified and the potential risks to achieving these assessed for inclusion on the framework. As such, all risk on the BAF are set out under strategic aims.

The BAF is based on based on seven key elements:

- Clearly defined Key Priorities for 2018/19 (aligned to the Trust Strategic Aims)
- Clearly defined principle risks to the key priorities together with an assessment of their potential impact and likelihood.
- Key controls by which these risk can be managed.
- Potential and positive assurance that risk are being reasonably managed.
- Board reports detailing how risk are being managed and objectives met, together with the identification of gaps in assurances and gaps in control.
- Risk reduction plans, for each risk, which ensures the delivery of the objectives, control of risk and improvements in assurances.
- A target risk rating.

The Head of Governance and Quality continues to meet with each of the Executive Director leads on a monthly basis to ensure the BAF is maintained as a live document.

Each of the sub committees of the Trust Board with BAF risks continues to have the responsibility to review and gain assurance to controls and any required actions.

Report

1. Introduction

This report seeks to assure and inform the Board of the process and outcomes from Board and sub-committee review of risks assigned to the Board Assurance Framework.

Any changes in risk score or escalation / de-escalation proposals made by sub-committees after consideration of risks within their remit are conveyed via the Head of Governance and Quality to ensure reflection of proposed and approved changes in the BAF dashboards.

The current BAF is embedded below:

BAF Risks – November 2018: Appendix 1

2. Sub-Committee Changes to Risks

Since the last report to the Board, the sub-committees have further reviewed the risks within their remit and proposed changes as described below:

Key Changes for November 2018 BAF:

- Deliver Annual Plan : Reduced current score to 20 (likelihood reduced to 4 from 5)
  Two additional controls added
  One additional source of assurance added

- Long-term Sustainability: Changes made to the timescales for all actions

- Learning from Events: Actions completed:
  Proposal for introduction of Patients Safety Walk Rounds Agreed at QC
  Review of Risk Management Training (following review by HoG&Q changes are being made to delivery of risk management training for staff from Workbook to Face to Face).

3. New Risks and Closed Risk

Since the last report to the Trust Board there have been no new risks added to the BAF and no risks have been closed.

4. Conclusions / Recommendations

The report reflects ongoing review of BAF Risks by the Board sub-committees and the resulting changes to scores mitigation and supporting corporate and service risks in accordance with the review and escalation and de-escalation processes.

The Board are asked to:

1. Note the assurance presented re process and proposal(s) within this report.
2. Advise the Governance team of approval /views in respect of the process, proposals and rationale.

2018/19 Live Board Assurance Framework – November 2018

Strategic Objective: To develop a well led, capable, motivated and entrepreneurial workforce

Risk Appetite: Moderate

Objective: To deliver a well-led, engaged, motivated and effective workforce

CQC Domain: Well-Led

Enabling Strategy: Putting People First Strategy

Executive Lead: Michelle Turner

Operational Lead: Susan Westbury

Assurance Committee: Putting People First (PPF)

Risks to objective	Controls	Gaps in controls	Sources of assurance	Assurance outcomes / gaps	Action plan	Timescales
Principal Risks - 1744 **Condition:** Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust **Cause:** Poor staff morale, lack of clarity around objectives, lack of ability to influence in the workplace, lack of organisational/job security, lack of leadership, behaviour contrary to the trust values **Consequence:** Failure to deliver high quality, safe patient care, impact on recruitment & retention, failure to achieve strategic vision, potential for regulatory action and reputational damage	• Appraisal policy, paperwork and systems for delivery and recording are in place for medical and non-medical staff • Consultant revalidation process • Reward and recognition processes linked to values • Retirement Intentions annual exercise • Pay progression linked to appraisal and mandatory training compliance. • Targeted OD intervention for areas in need of support • Management Development Training Programme • Aspirant Talent Programme for aspiring ward managers and matrons • Programme of health and wellbeing initiatives • All new starters complete mandatory PDR training as part of corporate induction ensuring awareness of responsibilities. • Extensive mandatory training programme available • Value-based recruitment & induction • Workforce planning processes in place to deliver safe staffing • Investment in engagement tool (2018) • Shared decision making with JLNC & Partnership Forum • Putting People First Strategy • Quality Strategy 2017-2020 • Staff engagement programmes • Two Freedom to Speak Up • Whistleblowing Policy • Guardian of Safe Working	• Quality of appraisal • Poor attendance at non-mandatory training eg. leadership training • Requirement for further development middle managers • Talent management programme is newly implemented and not yet fully embedded • Ongoing challenges of engaging effectively with all staffing groups due to rota patterns	**Management assurance** • National Staff surrey (annual) • Quarterly internal staff survey (Go Engage System) • Monthly KPI's for controls • Performance Reports (monthly) • Quarterly Learning Events • Bi-annual Speak up Guardian Reports • Report form Guardian of Safe Working **Metrics** • Increase in managers attending training programme • Mandatory training data • Absence data • Turnover data • Whistleblowing data • Staff Engagement Score • Sickness data • Guardian for Safe Working Exception Reports	**Assurance Gaps** • None at this time	• PPF deep dive into service workforce risks • Aspirant Managers programme being rolled out • Executive Team and staff side walkabouts • Launch of Fair and Just Culture Project • Revised People Strategy • Roll out of engagement tool	• Monthly monitoring • Monthly monitoring 2018 • Monthly monitoring 2018 • Dec 18 • Nov 18 • December 2018
Risks from Risk Register • 8 x Service Risks			**Independent / semi-independent** • POPPY study • RCM culture survey findings due Q1/2 2018 • CQC regulatory inspection in 2018 • National Workforce and Wellbeing Charter -2018	**Outcome Gaps** • Staff Survey Engagement score not improved in year • Mandatory training currently below target • PDR compliance currently below target • Sickness absence above target		

Inherent risk level			Current risk level			Target risk position by 31.3.19		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
5	5	**25**	2	5	**10**	2	5	**10**

Strategic Objective: To develop a well led, capable, motivated and entrepreneurial **workforce**

Risk Appetite: Moderate

Objective: Fully Resourced, Competent & Capable Junior Medical Workforce

CQC Domain: Well-Led

Enabling Strategy: Putting People First Strategy

Executive Lead: Michelle Turner

Operational Lead: Susan Westbury

Assurance Committee: Putting People First (PPF)

Risks to objective	Controls	Gaps in controls	Sources of assurance	Assurance outcomes / gaps	Action plan	Timescales
Principal Risks – 1743 **Condition:** Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have sufficient numbers of junior medical staff with the capability and capacity to deliver the best care. **Cause:** Health Education North (HEN) has the inability to recruit sufficient junior medical staff to cover all Trust rotas across the region due to the national shortage of junior doctors. **Effect:** Insufficient junior medical staffing numbers to ensure patient safety and workforce wellbeing. Insufficient numbers to facilitate all junior doctors training. May result in unsafe care to patients. May result in funding withdrawn from HEN if junior doctor training not met. May result in increased sickness absence and clinical incidents.	• Annually agreed funding contract with HEN • Regional Training Programme Directors manage the junior doctor rotation programme and highlight shortages to the Lead Employer. • Lead Employer notifies the Trust of gaps in local rotations, giving the Trust autonomy to recruit at a local level in to these gaps. • Effective electronic rota management system implemented in 2015. • Consultant Rota Leads appointed for management of junior doctor rotas within all specialties. • Director of Medical Education (DME) to ensure training requirements are met, reporting to the Trust Medical Director and externally to HEN • Guardian of Safe Working Hours appointed in 2016 under new Junior Doctor Contract (2016). • Exception Reporting system implemented under the new Junior Doctor Contract (2016) in relation to hours worked, training and safety • College Tutors in each specialty to ensure junior doctors have sufficient opportunities to meet their training objectives. Escalation system in place to DME or Guardian of Safe Working	• Further utilisation of the rota management system	**Management assurance** • Quarterly reporting by Guardian of Safe Working to JLNC, PPF and the Lead Employer. • Annual report to Board by the Guardian of Safe Working. • Escalation process in place for Exception Reporting to the Medical Director • DME reports to HEN on an annual basis in relation to junior doctor training • Junior Doctor Forum with Executives • Junior Doctor Contract (2016) with Lead Employer validates Jr Dr work plans • Junior Medical Staff – annual internal staff survey • Annual GMC Survey • Strategic Workforce reporting to PPF **Metrics** • Exception reporting data • Monitoring exercise data • Absence data from Lead Employer • Whistleblowing reports	**Assurance Outcomes** • New Exception Reporting system and process working effectively. • Junior Medical Staff GMC survey reporting to Education Governance & PPF – no areas of specific concern identified **Assurance Gaps** • None Identified	• Clinical & nursing roles being developed and enhanced to mitigate the gaps in the junior doctor workforce. Roles include; Physician Assistants, Surgical Assistants, ANP's, Consultant Nurses, ER Practitioners. • New programme for recruitment of Drs from India for Gynaecology • Operational Plan for increased number of consultants • GMC Survey 2018 action plan to be agreed	• Monthly monitoring • Monthly monitoring • Monthly Monitoring • Sept 2018

	Risks from Risk Register • 2 x Corporate Risks • 9 x Service Risks	Hours. • Junior Doctor Forum held quarterly for concerns to be raised. • Remediation Policy. • Monitoring exercises undertaken on annual basis to ensure compliance on junior doctor rotas • Acting-down policy and process in place to cover junior doctor gaps • National Medical Revalidation process ensuring competent doctors • Annual Workforce Planning exercise with operational and clinical teams • Shared decision making and review of risks with Joint Local Negotiating Committee • Putting People First Strategy • Quality Strategy 2017-2020 • Strategic Workforce Group established • Advanced and Enhanced nursing and midwifery roles		**Independent / semi-independent** • GMC Revalidation process. • HEN visit – regular (next due 2019 due to satisfactory report in 2016). • GMC Medical Staff survey - annual	**Outcome Gaps** None identified at this time		

Inherent risk level			**Current risk level**			**Target risk position by 31.3.19**		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
5	5	**25**	4	5	**20**	2	5	**10**

Strategic Objective: To be ambitious and **efficient** and make the best use of available resources
Risk Appetite: Moderate

Objective: Long-term financial sustainability

CQC Domain: Well-Led / Effective

Enabling Strategy: Strategic Options Appraisal

Executive Lead: Jenny Hannon

Operational Lead: Eva Horgan

Assurance Committee: Finance, Performance, & Business Development (FPBD)

Risks to objective	Controls	Gaps in controls	Sources of assurance	Assurance outcomes / gaps	Action plan	Timescales
Principal Risks - 1986 **Condition:** The Trust is not financially sustainable beyond the current financial year **Cause:** • Ongoing requirement for annual CIPs (inc delivery of EPR) • Significant CNST premium • Overhead costs **Consequence:** Lack of financial stability, invocation of NHSI sanctions, special measures. Continued borrowing to meet operational expenses resulting in significant debt.	• 5 year financial model produced giving early indication of issues • Business case to Trust Board which identified a solution which minimised deficit, including relocation to an acute site and merger • Early and continuing dialogue with NHS Improvement and NHS England • Active engagement with CCG through the Healthy Liverpool Programme and Women and Neonatal Oversight Board, resulting in a Pre Consultation Business Case • Agreement for merger proposals with partner Trusts approved by three BoDs • Advisors with relevant experience (PWC) engaged early to review strategic options • Clinical engagement and support for proposals • Review of open claims and legal processes	• Implementation of business case is dependent on decision making external to the trust (CCG, NHSI, NHSE) • Uncertainty regarding availability of capital funding necessary to implement business case • Establishment of governance procedures to manage the merger transaction • Merger dependent on external partners	**Management assurance** •5 year plan approval (BoD – Nov 2014) •Future Generations Clinical Strategy and Business Plan (BoD Nov15) •Sustainability & Transformation Plan (FPBD – Jul' 16) •PCBC Approval (FPBD – Oct' 16) •Strategic Outline Case for merger approved by three Trust Boards (BoD Jun 16) •SOC for preferred option proved by Board – Sep 17	**Gaps** • Final approval for business case	• Public consultation by CCG following development of preferred option • Further discussion with key stakeholders following outcome of consultation exercise • Decision making business case produced by CCG and final decision following outcome of public consultation • Business Case to support the application for capital to support the relocation • Merger transaction • Implementation of changes	• April 2019 (subject to approval of wave 4 STP capital bid in December 2018) • July 2019 (subject to approval of wave 4 STP capital bid in December 2018) • December 2019 (subject to approval of wave 4 STP capital bid in December 2018) • TBC –requirement to be confirmed subject to outcome of STP bid • April 2021 (subject to NHSI approval) • April 2020 - 2025
Risks from Risk Register • 7 x Service Risks			**Metrics** • Monthly formal data submission • Long term financial projections **Independent / semi-independent** • CCG Pre Consultation Business Case, approved by CCG Committees in Common • Northern Clinical Senate Report supporting preferred option	**Outcomes** • Delivery of a surplus • NHS I use of resources rating above 2 over a five year time period • Clinical Senate Report – Sept 17 • Reduction in CNST Premium • Reduction in back office overhead costs		

Inherent risk level			Current risk level			Target risk position by 31.3.19		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
5	5	**25**	5	5	**25**	5	5	**25**

Strategic Objective: To be ambitious and **efficient** and make the best use of available resources

Risk Appetite: Moderate

Objective: Deliver the annual financial plan

CQC Domain: Well-Led / Effective

Enabling Strategy: Operational Plan

Executive Lead: Jenny Hannon

Operational Lead: Eva Horgan

Assurance Committee: Finance, Performance, & Business Development (FPBD)

Risks to objective	Controls	Gaps in controls	Sources of assurance	Assurance outcomes / gaps	Action plan	Timescales
Principal Risks - 2168 **Condition:** Failure to deliver the annual financial plan **Cause:** • Slippage against CIP targets (inc EPR delivery and CNST contribution reduction) • Hewitt Fertility Centre loss of patient numbers resulting in reduced contribution • Increases in patient activity as contracts are largely on a block basis • Workforce cost pressures **Consequence:** Breach of license conditions resulting in financial special measures	• Robust budget setting process • Turnaround process adopted to identify robust CIP schemes • Quality Impact Assessments of all CIPs and post evaluation reviews • Sign off of budgets by accountable officers • FPBD & Board approval of budgets • Budget holder training programme in place • Monthly reporting to all budget holders with variance analysis • Monthly reporting to FPBD & Trust Board • Monthly reporting to and feedback from NHS Improvement • Internal audit reviews of systems and controls • Vacancy control process well established and monitored • Control of expenditure through actively monitoring spends • Holding of discretionary spend areas (i.e. Transformation Team).	• Lose of CNST maternity incentive monies	**Management assurance** •2018/19 budget approval (BoD – May' 2018) •Budget holder training manual and attendance records •Performance & Finance Report (monthly to FPBD and BoD) •Finance & CIP achievement (monthly to FPBD) •Executive Team & Board oversight •Internal audit report provides significant assurance (Oct 17) •Sustained performance above plan	**Gaps** • Assurance is available re: controls but not on delivery	• Ongoing review of position • Quality performance challenge meetings • Regular Turnaround and transformation meetings • Ongoing review of CIP • Monthly budget meeting with variance analysis.	Monthly monitoring
Risks from Risk Register • 1663 – Operational grip on the creation and delivery of a financially sustainable plan (Corporate Risk)			**Metrics** •Monthly financial data **Independent / semi-independent** • Monthly reports to NHSI with feedback • Internal audit review of budgetary controls • External audit opinion •	**Outcomes** • Delivery of control total in 18/19 • Delivery of £3.6m CIP for 18/19 • NHS I Use of Resources Risk Rating – 3		

Inherent risk level			Current risk level			Target risk position by 31.3.18		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
5	5	**25**	4	5	**20**	2	5	**10**

FPBD approved on 26 November the re-scoring of the current risk level from 25 (5L x5I) to 20 (4Lx5I)

Strategic Objective: To deliver **safe** services

Risk Appetite: Low

Objective: Long-term clinical sustainability | **CQC Domain:** Safe | **Enabling Strategy:** Risk Management Strategy

Executive Lead: Andrew Loughney | **Operational Lead:** Devender Roberts | **Assurance Committee:** Quality Committee (QC)

Risks to objective	Controls	Gaps in controls	Sources of assurance	Assurance outcomes / gaps	Action plan	Timescales
Principal Risks - 1986 **Condition:** Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision. **Cause:** Deteriorating estate, off site ITU blood bank and diagnostic services, changing clinical standards, staffing levels, staff profile, changing demographics and co-morbidities, lack of co-located paediatric support **Consequence:** Patient harm, poor continuity of care, poor patient experience due to transfer away from booking location, the trust service offer is less attractive to commissioners **Risks from Risk Register** • 12 x Corporate Risks	• Clinical engagement in case for change through Future Generations Strategy and PCBC • Advisors with relevant experience (PWC) engaged to review strategic options • Early and continuing dialogue with regulators • Active engagement with CCGs through the Healthy Liverpool Programme • Putting People First Strategy • Facilities Improvement Programme • Environmental risk assessments • Professional standards • Leadership & Management Development Programme • Acuity exercises • Clinical risk assessments • Engagement with other acute providers for diagnostic and treatment services • Contract in place for cancer patients to be operated on at RLH on a regular list • Programme for the establishment of single service for Neonates with AHCH • Programme for expansion of NICU on site due to ICC risks. • CQC unannounced and Well Led visits completed March 2018 • Fire risk assessments completed and plan for improvement works in place and being actioned	• Clinical case for change is dependent on decision making external to the trust (CCG, NHSI, NHSE) • Financial constraints for delivery of facilities improvements	**Management assurance** •Corporate Objectives 2018-19 •Board Performance Reports •DIPC Reports •Staffing Reports to Board •Incident and SI reports to Safety Senate and Board **Metrics** •Performance monitoring of patient experience and clinical outcomes •Incident Data (including SIs / Never Events) •Safe staffing levels •Transfers out •Data reviewed regularly and reported through HDU group **Independent / semi-independent** • CQC Inspection (2018) • Review of fire provision • Vanguard review of Maternity Base • Neonatal ODM • Maternity SCN Dashboard • Clinical senate report • NICU SOC • Neonatal peer review Jan 18	**Gaps** • Gaps in fire provision (SLA with Aintree estates in place, review completed and risks assessed with generation of priorities presented to Exec Dir) – Jan 18) **Outcomes** • Failure to meet BAPM standards • Non-compliance of HBN accommodation standards on Neonatal Unit • Consultant presence on Delivery Suite • Transfers of complex cancer patients • Failure to meet RCOA Standards for Care of Women Critically Ill and Women in Childbirth, August 2018.	• Agree a business case for a new build • Submission of capital bid • Commence public consultation	• Monthly monitoring (external lead) • April 2019 (revised date) • Monthly monitoring (NHSE lead)

Inherent risk level			Current risk level			Target risk position by 31.3.19		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
5	5	**25**	4	5	**20**	4	5	20

ve: To deliver **safe** services

Objective: Learning from events | **CQC Domain:** Safe | **Enabling Strategy:** Risk Management Strategy

Executive Lead: Andrew Loughney | **Operational Lead:** Christopher Lube | **Assurance Committee:** Quality Committee (QC)

Risks to objective	Controls	Gaps in controls	Sources of assurance	Assurance outcomes / gaps	Action plan	Timescales
Principal Risks - 1742 **Condition:** Ineffective understanding and learning following significant events **Cause:** Failure to identify root cause, system structures and process, failure to analyse thematically, failure to respond proportionately **Consequence:** Patient harm, failure to learn and improve the quality of service and experience, poor quality services, loss of income and activity, reputational damage, increased staff turnover	• Regular dialogue with regulators and CCGs • Incident reporting and investigation policies and procedures. • MDT involvement in safety projects • HR policies in relation to issues relating to professional and personal responsibility. • Mandatory training in relation to safety and risk. • Staffing level acuity exercises • Scoping for relevant national reports • Quality Strategy 3 yr programme in progress • Risk Management Strategy • Governance structure • Serious Incident Feedback Form • Serious Incident Panels • Corporate level engagement by board • Listening events • Never events reported through Safety Senate and BoD • 1st year of Quality Strategy Delivered	• Inconsistent completion and dissemination of actions and improvement plans. • Limited evidence of Patient Safety walkarounds. • Inconsistent implementation of lessons learnt and lack of evidence • Pace of implementing change • Lack of opportunity to deliver bespoke training for staff groups in relation to risk management and patient safety.	**Management assurance** • CQPG Meetings • Reporting of incidents and management of action plans through Safety Senate • Reflection of risks and Cooperate Risk Register and Board Assurance Framework • CQC Assessment • Annual Quality Account Report	**Gaps** • Inconsistent use of benchmarking tools • Difficult to gain consistent assurance that clinicians are following best practice • Some national audits / studies do not provide benchmarking of data, if they do this is in an inconsistent format making it difficult to accurately assess and compare trust status. • Lack of testing of action plans following audits to ensure they lead to embedded change. • External and internal reporting structures	• Fair and Just culture Project • Maintain close involvement with regional and local safety collaborative	• Dec 2018 • Monthly monitoring (revised date)
Risks from Risk Register • 3 x Corporate Risks • 11 x Service Risks			**Metrics** • Safe domain performance metrics • Incident reporting • Levels of patient harm • Quarter reports to CCG • Benchmarking through VON, EMBRACE	**Outcomes** • CQC assessment from 2018 visit Safe as 'Good' across all areas of the Trust		
			Independent / semi-independent • Internal audit of Risk Management (Oct-16) • External audit of risk maturity by Gorisa Ltd (Nov-16) • CQC assessment form 2018 visit Safe as 'Good' across all areas of the Trust • NRLS Incident Reporting Report • MIAA report on Duty of Candour • Safety Senate Reports			

Inherent risk level			Current risk level			Target risk position by 31.3.19		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
5	4	**20**	3	4	**12**	2	3	**6**

Strategic Objective: To deliver **safe** services

Risk Appetite: LOW

Objective: Regulatory compliance | **CQC Domain:** Safe / Well-Led | **Enabling Strategy:** Risk Management Strategy

Executive Lead: Caron Lappin | **Operational Lead:** Christopher Lube | **Assurance Committee:** Quality Committee (QC)

Risks to objective	Controls	Gaps in controls	Sources of assurance	Assurance outcomes / gaps	Action plan	Timescales
Principal Risks - 1739 **Condition:** Inability to achieve and maintain regulatory compliance, performance and assurance **Cause:** Lack of robust processes and management systems to provide evidence and assurance to regulatory agencies **Consequence:** Enforcement action, prosecution, financial penalties, reputational damage, loss of commissioner and patient confidence in provision of services	• Regular meetings with NHS Improvement • CQC engagement meetings • Maintenance of CQC registration • Regulatory information provided to staff in update sessions. • Committee structures in place to monitor compliance. • Board assurance visits. • An integrated approach between corporate, operational and governance teams. • Quality Impact Assessments for all service changes and CIPs that are considered • Professional standards • Trust policies and procedures • Risk Management Strategy and culture • National audits • Local audits • Ward accreditation scheme in place • Quality and independence of QIA's by DoN and MD • External peer reviews • Completion and Submission of Annual Quality Report	• Benchmarking data can make the trust appear an outlier due to the specialist nature of the services provided and attract regulatory attention • All Fundamental Standards need to be allocated an Executive, Non-Executive and Operational lead; • Lack of patient safety walkroudns by Execs	**Management assurance** • NHS Improvement monthly returns • MIAA Audit • CQC Visit • CCG Meetings monthly **Metrics** • Internal audit metrics • High level performance metrics **Independent / semi-independent** • Internal Audit Report (Mar-17) • CQC Inspection Report (2018) Good' for the Trust	**Gaps** • Regular internal monitoring of professional and regulatory standards **Outcomes** • Collaborative meetings with CCG • CQC assessment form 2018 visit as 'Good' for the Trust	• Regular review of compliance position • Provide assurance to CQC in relation to risks with appropriate information.	• Monthly monitoring (revised date) • As and when required
Risks from Risk Register • 1736 Business Continuity (Corporate Risk) • 2074 Fire Regulations (Corporate Risk) • 1734 Repeat can costly events (Corporate Risk) • 1966 Risk of safety incidents (Corporate Risk)						

Inherent risk level			Current risk level			Target risk position by 31.3.19		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
5	4	**20**	3	4	**12**	2	4	**8**

Strategic Objective: To deliver **safe** services
Risk Appetite: Low

Objective: Long-term clinical sustainability (Electronic Patient Record)

CQC Domain: Safe

Enabling Strategy: Risk Management Strategy / IM&T Strategy

Executive Lead: Andrew Loughney

Operational Lead: David Walliker

Assurance Committee: Quality Committee (QC)

Risks to objective	Controls	Gaps in controls	Sources of assurance	Assurance outcomes / gaps	Action plan	Timescales
Principal Risks – 2184 **Condition:** Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) Failure to Deliver at agreed schedule of October 2018 Implementation of a system that is not fit for purpose **Cause:** Poor program management and product design **Consequence:** Impact on Patient Safety Quality and Experience Impact on patient and clinical services, such as e-prescribing, staff documentation and consent. Unable to meet contractual reporting arrangements linked to performance and finance Financial impact on delivery of control total leading to inability to deliver annual plan 2018/19 and beyond	• EPR programme board • Monthly EPR meetings chaired by AUHT CEO with LWH Exec Dir representation. • Governance structure for project in place • LWH Digital sub-committee in place with DoF chairing • Monthly IM&T mangers operational meetings in place • PID in Place • Testing programme for system in place prior to implementation • Communication plan in place • Benefit Strategy • Clinical leadership identified • Training and engagement plan in place	• Concern as to supplier management and product functionality UK Market • Programme board ineffective and requires top down focus • Test cycle may be ineffective and if not signed off will impact on programme • Unable to train staff until system has been signed off which may lead to a delay • Key partner awaiting NHSI approval and has not agreed contract with supplier	**Management assurance** • Executive Sign off programme plan • Clinical (operational) sign off • Bi-weekly Exec Team Briefing from CIO • Oversight from Digital Hospital Sub-group • Regular reporting to FPBD • Inclusion of LWH NED on EPR Program Board • Appointment of external Program Director in Jan 18 • MIAA gateway reviews • Clinician engagement undertaken **Metrics** • Monthly reports to show progress against plan • Highlight report presented against milestones • Monthly review at FPBD **Independent / semi-independent** • MIAA Report (limited assurance) 2017 • Gateway process in place with external verification	**Gaps** • Ability to influence supplier Functionality of modules for Maternity, Theatres and e-prescribing • Appetite of other Trusts to prioritise the program • Effectiveness of Program Board **Outcomes** • Full EPR against planned date • No impact on the delivery of control total in 18/19 • Supports the delivery of £3.6m CIP for 18/19	• Test System built and tested against clinically approved script • Recommendations undertaken of audit and repeat audit by MIAA • Delivery of live system against design and configuration set-out through the programme and clinically signed off. • Completion of the business intelligence strategy to enable the successful delivery of statuary and operational reporting post deployment	• Completed for Wave One elements, to complete for Wave 2 (requires the completion of the detailed ISC plan) TBC • Recommendations completed, follow up Audit to be scheduled for August 2018 • Under review following rebasing of plan. Timescales to be determined following EPR Program Board in July 2018 • Strategy approved by programme board in March 2018 in readiness for deployment against plan.
Risks from Risk Register • 2024 – IM&T service risk						

Inherent risk level			Current risk level			Target risk position by 31.3.19		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
4	5	**20**	5	5	**25**	5	5	**25**

Strategic Objective: To participate in high quality research and to deliver the most **effective** outcomes

Risk Appetite: Moderate

Objective: Best clinical outcomes

CQC Domain: Effective

Enabling Strategy: Quality Strategy

Executive Lead: Caron Lappin

Operational Lead: Devender Roberts

Assurance Committee: Quality Committee (QC)

Risks to objective	Controls	Gaps in controls	Sources of assurance	Assurance outcomes / gaps	Action plan	Timescales
Principal Risks - 2168 **Condition:** Inability to deliver the best clinical outcomes for patients **Cause:** Clinical capabilities and competence, recruitment and retention problems, trust location and estate **Consequence:** Increased patient safety incidents, increased levels of patient harm, loss of commissioner and patient confidence in provision of services, enforcement action, prosecution, financial penalties, reputational damage.	• Management of NICE guidance and clinical audit • Automated compliance reports • Regular programme of divisional reports to Safety and Effectiveness Senates • Training programme (mandatory and non-mandatory) • Clinical revalidation • Biannual internal inspection regime • Application of guidelines /policy led practice. • Governance processes around policies and guidelines • Clinical Audit Strategy including full involvement in relevant National Audit Programmes and reviews. • Mortality Strategy 2018 • All medical staff have work plans agreed with CDs and MD. • Analysis of patient feedback • Application of Patient Safety and other safety alerts. • Analysis of incidents, complaints and claims to identify areas of risk. • Case note reviews, morbidity and mortality reviews. • Supervision and education of clinical staff across all professions. • Application of clinical pathways and guidelines. • Increasing R&D involvement across the organisation • Performance data presented at Clinical Comm Meetings • R&D strategy approved by Board April 2018	• Further improvements to be made in relation to support for clinical teams to be involved in clinical audit • Need to further enhance the shared learning across relevant directorates from audits • Availability of allocated time and people to undertake and provide clinical and educational supervision. (indicated time is allocated in Consultant job plans for this activity) • Consultant Nurse job plans	**Management assurance** • Internal Audit Programme • Clinical Effectiveness audit programme • MDT approach to patient management • Directorate performance reviews • Case reviews and analysis • Research participation • Quarterly Mortality Reports • Annual Trust Mortality Report • External auditors programme (KPMG) **Metrics** • Mortality metrics • Never events • Incident data • Quality Strategy metrics • CQUINS • Performance data	**Gaps** • Difficult to gain consistent assurance that clinicians are following best practice • Lack of Lack of available benchmarking data due to nature of specialist services provided • Lack of testing of action plans following audits to ensure they lead to embedded change.	• Continue to explore potential for direct research relationships with other local trusts and universities	• Ongoing process to be reviewed in October 2018 (revised date)
Risks from Risk Register • 4 x Corporate Risk • 14 x Service Risks			**Independent / semi-independent** • GMC / NMC Reports • Royal College Reports / Visits. • NCEPOD Reports • MBRRACE Reports • SHMI / RAMI • CQC Outlier Alerts • National Audits • Peer Reviews and accreditation. • R&D Performance and • initiation data via DoH • CQC inspection visits • CCG monthly quality and performance meetings.	**Outcomes** • CQC rating Good 2018 • Neonatal Peer review Jan 18 • Liverpool University Review • Accredited NMC for MSc conversion course		

Inherent risk level			Current risk level			Target risk position by 31.3.19		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
4	5	**20**	3	4	**12**	3	4	**12**

Strategic Objective: To deliver the best possible experience for patients and staff
Risk Appetite: Low

Objective: A positive patient experience

CQC Domain: Experience

Enabling Strategy: Quality Strategy / Patient Experience Strategy

Executive Lead: Caron Lappin

Operational Lead: Michelle Morgan

Assurance Committee: Quality Committee (QC)

Risks to objective	Controls	Gaps in controls	Sources of assurance	Assurance outcomes / gaps	Action plan	Timescales
Principal Risks - 2167 **Condition:** Potential for poorly delivered positive experience for those engaging with our services **Cause:** There are a number of issues impacting on the issue, such as: Capacity and capability of staff, high turnover of staff, poor staff morale, non-acceptance of personal and professional responsibility, excessive waiting time, poor food standard, poor staff attitude and behaviour **Consequence:** Failure to be the provider of choice, failure to achieve the strategic vision, loss of income and activity, reputational damage, regulatory intervention.	• Patient experience strategy • Professional Codes of Conduct • Mandatory training and development for all staff groups. • Engagement with third party stakeholders, including Healthwatch and hard to reach groups • Complaints and compliments are reported and managed locally but with oversight by Board. • Application of policies, guidelines, procedures and strategies • Revalidation and clinical supervision • Trust values and objectives. • Attendance management policy • Appropriate skill mix across staff groups. • Peer support groups • Quality Strategy 2017-20 • PALS plus • Patient engagement • Use of volunteers • Consistent application of supporting staff policy • All staff , Trust members and volunteers have exit surveys	• Environment and estates issues require implementation of the PCBC • Confirmation of sustainability of changes and improvements is required • Consistent and accurate data regarding skill mix • Removal of statutory supervision with no agreed model in place for MW • Insufficient quality of interpretation services • Nurses and AHP's supervision needs development and implementation • Access centre and bookings • Telephone line services for booking and advice in GED and MAU	**Management assurance** • Patient stories (reports to board) • Staffing red flags (reports to board) • Patient Opinion (monthly to board) • PLACE Assessment • Health watch peer review • Governor experience and safety committee in place • Daily Huddle • Board Walkabouts (1/12)	**Gaps** • Out of date policies • Put of date patient information leaflets	• Consider how to enhance assurance levels around the involvement of hard to reach groups. • Respond to the findings of the CQC's national surveys (Maternity / Inpatient)	• November-18 (revised date) • Ongoing (revised form specific date)
Risks from Risk Register • 2 x Corporate Risk • 13 x Service Risks			**Metrics** • Complaints data • PALS data • FFT Results • Staff survey engagement score • Vacancy / turnover levels • Safe staffing levels	**Outcomes** • Staff survey results awaited		
			Independent / semi-independent • National Maternity Survey • National Inpatients Survey • Regulatory inspection			

Inherent risk level			Current risk level			Target risk position by 31.3.19		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
5	4	**20**	3	3	**9**	2	2	**4**