Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

Board of Directors Meeting

HELD IN PUBLIC

5 December 2019

Meeting of the Board of Directors
HELD IN PUBLIC
Thursday 5 December 2019 at 0930hrs
Liverpool Women's Hospital
Board Room

Item no. 2019/	Title of item	Objectives/desired outcome	Process	Item presenter	Time
191	Thank you	To provide personal and Team thank you – above and beyond			0930 (10mins)
192	Apologies for absence Declarations of interest	Receive apologies	Verbal	Chair	
193	Meeting guidance notes	To receive the meeting attendees' guidance notes	Written	Chair	
194	Patient Story - Maternity	To receive a patient's story	Verbal	Acting Head of Midwifery	0940 (20mins)
195	Minutes of the previous meeting held on 7 November 2019	Confirm as an accurate record the minutes of the previous meetings	Written	Chair	1000 (5mins)
196	Action Log and matters arising	Provide an update in respect of on-going and outstanding items to ensure progress	Written	Chair	
197	Chair's announcements	Announce items of significance not found elsewhere on the agenda	Verbal	Chair	1005 (10mins)
198	Chief Executive Report	Report key developments and announce items of significance not found elsewhere on the agenda	Written	Chief Executive	1015 (10mins)
BOARD COMMITTEE ASSURANCE					
199	Chair's Report from Quality Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	1025 (5 mins)
200	Chair's Report from Finance, Performance and Business Development Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	1030 (5 mins)
201	Chair's Report from Putting People First Committee	For assurance, any escalated risks and matters for approval	Written	Committee Chair	1035 (5 mins)
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					
202	Safeguarding Annual Report 2018/19	For assurance	Written	Director of Nursing & Midwifery	1040 (10mins)
TRUST PERFORMANCE - TO DELIVER THE MOST EFFECTIVE OUTCOMES; TO BE EFFICIENT AND MAKE BEST USE OF AVAILABLE RESOURCES					
203	Safer Nurse/Midwife Staffing Monthly Report period M7 2019/20	For assurance and to note any escalated risks	Written	Director of Nursing and Midwifery	1050 (10mins)

Item no. 2019/	Title of item	Objectives/desired outcome	Process	Item presenter	Time
204	Operational Performance Report period M7, 2019/20	For assurance –To note the latest performance measures	Written	Director of Operations	1100 (10mins)
205	Finance Report period M7, 2019/20	For assurance - To note the current status of the Trusts financial position	Written	Director of Finance	1110 (10mins)
206	Review of Headroom / Mandatory Training – Assurance Report	For assurance	Written	Director of Nursing and Midwifery	1120 (10mins)
207	Corporate Objectives 2019/20		Written	Chief Executive	1130 (5mins)
208	EPRR Annual Assurance Report	For assurance	Written	Director of Operations	1135 (5mins)
BOARD GOVERNANCE					
209	Board Assurance Framework 2019/20	For assurance and approval	Written	Trust Secretary/ Executive Lead	1140 (10mins)
210	Review of risk impacts of items discussed	Identify any new risk impacts	Verbal	Chair	1150 (5mins)
HOUSEKEEPING					
211	Any other business & Review of meeting	Consider any urgent items of other business	Verbal	Chair	1200 Meeting ends

Date of next meeting
Board in Public: 6 February 2020

Meeting to end at 1200

1200-1215	***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

Liverpool Women's

Meeting attendees' guidance, April 2019

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. At all times the members should be cognisant of the meetings Terms of Reference.

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 for issue 7 days before the meeting (see bullet 2 below under Standards and Obligations)
- 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. Please check Terms of Reference of the Committee on each committees requirement.

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 should be issued 7 days before the meeting. Any changes to this timeframe require the agreement of the Chair of the meeting.
3. The draft minutes, Chair's Report and action schedule will be prepared and circulated to all members of the meeting within 7 days following the meeting.
4. Chair and members are also responsible for the committee/ subcommittee's compliance with relevant legislation and Trust policies
5. It is essential that meetings are chaired with an open and engaging ethos, where challenge is respectful but welcomed
6. 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
7. 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 members of the committee.
8. 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
9. 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 Secretary
10. 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 escalating the concern to their line manager or if this is not appropriate to the Trust Secretary or via the Trusts raising concerns policy
11. 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 raising concerns 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
12. 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, following 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

Liverpool Women's NHS Foundation Trust

Board Agenda item 2019/195

Board of Directors

Minutes of the meeting of the Board of Directors
held in public on 7 November 2019
at Liverpool Women's NHS Foundation Trust, Crown Street Liverpool.

PRESENT

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

IN ATTENDANCE

Mr Paul Buckingham	Interim Trust Secretary
Mr Kevin Robinson	Deputy Head of Patient Experience
Mrs Clare Fitzpatrick	Head of Midwifery
Mr Christopher Lube	Head of Governance & Quality
Mrs Janet Brennan	Deputy Director of Nursing & Midwifery

APOLOGIES:

Ms Jo Moore	Non-Executive Director & Vice Chair

2019	
	Thank You **Sarah Woods, a member of the Learning & Development Team -** The Director of Workforce & Marketing congratulated Ms Woods on her recent achievement as Regional Winner in the Skills for Health 'Our Health Heroes Operational Support Worker' Awards. She advised the Board of Ms Woods' personal and professional development since joining the Trust as a Business Administration Apprentice at the age of 16 and noted that her efforts were also recognised by colleagues having received 4 recognition stars from staff in appreciation of her help and support. **Geoff Shaw, Kathy Smith and Jenny Lucas, members of the Education Team** – The Director of Workforce & Marketing noted receipt of a letter from the School of Medicine, University Liverpool thanking the team for their sterling efforts to ensure effective timetabling and noting their proactive approach in tailoring timetable displays to improve the student experience. **Rachel Gregoire, Stephanie Brooks, Jennifer Edge, Paul Mallanaphy, Cheryl Thomas and Amanda Hall, members of the Andrology Team** – The Director of Workforce & Marketing congratulated the team for their work in achieving UKAS accreditation for a fifth consecutive year. She advised that the Hewitt

	Fertility Centre had been assessed on the Diagnostic Andrology Service in May 2019 and that confirmation had recently been received on achievement of the UKAS Maintenance of Accreditation. She noted that the accreditation contributed to making the Diagnostic Andrology Service one of the furthest advanced laboratories nationally. Board members collectively congratulated all the members of staff on their successes and thanked them for their contributions to the work of the Trust.
159	**Apologies** – as above **Declaration of Interests** – Prof L Kenny informed the Board of her appointment as a University-nominated Non-Executive Director of Liverpool University Hospitals NHS Foundation Trust with effect from 1 October 2019. **Welcome:** The Chair formally opened the meeting and welcomed everyone present. He noted the recent announcement of a General Election to be held on 12 December 2019 and advised of the 'purdah' requirements during the pre-election period. He noted that, while Trusts were unable to announce significant strategy or policy initiatives during this period, the Board was able to consider and discuss subjects which were already in the public domain.
160	**Meeting guidance notes** The Board received the meeting attendees' guidance notes. *Mr K Robinson joined the meeting.*
161	**Patient Story** Mr K Robinson, Deputy Head of Patient Experience, joined the meeting to present a patient story on behalf of an individual who had experienced the loss of a baby. He advised that the Trust had received a letter from the individual which described the circumstances, and the individual's subsequent experiences, of a bereavement which occurred in 1978. Mr K Robinson briefed the Board on the significant impact that the circumstances surrounding the bereavement had had on the individual and noted the research undertaken by the Trust and the support provided to the individual. Mr K Robinson advised the Board that, with the agreement of the individual, the case was being used as a learning experience for both new and current staff to ensure an understanding of the potential implications where bereavement care is not provided effectively. He noted that the Trust remained in contact with the individual and was continuing to provide support where possible. The Chair noted that the subject of baby loss and the quality of support provided by staff was really important and advised those present of the Remembrance Service that had recently been held at St George's Hall. The Director of Nursing & Midwifery thanked Mr Robinson for his efforts and commitment in supporting the individual in the case described. In response to a question from the Director of Workforce & Marketing, Mr K Robinson advised that there was no time limit in relation to provision of support in cases involving loss of a child due to miscarriage. The Chair thanked Mr K Robinson for delivering such a moving patient story and requested that he express the Board's thanks to the individual for allowing his story to be shared and used for staff development purposes. *Mr K Robinson left the meeting.*
162	**Minutes of previous meeting** The Board of Directors reviewed the minutes of a meeting held on 5 September 2019. The Interim Trust Secretary advised that the first paragraph on page 2 should be amended to read "*The Director of Finance advised on the amazing things that the Trust had been involved in and achieved over the*

	last six years, referring to the Trust's status as a Global Digital Exemplar Fast Follower, working towards achieving HIMMS Level 5 and the incredible work in developing the Trust's cyber essentials infrastructure. The Director of Workforce & Marketing advised that minute reference 133 should relate to pre-employment students rather than apprentices. Subject to these amendments, the Board of Directors approved the minutes of the meeting held on 5 September 2019 as a true and accurate record.
163	**Matters arising and action log.** There were no matters arising. The Board of Directors reviewed the Action Log and the Medical Director advised that both outstanding actions had been completed. He confirmed that a Trust Research Committee had been established and, with regard to support for academic posts in hard to recruit specialties, the Board agreed that progress should be reported through the Quality Committee.
164	**Chair's Announcements** The Chair reported on the following matters: **Remembrance Service:** The Chair thanked all staff involved in organising the Remembrance Services held in St George's Hall on 14 October 2019. He noted that the services had been both moving and well-attended. **Non-Executive Director Network:** The Chair advised that, along with Mr I Knight, he had attended a Network event held in Leeds on 5 November 2019. He provided an overview of matters discussed at the event and noted in particular, consideration of recently published guidance relating to development and annual appraisals of NHS Provider Chairs. He advised that the guidance would be assessed in conjunction with Governors at the next meeting of the Nominations & Remuneration Committee. The Board noted the Chair's verbal update.
165	**Chief Executive's report** The Chief Executive presented her report and noted in particular that the Maternity Team had been highly commended by the Royal College of Midwives for their Newly Qualified Package and Preceptorship Programme. She advised of the importance of newly qualified midwives feeling supported in such a busy unit. The Chief Executive also noted that good progress was being made with the Neonatal Re-Development project with the project on-budget and subject to just minimal time slippage. At the invitation of the Chief Executive, the Medical Director briefed the Board on matters discussed during a meeting with Dr D Levy, North West Region Medical Director, held on 17 October 2019. He advised that the meeting had resulted in the establishment of a Quality Surveillance Group (QSG), comprised of system-wide representatives, which had met for the first time on 6 November 2019. In response to a question from the Chair, the Medical Director advised that, while support for the Trust had been expressed during the QSG meeting, no fundamentally new ideas had emerged from the meeting. The Medical Director noted a focus on how services could be delivered safely in the short to medium term in advance of relocation in the long term. The Director of Workforce & Marketing referred the Board to a Flu Campaign Update and Self-Assessment report. She briefed the Board on the content of the report and noted a vaccination rate to date of 34.2% for frontline staff. She advised that the Trust was expecting to take a further delivery of the vaccine on 8 November 2019. The Director of Workforce & Marketing referred the Board to a

	best practice management checklist included at Appendix 1 of the report and noted a requirement for Boards to endorse the completed checklist by December 2019. The Board of Directors: • Received and noted the Chief Executive's Report • Endorsed the Flu Vaccination Management Checklist and noted the assurance provided therein.
166	**Chair's Report from Quality Committee (QC)** Dr S Milner presented the Chair's Reports from meetings of the Quality Committee held on 23 September and 21 October 2019. She briefed the Board on the content of the reports and noted in particular the Committee's consideration of preparations for a forthcoming Care Quality Commission (CQC) inspection during the meeting held on 21 October 2019. Dr S Milner advised that the Committee had requested a follow-up report on Neonatal Mortality for its next meeting and noted that the Clinical Case for Change was now a standing agenda item for the Committee. She concluded her report by noting work to ensure effective management of agenda time and prioritisation of the Committee's work plan. In response to a question from the Chair, Dr S Milner briefed the Board on the development of new entries for the Board Assurance Framework (BAF) relating to; Seven Day Services, Networked Maternal Medicine and Gynaecology Oncology Consultants which were expected to be added to the BAF, subject to Board approval, in December 2019. The Board of Directors: • Received and noted the Chair's Reports from Quality Committee meetings held on 23 September and 21 October 2019.
167	**Chair's Report from Finance, Performance and Business Development Committee (FPBD)** Mr P Huggon presented the Chair's Reports from meetings of the Finance, Performance and Business Development Committee held on 23 September and 21 October 2019. He briefed the Board on the content of the report and noted in particular ongoing work relating to resolution of funding for Liverpool Neonatal Partnership developments. The Director of Operations advised that this subject would be considered further at a meeting with Specialist Commissioners scheduled to be held later in the month. The Board of Directors: • Received and noted the Chair's Reports from Finance, Performance & Business Development Committee meetings held on 23 September and 21 October 2019.
168	**Chair's Report from Putting People First Committee (PPF)** Mr T Okotie presented the Chair's Report from a meeting of the Putting People First Committee held on 23 September 2019. He briefed the Board on the content of the report and noted in particular the Committee's consideration of a report regarding the Leadership Development Programme. He advised that, while the Committee had been assured that the programme remains active, concerns had been expressed in relation to levels of participation and attendance at programme meetings. In response to a question from the Chair, the Director of Workforce & Marketing confirmed that an appropriate element of relief had been included in budgets for 2019/20 but advised that levels of attendance had not improved.

	Mr T Okotie noted an inherent link with levels of mandatory training compliance which he noted were improving, albeit slowly. In response to questions from the Chair, the Chief Executive advised that this matter was being addressed through Divisional Performance Reviews and noted the expectation of a return on investment in relation to the funding of additional hours. The Director of Nursing & Midwifery confirmed that all areas had trajectories for improvement and advised that no Divisions had identified any particular barriers to improvement. The Chief Executive commented on the potential need to consider measures available through Agenda for Change and the need to effectively hold leaders and individuals to account. She also emphasised that individuals had both a personal and professional responsibility to complete mandatory training requirements. Mr T Okotie concluded his report by noting that the Committee had requested an assurance report on the practical steps to address sickness absence performance for consideration at its next meeting. The Board of Directors: • Received and noted the Chair's Report from the Putting People First Committee meeting held on 23 September 2019.
169	Chair's Report from Audit Committee Mr I Knight presented the Chair's Report from a meeting of the Audit Committee held on 21 October 2019. He briefed the Board on the content of the report and noted in particular the Committee's consideration of a Waiver Report for Quarter 2 which provided information on the trends relating to instances of waiver requests. Mr I Knight advised that the Committee had reviewed a comprehensive on the subject of the transactional processes relating to Charitable Funds and had recommended that the report also be presented at the next meeting of the Charitable Funds Committee. The Board of Directors: • Received and noted the Chair's Report from the Audit Committee meeting held on 21 October 2019.
170	Clinical Summit Outcomes The Medical Director presented a report which detailed outcomes from a Clinical Summit held on 11 June 2019. He briefed the Board on the content of the report and provided an overview of outcomes relating to: • Networked Maternal Medicine Services (NMMS) • Gynaecological Oncology • Age Profile of Consultants at the Trust With regards to NMMS, the Medical Director advised that the Trust was not in a position to comply with the national standards required for a Maternal Medicine Centre and noted a joint bid submitted based on a MMC at Saint Mary's Hospital, Manchester and two 'sub-hubs' one of which would be at Liverpool Women's Hospital. The Chair noted that it was disappointing that the Trust was unable to satisfy the MMC requirements and commented on the need for a pragmatic approach to the sub-hub proposals. In response to a question from Mr P Huggon, as to whether the sub-hub arrangement would weaken the Trust's position in the longer term, the Medical Director advised that the MMC, or full hub, was likely to attract the best Consultants with a potential impact on Trust reputation. He also noted the impact on a discrete number of patients who may be required to travel to Manchester for care in the future. Prof L Kenny advised that it was incredibly depressing for services in Liverpool to be diminished in this way and noted that, while patient numbers be may be relatively low, the patients

	would often be from the most vulnerable and marginalised section of society. She also advised that the arrangements would have a huge impact on the Trust's ability to attract the best Maternal Medicine specialists. In response to a question from Mr I Knight, the Medical Director advised that the standards relating to MMCs were based on the best interests for patient care and noted that, from a Trust perspective, co-location was essential to achieve compliance. The Chief Executive endorsed the comments made by Prof Kenny and noted that the potential impact on women in the city should not be underestimated. She advised that during a meeting held with NHS England on 6 November 2019, she had requested clarification of the requirements for the Trust to proceed with public consultation on the Future Generations strategy. She noted that no response had been received to date. Mr T Okotie suggested that the current small cohort of affected patients could be the tip of an iceberg. Prof L Kenny advised that recruitment issues could result in further services being moved elsewhere with a consequent impact on a significantly greater number of patients. In response to a question from Mr P Huggon, the Medical Director advised that the sub-hub proposal was the best short-term solution available and the Chief Executive noted that the situation would continue until such time as the Trust was able to relocate. Mr I Knight commented on the need for a system approach as the issue affected the city and the wider Cheshire and Merseyside area rather than simply the Trust. In response to a question from the Chair, the Medical Director briefed the Board on work being undertaken to establish a Partnership Board with Liverpool University Hospitals NHS Foundation Trust which would formalise operational relationships and consider potential future service developments. He explained how representation on the Partnership Board and reporting arrangements would ensure contact with the wider Cheshire & Merseyside system. In response to a question from Dr S Milner, regarding engagement with the Health & Wellbeing Board and Overview & Scrutiny Committee (OSC), the Chief Executive confirmed that the Trust had engaged with the OSC. She noted that there was a good level of support for the Trust's position across the city and from local politicians but advised that public consultation was a key next step. The Medical Director concluded his report by providing an overview of measures to maximise recruitment and retention of Consultants based on optimising both the professional and personal offer to individuals. The Board of Directors fully endorsed this approach. The Board of Directors: • Received and noted the Clinical Summit Outcomes report • Supported the establishment of the Trust as a MMC sub-hub • Supported further development of partnership working with Liverpool University Hospitals NHS Foundation Trust • Endorsed the principles behind a review of recruitment and retention for senior medical staff. *Mrs C Fitzpatrick and Mr C Lube joined the meeting.*
171	Learning from Incidents Report Mr C Lube, Head of Governance & Quality, presented a report which provided the Board with assurance that learning was being identified as a result of incidents and that learning was subsequently disseminated across all relevant Trust areas. He briefed the Board on the content of the report and noted in particular the themes arising from incidents and the actions taken in response to these themes. He then referred the Board to Appendix 1 of the report and provided an overview of incidents and learning identified by Division.

	Mrs C Fitzpatrick, Head of Midwifery, delivered a presentation which provided an overview of the approach adopted for learning from incidents in the Maternity department together with examples of learning applied. She also noted arrangements in place to ensure that the Trust was able to learn from experiences in other organisations. The Director of Nursing & Midwifery commented on expansion of the 'Learning of the Week' section of the Trust's intranet and noted the use of 7-minute briefings to disseminate learning in a simple and easy to understand format. Dr S Milner noted the walk arounds undertaken by Non-Executive Directors and advised that questions asked of staff during the walk arounds regarding lessons learned suggested that not all staff were aware of how such information was disseminated. The Director of Nursing & Midwifery acknowledged these comments and advised that a focus on lessons learned practice and dissemination of information was a key element of the role of a recently appointed Risk & Safety Manager. The Director of Operations noted the reference to Fair and Just Culture in the presentation and commented on the need for consideration during the next planning round of how this could be operationalised. Mr T Okotie advised that he was heartened by the adoption of a multimedia approach and the focus to be provided by the Risk & Safety Manager but queried how the Board could be confident of what good looks like. Mrs C Fitzpatrick commented on connecting the application of learning to clinical outcomes and the Medical Director noted the need for assurance that learning was sufficient to ensure that an event in one area was not repeated in another area. The Chair thanked the Director of Nursing & Midwifery for the information provided in the report at the request of the Board and suggested that the matter of learning from incidents should be a standard line of enquiry during consideration of reports by the Quality Committee. Board members endorsed this suggestion. The Board of Directors: • Received the Learning from Incidents report and noted the assurance provided. *Mrs C Fitzpatrick and Mr C Lube left the meeting.*
172	Freedom to Speak Up - Self-Assessment The Director of Workforce & Marketing presented a report which detailed a Freedom to Speak Up (FTSU) Self-Review Tool and associated Trust action plan. She briefed the Board on the content of the report and noted development of a FTSU Strategy which would be the subject of consideration by the Board during its Workshop session on 9 January 2020. The Chair acknowledged that Board members would have the opportunity to discuss the FTSU Strategy in detail at the workshop session and commented on the need to look beyond the 'tick box' approach implied by reliance on the Self-Review Tool. The Board of Directors: • Received the report and noted the assurance provided on compliance with national guidance for Freedom to Speak Up processes • Agreed that progress against the Freedom to Speak Up action plan would be monitored by the Putting People First Committee.
173	Safer Nurse / Midwife Staffing Monthly Report The Director of Nursing & Midwifery presented a report which detailed Ward Staffing levels across all inpatient clinical areas during August and September 2019. She briefed the Board on the content of the report and noted in particular a focus on recruitment for staffing Theatres. She also advised that challenge relating to effective rostering had been incorporated into Divisional Performance Reviews.

The Board of Directors:

- Received and noted the Safer Nurse / Midwife Staffing Monthly Report.

174 **Operational Performance Report Month 6, 2019/20**

The Director of Operations presented the Operational Performance Report for Month 6 2019/20. He briefed the Board on the content of the report and provided an overview of performance against key national standards as detailed at s2 of the report. The Director of Operations advised the Board of capacity issues impairing performance against Referral to Treatment (RTT) and Cancer standards and noted the recruitment initiatives in place to address these issues. In response to a question from Mr T Okotie, the Director of Operations advised that data for October 2019 suggested that the downturn in 104-day Cancer Standard performance in Month 6 was a one-off spike rather than a trend of deteriorating performance.

The Medical Director advised the Board that job plan adjustment had been undertaken to mitigate Consultant capacity issues but noted that the loss of further individuals presented a risk that care could be compromised. In response to a question from the Chair, regarding capacity in other Centres, the Medical Director explained the factors which made local support difficult but acknowledged that 'what if' scenarios would need serious consideration. With regard to recruitment, Prof L Kenny commented on the continuing difficulty of attracting suitable individuals to work at the Trust due to the reasons discussed earlier in the meeting. The Chief Executive acknowledged these comments and noted the need to progress a joint appointment approach with Liverpool University Hospitals NHS Foundation Trust. In response to a follow-up question from Prof L Kenny, the Medical Director explained how the current reduced cohort of Consultants were able to remain sighted on wider patient pathways.

The Board of Directors:

- Received and noted the Month 6 Operational Performance Report.

175 **Financial Report & Dashboard Month 6, 2019/20**

The Director of Finance presented the Finance Report and Financial Dashboard for Month 6, 2019/20. She briefed the Board on the content of the report and advised that at Month 6 the Trust was reporting a deficit of £1m against a deficit budget of £1.2m, giving a year to date favourable variance of £0.2m. She noted that the Trust remained on plan to achieve a breakeven position for the financial year.

The Director of Finance referred the Board to s3 of the report and provided an overview of performance against the Cost Improvement Programme for the year and noted that the Trust remained on plan to deliver the full value of the CIP programme for 2019/20. She also noted that the Finance, Performance & Business Development Committee had considered the outcomes of a post-implementation review of CIP schemes during a meeting held on 21 October 2019 and advised that outcomes from the review were generally positive with no areas for concern identified. She advised that a post-implementation review would also be undertaken at year-end.

The Director of Finance then referred the Board to s2 of the report and noted agency spend in excess of budget for the year to date with a consequent risk that the agency cap for 2019/20 would be breached. She advised that actions were in place to mitigate this risk and noted that the implications of a breach had been considered by the Finance, Performance & Business Development Committee on 21 October 2019. Mrs T Ellery noted that breach of the agency cap could affect the Trust's financial risk rating and queried whether the Director of Finance had any concerns in relation to the profiling of CIP schemes over the remainder of the financial year. The Director of Finance advised that she was not expecting any issues relating to CIP scheme profile. In response to a question from Mr I

	Knight, the Director of Finance advised that the level of non-recurrent savings in the programme was relatively modest and was not a cause for concern. The Board of Directors: • Received and noted the Month 6 Financial Performance Report. *Mrs J Brennan joined the meeting.*
176	**Nursing, Midwifery and Allied Health Professions Strategy** Mrs J Brennan, Deputy Director of Nursing & Midwifery presented a report seeking approval of a Nursing, Midwifery and Allied Health Professions Strategy. She briefed the Board on the content of the report and provided an overview of the engagement undertaken in development of the Strategy over the previous six months. Mrs J Brennan advised that the draft Strategy had been reviewed by the Putting People First Committee on 23 September 2019 and noted that the current draft incorporated amendments suggested by the Committee. Mr T Okotie confirmed that the current draft included amendments made subsequent to review by the Committee. Dr S Milner noted the extensive list of key performance indicators detailed in the Strategy document and suggested that some could be common to other Trust strategies. She commented on the need to avoid duplication. The Chief Executive referred to the National Context section of the document and advised that job titles should be used rather than names of individuals in order to maintain currency of the document. The Board of Directors: • Approved the Nursing, Midwifery and Allied Health Professions Strategy, subject to the amendment suggested by the Chief Executive. *Mrs J Brennan left the meeting.*
177	**Board Assurance Framework** The Interim Trust Secretary presented the Board Assurance Framework 2019/20. He briefed the Board on the content of the report and noted the inclusion of a Dashboard which summarised the current position for each of the eight BAF risks. The Chair noted that risk ratings for individual BAF entries remained stagnant at the mid-point of the year and queried whether the target risk scores continued to be realistic. It was agreed that this matter would be the subject of consideration during review of the Board Assurance Framework by relevant Committees in November 2019. The Board of Directors: • Received Board Assurance Framework and confirmed that the Board Assurance Framework adequately identified the principal risks to achieving the Trust's strategic objectives.
178	**Review of risk impacts of items discussed** The Board noted the following identified during the meeting: • Clinical safety issues detailed in the Clinical Summit Outcomes report • Mandatory Training and Sickness Absence performance • Recruitment and Retention of Consultants With regards to Mandatory Training, the Chief Executive noted that the Board had agreed to review investment in capacity in the context of performance and suggested that an assurance report on this

	subject be provided at the Board of Directors meeting on 5 December 2019. The Board of Directors endorsed this suggestion.
179	**Any other business & Review of meeting** There was no other business.
	Date of next meeting The Chair reported that the next meeting of the Board of Directors in public would be held on 5 December 2019.

TRUST BOARD
5 December 2019
Action Plan

Meeting date	Minute Reference	Action	Responsibility	Target Dates	Status
7 Nov 2019	2019/178	With regards to Mandatory Training, the Chief Executive noted that the Board had agreed to review investment in capacity in the context of performance and suggested that an assurance report on this subject be provided at the Board of Directors meeting on 5 December 2019. The Board of Directors endorsed this suggestion.	Director of Workforce & Marketing	In Progress	*Arrangements are currently being put in place with the Director of Research and Development. An update on progress will be made at the Quality Committee on 23 September 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

Liverpool Women's NHS Foundation Trust

Agenda Item	2019/198

MEETING	Board of Directors
PAPER/REPORT TITLE:	Chief Executive's Report
DATE OF MEETING:	Thursday, 05 December 2019
ACTION REQUIRED	Information
EXECUTIVE DIRECTOR:	Andrew Loughney, Medical Director
AUTHOR(S):	Paul Buckingham, Interim 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 clinical 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) ……* ☒
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 receive 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.

Report

SECTION A – Internal

Care Quality Commission (CQC) - Well Led Review: The Trust received formal notification from the CQC on 18 November 2019 that a Provider level inspection of 'Well Led' will be undertaken between Tuesday, 14 January and Thursday, 16 January 2020. As a minimum, the following staff members will be interviewed as part of the inspection:

- Chairman
- Chief Executive
- Medical Director
- Director of Nursing & Midwifery
- Director of Finance
- Director of Operations
- Director of Workforce & Marketing
- Non-Executive Directors
- Chair of the Audit Committee

- Freedom to Speak Up Guardians
- Guardian of Safe Working Hours
- Focus Group of Governors

At some point prior to the Well Led Inspection, the CQC will also carry out an unannounced inspection of at least one core service and the Trust can expect a phone call approximately 30 minutes before the inspection team arrives on site.

Managing Conflicts of Interests: Senior Decision-Making staff i.e. staff at Band 7 and above and all Medical staff are required to make declarations on Conflicts of Interests, including nil returns, on an annual basis. The annual declaration process has now commenced and will be coordinated by the Interim Trust Secretary. Declaration forms, together with Q&A guidance for various staff groups published by NHS England, are available on the Trust's Intranet site. Full registers, including entries where individuals fail to make declarations, will subsequently be published on the Trust's website. Board members should note that, regardless of the annual process for senior decision-makers, the Trust's Managing Conflicts of Interests Policy requires all staff to declare any interests and/or offers of gifts, hospitality and sponsorship as soon as they arise and within 28 days at the latest.

Division of Family Health:

a) **Head of Midwifery - Secondment:** Mrs Clare Fitzpatrick, Head of Midwifery, recently commenced a six-month secondment with NHS England with a focus on projects aimed at the transformation of Maternity Services. Cover arrangements during the secondment period are as follows:

    - Ms Sue Orchard – Acting Head of Midwifery
    - Ms Alison Murray, Acting Deputy Head of Midwifery

b) **Delivery Suite Estate:** A task and finish group has recently commenced work to review the current estate within the Delivery Suite in order to increase the bed complement in this area. It is anticipated that outcomes from the work of the group will result in significant improvements to the facilities available to our women/babies and their families.

c) **Neonatal Re-Development:** The new-build project continues to progress well with the overall programme subject to just a 2-3 week slippage, with the potential that this could be recovered over the remainder of the build programme.

Clinical Support Services Division:

a) **Adult Resuscitation Trolley:** A new Adult Resuscitation Trolley was introduced to all Trust areas from 27 November 2019. 'Drop-in' sessions for staff familiarisation with the new equipment took place each day during week commencing 25 November 2019.

Gynaecology:

a) **Stop the Pressure Ulcer Day:** Staff in the Gynaecology Division supported a Stop the Pressure Ulcer Day which took place on 21 November 2019.

b) **Staffing:** A Pregnancy Loss Link Nurse position has been established on the Gynaecology Ward and two cancer support workers have been appointed to support patients on their cancer pathway.

SECTION B – Local

Chair's Communication: The first of what will be regular Communications from Alan Yates, Chair of the Cheshire and Merseyside Health and Care Partnership was received by the Trust on 14 November 2019. A copy of the Communication is included for information at Appendix 1 to this report.

SECTION C – National

There are no significant national developments to report for November 2019.

Cheshire & Merseyside
Health & Care Partnership

14 November 2019

Dear colleague,

First of all, I'd like to begin by saying thank you to everyone who has been so welcoming, it has been great to start in the last week or so as Chair of the Cheshire and Merseyside Health and Care Partnership. I'm looking forward to working with all of you and getting to know everyone better.

Secondly, I'd like to congratulate our partners who won, were highly commended and shortlisted for awards in the Health Service Journal annual awards last week. I was pleased to see such a good showing from across Cheshire and Merseyside which includes;

Shortlisted

- Patchwork and Aintree University Hospital FT - Driving Efficiency Through Technology
- St Helens and Knowsley Teaching Hospitals Trust - Reservist Support Initiative Award
- University of Chester: Westminster Centre for Research in Veterans - Military and Civilian Health Partnership Award
- Wellbeing Enterprises CIC and North West Boroughs Healthcare FT - Community or Primary Care Service Redesign - North/Midlands/East
- Mersey Care FT - Mental Health Innovation of the Year
- Cheshire and Wirral Partnership FT - Mental Health Provider of the Year

Highly commended

- Wellbeing Enterprises CIC and North West Boroughs Healthcare FT - Community or Primary Care Service Redesign - North/Midlands/East

Winners

- South Cheshire CCG - Connecting Services and Information Award
- St Helens and Knowsley Teaching Hospitals Trust - Acute or Specialist Trust of the Year

I think recognition of great work is really important and I know there is so much innovative and inter-dependent work taking place in this region. I will be trying to make sure we celebrate and share the good work being done and not concentrate only on the problems we face.

As excited as I am about the agenda partners have established about reducing health inequalities, the importance of localities, the emphasis on good health, the benefits of cooperation and the principle of subsidiarity, I need to adopt some personal discipline from the outset. This will involve concentrating at the start on governance, structure, systems and processes. We are trying to do a very complicated and sometimes difficult thing and it is vitally important that we are orientated, clear and motivated to make our contribution. At least a part of the circumstances that enable that is our agreed approach to governance and a good memorandum of understanding.

I plan to adopt an inclusive approach which will encourage cooperation and discourage isolationism. I am clear that we do not want a vast centralised bureaucracy, but I am also clear that most things we do have a degree of inter-dependence. Governance is a case in point, we need systems which allow for different perspectives to be brought into the debate and be heard before we finalise decisions. I am grateful to Simon Barber who has been working on our behalf to develop governance proposals for the Partnership, they will be ready in mid-December. We will have the opportunity to discuss

them further at the System Management Board on 18th December and then bring them back to the January Board for decision.

I am now looking to establish the next Executive STP lead role, I will work with the partnership members to assess what we need from this role going forward. Whilst we undertake this work, I am delighted to say that Sam Proffitt has agreed to remain the interim STP lead.

I am going to spend most of my time before Christmas getting out of the office, visiting partners in their places, to find out more about what is important to us and how we might go about making progress on those issues. If, as I get out, I haven't got to you and you have a pressing issue, please feel free to contact me.

I look forward to meeting as many of you as I can and working with you in the future.

Regards,

Alan Yates
Chair
Cheshire and Merseyside Health and Care Partnership

Liverpool Women's NHS Foundation Trust

Board of Directors

Committee Chair's report of Quality Committee meeting held 25 November 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 received assurance that the risks attributed to the Committee were being managed appropriately. Last month the Committee reported on the preparation of three new risk entries for inclusion on the Board Assurance Framework in November 2019. This was an error, and the Committee was advised that risks relating to Seven Day Services, Networked Maternal Medicine and Gynaecology Oncology Consultants have been included in the Corporate Risk Register rather than the Board Assurance Framework.

~ **Subcommittee Chairs reports**: The Committee received Chair's Reports from the Safety Senate, the Experience Senate and the Hospital Safeguarding Board. There were no new risks escalated to the Committee for review.

~ **Future Generations Project Group**: The Committee received a report which detailed establishment of a Future Generations Project Group together with draft Terms of Reference for the Group. The Committee considered the role of the Group and agreed that reports summarising business conducted at the fortnightly meetings of the Group would be presented to the Quality Committee. The Committee approved the Terms of Reference for Future Generations Project Group.

~ **Clinical Case for Change**: The Medical Director presented two reports relating to Onsite Adult Mitigations and a draft Counterfactual Clinical Case. With regard to the former, the Committee noted that the report had previously been considered by the Board of Directors on 7 November 2019 and was updated on work to prepare business cases on potential developments relating to a Blood Bank, MRI/CT Scanner and a Diagnostics Suite for inclusion in 2020/21 planning round. The Committee reviewed the draft Counterfactual Clinical Case and agreed that an independent clinical peer review of document content should be arranged once the content is further developed. The need for internal clinical agreement on the detail in the document was also noted in order to facilitate financial costing and planning. The Committee agreed to review the next iteration of the draft document in January 2020.

~ **Quality and Regulatory Update:** The Committee noted that the Care Quality Commission (CQC) will undertake a Well Led Review inspection from 14-16 January 2020 and the Committee was briefed by the Director of Nursing & Midwifery on preparations for both the Review and an unannounced inspection of core services which will take place prior to the Well Led Review. The Director of Nursing & Midwifery also presented a report that detailed the current position on six outstanding actions from the 2018 Care Quality Commission (CQC) inspection, all of which remain amber-rated.

NHS

- **Local Safety Standards for Invasive Procedures (LocSSIPs) Update Report:** The Deputy Medical Director presented a report and supporting slide set which detailed progress with compliance against relevant LocSSIPs requirements. The Committee acknowledged the Moderate Assurance provided by an earlier Internal Audit review but agreed that the data presented provided insufficient assurance on the level of progress made to improve compliance. The Deputy Medical Director briefed the Committee on measures being taken to improve compliance and advised that a significant improvement was expected in the next two months. The Committee requested a further assurance report for its meeting on 27 January 2020.

- **Electronic Patient Record (EPR) Update:** The Director of Finance briefed the Committee on the current position with the EPR project and advised that an updated assessment of risks relating to the use of multiple systems had been prepared for consideration by the Digital Hospital Sub-Committee on 27 November 2019. The Committee emphasised the need for clear and effective communication with staff on matters relating to EPR and use of multiple systems.

- **Monthly Quality Performance Review M7 2019/20:** The Committee received an update on Operational Performance at Month 7 2019/20 together with performance against the suite of Quality Indicators. The Committee noted that performance against both the Referral to Treatment (RTT) standard and Cancer standards continued to be challenging. The Director of Operations briefed the Committee on the actions being taken to address capacity and demand issues but the Board should be aware that these are not expected to result in a material improvement in performance in the short term.

- **Corporate Objectives 2019/20 – Six Monthly Review:** The Committee received a report which detailed progress against the Quality-related Corporate Objectives for 2019/20. The Committee endorsed the position set out in the report for each of the objectives which will be incorporated in a consolidated report for consideration by the Board of Directors on 5 December 2019.

- **Adult Mortality & Perinatal Quarterly Report (Quarter 2):** The Committee received and noted a report from the Deputy Medical Director which provided detail of the oversight and assurance monitoring of the mortality rates related to the clinical activity of the Trust.

- **National Inpatient Survey - Cancer:** Ms Dawn Grey, Lead Cancer Nurse, joined the meeting to present a report detailing outcomes of a National Cancer Survey based on a cohort of patients that had undergone treatment at the Trust during the period April-June 2018. The Committee noted the outcomes from the survey and Ms D Grey provided an overview of progress against the associated action plan.

- **Quality Strategy Progress Report:** The Committee took positive assurance from a report which detailed progress against Quality Strategy indicators as at Quarter 2 2019/20. The Committee noted that all indicators were green-rated with the exception of just one indicator which was amber-rated. This related to 'Unplanned Admissions and Readmissions' and the Committee was advised of work to ensure that a green-rating is achieved for this area by March 2020. The Committee was also briefed on progress with the preparation of a revised Quality Strategy and will be reviewing a draft strategy document at its meeting on 27 January 2020.

- **Integrated Governance Assurance Report (Quarter 2):** The Committee considered a report that detailed the position at Quarter 2 in relation to; Serious Incidents, Incidents, Lessons Learned from Incidents, Complaints, Claims and Clinical Audit. The Committee received and noted the report and welcomed the inclusion of additional narrative relating to Lessons Learned.

- **Equality & Human Rights Goals 1 and 2 (Quarter 2):** The Committee took positive assurance from a report which detailed the Quarter 2 position against patient-focused goals with each of the nine areas green-rated as at 30 September 2019.

3. **Board Assurance Framework (BAF) risks reviewed**
   No changes to existing risks were identified.

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

5. **Issues to highlight to Board**
   Board members should note the Committee's concerns in relation to LocSSIPs compliance and the request for a further assurance report for its meeting on 27 January 2020.

6. **Action required by Board**
   None

Susan Milner
Chair of Quality Committee
25 November 2019

Board of Directors

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

1. Was the quorate met? Yes

2. Agenda items covered

~ Operational Performance Month 7 2019/20 including RTT and Cancer Targets: The Committee received a report on Operational Performance as at Month 7 2019/20 and noted the position in relation to performance against RTT and Cancer standards continues to be challenging. With regard to Cancer performance, while the standard for Two Week Waits was again comfortably achieved, performance against both the 31 Day and 62 Day standards fell far short of required levels. The Committee was briefed by the Director of Operations on actions being taken to improve performance but acknowledged the limitations relating to current consultant numbers. RTT performance of 83% was marginally below the improvement trajectory which aims to achieve 92% standard by the spring of 2020.

~ Finance Performance Review Month 7 2019/20 including CIP: The Committee received a report on the Month 7 finance position noting that, as at 31 October 2019, the Trust was reporting a deficit position of £0.8m against a planned position of £0.9m and a favourable variance of £0.1m. The Trust continues to forecast delivery of the breakeven control total. The Committee was assured of continued strong performance against the cost improvement programme in Month 7 and the programme remains on track for full delivery in 2019/20. In reviewing Divisional performance, the Committee welcomed the recent improvements in the financial position made by Gynaecology with actions taken by divisional management having a positive effect. In its report to the Board on 7 November 2019, the Committee had identified a risk in relation to a potential breach of the agency cap for 2019/20. The Committee is now able to report that the level of risk has reduced as a result of actions to control agency expenditure and the current forecast is that expenditure for the year will be within the agency cap limits. The Committee will continue to closely monitor this position. The Committee was advised of a challenge relating to the Trust's ability to realise capital expenditure of the remaining four months of the year. The Committee noted imminent approval of business cases to effect expenditure and was assured that contingency schemes are in place for re-prioritisation if necessary. The Committee discussed associated implications for the cash position and will be considering the quarterly Treasury report at its meeting in January 2020.

~ Future Generations Programme Update: The Committee received a comprehensive update report on the Future Generations Programme from the Director of Finance which provided a summary of the current status of work across the various elements of the programme. The Committee noted in particular the work being undertaken on development of the key clinical issues, with the aim of presenting a final version of the document to the Board of Directors for approval during Quarter 4 2019/20, and emphasised the importance of detailed plans to facilitate accurate costing and financial planning.

Capital Funding: The Director of Finance presented a report which detailed the current status of capital funding to support the Trust's Future Generations plans.

~ Corporate Objectives 2019/20 – Six Month Review: The Committee received a report which detailed progress against the finance and performance-related Corporate Objectives for

2019/20. The Committee endorsed the position set out in the report for each of the objectives which will be incorporated in a consolidated report for consideration by the Board of Directors on 5 December 2019.

~ **Neonatal Capital Build Programme:** The Committee noted that good progress continues to be made on the Capital Build which continues to be on-budget and with just a marginal 2-week slippage against build timescales.

~ **IM&T Update:** The Director of Finance provided a verbal briefing on IM&T matters and noted preparation of a report for the next Digital Hospital Committee meeting relating to the management and mitigation of risks associated with multiple systems.

~ **Liverpool Neonatal Partnership:** The Director of Operations presented a report which provided an update on the Liverpool Neonatal Partnership and the Committee was assured that there are currently no significant operational concerns and that there continues to be good, collaborative relationships between the partners. However, as previously reported to the Board, a resolution to future funding of the arrangements has yet to be identified. The Committee noted that work continues with Specialist Commissioning colleagues to resolve this matter.

~ **Board Assurance Framework (BAF):** The Committee reviewed the risks that it was accountable for within the BAF and agreed that no amendments were required. With regards to risk scores, the Committee agreed that the current and target risk scores for BAF content generally should be reviewed by the Executive Team.

~ **Sub Committee Chairs reports received:**
- Digital Hospital Committee. The Committee approved revised Terms of Reference.
- Information Governance Committee.

3. **Board Assurance Framework (BAF) risks reviewed**
No changes to existing risks were identified.

4. **Escalation report to the Board on Performance Measures**
None –note RTT and Cancer referred above.

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

6. **Action required by Board**
No actions required.

Jo Moore
Chair of FPBD Committee
25 November 2019

BOARD OF DIRECTORS

Chair's report of Putting People First Committee held on Monday 25 November 2019

1. Was the quorate met? Yes/

2. Agenda items covered:

Board Assurance Framework – **Workforce Risks** – The Committee noted the additional controls to Risk 2294 and noted that no risks had been added or closed.

Neonatal Services Workforce Review – The Committee received the workforce review for Neonatal Services, noting an overall positive year, with strong recruitment activity in both medical and nursing, and evidence of succession planning. Sickness had increased slightly but was being effectively managed with evidence of a person-centred approach to the management of long-term absence having a positive impact on morale and engagement. A new approach to staff engagement and teambuilding had been adopted to good effect. The new build was progressing well and the service was actively planning for working differently in the new-build environment at Liverpool Women's and the developing partnership working with Alder Hey for surgical pathway neonates. The Committee encouraged the sharing of good people practice in Neonatal Services across the wider Trust workforce.

Staff Story – Kirsty Cassidy, a Band 6 Neonatal Nurse, presented an impactful and moving insight into a day in the life of a neonatal nurse at Liverpool Women's.

Director of Workforce Report – The following issues were highlighted

- Pension Tax – Trusts had been encouraged by NHSI/E to put in place local arrangements to mitigate the impact of Pension Tax charges; LWH already had such a policy in place. This was followed by a further announcement by NHSE/I advising that clinical staff impacted by Annual Allowance charges should use the Scheme Pays option with their pension pot being replenished by the NHS.
- Summer of Listening – feedback from a series of listening events with staff held over the summer to inform the ongoing development & delivery of the LWH People Plan

Workforce KPI Report – The Committee received the KPI report.

- Sickness had increased in month (6.24% against target of 4.5%). The Committee to spend some focused time on actions to address at Divisional level at next meeting.
- Turnover – no areas of concern with turnover at 9% against a target ceiling of 13%
- Mandatory Training – The Committee received a detailed report on the action taken to ensure accuracy of data and the move to Power BI reporting which allowed for ease of access to data for local managers. Performance demonstrated an improving trend in both core and clinical mandatory training. Divisions had clear trajectories to achieve compliance by year end which would be monitored monthly at Executive led monthly Divisional Performance Reviews. (Core 90% against target of 95%; Clinical 80% against target of 95%)
- PDR compliance also demonstrating an improving trend and would be monitored via monthly Divisional performance reviews. (88% against a target of 90%)
- Internal Audit Report – Gained assurance of the progress being made against Audit Action plan for Mandatory Training with quarterly review audits planned to commence in January.

Guardian of Safe Working Hours Quarterly report – Committee assured doctors in training were working to compliant rotas and shift patterns.

HENW GMC Survey Results 2019 – Committee noted the feedback from the GMC Survey and the actions outlined to improve the experience and access to training of junior doctors. The action plan to be monitored via the Education Governance Committee

Equality Delivery System 2 Assessment Results & Plan – Committee noted the positive progress made against EDS objectives and were assured that the Trust had complied with its statutory reporting duties. The Committee also endorsed the actions proposed following the analysis of the Trust's Workforce Race Equality and Disability Schemes. Work was underway to commission external support for the Equality agenda moving forward.

Corporate Objectives – The Committee were assured that good progress was being made against each of the Corporate objectives aligned to the Committee.

Health & wellbeing/Attendance Improvement Committee – The Committee noted the work of the Committee, specifically the focus on good mental health at work and the progress being made towards achievement of the Work Wellbeing Charter certification in March 2020. The Director of Nursing was asked to encourage clinical staff involvement in the Committee.

NHSI Retention Group – The Committee received the update and noted no significant issues with turnover.

3. Matters to be highlighted to the Parent Committee

Nil

4. Escalation report on Performance Measures discussed

Note the improving trends in Mandatory Training & PDR compliance and trajectories to drive continued improvement, and the work undertaken to improve data quality and reporting.

To highlight the increase in Sickness absence in month and the actions of the Committee to gain assurance that it is being actively managed.

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

None

6. Learning identified for dissemination within the Trust

Good people management practice noted in Neonates with respect to person centred management of long term absence and effective teambuiding.

7. Action required by Parent Committee

None

Susan Milner
(acting) Chair of Putting People First Committee
Date 28 November 2019

		Agenda Item	**19/20/202**
MEETING	Trust Board		
PAPER/REPORT TITLE:	**Safeguarding Annual Report 2018/19**		
DATE OF MEETING:	Thursday, 5 December 2019		
ACTION REQUIRED	**For Assurance**		
EXECUTIVE DIRECTOR:	**Caron Lappin** **Director of Nursing & Midwifery / Executive Lead for Safeguarding**		
AUTHOR(S):	**Mandy McDonough, Associate Director of Nursing and Midwifery for Safeguarding**		
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 clinical 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) …* ☐		
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	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:-….)***	***To note an overview of safeguarding practice across the Trust and receive assurance that systems and processes are in place to protect vulnerable Children and Adults.***	
PREVIOUSLY CONSIDERED BY:	**Committee name**	Hospital Safeguarding Board
	Date of meeting	Tuesday, 24 September 2019

Executive Summary

The purpose of this report is to provide an overview of Safeguarding activity within the Trust for the period 1st April 2018 – 31st March 2019 and to assure our Board of Directors that the Trust has effective systems and processes in place to safeguard patients who access services provided within Liverpool Women's NHS Foundation Trust.

Safeguarding remains a fundamental component of all care within the Trust and this year has again been both exciting and challenging in respect to ensuring that we respond effectively and efficiently to the challenges of safeguarding both our patients and our staff.

The Hospital Safeguarding Board (HSB) and Safeguarding Operational Group (SOG), continues to provide the Board of Directors, Clinical Commissioning Group (CCG) and External Safeguarding Boards with assurance of our ability to respond effectively and demonstrate accountability, for all aspects of safeguarding Children and Adults.

Much has been achieved in this reporting period with regards to our key safeguarding activities and again this year, we have seen an increase in our referral rates into the Team, which is positive in terms of our training and staffs knowledge.

This Annual Report will differ slightly from previous years as the Safeguarding Service has concluded its implementation phase following the previous Corporate Safeguarding Strategy. The service is now entering the evaluation phase and therefore will only be reporting on previous objectives, legislative and service changes or updates, as well as trend analysis upon Safeguarding performance data.

The report will again demonstrate that the Trust is meeting its statutory and commissioned responsibilities in relation to safeguarding children and adults and will outline the key priorities for the coming 12 months which are central to supporting core activities to safeguard Children and Adults.

Board Approval

I would request the Trust board receives and approves this annual report.

Once approved this annual report will be submitted to the Liverpool, Sefton and Knowsley Safeguarding Children's Board's and the combined Safeguarding Adult Board and become a composite with other partner organisations.

Caron Lappin
Director of Nursing & Midwifery / Executive Lead for Safeguarding

Contents

Introduction

Liverpool Women's NHS Foundation Trust (LWH) understands and acknowledges that safeguarding children and adults is everybody's business and everyone working in health care has a responsibility to help prevent abuse and to act quickly and proportionately to protect children and adults when abuse is suspected.

The Safeguarding Team is an established, fully integrated, multi professional safeguarding unit. The Team comprise of Senior Health and Social Care Professionals with experience in Midwifery, A&E, Critical Care, Elderly and Social Care, who are able to act both strategically and operationally in preventing and investigating potential abuse.

Maintaining the function and quality of all aspects of safeguarding practice across the Trust is essential; with a particular focus on ensuring effective strategic Safeguarding leadership is in place.

This year the Team have continued to implement relevant Safeguarding processes and recommendations in conjunction with continuing financial austerity and change across other partner agencies; establishing robust governance and assurance processes and embedding a continually developed Safeguarding Strategy.

Summary of Current Position

Once again throughout the reporting period for 2018/19, significant progress has been made with the safeguarding adults and children's work plans; ensuring we are able to meet our overall Trust objective, which is to:

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

Key areas of priority were identified and reported in the Safeguarding Annual Report 2017/2018 and progress against these areas has now been completed. The key priorities were as follows:

Number	Objective	RAG Status
1	Fully implement Safeguarding Adults Intercollegiate (August 2018) guidance in respect to levels of training	
2	Fully implement Working Together to Safeguard Children (August 2018) guidance ensuring the changes are reflected in Safeguarding policy, protocol and training	
3	Develop and implement advanced training sessions for senior medical staff in respect to managing complex cases involving the Mental Capacity Act	
4	Review the Trust Cognitive Impairment strategy and the supporting policies and procedures in accordance with recently released national guidance	
5	Liaise further with EPR to ensure that all safeguarding processes currently in place can be replicated robustly within the new EPR system to enable greater confidential sharing of safeguarding information across the workforce*	
6	Set up enhanced data-sets for specific Trust safeguarding agendas to assist strategic direction for resource allocation and improve the ability of external partners to present an accurate picture of the local safeguarding landscape*	

7	Further develop and strengthen our domestic abuse processes in particular responses to disclosures, collaboration with external partners and implementation of advanced training sessions for senior staff in respect to managing complex cases and risk assessments	

*A number of areas remain ongoing and added to future work plans, as the completion is reliant on other Trust work streams prior to us providing the necessary assurance. The key objectives for 2019/2020 will be summarised at the end of this report.

Safeguarding Governance

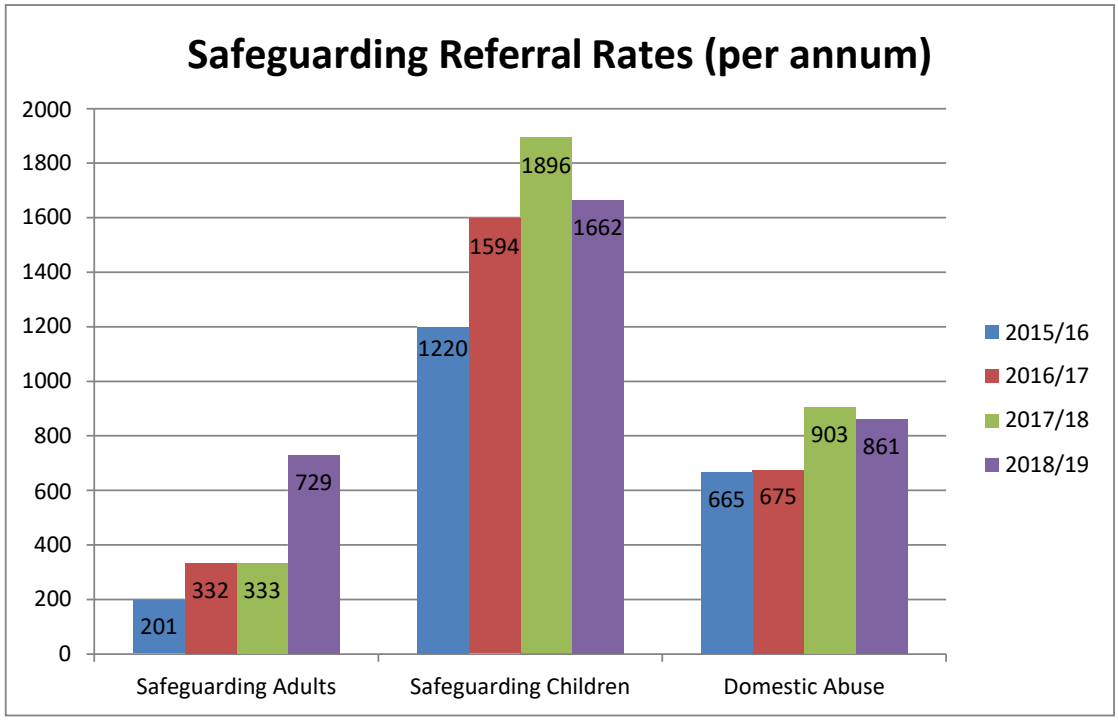
Risk

Safeguarding Risk Register

During 2018/19 there were no service level risks identified within the Safeguarding Service.

Performance

Safeguarding Performance Data



For the fourth year running, the amount of Safeguarding referrals received by the service has increased (120 more than 2017/18).

However for the first time the amount of referrals for safeguarding children has decreased compared to the previous years. This is potentially due to staff learning from the feedback process which is embedded into the referrals, alongside the

Safeguarding Children Level 3 Training now including more specific training around applying the 'Levels of Need' for a child.

This year there has been a notable increase in safeguarding referrals compared to 2017/18 (333 to 729) identifying concerns related to Adults at Risk of abuse. This can be attributed to the significant investment in the Safeguarding Adults Agenda across the Trust and continued promotion of how to identify potential abuse. The Safeguarding Team now also receive referrals for patients who suffer with a physical disability and may require more support when accessing care; which will also impact on our referral increase.

Clinical Commissioning Group (CCG) Key Performance Indicator (KPI) Reports

Due to the issues around training compliance during 2018/19 an overall rating of limited assurance was applied by the CCG. As a consequence and to mitigate any potential risk, LWH Safeguarding Team provided a detailed training recovery action plan/trajectory with executive sign off by the Director of Nursing.

In order to provide some assurance, the Team have also increased Unannounced Safeguarding Inspections to the clinical areas in order to review staff knowledge and awareness; which will enable identification of potential risks or gaps in knowledge.

The CCG did acknowledge that all other Safeguarding KPI domains have achieved significant assurance throughout the reporting year 2018/19, but progress is required in line with the training trajectory before there will be any change to the overall assurance rating.

From Q1 2019/20 a revised set of Safeguarding KPI's will be introduced for all Liverpool CCG commissioned services. The KPI's have been agreed with the Trust and the CCG will also undertake an on-site Safeguarding Assurance Visit within the reporting year.

LWH	Q1 (2018/19) Assurance rating			Q2 (2018/19) Assurance rating			Q3 (2018/19) Assurance rating			Q4 (2018/19) Assurance rating		
	C	A	T	C	A	T	C	A	T	C	A	T
Training			↓			↔			↔			↔
Gov P&P			↔			↔			↔			↔
Multi Agency			↓			↔			↔			↔
Supervision			↔			↔			↔			↔
Audit Tool			↔			↔			↔			↔
CiC/LAC												
Overall			↓			↓			↔			↔

Local Safeguarding Children Board (LSCB) Section 11 Audit

In 2018, there was a change to the scrutiny process for the Section 11 audit (2017/18), as a pan Merseyside approach was undertaken for Knowsley, Liverpool, Sefton, and St Helens based on one single submission.

The stages of the process were as follows:

January 2018	LSCB distributes online workforce survey asking LWH staff to complete review against Trust self-assessment
April 2018	Liverpool LSCB undertakes assessment of returned all audits from NHS Trusts on behalf of the all local boards.
July 2018	Cross Merseyside agencies complete audit for 2018/19 consideration.
August 2018	Board representatives from across Merseyside will meet to consider scrutiny requirements to address standards deemed not sufficiently evidenced.
Autumn 2018	Front Line visits will be scheduled and inform the decision to proceed to scrutiny panel.
April 2019	LWH receive frontline visit by two members of the newly formed Merseyside Safeguarding Children's Board (MSCB)
April 2019	LWH informed they do not require a scrutiny panel

2018 LWH Section 11 Self-Assessment

From the Section 11, the requirements are divided in to 11 auditable standards, which are further broken down to 51 individual metrics. Agencies are required to self-assess against these metrics whilst providing evidence to rationalise their grading.

	Standard	LWH Self-Assessment
1	Senior management commitment to the importance of safeguarding children	
2	A clear statement of the agency's responsibilities towards children is available for all staff	
3	A clear line of accountability within the organisation for work on safeguarding and promoting the welfare of children	
4	Service development takes account of the need to safeguard and promote welfare.	
5	Service development is informed by the views of families and children	
6	Individual case decisions are informed by the views of children and families	
7	Effective inter-agency working enabling information sharing to service users	
8	Staff training on safeguarding and promoting the welfare of children for all staff working with, or in contact with children and families	
9	Safer recruitment	
10	Effective inter-agency working to safeguard and promote the welfare of children (S11) & Working Together (2015)	
11	Effective inter-agency working information in order to ensure safeguarding and promoting children's welfare.	

LSCB Section 11 Workforce Survey

The workforce survey asked staff to complete responses to twelve questions, the full compliance target was 90% positive responses, LWH received this rating (or higher) in eight of the questions, whereas the following four questions received lower scores:

1. Do you know who the lead person is for child sexual exploitation within your agency? (60%)
2. If you work with children, have you received training in e-safety working practices, for example regarding contact and professional boundaries? (78%)
3. Do you understand the threshold for making a referral to Children's Services or initiating an Early Help Assessment? (69%)
4. Are Local Safeguarding Children in Board inter-agency guidance and procedures made available to you and other members of staff? (74%)

As a consequence, LWH Safeguarding Team have included further information around roles & responsibilities, E-safety and the Levels of Need within its Safeguarding Children Training programmes.

LSCB Section 11 Front Line Visit

A front Line visit was conducted by the Designated Nurse for Safeguarding Children and Board Manager for Sefton LSCB on 1st April 2019.

A formal meeting was held with the Associate Director of Nursing and Midwifery for Safeguarding prior to discussions with the frontline practitioners. The discussions with the practitioners were all held in the clinical areas in which they work and the length of discussion was variable according to clinical demands at the time. 3 frontline practitioners were interviewed, 1 from the Maternity Ante-Natal Clinic, 1 from Gynaecology Outpatients Department and 1 from the Bedford Centre.

Headline findings from the LSCB visit:

- Detail was given that the Trust had been involved in a high number of SCR's over recent months. It was also reported that the referral rate for the number of unborn children was becoming higher and it had been noted by the Trust that the number of ICO's issued for babies was also increasing

- Reference was made by more than one practitioner to a heightened awareness of trafficking cases and that the links between CE, trafficking and

pregnancy were being made. It was evidenced in discussion with staff that professional curiosity was being used more often to establish the relationship between the woman attending for the appointment and the people that were accompanying her

- It was discussed that there is an increasing number of bookings made by women who are seeking asylum and attached to this it appeared that there was an increase in the number of women who were booking late in pregnancy

- It was reported that it was felt that there was an increase in the number of young people with mental health issues who were accessing services

- It was reported that there is an increased awareness around FGM

- Staff made reference to the fact that they serve a wide geographical area and that each local authority area has their own referral form and mechanism for referral. It was asked whether there could be a universal referral form agreed between LA areas.

- All staff were aware of the LSCB's and could articulate who would represent the Trust at the Boards and how to get information from LSCB's.

- Staff that were spoken to had some difficulty in articulating practice changes that had been made as a result of Serious Case Reviews. The staff could not always link SCR's to what they did in day to day practice.

The visit raised the following concerns or issues from the LWH to be brought to the attention of LSCB's and MASAs:

- Staff made reference to the fact that they serve a wide geographical area and that each Local Authority area has their own referral form and mechanism for referral. It was asked whether there could be a universal referral form agreed between LA areas.

Analysis of compliance and identified actions to address concerns:

- Following analysis of evidence submitted for consideration by Scrutiny, Audit, and Review Group, there was significant assurance that Liverpool Women's Hospital is compliant with Section 11 to a sufficient standard.

Liverpool Women's Hospital has committed to undertake the following actions to address areas where compliance could be further strengthened:

Std	Metric	Grade	Required
4.1	Service plans consider how the delivery of services will take account of the need to safeguard and promote the welfare of children	3	Service plans developed in sequence with evidence collection and interpretation. Programme of client feedback and information gathering timed to influence development of service plan. All areas of organisation include client informed decisions. Evidence of children and their families influencing the service plan development, verifying, prioritising and agreeing sign off together with the organisation and their partners.
5.2	Service development plans are informed by the views of children and families	2	Service plans developed in sequence with evidence collection and interpretation. Programme of client feedback and information gathering timed to influence development of service plan. All areas of organisation include client informed decisions. Evidence of children and their families influencing the service plan development, verifying, prioritising and agreeing sign off together with the organisation and their partners.
9.3	Identity and qualifications are verified (Essential Standard: Minimum Expectation Grade 3)	3	Checks are made on the authenticity of qualifications, either by contacting the qualification board or university/ college. Verified copies of certificates are kept on the HR file.

Follow up on the effectiveness of actions stated will be contingent on their relevance to standards published in Working Together 2018, which are effective from 1st April 2019. The new auditable standards are:

Standard	Working Together 2018 Descriptors
Standard 1	a senior board level lead with the required knowledge, skills and expertise or sufficiently qualified and experienced to take leadership responsibility for the organisation's/agency's safeguarding arrangements
Standard 2	clear whistleblowing procedures, which reflect the principles in Sir Robert Francis' Freedom to Speak Up Review and are suitably referenced in staff training and codes of conduct, and a culture that enables issues about safeguarding and promoting the welfare of children to be addressed
Standard 3	clear escalation policies for staff to follow when their child safeguarding concerns are not being addressed within their organisation or by other agencies
Standard 4	a designated practitioner (or, for health commissioning and health provider organisations/agencies, designated and named practitioners) for child safeguarding. Their role is to support other practitioners in their organisations and agencies to recognise the needs of children, including protection from possible abuse or neglect. Designated practitioner roles should always be explicitly defined in job descriptions. Practitioners should be given sufficient time, funding, supervision and support to fulfil their child welfare and safeguarding responsibilities effectively
Standard 5	a clear line of accountability for the commissioning and/or provision of services designed to safeguard and promote the welfare of children
Standard 6	a culture of listening to children and taking account of their wishes and feelings, both in individual decisions and the development of services
Standard 7	appropriate supervision and support for staff, including undertaking safeguarding training
Standard 8	safe recruitment practices and ongoing safe working practices for individuals whom the organisation or agency permit to work regularly with children, including policies on when to obtain a criminal record check
Standard 9	arrangements which set out clearly the processes for sharing information, with other practitioners and with safeguarding partners
Standard 10	creating a culture of safety, equality and protection within the services they provide
Standard 11	employers are responsible for ensuring that their staff are competent to carry out their responsibilities for safeguarding and promoting the welfare of children and creating an environment where staff feel able to raise concerns and feel supported in their safeguarding role
Standard 12	staff should be given a mandatory induction, which includes familiarisation with child protection responsibilities and the procedures to be followed if anyone has any concerns about a child's safety or welfare
Standard 13	all practitioners should have regular reviews of their own practice to ensure they have knowledge, skills and expertise that improve over time

Policies

Following publication of updated legislation and national guidance, LWH Safeguarding Team ensures all safeguarding policies are compliant and accurate and although the Trusts policy is to ensure 3 yearly reviews; Safeguarding policies are reviewed every 12 months due to the regular changes in guidance and law.

Updated documents in 2018/19:

1. Safeguarding Corporate Strategy
2. Safeguarding Training Strategy
3. Safeguarding Children Policy
4. Safeguarding Adults Policy
5. MCA/DoLS Policy
6. Domestic Abuse Policy
7. Supporting Patients with a Disability Policy
8. Managing Allegations for People working with Children Adults and Vulnerable Adults
9. Safeguarding Supervision Policy
10. Prevent Policy
11. Missing Child Guideline
12. LeDeR Guideline

Audits

Forward Plan No.	Title	Auditor / Audit Supervisor	Changes in practice / Improvements
2018/029	Trust compliance with the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS)	Carl Griffiths / Matt O'Neill	No changes in practice were required as all standards were met.
2018/050	Safeguarding children procedures in accordance with statutory guidance audit	Maria Clegg / Matt O'Neill	Very high standard of compliance with policy and procedures. The importance of staff updating the Safeguarding Team with relevant information especially out of hours will be reiterated, which will reduce the possible risk of delay of timely communication in respect of admissions/discharges of patients with safeguarding issues. LWH will communicate with the Local Authorities in respect of the importance of 37/40 weeks of pregnancy being term and the importance of any plans being in place at this time to reduce any potential social delays in discharge.
2018/025	Audit of compliance with Reasonable Adjustments and patient/carer feedback in relation to Supporting Patients with a Cognitive Impairment	Carl Griffiths / Matt O'Neill	Very high standard of compliance with policy and procedures. To increase awareness as to the need to notify the safeguarding team in respect to completing a Reasonable Adjustment Risk Assessment, the Gynaecology Division will ensure all relevant staff access Reasonable Adjustment Risk Assessment Awareness training. The Safeguarding Team will establish a cross Divisional working group to embed the current Reasonable Adjustment Risk Assessment process into existing admission procedures.
2018/028	Auditing the compliance against Domestic Abuse Protocol/Procedure	Rebecca Holland / Matt O'Neill	Very high standard of compliance with policy and procedures. Level 3 children's safeguarding training will be reviewed to include case studies/scenarios of Domestic Abuse and specific actions required. Senior staff will be identified and updated on how to complete Co-ordinated Action Against Domestic Abuse - Domestic Abuse, Stalking and 'Honour'-based violence (CAADA-DASH) risk assessments for patients who disclose domestic abuse. This will improve the resilience around staff trained to complete Risk Assessments

Assurance

Hospital Safeguarding Board (HSB)

The HSB ensures that all safeguarding arrangements within the Trust are regularly reviewed, thus providing assurance to the Trust Board that LWH is meeting its statutory obligations and locally agreed objectives.

The HSB Terms of Reference include representation from the Designated Nurses (CCG), Non-Executive Director (Safeguarding Champion) and is chaired by the Director of Nursing and Midwifery and/or the Associate Director of Nursing and Midwifery for Safeguarding. The Board provides strategic overview and scrutiny across all aspects of Safeguarding.

In this reporting period, the HSB has focused on monitoring progress with CCG compliance and multi-agency engagement with external partners.

We have also completed a review of the Terms of Reference in which the body of work encompassed within the HSB was clarified ensuring the following items are continually discussed and monitored:

- Partnership Working
- Risks & Serious Incidents
- Legislation and National/Local guidance changes
- Training
- Serious Case Reviews (SCRs) & Domestic Homicide Reviews (DHRs)
- CCG Key Performance Indicators (KPIs)
- Governance
- Assurance
- Effectiveness
- Performance

Safeguarding Operational Group (SOG)

The Safeguarding Operational Group (SOG) supports the HSB; its primary purpose being to ensure that safeguarding children and adults is a Trust wide priority. Again this year, through monitoring compliance with training, incident trends, Safeguarding Unannounced Inspection Reports, Serious Case Review findings and Safeguarding performance and activity; the group have provided assurance to the HSB that safeguarding arrangements within the Trust are developed and implemented, compliant with appropriate legislation and national/local guidance in respect of Safeguarding Children and Adults. Meetings are quarterly and have full divisional representation, which again has been noted as positive and consistent.

Care Quality Commission (CQC) - (NHS South Sefton CCG & NHS Southport & Formby CCG)

In July 2018, the CQC completed a review of the Health Services (South Sefton CCG and Southport & Formby CCG) Safeguarding Arrangements and Children Looked After. It focused on the experiences and outcomes for children within the geographical boundaries of the Local Authority area and on the performance of health providers serving the area including Clinical Commissioning Groups (CCGs) and Local Area Teams (LATs). Although not our direct commissioning group, Sefton CCG identified Liverpool Women's to participate in the review.

The review was conducted under Section 48 of the Health and Social Care Act 2008 which permits CQC to review the provision of healthcare and the exercise of functions of NHS England and Clinical Commissioning Groups and explored the effectiveness of health services for looked after children and the effectiveness of safeguarding arrangements within health for all children; taking their experiences and views into consideration.
During the review the CQC explored:

- ✓ The role of healthcare providers and commissioners.
- ✓ The role of healthcare organisations in understanding risk factors, identifying needs, communicating effectively with children and families, liaising with other

agencies, assessing needs and responding to those needs and contributing to multi-agency assessments and reviews.

- ✓ The contribution of health services in promoting and improving the health and wellbeing of looked after children including carrying out health assessments and providing appropriate services.

Responsibilities under Section 11 of the Children Act 2004, was also reviewed to ascertain whether healthcare organisations were working in accordance with the statutory guidance.

In total, the experiences of 140 children and young people were considered with the CQC using a range of methods to gather information both during and before the visit. This included document reviews, interviews, focus groups and visits and where possible meeting with children and young people to speak with them directly. The findings of previous CQC inspections of all five of the provider NHS Trusts identified to participate in the review in relation to children and young people were also taken into account as part of this review.

Although it featured many areas of good practice from Liverpool Women's throughout, the inspection report (*released in November 2018*) outlined 49 recommendations; of which LWH were part of five of those recommendations in relation to sharing our practice with the other Maternity Providers:

Ref	Recommendation	Action	Date Completed
3.1	Providers work together to ensure that all practitioners working with pregnant women are fully cognisant in current LSCB processes for pre-birth assessments.	LWH will ensure that training specifically focuses on LSCB pre-birth assessments as well as sending out communications to increase understanding of existing multi-agency processes to staff via various methods	Dec 2018
12.1	Mat Providers to implement a proactive process of follow-up to ensure that Child Protection Conference minutes are shared with health practitioners and routinely	LWH Policy follows LSCB guidance which details the processes for managing attendance and documentation for Child Protection Case Conferences. LWH Safeguarding exercise a specific SOP in relation to these processes and monitor all	N/A (*practice already in place*)

	stored securely on service users' records.	conference documentation received.	
12.2	Providers work together to implement a rolling programme of training and audit which will embed and regularly evaluate, the effective capture of the voice of the child in daily practice, including the unborn child, through improved record-keeping.	LWH will continue to annually audit the voice of the child with respect to any young women who access Maternity Services. With regard to the voice of the unborn, the expectation is that professionals advocate for the unborn and as such our training, policy and procedure is in accordance with the Children Act 2004 and as per local/national safeguarding policy and guidance. LWH will continue to regularly monitor and audit effectiveness and compliance with policy and guidance.	N/A (*practice already in place*)
12.3	Providers work together to implement a rolling programme of training for practitioners on the analysis and articulation of risk and its impact on children and young people. This should include clear evaluation of the impact of the training on practice through regular audit.	LWH Safeguarding receives and quality assures all Sefton MASH referrals before being sent securely, quarterly training (& learning) on these referrals are delivered to staff. Quality of referrals is also within Safeguarding training and audited annually.	N/A (*practice already in place*)
13.1	Implement a process to effectively monitor midwives' compliance with Level 3 Child Safeguarding Training as per RCPCH Intercollegiate Document (2014).	LWH are implementing a system of recording each staff members (from L3 TNA) additional training (external to Trust) on a centralised spreadsheet for easier monitoring and control	Feb 2019

Safeguarding Training

The Trusts compliance levels for Safeguarding training at the end of the 2018/19 period are:

Session	CCG Compliance Threshold (%)	Compliance as of April 2019 (%)
Safeguarding Children Level 1	90%	**72.4%**
Safeguarding Children Level 2	90%	**72.4%**
Safeguarding Children Level 3	90%	**65.2%**
Safeguarding Children Level 4	90%	**100%**
Safeguarding Adults Level 1	90%	**72.4%**
Safeguarding Adults Level 2	90%	**72.4%**
Safeguarding Adults Level 3	90%	**77.3%**
Safeguarding Adults Level 4	90%	**100%**
MCA & DoLS (Advanced)	90%	**65.2%**
Prevent (Basic Awareness)	90%	**72.4%**
Prevent (WRAP)	90%	**91%**

**due to the Trust commencing initial training for this programme in 2015 there is now a drop off in compliance, which is being managed with staff release and a training plan/trajectory.*

Following publication of the Adult Safeguarding: Roles and Competencies for Health Care Staff published in August 2018 concerns were raised by a number of health providers regarding the difficulties in embedding this statutory guidance into practice.

To support the implementation and reduce impact a transition phase was agreed with the CCG up to 2020-21.

This statutory guidance now provides clarity in respect to the competencies required in order to support individuals to receive personalised safeguarding and sets out the minimum training requirements along with education and training principles.

Despite the implementation phase, a decision was made to complete a review of all relevant training packages and associated processes and if required amend to ensure compliance with the statutory guidance.

Safeguarding Children

All NHS health services, including Foundation Trusts are required to identify a Named Doctor and Named Professional for Safeguarding Adults and Children and a Named Midwife (if the organisation provides maternity services). LWH supports the statutory requirements for Safeguarding Children with the roles of the Associate Director of Nursing and Midwifery for Safeguarding who is the Trust's Named Nurse and Midwife for Safeguarding Children and Dr Helen Chitty who is now the Named Doctor for Safeguarding Children, replacing Dr Chris Dewhurst.

Following the Children & Social Work Act (2017) receiving Royal Assent in 2017, in July 2018, Working Together to Safeguard Children (2015) was revised to reflect the legislative changes within the Act. All necessary policy and procedure updates for Liverpool Women's have now been completed to reflect the changes from the revised Working Together.

The new guidance set out a number of changes required to support the new system of multi-agency safeguarding arrangements established by the Children and Social Work Act (2017).

Changes to the new guidance are anticipated to be:

Multi-agency safeguarding arrangements

Local Safeguarding Children Board (LSCB) will be replaced by Multi-Agency Safeguarding Arrangements Committee (MASAC) – of which there will be 3 'Safeguarding Partners'

- Under the new legislation, three safeguarding partners (local authorities, chief officers of police, and clinical commissioning groups) must make arrangements to work together with relevant agencies (as they consider appropriate) to safeguard and protect the welfare of children in the area
- The 3 safeguarding partners will agree on how to co-ordinate their safeguarding services; act as a strategic leadership group in supporting and

engaging others; and implement local and national learning including from serious child safeguarding incidents

- To fulfil this role, the three safeguarding partners must set out how they will work together and with any relevant agencies
- All 3 safeguarding partners have equal and joint responsibility for local safeguarding arrangements

Relevant agencies are those organisations and agencies whose involvement the safeguarding partners consider is required to safeguard and promote the welfare of local children. For local arrangements to be effective, they should engage organisations and agencies that can work in a collaborative way to provide targeted support to children and families as appropriate. The safeguarding partners must set out in their published arrangements which organisations and agencies they will be working with to safeguard and promote the welfare of children.

The Trust is a statutory partner of Liverpool, Sefton and Knowsley Safeguarding Children Boards and shares in the responsibility for effective discharge of the MASAC functions. Liverpool Women's NHS Foundation Trust will remain committed to fulfilling its roles in relation to safeguarding practices.

National and Local Safeguarding Reviews (previously Serious Case Reviews)

The new Working Together to Safeguard Children (2018) sets out the process for National and Local Safeguarding Reviews (previously Serious Case Reviews – SCR's). The responsibility for how the system learns the lessons from serious child safeguarding incidents will now lie at a national level with the Child Safeguarding Practice Review Panel (the Panel).

At a local level, the safeguarding partners have strict timeframes to complete a rapid review of cases to ascertain whether cases meet the criteria for the Panel. This is usually when:

- A child dies and abuse or neglect are known or suspected to be a factor in the death

- A child has sustained a potentially life threatening injury, serious or permanent impairment or has been subjected to particularly serious sexual abuse

The Child Safeguarding Practice Review Panel are responsible for identifying and overseeing the Review of serious child safeguarding cases and that raise issues that are complex or of national importance.

In this reporting period, the Trust has provided information and been involved in four reviews. Sefton Local Authority commissioned three reviews and Warrington Local Authority commissioned one.

Child Death Reviews

The 2018 'Working Together' guidance replaces the requirement for LSCBs (now MASAC's) to ensure that child death reviews formerly undertaken by a Child Death Overview Panel (CDOP) now completed by the 'Child Death Review Partners' which consists of local authorities and any clinical commissioning groups for the local area.

Child Exploitation (CE)

The nationally agreed definition of Child Sexual Exploitation (CSE) which is used across Merseyside is as follows:

Child Sexual Exploitation is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) In exchange for something the victim needs or wants, and/or (b) For the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child Sexual Exploitation does not always involve physical contact; it can also occur through the use of technology

(Home Office 2017)

The nationally agreed definition of Child Criminal Exploitation (CCE) which is used across Merseyside is as follows:

Child Criminal Exploitation occurs where an individual or group takes advantage of a person under the age of 18 and may coerce, manipulate or deceive a child or young person under that age into any activity (a) In exchange for something the victim needs or wants, and/or (b) For the financial advantage or increased status of the perpetrator or facilitator and/or (c) Through violence or the threat of violence. The victim may be exploited even if the activity appears consensual (i.e. moving drugs or the proceeds of drugs from one place to another). 7 Child Criminal Exploitation does not always involve physical contact; it can also occur through the use of technology.

(Home Office 2018)

All staff must be alert and vigilant to the possibility of Child Sexual/Criminal Exploitation when caring and in contact with under 18 year olds. If it is suspected the child must be referred to the Trust Safeguarding Team and the appropriate Local Authority. Staff can refer to Merseyside Multi-Agency protocol for Child Exploitation for further guidance.

Regardless of whether exploitation is suspected, if a child is under the age of 13, is known to be sexually active and accesses services from Liverpool Women's, a referral should be made to children's Social Care. If possible the consent of the child should be sought prior to making the referral. The concerns should be reported immediately to the Safeguarding Team as consideration will need to be made around making a Police referral.

Early Help Assessment Tool (EHAT) / Common Assessment Framework (CAF)

The Early Help Assessment Tool (EHAT) is used for children/young people and families who would benefit from the provision of additional services and where universal services do not meet any identified needs. The assessment promotes a coordinated service response to meet those needs to significantly improve the outcomes for the child.

Liverpool Women's have historically had some difficulties in the completion of Early Help documentation in relation to the information required and have explored whether a midwifery version or a reduced version of EHAT would be more appropriate. This is used by GP's (pre- EHAT) and would enable all midwifery staff to record vital information and observations obtained through routine midwifery care and share with external partners/agencies.

Liverpool Women's have highlighted the desire to undertake a bespoke EHAT to the Local Authority, the LSCB (now MASAC) and the Chief Nurse (CCG), through various forums such as Clinical Quality and Performance Group (CQPG), Hospital Safeguarding Board, and the Children's Transformation Board.

As this had not progressed, in an attempt to move forward with the EHAT agenda and mobilise the universal adoption of EHAT, it has now been agreed to pilot a 'referral model'; which would be a worker(s) to take the referrals from professionals who identify a family who may require Early Help support. The EHAT Worker would be responsible for the completion of assessments, development of dynamic plans, co-ordination of the interventions and undertake direct work with children.

In terms of location for the 'pilot'; it has been agreed that it would make more sense to trial in the Speke/Garston area as the geographical boundaries present less of a challenge. If the pilot was successful and agreed moving forward, additional workers would then need to be recruited. The Local Authority has agreed to prepare a proposal for the Children's Transformation Board and if this is approved we will be able to commence the pilot.

Voice of the Child

Actively involving children to communicate their experiences of care, with a particular emphasis on how a service has helped to improve their health and wellbeing, is essential in ensuring that the care we provide is improving children's lives and keeping them safe.

This can be difficult to embed in a provider organisation which predominantly delivers healthcare to adults and babies. However in Liverpool Women's we

sometimes treat young adults under 18 years of age in our unplanned and/or specialist care setting. In this instance, completion of our patient feedback cards enables us to capture their views.

Whilst, the failure to listen to children and ensure their views are taken into account in child protection cases has been highlighted in many Serious Case Review (SCR) findings; it is also well documented that an unborn child can be perceived as at risk when there are known Safeguarding concerns. This may not be considered by agencies involved in the same way as a victim of an incident or as a child that had been present.

But when agencies are involved in the direct care of an unborn, they have a key role in representing their interests as a proxy for the voice of the child. If there are known Safeguarding concerns, it is paramount that agencies always consider the implications for the unborn. If there are concerns regarding any present and future risk, in accordance with statutory guidance they must make a Child Protection Referral to Children's Social Care.

If the concerns meet the threshold for Level 4 intervention, the unborn will require a statutory service to promote their welfare (under section 17, of the Children Act 1989). This process is deemed as 'acting by proxy' for the unborn.

In a provider organisation which predominantly deals with Safeguarding issues for pregnant women, it has been difficult to embed and evidence the 'Voice of the Child' agenda, when staff may not consider that the Safeguarding referral processes followed are indeed acting by proxy.

Therefore, for 2019/20, the Associate Director of Nursing and Midwifery for Safeguarding will develop a 'Voice of the Child Practice Guidance' for Liverpool Women's Health Professionals and Midwives with regards to the unborn.

Looked After Children (LAC)

A ‘Looked after Child’ (LAC) is a child who is accommodated by the local authority; a child who may be the subject of an Interim Care Order, full Care Order or Emergency Protection Order; or a child who is remanded by a court into local authority accommodation or Youth Detention Accommodation.

As healthcare services have a responsibility to keep children safe, if a LAC accesses the Trust via unscheduled care, the Child Protection Information Sharing (CP-IS - which connects Local Authority Children's Social Care systems with those used by NHS unscheduled care settings and Maternity Units) ensures that the appropriate Local Authority are automatically alerted regarding the child in their care.

Instant access to this information means when vulnerable children are treated at an unscheduled care setting; they can be identified wherever they are cared for in England. Staff are asked to notify the Safeguarding Team of this young person’s admission or attendance in order for any relevant information sharing with the relevant Social Worker and Local Authority.

Special Educational Needs & Disability (SEND)

As part of the 0-25 Special Educational Needs & Disability (SEND) improvement journey our local Commissioners have established a Health Economy SEND Strategic Working Group. The Trust Associate Director for Nursing and Midwifery for Safeguarding is the strategic lead for SEND from within our organisation and the Specialist Nurse/Midwife for Safeguarding Children attends the meetings to progress this work, which also takes into account the voice of the child.

Safeguarding Adults

This year has seen a focus on scoping and where required amend the current arrangements for Safeguarding Adults at Risk in preparation for the implementation of the Adult Safeguarding: Roles and Competencies for Health Care Staff which was published in August 2018.

As a consequence the investment in preparation combined with the specialist nature of the Trust resulted in the ability of the Trust to meet the requirements of this statutory document with minimal disruption.

Whilst the limited numbers of adults at risk of abuse who attend the Trust have continue to contribute to relatively low referral rates to Social Care for further enquiries this year has seen a considerable rise in referrals to the Safeguarding Team identifying adults at risk of abuse

We have seen an increase in staff identifying patients with additional needs who may require support or be vulnerable to abuse as well as adults with Mental Health needs who may, as a consequence of their mental health increase their vulnerability.

In the cases where the vulnerability has led to abuse being perpetrated then the Safeguarding Team continue to take a proactive approach to working collaboratively with both the patient and external partner agencies in agreeing safeguarding arrangements.

For those cases that require a preventative approach, again the team continue to act as both a conduit and advocate in ensuring support is available to ensure their Human rights are upheld.

This demonstrates a greater awareness of front line staff in respect to the diverse nature of safeguarding adults and the need to recognise potential vulnerabilities and the benefits of seeking specialist advice.

Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (2009) (MCA & DoLS)

This year sees the third year in succession where compliance, demonstrated through audit, has been evidenced, providing the relevant assurance required in respect to embedding the Act in practice.

Although it can be seen that our clinicians have a clear understanding of the Act and comply with the principles appropriately; the Safeguarding Team continue to provide support in respect to complex and challenging cases. Ultimately this reduces the need to access legal advice and maintains the safe provision of care.

Following publication of the Decision-making and Mental Capacity NICE guidelines in October 2018 a review of all associated guidance was completed. As significant work had been completed between 2015-17 developing internal processes with the guidance in mind, minimal changes were required.

In respect to Mental Capacity (Amendment) Bill (2017-19), the Trust has contributed to the reform of the Deprivation of Liberty Safeguards (DoLS) legislation. The Bill follows on from the Law Commission's recommendations published in 2017 and proposes to abolish the Deprivation of Liberty Safeguards, by deleting Mental Capacity Act 2005 (MCA) Schedule A1 and 1A, and adding a new Schedule AA1, commonly referred to as the 'Liberty Protection Safeguards'.

Key features of the Bill include hospitals becoming responsible for authorising their own DoLS, as opposed to Local Authorities currently providing authorisation; and the introduction of Approved Mental Capacity Professionals. They will bring independent scrutiny to cases where the "person being cared for does not wish to reside in hospital or to receive care", i.e. effectively only in cases of "objection" by the patient.

Whilst the Bill is expected to be enacted in May 2019 the date for implementation of the Mental Capacity (Amendment) Act 2019 is scheduled for October 2020. A clear timetable for implementation has yet to be published and further steps will be required. These include:

- Preparation and enactment of the secondary legislation to provide further detail (e.g.) the knowledge and experience required to conduct assessments;
- The drafting and Parliamentary approval of a Code of Practice.

LWH Safeguarding continues to monitor progress in readiness for any required changes to be implemented.

Learning Disabilities & Dementia

This year has seen the Trust continue to work in collaboration with external health providers and service users to improve the experiences of patients with additional needs.

LWH Safeguarding continue to deliver key aspects of the Department of Health's 'Transforming Care Programme' for patients with additional needs; including ensuring reasonable adjustments are made to improve access to health care and ensuring those caring for patients with a learning disability or Autism are appropriately trained to recognise individual needs of both the patient and those involved in their care.

Moving forward we will be reviewing the current process for implementing Reasonable Adjustments to include those patients with a physical disability, ensuring compliance with the Equality Act 2010, as well as preparing for the implementation of the learning disability improvement standards for NHS Trusts.

In conjunction Safeguarding will look to 'roll out' the skill set for completing Reasonable Adjustments, currently held by safeguarding, to include key services such as the Enhanced Midwifery Service and Pre-Operative Assessment staff. This will further improve access to assessments and in turn equality in access to care.

Mental Health Act

The Trust has a statutory obligation to ensure that its service users, detained under the Mental Health Act 1983 as amended by the Mental Health Act 2007 are treated lawfully.

Whilst not having any direct responsibility for ensuring compliance with the Act, in response Safeguarding contributed to developing the policies and processes required to ensure compliance which were ratified in 2018.
However concerns have been identified that there has been a significant increase in the number of complex Mental Health cases accessing the Trust and providing care within the framework of the Act presents a particular challenge due to a lack of clarity or access to direct support.

Therefore, moving forward safeguarding will be reviewing the established processes with a view to take responsibility for compliance.

Domestic Abuse

Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality; is referred to as domestic abuse.

To heighten awareness and ensure the appropriate identification, referrals and support for our patients who disclose domestic abuse, Liverpool Women's have an Independent Domestic Violence Advocate (IDVA) in the Safeguarding Team, who is also a qualified Children's Social Worker.

This has been an extremely positive appointment to the Team. Alongside national guidance and evidence based research around best practice, it is in line with our Trust vision and values, to be a recognised leader of healthcare for women, babies and their families and dedicated to the delivery of excellent healthcare and safe services, in a safe environment.

Multi-Agency Risk Assessment Conference's (MARAC)

The Trust continues to work in collaboration with our external statutory partners by referring and attendance when required at the MARAC; enabling maximum information sharing between relevant agencies within an agreed protocol. Agencies are then able to identify those most at risk from violence and abuse and thereafter jointly construct a management plan to provide a professional, co-ordinated approach to all reported incidents of domestic abuse.

All Trusts are required to provide health information relevant to the cases being discussed for all MARAC meetings and attend the meetings where victims who are referred by the Trust are discussed. Throughout this reporting period Liverpool Women's have continued to provide all appropriate health information to Liverpool (North and South), Sefton and Knowsley MARAC's; attending as required.

In this reporting period, Merseyside Police implemented some structural changes to their workforce which affected some of their administrative function. This was centralised and standardised across the force, combining much of the workload into one locality to provide support and dedicated resources on a pan-Merseyside basis. These changes impacted on the following areas of business:

- MARAC
- Domestic Violence Disclosure Scheme (DVDS – Clare's Law)
- Child Protection Conferences
- Routine Safeguarding Information Sharing Requests
- Safeguarding Referral Processing

The rationale for the changes is to ensure there are more resources put to these functions, which is believed will result in a more timely response and better outcomes.

Alongside this, the software used to create their referrals (VPRF1) was updated, in order to gather more safeguarding history automatically and incorporate it into the information shared along with the referral. In order to comply with new General Data Protection Regulation (GDPR) regulations and the new Data Protection Act 2018, the "Levels of Need" were applied to their referrals, to ensure consent processes are adhered to. This change was in order to improve agencies ability to make decisions on the information provided. This should result in a better quality of referral in terms of information shared and more appropriate referrals.

That said, in this reporting period, there were 861 referrals for domestic abuse into the Safeguarding Team, which is a decrease of 42 cases compared to 2017/18. Although not a substantial reduction in numbers, we believe this may be attributed to the revised processes implemented across Merseyside Police.

However, the number of Domestic Abuse Risk Identification Checklists and the amount of referrals to both IDVA Services and MARAC doubled in 2018/19. This

highlights that Liverpool Women's staff are recognising and reporting more concerns and disclosures.

Domestic Homicide Reviews (DHRs)

Liverpool Women's have been involved in DHR processes since they were established on a statutory basis in April 2011, under section 9 of the Domestic Violence, Crime and Victims Act (2004).

In this reporting period, the Trust has had no DHR involvement, but has received the approved final report from the Home Office (published in December 2018) from a previous review (DHR 11), which was also a Joint Safeguarding Adults Review (SAR).

Within the report the Independent Author, commissioned by the Home Office, outlined a number of good practice points and agency recommendations.

Good Practice Points:

"The way this disclosure of domestic abuse was managed by staff at Liverpool Women's was exemplary."

"Examples of good practice being providing an opportunity for initial disclosure, conducting and accurately recording a robust risk assessment enabling appropriate referrals based on the high-risk assessment and involvement of the Safeguarding Team, who have the specific training and skill set for this role"

Recommendations (for Liverpool Women's):

Recommendation	Key Actions	Evidence	Key Outcomes	Lead Officer	Target Date
Share good practice from Liverpool Women's NHS Foundation Trust staff.	To ensure that learning is shared across the organisation and with other health colleagues.	Internal staff briefing from ADN for Safeguarding LWH	Patients/Service Users supported and enabled to be in a safer situation.	Head of Safeguarding LCCG	Completed & Closed April 2018

	Disseminate via Supervision with LWH Safeguarding team, internal governance and safeguarding meetings, contract and performance meetings and LCCG Quality and Safety Committee.	Minutes of Hospital Safeguarding Board, CQPG and LCCG QSOC	LWH Staff confident of actions to take to safeguard service users/ patients	ADN for Safeguarding LWH	

The 'Protecting Vulnerable People Agenda'

This remains a priority for Liverpool with Harmful Practices (Female Genital Mutilation (FGM), Forced Marriage (FM) and Honour Based Violence (HBV) sitting within this agenda.

The Pan Merseyside Harmful Practices Group lead on raising awareness among professionals and practitioners of harmful practice; such as Forced Marriage, Honour Based Violence and Female Genital Mutilation. They meet on a quarterly basis and Liverpool Women's have representation at that meeting.

Human Trafficking / Modern Slavery

On average the Safeguarding Team receive 1 or 2 referrals per week for women who disclose / or it is suspected that they have been trafficked also known as Serious & Organised Crime threats.

Following on from our 'pilot' in 2017, we now work closely with Merseyside Police Human Trafficking Team and have robust processes in place as standard; which includes 'real time' access to operational data and intelligence.

This has enabled clearer identification of individuals and groups involved; ensuring vulnerable victims are safeguarded as appropriate and outcomes can be evidenced. Information and knowledge regarding trafficked cases has also led to the appropriate challenge around Local Authority decision making; ensuring Liverpool Women's advocate for this vulnerable cohort of women.

General Data Protection Regulation (GDPR) and the Data Protection Act 2018

The GDPR and the Data Protection Act 2018 introduced in May 2018 (which superseded the Data Protection Act 1998), outlines that practitioners must have due regard to the relevant data protection principles which allow them to share personal information. There is now a greater significance placed on organisations to be transparent and accountable in relation to their use of data, their handling of personal data needs and to have comprehensive and proportionate arrangements for collecting, storing, and sharing information.

As no single agency has the sole responsibility for the protection of children, arrangements for the protection of children from abuse can only be successful if the professional staff concerned do all they can to work in partnership and share and exchange relevant information.

Although the GDPR and the Data Protection Act 2018 do not prevent, or limit, the sharing of information for the purposes of keeping children and young people safe, the sharing of appropriate information has become a cause for concern with many of our frontline practitioners, particularly in reference to the unborn.

As such we have amended our Safeguarding Children Policy and Safeguarding Training to reflect the changes and the principles set out in order to assist our staff share information confidently between organisations.

The following considerations should be made before sharing information and have been added to the Policy;

- Is it necessary and appropriate to share the information?
- Is parental consent required to share this information?
- Who should the information be shared with?
- If a parent has refused consent, is there sufficient concern to override this and share information in the best interests of the child / public?

The Law permits the disclosure of confidential information without consent if deemed necessary to safeguard a child/ young person in the public interest. Public interest in child protection may override the public interest in maintaining confidentiality. The child's safety and welfare must be the overriding consideration when deciding whether to share information about them.

In the case of an unborn; if individual staff members and professionals have concerns regarding any future risk to a child not yet born they must make a Child Protection Referral to Children's Social Care. If child protection concerns are identified and the concerns meet the threshold for Level 4 intervention, the unborn will require a statutory service to promote their welfare (under section 17, of the Children Act 1989). A Strategy Discussion will be held and a Section 47 investigation will be undertaken by Children's Social Care. If the risks cannot be reduced, then a Pre-Birth Child Protection Conference will be held.

Although at this stage the unborn child has no statutory status, information must always be shared for pre-birth plans to be put in place to ensure the safety of the child following birth.

Staff must ensure that information is:

- Accurate and up to date
- Necessary for the purpose
- Shared with only the relevant people
- Shared securely
- Record the reasons for the decision to share
- Record the name and details of any person who contacts Liverpool Women's NHS Foundation Trust for information, and the reason for their request for information
- Record if any information was not shared and why

Where there is a lack of operational clarity as to the validity of sharing the information advice should always be sought from the Associate Director of Nursing and Midwifery for Safeguarding.

Safeguarding Supervision

Safeguarding Supervision continues to be provided for all Trust staff that hold a child protection caseload. Supervision provides a framework for examining a case from different perspectives and enables staff members to deal with the stresses inherent in working with vulnerable children, young people and adults at risk and their families. In a safe environment, it allows staff to explore their own role and responsibilities in relation to the families they are working with and facilitates good quality, innovative and reflective practice.

The provision of Safeguarding Supervision ensures that the Trust is discharging its statutory duties and responsibilities as a safeguarding agency; providing a high quality service to those deemed to be at risk of abuse and forges a line of accountability between the individual, the employee and the organisation.

Key Objectives for 2019/20

2018/19 has again been a year of significant activity and scrutiny. Throughout this time, the Trust has successfully demonstrated that robust mechanisms remain in place to safeguard children, young people and adults from abuse.

However, as approach's to Safeguarding continually evolve and the complexity of decision making increases around newly recognised forms of harm and abuse, the current structures and process will be required to continue to develop in response.

Therefore, aside from further embedding of existing overall process, the following key areas / objectives for improvement have been identified in the priorities for 2019/20:

1. Ensure the newly embedded Safeguarding Adults Intercollegiate (August 2018) guidance is assessed via the unannounced inspection programme for 2019/20

2. Ensure that all safeguarding processes currently in place are replicated robustly within electronic health records and enable greater confidential sharing of safeguarding information across the workforce.

3. Continue to develop enhanced data-sets for specific Trust safeguarding agendas to assist strategic direction for resource allocation and improve the ability of external partners to present an accurate picture of the local safeguarding landscape

4. Building on the recognised good practice of Liverpool Women's when recognising and responding to domestic abuse as a healthcare issue; plan and host a multi-agency event aimed at Commissioners, managers and other professionals working in the NHS, Police, Social Care / Local Authorities and the wider public, private, voluntary and community sectors.

5. Complete a full self-assessment against the new Section 11 standards detailed within the new Working Together 2018 guidance

6. Complete a full self-assessment against the new Learning Disability improvement standards detailed within the NHS Improvement guidance (July 2018)

7. Review the current established processes and arrangements for patients, detained under the Mental Health Act 1983 with a view as to providing further assurance that the Trust are meeting its statutory obligations

8. Develop a 'Voice of the Child Practice Guidance' for Liverpool Women's Health Professionals and Midwives to ensure the ability to capture the unborn.

Liverpool Women's NHS Foundation Trust

Agenda Item	19/20/203

MEETING	**Trust Board**
PAPER/REPORT TITLE:	**Safer Nurse/Midwife Staffing Monthly Report Period Month 7 2019/20**
DATE OF MEETING:	Thursday, 05 December 2019
ACTION REQUIRED	**Assurance**
EXECUTIVE DIRECTOR:	Caron Lappin, Director of Nursing and Midwifery
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 clinical 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) ……* ☐
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: **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 organisation 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**	Not Applicable
	Date of meeting	

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 June and July 2019 remained appropriate to deliver safe and effective high-quality family centred patient care day and night.

Ward Staffing Levels – Nursing and Midwifery
Report October 2019

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. It has been agreed that maternity can over establish by 10 midwives to cover maternity leave.
- The trust has introduced a ward accreditation system which is required to support the collection of quality indicators alongside real time patient safety flags. Ward accreditation baseline assessment was rolled out to 5 areas in April 2019.
- 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 of **October 2019.**

- Jeffcoate has seen a decrease overall due to flexing of opening of the unit.
- Gynaecology has seen an increase in fill rate of care staff
- Mat base has seen a decrease in fill rate, MLU has seen an increase
- Delivery has seen a reduction in fill rate of care staff
- Neonates remains to have a very good fill rate

Staffing is monitored across maternity every 2 hours by the 104-bleep holder who has an over view of the whole of maternity service. Staff are moved between areas depending on activity. The Neo-natal unit uses an acuity model of staffing which is used every 12 hours. It should be noted that Jeffcoate ward is sometimes closed due to staffing and they are re-deployed to other areas in maternity.

2.2 Red Flags

In October 2019 there were 41 red flags reported. Out of these were 14 for staffing shortfalls. Investigations into these concluded that staffing levels and skill mix were safe at the time and did not contribute directly to any incidents.

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 midwives in the NHS in England.

4.0 Vacancies

There are currently no RM vacancies across Maternity however, 15.49 wte support worker vacancies which are out to advert. 2 Band 5 vacancies on the Gynaecology Ward. 8 band 5 vacancies in theatres. 8 band 5 vacancies in Neonates. 10 Neonatal nurses have commenced as part of the partnership working across sites. Theatres is of some concern as there hasn't been many applicants in recent recruitment. Vacancies are being covered by bank and agency, CSS HR business partner is working with theatres to discuss other initiatives to improve recruitment.

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 NMPF and PPF.

Further work is currently being undertaken 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. Each division undertakes health roster challenges led by HON/M.

5.0 Summary

During the month of **October 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.

Theatres is a concern with unfilled vacancies and agency costs
Maternity has seen a rise in bank costs and overspends with a reduction in births.
DDONM, DDOF and DDHR are commencing monthly meetings with divisions to take control of vacancies and spend.

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

Appendix 1

October 2019

WARD	Fill Rate Day% RN/RM	Fill Rate Day % Care staff	Fill Rate Night % RN/RM	Fill Rate Night % Care staff
Gynae Ward	93.5%	98.4%	98.9%	100%
Delivery Suite	92.2%	81.7%	91.2%	79.6%
Mat Base	89.5%	61.9%	88%	80.6%
MLU	106.5%	90.3%	108.9%	83.9%
Jeffcoate	68.4%	63.2%	60%	46.7%
Neo-nates	108.9%	104.8%	110.3%	106.5%

Liverpool Women's NHS Foundation Trust

Agenda Item	19/20/204

MEETING	**Trust Board**
PAPER/REPORT TITLE:	**Performance Report - Month 7**
DATE OF MEETING:	Thursday, 05 December 2019
ACTION REQUIRED	**Assurance**
EXECUTIVE DIRECTOR:	Gary Price, Director of Operations
AUTHOR(S):	Gary Price, Director of Operations
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** 1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☐ 2. To be ambitious and *efficient* and make the best use of available resource ☒ 3. To deliver *safe* services ☒ 4. To participate in high quality research and to deliver the most *effective* Outcomes ☐ 5. To deliver the best possible *experience* for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust…….* ☐ ***2.*** *Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have sufficient numbers of clinical 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) ……* ☐
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	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 committee is asked to note the report***			
PREVIOUSLY CONSIDERED BY:	**Committee name**	Finance Performance and Business Development Committee Quality Committee		
	Date of meeting	Monday, 25 November 2019		

Executive Summary

This report has been produced to provide a performance position for month 7 and for the Trust Board to be assured of the measures taken to address the patient access targets.

In month 7 the 18-week Referral to Treatment (RTT) target remained static.

In Oncology the 2-week target was achieved, the 31-day target improved from the previous month however was not achieved. The 62-day target was not achieved

Report

1. Introduction

This report will provide an overview of the Trust's performance against the Key Performance Indicators highlighting those where the targets have not been met in month and subsequent actions taken to improve this position.

2. Performance

INDICATOR		METRIC	THRESHOLD		ACTUALS						
					Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Cancer	2WW for suspected cancer	%	≥93%	Higher values are better	94.2	97.7	93.3	95.0	93.9	96.23	97.92
	31 Days from Diagnosis to 1st Definitive Treatment	%	≥96%	Higher values are better	83.3	90.3	60.0	70.3	59.1	28.5	60.0
	62 Days for First Treatment from urgent GP Referral **(After re-allocation)** Final Reported Position	%	≥85%	Higher values are better	54.3	80.9	22.2	32.3	33.3	28.5	22.7
	104d Referral to First Definitive Treatment	Count	0	Zero tolerance	0	1	3	0	1	7	2
RTT	RTT Incomplete Pathways <18 weeks	%	≥92%	Higher values are better	84.6	83.0	81.5	81.95	83.0	83.3	83.1
	Incomplete Pathway > 52 Weeks	Count	0	Zero tolerance	6	3	3	1	1	1	3

2.1 Referral to Treatment (RTT)

RTT incomplete 18-week pathway performance remained static in in October at 83%. This was largely due to the continuation of unplanned Consultant absence.

There were 3 52-week breeches for September. All these patients have a planned treatment date now agreed. The Trust is on track to achieve Zero 52-week breeches by December as planned.

The focus continues to be aimed, in line with NHSI guidance, on prioritising treating those clinically urgent, longest waiting patients for in both our admitted and non-admitted RTT pathways. RTT training for staff continues with over 100 staff undertaking the training to date. The Trust has recommenced the RTT weekly submission to the CCG and NHSI&E in November due to greater confidence in data quality.

Through October there has been a continuation of sickness and absence in the Consultant workforce resulting in an unplanned pressure on the service. Additional resource has been sourced going forwards

The service is still planning to achieve 92% compliance by Spring 2020

2.2 Cancer

Cancer performance remains a significant concern for the Trust with long term sickness within the speciality and vacancy.

The 2-week target was achieved in month 7. The 31-day target improved from previous month but was not achieved. The 62 day target was not achieved. There were 2 104-day breeches.

Of the 104-day breeches. One was a late referral from another Trust and one was a complex patient.

Of the 62 day breeches 2 were late referrals, 4 were complex needing input from anaesthetics/critical care, 1 was delayed due to diagnostics and 1 due to theatre capacity at LWH.

The service has a medical establishment of 6 sub-speciality oncologists. At present there are 3 Consultants in post due to vacancy and sickness. One of the 3 is due to leave the Trust in January 2020.

Regional escalation through the Cancer Alliance, NHSI and E and Liverpool CCG has taken place. The strategic view of the Trust is that cancer targets will remain a challenge whilst services are not collocated with appropriate surgical, critical care and diagnostic support. A formal partnership board with Liverpool University Hospitals is being established to attempt to address these issues.

In addition to the strategic actions the service is focussing operationally to mitigate wherever possible the reduced workforce. This is managed via a weekly Executive lead oncology action plan meeting.

The themes for local operational action are all based around maximising the existing resource to support the service and our patients. CCG and other commissioning colleagues are encouraged to attend these meetings in a partnership approach and have done. The key themes are:

1) Ongoing review of all patient pathways to reduce breeches, escalation of pathway delays (diagnostics including pathology).
2) Delivering combined theatre lists with Liverpool University Hospitals.
3) Review of current capacity and demand: Updating Job Planning and continue to try and recruit.
4) Recruitment to a dedicated cancer manager post is underway.
5) Decompression of service: working with the Cheshire and Merseyside Cancer alliance to reduce pressure on the service through pathway redesign.
6) Co-location of all the cancer team (administrative and clinical) with increased funding secured for cancer support workers.

As per the NHS Long Term Plan the Cheshire and Mersey Cancer Alliance will now be held to account for improving cancer performance with a view to addressing the regional failure to achieve the 62-day target. The Trust is engaged in this work which began in September. This proposes to move to a system level cancer improvement plan.

2.3 - Complaints

Complaints are acknowledged with the patient within 3 working days- LWH is at 100%. National and LWH policy states that complaints must be responded to within 6 months- LWH is at 100%. However, when a complaint is received the patient experience team, in discussion with the complainant, agree a timescale for a response, this is generally within 45 days some being shorter and some being longer if complex complaints involving other hospitals or departments. Some responses require an extension if there are specific reasons for delays.

There has been a decrease in the performance of response rates of complaints, in relation to agreed timescales, in October 2019. The response rate was 16.57% which equates to only 1 out of 6 complaints responded to in the agreed timeframe. Reasons for this are varied, some complex complaints which have not asked for an extension therefore breach. Some delays in divisions responding therefore a tight timescale for patient experience team and executive sign off.

Actions- DDONM – weekly complaint performance meetings with divisions. Each division to discuss complaints at weekly triumvirate meetings. Weekly report to executive team until response rate improves. Patient experience team continue to support divisions as required. Focus on complaints at monthly divisional performance meetings.

3. Conclusion

18-week RTT performance remained static, however further improvement is still subject to appropriate capacity and the service continues to work hard to maintain those levels.

Oncology performance remains a significant challenge to the Trust, largely due to lack of clinical capacity and there are significant operational and strategic actions being undertaken to address this.

Liverpool Women's NHS Foundation Trust

Agenda Item	19/20/205

MEETING	**Trust Board**
PAPER/REPORT TITLE:	Finance Performance Review Month 7 2019/20
DATE OF MEETING:	Thursday, 05 December 2019
ACTION REQUIRED	**Assurance**
EXECUTIVE DIRECTOR:	Jenny Hannon, Director of Finance
AUTHOR(S):	Eva Horgan, Deputy Director of Finance Claire Scott, Head of Financial Management
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 clinical 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)* ☐
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):	3. This report will not be published under the Trust's Publication Scheme due to exemptions under S22 of the Freedom of Information Act 2000, because the information contained is intended for future publication	
RECOMMENDATION: ***(eg: The Board/Committee is asked to:-….)***	***The Board is asked to note the Month 7 Financial Position.***	
PREVIOUSLY CONSIDERED BY:	**Committee name**	Finance Performance and Business Development Committee
	Date of meeting	Monday, 25 November 2019

Executive Summary

The 2019/20 Board-approved budget is a breakeven position, after the delivery of £3.6m CIP, and receipt of £4.6m Provider Sustainability Funding (PSF), Financial Recovery Fund (FRF) and central Marginal Rate Emergency Threshold (MRET). The control total includes £0.3m of agreed investment in the costs of the clinical case for change identified in the 2019/20 operational plan, in addition to the £1.5m 2017/18 and 2018/19 investments, as well as investment in other clinical areas for safety and quality reasons.

At Month 7 the Trust is reporting a YTD deficit of £0.8m against a deficit budget of £0.9m, giving a year to date favourable variance of £0.1m. The key areas of financial performance are summarised below.[1]

	Plan	Actual	Variance	RAG
Surplus/(Deficit) YTD	-£0.9m	-£0.8m	£0.1m	↓
Surplus/ (Deficit) FOT	£0.0m	£0.2m	£0.2m	↔
NHSI Rating	3	3	0	↔
Cash	£4.6m	£1.9m	-£2.7m	↔
Total CIP Achievement YTD	£1.0m	£1.0m	-£0.0m	↔
Recurrent CIP Achievement YTD	£1.0m	£1.0m	-£0.0m	↔
Capital Spend YTD	£13.0m	£9.7m	-£3.3m	↑

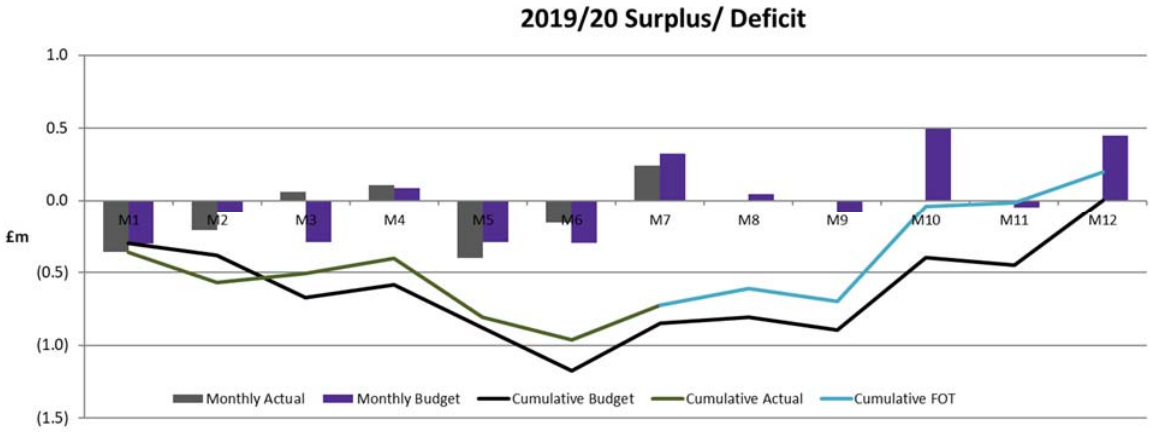
The Month 7 financial submission to NHSI is consistent with the contents of this report.

[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.

Report

1. Summary Financial Position

At Month 7 the Trust is reporting a deficit of £0.8m against a deficit budget of £0.9m. The Trust is forecasting delivery of the breakeven control total, after £4.6m of central funding. The actual forecast is a £0.2m surplus due to receipt of PSF in 2019/20 in relation to 2018/19, but this is adjusted out in the control total calculation.



CIP is on track for Month 7. The forecast remains on plan.

2. Divisional Summary Overview

Family Health: Overall the division remains on plan in month, year to date and in the full year, forecasting a favourable variance of £0.8m. However activity is significantly below plan in both neonates and maternity. This is being managed through the Operational Planning round which is now underway

Gynaecology: The division is still significantly behind plan year to date and is forecasting an adverse variance against budget of £3m. However, the overall position was favourable to plan in Month 7. The Recovery Plan and actions being taken by divisional management are starting to take effect and the position in both Hewitt Fertility Centre and the Gynaecology directorate were much improved in month.

Concerted work is ongoing within the division to maintain and continue to improve this position.

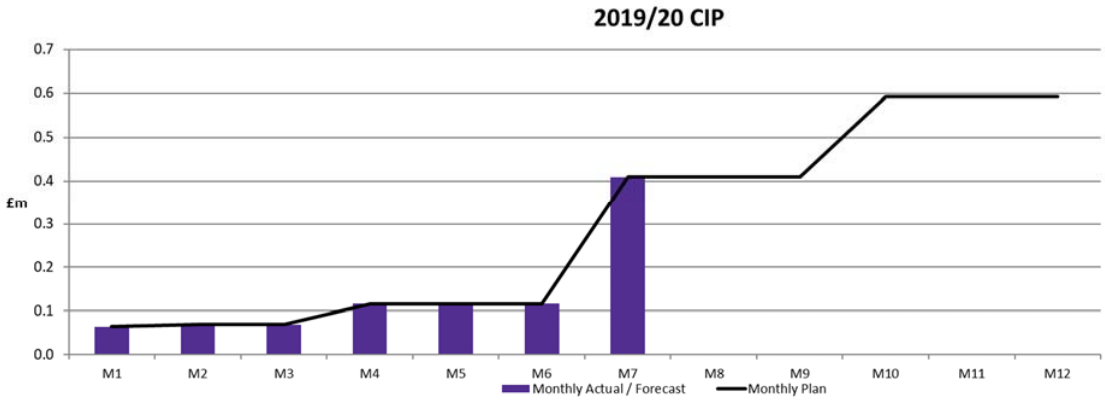
Clinical Support Services: The division remains within budget year to date and in the full year forecast.

Agency: Agency costs, although ahead of plan, slowed in month and stand at £1.2m year to date. Work has been undertaken to agree exit plans for all agency usage and the forecast has reduced to £1.65m, leaving a small amount of contingency against the £1.8m cap. This is being monitored closely via both SMT and Executive Team meetings.

3. CIP

Although the Trust is facing other financial challenges in the underlying position, the position in relation to CIP remains positive, reflective of the early, robust planning and also compensating actions taken at an early stage. Risks which have materialised were not unexpected and have been managed through the application of grip and control measures such as a review of contracts. The result of this is that the Trust is on plan YTD and expects to deliver the required level of CIP.

The graph below shows current performance and plan. The large increase in month relates to the CNST maternity incentive.



4. Contract Performance

Income YTD is £1.5m higher than would have been received under PbR under Acting as One.

Directorate	CCG	Month 7 Block	Month 7 Actual	Month 7 Variance	YTD Block Block	YTD Block Actual	YTD Block Variance	YTD % Variance
Maternity	Liverpool	2,317	2,209	(107)	16,531	16,138	(393)	-2%
Maternity	South Sefton	527	504	(23)	3,766	3,632	(134)	-4%
Maternity	Southport & Formby	53	68	15	378	314	(64)	-17%
Maternity Total		**2,896**	**2,781**	**(116)**	**20,676**	**20,085**	**(591)**	**-3%**
Gynaecology	Liverpool	1,094	1,014	(81)	7,470	6,993	(477)	-6%
Gynaecology	South Sefton	303	255	(48)	2,069	1,784	(285)	-14%
Gynaecology	Southport & Formby	38	25	(13)	258	204	(54)	-21%
Gynaecology Total		**1,435**	**1,293**	**(142)**	**9,797**	**8,981**	**(816)**	**-8%**
Hewitt	Liverpool	151	96	(55)	1,031	862	(168)	-16%
Hewitt	South Sefton	40	26	(14)	274	236	(38)	-14%
Hewitt	Southport & Formby	23	15	(8)	157	127	(30)	-19%
Hewitt Total		**214**	**137**	**(77)**	**1,462**	**1,225**	**(236)**	**-16%**
Other	Liverpool	19	15	(4)	131	162	31	24%
Other	South Sefton	5	4	(0)	31	84	53	169%
Other	Southport & Formby	1	0	(1)	6	20	14	224%
Other Total		**25**	**20**	**(5)**	**168**	**266**	**98**	**58%**
Total		**4,570**	**4,231**	**(339)**	**32,103**	**30,558**	**(1,545)**	**-4.81%**

The position has reduced in month from a 5.7% variance to 4.8%. There have been no indications from the lead commissioner that this will be clawed back due to the current wider system approach.

Neonatal income is also higher than it would be on an activity basis based on 2018/19 tariffs (by £1.8m YTD). However it is important to note that these tariffs were not national or mandatory. The cost of the neonatal service is in excess of the notional tariffs. Work is ongoing with commissioners to resolve this and agree an appropriate basis of payment.

5. Forecast Out-turn

The overall forecast remains unchanged from Month 6 and there are some favourable signs in month, in particular the improved Gynaecology position and reduced agency spend. A further detailed forecast will be undertaken at Month 9.

6. Cash and Borrowings

At £1.9m, the cash balance is lower than planned by £2.7m, reflecting reduced creditors as work is undertaken to clear disputes and settle historic issues. The Trust continues to produce a forecast cash flow on a 13 week and in year basis, and there are no issues to flag from this.

7. Capital Expenditure

Capital expenditure is increasing as the Neonatal redevelopment nears completion and the Global Digital Exemplar (GDE) Fast Follower programme continues. There remains over £8m to spend in the last five months of the year.

The forecast is above plan as the Trust has secured an additional £1.2m of funding from NHS Digital for the GDE FF programme, and secured permission from NHSI to increase baseline capital expenditure as well. Work is underway to progress this expenditure in good time for year end, with a full prioritisation exercise completed.

8. Balance Sheet

Debtors have remained fairly steady, but there are some large payments anticipated over the next few months. Considerable work has been undertaken to resolve disputes with several commitments to pay made.

A number of provisions have been released or are expected to be released within the year which are supporting delivery of the position.

9. BAF Risk

There are no proposed changes to the BAF risk score.

10. Conclusion & Recommendation

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

Appendix 1 – Board Pack

Finance Pack M7 - Board.xlsx

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

FINANCE REPORT: M7

YEAR ENDING 31 MARCH 2020

Contents

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 1
NHS IMPROVEMENT RATIOS: M7
YEAR ENDING 31 MARCH 2020

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	3,017	3,208	6,661	7,212
(b) PDC + Interest Payable + Loans Repaid	6,092	8,136	7,262	9,327
CSC Ratio = (a) / (b)	**0.50**	**0.39**	**0.92**	**0.77**
NHSI CSC SCORE	4	4	4	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	(14,843)	(14,818)	(13,172)	(13,390)
(b) Expenditure	65,081	64,997	110,554	109,188
(c) Daily Expenditure	304	304	303	299
Liquidity Ratio = (a) / (c)	**(48.8)**	**(48.8)**	**(43.5)**	**(44.8)**
NHSI LIQUIDITY SCORE	4	4	4	4
Ratio Score 1 = > 0 2 = (7) - 0 3 = (14) - (7) 4 = < (14)				
I&E MARGIN				
Deficit (Adjusted for donations and asset disposals)	851	891	(4)	(32)
Total Income	(68,069)	(68,002)	(117,167)	(116,178)
I&E Margin	**-1.3%**	**-1.3%**	**0.0%**	**0.0%**
NHSI I&E MARGIN SCORE	4	4	2	2
Ratio Score 1 = > 1% 2 = 1 - 0% 3 = 0 - (-1%) 4 < (-1%)				
I&E MARGIN VARIANCE FROM PLAN				
I&E Margin (Actual)		-1.30%		0.00%
I&E Margin (Plan)		-1.30%		0.00%
I&E Variance Margin	**0.00%**	**0.00%**	**0.00%**	**0.00%**
NHSI I&E MARGIN VARIANCE SCORE	1	1	1	1
Ratio Score 1 = 0% 2 = (1) - 0% 3 = (2) - (1)% 4 = < (2)%				
AGENCY SPEND				
YTD Providers Cap	1,043	1,043	1,792	1,792
YTD Agency Expenditure	693	1,175	1,188	1,652
	-33.6%	**12.7%**	**-33.7%**	**-7.8%**
NHSI AGENCY SPEND SCORE	1	2	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

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
INCOME & EXPENDITURE: M7
YEAR ENDING 31 MARCH 2020

INCOME & EXPENDITURE	MONTH			YEAR TO DATE			YEAR		
£'000	Budget	Actual	Variance	Budget	Actual	Variance	Budget	FOT	Variance
Income									
Clinical Income	(8,878)	(8,888)	9	(61,543)	(61,235)	(308)	(104,520)	(103,949)	(570)
Non-Clinical Income	(1,081)	(992)	(89)	(6,526)	(6,932)	406	(12,647)	(12,394)	(253)
Total Income	**(9,959)**	**(9,880)**	**(79)**	**(68,069)**	**(68,167)**	**98**	**(117,167)**	**(116,343)**	**(824)**
Expenditure									
Pay Costs	5,913	5,836	77	41,263	41,264	(1)	70,856	71,224	(368)
Non-Pay Costs	2,165	2,202	(37)	15,796	15,710	86	26,634	24,900	1,734
CNST	1,009	1,009	(0)	8,022	8,022	(1)	13,064	13,064	(0)
Total Expenditure	**9,087**	**9,047**	**40**	**65,081**	**64,997**	**85**	**110,554**	**109,188**	**1,366**
EBITDA	**(872)**	**(833)**	**(40)**	**(2,987)**	**(3,170)**	**183**	**(6,613)**	**(7,155)**	**542**
Technical Items									
Depreciation	378	374	4	2,712	2,758	(46)	4,641	4,707	(66)
Interest Payable	38	24	13	212	166	46	402	328	74
Interest Receivable	(4)	(2)	(2)	(30)	(38)	9	(48)	(57)	9
PDC Dividend	135	171	(36)	944	1,013	(70)	1,617	1,737	(120)
Profit/Loss on Disposal or Transfer Absorption	0	25	(25)	0	25	(25)	0	275	(275)
Total Technical Items	**546**	**592**	**(46)**	**3,838**	**3,925**	**(87)**	**6,613**	**6,990**	**(378)**
(Surplus) / Deficit	**(326)**	**(240)**	**(86)**	**851**	**755**	**96**	**0**	**(165)**	**165**
Control Total Adjustments									
18/19 Additional PSF					*165*	*(165)*		*165*	*(165)*
Remove capital donations/grants I&E impact					*-2*	*2*	*-4*	*-7*	*3*
Adjusted Control Total	***(326)***	***(240)***	***(86)***	***851***	***918***	***(67)***	***(4)***	***(7)***	***3***

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 3
EXPENDITURE: M7
YEAR ENDING 31 MARCH 2020

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	379	303	75	2,665	2,181	484	4,558	3,902	656
Medical	1,500	1,597	(97)	10,160	10,372	(212)	17,682	18,109	(427)
Nursing & Midwifery	2,598	2,626	(28)	17,729	18,095	(366)	30,719	31,565	(846)
Healthcare Assistants	452	421	31	3,134	2,913	221	5,393	4,937	455
Other Clinical	348	270	78	3,103	2,934	169	4,842	4,663	179
Admin Support	178	171	6	1,245	1,130	115	2,140	2,003	137
Corporate Services	360	364	(3)	2,538	2,465	74	4,340	4,393	(53)
Agency & Locum	98	83	15	689	1,174	(486)	1,180	1,651	(471)
Total Pay Costs	**5,913**	**5,836**	**77**	**41,263**	**41,264**	**(1)**	**70,856**	**71,224**	**(368)**
Non Pay Costs									
Clinical Suppplies	652	668	(16)	4,651	4,827	(177)	7,859	8,116	(257)
Non-Clinical Supplies	509	483	26	3,565	3,409	156	6,116	5,622	495
CNST	1,009	1,009	(0)	8,022	8,022	(1)	13,064	13,064	(0)
Premises & IT Costs	491	521	(29)	3,417	3,581	(164)	5,931	6,233	(302)
Service Contracts	513	531	(18)	4,163	3,893	271	6,727	4,929	1,798
Total Non-Pay Costs	**3,174**	**3,211**	**(37)**	**23,818**	**23,732**	**86**	**39,698**	**37,964**	**1,734**
Total Expenditure	**9,087**	**9,047**	**40**	**65,081**	**64,997**	**85**	**110,554**	**109,188**	**1,366**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
BUDGET ANALYSIS: M7
YEAR ENDING 31 MARCH 2020

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	(3,799)	(3,741)	(58)	(26,236)	(26,410)	174	(44,885)	(45,318)	433
Expenditure	1,880	1,866	14	12,883	13,052	(168)	22,204	22,505	(301)
Total Maternity	**(1,919)**	**(1,875)**	**(44)**	**(13,353)**	**(13,359)**	**6**	**(22,681)**	**(22,813)**	**132**
Neonatal									
Income	(1,445)	(1,690)	245	(9,991)	(10,131)	140	(17,072)	(17,438)	365
Expenditure	1,100	1,081	19	7,659	7,429	230	13,158	12,841	317
Total Neonatal	**(345)**	**(609)**	**264**	**(2,332)**	**(2,703)**	**370**	**(3,914)**	**(4,596)**	**682**
Division of Family Health - Total	**(2,264)**	**(2,484)**	**220**	**(15,685)**	**(16,061)**	**376**	**(26,595)**	**(27,409)**	**814**
Gynaecology									
Income	(2,388)	(2,416)	29	(16,280)	(15,393)	(886)	(27,996)	(26,508)	(1,488)
Expenditure	980	1,079	(99)	6,522	7,017	(494)	11,444	12,068	(624)
Total Gynaecology	**(1,407)**	**(1,338)**	**(70)**	**(9,757)**	**(8,376)**	**(1,381)**	**(16,552)**	**(14,440)**	**(2,112)**
Hewitt Centre									
Income	(946)	(1,195)	248	(6,322)	(6,432)	110	(11,001)	(10,556)	(445)
Expenditure	684	665	19	4,760	4,961	(201)	8,130	8,587	(457)
Total Hewitt Centre	**(262)**	**(529)**	**267**	**(1,562)**	**(1,471)**	**(91)**	**(2,871)**	**(1,969)**	**(902)**
Division of Gynaecology - Total	**(1,670)**	**(1,867)**	**197**	**(11,319)**	**(9,847)**	**(1,472)**	**(19,423)**	**(16,409)**	**(3,014)**
Theatres									
Income	(39)	(42)	2	(275)	(289)	14	(472)	(489)	17
Expenditure	702	779	(77)	4,901	4,932	(31)	8,411	8,662	(251)
Total Theatres	**662**	**738**	**(75)**	**4,626**	**4,643**	**(17)**	**7,938**	**8,173**	**(234)**
Genetics									
Income	(307)	(315)	8	(3,105)	(3,530)	425	(4,640)	(5,326)	686
Expenditure	187	169	18	2,044	2,334	(291)	2,979	3,472	(493)
Total Genetics	**(121)**	**(147)**	**26**	**(1,061)**	**(1,195)**	**134**	**(1,661)**	**(1,855)**	**193**
Other Clinical Support									
Income	(30)	(27)	(3)	(208)	(183)	(25)	(357)	(309)	(47)
Expenditure	677	746	(70)	4,731	4,472	260	8,121	7,747	374
Total Clinical Support	**647**	**719**	**(72)**	**4,524**	**4,289**	**235**	**7,764**	**7,438**	**326**
Division of Clinical Support - Total	**1,188**	**1,310**	**(122)**	**8,089**	**7,737**	**352**	**14,041**	**13,756**	**285**
Corporate & Trust Technical Items									
Income	(1,004)	(453)	(551)	(5,652)	(5,798)	146	(10,743)	(10,398)	(345)
Expenditure	3,424	3,254	170	25,418	24,725	693	42,720	40,296	2,424
Total Corporate	**2,420**	**2,800**	**(381)**	**19,766**	**18,927**	**839**	**31,977**	**29,898**	**2,079**
(Surplus) / Deficit	**(326)**	**(240)**	**(86)**	**851**	**755**	**96**	**0**	**(165)**	**165**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
CIP: M7
YEAR ENDING 31 MARCH 2020

NHSI SCHEME REFERENCE	SCHEME NAME	ACCOUNTING	RISK RATING	MONTH 7 TARGET	MONTH 7 ACTUAL	MONTH 7 VARIANCE	YTD TARGET	YTD ACTUAL	YTD VARIANCE	YEAR TARGET	YEAR FOT	YEAR VARIANCE	FYE TARGET	FYE FOT	FYE VARIANCE
Trust scheme 1	Car Parking Consumables	Non-Pay	Medium	1	1	0	7	7	0	12	12	0	12	12	0
Trust scheme 2	CNST Maternity Incentive	Non-Pay	Medium	160	160	0	160	160	0	960	960	0	960	960	0
Trust scheme 3	Estates Income Generation	Income	Low	3	1	(2)	21	19	(2)	36	28	(8)	36	36	0
Trust scheme 4	Contract Savings	Pay	Low	14	14	0	98	98	0	168	168	0	168	168	0
Trust scheme 5	Coding & Counting	Income	Low	13	13	0	91	91	0	156	156	0	156	156	0
Trust scheme 6	Decontamination Contract	Non-Pay	Low	3	3	0	21	21	0	36	36	0	36	36	0
Trust scheme 7	Meeting Utilisation	Income	Low	1	1	0	6	5	(1)	11	10	(1)	11	12	1
Trust scheme 8/9	HFEA Tender	Income/Pay	Medium	2	2	0	14	14	0	24	24	0	24	24	0
Trust scheme 10	HTE Contract Fees	Non-Pay	Low	3	3	0	21	21	0	36	36	0	36	36	0
Trust scheme 11	Imaging Income Opportunities	Income	Low	2	2	0	14	14	(0)	24	24	0	24	24	0
Trust scheme 12	Midwifery Productivity	Pay	Medium	23	23	0	113	113	0	228	228	0	228	228	0
Trust scheme 13	Pharmacy Review	Non-Pay	Medium	31	12	(19)	124	49	(75)	279	180	(99)	279	311	32
Trust scheme 14	Private Patient Fees	Income	Low	33	136	103	33	136	103	198	401	203	198	198	0
Trust scheme 15	Procurement (various)	Non-Pay	Medium	95	0	(95)	95	0	(95)	570	570	0	570	570	0
Trust scheme 16	Rateable Value Review	Non-Pay	Medium	5	0	(5)	5	0	(5)	30	0	(30)	30	0	(30)
Trust scheme 17	CQC Fees	Non-Pay	Low	7	7	0	49	49	0	84	84	0	84	84	0
Trust scheme 18	Restructuring	Pay	Low	7	7	0	49	49	0	84	84	0	84	84	0
Trust scheme 19	Section 106	Income	High	0	0	0	0	0	0	501	0	(501)	501	75	(426)
Trust scheme 20	Job Planning	Pay	Medium	4	4	0	24	24	0	44	44	0	44	48	4
Trust scheme 21	Sperm Bank	Non-Pay	High	0	0	0	0	0	0	51	51	0	51	204	153
Trust scheme 22	Sutures	Non-Pay	Low	2	2	0	14	14	0	24	24	0	24	24	0
Non-recurrent Mitigation	Gynaecology	Non-Pay	Low	0	0	0	0	1	1	0	1	1	0	0	0
Recurrent Mitigation	Genetics Overheads	Income	Low	0	0	0	0	0	0	0	137	137	0	137	137
Recurrent Mitigation	Contracts Review	Non-Pay	Low	0	18	18	0	74	74	0	298	298	0	100	100
TOTAL				409	409	0	959	959	0	3,556	3,556	0	3,556	3,527	(29)

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 6
BALANCE SHEET: M7
YEAR ENDING 31 MARCH 2020

BALANCE SHEET £'000	YEAR TO DATE Opening	M07 Actual	Movement	YEAR TO DATE Budget	M07 Actual	Movement
Non Current Assets	**79,968**	**86,267**	6,299	**90,534**	**86,267**	(4,267)
Current Assets						
Cash	9,066	1,934	(7,132)	4,600	1,934	(2,666)
Debtors	7,273	9,528	2,255	8,294	9,528	1,234
Inventories	489	437	(52)	452	437	(15)
Total Current Assets	**16,828**	**11,899**	**(4,929)**	**13,346**	**11,899**	**(1,447)**
Liabilities						
Creditors due < 1 year - Capital Payables	(1,347)	(1,316)	31	(266)	(1,316)	(1,050)
Creditors due < 1 year - Trade Payables	(13,661)	(17,322)	(3,661)	(19,084)	(17,322)	1,762
Creditors due < 1 year - Deferred Income	(2,428)	(3,187)	(759)	(3,471)	(3,187)	284
Creditors due > 1 year - Deferred Income	(1,654)	(1,636)	18	(1,633)	(1,636)	(3)
Loans	(13,635)	(11,957)	1,678	(17,252)	(11,957)	5,295
Provisions	(4,631)	(4,063)	568	(4,870)	(4,063)	807
Total Liabilities	**(37,356)**	**(39,481)**	**(2,125)**	**(46,576)**	**(39,481)**	**7,095**
TOTAL ASSETS EMPLOYED	**59,440**	**58,685**	**(755)**	**57,304**	**58,685**	**1,381**
Taxpayers Equity						
PDC	40,088	40,088	0	40,700	40,088	(612)
Revaluation Reserve	14,503	14,503	0	15,367	14,503	(864)
Retained Earnings	4,849	4,094	(755)	1,237	4,094	2857*
TOTAL TAXPAYERS EQUITY	**59,440**	**58,685**	**(755)**	**57,304**	**58,685**	**1,381**

**Please note that the closing balance used for retained earnings in the plan did not include the bonus PSF received for 2018/19 due to timing. The variance above is made up of a £96k favourable I&E variance and a £2,761k bonus PSF figure not included in the plan.*

Liverpool Women's NHS Foundation Trust

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 7
CASHFLOW STATEMENT: M7
YEAR ENDING 31 MARCH 2020

CASHFLOW STATEMENT	YEAR TO DATE		
£'000	Budget	Actual	Variance
Cash flows from operating activities	273	411	(138)
Depreciation and amortisation	2,712	2,758	(46)
Movement in working capital	1,499	2,021	(522)
Net cash generated from / (used in) operations	**4,484**	**5,190**	**(706)**
Interest received	30	38	(8)
Purchase of property, plant and equipment and intangible assets	(12,963)	(9,723)	(3,240)
Proceeds from sales of property, plant and equipment and intangible assets	721	0	721
Net cash generated from/(used in) investing activities	**(12,212)**	**(9,685)**	**(2,527)**
PDC Capital Programme Funding - received	612	0	612
Loans from Department of Health Capital - received	8,554	5,278	3,276
Loans from Department of Health Capital - repaid	(306)	(306)	0
Loans from Department of Health Revenue - received	0	0	0
Loans from Department of Health Revenue - repaid	(4,630)	(6,650)	2,020
Interest paid	(96)	(137)	41
PDC dividend (paid)/refunded	(806)	(822)	16
Net cash generated from/(used in) financing activities	**3,328**	**(2,637)**	**5,965**
Increase/(decrease) in cash and cash equivalents	**(4,400)**	**(7,132)**	**2,732**
Cash and cash equivalents at start of period	9,000	9,066	(66)
Cash and cash equivalents at end of period	**4,600**	**1,934**	**2,666**

LOANS SUMMARY			
£'000	Loan Principal Drawndown	Loan Principal Repaid	Loan Principal Outstanding at M7
Loans from Department of Health Capital (ITFF) - 2.0% Interest Rate	5,500	(2,446)	3,054
Loans from Department of Health Capital (Neonatal) - 2.54% Interest Rate	8,903	0	8,903
Loans from Department of Health Revenue - 1.50% Interest Rate	14,612	(14,612)	0
Total	**29,015**	**(17,058)**	**11,957**

LIVERPOOL WOMEN'S NHS FOUNDATION TRUST 8
CAPITAL EXPENDITURE: M7
YEAR ENDING 31 MARCH 2020

CAPITAL EXPENDITURE	Year to Date			Full Year		
£'000	Budget	Actual	Variance	Plan	Forecast	Variance
Neonatal New Building	8,554	7,768	786	10,410	10,731	(321)
Estates Schemes	560	205	355	960	527	433
Global Digital Examplar Fast Follower Project	690	646	44	1,225	2,400	(1,175)
Medical Equipment	1,997	505	1,492	2,177	2,695	(518)
IT Schemes	1,169	569	600	1,479	1,501	(22)
Total	**12,970**	**9,693**	**3,277**	**16,251**	**17,854**	**(1,603)**

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.

Liverpool Women's NHS Foundation Trust

Agenda Item	19/20/206

MEETING	**Trust Board**
PAPER/REPORT TITLE:	**Review of Headroom / Mandatory Training – Assurance Report**
DATE OF MEETING:	Thursday, 05 December 2019
ACTION REQUIRED	**Assurance**
EXECUTIVE DIRECTOR:	Caron Lappin, Director of Nursing and Midwifery
AUTHOR(S):	Janet Brennan, Deputy Director of Nursing & Midwifery Jeanette Chalk, Deputy Director of Marketing and Workforce 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 clinical 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) ……* ☐
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:-….)***	***To provide assurance to the board on the progress around mandatory training compliance in relation to the increase in headroom.***			
PREVIOUSLY CONSIDERED BY:	**Committee name**		Not Applicable	
	Date of meeting			

Executive Summary

The Trust invested the equivalent of £598K annually to increase the headroom from 18.9% to 21% in nursing and 21.4% in maternity. A plan to phase in the required investment was agreed and the money was released into the budgets by July 2019 giving a part year effect of £ 399K.

In the period following additional investment there has been an improving trend albeit compliance has not been fully met.

Divisional trajectories are in place to achieve full compliance by March 2020.

Compliance against trajectory will be monitored through divisional performance reviews.

Report

1. Introduction

Headroom is the term used to calculate the number of whole-time equivalent staff required to provide cover against a rota, to take account of sickness, annual leave, training and other time away from work. Typically, it does not cover maternity leave.

The revised calculation was based on an assessment of actual leave entitlement (which is 31 days on average for the clinical workforce at LWH) and rebased to match the Trust's sickness target of 4.5%.

Training was also re-assessed and reviewed in detail with managers and clinical leadership, with the relevant Head of Nursing/Midwifery agreeing the mandatory training requirement for each area. This averages at 5 days per year for Maternity and 4 days per year for all areas.

The headroom is intended to support safe staffing and compliance around mandatory training

	2018/19		2019/20	
Annual Leave	28.00 Days	10.8%	31.00 Days	11.9%
Bank holidays	8.00 Days	3.1%	8.00 Days	3.1%
Training	4.00 Days	1.5%	4.00 Days	1.5%
Sickness Absence	3.50 %	3.5%	4.50 %	4.5%
TOTAL HEADROOM		**18.9%**		**21.0%**

In total, budgets were uplifted by a part year value of £399k in respect of headroom. This was released into budgets in Month 4 (July 2019).

3. Mandatory Training

In April of this year, the OLM project commenced with the sole aim of reaching a point where Trust compliance data in relation to mandatory training was robust, and more easily available directly to line managers. Significant progress has been made, with further developments underway.

At mid-November work is completed to align ESR and the Master Record for both Core and Clinical Core training. Work will be completed on Local Mandatory Training before the end of November. This meets the timeline set within the project plan and will take the Trust to a position where training data will be robust monthly.

A number of developments to improve user experience and reduce paper-based admin are underway and will continue into 2020, including the introduction of e-PDR's, wider use of e-Workbooks and the introduction of Power Bi reporting allowing easier data access for managers.

Reporting of October data shows that many areas across the Trust are making progress with core mandatory training, albeit not yet reaching target, but compliance levels for clinical mandatory training remain some way from target although improving.

Divisional Management teams have developed realistic trajectories for the completion of core and core clinical mandatory training in all areas. Appendix 1

4. Conclusion

The Trust invested the equivalent of £598K on an annual basis to increase the headroom from 18.9% to 21% in nursing and 21.4% in maternity. A plan to phase in the required investment was agreed and the money was released into the budgets by July 2019.

The headroom that has been invested into budgets will support the delivery of compliance of mandatory training and Divisional trajectories are in place to achieve full compliance by March 2020.

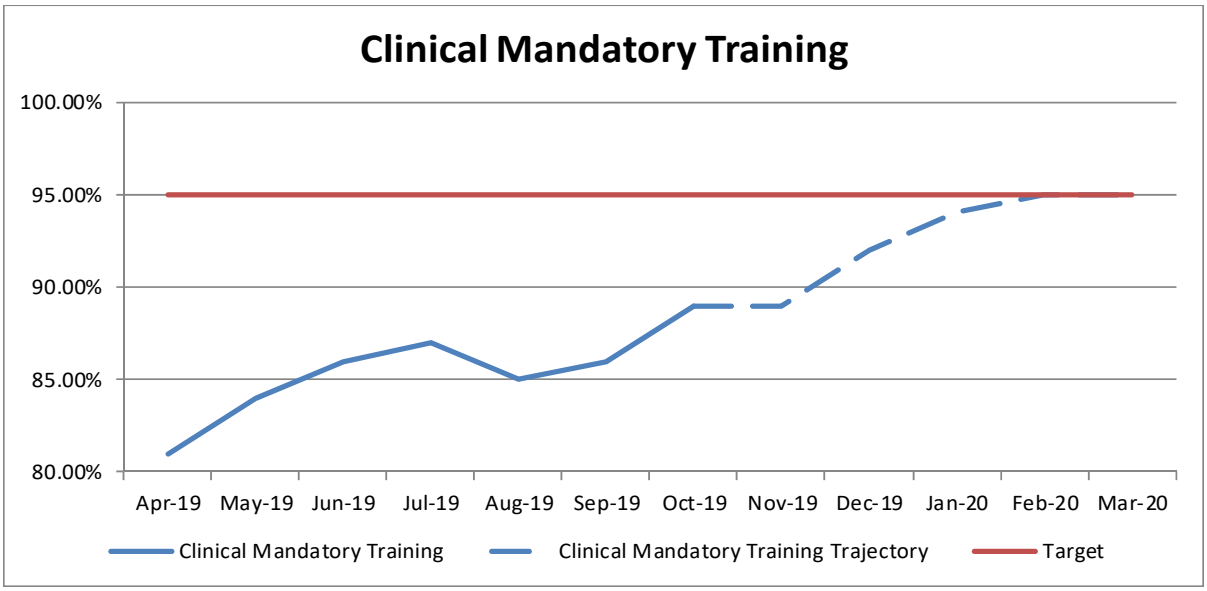
Compliance against trajectory will be monitored through divisional performance reviews.

6. Recommendation

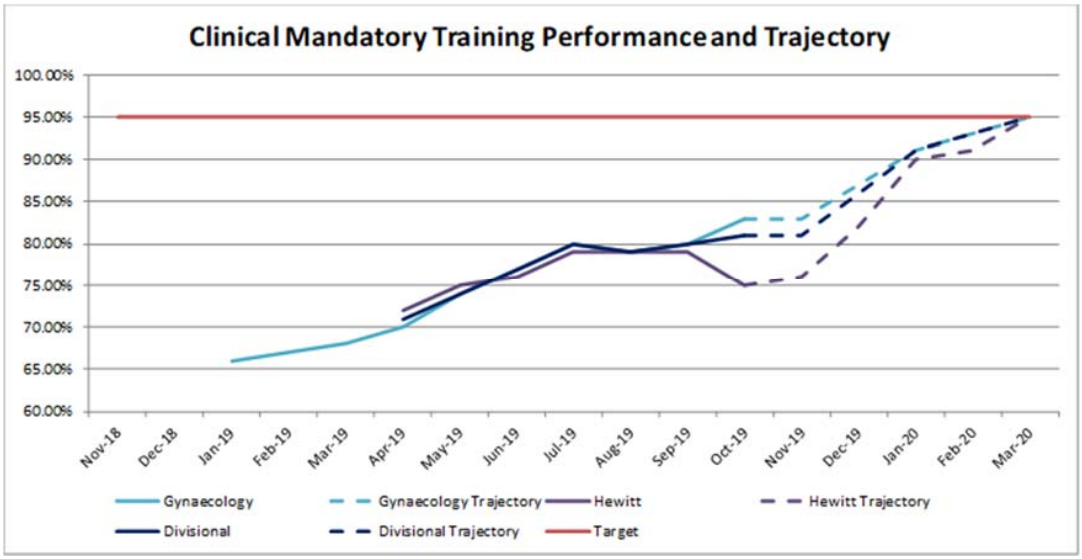
The Board are asked to be assured that there are robust plans in place to meet compliance of mandatory training by March 2020. Head room will be reviewed as part of the annual staffing plans and safe staffing review.

Appendix 1

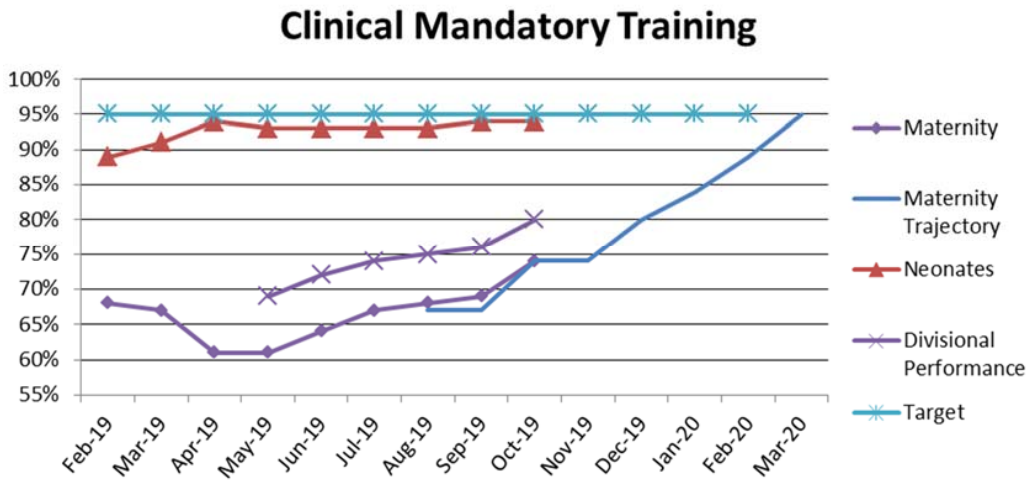
Clinical Support Services



Gynaecology



Family Health



Liverpool Women's NHS Foundation Trust

Agenda Item	19/20/207

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Corporate Objectives 2019/20: Six Monthly Review**
DATE OF MEETING:	Thursday, 05 December 2019
ACTION REQUIRED	**Receive**
EXECUTIVE DIRECTOR:	Andrew Loughney, Medical Director Choose an item. Choose an item.
AUTHOR(S):	Executives
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 clinical 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) ……* ☒
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 of Directors is recommended to note performance against the Corporate Objectives for the first 6 months of financial year 2019/20.			
PREVIOUSLY CONSIDERED BY:	**Committee name**		Not Applicable	
	Date of meeting			

Executive Summary

The Board of Directors formally approved the Corporate Objectives for 2019/20 at a meeting held on 2 May 2019 and agreed the alignment of objectives to Board Committees for periodic review.

Progress against each of the Corporate Objectives has been assessed by the relevant lead Directors and outcomes were reviewed, and endorsed, on 25 November 2019 by the following Committees:

- Finance, Performance & Business Development Committee
- Putting People First Committee
- Quality Committee

Recommendation

The Board of Directors is recommended to note performance against the Corporate Objectives for the first six months of financial year 2019/20.

Liverpool Women's NHS Foundation Trust

STRATEGIC AIMS AND CORPORATE OBJECTIVES 2019/20

By Committee

The Vision, Aims and Values have been developed over a long period of time with input from the Board, Staff, Governors and Stakeholders. These were commended by both CQC and Deloitte's (when they undertook the Well Led Governance review in 2014)

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

Corporate Objective To be ambitious and Efficient and make best use of available resources	Executive Lead	Relevant Strategy	Board Committee	6 monthly Review Comments
Deliver the financial plan for 2019/20	DoF	Operational Plan 19/20	FPBD	The Trust is on target to deliver the financial plan for 2019/20, including the delivery of CIP. There are, however, concerns in relation to the underlying position and levels of activity moving into 2020/21.
Deliver the operational plan for 2019/20	DoO	Operational Plan 19/20	FPBD	The Trust is delivering our planned trajectory for 18 week RTT at month 6. An increase in Consultant appointments through 2019 has supported this. The Trust maintains good performance against the national cancer 2 week target however is struggling to achieve the 31- and 62-day target, largely due to lack of speciality Consultants that is linked to our need to co-locate services with an adult acute site. As a strategic priority for the Trust, work to mitigate this is ongoing with commissioning and provider partners and stakeholders including the Cancer Alliance. The Trust's performance against the 4-hour emergency target and national diagnostic standard is good.
Demonstrate the effective use of resources in providing high quality, efficient and sustainable care in line with the recommendations of Lord Carter's review of Operational productivity and current National initiatives (Model Hospital/GIRFT)	DoF	Operational Plan 19/20	FPBD	A review against model hospital data is underway to inform planning for 2020/21, as well as a review of the NHS Efficiency Map which is a tool that promotes best practice in identifying, delivering and monitoring cost improvement programmes (CIPs) and quality, innovation, production and prevention (QIPP) schemes in the NHS Efficiencies and the effective use of resources however is impacted on an ongoing basis by being on a standalone site, and the requirement for clinical workarounds. The Trust continues to participate in collaboration at scale work streams across Cheshire and Merseyside.

Corporate Objective To deliver Safe services	Executive Lead	Relevant Strategy	Board Committee	6 monthly Review Comments
Maintain regulatory confidence & compliance	CEO	All	All	• The Trust continually keeps NHSI/E and CQC up to date with developments within the Trust and confidence in management and compliance is high. • Attendance and reporting at new System Assurance meetings led by NHSI/E. • Achieved Overall 'Good' rating following CQC inspection in February 2018 • Monthly and annual submissions to NHSI/E completed within timeframes set • Annual Report and Accounts 2018/19 submitted to Parliament within required timeframes.
Successfully delivering Year 2 of the Neonatal new build	MD/DoO/ DoF	Future Generations	FPBD	The build is progressing to time and budget and is on plan to open in the summer of 2020. A small net slippage of 2.5 weeks on the final completion date at the mid-year point is likely to be recovered.
Working in partnership with providers and commissioners to ensure quality safe services are delivered to the population of the region. This will include working closely with the following :- • Cheshire and Merseyside Partnership (STP) to develop and influence regional strategy • Liverpool CCG in supporting the Place plans • Alder Hey to implement the Neonatal Single Service on two sites	DoO	Operational Plan	FPBD	The Trust plays an active role in the Cheshire and Mersey Health and Care Partnership (HCP) which was previously known as the STP. The Women and Children's workstream for this programme is being refreshed and the Trust is promoting the sustainability of LWH in its current form as one of the key regional challenges to the sustainability of acute services. The Trust has developed a Liverpool Neonatal Partnership with Alder Hey Children's Hospital in order to provide best care and support for neonatal surgical babies. The partnership has recruited a leadership team and is developing and enhancing staffing in order to support delivery and development of this service through the rest of 2019/20.

Electronic Patient Records project delivery and implementation with required timeframe • Dependant on outcome discussions	DoF/MD/ DoO	EPR Project Plan	FPBD/ Quality Committee	The project has not delivered to timescales and is currently under review.
Develop IM&T as a strategic enabler ensuring that clinical systems are fit for purpose, forward focussed and embrace the wider strategic view of the health economy	DoF	IT Strategy	FPBD	The GDE Fast Follower programme and milestones, linked to the Health and Care Partnership Digit@ll strategy have formed the basis of the 2019/20 strategy. These have underpinned positive clinical developments throughout the year, although delays to EPR have meant that the current position is sub-optimal. The future strategy will be developed during Q4 of 2019/20 by the incoming Chief Information Officer (from December 2019).
Corporate Objective To deliver Safe services	**Executive Lead**	**Relevant Strategy**	**Board Committee**	**6 monthly Review Comments**
Delivery of in-year Quality Strategy objectives	MD/ DoN&M	Quality Strategy	Quality	The Trust is in the third year of the 2017/2020 Quality Strategy. The strategy objectives have been monitored on a quarterly basis via the Quality Committee. The strategy consists of 9 key areas. Progress to date is as follows: • 8 have been completed in full (including learning from incidents; sepsis; neonatal mortality and stillbirth; adult mortality; health and wellbeing; engagement; and learning from experience). • One has a recovery process in place (unplanned admissions and readmissions) and it is anticipated that this will be completed in early 2020.
Deliver the objectives defined in the Trust LocSSIP Group's Terms of Reference	MD	Quality Strategy	Quality	A LocSSIP Implementation Group has been established, chaired by the Deputy Medical Director, and a detailed action plan developed. A monthly progress report against the action plan is provided to the Quality Committee for assurance. Regular updates are also provided to the Clinical Commissioning Group. MIAA have completed an audit of LocSSIPs procedures which resulted in an assessment of Moderate Assurance.

Corporate Objective To participate in high quality research in order to deliver the most Effective outcomes	Executive Lead	Relevant Strategy	Board Committee	6 monthly Review Comments
Develop closer working relationships with University of Liverpool with respect to research and innovation	MD	R&D	Quality	The Liverpool Health Partners board (attended by LWH CEO) has established a Joint Research Service (JRS) across Liverpool bringing together all Trust and HEI RD&I departments. LWH has been a key stakeholder in that development. A starting well workstream is now established at LHP, pairing LWH with AHUH and a consultant neonatologist from LWH has taken up a senior role in that process.
Successful implementation of the Trust's Research and Development Strategy to enhance the Research and Innovation capabilities of the Trust	MD	R&D	Quality	Work towards implementation of the Trust's Research and Development strategy has been ongoing throughout the year. A full report of progress to date was presented to the Quality Committee in January 2019. There continues to be an investment of PAs to consultants in the Trust with an interest in R&D and this has helped LWH to establish itself as one of the leading performers in the region with relation to patient recruitment. R&D leadership within the nursing and midwifery workforce is currently under review in line with the R&D strategy.
Corporate Objective To deliver the best possible Experience for patients and staff	**Executive Lead**	**Relevant Strategy**	**Board Committee**	**6 monthly Review Comments**
Providing a patient led experience, continuously seeking feedback to further enhance our service provision.	DoN&M	Patient Experience Strategy	Quality	The Trust continues to monitor the Patient Experience Strategy through the Experience Senate. A texting facility has been rolled out to Gynaecology, Maternity and Genetics, this has increased patient feedback as part of Friends and Family Test. There are also still cards available in the areas for those who do not have access to text services. This is monitored via the Experience Senate and also by the CCG at CQPG. Regular monitoring and review of trends and themes from patient complaints and PALs contacts are provided to the Experience Senate and to the Quality committee to ensure

				that we are able to put actions in place in response to trends or themes. Further work is ongoing in relation to the collation of themes and trends from PALs+ meetings to ensure all areas receive appropriate feedback to plan actions. Regular monitoring and review of trends and themes from patient complaints and PALs contacts are provided to the Quality Committee quarterly to ensure that we are able to put actions in place in response to trends or themes.
Corporate Objective To develop a Well Led, capable, motivated and entrepreneurial Workforce	**Executive Lead**	**Relevant Strategy**	**Board Committee**	**6 monthly review**
Improving the Health & Wellbeing of the workforce by moving to upper quartile performance for % sickness absence and stress related absence incrementally between 2019-2021 as measured by the Annual Staff Survey	DoW&M	People Strategy	Putting People First	• This year's HWB priority is mental wellbeing. The PPF Strategy provides a five year target to achieve 10% of the workforce training as Mental Health First Aiders. The aim in Year 1 (ending March 20) is to achieve 5%. Support mechanism is now in place for all MHFAs. • HWB objectives to become mandatory for all people managers from January 2020 – this will support our strategic aim on HWB being viewed as a positive leadership behaviour and ensure engagement of people managers with the Trust wide options for supporting and improving HWB. • Quarterly health education campaigns have been introduced from October 2019, with the support of Occupational Health. Q1 = flu jabs; Q2 from January to March 2020 will be focussed on proactive targeted staff physio sessions where sickness related to musculoskeletal issues is high. • The rate of sickness absence this year so far has consistently tracked above target – localised plans are in place to focus on this. • Freedom to Speak Up Guardian service actively promoted and known to staff.

Improving the organisation's climate and increasing the overall staff engagement score (as measured by Annual Staff Survey & the Staff Friends & Family Test) to upper quartile for acute specialist Trusts incrementally between 2019-2021	DoW&M	People Strategy	Putting People First	• The overall staff engagement figure from the 2018 survey (known in March 2019) remained static. Whilst no improvement in the score was noted, it is positive that the engagement score remained the same given the significant organisational changes which occurred in the latter part of 2018. • Fair and Just Culture project has continued, with a full programme of book clubs for managers, and with a pilot of the training programme. • The pilot of the electronic quarterly survey "Listening to Our People" will draw to close at the end of the current annual contract. Response levels have been low, and consideration is being given to a different approach for 2020. • Summer of Listening events took place between June and September 2019. Outputs have been collated into a number of key themes and feedback will be shared across all areas with a view to building appropriate actions into Trust wide or Divisional People Plans.
Expanding the Trust's reach into its communities through extending its work experience, work training, guaranteed interview and apprenticeship schemes	DoW&M	People Strategy	Putting People First	• ***Work Experience*** **-** Placements for school students remain in high demand. All areas booked until March 2020. Next year is filling up fast with schools block booking unpopular weeks so that an even spread of students throughout the year is achievable. • ***Pre-employment*** **-** The third cohort of Pre-Employment participants has recently been completed. Once again the Trust has been able to offer Bank worker contracts to the majority of participants. • ***Acorns*** **-** This is a programme that replaces the familiar nursing cadets. It is a Health and Social Care Level 3 Extended Diploma course that allows students to have a placement in a healthcare setting and complete the Care Certificate and provides necessary qualifications to go onto higher study (eg nursing, paramedics, midwifery). The Trust is running this programme in partnership with Southport College. The first cohort of Acorns commences in January 2020

				• **Greenbank College** - The Trust continues with our 2 learning disability students on a year=long placement from Greenbank College. • **Schools Activities –** The Trust continues to support local schools and colleges by participating in events in the community around healthcare careers
Shaping workforce to meet operational needs through effective workforce planning and partnerships	DoW&M	People Strategy	Putting People First	• The trust continues with the approach to workforce planning which was adopted in 17/18 with finance, HR and operational colleagues working closely together to define and plan future workforce needs. • The Trust has participated Health Education England's national workforce planning data collection processes. • PPF continues deep dives into workforce risks & mitigation • Funding secured from Leadership Academy for Shadow Board project to develop Board directors for the future. The programme starts in January 20 and runs for 6 months. • Pension alternative award scheme now in place
Corporate Objective To deliver Safe services	**Executive Lead**	**Relevant Strategy**	**Board Committee**	**6 monthly review**
Maintain Safe Staffing levels	DoN&M	Quality & People Strategies	Putting People First	• Continue to provide monthly safer staffing reports to the Board, triangulating red flags against staffing levels and monitoring areas of high vacancies as mirrored with the National Picture of workforce across Nursing and Midwifery. • Commenced advanced midwifery practitioner pilot • Surgical Care Practitioner recruited and commenced training • Continue to identify shared ways of working to minimise clinical risk and improve recruitment to hard to fill roles

Corporate Objective Delivery of the Future Generations Strategy	Executive Lead	Relevant Strategy	Board Committee	6 monthly Review Comments
Support Commissioners and Regulators to agree strategic direction for Trust services, commencing with public consultation and Commissioner Decision Making Business Case.	CEO	Future Generations	Board specific	• Extensive engagement with Commissioners and Regulators throughout the year to date to ensure that the Trust's strategy is reflected in both local and regional plans. • Direct engagement with national and regional senior leaders in relation to the Trust's clinical case and capital requirements
Work jointly with other providers and regulators to consider options for future collaborations and organisational form.	DoF	Future Generations	Board specific	• Plans in place to establish a Partnership Board with Liverpool University Hospitals NHS Foundation Trust underpinned by a Memorandum of Understanding. • Partnership agreement with Alder Hey to support neonatal surgery arrangements • Engagement in the Cheshire and Merseyside Health and Care partnership work streams inc Women's and Children's and Acute Sustainability.
Retain Public and Staff Confidence through an effective Communications and Engagement Strategy	DoW&M	Future Generations	Board specific	All year to date actions in the delivery plan for 2019/20 have been completed. Work underway on a review of the Communications and Engagement Strategy.

Liverpool Women's NHS Foundation Trust

Agenda Item	19/20/208

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**EPRR Annual Assurance Report**
DATE OF MEETING:	Thursday, 05 December 2019
ACTION REQUIRED	**Assurance**
EXECUTIVE DIRECTOR:	Gary Price, Director of Operations
AUTHOR(S):	Lorraine Thomas Emergency Planning & Business Continuity Manager
STRATEGIC OBJECTIVES:	***Which Objective(s)?*** 1. To develop a well led, capable, motivated and entrepreneurial *workforce* ☒ 2. To be ambitious and *efficient* and make the best use of available resource ☒ 3. To deliver *safe* services ☒ 4. To participate in high quality research and to deliver the most *effective* Outcomes ☐ 5. To deliver the best possible *experience* for patients and staff ☒
LINK TO BOARD ASSURANCE FRAMEWORK (BAF):	***Which condition(s)?*** ***1.*** *Staff are not engaged, motivated or effective in delivering the vision, values and aims of the Trust…….* ☐ ***2.*** *Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have sufficient numbers of clinical 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) ……* ☐
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 requested to note this assurance report***	
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 report provides a summary of the Trust's compliance to the NHSE Emergency Preparedness, Resilience and Response (EPRR) Core Standards version 6.1 based on a self-assessment conducted October 2019.

- As a category 1 responder under the Civil Contingencies Act (CCA) 2004 the Trust is required to prepare for emergency and business continuity incidents and ensure that it has the capacity and capability to respond to emergency situations. Whilst managing emergency situations the Trust must as far as is reasonably practicable maintain continuity of services, prioritising critical service delivery when necessary.

- The NHSE EPRR Core Standards support the requirements of the CCCA and are utilised as an audit tool to measure compliance rates for NHS funded organisations. The NHSE EPRR annual assurance process for 2019/20 took the form of a self-assessment against the EPRR Core Standards version 6.1 and additional 'deep dive' criteria.

- The Trust achieved a rating of substantial compliance against the NHSE EPRR Core Standards for 2019/20.

Report

Assurance Process

NHS organisations were required to complete a self-assessment of compliance against the NHSE EPRR Core Standards version 6.1. Specialist Trusts were required to self-assess against 55 Standards. In addition, NHS organisations were required to self-assess against 20 'deep dive' criteria. For 2019/20 the deep dive criteria related to severe weather response and long term adaptation planning. The Trust has an Adverse Weather Plan in place and actions are in

progress via estates and facilities to support long term adaptation planning. Compliance against the deep dive criteria does not contribute to the overall compliance rating.

The NHSE EPRR Core Standards assessment process was completed by the Emergency Planning and Business Continuity Manager in conjunction with the EPRR Accountable Emergency Officer. Responses were based on activities monitored via the EPRR Committee and included activities and achievements reported within the EPRR Annual Board Report to the Finance, Performance and Business Development Committee (September 2019). The EPRR Committee standing agenda items, including development and revision of emergency and business continuity plans and arrangements, delivery of training and monitoring of the EPRR risk register directly support the EPRR annual assurance requirements.

Assurance Outcome

Of the 55 EPRR Core Standards applicable to Specialist Trusts the Trust met 52 standards with a rating of 'Green'. Three standards were partially met and therefore rated as 'Amber'. Based on this outcome the Trust submitted an overall rating to NHSE/I of 'Substantial Compliance' against the EPRR Core Standards for 2019/20. In addition the Trust met 15 of the 20 deep dive criteria with a rating of 'Green'. The remaining 5 criteria relate to long term adaptation planning. On conclusion of the national assurance process which includes facilitation of a 'confirm and challenge' process conducted by NHSE/I, the Trust will receive confirmation of the assessment outcome.

Actions Taken

An integral part of the EPRR annual assurance process is the development of an action plan to ensure achievement of compliance against any outstanding core standards. An action plan has been developed and submitted and progress will be monitored via the EPRR Committee and Information Governance Committee.

EPRR Activities

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

Conclusion

The EPRR annual assurance outcome of 'Substantial Compliance' against the NHSE EPRR Core Standards version 6.1 demonstrates that the Trust remains focused on continuing to meet its duties under the Civil Contingencies Act 2004.

Liverpool Women's NHS Foundation Trust

Agenda Item	2019/210

MEETING	**Board of Directors**
PAPER/REPORT TITLE:	**Board Assurance Framework**
DATE OF MEETING:	Thursday, 05 December 2019
ACTION REQUIRED	**Assurance**
EXECUTIVE DIRECTOR:	Paul Buckingham, Interim 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.*** *Potential risk of harm to patients and damage to Trust's reputation as a result of failure to have sufficient numbers of clinical 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) ……* ☒
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 Trust Board members are requested to review the contents of the paper and gain assurance as to the BAF management process and identify any changes they consider necessary for consideration by the sub-committees.	
PREVIOUSLY CONSIDERED BY:	**Committee name**	The Committees of: Finance, Performance and Business Development, Putting People First Quality Committee
	Date of meeting	November 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 2019/20 (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.

BAF Dashboard: November 2019

Please refer to 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 there have been some minor changes or alterations completed to a number of risk but a significant review of the risk relating to sustainability – number 2297 - Four new actions created to supplement current actions and reflect gaps in assurance. Risk Score increased to 25 from 20 and the target score also increased to 25.

3. New Risks and Closed Risk

Since the last report to the Trust Board the Electronic Patient Record risk has been rewritten and reviewed at the relevant November 2019 FPBD Committee meeting.

Since the last report, no BAF risks have been closed.

4. Conclusions

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.

5. Recommendation

The Trust Board members are requested to review the contents of the paper and gain assurance as to the BAF management process and identify any changes they consider necessary for consideration by the sub-committees.

Appendix 1 – BAF Dashboard November 2019

Risk No.	Description	Current risk score			Target	Assurance				Proposed Changes, Additions & Removals
		Severity	Likelihood	Risk Score	Risk Score by 31/03/2020	Status	Controls identified	Gap in Controls Identified	Assurances identified	
1663	**Condition:** Failure to deliver the annual financial plan **Cause:** Slippage against CIP targets (inc EPR delivery & CNST contribution reduction); Loss of activity resulting in reduced contribution; Increases in patient activity as contracts are largely on a block basis; Workforce cost pressures; Pressure to deliver national targets; Pension changes for consultants affecting additional activity **Consequence:** Breach of license conditions resulting in financial special measures	5	5	25	10	⟺	Y	Y	Y	Minor updates made
1986	**Condition:** The Trust is not financially sustainable beyond the current financial year **Cause:** Ongoing requirement for annual CIPs; Significant CNST premium; Overhead costs; Impact of service change **Consequence**: Lack of financial stability, invocation of NHSI sanctions, special measures. Continued borrowing to meet operational expenses resulting in significant debt.	5	5	25	25	⟺	Y	Y	Y	Minor updates made
2184	**Condition:** Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) by the proposed schedule May 2020 which may lead to the implementation of a system that is not fit for purpose **Cause:** Poor programme management and product design **Consequence:** Impact on Patient Safety, Quality and Experience; Impact on patient 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.	5	5	25	25	⟺	Y	Y	Y	Risk reviewed by FPBD and it was agreed that the nature of the risk would be further reviewed at the relevant November 2019 Committee meetings. Current risk to remain on BAF until new risk approved

Risk No.	Description	Current risk score			Target	Assurance				Proposed Changes, Additions & Removals
		Severity	Likelihood	Risk Score	Risk Score by 31/03/2020	Status	Controls identified	Gap in Controls Identified	Assurances identified	
2266	**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.	4	3	12	6	⟺	Y	Y	Y	One action was closed in relation to divisional review of implementation of lessons learnt to divisional assurance as to lesson learnt.
2293	**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 and retention, failure to achieve strategic vision, potential for regulatory action and reputational damage.	5	2	10	10	⟺	Y	Y	Y	Minor updates made
2294	**Condition**: Insufficient numbers of clinical staff resulting in a lack of capability to deliver safe care and effective outcomes. **Cause:** Insufficient numbers of doctors in training; Aging workforce; National shortage of nurses and midwives; Isolated site and associated clinical risk impacting on recruitment and retention of specialist consultant staff; pension tax changes impacting on the retention of consultant medical staff (early retirement or reduction in working time). **Consequence:** Gaps on junior doctor rotas; Loss of highly experienced nursing staff due to retirement; Impact on the quality of junior doctors in training; This may result in unsafe patient care and less effective outcomes, status of teaching hospital and impact on retention of specialist services.	5	4	20	10	⟺	Y	Y	Y	Minor updates made

Risk No.	Description	Current risk score			Target	Assurance				Proposed Changes, Additions & Removals
		Severity	Likelihood	Risk Score	Risk Score by 31/03/2020	Status	Controls identified	Gap in Controls Identified	Assurances identified	
2297	**Condition:** Location , size, layout an accessibility of current services do not provide for sustainable integrated care or safe and high quality service provision. **Cause:** Lack of onsite multidisciplinary provision, no ITU or Blood bank on site, very limited diagnostic imaging on site; Failure to meet multiple clinical standards; Senior staff recruitment and retention very difficult, lack of collocated paediatric surgical support. **Consequence:** Patient harm, poor continuity of care, poor patient experience due to transfer away for booking location.	5	↑ 5	25	↑ 25	↑	Y	Y	Y	Significant rewrite of this risk has been completed, included in attached BAF report. Four new actions created to supplement current actions and reflect gaps in assurance. Risk Score increased to 25 from 20 Target score also increased to 25.

Attach to BAF Report

Listing For: 4. BAF | **Risk Register Level:** 4. BAF | **Directorate:** Financial Services | **Service / Department:** Finance | **Position at:** 18/11/2019 15:10:19

Risk Number: 1663 **Version:** 21 **Domain:** Finance Including Claims

Strategic Objective: To Be Ambitious & Efficient & Make Best Use Of Available Resources

Risk Appetite: 3.Moderate

Risk Description:

Condition: Failure to deliver the annual financial plan

Cause: Slippage against CIP targets (inc EPR delivery & CNST contribution reduction); Loss of activity resulting in reduced contribution; Increases in patient activity as contracts are largely on a block basis; Workforce cost pressures; Pressure to deliver national targets; Pension changes for consultants affecting additional activity

Consequence: Breach of license conditions resulting in financial special measures

Executive Lead: Jenny Hannon **Operational Lead:** Eva Horgan

Assurance Committee: Finance, Performance & **Review Due:** 01/12/2019

Last Review Narrative: **Date:** 31/10/2019 **Reviewed By:** Eva Horgan

No further changes required at this point

Control	Control Description	Gaps in Control	Effectiveness	Internal Assurance	External Assurance	Gaps in Assurance	Adequacy of Assurance
Prevent	Robust Budget setting process Quality Impact Assessment of all CIPs and post evaluation reviews Sign off of budgets by accountable officers FPBD and Board approval of budgets Budget Holder Training programme in place Monthly reporting to all budget holders with variance analysis Monthly reporting to FPBD and Trust Board Monthly reporting and feedback from NHSE/I Vacancy control process well established and monitored Control of expenditure through activity monitoring spends Monthly performance meetings Divisional performance reviews	Lack of contingency in budgets External influences and national policy	Not Yet Tested	2019/20 Budget approval (BoD - April 19) Budget holder training manual and attendance records Performance and finance reports (monthly to FPBD and BoD) Finance and CIP achievement (Monthly to FPBD) Executive Team and Board oversight Internal Audit report provides significant assurance (Oct 17) Sustained performance above plan Delivery of control total in previous years	Monthly reports to NHSI with feedback Internal audit review of budgetary controls External Audit opinion	Assurance is available re; controls, but is not on delivery Delivery of control total in 19-20 Delivery of £3.6m CIP for 19-20 NHSI use of resources risk rating - 3	Inconclusive
Detect	Internal audit reviews of systems and controls	None Known	Effective	Performance and Finance Reports to FPBD	External Audit Opinion	Assurance is available on controls but not on delivery	Inconclusive

Action	Action Description:	Start Date	Target Date	Person Responsible	Progress	Status	Date Completed
1	Ongoing review of position in Divisional Performance meetings and finance committee	01/05/2019	31/03/2020	Eva Horgan	Ongoing monthly monitoring Action rewritten following exec review and risk being placed back onto Ulysses. Date Entered : 09/08/2019 14:43 Entered By : Christopher Lube	Ongoing	/ /
2	Quality performance challenge meetings	01/04/2019	31/03/2020	Eva Horgan	Ongoing monthly monitoring Date Entered : 09/08/2019 14:45 Entered By : Christopher Lube	Ongoing	/ /
3	Ongoing review of CIP	01/04/2019	31/03/2020	Eva Horgan	Ongoing monthly review Date Entered : 09/08/2019 14:46 Entered By : Christopher Lube	Ongoing	/ /
4	Monthly budget meeting with variance analysis	01/04/2019	31/03/2020	Eva Horgan	Ongoing monthly monitoring Date Entered : 09/08/2019 14:47 Entered By : Christopher Lube	Ongoing	/ /

Initial Assessment		
Severity	Likelihood	Risk Score
5 Catastrophic	5 Almost	25

Current Assessment		
Severity	Likelihood	Risk Score
5 Catastrophic	5 Almost	25

Target Assessment		
Severity	Likelihood	Risk Score
5 Catastrophic	2 Unlikely	10

Listing For: 4. BAF | **Risk Register Level:** 4. BAF | **Directorate:** Financial Services | **Service / Department:** Finance | **Position at:** 18/11/2019 15:10:19

Risk Number: 1986 **Version:** 5 **Domain:** Finance Including Claims

Strategic Objective: To Be Ambitious & Efficient & Make Best Use Of Available Resources

Risk Appetite: 3.Moderate

Risk Description:

Condition: The Trust is not financially sustainable beyond the current financial year

Cause: Ongoing requirement for annual CIPs; Significant CNST premium; Overhead costs; Impact of service change

Consequence: Lack of financial stability, invocation of NHSI sanctions, special measures. Continued borrowing to meet operational expenses resulting in significant debt.

Executive Lead: Jenny Hannon **Operational Lead:** Eva Horgan

Assurance Committee: Finance, Performance & **Review Due:** 16/12/2019

Last Review Narrative: **Date:** 16/11/2019 **Reviewed By:** Christopher Lube

Reviewed by DoF, minor changes to Internal Assurance and Gaps in Assurance.

Control	Control Description	Gaps in Control	Effectiveness	Internal Assurance	External Assurance	Gaps in Assurance	Adequacy of Assurance
Prevent	5 Year financial model produced giving early indication of issues Business case to Trust Board which identifies a solution which minimised deficit, including relocation to an acute site and merger Early and continuing dialogue with NHSE/I Active engagement with CCG resulting in a pre-consultation Business Case Agreement for merger proposals with partner Trusts approve by three BoD's Advisors with relevant experience (PWC) engaged early to review strategic options Clinical Engagement and support for proposals Review of open claims and legal processes Engagement in place with Cheshire and Mersey Partnership to review system solutions Update review against clinical standards and financial consequences. Reduction in CNST Premium Reduction in back office overheads costs.	Implementation of business case is dependent on decision making external to the Trust (CCG, NHSE/I) 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 National CDEL Issue.	Not Yet Tested	5 Year plan Approval (BoD, Nov 2014) resubmission due Sept 19 Future Generations Clinical Strategy and Business Plan (BoD Nov 15) Sustainability and 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 approved by Board - Sept 17 Submission of Cheshire and Mersey STP capital bid Summer 2018 ranked no1 of schemes Long Term Plan Submission Nov 19 NHSE/I use of resources rating above 3 over 5 year period	CCG Pre Consultation Business Case approved by CCG Committees in common Northern Clinical Senate Report supporting preferred option Cheshire and Mersey Partnership Support	Final approval for business case Lack of capital nationally Delivery of surplus Capital to invest on site while awaiting approval	Inconclusive

Action	Action Description:	Start Date	Target Date	Person Responsible	Progress	Status	Date Completed
4	Revision of SOC following unsuccessful STP capital bid Target has been put back based on initial feedback from TU readiness assessment - system buy in to be initial focus ahead of SOC update.	01/04/2019	01/04/2020	Eva Horgan	Work ongoing Date Entered : 09/08/2019 14:11 Entered By : Christopher Lube	Ongoing	/ /
5	Approval of revised capital route	01/04/2019	31/12/2019	Eva Horgan	Work ongoing Date Entered : 09/08/2019 14:12 Entered By : Christopher Lube	Ongoing	/ /
6	Public consultation by CCG following development of preferred option (Subject to capital bid)	01/04/2019	30/04/2020	Eva Horgan	Dependent on external influences and agencies Date Entered : 09/08/2019 14:14 Entered By : Christopher Lube	Ongoing	/ /
7	Decision making business case produced by CCG and final decision following outcome of public consultation required	01/04/2019	31/12/2020	Eva Horgan	Closely linked to other actions and external influences Date Entered : 09/08/2019 14:16 Entered By : Christopher Lube	Ongoing	/ /
8	Business case to support the application for capital to support the relocation required	01/04/2019	31/03/2020	Eva Horgan	Timescale TBC - requirements to be confirmed, subject to outcome of bid. Date Entered : 09/08/2019 14:18 Entered By : Christopher Lube	Ongoing	/ /
9	Merger Transaction	01/04/2020	01/04/2021	Eva Horgan	Actual timescale is April 2021 - subject to NHSI approval. Monitor monthly as part of ongoing overall	Ongoing	/ /

					risk review Date Entered : 09/08/2019 14:21 Entered By : Christopher Lube			
10	Implementation of changes	01/04/2021	01/04/2022	Eva Horgan	Actual timescale April 2021-2026, monitor as part of overall monthly risk review Date Entered : 09/08/2019 14:22 Entered By : Christopher Lube		Ongoing	/ /

Initial Assessment		
Severity	**Likelihood**	**Risk Score**
5 Catastrophic	5 Almost	25

Current Assessment		
Severity	**Likelihood**	**Risk Score**
5 Catastrophic	5 Almost	25

Target Assessment		
Severity	**Likelihood**	**Risk Score**
5 Catastrophic	5 Almost	25

Listing For: 4. BAF | **Risk Register Level:** 4. BAF | **Directorate:** IM & T | **Service / Department:** IM & T | **Position at:** 18/11/2019 15:10:19

Risk Number: 2184 **Version:** 3 **Domain:** Impact On The Safety Of Patien

Executive Lead: Andrew Loughney **Operational Lead:** Steve Chokr

Strategic Objective: To Deliver SAFE Services

Risk Appetite: 2.Low

Assurance Committee: Quality Committee **Review Due:** 16/12/2019

Risk Description:

Condition: Failure to deliver an integrated EPR against agreed Board plan (Dec 2016) by the proposed schedule May 2020 which may lead to the implementation of a system that is not fit for purpose

Cause: Poor programme management and product design

Consequence: Impact on Patient Safety, Quality and Experience; Impact on patient 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.

Last Review Narrative: **Date:** 16/11/2019 **Reviewed By:** Christopher Lube

Reviewed by DoF, risk has evolved and a revised risk is being developed for approval by FPBD and Board. Current risk to remain on BAF until new risk is articulated and approved.

Control	Control Description	Gaps in Control	Effectiveness	Internal Assurance	External Assurance	Gaps in Assurance	Adequacy of Assurance
Prevent	EPR programme board chaired by AUHT CEO and attended by LWH Exec Dir, CIO and CCIO. Governance structure for project in place with independent reviews LWH Digital sub-committee review of project in place with DoF chairing Oversight of programme by FPBD (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 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 waiting NHSI approval and has not agreed contract with supplier	Effective	Executive sign off initial programme plan Clinical (operational) sign off Exec team briefing from CIO Oversight from digital hospital sub-group Regular reporting to FPBD Clinician engagement undertaken	MIAA Gateway reviews MIAA Report (limited assurance) 2017 Gateway process in place with external verification NHS Digital review (March 19) Independent review to Director of Finance (April 19)	Ability to influence supplier Functionality of modules for Maternity, Theatres and e-prescribing Appetite of other Trust to prioritise the program Effectiveness of program Board in delivering the solution Effectiveness of supplier and product as evidenced by Digital and Independent reports. Subjectivity of progress	Negative

Action	Action Description:	Start Date	Target Date	Person Responsible	Progress	Status	Date Completed
2	Recommendations of NHS Digital follow up report	21/02/2018	31/12/2019	Steve Chokr	NHS Digital report suggested a go.no go decision be postponed until Oct pending further actions to address the outstanding issues. Date Entered : 13/08/2019 14:01 Entered By : Sandra Goulden ---------- Action reviewed and updated in line with moving BAF back onto Ulysses. Date Entered : 08/08/2019 15:52 Entered By : Christopher Lube ---------- Integrated EPR remains a key issue for LWH. Programme Board notes and is managing the delays in implementation. Date Entered : 15/02/2019 13:11 Entered By : Andrew Loughney	Ongoing	/ /
4	Delivery of live system against design and configuration through the programme and clinically signed off	21/02/2018	31/05/2020	Andrew Loughney	Action reviewed and updated in line with moving BAF back onto Ulysses. Date Entered : 08/08/2019 15:57 Entered By : Christopher Lube ---------- Action plan and sub logs are available and viewed by Programme Board. Achieving set	Ongoing	/ /

					targets remains problematic. Date Entered : 15/02/2019 13:13 Entered By : Andrew Loughney		
5	Test system built and tested against clinically approved script with additional scrutiny and assurances around areas highlighted as a concern.	21/02/2018	30/04/2020	Andrew Loughney	Action reviewed and updated in line with moving BAF back onto Ulysses. Date Entered : 08/08/2019 15:55 Entered By : Christopher Lube ---------- Test cycles in several steps, progress being monitored by Programme Board. Date Entered : 15/02/2019 13:14 Entered By : Andrew Loughney	Ongoing	/ /
6	Completion of business intelligence strategy to enable the successful delivery of statutory and operational reporting post deployment	21/02/2018	31/05/2020	Steve Chokr	Business Intelligence functionality remains unproven, Programme Board is monitoring. Date Entered : 15/02/2019 13:15 Entered By : Andrew Loughney	Ongoing	/ /
8	Recommendation to Trust Boards from EPRL Programme Board following review of Digital report and actions to continue or not	01/09/2018	31/12/2019	Steve Chokr	Exec team and board are reviewing and awaiting updated. Date Entered : 30/10/2019 12:23 Entered By : Steve Chokr ---------- SG 13/8/19 NHS Digital report suggested that there was not enough evidence to cease or to approve, Oct Board is the next decision point for go/no go. Date Entered : 13/08/2019 13:59 Entered By : Sandra Goulden ---------- Action reviewed and updated in line with moving BAF back onto Ulysses. Date Entered : 08/08/2019 15:58 Entered By : Christopher Lube ---------- EPR being managed at Exec and Board level. New EPR go-live date for LWH now May 2020. Red line items for Pharmacy and Theatres still being managed a progress being monitored. Any impact to new go-live date will be articulated through FPBD and onto Board. Date Entered : 05/03/2019 16:12 Entered By : Steve Chokr	Ongoing	/ /

Initial Assessment		
Severity	**Likelihood**	**Risk Score**
5 Catastrophic	4 Likely	20

Current Assessment		
Severity	**Likelihood**	**Risk Score**
5 Catastrophic	5 Almost	25

Target Assessment		
Severity	**Likelihood**	**Risk Score**
5 Catastrophic	5 Almost	25

Listing For: 4.BAF **Risk Register Level:** 4. BAF **Directorate:** Governance **Service / Department:** Governance **Position at:** 18/11/2019 15:10:19

Risk Number: 2266 **Version:** 1 **Domain:** Impact On The Safety Of Patien

Executive Lead: Devender Roberts **Operational Lead:** Christopher Lube

Strategic Objective: To Deliver SAFE Services

Risk Appetite: 2.Low

Assurance Committee: Quality Committee **Review Due:** 29/11/2019

Risk Description:

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.

Last Review Narrative: **Date:** 30/10/2019 **Reviewed By:** Christopher Lube

Work continues with the Division to ensure lesson learnt form incidents are identified and shared. Risk Management Web Site to be reviewed and updated. Lesson Learnt site on Trust web site being updated, New Risk an patient Safety Manager has been appointed to commence 02/01/20 who will take lead on lesson learnt and linking with Quality Improvement.

Control	Control Description	Gaps in Control	Effectiveness	Internal Assurance	External Assurance	Gaps in Assurance	Adequacy of Assurance
Prevent	Regular dialogue with regulators. Incident reporting and investigation policies and procedures. MDT involvement in safety 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 3yr programme in place Risk Management Strategy Governance structure Serious Incident Feedback form Serious Incident panels Corporate level engagement by Trust Board Listening events Never events reported though Safety Senate and BoD 2nd Year of Quality strategy delivered Safety is included as part of executive walk rounds. Close working with safety collaborative being maintained	Inconsistent completion and dissemination of actions and improvement plans Inconstant implementation of lessons learnt and lack of evidence Pace of implementing change, Monitored via effectiveness senate Lack of opportunity to deliver bespoke training for staff groups in relation to risk management and patient safety.	Effective	CQPG Meetings Reporting of incidents and management of action plans through Safety Senate Reflection of risks and Corporate Risk Register and Board Assurance Framework CQC Assessment Annual Quality Account Report	Internal Audit of Risk Management External Audit or Risk Maturity CQC Assessment, safe as 'Good' across all areas of the Trust NRLS Incident Reporting MIAA Report on Duty of Candour Safety Senate Reports	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 embedded change External and internal reporting structures.	Inconclusive

Action	Action Description:	Start Date	Target Date	Person Responsible	Progress	Status	Date Completed
1	Introduction of Fair and Just Culture process	01/04/2019	31/10/2024	Chris McGhee	Initial stages of training staff via book clubs in progress. Mapping exercise of SI ongoing Date Entered : 31/07/2019 10:57 Entered By : Christopher Lube	Ongoing	/ /
2	Maintain close involvement with regional and local safety collaborative	01/04/2019	01/04/2020	Alan Clark	Links with Safety collaboratives re being maintained, this has become a control. Date Entered : 30/09/2019 17:47 Entered By : Christopher Lube ---------- Working is ongoing in this area. New NHS Patient safety strategy published which highlights this action. Trust local implementation plan in development Date Entered : 31/07/2019 10:58 Entered By : Christopher Lube	Completed	30/09/2019
3	Develop better reporting from the Ulysses System	01/04/2019	31/12/2019	Christopher Lube	The Upgrade of the Ulysses system is progressing. A slight delay was encountered due to the need to move to a new server.	Ongoing	/ /

					Date Entered : 30/10/2019 14:47 Entered By : Christopher Lube ---------- Governance team currently working with Ulysses to develop the current system and implement new modules to support RCA investigation, Action Planning and CQC compliance monitoring, Audit module to come later in year.		
4	New divisional structure to review implementation of lessons learnt and provision of evidence	01/04/2019	30/09/2019	Christopher Lube	Date Entered : 31/07/2019 10:56 Entered By : Christopher Lube Action completed as divisions in place and have established governance groups. New action developed. Date Entered : 30/09/2019 17:50 Entered By : Christopher Lube ---------- Review of SI learning and complaint learning requested via divisional performance meetings.	Completed	30/09/2019
5	Divisions to undertake gap analysis of risk management resources	01/04/2019	31/12/2019	Christopher Lube	Date Entered : 31/07/2019 10:58 Entered By : Christopher Lube Review ongoing, Secondment to be provided for CSS, interviewing for Risk and Pt Safety Managers post, Replacement for Gov Man (Mat) commencing in post 7th Nov 19. Date Entered : 03/10/2019 16:40 Entered By : Christopher Lube ---------- Review being led buy Head of Governance in line with new divisional structures.	Ongoing	/ /
6	Business case for the provision of Human Factors Training to be developed and submitted to education governance committee	01/04/2019	31/12/2019	Linda Watkins	Date Entered : 31/07/2019 10:59 Entered By : Christopher Lube There is currently no lead for SIM Training in Trust, Lead for action has been changed to Chair of Ed Gov Comm. Date Entered : 03/10/2019 16:38 Entered By : Christopher Lube ---------- Update Received from Dr Hurst as to current position of Simulation Tranining. See Document section for further detail. Date Entered : 14/08/2019 14:19 Entered By : Elaine Eccles ---------- Initial paper presented to Ed Gov and Safety Senate, acting Medical Director requested further	Ongoing	/ /

					information Date Entered : 31/07/2019 11:01 Entered By : Christopher Lube			
7	New risk management and patient safety training package to be developed	01/04/2019	31/12/2019	Christopher Lube	Work is ongoing, plan for completion Nov 19 Date Entered : 03/10/2019 16:39 Entered By : Christopher Lube ---------- Head of Governance in planning stages. May be affected by new national training system and curriculum which is due to be published in 2019-20. Date Entered : 31/07/2019 11:00 Entered By : Christopher Lube	Ongoing	/ /
8	Divisions to report process for the dissemination of actions, lessons learnt and improvement plans	30/09/2019	31/12/2019	Christopher Lube	Process for the dissemination for lessons learnt, actions and improvement plans requested from Divisions by HoG&Q Date Entered : 30/09/2019 17:54 Entered By : Christopher Lube		/ /

Initial Assessment		
Severity	Likelihood	Risk Score
4 Major	5 Almost	20

Current Assessment		
Severity	Likelihood	Risk Score
4 Major	3 Possible	12

Target Assessment		
Severity	Likelihood	Risk Score
3 Moderate	2 Unlikely	6

Listing For: 4.BAF **Risk Register Level:** 4. BAF **Directorate:** Human Resources **Service / Department:** HR **Position at:** 18/11/2019 15:10:19

Risk Number: 2293 **Version:** 2 **Domain:** HR/Organisational Development/

Strategic Objective: Develop A Well-Led, Capable, Motivated And Entrepreneurial Workforce

Risk Appetite: 3.Moderate

Risk Description:

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 and retention, failure to achieve strategic vision, potential for regulatory action and reputational damage.

Executive Lead: Michelle Turner **Operational Lead:** Jeanette Chalk

Assurance Committee: Putting People First **Review Due:** 16/12/2019

Last Review Narrative: **Date:** 16/11/2019 **Reviewed By:** Christopher Lube

Reviewed by DoW&C and DDW&C , minor changes to controls and action descriptions.

Control	Control Description	Gaps in Control	Effectiveness	Internal Assurance	External Assurance	Gaps in Assurance	Adequacy of Assurance
Prevent	Appraisal policy, paperwork and systems for delivery and recording are in place for medial and non-medical staff. Consultant revalidation process. Reward and recognition processes linked to values. Pay progression linked to mandatory training compliance. Targeted OD intervention for areas in need to 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 and induction. Workforce planning processes in place to deliver safe staffing. Shared decision making with JLNC and Partnership Forum. Putting People First Strategy. Quality Strategy. Guardian of Safe Working. People strategy revised and agreed PDR training programme in place	Quality of appraisal. Poor attendance at non-mandatory training e.g. leadership training. Requirement for further development of middle managers. Talent management programme is newly implemented and not yet fully embedded.	Effective	Quarterly internal staff survey (Go Engage System). Monthly KPI's for controls. Performance Repots (monthly) Quarterly Learning events. Bi-annual Speak UP Guardian Reports. Report form Guardian of Safe Working	National Staff Survey(annual). POPPY study RCM culture survey findings CQC regulatory inspection in 2018. National Workforce and Wellbeing Charter - 2018	Staff survey engagement score not improved in year. Mandatory training currently below target. Sickness absence above target.	Positive
Detect	Recruitment intentions annual exercise. Staff engagement programmes. Two Freedom to Speak Up Guardians. Whistle Blowing Policy Engagement Tool Implemented.	Ongoing challenges of engaging effectively with all staffing groups due to rota patterns.	Effective				

Action	Action Description:	Start Date	Target Date	Person Responsible	Progress	Status	Date Completed
1	PPF deep dive into service level workface risks	01/04/2019	31/03/2020	Jeanette Chalk	To be completed on a monthly basis Date Entered : 08/08/2019 11:31 Entered By : Christopher Lube	Ongoing	/ /
2	Aspirant managers programme in place	01/04/2019	31/03/2020	Jeanette Chalk	Aspirant managers programme in place and 1st cohort have completed with 2nd cohort to commence. Date Entered : 16/11/2019 12:04 Entered By : Christopher Lube ---------- To be monitored monthly Date Entered : 08/08/2019 11:33 Entered By : Christopher Lube	Ongoing	/ /
3	Executive team and staff side walkabouts	01/04/2019	31/03/2020	Jeanette Chalk	To be monitored monthly	Ongoing	/ /

4	Launch of Fair and Just Culture Project	01/04/2019	31/03/2020	Chris McGhee	Date Entered : 08/08/2019 11:35 Entered By : Christopher Lube Year 1 completed on timescale in accordance with project plan. Date Entered : 16/11/2019 12:04 Entered By : Christopher Lube ---------- Initial development work and staff training in progress Date Entered : 09/08/2019 15:24 Entered By : Christopher Lube		Ongoing	/ /

Initial Assessment		
Severity	**Likelihood**	**Risk Score**
5 Catastrophic	5 Almost	25

Current Assessment		
Severity	**Likelihood**	**Risk Score**
5 Catastrophic	2 Unlikely	10

Target Assessment		
Severity	**Likelihood**	**Risk Score**
5 Catastrophic	2 Unlikely	10

Listing For: 4.BAF **Risk Register Level:** 4. BAF **Directorate:** Human Resources **Service / Department:** HR **Position at:** 18/11/2019 15:10:19

Risk Number: 2294 **Version:** 3 **Domain:** HR/Organisational Development/

Executive Lead: Michelle Turner **Operational Lead:** Jeanette Chalk

Strategic Objective: Develop A Well-Led, Capable, Motivated And Entrepreneurial Workforce

Risk Appetite: 3.Moderate

Assurance Committee: Putting People First **Review Due:** 16/12/2019

Risk Description:

Condition: Insufficient numbers of clinical staff resulting in a lack of capability to deliver safe care and effective outcomes.

Cause: Insufficient numbers of doctors in training; Aging workforce; National shortage of nurses and midwives; Isolated site and associated clinical risk impacting on recruitment and retention of specialist consultant staff; pension tax changes impacting on the retention of consultant medical staff (early retirement or reduction in working time).

Consequence: Gaps on junior doctor rotas; Loss of highly experienced nursing staff due to retirement; Impact on the quality of junior doctors in training; This may result in unsafe patient care and less effective outcomes, status of teaching hospital and impact on retention of specialist services.

Last Review Narrative: **Date:** 16/11/2019 **Reviewed By:** Christopher Lube

Reviewed by DoW&C and DDoW&C, updates to progress on action and additions to controls.

Control	Control Description	Gaps in Control	Effectiveness	Internal Assurance	External Assurance	Gaps in Assurance	Adequacy of Assurance
Prevent	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 into these gaps. Effective electronic rota management system implemented. 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. Acting down policy and process in place to cover junior doctor gaps. National Revalidation process ensuring competent staff. Shared decision making and review of risk with JLNC. Putting People First Strategy. Quality Strategy. Strategic Workforce Group established. Aspirational Ward Manager Programme. Succession Planning and Talent Programme NHSE Retention Improvement Programme NHSI Sickness Improvement Programme Shared appointments with other providers Secured operating time at the LUH Increased consultant recruitment with incentives Neonatal Partnership Maternity introduction of ACP Midwives Policy to mitigate impact on LTA and AA on senior staff in place	Further utilisation of the rota management system. E-Roistering System not fully utilised	Effective	Quarterly reporting by Guardian of Safe Working. Strategic Workforce reporting to PPF. Leadership Development programme Review (annual to PPF). Exception Reporting System and process working effectively. Junior Medical Staff GMC survey reporting to Education Governance and PPF - No concerns areas of specific concerns identified. Clinical and nursing roles being developed and enhanced to mitigate the gas in junior doctor workforce. Roles include: Physicians Assistants, Surgical assistants, ANP's, Consultant Nurses, ER Practitioners.	DME reports to HEN on an annual basis in relation to junior doctor training. Annual GMC Survey. Annual Staff survey NHS Ed SAR. DME Annual Report GMC Revalidation Process HEN Visit - Regular (next due 2019 due to satisfactory report in 2016) GMC Medical Staff survey - annual.	None identified at this time	Positive
Detect	GMC Survey 018 - action plan in place						

Action	Action Description:	Start Date	Target Date	Person Responsible	Progress	Status	Date Completed
1	Action plan from strategic group	01/04/2019	31/03/2020	Jeanette Chalk	New Divisional Structure has superseded this action Date Entered : 16/11/2019 12:10 Entered By : Christopher Lube ---------- To be monitored monthly Date Entered : 08/08/2019 12:14 Entered By : Christopher Lube	No Further Action	16/11/2019
3	Business case to go to NHSI to develop E-Rostering System Collaborative work with CMHRD Network. Health and Care Partnership for Cheshire and Merseyside have indicated that we will not be able to submit a business case to	01/04/2019	30/11/2019	Kathryn Allsopp	Bid Submitted, outcome awaited Date Entered : 16/11/2019 12:12 Entered By : Christopher Lube ----------	No Further Action	16/11/2019

	develop for E-Rostering. Reviewing situation. Due date: end of September 2019. The Trust submitted a bid for capital funding to implement eRostering software across the medical workforce to the NHSI capital funding for workforce deployment systems on 24.09.2019. SMT approved the business case to fund the ongoing system costs should the bid be successful. Bid outcomes are due in November 2019 (no specific date given).				Work is ongoing Date Entered : 09/08/2019 15:25 Entered By : Christopher Lube		
4	Await outcome of Business case sent to NHSI to develop E-Rostering System Collaborative	16/11/2019	31/03/2020	Jeanette Chalk		Ongoing	/ /
5	Medical Workforce Recruitment and Retention process being developed	01/11/2019	31/03/2020	Jeanette Chalk		Ongoing	/ /

Initial Assessment		
Severity	**Likelihood**	**Risk Score**
5 Catastrophic	5 Almost	25

Current Assessment		
Severity	**Likelihood**	**Risk Score**
5 Catastrophic	4 Likely	20

Target Assessment		
Severity	**Likelihood**	**Risk Score**
5 Catastrophic	2 Unlikely	10

Listing For: 4. BAF | **Risk Register Level:** 4. BAF | **Directorate:** Governance | **Service / Department:** Governance | **Position at:** 18/11/2019 15:10:19

Risk Number: 2295 **Version:** 1 **Domain:** Impact On The Safety Of Patien

Executive Lead: Caron Lappin **Operational Lead:** Christopher Lube

Strategic Objective: To Deliver SAFE Services

Risk Appetite: 2.Low

Assurance Committee: Quality Committee **Review Due:** 16/12/2019

Risk Description:

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.

Last Review Narrative: **Date:** 16/11/2019 **Reviewed By:** Christopher Lube

Regulatory compliance maintained, no issues or incidents identified. Await CQC inspection for further review

Control	Control Description	Gaps in Control	Effectiveness	Internal Assurance	External Assurance	Gaps in Assurance	Adequacy of Assurance
Detect	Board Assurance visits NED walk rounds National Audits Local Audits Ward accreditation scheme H&S Executive inspections Human Tissue and Embryology Authority Inspections External Peer reviews CQC inspections	None identified	Effective		MIAA Audits Collaborative meetings with CCG CQC Inspections NHSE/I reviews with LWH	None identified	Positive
Prevent	Regular meetings with NHSE/I CQC engagement meetings Maintenance of CQC registration Regulatory information provided to staff at induction Committee structures in place to monitor regulatory compliance An integrated approach between corporate operational and governance teams Quality impact assessments for all service changes and CIP's that are considered. Professional Standards Trust Polices and Procedures Risk Management Strategy and culture Quality and Independence of QIA's by DoN and MD Completion and submission of Annual Quality Report	Benchmarking data can make the Trust appear an outlier due to specialist nature of the services provided and attract regulatory attention	Effective	Executive Walk rounds Matron walk rounds Ward accreditation Internal H&S walk rounds and annual audits Internal Fire Safety Inspection's	MIAA Audits CQC Visits CCG Meetings HFEA Inspections H&S Executive inspections Fire Service Inspections Safeguarding regulatory Inspections	Monitoring of regulatory reports and action plans to completion	Positive

Action	Action Description:	Start Date	Target Date	Person Responsible	Progress	Status	Date Completed
1	Provide assurance to CQC in relation to risk with appropriate information	01/04/2019	31/03/2020	Christopher Lube	Information provided to CQC on request and at quarterly engagement meetings. Action to be monitored monthly Date Entered : 08/08/2019 14:57 Entered By : Christopher Lube	Ongoing	/ /
2	Ward accreditation to be rolled out following completion of pilot	01/04/2019	31/03/2020	Janet Brennan	Meeting with Ward Accreditation providers due on 08/08/19. Progress on pilot to be discussed and review of software to log data. Date Entered : 08/08/2019 15:00 Entered By : Christopher Lube	Ongoing	/ /
3	To embed process for monitoring of regulatory reports and action plans at divisional boards	01/04/2019	31/03/2020	Christopher Lube	New CQC compliance monitoring module being developed by Ulysses. Due for implementation in September 2019. Date Entered : 08/08/2019 15:02 Entered By : Christopher Lube	Ongoing	/ /

4	Report regulatory exceptions form Divisional Boards to Quality Committee	01/04/2019	31/03/2020	Christopher Lube	Once CQC compliance module in place in Ulysses Divisions will be able to provide exception report to Quality Committee on status and planned actions. Date Entered : 08/08/2019 15:05 Entered By : Christopher Lube		Ongoing	/ /
5	Undertake intermittent deep dive reviews into specialist services	01/04/2019	31/03/2020	Christopher Lube	Reviews to be completed as and when identified by sub-committee of the board or at divisional board level. Date Entered : 08/08/2019 15:08 Entered By : Christopher Lube		Ongoing	/ /

Initial Assessment		
Severity	Likelihood	Risk Score
4 Major	5 Almost	20

Current Assessment		
Severity	Likelihood	Risk Score
4 Major	3 Possible	12

Target Assessment		
Severity	Likelihood	Risk Score
4 Major	2 Unlikely	8

Attach to BAF Report

Listing For: 4.BAF **Risk Register Level:** 4. BAF **Directorate:** Governance **Service / Department:** Executive Office **Position at:** 18/11/2019 15:10:19

Risk Number: 2297 **Version:** 2 **Domain:** Impact On The Safety Of Patien

Executive Lead: Andrew Loughney **Operational Lead:** Jennifer Huyton

Strategic Objective: To Deliver SAFE Services

Risk Appetite: 2.Low

Assurance Committee: Quality Committee **Review Due:** 18/12/2019

Risk Description:

Condition: Location , size, layout an accessibility of current services do not provide for sustainable integrated care or safe and high quality service provision.

Cause: Lack of onsite multidisciplinary provision, no ITU or Blood bank on site, very limited diagnostic imaging on site; Failure to meet multiple clinical standards; Senior staff recruitment and retention very difficult, lack of collocated paediatric surgical support.

Consequence: Patient harm, poor continuity of care, poor patient experience due to transfer away for booking location.

Last Review Narrative: **Date:** 16/11/2019 **Reviewed By:** Christopher Lube

Risk reviewed by DoF and MD with HoG&Q, significant revision in line with current position, risk score increased to 25. New version created.

Control	Control Description	Gaps in Control	Effectiveness	Internal Assurance	External Assurance	Gaps in Assurance	Adequacy of Assurance
Prevent	Continuing dialogue with regulators Active management with all commissioners Putting People First Strategy Leadership and Management development programme Programme for the establishment of partnership for Neonates with AHCH. £15m capital investment in neonatal estate to address infection risk Transfer arrangements well established Partnership with LUH with respect to: -Diagnostics -Medical and surgical expertise -Intensive care facilities -Theatre access at LWH for women with Gynae cancers Blood product provision by motorised vehicle from near by facility. Investments in additional staffing inc. towards 24/7 cover Enhanced resuscitation training provision	Clinical case for change is dependent on decision making external to the Trust (NHSE/I, CCG) Lack of system drive to secure the capital case H&CP submissions for capital bids not successful despite system agreement of clinical case Financial and workforce constraints for delivery of additional facilities on site. - No blood bank on site -No 24/7 cover on site - No CT or MRI on site - No agreed funding for new Neonatal Unit at AHCH Onsite and partnership mitigations cannot fully address the clinical risk - this can only be achieved through co-location Neonatal estate not due for completion until summer 2020 Emerging clinical standard leading to further deterioration of clinical position.	Not Effective	Corporate Objectives 2019-20 Board performance reports DIPC Reports Staff Staffing levels reports to board Incident and Serious Incident reports to Safety Senate Quality Committee, Divisions and Trust Board. Mortality and Morbidity reviews in all areas Performance monitoring of patient experience and clinical outcomes Transfers out monitored at HDU Group Data reviewed regularly and reported through HDU and Sepsis Group.	Approval of NNU Business case CQC inspection (2018) - Good Meetings with CCG via Clinical Quality and Performance Group (CQPG) Negative - North East clinical senate report - Neonatal ODM - Maternity SCN Dashboard Counterfactual clinical case (2019) Output from Clinical Summit report (2019) Divisional Performance Reports Quality Data Serious Incident Investigation Reports	Improved data reporting required with respect to: -acuity of patients on HDU -number of women with highest level of medical conditions - in maternal and Termination of Pregnancy Services -Where services data is collated and acted upon	Negative

Action	Action Description:	Start Date	Target Date	Person Responsible	Progress	Status	Date Completed
1	To commence public consultation (external control of this action by NHSE/I)	01/04/2019	31/03/2020	Andrew Loughney	To be monitored monthly Date Entered : 09/08/2019 13:40 Entered By : Christopher Lube	Ongoing	/ /
2	Agree Business Case for new build	01/04/2019	31/03/2020	Jennifer Huyton	To be monitored monthly Date Entered : 09/08/2019 13:41 Entered By : Christopher Lube	Ongoing	/ /
4	Divisional plans to be developed to support long term clinical sustainability via operational plan	01/04/2019	31/12/2019	Jennifer Huyton	Work ongoing in Divisions Date Entered : 09/08/2019 13:46 Entered By : Christopher Lube	Ongoing	/ /
5	Outcomes form the clinical summit to be actioned.	27/09/2019	31/12/2019	Jennifer Huyton	Acting Medical Director working with Strategic Finance Manager on reviewing summit outcomes. Date Entered : 27/09/2019 08:43 Entered By : Christopher Lube	Ongoing	/ /
7	Management of Futuire Generations Strategy through Project Management Office	16/11/2019	31/03/2020	Andrew Loughney		Ongoing	/ /
8	Development of counter factual arguement	16/11/2019	31/03/2020	Jennifer Huyton		Ongoing	/ /

9	Agree funding for mitigations on site (Blood Bank, MRI, Diagnositics, CT and Staffing) for inclusion in 20/21 operational plan	31/03/2020	31/03/2020	Jennifer Huyton		Ongoing	/ /
10	Lobby systems and MP's for active support	16/11/2019	31/03/2020	Kathryn Thomson		Ongoing	/ /

Initial Assessment		
Severity	**Likelihood**	**Risk Score**
5 Catastrophic	5 Almost	25

Current Assessment		
Severity	**Likelihood**	**Risk Score**
5 Catastrophic	5 Almost	25

Target Assessment		
Severity	**Likelihood**	**Risk Score**
5 Catastrophic	5 Almost	25