Meeting of the Board of Directors
HELD IN PUBLIC
4 April 2019 at 0930hrs Liverpool Women's Hospital Board Room

Item no. 2019/	Title of item	Objectives/desired outcome	Process	Item presenter	Time	CQC Domain
	Thank you	To provide personal and Team thank you – above and beyond			0930 (10mins)	caring
033	Apologies for absence Declarations of interest	Receive apologies	Verbal	Chair		-
034	Meeting guidance notes	To receive the meeting attendees' guidance notes	Written guidance	Chair		Well Led
035	Patient Story – Home Birth Service	To receive a patients story	Presentation	TBC	0940 (20mins)	Safe, Experience, Well led
036	Minutes of the previous meeting held on 1 February 2019	Confirm as an accurate record the minutes of the previous meetings	Written	Chair	1000 (5mins)	Well Led
037	Action Log and matters arising	Provide an update in respect of on-going and outstanding items to ensure progress	Written	Chair		Well Led
038	Chair's announcements	Announce items of significance not elsewhere on the agenda	Verbal	Chair	1005 (10mins)	Well Led
039	Chief Executive Report	Report key developments and announce items of significance not elsewhere	Written	Chief Executive		Well Led

Item no. 2019/	Title of item	Objectives/desired outcome	Process	Item presenter	Time	CQC Domain
BOARD COMMITTEE ASSURANCE						
040	Chair's Report from Quality Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	1015 (20mins)	Safe Well Led
041	Chair's Report from Finance, Performance and Business Development Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair		Well Led
042	Chair's Report from Audit Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair		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						
043	Annual Staff Survey	To receive the findings of the annual staff survey and actions arising.	Written Written	Director of Workforce and Marketing	1035 (10mins)	Safe Well Led
044	Feedback from The Nursing and Midwifery Listening Event	For information and assurance	Written	Director of Nursing and Midwifery	1045 (10mins)	Well Led, caring
045	Serious Incidents and Learning from Events Report	For Assurance	Written	Director of Nursing and Midwifery	1055 (10mins)	Well Led, caring
TRUST PERFORMANCE - TO DELIVER THE MOST EFFECTIVE OUTCOMES; TO BE EFFICIENT AND MAKE BEST USE OF AVAILABLE RESOURCES						
046	Safer Nurse/Midwife Staffing Monthly Report period M11 2018/19	For assurance and to note any escalated risks	Written	Director of Nursing and Midwifery	1105 (10mins)	Well Led, caring, Safe
047	Operational Performance Report period M11, 2018/19	For assurance –To note the latest performance measures	Written	Interim Director of Operations	1115 (10mins)	Well Led
048	Finance Report period M11, 2018/19	For assurance - To note the current status of the Trusts financial position	Written	Director of Finance	1125 (10mins)	Well Led
TRUST STRATEGY						

Item no. 2019/	Title of item	Objectives/desired outcome	Process	Item presenter	Time	CQC Domain
049	Future Generations	For noting.	Verbal	Chief Executive	1135 (5mins)	Well Led
BOARD GOVERNANCE						
050	Board Assurance Framework	For assurance and approval	Written	Trust Secretary	1140 (05mins)	Well Led
051	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair		Well Led
HOUSEKEEPING						
052	Any other business & Review of meeting	Consider any urgent items of other business	Verbal	Chair	1150 Meeting ends	Well Led

Date, time and place of next meeting Friday 2 May 2019

Meeting to end at 1150

1150-1200	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

Meeting attendees' guidance, April 2018

Under the direction and guidance of the Chair, all members are responsible for ensuring that the meeting achieves its duties and runs effectively and smoothly.

Before the meeting

- Prepare for the meeting in good time by reviewing all reports
- Submit any reports scheduled for consideration at least 8 days before the meeting to the meeting administrator
- Ensure your apologies are sent if you are unable to attend and *arrange for a suitable deputy to attend in your absence
- Notify the Chair in advance of the meeting if you wish to raise a matter of any other business

*some members may send a nominated representative who is sufficiently senior and has the authority to make decisions. Refer to the terms of reference for the committee/subcommittee to check whether or not this is allowable

At the meeting

- Arrive in good time to set up your laptop/tablet for the paperless meeting
- Switch to silent mobile phone
- Focus on the meeting at hand and not the next activity
- Actively and constructively participate in the discussions
- Think about what you want to say before you speak; explain your ideas clearly and concisely and summarise if necessary
- Make sure your contributions are relevant and appropriate
- Respect the contributions of other members of the group and do not speak across others
- Ensure you understand the decisions, actions, ideas and issues agreed and to whom responsibility for them is allocated
- Do not use the meeting to highlight issues that are not on the agenda that you have not briefed the chair as AoB prior to the meeting
- Re-group promptly after any breaks
- Take account of the Chair's health, safety and fire announcements (fire exits, fire alarm testing, etc)

Attendance

- Members are expected to attend at least 75% of all meetings held each year

After the meeting

- Follow up on actions as soon as practicably possible
- Inform colleagues appropriately of the issues discussed

Standards & Obligations

1. All documentation will be prepared using the standard Trust templates. A named person will oversee the administrative arrangements for each meeting
2. Agenda and reports will be issued 7 days before the meeting
3. An action schedule will be prepared and circulated to all members 5 days after the meeting
4. The draft minutes will be available at the next meeting
5. Chair and members are also responsible for the committee/ subcommittee's compliance with relevant legislation and Trust policies
6. It is essential that meetings are chaired with an open and engaging ethos, where challenge is respectful but welcomed
7. Where consensus on key decisions and actions cannot be reached this should be noted in the minutes, indicating clearly the positions of members agreeing and disagreeing – the minute should be sufficiently recorded for audit purposes should there need to be a requirement to review the minutes at any point in the future, thereby safeguarding organisational memory of key decisions
8. Committee members have a collective duty of candour to be open and honest both in their discussions and contributions and in proactively at the start of any meeting declaring any known or perceived conflicts of interest to the chair of the committee
9. Where a member of the committee perceives another member of the committee to have a conflict of interest, this should be discussed with the chair prior to the meeting
10. Where a member of the committee perceives that the chair of the committee has a conflict of interest this should be discussed with the Trust Board Secretary
11. Where a member(s) of a committee has repeatedly raised a concern via AoB and subsequently as an agenda item, but without their concerns being adequately addressed the member(s) should give consideration to employing the Whistle Blowing Policy
12. Where a member(s) of a committee has exhausted all possible routes to resolve their concerns consideration should be given (which is included in the Whistle Blowing Policy) to contact the Senior Independent Director to discuss any high level residual concerns. Given the authority of the SID it would be inappropriate to escalate a non risk assessed issue or a risk assessed issue with a score of less than 15
13. Towards the end of the meeting, agendas should carry a standing item that requires members to collectively identify new risks to the organisation – it is the responsibility of the chair of the committee to ensure, follow agreement from the committee members, these risks are documented on the relevant risk register and scored appropriately

Speak well of NHS services and the organisation you work for and speak up when you have Concerns

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Board Agenda item 2019/036

Board of Directors

Minutes of the meeting of the Board of Directors
held in public on Friday 1st February 2019
at Liverpool Women's NHS Foundation Trust, Crown Street Liverpool.

PRESENT

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

IN ATTENDANCE

Mr Colin Reid	Trust Secretary

APOLOGIES:

2019	
	Thank You **Angela Douglas, Scientific Director, Genetics:** The Medical Director provided thanks on behalf of the Board to Angela Douglas who was due to leave the Trust and join NHS England. He advised the Board of Angela's profile which was recognised across the North West and this was recognised by being awarded the MBE. The Medical Director advised on the great respect her peers had for Angela. Referring to the new Genomics hubs, The Medical Director advised that Angela was key in developing the concept of the Hubs and acted with great dignity during the process. **Access Centre Team, Admissions and IM&T Team**: The Director of Operations thanked the access and admissions team who had been working behind the scenes to bring the Trust back in line with delivery of the national targets for RTT and 62 day cancer. Referring to the IM&T team, the Director of Finance recognised the work of the team who had personally put in a huge amount of time to support the Trust objectives. Attending from each of the teams were: Richard Strover; Hayley McCabe; Debbie Pink; Wendy Currin; Rob Cushion; Louise Smith; and Sandra Cooper.
001	**Apologies** – as above. **Declaration of Interests** – None **Welcome:** The Chair opened the meeting he advised that the Patient story would take place later in the meeting.
002	**Meeting guidance notes** The Board received the meeting attendees' guidance notes.

004 **Minutes of previous meeting held on Friday 7 December 2018**
The minutes of the board meetings held on 7 December 2018 were approved subject to a number of minor typographical amendments.

005 **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.

006 **Chair's Announcements**
The Chair reported on the following matters:

Neonatal Redevelopment Ground Breaking: the Chair advised the Board that the Ground breaking event would take place in the Conservatory immediately after the meeting had concluded.

Meeting with Ian Dalton: Referring to his meeting with Ian Dalton, the Chair reported that arrangement would be made for his visit to the Trust following a discussion he had with Ian Dalton at a recent event.

Recruitment of Non-Executive Directors: The Chair updated the Board on the progress in the recruitment of two additional Non-Executive Directors to the Board. He explained that six candidates had been shortlisted for interview, three with recent and relevant financial experience and three with clinical experience. Following interviews, the preferred candidate would be recommended to the Council of Governors for approval at its meeting on 20 February 2019.

The Board noted the Chair's verbal update.

007 **Chief Executive's report**
The Chief Executive referred to her report and commented on the following:

Future Generations: The Chief Executive advised that the Trust had not as yet received formal notification from the Department of Health regarding the funding application for the new build on the University Health Campus close to the New Royal Liverpool Hospital, although it was recognised that the Trust was not successful in its application.

Hospital Programme: The Chief Executive reported on the success of the Hospital Programme and in particular the viewing figures which was thought to be in the region of 1.2-1.4 million viewers. Tony Okotie advised on his "second screen" viewing of social media whilst he watched the programme and was pleased to see the recognition of why the Trust needed to move to a new build from a clinical perspective from members of the public. Ian Knight recognised the positive contribution of the Communications team both during and after the programme. The Chair recognised the work of all staff in the making of the Programme and proffered his thanks and that of the Board for their contribution.

Fair and Just Culture Update January 2019: The Director of Workforce and Marketing reported on the first cohort of 6 senior leaders from a range of departments who had visited the USA and undertaken certificated training in Fair and Just Culture principles and implementation. She advised that all participants had successfully completed a 2 hour exam. The course was an opportunity to meet organisations and individuals already involved in implementation of a Fair and Just Culture. The second cohort of 4 people would be leaving for Vienna, on 28th January 2019 and not only would they achieve certification in Fair and Just Culture they would be able to attend a "Train the Trainers" course which will then enable us to develop a training plan for LWH staff in the principles of a Fair and Just Culture. The steering group would agree the project plan, work streams and

timeframes, which would be presented to the Putting People First Committee in March 2019.

The Chair thanked the Chief Executive for presenting her Report, which was noted.

003 **Patient Story Presentation**

The Director of Nursing and Midwifery introduced Betty Batt and her parents Karen and Phil Batt who would articulate the care Betty had received on the Neonatal unit and the impact of Betty having to receive surgery at Alder Hey.

Karen and Phil Batt expressed their thanks to the Trust staff for all the medical and non-medical care, support and love they provided whist Betty was treated on the Neonatal unit, they could not express enough the gratitude they felt for the Trust and staff.

Phil Batt advised on the birth of Betty at 23 weeks and her medical conditions which felt like a snakes and ladders board game, where Betty's condition would improve and be very positive going forward and then effectively hit a snake and her condition deteriorate. Phil Batt advised what he called the uniqueness of Liverpool Women's explaining the sense of involvement they had had from the very beginning which included being involved in the ward rounds which provided a sense of empowerment and involvement in Betty's care in every way. He explained that transparency was key to understanding what was required in the care of Betty and the consultants and nursing staff that were completely transparent in explaining Betty's care needs.

Referring to Betty's requirement to receive surgery at Alder Hey, Phil Batt advised that the care at Alder Hey was so different to that received at the Trust, given that Betty was treated on a paediatric ward rather than in a neonatal unit; explaining that the different processes and involvement of parents was not as transparent and inclusive. He understood that arrangements were being made to have a single neonatal service across the two sites and supported what was being developed. Phil Batt advised that moving from one neonatal unit to another at a different hospital but with the same ethos, procedures, nursing staff, parent involvement and similar surroundings would be a really positive move. The Chief Executive supported the comments and felt that having two neonatal units run by one team would improve the care to patients and parents of the patients using the service.

Responding to a question from the Chair on how the parents had been able to manage their lives around the care of Betty, Phil Batt explained that his employer had been very supportive and understood his and Karen's needs and Betty's and had allowed him the time off work. He went on to advise that other employers were not as supportive to parents and that parents become under pressure to return to work. He felt that the supportive staff at on the Unit helped parents in that situation.

The Chair thanked Betty, Karen and Phil for attending the Board and sharing their story. He recognised the professionalism and supportive nature of the Neonatal team in the provision of the service which has been highlight again today in the story.

The Chair agreed to take the Safeguarding agenda item.

012 (1) **Safeguarding Annual Report 2017/18**

Amanda McDonough, Associate Director of Nursing and Midwifery for Safeguarding presented the Safeguarding Annual report explaining that the Report had passed through the integrated governance structure and had previously been presented to the Quality Committee at its January 2019 meeting.

The Chair referring to the increase in referrals asked whether the increase created any resource implications for the team. In response the Associate Director of Nursing and Midwifery for Safeguarding felt that the team was well resourced and able to manage the work flow; she had an expectation that the workflow would

increase in the coming months referring to her next paper "Care Quality Commission (CQC) Review of Health Services for Looked After Children and Safeguarding in Sefton – implications for Liverpool Women's" with the need to support other health providers in the local footprint. The Chief Executive was mindful that the Team should not be supporting other health providers to the detriment of the Trust's patients and that a balance needed to be struck so that there was a best possible out-come for the population of Liverpool and surrounding area whist not impacting on the Trust's ability to provide safeguarding services to its patients.

The Board approved the Safeguarding Annual Report 2017/18; noted the safeguarding practice across the Trust; and received assurance that systems and processes were in place to protect vulnerable Children and Adults.

012 (2) **Care Quality Commission (CQC) Review of Health Services for Looked After Children and Safeguarding in Sefton – implications for Liverpool Women's**

Amanda McDonough, Associate Director of Nursing and Midwifery for Safeguarding presented the paper setting out the implications to the Trust following the Care Quality Commission's (CQC) Review of Health Services for Looked After Children and Safeguarding in Sefton.

The Associate Director of Nursing and Midwifery for Safeguarding advised that in response to the recommendations identified, the Trust needed to agree how best to prepare working together to support other health providers to improve Safeguarding processes and children's experiences of health services. She explained that as part of any joint working discussions and supporting neighbouring trusts, the team would, noting earlier conversations, need to take into account capacity and resourcing availability and its current strategic and operational safeguarding responsibilities.

Susan Milner supported the working together approach that supported sharing of best practise and having a consistent approach to safeguarding of children across the local footprint but was mindful of the potential resourcing issues referred to. She felt it was very important that such an initiative did not result in a detrimental impact on the Trust's service. The Associate Director of Nursing and Midwifery for Safeguarding advised that she was mindful of the potential pitfalls that may arise and would not sign up to anything that looked to be a half-hearted attempt to address the concerns raised by the CQC. She also felt that it was not the responsibility of the Trust to fix other health providers issues but would be supportive in helping them find their own solutions.

The Chair thanked the Associate Director of Nursing and Midwifery for Safeguarding for her report which was noted and asked that the comments be taken on board when supporting the initiative once the report was published.

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

The Chair asked Jo Moore to present the Chairs report from the FPBD meeting held on 21 January 2019.

Reporting on the assurance the Committee had received, Jo Moore commented that the committee was comfortable with the financial position for 2018/19 and reported that it had assurance that the control total for the year would be better than plan. She referred to the Operations Report and advised that the Committee had reflected on the delivery of RTT and Cancer targets, noting that the RTT had stabilised at 87% with the backlog queues being maintained at around 600 and it was anticipated that the ASI backlog queues would reduce to zero by March 2019. Jo Moore advised that Cancer Targets still remained a concern, although some improvement had been made. She advised that the Committee had been informed that the Trust would not be able to deliver 62 day cancer target by the end of the financial year.

Jo Moore referred to the other agenda items dealt with at the meeting noting that a number had already been discussed or would be discussed. Referring to the Board Assurance Framework (BAF)

risks the Committee had agreed to reduce the current risk score for the "delivery of the annual plan 2018/19" score to 15 by reducing the likelihood of the risk from 4 to 3 and this was recommended for Board approval in the BAF report later in the meeting.

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

009 **Chair's Report from Audit Committee**

Ian Knight, Chair of the Audit Committee updated the Board on the work of the committee arising from the meeting held on 21 January 2019. In particular Ian Knight highlighted the work of the Committee with regards to the assurances arising from the work of MIAA in undertaking internal audits in relation to risk management and conflicts of interest.

Ian Knight reported that the Committee had received reports in relation to the end of year Annual Reports and Financial statements and had received KPMG's audit plan, which had identified three significant opinion risks: valuation of land and buildings; revenue recognition; and management override of control. Other areas of focus as part of the Audit would include new accounting standards and going concern.

The Chair thanked Ian Knight for his report which was noted.

010 **Chair's Report from Quality Committee (QC)**

Susan Milner presented the Chair Report from the Quality Committee meetings held on 22 January 2019 and advised that the Committee had received assurance from each of its sub-committees/senates on the work they had been carrying out.

Referring to the BAF Risks aligned to the Committee, Susan Milner advised that the Committee had made no recommendation to change any of the risk scores, however there had been changes made to the "Potential for poorly delivered positive experience for those engaging with our services" risk, in relation to the "controls" in place to manage the risk, the removal of elements in the "gaps in control" and the removal of action plans that had been delivered.

Referring to the Monthly Quality Performance Review, Susan Milner advised on the assurances that had been provided regarding RTT and Cancer targets as reported by the Chair of FPBD. She advised that the Committee had also received assurance regarding the validation of data quality through two external audits having been undertaken.

Susan Milner reported on the requirement for future board assurance relating to Seven Day Acute Services and advised that the Committee had noted that NHSI would be piloting the new system from the end of February 2019; a report on the findings would be presented to the Committee in March 2019 with a paper to the Board in either April or May 2019. The Board noted the requirement for board assurance and agreed that for the time being a report would go to the Quality Committee for review and thereafter to Board for noting, with the process being kept under review.

Susan Milner advised that the Committee had received an update on the Research and Innovation Strategy and received assurance on the progress demonstrated to date, particularly in respect of delivering the Joint Research Service and agreement of Consultant Research PAs. She explained that further efforts would intensify during 2019 to develop and implement the aims and objectives of the strategy. The Medical Director reported on the current developments at Liverpool Health Partners in developing its role in the co-ordination of research and innovation across the city. He explained that key post holders had now been appointed to provide the leadership going forward.

With regards to issues to highlight to the Board, Susan Milner advised that the two matters,

Safeguarding Annual Report and the Care Quality Commission (CQC) Review of Health Services for Looked After Children and Safeguarding in Sefton had already been addressed by the Board earlier in the meeting.

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

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

Tony Okotie presented the Chairs report from the PPF meeting held on 25 January 2019 and reported on a number of matters that the Committee felt was important to highlight to the Board.

Referring to the staff story and service assurance workforce report for Gynaecology and the Hewitt, Tony Okotie advised that the Committee had heard that there were some significant workforce challenges that needed to be addressed by the Division in the coming year particularly in the areas of succession planning in response to the ageing workforce profile, initiatives to increase staff morale which had fallen over the last 12 months and redefining role and responsibilities within senior nursing roles. He advised that the Committee would be keeping a watching brief and would be seeking assurances that the action plans being put in place to address these issues had been completed with positive outcomes.

Tony Okotie drew the Board attention to the potential industrial action by OCS staff, with the ballot taking place today [1 February 2019]. The Director of Workforce and Marketing advised on the reasons why Unison had called for industrial action; explaining that this related to the agenda for change award made to ex-Trust staff that had been passed through OCS to their staff members currently on the agenda for change contracts; however the Trust had not funded pay increases of OCS staff who had not previously been staff of the Trust and had not transferred to the facilities organisation under a transfer of undertaking. The Director of Workforce and Marketing advised that the Trust had done as much as it could do in the circumstances, reporting that the payments made through OCS where not funded from the Department of Health and Social Care and would be therefore be a cost pressure to the Trust and stressed that the industrial action was not a dispute between staff and the Trust but between OCS and its staff.

The Director of Workforce and Marketing advised that should there be any industrial action this would take place before July 2019 and the Trust's EPRR processes would be implemented to mitigate any impact on patients. She re-iterated that the action was in relation to OCS and its staff.

Referring to the NHS Long Term Plan recently published by the Department of Health and Care, Tony Okotie reported on the review undertaken by the Committee on any workforce implications and what the key workforce challenges were. He advised that the Committee was assured that the Trust was well sighted on the key challenges ahead and these were appropriately reflected in the Putting People First Strategy.

The Chair's thanked Tony Okotie for his report from Putting People First Committee which was noted.

The Chief Executive reminded all the Committees of the need for each to review the corporate objectives for 2018/19 at their March meeting to close off for the year and report into the Board, however recognised that the next Putting People First Committee was in April and therefore the Board review would take place at the 2nd May 2019 Board meeting. There would also be a requirement to review the objectives for 2019/20, again so that they can be reported to the Board for final sign off.

013 **Listening Events Summary Report – 12month review**

The Director of Workforce and Marketing presented the Listening Events Summary Report taking

into account the last 12 months and provides a summary of the four events held so far. She reminded the Board that the Listening Events was part of the Trust response to feedback in the Annual Staff Survey and a desire to strengthen the relationship between staff, senior managers and Board.

The Director of Workforce and Marketing advised that the outcomes of the individual events inform actions in their respective work streams and "you said, we did" progress updates provided through a number of channels including: follow up listening events; In the Loop; the Health and Wellbeing Newsletter; and Staff Track.

The Director of Workforce and Marketing advised that Progress and effectiveness continued to be monitored through the Putting People First Committee as part of the ongoing delivery of the Putting People First Strategy.

The Board noted the content of the paper and recognised the need to consider different ways of holding the listening events so that staff energy levels does not wain and supports keeping staff engaged in the process. There were additional comments raised regarding the number of attendees and the lack of medical staff attendance.

The Board received the summary of the Listening Events Report and committed to continued regular attendance at the events.

014 Putting People First Strategy 2019-2024

The Director of Workforce and Marketing presented the Putting People First Strategy 2019-2024 and reminded the Board that the Strategy had been developed in collaboration with staff, partners, volunteers, patients and other stakeholders over the last 6 months. She advised that it builds on the achievements of the previous Strategies and seeks to further respond to the key workforce risks, challenges and opportunities facing the Trust and its workforce over the next five years.

Referring to the themes in the Strategy, Tony Okotie [as Chair of the Putting People First Committee] advised that they follow the themes in the recently published Governments longer term plan, even though the plan had not been published when the final version of the Strategy was approved by the Committee which was a positive outcome.

The Chair noting that the Board had been party to the Strategy's development over the last 6 months sought approval of the Strategy. The Board approved the Putting People First Strategy 2019-2024.

015 (1) Bi-Annual Safe Staffing Review

The Director of Nursing and Midwifery presented the Bi-Annual Staffing Review report that covered the period from June 2018 to December 2018. She explained that the Report had been reviewed by the Putting People First Committee before being presented to this meeting and advised that the Committee had noted the assurance provided in relation to the Trust having robust systems and processes in place to monitor and manage nursing and midwifery requirements.

The Director of Nursing and Midwifery reported that in line with the National Quality Board requirements a six monthly board report of nursing and midwifery staffing review was undertaken together with monthly board reporting of actual/planned staffing requirements. She went on to advise that the monthly staffing reports were published on the Trust website with the Board papers and submitted to NHS choices and reported via unify staffing. Staffing levels both planned and actual displayed at ward level and evidence based tools, professional judgement and outcomes had been used as part of the safe staffing processes.

Referring to vacancy rates for registered nursing, midwifery and AHPs, the Director of Nursing and Midwifery advised that the rate for Cheshire and Merseyside region was recoded at 9.3% against the national position of 11.6% and a Trust position of 4.91%. She saw this as a very positive position for the Trust; however the Trust should not be complacent and needed to consider innovative recruitment and retention solutions particularly in the context of an ageing nursing and midwifery workforce. The Director of Nursing and Midwifery advised that 30% of the nursing and midwifery workforce was aged between 51 and 65 years of age which was a concern.

Recognising one of the key concerns expressed in previous Bi-Annual Staffing Review reports, the Director of Nursing and Midwifery advised that the Trust was currently funding headroom within operational budgets at 18.9% this was less than the national accepted position for maternity and neonatal units and a proposal was being drafted to increase the headroom to 21% across the Trust; the proposal would consider any funding requirements which would be addressed through cost pressures and budget setting.

The Chair thanked the Director of Nursing and Midwifery for her paper.

The Board: noted the content of the report and the assurances provided; noted the potential risk to the organisation associated with an ageing nursing workforce and the recruitment, retention and role redesign required to mitigate this risk; and was sighted on the national shortage of Nursing and Midwifery staff which had not as yet impacted on the Trust.

015 (2) Safer Nurse/Midwife Staffing Monthly Report Period 8&9 2018/19

The Director of Nursing and Midwifery presented the safer staffing report for months 8&9 and highlighted the key findings. 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.

016 Performance Report Period 9 2018/19

The Director of Operations presented the Performance Report for period 9 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 RTT performance had remained constant at 87% over the last three months reporting (September, October and November). He reported that two locum consultants had revised job plans from January that would start to address the ASI list and then ultimately RTT performance. Referring to backlogs, the Director of Operations reported that the service maintained consistent queues of 600 for both first and follow ups appointments up to the end of December 2018. As reported previously the polling range for Uro-gynaecology had been extended to 10 weeks and with additional capacity from locum consultants and the Trust's consultants which had reduced the ASI (first appointment) to 250 in January 2019.

Cancer targets continued to remain a challenge, in particular with regards to 62 day Cancer target. The Director of Operations advised that there were still issues with delays with diagnostic testing MRI, CT, echo and pathology testing and the service was actively tracking patients and chasing results, however, capacity issues were restricting early diagnosis. He explained that the clinical lead for Gynaecology was reviewing clinical pathways and the service had accepted additional support from the cancer alliance to improve the wait to diagnosis.

With regards to sickness absenteeism, the Director of Operations reported that the indicator had spiked in the last two months to 5% and advised that the HR department, services managers and Heads of Nursing and Midwifery were working collaboratively to manage sickness across the services.

The Board noted the Performance Report for period 9 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.

017 Financial Report & Dashboard Period 9 2018/19

The Director of Finance presented the Finance Report and financial dashboard for month 9, 2018/19 and reported that at month 9 the Trust was reporting a deficit of £0.3m against a deficit budget of £2.4mm, giving a year to date favourable variance of £2.1m. She advised that this was a sustained improvement and after careful and detailed review, the forecast had now been revised and improved by £0.5m. The Director of Finance advised that an assumption has been made that the improved position would result in a further £0.5m of Provider Sustainability Fund income; however the underlying position going into future years was a cause of concern referring to the acting as one contract with Liverpool CCG.

With reference to the Board Assurance Framework, the Director of Finance advised that the reason to reduce the risk score for the "in-year risk to delivery of the annual plan 2018/19" reported under the Chairs report for FPBD continued to be due to sustained over-performance against plan over a number of months, and the crystallisation and management of a number of key risks.

The Chair thanked the Director of Finance for presenting the Financial Report & Dashboard Period 9 2018/19 which was noted.

018 Future Generations

The Chief Executive advised that she had nothing further to add from the earlier discussion.

019 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 the amendments identified in the paper and approved the reduction of the risk score relating to the corporate risk "delivery of the annual plan 2018/19" to 15 by reducing the likelihood of the risk from 4 to 3 and received assurance from the Board Assurance committees that the risks were being appropriately managed.

020 Review of risk impacts of items discussed

The Board noted the following additional risks identified during the meeting:

- Safeguarding capacity and resource arising from the CQC Review of Health Services for Looked after Children and Safeguarding in Sefton.
- Seven day services – access to diagnostics
- OCS staff industrial action
- Delivery of cancer indicators
- Risks arising from the further delays to addressing the isolated site clinical risks following the decision that the Trust would not receive capital allocation in the 2018/19 funding round.
- Ageing Nursing, Midwifery and Consultant workforce.
- Although not an additional risk to those already known, the Financial Risks would continue into 2019/20.

021 Any other business & Review of meeting

There was no other business.

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 4 April 2019, recognising that a board workshop would be held on 1 March 2019.

Agenda Item 2019/037

TRUST BOARD
4 April 2019
Action Plan

Meeting date	Minute Reference	Action	Responsibility	Target Dates	Status
7 December 2018	2018/289	The 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 4 July 2019	Director of Nursing and Midwifery	4 July 2019	

	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	2019/039

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Chief Executive Report**
DATE OF MEETING:	Thursday, 04 April 2019
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

Executive Director Appointments: The following changes have taken place since the last Board of Directors meeting: Andrew Loughney, Medical Director has gone on a secondment for 4 days a week to the Royal Liverpool and Broadgreen University Hospitals Trust at their Medical Director. The secondment is for the period up the October 2019. Acting into the role of Medical Director whilst Andrew is on secondment is Dr Devender Roberts who has recently been the Deputy Medical Director at the Trust. Andrew will continue to provide support to the Trust in specific areas requested by the Chief Executive including the Trust's Future Generations Strategy. For the duration of Andrews's secondment, Michelle Turner will assume the role of Deputy Chief Executive. Jeff Johnson, Director of Operations resigned from the Trust and is currently working out his notice. Loraine Turner has been appointed interim Director of operations whilst the Trust seeks to find a permanent replacement.

Reporting HCW flu vaccination information: The paper set out in appendix 1 provides details of the 2018/19 flu vaccination campaign at the Trust. NHS England/Improvement has requested that the Trust Board receives a self-assessment detailing the Trust's performance against the recommended best practice management checklist.

Making Every Contact Count (MECC): Making every contact count (MECC) is an initiative being implemented within the Trust that enables staff to be proactive in facilitating greater awareness to patients and service users of health and wellbeing initiatives. The Trust is already undertaking some great work in giving advice on smoking, alcohol and weight and there are a number of CQUINS to support this. Liverpool CCG have requested that the Trust build on the great work that is already being undertaken both for patients and staff to include other healthy initiatives to prevent ill health, improve health and wellbeing and to reduce health inequalities.

- MECC will be part of normal pathways
- The implementation and action plan will be reviewed by the CCG
- The action plan will be monitored quarterly at patient experience senate
- Staff will need to be trained and champions identified
- This is a long term programme to reduce health inequalities

Ward Accreditation Scheme: As previously reported the Trust is involved in the The Trust is undertaking the Ward Accreditation Scheme as a process of assurance from ward to board and include an "awarded status" based on the level of success achieved. The Focus is on knowing if the ward/department is achieving safety/quality standards and are committed to continuous improvement. When accreditation programme is established, board level knowledge or each ward/ dept. is increased giving a greater level of assurance. The Scheme provides an opportunity for the senior team to role model the desired Trust culture at all levels; ensuring women, patients and families are at the heart of everything we do. The Ward Accreditation Scheme drives real pride between wards and departments. If areas are struggling, it's about a supportive approach people knowing how they are doing and then encouraging ownership of what needs to be done to get better in a continuous improvement approach. The Scheme focuses on engaging staff and empowering leaders to improve standards and quality. It is based on the continuous improvement principle of standardisation – recognising, sharing and sticking to best practice in the interests of patient care. There will be considerable focus on celebrating achievements, providing board assurance and ensuring actions are completed where needed. The launch of the scheme took place on 19 March 2019 at which staff were informed on the initial base line ward accreditation on 5 areas in commencing in April 2019: Mat Base; Delivery Suite; Gynaecology ward; MLU; and Neonates.

Genetics: As reported previously, in July 2017, NHS England (NHSE) formally tendered the Genetics Laboratory Services for the whole of England in response to which the laboratories in the North West submitted a joint bid. In October 2018, NHS England confirmed the seven successful Genomic Laboratory Hubs (GLH); one of which was the North West Hub. As the North West GLH will be managed by Manchester University NHS Foundation Trust (MFT), it was anticipated that the Trust's associated staff would transfer to MFT on 1st April 2019. This transfer has since been delayed to 1st July 2019. Despite this delay, work to deduplication the tests conducted within the North West has continued as scheduled.

Dedicated to Excellence Awards 2019 - Shortlist: Thank you to all staff who have entered this year's 'Dedicated to Excellence Awards'. We received an outstanding amount of entries. Judging of entries has taken place over the last couple of weeks and I am pleased to say the final shortlist has been confirmed. The top 3 nominations for each category are being invited to the awards this year, allowing those who submitted strong nominations, demonstrating how the criteria was met by the fantastic work completed over the last 12 months, to celebrate their achievements with more members of the team. A huge thank you to all who took the time to submit a nomination showcasing the amazing work you do each and every day. Congratulations to those who have been shortlisted - winners will be announced on the night.

The list below details all of the shortlisted entries:

Dedicated to Patients and their Families

- Neonatal Infant Feeding team
- What's behind the door?
- Midwife at home team

Dedicated to Research

- The Invest Study
- ANODE: prophylactic Antibiotics for the prevention of infection
- SuPPort Stitch, Pessary of progesterone: a randomised control trial

Dedicated to Working together (team working and partnerships)

- GED People: Movin on up We are Movin on Out
- Reducing term admissions to minimise separation of mothers and babies
- Getting to the Bottom of things

Dedicated to Innovation and Improvement (clinical)

- La La La Can't Hear You
- Delivery Room CPAP quality Improvement Project (DR CPAP QIP)
- No more pressure, turn up the volume

Dedicated to Innovation and Improvement (non-clinical)

- Logistics With Hear@LWH
- Read all about it
- 100,000 Genomes Project

Dedicated to Clinical Audit

- On Our Breast Behaviour
- Routine Cranial USS for Preterm Neonates
- Safety first 'A re-audit of the Prenatal Situation, Background, Assessment, Recommendation (SBAR) database in clinical Genetics

Dedicated to Patient Safety

- Relieve that pressure: Risk assessment an prevention of pressure ulcers on Delivery Suite
- Right Care, Right Treatment
- Infant tagging System – Safeguarding Manager Matt O'Neill

Staff Fundraiser of the Year

- Staff coast to Coast Cycle Challenge
- Choir raises funds for NICU
- Julie Butler Infant feeding support worker

Mentor of the Year

- Barbara Freeman
- Sarah Hogg
- Charlotte Mowatt

Learner of the Year

- Learning…. It's in her Genes!
- Every day is a learning day in Genetics
- Fair and Just Culture

Maternity Award: Liverpool Women's Maternity services have been successful in winning the "Taking Research into Practice" award at the recent North West Coast Research and Innovation Awards 2019. The Trust was a collaborator site with collaborative working between its Obstetricians, Midwifery research midwives and Intrapartum midwives. The 'WOMAN Trial' was a large, international, double blind placebo clinical trial examining the use of tranexamic acid to reduce maternal deaths and improve outcomes linked to excessive postnatal bleeding.

Cycle the Trans Pennine Trail September 2019: Staff are again undertaking a sponsored cycle this year. The route this year will be from Hull to Liverpool Women's taking place on Friday 6th – Sunday 8th September 2019. A reminder of how you can support staff taking part will be provided in future CEO reports.

Neonatal Capital Program Build Project: The Neonatal Capital Program Build Project is currently 61 weeks into an anticipated 137 week programme and due to complete on 22nd July 2020. There are currently no program concerns in terms of operational progress; however there have been developments with the program's principal supply chain partner, Interserve PLC. At the time of contract award under the Procure 22 framework the Trust became aware of some financial issues with Interserve. These were raised with the Department for Health and Social Care (DHSC) who oversees the Procure 22 framework and assurances from DHSC were given with regards to the ongoing viability of the partner. The Board and Finance Performance and Business Development Committee had discussed details of this, and the safeguards the Trust had in place. Since the contract award the Trust has continued to closely monitor the position around Interserve's debt restructure which has also been publicised in the media. Board, Staff and Governor Briefings have been released alongside the media attention. On 15 March 2019 a deleverage plan was put to Interserve's shareholders. This was rejected; however a pre-pack administration deal has seen the company bought out by its lenders in a similar deal to that which was rejected.

Department of Health and Social Care (DHSC) issued the following to the Trust on 18 March 2019.

> *'Interserve plc was placed into administration, from where all of its operating companies and subsidiaries were sold to a new company owned by the lenders to the plc. This new company is being renamed "Interserve Group Limited". Interserve has executed its pre-pack administration and will shortly implement its refinancing.*
>
> *This follows the rejection of the refinancing by the shareholders today. Interserve plc was placed into administration, from where all of its operating companies and subsidiaries were sold to a new company owned by the lenders to the plc. This new company is being renamed "Interserve Group Limited". The owners of the new company will implement the refinancing today and over the weekend.*
>
> *As a result Interserve will be able to continue delivering its services with no interruption.*
>
> *The administration has only affected Interserve plc. Its operating companies, which actually hold contracts and deliver services, did not enter administration.*
>
> *This is good news - services should continue without disruption, employment maintained.'*

The DHSC noted that Interserve will receive an injection of £110m of cash and that the operating companies will remain intact. They also noted that they expect some negative press to continue. They do however reiterate that this is 'business as usual'. The Trust will continue to monitor the situation and maintain payment for services in arrears and will continue to seek assurances about payments along the supply chain.

Charitable Funds Strategy: The Big Tiny Steps Appeal - The Board is reminded that it agreed 'The Big Tiny Steps Appeal' at its workshop on 1 March 2019 following a presentation from Impact Fundraising. The appeal pledges to raise £250,000 to introduce essential family facilities to make the new Neonatal Unit a truly first class environment when it opens in 2020. Each year, over 1,000 families accompany their premature and critically ill babies to our Neonatal Unit, in need of the specialist care that Liverpool Women's provide. The Trust received £15m of NHS funding to redevelop their existing Neonatal Unit to provide a better environment to care for the most vulnerable babies. The Big Tiny Steps Appeal is asking for support to provide vital facilities which include: high quality comforts for use at incubator and cot-side, additional parent accommodation; parents sitting room; kitchen and laundry areas; improved breastfeeding facilities, end of life suite; and outdoor sensory garden. This support will enable families to stay by their babies' side during the most critical time of their lives. Creating a spacious, home-like and comfortable setting for families with the most state of the art facilities close at hand will alleviate some of the pressures of having a baby in intensive care, enabling them to concentrate on being there for their babies.

Data Quality: The Board is reminded that received a presentation from the Trust's Head of Performance & Information on Data Quality Assurance and in particular how the Board could be assured that systems, processes and procedures were in place to address the concerns that had arisen in 2017/18 surrounding the data quality for RTT and 62 Day Cancer. The Board recognised and supported the actions taken to address the data quality concerns; in particular it noted the audit programme in place to identify any gaps. With regard to validation of data seen by the Board, Board Committees and sub committees/groups/senate the Board asked that where a dashboard is provided and the figures included were validated/unvalidated the dashboard should be able to show this at a glance by the use of some sort of kite marking and shows the reader the depth of validation and any trajectory/trends. The Board also supported the need to make sure that all staff were sufficiently trained in the systems, processes and procedures such that they recognise that the data quality was keeping patients safe and given the best quality of care the Trust can i.e. knowing that they were making a difference to patients. The Chief Executive and Chair on behalf of the board would like to thank the staff for all their hard work and dedication in addressing the data quality issues over the last 15months following the identification of the data quality concerns.

SECTION C – National

Brexit developments: The Trust continues to follow the operational readiness action plan issued by the Department for Health and Social Care in the event of a 'no deal' Brexit which was issued in December 18. There are no concerns at present. The Trust continues to submit daily and weekly situation reports to NHS England.

NHS Improvement/NHS England – NHSI/NHSE have recently announced the senior appointments for the North West and North East and Yorkshire Regions;

North West

Medical Director and Chief Clinical Information Officer – Dr David Levy,
Finance Director – Jonathan Stephens,
Director of Strategy and Transformation – Clare Duggan,
Director of Performance and Improvement – Graham Urwin,
Director of Public Health (Public Health England) Prof. Melanie Sirotkin

North East and Yorkshire

Medical Director and Chief Clinical Information Officer – Dr Mike Prentice,
Finance Director – Tim Savage,
Chief Nurse – Margaret Kitching,
Director of Performance and Improvement – Warren Brown,
Director of Commissioning – Robert Cornall,
Director of Workforce and OD – Daniel Hartley,
Director of Public Health (Public Health England) Dr Paul Johnstone

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Flu Campaign – Plan for Occupational Health**
DATE OF MEETING:	Click here to enter a date.
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	Michelle Turner, Director of Workforce and Marketing
AUTHOR(S):	Jackie Thomas – Clinical Nurse Specialist OH
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** 6. To develop a well led, capable, motivated and entrepreneurial *workforce* ☒ 7. To be ambitious and *efficient* and make the best use of available resource ☒ 8. To deliver *safe* services ☒ 9. To participate in high quality research and to deliver the most *effective* Outcomes ☐ 10. To deliver the best possible *experience* for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***11.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust……* ☐ ***12.*** *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. ……* ☐ ***13.*** *The Trust is not financially sustainable beyond the current financial year……* ☐ ***14.*** *Failure to deliver the annual financial plan ……* ☐ ***15.*** *Location, size, layout and accessibility of current services do not provide for sustainable integrated care or quality service provision ……* ☐ ***16.*** *Ineffective understanding and learning following significant events……* ☐ ***17.*** *Inability to achieve and maintain regulatory compliance, performance and assurance……* ☐ ***18.*** *Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) ……* ☐ ***19.*** *Inability to deliver the best clinical outcomes for patients……* ☒ ***20.*** *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	**7.** Trust Constitution ☐ **8.** Operational Plan ☒ **9.** NHS Compliance ☒		**10.** NHS Constitution ☐ **11.** Equality and Diversity ☐ ***12.*** 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:-….)***	For the Organisation to have assurance in this campaign and the effective execution of the plan.			
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

This information paper details the OH activity in support of the 2018/19 flu vaccination campaign at Liverpool Women's Hospital. We have been instructed by NHS Employers in a letter dated 7th September 2018 to our Chief Executive that we must publish a self-assessment for the board that details our performance against the recommended best practice management checklist.

Report

Background

In 2017/18, Liverpool Women's immunised 76.9 % of frontline staff. 699 vaccines were administered to staff during our main campaign which ran from 8th Oct 17 to 30 Nov 17 – although vaccines were available until Feb 18.

The Flu CQUIN and the flu fighter's campaign in conjunction with effective leadership have resulted in some organisations now vaccinating over 90% of staff.

This year NHS Employers have proposed that 100% of healthcare workers with direct patient contact are vaccinated.

Key Issues / Proposal

1. **Consideration of factors that will impact upon the attainment of 100% uptake**:
   - Liverpool Women's has historically always had a good uptake of vaccine from its health care workers and there is a risk that some staff will perceive that this is a coercive approach
   - Staff can become resentful if constantly asked if they have had their flu jab in a prolonged campaign.
   - Some staff have a genuine reaction to the vaccine
   - Some staff have a fear of the safety of the vaccine

- Unseasonably warm weather can slow demand and affect take up
- Some staff perceive that the evidence does not prove the vaccines efficacy
- Some staff have significant fear of needles
- The vaccination sessions must be commensurate to the needs of the individual

2. **Myths detected in Women's staff include:**
   - The flu jab does not offer protection
   - Washing hands provides protection
   - They are healthy so won't get it
   - The responsibility for the success of this campaign sits entirely with OH and is not seen as a Trust wide campaign

3. **What motivates staff:**
   - Peer support and pressure
   - Flu vaccination will protect their family and their patients
   - Receipt of 'gizits' such as coffee voucher and pens

4. **Objectives**

   This plan is founded on the attainment of the following factors:

   - Committed leadership and promotion at all levels of the Organisation
   - Effective and dynamic communications plan
   - Flexible accessibility for vaccination recipients
   - Incentives for uptake

5. **Target Audience**

   Major audiences include:

   - Women's staff who are eligible to get the flu vaccination
   - Frontline occupations.

6. **Strategic approach**

   The enabling strategy is:

   - To ensure that staff are aware of what is expected of them in terms of the benefits of being vaccinated
   - To ensure that staff are given the correct facts about the flu vaccination in order to eliminate rumours/myths this will be facilitated with the support of Comms.
   - OH engagement at all divisional meetings in the lead up to the campaign to rally support for divisional/departmental peer vaccinators and to ensure 'buy in' from organisation as to the multifaceted benefits of vaccination
   - Afford engaged staff the opportunity to be vaccinated at their convenience in the form of pop up clinics, walkabouts, flu to you, drop in sessions daily, evening cover within the ward and departments(which will capture nights), early morning vaccination (available from 7am) and weekend vaccination sessions throughout the hospital.

7. Timescales

Vaccinations have been available from 8th October and will be available until 28th February 2019. The submission of uptake to IMMFORM closes on 31 Dec 18.

8. Resources

The campaign is delivered by the Occupational Health and Wellbeing team with support from trained peer vaccinators and augmented by flu bank nurses to cover out of hours and weekends.

9. Implications / Impact

- Quality – the impact on patient care delivery if we have a depleted workforce
- Finance – the cost of using bank and agency staff to cover potential sickness
- Workforce – the impact on both patient facing and support staff roles if high levels of transmission of flu within the workplace
- Compliance – we have been mandated by NHS Employers to prepare this assurance paper and strive towards 100% uptake in patient facing roles.

10. Vaccination Figures

The vaccination figures as at the end of December 2018 are:

staff group	medical	nursing & midwifery	allied health professionals	support	totals
staff eligable to be vaccinated	73	604	33	223	933
actual number vaccinated	71	424	33	190	718
percentage vaccinated	97.3%	70.2%	100.0%	85.2%	77.0%

as well as the above frontline staff for who vaccination is required, a further 145 no frontline staff were also vaccinated

11. Conclusion

The attached appendix demonstrates our delivery of best practice in the effective delivery of the flu campaign for our workforce. Despite the desire to achieve 100% uptake amongst our frontline staff by NHS employers we will likely have a cohort of employees who chose to make an informed decision and decline the offer of the vaccine. We will continue to capture the reasons as to refusal where possible as this information will be submitted to Public Health England.

Nevertheless, the figures above show that the CQUIN target of 70% of front line clinical staff being vaccinated has been achieved.

12. Recommendation

For the Organisation to have assurance in this campaign and the effective execution of the plan.

Appendix 1 – Healthcare Worker Flu vaccination best practice management checklist for public assurance via Trust Board.

A	Committed leadership	Evidence	Trust self-assessment
A1	Board record commitment to achieving the ambition of 100% of front line healthcare workers being vaccinated, and for any healthcare worker who decides on the balance of evidence and personal circumstance against getting the vaccine should anonymously mark their reason for doing so.	Board support at commencement of campaign. Staff declining offer of vaccine asked to complete anonymised proforma to capture reasons for refusal	
A2	Trust has ordered and provided the quadrivalent (QIV) flu vaccine for healthcare workers (1).	QIV ordered for HCW's and aTIV ordered for HCW's over the age of 65	
A3	Agree on a board champion for flu campaign (3,6)	Director of Workforce identified as board champion	
A4	Agree how data on uptake and opt-out will be collected and reported	Task and finish group confirmed plan of collation Sept 18	
A5	All board members receive flu vaccination and publicise this (4,6)	Delivered in 2 phases commencing Oct 18 (Chief Exec and Chairman) and then board including NED's photographs taken (with consent) and promoted	
A6	Flu team formed with representatives from all directorates, staff groups and trade union representatives (3,6)	Peer vaccinators trained Aug 18 and PGD signed off	
A7	Flu team to meet regularly from August 2018 (4)	Monthly review by task and finish group to review progress against planned activity.	
B	Communications plan		
B1	Rationale for the flu vaccination programme and myth busting to be published – sponsored by senior clinical leaders and trade unions (3,6)	Delivered under the supervision of the Director of Communications	
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper (4)	Accessibility across a 24/7 programme with open access to all employees	
B3	Board and senior managers having their vaccinations to be publicised (4)	Photographs captured and promotion through Trust media	
B4	Flu vaccination programme and access to vaccination on induction programmes (4)	Delivered through the 'flu to you' ability where staff are able to book the flu team to deliver in location vaccination sessions	
B5	Programme to be publicised on screensavers, posters and social media (3, 5,6)	Established comms plan detailing delivery of messages across all available means	
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups (3,6)	Weekly figures submitted to the key stakeholders and headline figures promoted widely	

C	Flexible accessibility		
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered (3,6)	Support from senior leadership for identified peer vaccinators.	
C2	Drop in clinics available every day at Aintree	All clinics offer 'no appointment needed' drop in format	
D	Incentives		
D1	Board to agree on incentives	flu fighter pens	
D2	Success to be celebrated weekly (3,6)	Feature in Trust publication AAA and key messages on social media weekly	

Reference links

1. http://www.nhsemployers.org/-/media/Employers/Documents/Flu/Vaccine-ordering-for-2018-19-influenza-season-06022018.pdf?la=en&hash=74BF83187805F71E9439332132C021EFA3E6F24C

2. http://www.nhsemployers.org/-/media/Employers/Publications/Flu-Fighter/Reviewing-your-campaign-a-flu-fighter-guide.pdf

3. http://www.nhsemployers.org/-/media/Employers/Documents/Flu/Flu-fighter-infographic-final-web-3-Nov.pdf

4. http://www.nhsemployers.org/-/media/Employers/Publications/Flu-Fighter/good-practice-acute-trusts-TH-formatted-10-June.pdf

5. http://www.nhsemployers.org/-/media/Employers/Publications/Flu-Fighter/good-practice-ambulance-trusts-TH-formatted-10-June.pdf

6. https://www.nice.org.uk/guidance/ng103/chapter/Recommendations

2019/040

Board of Directors

Committee Chair's report of Quality Committee meeting held 18 March 2019

1. Was the quorate met? Yes

2. Agenda items covered

~ Board Assurance Framework – Quality Related Risks: The Committee reviewed the Quality related BAF risks and had agreed the amendments which would be reported to the Board. The Committee received assurance that the risks attributable to the Committee were being managed appropriately, however recommended that each risk be reviewed in light of the current year end to ascertain whether the risks continued to be relevant and that the risk scores were to be assessed against the Trust's agreed risk appetite statement for 2019/20

~ Subcommittee Chairs reports:
- Safety Senate held 8 February 2019
- Effectiveness Senate held 15 February 2019

The Committee was appropriately assured by the contents of the Chairs' reports of its reporting sub-committees.

~ CQC Inspection Action Plan: The Committee received assurance on the progress being made against the CQC inspection action plan. The Committee received a verbal update on recent MIAA spot checks with regards to Gynaecology and Bedford and were assured that with regards to Gynaecology there had been very positive feedback from staff following the introduction of the new leadership team. The Committee also noted that with regards to Bedford there were improvements that needed to be made to the estate. The Committee were assured arrangements were in place to address the regulation 10 breach with related to the fitting of a door to the admission room which would take place during the week of 25 March 2019.

~ Monthly Quality Performance Review M11: The Committee noted the performance report and received assurance that the Trust was continuing to address, within its control, the underperformance in RTT and Cancer. The Committee also commented positively on the new format of the Report and the tables included in the commentary.

~ PLACE Annual Report: The Committee received the PLACE Assessment action plan arising from the Annual Report for 2018 and was assured that the outstanding actions were being addressed.

~ Review of Risk Management Strategy: The Committee received the amendments to the Trust's Risk Management Strategy approved the Strategy noting that the Strategy would also be presented to the Audit Committee. The Committee received assurance from a MIAA Internal Audit review of the risk management process during 2018/19, which had provided substantial assurance that the core control mechanisms were in place to manage the risk management process.

~ Risk Appetite Statement: The Committee reviewed the Risk Appetite statement that related to the Committees areas of responsibility ie: to deliver safe services; to participate in high quality research and to deliver the most effective outcomes; and to deliver the best possible experience

for patients and staff. The Committee agreed that its risk appetite for 'Safe Services' and 'Patient Experience' the level of risk appetite was appropriate and would remain as approved in 2018/19 'low'; however with regards to effective outcomes, the Committee felt that the Trust should change the appetite to 'high' as the Trust in participating in high quality research would be open to consider all potential delivery options.

~ Clinical Audit Work Programme: The Committee approved the Trust's Clinical Audit Programme for 2019/20 and was assured that the clinical audit plan addresses the significant risks the Trust holds.

~ The Seven Day Working Board Assurance: The Committee was assured of the content of the report and completed template and agreed that a six monthly audit against the priority standards would be completed and reported to the Committee with completed templates for consideration and appropriate action.

~ Quality Committee Terms of Reference and Business Cycle: The Committee approved the Terms of Reference and Business Cycle 2019/20, noting that changes to the Cycle may need to be made to take account of changes to the business cycle of the Safety and Effectiveness Senates.

~ Review of Corporate Objectives Outturn 2018/19 and Corporate Objectives 2019/20 in relation to Quality Committee Responsibility: The Committee approved the Corporate Objectives Outturn 2018/19, which was subject to amendment as discussed and the Corporate Objectives 2019/20 in relation to Quality Committee Responsibility.

~ **LocSIIPs:** The Committee received partial assurance in relation to the implementation of LocSIIPs to the necessary standards required by the Commissioners and would receive a full assurance report at its meeting in June 2019.

~ HSIB Update: The Committee received an update on the Trust's involvement in the national initiative that was being undertaken in reviewing 1000 Serious Maternity Incidents by the Health and Safety Investigation Branch (HSIP). The Committee noted that 2 of the three cases had received parental consent for HSIB to continue with a review and these would be undertaken whilst parental consent was received for the third case. The Committee received assurance that the Trust would undertake its own internal investigations in accordance with its local policy.

~ Senate Structure: The Committee approved the Terms of Reference for the Safety Senate and the Effectiveness Senate.

3. Review of risk impacts of items discussed: The Committee noted the risks considered at the Meeting:
   - Changes to be made to the Risk Appetite Statement for 2019/20.
   - LocSIIPs – the Committee felt that until the final report was published in June the Committee had received only partial assurance that the LocSIIPs safety standards would be implemented and embedded in the Trust.
   - The BAF require review regarding the clinical risks surrounding Future Generations following the unsuccessful bid for capital finding.

4. Issues to highlight to Board
   None

5. Action required by Board

- Approval of the amendments to the Terms of Reference of the Committee set out in appendix 1
- Approval of the amendments to the Board Assurance Framework Risks which would be reported in a separate paper to the Board.
- Approval of the Corporate Objectives Outturn 2018/19 and Corporate Objectives 2019/20 in relation to Quality Committee Responsibility which would be presented to the Board at its May meeting together with the outputs from Finance Performance and Business Development Committee and Putting People First Committee.
- Approval of the Risk Appetite statement that related to the Committees areas of responsibility: to deliver safe services; to participate in high quality research and to deliver the most effective outcomes; and to deliver the best possible experience for patients and staff which would be presented to the Board at its May meeting together with the outputs from Finance Performance and Business Development Committee and Putting People First Committee.

Susan Milner
Chair of Quality Committee
March 2019

QUALITY COMMITTEE

TERMS OF REFERENCE

Constitution: The Committee is established by the Board of Directors and will be known as the Quality Committee (QC) (the Committee).

Duties: The Committee's responsibilities fall broadly into the following three areas:

Strategy and Performance

a) Oversee the development and implementation of the Quality Strategy with a clear focus on upholding the tenants of quality (Governance, safety, patient experience and clinical effectiveness).

b) Ensure that the Quality Strategy and performance are consistent with the Trust's; Vision and strategic objectives and oversee any initiatives undertaken by the Trust that relates to the development and implementation of the Quality Strategy.

c) Review trends in patient safety, experience and outcomes (effectiveness) to provide assurance to the Board on performance and commission 'deep dives' as appropriate.

d) To receive assurance that action plans arising from in-patient, out-patient and other care related surveys are being undertaken and make recommendations to the Board as appropriate.

e) Oversee the implementation of key national reports and inquiries recommendations and provide assurance to the Board on its delivery.

Governance

f) Oversee the effectiveness of the clinical systems developed and implemented to ensure they maintain compliance with the Care Quality Commission's Fundamental Standards in relation to Quality, Safety, experience and effectiveness.

g) Obtain assurance of the Trust's ongoing compliance with the Care Quality Commission registration.

h) Review the controls and assurance against relevant quality risks on the Board Assurance Framework and provide assurance to the Board that risks to the strategic objectives relating to quality and safety are being managed and facilitate the completion of the Annual Governance Statement at year end.

i) Obtain assurance that the Trust is compliant with guidance from NICE

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(through receipt of an Annual Report) and other related bodies.

j) Consider external and internal assurance reports and monitor action plans in relation to clinical governance resulting from improvement reviews / notices from NHSI, the Care Quality Commission, the Health and Safety Executive and other external assessors.

k) Receive the annual clinical audit programme and provide assurance to the Board that clinical audit supports the Trust to provide safe and clinically effective patient care and obtain assurance that there is delivery against agreed annual clinical audit programme.

l) Implement and monitor the process for the production of the Trust's year end Quality Report before it is presented to the Trust Audit Committee and Board for formal approval.

m) Undertake an annual review of the Quality and Risk Management Strategies to ensure that they reflect all required priorities.

n) To have oversight of the Committees performance measures to ensure they are appropriate and provide assurance of compliance and escalate exceptions to Trust Board.

o) To review the proposed internal audit plan for all functions areas within the Committees remit e.g. Clinical Audit, Safety, Experience and Effectiveness.

p) Review the Trust's Research and Development Strategy and Innovation Strategy prior to their recommendation it to the Board of Directors.

q) Approving the terms of reference and memberships of its subordinate committees.

Overall

r) To approve any matters that, due to time constraints, could not be approved by the Board within the scope of the Committees areas of responsibility.

s) Referring relevant matters for consideration to other Board Committees as appropriate.

t) Considering relevant matters delegated or referred to it by the Board of Directors or referred by any of the Board Committees.

u) Escalating matters as appropriate to the Board of Directors.

Assurances will be provided from internal and external sources and will be included in a work plan approved by the Committee at the commencement of each financial year.

Membership: The Committee membership will be appointed by the Board of Directors and will

consist of:

- Non-Executive Director (Chair)
- Two additional Non-Executive Directors
- *Medical Director
- *Director of Nursing and Midwifery
- *Director of Finance
- *Director of Workforce and Marketing
- *Director of Operations
- *Committee Chairs of the Safe, Experience and Effectiveness Senates
- Deputy Director of Nursing and Midwifery
- Head of Governance

*or their nominated representative who will be sufficiently senior and have the authority to make decisions.

Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum.

The Board of Directors will appoint a Non-Executive Director as Chair of the Committee. Should the Chair be absent from a meeting of the Committee, the Committee may appoint a Chair of the meeting from amongst the Non-Executive Directors present.

Quorum: A quorum shall be three members including two Non-Executive Directors and one Executive Director (one of whom must be either the Medical Director or Director of Nursing and Midwifery or their deputy). The Chair of the Trust may be included in the quorum if present.

Voting: Each member will have one vote with the Chair having a second and casting vote, if required. Should a vote be necessary a decision will be determined by a simple majority.

Attendance: a) Members
Members will be required to attend a minimum of 75% of all meetings.

b) Officers
The Trust Secretary shall normally attend meetings. Other executive directors (including the Chief Executive) and officers of the Trust will be invited to attend the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed.

Representatives from partner organisations or other external bodies may be invited to attend as appropriate. Such representatives will not have voting rights.

Frequency: Meetings shall be held monthly. Additional meetings may be arranged from time to time, if required, to support the effective functioning of the Trust.

Authority: The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any

	employee and all employees are directed to cooperate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities. The Committee is authorised to approve those policies and procedures for matters within its areas responsibility.
Accountability and reporting arrangements:	The Quality Committee will be accountable to the Board of Directors. A Chair's Report will be submitted to the next following Board of Directors for assurance (see Appendix 1). Approved minutes will be made available to all Board members. The Committee will report to the Board annually on its work and performance in the preceding year. Trust standing orders and standing financial instructions apply to the operation of the Committee.
Reporting Committees/ Groups	The sub committees/groups listed below are required to submit the following information to the Committee: a) Chairs Report; and b) Annual Report setting out the progress they have made and future developments. The following sub committees/groups will report directly to the Committee (See appendix 2): • Safety Senate • Effectiveness Senate • Experience Senate • Corporate Risk Committee • Hospital Safeguarding Board
Monitoring effectiveness:	The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements.
Review:	These terms of reference will be reviewed at least annually by the Committee.
Reviewed by Quality Committee	~~19 March 2018~~18 March 2019
Approved by Board of Directors:	~~6 April 2018~~
Review date:	March ~~2019~~2020
Document owner:	Colin Reid, Trust Secretary , Email: colin.reid@lwh.nhs.uk Tel: 0151 702 4033

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2019/041

Board of Directors

Committee Chair's report of Finance, Performance and Business Development Committee meeting held 25 March 2019

1. Was the quorate met? Yes

2. Agenda items covered

~ Finance Performance Review Month 11 2018/19 including CIP: The Committee received Month 11 2018/19 finance position and noted that the trust was on target to deliver an improved deficit for the year of £0.6m, which was £1m ahead of the control total taking into account receipt of £4.1m of PSF. The Committee noted however that this had been partly due to the benefit of the Acting as One contract with Liverpool CCG which provides for a block payment which would be higher than would have been earned by PbR.

~ Revenue and Capital Budget 2019/20: The Committee received a report on the Revenue and Capital budgets 2019/20 which delivers a breakeven control total set by NHSI. The Committee recognised that it was a challenging plan to achieve and contained a number of risks to delivery. The Committee was assured that there was a solid and robust process of challenge and prioritisation that had been undertaken across the organisation to achieve the position. The Committee also recognised that the plan reflected ongoing investment in the clinical case for change and keeping services safe on site whilst the Trust continues to push forward with the preferred option of co-location with the local adult acute. The Committee approved the plan and acceptance of the breakeven control total, subject to agreement of Contracts with Commissioners. The Committee recommends the Plan for approval to the Board of Directors ahead of submission on 4 April 2019.

~ Operational Performance Month 11 2018/19 including RTT and Cancer Targets: The Committee received an update on Operational Performance at Month 11 and received assurance on the actions being taken to continue to address the Trust performance in RTT and Cancer that were within the Trust's control.

~ Strategic Outline Case: The Committee received an update on the work being undertaken to identify future sources of capital following the unsuccessful application for Funding from the Centre.

~ Operational Plan 2019/20: The Committee received and agreed the update of the Operational Plan 2019/20 narrative which would be presented to the Board at its meeting on 4 April 2019. The Committee recommended that the Board approves the activity and workforce plans for submission to NHS Improvement on 4th April 2019.

~ EPR Update: The Committee received a presentation from the Chief Information Officer on the EPR project. The Committee noted the lack of progress being made and its impact on the Trust and that this would be escalated to the Board for its consideration.

~ **Brexit:** The Committee noted the Trust was complying with all requirements from the Centre with regard to requests for submission of data.

~ **Neonatal Capital Build**: The Committee received an update on the current status of the Trust's contractual relationship with Interserve following the recent events leading to Interserve going into administration. The Committee was assured the entity Interserve Group Limited will receive an injection of £110m of cash and that the operating companies will remain intact and the Trust's contractual relationship had not changed and was 'business as usual'.

~ **Neonatal Single Service:** The Committee received an update on the Neonatal Single Service. Income for 2018/19 was now agreed and offered a small benefit against costs incurred. NHS England had agreed part of the investment requested going forward. The Trust continues to work with NHS England and Alder Hey on working through the detail of this.

~ **Genetics Service Transfer**: The Committee received a report on the Genetics Service Transfer and noted that there has been a delay in the transfer of the Trust's associated staff to MFT and that this transfer would now take place on 1st July 2019.

~ **Board Assurance Framework (BAF)**: 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 10 by reducing the likelihood of the risk from 3 to 2. The Committee discussed changes to BAF risk 2184 'electronic patient record', noting that the risk also falls under the remit of Quality Committee and agreed the amendments. The Committee agreed to recommend the changes to the Board for approval.

~ **Corporate Objectives Outturn 2018/19 and Corporate Objectives 2019/20**: The Committee approved: the Corporate Objectives Outturn 2018/19; and the Corporate Objectives 2019/20 in relation FPBD Committee responsibility.

~ **Review of FPBD ToR and Business Cycle 2019/20**: The Committee reviewed and approved the terms of reference and business cycle. The Terms of reference would be submitted to the Board of Directors for ratification

~ **Sub Committee Chairs reports received:**
  - Turnaround and Transformation Committee – changes to direct engagement model – on hold.
  - TTC – the Committee reviewed reports from 14 January 2019; 4 February 2019; 11 February 2019; and 11 March 2019.

The Committee was appropriately assured by the contents of the Chairs' reports of its reporting sub-committees.

3. **Review of risk impacts of items discussed:** The Committee noted the risks considered at the Meeting

4. **Issues to highlight to Board**
   ~ Escalation of concerns regarding the lack of progress being made with regards to the EPR project and its impact on the Trust; together with any actions that may be appropriate for the Board to take.

5. **Action required by Board**

- Approval of the amendments to the Terms of Reference of the Committee set out in appendix 1
- Approval of the amendments to the Board Assurance Framework Risks which would be reported in a separate paper to the Board.
- Approval of the Corporate Objectives Outturn 2018/19 and Corporate Objectives 2019/20 in relation to FPBD Responsibility which would be presented to the Board at its May meeting together with the outputs from Quality Committee and Putting People First Committee.
- Approval of the Risk Appetite statement that related to the Committees areas of responsibility which would be presented to the Board at its May meeting together with the outputs from Finance Performance and Business Development Committee and Putting People First Committee.

Jo Moore
Chair of FPBD
March 2019

FINANCE, PERFORMANCE AND BUSINESS DEVELOPMENT COMMITTEE TERMS OF REFERENCE

Constitution:	The Board hereby resolves to establish a Committee of the Board to be known as the Finance, Performance and Business Development Committee (the Committee).
Duties:	The Committee will operate under the broad aims of reviewing financial and operational planning, performance and business development. The Committee's responsibilities fall broadly into the following two areas: **Finance and performance** The Committee will: a. Receive and consider the annual financial and operational plans and make recommendations as appropriate to the Board. b. Review progress against key financial and performance targets c. Review on behalf of the Board, financial submissions (as reported in the Financial Performance Report) or others, as agreed by the Board, to NHS Improvement for consistency on financial data provided. d. Review the service line reports for the Trust and advise on service improvements e. Provide oversight of the cost improvement programme f. Oversee external financing & distressed financing requirements g. Oversee the development and implementation of the information management and technology strategy h. Examine specific areas of financial and operational risk and highlight these to the Board as appropriate through the Board Assurance Framework i. To undertake an annual review of the NHS Improvement Enforcement Undertaking. ~~h.~~j. To review and receive assurance on the appropriateness of the Trust's Emergency Planning Resilience & Response processes and procedures. **Business planning and development** The Committee will: ~~i.~~k. Advise the Board and maintain an overview of the strategic

	business environment within which the Trust is operating and identify strategic business risks and opportunities reporting to the Board on the nature of those risks and opportunities and their effective management ~~j.~~l. Advise the Board and maintain an oversight on all major investments, disposals and business developments. ~~k.~~m. Advise the Board on all proposals for major capital expenditure over £500,000 ~~l.~~n. Develop the Trust's marketing & communications strategy for approval by the Board and oversee implementation of that strategy
Membership:	The Committee membership will be appointed by the Board of Directors and will consist of: • Non-Executive Director (Chair) • Two additional Non-Executive Directors • Chief Executive • Director of Finance • Director of Operations • Director of Nursing and Midwifery Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. The Board of Directors will appoint a Non-Executive Director as Chair of the Committee. Should the Chair be absent from a meeting of the Committee, the Committee may appoint a Chair of the meeting from amongst the Non-Executive Directors present.
Quorum:	The quorum for the transaction of business shall be three members including at least two Non-Executive Directors (one of whom must be the Chair or Vice Chair of the Committee), and one Executive Director. The Chair of the Trust may be included in the quorum if present.
Voting:	Each member will have one vote with the Chair having a second and

	casting vote, if required. Should a vote be necessary a decision will be determined by a simple majority.
Attendance:	a. Members Members will be required to attend a minimum of 50% of all meetings. b. Officers Ordinarily the Deputy Director of Finance and Trust Secretary will attend all meetings. Other executive directors and officers of the Trust will be invited to attend the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed.
Frequency:	Meetings shall be held at least ~~5~~ 8 times per year. Additional meetings may be arranged if required, to support the effective functioning of the Trust.
Authority:	The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities. The Committee is authorised to approve those policies and procedures for matters within its areas responsibility.
Accountability and reporting arrangements:	The Finance, Performance and Business Development Committee will be accountable to the Board of Directors. A Chair's Report will be submitted to the next following Board of Directors for assurance (see Appendix 1). Approved minutes will be made available to all Board members.

	The Committee will report to the Board annually on its work and performance in the preceding year. Trust standing orders and standing financial instructions apply to the operation of the Finance, Performance and Business Development Committee.
Reporting Committees and Groups	The sub committees/groups listed below are required to submit the following information to the Committee: a) Chairs Report; and b) an Annual Report setting out the progress they have made and future developments. The following sub committees/groups will report directly to the Committee: • Information Governance Committee • ~~Turnaround and Transformation Committee~~ • Emergency Planning Resilience & Response Committee • Digital Hospital Sub-Committee
Monitoring effectiveness:	The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements.
Review:	These terms of reference will be reviewed at least annually by the Committee.
Reviewed by Finance, Performance & Business Development Committee:	25~~6~~ March 2019~~8~~
Approved by Board of Directors:	~~4~~6 April 2019~~8~~
Review date:	March 2020~~19~~
Document owner:	Colin Reid, Trust Secretary Tel: 0151 702 4033

Appendix 1

Board of Directors

Chair's report of [Committee name] meeting held [Date]

1. Was the quorate met? Yes/No
   If No why not.
   Any actions taken.

2. Agenda items covered [including brief description arising from discussion]

3. Escalation report on Performance Measures discussed

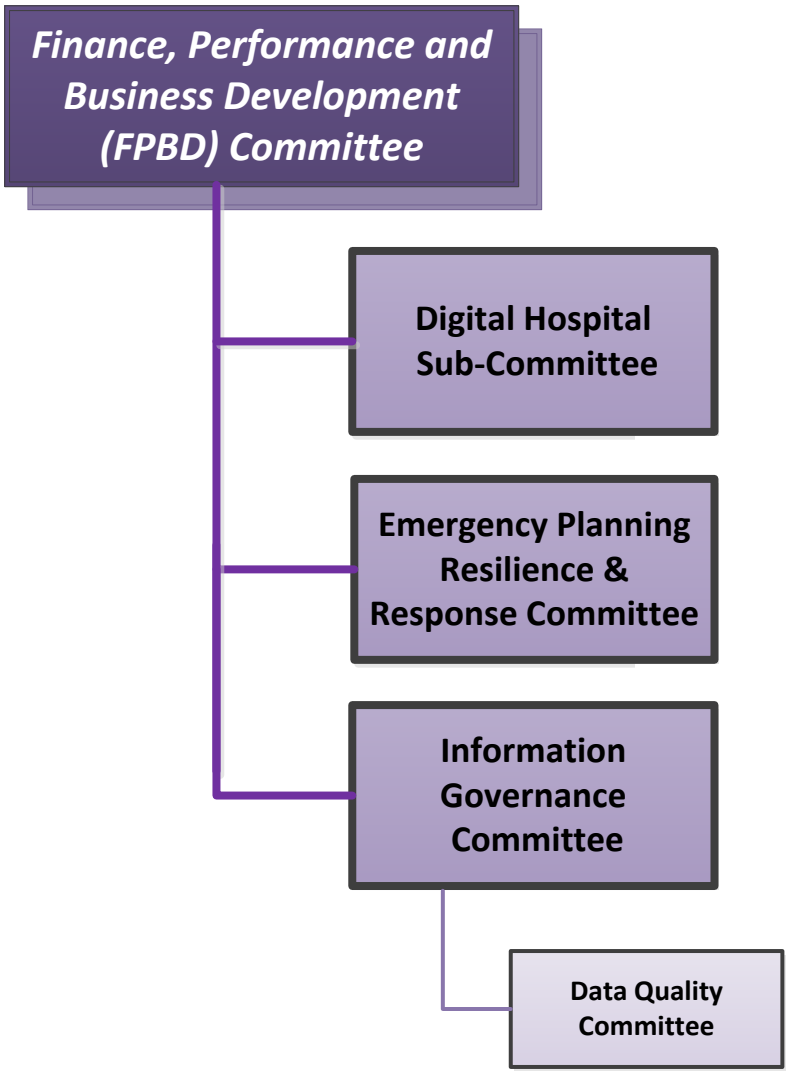
4. New risks identified/action taken/escalation to BAF

5. Learning identified for dissemination within the Trust

6. Matters to be highlighted to the Board

7. Action required by the Board

[Name]
Chair of [Committee name]
Date


Finance, Performance and Business Development (FPBD) Committee
Digital Hospital Sub-Committee
Emergency Planning Resilience & Response Committee
Information Governance Committee
Data Quality Committee

2019/042

Board of Directors
Committee Chair's report of Audit Committee meeting held 25 March 2019

1. Meeting Quorate: Yes

2. Agenda items covered

~ Follow up of Internal Audit and External Audit Recommendations: The Committee received an updated position on audit recommendations, noting that there were a number of actions that were due for closing by 31 March 2019. The Committee was assured that the majority of actions were being implemented and followed up on a timely basis, however in some cases, extensions had been requested.

~ Internal Audit Progress Reports: The Committee received assurance on two reports that had been undertaken since the last meeting. The Board Assurance Framework Opinion met the Board's requirements and was structured to meet the NHS guidelines; it had been visibly used by the Trust Board and clearly reflects the risks discussed by the Trust Board. No new actions arose from the Review; however consideration was needed to be given as to how the Board articulated the risk appetite to match the risk scores in a number of areas. The Audit Committee Effectiveness review findings identified a number of areas of good practice from benchmarking against the HfMA Audit Committee Handbook. These development areas identified would be actioned. The Committee noted the work in progress, planned and the follow up on previous audits, specifically IT Cyber Security and IT Resilience.

~ Head of Internal Audit Draft Opinion: The Committee received the draft Head of Internal Audit Opinion and noted the opinion provided Substantial Assurance that that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.

~ Internal Audit Plan 2019/20: the Committee received the 2019/20 internal audit plan and was assured that the areas for audit were relevant to the risks faced by the Trust.

~ Internal Audit Charter: The Committee received the Internal Audit Charter that defines the internal audit activity's purpose, authority and responsibility. The internal audit charter establishes the internal audit activity's position within the organisation; authorises access to records, personnel and physical properties relevant to the performance of engagements; and defines the scope of internal audit activities. The Committee was assured that the process adopted by MIAA fell within the charter.

~ Counter Fraud: The Committee received three reports from counter fraud, the 2018/19 progress report, draft annual report 2018/19 and the Counter Fraud work plan 2019/20. The Committee received assurance on the work of counter fraud for the year and actions taken to engage with staff at the Trust to highlight counter fraud measures. There were no counter fraud investigations undertaken in 2018/19.

~ KMPG External Audit Progress Report and Sector Update: The Committee received an update from the Audit Director, Tim Cutter on progress made to date. It was noted that the majority of the audit would be undertaken after year end. The Committee received the 'Sector update March 2019' report that highlighted the main technical issues which were currently having an impact on the health sector and included actions required in the production of the Annual

Report and Accounts including IFRS 15 and the NHS Standard Contract. The Committee was assured that the Trust was already addressing the requirements of IFRS 15.

~ **Area of Judgement in the Annual Accounts:** The Committee noted the areas in the 2018/19 accounts requiring the judgement of management. The Committee approved the approach that the accounts should be prepared on a going concern basis and noted the areas of judgement.

~ **Losses and Special Payments:** The Committee was assured that there were no identified items for write off and all outstanding debt was being pursued.

~ **Waiting Times External Audit December 2018:** The Committee received assurance from receiving the external audit undertaken by Himatix in December 2019 that shows that data issues regarding national submissions identified in the two SIs declared early in 2018 had been addressed and rectified. The audit also shows that cancer patients were being reported and tracked according to national guidance and RTT pathways are being reported accurately with all patients included in submissions regardless of whether they have future appointments scheduled or not.

~ **Raising Staff Concerns Arrangements**: The Committee was assured that the procedures and processes were in place for staff to raise concerns noting the commitment of the Trust to developing and maintaining an open and constructive culture (including the Fair and Just project currently being rolled out).

~ **Clinical Audit Forward Plan 2019/20:** The Committee received the Trust's Clinical Audit Programme for 2019/20 noting that it had been received by the Quality Committee regarding the audits to be undertaken. The Committee was assured that appropriate processes and procedures were in place and that the clinical audits were prioritised according to clinical risks.

~ **Risk Management Strategy:** The Committee received the amendments to the Trust's Risk Management Strategy and approved the Strategy noting that they had also been received and approved by the Quality Committee. The Committee received assurance from the MIAA Internal Audit review of the risk management process during 2018/19 (received at the January 2019 Audit Committee meeting), which had provided substantial assurance that the core control mechanisms were in place to manage the risk management process.

~ **Audit Committee Effectiveness and Review Output**: The Committee received the report from the Effectiveness review undertaken in January 2019 and noted the actions being taken.

~ **Review of Audit ToR and Business Cycle 2019/20**: The Committee reviewed and approved the Audit Committee terms of reference and business cycle. The Terms of reference would be submitted to the Board of Directors for ratification.

~ **Chairs Reports**: The Committee received and reviewed the Chairs reports for FPBD, PPF and QC noting that the committees were working effectively with no areas of concerns regarding the processes and procedures in place to support the committees work.

3. Board Assurance Framework (BAF) risks reviewed
   ~ **Board Assurance Framework:** The Committee was assured of the processes in place to review the BAF, consistent with the outcome from the completed internal audit report earlier in the meeting.

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

5. Issues to highlight to Board
   ~ None

6. Action required by Board
   ~ Approval of Audit Committee terms of reference (enclosed).

Ian Knight
Chair of Audit Committee
March 2019

AUDIT COMMITTEE
TERMS OF REFERENCE

Constitution:	The Committee is established by the Board of Directors and will be known as the Audit Committee (the Committee). The Committee is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference.
Duties:	The Committee is responsible for: **a. Governance, risk management and internal control** The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the Trust's activities (both clinical and non-clinical) that supports the achievements of the Trust's objectives. It will provide an independent and objective view on internal control and probity. In addition, the committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to its financial performance, reviewing significant financial reports and the judgements contained in them. In particular, the Committee will review the adequacy of: • All risk and control related disclosure statements (in particular the Annual Governance Statement and declarations of compliance to external bodies), together with any accompanying Head of Internal Audit opinion, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board • The process of preparing the Trust's returns to NHS Improvement (which returns are approved by the Board's Finance and Performance Committee) • The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements • The policies for ensuring that there is compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification • The Trust's standing orders, standing financial instructions and scheme of delegation • The policies and procedures for all work related to fraud and corruption as set out in the Secretary of State directions and as required by the NHS Counter Fraud Security Management Service • The arrangements by which Trust staff may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. In so doing

the Committee's objective should be to ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.

In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

The Committee will undertake an annual training needs assessment for its own members.

b. Internal audit

The Committee will ensure that there is an effective internal audit function established by management that meets mandatory government and Public Sector Internal Auditing Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by:

- Consideration of the appointment of the internal audit service, the audit fee and any questions of resignation and dismissal
- Review and approval of the internal audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework
- Reviewing the internal audit programme, considering the major findings of internal audit investigations (and management's response), and ensuring coordination between internal and external auditors
- Ensuring that the internal audit function is adequately resources and has appropriate standing within the organisation
- Annual review of the effectiveness of internal audit.

c. External audit

The Committee shall review the independence, objectivity and work of the external auditor appointed by the Council of Governors and consider the implications and management's response to this work. This will be achieved by:

- Consideration of the appointment and performance of the external auditor, including making recommendations to the Council of Governors regarding the former
- Discussion and agreement with the external auditor, before the audit commences, of the nature and scope of the audit as set out in the annual audit plan and ensure coordination with internal auditors and

with other external auditors

- Discussion with the external auditors of their local evaluation of audit risks and assessment of Trust and associated impact on the audit fee
- Reviewing all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Board and any audit work performed outside the annual audit plan, together with the appropriate of management's response
- Recommending to the Council of Governors the engagement of the external auditor in respect of non-audit work, taking into account relevant ethical guidance regarding the provision of such services
- Annual review of the effectiveness of external audit.

d. Other assurance functions

The Committee will review the findings of other significant assurance functions, both internal and external to the Trust, and consider the implications to the governance of the Trust. These will include, but will not be limited to, reviews and reports by the Department of Health, arms length bodies or regulators/inspectors (e.g. Care Quality Commission, NHS Resolution ~~[Litigation Authority]~~, etc), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc) or the Local Counter Fraud Specialist.

In addition the Committee will review the work of other Committees within the Trust, whose work can provide relevant assurance to the Audit Committee's own scope of work. This will particularly include the Quality Committee, Finance and Performance Committee and Putting People First Committee, and include a review of an annual report of each of the Committees against their terms of reference. In reviewing the work of the Quality Committee, and issues around clinical risk management, the Audit Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

The Committee will also review all suspensions of standing orders and variation or amendment to standing orders.

The Audit Committee will report to the Board and to the Council of Governors any matters in respect of which it considers action or improvement is needed.

e. Counter fraud

The Audit Committee will satisfy itself that the Trust has adequate arrangements in place for countering fraud and will approve the appointment of the Local Counter Fraud Specialist. The Committee will review the outcomes of counter fraud work.

	f. Management The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control. They may also request specific reports from individual functions within the organisation (e.g. clinical audit) as they may be appropriate to the overall arrangements. **g. Financial reporting** The Audit Committee shall monitor the integrity of the Annual financial statements of the Trust ~~and any formal announcements relating to the Trust's financial performance~~. The Audit Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board. The Audit Committee will review the Trust's annual report and financial statements before submission to the Board, focusing particularly on: • The wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee • Changes in, and compliance with, accounting policies and practices • Unadjusted mis-statements in the financial statements • Major judgemental areas, and • Significant adjustments resulting from the audit • Letter of representation • Qualitative aspects of financial reporting.
Membership:	The Committee membership will be appointed by the Board of Directors from amongst its Non-Executive members and will consist of not less than three members. Members can participate in meetings by two-way audio link including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. The Board of Directors will appoint a Non-Executive Director as Chair of the Committee. Should the Chair be absent from a meeting of the Committee, the Committee may appoint a Chair of the meeting from amongst the Non-Executive Directors present.
Quorum:	A quorum shall be two members.

Voting:	Each member will have one vote with the Chair having a second and casting vote, if required. Should a vote be necessary a decision will be determined by a simple majority.
Attendance:	a. Members Members will be required to attend a minimum of 75% of all meetings. b. Officers The Director of Finance, Deputy Director of Finance, Financial Controller and Deputy Director of Nursing & Midwifery shall normally attend meetings. At least once a year the Committee will meet privately with external and internal auditors. The Chief Executive and other executive directors will be invited to attend, particularly when the Committee is discussing areas of risk or operation that are within the responsibility of that director. The Chief Executive will also be required to attend when the Audit Committee discusses the process for assurance that supports the Annual Governance Statement. The Trust Secretary will attend to provide appropriate support to the Chair and Committee members.
Frequency:	Meetings shall be held at least four times per year. The external auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.
Authority:	The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities.
Accountability and reporting arrangements:	The Audit Committee will be accountable to the Board of Directors. A Chair's Report will be submitted to the next following Board of Directors for assurance (see Appendix 1). Approved minutes will be made available to all Board members. The Committee will report to the Board annually on its work and performance in the preceding year and, as part of this report, will provide

	commentary in support of the Annual Governance Statement, specifically dealing with the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the Trust, the integration of governance arrangements and the appropriateness of the evidence compiled to demonstrate fitness to register with the Care Quality Commission and the robustness of the processes behind the quality accounts. In providing this commentary in support of the AGS the Committee will seek relevant assurance from the Chair of the Board's Quality Committee. Trust standing orders and standing financial instructions apply to the operation of the Audit Committee.
Monitoring effectiveness:	The Committee will undertake an annual review of its performance against its duties in order to evaluate its achievements.
Review:	These terms of reference will be reviewed at least annually by the Committee.
Reviewed by Audit Committee:	25 March 2019
Approved by Board of Directors:	~~46~~ April 2019~~8~~
Review date:	March 2020
Document owner:	Colin Reid, Trust Secretary Email: colin.reid@lwh.nhs.uk Tel: 0151 702 4033

Liverpool Women's NHS Foundation Trust

Agenda Item	**2019/043**

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Staff Survey Results 2018**
DATE OF MEETING:	Thursday, 04 April 2019
ACTION REQUIRED	**For Discussion**
EXECUTIVE DIRECTOR:	Michelle Turner, Director of Workforce and Marketing
AUTHOR(S):	Jeanette Chalk, Head of Operational HR (Interim)
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 content of Report and approve the actions set out within it.***	
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

This paper provides an overview of the Staff Survey results 2018, which were published in March 2019.

It highlights that there have been no significant changes compared to the 2017 results, and notably, the key "Engagement" score has remained stable. This is in line with the "Engagement" score at a national level which also remained static.

It is important to note however, that whilst there has been no significant change in the results this year, when reviewing performance against the newly introduced "Themes", we score below the average in 6 of the 10 in relation to other Trusts within our comparator group. When the newly established Theme results are reviewed over a 4/5 year period, the trend of tracking below average scores is highlighted further.

This paper specifies additional detail around noteworthy results and provides an overview of activity moving forward.

Report

Introduction

The NHS Staff Survey is the national tool to measure levels of engagement and wellbeing amongst NHS Staff. It is one of the largest workforce surveys in the world and has been conducted every year since 2003, asking NHS staff in England about their experience of working for their respective NHS organisations.

The NHS survey discussed herein was carried out between September and December 2018, with the results published in March 2019. Participation remains mandatory for trusts and voluntary for non-trust organisations – more than 300 NHS organisations took part in the 2018 survey, including 230 trusts in England.

Over 1.1 million NHS employees were invited to participate in the 2018 survey and just under half a million staff responded, driving a national response rate of 46% - up from 45% in 2017.

It is important to note that the reporting within the survey has changed this year. This follows a review by the Staff Survey Coordination Centre in 2017. A summary of the key changes is attached as Appendix One.

A central change is the creation of 10 themes to replace the many Key Findings (KF's) previously reported upon. All themes will be consistently scored on a 0-10pt scale. The themes are:

- Equality, diversity & inclusion
- Health & wellbeing
- Immediate managers
- Morale
- Quality of appraisals
- Quality of care
- Safe environment – Bullying & harassment
- Safe environment – Violence
- Safety culture
- Staff engagement

The National Picture

The National Briefing, produced centrally, highlights performance in relation to the new 10 Themes. In the table below the 2017 results have be calculated to the new 10pt scale to ease comparison. Historical data is not available for "Morale".

Whilst movement can be identified, both positive and negative, across the themes, it is clear that these shifts are relatively small.

It is also worth noting that the national engagement score is 7.0, remaining the same as 2017 – **LWH has also scored 7.0 for 2018 and 2017.**

Nationally, a number of specific changes have been highlighted from the 2018 results:

Theme	2017	2018
1. Equality, diversity & inclusion	9.0	9.0
2. Health & wellbeing	6.0	5.9
3. Immediate managers	6.8	6.8
4. Morale	N/A	6.1
5. Quality of appraisals	5.4	5.5
6. Quality of care	7.5	7.4
7. Safe environment – Bullying & harassment	8.0	8.0
8. Safe environment – Violence	9.4	9.4
9. Safety culture	6.6	6.7
10. Staff engagement	7.0	7.0

- ***Level of pay*** – 36.3% of staff were satisfied with their salary – an increase of over 5% versus 2017, but below the 2016 result of 36.8%. **This question also saw a positive shift for LWH with 40.8% satisfied versus 37.1% in 2017.**

- ***Errors & near misses*** – 27.8% reporting seeing an error, near miss or incident in the last month that could have hurt patients/service users – close to a 3% increase versus 2017. **For LWH, this has remained fairly static – 21.5% this year versus 21.3% in 2017.** On a more positive note, 58.2% said their organisation treats staff who are involved in an error, near miss or incident fairly, which has improved by 4% from last year. **This is slightly improved for LWH at 50.7% from 49.1% in 2017.**

- ***Health & wellbeing*** – 28.6% of staff feel their organisation definitely takes positive action on health & wellbeing, which is a 3% decline from last year. **Conversely, for LWH 32.3% staff feel the Trust takes positive action, up from 28.1% in 2017.** Furthermore, 27.6% experienced MSK problems as a result of work activities in the last year, close to a 2% increase from 2017. **This upward (negative) trend has also been identified at LWH with 19.7% reporting MSK problems, up from 15.7% last year.** The Theme score nationally for health & wellbeing was 5.9 compared to 6.0 for 2017 showing an overall decline in this area. **For LWH the Theme score has remained the same at 6.3.**

- ***Staff recognition*** – 46.1% of staff said they were satisfied with the extent to which their organisation values their work – a 3% increase from 2017. **This question also saw a positive shift for LWH with 46.2% satisfied versus 43.1% in 2017.** 56.4% of staff said they were satisfied with the recognition they get for good work – a 4% increase. **This question also saw a positive shift for LWH with 54.7% satisfied versus 50.9% in 2017.**

- ***Quality of Appraisals*** - There was an overall improvement in the quality of appraisals, with the Theme scoring 5.5 versus 5.4 in 2017 and continuing the positive trend since a score of 5.2 in 2015. **For LWH there has also been positive movement in this timeframe scoring 5.2 in 2018, 5.0 in 2017 and 4.9 in both 2015 and 2016.**

Our Trust

As a Trust, our response rate for the 2018 survey was 63%, improving on 61% for 2017. This compares to the national response rate, noted above, of 46%. We are benchmarked against Acute Specialist Trusts where the average response rate is 53%.

It is encouraging that despite ongoing financial efficiency targets, ongoing demand for our services and planned organisational changes, our overall Engagement Score has remained stable.

Results Overview – 2018 by Theme – Best, Average, Worst

An overview of our Trust results, by Theme, is shown below. The results are presented in the context of the best, average and worst results for similar organisations where appropriate.

To aid review:

- **Boxes shaded green** indicate a score matching the "best" score for the Theme amongst our comparator group.
- **Boxes shaded in amber** indicate a score for the Theme which is below the average for our comparator group.
- **Boxes shaded in red** indicate a score matching the "worst" score for the Theme amongst our comparator goup

Theme	Best	LWH	Average	Worst
1. Equality, diversity & inclusion	**9.5**	**9.5**	9.3	8.6
2. Health & wellbeing	6.6	6.3	6.3	5.6
3. Immediate managers	7.3	**6.8**	**7.0**	6.5
4. Morale	6.7	**6.1**	**6.3**	5.6
5. Quality of appraisals	6.4	**5.2**	**5.7**	4.9
6. Quality of care	8.1	**7.6**	**7.8**	7.0
7. Safe environment – Bullying & harassment	8.8	8.6	8.2	7.9
8. Safe environment – Violence	**9.9**	**9.9**	9.7	9.2
9. Safety culture	7.6	**6.7**	6.9	**6.7**
10. Staff engagement	7.7	**7.0**	**7.4**	6.9

On a positive note, we can see that our scores for "ED&I" and "Safe Environment – Violence" have identified the Trust as "best" – both scores have increased marginally from last year and show our continued focus in these areas.

More concerning, however, is that 6 of the 10 theme scores are sitting below average – one of which is ranked "worst" – "safety culture". Whilst this theme is tracking below average, it is of equal concern that the score has remained static in recent years.

It is perhaps unsurprising for "Immediate Managers" and "Morale" to track below average, given that we had a number of senior leadership changes and organisational moves that had not yet occurred at the time the survey was completed.

In terms of "quality of appraisals", whilst the score is tracking below average it is worth noting that the score itself (5.2) has increased from 2017 (5.0) and we are therefore seeing a slight positive trend (refer to the table below for further details). Given that the new pay progression process has completion of PDR's as a KPI – it is important that quality as well as quantity is monitored to ensure we can see continued improvement here.

Results Overview – LWH Trends

The table below provides our Theme scores over the last 4 or 5 years (where available) to allow trends to be noted. We can see more clearly here that scores in a number of areas have consistently tracked below the average for our comparator group.

To aid review:

- **Boxes shaded green** indicate a score matching the "best" score for the Theme amongst our comparator group in that particular year.
- **Boxes shaded in amber** indicate a score for the Theme which is below the average for our comparator group in that particular year.
- **Boxes shaded in red** indicate a score matching the "worst" score for the Theme amongst our comparator group in that particular year.

Theme	2014	2015	2016	2017	2018
1. Equality, diversity & inclusion	9.3	9.5	9.5	9.4	**9.5**
2. Health & wellbeing	---	6.4	6.3	6.3	6.3
3. Immediate managers	---	**6.8**	**6.7**	**6.7**	**6.8**
4. Morale	---	---	---	---	**6.1**
5. Quality of appraisals	---	**4.9**	**4.9**	**5.0**	**5.2**
6. Quality of care	---	**7.6**	**7.6**	**7.6**	**7.6**
7. Safe environment – Bullying & harassment	---	8.5	8.4	**8.3**	8.6
8. Safe environment – Violence	---	9.8	**9.9**	9.8	**9.9**
9. Safety culture	---	**6.8**	**6.6**	**6.7**	**6.7**
10. Staff engagement	**6.8**	**7.1**	**6.9**	**7.0**	**7.0**

Significance testing has been undertaken both in relation to the scores for the newly established Themes and the previous measures of Key Findings. This has shown that there is no statistical difference between the scores in 2018 v. 2017.

The above table illustrates that since 2015 we have scored below average in a minimum of 5 - that is half - of the themes. For 2018 this number was 6. It is also notable that the scores for each theme, and indeed the engagement score overall have remained largely unchanged over the last 4 years.

This can be viewed in both positive and negative terms. Positive in that there has been challenge in terms of financial pressures and organisational change, and yet results have remained consistent. But negative in that consistent effort has been focussed in numerous initiatives, and yet results have not improved.

Results Overview – Trends by Directorate & Staff Group

Staff engagement score – scores in **red** denote a lower score than the Trust overall, with **green** highlighting a higher score.

Staff Group	Directorate 2018	LWH 2018
Scientific & Technical	**6.3**	7.0
Additional Clinical Services	**6.6**	7.0
Administrative & Clerical	**6.9**	7.0
Allied Health Professionals	**5.6**	7.0
Estates & Ancillary	**6.7**	7.0
Healthcare Scientists	7.0	7.0
Medical & Dental	**8.2**	7.0
Nursing & Midwifery - Registered	**7.1**	7.0

We continue to see positive results for the neonatal department, reflecting the ongoing benefit of a revised leadership structure, career development opportunities, investment in staffing and improved communications.

Whilst we seen gynaecology scoring significantly below other parts of the Trust, in recent months the leadership team has been strengthened and plans are in place to change/improve and focus on a number of key activities in this area.

Focused efforts will be made in the areas where it has been identified staff feel less engaged, specifically to ensure that meaningful action plans are produced by each Division.

Directorate	Directorate 2018	LWH 2018
Estates & Facilities	**6.5**	7.0
Finance	**7.4**	7.0
Genetics	**7.3**	7.0
Gynaecology	**6.4**	7.0
Hewitt Fertility	**7.3**	7.0
Human Resources	**7.5**	7.0
Imaging	N/A	7.0
Integrated Administration	**6.0**	7.0
Integrated Governance	**7.2**	7.0
IT & Information	**6.3**	7.0
Maternity	7.0	7.0
Medical	**8.2**	7.0
Neonates	**7.3**	7.0
Operational Support Services	N/A	7.0
Pharmacy	**5.3**	7.0
Surgical Services	**6.4**	7.0
Trust Offices	N/A	7.0

Results Overview - Staff Engagement Scores compared to other Trusts

We continue to be positioned "mid table" against the following other Trusts:

Trust	2018
Heart & Chest	7.7
St Helen's & Knowsley	7.6
Walton Centre	7.4
Alder Hey	7.3
Clatterbridge	7.3
Mid Cheshire NHS FT	7.2
Liverpool Women's NHS Foundation Trust	**7.0**
Wigan Wrightington & Leigh	7.0

Trust	2018
Royal Liverpool & Broadgreen	7.0
Warrington & Halton	7.0
Birmingham Women's	6.9
Countess of Chester	6.9
Aintree	6.9
Wirral University NHS FT	6.7
Southport & Ormskirk	6.5

Results Overview – Noteworthy Results

The key results and themes from the 2018 staff survey are summarised below:

EQUALITY, DIVERSITY & INCLUSION

Underlining the "best" theme score of 9.5, it should also be noted that a **"best" result of 4.4%** was achieved in answer to "In the last 12 months have you personally experienced discrimination at work from manager, team leader or other colleague?"

IMMEDIATE MANAGERS

This theme scored below average overall. Two questions in particular scored only **marginally above "worst"** – "my immediate manager takes a positive interest in my H&W" scored 65.4% versus worst of 65.1%. It was also a deterioration from 2017 where it scored 66.2%.
"My immediate manager values my work" scored 69.9% v. worst of 69.2%, although this was marginally above last year, which scored 69.0%

HEALTH & WELLBEING

Whilst scoring the average of 6.3 within our comparator group, it should be noted that a **"best" result of 19.7%** was achieved in answer to "in the last 12 months have you experienced MSK problems as a result of work activities? – In spite of the "best" score, it should be highlighted that this result has **deteriorated from 2017, when it scored 15.7%**

QUALITY OF APPRAISALS

Whilst the theme score of 5.2 was **below average,** this was an improvement v. 2017.
Each individual question scored below average, but the **biggest improvement** (from 32.8% to 37.9%) was in "The values of my organisation were discussed as part of the appraisal process."

MORALE

A new category this year, so no yoy comparison available. However, one question is consistent in which we scored as **"worst"** – "I am involved in deciding on changes introduced that affect my work area/team/department – **49.7%** versus 52.2% in 2017.

From a succession standpoint, it is important to note:

- 30.6% often think about leaving this organisation.
- 22.5% will probably look for a job elsewhere in the next 12 months
- 17.7% will leave as soon as they can find another job.

VIOLENCE

"Best" theme score of 9.9. A very solid result, however, 0.4% state they have personally experienced physical violence at work from managers in the last 12 months, and 1.1% indicate they have experienced this from colleagues. 1.8% stated they have experienced violence from patients/service users/relatives or the public.

STAFF ENGAGEMENT

Theme score remained unchanged at 7.0, although this is below average. Important to note here:
"I would recommend my organisation as a place to work" reduced slightly from 60.8% to 59.6%.
"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation" reduced from 79.8% to 77.5% which is the **"worst" score for this question.**

QUALITY OF CARE

The theme score of 7.6 was **"below average".** Of concern here is that 2 of 3 questions also **showed deterioration from 2017.** "I am satisfied with the quality of care I give to patients/service users" reduced from 84.6% to 84.1% and "I feel that my role makes a difference to patients /service users" reduced from 90.6% to 88.8%.

BULLYING & HARASSMENT

The theme score has **improved from 8.3 to 8.6.** The most improved score was in relation to "In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from managers?" – improving from **15.5% to 10.9%**

SAFETY CULTURE

"Worst" theme score of 6.7, although this remains the same as last year. Whilst scores in a number of specific questions showed a deterioration from 2017, the most notable was "my organisation acts on concerns raised by patients /service users" which reduced from 79.2% to 73.1% - which was a **"worst" score for this question.**

Moving Forward

The revised "Putting our People First Strategy" has recently been approved and will be formally launched in the coming weeks.

This strategy will be underpinned by both a Trust-wide and Divisionally focussed people plans, ensuring resources and time are given to driving improvement in the key areas identified both within this report and in our "business as usual" management of the Trust. It will be important for Divisional Boards and their management teams to "own" the people plans for their Division.

Success in "turning the dial" and improving the results lies in a joined up approach across all staff groups and all levels across the organisation and therefore communication and clarity around our plans will be key. The Board is asked for its support in this.

Activities which are underway will continue to be reviewed for their effectiveness and will be adjusted where needed to ensure we gain maximum value, including:

- Retention working group – focussed on nursing an midwifery
- Absence Management group – focussed on reducing absence Trust-wide
- Health & Wellbeing Group – focussed on identifying ways to improve H&W in the workplace.
- Development programmes – including Leadership and Aspirant Talent
- Listening Events – to driving understanding and provide an opportunity to garner ideas.
- Surveys – annual national survey and quarterly "Listening to our People" will be supplemented with "Face to Face" mini pulse surveys to temperature check key messages.
- Reward & Recognition – highlighted previously, a review is required in this area looking at our recognition arrangements most specifically.
- Talent Mapping & Succession Planning – a method will be devised for an annual talent mapping process. This will feed career development discussions, performance discussions and succession planning.
- Friends & Family – the Nursing & Midwifery Strategy is currently in the development stages and will have a real focus on improving opinion on recommending treatment at the Trust to friends and family. Further insight and opportunities to shift perceptions will be garnered through the staff survey processes noted above throughout the year and any Divisional activity will be driven through the Divisional People plans.

Conclusion

The results of the staff survey demonstrate that whilst stability remains, focus at all levels of the organisation is required to "move the dial" and begin to see improvement across all areas, most specifically those areas where our scores are "below average" or "worst".

Recommendations

The board is asked to note the contents of this report and provide support for the actions proposed as we progress through the year.

Appendix 1

NHS STAFF SURVEY 2018

Changes in Reporting

- **For 2018, following a review by the Survey Centre, changes in Staff Survey reporting have taken place.**
- **Key issues identified around:**
    - Inconsistencies in scale and presentation of key findings
    - large number of key findings
    - desire for question level results
    - usability, clarity and format of the benchmark reports
    - desire for local trend data
    - demand for faster results
- **Updates for this year include:**
    - Creation of 10 Summary Indicators – referred to as Themes, replacing key findings. These have been calculated for previous years were possible. All Themes are score 0 (worst) to 10 (best).
    - Reduced number of summary indicators and question level benchmarking – this is to encourage users to engage with the question-level data rather than rely solely on the summary indicator which can mask details.
    - More visual benchmark report
    - Focus on providing 5 year trend data through the reporting, where comparable data exists.
- **The newly created 10 themes are:**
    - E, D & I
    - Health & Wellbeing
    - Immediate Managers
    - Morale
    - Quality of Appraisals
    - Quality of care
    - Safe environment – Bullying & Harassment
    - Safe environment – Violence
    - Safety culture
    - Staff engagement – this will be calculated using the same questions as in previous years, but adjusted to the 10pt scale. Historical data will be re-calculated to suit the new scale to that we can easily make comparisons with previous year.
- **Transitionary measures in place for this year:**
    - a version of the Organisational Weighted Data that includes 2017 and 2018 Key Findings data has been created to ensure organisations can access the KF data for this year as required – allowing some easy comparisons.

Agenda Item	2018/044

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Feedback from Listening Event – Nursing and Midwifery Strategy**
DATE OF MEETING:	Thursday, 04 April 2019
ACTION REQUIRED	**For Noting**
EXECUTIVE DIRECTOR:	Michelle Turner, Director of Workforce and Marketing
AUTHOR(S):	Janet Brennan, Deputy Director of Nursing and Midwifery
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 and consider the feedback from the Nursing, Midwifery and AHP strategy Listening Event • Endorse the approach and commit to supporting the development of the strategy • Gain assurance that the feedback from staff is being acted upon in the development of the strategy.	
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

As an acknowledgement of the success of previous Listening events as a welcome opportunity for all staff to share views and ideas, the Trust has committed to hosting Listening Events every quarter, supported by Board attendance. The February event coincided with the launch of staff engagement in developing the Nursing, Midwifery and AHP strategy .The interactive nature of the Listening Event provided an excellent forum to engage and to gather information. This paper provides a review of the event.

In broad terms, the feedback from the second Listening Event was

- Staff welcomed the opportunity to be part of the development of the Nursing, Midwifery and AHP Strategy.
- Staff contributed honestly to the questions raised
- Opportunity to shape the strategy
- Proud to work here
- Value of staff and celebrate what we do
- Person patient focus
- Priorities- safety, consistency, caring, empathy, advocate, training, values and behaviours, professional, patient voice, research, listen, correct terminology
- Customer care
- Too many straplines
- Not enough engagement with AHP
- They enjoyed the opportunity to spend time with colleagues from other areas/disciplines
- They wanted the values and behaviours of the Trust to be linked into the strategy
- They wanted the strategy to be linked with all other strategies and not to be a stand-alone strategy
- Caring featured heavily.
- Further engagement is needed with all staff groups and service users

Board are asked to

- Receive and consider the feedback from the Listening Event
- Endorse the approach and continue to support the development of the Nursing, Midwifery and AHP Strategy.
- Provide challenge into the organisation and gain assurance that the feedback from staff is being acted upon

Report

1. Background

The listening event was the first of many focus groups in the next couple of months to engage all groups of staff in the development of the nursing, midwifery and AHP strategy. The previous strategy, which is available for review ended in 2017, we want to build on the previous strategy but also develop new areas of focus that matter to everyone not just nurses, midwives and AHPs. The strategy also needs to include how the staff survey results are going to improve particularly 3 specific questions where we are the worst scoring NHS trust –

- My organisation acts on concerns raised by pts/ service users
- Care of patients/ service users is my organisations top priority
- If a friend or relative needed treatment I would be happy with the standard of care provided by the organisation

The key questions were:

- What makes you proud of your role within patient care?
- What do you think are the top priorities for people in a Nursing, Midwifery and AHP strategy?
- What matters to you in terms of your role in patient care?
- What do you think of the 3 P's (professional personal and proud)

Once again, the event evaluated very well and the greatest positive was that staff enjoyed the opportunity to contribute at the start of the project. Due to annual leave and sickness absence, and it being half term attendance was quite low especially from clinical teams; however, for staff that were present, it was easier for their voices to be heard and to complete longer discussions. Engagement in conversation was evident throughout the session with a good a mixture of returnees and new attendees.

Building on the reputation of previous Listening Events as a productive space for sharing ideas and voicing concerns across the system, the creative relationships that result from these discussions provided the perfect forum for beginning Trust wide discussions and engaging staff with the piece of work that will lead to the Trust becoming an exemplar in Fair and Just Culture.

Table of Actions

Key Messages	**Update**
A lot of discussion about what is needed in the strategy	Feedback from the event will be used towards the development of the strategy
Further engagement required with other staff groups and users of the service, CCG, etc.	Senior team away day focus on development of strategy and what was discussed at listening event Questions further developed and sent out to all teams via group survey. Attended Consultant meeting Senior team focus events in the foyer to capture staff, visitors Matrons speaking to inpatients Survey sent to safeguarding boards, maternity voices and CCG
They wanted learning from incidents to be constructive, positive and widely shared, driving an 'Always Event' culture rather than a 'Never Event' culture	Human factors training to be delivered to key staff with cascade trainers widening impact. Feedback a critical part of training

2. Summary

The listening event started off the engagement sessions for the development of the Nursing, Midwifery and AHP strategy. The information has been collated and reviewed and will be used with other extensive engagement sessions in the development. It is clear from the conversations the strategy must fit with existing strategies and values and behaviours already in place. Wider engagement continues until the end of March when it is hopeful there will be enough information to write a first draft strategy in time for Midwives, Nurses day in May. The strategy will hopefully be fully launched in the autumn at the Nursing and Midwifery conference planned.

3. Board Actions

The Board is asked to

- Receive and consider the feedback from the Nursing, Midwifery and AHP strategy Listening Event
- Endorse the approach and commit to supporting the development of the strategy
- Gain assurance that the feedback from staff is being acted upon in the development of the strategy.

Agenda Item	2019/045

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Serious Incidents Combined Report for 2018/19**
DATE OF MEETING:	Tuesday, 23 April 2019
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	Caron Lappin, Director of Nursing and Midwifery
AUTHOR(S):	Christopher Lube, Head of Governance and Quality
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):	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 contents of the report and gain assurance in relation to the Trust SI process.			
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

The following report provides an update as to the number of Serious Incidents (SI's) reported via the StEIS system to the Clinical Commissioning Group (CCG) for the financial year of 2018/19, and any outstanding actions related to previous SI's reported to the CCG.

Total Number of Serious Incidents reported by Quarter in last 3 financial years is:

Financial Year	Quarter	Total Number of SI's
2016/17	1	2
	2	5
	3	13
	4	4
2017/18	1	6
	2	7
	3	7
	4	5
2018/19	1	2
	2	5
	3	6
	4	3
Total Overall		**65**

Location of SI for 2018/19

Gynaecology	Maternity	Neonatal	Other
8	5	2	1

CCG Feedback

The CCG Serious Incident Review Panels have consistently complimented LWH and our investigators on the comprehensive nature of investigations and reports and identified these as being the best they had received form any organisation to date.

Introduction

Under the quality Contract with Liverpool Clinical Commissioning Group Liverpool Women's NHS Foundation Trust is required to declare and Serious Incidents in line with the National Policy. Incident have to be reported to the CCG within 48hrs of being identified as an SI by the provider organisation.

Once an SI has been reported to the CCG, the Trust has 60 working day to undertake the Root Cause Analysis investigation and provide a final report and action plan to the CCG. The CCG will undertake a review of the report and provided feedback to the Trust and may ask for clarification on some areas if required.

The Trust has a fully approved Serious Incident and Incident Management Policy and process in place which supports our risk management Strategy.

Report

The following section provides an overview of the Serious Incidents, which have been reported to the CCG during the financial period of 2018/19. During 2018/19 a total of 16 Serious Incidents have been reported to the CCG and investigated using the Root Cause Analysis Process. Investigations of Serious Incidents follows the trust Serious Incident and Incident Management Policy and all incident are reported to the Safety Senate and to the Quality Committee. Progress of any actions are also reported to the Safety Senate to scrutiny and assurance on progress.

April 18

There was 1 SI reported to the CCG in April

SI Ref.	Incident Recognition Date	Department	Summary
2018/8220	03/04/18	Gynaecology	Emergency admission for care form BPAS service following TOP. Concern BPAS using LWH as contingency plan.

May 2018

There were no SI's reported to the CCG in May

June 2018

There was 1 SI reported to the CCG in June

SI Ref.	Incident Recognition Date	Department	Summary
2018/15034	18/06/2018	Maternity	Therapeutic hypothermia at 9 hours of age due to abnormal neurology

July 2018
There were no Serious Incidents reported to the CCG in July

August 2018
There were 3 SI reported to the CCG in August

SI Ref.	Incident Recognition Date	Department	Summary
2018/20192	15/07/2018	Maternity	Low risk pregnancy identified at booking and received regular antenatal care in pregnancy. Baby born in poor condition, cooing therapy on NNU. Declared SI following review at Every Baby Counts
2018/20201	13/08/2018	Gynaecology	Delayed/mis-diagnosis of Ectopic Pregnancy, required surgery.
2018/20528	21/08/2018	Gynaecology	Delay in diagnosis of renal injury during Hysterectomy leading to Hydronephropsis.

September 2018
There were 2 SI reported to the CCG in September

SI Ref.	Incident Recognition Date	Department	Summary
2018/22491	07/09/2018	Maternity	Diagnosed Acute Kidney Injury The patient had anti-JKA antibody.
2018/23401 **Never Event**	26/09/2018	Gynaecology	Patient discharged with a retained swab following surgery.

October 2018
There was one SI reported to the CCG

SI Ref.	Incident Recognition Date	Department	Summary
2018/24403	02/10/18	Maternity	Incident represented an unexpected admission to the neonatal unit with possible failure to recognise the deteriorating condition of a newborn baby.

November 2918
There were five SI reported to the CCG

SI Ref.	Incident Recognition Date	Department	Summary
2018/26745 **Never Event**	06/11/08	Gynaecology	Patient consented for a copper coil and in error at Levosert (hormonal) coil was inserted.
2018/26851	09/11/18	Neonatal	Potential delayed diagnosis of necrotizing enterocolitis (NEC) and infection, leading to periventricular leukomalacia
2018/26890	08/11/18	Maternity	Intrapartum fetal death of twin 1 at 24 weeks gestation.
2018/27163	13/11/18	Gynaecology	Patent became unwell post operatively, transferred to Accident & Emergency at the Royal Liverpool University Hospital, remained in the Royal Liverpool University Hospital and sadly passed away.
2018/27248	14/11/18	Maternity	Intrapartum Still Birth on MLU 11 November 2018

December 2018
There were no SI reported to the CCG

January 2019
There were no SI reported to the CCG

February 2019
There was 1 SI reported to the CCG

SI Ref.	Incident Recognition Date	Department	Summary
2019/4738	21/02/2019	Gentetics	Laboratory information management system issue preventing report authorisation review and report issue. Issue also impacting on system generation of turnaround data from system time stamps, which in turn impacts on NHSE funding. Issue resolved and maintenance programme in place – request for de-escalation made to CCG

March 2019
There were 2 SI's reported to the CCG

SI Ref.	Incident Recognition Date	Department	Summary
2019/6522	08/03/2019	Gynaecology	Bowel injury at the time of hysteroscopy, consultant asked for help from oncologist, performed laparoscopy and diagnosed bowel injury and then called on call surgeons from Royal Liverpool University Hospital who performed a laparotomy and small bowel resection and primary anastomosis.
2019/6487	13/03/2019	Gynaecology	Informed by Radiologist at the Oncology Multi-Disciplinary that a patient had recently been diagnosed with recurrent endometrial cancer. On reviewing the previous pre-operative chest, x-ray at the time of the initial treatment one year earlier a lung metastasis was noted. It appears that no action was taken at the time.

Outstanding Action form SI Investigations

At the time of writing the report there are no actions, which are overdue for completion in line with the target date, set on the action plan for the investigation.

Never Events

As can be seen from the report above, during 2018/19 the Trust has reported two Never Events to the CCG. One related to the wrong prosthesis (coil) and one related to a retained swab. In both cases, staff stepped outside of the local procedures related to checking procedures. These issues form part of the work now being carried out via a re-established Local Safety Standards for Invasive Procedures implementation group, which is being led by the Acting Medical Director.

Duty of Candour

As per the Trust policy in each of the Serious Incident's which has occurred the Duty of Candour process has been followed.

Conclusions & Recommendations

The Board is asked to note the contents of the report and gain assurance in relation to the Trust SI process.

Agenda Item	**2019/046**

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Safer Nurse/Midwife Staffing Monthly Report**
DATE OF MEETING:	5th April 2019
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	**1.** Trust Constitution ☐	**4.** NHS Constitution ☐

STRATEGY, PLAN AND EXTERNAL REQUIREMENT	**2.** Operational Plan **3.** NHS Compliance	☐ ☒	**5.** Equality and Diversity ***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: Trust Board	
	Date of meeting		Friday, 05 April 2019	

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.

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 November/ December 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 trust has been developing a ward accreditation system which is required to support the collection of quality indicators alongside real time patient safety flags. Ward accreditation in totality is being rolled out in April 2019 to 5 areas.
- 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 **January 2019.**

Gynaecology ward has seen an increase in fill rates since November and December
Delivery suite have seen a slight drop in day fill rate
Jeffcoate and Neonates have seen an overall increase from December.

The inpatient wards have been able to maintain safe fill rates for **February 2019.**

Gynae ward remains a good fill rate despite vacancies and maternity leave
Delivery suite saw an increase in fill rate from January
Mat base and MLU support workers saw a decrease due to sickness

2.2 Red Flags

January and February 2019 – Red Flags

There were a total of 42 incidents, reported under the Nursing/ Midwifery red flag criteria. 9 relating to staffing shortfalls across Gynaecology, Neonates and Maternity.

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 circa 43 ,000 nursing vacancies and 3,500 midwife in the NHS in England.

4.0 Vacancies

There are currently 0 however, there are 10.69 WTE on Maternity leave across Maternity. 1.0 WTE registered nurse vacancies on the Gynaecology Ward however, 4.0 WTE on maternity leave. 1.0 WTE band 5 vacancies in Neonates with 5 WTE on maternity leave. 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. The action plan has been submitted and is being monitored through NPF and PPF.

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 months of January and February 2019 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. 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 and retention, 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

Appendix 1

January 2019

WARD	Fill Rate Day% RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff
Gynae Ward	97.5 %	97.8%	100%	100%
Delivery Suite	76.7%	69.9%	84.9%	78.5%
Mat Base	94.4%	78.1%	98.2%	90.3%
MLU	96.8%	80.6%	98.4%	77.4%
Jeffcoate	96.8%	58.1%	100%	64.5%
NICU	107.7%	90.3%	108.5%	98.4%

February 2019

WARD	Fill Rate Day% RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff
Gynae Ward	101.7%	98.7%	102.4%	94.3%
Delivery Suite	81.2%	73.8%	89%	75%
Mat Base	90.6%	76.4%	94.9%	66.1%
MLU	94.6%	50%	100%	78.6%
Jeffcoate	100%	60.7%	96.4%	60.7%
NICU	109.2%	92.9%	105.8%	96.4%

Agenda Item	2019/047

MEETING	**Trust Board**
PAPER/REPORT TITLE:	**Performance Report month 11**
DATE OF MEETING:	Thursday, 04 April 2019
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	Loraine Turner, Director of Operations
AUTHOR(S):	Sarah Sherrington, Service Improvement & Business Manager Richard Strover, Head of Information & Performance
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**	**Finance Performance and Business Development Committee** **Quality committee**
	Date of meeting	

1. Introduction

The full Trust performance dashboard is attached in **Appendix 1** below.

2. Performance

Indicator		Metric	Threshold		Actuals				Δ
					Oct-18	Nov-18	Dec-18	Jan-19	
Cancer	2WW for suspected cancer	%	≥93%	Higher values are better	96.8%	95.3%	95.2%	97.1%	▲
	31d Decision to First Treatment	%	≥96%	Higher values are better	87.5%	87.5%	95%	96.9%	▲
	31d from Diagnosis to Definitive Treatment	%	≥96%	Higher values are better	60%	91.3%	95.0%	93.3%	▼
	62d Consultant Upgrade to First Treatment	%	≥85%	Higher values are better	44.4%	54.5%	77.8%	66.7%	▼
	104d Referral to First Definitive Treatment	Count	0	Zero tolerance	2	5	0	3	▼
RTT	RTT Incomplete Pathways <18weeks	%	≥92%	Higher values are better	87.1%	87.2%	85.9%	85.5%	▼
	RTT Incomplete Pathways 52+weeks	Count	0	Zero tolerance	14	14	11	5	▲

Cancer:

- January confirmed position reported above evidences renewed focus at PTL meetings combined with matching capacity to demand for 2WW patients is having a positive impact upon the 31d targets. However, work continues with NHSI IST and the Cancer Alliance to map timed clinical pathways and understand efficiencies which may be gained within the front end of pathways which would have a subsequent positive impact upon the 62d targets.
- Significant challenges to meet the 62d targets remain including appropriate access/availability to theatres at LWH and RLUH. Demand and capacity modelling has evidenced admitted oncology demand requires an additional 3 Gynae-Oncology theatre lists weekly and staff to support this. One ATSM Oncologist commenced in post March 2019 and business cases are being developed for additional posts.

RTT:

- RTT incomplete 18 week pathways remains consistent at ~85% in December/January as focus continues on managing long waiting patients and ASI lists. Capacity issues persist in Uro-Gynaecology with 2 Consultants successfully recruited in March 2019 to address this shortfall.
- 52 week patients continue to reduce. All 52week patients have had clinical reviews with plans in place for next steps and appointments ghosted as required.
- 1 x patient requires PTNS Physio; awaits outsource as treatment no longer offered at LWH. We are now exploring an alternative solution for the patient.
- There is a continued operational focus on data validation ascertaining next steps in patients' pathways. This is complete for all patients 40+ week patients, with focus moving forward now on validating the 30-39week patients to reduce likelihood of future breaches.

Indicator	Metric	Threshold		Actuals					Δ
				Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	
Diagnostics 6 week wait	%	≥99%	Higher values are better	98.6%	96.7%	95.5%	98.4%	97.3%	▼

Diagnostics:

The Trust has failed this target by 1.7% in February. The two most challenged areas are cystometry and urodynamics capacity due to vacancy factor within the urogynaecology service. Two new urogynaecology Consultants have been recruited with diagnostic sessions scheduled into job plans. Consultants are due to start in post May 2019.

Future Board Reports:

In 2019/20 the indicators included in the Board's performance report will not change. NHS England has stated that changes to the RTT and cancer measurements are likely to be introduced in 2019/20 and these will be included as confirmed. The new reports will also aim to be more fluid with the pie charts removed, KPIs grouped based on Trust values, trend lines for each KPI and RAG rated arrows to indicate performance trends in month. This is intended to allow for earlier identification of a potential KPI performance issue, allowing for early escalation, timely reviews into the root causes and corrective measures to be implemented.

The layout of the current performance report will be updated and Board members will be provided with access to a portal where the data for each individual KPI will be available, including historic performance data from the previous two years.

NHSI Intensive Support Team (NHSI IST):

From February 2019 NHSI IST has been providing additional expert support to the Trust following assessment against the Trust's RTT & CWTs recovery plan, in particular to focus on the following objectives:

1. **Pathway Design** – To review and revise pathways ensuring in line with best practice, include timescales for clinical events and administrative processes and equitable access across all sites. Gap analysis to be performed to be compliant with national standards and reduce waiting times.
2. **Access Policy** – To review the Trust Access Policy and the booking and admin processes for the cancer pathway to ensure they are consistent and streamlined.
3. **Cancer training strategy** - To undertake training needs analysis to include all staff who 'touch' the patient pathway, including clinicians
4. **Critical review of key Cancer Meetings** – To provide written feedback and recommendations for strengthening key cancer governance meetings from a systems and process perspective
5. **Undertake demand and capacity modelling for 2WW appointments and other key pathway milestones** – To ensure clear understanding of the capacity required for cancer pathways and identification of gaps with mitigating actions documented as part of an overall capacity plan for operations to own.

IST have made three visits to the Trust, most recently on 27th March where it was recognised that the Trust has made significant progress, aided by a full operational team being in place, and are in the process of producing the overarching action plan, which allows for continuous robust assessment of progress, and supports managers in holding individuals to account through governance structures.

Demand and capacity work is on-going with gynaecology outpatients complete and inpatients in progress. It was highlighted that the teams are confident in the use of the tools, understand the outputs, and that this work is supporting the review and plans to amend clinical and administrative pathways, including mapping clinician time utilisation which is currently in development.

The access policy has been reviewed and amended. IST has provided very positive feedback and is happy for this to move to being ratified internally. IST recognises there is a gap within the training programmes for RTT and Cancer which will require administrative, operational and clinical involvement. Due to a lack of internal expert resource to deliver this IST support the Trust in sourcing external providers to develop a training strategy with a training programme to be negotiated and implemented during Q1-2.

Due to progress made and the plans in place moving forward, IST have acknowledged that they would likely be recommending sign off to withdraw support from the Trust in the very near future.

Sickness Absence:

Sickness levels remain above target at 4.60% cumulative 18/19. The Trust has seen an increase in month by 0.53% at 5.75%, albeit there is a trend reduction of 0.62% in year at 4.60%, and a 0.63% reduction in comparison to February 18 at 5.23%.

The top three diagnoses for Month 11 remain mainly unchanged as - anxiety/stress/depression and other psychiatric illness – cold, coughs and Influenza – and gastrointestinal illness.

In line with the reporting format for RTT & CWTs the new style dashboard will provide RAG indicators and trend analysis for the whole Trust, with narrative for areas of exception reporting and recovery plans available through committee.

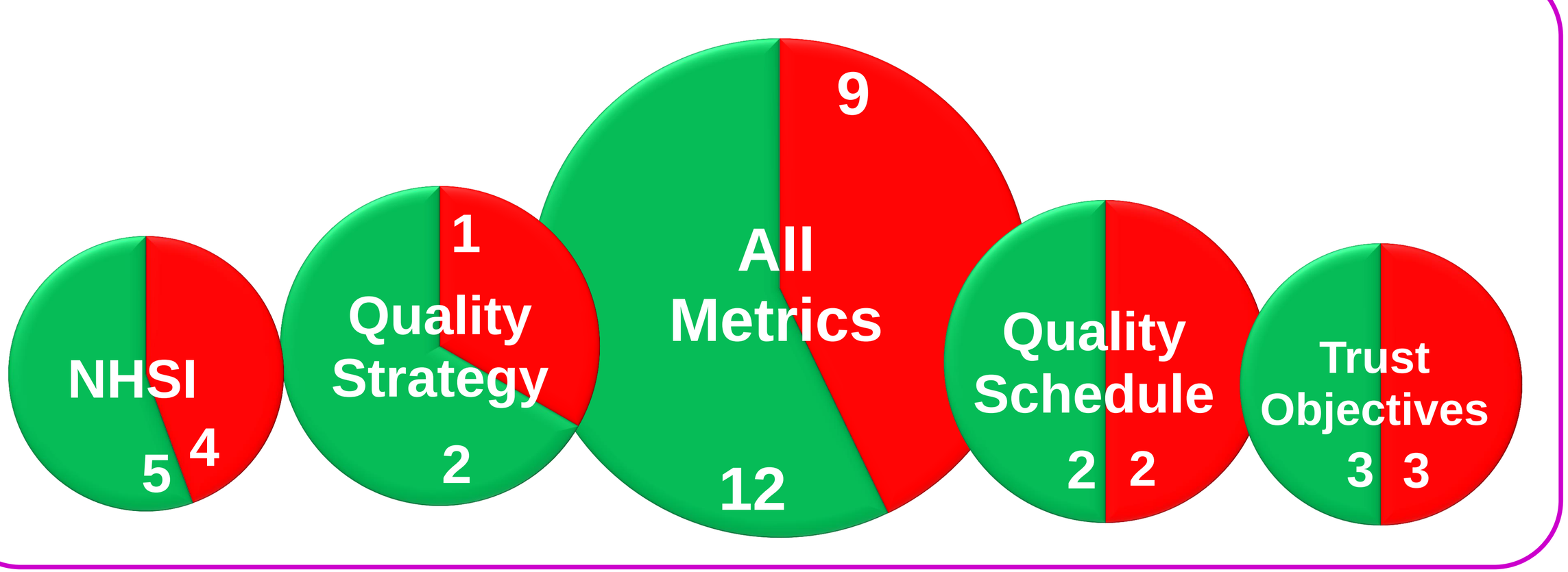
Appendix 1 – Scorecard

Performance Dashboard Trust Boa

Performance and Information Department
Performance Team

Liverpool Women's NHS Foundation Trust

Performance Report for Trust Board — Month 11 - February 2019



* 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 11 - February 2019

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	Deputy Director of Finance	3	3	3	3		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	0		0	1	0		0	0		
NHSE / NHSI Safety Alerts Outstanding	KPI193	Head of Governance	0	0	0	0		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%	5.0%	5.0%		5.2%	5.8%		

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%		87.10%	87.22%	85.90%		85.48%			
KPI003 Numerator				4137	4130	4238		4288	4312	4616		4522	4580	4551		4481			
KPI003 Denominator				4627	4636	4827		4888	4988	5295		5192	5251	5298		5242			
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%		45.45%	28.57%	66.67%		66.67%			
KPI1031 Final Numerator				5.0	4.0	10.5		8.5	2.0	4.0		5.0	3.0	4.0		7.0			
KPI1031 Final Denominator				9.5	11.5	16.5		16.5	6.5	11.5		11.0	10.5	6.0		10.5			
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%		37.04%	23.08%	80.00%		58.33%			
KPI1030 Final Numerator				5.0	4.0	10.5		12.5	2.0	4.0		5.0	3.0	4.0		7.0			
KPI1030 Final Denominator				9.5	12.0	18.5		20.5	7.0	11.5		13.5	13.0	5.0		12.0			
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	1		2	1	2		2			
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		N/A	N/A	N/A		N/A			
KPI1034 Numerator				0	1	0		7.0											
KPI1034 Denominator				0	1	0		7.0											
Complaints: Number Received	KPI038	Head of Nursing / Midwifery	<= 15	10	4	8		6	3	2		8	5	7		8	7		

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%	5.0%	5.0%	5.2%	5.8%	
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	14	14	11	5		
A&E: Total Time Spent in A&E 95th percentile	KPI012 (KPI_62)	Head of Nursing	<= 240	230	235	225	225	236	229	238	217	229	229	232	
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%	98.4%	99.4%	98.8%	93.7%	

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%	4.97%	5.0%	5.2%	5.8%	

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	0	0	1	0	0	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	8	5	7	8	7	

Liverpool Women's NHS Foundation Trust

LWH Trust Objectives 2018/19 Month 11 - February 2019

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%	0.44%	0.14%	0.14%	0.34%	
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%	0.45%	0.14%	0.15%	0.34%	

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	4	3	2	3	

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	5.0	2	5	0	3.0		
18 Week RTT: Admitted	KPI001	Access Turnaround Manager	>= 90%	85.3%	90.6%	93.1%	93.0%	86.7%	86.7%	84.5%	80.9%	87.7%	75.4%		
KPI1001 Numerator				412	465	416	436	455	456	420	381	342	304		
KPI1001 Denominator				483	513	447	469	525	526	497	471	390	403		
18 Week RTT: Non-Admitted	KPI004	Access Turnaround Manager	>= 95%	91.0%	94.6%	91.9%	90.7%	81.2%	88.5%	90.3%	89.8%	92.1%	90.3%		
KPI1004 Numerator				1580	1684	1551	1742	1354	1450	1652	1817	1208	1834		
KPI1004 Denominator				1737	1781	1687	1921	1667	1639	1830	2023	1312	2032		

Agenda Item	2019/048

MEETING	**Trust Board**
PAPER/REPORT TITLE:	Finance Performance Review Month 11 2018/19
DATE OF MEETING:	Thursday, 04 April 2019
ACTION REQUIRED	**For Assurance**
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):	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 Month 11 Financial Position.***			
PREVIOUSLY CONSIDERED BY:	**Committee name**	Finance Performance and Business Development Committee		
	Date of meeting	25/03/2019		

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 recurrent 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 11 the Trust is reporting a year to date (YTD) deficit of £0.3m against a deficit budget of £2.1m, giving a year to date favourable variance of £1.8m. The forecast has been maintained at a £0.5m improvement. It is assumed that this will lead to a further £0.5m of Provider Sustainability Fund income. However the underlying position going into future years remains a cause for concern. The key areas of financial performance are summarised below.[1]

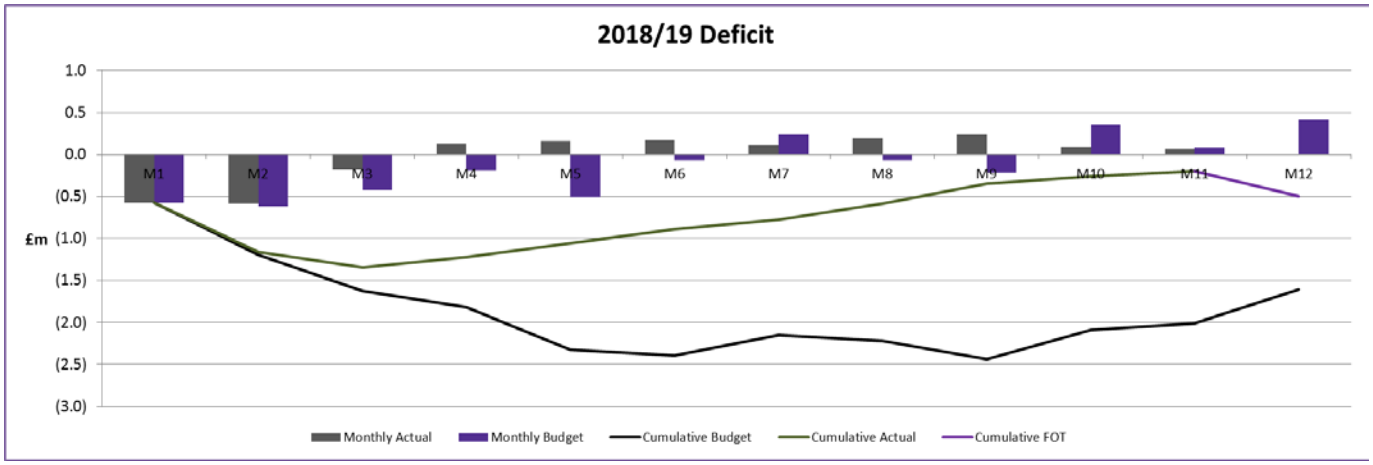
	Plan	Actual	Variance	RAG
Surplus/(Deficit) YTD	-£2.1m	-£0.3m	£1.8m	↑
Surplus/ (Deficit) FOT	-£1.6m	-£0.6m	£1.0m	↔
NHSI Rating	3	3	0	↔
Cash	£1.0m	£7.6m	£6.6m	↑
Total CIP Achievement YTD	£3.2m	£3.2m	£0.0m	↔
Recurrent CIP Achievement YTD	£3.2m	£1.7m	-£1.5m	↔
Capital Spend YTD	£11.6m	£7.8m	-£3.8m	↑

The Month 11 financial submission to NHSI is consistent with the contents of this report.

[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.

1. Summary Financial Position

At Month 11 the Trust is reporting a deficit of £0.3m YTD against a deficit budget of £2.1m. The Trust is forecasting delivery of a revised £0.6m deficit for the full year, £1m ahead of the agreed control total as outlined below. The control total now assumes receipt of £4.1m PSF (including a £0.5m bonus). This may be further improved by bonus PSF to be advised.



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.

Although recurrent CIP programmes are behind plan, non-recurrent mitigations have been found and it is not anticipated that this under-delivery will impact the achievement of the control total.

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: There is a small (£65k) overspend forecast for the full year, with an underspend in Maternity (£81k forecast) partly offsetting an overspend in Neonatal (£146k forecast). This has largely been driven by income under-performance and offset by an underspend in pay in Maternity.

Division of Gynaecology: The division is now forecast to overspend by over £2.3m. This largely relates to income, with a forecast £1m shortfall expected in the Hewitt Fertility Centre (HFC) and a further £0.6m in Gynaecology (before the block adjustment is applied). Activity has been lower than anticipated, with out of areas referrals down at HFC, and underperformance on a number of service developments. There are also overspends, most significantly on drugs.

Division of Clinical Support: The division continues to be underspent, forecasting a £0.3m favourable variance to plan, primarily driven by Theatres, where there continue to be expenditure under-spends, reflecting the lower level of activity than plan in Maternity and Gynaecology.

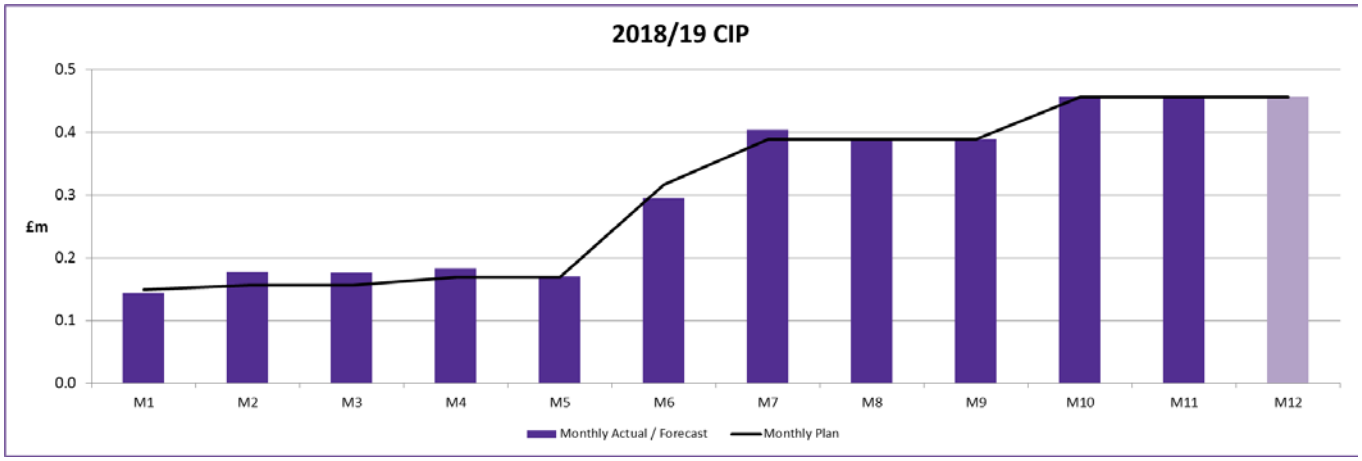
Corporate Services and Technical Items: Overall these are better than plan in-month, YTD and in the forecast.

Agency: Expenditure against agency staff remains within the limits set by NHSI, with £1.4m 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 11 the Trust has delivered £0.5m against the in-month target of £0.5m, 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.



The main areas of under-performance in the forecast remain as at previous months, and is primarily due to CNST Maternity Incentive (£1m), EPR slippage (£0.2m) and Gynaecology workforce (£0.3m). This has been offset by an anticipated £1.8m of non-recurrent underspends. (Note that the original plan contained £0.2m of non-recurrent schemes).

4. Contract Performance

Income YTD is £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 11 Block	Month 11 Actual	Month 11 Variance	YTD Block Block	YTD Block Actual	YTD Block Variance
Maternity	Liverpool	2,434,189	2,275,646	(158,543)	27,470,711	26,164,736	(1,305,975)
Maternity	Knowsley	350,740	341,897	(8,843)	3,934,408	3,664,582	(269,826)
Maternity	South Sefton	578,479	532,515	(45,964)	6,532,110	6,007,311	(524,799)
Maternity	Southport & Formby	47,206	52,449	5,243	535,792	597,306	61,514
Maternity Total		**3,410,614**	**3,202,507**	**(208,107)**	**38,473,021**	**36,433,936**	**(2,039,085)**
Gynaecology	Liverpool	1,027,915	826,194	(201,721)	11,229,092	10,271,064	(958,028)
Gynaecology	Knowsley	222,110	159,898	(62,212)	2,425,343	2,003,373	(421,970)
Gynaecology	South Sefton	272,719	228,684	(44,035)	2,980,198	2,742,302	(237,896)
Gynaecology	Southport & Formby	38,660	30,185	(8,475)	423,497	332,572	(90,925)
Gynaecology Total		**1,561,404**	**1,244,961**	**(316,443)**	**17,058,130**	**15,349,310**	**(1,708,820)**
Hewitt	Liverpool	99,229	84,140	(15,089)	1,187,866	1,131,377	(56,489)
Hewitt	Knowsley	29,452	28,057	(1,395)	352,534	278,852	(73,682)
Hewitt	South Sefton	25,990	47,689	21,699	311,070	293,601	(17,469)
Hewitt	Southport & Formby	18,567	22,243	3,676	222,296	181,486	(40,810)
Hewitt Total		**173,238**	**182,129**	**8,891**	**2,073,766**	**1,885,316**	**(188,450)**
OSI	Liverpool	23,497	22,058	(1,439)	256,710	248,483	(8,227)
OSI	Knowsley	4,867	4,430	(437)	53,176	48,569	(4,607)
OSI	South Sefton	5,244	4,600	(644)	57,294	47,500	(9,794)
OSI	Southport & Formby	1,683	2,058	375	18,392	17,022	(1,370)
OSI Total		**35,291**	**33,146**	**(2,145)**	**385,572**	**361,574**	**(23,998)**
Radiology	Liverpool	9,168	10,673	1,505	96,093	96,407	314
Radiology	Knowsley	2,287	1,262	(1,025)	24,471	16,430	(8,041)
Radiology	South Sefton	2,711	3,471	760	29,379	25,181	(4,198)
Radiology	Southport & Formby	287	136	(151)	3,079	1,912	(1,167)
Radiology Total		**14,453**	**15,542**	**1,089**	**153,022**	**139,931**	**(13,091)**
Neonates	Liverpool	2,046	0	(2,046)	22,762	0	(22,762)
Neonates	Knowsley	557	0	(557)	6,195	0	(6,195)
Neonates	South Sefton	310	0	(310)	3,453	0	(3,453)
Neonates	Southport & Formby	115	0	(115)	1,275	0	(1,275)
Neonates Total		**3,028**	**0**	**(3,028)**	**33,685**	**0**	**(33,685)**
Total		**5,198,028**	**4,678,284**	**(519,744)**	**58,177,196**	**54,170,067**	**(4,007,129)**

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. Work is ongoing with Liverpool CCG on activity for 2019/20, which is expected to increase from the forecast in 2018/19.

5. Forecast Out-turn

The forecast out-turn at month 11 has been held at a £1m improvement, comprising £0.5m non-recurrent improvement and £0.5m assumed additional PSF. Note that there is a potential additional upside to this position, depending on performance in M12 and the position on provisions.

6. Cash and Borrowings

The cash balance at the end of Month 11 was £7.6m 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 have increased to £12.4m, reflecting the drawdown of the neonatal build loan.

The Trust received in March the full £1.6m Public Dividend Capital related to achievement of the milestones on the Global Digital Exemplar Fast Follower programme.

The Trust has a planned operational cash borrowing requirement of £1.6m for 2018/19. The Trust continues to submit 13 week cash flow statements each month to the Department of Health & Social Care. There was no requirement for a cash drawdown in Month 11 or YTD and the Trust is no longer forecasting any requirement for this facility.

7. Capital Expenditure

Of the total £12.5m capital plan, £7.8m has been spent YTD, primarily on GDE Fast Follower infrastructure and implementation costs and the Neonatal redevelopment. A total of £3.1m 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). The loan drawdown has been revised accordingly.

8. BAF Risk

The Finance, Performance and Business Development Committee approved reduction of the BAF risk relating to in-year performance to 10 (a likelihood of 2 and impact of 5). At this stage it is unlikely that the Trust will not achieve the in-year Control Total. This has no impact on the underlying or longer term position.

9. Conclusion & Recommendation

The Board are asked to note the Month 11 financial position.

Appendix 1 – Board Pack

Board Finance Pack
M11

LIVERPOOL WOMEN'S NHS FOUNDATION

TRUST FINANCE REPORT: M11

YEAR ENDING 31 MARCH 2019

Contents

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
NHS IMPROVEMENT RATIOS: M11
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	4,068	5,793	5,053	5,955
(b) PDC + Interest Payable + Loans Repaid	2,198	7,567	2,684	8,043
CSC Ratio = (a) / (b)	**1.85**	**0.77**	**1.88**	**0.74**
NHSI CSC SCORE	**2**	**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	(2,717)	(9,294)	(2,385)	(8,569)
(b) Expenditure	102,468	100,617	111,627	111,119
(c) Daily Expenditure	307	301	306	304
Liquidity Ratio = (a) / (c)	**(8.9)**	**(30.9)**	**(7.8)**	**(28.1)**
NHSI LIQUIDITY SCORE	**3**	**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)	2,012	187	1,601	597
Total Income	(106,514)	(106,360)	(116,656)	(117,019)
I&E Margin	**-1.9%**	**-0.2%**	**-1.4%**	**-0.5%**
NHSI I&E MARGIN SCORE	**4**	**3**	**4**	**3**
Ratio Score 1 = > 1% 2 = 1 - 0% 3 = 0 - (-1%) 4 < (-1%)				
I&E MARGIN VARIANCE FROM PLAN				
I&E Margin (Actual)		-0.20%		-0.50%
I&E Margin (Plan)		-1.90%		-1.40%
I&E Variance Margin	**0.00%**	**1.70%**	**0.00%**	**0.90%**
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	1,655	1,655	1,805	1,805
YTD Agency Expenditure	1,177	1,372	1,284	1,538
	-28.9%	**-17.1%**	**-28.9%**	**-14.8%**
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: M11
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	(8,800)	(8,769)	(31)	(96,951)	(95,428)	(1,522)	(106,086)	(104,435)	(1,650)
Non-Clinical Income	(1,000)	(1,162)	162	(9,563)	(10,932)	1,368	(10,570)	(12,584)	2,014
Total Income	**(9,800)**	**(9,931)**	**131**	**(106,514)**	**(106,360)**	**(154)**	**(116,656)**	**(117,019)**	**363**
Expenditure									
Pay Costs	5,779	5,768	11	63,716	61,530	2,186	69,491	67,490	2,001
Non-Pay Costs	2,249	2,278	(29)	25,611	25,064	548	27,868	28,330	(462)
CNST	1,128	1,275	(147)	13,140	14,024	(884)	14,268	15,299	(1,031)
Total Expenditure	**9,155**	**9,321**	**(166)**	**102,468**	**100,617**	**1,850**	**111,627**	**111,119**	**508**
EBITDA	**(644)**	**(610)**	**(35)**	**(4,046)**	**(5,743)**	**1,697**	**(5,029)**	**(5,900)**	**871**
Technical Items									
Depreciation	394	401	(7)	4,191	4,322	(131)	4,586	4,725	(139)
Interest Payable	33	17	16	319	220	99	356	257	99
Interest Receivable	(2)	(5)	3	(22)	(51)	29	(24)	(54)	30
PDC Dividend	143	135	8	1,573	1,442	131	1,716	1,574	142
Profit / Loss on Disposal	0	0	0	0	0	0	0	0	0
Total Technical Items	**568**	**548**	**20**	**6,061**	**5,933**	**128**	**6,634**	**6,502**	**132**
(Surplus) / Deficit	**(76)**	**(61)**	**(15)**	**2,015**	**190**	**1,825**	**1,605**	**601**	**1,004**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
EXPENDITURE: M11
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	343	18	3,970	3,717	253	4,331	4,100	231
Medical	1,377	1,456	(79)	15,144	14,618	527	16,521	16,319	202
Nursing & Midwifery	2,469	2,400	69	27,303	26,278	1,024	29,768	28,534	1,234
Healthcare Assistants	390	403	(13)	4,300	4,252	48	4,690	4,647	43
Other Clinical	558	532	26	6,138	5,882	256	6,696	6,422	274
Admin Support	168	156	12	1,845	1,747	98	2,013	1,910	103
Corporate Services	349	317	32	3,838	3,665	173	4,187	4,019	168
Agency & Locum	107	161	(54)	1,178	1,371	(193)	1,285	1,538	(253)
Total Pay Costs	**5,779**	**5,768**	**11**	**63,716**	**61,530**	**2,186**	**69,491**	**67,490**	**2,001**
Non Pay Costs									
Clinical Suppplies	730	792	(62)	8,179	8,446	(267)	8,930	9,239	(309)
Non-Clinical Supplies	492	480	11	5,517	5,251	266	6,009	5,812	197
CNST	1,128	1,275	(147)	13,140	14,024	(884)	14,268	15,299	(1,031)
Premises & IT Costs	392	556	(164)	4,912	5,551	(640)	5,303	6,106	(803)
Service Contracts	636	450	186	7,004	5,816	1,188	7,626	7,173	452
Total Non-Pay Costs	**3,376**	**3,553**	**(176)**	**38,752**	**39,088**	**(336)**	**42,136**	**43,629**	**(1,493)**
Total Expenditure	**9,155**	**9,321**	**(166)**	**102,468**	**100,617**	**1,850**	**111,627**	**111,119**	**508**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
BUDGET ANALYSIS: M11
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
Maternity									
Income	(3,908)	(3,858)	(50)	(43,979)	(43,424)	(555)	(47,997)	(47,451)	(546)
Expenditure	1,797	1,787	10	19,791	19,149	642	21,591	20,965	627
Total Maternity	**(2,111)**	**(2,072)**	**(40)**	**(24,188)**	**(24,275)**	**88**	**(26,406)**	**(26,487)**	**81**
Neonatal									
Income	(1,362)	(1,245)	(117)	(15,019)	(14,839)	(180)	(16,388)	(16,258)	(130)
Expenditure	1,020	1,088	(68)	11,252	11,202	50	12,276	12,292	(16)
Total Neonatal	**(342)**	**(156)**	**(185)**	**(3,767)**	**(3,637)**	**(131)**	**(4,112)**	**(3,966)**	**(146)**
Division of Family Health - Total	**(2,453)**	**(2,228)**	**(225)**	**(27,955)**	**(27,912)**	**(43)**	**(30,518)**	**(30,452)**	**(65)**
Gynaecology									
Income	(2,179)	(2,122)	(58)	(23,861)	(23,324)	(537)	(26,139)	(25,544)	(594)
Expenditure	872	914	(42)	9,783	9,950	(167)	10,659	10,883	(224)
Total Gynaecology	**(1,307)**	**(1,207)**	**(100)**	**(14,078)**	**(13,374)**	**(704)**	**(15,480)**	**(14,662)**	**(819)**
Hewitt Centre									
Income	(850)	(727)	(123)	(9,608)	(8,692)	(916)	(10,555)	(9,618)	(937)
Expenditure	632	734	(102)	6,990	7,470	(480)	7,627	8,175	(548)
Total Hewitt Centre	**(218)**	**6**	**(225)**	**(2,618)**	**(1,222)**	**(1,396)**	**(2,928)**	**(1,443)**	**(1,485)**
Division of Gynaecology - Total	**(1,525)**	**(1,201)**	**(324)**	**(16,696)**	**(14,596)**	**(2,100)**	**(18,408)**	**(16,104)**	**(2,303)**
Theatres									
Income	(39)	(39)	0	(428)	(432)	4	(467)	(473)	6
Expenditure	670	664	6	7,413	7,161	252	8,088	7,863	225
Total Theatres	**631**	**624**	**6**	**6,984**	**6,729**	**255**	**7,621**	**7,390**	**231**
Genetics									
Income	(603)	(598)	(6)	(6,641)	(6,718)	78	(7,246)	(7,339)	94
Expenditure	473	499	(26)	5,207	5,251	(44)	5,680	5,740	(60)
Total Genetics	**(130)**	**(99)**	**(31)**	**(1,434)**	**(1,467)**	**33**	**(1,565)**	**(1,599)**	**34**
Other Clinical Support									
Income	(29)	(32)	3	(301)	(285)	(16)	(330)	(318)	(12)
Expenditure	733	658	74	8,255	8,310	(55)	8,987	8,963	24
Total Clinical Support & CNST	**704**	**627**	**77**	**7,954**	**8,025**	**(71)**	**8,657**	**8,645**	**12**
Division of Clinical Support - Total	**1,205**	**1,152**	**52**	**13,504**	**13,287**	**218**	**14,712**	**14,436**	**277**
Corporate & Trust Technical Items									
Income	(829)	(1,310)	481	(6,677)	(8,647)	1,969	(7,534)	(10,018)	2,484
Expenditure	3,526	3,525	1	39,839	38,058	1,781	43,353	42,740	612
Total Corporate	**2,697**	**2,215**	**482**	**33,162**	**29,411**	**3,751**	**35,819**	**32,723**	**3,096**
(Surplus) / Deficit	**(76)**	**(61)**	**(15)**	**2,015**	**190**	**1,825**	**1,605**	**601**	**1,004**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 5
CIP: M11
YEAR ENDING 31 MARCH 2019

SCHEME	MONTH 11			YTD			YEAR		
	TARGET	ACTUAL	VARIANCE	TARGET	ACTUAL	VARIANCE	TARGET	FOT	VARIANCE
Legal Premium Reduction	147	0	(147)	883	0	(883)	1,030	0	(1,030)
Patient Flow & Demand	16	9	(7)	79	36	(43)	95	47	(48)
Service Development Income	11	4	(7)	113	48	(65)	124	54	(69)
Service Development Non Pay	49	31	(18)	433	340	(93)	482	372	(110)
Service Development Pay	34	4	(29)	207	46	(161)	240	50	(191)
System & Environmental Income	7	6	(1)	67	63	(4)	73	69	(5)
System & Environmental Non Pay	20	21	1	127	174	47	147	201	54
Technology	94	27	(67)	421	282	(139)	515	310	(206)
Workforce	80	62	(18)	869	671	(198)	949	735	(214)
Non-recurrent Mitigation	0	289	289	0	1,577	1,577	0	1,817	1,817
TOTAL	**457**	**454**	**(3)**	**3,199**	**3,237**	**38**	**3,656**	**3,655**	**0**

*Scheme names as per NHSI return

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
BALANCE SHEET: M11
YEAR ENDING 31 MARCH 2019

BALANCE SHEET £'000	YEAR TO DATE Opening	M11 Actual	Movement
Non Current Assets	**76,313**	**79,086**	2,773
Current Assets			
Cash	6,013	7,563	1,550
Debtors	8,407	6,640	(1,767)
Inventories	452	487	35
Total Current Assets	**14,872**	**14,690**	**(182)**
Liabilities			
Creditors due < 1 year	(11,257)	(18,625)	(7,368)
Creditors due > 1 year	(1,686)	(1,657)	29
Loans	(17,221)	(12,413)	4,808
Provisions	(4,514)	(4,764)	(250)
Total Liabilities	**(34,678)**	**(37,459)**	(2,781)
TOTAL ASSETS EMPLOYED	**56,507**	**56,317**	**(190)**
Taxpayers Equity			
PDC	38,451	38,451	0
Revaluation Reserve	15,367	15,367	0
Retained Earnings	2,689	2,499	(190)
TOTAL TAXPAYERS EQUITY	**56,507**	**56,317**	**(190)**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
CASHFLOW STATEMENT: M11
YEAR ENDING 31 MARCH 2019

CASHFLOW STATEMENT	YEAR TO DATE		
£'000	Budget	Actual	Variance
Cash flows from operating activities	(145)	1,421	(1,566)
Depreciation and amortisation	4,191	4,322	(131)
Movement in working capital	(4,553)	8,918	(13,471)
Net cash generated from / (used in) operations	**(507)**	**14,661**	**(15,168)**
Interest received	22	51	(29)
Purchase of property, plant and equipment and intangible assets	(11,599)	(7,356)	(4,243)
Proceeds from sales of property, plant and equipment and intangible assets	0	0	0
Net cash generated from/(used in) investing activities	**(11,577)**	**(7,305)**	**(4,272)**
PDC Capital Programme Funding - received	1,600	0	1,600
Loans from Department of Health Capital - received	5,366	1,097	4,269
Loans from Department of Health Capital - repaid	(306)	(306)	0
Loans from Department of Health Revenue - received	1,449	0	1,449
Loans from Department of Health Revenue - repaid	0	(5,600)	5,600
Interest paid	(180)	(166)	(14)
PDC dividend (paid)/refunded	(858)	(831)	(27)
Net cash generated from/(used in) financing activities	**7,071**	**(5,806)**	**12,877**
Increase/(decrease) in cash and cash equivalents	**(5,013)**	**1,550**	**(6,563)**
Cash and cash equivalents at start of period	6,013	6,013	0
Cash and cash equivalents at end of period	**1,000**	**7,563**	**(6,563)**

LOANS SUMMARY £'000	Loan Principal Drawndown	Loan Principal Repaid	Loan Principal Outstanding at M11
Loans from Department of Health Capital (ITFF)- 2.0% Interest Rate	5,500	(1,834)	3,666
Loans from Department of Health Capital (Neonatal)- 2.54% Interest Rate	2,097	0	2,097
Loans from Department of Health Revenue - 1.50% Interest Rate	14,612	(7,962)	6,650
Total	**22,209**	**(9,796)**	**12,413**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 8
CAPITAL EXPENDITURE: M11
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	6,334	3,135	3,833	3,199
Other Building Projetcs	293	276	19	274	257
Estates & Environmental Projects	441	412	243	198	169
Global Digital Examplar Fast Follower & IM&T Projects	3,200	2,933	3,074	126	(141)
Medical Equipment	1,418	1,427	1,299	119	128
Other	222	204	18	204	186
Total	**12,542**	**11,585**	**7,788**	**4,754**	**3,797**

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	2019/050

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Board Assurance Framework**
DATE OF MEETING:	Thursday, 04 April 2019
ACTION REQUIRED	**For Assurance**
EXECUTIVE DIRECTOR:	Colin Reid, Trust Secretary
AUTHOR(S):	Christopher Lube, Head of Governance and Quality
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 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 are asked to:** 1. Approve the changes made to the risks as recommended by the Board Committees; 2. note the assurance that the risks are being managed appropriately; and 3. advise the Governance team of approval /views in respect of the process, proposals and rationale.	
PREVIOUSLY CONSIDERED BY:	**Committee name**	FPBD Committee and Quality Committee
	Date of meeting	During March 2019

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 (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 March 2019 BAF:

- **To deliver a well-led, engaged, motivated and effective workforce and Fully Resourced, Competent & Capable Junior Medical Workforce**
  These two risks are currently under review by the Executive Director to be discussed at the next PPF in April 2019.

- **Long-Term Financial Sustainability and Deliver the Annual Financial Plan**
  Both these risks have been reviewed at FPBD in March and the current changes are highlighted on the BAF. The BAF risk; Deliver the Annual Financial Plan, has had its current risk score reduced to 10 and has met its planned risk score target.

- **Long Term Clinical Sustainability (Electronic Patient Record)**
  This risk has had a number of recent changes due to the current status of the development of EPR system. The changes are highlighted on the BAF.

- **Best Clinical Outcomes**
  The current risk score for this BAF risk has reached its target score. A discussion was held in the Quality Committee and a recommendation has been made to the Executive team for it to be cross referenced with the other BAF risks to identify if key issues are included in them and if so consider closing this risk for 2019/20.

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. Approve the changes made to the risks as recommended by the Board Committees;
2. note the assurance that the risks are being managed appropriately; and
3. advise the Governance team of approval /views in respect of the process, proposals and rationale.

2018/19 Live Board Assurance Framework – March 2019 – Version 10.7

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 • Engagement tool implemented • People Strategy revised and agreed	• 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	• Monthly monitoring • Monthly monitoring 2019 • Monthly monitoring 2019 • Feb 19 (revised date)
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		

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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	**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	• 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	• Monthly monitoring • Monthly monitoring • Monthly Monitoring
			Metrics • Exception reporting data • Monitoring exercise data • Absence data from Lead Employer • Whistleblowing reports	**Assurance Gaps** • None Identified		

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	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 • GMC Survey 2018 action plan in place		**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**

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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	• Revision of SOC following unsuccessful STP capital bid. • Clinical Summit to review and update clinical risk and outcomes. • Approval of revised capital route. • 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	• June 2019 • June 2019 • November 2019 • April 2020 ~~2019~~ (subject to approval of ~~wave 4 STP~~ capital bid ~~in December 2018~~) • July 2020 ~~2019~~ (subject to approval of wave 4 STP capital bid in December 2018) • December 2020 ~~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 2021-2026 ~~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		

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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	**Outcomes** • Delivery of control total in 18/19 • Delivery of £3.6m CIP for 18/19 • NHS I Use of Resources Risk Rating – 3		
			Independent / semi-independent • Monthly reports to NHSI with feedback • Internal audit review of budgetary controls • External audit opinion •			

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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**	Reduce to 2 from 3	5	**Reduce to 10 from 15**	2	5	**10**

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 • Await and review outcome of clinical senate (June 2019)	• Monthly monitoring (external lead) • April 2019 (revised date) • Monthly monitoring (NHSE lead) • July 2019

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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

Strategic Objective: To deliver **safe** services

Risk Appetite: Low

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 **Risks from Risk Register** • 3 x Corporate Risks • 11 x Service Risks	• 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 **Metrics** • Safe domain performance metrics • Incident reporting • Levels of patient harm • Quarter reports to CCG • Benchmarking through VON, EMBRACE **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	**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 **Outcomes** • CQC assessment from 2018 visit Safe as 'Good' across all areas of the Trust	• Fair and Just culture Project • Maintain close involvement with regional and local safety collaborative	• August 19 (Revised Date) • Monthly monitoring (revised date)

BAF 2018-19 Version 10.7

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 **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)	• 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 pilot commencing in April • Quality and independence of QIA's by DoN and MD • External peer reviews • Completion and Submission of Annual Quality Report • Exec and NED leads in place for key CQC areas • Patient Safety included in Exec , NED and senior staff walk rounds	• Benchmarking data can make the trust appear an outlier due to the specialist nature of the services provided and attract regulatory attention	**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 • As and when required

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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~~ proposed schedule ~~of October 2018~~ May 2020. 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 chaired by AUHT CEO and attended by executive directors, CIO and CCIO • ~~Monthly EPR meetings chaired by AUHT CEO with LWH Exec Dir representation.~~ • Governance structure for project in place with independent reviews (MIAA). • LWH Digital Hospital sub-committee review of project in place with DoF chairing • Oversight of programme by PFBD (inc NEDs). • 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 ineffectiveness ~~and requires top down focus~~ • Lack of confidence in plan • 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 initial programme plan • Clinical (operational) sign off • ~~Bi-weekly~~ Exec Team Briefings 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 • Report from NHS Digital (expected March 19) **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 • NHS Digital review (due March 19)	**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 in delivering the solution. **Outcomes** • Full clinically safe 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~~	• Review of NHS Digital findings (March 19) • Test System built and tested against clinically approved script with additional scrutiny and assurances around areas highlighted as a concern. • 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	• March 2019 • ~~Completed for Wave One elements, to complete for Wave 2 (requires the completion of the detailed ISC plan) TBC~~ • TBC 2020 • ~~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~~ • As part of above • ~~Strategy approved by programme board in March 2018 in readiness for deployment against plan.~~ • May 2020
Risks from Risk Register • 2024 – IM&T service risk						

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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 available benchmarking data due to nature of specialist services provide • 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 February 2019 (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		

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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. **Risks from Risk Register** • 2 x Corporate Risk • 13 x Service Risks	• 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 • All patient leaflet electronic with translation available. • New supervision policy for Nurses, MW and AHPs' agreed	• 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 • Insufficient quality of interpretation services • Access centre and bookings	**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) **Metrics** • Complaints data • PALS data • FFT Results • Staff survey engagement score • Vacancy / turnover levels • Safe staffing levels **Independent / semi-independent** • National Maternity Survey • National Inpatients Survey • Regulatory inspection	**Gaps** • Out of date policies • Telephone line services for booking and advice in GED and MAU • Insufficient quality of interpretation services **Outcomes** • Staff survey results awaited	• Policies Group to continue monitoring and working to reduce Out of date levels. • Ensure patient access and message system in place. • Review current service and commission replacement if required	• Ongoing • March 2019 • Review completed Jan 2019. Commissioning of new service due to commence 1st March 2019.

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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**